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Faith-Based Organizations and the Affordable Care Act:

Reducing Latino Mental Healthcare Disparities

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Disparities Solutions

Running Head: FBOs and Latino Mental Healthcare Disparities

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Abstract

The Patient Protection and Affordable Care Act (ACA) is expected to increase access to mental healthcare through provisions aimed at increasing health coverage among the nation's uninsured, including 10.2 million eligible Latino non-elderly adults. The ACA will increase health coverage by expanding Medicaid eligibility to individuals living below 138% of the federal poverty level, subsidizing the purchase of private insurance among individuals not eligible for Medicaid, and requiring employers with 50 or more employees to offer health insurance. An anticipated result of this landmark legislation is improvement in the screening, diagnosis, and treatment of mental disorders in racial/ethnic minorities, particularly for Latinos, who traditionally have had less access to these services. However, these efforts alone may not sufficiently ameliorate mental healthcare disparities for Latinos. Faith-based organizations (FBOs) could play an integral role in the mental healthcare of Latinos by increasing help-seeking, providing religion-based mental health services, and delivering supportive services that address common access barriers among Latinos. Thus, in determining ways to eliminate Latino mental healthcare disparities under the ACA, examining pathways into care through the faith-based sector offers unique opportunities to address some of the cultural barriers confronted by this population. We examine how partnerships between FBOs and primary care patient-centered medical homes (PCMH) may help reduce the gap of unmet mental health needs among Latinos in this era of health reform. We also describe the challenges FBOs and PCMH providers need to overcome in order to be partners in integrated care efforts.

Keywords: Mental healthcare, Latinos, faith-based organizations, ACA, disparities

Introduction

Latinos are the largest and fastest growing racial/ethnic minority group in the United States (U.S), currently representing 17% of the total population (U.S. Census Bureau, 2012). Between 2000 and 2009, the population of Latinos increased by 37% with projections suggesting that Latinos will make up approximately 25% of the nation's total population by 2050. Specific states such as New Mexico, Texas, and California will be especially affected by this growth because Latinos are expected to represent the majority of its residents much sooner than 2050. In light of this projected population growth and the activation of the Patient Protection and Affordable Care Act (ACA; H.R. 3590; 2010), there is an emerging necessity to be better prepared to address the mental health needs of Latinos, particularly in public mental health services.

Under the ACA, some Latinos will have increased access to mental health services, especially within the primary care setting, by obtaining health coverage through either the private or public health insurance markets (Alegría et al., 2012; KFF, 2013a). The primary care settings of the public healthcare sector, in particular, are going to have predominant oversight of the mental healthcare for eligible Latinos because of the ACA's emphasis on integrated care models (Mechanic, 2011, 2012). Therefore, as we move toward an integrated primary care model in mental health, it is important to consider how we can enhance the care of Latinos in the public sector as a way to eliminate their disparities in mental healthcare. In this paper, we examine the aspirations and expectations of healthcare reform in the ACA to increase screening, diagnosis, and treatment services among Latinos and discuss how faith-based organizations (FBOs) may play a significant role in reducing disparities in their mental healthcare. Specifically we argue

that FBOs can be essential partners in the primary care patient-centered medical homes of Latinos.

Defining Faith-Based Organizations

Faith-based organizations represent a broad spectrum of agencies that are founded on the principles and values of faith and religion (Ebaugh, Pipes, Chafetz, & Daniels, 2003). FBOs deliver a variety of health services, including physical, mental, and social services in a religious context as a means to meet the spiritual needs of the individuals and populations they are founded to serve (Ebaugh et al., 2003). They can vary as agencies, including religious congregations (e.g., churches, mosques, synagogues, or temples); programs or projects sponsored by a religious congregation; or nonprofit organizations founded by a religious congregation or religiously motivated incorporators (e.g., hospitals, health and social service agencies, and health clinics). Religious congregations also may provide services such as food and clothing drives directly to families in need. It is estimated that almost one in five Latinos in the U.S. has at some point sought economic aid from religious groups to make ends meet (Pew Forum and Pew Research Center, 2009). In contrast, large FBOs such as Catholic Charities USA (CCUSA), Christian Community Health Fellowship (CCHF), or Lutheran Social Services have extensive networks of services that directly deliver formal healthcare services to a wide range of individuals based on their religious mission. Lastly, religious organizations also have been active founders and have a long history as operators of hospitals, with the Catholic Church being the most active denomination (Fossett & Burke, 2004).

As illustrated by these examples, the term FBO can refer to a wide range of organizations, both large and small. In this paper, FBO refers to both small and large faith-based

organizations ranging from individual religious congregations to large-scale social service agencies, clinics, or hospitals that deliver health and/or mental health–related services. It is important to consider this range, as small FBOs such as religious congregations may be the initial point of contact for Latinos in identifying their mental health needs while large FBOs such as clinics and social service networks may be instrumental sites for the actual delivery of mental health or physical healthcare services.

Mental Health Needs and Services Utilization Patterns of Latinos

Epidemiologic studies such as the National Latino and Asian American Study (NLAAS) have shown that approximately 60% of Latinos meet lifetime diagnostic criteria for any mood, anxiety, or substance use disorder, including 30% who meet 12-month criteria (Alegría et al., 2007a). Although the aggregate prevalence of mental disorders among Latinos in the U.S. is lower or equivalent to that of non-Latino whites (Breslau et al., 2006), the mental health needs of Latinos may be disproportionately greater because often these disorders are left untreated (Alegría et al., 2002; Alegría et al., 2008b) . Consequently, Latinos as a whole exhibit higher prevalence of affective disorders and active mental health comorbidities (Kessler et al., 1994) and demonstrate higher prevalence of persistent mood disorders than non-Latino whites (Breslau, Kendler, Su, Aguilar-Gaxiola, & Kessler, 2005). Mental disorders also have been shown to create limitations in functioning and well-being (Moitra et al., 2014; Wells, Klap, Koike, & Sherbourne, 2001) and increase risk of disability (McKenna, Michaud, Murray, & Marks, 2005). This burden of mental illness may be especially profound among Latinos when we consider their high degree of unmet need as a result of their lower utilization of mental health services and receipt of poorer quality mental healthcare (Alegría et al., 2002; Wells et al., 2001). Thus, these

studies suggest that the lack of treatment may be more negative for Latinos than non-Latino whites.

Findings from the NLAAS also highlight differences in mental health need within the Latino population. For example, although Mexican Americans are the largest subpopulation of Latinos in the U.S., Puerto Ricans overall have significantly higher prevalence of any lifetime and past-year depressive, anxiety, or substance use disorder compared to other Latino subgroups (Alegría et al., 2007a). Empirical evidence also points to the "healthy immigrant" effect within mental health, as U.S.-born Latinos are more at risk of any lifetime psychiatric disorder than immigrant Latinos (Alegría et al., 2008a). However, the protective effects of immigrant status vary by Latino subgroups, the number of years living in the U.S., and age of immigration (Alegría et al., 2008a; Alegría et al., 2007d). Within Latino immigrant subpopulations, the healthy immigrant effect is most apparent among Mexicans compared to other Latino subgroups, where Mexican immigrants have significantly lower prevalence of mood, anxiety, and substance use disorders compared to U.S.-born Mexicans (Alegría et al., 2008a). Latino immigrants who have a long residency in the U.S. or immigrated at a young age are more at risk of a mental disorder than those who have lived in the U.S. for a short period of time or immigrated later in life as an adult (Alegría et al., 2007a; Alegría et al., 2007d). There also are generational differences within Latinos where second- and third-generation Latinos are significantly more likely to have a lifetime mental disorder than first-generation Latinos. Collectively, these studies illustrate the varying degrees of need across different subgroups of Latinos that merit our attention.

While the mental health needs of Latinos are multifaceted, their participation in mental health services lags behind that of the general population (Alegría et al., 2002; Alegría et al.,

2008b). Among individuals meeting diagnostic criteria for a past-year depressive disorder, 64% of Latinos versus 40% of non-Latino whites do not use any form of mental health service (Alegría et al., 2008b). Similarly, Latinos are more likely to have less mental healthcare than needed as well as delayed and less active care than non-Latino whites (Wells et al., 2001). Even when Latinos with depression, for example, are assumed to have the same distribution of socioeconomic (e.g., education, poverty threshold), demographic (e.g., age, gender, marital status), and need (e.g., functional impairment, chronic conditions) characteristics as non-Latino whites, the predicted probability that Latinos will access and receive adequate depression treatment is significantly lower (25.0%) than the probability of non-Latino whites (33.4%) (Alegría et al., 2008b).

Similar to the prevalence patterns of mental disorders previously discussed, there is considerable heterogeneity in utilization patterns within Latinos. For example, a study by Alegría and colleagues (2007) finds that rates of specialty mental health and general medical services are highest among specific Latino subpopulations, such as: (1) Puerto Ricans compared to Mexicans; (2) U.S.-born Latinos as opposed to foreign-born Latinos (for specialty services only); (3) English-speaking versus Spanish-only or bilingual Latinos (for specialty services only); (4) third-generation over first-generation Latinos; and (5) Latinos with long residencies in the U.S. Although use of mental health services is highest among Latino subpopulations that have substantial need for mental healthcare (e.g., Puerto Ricans, U.S.-born), it is important to note that the majority of these individuals still do not use mental health services.

Mental Healthcare Barriers and the Affordable Care Act

The underutilization of mental health services in the Latino population is in part a function of structural factors that affect their opportunities to obtain services. These factors

include lack of access (e.g., being uninsured; Vega & Lopez, 2001); costs of services (Alegría et al., 2002; Cabassa, 2007); mental health workforce shortages of Latino and Spanish speaking providers (Sentell, Shumway, & Snowden, 2007; Vega & Lopez, 2001); and shortage of public mental health facilities to fulfill mental health referrals (Cabassa, Zayas, & Hansen, 2006). As a result of healthcare reform, provisions of the ACA are anticipated to help address some of these barriers to care and increase utilization of mental health services among Latinos (Alegría et al., 2012).

The primary mechanism through which the ACA is expected to increase access to health and mental healthcare services for some Latinos is by expanding healthcare coverage among the uninsured. The ACA will do this by reducing financial barriers to care, including: expanding Medicaid; subsidizing the purchase of private insurance among individuals not eligible for Medicaid through the Health Insurance Marketplace; and requiring employers with 50 or more employees to offer health insurance, known as the employer mandate (KFF, 2013b). The Medicaid expansion, in particular, offers an important opportunity to increase health coverage among Latinos (except those who are undocumented) because they represent the highest percentage of uninsured non-elderly adults who have family incomes at or below the federal Medicaid expansion limit (138% federal poverty level) (e.g., KFF, 2013a). Preliminary reports suggest that there has been a considerable influx of newly insured Latinos as a result of the ACA; the proportion of uninsured Latinos dropped from 36% to 23% between July 2013 and June 2014 (Doty, Rasmussen, & Collins, 2014).

Despite these positive changes, the Medicaid expansion under the ACA is a state option, not a requirement. Consequently, states that approved the Medicaid expansion experienced higher growth in Medicaid and CHIP enrollment (by 15.3%) than states that chose not to expand

Medicaid at this time (by 3.3%) (KFF, 2014). More specifically, states that have not yet expanded eligibility for Medicaid such as Texas and Florida, on average, only had a negligible decrease in the proportion of uninsured Latinos (from 39% to 33%) since inception of open enrollment while states that expanded Medicaid eligibility saw a sharp decline in the number of uninsured Latinos (from 35% to 17%, on average) (Doty et al., 2014).

Given that the ACA builds on the Mental Health Parity and Addiction Equity Act (MHPAE), there also is the added potential for the improvement of utilization of mental health services among Latinos. The MHPAE requires parity of coverage for mental health treatment in that all health plans accessible through the health insurance marketplace under the ACA will be required to provide mental health services in a comparable manner to medical and surgical benefits (Mechanic, 2012). In other words, parity will require health plans to ensure that financial requirements (e.g., copays, deductibles) and treatment limitations (e.g., number of visits) of mental health services are no more restrictive than those applied to medical and surgical benefits. Not only may parity help ensure access to mental health services, but it may also help to facilitate continuity of mental healthcare among Latinos with substantial mental health needs.

Aside from structural barriers, attitudinal and cultural barriers also interfere with whether and how mental health services are sought by Latinos. For example, negative beliefs and attitudes about mental health services and treatment (Cabassa, 2007) and stigma (Gary, 2005; Vega & Lopez, 2001) negatively affect mental health help-seeking. Religious and cultural values such as fatalism (i.e., the belief that illness and misfortune are beyond the individual's control and due to God's will, luck or destiny), religiosity (i.e., activities associated with religious beliefs

and involvement), and *familismo* (i.e., loyalty to family) can influence the help-seeking process by slowing the path into formal mental health services (Rogler, Malgady, & Rodriguez, 1989).

Using a cultural framework of behavioral *familismo* (i.e., the actions and behaviors associated with attitudes about families), Villatoro, Morales, and Mays (2014) argue that the act of avoiding conflict and bringing shame on the family by participating in traditional mental health services is likely to push Latinos with strong family support networks to other culturally accepted sources of help, such as religious advisors or community recognized alternative healers. Their findings reveal that Latinos with high levels of family support were more likely to use informal sources of care such as a religious advisor or healer for assistance with mental healthcare needs than those with lower levels of family support. However, family support neither prevented nor increased use of formal mental health services. Although some of these cultural values may generate barriers to formal mental health services for some Latinos (Rogler et al., 1989), the ACA does not explicitly address ways to reduce these impediments to care. As will be demonstrated in later sections, it is important to think about how these community-based and trusted informal sources of care such as faith-based organizations can become part of the formal systems of care in order to improve the mental healthcare of Latinos.

Consequences of the ACA in Undocumented Latinos' Mental Healthcare

Despite the ACA's promise to improve access, continuity, and quality of healthcare and mental healthcare services for Latinos, undocumented immigrants will not benefit from the law, unless specific states choose to include them; a large number of Latinos in the U.S. fall into this category. The ACA excludes 11.2 million undocumented immigrants, including one million children, from participating in the selection of healthcare coverage in the health market set up

and are prohibited from enrolling in non-emergency Medicaid (Wallace, Torres, Sadegh-Nobari, Pourat, & Brown, 2012). Since the end of open enrollment, an estimated 16% of uninsured, non-elderly Latinos are undocumented (Doty et al., 2014). Undocumented immigrants will therefore need to rely on other sources of care such as emergency care (including emergency Medicaid for low-income immigrants) and the safety-net system (i.e., healthcare institutions that provide services to low-income, medically underserved populations) (Wallace et al., 2012). However, this exclusion from the ACA may lead to a pervasive perception among undocumented Latinos that mental health services are dangerous to seek, including within the safety net, because of fears of deportation if they seek help for themselves or other eligible family members (Wallace et al., 2012). This is particularly consequential for U.S.-born Latino children because roughly 4.5 million live in mixed-status families with undocumented immigrant parents (Wallace et al., 2012). For undocumented Latino adults and children from mixed-status families, this exclusion may influence them to rely on other informal sources of help such as religious organizations, which have a long history in providing mental health and other supportive social services to the undocumented (Vásquez, 2010).

States like California, Arizona, Texas, Florida, New York, and New Jersey will be disproportionately affected by the lack of coverage for the undocumented because they have the largest populations of undocumented immigrants in the U.S. (Wallace et al., 2012). Of these states, California (38.1%), Texas (38.1%), and Florida (22.9%) have the largest population of Latinos in the nation (U.S. Census Bureau, 2013). Upon full implementation of the ACA, undocumented immigrants in California, for example, (and throughout all states) will potentially remain uninsured, representing 41% of California's uninsured population compared to 25% nationwide (Wallace et al., 2012), if policies are not passed to address the health needs of this

group. In contrast, New York is expected to have the third largest statewide number of uninsured undocumented immigrants (16%) in the country (Wallace et al., 2012). As a consequence, their exclusion from the ACA will make them a significant share of the total uninsured population (Zuckerman, Waidman, & Lawton, 2011).

In response to this, California lawmakers are proposing to develop special initiatives to address the healthcare needs of undocumented immigrants. In 2014, individuals in California's Low Income Health Program (LIHP) were eligible for Medi-Cal, the state's Medicaid program, making their care fully paid for by the federal government and saving counties $1.4 billion in LIHP-related costs. Some lawmakers are proposing to utilize an estimated $700 million from these savings to offer basic healthcare services to undocumented immigrants (Sanders, 2013). However, it remains to be seen how other states like Texas and Florida will respond to undocumented Latino immigrants under the ACA. Historically, Southern states have held conservative attitudes toward immigrants and immigration policy (Schmid, 2003), and thus may be less inclined to develop special programs for the undocumented. If states choose *not* to adopt new policies or programs aimed at addressing the health needs of undocumented immigrants, this may widen health disparities for Latinos due to lack of access to preventive care services (Sommers, 2013). A larger reliance on the safety-net system among this population also may increase financial stress among these types of providers (Zuckerman et al., 2011).

The exclusion of undocumented immigrants in the ACA will also be felt by states with emerging Latino populations. Over the last decade, the lessening of jobs in states with large Latino populations has led to an influx of immigrants, especially undocumented immigrants, to "new destination" states such as Illinois and Georgia (Wallace et al., 2012). In all of these states, providers of uncompensated public mental health services will be seriously affected by the

inability of undocumented immigrants to be covered under the ACA. Establishing partnerships with large-scale FBOs with their community clinics and hospitals, who provide care without attention to citizenship status, may prove to be both prudent and necessary, as FBOs play a critical role in these "new destinations" in helping Latino immigrants integrate into their new social environment (Vásquez, 2010). Most importantly, these partnerships may help enable Latino undocumented immigrants to seek medical care (López-Cevallos, Lee, & Donlan, 2013).

Integrated Mental Healthcare Services Under the ACA

The ACA is also expected to open the door for better mental health services for Latinos because of the ACA's push to integrate mental health treatment services in the primary care setting (Mechanic, 2011, 2012). In particular, the ACA's Medicaid "health home" option will allow enrollees with multiple chronic conditions, including serious and persistent mental illness, to receive patient-centered medical care (KFF, 2011). Modeled after the patient-centered medical home (PCMH), the patient-centered health home option integrates and coordinates all primary, acute, behavioral health, and long-term services and supports to treat the "whole person" (KFF, 2011).

The patient-centered health home supported by Medicaid expands on the traditional PCMH by building linkages to other community and social supports (Bao, Casalino, & Pincus, 2013). Thus, the notion of the health home also incorporates community health teams such as collaborations with FBOs, which could for Latinos increase mental health screening, care coordination, and patient case management within a religious/spiritual framework. This delivery model, if adopted by states with high Latino populations such as California and Texas, may help improve utilization, coordination, and integration of primary care and behavioral/mental health

services for Latinos. This is especially significant considering that over one-quarter of insured Latinos are covered by Medicaid and a significant proportion suffer from multiple chronic conditions including mental illness (Ortega, Feldman, Canino, Steinman, & Alegría, 2006). Most pertinent to Latinos, efforts to expand culturally relevant health services and strengthen cultural competency in the medical setting will increase the likelihood that Latinos will use their increased access to primary care where appropriate screening and diagnosis can take place (KFF, 2013b).

Coupled with the ACA provisions, what do these changes in the delivery of mental health services mean for Latinos? In general, the ACA is expected to have a positive effect on the health of Latinos, in that more Latinos will now have opportunities to obtain health coverage through the health insurance marketplace and Medicaid, including 10.2 million uninsured Latinos (HHS, 2013). Integrated models of care and federal investments to enhance quality of care are expected to help improve the management of chronic diseases that are most prevalent among Latinos (HHS, 2013; Kaiser Family Foundation, 2011). Lastly, efforts to increase healthcare workforce diversity may help promote cultural competency and culturally relevant care for Latinos in primary care (HHS, 2013; Kaiser Family Foundation, 2013b).

The Influence of Faith and Religion in Latino Culture and Mental Health

The significance of the contributory role of FBOs as a pathway to mental healthcare becomes apparent when the saliency of religious participation in the lives of Latinos is examined. Approximately 80% of Latinos indicate a religious affiliation, with most being Catholic (55%) or Protestant (22%, which includes 16% Evangelical); only 1% identify with other religions such as Mormonism, Judaism, or Buddhism (Pew Research Center, 2014). While

Catholic Latinos are the majority, over the last few years there has been a decline in the proportion of Catholic Latinos due to the rise of two groups, evangelical Protestants and the religiously unaffiliated. Nearly one-quarter of Latinos identify themselves as former Catholics. Compared to the general U.S. population, Latinos are also more likely to attend religious services, with 20% of Latinos attending services at least once a week (Taylor, Lopez, Martínez, & Velasco, 2012). Within Latinos, however, church attendance and religious engagement (e.g., Scripture reading, Bible study classes) is highest among Latino Protestants than Latino Catholics (Pew Research Center, 2014).

The limited research on Latinos suggests that religious practices such as church attendance may serve as protective factors against certain mental disorders (e.g., anxiety, substance use, and depressive disorders) and function as a psychological and social resource for coping with stress (e.g., Alegría et al., 2007c; Koenig, 2009). A study on the risk factors of psychiatric disorders among Latinos finds that high religious attendance (i.e., attending religious services at least once per week) is associated with decreased likelihoods of developing a past-year anxiety or substance use disorder (Alegría et al., 2007c). Similar patterns are seen among older Latinos in that higher levels of religious attendance minimize risk of depression (Aranda, 2008). It is thought that religious attendance helps Latinos cope with hardships by establishing socially protective ties that buffer life stressors (Alegría et al., 2007c). Furthermore, religious involvement is believed to lead to better mental health by advising and encouraging attendees of religious services to avoid negative, high-risk behaviors (e.g., alcohol and drug use) (Aranda, 2008). Thus, the combination of strong supportive ties within the church and the avoidance of risky mental health–related behaviors may help minimize the risk of mental illness among Latinos with strong religious engagement.

Aside from influencing mental health, cultural values linked to the primacy of religion and faith in the lives of many Latinos also affect how and whether they engage in formal help-seeking. Some Latinos, for example, are likely to seek help for mental health problems from informal sources such as family, friends, and faith leaders (e.g., priests, ministers) (Cabassa, 2007; Villatoro et al., 2014). Studies have found that a significant proportion of Latinos report preferring to seek help for a mental health or psychologically distressing problem from clergy or faith leaders rather than from formal mental health providers (Kane & Williams, 2000; Moreno & Cardemil, 2013). Seeking out the help of religious leaders is highly valued by some Latinos because these figures are seen as having close ties to God and having the ability to provide services that complement their ways of coping with stress and adversity (Moreno & Cardemil, 2013). In some cases, Latinos consider seeking formal mental health services only as a last resort, after turning to religiously oriented spiritual care. On one hand, these informal sources act as alternatives to formal mental healthcare, providing supportive responses that for some can alleviate the need for care in the formal mental health system (Golding & Wells, 1990; Pescosolido, Wright, Alegría, & Vera, 1998). On the other hand, these same sources may also serve as a gateway to formal services via treatment referrals for individuals with severe mental illness (Dossett, Fuentes, Klap, & Wells, 2005; Wang, Berglund, & Kessler, 2003).

Given religion's prominent role and acceptability in the Latino culture (McField & Belliard, 2009; Taylor et al., 2012), religion-oriented mental health services may be less stigmatizing and more attractive to some Latinos in need of mental healthcare. For example, Catholic Latinos in Florida are more likely to indicate a preference for mental health assistance from a priest than receive help from a licensed mental health professional (Kane & Williams, 2000). Likewise, some Latinos are more likely to prefer seeking counseling services and use

prayer over antidepressant medications to treat depression because they regard these sources of coping and care to be more effective and less addictive than medications (Givens, Houston, Voorhees, Ford, & Cooper, 2007). Unlike mental health specialists that focus specifically on treating mental health problems, faith leaders offer counseling services that incorporate spiritual/religious beliefs of healing and provide support for social stressors (Milstein, Manierre, Susman, & Bruce, 2008). The appeal of seeking religious leaders or advisors for mental health concerns is further strengthened by the trustworthy and dependable reputations of these providers, the degree of shared beliefs and values between the provider and client, and their greater ease of accessibility (Moreno & Cardemil, 2013). This accessibility also facilitates continuity of care, in contrast to formal providers who may deliver inconsistent care due to access barriers, such as lack of health coverage or plan limitations in the number of mental health visits (Milstein et al., 2008).

Specific religious activities and spiritual practices also shape the ways in which Latinos cope with mental health concerns (McField & Belliard, 2009; Moreno & Cardemil, 2013). For example, Catholic Latinos participate in *confesión* (confession), a useful vehicle where individuals can anonymously share their worries and receive religious counsel from trusted faith leaders (McField & Belliard, 2009). Prayer is also used as a frequent spiritual practice to help manage stress because it is thought to create a personal connection with God and produce a sense of hopefulness during difficult times (Moreno & Cardemil, 2013). Findings from a national study on ethnicity and mental health treatment preferences also show that Latinos are generally more likely to believe that prayer is an effective means to treating depression (Givens et al., 2007). Other common spiritual mechanisms used to cope with adversity include reading spiritual books and reciting Bible verses (Moreno & Cardemil, 2013). Such religious and spiritual practices are

considered therapeutic and easily accessible to people with mental health needs. In consideration of these preferred coping mechanisms, it is important to consider how FBOs may be essential partners in the mental healthcare of Latinos. While a majority of care under the ACA will be through the primary care patient-centered medical home, the ACA also has provisions for community participation in delivering healthcare services and screening. Thus, FBOs may help ensure that the mental health needs of Latinos are addressed, particularly in the primary care setting.

Traditional Role of FBOs in Mental Healthcare

Traditionally, the role of FBOs in the mental healthcare system has been limited. Small FBOs like religious congregations have at times provided limited faith-placed mental health services. For example, pastoral counseling is an important expertise that faith leaders employ to provide counsel and support to psychologically distressed individuals. Much of pastoral counseling is focused on issues of life stressors, such as divorce, loss, and bereavement (Leavey, Loewenthal, & King, 2007; Moran et al., 2005). Faith leaders are often in long-term relationships with their congregants, which enable them to detect signs of distress and intervene early in some instances referring individuals with a serious mental disorder to formal care (Leavey et al., 2007; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). Though faith leaders primarily counsel individuals on stressful life events, the majority also report having to provide counsel to individuals suffering from serious mental illness (Dossett et al., 2005; Leavey et al., 2007), and oftentimes describe arranging referrals to formal services for these individuals (e.g., Dossett et al., 2005; VanderWaal, Sandman, Linton, Hernandez, & Ippel, 2011).

Second, FBOs have also played a prominent part in delivering primary preventive care services to vulnerable populations, most of which have focused on preventing physical diseases. For example, faith-based programs aimed at improving health education within Latino religious congregations have been shown to be effective in decreasing or delaying obesity and diabetes (Nies, Artinian, Schim, Wal, & Sherrick-Escamilla, 2004) and increasing screening rates of cervical and breast cancer among Latinas (Lopez & Castro, 2006). Despite these studies, more research is needed on how faith-based prevention programs might help prevent or improve mental illness among Latinos. The research on Latinos in this area is practically non-existent, but some findings exist for African Americans that can give us insights into how it works.

A review by Hankerson and Weissman (2012) reveals that most studies on church-based health programs among African Americans focus on substance-related disorders, with few addressing other mental disorders. Drawing on the socio-ecologic model, the authors contend that implementing health promotion programs that address the multilevel nature of health problems in religious settings such as churches may result in lasting behavior change and positive outcomes. The benefits of implementing these programs in religious settings is due to their ability to engage individuals, promote positive interpersonal/social interactions within the religious community, and create organizational structures and resources (e.g., church-sponsored education/events) to enhance health promotion (Hankerson & Weissman, 2012). These church-based programs have been shown to prevent drug use among adolescents (Marcus, Walker, & Swint, 2004), improve depressive symptoms (Mynatt, Wicks, & Bolden, 2008), and improve the understanding of the causes and treatment of mental illness (Pickett-Schenk, 2002). Nevertheless, the evidence for the efficacy of these programs remains debatable because these studies rely on small sample sizes, are conducted in specific regions of the country, or lack

generalizability to the larger African-American population. Despite these limitations, it indicates that churches have a place in addressing mental health in racial/ethnic minority populations.

Third, there are also religious denominations with well-established social service agencies. For example, Catholic Charities USA (CCUSA) includes a private network of social service organizations in the U.S. that have provided social services including mental health to families and individuals living in poverty (CCUSA, 2012). Organizations like CCUSA have been able to build an infrastructure of accessible care. In particular, these FBOs have been able to offer multi-lingual behavioral health services, develop partnerships with local health departments, and develop specialized mental health programs for specific populations (e.g., children, older adults).

Lastly, there are instances of partnerships between FBOs and healthcare agencies such as federally qualified health centers (FQHCs). Services provided by FQHCs in partnerships with neighborhood churches have been shown to enable access to medical and dental care among undocumented Mexican-origin farm workers, despite apprehension to use these services for fears of deportation (López-Cevallos et al., 2013). Other public healthcare entities such as the Department of Veterans Affairs (VA) have established relationships with chaplains to provide care for veterans with mental health problems (Nieuwsma et al., 2013). These partnerships are seen as necessary to increasing access to care and providing holistic care that includes medical care and social and spiritual support to help patients sustain health-promoting behaviors and effective disease management (Gee, Smucker, Chin, & Curlin, 2005; National Center for Cultural Competence, 2001). Similar to secular FQHCs, faith-based community health centers (CHCs) play a role in the primary care safety net by serving as a site for referral from religious congregations for health and mental healthcare services. Services offered through these agencies

are comparable to secular FQHCs with the added potential for services that blend spiritual care in their models of care. Despite the perceived benefits of establishing partnerships between FQHCs (one of the largest providers of primary care services for the uninsured) and small FBOs, this has been an area of limited partnerships, especially within integrated, patient-centered medical homes.

The Evolving Role of FBOs Under the ACA

Aside from their potential to influence access to mental health services among Latinos, it is worthwhile to consider the notable role FBOs may play in the ACA's Medicaid patient-centered health home. As part of its goal to improve access and continuity of care, the ACA recognizes the role of community organizations as partners in care for increasing screening, delivering health services, and improving community well-being. A considerable proportion of low-income Latinos with comorbid health conditions are anticipated to take part in Medicaid, and thereby also find themselves enrolled in patient-centered health homes. Collaborative, integrated primary care such as the PCMH has been demonstrated to be an effective delivery model to treat behavioral and mental health disorders for Latinos and other racial/ethnic minority groups (Areán et al., 2005; Ayalon, Areán, Linkins, Lynch, & Estes, 2007). Incorporating FBOs into the patient-centered health home provides the opportunity to augment the reach and scope of these services (e.g., support for treatment adherence, disease management) that may otherwise be difficult to integrate. In addition, it may for some Latinos serve to increase satisfaction and maintenance of mental disorder treatment (Alegría et al., 2007b; Wells et al., 2001). The following sections provide four examples of the specific roles congregation-based FBOs and faith-based CHCs can play in the Medicaid patient-centered health home.

Providers of Mental Health Prevention and Promotion Services

The ACA recognizes the need to create community health teams that engage community and faith-based organizations with healthcare systems to improve the health of vulnerable populations (KFF, 2013b). Built within the ACA law are provisions to increase community participation in preventive care services and health screenings (KFF, 2013b). Religious congregations, for example, may offer classes on how to cope with stress to reduce the risk of mental illness or provide mental health education programs that focus on increasing knowledge about mental illness, its causes, and how to seek care to diminish barriers to care (e.g., stigma, lack of information). Such faith-based mental health promotion activities have been instrumental in improving mental health literacy and reducing risk of poor mental health (Hankerson & Weissman, 2012).

In addition to preventive care, FBOs may also provide mental health screenings as a way to increase awareness of mental illness in the hopes of providing timely referral to formal mental healthcare. For example, faith leaders often times have longstanding relationships with their congregants, which may enable them to recognize unusual behaviors or problems that are reminiscent of a mental illness when they arise (Moreno et al., 2013). Periodic mental health screenings conducted by lay community health workers may further facilitate the identification of a mental illness and need for mental healthcare at a larger scale within religious communities. Such screening practices could help reach large populations of Latinos that may benefit from mental health treatment, particularly the undocumented who would not be able to get screened in the primary care setting. If traditional systems of care within the primary care setting promote collaborations with FBOs, the recognition of mental illness by members within FBOs may then serve as a gateway to formal mental healthcare via referrals for individuals with serious mental

health needs (National Center for Cultural Competence, 2001). As a whole, these roles of providing preventive care and referral services could contribute to reducing mental healthcare disparities in Latino populations. Expanding preventive mental health and screening services in congregation-based FBOs could also serve to address the mental health needs of undocumented immigrant Latinos, who are not covered by the ACA.

Facilitators in Treatment Adherence and Disease Management

FBOs could also augment the capacity of mental health services in the Medicaid patient-centered health home of Latinos through partnerships with CHCs (National Center for Cultural Competence, 2001). FBOs can help refer people with a serious mental illness to formal mental health services, and this referral is easiest when there is an established partnership between FBOs and specific healthcare agencies like secular FQHCs or faith-based CHCs. Once individuals with mental health needs transition into formal care, FBOs could offer support services that may not be readily available in traditional FQHCs or patient-centered health homes, but that are crucial for continuity of care and adherence to mental healthcare treatment regimens. For example, congregations have been successful in operating programs that provide non-emergency transportation to medical appointments and personal care services such as house cleaning, grocery shopping, and help with activities of daily living (Fossett & Burke, 2004). In some states, Medicaid helps fund and support these activities by congregation-based FBOs (Fossett & Burke, 2004).

Providers of Limited After-Care Services

To further ensure patient-centered and comprehensive care, FBOs such as religious congregations partnered with CHCs may deliver limited after-care services that focus on

treatment adherence (Milstein et al., 2008; National Center for Cultural Competence, 2001). For example, faith-based rituals and spiritual practices such as prayer or meditation have been shown for some to foster recovery among people with mental illness (Fallot, 2001). In particular, religious involvement assists with the recovery from severe and persistent mental illness because it plays a positive role in coping with stress and decision-making, helps with avoidance of negative activities such as substance use, enhances tangible and emotional support, and strengthens a sense of personal coherence (i.e., being a "whole person") (Fallot, 2001). A review of FBO programs that address substance abuse issues through 12-step programs, meditation, and prayer demonstrates that faith-based treatments are comparable to the success of secular substance abuse programs (Stoltzfus, 2007).

Programs such as the Nebraska Expanding Behavioral Health Access through Networking Delivery Systems (NEBHANDS) recognize how stressful navigating the mental healthcare system can be for individuals suffering from serious mental illness. NEBHANDS encourages congregations to assist with care coordination by either leading or acting as a member of a team that helps to arrange services that are necessary for successful integration of mentally ill individuals into the community (University of Nebraska Public Policy Center, 2005). Faith-based programs delivered in religious congregations that target specific physical health and mental health conditions (e.g., diabetes and depression) have been shown to successfully provide additional support in managing the mental health and behavioral side of these conditions (DeHaven, Hunter, Wider, Walton, & Berry, 2004). However, most of these initiatives have relied on partnerships with local mental health departments and have not been adopted in the primary care setting. Yet under the ACA, there are opportunities to create similar relationships that can support integrated care efforts.

Enablers in the Delivery of Mental Health Services

Faith-based organizations also have played an extensive role as providers of mental health services to individuals with varying mental health needs. As previously mentioned, it is common practice for faith leaders in congregation-based FBOs to counsel their congregants on life stressors such as divorce, loss, and bereavement and in some cases counsel individuals suffering from substance use problems and serious mental illness, irrespective of any formal mental health training (Dossett et al., 2005; Leavey et al., 2007; Moran et al., 2005). Under the ACA, FBOs may continue to deliver faith-placed mental health counseling services to Latinos with mental health needs and, when appropriate, transition those with severe mental illness into formal mental healthcare (e.g., refer to a primary care physician, psychiatrist). These faith-placed services may be particularly useful for undocumented Latinos who already have limited access to mental health services under the ACA.

In addition to congregation-based FBOs, mental health services can also be delivered in faith-based CHCs. As part of the primary care safety net, faith-based CHCs, like secular FQHCs, are responsible for primary and preventive care services, which include mental healthcare. Faith-based CHCs embrace a holistic vision of health compatible with a PCMH model. Their care emphasizes not only physical, emotional, and social components of health but also the spiritual (Gee et al., 2005). For example, similar to Catholic Charities, Christ Community Health Services is the second-largest faith-based health center in the country that provides integrated healthcare services with an added spiritual component to the poor, uninsured, and homeless (CCHS, 2014). This holistic view of health may be an attractive feature for religious congregations to form partnerships with faith-based CHCs as well as attract individuals who seek care that embraces their religious values. With the focus on patient-centered health homes in Medicaid, both faith-

based CHCs and secular FQHCs may be motivated to provide more behavioral health services in primary care thereby improving integration of mental and physical healthcare.

Challenges in Partnerships with FBOs

While the FBO movement in healthcare has gained political and public support (Fossett & Burke, 2004; Kramer, 2010), many obstacles remain that challenge the ability for FBOs to help Latinos access public mental healthcare under the ACA. First, ACA funding will be critical to expanding Medicaid patient-centered health home services to vulnerable populations in secular and faith-based CHCs, but funding restrictions may limit the participation of congregation-based FBOs. Second, while faith leaders can play a significant role in referring individuals with mental health needs to formal services, the greatest barrier is their limited training in recognition of serious mental disorders. Last, although the ACA recognizes the benefits of health systems establishing partnerships with community organizations such as FBOs to improve the patient-centered health home, the formulation of these partnerships ranging from their role in the patient-centered health home team relative to HIPPA and having non-covered staff participate in healthcare teams may prove to be too difficult to overcome. The challenges discussed are not necessarily unique to FBOs that serve Latinos, but speak to the general needs of FBOs across the U.S.

Since the Charitable Choice statute was enacted during the Clinton administration, FBOs have been able to participate in publicly funded programs (Kramer, 2010). More specifically to the ACA, FBOs are eligible to apply and receive grants from the Prevention and Public Health Fund (PPHF) to increase community-based prevention efforts (HRSA, 2014). These funding opportunities may encourage FBOs to partner with secular FQHCs or faith-based CHCs and

develop grant proposals for faith-based programs that expand the delivery of mental health support services within the Medicaid patient-centered health home or FBO, as those previously described. Despite increasing efforts to engage FBOs in public funding, the number of FBOs that could be engaged as federal grantees has remained relatively small and represents a small proportion of total federal spending in human services (Kramer, 2010). Congregation-based FBOs are especially less likely to apply for federal grants and must compete with larger FBOs (Ebaugh et al., 2003), limiting the diversity of FBO's in the pool to provide services. It remains to be seen how ACA funds will be distributed and whether congregation-based FBOs will apply for and receive some of the PPHF funds. One solution to increase their funding under ACA is to include congregation-based FBOs in workforce development efforts that are designed to re-engineer healthcare support positions (e.g., increasing mental health training among faith-leaders to improve recognition and screening of mental illness and transition into formal care).

Faith-based CHCs are also eligible to receive funds from the Community Health Center Fund to operate and expand preventive and primary care services (HRSA, 2014). Faith-based CHCs such as Christ Community Health Services have been able to receive funds to expand integrated healthcare services, including dental and physical therapy services (CCHS, 2014). More recently, the Health Resources and Services Administration (HRSA) announced new funding opportunities to assist CHCs in expanding behavioral health services in the patient-centered health homes (HRSA, 2014). The ACA creates pathways in federal funding to increase successful partnerships between primary care and FBOs, but we must also remember that many initiatives within the ACA are also state supported. States need to be cognizant of any barriers to collaborations between religious organizations and healthcare facilities.

The need for the mental health training of faith leaders is a significant issue for FBOs, specifically religious congregations (Dossett et al., 2005; Leavey et al., 2007). Better mental health literacy among faith leaders is essential to the recognition of mental illness and facilitation into formal mental healthcare. Surveys of faith leaders reveal that many are insufficiently trained to recognize the signs and severity of mental disorders (Dossett et al., 2005; Leavey et al., 2007; Weaver et al., 2003). However, little information exists on national estimates of faith leaders with advanced mental health training. In high-density Latino areas such as Los Angeles, for example, less than one-quarter of faith counselors have had at least a moderate amount of mental health training (Dossett et al., 2005). In a study of pastoral care of New York City clergy, less than half reported having any form of clinical pastoral education (CPE)—specialized training of hospital or hospice chaplains or other clergy in pastoral care and counseling—with the highest percentage of training observed among Protestant clergy (65%) and the lowest among rabbis (33.5%) (Moran et al., 2005). In another study of Catholic priests, less than one-fourth are trained to provide counseling or mental health services (Kane, 2003).

In response to these training needs, pastoral care education programs have been established to train faith leaders on issues of mental health, including how to provide short-term counseling and how to refer individuals to longer-term mental healthcare. For example, the Blanton-Peale Institute is a licensed, nonprofit, multi-faith counseling center that established a Spanish-language mental health counseling training program for Latino pastors in New York City (Collins, 2006). More than 1,000 religious leaders completed various levels of training through the institute's pastoral care training program, including pastors, church deacons, and youth leaders (Collins, 2006). Similarly, Mental Health First Aid offers an evidence-based interactive education program that focuses on identifying, understanding, and responding to

signs of mental and substance use disorders (Kitchener & Jorm, 2006). The program targets faith communities, health professionals (e.g., primary care physicians), and community members, and has been shown to improve recognition of mental disorders and increase confidence in providing care to those in need of mental healthcare (Kitchener & Jorm, 2006).

Making programs such as these accessible to faith leaders and other faith community volunteers will be important to increasing mental health literacy in religious communities. One way of doing so is to extend ACA workforce training and development funds to FBOs. Currently, the ACA does not extend these training funds to providers in nonmedical settings. If ACA is to be successful at decreasing Latino mental healthcare disparities, the mental health training of faith leaders should be an added priority in order to ensure Latinos with serious mental illness who seek their help are better able to receive a response that results in appropriate and timely entry into care. It is also important that particularly in areas with undocumented Latinos not covered at the local level by ACA that access to and participation in this mental health training for faith leaders be facilitated and encouraged as it is religious organizations that have had a long tradition of providing services to the undocumented.

There is also a dearth of established partnerships between FBOs and formal systems of care such as CHCs (Dossett et al., 2005). Conflicting perspectives on the origins of mental health disorders and mental health treatment may keep congregation-based FBOs and CHCs from developing partnerships. For example, while most faith leaders are trained in a broad set of approaches to mental health etiology and care, there are a sizeable number, in particular religious sects, who believe individuals suffering from serious mental health challenges are dealing with a spiritual or moral problem (Dossett et al., 2005; Leavey et al., 2007; VanderWaal et al., 2011).

Some African-American Pentecostal preachers, for example, even believe that the use of medications in treating mental health concerns is a weakness in strength of faith (Payne, 2008).

Another area of disagreement relates to the efficacy of faith healing. A significant proportion of faith leaders consider faith healing or pastoral counseling an appropriate and fully adequate way to treat serious mental illness because it focuses on the "whole person" (Leavey et al., 2007). The efficacy of these approaches to "treating" individuals with mental illness is unknown because of the lack of empirical research in this area (Jankowski, Handzo, & Flannelly, 2011). However, one study finds that a pastoral intervention designed to treat depression and conducted by ordained ministers with some chaplaincy training was associated with decreased depressive symptoms in a retirement community sample (Baker, 2001). While there is some overlap between faith leaders and mental health professionals, it is also clear that these two groups can have incongruent conceptualizations of the nature, cause, and treatment of mental health problems (Weaver et al., 2003).

Lastly, although ACA recognizes the benefits of establishing partnerships between community organizations and the patient-centered health home, there are no incentives set in place to promote collaboration between these two entities. The Medicaid patient-centered health home provision is likely to be adopted by states because of additional payment incentives to help pay for care management, coordination, and use of clinical information technologies (Bao et al., 2013). However, these payment incentives are limited to Medicaid providers such as those found in secular FQHCs and faith-based CHCs. If congregation-based FBOs can be funded through Medicaid to provide patient-centered health home supportive services as those previously described (e.g., transportation to care), this may help encourage congregation-based FBOs to develop relationships with health home settings like CHCs. Likewise, PCMH providers in

FQHCs and faith-based CHCs should be encouraged to make referrals to community and social supports to enhance patient clinical and nonclinical services under ACA (KFF, 2011). In this circumstance, providers will need to know who to contact and how these support services should be structured. It may be more challenging to create incentives that persuade FQHCs, for example, to develop partnerships with FBOs while it may be easier to develop ties between faith-based CHCs and other congregation-based FBOs. Thus, in the ACA where the patient-centered health home is the goal, it raises the question of how FBOs will be viewed by safety-net providers and whether there is a place for them in secular statutes.

It is important to note that partnerships with FBOs do not necessarily need to be limited to FQHCs or faith-based CHCs. Other public healthcare systems such as the Department of Veterans Affairs (VA) and hospitals have developed relationships with clergy and chaplains to improve the care of individuals with mental health problems (Galek, Flannelly, Koenig, & Fogg, 2007; Nieuwsma et al., 2013; Weaver et al., 2003). However, the biggest challenge remaining is the lack of integration between religious and mental health providers. For example, although chaplains in the VA report being extensively involved in the care of mentally ill veterans, integration of services between mental health providers and chaplains is limited because of lack of familiarity and trust between these two distinct disciplines (Nieuwsma et al., 2013). As a result, referrals from chaplains to mental health providers and vice versa are infrequent (43% and 37%, respectively). Within hospitals, willingness to refer patients to clergy or chaplains varies by discipline of the health professional and hospital type (Galek et al., 2007). Pastoral care directors and nurses are more likely to refer patients to chaplaincy services for treatment and mental health–related issues, while medical professionals such as physicians are more inclined to refer for loss and death issues. Likewise, providers within general hospitals, especially those with a

religious affiliation, express higher values in referring patients to chaplains than providers in psychiatric hospitals. These examples suggest that the culture within these healthcare institutions may generate difficulties in integrating FBOs in mental healthcare.

Nieuwsma and colleagues (2013) identify four key steps for improving integration of chaplaincy care and mental health services. These steps include: (1) jointly training chaplains and mental health providers; (2) enhancing communication between providers via reliable documentation of chaplains' assessment and care practices while maintaining confidentiality; (3) promoting teamwork (e.g., joint clinical round and clinical team meetings); and (4) increasing interaction between VA and Department of Defense chaplains as a way to improve continuity of care for service members transitioning to civilian life. While their suggestions were framed in the context of the VA system, these actions also have ramifications for better integrating FBOs within the patient-centered health home and other healthcare institutions (e.g., hospitals).

Special initiatives also will likely be needed to foster partnerships between FBOs and healthcare systems. For example, the White House Office of Faith-Based and Neighborhood Partnerships (OFNP) was developed to promote bridges between the federal government and faith-based and neighborhood organizations to better serve Americans in need of economic and social assistance (The White House, 2014). As a result, the White House published a "Partnership Guide" detailing the opportunities available to FBOs to form partnerships across the government and information on how to apply for federal grants. Partnerships between FBOs and healthcare systems may better flourish under the guidance of an external entity similar to the OFNP that takes charge in disseminating resources and tool kits on how to establish these connections. As the U.S. Surgeon General champions mental health as a priority, increasing the

OFNP charge to include better serving Americans in need of mental health assistance would be helpful to addressing mental healthcare disparities in Latinos.

Likewise, the Bureau of Primary Health Care (BPHC), the agency that supports FQHCs, developed the Faith Partnership Initiative to promote collaboration between public providers of primary care services and FBOs. The purpose of Faith Partnership Initiative was to inform healthcare policymakers, providers, and FBOs about the values in establishing these partnerships, the types of partnerships that can support individual and community health and strengthen the safety net, and the benefits and challenges that may arise when forging these relationships (National Center for Cultural Competence, 2001). Initiatives such as the BPHC's Faith Partnership Initiative could provide helpful resources to primary care providers that include educating providers and other active participants in the patient-centered health home on the value and potential of FBOs in primary care and extending training opportunities among these providers on how to establish and maintain meaningful partnerships with FBOs. Thus, with more focus on community health teams in the Medicaid patient-centered health home, it would be important to create a central entity that provides the tools necessary for enhancing these services through partnerships with FBOs and that offers specific information about ACA provisions that are available to both agencies to support these partnerships.

The Road Ahead

To increase the likelihood of effective mental healthcare and the reduction in mental health disparities in Latinos, the integration of community assets such as FBOs into the ACA might help accomplish those goals. First, FBOs will need to focus their efforts on increasing mental health training among their faith leaders. In order to identify Latinos with mental health

needs, this may require expansions in the eligibility of ACA and state workforce training funds for nonmedical professionals, as those previously described. Second, FBOs will need to focus on building relationships with healthcare agencies like secular or faith-based CHCs that adopt a patient-centered health home model to enhance the reach of formal mental healthcare services to Latinos in need. If Medicaid patient-centered health homes are to be successful in increasing mental healthcare and retention in mental health services of Latinos, partnerships and participation as part of a team that includes FBOs might make that goal more attainable.

Third, additional research will be necessary to assess how these partnerships should be structured and their efficacy. Such research should involve needs assessments of local CHCs and Latino faith communities, including the needs of the faith leaders, the congregants they serve, primary care providers, and CHC patients. Most importantly, there is a need for demonstration research of models of care aligned with primary care and patient-centered health homes that include FBOs and the diverse Latino populations that they serve. Another effective approach for doing this research would be the use of community-engaged and community-based participatory research with FBOs. Both demonstration research and other methods of evaluating whether FBOs can add value in efforts to reduce disparities in Latino's mental healthcare are necessary. Research on FBO's and healthcare partnerships would help inform and validate the importance of identifying how and which community-based organizations and institutions beyond federally qualified health centers can serve as strong assets in cost effective and efficient healthcare services for the poor and underserved racial/ethnic minority populations.

While our discussion was framed within the primary care patient-centered health home, it is important to also note that partnerships with FBOs may also provide benefits for Latinos in other public healthcare institutions. For example, Latinos are a growing population within the

U.S. military with projections suggesting that the population of Latino service men and women to increase by 23% by 2030 (Pittman, 2014). One report further suggests that need for mental healthcare is high among this group because almost 40% of Latino Vietnam veterans suffer from lifetime post-traumatic stress disorder (PTSD) (Loo, 2014), and in some cases have higher rates of PTSD symptom severity than non-Latino whites (Duke, Moore, & Ames, 2011). Yet despite this prevalence, their treatment needs are often left unmet because of cultural barriers to care (Duke et al., 2011; Pittman, 2014). Thus, efforts to increase mental health service utilization within the VA and other public healthcare settings will be critical to reducing mental health disparities of Latinos. FBOs may prove to be key partners for linking Latinos to mental health services in settings not preferred or trusted by Latinos such as VA care centers or county or state public care facilities by incorporating cultural and spiritual relevance as part of their care experience.

With the Affordable Care Act in full implementation, it is clear that additional efforts are needed to achieve the goal of equitable mental healthcare services for Latinos. Faith-based organizations have the ability to become valuable allies to the mental healthcare system, but also can be valuable partners in the primary care patient-centered medical home. FBOs are just one example of a pathway to minimize the gap of unmet mental healthcare and treatment needs of Latinos in the U.S.

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