Screening for Early Psychosis in a College Counseling Center: Process Outcomes and Implementation Challenges

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Background & Methods

• The earlier the detection of psychosis, the better the long-term outcomes.1,2 Early detection (ED) programs are intended to decrease the duration of untreated psychosis through screening and referral to coordinated specialty care (CSC). Although the evidence on community-based ED programs is large and growing, very little is known about the effectiveness of ED programs on college campuses.

• With the first symptoms of psychosis being most likely to surface among college age young adults, research on the feasibility of implementing an ED program within a college counseling center is warranted.

Study Purpose: Determine the feasibility of an ED program that would identify college students at risk for early psychosis and link them to CSC

Study Partners: University of New Mexico (UNM) Health Sciences Center, Department of Psychiatry and Behavioral Sciences; and UNM Main Campus Student Health and Counseling (SHAC)

Screening Tool: Prodromal Questionnaire Brief (PQ-B): a 21-item early psychosis screening tool implemented during triage for students seeking mental health services at SHAC.

Fig. 1: Study Design and Timeline Overview

Phase 1

Sept. 1, 2019- Jul. 31, 2020
• CSC referrals made as usual
• No ED program in place
• Psychotherapy literacy training provided to SHAC counselors

Phase 2

Aug. 1, 2020- Sept. 30, 2021
• Implementation of ED program: PQ-B & secondary phone screen
• Decision tools
• Weekly study partner meetings

Phase 1: Original Referral Process – Unstructured and Informal

1. Counselor suspected psychosis in a student, at any point in treatment, based on self-reported symptoms or clinical observation.
2. Counselor consulted with CSC Program Director. Usually via telephone and sometimes included the student.
3. CSC Program Director determined eligibility based on counselor’s clinical assessment, student input and mental health records.

Phase 2: New Process – Implementation of PQ-B, phone screen and decision tools along with frequent and structured communication between SHAC and CSC

1. Student enters counseling center for services and completes PQ-B as part of intake triage paperwork.
2. Students with a distress score ≥20 referred to UNM Psychiatry for in-depth secondary screen to determine eligibility for CSC.
3. Program specialist completes phone screen and based on eligibility, refers to CSC or back to college counseling center.
4. Weekly check-in with study team and counseling center to discuss the results of referrals and close the loop.

Results

Several process outcomes were tracked, including the number of: (1) PQ-B’s completed, (2) students who met the cut-off score, (3) referrals to CSC, (4) students who completed a phone screen and clinical assessment, and (5) students enrolled in CSC.

Fig. 2: CSC Enrollment Resulting from ED Program

Discussion

• Implementing the PQ-B at a college counseling center has identified a small number of students who meet criteria for CSC. There are many steps at which students either disengage from services or fall through the cracks, called the “leaky” referral pipeline. Special efforts should be made to engage these students.
• While a large amount of the PQ-B referrals turned out to be “false positives”, the ED program captured 18 students who may not have been identified and linked to CSC without it.
• Given the benefits of identifying FEP as early as possible, further research on the implementation of early psychosis detection programs is necessary.

Implementation Challenges

• Counselor Level: 1. Buy in; 2. Relying on “clinical judgment” and not referring students who met the PQ-B cutoff; 3. Staff turnover; 4. Lack of psychosis literacy
• System Level: 1. Difficulty sharing information between departments i.e. HIPAA and deidentified data
• Societal Level (COVID): 1. shift to remote learning/services; 2. decrease in numbers of students accessing services at SHAC

Recommendations

• A more thorough secondary screen is necessary after the PQ-B is administered. The PQ-B score alone is not enough to determine eligibility for CSC.
• Ensure the ability to share clinical information about referrals across agencies/departments.
• Need a dedicated person from each department/agency to communicate about referrals to ensure continuity of care.
• Disseminate psychosis literacy trainings, decision tools, and other helpful materials to the clinical staff early and often.

References & Acknowledgments

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