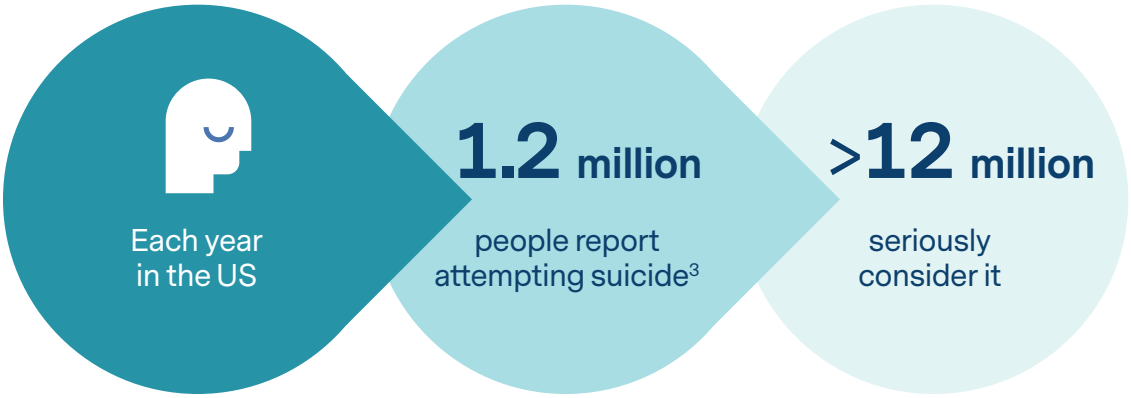
Addressing Suicide Risk with Virtual Care

Exploring Referral Pathways for Severe and High-Acuity Cases

Brightside Health

A mental health crisis with a shortage of providers

While nearly every other leading cause of death in the US has decreased in the past 50 years, suicides have doubled. The incidence of high severity and acuity mental health conditions is growing, yet effective treatment is increasingly difficult to find.



These numbers underscore a failing system. Structural barriers to care, along with disparities in access to mental health services have been accompanied by an increased rate of suicide. It's undeniable that we must alter the trajectory of this mental health crisis, but access to quality care is still scarce, particularly for those in crisis. Resources such as the 988 mental health hotline, mobile response teams, and intensive treatment programs are essential, but don't sufficiently meet the needs of a rising number of higher acuity cases. It is not a surprise that more than half of Americans[4] view the mental health care system unfavorably.

Providers and health systems feel the effects as well. Primary care physicians may screen for mental health conditions, but because of a scarcity of referral resources, they are often left in the position of having to deliver mental health treatment themselves. Nearly 60% of patients receive mental health treatment in the primary care setting, yet these providers typically lack the training and resources to treat higher acuity cases or higher severity illnesses.

A shortage of psychiatrists could climb above

30,000

over the next few years

150 million +

people live in federally-designated **mental health professional shortage**[6]

More than half

of US counties don't even have one psychiatrist.[7]

This problem is only projected to get worse, with a shortage of between 14,280 and 31,091 psychiatrists projected through 2024[5]. Additionally, more than 150 million people live in federally-designated mental health professional shortage areas, with over half of US counties lacking even one psychiatrist.

This shortage means wait times for mental health specialty care stretch for months–an unacceptable timeline for patients with severe or acute symptoms. **We need better solutions.**

Virtual Care's Role in Addressing the Suicide Crisis

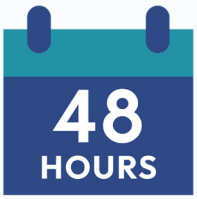
How do we ensure access to specialized care in an already strained mental healthcare system? Virtual care is well-positioned to be the answer, but simply bringing care online isn't enough to address the growing mental health crisis.

Forward-thinking payers, providers, and health systems should look to partner with high-quality, tech-enabled virtual solutions that leverage their technology to deliver additional resources to both providers and patients. Such solutions do more than connect patients and providers to an online platform. Sophisticated telemedicine platforms incorporate remote patient monitoring, tailored treatment selection, and practice management software that can alert providers to urgent patient needs in real-time. These features drive clinically significant outcomes that an older model of telemedicine will fail to deliver.

Innovative platforms optimize the treating mental health professional's efficiency, allowing for larger patient panels without compromising the quality of care. They can also more effectively and efficiently handle the challenges of remote patient monitoring by creating a closed-loop system so that patients can interact with the platform and their clinician between appointments. The clinician has access to up-to-date clinical information in order to adjust treatment as necessary and embedded clinical decision support to ensure patients get the right treatment at the right time. Remote monitoring also allows for responsive intervention, so clinicians can deliver care when it's needed and address issues before they become obstacles.

Traditional mental health treatment lasts at most one hour per week, while people experience their mental health condition throughout the 168 hours that comprise a week. In this way, specialized virtual care effectively covers the 167 hours per week an individual is not in session with their provider.

Brightside Health's care model was uniquely built to treat even the most severe cases of depression and anxiety.

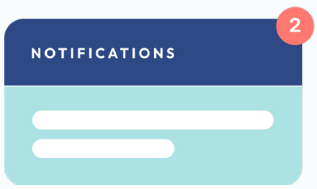


TIMELY ACCESS

Appointments in as little as 48 hours. Ninety-nine percent of patients are seen within 5 days.

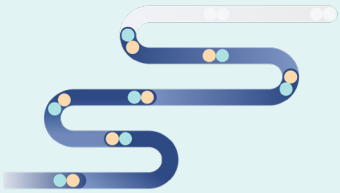
PRECISION TREATMENT

Using proprietary machine learning models, our decision support helps clinicians get treatment right the first time 70% of the time—2x the average.



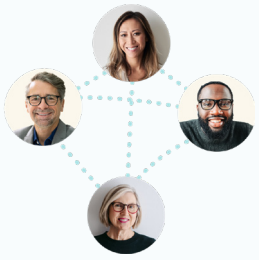
REAL-TIME CARE MANAGEMENT

Along with anytime messaging, Brightside's RapidResponse system can detect that a patient is off track, alert the clinician, and ensure prompt, proactive intervention.



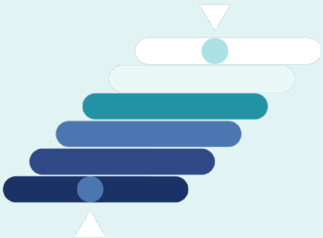
DEDICATED 1:1 CARE

Brightside patients work 1:1 with the same clinician throughout treatment, enabling connection, continuity of care, and improved outcomes.



PREMIUM CLINICIAN NETWORK

Every member of our Premium Clinician Network is a licensed professional, hand-picked to provide best-in-class mental health care.



ADVANCED QUALITY MANAGEMENT

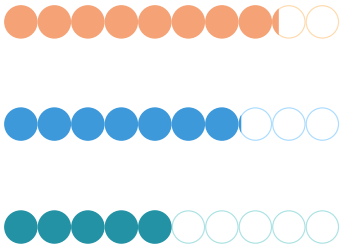
Our quality management system rivals the best of in-person treatment with rigorous clinical protocols, escalation pathways, and AI-driven supervision.

Treating Suicidal Ideation Through Telepsychiatry

In light of the growing mental health crisis and ongoing provider shortage, virtual care offers an important pathway for treating higher-severity cases, including patients with suicidal ideation. But questions remain–is it safe, is it effective, and can it scale?

The answer is yes–when delivered by a data-driven care model that uses state-of-the-art technology and a network of rigorously trained clinicians who have access to 24/7 supervision and support.

One of the biggest strengths of our model is the meticulous collection of data, allowing us to track outcomes for every individual and across populations. We've treated tens of thousands of patients to date, and our treatment approach works even for high severity cases. In fact:

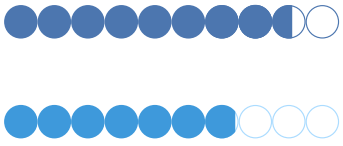


82% start treatment with moderate to severe symptoms

71% start with three or more conditions

47% start with suicidal ideation

Our data-driven model enables us to measure the impact of our care on those individuals, and we've found that:



71% of our patients achieve remission in 12 weeks

69% of patients who reported suicidal ideation eliminate it within 12 weeks.

With promising outcomes like these, we wanted to better understand the impact of a telepsychiatric care platform like ours on suicidal ideation and recently published our findings in the journal JMIR Formative Research.

LET'S TAKE A DEEPER LOOK.

Telehealth-Supported Decision-Making Psychiatric Care for Suicidal Ideation: Longitudinal Observational Study

BACKGROUND

Suicide is a leading cause of death in the United States, and suicidal ideation (SI) is a significant precursor and risk factor for suicide.

Suicide claimed the lives of

46,000

people in 2020 alone[8]

The prevalence of suicidal ideation (SI) is high:

12 million

adults endorse suicidal thoughts

In a large retrospective study, those with nearly daily SI were:

5 to 8x

more likely to attempt suicide

3 to 11x

more likely to die by suicide within 30 days[9]

These trends emphasize a critical need to better understand the predictive risks of suicide and effective mediation.

OBJECTIVE

Given the limited and inconsistent understanding of the effects of antidepressant treatment on SI, this study sought to add to the literature by investigating the impact of psychiatric care, when delivered via a telehealth platform, on change in SI over time, and remission of SI.

METHODS

Participants seeking treatment for **depression**, **anxiety**, or **both** included:

TREATMENT GROUP

Patients who had completed at least 12 weeks of treatment and had received a prescription for at least one psychiatric medication during the study period.

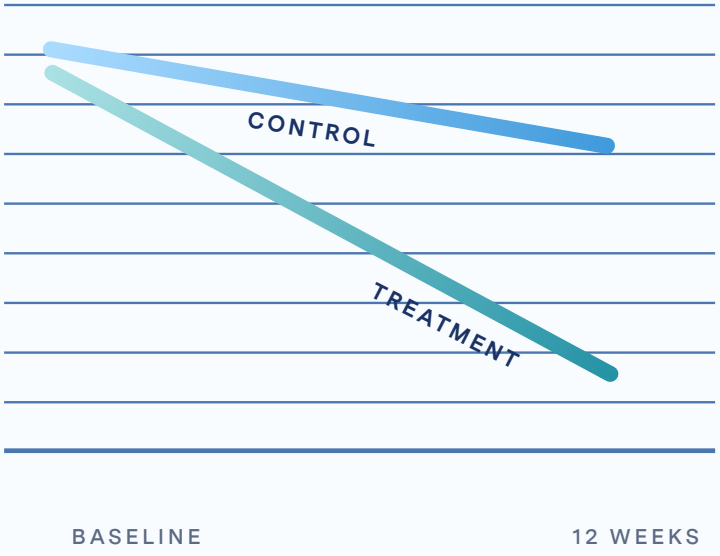
CONTROL GROUP

Individuals who completed the initial enrollment data and completed surveys at baseline and 12 weeks but did not receive care.

Providers prescribed psychiatric medications for each patient after clinical evaluation and then received regular data on participants during ongoing care. They also received clinical decision support at treatment onset via the digital platform that employs an empirically derived proprietary precision-prescribing algorithm to give providers real-time care guidelines.

RESULTS

AVERAGE SUICIDAL IDEATION SCORES OVER TIME BY GROUP



Treatment effects:

AFTER 12 WEEKS

47%
Baseline presence of SI for both groups

Only **12.3%** of the participants in the treatment group expressed any SI

VS.

34%
of the participants in the control group

Emergence of new SI:

In terms of the emergence of new SI in those not initially endorsing it:

2.98%
of the treatment group

15.6%
of the control group

Those in the treatment group were

5x

less likely to show emergent SI

Remission:

Among those who endorsed SI at baseline but then endorsed none at 12 weeks, complete remission of SI symptoms was observed in:

77.2%
of the treatment group

44%
of the control group

Those in the treatment group were

4.3x

more likely to remit than those in the control group

CONCLUSIONS

These results suggest that antidepressant intervention administered via a telehealth platform with decision support is effective in treating suicidal ideation.

O'Callaghan et al. (2022). Telehealth supported decision-making psychiatric care for suicidal ideation: Longitudinal observational study. JMIR: Formative Research, 6(9)

THE NEXT STEP

Crisis Care for Elevated Suicide Risk

Brightside Health's results have demonstrated significant treatment response in patients presenting with severe symptoms and passive suicidal ideation. We're determined to take it a step further, applying the same clinical rigor to a virtual solution built for a higher-need population: those experiencing acute suicidal thoughts and behaviors.

While telemedicine is an important addition to outpatient mental health, it has not commonly been used in treating higher-risk populations, such as patients with elevated suicide risk. With specific clinical protocols and rigorous oversight, a well-structured virtual solution can feasibly provide safe, effective treatment. In some instances, it may serve as an alternative to the emergency department or intensive outpatient programs, filling a gap in care that exists for higher acuity patients.

After demonstrating the feasibility of reducing suicidal ideation through the Brightside platform with published results, we developed **Crisis Care**–a highly structured program built to serve patients with elevated suicide risk.

Crisis Care uses a digital deployment of the Collaborative Assessment and Management of Suicidality (CAMS) framework, a care model backed by 30 years of research and five randomized controlled trials. The life-saving new program is the natural evolution of our treatment model and provides timely access to specialized care for individuals experiencing acute suicidal thoughts and behaviors.

With **Crisis Care**, we've brought the best of Brightside and CAMS together in one platform. The clinically-proven framework is fully integrated into our care model and technology, resulting in the most powerful, effective treatment for our patients. The new program offers providers and health systems a referral pathway that is:

SUICIDE-SPECIFIC

For those actively suicidal and/or have had a recent suicide attempt, as well as those in need of follow-up care after hospitalization.

TIMELY

Patients can be seen by a CAMS clinician in 48 hours or less and have access to 24/7 call support.

HIGH-TOUCH & TECH-ENABLED

Treatment is powered by technology with weekly video sessions, messaging, documentation, and proactive risk monitoring.

HIGH-QUALITY & SAFE

Delivered by highly vetted, supported, and supervised CAMS clinicians.

EASY TO NAVIGATE

Provides care navigation to both higher and lower levels of care.

AFFORDABLE

An in-network service for 60 million people and counting.

CONCLUSION

Payers, providers, and health systems are working toward a solution to our mental healthcare crisis, and virtual care offers a viable pathway for extended patient support. This is particularly important for patients at the higher end of the severity and acuity spectrum who cannot afford to wait.

Partnering with Brightside Health means granting patients timely access to precision psychiatry, clinically proven therapy, and crisis care in 48 hours or less. Our patient portal makes it easy to secure appointments, and with shared data and treatment updates, we keep referring partners informed at every step. Brightside Health saves lives. Together, we can save even more.

Connect with our team to learn more about this affordable solution for high-severity cases that's in-network for 60 million people (and counting).

GET IN TOUCH

Help your patients get life-changing care, with Brightside by their side.

REFER A PATIENT

ENDNOTES

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2 "Suicide Statistics." American Foundation for Suicide Prevention, American Foundation for Suicide Prevention, 14 Oct. 2022, https://afsp.org/suicide-statistics/.

3 "Suicide Data and Statistics." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 28 June 2022, https://www.cdc.gov/suicide/suicide-data-statistics.html.

4 "NAMI 988 CRISIS RESPONSE RESEARCH." Nami.org, National Alliance on Mental Illness/ IPSOS, https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/988-Crisis-Response-Report-November-FINAL.pdf.

5 Satiani A, Niedermier J, Satiani B, Svendsen DP. Projected Workforce of Psychiatrists in the United States: A Population Analysis. Psychiatr Serv. 2018 Jun 1;69(6):710-713. doi: 10.1176/appi.ps.201700344. Epub 2018 Mar 15. PMID: 29540118.

6 HPSA Find, Health Resources & Services Administration, https://data.hrsa.gov/tools/shortage-area.

7 Beck, Angela J., et al. "Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce." University of Michigan School of Public Health Behavioral Health Workforce Research Center, Dec. 2018.

8 "Suicide Data and Statistics." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 28 June 2022, https://www.cdc.gov/suicide/suicide-data-statistics.html.

9 Rossom RC, Coleman KJ, Ahmedani BK, Beck A, Johnson E, Oliver M, et al. Suicidal ideation reported on the PHQ9 and risk of suicidal behavior across age groups. J Affect Disord 2017 Jun;215:77-84: https://europepmc.org/abstract/MED/28319695

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