Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/best-practices-use-long-acting-injectables-bipolar-disorder-part-2/12982/

Released: 11/23/2021
Valid until: 11/23/2022
Time needed to complete: 30 minutes

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Best Practices in the Use of Long-Acting Injectables in Bipolar Disorder – Part 2

Announcer:
Welcome to CME on ReachMD. This activity, entitled “Best Practices in the Use of Long-Acting Injectables in Bipolar Disorder – Part 2” is jointly provided by Novus Medical Education and Medical Education Resources and is supported by an independent educational grant from Otsuka America Pharmaceutical, Inc.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the Learning Objectives.

Dr. McIntyre:
Hello. I’m Roger McIntyre, Professor of Psychiatry and Pharmacology, University of Toronto, and I’m pleased to welcome you to our session today, entitled, “Best Practices in the Use of Long-Acting Injectables in Bipolar Disorder.” Throughout my career, I have been implementing long-acting injectables in people who have bipolar disorder, and throughout that time, there are common scenarios that I’ve encountered with patients, vis-à-vis, how to have that discussion, and what are some of barriers, some of the attitudinal barriers, and some of the implementation barriers to implementing long-acting injectables in bipolar, and what we’re going to do today is we’re going to have some provider-patient scenarios that I frequently come in contact with, that we want to share with you to help you, in fact, learn more about long-acting injectables, but also how to address some of these very common scenarios that emerge when having discussions with our patients about long-acting injectables in bipolar. And I’m very pleased to welcome Frank. Frank, nice to see you again. I just was reviewing your health record, as well as your medication. I know that you’ve had the diagnosis of bipolar I disorder now, from what’s in the chart, about three years, and there’s a number of different medications that you’re taking. And I was asked to see you today to really see how things are going.

Frank (Dr. Raison):
Well, you know. I – as you know, I had to move recently. That last manic episode, I made such a fool of myself, and I can’t even see my old friends. But, you know, I’ve been struggling. I’m kind of feeling down, but like not cataclysmically depressed. I don’t feel suicidal or anything, but yeah, so, I don’t know.

Dr. McIntyre:
And during the last, say, year, we haven’t seen you here in the clinic for quite some time. I noticed that your medications are being renewed some of the time, but we don’t have all of the records. Are you taking your medications on a regular basis?

Frank (Dr. Raison):
Yeah. Yeah. Yeah. Yeah. Yeah. Yeah. Yeah.

Dr. McIntyre:
I noticed from the count of medications, you’ve been prescribed three different types of medications for bipolar disorder. Can you tell me if you’re able to take all three of them during this period of time?

Frank (Dr. Raison):
Yeah, yeah, yeah, I don’t know. You know, yeah, I’ve been, yeah. Yeah, pretty much, pretty much.

Dr. McIntyre:
Frank, what I'd like to do, just to give myself a benchmark is really get a percentage. What percentage of the time have you been taking each of these three medications during the past, say three to six months?

Frank (Dr. Raison):
God, I – yeah, this is part of my problem, doc. Honestly, you know, I – I don't know. My memory is not what it was. I don't know, I – the lithium is the hardest for me. It makes me shake. At least half the time, I would say, I'm taking the lithium.

Dr. McIntyre:
What about the other two that you're taking also? You have an antipsychotic, and I notice a medication for your depression as well.

Frank (Dr. Raison):
Yeah, yeah. Well I, you know, I'm better with the antidepressant. I don't know, the antipsychotic, same thing, it just makes me feel so sleepy. That one, a couple days a week, probably. The antidepressant I'm pretty good with. I probably do that five or six days a week, I would say.

Dr. McIntyre:
Okay. So most people that we see here in the clinic, Frank, take their medications between 20 to 50% of the time, so would you say that's around the same range you're taking it?

Frank (Dr. Raison):
Whew, yeah…

Dr. McIntyre:
A little bit lower than that?

Frank (Dr. Raison):
No, no, no, no. I don't know. Probably yeah, that's probably about right.

Dr. McIntyre:
And do you have a sense, and sometimes people do, often they don't. What are the, maybe, reasons you don't take it more, like say, 75% of the time, or more than that?

Frank (Dr. Raison):
I don't know, I get busy, I don't know. I forget, you know, it's – I forget my antibiotics, right?

Dr. McIntyre:
Right.

Frank (Dr. Raison):
And then, you know, it's hard. Having to think about taking it every day, it just, I don't know, reminds me of that manic episode, to be honest with you.

Dr. McIntyre:
And would you say forgetfulness has been probably the enemy of the state here? Has that been the biggest problem?

Frank (Dr. Raison):
Yeah, probably. I mean, I don't ever want to have another one of those manic episodes like that last one. It was just, lost pretty much everything, so I – it's just hard.

Dr. McIntyre:
And of the three medications that you're prescribed, are there any one of these medications you think are absolutely critical, for you to keep well?

Frank (Dr. Raison):
Well, it was stopping the antipsychotic, probably, that did me down, and set me off for the last manic episode.

Dr. McIntyre:
Okay. If you haven't already figured this out, this is my good friend and colleague, Dr. Charles Raison. Charles, introduce yourself.

Dr. Raison:
Jeff Raison, I'm a Professor of Psychiatry at the University of Wisconsin, Madison. I've seemed to have – I really enjoy doing these sort

of – these role plays. They're really, actually, quite educational, I think, right?

Dr. McIntyre:
It really is. I think nothing's more educational than trying to put yourself in the minds of your patients….

Dr. Raison:
Yeah, really. That's right, you know, and the embarrassment, in this case, of – this is a person who knows he needs to take the medicine.

Dr. McIntyre:
Yup.

Dr. Raison:
He's freaked out about what's happening.

Dr. McIntyre:
That's right.

Dr. Raison:
But like all of us, he's struggling, and he doesn't want to 'fess up that he's not, you know, living up to your expectations. But it does, it opens a door for a discussion about other ways to enhance adherence.

Dr. McIntyre:
And for me, Chuck, what I've done over the years is I've just had a working premise that people take medications on a percentage spectrum.

Dr. Raison:
That's right.

Dr. McIntyre:
And just leave it open.

Dr. McIntyre:
Yeah.

Dr. McIntyre:
It's nonjudgmental. Just, hey, listen, look, you know, I rarely meet anyone with 100% batting average. Let's just find out where you're at and let's work together on that.

Dr. Raison:
That was a key move, right? So when you said, you know, 20 to 50%, that was beautiful, and you said below that, it kind of gave me a chance to go, "No." You know, this guy was probably hitting 30%.

Dr. McIntyre:
Yeah.

Dr. Raison:
Something like that, right? But obviously, 30% puts him at huge risk for relapses.

Dr. McIntyre:
That's right. And for me, when I hear that, then my next, sort of, job is, okay what are some of the reasons? What's the barriers? What are the facilitators there? And so I'm getting into the conversation – obviously not exhaustive – but beginning to get some of the top-line reasons for that nonadherence.

Dr. Raison:
Exactly. And in this case, the gentleman – it was really, kind of inertia, right?

Dr. McIntyre:
Yeah.

Dr. Raison:
He had insight, but it was inertia.

Dr. McIntyre:
That's right. And that's a great word. I have found that to be very, very common, and the positive is, it's malleable because inertia is not no. Inertia is inertia, and that's where the motivational interviewing, the engagement, the therapeutic alliance comes in.

Dr. Raison:
Exactly.

Dr. McIntyre:
Okay, let's now speak to another scenario, which I very commonly encounter, and that's persons who have bipolar disorder, who might be candidates for long-acting injectables, who are struggling with the need for long term care for bipolar disorder. Frank? Welcome back …

Frank (Dr. Raison):
Hey, how ya doing, Dr. Mac. I am glad to see you.

Dr. McIntyre:
Frank, really nice to see you for today's session.

Frank (Dr. Raison):
Good. Cool. So what are we doing?

Dr. McIntyre:
Well, we wanted to sit down today and have a discussion about taking treatment during the long term. I think you had …

Frank (Dr. Raison):
Cool.

Dr. McIntyre:
You'd made a call to the office, and you wanted to discuss this?

Frank (Dr. Raison):
Well, yeah, I just, you know, I don't… So, you know, I was feeling so depressed, but I, you know, it's weird. I feel better. I feel so much better, that I don't think I need the long term treatment. I was so depressed, I couldn't get out of bed, but now I'm just ready to go, and I've got some ideas, and you know, I don't want to do anything that might mess things up. But I wanted to call you first, because I, I don't know, I feel kind of sad. I just wanted to inform you, so you'd be aware.

Dr. McIntyre:
It sounds as though some of the symptoms of bipolar might be coming back.

Frank (Dr. Raison):
And I – no. What?

Dr. McIntyre:
Well, you know, some of the – I noticed you're a bit more animated today, talking about…

Frank (Dr. Raison):
Yeah, but that's a good thing, isn't it? I mean, I don't know. I just, I, you know. So anyway, I think, you know, I've been taking the medicine, but I've stopped in the last couple days, because like you say, I feel better, so I think I'm set. I think I'm fine.

Dr. McIntyre:
Let me ask this question. During our last appointment, you were mentioning that you do believe you have bipolar disorder. Is that still the case?

Frank (Dr. Raison):
Well, yes, I – I, you know, I mean I was clearly depressed.

Dr. McIntyre:
Yeah.

Frank (Dr. Raison):
There's no doubt about that, and you know, so I mean, you know…

Dr. McIntyre:

That's clearly changed.

Frank (Dr. Raison):
Yeah. Clearly. You know. And so, yeah, I don't know. But yeah.

Dr. McIntyre:
And do you think that you need long term treatment?

Frank (Dr. Raison):
Well, you know, see, this is the thing. I don't think so, because I'm feeling so much better right now.

Dr. McIntyre:
So, what do you think would happen if you were to stop all of your medications then? What would be your – would you have any concern with that?

Frank (Dr. Raison):
Well, no, I think I'd be fine, probably. I mean, like I say, I'm feeling so much better, that I don't think this would be a problem. You know, I don't, you know. My wife's kind of worried about me, so that's another reason I called, because she thinks I'm getting a little bit manic. So, I don't know. You know.

Dr. McIntyre:
So she has justified concerns. So what would happen then? What do you think your risk would be if you don't take any medication over the next, say, year or two years?

Frank (Dr. Raison):
Well, I don't know. I mean, that's an interesting question. I, I, I don't know. You know, I mean, I don't want to end up back in the hospital again. I mean, that's one thing for sure. That was a terrible experience.

Dr. McIntyre:
That was awful.

Frank (Dr. Raison):
Horrible. Horrible. I mean, I just, I, I don't want to do that again.

Dr. McIntyre:
And that was a long admission, as well.

Frank (Dr. Raison):
That was a long admission. Yeah, that was a bad one.

Dr. McIntyre:
Well, I'm glad you still have that concern. The medications – do they cause you any side effects or anything like that?

Frank (Dr. Raison):
Uh, no, I – I mean, they were okay. They were okay. You know. Nah, that was – that wasn't a problem, I just – I just started feeling so much better, I thought maybe I, you know, maybe I don't need them.

Dr. McIntyre:
So do you feel you're back to your regular self again at this point?

Frank (Dr. Raison):
Well, I – no, I'm a little bit, you know.

Dr. McIntyre:
Yeah.

Frank (Dr. Raison):
I'm a little bit excited.

Dr. McIntyre:
Yeah. So you actually don't really think you need long term treatment for bipolar disorder?

Frank (Dr. Raison):

I, well, um, I don't know. My wife was kind of giving me trouble this morning.

Dr. McIntyre:
Sounds like you guys are not on the same page on this one.

Frank (Dr. Raison):
Yeah, yeah. And you know. She's been my rock, so I don't know. I definitely do – I don't want to do anything that might risk that relation – I mean, that's such an important thing to me. I just, you know. That's really important, so I, I, you know. I don't know. I mean, what do you think?

Dr. McIntyre:
Well, I will come back to that. I have a few thoughts on that, but let me just finish my other thought, and that being, do you feel you need to take medications all the time, or just some of the time?

Frank (Dr. Raison):
Um, well, I was taking the medicine all the time. You know, it's just that I felt better now, so I – I mean, for quite a while, you know, Dr. McIntyre, I was like a star patient. I was definitely taking the medicines, so…

Dr. McIntyre:
Well, I remember you gave that lecture to the medical students.

Frank (Dr. Raison):
Yeah, exactly. I mean, you invited me in and I talked about that, so I, you know…

Dr. McIntyre:
They're still talking about that last session you did.

Frank (Dr. Raison):
Well, thank you. That – that's really good, but, so, you know. I mean, I remember what I said. I said you need to keep taking the medicine, you know, regularly because, you know. I mean, the last manic episode was because I'd stopped – stopped taking the medicine, so, I don't know. I mean, yeah, maybe – maybe. I did say that.

Dr. McIntyre:
Well, this is actually a really common situation that Frank and I were role-playing. Of course, this is Chuck, and we're talking about a situation we've commonly encountered, where I would describe one of, really, an appraisal of risk, where many people with bipolar disorder, they have insight. They recognize they have bipolar I disorder. The treatment may have helped them acutely, but they don't really think that they really need long term treatment. They've appraised themselves as being at minimal risk.

Dr. Raison:
Right. And of course, the risk is worse when people are manic. I mean…

Dr. McIntyre:
Yeah.

Dr. Raison:
The classic thing of mania is people lose that, sort of, awareness of a disease state. So especially – I always find this. It's a very difficult one, you know. I mean, this one was fortunate because he had some sort of rocks that you could grab on to.

Dr. McIntyre:
Right, right.

Dr. Raison:
The wife, for instance.

Dr. McIntyre:
Good insight.

Dr. Raison:
Yeah. He had insight, you know, and then that allowed you to sort of key in and you could see Frank beginning to – there was that waffle there.

Dr. McIntyre:

Yeah.

Dr. Raison:
That you were able to grab hold of.

Dr. McIntyre:
That's right.

Dr. Raison:
And he's a lucky man.

Dr. McIntyre:
That's right.

Dr. Raison:
Because otherwise, he's heading back to the psych hospital. He was ramping up like crazy.

Dr. McIntyre:
You know, I've struggled with this, because it almost becomes almost an impasse, because the patient has decided that they are in a non-risk category for relapse recurrence, and that they've overestimated their resiliency, so to speak.

Dr. Raison:
Yeah, absolutely.

Dr. McIntyre:
And underestimated the risk. So I find that I've just had to go to psychoeducation 101, and just keep pounding that, obviously trying to maintain an empathic engagement with my patient.

Dr. Raison:
Yeah. Which you did very, very well. That's exactly right. And that's definitely the trick with this.

Dr. McIntyre:
Yeah. And, in your practice, Chuck, you've seen lots of patients in your career. This situation comes up very commonly.

Dr. Raison:
Very common.

Dr. McIntyre:
A couple of tips for our participants today?

Dr. Raison:
Yeah, well, do what you did, and look for any – you know, look for any kind of leverage that you can find in there that would help a person, especially somebody like this, who's escalating up, because this is going to be an emergent situation for this guy.

Dr. McIntyre:
Yeah.

Dr. Raison:
So any handle, any leverage you can get, to do the very simple thing of getting them to start taking their medicine, and of course, this is a classic example of – this gentleman, when he gets down a little bit, and his awareness and his insight returns, that would be a time that would be really important to talk about an LAI, right. Right. So it's interesting, because here, there was probably a first step that needed to be made, which was he needed to get back on his medicine right away.

Dr. McIntyre:
Yeah.

Dr. Raison:
But then, this is an example of how, when his mood begins to escalate up, he needs protection. He needs protection from where he was when he came into your office.

Dr. McIntyre:
So we talk so much about striking when the iron is hot or the iron is cold. This is about striking during that window, that lacunae, if you will, of insight – those times, and trying to work with people because insight is a very fluid phenomenon for many people with bipolar

disorder, and that's a great opportunity to work with that, leverage that. But obviously, keep the patient coming back and keep that engagement, and it has to be a shared decision process, to make this work for the patient in the long run.

Okay. Let's now look at a very common scenario in my experience, and no doubt yours, and that's patients who believe there's a stigma with taking long-acting injectable antipsychotics. Comes up very frequently in my conversation. Frank, welcome back to the clinic. Nice to see you again.

Frank (Dr. Raison):
Thank you. Good to see you again, Dr. McIntyre.

Dr. McIntyre:
Now, I know that you're meeting with the team, and I was chatting with the team this morning before you came. I think you had raised some concerns about taking a long-acting injectable for your bipolar I disorder.

Frank (Dr. Raison):
Yeah. Oh, man, you know, the optics in that are just not good, Doctor. I don't know, I mean, it – I remember when I was in the psych hospital, you know, back now, a couple few years ago, and, um, I saw some really sick schizophrenic people, getting those shots.

Dr. McIntyre:
Mm-hmm.

Frank (Dr. Raison):
And, you know, they were stiff. I just – I just, and you know, and I – I don't know. It just makes me feel like I'm a total loser, frankly.

Dr. McIntyre:
So, and that's important to say that, and I'm glad you expressed that with me, and say more about that in the inpatient unit, when you were there, something was a very traumatic experience. What is it about that? Is it – say more about what's affecting you so much.

Frank (Dr. Raison):
Yeah, I just, you know, the idea of taking a shot just, you know, is sort of like a condemnation, right? It's like, you know, it's one thing to take a pill, although I, you know, the one thing I did tell the people, this morning when I was meeting with the team is, you know, it's also a drag to have to take all these pills every day. Right?

Dr. McIntyre:
Yes.

Frank (Dr. Raison):
I mean, that – I recognize that, but I just, you know, it just seems like going in and – it just – it makes me feel like, like I'm really, really sick. Like I'm even more abnormal than I already feel.

Dr. McIntyre:
I worked at an inpatient unit for many, many years, and often patients get needles because of – you know, it's almost like they're being put into restraints, and so on. It's a punishment that some people see this as.

Frank (Dr. Raison):
Well, that – and you know, I mean, maybe you don't know. That happened to me.

Dr. McIntyre:
Oh, I didn't know that. Okay.

Frank (Dr. Raison):
Oh, yeah. So I was – I came in, you know, and I was really manic. I mean, I had no insight, and you know, I took a swing at one of the nurses, and the next thing I knew, I was in four-point – you know, what do they call it? Four-point restraints, is that what they call it. Yeah.

Dr. McIntyre:
Four-point restraints, yep. Absolutely, yeah.

Frank (Dr. Raison):
And they injected me with, what is that? Hal…

Dr. McIntyre:

Oh, Haldol. Yeah, yeah.

Frank (Dr. Raison):
And, oh, it was so – you know, to be honest with you, there is that, too.

Dr. McIntyre:
So that's a very traumatic experience.

Frank (Dr. Raison):
Yeah, so I'm like, you know, it's like I have post-traumatic stress disorder…

Dr. McIntyre:
Right.

Frank (Dr. Raison):
Over needles, so, you know. So it's hard.

Dr. McIntyre:
A lot of people have talked about how humiliating it is, you know, when they have their trousers taken down, they're putting a needle in. That often happens in the inpatient.

Frank (Dr. Raison):
Yep.

Dr. McIntyre:
Was that part of this for you as well?

Frank (Dr. Raison):
Yeah. Oh, definitely.

Dr. McIntyre:
Yeah.

Frank (Dr. Raison):
Yeah. I mean, you know, it's interesting. You're a good psychiatrist. I hadn't talked about that this morning with the team, but that is part of it with me, yeah.

Dr. McIntyre:
Yeah. Do you have any other concerns with respect to, for example, how people think about you, or is there other aspects? I want to hear more of the other, sort of, concerns about just the – you know, the stigma of taking these types of medications.

Frank (Dr. Raison):
Well, I mean, where would I get the shots? Would it be in – I mean, it would be a private thing, wouldn't it?

Dr. McIntyre:
Yeah, you have to come here to the clinic, and one of our team would provide it for you, on a monthly basis, for example.

Frank (Dr. Raison):
Yeah, yeah. So it's not, I mean, other people wouldn't necessarily know about it. I mean…

Dr. McIntyre:
No.

Frank (Dr. Raison):
But people know…

Dr. McIntyre:
Sure.

Frank (Dr. Raison):
I mean I – I've talked to people about this. Yeah, I guess in my case, it really is this sort of felt sense, that it just – you know, it's like, it's like it's a bigger thing to get a shot for something. It just – it just feels, you know, like it's hard.

Dr. McIntyre:

When you were here last time, Frank, you had mentioned you'd been going to a bipolar support group. Do you know anyone who has bipolar, who takes needles and if so, have you heard any experience, bad or good or anything like that?

Frank (Dr. Raison):
Hmm, that's an interesting question. Um, I knew there was one lady, who was doing the needles, and she said it was fine.

Dr. McIntyre:
Hmm.

Frank (Dr. Raison):
Um, it's not something people talk about very much, is it?

Dr. McIntyre:
Not so much as they should. You know, for example, the DBSA – Depression and Bipolar Support Alliance – we have chapters across America. It's virtual, telehealth, and there's opportunities through peer support to learn more about taking treatments, including long-acting injectables. And that's why I was curious because sometimes, people find it a very positive experience to hear it refrained, or hear it presented by someone else who's functioning quite well.

Frank (Dr. Raison):
Would you – would you be able to provide me, like some kind of contact where I could talk to people about it?

Dr. McIntyre:
Oh, absolutely. I'm happy to provide the resource for the DBSA and you can hear more about it. This is one peer support area, to hear more about, not just long-acting injectables, but other treatments for bipolar disorder.

Frank (Dr. Raison):
Okay. Well, let me think about it.

Dr. McIntyre:
Okay. That's great.

Okay, well, again – so obviously, Frank is my good friend, Chuck Raison, and this is a very common scenario, Chuck as you know…

Dr. Raison:
It is.

Dr. McIntyre:
…and is one that is understandable. It has a long history, and unfortunately, a very checkered history in psychiatry, the use of needles and so on. So people have an understandable reaction to that. But my experience has been that it's not a deal-breaker, for most. It can be.

Dr. Raison:
Yeah.

Dr. McIntyre:
But it's one that does require, I think, a fair bit of direct, frank, and really empathic discussion with patients.

Dr. Raison:
Oh, absolutely. You know, and it can be a variety of reasons. Some people are more publicly – you know, it's interesting, I mean, in this scenario, we chose a guy who had been, you know, medicated against his will…

Dr. McIntyre:
Yeah.

Dr. Raison:
…with a needle. You know, that's – I wonder if we ask about that enough, right? A lot of people that have, you know, really significant bipolar disorder will have had a manic episode.

Dr. McIntyre:
Yeah. Absolutely.

Dr. Raison:
So, you know, like you, it's funny, I ran the UCLA inpatient service for years, and my Friday – my 5:00 activity was usually standing over

some poor person that was being put in four-point restraints.

Dr. McIntyre:
Yeah. Yeah, sure.

Dr. Raison:
And, you know, if people have memories of that when they come into a normal mood state, that's hard.

Dr. McIntyre:
Oh, it's absolutely humiliating…

Dr. Raison:
I know a lot of people that have sort of PTSD symptoms from that, and you know, sometimes you've gotta do it in the hospital, though.

Dr. McIntyre:
Yeah, sure.

Dr. Raison:
I mean, it's a no-win. But there's an example of something where – because you sort of queried me, I …

Dr. McIntyre:
Yep. Yeah.

Dr. Raison:
Had you not asked, I wouldn't have said.

Dr. McIntyre:
Right.

Dr. Raison:
So that was a really sharp move.

Dr. McIntyre:
Well, you know, I've noticed people feel very humiliated, uh, by this, understandably. It's also traumatizing. Um, and one of the aspects, as you know, Chuck, with bipolar disorder is that people don't like meds to control their moods, their thoughts, their behaviors.

Dr. Raison:
Yeah.

Dr. McIntyre:
And in this – kind of has that sort of association for many people.

Dr. Raison:
It does, yes.

Dr. McIntyre:
Right?

Dr. Raison:
Yes, it does.

Dr. McIntyre:
It's like a lack of control.

Dr. Raison:
It's kind of a "One Flew Over the Cuckoo's Nest" kind of feeling, right?

Dr. McIntyre:
Yeah.

Dr. Raison:
All of a sudden, you're pulling in, which the – Frank in the scene, was trying to articulate a little bit of this sort of, all of a sudden, you're into some sort of more …

Dr. McIntyre:

Yeah.

Dr. Raison:
Yeah. You know.

Dr. McIntyre:
You know what I've found, Chuck, is that conversely, I find patients will tell me that when they take LAIs, they feel that they're more in control of their mood, rather than the medications controlling, orally every day. Because they take their medications every day, there's that daily reminder, it's controlling my mood. The once a month is almost a bit of a, kind of a locus of control enhancer, if you will.

Dr. Raison:
Yes. That makes perfect sense. And of course, you know, these medicines have acute effects. You know, you take a medicine in the morning, and you take it, and you know, you feel a little sleepy, you feel a little bit funny. You know, whereas with an LAI, you've got this, sort of… It's like a background thing – you're right.

Dr. McIntyre:
Yeah.

Dr. Raison:
You can safely do a little bit more ignoring…

Dr. McIntyre:
That's right. That's right.

Dr. Raison:
…of your treatment. And that's a very powerful thing.

Dr. McIntyre:
One final point, Chuck, is that I've noticed in my career that patients have a surplus of horror stories, and they have a deficit of positive stories around the medications.

Dr. Raison:
Yeah.

Dr. McIntyre:
And I find that peer support can often be an opportunity to, maybe, augment the positive. Not Pollyanna, but a different framework around …

Dr. Raison:
Absolutely. Because, you know, so many patients, especially with bipolar disorder, just credit these medicines with saving their life.

Dr. McIntyre:
Yeah, sure. Sure.

Dr. Raison:
Yeah, absolutely.

Dr. McIntyre:
Okay. Let's look at this last case scenario, and this time, what we're going to do – both Chuck and I – we're just going to discuss this out loud. This is a situation I very frequently encounter, where people just don't even know that long-acting injectables are an option, and quite frankly, Chuck, this is where maybe my own bias comes in, because when I trained, I guess it was more conventional training, long-acting injectables meant you had late-stage, tertiary bipolar. You were non-adherent…

Dr. Raison:
Oh, yeah.

Dr. McIntyre:
You had very – you know, treatment failures all over the place. And no, clearly that person could still be a candidate for a long-acting injectable, but increasingly, I use long-acting injectables earlier in the illness trajectory. Right out of the gate when I first diagnose someone with bipolar, I lay the options all on the table and say, "These are the options, including LAIs."

Dr. Raison:

I think that's exactly right. You know, I mean, we know, I think, from just, you know, tons of data that early in these psychotic disorders – disease states – stopping the recurrence of symptomatic episodes is hugely protective of the brain. There's like that window, right? So that is the time when adherence is key, right?

Dr. McIntyre:
Yep.

Dr. Raison:
And it's also the time when people are often likely to quit, because, you know, so they have an episode and you treat them, and they get better. And then they truly do feel, well, you know, hey. I had one thing, and so I got – I don't want to keep taking this. I'm going to be okay.

Dr. McIntyre:
Yeah.

Dr. Raison:
Boom. Then they have another one, and then there's – you know. As we talked about, you and I have both worked on inpatient units. You see the people coming back from a first episode, to a second, to a third, and you see them deteriorating and going down and losing insight, and so there, especially, it's valuable to get something onboard, where that coverage is there, and they're not going to, you know, just stop it. Sort of (finger snap) like that. Absolutely.

Dr. McIntyre:
Yeah, and you know what's interesting to me, is I've had patients now say to me, in so many words, that taking a treatment once a month, versus daily – making decisions daily versus once a month, they say this is kind of a no-brainer. I want to take it once a month. And these are people who, frankly, are taking their medications religiously, and on a regular basis. And in fact, the next question I often get from people is – or receive from people is, "Are there other – why can't I have lithium like this? Why can't I have anticonvulsants like this?" So in other words, it does seem like that there's an openness to it, and then that's followed up with, "Why has anyone not told me this before?"

Dr. Raison:
Yeah. Well, I mean, let's face it. I mean, we don't talk about it much. Right? I mean, it really is terra incognita, especially for bipolar disorder.

Dr. McIntyre:
Yeah.

Dr. Raison:
Right? I mean, you know, you're talking about the old days. Remember the Prolixin shuffle, right?

Dr. McIntyre:
(laughs) Sure.

Dr. Raison:
You know, you'd see these folks that would be on these high-potency old agents, and I mean, I trained in the early 90's and I – this was my sort of memory of these agents, right? So the fact that there's been this sort of huge sort of technological development.

Dr. McIntyre:
Yeah, yeah.

Dr. Raison:
That we have these new agents that don't have those side effects, you know…

Dr. McIntyre:
That's right.

Dr. Raison:
And that we have now agents that have extended periods of coverage. So you, you know, not like you're going in and getting a shot every couple of weeks. I just think we don't talk about it enough.

Dr. McIntyre:
Yeah, I think that's true, and you know, it's interesting that you mentioned Prolixin, because over the years, I remember when I first

started my career, I used to use a lot of the first generation. That's what we had at the time.

Dr. Raison:
Yeah.

Dr. McIntyre:
And the first generation, antipsychotic, long-acting injectable for bipolar are linked to a higher risk of depression. And one of the points I try to press with patients and families is, with the long-acting injectable second generation, we don't see that. We don't, we see a lower rate of EPS, lower rate of depression induction. In fact, these drugs don't cause depression.

Dr. Raison:
No, in fact, they often treat depression…

Dr. McIntyre:
Absolutely.

Dr. Raison:
They can be augmenting agents for depression.

Dr. McIntyre:
Absolutely. And that's a huge difference, and you know what I've noticed as well, when you sit with someone with bipolar who's had one or two episodes, versus someone who's had, say, ten episodes – that's a different person you're sitting with. You can just tell. The social cognition, the timing, the attunement. And what I have found with the LAIs is it gives people an opportunity for the better trajectory, and perhaps reduce some of that progressive damage over time.

Dr. Raison:
Yeah, exactly. I mean, that's, certainly if you look in the schizophrenic world, taking antipsychotic agents early in the illness is a huge protector against relapse, right? I mean, in some of those early relapse studies, they had to stop the studies, because the people would stop taking the agents. Had relapse rates that were just ethically unacceptable. Again, so it goes to this point, that really, you know, there's no time where adherence is more important than when it first starts up.

Dr. McIntyre:
Oh, absolutely. Absolutely. So, during this session, we've been talking about LAIs, and we're in a new time in psychiatry medicine, broadly with more technology, and apps, and virtual reality, even you know, all kinds of technologies are entering into our world. We talk about "just in time medicine." And really, long-acting injectables are the ultimate in just in time medicine, in the sense that the medication's there when you need it, because you're taking it.

Dr. Raison:
Right.

Dr. McIntyre:
And it also makes life easier when you have symptom breakthrough, because we know what the cause is. It's either – it's not adherence, right?

Dr. Raison:
That is a key point that we haven't touched upon, because so often, you know, people begin to have a relapse, and you don't know if it's the progression of the disease, or is it just that they're not taking their medicines…

Dr. McIntyre:
Absolutely.

Dr. Raison:
Cordoning off 50% of that dilemma is huge…

Dr. McIntyre:
Yeah.

Dr. Raison:
… in terms of understanding what to do next.

Dr. McIntyre:
Absolutely. Chuck, we've covered four scenarios in this.

Dr. Raison:
Yeah, this was great.

Dr. McIntyre:
It's always fun. I hope, for all of our participants this is useful. We tried to make it a bit more dynamic and a bit more real world, in vivo, as what we see.

Dr. Raison:
Yeah. We tried.

Dr. McIntyre:
Because, in fact, this is something that we see so common. We do think that the longitudinal course of bipolar can be favorably influenced by giving people the right treatment – of course, part of shared decision-making. So thank you all for joining us for today's session. Chuck, thank you …

Dr. Raison:
Thank you, Yeah, thanks, Roger. It was great seeing you, man.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Novus Medical Education and Medical Education Resources and is supported by an independent educational grant from Otsuka America Pharmaceutical, Inc.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.