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EDITORIALS

Non-benzodiazepine hypnotics: do they work for insomnia?

Their modest effect highlights the need to use alternative approaches

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Insomnia is a common disorder that greatly affects health and quality of life as well as having direct and indirect costs for healthcare systems and society.[1 2] People with insomnia present to many areas of healthcare: primary care; specialist services, such as internal medicine and psychiatry; and allied health providers. Healthcare practitioners therefore need to understand the treatment options available for insomnia and their relative effectiveness.

In a linked research paper (doi:10.1136/bmj.e8343), Huedo-Medina and colleagues report on the effectiveness of non-benzodiazepine hypnotics in the treatment of adults with insomnia.[3] The authors aimed to reduce the impact of publication bias by using all studies submitted to the Food and Drug Administration for drug approval, thereby adding to the current literature. They found that non-benzodiazepine hypnotics reduced the time taken to fall asleep (sleep onset latency) by 22 minutes (95% confidence interval −33 to −11) compared with placebo. When drug and placebo effect components were combined the reduction in sleep onset latency increased to 42 minutes. It was not possible to evaluate secondary outcomes because not enough studies consistently reported them.

These findings are in keeping with previous studies that have shown a similar modest effect size for both non-benzodiazepine and benzodiazepine hypnotics.[3] Non-benzodiazepines are commonly used in the management of insomnia. However, their relatively modest effects serve to highlight the need to reduce reliance on hypnotic drugs as sole treatments for insomnia. Data from many developed countries show that hypnotics are the most commonly used treatment for people who seek help for insomnia in primary care. Australian data from 2987 general practice treatment episodes of sleep disorder showed that 81% of patients who reported a new problem of insomnia were prescribed a drug.[4] Rates of referral for advice or counselling were low and only 0.8% of patients were referred for specialist care compared with an average across all general practice presentations of 8.3%.

Psychological treatments, such as cognitive and behavioural therapy for insomnia (CBTi), have been shown to be effective, with similar effect sizes to those seen for non-benzodiazepine hypnotics.[5 6] In addition, the effects of CBTi persist even after active treatment has stopped. This is important because we now know that insomnia has the characteristics of a chronic illness, with persistence of symptoms or relapse after remission, rather than isolated episodes.[7]

The current study, together with the existing literature, shows that non-benzodiazepine hypnotics, benzodiazepine hypnotics, and CBTi are all effective treatments for the stable symptoms of insomnia. What is not clear is how, in practice, to combine these treatments. An insight into how treatments might be combined comes from a trial of 160 patients randomised to CBTi or CBTi plus the non-benzodiazepine hypnotic, zolpidem 10 mg, for six weeks.[8] A subgroup of 37 people, who used zolpidem plus CBTi for six weeks and then stopped zolpidem, did better at six months than those who continued to use zolpidem as needed, or those who had CBTi alone. Further work is needed to clarify how combined treatments that have different mechanisms of action and time courses of onset and offset of effect should be sequenced for optimum effect. In addition, the significant placebo effect seen in this and other insomnia studies highlights that, to improve symptoms, clinicians need to take a caring, informed, and structured approach to the management of insomnia.

To date, much of the research in this area has focused on sleep related outcomes. However, as our understanding of insomnia—particularly its chronicity and interaction with other disease processes—increases, we need to reconsider what the aims of treatment should be. Although patients often worry about minutes of sleep "lost" each night, it may be more important from a broader health perspective to focus on outcomes such as frequency of relapse or the effect of insomnia on comorbid conditions. As an example, because insomnia is commonly associated with depression, the effect of managing insomnia on depression outcomes could be evaluated.

Current evidence suggests that reliance on hypnotic drugs as the only treatment option for insomnia is misguided. It is important to consider other effective treatments, such as CBTi, to optimise outcomes for patients with insomnia.

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