SMIAdviser
A Clinical Support System for Serious Mental Illness

MYTH vs FACT on Serious Mental Illness

TREATMENT

There are many myths around serious mental illness (SMI) that are not always accurate. Let's take a look at common myths around treatment for SMI.

MYTH	FACTS
Safety Plans Are Not Effective For Individuals Who Have SMI	A safety plan is different from a safety contract. Only safety plans are effective in mitigating risk of suicide. Safety contracts, or Contracts for Safety (CFS), are when an individual agrees verbally or in writing not to engage in any self-harm.[1] It is like signing a contract not to attempt suicide. Safety contracts have been used for years but the research shows that they do not mitigate risk for suicide.[2,3] Safety plans are exactly that – plans. They focus on what individuals plan to do to keep themselves safe.[4,5] In advance of a mental health crisis, individuals write down coping strategies and supports that are helpful to them when they feel a sense of self-harm arise. Research shows that safety plans work.[3-5] Safety plans typically include: ✔ Early warning signs ✔ Coping strategies ✔ Safe places for the person to go to ✔ Individuals or groups who can provide distractions or support ✔ Professionals who can be contacted ✔ How to make the environment safe ✔ One or more things worth living for

my Mental Health Crisis Plan

A Psychiatric Advance Directive (PAD) can assist in safety planning. A PAD allows an individual to state their preferences for care if a mental health crisis arises. A free app called My Mental Health Crisis Plan is a helpful tool to create and share a PAD. Download the app at SMIadviser.org/mymhcp.

MYTH	FACTS
Only Psychiatrists Can Effectively Treat and Manage Individuals Who Have SMI	Given the waxing and waning course of diagnoses within the category of SMI and the difference in experience of these diagnosis, a care plan for an individual varies over time and also varies between individuals with the same diagnosis. Care may include psychotherapy, psychopharmacology, and utilization of other support services.[6] Some undoubtedly need specialized care from psychiatrists. Yet emerging evidence suggests that some individuals who are seen in mental health settings and have stable medication regimens can be managed by primary care using a stepped approach. In a study of individuals who received psychiatric care and were stable before being transferred to primary care, only 2.1% were transferred back to specialized mental health settings.[7] Transition to primary care was an indication to the individual that their illness had improved and was consistent with recovery-oriented practices.[8] Other studies are now under way that look at transitions in mental health care to primary care settings.[9]

MYTH	FACTS
The State of Clinical High Risk is Not Valid As A Clinical Construct	The early identification of individuals who have an increased risk for psychosis may allow clinicians to intervene more promptly. This can potentially alter the trajectory of the illness. The term clinical high risk for psychosis (CHR-P) is sometimes referred to as the prodrome, at risk mental state, or ultra-high-risk state. It describes the period of time when an individual has subthreshold signs or symptoms of psychosis prior to the onset of frank psychotic symptoms.[10] Some of the more common instruments used in CHR-P research are semi-structured interviews like the Structured Interview for Prodromal Symptoms[11] and the Comprehensive Assessment of the At-Risk Mental State.[12] In an umbrella review summarizing 42 meta-analyses, among individuals who met CHR-P criteria, the risk of conversion to psychosis was 22% at three years among individuals who met CHR-P criteria.[13]

MYTH	FACTS
Individuals Who Have SMI Do Not Benefit From Therapy	Evidence-based practices (EBPs) include therapies that are studied scientifically in individuals who have SMI and are proven to be effective.[14] In fact, a large body of research shows that many EBPs are very effective in reducing debilitating symptoms. Two of the primary EBP approaches are Cognitive Behavior Therapy (CBT) and Cognitive Behavior Therapy for psychosis (CBTp). In order for these treatments to be effective, individuals need to actively engage in their care and clinicians need to provide that care according to the principles and standards of the EBP.[15] ✔ EBPs lead to higher quality care, reduced costs, greater clinician satisfaction, and improved outcomes compared to traditional approaches to care[16] ✔ EBPs are based on the best scientific evidence available about treatments that work ✔ EBPs lead to improved outcomes because specialized training is required in order to provide this kind of care

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