

Case Examples: Primary Care Behavioral Health Referrals by Psychosocial Need

Activity: Examine each case listed below and identify potential referrals at each level of priority including immediate placement. Describe the BHSS role in identifying, facilitating, and following up with the referral.

Case 1: Low Psychosocial Needs

A 32-year-old patient presents in primary care with mild depressive symptoms following a recent job change. The patient is employed full-time, has stable housing, reliable transportation, and a supportive social network. There are no significant financial stressors or barriers to care. The primary care provider identifies the need for outpatient counseling and refers the patient to a community-based therapist within their insurance network. A standard referral with contact information is provided, and the patient independently schedules the appointment. Follow-up at the next visit confirms successful connection and engagement in therapy.

Case 2: Moderate Psychosocial Needs

A 45-year-old patient presents with symptoms of anxiety and problematic alcohol use. The patient reports financial strain, limited social support, and difficulty managing work responsibilities but maintains housing and part-time employment. Transportation is inconsistent, and the patient expresses hesitation about seeking specialty care. The primary care provider refers the patient to an outpatient substance use treatment program and behavioral health counseling. Barriers are addressed by identifying a program offering telehealth and sliding-scale fees. A warm handoff is initiated with a same-day phone call to the program, and the provider helps schedule an intake appointment. Follow-up contact ensures the patient attended the initial session and is engaged in services.

Case 3: High Psychosocial Needs

A 52-year-old patient presents with severe depression, uncontrolled diabetes, and recent suicidal ideation. The patient is experiencing homelessness, lacks insurance, and has limited access to food and transportation. There is minimal social support and a history of trauma. The primary care provider determines that urgent specialty mental health services and social supports are required. The provider initiates a referral to a community mental health center offering crisis services and case management. A warm handoff is completed by directly coordinating with the receiving agency and arranging immediate transport. The provider also connects the patient to housing resources and Medicaid enrollment assistance. Ongoing care coordination and close follow-up ensure continuity of care and stabilization.