

PEER SUPPORT GROUP INITIATIVE FOR  
HISPANIC/LATINX INDIVIDUALS WITH ALCOHOL USE DISORDER  
IN RURAL MONTANA

by

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DEDICATION

To William, my husband, whose love, understanding, and grace made this work possible. And to my mom, whose help with dinners and daughters gave me the time and energy I needed. I am eternally grateful for you both.

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## TABLE OF CONTENTS

1. REVIEW OF THE LITERATURE .....	9
Introduction.....	9
Background and Significance .....	11
Methods.....	13
Search Strategy .....	13
Inclusion Criteria .....	14
Results.....	15
Synthesis of Literature .....	15
Peer Support Group Definition .....	15
PSG Benefits.....	16
Culturally Specific PSG Benefits.....	17
Overcoming Barriers with Structural Components of Culturally Sensitive PSG Implementation .....	18
PSG Group Content .....	19
PSG Facilitator.....	22
Outcome Measures.....	24
Discussion and Conclusions .....	25
2. PROJECT PROPOSAL .....	27
Introduction.....	27
Problem and Aim Statement .....	29
Organizational Context .....	30
Quality Improvement Model.....	32
Methods.....	34
Implementation Summary.....	34
Implementation Plan .....	35
Structural Elements of Culturally Supportive PSG Intervention .....	38
Facilitator, Facilitator Training and Facilitator Handbook .....	40
Overcoming Barriers to PSG Implementation .....	42
Evaluation and Analysis.....	44
SMARTIE Goals #1 and #2 .....	44
SMARTIE Goal #3 .....	46
SMARTIE Goal #4 .....	48
PDSA Cycles.....	50
Safety and Confidentiality .....	51
3. QUALITY IMPROVEMENT MANUSCRIPT .....	53
Contribution of Authors and Co-Authors .....	53
Manuscript Information .....	54

## TABLE OF CONTENTS CONTINUED

Clinical Problem .....	55
Review of the Literature .....	56
PSG Benefits.....	57
Structural Guidelines for Hispanic/Latinx PSGs .....	57
Facilitator Guidelines for Hispanic/Latinx PSGs .....	58
Conceptual Framework.....	60
Project Aim .....	60
Methods.....	60
Context.....	60
Intervention.....	61
Measures .....	65
Ethical Considerations .....	66
Analysis.....	66
Results.....	67
Attendance .....	67
Material Feedback.....	68
Facilitator Confidence.....	69
Outcomes Beyond Measured Projections .....	69
Discussion.....	70
Limitations .....	72
Recommendations.....	73
Conclusion .....	74
 4. ADVANCED NURSING ESSENTIALS REFLECTION .....	 75
Introduction.....	75
Domain One: Knowledge for Nursing Practice .....	75
Domain Three: Population Health .....	76
Domain Five: Quality and Safety .....	78
Domain Six: Interprofessional Partnerships .....	79
Domain Seven: Systems-Based Practice .....	81
Domain Eight: Informatics and Healthcare Technologies .....	82
Quality Improvement Implementation and Impact on Future Career.....	83
 REFERENCES CITED.....	 85
 APPENDICES .....	 95
PRISMA DIAGRAM.....	96
FACILITATOR HANDBOOK: ENGLISH WITH SPANISH ADDENDUM .....	98

## TABLE OF CONTENTS CONTINUED

WRITTEN MATERIALS FOR PARTICIPANTS: ENGLISH AND SPANISH .....	127
PEER PACKET: ENGLISH AND SPANISH.....	142
GROUP LEADER SELF-EFFICACY INSTRUMENT: FOCUSED.....	163
FLYERS .....	165
QUALITATIVE FEEDBACK QUESTIONNAIRE .....	168
ATTENDANCE SURVEY .....	170

## LIST OF TABLES

Table	Page
1. Table 1.1. Summary of the structural elements of culturally supportive PSGs.....	21
2. Table 1.2. Summary of facilitator guidelines for culturally supportive PSGs. .....	23
3. Table 2.1. Summary of costs.....	36
4. Table 2.2. Summary of structural elements of culturally supportive PSGs. ....	40
5. Table 2.3. Summary of facilitator guidelines for culturally supportive PSGs. .....	43
6. Table 2.4. SMARTIE Goal #1.....	45
7. Table 2.5. SMARTIE Goal #2.....	46
8. Table 2.6. SMARTIE Goal #3.....	47
9. Table 2.7. SMARTIE Goal #4.....	49
10. Table 3.1. Key components of culturally supportive PSGs summarized from the literature review.....	59
11. Table 3.2. Excerpted details from the project coordinator-created PSG Facilitator Handbook. ....	63
12. Table 3.3. Summary of implementation steps.....	65

## LIST OF FIGURES

Figure	Page
1. Figure 1.1. Project timeline.....	38
2. Figure 2.1. Graphic depiction of PDSA cycles and data evaluation intervals. .....	51
3. Figure 3.1. Bar graph depicting new and repeat PSG participant attendance by week. ....	68
4. Figure A1. Preferred Reporting Items for Systematic Reviews and Meta- Analyses (PRISMA) diagram. ....	97

## ABSTRACT

**Background:** Only 7.9% of Americans with Alcohol Use Disorder (AUD) received treatment in 2023. Hispanic/Latinx populations face further access disparities, especially in underserved rural areas. Peer support groups (PSGs) are the most frequently sought recovery resource, but language barriers often prevent Spanish speakers from participating. **Local Problem:** Although more than 15 English-language PSGs existed in the local Montana area, no Spanish-language PSGs were available. Spanish speakers with court mandates for AUD treatment and PSG attendance were risking jail time and deportation for non-compliance related to inaccessibility. **Intervention:** The project developed the skills of non-licensed personnel to initiate a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults with AUD. **Methods:** Data collection via facilitator surveys and analysis informed iterative adjustments to improve attendance, material efficacy, and facilitator confidence. **Results:** The resulting PSG consistently exceeded attendance targets with a mean of 5.2 participants and 85.2% repeat attendance. Alcoholics Anonymous material preparation and the freedom to follow participant-led discussions enabled facilitators to feel prepared, adapt to conversation flow, integrate new members, and utilize resources as needed. Facilitator confidence improved by a mean of 20% but remained below the 90% target. Group success and sustainability were exhibited by its continued operation, location contract assumption, secured funding for ongoing needs, and application for official AA recognition. **Conclusion:** This project demonstrated that non-licensed personnel could be equipped to effectively address provider scarcity and AUD treatment inequity by initiating culturally sensitive PSGs for Spanish-speaking Hispanic/Latinx adults with AUD.

**Keywords:** Hispanic, Alcohol Use Disorder, rural, peer support groups, Alcoholics Anonymous

## CHAPTER ONE

## REVIEW OF THE LITERATURE

Introduction

In the United States (U.S.), excessive alcohol consumption poses a significant threat to public health (Hall et al., 2023; Suzuki et al., 2023). Alcohol ranks as the leading cause of preventable death, leads to more than 178,000 fatalities annually, and resulted in an estimated \$249 billion economic burden in the United States in 2010 (Centers for Disease Control, 2024). Alcohol Use Disorder (AUD) is a chronic and relapsing disease involving compulsive alcohol use despite the harmful interpersonal, professional, and medical consequences (National Institute on Alcohol Abuse and Alcoholism, 2024c). AUD profoundly impacts society as well as the individual, resulting in disability, lost productivity, accidents, violence, imprisonment, and significant healthcare demand (Kelly et al., 2020). As of 2023, approximately 10.8%, or 28.1 million Americans, aged 18 and older, struggle with AUD (National Institute on Alcohol Abuse and Alcoholism, 2024b).

Certain underserved ethnic and racial minorities experience disproportionate AUD rates and negative health outcomes (Eghaneyan et al., 2020; Wagner & Baldwin, 2020). In 2023, the Hispanic/ Latinx community represented the largest U.S. ethnic minority and accounted for 19.5% of the total population, or over 65 million people (United States Census Bureau, 2023b). Projections anticipate Hispanic/Latinx population growth to reach 30% by 2050 (Bacio et al., 2015). As of 2023, approximately 4.6 million Hispanic/Latinx adults, aged 18 and older, suffer from AUD (National Institute on Alcohol Abuse and Alcoholism, 2024b). In 2022, 19.7%

reported binge drinking, consuming four or more drinks at once for women or five or more drinks at once for men during the past thirty days, or heavy drinking, consuming eight or more drinks per week for women or fifteen or more drinks per week for men during the last year (United Health Foundation, 2022).

Complex systemic disparities affect Hispanic/Latinx AUD rates. Acculturation stress, or a sense of isolation or exclusion from mainstream American society, can raise the risk of harmful coping mechanisms, including alcohol abuse (Barrio, 2000; Moyce et al., 2022; Rogers et al., 2022). Conversely, assimilation can also lead to problematic drinking behaviors. Hispanic/Latinx people who integrate more deeply within the U.S. culture, associate with non-Hispanic people, consume English-language media, and express U.S. cultural values are more likely to drink alcohol than those who speak Spanish, regularly visit their country of origin, and maintain a strong commitment to their Hispanic culture (Alvarez et al., 2007). Discrimination (Wagner & Baldwin, 2020), immigration trauma (Hall et al., 2023), socioeconomic hardship (Barrio, 2000; Eghaneyan et al., 2020; Wagner & Baldwin, 2020), and inequities in healthcare access (Wagner & Baldwin, 2020) compound stress-related triggers in the Hispanic/Latinx community.

As an emerging immigration hub, the Hispanic/Latinx population doubled in Montana since 2010 (Krogstad, 2020). According to the 2020 census, 4.2% of Montana's population, or approximately 45,900 individuals, identified as Hispanic (United States Census Bureau, 2023a). In Montana, 23.4% of White and 25.7% of Hispanic/Latinx adults report excessive drinking (binge or heavy drinking) (United Health Foundation, 2022). Regardless of race, the number of Montanans dying from alcoholism rose dramatically, from 29 in 2000 to 102 in 2020. Moreover, between 2015 and 2019, the alcohol-induced death rate for Montanans 25 years and older was

almost twice the national rate, at 27 per 100,000 compared to 15 per 100,000 (Montana Department of Public Health and Human Services, 2023b). The growing Hispanic/Latinx population in a state grappling with AUD underscores the urgency of addressing cultural disparities and disproportionate AUD rates within this Montana community.

### Background and Significance

Despite the high prevalence of alcohol use, the U.S. falls drastically short in treating AUD (Colditz et al., 2023; Worley, 2021; Yoo et al., 2020). In 2023, only 7.9% of Americans diagnosed with AUD received alcohol treatment of any kind (National Institute on Alcohol Abuse and Alcoholism, 2024a). In Montana, the ratio of 4,761 residents to each mental health provider (Rosston, 2022) further reduces the reach of AUD treatment. Moreover, the Hispanic/Latinx population experiences a variety of cultural barriers that interfere with treatment initiation such as limited English proficiency, lack of acculturation, reduced duration of residency in the U.S., and stigma related to discussing substance use problems (Eghaneyan et al., 2020; Substance Abuse and Mental Health Services Administration, 2014). Additionally, systemic issues impede Hispanic/Latinx access including limited health literacy, lower internet availability (Eghaneyan et al., 2020; Substance Abuse and Mental Health Services Administration, 2014), financial constraints, and lack of insurance (Arroyo, 2008; Barrio, 2000; Eghaneyan et al., 2020; Moyce et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Altogether, compounded disadvantage results in fewer recovery resources and more adverse consequences (Alvarez et al., 2007; Wagner & Baldwin, 2020) for Hispanic Montanans compared to their White counterparts.

National and state policies recommend expanding access to culturally and linguistically appropriate services and fostering recovery support groups in all communities (Montana Department of Public Health and Human Services, 2023a; Montana Legislature, 2023; U.S. Department of Health & Human Services, n.d.; U.S. Department of Health and Human Services, 2021); however, there are no Spanish-speaking or Hispanic/Latinx recovery services in many of the rural Montanan areas experiencing immigration growth. The inequity in service provision persists due to a lack of infrastructure development (Moyce et al., 2022), linguistically and culturally appropriate services (Enriquez, 2020; Substance Abuse and Mental Health Services Administration, 2014; Wagner & Baldwin, 2020) and Hispanic/Latinx providers (Arroyo, 2008). In 2008, the U.S. recorded 29 Hispanic/Latinx providers, compared to 173 White providers, for every 100,000 patients (Arroyo, 2008). Unsurprisingly, Spanish-speaking Hispanic individuals were seven times less likely to receive outpatient mental health services than non-Hispanic White individuals (Moyce et al., 2022). Language often bars Spanish speakers from participating in peer support groups (PSGs) (Substance Abuse and Mental Health Services Administration, 2014), which are the most frequently sought resources for those struggling with AUD in the United States (Kelly & Yeterian, 2011; Substance Abuse and Mental Health Services Administration, 2014). Since PSGs commonly complement or replace professional treatment, decreased access widens the treatment gap (Kelly & Yeterian, 2011) and increases negative outcomes (Eghaneyan et al., 2020).

The limited availability of Hispanic/Latinx professionals and the plurality of obstacles to treatment for this population in Montana highlight the urgent need for culturally responsive services. Although high-quality evidence examining AUD treatments in the Hispanic/Latinx

community is limited, inaction is unacceptable. The Montana Substance Use Disorder Task Force Strategic Plan Strategy 4.3 aims to expand access to culturally and linguistically appropriate services and foster recovery support groups in all communities (Montana Department of Public Health and Human Services, 2023a). Moreover, Montana Legislature Code 53-21-1012 details that mental health services must be made available regardless of race or ethnicity (Montana Legislature, 2023). Full compliance with the law demands practitioners actively pursue all available avenues toward advancing equitable practices. To reduce AUD treatment disparity in the Hispanic/Latinx community, this quality improvement project aims to develop the skills of non-licensed personnel in a rural Montanan recovery clinic to initiate a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults with AUD.

## Methods

### Search Strategy

A comprehensive search of the existing literature from 2007 to 2024 was conducted in September 2024 to examine outpatient treatments for Alcohol Use Disorder (AUD) in the Hispanic/Latinx (H/L) population. The investigation was carried out across five electronic databases including PsycINFO, Web of Science, CINAHL, PubMed and Google Scholar. A combination of MeSH terms, keywords and Boolean operators were used to form search headings such as “AUD treatment AND Hispanic OR Latinx,” “support groups AND Hispanic,” “peer support groups AND alcohol,” “support group initiation,” and “peer support groups AND facilitator.” A total of 247 varied articles were initially identified.

### Inclusion Criteria

A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram was created to assist with transparency and replication of results by depicting the refinement of evidence (see Appendix A). A review of abstracts reduced the initial 247 articles to 111 that focused on peer support groups or recovery treatments for the Hispanic/Latinx population. The search population was restricted to Hispanic/Latinx whenever possible, but generalized when specifics about peer support groups in this population were unavailable. While initiatives to enhance minority representation in clinical trials have been implemented, the Hispanic/Latinx community continues to experience underrepresentation (Eghaneyan et al., 2020) and a significant gap in scientifically validated research exists related to recovery interventions for Hispanic/Latinx individuals (Substance Abuse and Mental Health Services Administration, 2014). According to a scoping review of studies focusing on the Hispanic/Latinx population with substance use disorders (SUD) from 2000-2020, only 30% of studies had sample groups composed entirely of Hispanic/Latinx individuals. The remaining studies involved 10-44% Hispanic/Latinx individuals. Gray materials and non-English evidence were found to lack articles focused on the Hispanic/Latinx population and were excluded.

To ensure the inclusion of the highest-quality studies, criteria were then applied following Melnyk & Fineout-Overholt's Levels of Evidence, reducing 111 articles to 47. Level one represents the highest level of evidence, while level seven represents the lowest (Melnyk & Fineout-Overholt, 2023). Attempts were made to limit inclusion to the past five years; however, to incorporate higher quality evidence or more detailed data focusing on the Hispanic/Latinx population, publication dates on four of the final 12 articles extend the exclusion date to 2007.

All 47 articles were read to find the richest qualitative or most robust quantitative data that adhered to the implementation topic. Ultimately, twelve articles were retained for final analysis.

## Results

The final twelve articles and their level of evidence according to Melnyk & Fineout-Overholt's Levels of Evidence include one meta-analysis (level one), one randomized controlled trial (level two), two mixed-method trials (level three), one retrographic review of databases (level four), one cross-sectional study (level four), two narrative reviews (level five), one scoping review (level five), one empirical review (level five), one qualitative study (level six), and one protocol (level seven) (Melnyk & Fineout-Overholt, 2023). All the studies were conducted in the United States, with only 8% in rural areas. Studies included community (67%), inpatient (25%), and outpatient (25%) settings. Participants included Hispanic/Latinx individuals (67%), Spanish speakers (58%), and unspecified minorities (8%). All studies included a mix of male and female participants aged eighteen to sixty-five (92%), under eighteen (33%), and over age 65 (8%). Study inclusion criteria incorporated diagnoses of AUD (67%), co-occurring severe mental illnesses (25%), homelessness (17%), and other SUDs (17%).

## Synthesis of Literature

### Peer Support Group Definition

To improve outcomes for Hispanic/Latinx individuals with AUD in communities with recent immigration expansion, evidence describes how care providers must develop culturally sensitive AUD treatments at the client level (Jackson et al., 2022). Peer support groups (PSGs), also known as mutual help or self-help groups, have been assisting people struggling with

alcoholism for more than a century (Kelly et al., 2020). A PSG brings together at least two people sharing a common experience to offer problem-specific support and guidance.

Participants, rather than trained professionals, conduct group sessions in community-based locations (Kelly & Yeterian, 2011). Peer-to-peer interactions eliminate professional reliance and enhance communication by circumventing the power differential that can hinder open dialogue between patient and provider (Ashford et al., 2019). PSGs often feel more accessible to clients who stigmatize professional services or healthcare settings (Hall et al., 2023). PSGs permit individuals to participate confidentially for as long as they find beneficial, without requiring insurance or payments (Ashford et al., 2019; Kelly & Yeterian, 2011; O'Connell et al., 2020; Ojeda et al., 2020), and are essential in areas of provider scarcity.

### PSG Benefits

PSGs have demonstrated effectiveness in enhancing AUD recovery outcomes, including reduced or ceased alcohol consumption and improved quality of life (Colditz et al., 2023). More specifically, PSGs improve functioning (O'Connell et al., 2020), reduce co-occurring mental health symptoms (Ashford et al., 2019), reduce binge drinking (Hall et al., 2023), extend the length of abstinence (Ashford et al., 2019; Hall et al., 2023; O'Connell et al., 2020), increase engagement in outpatient services (Ashford et al., 2019; O'Connell et al., 2020; Suzuki et al., 2023), and reduce hospital admissions (Ashford et al., 2019). PSGs have been shown to extend the length of continuous sobriety one to three years posttreatment (Kelly et al., 2020; Kelly & Yeterian, 2011).

### Culturally Specific PSG Benefits

The Hispanic/Latinx community's cultural values are prosocial and rely on interconnectedness, social engagement, and empathy (Barrio, 2000). Evidence suggests that PSGs are even more effective for prosocial Hispanic/Latinx individuals than for White individuals. Hispanic/Latinx participants engaging in PSGs have higher rates of sobriety and committed engagement to treatment than do White participants (Substance Abuse and Mental Health Services Administration, 2014). One study found that peer support interventions were associated with reduced disparities in Hispanic/Latinx service use and resulted in higher rates of treatment engagement, as evidenced by greater outpatient service utilization (Ojeda et al., 2020).

Although Hispanic/Latinx community's cultural values are prosocial, researchers do not frequently include the Hispanic/Latinx population in their sample groups, and AUD treatments in the U.S. typically lean on the Western cultural value of independence and self-sufficient recovery. The social structure, mentorship model, and interpersonal problem-solving inherent in PSGs are more congruent with the prosocial facets of Hispanic culture than treatment options intent on achieving patient autonomy (Garcia et al., 2022; Ojeda et al., 2020; Substance Abuse and Mental Health Services Administration, 2014). *Familismo* and *personalismo* are Spanish terms that reflect these concepts. *Familismo* describes a key cultural value for social networks that provide emotional support when faced with challenges (Cahill et al., 2021; Moyce et al., 2022). *Personalismo* describes warm and empathetic interactions that convey understanding and concern for a person's well-being (Garcia et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Encouraging Hispanic/Latinx patients to strive for recovery through self-determination may contradict these cultural values and hinder therapy (Barrio, 2000). In contrast, incorporating socially-oriented PSGs that prioritize honest, hopeful, and

emotionally supportive relationships enhances Hispanic/Latinx treatment outcomes and facilitates the rehabilitation process (Barrio, 2000; De La Rosa & White, 2001).

A healthy social system can be particularly beneficial for Hispanic/Latinx individuals who when relocating to a new country have been separated from their family support network (Moyce et al., 2022). Discrimination and acculturation can lead individuals to prioritize social conformity, which may increase substance use and necessitate supportive peer relationships (Edwards et al., 2019; Yoo et al., 2020). Therapeutic interventions for Hispanic/Latinx individuals should incorporate PSGs to leverage their natural inclination towards social support and protective cultural values (Rogers et al., 2022).

#### Overcoming Barriers with Structural Components of Culturally Sensitive PSG Implementation

Delivering accessible AUD care to the Hispanic/Latinx community requires tailoring social, cultural, and linguistic aspects of PSGs. For example, the Hispanic/Latinx value for *discreción*, a hesitation to divulge personal issues in public, can bar Hispanic/Latinx individuals from attending PSGs. PSGs composed solely of Hispanic/Latinx individuals can address this issue by providing a context where participants are more inherently sensitive to each other's privacy concerns (Substance Abuse and Mental Health Services Administration, 2014).

Providing Spanish advertisements and written materials describing session activities improves relatability and inclusivity as well (Georgetown University National Center for Cultural Competence, 2009; Substance Abuse and Mental Health Services Administration, 2014).

Language congruence and ethnic matching with peers and facilitators increase participant involvement (Garcia et al., 2022), enhance the building of trust (Alvarez et al., 2007), and result in fewer emergency room visits (Barrio, 2000). Similarly, by incorporating culturally relevant

food, pictures, and posters, attendees experience increased comfort and willingness to share personal experiences (Georgetown University National Center for Cultural Competence, 2009).

Hispanic/Latinx individuals who have limited acculturation or lack health literacy are often apprehensive of treatment services and will benefit from an orientation to group processes, goals, expectations, and ground rules (Substance Abuse and Mental Health Services Administration, 2014). The facilitator should outline PSG advantages, clarify misunderstandings, and address common concerns (Walitzer et al., 2009). The fear of deportation can further deter Hispanic/Latinx individuals, especially recent immigrants, from seeking assistance; therefore, assuring attendees of the group's confidentiality is crucial (Substance Abuse and Mental Health Services Administration, 2014). Members of minority groups can feel marginalized or controlled when seeking healthcare services. Group leaders foster an equitable and collaborative environment by refraining from positioning themselves as content experts, encouraging participation, allowing participants to learn from one another, and incorporating personalismo when discussing difficult topics directly (Alvarez et al., 2007; Garcia et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Finally, facilitators should recognize that Hispanic/Latinx individuals may have a more relaxed attitude towards time than those from Western cultures. Scheduling an introductory period at the beginning of each session to buffer late arrivals can provide flexibility that accommodates Hispanic/Latinx customs (Substance Abuse and Mental Health Services Administration, 2014).

### PSG Group Content

The most widely available PSG, Alcoholics Anonymous (AA), founded in 1935, incorporates a spiritually based, Twelve-Step Program (TSP). AA promotes sustained remission

from alcohol through sharing personal stories, building healthy relationships, and learning stress management skills. Recommended components of the AA approach include keeping session length from 60 to 90 minutes, monitoring attendance and encouraging interactions between new and existing members (Kelly et al., 2020). Strong evidence suggests that TSP groups double sobriety rates compared to groups without (Zemore et al., 2017); thus, the vast majority of AUD treatment programs in the U.S. integrate twelve-step principles or encourage AA involvement (Wagner & Baldwin, 2020). Proactive referrals from clinicians to TSPs link services and extend remission (Kelly et al., 2020). When available, AA can be a valuable addition to, or when necessary, a substitute for, professional treatment (Kelly & Yeterian, 2011).

While robust, empirical evidence is limited regarding AA and TSPs tailored to the Hispanic/Latinx community, AA has a vast network of over 118,000 groups in more than 180 countries, serving over two million members worldwide; therefore, research suggests that AA and TSPs are helpful to a diverse range of people (Kelly & Yeterian, 2011). The spiritual base, narrative integration, and interpersonal problem-solving inherent in AA are congruent with the priorities of Hispanic culture (Garcia et al., 2022; Ojeda et al., 2020; Substance Abuse and Mental Health Services Administration, 2014).

Some minority populations have adapted AA resources to better resonate with their communities (Garcia et al., 2022; Wagner & Baldwin, 2020). *Anexos*, for example, originally annexed onto existing AA sites by Hispanic/Latinx immigrants in California. Researchers examined the successes of anexos and discovered that they provided a milieu conducive to exchanging vivid testimonials in Spanish where discussing shared cultural challenges like immigration, acculturation and discrimination sparked self-reflection and transformation

(Substance Abuse and Mental Health Services Administration, 2014). The incorporation of culturally appropriate social support fosters inclusion, thus facilitating the exploration of stigmatized topics and reducing the impact of immigration-related stress on unhealthy coping mechanisms like alcohol use (Ashford et al., 2019; Garcia et al., 2022). Failing to acknowledge the unique adversities immigrants encounter neglects a critical factor that can trigger relapse and negatively influence healthcare outcomes in this population (Garcia et al., 2022). A summary of the literature-supported structural elements of culturally supportive PSGs is exhibited in Table 1.1.

Table 1.1. Summary of the structural elements of culturally supportive PSGs.

<b>Summary of Structural Elements of Culturally Supportive Peer Support Groups</b>
100% Hispanic/Latinx participants
Spanish-language speaking facilitator
Spanish-language advertisements and written materials
Culturally relevant food, pictures, and posters
Discussion of cultural topics including acculturation, discrimination, socioeconomic disparity
Introductory period at beginning of each session for late arrivals
Monitoring attendance
Orientation to group processes, goals, expectations, and ground rules
Assurance of Confidentiality
Sixty-to-ninety-minute sessions
Facilitator Initiated
Peers and mentors who have navigated similar life experiences
Incorporation of spiritually-based, Twelve Step Program
Participation, honest sharing of personal stories
Problem-specific support and guidance
Time for interactions between new and existing members
Empathetic, emotionally supportive, and health-oriented relationships
Shared experiences with interpersonal strategies and stress management skills
Proactive referrals
Free Attendance

### PSG Facilitator

Vulnerable populations struggling with mental health conditions, such as AUD, benefit from peer-led support groups initially facilitated by trained leaders (Castelein et al., 2015). Practical assistance with creating group advertisements, finding a meeting location, and developing an agenda help a group get started (Tregua & Brown, 2013). Furthermore, individuals with AUD may face challenges like lack of motivation, limited communication skills, and other negative symptoms that hinder their ability to lead or participate in groups at the outset.

A support group facilitator can be instrumental in determining group success, yet many lack formal training and report difficulties in fulfilling their roles. While the facilitator does not require a formal certification to initiate a community peer support group (PSG), researchers suggest that a brief training program can mitigate facilitator challenges, enhance facilitator self-efficacy and competence, and ultimately improve peer group outcomes (Delisle et al., 2016). The training program should include a background on the benefits, barriers, and misconceptions of PSGs (Walitzer et al., 2009); an orientation to group processes, goals, expectations, and ground rules; information about creating a safe and supportive group environment (Substance Abuse and Mental Health Services Administration, 2014); education on the Twelve Steps (Kelly et al., 2020); and information about cultural triggers like acculturative stress and discrimination (Barrio, 2000; Moyce et al., 2022; Rogers et al., 2022). Information for all the above can be found in the facilitator handbook (see Appendix B). A summary of facilitator guidelines gathered from a review of literature is presented in Table 1.2.

Table 1.2. Summary of facilitator guidelines for culturally supportive PSGs.

<b>Summary of Facilitator Guidelines, Culturally Supportive Peer Support Groups</b>
Include a background on the benefits, barriers, and misconceptions of PSGs and AA
Provide information about cultural triggers like acculturative stress and discrimination
Educate participants about Twelve Steps
Provide orientation to group processes, goals, expectations, and ground rules
Create a safe and supportive group environment by setting ground rules for confidentiality and respectful communication
Model empathetic listening and emotional support
Incorporate personalismo when discussing difficult topics directly
Pose open ended questions
Encourage participation through honest sharing of personal stories
Refrain from positioning self as content expert, allows participants to learn from one another
Share personal experiences (if appropriate) to demonstrate resilience
Encourage participants to develop healthy coping strategies
Offer validation
Celebrate successes and provide motivation during challenges
Encourage participants to take on leadership roles and facilitate discussions
Connect participants with community resources
Complete self-reflective questionnaire prior to initiation to improve cultural humility

This training program will not only enhance the facilitator's confidence in leading group sessions, but will give them the information they will, in turn, convey to participants to prepare them to self-lead when facilitation ends (Delisle et al., 2016). Training should include a review of the written materials for participants (see Appendix C) and the Peer Packet designed to support self-leadership (see Appendix D).

When facilitator-attendee ethnic congruence is unattainable, a culturally sensitive peer group facilitator must develop cultural humility (Clark et al., 2011). Cultural humility demands a continuous examination of one's own cultural perspectives to ensure these do not impact the care relationship (Clark et al., 2011; Gervin et al., 2014). Answering self-reflective questions can enable this examination (Gervin et al., 2014) (see Appendix B). The simple awareness of cultural variations in nonverbal communication, personal space, and eye contact can promote

cultural humility (Andrews, 2021). Evidence shows that improving a care leader's cultural humility by reflecting on personal cultural identity will improve service utilization (Moyce et al., 2022).

### Outcome Measures

The Group Leader Self-Efficacy Instrument (GLSI) consists of 37 questions with a 6-point Likert scale capturing the self-efficacy and confidence of a group leader (see Appendix E). Although the GLSI has not been used to evaluate facilitators of recovery PSGs, it has been used with counselors trained to lead treatment groups. The GLSI's construct validity was supported by non-significant correlations with the NEO Five-Factor Inventory (neuroticism,  $r = -0.14$ ; extroversion,  $r = 0.25$ ; openness,  $r = 0.17$ ) and the S-Anxiety scale ( $r = -0.12$ ). The tool demonstrated high reliability, as evidenced by a Cronbach's alpha of 0.95 and a test-retest reliability of 0.72 ( $p > 0.01$ ) (Page et al., 2001). No claims to the copyright can be found; thus, the tool appears to be available for public use.

The advantage of employing the GLSI in a series of facilitator evaluations during the PSG implementation process lies in its ability to identify specific areas for skill development, mentoring, and education in response to weak answers. Iterative changes could improve the facilitator's leadership confidence and self-efficacy over time. Research shows that strengthening facilitator confidence is instrumental in determining group success (Delisle et al., 2016). Limitations of the tool include its length and the presence of several questions that are not fully applicable to the context of this implementation. Such factors may lead to question fatigue and diminish the reliability of answers. Although research supporting the validity of a shortened

version of this tool is absent, reducing the length and deleting irrelevant questions might be done to avoid facilitator confusion and answer attrition.

### Discussion and Conclusions

Culturally sensitive AUD treatment options are urgently needed for the growing U.S. Hispanic/Latinx population which faces disproportionate disadvantages (Alvarez et al., 2007; Wagner & Baldwin, 2020), treatment disparities (Arroyo, 2008), and an increased risk for negative outcomes (Eghaneyan et al., 2020). Developing the skills of non-licensed personnel in a rural Montanan recovery clinic to initiate a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults with AUD would feasibly launch a practical change that promotes equitable access to crucial AUD services.

Research supports the inherent social structure of PSGs as the most culturally congruent treatment option that employs protective factors of the prosocial Hispanic/Latinx community (Barrio, 2000). Developing effective PSGs for Hispanic/Latinx individuals requires incorporating essential elements such as Hispanic/Latinx-only participants; Spanish-speaking facilitators (Garcia et al., 2022); Spanish-language materials (Georgetown University National Center for Cultural Competence, 2009; Substance Abuse and Mental Health Services Administration, 2014) ; and culturally relevant food, pictures, or posters (Georgetown University National Center for Cultural Competence, 2009) to create a familiar and inclusive environment that fosters open sharing. Incorporating AA's spiritually-based Twelve Steps will be conducive to the religious norms of the Hispanic/Latinx culture (Kelly et al., 2020). Additionally, incorporating discussions derived from the Hispanic/Latinx-specific anexos to address social and

immigration stressors like acculturation and discrimination will reduce immigration stress that potentiates AUD (Ashford et al., 2019; Garcia et al., 2022).

The most successful implementations will also address access barriers by including elements such as an introductory period for late arrivals to support the flexible Hispanic/Latinx time customs; an orientation to group processes, goals, and expectations to improve knowledge for those with low acculturation or health literacy; and an assurance of confidentiality to increase comfort and confidence for those that have privacy concerns or fear deportation (Substance Abuse and Mental Health Services Administration, 2014).

A facilitator can enhance group outcomes by guiding participants through establishing goals, ground rules, and group dynamics, empowering them to take ownership of their recovery journey and eventually self-lead the group (Castelein et al., 2015). The facilitator will support the establishment of an equitable and collaborative environment by refraining from positioning themselves as content experts, encouraging participation, allowing participants to learn from one another, and modeling empathetic listening, emotional support, and personalismo (Alvarez et al., 2007; Garcia et al., 2022; Substance Abuse and Mental Health Services Administration, 2014).

National and state policies advocating for equitable access to culturally and linguistically responsive healthcare services (U.S. Department of Health & Human Services, n.d.) have existed for years. In rural Montana, the onus is on professionals to advance toward equitable practices with whatever resources are available. Establishing community-based, peer-led support groups (Castelein et al., 2015) attends to cultural needs, expands access to AUD treatments, and begins to address the upstream social, political and economic forces perpetuating Hispanic/Latinx disparity (Jackson et al., 2022).

## CHAPTER TWO

## PROJECT PROPOSAL

Introduction

In the United States (U.S.), alcohol caused over 178,000 deaths in 2023, surpassing all other preventable causes of death, and in 2010 resulted in an estimated \$249 billion economic burden in the United States (Centers for Disease Control, 2024). Alcohol Use Disorder (AUD) results in disability, lost productivity, accidents, violence, imprisonment, and significant healthcare demand (Kelly et al., 2020). As of 2023, 10.8%, or approximately 28.1 million White Americans, aged 18 and older, struggled with AUD (National Institute on Alcohol Abuse and Alcoholism, 2024b). In the same year, 4.6 million Hispanic/Latinx Americans, or 7.0% of the population, suffered from AUD (National Institute on Alcohol Abuse and Alcoholism, 2024b), and in 2022, 19.7% Hispanic/Latinx Americans reported excessive drinking (United Health Foundation, 2022). Excessive drinking has been reported in 23.4% of White and 25.7% of Hispanic/Latinx Montanan adults (United Health Foundation, 2022). In Montana, between 2015 and 2019, the alcohol-induced death rate was almost twice the national rate, at 27 per 100,000 compared to 15 per 100,000 (Montana Department of Public Health and Human Services, 2023b). Regardless of race, the number of Montanans dying from alcoholism rose dramatically, from 29 in 2000 to 102 in 2020 (Montana Department of Public Health and Human Services, 2023b).

Despite the rising prevalence of alcohol use, the U.S. falls drastically short in treating AUD (Colditz et al., 2023; Worley, 2021; Yoo et al., 2020). In 2023, only 7.9% of Americans

diagnosed received alcohol treatment of any kind (National Institute on Alcohol Abuse and Alcoholism, 2024a). In Montana, the ratio of 4,761 residents to each mental health provider (Rosston, 2022) further reduces the reach of AUD treatment. Moreover, the Hispanic/Latinx population experiences a variety of treatment barriers including limited English proficiency, lack of acculturation, reduced health literacy (Eghaneyan et al., 2020; Substance Abuse and Mental Health Services Administration, 2014), financial constraints, and lack of insurance (Arroyo, 2008; Barrio, 2000; Eghaneyan et al., 2020; Moyce et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Unsurprisingly, Spanish-speaking Hispanic individuals were seven times less likely to receive outpatient mental health services than non-Hispanic White individuals (Moyce et al., 2022) resulting in more adverse AUD consequences for Hispanic Montanans compared to their White counterparts (Alvarez et al., 2007; Wagner & Baldwin, 2020).

Culturally sensitive AUD treatment options are urgently needed for the growing U.S. Hispanic/Latinx population which faces disproportionate disadvantages (Alvarez et al., 2007; Wagner & Baldwin, 2020), treatment disparities (Arroyo, 2008), and an increased risk for negative outcomes (Eghaneyan et al., 2020). National and state policies advocating for equitable access to healthcare services (U.S. Department of Health and Human Services, 2021), culturally and linguistically responsive care (U.S. Department of Health & Human Services, n.d.), recovery support groups in all communities, and the mitigation of disparities in access (Montana Legislature, 2023) have existed for years; however, many rural Montanan areas experiencing immigration growth still lack Spanish-speaking or Hispanic/Latinx recovery services. Furthermore, language often bars Spanish speakers from participating in community peer support

groups (PSG), the most frequently sought resource for those struggling with AUD (Kelly & Yeterian, 2011; Substance Abuse and Mental Health Services Administration, 2014).

Multiple studies show that PSGs improve functioning (O’Connell et al., 2020), reduce co-occurring mental health symptoms (Ashford et al., 2019), reduce binge drinking (Hall et al., 2023), extend the length of alcohol abstinence (Ashford et al., 2019; Hall et al., 2023; O’Connell et al., 2020), increase engagement in outpatient services (Ashford et al., 2019; O’Connell et al., 2020; Suzuki et al., 2023), and reduce hospital admissions (Ashford et al., 2019). Furthermore, the social structure, mentorship model, and interpersonal problem-solving inherent in PSGs are more congruent with the prosocial facets of Hispanic culture than one-on-one clinician services (Garcia et al., 2022; Ojeda et al., 2020; Substance Abuse and Mental Health Services Administration, 2014). Hispanic/Latinx participants engaging in PSGs have higher rates of sobriety and committed engagement to treatment than do White participants (Substance Abuse and Mental Health Services Administration, 2014).

### Problem and Aim Statement

This project seeks to address the problem of a lack of local recovery support for Spanish-speaking individuals with AUD who require treatment in a rural Montanan recovery clinic service area. The project aim is to develop the skills of non-licensed personnel to initiate a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults, 18 years or older, with AUD. By developing this essential PSG service, the project intends to demonstrate a successful launch, with the goal of sustainability by the recovery clinic after project completion, thus providing a PSG that promotes equitable access to local AUD recovery services.

The Strategic, Measurable, Achievable, Realistic, Time-bound, Inclusive, and Equitable (SMARTIE) goals for this project are for two or more participants to attend the PSG sessions by the end of four weeks, to have 50% repeat attendance by the end of six weeks, for the facilitators to achieve greater than or equal to 90% self-efficacy and confidence as evidenced by the Group Leader Self-Efficacy Instrument (GLSI) scores by the end of six weeks, and to obtain 100% positive response rate to qualitative feedback questions posed to facilitators by the end of six weeks.

### Organizational Context

The doctor of nurse practice (DNP) project site is a rural Montanan outpatient recovery clinic that primarily works with people mandated by the justice system to attend a treatment program for AUD as part of their sentencing. The organization's mission is to provide client-centered care, serve the justice system, and accept all individuals seeking help (J. Holton, personal communication, September 4, 2024). Although the organization treats over 900 patients annually, they turn away 100% of Spanish-speaking individuals due to a lack of Spanish language services. The organization most frequently refers Spanish speakers to another Montanan recovery center over 140 miles away. This poses a particular challenge for those who have had their driver's license revoked as part of sentencing requirements, work during the recovery center's hours, or have local family obligations (Marissa, organization staff, personal communication, September 11, 2024; Eghaneyan et al., 2020). Non-compliance with the recovery sentencing mandates can result in jail time. The staff has noticed a significant increase in requests for services from Spanish-speaking individuals over the past year. Despite being informed by the courts that there were no local Spanish services available, an estimated 20

individuals still sought help from the clinic (Marissa, organization staff, personal communication, September 11, 2024). The primary site representative asked the doctoral student to address the gap between the organization's commitment to helping everyone and the lack of available recovery services for Spanish-speaking individuals with AUD.

The organization's current recovery services are divided into five phases: 1) clinical stabilization, involving inpatient detoxification; 2) psychosocial stabilization, addressing underlying issues with individual clinician services; 3) prosocial habitation, facilitated by community peer support groups (PSGs); 4) life skills development, including practical assistance in budgeting, GED attainment, and employment; and 5) recovery capital, featuring trigger identification and relapse prevention education (J. Holton, personal communication, September 4, 2024).

Phase one involving inpatient detoxification occurs before clients arrive at the recovery center. The organization is fortunate to have a Spanish-speaking clinician joining their staff within the next year who will provide Spanish-language clinician services addressing phases two, four, and five; however, the third phase of prosocial habitation depends on community PSGs for treatment maintenance and relapse prevention. While there are over fifteen separate AA groups along with Wellbriety, Self-Management and Recovery Training (SMART), and other peer-support meetings available to English speakers, there are currently no AUD PSGs available for Spanish-speaking individuals in a 140-mile radius (Alcoholics Anonymous, 2024).

Developing the skills of non-licensed personnel in this Montanan recovery clinic to initiate a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults with AUD would allow the organization to locally provide the complete

five-phase recovery process to Spanish-speaking Hispanic/Latinx individuals. Involved stakeholders include the organization's site representative, a substance use clinician and doctorate-prepared implementation scientist; the facilitator, the clinic's Spanish-speaking Peer Support Specialist; and the co-facilitator, a Spanish-speaking Puerto Rican individual who recently completed the recovery process and volunteered to assist with initiating support groups and participate in training program and evaluation. Given that there are currently no Spanish-speaking clients at the clinic, the peer support group initiative will be open to all Spanish-speaking individuals in the community, rather than restricted to the clinic's patient population.

#### Quality Improvement Model

The Institute for Healthcare Improvement Model for Improvement offers a framework for clarifying the project's aim, target population, outcome measures, principal interventions, and improvement opportunities (Ogrinc et al., 2022). The Institute for Healthcare Improvement Model consists of three fundamental questions followed by Plan-Do-Study-Act (PDSA) cycles. The first question of the model prompts the identification of an aim statement, population of interest, primary goals, and project timeframe. The second question requires the establishment of outcome measures that evaluate progress toward aim achievement. The third question allows stakeholders to generate ideas for change implementation specific to their institution. Finally, iterative PDSA cycles test small-scale change ideas through the process of planning the change, doing the change, studying the results, and acting in accordance with the results (Institute for Healthcare Improvement, n.d.; Ogrinc et al., 2022).

Answering the IHI Model for Improvement questions and conducting PDSA cycles will assist the doctoral student in more successfully initiating a culturally sensitive, peer-led

community support group for Spanish-speaking Hispanic/Latinx individuals with AUD. The IHI model questions will assist with establishing a clear vision for the PSG initiative through guidance to set goals, measure progress, and gather stakeholder ideas prior to the first PSG session (Institute for Healthcare Improvement, n.d.; Ogrinc et al., 2022). Gaining a clear vision allows the student to create a plan for the initial PDSA cycle.

During the Plan phase of the PDSA cycles, the student will determine the specific changes needed to achieve the goal of initiating a PSG. For the first PDSA cycle, this will include plans for recruiting participants, finding a suitable meeting location, and developing a facilitator training session. During the Do phase, the student will carry out the planned changes, including, for example, recruiting participants, securing a meeting location, conducting facilitator training sessions, and having the facilitators deliver the first PSG sessions. At the same time, the Do phase will involve gathering data on participant attendance and the facilitators' confidence in leading the sessions. The Study phase will occur when the student analyzes the collected data to assess the effectiveness of the changes, identify any issues and reflect on areas of weakness that may need to be improved upon. Stakeholders can be consulted during this phase to help generate ideas for iterative improvements. For example, if attendance is low for the first two sessions, the facilitators, site representative and student may want to meet to reflect on barriers to attendance. Finally, during the Act phase, the student will adjust the plan based on the analysis and implement the revised changes. By employing the PDSA cycles, the doctoral student can systematically improve the group's structure, activities, and approach through ongoing feedback and data analysis (Institute for Healthcare Improvement, n.d.; Ogrinc et al., 2022). This iterative

process intends to enhance the success of the PSGs and increase the facilitators' confidence in leading them.

## Methods

### Implementation Summary

The planned PSG process change will be implemented at a rural Montana recovery clinic. PSG sessions will be conducted at a local recovery rental space, a common venue for various PSG groups in the community. The project aims to develop the skills of non-licensed, Spanish-speaking personnel and will most directly affect the two facilitators, one a member of the clinic's staff and the other a volunteer community member. The facilitators' confidence and self-efficacy will be measured with the GLSI evaluation tool before a training session provided by the doctoral student. To support the PSG sessions, the doctoral student will equip the facilitators with a facilitator handbook and Spanish-language written materials describing each session's activities. Three questions prompting nominal and qualitative feedback on the session materials will be administered to the facilitators biweekly during project implementation. De-identified attendance and repeat attendance numerical data will be collected at each session to measure PSG participation. A final GLSI survey will be administered to the facilitators at the end of the six-week project implementation.

The total implementation time will include six one-hour sessions over six weeks from January 14<sup>th</sup> to February 18<sup>th</sup>, 2025. Data collection will inform iterative adjustments to the implementation, aiming to improve the facilitators' skills and the effectiveness of the provided materials, ultimately creating a more effective facilitator package for developing the skills of

current and future non-licensed personnel willing to lead PSGs for Spanish-speaking Hispanic/Latinx adults with AUD.

### Implementation Plan

The aim of this practice change is to develop the skills and confidence of non-licensed personnel in a rural Montanan recovery clinic to initiate a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults with AUD.

The initial planning steps for implementing this initiative include finding a facilitator, scheduling six one-hour sessions, securing a location for PSG meetings, estimating costs (see Table 2.1 for a summary of costs), creating flyers and a distribution list (see Appendix F), developing a facilitator training program and handbook with session agendas (see Appendix B), creating Spanish-language written materials and a peer packet for participants (see Appendices C and D), and developing evaluation tools (see Appendices E, G and H). These steps are necessary for the development of the PSG sessions and were accomplished by the doctoral student prior to the project proposal submission date of November 1<sup>st</sup>, 2024. The doctoral student will, ultimately, volunteer 300 hours throughout the implementation of this project, saving the organization \$7,500 based on a conservative hourly rate of \$25.

Table 2.1. Summary of costs.

Material/Service	Quantity	Cost/unit	Total
<b>Location</b>	1 hour x 6	\$14/month	\$28
<b>Refreshments for group session</b>	Each week x 6 weeks: 1 pack muffins 1 box tea bags Chiclets Chewing Gum	Muffins: \$10/pack Tea: \$3/box Gum: \$2/pack	\$80
<b>Facilitator Time</b>	1 hour x 6 sessions, 2h training session	\$50/session hour, training time falls within work hours and pay	\$300
<b>Flyer Printing</b>	100	\$.22/flyer	\$22
<b>AA Big Book</b>	1	\$25/ book	\$25
<b>Co-Facilitator Time</b>	1 hour x 6 sessions	\$0 (volunteer)	\$0
<b>Flyer Creation/ Distribution</b>	1	provided by student	\$0
<b>Handbook/ Written Material Creation</b>	1	provided by student	\$0
<b>Total</b>			<b>\$455</b>

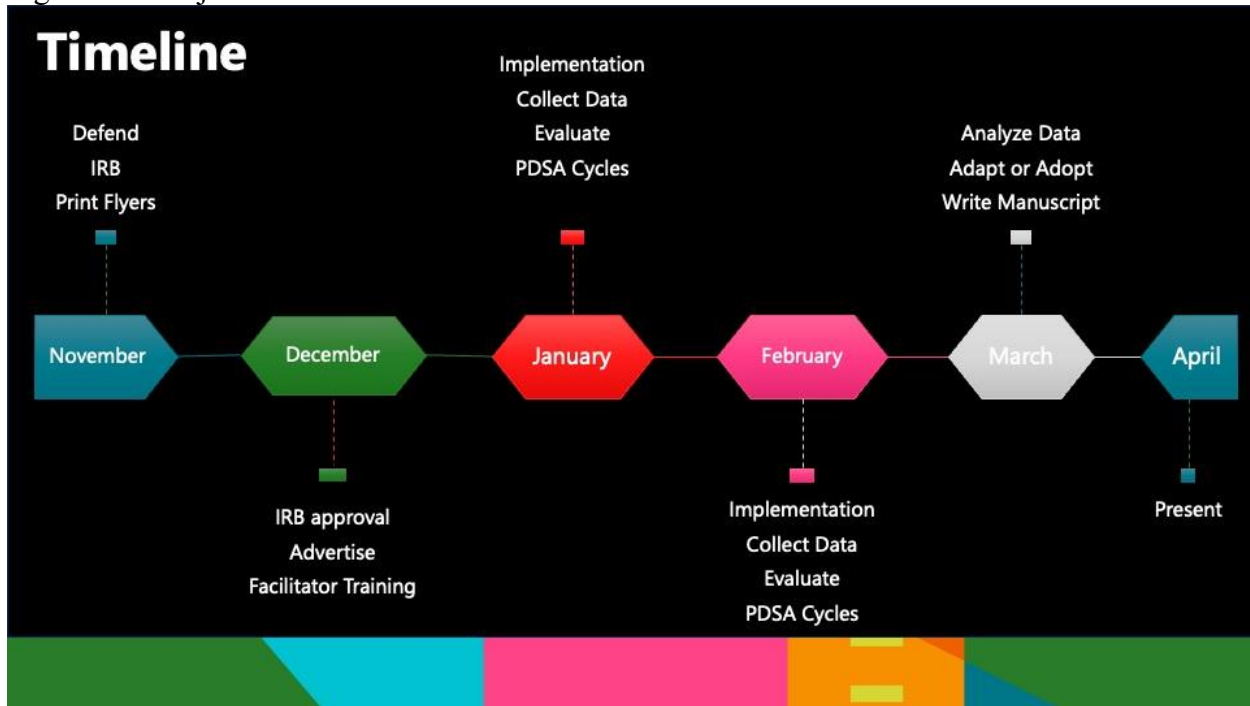
The PSG initiation project requires doctoral committee and Institutional Review Board (IRB) approval for implementation. The project defense is scheduled for November 19th, 2024, and IRB submission will follow with a due date of December 11, 2024. After project approval, the doctoral student will provide training to the facilitators and distribute flyers to promote the PSG sessions. Flyers will be hand-delivered or emailed to the 37 organizations on the distribution list that interact with Spanish-speaking individuals throughout the state, including churches, restaurants, recovery facilities, and courts. To measure the facilitators' self-efficacy and confidence, the Group Leader Self-Efficacy Instrument (GLSI) (see Appendix E) will be administered to each of the facilitators before the training session via a secure and confidential Qualtrics survey link. These steps are to be accomplished by December 20<sup>th</sup>, 2024.

A one-hour PSG session will be co-facilitated weekly for six weeks, from January 14<sup>th</sup> to February 18<sup>th</sup>, 2025. On the day of a session, the doctoral student will deliver refreshments and Spanish language written materials to the recovery clinic for the facilitators to transport to the group location. The facilitators will utilize the facilitator handbook while conducting sessions and distribute Spanish-language written materials to participants.

To measure PSG participation, data including attendance and repeat attendance will be collected weekly by the facilitators during each PSG session via a secure and confidential Qualitrics link on a laptop (see Appendix H). Data will contain no identifiers and will only be accessible by the doctoral student once entered. The qualitative feedback questions about the usefulness of the materials (see Appendix G) will be made available to the facilitators via another secure and confidential Qualitrics link following every other PSG session during the six-week implementation process. The GLSI will be administered a second time at the end of project implementation to gather data about the change in the facilitator's confidence in leading the group sessions over time.

The IHI PDSA cycles will be employed to help the doctoral student achieve the project's SMARTIE goals. Each two-week PDSA cycle will involve the doctoral student analyzing data on attendance, repeat attendance, and qualitative feedback on material usefulness. The GLSI data will be analyzed once during the final PDSA cycle. Through the six-week implementation and three PDSA cycles, a corresponding analysis will occur to assess the effectiveness of the changes, identify any issues, and pinpoint areas for improvement. The student will consult stakeholders to generate ideas for iterative improvements and will adjust the plan for the following sessions accordingly. Figure 1.1 shows the project timeline.

Figure 1.1. Project timeline.



### Structural Elements of Culturally Supportive PSG Intervention

PSGs will be conducted by Spanish-speaking facilitators and composed solely of Hispanic/Latinx individuals to provide a more culturally sensitive context where participants are inherently sensitive to each other's cultural and privacy concerns (Substance Abuse and Mental Health Services Administration, 2014). The doctoral student will create and distribute Spanish advertisements to attract Hispanic/Latinx individuals. The student will create Spanish-language written materials describing session activities that the facilitators will distribute to promote a welcoming and inclusive environment (Georgetown University National Center for Cultural Competence, 2009; Substance Abuse and Mental Health Services Administration, 2014). Evidence shows that language congruence and ethnic matching increase participant involvement (Garcia et al., 2022), enhance the building of trust (Alvarez et al., 2007), and result in fewer

emergency room visits (Barrio, 2000). Additionally, the student will obtain culturally relevant foods from a local Hispanic grocer to be supplied to participants by facilitators to increase comfort and enhance participant willingness to share personal experiences (Georgetown University National Center for Cultural Competence, 2009).

Successful structural elements identified in the research of Alcoholics Anonymous groups will be incorporated to create a consistent and evidence-based session format. These elements include maintaining 60-minute sessions, monitoring attendance, and providing proactive referrals from clinicians to connect services and extend remission (Kelly et al., 2020). As previously described, attendance will be monitored by the facilitators. Since the implementation will occur before the organization integrates a Spanish-speaking clinician, the student will distribute advertisements to recovery centers throughout the state. These recovery centers will be encouraged to refer their clients to the PSGs.

Drawing from the specific cultural successes of anexos, discussions of shared cultural challenges like immigration, acculturation, and discrimination will be incorporated into each PSG session to spark self-reflection and transformation (Substance Abuse and Mental Health Services Administration, 2014). The student will provide the facilitators with a list of related discussion questions in the facilitator handbook (see Appendix B). Facilitators will use the questions to prompt the exploration of stigmatized topics and reduce the impact of immigration-related stress on unhealthy coping mechanisms like alcohol use (Ashford et al., 2019; Garcia et al., 2022). A summary of the structural elements of culturally supportive PSGs gleaned from the literature review is presented in Table 2.2.

Table 2.2. Summary of structural elements of culturally supportive PSGs.

<b>Summary of Structural Elements of Culturally Supportive Peer Support Groups</b>
100% Hispanic/Latinx participants
Spanish-language speaking facilitator
Spanish-language advertisements and written materials
Culturally relevant food, pictures, and posters
Discussion of cultural topics including acculturation, discrimination, socioeconomic disparity
Introductory period at beginning of each session for late arrivals
Monitoring attendance
Orientation to group processes, goals, expectations, and ground rules
Assurance of Confidentiality
Sixty-to-ninety-minute sessions
Facilitator Initiated
Peers and mentors who have navigated similar life experiences
Incorporation of spiritually-based, Twelve Step Program
Participation, honest sharing of personal stories
Problem-specific support and guidance
Time for interactions between new and existing members
Empathetic, emotionally supportive, and health-oriented relationships
Shared experiences with interpersonal strategies and stress management skills
Proactive referrals
Free Attendance

### Facilitator, Facilitator Training and Facilitator Handbook

To prepare non-licensed staff, the doctoral student will create and provide a two-hour facilitator training program and handbook for the two PSG facilitators. The training and handbook will include a background on the benefits, barriers, and misconceptions of PSGs (Walitzer et al., 2009); an education on the Twelve Steps (Kelly et al., 2020); information about cultural triggers (Barrio, 2000; Moyce et al., 2022; Rogers et al., 2022); session agendas; an orientation to group processes, goals, expectations, and ground rules; and information about creating a safe and supportive group environment (Substance Abuse and Mental Health Services Administration, 2014) (see Appendix B). The in-person facilitator training will cover these topics through interactive discussion, using the handbook as a guide and providing opportunities for questions and support. The training program and handbook will equip facilitators with evidence-

based materials, boost their confidence in leading group sessions, and supply facilitators with information to convey to participants, enabling them to prepare for self-leadership upon completion of the facilitated sessions (Delisle et al., 2016).

To promote the success of self-leadership post project implementation, the student will remind the facilitators that their primary responsibility is to use their training and the supplied materials to equip the participants to lead the group independently. At the beginning of each session, the facilitators will also remind the participants of their role in self-facilitation. The student will acquire the Spanish language AA Big Book (*Alcohólicos Anónimos*, 2023) to be referred to by participants and facilitators throughout the implementation and gifted to one repeat participant who plans to return after the sixth session. At the sixth session, the facilitators will distribute a student-created, Spanish-language Peer Packet to the participants (see Appendix D). The Peer Packet will be a condensed version of the Facilitator Handbook including resources for self-guidance for participants to use, along with the AA Big Book, as they continue the PSG groups independently.

The facilitator training and handbook will incorporate essential components of Alcoholics Anonymous, such as the Twelve Steps, personal storytelling, building healthy relationships, learning stress management skills, and fostering interaction between new and existing members (Kelly et al., 2020). Additionally, to enable a personal cultural examination and enhance cultural humility, the facilitators will answer self-reflective questions during their training (Gervin et al., 2014) (see Appendix B). Cultural humility demands a continuous examination of one's own cultural perspectives (Clark et al., 2011; Gervin et al., 2014) and evidence shows that reflecting

on personal cultural identity will improve cultural humility and participant service utilization (Moyce et al., 2022).

### Overcoming Barriers to PSG Implementation

Hispanic/Latinx individuals who have limited acculturation or lack health literacy are often apprehensive of treatment services (Eghaneyan et al., 2020; Substance Abuse and Mental Health Services Administration, 2014). At the start of each session, the facilitators will provide an orientation to group processes, goals, and ground rules to familiarize participants with expectations and create a welcoming and safe environment (Substance Abuse and Mental Health Services Administration, 2014). The facilitators will outline PSG advantages and address common concerns to increase group acceptance and decrease apprehension (Walitzer et al., 2009). The fear of deportation can further deter Hispanic/Latinx individuals, especially recent immigrants, from seeking assistance; therefore, the facilitators will assure attendees of the group's confidentiality (Substance Abuse and Mental Health Services Administration, 2014). Members of minority groups can feel marginalized or controlled when seeking healthcare services. Group facilitators will foster an equitable and collaborative environment by refraining from positioning themselves as content experts, instead encouraging participation, allowing participants to learn from one another, and incorporating personalismo when discussing difficult topics directly (Alvarez et al., 2007; Garcia et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Finally, the facilitators will allow for an introductory period to accommodate late arrivals. Hispanic/Latinx individuals may have a more relaxed attitude towards time than those from Western cultures and the buffer can provide flexibility that accommodates Hispanic/Latinx customs (Substance Abuse and Mental Health Services

Administration, 2014). A summary of facilitator guidelines summarized from a literature review is presented in Table 2.3.

Table 2.3. Summary of facilitator guidelines for culturally supportive PSGs.

<b>Summary of Facilitator Guidelines, Culturally Supportive Peer Support Groups</b>
Include a background on the benefits, barriers, and misconceptions of PSGs and AA
Provide information about cultural triggers like acculturative stress and discrimination
Educate participants about Twelve Steps
Provide orientation to group processes, goals, expectations, and ground rules
Creating a safe and supportive group environment by setting ground rules for confidentiality and respectful communication
Model empathetic listening and emotional support
Incorporate personalismo when discussing difficult topics directly
Pose open ended questions
Encourage participation through honest sharing of personal stories
Refrain from positioning self as content expert, allows participants to learn from one another
Share personal experiences (if appropriate) to demonstrate resilience
Encourage participants to develop healthy coping strategies
Offer validation
Celebrate successes and provide motivation during challenges
Encourage participants to take on leadership roles and facilitate discussions
Connect participants with community resources
Complete self-reflective questionnaire prior to initiation to improve cultural humility

The greatest barrier to PSG implementation is the potential for having no participants attend a session. If this happens, the student will meet with all stakeholders to explore potential contributing factors, including the meeting time, missed advertisements, transportation issues, and other possibilities. If this occurs after the initial session, collected data and feedback on provided materials will be considered. Facilitators will still be surveyed with the GLSI and qualitative questions to better evaluate the perceived barriers, training, and materials provided.

### Evaluation and Analysis

The project aims to develop the skills of non-licensed personnel to initiate a culturally sensitive, community peer-led support group (PSG) for Spanish-speaking Hispanic/Latinx adults with AUD. The SMARTIE goals for this project are for two or more participants to attend the PSG sessions by the end of four weeks, to have 50% repeat attendance by the end of six weeks, for the facilitators to achieve greater than or equal to 90% self-efficacy and confidence as evidenced by GLSI scores by the end of six weeks, and to obtain 100% positive response rate to qualitative feedback questions posed to facilitators by the end of six weeks (see Tables 2.4, 2.5, 2.6 and 2.7).

#### SMARTIE Goals #1 and #2

To measure progress toward the attendance goals (see Tables 2.4 and 2.5), the facilitator will complete an attendance survey accessed through a secure and confidential Qualtrics link on a laptop at the beginning of each PSG session. The facilitator will document the total number of participants and repeat participants that attend (see Appendix H). The doctoral student will export the instrument results into an Excel spreadsheet for data analysis. Descriptive statistics and a bar chart depiction will be used to identify trends, outliers, or patterns over time.

Table 2.4. SMARTIE Goal #1.

<p>SMARTIE Goal #1: Two or more community participants will attend the PSG sessions by the end of four weeks</p>		
<ul style="list-style-type: none"> <li>Spanish-language flyers will be made and distributed one month prior for advertising the time, location and content of the PSGs.</li> <li>A distribution list will be made by consulting stakeholders and others that are familiar with points of access to Spanish speaking individuals with AUD.</li> </ul>		
Data to be collected	Collection Process	Planned data analysis
<ul style="list-style-type: none"> <li>Total number of participants that attend each session</li> <li>Date, time and location of session</li> </ul>	<ul style="list-style-type: none"> <li>Facilitator will record attendance data using a secure, confidential Qualtrics survey link</li> <li>Doctoral student will record results in an Excel spreadsheet for data analysis</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive Statistics of attendance numbers, depicted as a bar chart to identify trends, outliers or patterns over time</li> </ul>

Table 2.5. SMARTIE Goal #2.

SMARTIE Goal #2: 50% repeat attendance by the end of six weeks.		
<ul style="list-style-type: none"> <li>• Facilitator will be trained to create a comfortable, safe and welcoming environment</li> <li>• Research-based engaging session agenda will be created and provided to facilitator</li> <li>• Refreshments will be provided during each session</li> <li>• Facilitator will pay attention to participant engagement and disengagement and report any areas in need of improvement via qualitative feedback opportunities</li> </ul>		
Data to be collected	Collection Process	Planned data analysis
<ul style="list-style-type: none"> <li>• Total number of each week’s participants</li> <li>• Total number of each week’s repeat participants who returned to attend more than one session</li> <li>• Date, time and location of each session</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitator will record repeat attendance data using a secure, confidential Qualtrics survey link</li> <li>• Doctoral student will record results in an Excel spreadsheet for data analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive Statistics of repeat attendance numbers, depicted as a bar chart to identify trends, outliers or patterns over time</li> </ul>

SMARTIE Goal #3

To measure the facilitator’s self-efficacy and confidence (see Table 2.6), the Group Leader Self-Efficacy Instrument (GLSI) will be completed before the training program and at the end of the six-week implementation (see Appendix E). The facilitator will complete the GLSI using a secure, confidential Qualtrics survey link on a laptop. 100% completion of the evaluation tool and comparison between the two facilitators will ensure the completion and accuracy of the data measured. The doctoral student will export the GLSI results into an Excel spreadsheet for

data analysis. Likert scale responses will be translated into a percentage of total possible points: twenty questions times six possible answers make 120 total possible points. The goal of achieving a score of 90% will occur once 108/120 points have been recorded. Descriptive statistics will be used by the doctoral student at the end of the six-week implementation to analyze the gross GLSI percentage trend over time.

Table 2.6. SMARTIE Goal #3.

SMARTIE Goal #3: Facilitator achievement of greater than or equal to 90% self-efficacy and confidence as evidenced by instrument scores by the end of six-week implementation		
<ul style="list-style-type: none"> <li>• Pre-educational assessment using the Group Leader Self-Efficacy Tool (GLSI)</li> <li>• Two-hour, in -person facilitator training program and Facilitator Session Agenda Packet development and delivery</li> <li>• Post-implementation assessment using the Group Leader Self-Efficacy Tool (GLSI)</li> </ul>		
Data to be collected	Collection Process	Planned data analysis
<ul style="list-style-type: none"> <li>• Completion of Group Leader Self-Efficacy Tool (GLSI) before and after training program and bi-weekly during implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitator will complete GLSI using a secure, confidential Qualtrics survey link</li> <li>• Doctoral student will record instrument results in an Excel spreadsheet for data analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Likert scale responses translated into a percentage of total possible points (20 questions x 6 possible answers = 120 total possible points; 90% is score of 108/120 points)</li> <li>• Descriptive statistics used to analyze GLSI percentage trend over time</li> </ul>

SMARTIE Goal #4

To measure the usefulness of the facilitator materials (see Table 2.7), qualitative feedback questions will be completed bi-weekly during implementation using a secure and confidential Qualtrics link accessed on a laptop (see Appendix G). The doctoral student will export feedback results into an Excel spreadsheet for data analysis. Nominal data of Yes/No responses to each question will be translated into percentages of 100 or zero respectively; analyzed with descriptive statistics; and depicted as a bar chart to identify trends, outliers, or patterns over time. The goal will be met once the nominal data scores are 100% for all three questions. Comparison between the two facilitators' answers and 100% completion of the nominal data will ensure the accuracy and completion of the data measured.

The doctoral student will carefully read through the qualitative responses stored anonymously on the MSU server and identify recurring themes, suggestions for content improvement, or areas of weakness that could be addressed. The doctoral student will prepare for any responsive adjustments and communicate them to the facilitators by email or in person with time for an improved implementation during the subsequent session. If more information is needed to improve upon weak responses, the student will consult stakeholders to generate ideas for iterative improvements and will adjust the plan for the following sessions accordingly.

Table 2.7. SMARTIE Goal #4.

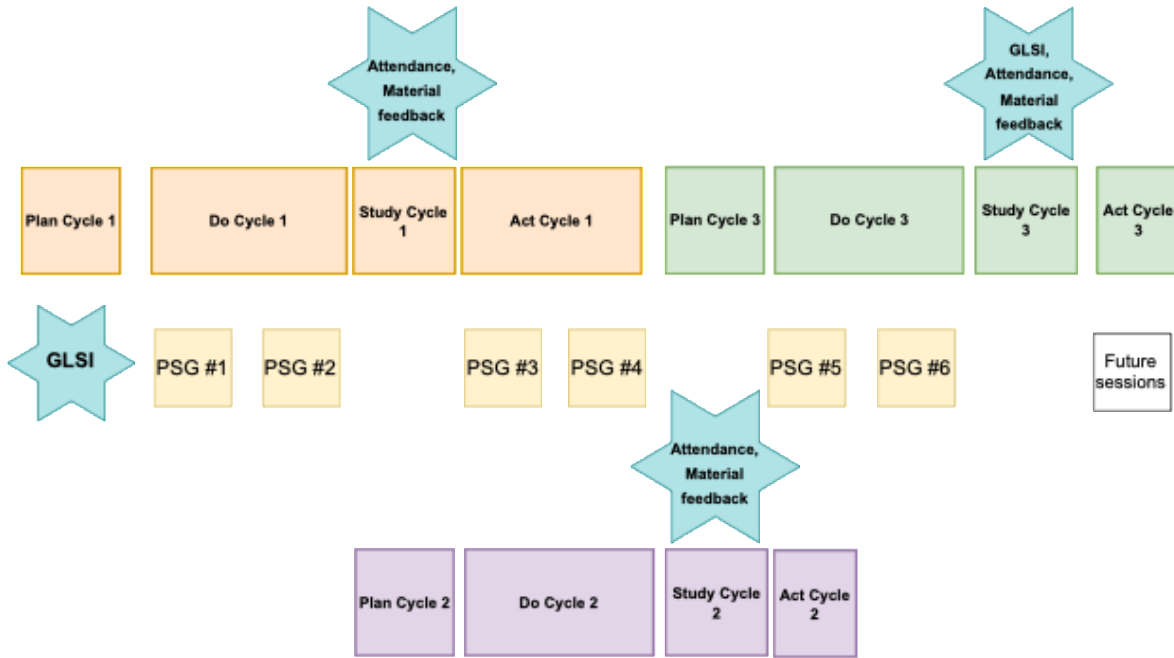
<p>SMARTIE Goal #4: 100% positive response rate to qualitative feedback questions posed to facilitator by the end of six weeks</p> <ul style="list-style-type: none"> <li>• Develop qualitative feedback questions</li> <li>• Administer qualitative feedback questions biweekly during implementation</li> </ul>		
Data to be collected	Collection Process	Planned data analysis
<ul style="list-style-type: none"> <li>• Yes/No response to each question</li> <li>• Qualitative data facilitator provides in response to qualitative feedback questions:</li> </ul> <ol style="list-style-type: none"> <li>1. Were session materials easy to follow?</li> <li>2. Did session materials help inspire participation?</li> <li>3. Did the session materials provide valuable information and tools for recovery?</li> </ol>	<ul style="list-style-type: none"> <li>• Facilitator will complete nominal and qualitative feedback questions using a secure, confidential Qualtrics link</li> <li>• Doctoral student will record feedback results in an Excel spreadsheet for data analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Nominal data of Yes/No response to each question will be translated into a percentage (100 or zero respectively); analyzed with descriptive statistics; and depicted as a run chart to identify trends, outliers, or patterns over time</li> <li>• Thematic and content analysis: doctoral student will carefully read through the responses and identify recurring themes or content that expresses suggestions for improvement or areas of weakness that could be addressed.</li> </ul>

### PDSA Cycles

Each PDSA cycle will involve a Study phase when the doctoral student evaluates the data on attendance, repeat attendance, and the feedback on material usefulness to assess the effectiveness of the changes and pinpoint areas needing improvement. Summarized data and the results of analysis will be shared with the stakeholders during this phase before subsequent sessions.

The PDSA cycles will be conducted every two weeks (see Figure 2.1 for a graphic depiction of PDSA cycles and data evaluation intervals) with the Plan phase of the first PDSA cycle coming before the first PSG session. The first Do phase will encompass the first and second PSG sessions. The first Study phase will take place between the second and third sessions, allowing for the first Act phase to proceed during the third and fourth sessions. This pattern will continue, with the Do phase of the second PDSA cycle occurring during the third and fourth sessions, and the Do phase of the third PDSA cycle during the fifth and sixth sessions. The results of the analysis of the Third Study phase, which will incorporate the additional GLSI data, will be reflected in the final materials of the manuscript and could be applied to any future sessions as the project is disseminated. The goal of iterative improvements is to enhance the facilitators' skills and the success of the provided materials, creating a more effective facilitator package for initiating culturally sensitive, peer-led community support groups for Spanish-speaking Hispanic/Latinx individuals with AUD.

Figure 2.1. Graphic depiction of PDSA cycles and data evaluation intervals.



Safety and Confidentiality

Since there are currently no local Spanish-language recovery services, this PSG initiation project poses no increased risk to participants with AUD beyond the risks involved in otherwise remaining untreated and, in some cases, facing jail time for unfulfilled sentencing mandates. No health records will be accessed at the project’s site. The only data collected from the participants will be the attendance numbers which will be free of personal identifiers. The data will be captured by the facilitator using a secure and confidential Qualtrics link and stored anonymously on an MSU server until the doctoral student exports the data to an Excel spreadsheet on a password-protected desktop. The doctoral student will have exclusive access to the attendance numbers once entered into the survey.

The project does not pose any additional risks to the facilitator beyond those inherent in her role as a Peer Support Specialist. The co-facilitator has voluntarily offered his services without compensation. The data collected from the facilitators will be the GLSI survey results and the responses to the qualitative feedback questions. The data will be captured free of personal identifiers through the completion of a self-survey accessed via a secure and confidential Qualtrics link and stored anonymously on an MSU server until the doctoral student exports the data to an Excel spreadsheet on a password-protected desktop. The doctoral student will have exclusive access to the data once entered into the surveys.

The project initiative has the full support of site stakeholders but requires DNP committee and IRB approval for implementation. The doctoral student will only share summarized, de-identified data during project defense and dissemination.

CHAPTER THREE

QUALITY IMPROVEMENT MANUSCRIPT

Contribution of Authors and Co-Authors

Manuscript(s) in Chapter(s) 4

Author: Jaimee Culpepper, RN, BSN

Contributions: Investigation of clinical problem, research of existing literature and area resources, development of implementation plan, creation of handbook and session materials, training of facilitators, provision of session materials, collection and analysis of data, writing of original manuscript, and dissemination of project findings.

Co-Author: Dr. Amanda Lucas, DNP, MSN, RN

Contributions: Expert guidance and continuous support throughout the project, from design and manuscript feedback to presentations and dissemination; focused direction on next steps, especially for data collection and survey development; review of the proposal, project materials, and final manuscript.

Co-Author: Dr. Rebecca Hoover, PhD

Contributions: Manuscript review as a second reader, project guidance and question prompts during the project proposal.

Manuscript Information

Jaimee Culpepper, RN, BSN; Dr. Amanda Lucas, DNP, MSN, RN; Dr. Rebecca Hoover, PhD

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### Clinical Problem

Surpassing all other preventable causes of death in the United States, alcohol consumption caused over 178,000 fatalities in 2023 and cost an estimated \$249 billion in 2010 (Centers for Disease Control, 2024). Alcohol Use Disorder (AUD), a chronic and relapsing disease characterized by compulsive alcohol use despite harmful consequences (National Institute on Alcohol Abuse and Alcoholism, 2024c), results in disability, lost productivity, accidents, violence, imprisonment, and significant healthcare demand (Kelly et al., 2020). In 2023, 10.8% of White Americans (28.1 million) and 7.0% of Hispanic/Latinx Americans (4.6 million) aged 18 and older struggled with AUD (National Institute on Alcohol Abuse and Alcoholism, 2024b).

Excessive drinking affects 23.4% of White and 25.7% of Hispanic/Latinx Montanan adults (United Health Foundation, 2022). Montana's alcohol-induced death rate has steadily risen since 2015. By 2019, it reached 27 deaths per 100,000 residents, nearly double the national average of 15 per 100,000. In 2020, Montana's alcohol-related deaths increased to 102, compared to 29 two decades earlier (Montana Department of Public Health and Human Services, 2023b).

Despite the rising prevalence of alcohol use, only 7.9% of Americans with AUD received any treatment in 2023 (National Institute on Alcohol Abuse and Alcoholism, 2024a). The low ratio of mental health providers in Montana, one for every 4,761 residents, limits the accessibility of AUD treatment (Rosston, 2022). Moreover, Hispanic/Latinx individuals face additional barriers to access, like limited English proficiency, acculturation challenges, low health literacy (Eghaneyan et al., 2020; Substance Abuse and Mental Health Services

Administration, 2014), financial constraints, and lack of insurance (Arroyo, 2008; Eghaneyan et al., 2020; Moyce et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Unsurprisingly, Spanish-speaking Hispanic individuals remain seven times less likely to receive outpatient mental health services than non-Hispanic White individuals (Moyce et al., 2022) leading to worse AUD outcomes for the Hispanic community (Alvarez et al., 2007; Wagner & Baldwin, 2020).

The growing United States Hispanic/Latinx population urgently requires culturally sensitive AUD treatment options (Alvarez et al., 2007; Arroyo, 2008; Eghaneyan et al., 2020; Wagner & Baldwin, 2020). National and Montana state health policies promote equitable healthcare access, culturally and linguistically responsive care (U.S. Department of Health & Human Services, n.d.), AUD recovery support groups in all communities, and disparity mitigation (Montana Legislature, 2023). However, many rural Montana areas with growing immigrant populations still lack Spanish-language or Hispanic/Latinx recovery services. Language barriers often prevent Spanish speakers from accessing community peer support groups (PSGs), the most frequently sought AUD resource (Substance Abuse and Mental Health Services Administration, 2014). This project aims to expand Hispanic/Latinx recovery options in a rural Montana recovery clinic's service area by developing the skills of non-licensed personnel to initiate and sustain a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults with AUD.

### Review of the Literature

Three key themes emerged during the literature review: PSG benefits, structural guidelines, and facilitator guidelines for Hispanic/Latinx PSGs.

### PSG Benefits

Multiple studies show that Peer Support Groups (PSGs) improve functioning, reduce co-occurring mental health symptoms (Ashford et al., 2019), extend the length of alcohol abstinence (Ashford et al., 2019; Hall et al., 2023), increase engagement in outpatient services (Ashford et al., 2019; Suzuki et al., 2023), and reduce hospital admissions (Ashford et al., 2019).

Additionally, the Hispanic/Latinx community's cultural values are prosocial and rely on interconnectedness and social engagement. The social structure and interpersonal problem-solving inherent in PSGs are more congruent with these facets of Hispanic culture than traditional one-on-one clinician services (Garcia et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Evidence shows that Hispanic/Latinx participants engaging in PSGs benefit from higher rates of sobriety and committed engagement to treatment than do White participants (Substance Abuse and Mental Health Services Administration, 2014).

### Structural Guidelines for Hispanic/Latinx PSGs

Effective PSGs for Hispanic/Latinx individuals require culturally sensitive structural elements to create an inclusive environment and foster open sharing. This can include Hispanic/Latinx-only participants (Garcia et al., 2022), Spanish-language materials (Substance Abuse and Mental Health Services Administration, 2014), and Spanish-speaking facilitators (Garcia et al., 2022). To maximize accessibility and address the increased risk of relapse during non-work hours, PSGs should ideally be scheduled for evenings and weekends (Kelly et al., 2020).

Alcoholics Anonymous (AA), a widely available PSG, promotes sustained alcohol remission through a spiritually-based Twelve-Step Program (Kelly et al., 2020). Twelve-Step

groups double sobriety rates compared to groups without (Zemore et al., 2017) and align well with the religious norms found in Hispanic/Latinx cultures (Garcia et al., 2022; Kelly et al., 2020). AA best practices include interaction between participants and facilitators with similar experiences (Ashford et al., 2019; Kelly et al., 2020), 60 to 90 minute sessions, and clinician referrals to treatment programs for sustained remission (Kelly et al., 2020).

Minority groups have adapted AA resources for their communities (Garcia et al., 2022; Wagner & Baldwin, 2020). California's *anexos* offers Spanish-speaking immigrants a supportive environment for sharing experiences and discussing cultural challenges like immigration and discrimination (Substance Abuse and Mental Health Services Administration, 2014). Discussion of stigmatized topics mitigates immigration-related stress that can trigger AUD relapse (Ashford et al., 2019; Garcia et al., 2022). Table 3.1 presents key structural guidelines summarized from the literature review.

#### Facilitator Guidelines for Hispanic/Latinx PSGs

Peer-led support groups, initially facilitated by trained leaders, benefit vulnerable populations with mental health conditions like AUD. Facilitators foster an equitable and collaborative environment by using open-ended questions, encouraging participation, modeling empathy, and promoting peer learning (Alvarez et al., 2007; Garcia et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). Addressing access barriers by assuring confidentiality and providing orientation to group processes improves comfort, especially for those with privacy or deportation concerns, low acculturation, or reduced health literacy (Substance Abuse and Mental Health Services Administration, 2014). Table 3.1 presents a summary of key facilitator guidelines compiled from the literature review.

Table 3.1. Key components of culturally supportive PSGs summarized from the literature review.

<b>Structural Guidelines</b>
100% Hispanic/Latinx participants
Facilitator initiated (Spanish-speaking)
Spanish-language advertisements and written materials
Scheduled during evenings or weekends
Sixty-to-ninety-minute sessions
Participants and facilitators who have navigated AUD recovery experiences
Incorporation of Twelve Step Program
Openness to cultural topics like acculturation, discrimination, and socioeconomic disparity
Proactive referrals
Free Attendance
<b>Facilitator Guidelines</b>
Create a safe and supportive environment by setting ground rules for confidentiality and respectful communication
Provide orientation to group processes and goals
Educate participants about Twelve Steps
Pose open ended questions
Encourage participation through honest sharing of personal stories
Model empathetic listening and emotional support
Allow participants to learn from each other, refrain from positioning self as content expert
Encourage participants to take on leadership roles and guide discussions

A brief facilitator training can mitigate challenges, enhance self-efficacy, and improve group outcomes (Delisle et al., 2016). Facilitator training should cover PSG benefits (Walitzer et al., 2009); group processes, goals, expectations, and ground rules; approaches for creating a safe environment (Substance Abuse and Mental Health Services Administration, 2014); the Twelve Steps (*Alcohólicos Anónimos*, 2023; Kelly et al., 2020); and stressful cultural triggers (Moyce et al., 2022; Rogers et al., 2022). This training equips facilitators with evidence-based materials, enhances confidence in leading, and provides information to enable participant self-leadership upon completion of the facilitated sessions (Delisle et al., 2016).

### Conceptual Framework

The Institute for Healthcare Improvement Model for Improvement offers a framework for quality improvement implementations. Its core component, the Plan-Do-Study-Act cycle, facilitates iterative testing and refinement of small-scale change through planning a change, doing the change, studying the results, and acting according to the results (Ogrinc et al., 2022). By employing three Plan-Do-Study-Act cycles, the Doctor of Nursing Practice student, who served as the project coordinator, systematically refined the support group's structure, activities, and approach, incorporating anonymous survey feedback and data analysis to boost PSG effectiveness and facilitator confidence.

### Project Aim

To promote equitable access to local AUD recovery services, the project aimed to develop the skills of non-licensed personnel to initiate a culturally sensitive, peer-led community support group for Spanish-speaking Hispanic/Latinx adults, 18 years or older, with AUD. Furthermore, the project intended to equip participants with the skills to self-lead the groups after the facilitated sessions, ensuring long-term sustainability.

### Methods

#### Context

The project site was a rural Montana recovery clinic primarily serving individuals with court mandates for AUD treatment. Although the organization treated over 900 patients in 2024, a lack of Spanish services required the clinic to refer all Spanish speakers to a center over 140 miles away (J. Holton, personal communication, September 4, 2024). The lack of accessibility

creates a particular hardship for those with revoked driver's licenses, work commitments, or family obligations (Marissa, organization staff, personal communication, September 11, 2024; Eghaneyan et al., 2020). An inability to attend the court-mandated PSG services results in an increased risk of jail time and deportation. Despite court communication expressing the lack of local Spanish services, an estimated 20 individuals sought help from the clinic in 2024, further demonstrating the need for local Spanish language AUD resources (Marissa, organization staff, personal communication, September 11, 2024).

While the clinic will employ a Spanish-speaking clinician starting in the summer of 2025, the full range of recovery services depends on community PSGs for treatment maintenance and relapse prevention. Although in 2025 more than 15 English-language PSGs exist within a 20-mile radius, none include Spanish-language PSGs (Alcoholics Anonymous, 2024). Three Spanish-speaking individuals with AUD recovery experience volunteered to facilitate support group initiation, including a Peer Support Specialist associated with a local recovery center, a recently recovered community member, and a graduate counseling student. Developing the skills of this volunteer staff to initiate a culturally sensitive, peer-led support group would enable the clinic to locally provide its full range of recovery services to Spanish-speaking individuals, thus mitigating barriers to equitable access.

### Intervention

Planning steps necessary for the development of the PSG sessions consisted of finding a facilitator, securing a location, creating flyers, and generating a statewide distribution list. A local recovery rental space, a common venue for various PSG groups in the community, served as the location for the PSGs. The project coordinator created flyers that were hand-delivered or emailed

to over 50 organizations that interact with Spanish-speaking individuals throughout the state, including churches, restaurants, recovery facilities, and county courts.

To support facilitator knowledge and confidence, the project coordinator created and equipped the facilitators with a PSG Facilitator Handbook, Spanish-language written materials (obtained from the session agendas in the handbook), and the Spanish-language AA Big Book (*Alcohólicos Anónimos*, 2023). The PSG Facilitator Handbook covered group benefits (Walitzer et al., 2009); the process for creating safe, supportive environments (Substance Abuse and Mental Health Services Administration, 2014); group processes, goals, expectations, rules, and agendas; the Twelve Steps (*Alcohólicos Anónimos*, 2023; Kelly et al., 2020); and cultural triggers known to exacerbate AUD (Moyce et al., 2022; Rogers et al., 2022) (see Table 3.2 for excerpted details from the PSG Facilitator Handbook).

Table 3.2. Excerpted details from the project coordinator-created PSG Facilitator Handbook.

<p><b>Group Goals:</b></p> <ul style="list-style-type: none"> <li>• Increase support</li> <li>• Reduce isolation</li> <li>• Improve coping skills</li> <li>• Reduce stress</li> <li>• Increase Readiness for participants to self-lead</li> </ul>
<p><b>Group Process:</b></p> <ul style="list-style-type: none"> <li>• 10-minute Introduction</li> <li>• 20-minute Twelve Steps</li> <li>• 20-minute Cultural topics</li> <li>• 10-minute Summary</li> </ul>
<p><b>Ground Rules and Expectations:</b></p> <ul style="list-style-type: none"> <li>• Everything is confidential</li> <li>• Respectful and empathetic interactions</li> <li>• Active participation</li> <li>• Work toward healthy coping strategies</li> </ul>
<p><b>Cultural Discussion Questions</b></p> <p><b>Acculturation stress</b></p> <ul style="list-style-type: none"> <li>• What are some of the challenges you've faced in adapting to American culture?</li> <li>• How does acculturative stress affect your relationships and sense of community?</li> </ul> <p><b>Coping with Discrimination and Prejudice</b></p> <ul style="list-style-type: none"> <li>• How has discrimination affected your self-esteem and sense of belonging?</li> <li>• What are some of the harmful stereotypes associated with the Hispanic community?</li> </ul> <p><b>Socioeconomic Disparities and Alcohol Use</b></p> <ul style="list-style-type: none"> <li>• How have socioeconomic disparities affected your access to education, healthcare, and opportunities?</li> <li>• What are some of the barriers you've faced in achieving your goals?</li> </ul>

For the complete PSG Facilitator Handbook, see the Montana State University website ([https://1drv.ms/b/c/dd2ca0e179266169/EfdBomZ3ya5Ik6cbBbDlux8B\\_2qsPSEHX3jMgsL4HtgKQQ?e=c5YU7K](https://1drv.ms/b/c/dd2ca0e179266169/EfdBomZ3ya5Ik6cbBbDlux8B_2qsPSEHX3jMgsL4HtgKQQ?e=c5YU7K)). To prepare non-licensed staff to facilitate PSG sessions, the project coordinator provided a two-hour, in-person facilitator training program. The training involved interactive discussion of key topics, guided by the PSG Facilitator Handbook, and introduced the written materials covering each session's topics.

Implementation included a one-hour PSG session conducted by two to three facilitators weekly for six weeks, from January 14<sup>th</sup> to February 18<sup>th</sup>, 2025. The PSG initiative was open to all Spanish speakers in the community. All evidence-based components summarized in Table 3.1 were incorporated into the PSG sessions. Before each session, the project coordinator delivered written materials and refreshments to the facilitators, who distributed these to the participants. During each week's session, facilitators accessed the PSG Facilitator Handbook and AA Big Book for guidance. Throughout the project timeline, the project coordinator provided support to facilitators via email, text, phone, and in-person meetings, offering praise, encouragement, and reminders of progress toward project goals.

In the final two sessions, facilitators prepared participants for self-leadership by introducing the project coordinator-created Spanish-language peer packet (condensed from the PSG Facilitator Handbook) and assessed PSG participant readiness to assume leadership. One returning PSG participant agreed to serve as the future PSG session leader, assumed the meeting location contract for ongoing sessions, and applied for official AA group designation. Additionally, the peer packet and Spanish AA Big Book were left for continued use (see Table 3.3 for a summary of implementation steps for initiating groups).

The total cost of project implementation was \$435, primarily for lead facilitator time (\$50/session) and refreshments (\$10/session). The AA Big Book, flyers, and location rental were \$25 each. Co-facilitators and the project coordinator volunteered their time.

Table 3.3. Summary of implementation steps.

<b>Summary of Implementation Steps</b>
1. Secure a location for PSG meetings
2. Find a facilitator
3. Create flyers and a distribution list
4. Equip facilitators with Spanish language AA Big Book, PSG Facilitator Handbook, and written materials
5. Provide a two-hour, in-person facilitator training program
6. Deliver flyers and direct referrals
7. Host a one-hour facilitated PSG session weekly for six weeks
8. Deliver written materials and refreshments to the facilitators on day of each session
9. Prepare participants with resources for continuation including the Peer Packet, AA Big Book, and a review of materials
10. Remain available to facilitators and support with praise, encouragement, and reminders of progress toward project goals
11. Have lead participant take over rental contract and apply for AA group designation

### Measures

The goals for this project were 1) two or more participants to attend the PSG sessions by the end of four weeks, 2) to have 50% repeat attendance by the end of six weeks, 3) to obtain 100% positive PSG facilitator response rate to qualitative material feedback questions by the end of six weeks, 4) and for the facilitators to achieve greater than or equal to 90% self-efficacy and confidence as evidenced by Group Leader Self-Efficacy Instrument (GLSI) (Page et al., 2001) scores by the end of six weeks.

To measure PSG participation, de-identified attendance and repeat attendance numerical data were collected weekly by the facilitators during each PSG session. To measure the usefulness of the facilitator materials, all three facilitators responded biweekly to three questions: "Were materials easy to follow?", "Did they inspire participation?" and "Did they provide valuable recovery tools?" Nominal and qualitative feedback were recorded. To measure the facilitators' growth in self-efficacy and confidence in leading the group sessions, the GLSI was

administered to the two participating facilitators before the training session and again after they completed their facilitation role. The third facilitator was excluded from the GLSI survey as they joined the project after the initial survey, but before the PSG began.

### Ethical Considerations

All data was collected from facilitators via secure and confidential Qualtrics links accessible by phone or laptop. Data contained no identifiers, required no health records from the project's site, was stored anonymously on the Montana State University server, and was only accessible by the project coordinator. Every two weeks, the project coordinator exported the instrument results directly into an Excel spreadsheet on a password-protected desktop for data analysis. The project coordinator only shared summarized data during project presentations and dissemination. The proposed work was approved by the Institutional Review Board through Montana State University before project initiation.

### Analysis

Data collection and analysis informed iterative adjustments to the implementation, aiming to improve attendance, the facilitators' confidence, and the effectiveness of the provided materials. To analyze PSG participation survey data, descriptive statistics, and a bar chart depiction were used to identify data patterns over time.

To analyze the usefulness of the facilitator materials, nominal data of Yes/No survey responses were translated into percentages of 100 or zero, respectively, and analyzed with descriptive statistics to identify patterns over time. The goal would have been achieved once the nominal data scores were 100% for all three questions. The project coordinator also read the

associated qualitative survey responses to identify recurring themes or suggestions for content improvement.

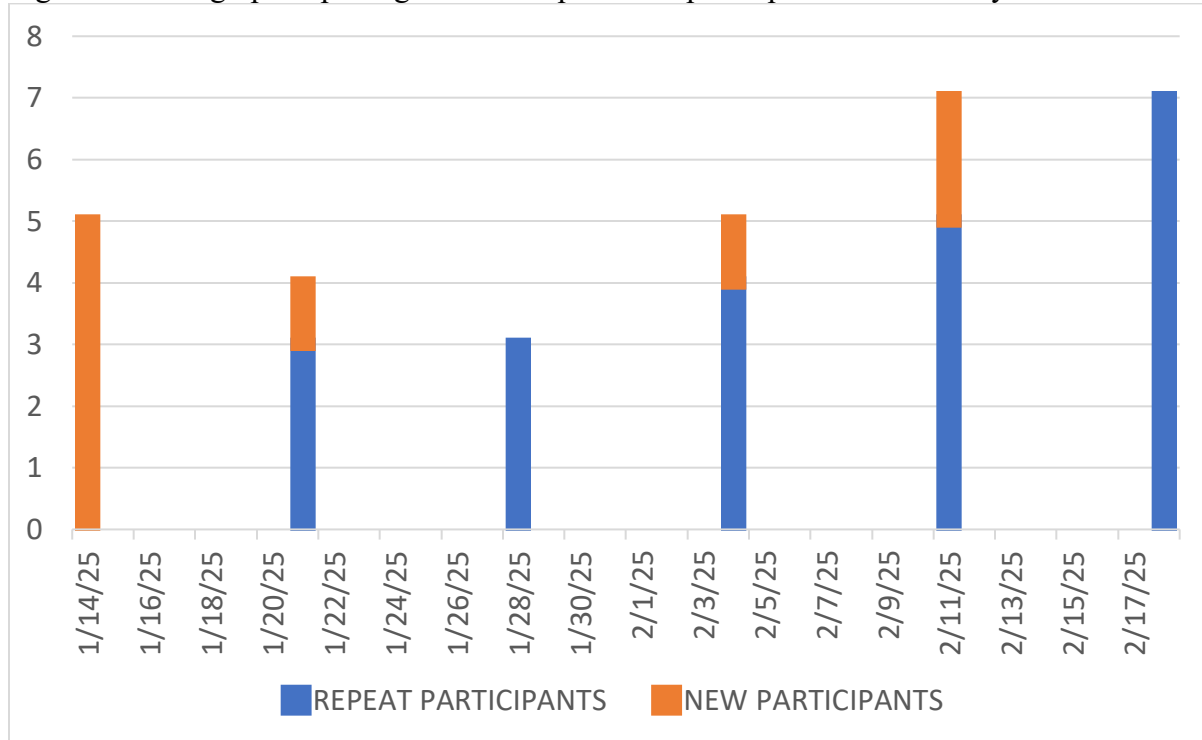
To analyze the facilitators' growth in confidence in leading the group sessions over time, Likert scale responses to the GLSI surveys were translated into a percentage of total possible points: twenty questions times six possible answers made 120 total possible points. The goal of achieving a score of 90% would have been achieved once 108/120 points were recorded. Descriptive statistics were used at the end of the six-week implementation to analyze the GLSI percentage trend over time.

## Results

### Attendance

Attendance targets for the PSG sessions—a minimum of two participants by week four and 50% repeat attendance by week six—were exceeded. Attendance remained consistently above two, with a mean of 5.2 and a range from three to seven participants. Repeat attendance varied between 71-100% with a mean of 85.2%. Although attendee demographics were not purposefully collected, facilitators reported that all attendees were male and between 18 and 65 years old. Session three attendance dropped due to reported work conflicts with the 4:00 pm PSG session start time. A 7:00 pm meeting time, implemented in response to stakeholder input by the fourth session, correlated with an immediate increase to five participants. Attendance further increased to seven by the fifth session, with 100% repeat attendance of these seven participants for the final facilitated session. Figure 3.1 shows a bar graph depicting new and repeat PSG participant attendance by week.

Figure 3.1. Bar graph depicting new and repeat PSG participant attendance by week.



### Material Feedback

The PSG Facilitator Handbook was evaluated through three questions: "Were materials easy to follow?", "Did they inspire participation?" and "Did they provide valuable recovery tools?" Nominal and qualitative feedback was recorded. Surveys documented a "Yes" response to all nominal questions from start to finish, achieving the goal of a 100% positive response rate by week six. Via the accompanying qualitative feedback data, the facilitators reported the group naturally focused on the Twelve Steps and AA materials and did not actively target cultural topics. One facilitator noted, "The group has naturally gravitated toward the AA format out of necessity for AA in Spanish". Another facilitator expressed hesitancy in targeting "more intense" cultural topics like discrimination and preferred to allow them to emerge organically.

Facilitators indicated they valued the training, PSG Facilitator Handbook, AA Big Book, and written materials, which boosted their confidence and provided a foundation for the PSG discussions. Flexibility to follow the group's lead, especially for integrating new members, proved essential. The combination of preparation and adaptability enabled effective material use, conversation flow, and resource referral. Facilitators noted lively discussions and the all-male group's particular appreciation for open, honest sharing about alcohol experiences with other men.

### Facilitator Confidence

GLSI scores revealed increased facilitator confidence from 52.5% to 70.8% and 62.5% to 85.8% (a mean 20.8% increase) but remained below the 90% goal by week six. Facilitators gained notable improvements (represented by a movement of three Likert points, or 50% score elevation) in processing participant experiences, responding to group dynamics, providing support, and shifting focus. Despite ongoing guidance and education, facilitators remained unsure about managing strong emotions and cultural topics.

### Outcomes Beyond Measured Projections

Beyond the project goals, this project demonstrated meaningful change. One participant achieved four weeks of sobriety during the six-week program, abstaining from alcohol to attend the PSG sessions, and five participants completed the PSG attendance component of their court-mandated sentencing checklist. The group further exhibited sustainability by having a participant assume the meeting space rental contract, add an additional Saturday session, and apply for official AA recognition (which would provide broader visibility via the AA website). The group

also collected \$25 for ongoing expenses, and one facilitator volunteered additional time to continue attending as a participant.

### Discussion

To promote equitable access to local AUD recovery services, this project showed that non-licensed personnel could be equipped with the skills to initiate and sustain a culturally sensitive, peer-led support group for Spanish-speaking Hispanic/Latinx adults with AUD. Consistent PSG attendance surpassed expectations, validating the organization's claim of a significant local need. Shifting the support group to after-work hours improved attendance and was likely the most significant factor impacting project sustainability. The literature supports the assertion that strategic scheduling plays a vital role in PSG outcomes (Colditz et al., 2023; Garcia et al., 2022).

As the organization lacked an existing Spanish-speaking client base, the project relied on flyers and organizational outreach for PSG promotion. However, participant feedback revealed direct referrals from organizations, facilitators, and participants were most effective. With a new Spanish-speaking clinician, future implementations using clinician-prescribed attendance are expected to increase participation, aligning with research showing proactive referrals enhance service linkage and PSG participation (Kelly et al., 2020).

Facilitators consistently gave 100% positive nominal feedback on the PSG Facilitator Handbook, participant literature, and PSG member leader resources. Accompanying qualitative data showed that the group naturally gravitated toward the Twelve Steps and AA materials, with cultural topics emerging organically rather than being actively guided by facilitators. Such topic

focus reflects prior evidence suggesting the attraction and efficacy of Twelve Step groups over those without (Zemore et al., 2017). Given the prevalence of the Twelve Step principles in the United States AUD treatment programs (Wagner & Baldwin, 2020), starting future groups with the Twelve Steps, without cultural stressor questions, could be equally effective while ensuring facilitator and participant comfort and confidence with familiar content. Otherwise, material preparation and the freedom to follow participant-led discussions enabled facilitators to feel prepared, adapt to conversation flow, integrate new members, and utilize resources as needed.

While the facilitators' confidence, as measured by the GLSI scores, increased over the six-week implementation period, overall scores remained below the target of 90%. Facilitators indicated increased confidence regarding processing participant experiences, responding to group dynamics, creating a supportive environment, and shifting group focus. Coupled with qualitative feedback, these results evidenced the positive impact of the facilitator training and handbook. Still, facilitators expressed lower confidence in managing strong emotions and cultural topics. Given the facilitators' vulnerability as first-time, non-licensed individuals with lived AUD experience, achieving 90% confidence on all items in six weeks was likely unrealistic. The optimal duration for PSG facilitator training remains unclear (Delisle et al., 2016); however, measured improvements suggest that continued facilitation and additional training could further enhance confidence levels on GLSI items with lower scores.

Project success was not limited to the facilitators but included positive and impactful outcomes for the participants. The implementation achieved the aim of increased accessibility for the Hispanic/Latinx population as five participants, mandated by the court to attend PSGs, avoided a 140-mile commute to the nearest Spanish-language group, thereby mitigating risks of

incarceration and deportation related to incomplete sentencing requirements. Additionally, one participant credited four weeks of sobriety to the group's accessibility and peer support.

Similarly, the recently recovered facilitator continued attending, recognizing the group as a vital resource for maintaining sobriety that had been absent during his recovery.

By providing a location, trained facilitators, and resource materials, the project design fostered participant empowerment, leading to long-term PSG sustainability. This outcome was evidenced by a participant's leadership as chairperson, assumption of the rental contract, addition of a Saturday session, and pursuit of AA recognition. Overall, the project confirmed that non-licensed personnel can be effectively trained to enhance AUD treatment accessibility for underserved populations through the implementation of support groups.

### Limitations

The results of this project should be considered with the following limitations. Not explicitly recruited, the participant population was all male, which limits generalizability for those with AUD and identifying as female. Although the participation number exceeded the goal of the project, several factors likely limited broader attendance. The absence of an established Spanish-speaking client base within the organization precluded direct clinician-to-client outreach and likely limited attendance. Furthermore, local organizations and participants confirmed widespread fear of deportation within the Hispanic/Latinx community, particularly given the then-heightened government deportation activity in early 2025. These concerns may have deterred more from attending.

Limited external validity and reliability of the GLSI exists since only two facilitators participated in the surveys. Nonetheless, the project data analysis showed facilitator materials

presented during a six-week implementation could only partially address first-time facilitator development of non-licensed personnel with AUD recovery experience. Facilitators continued to express reluctance to target “more intense” cultural topics despite evidence indicating that the exploration of stigmatized topics could further reduce stressors triggering alcohol use (Ashford et al., 2019; Garcia et al., 2022). Facilitator hesitation may have limited PSG outcomes (Delisle et al., 2016). Acknowledging limitations, the overwhelmingly positive results warrant continued work to maximize community access and impact.

### Recommendations

Future PSG initiation projects should consider after-work scheduling crucial to optimizing attendance and sustainability. The organization's future Spanish-speaking clinician should prioritize direct participant referrals and provide consistent confidentiality assurances to establish treatment continuity, increase PSG attendance, and alleviate deportation fears. To maintain facilitator comfort and boost confidence, a phased approach is recommended, starting with the Twelve Steps and gradually introducing cultural topics as facilitators gain experience or receive further training or counseling on unresolved personal AUD and cultural experiences. A training session or mentorship, provided by the project implementer or facilitators, could further prepare the participant-leader for their new role. Future research exploring the correlations between PSG participation, relapse rates, session content, and extended facilitator training would further contribute to optimizing this vital model of care.

### Conclusion

In response to the rising prevalence of AUD, the expanding Hispanic/Latinx population, and the dearth of mental health providers, particularly those proficient in Spanish, this project employed an innovative methodology to promote AUD treatment equity in Montana. By establishing a PSG structure, creating a PSG Facilitator Handbook with session agendas, providing facilitator training, and offering ongoing mentorship, the project coordinator developed a replicable blueprint for Spanish-language PSG implementation. The project fostered a self-sustaining community resource that allows the organization to provide its full range of services to Spanish-speaking clientele. This initiative aligns with national and state policies and begins to address the service gap for Spanish speakers in the area. Furthermore, this Doctor of Nursing Practice project provides other rural clinics with the tools and roadmap to replicate its success in establishing culturally sensitive, Spanish-language support groups throughout Montana. Participants renamed the group *Camina di Esperanza*, or Path of Hope, serving as both a testament to their progress and a clear call to action, urging healthcare practitioners to replicate the pathways to hope outlined in this project in other underserved communities.

## CHAPTER FOUR

## ADVANCED NURSING ESSENTIALS REFLECTION

Introduction

I am deeply appreciative of the chance to undertake a doctoral education. This advanced preparation granted me a wider view of nursing, beyond patient care. I am encouraged by the potential of doctorally prepared nurses to significantly contribute to improving community health, enhancing patient outcomes, and expanding the knowledge base within the nursing profession. The American Association of Colleges of Nursing established a framework for developing doctorally prepared advanced practice nurses and eight essential curricular foci (American Association of Colleges of Nursing, 2021). The Psychiatric Mental Health Nurse Practitioner program within Montana State University's (MSU) Doctor of Nursing Practice (DNP) Degree integrates these essentials to equip students with the expertise to excel in diverse clinical settings and innovate practices to optimize patient healthcare outcomes. This chapter presents a personal reflection on my progress in achieving these essentials through my educational experiences at MSU.

Domain One: Knowledge for Nursing Practice

Domain One addresses both the liberal arts and scientific basis of nursing practice. DNP-prepared nurses exhibit a strong foundation in biology, genomics, psychology, and sociology. Scientific and liberal arts knowledge allows practitioners to address complex healthcare challenges and develop innovative solutions. By integrating scientific and liberal arts theories

and concepts, DNP nurses can enhance patient care, evaluate outcomes, and drive advancements in nursing practice (American Association of Colleges of Nursing, 2021).

MSU's DNP program fostered a strong foundation in scientific inquiry. While the advanced pathophysiology, pharmacology, and health assessment courses gave me a strong foundation of biological and genomic information, the Evidence-Based Practice courses specifically honed my skills in asking research questions, accessing relevant evidence-based resources, and critically evaluating more expansive evidence. Collaboration with the College of Nursing librarian further strengthened my ability to sift through the continuously growing body of scientific evidence. Live discussions with classmates during the Ethics, Law and Policy course intensives broadened my liberal arts perspective, enabling me to integrate social and psychological factors into my decision-making. Additionally, the Scholarly Project Seminar course's assigned completion of Stanford University's *Writing in the Sciences* online class (Sainani, 2020) and the associated writing assignments refined my ability to effectively organize and logically integrate multi-disciplinary knowledge. The mandatory citation of evidence-based research in all papers, posts, and oral assignments throughout MSU's DNP program has encouraged my habit of reflexively turning to the collected knowledge of literature when addressing clinical gaps, problems, or questions. This skill will be invaluable in my future career as I navigate the dynamic and ever-changing healthcare landscape.

### Domain Three: Population Health

Domain Three emphasizes the critical need to continuously evaluate and adapt current clinical practice models to meet the evolving needs of individuals and populations. DNP-prepared nurses possess the skills to analyze existing data, synthesize national guidelines, and

develop innovative interventions that address practice gaps and enhance the quality of care delivery (American Association of Colleges of Nursing, 2021).

The skills of this essential were fundamental to the development of my final Quality Improvement Project for the Scholarly Project course. To address the gap in care of the aggregated population of Spanish speakers suffering from Alcohol Use Disorder, I had to synthesize information about the individual needs, the organizational and community gaps, the state and national standards, and the resources available before determining the intervention I would initiate. My analysis considered the impact at multiple levels, including the microsystem (organizational), mesosystem (community), and macrosystem (state and national). Instead of solely focusing on internal organizational solutions like translation services, I prioritized the development of peer support groups to enhance care access for the entire community. I further created a facilitator package to disseminate this model across the state and other rural areas nationwide, aiming to improve access for the wider Spanish-speaking population.

My final Quality Improvement Project highlighted the importance of a dynamic perspective, constantly shifting between the clinical level and the broader population health impact. The project demanded a constant balancing act, addressing the needs of diverse stakeholders, from participants and facilitators to organizational managers, community leaders, and research professors, while maintaining a larger population health perspective. I will strive to effect meaningful change in my future practice by addressing care gaps through a population health lens, ensuring that my interventions benefit both individual patients and the overall health of the community.

### Domain Five: Quality and Safety

Domain Five equips nurses to lead and innovate safety and quality initiatives within healthcare systems. DNP-prepared nurses broaden their focus to communities of patients and consider organizational and policy perspectives when addressing safety issues, designing and implementing new care models, optimizing resource utilization, and improving patient outcomes. With a foundation in finance, leadership, and systems thinking, DNP-prepared nurses can effectively navigate complex healthcare environments, advocating for a balance of safety, quality, costs, and patient-centered care (American Association of Colleges of Nursing, 2021).

MSU's Design of Healthcare Systems course assignments to develop swimlane, fishbone, and spaghetti diagrams obligated students to consider meso and macrosystem implications when addressing microsystem problems (Griffin et al., 2016). This course broadened my perspective and influenced my decision to address my scholarly project organization's care gap through a community-level approach. Although the organization planned to address the language barrier internally by hiring a Spanish-speaking clinician, I recognized that patient progress would remain stagnant without sufficient community resources. I felt that lasting quality improvement necessitated a systemic approach, as supported by Domain Five.

The final assignment of the Advanced Nursing Leadership course prompted students to reflect on their personal philosophy of leadership after completing self-assessments and reading articles covering a variety of leadership theories. My DiSC assessment identified me as a Type "S" (Steadiness, Supportive, Stable) personality. Type "S" individuals are often perceived as good employees who prioritize others and avoid conflict. While this stability is an asset to teammates, I learned that Type "S" personalities can sometimes lose sight of their own goals while helping others (*DISC Personality Type S: Steadiness*, n.d.). Receiving this feedback during

my first DNP semester prompted me to reflect on my emerging role as a doctorally prepared nurse and bolstered my confidence in my leadership potential to influence broader changes in healthcare (Northouse, 2021). This self-reflection empowered me to assert my ideas and advocate for myself within teams. This proved particularly valuable during my final scholarly project, where I consistently encouraged, guided, and reminded facilitators of our project goals, maintaining their motivation throughout the six-week implementation. Domain Five underscores such leadership skills for effecting change through quality and safety team initiatives.

The lectures in the Financing and Budgeting course instilled in me the importance of conducting a thorough financial analysis of any proposed changes I advocate for, ensuring a fiscally responsible approach to healthcare quality improvement. My interview with a business manager for the course interview assignment reinforced this concept. Additionally, developing the cost-benefit analysis honed my ability to present a financially compelling argument for quality improvement (Leger, 2023), a skill I applied to my final scholarly project manuscript. While my project's promising improvements in care quality should inspire replication, I recognized that broader adoption required a persuasive cost-benefit analysis demonstrating how initial startup costs would be recouped and exceeded through the creation of a complete service line for a new population of patients. Domain Five prepares nurses to lead and innovate safety and quality initiatives with a foundation in finance, leadership, and systems thinking, enabling effective navigation of multifaceted healthcare environments.

#### Domain Six: Interprofessional Partnerships

Domain Six cultivates interpersonal skills. DNP-prepared nurses are collaborators who can lead and participate in interprofessional teams. They can effectively communicate, problem-

solve, and implement innovative solutions to complex healthcare challenges in a summative manner. By fostering teamwork and collaboration, DNP nurses contribute to improved patient outcomes and system-wide improvements (American Association of Colleges of Nursing, 2021).

MSU's DNP program offers continual opportunities for partnerships through team projects, allowing students to develop professional communication skills with classmates. Furthermore, success in the program increases when students network with professors, administrators, and professional colleagues to gain insights along the way. My interpersonal development culminated academically with the final Quality Improvement Project conducted in fulfillment of the Scholarly Project course. In securing a site, advertising peer support groups, training facilitators, and coordinating roles and responsibilities, I collaborated with clinicians, topic experts, a site representative, a peer support specialist, recovery graduates, multiple boards of directors, community members, and organizational leaders.

The Advanced Nursing Leadership course, through emotional intelligence surveys and peer evaluations, heightened my self-awareness of leadership strengths and weaknesses. It also fostered an understanding of providing constructive feedback to enhance teammate participation (Northouse, 2021). The Group Member Paper in the Program Planning and Evaluation, Outcomes and Quality Improvement course inspired me to systematically break down my and my teammates' roles, tasks, and contributions toward cohesive group accomplishments. These analyses set me up with the tools to contribute toward team goals proactively and specifically when innovating during the program. These skills were invaluable during my final Quality Improvement Project and I expect they will continue to support my successful participation in future collaborations.

### Domain Seven: Systems-Based Practice

Domain Seven describes how DNP-prepared nurses must proactively combat systemic inequities with policy awareness, ethical leadership and innovative solutions. The Ethics, Law and Policy course assignment of creating an advocacy letter brought my attention to the effects of government policies on what is done at the clinical level. I developed advocacy skills and a profound understanding of the critical responsibility DNP nurses bear in advocating for patients who may lack the power to advocate for themselves. The DNP nurse must commit time and energy to amplify individual voices throughout the system (Grace, 2018). Informed by this, I chose a final scholarly project that advocated for the Spanish-speaking Hispanic/Latinx population in the Gallatin Valley, a community that quite literally could not speak for itself. I focused on promoting equity by establishing the first Spanish-language peer support groups for adults recovering from Alcohol Use Disorder, addressing a significant gap in services where over 15 English-language options already existed.

Most significantly, the combined knowledge I gained in organizational leadership, quality improvement, and systems thinking proved invaluable in successfully executing the quality improvement projects required for the Program Planning and Evaluation, Outcomes and Quality Improvement; Vulnerability and Healthcare in Diverse Communities; and Scholarly Project courses. Considering how best to integrate ACE and depression screening tools within the clinic setting and a peer support group initiative for Alcohol Use Disorder within the community exercised all my Domain Seven skills. The collective impact of these academic experiences has cultivated within me a systems-based perspective that will affect my professional approach to practice as I continue to evaluate the potential systemic implications of each decision I make.

### Domain Eight: Informatics and Healthcare Technologies

Domain Eight focuses on using technology and informatics to enhance patient care. DNP-prepared nurses design and implement innovative technological solutions to optimize care delivery; analyze data to improve efficiency and patient outcomes; and address ethical and legal considerations related to technology use (American Association of Colleges of Nursing, 2021).

MSU's Healthcare Informatics course prepared me with technology terminology and a broader understanding of care intervention options that integrate various technologies, including Artificial Intelligence. Proposing management plans exercised these skills as I incorporated big data, patient portals, and technological filters to prevent disease progression for pre-diabetic patients.

The Statistical Applications course prepared me to better collaborate and communicate numerical data and associated phenomena with colleagues. I learned to use online software to manage statistical data (*Intellectus Statistics*, 2021) and describe information with a variety of descriptive statistics (Myoungjin et al., 2022). For instance, I created a bar chart in Excel visualizing mean peer support group attendance data from my final scholarly project. Sharing this graphic with facilitators effectively communicated the positive impact of the time change on attendance, which helped maintain their motivation despite the added burden. Although I had previously communicated this information verbally, the visual presentation of the statistical analysis proved more persuasive.

MSU's Design of Healthcare Systems course revealed the benefits and limitations of pharmacological technologies through presentations of articles and class discussions on topics including prescription errors, medication delivery mistakes, and checks and balances between technology and the human factor (Griffin et al., 2016). As a future DNP leader, I will consider

technology a tool but never a singular solution, recognizing the limitations of any system. For example, in my future psychiatric practice, I would not rely solely on a brief screening survey for diagnosis without also conducting a thorough holistic patient assessment. At the same time, the screening survey would be used as a component of my assessment, serving to identify important areas of potential oversight, and completing the full system of recommended care.

Online study throughout the entire DNP program propelled me to become more fluent in virtual meeting platforms like Zoom and Webex. Ongoing team collaborations and class presentations strengthened my professional written abilities in email and text formats and my presentation abilities using software like PowerPoint and Adobe Express.

My DNP education, encompassing coursework in healthcare informatics, statistics, systems design, and virtual learning, has equipped me with the skills necessary to effectively utilize technology to enhance patient care through data-driven decision-making, effective online and descriptive communication, and the ethical and responsible use of technology. I anticipate telehealth to be an essential offering in my future practice as a psychiatric practitioner in a rural state. These capabilities will serve to extend the reach of my practice.

#### Quality Improvement Implementation and Impact on Future Career

My final Quality Improvement Project pushed me to integrate the knowledge and skills acquired across the DNP Essentials outlined by the American Association of Colleges of Nursing (American Association of Colleges of Nursing, 2021). These competencies helped me overcome challenges during project implementation and have become an integral part of my professional identity that will undoubtedly guide my future practice. Whether treating a patient, identifying a

care gap, or implementing practice changes, I will instinctively draw upon the insights gained during my final Quality Improvement Project and throughout the MSU DNP program.

The final Quality Improvement Project provided invaluable hands-on experience, demonstrating the practical steps involved in implementing successful quality improvement initiatives. As I designed evidence-based session content, collaborated with organizational leaders, and responded to facilitator evaluations, I remembered that impactful change does not require heroic feats; it requires persistent individual action. MSU's DNP program has equipped me with the skills and empowerment to step outside my comfort zone and effect change across various dimensions— from individual patient care to community-wide initiatives and even potential contributions at the state and national levels. I eagerly anticipate future opportunities to apply these skills beyond my routine clinical practice.

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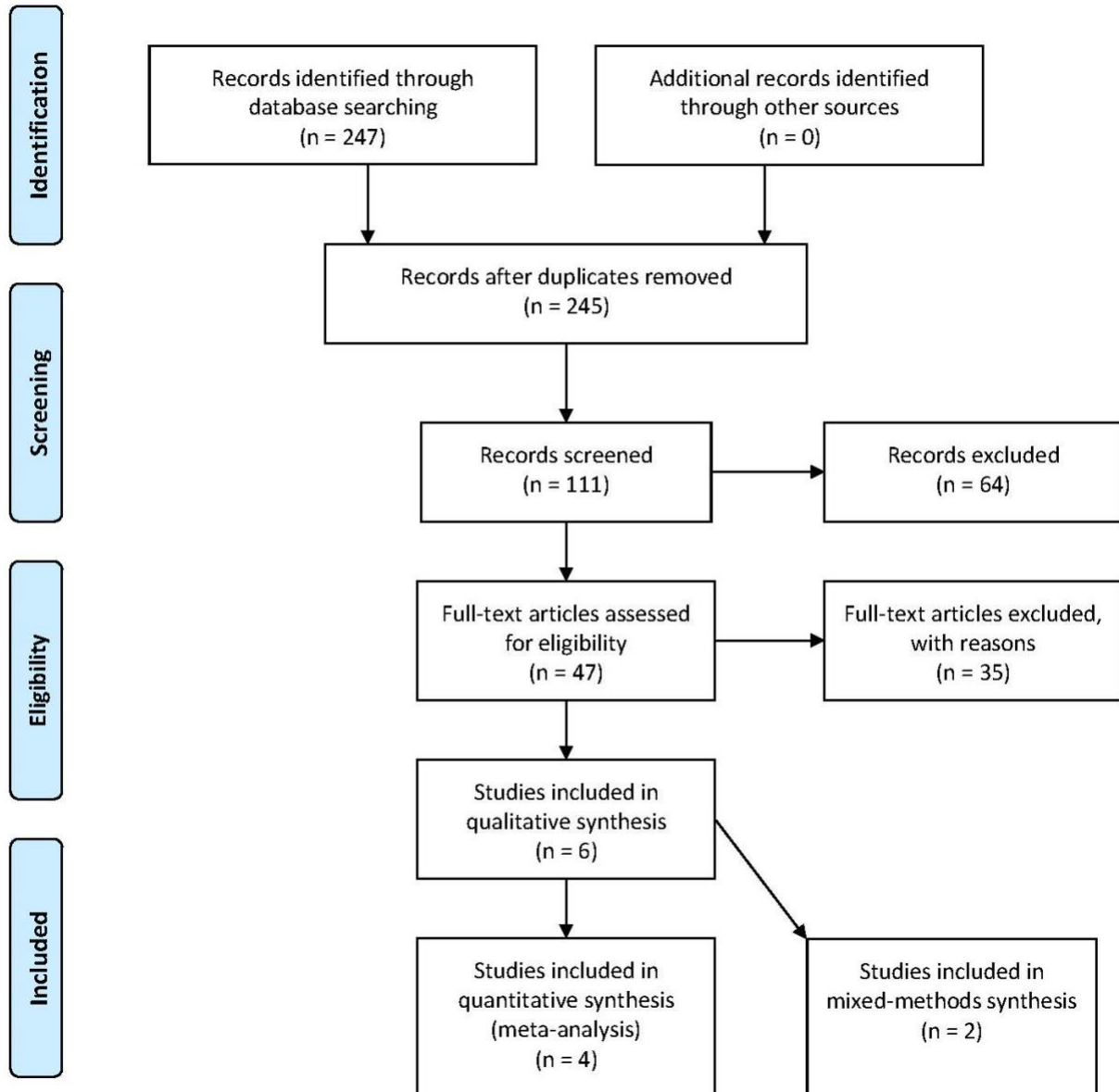
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APPENDICES

APPENDIX A

PRISMA DIAGRAM

Figure A1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram.



APPENDIX B

FACILITATOR HANDBOOK: ENGLISH WITH SPANISH

ADDENDUM

**FACILITATOR PACKET: ENGLISH****Session Structure****1. Check-In (10 minutes):**

- Facilitator reviews group processes, goals, expectations, ground rules
- Facilitator distributes or directs participants to location of written materials
- Participants share their experiences and feelings since the last meeting.
- Facilitator listens attentively and provides validation.
- Welcome late arrivals
- **\*\*Qualtrics Attendance Count, including the number of repeat participants**

**2. Review of Twelve Steps (20 minutes):**

- Facilitator briefly reviews the relevant twelve steps for the session.
- Participants discuss their understanding and application of these steps.
- Participants share their successes, challenges, and questions.
- Facilitator encourages honest, open dialogue and provides problem-specific support and guidance.

**3. Discussion of Triggers (20 minutes):**

- Facilitator introduces the concept of triggers related to acculturation stress, discrimination, and socioeconomic disparities.
- Participants share personal experiences and strategies for coping with triggers.
- Facilitator encourages honest, open dialogue and provides problem-specific support and guidance.

**4. Closing (10 minutes):**

- Facilitator summarizes key points and encourages participants to continue their recovery journey.
- Facilitator briefly previews next week's topics, encourages attendance
- Facilitator reminds participants they can use provided materials to exchange names and numbers, review session topics and Twelve Steps

**5. \*\*Facilitator completes evaluation tools via Qualtrics links on weeks 2, 4, and 6**

## Facilitator Roles and Responsibilities

- **Create a Safe and Supportive Environment:**
  - Establish ground rules for confidentiality and respect.
  - Foster a sense of community and belonging.
  - Be mindful of cultural sensitivities and avoid stereotypes.
- **Guide the Discussion:**
  - Ask open-ended questions to encourage participation.
  - Facilitate constructive dialogue and conflict resolution.
  - Provide information and resources as needed.
- **Model Healthy Coping Mechanisms:**
  - Share personal experiences (if appropriate) to demonstrate resilience.
  - Encourage participants to develop healthy coping strategies.
  - Provide opportunities for participants to practice these skills in a supportive environment.
- **Provide Support and Encouragement:**
  - Offer validation and empathy for participants' experiences.
  - Model *personalismo*: warm and empathetic interactions that convey understanding and concern for a person's well-being.
  - Celebrate participant successes and provide motivation during challenges.
- **Prepare for Peer-led Group Structure**
  - Refrain from positioning self as a content expert, allow participants to learn from one another
  - Encourage participants to take on leadership roles and facilitate discussions
  - Gradually convey information from facilitator training to the participants as outlined in weekly sessions to transition to a group structure where participants take on more responsibility for leading the group.
- **Provide Language-Congruent Handouts**
- **Collect Attendance, Repeat Attendance Data/ Complete Qualtrics Evaluations**

Reminders:

- Everyone's journey is unique, it is a journey, not a race. Respect the pace at which each works through the steps.
- Group members can offer support and encouragement, regardless of progress.
- No competition. Focus is on personal growth and community support and well-being.

**Note:** These sessions can be adapted to meet the specific needs and interests of the participants. It is important for the facilitators to provide guidance and support while allowing participants to take the lead in the discussions.

### **Self-Reflective Questions for Facilitators to Build Cultural Humility**

To understand the impact of culture in our own lives and others', we can look directly at how we are situated and the ways in which it might influence our perspectives and behaviors. To help us explore our own identity, we can ask ourselves the following self-reflection questions:

Where am I from (nationality, region, and heritage)?

What are my beliefs, values, and religious and political orientations?

What is my age group?

What is my social class?

What are my vocations and avocations?

What life events have greatly affected me?

Which of the above factors are significant to me?

What stereotypes do I hold? (*Gervin et al., 2014*)

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**Summary of Structural Elements of Culturally Supportive Peer Support Groups**


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100% Hispanic/Latinx participants

Spanish-language speaking facilitator

Spanish-language advertisements and written materials

Culturally relevant food, pictures, and posters

Discussion of cultural topics including acculturation, discrimination, socioeconomic disparity

Introductory period at beginning of each session for late arrivals

Monitoring attendance

Orientation to group processes, goals, expectations, and ground rules

Assurance of Confidentiality

Sixty-to-ninety-minute sessions

Facilitator Initiated

Peers and mentors who have navigated similar life experiences

Incorporation of spiritually-based, Twelve Step Program

Participation, honest sharing of personal stories

Problem-specific support and guidance

Time for interactions between new and existing members

Empathetic, emotionally supportive, and health-oriented relationships

Shared experiences with interpersonal strategies and stress management skills

Proactive referrals

Free Attendance

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**Summary of Facilitator Guidelines, Culturally Supportive Peer Support Groups**


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Include a background on the benefits, barriers, and misconceptions of PSGs and AA

Provide information about cultural triggers like acculturative stress and discrimination

Educate participants about Twelve Steps

Provide orientation to group processes, goals, expectations, and ground rules

Creating a safe and supportive group environment by setting ground rules for confidentiality and respectful communication

Model empathetic listening and emotional support

Incorporate personalismo when discussing difficult topics directly

Pose open ended questions

Encourage participation through honest sharing of personal stories

Refrain from positioning self as content expert, allows participants to learn from one another

Share personal experiences (if appropriate) to demonstrate resilience

Encourage participants to develop healthy coping strategies

Offer validation

Celebrate successes and provide motivation during challenges

Encourage participants to take on leadership roles and facilitate discussions

Connect participants with community resources

Complete self-reflective questionnaire prior to initiation to improve cultural humility

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## **Group Goals, Processes, Ground Rules, Expectations and Benefits: English**

- **Group Goals:**

- Increase support
- Reduce isolation
- Improve coping skills
- Reduce stress
- **Increase Readiness for participants to self-lead**
  - Gradually transition to where participants take on more responsibility for leading the group.

- **Group Process:**

- 10-minute Introduction
- 20-minute Twelve Steps
- 20-minute Contributing Factors topics
- 10-minute Summary

- **Ground Rules and Expectations:**

- Everything is confidential
- Respect and *personalismo* (warm and empathetic interactions that convey understanding and concern for a person's well-being)
- Active participation
- Work toward healthy coping strategies

- **Research-backed Group Benefits:**

- Positive connections with others who are or have successfully navigated similar life experiences
- Confidential participation for as long as participants finds it beneficial
- Free of charge
- Improves quality of life and functioning
- Reduces co-occurring mental health symptoms and hospital admissions
- Extends the length of abstinence by one to three years posttreatment

### Group Content and Understanding AUD: English

**Alcohol Use Disorder (AUD)**: a chronic and relapsing disease involving compulsive alcohol use despite the harmful interpersonal, professional, and medical consequences.

- **Group Content:**

- **AA:**

- **Introduction:** Briefly explain the concept of the Twelve Steps and their role in recovery.

- AA incorporates a spiritually based, Twelve-Step Program (TSP) that promotes sustained remission from alcohol and enhances interpersonal skills and stress management through the sharing of personal stories.

- Strong evidence suggests that TSP groups **double sobriety rates** compared to groups without

- Currently, there are no other Spanish-speaking AA/TSP programs in our area.

- **Culturally Specific Topics:**

- Some minority populations have adapted AA resources to better resonate with their communities

- *Anexos*, for example, originated as grassroots meeting spaces annexed onto existing AA sites by Hispanic/Latinx immigrants in California.

- Researchers examined the successes of anexos and discovered that they provided a milieu conducive to discussing shared cultural challenges like immigration, acculturation and discrimination that sparked self-reflection and transformation. Facilitating the exploration of stigmatized topics reduced the impact of immigration-related stress on unhealthy coping mechanisms like alcohol use.

## Glossary of Terms

**Acculturation Stress:** A sense of isolation or exclusion from mainstream American society

**Defects of Character:** Personal flaws or weaknesses that hinder one's ability to live a fulfilling life.

**Discriminations & Prejudice:** Unfair treatment of individuals or groups based on characteristics like race, gender, or religion.

**Harm:** Negative consequences of one's actions, including damage to oneself and others.

**Humility:** The quality of being humble or recognizing one's limitations and imperfections.

**Moral Inventory:** A thorough examination of one's character, values, and behaviors.

**Resilience:** The ability to recover from adversity and bounce back from setbacks.

**Shortcomings:** Deficiencies or weaknesses in one's character or abilities.

**Social Justice:** The principle of fairness and equality for all members of society.

**Systemic inequalities:** Injustice built into the systems and structures of society, often favoring certain groups over others.

**Socioeconomic disparities:** Unequal distribution of wealth, income, and opportunities across different groups in society.

**Spiritual Awakening:** A profound transformation of one's consciousness and values.

**Supportive & Inclusive:** A welcoming and encouraging environment that embraces diversity and fosters a sense of belonging.

## Session Topics and Twelve Steps

### Session 1: Introduction of Twelve Steps and Triggers

- Introduce facilitator and group members
- Introduce group goals, processes, ground rules, expectations and benefits
- Introduce AUD and group content
- **ATTENDANCE**
- **Icebreaker:**
  - *¿Cuál es tu comida favorita y por qué?* (What is your favorite food and why?)
  - **Other option:** *¿Cuál es tu hobby favorito?* (What is your favorite hobby?)
    - This icebreaker is simple, easy to understand, and can help people feel more comfortable sharing about themselves. It also allows for a variety of responses, from personal anecdotes to cultural preferences.
    - Remember, the goal of the icebreaker is to create a relaxed and welcoming atmosphere where people feel comfortable sharing and connecting with each other.

### Initiate the Twelve Steps

- **Step 1:** *We admitted we were powerless over alcohol—that our lives had become unmanageable.*
  - **Discussion:**
    - What does it mean to be powerless over alcohol?
    - How has alcohol negatively impacted your life?
    - What are some signs or symptoms that your life has become unmanageable?

## Introduction to Concept of Triggers

- Discuss **common triggers** (HALT: hungry, angry, lonely, tired) for alcohol use
- Explore **healthy coping mechanisms** and stress management techniques: deep breathing, meditation, outdoors/ grounding
- Encourage participants to share their experiences
- Encourage participants to feel empowered and capable at overcoming challenges

### Discussion Questions:

- What are some personal triggers you've identified?
- How do these triggers affect your thoughts, feelings, and behaviors?
- What strategies have you tried to cope with these triggers?

## Session 2: Twelve Steps and Introduction of Acculturation Stress

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

### Twelve Steps: Step 2 and 3

- **Step 2:** *Came to believe that a Power greater than ourselves could restore us to sanity.*
  - **Discussion:**
    - What is your understanding of a Higher Power?
    - How can a Higher Power help you in your recovery?
    - What are some ways you can connect with your Higher Power?
- **Step 3:** *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
  - **Discussion:**
    - What does it mean to surrender your will to a Higher Power?

- How can surrendering your will help you in your recovery?
- What are some challenges you may face in surrendering your will?

### **Introduction to Acculturation Stress**

- **Understanding Acculturative Stress:** The group discusses the concept of acculturative stress and its impact on individuals.
  - **Acculturation stress:** a sense of isolation or exclusion from mainstream American society, can raise the risk of harmful coping mechanisms, including alcohol abuse
- **Balancing Cultures:** Participants explore the challenges of balancing cultural identities and adapting to a new culture.
- **Coping with Acculturative Stress:** The group shares strategies for managing acculturative stress and promoting well-being.
- **Discussion Questions:**
  - What are some of the challenges you've faced in adapting to American culture?
  - How does acculturative stress affect your relationships and sense of community?
  - How can cultural factors impact alcohol use?
  - What can we do to support each other in navigating cultural differences?

**\*\*PLEASE COMPLETE EVALUATIONS VIA QUALTRICS LINKS**

### **Session 3: Twelve Steps and Discrimination and Prejudice**

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

### **Twelve Steps: Step 4 and 5**

- **Step 4:** *Made a searching and fearless moral inventory of ourselves.*
  - **Discussion:**

- What does it mean to conduct a moral inventory?
- How can a moral inventory help you identify areas for growth?
- What are some strategies for conducting a moral inventory?
- **Step 5:** *Admitted to God, to ourselves, and to another human being the nature of our wrongs.*
  - **Discussion:**
    - What is the importance of admitting your wrongs?
    - How can sharing your wrongs with others help you in your recovery?
    - What are some challenges you may face in admitting your wrongs?

### **Coping with Discrimination and Prejudice**

- **Experiences of Discrimination:** Participants share their experiences with discrimination, both overt and subtle.
- **Impact on Mental Health:** The group discusses how discrimination can negatively impact mental health and contribute to alcohol use.
- **Coping with Discrimination:** Participants share strategies for coping with discrimination and building resilience.
- **Discussion Questions:**
  - How has discrimination affected your self-esteem and sense of belonging?
  - What are some of the harmful stereotypes associated with the Hispanic community?
  - How can we challenge and dismantle these stereotypes?

### **Session 4: Twelve Steps and Socioeconomic Disparities**

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

## Twelve Steps: Step 6 and 7

- **Step 6:** *Were entirely ready to have God remove these defects of character.*
  - **Discussion:**
    - What are some defects of character that have contributed to your alcoholism?
    - How can you be ready to have these defects removed?
    - What are some ways you can work with your Higher Power to remove these defects?
- **Step 7:** *Humbly asked Him to remove our shortcomings.*
  - **Discussion:**
    - What does it mean to humbly ask for help?
    - How can humility help you in your recovery?
    - What are some ways you can practice humility?

## Socioeconomic Disparities and Alcohol Use

- **Understanding Socioeconomic Disparities:** The group discusses the impact of socioeconomic disparities on the Hispanic community.
- **Challenges of Poverty:** Participants share their experiences with poverty and its effects on their lives.
- **Overcoming Obstacles:** The group explores strategies for overcoming socioeconomic challenges and achieving personal goals.
- **Discussion Questions:**
  - How have socioeconomic disparities affected your access to education, healthcare, and opportunities?
  - What are some of the barriers you've faced in achieving your goals?
  - How can we advocate for social justice and address systemic inequalities?

**\*\*PLEASE COMPLETE EVALUATIONS VIA QUALTRICS LINKS**

## Session 5: Twelve Steps and Building Healthy Relationships/Creating a Support Network

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

### Twelve Steps: Step 8 and 9

- **Step 8:** *Made a list of persons we had harmed, and became willing to make amends to them all.*
  - **Discussion:**
    - Who have you harmed as a result of your alcoholism?
    - How can making amends help you heal and move forward?
    - What are some challenges you may face in making amends?
- **Step 9:** *Made direct amends to such people wherever possible, except when to do so would harm them or others.*
  - **Discussion:**
    - What does it mean to make direct amends?
    - How can you make direct amends to those you have harmed?
    - What are some ways to approach making amends?

### Creating a Support Network

- **The Importance of Support:** The group discusses the importance of healthy relationships and how to establish them.
- **Support systems:** explore different support systems, such as family, friends, professionals
- **Building Connections:** Participants share strategies for building connections with others in the Hispanic community.
- **Communications skills:** practice effective communication skills to build stronger relationships

- **Seeking Professional Help:** The group explores the benefits of seeking professional help when needed.
- **Discussion Questions:**
  - Who are some of the people you can rely on for support?
  - How can we create a supportive and inclusive community within this group?
  - When might it be helpful to seek professional help?

**Begin Transition to Shared Leadership:** Gradually transition to a model where participants take on more responsibility for leading the group.

- Assess readiness for Peer-led groups: begins in two weeks
  - **Provide Examples:** Share stories or case studies of successful peer-led groups in the community.
  - **Address Concerns:** Acknowledge potential concerns or anxieties participants may have about transitioning to a peer-led group.

### **Session 6: Twelve Steps and Coping Skills / Maintaining Sobriety and Wellness**

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

#### **Twelve Steps: Step 10, 11 and 12**

- **Step 10:** *Continued to work a Twelfth-Step Program and carried this message to others, and practiced these principles in all our affairs.*
  - **Discussion:**
    - What does it mean to work a Twelve-Step Program?
    - How can carrying the message to others help you stay sober?
    - What are some ways you can practice these principles in all your affairs?

- **Step 11:** *Sought through prayer and meditation to improve our conscious contact with God as we understood Him.*
  - **Discussion:**
    - What is the importance of prayer and meditation in recovery?
    - How can prayer and meditation help you connect with your Higher Power?
    - What are some ways you can incorporate prayer and meditation into your daily life?
- **Step 12:** *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.*
  - **Discussion:**
    - What is a spiritual awakening?
    - How has working the Twelve Steps led to a spiritual awakening for you?
    - What are some ways you can share your experience, strength, and hope with others?

### **Developing Coping Skills**

- **Identifying Coping Mechanisms:** Participants identify their current coping mechanisms and assess their effectiveness.
- **Healthy Coping Strategies:** The group explores healthy coping strategies, such as mindfulness, exercise, and seeking support.
- **Building Resilience:** Participants discuss the importance of building resilience and overcoming challenges.

### **Discussion Questions:**

- What are some healthy coping mechanisms you've found helpful?
- How can you incorporate these strategies into your daily life?
- What can we do to support each other in building resilience?

## **Developing a Recovery Plan/ Relapse Prevention**

### **Recovery Goals:**

- **Discussion:** Strategies for preventing relapse, promoting wellness, and remembering support system

### **Transition to Shared Leadership:**

- Assess readiness for Peer-led groups: begins next week
  - **Address Concerns:** Acknowledge potential concerns or anxieties participants may have about transitioning to a peer-led group.
  - **\*\*\*Offer peer-led written materials and the AA Big Book to participants who wish to continue their involvement the following week.**

**\*\*PLEASE COMPLETE EVALUATIONS VIA QUALTRICS LINKS**

**SPANISH ADDENDUM****Group Goals, Processes, Ground Rules, Expectations and Benefits: Spanish  
Objetivos, Procesos, Reglas Básicas, Expectativas y Beneficios del Grupo****• Objetivos del Grupo:**

- \* Aumentar el apoyo
- \* Reducir el aislamiento
- \* Mejorar las habilidades de afrontamiento
- \* Reducir el estrés
- \* Aumentar la preparación de los participantes para liderarse a sí mismos

**• Proceso del Grupo:**

- \* 10 minutos de Introducción
- \* 20 minutos de Doce Pasos
- \* 20 minutos de temas sobre Factores Contribuyentes
- \* 10 minutos de Resumen

**• Reglas Básicas y Expectativas:**

- \* Todo es confidencial
- \* Respeto y personalismo (interacciones cálidas y empáticas que transmiten comprensión y preocupación por el bienestar de una persona)
- \* Participación activa
- \* Trabajar hacia estrategias de afrontamiento saludables

**• Beneficios del Grupo Respaldados por Investigación:**

- \* Conexiones positivas con otros que están o han navegado con éxito experiencias de vida similares
- \* Participación confidencial durante el tiempo que los participantes lo encuentren beneficioso
- \* Gratuito
- \* Mejora la calidad de vida y el funcionamiento
- \* Reduce los síntomas concurrentes de salud mental y las admisiones hospitalarias
- \* Extiende la duración de la abstinencia de uno a tres años después del tratamiento

## Group Content and Understanding AUD: Spanish

### Contenido del Grupo y Comprensión de AUD

**Trastorno por Consumo de Alcohol (TCA), también conocido como trastorno por uso de alcohol (AUD):** una enfermedad crónica y recurrente que implica el uso compulsivo del alcohol a pesar de las consecuencias perjudiciales interpersonales, profesionales y médicas.

- **Contenido del Grupo:**
  - **AA:**
    - **Introducción:** Explique brevemente el concepto de los Doce Pasos y su papel en la recuperación.
      - AA incorpora un **Programa de Doce Pasos (TSP)** basado en la espiritualidad que promueve la remisión sostenida del alcohol y mejora las habilidades interpersonales y la gestión del estrés a través del intercambio de historias personales.
        - Evidencias sólidas sugieren que los grupos de TSP duplican las tasas de sobriedad en comparación con los grupos sin TSP.
        - Actualmente, no hay otros programas de AA/TSP en español en nuestra área.
  - **Temas Culturalmente Específicos:**
    - Algunas poblaciones minoritarias han adaptado los recursos de AA para resonar mejor con sus comunidades.
    - **Los anexos**, por ejemplo, se originaron como espacios de reunión de base anexos a los sitios existentes de AA por inmigrantes hispanos/latinos en California.
      - Los investigadores examinaron los éxitos de los anexos y descubrieron que proporcionaban un entorno propicio para discutir desafíos culturales compartidos como la inmigración, la aculturación y la discriminación, lo que impulsó la autorreflexión y la transformación. Facilitar la exploración de temas estigmatizados redujo el impacto del estrés relacionado con la inmigración en los mecanismos de afrontamiento no saludables como el consumo de alcohol.
      - El hecho de no reconocer las adversidades únicas que enfrentan los inmigrantes descuida un factor crítico que puede desencadenar recaídas e influir en los resultados de atención médica en esta población.

## Glosario de Términos

**Estrés por Aculturación:** Una sensación de aislamiento o exclusión de la sociedad estadounidense dominante.

**Defectos de Carácter:** Fallos o debilidades personales que obstaculizan la capacidad de llevar una vida plena.

**Discriminación y Prejuicio:** Trato injusto a individuos o grupos basado en características como raza, género o religión.

**Daño:** Consecuencias negativas de las acciones propias, incluyendo daño a uno mismo y a otros.

**Humildad:** La cualidad de ser humilde o reconocer las propias limitaciones e imperfecciones.

**Inventario Moral:** Un examen exhaustivo del propio carácter, valores y comportamientos.

**Resiliencia:** La capacidad de recuperarse de la adversidad y superar los obstáculos.

**Deficiencias:** Deficiencias o debilidades en el carácter o las habilidades propias.

**Justicia Social:** El principio de justicia e igualdad para todos los miembros de la sociedad.

**Desigualdades Sistémicas:** Injusticia incorporada en los sistemas y estructuras de la sociedad, a menudo favoreciendo a ciertos grupos sobre otros.

**Desigualdades Socioeconómicas:** Distribución desigual de la riqueza, el ingreso y las oportunidades entre diferentes grupos de la sociedad.

**Despertar Espiritual:** Una profunda transformación de la conciencia y los valores propios.

**Apoyador e Inclusivo:** Un ambiente acogedor y alentador que abraza la diversidad y fomenta un sentido de pertenencia.

## Session Topics and Twelve Steps: Spanish

### Sesión 1: Introducción a los Doce Pasos y Desencadenantes

- Introduce facilitator and group members
- Introduce group goals, processes, ground rules, expectations and benefits
- Introduce AUD and group content
- **ATTENDANCE**
- **Icebreaker:**
  - *¿Cuál es tu comida favorita y por qué?* (What is your favorite food and why?)
  - **Other option:** *¿Cuál es tu hobby favorito?* (What is your favorite hobby?)
    - This icebreaker is simple, easy to understand, and can help people feel more comfortable sharing about themselves. It also allows for a variety of responses, from personal anecdotes to cultural preferences.
    - Remember, the goal of the icebreaker is to create a relaxed and welcoming atmosphere where people feel comfortable sharing and connecting with each other.
- **Paso 1:** *Admitimos que éramos impotentes ante el alcohol, que nuestras vidas se habían vuelto inmanejables.*
  - **Discusión:**
    - ¿Qué significa ser impotente ante el alcohol?
    - ¿Cómo ha afectado negativamente el alcohol tu vida?
    - ¿Cuáles son algunas señales o síntomas de que tu vida se ha vuelto inmanejable?

### Introducción al Concepto de Desencadenantes

- Discutir desencadenantes comunes (HALT: hambre, enojado, solo, cansado) para el consumo de alcohol

- Explorar mecanismos de afrontamiento saludables y técnicas de manejo del estrés: respiración profunda, meditación, actividades al aire libre/enraizamiento
- Animar a los participantes a compartir sus experiencias
- Animar a los participantes a sentirse empoderados y capaces de superar desafíos

### **Desencadenantes:**

- ¿Cuáles son algunos desencadenantes personales que has identificado?
- ¿Cómo afectan estos desencadenantes tus pensamientos, sentimientos y comportamientos?
- ¿Qué estrategias has intentado para lidiar con estos desencadenantes?

## **Sesión 2: Los Doce Pasos y Introducción al Estrés de Aculturación**

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

### **Twelve Steps: Step 2 and 3**

- **Paso 2:** *Llegamos a creer que un Poder superior a nosotros mismos podía devolvernos a la cordura.*
  - **Discusión:**
    - ¿Cuál es tu comprensión de un Poder Superior?
    - ¿Cómo puede un Poder Superior ayudarte en tu recuperación?
    - ¿Cuáles son algunas formas en que puedes conectarte con tu Poder Superior?
- **Paso 3:** *Tomamos la decisión de entregar nuestra voluntad y nuestras vidas al cuidado de Dios como lo entendíamos.*
  - **Discusión:**
    - ¿Qué significa entregar tu voluntad a un Poder Superior?

- ¿Cómo puede entregar tu voluntad ayudarte en tu recuperación?
- ¿Cuáles son algunos desafíos que puedes enfrentar al entregar tu voluntad?

### **Introducción al Estrés Aculturador**

- **Comprender el Estrés Aculturador:** El grupo discute el concepto de estrés aculturador y su impacto en los individuos.
  - **Estrés aculturador:** un sentimiento de aislamiento o exclusión de la sociedad estadounidense dominante, puede aumentar el riesgo de mecanismos de afrontamiento dañinos, incluido el abuso de alcohol.
- **Equilibrando Culturas:** Los participantes exploran los desafíos de equilibrar las identidades culturales y adaptarse a una nueva cultura.
- **Enfrentando el Estrés Aculturador:** El grupo comparte estrategias para manejar el estrés aculturador y promover el bienestar.

### **Estrés de Aculturación:**

**Discusión:** Desafíos de la aculturación, la identidad cultural y la autoestima.

- ¿Cuáles son algunos de los desafíos que has enfrentado al adaptarte a la cultura estadounidense?
- ¿Cómo afecta el estrés aculturativo tus relaciones y tu sentido de comunidad?
- ¿Cómo pueden los factores culturales impactar el consumo de alcohol?
- ¿Qué podemos hacer para apoyarnos mutuamente en navegar las diferencias culturales?

**\*\*PLEASE COMPLETE EVALUATIONS VIA QUALTRICS LINKS**

### **Sesión 3: Los Doce Pasos, la Discriminación y el Prejuicio**

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**
- **Paso 4:** *Hicimos un inventario moral escrupuloso de nosotros mismos.*

- **Discusión:**
  - ¿Qué significa hacer un inventario moral?
  - ¿Cómo puede un inventario moral ayudarte a identificar áreas de crecimiento?
  - ¿Cuáles son algunas estrategias para realizar un inventario moral?
- **Paso 5:** *Admitimos ante Dios, ante nosotros mismos y ante otro ser humano la naturaleza de nuestros errores.*
  - **Discusión:**
    - ¿Cuál es la importancia de admitir tus errores?
    - ¿Cómo puede compartir tus errores con los demás ayudarte en tu recuperación?
    - ¿Cuáles son algunos desafíos que puedes enfrentar al admitir tus errores?

### **Enfrentando la Discriminación y los Prejuicios**

- **Experiencias de Discriminación:** Los participantes comparten sus experiencias con la discriminación, tanto abierta como sutil.
- **Impacto en la Salud Mental:** El grupo discute cómo la discriminación puede afectar negativamente la salud mental y contribuir al consumo de alcohol.
- **Enfrentando la Discriminación:** Los participantes comparten estrategias para enfrentar la discriminación y construir resiliencia.

### **La Discriminación y el Prejuicio:**

- ¿Cómo ha afectado la discriminación tu autoestima y tu sentido de pertenencia?
- ¿Cuáles son algunos de los estereotipos dañinos asociados con la comunidad hispana?
- ¿Cómo podemos desafiar y dismantelar estos estereotipos?

## Sesión 4: Los Doce Pasos y las Desigualdades Socioeconómicas

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

### Twelve Steps: Step 6 and 7

- **Paso 6:** *Estuvimos completamente dispuestos a que Dios nos liberara de estos defectos de carácter.*
  - **Discusión:**
    - ¿Cuáles son algunos defectos de carácter que han contribuido a tu alcoholismo?
    - ¿Cómo puedes estar dispuesto a que se eliminen estos defectos?
    - ¿Cuáles son algunas formas en que puedes trabajar con tu Poder Superior para eliminar estos defectos?
- **Paso 7:** *Humildemente le pedimos que nos liberara de nuestros defectos.*
  - **Discusión:**
    - ¿Qué significa pedir humildemente ayuda?
    - ¿Cómo puede la humildad ayudarte en tu recuperación?
    - ¿Cuáles son algunas formas en que puedes practicar la humildad?

### Desigualdades Socioeconómicas y Consumo de Alcohol

- **Comprender las Desigualdades Socioeconómicas:** El grupo discute el impacto de las desigualdades socioeconómicas en la comunidad hispana.
- **Desafíos de la Pobreza:** Los participantes comparten sus experiencias con la pobreza y sus efectos en sus vidas.
- **Superando Obstáculos:** El grupo explora estrategias para superar los desafíos socioeconómicos y alcanzar metas personales.

### **Las Desigualdades Socioeconómicas y el Consumo de Alcohol**

- ¿Cómo han afectado las desigualdades socioeconómicas tu acceso a la educación, la atención médica y las oportunidades?
- ¿Cuáles son algunas de las barreras que has enfrentado para alcanzar tus metas?
- ¿Cómo podemos abogar por la justicia social y abordar las desigualdades sistémicas?

**\*\*PLEASE COMPLETE EVALUATIONS VIA QUALTRICS LINKS**

### **Sesión 5: Los Doce Pasos y el Construyendo Relaciones Saludables**

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

#### **Twelve Steps: Step 8 and 9**

- **Paso 8:** *Hicimos una lista de las personas a quienes habíamos hecho daño y estuvimos dispuestos a repararles el daño a todas.*
  - **Discusión:**
    - ¿A quién has hecho daño como resultado de tu alcoholismo?
    - ¿Cómo puede reparar el daño ayudarte a sanar y avanzar?
    - ¿Cuáles son algunos desafíos que puedes enfrentar al reparar el daño?
- **Paso 9:** *Reparamos directamente a esas personas siempre que fuera posible, excepto cuando hacerlo les dañaría a ellas o a otros.*
  - **Discusión:**
    - ¿Qué significa reparar directamente el daño?
    - ¿Cómo puedes reparar directamente el daño a quienes has hecho daño?
    - ¿Cuáles son algunas formas de abordar la reparación del daño?

#### **Creando una Red de Apoyo**

- **La Importancia del Apoyo:** El grupo discute la importancia de las relaciones saludables y cómo establecerlas.
- **Sistemas de Apoyo:** Exploración de diferentes sistemas de apoyo, como familia, amigos, profesionales.
- **Construyendo Conexiones:** Los participantes comparten estrategias para construir conexiones con otros en la comunidad hispana.
- **Habilidades de Comunicación:** Práctica de habilidades de comunicación efectivas para construir relaciones más sólidas.
- **Buscando Ayuda Profesional:** El grupo explora los beneficios de buscar ayuda profesional cuando sea necesario.

### **Creando una Red de Apoyo**

- ¿Quiénes son algunas de las personas en las que puedes confiar para obtener apoyo?
- ¿Cómo podemos crear una comunidad solidaria e inclusiva dentro de este grupo?
- ¿Cuándo podría ser útil buscar ayuda profesional?

**Begin Transition to Shared Leadership (Comenzar la Transición a Liderazgo Compartido:** Gradually transition to a model where participants take on more responsibility for leading the group.

Assess readiness for peer-led groups (**grupos dirigidos por pares**) begins in two weeks

- **Provide Examples:** Share stories of successful peer-led groups in the community.
- **Address Concerns:** Acknowledge potential concerns or anxieties participants may have about transitioning to a peer-led group. (**Abordar Preocupaciones:** Reconocer posibles preocupaciones o ansiedades que los participantes puedan tener sobre la transición a un grupo dirigido por pares).

## Sesión 6: Los Doce Pasos y las Habilidades de Afrontamiento/ Manteniendo la Sobriedad y el Bienestar

- Introduce facilitator and group members
- Review group goals, processes, ground rules, expectations and benefits
- **ATTENDANCE**

### Twelve Steps: Step 10, 11 and 12

- **Paso 10:** *Continuamos trabajando en un Programa de Doce Pasos, llevamos este mensaje a otros y practicamos estos principios en todos nuestros asuntos.*
  - **Discusión:**
    - ¿Qué significa trabajar en un Programa de Doce Pasos?
    - ¿Cómo puede llevar el mensaje a otros ayudarte a mantenerte sobrio?
    - ¿Cuáles son algunas formas en que puedes practicar estos principios en todos tus asuntos?
- **Paso 11:** *Buscamos a través de la oración y la meditación mejorar nuestro contacto consciente con Dios como lo entendíamos.*
  - **Discusión:**
    - ¿Cuál es la importancia de la oración y la meditación en la recuperación?
    - ¿Cómo pueden la oración y la meditación ayudarte a conectarte con tu Poder Superior?
    - ¿Cuáles son algunas formas en que puedes incorporar la oración y la meditación en tu vida diaria?
- **Paso 12:** *Habiendo tenido un despertar espiritual como resultado de estos pasos, tratamos de llevar este mensaje a los alcohólicos y de practicar estos principios en todos nuestros asuntos.*
  - **Discusión:**
    - ¿Qué es un despertar espiritual?
    - ¿Cómo ha llevado a un despertar espiritual trabajar los Doce Pasos para ti?

- ¿Cuáles son algunas formas en que puedes compartir tu experiencia, fuerza y esperanza con los demás?

### **Desarrollando Habilidades de Afrontamiento**

- **Identificando Mecanismos de Afrontamiento:** Los participantes identifican sus mecanismos de afrontamiento actuales y evalúan su efectividad.
- **Estrategias Saludables de Afrontamiento:** El grupo explora estrategias saludables de afrontamiento, como la atención plena, el ejercicio y buscar apoyo.
- **Construyendo Resiliencia:** Los participantes discuten la importancia de construir resiliencia y superar desafíos.

### **Desarrollando las Habilidades de Afrontamiento**

- ¿Cuáles son algunos mecanismos de afrontamiento saludables que has encontrado útiles?
- ¿Cómo puedes incorporar estas estrategias en tu vida diaria?
- ¿Qué podemos hacer para apoyarnos mutuamente en desarrollar resiliencia?

### **Desarrollando un Plan de Recuperación/Prevención de Recaídas**

#### **Objetivos de Recuperación:**

- **Discusión:** Estrategias para prevenir recaídas, promover el bienestar y recordar el sistema de apoyo.

#### **Transition to Shared Leadership:**

- Assess readiness for peer-led groups (**grupos dirigidos por pares**) begins in two weeks
  - **Abordar Preocupaciones:** Reconocer posibles preocupaciones o ansiedades que los participantes puedan tener sobre la transición a un grupo dirigido por pares.)

**\*\*\*Offer peer-led written materials and the AA Big Book to participants who wish to continue their involvement the following week.**

**\*\*PLEASE COMPLETE EVALUATIONS VIA QUALTRICS LINKS**

APPENDIX C

WRITTEN MATERIALS FOR PARTICIPANTS: ENGLISH AND  
SPANISH

**WRITTEN MATERIALS: ENGLISH****Session 1: Introduction to the Twelve Steps and Triggers**

- **Step 1:** *We admitted we were powerless over alcohol—that our lives had become unmanageable.*
  - **Discussion:**
    - What does it mean to be powerless over alcohol?
    - How has alcohol negatively impacted your life?
    - What are some signs or symptoms that your life has become unmanageable?

**Triggers:**

- What are some personal triggers you've identified?
- How do these triggers affect your thoughts, feelings, and behaviors?
- What strategies have you tried to cope with these triggers?

**Session 2: Twelve Steps and Introduction of Acculturation Stress**

- **Step 2:** *Came to believe that a Power greater than ourselves could restore us to sanity.*
  - **Discussion:**
    - What is your understanding of a Higher Power?
    - How can a Higher Power help you in your recovery?
    - What are some ways you can connect with your Higher Power?
  
- **Step 3:** *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
  - **Discussion:**
    - What does it mean to surrender your will to a Higher Power?
    - How can surrendering your will help you in your recovery?

- What are some challenges you may face in surrendering your will?

### **Acculturation Stress:**

Discussion: Challenges of acculturation, cultural identity, and self-esteem.

- What are some of the challenges you've faced in adapting to American culture?
- How does acculturative stress affect your relationships and sense of community?
- How can cultural factors impact alcohol use?
- What can we do to support each other in navigating cultural differences?

### **Session 3: Twelve Steps, Discrimination and Prejudice**

- **Step 4:** *Made a searching and fearless moral inventory of ourselves.*
  - **Discussion:**
    - What does it mean to conduct a moral inventory?
    - How can a moral inventory help you identify areas for growth?
    - What are some strategies for conducting a moral inventory?
- **Step 5:** *Admitted to God, to ourselves, and to another human being the nature of our wrongs.*
  - **Discussion:**
    - What is the importance of admitting your wrongs?
    - How can sharing your wrongs with others help you in your recovery?
    - What are some challenges you may face in admitting your wrongs?

### **Discrimination and Prejudice:**

- How has discrimination affected your self-esteem and sense of belonging?
- What are some of the harmful stereotypes associated with the Hispanic community?
- How can we challenge and dismantle these stereotypes?

### **Session 4: Twelve Steps and Socioeconomic Disparities**

- **Step 6:** *Were entirely ready to have God remove these defects of character.*
  - **Discussion:**
    - What are some defects of character that have contributed to your alcoholism?
    - How can you be ready to have these defects removed?
    - What are some ways you can work with your Higher Power to remove these defects?
- **Step 7:** *Humbly asked Him to remove our shortcomings.*
  - **Discussion:**
    - What does it mean to humbly ask for help?
    - How can humility help you in your recovery?
    - What are some ways you can practice humility?

### **Socioeconomic Disparities and Alcohol Use**

- How have socioeconomic disparities affected your access to education, healthcare, and opportunities?
- What are some of the barriers you've faced in achieving your goals?
- How can we advocate for social justice and address systemic inequalities?

### **Session 5: Twelve Steps and Building Healthy Relationships**

- **Step 8:** *Made a list of persons we had harmed, and became willing to make amends to them all.*
  - **Discussion:**
    - Who have you harmed as a result of your alcoholism?
    - How can making amends help you heal and move forward?
    - What are some challenges you may face in making amends?
- **Step 9:** *Made direct amends to such people wherever possible, except when to do so would harm them or others.*

- **Discussion:**
  - What does it mean to make direct amends?
  - How can you make direct amends to those you have harmed?
  - What are some ways to approach making amends?

### **Creating a Support Network**

- Who are some of the people you can rely on for support?
- How can we create a supportive and inclusive community within this group?
- When might it be helpful to seek professional help?

### **Session 6: Twelve Steps and Coping Skills / Maintaining Sobriety and Wellness**

- **Step 10:** *Continued to work a Twelfth-Step Program and carried this message to others, and practiced these principles in all our affairs.*
  - **Discussion:**
    - What does it mean to work a Twelve-Step Program?
    - How can carrying the message to others help you stay sober?
    - What are some ways you can practice these principles in all your affairs?
- **Step 11:** *Sought through prayer and meditation to improve our conscious contact with God as we understood Him.*
  - **Discussion:**
    - What is the importance of prayer and meditation in recovery?
    - How can prayer and meditation help you connect with your Higher Power?
    - What are some ways you can incorporate prayer and meditation into your daily life?
- **Step 12:** *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.*

○ **Discussion:**

- What is a spiritual awakening?
- How has working the Twelve Steps led to a spiritual awakening for you?
- What are some ways you can share your experience, strength, and hope with others?

**Developing Coping Skills**

- What are some healthy coping mechanisms you've found helpful?
- How can you incorporate these strategies into your daily life?
- What can we do to support each other in building resilience?

<b>Name</b>	<b>Contact Information</b>	<b>Notes</b>

This contact information is for your personal use if you ever need support. it is confidential and for your use only.

Complete this sentence: I will call when....
Complete this sentence: I want to stay sober because....

## Twelve-Steps to Alcohol Recovery

- **Step 1:** *We admitted we were powerless over alcohol—that our lives had become unmanageable.*
- **Step 2:** *Came to believe that a Power greater than ourselves could restore us to sanity.*
- **Step 3:** *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
- **Step 4:** *Made a searching and fearless moral inventory of ourselves.*
- **Step 5:** *Admitted to God, to ourselves, and to another human being the nature of our wrongs.*
- **Step 6:** *Were entirely ready to have God remove these defects of character.*
- **Step 7:** *Humbly asked Him to remove our shortcomings.*
- **Step 8:** *Made a list of persons we had harmed, and became willing to make amends to them all.*
- **Step 9:** *Made direct amends to such people wherever possible, except when to do so would harm them or others.*
- **Step 10:** *Continued to work a Twelfth-Step Program and carried this message to others, and practiced these principles in all our affairs.*
- **Step 11:** *Sought through prayer and meditation to improve our conscious contact with God as we understood Him.*
- **Step 12:** *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.*

## WRITTEN MATERIALS: SPANISH

### Sesión 1: Introducción a los Doce Pasos y Desencadenantes

- **Paso 1:** *Admitimos que éramos impotentes ante el alcohol, que nuestras vidas se habían vuelto inmanejables.*
  - **Discusión:**
    - ¿Qué significa ser impotente ante el alcohol?
    - ¿Cómo ha afectado negativamente el alcohol tu vida?
    - ¿Cuáles son algunas señales o síntomas de que tu vida se ha vuelto inmanejable?

#### Desencadenantes:

- ¿Cuáles son algunos desencadenantes personales que has identificado?
- ¿Cómo afectan estos desencadenantes tus pensamientos, sentimientos y comportamientos?
- ¿Qué estrategias has intentado para lidiar con estos desencadenantes?

### Sesión 2: Los Doce Pasos y Introducción al Estrés de Aculturación

- **Paso 2:** *Llegamos a creer que un Poder superior a nosotros mismos podía devolvernos a la cordura.*
  - **Discusión:**
    - ¿Cuál es tu comprensión de un Poder Superior?
    - ¿Cómo puede un Poder Superior ayudarte en tu recuperación?
    - ¿Cuáles son algunas formas en que puedes conectarte con tu Poder Superior?
- **Paso 3:** *Tomamos la decisión de entregar nuestra voluntad y nuestras vidas al cuidado de Dios como lo entendíamos.*
  - **Discusión:**
    - ¿Qué significa entregar tu voluntad a un Poder Superior?

- ¿Cómo puede entregar tu voluntad ayudarte en tu recuperación?
- ¿Cuáles son algunos desafíos que puedes enfrentar al entregar tu voluntad?

### **Estrés de Aculturación:**

**Discusión:** Desafíos de la aculturación, la identidad cultural y la autoestima.

- ¿Cuáles son algunos de los desafíos que has enfrentado al adaptarte a la cultura estadounidense?
- ¿Cómo afecta el estrés aculturativo tus relaciones y tu sentido de comunidad?
- ¿Cómo pueden los factores culturales impactar el consumo de alcohol?
- ¿Qué podemos hacer para apoyarnos mutuamente en navegar las diferencias culturales?

### **Sesión 3: Los Doce Pasos, la Discriminación y el Prejuicio**

- **Paso 4:** *Hicimos un inventario moral escrupuloso de nosotros mismos.*
  - **Discusión:**
    - ¿Qué significa hacer un inventario moral?
    - ¿Cómo puede un inventario moral ayudarte a identificar áreas de crecimiento?
    - ¿Cuáles son algunas estrategias para realizar un inventario moral?
- **Paso 5:** *Admitimos ante Dios, ante nosotros mismos y ante otro ser humano la naturaleza de nuestros errores.*
  - **Discusión:**
    - ¿Cuál es la importancia de admitir tus errores?
    - ¿Cómo puede compartir tus errores con los demás ayudarte en tu recuperación?
    - ¿Cuáles son algunos desafíos que puedes enfrentar al admitir tus errores?

### **La Discriminación y el Prejuicio:**

- ¿Cómo ha afectado la discriminación tu autoestima y tu sentido de pertenencia?
- ¿Cuáles son algunos de los estereotipos dañinos asociados con la comunidad hispana?

- ¿Cómo podemos desafiar y dismantelar estos estereotipos?

#### **Sesión 4: Los Doce Pasos y las Desigualdades Socioeconómicas**

- **Paso 6:** *Estuvimos completamente dispuestos a que Dios nos liberara de estos defectos de carácter.*
  - **Discusión:**
    - ¿Cuáles son algunos defectos de carácter que han contribuido a tu alcoholismo?
    - ¿Cómo puedes estar dispuesto a que se eliminen estos defectos?
    - ¿Cuáles son algunas formas en que puedes trabajar con tu Poder Superior para eliminar estos defectos?
- **Paso 7:** *Humildemente le pedimos que nos liberara de nuestros defectos.*
  - **Discusión:**
    - ¿Qué significa pedir humildemente ayuda?
    - ¿Cómo puede la humildad ayudarte en tu recuperación?
    - ¿Cuáles son algunas formas en que puedes practicar la humildad?

#### **Las Desigualdades Socioeconómicas y el Consumo de Alcohol**

- ¿Cómo han afectado las desigualdades socioeconómicas tu acceso a la educación, la atención médica y las oportunidades?
- ¿Cuáles son algunas de las barreras que has enfrentado para alcanzar tus metas?
- ¿Cómo podemos abogar por la justicia social y abordar las desigualdades sistémicas?

#### **Sesión 5: Los Doce Pasos y el Construyendo Relaciones Saludables**

- **Paso 8:** *Hicimos una lista de las personas a quienes habíamos hecho daño y estuvimos dispuestos a repararles el daño a todas.*
  - **Discusión:**

- ¿A quién has hecho daño como resultado de tu alcoholismo?
- ¿Cómo puede reparar el daño ayudarte a sanar y avanzar?
- ¿Cuáles son algunos desafíos que puedes enfrentar al reparar el daño?
- **Paso 9:** *Reparamos directamente a esas personas siempre que fuera posible, excepto cuando hacerlo les dañaría a ellas o a otros.*
  - **Discusión:**
    - ¿Qué significa reparar directamente el daño?
    - ¿Cómo puedes reparar directamente el daño a quienes has hecho daño?
    - ¿Cuáles son algunas formas de abordar la reparación del daño?

### **Creando una Red de Apoyo**

- ¿Quiénes son algunas de las personas en las que puedes confiar para obtener apoyo?
- ¿Cómo podemos crear una comunidad solidaria e inclusiva dentro de este grupo?
- ¿Cuándo podría ser útil buscar ayuda profesional?

### **Sesión 6: Los Doce Pasos y las Habilidades de Afrontamiento/ Manteniendo la Sobriedad y el Bienestar**

- **Paso 10:** *Continuamos trabajando en un Programa de Doce Pasos, llevamos este mensaje a otros y practicamos estos principios en todos nuestros asuntos.*
  - **Discusión:**
    - ¿Qué significa trabajar en un Programa de Doce Pasos?
    - ¿Cómo puede llevar el mensaje a otros ayudarte a mantenerte sobrio?
    - ¿Cuáles son algunas formas en que puedes practicar estos principios en todos tus asuntos?
- **Paso 11:** *Buscamos a través de la oración y la meditación mejorar nuestro contacto consciente con Dios como lo entendíamos.*
  - **Discusión:**
    - ¿Cuál es la importancia de la oración y la meditación en la recuperación?

- ¿Cómo pueden la oración y la meditación ayudarte a conectarte con tu Poder Superior?
- ¿Cuáles son algunas formas en que puedes incorporar la oración y la meditación en tu vida diaria?
- **Paso 12:** *Habiendo tenido un despertar espiritual como resultado de estos pasos, tratamos de llevar este mensaje a los alcohólicos y de practicar estos principios en todos nuestros asuntos.*
  - **Discusión:**
    - ¿Qué es un despertar espiritual?
    - ¿Cómo ha llevado a un despertar espiritual trabajar los Doce Pasos para ti?
    - ¿Cuáles son algunas formas en que puedes compartir tu experiencia, fuerza y esperanza con los demás?

### **Desarrollando las Habilidades de Afrontamiento**

- ¿Cuáles son algunos mecanismos de afrontamiento saludables que has encontrado útiles?
- ¿Cómo puedes incorporar estas estrategias en tu vida diaria?
- ¿Qué podemos hacer para apoyarnos mutuamente en desarrollar resiliencia?

<b>Nombre</b>	<b>Información de contacto</b>	<b>Notas</b>

Esta información de contacto es para su uso personal si alguna vez necesita apoyo. Es confidencial y solo para su uso.

<b>Completa esta oración: Llamaré cuando...</b>

<b>Completa esta oración: Quiero mantenerme sobrio porque...</b>

## Los Doce Pasos para la Recuperación de Alcoholismo

- **Paso 1:** *Admitimos que éramos impotentes ante el alcohol, que nuestras vidas se habían vuelto inmanejables.*
- **Paso 2:** *Llegamos a creer que un Poder superior a nosotros mismos podía devolvernos a la cordura.*
- **Paso 3:** *Tomamos la decisión de entregar nuestra voluntad y nuestras vidas al cuidado de Dios como lo entendíamos.*
- **Paso 4:** *Hicimos un inventario moral escrupuloso de nosotros mismos.*
- **Paso 5:** *Admitimos ante Dios, ante nosotros mismos y ante otro ser humano la naturaleza de nuestros errores.*
- **Paso 6:** *Estuvimos completamente dispuestos a que Dios nos liberara de estos defectos de carácter.*
- **Paso 7:** *Humildemente le pedimos que nos liberara de nuestros defectos.*
- **Paso 8:** *Hicimos una lista de las personas a quienes habíamos hecho daño y estuvimos dispuestos a repararles el daño a todas.*
- **Paso 9:** *Reparamos directamente a esas personas siempre que fuera posible, excepto cuando hacerlo les dañaría a ellas o a otros.*
- **Paso 10:** *Continuamos trabajando en un Programa de Doce Pasos, llevamos este mensaje a otros y practicamos estos principios en todos nuestros asuntos.*
- **Paso 11:** *Buscamos a través de la oración y la meditación mejorar nuestro contacto consciente con Dios como lo entendíamos.*
- **Paso 12:** *Habiendo tenido un despertar espiritual como resultado de estos pasos, tratamos de llevar este mensaje a los alcohólicos y de practicar estos principios en todos nuestros asuntos.*

APPENDIX D

PEER PACKET: ENGLISH AND SPANISH

**PEER PACKET: ENGLISH****Group Goals, Processes, Ground Rules, Expectations and Benefits: English**

- **Group Goals:**
  - Increase support
  - Reduce isolation
  - Improve coping skills
  - Reduce stress
  - **Increase Readiness for participants to self-lead**
    - Gradually transition to where participants take on more responsibility for leading the group.
- **Group Process:**
  - 10-minute Introduction
  - 20-minute Twelve Steps
  - 20-minute Contributing Factors topics
  - 10-minute Summary
- **Ground Rules and Expectations:**
  - Everything is confidential
  - Respect and *personalismo* (warm and empathetic interactions that convey understanding and concern for a person's well-being)
  - Active participation
  - Work toward healthy coping strategies
- **Research-backed Group Benefits:**
  - Positive connections with others who are or have successfully navigated similar life experiences
  - Confidential participation for as long as participants finds it beneficial
  - Free of charge
  - Improves quality of life and functioning
  - Reduces co-occurring mental health symptoms and hospital admissions
  - Extends the length of abstinence by one to three years posttreatment

## Group Content and Understanding AUD: English

**Alcohol Use Disorder (AUD)**: a chronic and relapsing disease involving compulsive alcohol use despite the harmful interpersonal, professional, and medical consequences.

- **Group Content:**
  - **AA:**
    - **Introduction:** Briefly explain the concept of the Twelve Steps and their role in recovery.
      - AA incorporates a spiritually based, Twelve-Step Program (TSP) that promotes sustained remission from alcohol and enhances interpersonal skills and stress management through the sharing of personal stories.
        - Strong evidence suggests that TSP groups **double sobriety rates** compared to groups without
        - Currently, there are no other Spanish-speaking AA/TSP programs in our area.
  - **Culturally Specific Topics:**
    - Some minority populations have adapted AA resources to better resonate with their communities
    - *Anexos*, for example, originated as grassroots meeting spaces annexed onto existing AA sites by Hispanic/Latinx immigrants in California.
      - Researchers examined the successes of anexos and discovered that they provided a milieu conducive to discussing shared cultural challenges like immigration, acculturation and discrimination that sparked self-reflection and transformation. Facilitating the exploration of stigmatized topics reduced the impact of immigration-related stress on unhealthy coping mechanisms like alcohol use.
      - Failing to acknowledge the unique adversities immigrants encounter neglects a critical factor that can trigger relapse and influence healthcare outcomes in this population.

## Glossary of Terms

**Acculturation Stress:** a sense of isolation or exclusion from mainstream American society

**Defects of Character:** Personal flaws or weaknesses that hinder one's ability to live a fulfilling life.

**Discriminations & Prejudice:** Unfair treatment of individuals or groups based on characteristics like race, gender, or religion.

**Harm:** Negative consequences of one's actions, including damage to oneself and others.

**Humility:** The quality of being humble or recognizing one's limitations and imperfections.

**Moral Inventory:** A thorough examination of one's character, values, and behaviors.

**Resilience:** The ability to recover from adversity and bounce back from setbacks.

**Shortcomings:** Deficiencies or weaknesses in one's character or abilities.

**Social Justice:** The principle of fairness and equality for all members of society.

**Systemic inequalities:** Injustice built into the systems and structures of society, often favoring certain groups over others.

**Socioeconomic disparities:** Unequal distribution of wealth, income, and opportunities across different groups in society.

**Spiritual Awakening:** A profound transformation of one's consciousness and values.

**Supportive & Inclusive:** A welcoming and encouraging environment that embraces diversity and fosters a sense of belonging.

## Twelve-Steps to Alcohol Recovery

- **Step 1:** *We admitted we were powerless over alcohol—that our lives had become unmanageable.*
- **Step 2:** *Came to believe that a Power greater than ourselves could restore us to sanity.*
- **Step 3:** *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
- **Step 4:** *Made a searching and fearless moral inventory of ourselves.*
- **Step 5:** *Admitted to God, to ourselves, and to another human being the nature of our wrongs.*
- **Step 6:** *Were entirely ready to have God remove these defects of character.*
- **Step 7:** *Humbly asked Him to remove our shortcomings.*
- **Step 8:** *Made a list of persons we had harmed, and became willing to make amends to them all.*
- **Step 9:** *Made direct amends to such people wherever possible, except when to do so would harm them or others.*
- **Step 10:** *Continued to work a Twelfth-Step Program and carried this message to others, and practiced these principles in all our affairs.*
- **Step 11:** *Sought through prayer and meditation to improve our conscious contact with God as we understood Him.*
- **Step 12:** *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.*

## 100% Peer-Led Group Session Plan

### Session 1: Introduction and Ground Rules

- **Introductions:** Participants introduce themselves and share a brief background.
- **Ground Rules:** The group establishes ground rules for confidentiality, respect, and active participation.
- **Group Goals:** Participants discuss and set goals for the group, such as increased support, reduced isolation, and improved coping skills.

### Session 2: Sharing Experiences and Challenges

- **Check-In:** Participants share their experiences and feelings since the last meeting.
- **Identifying Triggers:** The group discusses common triggers related to acculturation stress, discrimination, and socioeconomic disparities.
- **Coping Strategies:** Participants share their coping strategies for dealing with these triggers.

### Session 3: Exploring Twelve Steps

- **Step Review:** The group reviews relevant twelve steps and discusses their meaning and application.
- **Personal Reflections:** Participants share their experiences with the twelve steps and how they have helped them in their recovery.
- **Support and Encouragement:** The group offers support and encouragement to each other.

### Session 4: Building Healthy Relationships

- **Importance of Relationships:** The group discusses the importance of healthy relationships in recovery.
- **Challenges and Opportunities:** Participants share their experiences with relationships and identify potential challenges and opportunities.
- **Relationship Building Skills:** The group practices relationship-building skills, such as active listening, empathy, and effective communication.

### Session 5: Developing a Recovery Plan

- **Individual Recovery Goals:** Participants set personal recovery goals.
- **Support Systems:** The group discusses the importance of support systems and how to build them.
- **Action Plans:** Participants create action plans to achieve their recovery goals.

### Session 6: Maintaining Sobriety and Wellness

- **Relapse Prevention:** The group discusses strategies for preventing relapse, such as identifying early warning signs and developing coping mechanisms.
- **Self-Care:** Participants explore self-care practices to promote physical, emotional, and spiritual well-being.
- **Giving Back:** The group discusses the benefits of giving back to the community and how to get involved.

### Session 1: Introduction to the Twelve Steps and Triggers (for reference, from group initiation)

- **Step 1:** *We admitted we were powerless over alcohol—that our lives had become unmanageable.*
  - **Discussion:**
    - What does it mean to be powerless over alcohol?
    - How has alcohol negatively impacted your life?
    - What are some signs or symptoms that your life has become unmanageable?

#### Triggers:

- What are some personal triggers you've identified?
- How do these triggers affect your thoughts, feelings, and behaviors?
- What strategies have you tried to cope with these triggers?

### Session 2: Twelve Steps and Introduction of Acculturation Stress

- **Step 2:** *Came to believe that a Power greater than ourselves could restore us to sanity.*
  - **Discussion:**
    - What is your understanding of a Higher Power?
    - How can a Higher Power help you in your recovery?
    - What are some ways you can connect with your Higher Power?
- **Step 3:** *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
  - **Discussion:**
    - What does it mean to surrender your will to a Higher Power?
    - How can surrendering your will help you in your recovery?
    - What are some challenges you may face in surrendering your will?

**Acculturation Stress:**

Discussion: Challenges of acculturation, cultural identity, and self-esteem.

- What are some of the challenges you've faced in adapting to American culture?
- How does acculturative stress affect your relationships and sense of community?
- How can cultural factors impact alcohol use?
- What can we do to support each other in navigating cultural differences?

**Session 3: Twelve Steps, Discrimination and Prejudice**

- **Step 4:** *Made a searching and fearless moral inventory of ourselves.*
  - **Discussion:**
    - What does it mean to conduct a moral inventory?
    - How can a moral inventory help you identify areas for growth?
    - What are some strategies for conducting a moral inventory?
- **Step 5:** *Admitted to God, to ourselves, and to another human being the nature of our wrongs.*
  - **Discussion:**
    - What is the importance of admitting your wrongs?
    - How can sharing your wrongs with others help you in your recovery?
    - What are some challenges you may face in admitting your wrongs?

**Discrimination and Prejudice:**

- How has discrimination affected your self-esteem and sense of belonging?
- What are some of the harmful stereotypes associated with the Hispanic community?
- How can we challenge and dismantle these stereotypes?

**Session 4: Twelve Steps and Socioeconomic Disparities**

- **Step 6:** *Were entirely ready to have God remove these defects of character.*
  - **Discussion:**

- What are some defects of character that have contributed to your alcoholism?
- How can you be ready to have these defects removed?
- What are some ways you can work with your Higher Power to remove these defects?
- **Step 7:** *Humbly asked Him to remove our shortcomings.*
  - **Discussion:**
    - What does it mean to humbly ask for help?
    - How can humility help you in your recovery?
    - What are some ways you can practice humility?

### **Socioeconomic Disparities and Alcohol Use**

- How have socioeconomic disparities affected your access to education, healthcare, and opportunities?
- What are some of the barriers you've faced in achieving your goals?
- How can we advocate for social justice and address systemic inequalities?

### **Session 5: Twelve Steps and Building Healthy Relationships**

- **Step 8:** *Made a list of persons we had harmed, and became willing to make amends to them all.*
  - **Discussion:**
    - Who have you harmed as a result of your alcoholism?
    - How can making amends help you heal and move forward?
    - What are some challenges you may face in making amends?
- **Step 9:** *Made direct amends to such people wherever possible, except when to do so would harm them or others.*
  - **Discussion:**
    - What does it mean to make direct amends?

- How can you make direct amends to those you have harmed?
- What are some ways to approach making amends?

### **Creating a Support Network**

- Who are some of the people you can rely on for support?
- How can we create a supportive and inclusive community within this group?
- When might it be helpful to seek professional help?

### **Session 6: Twelve Steps and Coping Skills / Maintaining Sobriety and Wellness**

- **Step 10:** *Continued to work a Twelfth-Step Program and carried this message to others, and practiced these principles in all our affairs.*
  - **Discussion:**
    - What does it mean to work a Twelve-Step Program?
    - How can carrying the message to others help you stay sober?
    - What are some ways you can practice these principles in all your affairs?
- **Step 11:** *Sought through prayer and meditation to improve our conscious contact with God as we understood Him.*
  - **Discussion:**
    - What is the importance of prayer and meditation in recovery?
    - How can prayer and meditation help you connect with your Higher Power?
    - What are some ways you can incorporate prayer and meditation into your daily life?
- **Step 12:** *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.*
  - **Discussion:**
    - What is a spiritual awakening?

- How has working the Twelve Steps led to a spiritual awakening for you?
- What are some ways you can share your experience, strength, and hope with others?

### **Developing Coping Skills**

- What are some healthy coping mechanisms you've found helpful?
- How can you incorporate these strategies into your daily life?
- What can we do to support each other in building resilience?

**PEER PACKET: SPANISH****Objetivos, Procesos, Reglas Básicas, Expectativas y Beneficios del Grupo****• Objetivos del Grupo:**

- \* Aumentar el apoyo
- \* Reducir el aislamiento
- \* Mejorar las habilidades de afrontamiento
- \* Reducir el estrés
- \* Aumentar la preparación de los participantes para liderarse a sí mismos

**• Proceso del Grupo:**

- \* 10 minutos de Introducción
- \* 20 minutos de Doce Pasos
- \* 20 minutos de temas sobre Factores Contribuyentes
- \* 10 minutos de Resumen

**• Reglas Básicas y Expectativas:**

- \* Todo es confidencial
- \* Respeto y personalismo (interacciones cálidas y empáticas que transmiten comprensión y preocupación por el bienestar de una persona)
- \* Participación activa
- \* Trabajar hacia estrategias de afrontamiento saludables

**• Beneficios del Grupo Respaldados por Investigación:**

- \* Conexiones positivas con otros que están o han navegado con éxito experiencias de vida similares
- \* Participación confidencial durante el tiempo que los participantes lo encuentren beneficioso
- \* Gratuito
- \* Mejora la calidad de vida y el funcionamiento
- \* Reduce los síntomas concurrentes de salud mental y las admisiones hospitalarias
- \* Extiende la duración de la abstinencia de uno a tres años después del tratamiento

## Group Content and Understanding AUD: Spanish

### Contenido del Grupo y Comprensión de AUD

**Trastorno por Consumo de Alcohol (TCA), también conocido como trastorno por uso de alcohol (AUD):** una enfermedad crónica y recurrente que implica el uso compulsivo del alcohol a pesar de las consecuencias perjudiciales interpersonales, profesionales y médicas.

- **Contenido del Grupo:**
  - **AA:**
    - **Introducción:** Explique brevemente el concepto de los Doce Pasos y su papel en la recuperación.
      - AA incorpora un Programa de Doce Pasos (TSP) basado en la espiritualidad que promueve la remisión sostenida del alcohol y mejora las habilidades interpersonales y la gestión del estrés a través del intercambio de historias personales.
        - Evidencias sólidas sugieren que los grupos de TSP duplican las tasas de sobriedad en comparación con los grupos sin TSP.
        - Actualmente, no hay otros programas de AA/TSP en español en nuestra área.
  - **Temas Culturalmente Específicos:**
    - Algunas poblaciones minoritarias han adaptado los recursos de AA para resonar mejor con sus comunidades.
    - **Los anexos**, por ejemplo, se originaron como espacios de reunión de base anexos a los sitios existentes de AA por inmigrantes hispanos/latinos en California.
      - Los investigadores examinaron los éxitos de los anexos y descubrieron que proporcionaban un entorno propicio para discutir desafíos culturales compartidos como la inmigración, la aculturación y la discriminación, lo que impulsó la autorreflexión y la transformación. Facilitar la exploración de temas estigmatizados redujo el impacto del estrés relacionado con la inmigración en los mecanismos de afrontamiento no saludables como el consumo de alcohol.
      - El hecho de no reconocer las adversidades únicas que enfrentan los inmigrantes descuida un factor crítico que puede desencadenar recaídas e influir en los resultados de atención médica en esta población.

## Glosario de Términos

**Estrés por Aculturación:** Una sensación de aislamiento o exclusión de la sociedad estadounidense dominante.

**Defectos de Carácter:** Fallos o debilidades personales que obstaculizan la capacidad de llevar una vida plena.

**Discriminación y Prejuicio:** Trato injusto a individuos o grupos basado en características como raza, género o religión.

**Daño:** Consecuencias negativas de las acciones propias, incluyendo daño a uno mismo y a otros.

**Humildad:** La cualidad de ser humilde o reconocer las propias limitaciones e imperfecciones.

**Inventario Moral:** Un examen exhaustivo del propio carácter, valores y comportamientos.

**Resiliencia:** La capacidad de recuperarse de la adversidad y superar los obstáculos.

**Deficiencias:** Deficiencias o debilidades en el carácter o las habilidades propias.

**Justicia Social:** El principio de justicia e igualdad para todos los miembros de la sociedad.

**Desigualdades Sistémicas:** Injusticia incorporada en los sistemas y estructuras de la sociedad, a menudo favoreciendo a ciertos grupos sobre otros.

**Desigualdades Socioeconómicas:** Distribución desigual de la riqueza, el ingreso y las oportunidades entre diferentes grupos de la sociedad.

**Despertar Espiritual:** Una profunda transformación de la conciencia y los valores propios.

**Apoyador e Inclusivo:** Un ambiente acogedor y alentador que abraza la diversidad y fomenta un sentido de pertenencia.

## Los Doce Pasos para la Recuperación de Alcoholismo

- **Paso 1:** *Admitimos que éramos impotentes ante el alcohol, que nuestras vidas se habían vuelto inmanejables.*
- **Paso 2:** *Llegamos a creer que un Poder superior a nosotros mismos podía devolvernos a la cordura.*
- **Paso 3:** *Tomamos la decisión de entregar nuestra voluntad y nuestras vidas al cuidado de Dios como lo entendíamos.*
- **Paso 4:** *Hicimos un inventario moral escrupuloso de nosotros mismos.*
- **Paso 5:** *Admitimos ante Dios, ante nosotros mismos y ante otro ser humano la naturaleza de nuestros errores.*
- **Paso 6:** *Estuvimos completamente dispuestos a que Dios nos liberara de estos defectos de carácter.*
- **Paso 7:** *Humildemente le pedimos que nos liberara de nuestros defectos.*
- **Paso 8:** *Hicimos una lista de las personas a quienes habíamos hecho daño y estuvimos dispuestos a repararles el daño a todas.*
- **Paso 9:** *Reparamos directamente a esas personas siempre que fuera posible, excepto cuando hacerlo les dañaría a ellas o a otros.*
- **Paso 10:** *Continuamos trabajando en un Programa de Doce Pasos, llevamos este mensaje a otros y practicamos estos principios en todos nuestros asuntos.*
- **Paso 11:** *Buscamos a través de la oración y la meditación mejorar nuestro contacto consciente con Dios como lo entendíamos.*
- **Paso 12:** *Habiendo tenido un despertar espiritual como resultado de estos pasos, tratamos de llevar este mensaje a los alcohólicos y de practicar estos principios en todos nuestros asuntos.*

## Plan de Sesión de Grupo Dirigido por Pares al 100%

### Sesión 1: Introducción y Reglas Básicas

- **Presentaciones:** Los participantes se presentan y comparten un breve historial.
- **Reglas Básicas:** El grupo establece reglas básicas para la confidencialidad, el respeto y la participación activa.
- **Objetivos del Grupo:** Los participantes discuten y establecen objetivos para el grupo, como aumentar el apoyo, reducir el aislamiento y mejorar las habilidades de afrontamiento.

### Sesión 2: Compartiendo Experiencias y Desafíos

- **Registro:** Los participantes comparten sus experiencias y sentimientos desde la última reunión.
- **Identificación de Desencadenantes:** El grupo discute desencadenantes comunes relacionados con el estrés de aculturación, la discriminación y las desigualdades socioeconómicas.
- **Estrategias de Afrontamiento:** Los participantes comparten sus estrategias de afrontamiento para lidiar con estos desencadenantes.

### Sesión 3: Explorando los Doce Pasos

- **Revisión de los Pasos:** El grupo revisa los pasos relevantes y discute su significado y aplicación.
- **Reflexiones Personales:** Los participantes comparten sus experiencias con los doce pasos y cómo les han ayudado en su recuperación.
- **Apoyo y Aliento:** El grupo ofrece apoyo y aliento mutuo.

### Sesión 4: Construyendo Relaciones Saludables

- **Importancia de las Relaciones:** El grupo discute la importancia de las relaciones saludables en la recuperación.
- **Desafíos y Oportunidades:** Los participantes comparten sus experiencias con las relaciones e identifican posibles desafíos y oportunidades.
- **Habilidades para Construir Relaciones:** El grupo practica habilidades para construir relaciones, como la escucha activa, la empatía y la comunicación efectiva.

### Sesión 5: Desarrollando un Plan de Recuperación

- **Metas Personales de Recuperación:** Los participantes establecen metas personales de recuperación.
- **Sistemas de Apoyo:** El grupo discute la importancia de los sistemas de apoyo y cómo construirlos.
- **Planes de Acción:** Los participantes crean planes de acción para alcanzar sus metas de recuperación.

### Sesión 6: Manteniendo la Sobriedad y el Bienestar

- **Prevención de Recaídas:** El grupo discute estrategias para prevenir recaídas, como identificar señales de alerta temprana y desarrollar mecanismos de afrontamiento.
- **Cuidado Personal:** Los participantes exploran prácticas de autocuidado para promover el bienestar físico, emocional y espiritual.
- **Dar Atrás:** El grupo discute los beneficios de retribuir a la comunidad y cómo involucrarse.

## Sesión 1: Introducción a los Doce Pasos y Desencadenantes

- **Paso 1:** *Admitimos que éramos impotentes ante el alcohol, que nuestras vidas se habían vuelto inmanejables.*
  - **Discusión:**
    - ¿Qué significa ser impotente ante el alcohol?
    - ¿Cómo ha afectado negativamente el alcohol tu vida?
    - ¿Cuáles son algunas señales o síntomas de que tu vida se ha vuelto inmanejable?

### Desencadenantes:

- ¿Cuáles son algunos desencadenantes personales que has identificado?
- ¿Cómo afectan estos desencadenantes tus pensamientos, sentimientos y comportamientos?
- ¿Qué estrategias has intentado para lidiar con estos desencadenantes?

## Sesión 2: Los Doce Pasos y Introducción al Estrés de Aculturación

- **Paso 2:** *Llegamos a creer que un Poder superior a nosotros mismos podía devolvernos a la cordura.*
  - **Discusión:**
    - ¿Cuál es tu comprensión de un Poder Superior?
    - ¿Cómo puede un Poder Superior ayudarte en tu recuperación?
    - ¿Cuáles son algunas formas en que puedes conectarte con tu Poder Superior?
- **Paso 3:** *Tomamos la decisión de entregar nuestra voluntad y nuestras vidas al cuidado de Dios como lo entendíamos.*
  - **Discusión:**
    - ¿Qué significa entregar tu voluntad a un Poder Superior?
    - ¿Cómo puede entregar tu voluntad ayudarte en tu recuperación?

- ¿Cuáles son algunos desafíos que puedes enfrentar al entregar tu voluntad?

### **Estrés de Aculturación:**

**Discusión:** Desafíos de la aculturación, la identidad cultural y la autoestima.

- ¿Cuáles son algunos de los desafíos que has enfrentado al adaptarte a la cultura estadounidense?
- ¿Cómo afecta el estrés aculturativo tus relaciones y tu sentido de comunidad?
- ¿Cómo pueden los factores culturales impactar el consumo de alcohol?
- ¿Qué podemos hacer para apoyarnos mutuamente en navegar las diferencias culturales?

### **Sesión 3: Los Doce Pasos, la Discriminación y el Prejuicio**

- **Paso 4:** *Hicimos un inventario moral escrupuloso de nosotros mismos.*
  - **Discusión:**
    - ¿Qué significa hacer un inventario moral?
    - ¿Cómo puede un inventario moral ayudarte a identificar áreas de crecimiento?
    - ¿Cuáles son algunas estrategias para realizar un inventario moral?
- **Paso 5:** *Admitimos ante Dios, ante nosotros mismos y ante otro ser humano la naturaleza de nuestros errores.*
  - **Discusión:**
    - ¿Cuál es la importancia de admitir tus errores?
    - ¿Cómo puede compartir tus errores con los demás ayudarte en tu recuperación?
    - ¿Cuáles son algunos desafíos que puedes enfrentar al admitir tus errores?

### **La Discriminación y el Prejuicio:**

- ¿Cómo ha afectado la discriminación tu autoestima y tu sentido de pertenencia?
- ¿Cuáles son algunos de los estereotipos dañinos asociados con la comunidad hispana?

- ¿Cómo podemos desafiar y dismantelar estos estereotipos?

#### **Sesión 4: Los Doce Pasos y las Desigualdades Socioeconómicas**

- **Paso 6:** *Estuvimos completamente dispuestos a que Dios nos liberara de estos defectos de carácter.*
  - **Discusión:**
    - ¿Cuáles son algunos defectos de carácter que han contribuido a tu alcoholismo?
    - ¿Cómo puedes estar dispuesto a que se eliminen estos defectos?
    - ¿Cuáles son algunas formas en que puedes trabajar con tu Poder Superior para eliminar estos defectos?
- **Paso 7:** *Humildemente le pedimos que nos liberara de nuestros defectos.*
  - **Discusión:**
    - ¿Qué significa pedir humildemente ayuda?
    - ¿Cómo puede la humildad ayudarte en tu recuperación?
    - ¿Cuáles son algunas formas en que puedes practicar la humildad?

#### **Las Desigualdades Socioeconómicas y el Consumo de Alcohol**

- ¿Cómo han afectado las desigualdades socioeconómicas tu acceso a la educación, la atención médica y las oportunidades?
- ¿Cuáles son algunas de las barreras que has enfrentado para alcanzar tus metas?
- ¿Cómo podemos abogar por la justicia social y abordar las desigualdades sistémicas?

#### **Sesión 5: Los Doce Pasos y el Construyendo Relaciones Saludables**

- **Paso 8:** *Hicimos una lista de las personas a quienes habíamos hecho daño y estuvimos dispuestos a repararles el daño a todas.*
  - **Discusión:**

- ¿A quién has hecho daño como resultado de tu alcoholismo?
- ¿Cómo puede reparar el daño ayudarte a sanar y avanzar?
- ¿Cuáles son algunos desafíos que puedes enfrentar al reparar el daño?
- **Paso 9:** *Reparamos directamente a esas personas siempre que fuera posible, excepto cuando hacerlo les dañaría a ellas o a otros.*
  - **Discusión:**
    - ¿Qué significa reparar directamente el daño?
    - ¿Cómo puedes reparar directamente el daño a quienes has hecho daño?
    - ¿Cuáles son algunas formas de abordar la reparación del daño?

### **Creando una Red de Apoyo**

- ¿Quiénes son algunas de las personas en las que puedes confiar para obtener apoyo?
- ¿Cómo podemos crear una comunidad solidaria e inclusiva dentro de este grupo?
- ¿Cuándo podría ser útil buscar ayuda profesional?

### **Sesión 6: Los Doce Pasos y las Habilidades de Afrontamiento/ Manteniendo la Sobriedad y el Bienestar**

- **Paso 10:** *Continuamos trabajando en un Programa de Doce Pasos, llevamos este mensaje a otros y practicamos estos principios en todos nuestros asuntos.*
  - **Discusión:**
    - ¿Qué significa trabajar en un Programa de Doce Pasos?
    - ¿Cómo puede llevar el mensaje a otros ayudarte a mantenerte sobrio?
    - ¿Cuáles son algunas formas en que puedes practicar estos principios en todos tus asuntos?
- **Paso 11:** *Buscamos a través de la oración y la meditación mejorar nuestro contacto consciente con Dios como lo entendíamos.*
  - **Discusión:**
    - ¿Cuál es la importancia de la oración y la meditación en la recuperación?

- ¿Cómo pueden la oración y la meditación ayudarte a conectarte con tu Poder Superior?
- ¿Cuáles son algunas formas en que puedes incorporar la oración y la meditación en tu vida diaria?
- **Paso 12:** *Habiendo tenido un despertar espiritual como resultado de estos pasos, tratamos de llevar este mensaje a los alcohólicos y de practicar estos principios en todos nuestros asuntos.*
  - **Discusión:**
    - ¿Qué es un despertar espiritual?
    - ¿Cómo ha llevado a un despertar espiritual trabajar los Doce Pasos para ti?
    - ¿Cuáles son algunas formas en que puedes compartir tu experiencia, fuerza y esperanza con los demás?

### **Desarrollando las Habilidades de Afrontamiento**

- ¿Cuáles son algunos mecanismos de afrontamiento saludables que has encontrado útiles?
- ¿Cómo puedes incorporar estas estrategias en tu vida diaria?
- ¿Qué podemos hacer para apoyarnos mutuamente en desarrollar resiliencia?

APPENDIX E

GROUP LEADER SELF-EFFICACY INSTRUMENT: FOCUSED

## GROUP LEADER SELF-EFFICACY INSTRUMENT (Focused)

Rate each item according to the following scale:

1 = strongly disagree, 2 = disagree, 3 = slightly disagree, 4 = slightly agree, 5 = agree, 6 = strongly agree

I am confident I can make interventions based on the purpose of the group	
I am confident I can provide moderate emotional stimulation	
I am confident I can help members integrate and apply learnings	
I am confident I can help the group set productive norms	
I am confident I can develop a clear purpose statement for the group	
I am confident I can provide structure for sessions (e.g., warm up, action, closure)	
I am confident I can draw out quiet members	
I am confident I can hold the focus on a topic, an activity, or a person	
I am confident I can use my voice to set the tone of the group	
I am confident I can impart information or give mini-lectures	
I am confident I can help members process the meaning of experiences	
I am confident I can respond to the group level of group process	
I am confident I can give corrective feedback	
I am confident I can apply ethical and professional standards in group work	
I am confident I can encourage expression of differences	
I am confident I can provide an atmosphere of support and caring	
I am confident I can change the focus from a topic, a person, or an activity to another topic, person, or activity	
I am confident I can cut off members	
I am confident I can give positive feedback	
I am confident I can use my eyes to monitor group members	

APPENDIX F

FLYERS

**JUNTOS, SOMOS MÁS FUERTES**

## Grupo de Apoyo para el Alcohol

**Martes a las 4:00–5:00 PM**  
comenzando el 14 de enero



(Location deleted for confidentiality)



Confidencialidad ~ Español solamente ~ Gratis





## Grupo de Apoyo para el Alcohol



Nuestro objetivo es brindar un espacio seguro y comprensivo donde puedas compartir tus experiencias, recibir apoyo y aprender herramientas para enfrentar los desafíos relacionados con el alcoholismo.

**Martes a las 4:00-5:00 PM  
comenzando el 14 de enero**

(Location deleted for confidentiality)

Confidencialidad total. Español solamente. Gratis.

# Juntos, somos más fuertes

APPENDIX G

QUALITATIVE FEEDBACK QUESTIONNAIRE

**Qualitative Feedback Questions for Facilitator**

<b>1. Were session materials easy to follow?</b>	Yes / No
Additional Feedback:	
<b>2. Did session materials help inspire participation?</b>	Yes / No
Additional Feedback:	
<b>3. Did the session materials provide valuable information and tools for recovery?</b>	Yes / No
Additional Feedback:	

APPENDIX H

ATTENDANCE SURVEY

<b>Date</b>	<b># of Attendees</b>	<b># of Repeat Attendees</b>
		Ask if anyone has been to any one of the other six peer support sessions

\*\* Please write in number only, do not use any personal identifiers