

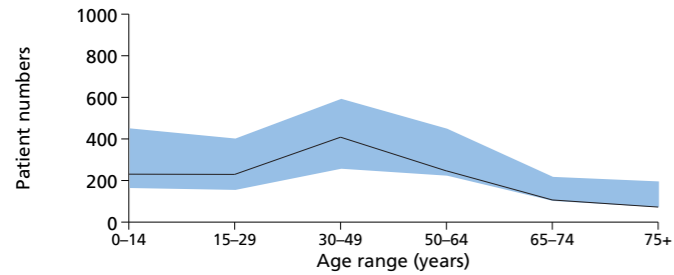


Practice profile

Some data shown earlier are presented as prescribing rates (per 1000 Medicare consultations) to adjust for volume of service. Age profile and concession card holding status of patients in your practice are provided to assist you in interpreting your prescribing data.

Age profile of patients in your practice

(1 July 2008 to 30 June 2009)



The black line represents the age profile of patients in your practice. 25% to 75% of other GPs in your RRMA[‡] fall within the shaded area. Your RRMA peer group is 3.

Medicare patients and concession card holders in your practice

(1 April 2009 to 30 June 2009)

Patients	You	Median other GPs in your RRMA [‡]
Total Medicare	559	684
Concession card holders [#]	195	247

[#] Includes those reaching Safety Net.

Data from a three month period (1 April 2009 to 30 June 2009) that best represent your patient mix have been provided.

Confidentiality

NPS has a contract with Medicare Australia to provide your prescribing feedback data directly to you. NPS does not have access to these data. The data contained in this feedback are not used for any regulatory purposes.

Discrepancies may occur between the data provided and your own prescribing practice. This may be due to either inaccurate recording of your prescriber number in the pharmacy or your prescription pad having been used by another doctor.

If you consider your individual data to be incorrect, have other data queries or general feedback, please contact NPS on 02 8217 8700 or by email at info@nps.org.au

This information is derived from a critical analysis of a wide range of authoritative evidence. NPS has taken reasonable care to ensure that the information is accurate and up-to-date at the time of creation. NPS does not warrant its completeness and excludes liability where permitted by law. Health care professionals must continue to rely upon their own skill, care and inquiries taking into account the individual circumstances of each patient when providing medical advice.

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Notes

- * Data shown are an aggregate for all your provider locations.
- ‡ The comparator group 'other GPs in your RRMA' includes all prescribers who are currently located in a similar geographical region i.e. 1. capital cities, 2. other metropolitan centres, 3. large rural centres, 4. small rural centres, 5. other rural centres, 6. remote centres and 7. other remote centres. **Your RRMA peer group is 3.**

▲ 25% to 75% of 'other GPs in your RRMA' fall in the range shown by the triangular symbols.

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National Prescribing Service Limited



000007 000
Dr Sam Sample
123 Sample Street
SAMPLETOWN ABC 1234

1 March 2010

Dear Dr Sample,

Please find enclosed the current issue of *Prescribing Practice Review* and confidential data on your prescribing of benzodiazepines.

Hypnotic medicines were prescribed for 95 per 100 insomnia problems encountered in general practice in 2006-08.¹ Identifying and managing underlying causes is the first step to treating insomnia. Engaging patients and carers in managing sleep difficulties can help to avoid the potential harms of hypnotic medicines.

The *Prescribing Practice Review* discusses the management options for insomnia, including a comparison of behavioural and cognitive therapies with hypnotic medicines, limiting the supply of hypnotic medicines in consultation with the patient, and approaches to trialling discontinuation of hypnotic medicines.

The clinical audit *Use of benzodiazepines, zolpidem and zopiclone in insomnia* is now available to assist with reviewing your practice. See the enclosed enrolment form for more information or enrol online (at www.nps.org.au/clinical_audits).

Yours sincerely,

Dr Janette Randall
Chair, National Prescribing Service Limited

Reference: 1. Charles J, Harrison C, Britt H. Aust Fam Physician 2009;38:283.



Thinking differently
about medicines

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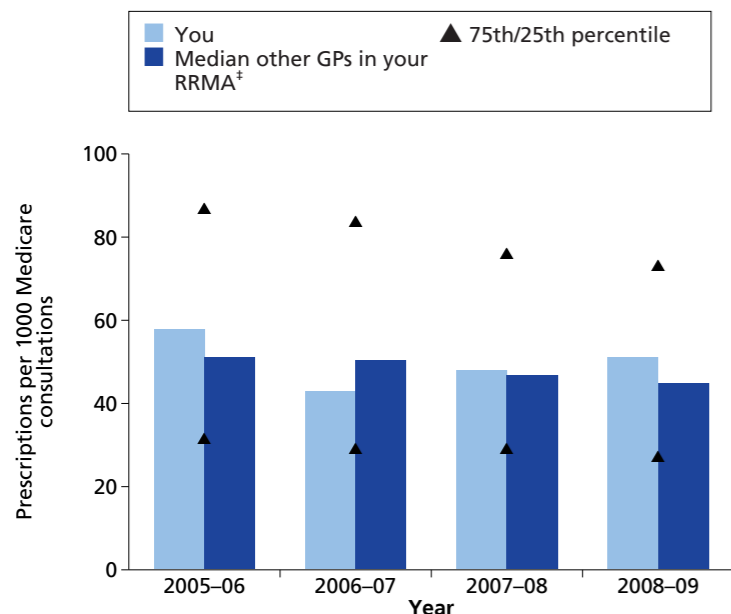
National Prescribing Service Limited

Your confidential prescribing data

The data presented from Medicare Australia includes PBS prescriptions dispensed for concession card holders **only**, as all listed benzodiazepines (alprazolam, diazepam, nitrazepam, oxazepam and temazepam) are below the general co-payment.

As the indication for use cannot be determined, data includes the use of these agents for conditions other than anxiety or insomnia. Palliative care indications are not included.

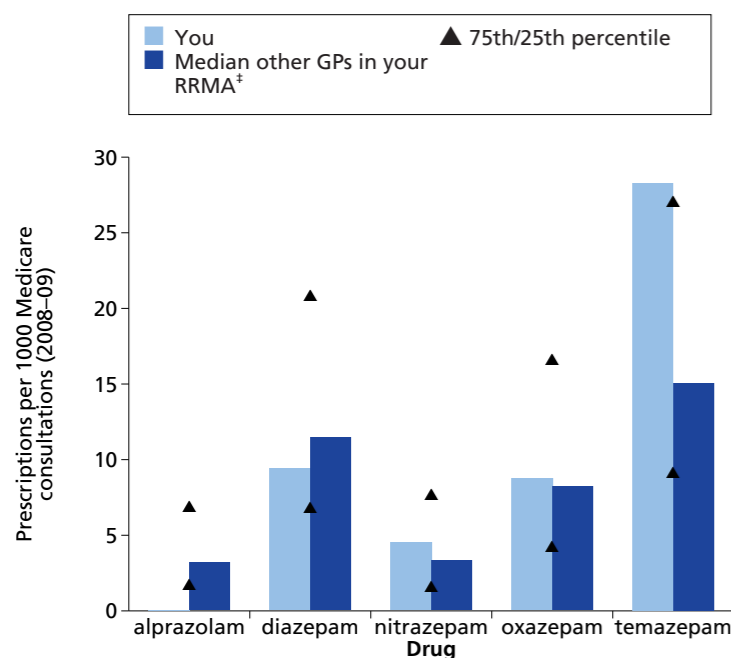
How has your benzodiazepine use in concession card holders changed over time?



Points for reflection

- Benzodiazepines are not first-choice treatment in anxiety disorders or insomnia.^{1,2}
- Generally, reserve benzodiazepine use to the short-term for anxiety disorders that have not responded to at least 2 therapies (e.g. psychological therapy, antidepressants).^{3,4}
- Only consider short-term benzodiazepine or other hypnotic medicine use if immediate symptom relief is required and non-drug therapies:
 - cannot be implemented for acute insomnia (< 4 weeks and expected to be short lived), or
 - are ineffective when used alone for chronic insomnia.^{1,5}
- Use the lowest effective dose for the shortest duration when using benzodiazepines for anxiety or insomnia.^{1,2,6,7} Ideally use intermittently (2-5 times per week) for < 2 weeks in insomnia.^{1,8}

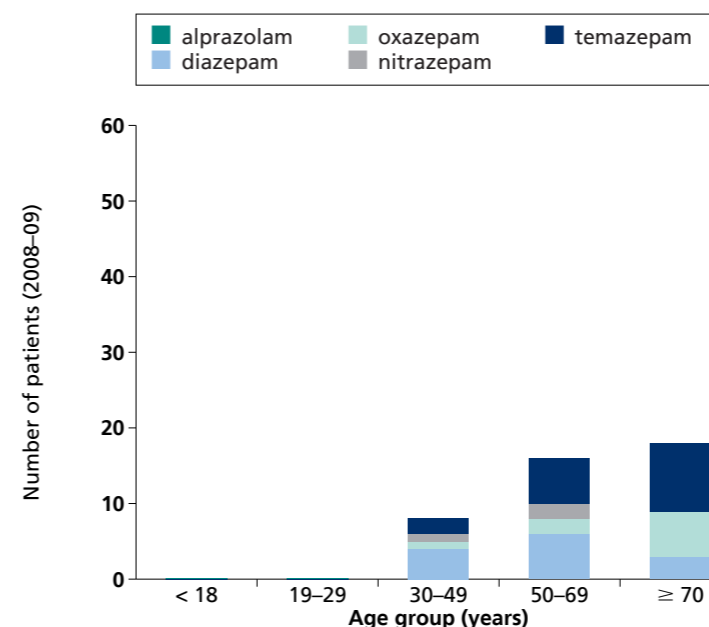
Which benzodiazepines are you prescribing for concession card holders?



Points for reflection

- If use is required for insomnia, select a short-acting benzodiazepine (e.g. temazepam) to minimise daytime sedation.⁹
- Discuss and agree on a definite duration of therapy with the patient at the start of treatment.^{1,7,8}
- Advise patients that long-term benzodiazepine treatment is harder to stop; reassure them that stopping abruptly after short-term use usually occurs without adverse effects.¹

Which benzodiazepines do you prescribe for different age groups of concession card holders?



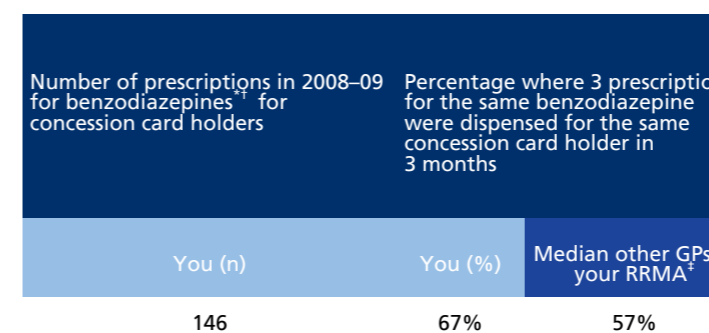
Points for reflection

- Use low doses of a short or medium-acting benzodiazepine (see Table 1) in older people, if use cannot be avoided.^{1,2} Higher doses and long-acting agents have an increased risk of oversedation, ataxia, confusion, falls, respiratory depression and short-term memory impairment.^{2,7}

Table 1: Benzodiazepine comparative information¹

Duration of action	Drug
Short ($t_{1/2}$ = 6-12 hours)	alprazolam, oxazepam, temazepam
Medium ($t_{1/2}$ = 12-24 hours)	bromazepam, lorazepam
Long ($t_{1/2}$ ≥ 24 hours)	clobazam, clonazepam, diazepam, flunitrazepam, nitrazepam

Do you prescribe three or more consecutive benzodiazepine prescriptions?



* Alprazolam, diazepam, nitrazepam, oxazepam, temazepam

† PBS Authority indications not included.

Points for reflection

- Specify the agreed duration of use for the benzodiazepine on the prescription (preferably < 2 weeks in insomnia). Long-term benzodiazepine use (> 4 weeks) increases the risk of dependence; this risk increases with duration of treatment.¹
- Tailor gradual dose reduction to the current dosage and duration of use to minimise severity of withdrawal symptoms e.g. reduce dose by 10% to 20% per week if the dose is within or slightly above therapeutic range for several months.^{1,10} (See enclosed PPR 49.)

Management options for improving sleep

KEY MESSAGES

- Explore patient concerns with sleep difficulties — identify and address causes.
- Offer behavioural and cognitive therapies for insomnia.
- Discuss and specify the duration of hypnotic medicines use.
- Trial discontinuation of hypnotic medicines in long-term use.
- Minimise potential harms of hypnotic medicines by engaging patients/carers in managing sleep difficulties.

Explore patient concerns with sleep difficulties

Insomnia is a subjective problem with falling or staying asleep, waking up too early or having poor sleep quality, which then results in daytime impairment.¹ Ask patients or carers about their views on normal sleep and the impact of insomnia.² Reassure those people without daytime impairment that they may be getting sufficient sleep: address any misperceptions or unrealistic expectations (see page 2).²⁻⁵

Investigate common causes of insomnia first

Up to 80% of cases are secondary to a comorbidity (Box 1) although the cause can be multifactorial.^{1,2} Patients can assist in identifying causes by documenting their sleep-wake patterns and activities in a sleep diary (link available at www.nps.org.au/ppr_49).³

Treat by addressing the identified causes

Modify poor sleep practices, optimise management of comorbidities and/or change the use of problematic substances or medicines (Box 1).^{3,5} Sleep difficulties caused by acute stressors are usually short-lived and should resolve if the cause is removed or alleviated.^{1,2}

Use behavioural and cognitive therapies if no underlying cause is identified (primary insomnia) or if managing underlying causes alone does not improve sleep.^{1,5} Ensure that carers are also involved in managing sleep difficulties and advise on how they can help to improve a person's sleep without hypnotic medicines.

Box 1: Common causes of insomnia^{1,2,6-8}

Psychosocial, physical and environmental stressors

E.g. grief, illness, changing time zones, light, noise, hot or cold ambient temperatures, stress (interpersonal, occupational, academic or financial).

Medical conditions

Includes cardiovascular (e.g. angina), endocrine (e.g. thyroid dysfunction), gastrointestinal (e.g. GORD), genitourinary (e.g. incontinence), musculoskeletal (e.g. arthritis), neurological (e.g. chronic pain), respiratory (e.g. COPD), sleep disorders (e.g. sleep apnoea).

Psychiatric disorders

E.g. anxiety disorders, attention deficit disorder, bipolar disorder, dementia, depression, schizophrenia.

Poor sleep practices

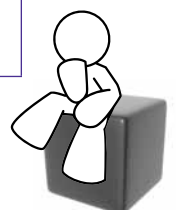
E.g. daytime napping, use of bed for activities other than sleep or sex, heavy meals or exercise near bedtime, variable sleep/wake time.

Substance use

E.g. alcohol, caffeine (including in food and energy drinks), nicotine, recreational drugs.

Medicines

Includes antidepressants (e.g. SSRIs), antiepileptics (e.g. phenytoin), beta blockers, CNS stimulants (e.g. methylphenidate), corticosteroids, diuretics, levodopa, sympathomimetics (e.g. salbutamol), thyroid hormones.



Use non-drug therapies to manage insomnia

Advise every patient on good sleep practices, such as regular daytime exercise, keeping a set sleep/wake time and a bedroom environment conducive to sleep (see the *Sleep right. Sleep tight* leaflet available at www.nps.org.au/sleep).^{1,2} Use behavioural and cognitive therapies (Box 2) to target specific factors that perpetuate sleep difficulties over time, including in people with secondary insomnia.¹

Discuss the benefits of non-drug management with patients and carers

Non-drug therapies have comparable efficacy to benzodiazepines and other related drugs, and:

- have longer-lasting effects on sleep
- avoid the potential harms and dependence of hypnotic medicines
- do not disrupt normal sleep patterns.^{9–15}

Combining advice on good sleep practices with the therapies in Box 2 (over 4–8 weeks) helps people to fall asleep faster and reduces their time awake after sleep onset by up to 30 minutes more than placebo or no treatment.^{9,10,13,16} Improvements can persist for up to 2 years after therapy — hypnotic medicines do not provide this benefit.^{9–12}

Treat persisting sleep difficulties with at least one behavioural and cognitive therapy

Use the therapies in Box 2 to manage chronic insomnia (present for > 4 weeks) — advising on good sleep practices alone may not be sufficient.^{1,2,9} People with acute insomnia that persists despite addressing poor sleep practices and other factors should also receive these therapies.²

Discuss the choice with the patient and/or carer: as a guide, assess the sleep history and/or sleep diary, preferences, and physical and cognitive capacities to engage in therapy.^{2,3} If one approach is ineffective or unmanageable, a different therapy or combination can still be helpful.¹

Start behavioural and cognitive therapies or refer patients to a specialist sleep clinic, sleep physician, psychiatrist or psychologist (see *NPS News 67* [www.nps.org.au/news_67] for how to locate a suitable health professional).^{3,17} Self-help materials (e.g. books) are an alternative to face-to-face therapy, but might not be as effective.¹⁸

For more information on behavioural and cognitive therapies for insomnia, refer to the materials in Veterans MATES Therapeutic Brief 18 (link available at www.nps.org.au/ppr_49).

Box 2: Behavioural and cognitive therapies for insomnia^{1–3,17}

Cognitive therapy

Suitable for people with negative beliefs and attitudes, unrealistic expectations, or who are excessively worried about sleep and the consequences of sleep loss.

- Techniques identify and change distorted thoughts such as ‘I must sleep at least 8 hours a night or I’ll do myself harm’, ‘If I don’t sleep well I should stay in bed longer and rest’, ‘I won’t cope tomorrow if I’m not asleep soon’.

Stimulus control

Suitable for people who have difficulty falling asleep due to a learned association between the bed or bedroom and sleeplessness, frustration and worry.

- Technique: patient goes to bed only when tired (using the bed for sleep or sex only) and gets out of bed if unable to fall asleep within a perceived 20 minutes (i.e. without watching the clock); this is repeated each night until a stable sleep–wake schedule is established.

Sleep restriction

Suitable for people who have difficulty staying asleep due to poor sleep drive that causes broken sleep or excessive time spent in bed awake.

- Technique: patient limits time in bed to the actual total sleep duration per night (setting the wake-up time), gradually increasing as total sleep duration improves and until target is achieved (no less than 5 hours).
- Monitor for and warn about possible daytime sleepiness with this technique.

Relaxation training

Suitable for patients who cannot ‘wind down’ and sleep at bedtime due to physical tension, overactive mind or worry. Techniques used during the day and night include:

- Progressive muscle relaxation: patient focuses on and relaxes each muscle group gradually, allowing them to become heavy.
- Mental imagery: patient takes a few deep breaths, relaxes and imagines something pleasant for as long as possible.

Limit supply of hypnotic medicines when these are required

Avoid prescribing hypnotic medicines whenever possible. A short-acting benzodiazepine (e.g. temazepam) or other related drug (zolpidem or zopiclone) should *only* be considered if:

- immediate short-term symptom relief is required, *and*
- sleep difficulties are expected to be short-lived (acute insomnia) and non-drug therapies cannot be implemented readily, *or*
- chronic insomnia has not responded to non-drug therapies alone.^{2–5}

Prescribe only for a short duration

If treatment is required, prescribe for < 2 weeks and ideally intermittently (e.g. 2–5 nights per week).^{1,4} Prolonged hypnotic medicine use (for > 4 weeks), especially at high doses, increases the risk of dependence.⁴

Engage patients and carers in limiting use at the time of the initial prescription (Box 3). Check the need for and duration of hypnotic medicines initiated during hospital admission and in aged care facilities: treatment is usually intended to be short-term and should be ceased.

Use zolpidem or zopiclone as cautiously as a benzodiazepine

There is no evidence that zolpidem and zopiclone differ in their efficacy or safety.^{22–24} Zolpidem or zopiclone can cause tolerance, dependence and

withdrawal symptoms.^{4,8,19,25} Visual hallucinations, psychosis and bizarre behaviours with amnesia (e.g. sleep driving) have been reported with these drugs²⁵: see the NPS Position Statement: *Zolpidem and sleep-related behaviours* (link available at www.nps.org.au/ppr_49).

Limited role for over-the-counter and complementary medicines

There is less evidence for treating insomnia with other drugs and complementary medicines (e.g. melatonin, valerian).^{1,4,19} Sedating antihistamines (diphenhydramine, doxylamine) are not recommended because tolerance can develop quickly and adverse effects (e.g. daytime sedation) can be a problem, especially for older people.^{6,8,19,26}

Box 3: Discussion points on hypnotic medicines use for patients and carers

Agree up front on a definite duration of therapy outlining:

- the risk of adverse effects, tolerance and dependence with the medicine
- that long-term use is rarely necessary and is more difficult to stop
- the importance of continuing with non-drug therapies.^{1,4,6,19}

Discuss a stopping plan — stopping is more likely to be successful when a shared decision has been made with the patient, and there is cooperation from family, carers and staff in aged care facilities.^{3,4,20,21} Short-term use for < 2 weeks can usually be stopped abruptly without problem.⁴

Actively pursue discontinuation of long-term use

Systematically discuss cessation of long-term use with each patient at every opportunity. Hypnotic medicines have the potential to cause harm and stopping their use improves alertness, cognition and sleep quality.^{3,15} Older people in particular are at greater risk of adverse effects including memory impairment, falls, fractures and motor vehicle accidents.^{4,22} Establish the patient's willingness and goals and agree on a stopping plan (see *NPS News 67* [www.nps.org.au/news_67] for a guide).

Simple strategies in primary care can motivate patients to stop

Brief intervention in general practice or outpatient settings is at least twice as likely to lead to stopping benzodiazepines as usual care or not raising awareness at all.^{27,28} Effective strategies include a letter from a GP outlining the need for discontinuation, a short consultation or meeting and self-help advice.^{21,27,28} (A patient leaflet with helpful tips on stopping such medicines and a reduction plan is available at www.nps.org.au/sleep).

Gradually taper dosage on an individual basis

Discuss and agree on a tailored dose reduction and titrate to the patient's severity of withdrawal symptoms (see examples in Box 4).^{1,3,4,20} An optimal approach has not been established.²¹

To help patients commit to and achieve their goals:

- allow them to choose on what days they reduce their dose
- maintain regular contact (e.g. weekly) during dose reduction phases
- outline the type, nature and possible duration of withdrawal symptoms
- explain that rebound insomnia is a symptom of stopping and not a sign that treatment should continue
- advise on ways to manage changes in mood, sleep, substance use and withdrawal symptoms (e.g. temporary dose increases).^{1,3,20}

Support and encourage further attempts if discontinuation is unsuccessful

Switching to the long-acting benzodiazepine diazepam may result in less withdrawal symptoms if these are problematic with short-acting drugs or high doses (see Box 4) — however, avoid diazepam in older people.^{4,20} Using behavioural and cognitive therapies with gradual dose reduction also increases the chance of stopping.^{27,28}

Consider referral to a specialist if discontinuation is too difficult in primary care. Reassure patients and carers that further attempts are worthwhile, suggest non-drug therapies that might reduce the need for a hypnotic medicine, and plan for regular medication reviews.^{4,6,20}

Box 4: Examples of approaches to gradual dose reduction^{4,20,21}

Reduce by a proportion of the starting dose per week (e.g. 10% to 20%)

E.g. temazepam 20 mg per night

Can reduce by 15–20 mg per week (a rate of 10% to 15%), starting with 2 x 10 mg on three nights plus 1.5 x 10 mg tablets on four nights.

First stabilise on an equivalent dose of diazepam for a few days then reduce

E.g. temazepam 30 mg per night

Switch to diazepam 15 mg daily in divided doses, can then reduce by 10% per day (for inpatients) or slower in an outpatient setting (e.g. by 25% every fortnight).

- Tailor further reductions according to the patient's response.
- Allow at least several days to stabilise between dose reductions.
- If multiple drugs are used, reduce the dose of each drug one after the other or switch to diazepam by summing dose equivalents.

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