An ethnography of clinic "noise" in a community-based, promotora-centered mental health intervention

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Abstract

Community-based health interventions have emerged as a growing focus for anthropological research. The application of ethnographic approaches in clinical practice settings reveals that community-based interventions must grapple with "noise," or unanticipated factors such as patients' own perceptions of illness and treatment, primary care providers' non-adherence to guidelines-based treatment, the social dynamics of the clinic site itself, and incomplete understanding and acceptance of an intervention by a clinic's staff members. Such noise can influence the implementation and quality of treatment. Thus, identifying clinic-based noise is critical in assessments of fidelity to intervention protocols as well as outcomes of community-based interventions. This paper highlights findings from an evaluation of a mental health intervention focusing on the role of *promotoras* (briefly trained, non-professional community health workers) as mental health practitioners in two urban New Mexico, USA, community health centers. Our research identified three areas of clinic-based noise: the clinics' physical ability to "absorb" the intervention, the challenges of co-worker instability and interpersonal relationships, and balancing extra workplace demands. The findings demonstrate the value of ethnographic approaches in community-based intervention research.
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Introduction

Community-based health interventions have emerged as a growing area of concern for anthropological research. Scholars from diverse fields have recognized that ethnographic methods constitute a "powerful set of strategies that research funding agencies and health services researchers can use to meet the challenges of the health care environment of the twenty-first century" (Rundall, Devers, & Sofaer, 1999). Recent ethnographic evaluations of community-based interventions have focused principally on HIV/AIDS outreach (Bourgois & Bruneau, 2000; Dickson-Gómez, Knowlton, & Latkin, 2003; Sterk, 2002), drug and alcohol use (Nichter, Quintero, Nichter, Mock, & Shakib, 2004), and physical activity and diet (Brett, Heimendinger, Boender, Morin, & Marshall, 2002). Researchers have used ethnographic approaches for some time to study mental health service delivery (Bolton &

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Tang, 2004; Donald, 2001; Hopper, Jost, Hay, Welber, & Haugland, 1997; Kirschner & Williams, 2001; Robins, 2001; Santiago-Irizarry, 2001). Although some ethnographic research has explored the theoretical and empirical importance of spatial and interpersonal relationships in health and/or mental health services (Ventres et al., 2006; Ware, Tugenberg, Dickey, & McHorney, 1999; Ware, Tugenberg, & Dickey, 2003), analogous to prior research in work organizations (Baba, 1999), these efforts generally have not addressed the potential contribution of non-professional community health workers for mental disorders such as depression.

Mental health researchers increasingly are moving in the direction of more inclusive, community-based research (Bruce, Smith, Miranda, Hoagwood, & Wells, 2002; Hohmann & Shear, 2002; Wells, Miranda, Bruce, Alegría, & Wallerstein, 2004). For instance, recent research substantiates the value of interventions for depression in primary care for minority and other underserved populations (Miranda et al., 2005). In the Partners in Care (PIC[1]) Study, coordinated by Wells and colleagues, psychotherapy-enhanced programs improved outcomes for Latino and African American patients and reduced outcomes disparities (Wells, Sherbourne et al., 2004). Evidence-based treatment of depression proved equally effective in reducing depression for minority and non-minority patients. However, improved functional outcomes of care such as continued employment were less evident in minorities (Miranda, Schoenbaum, Sherbourne, Duan, & Wells, 2004). Based on the same data, Miranda et al. reported that modest modifications of interventions for minority patients, such as translations and cultural training for clinicians, led to substantial improvements (Miranda et al., 2003). Additional research in primary care, such as that conducted by Katon and colleagues, has assessed the impact of other interventions targeting mental health (Bush et al., 2004). In the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study, collaborative services in primary care proved more effective than usual care for depressed older patients (Hegel et al., 2005).

Because community-based interventions take place in real-world settings—unlike clinical trials,

which are designed to test an intervention in a more controlled environment—their implementation can prove particularly challenging. Community-based interventions must grapple with what Hohmann and Shear (2002) refer to as "noise," which they describe as unanticipated factors such as patients' own perceptions of mental illness and treatment, primary care providers' non-adherence to guidelines-based treatment, and the social dynamics of the clinic site itself. Such noise can impact the implementation and quality of treatment. Within the clinic site, Hohmann and Shear (2002) identify such variables as patient flow, staff organization, personnel chaos, and organizational culture and climate as exerting potential impacts on interventions. Ethnographic methods provide a useful way to study the crucial problem of community- and clinic-based noises.

We conducted a multi-method evaluation of a mental health intervention centered in two urban New Mexico (United States) community health centers (CHCs) and focusing on the role of *promotoras* (briefly trained, non-professional community health workers) as mental health practitioners. For the study, we asked two focused research questions that previous research, to our knowledge, had not yet answered: (1) As assessed by ethnographic methods, what processes foster or impede a *promotora*-based intervention addressing depression in primary care, suitable for dissemination to other CHC settings? (2) As assessed by quantitative study of outcomes and by ethnographic methods, how well can an intervention involving *promotoras* address depression among patients who utilize CHCs? We believe that our project comprises the first evaluation of *promotoras* as mental health practitioners focusing on depression.

In this paper, we present findings from the study's ethnographic component. (A second article reports quantitative findings regarding the intervention's impact on depression and contextual sources of depression.[2]) Ethnographic methods, utilized continuously during the project's two-year duration, proved valuable in identifying the clinic-based

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[1]We have used the following abbreviations throughout the paper: CHC: community health center; MMC: Medicaid managed care; PIC: Partners in Care study; UNM: University of New Mexico; PCP: primary care practitioner.

[2]Not yet published, the second article presents quantitative findings that show the intervention's mixed impact. Some indicators of depression and contextual sources of depression favored the *promotora* intervention, while others did not. Clinic "noise," analyzed in the current article, provides a partial explanation for the intervention's not exerting a more consistently favorable impact.

"noise" that affected the project's implementation and outcomes. To understand the intervention's context, we first briefly describe specific challenges of health care delivery in New Mexico. We then examine the potential utility of *promotoras* as paraprofessional mental health providers in primary care settings and outline our *promotora*-centered mental health intervention developed to address depression among underserved populations. After detailing our methodology, we turn to the research findings and illustrate how the spatial and social environment of the CHCs affected the intervention's implementation. Specifically, we highlight several dimensions of clinic "noise" that complicated the intervention. We next offer recommendations for incorporating community-based interventions into the primary care setting, drawing from our ethnographic observations, and suggest productive directions for ethnographic evaluations of such interventions.

New Mexico: a challenging context

New Mexico exemplifies a particularly difficult context for physical and mental health service delivery. The state recently has ranked 47th among the 50 states in personal income per capita ($24,291), 3rd in persons below the poverty level (18.4%), 2nd in lack of health insurance (22.1%), and 1st to 11th in unemployment, reflecting the economy's volatility (US Census Bureau, 1999, 2005a). In a population of 1.8 million, approximately 21% have held Medicaid coverage (US Census Bureau, 2005a). Hispanics and American Indians make up 51.6% of the state's population (US Census Bureau, 2005b). Of the state's 33 counties, 32 contain federally designated Health Professional Shortage Areas and/or Medically Underserved Areas (US Health Resources and Services Administration, 2006).

In addition, the prevalence of mental health disorders is high. According to the state government's mental health statistics, approximately 370,000 adults—one fifth of the state's population—manifest at least one disorder; about 71,000 adults suffer from serious mental illness (Technical Assistance Collaborative Inc., 2002). The state's drug- and alcohol-induced death rates per population rank 1st and 2nd highest respectively in the United States, the suicide death rate ranks 5th highest, and the homicide death rate ranks 6th highest (Morgan & Morgan, 2005). These mental health outcomes disproportionately involve Hispanics and American Indians (Landen, 2001).

The state's decision to implement Medicaid managed care (MMC) in July 1997 heightened the challenges of health care delivery. MMC reflects the growing trend in the United States toward privatization of health care, in which governments utilize for-profit managed care organizations (MCOs) to manage services for Medicaid recipients (Horton, 2004). Proponents of MMC embrace an emerging paradigm, often termed neoliberal, in which privatization of services becomes an effective way to reduce the costs of health and social services (Horton, 2004; Waitzkin, 2001). Practically, MMC has restricted the care available to vulnerable populations in New Mexico, such as uninsured patients and undocumented immigrants (Boehm, 2005; Horton, 2004; Waitzkin et al., 2002). Safety-net institutions that serve these vulnerable populations have "buffered" this unintended impact, which has created increased workloads for providers and staff, as well as financial stress for these institutions (Lamphere, 2005; Waitzkin et al., 2002). In effect, safety-net institutions have subsidized the MMC program financially and administratively by taking on roles formally assigned to MCOs (Boehm, 2005; Lamphere, 2005). Regarding mental health specifically, MMC has reduced the availability of mental health services (Waitzkin et al., 2002; Willging, Waitzkin, & Wagner, 2005) and has shifted responsibility for these services from the state government and its corporate partners to frontline service providers (Willging, 2005).

Promotoras in primary care

Within this challenging health delivery context, an interdisciplinary team based at the University of New Mexico (UNM) designed an intervention to address social and contextual sources of depression among a predominantly ethnic and racial minority population in the primary care setting. Such settings comprise an important gateway to mental health treatment, since patients tend to seek help in primary care rather than in specialty mental health care (US Department of Health & Human Services [USDHHS], 2004; Miranda, Lawson, & Escobar, 2002; Vega, Kolody, & Aguilar-Gaxiola, 2001). Because major disparities in mental health services affect ethnic and racial minority groups, many authorities have called for improved access to primary care as a portal to mental health diagnosis

and treatment for depression in these groups (USDHHS, 2004; Wells, Miranda et al., 2004).

In our project, university-based researchers collaborated with a major network of CHCs to develop an innovative intervention in which *promotoras* would work as integral members of the primary care team at two specific CHCs within the network. Authorities such as the US Surgeon General recognize the use of *promotoras* as a promising, if largely untested, strategy to reduce barriers to mental health services (Surgeon General, 2001). The *promotora* model enhances services for under-served persons, while offering a link between patients and primary care practitioners (PCPs) (Hanscom, 2001; McElmurry, Park, & Buseh, 2003). In Latin America and the United States, nearly 30 titles refer to CHWs, including *promotoras de salud* (Spanish for health promoter), community health advocates, outreach workers, indigenous health workers, lay health educators, community health aides, and lay health workers (McElmurry, et al., 2003). The idea that promotoras facilitate trust, understanding, and empathy with patients because they come from similar backgrounds has remained untested in CHCs that try to address mental health problems.

Some observers might criticize the *promotora* model from various viewpoints. For instance, encouragement of non-professional roles like that of *promotoras* might appear to conform to a "neoliberal" strategy of substituting less trained for more trained professionals, thus "deskilling" the health care labor force (Castro & Singer, 2004; Nelson, 2005; Rylko-Bauer & Farmer, 2002). However, in our own and most previous accounts of *promotoras*' roles and activities, *promotoras* have assisted people in navigating and obtaining services to which access otherwise would remain limited and therefore have contributed to empowerment of patients and communities.

While existing studies reinforce the rationale for incorporating *promotoras* into primary health care teams (Hanscom, 2001; McElmurry, et al., 2003), no research to our knowledge has examined the specific role that they might play in the identification and treatment of patients with depression. Nor have prior studies assessed the contribution of *promotoras* to such issues as cost-effectiveness and quality assurance in depression care. Our study aimed to determine whether and to what degree the introduction of *promotoras* after brief training into the primary care setting would improve depression care,

partly by helping patients address some sources of depression in their social context.

Methods

Overview

To assess the utility of *promotoras* as mental health practitioners, the UNM team and a network of CHCs developed a multi-method research project that aimed to offer a culturally sensitive approach to diagnosing and treating depression among under-served patients, especially Hispanics/Latinos.[3] Because of his interest in expanding the role of *promotoras*, the chief executive officer of the CHCs initiated the project and entered into dialogue with the university-based research team. In planning the project and in obtaining funds from a major foundation, administrative and clinical leaders of the CHCs met over a one-year period with leaders of the research team. Two CHCs (which we call Rio Grande and Sandia) within the same non-profit network comprised sites for this intervention research. Prior to the project, neither site employed mental health practitioners on a regular basis. The *promotora*-centered project aimed to bring mental health services to the CHCs in an organized manner for the first time. As the funded project began, leaders of the CHCs and research teams held organizational meetings with PCPs, nurses, nursing assistants, and other personnel at the participating CHC sites; these additional people had not participated earlier in planning the intervention. The project began in July 2003 and continued through June 2005.

The CHCs recruited two high-school educated, bilingual *promotora*s (one female and one male, whom we will call Lisa and Marcos) from the local community. Recruited directly from the CHC system, Lisa had been working as a receptionist at the Sandia site for approximately one year before the project began. Marcos, however, had never worked in a medical setting, having been previously employed as a security guard. Both *promotoras* participated in training sessions on depression and other mental health disorders; ethics and values in research studies; research objectives; basic principles

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[3]Following Guarnaccia and Rodríguez (1996, p. 434), we approach the label "Hispanic/Latino" cautiously, taking into account the intra-cultural diversity of people subsumed under that descriptor.

of professional behavior in medical settings; the patient recruitment process; fundamentals of interviewing; and mobilizing local resources for patients. The *promotoras* also completed training on patient privacy and confidentiality, as part of required procedures at the CHCs and through the university's human subjects institutional review board; later ethnographic observations showed that the *promotoras* firmly upheld these standards in their interactions with patients. After this approximately one-month educational orientation, *the promotoras* conducted standardized interviews with patients, organized and maintained databases, and attended bi-monthly research team meetings. Two physicians on the research team—a psychiatrist and a general internist with a focus on psychiatric problems in primary care—provided supervision and support for the *promotoras* on an ongoing basis.

At the beginning of the intervention, the *promotoras*, PCPs, nurses, medical assistants, and receptionists also participated in a brief series of training sessions. For this training, a psychiatrist on the research team developed a detailed curriculum regarding the clinical features, causes, and treatment guidelines for depression, partly based on a curriculum developed in a mentorship program focusing on mental health services research training for junior minority faculty members and graduate students (Waitzkin, Yager, Parker, & Duran, 2006). The training included sample case vignettes for teaching and discussion about depression in primary care. At the training sessions, PCPs considered and helped refine the procedures that they would use in interacting with the *promotoras*. These training sessions also addressed the principles of privacy and confidentiality that applied to the PCP-*promotora* interactions. The consent forms, required for patient participation, also emphasized confidentiality and comprised a focus of the training sessions, as did a review of the CHCs' standard confidentiality expectations for all interactions with patients.

The intervention algorithm

Procedurally, the intervention unfolded in the following way. In the algorithm that guided the intervention, the *promotoras* randomly selected (with a table of random numbers) and recruited patients who had come into the CHC for an appointment with a PCP and who were not already under treatment for depression or anxiety. After

gaining the patient's consent, the *promotoras* administered a structured interview that consisted of 16 instruments, including the well-validated Primary Care Evaluation of Mental Disorders (PRIME-MD) Patient Health Questionnaire (PHQ), which served as the main diagnostic tool for identifying depression (Kroenke & Spitzer, 2002; Rost & Smith, 2001; Spitzer, Kroenke, & Williams, 1999). The PHQ assesses threshold diagnoses of major depressive disorder, panic disorder, other anxiety disorder, and bulimia nervosa (corresponding to the *Diagnostic and Statistical Manual*, 4th Edition (DSM-IV)); and sub-threshold disorders (encompassing fewer symptoms than required for specific DSM-IV disorders) of other depressive disorder, probable alcohol abuse or dependence, and somatoform and binge eating disorders. These instruments were extensively validated in clinical settings and in a variety of languages, including both English and Spanish.

After completing the interview with the patient, the *promotoras* delivered the PHQ diagnoses to the PCPs, and the PCPs made their own clinical assessments of the patient's mental health status. The *promotora* and PCP then jointly developed a treatment plan for patients with "major depressive disorder" and "other (sub-syndromal) depressive disorder," based upon the PCP's understanding of "best practice" guidelines for medication and counseling.

Our quasi-experimental design focused on social and contextual sources of depression. The training, intake interview with patients, and *promotora*'s consultation with the PCP took place at both intervention and augmented intervention sites. At the augmented intervention site, however, the *promotora* also assisted the patient in addressing contextual sources that contribute to depression, such as housing problems, inadequate food, unemployment, and violence/trauma. We chose these contextual challenges because much research has identified them as determinates of depression but, to our knowledge, no prior research had tried to study an intervention in primary care to address these specific sources of depression. The *promotoras* worked closely with patients to identify and to access local resources, such as housing programs, food banks, employment programs, and domestic violence shelters. Because they focused only on addressing the contextual sources of depression, the *promotoras* did not assume an overall function of care management. The *promotoras* therefore

differed from care managers in nursing or social work, who address a wider range of functions including medication management or psychotherapeutic counseling.

After the initial visit, the *promotoras* followed up with patients from the augmented intervention site on a monthly basis to determine if they had successfully accessed local resources and if they needed additional assistance. The *promotoras* then shared this information with the PCPs, both verbally and through written reports placed in the patients' files. At four- and eight-month intervals, the *promotora* re-contacted the patients at both sites to re-administer the interview and to re-assess the patient's depression. Analysis of quantitative data from the baseline and two follow-up interviews allowed the UNM research team to determine whether the *promotoras'* assistance enabled patients from the augmented intervention site to address effectively the contextual factors that affected their depression.

Ethnographic methods

Anthropologists served as core team members in the intervention and conducted ongoing ethnographic research throughout the two years of the project. Participant observation and semi-structured interviews comprised the principal ethnographic methods by which the ethnographers assessed fidelity (the degree to which the algorithm was implemented as intended) and perceived value of the intervention. Ethnographic research occurred in three phases that corresponded to the completion of the intake, four-, and eight-months interviews.

Participant observation enabled us to evaluate the implementation process as well as to observe interactions between the *promotoras* and the PCPs, patients, and other co-workers. Four anthropologists completed more than 200 h of participant observation at the two CHC sites. Observations, which took place during 4-h periods of time, focused on interactions that involved PCPs, patients, *promotoras,* and staff members. The ethnographers "shadowed" the *promotoras* as they went about their workdays. In order to capture the breadth of experiences at both CHC sites, we randomized (through a table of random numbers) observation periods by ethnographer, *promotora* observed, CHC site (augmented intervention or intervention), day of the week, and time of day (morning or afternoon shift). The ethnographers

took extensive field notes during these observation periods and then inputted the field notes into NVivo,[4] a software package for iterative coding and data analysis. The ethnographers met staff members at the clinics during training sessions held to familiarize staff about the project. Clinic staff accommodated and tried to assist the ethnographers. Mainly because the ethnographers participated at the clinic on only a part-time basis, they generally did not develop deeper relationships that may have emerged from a more full-time presence.

In-depth interviews with primary stakeholders (patients, PCPs, and *promotoras*) allowed the evaluation team to assess barriers and facilitators that influenced fidelity to the algorithm and overall intervention implementation as well as its perceived value. Interview guides followed a standardized structure, tailored to capture the experiences of each respondent group. The ethnographers interviewed both *promotoras* and a random selection of PCPs and patients. At the two CHC sites, interviews took place in break rooms, conference rooms, and PCP offices. In all, we conducted 35 structured interviews with members of the three main stakeholder groups: 18 with patients, 12 with PCPs, and five with *promotoras*.

Results

The clinics' physical ability to "absorb" the intervention

One area of clinic noise that emerged almost immediately involved the CHCs' physical configurations. Before the intervention, the research team regarded the two CHC sites as similar. The two CHC sites served patients from similar demographic profiles; Hispanics/Latinos comprised approximately 68% of patients seen within the CHC network. Because the CHCs were operating within similar constraints under MMC and served a similar ethnic profile, the research team believed that the two CHCs comprised suitable sites to assess the *promotora*-centered intervention. The researchers decided which CHC served as intervention versus augmented intervention site by a three out of five coin flip.

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[4]NVivo is a software program that enables researchers to link, search, and model qualitative datasets (http://www.qsrinternational.com, accessed 4 May 2006).

In practice, however, the physical configuration of one CHC site proved more suitable for the intervention study. Sandia CHC (the intervention site) had an office for the *promotora*s, whereas the Rio Grande CHC (the augmented intervention site) had hoped to furnish such space but ultimately was unable to do so. Moreover, the augmented intervention site lacked telephones suitable for private interviews, filing cabinets, and convenient computer access.

A lack of suitable space and equipment at the Rio Grande CHC challenged the *promotoras'* work conditions. In commenting on the *promotoras'* lack of fixed workspace, one Rio Grande PCP stated that the CHC could not "absorb" the intervention: "you can't do mental health in the hallway!" (PCP Interview, 19 May 2004). Because of space constraints, the *promotoras* needed to find creative ways to interview and to consult with patients confidentially. They took advantage of open exam rooms or staff members' break rooms to meet with patients privately, although staff members on occasion needed these rooms for different functions and therefore asked the *promotoras* and the study participants to leave. The *promotoras* ultimately created an informal office in the medical records room, despite its crowdedness.

Lack of space and infrastructure proved problematic for the *promotoras'* socialization at the Rio Grande CHC. One PCP commented that if the *promotoras* had received their own space, it would "legitimize what they're doing" (PCP Interview, 19 May 2004). Both *promotoras* and all five of the Rio Grande PCPs identified space as a major constraint impinging on the efficient functioning of the intervention. In contrast, no PCP at Sandia CHC mentioned space as a limitation. The Sandia site proved physically able to accommodate the *promotoras*, whose work functioned more smoothly with sufficient space. Another Rio Grande PCP stated: "I think the *promotora*s are perfect for this kind of context, this kind of clinic setting. [The study design] just needs to mesh with the clinic" (PCP Interview, 19 May 2004).

Challenges of co-worker instability and interpersonal relationships

Staff turnover emerged as another problem at Rio Grande that adversely affected the flow of the intervention. Every PCP employed by the CHC when our study began took a position elsewhere before the study concluded. Additionally, four PCPs at Rio Grande who started after the intervention began left before the project ended. Medical assistants (MAs) also cycled in and out to a notable extent at the Rio Grande CHC. At the Sandia site, most PCPs (six out of eight) and MAs remained on staff for the duration of the project, thereby making their participation simpler and more consistent. The longer-term staff at Sandia had attended initial training sessions on the intervention and possessed a clearer understanding of the project as a whole; the less formal training sessions for new staff members provided less orientation to the research process.

Staff members' morale generally appeared higher at Sandia, which facilitated the integration of the *promotoras* into this setting. At Sandia, the *promotoras* perceived staff members as friendly and welcoming, often offering them job-related assistance. Lisa stated that she preferred to work there because the staff were much more "accommodating" (Field Notes, 30 September 2004). The Sandia PCPs generally expressed enthusiasm for having the *promotoras* on site, making such statements as "we've been so excited to have the *promotoras* here because they've been so helpful" (PCP Interview, 20 May 2004). Conversely, at Rio Grande certain PCPs expressed uncertainty about "buying into" the project (PCP Interview, 20 May 2004). One Rio Grande PCP said that "we don't really know whether to absorb them into the environment" (PCP Interview, 19 May 2004).

The *promotoras'* relationships with co-workers impacted the intervention. The intervention involved many participants beyond the *promotora*-patient-PCP triad. In their day-to-day interactions with co-workers, the *promotoras* remained in greater contact with MAs, medical records and billing clerks, and other administrative staff than with the PCPs. The MAs—whom the study design had not considered in depth—became critical players in the intervention. As unofficial gatekeepers, MAs controlled the *promotoras'* access to medical files, exam rooms, and patients. In particular, the *promotoras* required permission from MAs to review patient files or to interview the patients at both clinic sites.

At the Rio Grande CHC, *promotora*-MA interactions manifested confusion, tension, and even contention at times, particularly during the project's early phases, as the *promotoras* grappled with the workplace hierarchy and co-worker territoriality. For instance, Lisa found herself involved in

low-grade "turf wars" with some Rio Grande MAs because, as one MA exclaimed, she "hogged" the charts (Field Notes, 28 January 2004). Lisa felt this tension very clearly, stating that "at Sandia it's very easy to work with the MAs" while "at Rio Grande, I feel like I'm just more of an annoyance to them" (Promotora Interview, 3 June 2004). On one occasion when Lisa asked an MA for an introduction to a PCP who recently had joined the staff, the MA responded "after I go commit suicide," and then walked away, not making it clear whether the introduction would occur (Field Notes, 16 April 2004). Even by the project's end, Lisa reported that the Rio Grande CHC staff still did not understand exactly what her job entailed and did not treat her as a full member of the clinic's staff (Promotora Interview, 17 May 2004).

Staff members' lack of understanding about the intervention presented another problem. While the research team held initial and periodic training sessions at both sites to introduce and to reinforce the study design, MAs often did not attend these meetings. Not fully aware of the study design, they often attempted to refer patients to the *promotoras* for participation in the intervention, even though the *promotoras* could only recruit patients randomly. Lisa commented that such attempts reflected staff members' "buying into" the intervention; she elaborated: "Maybe they [MAs] want to be able to participate, because right now I pick the patients. They can't pick them even though they know they need help" (Promotora Interview, 3 June 2004).

Marcos felt that his inability to help patients referred to him by coworkers became a source of irritation for staff members (Field Notes, 24 February 2004). While staff members at both CHC sites tried referring patients, the *promotoras* received more referrals at the Sandia CHC, where there was greater support for the project. Three months into the intervention, a Sandia MA who had referred a patient to Marcos stated: "I didn't realize that there was so much depression. It's like an epidemic here" (Field Notes, 20 February 2004). Referrals put the *promotoras* in an awkward position. Ironically, the staff members' efforts to assist patients stemmed from their own increased awareness about mental health issues as a result of their exposure to the intervention. However, as Marcos noted, when the *promotoras* needed to turn down their co-workers' well-intentioned referrals, this action put strain on the relationship.

About midway through the project, a different type of referral emerged: on-the-spot requests for assistance with suicidal patients. As lay health workers, the *promotoras* were not qualified to handle these emergency cases. Marcos said that such referrals made his job "much harder" and stressful: "There are no psychiatrists or counselors here, and the first people that they think of to help with all of this are the *promotoras*. It worries me a lot" (Promotora Interview, 2 June 2004).

Referrals also interfered with the *promotoras*' ability to complete their assigned tasks. On one occasion, a staff member found Lisa in an exam room, where she was interviewing a depressed study participant; the staff member asked that Lisa immediately attend to a suicidal patient not in the study who had caused himself bodily harm. Medical personnel feared that this patient's situation would worsen and wanted Lisa to provide counseling and support services (Field Notes, 3 June 2004). This situation compromised the quantity and quality of time that Lisa was able to spend with the study participant and put her in an awkward position when asked to intervene in an area outside her training and expertise.

Balancing workplace demands

Because of their problematic integration into the CHC setting and need to work well with other staff members, the *promotoras* spent considerable time balancing extra demands placed on them by clinic workers, PCPs, and patients. For instance, they tried to facilitate their integration by doing favors for staff members. These favors included answering phones at the front desk, checking in patients, scheduling appointments, bringing patients to the exam rooms, translating, and retrieving medical charts. In particular, Lisa was frequently asked for favors because of her prior work as a receptionist at Sandia. Lisa also took initiative in providing assistance at the front desk when she perceived temporary understaffing. In these situations, Lisa performed these tasks without requests for assistance from her co-workers. While such favors may have improved the co-worker relationships, they detracted from the *promotoras*' assigned work, as one Sandia PCP recognized. The PCP commented, "[Lisa is] constantly being asked to fill in, pitch in, do a little registration, make some appointments, you know, maybe even be an MA part of the day because she can. And that takes her

away from the *promotora* job" (PCP Interview 18 October 2004).

Promotoras also received requests to undertake work with patients that extended beyond the purview of the intervention. Such requests often proved difficult. One PCP at Sandia frequently asked the *promotoras* to help with non-study patients in crises, requesting that the *promotoras* offer "a listening ear." When the *promotoras* tried to clarify that they could not intervene at the intervention site, the PCP openly expressed frustration (Field Notes, 20 February 2004; 8 June 2004). PCPs often stated a preference that *promotoras* screen all patients and provide referrals for those who needed it. Ethnographic observations corroborated that some the PCPs appeared somewhat desperate to garner assistance from the *promotoras*, so that patients who needed help could receive it.

While these situations underscored the need for expanded mental health services at the CHCs, the *promotoras* needed to navigate such encounters so that they would not alienate the PCPs from continuing as active participants in the project. While most PCPs expressed an understanding that the *promotoras* could not act as counselors, some PCPs observed that the *promotoras* did "serve a little bit in the counseling role" (PCP Interview, 19 May 2004). Although some PCPs recognized that the patients' mental health needs might "be beyond the scope of a *promotora*" (PCP Interview, 24 May 2004) or that the *promotoras* might find themselves "completely out of their realm" (PCP Interview, 18 October 2004), others expressed sentiments similar to the Sandia PCP who stated that "it would be nice if the *promotoras* could provide some…not necessarily counseling…but some other little piece where they could actually have time to sit down with the patient and maybe do a little problem solving" (PCP Interview, 24 May 2004). Thus, the *promotoras'* inability to respond to PCPs' requests challenged their working relationships.

Requests for expanded services also came from some patients, who requested help outside the scope of the *promotoras'* specified duties. Such requests mainly involved assistance in navigating the medical system (obtaining referrals, filling prescriptions, making appointments, etc.). For one patient, this help meant making appointments. Lisa helped her find a dentist and made appointments for "seeing doctors" (Patient Interview, 31 January 2005). Patients commonly needed assistance when dealing with insurance. Another patient reported that Lisa had helped her by consulting directly with her insurance company about her health situation so that the company would cover forthcoming surgery (Patient Interview, 28 July 2004). The patient had been unable to complete this task on her own. Patients' comments indicated that, partly through their experience as members of the community with similar ethnic and cultural background as the patients, the *promotoras* had achieved a position of trust and understanding in addressing patients' contextual problems.

Conclusion

Lessons learned

Our research identified three areas of clinic-based "noise"—the clinics' physical ability to "absorb" the intervention, the challenges of co-worker instability and interpersonal relationships, and balancing extra workplace demands. The findings highlight that differences in CHCs' spatial and social environments should receive attention in the development of community-based interventions. Although other issues (such as gender, language, and age) also warrant attention in such interventions, our research highlights the conceptual and practical importance of the intervention sites' spatial and social environments.

Whether a clinic site actually can integrate a proposed intervention requires careful assessment. A CHC that lacks appropriate space and infrastructure, that manifests staff turnover, and/or that suffers from low staff morale, as did the Rio Grande site in this project, may not prove suitable for a new intervention. In conceptualizing and analyzing fidelity to an intervention's protocol, investigators must consider preexisting differences in CHCs' internal environments.

In an intervention involving *promotoras* or other auxiliary positions, these individuals negotiate their places within the clinic workplace and forge relationships with co-workers who may or may not see themselves as participants in the intervention. Professional and non-professional staff members such as MAs should take part in all stages of project planning and design, which unwittingly did not occur in the present intervention. Such staff member also should attend discussion sessions about the intervention, when their opinions about its operationalization gain serious attention.

Reinforcement of the study design must take place on an ongoing basis, including clarification of participants' roles. From this perspective, lack of full participation by staff members at all levels in planning and implementing our project contributed substantially to the "noise" that the ethnographic assessment uncovered.

Promotoras or other auxiliary positions introduced into the clinic setting likely will receive requests to perform work that falls outside their formal job description. Smooth integration of new roles into the workplace may hinge on participants' willingness to balance these extra demands and requests for assistance. What a *promotora* can or cannot do may not become clear to co-workers, PCPs, and patients. Researchers should expect that co-workers' "buying into" the intervention may result in a request for expanded services that extend beyond the scope of the intervention

Future directions

Ethnographic research may prove valuable during the formative phases of multi-method project development (Brett et al., 2002; Hohmann & Shear, 2002; Sterk, 2002). Documenting pre-existing "noise" can assist in developing a study design suitable for a clinic's spatial and social environments. In our project, for instance, preliminary ethnographic reconnaissance might have suggested that the two CHC sites differed in certain key characteristics, that MAs would emerge as key players in the intervention, and that the *promotoras* would need to spend substantial time in building and maintaining co-worker relationships. Knowledge about these issues would have enhanced the project design. For our continuing work with *promotoras* in both urban and rural areas of New Mexico, we have taken these lessons about ethnographic reconnaissance into account.

Our work contributes to an emerging direction of policy-oriented research within medical anthropology. Ethnographic research has illuminated the influence of culture on health and healing practices, as well as the impact of spatial and social dynamics in service delivery (Bolton & Tang, 2004; Brett, et al., 2002; Donald, 2001; Ventres, et al., 2006; Ware et al., 2003, 1999; Willging et al., 2005). In addition, through studies of policies such as MMC, ethnography has clarified elements of power and bureaucratic organization in social policy initiatives (Lamphere, 2005; Willging, 2005; Willging et al., 2005). Such initiatives have tended to follow a neoliberal model, in which less trained nonprofessional workers increasingly substitute for more highly trained professionals, often as part of efforts to privatize public services (Castro & Singer, 2004; Nelson, 2005; Rylko-Bauer & Farmer, 2004).

Although critics might view the emergence of *promotoras* in mental health services as another example of a neoliberal policy, our observations demonstrate that this nonprofessional role can lead to empowerment, enhanced ability to navigate services, and capacity to address the contextual sources of suffering. Our study has provided new answers to research questions that, we believe, hold theoretical importance for anthropology and the social sciences, as well as practical relevance for mental health services research. These findings improve our understanding of the social structural constraints that impinge upon "culturally sensitive" interventions.

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