SMIAdviser
A Clinical Support System for Serious Mental Illness

# MYTH vs FACT on Serious Mental Illness

## CHARACTER

**There are many myths around serious mental illness (SMI) that are not accurate. Let's take a look at common myths around the character of individuals who have SMI.**

| MYTH | FACT |
|---|---|
| **Individuals Who Have SMI Lack Insight About Their Conditions** | Studies show that about half of people who have psychotic disorders lack insight about their illnesses to some degree. This is known as anosognosia. However, we know that this lack of insight is now viewed as more of a multidimensional, dynamic process. It is not simply a neurocognitive deficit.[1]<br><br>The views that individuals have about their illnesses are shaped by social and cultural factors. These can change over time. Mental health professionals should see this issue as more than simply a need to educate patients about their conditions. You can best address insight through a dialogue that probes a range of factors that may affect how a person understands their condition.[2] |

| MYTH | FACT |
|---|---|
| **Individuals Who Have SMI Cannot and Should Not Make Decisions for Themselves** | Individuals who have SMI are far more informed than they were a few decades ago. Yet they still are often left out of decision making about their physical and mental health.[3] This can cause people who have SMI to feel frustrated and undervalued by the mental health care team. They may not feel like they have adequate - if any - input into their treatment plan and targeted outcomes. We can do better and should do better.<br><br>Decision-making capacity is impaired in only a subset of individuals who have SMI.[4] This may change over time and depends on a person's emotional state. Clinicians have an ethical obligation to let people have a role in choices around their physical and mental health care.[5] Shared decision making strengthens the therapeutic relationship and builds trust and understanding.<br><br>All meetings between the care team and individual who have SMI should account for the two experts in the room. One is the clinical team. They are experts who have knowledge about treatment choices and the evidence that informs those options. The other is the individual. They know best their own goals, supports, and history. Together they should develop a treatment plan that represents the results of their shared decision making. This plan should be shared with the whole treatment team and revisited on a routine basis. |

| MYTH | FACT |
|---|---|
| **Individuals Who Have SMI are Prone to Violence** | This is a harmful myth that contributes to stigma around SMI. It leads to a false public perception that equates criminality with SMI and other mental health conditions.[6] However, data do not support this perception. Overall, people who have SMI are much more likely to be victims of violent crime than perpetrators. There is some risk for violence linked with schizophrenia,[7] yet most of the excess risk for violence is linked to:<br><br>✔ co-occurring substance use disorders[7,8,9]<br>✔ violence that occurs before the start of treatment[10]<br>✔ treatment non-adherence[9] |

**2%**
Annual rate of violent behavior for the general population[11]

**2%**
Annual rate of violent behavior for individuals who have SMI and no history of violent victimization, exposure to violence, or co-occurring disorders[11]

**25%**
Annual rate that people who have SMI are victims of violent crime each year[12]

**11.8x higher**
Likelihood for someone who has SMI to be the victim of a violent crime, compared to the general public[12]

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# MYTH vs FACT on Serious Mental Illness

## CLOZAPINE

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

### MYTH
**You Should Not Prescribe Clozapine Until All Other Medications Have Failed**

### FACT
Do not think of clozapine as a last-resort option. The *APA Practice Guideline for the Treatment of Patients with Schizophrenia* recommends clozapine if:

- a patient shows no or minimal response to two antipsychotic medications at an adequate dose.[1]
- the risk of suicide attempts or suicide remains substantial despite other treatments.[1]
- the risk for aggressive behavior remains high despite other treatments.[1]

In fact, some studies suggest that if you delay the use of clozapine for patients who may benefit from it, it may lead to poorer treatment outcomes.[2,3]

### MYTH
**You Can Only Be Proficient with Clozapine if You Had Specific Training During Residency**

### FACT
Certainly if you have training in residency or other programs, that can help. Yet one study finds that many current prescribers of clozapine do not have specific training during residency.[4] Today, many resources are available to help you get the skills you need to build your confidence if you want to prescribe clozapine. For example, through the resources in SMI Adviser's Clozapine Center of Excellence, you can:

- access live webinars and on-demand courses
- join a discussion-based learning community
- download and share various resources
- submit questions and receive free clinician-to-clinician consultations
- participate in 12-week, interactive virtual learning collaboratives

These free resources help you identify the right clozapine candidates, effectively use Clozapine REMS, find information about dosing, mitigate side effects, and more. For specific questions, use SMI Adviser's FREE clinician-to-clinician consultation service. Submit a question and receive a personalized reply from one of our national experts within one business day.

### MYTH
**People Who Take Clozapine Can Benefit from a Standard Dose and Personalized Dosing is Not Needed**

### FACT
The dose that is needed to maximize the tolerability and efficacy of clozapine can vary quite considerably. Clozapine efficacy is more closely correlated with clozapine plasma levels rather than dose. Studies suggest that most people respond with a level between 350 to 600 ng/mL.[5,6] On average, a female who does not smoke needs about half the clozapine dose (265 mg) to get to a level of 350 ng/mL than a male who smokes (525 mg).[7] For more information on how to interpret clozapine levels, see the details in this post from SMI Adviser.

SMI Adviser offers a Clozapine Dose Planner to help you estimate a person's level based on their age, gender, weight, and smoking status.

### MYTH
**You Cannot Ever Prescribe Clozapine to Individuals of African Descent with a Low Absolute Neutrophil Count**

### FACT
People in certain ethnic groups may have absolute neutrophil counts that are lower than "standard" reference laboratory ranges. This includes individuals of African descent. There is a separate algorithm in Clozapine REMS for people who have benign ethnic neutropenia (BEN). BEN is also sometimes called benign familial neutropenia. Before they start treatment with clozapine, individuals who have BEN must have a baseline absolute neutrophil count of at least 1000/μL. People who have BEN are not more likely to develop infections or clozapine-induced neutropenia.[8]

For more on BEN, see this post from SMI Adviser and a recording from the Clozapine & LAI Virtual Forum.

### MYTH
**There is Only One Best Titration Standard for a Person When They Start Clozapine**

### FACT
A clozapine titration plan should be individualized based on a number of factors. This includes age, gender, smoking status, other medications, race/ethnicity, and clinical urgency. Published sample inpatient titrations are generally faster than outpatient ones.[9] Slower titrations may be less likely to result in clozapine-induced myocarditis and may help to prevent early discontinuation or settling on a dose that is too high for the patient.[10,11] Prescribers need to be flexible when they conduct new clozapine titrations. You may need to adjust the plan as the titration continues. For more about how to titrate clozapine, see this post from SMI Adviser.

**Have more questions on clozapine?**
**Ask us at SMIadviser.org/submit-consult.**

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## PSYCHOPHARMACOLOGY

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

| MYTH | FACT |
|---|---|
| **You Should Not Prescribe Clozapine Until All Other Medications Have Failed** | Do not think of clozapine as a last-resort option. The APA Practice Guideline for Treatment of Patients with Schizophrenia recommends clozapine for these situations:<br>✓ a patient shows no or minimal response to two antipsychotic medications at an adequate dose.[1]<br>✓ the risk of suicide attempts or suicide remains substantial despite other treatments.[1]<br>✓ the risk for aggressive behavior remains high despite other treatments.[1] |

| MYTH | FACT |
|---|---|
| **Weight Gain from Antipsychotics is a Side Effect that Cannot Be Treated** | There are options to help manage this side effect!<br>Some medications have higher risk for weight gain than others. Simply switch from a higher-risk medication to one with a lower risk.[2] Among second-generation agents, aripiprazole, brexpiprazole, lurasidone, and ziprasidone are lower risk.[1, 3]<br>There are other approaches that can be helpful:[4]<br>✓ Nutritional counseling<br>✓ Exercise<br>✓ Cognitive-behavioral therapy<br>Finally, you can augment with medications that can be helpful for weight gain. The best studied option is metformin.[5] |

| MYTH | FACT |
|---|---|
| **Long-Acting Injectables Are Only For People Who Are Nonadherent** | Even if adherence is not a problem, some patients prefer long-acting injectable (LAI) antipsychotic medications.[6, 7, 8]<br>In fact, some find LAIs to be more convenient because they don't need to remember to take a pill every day.[9] Studies across different settings show that LAIs can prevent relapse. This includes people who experience first episode psychosis.[10]<br>Clinicians can discuss LAIs in the context of a shared decision-making approach. You can:<br>✓ inform your patients about long-acting formulations.<br>✓ discuss the available advantages and disadvantages.<br>✓ let patients make the best decision for themselves. |

| MYTH | FACT |
|---|---|
| **You Should Not Prescribe Antidepressants to Individuals Who Have Bipolar Disorder** | A subset of people actually appear to benefit from antidepressants.<br>This happens when they are combined with mood stabilizers or atypical antipsychotics for bipolar depression. However, in general this is not considered a first line strategy.[11, 12, 13]<br>When you add antidepressants to adjuvant mood stabilizers or atypical antipsychotics, the risk of treatment-emergent affective switch is similar to placebo in the short-term.[13]<br>You should avoid antidepressants:[12, 14]<br>✓ in people who have a history of antidepressant-induced mania or hypomania.<br>✓ for those with recent rapid cycling.<br>✓ for those with current mixed features.<br>✓ as monotherapy for people with Bipolar I disorder. |

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# MYTH vs FACT on Serious Mental Illness

## RECOVERY

**There are many myths around serious mental illness (SMI) that are not accurate. Let's take a look at common myths around recovery and individuals who have SMI.**

### MYTH

**Individuals Who Have SMI Cannot Reach and Maintain Recovery**

### FACT

Historically, recovery from SMI was not considered likely or even possible. However, a range of evidence over the last two decades indicates that around 65% of people with SMI experience partial to full recovery over time.[1]

Recovery does not necessarily mean the absence of symptoms. Recovery from SMI is defined in both objective and subjective ways.[2,3,4,5] This incorporates concepts that go beyond just having stable symptoms. It includes well-being, quality of life, functioning, and a sense of hope and optimism.[6,7,8,9]

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The four major dimensions that support recovery are health, home, purpose, and community.[10,11]

- Health – overcome or manage one's disease(s) or symptoms, and make informed, healthy choices that support physical and emotional well-being
- Home – have a stable and safe place to live
- Purpose – conduct meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- Community – have relationships and social networks that provide support, friendship, love, and hope

Individuals should identify their recovery goals and receive support for them in their treatment plans.

### MYTH

**People Who Have SMI Cannot Obtain Competitive Employment or Complete Education**

### FACT

Employment and education provide a sense of purpose that is a critical aspect of life in recovery.[10] In fact, most people who have SMI do want to work and see work as an essential part of their recovery.[6,7] Between 40% and 60% of people who enroll in supported employment obtain competitive employment.[12]

There is ample evidence that employment is not "too stressful" for individuals who have SMI.[13] The benefits of employment and education for people with SMI are well documented.[8] They include improved economic status, increased self-esteem, and symptom reduction. In fact, the detrimental effect of unemployment creates clinical risks for people who have SMI.[9] These are often overlooked.

Supported employment programs can improve outcomes for individuals who have SMI.[14] This includes a higher likelihood that they obtain competitive employment, work more hours per week, maintain employment for a longer period, and have a higher income. In turn, supported education programs can reduce burdens for people who have SMI and want to finish or go back to school.[15] It offers specialized, one-on-one support to help navigate academic settings and link to mental health services.

Individuals should receive encouragement if their recovery goals include employment or education. There are supportive and effective programs to reach these goals and they have considerable benefits.

### MYTH

**People Who Have SMI Burned All Their Bridges**

### FACT

Social connections are important for people who have SMI. At times, they may have symptoms at critical developmental periods that can disrupt how they establish and maintain social networks. Healthy social connections can stabilize mood, help them to feel grounded, connect them to others, and provide support through their recovery process.[16]

Isolation can be gut-wrenching, overlooked, and/or not prioritized in a recovery plan for people who have SMI.[17,18] The specific benefits of socialization for each diagnosis are unclear. Yet just like any other person, they do better when they create friendships, repair severed connections, and build communities that support them.

In fact, meaningful community participation is an important part of recovery from SMI.[10] Research shows a statistically significant positive relationship between community participation and recovery and quality of life.[19] Full community participation is linked with positive health outcomes for individuals who have SMI.[20] When they get involved with mainstream community activities in a range of life domains, it supports their valued social roles.[21] These roles align with "personhood" in contrast to "patienthood."

Social connectedness – and its development and maintenance – should be considered part of a recovery plan.

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# MYTH vs FACT on Serious Mental Illness

## TECHNOLOGY

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

### MYTH
**Telehealth Is Not Effective For People Who Have SMI**

### FACT


Several reviews show that telehealth offers the same benefits as in-person care for all mental health conditions. This includes SMI.[1, 2, 3]

The only known contraindication to telehealth is if a patient does not want to participate.

### MYTH
**People Who Have Schizophrenia Are Paranoid About Telehealth**

### FACT


Studies on telehealth do not suggest that it causes paranoia or adverse symptoms for individuals who have schizophrenia.[4, 5]

In fact, when it comes to technology, paranoia is not the biggest barrier. They are more concerned about privacy issues.[6]

Other studies show that technology-based interventions may even help reduce symptoms of paranoia.[7]

### MYTH
**People Who Have SMI Do Not Own Smartphones**

### FACT


A 2019 survey of the U.S. population shows that 81% already own a smartphone. This is forecast to rise as prices for devices and data continue to fall.[8]

There are several smaller studies on individuals who have SMI. These studies suggest that as many as 70% own smartphones.[9, 10, 11, 12]

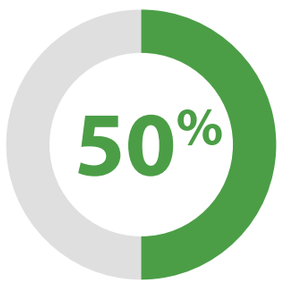
### MYTH
**People Who Have SMI Cannot Use Smartphones Or Health Apps**

### FACT

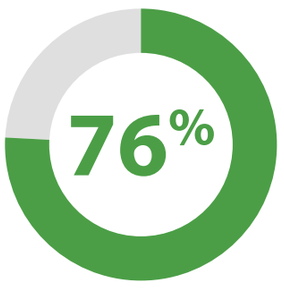

Smartphones are common now since so many things in our world are driven by technology. Like the broader population, some individuals who have SMI are wizards on their phones. Others find it to be more challenging.

Recent studies show that:

- Individuals who have SMI offer peer support to others via smartphones and other technology platforms.[13]




50% of people who have SMI have downloaded apps onto their smartphones.[14]




76% of people who have SMI say they are somewhat or very satisfied with their phone or tablet.[15]

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# 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.<br><br>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]<br><br>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]<br>Safety plans typically include:<br>✔ Early warning signs<br>✔ Coping strategies<br>✔ Safe places for the person to go to<br>✔ Individuals or groups who can provide distractions or support<br>✔ Professionals who can be contacted<br>✔ How to make the environment safe<br>✔ 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]<br><br>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]<br>✔ EBPs lead to higher quality care, reduced costs, greater clinician satisfaction, and improved outcomes compared to traditional approaches to care[16]<br>✔ EBPs are based on the best scientific evidence available about treatments that work<br>✔ EBPs lead to improved outcomes because specialized training is required in order to provide this kind of care |

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## 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 |
|---|---|
| **Treatment Plans Must Address SMI First And Then Address Any Substance Use/Co-Occurring Disorders** | About one quarter of individuals who have SMI also have substance use disorders.[1] They are at high risk for disengagement from mental health services,[2] in part due to the history that treatment for mental health and substance use are fragmented into two separate systems.[3] Integrated approaches are treatments that address co-occurring mental health and substance use disorders and account for their bidirectional and complex interplay.[4] Through integrated assessment, individuals and clinicians can better understand the role that mental illness plays on substance use, and vice versa.[5] Integrated approaches have been successfully used in a variety of services, such as case management and assertive community treatment.[6]<br><br>Overall, data on integrated treatment are not definitive. However, they do suggest that integrated treatment increases the probability that persons with schizophrenia and co-occurring disorders have better treatment participation.[7] They may also have some reductions in substance use, more days in stable housing, and greater reductions in psychiatric hospitalization and arrests.[7] |

| MYTH | FACTS |
|---|---|
| **It Is Too Difficult And Not Possible To Help Individuals Who Have SMI To Quit Smoking** | There is strong evidence that treatment for nicotine use disorder is both efficacious and tolerable for individuals who have SMI. In fact, it is comparable to that for persons without SMI. The most effective treatments include varenicline and bupropion (versus nicotine replacement and placebo) for sustained remission of six months or more.[8] |

| MYTH | FACTS |
|---|---|
| **Electroconvulsive Therapy (ECT) is Not An Effective Treatment Option For SMI** | ECT is actually considered the most effective intervention for severe depression.[9] Numerous clinical studies show that it is both safe and effective compared to placebo and antidepressants.[10]<br><br>Even during the height of the COVID-19 pandemic, ECT was deemed a vital treatment[11] given its numerous benefits. |

| MYTH | FACTS |
|---|---|
| **There Is Little Evidence That Measurement-Based Care Impacts Recovery From SMI** | A great deal of research shows that Measurement-Based Care (MBC) has a favorable impact on recovery from SMI.[12,13] The cornerstone of MBC is a treatment team approach that fosters routine, objective assessment. Interpretation and communication follows that, if when adjustments are needed to the intervention plan to improve outcomes. Assessments should include symptoms and functioning and interventions to be adjusted may include therapy or medications. One of the basic principles of MBC is: Things that get measured get better, and get better faster.<br><br>✔ MBC increases the likelihood for improvement and even recovery<br>✔ MBC provides expert guidance for a care team's treatment choices<br>✔ MBC can detect early if a treatment is not helping so adjustments can be made<br>✔ MBC bolsters an individual's participation in treatment |

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