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A Mixed-Method Assessment of a Pilot Peer Advocate Intervention for Rural Gender and Sexual Minorities

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Abstract

Mental health disparities affect lesbian, gay, bisexual, transgender, and queer (LGBTQ) people in rural America. There are few empirically-based mental health interventions for this population. This exploratory study uses a mixed-method approach to assess implementation issues related to the feasibility, acceptability, appropriateness, and preliminary impacts of a novel peer-based intervention designed to enhance support and treatment engagement among rural LGBTQ people with mental distress and/or addiction issues. Quantitative and qualitative results illuminate intervention strengths and areas for improvement. Strengths centered on enhancing social support, advocacy behaviors, and engagement in treatment. Implementation challenges and recommendations to advance the intervention model are discussed.

Introduction

When compared to heterosexual and cisgender (i.e., gender identity aligns with sex at birth) individuals, lesbian, gay, bisexual, transgender, and queer (LGBTQ) people in the United States (U.S.) are disproportionately affected by mental illness and substance use disorder (SUD; Institute of Medicine, 2011). These disparities are often the outcomes of chronic exposure to discrimination, stigma, and violence directed at marginalized groups, resulting in “minority stress” (Meyer, 2003). Geographic distance (e.g., proximity to services and resources), socially-conservative gender norms, little opportunity to socialize with other LGBTQ people, and concealment of identity can further undermine mental health (McCarthy, 2000; Barefoot, Rickard, Smalley, & Warren, 2015; Hastings & Hoover-Thompson, 2011; Oswald & Culton, 2003). Such factors can isolate rural LGBTQ people from supportive social networks and resources (Willging, Salvador, & Kano, 2006a) that

might otherwise diminish the effects of minority stress and enhance mental wellbeing (D'Augelli & Hart, 1987; Williams, Bowen, & Horvath, 2005; McLaughlin, Hatzenbuehler, & Keyes, 2010; Hastings & Hoover-Thompson, 2011; McCarthy, 2000).

Societal institutions, including healthcare systems, are sources of minority stress, especially for rural LGBTQ persons. Rural residents, particularly those who are LGBTQ, have long reported hardship accessing quality mental health services (Barefoot et al., 2015; D'Augelli & Hart, 1987; Heckman et al. 1998). Clinicians may lack culturally-relevant training and supervision to effectively treat LGBTQ people, while individual and institutional bias in treatment settings can adversely affect care. In heteronormative practice environments, even the best-intentioned providers may not recognize how minority stress affects rural LGBTQ people, thus limiting their ability to adequately serve this population (Willging et al., 2006a, 2006b; Williams, Williams, Pellegrino, & Warren, 2012).

This exploratory study assesses implementation outcomes related to the feasibility, acceptability, appropriateness of a pilot intervention that builds on Community Health Worker (CHW) models to enhance social support and treatment engagement among LGBTQ help-seekers affected by mental distress and/or SUD. It also examines preliminary participant outcomes. As we describe elsewhere (Author citation, 2016), CHWs have close knowledge of local social realities, and can improve access to quality care for underserved populations by functioning as trusted liaisons between the broader community and social- and health-service systems. In contrast to paraprofessional peer specialists, lived experience of the health-related adversities faced by the populations they serve is not a requirement for CHWs (Gillard, Edwards, Gibson, Owen, & Wright, 2013; Salzer, Katz, Kidwell, Federici, & Ward-Colasante, 2009; Solomon, 2004). Emphasis is instead placed on identification with communities (here, rural LGBTQ communities). Such models keep with LGBTQ advocacy efforts (Wertheimer, 1992), and have been effective in risk contexts of HIV infection among gay men and transgender people (Kelly et al., 1997; Latkin & Knowlton, 2005; Tobias et al., 2010). They hold promise for rural areas, where gender/sexuality diversity and mental illness is commonly stigmatized (Barefoot et al., 2015; Willging et al., 2006a, 2006b; Williams et al., 2012).

There are alarmingly few empirically-based interventions for rural LGBTQ people, despite their need for mental health support. Most existing interventions (e.g., Bowen, Horvath, & Williams, 2007; Heckman & Carlson, 2007; Heckman et al., 2002) focus on HIV issues, are geared toward gay men, and/or are delivered remotely (via telephone or Internet). Peer- and community-based interventions, including CHW approaches, can enhance social support for vulnerable groups, in order to improve self-acceptance and -esteem and to reduce depression and other forms of mental distress (Solomon, 2004). Such potentialities are of critical importance, given the subpar treatment from professional sectors historically provided to LGBTQ people (Willging et al., 2006b).

The first, third, and fourth authors of this study developed a peer-based mental health intervention based on CHW models (Grant, Ernst, & Streissguth, 1999; Waitzkin et al., 2011; Weeks et al., 2009a; Weeks et al., 2009b) and input from rural LGBTQ New Mexicans who took part in five focus groups and two community advisory boards that met throughout

the study. The result was a program called the “LGBTQ peer advocate intervention,” in which lay providers received specialized training to enhance social support and services for LGBTQ persons in rural communities. Peer advocates (hereafter PAs) were defined as lay people from LGBTQ communities possessing knowledge and skills to address LGBTQ mental health issues locally. Per the logic model in Table 1, the intervention trained PAs in the essentials of outreach and education, mental health, and support services, while emphasizing community activities that: (1) strengthen social support in rural areas; (2) teach advocacy behaviors for LGBTQ people who must navigate heteronormative treatment systems; and (3) facilitate contact between LGBTQ-affirmative providers and LGBTQ people with mental health and/or substance use concerns.

Implementation required prospective PAs to complete a four-day didactic and interactive training, which was designed and delivered by the first, third, and fourth authors. Content focused on mental health and SUD, minority stress, LGBTQ diversity, and rural treatment systems. The goal was to impart basic helping skills (Aladag & Tezer, 2009; D’Augelli & Levy, 1978) and the knowledge and resources to support individuals seeking services (Lenihan & Kirk, 1990). We describe the content and evaluation of the training elsewhere (Author citation, 2016). As they were based in geographically-distant areas, the PAs also participated, individually and as a group, in conference call-based coaching sessions with the third and fourth authors. As previously described (Author citation, 2016), coaching provided ongoing mentorship to augment the in-person training.

Methods

Participants

Participants were recruited from three adjacent rural counties in New Mexico that featured large populations of ethnic minorities. Participants had to be 18 years of age; identify as LGBTQ, “questioning,” “same-sex attracted,” or “troubled by or uncomfortable with one’s gender,” and meet criteria for a DSM-IV-TR Axis I mental health disorder or SUD, as determined by the M.I.N.I. International Neuropsychiatric Interview (Sheehan et al., 1998). See Table 2 for an overview of participant demographics and Table 3 for a summary of their psychiatric conditions.

Qualitative Measures

At the 6-month follow-up, experimental participants completed a semi-structured interview concerning implementation outcomes (feasibility, acceptability, and appropriateness of intervention) and preliminary participant outcomes (satisfaction with the PAs and the resources made available through them). Two other sources of qualitative data used were semi-structured interviews with the coaches (third and fourth authors) and PAs (sixth, seventh, and eighth authors), and written logs compiled during the intervention period. The interviews elicited assessments of the intervention overall, its specific effects on practice, and factors that influenced fidelity to the implementation plan. Issues encountered during coaching sessions were recorded in the coaches’ logs; similarly, outreach efforts and contacts/interactions with participants were to be detailed in the PA logs.

Quantitative measures

Brief Symptom Inventory (BSI)—Participants rated this 53-item self-report measure of psychiatric symptoms using a 5-point Likert scale from “not at all” to “extremely” (Derogatis & Melisaratos, 1983). The BSI included nine symptom subscales (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), and three overall indicators of psychopathology.

Alcohol and Drug Consumption—This 5-item self-report substance use questionnaire included items from the Texas Christian University Drug Screen II (Institute of Behavioral Research, 2007) and the Behavioral Risk Factor Surveillance System (Centers for Disease Control and Prevention, 2014). Frequency of use of 14 substances in the past 12 months was assessed, as well as alcohol use in the past 30 days. Participants also reported the substance causing the most serious problem for them (of the 14 listed or “none”).

Medical Outcomes Study (MOS): Social Support Survey Instrument—This 19-item measure assessed perceptions of social support across several dimensions (emotional/informational support, tangible support, affectionate support, and positive social interaction), rating its availability on a 5-point Likert scale from “none of the time” to “all of the time.” Responses were averaged across the 19 items and then transformed to a scale from 0 (least social support) to 100 (most social support). This scale has high internal consistency ($\alpha > 0.91$; Sherbourne & Stewart, 1991).

Psychosocial Treatments Interview (PTI)—Participants completed a modified version of the PTI to indicate whether or not they were engaged in treatment (Steketee et al., 1997). Participants in treatment specified type and focus of treatment, treatment provider and setting, number and frequency of sessions attended, number of sessions missed, reasons why sessions were missed, and reactions to treatment. Those not in treatment specified whether or not treatment was recommended for them and reasons why they did not access it. We added queries to assess perceptions of treatment as LGBTQ-friendly or -unfriendly and created a scale based on reactions to treatment items by summing responses across eight items of the PTI, resulting in a score range from 0 (most negative reactions to treatment) to 16 (most positive reactions to treatment). The reactions to the treatment scale we created had high inter-item reliability at both baseline (Cronbach’s $\alpha = 0.86$) and post-test (Cronbach’s $\alpha = 0.81$).

Procedure

Recruitment of participants took place via flyers, social media, email, and radio and newspaper ads from September 2012 through August 2013. Trained Masters-level research staff received 117 inquiries via a toll-free number and conducted 83 screenings for eligibility. Ultimately, 73 callers met inclusion criteria, and 65 of these completed the 60 to 90-minute baseline interview, for which they received \$30. This structured interview collected demographic information and data from the M.I.N.I., BSI, Alcohol and Drug Consumption, MOS Social Support Survey and PTI measures. The participants were then randomized into experimental ($n = 34$) or control ($n = 31$) groups. Control participants were given LGBTQ-focused support resources (a list of service providers and advocacy

organizations, plus an LGBTQ-affirmative book or LGBTQ rights documentary). Forty-seven participants (22 experimental; 25 control) completed the 6-month follow up and were included in pre-post exploratory analyses.

Four PAs hired for 15 to 18 hours a week carried out the intervention: a Native American transgender woman and youth coordinator, a Native American cisgender health educator and mother of a lesbian daughter, a White cisgender lesbian art gallery owner, and a White cisgender gay man business student. Their ages ranged from mid-20s to mid-50s. Although none had prior training in addressing mental health or SUD, three had lived experience with mental illness or SUD. Per CHW models, PAs were chosen for their identification with rural LGBTQ communities, rather than lived experience of a specific health issue. The youth coordinator left her position after holding it for four months for reasons unrelated to the study. The remaining PAs continued for the 18-month intervention period. The two bisexual and cisgender coaches were licensed psychologists; one was a White male, and the other a bi-racial Asian-American/White female. One was a mental healthcare agency director, and the other a professor. Research staff conducted 60- to 90-minute semi-structured interviews with the coaches and PAs halfway through the intervention and at the end of implementation. The youth coordinator was interviewed once.

The PAs endeavored to contact participants within 72 hours of assignment and conducted in-person needs assessments during early visits so both parties could agree on priority areas, i.e., treatment access, advocacy, and social support, and strategies for addressing them in a collaborative action plan. The PAs aimed for at least six contacts with each participant by phone or in-person over a 6-month period. They also documented the type, amount, and nature of each resource provided, resulting actions/activities, and progress addressing each priority in their logs. The PAs were to check email, initiate and return phone calls, contact assigned participants, undertake outreach with providers and community stakeholders, identify local social support for rural LGBTQ people, develop new resources where none existed, and take part in bimonthly coaching calls (Author citation, 2016).

The research staff re-interviewed participants 6 months after baseline data collection. During this 60- to 90-minute encounter, all measures (except the M.I.N.I.) were repeated to assess change. Experimental participants also completed the qualitative interview (described above). Participants received \$30 as compensation.

Data Analyses

Qualitative—The first author and a research assistant analyzed transcribed interviews and logs via iterative coding procedures. This involved systematically categorizing data line-by-line into codes using NVivo qualitative software to identify the most salient themes related to the overall intervention process and preliminary impacts (QSR International, 2012). Interview questions and logs were used to develop a descriptive coding scheme, followed by “open coding” to determine new themes, and “focused coding” to pinpoint themes that were frequently repeated or represented unusual concerns. Codes were described and connected to themes with the use of memos. Broad themes were then formed through an ongoing process of comparing and contrasting codes with similar content or meaning (Glaser & Strauss,

1967; Corbin & Strauss, 2008). Finally, accuracy checks of the findings and assistance with interpretation of data were provided by PAs (Patton, 2015).

Quantitative—As this was a pilot study, the sample size was small, limiting the power of statistical testing. Rather than discard the quantitative data altogether, we present the findings of the statistical tests paired with their effect sizes and descriptive statistics between conditions. A strength of this study is its mixed-method approach, enabling us to explore both congruence and discrepancy between qualitative and quantitative data. The quantitative results are considered preliminary due to the low power of the analyses and complexity related to heterogeneity among participants; they should be interpreted with caution and in the context of the qualitative findings.

All human subjects' protocols and written informed consent procedures were approved by the Pacific Institute for Research and Evaluation Institutional Review Board. All authors certify their responsibility for this manuscript.

Results

Prior to conducting the pre-post analyses, we explored baseline differences between completers and non-completers due to higher than expected attrition. Incarceration was the most frequent reason for non-completion in the experimental ($n = 6$) and control ($n = 4$) groups. Regarding substance use, Fisher's exact tests (two-sided) revealed no significant associations between substance use and study completion, with the unexpected exception of a significant association between past 12-month tobacco use and non-completion ($p = 0.05$). Independent samples t-tests showed no significant differences between completers and non-completers on BSI psychiatric symptom severity, although the means for all symptoms (except anxiety) were higher for non-completers than completers.

The study's main purpose was to document implementation outcomes and preliminary participant outcomes of the PA intervention based on the perspectives of LGBTQ help-seekers (participants) and key staff (PAs and coaches) pertaining to three domains of interest: (1) social support; (2) advocacy behaviors; and (3) engagement in treatment. Consistent with Proctor and colleagues (2011), we sought to assess three implementation outcomes: (1) *feasibility*, or the degree to which the intervention was implementable among participants; (2) *acceptability*, or the degree to which participants viewed the intervention as satisfactory; and (3) *appropriateness*, or the degree to which the intervention was relevant and compatible with the participants' needs. Beyond this, we assessed preliminary participant outcomes, or the degree to which participants' symptoms and functioning changed over time. To triangulate between the qualitative and quantitative data, we first examined qualitative and quantitative results separately, garnering insight into implementation issues and preliminary impacts. We then compared findings from both analytic approaches to evaluate convergence and divergence related to research questions informed by the logic model: Does consulting with an LGBTQ PA enable participants to: (1) develop social support outside of mental health/substance use services; (2) increase advocacy behaviors towards mental health/substance use services; and (3) increase

engagement in mental health/substance use treatment? We describe the findings below, using quotations to exemplify common views and experiences of participants, PAs, and coaches.

Social Support

Qualitative data offered evidence for the acceptability of having participants turn to PAs to bolster social support. With rare exceptions, participants commented on the “acceptance” of the PAs, characterizing them as “trustworthy,” “nonjudgmental,” and “sensitive” to their needs. A few remarked that interacting with PAs differed from seeing a therapist. One participant said, “It didn’t seem like a session with [my PA]. . . . It’s sitting down with a friend.” A second claimed the PA was always there when needed, offering emotional support outside of their traditional social network. A third noted a PA’s genuine concern: “There was someone to talk to and [s/he] was someone who is actually looking at you in the eyes and not being fake.”

Regarding preliminary participant outcomes, the PAs helped reduce feelings of social isolation while enabling participants to explore issues surrounding their genders and sexualities in greater depth. For example, a woman in a mixed-sex marriage had questioned her sexuality for years, but had never reached out to others for support. Meeting with the PA made it possible for her to process feelings with an empathic listener, and provided a sense of relief. Spending time with PAs made others feel less isolated, as well. A participant observed, “I didn’t have anybody to talk to at all. . . . It was just my little secret and I didn’t know where to go or anything, so [having the PA] was good.”

The PAs also strengthened social networks, another positive intervention outcome. Participants often clarified that social resources for LGBTQ people were limited, and hesitated to draw from them over fears of “outing” themselves. Practical matters, such as a lack of transportation, intensified their social isolation. Because of their contact with the PAs, participants learned of nearby LGBTQ events and resources, including the first annual LGBTQ Pride Picnic that a PA had co-organized locally. One participant learned about and began taking part in a previously unknown LGBTQ support group at a local church. A second was linked with hosts of a community drag show and later volunteered to organize the event. Two others joined a support group for transgender women to learn about gender transitioning from persons involved in this process. Even participants who did not take part in such groups felt the protective effects of social support. One participant, for example, reported increased confidence that he could tap into LGBTQ resources if he so desired.

We also explored social support as a preliminary participant outcome. This was assessed quantitatively with the MOS social support measure. A mixed-factor ANOVA comparing change in social support from baseline to post-test across the two groups was not significant, $F(1,44) = 0.54$, $p = .47$, $\eta^2 = .012$. We interpreted the small effect size and pattern of the marginal means to not preclude the possibility that an intervention effect may have been found with a larger sample. Comparison of the marginal means of the control group ($M_{pre} = 48.58$, $SD_{pre} = 4.69$; $M_{post} = 48.11$; $SD_{post} = 5.49$) and experimental group ($M_{pre} = 51.00$, $SD_{pre} = 5.12$; $M_{post} = 56.57$; $SD_{post} = 5.99$), suggested an increase in social support from baseline to post-test only for the experimental group. This increase (+5.57 on the 0-100 scale) is comparable in magnitude to the significant increase in social support (+6.9, $p =$

0.02) in a fully powered study of an inpatient mental health intervention for depression (McCall, Reboussin, & Rapp, 2001), indicating that low statistical power likely led to our non-significant findings for social support.

Bringing together the qualitative and quantitative findings, participant narratives suggest that experimental group participants showed an amelioration of isolation through increased social bonding and membership in the LGBTQ community, which they attributed to the intervention. By comparison, the significance testing for the quantitative measure of social support was null, yet we observed a small effect size and marginal means comparable to significant increases in social support related to an intervention reported elsewhere. Further, the qualitative interviews suggest participants viewed the intervention positively indicating the acceptability of the intervention.

Advocacy Behaviors

The intervention was intended to increase participant advocacy behaviors, such as obtaining health information and accessing treatment options (Wiltshire, Cronin, Sarto, & Brown, 2006; Brashers, Haas, & Neidig, 2000), making healthcare decisions, communicating needs effectively and negotiating with providers (Walsh-Burke & Marcusen, 1999), and mindfully non-adhering to treatment (Brashers et al., 2000). Successful advocacy would likely result in participants being engaged in treatment, having positive reactions to treatment, and perceiving treatment as LGBTQ-friendly.

Qualitatively, some participants described having an increased ability and motivation to assert themselves effectively in personal, professional, and therapeutic relationships, a positive participant outcome. Working with a PA assisted one person to establish safer boundaries with a violent intimate partner. A second participant with precarious housing became emboldened to ask for and receive support from the local homeless shelter, where she had been reluctant to seek assistance based on past negative experiences with staff reactions to her gender. A third participant shared with the PA that he was planning to undergo religious-based conversion therapy. In supporting his right to self-determination, the PA accepted this decision but shared concerns about such therapy, and the potential for adverse emotional impact. This enabled the participant to approach the conversation therapy in an informed and mindful manner. The participant later returned to the PA, reporting that the therapy had been unhelpful and that he was able to self-advocate and feel better about himself as a sexual minority, in part, due to the PA's consultation.

We also explored the quantitative data regarding advocacy behaviors. At baseline, two control participants and three experimental participants missed or did not schedule appointments due to perceptions that treatment would be LGBTQ-unfriendly. At post-test, all three control group participants who had missed or not scheduled appointments at baseline due to LGBTQ-unfriendly expectations of treatment continued to endorse this item. In contrast, none of the experimental group items endorsed this item at post-test. Although this exploration of descriptive data was not assessed with significance testing and cannot generalize to a broader population due to the small sample, it suggests a positive trend in self-advocacy via engagement in LGBTQ friendly care among these particular participants.

We queried participants about their feelings regarding treatment at baseline and post-test. For the subset who reported being in treatment, a mixed-factor ANOVA that compared change from baseline to post-test in reactions to treatment between the two conditions was not significant $F(1,15) = 0.29, p = .59, \eta^2 = .019$. Because of the especially small sample size for this analysis (e.g. only including participants already engaged in treatment) we also explored the pattern of the quantitative data via the effect size and marginal means. The marginal means from the null significance test showed the control participants had similar reactions to treatment scores over time ($M_{pre} = 9.54, SD_{pre} = 4.34; M_{post} = 9.09, SD_{post} = 4.21$) while experimental participants had slightly improved reactions to treatment ($M_{pre} = 12.17, SD_{pre} = 3.37; M_{post} = 13.00, SD_{post} = 2.83$) from baseline to post-test, corresponding to a small effect size ($\eta^2 = .019$). However, the marginal means should not be interpreted as a generalizable result, rather they suggest the utility of further exploring this relationship in a more robust trial of the intervention. One reaction to treatment item assessed perceptions that the provider understood the participant's needs as an LGBTQ person. Although about half of participants in both groups reported no change from baseline to post-test on this item, observed changes were in the expected directions. About one-third of control participants reported a worsened reaction from baseline to post-test, whereas about one-third of experimental participants reported an improved reaction to this item. Overall, the statistical testing for the impact of the PA intervention on self-advocacy skills was null, although the pattern of the quantitative data suggests that the data trends in the expected direction, an observation that should be interpreted with caution. Combined, the qualitative findings suggest that PAs helped participants garner self-advocacy skills, leading to increased engagement in LGBTQ-affirming treatment, whereas the quantitative findings were null with non-significant trends in the expected direction.

Engagement in Treatment

The qualitative findings suggested that the PAs increased participants' openness to treatment. Several participants mentioned that the PAs offered new information about available mental health/substance use services and motivated them to access treatment, or begin to seriously contemplate this option. One participant credited his PA with enabling him to understand that he needed to stop relying on the "old way of doing things," i.e., self-medicating with alcohol, and to access care. He explained, "My [employer] wanted me to seek some type of treatment because of my drinking. The advocate suggested that was a good thing for me. [S/he] steered me in a way to step back and think that there's no wrong in doing it, and it could help." The PAs were also able to increase openness to treatment through disclosures of their own experiences of mental health. A second participant clarified, "Everything I was going through were the same exact symptoms—the chest pains, to the anxiety, to the getting mad—that [s/he] was going through. [S/he] did state that [s/he] went to a counselor to talk to somebody and that took everything away." The personal experience of the PA enabled this participant to contemplate and pursue treatment that he was previously unwilling to utilize. These qualitative findings support that the intervention was both acceptable and had preliminary positive participant effects.

The PAs also facilitated continued engagement in treatment. Participants who described consistent contact with PAs during interviews also reported greater satisfaction with local

services. The PAs reportedly helped participants navigate treatment systems to access particular services, especially medication management. One participant, for example, who received services at the community mental health center where long wait times between visits were the norm, explained how the PA helped her refill prescriptions: “I was out of medication... [The PA] told me what to do, like to go to the hospital, and they have an on-call and you can get them like real quick because I was [having] anxiety attacks when I first met [her/him] and now I’m doing a lot better.” A second participant’s PA encouraged him to obtain professional help: “[The PA] just talked to me about what places I could go to... [S/he] talked to my psychiatrist and recommended looking at my medication... That helped a lot too.” Here, the PA consulted with the participant’s psychiatrist to enhance understanding of his mental health struggles, which resulted in a medication adjustment. This participant reportedly became more confident in asking for assistance when he needed it.

Finally, many participants turned to PAs to supplement their current treatment, which likely exerted a positive effect on their overall engagement with services. One participant discussed how the PA supported her adherence to a court-ordered treatment plan: “I was doing all of my treatment. [The PA] sat me down and we had good discussions about how my treatments were going, what I needed. [S/he] helped me stay focused.... We set up schedules to keep me focused.” She cited this extra support as critical to her success. Others claimed to have positive relations with their providers, but confided more deeply in the PA about gender and sexuality issues. A second participant summed up this view: “[The PA] was the only [person] local that I could go to for help with that [gender transition].”

Although the qualitative findings suggested an effect of the intervention on treatment engagement, this was not detected quantitatively. About half of all participants either initiated or continued treatment from baseline to follow up. When examining whether participants increased, decreased, or showed no change in their number of treatment sessions from baseline to post-test, a slight majority of experimental participants increased their number of sessions ($n = 8$, 36.4%), whereas the slight majority of control participants showed no change in their number of treatment sessions ($n = 10$, 40.0%). However, this difference did not appear to have clinical significance.

Combined, the qualitative findings highlight changes in treatment engagement (e.g. increased contemplation of treatment and greater satisfaction with treatment) whereas the quantitative measure did not reveal this pattern. It is notable that the quantitative measure, which assessed treatment status as a binary variable (e.g. in treatment versus not in treatment), the qualitative data assessed treatment engagement as a continuum. Changes in treatment engagement in the qualitative data may not have been detectable via our mode of quantitative assessment.

Challenges with the Intervention

Implementation was challenging at times. Regarding intervention feasibility and appropriateness, the PAs raised concerns about participants with SUD that were broadly related to the ability of these participants to “forge connections.” “Connection” referred to two interrelated phenomena: (1) the building of a viable social bond between participant and

PA; and (2) the act of staying in touch. While most participants described relationships with PAs in positive terms, a minority did not benefit from a connection enduring for the 6-month intervention period. One participant disclosed having a hard time relating to a PA of a more privileged racial and economic background. In another case, the participant described the initial meeting with the PA as “a letdown,” commenting that “it didn’t seem like [her/his] heart [was into it].” He opted not to remain in contact. Based on interviews with the participants, PAs, and coaches, each PA had the greatest difficulties connecting with participants presenting with severe substance use issues, whom they often perceived as suffering from intractable problems. Thus, the intervention appeared to be most feasible when implemented with participants without severe substance use problems, a group for whom the intervention was less appropriate.

The PAs and participants typically stayed in touch via phone calls and face-to-face meetings. Participants reportedly benefiting most from having a PA were the ones with the most face-to-face contact, usually those making the effort to initiate contact rather than relying on the PA to do so. One benefited from phone calls with his PA more frequently than most, connecting two to three times per week. The PA encouraged him to reach out by any means necessary when he was struggling with acute mental health concerns. Participants also appreciated the ability to interact with PAs in different ways, including texting and email. Yet, some lacked access to such technologies and related this to the difficulties of forming a strong connection with PAs, suggesting a feasibility challenge in some cases. One explained, “The only contact I made with [the PA] was with voicemail. I tried waiting for [him/her] to call back, and then I called [him/her] four times. I gave up.” The PAs attempting to respond to these overtures frequently noted they were unsuccessful because participants’ Internet and phone bills were unpaid and deactivated.

Another feasibility concern involved the lack of a dedicated professional office space in which to meet with participants. The PAs operated outside of mental healthcare agencies to facilitate engagement in the broader community, meeting participants in homes, libraries, coffee shops, and parks. Although the participants did not complain about this strategy, the PAs and the coaches were critical. The PAs wanted to present a “professional” face to participants and argued that convening in public risked exposure of gender or sexual identities, while the coaches believed that meeting with participants in their homes posed greater risks to safety and liability.

Physical distance from one another also made the PAs feel “isolated” in their work. Despite consulting monthly on the phone and convening occasionally during meetings and trainings, their dispersal across regions meant they lacked regular contact with co-workers. One coach called for establishing offices in advocacy organizations and public health departments where PAs would benefit from interactions with others doing health-related work.

Finally, the PAs experienced challenges navigating the public mental health system, the only affordable treatment option for most participants, as the majority were economically challenged (Table 2). During the intervention period, a new managed care model introduced by the state government caused major disruptions to the system by restricting adult case management services. Notwithstanding their efforts to educate the PAs about system

nuances, the coaches were discouraged by the extent of obstacles brought about by these disruptions. The PAs found themselves assisting participants in applying for public benefits, arranging transportation, negotiating bureaucracies, and performing other case management tasks. The accessibility of clinical services was impeded, undermining PA efforts to work with providers, a feasibility issue rooted in pre-existing structural barriers. Additionally, while two PAs organized well-attended and highly-rated LGBTQ competency workshops for local providers, they still had few readily accessible clinical resources to draw from in the regions they served (Author citation, 2016).

Unanticipated outcomes

Given the implementation challenges, particularly in relation to forging connections with persons with severe SUD, it is not surprising that key symptoms did not appear to reduce for the experimental group. In contrast, we found similar rates of psychiatric and substance use symptoms between experimental and control groups. The BSI revealed similar psychiatric symptom severity at post-test. The exception to this was in the reverse direction, such that control participants showed a mean decrease in paranoid (-0.49) and psychotic symptoms (-0.58), whereas these paranoid ($+0.11$) and psychotic ($+0.02$) symptoms remained relatively stable in experimental participants. Moreover, there was little change from baseline to post-test in frequency of use for *all* substances. This was likely due to pre-treatment inequality in baseline substance use, such that mean use for *all* substances was higher at baseline in the experimental group. Notably, some more severe substance use endorsements, such as cocaine and heroin, occurred occasionally in the experimental group and not at all in the control group at baseline. These results suggest that the PA intervention may have yielded different outcomes for different subgroups of participants, an implementation outcome regarding appropriateness. Future implementation and development of the PA intervention may require adaptation to enhance its appropriateness with substance-using populations.

To better understand the intervention's appropriateness for participants with and without SUD, we explored whether differences in baseline substance use related to post-test psychiatric symptoms in the experimental group. We compared participants who reportedly did not use cocaine, heroin, and methamphetamine at baseline to those who used these substances at baseline in terms of their psychiatric symptoms (per BSI) at post-test. We selected these three substances because they were used at substantially higher rates in the experimental group than the control group at baseline. Mean symptom severity on all BSI scales was lower at post-test for those with no baseline cocaine, heroin, or methamphetamine use than for those endorsing using any of these substances at baseline. Baseline cocaine, methamphetamine, and heroin use were associated with greater psychiatric symptoms at post-test, further underscoring the need for adaptation to implement this intervention among individuals with severe SUD.

The qualitative data shed further light on the above findings on symptoms. First, the participants, PAs, and coaches all pointed to the limitations of the intervention when applied to persons with severe SUD. The PAs felt ill-prepared and were dismayed by what they perceived as some participants' lack of desire to address their SUD proactively, also

asserting that a licensed alcohol and drug counselor be added to the project team to help with this population. The coaches attempted to build greater enthusiasm among the PAs for working with persons with SUD, dispelling problematic beliefs about these participants, and providing advice to assist participants in behavioral change. They also organized a booster training to build the confidence of PAs, but the training fell short in empowering them to lend the type of support that was needed.

Discussion

The evidence base for mental health interventions for LGBTQ people is in a nascent stage of development (Institute of Medicine, 2011). In rural areas, the singular strategy of training the provider workforce is likely to fall short due to high clinician turnover (Humphreys et al., 2007). Peer advocacy is a generally acceptable community-based intervention strategy that is feasible to implement with some modification. The approach builds on CHW models, calling for PAs to function as “change agents” for building community capacity to address mental distress and substance use among rural LGBTQ people (Weeks et al., 2009a; Weeks et al., 2009b). By interacting with PAs and strengthening their own ability to advocate for self and others, participants may add to this capacity. Yet, the success of such initiatives may hinge on the viability of rural mental health systems, which are at-risk of forcing PAs into roles they are unprepared to deliver in an effort to fill professional service gaps elsewhere.

The qualitative results provide preliminary evidence for the intervention’s effectiveness in terms of enhancing (a) social support and (b) self-advocacy. Although the quantitative significance testing for these two effectiveness questions were null, there were some trends in the expected direction that, when integrated with the qualitative findings might further serve as preliminary effectiveness evidence. However, further evaluation is needed in order to determine the reasons for the non-significant findings for the quantitative measures. It may be that because the experimental group was diagnostically complex; with high rates of severe substance use, there could be a moderation effect such that the intervention was differentially effective and appropriate for participants with and without SUD. A larger sample would be needed to assess a possible moderation effect. With a small sample size, intervention effects observed among non-SUD participants may have been washed out by non-effects among those with SUD. Further, although there were not differences between groups in treatment engagement in the quantitative results, the qualitative results highlight positive outcomes (Table 4). Such outcomes may buffer rural LGBTQ people from the effects of minority stress. Based on the interviews, participants generally felt that PAs were a positive force in their lives, connecting them to the few LGBTQ-friendly providers and support services in their regions. Many also reported increased motivation to engage in treatment and improved attitudes toward providers.

Experimental participants appeared more receptive to treatment even when not availing themselves of this opportunity. The Transtheoretical Model of Change describes health behavior change as a five-step psychological process: pre-contemplation, contemplation, preparation, action, and maintenance of the change (Prochaska & DiClemente, 1982; Prochaska & Velicer, 1997). The movement from pre-contemplation to contemplation can be viewed as a treatment effect that we could not detect quantitatively with our binary measure

of engagement in treatment and possible difficulties with self-reported recall of number of past sessions attended. Under this model, different interventions (e.g. consciousness raising, catharsis, choosing) may be more appropriate depending on a person's readiness for change (Prochaska & DiClemente, 1982). Future iterations of our intervention should incorporate this model to tailor support for help-seekers, deploy more specific quantitative measures for monitoring progress during the change process, and examine whether the program is more successful when applied to persons in particular change stages. Future research assessing engagement in treatment might also benefit from measuring readiness for change at baseline and post-test, as well as a clinician-administered interview to assess number of sessions attended more accurately, such as the Timeline Followback (Sobell & Sobell, 1996). These findings also highlight the value of using mixed-methods research designs in studies assessing feasibility and acceptability of new interventions. A strength of this study is that although the quantitative measures we used did not detect effects on treatment engagement, the qualitative results provided a possible explanation for these null quantitative findings.

There are multiple issues to tackle in future iterations of the intervention. First, we did not anticipate the severity of symptoms, nor that they would stay the same for the experimental group. Although experimental participants showed improved experiences of treatment and perceived receipt of more social support, these effects were observed qualitatively whereas quantitative results were null. Further, experimental participants' psychiatric symptoms remained stable, rather than improving as we had expected. We attribute this to the pre-treatment inequality between groups, with more severe symptoms in the experimental group and less severe diagnoses overrepresented in the control group and the limitations in the appropriateness of the PA intervention for more severe substance users. It is very likely that the former had higher levels of need than the intervention could meet. Another observed difference in conditions at baseline was years lived in current zip code, with experimental participants reporting significantly fewer years in their current community. Thus, experimental participants may have had fewer coping and social support resources due to less community connectedness, a construct not directly assessed in this study. We believe that the intervention may still be of value to persons with substance use problems. However, the intervention must be supplemented with other modalities, such as motivational interviewing, or additional trained clinical providers to optimize its usefulness with this population.

A second issue were pressures on PAs to act as *de facto* case managers and counselors. Originally, the PAs were to be adjuncts, rather than replacements, to treatment and sources of community outreach and informal social support. This approach keeps with existing research on the effectiveness of peer support as a complement to, rather than a stand-in for professional care (Gidugu et al., 2015). In contrast, participants were often less interested in support for issues related to gender and sexuality, and instead needed direct assistance with concerns affecting their quality of life, such as accessing medication. This can likely be attributed to professional provider shortages, and the systemic issues and inadequacies affecting service delivery as described above. The PAs lacked the training, supervision infrastructure, and time to optimally function in this capacity (Author citation, 2016).

A third issue to consider is whether to situate the intervention in the community with volunteer lay practitioners who resemble CHWs (as in the current model) or a formal clinical setting staffed by paraprofessional peer specialists with greater lived experience of the health issues found within our sample. When based in the community, PAs can provide one-on-one support and link help-seekers to local resources. We also envisioned the PAs being most accessible to marginalized participants if they were seen as independent from the public mental health system. Yet, the level of unmet need encountered by PAs points to the importance of engagement with a range of specialty and non-specialty providers, and for future interventions to tap into paraprofessionals with firmer footings in the public mental health system and populations struggling with SUD. Notwithstanding, if the intent is to cultivate lay practitioners outside of the public system, it may be useful to embed the PAs in LGBTQ-identified spaces, such as Pride Centers (if available), or in other professionalized workspaces focused on advocacy work or public health. It is also essential to provide a strong coaching and supervision infrastructure to ensure ongoing training and troubleshooting. In this context, the expectations placed on PAs should be measured. Given the challenges presented by both participants and the public mental health system, it is clear that our initial expectations were too ambitious for the limited training PAs received (Author citation, 2016). When possible, peer-based interventions, such as the one described here, should be introduced alongside other larger system-wide reforms.

Regardless of whether this intervention is based in a community or a clinical setting, efforts should be made to broaden the pool of PAs to ensure a more effective and enduring match with participants. For this pilot study, project resources limited the number of PAs that we could hire. Thus, we were unable to ensure optimal pairings between participants and PAs, in terms of race/ethnicity, income, and mental health/substance use background. In some instances, it was clear that the participants and the PAs experienced difficulties relating to one another. Such difficulties likely impacted the amount of contact between both parties and possibly diluted the impact of the intervention on the presenting symptoms of the participants. Importantly, the capacity to assess and address “fit” early on may enhance program acceptability, making it possible for PAs and participants to forge more productive connections, and providing greater impetus for both parties to maintain contact and communication. Of note, income disparities that are emblematic of rural areas in New Mexico (e.g., access to phone and Internet) likely impacted the ability of some participants to remain in contact with the PAs. While our study provided resources (e.g., transportation) for the PAs to meet with participants in-person, it is possible that geographic distance may compromise connection between both parties if left unaddressed in future iterations of the intervention.

Limitations

This study occurred in a single state, which limits generalizability. Given its exploratory nature, the intervention sample was also small, hindering our ability to detect significant differences when they may have existed, and to analyze the degree to which the intervention differentially impacted the diverse LGBTQ subpopulations, or persons of varying ethnic/racial backgrounds. While our study effectively demonstrated the implementation of this pilot intervention and suggests several positive outcomes that appear to be associated with

the intervention, a larger sample size would assist in evaluating its effectiveness. Some unanticipated outcomes in this study may be attributable to pre-treatment inequality in SUD. Several participants were also lost to follow up due to the unanticipated frequency of incarceration, also likely related to substance use. We considered adding substance use as a moderator variable to our main analyses, however this was not feasible due to the already small sample size. Still, exploratory analyses allow us to speculate that the intervention was more useful for persons without severe SUD. For this pilot study, we had no *a priori* expectation of optimal intervention dose (e.g., contacts between PAs and participants), although the PAs were instructed to, at minimum, make six contacts with each participant, by phone or in-person, over the 6-month intervention period. Some were more vociferous about systematically documenting efforts to contact participants than others. Future study must include a more detailed study of the intervention dose to facilitate analyses regarding efficacy. A study strength is a mixed-method research design that has yielded crucial insight into specific implementation issues to address to improve feasibility, acceptability, and impacts for rural LGBTQ people who might benefit from this type of CHW intervention model.

Conclusion

There is a pressing need to advance the evidence base for mental health interventions that can support rural LGBTQ people. This study demonstrates that (a) it is feasible to establish PAs as a resource, (b) there exist rural LGBTQ people who view this resource as acceptable and for whom the intervention was appropriate, and (c) PAs can assist in facilitating social support, helping marginalized populations gain self-advocacy skills, and increasing engagement in treatment. For this intervention to result in positive effects for LGBTQ help-seekers, there are infrastructural issues requiring close attention, including access to coaching, supervision, ongoing training, and greater opportunities to build camaraderie across long distances. An unexpected finding was the magnitude of SUD prevalence and the pervasive poverty and consequent problems-in-living within the participant population. These problems may be influenced by experiences of minority stress, but they may also be attributed to endemic contextual features within the rural implementation environment. To enhance implementation, it may be necessary to base PAs in clinical or social service settings where existing staff and infrastructure can be modified to ensure greater cognizance of LGBTQ-related best practices, outreach and support strategies, and policies to reduce the myriad health and healthcare disparities related to mental health and SUD.

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Table 1

Logic model for the LGBTQ peer advocate intervention.

<i>Assumptions</i>	<i>Inputs</i>	<i>Activities/Outputs</i>	<i>Outcomes</i>
<ul style="list-style-type: none"> Reducing isolation of rural LGBTQ help-seekers can play a part in protecting them from risks associated with minority stress 	<ul style="list-style-type: none"> Social support and mentoring provided by peer advocates List of LGBTQ-affirming resources in the community Culturally-appropriate educational materials for families and friends 	<ul style="list-style-type: none"> Peer advocates establish support groups or other resources for help-seekers and other interested LGBTQ individuals Peer advocates aid help-seekers in connecting with extant sources of support, such as affirming faith communities 	<ul style="list-style-type: none"> Increased satisfaction with social support within rural communities Overall increase in size and depth of social support networks
<ul style="list-style-type: none"> Rural LGBTQ help-seekers prematurely terminate mental healthcare/substance use services when they encounter professional providers who are not sensitive to their needs 	<ul style="list-style-type: none"> Peer advocates trained in advocacy skills that help-seekers can apply Peer advocates supplied with guidelines for promoting help-seeker advocacy in treatment systems List of resources (including training opportunities) for providers 	<ul style="list-style-type: none"> Peer advocates educate help-seekers on guidelines to promote self-advocacy within treatment systems Peer advocates provide advice and/or conduct role plays with help-seekers to enhance their advocacy skills Peer advocates provide resources (including training opportunities) to treatment providers Peer advocates undertake informational outreach with providers at help-seeker request 	<ul style="list-style-type: none"> Increased self-efficacy for advocacy among LGBTQ help-seekers, leading them to advocate for their needs and avoid premature treatment termination Increased access to resources (including training) for providers in treatment systems
<ul style="list-style-type: none"> LGBTQ individuals do not necessarily recognize their level of risk and seek out mental healthcare/substance use services when needed 	<ul style="list-style-type: none"> Peer advocates trained in basic helping skills Information regarding risk behaviors and benefits of treatment services Information on available providers and how to access services 	<ul style="list-style-type: none"> Peer advocates help LGBTQ individuals identify risky behaviors and recognize benefits of treatment services Peer advocates provide LGBTQ individuals with information regarding available treatment services 	<ul style="list-style-type: none"> LGBTQ individuals initiate or continue use of treatment services

Table 2

Participant demographics.

	Control N= 25	Experimental N = 22	Total N = 47
<u>Sociodemographics</u>			
Age $\mu \pm$ S.D (range)	33.3 $\pm$ 11.1 (18 – 54)	37.1 $\pm$ 12.3 (20 – 61)	35.1 $\pm$ 11.6 (18 – 61)
<u>Sex Assigned at Birth</u> n(%)			
Female	11 (44.0%)	9 (40.9%)	20 (42.6%)
Male	14 (56.0%)	13 (59.1%)	27 (57.4%)
<u>Gender Identity/Expression</u> ^a n(%)			
Woman/Girl	10 (40.0%)	13 (59.1%)	23 (48.9%)
Man/Boy	9 (36.0%)	9 (40.9%)	18 (38.3%)
Transgender	4 (16.0%)	4 (18.2%)	8 (17.0%)
<u>Sexual Orientation</u> n(%)			
Bisexual	11 (44.0%)	8 (36.4%)	19 (40.4%)
Heterosexual	1 (4.0%)	1 (4.5%)	2 (4.3%)
Lesbian/Gay	10 (40.0%)	9 (40.9%)	19 (40.4%)
Questioning	1 (4.0%)	3 (13.6%)	4 (8.5%)
Other	2 (8.0%)	1 (4.5%)	3 (6.4%)
<u>Race/Ethnicity</u> ^a n(%)			
American Indian	14 (56.0%)	7 (31.8%)	21 (44.7%)
African American	1 (4.0%)	2 (9.1%)	3 (6.4%)
Asian American or Asian	1 (4.0%)	0 (0.0%)	1 (2.1%)
Non-Hispanic White	5 (20.0%)	9 (40.9%)	14 (29.8%)
Hispanic/Latina/o	8 (32.0%)	6 (27.3%)	14 (29.8%)
<u>Education</u> n(%)			
Less than High School	5 (20.0%)	6 (27.3%)	11 (23.4%)
High School/GED	4 (16.0%)	2 (9.1%)	6 (12.8%)
Some college, no degree	12 (48.0%)	9 (40.9%)	21 (44.7%)
Trade School/Associates Degree	2 (8.0%)	1 (4.5%)	3 (6.4%)
Bachelor's Degree or more	2 (8.0%)	4 (18.2%)	6 (12.8%)
<u>Employment Status</u> n(%)			
Full time	6 (24.0%)	5 (22.7%)	11 (23.4%)
Part time	6 (24.0%)	3 (13.6%)	9 (19.1%)
Unemployed – looking for work	3 (12.0%)	5 (22.7%)	8 (17.0%)
Unemployed – disabled, retired, or not looking for work	5 (20.0%)	5 (22.7%)	10 (21.3%)
Volunteer, Homemaker, or Student	5 (20.0%)	4 (18.2%)	9 (19.1%)
<u>Monthly Income</u> n (%)			
Less than \$500	6 (24.0%)	9 (40.9%)	15 (31.9%)

	Control N= 25	Experimental N = 22	Total N = 47
\$500-\$999	8 (32.0%)	6 (27.3%)	14 (29.8%)
\$1,000 - \$1,999	8 (32.0%)	5 (22.7%)	13 (27.7%)
\$2,000 - \$2,999	2 (8.0%)	2 (9.1%)	4 (8.5%)
\$3,000 - \$3,999	1 (4.0%)	0 (0.0%)	1 (2.1%)
<u>Relationship Status^a n (%)</u>			
Never married	8 (32.0%)	5 (22.7%)	13 (27.7%)
Legally married to mixed-sex partner	2 (8.0%)	3 (13.6%)	5 (10.6%)
Legally married to same-sex partner	0 (0.0%)	1 (4.5%)	1 (2.1%)
Cohabiting with mixed-sex partner	0 (0.0%)	1 (4.5%)	1 (2.1%)
Cohabiting with same-sex partner	6 (24.0%)	3 (13.6%)	9 (19.1%)
In a polyamorous/open relationship	0 (0.0%)	1 (4.5%)	1 (2.1%)
Separated	3 (12.0%)	0 (0.0%)	3 (6.4%)
Divorced	1 (4.0%)	3 (13.6%)	4 (8.5%)
Dating	2 (8.0%)	2 (9.1%)	4 (8.5%)
Other	4 (16.0%)	7 (31.8%)	11 (23.4%)
<u>Years in Geographic Area $\mu \pm S.D$ (range)</u>	15.92 $\pm$ 15.32 (.50 – 54.00)	8.38 $\pm$ 13.79 (.08 – 54.00)	12.48 $\pm$ 14.97 (.08 – 54.00)

^aParticipants could check all that apply, thus totals may add up to more than 100%.

Table 3

Participant baseline psychiatric conditions, assessed by the M.I.N.I. International Neuropsychiatric Interview 6.0.

Psychiatric Condition	Control N = 25	Experimental N = 22	Total N = 47
<u>Depression n (%)</u>			
Current or Recurrent Major Depressive Episode	20 (80.0%)	17 (77.3%)	37 (78.7%)
Current or Recurrent Major Depressive Disorder	2 (8.0%)	2 (9.1%)	4 (8.5%)
<u>Bipolar Disorder n (%)</u>			
Current Manic or Hypomanic Episode	3 (12.0%)	3 (13.6%)	6 (12.8%)
Bipolar Disorder I, II, or NOS (Past or Current)	5 (20.0%)	6 (27.3%)	11 (23.4%)
<u>Generalized Anxiety Disorder (current) n (%)</u>	7 (28.0%)	2 (9.1%)	9 (19.1%)
<u>Panic Disorder n (%)</u>			
Current	8 (32.0%)	5 (22.7%)	13 (27.7%)
Lifetime	11 (44.0%)	9 (40.9%)	20 (42.6%)
<u>Post-Traumatic Stress Disorder (current) n (%)</u>	7 (28.0%)	5 (22.7%)	12 (25.5%)
<u>Alcohol n (%)</u>			
Alcohol Dependence	9 (36.0%)	10 (45.5%)	19 (40.4%)
Alcohol Abuse	4 (16.0%)	7 (31.8%)	11 (23.4%)
<u>Substance n (%)</u>			
Substance Dependence	5 (20.0%)	10 (45.5%)	15 (31.9%)
Substance Abuse	4 (16.0%)	8 (36.4%)	12 (25.5%)

Table 4

Triangulation results organized by research questions, quantitative findings, qualitative findings, and convergence.

Research Questions	Qualitative Findings	Quantitative Findings	Convergence
Does consulting with an LGBTQ peer advocate enable help-seekers to develop social support outside of mental health/substance use services?	Participants expressed greater interest in increasing interactions and forging stronger social bonds with other LGBTQ people and allies. In general, they felt the peer advocates helped reduce feelings of social isolation.	Participants in the experimental and control groups did not show significant differences in social support over time. The marginal means and small effect size were in the expected direction; however, the clinical significance of these trends was small.	Qualitative results underscore that participants felt a sense of social isolation and lack of support in their communities. As they worked with the peer advocates, they began to experience decreased isolation. Quantitative findings suggest that (a) there was not an increase in social support for the experimental group or (b) an increase may have been detected with a larger sample.
Does consulting with an LGBTQ peer advocate enable help-seekers to increase advocacy behaviors involving their own mental health/substance use services?	Participants reported on their increased ability and motivation to assert themselves effectively in personal, professional and therapeutic relationships.	Participants did not significantly differ in their reactions to treatment over time. The marginal means and effect sizes were in the expected direction, which was notable given the small sample size.	Qualitative findings suggest that engaging with a peer advocate may have helped participants learn self-advocacy skills, leading to increased engagement in treatment with LGBTQ-affirming providers. Quantitative findings were not inconsistent with the qualitative results, yet the low power and small effect size yield inconclusive findings.
Does consulting with an LGBTQ peer advocate enable help-seekers to increase engagement in mental health/substance use treatment?	Experimental participants not already in treatment began contemplating seeking treatment services. Those in treatment reported increased engagement and satisfaction with services.	The quantitative results did not reveal differences in engagement in treatment.	Although the dichotomous quantitative variable did not reveal a pattern of increased treatment engagement, qualitative results underscore that many participants turned to their peer advocates to supplement their treatment, while others began to contemplate treatment.