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# Coaching mental health peer advocates for rural LGBTQ people

**Cathleen E. Willging, Ph.D.**[a], **Tania Israel, Ph.D.**[b], **David Ley, Ph.D.**[c], **Elise M. Trott, MA**[a], **Catherine DeMaria**[a], **Aaron Joplin**[a], and **Verida Smiley**[a]

[a]Behavioral Health Research Center of the Southwest a center of the Pacific Institute for Research and Evaluation, Albuquerque, NM

[b]University of California Santa Barbara

[c]New Mexico Solutions, Albuquerque, NM

## Abstract

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) people are affected by mental health disparities, especially in rural communities. We trained peer advocates in rural areas in the fundamentals of mental health, outreach, education, and support for this population. The peer advocates were coached by licensed mental health professionals. We evaluated this process through iterative qualitative analysis of semi-structured interviews and written logs from coaches and advocates. The six major themes comprising the results centered on (1) coaching support, (2) peer advocate skills and preparation, (3) working with help seekers, (4) negotiating diversity, (5) logistical challenges in rural contexts, and (6) systemic challenges. We concluded that peer advocacy for LGBTQ people with mental distress offers an affirmative, community-based strategy to assist the underserved. To be successful, however, peer advocates will likely require ongoing training, coaching, and infrastructural support to negotiate contextual factors that can influence provision of community resources and support to LGBTQ people within rural communities.

## Introduction

Lesbian, gay, bisexual, transgender, and queer or questionning (LGBTQ) people in the United States experience greater mental health and substance use challenges than their heterosexual and cisgender counterparts (Institute of Medicine, 2011). Their disproportionate rates of depression, anxiety, and suicidality likely originate in “minority stress” resulting from stigma, discrimination, and violence toward socially marginalized groups (Meyer, 2003). Minority stress operates within cultural institutions and social structures, including healthcare systems (Meyer, 2003), and may especially affect LGBTQ persons in rural areas (Barefoot, Rickard, Smalley, & Warren, 2015; McCarthy, Fisher, Irwin, Coleman, & Kneip Pelster, 2014; Willging, Salvador, & Kano, 2006; Williams, Bowen, & Horvath, 2005). When isolated from supportive social networks and unable to access LGBTQ-specific resources, risks for mental distress can multiply for rural gender and sexual minorities. However, social support that affirms gender and sexuality may buffer LGBTQ people in rural areas from the effects of minority stress and improve their mental health (Cohn & Leake, 2012; D’Augelli & Hart, 1987; Williams, et al., 2005).

Community health workers (CHWs) are individuals who have close knowledge of and want to contribute to the health and wellbeing of a local population. As described by the American Public Health Association (2015), CHWs are typically trusted members of the communities they serve, functioning as liaisons or intermediaries between health and social service systems and the community to improve access to needed care or assistance and the culturally competent service delivery. They can spearhead local outreach and education on public health issues and play pivotal roles in linking people to services and support. In contrast to the paraprofessional role of peer specialist who offers recovery-oriented support within mental health teams based in professional treatment systems (Gillard, Edwards, Gibson, Owen, & Wright, 2013; Salzer, Katz, Kidwell, Federici, & Ward-Colasante, 2009; Solomon, 2004), CHWs need not have personal experience of the particular health issues with which they are concerned. Whereas CHWs have tended to focus on physical health issues, this role has been adapted to address mental health concerns in underserved ethnic minority populations (Waitzkin et al., 2011). Community health worker models are consistent with peer counseling and advocacy efforts in LGBTQ communities (e.g., Wertheimer, 1992), and have been applied among gay men and transgender individuals at risk for or struggling with HIV infection (e.g., Kelly et al., 1997; Latkin & Knowlton, 2005; Tobias et al., 2010). Use of CHW models holds great promise in rural areas, where stigma related to alternative genders and sexualities and mental illness is common (Barefoot et al., 2015; Willging et al., 2006; Williams, Williams, Pellegrino, & Warren, 2012).

Peer- and community-based interventions are valued for enhancing social support for vulnerable groups (Solomon, 2004). For LGBTQ people, insufficient social support is associated with depression, decreased self-acceptance and self-esteem, suicidality, and other psychological and physical distress (Institute of Medicine, 2011). Given the prominent role that social support can play in alleviating such distress, the dispersed nature of rural LGBTQ people, and the history of subpar treatment in professional sectors (Willging et al., 2006), CHW approaches that aim to improve access to affirmative social support may promote positive outcomes for this population.

To enrich the mental health of rural LGBTQ people, the first three authors developed a peer-based intervention influenced by community psychology (Langhout, 2015) and the counseling profession (Glosoff & Durham, 2010), and CHW models (Grant, Ernst, & Streissguth, 1999; Waitzkin et al., 2011; Weeks et al., 2009). Called the “LGBTQ peer advocate intervention,” this program deployed specially trained CHWs to enhance services and social support for rural LGBTQ persons. Defined as lay people from LGBTQ communities, peer advocates are ideally knowledgeable and skilled in addressing LGBTQ mental health issues. The intervention involves grounding the advocates in the fundamentals of mental health, outreach and education, and support provision, and emphasizes engagement in community-based activities to: (1) facilitate contact between LGBTQ people with mental distress and substance use problems and LGBTQ-affirmative professional services; (2) promote advocacy behaviors among LGBTQ people as they navigate heterosexist treatment systems; and (3) assist in developing social support in rural areas.

Implementation of the intervention model required that prospective peer advocates take part in a four-day didactic and interactive training. Designed and delivered by the first three

authors, the training covered information on mental health and substance abuse, minority stress, diversity within LGBTQ communities, and rural treatment systems. The training was designed to increase the ability of the peer advocates to use basic helping skills (Aladag & Tezer, 2009; D'Augelli & Levy, 1978) and effectively support people seeking mental health services (Lenihan & Kirk, 1990). Skill development focused on needs assessment, solution-focused helping, suicide prevention, conducting presentations, negotiating communication conflicts, outreach, ethical decision-making, and self-care. Structure, content, and evaluation of the training is described in detail in a prior publication (Israel, Willging, & Ley, under review). Because they were based in diverse rural communities, the advocates participated in individual and group coaching sessions with the second and third authors via conference calls. Coaching was intended to augment the knowledge and skills gained from the in-person training through provision of ongoing mentorship to improve individual and team performance.

Mental health professionals, such as psychologists and counselors, have important roles to play in advocating for marginalized populations (Glosoff & Durham, 2010), and in training and supervising others in the provision of LGBTQ-affirmative services (Graham, Carney, & Kluck, 2012). They are also uniquely positioned to supervise and consult with paraprofessionals who provide mental health support and resources to underserved populations. Although a considerable body of scholarship on clinical supervision for mental health professionals exists, there is a gap in research regarding the actual delivery and effectiveness of coaching support for paraprofessionals. However, over two decades of research attest to the difficulties of tasking clinical staff to supervise paraprofessionals employed as CHWs (Gilson et al., 1989) and peer specialists (Cabral, Strother, Muhr, Sefton, & Savageau, 2014). In a variety of settings, clinically-oriented supervisors have been found to devalue the prevention and support work of these types of paraprofessionals. Clinicians, who are often not prepared in advance to supervise paraprofessionals, may also impose unrealistic expectations, or discover that supervision is too time consuming (Gilson et al., 1989; Rowe, de Savigny, Lanata, & Victora, 2005). Complicating matters, transportation and financial challenges can adversely affect supervision of lay providers in rural areas (Rowe et al., 2005).

While an evaluation of the LGBTQ peer advocate training program, a mixed-method intervention assessment, and an analysis of social support among LGBTQ help seekers are forthcoming, the purpose of the present study was to pilot test a largely remote coaching process to ensure that advocates in far flung rural areas received support and did not feel isolated. Group and individual coaching provided forums in which the advocates could ask questions and seek advice about the broad range of issues they encountered when working with help seekers. Coaching occurred over the phone once a month as a team, and once a month and as needed individually via phone, email, and occasional in-person meetings. The group sessions focused on broader concerns shared among advocates; individual sessions centered on the specific needs of each advocate, who came to the intervention with varying knowledge and skills in undertaking community-based activities for improving the mental health of rural but diverse LGBTQ people.

We draw upon qualitative process evaluation data collected during a feasibility and acceptability assessment of the LGBTQ peer advocate intervention led by the first author to report on implementation issues identified during the psychologist-led coaching process. Our analysis of this process highlights contextual factors affecting the activities of the advocates as they interacted with LGBTQ community members with mental distress in New Mexico, a poor and rural state with a public mental health system that has been subject to several major reforms in recent years (Willging & Semansky, 2014). Through this critical examination of the coaching process, we elucidate challenges influencing provision of social support and community resources to LGBTQ people, and consider the implications of these challenges for training and continued skill-building of LGBTQ peer advocates in particular and peer support specialists more generally. Finally, we discuss the implications of study findings for mental health professionals supervising paraprofessionals, such as peer advocates and peer specialists.

## Methods

### Study Context

New Mexico is unique in its social, racial, and cultural diversity. Hispanic and Native American people comprise over 57% of its 2,085,287 residents (U.S. Census Bureau, 2014). Poverty is a pervasive problem and the state's many small and dispersed rural communities are often medically underserved. Of New Mexico's 33 counties, 32 are federally designated Health Professional Shortage Areas or Medically Underserved Areas (Health Resources and Services Administration, 2015). The state also suffers from the first and second highest rates of substance-related illness and suicide respectively nationwide (New Mexico Department of Health, 2013).

### Sample

We hired four peer advocates to work 15 to 18 hours a week: a youth coordinator who identified as a Native American transgender person (male to female), a health educator who identified as a Native American mother of a lesbian daughter, an art gallery owner who identified as a White lesbian, and a business student who identified as a White gay man. Three had struggled with mental health or substance use issues in the past. None had prior mental health training. Although most advocates had some lived experience with mental health or substance use issues, they were chosen in accordance with a CHW model. Such models target individuals based on their identification with specific communities (in this case, rural LGBTQ communities), rather than limit participation to those with lived experience of particular mental health or substance use issues, as peer specialist models do (Gillard et al., 2013). After four months of employment, the youth coordinator terminated her position for reasons unrelated to the intervention. We conducted only one interview with this individual. The remaining three advocates (authors four, five, and six) remained for the 18-month intervention period. The two coaches were licensed psychologists who identified as bisexual; one classified her race as bi-racial Asian-American/White and the second described himself as White. One was a university professor; the other was the director of a mental healthcare agency. Both devoted approximately one afternoon per week to coaching advocates and study activities.

Recruitment for the peer advocate intervention focused on adult LGBTQ help seekers who were "experiencing mental health, emotional, or addiction issues" and interested in taking part in an "LGBTQ-affirming research study" in which they would be offered "LGBTQ-focused support resources." We used a combination of flyers, social media, email, and radio and newspaper ads from September 2012 through August 2013 to recruit help seekers living in the vicinity of three adjacent rural counties. These counties shared similar population characteristics, including large numbers of Latino and Native American participants. Moreover, the peer advocates also self-identified as being part of loosely-organized LGBTQ communities within these same counties. Potential candidates for the study called a toll-free number to determine if they were eligible for participation. Approximately half of candidates who qualified for the study were assigned LGBTQ peer advocates who were to work one-on-one with them and others in the community to better support LGBTQ people and to advocate on behalf of their treatment needs. The research staff received 117 inquiries and conducted 83 initial eligibility screenings. Of the 73 callers who met initial eligibility criteria (i.e., age 18 and older, identification as LGBTQ or as "questioning," "same-sex attracted," or "troubled by or uncomfortable with one's gender," and having a mental health or substance use disorder), 65 took part in a longer baseline interview. The 65 help seekers who completed the baseline interview all met study criteria, and were either assigned to the experimental ($n$ = 34) or control ($n$ = 31) condition via a randomization procedure. The help seekers in the experimental condition were told that the peer advocate assigned to them would contact them within the next 72 hours.

## Data Sources

We conducted semi-structured interviews with the peer advocates and coaches midway through implementation to ascertain the need for mid-course corrections, and at the end of implementation. As noted by the respected evaluator, Michael Quinn Patton (2015, p. 311), "in-depth information from a small number of people can be very valuable, especially if the cases are information-rich." As the only project interventionists, the advocates and coaches possessed a great deal of first-hand information regarding program implementation and the coaching process. The 60- to 90-minute interviews consisted of open-ended questions to obtain this information, including overall assessments of the intervention, its effect on their own practice, and factors affecting fidelity to the intervention implementation plan. Due to the limited size of our sample, the interviews afforded a deep understanding of the coaching process but were unable to produce empirical generalizations. However, we augmented the interviews with the written logs of the coaches and advocates that were compiled throughout the intervention period. The coaches completed the logs to document problems or issues identified during group and individual coaching sessions with the advocates, i.e., factors affecting implementation of the intervention or "lessons learned" while mentoring these lay providers. Likewise, peer advocates drafted logs detailing their outreach efforts and interactions with help seekers. The digitally-recorded interviews and logs were transcribed into an electronic database and analyzed through a series of iterative readings and codings, as described below.

### Analysis

A systematic line-by-line categorization of data into codes using the qualitative software NVivo (QSR International, 2012) allowed us to determine prominent themes pertaining to the coaching process. To analyze these data, we developed a descriptive coding scheme from transcripts based on the interview questions and the written logs. We undertook "open coding" of all transcripts and logs to determine new themes and then used "focused coding" to determine which themes were repeated often and which represented unusual concerns. We created detailed memos that described and connected the codes to each theme. By continually comparing and contrasting codes, those with similar content or meaning were grouped together into broad themes linked to segments of text in the NVivo database (Corbin & Strauss, 2008; Patton, 2015).

## Results

The first and fourth authors condensed the final codes from our iterative analytic process into six major themes: (1) Coaching support; (2) Peer advocate skills and preparation; (3) Working with help seekers; (4) Negotiating diversity; (5) Logistical challenges in rural contexts; and (6) Systemic challenges. The peer advocates reviewed the findings while performing a final accuracy check, and offered input into the analysis and interpretation of the data (Patton, 2015). We describe each finding in detail below, and include quotations to illustrate significance.

### Coaching Support

All participants agreed that group and individual coaching helped the peer advocates to be more responsive to help seekers who presented with a range of needs, and to identify and deal with problematic issues that arose in the course of their interactions with help seekers. With regard to the individual coaching, the advocates praised the coaches for providing a sounding board and for being both useful and "responsive" to their concerns about engaging help seekers and navigating local service systems. One advocate stated that, "They're [the coaches] available. They're always there when you need support." A second advocate agreed: "Every time I've ever needed [advice], usually [name of coach] is who I talked with. I've always been able to get a hold of [her/him] or [s/he] calls me back fairly quickly." The third advocate confirmed that whenever there was a need for coaching, "We always got a call back in a reasonable amount of time and we were able to work through whatever it was that we needed assistance with." A key example of the assistance provided by coaches included an instance in which a coach guided an advocate through a crisis with a suicidal client. The advocate explained, "My first reaction was to call the ambulance… I calmed down and I called [the coach]." This advocate's coach then helped her/him ask questions to help the participant work through the crisis. The advocate concluded, "That was really good coaching and they're available whenever you need them."

In contrast, the coaches suggested that competing demands, scheduling, and keeping up with email correspondence represented significant challenges that sometimes prevented them from fully attending to the issues presented by the advocates. They indicated that hiring a full-time coordinator and supervisor would strengthen the support for the advocates and

afford more immediate access to in-depth consultation, yet also recognized that such a strategy was not cost-effective and likely to be difficult to implement in rural underserved environments.

The evolving nature of the coaching process underscored the need for greater structure in the group sessions. Both coaches described initial problems with the conference call format. One explained, "[At the beginning,] it was these vague unstructured calls that I suspect the peer advocates weren't finding very useful." This coach decided to organize the calls differently a quarter-way through the intervention period, creating fictional scenarios based on real issues discussed in individual coaching sessions to impart strategies to deal with difficult situations. Both coaches reported that this structure appeared to enhance discussion and better prepare the advocates for their work with help seekers. They also felt that by tackling the different scenarios together, the phone calls were less daunting to the advocates, enabling them to connect with one another and understand that they all had similar concerns and experiences to share. Both coaches, moreover, were firm in stressing the need for a formal and consistent coaching process that entailed ongoing formal assessment that would make it easier to ascertain the ways in which peer advocates were building skills and using information from group and individual sessions.

For their part, the peer advocates noted that the group calls sometimes devolved into "reporting" sessions. To deepen their connections to one another, they often took the initiative to interact and learn from one another without the coaches present. One advocate explained,

> The advocates talk to one another…. 'What do you think about this?' 'How about that?' 'This is what I ran into.' We help each other as best as we can for whoever is available…. Sometimes I feel that that interaction is almost much more productive than our monthly meetings because all we're doing really on our monthly meetings is kind of reporting.

A second advocate emphasized the importance of "just being available" to support each other when engaging in cross-cultural communication:

> I was telling [another advocate], 'Whenever you're ready for a presentation,' I [will] make myself available to [assist]; since s/he's not Native and s/he's [in place where] there's a lot of Natives. I said 'if you'd like for me to attend—if you set up anything and you'd like for me to go out there and talk…. I would be happy to help you out that way.'

In sum, the advocates appreciated the support they received from the coaches. However, the growing camaraderie among the advocates helped to augment the coaching process by providing outlets to share, analyze, and learn from the challenges of engaging in paraprofessional work.

### Peer Advocate Skills and Preparation

In the course of implementing the intervention, the peer advocates and coaches gained further insight into the range of knowledge and skills required for peer advocacy. Peer advocates needed to be computer literate and possess basic word processing skills to

complete study documentation and store it in a centralized server, and to navigate the Internet and social media sites to conduct community outreach. However, these requirements were not included in the initial list of skills recommended for advocates. The intervention team, comprised of persons immersed in academic, research, and service settings, erroneously assumed that the advocates would already possess these skills. However, their prior work experience simply had not required a great deal of proficiency in these areas. One advocate noted the irony, “Just like us as peer advocates we meet certain people and you’ve got to bring yourself down to their level. I think the coaches have high expectations and they have knowledge of the computers and everything else so they just figure everybody does.” Two peer advocates also lacked previous experience with social media, let alone how it could be utilized for community outreach purposes. During the coaching sessions, the advocates identified the need for technology skills training, such as utilizing Facebook, cell phones to access email, and PowerPoint for presentations. The coaches enlisted the support of a project staff member who checked in by phone with each advocate on a weekly to biweekly basis to provide skill building in these areas.

Second, peer advocates were expected to develop outreach skills for forging connections to community resources, particularly service agencies and healthcare practitioners, to point help seekers in the direction of available services, and to encourage local providers to reach out to LGBTQ people in their communities. To fulfill this bridging function, the advocates required familiarity with the service continuums in their catchment areas. One coach explained, “It’s really important to be able to understand specifically like what are the key agencies and systems and individuals within that particular peer advocate’s geographic area.” Yet, the majority of rural areas where they were both living and working were characterized by the advocates as “resource deserts” for LGBTQ people. As we describe below (Systemic Challenges), the broader changes taking place to mental healthcare throughout the state also created complications in identifying and accessing needed providers and services. At the same time, two of the advocates were unfamiliar with the overall process of performing outreach and experienced discomfort when engaging in such activities, although their confidence grew over time.

Both the peer advocates and coaches reported that the initial training fell short in preparing the former to perform outreach and build resources within the community. While the basics of establishing support groups and organizing social events were covered, these topics were not explored in sufficient depth, and due to the truncated timeline for the intervention pilot test, the advocates did not have sufficient time to fully involve themselves in these activities prior to taking on caseloads. One coach gave an example of an advocate not feeling either prepared for or supported in starting an LGBTQ support group in her/his home community. The coach explained that in contrast to the one-on-one work with help seekers,

> …the [community organizing] things have more variables of multiple people and dynamics in the community. It’s more challenging than having an established protocol and program to implement. Part of it requires being responsive to the needs of the community and recognizing the differences in varied communities…. We didn’t lay it out enough even in the training…to the point of [peer advocates] being able to do that.

As a result of this shortcoming, the coaches worked with the advocates individually and collectively to identify aspects of the intervention that most excited them and that might have made a difference in their own lives had they received support from an LGBTQ peer advocate in their pasts. The advocates were encouraged to tap into these perspectives when eliciting interest in and building enthusiasm for the intervention among LGBTQ people, local service systems and providers, and the broader public through community presentations. At the same time, outreach work turned out to be new to at least one of the coaches as well, limiting this individual's ability to adequately train advocates to perform community engagement activities.

### Working with Help Seekers

Peer advocates generally believed that their work was significant and valuable, for both themselves and the help seekers. One advocate appreciated the "human contact" and feeling "as though something I did or said made a difference in somebody else's life." This advocate also underscored the satisfaction of being able to assist help seekers in crisis, observing, "I felt like what I did had value." A second advocate also felt empowered by the opportunity to "make a change in a positive way" in the life of a help-seeker. At the same time, the advocates clarified that their work as lay providers was not easy. A third advocate referred to the experience as an "up and down roller coaster…. Happy, sad, all the emotions that you can think of."

Peer advocates suggested that while the training and the coaching helped build confidence in their new roles as paraprofessionals, the magnitude and intensity of the serious mental health and substance use issues faced by underserved help seekers still came as a shock. Consistent with a CHW model, peer advocates did not necessarily have personal knowledge of or experience with these issues. Accordingly, the "easiest" help seekers for advocates were "ones that had problems related to sexual orientation," "wanted mental health or substance use services," and were engaged in "goal setting" and "action planning." However, the advocates observed that they were frequently dealing with "harder" help seekers. Echoing colleagues' sentiments, one advocate disclosed that s/he had initially considered only the "pretty side of the picture" when it came to the lives of help seekers. Peer advocates often referred to the poverty that affected the majority of help seekers and intensified their mental distress, which in turn exacerbated their feelings of social isolation and exclusion.

Peer advocates were also surprised by delays or challenges in connecting with help seekers that they sometimes attributed to a lack of desire among these individuals to proactively address their mental distress and substance use concerns. They felt that some help seekers did not "pull their weight in the change process." One advocate had the perception that such persons were not in a place where they could accept help: "You get help for somebody and the resource is there, everything is right there, and they turn their back and they say, 'No that's not what I want.' It's like, 'Come on!'" This advocate was disheartened by unreturned phone calls and emails: "It's kind of frustrating to be exhausting your phone calls and emails and everything else. To me it seems like is it my fault they're not calling back?" This advocate often blamed her/himself when help seekers did not respond to overtures for assistance.

The coaches, in turn, sought to help the advocates set reasonable goal expectations and boundaries with help seekers. They affirmed the difficulties of maintaining optimism when help seekers displayed low levels of personal motivation for change, and set up additional in-person training opportunities on addiction issues and engagement strategies. One coach explained the rationale for this course of action, “Some of that had to do with understanding peoples’ personal and situational limitations in their lives, and recognizing that they weren’t going to make as much progress as they might hope or that the peer advocates might hope.” Yet, despite these efforts, the advocates underscored the learning curve involved in assisting rural LGBTQ people with complicated needs, with one explaining, “This isn’t my background. It takes a long time for things to sink in.” This learning curve also entailed recognizing how stigma related to addiction and mental illness impacted their interactions with help seekers, especially persons with chronic alcohol or heroin dependence, or social limitations from psychosis or emotional disturbance.

Both the peer advocates and coaches underscored the importance of recognizing the degrees of turmoil that might exist in the lives of help seekers. Interestingly, however, several help seekers expressed needs that were apparently quickly resolved, after which time they felt no need for continued support. One help seeker asked for assistance both accessing Medicaid and coming out as LGBTQ to her/his parent. Once those tasks were accomplished, s/he no longer felt the need for continued support. In such cases, the coaches advised the advocates to maintain positive connections to the help seekers in anticipation of offering them support in the future if the need arose. Notably, however, the advocates often experienced help seekers who were more interested in general assistance to improve their quality of life, from aid applying for public assistance programs to developing budgeting skills, than support for gender and sexuality issues. The peer advocates thus found themselves performing case management work, even though they lacked the education, training, and hours of employment to adequately meet those needs.

To address these concerns, the coaches hosted group sessions with a case manager representing a multi-service mental health agency and a peer specialist who worked for a large managed care company that oversaw statewide delivery of publicly-funded behavioral health care. These individuals shared information about their backgrounds, experiences, and approaches to assisting help seekers in underserved areas of the state. The advocates learned that many of the challenges they were experiencing were not uncommon, even for persons integrated into mental health teams and occupying a more professionalized role within the delivery system. Both the advocates and the coaches agreed that these interactions helped the advocates better understand and define the value of their work and how easily it could slip into case management due to the sheer lack of community resources within the regions where they were based.

Additionally, the peer advocates occasionally encountered help seekers whose desired support was at odds ideologically with the goals of the intervention. Specifically, two help seekers who identified as gay men expressed desires to be heterosexual. In both cases, the coaches encouraged the advocates to acknowledge these goals while also providing these help seekers with information about protecting themselves from shame and the harmful effects of conversion practices. In both instances, the advocates successfully offered positive,

encouraging, and supportive relationships without judgment, such that both help seekers later returned seeking support for establishing healthy sexual identity and engaging other LGBTQ people.

Finally, the peer advocates cited the difficulties of maintaining consistent contact with help seekers when itinerant working phone lines or Internet connections affected the largely impoverished help seekers in their caseloads. To encourage tenacity, one coach reiterated to the advocates that sustaining contact was a pervasive problem in the healthcare fields: “[It is] a common issue among clinicians and health workers, which is ‘Out of sight, out of mind,’ and it’s the folks that [peer advocates] hadn’t heard from that would kind of drop off.”

Although the advocates never experienced verbal or physical threats to their own person, the coaches dealt repeatedly with their risks and concerns related to working with help seekers involved in violent domestic relationships, or actively using illicit drugs or alcohol. As the advocates encountered these situations, the coaches put additional policies and protocols in place to guide their responses and monitor their safety. The protocols were adapted from existing ones used in mental health agencies. However, use of these guidelines with a group of non-clinical semiprofessionals raised new challenges. Nonetheless, one of the advocates insisted that her/his exposure to the problems-in-living encountered by other LGBTQ people with mental health and substance use issues led her/him to comment that the peer advocates were “definitely needed” within the region s/he served.

From the perspective of the coaches, the specific context of the implementation environment (e.g., a public behavioral health system under stress and the constraints of rural and economically-challenged communities) meant that the peer advocates required a great deal of support in developing their abilities to make effective decisions and protect their own boundaries. In some cases, advocates did not perceive situations, such as entering a help seeker’s home or providing them with transportation, as risky or unsafe. In other similar circumstances, they were very concerned about situations that seemed unlikely to escalate or be unsafe. Coaches used material and information related to crisis de-escalation and awareness to assist advocates in identifying risky situations and preparing to deal more effectively with them. Special attention was given to situations where help seekers were under the influence of drugs and/or alcohol, as well as where weapons and/or a history of violence were known to be present. When the advocates interacted with help seekers in possibly risky situations, arrangements were made to notify coaches before and after the interaction to ensure that both the advocates and the help seekers were supported. In one such instance, an advocate described feeling much more comfortable about visiting a help seeker in her/his home when the coach was monitoring her/his safety by phone. S/he appreciated “[having] that support to say ‘I’ll call you, give me the phone number, what time you’re going there, what time you’re coming out.’ It was really good.” Another advocate recalled being taught to be more “assertive” about establishing boundaries and expectations with help seekers, such as asking a participant not to use drugs in her/his presence or pursuing other participants who did not show up to meetings. At first, the advocate had been unsure whether it was appropriate to set such boundaries “because I know that we’re working with folks that can kind of shy away [from help];” however, “[the coach] let us know that it is okay. You can be assertive…. It’s okay to kind of put your foot down.”

### Negotiating Diversity

Peer advocates and coaches agreed that knowledge about LGBTQ people and cultural difference was crucial to serving effectively as advocates. The advocates all entered the training program with strong commitments to support diversity and promote LGBTQ acceptance. They each came with deep familiarity with their particular communities and both knowledge and empathy stemming from their individual experiences with LGBTQ issues in those communities. In this sense, the advocates possessed greater in-depth knowledge of their particular cultural niches than the professionally-trained coaches. However, through their training, teaching, and clinical expertise, the coaches contributed both a broader perspective on a range of populations and situations and a greater familiarity with the process of critically examining their own views and values. Consequently, the coaches were able to complement the deep knowledge of the peer advocates by encouraging them to expand their frames of reference beyond their individualized experiences and those of their immediate social networks. As an example, one advocate was assigned to work with a help seeker who identified as bisexual and polyamorous. Although the advocate was accepting and supportive, s/he had no prior experience with polyamorous-identified individuals. Through individual coaching sessions, s/he was able to work with the coach to increase her/his knowledge and understanding of polyamory and explore how to approach individuals engaged in such relationships in the peer advocacy process. Another advocate reportedly expanded his/her familiarity with lesbian and gay identities and issues prior to becoming part of the intervention: “The other, transgender and queer and all that stuff, was really helpful to understand where my peers were coming from…. That was really helpful.”

Although the peer advocates indicated that initial training about cultural difference was useful, it was actually their interactions with help seekers that appeared to increase their overall comfort level and confidence with a wide range of LGBTQ people. However, during coaching sessions, it became clear that ongoing attention needed to be paid to stigma arising from internalized homo-, bi-, and trans-phobia, and how the advocates might inadvertently reinforce this stigma during their interactions with help seekers. As one coach clarified, the persistence of such stigma was perhaps best exemplified by a peer advocate who once assured a help seeker that her/his problems were “perfectly normal ones that were even encountered by straight people.” The coach focused on mentoring this advocate to grow in critical awareness of how ideas about “normality” worked to reinforce heterosexual privilege and anti-LGBTQ stigma.

The individual and group coaching sessions provided opportunities for the peer advocates to reflect on their own possible biases related to segments of the LGBTQ population. For example, the advocates who identified themselves as lesbian or gay were admittedly reluctant to work with individuals with bisexual histories. In one instance, an advocate asked the coach whether a help seeker was truly “gay enough” to meet intervention inclusion criteria. Over time, the advocates became more aware of how the experience of being LGBTQ might differ culturally. “It is so important to respect the cultures that you’re going into,” expounded one advocate, while a second recommended that future trainings should dig even further into the range of cultural diversity within the multi-ethnic state of New Mexico. Concurrently, peer advocates expressed frustration with being unable to reach out

effectively to individuals of cultural backgrounds different from their own, such as Latino people with socially conservative upbringings, whom they characterized as less likely to seek help for mental health issues.

Finally, the "fit" between peer advocates and help seekers emerged as a concern for the coaches, one of whom observed that the advocates sometimes struggled to build helping relationships with culturally and socio-economically diverse individuals. The coaches explained how advocates occasionally lapsed into a view of help seekers as intrinsically different from themselves and others. Such attitudes, they suggested, impeded development and maintenance of empathic relationships with help seekers. Like the peer advocates, the coaches suggested that future iterations of the intervention would require far greater and consistent attention to developing skills to recognize and bridge these differences in pragmatic and meaningful ways.

### Logistical Challenges in Rural Contexts

A common challenge for peer advocates was finding safe locations to meet and support peers. Some efforts were made to partner with mental health agencies to facilitate the sharing or leasing of office space; however, such efforts failed due to liability issues compounded by the systemic challenges faced by these agencies. Consequently, the advocates met with help seekers in their homes, libraries, coffee shops, cafeterias, and public park settings. Many coaching sessions included troubleshooting this limitation. The advocates preferred to present a "competent" and "professional" face to the help seekers and struggled with this when meeting in public venues. Convening in such venues also posed the risk of exposing the help seeker's gender or sexual identity through visible contact with persons potentially known to the general community as LGBTQ advocates. Meeting in homes, which offered protection from public exposure, posed risks to safety and liability. One advocate summed up the concerns shared with her/his colleagues, "[It feels] like you're on your own out on the frontline. You're really sticking your neck out in your community and you don't really know how that might backfire on you."

Logistical issues of rural areas also placed limitations on the coaching process. Because Internet connections were not always available to the advocates, it was difficult to connect via Skype, which would make face-to-face contact possible. One coach felt unable to stay on top of the advocates' needs from a distance: "Telephonic supervision or coaching or consultation is fine up to a point, but it makes it hard to identify what you don't know and to catch it." This coach suggested that advocates were more willing to openly share frustrations and struggles in person. Long-distance interactions thus made it harder to isolate issues and concerns to address with each advocate. The advocates echoed the coaches' comments about the limitations of online coaching imposed by their rural context, and would have preferred more in-person coaching. In particular, the peer advocates wanted the coaches to observe and experience firsthand some of the settings where they were meeting with peers. One advocate explained, "I would say the coaches [should] come up and see what we're all dealing with in our individual areas because it sounds like we're all facing a lot of the same problems, but it's also different." Nonetheless, one advocate summed up, "I think having it [coaching] a little bit more personable would help with like being able to do some face to

face. But having somebody even at the other end [of the phone] that was really responsive was wonderful."

As noted above, the peer advocates communicated with one another by phone and made themselves available to provide input into each other's outreach presentations. However, the wide dispersal of advocates across service regions meant that they also lacked regular and face-to-face contact with co-workers engaged in similar work. Both the advocates and coaches believed that this source of support would buffer the former from sometimes feeling "alone" in their efforts. One coach elaborated on the significance of having a centralized office location:

Most people in their work have a place to go with other people around who share similar struggles and have resources and experience to share…. If we were able to place the peer advocates in a setting like the public health department, it would increase their engagement with existing systems, and reduce the degree to which they have to generate new solutions to each problem.

This coach also emphasized that it is important in such situations to ensure that the peer advocates continue to prioritize in-community or out-of-office services and connections.

### Systemic Challenges

The vast majority of help seekers were reliant on a fractured and underfunded public mental health system. The initial training and coaching included several hours of description of this highly bureaucratic yet often disorganized system to prepare the advocates for the challenges that likely awaited them. Despite these efforts, the coaches were consistently dismayed by the magnitude of obstacles that the advocates and help seekers faced in obtaining mental healthcare. Peer advocates had to assist help seekers in applying and qualifying for health insurance benefits, arranging transportation, and navigating complex bureaucracies. One advocate struggled for a long time to assist a help seeker in procuring Social Security benefits and establishing eligibility for public mental healthcare. Access to these benefits was impeded by a history of violence that led the help seeker to be banned from Federal buildings. The advocate assumed the unique task of educating Federal security staff about mental health needs, and negotiating safe compromises, in order to allow the help seeker to gain benefits and subsequent mental healthcare.

During the intervention period, the public mental health system experienced major disruptions, as the state government introduced a new managed care model and enacted stringent restrictions to basic services, particularly case management for adults with mental illness. These disruptions made it harder to access clinical services in general and undermined the ability of the advocates to work in tandem with providers. One advocate was even forced to make her/his own intake appointment simply to be able to talk to a provider. The limited supply of accessible clinicians created difficulties for both advocates and coaches, who struggled to identify feasible goals and interventions within the scope of their training and role.

## Discussion

Supervision for practicing mental health professionals usually involves a process that is quasi-therapeutic, with the supervisor identifying and understanding the strengths and weaknesses of their supervisees, and then monitoring them in ongoing interactions of coaching and consultation (Barnett & Molzon, 2014). This study has illuminated the critical role that coaching processes can and must play for paraprofessionals who provide mental health-related support. The results of this study also revealed that although the peer advocates and coaches agreed that coaching was integral to the intervention, the process required modification. In addition, the experiences related to coaching helped to identify limitations of the initial peer advocate training and the intervention as a whole.

Overall, the peer advocates viewed the coaches as assets who offered useful information and suggestions, and who nurtured a space to reflect on their work and relationships with LGBTQ help seekers of diverse cultural backgrounds. Coaching was most effective in offering guidance through structured individual and group interactions focused on working directly with help seekers. This was useful even for addressing issues with help seekers with complex needs (e.g., those with comorbid illnesses) and the reactions of the advocates to some marginalized help seekers. While multiple challenges arose over the course of the intervention, the coaching process proved to be resilient and adaptable to many unforeseen circumstances. Coaches were able to provide timely guidance to advocates in establishing treatment goals, problem solving, and managing countertransference. Their training as licensed psychologists skilled in clinically supervising trainees in individual and group settings and expertise in both mental health and LGBTQ issues also seemed crucial to their ability to identify and tackle complicated issues and intersections, such as biases among advocates and substance use among rural LGBTQ residents.

Nevertheless, this study revealed important limitations to be addressed in future iterations of the intervention. First, while training and coaching prepared peer advocates well for much of their work directly with LGBTQ help seekers, they felt unprepared and unsupported to perform outreach among LGBTQ people, community groups, and service providers. Although we recognized that the training would not be sufficient to completely prepare the advocates for their community outreach role, we underestimated the amount of preparation required for this aspect of their work. Without a foundation of outreach skills, the coaches were then constrained in their ability to offer sufficient guidance from afar. The limited effectiveness in coaching the advocates to conduct outreach was also likely due to their own lack of experience and the inadequacies of models of clinical supervision to address the complexities and practicalities of community outreach, i.e., dissemination of information to the public about LGBTQ mental health and substance use issues, helping LGBTQ people actually access treatment services, sharing strategies for social empowerment, and creating supportive community networks.

In future interventions, offering more training content on outreach, and interspersing this content over time, may enable the advocates to absorb and practice outreach skills prior to learning and implementing work with individual help seekers, thus enhancing their self-efficacy related to outreach, and the effectiveness of coaching and of the overall intervention.

Strategies to strengthen the training could include broadening the pool of coaching experts to include persons who specialize in strategies for undertaking community outreach, lengthening the number of sessions to accommodate new content and to role play various outreach scenarios, and to involve representatives from local provider agency and advocacy groups so trainees may learn about how best to make contact and collaborate effectively with them. This would also provide the staff of these entities an introduction to the LGBTQ peer advocate role (Grant et al., 1999).

Coaching activities must also build upon initial training to cultivate confidence among peer advocates in a range of activities that may fall outside the comfort zones of both coaches and advocates, such as public speaking or making headway communicating with beleaguered providers in local mental health systems. In contrast, common supervisory models in psychology and counseling center on the conduct of psychotherapy and the practitioner-client relationship, rather than community outreach. It would be potentially beneficial to supplement coaching provided by mental health professionals with guidance from people with experience conducting outreach in rural areas, such as health educators or community organizers. Indeed, the advocates benefitted from follow-up training by a case manager and peer specialist.

Other challenges related to coaching may be best explained through infrastructural limitations of the intervention. In contrast to other programs in which peer specialists are recruited to work in professional clinical settings and as part of interdisciplinary mental health teams (Gillard et al., 2013), the peer advocates in this study were positioned as CHWs outside of professional systems of care and expected to work largely independently. This strategy was derived from the recognition that mental health agencies in rural areas were sometimes identified as being “part of the problem” for not providing LGBTQ-affirmative services or dealing with the adverse repercussions of minority stress (Barber, 2009; McCarthy et al., 2014; Willging et al., 2006). This lack of infrastructure coupled with rurality created an environment in which the peer advocates were physically isolated from each other and from clinical support due to their rural and geographically separate locations. Electronic and phone support provided the best possible opportunities to coach advocates but prevented observation of the visible signals or cues that the coaches usually relied on to gauge issues of transference, resistance, parallel processes, or other common issues encountered by novice mental health professionals (Falender et al., 2004; Goodman, 2005).

Independence from professional clinical settings was not problematic for peer advocates when they were working with relatively high-functioning help seekers and may even have facilitated their interactions with individuals who were critical of local systems. However, for help seekers with more severe and complex mental health and substance use issues, the advocates had neither the training nor the supportive infrastructure to be the most optimal helpers. In these situations, the coaches struggled at times to identify different expectations for each advocate, compared to those they might otherwise set for both specialty mental health providers and case managers in professional treatment systems who typically have greater education in care provision (Cabral et al., 2014), and training in maintaining personal and emotional boundaries when working with vulnerable and emotionally-demanding individuals (Chinman, Shoai, & Cohen, 2010). As a result, coaching in the context of this

intervention had to take on a more directive, didactic approach to ensure that the advocates set and maintained appropriate and effective boundaries with help seekers.

It is possible that paraprofessionals outside existing systems of care cannot work optimally with people with serious mental health and substance use issues if they do not have direct experience of these issues or without support from a broader team of treatment and social service professionals. For some level of severity, it may be necessary to train and use certified peer specialists already versed in the nuances of mental health, addiction, and treatment to also address the unique support needs of LGBTQ populations. For example, the State of New Mexico designates “certified peer support workers” as “individuals in recovery from mental health and/or substance use issues who have successfully completed a training class and passed a certification exam” (Office of Peer Recovery & Engagement, 2015). These certified workers “use their experience to inspire hope and instill in others a sense of empowerment” and “are trained to deliver an array of support services and to help others identify and navigate systems to aid in recovery” (Office of Peer Recovery & Engagement, 2015). As members of interdisciplinary mental health teams, certified peer support workers should ideally have greater access to clinical and organizational support resources when assisting help seekers down their recovery paths.

Finally, the LGBTQ peer advocates and coaches were sometimes frustrated by the lack of structure and professional affiliation resulting from their independence from a professional clinical setting. Because the advocates had opportunities to interact with individuals such as therapists or case managers based in agencies, they were well aware of the professional resources available to these staff but not to them (e.g., a dedicated office for meeting with help seekers). Although the advocates never stated that they themselves wanted to assume professional roles as therapists or case managers, they evinced a strong and understandable desire for interpersonal support and tangible resources that come with deeper funding and organizational structure. When working in an outreach capacity, the advocates wanted to be perceived as “professionals” by others, such as local government officials, health and mental health providers, and advocacy groups, to enhance their credibility and ability to form collaborative relationships locally. At the same time, they also experienced pressure in communities to function in a more “professional” capacity as *de facto* case managers and even as counselors. This pressure likely arose from professional provider shortages and service delivery inadequacies exacerbated by the systemic issues faced by mental healthcare agencies in New Mexico (Willging & Semansky, 2014).

Study findings point to several recommendations for interventions involving coaching of community-based paraprofessionals. Consistent with the broader CHW literature, we emphasize the need to plan for ongoing training and supervision to adapt to the challenging environments and infrastructures in which CHWs find themselves (Crigler, Gergen, & Perry, 2013; Naimoli, Perry, Townsend, Frymus & McCaffery, 2015). Training should not be restricted to the beginning of a CHW’s tenure, as concerns will likely arise post-training when supervision may occur infrequently (Salzer et al., 2009). The peer advocates in this study reported minimal problems obtaining consultation from the coaches, whom they repeatedly praised for being responsive. Yet, while they felt supported, they also suggested that the coaches did not anticipate and thoroughly prepare them in advance for the various

challenges they experienced as advocates. They also expressed the need for coaching that responded more directly to their local contexts. Based on this finding, we encourage designers of programs based on CHW models to engage workers in bottom-up planning processes that identify specific goals and strategies for supervision based on local implementation circumstances, and that also attend to testing and refining those strategies over time.

Mental health professionals who serve as coaches must also remain mindful of social attitudes and biases possibly inhibiting peer advocates from connecting with help seekers. When such sentiments are uncovered, it is essential to incorporate them into “teachable moments,” wherein peer advocates are encouraged to identify and understand their own biases to improve their abilities to serve diverse individuals. Ongoing assessment and training can increase the sensitivities of peer advocates to alternative gender identities and sexual orientations, and bolster their boundary maintenance skills when working with help seekers experiencing severe and multifaceted mental health, substance use, and psychosocial problems.

Possible approaches for supervision in places where professional in-person support is lacking include formal engagement with community-based organizations with capacity to provide mentorship in areas relevant to the specific intervention that is to be implemented and the training of CHWs to provide peer supervision to one another. Based on our findings, we believe the LGBTQ peer advocate intervention would benefit from a hybrid supervision structure in which community and/or peer supervision supplements periodic consultation with mental health professionals (Crigler et al., 2013; Naimoli et al., 2015).

Depending on the size and scope of similar interventions in the future, a dedicated supervisor may be needed to organize and support the work of LGBTQ peer advocates and to facilitate timely access to in-depth professional consultation. We would also recommend sharing centralized coaching expertise across multiple peer advocacy programs to justify this position while maximizing local resources to address LGBTQ mental health disparities. Periodic retreats in which advocates, coaches, and other project staff can step back to assess progress and implementation needs, troubleshoot logistical and practice-related issues, and celebrate accomplishments may help build morale and facilitate adoption of a wider perspective regarding these challenges and the intricacies of resolving them (Grant et al., 1999). Regular meetings will make it possible to actively exchange information and ideas while staffing individual help seekers, to foster a spirit of creativity, flexibility, and perseverance among the advocates, and to identify and resolve administrative or logistical matters as they may arise (Grant et al., 1999).

## Limitations

This process evaluation focuses on the experiences of a small sample of coaches and lay community providers who took part in the pilot test of a novel peer advocate intervention within a single state. The richly descriptive interview data gathered for this study are therefore of modest quantity, although they are supplemented with extensive written logs compiled by both parties throughout the intervention period. These logs augment the interview data by providing detailed insight into implementation issues encountered by the

project interventionists in “real time.” Despite its generalizability constraints, this study contributes to the limited research base on coaching for mental health paraprofessionals. It also sheds light on coaching processes both in rural communities and to deliver CHW interventions for LGBTQ people. Additional studies are needed to determine the degree to which the implementation issues documented here are relevant to paraprofessional interventions for LGBTQ people in other remote localities, or are unique to the New Mexico context. Finally, this study does not report the perspectives of (a) individuals who participated in the larger training initiative or (b) LGBTQ community members who sought assistance from the peer advocates. However, these perspectives are described in separate publications and do not controvert the analysis presented in this article.

## Conclusion

Peer advocacy for LGBTQ people with mental distress or addiction issues offers an innovative, affirmative, and community-based strategy to assist the underserved. To be successful, LGBTQ peer advocates require ongoing training in several areas, such as safety protocols, boundary maintenance, cultural issues, confronting personal biases, and community outreach in rural social contexts. Coaching must continue to help the advocates refine the knowledge and skills they gain from their initial training. A key objective for coaching should be the creation of forums in which to reflect upon the dynamics of being an advocate and the challenges that affect the lives and particular needs of LGBTQ help seekers in rural areas. Mental health professionals acting as coaches may need to depart from conventional models of clinical supervision to help peer advocates negotiate the complexities of community outreach. Both initial training and ongoing coaching will benefit from early and frequent attention to developing competencies to connect with both providers and the public, serve diverse populations and groups, and acknowledge the effects of gender, sexual orientation, ethnicity, race, mental health, and socio-economic disparities. Future versions of this intervention require greater consideration of infrastructural issues, such as confidential office space, which will likely take significant time to arrange. It may be possible to establish peer advocacy programs in professional service settings, with regular office hours at mental health agencies or public health departments. In-person interactions with coaches and advocates should be fostered, as well as hybrid arrangements optimizing use of community and peer supervision. Coaching resources focused on reduction of LGBTQ mental health disparities might be most fruitfully leveraged across multiple agencies and programs engaged in peer specialist work.

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