



MENTORING FOR YOUTH WITH MENTAL HEALTH CHALLENGES

National Mentoring Resource Center Population Review

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December 2016

Summary

This review examined research on mentoring for youth (ages 18 and younger) who are experiencing mental health challenges, including those with a formal diagnosis, as established by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), those experiencing what has been defined in the literature as internalizing problems (depression, anxiety, withdrawal, and eating disorders) and/or externalizing problems (aggression, oppositional disorders, delinquency, and school problems),¹ and those who have been identified as “emotionally and/or behaviorally disturbed.” The review focuses on four questions:

1. What is the documented effectiveness of mentoring for youth with mental health challenges (YMHC)?
2. What factors condition or shape the effectiveness of mentoring for YMHC?
3. What are the intervening processes most important in linking mentoring to outcomes for YMHC?
4. To what extent have efforts to provide mentoring to YMHC reached and engaged targeted youth, been implemented with high quality, and been adopted and sustained by host organizations and settings?

The review found a total of 25 studies addressing these questions, with the bulk of the studies focused on youth under age 12 and, in the case of formal mentoring programs, a relatively small

group of programs. Although the scope of available research is limited, with mixed (i.e., inconsistent) findings complicating conclusions, the existing evidence does point toward several noteworthy possibilities:

- Beneficial effects of mentoring programs for YMHC, in particular those that have had a relatively high degree of structure, those that have been directed toward higher functioning younger children (i.e., those receiving outpatient mental health services or identified as having mental health–related challenges while still functioning in a regular school setting), and those directed toward young children and adolescents with Attention Deficit Hyperactivity Disorder (ADHD).
- Relatively more robust effects of mentoring program participation on mental health and academic outcomes for YMHC.
- Individual factors (e.g., severity of symptoms) and program factors (e.g., formal programs) conditioning the effect of mentoring for YMHC. Specifically, youth with more significant symptoms benefitting more from mentoring, and formal mentoring programs having a greater effect than natural mentoring.
- Reductions in the level of stress experienced by the caregiver, along with increases in the mentee’s level of trust and affect regulation, as processes or paths through which mentoring may improve outcomes for YMHC.

Available research also suggests:

- Minimal scale-up, and thus collective reach, of the programs directed toward youth with mental health challenges that have received the most rigorous evaluation.
- That mentoring programs engage and serve significant numbers of YMHC even when not targeting this population specifically.
- Interest and amenability of youth and their caregivers to involving youth in mentoring as part of mental health service provision as well as the potential for sustained engagement of YMHC in mentoring relationships that are established in this context.

INTRODUCTION

Unmet mental health needs among youth are a significant public health concern, one that some have concluded is a crisis.² Mental health problems tend to manifest early in life, with three-fourths of lifetime cases of mental disorders, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision (also known as DSM-IV-TR) beginning by the time individuals reach young adulthood.³ Lifetime prevalence rates of mental disordersⁱ among children and adolescents in the United States have been estimated at 37%⁴ and 46%,⁵ respectively. These numbers reveal how pervasive mental health challenges are among our nation’s young people.

i Lifetime prevalence in this context refers to a youth currently or at some point previously in his or her development having met criteria for a mental disorder.

Adding to this concern, research points to mental health challenges in childhood and adolescence as frequent contributors to negative outcomes in critical domains during development, including poor academic achievement,^{6,7} strained relationships, risky sexual behaviors, increased suicide risk⁸ and involvement with the judicial system.⁹ These negative outcomes often have a lasting impact as youth with mental health challenges (YMHC) strive to become independent and productive contributors to society, including financial and social costs.¹⁰

Mentoring is one approach that may improve the health and well-being of YMHC, through both prevention efforts, before serious mental health concerns emerge, and intervention efforts, when symptoms have already appeared. In the past decade, programs have been emerging that are designed to target youth (mentees), and sometimes even mentors, specifically because they have been identified as having mental health challenges, and/or as meeting criteria for an emerging mental health problem, such as heightened aggression, inattention, or suicide ideation. The field is in its infancy in understanding the promise, potential impact, and potential challenges of mentoring relationships for YMHC, and the evidence-based program elements needed to implement and sustain programs designed to serve YMHC in the community and mental health system contexts.

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Mentoring programs for YMHC may focus on providing mentoring as *primary prevention*, in order to prevent mental health symptoms from developing in the first place among youth identified as at-risk, and/or mentoring as *early intervention*, in order to prevent additional negative developmental outcomes (e.g., cognitive, socio-emotional, identity) among youth with existing mental health challenges (i.e. after symptoms emerge). The focus of this review is not on primary prevention studies, but rather on intervention studies of mentoring for those with existing mental health challenges.

Additional innovative mentoring program strategies under investigation include those that use mentoring to address the lack of continued engagement in mental health care among YMHC. More specifically, a program that includes those who have lived experience with mental health challenges (i.e., peers) as mentors and recovery role models is being tested to examine whether it can improve the overall engagement of youth and their families in mental health services.^{11,12} The impact of mentoring that is provided specifically to address issues such as stigma and acceptance, and increase efficacy, among participants are also being examined.¹¹ Programs can also focus on improving known determinants of mental health service engagement and using and/or providing mentors that assist and support youth in accessing clinics, advocating for needed services, and continuing follow-up with care and services. Although these programs have a focused approach on mentoring to address barriers to mental health service use, it is not assumed that all YMHC need continuous mental health care. Rather, these approaches focus on matching youth with mentors who also live with mental health conditions and can be trusted guides in navigating the mental health system and life with a mental health condition. In addition to the importance of the relationship, this approach utilizes mentors to provide psychoeducation and advocacy, among other services.

Rhodes’s¹³ conceptual model of youth mentoring is a useful framework when considering how mentoring relationships may influence outcomes for YMHC. Rhodes’s model posits a socio-emotional mediating path (based on attachment theory), a cognitive mediating path (based on learning theory), and a role modeling mediating path (based on social cognitive theory). It is important to note that the model suggests that more than one of these mechanisms may be activated in any given mentoring relationship.

Munson and colleagues¹⁴ conducted a qualitative study with fifty-nine marginalized young adults, ages 18 to 25, all of whom had been diagnosed with a mood disorder and had indicated that they were still struggling with mental health challenges. The aim of the study was to build understanding on *how* natural supports, defined in the study as “key helpers” (someone who was older than them and had assisted or guided them in their lives with their mental health), impacted the lives of these YMHC, extending Rhodes’s model¹³ in several ways. See conceptual framework in Figure 1 below. First, it suggests specific aspects of the relationships that emerged for YMHC as important beyond mutuality, empathy, and trust, specifically providing consistency and also care (or love). Data also suggest the salience of a constant presence, tutoring, and inspiration as important relationship and program elements for this population. Moreover, there were mediators and moderators that emerged as potentially important for YMHC, such as interpersonal trust, affect regulation, and placement factors (e.g., removals from home). This study is further discussed (where appropriate) in the text below.

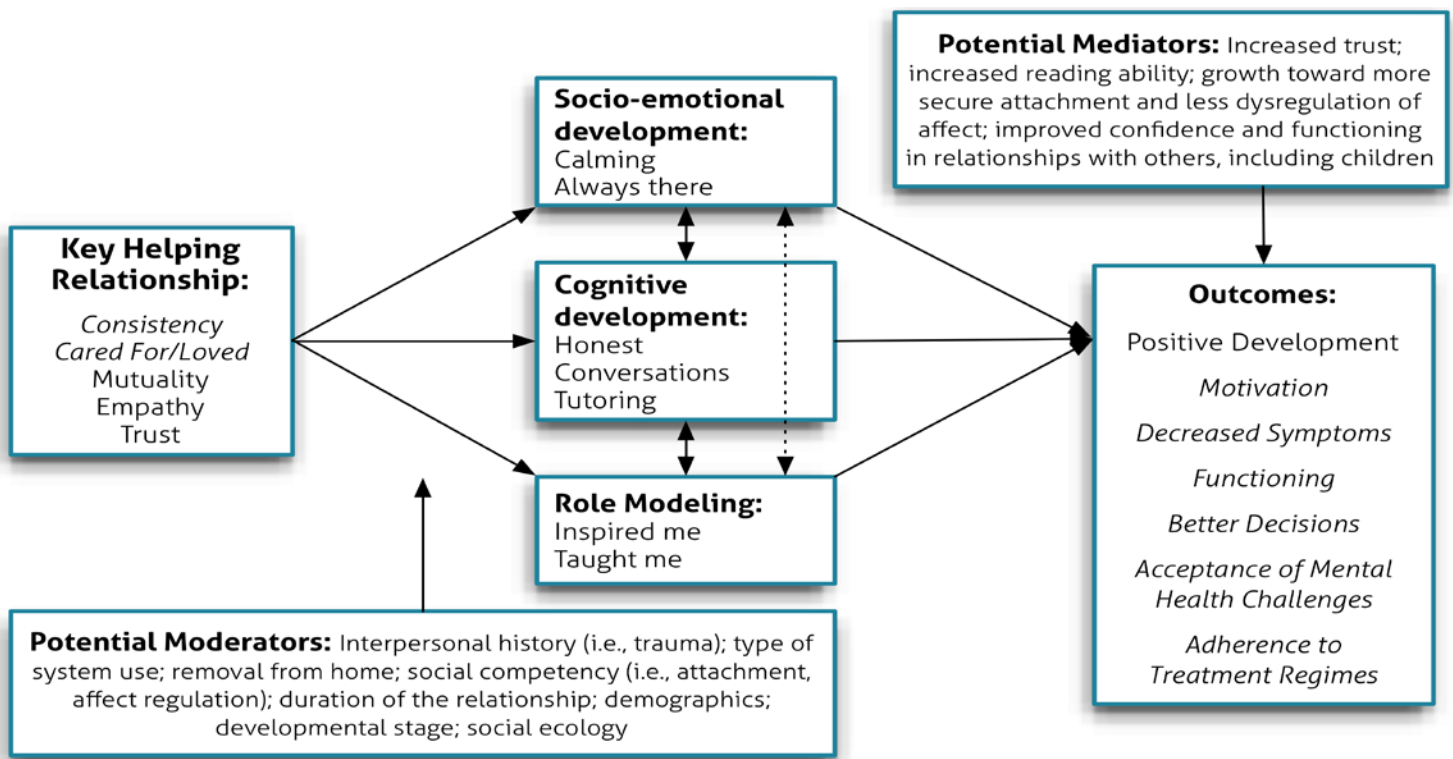


Figure 1. Conceptual model of the effects of supportive relationships between YMHC and key helpers. *Italicized items represent additions to the original model by Munson and colleagues.*

The review presented here utilizes the term *mental health challenges* (MHC), to reduce potential value judgments that can occur when using diagnostic labels and paternalistic language regarding individuals with these conditions who are often discriminated against in society, overtly and

covertly. At times, we do use specific conditions or diagnostic terms, particularly when studies have populations or target groups with specific diagnosis as the focus of the program. Further, MHC is less connected to the medical model of disorders and provides a more nuanced perspective that symptoms of mental health challenges are both environmental and biological. In the review, we included studies that examined both formal mentoring programs and mentoring relationships for YMHC, which occur more naturally (e.g., natural mentors, nonparent adults, and natural supports). The review was limited (with selective exceptions that are noted) to studies on mentoring for youth younger than age 18 (i.e., studies in which either the mean age of participants or a majority of the sample was in this age range). We included studies with a variety of designs, such as randomized control evaluations, correlational studies, and qualitative research.

A systematic literature search for research that examined mentoring as defined above was carried out to identify articles, book chapters, and evaluation reports that have reported findings pertinent to one or more of the central questions for this review. A total of 25 research articles or reports were identified that met criteria for inclusion. The review of available research for each question begins with a background section. These sections are guided by the perspective that the review must orient the reader to related studies, particularly in areas of mentoring research that are emerging in the literature and where there currently is a dearth of studies.

1. What Are the Demonstrated Effects of Mentoring on Youth with Mental Health Challenges?

BACKGROUND

There are many reasons to believe that YMHC could benefit from a mentoring relationship (See Kerr & King¹⁵). Mentoring can provide easy access to supportive relationships with caring adults when they are in need. They also may provide a positive relationship that could act as a corrective emotional experience^{13, 16} and as a critical form of social support for YMHC who have often had insecure attachments with primary caregivers and teachers.^{14, 15} Additionally, research suggests that mentoring relationships can also improve youth relationships with their parents and reduce the stress levels of their parents and other caregivers.^{17, 18} In this way, mentoring (i.e., time the mentor spends with the child) may serve as a form of respite for parents, which may then enable them to provide more attention and a more therapeutic parenting environment for their children—research is needed to test this hypothesis. Finally, mentoring relationships may provide an opportunity for behavioral and cognitive interventions that are geared specifically toward the needs of YMHC.¹⁹

RESEARCH

The studies considered for this review have investigated potential effects of mentoring for YMHC in several different areas of their development and functioningⁱⁱ. Overall, though, the following broad types of outcomes have been examined and thus will serve as an organizing framework within this review: 1) mental health, 2) academics, and 3) social and life functioning.

ⁱⁱ Six of the seven studies included in this section (Challenging Horizons Program, Rochester Resilience Project, Jent and Niec's cognitive behavioral mentoring intervention, Early Risers, Better Futures, and Youth Nominated Support Team) have been reviewed for [CrimeSolutions.gov](https://www.crimesolutions.gov); these reviews and, in most cases, accompanying insights for practitioners are available at the National Mentoring Resource Center [website](https://www.nationalmentoringresourcecenter.org).

Of particular note, a recent meta-analysis synthesized the findings of evaluations of the effectiveness of formal mentoring programs for youth with emotional and behavioral problems.¹⁹ Averaging across findings in 14 study samples (7 of which were also included in this review), this review found evidence of small- to moderate-size effects of mentoring on each of four categories of outcomes—internalizing symptoms, externalizing symptoms, interpersonal, and school/academic—all statistically significant in a direction indicating benefits for participating youth (e.g., fewer internalizing symptoms).

Mental health. Perhaps not surprisingly, the majority of studies examined at least one mental health outcome (e.g., inattention, self-esteem, and self-regulation). Evans and colleagues have conducted a number of evaluations of the Challenging Horizons Program (CHP)—a multicomponent, school-based program focused on improving behavioral and educational outcomes for middle school children who live with Attention Deficit Hyperactivity Disorder (ADHD). CHP utilizes both individual and group program formats and combines family, academic, social, and behavioral interventions implemented as a weekly in-school program or as part of an after-school program that met two days a week for approximately two hours each day.^{20, 21} CHP involves a primary counselor (PC) who engages in a supportive and therapeutic relationship with the youth and their parents. In the after-school version of the program, undergraduate students served as PCs and received 9 hours of preprogram training, and 15–30 minutes of individual and 60–90 minutes of group supervision during the school year on a weekly basis; in the in-school version, the role of the PC was filled by teachers.²⁰

An important philosophical underpinning of CHP is that it is a training model, as opposed to a behavioral management model, meaning that the focus is on training youth and parents in skills so that they can better manage their loved one's mental health, as opposed to the more common approach of training them to change behaviors with operant conditioning.²⁰ In the after-school version (CHP-AS), providers engage in a "mentoring-type" relationship, teaching skills to youth and parents, and in the mentoring version (CHP-M), the whole program is provided within the context of a mentoring relationship.²⁰ In early investigations of CHP, which used pre-post quasi-experimental designs, there were mixed results, possibly at least in part due to small sample sizes.^{21, 22} However, two early studies of CHP-AS show significant results in mental health outcomes. First, in a randomized control trial of CHP-AS with middle school children experiencing learning and behavior challenges (N = 48), it was found that those in the CHP-AS program, relative to those in a "community control condition," made significant improvements in their self-esteem and in overall severity of problems as rated by parents.²³ However, when using teacher-report measures, there were no significant differences. In a randomized control trial that examined CHP-AS in comparison to a community control condition among adolescent students with ADHD (N = 49, 31 in CHP and 18 in control group) results, based on teacher report, suggest that those in the CHP-AS condition improved in overall symptoms and functional impairment.²⁴ In the only large-scale evaluation of CHP, which used a pre-post design and assessments at four time points, Evans and colleagues²⁰ examined CHP-AS and CHP-M, and compared them both to a control condition. Adolescents in the CHP-AS group showed improved mental health symptoms, such as decreased inattention and improved organization skills. The CHP-M program did not show significant results. Overall, the Challenging Horizons Program reveals significant promise for improving the mental health, in particular ADHD symptoms, of middle school youth. In all of its iterations, it centers on a relationship-driven intervention with either a "primary counselor" or a "mentor" who are in the lives of the youth, in most

cases, for an entire academic year. Future research can explicate the impact of CHP for youth with ADHD of other age groups, and youth experiencing other mental health challenges.

Another mentoring program reviewed, which was embedded within the Rochester Resilience Project, was designed to strengthen the emotional self-regulations skills of its participants who were in kindergarten through third grade.²⁵ The program, uses “resilience mentors” (described by the researchers as paraprofessionals hired by the school district and as empathic adults who are informed about each child’s life context, strengths, and challenges) to provide reinforcement and skills training on monitoring emotions, self-control/reducing escalation of emotions, maintaining control, and regaining equilibrium.²⁵ In an evaluation of the program that included 226 youth, randomly assigned to either the mentoring (N= 111) or waitlist control group (N = 115), youth in the mentoring intervention showed evidence of improvements in behavioral, socio-emotional, and/or learning problems on a standardized measure. Findings suggested that participation in the program contributed to reduced problems in behavioral control as well as less difficulties with “being shy” and withdrawn as rated by teachers.

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Jent and Niec¹⁷ evaluated a mentoring program for children ages 8 to 12, which was based on behavioral principles and using mentors who were paraprofessionals or college students employed by the mental health center the program was implemented in. The children in the study were all diagnosed with a DSM-IV-TR mental disorder and were assigned randomly to either a treatment group that received mentoring for eight weeks or a waitlist control group. Mentors met with mentees once a week for approximately three hours to engage in activities for fun (e.g., sports) and to work on specific goals. Mentors promoted and supported positive behaviors in the areas of social skills, communication, and emotion regulation. They also role modeled and coached youth, and engaged their parents in evaluations of how their loved one was doing in the program. Caregiver report revealed that youth in the mentoring program had significantly fewer externalizing and internalizing symptoms. Furthermore, results revealed that parents in the mentoring group reported significantly stronger social support and less stress.

An additional study examined an adapted version of the behavioral mentoring program described above, a group model based on both mentoring and principles of cognitive behavioral interventions for children with behavior problems.²⁶ The group program included ongoing training for mentors, structured activities for youth, and consistent contact between mentors and children (mentees) in the program. Structured activities for the program included sessions with a discussion topic, an activity, and one goal for the session. Results of the randomized trial at 12-weeks suggested that youth ages 8 to 12 with mental health challenges in the mentoring group, as compared to those in the waitlist condition, had improvements in their mental health (e.g., they had improved externalizing and internalizing symptoms, and improved attachment with their parents).²⁶

Early Risers “Skills for Success” is an intervention program based on social learning, social development, and cognitive-behavioral models of behavior change targeting elementary school children who are at risk for developing conduct problems.^{27,28} The two main components of the

program, FLEX and CORE, are delivered over a six-week session during summer school. The CORE component included the provision of mentoring during the school day and a family program held every two weeks, while the FLEX component provided prevention case management services to children and their families. A 2001 study using a randomized controlled trial design evaluated the impact of the Early Risers program over a two-year period and found that children in the program showed greater improvement in behavioral self-control than those in the control group. A 2002 randomized controlled trial, however, suggested no differences in mental health outcomes.²⁸

The Better Futures program provided mentoring to assist older youth with mental health challenges in foster care with developing life skills and improving psychological and well-being outcomes.²⁹ The program provided individualized coaching and mentoring workshops where both mentor and mentee were close in age (“near peers”) and had the shared experience of having been in foster care. In a longitudinal randomized controlled trial study using self-report measures, youth assigned to Better Futures (N = 36) reported significant gains in hope, self-determination, and mental health empowerment, as well as in mental health recovery and quality of life, as compared to the control group who received services as usual (N = 31).

King and colleagues^{30, 31} developed and evaluated a program for youth experiencing suicidal ideation entitled “Youth Nominated Support Team.” In an initial version of the program, participating youth were asked to nominate a set of support providers, which could include same-age or “near” peers. Members of the youth’s support team were asked to connect with the participant on a weekly basis and participate in psychoeducation sessions to learn about mental health challenges and how to support their loved ones. The 289 participants in the randomized control evaluation of this program (92 of whom were male) were psychiatrically hospitalized adolescents (12–17 years of age) who had experienced a suicide attempt or significant suicidal ideation or intent during the past month, and were above the clinical cut-off score for self-harm. At a six-month follow-up, youth assigned to the program did not differ significantly from youth assigned to treatment as usual on outcome measures, which included suicide ideation or attempts, internalizing symptoms, and related functional impairment. Informed by the results of this study, King and colleagues³⁰ modified the original program to exclude same age peers from the support teams, as it was deemed too much for them to be exposed to and responsible for their suicidal friends. Using a similar randomized control design as the original study, findings again generally did not indicate significant beneficial effects of the program. Both versions of the program, however, did show some promise for particular subgroups of participants—these results are described in a later section of this review.

Cavell and Hughes³² developed a community-based mentoring program using college student mentors called “PrimeTime,” which included mentoring and social problem solving skills training (PSST) consultation and support for parents and teachers, for second and third graders (N = 62). They randomly assigned children who were deemed aggressive to either PrimeTime or a standard mentoring condition over the course of three semesters. The mentors in PrimeTime were extensively trained and supervised whereas those in the standard mentoring condition were not. The outcomes from the study showed no differences between children in the two conditions; children in both groups improved in their parent-, teacher-, and peer-rated aggressive behaviors.

In another study of PrimeTime, Hughes and colleagues³³ examined differences between PrimeTime and a mentoring program with little opportunity for relationship formation called the Lunch Buddy program. The study examined outcomes for 174 second and third graders who were identified as exhibiting elevated levels of aggression by their teachers and peers.³³ The Lunch Buddy program provided the children with brief 30-minute visits from mentors in the lunchroom, and the mentors frequently changed over the course of the program. Findings were surprising in that both conditions had significant improvements at one- and two-year follow-ups on externalizing problems and behavioral and academic outcomes.

Academics. In evaluations of the Challenging Horizons Program (CHP), described earlier, youth involved in the program, as compared to those in control conditions, demonstrated better academic outcomes,^{20, 21, 23, 34} including, ability to do homework and function academically,²¹ grade point average,²¹ and overall academic progress.²³ Also, Early Risers made a significant impact on the academic outcomes of youth in the mentoring group versus those in the control condition, specifically in academic achievement and overall school behaviors.^{27, 28} Additionally, the Better Futures program for older youth in foster care, which includes a significant mentoring component, reported significant gains for the intervention group in academic outcomes, such as postsecondary preparation and participation, when compared to the control group.²⁹ Youth in the intervention group also showed positive trends in high school completion. The foregoing results are notable in the context of research that has highlighted the trend for youth with mental health challenges to be more likely to experience academic difficulties in school.^{35, 36}

Social and life functioning. Evaluations of CHP also have found evidence suggesting beneficial effects of the program on social and life functioning outcomes. These include improved overall social functioning²¹ and, with relevance to life functioning, improved organizational skills and time management skills.²⁰

CONCLUSIONS

1. Available research offers minimal support for the effectiveness of mentoring programs for youth with mental health challenges.
2. The evidence for mentoring program effectiveness is strongest for programs that have had a relatively high degree of structure and been directed toward higher functioning younger children (i.e., those receiving outpatient mental health services or identified as having mental health–related challenges while still functioning in a regular school setting) or young adolescents with ADHD.
3. Research on mentoring programs for youth with mental health challenges show the most evidence of having a positive effect on mental health symptoms and academic outcomes, with less evidence supporting social and life functioning outcomes.
4. Both site-based mentoring programs in schools and community-based natural support teams show preliminary evidence of being helpful for youth with mental health challenges.

2. What Factors Condition the Effectiveness of Mentoring for Youth with Mental Health Challenges?

BACKGROUND

Theoretically, the impact of mentoring on youth with mental health challenges may vary due to individual-level factors (e.g., youth or mentor) and/or program factors (e.g., duration, setting), as have been evident to varying degrees in research on formal and natural mentoring for other populations of youth. One factor that could be particularly important for this population is the interpersonal background of the youth. Research has shown that youth with mental health challenges (YMHC) often have histories that include trauma, and sometimes trauma specifically surrounding caregiving relationships.³⁷ The level of interpersonal trauma and its impact on a young person's attachment style could potentially condition the effectiveness of a mentoring relationship; for example, those youth with more severe insecure attachments could have a much harder time consistently engaging in a mentoring relationship and gaining benefit from the relationship.

Furthermore, the impact of mentoring and/or natural mentoring can depend on program practices. For example, the training and supervision of the mentor, with the impact being greater for youth who have mentors who are receiving structured, tested, and consistent monitoring and supervision. The impact can also depend on where the program is located and whether the organization supports the implementation of the program within its culture and climate. Additionally, consistency—a specific aspect of consistency reported was “being there” during crisis situations and/or when symptoms emerge—was discussed in the Munson et al.¹⁴ study as an important component for mentoring programs for YMHC. This suggests it may be valuable for programs to assist mentors in preparing to address crises that may come up for youth and suggests the potential value of training on crisis management for any program model focused on cultivating new or strengthening existing supportive relationships.

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RESEARCH

In the previously described evaluations of the youth support team (YST) model for adolescents with backgrounds of suicidality,³¹ there was some evidence of greater benefits for girls. Specifically, relative to the girls in the control group, girls who received YST-1 self-reported lower levels of suicidal ideation and had less mood-related functional impairment, as rated by their parents, at the follow-up. Furthermore, in the YST-II study, youth who attempted suicide multiple times reported more rapid decreases in suicidal ideation during the six weeks immediately following hospitalization, when compared to those who did not have multiple suicide attempts. However, these findings are relatively isolated among a larger number of tests for conditioning factors and did not replicate across the two trials. On the other hand, as described below, findings suggesting greater benefits for girls and those with more severe forms of mental health challenge have been reported in research on other programs.

In research on the Early Risers program, findings indicated stronger favorable effects of the program on behavioral self-regulation among the most severely aggressive children. Program attendance also was associated with more positive outcomes for parents, with those parents with high program attendance rates showing improvement in outcomes, specifically discipline methods. In the Rochester Resilience Project, there was also evidence of a positive effect of program participation on peer social skills for girls, but not for boys.²⁵

Finally, the previously noted Meyerson¹⁹ meta-analytic review of mentoring for youth with mental health challenges found greater estimated favorable effects on outcomes for formal mentors (compared to natural mentors), and for school/hospital-based settings (compared to community-based settings). Surprisingly, programs that provided ongoing support/supervision to mentors fared worse in estimated effects on outcomes than those that did not; notably, however, programs that provided a support opportunity to parents and those that directly involved parents had greater estimated favorable effects on outcomes.¹⁹ A difference in estimated program effects in association with the duration of the program among the studies reviewed was not found.

The review also looked at possible differences in program effects in association with individual-level characteristics of participating youth. Programs that enrolled youth with externalizing problems had greater estimated favorable effects on outcomes than those that did not. Other characteristics of the samples of participating youth considered “risk factors” (internalizing, school, and additional mental health problems) did not have significant associations with estimated effects on outcomes. Nor did gender, race/ethnicity, and age of participating youth. It should be noted that the foregoing findings relating to characteristics of participating youth are based on characteristics of youth in the program as a whole; the role of such factors in conditioning effects on outcomes at the level of individual youth (e.g., whether a particular youth in a program is male or female) may be different.

CONCLUSIONS

1. Available research suggests that the youth’s gender and severity of symptoms have the potential to condition the impact of mentoring on outcomes for youth with mental health challenges, with females and those with more severe symptoms receiving greater benefit than boys and those with fewer symptoms, respectively.
2. There is some evidence that formal mentoring programs (versus natural mentoring) may have more of a positive impact for youth with mental health needs.
3. Qualitative research suggests that the relatively high levels of interpersonal trauma in the backgrounds of youth with mental health challenges have the potential to constrain their ability to form strong mentoring relationships; this suggests that interpersonal trauma could similarly condition the impact of mentoring on the outcomes of this population of youth, although research does not appear to have addressed this possibility.
4. Theoretically, consistency of the person (mentor), place (site), and program may be important in conditioning the effects of mentoring for youth with mental health challenges; however, research has not addressed this possibility.

3. What Processes Are Most Important in Linking Mentoring to Outcomes for Youth with Mental Health Challenges?

BACKGROUND

Rhodes's model¹³, as described previously, proposes several factors that may be important as processes or pathways through which mentoring can have positive effects on young people. As was introduced earlier, Munson and colleagues¹⁴ examined the active ingredients in the supportive relationships among marginalized young adults with mental health challenges and the natural supports in their lives. In addition to mutuality, trust, and empathy—all emphasized in Rhodes's model¹³—the participants in this study emphasized the importance of consistency in their relationships, especially over extended periods of time and through major life transitions, including mental health crises.¹⁴ Such consistency is something that these youth found hard to obtain, making the support their key helpers provided especially meaningful. Although this was a cross-sectional study (i.e., participants were not followed over time), findings suggested that this type of consistency contributed to participants developing a sense of trust in their relationships, a dimension that is often a barrier in relationships for individuals with mental health challenges.¹⁴ Supportive relationships with key helpers, in contrast, may provide a safe connection within which youth can reappraise their representational models of self and others. Findings indicated that the fostering of these kinds of relationships may depend on a high level of consistency on the part of the mentor and, if applicable, the larger program within which the relationship develops. Munson and colleagues¹⁴ posited that programs providing consistent support to YMHC, over time, have the potential to bolster the impact of existing natural supports and/or help youth identify and invest in relationships that have features that have been found to undergird consistency. For example, assist YMHC in identifying people they can trust.

Finally, thinking broadly about the results reported by Munson and colleagues¹⁴ through the lens of the Rhodes's model¹³, these data offer some hints as to potentially important pathways through which mentoring relationships may influence outcomes for YMHC (see Figure 1). The data suggest that the majority of youth are in need of, and yearning for, healthy socio-emotional connections.¹⁴ Young adults' descriptions of characteristics of key helpers that mattered to them were caring, emotionally close, consistent, and available. These data indicate that having someone who is there for them emotionally, encouraging them, and "showing up for them" helped individuals feel connected and more motivated to pursue their goals and adhere to their treatment regimens as they made their way into adulthood.

Munson and colleagues'¹⁴ data also suggest that some young adults valued supportive relationships for the chance to simply have someone there to talk to, learn from, and engage in meaningful conversation with about important topics. Having someone listen to you was repeatedly noted as well, suggesting the potential for there to also be a cognitive dimension to processes through which mentoring relationships may benefit YMHC. The young adults in this study talked about some of their key helpers, often those who were professionals, as helping them see their worth and as promoting positive self-talk, both of which served to help them manage their symptoms and negative thoughts about themselves as well as to appreciate their own potential. These contacts with key helpers may also offer a sense of belonging and a feeling that YMHC are not a burden to others, which research has indicated to be a key factor in mitigating suicidality among adults.³⁸

Finally, some young adults discussed the importance of shared experiences and of key helpers showing them how to do things and manage tasks (e.g., getting prescriptions filled) or making suggestions on how to cope with their mental health challenges. It became clear that youth were looking for role models—individuals who they trust and can provide a positive example of how to be a productive adult with a mental health challenge.

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These young people have often experienced very painful relational pasts, which include significant violations of trust, and these factors must be considered in program design. The findings from this research, although conducted with young adults, suggest potential factors to consider when developing, refining, and testing mentoring programs for YMHC, specifically that relationship-based variables, such as trust, and mentoring could influence important outcomes, in part through more immediate or proximal effects, in areas such as affect regulation and anxiety, among others. Finally, there are emerging innovative mentoring programs aimed at increasing children and families' willingness to engage in mental health services. In these cases, mentoring relationships may influence important empirically based mediators of service use intention and actual behavior, such as mental health stigma and beliefs about the effectiveness of treatment (See Munson et al.¹¹).

RESEARCH

There have been very few direct tests or investigations of processes through which mentoring may influence outcomes for YMHC. One study of this type was an evaluation of a group mentoring program for youth receiving outpatient mental health services.¹⁷ Observed relative improvements in externalizing symptoms for mentored youth occurred, at least in part, through the process of decreasing parental stress. It should be noted, however, that both externalizing symptoms and parental stress were measured at the same points in time, which leaves open the possibility that improvements in parental stress might instead have flowed from decreased levels of externalizing symptoms.

In their study of the PrimeTime and Lunch Buddy programs, Cavell and colleagues³⁹ found that the quality of the mentoring relationships predicted outcomes for participating youth, suggesting that relationship quality may have been an important process through which program involvement influenced the outcomes of participating youth.

Finally, mediational analyses carried out by Jent and Niec¹⁷ in their evaluation of their cognitive-behavioral mentoring program described earlier suggest that mentoring program participation may have reduced externalizing problems of the participants by decreasing the stress of parents and/or guardians. This may work by providing respite for caregivers, as caring for a youth with mental health challenges can be particularly exhausting and isolating for parents for a number of reasons, such as stigma and increased numbers of appointments with social services and school personnel needed to assist these youth. Comparable analyses failed to provide support for changes in perceived parent-social support or parent-child relationship quality as intervening processes; although each

did show more favorable levels for the mentored group, neither was related, in turn, to the level of externalizing problems as an outcome in mediational analyses.

CONCLUSIONS

1. Preliminary evidence suggests that decreases in the stress level of caregivers represents one pathway through which mentoring may improve outcomes for youth with mental health challenges.
2. Relationship quality should be further considered as an important process linking mentoring to positive outcomes.
3. Preliminary research with young adults experiencing mental health challenges suggests processes involving improvements in trust, socio-emotional support, affect regulation, and anxiety, among others, as potentially important ways through which mentoring may beneficially influence outcomes for this population; however, these processes have not been investigated among younger samples.

4. Have Mentoring Programs and Supports for Youth with Mental Health Challenges Reached Intended Youth, Been Implemented with High Quality, and Been Adopted and Sustained?

BACKGROUND

Mentoring programs described in this review that have been designed specifically for youth with mental health challenges have shown *some* evidence of reach through their ability to enroll substantial numbers of youth in evaluations of these programs and thus the programs themselves. These programs have targeted a specific community, however, and have not been adopted nationwide. This includes the most evaluated program to date, the Challenging Horizons Program²⁰, which serves youth with ADHD. It is important to note, however, that programs that do not intentionally target youth with mental health challenges, including those that have had success in scaling up (e.g., Big Brothers Big Sisters) represent a potential route for reaching this population of youth.

Legislative mandates may also play a role in the reach of mentoring programs for YMHC. For example, agencies in California that have historically provided mentoring programs and support to mentoring programs are now being asked, under the new legislation, to involve mentors in providing linkage and referral to mental health services for children and families suffering with mental health challenges. This type of legislation, known in this instance as the California Mental Health Services Act (aka Proposition 63), could potentially transform the use of mentorship as an intervention for YMHC.

RESEARCH

A recent national survey of mentoring programs for youth asked what percentage of the youth served by the program has mental health challenges. Responses to this question (N = 746 programs) suggested that one third of the programs surveyed do not track this information. An additional 40% of programs reported either less than 10% of their participants (N = 152) or 10% to 25% of their

participants (N = 142) as having mental health challenges.

In the Role of Risk study that included seven mentoring programs (five of which were Big Brothers Big Sisters and only one of which focused on serving higher-risk youth),⁴⁰ nearly half (48%) of the youth in the study had mental health concerns as indicated by a parent report of the youth endorsing either an item describing depressive symptoms (“My child often says he/she feels alone, sad, upset, cries a lot, or is unhappy”) or an item referring to diagnosis or treatment of a mental health concern (“My child has been diagnosed with a mental health issue or is currently under the care of a mental health care provider (a therapist or counselor).”). This provides further evidence that traditional mentoring programs are reaching larger numbers of youth with mental health challenges.

In an analysis of responses of 251 youth and their caregivers to open-ended questions about positive and negative aspects of the mental health services for youth received at community agencies,⁴¹ it was noted that “the one type of service that both youth and caregivers appeared to value highly was mentorship for

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Youth often cited **having their mentor, to do activities with** and to keep them out of trouble as the **most helpful aspect of the program.**
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the youth. Youth often cited having someone, like their counselor or mentor, to do activities with and to keep them out of trouble as the most helpful aspect of the program. Likewise, it was important to caregivers for the youth to be assigned a mentor who could act as a role model and who could get the youth involved in positive activities (p. 463). As such, the authors concluded that mentoring could be a way to increase engagement of youth in mental health services.

Illustrating an approach to combining mentoring with outpatient mental health services for youth, the [Great Life Mentoring](#) program (formerly called 4Results Mentoring) in the state of Washington provides an infrastructure to support YMHC and particularly to help them achieve life goals, including academic, social, and behavioral goals, which are important to these youth. This one-to-one mentoring program, which utilizes community volunteers who receive extensive initial training and ongoing individualized support from staff, stresses the importance of match longevity and is based on the importance of helping youth to develop secure attachments. When considering data over a seven-year period, the program was remarkably reported to have successfully retained 98% of mentors for at least 1 year with an average match (i.e., mentoring relationship) length of 3.7 years.⁴²

CONCLUSIONS

1. Mentoring programs intended specifically for youth with mental health challenges that have received rigorous evaluation appear to have successfully engaged substantial numbers of youth on a local level; however, these programs have not apparently been adopted and implemented on a larger scale and related research (e.g., on factors influencing adoption and sustainability of programs) is lacking.
2. There is preliminary evidence of the interest and amenability of youth receiving mental health services and their caregivers for involving youth in mentoring as part of service provision, as well as the potential for sustained engagement of youth and families in services with the support of mentoring relationships that are established.

IMPLICATIONS FOR PRACTICE

(Mike Garringer, *MENTOR: The National Mentoring Partnership*)

There are several recommendations for practice that can be inferred from this evidence review—particularly in the nuances of both service design and areas of emphasis for mentor training—that might help to maximize the value of a mentoring relationship for youth with mental health needs. But perhaps the biggest challenge facing more traditional community-, school-, and other site-based mentoring efforts is understanding how their services, as currently designed, relate to this population and where their ability to help may be limited or, alternatively, underutilized. Many of the evaluated programs mentioned in this review were dedicated interventions designed to maximize mental health–related outcomes or fill clearly identified related gaps in youths’ development (e.g., being several grades behind peers in reading comprehension). But many mentoring programs find themselves in the position of trying to better understand the mental health needs of the diverse groups of youth they already serve and determine exactly how their mentors might contribute more effectively to improving mental health outcomes, even if they are not the primary goals of the program as designed. The recommendations that follow are offered primarily with the broader field in mind, although mentoring programs explicitly serving those with mental health needs will also find ideas for potentially strengthening their work.

1. **UNDERSTANDING TRAUMA EXPOSURE AND OTHER NEGATIVE LIFE EXPERIENCES CAN HELP YOU DETERMINE THE ROLE YOUR PROGRAM CAN PLAY.**

As noted in the review, many youth with mental health challenges have histories that include trauma, often trauma that involved caregivers and other caring adults in some way. Programs should consider doing a brief assessment when youth enter the program to determine if they have been exposed to trauma or have otherwise endured what can be called “adverse life experiences.” [A 2015 report](#) by The Center for Promise defined these as “instability or negative experiences in their families and other close relationships” and found that events like becoming a parent, experiencing homelessness, drug use, death of a parent or loved one, and frequent changing of schools are experienced far more by students who leave school early than by those who persist. Programs should ask about these types of experience, as well as others (e.g., engagement with the child welfare or juvenile justice systems), as a way of perhaps better understanding which youth in the program might be at elevated risk for mental health concerns. And the National Mentoring Resource Center’s [Measurement Guidance Toolkit](#) even offers a scale that can help measure trauma exposure (as well as depressive symptoms and other areas related to mental health and well-being).

Now, this doesn’t mean that programs should start getting into the formal diagnosis business without the proper clinical expertise or support. It also does not mean that programs should start asking a lot of probing and personal questions, which are inappropriate to the age-range of the youth or the services of the program. (Remember, asking youth about past trauma can retrigger that trauma, so use caution when probing about past experiences.) But for many programs, a better understanding of trauma and adverse life experience exposure can help with tailoring services, finding the right mentor, and referring more serious challenges or needs to other service providers. The [Mentoring At-Risk Youth](#) study used a nice set of questions on individual and environmental risks that programs

may look to for inspiration, and the aforementioned *Measurement Guidance Toolkit* has many measures of risk and protective factors that programs may consider adopting.

2. DETERMINE HOW YOUR PROGRAM CAN SUPPORT TWO KEY STRATEGIES NOTED IN THIS REVIEW.

This review notes that two innovative strategies hold potential promise for working with youth with mental health needs: 1) providing mentoring to help youth and their families engage more deeply or effectively with needed mental health services, and 2) providing mentoring to help reduce the stigma of a mental health challenge while also getting them to embrace the challenge of recovery. The first could be addressed by training mentors on how they can encourage youth and families to seek formal treatment for an emerging mental health issue, how they can support a youth's existing treatment plan, and how they can respond when a family seems reluctant or unable to help their child get the help they need.

These can be tricky situations, as families are often overwhelmed by the challenges of having a child with a mental health issue and may try to avoid or downplay the problem. Or they may simply be exhausted from trying to address their child's externalizing symptoms. In fact, this review notes that one of the benefits mentors may provide a family is simply getting a youth with mental health needs out of the house and giving their caregivers a "respite" from the situation and some much-needed downtime for a few hours a week. But mentors can also encourage the family to seek professional treatment for their child (your program should maintain a list of providers to refer families and youth to) and help youth stick to their treatments (e.g., attending therapy or counseling sessions regularly) once they are getting the help they need.

But mentors, in principle, also have the potential to be effective at reducing the stigma around mental illness, which is in itself often a powerful barrier to seeking support. Mentors who have some personal experience with their own mental health challenges (or with a loved one who has a mental health need) may be particularly useful in this effort, although it should be noted that research appears to be silent on this question. They may be able to show youth and families that it is possible to manage and even overcome mental health challenges and role model what effective treatment and symptom management look like. They also may be able to serve as powerful examples of the mindset needed to face these challenges. Addressing a mental health issue is hard work and can be very scary, but mentors who have embraced that challenge and succeeded seem like prime candidates to help youth and families understand that this is a hurdle that can be overcome.

3. DESIGN PROGRAM ACTIVITIES AND MENTOR TRAINING TO EMPHASIZE POTENTIALLY IMPORTANT ADDITIONAL RELATIONSHIP CHARACTERISTICS AND MEDIATORS OF OUTCOMES.

Practitioners can gain insight about possibly how to best serve youth with mental health needs by looking at the adaptations to Jean Rhodes's conceptual model of youth mentoring earlier in this review. Here we see several additions and clarifications at each stage of the model that may be particularly important for helping mentored youth address mental health challenges, although again it must be noted that none of these appear to have been the topic of substantial amounts of

research. These can be effectively summarized by several key relationship features that emerged from the lead author’s qualitative research on what young adults reported as being important to them in their struggle with mental health challenges: caring, emotionally close, consistent, and available. At first glance, these may seem like characteristics that we would desire for all mentoring relationships. Yet the reality is that they are especially critical to this population in overcoming that stigma and embracing the challenge of their treatment. But many mentoring programs will need to consider whether, and how, they can meet youths’ needs in each of these areas. Offering mentoring without getting these factors right might bring additional harm or stigma to these mentees.

- **Caring and emotional closeness** – Most mentors clearly try to be a caring presence for their mentees. But in many programs, the relationships don’t carry an *expectation* of deep emotional resonance (and this may similarly be the case for many relationships that arise through less formal routes, such as teaching or coaching). Many excellent mentoring programs emphasize more instrumental activities designed to help youth achieve some goal or develop a specific skill. Or they simply work with a “lighter touch” that emphasizes having fun or being recreational. That isn’t to say that mentoring relationships for youth experiencing mental health challenges can’t be fun, recreational, or focused on specific activities. But, if the goal is to seriously support youth with identified mental health challenges, the research suggests those young people (at least those who are older as in the lead author’s research) are pretty clear that they value the deep connection, empathy, understanding, and personal sharing that helps them fight through that stigma and overcome barriers. They may place a special premium on feeling that caring and sense of belonging. These themes emerged mostly in research on natural mentoring relationships with young adults, where mentors were theoretically already connected to the youth in meaningful ways: an extended family member, a neighbor or family friend, a trusted coach or teacher. It may be challenging for some mentoring programs to place more of an emphasis on emotional closeness and deeper, more meaningful conversations, especially for younger youth for whom such dialogue may come less easily. But for those programs with room to grow in this area, emphasizing these concepts during mentoring training, including offering role plays and other opportunities to practice being supporting and when to disclose personal information, can be helpful in better serving these youth. Another alternative for programs is to take a bit of a hybrid [Youth-Initiated Mentoring](#) approach where the program perhaps works with the current mentor and the youth to identify other mentors that could be brought into a fuller “web of support” for the young person and perhaps provide some of that deeper emotional closeness through other supportive relationships, rather than relying solely on the lone program-provided mentor.
- **Consistency and availability** – This is another area where mentoring programs will need to think about what they can reasonably offer based on their existing policies and procedures. Consistency is something that every program strives for with its mentoring relationships. But mentoring for youth with mental health challenges may need to be even more tightly scheduled and honored so that youth don’t feel rejected, unworthy of support, or like they are a “burden” on their mentors. Mentors may be asked to support treatment plans or provide very instrumental, tangible support, such as helping a mentee get to an appointment or remembering to take her medication. Clearly, mentoring that is delivered inconsistently or in a disorganized way isn’t going to be very helpful from a practical point of view and might

actually harm youth from an emotional point of view. The emphasis on availability, especially in crisis situations or when stress and externalizing symptoms flare up, may also be a high bar for many mentoring programs. Most programs have extensive rules around when mentors and youth can be in contact, where mentors and youth can meet, and how deeply mentors should try and help with certain situations. In many ways, natural mentors may be much better equipped to handle the random-point-in-time need for support that these youth can present. They may simply be more available (e.g., “you can call me at 2:00 a.m. if you need to”) and freer to provide different kinds of help (e.g., “I can come pick you up in a crisis”) than mentors through a typical community-based mentoring program. So think about the policies and guidelines you have around these types of availability issues and determine clearly what kind of help your mentors can offer and what kinds of help might be better provided through a web of other caring adults. Making the care of this young person [a team effort](#), of which the mentor is just one part, might be a promising approach, although more research is needed into this kind of team-based approach. (See the Resources section that follows for more information on how to prepare mentors to work with youth with mental health needs.)

4. DEFINE WHAT SUCCESS LOOKS LIKE FOR SERVING YOUTH WITH MENTAL HEALTH CHALLENGES AND MEASURE ACCORDINGLY.

As noted in the review, programs can choose a prevention approach (helping youth who are at risk of mental health issues avoid them) or an intervention approach (helping youth who already have an identified mental health challenge manage their symptoms and maximize their treatment adherence and emotional support). Within those two paths, the modified Rhodes model presented in the review also hints at some potentially important goals for programs to set or outcomes that they may wish to measure to help both further understand the needs of their mentees and to gain perhaps even some insight into whether they are making a difference in these areas. Those more on the “intervention” side of things can look to the “outcomes” box of that model and see that goals such as reduced depressive symptoms, acceptance of mental health challenges, and adherence to treatment regimens all make sense as outcomes that the literature suggests mentoring might address effectively. These youth might also have measurable improvements in their academic success, delinquency or disciplinary incidents, and their overall functioning that speak to how mentors are acting as a stabilizing and healthy influence. Those on the “prevention” side—a topic that was primarily outside of the scope of the current review—may choose to look at signs that indicate the mentoring relationship is providing resiliency, which can keep a mental health issue at bay: increased levels of trust, improved hopefulness for the future, improved relationships with caregivers and peers, lower levels of stress or anxiety. Regardless of whether your program’s work is more preventive or more of a targeted intervention, it will be useful to think about the outcomes you can measure to understand the needs of the youth you serve and the program as a whole and to track potential changes in these outcomes for youth as they progress through the program.

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As noted in this review, the research on the topic of mentoring for youth with mental health challenges is in its infancy. With this in mind, any contribution your program can make to our understanding of how to best serve youth with mental health challenges through mentoring will be a valuable addition to our field.

SELECT ADDITIONAL RESOURCES FOR PRACTITIONERS

- [A New Lens for Mentoring: Trauma Informed Care](#) – This webinar provides information and tools about trauma-informed approaches to meeting the needs of youth with mental health needs in mentoring programs.
- [Best Practices for Mentoring Youth with Disabilities](#) – This guidebook has a wealth of advice and recommended practices for programs serving young people with mental health–related special needs and disabilities.
- [Guideposts for Success for Youth with Mental Health Needs](#) – Although originally developed for workforce development practitioners, this framework offers good advice for any service provider working with youth, particularly older youth, with mental health needs.
- [Mentoring At-Risk Youth Study](#) – Published in 2013, this report found evidence of a beneficial effect of mentoring on the levels of depressive symptoms that youth reported. Notably, the study authors concluded that findings were most consistent with a benefit for youth who entered programs already exhibiting a need for assistance in this area.

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