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Faith-Based Organizations and the Affordable Care Act: Reducing Latino Mental Health Care Disparities

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The Patient Protection and Affordable Care Act (ACA; 2010) is expected to increase access to mental health care through provisions aimed at increasing health coverage among the nation's uninsured, including 10.2 million eligible Latino 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 health care disparities for Latinos. Faith-based organizations (FBOs) could play an integral role in the mental health care 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 health care 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 health homes 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 primary care providers need to overcome to be partners in integrated care efforts.

Keywords: mental health care, Latinos, faith-based organizations, ACA, disparities

Latinos are the largest and fastest growing racial/ethnic minority group in the United States, 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; 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; Kaiser Family Foundation, 2013a). The primary care settings of the public health care sector, in particular, are going to have predominant oversight of the mental health care 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 health care. In this paper, we examine the aspirations and expectations of health care 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 health care. In particular, we argue that FBOs can be essential partners in the primary care patient-centered health homes of Latinos.

Defining Faith-Based Organizations

FBOs 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

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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, 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, 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 United States has at some point sought economic aid from religious groups to make ends meet (Pew Forum & Pew Research Center, 2009). In contrast, large FBOs such as Catholic Charities U.S.A. (CCUSA; 2012) and Christian Community Health Fellowship (CCHF; 2014) have extensive networks of services that directly deliver formal health care services to a wide range of individuals based on their religious mission. Last, 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 services.

Mental Health Needs and Services Utilization Patterns of Latinos

Epidemiologic studies such as the National Latino and Asian American Study (NLAAS) demonstrated 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, Mulvaney-Day, Torres, et al., 2007). Although the aggregate prevalence of mental disorders among Latinos in the United States 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, Chatterji, et al., 2008). As a consequence, 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 health care (Alegría et al., 2002; Wells et al., 2001).

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 United States, Puerto Ricans overall have significantly higher prevalence of any lifetime and 12-month depressive, anxiety, or substance use disorder compared to other Latino subgroups (Alegría, Mulvaney-Day, Torres, et al., 2007). 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, Canino, et al., 2008). However, the protective effects of immigrant status vary by Latino subgroups, the number of years living in the United States, and age of immigration (Alegría, Canino, et al., 2008; Alegría, Scribney, Woo, Torres, & Guarnaccia, 2007). 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, Canino, et al., 2008). Latino immigrants who have a long residency in the United States or immigrated at a young age are more at risk of a mental disorder than those who have lived in the United States for a short period of time or immigrated later in life as an adult (Alegría, Mulvaney-Day, Torres, et al., 2007; Alegría, Scribney, et al., 2007). 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.

Although 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, Chatterji, et al., 2008). Among individuals meeting diagnostic criteria for a 12-month depressive disorder, 64% of Latinos versus 40% of non-Latino Whites do not use any form of mental health service (Alegría, Chatterji, et al., 2008). Likewise, Latinos are more likely to have less mental health care than needed as well as delayed and less active care than non-Latino Whites (Wells et al., 2001). Even when Latinos with depression 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, Chatterji, et al., 2008).

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, Mulvaney-Day, Woo, & Torres, et al. (2007) found 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 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 United States. Although use of mental health services is highest among Latino subpopulations that have substantial need for mental health care (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 Health Care Barriers and the ACA

The underutilization of mental health services among Latinos 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 health care reform, provisions of the ACA are anticipated to help address some of these barriers to care and increase utilization of mental health services within this population (Alegría et al., 2012).

The primary mechanism through which the ACA is expected to increase access to health and mental health care services for some Latinos is expanding health care 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 (Kaiser Family Foundation, 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 adults who have family incomes at or below the federal Medicaid expansion limit (138% federal poverty level; e.g., Kaiser Family Foundation, 2013a). Preliminary reports have suggested that there has been a considerable influx of newly insured Latinos as a result of the ACA; the overall 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. As a consequence, states that approved the Medicaid expansion experienced higher growth in Medicaid and Children's Health Insurance Program (CHIP) enrollment (by 15.3%) than states that chose not to expand Medicaid at this time (by 3.3%; Kaiser Family Foundation, 2014). More specific, 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 (MHPAEA; 2008), there also is the added potential for the improvement of utilization of mental health services among Latinos. The MHPAEA 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 also may help to facilitate continuity of mental health care 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) argued 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 health care 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 demonstrated in later sections, it is important to think about how these community-based and trusted informal sources of care such as FBOs can become part of the formal systems of care to improve the mental health care of Latinos.

Consequences of the ACA in Undocumented Latinos' Mental Health Care

Despite the ACA's promise to improve access, continuity, and quality of health and mental health care 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 United States fall into this category. The ACA excludes 11.2 million undocumented immigrants, including one million children, from participating in the selection of health care coverage in the health market system 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 Latino adults 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., health care 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 such as California, Arizona, Texas, Florida, New York, and New Jersey will be disproportionately affected by the lack of health coverage for the undocumented because they have the largest populations of undocumented immigrants in the United States (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). On 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, Waidmann, & Lawton, 2011).

In response to this, California lawmakers are proposing to develop special initiatives to address the health care 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 health care services to undocumented immigrants (Sanders, 2013). However, it remains to be seen how other states such as 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 also will 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 important, these partnerships may help enable Latino undocumented immigrants to seek medical care (López-Cevallos, Lee, & Donlan, 2014).

Integrated Mental Health Care Services Under the ACA

The ACA also is 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 Medicaid enrollees with multiple chronic conditions, including serious and persistent mental illness, to receive patient-centered medical care (Kaiser Family Foundation, 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" (Kaiser Family Foundation, 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, 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 (Kaiser Family Foundation, 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 (U.S. Department of Health and Human Services, 2013). Integrated models of care and federal investments to enhance quality of care are expected to improve the management of chronic diseases that are most prevalent among Latinos (Kaiser Family Foundation, 2011; U.S. Department of Health and Human Services, 2013). Last, efforts to increase health care workforce diversity may help promote cultural competency and culturally relevant care for Latinos in primary care (Kaiser Family Foundation, 2013b; U.S. Department of Health and Human Services, 2013).

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 health care 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). Although 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 also are 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 has suggested that religious practices such as church attendance may serve as protective factors against certain mental disorders (e.g., anxiety, substance use, depressive disorders) and function as a psychological and social resource for coping with stress (e.g., Alegría, Shrout, et al., 2007; Koenig, 2009). A study on the risk factors of psychiatric disorders among Latinos found that high religious attendance (i.e., attending religious services at least once per week) is associated with decreased likelihoods of developing a 12-month anxiety or substance use disorder (Alegría, Shrout et al., 2007). 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, Shrout, et al., 2007). 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, drug use; Aranda, 2008). Thus, the combination of strong supportive ties within the church and the avoidance of risky 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 first turning to religiously oriented spiritual care. On one hand, these informal sources act as alternatives to formal mental health care, 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 also may 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 health care. 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, Van 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 in which individuals can anonymously share their worries and receive religious counsel from trusted faith leaders (McField & Belliard, 2009). Prayer also is 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 health care of Latinos. Although a majority of care under the ACA will be through the primary care patient-centered health home, the ACA also has provisions for community participation in delivering health care 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 Health Care

Traditionally, the role of FBOs in the mental health care system has been limited. Small FBOs such as religious congregations have at times provided limited faith-placed mental health services. First, 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, and in some instances, refer 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 nonexistent, but some findings exist for African Americans that can give us insights into how it may work.

A review by Hankerson and Weissman (2012) revealed that most studies on church-based health programs among African Americans focused on substance-related disorders, with few addressing other mental disorders. Drawing on the socioecologic model, the authors contended that implementing health promotion programs that addressed 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 was 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 et al., 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, CCUSA includes a private network of social service organizations in the United States that have provided social services including mental health services to families and individuals living in poverty (CCUSA, 2012). Organizations such as CCUSA have been able to build an infrastructure of accessible care. In particular, these FBOs have been able to offer multilingual behavioral health services, develop partnerships with local health departments, and develop specialized mental health programs for specific populations (e.g., children, older adults).

Last, there are instances of partnerships between FBOs and specific health care agencies. For example, services provided by federally qualified health centers (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., 2014). Other public health care 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 health care 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 health 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 main-

tenance of mental disorder treatment (Alegría, Mulvaney-Day, Woo, et al., 2007; 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

Built within the ACA law are provisions to increase community participation in preventive care services and health screenings (Kaiser Family Foundation, 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 also may provide mental health screenings as a way to increase awareness of mental illness in the hopes of providing timely referral to formal mental health care. 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 health care 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 health care 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 health care disparities in Latino populations. Expanding preventive mental health and screening services in congregation-based FBOs also could 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 also could augment the capacity of mental health services in the Medicaid patient-centered health home of Latinos through partnerships with safety net health care agencies (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 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 health care treatment regimens. For example, religious congregations have been successful in operating programs that provide nonemergency 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 Aftercare Services

To further ensure patient-centered and comprehensive care, FBOs such as religious congregations partnered with CHCs may deliver limited aftercare 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; University of Nebraska Public Policy Center, 2005) recognize how stressful navigating the mental health care 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 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, Wilder, 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

FBOs 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 health care. 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 also can be delivered in faith-based CHCs. As part of the primary care safety net, faith-based CHCs, as with secular FQHCs, are responsible for primary and preventive care services, which include mental health care. 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 CCUSA, Christ Community Health Services (CCHS) is the second-largest faith-based health center in the country that provides integrated health care services with an added spiritual component to the poor, uninsured, and homeless (Christ Community Health Services, 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 physical and mental health care.

Challenges in Partnerships With FBOs

Although the FBO movement in health care 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 health care 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, although 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 the 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 health home team relative to the Health Insurance Portability and Accountability Act (HIPAA) and having noncovered staff participate in health home care teams may prove to be too difficult to overcome. The challenges discussed are not necessarily unique to FBOs that serve Latinos, but also speak to the general needs of FBOs across the United States.

Since the Charitable Choice statute was enacted during the Clinton administration, FBOs have been able to participate in publicly funded programs (Kramer, 2010). More specific to the ACA, FBOs are now eligible to apply and receive grants from the Prevention and Public Health Fund (PPHF) to increase community-based prevention efforts (Health Resources and Services Administration [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 FBOs 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 the ACA is to include congregation-based FBOs in workforce development efforts that are designed to reengineer health care 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 (CHCF) to operate and expand preventive and primary care services (Health Resources and Services Administration, 2014). Faith-based CHCs such as Christ Community Health Services (2014) have been able to receive funds to expand integrated health care services, including dental and physical therapy services. More recent, the Health Resources and Services Administration (HRSA; 2014) announced new funding opportunities to assist CHCs in expanding behavioral health services in patient-centered health homes. The ACA creates pathways in federal funding to increase successful partnerships between primary care and FBOs, but we also must 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 health care 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 health care. 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—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 were 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 health care. For example, the Blanton–Peale Institute is a licensed, nonprofit, multifaith 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). Likewise, 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 health care (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 health care disparities, the mental health training of faith leaders should be an added priority 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 longstanding 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, although most faith leaders are trained in a broad set of approaches to mental health etiology and care, there are a sizable 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). Although there is some overlap between faith leaders and mental health professionals, it also is clear that these two groups can have incongruent conceptualizations of the nature, cause, and treatment of mental health problems (Weaver et al., 2003).

Last, 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 such as CHCs. Likewise, patient-centered health home 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 (Kaiser Family Foundation, 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 secular 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 health care systems such as the 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) (Nieuwsma et al., 2013). 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 health care institutions may generate difficulties in integrating FBOs in mental health care.

Nieuwsma and colleagues (2013) identified 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. Although 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 health care institutions (e.g., hospitals).

Special initiatives also will likely be needed to foster partnerships between FBOs and health care systems. For example, the White House Office of Faith-Based and Neighborhood Partnerships (OFNP; The White House, 2014) 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. 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 health care 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 health care disparities in Latinos.

Likewise, the Bureau of Primary Health Care, the agency that supports FQHCs, developed the Faith Partnership Initiative to promote collaboration between public providers of primary care services and FBOs (National Center for Cultural Competence, 2001). The purpose of the Faith Partnership Initiative was to inform health care 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 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 collaborations.

The Road Ahead

To increase the likelihood of effective mental health care and reduce 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. 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 health care agencies such as secular or faith-based CHCs that adopt a patient-centered health home model to enhance the reach of formal mental health care services to Latinos in need. If Medicaid patient-centered health homes are to be successful in increasing mental health care 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 whether they are efficacious. 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 important, 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. An 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 health care are necessary. Research on FBOs and health care 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 health care services for the poor and underserved racial/ethnic minority populations.

Although our discussion was framed within the primary care patient-centered health home, it is important to also note that partnerships with FBOs also may provide benefits for Latinos in other public health care 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 health care is high among this group because almost 40% of Latino Vietnam veterans suffer from lifetime posttraumatic 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 health care 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 ACA in full implementation, it is clear that additional efforts are needed to achieve the goal of equitable mental health care services for Latinos. FBOs have the ability to become valuable allies to the mental health care system, but also can be valuable partners in the primary care patient-centered health home. FBOs are just one example of a pathway to minimize the gap of unmet mental health and treatment needs of Latinos in the United States.

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