CHAPTER 4

Youth initiated mentors: Do they offer an alternative for out-of-home placement in youth care?

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ABSTRACT

The present study evaluates the Youth Initiated Mentoring (YIM) approach in which families and youth care professionals collaborate with an informal mentor, who is someone adolescents (12-23) nominate from their own social network. The informal mentor can be a relative, neighbour or friend, who is a confidant and spokesman for the youth and a cooperation partner for parents and professionals. This approach fits with the international tendency in social work to make use of the strengths of families socialt networks and to stimulate client participation. The current study examined through case-file analysis of 200 adolescents (YIM group n = 96, residential comparison group n = 104) whether the YIM approach would be a promising alternative for out-of-home placement of youth with complex needs. A total of 83% of the juveniles in the YIM group were able to nominate a mentor after on average 33 days. Ninety percent of the adolescents in the YIM group received ambulatory treatment as an alternative for indicated out-of-home-placement, while their problems were largely comparable with those of juveniles in Dutch semi-secure residential care. Results suggest that the involvement of important non-parental adults may help to prevent out-of-home placement of adolescents with complex needs.

INTRODUCTION

Professional care for juveniles with complex needs, who may be at risk for out-of-home placement, often lacks continuity (Ungar et al., 2014). Research suggests that at least one person should provide continuity for these juveniles and help them to express their needs (Pehlivan & Brummelman, 2015). Given the instability that youth with complex needs experience in their own family – due to disturbed relationships – the search for 'arenas of comfort' is urgent, particularly during adolescence (Mortimer & Call, 2001). An arena of comfort is a soothing and accepting context or a supportive relationship that gives the juvenile the chance to relax and rejuvenate, so that potentially stressful experiences and changes in another arena can be endured or mastered.

Although many youth services try to establish continuity and client participation through organisational solutions (e.g., working with a case manager, a treatment trajectory coach), we focus on strengthening the juvenile's network through collaboration with an informal mentor, a Youth Initiated Mentor (YIM). This informal mentor is a person (e.g., relative, neighbour, or friend) adolescents nominate from their own network, and who functions as a confidant and spokesman for the adolescent and a cooperation partner for parents and professionals (Schwartz et al., 2013; Spencer et al., 2016; Van Dam & Verhulst, 2016). This fits with the international tendency in child and family social work to make use of the strengths of families and their own networks and to stimulate client participation (Burford, 2005; De Winter, 2008). The goal is to reduce psychological and behavioural problems of youth and family and to increase their resilience through collaboration with the family and its social network.

Social networks are defined by the connections among the network members and contagion, that is, what is distributed through the existing connections (Christakis & Fowler, 2012). Professional involvement expands the existing network by adding new connections, and influences the contagion by distributing new information. However, this expansion is temporary and its influence is often limited (Euser et al., 2015; 2014; Weisz et al., 2013), which is especially the case during out-of-home placement: there is a lack of continuity and trustworthy relationships due to placement instability (Strijker et al., 2008). Also, the negative consequences of instability of foster care placements have been highlighted in a vast body of research (Rock et al., 2015). The impact of out-of-home placement on a family is substantial, it is traumatic and has a negative influence on, for example, academic performances of youths (Stone, 2007). The positive effect of out-of-home placement on children's psychological functioning is modest at best (Goemans et al., 2015; Strijbosch et al., 2015). Therefore, and as also stated in the international Convention on the Rights of the Child (United Nations [UN], 1990), out-of-home-placement should be a last resort option.

As the expansion of the social network through involvement of professionals is temporary and the influence is limited, especially during out-of-home placement, alternatives to out-of-

home placement are needed. Collaborating with the social network of the family may offer more sustainable solutions. In particular, we assume that collaborating with an informal mentor can offer a new way to make use of existing connections and expand their contagion, resulting in more continuity and better client participation during treatment. This paper describes the theoretical background of a newly developed approach that makes use of collaboration with a youth initiated mentor (i.e. the so-called 'YIM approach') and the results from a first evaluation study of this approach.

THEORETICAL BACKGROUND OF THE YIM APPROACH

Adolescence, complex needs and the need for supportive relationships

Supportive social relationships, particularly perceived social support and social integration, are generally recognized as beneficial for individuals' health (Cohen, 2004). Social support concerns a social network's provision of psychological and material resources intended to benefit an individual's ability to cope with stress (House & Kahn, 1985). Social support eliminates or reduces the effects of stressful experiences by promoting effective coping strategies, such as less threatening interpretations of adverse events (Kawachi & Berkman, 2001). Social integration reflects participation in a broad range of social relationships and promotes positive psychological states, such as self-worth and positive affect, which induce health-promoting physiological responses (Brisesette et al., 2000). Social integration is thought to provide information and to be a source of motivation and social stimulation to care for oneself (Cohen, 2004). Negative social interactions, on the other hand, may elicit psychological stress and physiological concomitants that increase risks for disease (Cacioppo et al., 2002).

During adolescence youths re-examine the way in which they express experiences and feelings to their parents (Keijsers et al., 2010) in order to develop their autonomy and independence and a more equal relationship with their parents (Branje et al., 2013). This developmental task is related to another task, namely, to create and maintain supportive relationships with other adolescents (Goede et al., 2009) and non-parental adults. Non-parental adults can be supportive individuals with informal or formal status who are a natural part of the family's social environment (Kesselring et al., 2016). Longitudinal research (Werner, 2005; 1993) has shown that youths who formed bonds with supportive non-parental adults are more resilient: the bond buffers against risk factors. This is confirmed by a meta-analysis (Zolkoski & Bullock, 2012). Research indicates that vulnerable juveniles find it difficult to establish positive natural relationships due to low self-esteem, lack of trust and social skills deficits (Ahrens et al., 2011).

Effective collaboration with social networks

Integrating professional involvement with informal mentoring is thought to stimulate shared decision making between families, their social network and professionals, and it enhances client participation. This idea of shared decision making and participation is in line with the concept of the educative civil society, in which the joint activities of citizens in the upbringing of children and adolescents are emphasized (De Winter, 2008). The effectiveness of activities aimed to realise an educative civil society with a focus on meeting, dialogue, enhancing neighbourhood climate and network formation, are promising (Kesselring et al., 2015). Shared decision making with the social network means that the learning goals are created with and embedded in the family's social network, which is thought

to result in personal goals that are selected for autonomous reasons (Koestner et al., 2002). These self-concordant goals increase goal-directed effort, and thereby facilitate development in juveniles (Vasalampi et al., 2009). However, shared decision making with the social network may not always yield positive effects. For instance, a recent meta-analysis did not find robust empirical evidence for the effectiveness of family group conferences – a process led by family members to plan and make decisions for a child who is at risk for maltreatment – and even reported non-anticipated results that may even be evaluated as negative from a family preservation perspective, such as increase in the number and length of out-of-home placements with older children and minority groups (Dijkstra et al., 2016). Such lack of positive effects may be explained by the collaboration of too many persons (i.e., all relevant social network members), because research shows that teams with more than five individuals perform worse than smaller teams (Mueller, 2012).

A more effective way of collaborating with multi-problem families and their social network might be to start with asking the juvenile in need to nominate a Youth Initiated Mentor (Van Dam & Verhulst, 2016). Working with a YIM requires a functional position of the YIM. From a social psychology perspective, this reduces the possibility of social loafing: the presence of others results in less effort (Liden et al., 2004). Although, if the positioning of this person is not accepted by the family, social network and professionals, his or her input can backfire on the results of the team (Harre et al., 2009). This process of positioning is a so-called top-down process, which includes setting a group structure, norms and routines that regulate collective behaviour in ways that enhance the quality of coordination and collaboration (Woolley et al., 2015). Top down processes facilitate collective intelligence, or the general ability of a group to perform well across a wide range of different tasks (Woolley et al., 2010). The YIM approach translates those insights into a methodology, to create lasting and functional pedagogical alliances between the family and its social network.

The YIM approach in social work

Relationships with non-parental adults might serve as informal and natural mentoring relationships, and are a predictor of adolescent health (DuBois & Silverthorn, 2005). Taking advantage of and strengthening these existing supportive relationships in working with vulnerable youth recently received attention in America as an intervention strategy, designated as Youth Initiated Mentoring (YIM) (Schwartz et al., 2013; Spencer et al., 2016). The YIM approach is a systemic treatment approach in which access, mobilisation and consultation of informal mentors is a central aspect (Van Dam & Verhulst, 2016).

The YIM approach is characterized by four phases. The total duration of the treatment is between six and nine months. The overall duration and the duration of each separate phase depends on the complexity of the problems, the willingness and the possibilities of the family members, the social network and the professionals to collaborate with each other. Phase 1 is focused on 'who':

which member of the social network can become the YIM? The professionals seek collaboration with an informal mentor by stimulating youth to nominate a person in their environment they trust (*eliciting*). After nomination, the YIM is *informed* about the YIM-position and *agreements* are made about privacy, termination and the type of support he or she provides when *installed* as 'the YIM'. Phase 2 is focused on 'what': what is everyone's perspective on the current and desired situation? By means of shared decision making, youth, parents, YIM, and professionals *analyse* the individual and family problems and describe productive solutions that respect the family members' autonomy. Phase 3 is focused on 'how': each participant can contribute to the desired situation. All participants provide advice about how to collaborate, and a plan is made in which the *learning goals* and *efforts* to reach those goals are described and acted upon. The plan serves as a *monitoring* tool during enactment of the plan. Phase 4 is focused on 'adaptivity', that is, the degree to which the current informal pedagogical alliance can meet new challenges? When all involved parties agree the *social environment* or family members' *self-regulation* secures safety of the adolescent and promotes his or her development (Saxe, Ellis, & Brown, 2015), which could make professional care unnecessary.

During the final meeting the parties discuss the system's adaptivity - how will the family and YIM deal with new challenges, and can the informal pedagogical alliance do its work if necessary - and they make agreements about the professional's availability. Usually the family is allowed to reach out to the professionals during the next months if necessary. A good working alliance and a continuous process of shared decision making between all involved parties is crucial in all four phases. The phases, described from the perspectives of the formal involvement (professionals), family and natural mentor, are illustrated in Figure 1, in which the direction is emphasized to the extent that formal involvement decreases with increasing informal problem ownership.

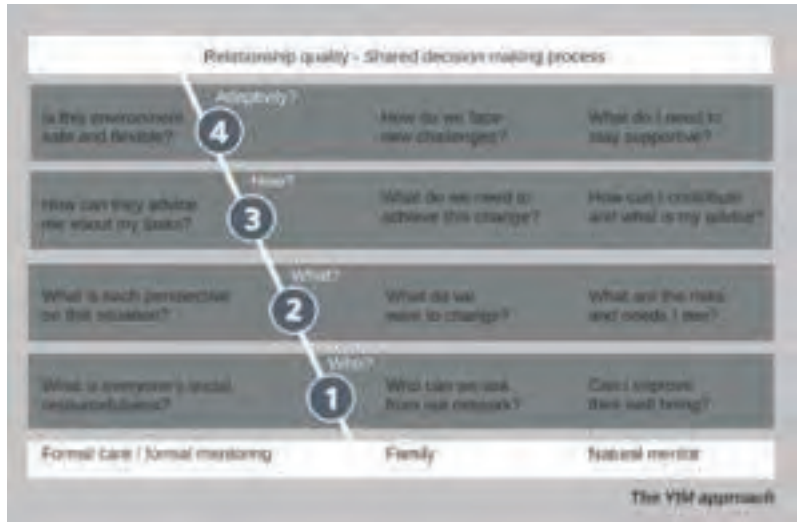

Figure 1: The four phases of the YIM approach

The YIM approach focuses on reducing psychological and behavioural problems of youth and family and is meant to increase their resilience. The overall goal is to create adaptive informal pedagogical alliances with enough collective intelligence to cope with new stressful situations and work on productive solutions that respect the family members' autonomy.

The YIM-approach has implications for the total process of professional care, including diagnostics and treatment. Creating sustainable decision-making partnerships between family and the social network becomes an integral and continuous part of treatment (Walker et al., 2015). The professional uses knowledge and techniques from position theory to realize a positioning of the youth initiated mentor that is viable for all participants (Harre et al., 2009), and from systemic theory to create lasting and healthy informal partnerships (Bronfenbrenner & Morris, 2007). The professional stimulates the family members' social resourcefulness, that is, family members' covert and overt behaviour to request and maintain support from others (Rapp et al., 2010). Enhancing social resourcefulness is meant to optimize capacity of the involved adolescents to cope with stressful life events.

Due to differences in quality, intensity and nature of the relationship between the informal mentor and juvenile, professionals need to be flexible and responsive to each unique relationship. The kind of support the YIM offers depends on the capacities, needs and interests of both the mentor and the juvenile, the individual and family problems and type of support the juvenile needs, and the fit between the two persons. In general, the type of support consists of five basic elements: social emotional support (e.g., providing a listening ear), practical support (e.g., support with writing an application letter), guidance and advice (e.g., regarding work or education), role modelling (including normative guidance) and social capital (providing acces to a supportive social network) (Spencer et al., 2016).

In this study, we use data from the six organisations which originally developed the YIM-approach, and examine whether or not YIM is a feasible ambulant alternative for early and late adolescents with complex needs for whom out-of-home placement is indicated. We will examine if 1) youths are able to nominate an informal mentor at the start of treatment, 2) if they receive solely ambulatory treatment and 3) if the population of the YIM group is comparable with two residential populations of Dutch youths.

METHODS

Participants

Case-file analyses were conducted on a total of 200 youths to compare the nature of problems between youths who received ambulant treatment (YIM group, n = 96) and those who received residential treatment (control group, n = 104). All participants were informed about the new YIM approach, and that data was collected for research purposes. They gave informed consent, and the original data were anonymised. Seventy-eight participants of the YIM group completed treatment between September 2013 and December 2014, 18 YIM participants still received care when the data collection of this study ended. Therefore, outcome data were not available for the latter group, and participants of this group were excluded from the analyses of outcomes (e.g., being able to nominate an informal mentor and receiving outpatient or inpatient treatment). However, data for the whole YIM sample (n=96) were used in the analyses of indicated youth problems (i.e., research question 3: the comparability of the YIM group with two residential populations of Dutch youths). The majority of participants were boys (n = 61; 63.5%) and 35 participants were girls. Ages ranged from 11 to 19, with an average of M = 15.40 (SD = 1.81).

In preparation on working with the YIM-approach, child psychologists from the Dutch youth care organisation Youké randomly selected a sample of case files (n = 104) of youths who received residential care between January 2012 and December 2012 to describe the nature of the problems of youths receiving residential care. These youths formed the comparison group. The comparison group was separated in two subgroups based on age and the focus of residential care: early adolescents with the focus on 'returning to their family' (parents or foster care) and late adolescents with the focus on 'becoming independent' (e.g., getting a room, learning to cook, finding a job, etc.). The group 'return to family' contained 19 participants, 8 boys (42.1%) and 11 girls. Ages ranged from 14 to 17, with an average of M = 15.51 (SD = .81). The group 'become independent' contained 85 participants, including 48 boys (56.5%) and 37 girls. Ages ranged from 16 to 24, with an average of M = 18.43 (SD = 1.76).

Measures

Descriptives. Professionals working with the YIM-approach registered whether youths were able to nominate a YIM from their social network, and how many days it did take from the start of treatment to nominate the YIM. If a YIM was installed, professionals registered the nature of the relationship between the youth and the selected YIM (family member, friend of youth, friend of parents, other) and what kind of support this person offered to the adolescent (social emotional support, practical support, or guidance and advice). They also registrated whether they offered solely ambulant treatment; if out-of-home placement was needed, they registered the type of residential treatment.

Youth problems The Dutch classification instrument *CAP-J (*Netherlands Youth Institute, 2009*)* was used to identify the nature and severity of the youths' problems. This instrument assesses problems on five axes: a) adolescent psychosocial functioning, such as emotional, behavioural and (psycho)social problems, b) physical health and physical related functioning, such as physical injury or physical health problems, c) competences and cognitive development, d) family and child-rearing, such as problematic parent-child relationships and problems of parent and/or social network, and e) the social environment, such as problems at work or with relationships. Intercoder agreement of the CAP-J has been shown to be satisfactory (Konijn et al., 2009). Based on anonymised case files, including treatment indications, referrals, and family plan and evaluations, the child psychologists scored in retrospective a maximum of five core problems on the CAP-J for each of the included youngsters.

Professionals using the YIM-approach scored a maximum of five core problems on the CAP-J for each client at the beginning of treatment (during the first six weeks). The scores were based on treatment indications and referrals, the family plan, case files, social network analysis and their first impression of the family.

Strategy of analysis

Chi-Square analysis was used to examine differences in youth problems between the YIM group and the two residential comparison groups, with Cramers V effect sizes to evaluate the magnitude of the difference between the YIM and the comparison group: $V > .10$ small difference, $V > .30$ moderate difference and $V > .50$ large difference (Gravetter & Wallnau, 2009).

Results

Sixty-five of the seventy-eight youths (83%) were able to nominate an informal mentor from their social network, on average within 33 days. Twenty-eight youths (43%) nominated a family member as a YIM, eleven youths (17%) selected a friend of their own, eight (12%) a friend of the parents, seven (11%) an acquaintance, three (5%) a neighbour and eight youths (12%) selected another person (e.g., teacher, sports coach). Professionals indicated the type of support the YIMs offered to the youth as follows: in 61% of the cases social emotional support, in 21% of the cases practical support and in 18% of the cases guidance and advice.

A total of 70 families (90%) received ambulatory care as an alternative for indicated out-of-home placement. The care was individualised and consisted of collaboration with a YIM and the needed treatment, such as diagnostics, systemic therapy, cognitive therapy, instrumental support and psycho-education. An out-of-home placement was considered necessary for eight adolescents (10 %), including placement in a psychiatric crisis residential facility or a kinship or non-kinship foster care family.

Residential care compared with the non-residential YIM-approach

To examine the nature of problems of youth receiving ambulant treatment with the YIM-approach, we compared them with two residential care groups. Pearson Chi Square tests showed no differences between the YIM group ($n = 96$) and the residential 'become independent' group ($n = 85$) on axes B (physical health and physical related functioning) and C (competences and cognitive development of youth) of the CAP-J (Table 1). On axis A the 'become independent' group reported a significantly higher prevalence of psychosocial problems, χ^2 (1, $n = 181$) = 16.33, $p < .01$, with a moderate effect size of $V = .30$. On axis E this group reported a significantly higher prevalence of youth and social environment problems, χ^2 (1, $n = 181$) = 26.19, $p < .01$, with a moderate effect size of $V = .38$. On axis D the YIM-group reported a significantly higher prevalence of family and child-rearing problems, χ^2 (1, $n = 181$) = 56.26, $p < .01$, with a large effect size of $V = .56$.

Pearson Chi Square tests showed no differences between the YIM ($n = 96$) and the residential 'return home' ($n = 19$) group on 4 of the 5 axes (axes B, C, D, and E). The only difference between the groups was found on axis A, on which the 'return home' group reported a significantly higher prevalence of problems in psychosocial functioning than the YIM group, χ^2 (1, $n = 115$) = 4.20, $p = .04$, with a small effect of $V = .19$.

Table 1. Classified problems of youths in residential treatment (focus on independency; n = 85 or returning home; n = 19) and youths treated with the non-residential YIM-approach (n = 96)

	Residential treatment		**YIM-approach**				
Axis A	*Problems in psychosocial functioning of youth*						
	Yes	No	Yes	No	χ^2	*Df*	*V*
Independency	81 (95.3%)	4 (4.7%)	70 (72.9%)	26 (27.1%)	16.32*	1	.30
Return home	18 (94.7%)	1 (5.3%)		4.20* 1	.19		
Axis B	*Problems in physical health and physical related functioning*						
	Yes	No	Yes	No	χ^2	df	*V*
Independency	10 (11.8%)y	75 (88.2%)	9 (9.4%)	87 (90.6%)	.27	1	-
Return home	0 (0.0%)	19 (100%)		1.93 1	-		
Axis C	*Problems in competences and cognitive development of youth*						
	Yes	No	Yes	No	χ^2	df	*V*
Independency	16 (18.8%)	69 (81.2%)	25 (26.0%)	71 (74.0%)	1.34	1	-
Return home	3 (15.8%)	16 (84.2%)		.91 1	-		
Axis D	*Problems in family and child-rearing*						
	Yes	No	Yes	No	χ^2	df	*V*
Independency	39 (45.9%)	46 (54.1%)	92 (95.8%)	4 (4.2%)	56.26*	1	.56
Return home	18 (94.7%)	1 (5.3%)			0.5	1	-
Axis E	*Problems with social environment*						
	Yes	No	Yes	No	χ^2	df	*V*
Independency	73 (85.9%)	12 (14.1%)	48 (50.0%)	48 (50.0%)	26.19*	1	.38
Return home	9 (47.4%)	10 (52.6%)			.04 1	-	

Note: *p <.05. Problems were coded using the CAP-J (Netherlands Youth Institute, 2009)

The results indicate that the ambulant YIM-group is quite comparable with a sample of residential youth with a focus on returning home. Only the prevalence of problems with psychosocial functioning was somewhat higher in the latter group (small effect size), but no significant differences were found in the prevalence of physical health and physical related functioning, competences and cognitive development, family and child-rearing and problems in the social environment.

Adolescents in the residential group with a focus on becoming independent mainly had problems with psychosocial functioning and their social environment, whereas problems in the group receiving the YIM-approach were more often found in family problems and inadequate child-rearing.

DISCUSSION AND IMPLICATIONS FOR SOCIAL WORK

The main research questions where whether juveniles with complex needs at risk for out-of-home placement could nominate an informal mentor and how much time it took, whether they received solely ambulant treatment, and if the problems of the YIM group were similar to the problems of two different age groups of Dutch youth receiving residential care with a separate treatment focus. Our study showed that a total of 83% of the juveniles with complex needs appointed a YIM within 33 days. while in 90% of the cases ambulatory treatment was sufficient. The YIM group was comparable with the younger residential population with treatment focus 'return home', but not with the older group with the treatment focus 'become independent'.

The fact that in total 83% of the juveniles was able to nominate a YIM is in accordance with previous studies on the availability of spontaneous supportive non-parental adults, indicating that 35% to 83% of youth are able to find a supportive person (DuBois & Silverthorn; 2005; Hurd & Zimmerman, 2010). The average five weeks for youth to find an informal mentor is may be considered a relatively fast way to realise formalised collaboration with the informal network compared to family group conferences where certain time consuming and complex procedures have to be followed, which takes on average 18 weeks from the beginning of treatment to start the actual family group conference (Dijkstra et al., 2016). This may be explained by the difference between the two approaches: whereas family group conferences work with several social network members, the YIM approach works with one social network member and involves other social network members during (mostly ambulant) treatment if necessary. Thus, the organisational part of the YIM-approach is more simple and flexible, making it easier to realise social network participation in complex family systems in which risks penetrate the family social support system as a whole (Vanderbilt-Ardriance & Shaw,2008).

The type of informal mentors selected by the youths in our study (mainly family members) is also comparable with other studies (Dang et al., 2014; DuBois & Silverthorn; 2005). The finding that YIMs mainly offer social emotional support is also found in previous studies on informal mentoring (Schwartz et al., 2013).

The ambulant YIM-group is comparable with a sample of residential youth with a focus on returning home. The differences reported between the ambulant and residential groups may reflect differences in professional perspective because of the different ages of youth and the focus of each approach. For example, residential care professionals working with older youth with a focus on becoming independent are likely to report more problems in psychosocial functioning and the social environment. Professionals working with younger youth with a focus on 'staying at home', working with the family-system, may be prone to report more family and child-rearing problems. The age difference might also explain the different nature of reported problems. Therefore, using

independent coders and two groups of peers, would give a better indication of the comparability between the groups.

The present study provides preliminary evidence that the YIM-approach is promising, because it might offer a viable alternative for out-of-home placement, which is in line with the notion in the international Convention on the Rights of the Child that residential care is a 'last resort option'. It is also in line with other studies showing that participatory network approaches might contribute to effective formal and informal care and lasting 'informal alliances' (Seikkula et al., 2003). The main focus is on building a supportive relationship between vulnerable juveniles and someone they trust from their social network. This focus should not overlook parents in their need of social support, because parents may also benefit from supporting social networks (Kesselring et al., 2016). The results also indicate residential treatment is sometimes indicated, therefore residential treatment should be in an integral part (as an intervention) of the ambulant treatment.

This study has limitations. First, the time-span of this study is short (compared to the duration of the care process for most youths), and the focus was on results during the treatment phase, while the aim is to create lasting informal pedagogical alliances. Although there is empirical evidence showing that informal mentoring relationships last longer than formal mentoring relationships (Schwartz et al., 2013), future (qualitative and quantitative) studies should investigate the duration of the collaboration between YIM, parents and youth after having ended treatment. This research should include follow-up measurements to examine the long-term effects of the YIM-approach. Second, the nature of youth problems was recorded by professionals with an instrument only investigated for interrater reliability and not for validity (the CAP-J). We recommend future studies to use repeated measurements with both self-reports and observational data to get a better understanding of the specific characteristics of the YIM group. Third, the research design should include a comparison group in order to prove effectiveness of the YIM approach, program fidelity should be established, and intervening variables should be examined that may account for the effect of mentoring, such as parent-child interaction, social competence, program practices and the community context (Rhodes & DuBois, 2008). Because of the small sample size, caution should be exercised in generalising the results to other populations.

A previous small qualitative evaluation study with parents (*n* = 8), juveniles (*n* = 10), informal mentors (*n* = 10) and professionals (*n* = 10) during the first year of the YIM approach concluded that 'this approach is a promising alternative for out-of-home placement of youth' (Razenberg & Blom, 2014). The evaluation gave insight in the needs of the new partner for professionals: the informal mentor. YIMs expressed the need for support from parents and professionals in their positioning as a YIM. They wanted good accessibility of professionals for support and advice, and they experienced a need for training in, for example, behaviour management and interviewing skills. Still, as we know

too little about their perspective (Smith et al., 2015), future studies need to investigate this and incorporate it in training and education of social work professionals.

The results of this evaluation study of Youth Initiated Mentoring are promising, and offer a glimpse of how we might prevent out-of-home placement of vulnerable youth. It suggests that continuity and adolescent and family participation can be achieved by acknowledging the limitations of professional involvement (formal) and increasing the involvement of important non-parental adults (informal). Because of the limitations of the current study, the YIM approach should be examined with a more robust research design. Future studies should examine whether the YIM approach is effective in reducing problems and increasing resilience as an alternative intervention, and which factors (e.g., ethnicity, age, gender, effective collaboration in the triad YIM-youth-parents, stability and continuity of the relationship and the distribution of tasks and responsibilities) create sustainable informal pedagogical alliances with enough collective intelligence to cope with new stressful situations. Currently the YIM approach has been implemented by 22 mental health care organisations in the Netherlands. If the results continue to be positive, we recommend further research in different populations (e.g., foster care, incarcerated youth, school drop-outs, refugees), to create lasting arenas of comfort for all youths (Putnam, 2015).

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