STEPPS EI in a primary care setting

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Primary care and IAPT

- National programme since 2009 to deliver psychological therapies for mild to moderate common mental health problems

- Massive national change in primary care MH services

- East Sussex and B&H – IAPT plus PCMHPs

- National IAPT KPIs linked to 15% of MH population into treatment, everyone to enter into treatment within 6 weeks, 50% to recover on PHQ-9 and GAD-7 or other ADSM.

- What about the 50% who don’t recover?
Service experience of this client group and what we currently offer

- More complex (as measured on PHQ/GAD)
- Multiple referrals, multiple interventions
- Refer in crisis, poor engagement
- Poor outcomes in IAPT (*Goddard et al 2015*),
- Childhood trauma and comorbid personality traits (*Hepgul 2017*)
- Enhancing choice of interventions outside of IAPT compliant modalities
- Brief interventions by PCMHPs
- Intervention for prevention
STEPPS EI compared to STEPPS

- 13 sessions in 3 modules (1,6,6) compared to 20 sessions
- No weekly reinforcement sessions
- Referral criteria excludes BPD/EUPD diagnosis – primary care appropriate
- Screening based on the McLean Screening Instrument (*Zanarini et al 2003*) and other IAPT measures compared to Millon inventory
- QuEST self-rating scale and IAPT measures
- BPD reframed as emotional intensity difficulties
- STEPPS EI delivered by primary care mental health practitioners
- Development led by Renee Harvey
Exclusion /inclusion criteria in primary care

- Illicit substances including alcohol to excess
- Co-morbidity – on-going physical health problems which impact on the ability to attend / participate in the course
- Specific diagnosis of EUPD or features of other personality disorders, including Antisocial, Avoidant or Narcissistic. These presentations are not suitable for a primary care STEPPS EI course.
- History of long term severe and enduring mental health problems - mood disorders, psychosis, schizophrenia
- Active impulsive behaviour which poses high risk to self and others, the client must be able to manage their own risk
- Motivation / engagement
- Tolerance of groups/courses
- Literacy
- Therapy history
Measures

- Patient health questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001)
- Generalised anxiety disorder assessment (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006)
- Work and social adjustment scale (W&SAS; Mundt, Isaac, Shear, & Greist, 2002)
- QuEST - Quick Evaluation of severity over time (Pfohl & Blum 1997, 2012)
Participants

• Qualitative feedback from group evaluation – benefit of the group, managing crisis in the group, skills rather than therapy focused, pot charts
• Kelly https://youtu.be/0N2N2R2bhiU
• Opportunities for peer involvement
• Facilitator training and feedback
## East Sussex groups

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<th>Stepps EI group attrition data 2016-17</th>
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Learning from the East Sussex groups

- Referral criteria review underway
- Timing of the group
- Use of language
- Friends and family sessions
- Fear and commitment of the facilitators
- Implementation in an already pressured workforce
- Male:female, 2-3 facilitators
Challenges in the groups

- Reinforcers
- Managing the group process for facilitators
- Training and supervision requirements for facilitators and referrers
Future research...

• A review of the STEPPS EI Manual in primary care settings – outcomes

• Review of care pathways in and out of STEPPS EI - after multiple interventions in IAPT (including low intensity stress management workshops, high intensity one to one CBT for depression or anxiety disorders)

• Limited literature on people presenting with subthreshold BPD yet significant in IAPT population (Hepgul 2017, Goddard 2015)
References


