Hanlon-Wilde J, Rodriguez Y, Eddy L. Perspectives of rural, English and Spanish-speaking families on healthcare for alcohol use disorder. *BCPHR*. 2026;April 2026(95). doi:10.54111/001c.156424

Boston Congress of Public Health Review - 2025-Present

Perspectives of rural, English and Spanish-speaking families on healthcare for alcohol use disorder

Jennifer Hanlon-Wilde, MSN, MA, DNP[1], Yolanda Rodriguez, BSN, DNP[1], Linda Eddy, PhD[1]

[1] College of nursing, Washington State University

Keywords: alcohol use disorder, heavy alcohol use, Spanish-speaking, rural health, patient perspectives on healthcare

https://doi.org/10.54111/001c.156424

Boston Congress of Public Health Review (BCPHR, Formerly HPHR)

Vol. April 2026, Issue 95, 2026

Introduction

Heavy alcohol use and alcohol use disorder (AUD) are prevalent in the U.S., particularly in rural areas, and are associated with significant morbidity and mortality. AUD occurs across all demographics; while treatment rates are below 10% for all groups, individuals from diverse backgrounds experience additional socioeconomic, linguistic, and cultural barriers to care. Learning about the patient experience can offer actionable recommendations for health systems and healthcare workers (HCW) to make such care more accessible and equitable.

Methods

This study employed listening sessions in English and Spanish to explore the perspectives of individuals who previously had received alcohol use treatment, and their family members, living in the rural Pacific Northwest. Using qualitative descriptive methodology, we identified both overlapping and distinct themes in the two linguistic groups.

Results

Spanish-speakers reported frustration with alcohol-related resources being in English, wanted HCW to include family members more, and reported life stressors as a trigger for alcohol use. English-speakers reported not answering questionnaires honestly, struggling to ask for help, and feeling that trauma and family issues are not well understood by HCW. Additionally, one American Indian participant reported experiencing overt racism. Among both groups, support groups and outreach were highly valued; participants wanted HCW to be more proactive; both groups recognized trauma as both a cause and effect of alcohol and cited a lack of trust in HCW.

Discussion

Results suggest directions for HCWs and systems to improve the experience for patients with alcohol problems, such as allowing time to build relationships, offering linguistically appropriate resources, and addressing stress and trauma.

Conclusion

The patient experience with healthcare for alcohol use disorder was mixed, but generally unsatisfactory for both groups. Improvements are needed.

INTRODUCTION

Heavy alcohol use, including alcohol use disorder (AUD), is prevalent in the U.S., particularly in rural areas, and is associated with over a hundred thousand annual deaths.[1,2] Morbidity and mortality related to alcohol had already increased steadily over the previous two decades, then accelerated during the COVID-19 pandemic.[3,4] While the opioid crisis is widely recognized, deaths related to alcohol actually outnumber opioid overdose deaths due to alcohol's role in motor vehicle crashes, end-organ disease, unintentional injury, homicide, and suicide.^4 ^Alcohol is also a cofactor in approximately 15% of opioid overdoses.[5]

Healthcare providers can address alcohol use problems using the screening, brief intervention, and referral to treatment (SBIRT) model. While data is mixed on the effectiveness of brief interventions,[6,7] for very heavy users of alcohol, medication treatment is highly effective in conjunction with psychotherapeutic modalities.[8] Nevertheless, treatment rates are low. According to the National Institute of Alcohol Abuse and Alcoholism (NIAAA), of all Americans over the age of 12 with a diagnosis of AUD, only 7.8% received treatment in the previous year.[2] Rates were similar for people identifying as white (8.1%) and Hispanic or Latino (8.6%), but only 3.4% for those identifying as Black or African American.^10 ^Individuals with Medicaid coverage had even lower treatment utilization, with the lowest rates among Latinx females.[9]

Given the effectiveness of treatment, it is important to understand why treatment rates remain low. Identified barriers on the HCW side include time constraints, a sense that treatment is futile, and discomfort with raising the topic of alcohol use.[10] On the patient side, lack of access to healthcare in general is problematic for many Americans. Individuals from diverse backgrounds, especially those without English proficiency, experience additional socioeconomic, linguistic, and cultural barriers to care.[11] In rural areas, high turnover of healthcare providers, structural factors such as poor infrastructure and workforce shortages, and relatively poor access to resources such as cultural centers and professional interpreter services create additional access issues.[12] Some of our data illustrate these factors, especially about language services and provider turnover. Little is known about the subjective experience of individuals in rural settings who receive healthcare for alcohol use problems, especially those whose primary language is Spanish. Learning about the patient experience can yield actionable recommendations for healthcare systems and healthcare workers (HCWs), particularly for providers such as physicians and nurse practitioners.

This exploratory qualitative study took place in an agricultural, low-income county in the Pacific Northwest with a significant proportion of Spanish-speaking inhabitants, including many farmworker families. While the study is small and context-specific, there may be some generalizable insights that can be gleaned from the data; the setting is not unique, as rural areas across the country employ farmworkers with roots in Mexico, and many Western communities have disproportionate rates of alcohol use disorder.

METHODS

A community agency with two decades of experience in this rural county setting, well known for offering bilingual social services, provided recruitment services and hosted the listening sessions. The agency used flyers and word of mouth to recruit a purposive sample of individuals and families affected by alcohol use. Participants received a $50 gift card for their time. Approval was granted by the Mid-Columbia Medical Center research committee. Next Door group facilitators ran the sessions virtually due to the COVID pandemic. Two 90-minute listening sessions were held via videoconference, one in English (N=6) and one in Spanish (N=10). The primary investigator sat in on the sessions but did not participate.

Participants were asked about their own and family members' experiences seeking and receiving help with alcohol use from HCW. Follow-up questions solicited participants' opinions on how HCW should address alcohol use and what HCW should know about families affected by AUD.

Results were transcribed and professionally translated into English. Three investigators (the authors) independently read and coded the transcripts for themes using principles of qualitative descriptive methodology.[13] Investigators used Excel to organize the questions and responses, then added separate pages to code the data and file text under themes; we came together in a series of meetings to share our findings and identify common themes. Since one of our team members has many years of experience performing qualitative descriptive analysis of this type of data, considerable weight was given to her views; when differences in interpretation arose, we returned to the data and discussed it until consensus was achieved. All team members agreed on the final themes. We identified recurring themes that arose in the English-language group, then the Spanish-speaking group, and then noted which themes overlapped.

RESULTS

More themes were common to both groups than unique to one, with the exception of linguistic access. Conceptually, all the issues our group members reported should be considered as important and potentially relevant to all persons, while acknowledging that each group offered a unique perspective.

Common themes in the two groups: In both groups, participants reported finding support outside of the healthcare setting. Support groups, friends, and relatives who had experienced AUD, and church members were cited as helpful. Rarely were HCW consulted as the initial step towards getting help, unless the alcohol use led to acute medical problems, as in this case: "I was drinking for a straight year. I had to go to the hospital for mixing my meds and alcohol. I was in bad shape." Even in that case, participants recalled non-medical people offering help within the healthcare setting, such as the hospital chaplain or "some ladies (who) came to talk to me."

However, healthcare was also seen as important, even if imperfect. In both groups, people wanted HCWs, especially providers such as physicians and nurse practitioners, to be more proactive in providing outreach, education, and follow-up. Some participants reported wanting to be asked about alcohol use, and others wanted their provider to remember and follow up on these discussions: "It is important that once the problem is detected, they should call them often so that they know they care and want to help them. Set goals with them… don't wait a long time between follow-ups, so you lose them."

Trust emerged as a theme in both groups. Participants were more likely to disclose alcohol problems to a trusted nurse or provider, but trust was not given readily. Having "random doctors" or new providers at every visit did not promote trust. One participant said, "Not being able to open up to doctors. People have a hard time opening up to doctors. I don't like to give doctors information, only enough to help me. I don't want them to know everything." Two participants did report trusting their doctors; one adult participant had seen the same doctor since the age of four years, and the other reported that their new doctor was consistent and followed up regularly: "She always makes sure that I have the info that I need. She also follows up after giving me resources, to see if I used them or [if] I need help."

The common experience of *harm* emerged as a theme in both groups. Participants recognized that alcohol use caused harm to them and their families, and also pointed out that previous harm and trauma contributed to their alcohol use.

English-language group themes: In addition to the themes noted in both groups, the English-language group reported that they did not answer truthfully on health questionnaires and reported being very reluctant to open up to new doctors.

Participants in this group were unanimous in pointing out that HCWs do not seem to understand or address trauma and family issues. "Doctors should know that it is a generational thing. Generational change." One participant recommended "learning about family trauma."

One English-speaking participant reported experiencing overt racism during treatment, stating, "When I got a DUI, I had to go to a program, and the person said to me, 'Oh, you're Native American, we already knew you were going to be an alcoholic.'"

Spanish-language group themes: Language barriers were frequently mentioned. Participants reported frustration when resources and written materials were not available in Spanish. "There are a lot of barriers for the Latino community and accessing resources."

Spanish-speakers particularly valued family involvement in care. They frequently expressed a desire for family members to be brought into treatment decisions and not excluded based on confidentiality, especially if the family member with AUD was their child. "As parents, we also suffer and, in a way, feel sick watching our kids go through this." One participant wished that treatment decisions could be made about the person with AUD: "They could help by not giving the person the choice when they are too far gone. It is hard for people to admit it, so making them get help would be good, and [it's] up to the loved ones to seek that help."

Some participants reported that an initial stressor led to their alcohol use. One participant specified that having a sick family member in Mexico caused depression and anxiety, which prompted him to start drinking. This group recognized a need for culturally and linguistically appropriate counseling services and social support.

DISCUSSION

The study is small and may be context-specific. The snapshot nature of the single listening session is another limitation. Unfortunately, it was not possible to follow up to learn more about specific experiences. For example, the experience of racism that was disclosed in the listening session is likely the tip of an iceberg, and the impact of that experience on acceptance and efficacy of alcohol treatment among Native American and other individuals from racialized, minoritized groups is worth exploring. Our positionality as researchers who are not, ourselves, members of the communities represented here is another potential limitation. Future research should focus on what types of interventions are most effective in rural populations with high rates of alcohol use problems and how these interventions can be offered without barriers.

CONCLUSION

Based on the data from this study, we make the following recommendations for HCW and system administrators in primary care or substance use disorder treatment settings with rural English and/or Spanish-speaking populations.

1. Be proactive. Follow up after appointments to check in, ask whether resources were used, and whether they were helpful. Schedule follow-up visits.
2. Acknowledge and address stressors and harms that may pre-date alcohol use, as well as the harms that result from such use.
3. Take time to build relationships with patients and engender trust.
4. Understand that patient honesty and accuracy on questionnaires about alcohol use may be limited, especially if a positive therapeutic relationship has not been previously established.
5. Learn about and acknowledge non-medical support systems such as Alcoholics Anonymous, the patient's friend group, and others.
6. Offer culturally appropriate, unbiased care, including resources in the patient's preferred language.
7. Offer to include family members in care planning around alcohol use disorder.

Health systems serving rural populations can:

1. Provide training in trauma-informed care for all HCW.
2. Make efforts to retain HCW and reduce turnover, especially of primary care providers, to allow trusting patient-provider relationships to develop.
3. Ensure that culturally and linguistically relevant materials and services are available.
4. Reduce the risk of explicit and implicit bias by implementing anti-bias policies, procedures, and training; recruit and retain a diverse health care workforce that reflects the community; and strengthen/develop partnerships with culturally based community organizations and leaders to help bridge the gaps between the healthcare system and minoritized people.

ACKNOWLEDGMENTS

The authors acknowledge and appreciate the families who participated in the listening sessions, The Next Door, Inc., for the assistance with recruitment and operations, and Debby Jones at Youth Think for funding this work.

DISCLOSURE STATEMENT

The authors have no relevant conflicts of interest to report. Funding for the listening sessions was provided by a grant for $6000 from Youth Think in The Dalles, OR, used to pay for professional transcription and translation, and $50 store gift cards for each participant.

AUTHOR POSITIONALITY

Jennifer Hanlon-Wilde: I write from my position as a white, female nurse practitioner, public health clinician, and nurse educator, with over 20 years of experience as a bilingual primary care provider in rural Oregon. My practice includes migrant farmworkers, orchardists, and many others, catalyzing my drive to improve health equity and culturally humble care via education, practice, and scholarship.

Yolanda Rodriguez: Dr. Rodriguez's work is informed by extensive experience across all levels of nursing and diverse healthcare systems. This breadth of practice shapes her patient-centered perspective, emphasizing dignity, respect, and the integration of patients' lived experiences into care and decision-making. Her clinical, educational, and scholarly efforts are guided by an awareness of how context, systems, and professional roles influence health outcomes and nursing practice.

Linda Eddy: My 39 years of practice as a pediatric nurse practitioner have been spent primarily working with families that often feel left behind in our current healthcare system: families experiencing houselessness, mental health challenges, and caregiving for children with special healthcare needs. This work informs my research, teaching, and clinical practice.

Submitted: January 07, 2026 EDT. Accepted: February 07, 2026 EDT. Published: February 07, 2026 EDT.

REFERENCES

1. Kaiser Family Foundation. A Look at the Latest Alcohol Death Data and Change Over the Last Decade. May 23, 2024. Accessed September 23, 2025. https://www.kff.org/mental-health/a-look-at-the-latest-alcohol-death-data-and-change-over-the-last-decade/

2. National Institute on Alcohol Abuse and Alcoholism (NIAAA). Alcohol-Related Emergencies and Deaths in the United States. August 2025. Accessed September 23, 2025. https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics-z/alcohol-facts-and-statistics/alcohol-related-emergencies-and-deaths-united-states

3. Planalp C, Au-Yeung C, Winkelman T. Escalating Alcohol-Involved Death Rates: Trends and Variation Across the Nation and in the States from 2006 to 2019. State Health Access Data Assistance Center (SHADAC). April 19, 2021. https://www.shadac.org/escalating-alcohol-involved-death-rates-trends-and-variation-across-nation-and-states-2006-2019

4. White AM, Castle IP, Powell PA, Hingson RW, Koob GF. Alcohol-related deaths during the COVID-19 pandemic. *JAMA*. Published online March 18, 2022. doi:10.1001/jama.2022.4308

5. Tori ME, Larochelle MR, Naimi TS. Alcohol or benzodiazepine co-involvement with opioid overdose deaths in the United States, 1999-2017. *JAMA Netw Open*. 2020;3(4):e202361. doi:10.1001/jamanetworkopen.2020.2361

6. Kaner EF, Beyer FR, Muirhead C, et al. Effectiveness of brief alcohol interventions in primary care populations. *The Cochrane Database of Systematic Reviews*. 2018;(2). doi:10.1002/14651858.CD004148.pub4

7. Platt L, Melendez-Torres GJ, O'Donnell A, et al. How effective are brief interventions in reducing alcohol consumption: do the setting, practitioner group and content matter? Findings from a systematic review and metaregression analysis. *BMJ Open*. 2016;6(8):e011473. doi:10.1136/bmjopen-2016-011473. PMID:27515753

8. McPheeters M, O'Connor EA, Riley S, et al. Pharmacotherapy for Alcohol Use Disorder: a systematic review and meta-analysis. *JAMA*. 2023;330(17):1653-1665. doi:10.1001/jama.2023.19761

9. Acevedo A, Adams RS, Cook BL, Feltus SR, Panas L, Stewart MT. Disparities in alcohol treatment use at the intersection of race, ethnicity, gender, and insurance. *Subst Use Addctn J*. 2025;46(1):78-89. doi:10.1177/29767342241278871

10. Rosário F, Santos MI, Angus K, et al. Factors influencing the implementation of screening and brief interventions for alcohol use in primary care practices: a systematic review using the COM-B system and Theoretical Domains Framework. *Implement Sci*. 2021;16(1):6. doi:10.1186/s13012-020-01073-0

11. Wolfe DM, Hutton B, Corace K, et al. Service-level barriers to and facilitators of accessibility to treatment for problematic alcohol use: a scoping review. *Front Public Health*. 2023;11:1296239. doi:10.3389/fpubh.2023.1296239

12. Javed A. Bridging the healthcare gap in rural populations: challenges, innovations, and solutions. *The American Journal of Medicine*. 2025;138(5). doi:10.1016/j.amjmed.2025.01.008

13. Doyle L. An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*. 2020;25(5):443-455. doi:10.1177/1744987119880234

SUPPLEMENTARY MATERIALS

Bios

Download: https://www.bcphreview.org/article/156424-perspectives-of-rural-english-and-spanish-speaking-families-on-healthcare-for-alcohol-use-disorder/attachment/328623.docx