Standing Up for Mental Health Impact Report

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Executive Summary

Despite a well-documented need, many youths in need of mental health services do not receive care due to workforce shortages, long waitlists, and limited accessibility. These barriers disproportionately affect historically minoritized youth, who face greater disparities in access and treatment. As schools and community programs increasingly serve as de facto mental health systems, accessible, evidence-based interventions are needed. Mentoring is widely used to promote positive youth development across emotional, behavioral, and academic domains, yet practice has outpaced the supporting science. One such model, cross-age peer mentoring (CAPM), which pairs an older youth mentor with a younger mentee, may offer a promising approach for promoting youth mental health when programming targets specific outcomes.

This community-based participatory research study reports findings from an open trial of Standing Up for Mental Health, a targeted CAPM intervention implemented at StandOUT Youth Inc., a community-based mentoring program serving primarily racially and ethnically minoritized youth. The program integrates strategies from the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Adolescents (UP-A) and is delivered by trained peer mentors under adult supervision. Older adolescent mentors (n=20, M_{age}=18.45) and younger mentees (n = 18, M_{age}= 13.43) were matched into dyads and completed the 10-week intervention. Participants completed the several social-emotional, psychological, and mentoring-specific measures. Mentors also completed the Training Self-Efficacy Scale-Short to assess their perceived preparedness for the mentoring role.

Results highlight benefits for peer mentors, including reductions in internalizing and externalizing symptoms and increased confidence in managing their own mental health. Among mentees, greater intervention engagement was associated with improved internalizing outcomes. These findings suggest CAPM interventions may be promising approach for delivering mental health support within community settings, particularly those servicing racially and ethnically minoritized youth. Further research using controlled designs are needed to evaluate effectiveness and mechanisms of change.

Background

The youth mental health burden in the United States continues to endure a substantial rise, where emotional and disorders presently affect one in five youth. Rates of both internalizing (e.g., anxiety, depression) and externalizing (e.g., behavior disorders) symptoms are among the most impacted, reaching historic highs in the last two decades. For example, more than 40% of high school students report persistent feelings of sadness or hopelessness, and nearly one in five has seriously considered suicide. Despite this growing need, the majority of youth in need of mental health services receive no treatment, where more than two-thirds of youth with a diagnosable mental health condition remaining untreated. Structural barriers (e.g., cost, provider shortages, long wait times, etc.) continue to impede access, while traditional clinic-based models often struggle to engage youth consistently. Discrepancies remain evident across multiple system levels, prompting a shift toward identifying opportunities for preventative intervention that span diverse care systems. These gaps underscore the importance of meeting youth where they are by delivering support in settings youth already inhabit and trust. Innovative, scalable strategies embedded within youths' everyday environments offer a critical opportunity to enhance engagement, reduce barriers to care, and expand access to timely, equitable mental health support.

Targeted Cross-Age Peer Mentoring as an Accessible and Scalable Treatment Model

Mentoring programs are one of the most popular and widely used prevention interventions utilized in the United States. Cross-age peer mentoring (CAPM) programs, where older youth support younger peers, have been widely recognized for its potential to promote positive youth development and prosocial outcomes. Mentors who are close in age to their mentees often serve as powerful role models, facilitating identity formation and peer socialization in ways that adult mentors may not.

Targeted CAPM interventions differ from traditional CAPM models by providing structured guidance and skill-building to address specific developmental, academic, or behavioral needs. When designed to meet specific mental health goals, targeted CAPM programs may function both as an effective intervention approach and preventative framework. This differs from the traditional "friendship-

based" mentoring model that, while effective, may not adequately address emotional difficulties that youth face. Given that targeted CAPM can be implemented across child and family-serving systems of care with minimal infrastructure (e.g., after-school programs, clinics, etc.), the proposal integrates a scalable youth peer support intervention (PSI) within established systems of care to support cost-effectiveness, increase accessibility, and decrease burden on the healthcare system without use of high-level personnel. Further, given that access to specialized care and empirically supported treatments (EST) is limited, it is important to design and test robust EST for real-world application in nontraditional intervention contexts.

The persistent disparity between youth mental health demands and available services underscores the urgent need for innovative, scalable interventions that both (1) employ evidence-based protocols and (2) leverage the developmental importance of safe and supportive relationships to enhance accessibility and engagement. Targeted CAPM may serve as a scalable preventative intervention model by employing the influence of youth's developmental context (i.e., adolescence) and positive peer dynamics to promote adaptive responses to the increasing risk of future psychopathology.

The Standing Up for Mental Health Study

The Standing Up for Mental Health Study is a collaborative project between Baylor College of Medicine and StandOUT Youth, Inc. aiming to investigate CAPM as an effective youth PSI for mental health. The study consisted of three phases. In Phase 1, a community advisory board (CAB) was formed in collaboration with the academic-community partnership. Relevant stakeholders (peer mentoring supervisors, former peer mentors, and parents) were identified and recruited with the assistance of StandOUT program leadership.

Following the initial CAB meeting, the Standing Up for Mental Health Workgroup (Workgroup) consisting of Dr. Onyeka, Andrea Gonzales (Executive Director, StandOUT Youth Mentoring Program), April Street, and Jennifer Grant. The primary goal of the Workgroup was to design a trauma-informed, mental health curriculum (*Standing Up for Mental Health*) and mentor training based on the UP and

informed by the CAB. Mentors and mentees were recruited for the open trial and mentors will be trained in the intervention.

In Phase 2, the open trial of the cross-age peer mentoring intervention was conducted (n=25 mentor-mentee dyads) from May 2025 to Aug 2025. Participants completed baseline, mid-treatment, post-treatment assessments and exit interviews to evaluate primary and secondary outcomes, explore mechanisms of change, and acceptability.

In Phase 3, participants completed 1-month follow up assessments. Adult peer support supervisors and the Workgroup completed periodic reflections with Dr. Onyeka and trained research volunteers at mid-treatment and post-treatment to evaluate implementation context and reflect on accomplishments and challenges.

Community-Based Partnership

The CBPR framework for this study was organized into four sequential phases, consistent with established participatory research models. Phase 1 centered on establishing the academic–community partnership, conducting capacity-building activities, and co-developing the intervention design in collaboration with stakeholders. Phase 2 encompassed implementation planning, execution of the feasibility trial, and systematic data collection. Phase 3 involved data analysis, collaborative interpretation of findings, and engagement with community partners to ensure contextual relevance. Phase 4 will focus on process evaluation, dissemination of findings to both academic and community audiences, and strategic planning for sustainability. Figure 1 presents an overview of the CBPR workflow implemented in this study.

CBPR approaches were initiated at the project's infancy, starting with the grant proposal process. During Phase 1, the first author established an academic-community partnership with StandOUT Youth Mentoring Program, Inc., a community-based, youth peer mentoring program based in Houston, TX. Together, the first author and Executive Director of StandOUT Youth Mentoring Program (co-author) collaborated on developing the study design, methodology, and preparing the grant submission. Upon

receiving the grant award, the authors convened a Community Advisory Board (CAB) comprised of key stakeholders (e.g., parents, current and former youth peer mentors, mentoring supervisors). Initial meetings consisted of conducting a needs assessment to determine intervention priorities and assess the appropriateness of the methods. Goals of subsequent meetings consisted of reviewing mentor-mentee match protocols, providing feedback on intervention curriculum, and interpreting preliminary findings.

During Phase 2, an Intervention Workgroup was established to collaboratively co-develop the program curriculum with community members. The workgroup included the authors, select members of the CAB, and local educators with peer mentoring experience. Over an eight-month period, the group met regularly to design the 10-week targeted, cross-age peer mentoring intervention, drawing from the UP-A (Ehrenreich-May et al., 2018) as a guiding framework. Program materials including study manuals, intervention handouts, session activities, and parent-facing resources were created collaboratively with the workgroup and then reviewed by the CAB for additional feedback. One salient example of this process involved modification of the Top Problems Assessment (a validated, brief self-report measure used to identify youth-defined treatment targets; Weisz et al., 2011). Based on CAB recommendations, the measure was reframed as the "Top Priorities Assessment" to avoid a deficits-based interpretations and encourage mentors and mentees to approach goal setting from a strengths-oriented perspective.

The CBPR process also informed program logistics such as recruitment, matching criteria for mentors and mentees, mentor training materials, ad hoc session changes during the feasibility trial, and engagement with parents. Evaluation activities were similarly co-developed, emphasizing mixed-methods data collection (i.e., survey data and exit interviews) that capture not only symptom change and well-being, but also youth empowerment, mentor and mentee mutuality, mentor training self-efficacy, help-seeking, and program satisfaction.

Study Method

Areas Assessed

All study participants completed assessments at baseline, mid-treatment, post-treatment, and 1-month follow-up assessment (see Table 2). Mentor and mentee participants were compensated $25 following completion of each assessment. Mentors and mentees also completed exit interviews with Dr. Onyeka to assess program satisfaction and recommendations for improvement at the end of the intervention. The following domains were assessed in mentors and mentees:

Table 1. Domains of Assessment

Measure	Construct
Youth Self Report (YSR)	Internalizing and Externalizing Symptoms (11-17 yo)
Adult Self Report (ASR)	Internalizing and Externalizing Symptoms (>18 yo)
Youth Efficacy/Empowerment Scale-Mental Health (YES-MH)	Empowerment in managing mental health
Top Problem Assessment (TPA)	Top Problems
Mentor Strength of Relationship Scale (MSoR)	Mentor Strength of Relationship with Mentee (mentor only)
Youth Strength of Relationship Scale (YSoR)	Mentee Strength of Relationship with Mentor (mentee only)
Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS)	Life Satisfaction
Self-Esteem Questionnaire – Global Self-Worth Scale (GSWS)	Self-Esteem
Mutuality Scale – Adapted for Mentors (MS)	Peerness (mutuality between mentors and mentees)
Mutuality Scale – Adapted for Mentees (MS)	Peerness (mentee only)
Youth Experiences of Program Quality (YEPQ)	Support from Program
Adapted Client Satisfaction Questionnaire (CES-8)	Satisfaction with Program
Multigroup Ethnic Identity Measure (MEIM)	Ethnic Identity Membership
Adapted Training Self-Efficacy Scale (TSES)	Mentor Training Effectiveness (mentors only)
Help-Seeking Scale (HSS)	Self-Advocacy for Help
Avoidance and Fusion Questionnaire in Youth-8	Psychological Inflexibility

The *Standing Up for Mental Health* Intervention

Standing Up for Mental Health is a manualized, targeted CAPM intervention delivered over 10 weekly, 50-minute mentoring sessions (see Table 2). The intervention grounded transdiagnostic cognitive-behavioral therapy (CBT) strategies adapted from the UP-A**,** an evidence-based treatment for youth with emotional and behavioral difficulties. The UP-A integrates core CBT principles with emotion regulation and mindfulness-based strategies to share mechanisms that underlie internalizing and

externalizing psychopathology, including emotion avoidance, maladaptive cognitions, and emotion-driven behaviors. Several studies support the efficacy of the UP-A, indicating robust improvements in internalizing and externalizing symptoms. The curriculum retains the five key components of the UP-A modules: emotional awareness, interoceptive exposure, opposite action, cognitive flexibility, mindfulness, and situational exposure.

Intervention delivery was supported by Adult Peer Support Supervisors who provide regular supervision, review mentor fidelity checklists, and offer guidance to mentors. Informed consent for youth >18 years old or parental consent and youth assent for youth <18 years old was obtained prior to study enrollment. Baseline assessments will be completed by mentors and mentees prior to the start of the intervention at Week 1. Dr. Onyeka, Ms. Gonzales, and Adult Peer Supporter Supervisors facilitated mentoring sessions. Mentor-mentee dyads worked through curriculum activities during the mentoring session, with the mentors guiding the mentees through tasks.

Table 2. Standing Up for Mental Health Intervention Curriculum

Session #	Session Title	What is Covered?
Session 1	Welcome to Standing Up for Mental Health!	- Introduction to the program - Meet your mentor/mentee - Understanding our values and setting our goals
Session 2	Getting To Know Our Emotions	- Learning to identify our emotions - Learning that emotional experiences are normal - Learning the three parts of emotions
Session 3	Avoidance Cycles and Acting Opposite	- Learn about the avoidance cycle and how we can get stuck - Learn about emotional behaviors and opposite action
Session 4	Sensational Awareness	- Learn about how our body experiences emotions physically - Learn about sensational exposures
Session 5	Thinking Traps and Detective Thinking	- Learn about thinking traps and detective thinking
Session 6	We Can Do Hard Things: Learning about Exposure	- Learn about gradually learning how to handle strong emotions and experiences
Session 7	Emotions aren't Good or Bad: Awareness of Emotions in the Present	- Learn how to slow down our thoughts and focus on emotions in the present - Learn how to experience our emotions and not judge them
Session 8	How to Solve Problems, Keeping Up with Our Skills, and Preparing for the Future	- Learn how to get unstuck from a problem and solving skills - Learn how to celebrate our accomplishments and continue to practice our skills

Participants

The mentors consisted of adolescents and emerging adults ranging between ages 16 and 22. Mean mentor age was 18.45 (SD=2.06). Most mentors identified as female (76.5%) and identified as Black/African American (88.2%). Mentee participants ranged between ages 11 and 15 (M_{age}= 13.43), were majority male (75%), and were predominantly Black/African American (87.5%). For detailed demographic information, see Table 3.

Table 3. Demographic Summary of Mentor and Mentee Participants

	Mentors N=20	**Mentees N=18**
Biological Sex		
Male	23.5	75
Female	76.5	25
Gender Identity		
Boy	23.5	75
Girl	76.5	25
Age *(M, SD)*	*18.45(2.06)*	*13.25 (1.77)*
Race		
Black/African American	88.2	87.5
Mixed Race	0.0	12.5
White	5.9	0.0
Other	5.9	0.0
Ethnicity (Hispanic)		
Yes	11.8	6.3
No	88.2	93.8
Perceived Income		
A lot more	20.0	14.3
A little more	40.0	35.7
About the same	0.0	7.1
A little less	0.0	0.0
A lot less	0.0	7.1
I'm not sure	40.0	35.7
Living Situation		
Independent/On My Own	17.6	7.1
Foster Care	0.0	5.6
Living with parent(s)	94.1	73
Living with relatives other than parent(s)	5.9	14.3
Group home/residential treatment/psychiatric facility	0.0	0
Homeless	0.0	0
Free Lunch		
Yes	76.5	78.6
No	23.5	21.4
Have you been diagnosed with emotional or mental health difficulties?		

Yes	17.6	14.3
No	82.4	85.7
Have you ever had mentor before?		
Yes	---	50.0
No	---	50.0
Have you ever been a mentor before?		
Yes	52.9	---
No	47.1	---
Dosage (out of 8 sessions; *M, SD*)	*6.65(1.39)*	*6.88(1.5)*
Number of people in the home including you		4.21(1.85)
Mentee Grade		
6th grade	---	25
7th grade	---	18.8
8th grade	---	6.3
9th grade	---	6.3
10th grade	---	25
11th grade	---	18.8
Mentor Education Level		
11th grade	8.3	---
12th grade	8.3	---
Did not graduate high school	0.0	---
Attending college/university	83.3	---
Associate's degree	16.7	---
Bachelor's degree	0.0	---
Trade school	0.0	---

Mentor Training

Mentors completed a six-hour training program prior to initiating mentor–mentee matching and mentoring sessions. The training was informed by MENTOR's Peer *Mentoring Supplement to the Elements of Effective Practice for Mentoring* standards. The training consisted of didactic instruction, interactive activities, and applied skill practice. Specific content included: (a) foundational principles of transdiagnostic CBT (b) role expectations and boundaries for peer mentors, (c) facilitation of skills-based sessions, (d) appropriate disclosure of lived experiences, (e) boundary setting, and (f) procedures for managing challenging situations and escalating concerns to supervisors. Mentor competence and readiness was assessed using the TSES. In line with recommendations in the literature, mentors were compensated $25/hour for training.

Results

Among mentors, there were significant reductions from baseline to post-treatment in anxious/depressive symptoms (t (18) =2.46, p=.014, Hedges's g=4.62), withdrawn symptoms (t (18) =2.80, p=.008, Hedges's g=1.73), and broadband internalizing symptoms (t (18) =2.81, p=.007, Hedges's g=6.78). Significant reductions were also observed aggressive behaviors (t (18) =2.19, p=.024, Hedges's g=2.59) and externalizing symptoms over time (t (18) =1.91, p=.039, Hedges's g=4.32). Additionally, mentors who reported greater training self-efficacy demonstrated increased confidence in managing their own mental health and accessing supports over time, (b=.45, p=.043). See Figures 1-5 for details.

Although mentees did not show symptom changes, treatment dosage was associated with internalizing problems over time, where increase session attendance predicted fewer anxious/depressed symptoms at post-treatment (b=-.544, p=.030), accounting for approximately 30% of the variance in symptoms (R^2=.296).

Conclusion

Findings from the *Standing Up for Mental Health* study provide preliminary support for the potential benefits of targeted cross-age peer mentoring for youth mental health, particularly among peer mentors. Mentors demonstrated significant reductions across multiple domains of psychopathology, including anxious/depressive symptoms, withdrawal, and broadband internalizing difficulties, alongside decreases in aggressive behavior and overall externalizing symptoms. These improvements were accompanied by increases in mentor training self-efficacy, which was positively associated with greater confidence in managing their own mental health and navigating support systems over time. Together, these findings suggest that participation in structured, skills-based mentoring interventions may confer meaningful intrapersonal benefits for mentors, highlighting an often underexamined pathway through which mentoring programs can promote youth mental health, particularly through the development and well-being of the mentors themselves.

In contrast, mentees did not exhibit significant overall symptom change across the study period. However, treatment dosage emerged as a meaningful predictor of outcomes, such that greater session

attendance was associated with fewer anxious/depressed symptoms at post-treatment, accounting for a substantial proportion of the variance. This pattern underscores the importance of engagement and intervention exposure in driving clinical benefit and suggests that insufficient dosage or variability in participation may partially explain the absence of detectable group-level effects among mentees.

Several limitations warrant consideration. First, the gender distribution within the sample was imbalanced, with a higher proportion of female mentors and a higher proportion of male mentees. This asymmetry may have influenced both relational dynamics and intervention effects, as prior literature suggests that gender can shape mentoring relationships, communication styles, and responsiveness to intervention content. The predominance of female mentors may limit the generalizability of findings regarding mentor outcomes, particularly for male mentors, who may experience and benefit from mentoring roles differently. Similarly, the overrepresentation of male mentees may obscure potential gender-specific intervention effects or mask differential responsiveness among female mentees. Additionally, gender mismatch within mentor–mentee dyads may have affected relationship quality, engagement, and outcomes, although this was not directly examined.

Second, variability in mentees' understanding and uptake of cognitive behavioral therapy (CBT) strategies may have limited intervention effects. Given that the intervention relies on peer mentors to deliver and reinforce CBT-informed skills, differences in developmental readiness, cognitive capacity, and prior exposure to mental health concepts among mentees may have influenced their ability to comprehend and apply these strategies. Inconsistent understanding or skill acquisition may, in turn, attenuate symptom change, particularly in the absence of more intensive scaffolding or reinforcement. Future work should incorporate direct assessments of CBT skill acquisition and comprehension, as well as consider developmentally tailored adaptations or additional supports to enhance learning and generalization.

Altogether, these findings highlight several key implications. First, they reinforce the promise of CAPM as a dual-impact intervention that may simultaneously benefit both mentors and mentees, albeit

through potentially different mechanisms and timelines. Second, the results emphasize the importance of optimizing intervention engagement and dosage to maximize outcomes for mentees. Finally, these preliminary findings point to the need for future research using larger, controlled designs to more rigorously evaluate effectiveness, clarify mechanisms of change (e.g., mentor self-efficacy, peerness), and identify contextual factors such as including gender dynamics and skill acquisition processes that may influence implementation and sustainment. Such work is critical to advancing scalable, community-based approaches that address gaps in youth mental health service access while leveraging the strengths of peer relationships.

References

1. Merikangas KR, He J ping, Burstein M, et al. Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*. 2010;49(10):980-989. doi:10.1016/j.jaac.2010.05.017
2. Herman KC, Reinke WM, Thompson AM, et al. A Public Health Approach to Reducing the Societal Prevalence and Burden of Youth Mental Health Problems: Introduction to the Special Issue. *School Psychology Review*. 2021;50(1):8-16. doi:10.1080/2372966X.2020.1827682
3. Woolf SH. The Youth Mental Health Crisis in the United States: Epidemiology, Contributors, and Potential Solutions. *Pediatrics*. 2025;156(5):e2025070849. doi:10.1542/peds.2025-070849
4. Simon AE, Pastor PN, Reuben CA, Huang LN, Goldstrom ID. Use of Mental Health Services by Children Ages Six to 11 With Emotional or Behavioral Difficulties. *PS*. 2015;66(9):930-937. doi:10.1176/appi.ps.201400342
5. Ajluni V, Amarasinghe D. Youth suicide crisis: identifying at-risk individuals and prevention strategies. *Child Adolesc Psychiatry Ment Health*. 2024;18(1):58. doi:10.1186/s13034-024-00753-9
6. Ruch DA, Horowitz LM, Hughes JL, et al. Suicide in US Preteens Aged 8 to 12 Years, 2001 to 2022. *JAMA Netw Open*. 2024;7(7):e2424664. doi:10.1001/jamanetworkopen.2024.24664
7. Weisz JR, Venturo-Conerly KE, Fitzpatrick OM, Frederick JA, Ng MY. What Four Decades of Meta-Analysis Have Taught Us About Youth Psychotherapy and the Science of Research Synthesis. *Annual Review of Clinical Psychology*. 2023;19(1):79-105. doi:10.1146/annurev-clinpsy-080921-082920
8. Weisz JR, Ng MY, Bearman SK. Odd Couple? Reenvisioning the Relation Between Science and Practice in the Dissemination-Implementation Era. *Clinical Psychological Science*. 2014;2(1):58-74. doi:10.1177/2167702613501307
9. Valdez CR, Rodgers CRR, Gudiño OG, et al. Translating research to support practitioners in addressing disparities in child and adolescent mental health and services in the United States. *Cultural Diversity & Ethnic Minority Psychology*. 2019;25(1):126-135. doi:10.1037/cdp0000257
10. Garza R. Youth Peer Support in Schools - Defining the Position | TxSOC. Texas System of Care. Published October 30, 2023. Accessed March 12, 2024. https://txsystemofcare.org/txsoc-youth-peer-support-role/
11. Gopalan G, Lee SJ, Harris R, Acri MC, Munson MR. Utilization of peers in services for youth with emotional and behavioral challenges: A scoping review. *Journal of Adolescence*. 2017;55(1):88-115. doi:10.1016/j.adolescence.2016.12.011
12. Halsall T, Daley M, Hawke L, Henderson J, Matheson K. "You can kind of just feel the power behind what someone's saying": a3 participatory-realist evaluation of peer support for young people coping with complex mental health and substance use challenges. *BMC Health Services Research*. 2022;22(1):1358. doi:10.1186/s12913-022-08743-3
13. Repper J, Carter T. A review of the literature on peer support in mental health services. *Journal of Mental Health*. 2011;20(4):392-411. doi:10.3109/09638237.2011.583947
14. Karcher MJ. Cross-Age Peer Mentoring. In: *Handbook of Youth Mentoring*. 2nd ed. SAGE Publications, Inc.; 2014:233-258. doi:10.4135/9781412996907
15. Christensen KM, Hagler MA, Stams GJ, Raposa EB, Burton S, Rhodes JE. Non-Specific versus Targeted Approaches to Youth Mentoring: A Follow-up Meta-analysis. *J Youth Adolesc*. 2020;49(5):959-972. doi:10.1007/s10964-020-01233-x
16. Cavell TA, Spencer R, McQuillin SD. Back to the Future: Mentoring as Means and End in Promoting Child Mental Health. *Journal of Clinical Child & Adolescent Psychology*. Published

online March 4, 2021. Accessed March 13, 2024. https://www.tandfonline.com/doi/full/10.1080/15374416.2021.1875327
17. Ehrenreich-May J, Kennedy SM, Sherman JA, et al. *Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents: Therapist Guide*. Oxford University Press; 2017. doi:10.1093/med-psych/9780199340989.001.0001
18. Lerner RM, Lerner JV, Lewin-Bizan S, et al. Positive Youth Development: Processes, Programs, and Problematics. JYD. 2011;6(3):38-62. doi:10.5195/jyd.2011.174
19. Lerner JV, Phelps E, Forman YE, Bowers EP. Positive Youth Development. In: Lerner RM, Steinberg L, eds. Handbook of Adolescent Psychology. 1st ed. Wiley; 2009.
20. Fenn N, Sacco A, Monahan K, Robbins M, Pearson-Merkowitz S. Examining the relationship between civic engagement and mental health in young adults: a systematic review of the literature. Journal of Youth Studies. 2024;27(4):558-587. doi:10.1080/13676261.2022.2156779doi:10.1002/9780470479193.adlpsy001016
21. Moullin, J. C., Dickson, K. S., Stadnick, N. A., Rabin, B., & Aarons, G. A. (2019). Systematic review of the Exploration, Preparation, Implementation, Sustainment (EPIS) framework. Implementation Science, 14(1), 1. https://doi.org/10.1186/s13012-018-0842-6Verlenden JV. Mental Health and Suicide Risk Among High School Students and Protective Factors — Youth Risk Behavior Survey, United States, 2023. *MMWR Suppl*. 2024;73. doi:10.15585/mmwr.su7304a9
22. Damschroder LJ, Reardon CM, Widerquist MAO, Lowery J. The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation Sci*. 2022;17(1):75. doi:10.1186/s13012-022-01245-0
23. Mahmood A, Kedia S, Arshad H, Mou X, Dillon PJ. Disparities in Access to Mental Health Services Among Children Diagnosed with Anxiety and Depression in the United States. *Community Ment Health J*. 2024;60(8):1532-1546. doi:10.1007/s10597-024-01305-3
24. Meng JF. Factors Associated With Not Receiving Mental Health Services Among Children With A Mental Disorder in Early Childhood in the United States, 2021–2022. *Prev Chronic Dis*. 2024;21. doi:10.5888/pcd21.240126
25. Petosa RL, Smith LH. Peer Mentoring for Health Behavior Change: A Systematic Review. *American Journal of Health Education*. 2014;45(6):351-357. doi:10.1080/19325037.2014.945670
26. Garringer M, McQuillin S, & McDaniel H. Examining youth mentoring services across America: Findings from the 2016 National Mentoring Program Survey. The National Mentoring Partnership: Technical Report Produced by MENTOR, 2017. http://www.mentoring.org/program-resources/mentor-resources-and-publications/national-survey/.
27. Richards M, Tyson-McCrea K., DiClemente C., Onyeka O., Dusing C., Moore A., Miller K., Watson H., … & Pentakainen A. (2019). Final technical report: Cross-age peer mentoring to enhance resilience among low-income urban youth living in high-violence Chicago communities. *Department of Justice: Office of Juvenile Justice and Delinquency Prevention.* Retrieved March 13, 2023, from https://www.ojp.gov/pdffiles1/ojjdp/grants/255962.pdf
28. Burton S, Raposa EB, Poon CYS, Stams GJJM, Rhodes J. Cross-age peer mentoring for youth: A meta-analysis. *American Journal of Community Psychology*. 2022;70(1-2):211-227. doi:10.1002/ajcp.12579
29. Quimby D, Richards M, Onyeka O "Cynthia," et al. The Effects of Cross-Age Peer Mentoring on Adolescent Mentors of Color Residing in Low Income, Urban Communities. *Youth & Society*. 2023;55(5):970-998. doi:10.1177/0044118X221115761
30. Lyons MD, McQuillin SD, Henderson LJ. Finding the Sweet Spot: Investigating the Effects of Relationship Closeness and Instrumental Activities in School-based Mentoring. *American J of Comm Psychol*. 2019;63(1-2):88-98. doi:10.1002/ajcp.12283

31. Garringer M, Kupersmidt J, Rhodes J, Stelter R, Tai T. Elements of effective practice for mentoring [TM]: Research-informed and practitioner-approved best practices for creating and sustaining impactful mentoring relationships and strong program services. MENTOR: National Mentoring Partnership. 2015.
32. Gowdy G, Jones K, Griffith AN. Youth Mentoring as a Means of Supporting Mental Health for Minoritized Youth: A Reflection on Three Theoretical Frameworks 20 Years Later. *Youth*. 2024;4(3):1211-1223. doi:10.3390/youth4030076
33. Karcher M. The Cross-Age Mentoring Program: A Developmental Intervention for Promoting Students' Connectedness Across Grade Levels. *Professional School Counseling*. 2008;12(2):137-143. doi:10.5330/PSC.n.2010-12.137
34. Onyeka OC, Gonzales A, Street A, Grant J, Dews A, Williams I & Zavala Cruz V. Investigating cross-age peer mentoring as youth peer support for mental health: An open trial. Unpublished manuscript.
35. Vandewalle J, Debyser B, Beeckman D, Vandecasteele T, Van Hecke A, Verhaeghe S. Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *Int J Nurs Stud*. 2016;60:234-250. doi:10.1016/j.ijnurstu.2016.04.018
36. Muralidharan A, Peeples AD, Lucksted A, Goldberg RW. Defining "peerness" in peer-delivered health and wellness interventions for serious mental illness. *Psychiatric Rehabilitation Journal*. 2017;40(1):116-116. doi:10.1037/prj0000249
37. Bandura A. Social-learning theory of identificatory processes. Handbook of socialization theory and research. 1969;213:262.
38. Rhodes JE. A Model of Youth Mentoring. In: *Handbook of Youth Mentoring*. SAGE Publications, Inc.; 2005:30-43. doi:10.4135/9781412976664.n3
39. Lyons MD, McQuillin SD. It's Not a Bug, It's a Feature: Evaluating Mentoring Programs with Heterogeneous Activities. *Child Youth Care Forum*. 2021;50(6):1131-1145. doi:10.1007/s10566-021-09609-1
40. Alwani NA, Lyons MD, Edwards KD. Examining heterogeneity in mentoring: Associations between mentoring discussion topics and youth outcomes. *Journal Community Psychology*. 2023;51(3):1233-1254. doi:10.1002/jcop.22938
41. Rhodes J. It's time to shed light on the "black box" of mentoring programs. The Chronicle of Evidence-Based Mentoring. October 4, 2022. Accessed January 27, 2026. https://www.evidencebasedmentoring.org/its-time-to-shed-light-on-the-black-box-of-mentoring-programs/
42. Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. Implementation Science, 10(1), 53. https://doi.org/10.1186/s13012-015-0242-0
43. Weisz JR, Kuppens S, Eckshtain D, Ugueto AM, Hawley KM, Jensen-Doss A. Performance of Evidence-Based Youth Psychotherapies Compared With Usual Clinical Care: A Multilevel Meta-analysis. JAMA Psychiatry. 2013;70(7):750. doi:10.1001/jamapsychiatry.2013.1176
44. Kazdin AE. Treatment as usual and routine care in research and clinical practice. Clinical Psychology Review. 2015;42:168-178. doi:10.1016/j.cpr.2015.08.006
45. Chow D, Matungwa DJ, Blackwood ER, Pronyk P, Dow D. A scoping review on peer-led interventions to improve youth mental health in low- and middle-income countries. *Camb prisms Glob ment health*. 2025;12:e1. doi:10.1017/gmh.2024.149
46. Moreno MA, Jolliff A, Kerr B. Youth Advisory Boards: Perspectives and Processes. Journal of Adolescent Health. 2021;69(2):192-194. doi:10.1016/j.jadohealth.2021.05.001
47. Young A, Levitt A, Kodeeswaran S, Markoulakis R. "Just because we're younger doesn't mean our opinions should be any less valued": A qualitative study of youth perspectives on a Youth Advisory Council in a mental healthcare context. Health Expect. 2023;26(5):1883-1894. doi:10.1111/hex.13794

48. Schäpermeier M, Jesussek AL, Kirchherr J, Monninger M, Feneberg AC, Hechler T. The efficacy of the unified protocol for emotional disorders in children and adolescents: A systematic review and meta-analysis. Journal of Affective Disorders Reports. 2025;22:100970. doi:10.1016/j.jadr.2025.100970
49. García-Escalera J, Chorot P, Sandín B, Ehrenreich-May J, Prieto A, Valiente RM. An Open Trial Applying the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Adolescents (UP-A) Adapted as a School-Based Prevention Program. Child Youth Care Forum. 2019;48(1):29-53. doi:10.1007/s10566-018-9471-0
50. Grossman RA, Ehrenreich-May J. Using the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders With Youth Exhibiting Anger and Irritability. Cognitive and Behavioral Practice. 2020;27(2):184-201. doi:10.1016/j.cbpra.2019.05.004
51. Slimmen S, Timmermans O, Lechner L, Oenema A. A socio-ecological approach of evidence on associations between social environmental factors and mental health outcomes of young adults: A systematic review. Social Sciences & Humanities Open. 2024;10:101068. doi:10.1016/j.ssaho.2024.101068
52. Rajagopal S, Harper K, Holzhauer K, Kumra T. Utilization of Positive Youth Development Framework by Youth-Facing Organizations in Baltimore City. JYD. 2022;17(4):84-105. doi:10.5195/jyd.2022.1225
53. Onyeka O, Richards M, Tyson McCrea K, et al. The role of positive youth development on mental health for youth of color living in high-stress communities: A strengths-based approach. *Psychol Serv*. Published online November 4, 2021. doi:10.1037/ser0000593
54. The National Mentoring Partnership. *Peer Mentoring Supplement to the Elements of Effective Practice for Mentoring™ (EEP)*. MENTOR; 2020. Accessed February 5, 2026. https://www.mentoring.org/wp-content/uploads/2020/08/Peer-Mentoring-Supplement-to-the-EEP.pdf
55. Pryce J, Kelly MS, Guidone SR. Mentor and youth matching. In: DuBois DL, Karcher MJ, eds. Handbook of Youth Mentoring. SAGE Publications. 2013; 427-456.
56. Herrera C, DuBois DL, Grossman JB. *The role of risk: Mentoring experiences and outcomes for youth with varying risk profiles*. New York, NY: Public/Private Ventures; 2013. Distributed by MDRC.
57. Tirrell JM, Dowling EM, Gansert P, et al. Toward a measure for assessing features of effective youth development programs: Contextual safety and the "Big Three" components of positive youth development programs in Rwanda. *Child Youth Care Forum*. 2019;49(2):201-222. doi:10.1007/s10566-019-09524-6
58. Rhodes JE, Schwartz SEO, Willis MM, Wu MB. Validating a mentoring relationship quality scale: Does match strength predict match length? *Youth Soc*. 2017;49:415-437. doi:10.1177/0044118X14531604
59. Achenbach TM. *Manual for the ASEBA School-Age Forms & Profiles: An Integrated System of Multi-Informant Assessment*. ASEBA; 2001.
60. Achenbach TM, Rescorla L. *Manual for the ASEBA Adult Forms & Profiles: For Ages 18-59 : Adult Self-Report and Adult Behavior Checklist*. ASEBA; 2003.
61. Jefferies P, McGarrigle L, Ungar M. The CYRM-R: A Rasch-Validated Revision of the Child and Youth Resilience Measure. Journal of Evidence-Based Social Work. 2019;16(1):70-92. doi:10.1080/23761407.2018.1548403
62. Achenbach TM. Child Behavior Checklist. In: Kreutzer JS, DeLuca J, Caplan B, eds. *Encyclopedia of Clinical Neuropsychology*. Springer; 2011:546-552. doi:10.1007/978-0-387-79948-3_1529
63. Greco LA, Lambert W, Baer RA. Psychological inflexibility in childhood and adolescence: Development and evaluation of the Avoidance and Fusion Questionnaire for Youth. Psychological Assessment. 2008;20(2):93-102. doi:10.1037/1040-3590.20.2.93

64. Rodriguez EM, Donenberg GR, Emerson E, Wilson HW, Brown LK, Houck C. Children's Coping Strategies Checklist--Modified. Published online October 10, 2016. doi:10.1037/t48241-00
65. DuBois DL, Felner RD, Brand S, Phillips RSC, Lease AM. Early adolescent self-esteem: A developmental-ecological framework and assessment strategy. *J Res Adolesc*. 1996;6:541-578
66. Howard MC. The Effect of Training Self-Efficacy on Computer-Based Training Outcomes: Empirical Analysis of the Construct and Creation of Two Scales. *Performance Improvement Quarterly*. 2020;32(4):331-368. doi:10.1002/piq.21301
67. Archbold PG, Stewart BJ, Greenlick MR, Harvath T. Mutuality and preparedness as predictors of caregiver role strain. *Research in Nursing & Health*. 1990;13(6):375-384. doi:10.1002/nur.4770130605

Figure 1.

Community-engaged study framework from Onyeka & Gonzales[34]

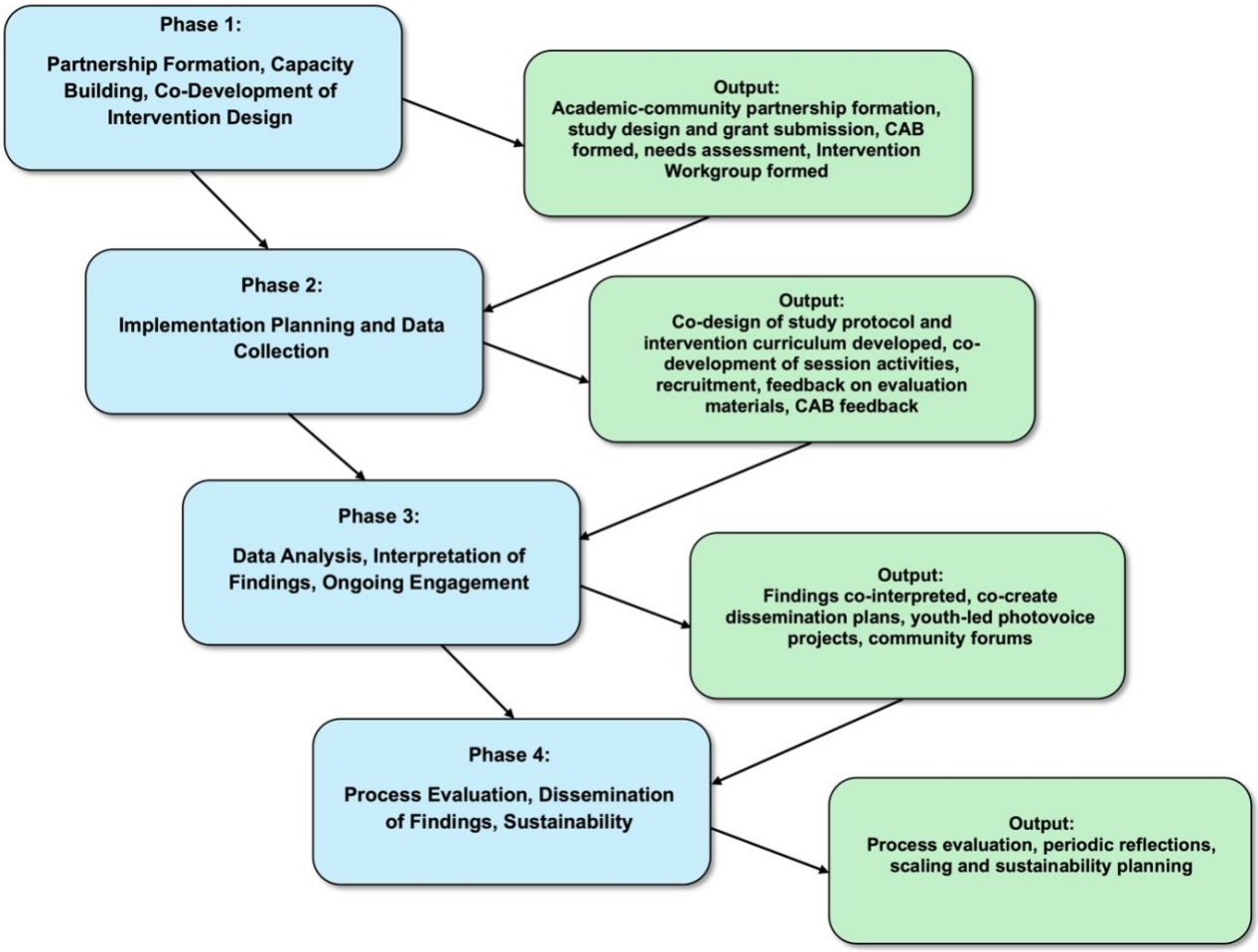


Figure 2.

Mentor pre-post anxiety/depressive symptoms

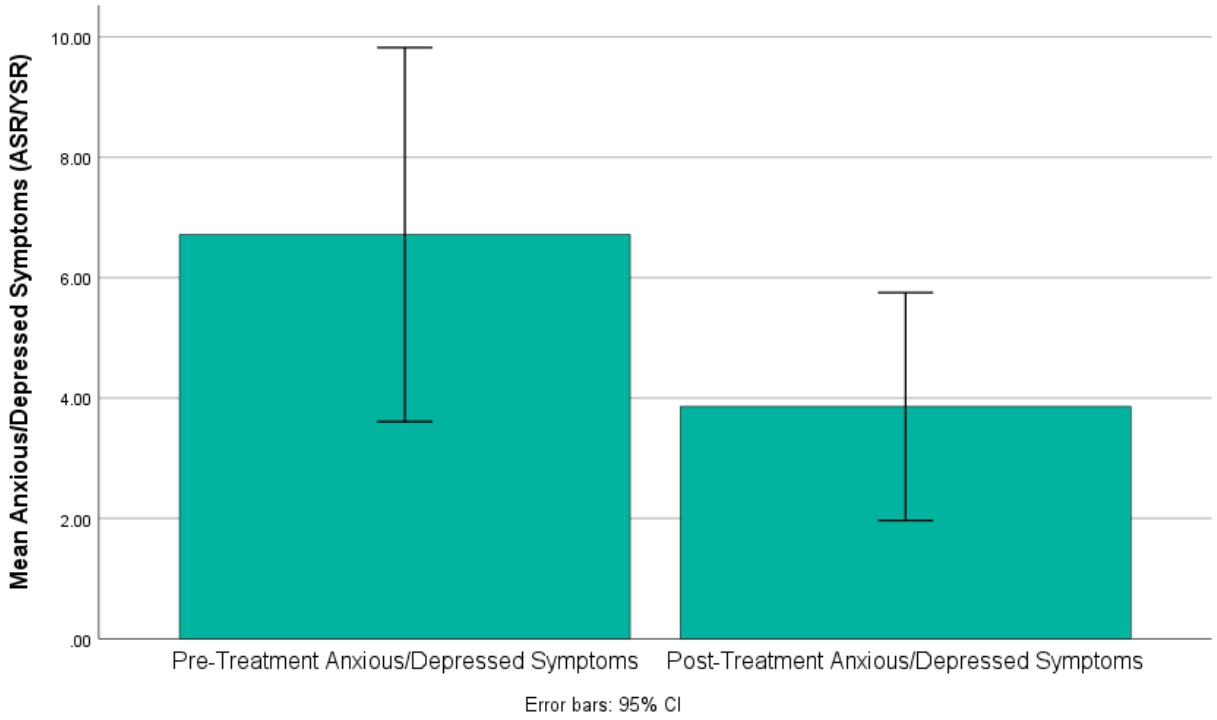


Figure 3.

Mentor pre-post rule-breaking behavior

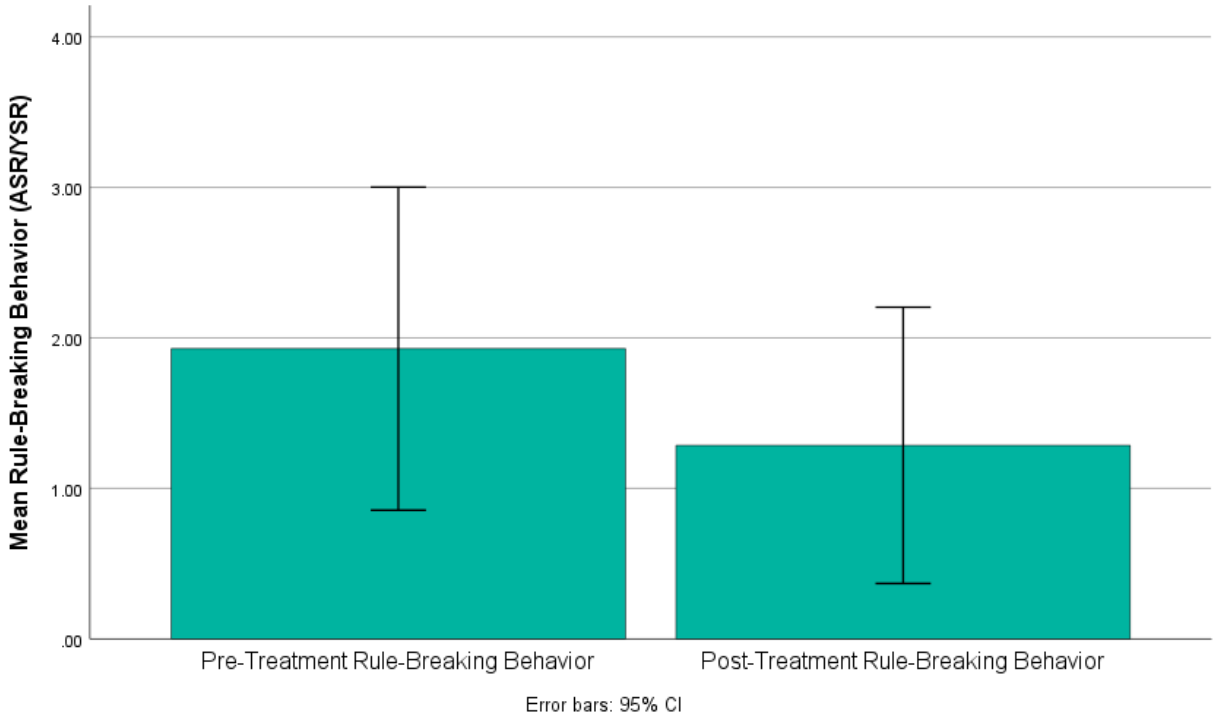


Figure 4.

Mentor pre-post aggressive behavior

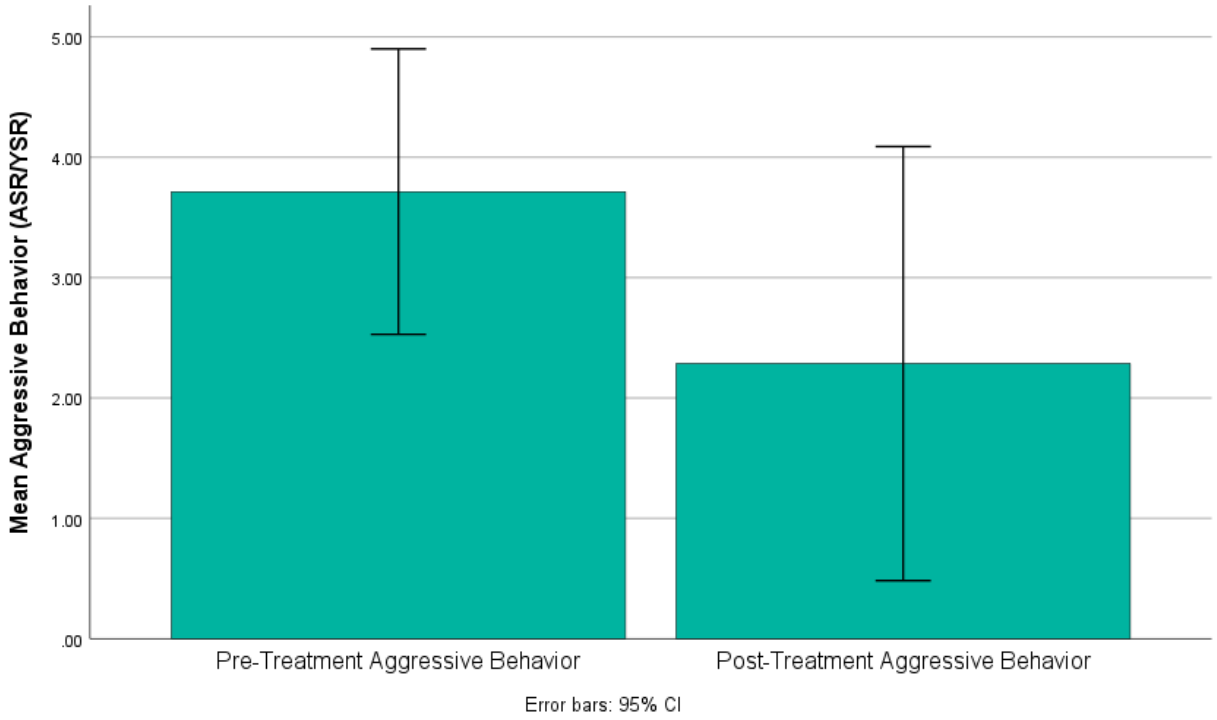


Figure 5.

Mentor pre-post withdrawn symptoms

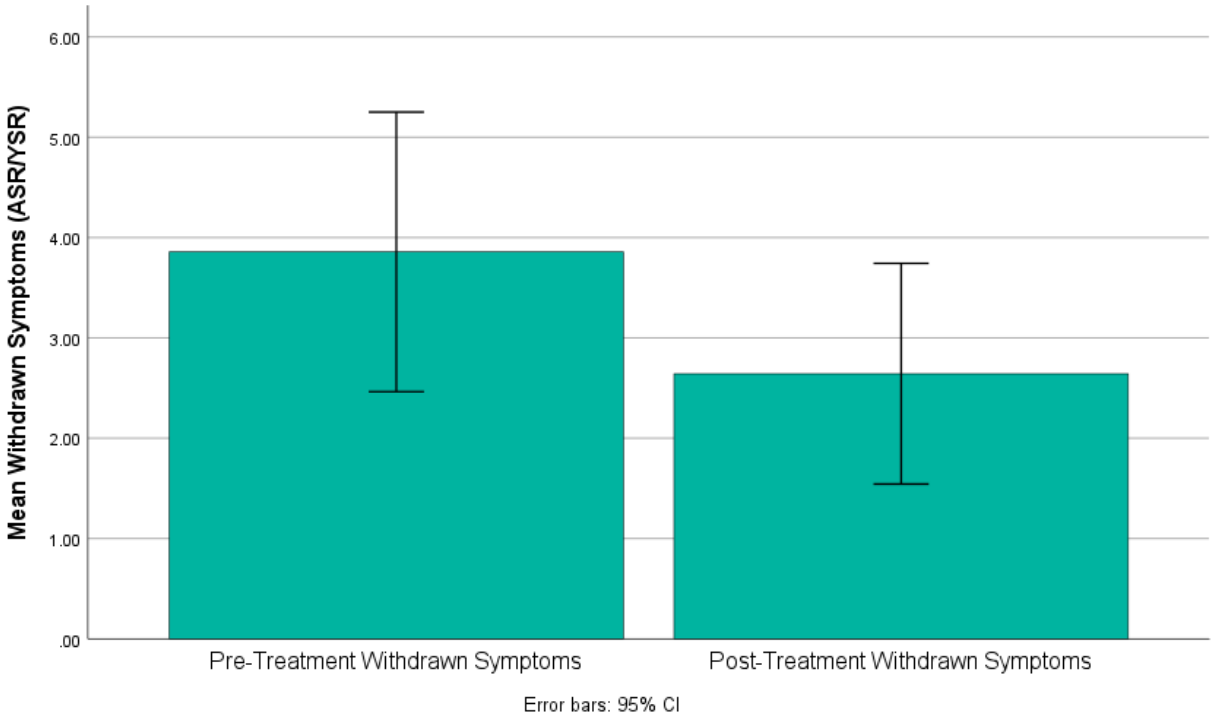


Figure 6.

Mentor pre-post externalizing symptoms

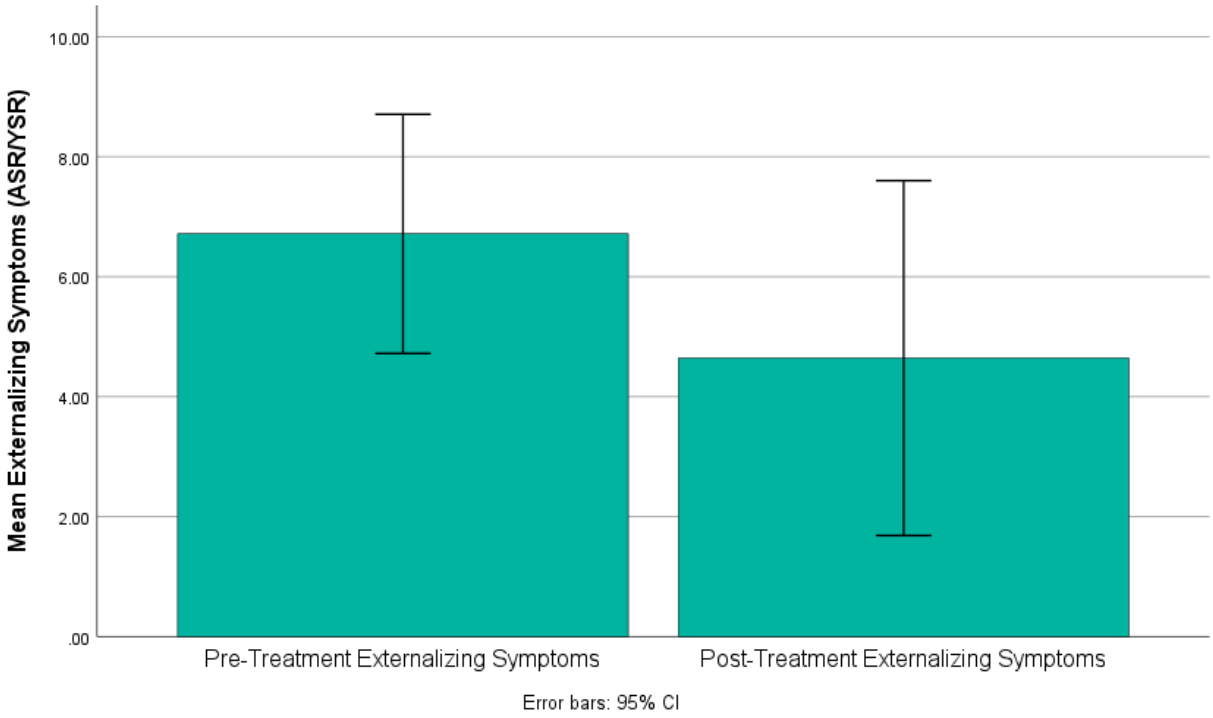


Figure 7.

Mentor pre-post internalizing symptoms

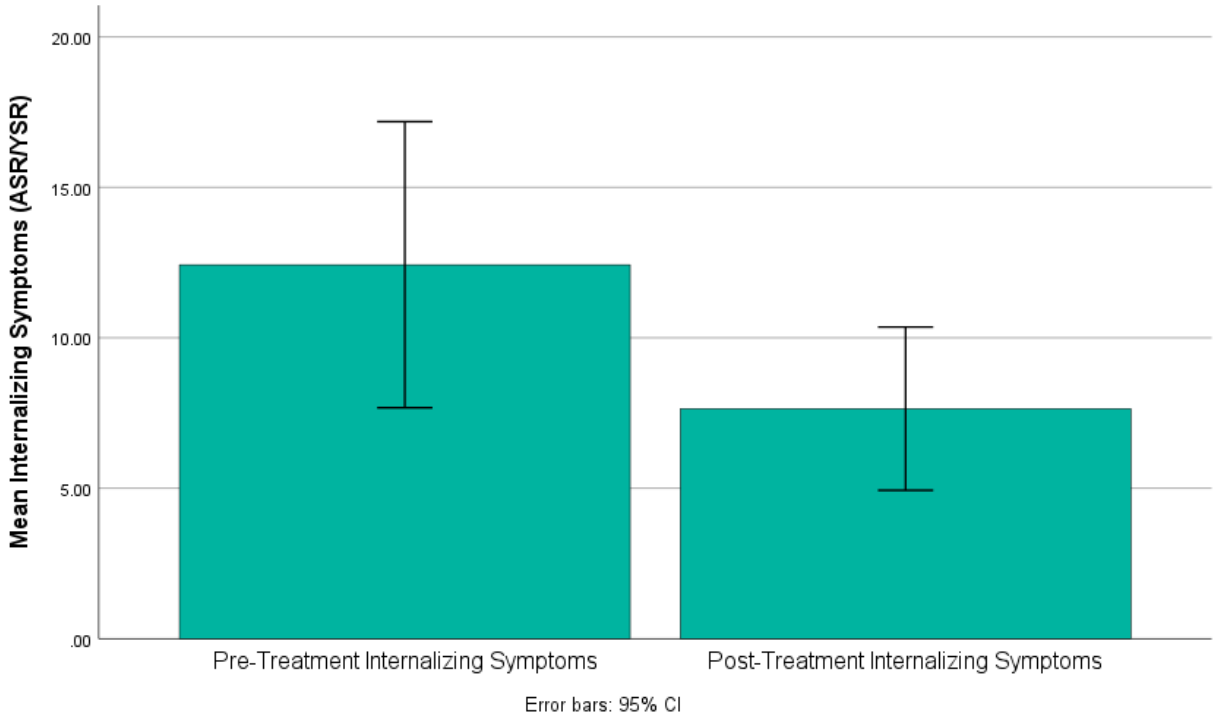


Figure 8.

Mentor pre-post self-esteem

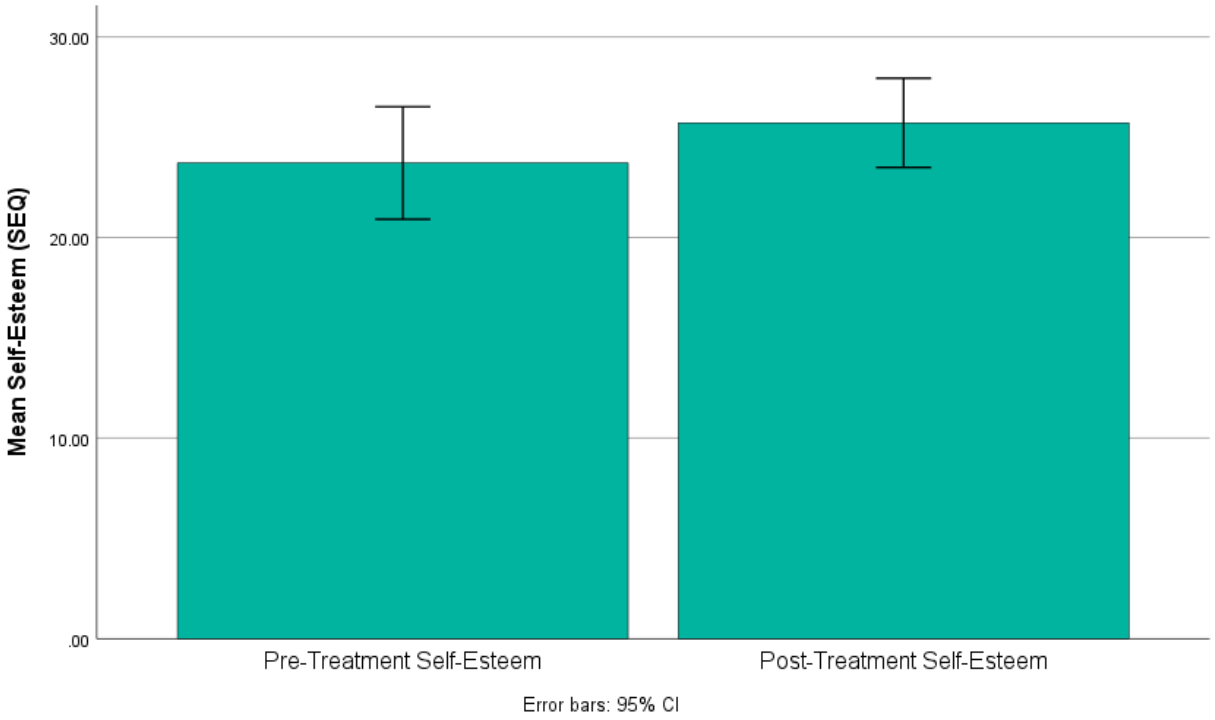


Figure 9.

Mentor pre-post life satisfaction

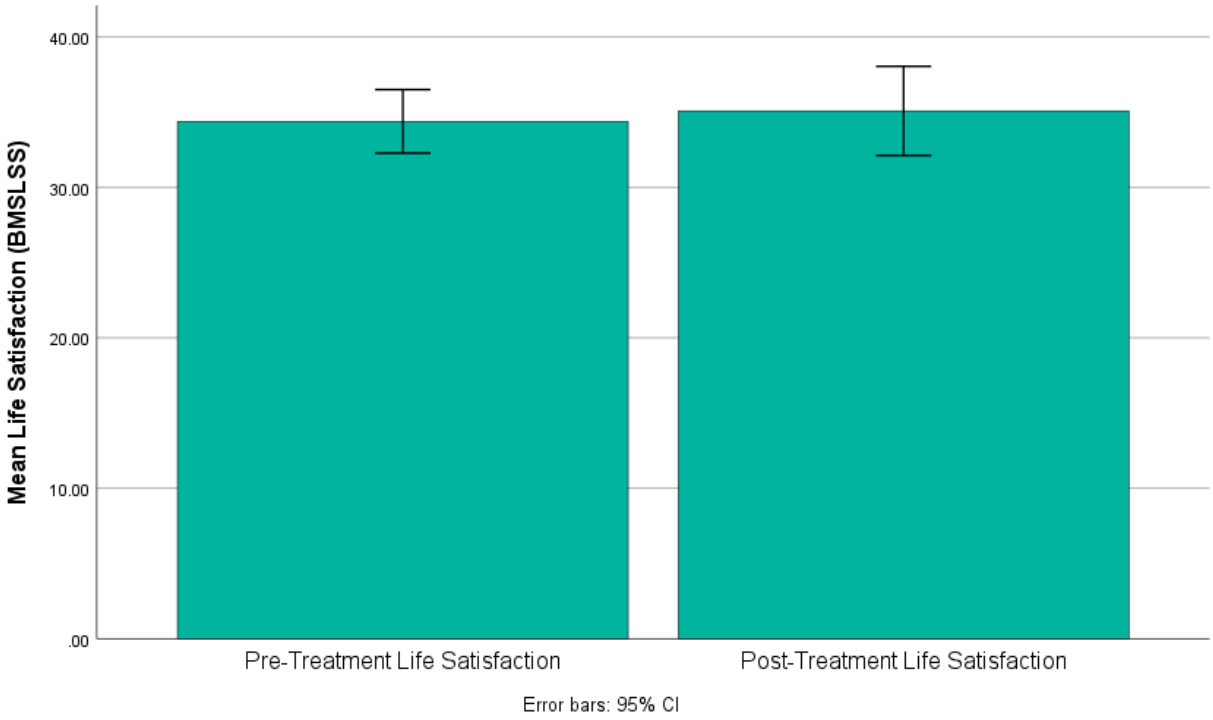


Figure 10.

Mentor pre-post psychological inflexibility

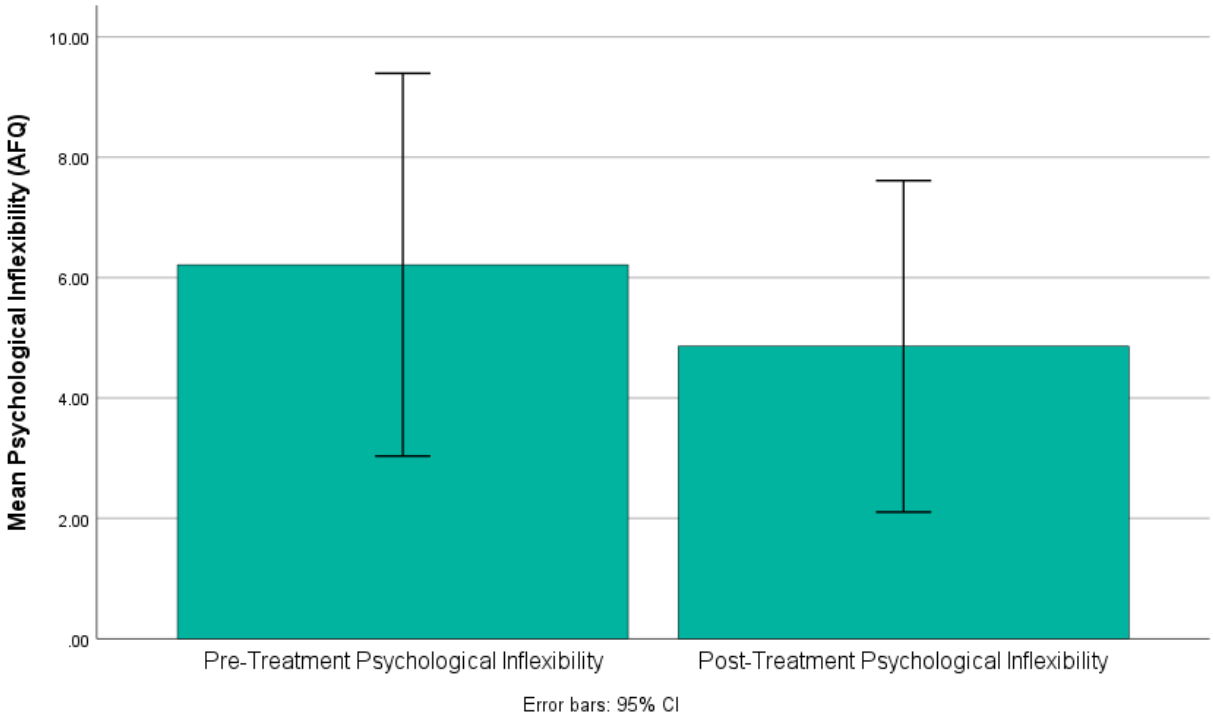


Figure 11.

Mentor pre-post help-seeking behaviors

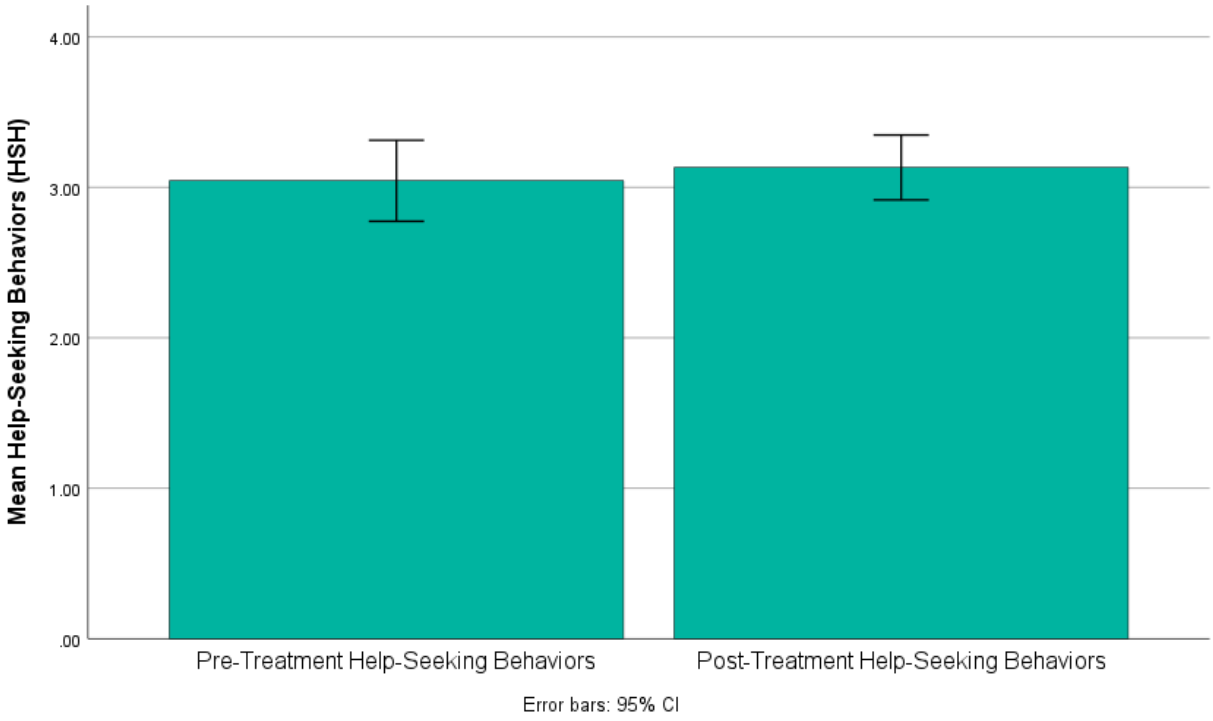


Figure 12.

Mentor pre-post mental health efficacy

