Abstract

Human service and educational agencies often convene interdisciplinary teams to work collaboratively with adolescents and their parents or caregivers. However, research on adolescent development suggests that it may be difficult to successfully engage adolescents this kind of team-based planning. **Objective:** This article focuses on wraparound as an example of a team planning process, and uses data from several sources to reflect on questions about whether—and under what conditions—collaborative teams are successful in engaging young people—and their caregivers—in planning. **Methods:** We used data collected in three studies to address our research questions. The first data set comes from a study on wraparound service planning in Nevada. We examined data collected from 23 matched pairs of caregivers and youth at 6 months after wraparound planning began. Our second data set came from a national study of 41 local wraparound programs throughout the United States. Our analyses use data from 366 matched pairs of caregivers/youth. The third dataset comes from the pilot test of the *Achieve My Plan!* intervention. Data was gathered from eight teams before and after the intervention was implemented. **Conclusions and Implications for Practice:** Taken together, the findings suggest that teams' success in managing caregiver and adolescent perspectives simultaneously during care and treatment planning is more strongly related to the quality of the team process than to youth age. Furthermore, through attention to youth engagement, preparation, and team process, it appears possible to increase meaningful youth participation in planning without sacrificing caregiver satisfaction with the team experience.

Human service and educational agencies often convene interdisciplinary teams to work collaboratively with adolescents and their parents or caregivers. These teams create comprehensive education, transition, care or treatment plans for adolescents with mental health conditions and related needs. Typically, these teams are convened for adolescents who are involved with multiple child- and family-serving systems, and who are thought to be in need of intensive support. The teams go by many names, including IEP (Individualized Education Plan) teams, wraparound teams, foster care Independent Living Program teams, transition planning teams, and youth/family decision teams. These various team approaches have many features in common, including a requirement to fully include the young person and parents in the planning process. However, research on adolescent development suggests that it may be difficult to successfully engage adolescents in this kind of team-based planning. This article focuses on wraparound as an example of a team planning process, and uses data from several sources to reflect on questions about whether—and under what conditions—collaborative team planning approaches are likely to be effective for adolescents, particularly those with serious mental health conditions.

The wraparound process is perhaps the most frequently implemented comprehensive approach for planning and providing individualized, community-based care for children and adolescents with serious mental health conditions and, typically, involvement in multiple child- and family-serving systems (Walker, Bruns, & Penn, 2008). It has been estimated that there are at least 98,000 youth enrolled in over 800 wraparound initiatives in the United States (Bruns, in press). Wraparound is intended to be a strengths-based approach in which both child/youth and family perspectives are to be prioritized in determining the primary needs to be addressed, as well as the service and support strategies to be included in the wraparound plan of care (Bruns et

al., 2004; Walker et al., 2008). In order to ensure that these family perspectives are fully represented in the planning process, the wraparound practice model calls for an extensive engagement period with the child/youth and family, during which there is a thorough exploration of their strengths and needs, their past experiences with services and supports, and their vision for a better life. This information is then combined with information provided by other team members, and summarized into documents and statements that become the basis for the team's collaborative work. Thus, in order to be successful, wraparound requires that the family—including most importantly the primary caregiver(s) and the child or youth who has been identified as needing intensive support—disclose information that is often of a deeply personal nature. This information is subsequently discussed by the entire team, a group that typically includes five or more team members, most of whom are professional service providers from child- and family-serving systems such as mental health, child welfare, juvenile justice, schools, and so on. Furthermore, the adults who are present for these team discussions often have access to extensive agency records that may date back for many years. These records describe the young person's service history with the system, usually in ways that highlight pathology, problems, deficits and crises (e.g., Malysiak, 1997; Rosenblatt, 1996).

In theoretical models that describe how wraparound produces outcomes (Walker & Matarese, in press; Walker & Schutte, 2004), a thorough exploration of underlying needs is seen as crucial to success. Furthermore, as team members work together, they must continually evaluate the extent to which the service and support strategies included in the plan of care are being successful in meeting needs. In order to do so, the team needs ongoing input from the caregiver(s) and the young person. From a theoretical standpoint, a key strength of the wraparound process is that it unites the young person, the family, service providers and other

team members around a shared vision of the most pressing underlying needs and the best strategies for meeting the needs. Wraparound's effectiveness is seen as stemming from the fact that the team is collectively oriented toward the most important needs, and because it is addressing needs at a more profound and holistic level than usual treatment planning.

Existing research on adolescent development and adolescent experiences in mental health therapy, however, suggests a series of challenges that may make it difficult for wraparound teams to engage youth—particularly older adolescents—in a way that promotes self-disclosure and unites the young person and the team in support of the plan. These challenges reflect tensions that naturally arise during the course of this adolescent development, as young people negotiate changing relationships and become more self-directed in making decisions about their lives (Peterson, Bush, & Supple, 1999; Smetana, Campione-Barr, & Metzger, 2006; Wray-Lake, Crouter, & McHale, 2010).

One set of potential challenges is related to the expectation that young people will be willing to disclose personal information to a group of adults that includes caregivers and other authority figures. Particularly for an older adolescent, such openness in a group situation may feel unreasonable and intrusive. Throughout the course of adolescence, young people gradually expand the boundaries of what they consider their private sphere, and become more reluctant to disclose to parents information about, for example, their whereabouts and activities, their friends, and their romantic relationships (Daddis & Randolph, 2010; Hawk, Keijsers, Hale Iii, & Meeus, 2009; Masche, 2010; Smetana, Villalobos, Tasopoulos-Chan, Gettman, & Campione-Barr, 2009). Secrecy and reluctance to disclose are particularly pronounced among young people with externalizing behavior and general adjustment problems, as well as in situations in which the young person is unwilling to trust adults (Daddis & Randolph, 2010; Soenens, Vansteenkiste,

Luyckx, & Goossens, 2006; Stattin & Kerr, 2000). Negotiating these boundaries is a primary cause of conflict and turmoil in families with adolescent children, and increased pressure on young people to disclose can trigger cycles of increased secrecy and further conflict (Hawk et al., 2009; Tilton-Weaver et al., 2010). As described previously, effective wraparound is predicated on adolescents disclosing information to caregivers and other adults on the team. If a young person does not trust the team or is reluctant to disclose information related to needs and service/support strategies, then the plan will not truly represent the youth's perspective, and the team's effectiveness will likely be limited as a result. Furthermore, if a reluctant adolescent is pressured to disclose, he or she may respond with increased secrecy and heightened distrust toward the team.

Another set of challenges stems from the potential difficulty in simultaneously managing parent and child viewpoints during the wraparound process. Wraparound stresses the importance of family *and* youth voice throughout the process, and its principles recognize that, as a young person matures and makes more self-guided decisions, it becomes necessary to balance team collaboration in ways that allow the youth to have growing influence within the wraparound process. It may be quite challenging in some families to achieve unity among caregiver, youth, and team, and to manage youth and caregiver voice in a way that builds cohesiveness. In general, young people's relationships with their parents are transformed during the period of adolescence, from more subordinate and dependent in early adolescence to more egalitarian and autonomous later on (Peterson et al., 1999; Wray-Lake et al., 2010). As youth age, rebalancing parent-adolescent power in decision making is often not a smooth process. Across families of varying cultural and ethnic backgrounds, this rebalancing typically engenders significant parent-adolescent conflict (Smetana et al., 2006). What is more, these conflicts most often end by youth

either disengaging (e.g., walking away) or giving in to parents (Smetana et al., 2006). Thus parents and their adolescents do not typically resolve conflicts in ways that promote unity behind a negotiated decision. Finally, there is at least some evidence that parent-child conflict is higher within the population that is likely to receive wraparound: families with adolescents who have emotional or behavioral disorders (Marmorstein & Iacono, 2004).

Research on adolescent mental health treatment suggests a related, more specific set of challenges to achieving team unity and cohesion. These challenges stem from a potential lack of agreement between youth and their parents/caregivers, and between youth and clinicians, about the need for treatment, its purpose or goals, and its helpfulness. Available research shows that parents and children often disagree regarding whether treatment is needed (Phares & Compas, 1990; Phares & Danforth, 1994), and young people overwhelmingly feel that they are not part of the decision to seek treatment (Center for Mental Health Services, 2007). Overall, there is consistent documentation of a pronounced lack of agreement between parents and their children about the problems for which treatment is being sought and/or the goals of treatment (Garland, Lewczyk-Boxmeyer, Gabayan, & Hawley, 2004; Hawley & Weisz, 2003). Young people also disagree with clinicians about target problems, while clinicians agree with parents only somewhat more often than with young people. Parents and children also show little agreement in their satisfaction with treatment (e.g., Garland, Aarons, Hawley, & Hough, 2003). Taken together, these findings suggest that young people often feel coerced into treatment. Further, young people and their caregivers, as well as caregivers and clinicians, are likely not to be united behind treatment-related decisions. In the wraparound context this may lead young people to feel coerced or unengaged (since wraparound is a form of treatment) and may also make it difficult to unite the team behind clinical strategies.

These challenges suggest substantial difficulties that may well emerge in during efforts to engage youth, particularly older adolescents, in wraparound or other comprehensive, team-based planning approaches. However, the research literature that describes these challenges also supports the idea that it is both possible and beneficial for young people and their parents/caregivers to work through their disagreements. Indeed, contemporary theory and interpretations of research on adolescence suggest that working through these challenges is a central task of adolescent development, and that adolescents fare best when they are able to develop increased self-direction while maintaining connectedness with parents (Hawk et al., 2009; Peterson et al., 1999; Smetana et al., 2006; Smetana, Daddis, & Chuang, 2003; Wray-Lake et al., 2010). In short, wraparound may be a crucible in which the developmental challenges of adolescence are exacerbated. On the other hand, wraparound may provide a unique opportunity to support adolescent development and manage family conflict in a way that promotes connectedness between adolescents and their adults.

Our goal in the remainder of this paper is to examine available data for evidence that speaks in a preliminary way to the question of whether or not wraparound seems to "work" for adolescents, particularly older adolescents. More specifically, we will address the following research questions: Are youth generally satisfied with wraparound, and do they feel that they participate meaningfully in the planning process? Are perceptions of meaningful participation in planning lower among older versus younger adolescents? Do caregivers and youth both feel that their perspectives are meaningfully included in planning, or is there apparent discrepancy between youth and caregiver perspectives? If such discrepancy does occur, is it more pronounced when the youth are older? Finally, can meaningful youth participation be increased on teams,

through attention to engagement and team process, and can this be accomplished without creating causing a decrease in caregivers' satisfaction with the team experience?

A Study of Wraparound in Nevada

We used data collected in three studies to address our research question. The first dataset comes from a study on wraparound service planning in Nevada (Bruns, Pullmann, Brinson, Sather, & Ramey, submitted; Bruns, Rast, Walker, Bosworth, & Peterson, 2006). We examined data collected from 23 matched pairs of caregivers and youth at 6 months after wraparound planning began. Youth age ranged from 10 to 17 years old (M = 13.8, SD = 2.4; Median=13.3; Skew=.02 SE_{Skew}=.48; Kurtosis=-1.29, SE_{kurt}=.94). The age distribution was functionally continuous, as indicted by the non-skew and negative kurtosis (flatness of the distribution) while remaining within acceptable bounds of normality, and the fact that binning age into whole years resulted in each year of age being represented by at least one participant. Participants responded to five satisfaction questions; most salient was satisfaction with level of involvement in planning services, but questions also included overall satisfaction with services, level of progress in last 6 months, and whether the services had been helpful. Response categories ranged from 1 to 5, defined as "very dissatisfied," "dissatisfied," "neutral," "satisfied," and "very satisfied".

The average for youth and caregiver ratings was between "neutral" and "satisfied" (Table 1). Youth were slightly less satisfied than caregivers on all items, but this was only statistically significant for level of involvement in planning services (M_y = 3.43, M_c = 3.91, p = .031). There was no significant correlation between youth age and satisfaction with level of involvement in planning services (r = -.208, p = .341). Older youth were significantly less satisfied than younger youth on overall ratings of satisfaction (r = -.442, p = .035), progress over the last 6 months (r = -.498, p = .015) and mean of all items (r = -.457, p = .028). There was a non-significant trend

towards less satisfaction for older youth in terms the helpfulness of services (r = -.318, p = .140). There were no significant relationships between youth age and caregiver ratings of satisfaction. Overall, youth were less satisfied than parents, regardless of the youth's age. Older youth were less satisfied in terms of overall services and their progress over time, and caregivers' satisfaction and perceptions of participation were not linearly related to youth age.

A further question is whether youth and caregivers can simultaneously be satisfied with their team experience, and particularly with their level of participation in planning. The potential for discrepancies between viewpoints may increase across adolescence, and thus there may be a growing likelihood that either the caregiver's or youth's perspective may come to dominate team planning, with the other's perspective being crowded out. We performed a series of analyses exploring whether discrepancies between youth and caregiver ratings were correlated with youth age. "Discrepancy" was operationalized as the absolute difference between caregiver and youth ratings. Positive correlations between discrepancy and age indicate that increasing youth age is related to greater differences between youth and caregiver scores, and negative correlations indicate smaller differences as youth age.

The data indicated that, as youth aged, there was indeed more discrepancy between young people and their caregivers regarding satisfaction with level of involvement in planning (r = .651, p < .001; see Table 2). Older youth who felt more involvement had parents who felt less involvement, and vice-versa; younger youth were more likely to give ratings of their involvement that were similar to their caregivers' ratings of involvement. This was a very large effect size, though the sample size was small and therefore highly susceptible to influence from outliers. (Removing the three most outlying cases reduces the correlation to .488, still relatively large.) Also significant were correlations between age and discrepancy on mean satisfaction (r =

.477, p = .022), and with borderline significance, discrepancy on overall satisfaction (r = .383, p = .072). This supports the hypothesis that there may be an age-related discrepancy occurring in wraparound teams that is most focused on the satisfaction with the level of involvement in planning.

However, the sample size for this study was very small, resulting in less confidence in the reliability of the findings. Additionally, the overall fidelity to wraparound in the Nevada study was quite low—on average, caregivers rated wraparound fidelity in the 26th percentile of national norms. Therefore, we undertook secondary analyses of a larger dataset of youth and caregiver reports of wraparound fidelity.

A National Study of Wraparound Fidelity

Our second dataset came from a national study of 41 local wraparound programs throughout the United States. Data were collected by local evaluators and submitted to a data pool managed by the Wraparound Evaluation and Research team (described in Pullmann, Bruns, & Sather, submitted). Data were collected via the Wraparound Fidelity Index, Version 4 (WFI-4, Bruns, 2010) which includes a 40-item version for caregivers and a 32-item version for youth, with 28 parallel items between them. It is those items that we report on in this paper. Our primary analyses address eight items specifically focused on level of participation in various aspects of the team. Caregivers and youths reported on their respective levels of participation. Item responses ranged from 0 to 2, representing “no,” “sometimes/somewhat,” and “yes.” For all items, higher scores represent higher levels of fidelity to the wraparound process. Our analyses use data from 366 matched pairs of caregivers and youth. Youth age ranged from 11 to 20 years and this distribution was normally distributed, though only 6% of respondents were older than 18 (M = 15.2, SD = 2.0; Median = 15.4; Skew = -.32 SE_{Skew} = .08; Kurtosis = -.73, SE_{kurt} = .16).

Caregivers generally reported higher levels of fidelity. Caregivers' overall fidelity score (expressed as a mean item score) was significantly, though only slightly, higher than youths' (M_y = 1.46, M_c = 1.50, p =.031). Of the 28 t-tests, 13 revealed statistically significant differences between youth and caregiver scores. Eight of these had higher caregiver scores, and five had higher youth scores. More importantly, youth gave significantly lower ratings to four of the eight items specifically related to participation; two of these had small effect sizes (Cohen's d <.25), one moderate (d = .33), and one large (d = .98). Hence, though the differences between caregivers and youth on item-level fidelity ratings were somewhat equivocal, caregivers rated several of the items specifically relating to participation in wraparound higher than youth.

All correlations between youth age and youth and caregiver ratings of wraparound fidelity were weak (r < .15) or non-significant (Table 3). Caregivers of older youth reported slightly lower levels of wraparound fidelity than caregivers of younger youth on several items. Consistent with the findings from the Nevada study, caregivers of older youth did not report lower levels of involvement in planning. Analyses of curvilinear (quadratic or cubic) relationships between age and caregiver and youth ratings of fidelity were non-significant (p < .05) or very weak (R^2 < .015). Findings were nearly equivalent when running identical analyses while restricting the sample to only include youth aged 11 to 17 in order to better match the Nevada sample.

We also examined correlations between youth age and discrepancies between caregiver and youth scores, calculated as absolute differences between scores (Table 3). All correlations were weak or non-significant. Discrepancies on mean overall fidelity score had a significant, though weak, positive correlation of .116, indicating that as youth aged, discrepancies in fidelity ratings increased. However, discrepancies for the participation items were non-significant or

inconsistent, with one item having a weak negative correlation of -.111 (helping pick members of wraparound team), and one item having a weak positive correlation of .118 (able to talk about what family values and believes in). As above, findings were nearly equivalent when restricting the sample to youth aged 11 to 17 to match the Nevada sample data. In sum, the national data indicated that there was no consistent age-related trend toward greater discrepancy in ratings of participation in planning.

Pilot Test of the *Achieve My Plan!* Intervention

The findings presented thus far suggest that, regardless of youth age, parents feel somewhat more involved in planning than do youth. The findings on age-related discrepancy between youth and parent ratings of their participation in the planning process were not consistent across the two studies. The Nevada data provided some evidence that discrepancy increased with youth age, whereas the national data did not. However, overall level of wraparound fidelity in the Nevada study was very low compared to national norms, raising the possibility that discrepant levels of participation are more likely to emerge when youth are older *and* the overall quality of team process is low. While we could not test this possibility directly using available data, analyses of a third dataset did allow us to gain additional perspective on the question of whether strengthening team process can increase meaningful participation among older youth, and whether this can be accomplished without reducing caregiver satisfaction with the team experience.

To address these questions, we examined data gathered during the pilot test of the *Achieve My Plan!* (AMP) intervention. AMP is designed for use in any context in which a young person is involved with a team of adults in planning for his or her care, treatment, education or future. Thus AMP can be used not only to support the work of wraparound teams, but also that of

IEP teams, wraparound teams, youth/family decision teams, transition planning teams, and so on. AMP aims to increase the extent to which youth are involved and engaged in planning, the extent to which the plans that are produced reflect participating youths' own goals and perspectives, and the extent to which the young people are actively involved in carrying out action steps for their plans. In turn, this greater engagement with the planning process is expected to impact the overall effectiveness of the team process and, ultimately, treatment engagement, and mental health outcomes. One of the unique features of AMP is that the intervention was developed in collaboration with an advisory board that included youth, caregivers and service providers.

In the intervention, an AMP "coach"—which can be the wraparound care coordinator or facilitator, a peer support worker, a clinician, or someone with another role—works one-on-one with a young person to prepare him/her to participate actively and constructively in the team meetings. The AMP coach also supports the young person to communicate with caregivers prior to the meeting and to secure their support for the ideas and suggestions that the young person intends to present to the group. The coach helps the youth to anticipate conflicts that may arise during the team meeting, and provides the young person with specific strategies for how to manage these situations. The coach also teaches the youth specific skills for managing conflicts that may occur unexpectedly. Other team members, particularly the person who is in charge of facilitating the team meeting, also receive AMP training and ongoing coaching, so that they can become skilled in creating a team atmosphere that is conducive to and supportive of meaningful youth participation. For example, the team facilitator is trained to recognize and respond constructively to specific kinds of team interactions and situations that are most likely to cause conflict and lead youth to disengage from the team process.

During the pilot test of AMP, data was gathered from eight teams serving older adolescents (M = 16.9, SD =.5). Data was collected before and after the AMP intervention was implemented with the young person and the team (Walker & Gowen, in press). Some of the data was derived from video that was recorded during each team's pre- and post-AMP meeting. The entire meeting was recorded, and the video data was subsequently coded in 20-second segments, using a system that reflected key aspects of teamwork and participation. There was an average of 121 segments per meeting, and coders had been trained until they could reliably achieve at least 97% accuracy for each category. Significant pre- post- differences were found in three of the five key categories reflecting youth participation in planning. Wilcoxon related sample signed-rank tests showed significant increases in the percentage of segments in which youth spoke for the entire segment without substantial interruption (M_{Pre} = .02, M_{Post} = .10, $W(8) = 1.50$, p = .010); the percentage of segments during which the youth made a significant verbal contribution to the discussion or plan (M_{Pre} = .40, M_{Post} = .52, $W(8) = 4.00$, p = .025); and the percentage of segments during which adults agreed to include a youth's suggested action step in the plan (M_{Pre} = .00, M_{Post} = .03, $W(8) = 0.00$, p = .013). Another pre- post- difference was observed in one of the three categories reflecting positive interactions between youth and other team members during the meeting: the percentage of segments in which the youth made a supportive or strengths-focused verbal contribution (M_{Pre} = .02, M_{Post} = .04, $W(8) = 4.50$, p = .028). Additionally, there was a difference in one of the two categories reflecting improvements in the overall quality of the team process: the percentage of segments during which any team member made a team process-oriented comment (e.g., helping the team stay focused on the agenda, reminding team members about ground rules, clarifying follow-up steps, etc.; M_{Pre} = .02, M_{Post} =

.09, $W(8) = 0.00$, $p = .009$). None of the indicators for participation, interaction or team process was lower post-AMP.

Data from pre- post- assessments with team members reinforced the findings from video data regarding youth participation in planning. On the Youth Participation in Planning scale (Walker, et al., 2010), youth's scores showed significant increases in participation overall (M_{Pre} = 55.56, M_{Post} = 65.56, $t(8) = -2.48$, $p = .038$) as well as on two of the three subscales: youth preparation (M_{Pre} = 13.78, M_{Post} = 18.78, $t(8) = -3.81$, $p = .005$), and team accountability to the youth (M_{Pre} = 15.00, M_{Post} = 29.11, $t(8) = -2.50$, $p = .037$). Additionally, data on adult perceptions of youth participation was collected from post-meeting surveys, using an adapted form of the Youth Participation in Planning scale with the items rephrased from first person to third person (i.e., "the youth") for the adult form. This assessment was completed by all team members at the conclusion of the pre-AMP and post-AMP team meetings. Adults' mean score on the participation scale was significantly lower on the pre-AMP than the post-AMP surveys (M_{pre} = 3.40, M_{post} = 3.72, $t(61) = -2.88$, p=.005). What is more, the increases in youth participation did not appear to come at the cost of lower caregiver satisfaction; in fact, caregivers were significantly more satisfied with the post-AMP meeting than the pre-AMP meeting (M_{Pre} = 3.33, M_{Post} = 3.67, $W(9) = 0.00$, $p = .042$), with no caregiver rating the post-AMP meeting as worse than the pre-AMP meeting, and two-thirds of the caregivers rating the post-AMP meeting as "among the very best" meetings they had ever attended. (Other possible responses were *better than average*, *worse than average*, and among the very worst.) Youth satisfaction was also higher in the post-AMP meetings (M_{Pre} = 3.13, M_{Post} = 4.00, $W(8) = 0.00$, $p = .010$), with all youth giving the post-AMP meetings the highest satisfaction rating. Finally, the young people's overall empowerment with respect to their mental health condition was assessed with the Youth

Empowerment Scale (Walker, et al., 2010). Total scores increased significantly from pre- to post-AMP (M_{Pre} = 72.22, M_{Post} = 84.00, $t(8)$ = -2.35, p = .047). Scores from one of the three subscales indicated that youth were also significantly more confident in working with service providers to optimize their services and supports (M_{Pre} = 27.67, M_{Post} = 31.56, $t(8)$ = -2.70, p = .027). Scores on the other two subscales were not significantly different from pre- to post-AMP.

Conclusions and Implications for Practice

Results from the Nevada and national fidelity studies showed caregivers generally reporting higher levels of satisfaction with their participation in wraparound planning than youth. Unlike previous qualitative research with parents (Jivanjee, Kruzich, & Gordon, 2009), parents of older youth did not report less satisfaction with their own involvement in planning services in the Nevada study, and any negative linear or curvilinear relationships between youth age and caregiver participation from the national study were very weak or non-significant. Thus, youth age was not a useful predictor of perceptions of participation in wraparound for either caregivers or youth.

The Nevada study revealed a strong pattern of increasing discrepancies as youth got older, such that older youth were more likely to rate their level of participation in planning differently than caregivers rated their own levels. This pattern did not emerge in the data from the national study. This raised the possibility that discrepancies on teams with older youth was emerging in Nevada because fidelity to the wraparound process was low. The findings from the AMP pilot study could not test this hypothesis directly; however, the data did provide evidence that, through attention to youth engagement, preparation, and team process, it is possible to increase both objective (as assessed through coding of video data) and subjective (as assessed through surveys filled out by youth, caregivers, and other team members) indicators of

meaningful participation among older youth. After participation in AMP, youth felt more empowered and had greater confidence in their ability to work with providers to optimize their services. What is more, the increase in youth participation and empowerment did not appear to come at the expense caregivers' satisfaction with the team experience.

Findings from these studies should be taken in light of a number of limitations. An overall caution is that data from the studies described here can only provide preliminary responses to the research questions. Only the AMP study was specifically designed to test propositions about youth participation in team planning, and the sample sizes in two of the studies (Nevada and AMP) were quite small. Furthermore, none of the analyses included youth characteristics—such as a history of trauma or living in substitute care—that may well impact adolescents' participation in wraparound. Additionally, the integration of findings across studies 1 and 2 is complicated by the fact that different measures were analyzed for each study. It is also important to note that the studies do not speak to what might happen on teams on which the young person has passed the age of 18. Two of the studies did not include youth over age 18, and in the third (the national study), only a few (6%) of the respondents were over 18. Additionally, it should be kept in mind that even in the absence of a negative relationship between youth age and participation, it is still possible that participation is more meaningful for older than for younger youth (e.g., the same level of participation have a greater impact on treatment outcomes for older than for younger youth), due to the increasing importance of achieving autonomy and individuation as youth approach adulthood.

As noted at the introduction, there are large numbers of youth who are served by programs employing team-based collaborative planning and espousing the importance of having youth participate meaningfully in the planning process. It thus seems quite uncontroversial to

suggest that these programs have a responsibility to gather reliable information about youth perceptions of involvement, and to use this data as part of quality assurance and supervisory processes. At least in the case of wraparound, the findings presented here suggest that team members should be made aware that, if a young person is alienated from the team process, it may well be due to remediable problems related to engagement, preparation or overall team process, rather than factors outside of team control, particularly youth age. Team members should also be aware that there are specific strategies—such as those incorporated into the AMP intervention—that may be helpful for increasing youth participation and engagement in team planning. Finally, these findings challenge the notion that youth participation necessarily comes at the expense of caregiver participation; post-AMP, caregivers were significantly more satisfied with the meetings even as youth participation—as measured by objective indicators and as assessed from both youth and adult perspectives—increased.

While all of the data examined in this study came from teams that were striving to implement a wraparound-like approach, the findings may nonetheless be of interest to people involved in other sorts of team planning as well, including IEP, youth decision meetings, and other approaches. Other planning approaches that include youth do so for reasons similar to those laid out in wraparound's theory of change, and the practice elements that are part of high quality wraparound practice or the AMP intervention could be implemented with other populations as well. Thus, it is clear that further study is needed to more fully explore links between youth participation in planning and important mental health-, education- and transition-related outcomes.

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