Expanding the Reach of Psychosocial Services for Youth:
Untapped Potential of Mentor-Delivered Single Session Interventions

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Abstract

At present, the mental healthcare system cannot meet the demand for services, and the need-to-access gap is widest among children and adolescents. Single session interventions (SSIs) are brief, intentional, and mechanism-targeted programs that have shown promise in increasing the reach of effective, evidence-based services; yet, a wide gap still remains due to structural barriers (e.g., workforce shortages). The present paper posits the integration of SSIs and mentor-delivered programs as a promising future step to further overcome the inaccessibility of youth mental health services. Capitalizing on the advantages of mentoring relationships (e.g., the associated interpersonal benefits and mentors' pre-existence in most community settings) has potential to complement and enhance the value of SSIs, and to expand the acceptability and reach of evidence-based mental health services. In this paper, we discuss the anticipated benefits of mentor-delivered SSIs, as well as cautionary considerations related to the proposed model. To conclude, we highlight necessary implementation and research implications.

Expanding the Reach of Psychosocial Services for Youth: Untapped Potential of Mentor-Delivered Single Session Interventions

Despite modern and ongoing advancements in designing, validating, and disseminating mental health interventions, an estimated 50% of individuals in need of services do not receive treatment (Merikangas et al., 2009). This percentage is higher among children and adolescents (herein, “youth”), due to increases in the prevalence of youth mental health issues and associated needs for treatment (Centers for Disease Control and Prevention [CDC], 2020), and to the shortage and inequitable distribution of professional providers (American Psychological Association [APA], 2015; Thomas et al., 2006) among other structural and stigma-linked challenges. In other words, barriers to accessing and receiving youth mental health services remain rampant, though clinical science has developed and validated treatments for many presenting problems. In the current cultural, health, and sociopolitical landscape (e.g., the increasing visibility of discrimination and prejudice, the ongoing COVID-19 pandemic), this need-to-access gap is expected to maintain or widen as people face increased and new stressors and resources become sparser (Liang et al., 2020; Vargas et al., 2020). Youth from low-resource environments are particularly vulnerable to the negative consequences associated with these changes (McQuillin et al., 2019).

Due to entrenched scarcities in quality treatment access, recent years have seen continuing efforts to restructure the development and dissemination of youth mental health treatments—for instance, through improving community- and school-based service delivery (Bearman et al., 2020; Bruckner et al., 2019), engaging parents and teachers in mental health promotion efforts (Acevedo-Polakovich et al., 2019), and shifting treatment to nontraditional platforms (i.e. tele-health and app- or web-based care; Kaonga & Morgan, 2019). Many of these efforts have shown great promise, but they have yet to be implemented sustainably, systematically, or on a nationwide scale in a way that allows for widespread accessibility. As such, the need remains to expand youth access to mental healthcare in ways that are flexible (i.e., easily applied across multiple service settings), cost-effective (i.e., sustainable without

highly trained providers or expensive, specialized materials), and rapidly scalable (i.e., able to quickly and widely disseminate without requiring new infrastructure).

One approach with potential to fit these needed features (i.e., flexible, cost-effective, and scalable), and in turn to help reform mental health treatments for youth, involves *single session interventions* (SSIs). These treatments are defined as brief, intentional, and mechanism-targeted programs designed to reduce one or more components of targeted problems in one sitting (Schleider et al., 2020b). There is mounting evidence that SSIs can avert or mitigate a variety of youth mental illness symptoms (Davis et al., 2012; Eaton et al., 2012), and that SSIs have accessibility benefits over traditional forms of service delivery. Regarding these advancements, Schleider and colleagues (2020b) delineated several future directions for the development, evaluation, and execution of SSIs, including to “examine diverse SSI implementation opportunities” (p. 274). Herein, we heed that recommendation by exploring the coupling of SSIs with *task-shifting*, or the practice of moving service delivery from experts and professionals to individuals with less extensive but still specialized training, thereby expanding the qualified workforce (World Health Organization [WHO], 2007). Particularly, we encourage researchers to examine task-shifting certain SSIs from professionals who work in formal treatment roles (e.g., counselors, psychologists, social workers), to mentors, or community-based adults and older peers who work with and offer support to young people, often in one-on-one or small group settings (Garringer et al., 2017; Hagler et al., 2017). Like studies of SSIs, studies of youth mentoring demonstrate this approach’s capacity for promoting positive outcomes for diverse youth populations and presenting problems, but current best practices indicate room for future growth.

Mentor-delivered programs and SSIs each show promise for increasing the reach of mental health services for in-need youth; however, the potential of integrating these two approaches (e.g., equipping mentors with the tools and resources to deliver SSIs as part of their mentorship practice) has not been examined to date. We outline and suggest piloting a novel service delivery model for youth mental health supports, incorporating both SSIs and mentoring practices, and we posit that *mentor-delivered SSIs* may confer several pragmatic advantages over exclusive reliance on traditional treatment delivery approaches

(e.g., clinic-based services provided by highly trained healthcare professionals). At present, research supports that SSIs can reduce and prevent youth psychopathology—although the prospect of *mentor-delivered* SSIs has not been empirically explored. Acknowledging that the literature on this front is in nascent stages, we propose that disseminating evidence-based SSIs via youth mentors has potential to strengthen SSIs’ acceptability and accessibility rapidly and sustainably within community-based organizations and among the young people they serve. We also emphasize the importance of implementing mentor-delivered SSIs carefully and thoughtfully, as initial pilot work is still needed to demonstrate the potential of this joint approach.

In the following sections, we provide an overview of each intervention approach and their respective advantages and drawbacks; then, we organize support for our position that the cumulative public health benefit conferred by mentor-delivered SSIs could exceed the summed benefit of both parts. We highlight barriers in the current intervention provision landscape and corresponding ways in which mentor-delivered SSIs might combat them. Then, we provide envisioned practice-oriented suggestions surrounding this integrated model. For example, we discuss implementation considerations and limitations of our model, while providing suggestions for future research. We hope that by drawing attention to this area for empirical inquiry, we can spur an exploration of the benefits and feasibility of mentor-delivered SSIs. Such work may yield actionable avenues for expanding the reach of youth mental health services.

Single Session Interventions (SSIs) for Youth Mental Health

Single Session Interventions (SSIs) are modularized, targeted interventions intentionally designed for delivery in one “dose” (Schleider et al., 2020b), and can span a range of formats (e.g., administered face-to-face or virtually by a provider; available for self-delivery via technology or workbooks). Relative to standard treatments in youth mental health (e.g., traditional psychotherapy), the condensed nature of SSIs is useful in counteracting premature client dropout—an occurrence in up to 40% of opened psychotherapy cases (Swift & Greenberg, 2012)—before interacting with the therapeutic mechanisms that

make treatment effective. The need for abridged clinical treatments is underscored by findings that youth who access traditional, multi-session treatments attend an average of 3.9 sessions (Harpaz-Rotem et al., 2004) and that the modal number of sessions completed prior to termination is just one (Hoyt et al., 2018). In contrast, the average number of sessions included in standard, manualized youth-focused psychotherapies exceeds 15 (Weisz et al., 2017). These attrition patterns suggest that many youth end treatment prior to engaging with the active ingredients of psychotherapy for a wide variety of reasons (e.g., structural, personal, or financial barriers to care). As such, there is great need for providers to capitalize on the opportunity of the first and often-only point of clinical contact. SSIs may help the mental healthcare system to achieve this goal, as they are empirically based and designed with intentional brevity to ensure that treatment-seeking individuals receive the full dose of an intended intervention, even if it is accessed only once.

SSIs are also noted for their adaptable, flexible nature, which allows them to (a) circumvent many commonly cited barriers to accessing mental health supports, and (b) expand to additional, nontraditional treatment contexts. Some SSIs are amenable to technology-based platforms and can be administered anywhere (e.g., at clinics, homes, hospitals, schools, etc.) with a device that connects to internet, versus only in a mental health provider's office (Schleider & Weisz, 2017a). In this vein, SSIs extend the reach of mental health supports beyond geographical constraints of professional providers and can eliminate the need for transportation, an often-cited barrier to receiving services (Syed et al., 2013).

Further, SSIs are effective when entirely or partially self-administered, thereby reducing the need for trained providers in direct service contexts (Schleider et al., 2020b; Schleider et al., 2020c). SSIs can be offered as stand-alone services (i.e., as a brief, one-time intervention) or as adjunctive supports (e.g., assigned as homework in existing therapy relationships). Moreover, various SSIs are designed for delivery to individuals, family units, or groups. This versatility allows for the easy integration of SSIs into diverse, existing systems of care. Given these characteristics and strengths, SSIs have reached traditionally un- or under-served populations, illustrated by the diverse participant demographics of a

recent trial that offered fully self-administered, online, cost-free SSIs to young people (e.g., a 54% non-white; 43% sexual minority community sample; Schleider et al., 2020c).

Beyond their relative ease of access and delivery, SSIs can be effective; several have shown capacity to reduce various symptoms of youth psychopathology (Cartwright-Hatton et al., 2018; Mejia et al., 2015; Schleider & Weisz, 2018). One recent meta-analysis found an average meta-analytic effect size for SSIs (relative to control conditions) of $g=0.32$, reflecting a small-to-medium effect for SSIs targeting youth mental health problems—only a slightly smaller overall treatment effect than observed for full-length, multi-session youth psychotherapies (mean $g=0.46$; Weisz et al., 2017). Similarly, significant differences between the follow-up effects of SSIs (mean $g=0.31$ after nine months; Schleider & Weisz, 2018) and multisession youth psychotherapy (mean $g=0.36$ after 11 months; Weisz et al., 2017) were not observed. Moreover, the overall effects of SSIs that were therapist-delivered versus self-guided (e.g., online) did not differ, highlighting the potential benefits of SSIs that do not require a provider to implement. Previous work also shows that youth and their parents find SSIs “extremely acceptable” (e.g., easy to understand and use, enjoyable and valuable) in addition to noting their value in decreasing mental illness symptomatology (Schleider et al., 2020c).

However, the use of SSIs—particularly those that are delivered digitally—is accompanied by limitations. For example, the targeted and intentionally brief nature of SSIs typically leads to a one-problem-per-program model, but various psychosocial concerns often overlap with each other (DeSocio & Hootman, 2004). Further, when administered online (i.e., via self-guided administrations), SSIs inherently lack the prospect of building therapeutic alliance with a caring professional. This alliance, or the positive interpersonal connection that can form between a service provider and recipient, shows well-established links to improved treatment outcomes in traditional, face-to-face psychotherapy (Ardito & Rabellino, 2011; Follette et al., 1996). It remains possible, albeit untested, that some youth may require therapeutic alliance, rapport, and trust to benefit from treatment. Lastly, SSIs can only take effect if youths choose to engage with them. As such, if youths have limited insight into their own difficulties, or

limited knowledge of existing, free-of-charge SSIs available to them, they are unlikely to access the interventions.

Given these considerations, the budding model of both digital and provider-delivered SSIs is well positioned to couple with other approaches designed to promote psychosocial wellness in youth, particularly if the other approaches offer compensatory strengths (Kazdin & Blase, 2011). For example, youth mentoring is a hopeful pairing, as mentors are often noted for offering empathy and support (DuBois & Neville, 1997), and the presence of a caring adult (i.e., a supportive relationship) is often an explicitly stated goal of mentoring programs (Garringer et al., 2017). As such, having a mentor facilitate SSI access and delivery may offer a therapeutic alliance and potentially counteract the impersonal nature of self-administered (e.g., workbooks) or technology-based SSIs. Moreover, mentors are often considered advocates and social capital for youth (Babcock, 2012; McQuillin et al., 2021), and mentors who know of SSIs can recommend or select interventions for youth as needed. This approach could connect youth to available resources, and perhaps match mentees with specific SSIs that would confer benefits to them (i.e., maximize the fit between mentees' needs and the services they receive). Furthermore, in professional treatment contexts, youths reap more benefit from digital and remote psychotherapies that are supported by providers than from those that lack interpersonal contact (Venturo-Conerly et al., 2022). These trends suggest that though youth can in theory access SSIs on their own (i.e., as an SSI can be advertised and distributed electronically), involving mentors in their delivery could (a) further facilitate youth access and completion of these interventions, (b) empower mentors to help match youths to the most appropriate SSI, and (c) enhance an SSI program's acceptability and utility by capitalizing on existing mentee-mentor relationships. Indeed, there are numerable benefits of mentoring interventions, many of which might align with or complement the nature of SSIs.

Mentor-Delivered Mental Health Interventions

Mentors, or adults or older peers who serve as caring, positive figures (Hagler et al., 2017), offer immense and largely untapped potential for increasing the reach of psychological supports for young

people: In 2015, the estimated number of mentors serving in formal youth mentoring programs in the U.S. was 2.59 million (Raposa et al., 2019), which was 25 times higher than the number of licensed psychologists in the same year (APA, 2015). In addition to their sheer number and prevalence, mentors exhibit youth-helping behaviors (Davis & McQuillin, 2022) and are often ubiquitous in public sector settings, such as non-profit and religious organizations and schools (Garringer et al., 2017). This positioning allows youth mentoring to increase the accessibility of services within individuals' existing communities, and thus (a) likely makes services more acceptable and effective through coordination with the existing community system (Belling et al., 2011), and (b) offers structural advantages over traditional, brick-and-mortar clinic service delivery models. Although informal or natural mentors (e.g., coaches and teachers who offer advice and support beyond their job requirements) also offer value to the youth they serve (Hagler et al., 2017; McDonald et al., 2007), we focus this manuscript on formal mentors and mentoring programs for clarity, as well as due to their associated infrastructures (e.g., processes for crisis management, intakes, referrals, etc.; Keller et al., 2020) and research work (e.g., meta-analyses of outcome studies; Raposa et al., 2019).

Enabling mentors to act as psychosocial health service providers in more earnest roles, and capitalizing on their existing presence within community settings, holds many advantages. For example, engaging mentors as mental health providers may decrease some of the stigma associated with treatment-seeking, a barrier often noted by teens (Gulliver et al., 2010). Bruce and Bridgeland (2014) found that more than 50% of youth report wanting a mentor and mentoring practices and programs are often found acceptable (Owen et al., 2018), suggesting that mentor-delivered interventions would have a high level of acceptability on individual and community levels. Further, nearly 50% of mentors are non-white (Garringer et al., 2017) whereas only 16% of licensed psychologists identify as ethnic or racial minorities (APA, 2015). This difference is notable, as racial congruence between clients and therapists predicts greater retention in youth psychotherapy (Wintersteen et al., 2005), suggesting that adolescents may prefer to work with mentors with backgrounds like their own even when professional services are available. Because minoritized youths with elevated psychological distress are less likely to access

professional mental healthcare than their non-minoritized peers (Garland et al., 2005), these types of cultural and demographic considerations are vital to increasing the accessibility and acceptability of supports.

Furthermore, the current practice of youth mentoring yields broad-level benefits, many of which could dovetail with SSIs. Though some evidence is mixed, a recent meta-analysis of youth mentoring program outcomes indicated significant positive effects (i.e., improvements in categories including psychological and health outcomes, school performance, and measures of social competence) of mentoring programs (mean $g=0.21$) over the last 40+ years (Raposa et al., 2019). This meta-analysis also echoed previous findings, including that having a mentor is linked with higher levels of youth engagement in positive recreational activities such as sports, extracurriculars, and community involvement (Bruce & Bridgeland, 2014), increased life satisfaction (McQuillin et al., 2016) and academic performance (Herrera et al., 2013), as well as decreased behavioral issues (DeWit et al., 2016).

In addition to these benefits, mentors' established presence in community settings may foster communication and coordination among caring adults who interface with youths. For example, a school-based mentor may be able to gather ongoing information from administrators, teachers, and support staff on site, and consult with guardians via phone to collaboratively share concerns and set relevant goals with students. This mentor could also then access additional data—such as attendance, disciplinary records, and grades—to accurately track progress towards that goal. Although mentors' roles differ from those of formal advocates or case managers, there are similarities among their practices (e.g., noticing concerns, tracking progress, and working towards goals). More than 40% of parents of youth with mental health conditions indicate a desire for care coordination (Brown et al., 2014), and care coordination has been linked to greater mental healthcare access, particularly among students with disabilities (Witt et al., 2003). In sum, mental health, behavioral, and academic concerns often co-occur and reinforce one another (DeSocio & Hootman, 2004), and capitalizing on pre-existing avenues (e.g., mentoring programs) to improve coordination of youth mental health supports can aid the identification and rapid deployment of services for the diverse, often-shifting issues that youth face.

Mentoring relationships may also help address youth mental health concerns. Youth with mentors have reported fewer depression and social anxiety symptoms than their non-mentored peers (DeWit et al., 2016), and an evaluation of five U. S. mentoring agencies over a period of 13 months showed that depressive symptom reduction emerged as the strongest and most consistent benefit of youth mentoring (Herrera et al., 2013). These findings are especially notable as youth referred to mentoring programs are more than twice as likely as their same-aged peers to meet criteria for a mental health concern, and particularly in low-resource environments, parents may first seek mental health services for their children via mentoring programs, (i.e., parents of mentored youth might embrace SSI delivery as an opportunity to meet the needs of youth; Herrera et al., 2013; McQuillin et al., 2021; Sourk et al., 2019). These patterns lend support for exploring the use of mentors in intentional, targeted efforts to reduce youth psychosocial suffering, such as through coupling them with SSIs.

Reconceptualizing and Strengthening Mentoring

Notwithstanding their benefits, existing mentoring programs may be ripe for structural expansion through the introduction of SSIs. Currently, many youth mentoring programs lack specified treatment targets, and “mentoring” refers to a broad range of potential activities (McQuillin et al., 2018). Some of these activities may not confer any benefit to—and some may even harm—participants (McQuillin et al., 2011), and unregulated practices between mentees and mentors warrant general concern. Moreover, mirroring attrition rates in traditional psychotherapy, approximately one-third of mentoring relationships terminate prematurely and to youths’ detriment (Garringer et al., 2017; Zilberstein & Spencer, 2014), suggesting a need for briefer service models where key activities or supportive elements are intentionally introduced early on in mentoring relationships. Previous research has also highlighted the persistent gap between research and practice within the youth mentoring field (Rhodes & DuBois, 2008). Streamlining, prescribing, and giving structure and empirical backing to the services that mentors provide—such as by having mentors deliver SSIs—could amplify the benefits of mentoring and enable the practice to be delivered and studied with more acuity.

To this end, Cavell and Elledge (2013) first suggested reconceptualizing the field of youth mentoring by characterizing such relationships as *contexts* for service delivery, versus as independent mechanisms of change. In an emendation of this position, Cavell and colleagues (2021) put forth a bilateral framework of mentoring in which the practice simultaneously serves as a means (i.e., as a platform for formal services) and an end (i.e., as a supportive relationship that is unto itself beneficial for participants). Similarly, McQuillin and colleagues (2021) identified how paraprofessional youth mentors can work with existing helping institutions and professions, and identified the following roles for paid or volunteer youth mentors who are supervised by professionals: First, mentors may reduce barriers to mental health services through providing outreach, transportation, or other adjunctive assistance that could make mental health programming more accessible; Second, mentors may increase engagement in existing services, such as through supervising homework or other practice assigned by a licensed professional, and; Third, mentors may provide direct services (McQuillin et al., 2021). The same work considers why mentors are particularly well-positioned to take on these tasks, recognizing that they already work in “quasi-therapeutic” roles that explicitly support youths’ social, emotional, and behavioral development (Garringer et al., 2017; McQuillin et al., 2021). Mentors may be even better positioned than others (e.g., parents, teachers) to support youth in this role, given their formal focus on positive youth development (i.e., mentors may be particularly motivated to seek structured activities, such as SSIs, to support youths’ psychosocial needs) and lack of competing demands (e.g., though teachers often report wanting to support students’ psychosocial development, job duties dictate they prioritize academics; Baweja et al., 2016).

Introducing SSIs into the service context of youth mentoring would directly align with the two abovementioned frameworks (e.g., Cavell et al., 2021, McQuillin et al., 2021), and would add actionable and testable suggestions to this prior conceptual work. Simultaneously, integrating SSIs and youth mentoring would help to ensure that youth mentees engage in evidence-based exercises with their mentors with optimized potential for conferring mental health benefits. As such, having mentors deliver SSIs could strengthen the practical utility and public health impact of mentoring science. This proposed model

is also backed and informed by prior investigations of mobilizing natural helpers and community health workers—both categories in which mentors fall—in closing service disparities and reducing mental health symptoms in individuals from marginalized backgrounds (Acevedo-Polakovich et al., 2014; Barnett et al., 2018).

Mentor-Delivered SSIs

Combining the availability of mentors as lay providers with the potency of targeted, developmentally sensitive SSIs may offer a yet-untested path toward supporting un- and under-served youth. Recent reviews of SSIs and mentoring, such as those included above, point to uniting the two practices as a potentially advantageous direction given their compensatory strengths and weaknesses (i.e., both intervention approaches may benefit from this strategic pairing). Some applied youth mentoring programs have also noticed this potential and begun implementing select excerpts of validated interventions into their practice. For example, Mentor Together, the first and largest youth mentoring organization in India—a country where the youth mental health need-to-access gap is even greater than in the U.S.—had mentors administer the Student Checkup (SCU) during intake meetings with prospective participants (Hart et al., 2022). The SCU (Strait, 2018) is a semi-structured motivational interview that has been shown to significantly increase students' semester-long academic motivation in as little as one session (Strait et al., 2017). Mentor Together stakeholders and staff reported that the SCU was usable and valuable in engaging youth (i.e., building and facilitating rapport), gaining information, and strengthening students' commitment to the program, which demonstrates that some applied programming has already noted (a) how mentoring practices and SSIs can complement and enrich each other, and (b) that mentored youth are likely to use SSIs with the support of their mentors. However, Mentor Together's work also demonstrated the extensive initial assessment and planning processes that could be required to implement mentor-delivered SSIs, as well as the ongoing and rigorous evaluation, monitoring, and refinement of practices that enabled an effective program (Hart et al., 2022).

Extant literature further supports the potential coupling of mentor-delivered SSIs: Raposa and colleagues (2019) found that mentoring programs that require shorter meetings yield larger effect sizes on average, suggesting that the characteristic brevity of SSIs may aid in fostering positive outcomes for mentored youth. Moreover, goals-oriented and targeted approaches to mentoring (e.g., mentoring focused on academic performance, psychological health, or social wellbeing) yield effect sizes more than twice as large as non-specific/ relational comparison approaches ($g=0.11$ versus $g=0.25$; Christensen et al., 2020), underscoring the benefit of equipping mentors with evidence-based and specific practices. Similarly, Schleider and colleagues (2020b) identified that almost 90% of SSIs developed in the last three years that have demonstrated effectiveness for mental health concerns have targeted adolescents, showing that SSIs have been designed and found acceptable and effective for the age of individuals who typically receive mentoring. The same piece noted that SSIs have already shown promise outside of traditional therapeutic contexts (e.g., in community centers and schools), further supporting that coupling them with mentoring offers an optimal starting point for exploring novel ways to expand the reach of youth mental health services.

Mentor-delivered SSIs may also be acceptable to and aid mentors as providers, given the decreased duration and heightened structure that characterize SSIs. Compared to other, lengthier services that mentors can provide (e.g., guiding career exploration and teaching youth “life and social skills;” Garringer et al., 2017), administering or supervising SSIs may lessen mentors’ cognitive load and thereby maximize treatment fidelity (Galy et al., 2012; Leppink & van den Heuvel, 2015). Further, mentor-delivered SSIs align with recent calls to examine the role of training in advancing the dissemination of evidence-based treatments (Park et al., 2016): In addition to offering a time-efficient training model, the use of intentionally short and structured programs (a) accommodates mentors’ typical lack of extensive or formal training in mental health services as lay providers, and (b) hinges on the idea that training is a continuing process, as mentors may receive training (e.g., from a psychologist in a supervisory role) or train themselves to use an SSI on an as-needed basis. Indeed, this approach mirrors *just-in-time trainings* (JITTs), or brief, on-demand, and targeted training modules, which have previously been posited to grow

and support mentors' skills (McQuillin et al., 2019). Relative to paraprofessional providers in control conditions, those who complete JITTs tend to deliver services with more confidence and fidelity (Kent, 2010). These findings perhaps elucidate an important future direction for youth mentoring, in which mentors complete JITTs that enable them to weave specific content into their programming as needed or when warranted.

At present, when trainings are prerequisite to delivering SSIs, they are often brief and low-intensity; when SSIs are designed for youth self-administration, mentor/provider training may not be required at all (Schleider et al., 2021). These features create a relatively low-risk context for mentors and program stakeholders, as introducing SSIs may take little time away from other tasks, while conferring tangible, immediately usable clinical skills and tools (Schleider et al., 2020b). Further, integrating evidence-based SSIs into their programming could allow mentoring organizations to maximize how directly and effectively they address their youth mentees' psychosocial needs (Herrera et al., 2013). In other words, it is likely that mentors and program leaders would embrace the integration of SSIs due to their accessibility and usability, in addition to their potential to help the youth that mentoring programs serve.

Lastly, the concept of mentor-delivered SSIs is explicitly aligned with and supported by the broader principles of community psychology. For example, engaging youth with mental health supports within their existing social and educational systems (e.g., at community centers and schools) is associated with higher ecological validity and increased generalization of therapeutic tools (Andrade, 2018). Mentor-delivered SSIs, as further described below, also honor existing contexts and infrastructures in efforts to integrate youth mental health service delivery into other systems. Through engaging individuals (e.g., mentees, mentors) to foster connectedness and access to resources, mentor-delivered SSIs demonstrate overlaps with community collaboration and empowerment (Belling et al., 2011). Due to this positioning, mentor-delivered SSIs may reap additional benefits over traditional mental health and psychosocial service delivery for youth, particularly related to acceptability and accessibility.

Accessibility of Mentor-Delivered SSIs: Overcoming Service-Access Barriers

By overcoming common treatment-access barriers—namely, cost and the shortage and inequitable distribution of professional providers—situating SSIs in the mentorship context could rapidly expand the reach of brief, evidence-based mental health support for youths in mentoring programs.

Cost. The financial burdens associated with mental health issues weigh heavy in the U.S., where mental disorders were the costliest medical conditions of the last decade (Roehrig, 2016). Government-sanctioned insurance and other programs spend upwards of \$200 billion annually on mental healthcare costs in the US (Roehrig, 2016) and costs are high for individuals, as well: Beyond the potentially-severe functional impairment due to mental disorders, which up to one in three people will experience (Merikangas et al., 2009; Merikangas et al., 2010), individuals' out-of-pocket costs for mental healthcare have recently exceeded those for physical healthcare in the U.S., resulting in traditional mental healthcare that is prohibitively costly for a large subset of the population (Hoyt et al., 2018; Xu et al., 2019).

Indeed, cost is the most commonly cited barrier to receiving professional mental health services among Americans (SAMHSA, 2018). This trend is particularly worrisome as the severity of mental illness and financial hardship are positively correlated (SAMHSA, 2016), resulting in a subgroup of Americans that is high-need and un-served. The inequitable inaccessibility of services is no better in youth client populations: Those who are racial and ethnic minorities, those who have caregivers with less education or come from single parent households, and those in families at or below the poverty level are significantly less likely than their peers to receive services due to a range of factors, including racial and socioeconomic structural inequalities (Fitts et al., 2019; Office of Disease Prevention and Health Promotion, 2014).

Mentor-delivered SSIs would be more affordable, and thus inherently more accessible, than traditional mental health services due to myriad factors. First, mentees and their families often incur minimal or no out-of-pocket costs to participate in mentoring, due to donations, public funding, and other wide-reaching forms of monetary support for mentoring initiatives (Bruce & Bridgeland, 2014). Similarly, several recently-designed SSIs are noted for their low or non-existent costs, as many evidence-based SSIs—including web-based programs and manuals for SSI delivery—are available online via open-

access sources (Schleider et al., 2020c). Notably, mentor-delivered SSIs—and indeed, neither mentoring nor SSIs independently—cannot and should not *replace* professional services, and deployment of this integration should be preceded by empirical support. Nonetheless, embedding SSIs within mentoring programs may help mentors to prevent or reduce mentees’ needs for more comprehensive treatment, thereby saving costs for clients with little disposable income or lower-quality insurance coverage. As such, this approach may appeal to families living in under-resourced environments. Likewise, it might be a streamlined means of expanding access to evidence-based mental health supports to youths in historically marginalized and under-served communities (McQuillin et al., 2021).

Workforce distribution. Other factors that maintain the need-to-access gap in youth mental healthcare are the shortage and inequitable distribution of professionally trained providers. It is estimated that over 122 million individuals live in mental health professional shortage areas, as three-quarters of counties in the U.S. do not have an adequate workforce of providers (Health Resources & Services Administration, 2021; Thomas et al., 2006). For example, the state of Mississippi had 160 psychologists at the time of the APA’s most recent report (2015), which equates to one psychologist per almost 20,000 residents (United States Census Bureau, 2013). This shortage yields professional treatment provision almost nonexistent for a large portion of the population. Given the brevity and efficiency of SSIs, their simplicity of delivery (i.e., many are highly-structured programs requiring little to no training to provide), and the ubiquity of mentors in community settings, our proposed model overcomes typical accessibility issues spurred by the professional workforce distribution. Instead of requiring transportation to designated, formal service sites, mentor-delivered SSIs could enable intervention and prevention programming to occur in local settings, and likely by providers who are familiar to and with the youth they serve. This positioning would enable evidence-based services, in the form of SSIs, to reach areas scarcely served by licensed professionals, and in a manner that neither burdens nor disrupts existing support systems.

Implementation Contexts and Considerations

Mentor-delivered SSIs may be beneficial and strategic in expanding the reach of mental health and psychosocial services for youth. Nonetheless, they could not overcome all constraints inherent in the U.S. healthcare system, and again, should not replace professional services; investment in accessible care remains needed at multiple levels to sustainably improve treatment accessibility. Further, attempts to deploy mentor-delivered SSIs indiscriminately, and without thoughtful planning and outcome assessment (i.e., prerequisite research), would be inappropriate and potentially wounding. For example, there is limited research examining whether SSIs may help mitigate high-acuity problems in youth such as self-injurious and suicidal behaviors (Schleider et al., 2020c; Schleider & Weisz, 2017a), with early research demonstrating helpful short-term effects on certain outcomes of interest (e.g., reduced self-hatred; Dobias et al., 2021). Moreover, mentors' typically-minimal level of training as interventionists rarely prepares them to treat acute psychopathology (Garringer et al., 2017), and community-based, paraprofessional mentors may experience moral injury or overwhelm if asked to provide services outside of their comfort or scope (i.e., training; Dean et al., 2019). In brief, we believe that the effective implementation, integration, and uptake of mentor-delivered SSIs require intentionality and thoughtfulness on multiple levels (e.g., from program administrators and stakeholders, mentors in service roles, and professionals in supervisory roles), as well as initial and ongoing research.

Given these challenges and considerations, the recommendations below are toward an envisioned model of mentor-delivered SSIs positioned to complement and enhance existing systems of care—mainly through expanding the reach of evidence-based psychosocial services for youth by leveraging the expansive mentor-provider networks already in place. To realize the potential of this model, researchers, youth mentoring agencies, and mental health providers and institutions will need to (a) accrue empirical evidence for this approach prior to deploying, (b) collaborate to practice ongoing evaluations of their efforts, and (c) remain willing to adjust efforts as needed. Indeed, many aspects of piloting new formats and uses of mentor-delivered treatments allow participants and stakeholders to make decisions on case-by-case or program-by-program bases (Hart et al., 2021). In other words, the specifics of how, when, and where mentors would facilitate SSI delivery depend on myriad factors. Based on context and need,

mentors' roles—if any—in delivering SSIs should vary (e.g., they may guide administration, lead follow-up discussions, or provide completion accountability; conversely, they may opt for different programming; McQuillin et al., 2021). While this flexibility can be a strength in optimizing the fit between mentor-delivered SSIs and each program, it also imbues responsibility (e.g., to ensure treatment fidelity, to recognize constraints, etc.).

Recommendations for Future Research and Use

Positioning Mentor-Delivered SSIs in Existing Care Models

We propose that mentor-delivered SSIs be nested into broader stepped care models (i.e., an approach to balancing the tradeoff between effectiveness and resource-intensity in matching an individual to a psychological treatment; Bower & Gilbody, 2005) to mental health service provision. Effective use of stepped care models can be seen in a variety of fields and settings, ranging from medicine to education (Fletcher & Vaughn, 2009). For example, in public health, primary, secondary, and tertiary care may consist of routine immunizations, screening practices, and early-stage treatment, respectively (WHO, 2020). In education, interventions are often developed and deployed within three tiers: Tier I refers to preventive strategies shared with all students; Tier II refers to targeted, short-term interventions for mild to moderate problems; and Tier III refers to longer-duration, higher intensity support for ongoing student challenges. In practice, reading instruction may include high-quality, evidence-based teaching for the whole class (Tier I), additional practice and instruction, such as in a teacher- or aide-led small group for students who exhibit minor learning difficulties (Tier II), and special education for students who continually do not respond to the aforementioned instruction (Tier III; Vaughn et al., 2008). Students' performance in a certain tier often indicates their level of need and can inform future placements and services (Fletcher & Vaughn, 2009).

In applying this framework to psychosocial interventions, we consider mentor-delivered SSIs the equivalent of intermediate or Tier II treatment options. This conceptualization suggests that mentor-delivered SSIs may (a) provide appropriate, goal-directed services to at-risk youth who may otherwise go

unsupported (i.e., those who exhibit mild to moderate mental health symptoms or discrete difficulties with coping skills, emotion regulation, or problem-solving), and (b) identify youth in need of higher-intensity services—that is, those who do *not* respond well to SSIs—by prioritizing their referral to more highly-trained professionals (i.e., licensed providers). There is no cause for mentor-delivered SSIs to disrupt existing or neighboring systems of care, and we encourage mentoring programs to continue using their preferred referral/ service provision options for higher-need cases (or, in the absence of these avenues, to review and update their program policies). After delivering an SSI, a mentee’s receptivity and response may help their mentor determine best-fit ways to support and understand their needs—including, but not limited to offering other SSIs to address co-occurring or emerging concerns, or referring to an outside, professional provider. At the same time, mentees *without* mental health needs will not be pushed out of existing programs, as SSIs can be delivered as preventive care, and we do not propose that SSIs replace any other programming. Rather, we posit mentor-delivered SSIs to complement and enhance usual programming. Just as not all students who struggle to read require high-intensity special education services, not all students who are at-risk or present with mild mental health concerns require long-term, professional treatment. For youth exhibiting mild or subclinical mental health problems, many evidence-based interventions involve brief, targeted materials or resources (Kolko & Perrin, 2014); as such, there is reason to expect that their needs could be addressed through mentor-delivered, evidence-based SSIs.

Mentor-delivered SSIs may co-occur with, precede, and at times eliminate the need for a formal referral—potentially helping to reduce the lengthy waiting times for professional services that are common across the country (Schleider & Weisz, 2017a; Sung et al., 2020). Moreover, nesting mentor-delivered SSIs into existing, well-established, and nationally-implemented stepped care models (e.g., special education in public schools) may also allow mentors to receive supervision and support from professionals with more extensive and specialized training (e.g., school psychologists, licensed professional counselors, clinical social workers; Hart et al., 2021). In addition to connecting mentors to professional assistance with decisions and recommendations, this positioning provides needed protections and regulations surrounding mentors’ conduct with youth (McQuillin et al., 2019).

Implementing Mentor-Delivered SSIs

As a practical first step, we encourage stakeholders interested in mentor-delivered SSIs to explore the degree and diversity of need within a given system, and to identify domains in which their mentees/ participants may be at risk. For example, staff members in one program may note increased interpersonal issues among youth and find content about communication skills and emotion regulation most helpful, while staff members at another site may prioritize help in dealing with depression and grief. Individual and program needs are often a function of many factors, including participant demographics and other ecological variables. Screener tools can also provide valuable measures of youth symptomatology and indicate areas of need (e.g., the Revised Children’s Anxiety and Depression Scale [RCADS-25]; Chorpita & Spence, 1998). These needs should be considered in conjunction with publicly available SSIs to best align treatment targets and interventions. Table 1 provides an incomplete directory of open-access, validated SSIs that we suggest mentoring programs explore for these purposes. In addition to descriptive summaries of each intervention (e.g., target problem[s] and age range), the table highlights training requirements to use each program. Given the ease of delivery and range of outcome targets across available modules, mentors could deliver multiple SSIs to the same mentee over the course of their relationship, when and where they are needed.

After needs have been “matched” with available SSI tools, stakeholder buy-in must be obtained (Bonfils et al., 2018). Relevant stakeholders will vary by setting, but in virtually all implementation cases, mentors themselves must report willingness to participate in and support the delivery of SSIs. Initial reasons for mentors’ hesitation might include feeling overwhelmed by existing program demands, or perhaps an unwillingness to change practice-as-usual. Buy-in may be obtained by eliciting staff feedback, maintaining effective and transparent communication, promoting pre-program training, and setting small initial goals, among other practices (Boden et al., 2020). Bypassing these steps to implementation may lead to contextual and program barriers (e.g., increased staff burden and low staff investment) in coupling mentoring and SSIs, thereby decreasing the quality of the proposed intervention model. Financially compensating and incentivizing mentors to deliver SSIs may also be considered, both to increase buy-in

and to avoid the exploitation of community members (Eddy et al., 2017). In initial trials of mentor-delivered SSIs, stakeholders should enable and prepare for modifications to the initial program plan, as the fit among goals, outcomes, and participants is dependent on many dynamic factors.

We also urge researchers and care systems (e.g., community- and school-based mentoring programs) to thoroughly examine how specific aspects of SSI-relevant training and supervision will operate in each context. Similarly, the documentation and evaluation of services is critical to effective programming (McQuillin et al., 2021). In addition to supporting mentors as lay providers, these programming features are crucial to holding checks and balances for the safety of youth participants, and to ensuring program fidelity. Recognizing constraints (e.g., mentors cannot and should not *replace* professional mental healthcare—although mentor-delivered SSIs may serve as useful adjunctive or stand-alone supports for many youth) is vital to effective task-shifting (McQuillin et al., 2019), and specific limitations will vary by context and the resources available. Future research work should also explore how mentor-delivered SSIs can augment existing systems. While mentor-delivered SSIs may be effective and helpful as standalone interventions, they could also be coupled with other professional or paraprofessional services (i.e., therapeutic treatment, school-based interventions, etc.) thus further increasing the accessibility of services. Given that our proposed intervention programs are self-contained modules, they could be deployed with short notice/ minimal planning and prep time, and during critical periods of development.

Conclusions

Youth mental healthcare is in increasingly high demand, due in part to the ongoing COVID-19 pandemic, and traditional providers and service models do not have the capacity to aid all those in need. At the same time, mentoring programs are as popular and prevalent as ever, with the practice of youth mentoring even becoming “professionalized” in some cases (i.e., working as a youth mentor can be a full-time, paid job; Eddy et al., 2017). While mentoring programs and relationships are already linked to a host of beneficial outcomes for youth, an expansion and reconceptualization of the field to this degree provides an opportunity to query and reexamine the mechanisms at play in youth mentoring relationships.

Under scrutiny, it becomes evident that current practices in youth mentoring lack actionable suggestions to keep pace with the conceptual developments across the field, due largely to a lack of affordable, flexible, and practical frameworks.

Future research exploring the introduction of mentor-delivered SSIs provides a hopeful future step for growing and strengthening youth mentoring programs, as the advantages of SSIs largely complement the shortcomings of mentoring (i.e., evidence-based SSIs are acceptable, brief, evidence-based, mechanism-targeted, and structured programs). Delivery by a mentor may also bolster SSI outcomes, as a mentor can guide youth participants in connecting them to resources and helping select a program that may be most helpful for them, and by providing a healthy, non-parental relationship. Indeed, mentor-delivered programs and SSIs offer many benefits in their own rights, and coupling these practices may be a step towards maximizing the accessibility and benefit of mental health services for youth. The nature of SSIs lends to intervention design that ensures developmental appropriateness, leading us to conceptualize mentor-delivered SSIs as an adaptive intervention approach that can change based on youths' needs. Because 'single session' refers only to the duration of the intervention's active ingredient, this approach does not limit the length of a mentee/ mentor relationship and therefore allows participants to also gain interpersonal support and social capital through the pairing. Mentor-delivered SSIs may also be acceptable, and even advantageous, for multiple tiers of providers, and may highlight valuable future directions for the field of mentoring, such as further exploring single-session JITTs for mentors. While we urge those involved in providing youth services to exercise care and caution in the uptake of our proposed model (i.e., through conducting prerequisite research), we hope to also draw attention to its substantial potential.

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Table 1. Descriptions of possible recommended, open-access single session interventions (SSIs)*

SSI Name	Short Description	Target Problem(s)	Required Training	Age Range	Delivery Mode	Link to Open-Access Program Materials
Single Session Consultation (see Schleider et al., 2021)	Based on solution focused brief therapy, the intervention identifies patient strengths and builds personalized, concrete strategies to work towards an achievable goal	Hopelessness; Broad psychological distress	1 hour	13 years and older	Guided (Delivered by therapist or lay-Provider)	https://osf.io/xnz2t/
Project Personality (see Schleider & Weisz, 2016; Schleider & Weisz, 2018; Schleider et al., 2020a; Schleider et al., 2020c)	The intervention teaches the principles of growth mindset and empower youth to make positive change	Depressive symptoms, Anxiety symptoms, Low Perceived Control, Hopelessness	None	11 - 17 years old	Self-guided	schleiderlab.org/yes
Project CARE (see Schleider et al., 2020c)	The intervention addresses self-dislike by teaching self-compassion and how to be kind to oneself	Depressive symptoms, Self-hate	None	11 - 17 years old	Self-guided	schleiderlab.org/yes
The ABC Project (see Schleider et al., 2020c)	Drawing from the principles of behavioral activation, the intervention teaches how to take action to manage mood difficulties	Depressive symptoms, Anhedonia	None	11 - 17 years old	Self-guided	schleiderlab.org/yes

*This table is not an exhaustive list of the SSIs that may be useful for the mentor-SSI delivery model. This table includes a few of the fully open-access SSIs to the best of the authors' knowledge.