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**Activities of Intellectual Disability Clinical Nurse Specialists in Ireland**
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**Title: Activities of intellectual disability clinical nurse specialists (ID-CNSs) in Ireland**


## ABSTRACT

**Purpose/Aim:**

The aim of this study was to identify the contribution of Irish intellectual disability clinical nurse specialist to service delivery.

**Design:**

A non-experimental descriptive design was selected to survey intellectual disability clinical nurse specialists presently working in Ireland. The questionnaire was developed based on focus group interviews, available literature and expert panel views.

**Methods:**

Ethical approval and access was granted to all intellectual disability clinical nurse specialists in Ireland. 32 responded (33.68% response rate) from all work areas (voluntary organisations or health service executive) practicing within residential, community or school services. Respondents were surveyed across a range of areas (demographic details, support to; client, staff, family, organisation, community, other agencies, and professional development).

**Results:**

Findings identify that intellectual disability clinical nurse specialists are active in all aspects of their roles as clinical specialist, educator, communicator, researcher, change agent and leader. Thus supporting person-centred care and improving service delivery.

**Conclusions:**

To meet changing healthcare demands, promote person-centred care, and improve service delivery, the clinical nurse specialist role in intellectual disability should be developed and supported. The findings merit further study on ID CNS role activity, possible variables influencing role activity and team members' views.

**KEY WORDS**

Clinical nurse specialist, intellectual disability, Ireland, survey, activities, contribution

## INTRODUCTION

Internationally the role of the clinical nurse specialist (CNS) has existed for some time and CNSs make an important contribution by playing a coordinating role and forming a central link between different settings/services. The evolution and development of CNS roles in the Republic of Ireland present some similarities to that in the US, Canada and UK although differences exists in entry requirements. Three pathways existed in Ireland where the immediate pathway (prior to the 30 April 2001) allowed for a CNS who held an appropriate post-registration qualification and/or a minimum of 5 years' experience in the area of specialty to be appointed[1]. The intermediate pathway (1 May 2001 to the 31 August 2010) advocated that academic qualifications and professional experience must be achieve within a specified time frame[1]. The future pathway (1 September 2010 onwards) requires a minimum of 5 years post-registration experience, 2 years practice in a specialist area and a post-registration diploma (minimum level 8 National Qualifications Authority of Ireland (NQAI)) related to the area of specialist practice[1].

Nonetheless, given the fact many countries do not have specifically trained Intellectual Disability (ID) nurses the uniqueness of Intellectual Disability (ID) CNSs role presents opportunities for research activity, knowledge creation and professional development. The development of CNSs in Ireland has been highlighted by Wickham[2] and Doody and Bailey[1] and ID CNSs in particular by Wickham[3] and Doody et al[4]. Irish research in the broad area of CNSs include; their contribution to the management of cystic fibrosis[5], views of nurse prescribing[6], use of dependency and prioritization tools in palliative care[7], their role[8], impact of educational level on role[9], activities in an acute hospital[10], community palliative care CNSs[11], lesser recognised roles[12] and perceived outcomes of research and audit activities[13].

However, activities of the ID CNS have rarely been explored and the only specific publication relates to a self-assessment audit conducted by an ID CNS on the core concepts of their role[14] (clinical focus, advocacy, education/training, consultancy, audit/research) and focus group interviews examining their contribution to services[15]. In addition, the National Council for the Professional Development of Nursing and Midwifery (NCPDNM) evaluated the CNS role across all disciplines of nursing and midwifery[16-17]. The 2004 evaluation[16] highlighted, ID CNSs have an active role in client care, education, and advocacy but limited evidence of their research role existed. Rating of the core concepts rated clinical components as most important (63%), followed by advocacy (26%), education and training (20%), consultancy (8%) and audit/research (4%)[16]. In 2010 further evaluation[17] indicated that education and health promotion roles contributed to the maintenance of quality standards of care and ID CNSs served as a role model for nursing and staff[16]. In addition, ID CNSs impacted on broader outcomes related to quality of life for clients and families[16].

While both evaluations[16-17] may be reflective of ID CNSs, results have to be considered in relation to the limited response (8%) and representation of the findings to ID CNS practice. Given that the role of caring for persons with ID is multifaceted including; direct care, management, administration, liaison work and educational activity[4] many ID CNSs may not have responded to the national evaluations. This may be due to the medical orientation of the survey and ID CNSs not feeling they could identify with the specific questions and thereby may have failed to capture the activities of the ID CNS. Consequently it is essential to highlight the work of ID CNSs and make their contribution visible[4] as the development of the clinical career pathway of ID nursing has not occurred in a comparable manner as that of the other nursing disciplines[16]. In addition there are difficulties for the concept of CNS in ID services due to focus on supporting the person to remain in their own home, as compared to acute care services where care is largely similar across acute care hospitals this is not the case in ID services. This paper reports the activities of Irish ID CNSs who were surveyed utilising a questionnaire developed for the study based on the findings of a focus group study[15] and engagement with the literature.

## METHODS

### Design

A quantitative approach (non-experimental, descriptive survey) best suited this study as it attempts to identify the activities of ID CNSs that contribute to practice and service delivery. The research instrument used to collect the data were a 56 item questionnaire which covered eight sections (Table 1) developed based on the findings from focus group interviews and supporting literature. A questionnaire is commonly

used in survey research and is a self-report form designed to collect specific information from participants about their knowledge, attitudes, beliefs and feelings on the research topic[18]. The decision to develop a questionnaire specific to this study was necessitated by the fact little work has been undertaken or published from an ID CNS perspective on their activities within the core concepts of their role. In addition, it was anticipated that by developing a questionnaire from focus groups with ID CNSs a greater response rate (8% as per the two previous nationals surveys) would be achieved.

**Table 1 Questionnaire Sections.**

### Recruitment and sample

A recognised technique for identifying possible participants is via already established membership lists[19]. Upon ethical approval and access ID CNSs presently working were identified (those on leave were excluded) through the national ID CNS list (n=105) held by the NCNM. Survey packs consisting of, invitation letter, information sheet, questionnaires and stamped addressed envelopes were distributed through the NCNM to each ID CNS. Initially 10 ID CNSs were randomly selected as the pilot and the remaining ID CNSs (n=95) were invited to contribute to the main study. All 10 CNS responded to the pilot study and a third of the ID CNS population (n=32) responded to the main study representing a 33.68% response rate.

### Ethics

Ethical approval for the study was granted by the lead author's university research ethics committee and upon approval, access was sought from the NCNM. Consent was obtained by providing a comprehensive information sheet and invitation letter, and each respondent was free to make an independent and informed choice to participate without coercion[20].

**Data collection**

Data were collected using a self-administered survey postal questionnaire developed based on focus group interviews and literature. Data were collected on demographic details and the CNS role contribution. In addition a Likert scale was used to capture gradations of agreement/disagreement about the importance of various roles. Respondents rated their level of agreement from 1 (strongly disagree) to 5 (strongly agree). The use of free text comments were also invited to allow respondents to expand upon some questionnaire items (e.g. professional development). Two weeks following the initial distribution of the questionnaire a reminder letter was sent to all ID CNSs regarding the study with an additional questionnaire attached for their convenience if they wished to reply. However, this did not assist in gaining any additional responses.

**Data analysis**

Data were coded and inputted into SPSS version 19, the data set was checked and cleaned against the original data so that missing values or errors in inputting were identified and rectified. Analysis involved descriptive statistics of various biographic and demographic details of the respondents being computed and reported mainly in frequencies and percentages. For inferential comparative analysis t-tests were planned to establish whether or not there were statistically significant differences in the means of a range of variables. However in order to use this test each group had to be 1) independent 2) approximately normally distributed and 3) of equal variance and failing these assumptions a non-parametric test (Mann-Whitney U-Test) were used to compare medians (instead of means). Chi-square tests were planned to identify associations between variables and in the case of any cell having an expected frequency less than 5 for a 2x2 table or in the case of any cell having an expected cell

frequency less than 0.5 for an nxr table Fishers Exact Test were used as an alternative. For the open ended questions, analysis was conducted through an inductive process to develop the themes guided by Burnard's[21] thematic analysis framework and are reported in a separate paper.

**Validity and Reliability**

Content and face validity were supported by the use of an expert panel (n=6) consisting of a lecturer who was a former ID CNS, a ID CNS who had just left their post two months previously, a UK academic researcher who has researcher and published on CNSs, a director of nursing (ID), and two UK ID lecturers with research expertise in survey design. There was agreement that the items focused on the constructs under investigation and only minor changes to wording of some questions were necessary. In addition, the pilot study (n=10) determined the usability and clarity of the questionnaire[22]. Where pilot participants commented on the ease/difficulty of answering the questionnaire and annotated anything that was not clear or they did not understand. This was facilitated by pilot study respondents also completing a 6 questions pilot checklist to give feedback on the instrument before its use. Within the main study a Cronbach alpha value was calculated to check the reliability of the total scale (α .916). In addition analysis of each sub-sections had acceptable alpha co-efficiency scores supporting the reliability of the questionnaire: client care α .949, family α .876, staff α .721, service/organisation α .708, community α .763, other agencies α .912 and professional development α .956.

**RESULTS**

The findings are presented under the survey questionnaire section headings which include demographics, client focus; family centred, supporting staff, supporting the

organisation, involvement in the community, supporting other agencies and professional development.

**Demographics**

The majority of respondents n=13 (40.6%) worked in a community service, n=12 (37.5%) worked in a residential service and n=5 (15.6%) worked in both community and residential services. Of the remaining two respondents' one worked across residential, community and day-service and one worked in a school setting. The specialist area of behaviour was the most common respondent at n=12 (37.5%) followed by early intervention n=7 (21.9%), community n=5 (15.6%) with both creational diversional and recreation activities and health promotion represented n=3 (9.4%). Of the remaining two one was a specialist in ageing and dementia and one working with people who had complex needs. Table 2 identifies the respondents profile regarding, experience, age, gender and work patterns.

**Table 2 Respondents profile**

56.3% (n=18) of respondents were supernumerary in their role while the remaining 43.8% (n=14) were not supernumerary and still fulfilled a staff role in addition to their CNS role (due to non-replacement). Of the respondents n=3 (9.4%) were dual qualified and n=2 (6.4%) held three nursing qualifications. Academically n=21 (65.6%) of respondents held a certificate in their specialist area and n=15 (46.9%) held other relevant certificates. 28.1% (n=9) held a primary degree, 40.6% (n=13) held a postgraduate or higher diploma and 12.5% (n=4) held a master's degree.

**Client focused**

Being involved in assessment scored the highest 93.8% (n=30) followed by design and implementation both 90.6% (n=29) and evaluation 84.4% (n=27). CNSs were in agreement that these items were a component of their role (table 3).

**Table 3 Contribution to client care**

**Contribution to the family**

93.8% (n=30) reported providing advice to family members, 81.3% (n=26) providing education/training for the families and facilitated family members to be part of the decision process. 68.8% (n=22) were available to families through an open referral system and 62.5% (n=20) provided support in the family home. An overall majority of CNS's believed these aspects were key components of their role with only the aspect of providing support in the home 12.5% (n=4) creating a level of disagreement. This disagreement level is reflective of fact that some respondents were from and residential services and a proportion of the CNSs were not supernumerary thereby holding a staff position. However given the number of respondents from a residential service it is interesting to see a high level of support in the family home. CNSs were in agreement that these items were a component of their role (table 4).

**Table 4 Contribution to the family**

Using Fishers exact test a significant association ($p = <0.05$) was found to exist between principal work setting and whether or not families are facilitated to be part of the care provision process. From analysis it was found that community CNSs reported to be significantly more likely to facilitate families to be part of the decision making process ($p= 0.014$). In addition a significant association Fishers exact test ($p. = 0.012$) was found to exist between principal work setting and whether or not families can access the individual through an open referral system. From analysis it was found that when the CNS worked in a community setting they were reported to be significantly more likely to be accessed by families through an open referral system ($p. = 0.011$).

**Contribution to staff**

All respondents reported that they were available for consultation regarding client care with 90.6% (n=29) indicating staff can directly refer clients to the CNS service. Additionally 90.6% (n=29) reported discussing issues regarding client care without having a referral, 96.9% (n=31) made recommendations relating to client care regardless of a formal or informal process of enquiry. Among the CNSs 78.1% (n=25) reported assisting staff in the development of practice guidelines/policies for their work areas and 90.6% (n=29) supporting staff in reviewing client care/programmes. CNSs were in agreement that these items were a component of their role (table 5).

**Table 5 Contribution to staff**

**Contribution to the service/organization**

96.9% (n=31) of respondents reported delivering education/training programmes within the organisation, 71.9% (n=23) conducted an audit of the service they provide and 68.8% (n=22) contributed to the service plan of the organisation. Regarding the referral system 96.9% (n=31) reported that they refer and receive referrals to other members of the multidisciplinary team. Additionally 53.1% (n=17) identified that in addition to their specialist role they also fulfil a management role. CNSs were in agreement that these items were a component of their role (table 6) with the aspect of fulfilling a management role creating a level of disagreement. Where 53.1% (n=17) scored fulfilling a management in addition to their CNS role as 3 or under indicating conflicting or competing roles.

**Table 6 Contribution to the service/organization**

**Contribution to the community**

All respondents reported been guided by evidence-based literature while 84.4% (n=27) reported disseminating evidence based knowledge related to their specialist area within the service/organization. 65.6% (n=21) of respondents were engaged in

research as a component of their work with 53.1% (n=17) of respondents reported providing guest lectures in third level institutes and 43.8% (n=14) had presented at a nursing conference on an area related to the specialist practice. 50% (n=16) of respondents identified that they sit on a professional committee whereas only 6.2% (n=2) sit on an academic committee. CNSs were in agreement that these items were a component of their role (table 7). However, providing guest lecturers (n=14, 43.8%), presenting at conferences (n=12, 37.5%) and sitting on an academic committee (n=19, 59.4%) were the areas that had the greatest level of disagreement among respondents scores of 3 or lower.

**Table 7 Contribution to the community**

Through the Fishers exact test a significant association (p=<0.05) was identified where a person has conducted guest lectures with a third level institution and their supernumerary status. Therefore identifying that a significantly higher proportion of those who are supernumerary have given guest lectures in third level institutes. In addition an association between whether a person has conducted guest lectures with a third level institution and their level of education was identified. A significantly higher proportion of those with a postgraduate diploma or higher level education had given guest lectures in third level institutes Fishers exact test (p=0.005).

**Contribution to other agencies**

90.6% (n=29) of CNSs reported consulting with other agencies/services and 84.4% (n=27) haven been available for other agencies/services to consult with them. Just over half of the respondents 59.4% (n=19) had referred clients to another agency with 50% (n=16) of respondents having received a client referral from another agency. CNSs were in agreement that these items were a component of their role (Table 8).

**Table 8 Contribution to other agencies**

Of the consultations with other agencies 53.1% had occurred with general practitioners, 50% with schools, 43.8% with public health nurses, 40.6% with both the general hospital and primary care team, 34.4% with mental health services, 18.8% with maternity services and 15.6% with the garda (police). Other consultations were identified and included third level institutes, vocational educational centres and family support organisations.

**Professional and resource issues**

With regards to the reporting structure all CNSs reported they report to the management grades of CNM3 (clinical nurse manager) and above which includes ADON (assistant director of nursing), NPDC (nurse practice development coordinator), DON/DOS (director of nursing/director of services). 84.4% (n=27) of respondents reporting receiving feedback on their performance and this feedback were generally verbal and informal as can be seen in Figure 1.

**Figure 1 Feedback on performance to the CNS**

93.8% (n=30) of respondents reported a need for further educational and professional development opportunities with 96.9% (n=31) identifying that specific courses related to their practice area are essential to developing their role. 96.9% (n=31) reported been committed to their ongoing professional development and 93.8% (n=30) identified that educational courses are essential to support their professional development.

## DISCUSSION

While differences may exist among CNS roles/definitions between countries[23-24] and across disciplines of nursing it is generally agreed and recognised that CNSs are autonomous, experienced practitioners who possess an advanced level of skills and

knowledge[25]. However, within this study the autonomy of CNSs was affected by the fact that CNSs are often fulfilling an addition role (staff nurse or manager) and not supernumerary. This restricted the ability of the CNS to fulfil both roles effectively and a distinction needs to be made between leadership within the CNS role and nurse management[17]. The practice of CNSs operating as staff members and not attaining supernumerary status, to take on a CNS caseload needs to be addressed in order for CNSs to collaborate and lead the profession[26]. It is recognised that CNSs influence practice through nursing activities, practice development, education, consultation, research and clinical research[27-32]. Our findings are similar to Acton Shapiro[33] who highlighted that CNSs are not being utilised to their full extent and are therefore unable to have the desired impact on practice that might be anticipated[33-34]. The utilization of CNSs in a dual role and not attaining supernumerary status may be as a result of the recent economic downturn and fiscal climate, nonetheless CNSs should be afforded the opportunity to champion change, collaborate and lead the profession[26].

Our findings indicated that CNSs make a clear contribution to improving clinical practice, service delivery and clinical leadership through consultation, education and support. These findings denote similarities to findings of CNSs from other disciplines[35-38] and this study extends the body of international knowledge regarding the contribution of ID CNSs across a range of domains. This is important given the minimal evidence that exists and the acknowledgement that the impact of CNSs is hard to quantify. The difficulty if quantifying the CNSs contribution lies in the fact that their contribution it is indirect (e.g. upskilling others), may be evident sometime after their intervention and they work as part of a team thereby difficult to attribute

changes in outcomes to the CNS[39]. Nonetheless this study highlight that ID CNSs fulfil the core concepts of their role (clinical/client focus, advocacy, education/training, consultancy, audit/research) and identifies some of the activities within these core concepts, which map onto the spheres of influence used in the USA (client direct care, nurses/nursing practice, organisation and systems).

In this study it was notable that only four respondents out of the 32 participants held a Masters qualification and thirteen held a postgraduate level qualification accounting for 53.1% of respondents. This needs to be considered in light of the Irish and international context, where in Ireland there has been three pathways for CNS appointment (immediate, intermediate and future[1]). These pathways differ from international requirements in that a level 8 qualification is the standard and other countries require a Masters level 9 qualification. Given the number of CNSs in Ireland who attained their post through the immediate and intermediate pathway there is a professional development need for CNSs. Especially as no specific timeline was placed on CNSs appointed through the immediate and intermediate pathways and the onus of responsibility was placed on the individual CNS[40]. Within this development there is a need for formal and informal mentorship[41] in partnership with university staff. As a master's level qualification is now an international agreed standard there is a need to revise the entry requirement and consider a strategic priority in this area in terms of providing opportunities and support for CNSs to undertake higher level courses[42]. The respondents of this study tend to engage in specialist course/educational programmes. However, given the complexity of intellectual disability (range of conditions, range of ability from profound disability to borderline disability) there is a need for CNSs to look broader at educational programmes that fit

the needs of the context (e.g. clinical knowledge, research knowledge, leadership, management and change). Thus it is important that there is collaboration between universities and employers through broad frameworks that allow for tailored learning and work-based learning[43-45].

However, this study does identify that even though a large proportion of the CNSs (87.5%) did not hold a Masters educational qualification 65.6% reported contributing to research, 53.1% providing guest lecturers and 43.8% presenting at conferences. This activity highlights the willingness and engagement of CNSs in these areas and it could be considered that with support for CNSs to attain masters level there would be greater engagement with these activities which support client care, evidence based practice and dissemination of practice/research based knowledge.

A key aspect within the CNSs activities is education which encompasses clients, families, staff, team members and outside personal. This education can be formal or informal, direct or indirect, at an individual or organisation level through role modelling, policy development or educational sessions. Education is widely recognised as a key aspect of the CNS role that supports both practice development and service users[45-46]. Also evident in this study was the CNSs collaborative practice both within the service and with outside agencies. This may be a result of the fact CNSs are seen as an important source of information, and people prefer the experiential and clinical knowledge of peers[47]. However, a significant proportion of education and collaboration is informal and may be invisible and suggests a need to highlight the work of the ID CNS and record services delivered[14].

## CONCLUSION

The survey identifies that a large proportion of the respondents reported fulfilling the roles identified within each section and rated the level of importance of these roles highly or very highly in the majority of areas of ID nursing. Only the areas of fulfilling a management role, sitting on an academic committee, providing guest lectures and presenting at conferences were rated as a mean score below 4 by the respondents, these areas ranged from 3.44-3.97. Overall the ID CNS reported the roles surveyed as been performed and important. However, CNSs must claim ownership of their own practice and highlight their contribution to quality, safe and cost-effective care[48], make their role visible[4, 49] and thus advancing their educational level to that of their international colleagues.

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**Table 1 Questionnaire Sections**

| Section | Purpose |
|---|---|
| 1. Demographic Data | Related to frequencies in the sample group of age, gender, education, qualifications and experience Q1-11. |
| 2. Contribution to Client Care | Related to identifying areas of contribution to client care and rating its importance to their role. Q12-16. |
| 3. Contribution to the Family | Related to identifying areas of contribution to the family and rating the importance of this to the CNS role Q17-21. |
| 4. Contribution to Staff | Related to identifying areas of contribution to other staff and rating the importance of this to the CNS role Q22-27. |
| 5. Contribution to the Service / Organisation | Related to identifying areas of contribution to the service/organisation and rating its importance to their role Q28-33. |
| 6. Contribution to the Community | Related to identifying areas of contribution and rating its importance to their role Q34-40. |
| 7 Contribution to Other Agencies | Related to identifying areas of contribution to other agencies and rating its importance to their role in addition to identifying the agencies with whom the CNS operates a referral system Q41-45. |
| 8. Professional Issues | Related to identifying resources, supports, reporting relationship and seeking the CNS opinion on their commitment to professional development, how the CNS in intellectual disability may develop and where they may contribute in the future Q46-56. |

**Table 2 Respondents profile**

| | |
|---|---|
| Years' experience | 3 – 20 years |
| Years qualified prior to CNS post | 5 - 35 years |
| Experience working in ID | 6 - 40 years |
| Age grouping | 25-35 (n=2, 6.3%)<br>36-47 (n=21, 65.6%)<br>48-59 (n=9, 28.1%) |
| Work pattern | 78.1% (n=25) - full time<br>15.6% (n=5) - part time<br>6.3% (n=2) - flexi-time |
| Work schedule | n=28 (87.5%) five day rota<br>n=4 (12.5%) seven day rota |
| Gender | 84.4% (n=27) female<br>15.6% (n=5) male |

**Table 3 Contribution to client care**

| **Having a direct involvement in (x) is a key component of my role** | **Mean score** | **Standard Deviation** |
|---|---|---|
| Assessment of client needs | 4.66 | .602 |
| Design of interventions for clients | 4.66 | .653 |
| Implementation of interventions for clients | 4.59 | .712 |
| Evaluation of interventions of clients | 4.53 | .716 |

**Table 4 Contribution to the family**

| **Providing (x) is a key component of my role** | **Mean score** | **Standard Deviation** |
|---|---|---|
| Advice to family members | 4.56 | .619 |
| Education / training to family members | 4.31 | .644 |
| Facilitation to family members to be part of the decision making process | 4.34 | .745 |
| Accessibility to families through an open referral system | 4.41 | .665 |
| Support to family caregivers in their home | 4.16 | 1.11 |

## Table 5 Contribution to staff

| (x) is a key component of my role | Mean score | Standard Deviation |
|---|---|---|
| Been available to staff for consultation regarding client care | 4.91 | .296 |
| Staff been able to refer clients to my service | 4.59 | .665 |
| Discussing issues with staff without having a referral to assist them in client care | 4.19 | .931 |
| Making recommendations to staff in relation to client care | 4.69 | .471 |
| Assisting staff in developing practice guidelines / policies for their work areas | 4.25 | .803 |
| Supporting staff in reviewing client care / programmes | 4.56 | .619 |

**Table 6 Contribution to the service/organization**

| **(x) is a key component of my role** | **Mean score** | **Standard Deviation** |
|---|---|---|
| Contributing to the service plan of the organisation | 4.41 | .665 |
| Delivering education/training within the organisation | 4.72 | .457 |
| Referring clients to other MDT members | 4.66 | .483 |
| Receiving referrals from MDT members | 4.66 | .483 |
| Fulfilling a management role | 3.44 | 1.21 |
| Conducting an audit of my service | 4.41 | .712 |

**Table 7 Contribution to the community**

| **(x) is a key component of my role** | **Mean score** | **Standard Deviation** |
|---|---|---|
| | 4.59 | .560 |
| Been engage in research activity as a component of my work | 4.25 | .880 |
| Conducting guest lectures with a third level institution | 3.91 | .963 |
| Presenting on an area related to my nurse specialism at a nursing conference | 3.97 | .933 |
| Disseminating evidence based knowledge related to my specialist area of practice within the organization | 4.69 | .535 |
| Sitting on a professional committee is a key component of my role | 4.16 | .987 |
| Sitting on an academic committee is a key component of my role | 3.53 | .950 |

## Table 8 Contribution to other agencies

| (x) is a key component of my role | Mean score | Standard Deviation |
|---|---|---|
| Consulting with other agencies | 4.41 | .615 |
| Been available for consultation with other agencies | 4.28 | .772 |
| Referring clients to other agencies | 4.13 | .883 |
| Receiving referrals from other agencies | 4.06 | .916 |

## Figure 1 Feedback on performance to the CNS