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## Addressing hypnotic medicines use in primary care

Hypnotic medicines were prescribed for 95 per 100 insomnia problems encountered in general practice between 2006–08.<sup>1</sup> Benzodiazepines and other related drugs can be avoided by using non-drug therapies. For people who have taken hypnotic medicines long-term, there are strategies to help them stop that can be used in primary care.

### Identify and manage contributing factors first

Most people develop insomnia secondary to an identifiable stressor, medical or psychiatric condition, poor sleep practice, medicine or substance use.<sup>2–5</sup> A comprehensive history, examination and/or investigations helps to identify secondary causes: treat and manage these first. Patients can assist in assessing their insomnia by documenting their sleep patterns in a sleep diary (see link at [www.nps.org.au/news\\_67](http://www.nps.org.au/news_67)).<sup>2,3,5–8</sup>

#### Use non-drug therapies for insomnia

Non-drug therapies are directed at the physiological, psychological, behavioural and environmental factors that affect sleep.<sup>2</sup> They have comparable efficacy to benzodiazepines and other related drugs.<sup>9–13</sup>

Discuss the benefits of non-drug therapies with patients. Such therapies avoid the adverse effects and dependence of hypnotic medicines, and can improve sleep long after therapy has stopped.

People using the therapies in Box 1 (over 4–8 weeks; see page 3) fall asleep faster and reduce their time awake after sleep onset by up to 30 minutes more than placebo or no treatment.<sup>9,11,14,15</sup> Improvements can persist for up to 2 years after therapy.<sup>10–12,14</sup> Hypnotic medicines do not provide this long-term benefit.<sup>10–12</sup>

Combine advice on good sleep practices with at least one other therapy — advice alone does not appear to be sufficient for chronic insomnia (present for > 4 weeks).<sup>2,14</sup> Bright light exposure and exercise (not near bedtime) can also help, especially in older people.<sup>7,8,16</sup>

Primary care practitioners can start non-drug therapies or refer patients to a specialist sleep clinic, sleep physician, psychiatrist or psychologist.<sup>5,6,17</sup> Patients can try self-guided therapy (in book, audiovisual or internet formats) but this may not be as effective as face-to-face therapy.<sup>18</sup> The Australian Psychological Society provides an online search tool and referral service to find a suitable psychologist. Members of the Australasian Sleep Association (ASA) who specialise in behavioural and cognitive therapies for insomnia are listed on the ASA website (links available at [www.nps.org.au/news\\_67](http://www.nps.org.au/news_67)).

For more information about good sleep practices and cognitive and behavioural therapies for insomnia, refer to the materials in Veterans MATES Therapeutic Brief 18 (link available at [www.nps.org.au/news\\_67](http://www.nps.org.au/news_67)).



Thinking differently about medicines

## Hypnotic medicines: who, when and how?

Avoid hypnotic medicine use where possible, especially in older people (see below). Short-term use of a benzodiazepine (e.g. temazepam) or other related drug (zolpidem or zopiclone)\* may be required for:

- acute insomnia (present for < 4 weeks) if the cause is expected to be short-lived (e.g. grief, noise) and non-drug therapies cannot be implemented readily
- chronic insomnia that has not responded to non-drug therapies alone.<sup>6,19</sup>

Limit use to the shortest time possible: ideally, intermittently (e.g. 2–5 times per week) for < 2 weeks.<sup>2,7,19</sup> **Agree up front on a definite duration of therapy with every patient**, outlining to them:

- 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.<sup>2,7,19–21</sup>

**Discuss a stopping plan for the hypnotic medicine at the time of the initial prescription.** 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.<sup>6,19,22,23</sup>

Ensure that hypnotic medicines prescribed at hospital discharge are not continued unnecessarily: treatment is usually intended to be short-term.

### Avoid use in older people

A meta-analysis found that 13 people aged ≥ 60 years need to be treated with a hypnotic medicine for up to a month, instead of placebo, to improve sleep in 1 person — but treating only 6 people leads to an adverse effect, including fatigue, cognitive impairment and serious events involving falls, fractures and motor vehicle accidents.<sup>24</sup>

If drug treatment cannot be avoided, warn patients and their carers about the risk of adverse effects.<sup>19</sup> Long-acting drugs (e.g. diazepam, flunitrazepam, nitrazepam) should not be prescribed in older people as they tend to accumulate and cause excessive sedation.<sup>6,19</sup>

## Stepped care approach to stopping hypnotic medicines

Prolonging treatment with hypnotic medicines (for > 4 weeks) increases the risk of dependence. Most long-term use occurs in older people: while this can be hard to avoid because of co-morbidities or long-standing dependence, there is a case for stopping use in older people as they are at greater risk of harm.<sup>19</sup>

Establish the willingness to stop or reduce use in patients who have been on long-term treatment: Box 2 is a guide to stopping.

### Stepwise interventions for helping patients to stop benzodiazepines in primary care include:

1. Brief intervention outlining the need and ways to stop treatment.
2. Systematic intervention involving gradual dose reduction.
3. Augmentation with behavioural and cognitive therapies.<sup>25,26</sup>

### Brief intervention can motivate patients to stop

Simple strategies used in general practice and outpatient settings — such as sending a letter advising patients to stop and providing self-help advice — are at least twice as likely to lead to benzodiazepines being stopped than usual care or not raising awareness at all.<sup>25,26</sup>

A systematic intervention can be used if a brief intervention is unsuccessful. Gradual dose reduction guided by a primary care practitioner increases the chance of stopping, which further improves when combined with behavioural and cognitive therapies.<sup>25,26</sup>

There is insufficient evidence for adjunctive drug interventions (e.g. tricyclic antidepressants, carbamazepine) when stopping benzodiazepines.<sup>25–27</sup> Abrupt drug substitution is no better than abruptly stopping the benzodiazepine — gradual dose reduction is more effective.<sup>26</sup>

### Gradual dose reduction may still be required after short-term use

Short-term benzodiazepine use (< 2 weeks) at recommended therapeutic doses can usually be stopped abruptly without problem.<sup>19</sup> However, rebound insomnia and other withdrawal symptoms are still possible.<sup>2</sup>

Zolpidem and zopiclone are very short acting and rebound insomnia may also occur on stopping.<sup>2,19,20</sup> A withdrawal syndrome has been reported with zopiclone.<sup>20</sup>

Reassure patients that rebound insomnia usually lasts for only 1–3 days, and does not indicate a need for ongoing treatment.<sup>2,19</sup> If necessary, gradually reduce the dose and/or frequency after short-term use to minimise rebound insomnia and withdrawal symptoms.<sup>2</sup>

\* Zolpidem (Dormizol, Somidem, Stildem, Stilnox, Zolpibell) is not listed on the Pharmaceutical Benefits Scheme; zopiclone (Imovane, Imrest) is available on the RPBS as a restricted benefit.

**Box 1: Educational, behavioural and cognitive therapies for insomnia<sup>2-7,17,19</sup>**

| What is the cause?   | Which therapy and what approach can I use?  |
|--|---|
| Lifestyle habits and environment not conducive to sleep                                      | <b>Advice on good sleep practices</b><br>Practical tips on how to modify diet, exercise patterns, substance use, sleep-wake schedule, daytime napping, and sleep environment.   |
| Negative thoughts or unrealistic expectations about sleep and the consequences of sleep loss | <b>Cognitive therapy</b><br>Techniques that replace distorted beliefs and attitudes with positive ones (e.g. reassure that < 8 hours sleep a night is not necessarily detrimental).   |
| Learned association between going to bed and being unable to sleep                           | <b>Stimulus control</b><br>Go to bed only when tired (and only use the bed for sleep or sex), get out of bed if not asleep within a perceived 20 minutes (do not watch the clock); repeat each night until a stable sleep-wake schedule is established. |
| Poor sleep drive results in broken sleep or excessive time spent in bed awake                | <b>Sleep restriction</b><br>Restrict time in bed to actual sleep duration and have a set wake-up time; increase gradually as total sleep duration improves, and until the target sleep time is reached (not < 5 hours).                                 |
| Unable to mentally and/or physically wind down each night                                    | <b>Relaxation techniques</b><br>Progressively focus on and relax each muscle group; taking deep breaths, relax and imagine something pleasant for as long as possible.  |

**Box 2: STOP guide for long-term use of hypnotic medicines<sup>2,6,19-23</sup>**

|   |
|---|
| <p><b>Share views and agree on a stopping plan</b></p> <p>Discuss the patient's goals for stopping or reducing use.</p> <p>Agree on a rate and duration of cessation.</p> <p>Outline the type, nature and expected duration of withdrawal symptoms.</p> <p>Advise on strategies for managing withdrawal symptoms (e.g. increasing dose temporarily, using behavioural and cognitive therapies, and avoiding substitutive therapy such as alcohol).</p>  |
| <p><b>Taper dosage gradually on an individual basis</b></p> <p>Modify dose and/or frequency based on severity of withdrawal symptoms.</p> <p>Allow time to stabilise between dosage reductions (at least several days).</p> <p>Consider referral to a specialist if dose reduction proves too difficult in primary care.</p> <p>Tailored approaches to benzodiazepine dosage reduction may include:</p> <ul style="list-style-type: none"> <li>• Reducing dose by 10% to 20% per week if it is within or slightly above the recommended amount.</li> <li>• Stabilising on an equivalent dose of diazepam for a few days before dose reduction, if patients were using higher than recommended doses or finding it difficult to reduce the dose of a short-acting benzodiazepine (avoid diazepam in older people).</li> <li>• If multiple benzodiazepines are used, the dose of each drug may be reduced one after the other.</li> </ul> |
| <p><b>Ongoing review and use of non-drug therapies</b></p> <p>Monitor the effect of stopping or reducing use on sleep patterns, mood, withdrawal symptoms and use of other substances (e.g. alcohol, nicotine): aim initially for weekly review.</p> <p>Encourage ongoing use of non-drug therapies to manage insomnia and to help with maintaining cessation or reduction in use.</p> <p>Suggest strategies for coping with increased anxiety or insomnia that may result from the stress of modifying use itself.</p>   |
| <p><b>Provide support and reassurance</b></p> <p>Engage family, carers and/or staff in aged care facilities in supporting patients who are attempting to stop or reduce use.</p> <p>If unsuccessful, reassure the patient that further attempts are worthwhile.</p> <p>Repeat STOP steps when patients are willing to try again.</p>  |

## What if hypnotic medicines cannot be stopped?

For patients who have been treated for more than 4–6 months, continued use for insomnia may be acceptable when:

- they are sleeping well and have no adverse effects,
- they are aware that they may be unintentionally dependent, and
- attempts to stop treatment are refused or unsuccessful (see Box 2).<sup>19</sup>

People who are unable or unwilling to stop long-term treatment should be offered non-drug strategies that might reduce their need for a hypnotic medicine, and should have regular medication reviews.<sup>19</sup>

### Other drugs and herbal medicines?

Because of limited evidence and/or the risk of adverse effects, other medicines such as sedating antihistamines, tricyclic antidepressants, melatonin and valerian, are generally not recommended for insomnia.<sup>2,19,20</sup> Antidepressants should only be prescribed for insomnia that coexists with depression.<sup>2,3,21</sup>

*The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence. Any treatment decisions based on this information should be made in the context of the clinical circumstances of each patient.*

### Expert reviewers

Prof John Tiller  
Professor of Psychiatry,  
The University of Melbourne  
And Albert Road Clinic, Melbourne VIC

Other reviewers are listed  
at [www.nps.org.au/news\\_67](http://www.nps.org.au/news_67)

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