



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Cultural Competency in Assessing and Treating Opioid Use Disorder

Disparities in health care, which are complex and pervasive, have implications for the assessment and treatment of opioid use disorder. Awareness of some of the core disparities provides clinicians with an opportunity to educate others, advocate assertively on behalf of patients, and anticipate treatment challenges.

Contributors to health-care disparities at the provider and systems levels include the following:

- Explicit and implicit clinician biases, such as misperceptions that African Americans experience less pain and may have greater addiction propensity.
- A lower probability of receiving buprenorphine treatment among people of color relative to higher income and non-Hispanic white counterparts.
- Misperceptions that patients with low health literacy, limited English language fluency, or who do not understand medication instructions will be less compliant, leading to attributions of patient noncompliance.
- Lack of culturally specific services.

Patient-level contributors to health-care disparities include:

- Hesitation to seek or accept professional intervention due to concerns regarding misdiagnosis, cultural mistrust, and cultural norms that may be inconsistent with treatment (e.g., self-reliance, beliefs that pain is inevitable and can be managed without prescription medication, fear of substance use disorders, and use of complementary or alternative treatments).
- Greater reticence to report opioid use due to fears of criminal prosecution or removal of parental rights (people of color are more likely to experience punitive criminal justice outcomes).

Given these and other biases, the following recommendations are provided for consideration as part of an integrated approach to the complex interactions between race, ethnicity, socioeconomic status, cultural context, and geography.

RECOMMENDATION 1

Develop a working knowledge of possible treatment barriers among racial/ethnic minorities, with consideration of health-care system, provider, and patient factors.

Barriers may include lack of adequate medical insurance and health system policies (e.g., hours of operation, cost, location of services); provider bias (e.g., inhumanization, stereotypes) toward certain groups or a lack of cultural humility; lack of culturally specific services; and patient hesitation to seek or accept professional intervention due to concerns regarding misdiagnosis, cultural mistrust, and cultural norms that may be inconsistent with treatment (e.g., self-reliance, a focus on religion). Moreover, disparities in the risk of criminal justice involvement for opioid misuse can result in concerns among people of color about confidentiality and the consequences of self-disclosure to a clinician.

RECOMMENDATION 2

Assess beliefs and expectancies regarding opioid use disorder treatment.

Enhance the standard intake and/or assessment with additional inquiries about treatment preferences and barriers to uptake and adherence, and provide feedback during the initial meeting. Knowledge of factors that may influence the care of racial/ethnic minority patients with opioid use disorder contributes to accurate cultural formulation of cases, proactive addressing of barriers, and satisfactory clinical encounters.



Disparities in the risk of criminal justice involvement for opioid misuse can result in concerns among people of color about confidentiality and the consequences of self-disclosure to a clinician.

For example, a 50-year old Hispanic male diagnosed with opioid use disorder who presents in a psychiatric clinic may believe that receiving treatment is a sign of vulnerability. He may also be hesitant to take a medication to treat his opioid use disorder. A brief assessment of beliefs regarding medications and counseling would allow a “teachable moment” regarding opioid use disorder and the benefits of buprenorphine. Assessment items might include: “Describe your experience in health-care settings. Overall, have they been positive or negative?” “What would you expect from another medication to help reduce your use of opioid?” Normalizing language intended to assess barriers can also be used, including “Some people may be worried about using a new medication to help them stop using opioids. What do you think?” Such questions can help providers determine whether potential ethnocultural concerns are relevant for individual patients.



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RECOMMENDATION 3

Deliver culturally appropriate care for opioid use disorder.

Culturally competent clinicians are aware of their own biases and stereotypes, as well as cultural factors that may influence patients’ opioid use, maintenance, abstinence, and relapse. In addition, culturally competent clinicians seek to gain the knowledge and skills to address these individual difference variables. Provider–patient communication should follow a model of shared decision-making to reduce unmet provider communication needs and increase adherence. Finally, shared decision-making processes should include significant others (e.g., family members, religious leaders), where appropriate.

Important note. There are significant individual differences in cultural beliefs and practices within racial/ethnic groups. These recommendations are offered as guidelines to consider as a component of a holistic approach while recognizing the potential importance of within-group heterogeneity across interrelated variables, such as race, ethnicity, socioeconomic status, cultural context, and geography.