PPN EAST OF ENGLAND
Psychological Professions Network
PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELLBEING

The growing impact of Clinical Associates in Psychology across the East of England: case studies and discussion to support planning in 2025 and beyond

Thursday 6th February 2025

13:00 – 15:00

Introduction

- **Dr Maggie Rosairo,** Consultant Clinical Psychologist, East of England Chair, Psychological Professions Network (PPN)

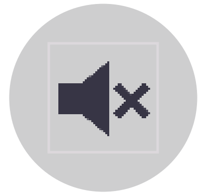
- **Dr Angela Husband**, Consultant Clinical Psychologist and Course Director, Essex / EPUT CAP MSc

- **Prof Paul Fisher,** Clinical Psychologist and Programme Director UEA CAP MSc

- Who is Today for?
  - Employers, Psychologists and Service Leads, Commissioners and NHSE colleagues
  - CAPs / Aspiring CAPs

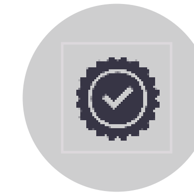
- A unique opportunity to hear from CAPs and Services directly

Allowing Us All To Get The Most From This event



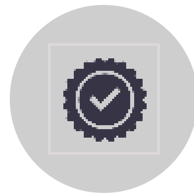
Microphone on mute / cameras off

Q&A for panel discussion question

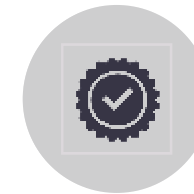


Safe space

Confidential & respectful



Non-judgemental



Non-pressured

Supportive

Promoting understanding and minimising jargon

Agenda

Time		Item	Person
13:00	1	Welcome & Introductions	Angela and Paul
13:10	2	The Growing Impact of Clinical Associates in Psychology (CAPs) – Cambridgeshire & Peterborough CAMHS	Martin Hall
13:20	3	Clinical Associates in Psychology in Child and Adolescent Mental Health and Learning Disability	Melanie Bruce
13:30	4	My Journey: Older Adult to Young Adult (18-25)	Chloe Wernick
13:40	5	My Journey: Specialist Dementia and Frailty Service	Darren Radford
13:50	**BREAK**		

Agenda

Time		Item	Person
14:00	5	Psychological Skills Service (PSS) and the Role of CAPs	Melanie Staley & Charlie Laker
14:10	6	CAP in Psychiatry Liaison Team	Hayley Metcalfe-Pfeifer
14:20	7	Assessing the Feasibility, Attendance Rates and Outcomes of Group Interventions Facilitated by Clinical Associates in Psychology in an NHS Secondary Care Community Mental Health Team	Sarah Knowles, Caitlin Laws & Tom Steverson
14:30	8	East Suffolk – CAPs in Later Life Community Mental Health Team & Acute Inpatient Service	Eve Cox and Amanda Price
14:40	9	Panel Discussion	
15:00		**CLOSE**	

Why are we here today?

- **Clinical Associates in Psychology as meeting an NHS need**

- **Unique contribution compared to other new psychological practitioners:**
  - Formulation based
  - Flexible application of psychologically informed practice from a variety of models and therapeutic frameworks
  - Trained to work in multidisciplinary contexts within a modern NHS

- **Training focused and embedded in practice to address service need through the apprenticeship route**

- Training pathways to reflect scope of practice: Adult, Child, Health Aging and Disability (HADs)

- **CAP career progression:** remain in roles and continue to make a valued contribution to the NHS.

Signposting to Practice information

Occupational Standard: https://www.instituteforapprenticeships.org/apprenticeship-standards/clinical-associate-in-psychology-cap-integrated-degree-v1-0

Apprenticeship Trailblazer Frequent asked questions about CAPs: https://ppn.nhs.uk/east-of-england/eoe-resources/communities-of-practice/caps-resources

Career Development for CAPs Post-Qualification: Opportunities and Approaches: Career Development for CAPs Post-Qualification Opportunities and Approaches-20241113_105819-Meeting Recording.mp4

Registration of quality CAPS: The British Psychological Society. https://www.bps.org.uk/news/clinical-associates-psychology-can-now-join-our-wider-psychological-workforce-register

Signposting to Training information

Training Accreditation Standards: The British Psychological Society. Standards for the accreditation of applied psychology programmes for Associate Psychologists. Education providers | BPS

EPUT Course: Clinical Associate in Psychology (CAP) Programme

UEA Course: Master's Clinical Associate in Psychology Masters Apprenticeship (Children and Young People) 2025/26 | UEA

Cap@uea.ac.uk

CAPs at UEA

Cohort	Completed	On Track	Ongoing
Dec 2021 (Adult)	34	1	1
Sept 2022 (Adult)	20	1	
Sept 2023 (CYP)	(March 2025)	19	1
Sept 2024 (Adult & CYP)	(March 2026)	26	-

CAPs at EPUT

Cohort	Completed	On Track	Ongoing
C1: May 21 AMH	23	-	-
C2: Jan 22 AMH	20	-	-
C3: Mar 23 HADs and AMH	9	3	1
C4: Nov 23 HADs and AMH	May 25	10	
C5: June 24 HADs and AMH	Dec 25	16	

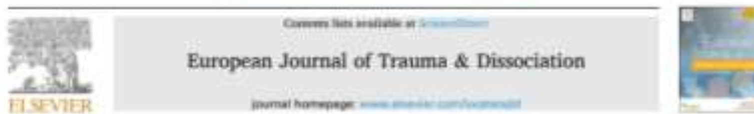
Impact of CAPs: Growing Evidence base

What Workplace Activities do Apprentice Clinical Associates in Psychology Report During Their Training?

Gabriel Markovich, Tom Steverson, and Paul Fisher*
Norwich Medical School, University of East Anglia

***corresponding author: (P.Fisher@uea.ac.uk)**

The Clinical Associate in Psychology (CAP) Occupational Standard (Institute for Apprenticeships and Technical Education, 2022) sets out a variety of activities within the CAP role, including a broad range of duties to meet the growing needs of NHS trusts. The University of East Anglia (UEA) is one of several programs in the UK training CAP apprentices to help meet the workforce needs outlined in the NHS Long Term Workforce Plan (NHS England, 2023). This study aimed to categorise the workplace activities that UEA CAP apprentices report undertaking during their training and understand the degree to which these activities relate to the CAP Occupational Standard. Results showed that the range of activities CAP apprentices reported during their training was consistent with the CAP Occupational Standard. The most frequently reported workplace activity was psychological intervention. These findings may be useful for services considering employing an apprentice CAP.



Research Paper

Evaluation of an online pilot 'Complex trauma stabilisation' group intervention in an adult mental health service

Ilana Foreman, Aimee Shipp, Melanie Staley, Catherine Ford

ARTICLE INFO

ABSTRACT

Enhancing Mental Health Care: The Value of Clinical Associates in Psychology in NHS Teams

Dorota Jagielska-Hall & Ciarán O'Driscoll*
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In this article we provide an overview of Clinical Associates in Psychology (CAPs): their training, how they complement existing psychological professions and mental health teams, and showcasing the work they have undertaken throughout the country. This takes the form of a case series, based on service-related research projects and conference presentations undertaken by CAPs themselves. We hope this can help clinicians consider how CAPs fit within the psychology professions and also how they can benefit various services.

Introduction

O'Driscoll et al. BMC Medical Education (2024) 24:825
https://doi.org/10.1186/s12909-024-05802-7

BMC Medical Education

RESEARCH — Open Access

The identity of clinical associates in psychology: a cross sectional, national survey

Ciarán O'Driscoll[1*], Kiana Azmoodeh[2], Ravinder Rana[3] and Gillian Hardy[3]

Abstract

Background The Clinical Associate in Psychology (CAP) is a new psychological profession within the National Health Service (NHS) in the United Kingdom. This paper considers the processes developing the CAPs' professional identity, specifically how their roles are embedded within services.

Methods This study utilised an online survey of CAPs and all academic, clinical and managerial staff involved with CAPs. An inductive thematic analysis was undertaken.

Results A total of 164 participants responded to the survey. Five themes were identified: Widening Access to Psychology, Workforce Development, Navigating the Unfamiliar, Trained [Master's level] Professionals and An Emerging Ethos. In addition, key skills and unique contributions from CAPs were identified.

Conclusions A clear professional identity is emerging, with CAPs depicted as offering versatile interventions in diverse health care settings, fostering a positive and encouraging integration of psychological expertise into the healthcare service. The study highlights areas for development to facilitate the growth and advancement of the role within the psychological workforce.

Keywords Clinical associate in psychology, Psychological training, Qualitative survey, Psychologists

New ways of working in psychology: evaluating a pilot of the clinical associate psychologist apprenticeship on an acute mental health ward

Katie Slender, Bethany Taylor

Gloucestershire Health & Care NHS Foundation Trust, UK
Correspondence to: Katie Slender, Inpatient Complex Psychological Interventions Team, Wotton Lawn Hospital, Gloucester, GL1 3WL, UK; katie.slender@ghc.nhs.uk

Aim: Acute mental health wards have been criticised for being untherapeutic. NHS England aims to move towards therapeutic wards by increasing psychological practitioner staffing. The new clinical associate psychologist (CAP) role may provide a cost effective way of enhancing existing psychological therapies teams. The current study aimed to evaluate the introduction of a CAP apprentice on an acute mental health ward. Specifically, the study aimed to (1) examine whether the CAP role could improve patients access to direct psychological interventions; and (2) explore the ward team's experiences of the role.

Method: Referrals for direct psychological interventions and sessions conducted were collected over a six-month period and compared to pre-collected data from the previous year. A focus group was held to explore the ward teams experiences of the role which was transcribed and thematically analysed.

A personal account of being a clinical associate psychologist in older adult services

Joshua Sargeant-Maynard

This article highlights the expanding role of Clinical Associate Psychologists (CAPs) within older adult mental health services, as showcased at the British Psychological Society's FPOP conference. CAPs bridge critical gaps in psychological services, providing evidence-based, psychologically informed care that addresses the unique needs of older adults. Through comprehensive training in a specific clinical area and supervised practice, CAPs develop skills in assessment, therapeutic interventions, and collaborative multidisciplinary work. Their integration into Older Adult services in West Suffolk has alleviated workloads for psychology teams while enhancing service provision and accessibility for older adults. CAPs' contributions have garnered positive feedback from colleagues, and ongoing research highlights their value in improving patient satisfaction, reducing waiting times, and supporting underserved communities. Despite the evolving nature of the role, CAPs are positioned as growing resources within the NHS, with potential for further career development and specialisation. This article underscores the meaningful impact of CAPs and their potential to shape the future of psychological services in the UK.

Keywords: Clinical Associate Psychologists (CAPs), Older adult mental health, NHS psychological services, Mental health workforce expansion.

Impact of CAPs:
Case Examples from service

- Case Example 1:

The Growing Impact of Clinical Associates in Psychology (CAPS) – Cambridgeshire & Peterborough CAMHS
Martin Hall

Cambridgeshire and Peterborough NHS Foundation Trust

The Growing Impact of Clinical Associates in Psychology (CAPS) – Cambridgeshire & Peterborough CAMHS

Dr. Martin Hall
Consultant Clinical Psychologist
Peterborough CAMHS

06/02/2025

Pride in our children's, young people's and families' services

CAPS - Service / Team Level Impact

- X 2 CAPS across both Core and Neuro CAMHS; just completed their training.
- Context – Limited psychology presence in Neuro CAMHS (maternity / recruitment issues) – CAP role has helped raised profile of psychological professions within the team.
- Assessment – Significant contribution to both core mental health assessments and diagnostic neurodevelopmental assessments.
  - Assessment form – Helping team to 'hold onto' information from a wide range / challenging unhelpful narratives regarding complex and difficult cases.
  - Core Mental Health – Psychological formulation skills, negotiating complex care pathways, risk formulation.

CAPS - Service / Team Level Impact

- Intervention – Limited CBT resources in Neuro CAMHS – CAP has been able to provide interventions with some complex OCD cases.
  - Increased range of evidence-based interventions

- Multidisciplinary Team – Increased psychological presence
  - Team formulations – complex cases.
  - Increased reflective capacity.
  - Questioning team processes / experimenting with change

- Next Steps
  - CPD / Ongoing development of CAPS
  - X1 CAP – Neuro / x1 CAP Core CAMHS - ‘critical mass’
  - Management – Measuring impact / short term vs long term planning around psychological professions.
  - Thinking across service / directorate boundaries.

Impact of CAPs:
Case Examples from service

- Case Example 2:

Clinical Associates in Psychology in Child and Adolescent Mental Health and Learning Disability
Melanie Bruce

Norfolk Community Health and Care
NHS Trust

Clinical Associates in Psychology

Dr Melanie Bruce

Clinical Psychologist and Clinical Lead

Our services

- Norfolk Community Health and Care NHS Trust
  - Childrens services
  - Range of specialist services for children within NCHC including continence, children's community nursing and services which have psychology within the teams:
  - Starfish (Child and Adolescent Mental Health and Learning Disability – CAMHS LD)
  - Starfish Plus (CAMHS LD- Intensive Therapeutic service)
  - Neurodevelopmental Service (NDS- Diagnostic pathway Autism, ADHD).

Psychology in NCHC

NHS
Norfolk Community Health and Care
NHS Trust

- .We have a range of psychological practitioners within NCHandC
- This includes clinical psychologists, counselling psychologists, educational psychologist as well as assistant psychologists and trainee clinical psychologists.
- We also have Psychological therapy practitioners working with children who have a learning disability and/ or are autistic.
- The work is broadly across the 3 services and focuses on assessment, formulation (and diagnosis) and intervention.

CAPS in NCH and C

- For many years we have had challenges with **recruitment** and **retention** of psychologists.
- There have been several reasons for this and a number of plans to address this.
- Some of the challenges we faced were; geographically, the group of children and young people the nature of the work and the clinical need
- We therefore applied and were successful in the appointment of 2 posts.

The process

Norfolk Community Health and Care NHS Trust

- The process was very well organised and planned
- There was lots of support and advice from the UEA
- The UEA and NCHC worked closely together
- We had lots of high quality applications and candidates

The Training

Norfolk Community Health and Care NHS Trust

- There is lots of support and information from the UEA (and the CAPS!)
- The structure and expectations are very clear
- We needed to readjust the planned clinical days in order to meet the requirements of the course
- There are regular planned and ad hoc points to check in, monitor, assess etc throughout the course
- 119 KSBs!

Norfolk Community Health and Care NHS Trust

CAPS 12 Duties & 119 KSBs

1: Be an accountable professional acting in the best interests of patients, by providing personalised psychological interventions that are evidence-based, compassionate and empowering.

2: Communicate effectively through creating and maintaining clinical records.

3: Conduct psychological assessment to identify the priorities and requirements for personalised, evidence-based psychological interventions.

4: Develop psychological formulations to inform the delivery of effective personalised care and to enhance the range of psychological interventions that other professionals may utilise in their practice.

5: Provide a range of psychological treatments to individuals and groups appropriate to the needs of patients in the context in which they experience distress.

6: Provide a range of psychological interventions when working with complex and chronic needs within scope of practice, selecting and implementing interventions where an established evidence-base is absent.

- 7: Choose appropriate psychological measurement tools for ongoing evaluation of psychological treatments that make a significant contribution to the continuous enhancement and quality improvement of clinical practice.
- 8: Provide support and guidance as part of the multidisciplinary teams.
- 9: Provide training to others in order to inform psychological interventions across a range of service settings.
- 10: Undertake research and service development activities to inform change in the area of work.
- 11: Provide psychological models of clinical supervision to the broader range of professionals they work with within their scope of practice.
- 12: Conduct risk assessments and risk formulations.

Examples in practise

- **Duty 3: Assessment**

- Includes standardised assessments (such as cognitive assessments, diagnostic assessments, assessments for children referred to CAMHS LD service).

- Also includes more individualised assessments, needing clinical skills, flexibility creatively and gathering information from a wide variety of people and places

- Also includes recognising when further assessment is needed, when more detailed risk assessments are needed and when assessment is "complete" and the young person or the system needs something else.

Examples of clinical work

- **Duty 5 and 6: Delivering interventions**

- Within our services very little “duty 5”
- However lots of formulation based intervention which has included;
  - Direct therapeutic interventions with children and young people
  - Indirect work (with parents and systems)
  - Working within multi disciplinary and multi agency teams

Examples of clinical work

- **Duty 8, 9 and 11 (Working within teams, training and supervision)**

- Bringing psychology to team discussions and wider thinking within teams
- Joint working and joint visits
- Training- to increase the skills and confidence of others
- Supervision to other members of the team

Impact

- Children: Increasing the number of children who are able to benefit from (formulation driven) psychological intervention
- Families: Increasing the number of families receiving detailed assessments and formulation driven intervention
- Range and scope of work
- The skills and competencies to deliver this
- The impact for services- access, waiting lists
- The impact for psychologists- our time, our clinical time and our other demands
- The future- building the workforce, maintaining a workforce, skilling up others, broadening the workforce

Norfolk Community
Health and Care
NHS Trust

Thank you

Impact of CAPs:
Case Examples from service

- Case Example 3:

My Journey: Older Adult to Young Adult (18-25)
Chloe Wernick

Video

My time as a CAP

CHLOE WERNICK

Training placement

- Community mental health with the Specialist Dementia and Frailty Service
- Older Adult inpatient service

Skills and roles:

- Specialist neurocognitive assessments on the Ward
- Working with both an internal and external MDT
- Identifying gaps in our population with Young Onset Dementia

Transition

- Transferable skills from being a Psychological Wellbeing Practitioner (PWP)
- Support from my service
- All my CAP skills (formulation, rapport building, intervention skills)

Current Placement – 18-25 Psychological service

- I complete assessment, formulation and intervention with complex PTSD cases

Skills and roles:

- Conducting my own research project on “soothing boxes”
- Being a part of a young adult forum and service development
- Working with highly complex cases

Being a CAP

- I love the variety and flexibility.
- The focus on development and progression.
- New more complex cases and varied types of intervention when compared to being a PWP

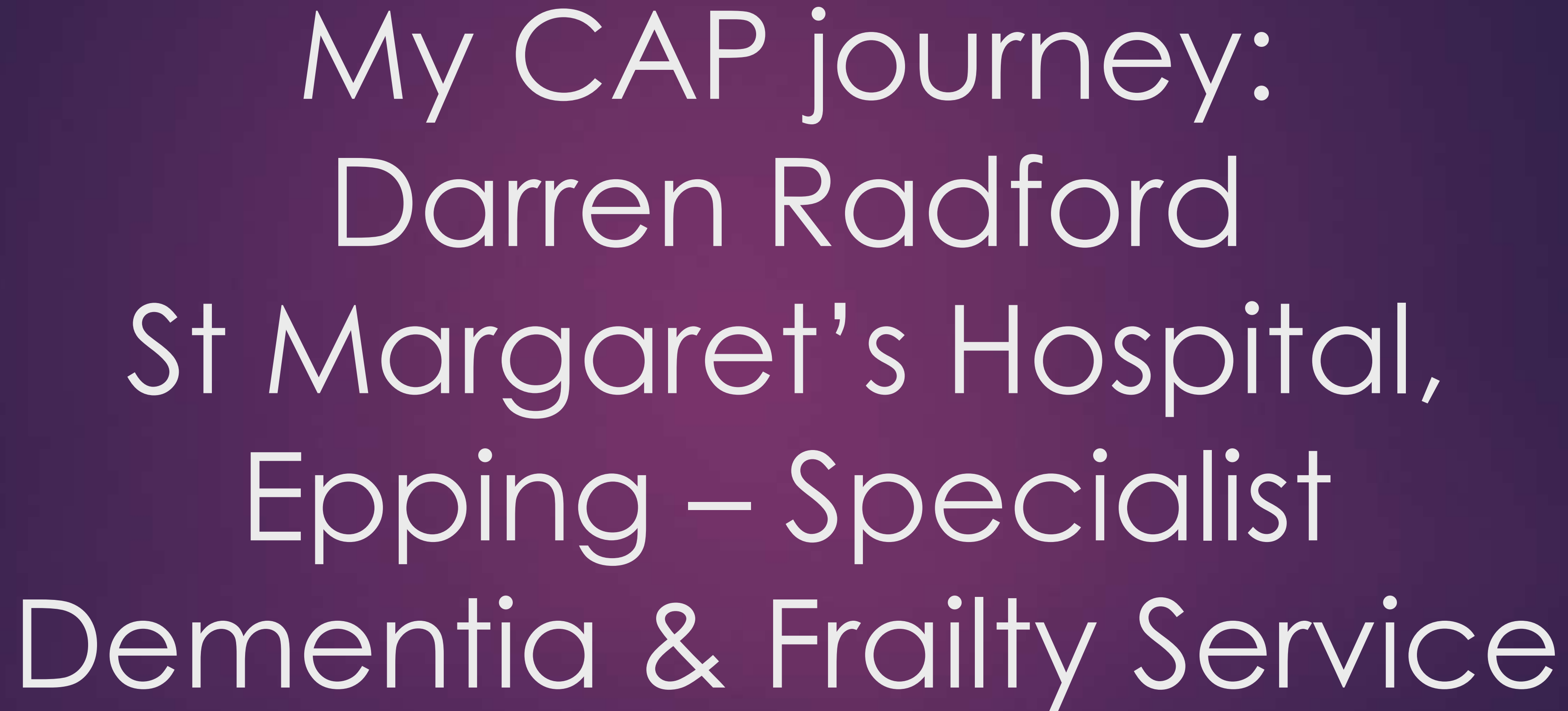
Thank you!

Any questions please email chloe.wernick@nhs.net – I will try my best to answer and support in a timely manner.

Impact of CAPs:
Case Examples from service

- Case Example 4:

My Journey: Specialist Dementia and Frailty Service
Darren Radford


My CAP journey:
Darren Radford
St Margaret's Hospital,
Epping – Specialist
Dementia & Frailty Service

CAP in Training

- Learning to carry out assessment, formulation and interventions under supervision. CBT model and 3rd wave e.g. ACT & CFT
- Developing clinical skills and knowledge.
- Audit, service development and research
- Specialist neuropsychological assessments
- Team working
- Presentation skills
- Developing and delivering training (doctors, MDT, DClinPsych trainees and APs

Qualified CAP

- Assessment, formulation and intervention – supporting the work of practitioner psychologists
- Referral triage and Memory Clinic management
- Working with complex cases
- Co-facilitating therapeutic groups
- Assisting with management of APs
- Working with translators/interpreters
- Managing research database

Impact on our service

- Positive feedback from service users
- Rewarding and fulfilling work - enhances service user's experience
- Making a difference/filling gaps – enabling access to services

Manger’s impact statement:

“The CAP MSc course enabled them to undertake a greater range of clinical work in the team, most notably undertaking therapy work with clients whose needs fall between the level of complexity seen in NHS Talking Therapy Services and those seen by Practitioner Psychologists in specialist mental health teams.”

“It also supported their professional development so that they were able to undertake more skilled neuropsychological assessment work, and leading on the triage of new referrals into a neuropsychological assessment service.”

Break Time

Impact of CAPs:
Case Examples from service

- Case Example 5:

Psychological Skills Service (PSS) and the Role of CAPs
Melanie Staley & Charlie Laker

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Psychological Skills Service (PSS) and the Role of CAPs

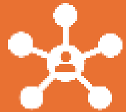
Charlie Laker (CAP)
Dr Melanie Staley (Consultant Clinical Psychologist)

Pride in our adults and specialist mental health services

The Psychological Skills service

- The Psychological Skills Service (PSS) was developed as part of the Exemplar project in Cambridgeshire and Peterborough NHS trust (CPFT).
- PSS was developed to try and address gaps in psychological service provision between primary and secondary care and support the development of a more seamless pathway and promoting joint working.

PSS Inclusion criteria

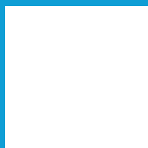


Service users who have a history of complex trauma*

AND

We believe their current difficulties need to be understood in the context of their early trauma

These service users do not meet the criteria for talking therapies or have tried Talking therapies in the past and CBT has not been effective



We believe that their main difficulties could be best helped by another therapy model offered in another service

The Psychological Skills Service

Core aims

1. To produce a seamless trauma informed service that fills gaps in current provision

2. To provide service users and the system with an understanding of their difficulties from a trauma informed perspective based on the answers to..

"What are you struggling with?, Why do you struggle with this?, How have you made sense of this? How have you had to adapt and survive?

3. To provide the right type of intervention, at the right time

(*What do you need, in what order? (and where should we start..What can you cope with right now)?*

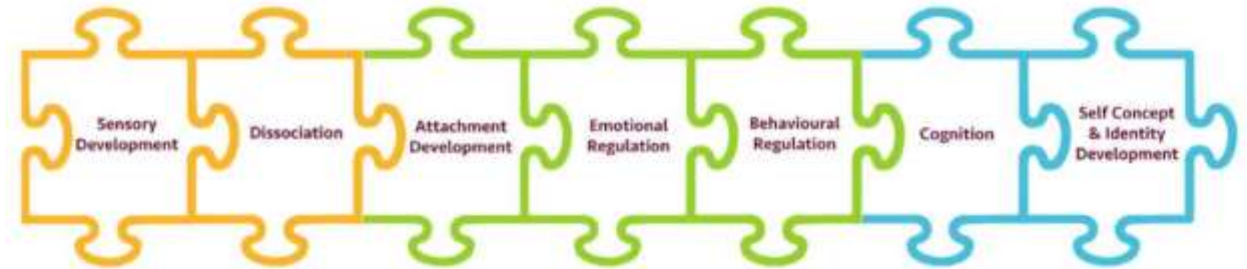
The interventions in PSS

- 1. **Formulation (CAPs and Psychologists)**
- **2. Support work (supervised by CAPs)**
- 3. Occupational therapy
- 4. **Brief psychological interventions CAP run**
- **5. Trauma stabilisation group (CAP and Band led)**
- 6. Schema group
- 7. Trauma processing

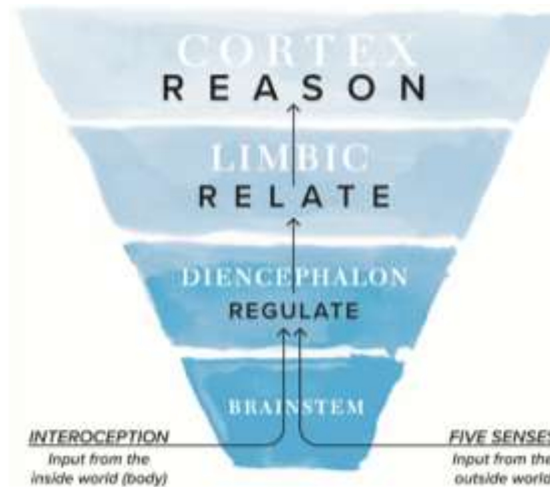
Interventions offered by CAPs

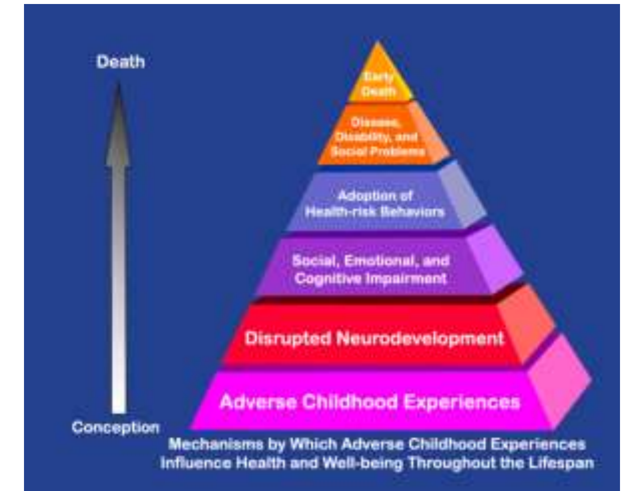
-Brief Psychological Therapy
-Sense Making
-Skills building (and getting practice-based evidence)
-Trauma Group

The CAPs help people to make sense of how early experiences lead to problems now and think about the order of treatment



Dissociation is caused when the three areas of the brain disconnect from each other, which results in the primitive brain shutting down as a way of protecting the self from harm.





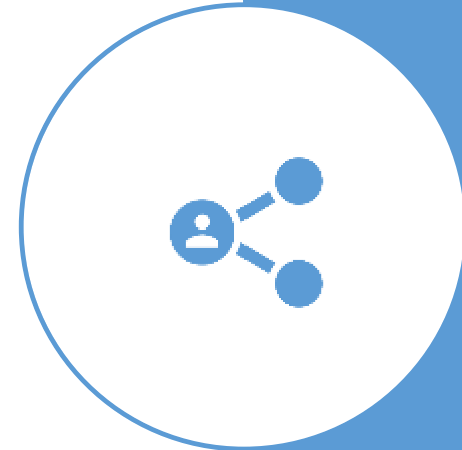
Case study- Charlie

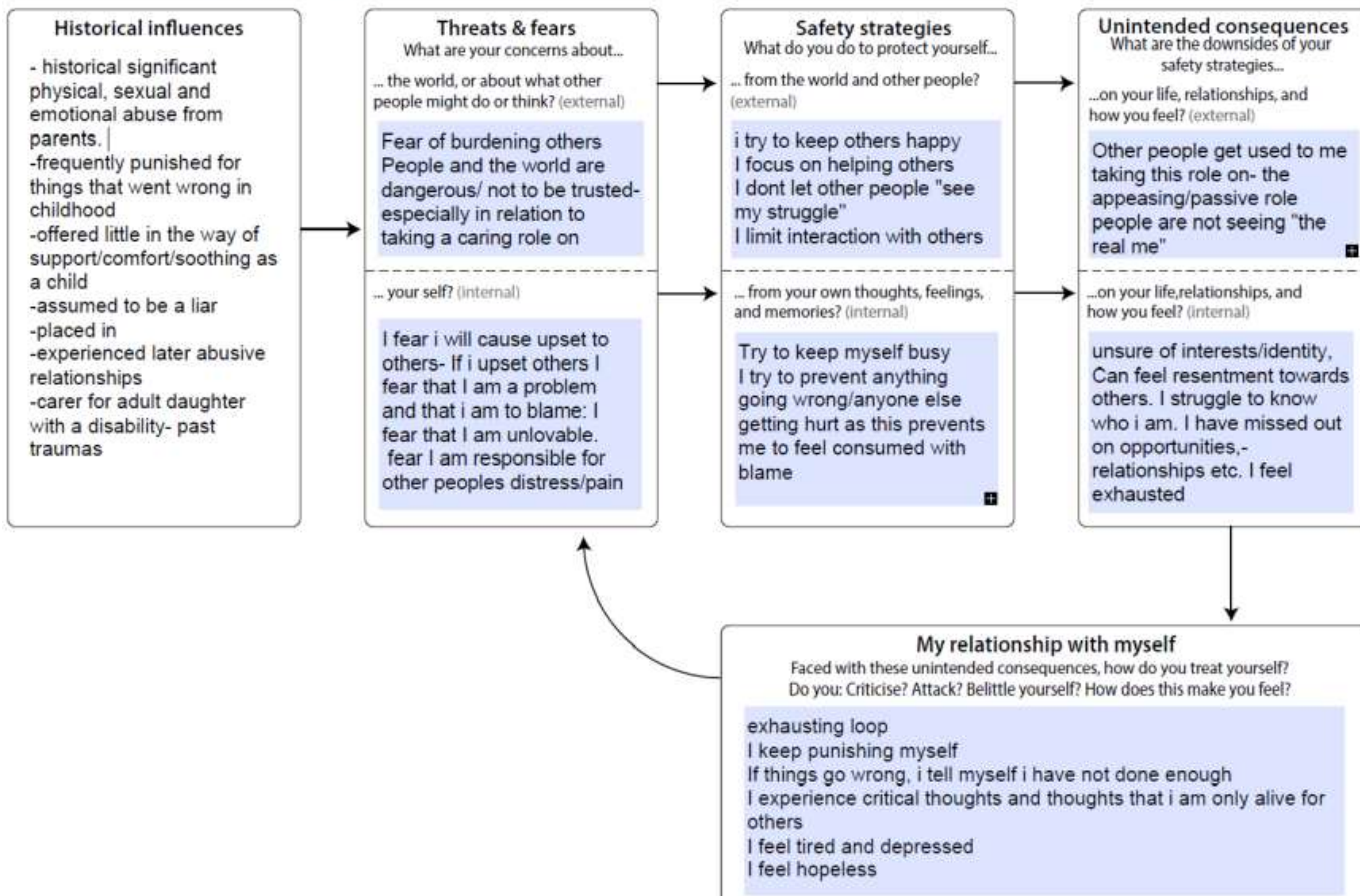
JANE- Reason for referral

- Reported ongoing high levels of Low Mood/Depression
- Suicidal thoughts but able to keep self safe
- Experiencing “moderate” flashbacks/nightmares
- Feelings of worthlessness
- Consumed with memories from her past experiences
- Experienced significant abuse during childhood- sexual, physical and emotional traumas
- Past abusive relationships as an adult
- Described self as being “on high alert” all of the time
- Had previous CBT sessions– reported to be helpful but didn’t feel much “changed”
- Initial therapy goal “To understand how her past experiences have impacted her”

PSS Treatment journey

- Formulation appointment
- Referral to a CAP for 121 Brief Psychological Therapies- with Compassion Focused Therapy recommended




CFT Compassion Formulation
Historical influences
- historical significant physical, sexual and emotional abuse from parents.
-frequently punished for things that went wrong in childhood
-offered little in the way of support/comfort/soothing as a child
-assumed to be a liar
-placed in
-experienced later abusive relationships
-carer for adult daughter with a disability- past traumas
Threats & fears
What are your concerns about...
... the world, or about what other people might do or think? (external)
Fear of burdening others
People and the world are dangerous/ not to be trusted- especially in relation to taking a caring role on
... your self? (internal)
I fear i will cause upset to others- If i upset others I fear that I am a problem and that i am to blame: I fear that I am unlovable.
fear I am responsible for other peoples distress/pain
Safety strategies
What do you do to protect yourself...
... from the world and other people? (external)
i try to keep others happy
I focus on helping others
I dont let other people "see my struggle"
I limit interaction with others
... from your own thoughts, feelings, and memories? (internal)
Try to keep myself busy
I try to prevent anything going wrong/anyone else getting hurt as this prevents me to feel consumed with blame
Unintended consequences
What are the downsides of your safety strategies...
...on your life, relationships, and how you feel? (external)
Other people get used to me taking this role on- the appeasing/passive role
people are not seeing "the real me"
...on your life,relationships, and how you feel? (internal)
unsure of interests/identity, Can feel resentment towards others. I struggle to know who i am. I have missed out on opportunities,- relationships etc. I feel exhausted
My relationship with myself
Faced with these unintended consequences, how do you treat yourself?
Do you: Criticise? Attack? Belittle yourself? How does this make you feel?
exhausting loop
I keep punishing myself
If things go wrong, i tell myself i have not done enough
I experience critical thoughts and thoughts that i am only alive for others
I feel tired and depressed
I feel hopeless

CFT Intervention

-Understanding the 3-emotion system

Building the soothing system- increasing grounding skills, soothing rhythm breathing

Visualisation Exercises/building mindfulness skills

Explored sense of self/identity- finding out her interests/learning about her values

Managing fears and blocks to self- compassion

Practiced putting these into practice and exploring difficulties

Explored experiences of shame and self-criticism

Challenges and Outcome

- Jane initially found it very difficult to do this as it was something different to her usual coping strategies
- Jane began to learn and practice bringing compassion to herself.
- Jane was able to understand why her brain was presenting so critically and we worked to help her to turn towards her pain rather than away from it
- Jane started to make some time for herself, and was able to develop her interests

Impact of CAPs:
Case Examples from service

- Case Example 6:

CAP in Psychiatry Liaison Team
Hayley Metcalfe-Pfeifer

CAP in Psychiatry Liaison Team

Hayley Metcalfe-Pfeifer

Psychiatry Liaison Team (Barnet)

- 24-hour multidisciplinary adult mental health team based in a general hospital
- Serves as the interface between physical and mental health, offering assessments, interventions, treatment plans and referrals to appropriate services
- 200 – 300 referrals a month (A&E and medical wards)
- Aim to see A&E in 1 hour and Ward referrals in 24 hours

My Role as a Trainee CAP in Barnet Psychiatry Liaison Team

- Initial Assessments/Risk Assessments
- Formulation (5 P's, ARC/ABC, chain analysis)
- Interventions (CBT, Motivational Interviewing, Behavioural activation, Exposure therapy, SCM)
- Internal training to the team
- Consultation
- QI Projects/Audits/Service Evaluation
- Carer's Group

Example One: Health Anxiety

Health anxiety affecting woman in her 60's medication compliance

- Initial treatment plan – Exposure to help reduce panic and phobia around health anxieties and taking medication.
- Progress was going well with the treatment plan, we had even attempted behavioral experiments where she was taking the medication whilst speaking to me, having breaks between each pill and eating ice cream to help with the taste.
- Complexity Issue: Relationship breakdown with the nursing team

Flexibility/Adaptions

Systemic Approach – Spoke to the nurse in charge, addressing the clients concerns and sharing the formulation. Advised the client of the certain ward rules that need to be followed. Highlighted how communication is key.

Individual Approach – Originally validated and normalised the clients' experiences, explored what was important to rebuild rapport with the nursing team. Then allocated 10 minutes per session to discuss any concerns regarding care before focusing on intervention.

Care Plan – Due to her physical health issues this client has been admitted to the hospital on several occasions and will often have challenges with the medical team/nursing staff. A care plan helped improve her rapport with staff.

Example Two: Adjustment

Man in his 40's with terminal cancer

- Finding it difficult to adjust to physical health difficulties including poor oral intake, fatigue and pain. Fed up with being in hospital, was previously active, owned his own company.
- Family finding it difficult to accept his prognosis.
- Medical team finding it difficult to sit with not being able to medically do much more for this young man.

Approaches

Individual Approach: Adjustment and values work on what is important to him. He wanted to be driven around in his new sports car he had purchased prior to becoming unwell and he wanted to eat puddings.

Systemic Approach: Normalising and validating families experiences. Highlighting how it was ok if some days he does not want to do much or he feels he needs a bit of time to be by himself. Worked with the medical team regarding making sure that he is comfortable and whether there was anything that could help with that i.e. mix milk with ensure to make it more palatable.

Key impact of the CAP role

- Increase the capacity for individual psychological work.
- Increasing the access of psychology to our clients.
- Free up senior psychologist who could then offer reflective practice to the team and potentially to the wider hospital and work more with high intensity users.
- Increasing psychological mindedness not just to the team but also the wider hospital.
- Understanding of complex presentations.

What I find rewarding about the role

- I get to work with a wide scope of people including those who have been under mental health services most of their life to those who this is their first experience of working with a mental health professional.
- Promoting psychology and supporting mental wellbeing within the hospital.
- Increasing peoples access to psychological formulation and therapy.
- The link between physical health and mental health.

Impact of CAPs:
Case Examples from service

- Case Example 7:

Assessing the Feasibility, Attendance Rates and Outcomes of Group Interventions Facilitated by Clinical Associates in Psychology in an NHS Secondary Care Community Mental Health Team
Sarah Knowles, Caitlin Laws & Tom Steverson

Video

Assessing the Feasibility, Attendance Rates and Outcomes of Group Interventions Facilitated by Clinical Associates in Psychology in an NHS Secondary Care Community Mental Health Team

Sarah Knowles, Caitlin Laws, Paul Fisher and Tom Steverson.

Context

In 2021, CAPs were first employed to work with adults within Norfolk and Suffolk NHS Foundation Mental Health Trust (NSFT).

Since then, some of the CAPs employed in NSFT have led the provision of group therapies in secondary care community mental health teams.

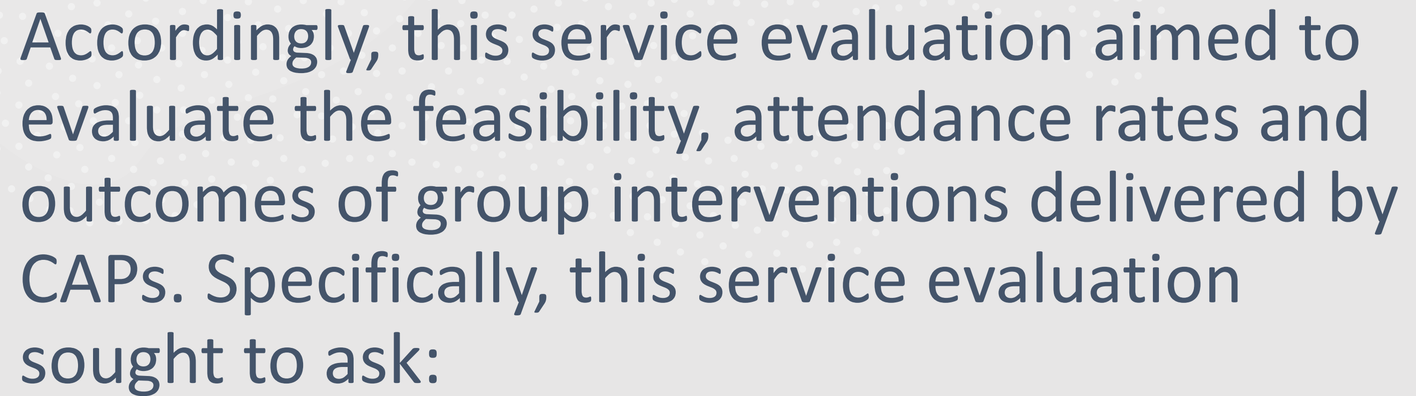
Clients within these teams are aged between 25 and 75 and most frequently, will have a moderate level of risk of self-harm and have been diagnosed with difficulties related to depression, anxiety, schizophrenia, trauma, and/or attachment.

Context

To meet service need, three groups were created by two CAPs (CL and SK) with support from Assistant Psychologists and Occupational Therapists.

The groups included a ‘Anxiety Management Group’, a ‘Behavioural Activation Group’ and a ‘Living with Emotions Group’.

It was important to carry out an evaluation to assess whether the demands of running groups for service users in secondary care mental health services are matched to the knowledge skills and behaviours of the CAP role.



Accordingly, this service evaluation aimed to evaluate the feasibility, attendance rates and outcomes of group interventions delivered by CAPs. Specifically, this service evaluation sought to ask:

a. Is it feasible for CAPs to run group interventions in secondary care, mental health, community teams?

b. Are attendance rates for these groups comparable to groups in similar settings?

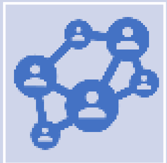
c. What is the impact of the groups on the outcome measures of those who attend?

d. Based on the above, can further delivery of these groups be justified?

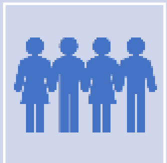
Week	Anxiety Management	Behavioural Activation	Living with Emotions
1	Introduction to the group, administering pre group questionnaires, understanding of anxiety and its symptoms	Introduction to the group, administering pre group questionnaires, understanding depression and its symptoms	Introduction to the group, administering pre group questionnaires and mindfulness skills (wise mind and centring)
2	Behaviour- Safety behaviours, avoidance and graded exposure	Introduction to the vicious cycle of depression and behavioural activation	Mindfulness skills (What skills: Describe, Observe, Participate)
3	Thoughts (1) - Anxious thoughts and unhelpful thinking styles	Identifying values and goals to guide activities	Mindfulness skills (How skills: non-judgementally, effectively, one-mindfully)
4	Thoughts (2) - Thought challenging and coping statements	Identifying routine, necessary and pleasurable activities. How to make activities more manageable	Emotional regulation skills (emotional psychoeducation)
5	Physiology- Relaxation, breathing and mindfulness. Anxiety toolkit, summary and re-administration of questionnaires	Troubleshooting- what to do when activities feel too easy or too challenging	Emotional regulation skills (check the facts, opposite action, problem solving)
6		Low mood and motivation toolkit, summary and re-administration of questionnaires	Emotional Regulation skills (ABC PLEASE)
7			Distress tolerance skills (STOPP, Pros and Cons, TIPP)
8			Distress tolerance skills (Distraction, Self sooth and IMPROVE the moment)
9			Interpersonal effectiveness skills (the bill of rights, cheerleading statements)
10			Interpersonal effectiveness skills (DEARMAN, GIVE and communication styles)
11			Interpersonal effectiveness skills (FAST and troubleshooting interpersonal effectiveness)
12			Creating an ending, therapy blueprinting and re-administration of questionnaires

Groups

The groups ran between September 2022 and December 2024.

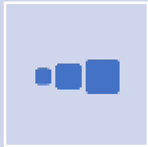


Over this period, seven Anxiety Management, four Behavioural Activation and three Living with Emotions groups took place.

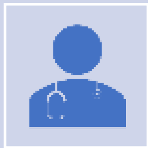


79 clients started one of the three groups. This sample had an average age of 44 years (SD = 12.5) and was 51% female.

Sample



Prior to starting the groups, the sample had an average length of time in service of 27.82 months (SD = 38.47), with 44% being in the service for less than one year, 23% being in the service for between one and two years, and 33% being in the service for more than two years.



The number of psychiatric diagnoses recorded on each client's electronic clinical record was "one" for 57% of the sample, "two" for 34% of the sample, "three" for 6% of the sample and "four" for 3% of the sample.

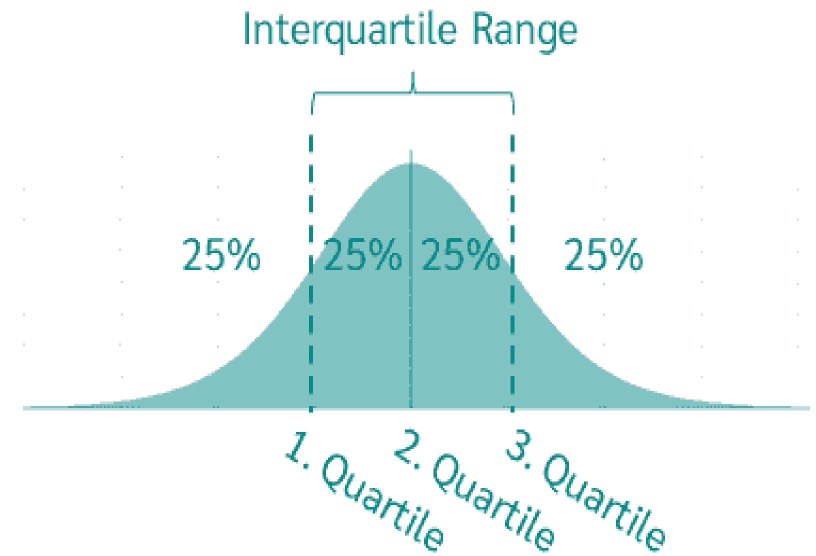
The average number of diagnoses for those in the Anxiety Management was 1.38, for the Behavioural Activation group; 1.40 and the Living with Emotions group; 2.05.

Feasibility

- Feasibility has been defined as "the cumulative impact of different influences that have an effect on the implementation of an intervention within a specific healthcare system or practice" (Bird et al., 2014, p. 316)
- This was assessed using the Structured Assessment of Feasibility (SAFE) tool (Bird et al., 2014).
- Blocks
  - The intervention:
    - Is "complex" (i.e., contains separate components including the group intervention itself, an initial assessment, an end of intervention review and supervision) .
    - Is "time consuming" (i.e., two or more hours per week per client).
    - Requires more than one member of staff.
    - Requires additional material resources (e.g., workbooks).
- Facilitators
  - The intervention:
    - *Does not require any specific training beyond standard skill-set of CAPs.*
    - *The intervention does not require any **additional** support sessions or supervision for CAPs.*
    - Was applicable to the population of interest (those in a secondary care mental health service).
    - Manualised.
    - Flexible (i.e., elements of the intervention can be tailored to the context and situation such as time out, adaptations to workbooks etc).
    - Likely to be effective (i.e., there is an established evidence base regarding the effectiveness of the intervention).
    - The primary aims of the intervention match valued NHS outcomes (e.g. improving mental health and wellbeing, supporting clinical and personal recovery).
    - The intervention can be piloted by a few members of staff AND with only a few service users
    - There were no known serious or adverse events associated with the intervention.
    - It was possible to stop the intervention without harmful, or unwanted, effects (e.g., there would be no clear "withdrawal symptoms").

Attendance

- Heatherington et al. (2014):
  - “low” attenders - those attending equal to or less than less than 24% of sessions,
  - “medium” attenders as those attending between 25% and 75% of sessions and
  - “high” attenders as those attending equal to or greater than 76% of sessions.



	Heatherington Median (lower and upper quartiles)	Anxiety Group	Behavioural Activation group	Living with Emotions Group	Total
Low	14% (10%-20%)	15%	0%	26.3%	14%
Medium	45% (42%-47%)	30%	40%	26.3%	32%
High	40% (34%-48%)	55%	60%	47.4%	54%

Outcome

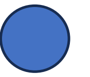
1.00
0.00
-1.00
-2.00
-3.00
-4.00
-5.00
-6.00

-3.00 -2.50 -2.00 -1.50 -1.00 -0.50 0.00 0.50 1.00 1.50 2.00

← Reliable Improvement

← Recovery

Anxiety Group/GAD-7
Depression Group/PHQ-9
Living with Emotions Group/AAQ-2

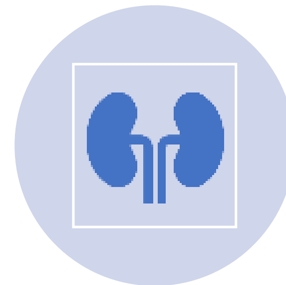


Limitations

Pre and post outcome data was only available for 52% of participants.

The outcome measures used across the groups were different.

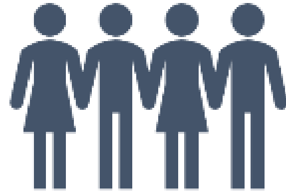
The outcome measure data was taken at two time points only.



There was no comparable "treatment as usual" sample.

These are all common issues when trying to combine methodological rigour with the reality of evaluation in clinical settings.

Conclusion and Recommendations



Conclusion

The data suggests that it is feasible for CAPS to run group therapies in secondary care community mental health teams.

Attendance rates are mostly comparable to similar samples.

Many treatment successes occurred in this secondary care clinical sample.

Recommendations

Continuation and further development of the groups.

Improve outcome measure collection.

Collect “acceptability” data to help ongoing evaluation.

Impact of CAPs: Case Examples from service

- Case Example 8:

East Suffolk – CAPs in Later Life Community Mental Health Team & Acute Inpatient Service
Eve Cox and Amanda Price

Clinical Associate Psychologist (CAP)

East Suffolk – CAPs in Later Life Community Mental Health Team & Acute Inpatient Service

Presenters – Eve Cox & Amanda Price

Service landscape pre-CAPs

- Pressure on already available resources.
- Critical gaps in psychological services.
- Service's ability to engage systemically with family and caregivers to provide non-pharmacological interventions was affected.
- Service development & evaluation projects were constrained due to limited resources.
- Lack of clarity and cohesion around referral processes across the locality.
- No psychological input in the OA acute unit.
- No resource to facilitate psycho-education groups.
- Lack of resource to deliver older adult specific Complex Emotional and Relational Needs training to colleagues across the specialty, and partnership services.
- Lack of resource to develop co-production/expert by experience pathways within the service.

Formation of a CAP in Later Life Services

- Following an apprenticeship model the role is shaped by a combination of the training and the specific service they train within, based on clinical need and service development goals.
- In East Suffolk there have been three cohorts of CAP trainees who have qualified and are now fully immersed and embedded into the workforce throughout Suffolk.
- Development of an understanding of how risk presents differently with older adults. Trainees are required to be flexible in adapting our training to meet the needs of the service and service providers.
- Development of specialist knowledge and skills to adapt a largely adult centric evidence base to the later life clinical population.
- Scope of practice is evolving.

CAP – Community Mental Health Team (CMHT)

- **Evidence- Based Psychological interventions** – Involving assessment, formulation and delivery of bespoke psychological interventions. Person-centred, needs-informed, collaborative approach. Individual and systemic.
- **Acceptance and Commitment Therapy** – Promote psychological flexibility, increase one's ability to connect with their values in the present moment. Focus on values, development of cognitive defusion skills to reduce, reducing experiential avoidance and inaction, and promoting self-compassion. Supporting clients to live well with chronic pain, distress, depression and anxiety, adjustment, and navigate complex grief.
- **Cognitive Behavioural Therapy** – Empowers people to manage their difficulties more effectively through the transmission of coping skills. Focus on here and now, problem solving orientation. Using cognitive restructuring and behavioural experiments.
- **Integrative approach in later life** – Cognitive Analytic Therapy, Mentalisation Based Treatment, Radically Open DBT, DBT, Systemic Family Therapy, Compassion Focused Therapy, Systemic Family Therapy.
- **MDT** – weekly meetings, psychology facilitate weekly MDT formulations and support staff to develop further with service users, risk assessment and management, reflective spaces, debriefs, training delivery.
- **Joint working** – Working across sectors to implement person-centred, system wide approaches to meet presenting needs.
- **Development of clinical pathways** – Complex Emotional and Relational Needs, Personality Disorder. Training, RODBT offer.
- **Development of Expert by Experience Groups**
- **Psychoeducation groups** – Living Well with Dementia.
- **Service improvement** – service evaluation projects.
- **Later Life Psychology team** - Working collaboratively, and innovatively with other psychology colleagues to manage waitlists, discuss referrals, share learning and resources, streamline ways of working and serve the clinical population effectively via the huddle.

CAP- Acute service

What the CAP role encompasses within an inpatient ward

- Group, joint and individual psychoeducational sessions
- Cognitive Behavioural Therapy- For older adults focuses on practical problem solving and adjusting to changes in health and lifestyle, rather than abstract cognitive restructuring.
- Acceptance and Commitment therapy- For older adults focuses on facing challenges such as loss, health, loved ones, independence, role transition with greater emotional resilience, to break free from limiting beliefs and allow flexible mindset and mindfulness to help live to their values and make their life meaningful.
- Compassion focus Therapy- Focuses on fostering meaningful relationships and creating supportive environments where they feel seen, valued, and heard.
- Mindfulness progressive muscle relaxation, and breathing techniques.
- Safety plans / Discharge planning
- Behaviour support plans / This is me
- Reflective practice, debriefs and distressed behaviour meetings..
- Weekly MDT
- Review meetings and discharge planning meetings.
- Psychology huddle and referrals via the care coordinator.
- Family and caregiver involvement.

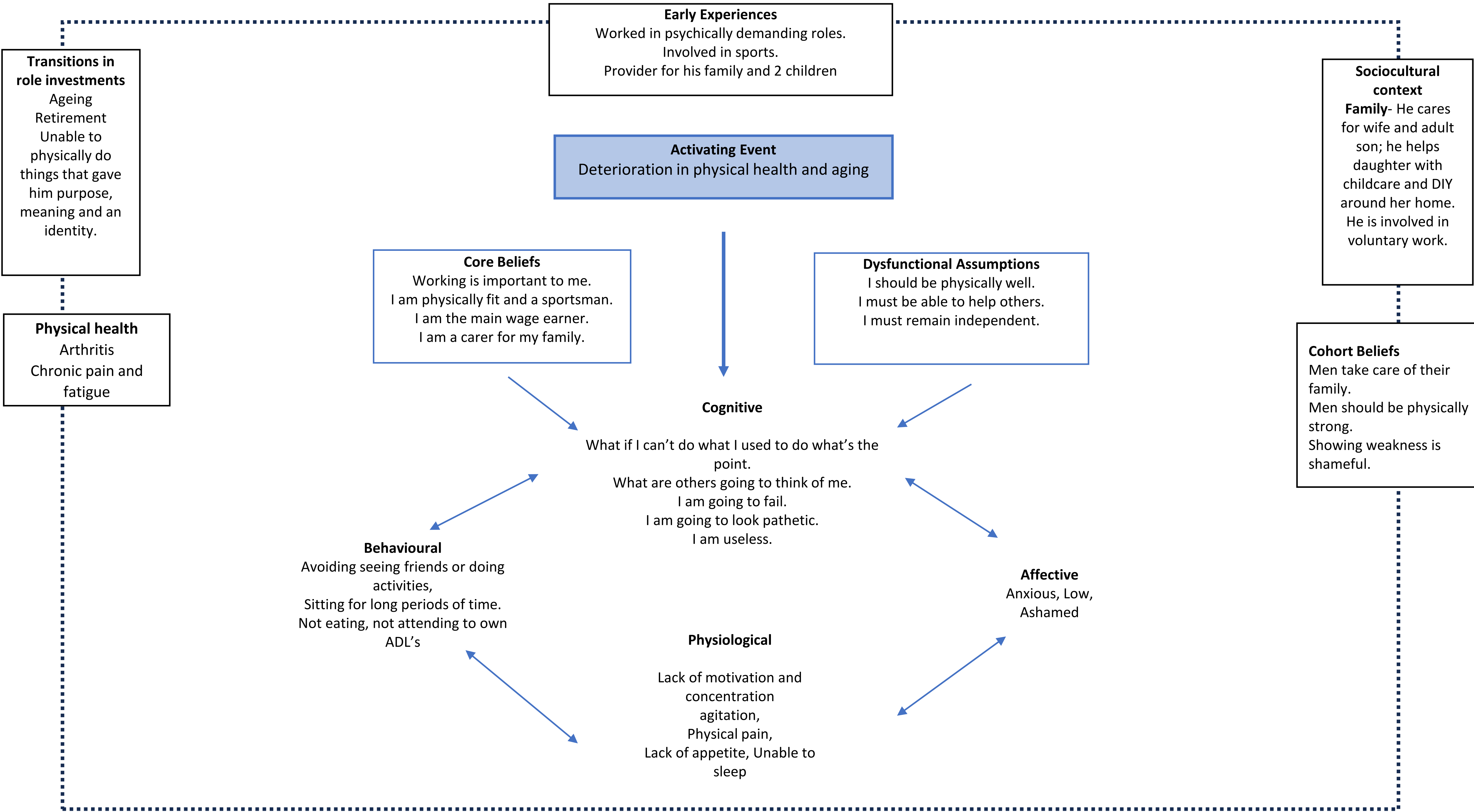
Service landscape post-CAPs

Impact of the work

- We have been able to alleviate the workload for psychology teams and enhance service provision and accessibility for older adults within East Suffolk to access evidence-based, psychologically informed interventions.
- Enabled increased engagement in working systemically, providing non-pharmacological interventions for distressed behaviours (adhering to NICE recommendations).
- Sustained the facilitation of regular team formulations, embedding psychological thinking within the MDT.
- Sustained delivery of psychoeducation groups on the ward and within the community.
- Conducted service evaluation projects.
- Streamlined referral processes and reduced wait times for psychological therapy.
- Ongoing development of a clinical pathway for Complex Emotional and Relational Needs (RODBT pilot).

Case study – Amanda (Acute)

- **Admission on to the acute ward-** 76-year-old male presenting with depression and anxiety who was admitted to hospital due to severe self -neglect.
- **On the ward -** He isolated himself in his bedroom and had limited communication with others.
- **1:1 sessions - I**nvolved building rapport and providing a safe place to share how he was feeling.
- We completed an assessment, Laidlaw formulation, and psycho-ed on transitions in later life, depression and anxiety.
- He began to socialise on the ward and his eating and sleeping improved.
- He began to attend to his own activities of daily living, and he attended various groups on the ward.
- He was discharged from hospital.
- **Goal in the community-** To focus on motivation and avoidance to return to meaningful activities such as walking, bowling, and working at the gymnastic club.
- **Barriers**- he was feeling ashamed about being in hospital and worried about meeting friends again which was feeding into the lack of motivation and increasing avoidance of most things.
- **Intervention**- CBT using behavioural activation with behavioural experiments.
- **Outcome**- Gradually returned to doing the things he valued, and his depression and anxiety reduced.



Early Experiences
Worked in psychically demanding roles.
Involved in sports.
Provider for his family and 2 children
Transitions in role investments
Ageing
Retirement
Unable to physically do things that gave him purpose, meaning and an identity.
Sociocultural context
Family- He cares for wife and adult son; he helps daughter with childcare and DIY around her home.
He is involved in voluntary work.
Activating Event
Deterioration in physical health and aging
Core Beliefs
Working is important to me.
I am physically fit and a sportsman.
I am the main wage earner.
I am a carer for my family.
Dysfunctional Assumptions
I should be physically well.
I must be able to help others.
I must remain independent.
Physical health
Arthritis
Chronic pain and fatigue
Cohort Beliefs
Men take care of their family.
Men should be physically strong.
Showing weakness is shameful.
Cognitive
What if I can't do what I used to do what's the point.
What are others going to think of me.
I am going to fail.
I am going to look pathetic.
I am useless.
Behavioural
Avoiding seeing friends or doing activities,
Sitting for long periods of time.
Not eating, not attending to own ADL's
Affective
Anxious, Low, Ashamed
Physiological
Lack of motivation and concentration
agitation,
Physical pain,
Lack of appetite, Unable to sleep

Case study Eve - CMHT

<u>Referral</u> – Resident in a care home. Referred to psychology on account of resistance to personal care administration, attempts to abscond, 'interfering with other residents' and aggression. Pharmacological approach tried but behaviours remain. Placement at risk of breakdown. Patient has a diagnosis of Alzheimer's, little known about their history and family struggling to engage with care staff due to safeguarding concerns around personal care.

<u>Assessment</u>

- Newcastle Model – behaviour checklist, ABC charts, observations and information gathering.
- Carer-centred & person-focused

<u>Intervention</u>

- Collaborative biopsychosocial formulation, developed with staff and family.
- Psychoeducation component
- Cultural considerations – history of being stigmatised for MH needs, racially discriminated, and periods of hospitalisation.
- Identification of possible unmet needs and generation of person-centred ways to meet these needs.

Unmet needs identified and strategies generated:

- <u>Need for respect, privacy and dignity</u> – talking to them, not over them when approaching personal care, connect relationally first, use visual prompts and clear short vocalisations that personal care will take place, include them in the intervention, *do with not to*.
- <u>Need to feel safe and cared for</u> – Female attendees only due to historical experiences and cultural and personal beliefs, non-threatening approach, language that promotes safety and trust, touch on the arm to introduce contact. Restrictive interventions or feeling unsafe/trapped likely to trigger distress.
- <u>Need for agency and choice</u> – particularly over body and liberty, allow them to leave if they are trying to, and re-attempt when calmer. Choose bath or shower etc and what time of day.
- <u>Need for stimulation/occupation and a purpose that aligns with values</u> – Faith important, stream church services on Sundays, access to worship music, opportunities to garden regularly, help with chores, opportunities to nurture/care, opportunities to leave the home with 1:1 support.

<u>Impact & Outcome</u>

- Staff reported that they felt more able to reflect on *why* certain behaviours may be occurring and felt skilled up to consider practical ways to meet the needs of the resident.
- Family felt more confident that the staff were meeting needs.
- Reduction in incidents reported and placement remained stable.
- Staff consistently worked on rapport prior to personal care interventions and promoted a calm and safe environment by using music of the president's choice, offering them to be involved, carrying out personal care during the night with female only attendees. Utilising clear, short communication and visual prompts to cue that personal care would take place. Emotional distress reduced, as did aggression.
- Resident was more settled, engaging in meaningful activities, supported to have a role/purpose where possible reducing boredom and restlessness.
- Staff pre-empted situations where they might trigger another resident, and they pro-actively provided alternative ways to care, help or redirect attention.

Mental health

Long standing history of manic depression, intermittent inpatient admissions under section – distressing experiences.

History of difficult encounter with male attendee impacted her sense of trust.

Life story

Gaps in knowledge of early life.

Grew up in xxxxx moved to xx when 18. Met xxx had three children.

Experienced difficulties with mental health, requiring admissions – children describe this as traumatic. Children cared for by local authority.

Recovered and worked in a caregiving role. Faith central to identity, regular attendance at church.

Keen gardener, enjoys music, signing, and walking. Finds females more trustworthy than males and responds well to mature women.

Social environment

Lives in a residential setting, with a garden. Variable recognition that it is home often attempts to leave becoming distressed when unable to, frequently fails to distinguish between her role and the staff, often attempting chores and mediating with other residents. Struggles to accept help from others or accept personal care interventions during the day, sleeps a lot. Discriminated against by another resident. Appears bored/restless at times.

Personality

Independent woman likes to be in control.

Does not like being told what to do.

Role as a carer, feels responsibility for others, described as caring, helpful, peacekeeper.

Not unusual for her to be nocturnal, hyperactive, likes to be busy.

Humorous and content temperament.

Prudish, taught body is private – more open with female friends.

Likes a bath at night, stuck to this routine.

Trigger

Lack of insight into care needs. Feeling threatened, approached without insight.

Male attendee – appears concerned, wary.

Attempts made to provide a personal intervention or suggest a bath or change of pad after periods of refusal.

Feeling trapped, wanting to 'escape'.

Typical cycle of Behaviour

Carers approach to begin personal care, staff feel apprehensive (3:1), often rush through; she feels outnumbered, unsafe. Lack of insight into needs compounds this, begins hitting out verbally and physically – pushing, restless, seeking escape. Throwing pads, grabbing at clothing to prevent personal care, walking off. Refusing personal care, refusing to change clothes. Protects herself by holding onto clothes.

Attempting to abscond. **Staff feel stuck.**

Cognitive abilities

Moderate Alzheimer's.

Little insight.

Mild expressive dysphasia.

Mild receptive dysphasia

*Insight into locked/restricted setting.

Physical health

Alzheimer's Disease

Knee replacement

Incontinent

Medication

Rivastigmine patch to support cognitive functioning.

PRN Lorazepam

Appearance (emotions)

Vulnerable, unsafe, confused, unsure, lack of insight, frustrated, anxious, angry, loss of control, loss of independence, embarrassed, private.

Needs

Need for respect, privacy and dignity. (Is private and protective about her body)

Need to feel safe and cared for. (May feel under threat, fears for safety/trapped– past experiences)

Need for agency and choice. (When and how interventions take place)

Need for stimulation/occupation. (Lack of connection to values, role and meaningful activities)

Vocalisations (cognitions)

'What are you doing to me'

'I don't need to'

'I can do it myself, I'll do it later'

'Leave me alone'

'Since when' *(when did that happen)'*

The Newcastle Model formulation

Reflections – The role of a CAPs is increasingly recognised in healthcare settings, especially in mental health and psychological services. It bridges the gap between more junior and fully qualified clinical psychologists, offering a wide range of valuable contributions to patient care. Reflecting on this role highlights its complexity, scope and the impact it can have on both individual service users and the wider team.

Strengths

Diverse skill set and versatility- CAPs are trained in a wide range of psychological methods. Their versatility allows them to adapt to various clinical settings.

Adaptability and flexibility- CAPs are trained to work with complex, chronic and acute psychological needs. They have ability to adapt to different clinical settings.

Research-orientated and evidence-based practice- CAPs are trained and involved in research to integrate evidence-based practices into their clinical work.

Capacity for independent work under supervision- while CAPS work under supervision, they also have the autonomy to carry out a range of tasks independently and manage a case load.

Developing leadership and supervisory skills- supervise and mentor less skilled staff and build a culture of support and professional development.

Challenges

Limited autonomy- CAPs work under the supervision of qualified clinical psychologists, which while necessary for professional development, can some time limit their ability to independently manage complex cases. This can be frustrating for those who have developed sufficient skill but still require approval for their interventions.

Restricted scope of practice- While trained to provide a wide range of psychological services , they are often restricted in their ability to fully apply certain therapeutic techniques or work autonomously without supervision.

Balancing clinical work with professional development- CAPs manage a case load while simultaneously developing their clinical skills. This dual responsibility can lead to time pressures, stress and difficulty finding work life balance.

Lack of clarity and recognition- since their role and responsibilities can vary across settings, there can be confusion about their scope of practice, which undermines their authority or ability to provide care.

CAPs contributions are less recognised compared to clinical psychologists, even though they perform similar tasks

Impact of CAPs: Panel Discussion

- Panel:

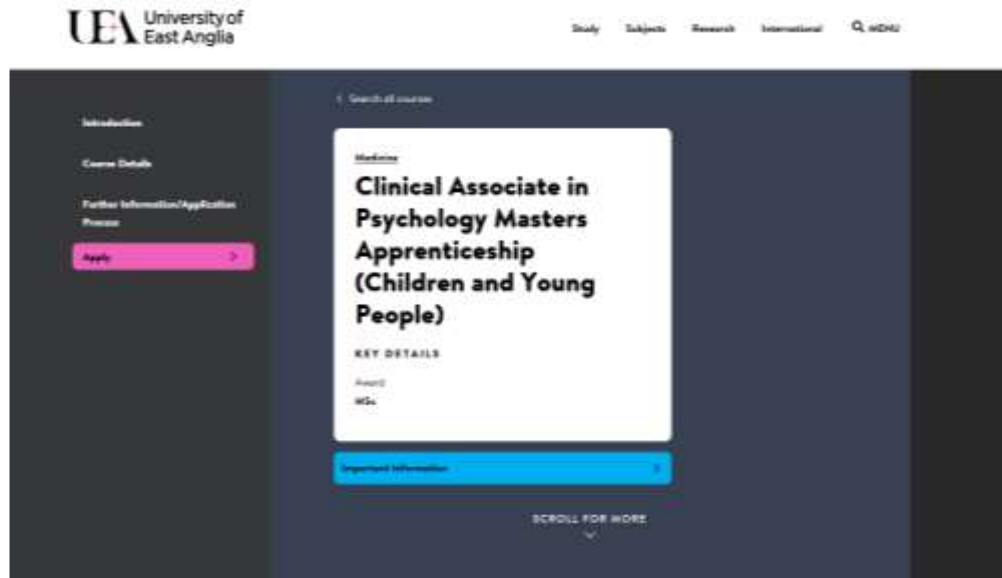
Darren Radford, Clinical Associate in Psychology, EPUT

Melanie Bruce, Clinical Psychologist and Clinical Lead, NCHC

Angela Husband, Consultant Clinical Psychologist and Course Director, Essex / EPUT CAP MSc

Ruth Mills, Consultant Clinical Psychologist, Suffolk Psychology/Psychological Therapies Lead

Impact of CAPs:
UEA Specific information



University of East Anglia

PROGRAMME OVERVIEW

Apprenticeships

University of East Anglia

Recruiting for September 2025

Clinical Associate in Psychology Degree Apprenticeship (MSc)

Widening participation in higher education
Earn while you learn

OVERVIEW

- At UEA we are recruiting our fifth intake of CAPs who will work under the supervision of doctoral-level psychologists in Adult and Child services.
- As an experienced training provider, we have excellent completion rates and over 50 graduates from our first two cohorts.
- Our innovative approach enables us to train CAPs over a wide geographical area.
- Close working with Employers and Supervisors is central to our programme and its success.
- Clinical Associates in Psychology (CAPs) are trained to work with complex presentations, such as those seen in secondary-care services, using psychological assessment and formulation skills to deliver tailored, evidence-based interventions.

https://www.uea.ac.uk/course/apprenticeship/masters-clinical-associate-in-psychology-masters-apprenticeship-children-and-young-people

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Impact of CAPs:
EPUT Specific information

- Cohort 6 due to start in June 2025
- Health, Aging and Disability (HADS), and Adult Mental Health pathways.
- https://eput.nhs.uk/CAP/
- Enquires:

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NHS
Essex Partnership University
NHS Foundation Trust

EPUT

The Clinical Associate in Psychology MSc Training Programme

Thank you

- Many thanks to:
  - Everyone for attending today
  - Our speakers and panel members
  - The PPN for hosting this event
  - The community of CAPs
  - CAP Supervisors across the region

- Follow Up:
  - P.Fisher@uea.ac.uk / cap@uea.ac.uk
  - A.Husband@nhs.net

  - To stay up to date with developments in the psychological professions, please join the PPN (quick and easy)
  - www.ppn.nhs.uk
  - Email: hpft.eoeppn@nhs.net