change in their responsibilities for child protection assessment and therapy, despite their desire to reduce their responsibilities in these areas. A content analysis of responses to open-ended questions underlined respondents' view that the unique contribution of clinical psychology to the Health Boards may shift from the current emphasis on face-to-face clinical service delivery to the provision of a broader consultancy service in the future.

INTRODUCTION

Policy documents produced by the Psychological Society of Ireland (PSI, 1975; 1984), important reviews of the profession conducted in the UK (MAS, 1989; MPAG, 1990) and comparative analyses of clinical psychology on both sides of the Atlantic (Pilgrim & Treacher, 1992) underline the complex professional roles clinical psychologists are expected to undertake. Surveys of clinical psychologists conducted in Ireland, the US and the UK highlight how such policies have shaped some aspects of the roles of clinical psychologists in practice (Carr, 1995, 1996a, 1996b; Norcross, Dryden & Brust, 1992; Norcross, Brust & Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b). A recent Irish survey concluded that clinical psychologists in Ireland were a small but highly trained group of professionals who shared certain core clinical, research and organizational skills but who also were segmented into specialties offering services to children and families; adults with psychiatric and medical problems; and people of all ages with learning disabilities (Carr, 1995, 1996a, 1996b). Learning disability

specialists were employed predominantly within the private voluntary sector whereas those working in the other two specialties were employed largely within the public Health Boards.

To date, in Ireland, a detailed analysis of the actual roles of clinical psychologists has not been conducted, nor has an attempt been made to identify either the role responsibilities that clinical psychologists ideally would like to adopt or indeed the role responsibilities they expect they will have to undertake given the current climate within Irish Health Services. The present study aimed to fill this gap in our knowledge and to focus specifically on clinical psychologists' roles within the public Health Board system.

METHOD

Participants and Procedure

Senior psychologists or service directors in each of the eight health boards in the Republic of Ireland were contacted at the outset of this study. With their help, all 123 clinical psychologists employed by the Health Boards in the later months of 1994 and the early months of 1995 were surveyed. Respondents were sent a questionnaire described below, an SAE and a covering letter in which the aims of the study were outlined and confidentiality was guaranteed.

Instruments

A 6 page, 89 item questionnaire which inquired about demographic characteristics and professional responsibilities of clinical psychologists was compiled for this study. The items, describing professional responsibilities and tasks, were drawn from policy documents and reports on the role of clinical psychologists in Ireland and the UK and questionnaires used in previous surveys (PSI, 1975; 1984; MAS, 1989; MPAG, 1990; Carr, 1995, 1996a, 1996b; Norcross, Dryden & Brust, 1992; Norcross, Brust & Dryden, 1992; Norcross, Prochaska & Gallagher, 1989a, 1989b; Norcross & Prochaska, 1982a, 1982b). Items that described related responsibilities, tasks and activities were combined into scales. For example the following items formed the Child Medical/Physical Disability Scale.

For the population Child Medical / Physical Disability Client Population indicate which of the following responsibilities form part of your actual role....

1. Involved in assessment of cognitive and psychological status of children
2. Treat children directly using psychological interventions
3. Treat children indirectly through consultation with multidisciplinary team members
4. Treat children indirectly through consultation with non-multidisciplinary team members
5. Co-work with multidisciplinary team members in the treatment of children
6. Co-work with non-multidisciplinary team members in the treatment of children

7. Work with relatives of children
8. Provide psychological support for children with problems such as diabetes, asthma etc., to enable them to adjust to the consequences of medical intervention and/or their condition.

Scales were constructed describing specialist clinical services for children in the following seven areas: child psychiatric problems; child medical/physical disability; child learning disability; child protection assessment; child protection therapy; access and custody consultations; and fostering and adoption consultations. For adult services, scales were constructed for adult psychiatric problems and for adult medical/physical disability. Scales were constructed for the following ten non-clinical areas of responsibility: service planning; staff support; community support; teaching and supervision; research and evaluation; organizational consultancy; management; routine administration; continual professional development; and public relations.

For all items in these scales, participants were asked to indicate three responses. First, they were asked to indicate if the responsibility described in the item formed part of their *actual role* as a clinical psychologist at the time of the survey. Second, they were asked to indicate if the activity described in the item was one that they would ideally like to undertake as part of their role. That is, they were asked to indicate if it formed part of their *desired role*. Third, they were asked to indicate if they realistically expected that the item would form part of their role in the future. That is, they were asked to indicate if the item formed part of their *expected future role*. Given this response structure, the questionnaire permitted scores on each scale to be computed for three role categories: actual role, desired role and expected future role.

For each role category of each scale, a respondent's score was obtained by summing the number of items endorsed and

dividing this sum by the number of items in the scale. This number was then multiplied by 100. Thus, when interpreting descriptive statistics, it may be borne in mind that the range for all scales is 1-100.

Chronbach's alpha reliability coefficient was computed to determine the internal consistency of all scales. For each scale, alpha coefficients were computed for actual role scores, desired role scores and expected role scores. For the clinical scales reliability coefficients ranged from .73 to .99. For the non-clinical scales, alpha coefficients from .61 to .91 were obtained. However 23 out of these 30 alpha coefficients were above .7. It may therefore be concluded that most of the scales used in this study showed a moderate to high degree of internal consistency and so each may be taken to reflect an underlying dimension of work role activity or responsibility.

In addition to items from the scales, the questionnaire also contained a series of four open-ended questions which asked for opinions about the current and future contributions of clinical psychologists to health services. A copy of the questionnaire is available for the corresponding author.

Table 3.1. Demographic characteristics

Variable	Category	N	%
Age	<30y	17	25
	30-40y	35	52
	41-51y	13	19
	52-62y	1	2
	63+y	1	2
Gender	Female	52	78
	Male	15	22
Marital status	Married	28	42
	Single	31	46
	Other	8	12
Qualifications	Accredited Masters in clinical psych	35	52
	Accredited diploma in clinical psychology	14	20
	Doctorate	2	3
	Non-accredited Masters in applied psych	10	15
	Other	6	9
Health Board where employed	Eastern	17	25
	North Eastern	8	12
	North Western	9	13
	Midland	2	3
	South Eastern	11	16
	Southern	5	8
	Western	5	8
	Mid-western	10	15
Health Board Programme	Community Care	39	58

	Special Hospital	28	42
Years of post-qualification experience	<3	25	37
	3-12	31	46
	13-25	11	16
Years employed in Health Boards	<3	30	45
	3-12	28	42
	13-25	9	13
Years employed with current Health Board	<3	30	45
	3-12	28	42
	13-25	9	13
Employment status	Full time	62	92
	Part time	5	8
Grade	Basic	35	52
	Senior	32	47
Specialty	Child & Family	40	60
	Adult	25	37
	Learning disability	2	3

RESULTS

Data were verified and analysed using SPSS (Norusis, 1990).

Response rate and demographic characteristics of respondents

Sixty-seven of 123 respondents returned questionnaires yielding a response rate of 54%. Demographic characteristics of respondents are given in Table 3. 1. Respondents were predominately female full time employees in their 20s or 30s with a PSI or BPS accredited qualification in clinical psychology. Respondents came from all eight health boards and both community care and special (psychiatric) hospital programmes with the vast majority having less than 12 years experience. Respondents were divided almost equally between senior (n=32) and basic grade (n=35) posts. Forty respondents were from the child specialty but only 25 were from the adult specialty. In the comparative analyses described in the next two section, for child scales, analyses are based on scores from the 40 participants from the child specialty. For adult scales, analyses are based on scores from the 25 participants from the adult specialty. Scores from all 67 participants are used for comparative analyses of non-clinical scales.

Comparison of desired and actual role responsibilities

Means and standard deviations based on actual role and desired role scores are presented in Table 3. 2. For each scale, actual and desired role scores were compared using paired t-tests. To reduce the chance of type 1 error arising from making 19 comparisons, a p value of .01 was set as the criterion for statistical significance.

Table 3.2. Comparison of actual and desired role responsibilities

Scale		Actual Role	Desired Role	t
Adult psychiatric	M	54.0	37.5	2.40
	SD	25.7	32.7	
Adult medical/physical disability	M	14.7	14.5	0.13
	SD	22.6	26.2	
Child psychiatric	M	79.3	60.7	3.18**
	SD	28.7	39.3	
Child learning disability	M	48.2	24.6	4.27**
	SD	44.0	38.3	
Child medical/physical disability	M	29.7	37.2	1.13
	SD	39.2	42.9	
Child protection assessment	M	57.5	38.8	2.60**
	SD	45.3	46.0	
Child protection therapy	M	80.8	60.0	2.88**
	SD	32.3	44.1	
Child fostering and adoption	M	26.3	40.0	2.32
	SD	35.9	45.6	
Child access and custody	M	31.3	28.8	0.31
	SD	41.9	45.1	
Service planning	M	54.5	74.6	2.68**
	SD	43.3	40.3	
Staff support	M	59.7	59.9	0.00
	SD	42.0	46.3	

Community support	M	37.5	43.6	1.09
	SD	33.2	36.3	
Teaching and supervision	M	33.1	49.3	3.32**
	SD	28.9	35.3	
Research and evaluation	M	21.8	66.0	7.69**
	SD	29.5	43.2	
Organizational consultancy	M	14.9	45.3	5.68**
	SD	25.5	40.1	
Management	M	37.3	39.6	0.39
	SD	43.1	44.8	
Routine administration	M	93.3	56.3	6.71**
	SD	21.1	46.1	
Continual professional development	M	74.6	70.9	0.52
	SD	29.3	43.7	
Public relations	M	29.8	55.2	5.16**
	SD	46.1	43.7	

Note: For child scales, N=40. For adult scales, N=25. For non-clinical scales N=67. ** p<.01

From Table 3. 2 it may be seen that for 10 out of 19 scales there were statistically significant differences between scores from actual and desired role categories. In five instances, scores on the desired role category were lower than those from the actual role category indicating a desire for fewer responsibilities in these areas. Thus, respondents wanted fewer face-to-face clinical responsibilities in the areas of child protection assessment and therapy; child psychiatric difficulties and child learning difficulties. They also wanted less routine administration.

In five instances scores on the desired role category were greater than those from the actual role category indicating a desire

for more responsibilities in these areas. Thus, respondents wanted more responsibilities in the areas of service planning; teaching and supervision; research and evaluation; organizational consultancy; and public relations.

In nine instances, scores for actual and desired role categories did not differ significantly. This suggest that respondents were content with the degree to which they were involved in adult psychiatric consultations; face-to-face clinical work with children and adults suffering from medical problems or physical disability; child fostering and adoption services; access and custody consultations; providing staff support; providing community support; management and continuing professional development.

Comparison of expected future and actual role responsibilities.

Means and standard deviations based on actual role and expected future role scores are presented in Table 3. 3. For each scale, actual and desired role scores were compared using paired t-tests. To reduce the chance of type 1 error arising from making 19 comparisons, a p value of .01 was set as the criterion for statistical significance.

Table 3.3. Comparison of actual and expected future role responsibilities

Scale		Actual Role	Expected future Role	t
Adult psychiatric	M	54.0	47.0	0.94
	SD	25.7	35.2	

Adult medical/physical disability	M	14.7	15.0	0.25
	SD	22.6	28.6	
Child psychiatric	M	79.3	58.9	3.27**
	SD	28.7	40.1	
Child learning disability	M	48.2	26.1	3.46**
	SD	44.0	40.5	
Child medical/physical disability	M	29.7	30.6	0.16
	SD	39.2	40.4	
Child protection assessment	M	57.5	46.9	1.25
	SD	45.3	50.1	
Child protection therapy	M	80.8	68.1	1.63
	SD	32.3	45.7	
Child fostering and adoption	M	26.3	45.0	2.42
	SD	35.9	45.8	
Child access and custody	M	31.3	41.3	1.11
	SD	41.9	47.9	
Service planning	M	54.5	71.6	2.27
	SD	43.3	42.8	
Staff support	M	59.7	56.7	0.46
	SD	42.0	46.0	
Community support	M	37.5	41.7	0.75
	SD	33.2	38.6	
Teaching and supervision	M	33.1	50.5	3.51**
	SD	28.9	30.8	
Research and evaluation	M	21.8	61.5	6.01**
	SD	29.5	48.5	

Organizational consultancy	M	14.9	43.8	4.90**
	SD	25.5	43.5	
Management	M	37.3	49.3	1.75
	SD	43.1	44.8	
Routine administration	M	93.3	62.7	5.52**
	SD	21.1	45.5	
Continual professional development	M	74.6	64.2	1.70
	SD	29.3	45.9	
Public relations	M	29.8	65.7	4.43**
	SD	46.1	47.8	

Note: For child scales, N=40. For adult scales, N=25. For non-clinical scales N=67. ** p<.01

From Table 3. 3 it may be seen that for 7 out of 19 scales there were statistically significant differences between scores from actual and expected future role categories. In three instances, scores from the expected future role category were lower than those from the actual role category indicating that respondents expected to have fewer responsibilities in these areas in the future. Specifically, respondents expected that they would have fewer face-to-face clinical responsibilities in the areas of child psychiatric difficulties and child learning difficulties. They also expected that they would engage in less routine administration.

In four instances scores from the expected future role category were greater than those from the actual role category. This indicated that respondents expected more responsibilities in these areas in the future. The areas were teaching and supervision; research and evaluation; organizational consultancy; and public relations.

In twelve instances, scores for actual and expected future role categories did not differ significantly. This suggests that

respondents did not expect their work-role responsibilities in these areas to change in the future. These areas where stability in responsibilities were expected were face-to-face clinical work with adults with psychiatric problems and medical/physical disability; face-to-face clinical work with children suffering from medical problems or physical disability; child protection assessment and therapy work; access and custody work; service planning; providing staff support; providing community support; management; and continuing professional development.

Content analysis of open-ended questions

The results of a content analysis (Miles & Huberman, 1994) of responses to four open-ended questions about the current and future role of clinical psychologists in the health boards is presented in Table 3. 4. From the table it is apparent that the delivery of a sophisticated face-to-face clinical service is viewed to be the main contribution of clinical psychology to the Health Boards at present.

Table 3.4. Results of content analysis of responses to four open-ended questions about the role of clinical psychologists in the health boards

Question	Answer category	N	%

What do you perceive to be the unique contribution of the clinical psychologist to your service compared to other service providers?	Level three skills	25	41
	Psychological assessment	18	30
	Psychotherapy	18	30
	Knowledge base	16	26
	Research	13	21
	Formulation	10	16
What do you view as the future contribution of the profession within the health boards?	Service planning and evaluation	25	41
	Management	17	28
	Primary prevention	16	26
	Consultation	15	25
	Research	15	25
	Health Psychology	6	15
How best is this (i.e. future contribution to the profession) to be achieved?	Participation in management	16	26
	Better professional organization	14	23
	Educating management	14	23
	More staff and training courses	13	21
	Improvement of career structure	10	16
What do you believe are the major obstacles (if any) to future role development?	Lack of professional organization	26	43
	Insufficient staff numbers	19	31
	Other professions	17	28
	Poor career structure	11	18

This clinical service includes psychological assessment and psychotherapy for which level three skills (MAS, 1989), a wide knowledge base and a systematic approach to formulation are required. However, in the future the unique contribution of clinical psychology, according to the results of the content analysis contained in Table 3. 4, may shift from face-to-face clinical service

delivery to the provision of a broader consultancy service. Respondents reported that important future contributions of clinical psychologists will be in the areas of service planning and evaluation, management, primary prevention and consultation, research and health psychology. Participation in management was identified as the most important route through which these future contributions could be realised.

Table 3.5. Summary of comparisons of desired and expected future role responsibilities with actual role responsibilities

	Desired Role Vs Actual Role	Future Role Vs Actual Role
Adult psychiatric	**0**	**0**
Adult medical/physical disability	**0**	**0**
Child psychiatric	**-**	**-**
Child learning disability	**-**	**-**
Child medical/physical disability	**0**	**0**
Child protection assessment	**-**	**0**
Child protection therapy	**0**	**0**
Fostering and adoption	**+**	**0**
Access and custody	**0**	**0**

Service planning	+	**0**
Staff support	**0**	**0**
Community support	**0**	**0**
Teaching and supervision	+	+
Research and evaluation	+	+
Organisational consultancy	+	+
Management	**0**	**0**
Routine administration	**-**	**-**
Continual professional development	**0**	**0**
Public relations	+	+

Note: 0=no difference between roles. + more of this responsibility in the desired or expected future role. - = less of this responsibility in the desired or expected future role.

Other avenues pinpointed by respondents for realising an expanded consultancy role for clinical psychologists included better professional organization, educating management, increases in staffing and training and an improved career structure. Lack of professional organization and low staff numbers were identified as the two major barriers to future developments in clinical psychology. Competition from other professions and a poor career structure were also viewed as obstacles to clinical psychologists realising potential future contributions.

DISCUSSION

Before addressing a number of substantive issues raised by the survey, the methodological issue of sample representativness deserves discussion. The target population for this study was a total population of 123 clinical psychologists employed by the eight Health Boards in the Republic of Ireland. The relatively high response rate of 54% gives grounds for confidence in the results (Moser & Kalton, 1971). The study provides information on over half of all clinical psychologists working in health boards in the Republic of Ireland. However, without comparative data on the demographic profile of non-responders, it is difficult to make strong claims for the generalizability of the results. Unfortunately, such comparative data could not be secured. It should also be noted that the results of this survey probably have only limited implications for clinical psychologists working outside the Irish Health Board system. Within the Republic of Ireland there are about 110 psychologists working in predominantly clinical positions, outside of the public health board system (Carr, 1995, 1996a, 1996b).

A schematic summary of the principal findings of the study are set out in Table 3. 5. The wish and expectation that teaching and supervision; research and evaluation; organizational consultancy; and public relations will all become an increasingly significant part of the clinical psychologists role in the future is a central finding of both the quantitative and qualitative parts this study. It underlines the growing confidence within the profession in Ireland that the broad role of the clinical psychologist in the health services highlighted by major UK reports (MAS, 1989; MPAG, 1990) will inevitably develop in Ireland. This may offer a way in which clinical psychologists as a highly trained yet numerically small group of professionals can be most usefully deployed

within the health service. If the trend underlying responses to this survey continues, clinical psychology will become a consultant-led service with a remit to meet population health needs. Such a psychology service will aim to promote and monitor healthier lifestyles through prevention programmes and ongoing evaluative research. There will be a greater emphasis on psychologists developing treatment programmes and training other professionals in their implementation. Psychologists will also offer direct psychological services to complement medical strategies in a partnership with colleagues from medicine and other disciplines. This shared-care/consultant-role model for clinical psychology services fits with current national plans for the development of the health service (Department of Health, 1994). Factors that may facilitate the evolution of the role of the clinical psychologist identified in this study include participation in management, improved organization of the profession, increases in staffing; increases in training opportunities and an improved career structure.

The desired and expected reduction in routine administrative role responsibilities identified in this survey, highlights the wish of many psychologists to prioritise their work-related responsibilities and look to management for appropriate administrative backup so that their time may be more appropriately deployed on clinical and organizational responsibilities.

The wish to reduce the amount of face-to-face clinical responsibilities in the child protection area is not surprising given the stressful nature of this type of work. The relatively isolated work context of Irish psychologists highlighted in a previous survey (Carr, 1995, 1996a, 1996b) and the widely accepted requirement for extensive support and supervision if child protection work (Glaser, 1991) is to be carried out on a long term basis offers a coherent explanation for the wish to reduce work-role responsibilities in this area. Current government policies on the implementation of the Child Care Act and the development of child

protection services underpin respondents' expectations that little reduction in child protection work role responsibilities is likely in the future (Department of Health 1991).

The wish and expectation for reduced responsibilities for working with children with psychiatric involvement and learning difficulties reflects a recognition that colleagues in educational psychology, applied behaviour analysis, psychotherapy, psychiatry and other disciplines may increasingly take on responsibilities in these areas where traditionally clinical psychology may have made a more substantial input. Reduced input in these areas may be matched by increased responsibilities entailed by broader consultative work described earlier.

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APPENDIX TO CHAPTER 3
SURVEY OF CLINICAL PSYCHOLOGISTS ROLES

For each question please place a tick, or write your answer in the appropriate box. Thank you for your help.

Demographic Information

1. What age are you?	<30 years	30-40 yrs	41-51 yrs	52 -62 yrs.	63 + yrs.	
2. What gender are you?	Female	Male				
3. What is your marital status?	Married	Single	Other			
4. What are your qualifications?	1 year MA in psychology	MSc/MPsychSc in Clin Psych	BPsS/PSI Diploma in Clin Psych	Graduate Diploma in Psychology	Doctorate in Clin Psych	Other (e.g. work experience)

Employment

5. What health board are you presently employed with?	Easter Health Board	North Eastern Health Board	N. Western Health Board	Midland Health Board		
	S. Eastern Health Board	Southern Health Board	Western Health Board	Mid-Western Health Board		
6.. What is your main Health Board setting?	Community Care Programme	Special Hospitals programme	General Hospitals prog.			
7. How many years post-qualification experience have you got?	Years =					
8. How long have you been work with the Irish Health Boards?	Years =					
9. How long have you been with your present Health Board?	Years =					
10. Do you work part-time or full time?	Part time	Full time				
11. What is your present grade in your Health Board?	Basic	Senior	Principal	Director		
12. What is your main area of speciality?	Child and Adolescent psych	Adult Psychology	Learning Disability	Physical Disability	Psychology of older adults	Other - Specify
	Health Psychology	Forensic psychology	Neuropsych	Psychotherapy	Family Therapy	

For each of the items listed below, please indicate if the item is part of your actual role by placing a tick in the box "actual role". If the item is part of your desired role place a tick in the box "desired role" If the item is part of the profession's future role place a tick in the box "future role" If you tick an item for "actual role" please encircle the appropriate number below, corresponding to your level of role satisfaction with that item.

For example: 1 = "Very dissatisfied": 2 = "Dissatisfied": 3 = "Neutral": 4 = "Satisfied": 5 = "Very Satisfied"

	Actual Role	Satisfaction with Actual Role	Desired Role	Future Role
1. Engage in service planning and development	√	1 2 (3) 4 5		√

For some items you may see them as part of your actual, desired and future role. In such cases tick all three boxes: e.g.

	Actual Role	Satisfaction with Actual Role	Desired Role	Future Role
2. Advise and support self-help groups	√	1 (2) 3 4 5	√	√

1. Your Actual Role - relates to the activities you are presently engaged in

2. Your Idealised Role - relates to the activities you would like to be engaged in

3. The Future Role - relates to the activities you believe will be included in the future

.

1. Clinical responsibilities **Adult - Psychiatric Client Population**	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Involved in assessment of adults' cognitive and psychological status.		1 2 3 4 5		
2. Treat adults directly using psychological interventions		1 2 3 4 5		
3. Treat adults indirectly through consultation with multidisciplinary team members.		1 2 3 4 5		
4. Treat adults indirectly through consultation with non-multidisciplinary team members		1 2 3 4 5		
5. Co-Work with multidisciplinary team members in the treatment of adults.		1 2 3 4 5		
6. Co-Work with non-multidisciplinary team members in the treatment of adults.		1 2 3 4 5		
7. Work with relatives of adults		1 2 3 4 5		
8. Develop community rehabilitation programme for long term clients		1 2 3 4 5		

Adult - Medical/Physical Disability Client Population	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Involved in assessment of adults' cognitive and psychological status.		1 2 3 4 5		
2. Treat adults directly using psychological interventions		1 2 3 4 5		
3. Treat adults indirectly through consultation with multidisciplinary team members.		1 2 3 4 5		
4. Treat adults indirectly through consultation with non-multidisciplinary team members		1 2 3 4 5		
5. Co-Work with multidisciplinary team members in the treatment of adults.		1 2 3 4 5		
6. Co-Work with non-multidisciplinary team members in the treatment of adults.		1 2 3 4 5		
7. Work with relatives of adults		1 2 3 4 5		
8. Provide psychological support for adults with problems such as diabetes, asthma, etc. to enable them to adjust to consequences of medical intervention and/or their condition.		1 2 3 4 5		

Adult - Learning Disability Client Population	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Involved in assessment of adults' cognitive and psychological status.		1 2 3 4 5		
2. Treat adults directly using psychological interventions		1 2 3 4 5		
3. Treat adults indirectly through consultation with multidisciplinary team members.		1 2 3 4 5		
4. Treat adults indirectly through consultation with non-multidisciplinary team members		1 2 3 4 5		
5. Co-Work with multidisciplinary team members in the treatment of adults.		1 2 3 4 5		

6. Co-Work with non-multidisciplinary team members in the treatment of adults.		1 2 3 4 5		
7. Work with relatives of adults		1 2 3 4 5		

Child - Psychiatric Client Population	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Involved in assessment of children's cognitive and psychological status.		1 2 3 4 5		
2. Treat children directly using psychological interventions		1 2 3 4 5		
3. Treat children indirectly through consultation with multidisciplinary team members.		1 2 3 4 5		
4. Treat children indirectly through consultation with non-multidisciplinary team members		1 2 3 4 5		
5. Co-Work with multidisciplinary team members in the treatment of children.		1 2 3 4 5		
6. Co-Work with non-multidisciplinary team members in the treatment of children.		1 2 3 4 5		
7. Work with relatives of children		1 2 3 4 5		

Child - medical/physical Disability Client Population	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Involved in assessment of children's cognitive and psychological status.		1 2 3 4 5		
2. Treat children directly using psychological interventions		1 2 3 4 5		
3. Treat children indirectly through consultation with multidisciplinary team members.		1 2 3 4 5		
4. Treat children indirectly through consultation with non-multidisciplinary team members		1 2 3 4 5		
5. Co-Work with multidisciplinary team members in the treatment of children.		1 2 3 4 5		
6. Co-Work with non-multidisciplinary team members in the treatment of children.		1 2 3 4 5		
7. Work with relatives of children		1 2 3 4 5		
8. Provide psychological support for children with problems such as diabetes, asthma etc. to enable them to adjust to consequences of medical intervention and/or their condition		1 2 3 4 5		

Child - Learning Disability Client Population	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Involved in assessment of children's cognitive and psychological status.		1 2 3 4 5		
2. Treat children directly using psychological interventions		1 2 3 4 5		
3. Treat children indirectly through consultation with multidisciplinary team members.		1 2 3 4 5		
4. Treat children indirectly through consultation with non-multidisciplinary team members		1 2 3 4 5		

5. Co-Work with multidisciplinary team members in the treatment of children.		1 2 3 4 5		
6. Co-Work with non-multidisciplinary team members in the treatment of children.		1 2 3 4 5		
7. Work with relatives of children		1 2 3 4 5		

Child abuse - involvement in the assessment of:	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Child physical abuse		1 2 3 4 5		
2. Child sexual abuse		1 2 3 4 5		
3. Child emotional abuse		1 2 3 4 5		
4. Child neglect		1 2 3 4 5		

Child abuse - involvement in the therapy and/or counselling of:	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Child physical abuse		1 2 3 4 5		
2. Child sexual abuse		1 2 3 4 5		
3. Child emotional abuse		1 2 3 4 5		
4. Child neglect		1 2 3 4 5		
5. Treatment of adult survivors of child abuse.		1 2 3 4 5		

Custody and Access	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1, Assessment of custody and access cases		1 2 3 4 5		
2. Mediation of custody and access cases.		1 2 3 4 5		

Fostering and Adoption	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Assessment of fostering and adoption cases		1 2 3 4 5		
2. Consultation to fostering and adoption agencies.		1 2 3 4 5		

2. Service Planning	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**

1. Undertake service evaluation - appraising delivery systems and monitoring the effectiveness, qualify and changes in the provision of services		1 2 3 4 5		
2. Identify target populations and develop a system of care delivery for them.		1 2 3 4 5		

3, Staff Support	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Provide emotional support to other disciplines, eg. nurses, in providing counselling or stress management and/or other therapeutic support		1 2 3 4 5		
2. Provide instrumental support to other disciplines, eg. nurses, in advice about clients		1 2 3 4 5		

4. Community Support	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Act as advocates for client groups		1 2 3 4 5		
2. Initiate and develop self help groups		1 2 3 4 5		
3. Advise and support self help groups		1 2 3 4 5		
4. Develop and give public health education programmes and lectures		1 2 3 4 5		

5. Teaching and Supervision	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Lecture clinical psychology students		1 2 3 4 5		
2. Provide supervision for clinical psychology students		1 2 3 4 5		
3. Provide supervision for clinical psychologists in specialist techniques		1 2 3 4 5		
4. Provide supervision among peers		1 2 3 4 5		
5. Train other healthcare staff in "psychological" skills (eg. interviewing techniques, problem definition and behavioural observation)		1 2 3 4 5		
6. Teach and supervise other disciplines in the application of psychological theories		1 2 3 4 5		

6. Research and evaluation	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Engage in epidemiological research - identifying and analysing population need for psychological health services		1 2 3 4 5		

2. Surveying of staff attitudes to changes in health services		1 2 3 4 5		
3. Research and develop new psychological methods of interventions and develop and apply new methodologies		1 2 3 4 5		
4. Conduct literature reviews and write position papers to inform management on service development.		1 2 3 4 5		
5. Develop health education and promotion programmes		1 2 3 4 5		

7. Public Relations	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Raise the profile of clinical psychology through the media (radio, tv etc.) and improve the knowledge of the public about its role and contribution)		1 2 3 4 5		

8. Organisational	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Input to personnel departments on the psychological aspects in recruitment and selection of potential staff		1 2 3 4 5		
2. Provide input on ways of reducing organisational stress		1 2 3 4 5		
3. Act as team facilitators		1 2 3 4 5		

9. Management	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Liaise with and co-ordinate other agencies' involvement in assessment and treatment.		1 2 3 4 5		
2. Manage workload, staff and other resources.		1 2 3 4 5		

10. Administration	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Make arrangements for client care (planning appointments)		1 2 3 4 5		
2. Keep patient notes and records up to date		1 2 3 4 5		
3. Deal with correspondence		1 2 3 4 5		
4. attend staff, team and/or management meetings		1 2 3 4 5		

11. Continual Professional Development	**Actual Role**	**Satisfaction with Actual Role**	**Desired Role**	**Future Role**
1. Hold planning support meetings with other psychologists in the region		1 2 3 4 5		
2. Attend regular development meetings and workshops to update clinical skills, organisational skills, supervision skills and management skills		1 2 3 4 5		

1. What do you perceive to be the unique contribution (if any) of the clinical psychologist to your service compared to the other service providers?
2. What do you view as the future contribution of the profession within the health boards?
3. How best is this to be achieved?
4. What do you believe are the obstacles (if any) to future role development?

Thank you.