BRINGING BIPOLAR I TO LIGHT

CONNECTING ON DIAGNOSIS AND TREATMENT CHALLENGES

forefront COLLABORATIVE

FACULTY PRESENTERS

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Please see faculty disclosures on the event page.

ACTIVITY OVERVIEW

1. **Panel Discussion**
   Overcoming Diagnostic Challenges for Bipolar I Disorder
2. **Presentation**
   Managing Bipolar I Disorder—Individualizing Treatment Based on the Evidence
3. **Question and Answer Session**
4. **Clinical Topic Debate**
   Atypical LAI Antipsychotics for Bipolar I Disorder—To Use or Not to Use (Based on the Evidence)
5. **Panel Discussion**
   Overcoming Challenges in Treatment Adherence in Patients With Bipolar I Disorder
6. **Question and Answer Session**
7. **Closing Remarks**

LAI=long-acting injectable.

TO SUBMIT QUESTIONS TO THE FACULTY

Submit your questions in the chat control panel on the left-hand side **throughout the program**

OR

In your comment box through Facebook Live

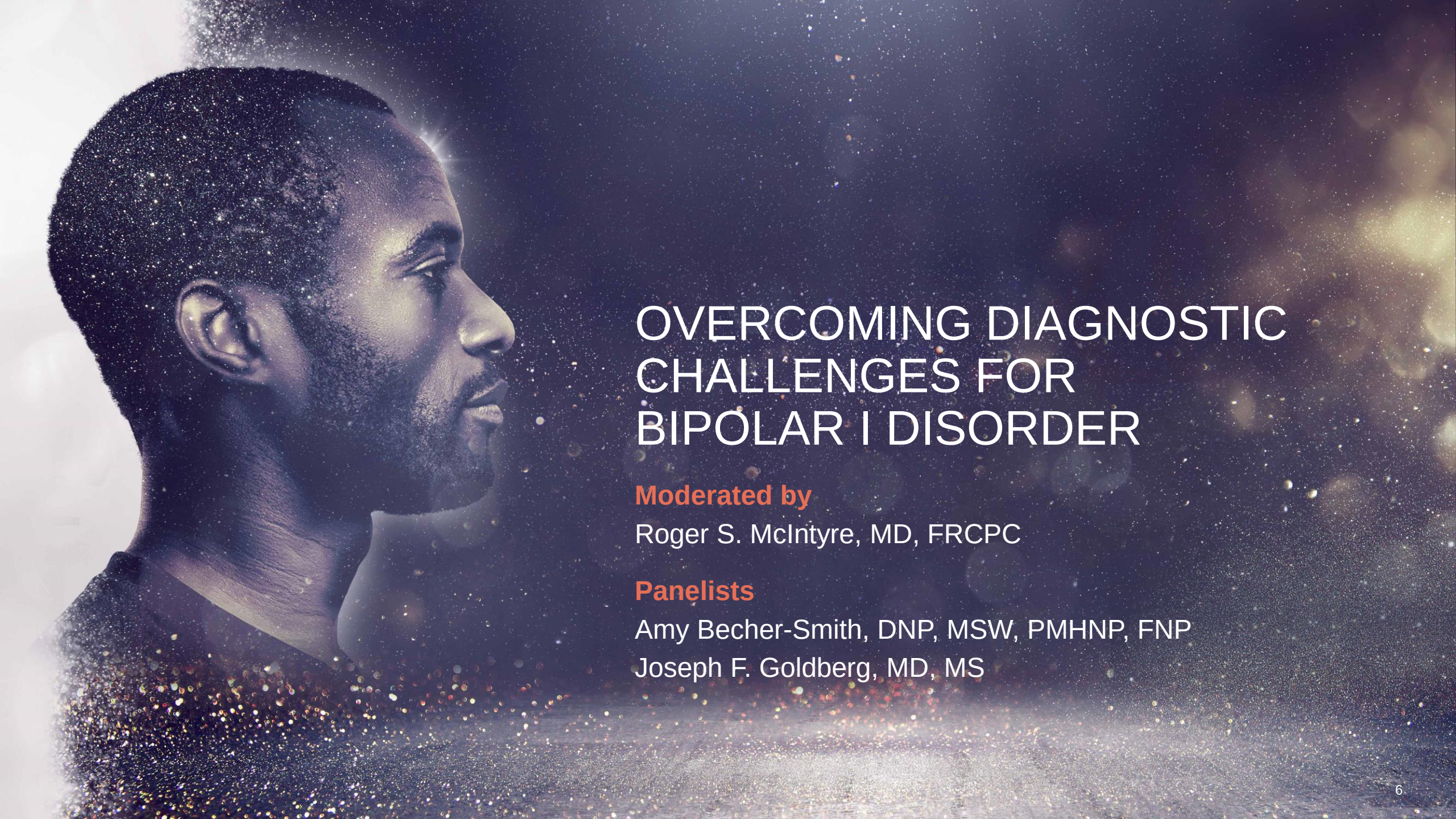
TO RESPOND TO POLLING QUESTIONS

Via your phone
Text ReachMD to 22333

Text in your message!

Via your computer
Go to PollEv.com
Enter **REACHMD**

Respond to activity!



OVERCOMING DIAGNOSTIC CHALLENGES FOR BIPOLAR I DISORDER

Moderated by

Roger S. McIntyre, MD, FRCPC

Panelists

Amy Becher-Smith, DNP, MSW, PMHNP, FNP

Joseph F. Goldberg, MD, MS

POLLING QUESTION

How confident do you feel utilizing the DSM-5 criteria to diagnose patients with bipolar I disorder?

A. Very confident
B. Confident
C. Somewhat confident
D. Not confident at all

DSM-5=Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

DSM-5 DIAGNOSTIC CRITERIA FOR BIPOLAR I DISORDER

The occurrence of **at least 1 manic episode** is essential for a diagnosis of bipolar I disorder

Manic episodes may be preceded by or followed by hypomanic or major depressive episodes

A manic episode is defined as at least 1 continuous week of daily, abnormal, and persistent elevated, expansive, or irritable mood and increased goal-directed activity or energy

- Includes at least **3 of 7 symptoms** (4 if the mood is only irritable)
  - Inflated self-esteem or grandiosity
  - Less need for sleep
  - Increased talkativeness
  - Racing thoughts
  - Easy distractibility
  - Increase in goal-directed activity
  - Excessive engagement in reckless activities
- Episode must be **severe**, causing impaired social or occupational functioning
- May include elements of **psychosis** and can require **hospitalization**
- Symptoms **cannot be explained by** substance abuse or any other medical condition

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th ed; 2013.

POLLING QUESTION

What do you think is the average time from disease onset to diagnosis for a patient with bipolar I disorder?

A. 1-2 years
B. 2-5 years
C. 5-10 years
D. 10-15 years
E. 15-20 years

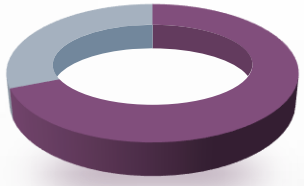
THE DIAGNOSIS OF BIPOLAR I DISORDER REMAINS A CHALLENGE

Delays in diagnosis are common

Mean delay between the onset of illness and diagnosis is

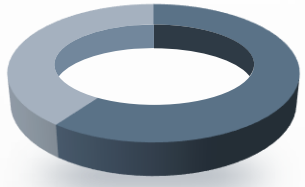
5 to 10 years

Misdiagnoses are common



69%

reported that they were initially misdiagnosed by psychiatrists*



60%

of patients were misdiagnosed with MDD*

MEAN OF

3.5

other diagnoses received*

Delays in accurate diagnosis lead to delays in appropriate treatment, inappropriate treatment, and worse patient outcomes.

*In a survey of patients with bipolar disorder involved with NDMDA support groups.
NDMDA=National Depressive and Manic-Depressive Association.
McIntyre RS, Calabrese JR. *Curr Med Res Opin*. 2019;35(11):1993-2005.

WHAT IS CONTRIBUTING TO THIS DIAGNOSTIC CHALLENGE?

- Manic episodes
- Depressive episodes
- Differential diagnosis
- Comorbidities
- Mixed features

- Misdiagnosis
- Delays in diagnosis

McIntyre RS, Calabrese JR. *Curr Med Res Opin*. 2019;35(11):1993-2005.

DISCUSSION

How can we overcome these challenges and improve the diagnosis of bipolar I disorder?

CLINICAL CLUES FOR BIPOLAR DEPRESSION

Early onset of depression (<25 years)	Multiple prior episodes (≥5)	Positive family history of bipolar disorder	Hypersomnia/increased daytime napping
Hyperphagia/ increased weight	Atypical depression signs	Psychomotor retardation	Psychotic features/ pathological guilt
Mood lability/ irritability/psychomotor agitation/racing thoughts	Postpartum affective symptoms	Substance abuse	Anxiety disorders

McIntyre RS, Calabrese JR. *Curr Med Res Opin*. 2019;35(11):1993-2005.

POLLING QUESTION

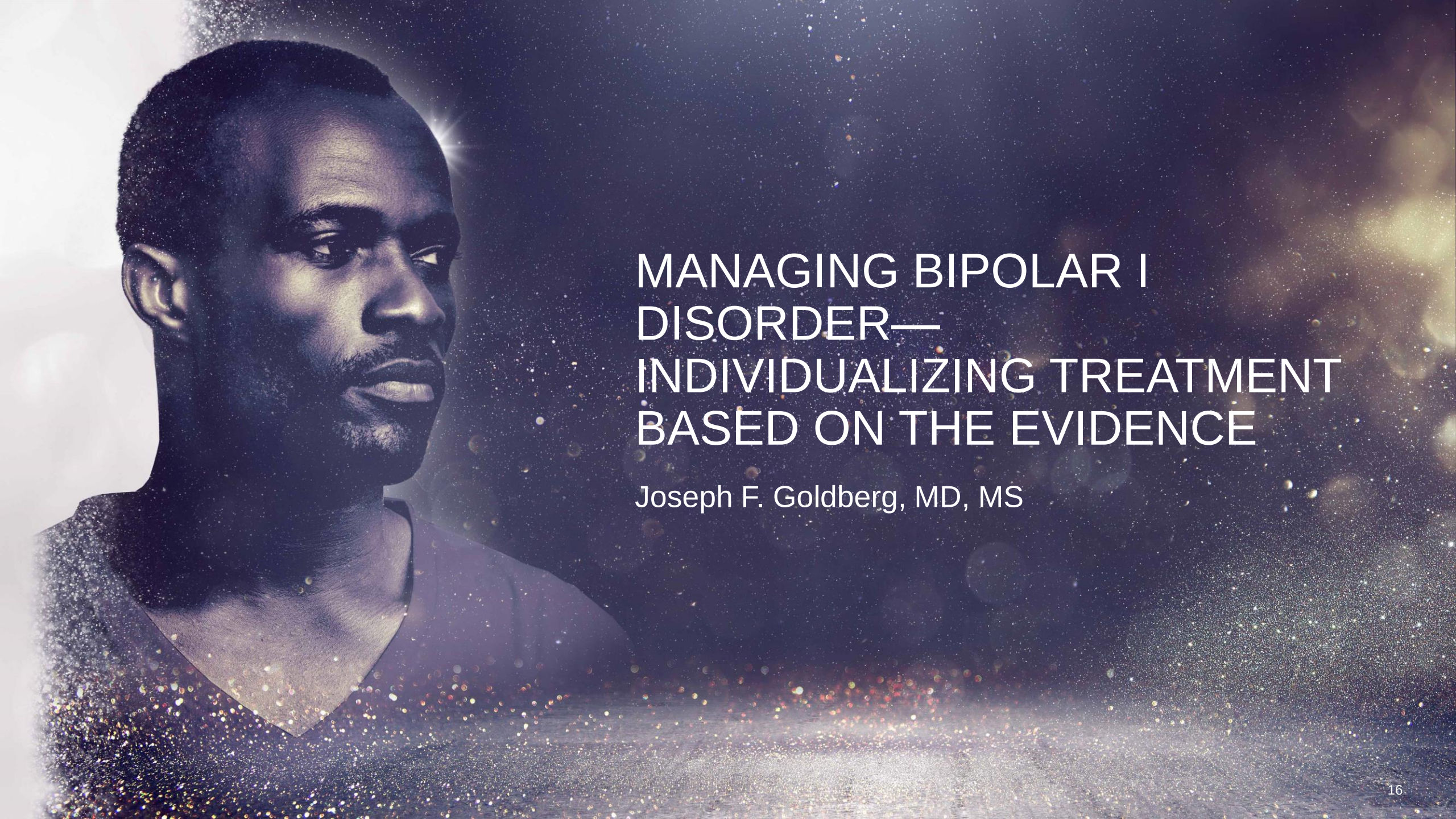
Which screening tool do you most commonly use in practice?

A. Mood Disorders Questionnaire (MDQ)
B. Rapid Mood Screener
C. Bipolar Spectrum Diagnostic Scale (BSDS)
D. Bipolar Disorder Screening Scale
E. Other
F. I do not use screening tools

DISCUSSION

How have you adapted to some of the new diagnostic challenges arising due to COVID-19?

COVID-19=coronavirus disease 2019.



MANAGING BIPOLAR I DISORDER—INDIVIDUALIZING TREATMENT BASED ON THE EVIDENCE

Joseph F. Goldberg, MD, MS

MATCHING: BROKERING THE BEST FIT[1,2]

Clinical Domains

- Mania
- Depression
- Mixed features
- Psychosis
- Rapid cycling
- Attentional problems
- Anxiety
- Alcohol/substance use disorders
- Impulsive aggression
- Affective instability
- Overweight/metabolic dysregulation
- Insomnia
- Suicidality
- Neuropathic pain

Moderators and Mediators

- Age
- Sex
- Race
- Age at onset
- Familiality
- Pharmacogenetics
- Baseline severity
- Polarity proneness
- Episode number
- Chronicity
- Past treatment response
- Psychosocial context
- Bipolar I vs II

Treatments

- Lithium
- Divalproex
- Carbamazepine
- Lamotrigine
- Topiramate
- Gabapentin
- Antidepressants
- Lurasidone, quetiapine, OFC
- Other AAPs
- Stimulants
- Hormones (eg, T4)
- Ca++ channel blockers
- Psychoeducation
- Therapy (cognitive behavioral, family-focused, interpersonal and social rhythm)
- Peer support

AAPs=atypical antipsychotics; Ca++-calcium; OFC=olanzapine and fluoxetine hydrochloride; T4=thyroid hormone.

1. Goldberg JF. *Focus (Am Psychiatr Publ)*. 2019;17(3):206-217. 2. Yatham LN, et al. *Bipolar Disord*. 2018;20(2):97-170.

CLINICAL PROFILING: WHEN TO USE LITHIUM

- First (few) episode(s)[1]
- \+ family history of lithium responsivity[2]
- Mania-prone > depression prone[3]
- Pure euphoric > mixed features[4]
- Absence of rapid cycling[5]
- Absence of comorbid substance use disorders[6]
- History of suicide attempt (though divalproex *may* be noninferior)[7]

Extra: presence of gout; absence of psoriasis; desired WBC bump during clozapine co-therapy.[8]

WBC=white blood cell.

1. Gelenberg AJ, et al. *N Engl J Med*. 1989;321(22):1489-1493. 2. Grof P, et al. *J Clin Psychiatry*. 2002;63(10):942-947. 3. Geddes JR, et al. *Am J Psychiatry*. 2004;161(2):217-222. 4. Swann AC, et al. *Arch Gen Psychiatry*. 1997;54(1):37-42. 5. Dunner DL, Fieve RR. *Arch Gen Psychiatry*. 1974;30(2):229-233. 6. Goldberg JF, et al. *J Clin Psychiatry*. 1999;60(11):733-740. 7. Oquendo MA, et al. *Am J Psychiatry*. 2011;168(10):1050-1056.
8. Goldberg JF, Ernst CL. *Managing the Side Effects of Psychotropic Medications*. APA Publishing; 2019.

CLINICAL PROFILING: WHEN TO USE DIVALPROEX OR CARBAMAZEPINE

- Multi-episode presentations[1]
- Mania-prone > depression prone[2]
- Mixed or pure manias[3]
- Impulsivity/aggression[4]
- Presence or absence of rapid cycling[5]
- Presence or absence of comorbid alcohol/substance use disorders[6]
- Potential for oral loading/rapid response[7]
- Avoid in sexually active women of reproductive potential

Extra: migraine

1. Swann AC, et al. *Am J Psychiatry*. 1999;156(8):1264-1266. 2. Popovic D, et al. *Eur Neuropsychopharmacol*. 2012;22(5):339-346. 3. Swann AC, et al. *Arch Gen Psychiatry*. 1997;54(1):37-42. 4. Kavoussi RJ, Coccaro EF. *J Clin Psychiatry*. 1998;59(12):676-680. 5. Calabrese JR, et al. *Am J Psychiatry*. 2005;162(11):2152-2161. 6. Goldberg JF, et al. *J Clin Psychiatry*. 1999;60(11):733-740. 7. Hirschfeld RM, et al. *J Clin Psychiatry*. 1999;60(12):815-818.

CLINICAL PROFILING: WHEN TO USE LAMOTRIGINE

Prevention of depression>mania in bipolar I disorder

Adjunctive therapy (with lithium[1] or quetiapine[2]) in bipolar depression

No known value in manic/mixed features episodes

1. van der Loos ML, et al. *J Clin Psychiatry*. 2009;70(2):223-231. 2. Geddes JR, et al. *Lancet Psychiatry*. 2016;3(1):31-39.

CLINICAL PROFILING: WHEN TO USE ANTIDEPRESSANTS

Favors Antidepressant Use	Discourages Antidepressant Use
Bipolar II disorder	Bipolar I disorder
Pure depressed episodes	Mixed features
Absence of rapid cycling	Past year rapid cycling
Absence of recent mania/hypomania	Mania/hypomania in past 2-3 months
Absence of comorbid alcohol/substance use disorders	Alcohol or substance use comorbidity
Prior favorable antidepressant response	Suboptimal responses to prior antidepressants
No history of antidepressant-induced mania	History of antidepressant-induced mania/hypomania

Goldberg JF. *Psychiatric Annals*. 2019;49(9):386-391.

CLINICAL PROFILING: WHEN TO USE SGAs

	Mania/Mixed	Depression	Maintenance	LAI	Short-Acting IM	AEs
Aripiprazole[1-3]	(+)	2 (-) trials	Prevention of mania	(+)	(+)	EPS, dizziness, drowsiness, tremor
Asenapine[1,4]	(+)	No data	(+)	--	--	Oral hypoesthesia, EPS, fatigue
Brexpiprazole[1,5]	2 (-) trials	No data	No data	--	--	Metabolics, EPS, sedation, dizziness
Cariprazine[1,6]	(+)	(+)	No data	--	--	GI, EPS, headache
Clozapine[1,7]	(+)	No data	No data	--	--	Metabolics, agranulocytosis, sedation
Lurasidone[1,8,9]	No data	2 (+) trials	1 (-) trial	--	--	Nausea, somnolence, EPS
Olanzapine[1,10,11]	(+)	(+)	(+)	+ (SZ)	(+)	Somnolence, metabolics, dry mouth
Quetiapine[1,12,13]	(+)	(+)	(+) (adjunctive)	--	--	Somnolence, dry mouth, metabolics
Risperidone[1,14,15]	(+)	No data	Prevention of mania	+	--	EPS, somnolence
Ziprasidone[1,16]	(+)	2 (-) trials	(+)	--	(+) (Sz)	Headache, nausea, somnolence, EPS

EPS=extrapyramidal symptoms; IM=intramuscular; SGA=second general antipsychotics; SZ=schizophrenia.

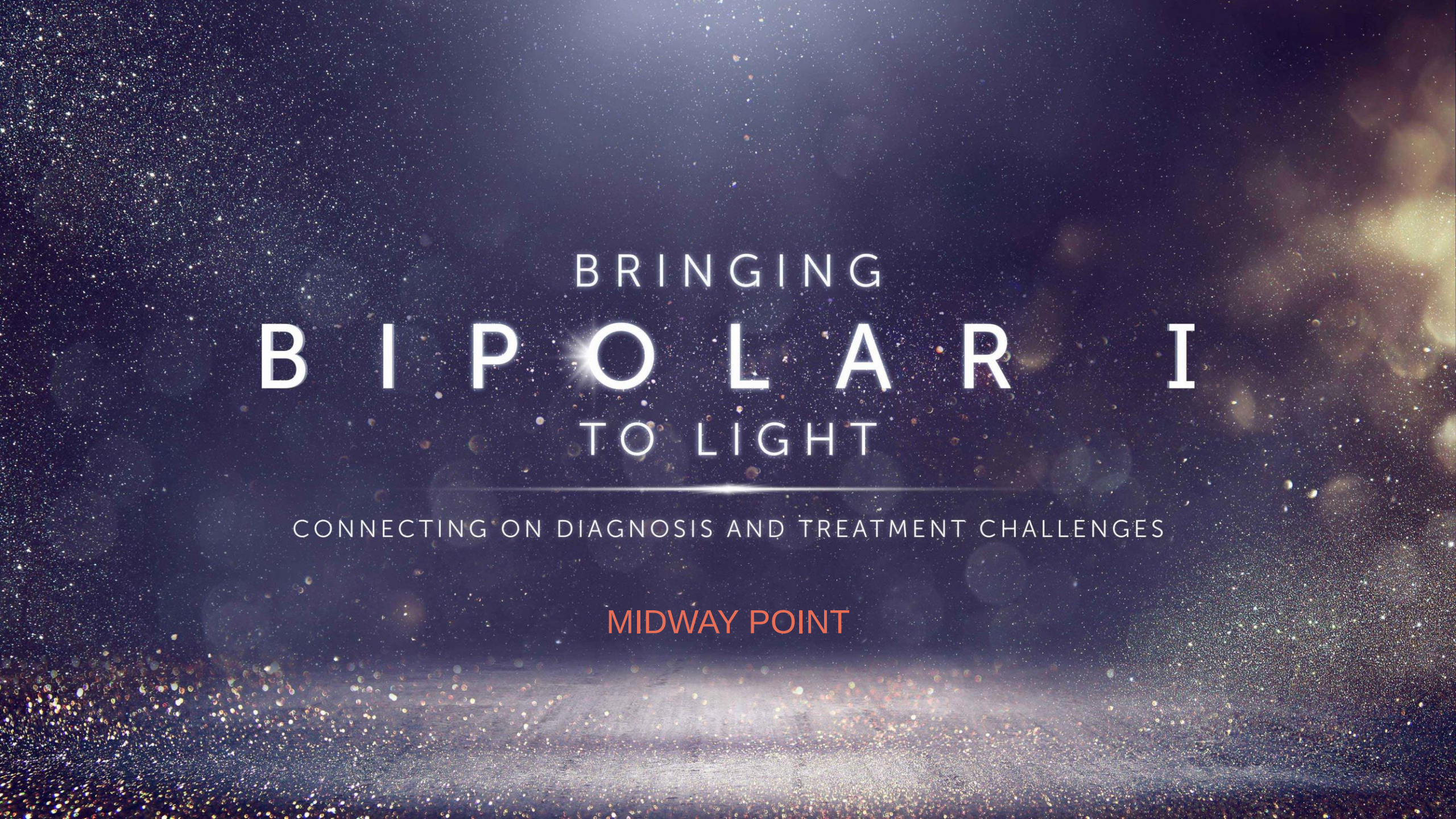
1. Yatham LN, et al. *Bipolar Disord*. 2018;20(2):97-170. 2. Aripiprazole LAI (Abilify Maintena) Prescribing Information. FDA website. Last updated January 2020. Accessed August 24, 2020. 3. Aripiprazole Oral (Abilify) Prescribing Information. FDA website. Last updated February 2020. Accessed August 24, 2020. 4. Asenapine (Saphris) Prescribing Information. FDA website. Last updated February 2017. Accessed August 24, 2020. 5. Brexpiprazole (Rexulti) Prescribing Information. FDA website. Last updated March 2020. Accessed August 27, 2020. 6. Cariprazine (Vraylar) Prescribing Information. FDA website. Last updated May 2019. Accessed August 24, 2020. 7. Clozapine (Clozaril) Prescribing Information. FDA website. Last updated February 2020. Accessed August 27, 2020. 8. Lurasidone (Latuda) Prescribing Information. FDA website. Last updated December 2019. Accessed August 24, 2020. 9. McIntyre, et al. *2015 J Clin Psychiatry*. 76(4):398-405. 10. Olanzapine oral and injection (Zyprexa) Prescribing Information. FDA website. Last updated October 2019. Accessed August 24, 2020. 11. Olanzapine LAI (Zyprexa Relprevv). Prescribing Information. FDA website. Last updated April 2020. Accessed August 24, 2020. 12. Quetiapine (Seroquel) Prescribing Information. FDA website. Last updated March 2020. Accessed August 24, 2020. 13. Quetiapine XR (Seroquel) Prescribing Information. FDA website. Last updated March 2020. Accessed August 24, 2020. 14. Risperidone Oral (Risperdal) Prescribing Information. FDA website. Last updated January 2020. Accessed August 24, 2020. 15. Risperidone LAI (Risperdal Consta) Prescribing Information. FDA website. Last updated January 2020. Accessed August 24, 2020. 16. Ziprasidone (Geodon) Prescribing Information. FDA website. Last updated January 2020. Accessed August 27, 2020.

POLLING QUESTION

Which one of the following would be the most appropriate intervention for managing a first-episode euphoric nonpsychotic mania in a 21-year-old female college student who has been taking escitalopram 20 mg/day for the past 8 months?

A. Lower the escitalopram from 20 to 10 mg/day and observe
B. Quickly taper off escitalopram and begin lithium carbonate
C. Quickly taper off escitalopram and begin divalproex
D. Quickly taper off escitalopram and begin brexpiprazole
E. Obtain pharmacogenetic testing to guide the best treatment


QUESTIONS?


BRINGING
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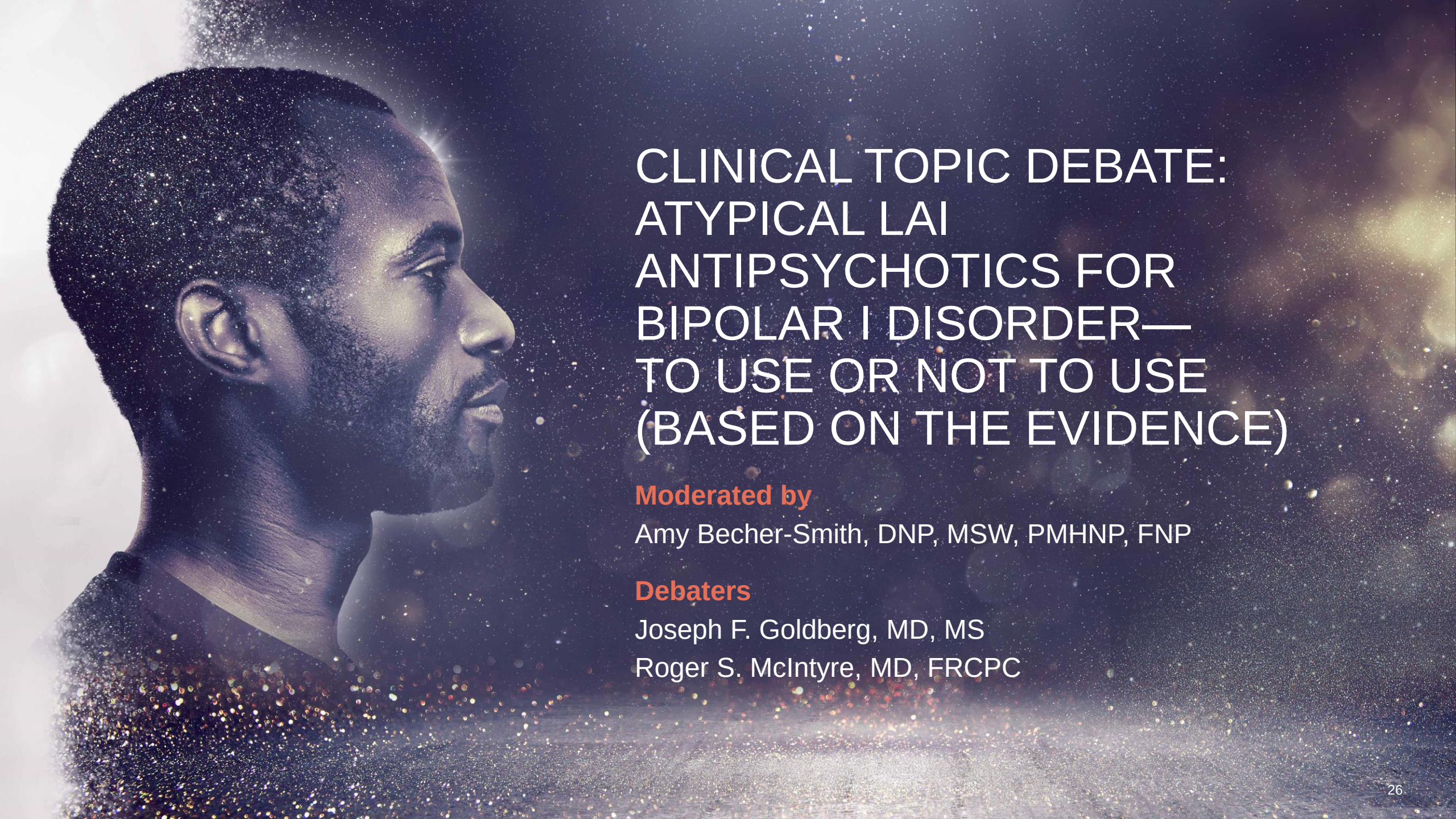
CONNECTING ON DIAGNOSIS AND TREATMENT CHALLENGES
MIDWAY POINT



CLINICAL TOPIC DEBATE: ATYPICAL LAI ANTIPSYCHOTICS FOR BIPOLAR I DISORDER—TO USE OR NOT TO USE (BASED ON THE EVIDENCE)

Moderated by

Amy Becher-Smith, DNP, MSW, PMHNP, FNP

Debaters

Joseph F. Goldberg, MD, MS

Roger S. McIntyre, MD, FRCPC

DEBATE TEAMS AND RULES

Team 1 (Dr. McIntyre)

Supports the use of atypical LAI antipsychotics for bipolar I disorder

Team 2 (Dr. Goldberg)

Opposes the use of atypical LAI antipsychotics for bipolar I disorder

Time Keeper/Moderator (Dr. Becher-Smith)

1) Speakers cannot interrupt each other; they must wait their turn to speak
2) Each speaker will be given 2.5 minutes to provide his opening argument and then 1.5 minutes to provide a rebuttal and closing statement
3) Speakers must use available evidence plus their clinical experience to support their side of the argument

POLLING QUESTION

Do you think that atypical LAI antipsychotics can be an appropriate treatment option for patients with bipolar I disorder?

Please select the response that best matches your viewpoint

A. Yes, for most patients this is a good option

B. Yes, for some of my patients

C. Yes, but only for a minority of my patients

D. No, I don’t think LAIs are an appropriate option for my patients

DISCUSSION

What is your real opinion about atypical LAI antipsychotics for bipolar I disorder?

Do you think that LAIs can be an appropriate treatment option for patients with bipolar I disorder?

OVERCOMING THE CHALLENGES OF TREATMENT ADHERENCE

Moderated by

Amy Becher-Smith, DNP, MSW, PMHNP, FNP

Panelists

Joseph F. Goldberg, MD, MS

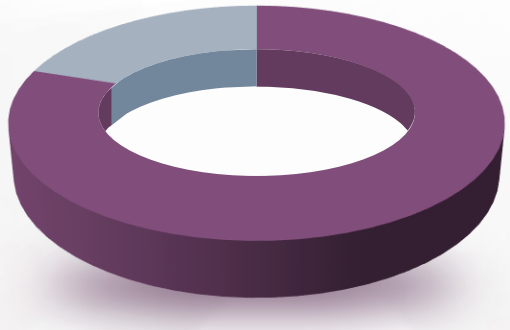
Roger S. McIntyre, MD, FRCPC

DEFINING TREATMENT NONADHERENCE IN BIPOLAR I DISORDER

Recommended definition of nonadherence in bipolar disorder[1]

Percentage of medication taken

<80%



2 Categories of Nonadherence[2]

Intentional Nonadherence

"An active process whereby the patients voluntarily do not take the prescribed medication"

Unintentional Nonadherence

"Refers to unplanned and unconscious behaviors resulting in nonadherence"

1. Velligan DI, et al. *J Clin Psychiatry*. 2009;70(Suppl 4):1-46. 2. Corréard N, et al. *PLoS One*. 2017;12(9):e0184313.

POLLING QUESTION

Approximately what percentage of patients with bipolar disorder are nonadherent to their treatment regimens?

A. 1-20%
B. 20-40%
C. 40-60%
D. 60-80%
E. 80-100%

CONSEQUENCES OF TREATMENT NONADHERENCE

Mislabeling patients as nonresponsive to medications, resulting in[1]

- Unnecessary dose increases
- Medication switches
- Adjunctive medications

Worse clinical outcomes[1,2]

- Disease recurrence
- Increased risk of hospitalization
- Suicide
- Lost productivity

Increased healthcare costs[3]

1. Yatham LN, et al. *Bipolar Disord*. 2018;20(2):97-170. 2. Greene M, et al. *Neuropsychiatr Dis Treat*. 2018;14:1545-1559. 3. Prajapati AR, et al. *BMJ Open*. 2019;9(2):e026980.

DISCUSSION

How do you monitor for signs of treatment nonadherence?

RISK FACTORS FOR POOR ADHERENCE TO TREATMENT

Category	Risk Factor
Sociodemographic	Male, younger age, low level of education, single
Psychological	Poor insight, lack of awareness of disease, negative attitude to treatment, fear of side effects, negative attitude to medication, low overall life satisfaction, low cognitive functioning
Comorbidity	Alcohol or cannabis use, obsessive compulsive disorder
Social	No social activities, work impairment
Chronology	Younger age of onset, current inpatient status, hospitalization or suicide attempt in past 12 months
Disease characteristics	Mixed episodes, rapid cycling, delusions and hallucinations, greater severity of illness, bipolar I disorder diagnosis, higher number of episodes
Treatment-related factors	Side effects of medications, inadequate efficacy of medication, use of antidepressants, low treatment doses

1. Yatham LN, et al. *Bipolar Disord*. 2018;20(2):97-170. 2. Leclerc E, et al. *J Affect Disord*. 2013;149(1-3):247-252.

DISCUSSION

What techniques do you use to improve treatment nonadherence?

FACILITATORS OF TREATMENT ADHERENCE

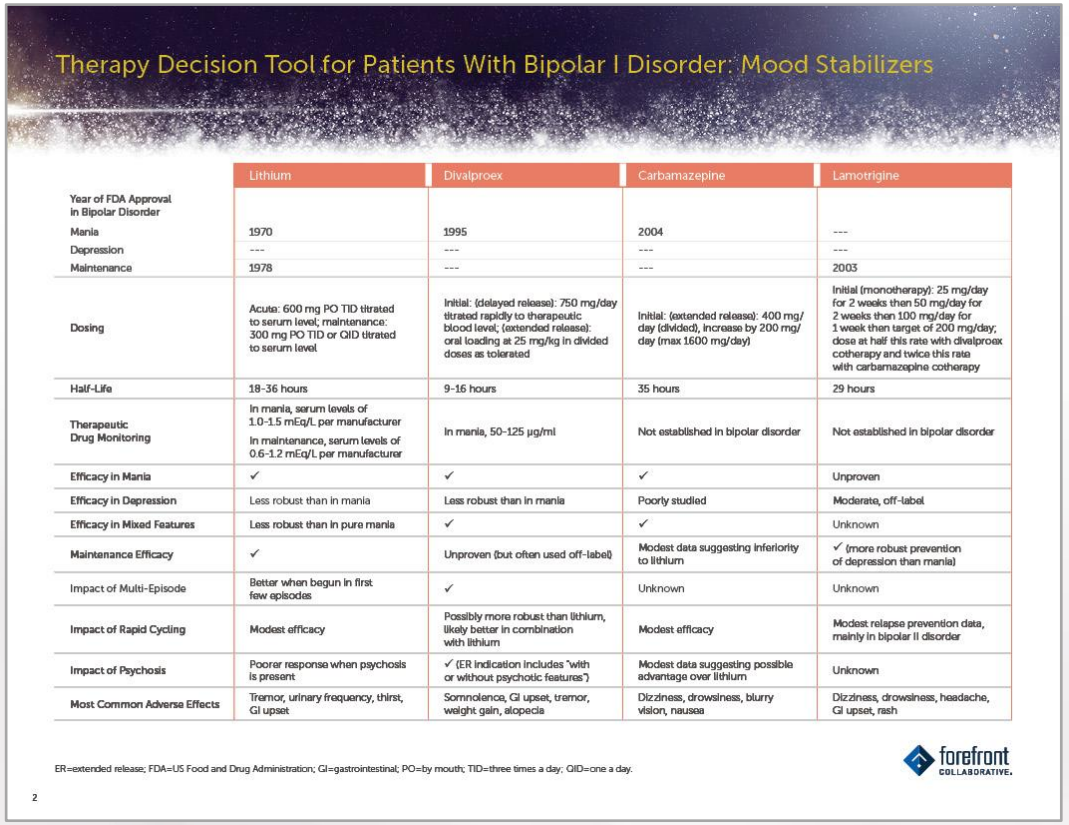
Patient-Focused Modifications	Treatment/Provider Modifications	
Adequate health literacy[1, 2, 3, 4]	Collaborative patient-provider relationship[11]	Long-acting injectables[13,14,15]
Belief in medication[5]	Shared-decision making[6,12]	Group delivery[8]
Patient empowerment[6]	Face-to-face intervention delivery[13]	Habit-based and behavioral-focused interventions[16]
Belief in one's own ability and control[6]	Pharmacist involvement[13]	Psychoeducational techniques[5,8,17]
Acknowledging the medical expertise and the prescribers influence on one's health[6]	Medication adherence scales[9]	Cognitive behavioral therapy (CBT)[5,8,17]
Regular routines[7]	Low cost medications[7]	Motivational interviewing[18]
Early detection of warning signs of relapse[8]	Simplified drug regimens[7]	Family focused therapy[8]
Value-action consistency[9]	Brief interventions focused on adherence[5]	Family intervention and involvement[17,18,19]
Mobile apps?[10]	Prevent progression into full episodes[8]	Decision aids[20,21]

1. Brown MT, Bussell JK. *Mayo Clin Proc*. 2011;86(4):304-314. 2. De Geest S, Sabaté E. *Eur J Cardiovasc Nurs*. 2003;2(4):323. 3. McHorney CA, et al. *Patient Prefer Adherence*. 2012;6:789-804. 4. Tibaldi G, et al. *Chronic Illn*. 2009;5(2):129-133. 5. MacDonald L, et al. *J Affect Disord*. 2016;194:202-221. 6. Náfrádi L, et al. *PLoS One*. 2017;12(10):e0186458. 7. Fung VC, et al. *J Affect Disord*. 2019;257:17-22. 8. Bond K, Anderson IM. *Bipolar Disord*. 2015;17(4):349-362. 9. Gaudiano BA, et al. *J Nerv Ment Dis*. 2017;205(3):178-181. 10. Nicholas J, et al. *J Med Internet Res*. 2015;17(8):e198. 11. Goodyear-Smith F, Buetow S. *Health Care Anal*. 2001;9(4):449-462. 12. Samalin L, et al. *BMC Psychiatry*. 2018;18(1):103. 13. Greene M, et al. *Neuropsychiatr Dis Treat*. 2018;14:1545-1559. 14. Lang K, et al. *J Med Econ*. 2011;14(2):217-226. 15. Greene M, et al. *J Med Econ*. 2018;21(2):127-134. 16. Conn VS, Ruppar TM. *Prev Med*. 2017;99:269-276. 17. Chatterton ML, et al. *Br J Psychiatry*. 2017;210(5):333-341. 18. Pakpour AH, et al. *Psychol Med*. 2017;47(14):2528-2539. 19. Hartung D, et al. *Psychosomatics*. 2017;58(2):101-112. 20. Aoki Y, et al. *Psychiatry Res*. 2019;281:112531. 21. Chakrabarti S. *World J Psychiatry*. 2018;8(5):114-124.

DECISION AIDS

Can be used during the shared decision making process to **assist in the discussion of treatment options**

Convey the **potential risks and benefits** of treatment options



Therapy Decision Tool for Patients With Bipolar I Disorder: Mood Stabilizers

	Lithium	Divalproex	Carbamazepine	Lamotrigine
Year of FDA Approval in Bipolar Disorder				
Mania	1970	1995	2004	---
Depression	---	---	---	---
Maintenance	1978	---	---	2003
Dosing	Acute: 600 mg PO TID titrated to serum level; maintenance: 300 mg PO TID or QID titrated to serum level	Initial: (delayed release): 750 mg/day titrated rapidly to therapeutic blood level; (extended release): oral loading at 25 mg/kg in divided doses as tolerated	Initial: (extended release): 400 mg/day (divided), increase by 200 mg/day (max 1600 mg/day)	Initial (monotherapy): 25 mg/day for 2 weeks then 50 mg/day for 2 weeks then 100 mg/day for 1 week then target of 200 mg/day; dose at half this rate with divalproex cotherapy and twice this rate with carbamazepine cotherapy
Half-Life	18-36 hours	9-16 hours	35 hours	29 hours
Therapeutic Drug Monitoring	In mania, serum levels of 1.0-1.5 mEq/L per manufacturer In maintenance, serum levels of 0.6-1.2 mEq/L per manufacturer	In mania, 50-125 µg/ml	Not established in bipolar disorder	Not established in bipolar disorder
Efficacy in Mania	✓	✓	✓	Unproven
Efficacy in Depression	Less robust than in mania	Less robust than in mania	Poorly studied	Moderate, off-label
Efficacy in Mixed Features	Less robust than in pure mania	✓	✓	Unknown
Maintenance Efficacy	✓	Unproven (but often used off-label)	Modest data suggesting inferiority to lithium	✓ (more robust prevention of depression than mania)
Impact of Multi-Episode	Better when begun in first few episodes	✓	Unknown	Unknown
Impact of Rapid Cycling	Modest efficacy	Possibly more robust than lithium, likely better in combination with lithium	Modest efficacy	Modest relapse prevention data, mainly in bipolar II disorder
Impact of Psychosis	Poorer response when psychosis is present	✓ (ER indication includes "with or without psychotic features")	Modest data suggesting possible advantage over lithium	Unknown
Most Common Adverse Effects	Tremor, urinary frequency, thirst, GI upset	Somnolence, GI upset, tremor, weight gain, alopecia	Dizziness, drowsiness, blurry vision, nausea	Dizziness, drowsiness, headache, GI upset, rash

ER=extended release; FDA=US Food and Drug Administration; GI=gastrointestinal; PO=by mouth; TID=three times a day; QID=one a day.

forefront COLLABORATIVE.

2

Therapy Decision Tool Courtesy of Joseph Goldberg, MD, MS

1. Aoki Y, et al. *Psychiatry Res*. 2019;281:112531. 2. Chakrabarti S. *World J Psychiatry*. 2018;8(5):114-124.


QUESTIONS?

SUMMARY

Delays in diagnosis and misdiagnosis are common and have significant consequences for patients, emphasizing the need for improvement[1]

- All patients presenting with depression **should be screened for bipolar disorder**
- There are **clinical clues** that can help you diagnose bipolar I disorder earlier

When selecting treatment, the data can help you determine the types of patients who may benefit most from each treatment

Atypical LAI antipsychotics are an approved but underutilized maintenance treatment option for patients with bipolar I disorder that **can provide benefit** to appropriate patients[2-6]

As many patients with bipolar I disorder are nonadherent to their treatment regimens, **identifying the lack of adherence and promptly intervening with modifications is key** to improving patient outcomes[7-11]

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