Appendix 1 (as supplied by the authors): Interview guide, themes and subthemes, and additional sample quotes to illustrate themes and subthemes

Supplementary Table S1: Interview Guide	
Main Topic Area	Specific Approach
Interview set up	Greeting, safe environment, study overview, purpose, consent and anonymity issues and express thanks.
Lead in (general exploratory question)	Can you tell me a little bit about the number and types of mental health patients you see in your practice?
Focus on prescribing	What are your tendencies when it comes to prescribing medication? If you can, walk me through your thought processes. (*Probe gently, this is a sensitive area*)
Focus on quetiapine	In the last few years, quetiapine, has been used by some family physicians. Have you prescribed quetiapine for any of your patients? Probes: - Can you give me some examples? (e.g. condition, if continuation, initiation) - What has been your experience of using quetiapine? *(ask for details, repeated examples)*
	In what situations would you consider quetiapine the drug of choice, or alternatively, the drug to avoid in in this patient population? Probes: a. How do you follow up patients on quetiapine…specifics b. Can you describe how you have come to use quetiapine? (influences – probes – patient request, pharma)
Wrap up	Anything you'd like to add?
	Thank you and end interview

Appendix to: Kelly M, Dornan T, Pringsheim T. The lesser of two evils: a qualitative study of quetiapine prescribing by family physicians. *CMAJ Open* 2018. DOI:10.9778/cmajo.20170145.

Supplementary Table S2: Themes and subthemes describing family physicians' use of quetiapine					
Main theme		**Subtheme**		**Codes**	
1.	Mental health plus	1.1	General use – it takes the edge off	1.1.1 1.1.2 1.1.3 1.1.4 1.1.5	Psychosis Depression Anxiety Behavioural disorders Insomnia/sleep disturbances
		1.2	Complex Conditions of Use	1.2.1 1.2.2	Patients who are unresponsive to first line therapy Patients with multiple/unclear psychiatric diagnoses or psychological and social complexity
2.	Choose cautiously – the lesser of two evils	2.1	Avoid addictive medication	2.1.1 2.2.1	Avoiding benzodiazepines Less harmful than alternatives
3.	My patients are fine on low doses			3.1.1 3.1.2	Use of low dose Side-effects
				3.1.3	Monitoring
4.	Prescribing influences			4.1 4.2 4.3 4.4	Learning in general Learning through peers Learning with psychiatrist Pharma not perceived as an influence

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Supplementary Table S3: Additional sample quotes to illustrate themes and subthemes IV=interview		
Main theme	Subtheme	Additional quotes
1. Mental health plus	1.1 General use – it takes the edge off	Mhm, so to me the most common reason for using quetiapine would be as a sedative…(IV4, L244) So it's definitely, it's not kind of my standard approach to somebody with anxiety….. I mean I obviously have a bit of a concern that I'm using it, you know, sort of off-label. I mean it's not been prescribed as a sleep aid. (IV 7, L257-8) …it really helps. I'm not too sure how it works but it does. (IV 11, L772) So I mean most of the reason in any situation that I've used quetiapine has been to like take advantage of the sedative properties, so situations where you kind of want that benefit and possibly, you know, any other, I don't know, people just seem to find it calming. (IV 15, L357-60)
	1.2 Complex Conditions of Use	*1.2.1 Patients who are unresponsive to first line therapy* The niche for me is that patient with depression who still has issues either with some, any depressive symptoms that are lingering… That depressed patient maybe who still ruminates a lot at night and, therefore, they have a hard time going to sleep and it's related to kind of their mind not shutting down, and I've seen it work quite nicely for that. (IV 9, L 142-147) So I usually start with an antidepressant and if there is, if there's still a fair bit of anxiety or agitation or sleep disturbance, that's when I will often add quetiapine. (IV 10, L88-90)

		1.2.2 Patients with multiple/unclear psychiatric diagnoses or psychological and social complexity Yeah, then I got the borderline personality sometimes. They don't react to the simple SSRIs so I mix them with a low dose of quetiapine. (IV 11, L320-21)
2. Choosing cautiously, the lesser of two evils	Need to avoid addictive medications	Okay, I don't want an addictive medication, I don't want to get them on a Z-drug, I don't think the trazodone is going to, to get to the dose I would need, I don't think it's really what they're after. What else is not addictive that might be kind of conking them out a little bit and maybe have the side effect of helping with their anxiety and that's where I come to quetiapine. (IV 14, L234-237)
3. My patients seem fine on low doses	3.1 Low doses are OK	I certainly have some concerns but at small doses, and I guess I don't know that this is technically correct, but I think of it as being at small doses, the most common concerns with quetiapine are quite mitigated, so like, you know, the weight gain, the metabolic syndrome, diabetes would all be, I think not as significant on the small doses. (IV 13, L258-266) Ah yes, oh, oh yeah, totally forgot about that whole side of things. Yes, we do worry about weight gain and diabetes and all of that stuff with quetiapine but that's more for the patients that are on the higher doses, like if they're on 12.5, not as worried. (IV 2, L565-568)
	3.2 Monitoring	I don't think I have a set schedule, it might depend on age, other risk factors, availability, what else? And how much they're on, so I mean if the patient is on a low dose, I'll probably be aware, okay, when did I last check? Okay, a couple of years ago, that's fine. Um, somebody who maybe has a lot of, who I know has

		got some risk factors and maybe they're on a high dose of it and they're going to be on it for the foreseeable future because they have a chronic illness that's not getting better, they might need to be screened annually and checked regularly that way. (IV 8, L269-275) Okay, so I've never gone into very higher doses, so the dose that I typically use is 25-50 mg at night. I will tell patients that it can be quite sedating but that's okay, taking it in the evening. The other, I usually won't titrate it up. I think I will just start at 25 and then go to 50, not any kind of slow titration. I will advise patients that it can, and I must admit I can't remember off the top of my head whether at that dose it can but it can have metabolic effects on things like weight, lipids and glucose. (IV 9, L 106-110) Uh, so I don't routinely like monitor in terms of, you know, like CBC every 3 months, looking to see if their white count is down, something, I don't but I guess I do give it a thought and again, more in, if I see people who are like on higher doses of it, and I don't see actually that many of those people, but I would be doing things like checking their cholesterol or like making sure it's been checked and same with like diabetes screening but I don't have like a hard and fast, you know, like every 3 months. I mean that would be overkill for those things and yeah, I don't do regular like, yeah like liver, like ALT monitoring or anything like that. (IV 13, L 323-329) No, you know, when I was in the hospital, I would do ECGs and I suppose that if somebody would be on a bigger dose of quetiapine, I would, you know, definitely probably do an ECG every year or something like that. If there was

		a big dose change, I would consider that but honestly, I haven't seen many people recently to think about but yeah, I would probably do, again, the metabolic stuff, you know, cholesterol and liver if somebody was on it for a long time. (IV 6, L 393-396) And I think if I were using larger doses, the few that I've used it in tend to be younger people and people who I'm not concerned about metabolic effects, at least for the short term. I think I would monitor things like weight and lipids and glucose if they were somebody who had issues with those problems. (IV 9, L 127-9)
4. Prescribing influences	Role models (psychiatrists and peers)	I don't actually know how I ended up prescribing quetiapine. Like I really don't remember going to an in-service on this is a great thing to add or, it kind of slipped in and I think it was, I think I was grasping at straws and not sure what else to try and I figured, okay, this patient population is probably a pretty safe thing to try, it's a pretty safe thing to stop, um, just give it a go and I think that, in my case, that's how I ended up doing it. (IV 14, L473-477) I think it does, I mean because there's a lot of, you know, when you get a patient like mine sent back from the specialist on this, there's definitely an impulse just to continue that treatment unless there's clearly a problem with it. If you see that happening repeatedly, there may be an increasing drive to, especially if you've had a message that this medicine works for this and you see that the specialists are doing it, that's certainly reinforcing a tendency to actually do that prescription. (IV 8, L 352-356) Um, so prescribing is, I would say, informed by clinical practice guidelines in addition to any CME, be it through

		journals or conferences but more so by practice of peers and practice of specialists, so again because of my mix of clinical work both in the hospital and within a primary care clinic that has access to specialists who also provide consultation in house, it's through those interactions, you know, with the inpatient psychiatrists as well as the consulting psychiatrists in our community practice that color or inform how I prescribe. (IV 5, L 26-31) Because we're taught that. We're taught that by the psychiatrists. Add a little quetiapine, add a little, you know, before it was the T3, you know, it's like yeah, yeah, but now it's add a little quetiapine. (IV 1, L 553-556) Usually psychiatrists in quetiapine's case, so you just get lots of consults back where they're using quetiapine for various reasons in people who aren't psychotic which, I mean in my view, would be sort of that sort of, was its primary indication when it came out, I think the depression and the bipolar are sort of secondary. (IV 7, L 341-345) In my residency program when we did our psychiatry, the psychiatrists were using it a fair amount and so it's just, you kind of got familiar with it and with quetiapine, especially like it, I don't know, for some reason I was always less scared about it than like risperidone or the other atypical antipsychotics and we were kind of taught, you know, olanzapine causes a ton of metabolic issues but low doses of quetiapine, again, I don't know if this is correct but might not have the same effect so. (IV 15, L 653-658)
	Initiating versus continuing quetiapine prescriptions	She was being treated by a psychiatrist who has now transferred the care back to me but without me having, I sort of see the patient before getting any information from the psychiatrist and

		they're on a prescription for, among other things, quetiapine, so then I'm stuck in that position of okay, do I continue this medication? I haven't had a chance to really assess this patient. They report, oh yeah, I'm doing much better than I was. How much of that is due to that, and that particular patient was actually quite young as well so she's actually probably younger than the quetiapine has an official indication for any kind of antidepressant effect. She's still a teenager where there's sort of warnings about, so she's now on an SSRI and an antipsychotic, and a benzodiazepine and kind of leaves me, you know, sort of pressured to continue all of those medications but I actually still haven't got, I have received an initial assessment from the psychiatrist. I haven't received any note where they've actually started those medicines and have agreed that yes, I think that this would be a good thing to be continuing on them and then I haven't gotten their final note where they say, I think I can stop seeing this person and transfer their care, so, um. (IV 8, L 140-152) There are some patients that I inherit that are on it and our first step is to get them off of it, but you ask them how they got on it and why are they using it and mostly it's their family doc started them on it and why are they using it? Well they think it's the sleep but mostly they really don't know. It's for nerves or to sleep, so you say, well, you know, I think there's other things we can do and let's try these other things and they don't seem to miss it. (IV 3, L 117-124) Um, I think I would probably leave them on them. I don't think I would change them off of that. I don't, yeah, usually most of my patients are coming, you know, from a psychiatrist. If they were coming from sort of another family

		physician and they were on quetiapine, I would probably leave them on it but I would usually sort of look to see who initiated it and if there was sort of say like a reasonable indication for it. (IV 7, L 531-535) I do tend to just continue. I think the only time that I would necessarily reevaluate, I reevaluate their mood on a regular basis but I think the only time that I would reevaluate their medications is if their mood was not as good as we would like it to be. (IV 2, L 396-398) I've had patients who have been on it a long time and they are counseled by me on the risks of staying on it long-term and they say, doctor, I want it, it helps me sleep and I feel better and my mood is better and I, they accept the risk and they want to stay on it. (IV 2, L 133-136) I've renewed it in patients who have had it for awhile and they're stable on their medications, I certainly renew it, though when I do, I ask why they're taking the medication and often times they don't really know why they're on it, and if somebody is taking it purely as a sleep aid where they don't have sort of, again, an axis I disorder, then I question whether we should continue it or not. (IV 6, L 124-127) Also depends on the patient's comfort because when they suffer so significantly from mood disorders, there is a significant reluctance to playing with psychotropic medications when they feel like they've made some progress and stabilize. (IV 5, L 250-252)