

2026

From Connection to Care

Year 2 of the Youth Mental Health Corps

A study by WestEd for the Youth Mental Health Corps

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Executive Summary

Across the country, millions of young people are navigating mental health challenges with too few trusted adults positioned to notice them when they are struggling or to clear paths to support when they do reach out.

The Youth Mental Health Corps (YMHC) is designed to address both youth mental health needs and labor market gaps. The program places young adults, ages 18 to 24, as near-peer mental health navigators in schools, community health centers, and after-school programs. For the young people it serves, it aims to expand access to mental health support. For the young adults who serve as navigators (referred to as *YMHC members*), it is a structured pathway into the behavioral health workforce, combining paid service, training, credentialing opportunities, and hands-on experience.

YMHC members serve as trusted first points of contact. They are not clinicians and do not replace licensed counselors or therapists. YMHC's near-peer model supports early intervention and prevention by making it easier for young people to ask for help and connect with professional care. The model is flexible, and each state adapts the framework to its particular needs.

In the 2025–26 school year, YMHC operated across 11 states: California, Colorado, Iowa, Maryland, Michigan, Minnesota, New York, Oregon, Texas, Utah, and Virginia. Since its launch in 2024, YMHC has deployed nearly 1,000 members across more than 490 service sites. YMHC members have served more than 75,000 youth and community members since the program's inception.

Evaluation of YMHC

This report presents findings from WestEd's evaluation of Year 2 (2025–26) of YMHC, using contribution analysis to examine the 11 states. Unlike an impact evaluation, which seeks to isolate a program's effects, contribution analysis examines whether the evidence supports the ways that YMHC is expected to contribute to change, along with everything else happening in young people's lives and in the organizations that serve them.

The evaluation examined whether YMHC made a meaningful contribution to the mental health outcomes and well-being of the youth it serves (Research Question 1) and the capacity of the schools, clinics, and community organizations in which members serve (Research Question 2). For each question, the evaluation identified three short-term outcomes and rated the evidence for each as *Strongest*, *Substantial*, or *Emerging*, reflecting how consistently an outcome appeared across the sources reviewed, not the size of its effect. Because the findings rest primarily on staff, leader, and member accounts from a single service year, they describe how YMHC appears to have contributed rather than establishing causal effects on clinical mental health outcomes.

Research Question 1 Findings

Did YMHC make a meaningful contribution to the mental health outcomes and well-being of the youth it serves? If so, how?

Even though YMHC is a flexible framework that each state adapts to its own context, three short-term outcomes were evident across all 11 states regardless of the setting.

Short-Term Outcome: TRUST AND CONNECTION

STRONGEST EVIDENCE

- Near-peer relationships made members feel more approachable.
- Repeated, consistent contact helped build familiarity and trust.
- Visibility and integration into everyday site routines created more opportunities for connection.

As one Maryland member described it, "I just make them feel seen and feel heard."

Short-Term Outcome: AWARENESS AND ACCESS

SUBSTANTIAL EVIDENCE

- YMHC members added a distinct, near-peer layer of support that complemented existing services.
- YMHC members expanded the availability and visibility of support.
- Access expansion depended on the local context.

In Colorado and Michigan, members created spaces, such as a calm room and a check-in corner. Members are there "to help support your caseload," as one California leader put it, not to replace school staff.

Short-Term Outcome: HELP-SEEKING

EMERGING EVIDENCE

- Trusted relationships gave youth a more comfortable starting point for seeking help.
- Members helped youth move from disclosure to connection with qualified adults.
- What happened after youth reached out depended on site capacity.

As one Maryland member described, "I'm going to walk you down to the counselor, and I'm going to be with you in the room." But the evaluation found no systematic tracking of whether a referral, once made, results in a young person connecting with services.

Research Question 2 Findings

Did YMHC make a meaningful contribution to the capacity of the schools, clinics, and community organizations where members serve? If so, how?

Short-Term Outcome: NEW OR STRENGTHENED PRACTICES AND ROUTINES

STRONGEST EVIDENCE

- Member-supported activities helped create or strengthen site practices and routines.
- Site conditions shaped whether new practices could take hold.
- Members contributed more effectively when they were integrated into day-to-day operations.

Maryland built a structured system for communicating across 12 host sites, one California program had supervisors and members complete orientation together from Day 1, and Iowa is centralizing its foundational training.

Short-Term Outcome: EXPANDED SERVICE REACH

SUBSTANTIAL EVIDENCE

- YMHC members filled distinct gaps in existing services.
- YMHC expanded what sites could offer.
- Added capacity translated into greater reach and varied by setting.

Smaller or less resourced organizations had a harder time. Oregon has been exploring "an administrative hub" so that several small organizations can share supervision and administration.

Short-Term Outcome: WORKLOAD RELIEF

EMERGING EVIDENCE

- YMHC members added capacity for supports and activities that existing staff could not consistently provide.
- YMHC member roles complemented existing staff responsibilities.
- Added YMHC member capacity may allow licensed staff to focus more on complex or high-need cases.

Supervisors described staff having more room to focus on complex cases, but staff time, caseloads, and waitlists are not yet measured.

Expected Longer Term Outcomes

The evaluation team drew on outside research, not evidence from this evaluation, to identify potential long-term outcomes. For youth, the short-term outcomes may lead to sustained mental health support, reduced crisis incidence, and educational stability in the long term. For host organizations, the short-term outcomes may lead to sustained organizational change, expanded community access, and a contribution to the workforce pipeline.

Looking Ahead

Three takeaways from the findings stand out, though the strength of the evidence varies across the six short-term outcomes:

Three Takeaways

YMHC added another approachable point of connection for young people.

Close in age and present where youth already spend time, members built trust through repeated contact, which gave some youth a comfortable starting point for seeking further help.

Members added capacity without replacing professional roles.

They provided a distinct layer of prevention, mentoring, and outreach, while licensed staff kept responsibility for clinical decisions and referrals.

Organizations strengthened the routines around the work, and site conditions mattered.

Sites with staffing, supervision, and systems to integrate a member were better able to put added capacity to use.

YMHC will not resolve the youth mental health crisis or the behavioral health workforce shortage on its own. But these early findings suggest a promising, flexible model that puts trusted, nonclinical support where young people already are and helps the organizations around them build stronger practices. Continued implementation and study can help clarify both what YMHC contributes and what other supports are needed for early progress to last.

Introduction

The Need for Youth Mental Health Support

Across the country, millions of young people are navigating mental health challenges with too few trusted adults positioned to notice them when they are struggling or clear paths to support them when they do reach out. The Youth Mental Health Corps (YMHC) was built to close that gap by placing young adults, ages 18 to 24, as near-peer mental health navigators in schools, community health centers, and after-school programs.

Youth mental health needs remain substantial even as some prevalence measures have begun to shift. For example, in 2024, 15 percent of adolescents aged 12 to 17 (about 3.8 million young people) had experienced a major depressive episode in the previous year, a decline from 18 percent in 2023 and from 21 percent in 2021.[i] Nineteen percent (4.9 million) reported moderate or severe symptoms of generalized anxiety the first year this measure was tracked nationally (2025).[ii] What has not shifted is the gap between need and care: Among adolescents with a major depressive episode in 2024, roughly 39 percent, an estimated 1.5 million young people, reported having received no mental health treatment in the previous year.[iii]

The labor market is not currently resourced to close that gap. As of December 2025, more than 137 million Americans—roughly 40 percent of the U.S. population—live in a federally designated Mental Health Professional Shortage Area, where on average only about one quarter of need is met.[iv] Projections through 2038 point to a shortage of nearly 100,000 mental health counselors and nearly 100,000 psychologists nationally if current trends continue. This gap reflects current service utilization and would be even larger if unmet need were fully captured.[v] This treatment gap, more than any single mental health prevalence trend, is the condition that YMHC is designed to address by creating an accessible first point of contact that can help more young people connect to existing supports.



live in a federally designated Mental Health Professional Shortage Area



number of adolescents who experienced a major depressive episode in the previous year



39% (~1.5 million) of adolescents

with a major depressive episode reported having received no mental health treatment in the previous year

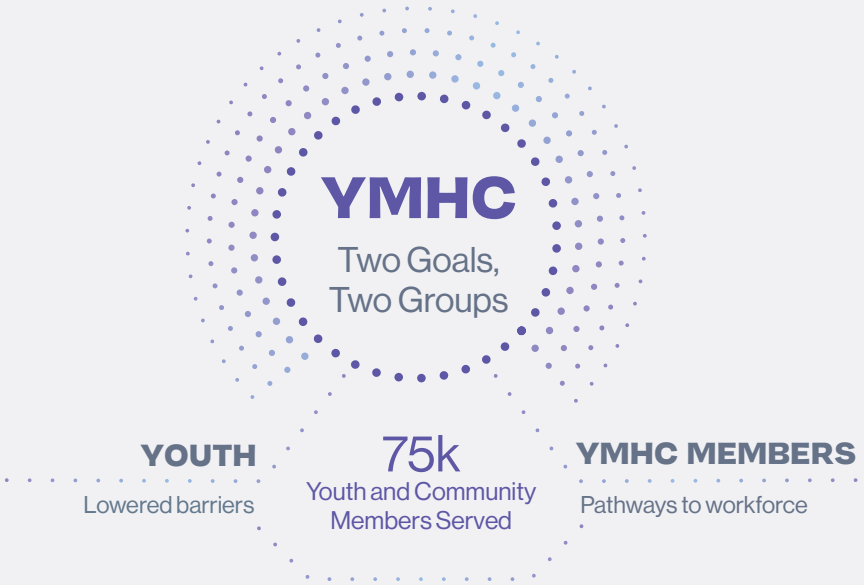
What YMHC Is and How It Works

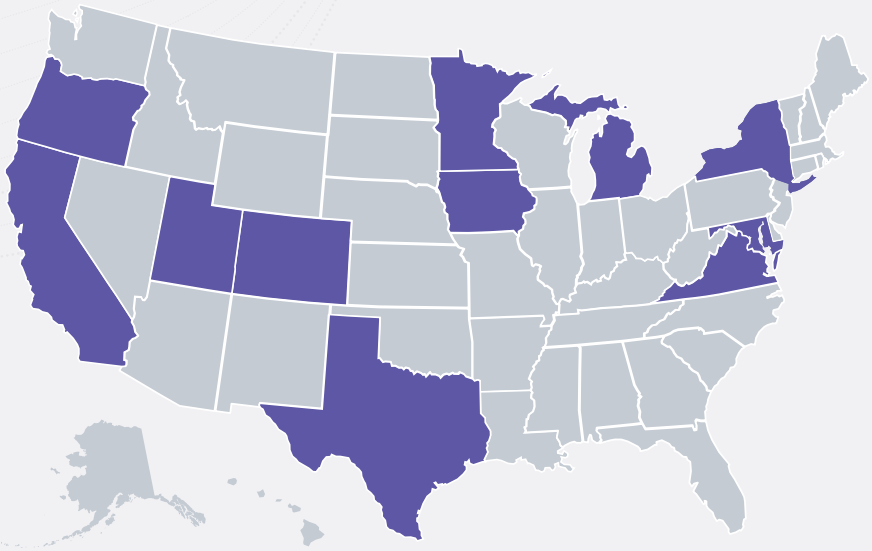
YMHC is designed to address both youth mental health needs and labor market gaps. For the young people it serves, it aims to expand access to mental health support and lower the barriers to seeking it. For the young adults who serve as the mental health navigators (referred to as *YMHC members*), it is designed as a structured pathway into the behavioral health workforce, combining paid service, training, credentialing opportunities, and hands-on experience navigating the systems many of them will go on to work in professionally.

YMHC members are not clinicians. They do not replace licensed counselors or therapists but rather serve as trusted first points of contact. The YMHC members are closer in age (generally between 18 and 24 years old) and experience to the youth they support.[vi] They are positioned to build the kinds of near-peer relationships that can make it easier for young people to ask for help and are equipped to connect them to professional care when more support is needed, and the licensed staff then decide on referrals and care. This near-peer model supports early intervention and prevention.

The model is flexible and state led rather than uniform. Each participating state's service commission adapts YMHC's core near-peer framework to its particular needs and decides how to recruit members and host sites and where to deploy them (for example, Texas, where schools already have counselors, focused on placing members in after-school programs and other community organizations). Each state's YMHC program places members at host sites (schools, clinics, and community organizations), and one program can span many sites. Typically, each site has one member—though more than one per site is possible—and designated host staff at each site serve as the member's supervisor.

Across participating states and host sites, members' day-to-day service can vary. A school-based member's service is shaped by class schedules and academic calendars, a clinic-based member's service is shaped by patient flow and care teams, and a rural member's service is shaped by geography and transportation in ways an urban placement is not.





YMHC Reach Since Launch

California
Colorado
Iowa
Maryland
Michigan
Minnesota
New York
Oregon
Texas
Utah
Virginia

~1,000 Members

75,000 Youth & Community Members Served

490 Service Sites

YMHC Reach

In the 2025–26 school year, YMHC operated across 11 states: California, Colorado, Iowa, Maryland, Michigan, Minnesota, New York, Oregon, Texas, Utah, and Virginia. Since its launch in 2024, YMHC has deployed nearly 1,000 members across more than 490 service sites in schools, community health centers, and after-school programs. YMHC members served more than 75,000 youth and community members during this period. Building on a first cohort of four states in 2024–25, YMHC's expansion reflects continued investment from the Schultz Family Foundation and Pinterest, alongside additional cross-sector funders that have joined the YMHC Collaborative Fund. The expansion also reflects growing interest from state service commissions in a model designed to address both the youth mental health crisis and the shortage of behavioral health professionals described above. Seven additional states not covered in this report completed planning in 2025–26 and began implementation in September 2026.

Evaluation of YMHC

This report presents findings from an evaluation conducted by WestEd of Year 2 (2025–26) of YMHC. It builds on WestEd's first-year study of YMHC, *Local Partnerships, National Impact: Year 1 of the Youth Mental Health Corps* (2025), which used in-depth site visits and case studies to profile four of YMHC's founding states: Colorado, Michigan, Minnesota, and Texas.[vii]

Approach

This evaluation extends that work by looking at all 11 states that implemented YMHC in 2025–26, using contribution analysis. Unlike an impact evaluation, which seeks to isolate a program's effects, contribution analysis examines whether the evidence supports the ways that YMHC is expected to contribute to change, along with everything else happening in young people's lives and in the organizations that serve them.

Research Question 1 (youth-focused):
Did YMHC make a meaningful contribution to the mental health outcomes and well-being of the youth it serves? If so, how?

Research Question 2 (site-focused):
Did YMHC make a meaningful contribution to the capacity of the schools, clinics, and community organizations where members serve? If so, how?

Evidence

For each question, the evaluation identified three short-term outcomes and rated the evidence for each, drawing on interviews, focus groups, and progress reports that reflect staff and member accounts:

- *Strongest Evidence*—The pattern appeared independently across multiple source types—such as member interviews, supervisor interviews, and report responses—with no contradicting accounts.
- *Substantial Evidence*—The pattern was consistent across states but rested more heavily on staff or leader reporting than on a validated measure or youth-reported data.
- *Emerging Evidence*—The pattern was credible and repeated but the evidence was thinner.

A detailed description of the methodology is in the Appendix.

Research Question 1 Findings

Did YMHC make a meaningful contribution to the mental health outcomes and well-being of the youth it serves? If so, how?

YMHC members serve as near peers. They are generally 18–24, close enough in age and lived experience to the youth they serve to build rapport quickly and distinct from the teachers, counselors, and clinicians already onsite. Because members are integral to connecting youth to relevant programs and support staff at each site, the findings for both research questions begin with what members do and then turn to the program features that inform and support that work.

Overview of What We Found

Even though YMHC is a flexible framework that each state adapts to its own context, three short-term outcomes were evident across all 11 states regardless of the setting.

Short-Term Outcome: TRUST AND CONNECTION

Strongest Evidence

- Near-peer relationships made members feel more approachable.
- Repeated, consistent contact helped build familiarity and trust.
- Visibility and integration into everyday site routines created more opportunities for connection.

Short-Term Outcome: AWARENESS AND ACCESS

Substantial Evidence

- YMHC members added a distinct, near-peer layer of support that complemented existing services.
- YMHC members expanded the availability and visibility of support.
- Access expansion depended on the local context.

Short-Term Outcome: HELP-SEEKING

Emerging Evidence

- Trusted relationships gave youth a more comfortable starting point for seeking help.
- Members helped youth move from disclosure to connection with qualified adults.
- What happened after youth reached out depended on site capacity.

These three short-term outcomes build on each other. Awareness opens the door, and trust brings a young person through it; and for a growing number of youth, that trust becomes the courage to ask for help.

Short-Term Outcome: TRUST AND CONNECTION

- Near-peer relationships made members feel more approachable.
- Repeated, consistent contact helped build familiarity and trust.
- Visibility and integration into everyday site routines created more opportunities for connection.

The short-term outcome of Trust and Connection was the strongest finding in the evaluation. Member interviews, supervisor interviews, and report responses were gathered separately, yet across every state we studied, they told a similar story: A young person who started out guarded slowly began to open up as a YMHC member kept showing up for them. Over time, that consistency can do more than build rapport. It can give young people the words and confidence to say what they are feeling and the confidence that someone will listen.

One Michigan member described spending weeks checking in with a quiet student who barely spoke:

> *I would just come to him constantly every day, ask him little bits of questions here and there ... just to see if he was okay. Over time, he slowly started to trust me. ... One day, he actually came over and sat with me at my desk, and that was what clicked for me. ... Being present and being consistent has been the most important part of my work. You should never rush the process and always be patient. Building trust takes time and students may not open up to you right away. If you continue to show up, stay consistent, and do your part, they will eventually come around. ... Always be yourself and don't fake it. Energy is everything, and students can tell when you're being genuine with them. Building real relationships with students starts with allowing them to see the real you.*

A CLOSER LOOK: IOWA

Showing Up as a Real Person, Not Just a Role

For one Iowa member, building trust started with something deceptively simple: letting the youth she worked with see her as a person, not just a role. She described sharing pieces of her own life—her hobbies, her friends, even her own struggles and losses—to show them that she understood what they were going through firsthand:

> *I personally think that just having somebody that's your own age or a similar age that is willing to talk about mental health is really important. ... I put my own personal pictures in there ... pictures of my own homework so that they can see that I'm a real person and I have real struggles too. ... Once I warm them up with talking about my own personal life ... I've noticed them open up a little bit more. But I share more than just photos of homework—sharing elements of my more personal life, like hobbies, friends, and struggles, is also really important for building rapport.*

That kind of ordinary self-disclosure was enough to help some youth open up "a little bit more"—a reminder that trust can take root in small, human moments rather than formal programming.

This pattern was not confined to Michigan. Members in two other states pointed to the same underlying mechanism: Consistency and relatability build the trust that everything else in this section depends on.

Being visible can also matter just as much as being approachable. When members are visibly woven into the everyday life of a school or program—such as in the classroom, lunch area, or hallway—students are able to learn who they are and what they are there for. One California member described a student who finally understood the member's role and the strategies she used, like coloring, to help students decompress: "You're not only here so I can color," the student told her, "you're also here when I have a problem with my friend, or when I'm feeling a little sad." That understanding, the member concluded, is when students are able to come to her, "when the door is open."

Members described intentionally making sure that the young people around them—not only the youth officially assigned to them—feel noticed and remembered. One Maryland member described keeping track of small details from earlier conversations, even weeks later: "I just make them feel seen and feel heard. ... Or even to bring up something that they mentioned a month ago and they'd be like, 'You remembered that? ... Oh, you really do care about me.'" Members in California and Iowa described this same pattern independently, in their own words—reaching youth who might otherwise go unnoticed, whether or not they were formally on their caseload.

Short-Term Outcome: AWARENESS AND ACCESS

- YMHC members added a distinct, near-peer layer of support that complemented existing services.
- YMHC members expanded the availability and visibility of support.
- Access expansion depended on the local context.

Before a young person can seek support, they have to know it exists and be able to actually access it. Across the country, YMHC members are addressing these awareness and access issues in ways that look different from place to place but add up to the same outcome: more young people finding their way to support.

In many communities, members created support structures that simply had not existed before. In Colorado and Michigan, for example, leaders

A CLOSER LOOK: CALIFORNIA

A Mentoring Program Triples Its Reach

A host site in California highlights how its YMHC member expanded student access to a districtwide mentoring program. This mentoring program matches students with school staff who support the student for the academic year. With limited resources, the program at one school site had the capacity to match 10 students. Within a year, the same site hosting the mentoring program went, in the program coordinator's words, "from a program of 10 matches to over 30 matches"—without adding a single new dollar to the school's budget. What changed was one person: a YMHC member who co-coordinated with a social worker to staff and expand the day-to-day work of running the program for her site—recruiting and following up with students, keeping the caseload moving, and staying present at the times when licensed staff were not available to circulate and catch students who needed attention. The mentoring program's leader told us,

> *The mentoring program would probably not exist in the same way [without the support of the YMHC member]. We would be looking at a much smaller number of students who are getting the support. ... When we have a full-time member placed at the school sites, they are doing a lot of the connecting with the mentors. They're doing a lot of the back end, making sure the pre-surveys and post-surveys are done, and so they're doing quite a heavy lift.*

Tripling a program's reach without adding a single new dollar is a striking example of a positive return on investment.

described member-created spaces where youth could go during the day for support or regulation—a calm room, a check-in corner—that had no equivalent before a member arrived. In other communities, members made it easier to find and use sources of support that already existed, such as a mentoring seat or a drop-in hour. Creating or strengthening support structures was an approach found across sites that had very different starting conditions, including both well-resourced and under-resourced schools and clinics and both urban and rural placements.

One of the clearest examples comes from California, where a school-based mentoring program grew dramatically once a YMHC member joined the team (see the text box above, A Closer Look: California). Members and leaders were also careful to describe how the role of YMHC members fit alongside, rather than in place of, the adults already doing this work—that is, a member's role is additive rather than duplicative of existing staff functions. In practice, that means members are positioned to potentially catch earlier stage concerns through their regular check-ins with youth. For instance, in one case, a student came to school hungry, and the member helped connect her with resources for food. In another, a student who had broken her computer was afraid to tell her parents, so the member worked with her to get it fixed. As one California leader put it, members are there "to help support your caseload," not to replace school staff.

What this looks like on the ground varies considerably by community. A member in a school might connect with students in the hallway or the lunchroom. A member in a rural community organization might be one of the few people a young person can turn to. As one leader of a rural Colorado program put it, "There's a little bit more variance to their services, but they're all kind of providing those individualized supports based on where they're placed."

Short-Term Outcome: HELP-SEEKING

- Trusted relationships gave youth a more comfortable starting point for seeking help.
- Members helped youth move from disclosure to connection with qualified adults.
- What happened after youth reached out depended on site capacity.

Building trust is often the first step toward enabling youth to ask for help. As one California district coordinator put it, watching students return repeatedly to a member's wellness center is a sign of trust: "The fact that the students are seeking them out is telling me the trust is there."

A CLOSER LOOK: MARYLAND

A Daily Routine That Connects Students to Care

At a YMHC host site in Maryland, every day before the first student walks in the door, the student support team, which includes a YMHC member, huddles to identify who is watching for what. Every day, after the last student leaves, they debrief to catch anything that surfaced during the day. Those daily routines may sound small, but they help ensure that the program effectively connects students to the appropriate services.

That daily rhythm means that when a YMHC member spots a student who needs more support, there is no guesswork or question of who to call—there is a clear and direct path to connecting a student to a clinician.

As members shared with us, they often physically walked youth to the support services to ensure the connection was established. As one Maryland member described, "I'm going to walk you down to the counselor, and I'm going to be with you in the room … because I want you to be safe." That sort of simple walk can make a routine handoff feel safe to a young person for whom that short walk can otherwise feel like the hardest part.

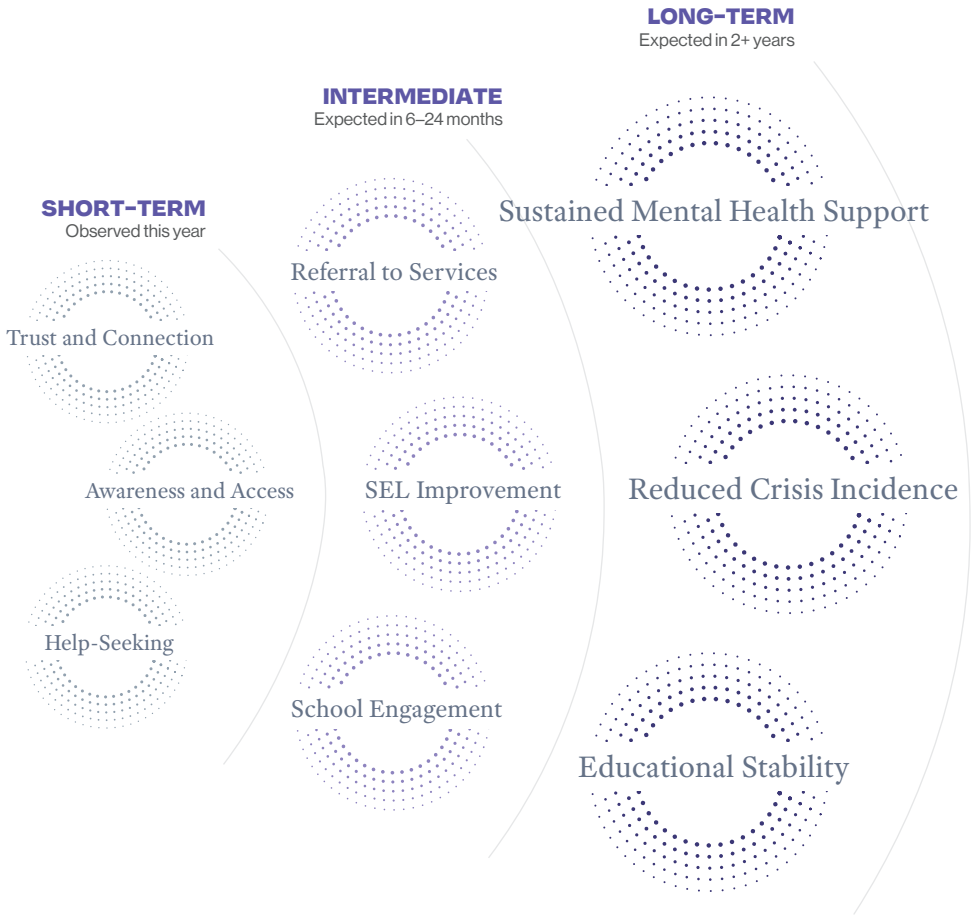
A site is ready for that sort of moment not only when it has trained and supervised its members well but also when it has built the capacity to receive those handoffs. When a site has built that capacity, as in Maryland (see the text box on p. 8, A Closer Look: Maryland), the path from a young person's first ask to actual care is clear and fast—they are told the name of the clinician who will provide support, taking out any guesswork about who to call.

That rhythm is not yet universal. No state in the 11-state portfolio currently tracks whether a referral, once made, results in a young person actually connecting with services. While we can document with confidence the moment someone reaches out, we are still building the evidence to track what happens afterward.

Expected Longer Term Outcomes

The findings for Research Question 1 described throughout this section reflect the short-term outcomes that have been observed in 2025–26 related to YMHC's youth-facing services. This section draws on outside research (not evidence from this current evaluation) to show the long-term outcomes that these short-term outcomes may lead to.

Figure 1. Expected Pathways From Short-Term to Longer Term Outcomes for Youth (Research Question 1)



Why these pathways are plausible: Research from other settings suggests links between the short-term outcomes found in this 2025–26 evaluation and the longer term outcomes summarized in the Figure 1. Warm handoffs (i.e., walking a young person to a counselor rather than just pointing the way), are linked to youth being 3 times more likely to follow through on care than they would be with a standard referral.[viii] School connectedness, which includes the sense that an adult at school knows and cares about you, is a documented protective factor against depression and anxiety.[ix] And students whose social–emotional skills grew over a school year were about half as likely to be chronically absent, no matter where they started.[x] These studies do not involve YMHC, and this evaluation did not observe the intermediate or long-term outcomes summarized in Figure 1. But this research offers a reason to track these pathways as YMHC matures.

Research Question 2 Findings

Did YMHC make a meaningful contribution to the capacity of the schools, clinics, and community organizations where members serve? If so, how?

Host organizations in this evaluation are the schools, community health clinics, and community-based organizations that took on a YMHC member for the service year. Host organizations are a single site.

Overview of What We Found

Across the portfolio, three consistent short-term outcomes reflect what changed for the organizations that hosted YMHC members.

Short-Term Outcome: NEW OR STRENGTHENED PRACTICES AND ROUTINES

Strongest Evidence

- Member-supported activities helped create or strengthen site practices and routines.
- Site conditions shaped whether new practices could take hold.
- Members contributed more effectively when they were integrated into day-to-day operations.

Short-Term Outcome: EXPANDED SERVICE REACH

Substantial Evidence

- YMHC members filled distinct gaps in existing services.
- YMHC expanded what sites could offer.
- Added capacity translated into greater reach and varied by setting.

Short-Term Outcome: WORKLOAD RELIEF

Emerging Evidence

- YMHC members added capacity for supports and activities that existing staff could not consistently provide.
- YMHC member roles complemented existing staff responsibilities.
- Added YMHC member capacity may allow licensed staff to focus more on complex or higher need cases.

Short-Term Outcome: NEW OR STRENGTHENED PRACTICES AND ROUTINES

- Member-supported activities helped create or strengthen site practices and routines.
- Site conditions shaped whether new practices could take hold.
- Members contributed more effectively when they were integrated into day-to-day operations.

What is perhaps the most distinctive feature in this section is not about a single service or activity. It is about how organizations changed the way they worked in order to integrate YMHC into their operations. Bringing a YMHC member on board meant figuring out how a new role fit into existing teams, clarifying expectations and boundaries, setting up supervision, keeping communication flowing across sites, and adjusting when something was not working. Across several of the programs in the participating states, meeting those demands left organizations with new or strengthened routines around communication, coordination, training, planning, and role integration. These are changes that may outlast any single member's term.

Building strong routines is not only about coordinating across sites. It also involves thinking carefully about how a member gets woven into a single site's daily life from Day 1 (see the text box on page 13, A Closer Look: California).

This California example makes it clear that placement alone does not create organizational capacity. Role clarity, supervision, communication, and staff buy-in determine whether an additional person provides additional capacity and that host organizations provide adequate supervision and meaningfully integrate members into daily operations.

A CLOSER LOOK: MARYLAND

Building One Communication Structure Across 12 Different Sites

Coordinating a single YMHC program across 12 host sites, each with its own schedule and organizational culture, is no small task. Maryland's YMHC program felt that strain directly and responded by building a more structured system that involved regular check-ins, centralized program updates, clearly defined expectations for both host sites and members, and additional technical assistance.

What began as a coordination challenge became a more structured way of supporting every site consistently, making the rest of the program easier to carry out.

Learning From Early Implementation

A few states are already putting first-year lessons to work using what they learned during initial implementation to reduce friction and strengthen the systems around members. Iowa's experience shows what learning from Year 1 can look like in practice (see the text box on page 14, A Closer Look: Iowa).

Two of Utah's YMHC programs have also started working more collaboratively by sharing resources, coordinating applicants and host sites, and referring potential host organizations to one another when a different program model is a better fit. These YMHC programs have been working, as one Utah report put it, "more efficiently as one initiative and not necessarily as two separate programs." Together with Iowa's experience, this suggests that states are using early implementation lessons to strengthen how YMHC is organized as it grows.

However, this kind of adaptation based on Year 1 lessons has not been automatic or universal. Maryland pointed to supervisory capacity, local budgets, and cost-share requirements as real barriers to securing host sites for Year 2, even as interest in the program "remains high." Oregon described similar challenges among smaller, less resourced organizations.

In general, organizations need a baseline of staffing, administrative support, and resources to integrate a member and build new routines around them.

Taken together, the evidence suggests that YMHC members added capacity to a range of host organizations and, where the right implementation supports were in place, strengthened how youth mental health work was organized and carried out.

Short-Term Outcome: EXPANDED SERVICE REACH

- YMHC members filled distinct gaps in existing services.
- YMHC expanded what sites could offer.
- Added capacity translated into greater reach and varied by setting.

For many YMHC host organizations, the clearest change was not a new program; it was more room to do the work they already believed in. Prevention, mentoring, youth engagement, wellness activities, and behavioral health support were already part of the mission at most sites. What YMHC members added was capacity to sustain and extend that work in places where existing staff could not consistently keep up due to everything else on their plates.

A CLOSER LOOK: CALIFORNIA

Setting Up Members and Supervisors as a Team From Day 1

In one California program, integration was not left to chance. Program supervisors and YMHC members went through the same orientation together, heard the same guidance about roles and boundaries, and started planning as a team from the very beginning. Members worked directly alongside school social workers, with supervisors continuing to check in on how the member role was fitting into daily activities and team responsibilities. A California district coordinator described what an orientation looked like in practice:

> *During that orientation, the AmeriCorps [YMHC] members are in the room hearing the exact same information around what those dos and don'ts are … it also helps to set it up in a way that you are a team and, "I am now going to work with you as a team and support you with this." So, during that day, they're actually starting to do some planning where the social worker can talk about … "These are the tier one activities that we have going. Here's how you can plug in." … And so from the very beginning, we're setting it up to where they are working together.*

In practice, having a YMHC member meant that some organizations could deliver more of the work they were already trying to do. As one Colorado state leader put it, host sites that have hosted returning members now have "a better idea of how to work with those programs and embed them into those specific departments" and can offer a deeper level of service than they could before a member arrived.

That added capacity was most useful in sites that were already positioned to put it to work. That is, organizations with staffing, supervision structures, and systems to integrate a member were better able to use the additional capacity. Sites still building those foundations—particularly smaller or less resourced organizations in which supervision, administration, staffing, and sometimes cost-sharing requirements can be a heavier lift—had a harder time doing so. A few states are already thinking creatively about that gap. For instance, Oregon has been exploring intermediary models that would let several smaller organizations share supervision and administrative responsibilities under one sponsoring hub—described in a report as "an administrative hub" for shared recruitment, supervision, and cost-share responsibilities—instead of having each site build that capacity alone.

All of these examples point to something worth keeping in view as YMHC grows: A site's starting capacity shapes how quickly, and how fully, it can put a member to use.

Short-Term Outcome: WORKLOAD RELIEF

- YMHC members added capacity for supports and activities that existing staff could not consistently provide.
- YMHC member roles complemented existing staff responsibilities.
- Added YMHC member capacity may allow licensed staff to focus more on complex or higher need cases.

Across the evaluation data, organizations consistently described YMHC members as taking on a distinct, complementary layer of work involving prevention, mentoring, informal support, outreach, and early identification, while counselors, social workers, clinicians, and other specialized staff kept responsibility for anything beyond that near-peer role. Members could notice an emerging concern and flag it, and licensed staff still made the call on whether a student needed formal services, a referral, or something else. In this way, members added capacity to the support system rather than stepping into work that

A CLOSER LOOK: IOWA

Turning Year 1 Implementation Into a Year 2 System

Running a new program can surface friction that a written plan cannot fully anticipate. In Iowa's case, that friction showed up around training. In Year 1, timelines and required resources for foundational training were communicated separately to programs, host sites, and members, adding coordination burden for everyone involved.

Rather than treat that friction as a one-off implementation issue, Iowa's team turned it into a structural fix for Year 2, during which the state centrally scheduled and monitored foundational training for YMHC. As Iowa's team reported,

> *We learned that consolidating timelines and required resources into a single document reduces burden on programs, host sites, and members. We are implementing this for all three groups in Year 2.*

This relatively small operational change reflected something larger: a program using its own first-year experience to reduce friction before it compounds.

was already someone else's job. This is the additive, not duplicative, role that the YMHC model and the evaluation design assumes members should play.

A California district coordinator described what that additive role looks like day to day:

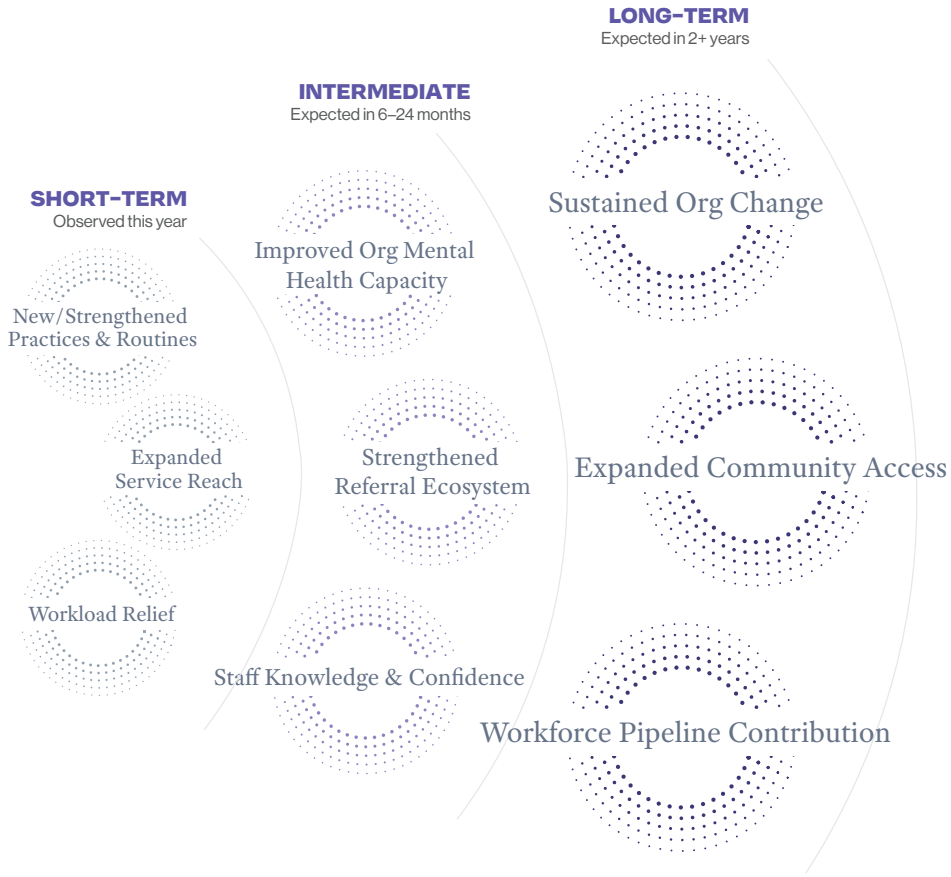
> *They'll say to the social worker, "I think something might be going on." And then the social worker takes it from there and does their job and will either take the student on into their caseload or refer the student or family out to other services. So, it's really helping the social worker understand how to triage the cases and the students that come in.*

The changes that supervisors described tended to be staff having more room to focus on complex or intensive cases—an early signal worth following. What the participating states cannot yet show is how far that translates into freed-up time for licensed staff specifically. There are no standardized measures of staff time, caseloads, or waitlists before and after a member's arrival, so it is difficult to say how common or how large that shift is. This is a question of building the right measurement.

Expected Longer Term Outcomes

The Research Question 2 findings described throughout the section reflect how YMHC contributed to host organizations as of 2025–26. This section draws on outside research (not evidence from this current evaluation) to show the long-term outcomes that these short-term outcomes may lead to.

Figure 2. Expected Pathways From Short-Term to Longer Term Outcomes for Host Organizations (Research Question 2)



Why these pathways are plausible: Research from other settings suggests links between the short-term outcomes and the longer term outcomes summarized in Figure 2. New or Strengthened Practices & Routines has the clearest backing in the research. A systematic review of school-based public health interventions found that whether new practices are sustained depends heavily on organizational factors such as leadership, staff capacity, and fit with existing systems, not simply on whether an intervention has evidence of effectiveness.[xi] That is consistent with what California, Iowa, Maryland, and Utah described here: Leadership attention, role clarity, communication, and staff buy-in were central to building stronger routines around the work.

Expanded Service Reach (i.e., members adding capacity that lets organizations do more of the work they were already committed to) is also supported by related research. A recent study of federally funded school mental health initiatives in Tennessee found significant declines in diagnosed mental

health conditions and disciplinary incidents alongside efforts to increase school mental health capacity.[xii] This study illustrates why added capacity is worth following as a mechanism for longer term change.

Workload Relief remains the more tentative of the three: Research on school counselors links heavy noncounseling duties and large caseloads to burnout risk,[xiii] and a related study found case managers in a Veterans Affairs behavioral health program describing workload shifts once peer specialists took on client contact.[xiv]

These studies do not involve YMHC, and this evaluation did not observe the intermediate or long-term outcomes summarized in Figure 2. But this research offers a reason to track these pathways as YMHC matures.

Looking Ahead

In its second year, YMHC operated in 11 states, each of which adapted the model to meet its particular needs. Despite those differences, the findings from Research Questions 1 and 2 point to a consistent pattern: YMHC is helping young people connect with support while expanding what host organizations can provide. Three takeaways stand out, though the strength of the evidence varies across the six short-term outcomes (as described in the findings):

Three Takeaways

YMHC added another approachable point of connection for young people.

Close in age and present where youth already spend time, members built trust through repeated contact, which gave some youth a comfortable starting point for seeking further help.

Members added capacity without replacing professional roles.

They provided a distinct layer of prevention, mentoring, and outreach, while licensed staff kept responsibility for clinical decisions and referrals.

Organizations strengthened the routines around the work, and site conditions mattered.

Sites with staffing, supervision, and systems to integrate a member were better able to put added capacity to use.

The evaluation's short-term outcomes suggest that YMHC is helping young people build trust and connect with support, as well as expanding what schools, clinics, and community organizations can provide. Whether these contributions lead to lasting improvements remains to be established. Understanding that progress would require looking beyond the initial connection between the member and the student to whether referrals lead to services, whether young people continue receiving the support they need, and whether their well-being improves over time. These questions extend beyond YMHC because a young person's care may involve several organizations, each able to see only part of that experience.

YMHC will not resolve the youth mental health crisis or the behavioral health workforce shortage on its own. But these early findings suggest a promising, flexible model that puts trusted, nonclinical support where young people already are and helps the organizations around them build stronger

practices. Its longer term contribution will depend in part on the broader system's capacity to respond when young people seek help. This points to shared work for YMHC, schools, clinics, community organizations, and funders: strengthening connections to care and developing practical ways to understand what happens afterward. Continued implementation and study can help clarify both what YMHC contributes and what other supports are needed for early progress to last.

Appendix: Methodology

This appendix describes the methodology used to inform this evaluation. This section is intended to give funders, partners, policymakers, and others enough grounding to understand how the report's findings were developed and what level of confidence they support, without requiring readers to have a technical research background.

Building on Year 1

This report builds on WestEd's first-year study of YMHC, *Local Partnerships, National Impact: Year 1 of the Youth Mental Health Corps* (2025), which used in-depth site visits and case studies to profile four of YMHC's founding states: Colorado, Michigan, Minnesota, and Texas. This evaluation extends that work by looking at all 11 states implementing YMHC in 2025–26, and it applies a more structured methodology of contribution analysis.

Evaluation Approach: Contribution Analysis

The WestEd evaluation team used contribution analysis as the primary methodology to conduct the evaluation. Contribution analysis is an approach for evaluating programs like YMHC that operate in complex, multi-actor environments in which schools, clinics, state agencies, other support programs, shifting policies, and broader conditions all simultaneously influence youth mental health. In these environments, a traditional experimental design (e.g., comparing outcomes for youth who did and youth who did not receive YMHC support) is not feasible.[xv]

This approach does not attempt to prove that YMHC alone caused a given outcome. Instead, it systematically tests whether the evidence is consistent with YMHC having contributed to observed changes; considers other plausible explanations; and is transparent about where the evidence is strong, where it is suggestive, and where it is simply not yet available. Where the evidence supports it, we describe what changed and how YMHC members appear to have contributed to that change. We do not present findings as proof of program impact in the way a controlled study would.

Two Research Questions Guiding This Evaluation

This evaluation examines the following two research questions that reflect the two groups at the center of the YMHC model: young people receiving support and the schools, clinics, and community organizations where members serve:

- **Research Question 1 (youth-focused):** Did YMHC make a meaningful contribution to the mental health outcomes and well-being of the youth it serves? If so, how?
- **Research Question 2 (site-focused):** Did YMHC make a meaningful contribution to the capacity of the schools, clinics, and community organizations where members serve? If so, how?

Program Assumptions

Contribution analysis works by testing a set of underlying assumptions about how a program is

expected to create change. Underlying YMHC's design are 10 specific assumptions that our research team developed about how the model is supposed to work:

- Young people will trust and open up to YMHC members, enabling help-seeking that might not otherwise occur.
- Host organizations provide adequate supervision and meaningfully integrate members into site operations.
- When members make referrals, those referrals lead to meaningful next steps for students rather than ending at the point of referral.
- Site conditions (readiness, leadership buy-in, existing infrastructure) enable members to work effectively.
- YMHC adds value beyond what was already available at the site—the counterfactual test.
- The member's role is additive, not duplicative—members do things that would otherwise go undone rather than repeating existing staff work.
- Having a member onsite redirects licensed staff time toward higher acuity work.
- Member activities lead to durable changes in site practices that outlast the member's term of service.
- The quality of supervision that members receive is net positive for their effectiveness onsite.
- Site type (school, clinic, or community-based organization) shapes the member's role, activities, and outcomes profile.

These assumptions guided this evaluation, spanning both research questions. Interviews, focus groups, and progress-report data were coded against these assumptions to identify recurring themes and to see where the evidence was strongest.

Data Sources

Findings draw on five sources of evidence collected between spring and fall 2026. Interviews and focus groups were conducted with program leads, state commission leads, YMHC members, and site supervisors. These were supplemented by a review of open-ended responses from state progress reports.

Table A1. List of All Data Sources Used

Source	Number
Interviews with program leads, directors, and supervisors for target states (California, Iowa, and Maryland)	14
Interviews with state service commission leads for all 11 participating states	11
Interviews with YMHC members from target states (California, Iowa, and Maryland)	8
Review of responses to open-ended questions from reports from Y2 states (California, Iowa, Maryland, New York, Oregon, Utah, and Virginia)	7
Focus groups with YMHC members representing California, Colorado, and Michigan	4

Focal States and Portfolio States

Three states—California, Iowa, and Maryland—were selected for deeper, structured interviews. They serve as the basis for the vignettes that appear throughout this report. These states were chosen to allow for in-depth data collection and to provide a range of implementation contexts for closer examination. They are intended as illustrative examples of how YMHC operates, not as a judgment that these states are more representative or more successful than others.

All 11 participating states—California, Colorado, Iowa, Maryland, Michigan, Minnesota, New York,

Oregon, Texas, Utah, and Virginia—contributed to the portfolio-wide findings presented in this report through state commission interviews and, where available, progress-report data.

Analytic Process

The evaluation team followed a consistent analytic process:

1. Coded interviews, focus groups, and progress-report entries using the 10 program assumptions as organizing categories
2. Identified recurring subthemes within and across coded assumptions
3. Examined which assumptions were most strongly aligned with each short-term outcome, including how frequently they appeared and how consistently they were represented across states
4. Refined the language of the assumptions based on the themes that emerged from the evidence
5. Mapped the strongest assumptions and themes to the RQ1 and RQ2 outcome frameworks
6. Assessed the breadth and consistency of evidence across states to inform the RQ1 and RQ2 findings writeups.

How to Read the Findings

This report uses three evidence labels to distinguish between findings that are well supported and findings that are still emerging:

- **Strongest Evidence** for patterns that appeared independently across multiple source types (e.g., member interviews, supervisor interviews, report responses) with no contradicting account
- **Substantial Evidence** for patterns that were consistent across states but rested more heavily on staff or leader report than on a validated measure or youth-reported data
- **Emerging Evidence** for patterns that were credible and repeated but thin, often because only the first part of a mechanism could be observed clearly

These tiers describe how consistently a pattern appeared across the sources reviewed. They are not intended or used as statistical measures of effect size.

A few additional principles guided how findings are presented:

- Qualitative frequency—how often a theme came up across interviews and states—tells us where the energy in the data is. It is not a statistical measure of impact, and it is not treated as one.
- Citations and examples were checked against the intended message of each subsection. Sources that did not clearly support a claim were set aside rather than used speculatively.
- Unconfirmed or emerging findings are framed with appropriate tentativeness and are clearly distinguished from findings grounded in converging evidence.
- The Expected Longer Term Outcomes subsections describe what the short-term outcomes may lead to over time. They draw on outside research, not evidence from this evaluation, and the evaluation did not observe those outcomes.

Scope and Limitations

This evaluation can credibly speak to the following:

- the patterns of need and support that YMHC members address and the volume and nature of the support provided
- suggestive evidence of increased help-seeking and referral activity, based on staff and member accounts
- staff- and member-reported perceptions of improved student access to support and improved host-organization capacity
- ways that implementation varies across site types and contexts and what that variation suggests about where YMHC's contribution is strongest

This evaluation cannot support the following:

- causal claims about clinical mental health outcomes

- direct attribution of changes in attendance or behavioral-incident rates to YMHC specifically, absent other confirming evidence
- generalized improvement claims based on validated pre- and post- instruments, which are not consistently in place across the 11 states
- conclusions about whether changes for youth or host organizations last beyond a member's term since the evaluation covers a single service year

These boundaries reflect what contribution analysis can and cannot establish given current data conditions across the YMHC portfolio.

A small number of structural conditions affect how findings should be interpreted across every state:

- Definitions of who counts as "served" vary across states. For example, some states use a pre- and post-completion standard while others use a broader "any participation" threshold, so state-to-state comparisons of reach should be read with that caveat in mind.
- No state currently has a functioning system for tracking whether a referral that a member initiates results in a student actually connecting with professional services. Evidence about referrals is strongest at the point of initial handoff and weaker about what happens afterward.
- Host-organization capacity evidence is drawn primarily from qualitative interview and progress-report accounts rather than a validated organizational instrument.
- There is no standardized pre- or post- measure of staff time, caseloads, or waitlists across sites, so Workload Relief cannot yet be quantified.

Endnotes

i Substance Abuse and Mental Health Services Administration. (2025). ***Key substance use and mental health indicators in the United States***.

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iv Health Resources and Services Administration, Bureau of Health Workforce. (2026). ***Designated Health Professional Shortage Areas***.

v Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. (2025). ***Health workforce projection***s.

vi This report uses the term ***youth*** as the broad term for those served by the YMHC members and ***students*** specifically when the setting is a school.

vii Huebner, T. (2025). *Local partnerships, national impact: Year 1 of the Youth Mental Health Corps*. WestEd. https://www.wested.org/resource/local-partnerships-national-impact-year-1-of-the-youth-mental-health-corps/

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ix Raniti, M., Rakesh, D., Patton, G. C., & Sawyer, S. M. (2022). The role of school connectedness in the prevention of youth depression and anxiety: A systematic review with youth consultation. *BMC Public Health*, *22*(1), Article 2152. https://doi.org/10.1186/s12889-022-14364-6

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xv Mayne, J. (2001). Addressing attribution through contribution analysis: Using performance measures sensibly. *Canadian Journal of Program Evaluation*, *16*(1), 1–24; Mayne, J. (2012). Contribution analysis: Coming of age? *Evaluation*, *18*(3), 270–280. https://doi.org/10.1177/1356389012451663