LEARNER TAKEAWAYS

At Risk in Primary Care

We know that identifying and managing clients who have mental health disorders is important because the physical and mental wellbeing of clients are often very closely connected. Up to 70% of primary care visits are rooted in psychosocial issues.[1] PTSD, depression, substance use disorder, and generalized anxiety disorder (GAD) are four of the most common mental health disorders.[2]

Mental Health Risk Factors and Warning Signs

Risk factors for all four conditions[3]

- Exposure to trauma
- Severe/chronic medical condition
- Death or illness of a loved one
- Exposure to life stressors, including job, financial, social loss
- Prior personal or family history of mental health disorders

PTSD: common warning signs seen in primary care settings

- Complaints of insomnia, nightmares, or other sleep problems
- Increased drug/alcohol use
- Appearance of having poor concentration and/or being in a daze, distracted, detached, restless
- Feeling worried and guilty
- Mention of social isolation, avoidance of social activities
- Reports of preoccupation with traumatic event(s) or avoiding reminders of traumatic event(s)
- Angry outbursts, rage, irritability, agitation
- Hypervigilance

[1] Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). Evolving models of behavioral health integration in primary care. New York: Milbank Memorial Fund, 504.
[2] Use, K. S. (2019). Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. HHS Pub No. PEP19 5068, NSDUH Series H-54. Rockville, MD. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
[3] World Health Organization. (2012). Risks to mental health: An overview of vulnerabilities and risk factors. Geneva: WHO.

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- Exaggerated startle reaction
- Flashbacks, caused by everyday things

Depression: common warning signs seen in primary care settings

- Difficulty sleeping or eating, or excessive sleeping or eating
- Excessive weight gain or loss, drastic change in appetite
- Lethargy, feeling exhausted (sometimes with chest pain or shortness of breath), restricted affect
- Disheveled appearance, poor grooming/hygiene
- Visible tearfulness
- Avoidance of eye contact
- Difficulty following the thread of the conversation
- Missed appointments
- Symptoms of social isolation, avoidance of social activities
- Reports of persistent sadness or stress
- Reports of lost enjoyment in previously enjoyed activities
- Statements of hopelessness, helplessness, worthlessness, or low self-esteem
- For male patients, anger and restlessness might be more pronounced

Substance use disorder: common warning signs seen in primary care settings

- Headaches, nausea, insomnia, racing heart, pain, feeling generally sick
- Drug-seeking behavior (e.g. repeatedly asking for painkillers)
- Physical injuries
- Missed appointments
- Disheveled appearance, poor grooming/hygiene
- Seems currently under the influence (bloodshot eyes, dilated or contracted pupils, shaking/tremoring, slow or rapid movements/speech, sweating or shivering)
- Noticeable weight gain or loss
- Noticeable marks on hands, arms, or other parts of the body

- Reports of drinking (or use of other substances, like marijuana) or misusing prescription drugs (e.g. taking more than the recommended dose; getting pills from a friend) to manage feelings of depressed mood, stress, or anxiety

GAD: common warning signs seen in primary care settings

- Stomachaches, chest pains, digestive problems, insomnia, rashes, or other physical problems
- Palpitations, sweating, trembling, shaking, nausea, lightheadedness, chills/hot flashes, chest pains, shortness of breath
- Sleep disturbances
- Fears that minor symptoms are signs of serious illness
- Fidgety, restless behavior
- Missed appointments or frequent appointments; frequent trips to the emergency room
- Unusual amount of anxiety, fear, distress
- Mentions of social isolation; avoidance of social activities, especially not leaving house or being unable to go into the subway, etc
- Reports of needing to use drugs (prescription or otherwise) or alcohol to reduce anxious feelings
- Reports of feeling depressed, anxious, nervous

Suicide Risk Factors and Warning Signs

Some providers have the misconception that asking a patient about suicide will plant the idea in the patient's head. This is not the case. Asking about suicide does not increase suicidal tendencies, and patients who are at-risk for suicide often welcome an opportunity to talk to someone about what they're going through.

The key is to be direct. You can say something like, "Sometimes people may feel like they don't want to live anymore or think about killing themselves. Have you had any thoughts like these?" If the patient answers "yes," ask if she has a plan and the means to carry out that plan. If the patient answers "no," ask what has prevented her from harming herself so far. This will help you determine how immediate the patient's risk might be.

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Here are some risk factors and warning signs for suicide.

Suicide Risk Factors

- Chronic illness or chronic pain
- Social stressors, like unemployment or financial loss that lead to a sense of worthlessness
- Risky use of substances
- Lack of social support
- The death of a loved one
- A previous suicide attempt
- Family history of suicide or psychiatric illness

Suicide Warning Signs

- An agitated, irritable, or depressed affect
- Dramatic changes in mood during your conversation
- Purposelessness or hopelessness
- Rage or uncontrolled anger
- Sleep disturbances, such as insomnia or hypersomnia
- Withdrawal from friends, family, and society
- Loss of interest in normal activities
- Feeling that the world would be better off without them

If you recognize risk factors and warning signs, you can ask the patient if they're having thoughts of suicide. You can also follow up with a screening tool—like the PHQ-9 or C-SSRS—to help determine the level of risk specifically related to symptoms of depression.

If the patient is actively suicidal and you believe they are an imminent threat to themselves, immediate action is required. Options include arranging for them to be admitted to the hospital voluntarily, or you may need to take steps to have them admitted involuntarily, which could require calling 911. If the patient's risk level is lower, work with them to develop a plan for what to do to stay safe when suicidal thoughts surface in the future.

- **Triggers:** Help patients identify triggers for suicidal crises. For example, a patient might know that they think about suicide more when they are drinking. Being aware of this can help them reduce the likelihood or plan for these feelings in advance.
- **Coping Strategies:** Ask patients what coping strategies have worked well for them in the past, such as relaxation techniques or physical activities.
- **Sources of Support:** Help the patient identify friends and family members who can help them during a crisis. And refer them to health professionals or agencies they can contact in the event of a crisis, such as the National Suicide Prevention Lifeline (1-800-273-TALK).
- **Access to Lethal Means:** If the patient has access to lethal means they may use in a suicidal crisis, talk to them about how to keep themselves safe. For example, they may choose to lock up painkillers or other drugs or get rid of them entirely. If a patient has considered using a gun to kill himself and has one in his house, he may want to let a friend or family member keep the gun or put it in a lock box in a difficult to reach place, so it won't be easily accessible if and when they have a crisis. Anything that increases the time it takes for a patient to access lethal means decreases the chances of acting on an impulse.

Effective Conversation Techniques

As you're interviewing patients, there are a few techniques you can use to gather more information and encourage them to open up to you within the short amount of time you have.

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Sit at eye level with patients to put them at ease.

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Ask open-ended questions (ones that can't be answered with a simple "yes" or "no") to get more info and save time.

DOCTOR: You mentioned hurting your back a while back. What happened?
ANTOINE: I tweaked it carrying some heavy stuff. I saw this doctor and he just gave me some Percocet and that worked like a charm.

DOCTOR: That must have been a horrible nightmare to make you fall out of bed like that. How frequently do you have nightmares?
ANTOINE: Well, my wife says that I have 'em a lot because it wakes her up and she sees me flailing around and stuff, and... ya know, I'm sleeping like crap, I'm tired... so I guess it makes sense.

DOCTOR: You indicated that you've been feeling kind of down lately and that you've been having trouble sleeping, feeling tired, and there are some changes in your appetite. What's your mood been like?
JUDITH: Not great, I guess. I just wake up, feed my cat, Rosie, watch a little TV, take a nap... Just kind of go through the motions... I really don't feel good. And my arthritis and headaches just make me feel even worse.

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Empathize with patients to promote open and honest dialogue.

> DOCTOR: I've had a lot of patients who are veterans, and it usually takes them a while to readjust when they come back because things are just so different here.
> ANTOINE: You got it, Doc. Especially when I'm kicked out of my own bed! Nobody gets it. My wife, my daughter, my boss – they don't know what it's like.

> DOCTOR: Since you're still coping with these losses in your life and with your wrist pain and your headaches… and retiring recently, having less to keep you busy… it's understandable you're feeling down.
> JUDITH: Yeah. (nods) Yeah, it's been difficult.

Reflect patients' statements in your own words to show that you're listening and that you care.

> ANTOINE: Everyone is on my nerves: my boss is on my case about missing work, my family… I do feel bad about it, but they just piss me off. My wife says… she says I drink too much. I don't know… (pause) maybe she's right.
> DOCTOR: So your wife thinks you're drinking too much.
> ANTOINE: She would prefer that I drink less. That's how she puts it.

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DOCTOR: Tell me more about your pain. How are your arthritis and headaches affecting your ability to get around and do things?
JUDITH: It's not easy. I don't move around much.
DOCTOR: So the pain and headaches are keeping you a bit isolated.
JUDITH: Yeah, I have a cat to keep me company, but besides her I never see anybody anymore. My friends from work, they still invite me places… they don't understand how hard it is.

Summarize what you discussed to clarify concerns and next steps.

DOCTOR: We've talked a lot about your back pain, sleep issues, and drinking patterns, and I have some things I'd like to discuss further. Let's talk about your treatment options.
ANTOINE: Okay…

DOCTOR: So we talked about trying propranolol for your headaches. I'm going to prescribe a low dose to start, and I don't expect you to have any problems, but if you have any concerns at all call the office. Nurse Lee is going to help you set up some more physical therapy sessions. And we also talked about seeing a psychotherapist. You said you'd prefer doing phone sessions if that's a possibility, and you'd like us to check on the insurance for you so you know you'll be covered no matter who you talk to. How does all that sound?
JUDITH: Sounds good.

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Screening Tools

Screenings can be administered by a doctor or nurse before an appointment begins or after talking with a client. Some screening tools can even be filled out by clients while they're in the waiting room. The following evidence-based tools are recommended by SAMHSA , the Substance Abuse and Mental Health Services Administration.

CONDITION	SCREENING TOOL	QUESTIONS	PURPOSE	POSITIVE RESULT
PTSD	PC-PTSD	4	Designed for primary care, currently used by the VA to screen veterans	"Yes" to 3 or more questions
Depression/ Suicide	PHQ-2	2	Assesses risk of depression	Score of 3 or greater Follow up with remaining 7 questions of PHQ-9 to further evaluate risk
	PHQ-9	9	Assesses risk of depression and suicide	Depression: total score of 5 or greater Suicide: any response other than "not at all" to question 9
	C-SSRS	6	Assesses full range of suicidal ideation and behavior including intensity, frequency, and changes over time	"Yes" to any question

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CONDITION	SCREENING TOOL	QUESTIONS	PURPOSE	POSITIVE RESULT
Substance Use	AUDIT-C	3	For alcohol use, assesses risk level and what intervention may be appropriate, if any	Men: score of 4 or greater Women: score of 3 or greater Follow up with remaining questions of full AUDIT
	ASSIST	8	For substance use, assesses risk level and what intervention may be appropriate, if any	Alcohol: score of 11 or greater Other substances: score of 4 or greater
Anxiety	GAD-7	7	Patients rate frequency of anxious feelings and behavior over the last two weeks	Likely mild anxiety: score of 5-9 Likely moderate anxiety: score of 10 or greater; follow up with further evaluation

Referral Options

Considering the warning signs you've noticed and the results of the screening tool (if you use one), discuss treatment options with your patient and collaboratively make a decision about the best course of action.

You may want to refer the patient to a mental health professional or prescribe a medication, or recommend a combination of both. Offering a referral for detox and/or rehab may also be appropriate for patients with risky levels of substance use.

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The key is to make treatment decisions collaboratively. Rather than telling patients they "need therapy," guide them toward making the decision themselves.

- Ask patients about their motivation for change—what, if anything, they'd like to change about their current circumstances and how willing they are to make that change.
    - You can use a 0-10 ruler to help gauge motivation and elicit arguments in favor of change. You can ask them to rate on a scale from 0-10 how ready they are to try treatment. Affirm their choice and ask why they didn't pick a lower number or what it would take to get them to a higher number.
- Outline treatment options, including the mental health referral.
- Ask the patient what treatment option they would like to pursue.
- If they're hesitant, discuss their concerns and potential barriers to treatment.
- Help them brainstorm solutions to overcome those barriers.
- Create an action plan together.

Follow-Up

Often, patients don't show up for their sessions, they stop taking their medications, or they use the medication in ways that were not intended, like changing their dosage. That's why follow-up care is so important in managing patients with mental health disorders. Anyone in your office can make follow-up calls—ideally someone who interacted with the patient when they were in the office. Thorough documentation of patient visits makes this multi-staff approach easier and is important for liability purposes. It's a good idea to flag or track the files of patients for whom you suggest mental health treatment, whether in your office filing system or in electronic medical records.

- If you **prescribed medication for depression** or **GAD**, call in **2 – 4 weeks**, to make sure the prescription was filled and to remind the patient that these medications often take a few weeks to take effect. At this point, you can also schedule a **follow-up appointment** to

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check in and discuss possible changes to the medication, if necessary.

- If you made a **referral to a mental health professional**, call the patient in **1 – 2 weeks**, and/or schedule a **follow-up appointment**, depending on the severity of the patient's situation. Ask if the patient was able to keep the appointment and if they found it helpful. Also, be in touch with the mental health professional to whom you referred the patient to keep apprised of the patient's progress.
- If the patient's **risk for suicide is at least moderate**, set up a time together for a follow-up call in the next **1-2 days**, and also schedule a **follow-up appointment** a few days after the therapist appointment. And, when the patient returns to your office for future appointments, remember to check in about how they're doing and how treatment is going.