

Paraprofessional Youth Mentoring: A Framework for Integrating Youth Mentoring with Helping Institutions and Professions

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Highlights

- We propose a framework for delegating some mental health service tasks to paraprofessional mentors.
- Appropriately scaled, paraprofessionals can reduce the burden of youth's mental health difficulties.
- With training, a subset of mentors could increase engagement in and deliver mental health services.
- Training, supervision, and documentation of services will be critical to scale.
- Paraprofessional youth mentorship requires research to establish efficacy.

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Abstract The demand for child mental health services, including those provided by psychologists, counselors, and social workers, exceeds the supply. This trend is expected to continue or worsen unless there are substantial structural changes in how mental health services are provided. We propose a framework for paraprofessional youth mentors, defined as a subgroup of professionally supervised, non-expert volunteer or paid mentors to whom aspects of professional helping tasks are delegated. Our proposal is aligned with historical and modern solutions to scaling mental health services, and this framework could simultaneously increase the number of youth receiving evidence-based mental health services and reduce the burden on existing systems of care. The framework defines three plausible tasks for paraprofessional mentors: (1) reducing barriers to mental health service, (2) increasing engagement in services, and (3) providing direct services. The safety and effectiveness of these task-shifting efforts will hinge on competency-based training and evaluation, supervision by professionals, and documentation of services rendered, all of which the field of youth mentoring currently lacks. We describe several requisite scientific, institutional, and regulatory advances that will be necessary to realize this

variant of youth mentoring for a subgroup of youth who are presenting for assistance with mental health problems.

Keywords Youth mentoring · Paraprofessionals · Task-shifting · Children's mental health

Introduction

In recent decades, prevention and intervention scientists have made notable advances in their efforts to reduce the severity and functional impairment of mental health and behavioral difficulties in children. Nonetheless, mental and behavioral disorders remain widespread and burdensome, particularly among children from low-resource communities who are exposed to multiple cumulative risk factors and have insufficient protective factors (McQuillin et al., 2019; World Health Organization, 2010). Internationally, approximately 20% of youth suffer from a impairing mental health condition (Belfer, 2008), and in the United States, 50% of youth are affected by at least one mental health disorder with 22% of adolescents struggling with severe impairments (Merikangas et al., 2010). Critically, in the United States, only one-third of adolescents struggling received treatment for mental health disorders (Merikangas et al., 2011). However, estimates of treatment utilization vary based on disorder; 53% of youth with current behavioral challenges, 59% of youth with current anxiety, and 78% of youth with current depression receive treatment as broadly defined (from providers including clinical social workers, psychologists, psychiatrists, and psychiatric nurses; Ghandour et al., 2019).

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And, treatment happens in a variety of settings; an estimated 14% of youth in the United States receive mental health services in a specialized mental health treatment setting, 13% receive services from educational settings, and 3% receive services from a general medical setting (Lipari et al., 2016). Moreover, the majority of the services that are received are not empirically supported (Shafran et al., 2009). Rates of unmet mental health needs are most highly concentrated among children who are from cultural and ethnic minority backgrounds and among those who live in under-resourced neighborhoods and communities (Alegria et al., 2010; Hodgkinson et al., 2017). Relative to European Americans, African American and Hispanic Americans are significantly less likely to receive adequate care for a range of mental health difficulties, including depression, attention deficit and hyperactivity disorder (ADHD), autism spectrum disorders, and substance use (Aarons et al., 2009; Alegria et al., 2015). The causal and maintaining factors of unmet mental health needs among marginalized children are complex and multifarious, but chief among them is a widespread shortage of highly trained mental health professionals (e.g., doctoral-level psychologists, clinical social workers), particularly those who are accessible and competent to work with culturally and linguistically diverse groups (Aarons & Sawitzky, 2006; Glisson et al., 2006; Montgomery et al., 2010). For example, the National Association of School Psychologists (2011) recommends a ratio of 500 students to one school psychologist, yet the national average is 1381 students to one school psychologist, with rates as high as 5000 to one in some states. Treatment options also are not easily accessible by those who could benefit: Almost half of mental health treatment costs for youth in the United States are paid by Medicaid (Davis, 2014); however, providers accepting Medicaid are geographically hard to locate (Harati et al., 2020). Thus, there remains a large treatment gap between those who could benefit from services and those who are currently receiving mental health services (Kohn et al., 2004).

Although there is a vital need for additional professionals to deliver evidence-based treatments, community psychologists have long argued that the direct delivery of services by highly trained professionals is neither the most efficient nor culturally suitable model of mental health care (Albee, 1968; Miller, 1969). More recently, Kazdin and Blase (2011) have argued that psychotherapy needs to be “rebooted” to meet the current demands, underscoring the need to expand traditional models of delivery to a wider range of settings and service providers. One such group of providers could be *paraprofessional mentors*, or professionally supervised, non-expert volunteer or paid mentors to whom aspects of professional helping tasks are delegated. In the mental health field, the term

paraprofessionals has been used broadly and has included full-time psychiatric providers without advanced degrees (e.g., psychiatric aides), professionals in allied fields (e.g., teachers, nurses, clergy), parents or caregivers, and volunteers and lay helpers who receive some specialized training, most often in structured, targeted interventions (Durlak, 1979; Hattie et al., 1984; L’Abate, 2007). Internationally, there has been increasing attention paid to paraprofessionals providing psychological services, such as midwives and nurses treating perinatal anxiety and depressive symptoms in Canada (Singla et al., 2020) and adults with a high school education providing evidence-based treatment for depressive symptoms in rural India (Weobong et al., 2017). It is notable that in many cases these mental health paraprofessionals are able to effectively support or deliver interventions secondary to their role as teachers, nurses, community health workers, part-time volunteers, and more (Armstrong, 2010; Boer et al., 2005; Jent & Niec, 2006; McQuillin & McDaniel, 2021). Thus, implementing paraprofessional mentoring does not necessarily require a large shift in the workforce or the creation of new occupations. Moreover, decades of studies have demonstrated that, with adequate support and supervision, paraprofessionals can deliver mental health interventions as effectively, if not more so, as professional providers (Durlak, 1979; Hattie et al., 1984; Montgomery et al., 2010).

In this paper, we propose that youth mentoring programs in the United States—organizations that arrange and support individual, often quasi-therapeutic relationships between young people and older, usually volunteer, adults—represent a potentially rich source of motivated paraprofessional helpers for children. To address widespread unmet mental health needs among youth, we propose a framework in which paraprofessional mentors are trained to deliver or support therapeutic activities under the supervision of mental health providers who are licensed and trained to supervise those activities. Because the central defining feature of paraprofessional mentoring is training and supervision by professional providers, this shift would necessarily involve increased training and supervision demands within youth-serving systems of care. Mentors would be trained, supervised, and supported by professionals. Depending on the jurisdiction, this may include doctoral-level psychologists, licensed clinical social workers, licensed professional counselors, or other types of trained providers based on what is permissible by the state and local boards. Such paraprofessional mentors might be involved in supporting intervention efforts in school-based multitiered systems of support, extending the efforts of social workers for home visits, or supplementing psychotherapy by providing supportive accountability for between-session

homework. Although each of these efforts has potential to strengthen and expand youth services, systems must be designed to accommodate the shift toward supervision and training of mentors.

A shift toward paraprofessional mentoring does not diminish the importance of good working relationships. Nor does it depend on mentoring organizations taking on the burden of training their volunteers to provide evidence-based psychotherapies at the level of clinicians. Instead, as described below, this model encompasses a range of roles, many of which involve paraprofessionals supporting and extending professionally developed services. Research in this area is nascent, and there are practical, ethical, and scientific concerns that should be addressed prior to widespread adoption of this approach. Chief among these concerns are questions around how the field might implement and maintain systems that support training, supervision, and documentation of paraprofessional mentoring activities, legal considerations about regulation and licensing, and the need for research on feasibility and effectiveness.

Overview

In this paper, we suggest that by changing the way youth mentoring programs train and manage their paid and volunteer workforce (paraprofessionals, in this case), the immense burden of mental health difficulties can be somewhat ameliorated. We open with a review of the current state of youth mentoring programs in the United States and some of the challenges that they face. Next, we highlight promising examples of national and international efforts to scale mental health interventions to more difficult-to-reach populations and draw comparisons to how those models could be reproduced in mentoring programs. We then suggest first steps toward encouraging task-shifting among volunteer youth mentors. Within this context, we propose three potential roles that paraprofessional mentors could serve in systems of care, by (1) reducing barriers to mental health service (e.g., outreach, transportation, stigma), (2) increasing engagement in services (e.g., skills application, supervised practice), and (3) providing direct mental health interventions (supervised task-shifting). As we will discuss, the most appropriate location of paraprofessionals along this spectrum of services will vary, depending on youth's stage of treatment, access to professional services, and type and severity of presenting concerns and risk profiles. Then, we suggest key components necessary for the effective and ethical practice of paraprofessional mentoring across all of these potential roles: (1) the identification, training, and evaluation of evidence-based competencies; (2) supervision by trained professionals; and (3) documentation of

interactions. Finally, we discuss key considerations for future research, policy, implementation, and practice.

Current Challenge: Mismatch Between Mentoring Programs and Youth Needs

Over the past 30 years, increased public and private investments in youth mentoring programs have expanded the number of young people being mentored in formal programs, many of whom are from marginalized backgrounds and present with clinically significant mental health needs (Herrera et al., 2013; Jarjoura et al., 2018; Raposa et al., 2017). A 2018 evaluation of over two thousand American youth participating in thirty nationally representative mentoring programs found that nearly 70% of mentees were from marginalized, non-majority racial backgrounds (Jarjoura et al., 2018). The vast majority (85%) of the mentees' parents reported that their children had recently been exposed to family stress (such as a family member struggling with substance use, frequent family arguments, or homelessness), while more than three quarters (76%) noted that their children faced economic adversity and safety concerns (such as housing insecurity, parental job instability, or gangs or drugs in the neighborhood). Compared to young people on average nationally, mentees were roughly twice as likely to be living in extreme poverty and to have an incarcerated parent or family member.

Not surprisingly, given these life circumstances, many mentees were struggling with relatively serious academic, social, and emotional difficulties. At intake, the referred youth were more than twice as likely than the average American youth to be suffering from a mental health problem such as depression or anxiety, and three times more likely to have been diagnosed with ADHD. Other studies have yielded similar trends. One research team found that a quarter of the youth in their large-scale evaluations reported high levels of depressive symptoms at baseline (Herrera et al., 2013).

There is also initial evidence that caregivers, especially those from more marginalized backgrounds, sometimes seek out mentoring programs with the goal of addressing mental health challenges. In a recent national survey, Black caregivers were significantly more likely to identify a need for mentoring services than professional services when their adolescent was facing clinically significant mental health challenges (Vázquez & Villodas, 2019), which the authors attributed, in part, to access, stigma, and mistrust of professional helpers. Likewise, in a survey of parents with children enrolling in Big Brothers Big Sisters of Canada, 25% of parents reported that having a child with disability or mental illness was the reason for

referral to mentoring program (Sourk et al., 2019). This relative comfort with mentoring programs may stem from the significant barriers that caregivers face (e.g., transportation, insurance, language differences, lack of knowledge/access, stigmatization) to obtaining mental health and other services for their children. This is compounded for families of color who are also more likely to experience mental health services and providers as discriminatory, coercive, culturally insensitive, and insufficiently attentive to structural and systemic inequality (Lê Cook et al., 2013). Although culturally competent services are growing, many marginalized communities and families remain understandably wary about treatment options (Alegría et al., 2016). Their children are still far more likely than those of affluent parents to receive medication as opposed to specialty behavioral or psychosocial intervention in response to emotional or behavioral struggles and, compared to white youth, youth of color have disproportionate rates of unmet mental health service needs (Planey et al., 2019). Even when controlling for mental health impairment, income, and health insurance, Black and Latino youth are less likely to receive outpatient mental health healthcare (Marrast et al., 2016). Importantly, additional research is needed to more clearly understand how families from diverse backgrounds may accept mentors as mental health paraprofessionals.

Despite mentees' high rates of mental health struggles and unmet needs, the majority of mentoring programs continue to emphasize nonspecific, unstructured relationship-building activities. This may account for the persistently small effects of many mentoring programs on youth's psychological, academic, and behavioral difficulties according to meta-analytic evidence (Christensen et al., 2020; DuBois et al., 2011; Raposa et al., 2019), particularly compared to other youth-focused prevention and intervention efforts (Gutman & Schoon, 2015). Moreover, the overall effect sizes of mentoring programs appear to diminish over time (DuBois et al., 2011; Raposa et al., 2019) and are inconsistent within and across studies (Raposa et al., 2019). We attribute these small effects, in part, to a mismatch between the structure and intensity of mentoring services, the goals of most mentoring programs, and the needs of children that most mentoring programs serve. In a recent meta-analysis of youth mentoring studies, programs that were targeted (i.e., explicitly matched interventions with youth's presenting problems) were more than three times as effective in reducing children's mental health symptoms compared to relationship-focused mentoring programs without targeted intervention (Christensen et al., 2020). This lack of specificity of mentoring practices has also made it difficult to study and improve the practice of mentoring, particularly as it related to mental health and other challenges. In fact, little

is known about what mentors actually do when they are with the young people they serve (McQuillin et al., 2020).

We assert that a more specialized volunteer and paid mentoring workforce could be developed in ways that better serve the mental health challenges of our nation's youth. Indeed, youth mentoring programs sit at the nexus of treatment and prevention science, offering both the structure for forging helping relationships and the apparatus for scaling them. Thus, they are exceptionally well positioned to benefit from the lessons and innovations from both fields. Treatment science provides the rationale and resources for developing theoretically informed, practically applicable helping approaches that serve youth more effectively. Prevention science provides a framework for the implementation, evaluation, and dissemination of effective programs across different settings, youth, cultures, and ethnicities. And, to the extent that programs begin to think of volunteers as paraprofessional helpers and begin to harness all that is relevant from treatment and prevention science, they will be better positioned to deliver effective care. Although youth mentoring programs should continue to target the full range of issues (such as academic performance, civic engagement, college access, and job skills), mental health and wellness are particularly promising priorities. The basic contours of formal mentoring relationships follow those of professional helping relationships (e.g., often meeting once a week in mostly one-on-one relationships), and many youth mentees present with acute symptoms of anxiety; depression; and social, emotional, and behavioral struggles that impede their academic performance and other long-term goals. Mental health concerns are often what prompt parent and teacher referrals, and mentoring programs are particularly successful in moving the needle on depression in vulnerable youth (Herrera et al., 2013).

The Paraprofessional Workforce in Psychology

The notion of paraprofessional helpers supporting, extending, or replacing professional helpers is not new. In 1968, pioneering community psychologist George Albee highlighted the insurmountable gaps between the small number of highly trained mental health professionals and the number of people who need care. To address this gap, he advocated that professional psychologists develop and support frontline bachelor-level providers: "I do not see psychology as the care-delivery field. We can never have the manpower to meet the demands. Rather, we must create the theory and show how it is applicable, to enable care to be given by bachelor's level people. . . Psychology can only be the developer of the conceptual models and of the research underpinning" (Kessler et al., 1992).

This sentiment was echoed a year later by the American Psychological Association presidential address of George Miller (1969), who argued that professionals' responsibility is "less to assume the role of experts and try to apply psychology ourselves than to give it away to the people who really need it..." (p. 1074). More recently, Kazdin (2019) outlined how traditional models of treatment delivery are not able to scale to meet the treatment gap, citing that in-person, one-on-one treatments that are delivered by highly trained professionals and held in private settings inherently create barriers to access. Although there are a number of proposals for increasing access to services for youth (e.g., behavioral health integration in pediatric primary care; Tyler et al., 2017), we focus on stepped care and task-shifting as effective ways to scale treatment access.

Task-Shifting to Scale Mental Health Treatment Access

The field of public health, particularly the World Health Organization, has embraced stepped-care as well as task-shifting initiatives to address widespread service shortages, in which services traditionally reserved by professionals are shifted to paraprofessional providers, who are more widely available and accessible in underserved communities (World Health Organization, 2007a, 2007b, 2008). There are several advantages to task-shifting. By engaging paraprofessionals in service provision, task-shifting enables more highly trained professionals to work with more severe or complex cases and to function in service development, training, or supervisory capacities, allowing their knowledge and expertise to become more widely disseminated and readily available (Bearman et al., 2017). This, in turn, improves access and efficiency of service delivery in underserved communities. Relatedly, task-shifting moves services closer to low-resource communities, which enhances opportunities for community-specific and culturally tailored interventions, thereby increasing the likelihood of uptake and acceptability of services and improving opportunities to rapidly identify prevention and intervention needs emic to the community (Eng & Parker, 2002; Pérez & Martínez, 2008).

International efforts to reduce the treatment gap have included training lay providers to deliver interventions for mental health difficulties. In rural India, the Healthy Activity Programme (a brief behavioral intervention for depression delivered by lay counselors) was found to reduce depression more than usual care and was found to be a cost-effective treatment option (Weobong et al., 2017). Also in India, an intervention for youth with diverse mental health difficulties delivered by lay counselors was found to be more effective for improving psychosocial outcomes than psychoeducation alone

(Michelson et al., 2020). In a review treatments for adults with common mental health difficulties delivered by non-specialists in low- and middle-income countries, the effect size for these psychological treatments was moderate to strong, suggesting that non-specialists have the ability to deliver effective mental health treatments (Singla et al., 2017). In a study of women with lived experience of perinatal depressive and anxiety symptoms, non-specialist-delivered psychotherapy was viewed as acceptable (Singla et al., 2020). Given promising findings internationally, it seems plausible to consider how existing groups of caring adults in the United States can be leveraged to reduce the treatment gap among our most vulnerable youth.

Given shortages of mental health professionals, the length and cost of professional graduate training, the rising costs of mental health care, and the stigma and distrust that professional care carries in many low-income, minority, and immigrant communities, mentoring programs have a potentially key role to play in this the continuum of care. Under the right circumstances, training even a fraction of the millions of mentors who volunteer to serve as psychological paraprofessionals could dramatically improve access to care, particularly for youth who demonstrate prodromal symptoms and would not typically qualify for primary care. This idea aligns with a "stepped-care" service model in which youth start with the least intensive, simplest approaches and move toward more intensive services only when the former have proven ineffective (Fleury et al., 2009; Kenya et al., 2011; Seekles et al., 2011).

Despite the demonstrated effectiveness of paraprofessional and lay helpers' delivery of interventions, task-shifting has not been systemically adopted in mental health care, in general, or in youth mentoring, specifically. McQuillin et al. (2019) recently proposed task-shifting as a useful framework for paraprofessional mentoring, though they highlight the importance of rigorous evaluation, training, and supervision, and they caution mentoring organizations from fully embracing task-shifting before rigorous scientific evidence (i.e., on efficacy and best practices) and infrastructures (e.g., training and supervisory standards, regulatory mechanisms, credentialing bodies) are in place.

Effectiveness of Paraprofessional Helpers

The potential merit of delivering psychological services through a paraprofessional workforce might be considered as an empirical question: Can paraprofessionals provide non-inferior services relative to those provided by professional psychologists? In an attempt to answer this question, Durlak (1979) conducted a meta-analysis of published studies ($n = 42$) that compared the outcomes of experienced

psychologists, psychiatrists, and social workers with those of paraprofessionals who, much like today's youth mentors, were defined as "nonexpert, minimally trained community volunteers, students, and helpers." Among the 42 studies of a broad range of populations and clinical issues, 28 studies showed no significant difference in the effectiveness of professionals and paraprofessionals, 12 showed superior effectiveness of paraprofessionals, while just two showed superior effectiveness of professionals. Of the six reviewed studies that examined pediatric populations, five found paraprofessionals to be more effective, while one found no significant difference between professionals and paraprofessionals. Taking stock of these results, Durlak (1979) concluded that "professional mental health training and experience are not necessary prerequisites for an effective helping person" (p. 6).

In subsequent studies of mental health services, researchers have found that paraprofessionals are effective in treating a range of difficulties, including autism spectrum disorders, ADHD, traumatic stress, substance use, and depression, even after controlling for the level of clinical acuity in each sample and study rigor in meta-analyses (Berman & Norton, 1985; Hattie et al., 1984; Weisz et al., 1987), including several recent studies showing effectiveness of paraprofessionals in treating pediatric populations (Barlow et al., 2014; Jordans et al., 2010; Shire et al., 2017; Tol et al., 2012). A recent systematic review of community health workers (CHWs) in mental health services concluded by stating: "evidence suggests that CHW models of mental health service delivery can be effective in addressing global and domestic disparities in care for underserved populations, as two-thirds of the randomized controlled trials demonstrated positive mental health outcomes for traditionally underserved communities over a comparison condition" (Barnett et al., 2018, p. 206). By definition, CHWs are members of the communities they serve and are typically compensated for their work, allowing for the provision of culturally congruent services without exploiting unpaid labor from marginalized communities (Barnett et al., 2018). It is likely that the expansion of lay providers, like CHWs, will increase in the coming years, with an emphasis on drawing upon helpers indigenous to affected communities.

Although expanding child mental health services through paraprofessionals is promising, the effectiveness of these efforts will undoubtedly depend on training infrastructures. Several researchers and meta-analysts have emphasized the importance of rigorous preliminary training and ongoing supervision of paraprofessionals by experienced professionals (Conley et al., 2017; Durlak, 1979; Weisz et al., 1987). Durlak (1979) also made the important point that, "Paraprofessional effectiveness in some studies may be due to the development of carefully standardized and systematic

treatment programs... Presumably, the more intervention procedures that can be clearly described and sequentially ordered in a helping program, the easier it is for less trained personnel to administer them successfully" (p. 88). Similarly, reflecting on the promise of CHWs, (2018) commented: "CHWs are likely to require a high level of support through ongoing supervision and consultation, as this is also required for mental health professionals to deliver EBTs with competence" (p. 207).

Thus, with appropriate training and supervision by professionals, paraprofessionals may be able to deliver care and support, extending the reach of services to underserved communities. If systems were to increase the use of paraprofessionals in lieu of professional services, the existing care professions would also change. For example, by increasing the amount of care provided by paraprofessionals, the roles of highly trained professionals might shift to program developers, directors, trainers, and supervisors (Weisz et al., 1987). These roles and opportunities are consistent with recent and intensifying calls for the reform of clinical psychology as a profession. In fact, psychotherapy researchers have argued that the continued emphasis on small, incremental improvements to treatment approaches may be misguided given the substantial gaps in youth's access to any evidence-based treatment whatsoever. They call instead for an emphasis on the development and evaluation of cost-effective interventions that can be provided by low-cost providers (Jones et al., 2019). Baker and McFall (2014) have proposed a revised service model in which the clinical psychologist would "support the use of interventions that: (1) are especially effective across multiple types of outcome measures, (2) can be implemented and disseminated easily (are relatively simple to learn/train), (3) are relatively cost-effective and cost-beneficial, (4) can be delivered by relatively low-cost providers... ." (p. 483). Some psychologists might still provide specialized services, but such expert care would be reserved for the most acute, complex, and high-risk cases and may be supplemented or supported by paraprofessional team members. Thus, we posit that paraprofessional youth mentors may be a key resource for realizing this reform in child mental health services, as providers of routine, manualized services for more commonplace disorders and in support roles for more acute cases in need of professional expertise. However, the potential of youth mentors to serve in this capacity is offset by existing field standards and the lack of programmatic research.

Volunteer Mentors as a Paraprofessional Workforce

Every year, an estimated 2.5 million adults serve in year-long, formal mentoring programs and devote several hours

weekly or biweekly in direct contact with young people, often with broad goals of improving developmental outcomes and trajectories (Raposa et al., 2017), with millions more providing shorter-term care. These volunteers are supported by thousands of mentoring organizations and chapters across the United States, in urban, suburban, and rural areas, making youth mentoring, collectively, among the largest and most widespread and familiar youth-serving programs (Garringer et al., 2017). Yet, volunteer mentors have rarely been called “paraprofessionals.” The literatures on paraprofessional mental health and formal mentoring have mostly remained separate, and mentoring programs largely operate independently, rather than being integrated with systems of care.

Indeed, although they often provide quasi-therapeutic care, volunteer mentors are rarely thought of as paraprofessionals or even as sitting on the same continuum of therapeutic care. The fact remains, however, that volunteer mentoring relationships and therapeutic relationships share much in common. For example, they are typically situated somewhat outside of the youth’s network of family, friends, and community and involve weekly “sessions.” They are both characterized by inherent power differentials and a focus on only one member’s improvement. Mentoring also adheres to the same rituals as therapeutic relationships, including imparting a ritual or intervention that both parties believe will be an effective means of restoring health. These “nonspecific” factors create positive expectations that can help bring about positive change (Frank & Frank, 1993; Wampold, 2015). Moreover, although rarely acknowledged and not particularly systematic, formal mentors frequently draw on a wide array of established therapeutic techniques (Renée, 2012). For example, as mentors encourage their mentees to think and act in more adaptive ways, they may employ principles of cognitive behavioral therapy (CBT), which helps young people develop the skills needed to effectively address many of the most common psychological problems. When mentoring is effective, it also appears to produce positive outcomes in a similar manner to psychotherapy, with a positive relationship serving as the foundation for more functional goal-focused activities and experiences (Lyons et al., 2019). There has also been a recent call for youth mentoring programs to focus on the goal of reducing social isolation among youth (Keller et al., 2020). The authors note that youth mentoring programs are well situated to address this goal and recommend using evidence-based intervention strategies to improve mentoring relationships to reduce social isolation.

Integral to our paraprofessional mentoring framework is an argument to reconceptualize formal mentoring further along the treatment–prevention continuum.

Historically, mentoring has been thought of as secondary or even tertiary prevention, with calls to close the “mentoring gap,” so that all youth have a mentor (Bruce & Bridgeland, 2014), and with focuses on relationship-building, character development, and other positive youth development outcomes with the hope of preventing the onset of psychopathology and other developmental issues (Garringer et al., 2017; Guetzloe, 1997; Rhodes & DuBois, 2008). Yet, as noted, mental health concerns may prompt referrals (Sourk et al., 2019), particularly for African American youth (Vázquez & Villodas, 2019).

Research suggests that mentoring programs can successfully move the needle on youth mental health symptoms (Bauldry, 2006; Raposa et al., 2019). Although difficult to scale, the few programs that have specifically targeted presenting problems with empirically supported, manualized interventions and provide mentors with some clinical training are the most successful in reducing mental health issues such as internalizing symptoms (Bauldry, 2006; Jent & Niec, 2006), trauma (Taussig & Culhane, 2010), ADHD and externalizing disorders (Jent & Niec, 2006), producing moderate to large effect sizes (Rhodes, 2020).

Barriers facing this model

Unfortunately, there have been barriers to scaling and sustaining these specialized programs. Many are implemented in settings that are proximal to the universities where they are developed and launched in response to time-limited funding opportunities. Most youth gain access to formal mentors through large, non-specialized programs that may have rolling enrollment but neither the portfolio of training manuals nor the incentives to engage volunteers in delivering specialized evidence-based services with fidelity.

In the majority of such mentoring programs, volunteer mentors receive fewer than two hours of pre-match training and then receive very little ongoing training or supervision after they are matched (Garringer et al., 2017). Matches are typically overseen by caseworkers with heavy caseloads, who are often stretched too thin to provide meaningful supervision of individual matches outside of acute crises (Keller & Spencer, 2017; Kuper-smidt et al., 2017; Spencer et al., 2021). Moreover, most mentoring caseworkers do not have professional training in mental or behavioral health care, despite children being served by these programs demonstrating nearly twice the risk of the average population (Jarjoura et al., 2018; Keller & Spencer, 2017). Perhaps as a result, most mentoring programs cite staff turnover and retention as a serious concern (Garringer et al., 2017). Likewise, attrition of mentor–mentee matches is high, with almost 40%

of matches ending prior to the planned duration, according to archival data from 170 representative youth mentoring programs ($n = 6468$ youth) (Kupersmidt et al., 2017). Many volunteers cite feeling unsupported by programs and overwhelmed by the nature and intensity of their mentees' struggles (Spencer et al., 2021). In addition to a lack of training and oversight, most programs do not provide mentors with manuals or systematic guidelines for what they should do when they are with their mentees, beyond a list of suggested recreational activities (Garringer et al., 2017). Instead, most mentoring programs encourage volunteers to prioritize intuitive relationship building over targeted skills instruction or problem-solving (Cavell & Elledge, 2014; Li & Julian, 2012; Raposa et al., 2019; Rhodes, 2020).

Yet such mentoring programs have the potential to make evidence-based mental health interventions more accessible to millions of marginalized, underserved youth. Some may argue that the paraprofessionalism is inconsistent, perhaps even at odds, with the construct of mentoring as it is popularly understood. In fact, an author of this paper previously bemoaned that "mentoring programs have moved in a direction that is in danger of trivializing what research indicates is at the very heart of their intervention: a caring adult-youth relationship," (Rhodes & DuBois, 2008, p. 257). This reasoning hinged on the assumption that the only active ingredient of mentoring is an enduring, close relationship between an adult and a young person, and that prescriptive or structured activities may, in fact, diminish or disrupt the development of a relationship (Li & Julian, 2012; Sipe, 2005). Yet, two pieces of evidence may constrain these assumptions. First, in most programs, arranged mentoring relationships are relatively short term (e.g., only around 5.8 months in school-based mentoring) and, although they occasionally become exceptionally close and enduring, this is not the norm (Herrera et al., 2011; Kupersmidt et al., 2017). Second, predominant theory in both psychotherapy and mentoring posits that relationship quality is likely an enabling factor, rather than an active ingredient, in behavior change (Baker & McFall, 2014; Cavell & Elledge, 2014). Indeed, recent research has indicated that the optimal effects of mentoring relationships often occur when there are positive relationships *in conjunction* with more goal-directed activities (Lyons et al., 2019), with even some brief goal-focused programs demonstrating promising results (McQuillin & Lyons, 2016). Finally, some of the most common definitions of mentoring can be applied to our proposed variant. For example, MENTOR: The National Mentoring Partnership (2005) defines mentoring as "a structured and trusting relationship that brings young people together with caring individuals who offer guidance,

support, and encouragement aimed at developing the competence and character of the mentee."

How Mentors as Paraprofessionals May Play a Role

Addressing barriers to engaging in mental health treatment

Underserved youth and families face vast and wide-ranging barriers to engaging in mental health treatment. Studies in child-serving community mental health care agencies have found that rates of failure to attend initial intakes range from 48 to 62% (rates that are notably larger than in other service-provision fields), and for the minority of clients seen for the initial intake, the length of care is estimated to be as low as four sessions (Gopalan et al., 2010; Harrison et al., 2004; McKay & Bannon Jr, 2004).

At a very practical level, mentors can provide logistical assistance by helping to schedule appointments, reminding youth and families of appointment times, and providing or facilitating transportation to appointments. Among the most common reason that adolescents cite for missing appointment is simply forgetting about them (Harrison et al., 2004), and routine reminders, particularly text messages, have been shown to boost adherence significantly (Branson et al., 2013; Schauman et al., 2013). However, exchanging mobile phone numbers and texting between professional therapists and clients have been subject to extensive ethical debates (Dubus, 2015; Moon, 2013; Sylweszczak et al., 2015). Thus, mentors, who tend to be more integrated in youth's lives and have fewer professional boundaries around communication, may be more appropriate sources for reminders and discussions of logistical difficulties. Another common logistical barrier is transportation, particularly for low-income youth who often lack reliable access to transportation and whose parents may have inflexible work schedules (Sylweszczak et al., 2015). This transportation could expand the access to, and hence availability of, affordable clinics and providers.

In addition to these practical difficulties, there are several less tangible, but significant, barriers to care, particularly among minority, low-income, and other marginalized families. These include mental health stigma (Corrigan et al., 2014) and concerns about the cultural sensitivity of care due to dominant Western-centric models of healing that have pathologized minority cultures and failed to contextualize mental health difficulties in broader social ecologies (Sue, 1998; Sue et al., 2008). Although attention, efforts, and progress toward the provision of culturally competent services have increased somewhat over the past decade (e.g., American Psychological Association, 2017), many marginalized communities and families understandably remain wary of professional mental health

(Alegría et al., 2016; Reardon et al., 2017; Vázquez & Villodas, 2019). In contrast, mentors and other paraprofessionals are viewed as more proximal to the communities they are serving and better able to conduct culturally responsive outreach and engagement activities in communities traditionally underserved by mental health services.

Likewise, if paraprofessional mentors can be integrated with professional systems of care, they might serve as cultural brokers or service liaisons, particularly if mentoring programs are able to recruit mentors from target communities and/or provide mentors with high-quality cultural responsiveness training (Bhui & Bhugra, 2002; Kirmayer et al., 2003). By engaging youth and families, providing culturally informed psychoeducation, and addressing their well-justified concerns, paraprofessional mentors might reduce stigma in seeking out mental health services, which, in turn, could have ripple effects by gradually reducing stigma in the broader community. Of course, it is vital that, following engagement, marginalized youth and families actually receive culturally responsive care, raising the importance of ongoing involvement of paraprofessional mentors with greater knowledge of non-dominant cultures (see Sánchez & Colón, 2005).

Facilitating between-session practice and real-world application of skills

In addition to initial and ongoing engagement activities, paraprofessional mentors may further support youth's participation in mental health services by facilitating the rehearsal, application, and retention of therapeutic content and skills. Engagement in mental health services is effortful and time-consuming, particularly because they tend to require at least weekly attendance over a period of time (unlike many other types of healthcare; Kim et al., 2012; King et al., 2014). Likewise, most effective, evidence-based interventions emphasize the importance of between-session "homework," noting that, in most cases, a very small percentage of clients' time is actually spent in therapy sessions, particularly in outpatient modalities. Between-session practice facilitates the generalization, adaptation, and real-life application of therapeutic skills that, if only practiced in session, may only be artificially learned and have little impact on one's actual life (Kazantzis & Ronan, 2006). For child-serving interventions, caregiver involvement has long been recognized as an important component of effective practice that boosts the size and maintenance of treatment effects (e.g., Mendlowitz et al., 1999; Podell et al., 2010; Wood et al., 2006), in part because caregivers play a key role in supporting homework, rehearsal, and generalizability of skills.

For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), the primary evidence-based treatment

for child and adolescent post-traumatic stress disorder, has a full caregiver component of the intervention. Throughout the intervention, the caregiver and child are asked to regularly practice skills at home, both within and outside of the context traumatic triggers and distress (Cohen & Mannarino, 2008). As another example, the Coping Cat program for childhood anxiety disorders is a 12-session structured treatment that has integrated caregiver sessions, through which children receive overviews and progress reports of treatment, psychoeducation, and skills instruction, and caregivers are asked to facilitate between-session workbook-based homework, skills practice, and exposures (Podell et al., 2010).

In this capacity, volunteer mentors may play a key role in providing support activities for children's and families' mental health treatment. Particularly when parents have limited availability, mentors may attend sessions, during which they could receive psychoeducation and co-learn therapeutic skills. This, in turn, would help them to facilitate children's between-session practice, homework, exercises, and exposures. Mentors could also serve as a liaison between providers and parents, particularly when parents cannot attend sessions in person, or when there are cultural differences between the family and treatment team.

Mentors also can play a role in supporting youth as they engage in mental health apps (MHapps) and other technology-delivered interventions (TDIs), which may be particularly appropriate for youth with somewhat milder presenting concerns or those who are otherwise unwilling or unable to engage in in-person therapy. MHapps, in particular, are increasingly being used to address youth's most common mentee behavioral and mental health concerns. A growing number of TDIs include paraprofessional coaching, which provides users with "supportive accountability," that is, regular check-ins, monitoring, and troubleshooting (Mohr et al., 2011). One meta-analysis, for example, showed that coached TDIs produced mental health improvements that were dramatically higher than those self-administered (Conley et al., 2016). Other meta-analyses of TDIs for children and adolescents have shown superior effects for coaching and support (Baumeister et al., 2014; Garrido et al., 2019; Podina et al., 2016). As Conley et al. (2016) noted, "support from paraprofessionals or even peers might enhance participant goal setting, expectations, and motivation, and thus improve intervention engagement, adherence, and outcomes" (p. 675). Importantly, this coaching and support need not be delivered by highly trained professionals. Previous studies have found no difference in technology-delivered engagement or outcomes when youth were supported by clinicians versus non-professionals (Titov et al., 2010). Mentors who are trained in supportive accountability may thus have a

vital role to play in supporting youth's use of TDIs (Rhodes, 2020).

Direct provision of evidence-based interventions

Paraprofessionals can be trained to competently deliver evidence-based psychological interventions, particularly those that are highly structured and manualized (Cramer et al., 2019; Durlak, 1979; Montgomery et al., 2010). As discussed above, direct service provision by paraprofessionals requires development of protocols, training, and supervision, as well as research establishing efficacy *and* effectiveness in real-world practice. Paraprofessionals should not take the place of professionals without rigorous empirical evidence for their ability to deliver particular treatments effectively, as well as the conditions under which they are able to do so. The application of paraprofessional mentors as direct service providers might be most appropriate for youth with mild to moderate symptom and risk profiles and those with presenting concerns that lend themselves to relatively short-term, structured interventions (e.g., CBT for anxiety and depression). With these caveats in mind, it is likely that the field could develop stepped-care infrastructures in which paraprofessional mentors take on the primary role of delivering evidence-based interventions, particularly those that are manualized and skills-based, such as applied relaxation for anxiety and behavioral activation for depression. This complex, multifaceted process would require intensive training and program infrastructure, the considerations for which we will discuss further below.

Practical and Theoretical Considerations for Paraprofessional Mentoring

Although the ideas of mentors directly providing evidence-based interventions or supporting professional- or technology-delivered interventions are promising, there are several practical and theoretical considerations. First, depending on the type of service mentors supplement, the time demands may exceed the capacity of the average volunteer mentor. For example, most volunteer mentors spend only 45 minutes to 1-hour per week with mentees, on average (Garringer et al., 2017). Assuming that general relationship-building activities are valuable (Lyons et al., 2019), shifting time from typical relationship-focused contact events to rehearsal and practice may be disruptive to both the relationship and one of the primary mechanisms through which mentoring is thought to help young people (i.e., a close relationship).

A second threat is that, despite program expectations, some mentors or mentees may not want to practice

therapeutic skills during their sessions. Such asymmetries may be particularly problematic in mentoring programs that tend to prioritize recreational or relationship-building activities. Program development work should consider and manage the potential disruptive on mentoring programs (Spencer et al., 2020). Relatedly, qualitative research suggests that mentors' unrealistic expectations entering the match and perceived lack of progress can lead to burnout and early match termination (Spencer, 2007; Spencer et al., 2016), and there may be risk that centering mentoring on therapeutic and symptom-reduction goals could contribute to these issues. Some quantitative evaluations of "enhanced" mentoring activities by incorporating evidence-based curricula into existing mentoring programs have shown disappointing effects and low rates of adherence (e.g., DuBois & Keller, 2017; Jarjoura et al., 2018), although these programs did not involve intensive supervision by professionals or clear matching between interventions with youth presenting problems.

There are some promising developments regarding how these challenges may be addressed. First, not all mentors are volunteers, and some mentors spend more than one hour per week with students. For example, Friends of the Children is a youth mentoring organization wherein full-time paid mentors, typically with a bachelor's degree, are expected to spend roughly four hours per week with youth, and at least some of that time is expected to be spent on focused activities (Eddy et al., 2017). Further, research has shown that mentor self-efficacy interacts with mentee environmental stress to predict relationship length, such that when a mentor has greater self-efficacy, there is no relationship between mentee environmental stress and relationship length (compared to when a mentor has low self-efficacy, greater environmental risk predicts a shorter relationship; Raposa et al., 2016). We would hypothesize that mentors who are taught to provide or support evidence-based skill-building may ultimately have stronger self-efficacy in their mentoring relationships, given that they would be following guidelines as opposed to guessing how to be a mentor. Thus, not only would a shift to paraprofessional roles for mentors be good for youth directly, but it may also confer indirect benefits through a mentor's self-efficacy. Finally, it is also notable that recent evidence suggests that not every therapeutic intervention requires substantial time investment, and emerging evidence shows that some interventions may only require a few or even single sessions to have a lasting effect (Schleider et al., 2020).

Overall, our proposal is not to shift the focus of all mentoring programs and all mentoring dyads to the delivery of mental health interventions. A focus on relationship building, companionship, and recreation may be suitable for many mentees and families who carry some risk but

have not yet manifested mental health symptoms, or whose symptoms are being adequately addressed elsewhere. Larger programs may consider developing specialized therapeutic mentoring arms that will support a subgroup of their matches. The development of specialized arms of larger mentoring programs is not unprecedented. For example, Big Brothers Big Sisters of America already has specialized programs for children of incarcerated parents and children of military families. Implementation consideration of such a model will be discussed further below. Through the use of technology-based training and supervision, even mentors in more remote chapters may be able to develop a therapeutic specialty and access the expertise of a relatively small number of professional staff. Overall, for the paraprofessional approach to succeed, structures and procedures (detailed below) must be in place.

Competency-Based Training and Evaluation

For the paraprofessional approach to succeed, competency-based training and corresponding measures will be needed. These measures should be capable of documenting successful skill transfer in response to training, able to distinguish between high- and low-quality performance, and related to core outcomes of the intervention. A requisite for such measures of competency includes a scientific basis for key ingredients or processes involved in a service, corresponding measures, and criterion or thresholds for demonstrating successful skill transfer. Fortunately, psychologists, social workers, and other helping professionals have spent decades developing and evaluating competency-based assessments for skills relevant to paraprofessional mentoring.

Moreover, most evidence-based interventions have measures of fidelity and implementation standards that are capable of documenting whether or not the presumed competencies are translated to practice. For example, the counseling approach Motivational Interviewing has several measures of provider competence that are performance-based (i.e., verbal behavior measured in actual or simulated counseling sessions) and that provide valid and reliable estimates of skill, thresholds for competence, and research supporting the validity of these measures in predicting client outcomes (Magill et al., 2019; Martino et al., 2016; Moyers et al., 2016). Similarly, there are well-established measures of suicide risk assessment and prevention competencies that are capable of measuring the transfer of skill from training programs, include multi-informant measures of skill, and are related to core outcomes, such as the ability to make accurate suicide risk judgments (Cramer et al., 2019). Such measures of competency, and corresponding trainings designed to promote

competency, will be crucial for realizing the potential of paraprofessional mentors.

Supervision by Professionals

In order for mentors to provide effective outreach, support, and, in some cases, direct service provision, it is essential that they receive adequate, meaningful supervision by trained professionals in their routine practices. Many mentoring programs do have supervision structures in place, but current supervision practices are limited. First, mentoring programs have high rates of supervisory staff turnover (Keller, 2007), with the majority of programs in a recent national study citing this as a major challenge to providing adequate services (Jarjoura et al., 2018; Wiger, 2012). In some programs, supervisors and caseworkers oversee very large caseloads, precluding the possibility of intensive supervision of day-to-day activities and practices (Keller & Spencer, 2017; Kupersmidt et al., 2017; Spencer et al., 2021). Finally, the experience and qualifications of match supervisors and caseworkers have been inconsistent across mentoring programs. Caseworkers may not have expertise in mental health or psychological supervision beyond a bachelor's degree (Jarjoura et al., 2018; Keller, 2007).

More intensive, professional supervision would ensure that paraprofessional mentors are adhering to evidence-based practices, maintaining necessary levels of competency, and building their own skills and expertise. Seemingly, requiring more intensive match supervision and smaller supervisory caseloads would limit program capacity. However, it would likely reduce high rates of turnover among staff and volunteers alike, reducing costs of staff and volunteer recruitment and onboarding, which may allow programs to hire more paid staff to serve as supervisors.

Requirements for who can provide supervision for mental health services differ based on jurisdictions, and this may present one barrier to using paraprofessionals in national mentoring programs. Programs will need to not only consider appropriate models for training and supervision of paraprofessionals, but will also need to comply with local and state boards for supervision of mental health interventions. Depending on the jurisdiction and the services provided by paraprofessional mentors, master's-level mental health counselors or clinical social workers might be well-suited to provide supervision. Further, the most rigorous stepped-care models have several levels of infrastructure, in which direct supervisors receive *supervision of supervision* from more experienced professionals (Richards & Suckling, 2009; Turpin & Wheeler, 2011). Thus, mentoring programs would also benefit from staffing licensed mental health professionals who are trained in clinical supervision and consultation. The use

of telesupervision (Bernhard & Camins, 2020) may enable mentoring programs to scale this stepped-care model and allow professional supervisors to access chapters in more remote or rural settings.

Documentation of Mentoring Activities

Ethical psychological service provision mandates regular documentation of activities and client contact (American Counseling Association, 2017; American Psychological Association, 2017). Clinical documentation typically requires providers to complete note templates that log session goals, content, providers' actions and interventions, and clients' response to services. Documentation exists, in part, for billing and liability purposes. Although billing and liability are not common concerns for many existing mentoring programs, they could become relevant, particularly if programs are better integrated within systems of service delivery and supervised by professionals, as we are proposing. So long as documentation is relatively straightforward and not overly burdensome, and mentoring programs are able to efficiently document that their paraprofessionals are delivering evidence-based interventions to children in need of mental health services, they may become eligible for governmental support and/or third-party payment.

Of course, formal integration into healthcare systems and services will require extensive research and development. Regardless, establishing documentation standards may increase the rigor of mentoring services in several ways. Clinical documentation allows for more efficient communication within treatment teams, across treatment settings, and between trainees and their supervisors (Wiger, 2012). Thus, documentation of mentoring services may assist program staff to efficiently and effectively supervise paraprofessionals. Further, when mentors are tasked with delivering or supporting evidence-based protocols, standardized documentation allows for ongoing monitoring of fidelity to protocols, which would benefit mentoring practice and research alike. Mentoring research tends to provide very vague, non-detailed accounts of activities, making evaluations of effective practices very difficult (McQuillin et al., 2020). Tasking mentors and researchers alike with documenting and communicating services would enhance knowledge and implementation of effective practice. Finally, documentation typically requires providers to identify goals for treatment, as well as individual sessions, and to track progress. Even if mentors are not directly delivering interventions and are serving primarily in engagement and support roles, documentation of their activities might encourage them to identify goals and pursue them with greater intentionality.

Regulation and Credentialing

Another implementation issue around paraprofessional mentoring involves regulation and credentialing. Although state laws and policies vary widely across the United States, all states have accreditation and regulatory standards for providers of psychological services and implementing a model of paraprofessional mentoring will likely require mentoring organizations to work closely with state regulatory bodies to establish new accreditation standards or to revise existing standards to include mentors, depending on the scope of policies currently in effect. In Massachusetts, for example, "therapeutic mentoring" has been implemented over the past decade. Therapeutic mentors, who are typically members of multidisciplinary treatment teams, largely operate in youth's homes and communities to support the pursuit and adherence of larger treatment goals. Massachusetts has established guidelines around the necessary background, training, and oversight of therapeutic mentors but does not license individual mentors. Rather, the state accredits agencies (hospitals, community health centers, private agencies) that have demonstrated competence in training and overseeing therapeutic mentors, which in turn have the discretion to hire, train, and supervise mentors (Commonwealth of Massachusetts Executive Office of Health & Human Services, 2012).

To ethically and legally implement a model of paraprofessional mentoring, organizations, researchers, and policymakers will need to collaborate, most likely within states given the variation in regulatory standards discussed above. If the Massachusetts model of accrediting at the organizational level is found to provide necessary rigor, oversight, and quality control, it is perhaps more efficient than individual licensure or certification and could be adopted and adapted in other states. In states with stricter laws, lobbying and legislation efforts could help to establish and certify a new category of paraprofessional providers. Of course, new policy and practice initiatives to implement paraprofessional models of mentoring should be predicated by rigorous scientific research that demonstrates feasibility and effectiveness.

As mentors take on more paraprofessional roles and partner with more advanced supervisors, programs should find ways to more explicitly recognize and credential volunteer service (e.g., course credits, continuing education unit, therapeutic mentoring certification). Just as the field has been slow to dispense with vague, non-specific approaches to mentoring, the implicit, falsely dichotomous belief that volunteers hold only altruistic motivations, and that career, academic, or other "egoistic" motivations somehow taint their service, has impeded programs' capacity to facilitate mentors' professional goals.

Although such goals are thought to undermine volunteer retention and effectiveness, the scientific literature has not supported this supposition. To the extent that programs recognize the inherently transactional nature of volunteer mentoring, they will reap the full benefits of a truly engaged volunteer workforce.

Cultural and Ethical Considerations

Of course, the promise of this model should be balanced against the potential for exploitation of paraprofessional mentors by professionals and mental health care systems. As mentors take on paraprofessional roles and partner with more advanced supervisors, efforts must be made to more explicitly privilege mentors' experiences voices, particularly those of more marginalized mentors who can serve as cultural bridges to youth and their families. Likewise, offering rigorous professional supervision and pathways to credentials could open new opportunities for workforce development and democratize access to mental health professions for mentors with such ambitions. There are a few promising developments in this regard. First, there are longstanding compensated models of community health workers (Rosenthal et al., 2010) and paid mentors (Eddy et al., 2017). While mentoring organizations have primarily relied on philanthropic funding and grants to compensate mentors, community health workers have been increasingly recognized and funded in health care legislation such as the Affordable Care Act (Rosenthal et al., 2010). Finally, more rigorous training, documentation, and supervisory standards may make the services eligible for third-party billing (e.g., through state Medicaid), which would increase programs' abilities to compensate mentors and decrease reliance on volunteer labor. Compensating mentors is particularly important as programs seek to recruit mentors from the communities they serve because demanding unpaid labor from marginalized communities risks becoming exploitative and colonizing (Traford et al., 2018).

In addition to questions of labor and compensation, additional ethical concerns remain regarding cultural colonization while paraprofessionalizing mentoring. On a national scale, the majority of mentors currently are white and middle class, while poor, youth of color are overrepresented as mentees (e.g., Jarjoura et al., 2018), leading mentoring scholars to raise concerns about the enactment of oppressive cultural dynamics such as the white savior narrative and coercive assimilation into dominant norms. These scholars have outlined a range of recommendations and reforms to address colonizing concerns. These include shifting the narrative from "saving" youth from risk environments to collaborating with and empowering them, diversifying organizations by recruiting and maintaining

mentors and staff from historically marginalized backgrounds, and providing all mentors and staff with evidence-based trainings on cultural responsiveness and humility (Albright et al., 2017; Weiston-Serdan, 2017). Such trainings have been developed and evaluated in mentoring programs, showing promising effects, such as increasing cultural sensitivity and sociopolitical awareness among predominantly White mentors and staff (Anderson et al., 2018). These efforts parallel those to decolonize professional psychology, which historically has underserved and marginalized communities of color and centered Western, White, middle-class cultural norms. Initiatives to train paraprofessional mentors to support and deliver psychological interventions should draw upon recent innovations, led predominantly by psychologists of color, to transform evidence-based interventions to more responsively serve and empower historically marginalized communities (Hall et al., 2016; Naeem, 2019). By recruiting, empowering, and compensating paraprofessionals from marginalized communities and by providing rigorous training in cultural responsivity to mentors and staff from outside affected communities, paraprofessional mentoring organizations can make important contributions in addressing health disparities while reducing risk of further exploitation and colonization.

Building a Science around Paraprofessional Youth Mentoring

There remains considerable uncertainty surrounding if, how, and under what circumstances paraprofessional youth mentors are capable of effectively and safely supporting existing helping institutions and professions. We recommend a tempered approach to adoption, guided by rigorous development and efficacy research and in close collaboration with other programs of research in existing helping professions, institutions, and research communities (e.g., research in school mental health, prevention science, behavioral medicine).

Research is necessary to begin to understand the feasibility, effectiveness, and implementation issues around paraprofessional mentoring. First, there is a need for more rigorous and systematic needs assessments among mentoring programs to better understand the needs of programs, as well as the goals of children and families who present to mentoring programs with mental health difficulties. Needs assessments at intake could help programs identify the youth and families for whom paraprofessional mentoring is most fitting and helpful. Second, pilot and proof-of-concept research is needed to establish whether and how paraprofessional mentors can be trained in core competencies and skills. A simulation model of training has been

widely evaluated and implemented in training motivational interviewing, and experts' ratings of competencies during simulations have been shown to predict competency ratings with real-life clients (Bennett et al., 2007; Lane et al., 2008; Söderlund et al., 2011). Paraprofessional mentoring training can then be evaluated in the context of randomized controlled trials, in which the effectiveness of mentors who received competency-based trainings are compared to mentors who received "business-as-usual" training. These studies should be conducted with finite resources in mind to identify the most time- and resource-efficient methods of training and evaluating mentors in core competency areas while maintaining rigor and fidelity.

Of course, it will be important to demonstrate the efficacy and effectiveness of each model. For example, randomized controlled trials may be conducted that compare youth receiving an evidence-based psychotherapeutic intervention with and without mentoring support, and compare symptom remission as well as attrition and treatment adherence. Beyond clinical trials, community-based studies could be conducted comparing treatment attendance, adherence, and outcomes among similar community clinics, some of which have embedded mentors who provide engagement and support services. In addition to efficacy and feasibility, it will be vital for research to examine and address potential harm and iatrogenic effects. As discussed above, it is possible that adding structure and skills-based instruction to mentoring matches could diminish its appeal to some youth and mentors. Variables such as dropout, relationship quality, mentor, youth, and caregiver satisfaction, and premature match termination should be monitored and compared to control groups.

National and local mentoring organizations have a key role to play in developing paraprofessional mentoring services that are feasible in communities, not just in laboratory and controlled trials. Strong research–practice partnerships, characterized by bidirectional, non-hierarchical mutual communication and regular dissemination of information and feedback, should be established to promote evidence-based practices. For example, Harvard University's Center for the Developing Child has developed an innovative research–practice model called "Innovation Clusters," which are partnerships among researchers, program developers, sites, and practitioners, which emphasize active collaboration, ongoing innovation and evaluation, immediate data-sharing, and revisions of theory and program practices based on data (Schindler et al., 2017). Likewise, members of marginalized communities should be involved throughout the research and implementation cycles, drawing on techniques of community-based action research.

As discussed above, shifts in program practices should be gradual, careful, and based on scientific evidence.

Nevertheless, the model of active, ongoing, mutual collaboration among researchers and field-based practitioners in these innovation clusters may be adapted among mentoring stakeholders to ensure that proposed changes to practice are practical and ecologically valid. Statewide and national mentoring organizations, such as Big Brothers Big Sisters of America and MENTOR: The National Mentoring Partnership, which already support a range of research–practice initiatives, are likely to play important roles in facilitating, overseeing, and funding partnerships among researchers and organizations to innovate, refine, and implement models of paraprofessional mentoring.

Conclusions

Mentoring programs are well positioned to help bridge gaps in service for youth facing mental health challenges. To achieve this, mentors can be leveraged to serve as paraprofessionals and can task-shift to support or even deliver evidence-based care. It is important to note that, even with this shift, mentoring programs can only do so much to bridge the enormous service gap in our mental health system. Only about 5% of U.S. children and adolescents are served by mentoring programs (Putnam, 2015; Raposa et al., 2017). Moreover, it would also be naïve to assume that developing evidence-based standards, curricula, and documentation structures would be sufficient to translate the effects of psychological intervention research studies to routine organizational practice with paraprofessional mentors (Wandersman et al., 2016). It is unlikely that organizations and institutions will realize these benefits in practice without substantial changes in the capacity and motivation to support the roles of paraprofessional mentors. Indeed, shifting from more traditional relational models of mentoring to paraprofessional models will require substantial shifts in the organizational culture, incentives, expectations, and resources. In many circumstances, this shift might involve adding structures, curricula, or new roles, yet in other cases this may involve letting go of existing guiding theories, expectations, or practices that have characterized mentoring for decades.

There will be other challenges as mentoring programs take on new service models. First, more specialized care may entail additional costs such as licensing fees for validated assessment tools, evidence-based curricula, evidence-based mental health apps, etc. Although programs often balk at such expenditures and opt instead to rely on homegrown tools and trainings, it will be important to consider the opportunity costs, and the better return on investment of more effective models. Additionally, embedding mentors in schools, mental health settings, and other contexts is likely to require additional coordination.

Ultimately, however, these shifts toward supporting roles will enable mentoring programs to focus their resources on what they do best—recruiting, screening, training, and supervising volunteers to form productive alliances.

Taken together, the paraprofessional model of mentoring will require shifts in a basic service model that has remained essentially unchanged since the early 1900s. Yet decades of mentoring program investment and research have failed to move the needle on youth outcomes and, despite being generally less effective than targeted evidence-based approaches, nonspecific models remain dominant. Many mentoring program staff and volunteers feel overwhelmed and ill-equipped to work with the increasingly vulnerable youth that programs are being asked to serve. These struggles are persisting against a background of the COVID-19 pandemic, record inequality, imbalanced opportunities, climbing rates of youth distress, a fiercely competitive funding landscape, and a consensus in the broader helping fields that decisions should be informed by the best available research and economic evidence. The mentoring programs that will thrive in the future will be those that can be delivered in ways that ensure fidelity and easy, straightforward use and can demonstrate a clear return on investment over the relatively short term. These criteria have led to improved effectiveness and cost-effectiveness across medicine and mental health care, and the same will be true for mentoring.

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Conflict of interest

No conflicts of interest to disclose.

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