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Mental Health Ambassadors: A Model for Supporting Youth Mental Health Within Mentoring Programs

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Abstract

Contemporary youth mental health challenges necessitate collaborative approaches to prevention and support. The Mental Health Ambassador (MHA) program was developed to equip youth and adults in mentoring programs with the skills and confidence to discuss and support youth mental health, with the broader goal of creating meaningful impact within their local communities. The 8-session MHA program involves group-based learning and a local youth-led advocacy project. This mixed-method pre-post pilot evaluation examined program acceptability, implementation experiences, and potential for effectiveness. Participants included youth aged 14–18 years (n = 9) and adult mentors (n = 11) from mentoring organizations across five counties in Minnesota. Quantitative surveys assessed mental health resource awareness, preparedness to address youth mental health concerns, confidence in engaging in mental health conversations, and confidence in providing resources and referrals. Post-program focus groups explored participants' experiences, perceived benefits, and implementation challenges. Findings indicated that both youth and adult participants reported positive experiences with the program and demonstrated increases in resource awareness, preparedness to address youth mental health concerns, confidence in discussing mental health, and confidence in providing resources and referrals. Qualitative findings further highlighted the value of youth-led advocacy activities and identified key considerations for implementation within mentoring settings. Mentoring programs may represent an ideal context for equipping youth and adults to provide early, community-based support for youth mental health concerns.

Keywords: youth mental health; peer support; mentoring; mental health first aid

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Academic Editor: Grace Gowdy

Received: 1 May 2026
Revised: 12 June 2026
Accepted: 17 June 2026
Published: 18 June 2026

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1. Introduction

Youth mental health challenges have intensified in recent years, reaching levels increasingly described as a national crisis (Bommersbach et al., 2023; Centers for Disease Control and Prevention, 2024). The long-term effects of mental health problems in childhood and adolescence are far-reaching, including reduced quality of life, thwarted educational and employment status, and greater risk of persistent mental health difficulties in adulthood (Schlack et al., 2021; Veldman et al., 2015). In response, public health and education leaders are turning toward community-based, mentor-rich approaches that align with stepped-care models emphasizing early, low-intensity supports delivered by trusted peers and adults (McQuillin et al., 2019, 2022). When grounded in a Positive Youth Development (PYD) framework, these approaches foster young people's strengths and autonomy to actively

shape their development (Catalano et al., 2019; Lerner et al., 2015). Such environments can strengthen young people's sense of belonging, affirm identity, and support navigation of resources, all while fostering relational well-being (Jones et al., 2024; Rhodes et al., 2006; Schwartz et al., 2026). The Mental Health Ambassador (MHA) program was developed within this context to equip youth and adults in mentoring programs with the skills and confidence to discuss and support youth mental health, with the broader goal of creating meaningful impact within their local communities. This preliminary study examines how the program is received by participants, identifies challenges and successful implementation strategies, and evaluates whether the program shows promise of yielding its intended outcomes.

1.1. Positive Youth Development and Mentoring

Broadly, PYD refers to the childhood and adolescent experiences that best prepare young people to realize their full potential and achieve well-being in adulthood (Catalano et al., 2019; Lerner et al., 2015; Skinner et al., 2026). Programs grounded in PYD not only reject deficit-driven views of youth, favoring a strengths-based approach, but they also generally share three key components: (1) help young people build the skills and strengths needed to flourish; (2) enhance the environments around youth so those settings better promote healthy development; and (3) cultivate young people's sense of agency, enabling them to shape their own growth and the contexts in which they live (Catalano et al., 2004, 2019).

PYD frameworks also highlight the importance of supportive relationships including mentoring relationships as a key mechanism through which positive development occurs (Bowers et al., 2015; Lerner et al., 2015). Adult–youth mentoring relationships, specifically, function as a critical developmental asset that fosters a sense of belonging, supports identity exploration, and strengthens resilience in youth (Benson et al., 2004; Jones et al., 2024). High-quality mentoring relationships provide youth mentees (under age 18) with reliable support, opportunities to reflect on their values and goals, and guidance in navigating challenges from vetted, trained, and supported older adult mentors (above age 18). These relationships also create spaces where young people feel seen, valued, and connected. Furthermore, by engaging youth in goal-setting, collaborative problem-solving, and meaningful connection to their broader communities, mentoring programs help young people practice agency in ways that closely align with PYD principles (Benson et al., 2004; Catalano et al., 2004; Rhodes et al., 2006). As such, mentoring relationships are developmentally rich settings through which the core intentions of PYD (i.e., strength building, environmental support, and youth agency) are enacted in practice.

PYD frameworks theorize that positive development emerges when young people are supported in cultivating the "Five Cs" (i.e., Competence, Confidence, Connection, Character, and Compassion), which collectively drive a sixth C (i.e., Contribution; Bowers et al., 2015; Geldhof et al., 2015; Lerner et al., 2015). High-quality mentoring serves as a catalyst for these attributes, building competence and confidence through skill-building and affirmation, while fostering connection and character through dependable, prosocial modeling. Mentors can also cultivate compassion by facilitating empathy, perspective-taking, and prosocial behavior. When these Five Cs are nurtured, youth are more likely to demonstrate contribution by engaging meaningfully with their families, schools, and communities (Hershberg et al., 2015; Lerner et al., 2021). Mentoring programs can further reinforce agency and social responsibility by offering structured opportunities for service, leadership, and collaborative problem-solving. Together, these processes position mentoring as a powerful asset.

1.2. Mentoring, Peer Support, and Youth Mental Health

The supportive relationships cultivated in mentoring not only advance core PYD outcomes but also serve as early, preventive mental health supports. Mentors and mentoring programs can play a critical, yet often underestimated, role in supporting youth mental health (McQuillin et al., 2022). Mentors are not expected to act as clinicians or provide mental health treatment. However, mentors can provide tangible support by noticing changes in mood, using supportive and non-judgmental language, and helping youth find trusted adults and/or resources when concerns arise. Research suggests that mentoring relationships may support youth well-being through emotional support and connection to broader networks and resources (Goldner & Ben-Eliyahu, 2021).

Supportive mentoring relationships may be able to help reduce mental health stigma, normalize conversations about emotional well-being, and encourage youth to seek help when concerns arise. Because mentors occupy a trusted yet nonclinical role, mentors may be able to validate youth's experiences, help them navigate informal and formal support systems, and create safe spaces where mental health concerns can be addressed before they escalate. Within stepped-care models, mentors may contribute to early support by offering relational scaffolding and helping connect youth to formal services when needed (Bower & Gilbody, 2005; McQuillin et al., 2019, 2022). Within these models, mentors can play a key preventive role by offering emotional regulation support, problem-solving assistance, and connections to social and community resources. Mentors may also be able to help normalize help-seeking and encourage youth to access higher-level services when needed (Gulliver et al., 2010; Sheikhan et al., 2023; Song et al., 2023). In doing so, mentoring programs can effectively expand the mental health frontline by providing an accessible, non-stigmatizing layer of care that reduces service bottlenecks, identifies emerging concerns earlier, and promotes well-being within everyday environments (Weiler et al., 2025; Werntz et al., 2025).

At the same time, mentor-delivered mental health supports carry risks if mentors are asked to take on responsibilities beyond their role, training, and capacity. Mentors may feel unprepared or uncertain about how to respond when youth disclose more serious mental health concerns (McQuillin et al., 2022). It is important to have clear boundaries and referral pathways set in place to prevent mentors from providing inappropriate guidance, missing signs of risk and/or harm, or failing to make a needed connection to clinical care. With this in mind, mentoring programs must clearly distinguish the support provided by a mentor and when it should be passed off to a clinician.

Beyond the role of caring adults, youth themselves are increasingly recognized as powerful sources of mental health support for their peers. Many young people turn to friends when experiencing stress, anxiety, or emotional concerns (Singh et al., 2019), making peer relationships a critical early point of intervention. Qualitative research shows that stigma often shapes whether youth seek formal services (Sheikhan et al., 2023), while peer spaces may feel safer and less judgmental, helping to reduce delays in help-seeking (Halsall et al., 2024). These peer interactions can normalize emotional struggles, validate difficult experiences, and help youth share coping strategies or encourage one another to seek additional support (de Beer et al., 2024). This dynamic aligns with emerging mental health frameworks emphasizing the importance of accessible, early-tier supports delivered within the environments where youth already spend their time and feel most understood (McQuillin et al., 2022).

In addition, recent literature emphasizes youth voice and community expertise as vital to effective mental health promotion. Asset-based and participatory approaches recognize that young people possess unique insights into the cultural norms and stressors that shape their mental health and help-seeking behaviors (Jagosh et al., 2015; O'Mara-Eves et al., 2015). This perspective reframes youth from passive service recipients to active

contributors, recognizing their lived experiences can foster community trust and enhance program relevance. Because empowerment is linked to positive psychosocial outcomes (Wong et al., 2010), programs should intentionally cultivate youth-adult partnerships that share power and decision-making (Heffernan et al., 2017). These community-informed approaches position youth power as an asset and elevate young people as essential leaders and knowledge holders within the systems designed to support them.

Yet, there are inherent risks to youth providing mental health support to one another (Carapeto et al., 2025). One qualitative study explored how adolescents experienced supporting friends with anxiety, depression, or suicidal thoughts, identifying diverse themes such as fear, vigilance, secrecy, boundary-setting, and feeling honored in the helping role (Roach et al., 2021). Participants often felt emotionally burdened and unprepared, frequently turning to the internet for information and relying on peers due to distrust of adults. Although adolescents recognized limits to what they could safely handle, many still found the role meaningful and central to their friendships. Another study exploring adolescents' experiences of supporting a friend who self-harms found that they face complex and evolving emotional, relational, and informational challenges, despite their willingness to help (Bilello et al., 2024). Results highlight significant unmet needs among youth providing support to friends and emphasize the need to develop pathways that "support the supporters" (Bilello et al., 2024, p. 9). Given the complexity of youth mental health crises and the role of youth as peer supporters, earlier mental-health education, better adult guidance, and training programs are needed to effectively equip youth who often serve as frontline support for their peers.

1.3. Community-Based Mental Health Training for Youth and Adults

Manualized mental health literacy training intended to increase the knowledge and skills needed to recognize and support mental health conditions (Jorm, 2012) offers a promising strategy for improving youth outcomes. The National Council for Mental Wellbeing has developed evidence-based variations in these programs, including Mental Health First Aid (MHFA) for adults, Youth MHFA for adults working with youth, and teen MHFA for peer support (Ng et al., 2021; Sánchez et al., 2021). Extant literature demonstrates positive outcomes when school staff, parents, and youth-serving professionals are trained to recognize, discuss, and support mental health symptoms (Marsico et al., 2022; Ng et al., 2021; Rose et al., 2019). After training completion, adults express better understanding of presenting mental health challenges, improved beliefs surrounding mental health (e.g., reduced stigma), and increased confidence in helping youth. Those trained in YMHFA report an increased likelihood of helping a youth in distress (Aakre et al., 2016) and report using the skills at a two-month follow-up (Marsico et al., 2022), indicating learned skills are impactful on an ongoing basis. Few studies demonstrate the effect of such training on youth mental health, but in a 3-year follow-up study, findings showed a significant increase in youth perception of general support from their parents who were YMHFA trained (Morgan et al., 2020).

Despite these benefits, most existing programs are adult-led and fail to bridge the gap between youth experience and adult support. Furthermore, many existing trainings are underutilized within mentoring organizations for various reasons (e.g., cost, accessibility, time). As a result, informal mental health discussions are common but often lack a structured or evidence-informed framework. Developed from a research-practice partnership, the current study aims to extend the scope of existing programs by integrating targeted mental health training into mentoring settings to support early identification and appropriate referral to formal mental health services. Through a locally tailored approach

that builds competence, confidence, and compassion among both mentors and mentees, youth-serving programs can more effectively align support with youth needs.

1.4. Mental Health Ambassador Program

1.4.1. Program Philosophy

The MHA program was developed in response to growing recognition that youth mental health promotion requires community-embedded, mentor-rich approaches that extend beyond clinical settings. Drawing on PYD, mentoring, and youth empowerment frameworks, the MHA program equips youth and adults in a variety of mentoring contexts with shared skills, knowledge, and language to support youth mental health within their communities. Current community-based mental health trainings are often adult-led and targeted for primarily adult audiences; this program aims to create meaningful change through youth-led advocacy efforts and empower youth to lead mental health initiatives within their local environment. Lastly, the MHA program purposefully embeds adult–youth partnerships, peer-to-peer relationships, and facilitated group experiences across the eight-session program to build connection, skills, and shared engagement in supporting youth mental health within local communities.

1.4.2. Learning and Skill-Building

A core component of the MHA program is applied, skill-based learning that builds youth mental health literacy and reduces mental health stigma among youth and adults. The MHA program curriculum focuses on early identification and response to youth mental health concerns. The MHA program uses a hybrid model that includes both virtual and in-person sessions. Across these sessions, mentors and mentees participate in most of the programming together as part of a larger cohort. While some mentor–mentee pairs may participate in the program, they do not complete the programming separately and, instead, engage in the larger group experience alongside other participants. There are a few points in the program where adults and youth learn in separate spaces. During the Onboarding Session, youth and adults briefly separate to learn about their roles in the program. Adults spend time learning about the concept of youth power and youth voice, while youth participants spend time reflecting on their strengths as individuals and how they can contribute those strengths to the larger cohort. Adults and youth also complete Session Two separately. During session two, adults complete the official YMHFA training while youth are guided by facilitators through the Be There training developed by the Born This Way Foundation. Both adults and youth attend the rest of the program sessions together, addressing unique topic such as suicide prevention, trauma, adverse childhood experiences (ACEs), protective factors, and ways to provide mental health support. The program emphasizes creating opportunities for participants to practice essential skills, such as using supportive language, engaging in direct conversations about suicidal ideation, identifying local resources, and making referrals. By prioritizing skill application, the MHA program builds participants' readiness and confidence to support peers and young people within their communities.

1.4.3. Youth-Led Leadership and Empowerment

The MHA program positions youth as leaders. Youth participants are encouraged to shape and lead mental health initiatives, engage in advocacy, and apply their learning within their own communities. Adults build supportive relationships with participating youth concurrently. The MHA program design addresses persistent gaps in both research and practice, where youth voice is often acknowledged when conceptualizing, but not utilized enough in the implementation process (Zeldin et al., 2014). During the onboarding session, youth engage in an identity mapping activity that allows them to connect their

personal identities to their advocacy projects. As a result, this helps these youth deepen self-awareness and strengthen their sense of agency. The program also mitigates potential risks of youth peer support by ensuring sufficient adult guidance and shared responsibility amongst participants.

1.4.4. Community Impact and Advocacy

The MHA program fosters individual growth while driving systemic community change by positioning youth and adults as community experts. Participants not only learn about key topics related to mental health, but they are also actively engaged in locating and interpreting community-specific data. For example, participants are asked to analyze local school district data on ACEs and identify specific risk and protective factors within their own environments. This data-driven approach aligns with mental health literacy frameworks that emphasize the importance of increasing knowledge, reducing stigma, and strengthening community capacity to recognize and respond to mental health concerns (Jorm, 2012). It also reflects adolescent mental health literacy programming, which focuses on knowledge about mental health, stigma reduction, and recognition of signs and symptoms (Nobre et al., 2021). As a result, this can transform participants into community assets who compile and distribute essential support and information to their peers.

Central to the MHA framework is the youth-led advocacy project which addresses a critical gap in traditional mental health initiatives. The framework was intentionally created to move beyond classroom training and into real-world application. By providing structured opportunities for participants to design and lead individualized projects that meet the needs of their peers and communities, the MHA program supports positive youth development and enhances their engagement (Dopson et al., 2017). These advocacy projects also empower youth to dismantle stigma and strengthen local support networks to ensure that mental health literacy is translated into meaningful, self-directed community action (Ozer, 2017). As part of the project requirements, youth must develop an informational resource tailored to their community's specific needs, such as digital or print media. Second, they execute a localized action designed to foster connection or awareness; examples from previous cohorts include distributing mental health awareness materials, conducting qualitative peer and educator interviews regarding school mental health culture, establishing pen-pal networks to mitigate social isolation, and organizing school-wide prosocial messaging campaigns (i.e., 'kindness slips'). The advocacy project culminates in a presentation during the concluding session where the cohort translates their efforts for friends, family, and stakeholders. As a result, participants become community assets who can share and provide essential mental health information and support to their peers. The preceding allows the MHA program to connect individual learning with broader impact on communities.

1.4.5. Supportive Relationships and Network Building

The MHA program centers on cultivating a robust network of supportive relationships between youth, their peers, and adults within mentoring organizations. By partnering with existing agencies, the program leverages and strengthens long-standing community bonds through a cohort-based model that prioritizes trust and shared accountability. This networked approach reflects research suggesting that youth help-seeking is highest when they are surrounded by multiple trusted adults and safe environments (Rickwood et al., 2005).

By moving beyond the traditional one-to-one mentoring dyad, the MHA program intentionally builds a robust support web. It also aims to address the needs that have been identified in the literature for needing more diversified youth networks and low-intensity interventions delivered by familiar figures in a young person's life (McQuillin et al., 2019,

2022). Subsequently, these multi-layered relationships facilitate early identification and support, reducing the likelihood that mental health concerns will escalate into a need for more intensive clinical intervention.

1.5. The Current Study

The current study evaluates the acceptability and potential effectiveness of the MHA program, a community-embedded initiative designed to address the escalating youth mental health crisis. Grounded in PYD, mentoring, and youth empowerment frameworks, the MHA program equips youth and adults within existing mentoring organizations with the skills, confidence, and language necessary to recognize and support emerging mental health concerns. By integrating manualized training with structured, youth-led advocacy projects, the program aims to bridge the gap between traditional mental health literacy and real-world application. Utilizing a mixed-method design, this pilot study investigates how the program is received by participants, identifies key implementation drivers and challenges, and evaluates targeted outcomes.

2. Materials and Methods

2.1. Study Design

This study used a mixed-method pre-post evaluation design to assess the implementation and outcomes of the MHA program. Quantitative survey data were collected from youth and adult participants before and after program participation to examine changes in mental health knowledge, preparedness, confidence in supporting youth, and program experiences. Qualitative data were also collected through post-program focus groups to capture participants' experiences, perceived program benefits, and implementation challenges.

2.2. Participants

Participants were youth (n = 9) and adults (n = 11) involved in the MHA program implemented in partnership with MENTOR Minnesota and the University of Minnesota during Fall and Spring 2025. Youth participants were high school students aged 14–18 years who were connected to mentoring programs in five counties in Minnesota and expressed interest in promoting youth mental health and wellbeing. Adult participants were mentors or staff affiliated with mentoring programs aged above 18 years. Demographic characteristics of youth and adult participants are presented in Table 1.

Table 1. Demographic characteristics.

Characteristic	Youth (n = 9)	Adult (n = 11)
Age (years), *M* (*SD*)	15.44 (1.33)	32.09 (14.53)
Range	14–18	19–62
Gender, *n* (%)		
Female/Girl/Woman	9 (100%)	10 (90.9%)
Another gender identity	0 (0%)	1 (9.1%)
Sexual Orientation, *n* (%)		
Heterosexual	3 (33.3%)	6 (54.5%)
Lesbian/Gay	1 (11.1%)	1 (9.1%)
Bisexual	2 (22.2%)	2 (18.2%)
Demisexual	0 (0%)	1 (9.1%)
Asexual	2 (22.2%)	0 (0%)
Prefer not to answer	1 (11.1%)	1 (9.1%)

Table 1. *Cont.*

Characteristic	Youth (*n* = 9)	Adult (*n* = 11)
Race/Ethnicity, *n* (%)		
Hispanic	2 (22.2%)	0 (0%)
White	5 (55.6%)	9 (81.8%)
Black or African American	2 (22.2%)	1 (9.1%)
American Indian/Alaskan Native	0 (0%)	1 (9.1%)
Asian American	0 (0%)	1 (9.1%)
Another Racial/Ethnic group	1 (11.1%)	0 (0%)
Missing	1 (11.1%)	0 (0%)

Note. Race/ethnicity are non-exclusive categories.

2.3. Procedures

The study protocol was approved by the University of Minnesota Institutional Review Board. Individuals interested in the program received information describing program expectations, study procedures, and confidentiality protections. Adult participants provided informed consent prior to participation. For youth under the age of 18, parental consent and youth assent were obtained before participation in the study. Data were collected from multiple sources throughout the program period, including program documentation, pre- and post-program surveys, and post-program focus groups.

The Mental Health Ambassadors program was implemented over eight sessions during two cohorts in Spring and Fall 2025, averaging 19 h of programming per cohort. Three out of eight sessions were held in person with the remainder occurring virtually. The curriculum included: Session 1, onboarding and program orientation; Session 2, Be There training for youth ambassadors and YMHFA for adult advocates; Session 3, suicide prevention training; Session 4, ACEs and trauma informed approaches; Session 5, community building and introduction to youth led advocacy projects; Session 6–7, learning about resources and referral processes, guided work time for developing and implementing advocacy projects; and Session 8, program graduation. The program emphasized skill-building in mental health literacy, supportive peer engagement, and youth-led advocacy.

2.4. Data Sources and Measures

2.4.1. Program Documentation

Program documentation was used to track program implementation indicators, including enrollment, attendance, completion status, and retention rates.

2.4.2. Program Satisfaction

Program satisfaction was measured using eight project-developed items assessing participants' perceptions of session quality and organization (e.g., "The sessions were well organized", "I liked the sessions"). Survey items were rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree).

2.4.3. Youth-Adult Connection

Youth perceptions of connection with adult participants were measured using four project-developed items assessing perceived support and care from adult mentors (e.g., "I feel supported by adults in this group", "Adults in this group care about me"). Survey items were rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The scale demonstrated acceptable internal consistency for youth ($\alpha = 0.92$).

2.4.4. Sense of Belonging

Sense of belonging within the program was assessed using five items adapted from measures developed by Youth Development Strategies, Inc. (e.g., "I belong at MHA", "If I didn't show up at MHA, people would miss me"). Items were rated on a 0–10 scale ranging from disagree to agree. The scale demonstrated acceptable internal consistency for youth ($\alpha = 0.81$).

2.4.5. Awareness of Mental Health Resources

Awareness of mental health resources was measured using three project-developed items assessing participants' knowledge of available mental health services and crisis resources for youth in their communities at pre-test and post-test (e.g., "I am aware of mental health services for youth in my community"). Survey items were rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The scale demonstrated moderate internal consistency ($\alpha = 0.64$–0.70).

2.4.6. Preparedness to Address Youth Mental Health

Preparedness to discuss mental health concerns was measured using two items assessing participants' readiness to talk with peers or adults about mental health issues at pre-test and post-test (e.g., "How prepared do you feel to talk to a peer about mental health concerns?"). These items were adapted from measures used in prior research evaluating Youth Mental Health First Aid training (Childs et al., 2020). Survey items were rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). Because the scale consisted of two items, internal consistency was assessed using the Spearman–Brown coefficient. The scale demonstrated strong reliability (Spearman–Brown = 0.78–0.93).

2.4.7. Confidence in Mental Health Conversations

Confidence in engaging in mental health conversations was assessed using three project-developed items evaluating participants' perceived ability to support peers experiencing mental health challenges (e.g., "I am confident that I can have a supportive conversation with a peer about mental health challenges"). Survey items were rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The scale demonstrated acceptable internal consistency ($\alpha = 0.69$–0.85).

2.4.8. Confidence in Referrals and Resource Sharing

Confidence in referring peers to appropriate mental health resources was measured using two project-developed items assessing participants' perceived ability to connect peers with professional support. (e.g., "I am confident that I can refer a peer experiencing mental health challenges to a health professional"). Survey items were rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). Reliability estimates indicated variable internal consistency for youth and adults (Spearman–Brown = 0.50–0.93).

2.4.9. Intention to Intervene

Participants' intentions to take action when peers experience mental health challenges were assessed using three project-developed items measuring willingness to intervene and provide support (e.g., "I believe that I intend to take action to help my peers to address their mental health challenges"). Survey items were rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The scale demonstrated acceptable internal consistency ($\alpha = 0.77$–0.96).

2.4.10. Post-Program Focus Groups

Post-program focus groups were conducted separately with youth and adult participants to gather qualitative insights into program experiences, implementation challenges, and perceived impacts of the program. Participants discussed their experiences in the program, the skills they developed, and how the program influenced their ability to talk about mental health. Example focus group questions included: "What aspects of the program were most meaningful to you?" "How did participating in the program influence your confidence in talking about mental health?" "What challenges did you encounter during the program?"

2.5. Analytic Strategy

Descriptive statistics were calculated to summarize participant characteristics, program uptake, and outcomes. Paired sample t-tests were conducted to examine the change between pre- and post-program survey responses. Hedge's g effect size was calculated due to the small sample.

Focus group transcripts were analyzed using thematic analysis following the approach outlined by thematic analysis principles (Braun & Clarke, 2023). Two researchers independently reviewed the youth and adults' focus group interview transcripts multiple times to become familiar with the data and generated initial codes by identifying meaningful segments of text. During subsequent rounds of coding, codes were refined, relabeled, and consolidated to ensure consistency across similar ideas. The coders then met to compare interpretations, discuss discrepancies, and reach consensus on a final set of codes. Next, each coder independently developed preliminary themes from the codes, followed by collaborative discussions to refine and finalize themes. Relevant excerpts, codes, themes, and summaries were organized, and final themes were grouped according to the research questions.

3. Results

3.1. Program Uptake

Nine youth and eleven adult participants enrolled and completed the program (100% retention). Youth participants attended between 5 and 8 sessions (M = 7.11, SD = 1.17), while adult participants attended between 3 and 8 sessions (M = 6.82, SD = 1.54).

3.2. Program Acceptability

Table 2 presents youth and adult participants' satisfaction with the program. On average, both youth and adult participants reported high levels of satisfaction with the program.

Across both cohorts, youth and adult participants described the MHA program in positive terms and highlighted the value of its interactive, youth-centered structure. Participants identified the advocacy project as one of the most meaningful aspects of the program, emphasizing the opportunity to create something tangible, purposeful, and impactful. Furthermore, shared activities, including icebreakers and collaborative exercises, were also viewed as important for building relationships, exchanging ideas, and strengthening connections within the group. Adult participants further noted the benefit of receiving educational content, including YMHFA, suicide prevention, and general mental health information. Overall, findings from both cohorts reflected strong engagement and satisfaction with the program. One youth participant said: *"It was something outside of school like it was kind of another thing that developed me and like is preparing me for college and applications and stuff, but also like obviously giving back to my community and like having. . . It's easy to do work and like research and whatever. But it's not always easy to have something to show for it. And so I think, having the brochure and having the video and having things that we can actually share*

out and like give back, it goes beyond me, which is really important to me." (Youth participant, Spring 2025).

Table 2. Program satisfaction ratings.

Item	Youth	Adults
	***M* (*SD*)**	***M* (*SD*)**
The sessions were well organized.	4.33 (1.00)	4.60 (0.69)
The facilitators were knowledgeable about the session content.	4.78 (0.44)	4.90 (0.31)
The facilitators were engaging and kept my attention.	4.33 (1.00)	5.00 (0.00)
I liked the sessions.	4.56 (0.72)	4.40 (0.69)
I would recommend the Mental Health Ambassador Program to a friend.	4.78 (0.44)	4.90 (0.31)
The in-person sessions were conducted effectively.	4.44 (0.72)	4.20 (1.68)
The online/virtual sessions were conducted effectively.	4.67 (0.50)	4.40 (0.84)

Note. Items measured on a 5-point scale.

Participants in Spring 2025 shared several factors that supported successful program implementation, while also offering suggestions for improvement. Overall, youth and adult participants viewed the curriculum as valuable and relevant. Content related to YMHFA, trauma and ACEs, suicide prevention, and onboarding was described as especially helpful. Youth further noted that receiving a completion certificate was meaningful recognition of their efforts.

There was a strong appreciation for the youth-led element of the program. A few of the youth participants noted that the youth-led aspect of the program was initially unexpected but a welcome surprise, while adults found it rewarding to observe as youth stepped up to lead and grow their leadership capabilities: *"The youth led aspect of it is really unique and really powerful, and walking away feeling like I can make a difference was, was huge. I always, always felt good when I left a session."* (Adult participant, Spring 2025).

Youth participants suggested expanding future content to include relationships, safety planning, boundary setting, and stronger neurodiversity representation. Adults recommended more visuals, printed materials, and structured guidance. Although survey ratings suggested that participants perceived both in-person and virtual sessions as being conducted effectively, focus group discussions revealed greater nuance. Participants appreciated the accessibility and convenience of virtual sessions; however, many described lower engagement, more distractions, and fewer opportunities for connection in the online format. In contrast, in-person sessions were described as more effective for hands-on learning, communication practice, relationship building, and collaborative advocacy project work. Across both cohorts, youth and adults requested more time and structure for completing advocacy projects, clearer communication before sessions, and additional instructional support during activities.

Table 3 presents youth-reported adult–youth connection and sense of belonging during the program. Overall, youth reported moderate levels of connection with adults and a strong sense of belonging during the MHA program.

Table 3. Adult–youth connection and youth sense of belonging ratings.

Youth	*M*	*SD*
Youth-reported Adult–Youth Connection [a]	3.16	0.60
Youth-reported Sense of Belonging [b]	8.57	1.45

Note. [a] Items measured on a 5-point scale. [b] Items measured on a 10-point scale.

Youth and adult participants in both cohorts described the MHA program as fostering meaningful connections among participants from diverse backgrounds, lived experiences, and social locations. Youth valued the inclusive and supportive community created through the program and identified building relationships as a meaningful aspect of their experience. Many youth noted that they first developed connections with peers and later became more comfortable engaging with adult mentors.

Adult participants similarly appreciated the unique opportunity to bring individuals from varied backgrounds together around a shared passion for mental health advocacy. They also described the program as a safe and comfortable space that supported communication, collaboration, vulnerability, and deeper mentoring relationships. Structured group activities, including icebreakers and guided discussions, were viewed as central to strengthening interactions, encouraging idea sharing, and promoting connection across the group.

3.3. Program Outcomes

Table 4 presents pre- and post-program outcomes for youth and adult participants, including awareness of resources, preparedness to address youth mental health, confidence in mental health conversations, confidence in referrals and resource sharing, and intention to intervene. Overall, both youth and adults reported improvements across these outcomes following program participation.

Table 4. Pre/post youth and adult outcomes.

Youth	Pretest *M* (*SD*)	Posttest *M* (*SD*)	*t*	*p*	Hedge's g
Awareness of Resources	3.92 (0.81)	4.85 (0.24)	−3.22	0.01	−0.96
Preparedness	3.55 (0.91)	4.77 (0.36)	−4.05	0.004	−1.21
Confidence in Mental Health Conversations	3.77 (0.78)	4.66 (0.28)	−3.41	0.009	−1.02
Confidence in Referrals	3.66 (0.93)	4.83 (0.35)	−3.74	0.006	−1.12
Intention to Intervene	4.29 (0.67)	4.70 (0.51)	−1.44	0.187	−0.43
Adults					
Awareness of Resources	3.59 (0.86)	4.88 (0.33)	−5.29	<0.001	−1.59
Preparedness	3.83 (0.82)	4.74 (0.45)	−2.96	0.018	−0.89
Confidence in Mental Health Conversations	3.74 (1.07)	4.81 (0.24)	−3.60	0.007	−1.08
Confidence in Referrals	3.94 (1.10)	4.77 (0.36)	−3.01	0.017	−0.90
Intention to Intervene	4.03 (1.00)	4.66 (0.44)	−2.44	0.040	−0.73

Note. Items measured on a 5-point scale. Negative values reflect that post-test scores were higher than pre-test scores.

Across the Spring and Fall 2025 cohorts, youth and adult participants described meaningful growth in mental health knowledge, awareness of resources, and confidence in supporting others, complementing the positive changes observed in the quantitative findings. Participants reported increased understanding of mental health concepts, including the impact of ACEs, greater familiarity with available mental health resources, and improved ability to make referrals or connect peers with appropriate support. Youth participants also described feeling more comfortable initiating conversations about mental

health with friends and family. In addition, youth reported developing practical skills such as active listening, sharing resources, communication, checking in over time, involving trusted adults or professionals when concerns become serious, leadership, and public speaking, and guiding supportive conversations. Adult participants similarly reported increased confidence discussing mental health topics, strengthening communication skills, and better understanding how to center youth voices.

4. Discussion

Growing youth mental health needs require equipping caring adults and youth with skills and confidence to talk about mental health, offer support, seek help, and/or provide referrals. Findings from this pilot study indicate that MHA, a group-based mental health literacy and youth-led advocacy program, is highly acceptable to youth and adult participants. The program appears to foster connection, sense of belonging, resource awareness, preparedness, and confidence in facilitating mental health conversations and referrals. Qualitative feedback mirrored these results. Participants highlighted the youth-led advocacy projects and the interactive, cohort-based structure as transformative elements. By bridging the gap between theoretical knowledge and real-world application, the program strengthened participants' capacity to serve as community experts, providing them with practical skills, such as active listening and resource mapping, necessary for early mental health intervention. Participants also identified several areas for improvement that inform program revisions. While virtual sessions increased accessibility, participants noted decreased engagement and fewer opportunities for organic connection compared to in-person learning. They also suggested expanding the curriculum while providing more time and structured guidance for the youth-led advocacy projects. All in all, these findings suggest that mentoring organizations are viable frontline settings for mental health conversations and support.

The study's findings reinforce the value of relational scaffolding as a preventative measure within youth mental health. Gains in preparedness, resource awareness, and confidence to talk about mental health and offer referrals suggest that participants derived both the knowledge and the self-efficacy required to navigate mental health challenges. Programs like MHA illustrate that when communities invest in equipping mentors and youth with these skills, they may be able to create accessible pathways to support, although more research is needed to determine how knowledge and confidence translate to action. Via manualized training and consistent adult guidance, the MHA program also appears to lessen the fear and emotional burden often experienced by youth who act as informal frontline responders (Bilello et al., 2024; Roach et al., 2021). Participants' specific requests for training in boundary setting reflect a sophisticated awareness of their own limitations, confirming that sustainable youth-led models must prioritize support for the supporters to ensure advocacy remains empowering rather than overwhelming.

The results also underscore the program's potential to enact positive youth development among adolescents, specifically by building competence and potential contribution to support mental health (Lerner et al., 2015). A key success of the MHA model was the youth-led advocacy project, which addressed a persistent gap in traditional mental health literacy by transforming theoretical knowledge into tangible community assets. This emphasis on structured contribution not only reinforced developmental gains (Dopson et al., 2017) but also shifted participants from service recipients to empowered experts (Jagosh et al., 2015). Ultimately, these projects allowed youth to exercise authentic agency, showing that when provided with the right tools and platform, young people can become active contributors to a more resilient community. Future research should further examine how the advocacy projects translate to community- or individual-level outcomes.

4.1. Implications for Practice

The MHA program offers an example of what community-based mental health support can look like. Specially trained youth and adults can play a meaningful role in recognizing and responding to mental health concerns when they are equipped with the right tools, knowledge, and shared language (Werntz et al., 2025). A key component of this youth-led, community-based approach is ensuring that support is not only available, but also relevant and actionable. Participants are taught how to have supportive conversations and identify relevant mental health resources. This allows program participants to move beyond awareness and into action, enabling them to navigate pathways to help others receive timely care in their own communities. This model is not meant to replace professional, clinical care. Instead, it fills a gap that often exists before young people ever receive formal services and/or serves as a supplement to clinical care as an extra layer of broadening support systems. Because this model embeds support within the trusting relationships youth already have, it also helps create low-risk entry points for conversation and early intervention.

To maximize feasibility and sustainability, program staff, educators, and youth-serving professionals should embed mental health literacy into the daily fabric of existing systems, such as schools, mentoring organizations, and after-school programs, rather than treating it as a standalone initiative. By using established staff, meeting times, and community partnerships, organizations can create consistent, non-stigmatizing support without the need for entirely new infrastructure. This approach is most effective when paired with clear guidance on roles and boundaries. Youth should be taught what it means to offer support, where their responsibility ends, and how to identify when a situation requires professional care. Programs should also include clear protocols for referring peers to the appropriate care when concerns escalate.

Finally, effective practice must shift the focus from passive learning to active contribution, reinforcing the "Sixth C" of PYD (Bowers et al., 2015; Geldhof et al., 2015; Lerner et al., 2015). By culminating training with a tangible advocacy project or community action, programs allow youth to transition into community leaders capable of driving systemic change. Formalizing this recognition through digital badges, certificates, or public showcases validates youth leadership and bolsters self-efficacy. When mental health initiatives combine accessibility and relevance with real-world application, they create the conditions necessary for a truly resilient community.

4.2. Limitations

There are several limitations to this study. First, the use of self-report measures for both youth and adult participants may introduce bias, including social desirability and shared method variance, which could inflate reported improvements in outcomes. Second, the study relied on a short-term pre-post design without long-term follow-up, limiting the ability to determine whether observed changes in mental health knowledge, preparedness, and confidence are sustained over time. Third, youth mental health was not assessed, limiting our ability to determine whether and how program accessibility and experiences may vary based on youth mental health profiles. Fourth, the small sample size and lack of a comparison group limit the generalizability of the findings. Additionally, the program was implemented across multiple mentoring sites, and variability in implementation across host sites (e.g., differences in context, facilitation, and participant engagement) may have influenced participant experiences and outcomes. Future research should include larger, more diverse samples, longitudinal follow-up assessments, and more standardized implementation procedures to strengthen the evidence base for the program.

4.3. Future Directions

Future research should prioritize the use of a comparison condition, larger sample, randomized controlled design, and longitudinal tracking to establish more robust evidence for the MHA model. While this pilot demonstrates strong initial acceptability and signals of positive change over time among participants, further testing is necessary to determine if these self-reported gains translate into sustained behavioral changes and actual community impact. Specifically, research should investigate whether the presence of trained ambassadors leads to an objective increase in youth accessing formal mental health services or a decrease in crisis-level escalations. Evaluating the referral-to-care pipeline will be critical in confirming if the MHA program effectively serves as a functional bridge to higher levels of care.

Additionally, future iterations must explore the integration of culturally specific mentoring to enhance the program's relevance for marginalized youth who face unique structural barriers and systemic stigma in accessing mental health care. As needed, culturally tailored versions of the MHA program should center on the specific cultural values, identities, and lived experiences of participants. By partnering with community leaders and incorporating culturally grounded mental health frameworks, the program can foster a deeper sense of belonging and relational trust. This approach is essential for advancing mental health equity, as it ensures that advocacy and support strategies are not only accessible but also culturally affirmed and trustworthy for diverse populations.

Finally, adapting the MHA model for direct integration into the school day represents a significant opportunity to increase its reach and long-term sustainability. Embedding the curriculum within existing structures, such as advisory periods, health classes, or social-emotional learning blocks, allows students to practice and apply mental health support skills in real-time within their primary social environment. A school-based approach effectively eliminates logistical hurdles like transportation and scheduling conflicts that can often limit outside participation in community-based programming. By aligning the MHA framework with state educational standards and fostering partnerships with school staff, the program can create a more seamless, preventative support system.

4.4. Conclusions

The MHA program represents a significant advancement in establishing community-based mentoring organizations as vital, non-clinical frontlines capable of addressing the youth mental health crisis. Through active participation, the program significantly increased resource awareness, preparedness, and confidence to talk about mental health and refer to resources when needed. Central to this success was the integration of PYD principles, particularly through youth-led advocacy projects, that transformed theoretical knowledge into tangible community assets. By intervening early in familiar, non-clinical settings, these programs may be able to mitigate the escalation of symptoms and reduce the immediate need for more intensive professional care, although more research is needed. All in all, the findings suggest that this type of mental health literacy programming can equip youth and adults to provide vital and appropriate mental health support within youth-occupied spaces.

Author Contributions: Conceptualization, E.P., B.J., Ċ.N. and L.M.W.; Methodology, L.M.W.; Formal analysis, C.H.M.; Writing—original draft, E.P., C.H.M., B.J., Ċ.N. and L.M.W.; Writing—review and editing, B.J. and L.M.W.; Funding acquisition, L.M.W. All authors have read and agreed to the published version of the manuscript.

Funding: This publication was made possible by the Centers for Disease Control and Prevention (CDC) under the non-research cooperative agreement CDC-RFA-CE23-0005: Essentials for Childhood:

Preventing ACEs through Data to Action. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the views of the CDC. This research was also funded in part by the Sauer Family Foundation.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of the University of Minnesota (STUDY00021236) on 16 January 2024.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available due to privacy restrictions.

Acknowledgments: We want to thank our community partners and the youth and adult participants who serve as critical partners in this work. We also want to acknowledge the collaborative contributions of Sarah Schaefer and Emily Geray and their dedication to youth mental health. Finally, during the preparation of this manuscript, the authors used Gemini 3 for the purpose of editing text for flow and effective organization.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

ACE	Adverse childhood experience
MHA	Mental Health Ambassadors
PYD	Positive Youth Development
YMHFA	Youth Mental Health First Aid

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