

AN ABSTRACT OF THE THESIS OF

Oona D. McNeil-Delaney for the degree of Master of Arts in Applied Anthropology presented on September 9, 2005.

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Abstract approved: _____

Courtland Smith

The Surgeon General of the United States in 2003 documented the existence of striking disparities for minorities and immigrants in mental health services and the underlying knowledge base. This thesis expands the knowledge base by examining the personal experiences and perspectives of community health workers (CHWs) employed in a mental health project. CHW interventions have been shown to increase access and reduce barriers to health care services. CHWs come from similar cultural and ethnic backgrounds as recipients of services and share similar life experiences. As cultural mediators between ethnic communities and a primary health care system, CHWs are able to provide valuable insight into immigrant mental health disparities.

Through case study analysis, this thesis explores the personal experiences of CHWs employed by a grant-funded mental health project. Utilizing ethnographic research methods to better understand the CHW intervention, this thesis focuses on CHW motivations, their challenges and the impact of work on their personal lives. Results suggest that CHWs experienced many positive changes in their own lives as a result of their work.

CHWs are better able to address their own physical and mental health needs. By increasing access to community and clinic services, CHWs help to improve the mental and physical health status of clients. Results suggest that the cultural competency of clinic staff, service providers and clients improved. CHWs help to strengthen community bonding or social capital by expanding social networks and empowering individuals to create change in their own lives.

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Empowering Others and Empowering Ourselves: A Case Study of Community
Health Workers in a Mental Health Project.
by

Oona D. McNeil-Delaney

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request

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Oona D. McNeil-Delaney, Author

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DEDICATION

To Christopher, Chloe and Lucy;

I am blessed to spend my life with each of you learning, living and loving.

Empowering Others and Empowering Ourselves: A Case Study of Community Health Workers in a Mental Health Project

CHAPTER 1: INTRODUCTION

This thesis examines the personal experiences and perceptions of community health workers (CHWs) employed by a mental health project. I look at changes in the lives of CHWs as a result of their work as well as their impact on clients and the primary care health system. CHWs come from similar cultural and ethnic backgrounds as recipients of services and often share similar life experiences (Giblin, 1987). As cultural mediators between ethnic communities and the primary health care system, CHWs provide valuable insights into the lives of clients as well as the primary care system in which they work.

Guided by the theories of critical medical anthropology, social capital and the writings of Arthur Kleinman, I study CHWs with the goal of answering two primary research questions: a.) How have the lives of CHWs changed as a result of their work? b.) What do CHW actions teach us about immigrant mental health? Utilizing ethnographic research methods to better understand the CHW intervention, this thesis focuses on the unique contributions and personal experiences of CHWs. Specifically, I concentrate on personal motivations, challenges and impact of work on lives of CHWs.

Overview of Project

In January 2002, I was hired as an evaluation and research specialist for a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to address disparities in identification and treatment of mental health disorders. This grant-funded project is herein referred to as "the project." The setting for the project and my thesis research is four primary care clinics of the Multnomah County Health Department (MCHD) in the Portland, Oregon metropolitan area.

My job entailed developing, implementing and monitoring an evaluation plan for the three-year project. I was excited by this opportunity, as I was keenly interested in the work and lives of CHWs and also in mental health services available to immigrants. My educational and theoretical training in applied anthropology prepared me to look at the project not only as a way of serving clients, but also as an opportunity to gain the perspectives of those being served and incorporate their voices into the program planning, implementation and evaluation. My previous experiences working with uninsured families and individuals in Portland opened my eyes to the myriad of problems facing immigrants, including a lack of access to mental health services.

My research can be viewed as one component of a larger program evaluation. The overall project evaluation plan is included as Appendix 1.

Thesis research questions developed over time from my direct experience as an evaluation assistant for the project. I was involved in the interviewing and hiring of the CHWs at the beginning of the project. I observed that the personal lives and real-world experiences of CHWs helped determine initial compatibility for the project. As time passed, I became further interested in how the personal attributes of the CHWs helped to shape the project interventions. Later, I examined the impact of the project on the lives of the CHWs as well as the broader influence of the CHWs on the primary care system.

Project rationale

The project aimed to increase the identification and treatment of mental health disorders for Latino and Russian-speaking clients, the two largest ethnic/language minority client groups served by MCHD clinics.

Data derived from MCHD health visit records demonstrated inequities in mental health identification and treatment. White English-speaking clients were diagnosed with a mental health disorder nearly four times more often than Latino clients and more than five times more often than Russian-speaking clients. As seen in Figure 1, over a three-year period prior to the implementation of the project, less than six per cent of Latino clients received a mental health diagnosis, despite the fact that Latinos comprised nearly 40

per cent of all clients seen. Even fewer Russian-speaking clients received mental health diagnoses (MCHD Health Research and Assessment, 2002).

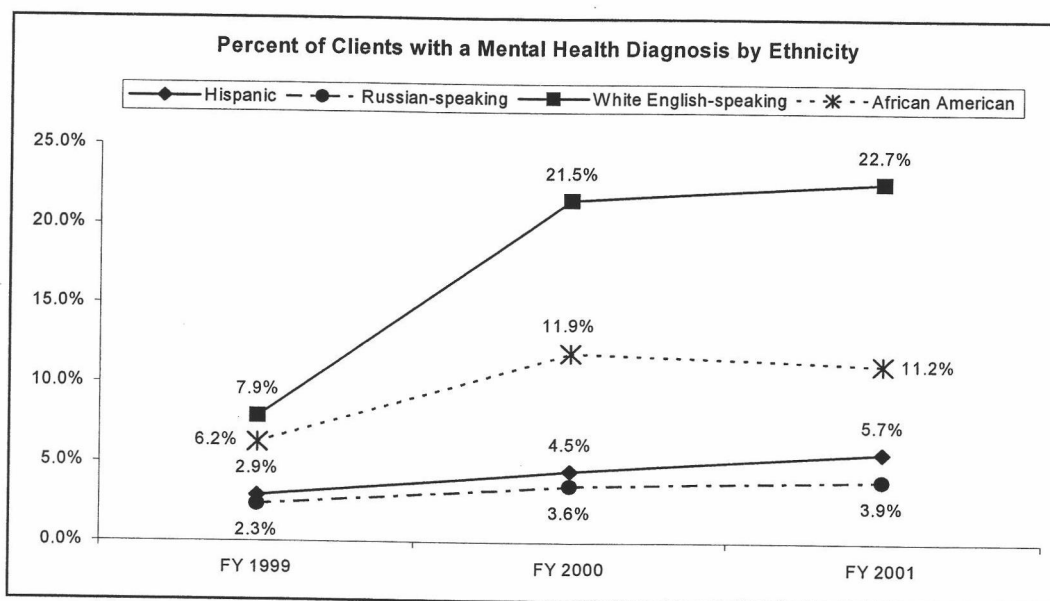


Figure 1: Clients with a Mental Health Diagnosis

Source: MCHD Health Research and Assessment 2002

This discrepancy was reason for alarm, considering the nature of many clients' migration and cultural adaptations experiences. Clients faced many challenges including isolation from family and support systems, language barriers, domestic violence situations and lack of knowledge about how to obtain different services. Some of these experiences are explored more fully in the results section (MCHD final report, 2004).

Goals of project

The overall goal of the project was to reduce disparities in mental health services for the target populations. To meet this goal the project had three main objectives with accompanying activities. The first objective was to increase the identification of mental health problems within the primary care setting with a particular focus on Latino and Russian-speaking clients. Activities to support this objective included screening and assessing all clients for depression at primary care visits.

The second objective was to expand the capacity of the community to provide culturally appropriate treatment and follow-up care for Latino and Russian-speaking clients once behavioral issues were identified within the primary care setting. This objective was met by hiring three CHWs, individuals from the community who shared similar cultural beliefs and language with the target populations. In addition, two mental health therapists who spoke Russian and Spanish were hired to provide treatment in community-based organizations.

The third objective was to incorporate culturally appropriate screening, assessment, and treatment of mental health problems within a more general model of chronic disease management. CHWs become certified to teach and adapted a specific support/education group for clients suffering from chronic conditions and depression (see Appendix 2 for list of complete CHW

trainings). Also, cultural competency trainings were scheduled for clinic staff and providers so that they could learn to be more culturally sensitive to the needs of clients (Final project report, 2004).

Participants in the project were recruited from existing primary care clients and were identified and referred for treatment based on an initial depression screening conducted at all primary care visits. As part of routine clinic visits, all clients were screened quickly for depression using a nine question screener called the PHQ (Patient Health Questionnaire). The PHQ is a self-reporting instrument designed for use in a primary care setting. Symptom-related questions were taken from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The PHQ consists of nine questions, which are the nine signs and symptoms of depression in the DSM (Spitzer, 1999).

Based on initial scores of the PHQ, clinicians determined if the client might benefit from further inquiry by a CHW and/or mental health therapist. A referral was made to the CHW housed at the clinic site and a follow-up meeting was initiated by the CHW. Clients were required to meet the following criteria: self-identify as a person of Latino or Russian/former-Soviet heritage; be an adult over the age of 18 years; be registered as an existing client of the health department; and be referred for service based on their initial PHQ score or the professional opinion that client may benefit from support of CHW and/or therapist (MCHD project planning documents, 2002).

Role of CHWs

The project hired three CHWs from the target population communities: two Latinos and one Russian-speaker of Ukrainian nationality. CHWs participated in a broad-based capacity-building program that included behavioral and mental health screening and intervention skills. They provided mental health and chronic disease education and follow-up to clients of the Health Department who received their primary health care from MCHD clinics. They also linked clients to culturally specific community-based services and supported clients and families who struggled with cultural barriers. These barriers included language, legal and bureaucratic hurdles, differences in health care systems and health and illness beliefs. CHWs worked with clients to establish and achieve self established health goals (MCHD final report, 2004).

Clients received ongoing support from CHWs for an average of six months. CHWs met with clients in their homes, at the health clinics and at various locations throughout the community in addition to telephone conversations.

In order to better understand the impact of CHWs, supports and interventions are described. During the first couple of client visits with a CHW, time was spent establishing trust and building a relationship. The CHWs administered a follow-up PHQ with the client to assess depression

severity. Often scores were more severe from initial screening by the primary care physician.

During visits, the CHW sought to understand what and how the client was experiencing and feeling. CHWs are not licensed therapists and did not provide formal counseling. CHWs sought to determine environmental factors that may be contributing to their depression. Based on these factors, CHWs developed individual plans with clients to monitor and self-manage their goals.

The CHW collected data from clients at each visit. Health assessment forms were logged into medical charts so that other providers could access information from CHW visits. Clients were informed that information shared with the CHW was also shared with other providers.

Data was entered into a disease registry database. The database stored client contact and treatment data in order to coordinate individual client's treatment plans. Reports were generated for each CHW, therapist and provider so that a client's medication, visit record, PHQ score and contact information could all be monitored. Depending on scores and according to DSM protocols, reports were developed for how often a client should be seen and by whom.

The database also served as means of communication between providers. Notes and important context information could be shared. CHWs were able to provide culturally relevant information to others. For example,

one client witnessed the murder of several of her family members in Ukraine. This traumatic event was only shared with the CHW after several visits, and it was relevant for the primary care providers and therapists providing treatment.

CHWs addressed general health concerns, family situations, housing, insurance status, employment, and history of domestic abuse. Visits took place individually with the client, or with members of the family. Once enrolled in the project, CHWs provided a range of services to clients. These included resource assistance—assistance finding housing, filling out applications and forms, transportation, access to food or clothing; screening and assessment—administering the PHQ, Sf-12 (self-functioning 12 question); self-management counseling—setting up personal plans for addressing symptoms of depression; health education—educating clients about general health, diabetes, hypertension and other chronic conditions; medication monitoring—helping clients to monitor their medication routine and identifying and keeping track of any symptoms or side effects; and referral or linkage services—linking clients to other agencies or organizations providing social services.

Health education accounted for nearly 30 per cent of all visits with CHWs. This included attendance in chronic disease self-management program courses facilitated by CHWs. Resource assistance and screening

assessment made up nearly 40 per cent of all other visits (MCHD Final report, 2004).

Client Outcomes

Over the course of the project, more than 600 clients received services. MHDP clients with two or more PHQ scores showed significant reductions in depression symptoms. Across all clients with two or more PHQ scores, mean scores declined from an initial score of 13.3 to a final score of 8.0, essentially from moderate major depression to sub-clinical depression. PHQ scores declined significantly for both Latino and Russian speaking clients over the period in which they received MHDP services. Latino clients' mean scores declined from 13.1 to 7.2 and Russian-speaking clients' scores declined from 13.6 to 9.7. (MCHD unpublished final report 2004).

Research Focus and Potential Bias

Although this project employed multiple interventions to address disparities in mental health care, my research focuses specifically on the CHWs themselves and their impact on clients and the health care system. I discovered through participant observation and semi-structured interviews that the personal life experiences of the CHWs helped to shape their response to clients' needs. The results of this thesis come both from my work and observations as an employee of the project, as well as research

conducted independently with CHWs and project staff after I left the project. A timeline of project and thesis activities is included as Appendix 3.

Bias and subjectivity are inherent in all research. I acknowledge that my research is influenced and guided by my experience as a woman, as a member of a majority ethnicity and as employee of this project. My close interactions and personal relationships with the CHWs influenced my objectivity as a researcher. I observed on a first hand basis the level of the CHWs' dedication and personal commitment to help clients. Similar to a parent who is convinced their child is the brightest or most athletic regardless of the talent of their peers, I may have been blinded by my professional affections. This bias shaped my research.

Acknowledging bias does not give a researcher carte blanche to ignore objectivity. By examining my limitations as a researcher, I am able to more fully understand my relationship to the topic of my research. I hope to break down traditional barriers between researchers/evaluators and research subjects. This philosophy is consistent with the methods of participatory research. Research takes a different shape when everyone involved takes ownership of the process. Bias becomes a lens through which every person can examine their own personal opinions and cultural influences. In participatory research, my role is less of an evaluator, and more a facilitator of a process to record and critically analyze the impact of a health intervention.

My role in the project and my personal research bias was also influenced by the broader primary care system. This biomedical system has a very hierarchical employment structure, which generally pays more to administrators than to direct service personnel (with the exception of doctors and nurses). While I was not a manager, I did have a good deal of decision-making input and met regularly with project managers. This level of authority may have influenced the CHW responses during interviews. It is more difficult to criticize a system that employs you, and therefore CHWs may have been reluctant to be overly critical.

When reporting research, I attempted to respect the individual opinions and experiences of clients and CHWs. I seek to understand the personal experiences and cultural contexts of the CHWs as well as the clients they served. I also recognize that my perceptions are mere reflections on another's life experience, and as such, cannot be generalized to represent any given population.

My use of language is also important. I struggled with the terms associated with health care, namely provider/ client. A 'client' is defined by Webster's dictionary as "party for which services are rendered" or "one that depends on the protection of another" or "a customer or patron" (Websters.com.) These definitions describe power relationships and place one party in control of another. Despite my reservations, I have decided to use the language of the system I studied. It is important for this research to

be shared and understood with broad audiences who recognize “client” as the term for participant or recipient of health care services.

Applied anthropology is defined as using the knowledge of anthropology to address human real-world problems. As a part of my underpinnings in applied anthropology, I am highly committed to the principles of participatory research and evaluation. Throughout my tenure with MCHD, I attempted to obtain and incorporate the perspectives of all program participants and staff in the evaluation. I worked diligently to change the perception of a typical project evaluator who is seen as an outsider coming into a project at the end to conduct assessments. Rather, I sought to serve as a facilitator of an evaluation process that reflected the views and work of the employees and recipients of services. In this process, I established continual feedback loops back into the project.

Since the project was new and its design was original, there were few restrictive guidelines set forth by the grantor. Therefore, I was able to help define these principals of participation and involvement and guide the process-evaluation whereby feedback from clients and project staff helped shaped the intervention.

CHAPTER 2: REVIEW OF LITERATURE

This literature review examines research articles and reports for evidence of CHW interventions and outcomes in three domains: impact on clients or participants in programs served by CHWs; impact of CHW on the broader primary health care system; and effects on the CHWs themselves as a result of their work. Within this literature search, I narrowed my focus to CHW interventions and evaluations in primary care settings similar to MCHD. I also paid particular attention to any study related to mental health interventions. Literature searches revealed an abundance of research on effects of CHW interventions for clients in disease prevention and health education. However, much less research examines CHW interventions in mental health and even fewer look at the impact on CHW themselves. The limited amount of published research about CHWs themselves guided my topic selection for this thesis research.

Literature search criteria included the following names used interchangeably to describe CHWs: lay health advisor, promotora de salud, community health liaison/advisor/specialist, and village health worker. Literature searches were performed on the internet and through cross-referenced online journal databases (EBSCO host).

To better understand the varied and diverse work of CHWs, I provide a brief overview of the CHW profession and typical work roles. I then explore CHW impacts. Literature is grouped by focus area: client outcomes resulting from CHW interventions, changes in primary care systems and changes in the lives of CHWs. Emphasis is given to CHW mental health interventions. A context for mental health disparities is also provided to add another dimension to the literature review.

Overview of the CHW Profession

Many definitions and titles are used to describe CHWS. These names include: lay health advisor, promotora de salud, village health worker, outreach worker, paraprofessional health workers and community health advisor (Rosenthal, 1998).

CHWs have formally participated in health and human services systems since the 1950's (Giblin, 1989; Meister et al., 1992). CHWs are generally described as community members who work with underserved populations and are indigenous to the community in which they work: ethnically, linguistically, socioeconomically, and experientially (Love, 1997). The World Health Organization defined CHWs as workers who live in the community they serve, are selected by that community, are accountable to the community they work within, receive a short, defined training and are not

necessarily attached to any formal institution (World Health Organization [WHO], 1987).

In the past 30 years, the CHW model has gained more prominence in the United States, and more recently, CHW programs have proliferated. (Pew Health Professions, 1994). The proliferation of CHW programs can be attributed to several factors. National trends reflect an increasing diversity in the U.S population and the nationality, ethnicity and linguistic makeup of the United States has changed dramatically in the past 15 years. In 2000, one-third of the population was people of color (U.S Bureau of the Census, 2002). Further, the pace of credentialing health care professionals, especially bilingual/bicultural practitioners has fallen far short of the need (Musser-Granski, J.& Carrillo, 1997). The cost of health care has soared and medical institutions have turned to paraprofessionals to fill in some of these gaps (Love, 1997).

CHWs serve in various capacities. Most consider themselves bicultural, as they speak multiple languages and interact in both the dominant culture and within their community. CHWs conduct a great number of tasks and possess a wide range of abilities and skills (Witmer et al, 1995).

In 1998, the Annie E. Casey Foundation commissioned The National Community Health Advisor Study through the University of Arizona. This report is the most comprehensive review of CHW work in the United States to date. The report brought together a core group of key researchers and

practitioners in the field of community health work and public health to “weave the center of the basket” (Rosenthal, 1998: ix) to create a guide to the profession. The report identified four broad CHW issues needing attention in the United States: development of CHW core role and job competency definitions; evaluation strategies for CHW programs; CHA career and field advancement; and integration of CHWs within the changing health system (Rosenthal, 1998). Through national surveys, focus groups and interviews, the research team identified seven core roles and services provided by CHWs. These roles include: bridging cultural mediation between communities and the health and social service systems; providing culturally appropriate health education and information; assuring that people get the services they need; providing informal counseling and social support; advocating for individual and community needs; providing direct service (such as screening tests); building individual and community capacity (such as helping individuals establish healthy lifestyles) (Rosenthal, 1998). Most CHW literature demonstrates effects of direct service and health and education interventions.

Client Impacts

There is substantial literature documenting the effects of direct service and education interventions provided by CHWs. Many studies have shown the ability of CHWs to do effective preventive and health education work in a

wide range of health issues such areas as: cardiovascular disease (Alcalay et al., 1999); cancer screening and education (Brownstein et al., 1992; Earp et al., 1997; Sung et al., 1997; Bird et al., 1998; Navarro et al., 1998); smoking cessation (Lacey et al., 1991); HIV and AIDS (Birkel et al., 1993; Pinkerton et al., 1998); asthma (Butz et al., 1994) and diabetes (Corkery et al., 1997). Still other CHW programs provide pregnancy-related services to low-income or at-risk women (Carrillo et al., 1986; Jones & Mondy, 1990; Meister et al., 1992; Poland et al., 1992; Bradley & Martin, 1994; Julnes et al., 1994; Kistin et al., 1994; Korfmacher et al., 1999).

Within these programs and studies, CHWs provided a wide spectrum of services including health screening and assessments, health education and informal counseling, resource assistance, peer-support and mentoring and interpretation.

In a recent integrative literature review, Swider scanned the literature for studies or articles that utilized CHWs as primary interventions. The guiding question of the literature review was: "Are CHWs effective in community health promotion and disease prevention efforts?" Some 275 abstracts were reviewed for potential inclusion in this review. Only nineteen met the inclusion criteria and were included. Of the studies reviewed, 79% were found to result in some positive outcome (Swider, 2002:16). The author noted however there are few rigorous research studies and there is a need

for better study design, documentation of CHW activities and carefully designed target populations.

When measuring impact of CHW interventions, typical outcome categories include increasing access to health care and services, improving the quality of care, reducing the costs of care and contributing to broader social action (Swider, 2002).

Health Care System Impacts

CHW interventions have also been shown to have positive impact on health care systems. CHWs help to increase access and reduce cultural and linguistic barriers to care (Eng et al., 1997; Zuvekas et al., 1999; Fedder et al., 2003). CHWs help patients successfully navigate in complex health systems (Witmer et al., 1995). Several studies have shown CHW interventions improve the quality and cost effectiveness of care (DiGilio et al., 1992; Wolff et al., 1997; Love, 1997; Pinkerton et al., 1998). Recent studies are looking at the role CHW play in reducing health disparities by increasing cultural competency of health care organizations (Minkler, 1997; Griffin et al., 1999; Brach et al., 2000; Findley et al., 2003; Farquhar et al., 2005).

CHWs interventions have been shown to improve the cultural competency of health care systems. CHWs help facilitate community participation in health systems and educate providers about community health needs, cultural beliefs that impact care and clients' outcomes (Griffin

et al., 1999). When CHWs work as part of a broader clinical or outreach team, they are able to contribute to the continuity, coordination, and overall quality of client's care (Witmer et al., 1997). This has been shown in several studies that demonstrated increased compliance with prescribed regimens and better appointment keeping (Witmer et al., 1997).

Brach et al. (2000) developed a conceptual model of cultural competency's potential to reduce racial and ethnic health disparities, using the cultural competency and disparities literature to lay the foundation for the model and inform assessments of its validity. The authors identified nine major cultural competency techniques: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The conceptual model shows how these techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities. The authors conclude that while there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.

CHW Interventions in Mental Health

As noted, most of the research related to CHW interventions investigates the role of CHWs to improve general health status of clients. Fewer research papers have investigated CHW interventions in mental health. This section of the literature review examines CHW interventions in mental health with the goal of providing an overview of types of services provided and client outcomes.

In their article titled "The Use of Bilingual, Bicultural Paraprofessionals in Mental Health Services," Musser-Granski and Dorothy Carrillo promote the use of health paraprofessionals from similar cultural backgrounds as clients to provide interpretation and outreach to refugee and immigrant populations. Their article is not an evaluation study, however it raises important issues about the lack of culturally appropriate mental health services. The primary motivation for hiring paraprofessionals is the lack of bilingual, bicultural professionals. Value is placed on the paraprofessionals' ability to interpret and relay messages between mental health counselors and clients (Musser-Granski, & Carrillo, 2002). The authors state, "until there are enough bilingual, bicultural professionals, there is a great need to use paraprofessionals" (Musser-Granski, & Carrillo, 2002: 2).

In a patient care utilization study, the effects of intensive case management were evaluated for individuals with chronic, serious mental

illness in rural Kentucky (Grand, 2002). Comparison groups were established between clients who received mental health services at the hospital and those who received additional care and support from paraprofessionals (CHWs). Services were provided by paraprofessionals who were familiar with the geography and culture. Paraprofessionals were members of the community and they were better able to respond to specific barriers to treatment in this Appalachian community. These barriers included proximity to health centers and distrust of government officials. CHWs worked with patients in their homes and referred them to psychiatric services. Overall, clients who received services from CHWs had a significant improvement in number of bed days and adherence to treatment plans as compared to those clients who only received services in the hospital (Grand, 2002).

In a school-based health program in Oregon, family assistants (CHWs) were found to be effective in helping families initiate and continue mental health services for at risk children (Elliott, 1994). The CHW encouraged and enabled families to enroll their children in mental health services. The CHWs served as system guides and provided families with information, emotional support and help with specific barriers such as lack of transportation or childcare. The authors compared the intervention group with data from counties that did not receive support of the CHWs. Results showed that the intervention group had higher levels of participation in mental health services and in addition, the CHWs helped families to improve their sense of

empowerment (Elliott, 1994). The authors defined empowerment as, “creating a feeling of mastery over one’s environment and the ability to independently navigate service systems” (Elliott, 1994: 581). The authors stressed the importance of establishing trust with families, dealing with the stress of listening to parents and caregivers and addressing program termination concerns (Elliott, 1994).

To find more expansive examples of CHW interventions in mental health, I found it necessary to expand my research to international programs. In England, health visitors (CHWs) treated clients suffering from postnatal depression by using cognitive behavioral counseling (Appleby, 2003). This intervention was designed to be delivered by non-specialists in mental health. Following training in the cognitive behavioral counseling, the CHWs were found to be more effective in providing counseling and referrals to mental health services increased (Appleby, 2003).

In Israel a CHW intervention similar to the MCHD project was implemented. The project aimed to improve detection of mental health disorders in the primary care setting (Laufer et al., 1998). Outcomes of the program showed that patients were more willing to meet with a CHW than a mental health professional. Further, clients who received treatment from CHWs had improved overall health status (Laufer et al., 1998).

To better understand the broader context of the problem addressed in this project, I briefly explore literature related to disparity in mental health

access and treatment for immigrants and the role of culture in determining mental health.

Disparity in mental health

In 2003, the Surgeon General of the United States released a groundbreaking report on the state of mental health and the disparity in mental health status and treatment for ethnic minorities in the United States (U.S. Surgeon General, 2003). This report brought together hundreds of researchers and practitioners to paint a picture of the ongoing efforts and needs to address mental health disparities for minorities and immigrants. Its scope and detail are impressive along with the fact that it was initiated and issued by the highest health policy organization in the country. The Surgeon General's report documented the existence of striking disparities for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care and when they receive care, it is more likely to be poor in quality (p.25). Most minority groups are less likely than whites to use services, and they receive poorer quality mental health care, despite having similar community rates of mental disorders (p.27). Five key themes were identified by the report: mental health and mental illness require the broad focus of a public health approach; mental disorders are disabling conditions; mental health and mental illness are

points on a continuum; mind and body are inseparable and finally, stigma is a major obstacle preventing people from getting help (Surgeon General report, 2001).

Mental disorders are found worldwide. Schizophrenia, bipolar disorder, panic disorder, and depression have similar symptom profiles across several continents (Weissman et al., 1998). Diagnosis can be extremely challenging, even to the most gifted clinicians, because the manifestations of mental disorders and other physical disorders vary with age, gender, race, ethnicity, and culture. Some of the symptoms of depression: persistent sadness or despair, hopelessness, social withdrawal, and imagine the difficulty of communication and interpretation within a culture, much less from one culture to another (Weissman et al., 1998).

More specifically within mental health disorders, depressive feelings are experienced by all people across the world and are considered a component of disappointment and grief (Kleinman, 2004). Depression may be a symptom of a mental disorder (such as bipolar disorder, an anxiety disorder, or schizophrenia) or of other medical diseases, ranging from diabetes and thyroid disorders to post-viral syndromes (Kleinman, 2004: 950). As one of the most prevalent diseases globally and an important cause of disability, depressive disorder is responsible for as many as one of every five visits to primary care doctors in the United States (Kleinman, 2004: 951). Depression occurs everywhere and affects members of all ethnic groups.

The rates of depression are increasing, and the disorder is nearly twice as common among the poor as among the wealthy (Weisman et al., 1998).

Role of culture in determining mental health

Marsella (1985) has suggested that cultural factors may affect and modify the behavioral expression of biological processes. "Individuals experiencing a biochemical deficit must still interpret the abnormal experience, translate the experience into active behavior, and respond to the social reaction to that behavior" (Marsella, 1985: 301).

This notion is consistent with the distinction between disease and illness proposed by Kleinman (1980). While disease refers to a problem involving biological or psychological processes, illness corresponds to the experience and meaning of the perceived disease. In this sense, the experience of illness is culturally shaped, and not necessarily restricted to the person that suffers the disease (Kleinman, 1988). When looking at immigrants' mental health experiences, it is important to consider differences in sex, age, social class, education, and degree of biculturalism.

The way in which depression and other mental health disorders are confronted, discussed, and managed varies among social worlds, and cultural meanings and practices shape the interactions. Kleinman states,

Culture influences the experience of symptoms, the idioms used to report them, decisions about treatment, doctor-patient interactions, the likelihood of outcomes such as suicide, and the

practices of professionals. As a result, some conditions are universal and some culturally distinct, but all are meaningful within particular contexts (Kleinman, 2004: 952).

In order to better identify and treat mental health disorders appropriately within a biomedical health system, the individual contexts or stories and experiences of clients must be incorporated into care and treatment. CHWs are a natural fit. They come from similar cultural backgrounds, speak the same language and have struggled with many of the problems clients encounter.

Personal Changes for CHWs

An essential concept of community health work is to empower community members to identify their own needs and implement their own solutions (Witmer et al., 1997). This suggests that CHW programs incorporate principles of participation and cross-learning between community members and agencies and in the process encourage change from within communities.

Very few program evaluations or research studies have looked closely at the impact of work on the personal lives of CHWs. Most often, and as shown in my literature review, emphasis is placed on measuring change in the health status of clients as the result of CHWs interventions. While these evaluations are important, an important piece is often overlooked in the process, namely the impact of work on CHWs themselves. CHWs are usually

selected for positions based on language and cultural backgrounds. They are also chosen based on personal characteristics including warmth, ability to learn, evidence of natural leadership, ability to accept responsibility, desire to help others and knowledge of community resources. Paul Gibling refers to this shared experience as “indigenouness” (Gibling, 1989).

Indigenouness is defined as the possession of the social, environmental and ethnic qualities of a subculture (Gibling, 1989: 360). In more specific terms, it includes a sharing with a client of a verbal and nonverbal language, an understanding of a community's health beliefs and barriers to health care services and an enhanced empathy with and responsibility toward a community and its health service needs (Gibling, 1989). This raises an important but overlooked point: if CHWs come from similar cultural and socio-economic backgrounds and experiences as clients, then do they not also share many of the hardships and disparities in access to care as the clients they serve? As Paul Gibling states in his article, “An important caveat in selecting an individual representative of a disadvantaged population is one also may be selecting a person who shares many of the client's problems...” (Gibling, 1989: 363). Indigenouness was a key concept for the intervention described in the next article reviewed.

In the article “Community Health Workers: Examining the Helper Therapy Principle,” Roman, Lindsay, Moore and Shoemaker (1999) explored the perceived benefits and stressors for low-income women who were hired

as CHWs. The women hired as CHWs were also mothers living in challenging circumstances. Utilizing Frank Riesman's helper therapy principle, the authors explored the benefits and stressors associated with their work (Roman et al., 1999).

The helper therapy principle was developed in the 1960's and became a cornerstone of most self-help movements, including many popular 12-step programs (Roman et al., 1999). The general helper-therapy principle stipulates that by helping others with similar problems, individuals are better able to overcome their own problems. The peer-based interactions result in increased trust between helper and receiver, resulting in better treatment outcomes for both parties. Further, helpers often experience greater success in their own treatment (Riesman, 1965).

In order to assess "helper" benefits experienced by CHWs, the authors developed a survey questionnaire that was administered by nurses employed by the program. CHWs perceptions were measured using a tool previously developed to assess helper therapy benefits and stressors in a group of "mentor" parents of preterm infants. Sixty-seven CHWs participated.

Applying the helper therapy principle to the work of the CHWs, the authors found that a majority of CHWs perceived helper benefits that included positive feelings about self (91%), a sense of belonging (94%), valuable work experience (80%), and access to health information and skills through training or contact with program staff (79%). There were also

stressors associated with the helper role. The highest ranking stressors included increased worry about their own family (29%) and feeling inadequate to help their clients (25%). Some CHWs reported feeling emotionally drained (13%) (Roman et al., 1999).

Brook, Robinson, Ka, Najera and Stewart measured changes in empowerment for CHWs who participated in a maternal/child outreach program (1997). This study was unique in that it focused on and measured specific factors related to CHW empowerment. A group of 33 CHWs were interviewed shortly after entering the program but before training began to assess their level of empowerment. The majority were interviewed again 4-8 months later after the training ended and again after 16 months. Of the 27 who completed the program, 24 reported some increase in personal empowerment during the study period. The conceptual model of personal empowerment included four factors: ability to articulate and concreteness of life goals; level of cognitive information about health problems; perspectives about health problems of CHWs in relation to other workers'; and the degree to which CHW saw her/his role as part of a community of client care and case management (Booker et al, 1997).

In another article, "Promoting Health, Promoting Women: The construction of female and professional identities in the discourse of community health workers," Ramirez-Valles (1998) views CHW as a discourse, and posits that CHW positions women living in the third world and

Latino women in the U.S as the “other” woman. This creates a dichotomy between the CHW and the public health professional or “first world woman.” Further, the author posits that CHW is a colonizing discourse that promotes the inferiority of CHWs and promotes dependency for success on the system. In her research, Ramirez-Valles finds that personal accomplishments of women CHWs are generalized to represent “empowerment” of women. The author states:

Claims are made in reports and articles about the ‘impressive changes’ women go through as they work as CHWs. Implicit in the writing of these accomplishments, of course, is that they are due to the hands of those who set up the program (i.e. professionals, development agencies), (Ramirez-Valles, 1998:175).

In 1992, the Center for Healthy Communities in Dayton, Ohio developed a program to train people indigenous to the communities in which they would be working. Since the first CHWs began work in January 1993, the effectiveness of the program has been evaluated from three perspectives: the CHWs, the managers/directors of the community sites at which the CHWs work, and the clients with whom the CHWs work. CHWs indicated that the training program adequately prepared them for their roles and functions. They also identified systematic frustrations and barriers that made it more difficult for them to perform their job. Community site directors and community leaders indicated that the CHWs were considered a positive force in meeting client needs and facilitating independence, and were very effective in

outreach and coordination of resources. A survey of CHW clients revealed an overwhelmingly positive response to their work, validating the belief that CHWs can fill an important niche in the health care community. The three evaluation processes described in this paper helped to document the need for and the effectiveness of this program and can serve as a model for similar programs (Rodney et al., 1998).

Theoretical Perspectives

This thesis draws on three theoretical positions from the disciplines of anthropology and social economics. First, is medical anthropology from the medical anthropologist and psychiatrist Arthur Kleinman (1977, 1980, 1988, 2004). Kleinman has influenced my interpretation and definition of health and illness and the important role CHWs can play in serving as cultural interpreters and health brokers. Second, critical medical anthropology (CMA) provides a powerful lens through which to critically analyze the political and economic context of the primary care system employing CHWs. Finally, I also draw on Robert Putnam's (1996) theory of social capital to guide my work. CHWs are able to increase social capital or social bonding within and between social groups and in the process, improve mental health inequities. All three theoretical approaches are briefly discussed and significance to this thesis is presented in the results.

Medical anthropology

The teachings and research of Arthur Kleinman guide my research and theoretical frameworks. Kleinman has been instrumental in the development and acceptance of medical anthropology as a sub-field within anthropology. He stresses the importance of recognizing illness as a personal, individual experience that takes place in a broader social and cultural context (Kleinman, 1977).

As a psychiatrist and anthropologist, Kleinman straddles two different disciplines yet is able to offer insight to both. He positions biomedicine as one of many ethnomedical systems found throughout the world. Biomedicine focuses on disease and ailments rather than on the individual. According to Kleinman, biomedicine is dictated by bureaucracy and health care becomes a valuable article of trade. In his book Writing At the Margin, Kleinman states, "Regulations control practice, transforming the doctor into the 'provider' of a 'product' that is advertised, marketed and sold. Care is commoditized," (Kleinman, 1995: 37). In this process, the suffering and subjective accounts of illness are lost.

Kleinman cautions anthropologists to avoid broadly categorizing disease and illness when he states, "What is lost in biomedical renditions is also missing when illness is reinterpreted as social role, social strategy, etc. as anything but human experience," (Kleinman, 1995: 38).

Kleinman coined the phrase “explanatory model of illness.”

Explanatory models of illness encompass a person’s ideas about the nature of their problem, its cause, severity, prognosis and treatment preferences (Kleinman, 1980: 4). This concept is very important in the context of mental health because individuals may have different ideas from biomedical doctors as to what is causing their problems and how best to treat them. Without an explanatory model of illness, a clinician cannot know how best to treat an individual. Kleinman states, “Mental illness, for example, is so stigmatized in some cultures that a diagnosis of depression is unacceptable and a euphemism is required” (Kleinman, 2003: 12). Clients may attribute their depressive disorder, for instance, to family conflicts. In addition, clients may have engaged in self-care or alternative and complementary treatments that can affect the biomedical drug treatments. Practitioners need to know about such treatments so that care can be negotiated.

Critical medical anthropology

Critical medical anthropology (CMA) is an emergent theoretical perspective within the sub-discipline of medical anthropology. CMA is rooted in neo-Marxian and postmodern critical perspectives. According to Baer, Singer and Susser, (1997) CMA views health and disease within the context of the capitalist world system and dissects the ways power differences shape social processes. The authors state,

CMA understands health issues within the context of encompassing political and economic forces—including forces of institutional, national and global scale— that pattern human relationships, shape social behaviors, condition collective experiences, reorder local ecologies, and situate cultural meanings (Baer et al., 1997: 27).

According to CMA, an individual's social status greatly dictates their health status. Access to health care and environmental exposure to disease agents vary depending on income, ethnicity and gender (Baer et al., 1997). In other words, social and economic inequality place particular groups of people at increased risk for disease.

Within the teachings of CMA, biomedicine is viewed as an entity of capitalism. The medical hierarchy replicates the class, racial/ethnic, and gender hierarchy found in advanced capitalist societies (Baer et al., 1997). Insurance and pharmaceutical companies, hospital administrators and governing boards sit on top with physicians, nurses, and all other health staff falling somewhere below. Power is concentrated at the top and great discrepancies exist in pay and decision making power.

Although much theoretical debate occurs at the academic level among anthropologists, CMA is also dedicated to making changes to improve the quality and structure of health care at the institutional and individual level. For this reason, there has been a movement of praxis-oriented anthropologists dedicated to reforming the biomedical system and “unmasking the origins of

social inequity” (Singer, 1998). A key concern of this praxis-oriented movement is how individuals operate in a biomedical system to create change without being co-opted by it.

One component of this thesis research explores CHWs’ ability to affect change within the biomedical system. Some academics and public health practitioners have called CHWs “change agents” (Eng et al., 1992) when describing their work to change health behaviors and empower individuals to initiate change at the community level. This notion is explored further in the results.

Social capital

Social capital describes the forces that shape the quality and quantity of social interactions and social institutions (Putnam, 1996). Social capital has been characterized as the glue that holds societies together. The American political scientist Robert Putnam describes social capital as: “Features of social life: networks, norms, and trust that enable participants to act together more effectively to pursue shared objectives” (Putnam, 1996).

An important feature of social capital is that it is a property of groups rather than of individuals. The ecological nature of social capital distinguishes it from social networks and social support, which are properties of individuals. The literature suggests four main theoretical strands, all of which overlap to some extent. Broadly, these are collective efficacy, social trust/reciprocity,

participation in voluntary organizations and social integration for mutual benefit (Lochner et al, 1999).

The concept also can be broken down into 'structural' and 'cognitive' social capital. Structural components refer to roles, rules, precedents, behaviors, networks and institutions. These may bond individuals in groups to one another, bridge divides between societal groups or vertically integrate groups with different levels of power and influence in a society, leading to social inclusion. 'Cognitive social capital' describes the values, attitudes and beliefs that produce cooperative behavior (Colletta & Cullen, 2000).

In health disparity research, social capital is being explored as a social determinant of health. Health practitioners and researchers have found that greater community involvement and increased social capital help to reduce inequities related to income, race, gender, ethnicity, and geographic location (Farquhar et al., 2005: 90). Further, it has been shown that higher levels of social capital have been associated with better health and health behaviors (Denner et al., 2001: 3).

In 2005, a CDC-funded grant in Portland, Oregon is looked to increase social capital in African-American and Latino communities through a CHW intervention. The goal of the project is to address social determinants of health and reduce health disparities in the target populations through a participatory approach. While results are not available, the project offers important "lessons learned" information that indicates an increase social

capital. CHWs have worked with target communities to identify health issues in their communities and design projects to address these issues (Farquhar et al., 2005: 91). These projects have expanded social networks and increased trust among members of the participating groups.

CHAPTER 3: METHODS

Overview of methods

Ethnographic methods were utilized to conduct research. Data were collected from semi-structured interviews, participant observation, surveys and focus groups. Grounded theory methods were employed to code and analyze interview data. The interview sample selection was *a priori* and included all project CHWs. Surveys were provided to a convenience sample of clinicians at clinic sites served by the project. Focus groups were administered to a convenience sample of clients who received project services. A timeline of project and thesis research activities is provided below.

Table 1. Timeline of research activities

2002

January: Hired as evaluation assistant for SAMHSA grant project

Jan-March: Participate in interviewing and hiring three project CHWs

Jan-June: plan, develop and implement evaluation tools for project

April: conduct evaluation workshop for project CHWs

May: begin collecting CHW personal and client narratives

August: interview project manager and staff re: project progress

2003

January: develop provider survey

February: develop client focus group questions

April: administer provider survey

June: resign from position and move to Maryland

2004

August: conduct semi-structured interviews with project CHWs, staff

Sept-November: transcribe and code interviews

Nov- December: cross-check and clarify data with CHWs

2005

Jan-August: write master's thesis

September: defend master's thesis

Data Collection

Establishing rapport and trust with key informants is a critical first step in ethnographic research. A researcher must gain access to a cultural setting. Key informants are trusted in their communities or social circles and they can provide an insider's or *emic* perspective into the daily experiences of their community (Agar, 1996). My first days working on the project were spent meeting and visiting with project CHWs in their clinic sites. We

conversed and shared personal experiences. Each of the project CHWs became trusted key informants.

Participant observation

Participant observation is a key component of ethnographic data collection. Participant observation allows the researcher to engage in the activities of the research subjects and get a sense of the natural or every day environment (Agar, 1996). Typically, participant observation takes place over a period of time and occurs wherever the key informant works, lives and socializes. I spent many hours shadowing the CHWs in their daily work. I observed CHWs in a variety of work and community settings which included: leading health education groups in clinics; interacting with other health clinic staff and providers in both formal staff meetings and informal interactions in their offices or hallways; socializing after work at restaurants or in community centers.

I also organized a CHW family event where friends and family members of CHWs came together for a potluck and recognition of the work of CHWs. At this event, I spoke with family members about changes they observed in their mother/father/husband/wife.

In all of these settings, I recorded observations and notes in a field notebook and maintained a personal journal to record my personal experiences and thoughts. These notes and observations were used to

develop themes and helped to triangulate findings from interview data.

Triangulation, or researching one topic from a variety of perspectives, is an important way of validating qualitative research findings.

From the onset of the project, I was very interested in the impact of work on the CHWs themselves and established this as one of several evaluation domains. As part of the CHWs' initial training, I conducted an evaluation workshop where I introduced the basics of program evaluation, including both qualitative and quantitative data collection methods. This training was for three project CHWs and two therapists and lasted approximately two-hours. Topics covered included types of evaluation (i.e. formative, summative and process); reasons why it is important to conduct evaluation; how each member on the project team plays an important role in evaluation; types of data (qualitative/quantitative) and different ways data can be collected.

The training was hands-on and incorporated principles of participatory research and evaluation. This format allowed participants to actively participate in the training by drawing on the personal experiences of the CHWs. In this way, I was able to connect existing knowledge to new concepts and actively engage the CHWs in the training process. This training also served as another way of collecting personal life experiences from the CHWs. Notes and observations were recorded by hand in my field notebook and I referred to these notes later when organizing and analyzing my data.

Semi-structured interviews

After the completion of the project, I returned independently to conduct in-depth interviews with the CHWs, project managers and providers who worked with the CHWs. The purpose of these semi-structured interviews was to discuss the experiences and personal impacts of work on the CHWs. All three project CHWs were interviewed. Interviews with CHWs lasted approximately two and half hours each and were recorded with a micro-cassette. The interview guides are provided in Appendix 5. Interview questions were developed using field notes and observations collected throughout my tenure as a project evaluator. I used a funnel approach when developing the questions. I began the interviews by asking broad, general questions and then narrowed the focus as the interviews progressed. The interviews were conversational and dynamic. I allowed the interviews to progress naturally and moved from topic to topic as they were brought up, rather than adhering strictly to the order of the interview guide. This format provided very personalized accounts and narratives of CHWs' experiences and perspectives.

I also conducted an in-depth interview with the project manager. This two-hour interview focused primarily on the role of the CHWs in the project and their impact in the lives of clients, their own lives and in the primary care

system. This interview was coded along with the CHW interviews to add another dimension to the perspectives of CHW impact.

Provider survey

Data were also collected from surveys administered to clinic providers at project implementation sites. The survey was developed and administered to assess providers' knowledge, use and perceived impact of the project services. I developed the survey questions by conducting several semi-structured interviews with providers and observing three staff meetings. At staff meetings, providers and other clinic staff including the project CHWs, discussed client case management, resolved issues related to role clarification and informally conducted cultural competency training. Surveys were developed with input from all project staff.

Surveys were administered to all providers at four implementation sites for a total of 43 surveys. Providers completed 33 surveys and 10 surveys were completed by other clinic staff and not used in the analyses. Topics covered included awareness of the project and its intended target populations; use of project services; satisfaction with project CHWs; and areas for improvement. A Lickert-scale response was offered for each question and results were coded and analyzed. I was responsible for the development and administration of this survey, however I departed the

project before analysis occurred. The survey was analyzed by another project member (see questions in Appendix 5).

Client focus groups

Data were collected from clients who received support from CHWs. Data sources included participant observation of client support groups, client narratives collected and translated by CHWs, and focus groups conducted with a sample of clients served by the project. I was pivotal in the design and development of focus group question guides. I worked extensively with CHWs as well as the project advisory board to ensure that questions were culturally appropriate and developed in a manner that built trust among the group and fostered real conversations, rather than just question-answer format. I also assisted in recruiting and training culturally and linguistically appropriate focus group facilitators.

Focus group question guides began with discussion of general immigration experiences and formal and informal support systems. Questions then focused on challenges and barriers clients faced once in the U.S. with a specific attention on health care services. Participants were encouraged to share and describe their experiences accessing medical services from MCHD and to comment on the type of care they received. Mental health services were not directly addressed but were discussed within the broader discussion of health care services. I departed the project prior to

completion of the focus groups. Therefore findings from focus groups are drawn from analyses performed by other project staff (see Appendix 6 for focus group question guides).

Other data sources

Data were collected from client visits and recorded in a project database. One of my primary roles as an employee of the project was the collection, reporting and analysis of client visit data. In the program planning phase of the project I developed most of the data collection instruments and forms. CHWs entered visit data into the registry and I produced monthly reports for project staff. During the first year of implementation, many revisions and additions were made to the registry to accommodate or account for project-specific reporting. I produced monthly reports that tallied number and type of client contacts as well as the focus of client contacts.

Data Analysis

Each semi-structured interview was recorded on audio micro-cassette. Interviews were transcribed verbatim and coded. Grounded theory approaches were employed in the analysis of interview data. Grounded theory research, often referred to as the constant comparative method is a qualitative tradition built on compared concepts (Glaser & Strauss, 1967). With this method, similar data are grouped and conceptually labeled. Concepts are categorized and organized by

relationship. Conditions and dimensions are developed and finally a theory emerges (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1990).

The researcher constructs theory from the data. By starting with data from the lived experience of the research participants, the researchers can, from the beginning, attend to how they construct their worlds. That lived experience shapes the researcher's approach to data collection and analysis, (Charmaz, 1994: 68).

During the open coding, approximately 15 categories emerged from the interview data. These categories were narrowed during selective or axial coding. Axial coding refers to collapsing themes into broader categories. Axial coding resulted in four main themes related to changes within the personal lives of CHWs. Interview findings were shared with the CHWs to cross-check for validity. Themes from interviews with CHWs were also triangulated with interviews from the project managers and overseeing physician.

Limitations of Methods

The ethnographic approach is an useful research method but does have limitations. Participant observation can not easily be replicated because factors such as environment cannot be controlled. Semi-structured interviews were not standardized. As noted, the interview format was loose to accommodate a more natural conversation style. While CHWs covered many of the same topics, the questioning was not identical.

The provider survey was not originally designed as a thesis research tool and therefore data were selected as deemed appropriate to this research. Only providers at project clinic sites were surveyed. It would be useful to include the perspectives of all staff at project implementation sites to get a more well-rounded point of view.

Analysis methods rely heavily on the primary researcher. While I attempted to be objective in my analysis and use of grounded theory, by nature, this method is subject to researcher bias. I attempted to control for this by sharing my results with the interviewees to check for accuracy.

CHAPTER 4: RESULTS

“Empowering others and empowering ourselves: a case study of community health workers in a mental health project”

Overview of Results

Results indicate that CHWs have great influence on their families, communities and workplace. Their influence reaches far beyond the individuals they assist each day and extends deep into the communities in which they live and work. Ethnographic research yields results which reflect the views and perspectives of project CHWs and their co-workers. As a result of their work, CHWs are better able to address the physical and mental health needs of themselves and their family members. In the course the project, they helped to improve the mental and physical health status of clients. This resulted from increasing access to community and clinic services as well as providing culturally appropriate health education and peer mentoring.

The project CHWs are uniquely situated between two cultural systems with access to both. In the community, CHWs help to strengthen bonding or social capital by expanding social networks and empowering individuals to create change in their own lives. In the primary care health system, CHWs serve on medical staff teams and help to equalize power relations between providers and clients.

Results of this thesis have implications for community-based agencies seeking to expand access to culturally appropriate health services through employment of CHWs. This thesis highlights the importance of evaluating the impact of work on CHWs' health and well-being along with client outcomes. It also raises important questions about the dual roles played by CHWs in a biomedical system and the difficulty of delineating clear boundaries between work and personal time.

To better understand the impact of CHWs, I look at the experiences and perspectives of the three CHWs employed by the project. Results are drawn from interviews with CHWs and program staff, a survey administered to clinic providers, client focus groups and client narratives recorded by CHWs. Perspectives from CHWs on mental health and the primary care system are included throughout.

CHW Profiles

***Maria**

Maria is now 33 years old and has lived in the United States for nearly ten years. She moved to U.S after she met and married an American. She recalled with a laugh how they met in Tijuana at a bar. She was young and looking for adventure. Unlike the other CHWs I interviewed, Maria was less open about discussing her childhood or life in Mexico. In passing she

* Names have been changed

mentioned her life was not easy, and that she moved around frequently looking for work in Mexico. When she came to the U.S, she felt very lost. She stated, "It was very difficult for me- kind of like how the patients used to do- I was afraid to use public transportation. I didn't know where anything was, I didn't know anything about schools, anything about the health care system" (personal interview, 2004). Maria admitted freely that her immigration experience was easier than most because she came to the U.S speaking a little English and under a legal status. She did not have to risk her life crossing the border and she did not live under the constant fear of deportation.

Almost immediately after arriving in the U.S, Maria enrolled in school and within six-months, she completed her GED. Soon after this she began working in her community as volunteer with her church. Her parish connected her with new immigrants. She stated, "It was an obligation for me to give my community things that I knew; to share with others who didn't now the language, or their legal status was worse, so that's how I went to outreach as a volunteer." This commitment grew throughout her experiences with the project.

Maria has two children from her marriage. During the course of the project, Maria began to undergo incredible personal changes. She became an advocate for bicultural children in her son's school after recognizing a lack of cultural competence. Maria also ended her marriage and began a new life

as a single mother. She stated that much of her courage to do this came from working with other women. "I became empowered- the fact that we are all women, and that we need independency and that we are strong, but sometimes we don't know how strong we are. That's the empowerment I got from them. Just to be able to be independent and strong in my own way."

During this tumultuous time, Maria recognized the advice she was giving to her clients was also applicable to her. She recalled a conversation with her mother:

Last year I was feeling really depressed about all the changes and just to see all these women who were depressed and I was feeling depressed too. I am giving advice to them, but really a lot of those suggestions were for myself. So it's like 'here's the moral coming to me.' Here's these women coming to me for help, and actually they are helping me!

Emilio

Emilio's immigration story is similar to Maria's. He too came to the United States after meeting and falling in love with an American woman in Mexico. He is 38 years old and has lived in the U.S since 1997. He described his CHW role as a natural progression of his life's experiences, and as an extension of his personality, his role within his family and his culture. Emilio stated, "In the community, the first circle is the family, but then you go bigger, then it's your neighborhood, and you go bigger, and it's wherever you are" (personal interview, 2004).

He recalled that within his immediate family he served as a mediator and problem solver. His oldest brother suffered from alcoholism and depression and Emilio was looked to as the head of the household. Emilio remembered his family's frequent requests: "Emilio, I'm having this problem with this and this- what can you do?" He continued, "They [his family] were always putting me in the middle of their fights to do the job of a mediator between them and to fix their issues." This role as a mediator continued wherever he worked and lived.

When he first came to the United States in 1997, he faced many challenges. Culturally, so many things were different. Emilio recalled: It's quite overwhelming- you have the language barrier, and you have things that were okay in your country and they're not here and basically you're breaking the law if you do. Like, it's quite normal in Mexico to see a parent leaving their nine year old by himself when they go to work. Here, many people don't understand they can't do that (personal interview, 2004).

Emilio described other barriers. When he first came across the border he could not find a job. This was very hard for him because he was accustomed to providing for his family and now "I couldn't find a job, I couldn't provide for myself, needless to say my wife." This feeling of hopeless and dependency led Emilio to feel depressed. He described this time when he stated,

"I never felt so--so, like I depend so much on some other people, and I felt guilty because I was putting too much pressure on my wife... I went from being on one side of the coin to the being on the other and it was too drastic for me. I didn't know what to do and I was ready to give up and go back [to Mexico.]"

His first jobs in the U.S included construction and telemarketing.

Emilio found that wherever he went, people always approached him with questions or to seek advice. "It's just something people see in you; it's not that you do it, it's that people come and share things with you because somehow they feel that you can help them," Emilio continued, "But they do come and they share things, and then you feel responsible for their problems." While Emilio felt a strong obligation to help others, he also at times felt burdened by the responsibility and experienced guilt when he was unable to help someone.

Victor

Victor was 16 when he came from Ukraine to the United States as an exchange student. He entered and won a visa lottery that allowed him to stay in the U.S to attend college. Now only 22, he has already finished his bachelor's degree and is working on his doctorate in psychology. Victor is an extremely hard-working and religious man. He described his family in Ukraine as lower middle-class, and alluded to previous religious persecution. Many Ukrainian immigrants belong to Pentecostal churches and were unable

to worship freely under Soviet rule. They came to the United States to seek religious asylum or as political refugees.

When asked about how he defined a community health worker, he hesitated, but then replied,

Before this project, I had no idea what a CHW was; now I realize it's really just people from the community trying to help their community. They can use their cultural beliefs, their cultural knowledge of medicines, herbs. I realize now it is just a definition for something I've done for a long time at my church. Here I was just getting paid for it! (personal interview, 2004).

Despite his young age, Victor described how people came readily to him for advice. He especially enjoyed meeting with the newest arrivals at his church because he wanted news from his home, but also because he was eager to assist people to adjust to life in the United States.

Victor worked up to five jobs at a time while attending college full-time. His jobs ranged from seasonal berry picking and Christmas tree pruning to clearing out blackberry brush, construction and interpreting for medical clinics. He attributes his motivation to further his studies to hard and physical labor. He sees education as a way to get away from physical and menial labor.

Victor had a difficult time adjusting to life his first year in the U.S. He did not speak fluent English and found that it was very difficult to meet friends. Culturally, he described some of the challenges, "Cultural things were totally different. Like what's appropriate or not appropriate? In Russian

culture, it's okay to say 'where are you working? How much are you making? How much do you pay for your house?' Here is more personal." Victor went through a period of time when he felt very low and wanted to return to the Ukraine. He stated, "There was a period of time right about 6 or 7 months where I was just so low. I remember writing a letter home and letting the whole thing out and it's a good thing I didn't mail it! I read it the next day and my mom wouldn't have been able to handle this" (personal interview, 2004).

The preceding profiles of CHWs give personal and cultural contexts to their work. Their own personal histories and experiences also draw focus to many of the barriers and challenges immigrants face upon entering the United States. For clients of the project, isolation from family, language barriers, lack of transportation or knowledge of how to navigate government agencies created much anxiety and stress. The process of learning how to overcome many of these barriers motivated all three CHWs to help others. Many of the personal struggles described by the CHWs were mirrored in client focus group responses.

Motivations for becoming a CHW

During each semi-structured interview with CHWs, personal motivations for becoming a CHW were explored along with ways they had changed as a result of their work on the project. Certain themes related to personal motivation consistently emerged from each of the three interviews.

These included: a sense of obligation to help others and the feeling that the CHW role was a “calling” or a “natural” position for them. Personal struggles adapting to life in the United States and difficulties with mental health helped them feel more qualified and obligated to share their personal lessons with others.

Sense of obligation

All three CHWs described a keen sense of obligation to serve as guides or mentors for individuals experiencing difficulties from their communities. When describing this obligation, Maria, Emilio and Victor all stated they felt responsible to share their knowledge to help others. For Maria, this grew out of her community service and volunteer work at her church. For Emilio and Victor, it seemed to go back further to their families in their native countries. All three described working to assist people as a “natural calling.” Victor stated that the job of a CHW was getting paid for something he had been doing all his life. Emilio shared how people always came to him for assistance with problems his whole life. Maria stated quite eloquently, “I have the opportunity, I have an obligation. I don’t feel like it’s a privilege, it’s an obligation to represent them [community members] because here I have these opportunities. Here I have this voice, they don’t, so it’s my obligation to voice their opinions and needs in society” (personal interview, 2004).

Personal Changes for CHWs

When discussing the impact of the project on their personal lives, several themes clearly emerged from the interviews. These themes include: personal empowerment; making changes in family life; experiencing professional growth and career advancement; and improving personal health to include an expanded understanding and application of mental health disorders and treatment. Each of these themes is explored.

Personal empowerment

In the course of their work, CHWs spent a great deal of time working with clients to address different health concerns and issues. For the CHWs there were many rewards and an equal number of challenges. Maria stated,

This project has taught us how to build something from scratch. We started this project from scratch and as time went by we started building up and empowering people and empowering ourselves. We were giving people opportunities they didn't have and we were even giving ourselves opportunities we didn't even know we had (personal interview, 2004).

Personal health

All three CHWs developed a deeper understanding of mental health and its significance within their communities as well as their own lives. This is due in part to their extensive training and also to their personal experiences over three years. The CHWs' perceptions of mental health changed drastically. When asked about the biggest change they had experienced in

their lives as a result of their work, all three mentioned increased knowledge and understanding about mental health.

Victor described his biggest realization from the project: that people really have mental health problems, beyond just hardships.

Victor stated,

The biggest realization for me was to really experience people with problems. Like people were diagnosed with depression or anxiety or something, but I never made the connection that this is a disorder before. For me, I just thought of it as a result of their hardships [with money, language.] People seemed normal to me; they won't tell you that they have a problem, they will just tell you the same things- just that 'it is difficult for me.' But then you start looking that this was a problem for you, and we took care of it, and you still feel bad. What's the problem now?" (personal interview, 2004).

Victor went on to describe his work, frustration and then realization that clients did suffer from a serious mental health disorder. Part of his realization came about because of his own initial skepticism about the use of medications and psycho-therapy. Victor described the typical viewpoint of mental health in his culture: "In Russia, mental health is very different. If you have a psychological problem, it is thought you cannot comprehend what is being said to you, and you should just be locked up and not be out in society."

This viewpoint changed for Victor when he began to see radical changes in client's health as a result of joint assistance from physician-prescribed medication and counseling. He also stated however that

medication was not an answer alone and that his work to help clients make improvements in their lives had equal impact. Victor felt that medication and counseling combined with CHW services made clients healthier.

For Emilio and Maria, their increased knowledge about the symptoms and manifestations of mental health disorders had personal significance.

When asked about changes in his own life, Emilio responded humbly,

The relationship between me and my wife; it basically improved because I understood more about depression. I started reading more, and I started just, seeing mental health therapists working with patients. It helped me to better understand what she [wife] was going through. It made me change what I was doing wrong also, because I was probably part of the causes of her depression (personal interview, 2004).

Maria made changes in how she dealt with her own problems. She described one of the most important lessons from her work on the project.

That was one of the biggest things for me-being able to see that humans experience so much and there are so many repercussions from when we were children. Now I am able to be more open-minded and non-judgmental about people's problems. I want to help them to learn to live and move forward, rather than dwell on problems of the past. That has been a big part of the help for my own self.

Maria went on to describe her own struggles with depression and how through helping others, she was able to help herself. Maria stated,

There were times I just felt horrible, but then I would see these women and they would come, and here I am helping them, and I am like, 'I should give that advice for me.' Because this is what I have been feeling and I actually take the advice for

myself. You think you are helping these people and they are actually helping you to grow and become a better person.

It was very powerful to hear Emilio, Maria and Victor describe ways in which they struggled with mental health issues and incorporated changes into their own lives. These positive changes are consistent with the helper-therapy model proposed by Riessman (1965). In the process of helping others with similar problems, the helper experiences many personal benefits.

Emilio described how the process of assisting clients helped him to reconnect to his community and reduce the isolation he felt from his family in Mexico. He stated,

I felt like I was not alone anymore. It made me feel like I was a part of something again and it gave me the opportunity to be even closer to my community. I was isolating myself, and that was one of my problems. That was one of the reasons why I was homesick all the time and depressed all the time. I started to listen to my own advice- it was like group therapy for all of us (personal interview, 2004).

Victor described how he received a personal benefit from his work with clients: "The best thing is a personal thing. If I give advice that will make someone's life better, for me that is very rewarding. When people come back and say 'yes- it worked' that's really cool!" He continued, "You see someone who comes, doesn't have a job, doesn't have a place to live, all this crying, and then after four months you see them working, moving. That's a big reward, that's the best part of it."

Professional development

Each CHW described tremendous professional growth and development as a result of their work. Professional development resulted from advanced training in mental health, experience leading chronic disease support groups, training the trainer workshops, presenting project findings and strategies at professional conferences and making appearances before county commissioners and other high-level executives. The CHWs were also publicly recognized for their work and each received a “public health hero” award from the MCHD director.

Victor now works part time for a private mental health provider as a counselor. He attributes his promotion in this job to his experience and training received in the project. He stated, “The SAMSHA project has really helped me in terms of experience. It opened my eyes to the problems of many people, not just Russians” (personal interview, 2004). Victor also attributes the project with helping him to get accepted into his doctorate program. He obtained recommendation letters from the project director and other providers at the clinics where he worked. His experiences with the project also guided his selection of a course of study. He plans to work as a therapist specializing in the needs of the Russian-speaking population.

During her work with the project, Maria became more active in political activities within the Latino community. She was introduced to several county

commissioners when she testified against cutting funding for community mental health centers. Maria networked with several activists and learned more about broader public policy issues. She stated,

I really feel we need good representation, not just by a name, but by somebody who really knows the struggles. So that's where I am heading. I am thinking about law school. I am really involved with the democratic campaign and doing a lot of work for the Latino community, and I'm thinking some years in the future, maybe, um, a commissioner for Multnomah county!

Maria again described her own personal empowerment through the work of helping other people in her community. Her eyes were opened to many issues, and she feels that she has an obligation to voice the concerns of her people to a higher level. "Here I have this voice, they don't, so it's my obligation to voice their opinions and their needs in society."

Maria feels that she has attained a high level of trust in her community. "I feel I have earned a good place in my community, and a good place of respect, that I know when I want to do something good for my community, I will have a place of support from them."

Emilio has experienced increased professional development from the training he received with project. He left the project in the final year to take another, non-grant funded position within a different health department division. In his new role, he works with people of many different ethnicities and cultures. He described how his training for the project assisted him in his new role. Although now he does not work specifically with mental health

issues, his training and experience with the project help him to recognize problems he might not have seen before. He stated that he applies his experience from the project to his current work every day.

Change in leadership status

Another change reported by CHWs and their manager was a change in the community's perception of them as leaders. Emilio described this change when he stated,

They [community members] see you as one of their own, but they also see you as a leader. They go to you for advice, to complain, but they feel they can open up a little more with you because you are one of them. I felt like I could understand what people were telling me because you know what they are going through (personal interview, 2004).

Maria experienced tremendous personal growth during the time she was employed by the project. One of the biggest changes she described was the leadership role she has assumed in her community.

My community began to see me as a leader, someone who could help with problems: with insurance issues, making medical appointments. But also bigger things: to empower them as women, as leaders in their communities, as mothers, as women with rights.

Maria became a "change agent" in her community. A change agent empowers others to make changes within their own lives. Change occurs over time and individuals develop the ability to move beyond a singular problem or obstacle and establish confidence in self to help one-self (Eng et

al., 1997). This creates a snow ball effect where individual changes lead to changes within the family structure and then further into the community. CHWs served as mentors to clients and as catalysts in a larger community development process.

Social capital increases as community cohesiveness is strengthened (Putnam, 1996). CHWs helped increase social capital. One example of increased social capital is found in the chronic disease support groups led by CHWs. The chronic disease support groups brought together clients who suffered from depression and other chronic conditions such as diabetes and hypertension. The groups met for a total of 8 weeks and followed a structure outlined by CHWs. Topics covered included personal health and awareness, diet, exercise, healthy mental health habits and ways to establish and follow through with self-directed health goals. The format for meetings varied but discussion and personal sharing was a large focus of gatherings.

The groups had both direct and indirect benefits for the participants. Directly, health knowledge and awareness increased. The PHQ scores for participants decreased significantly indicating reduced severity of depression. Indirectly, participants experienced a greater sense of belonging. Friendships were developed and flourished outside of the meetings. Mothers exchanged child care and job openings were shared. Isolation and loneliness experienced by many of the clients decreased. At the completion of the

program, several participants began their own informal support groups and expressed interest in becoming trained to conduct formal groups.

Focus Group Results

Results from client focus groups provide another perspective on CHW interventions in mental health. They also provide insight into the barriers faced by immigrants and validate the challenges shared by CHWs in their personal profiles.

Nearly all focus group participants spoke highly of the project staff and were appreciative of the services provided. Both Latinos and Russians found the support groups they had attended to be particularly helpful. One woman stated, "These groups are a must. You see we do not have information-do not know where to go to address our problems" (MCHD focus groups, 2003).

Both Latino and Russian-speaking immigrants described facing a variety of challenges when they came to the U.S. Both groups experienced extreme feelings of isolation and expressed a desire to return to their native homes.

Many of the challenges faced by Latinos were related to lack of documentation. The Latino focus group participants felt that lack of documentation was associated with having to accept the worst jobs and lowest salaries, discrimination in working conditions and job security, fear of deportation, and inability to enroll in the Oregon Health Plan. They said,

"I went back and forth until it got more difficult and then I just stayed here. I wasn't able to . . . acquire the amnesties, my English, or legal documents."

"It is like a cloud hanging over you. We are not (legal) residents, nor of any other significant status, and we have to take the worst jobs with the lowest salaries."

Lack of English and not having a job were identified by Russian-speaking participants as their greatest challenges. Many felt that their difficulty in finding employment was caused by their lack of English. Lack of English also made official documents hard to understand, medical visits difficult, and just generally led to feelings of not knowing where to turn. "The biggest problem is lack of language, but thanks to children that can help—it makes life a little easier." "You don't know English, there is no job" (MCHD focus groups, 2003).

Domestic violence emerged as a challenge for many of the women who participated in the focus groups. Many of the Latina women and one Russian-speaking woman disclosed incidences of abuse. It became clear from client responses that many of the Latina women had experienced domestic violence and other mental health related problems for many years before being connected with the project.

Many participants in both Latino and Russian-speaking groups expressed their frustration over lack of health care coverage. Latinos were often ineligible for the Oregon Health Plan and Russian speaking clients indicated their frustrations with income requirements.

I am a stay-at-home mom; my husband has a job. My children work half time and go to school half time. So when they get sick, I am asking God to help us find a doctor. One of my children was born here, and for the fact that my husband makes \$100 more (than the threshold) he doesn't qualify.

Both Latinos and Russian speakers were generally pleased with their health care providers, but frustrated with the system of care. Many noted long waits for appointments, long waiting times in the clinics before receiving care, and felt that 15-minute appointments were simply too short. Many, especially Russian-speaking clients, found interpretive services to be inadequate. Particularly disturbing was one woman who found it necessary to conceal her health problems because the interpreter was a member of her church.

Provider Survey

Results from a provider survey administered at the end of the first year of the project indicated that providers were satisfied with the services provided by the project. CHW services had the highest percentage of providers expressing satisfaction with 83% stating they were "satisfied" or "highly satisfied." Ninety-three percent of all surveyed providers "agreed" or "strongly agreed" that CHWs were "perceived as valuable members of the clinical support staff" (unpublished MCHD provider survey, 2003).

Providers were also asked to rank their preferences for CHW roles and feedback methods. Providers most preferred CHWs to assist clients to

receive services they needed and provide home visits to at-risk and vulnerable clients. This was followed by providing cultural mediation between clients and the primary care system.

There were many remarks from providers when asked to free respond to the question: What would help you to better address the physical and mental health needs of Latino and Russian-speaking clients? Some of the responses included: "I think individual support from CHWs is a great asset. I would love to build a community clinic addressing community issues like diabetes and obesity." "More CHW input, time and work. CHWs make the difference!!!" "I'm always looking for more info on cultural beliefs and practices" (unpublished MCHD provider survey, 2003).

Client Narratives

As part of their weekly reporting activities, CHWs were asked to write client narratives. The CHWs wrote in journal format about how they were able to assist clients, and about the successes and challenges faced in their work. The narratives allowed the CHWs to contribute directly to the project evaluation. Participatory research and evaluation strategies incorporate the perspectives of all stakeholders into research and evaluation. The narratives served as a marker by which to measure progress and change in client's mental and physical health. The narratives are written in the words of the CHWs and give a firsthand account of the types of services CHWs provided

to clients. Narratives give and the life circumstances that contributed to clients' poor mental health conditions.

Jose

Jose, a 60-year old man, has struggled with alcoholism for the last 10 years. Jose has been sober off and on, but his most recent relapse happened about 3 years ago when he started drinking constantly with no hope or desire to stop. Jose found in alcohol a way to cover up his financial and family problems. But because of the use of alcohol, Jose was also damaging his health and his family sanity. He knew how much damage he was causing to his family and to himself, but as he put it in one of our conversations, "I do not know what to do or how to stop drinking. I need help."

As a CHW, I knew almost immediately he was crying aloud for help, but he did not know how to start or how to ask for it. We started working to manage his diabetes by educating him about the health factors that might contribute to an uncontrolled condition. We talked about symptoms of a chronic disease such as depression, and we also discussed the need for family support, encouragement and motivation. Our journey made small progress, one step at a time. Sometimes he relapsed back to where we started, but not ever once did I lose hope in Jose. I knew that he needed support and someone that truly believed in him.

Through the journey I discovered that Jose had his drivers' license revoked because of the use of alcohol but in a couple months he was going to be able to obtain his license again. So I thought to myself this is it. Getting his license back will be a good tool to start working on getting his self esteem back, and proving to himself that things can get back to the way they were before, if we only believe in ourselves and have the support of others.

Jose, started taking his driver's education classes. Immediately, his wife decided to accompany him for support and also to get a license permit for herself. At the same time Jose and his wife started taking the Chronic Disease Self Management class held by my CHW coworker and myself. Right at the beginning of the class you could see Jose's immediate response to a leadership role. He started taking control of the little details that made our class possible and you could tell that he was very happy about feeling useful to others.

One of the purposes of our CDSM class was to accomplish a weekly goal regarding new changes with our diet, exercise and different habits that we would like to improve. Jose's first habit to change was his use of alcohol. He

decided he was going to try not to drink for the next week. When the next week came he testified he did not drink at all. The following week he offered to accomplish other goals, but always kept in mind not to use alcohol for another week. "I was afraid to commit aloud to others, myself or you. I did not want to disappoint anyone, but I wanted so bad to make another day or a whole week without alcohol."

Jose did it day by day, week by week, until now 3 months later, he is still sober and just recently he finally passed his drivers test (behind the wheel).

It gives me great satisfaction to know that everyday that goes by, he makes it through and all the calls I received from him to get support and to be thankful for every time I helped him did actually work.

Jose has stated that without my help and support and the support of my coworker he did not think he would make it through.

This client narrative was shared by Maria. It provides a glimpse into the support provided by the CHWs. The CHWs established close relationships with many of their clients and were trusted not only by the clients but also their family members. Jose became a leader in his community, in part due to his success with the CDSMP group. Sadly, Jose died in the Arizona/Mexican desert in 2004 while assisting his cousin cross the border illegally. Maria was devastated by his death and still keeps in touch with Jose's family.

Lupe

Lupe is a 24 year old female who has been struggling with an abusive situation for the last five years until recently when she decided enough was enough. I met Lupe 8 months ago. When I met her, she was very reserved and protective at times. One day I took her to the office of the Head Start Program to get her youngest child enrolled. I realized how many problems and struggles this client had in her life. This client opened up to me saying: "I feel very depressed and lonely. I have a husband but it seems like he is not

there at all. I think he has someone else but he is constantly accusing me of having an affair with our roommate.”

The client cried after telling me about the constant verbal and mental abuse this man was giving to her. I asked her about his behavior with the children and she replied, “He is very loving towards them, that is what confuses me the most.”

My role as a Community Health Worker was to inform and educate this client about the different forms of abuse and how to learn to try to identify each one of them. At first, the client was not very receptive to this information. She did not want to accept it, or like she said, “It is just the way life is, my mother went through the same thing, so I have to do the same.” It took her about 8 months going back and forth in the relationship to realize that it over. This man finally physically abused her in front of her children. This was the time when she decided “no more of this situation.” It needed to stop.

The client is currently attending domestic violence support groups. She is in the process of obtaining housing assistance through the support of victims of domestic violence. The client states feeling sad at times, but she also recognizes that her life feels more tranquil now.

In this client narrative, Emilio describes his interventions to assist a women in a domestic violence situation. As a CHW, he worked closely with the woman to identify how she could change her situation. Emilio stated that his own experiences as a child with domestic abuse helped him to relate to his client. Although he was a man, he felt that his experiences helped make his client more comfortable and together they were able to make positive change.

CHAPTER 5: ANALYSIS

Inherent in my research design, data collection and interpretation of results is a critical perspective espoused by CMA. In this project and through my employment in a biomedical primary health care system, I recognized a clear delineation between providers and clients. The primary care system and providers are perceived as the 'givers' of services and the client who manifests a health problem is the 'receiver'. This unequal distribution of power negatively affects the relationship between provider and client and sets up a system that mirrors the broader economic and political inequalities found in the United States. (Baer et al., 1997).

The perspectives of CMA also spotlight individuals who might otherwise have been overlooked in the traditional evaluation of client outcomes. A much richer and complex set of outcomes emerges by examining the personal experiences of the project CHWs alongside those of clients.

This thesis research suggests that CHWs improve the quality of services and may help to equalize provider/client relationships. Throughout literature, CHWs are often referred to as "bridges" who serve to connect community members with varied language, health practices and beliefs to a biomedical health system (Rodney et al., 1998). In this linear analogy,

biomedical health care exists on a bank divided by a wide river or ravine from clients. CHWs serve as cultural brokers or mediators (Love, 1998).

CHWs have a great responsibility to mediate and interpret between two very different sides, all the while retaining indigenous qualities of the community (Giblin, 1987), and simultaneously holding keys to the health care system. Giblin emphasized the importance of CHW indigeness. This concept is critical in order to fully appreciate the importance of studying the personal experiences of the CHWs.

CHWs struggle with many of the same problems new immigrants face: not speaking the language of a dominant culture; not knowing how to navigate the system and bureaucracies of obtaining employment or health care or simple tasks such as riding the bus. These shared experiences with clients may motivate CHWs to help others and also builds a level of trust between clients and CHWs that can not be replicated by other providers.

The traditional "bridge" analogy fails to acknowledge the dynamic, multi-lateral interactions that occur between CHWs, health care professionals and clients. Through interviews, surveys and focus groups with CHWs, clients and health care staff, I explored these interactions and examined the impact for CHWs, clients and the health care system.

My focus was most heavily oriented toward the impact for the CHWs, as this is an area that has been researched the least. I view the CHWs as

individuals with incredible powers to interpret, mediate and empower others to make changes. They sit between two entities with keys to both. I liken the role of CHWs to the 'borderlands' referred to by Arthur Kleinman who stated,

Perhaps it is at the margin, not the center, where we can find authorization to work out alternatives that can remake experience, ours and others....the margin may be near the center of a most important thing: transformation. Change is more likely to begin at the edge, in the borderland between established orders, (Kleinman, 1995:5).

Change is also seen in the fostering of social capital. Social capital refers to the social cohesion felt by a community or group comprised of individuals (Putnam, 1996). On a micro-level, CHWs worked with individuals to increase their well-being and sense of connectedness to society. CHWs brought together individuals from similar cultures to improve their ability to manage depression and other chronic conditions. As a result, social networks were strengthened as members of the groups connected with one another and established friendships. This type of process highlights how the work of CHWs increased social capital and improved the mental health of clients.

Challenges

While CHWs experienced many positive benefits as a result of the work, they also faced many challenges. One of the biggest challenges faced

by the CHWs in their work was defining boundaries between their work and their personal lives.

Difficulty defining personal/professional boundaries

CHWs felt responsible for the well-being of their clients and this responsibility extended beyond the limits of the health clinic or paid working hours. Emilio articulated this dilemma when he described a client who needed assistance after business hours. Emilio gave her verbal instructions instead of accompanying her to an appointment but problems arose.

She [client] wanted me there, but I didn't do it because it was after hours, so I told her how to deal with it. The next day when I talked to her, on top of her problems she had before, now she had a pretty big fine. I felt responsible, that I should be there and that this was my fault (personal interview, 2004).

Emilio went on to describe how culturally, it is expected that he be there to help his friends or community members at all hours and this clashes with the American mentality of separating work from personal life.

They [community] see it that way and I see it that way, and you talk to coworkers and they say that's not your problem, you know you are working and you leave your coat here. When you go home, you put on your 'home' coat. But that's not easy to do. And even now, two years later, I still feel responsible to that woman because it wouldn't have happened if I had been there.

Maria shared similar sentiments when she described the challenge of establishing lines between work and her personal life.

I tried to keep distance, but I don't think with our community there is a 'fine line.' I don't know why, but I always feel so vulnerable. I know there are times that I shouldn't be crossing the line, but I feel so tempted because I know how much these people suffer and I know how hard they work and I know how honest and loving they are.

Employee vs. community member

As employees of the health department CHWs are expected to work within certain guidelines and must observe certain rules. These rules do not always match with the needs of clients. Working after hours is one example. Another is providing rides to clients in personal or county vehicles. As members of the community, CHWs have specific cultural expectations from their neighbors. This dual responsibility was burdensome at times for the CHWs. Maria felt "very stressed out" and "frustrated" by this and described feeling torn at times between her employer and the clients she served. Emilio stated, "There were times when we were really stressed out. And it wasn't because of the quantity of work; it was for that sense of responsibility that you create, that you put on your shoulders. You feel like you are responsible" (personal interview, 2004).

Maria also battled her feelings of overwhelming responsibility. She described feeling incredibly helpless about her client Jose and fought her desires to go look for him in the desert.

I was so close to going, but a friend of mine said, 'you know, you have a family too. You need to take care of them. You need to be able to make clear boundaries to be crossed and

not to cross those boundaries.' I guess those are some of the challenges that get my involvement, and where my job and life end.

Enabling vs. supporting clients

Another challenge encountered by CHWs was finding a balance between assisting clients with problems and enabling them to depend on CHW support. This was especially relevant in the course of the project because initially there were not guidelines dictating the type, length or number of appointments with clients. After services were implemented for several months, treatment guidelines were developed with input from CHWs. The goal was to help clients manage and improve their depression and general health status.

Lack of professional recognition

A different but very real challenge faced by the CHWs was a lack of professional recognition. Because the roles of the CHWs were so broad and varied, many staff at the clinic sites did not know who or what CHWs did. The CHWs were funded by the grant but served as members of primary care team at clinic sites. As members in both, they reported to multiple managers. Some clinic staff regarded the CHWs as interpreters and expected them to serve on call for medical visits. Other staff didn't understand why the CHWs were gone from their offices so frequently. Victor described this challenge as his greatest.

For me, the hardest thing about this job is about me personally. I never heard of CHWs before this project, and in my same boat, many other people didn't hear about it, so they didn't know what we do. They didn't know what to make of us and that was really tough. People always asked me 'what do you do?' (personal interview, 2004).

Initially, the CHWs spent a lot of time educating other clinic staff about their roles. The project manager also met with all lead staff at clinics to review the project and the roles of the CHWs at their sites. A list of duties and roles was also developed to establish clear responsibilities.

Cultural expert

Another challenge described by the CHWs was feeling as though they were the voice for an entire group of people. As CHWs, their indigenouness and role as a cultural mediator was highly valued, but it was easily misinterpreted. Victor described his frustration about being considered the cultural expert for all Russian people.

Many times it was really frustrating because people always look for easy ways. They look for stereotypes and it's almost discriminatory. It is like, 'tell me, so why do Russians refuse immunizations?' Well, how many? You ask every single person and every single person is going to give you a different answer and it's that with many other things. 'So what would a typical Russian answer to this?' Depends on if he is from Moscow, he might answer this way; from Ruhel or an ultra Pentecostal extremist, they will answer another way (personal interview, 2004).

In response to broad questions about the Russian people, Victor usually tried to spend time explaining that like in America, there were many

different cultures within the larger society. He would answer, "I cannot say for sure what they [Russian people] would say, but they might say this, or think this. And these are some factors to consider when designing your program." Serving as a cultural mediator also had many positive effects for the primary care system and clients served by the CHWs. Some of these positive effects are now discussed.

CHW Impact on the Primary Care System

As employees of the health department, the CHWs helped to improve the quality of health delivered to the citizens of Multnomah county. CHWs increased access to mental health services by reaching out to existing clients with need. Quality of health care was improved by CHWs who facilitated community participation in health systems and educated providers about community health needs, cultural beliefs that impact care and clients' outcomes with care plans. When CHWs work as part of a broader clinical or outreach team, they are able to contribute to the continuity, coordination, and overall quality of client's care.

Cultural competency

As suggested in literature, CHWs help to improve the cultural competency of health care agencies (Brach & Fraser, 2000). CHWs were crucial in identifying and implementing many adaptations in project procedures in order to address cultural concerns of the clients and project

staff. These included adapting administration of screening instruments and outcome tools. Initially, the PHQ screening instrument was to be administered at the initial session with the mental health counselor or CHW. However based on feedback from the CHWs, this practice was modified to permit sufficient time to build rapport and trust with clients before administering the PHQ.

For the Ukrainian refugee population screening instruments were perceived as quite threatening, especially because the project was associated with a government agency. This may have been due in part to the history of religious persecution in the former Soviet Union, where there is a reluctance to share information, especially in writing. This belief system increased the importance of a strong relationship between the mental health provider or CHW and the client.

Another cultural competency factor in administration of screening instruments was that although questionnaire measures were translated into the clients' native languages, lower levels of formal education made literacy an issue. Visit times were increased so that more time could be spent reading the forms aloud and explaining unfamiliar terms.

As a part of the clients' medical management, medical information was recorded during each medical visit. Documentation of clinical services in the medical record, especially as it related to using psychiatric diagnoses, caused distress for many clients. There was a strong negative stigma

attached to the use of mental health diagnoses, especially among the Ukrainian Pentecostal community. Since psychiatric diagnoses are required for reimbursement purposes, CHWs spent considerable effort and time to interpret diagnoses and to help clients understand the implications of diagnoses in the context of their religious and ethnic cultures.

CHWs helped to expand the clinic's ability to accommodate families in visits. Latino and Russian cultures place a strong emphasis on the "whole" family, not just the individual. For some clients, it was important to include the entire family in visits and educational programs.

CHWs helped identify the importance of supporting clients in non-traditional ways. These included providing clients with phone cards to contact family in their native country to reduce social isolation; giving clients bus vouchers to increase visit attendance; and providing some clients with grocery store coupons to increase a sense of well-being and stability.

Many formal and informal cross-trainings and cultural exchanges occurred between CHWs and other providers during the project. Hallway conversations between Victor and a doctor in one of his clinics became regular. By exchanging details about clients, Victor was able to convey important issues raised in his visits regarding medication usage and other general concerns. Maria developed a very good relationship with the two primary care physicians at her clinic. In staff meetings, she was frequently called upon to describe her work, and also was able to ask and answer

questions related to clients' personal situations. Knowledge and comfort with mental health disorders increased by discussing cultural issues relevant to the mental health care treatment of clients.

CHAPTER 6: CONCLUSIONS

This thesis weaves together multiple perspectives to study the personal experiences and work roles of CHWs in a mental health project for immigrants. Specifically, the thesis examines changes in the lives of CHWs resulting from their work. The primary care health system employing the CHWs is reviewed within the theoretical framework of critical medical anthropology. Theories from social economics and medical anthropology also guide the research analysis.

Results indicate that CHWs have great influence on their families, communities and workplace. Their influence reaches far beyond the individuals they assist each day and extends deep into the communities where they live and work.

CMA provides a critical framework to analyze the work of CHWs within the primary care system. This thesis research demonstrates that CHWs are able to straddle two different environments and make changes in both. CHWs have great potential to improve quality of client services and help to equalize provider/client relationships.

Thesis research suggests that CHWs help to increase social capital within their communities. CHWs motivated clients to make positive changes

in their own lives and in their communities. Social bonding and interaction between groups was enhanced.

A great deal was learned about CHWs' personal histories and motivations to work from semi-structured interviews. These histories provide a context in which to examine the changes which occurred in their lives as a result of their training and work experiences. CHWs felt more personally empowered and inspired to create better lives for themselves, their families and their communities. The CHWs self-reported that they were better able to address their own physical and mental health needs as well as the needs of their family and clients.

CHWs attained professional and career development from their work experiences. Their leadership status was also positively affected.

Focus group data provides another perspective on CHW interventions and environmental factors that contribute to mental health problems for immigrants. Client participants spoke highly of CHW services and appreciated assistance.

Data from a provider survey indicated staff and providers were satisfied with project services. CHWs were seen as valuable members of the clinical team and their work was regarded highly.

Client narratives illustrate the dedication and commitment of CHWs to improving the health of their clients. Personal accounts of struggles and

accomplishments help others to better understand the CHW interventions in mental health.

CHWs improved the quality of client care by increasing access to community and clinic services as well as providing culturally appropriate mental health services. CHWs use a personal, one-on-one approach to identify sources of stress that contribute to clients' depression. This approach combined with similar life experiences allows CHWs to have a deeper understanding of the mental health problems within their communities. This cultural knowledge proved critical in the design of focus group questions, adaptations of screening assessments and interaction with community based agencies and representatives.

CHWs face many challenges in their work. This thesis identified several themes related to obstacles. CHWs had difficulty clearly defining their personal and professional boundaries. CHWs expressed a great sense of responsibility to help their clients and often felt emotionally and physically stressed. It was difficult to meet the expectations of clients within the confines of a 9 to 5 work day.

CHWs also struggled to empower rather than enable their clients to make changes in their lives. CHWs strive to assist clients to solve problems independently, however many clients grew dependent on the CHWs to assist or accompany them.

Within the primary care system, CHWs expressed frustration with a lack of knowledge of their profession. Many other clinic staff did not understand their job roles and responsibilities. This led to misunderstandings about appropriate uses of CHW services and criticism of time management.

As members of the same ethnic communities served by the project, CHWs were often looked to for cultural guidance by other project and clinic staff. This input and guidance was positive but also carried the potential for misuse. CHWs described feeling frustrated at times that they were expected to be the cultural experts for their community. It was easy to oversimplify or misrepresent the experiences of individuals when relying on the opinion of one person.

Results of this thesis have implications for community-based agencies seeking to expand access to culturally appropriate health services through employment of CHWs. The personal experiences of both the CHWs and clients contribute to the understanding of the barriers and challenges faced by immigrants. This knowledge can assist in the design of programs and evaluations. This thesis highlights the importance of evaluating the impact of work on CHWs' health and well-being along with client outcomes. It also raises important questions about the dual roles played by CHWs in a biomedical system and the difficulty of delineating clear boundaries between work and personal time.

Limitations of Study

While these findings cannot be generalized to other CHWs or mental health programs, they suggest a number of hypotheses for further study. It would be useful to repeat some of the research with larger samples of CHWs and use more standardized questions rather than highly personalized qualitative research methods.

Another limitation is a lack of clear researcher roles. As a simultaneous graduate student and employee of the primary health care system, my position and objectivity were not always clear. This complicated research efforts at times and made analysis of results difficult. While my particular research focus was unique, separating my research results from those of the project was not possible. My research can be viewed as one component of a broader evaluation effort and the two were naturally intertwined.

While reflective of my research data, readers may see the findings as overly complimentary of CHW interventions and services. I tried to be objective in conducting the research and analysis. In the Multnomah County setting, the CHWs were very successful. In order to provide a more balanced perspective, future research could control for setting factors and look harder for critiques of the CHW intervention and explore alternative approaches to achieving similar results.

As in most research, more questions are raised than answered by this thesis. Future research into the work of CHWs should examine more fully the CHW impact on cultural competency of health care organizations. A very important topic is the review of Cultural and Linguistic Accountability Standards (CLAS) and the role played by CHWs to meet these standards. Other areas for expanded research include measuring impact of CHW interventions on a community level, and more specifically assessing how CHWs help to increase social capital. Areas of particular interest include how increased status and rank within the health system affects community trust and sense of CHW indigenesness.

Another topic for further investigation is CHW stress management. CHWs appear to suffer from a great deal of job-related stress due to the difficulty of separating personal and professional roles.

Lasting Impact for CHWs

The CHWs employed by this project have experienced incredible personal growth as a result of their work. Maria, Emilio and Victor have assumed leadership roles in their work places and communities. They have presented findings and lessons learned from this project at national conventions. They also served as train-the-trainers for thirty clinicians from across the state for the CDSMP program.

CHWs have also experienced personal empowerment as a result of their work. Maria has become a political activist in the Latino community and aspires to become a lawyer representing immigrants. She met presidential candidates and many other political activists. She continues to work with members of her community to improve health status on a daily basis, but also strives to make changes at a policy level.

Victor is working towards a doctorate in psychology. He is dedicated to improving mental health status for Russian immigrants. He has incredible resolve and inner motivation. He attributes his career choice and educational focus in psychology to his experiences with the project.

Emilio applies knowledge and experience from this project to his current work with homeless and indigent populations. He also feels more personally connected to his community and has lessened the sense of isolation he once felt.

In conclusion, I offer words from Maria who described the lasting impact of this project.

This project lives on in the lives of clients who remember the lessons they learned. They are hopefully teaching their families and children better ways to reach out to each other so they are not so lonely. They are helping their neighbors who come over to get help. Even though we don't work for the project any more, we have connected people to many resources and taught them how to take better care of themselves. And, we have empowered ourselves along the way (Personal Interview, 2004).

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APPENDIX 1: EVALUATION PLAN

Goal: Reduce racial and ethnic disparities in mental health services and outcomes by expanding the availability of mental health treatment services to Latino and Russian-speaker populations.

Domain	Activity	Outcome/Measure	Indicator/Data Source	Next Steps	Audience
1. Increase the identification of mental health problems within the primary care setting with a particular focus for Latino and Russian-speaking clients.					
Providers-PC Delivery System	Increase screening for Mental health problems	Increased MH diagnoses and treatment among target population	HIS Disease Registry	Gather baseline data	
Providers-PC Delivery System	Train providers in culturally appropriate strategies of disease self-management	Improved understanding of unique beliefs/worldview of target populations; increased awareness of manifestations for ethnic minorities	IAPCC; pre/post training surveys; training attendance/document ation ; self-assessment inventory; client satisfaction surveys; CHW surveys		
CHW	CHWs act as case-finders	Increased MH identification	CHW charting forms	Develop a tracking tool to distinguish PC clients from "new" clients	

Domain	Activity	Outcome/Measure	Indicator/Data Source	Next Steps	Audience
2. Expand the capacity of the community to provide culturally appropriate treatment and follow up care for Latino and Russian-speaking clients identified in PC.					
CHW/ Client	CHWs will follow up with clients identified as having mental health problems in the PC setting	# of clients served;	Charting forms; Disease Registry; HIS		

		# of home-visits;	Charting forms; Disease Registry; HIS	Revise charting forms	
		Increased % of clients with case-closed/successfully treated status	Disease Registry; Charting forms		
	CHWs will provide education, support, advocacy and health screening.	# of community group sessions/attendees;	Group tracking form; Disease Registry; satisfaction surveys; Focus groups related to group activities	Develop group tracking form (content; activities, attendees etc.)	
		# of referrals to other services/agencies;	Referral form	Identify referral possibilities; type of referral service	
		Improved health status;	SF-12		
		Increased client self esteem and self-efficacy/Achievement of goals	Surveys; client interviews	Determine if this is possible; validated instruments?	
CHW	CHW will receive extensive MH and self-management training	Increased knowledge and skills	Post initial training evaluation; ongoing training evaluation		Ongoing needs assessment?
		Increased job satisfaction	Interviews; focus groups: (Issues/barriers/successes)		
		CHW self-esteem/professional identity formation	Interviews; focus groups		
CBO	Hire two bilingual-bicultural mental health professionals who will	Increased capacity for and access to culturally-specific mental health treatment	Baseline data on current capacity: -Language/Ethnicity served -# of BH visits Monthly Reports:	Contact CBOs to determine if data is available; Develop	

	operate in MCHD Health Centers and in CBOs that serve Latino and Russian-speaking clients.		# clients served/month # NEW clients served/month #Undup.clients with age, gender, primary and secondary psy. Diagnoses and insurance Total # encounters Average # of encounters per client/month Average # of encounters per client/YTD	monthly CBO report form	
	Development of inter-agency/community partnerships to increase capacity of culturally appropriate BH services	Increased community capacity	Retrospective qualitative interviews/focus groups to measure change in community capacity	Identify all area agencies serving target populations	
	Provide case rate reimbursement to CBOs serving client referred from MCHD clinics.	\$ amount paid to CBOs	# of billable services Average amount per client > monthly CBO reports		

Domain	Activity	Outcome/Measure	Indicator/Data Source	Next Steps	
3. Incorporate culturally-appropriate screening, assessment and treatment of mental health problems within a more general model of Chronic Disease Mgmt.					
PC System/ Provider	Train staff and others in the Stanford Disease self-management program	Increased knowledge/ implementation of self-management model;	Self-management training assessment/evaluation;		
	Increase treatment of	Increased treatment Increase in	Disease registry		

	BH disorders for Russian and Latino clients	"successfully treated"			
	Train providers on importance of adherence to client follow-up protocol	Increased adherence to client follow-up protocol	Disease registry; HIS visit table; Protocol: moderate to severe depressed: followed up w/in 2 wks.		
	Refer clients to CBO MH therapists	# of referrals to CBOS	Referral form		
	Refer clients to CHWs	# of referrals to CHWs	Referral form; provider/CHW surveys	Determine referral process	
Client/ Provider	Administer PHQ test at 3, 6, 12 month frequency	50% of clients have improved PHQ score	Disease Registry		
Client	Completion of self-management plan	% of clients with completed/updated plan; % of kept appointments	Disease Registry; Focus groups		
		Increased participation in clinic group sessions	Disease registry		
System	Increase organization cultural competence through trainings, hiring of CHWs	# of CHWs hired	HR records		
		Demographic composition of CHW	HR records		
		Increased staff diversity	HR records; surveys of clinic staff		

APPENDIX 2: COMMUNITY HEALTH WORKER TRAININGS

CHW Capacitation Training – Spring 2002 Multnomah County Health Department Community Capacitation Center

Skill Base

Skill Base courses are derived from the list of roles and competencies identified for CHWs/promotores in the National Community Health Advisor Study. Each Skill Base course is designed to enhance competency in one essential area of CHW practice. Therefore, we recommend skill base courses for all CHWs, regardless of the health area(s) in which they are working.

Introduction to Popular Education

Wendy Coppage, CHW, and Noël Wiggins

Popular Education is a way of thinking about and practicing education that is aimed at creating more just and equitable communities. Originally developed by Brazilian Paulo Freire, it grew out of the same historical roots that produced the model of promotores de salud (health promoters) throughout Latin America. In this workshop, participants will come to understand the critical link between Popular Education methodology and the CHW profession. They will develop the ability to use key methods of Popular Education, and be able to explain the philosophical ideas that underlie these methods. By increasing their understanding of the historical realities that produced Popular Education, they will enhance their ability to use it to strengthen their communities.

Date and Time: Friday, March 1, 8:30-4:30

Location: North Portland Health Center

Communication Skills

Lucrecia Suárez, MSW

Because CHWs' work depends on building trust and maintaining relationships, good communication skills are essential. Further, strategies for effective communication are important tools CHWs can pass on to community members. In this session, participants will increase their understanding about the basic elements of communication. They will develop greater appreciation for the role of feelings in the

communication process. Finally, they will learn strategies for communicating non-violently.

Date and Time: Tuesday, March 4, 8:30-12:00

Location: St. Michael and All Angels Church (see directions below)

Counseling Skills

Lucrecia Suárez, MSW

In this introduction to the counseling process, the facilitator will help participants understand how the counseling process is based on 2 main foundations: rapport and trust. By the end of the workshop, participants will be able to define both rapport and trust and identify two key elements of each. They will also be able to name 3 key components of the contracting process and know how to develop a contract (work plan) with the community members with whom they work.

Date and Time: Monday, March 18, 8:30-12:00

Location: St. Michael and All Angels Church

Outreach Skills

Hilton Levias, CHW, and Julie Goodrich, CHW

People outside the CHW field frequently use the word “outreach” as though it were one simple activity. In reality, however, “outreach” can be done in many ways and in many settings. In this workshop, participants will become familiar with some of the most common ways of conducting outreach. By the end of the session, they will be able to: 1) Demonstrate 3 outreach skills; 2) Describe 2 ways of establishing credibility; 3) Identify 2 agency referrals; and 4) State 2 reasons it is important to acknowledge differences when serving community members. The workshop is facilitated by two experienced CHWs, one an expert in street outreach and the other an expert in home visiting.

Date and Time: Friday, April 5, 9:00 –12:00

Location: St. Michael and All Angels Church

Self-Care Skills

Julie Goodrich, CHW, and Patricia Navin, RN

On a daily basis, CHWs are confronted by painful and unjust situations including poverty, racism, family dysfunction, illness and death. As members of the communities they serve, it can be especially challenging for CHWs to develop and maintain the boundaries they need to keep themselves healthy as they do their work. In this workshop, participants will become more aware of how their personal and professional histories affect them and their performance on the job. They will identify and discuss issues inherent in CHW practice that may “push their buttons”

or trigger unwanted emotional responses. Finally, they will name and practice 3 strategies for remaining emotionally, physically and spiritually healthy.

Date and Time: Wednesday, March 13, 8:30-12:00

Location: North Portland Health Center

Orientation to the Health and Social Service System

Wendy Coppage, CHW

Historically, one of the most important roles played by CHWs/promotores is that of bridge between their communities and the health and social service profession. In order to play that role effectively, it is essential that they have opportunities to become more familiar with aspects of the system and how to navigate it. Orientation courses are designed to help CHWs/promotores develop that familiarity.

Orientation to the Mental Health Disparities Project

Mark Spofford, PhD

To begin to understand the scope of the work it is important to learn about the theoretical, and practical issues which created the Mental Health Disparities Project, where did the idea come from for this project? How will it be accomplished? What are the goals? These questions and more will be addressed.

Date and Time: Monday, February 25, 1-5

Location: McCoy Building, 8th Fl, Room A

Chronic Care Model

Mark Spofford, PhD

The Chronic Care Model and its applicability to this project will be the focus of this session. More specifically, how can this patient centered approach to healthcare be of benefit to the people we serve and how can Community Health Workers help with this model? The use of registries, planning, outreach and patient self management will be introduced in this session.

Date and Time: Tuesday, February, 26, 2-5

Location: McCoy building, 9th Fl, Room A

Evaluative Training

Oona McNeil

This session will address how evaluative methods will be applied to the project and how they can help with a Quality Assurance/Quality Improvement plan. The role of Community Health Workers as key players in carrying out specific tasks (encounter forms, progress notes, intake data) to support this work will be highlighted.

Date and Time: Wednesday, February 27, 9-11

Location: McCoy building, 9th Fl, Room A

Social Justice Roots of the CHW Model

Teresa Rios, CHW, and Noël Wiggins

Historically, CHW/promotora programs have been a response to the systematic denial of health care to populations around the world. They have been efforts to help people improve their health by gaining more control over their lives. In this workshop, participants will increase their awareness about the social justice context in which they do their work. By the end of the session, participants will be able to: 1) Provide a definition of “social justice”; 2) Identify 2 political roles that CHWs have played; 3) Name 2 reasons why CHWs are especially able to help communities work for social justice; and 4) Explain 2 differences between liberating practice and maternalistic/paternalistic CHW practice.

Date and Time: TBA

Introduction to Public Health

Noël Wiggins, MSPH

CHWs/promotores have played a vital role in the U.S. public health system for over forty years. Nonetheless, their role has frequently been misunderstood and overlooked by other public health professionals. Some CHWs themselves have been largely unaware of the larger system of which they are a part. In this workshop, CHWs will have the opportunity to: develop familiarity with the “core functions” of public health; learn about differences between the medical system and the public health system; identify key public health agencies; and define and apply a public health approach to solving health problems. Finally, they will be introduced to the CHW Special Primary Interest Group (SPIG) of the American Public Health Association (APHA). The CHW SPIG is responsible for representing the interests of CHWs within APHA.

Date and Time: Monday, March 4, 8:30-12:00

Location: St. Michael and All Angels Church

Depression and Anxiety

Graham Harriman, MA, LPC

We will explore some of the common symptoms of depression and anxiety along with some helpful skills to use with patients who are experiencing these diagnoses. Also highlighted will be how to handle issues of suicidal/homicidal ideation. And how to handle crises which may be encountered with people who are experiencing a high level of distress. The last part of this session will address Self Management Plans and the administration of the PHQ and its relevance to this project.

Date and Time: Tuesday, March 5, 1:30-5

Location: McCoy Building, 8th Fl, rm A

Introduction to the Depression Registry

Mark Spofford, PhD, Oona McNeil

This session will help the CHWs to learn the basis and principles of the depression registry while learning some of the key queries and forms which will be crucial to the work. Time for input and questions is allowed and valued.

Date and Time: Thursday, March 7 9AM-12 Noon

Location: McCoy Building, 8th Fl

Safety Issues for CHWs

Julie Goodrich, CHW, and Teresa Rios, CHW

An important part of orientation for any CHW is an orientation to the possible risks and dangers s/he may encounter in the course of her/his work. In this workshop, participants will identify potential dangers and learn ways to keep themselves safe in a variety of settings. Both facilitators are experienced CHWs and between them have over 20 years of experience in the field.

Date and Time: Monday, March 11, 8:30-12:00

Location: St. Michael and All Angels Church

Orientation to Case Management and Social Work

Becca Surls, LCSW, Clara Welch, MSW and Lavaun Heaster, LCSW

It is crucial in the work of CHWs that they be aware of the systems that support the mental health needs of patients. This time will focus on the role of case management, social work, and other mental health providers. There will also be time to discuss how the community health workers will complement the existing mental health services.

Date and Time: Thursday, March 7, 3-5PM and Friday, March 8, 9-12:30PM

Location: McCoy Building, 8th Fl, rm A

Domestic Violence

How to respond to mental health symptoms commonly experienced by domestic violence victims/survivors, such as depression, anxiety, and post traumatic stress disorder will be covered in the March session. A panel of local experts will address housing issues facing domestic violence victims/survivors and provide an overview of housing programs in the Portland region in the April session.

Date and Time: Tuesday, March 19, 10-12 and April 16, 10-12

Location: Southeast Clinic

Confidentiality

This training will address the importance of confidentiality in working with patients. Laws and policy governing information from field visits and from medical charts will be addressed.

Date and Time: Wednesday, April 3

Location: McCoy, 9th Fl, rm A

Mentor Matches

Vera Samoylenko, Ruby Ibarra, Teresa Rios

Mentors will allow individual time for the new CHW to spend time observing home visits, processing duties, and receiving support for their new roles. These relationships are crucial in building a sense of direction for the work while also allowing for a development of comradery among CHWs. Each new CHW will have a minimum of 6 hours of mentor time in the training process.

Site Visits

We will visit each site which is involved in this program to begin to learn how Primary care services are delivered, learn the roles of different staff members involved, and introduce Community Health workers into Primary care services.

East County Clinic Thursday, February, 28, 1-3PM

La Clinica de Buena Salud Wednesday, February 27, 3:30-5PM

Southeast Clinic, Wednesday, March 6, 9AM-12noon

MidCounty Clinic, TBA

Rockwood, Monday, March 18, 1:30-3:30PM

Health Issues

In order to be effective in their work, CHWs need to become well versed in a variety of health topics. Usually, they need to develop in-depth knowledge in the health issue area(s) in which they will work, as well as general familiarity and knowledge of resources in other health topics.

Introduction to Chronic Diseases: Diabetes

Teresa Rios, CHW, and Judy Becher, NP

Recent research is confirming what many health professionals have long known: there is a close tie between both the causation and treatment of chronic diseases and mental health issues. In this workshop, participants will become familiar with diabetes, one of the most common chronic diseases in many communities of color. By the end of the workshop, they will be able to: 1) Name the 3 types of diabetes; 2) Identify 3 risk factors, symptoms, and complications of diabetes; 3) Name 3 things to consider to successfully manage diabetes; and 4) Educate others about the basics of diabetes. Teaching methods used include The Diabetes River, a technique developed by the facilitator that has been successfully used throughout the U.S.

Date and Time: Thursday, March 14, 2002

Location: St. Michael and All Angels Church

APPENDIX 3: TIMELINE OF THESIS ACTIVITIES

2002

January: Hired as evaluation assistant for SAMHSA grant project

Jan-March: Participate in interviewing and hiring three project CHWs

Jan-June: plan, develop and implement evaluation tools for project

April: conduct evaluation workshop for project CHWs

May: begin collecting CHW personal and client narratives

August: interview project manager and staff re: project progress

2003

January: develop provider survey

February: develop client focus group questions

April: administer provider survey

June: resign from position and move to Maryland

2004

August: conduct semi-structured interviews with project CHWs, staff

Sept-November: transcribe and code interviews

Nov- December: cross-check and clarify data with CHWs

2005

Jan-August: write master's thesis

September: defend master's thesis

APPENDIX 4: INTERVIEW GUIDE

Personal story/history:

Tell me about your life in Mexico/ Russia;

Why did you decide to come here?

What were some of your biggest challenges when you came?

How life experiences have shaped their career paths?

How have your own life experiences influenced your decision to become a CHW?

CHW:

What lead you to become a CHW?

What do you feel makes you qualified?

What is your definition of a CHW? How do you fit into this definition?

What does it mean to you? Are there social, political, justice issues?

How has your definition changed since you began working on this project?

Professional identity:

How do you define yourself professionally?

Changes since becoming CHW in this project:

Personal – family, health

Please describe some the areas in your life that have been affected by your profession. How have they changed?

Knowledge/Skills/Education:

Tell me about changes in your skills, education.

What about the trainings you've received- what has been most useful for you?

What would you have liked more training in?

Community awareness/involvement: Please talk about changes in these areas:

Mental health: Have your notions of mental health changed? How so?

Peer relationships- changes in way you relate to people in your community?

Unique role within Mental Health

Why are CHWs important? What can they contribute that others' may not?

What has been the greatest learning in this project?

What is your most important role?

Impact on clients

MCHD/organizational impact?

Greatest challenges?

Personal reflections on the project:

Did goals of project meet actual needs of clients as you perceived them?

Definition of “community”; notion of “token” cultural expert- did you feel that your views were presented as the voice of majority? Were you comfortable with this?

Did you feel able to share your views or disagreements with project staff?

Did you feel that your input was valued?

Do you feel that you represent a community?

What are you most proud of?

What was the hardest thing for you to do?

How has this experience changed you most?

Where do you see yourself in 5 years?

Stressors/motivators

Lessons for incorporating experiences and voices of employees into research grant evaluations; participatory research

APPENDIX 5: PROVIDER SURVEY QUESTIONS



Mental Health Disparities Provider Survey

Instructions:

Please select the answer that most accurately represents your views.

1. Please indicate which clinics you serve:

East County--- Mid-County--- Southeast---Northeast---
North---La Clinica

2. How familiar are you with the Mental Health Disparities project?

Very familiar -----Familiar -----Somewhat familiar -----Not familiar

3a. If your clients have used project services, which services have they used?

Check all that apply:

- ☐ Chronic Disease Self-Management Group
- ☐ Community Health Worker Home/Community visit
- ☐ Community Health Worker Office visit
- ☐ Mental Health Therapist visit
- ☐ Other

3b. If your clients have used services, approximately how many referrals have you made to a Community Health Worker or project therapist?

1-5 6-10 11-15
16 or more

4. How difficult has it been to identify clients who may benefit from assistance of Community Health Workers or therapist?

Very difficult-----Difficult-----Somewhat difficult-----Not difficult ---Easy

5. If your clients have used project services, what type(s) of feedback have you received from the CHW and/or therapist regarding client care? Check all that apply.

- ☐ Chart notes
- ☐ Informal in-person conversations
- ☐ Regularly scheduled case management meetings
- ☐ I do not receive feedback
- ☐ Other: _____

6. Please rate your preference for receiving feedback:

1- highly preferred 2- preferred 3- somewhat preferred 4- not preferred

- ☐ Chart notes
☐ Informal in-person conversations
☐ Regularly scheduled case management meetings
☐ Other: _____

7. Community Health Workers are perceived as valuable members of the clinical support staff.

Strongly Agree-----Agree-----Disagree-----Strongly Disagree

1. Please rate the usefulness of Community Health Worker roles:

1- most useful 2- useful 3- somewhat useful 4- not useful

- ☐ Providing cultural mediation between clients and health and human services system.
☐ Offering mental health and health education to individuals and families.
☐ Leading the Chronic Disease Self-Management Program for clients
☐ Providing home visits to at risk/vulnerable clients
☐ Assisting clients to receive the services they need
☐ Monitoring clients' self-management adherence and response to treatment
☐ Conducting health screenings procedures (e.g. PHQ)
☐ Other _____

2. What would better help you address the physical and mental health needs of Latino and Russian-speaking clients?

10. Overall, how satisfied are you with the services provided by:

a. Community Health Workers

Very Satisfied-----Satisfied-----Somewhat Satisfied-----Not Satisfied-----No Knowledge

b. Project bilingual therapists

Very Satisfied-----Satisfied-----Somewhat Satisfied-----Not Satisfied-----No Knowledge

c. Chronic Disease Self-Management Program

Very Satisfied-----Satisfied-----Somewhat Satisfied-----Not Satisfied-----No Knowledge

11. Please provide any suggestions or comments that will help us improve this project.

APPENDIX 6: FOCUS GROUP GUIDE/QUESTIONS

Spanish Focus Group Guide

Life Context and Experiences of Migration

1. How long have you lived in Portland?
2. Tell us what your life in Portland is like compared with where you lived before.

Settlement and Stresses

3. Describe some of the challenges that people from Latin American countries face during the first year that they are in the US. (explore health if it comes up)
4. What was the most difficult thing for you about living the US the first few years that you were here?

Finding Help

5. When you moved to the US what helped you to adjust? What else would have made your adjustment easier if it had been available? What things do you still struggle with?
6. (moderator: listen to what they are struggling with in #6.) Then pull their words into the question: What things do you do to help yourself when you feel _____ (such as depressed, lonely, sad, or anxious)?
7. What organizations or agencies helped you with some of the challenges of living here? (give some examples if needed). What kinds of assistance did they provide? What were the most helpful?
8. How did each of you find out about the Health Department clinics?
10. What services have been the most useful for you?
11. Please describe what it is like when you come to the clinic. How do you feel when you come?
12. Is there anything else you would you like to share?

Russian/Ukrainian Focus Group Guide

Life Context and Experiences of Migration

1. We would like to hear from everyone, how long have you lived in Portland?
2. Tell us what Portland is like compared with where you have lived before.

Settlement and Stresses

3. Describe some of the obstacles that you or other people you know experienced in the first year coming from the Ukraine and Russia (explore health if it comes up).
4. What were the most difficult things for you about living in the US the first few years that you were here?

Finding Help

5. When you moved to the US what helped you adapt or get used to life here? What would have helped you more?
6. What organizations or agencies helped you to overcome some of the obstacles of living here? (Give examples if needed) What kinds of assistance did they provide?
7. How long you have been coming to a Health Department clinic?
8. Besides medical services, what other services are available from the clinic that you are aware of? What services have you used? Which ones helped you the most?
9. When you felt worried or anxious about something or you were in a bad mood, how did your Community Health Worker help you? Can you think of any other way that they could have helped you?
10. Do you feel like the doctors working in the clinics help you to solve some of your problems? If so, how? If not, how can they better help you?