

# Essential Strategies for Optimizing the Use of Long-Acting Treatments in Schizophrenia



**long-acting injectables**360

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# Learning Objectives

- Evaluate the optimal role of LAIs versus oral antipsychotics in the treatment of schizophrenia according to the latest clinical and real-world data and current recommendations
- Assess the differing pharmacologic characteristics and practical requirements associated with available LAIs for schizophrenia to ensure optimal treatment selection for each patient
- Implement conversational strategies to improve discussion and initiation of LAI treatment with patients with schizophrenia, both in person and via telemedicine

# General Principles and Recommendations for Using LAIs in Schizophrenia



# Advantages of LAIs vs Oral Antipsychotics

**Oral Issue One:**  
Variable plasma concentrations

**Oral Issue Two:**  
28 more opportunities for missed doses per month

**Oral Issue Three:**  
The primary effects of antipsychotics are on maintenance of brain tissue

**Clinical Consequence:**  
Increased opportunities for symptom relapse, with increased relapse diminishing response to treatment over time

**Clinical Consequence:**  
Adherence improves outcome in schizophrenia treatment (oral non-adherence is as high as 50% in some studies)

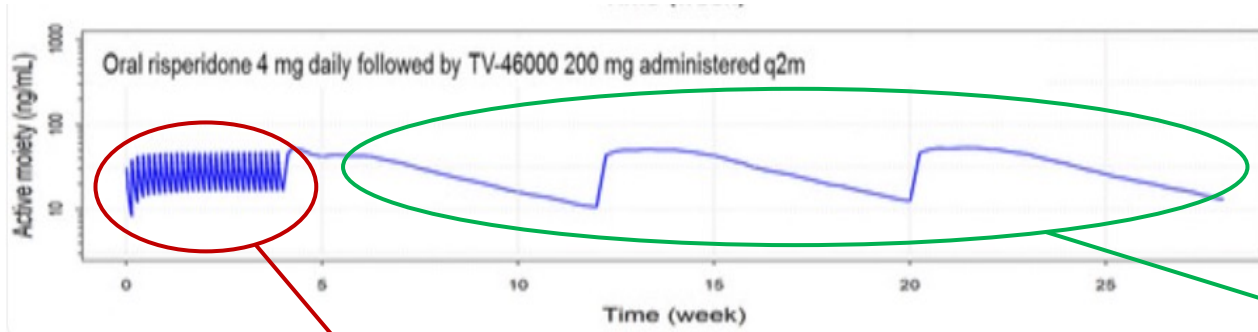
**Clinical Consequence:**  
Each psychotic episode and relapse results in progressive brain changes, potentially leading to irreversible loss of cognitive function

**How LAIs Help:**  
LAIs offer consistent plasma concentrations without the opportunity for missed doses

**How LAIs Help:**  
Adherence is a guarantee, rather than a goal

**How LAIs Help:**  
LAIs help prevent unnecessary relapses, protecting against cognitive decline and further brain damage

# Pharmacokinetic Differences, LAI vs PO



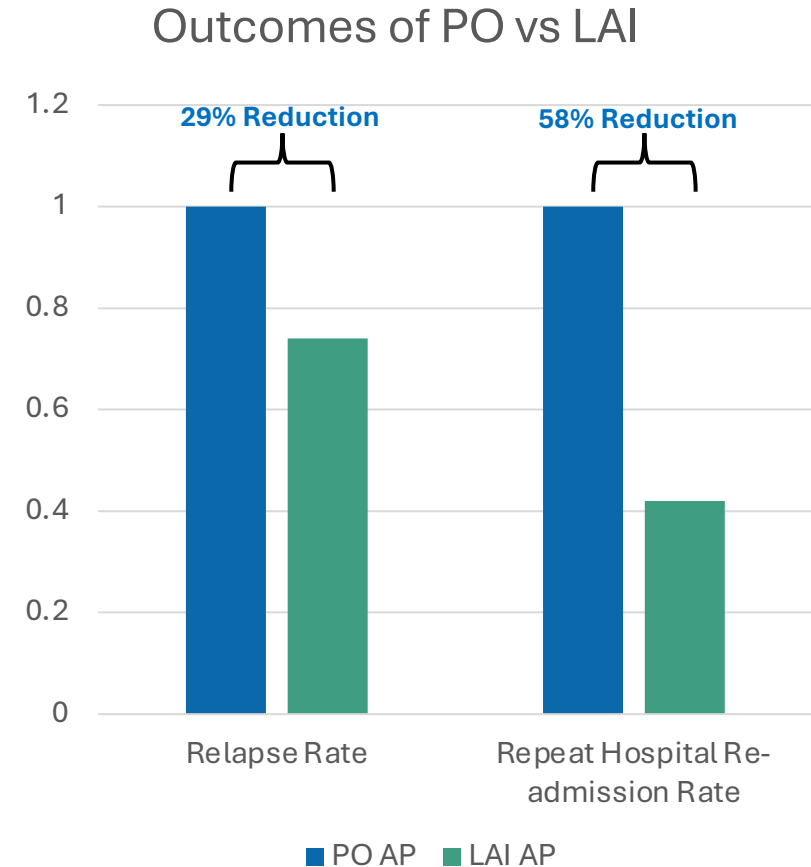
Plasma concentration  
variability of oral (with  
*perfect adherence*)

Plasma concentration  
variability of LAI

- Increased stability of plasma concentration
- Less opportunities for erratic plasma levels
- Greater stability = less relapse events

# Impact of LAIs on Relapse Reduction

- **Study:** Within-subject data analysis of 75,274 patients (10 years).
- **Data collection:** HIRA database from South Korea (132,028 episodes).
- **Study Findings:** Real-world data from 75,274 patients showed:
  - **29%** reduction in relapse with LAIs ( $p < 0.001$ ).
  - **58%** lower re-admission rates for repeat hospitalizations ( $p < 0.001$ ).

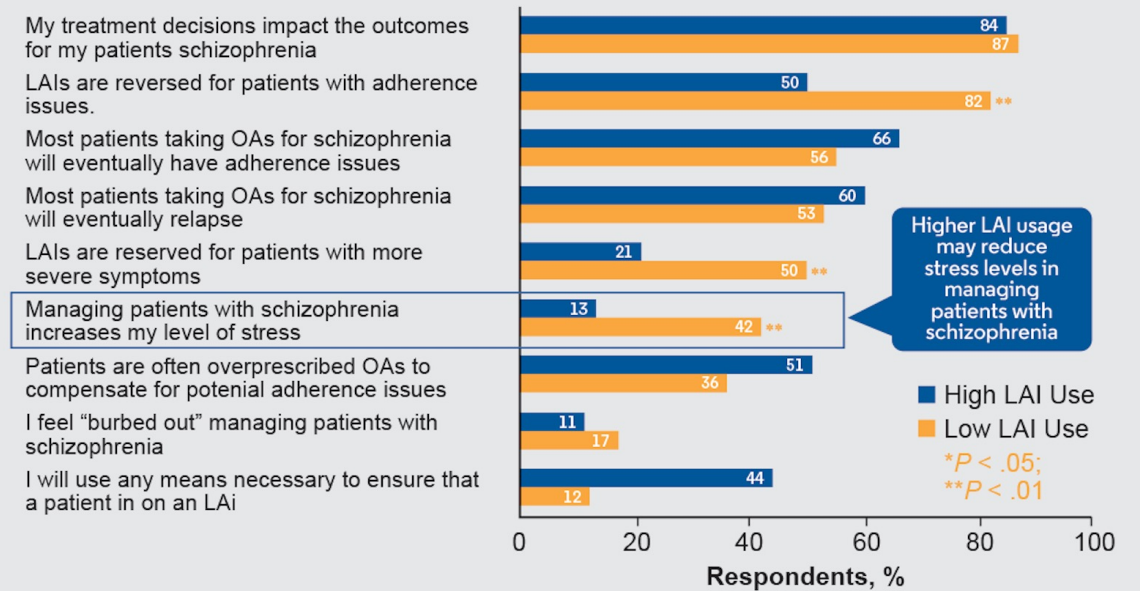


# Differences Between Clinicians Reporting High vs Low LAI Use

- The DECIDE study assessed differences among psychiatry clinicians (N=380) associated with how frequently they use LAIs for patients with schizophrenia.
- Clinicians reporting “high” LAI use (for  $\geq 31\%$  of patients) vs clinicians reporting “low” LAI use (for  $\leq 14\%$  of patients) differed across numerous measures of their experience with and attitudes towards LAIs.
  - High LAI utilizers estimated a significantly lower proportion of patients who refuse LAIs and a shorter time between LAI initiation and patient acceptance
  - In summary, high clinician utilizers of LAIs were much more confident in every area of their utilization and reported better outcomes.

**The only way to gain confidence in something is to practice it.**

Figure 3. Current Attitudes About Management of and Use of LAIs and OAs in Patients with Schizophrenia



# Patient Attitudes about LAIs Are Often Positive

**Survey in France: Patients (N=206) with schizophrenia with  $\geq 3$  months treatment with an LAI antipsychotic, injections were the favored dosage form**

67% said they felt better having received an injectable treatment than they felt before

51% considered injectable therapy to be more effective than other medication

49% reported that injectable treatment could impact positively on their plans and aspirations

# Barriers to Wider Adoption of LAIs

## HCP Concerns



- Misconceptions
  - Misbelief that LAIs are solely for non-adherent patients
  - Limits proactive discussions about LAIs for wider patient groups
- Lack of Training
  - HCPs may feel unprepared to recommend, educate on, and administer LAIs

## Patient Concerns



- Needle-related anxiety
  - Significant psychological barrier to acceptance
- Lack of awareness
  - Patients may be unaware of the long-term benefits and improved outcomes
  - They may even be unaware that LAIs exist at all

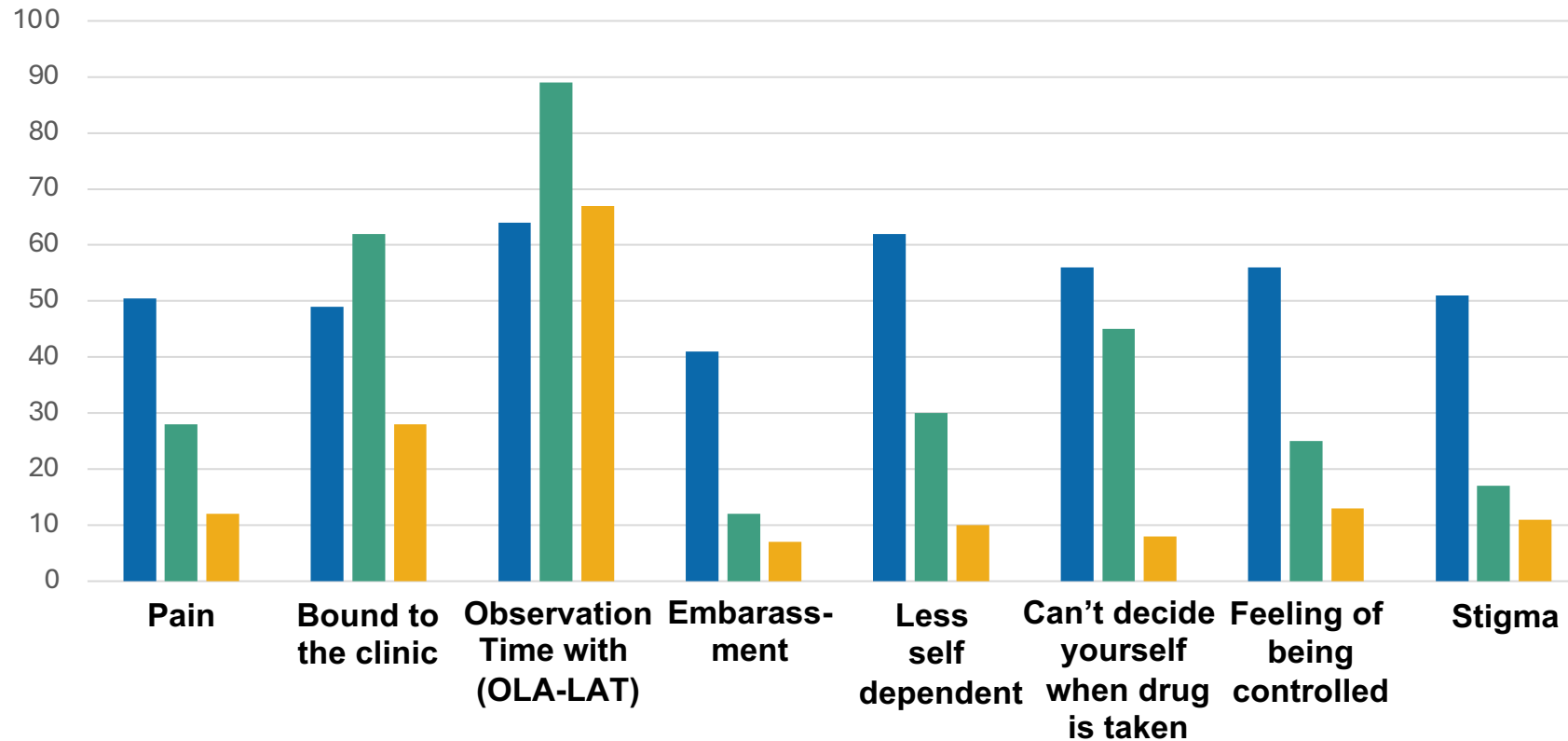
***41–59% of HCPs acknowledge that LAIs are underutilized***

# Clinician Assumptions of Patient Concerns Regarding LAIs May Be Inaccurate

Large impact to say NO to LAT



No impact



Cross-sectional study using semi-structured interviews to assess patient and HCP perceptions of LAIs (164 patients, 63 physicians/nurses) in a psychiatry catchment area in Stockholm, Sweden.

■ Doctors' or nurses' beliefs (n=63)

■ Patients' concern (pt on oral) (n=101)

■ Patients' experience (pt on LAT) (n=63)

LAT = long-acting treatment.

Cahling L, et al. *BJ Psych Bull.* 2017;41(5):254-259.

# Promoting Patient-Centered Care

## (With the DECIDE Framework)

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### Define the Problem



Patients are struggling with adherence to daily oral treatments for schizophrenia, leading to inconsistent symptom control and high risk of relapse.

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### Explore the Options



Present LAIs as a treatment option, emphasizing their benefits, including reduced burden from daily dosing and lower risk of relapse.

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### Consider Patient Preferences and Values



Allow patients to share their concerns about injections or treatment goals, ensuring these perspectives are respected.

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### Identify the Best Options



Collaboratively decide if an LAI is the best choice given the patient's needs, focusing on improving mental health outcomes and day-to-day convenience.

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### Develop a Care Plan



Set up a timeline for initiating an LAI, including a discussion of the first injection, follow-up schedules, and a plan for addressing side effects or concerns.

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### Evaluate and Monitor Treatment



Schedule regular follow-ups to assess side effects, symptom control, and satisfaction with treatment outcomes.

Guo KL. DECIDE: A Decision-Making Model for More Effective Decision Making by Health Care Managers. *Health Care Manag.* 2020;39(3):133-141. doi: 10.1097/HCM.000000000000299

# APA and Guideline Recommendations



- **APA 2020:**

- APA suggests (2B) that patients receive treatment with a **long-acting injectable antipsychotic medication if they prefer such treatment** or if they have a **history of poor or uncertain adherence**.
- This guideline statement should be implemented in the context of a person-centered treatment plan that includes evidence-based nonpharmacological and pharmacological treatments for schizophrenia.

- **NICE 2014**

- Consider offering **depot/long-acting injectable antipsychotic medication** to people with psychosis or schizophrenia:
  - **who would prefer such** treatment after an acute episode
  - **where avoiding covert non-adherence** (either intentional or unintentional) to antipsychotic medication **is a clinical priority** within the treatment plan.

- **BAP 2020:**

- Patients should be **offered the option of depot/long-acting injectable antipsychotic medication** for maintenance treatment, **given the evidence of lower risk of relapse**.

***Consistent themes across guidelines emphasize LAIs for adherence, relapse prevention, and patient preference.***



# Key Learning Points

- ✓ **LAI**s offer **significant clinical and pharmacokinetic benefits** over oral medications, particularly for improving adherence, preventing relapses, and reducing hospitalizations
- ✓ **Underutilized despite effectiveness:** LAIs are effective for relapse prevention but remain underused in clinical practice.
- ✓ **APA's Recommendation:** APA advocates for offering LAIs to patients with a history of non-adherence or those who prefer injectables.
- ✓ **Shared Decision-Making with DECIDE Framework:**
  - ✓ The DECIDE framework (*Define, Establish, Clarify, Identify, Develop, Evaluate*) aids in ensuring individualized, collaborative care.

# Updates on Recently FDA-Approved Longer Interval LAIs for Schizophrenia

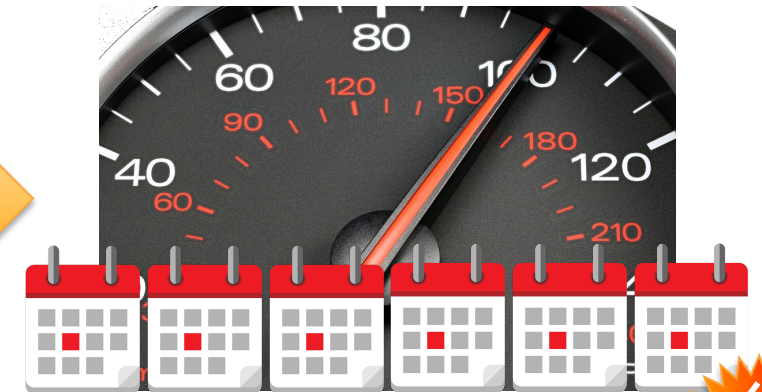


# The Dynamic Nature of Adherence May Benefit from Longer Interval LAIs

The further away humans get from a negative outcome, the less worried they become about that outcome reoccurring.



Reducing the number of times someone has to choose to continue treatment by using longer-duration LAIs may increase the odds of long-term treatment persistence

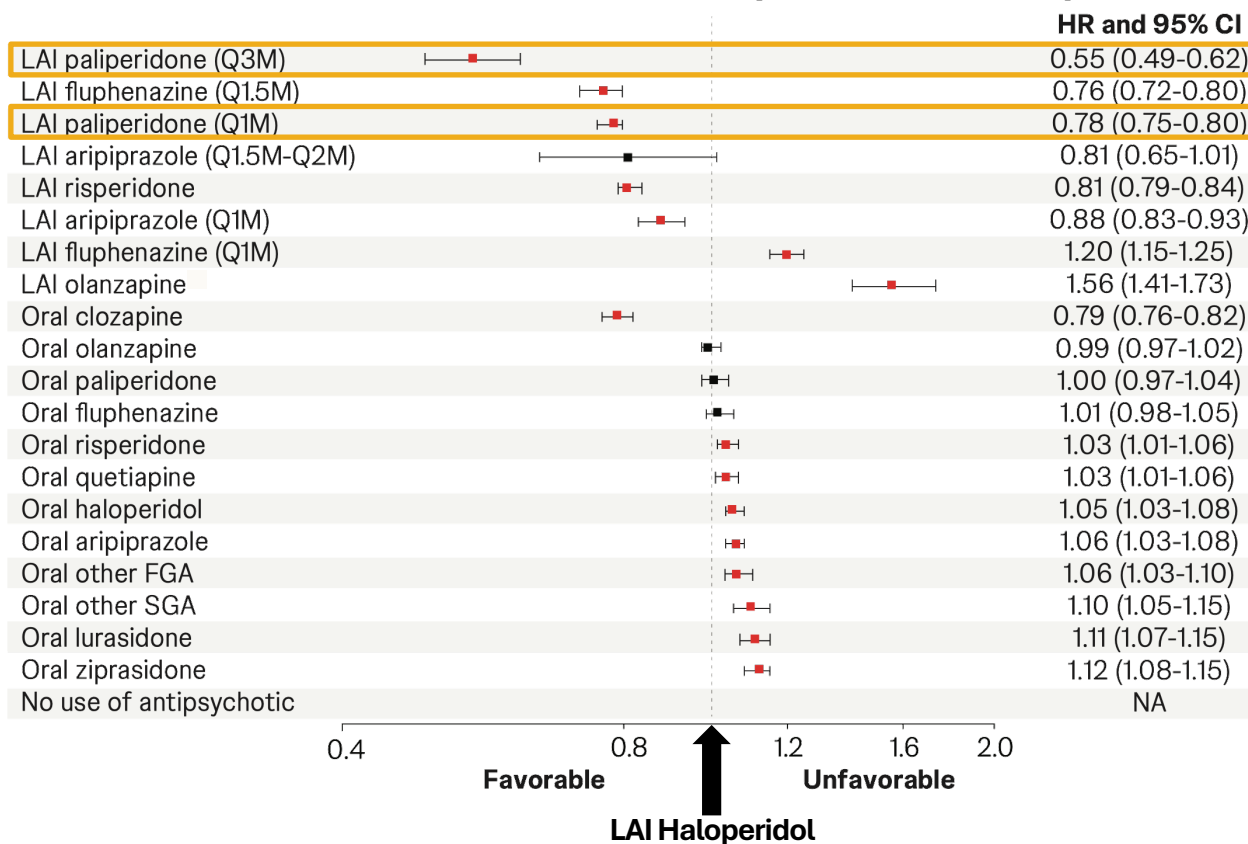


Setting adherence “cruise control” for more than 1-month at a time can help keep them on track for the long-haul!

Hot Take!

# Longer Duration LAIs May Have an Advantage in Real-World Comparative Effectiveness in Medicare Data

## Hazard Ratio of Treatment Failure Compared to LAI Haloperidol



PP3M was significantly better than PP1M

Data were taken from the 2006-2019 national Chronic Conditions Warehouse 100% Medicare Part A, B, and D claims and beneficiary summary files [N=152,835]

Treatment failure (primary study outcome) was a composite of psychiatric hospitalization, antipsychotic discontinuation, suicide attempts, or death

LAI generally had clear advantages over their oral counterparts, and longer duration LAIs may widen the lead

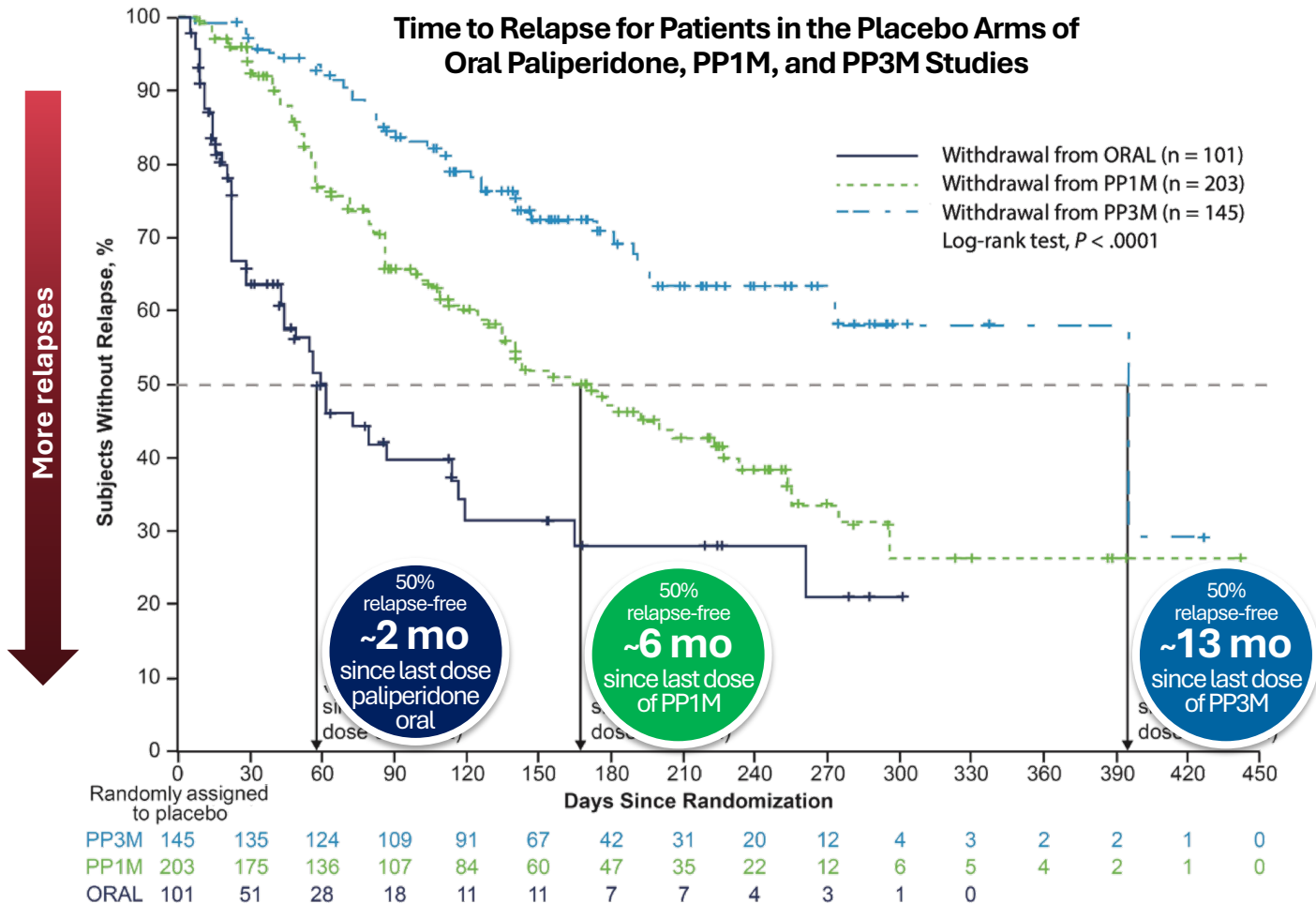


FGA = first-generation antipsychotic; HR = hazard ratio; LAI = long-acting injectable; NA = not available; QXM = every X months; SGA = second-generation antipsychotic.

Li P, et al. Real-World Comparative Effectiveness of Long-Acting Injectable and Oral Antipsychotics Among US Medicare Beneficiaries With Schizophrenia. Poster Presented at Psych Congress; October 29-November 2, 2024; Boston, MA.

# Longer Duration LAIs May Better Protect People Even after Discontinuation

Time to Relapse for Patients in the Placebo Arms of Oral Paliperidone, PP1M, and PP3M Studies



This post hoc analysis includes data from stable participants taking oral paliperidone, PP1M, and PP3M randomized to the double-blind placebo arms of each respective study

Relapse risk was:  
 56% lower for discontinuing PP1M vs. oral paliperidone ( $P < 0.001$ )  
 79% lower for discontinuing PP3M vs. oral paliperidone ( $P < 0.001$ )

**52%** lower for discontinuing PP3M vs. PP1M ( $P < 0.001$ )



If moving from 1M to 3M duration conferred as large of an improvement as moving from oral to 1M, 6M duration would likely be even better

PP=paliperidone palmitate; 1M=once-monthly, 3M=every-3-months  
 Weiden PJ, et al. *The Journal of Clinical Psychiatry*. 2017;7897: 17236.

# “Graduating” to Longer Injection Intervals



Many people with schizophrenia don't celebrate as many graduations as the average person.

Compared to healthy controls, the odds of a person with schizophrenia graduating high school are  
**2.58 times lower**

When transitioning from a monthly LAI to one with a longer duration, I've found that describing it as “graduating” has given a sense of pride to many individuals with schizophrenia.

***And that is something to celebrate!***

# What to Do with Non-Treatment Visits?

Build rapport and think about the whole person

Health and wellness interventions promote recovery

Talk about physical comorbidities and their treatment for them

Assess and counsel on Nutrition, Exercise, and Sleep

Nicotine cessation and Substance use counseling

Social Skills Training is typically delivered in a group, but we can incorporate elements such as:

Instruction and practice with social and emotional perceptions and verbal and nonverbal communication  
Role-playing, modeling, and feedback approaches to enhance interpersonal interactions

Medications are just part of a person-centered treatment plan, and appointments where meds aren't the center of attention are both productive and fulfilling!

Hot Take!



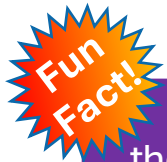
# 2-Month Aripiprazole LAIs

# Aripiprazole Lauroxil Clinical Snapshot

First approved in 2015 for adults with schizophrenia; 2-month duration approved in 2017

>2x PANSS reduction vs placebo in 12-week acute efficacy study

**NNT 6**  
for PANSS response  $\geq 30\%$



AL is a prodrug; the actual amount of aripiprazole delivered is 68% of total mg dose

$T_{max}$  41 d  
 $t_{1/2}$  54-57 d  
Steady State 6 mos

Most common AE was akathisia (NNH=14)

Discontinuation due to AE  
441 mg 6.8%, 882 mg 2.9% vs. PBO 17.9%

441 mg/1.6 mL Deltoid (21G)  
All doses Gluteal (20G)  
2.4-3.9 mL injection volume  
No refrigeration required

Comparable Daily Oral Doses

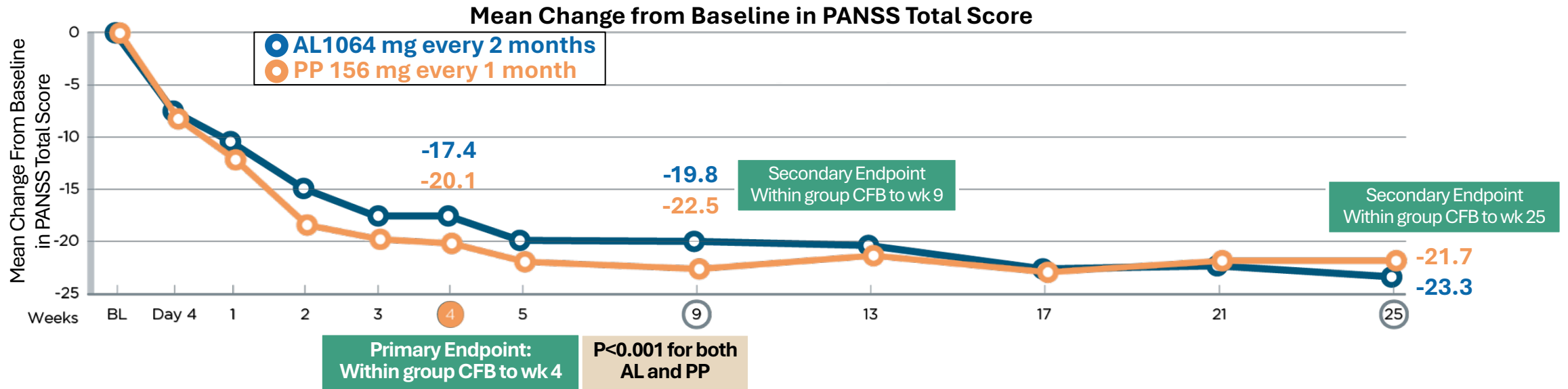
441 mg/4 wk  $\rightarrow$  ~10 mg  
662 mg/4 wk  
882 mg/6 wk  $\rightarrow$  ~15 mg  
1064 mg/8 wk  
882 mg/4 wk  $\rightarrow$  ~20 mg



Tap first and vigorously shake syringe, then rapidly and continuously inject medication

# Clinical Data on Aripiprazole Lauroxil 1064 mg Q2 mos

The primary objective was to evaluate efficacy of starting a 2-month AL regimen using the 1-day initiation. Paliperidone palmitate was included as an active control.



AEs occurring in ≥10% of either group	Aripiprazole Lauroxil	(n=99)	Paliperidone Palmitate	(n=101)
	Injection site pain	17 (17%)	Injection site pain	25 (25%)
	Weight increased	9 (9%)	Weight increased	17 (17%)
	Akathisia	9 (9%)	Akathisia	11 (11%)
	Discontinuation due to AE	10 (10%)	Discontinuation due to AE	11 (11%)
	Completed 25-week phase	56 (57%)	Completed 25-week phase	43 (43%)

AL1064 Q2 mos demonstrated safety and efficacy consistent with that seen in prior AL studies.



# Alternative to Initiating AL with 21-Day Oral Overlap

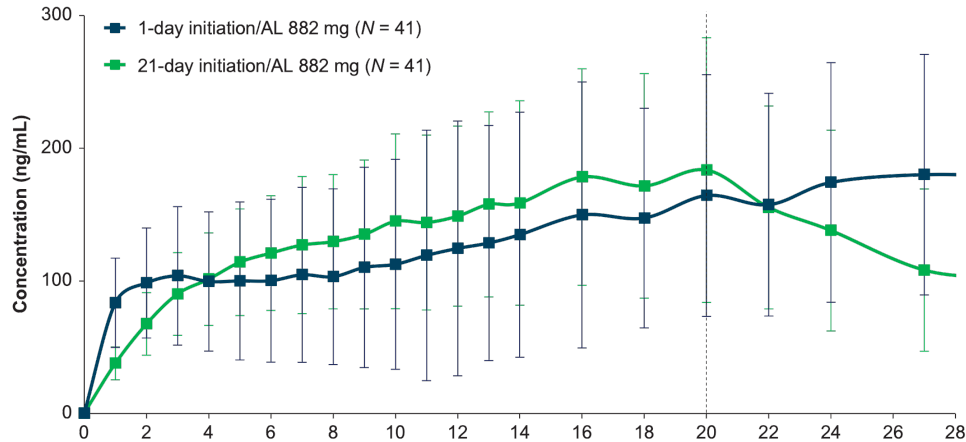
**1-day regimen:** 30 mg PO aripiprazole + AL nanocrystal injection + maintenance dose of AL

Either regimen gives relevant concentrations within 4 d (but not until day 11 if the 30 mg oral dose not given)

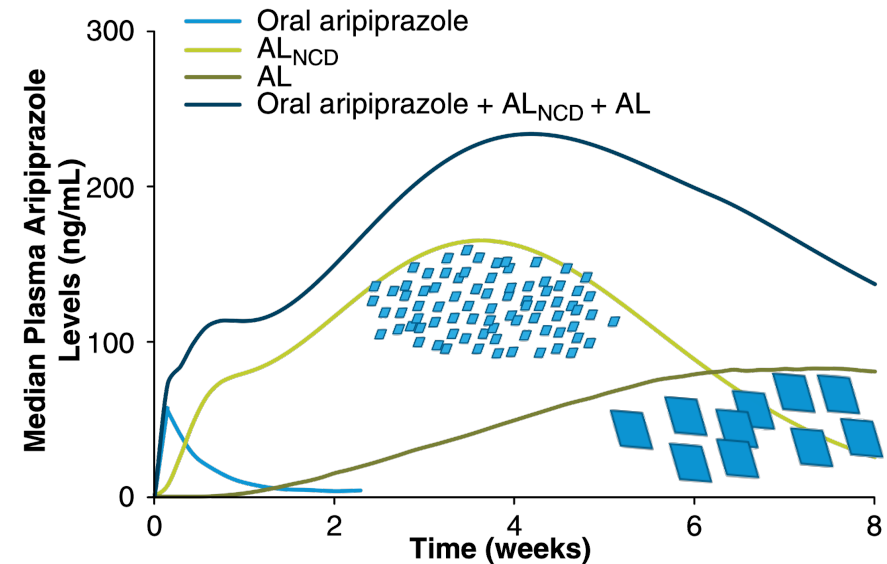
Deltoid (21G)/gluteal (20G)  
2.4 mL injection volume  
No refrigeration required

The nanocrystal initiation injection is only given at initiation, not with each subsequent dose

**Mean Aripiprazole Levels Over 28 days**



<b>Mean half-lives</b>	<b>75 hours</b>	Single 30 mg dose of oral aripiprazole
	<b>15-18 days</b>	Aripiprazole nanocrystal 675 mg
	<b>53.9 to 57.2 days</b>	Aripiprazole Lauroxil



The maintenance dose of AL may be given up to 10 days after the 30mg oral dose + AL NCD



AL=aripiprazole lauroxil; NCD=NanoCrystal Dispersion.

Aristada (aripiprazole lauroxil) [package insert]. Alkermes, plc. Waltham, MA; 2020. Jain R, et al. *CNS spectrums*. 2020;25(3): 323-330.

# Aripiprazole Monohydrate 2-Month Clinical Snapshot

Approved 2023  
**Schizophrenia**  
(and Monotherapy  
Bipolar I Maintenance)

Approval based on:  
1.) Pharmacokinetic bioequivalence to AOM  
2.) Open-label safety study in patients  
with schizophrenia and bipolar I

**>2x reduction** in PANSS vs.  
placebo in acute exacerbation  
**80% reduction** in impending  
relapse in maintenance (**NNT 4**)

$T_{max}$  28.0 d  
 $t_{1/2}$  29.4 d  
Steady State 8 mos

Weight change and akathisia were  
common adverse reactions and  
similar between Ari2M and AOM  
  
D/C due to AE: 3.0% Ari2M vs 7.5% AOM

960 or 720 mg Q2 months  
Initiated with 14-day oral overlap  
IM Gluteal 22G or 21G (obese)  
2.4-3.2 mL injection volume  
RTU; no refrigeration required

Comparable  
Daily Oral Dose 960 mg → ~28 mg  
720 mg → ~20 mg

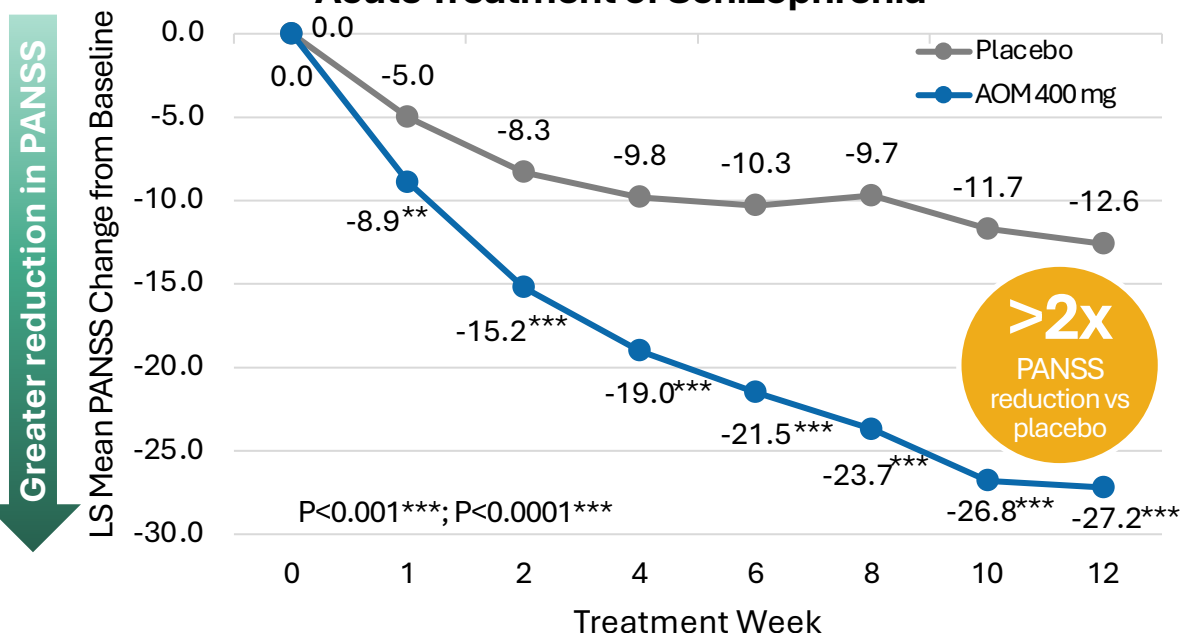
Mean patient-reported pain on a  
100-point scale was 3.7 for 1<sup>st</sup>  
injection and 1.4 for last injection

Since Ari2M is bioequivalent,  
its efficacy is considered  
equal to that of AOM

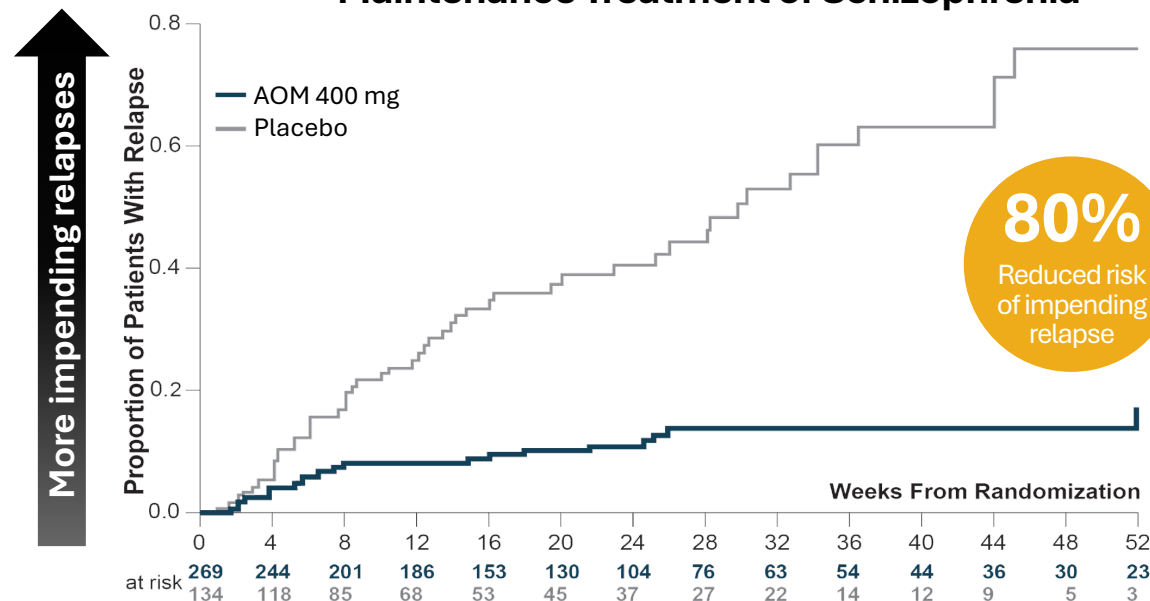


# Aripiprazole Once Monthly Clinical Data in Schizophrenia

## Acute Treatment of Schizophrenia



## Maintenance Treatment of Schizophrenia



Aripiprazole-naive patients were given 10 mg oral tablets daily for 3 days to assess tolerability

Aripiprazole Monohydrate demonstrated efficacy as both acute and long-term maintenance treatment of schizophrenia

Discontinuation due to AE  
AOM vs. Placebo  
4.2% vs. 7.6% in 12 wk Acute study  
7.1% vs. 13.4% in Maintenance study

PANSS=Positive and Negative Syndrome Scale; AOM=Aripiprazole Once-Monthly AE=adverse event  
Abilify Maintena (aripiprazole) [package insert]. Rockville, MD: Otsuka Pharmaceuticals; 2020. Kane, JM, et al. *J Clin Psych.* 2012;73(5): 1339. Kane JM, et al. *J Clin Psych.* 2014;75(11): 1347.



# Summary of Aripiprazole LAIs

	Aripiprazole Once-Monthly			Aripiprazole 2M RTU		Aripiprazole Lauroxil				
<b>Injection Interval</b>	4 weeks			8 weeks		4-, 6-, or 8-week options				
<b>Initiation protocol</b>	14-day oral overlap			14-day oral overlap		21 day oral or 1 day w/ NCD 675 mg				
<b>Injection Site</b>	Deltoid or gluteal muscle			Gluteal		Gluteal (all doses) (Deltoid: 441 mg and NCD only)				
<b>Needle Gauge</b>	23G or 22G (deltoid/obese) (21G for gluteal/obese)			22G (non-obese), 21G (obese)		20G (21G for 441mg or NCD in deltoid)				
<b>Injection Volume</b>	1.5 mL (300 mg), 1.9mL (400 mg)			2.4ml (720mg), 3.2mL (960mg)		1.6 mL (441 mg) - 3.9 mL (1064 mg)				
<b>Formulation</b>	Prefilled DCS or single use vial			Prefilled syringe		Prefilled syringe				
<b>How to Handle Missed Doses</b>						<b>AL Regimen</b>		<b>Time Since Last Dose</b>		
	<b>Last Dose</b>	<b>Time Since Last Dose</b>	<b>Next Steps</b>	<b>Time Since Last Dose</b>	<b>Next Steps</b>	441mg/4w	<6wk	6 to 7 wk	>7wk	
	2 <sup>nd</sup> or 3 <sup>rd</sup>	4-5 weeks	Administer usual dose	< 14 weeks	Administer usual dose	662mg/4w	<8wk	8 to 12 wk	>12wk	
		>5 weeks	Restart oral overlap			882mg/4w	<8wk	8 to 12 wk	>12wk	
	After 3 <sup>rd</sup>	4-6 weeks	Administer usual dose	>14 weeks	Restart oral overlap	882mg/6w	<8wk	8 to 12 wk	>12wk	
		>6 weeks	Restart oral overlap			1064mg/8w	<10wk	10 to 12 wk	>12wk	
	<b>Next Steps:</b>						Administer usual dose	Give 7d oral Ari or ALNCD	Restart initiation	

DCS=Dual Chamber Syringe; NCD=NanoCrystal Dispersion; 2M=2-month; RTU=ready-to-use

Abilify Maintena (aripiprazole) [package insert]. Rockville, MD: Otsuka Pharmaceuticals; 2020. Abilify Asimtufii (aripiprazole) [package insert]. Rockville, MD: Otsuka; 2023. Aristada (aripiprazole lauroxil) [package insert]. Alkermes, plc. Waltham, MA. 2020. Harlin, M, et al. CNS drugs 2023;37(3): 1-14.

**Risperidone Polymer  
Subcutaneous 1+2 Month**

# Risperidone Polymer SC 1-2 mo Clinical Snapshot

Approved 2023  
Schizophrenia  
in Adults

Reduced risk  
of relapse by  
**62.5% to 80%**

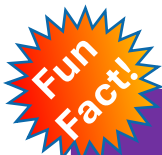
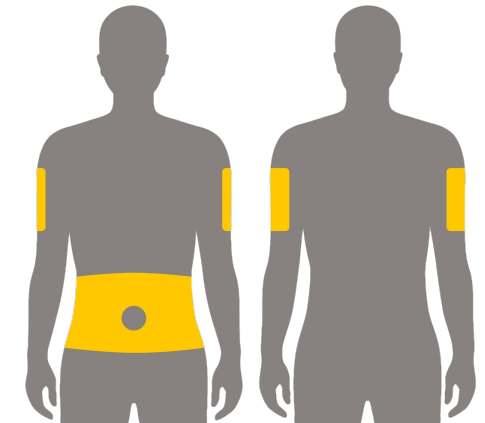
Prolonged time  
to relapse by  
**2.7 to 5 times**

**NNT 5-7**  
for prevention of  
impending relapse

$T_{max}$  8-14 d  
 $t_{1/2}$  14-22d  
Steady State 2 mos

Most common adverse  
reactions were “EPS”  
and weight increase  
Discontinuation due to AE:  
3% vs 11% placebo

- Subcutaneous (21G, 0.63 in)
- Abdomen or Back of Arm
- 0.1 to 0.7 mL injection volumes
- RTU; stable 90 days out of fridge
- No oral overlap/loading dose

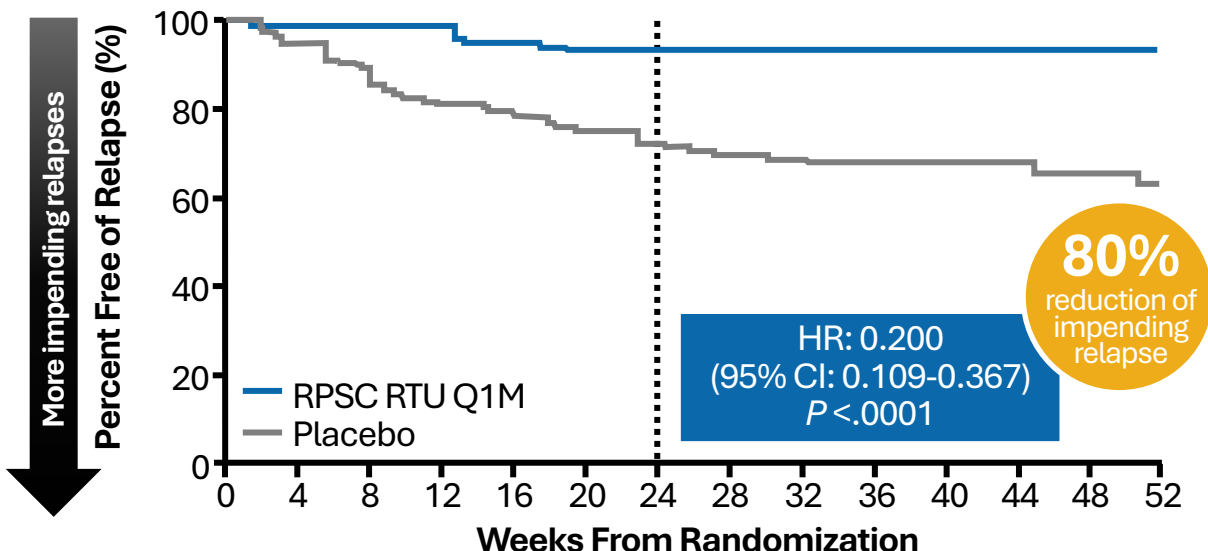


Therapeutic  
concentrations occur  
within 6-24 hours

Comparable oral daily dosage		2 mg/d	3 mg/d	4 mg/d	5-6mg/d
	Q1M	50 mg	75 mg	100 mg	125 mg
	Q2M	-	150 mg	200 mg	250 mg

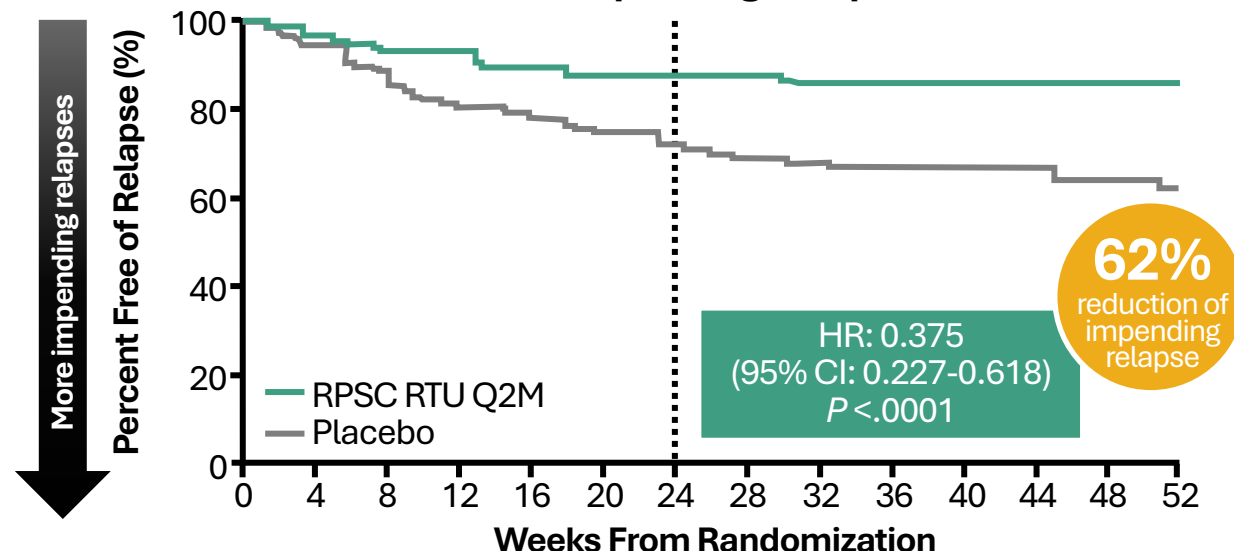
# Risperidone Polymer SC 1-2 mo Clinical Data

**Q1M Dosing  
Risk of Impending Relapse**



<b>RPSC Q1M</b>	183	178	169	156	144	131	124	112	106	94	89	77	68	61
<b>Placebo</b>	181	163	148	122	110	99	90	79	71	64	59	51	40	36

**Q2M Dosing  
Risk of Impending Relapse**



<b>RPSC Q2M</b>	179	168	148	137	127	119	115	103	94	83	75	67	61	54
<b>Placebo</b>	181	163	148	122	110	99	90	79	71	64	59	51	40	36



There is no statistical difference between the efficacy of Q1M and Q2M because the confidence intervals overlap

**Common AEs in DB Efficacy Trial  
(after PO risperidone stabilization)**

	Placebo	Q1M	Q2M
Weight Gain	3%	5%	7%
EPS	0%	5%	4%
D/C d/t AE	6%	11%	8%

**Selected AEs from Long-Term  
Randomized DB Safety Study**

	Q1M	Q2M
Injection Site Pain	5%	4%
D/C Due to AE	2%	3%

# Paliperidone Palmitate 6-Month

# Paliperidone Palmitate Clinical Snapshot

**PP1M** Indicated for schizophrenia and schizoaffective disorder as monotherapy or adjunct to mood stabilizers or antidepressants

Loading dose: 234 mg on day 1 & 156 mg on day 8 (both in deltoid)  
Monthly maintenance dose given 5 wks after first initiation injection

Shake prefilled syringe with tip down for 10 sec.  
22–23-gauge, 1-1.5 in. deltoid or gluteal

**PP3M** Indicated for schizophrenia after adequate treatment with PP1M for at least 4 months

Shake the prefilled syringe vigorously with tip up for 15 sec.  
22G, 1-1.5 in. deltoid or gluteal.

**PP6M** Indicated for schizophrenia after adequate treatment with PP1M for at least 4 months or PP3M for at least one 3-mo. cycle

Shake prefilled syringe with tip up **very fast** for ≥15 sec., rest briefly, then shake **again** for 15 sec.  
20G, 1.5 in. gluteal injection.

PO Risp	PO Pali	PP1M	PP3M	PP6M
1 mg	3 mg	→ 39 mg		
2 mg	3 mg	→ 78 mg	→ 273 mg	
3 mg	6 mg	→ 117 mg	→ 410 mg	
4 mg	9 mg	→ 156 mg	→ 546 mg	→ 1092 mg
6 mg	12 mg	→ 234 mg	→ 819 mg	→ 1560 mg

Mean patient-reported pain on a 100-point scale was ~5 in both PP3M and PP6M at the endpoint of a double-blind study.

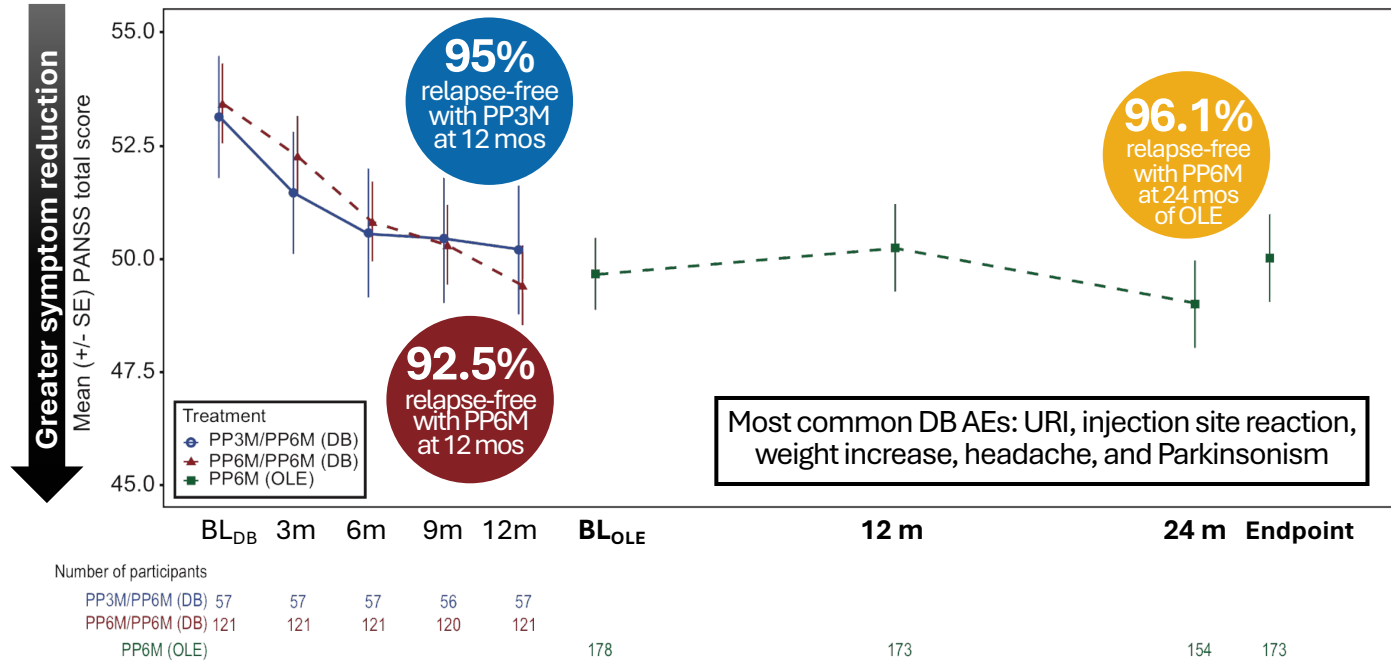
The 2<sup>nd</sup> initiation dose of PP1M can be given 4 days before or after the one-week point

**For Maintenance Doses:**  
PP1M: 1wk before or after  
PP3M: 2 wks. before or after  
PP6M: 2 wks before or 3 wks after

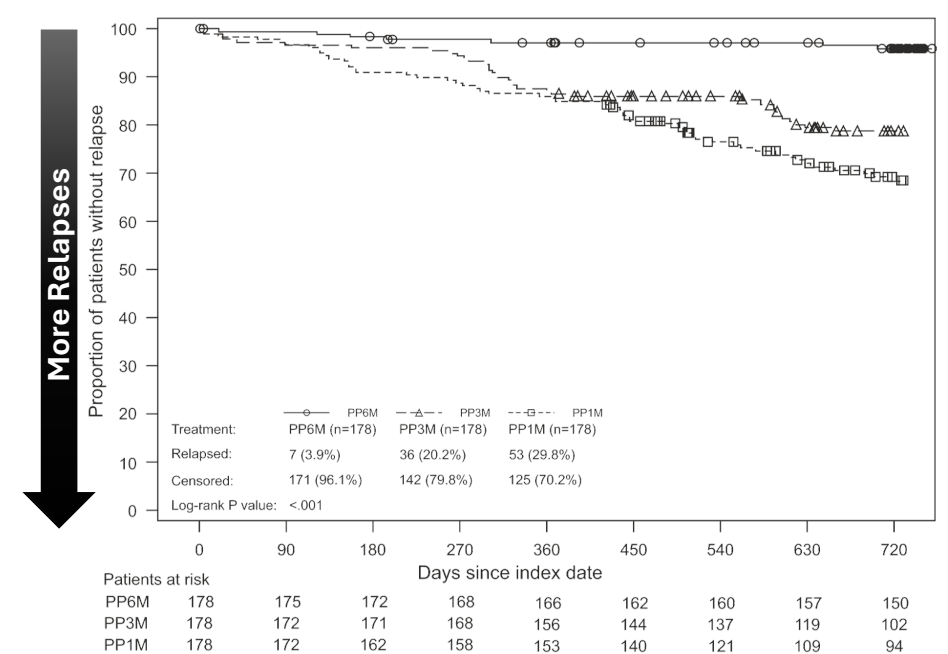
Common AEs for PP LAIs are generally:  
Injection site reactions, weight increase, headache, akathisia, parkinsonism, and prolactin increase.

# Acute and Long-Term Results of PP 6-Month

PP6M Acute Double-Blind Study and Open-Label Extension



Relapse Rates From PP6M Open-label Extension Study Compared to Real-World Data for PP1M and PP3M



PP6M was shown to be noninferior to PP3M in a 1-yr double-blind phase 3 trial.

Participants completing the acute trial without relapse (N=154) were enrolled in a 2-year OLE.

Clinical and functional improvements were maintained and relapse rate over 2-years was 3.9%

The relapse rate was lower in the PP6M cohort (3.9%) vs PP3M (20.2%) and PP1M (29.8%) external comparator cohorts

PP=Paliperidone Palmitate; 1M = 1-month; 3M = 3-month; 6M = 6-month; DB=Double-Blind; OLE=Open-Label Extension

Najarian D, et al. *Int J Neuropsychopharmacol.* 2022 March 1;25(3):238–251. Najarian D, et al. *Int J Neuropsychopharmacol.* 2023 Aug 29;26(8):537-544. Turkoz I, et al. *Int J Neuropsychopharmacol.* 27.2 (2024): 27, 1-11.



# Key Learning Points

- **Aripiprazole lauroxil**
  - Has both a 1-day and 21-day initiation regimen options
  - Pharmacokinetic profiles for Ari2M 960 and AOM are comparable and sufficient to bridge the established safety and efficacy of AOM to Ari 2M 960
- **Risperidone polymer subcutaneous 1-2 month**
  - Can reach therapeutic concentrations within 6-24 hours
  - Currently the only subcutaneous LAI that can be given every 2 months for the treatment of schizophrenia
- **Paliperidone Palmitate 6-month (PP6M)**
  - Maintenance doses may be given up to 2 weeks before or 3 weeks after the 6-month time point
  - Offers the most prolonged LAI dosing interval available for schizophrenia, with a clinical trial demonstrating statistical noninferiority to PP3M and real-world data suggesting potential advantages
- **LAIs with durations longer than 1 month have the potential to confer even greater benefits to people with schizophrenia than LAIs with a 1-month duration.**

# Panel Discussion: Strategies for Discussing and Initiating LAIs for Patients with Schizophrenia

- Techniques of Shared Decision-Making and Motivational Interviewing
- Responding to Patient Concerns
- Utilizing LAIs as a Telemedicine Provider



# Initiation of LAI and Subsequent Encounter

Live Role-Play

# Initial Discussions and Shared Decision-Making



# Motivational Interviewing

## **Coercive Interviewing (What NOT to Do)**

### **Fear tactics**

“You’ll relapse again if you don’t start LAIs”  
“Do you really want to end up back in the hospital?”

### **Pressure**

“You don’t have any other good choice.”

### **Ignoring their perspective**

“This is the best thing for you, so just agree to it”

## **Motivational Interviewing (What to Do)**

### **Open-ended questions**

“What are some things that get in the way of you taking your medication?”

### **Addressing concerns with empathy**

“Tell me more about why this is concerning to you.”

### **Focus on goals and benefits**

“It’s great that you’re motivated to reach your goals.  
Can we talk about some ways that we can work together to help you reach these goals?”

# Initiation of LAI and Subsequent Encounter (Do-Over)

Live Role-Play

# Responding to Patient Concerns: Needle Pain/Anxiety

"I don't like needles... and it's going to HURT!"

- "Most patients find gluteal injections minimally invasive and report little to no pain—oftentimes, it's more comfortable than they expect."
- "Would you like to know how others with needle anxiety felt after their first injection?"



Encourage breathing exercises

Distract the patient by engaging in conversation



# Responding to Patient Concerns: Gluteal Injections

“An injection in my butt sounds awkward or embarrassing.”

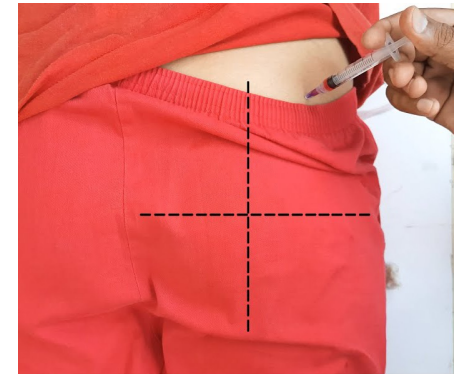
- "We can demonstrate with a simulated injection to show how discreet it is."

“Why can't it just be in my arm (deltoid)? Gluteal seems unnecessary.”

- "The medicine releases more slowly in gluteal muscle, so the maximum concentration is lower compared to deltoid injections. This minimizes side effects and ensures more stable medication levels, especially early in treatment."

“I don't want to get half-naked to get a shot”

- “The injection actually goes more in the hip— right below your waistline, so you'd just need to lower your pants a little bit, not take them all the way off.”
- “And it may be more convenient in the winter if you wear layers, and a deltoid injection might require taking off your shirt if you're wearing long sleeves.”



# Responding to Patient Concerns

Live Role-Play

# Using Telemedicine for LAIs



Telehealth  
Visit



Telehealth  
prescriber  
orders LAI



Collaborate with Pharmacy/  
Pharmacist or other site for  
LAI injection plan



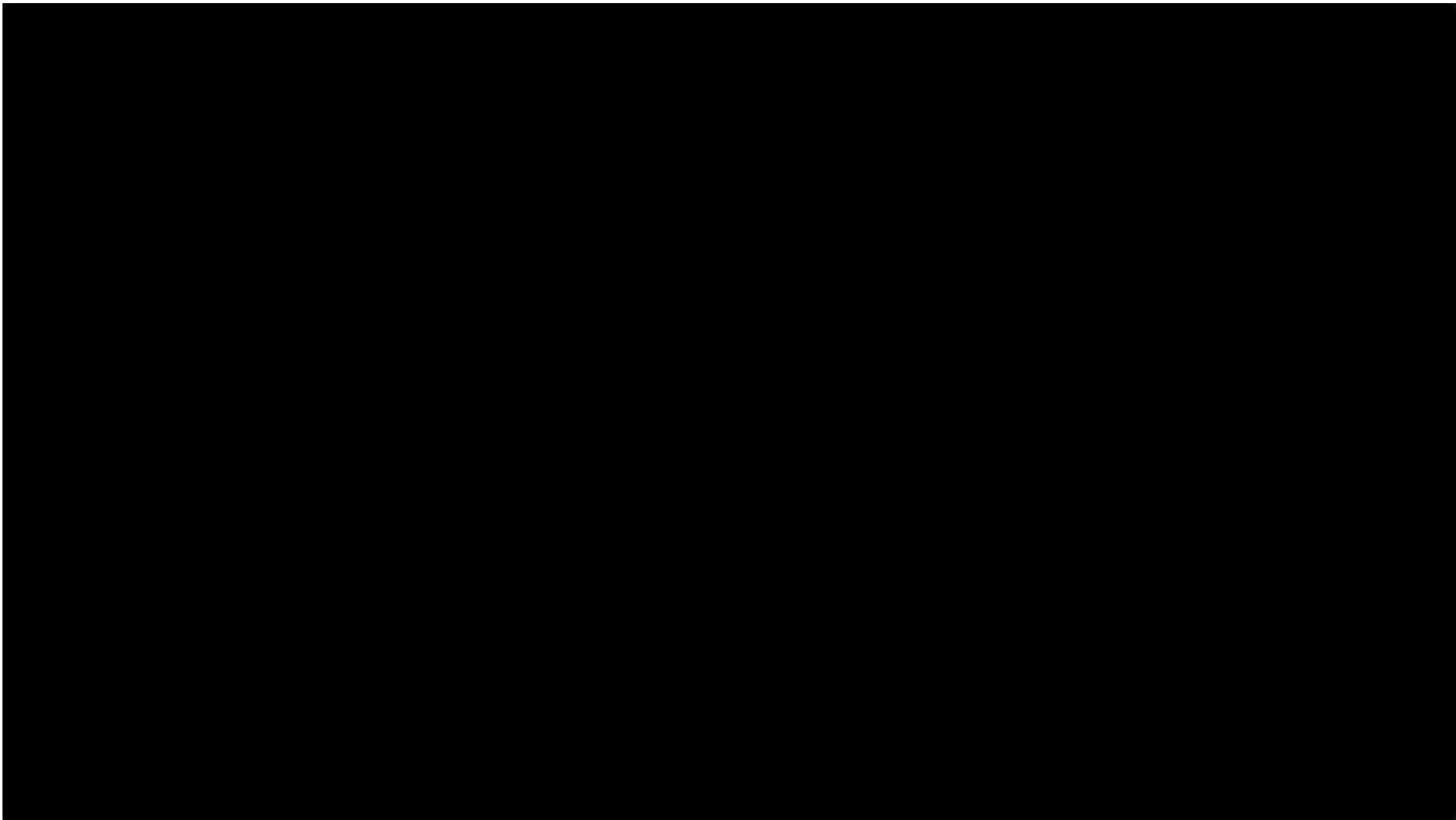
***The primary difference is operational.  
Key Takeaway: build a reliable network of care***

- ***Pharmacies***
- ***PCPs offices***
- ***CMHCs***



# Initiating LAI Treatment Plans via Telemedicine

Video Example



# Practical Take-Aways



LAI s have certain advantages over oral antipsychotics, and longer-duration LAIs may extend these advantages.



LAI s should be offered with a shared decision-making approach and by leading with the potential benefits an individual could obtain rather than the route of administration.





Patient concerns, such as fear of needle pain, embarrassment about gluteal injections, or others, should be acknowledged and explored rather than dismissed.


# You're on Your Way to Earning Your LAI360 Certificate!


 STEP 1: Attend this session!


STEP 2: Complete all 5 Hands-on Workshop Stations in the Exhibit Hall

 Station 1: Booth #514 Hands-On Practice of Injection Techniques Paliperidone Palmitate

 Station 2: Booth #825 Hands-On Practice of Injection Techniques Risperidone (SC)

 Station 3: Booth #627 Hands-On Practice of Injection Techniques Aripiprazole Lauroxil

 Station 4: Poster Hall (Back Exhibit Wall) Educational Posters on Long Acting Injectables

 Station 5: Booth #526 Motivational Interviewing and Telemedicine Practice

STEP 3: Receive Your Certificate! 



# Q&A

