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Understanding alcohol use disorder and help-seeking in a Hispanic faith-based community

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ABSTRACT

Introduction: Hispanic Americans are disproportionately affected by alcohol use disorders (AUD) yet many are reluctant to seek alcohol treatment. Faith-based communities could serve as an effective setting for raising awareness and supporting linkage to treatment given the strong role of faith within many Hispanic communities. Limited research, however, has focused on experiences of AUD and help-seeking among Hispanic Americans within congregational settings.

Methods: Using data from a California community-based longitudinal study of Hispanic church attendees with a probable AUD at baseline ($n = 169$), we examine the rates of help-seeking from health care providers and clergy at 1-year follow-up, and whether baseline sociodemographic characteristics and perceived need for treatment prospectively predict help seeking at 1-year follow-up.

Results: A little over half of the participants with AUD at baseline sought help from health care providers (30%), clergy (13%), or both (8%) at 1-year follow-up. Help-seeking from health care providers was significantly associated with perceived need for treatment at baseline ($OR = 4.05$) and reported clergy services at 1-year follow-up ($OR = 6.10$). Help-seeking from clergy at 1-year follow-up was solely associated with not having health insurance at baseline ($OR = 0.16$).

Conclusions: Findings highlight the potential role that faith-based communities can play in strengthening awareness of alcohol-related problems and reducing barriers to seeking care. Partnering with faith-based communities to promote early recognition and facilitate connections to treatment may enhance support for Hispanic individuals with AUD.

1. Introduction

In the United States (U.S.), Hispanic individuals are disproportionately affected by alcohol use disorder (AUD) (Correa-Fernandez et al., 2022; Guerrero et al., 2013; Robles et al., 2024).[1] Compared to non-Hispanic White adults who drink, Hispanic adults are more likely to experience alcohol-related problems (Mulia et al., 2009), report heavy drinking (Vaeth et al., 2017), and suffer greater adverse social consequences from drinking (e.g., alcohol-attributed partner violence) (Chartier & Caetano, 2010). Despite the pervasiveness of alcohol-related problems, Hispanic individuals are less likely to seek, access, and complete alcohol use treatment compared to non-Hispanic White individuals (Cuadrado, 2014; Pinedo et al., 2025; Vaeth et al., 2017).

U.S. Hispanic individuals may experience unique barriers to AUD treatment. In a national sample of individuals with an AUD, Hispanic individuals were less likely than non-Hispanic White individuals to seek treatment because of immigration-related fears, beliefs that receiving alcohol treatment would not be culturally accepted, and concerns that their treatment provider would not understand their culture (Pinedo et al., 2025). Even after controlling for various socio-demographic factors (nativity, gender, age, income, insurance status, recent history of alcohol treatment), immigration and cultural acceptance barriers

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[1] The Diocese of San Bernardino uses the term Hispanic when referring to their ministries and parish community which is the term adopted in this study in accordance with the Publication Manual of the American Psychological Association.

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continued to disproportionately hinder Hispanic individuals from seeking treatment. Preliminary evidence also suggests that alcohol treatment disparities may stem from Hispanic individuals being less likely than non-Hispanic White individuals to perceive a need for treatment (Pinedo & Villatoro, 2020). Moreover, whether an individual perceives an alcohol problem may be influenced by family and others' attitudes about AUD particularly within the Hispanic community given cultural values such as *familismo* which prizes the family unit over the individual (Boyer & Lutfey, 2010; Green & Pescosolido, 2024; Pinedo et al., 2018). Cultural factors can shape perceived need for treatment, potentially hindering access and recovery from AUD.

Faith-based communities could serve as an effective setting for raising awareness and supporting linkage to AUD treatment among those within the Hispanic community (Mulia et al., 2014; Torres et al., 2023; Villatoro et al., 2016; Wong et al., 2018). An estimated 70% of Hispanic individuals claim a religious affiliation, 43% are practicing Catholics, and 40% attend worship services at least once a week (Pew Research Center, 2023). Faith plays a strong role within many Hispanic communities, and many consider clergy to be a top and trusted resource for help with alcohol use problems (Carey et al., 2022; Garcia et al., 2022; Kane, 2003; Kane & Williams, 2000). Within Hispanic communities, clergy can also act as witnesses to alcohol abstinence pledges referred to as "juramentos"(Cuadrado, 2014; Hatchett et al., 2007) and thus model healthy practices for their congregation. Though these studies highlight the involvement of clergy and faith-based communities in supporting Hispanic individuals with AUD, most are qualitative studies with small samples.

Although faith-based communities and clergy can play an important role in addressing alcohol use problems (Hatchett et al., 2007; Torres et al., 2023), few studies have examined how Hispanic members of these communities experience AUD and how often they seek help from health care providers or clergy. Moreover, there is scant research on predictors of alcohol treatment use among Hispanic populations, particularly with respect to prospective longitudinal studies that examine the role of perceived need and perceptions of need among others within the social network of individuals with AUD (Pinedo & Villatoro, 2020; Zemore et al., 2009). If faith-based communities are a promising setting to reduce treatment access disparities, it is important to better understand how need for alcohol treatment is perceived and its utilization among Hispanic individuals within congregational settings.

To address the limited research in this area of study, the present study leveraged 12-month data from a community-based longitudinal study of Hispanic church attendees from the Roman Catholic Diocese of San Bernardino to examine: (1) the prevalence of probable AUD; (2) how common those with probable AUD sought help from health care providers and/or clergy; and (3) whether sociodemographic factors, perceived treatment need, and other-perceived need from family or others are prospectively linked with subsequent help-seeking from health care providers and clergy.

2. Methods

2.1. Participants

Participants (N = 1715) were drawn from a larger longitudinal randomized control trial (RCT) evaluating a multilevel, multicomponent parish-based intervention to increase mental health literacy, reduce stigma and improve service access for Hispanic church attendees from the Roman Catholic Diocese of San Bernardino which serves California's Riverside and San Bernardino counties (Wong et al., 2023) (ClinicalTrials.gov Identifier: NCT03631745). Participants were recruited from 14 churches within the Diocese with eligibility requirements limited to Spanish- or English-speaking church attendees who were at least 18 years old and regularly attended parish activities (at least twice in the past month). Participants received stipends of $20 for the baseline survey and $30 for the one-year follow-up. All study procedures were approved by RAND's Human Subjects Protection Committee. Participant retention from baseline to the one-year follow-up was 68%, which is considered acceptable. From the parent study sample (N = 1715), the subset of participants who met criteria for probable AUD based on AUDIT-C screening criteria at the baseline survey were included in the current study (n = 169). Among the subset of participants with baseline probable AUD (n = 169), 104 completed the one-year follow-up survey. The final analytic sample for models predicting health care provider and clergy service use consisted of participants who had complete data for predictor and outcome variables (n = 102). Comparisons between participants with probable AUD who were retained versus lost to one-year follow-up revealed no significant differences in baseline characteristics (see Supplemental Table S1).

2.2. Measures

Participant demographics included gender, age, educational attainment, income, language proficiency, health insurance, and nativity or US-born status. *Gender* was coded such that 1 = *females* and 0 = *males*. *Age* in years was calculated based on the number of years since the participant's birth. Age in years was then recoded as follows 1 = *18–26 year old*, 2 = *27–50 years old*, 3 = *51–64 years old*, and 4 = *65 years or older*. *Educational attainment* measures the highest level of education completed by the participant. Education was categorizedas: 6th grade or less; 7 to 11th grade; high school graduate or GED; some college (no degree); associate's degree; bachelor's degree (BA, BS); and some graduate school coursework. *Income* was measured by assessing the total family income in the past year for all sources (including oneself). Total income included interest or dividends, rent, Social Security, other pension, alimony or child support, unemployment, public aid, and armed forces/veterans' allotment. Responses were coded such that 1 = *$19,999 or less*, 2 = *$20,000-$49,999*, 3 = *$50,000-$99,999*, and 4 = *$100,000 or more*. *Language proficiency* was assessed by asking participants how well they spoke Spanish and English and then recoded to indicate fluency in one, both (bilingual), or neither language. *Health insurance* coverage was determined by asking participants if they have health insurance or coverage (including Medi-Cal and Healthy Families) that helps pay for medical bills. Having any form of insurance was coded as a 1 (*Medi-Cal/Healthy Families, Medicare, My Health LA, and private insurance*). Those with no health insurance were coded as 0. *Nativity (US-born) status* was determined by asking participants at what age they came to the US. Individuals who indicated they had lived in the US their whole life were coded as 1 and all other responses were recoded as 0 (i.e., all ages for US entry values).

2.2.1. Self-perceived need

Participants were asked in the past year if they felt the need to see a professional because of problems with your mental health, emotions or nerves, or alcohol or drugs (1 = *yes*, 0 = *no*) (CHIS, 2018).

2.2.2. Other-perceived need

Participants were asked in the past year if they felt there was any other person (relative, friend, neighbor, minister, priest or other) who thought they had a nervous, emotional, drug or alcohol problem (1 = *yes*, 0 = *no*) (Alegria et al., 2004).

2.2.3. Alcohol use disorder

The valid and reliable 3-item AUDIT-C (Bush et al., 1998) measure was used to determine probable AUD (sample α = 0.70). Items asked participants to determine the frequency that they drank alcohol (responses ranged from 0 = *never* to 4 = *4 or more times a week*), had six or more drinks on a single occasion (0 = *never* to 4 = *daily or almost daily*), and the number of drinks they typically drink when drinking (responses ranged from 0 = *0, 1, or 2 drinks* to 4 = *10 or more drinks*). Items were summed (range 0–12) and then participants were classified as screening positive for probable AUD if they scored ≥3 for women or ≥4 for men

based on established guidelines (Bradley et al., 2007).

2.2.4. Study condition

As the original study was designed as an RCT (Wong et al., 2023), we also included a study condition indicator to control for potential intervention effects. Participants in the study intervention condition were coded as 1 and those in the wait-list control condition were coded as 0.

2.2.5. Help-seeking for mental health or substance-related problems

Participants were asked in the past six months whether they had seen any of the following for problems with their emotions or nerves, or their use of alcohol or drugs: primary care physician or general practitioner; counselor, psychiatrist, psychologist, or social worker; or spiritual counselor or advisor like a priest or church leader (Alegria et al., 2004). Participants were coded as having sought services from a health care provider if they endorsed seeing either of the first two types of providers. Participants were coded as having sought clergy services if they had endorsed seeing a spiritual counselor/advisor. Responses were coded 1 = *yes*, 0 = *no*.

Health care provider and clergy service use were assessed at one-year follow-up, all other variables were assessed at baseline (i.e., demographics, self- and other-perceived need, AUD, and study condition).

2.3. Analytical plan

Logistic regressions were used to determine the factors associated with binary outcomes including use of health care provider or clergy services among our sample of Hispanic community members. Unadjusted (bivariate) as well as adjusted logistic regressions included select participant demographics, self-perceived need, and other-perceived need with estimated coefficient (odds ratio or *OR*), 95% confidence intervals, and model fit statistics details (*N*, likelihood ratio chi-square, *p*, and pseudo-R-square values) presented. The likelihood ratio chi-square test and McFadden's pseudo-R square values were generated by comparing the specified model to a model without any predictors (intercept only model) to provide evidence of model fit. Use of clergy services was also included as a predictor for health care provider service use. All adjusted models include study condition as a control variable. Analyses were conducted using complete case analysis, excluding observations with missing data on any variables included in the analytic models. Sample descriptive statistics were also presented as *N* and percentages.

3. Results

Of the 1715 participants with baseline data, 9.85% (n = 169) met criteria for an AUD according to the 3-item AUDIT-C (Bush et al., 1998). The mean AUDIT-C score for our sample of probable AUD individuals was 5 (SD = 1.8; scores range from 0 to 12). Descriptives for participants with baseline AUD (n = 169) are presented in Table 1. Our sample identified as majority female (58%), middle aged (54% aged 27–50 years and 26% aged 51–64 years), and Spanish-speaking (38% Spanish proficient and 55% bilingual). Most participants had access to health insurance (73%) and around a third were born in the U.S. (31%). Additionally, participants had on average a high school degree or GED (M = 2.39; SD = 1.22) and earned between $20,000–$49,999 a year (M = 2.35; SD = 0.91). At one-year follow-up, participants with baseline AUD reported receiving services for mental health or substance-related problems from health care providers (30%), clergy (13%), or both (8%). Only slightly over a third (33%) reported perceiving a need for services from health care providers.

Results from unadjusted and adjusted logistics regressions for health care provider service use can be found in Table 2. Unadjusted analyses (Model I) indicated that self-perceived need (OR = 2.66) and use of clergy services (OR = 3.88) were associated with a greater likelihood of receiving services for mental health or substance-related problems from health care providers, but no significant associations were observed for

Table 1
Sample descriptives among those with a baseline AUD (n = 169).

	N	%
Female	169	57.99
Age	167	
18–26	24	14.37
27–50	90	53.89
51–64	43	25.75
65+	10	5.99
Education	168	
Less than high school	53	32.55
High school graduate or GED	39	23.21
Associate's degree or some college	41	24.40
Bachelor's degree	27	16.07
Graduate degree	8	4.76
Income	158	
$19,999 or less	31	19.62
$20,000-$49,999	56	35.44
$50,000-$99,999	55	34.81
$100,000 or more	16	10.13
Language proficiency	168	
Bilingual	92	54.76
English	8	4.76
Spanish	64	38.10
Neither	4	2.38
Nativity status (U.S. Born)	169	31.36
Health Insurance	169	73.37
Self-perceived need	166	33.13
Other perceived need	167	31.14
Intervention	169	50.30
Help seeking (1-year post-baseline)[a]		
Health care providers	104	29.81
Clergy	104	13.46
oth	104	7.69

Note. Sample descriptive statistics are based on those who meet diagnostic criteria for an alcohol use disorder or AUD at baseline (n = 169). For this subsample of participants, the average AUDIT-C severity score was 4.67 (SD = 1.84).

[a] The correlation between seeking help from a health care provider (mental health, primary care or general practioner) or clergy member for those with an AUD was small (r = 0.24).

Table 2
Logistic regression of health care service use at one-year follow-up among those with baseline AUD (n = 169).

	Model I. Unadjusted *OR* (95% *CI*)[a]	Model II. Adjusted *OR* (95% *CI*)[b]	Model III. Adjusted *OR* (95% *CI*)[b]
Female	1.14 (0.49, 2.67)	0.90 (0.35, 2.34)	0.72 (0.26, 1.97)
Education	1.15 (0.81, 1.65)	1.04 (0.72, 1.52)	1.11 (0.75, 1.65)
Health Insurance	1.38 (0.52, 3.70)	1.35 (0.48, 3.75)	2.17 (0.68, 6.91)
Self-perceived need	2.66 (1.09, 6.50)*	3.27 (1.04, 10.27)*	4.05 (1.20, 13.63)*
Other perceived need	1.53 (0.62, 3.79)	0.82 (0.27, 2.50)	0.66 (0.21, 2.13)
Clergy service use	3.88 (1.22, 12.39)*		6.10 (1.50, 24.75)*

Note. Table abbreviations represent odds ratios (*OR*) and confidence intervals (*CI*). Model I includes only bivariate logistic regression statistics. Adjusted logistic regression model fit statistics are as follows: Model II.) $LR\ \chi^2 = 7.18$, $df = 6$, $p = 0.30$, Pseudo $R^2 = 0.06$ and Model III.) $LR\ \chi^2 = 14.17$, $df = 7$, $p = 0.05$, Pseudo $R^2 = 0.11$. The primary distinction between Model II and Model III is the inclusion of one predictor variable or seeking help from clergy 1 year post-baseline (clergy services). Models II and III controlled for study condition. In model III a total of 31 people reported receiving health care services at the one-year follow-up.

*$p < 0.05$.

[a]Model n = 104 except for self as well as other perceived need and education models (n = 103).

[b]Model n = 102.

sociodemographic factors. Adjusted regression analyses that simultaneously included sociodemographic and perceived need variables (Model II) found that self-perceived need was the sole significant factor associated with over a three-fold increase in odds ($OR = 3.27$) of health care provider service utilization at the 1-year follow-up relative those who did not perceive a need for services. Upon adding clergy services as a predictor, both self-perceived need ($OR = 4.05$) and clergy services ($OR = 6.10$) were found to be significantly and positively associated with health care service use 1-year later (Model III).

With respect to clergy services for mental health or substance-related problems, unadjusted (Model I) and adjusted (Model II) logistic regression models indicated health insurance status as the core driver of significance (see Table 3). Having health insurance coverage was associated with a lower likelihood of clergy service use (unadjusted $OR = 0.21$). Even after accounting for other sociodemographic factors and self- and other-perceived need, health insurance remains the only significant predictor of clergy service use ($OR = 0.16$), with participants indicating an 84% decrease in clergy services if they had health insurance coverage. Marginal effects ($p < 0.10$) were also found for participants who identified as female. These trend-level associations indicated that females, relative to males, were more likely to seek the counsel of clergy ($OR = 3.33$).

4. Discussion

U.S. Hispanic individuals experience high rates of AUD and low rates of alcohol treatment utilization (Vaeth, et al., 2017). Our study is the first to examine the prevalence and help-seeking patterns of Hispanic individuals attending Catholic churches. We found that participants had high rates of probable AUD – close to 10% – based on AUDIT-C screening criteria. This prevalence is comparable to the national estimate of 12-month AUD among U.S. adults (10.9%), which is based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (SAMHA, 2024). However, because the AUDIT-C is a screening measure for hazardous and harmful drinking rather than a diagnostic instrument, this comparison should be interpreted as contextual rather than direct equivalence between prevalence estimates. Only half (51%) of those with probable AUD based on AUDIT-C screening in our sample received help for mental health or substance-related problems from health care providers and/or clergy in the 1-year follow-up, indicating high rates of AUD and unmet treatment needs.

Predictors of help-seeking behavior for mental health or substance-related problems differed depending on whether assistance was being garnered from a health care provider or a member of clergy. Hispanic individuals with an AUD were more likely to seek services for mental health or substance-related problems from health care providers if they perceived a need for help. Self-perceptions around alcohol treatment need have been consistently observed as a driver of service use among individuals with AUD (Edlund et al., 2009; Mojtabai & Crum, 2013; Schuler et al., 2015), underscoring how self-recognition of problematic alcohol use can be essential toward initiating treatment. Faith communities could play a role in enhancing self-recognition of problematic alcohol use among Hispanic members through screening initiatives and culturally and faith-based tailored education. Given that stigma could act as a barrier to both acknowledging alcohol use problems and initiating treatment (Kilian et al., 2021; Kulesza et al., 2014), faith communities could also assist with decreasing stigma and promoting earlier recognition of the need for treatment (Torres et al., 2023; Wong et al., 2018). Future research should explore how faith communities can promote treatment initiation by increasing awareness of problematic alcohol use and reducing stigma associated with AUD.

Hispanic individuals with AUD were more likely to report help-seeking for mental health or substance-related problems from health care providers at 1-year follow-up if they had also reported seeking help for mental health or substance-related problems from clergy at 1-year follow-up. Given that help seeking from clergy was assessed only at 1-year follow-up, it is unclear whether receiving help from clergy preceded or followed receiving help from health care providers. Nevertheless, our findings indicate that a substantial proportion, approximately 1 in 5, Hispanic individuals with AUD had received help for mental health or substance-related problems from clergy (13% sought help from clergy alone; 8% from both clergy and health care providers). Our study adds to qualitative studies that have shown that clergy can offer timely, personal resources to Hispanic individuals experiencing probable AUD (Cuadrado, 2014; Garcia & Gonzalez, 2009). Clergy are viewed as valuable gatekeepers of care (Heseltine-Carp & Hoskins, 2020) whose services can pave the way to formal treatments (Bohnert et al., 2010). Within Hispanic communities, the importance placed on the family (*familismo)* may influence perceptions of need for help either by encouraging treatment when family members recognize a problem or by discouraging outside help due to preferences for handling problems within the family (Pinedo et al., 2018; Robles et al., 2024). Clergy, who are closely involved in significant family events (such as baptisms, weddings, and funerals) and maintain a visible presence in the community, may be particularly well-positioned to challenge harmful stereotypes about addiction treatment while also offering support to individuals in need. In predicting help-seeking for mental health or substance-related problems from clergy for those with reported AUD at the 1-year mark, we find that clergy help is more often sought by those *without* health insurance, suggesting that clergy members may be especially important in addressing alcohol use problems for the underserved (Garcia et al., 2022).

This study has limitations that prevent us from detailing the nature or extent of clergy aid. That is, as we did not explicitly measure the kind of supports clergy provided, perceptions of support quality, and their short- or long-term efficacy at curtailing alcohol addiction; thus we are unable to comment on the mechanistic utility of clergy help for individuals reporting an AUD. More work is therefore needed on understanding the role that clergy play in addressing AUD within faith-based communities. This study also relied on self-reported data, which may be affected by recall errors or social desirability bias given the sensitive nature of alcohol use and help-seeking behaviors within faith-based community settings. Also, our sample was limited to Catholic churches in southern California, which affects the generalizability of our results. For instance, our study may not capture the experience of Hispanic communities in other geographic regions of the U.S. nor the potential variation in how sub-groups perceive and respond to AUDs given the cultural and ethnic heterogeneity of the Hispanic population. Future research with more culturally and geographically diverse samples ris needed to examine AUD prevalence and help-seeking behaviors in

Table 3
Logistic regression of clergy services at one-year follow-up among those with baseline AUD ($n = 169$).

	Model I. Unadjusted *OR* (95% *CI*)[a]	Model II. Adjusted *OR* (95% *CI*)[b]
Female	2.19 (0.64, 7.49)	3.33 (0.80, 13.79)†
Education	0.81 (0.49, 1.34)	0.70 (0.38, 1.29)
Health Insurance	0.21 (0.07, 0.69)*	0.16 (0.04, 0.59)**
Self-perceived need	0.92 (0.26, 3.19)	0.62 (0.11, 3.36)
Other perceived need	1.42 (0.43, 4.66)	2.87 (0.56, 14.65)

Note. Table abbreviations represent odds ratios (*OR*) and confidence intervals (*CI*). Model I includes only bivariate logistic regression statistics. Model I and II also included study condition. Model II adjusted logistic regression model fit statistics are as follows: *LR* $\chi^2 = 14.80$, $df = 6$, $p = 0.02$, Pseudo $R^2 = 0.18$. In model II a total of 14 reported receiving clergy services at the one-year follow-up.

†$p < 0.10$. *$p < 0.05$. **$p < 0.01$.

[a]Model $n = 104$ except for self as well as other perceived need and education models ($n = 103$).

[b]Model $n = 102$.

Hispanic faith-based communities. In addition, findings should be interpreted with caution given the small sample size and low number of respondents who had sought help from health care providers or clergy, which may have resulted in unstable estimates. Given that preliminary analyses (not presented) indicated minimal between-parish variation and the small number of clusters which could result in unstable adjusted estimates, we did not adjust for clustering which may have yielded narrower confidence intervals. Findings should also be considered in light of the cross-sectional nature of the clergy and health care provider service use association at one-year follow-up and the use of the AUDIT-C as a screening tool to establish probable AUD instead of diagnostic assessment. Finally, our study did not examine other potential co-occurring mental health conditions such as depression and anxiety, which may influence rates of help-seeking. For instance, in U.S. national sample of college students, the number of mental health diagnoses moderated the association between alcohol use risk and mental health support seeking (Qeadan & Egbert, 2025).

Addiction is complex and is influenced by cultural factors, so it stands to reason that effective treatment might involve a robust network of supports. For Hispanic parishioners with an AUD, support *within* the church may be an important catalyst for help-seeking such that trusted encounters with clergy may help facilitate and encourage linkages to treatment. Clergy members have been described within the Hispanic community as natural caregivers in the context of addiction (Pillion et al., 2012), so efforts to train and integrate faith-based communities to facilitate AUD treatment linkages (Mulia et al., 2014) has the potential to benefit members of faith communities of Hispanic and non-Hispanic origins alike. Clergy can be instrumental in helping individuals and their families recognize alcohol-related issues and the perceived necessity for treatment, while also fostering vital connections with the treatment community (Torres et al., 2023).

Faith-based communities have a long history of caring for a broad spectrum of physical, emotional, and community needs, which include offering programs to support individuals with AUD. At a national level, *over a third* of all U.S. congregations (38%) provide programming to support people with drug or alcohol use problems (Torres et al., 2023). Faith-based communities have been recognized as invaluable partners who can play a key role in providing substance use prevention, intervention, and recovery services (Travis et al., 2021). Federal initiatives have recognized the critical role faith-based communities have in combating the substance use epidemic in the U.S. For more than three decades, the Substance Abuse and Mental Health Services Administration (SAMHSA) has supported faith-based communities' involvement in the delivery of local, grass-roots substance use prevention and treatment programs, providing education, training, curricula, and funding (SAMHSA, 2023). Expanding the delivery of high-quality alcohol-related services into alternative non-medical venues, such as within faith-based communities, has been posited as one solution to mitigate Hispanic disparities in alcohol outcomes (Mulia et al., 2014; Torres et al., 2023; Villatoro et al., 2016). Mulia et al. (2014) conducted simulation analyses and estimated that the disparity in receipt of alcohol-related services between U.S.-born Hispanic and non-Hispanic White individuals would be reduced by 39% if alcohol interventions were expanded into non-medical settings like faith-based communities. Integrating faith-based communities into the continuum of care for those experiencing AUD-related problems may be an effective means to reduce longstanding disparities within the U.S. Hispanic population.

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CRediT authorship contribution statement

Rupa Jose: Writing – review & editing, Writing – original draft, Conceptualization. **Mario O. Martinez:** Writing – review & editing, Project administration, Conceptualization. **Rachana Seelam:** Writing – review & editing. **Karen Chan Osilla:** Writing – original draft, Conceptualization. **Eunice Wong:** Writing – review & editing, Writing – original draft, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.abrep.2026.100670.

Data availability

The authors do not have permission to share data.

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