Transcript: Long-acting Injectable Antipsychotics in Mental Health Recovery

Complex Clinical Decisions Podcast Series

Hello. And welcome to the Recovery to Practice Podcast Series on Complex Clinical Decisions in Psychopharmacology. I'm Curley Bonds, the Chief Deputy Director for Clinical Operations at the Los Angeles County Department of Mental Health, as well as a Clinical Professor of Psychiatry at UCLA, and a Professor of Psychiatry at Charles R. Drew University of Medicine and Science.

This series is hosted by the Substance Abuse and Mental Health Services Administration's Recovery to Practice Initiative. Our goal is to help our fellow clinicians explore recovery-related issues so that we can all help the individuals we work with reach their goals.

In today's podcast we're going to explore the use of long-acting injectable antipsychotics, or LAIs, when working with individuals with serious mental illness. To help us, we'll be talking with two clinicians with a lot of insight on issues related to the use of LAIs, Dr. Anthony Carino and Dr. Delbert Robinson. Dr. Carino is an Assistant Clinical Professor of Psychiatry at Columbia University Vagelos College of Physicians and Surgeons.

Dr. Carino, welcome to the Recovery to Practice Podcast.

Thank you for having me.

Dr. Robinson is a Professor of Molecular Medicine in Psychiatry at the Zucker School of Medicine at Hofstra/Northwell, and an associate professor at the Center for Psychiatric Neuroscience at the Feinstein Institute for Medical Research. Dr. Robinson, welcome to the Recovery to Practice Podcast.

Thank you for inviting me.

Dr. Carino, many folks assume that long-acting injectables are fundamentally different from or medications. How would you more clearly explain what a long-acting injectable is to individuals you work with?

A long-acting injectable formulation of an antipsychotic is actually the same molecule as the antipsychotic but just packaged with a different delivery system. So, it's the same molecule as in the pill that one takes; however, it's delivered in a way where it's longer-acting, it's in one system for longer. Specifically, the medication is injected into the muscle with a slow release, and the blood levels are much more constant than if someone's taking an oral medication, and the administration would occur every 2 weeks, and up to every 12 weeks. So, I think there's a lot of confusion, where people think that a long-acting injectable is a new type of medication, but it's actually just a different delivery system for an antipsychotic medication.

Great. Thank you. Dr. Robinson, why might a physician suggest an individual use a long-acting injectable?

There are many different reasons, and it really depends on the individual. In terms of some of the advantages for an individual, some people actually prefer to just take an injection once a month, sometimes once every three months, because it doesn't remind them every day of their illness. Other individuals actually have some concerns about confidentiality. For example, if you work with people who are sort of young, going to school in dorms, they don't like to have other people see them take pills. And, again, if you're having an injection, the only people who see you get the injection are either the doctor or the nurse who is giving it to you at the clinic.

A lot of individuals say that, actually, just remembering to take the pills every day, or also taking the right number gets to be a burden or a hassle to them. And, again, which one of those things is important to each individual is going to vary. And the important thing is for the clinician, really, to know what the individual values and to sort of focus on those issues.

So, it sounds like what you're saying is that this long-acting version of the medication can take away some of the barriers that people encounter in adhering to a regimen.

Well, it's one tool. Obviously, we have a lot of different tools in terms of helping people follow their particular medication regime. We know from studies of people being treated in all of medicine, general internal medicine, et cetera, that about half of people find taking a pill every day consistently at the right dose to be something very difficult, so that's like every other person. So, the LAIs, again, can be something that can be very useful for people that are saying that's a hassle or that's a burden to them.

So, let's assume a prescriber is on board with suggesting LAIs to some of the individuals they work with. How can a prescriber have an effective conversation with an individual that may be considering a long-acting injectable, Dr. Robinson?

One of the things I think, that's really critical is to think about what are the benefits from the individual's point of view. Because one of the things that's very interesting about LAIs is we even have a negative thing in the name of them, because they're long-acting injectables. Obviously, for us, no individual is walking around saying, oh, I love having injections. Again, you're starting off even with a name of a medicine that has some negative connotations. So, the first thing to think about, again, talk with the individual about what are the potential advantages for their life circumstances about an LAI. That may be adherence, again, it may be confidentiality, and there are some others.

Now, if the person has identified a potential benefit for them, then you can talk about the sort of negatives, you know, the side effects, the fact that, you know, you will be getting an injection, the frequency, et cetera. But I think it's really critical, because sometimes people just start off discussing the sort of negatives. We have a medicine that comes in an injection. Well, who is going to say, oh, I want to have more injections. And also, if you talk to someone about the benefits of an LAI, and they say none of those benefits are of interest to me or would apply to me, then there's no reason to talk about the sort of negatives or the disadvantages, because they've already made their decision. They don't see an advantage.

So, once they see advantages and then talk about a full range of, for them, what might be disadvantages, and then help them sort of make a decision in terms of whether they'd like to try it or not. And that's always, you know, individual personal balance of the positives and the negatives. But the important thing is, again, not to start off with the negative.

You know, language is powerful, and Dr. Robinson has been talking about that eloquently. And I think it's really important for us, as the sort of provider in the healthcare system, to be aware of how we talk about these medications. For example, you know, I think it's important to educate and have the whole system not refer to LAIs as, quote, unquote, the needle or the IM, and, really, to use person-centered language and positive empowering language when we talk about this as an option. That can be very sensitive to the person who might have experienced treatment in a coercive manner in a period of crisis when they

weren't empowered, and it also helps for an individual to feel, actually, empowered and positive about them making this decision about their treatment.

So, it sounds like a lot of what you're saying is how you frame it to the individual receiving treatment can have an impact on their decision-making with you. Dr. Carino, do you have any ideas about how to those conversations with people about LAIs?

Yeah. I think it's extraordinarily important to lead with the individual's recovery goals and what they're working on trying to achieve, and sort of framing the approach based on that. So, there's a lot of people that I work with that are street homeless and trying to work towards permanent housing as a goal. And by really aligning with that goal of getting to permanent housing, oftentimes people will kind of see that sort of managing certain symptoms or minimizing worsened symptoms can help them achieve that goal. Starting there is important because it aligns the entire treatment approach around their specific goals and approaches and what the individual cares about.

The other thing that's really important to that is to empower them with a means for them to achieve those goals that they have chosen; right? So often times I'll be working with someone, and they'll say that anxiety, that fear that someone's going to harm me is really bothersome, and I've got to sort of minimize that. And we talk about different options, and they may choose or medication trials initially. We talk about the option of oral medications. We talk about the option of LAIs as well, and really empowering them with their own trials of treatment and their own sort of decision-making around how to treat it can be really, really important.

I worked with a couple, both of which had severe mental illness that were chronically street homeless, and the female that we worked with over time had a struggle with bipolar one disorder and PTSD and substance use. And we were talking about LAIs for a year-and-a-half while she was street homeless, and we went through a lot of trials of mood stabilizer therapy, oral antipsychotics. And she wasn't ready for the long-acting injectable for a period of time, and, you know. And she talked about, you know, you were kind of patient with me, and after sort of experiencing a lot of symptoms and recurrent homelessness and criminal justice involvement and rehospitalization, at some point she, you know, said, all right, let's try this option you've been talking about for a year-and-a-half. And she responded to that approach. They were able to both be housed together.

I think what's important about that is she came to that decision in a way that was really based on I want to get housing with my partner, and we want to be in a safe space, and this was sort the path that she ultimately chose to get there.

So, Dr. Robinson, is there a typical clinical profile of individuals using long-acting injectable antipsychotics in clinical practice?

Well, that's a very interesting issue, in that there are enormous differences across countries in terms of people who are using long-acting formulations. And one of the things that we know from the U.S. is that, essentially, anyone who would benefit by being on antipsychotics for an extended period is somebody who might benefit by an LAI. Now, we know from other countries that it's much more widely used, whereas in the U.S., unfortunately the data suggests that a lot of prescribers don't even present the option to individuals they're treating. And so one of the things that I think is important is that we become much more open to giving people the information. People may not decide that's what they want to do, but they really deserve to know that this is an option for their treatment.

How commonly are LAIs prescribed, and this is really directed to both of you?

In the U.S. healthcare system, because it's complex and has so many different payers, it's difficult to get an exact figure about the percentages of individuals who are using LAIs. Current estimates suggest around 10, slightly more, percentage of people who have, like, for example, schizophrenia, do avail themselves of an LAI. But, again, it's a little difficult in the U. S. to give the exact figure.

Dr. Carino, any thoughts?

I think that's an important question, and from what Dr. Robinson's been saying is that we should be thinking about offering LAIs in a more expansive way, where this option is talked about to more individuals. Historically it was thought of as an option for people demonstrating nonadherence for a period of time, but I think, given the idea of expanding the scope, what we do know is that LAIs are likely underutilized.

Most of the studies that we've seen in the U.S. are consistent with individuals with schizophrenia with a history of nonadherence or medication noncompliance as receiving these medications, somewhere between 19 to 30 percent of them; however, if we really are taking a more expansive scope of the indications, the numbers become very, very low. And I think that it's also significant that other systems and healthcare systems in other country, those that have government-based health care in their systems, oftentimes use LAIs with more frequency, and the prevalence is much higher. So, we do think that the use of LAIs is lower than it should be, in the U.S. in particular.

Thank you. That raises a question for me. I wonder if either of you have any familiarity with -- you mentioned that in other countries, these eradications are prescribed more frequently. Are there different algorithms for when to consider them that fall into practice workflows there, or are there are other factors that contribute it to the low use in the United States?

One example is in national health services in Britain, that LAIs are considered part of an option for individuals to choose much quicker, and I think part of this is that many individuals do have access to community-based nurses that may deliver and administer long-acting injections, and this is something that's been used much more frequently than in the states. You know, in some of the algorithms and sort of ways that many of us were traditionally taught was that this is something that you might consider for somebody that's nonadherent and repeatedly hospitalized or just someone with limited insight, and my understanding is that that's not how it's necessary little presented to individuals, for example in Britain.

Thanks Dr. Carino. Dr. Robinson, what are some misconceptions or hesitations that are seen in either individuals or among clinicians?

I think the primary problem, actually, is often within the clinicians. There's, interestingly, a lot of misperceptions about LAIs within the profession. Many psychiatrists just make the a priori assumption that an individual will not want a recommendation of an LAI, where, actually, studies show, that, again, individuals who are taking an antipsychotic report that they had not been told about them and that they would have liked to have been informed about them. Again, that doesn't necessarily mean they're going to say that's the option I want to take, but they do say they would like to have been informed.

There's also a lot of misperception that this should be reserved for people who have demonstrated nonadherence to their oral medications. Now, again, going back to the literature that half of all humans who are in any sort of medical treatment have difficulties taking medication over the long term; that, you know, it is something that we should sort of think about for everyone, because, again, every other person is going to, potentially, find it useful for helping them in terms of their adherence.

Another big myth is that it's sort of reserved for people who have had very long episodes of illness. And, in fact, some of the research data suggests that even people at the very earlier parts of their treatment for illnesses like schizophrenia may actually benefit from them.

What about practical barriers? I'm wondering about things like resource availability. Is that a factor as well?

Fortunately, yes, it is, and I think one of the things is like systems like the United Kingdom, they have much more of a culture of using LAIs. They also have the option of having visiting nurses. And, also, one

of the barriers in the U.S. is, in terms of payment, because LAIs often require a different level of review for authorization, and that varies very much from state to state.

So, the availability of support staff seems critically important, including those who can deliver the medication, as well as perhaps help out for the use of insurance authorizations that are required.

Yes, that's correct. Programs that are interested in increasing their use of LAIs, again, very simple things like having the support staff, who usually get authorizations for a particular procedure are very familiar with the authorization procedures for LAIs can make really enormous difference. The same way in terms of availability; for example, if you're an individual thinking about an LAIs one of the critical things is when are the injections given? Are they available every day, or are they only available, let's say, on Tuesdays from 11:00 to 1:00? That makes an enormous difference for them in terms of scheduling.

Good. Dr. Carino, what are some roadblocks you've seen?

Well, in terms of provider-based roadblocks, I think one of the things that I've seen is that it can be restrictive for individuals to access LAIs in certain systems, especially when the provider is actually not administering them, and so one of the approaches that we've taken -- and we've worked with many individuals experiencing homelessness -- is actually to support the prescribing providers in administering the medication, and this is a way to increase the flexibility and the access, not to mention, oftentimes the person with the mental health challenge is really engaging over time with the provider and the alliances built, and there's something that's sort of very appropriate, and people feel more comfortable, at times, to actually receive the LAI from the person that's been working with them over time.

So, there's also an issue with sort of just developing the workflow or the process to get the LAIs into the program site itself, and so it's helpful to coordinate closely with a pharmacy, have a process for the LAI to be delivered, and a process to actually, you know, administer, and working those details out operationally can be really helpful.

There's also a series of barriers at the person or consumer level that we do see. The one that comes up oftentimes for me is that many people with mental health challenges will encounter an injectable antipsychotic during states in which there's coercive care. So, specifically, oftentimes people are receiving short-acting injectable antipsychotic for agitation in the emergency room or in hospital settings in which they're not necessarily choosing that medication or consenting it to. And so, oftentimes, the people that I work with, when we start talking about different options, they associate the injection, actually, with those experiences, and so I think it's important to present the LAI in a very different manner. The person is actually choosing that delivery system as part of their recovery path, as opposed to something that's being sort of forced upon them in a crisis situation.

I think another significant barrier is that many individuals that we work with do have significant trauma history and, you know, ultimately, the LAIs are administered to a person using a needle, there's exposure of skin, and one has to be very mindful of trauma history and trauma sensitive when talking about, actually, the process of administering the LAI, and so it's extraordinarily important to have those conversations up front with an individual in order to address that potential barrier.

You bring up some really important points there, and I hear you saying that it's important to distinguish medication that's administered in an emergency setting, like an emergency room, and something that's done purely voluntarily without any coercion of force, especially in those individuals that might be sensitive because of their previous experiences with trauma or a course of treatment.

That's right. I think it's extraordinarily important to present this option of LAI in the context of a shared decision-making model, in which the individual is really empowered as the expert of their own body, of their own mental health condition, and their own goals and their own treatment. The provider has expertise and understanding the medications, the biology, but there's a real collaboration here. And especially with LAIs, I think it's extraordinarily important to work with the person over time so that, if they

are accepting the LAIs, they're coming to it through a process in which they see this as a way to help them attain their goals, and also as something that they've chosen that hasn't just been directed upon them by sort of a paternalistic healthcare system or provider. And the outcomes are much better when people have a period of time where they're sort of building up to making this decision, and they're much more likely to stick with and see a lot of benefits over time.

Thank you. Dr. Carino, how many does the fact that LAIs necessarily involve injecting someone with a needle affect some people. So, I've spoken about just an awareness of trauma-related symptoms that can be triggered. I mean, that's important to be aware of. I think the other piece to this is that it's extraordinarily important to be very sensitive to individuals' cultures or belief systems and practices when you're talking about LAIs.

I was working with a female on an Act team for many months, and it was not cultural rally appropriate for a male to see her skin, to physically touch her, and so part of our discussion of the LAIs actually involved being very sort of culturally sensitive and aware of that. It involved, actually, engaging her family, providing some education and clarification around how these medications could be administered in a very culturally sensitive way, because it would be prescribed through context of health care, through a healthcare delivery system, as a physician, providing the injection, for example. And we brought family into the process of the injections, especially at the beginning, to allow for her to feel more comfortable with that.

The other way that it comes up for me, in the population I serve, is that many individuals have co-occurring disorders and substance use disorders, and some individuals are sort of in long-term recovery with history of injection substance use, and just the idea or the thought of needles can actually trigger cravings. They have negative associations to them because they've been working on their recovery from injection substance use. And so, having a frank discussion around how they would be exposed to needles or the administration is important, especially in terms of their long-term recovery. That's not to say that these medications are in any way contraindicated for somebody in substance use recovery. In fact, oftentimes, there's really positive outcomes with that population. But I think it's important to have those conversations, and, frankly, I've been surprised that exposure to the needle can have a certain meaning to someone, so it's really important to explore that.

It does sound like a really valuable clinical conversation to have and to distinguish the two contexts in which a needle is entering a person's life. How do you address the concerns of people who may be afraid or reluctant to have changes made to their current medication?

There is, I think, two situations. One is that individual who is taking an oral formulation of a medication that's available as an LAI, for that person, it's essentially just moving from the formulation to the long-acting formulation. We have lots of data, which we can share with those individuals in terms of how the blood levels in the oral medication really map to the blood levels of the LAI. In fact, the LAI are often better, in that we don't get as many peaks and valleys. So, for that person, they're essentially just taking the same medication. It's just being given sort of in a different way. The other is, if an individual is interested in an LAI, they think that there's some advantages for them and they're really interested in exploring it, but they're not taking current antipsychotic that's already available in an oral formulation. And for those people, I mean, it's very important for them to know that before you try a long-acting formulation you are always given a trial of the oral medicine to make sure that physically they do just agree with you. So, if someone is moving from one medication, antipsychotic to another, again, there is going to be a period where they're going to be on the oral, so if they do develop problems like side effects that really are bothersome to them, then you just go right back, so you're not already on the LAI.

Dr. Carino, any thoughts about how you might have those conversations about switching someone who is reluctant, or maybe even afraid?

Yeah. So, I think that oftentimes we get into a situation where an individual may be stuck in this rigid orbit of struggling with significant symptoms, not achieving their goals, but they have sort of a comfort level with their current treatment. Not only does the person with the mental health challenge experience that comfort level, but sometimes the providers ourselves, we experience that and have the sense that, you know, the person is, quote, unquote, stable, or, quote, unquote, these are the best they can do. And I think one of the ways to really address this issue, which is to really communicate a sense of hope and a sense that, you know, the person is doing well, and their goals are so important that it's worth a trial of changing things, so they can do even better, especially when that's coupled with not just medication changes. But it's also coupled with psychosocial supports, peer-to-peer supports, you know, vocational rehab, supportive housing, those other really important psychosocial supports as well.

My experience is that, over time, people take a risk, and sometimes it's enough to sort of allow them to for a trial of something. I think the other piece that's important is to really reinforce to the individual that this is their choice, that if they start down a path of change, their treatment is in their hands and they ultimately can go back to that other option if it's not working or change options altogether and that, ultimately, your work with them is such that they feel empowered to direct their care.

I think one of the things that's also really important to have LAIs fit into a recovery-oriented approach is that we also, as a provider system, are accessing and engaging with the consumer support system. So, it's really important to provide a lot of education and support to families, to partners, to individuals in someone's social network to really discuss with them about this option, because, you know, we mentioned a lot of stigma associated with LAI and that it's important for us as providers to provide education, and it's really important to access the person's community, their social network, their primary social support as well. There are going to be really positive outcomes.

Also, it's important to educate the family members and community supports in a way where someone's really empowered with their decision. It's difficult for someone top continue to take the medication if their social support system kind of has negative associations with a certain type of treatment. So, it's really important to engage the community members and individuals supporting someone in those discussions and to provide the education there.

So, clearly, there are some obstacles to overcome when suggesting LAIs. What are some potential advantages of LAIs? What makes it worthwhile and worth the effort to use these agents?

My clinical experience is that the LAI option can be extraordinarily fitting for the person's sort of psychosocial context and situation. So, working with individuals who are experiencing homelessness and have a history of homelessness, oftentimes just the logistics of being able to take an oral medication and consistently take that medication, have access to it, can be a major barrier. The benefit of the long-acting injectable for individuals experiencing homelessness or with sort of a lot of disruption in their environment is that the medications sort of travel with them. They're something they choose to receive and then they are in their system and they don't have to worry about how do I get that bottle of pills, how am I going to get my next refill. And so for individuals that are homeless, it can be extraordinarily helpful.

Another population or clinical syndrome that I've seen that really can respond well to the LAIs is for individuals that experience an antipsychotic discontinuation syndrome. As Dr. Robinson pointed out, adherence is a struggle for all of us, and there are some individuals that will discontinue and stop their oral medications, and what can happen for some of these individuals is that they'll have an exacerbation of their symptoms that can occur in a few days after they stop their oral medication. They experience rebound symptoms. They might have difficulty sleeping, worsening of their clinical symptoms. They're at high risk of rehospitalization or decompensation in that period.

And so, for individuals that might go through this abrupt stop of oral medication and then have the antipsychotic discontinuation syndrome, the long-acting injectables can be very helpful, because the antipsychotic medication is in one's system for a longer period of time. And if they choose to discontinue

it, that's fine. The medication will actually self-taper. There is much less of a risk of the discontinuation syndrome with the LAI.

Dr. Carino, are there any drawbacks or things clinicians should keep in mind when prescribing LAIs?

That's a good question, because there are real drawbacks. That they have to do with the delivery system themselves. When someone is treated with an oral antipsychotic, you can make adjustments more quickly to address someone's symptoms and side effects quite quickly by change thing blood levels in a few days, and so the ability to change and alter blood levels with long-acting injectables is limited. You might have to wait for a few weeks to make that dose adjustment, and that medication might be at a certain level that's changed, it actually may take weeks to get there. So, it's more difficult to make these very quick changes with the medications.

The other limitation is that if individuals do experience side effects, they can sometimes experience the side effects for the period of time that the medicine is in their system. So, one of our approaches is to have lower doses for many individuals, especially those that are side-effect prone, and really educate people about side effects as they're sort of initiating the medication itself.

The other limitation that we see is that, for the vast majority of the LAIs, their needs to be a lead-in period of time for weeks when someone is on the oral antipsychotic medications until their antipsychotic medicine is at a therapeutic level from the injection itself. So, people would be taking oral medications in the beginning of treatment before the LAI becomes truly therapeutic, and that's an important kind of phenomenon to think about, that you have this lead-in period that's very critical for people, and it's important to sort of just be aware and educate individuals that it may take time for the LAI to actually become therapeutic, and so if they want therapeutic levels, the oral medication, for a few days to weeks, is important.

So, it sounds like you would advocate for maybe a crossover ramp up, during a person is on both the oral, as well as the injectable.

Yes. Most of the LAIs involve that oral titration in increased ramp up in the beginning, until the LAI is therapeutic. The biggest liability that we see is that the options for LAIs are a bit limited, so some really important medications, and one that I think of being prescribed quite often for individuals is Clozapine, which does not, for example, come along in an injectable form. So, an individual may be a responder and have a robust response to a certain antipsychotic agent, such as Clozapine; however, there's not an option to transition them to a long-acting injectable preparation of that.

The Recovery to Practice website actually has an E-learning course for clinicians about Clozapine.

Many of the antipsychotics actually do not have an LAI formulation. Only two of the typical antipsychotics are available as an LAI in the U.S. currently, and so that could be a real limitation, because someone might respond to an older medication or a typical antipsychotic, and it may not have an equivalent LAI.

The other important piece to note is that non-antipsychotic medications currently, except for sort of one agent, don't come in long-acting injectable forms in psychiatry. So, medications like mood stabilizers, such as lithium or Depakote or antidepressants, do not come in a long-acting injectable preparation. Part of the approach might a long-acting injectable with, also, the treatment of an oral medication as well to really improve their ability to achieve their goal and minimize symptoms.

Dr. Robinson, are there advantages to prescribing newer forms of long-acting antipsychotics versus older form of LAIs?

Even though the full range of medicines, antipsychotic medications, are not available as LAIs, one of the things that we've become very fortunate with is that we have more options than we used to. Also, there are differences in terms of how long there is between injections, and for some individuals that's a major consideration. The older agents were either available in a once-every-two-month formulation or a once-a-

month formulation, where the newer agents have agents that the injection is often once a month. But we do have a version now of one of the newer agents that's available so that, ultimately, the injections are only every three months. And for a number of individuals, that's quite an important distinction.

We certainly know that in treatment, as always, options and different alternatives are very helpful to be able to engage all different folks that bring different things to treatment. Dr. Robinson, for a clinician that is on the fence about incorporating LAIs in their practice, what would you say to help them consider offering individuals LAIs as one of their options?

Well, one of the things that I think is most valuable for people is if they have a colleague who actually has a lot of experience using LAIs, because I think that's the most powerful help that people can get. They do make changes in people's practice. For example, I have been fortunate enough to have funding to do adherence studies during some phases of my career, and because of that, I've done oral antipsychotic adherence assessments on hundreds of individuals, and one of the things, even if you have all of that experience, to do a really good assessment of somebody's adherence over the past 30 days takes 10 or 15 minutes, because, often, it involves actually having calendars out and going back over the days to see what days the individual remembered taking the medication, or taking it in sort of a different dose. I was supposed to take two pills and I only took one. And that takes a long time.

Approximately half the people have problems with adherence. That's something, as a good clinician, you have to sort of do, and you also have to do it, really, for just about every visit, and that takes up a lot of time, which, with an LAI, you don't have to do any of that. You don't have to do adherence assessment. So, you can actually spend your valuable time with your individuals you're treating, talking about things that really matter to them, you know, their life, their work, their relationships. It also makes clinical decision-making so much simpler, because, again, if you know that the person you're treating has been consistently going to get their LAI injection, and they still have persistent symptoms, you know this particular medicine that I'm suggesting isn't really working for that individual, so we should try something else.

Are there any special considerations you would make for the use of LAIs in a more rural setting, Dr. Carino?

Yeah. So, it's important to consider some of the sort of operational aspects of delivering long-acting injectables, and there can be definite challenges in a rural-based setting. Some of the LAIs involve an initiation of the medication with, actually, two injections in the first week or two, and so just it's important to kind of think through how often you're going to see the individual when talking about and discussing LAIs. The LAIs might need to be delivered as frequently as every two weeks, some of them. So, in certain rural settings that could be a real challenge to see the person that frequently.

Some of the workarounds that providers have developed working with individuals is the use of telepsychiatry so that people can access LAIs in which they're receiving the long-acting injectable by someone with the person, and the provider can remotely assess and provide care.

Another model that can be really effective as well, is collaboration with primary care, in which there is a prescribing mental health provider that's over seeing and providing the care; however, the long long-acting injectables might be administered by a primary care provider; that might sort of improve the access to the LAI for the individual in the rural setting.

It has been really a treat to sit with both of you and talk about your experiences in this area, two experts. I'm just wondering, the last question that I have that's for both of you, based on what you've seen in your practices, what pragmatic suggestions can you provide for other clinicians who would like to incorporate long-acting injectable in their work with individuals with serious mental illness? Let's start with Dr. Robinson.

Part of it depends on your treatment setting, in that, if you're working in, let's say a clinic setting, I think one of the critical things is to educate not only yourself about LAIs, the individuals you treat about LAIs, but also the entire treatment team. We've done some studies interviewing individuals being treated at clinics, prescribers, nurses, therapists, administrators about barriers about LAI use. And one of the things that came across from those studies is that, often, individuals being treated in a clinic, their primary person they see when they're treating them is actually their therapist, not their prescribers. And a lot of therapists' report that they get questions about LAIs from the people they're treating, but they're unable to answer them, so, essentially the person ends up with no information.

Now, obviously there's a different level of knowledge about LAIs that's required if you are prescriber or a nurse versus a therapist who doesn't actually do prescribing. But, again, having the whole treatment team have an understanding about LAIs and why they can be beneficial for a particular individual is really helpful.

Thanks Dr. Robinson. Dr. Carino? Yes, I think it's important that for those of us that have chosen the path of being providers for individuals with mental health challenges, it's really important for us to remember that our greatest asset is our ability to establish a relationship and to listen to the person that we're working with and to develop trust and understanding over time. And I think a big piece of this, and how this relates to LAIs, is that I think, as provider, it's important for us to use that relationship, that alliance that we've developed, and actually consider offering the long-acting injectables, and then potentially administering it.

So, I would encourage providers to really attempt to sort of get trained up, develop a system for them to actually administer the long-acting injectables themselves. There may be a time and a window where someone you've been working with a very long period of time decides that it's time for a trial. And my experience is that people really appreciate that the person that they've been discussing this really important treatment with over time, that's been providing the education and support and doing some of the prescribing is actually the person that's involved in the administration of the medication.

I really couldn't agree with you more, and I can't help but share a personal anecdote. I worked with a nurse to help me prepare to give my first injection to a client who would only receive it from me. And this person said, "If you'll give me the shot, I trust you, doc," so we practiced with an orange, and I surely went out and was able to do it, and the delivery system was a lot easier with some of the newer agents, so I'd just toss it out there as encouragement for those who might be standing on the fence.

Dr. Carino, Dr. Robinson, thanks for taking the time to be with us and for sharing your insights.

Thank you for having me.

Thank you for having me.

Thank you for joining us for this Clinical Decision Support Podcast. Links to relevant studies and sources of information for clinicians are included in the show notes. I hope you will listen to the other podcasts in this series. RTP is focused on improving the knowledge and skill of the behavioral health workforce to help expand the principles and practices that recovery-oriented behavioral health care across multiple service settings.

If you would like more information on this topic or other topics related to recovery from serious mental illness, please visit the Recovery to Practice website, where you can watch archived webinars, subscribe to our newsletter, or learn more about our discipline-based curriculum.