A COLLABORATIVE EVALUATION OF AN INDIVIDUAL PLAN SYSTEM

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INTRODUCTION

Background to the Study

A great deal of emphasis has been given in recent years to the need to plan services for people with a mental handicap on an **individual** basis. For example the important section in PASS (Wolfensberger & Glenn, 1975) on model coherency lays emphasis on the need for individually-orientated services. In Britain, both the Independent Development Council (1982) and the Welsh Office (1983) have stressed individual planning as an essential component of new services. Practical guidelines are available on setting up and running individual planning systems (for example, Blunden, 1980; Materials Development Center, 1978; Schater et al., 1978) as well as various components such as goal planning (Houts and Scott, 1975), writing behavioural contracts (De Risi and Butz, 1975), running meetings (Renton, 1980) and teamwork (Rubin, Plovnic and Fry, 1975).

However, there is little evidence in the literature to date of evaluations of the effectiveness of individual planning systems. Some components have been evaluated separately. Gilliam and Coleman (1981) and Pfeiffer and Naglieri (1983) investigated the effectiveness of multi-disciplinary team decision making; Page et al. (1981) reported an evaluation of a training workshop to teach inter-disciplinary teams to write IPP goals and objectives; Goldstein, Strickland Turnbull and Curry (1980), and Bailey et al. (1985) evaluated the participation of members in inter-disciplinary team meetings.

One evaluation of an entire system of individual programme planning was undertaken by Fleming (1985) at a small hospital for mentally handicapped people in Britain. He examined both the attendance at the IPP meetings and the goals set and their outcomes, and concluded that the IPP system had been an effective way of enabling a large number of different professionals jointly to set goals to meet the needs of mentally handicapped people.

The study reported here evaluated a system of individual planning adopted by the NIMROD Service – a pilot, comprehensive, community-based service for people with a mental handicap in Cardiff (Mathieson and Blunden, 1980). Since 1981, the Service has been the subject of a major long-term evaluation by the Mental Handicap in Wales – Applied Research Unit (Humphreys et al., 1983). The Research Unit has, in recent years, been influenced by the work of Patton (1982) on collaborative evaluation. This approach advocates close involvement of all 'stakeholders' in the products of research, in the design of the study, and in the interpretation of the resulting data. In this way, relevant questions are asked, and the utility value of the research is maximised. This increases the likelihood that the results of research studies will have implications for service practice and that recommendations become implemented. This approach to research has been successfully used in other recent studies undertaken by this Unit in collaboration with service personnel (Evans and Blunden, 1984; Evans et al., 1984).

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NIMROD's Individual Plan System

NIMROD has developed its own model for a system of Individual Planning (NIMROD, 1980) from an early draft guide document, setting out the principles on which Individual Planning is based (Blunden, 1980). The system adopted by NIMROD has been operational since 1980, and thus a vast amount of 'craft-knowledge' has been accumulated to date. As a developing, innovative service, NIMROD is committed to examining and modifying its practices as necessary in the light of experience. Initiatives for this study were therefore keenly taken up from research and service sides, both of which receive numerous requests for information and practical guidance on the establishment of IP systems, particularly in the light of new service developments initiated under the All-Wales Strategy (Welsh Office, 1983), whereby many Welsh counties are including in their plans, the establishment of individual planning systems as the corner-stone of their service co-ordination and service delivery networks. At this stage in developments, there were thus many valid reasons for mounting a study of one working model of Individual Planning.

AIMS OF THE STUDY

The aims of this study were:-

(i) to consult other agencies, staff and consumers on their views of the usefulness of the components of NIMROD's IP System.

(ii) to generate new ideas, based on suggestions made by the users of the System.

(iii) to raise key issues which the Service could develop as practical proposals to pilot.

SUBJECTS

The Clients

According to the NIMROD model of service delivery, each NIMROD client is included in the IP System. For the purposes of this study it was not considered feasible to include all NIMROD's clients because of time constraints. Accordingly, a 23% sample (19 clients) of those clients who had at least one IP meeting during the previous year was selected. The sample reflected the entire NIMROD population in terms of residential setting, age, degree of dependency and previous experience of the IP System. However, it was not representative of those who had infrequent or no IP meetings.* Eighty-four NIMROD clients (62%) had had at least one IP meeting in the previous year. However, there were 51 NIMROD clients who had not had an IP meeting in this period, the majority of whom (73%) lived in hospitals or hostels.

The NIMROD Service has been phased sequentially into each of four geographical areas ('Communities') over a 2-year period. The clients of the study were fairly evenly spread across these four Communities: there were 6 clients from Community 1; 5 from Community 2; 4 from Community 3; and 4 clients were from NIMROD's fourth Community.

The ratio of male:female clients in the study was 13:6. In the entire NIMROD sample there are approximately equal numbers of males and females. As regards

* A number of people, nominally NIMROD clients, did not have regular IP meetings. This was principally due to the difficulty in arranging such meetings when either the client or his or her relatives had declined to take up the services offered, or when major control or responsibility for the client's life was vested in another agency (such as a mental handicap hospital).

residential setting of the clients in the study, 14 (74%) lived at home with their families; 4 (21%) lived in NIMROD houses, and 1 client (5%) lived in non-NIMROD long-term residential care. These proportions are very similar to the residential settings of the entire sample of 84 clients who had IP meetings in the previous year.

Of the 19 subjects, there were 16 adults and 3 children, again representative of the 84 clients who had IP meetings in the previous year. The children ranged in age from 9 to 16 years. Eleven adults were aged between 17 and 25 years, 3 adults were aged between 26 and 40 years, and 2 were aged 41 - 60 years.

The main classifications of degree of dependency (Humphreys, Lowe and Blunden, 1984) occurred in similar proportions in the sample as they did in the entire NIMROD population: 8 (42%) clients were described as 'CAN' and able (continent, ambulant, not behaviour disordered and able to carry out the activities of washing, eating and dressing); 5 (26%) were described as medium dependency; 2 clients (11%) were of high dependency; 2 clients had severe problem behaviours only, and a further 2 clients had severe problem behaviours and high dependency.

As the NIMROD Service had been operational for different lengths of time in each of the 4 Communities, it was expected that clients and families would have varying degrees of experience of the IP system. In this respect, clients in Community 1 were attending their 7th or 8th IP meeting, Community 2 clients their 6th meeting, Community 3 clients were attending their 5th meeting, and Community 4 clients were attending their 3rd IP meeting.

The Interviewees and Respondents

The IP meetings of the above 19 clients formed the basis of the study. In order to collect information on the views of all people attending each of these 19 meetings, the clients and families were interviewed by a researcher. Accordingly, 25 'consumers' were interviewed: 11 clients were able to give verbal opinions and were interviewed following their IP meeting; 14 clients had a family member who attended their IP meeting, and these family members were also interviewed.

Staff attending each meeting were sent a postal questionnaire. The postal questionnaire was sent out to each of the 100 staff members who attended the 19 IP meetings. Seventy-six questionnaires were completed and returned: 48 from NIMROD staff and 28 from non-NIMROD staff.

METHODS

(i) I.P. Questionnaire

As a result of a series of collaborative meetings of the 'task force' of 2 researchers and 3 NIMROD staff, a questionnaire was designed to address the issues which were agreed by the group to be of importance in the evaluation of the I.P. system. A modified version of the postal questionnaire was produced so that it could also be administered by interviewing clients and families.

The areas covered in both questionnaire and interview included: attendance at IP meetings; venue; frequency and length of meeting; usefulness of Goal Lists and Strengths/Needs Lists; opportunities to express opinions at meetings and agreement with decisions reached; Key-Worker contact before and after the meeting; affective experiences of the meeting itself; involvement in other review systems;

achievements, problems and suggested improvements to the IP system. The majority of the questions had pre-defined response categories with space for respondents' comments. The questionnaire was sent out to all staff who attended the meetings, 7 - 10 days after the meeting had taken place. The questionnaire was administered by interview to clients and families, on average, 9 days after their IP meeting. All families interviewed were known to the researchers, as they were already part of the ongoing long-term evaluation of NIMROD (Humphreys et al., 1984).

(ii) Key-Worker Questionnaire

Key-Workers undertake the primary co-ordinating and preparatory role in the IP system, and so it was felt important to attempt to estimate the extent of the workload involved in administering the IP system. To this end, each of the 10 Key-Workers for the 19 clients in the study was sent an additional questionnaire to determine the time spent on preparation for the meetings studied; the type of preparation (visits, telephone calls, correspondence, administrative work), the number and range of contacts made, and the reasons for making these contacts. Nine out of ten questionnaires were returned completed.

(iii) Observational Checklist

All but one of the 19 IP meetings was attended by a member of the collaborative 'task force'. One client declined permission for a researcher to attend his IP meeting, but he did agree to be interviewed about his IP meeting. Using an observational checklist developed for the study, and drawing on some of the ideas of Bailey et al., (1983) for measuring individual participation on inter-disciplinary teams, the proceedings of the meeting were observed and recorded. The order of events and the time spent on each part of the meeting was noted, as were the type of contributions made and individuals making them. The 'meeting behaviours' targetted included: providing information to the group; seeking information; suggesting goals or strategies; accepting responsibility; submitting reports or papers; providing feedback to client. Behaviours other than 'meeting behaviours' per se, were noted when observed: use of technical terms or medical jargon; late arrivals and early departures; distracting behaviours; mode of delivery of written information on clients strengths and needs.

The general environment of the IP meeting was also observed and recorded: whether participants were seated around a table; whether there were 'preferential' seating arrangements; whether refreshments were served; disturbances from outside the room; whether the meeting began on time and ran for its scheduled length.

With regard to more specific content of the meetings, all instances of decisions being made and action reported were carefully recorded on the observer's checklist for eventual matching with the Goal List, the record of the meeting prepared by NIMROD.

(iv) Document Analysis and Goal Review

The NIMROD IP guide recommends that the outcome of all goals and tasks worked on during the six months preceding the meeting are recorded on a client's Goal List and reported at the meeting itself. Researchers abstracted goal outcome information from clients' files and compared this with the outcomes reported during the meeting. In addition, all goals and tasks agreed at the IP meetings and recorded on the *Goal List were analysed according to their type, degree of specificity and* whether they related to principles of normalisation.

RESULTS

Attendance at IP Meetings

The 19 meetings studied were well attended. Of the 169 people invited, 138 attended, i.e. 82% attendance. On average, 9 people were invited to each meeting (range 7 - 14) and 7 attended (range 5 - 9). Clients attended 18 out of 19 meetings. Fourteen clients were in contact with their families and family members attended all 14 meetings.

Representatives from a wide range of services attended the meetings studied. Typically, 3 members of NIMROD staff attended, 2 workers from the clients' day setting, a representative from the health service, and a social services representative. In only 2 of the 19 meetings was no other organisation besides NIMROD represented.

Superfluous attendance was not a problem identified by respondents; only 8 staff members (8% of all respondents) felt that someone had attended whose presence was felt to have been unnecessary. However, 59% of respondents identified people who did not attend the meeting, but who they felt should have been in attendance. Amongst clients and families, the presence of representatives from the health service, and volunteers or friends was requested most often, followed closely by short-term care and day care staff. Amongst staff, the attendance of other family members besides the client's mother was by far the most frequently requested.

Frequency of IP Meetings

IP meetings were being held regularly for the clients studied. Eighteen out of the 19 meetings sampled were being held at intervals of between 6 and 8½ months.

NIMROD schedules 6-monthly meetings whenever possible, and this was found to be the preferred frequency for most respondents (71%). However, 46% of non-NIMROD staff and 27% of clients advocated less frequent (i.e. annual) meetings. NIMROD staff were the only group of respondents who suggested more frequent IP meetings for some people.

Venue of IP Meetings

Sixteen of the 19 meetings studied were held in the client's day care setting. Seventy-two percent of respondents were satisfied with the venue of the IP meeting. Other suggestions, particularly amongst NIMROD staff and clients, were for meetings to be held in a more 'neutral' setting, such as the client's home.

The IP Meeting

Fifteen out of the 18 meetings for which an observer was present began within 5 minutes of their scheduled time. Meetings were arranged for one hour, and 50% finished in one hour, plus or minus 5 minutes. Three meetings continued for more than 5 minutes over the hour and 6 meetings finished more than 5 minutes early.

The meetings observed were generally informal events, but there were some indications that small adjustments could be made to improve 'comfort' factors at meetings. Refreshments were served in only 2 of the 18 meetings. Introduction of participants did not occur in 5 meetings. Meetings were held in small, uncomfortable rooms in 2 cases, and in 6 meetings there were disturbances outside of the room, such as extraneous noise. In 16 of the 18 meetings, there was some sort of

distraction during the meeting, such as late arrivals, early departures, and temporary entrances or exits from the room.

All attenders contributed to the meetings. Participants contributed to differing degrees, as appropriate to the individual nature of each meeting. As Table 1 shows, parents and Key-Workers tended to make the majority of the contributions and clients the least, although 13 out of 17 clients did make some contribution to their own meeting.

TABLE 1

Who Contributes to IP Meetings

Contributor	No. meetings present at (18 observed)	mean % contribution made	range
Key-Workers	17	23%	6 - 33%
Parents	14	22%	11 - 40%
Chairpersons	18	19%	11 - 30%
Community Care Workers	15	12%	5 - 30%
Teachers/ATC tutors	14	12%	2 - 32%
ATC/school managers	15	11%	5 - 17%
clients	17	8%	0 - 19%
OTHERS			
Community Nurses	3	9%	4 - 12%
Staffed House Workers	3	19%	11 - 30%
non-NIMROD social workers	2	5%	5%
home help	1	12%	—
psychologist	1	5%	—
volunteer	1	6%	—

There was a large measure of satisfaction among participants with the opportunities for expressing their opinions at IP meetings. Ninety-two percent of respondents felt that they had had opportunities to express their opinions. As a group, most respondents (85%) said that they agreed with decisions reached at IP meetings, although 15% noted that a decision had been taken with which they had disagreed. Amongst respondent groups, this figure was slightly higher (18%) for the clients themselves.

IP meetings tend to follow a set order. In 14 out of 18 meetings this was:- introductions/ apologies; review of goal progress during the past 6 months; presentation of client's Strengths/ Needs information; development of new goals; confirmation of new Goal List; arrangement of next meeting. The proportion of the total time spent on each activity varied greatly between meetings, suggesting that the meetings were being tailored to suit individual's requirements. The greatest

part of most meetings was taken up in reviewing the client's Strengths/ Needs list and in discussing new goals for clients (Table 2).

TABLE 2

Time Spent on Different Activities at IP Meetings

Activity	mean time (mins)	mean % of total time	range
introductions/apologies	2	3%	2 - 8%
reviewing old goals	12	21%	4 - 51%
presenting Strengths/Needs list	19	33%	11 - 61%
discussion of new goals	14	25%	12 - 71%
confirming new Goal List	8	14%	6 - 33%
agreeing date of next meeting	2	3%	1 - 9%

Of the various types of contributions made at meetings (Table 3), providing information to the group was the main activity undertaken. Parents were, by far, the main group of participants who provided information. Providing feedback to the clients was the next most prevalent type of contribution, and was primarily undertaken by the Key-Worker.

TABLE 3

Type of Contributions at IP Meetings

Type of Contribution	mean % contribution	Who contributes most
information providing	52%	parents
information seeking	16%	Chairperson
suggesting goals/ strategies	11%	Chairperson
accepting responsibility	2%	Key-Worker & CCW
submitting reports	1%	Key-Worker
feedback to clients	19%	Key-Worker

There was other evidence of efforts to involve clients and families in the meetings: at most meetings (13 out of 17) written, circulated information was presented in an informal style. There was little evidence of use of jargon or technical/medical terms: in only 6 meetings did somebody use a term which might not be widely understood.

However, despite obvious efforts to involve clients, of all participants, clients contributed the least. In choosing adjectives to describe how they felt at meetings, clients use adjectives like 'bored' or 'nervous' more than other groups of respondents and selected 'involved', 'relaxed' or 'confident', less. In general, all respondents

used positive adjectives much more frequently than their negative opposites when describing how they felt at IP meetings. Interestingly, clients described themselves most often as 'pleased' or 'happy', while staff and families used such adjectives as 'interested' or 'involved'.

The Paperwork of IP Meetings

One-third of IP meeting time is taken up with the presentation of information on the client's strengths and needs. 80% of NIMROD and non-NIMROD staff found the Strengths/Needs lists either very useful or quite useful. Over half of the families (57%) also recognised their usefulness, if not to them personally (having been the main providers of the Strengths/Needs data), then especially to new staff working with the client. The value of having such information recorded in clients' files was mentioned by families. Many clients (72%) were not able to express an opinion on the usefulness of Strengths/Needs lists.

Goal Lists were said to be useful by 89% of families and staff. Goal Lists do not appear to represent unnecessary paperwork associated with the IP system, as most respondents used, referred to and kept the Goal Lists.

Action reported during IP meetings concerned mainly the outcome of goals and tasks worked on since the last IP meeting. For the 18 observed meetings, 138 main items were discussed when progress since the last IP was reviewed. For 127 of these items, the outcome reported at the meeting agreed with the outcome entered on the Goal List. For 11 items, the outcome reported differed from the recorded outcome. These were mainly items reported at the meeting as 'not achieved', but recorded as 'achieved'.

All decisions taken at the meetings were also noted by the observer. Of 208 decisions made at the meetings, 160 were recorded on the Goal List. Many of the unrecorded decisions were 'to continue' goals, tasks or opportunities for clients. However, many appeared to be specific tasks for named staff members to follow up.

Goals and Tasks resulting from IP Meetings

Written goals, tasks, or both, resulted from every IP meeting studied. On average, 3 client-orientated goals (range 0 - 7) and 6 staff-related tasks (range 0 - 9) were agreed at the IP meetings observed. Goals were set in 15 different skill areas, but over one-third related to the development of clients' domestic, leisure or community-living skills. One-third of tasks were service-related, involving, for example, referrals to other services, or obtaining aids or benefits for clients.

Of the 61 goals which resulted from the IP meetings studied, all but 3 were judged to be culturally appropriate and related to the chronological age of the client. The majority of goals (93%) had a named person with responsibility for attaining them and 90% of goals indicated a clearly specified activity to be attained. However, for only 28% of goals was it apparent that the goal set would involve the use of non-segregated facilities, and in 31% of cases could the goal be said to directly promote independence.

Very few goals or tasks (less than 10%) included clearly specified criteria or conditions for attainment, to enable accurate or objective evaluation of their outcome. Of the 105 staff-related 'tasks' appearing on the Goal Lists, 20 were 'opportunities' for clients to learn various skills and could conceivably have been written as client-orientated goals.

A high proportion of goals (62%) and tasks (68%) which were set at the last IP meeting were reported as having been achieved. Comparisons made between the 19 clients sampled for this study and the entire NIMROD population indicated that levels of achievement were very similar. The results obtained would not appear to be a function of sampling only those clients who were having regular IP meetings.

Preparatory Work for IP Meetings

Key-Workers are the main people responsible for completing the necessary preparatory work before an IP meeting. Key-Workers typically spend 5 hours in IP preparation, this being accounted for by pre-meeting visits to clients, families, day care staff and NIMROD workers involved with the client. Key-Workers typically contact 5 sources to prepare for an IP. The main reasons for contact concerned the client's progress in day care, the client's goal progress, updating the Strengths/Needs list and checking on families' needs.

NIMROD Social Workers, as well as providing social work support to all NIMROD clients, act as Key-Workers, and each undertakes IP preparation for up to 25 clients. Each NIMROD Senior Care Worker acts as Key-Worker for an average of 5 clients living in NIMROD residential accommodation. The three non-NIMROD Key-Workers have generic caseloads as well as being involved in IP preparation for a total of 19 clients. All families said that they had been visited by their Key-Worker before the IP meeting, and for 13 out of 14 families, this was a usual occurrence. Eight out of 11 clients said that they had seen their Key-Worker before the meeting. For staff, 86% had been contacted by a Key-Worker prior to an IP meeting. Relevant people appear therefore to have been consulted in the preparatory work for IP meetings. Regarding Key-Worker visits following an IP meeting, 36% of clients and 50% of families said they had seen, or usually see their Key-Worker after an IP meeting.

There was little evidence of overlap between the IP system and other existing systems for reviewing clients' progress. Only 2 families (11%) were involved in other (paediatric) reviews, while 15% of staff were involved in other reviews for the client.

DISCUSSION

This study has focussed primarily on the IP meetings themselves and on the ensuing documentation, rather than on a descriptive analysis of the work of staff in putting the Plan into operation. The results of this review of the NIMROD Individual Planning System may have implications for the Service itself, and may also be of benefit to other agencies at various stages in the development and implementation of a system for individual planning.

The NIMROD IP System has been operating largely unchanged for over 4 years. Clearly, any such system needs to build in self-review procedures which define the major accomplishments of the system, and measure these in terms of outcomes for clients. It is conceivable that an IP system could operate within its procedural guidelines, be popular with clients, families and staff, but still not have any substantial effect on the lives of the people served. At present, neither research nor service has a systematic way of reviewing each individual's progress towards the general objectives of integration and independence, and such methods must be developed.

The attendance of clients and families at meetings helps to focus the meeting on their needs, but cannot guarantee their participation and involvement. There are many factors which help to contribute to a 'successful' meeting including adequate preparation; the Chairperson knowing the client and family; absence of disruptions or disturbances; comfortable room with non-preferential seating arrangements; the serving of refreshments; introductions to ensure that participants are known to each other; jargon-free discussions; talking **to** clients rather than **about** them, and presenting written information in an informal and conversational style. In addition, different ways of involving clients and allowing them, as far as possible, to present themselves as people with individual and changing strengths and needs are worthy of exploration. In particular, the establishment of small self-advocacy groups, where people with mental handicaps could be encouraged to share their experiences of IP meetings, and to derive meaningful ways of describing themselves and their ambitions, would be a positive step. The use of art, photography or video to describe their interests would be of particular benefit to people with limited verbal abilities. Adaption of repertory grid concepts to help individuals understand themselves, by considering ways in which they are similar to, or different from their peers may be a further approach in helping people with a mental handicap to describe their strengths and needs.

In the NIMROD System, Key-Workers are charged with the main responsibility for preparation for IP meetings. Sufficient time must be available for adequate preparation and follow through, given that all Key-Workers have other professional commitments in addition to their input to the IP System. Consideration also needs to be given to the possibility of distributing the Key-Worker role amongst a greater range of staff, or to the sharing out of the various tasks presently undertaken by Key-Workers. Ways of ensuring that preparation is more thorough and less repetitive need to be explored. Alternative methods of data collection prior to the IP meeting could be considered, and a more streamlined style for the presentation of written information may be of benefit: stipulating the source of the information, since performance often differs between environments; designing summaries which emphasise changes since the previous IP; organising information into categories such as 'social', 'educational, and 'domestic'.

Key people need to be identified, invited to and attend IP meetings. In their absence, important information may be lacking, which may lead to gaps in knowledge and services offered. Important decisions may have to be deferred if an appropriate person is not present to accept responsibility for required tasks. In addition, if key personnel leave their posts, or cannot attend, effective methods of summarising their progress on assigned tasks and goals need to be developed, so that participants are not left without important information at the meeting. With regard to the people attending an IP meeting, the level of input from staff of any organisation may be worthy of further consideration, in terms of whether both managers and direct care workers attend. If people working directly with a client and who have the greater knowledge attend, then they must be in a position to take on responsibilities and allocate resources if the manager does not attend. As a group, staff felt that other family members besides the mother should be encouraged to attend IP meetings. If this is a serious shortcoming, then the possibility of holding late afternoon or evening meetings has to be balanced against the proportion of staff who will be free to attend.

It appears to be important to hold the first two or three meetings at six-monthly intervals, but after that, their frequency could be determined on an individual basis,

with some clients needing more frequent, and others needing less frequent meetings. Key-Worker visits in the week following the IP could also be reviewed on this basis. However, if meetings are held less frequently than 6-monthly, then additional mechanisms for participants to review progress in the interim will need to be established.

CONCLUSIONS

This collaborative evaluation of one working model of an Individual Planning system has produced a wealth of qualitative and quantitative data, which have shown that the System, as operated by the NIMROD Service, has received a large measure of support from its users. The study has also identified a number of needs which the Service, and other services elsewhere could usefully adopt as starting points for a review of practice.

In general, it seems that Individual Plan systems appear to have two parallel aims. One set of aims is client- related and is often stated in terms of helping clients and families to express their needs with dignity, and to obtain, in a co-ordinated fashion, the services necessary to meet these needs. The second set of aims is more service-related; IP systems may be thought of as an administrative framework to service providers which maximises communication and minimises duplication and enables practitioners to discharge their roles effectively. Tensions inevitably arise between these two sets of aims. For example, the professionals' requirement for concise summaries of clients' needs and progress may result in statements which do less than justice to the clients' views and dignity. It may not always be apparent that the Individual Plan System is to enable clients to **choose** a preferred course of action, rather than simply defining and compensating for skill deficits. There appears to be no simple resolution to this conflict. However, the emergence of self-advocacy and citizen advocacy schemes may go a long way towards helping people with mental handicap to negotiate assertively and effectively with the service delivery system.

This study has raised a number of issues which could usefully form the subject of further applied research aimed at developing and evaluating methods of planning for individuals. Client outcome is one key area which merits further study. Research is needed which would examine the relationship between decisions made in the individual planning process (including goals set) and the style and quality of life experienced by service clients. For example, do decisions relating to people's accommodation, day occupation or leisure time, have a measurable impact upon their lifestyle? Within this Unit, measures of lifestyle are currently being developed which may assist in this area.

In addition to the refinement of outcome measures, further research is needed into the IP process itself. In the light of the findings of this study, a number of modifications are suggested which would also have implications for staff training and the design of record systems. Applied research, with an appropriate experimental design and outcome measures would clearly be a fruitful activity.

A full report of the study on which this paper is based may be obtained from the Mental Handicap in Wales - Applied Research Unit, St. David's Hospital, Cardiff CF1 9TZ, U.K.

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