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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 (aged twelve to twenty-three) 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 co-operation partner for parents and professionals. This approach fits with the international tendency in social work to make use of the strengths of families' social 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 per cent of the juveniles in the YIM group were able to nominate a mentor



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after an average of thirty-three days. Ninety per cent 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.

Keywords: Youth Initiated Mentoring, residential care, out-of-home placement, adolescents, shared decision making

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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 and 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 and 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. 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 co-operation partner for parents and professionals (Schwartz *et al.*, 2013; Spencer *et al.*, 2016; Van Dam and 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, namely what is distributed through the existing connections (Christakis and 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 (Weisz *et al.*, 2013; Euser *et al.*, 2015), 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 (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 'Youth Initiated Mentoring', or '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 recognised 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 and 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 and Berkman, 2001). Social integration reflects participation in a broad range of social relationships and promotes positive psychological states, such as self-worth and positive affection, which induce health-promoting physiological responses

(Brisette *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, 1993, 2005) 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 and 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 emphasised (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 is 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 of maltreatment—and even reported non-anticipated results that may even be evaluated as negative from a family preservation perspective, such as an increase in

the number and length of out-of-home placements with older children and minority groups (Dijkstra *et al.*, 2016). Such a 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 and Verhulst, 2016). Working with a youth initiated mentor requires a functional position of the youth initiated mentor. 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.*, 2010). 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 and 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 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 and Verhulst, 2016).

The YIM approach is characterised 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 depend 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 youth initiated mentor? The professionals seek collaboration with an informal mentor by stimulating youth to nominate a

person in their environment they trust (*eliciting*). After nomination, the youth initiated mentor 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 youth initiated mentor’. 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, the youth initiated mentor 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’: 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 *et al.*, 2015), which could make professional care unnecessary.

During the final meeting, the parties discuss the system’s adaptivity—how will the family and youth initiated mentor 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 are 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 emphasised to the extent that formal involvement decreases with increasing informal problem ownership.

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 realise 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 and Morris, 2007). The professional stimulates the family members’ social resourcefulness, namely family members’ covert and overt behaviour to

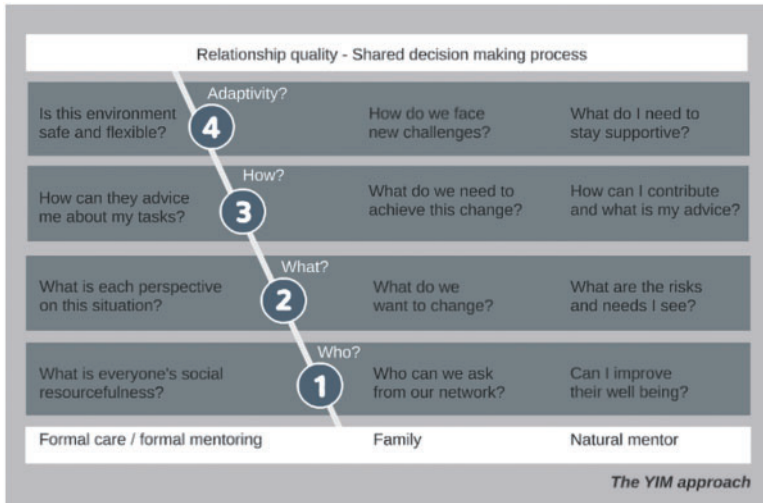


Figure 1: The four phases of the YIM approach

request and maintain support from others (Rapp *et al.*, 2010). Enhancing social resourcefulness is meant to optimise the capacity of the involved adolescents to cope with stressful life events.

Due to differences in the quality, intensity and nature of the relationship between the informal mentor and the juvenile, professionals need to be flexible and responsive to each unique relationship. The kind of support the youth initiated mentor offers depends on the capacities, needs and interests of both the mentor and the juvenile, the individual and family problems and the 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 access 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 (i) whether youths are able to nominate an informal mentor at the start of treatment, (ii) whether they receive solely ambulatory treatment and (iii) whether 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 those data were collected for research purposes. They gave informed consent, and the original data were anonymised. The IRB of Spirit gave permission for conducting the study. Seventy-eight participants of the YIM group completed treatment between September 2013 and December 2014; eighteen 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 per cent) and thirty-five participants were girls. Ages ranged from eleven to nineteen, with an average of $M = 15.40$ ($SD = 1.81$).

In preparation for 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 being to 'return home' to their family' (parents or foster-care) and late adolescents with the focus being to 'become independent' (e.g. getting a room, learning to cook, finding a job, etc.). The 'return home' group contained nineteen participants: eight boys (42.1 per cent) and eleven girls. Ages ranged from fourteen to seventeen, with an average of $M = 15.51$ ($SD = 0.81$). The group 'become independent' contained eighty-five participants, including forty-eight boys (56.5 per cent) and thirty-seven girls. Ages ranged from sixteen to twenty-four, 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 youth initiated mentor from their social

network, and how many days it took from the start of treatment to nominate the youth initiated mentor. If a youth initiated mentor was installed, professionals registered the nature of the relationship between the youth and the selected youth initiated mentor (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 registered 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 (Konijn *et al.*, 2009) was used to identify the nature and severity of the youths' problems. This instrument assesses problems on five axes: (A) adolescent psycho-social 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: $V > 0.10$ small difference, $V > 0.30$ moderate difference and $V > 0.50$ large difference (Gravetter and Wallnau, 2009).

Results

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

A total of seventy families (90 per cent) received ambulatory care as an alternative for indicated out-of-home placement. The care was individualised and consisted of collaboration with a youth initiated mentor 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 per cent), 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 psycho-social problems ($\chi^2(1, n = 181) = 16.33, p < 0.01$), with a moderate effect size of $V = 0.30$. On axis E, this group reported a significantly higher prevalence of youth and social environment problems ($\chi^2(1, n = 181) = 26.19, p < 0.01$), with a moderate effect size of $V = 0.38$. On axis D, the YIM group reported a significantly higher prevalence of family and child-rearing problems ($\chi^2(1, n = 181) = 56.26, p < 0.01$), with a large effect size of $V = 0.56$.

Pearson Chi-square tests showed no differences between the YIM ($n = 96$) and the residential 'return home' ($n = 19$) group on four of the five 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 psycho-social functioning

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 ($n = 96$)

Axis A	Residential treatment		YIM approach		χ^2	Df	V
	Yes	No	Yes	No			
<i>Problems in psycho-social functioning of youth</i>							
Independency	81 (95.3%)	4 (4.7%)	70 (72.9%)	26 (27.1%)	16.32*	1	0.30
Return home	18 (94.7%)	1 (5.3%)			4.20*	1	0.19
<i>Problems in physical health and physical-related functioning</i>							
Independency	10 (11.8%)	75 (88.2%)	9 (9.4%)	87 (90.6%)	0.27	1	–
Return home	0 (0.0%)	19 (100%)			1.93	1	–
<i>Problems in competences and cognitive development of youth</i>							
Independency	16 (18.8%)	69 (81.2%)	25 (26.0%)	71 (74.0%)	1.34	1	–
Return home	3 (15.8%)	16 (84.2%)			0.91	1	–
<i>Problems in family and child rearing</i>							
Independency	39 (45.9%)	46 (54.1%)	92 (95.8%)	4 (4.2%)	56.26*	1	0.56
Return home	18 (94.7%)	1 (5.3%)			0.5	1	–
<i>Problems with social environment</i>							
Independency	73 (85.9%)	12 (14.1%)	48 (50.0%)	48 (50.0%)	26.19*	1	0.38
Return home	9 (47.4%)	10 (52.6%)			0.04	1	–

* $p < 0.05$. Problems were coded using the CAP-J (Netherlands Youth Institute, 2009).

than the YIM group ($\chi^2 (1, n = 115) = 4.20, p = 0.04$), with a small effect of $V = 0.19$.

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 psycho-social 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 psycho-social 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 were 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 whether 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 per cent of the juveniles with complex needs appointed a youth initiated mentor within thirty-three days, while, in 90 per cent 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 per cent of the juveniles were able to nominate a youth initiated mentor is in accordance with previous studies on the availability of spontaneous supportive non-parental adults, indicating that 35–83 per cent of youth are able to find a supportive person (DuBois and Silverthorn, 2005; Hurd and Zimmerman, 2010). The average five weeks for youth to find an informal mentor 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 an average of eighteen weeks from the beginning of treatment to starting 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 and Shaw, 2008).

The type of informal mentors selected by the youths in our study (mainly family members) is also comparable with other studies (DuBois and Silverthorn, 2005; Dang *et al.*, 2014). The finding that youth initiated mentors 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 psycho-social 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 reporting 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, so 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 inter-rater 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, programme 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, programme practices and the community context (Rhodes and 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 and Blom, 2014). The evaluation gave insight into the needs of the new partner for professionals: the informal mentor. Youth initiated mentors expressed the need for support from parents and professionals in their positioning as a youth initiated mentor. They wanted

good accessibility to 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 the training and education of social work professionals.

The results of this evaluation study of YIM 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 youth initiated mentor–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 twenty-two 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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