# PROJECT OVERVIEW OF THE RESTORATION CENTER LOS ANGELES: STEPS TO WHOLENESS – MIND, BODY, AND SPIRIT

Bowen Chung, MD, MSHS; Eunice Wong, PhD; Paula Litt, MA; Reverend Ronald Wright; Delores A. Hill, LCSW; Felica Jones; Dennis Corbin, PhD; Ruthie Gray, BA; Kavita Patel, MD, MSHS; Kenneth B. Wells, MD, MPH

**Objectives:** Unmet needs for depression and substance abuse services are a concern in urban communities. This article summarizes the design and recommendations of the Restoration Center Planning Project to better address depression and substance abuse while promoting resiliency and wellness for persons of African descent in South Los Angeles.

**Design:** A partnered participatory planning process during 18 months involving community members, faith-based and service agency leaders, and investigators from academic organizations was implemented. Leaders formulated a set of principles to address diversity of the group, hosted community conferences and working groups, while developing recommendations.

**Results:** The community-academic partnership recommended the establishment of restoration centers in Los Angeles (RCLAs) that would serve as a one-stop shop for holistic services addressing depression, substance abuse, related social and spiritual needs, and coordinated care with a network of existing community-based services. Specific recommendations included that the RCs would aim to: 1) support community resilience and improve outcomes for depression and substance abuse; 2) be one-stop shops; 3) promote cultural competency; 4) facilitate ongoing community input and quality review; 5) assure standards of quality within centers and across the broader network; and 6) support the enterprise through a multi-stakeholder community-based board dedicated to RCLA goals.

**Conclusion:** A community-academic partnered planning process acknowledged the importance of respect for diversity and formulated plans for the Restoration Center network including the integration of health, social, cultural, and faith-based approaches to services with a multi-agency network and community leadership board. The feasibility of the plan will depend on the subsequent implementation phase. (*Ethn Dis.* 2011;21 [Suppl 1]: S1-100–S1-106)

**Key Words:** African American, Cultural Competency, Depression, Substance Abuse, Mental Health, Health Disparities, Community-based Participatory Research, Mental Health, Faith-based

## INTRODUCTION

The Restoration Center Planning Project arose in response to several overlapping concerns and interests of community-based agencies, faith-based leaders, community members, and academic investigators interested in the development of South Los Angeles and in the health of African Americans in Los Angeles. From a more traditional perspective of identifying areas of unmet need, African Americans as a group face many areas of health disparities in the United States and limited access to quality of services, which has been shown to be related in part to being lower in average socioeconomic status.[1–4] In terms of mental health and substance abuse, African Americans do not exhibit higher rates of need compared to the national average after adjusting for other factors, they are disproportionately affected by limited access to services and more adverse outcomes, particularly in underserved communities, such as South Los Angeles.[5–11] With respect to mental health and substance abuse services, African Americans experience high rates of underutilization, prema-

*"We need a place that can service the whole family, not just services funded by individual things. If I'm the mother and I'm stressed, I want to go to a place and get some services. I may have mild depression myself. I want a place where I can go talk and where I can get services for me and others and there's no cost directed towards it."* – Participant at "Presentation of Final Restoration Center Planning Report," Holman United Methodist Church, October 17, 2008

From the RAND Corporation (BC, KBW, EW) and Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine at UCLA (BC, KBW, KP) and West Angeles Church of God in Christ (PL) and New Vision Church of God in Christ (RW) and Ecumenical Congress of Black Churches (RW), Kaiser Permanente Watts Counseling and Learning Center (DAH) and Department of Social Work, College of Health and Human Services, California State University, Dominguez Hills (DC) and United Women in Transition (RG) and Healthy African American Families II (FJ).

Address correspondence to Bowen Chung, MD, MSHS; Assistant Professor-in-Residence; Harbor-UCLA Medical Center; Department of Psychiatry; 1000 West Carson Street, Box 498, Building D5.5; Torrance, CA 90509; 310.222.1801; bchung@mednet.ucla.edu

*"When I think about the restoration center, the word "restoration" means to make whole again. Our actions need to speak as compassion. People need to trust that they are coming here for that. Compassion has to be shown in our actions. We need to meet people where they're at and reach out to them. "* – Participant at "A Dialogue to Plan a Community-Partnered Restoration Center," The California Endowment, August, 3, 2007

ture drop out, and lower quality of care.[12–14] In addition, despite similar rates of substance use, African Americans experience more severe social, health, and criminal related costs than White Americans.[15]

African Americans are diverse, as are underserved communities. In Los Angeles County, a recent 2011 State of Black Los Angeles report found that African American households were characterized by a wide-range of demographics and lifestyles.[7] For instance, of the African Americans residing in Los Angeles County, 28% were considered cosmopolitan achievers (upper-middle class professionals), 24% struggling strivers (most economically challenged), 15% family-focused middle (homeowners with modest incomes), 9% urban professionals (high income, advanced degrees), and 8% up-and-coming climbers (suburban white-collar couples). Moreover, the composition of Los Angeles' Black community is shifting with the influx of foreign-born immigrants from East and West Africa, Central America, and the Caribbean, who are estimated to make up 10% of the city's Black population.[16] Originating from countries such as Nigeria, Somalia, Honduras, Panama, and Ghana, Los Angeles' foreign-born Black population come with a variety of faith traditions including Sufi and Sunni Muslims, Seventh-Day Adventists, Catholics, Presbyterians, and a wide array of independent charismatic and evangelical denominations.[16] Consequently, not only are existing traditional faith communities being infused with new life, but different religious narratives are being formed.[16]

More than any other racial ethnic group in the United States, religion figures prominently in the lives of African Americans. Nearly 90% of African Americans claim a formal religious affiliation, 79% state that religion is very important in their lives, and 76% report praying on a daily basis.[17] The large majority of African Americans are Protestant (78%) compared to only 51% of the US population.[17] Faith-based organizations, in particular the Black Church, has played a particularly prominent role in promoting the health and well-being of African American communities.[18] The Black Church has been critical in contributing to the survival and resilience of African Americans in the face of innumerable adversities including displacement from their native homelands, slavery, racism and discrimination. The Black Church provided one of the few places that African Americans could internally organize, express their cultural heritage, and find dignity and spiritual strength.[19] Compared to other religious congregations, the Black Church has been more extensively involved in the delivery of social service programs, crisis intervention, and counseling for individuals with mental illness.[20,21] In Los Angeles, the Black Church has played a pivotal role not only in shaping the social, cultural, and political lives of African American, but has had a tremendous impact though its involvement in commercial revitalization, the development of senior and low-income housing, the establishment of schools, and the provision of social and spiritual services.[16]

From a strength-based perspective, it is important to identify areas of cultural and community strength, such as resiliency, community traditions and institutions, as vital resources to draw upon in the quest to eliminate health disparities. As found in the general US population,[22,23] but even more so with African Americans, spiritual beliefs and practices are integral and highly-valued resources when coping with mental health or substance use problems.[24,25] Thus, it is not surprising that the church is often the first place that African Americans turn to for help.[25,26] African Americans may be reluctant to rely on formal health providers who may be insufficiently prepared to address, and thus underestimate, the importance of religion and spirituality.[23,25,27] In some communities, especially for African Americans, faith-based institutions and other trusted community-based organizations are an important entry point for services in general including for mental health and substance abuse conditions.[28–33]

Thus, the Restoration Center Planning Project sought to bring together a diverse set of partners to attempt program development that simultaneously addresses specific areas of unmet mental health and substance abuse needs, while celebrating and building upon cultural and community institutions to promote resiliency as a primary outcome. The origins of the Restoration Center Planning Project resulted as much from an interest in promoting the community development and resiliency of South Los Angeles' residents (including African Americans in Los Angeles), as in the recognition of unmet need for care for specific condi-

tions increasing the burden of illness in the community, such as depression and substance abuse. We felt that these conditions could serve as an important focal point on which to jointly address health disparities and resiliency as it has been previously shown that health outcome disparities in depression can be reduced through implementing evidence-based, comprehensive quality improvement programs for depression in primary care.[3,4]

To achieve these goals, an initial leadership group of community and academic leaders approached The California Endowment to support the conceptualization and planning of programs that would build upon existing community and faith-based services to address South Los Angeles' needs for depression and substance abuse care by integrating cultural and spiritual strengths into services. Other related goals included: considering the importance of person, family, and culture in wellness; incorporating resiliency in services planning and development; and promoting concepts of community leadership and accountability in designing and implementing services. The California Endowment agreed to support the project in 2007. This afforded the unique opportunity to call together faith-based institutions, other trusted community-based organizations, community members, and academics to leverage their varying perspectives and collective strengths to devise programs and services that would recognize and be fortified by the wealth of cultural and spiritual assets inherent within the African American community in Los Angeles. The resulting project design, plans and recommendations for services are the subject of this article.

## METHODS

The project began in 2007 as a partnered, participatory planning project that was led by a leadership group including representatives of each of four stakeholder perspectives: faith-based, community service provider, community, and academia, with a focus on depression and substance abuse as signature conditions and resiliency and cultural strengths as overarching concepts. The leadership agencies, which we referred to as founding partners were West Angeles Church of God in Christ; The Ecumenical Congress of Historically Black Churches; Kaiser Watts Counseling and Learning Center; the Los Angeles County Department of Mental Health Services/South Los Angeles District; Charles Drew University, Healthy African American Families; the RAND Corporation; and UCLA Semel Institute Health Services Research Center. Over time, we added additional supporting agencies, including United Women in Transition and California State University Dominguez Hills. This leadership group met one to two times a month for 18 months to guide the planning process, with each of the four perspectives having equal voice in all decisions. The history of the agencies was such that most agencies had collaborated previously with at least one of the other agencies, but not all together. That fact, along with the diversity of types of stakeholders represented, and the project's mission to integrate concerns with unmet need and community strengths, were important contextual factors that led to the group's initial focus on developing a statement that acknowledged and reinforced the importance of respecting the diversity within the context of the project goals, which in many aspects became the guiding common principle of the project. The diversity statement is presented in Table 1. The statement acknowledged the diversity of the partners at the table, while having recognized that despite the differences in backgrounds, all were committed to improving the health and well-being for those of African descent in South Los Angeles.

### Host Community South Los Angeles

South Los Angeles (LA) is a 100 sq-mile area of Los Angeles County that is composed of a series of contiguous communities with a shared history, demographic, health care and health outcomes profiles. South Los Angeles is generally considered to consist of several City of Los Angeles neighborhoods including Baldwin Hills, Baldwin Village, Baldwin Vista, Chesterfield Square, Crenshaw, Hyde Park, Jefferson Park, King Estates, Leimart Park, University Park, Vermont Square, Watts, and West Adams; as well as the independent cities of Compton, Florence, Hawthorne, Inglewood, Lennox; and the unincorporated areas of Willowbook. South LA has roughly 1.3 million residents with about one-third of the residents aged $<$18 and only 7.5% aged $>$65 years. Nearly one-third (31%) of residents are African American and almost two-thirds are Latino. The median annual income for South LA is about $27,000. Lack of access to health and mental health care providers is especially limited in local neighborhoods such as South LA with an estimated .30 physicians per 1,000 versus 4.06 per 1,000 in West Los Angeles; .09 community clinics per 1,000 uninsured and .9 hospitals per 100,000 versus .1 per 1000 uninsured and .9 hospitals per 100,000 in West Los Angeles. South LA has 5.8 mental health agency providers per 100,000 versus 6.9 available in West LA. And nearly one-third of the non-elderly adult population is uninsured.[6] While the African American community of South LA has significant unmet needs for health and mental health services, it also has higher rates of civic engagement than any other racial group in LA due to its higher voter registration and union participation.[7]

The leadership group structured the planning process around four components: a kick-off conference or day of dialogue; working groups with goals defined based on that kick-off confer-

**Table 1. Diversity Statement for Restoration Center Planning**

The Restoration Center Los Angeles Planning Committee remains committed to the belief that by bringing together community members, faith based organizations, mental health providers, substance abuse providers, and behavioral health researchers in a partnered planning process, we can improve the health and well-being for South Los Angeles Community members of African descent.

As a planning committee, we strive to respect the dignity, individuality, freedom, and beliefs of each member. At the same time, we strive to be a group where individuals and groups of all beliefs learn from each other. We aim to foster a sense of collective responsibility for each other's well-being and the well-being of the community as a whole by focusing on the common experiences of those of African descent in the South Los Angeles community. We acknowledge the challenges inherent in working within the different faiths and belief systems in the African American community of South Los Angeles, yet, we remain unwavering in our commitment to diversity and community for the common goal of creating health and wellness in our community. We seek to enable ALL members of our planning process to express their opinions and beliefs in an environment that recognizes the unique contributions of each individual's experience and beliefs. We believe that the diversity of each individual at the table in our planning process will permit us to take full advantage of the variety of insights, backgrounds, and beliefs of those who live, work and play in South Los Angeles.

Beyond the planning process, the project hopes to provide resources for and support actual operational centers that provide services and support to promote restoration, wellness, and health in the African American communities of Los Angeles. Just as the planning process seeks a process of respectful dialogue and consideration of diversity for developing a plan, we seek to plan for Centers that will themselves address the diverse needs and perspectives of the African American communities. We hope for centers that will be inclusive in addressing groups of different faiths and those who are not associated with a particular faith, as well as other types of diversity within the community. Similarly, we acknowledge the challenges of addressing diverse communities within one center, but seek individuals to help with planning who share this vision of restoration, faith-in-action, and services provision. In this way, we hope to develop the plans and resources for a community that can stand as one in declaring and promoting health, restoration, and mental wellness for all African Americans in Los Angeles, while serving as an example for other communities and cultural groups.

Please join us at the table to help plan the restoration center as we cannot hope to represent you unless you provide us feedback on your most valuable and unique perspective.

ence; a community feedback session to review, obtain input on, and celebrate the resulting plan; and a report summarizing the recommendations resulting from the work-groups and feedback. Each component is described briefly below.

## Day of Dialogue

The leadership group hosted a day of dialogue at The California Endowment in August 2007 to review the concept for the Restoration Centers and obtain broad community input. One hundred eighty-nine representatives of faith-based institutions, community-based agencies and service providers, grass-roots community members, and academics attended the conference. The day included brief talks on the history and background of the project, initial plans developed by the leadership group, a reading of the diversity statement, and a call for participation in discussion groups. Those present discussed the Restoration Center in breakout groups. Each group was asked to respond to three questions: 1) What are the mental health services that are most needed in the African American community? 2) How can we navigate through the stigma associated with mental health in the African American community? and 3) How do we integrate a faith-based perspective into the Restoration Center given the diverse faiths of our community?

Workgroup members took notes and summarized key points on flipcharts. Key themes were summarized in an end-of-conference discussion, enhanced by leader review of notes and flipcharts. The consensus reached in the discussion groups and affirmed at the wrapup discussion was that although there were existing services in the South LA community, these services were often fragmented and not sufficient to meet the unmet need for mental health and substance abuse services, given the high level of need in the community. A common theme for solutions was for one-stop shopping at centers of excellence that integrated mental health, medical (primary care), and social services, within faith-based perspectives. Likewise, participants had diverse views about dealing with stigma. Several community participants proposed a media campaign for sanity. Many expressed that the church is an important partner in the community, and many expressed their desire to see services that integrate various faiths and speak to every faith without preference. The importance of offering services that could respect diverse faiths such as Christianity or Islam, as well as people without an active faith, was also emphasized by many present consistent with the diversity statement read at the conference.

## Organizing Meeting for Working Groups

After the day of dialogue, the leadership sponsored an organizing meeting hosted at West Angeles Church of God in Christ. At that session, the feedback from the day of dialogue was reviewed and participants broke into workgroups: mental health and substance abuse needs and services; wellness and resiliency programs; and restoration center policies and operations. Ideas for action were reported back to the full body of participants, which approved the initial action plan concepts. Leaders for each working group were identified that included members of the founding partners as well as new agencies identified as interested from the initial organizational meeting.

## Working Groups

The three working groups met twice a month over several months to give

**Table 2. Recommendations for restoration centers**

1. One or more restoration centers should be developed and sustained to support the wellness and resiliency of the community and to improve outcomes of depression and substance abuse. These centers should be targeted for persons of African descent and other vulnerable populations in South Los Angeles and surrounding areas. Centers may be full centers with a broad range of services (depression care, substance abuse care, social services, and resiliency / wellness activities). Developing centers would have one or more type of services and add other services over time.
2. Centers should be designed as one-stop shops for mental health and substance abuse problems and to build wellness and resiliency. Centers should provide and coordinate services for diverse populations, and consider the needs of individuals, families, and the community. Center functions include:
a. Coordinating access to the range of community services available for depression, mental health, and substance abuse, as well as holistic and alternative/ folk medicine programs that support wellness and resiliency.
b. Providing outreach, education and training to increase community awareness and develop leadership, such as training for faith-based leaders to address mental health and substance abuse issues.
c. Providing direct services to fill gaps as needed.
3. The centers should promote cultural awareness and competency in program design and implementation.
4. Centers should support client and community participation in program design and ongoing review.
5. Policies and procedures should be developed to assure standards of quality of services. Management and financing training and support should be available to center directors and administrators.
6. The functions and activities of different centers should be supported and coordinated through a board or association of restoration centers. This body should also develop mechanisms to support the sustainability of centers.
7. This planning phase should be followed by phase 2 (a demonstration of at least one full center and a developing center). That demonstration should also evaluate the acceptability and impact of the centers and explore how they could be replicated and sustained in other areas of Los Angeles.

input to the leadership council. These meetings refined ideas generated at the day of dialogue, and developed the relationships between the diverse partners brought together by this project. For example, the mental health and substance abuse needs and services workgroup considered how the four different stakeholder groups defined needs and services, and sought to engage diverse service agencies and community members in reviewing options for programs. A key principle of the group was to respect existing community services and build on their strengths as well as to improve ties among them and support additional services quality and capacity. The wellness and resiliency programs reviewed existing community programs enhancing wellness from a holistic perspective and learned about faith-based programs and options for integrating services. The policies and operations group developed options for leadership and coordination, reviewed guidelines for safety and quality, and explored options for sustainability. Each group developed a brief initial report and set of principles or recommendations. Then the leadership group for the project as a whole integrated the principles and recommendations, which had some overlap, into an overall set of recommendations with supporting ideas from each of the groups in their distinct areas.

### Community Feedback and Celebration

The planning project concluded with a presentation of the recommendations and findings of the workgroups and leadership group to the community, which included participants of the kick-off conference held at West Angeles Church of God in Christ. The project provided documentation in a report with supporting appendices that provided more detailed information. In addition, the leadership made small group presentations to policy leaders to develop support for implementing pilot demonstrations of restoration centers. A preliminary approval for one center is being considered through the Mental Health Services Act Innovations Funding from the Los Angeles County Department of Mental Health Services. The integrated recommendations, following community feedback, are presented in Table 2. Our partnership recommended a one-stop shop called a restoration center for coordinated services across mental health, substance use, physical health, and social services. The restoration center would not only provide support for services, but would focus on outreach, education and training for services with an understanding of cultural competence.

## DISCUSSION

The goal of this project was to foster a unique unity of perspectives across faith-based, provider, other community, and academic perspectives that would serve to originate a services-delivery approach in support of the health and wellness of persons of African descent and other populations living in and near South Los Angeles, but with a major focus on depression and substance abuse on the one hand, and wellness and resiliency from a more holistic perspective on the other. The planning process built on both community traditions and processes for convening groups and on models of community-academic partnerships. For example, central structural features included a leadership group, a kick-off conference followed by a framing session for workgroups, followed by workgroup tasks, and resulting in a community-feedback conference and

report with policy meetings to develop support. While these features are common in other projects represented in this special issue,[35,36] this project particularly focused on developing a diversity statement that positively affirmed and celebrated the unique and diverse groups involved in the project's efforts to promote community well-being. These features permitted the group and the community to actively explore different avenues to fulfilling the common goal, which was present from the kick-off conference to centers of excellence and became associated with the idea of a network of diverse services, to both build capacity and strengthen existing community services while orientating the whole toward a common mission. In fact, the leadership body identified examples of the Restoration Center concepts in faith-based centers of excellence, including some with many components of this model within faith-based organizations represented on the leadership council. Under the confluence of diverse partners, recommendations focused on the full integration of spiritual, clinical, and culturally valued community approaches around health concerns and resiliency, as well as the inclusion of the broader network and centers of excellence. Coordinating this scope of effort and achieving quality management at scale across faith-based and non-faith-based agencies was challenging. However, the leadership group and community felt it was critical to give voice to the kinds of services and programs desired by the community. It was the hope that the set of recommendations issued by the restoration center planning project would help influence and enhance existing models of care.

Portions of this larger agenda are being actively explored in different projects and programs from the original partners such as: a new center for family development at one faith-based institution; expanded explorations of faith-based approaches to engage the community by a public sector agency; a greater focus on integrated health and social sector approaches to mental health care by academic and community partners; and a resiliency class developed in a community-based randomized trial. The convening of diverse partners within the Restoration Center planning process fostered new interactions and relationships that led to connections to long-standing and existing programs within faith-based centers of excellence that had already embodied much of the set of recommendations issued by the project. Consequently, a new partnership between faith-based and academic leadership members was formed that led to recently-funded partnered-research initiatives to build upon and bring to scale existing faith-based programs that integrate spiritual and cultural strengths in addressing substance abuse and mental health needs. Through demonstrating the feasibility and effectiveness of these different pieces of the overall concepts, and continuing to engage policy stakeholders locally, the partners hope to arrive at specific opportunities to integrate these approaches and realize the goals of this project at some scale.

Limitations of this project included: it being focused primarily, although not exclusively, on one large, underserved geographic area of Los Angeles; primarily focusing on one ethnic group that is historically underserved and subject to diverse health disparities; and its being limited to a planning phase. However, this project illustrates the promise of a partnered approach to planning to reflect as well as unite diverse community and academic partners into a common mission that directly involves community input and stakeholders and generates a broader vision to address local mental health disparities.

## ACKNOWLEDGMENTS

The Restoration Center Los Angeles Planning Project was funded through a grant to the RAND Corporation from the California Endowment. Additional support was provided through NIMH Partnered Research Center for Quality Care (5 P30 MH082760-02). The founding partners for this project were West Angeles Church of God in Christ; Kaiser Permanente Watts Counseling and Learning Center; The Ecumenical Congress of Historically Black Churches; Los Angeles County Department of Mental Health Services/South Los Angeles District; Charles Drew University, Healthy African American Families; the RAND Corporation; and UCLA Semel Institute Health Services Research Center. Supporting agencies include United Women in Transition, California State University Dominguez Hills. The authors wish to also thank Keith Norris, MD, Paul Koegel, PhD, and Loretta Jones, MA for their support, and West Angeles Church of God in Christ, Los Angeles County Department of Mental Health Services, and Holman United Methodist Church for hosting community and workgroup meetings.

## REFERENCES

1. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348(26): 2635–2645.
2. Liao Y, Bang D, Cosgrove S, et al. Surveillance of health status in minority communities - racial and ethnic approaches to community health across the US (REACH U.S.) Risk Factor Survey, United States, 2009. *MMWR Surveill Summ*. 2011;60(6):1–44.
3. Smedley BD, Stith AY, Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: Institute of Medicine, National Academy Press; 2003.
4. Asch SM, Kerr EA, Keesey J, et al. Who is at greatest risk for receiving poor-quality health care? *N Engl J Med*. 2006;354(11):1147–1156.
5. Williams DR, Gonzalez HM, Neighbors H, et al. Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic Whites: results from the national survey of American life. *Arch Gen Psychiatry*. 2007;64(3):305–315.
6. Park A, Watson N, Galloway-Gilliam L. *South Los Angeles Health Equity Scorecard*. Los Angeles, Calif: Community Health Councils; 2008.
7. Los Angeles Urban League. *2011 State of Black Los Angeles*. Los Angeles, Calif: Los Angeles Urban League; 2011.
8. Wang PS, Berglund P, Olfson M, Pincus HA, Wells KB, Kessler RC. Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity

Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):603–613.
9. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2006;62(6):590–602.
10. Wells KB, Klap R, Sherbourne CD, Koike AK. Ethnic disparities in care for alcoholism, drug abuse, and mental health care. *Am J Psychiatry*. 2001;158:2027–2032.
11. Macias EP, Morales LS. Utilization of health care services among adults attending a health fair in South Los Angeles County. *J Community Health*. 2000;25(1):35–46.
12. Alegría M, Canino G, Ríos R, et al. Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. *Psychiatr Serv*. 2002;53(12):1547–1555.
13. Perron BE, Mowbray OP, Glass JE, Delva J, Vaughn MG, Howard MO. Differences in service utilization and barriers among Blacks, Hispanics, and Whites with drug use disorders. *Subst Abuse Treat Prev Policy*. 2009;4:3.
14. Wells K, Klap R, Koike A, Sherbourne C. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *Am J Psychiatry*. 2001;158(12):2027.
15. Wallace Jr JM, Myers VL, Osai ER. *Faith Matters: Race/Ethnicity, Religion and Substance Use*. http://www.aecf.org/upload/publicationfiles/faith%20matters.pdf. Accessed July 18, 2011.
16. Walker D. *The Black Church: Challenges and Opportunities Facing African American Congregations in 21st Century Los Angeles*. Center for Religion and Civic Culture, University of Southern California, 2011. http://crcc.usc.edu/docs/NEXTPTMbrochure2011_finalSP.pdf. Accessed July 18, 2011.
17. Sahgal N, Smith G. *A Religious Portrait of African Americans*. The Pew Forum on Religion & Public Life. http://pewforum.org/A-Religious-Portrait-of-African-Americans.aspx. Accessed July 18, 2011.
18. Lugo L, Stencel S, Smith G, et al. *US Religious Landscape Survey. Religious Beliefs and Practices: Diverse and Politically Relevant*. Washington, DC: The Pew Forum on Religion & Public Life. http://religions.pewforum.org/pdf/report2-religious-landscape-study-full.pdf. Accessed July 18, 2011.
19. Allen A, Davey M, Davey A. Being examples to the flock: the role of church leaders and African American families seeking mental health care services. *Contemporary Fam Ther*. 2010;32(2):117–134.
20. Blank MB, Mahmood M, Fox JC, Guterbock T. Alternative mental health services: The role of the Black church in the South. *Am J Public Health*. 2002;92(10):1668–1672.
21. Mollica RF, Streets FJ, Boscarino J, Redlich FC. A community study of formal pastoral counseling activities of the clergy. *Am J Psychiatry*. 1986;143:323–328.
22. Quackenbos S, Privette G, Klentz B. Psychotherapy: Sacred or secular. *J Couns Dev*. 1985;63(5):290–293.
23. Huguelet P, Mohr S, Borras L, Gillieron C, Brandt PY. Spirituality and religious practices among outpatients with schizophrenia and their clinicians. *Psychiatr Serv*. 2006;57(3):366–372.
24. Cooper LA, Brown C, Thi Vu H, Ford DE, Powe NR. How important is intrinsic spirituality in depression care? *J Gen Intern Med*. 2001;16(9):634–638.
25. Taylor RJ, Ellison CG, Chatters LM, Levin JS, Lincoln KD. Mental health services in faith communities: The role of clergy in black churches. *Soc Work*. 2000;45(1):73–87.
26. Young JL, Griffith EEH, Williams DR. The integral role of pastoral counseling by African-American clergy in community mental health. *Psychiatr Serv*. 2003;54(5):688–692.
27. Brawer PA, Handal PJ, Fabricatore AN, Roberts R, Wajda-Johnston VA. Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Prof Psychol Res Pr*. 2002;33(2):203–206.
28. Dossett E, Fuentes S, Klap R, Wells K. Obstacles and opportunities in providing mental health services through a faith-based network in Los Angeles. *Psychiatr Serv*. 2005;56(2):206–208.
29. Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-based health promotion interventions: evidence and lessons learned. *Annu Rev Public Health*. 2007;28:213–234.
30. Markens S, Fox SA, Taub B, Gilbert ML. Role of Black churches in health promotion programs: lessons from the Los Angeles Mammography Promotion in Churches Program. *Am J Public Health*. 2002;92(5):805–810.
31. Derose KP, Hawes-Dawson J, Fox SA, Maldonado N, Tatum A, Kington R. Dealing with diversity: recruiting churches and women for a randomized trial of mammography promotion. *Health Educ Behav*. 2000;27(5):632–648.
32. Wang PS, Berglund PA, Kessler RC. Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Serv Res*. 2003;38(2):647–673.
33. Duan N, Fox SA, Derose KP, Carson S. Maintaining mammography adherence through telephone counseling in a church-based trial. *Am J Public Health*. 2000;90(9):1468–1471.
34. Wells KB, Sherbourne CD, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care: A randomized controlled trial. *JAMA*. 2000;283(2):212–220.
35. Springgate B, Wennerstrom A, Meyers D, et al. Building community resilience through mental health infrastructure and training in post-Katrina New Orleans. *Ethn Dis*. 2011;21(Suppl 1):s1-20–s1-29.
36. Lizaola E, Schraiber R, Braslow J, et al. The Partnered Research Center for Quality Care: Developing Infrastructure to Support Community-Partnered Participatory Research in Mental Health. *Ethn Dis*. 2011;21(Suppl 1):s1-58–s1-70.