



Operationalizing Adherence:

A Practical Guide
to LAI Integration in
Schizophrenia Care

MasterClass

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Learning Objectives

- Analyze the evolving role of LAIs versus OAPs in schizophrenia, integrating the latest clinical guidelines, real-world outcomes, and expert consensus recommendations
- Differentiate among current LAI formulations based on their pharmacologic profiles, dosing intervals, administration requirements, and patient-centered considerations to support individualized treatment planning
- Apply effective strategies, including shared decision-making and motivational interviewing, to initiate or reintroduce LAI treatment with patients and care partners

Rethinking Schizophrenia Treatment: Evolving Roles for Long-Acting Injectables

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)

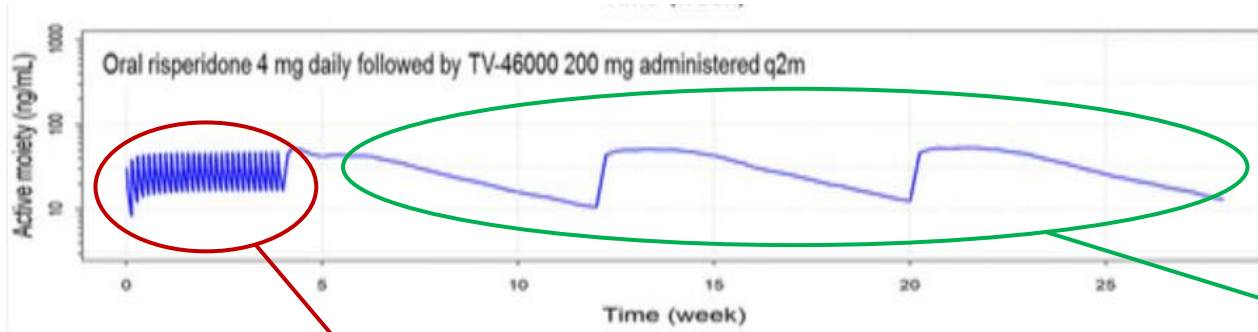
Clinical Consequence:
Each psychotic episode and relapse results in progressive brain changes, potentially leading to irreversible loss of cognitive function

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



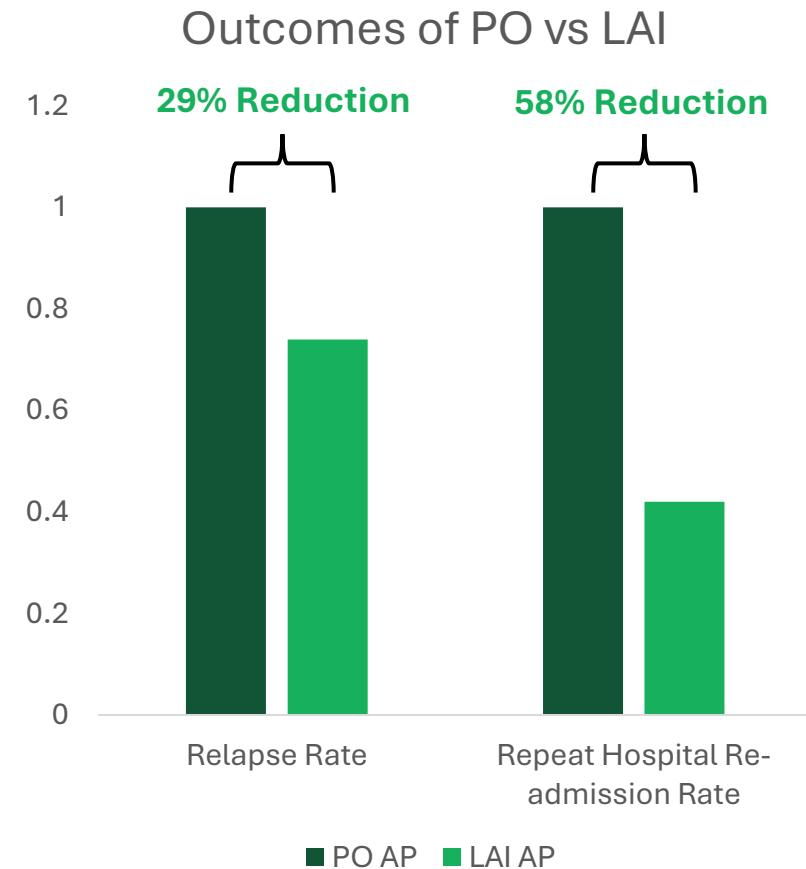
Plasma concentration
variability of oral (with
perfect adherence)

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.

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



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

Patient Attitudes about LAIs Are Often Positive

Survey in France: Patients (N=206) with schizophrenia with ≥ 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

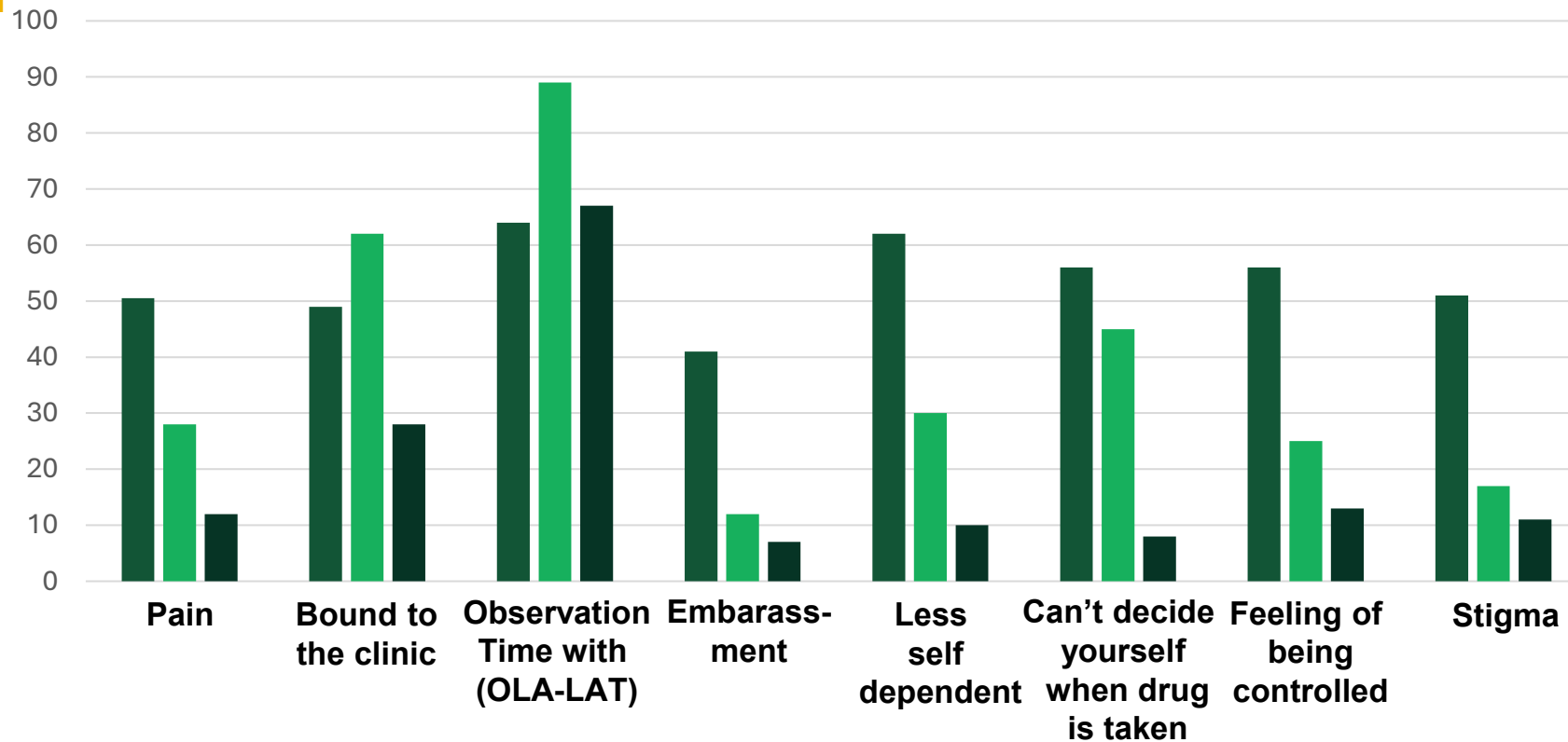
Cross-sectional study using semi-structured interviews to assess patient and HCP perceptions of LAIs (164 patients, 63 physicians/nurses) in a psychiatry catchment area in Stockholm, Sweden.

- Doctors' or nurses' beliefs (n=63)
- Patients' concern (pt on oral) (n=101)
- Patients' experience (pt on LAT) (n=63)

Large impact to say NO to LAT



No impact



OLA = olanzapine; LAT = long-acting treatment.
 Cahling L, et al. *BJ Psych Bull.* 2017;41(5):254-259.

Promoting Patient-Centered Care

(With the DECIDE Framework)

Define the Problem



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

Explore the Options



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

Consider Patient Preferences and Values



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

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.

Develop a Care Plan



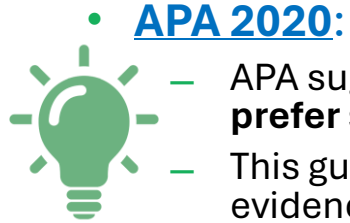
Set up a timeline for initiating an LAI, including a discussion of the first injection, follow-up schedules, and a plan for addressing side effects or concerns.

Evaluate and Monitor Treatment



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

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

- ✓ **LAIs 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.

**Recent Innovations:
Longer-Interval LAIs and
Expanded Formulations**

Exploring the Benefits of Longer Dosing Intervals

Reduced Treatment Burden

Longer-interval LAIs require only 2–4 injections per year, significantly reducing the number of clinic visits and minimizing disruption to patients' daily lives.

Stronger Adherence

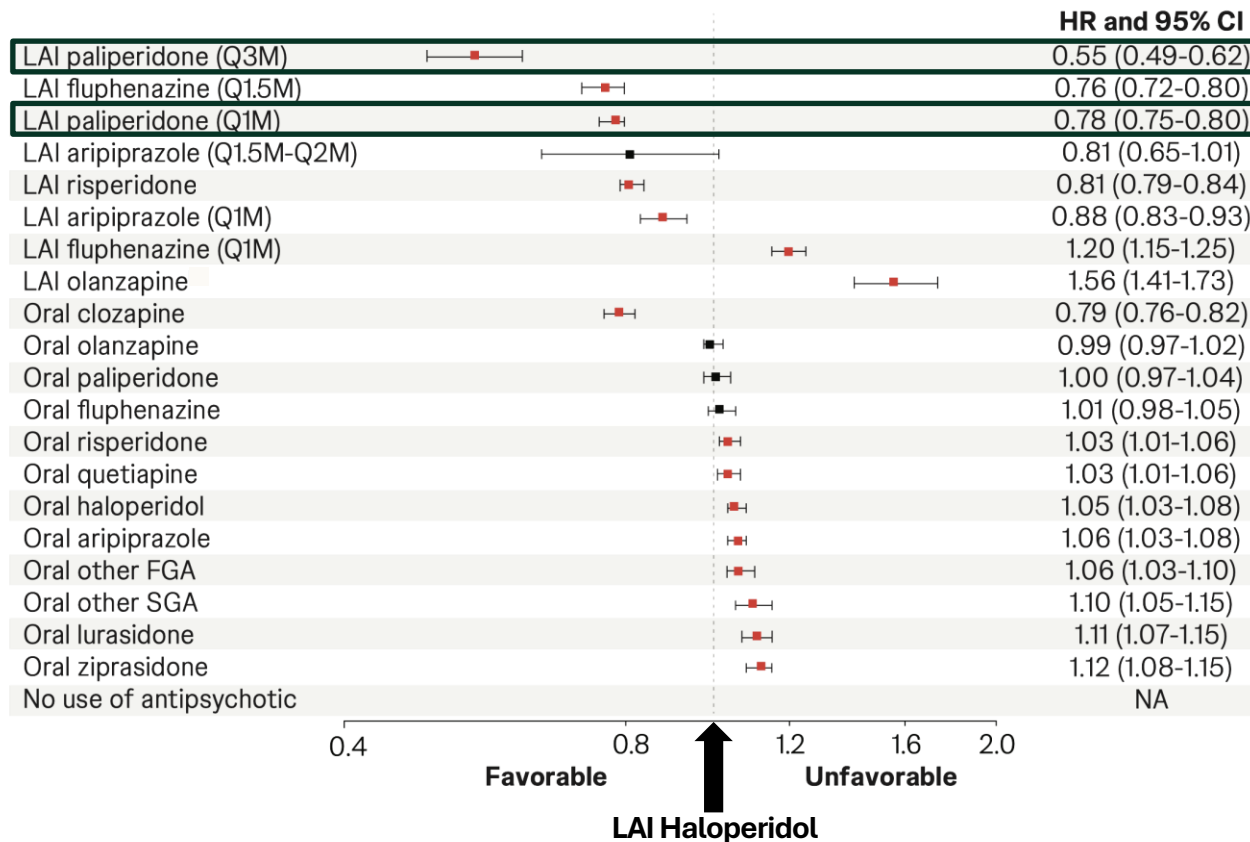
By providing sustained coverage with fewer doses, longer-interval LAIs decrease the risk of missed doses, thus promoting better adherence and persistence in treatment regimens.

Enhanced Patient Experience

Patients benefit from greater autonomy and reduced stigma, resulting in higher levels of satisfaction and improved experiences with their treatment.

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]

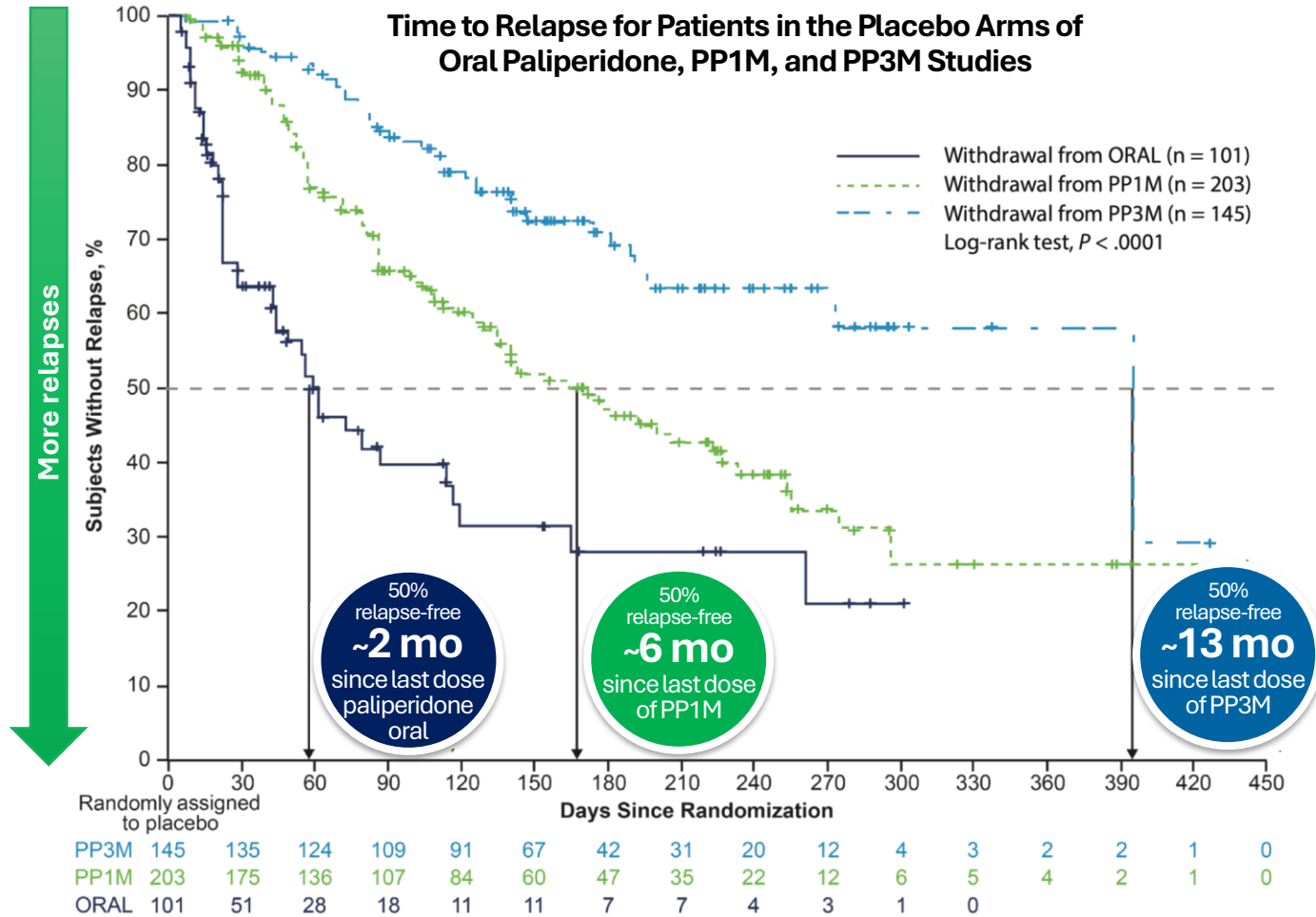
Treatment failure (primary study outcome) was a composite of psychiatric hospitalization, antipsychotic discontinuation, suicide attempts, or death

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



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.

What to Do with Non-Treatment Visits?

Therapeutic Engagement

Psychotherapy, supportive counseling,
address psychosocial goals

Preventive Health

Metabolic health, diet, exercise,
primary care coordination

Telehealth Monitoring

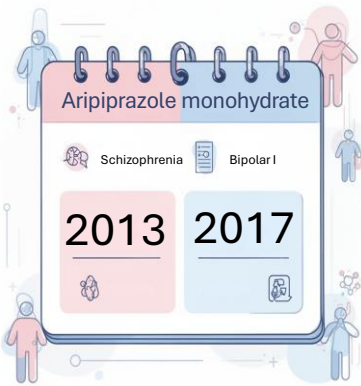
Virtual check-ins between injections
for monitoring and reduced travel

Functional Assessment

Evaluate social, occupational,
interpersonal function and quality of life

2-Month Aripiprazole LAIs

Aripiprazole Once Monthly Clinical Snapshot



Approval Dates

Approved in 2013 for schizophrenia, 2017 for bipolar.



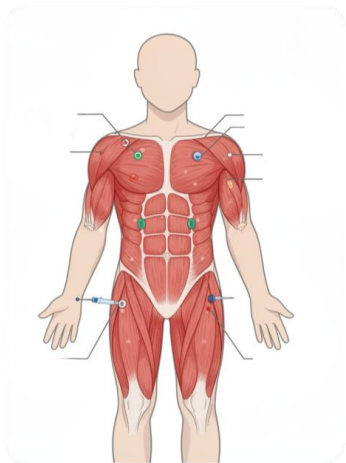
Dosing

Monthly injection: 400 mg once a month recommended,



Initiation Regimens

1-day initiation where 2 separate intramuscular injections of 400 mg along with a single oral dose of aripiprazole 20 mg (Approved 2025) **or** a 14-day oral supplementation of current oral antipsychotic or 10-20mg oral aripiprazole



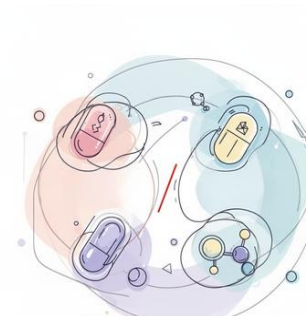
Administration

Delivered via deltoid or gluteal muscles, prefilled syringes.



Efficacy

Demonstrated efficacy as both acute (2x reduction in PANSS score vs placebo) and long-term maintenance treatment of schizophrenia (80% Reduced risk of relapse)



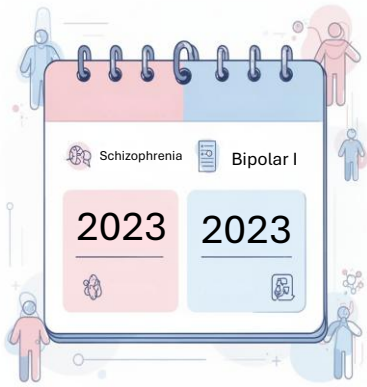
Safety

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.

Aripiprazole Monohydrate 2-Month Clinical Snapshot



Approval Dates

Approved in 2023 for schizophrenia for bipolar.



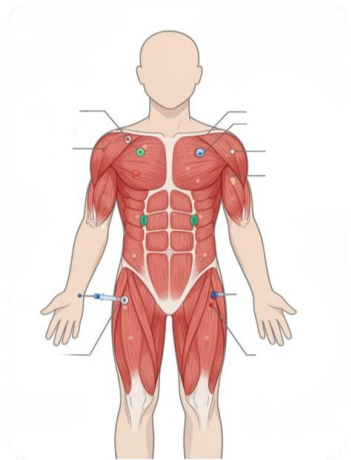
Dosing

Monthly injection: 960 mg recommended



Initiation Regimens

1-day initiation when intramuscular injections of 400 mg AOM plus injection of 960mg 2-month and single oral dose of aripiprazole 20 mg **or** a 14-day oral supplementation



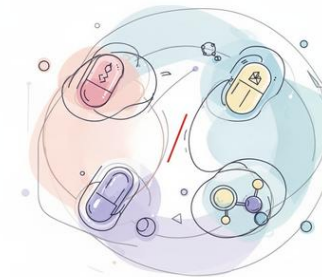
Administration

Delivered via gluteal muscles, prefilled syringes.



Efficacy

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



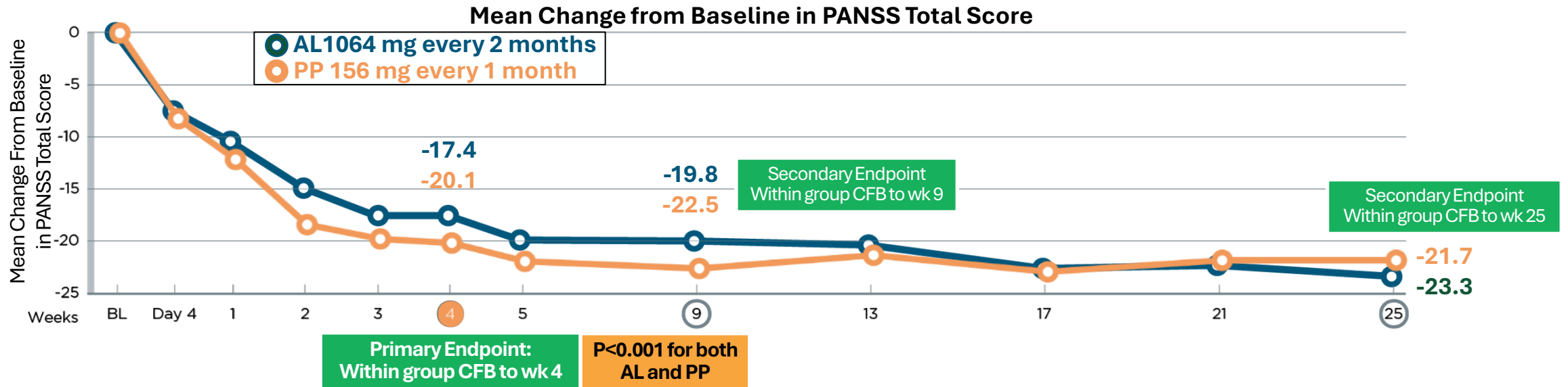
Safety

Weight change and akathisia were common adverse reactions and similar between Ari2M and AOM
Mean patient-reported pain on a 100-point scale was 3.7 for 1st injection and 1.4 for last injection

D/C due to AE: 3.0% Ari2M vs 7.5% AOM

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	% of n=99	Paliperidone Palmitate	(% of n=101)
	Injection site pain		17%	Injection site pain
Weight increased		9%	Weight increased	17%
Akathisia		9%	Akathisia	11%
Discontinuation due to AE		10%	Discontinuation due to AE	11%
Completed 25-week phase		57%	Completed 25-week phase	43%

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



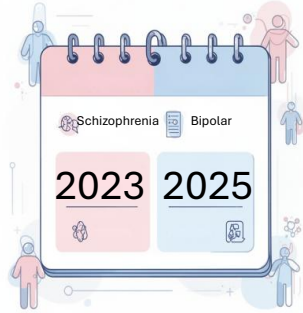
Summary of Aripiprazole LAIs

Category	Aripiprazole monohydrate monthly	Aripiprazole monohydrate 2 mo (Abilify Asimtufii)	Aripiprazole lauroxil (Aristada)	Aripiprazole lauroxil Nanocrystal dispersion (Aristada Initio)
Year approved	2013	2023	2015	2018
Approved indications (all adult)	Schizophrenia; bipolar I disorder maintenance treatment (monotherapy) (2017)	Schizophrenia; bipolar I disorder maintenance treatment (monotherapy)	Schizophrenia	Schizophrenia
Dosage forms/strengths	Vial kits and dual-chambered prefilled syringes: 300 mg, 400 mg	Injectable suspension: 720 mg, 960 mg	Injectable suspension: 441 mg, 662 mg, 882 mg, 1064 mg	Injectable suspension: 675 mg
Requires adding diluent/liquid	Yes	No	No	No
Injection type	Intramuscular	Intramuscular	Intramuscular	Intramuscular
Approved injection sites	Deltoid or gluteal muscle	Gluteal muscle	Deltoid (441 mg only) or gluteal muscle	Deltoid or gluteal muscle
Needle gauge and length	21G/2-inch, 22G/1.5-inch, or 23G/1-inch	21G/2-inch, 22G/1.5-inch	20G/1.5- or 2-inch, 21G/1-inch	20G/1.5- or 2-inch, 21G/1-inch
Injection volume	200 mg/mL; range 0.8 mL (160 mg) to 2 mL (400 mg)	2.4 mL (720 mg); 3.2 mL (960 mg)	276 mg/mL; range 1.6 mL (441 mg) to 3.9 mL (1064 mg)	2.4 mL
Injection interval (weeks)	4	8	4, 6, or 8	Not applicable
Starting dose	400 mg	960 mg	441 mg/4 wk, 662 mg/4 wk, 882 mg/4 wk, 882 mg/6 wk, 1064 mg/8 wk	Not applicable
Maintenance dose	300 or 400 mg/4 wk (adjust for CYP2D6 or CYP3A4 inhibitors; cannot give with CYP3A4 inducers)	720 or 960 mg/8 wk (adjust for CYP2D6 or CYP3A4 inhibitors; cannot give with CYP3A4 inducers)	Same as above (adjust for CYP2D6 or CYP3A4 modulators)	Not applicable
Oral dose equivalent	Blood levels with 400 mg comparable to oral aripiprazole 15–20 mg/day	Blood levels with 960 mg comparable to oral aripiprazole 15–20 mg/day	441 mg monthly \approx oral 10 mg/day; 662 mg monthly, 882 mg every 6 wk, or 1064 mg every 2 mo \approx oral 15 mg/day; 882 mg monthly \approx oral \geq 20 mg/day	Not applicable
Oral supplementation	14 days after initial injection, or 1 day if used with an additional IM 400 mg dose and one 20 mg oral dose	14 days after initial injection, or 1 day if used with an additional IM 400 mg dose and one 20 mg oral dose	21 days after initial injection, or 1 day when used with nanocrystal dispersion formulation and one 30 mg oral dose	One day of aripiprazole 30 mg
Stored refrigerated	No	No	No	No

**Risperidone Polymer
Subcutaneous 1+2 Month**

Risperidone Polymer SC 1-2 mo Clinical Snapshot

Approval Dates



Approved in 2023 for schizophrenia and maintenance treatment in Bipolar I monotherapy or adjunctive in 2025



Dosing

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

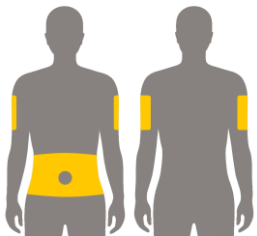
Initiation Regimen



No oral supplementation
Therapeutic concentrations occur within 6-24 hours



Administration



Subcutaneous

- Abdomen or Back of Arm
- 0.1 to 0.7 mL injection volumes
- RTU; stable 90 days out of fridge

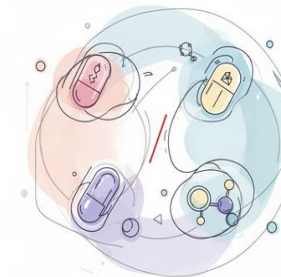


Efficacy

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



Safety

Most common adverse reactions were “EPS” and weight increase

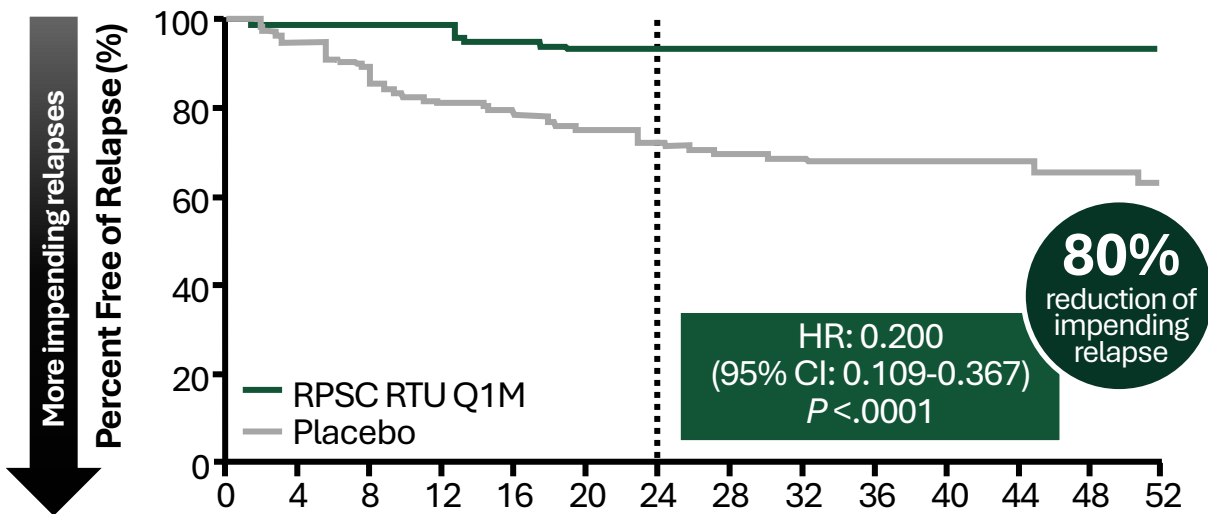
Discontinuation due to AE: 3% vs 11% placebo

AE=adverse event; RTU=ready-to-use; EPS=Extrapyramidal symptoms; NNT=number needed to treat

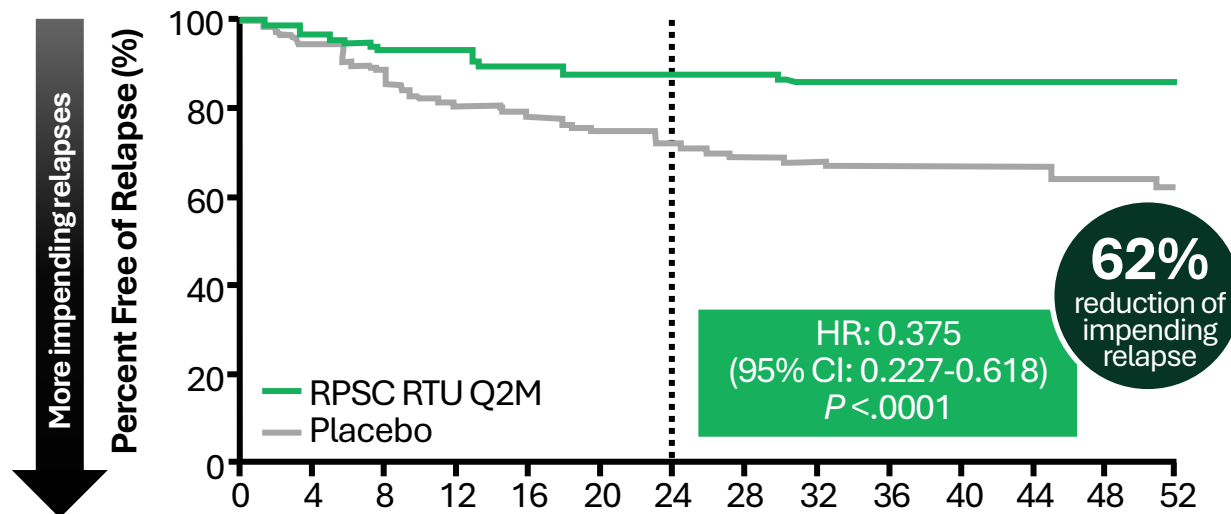
Uzedy (risperidone) [package insert]. Parsippany, NJ: Teva; 2023. Kane JM, et al. The Lancet Psychiatry 10.12 (2023): 934-943. Perlstein, I, et al. Switching Patients With Schizophrenia From Intramuscular Paliperidone Palmitate Once Monthly to TV-46000: Population Pharmacokinetic-Based Strategies. Poster Presented at Psych Congress; Oct. 29-Nov. 2, 2024; Boston, MA.

Risperidone Polymer SC 1-2 mo Clinical Data

Q1M Dosing
Risk of Impending Relapse



Q2M Dosing
Risk of Impending Relapse



	0	4	8	12	16	20	24	28	32	36	40	44	48	52
RPSC Q1M	183	178	169	156	144	131	124	112	106	94	89	77	68	61
Placebo	181	163	148	122	110	99	90	79	71	64	59	51	40	36

	0	4	8	12	16	20	24	28	32	36	40	44	48	52
RPSC Q2M	179	168	148	137	127	119	115	103	94	83	75	67	61	54
Placebo	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.

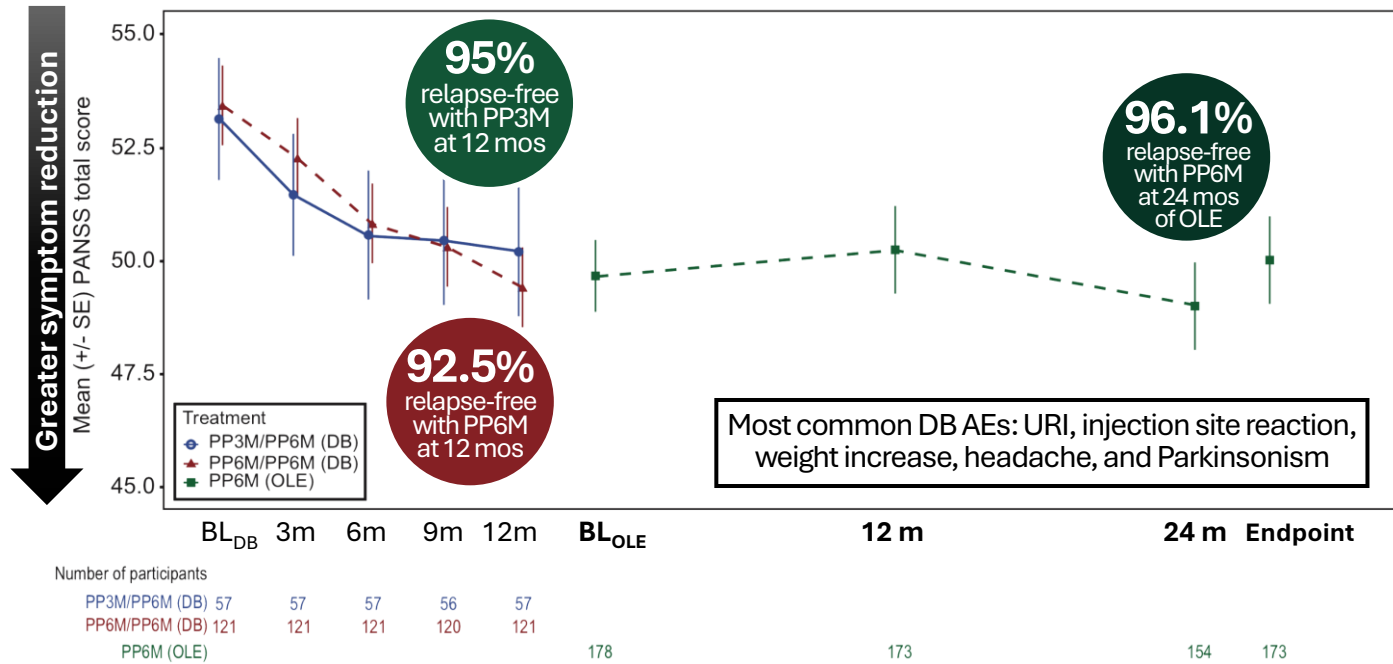
The 2nd initiation dose of PP1M can be given 4 days before or after the one-week point

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

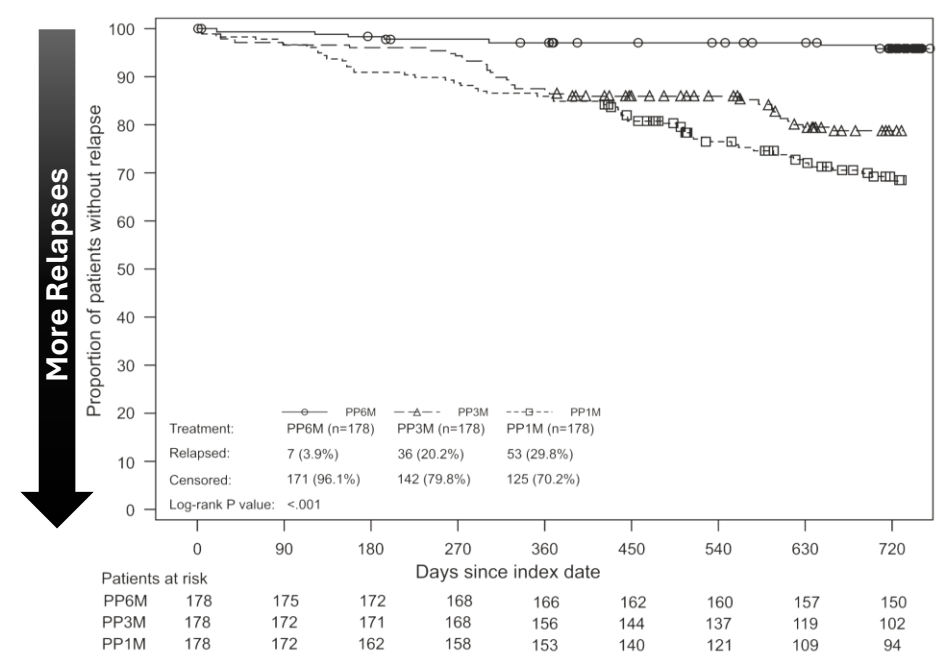
Common AEs for PP LAIs are generally:
 Injection site reactions, weight increase, headache, akathisia, parkinsonism, and prolactin increase.

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.

SC Olanzapine

Subcutaneous Long-Acting Injectable Olanzapine (TV-44749) for Adults With Schizophrenia

SOLARIS: First Phase 3 trial of SC olanzapine LAI

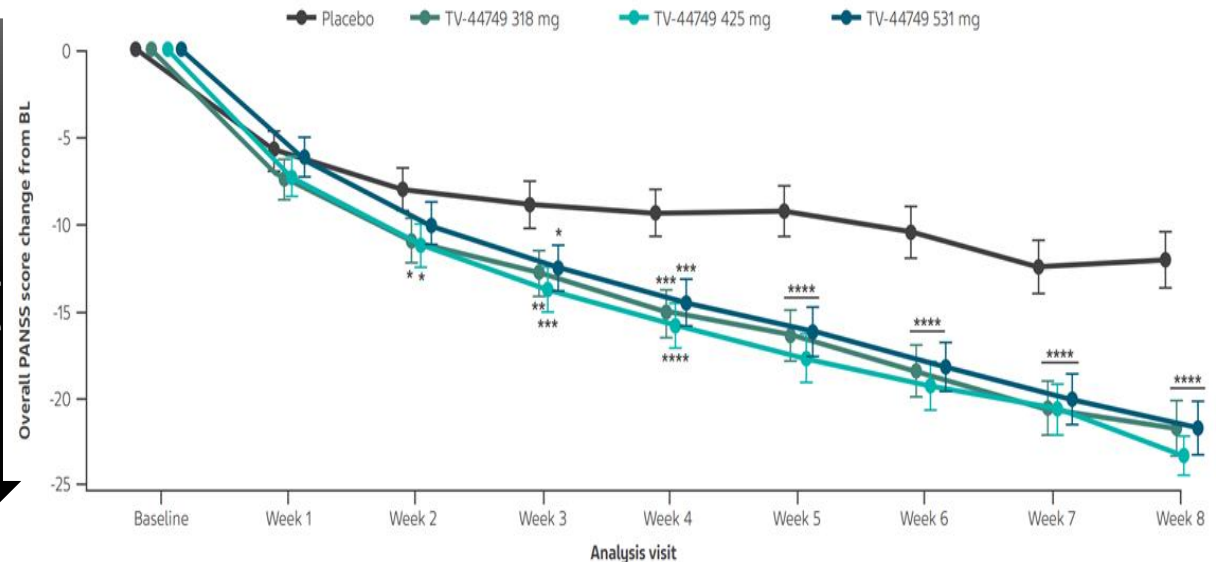
- Designed to eliminate PDSS risk seen with IM formulation
- Monthly doses: 318 mg, 425 mg, 531 mg (equivalent to oral 10, 15, 20 mg)

All TV-44749 doses exhibited long-term, continuous symptom improvement and maintenance of clinical effectiveness in Period 2 of the SOLARIS trial.

- TV-44749 provides long-term, effective subcutaneous LAI olanzapine treatment for adults with schizophrenia with **no suspected or confirmed PDSS events following 3470 injections.**



Greater symptom reduction



* $P < 0.05$; * $P < 0.01$; * $P < 0.001$; * $P < 0.0001$. Statistical significance was met beginning at week 2 for 318 mg ($P = 0.0276$) and 425 mg ($P = 0.0146$), and also at week 3 for 531 mg ($P = 0.0110$) versus placebo. Statistical significance was maintained through week 8 for all doses. Horizontal bar and asterisks indicate that all TV-44749 doses were significantly different versus placebo ($P < 0.0001$).

PDSS = Post-injection delirium/sedation syndrome

Cherniakov, I., Wagner, A. M., Eshet, R., Tiver, R., Bibi, D., Perlstein, I., Kalmanczhelyi, A., Sharon, N., Cohen, G., Ferderber, K., Roberts, J., Elgart, A., Gutman, D., & Rabinovich-Guilatt, L. (2026). Safety, Tolerability, and Pharmacokinetics of Subcutaneous Extended-Release Injectable Olanzapine in Patients with Schizophrenia and Schizoaffective Disorder. *Clinical drug investigation*, 46(3), 307–320. <https://doi.org/10.1007/s40261-025-01507-x>

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
- **SC Olanzapine**
 - Designed to eliminate PDSS risk seen in IM olanzapine
 - In a Phase 3 study, after 3470 injections, PDSS events were not suspected or confirmed in any participant
- **LAI 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.**

Enhancing LAI Uptake: Patient Engagement and Communication Strategies

Motivational Interviewing and Shared Decision-Making Techniques

Three-Talk Model for Shared Decision-Making

DECISION TALK

Collaboratively finalize the treatment decision, ensuring that patients feel **validated** and confident about their choice, while reaffirming their role in the decision-making process.

TEAM TALK

Build **collaboration and respect** by empowering patients, identifying their priorities, and fostering an environment where their autonomy and concerns are acknowledged during the decision-making process.

OPTION TALK

Provide a balanced overview of treatment choices, utilizing **numerical data** and discussing both positive and negative aspects of options, including the choice of "no treatment" when appropriate.



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?”

Re-engaging After Initial Refusal or Ambivalence

When patients initially refuse, **maintain a nonjudgmental, collaborative approach.**

Key strategies include:

- **Keep the door open:** Arrange follow-up to reassess readiness, as patient preferences may evolve with trust-building and education
- **Explore the refusal:** Use MI techniques to understand specific concerns—is it fear of needles, perceived coercion, lack of information, or logistical barriers?
- **Offer trial periods:** Some patients may accept trying one or two injections to evaluate tolerability before committing to long-term
- **Ensure samples are available:** Having LAI samples readily available in clinical settings facilitates acceptance when patients become willing
- **Repeatedly recommend:** Persistence matters—patients may need multiple conversations before accepting
- The 2023 VA/DoD guidelines suggest offering LAIs to improve medication adherence, acknowledging that patient values and preferences vary widely based on individual concerns about needles, clinic visits, and daily medication burden.

Addressing Patient Concerns and Misconceptions

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.”



Integrating LAI Planning into Virtual and Hybrid Care Models

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**

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 4 Learning Lab Stations in the Exhibit Hall (Ryland Hall)

-  Station 1: Booth #126 Hands-On Practice of Injection Techniques
-  Station 2: Booth #127 Hands-On Practice of Injection Techniques
-  Station 3: Booth #128 Educational Posters on Long-Acting Injectables
-  Station 4: Booth #129 Motivational Interviewing and Telehealth Practice

STEP 3: Receive Your Certificate! 

Attendees who visit all 4 interactive booths will earn a LAI360 Certificate. Due to the location of the learning lab in the exhibit hall, the activity is NOT accredited. The certificate earned just demonstrates an attendee's completion of an interactive course on long-acting injectables for schizophrenia.

DATES/TIMES

Thursday, March 19
4:40 PM – 5:40 PM

Friday, March 20
10:00 AM – 11:30 AM
4:20 PM – 5:20 PM

Saturday, March 21
10:00 AM – 11:30 AM

