

Thirteen Things Physicians and Patients Should Question

1 Do not use atypical antipsychotics as a first-line intervention for insomnia in children and youth.

Recent research confirms a dramatic increase in the use of atypical antipsychotics with subsequent side-effects including obesity, which is already a major health issue. It is prudent to pursue nonpharmacological measures first, such as behavioural modifications and ensuring good sleep hygiene (such as eliminating daytime napping and shutting off electronics an hour before bedtime). If these interventions are not successful, then consider short-term use of melatonin.

2 Do not use SSRIs as the first-line intervention for mild to moderately depressed teens.

Evidence clearly indicates that antidepressant medication is less effective in children and adolescents up to the age of 17 years and first-line treatment for this group should include cognitive behavioural therapy or interpersonal psychotherapy. Attention should always be focused on children's and teens' environmental safety and adequate parental support to avoid missing cases of neglect or abuse. Following this, a first-line intervention should be psychoeducation on the importance of regular sleep, diet and exercise to ensure healthy, age-appropriate developmental support.

3 Do not use atypical antipsychotics as a first-line intervention for Attention Deficit Hyperactivity Disorder (ADHD) with disruptive behaviour disorders.

Treatment of ADHD should include adequate education of patients and their families, behavioural interventions, psychological treatments and educational accommodations first. If this approach is not sufficient, stimulant medication and a behavioural analysis to ensure appropriate support from the parent and classroom is indicated. The use of alpha 2 agonists (such as guanfacine) and atomoxetine should be considered before using atypical antipsychotics (such as risperidone) in children with disruptive behaviour disorders (oppositional defiant disorder, conduct disorder).

4 Do not use psychostimulants as a first-line intervention in preschool children with ADHD.

Preschool children with ADHD need to be assessed for other neurodevelopmental disorders and consideration given to environmental stressors such as neglect, abuse or exposure to domestic violence. Treatment also includes adequate education and support of parents followed by advice on behavioural management and community placement.

5 Do not routinely use antipsychotics to treat primary insomnia in any age group.

Second-generation antipsychotics (SGAPs), such as olanzapine and quetiapine, have sedative properties, and are often prescribed off-label for complaints of insomnia. These drugs carry significant risk of potential side-effects including weight gain and metabolic complications, even at low doses used to treat insomnia. In patients with dementia, they can also potentially cause serious side-effects of increased risk of cerebrovascular event and increased risk of death.

6 Do not routinely order qualitative toxicology (urine drug screen) testing on all psychiatric patients presenting to emergency rooms.

Qualitative urine toxicology testing has not been shown to improve the routine management of psychiatric patients in emergency rooms because of the potential for false positives, false negatives, true positives which are unrelated or minimally relevant to the clinical presentation, and finally the delay in psychiatric assessment and management as a result of testing.

7 Do not routinely use antidepressants as first-line treatment for mild or subsyndromal depressive symptoms in adults.

Antidepressant response rates are higher for depression of a moderate to severe nature. For mild or subsyndromal depressive symptoms a complete assessment, ongoing support and monitoring, psychosocial interventions and lifestyle modifications should be the first lines of treatment. This may avoid the side-effects of medication and establish etiological factors important to future assessment and management. Antidepressants are appropriate in cases of persistent mild depression, where there is a past history of more severe depression, or where other interventions have failed.

8 Do not routinely order brain neuroimaging (CT or MRI) in first episode psychoses in the absence of signs or symptoms suggestive of intracranial pathology.

Signs and symptoms suggestive of intracranial pathology include headaches, nausea and vomiting, seizure-like activity, and later-age of onset of symptoms. Multiple studies have found that routine neuroimaging in first episode psychoses does not yield findings which alter clinical management in a meaningful way. The risks of radiation exposure and delay in treatment also argue against routine neuroimaging.

9 Do not routinely continue benzodiazepines initiated during an acute care hospital admission without a careful review and plan of tapering and discontinuing, ideally prior to hospital discharge.

Benzodiazepines, while helpful for short-term relief of anxiety and insomnia, are associated with a variety of side-effects and long-term problems including cognitive and psychomotor impairment as well as abuse and dependence. Benzodiazepines are commonly used in hospital to treat anxiety or insomnia in association with either the presenting condition or the hospital environment. Once the presenting condition is treated, benzodiazepines should be tapered and discontinued. For patients who are still on benzodiazepines at the time of discharge, a plan for tapering and discontinuing them after discharge should be completed and specified in the discharge summary and prescription.

10 Do not routinely prescribe antidepressants as first-line treatment for depression comorbid with an active alcohol use disorder without first considering the possibility of a period of sobriety and subsequent reassessment for the persistence of depressive symptoms.

The concurrent management of psychiatric illness and alcohol use disorders requires evaluation of the role alcohol plays as a causative factor for depressive symptoms. Studies have found that response rates to antidepressants are higher when antidepressants are reserved for persistence of symptoms after a period of sobriety lasting from two to four weeks. Additionally, studies have demonstrated remission from depressive symptoms with sobriety in the absence of antidepressant treatment in a significant percentage of cases. Management of comorbid psychiatric illness and substance use disorders including alcohol dependence involves assessment and treatment delivered in a concurrent manner.

11 Do not routinely prescribe high-dose or combination antipsychotic treatment strategies in the treatment of schizophrenia.

High-dose and combination strategies involving atypical antipsychotics (AAPs) are used in clinical practice for patients with schizophrenia who are inadequately controlled with one or more AAPs used at standard doses. A recent meta-analysis found no clinically significant improvements in patients with schizophrenia who were inadequately controlled on standard-dose antipsychotics when treated with combination or high-dose AAPs. In terms of safety, no clinically significant differences were evident between combination or high-dose therapy in comparison with standard-dose monotherapy.

12 Do not use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.

People with dementia often exhibit challenging behavioural symptoms such as aggression and psychosis. In such instances, antipsychotic medicines may be necessary, but should be prescribed cautiously as they provide limited benefit and can cause serious harm, including premature death. Use of these drugs should be limited in dementia to cases where nonpharmacologic measures have failed, and where the symptoms either cause significant suffering, distress, and/or pose an imminent threat to the patient or others. A thorough assessment that includes identifying and addressing causes of behaviour change can make use of these medications unnecessary. Epidemiological studies suggest that typical (i.e., first generation) antipsychotics (i.e., haloperidol) are associated with at least the same risk of adverse events. This recommendation does not apply to the treatment of delirium or major mental illnesses such as mood disorders or schizophrenia.

13 Do not use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia.

Nonpharmacological interventions such as cognitive behavioural therapy and brief behavioural interventions have proven benefit in the management of insomnia in older adults. Epidemiological studies have shown that the risk of motor vehicle accidents, falls and hip fractures leading to hospitalization and death can more than double in older adults taking benzodiazepines and other sedative-hypnotics. Prescribing or discontinuing sedative-hypnotics in hospital can have substantial impact on long-term use. These potential harms and others such as impaired cognition need to be recognized when considering treatment strategies for insomnia. Use of benzodiazepines should be limited to as short a period as possible, in cases where nonpharmacological therapies have failed, and the symptoms of sleep disturbance cause significant suffering or distress.

How the list was created

The Canadian Psychiatric Association (CPA) determined its *Choosing Wisely Canada* recommendations by establishing a working group that included representatives from the CPA's Professional Standards and Practice Committee, Research Committee, and Member-in-Training Section, as well as the Canadian Academy of Geriatric Psychiatry (CAGP) and the Canadian Academy of Child and Adolescent Psychiatry (CACAP). A person with lived experience from the Canadian Mental Health Association was also a member of the working group. CPA members were invited to provide suggestions for potential list items, as were the provincial psychiatric associations, the Canadian Academy of Psychiatry and the Law (CAPL) and the Canadian Academy of Psychosomatic Medicine (CAPM). The working group considered suggestions received, and assistance was obtained from the Addiction and Mental Health Strategic Clinical Network for Alberta Health Services in conducting rapid literature reviews on a number of potential CPA list items. List items were further refined in subsequent working group teleconferences, and a next-to-final draft was recirculated to the provincial psychiatric associations, CAPL and CAPM for final comments, which were considered by the working group in preparing its final list.

A small subcommittee of the CAGP was organized, with input from representatives from the CAPM and the Canadian Geriatrics Society (CGS). The group reviewed the recommendations made by members of a CPA membership survey, as well as the CGS, AGS and the American Psychiatric Association's (APA) recommendations for *Choosing Wisely*. Two recommendations were selected and discussed, and minor revisions were made to the paragraphs underneath the recommendations. The CAGP also focused the recommendation about benzodiazepines and other hypnotics on insomnia, rather than on a variety of conditions.

The Executive Committee of the Canadian Academy of Child and Adolescent Psychiatry (CACAP) developed a draft list of items after reviewing recommendations made by members of a CPA membership survey, as well as the American Psychiatric Association's (APA) recommendations for *Choosing Wisely*. The list was further discussed and refined and additional feedback was obtained from the CACAP Board of Directors, as well as the Section of Child and Adolescent Psychiatry of the Alberta Psychiatric Association and colleagues elsewhere in the country.

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About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

For more information on *Choosing Wisely Canada* or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwiselycanada.org. Join the conversation on Twitter @ChooseWiselyCA.

About The Canadian Psychiatric Association

The Canadian Psychiatric Association (CPA) is a proud partner of the *Choosing Wisely Canada* campaign. CPA is the national voluntary professional association for Canada's 4,700 psychiatrists and 900 residents. As the national voice of Canada's psychiatrists, the CPA advocates for the professional needs of its members in meeting the mental health needs of Canadians, and promotes excellence in education, research and clinical practice. Its mission is to provide a strong, collective voice for psychiatrists across the country and to foster a community dedicated to ensuring the highest possible standards of professional practice in providing psychiatric services to Canadians.

About The Canadian Academy of Child Psychiatry

The Canadian Academy of Child Psychiatry (CACAP) is a proud partner of the *Choosing Wisely Canada* campaign. CACAP promotes quality care and service to the children, youth and families of Canadians within an approach that includes the biological, the psychological and the social; that works with other professional disciplines; and across many sectors of health and other related service organizations.

About The Canadian Academy of Geriatric Psychiatry

The Canadian Academy of Geriatric Psychiatry (CAGP) is a proud partner of the *Choosing Wisely Canada* campaign. CAGP is a national organization of psychiatrists dedicated to promoting mental health in the Canadian elderly population through the clinical, educational, research and advocacy activities of its membership. It was founded in 1991, and is recognized as the voice of Geriatric Psychiatry in Canada. The CAGP is a member of the Council of Academies of the Canadian Psychiatric Association. There are over 300 current members.