Appendix 3. Themes, subthemes and illustrative quotes

General approach to sleep disorder	Sleeping problems are a symptom, not a diagnosis	Exploring the problem	And I would want to really flesh that out first. So, asking sort of why is it that you're not sleeping and what's going through your mind when you're laying down, and I would suspect that that would unearth quite a bit of kind of emotional baggage and, you know, grief, maybe depression, maybe some, you know, ruminating thoughts or guilt or whatever it is that she's processing that's going through that. Participant 4 [Explore] kind of those bigger picture things, and just try to really get a sense of this patient's context. So, yeah, like how is she coping, what are her support systems, what is she doing to help herself through this difficult time. Yeah, and then like in the background is there a family history of mental health issues, and is there a previous history of sleep disturbance and those kind of things. Certainly if she's using any unhealthy coping mechanisms like alcohol or stuff like that, that can affect sleep. Really try to get a sense of what her expectations are, especially if she's expecting a prescription for a sleep medication, what she knows about sleep medications or what she knows about healthy sleep habits. I would try to get a sense of that. Participant 6 so look at all the other factors that might be affecting this person….. You know, who knows what else is going on? Participant 8 Insomnia can be part of other health problems right? So you know, just you know back to the sleep history, trying to figure out well are they not sleeping because of pain? Are they not sleeping because they've got major

			depression that hasn't been treated properly and it's like an organic piece there? Participant 10
		Exploring takes time	If I'm running behind my clinic, this is something that warrants a deeper dive and a more in-depth conversation. Which obviously isn't going to be feasible on the day. So, I would refill and ask the – just, you know, let the patient know there is – there's other alternatives out there and this may or may not be an appropriate medication for you, but I can't really tell based on, you know, a limited interaction today. So, I'd really like it if we could connect for a bit of a longer session and talk about what this has been doing for you in the past, whether it's still working, make sure that you're aware of, you know, all the risks and alternatives that go along with this. Participant 4 Like a refill, refill, done. […] If we're running behind and this is a refill and we are swamped it's unlikely that I would have the resident do anything more than, "There's other options out there have you thought about these?" Participant 5 But I think certainly patient expectations around insomnia is a huge thing. Like sometimes it's actually like I can't even get to treatment on the first or second visit because it's just managing patient expectations. Participant 6
		Sleep disorder can be emotional - for patient - for physician	But it's such an emotional topic for patients and some of the concepts in CBT for insomnia are so counterintuitive that it takes a while to really help people understand it. Participant 2 I think sleep is an emotional discussion, right? Like, people get very upset about the lack of sleep, or perceived poor sleep. [Patients] who are not getting sleep lose the ability to be perfectly rational. Participant 3

			Looking at that emotionality. Participant 7
	Individualising care	Different from other presentations	It's very dissimilar to the approach to a lot of other meds, you know. Like managing asthma. Yeah, there's a little bit of individualization in someone's asthma action plan, but there's only so many ways you can create an asthma action plan. Participant 2 I don't have a sort of formula for it. Participant 7 It's a very situational kind of thing. Participant 8
		Individualize plans	So, then rapid follow up to go to other layers of stress management and maybe teach her Body Scan. She would probably be really amenable to it. I've known her for a long time, and she likes that sort of thing. You know she's not someone that would want to be taking Zopiclone. Participant 1 It's individual medicine it doesn't follow guidelines. It's like you're breaking rules so that you can actually do what's right…. So it's just a matter of knowing when patients are the exception and when you have to work with these drugs smartly and safely to help your patients. Participant 2 where clinical judgment and therapeutic relationship with the patient and kind of a longitudinal multi-step treatment plan come into play. Participant 4
	Balancing risks and breaking rules	Medication awareness	I'm not a huge fan of Zopiclone. But ….I might use, I might use Zopiclone. And why? Just because it's super short-term, you know. , I don't love the Benzo's. I certainly don't want them to take Gravol. Because we just know it doesn't benefit the sleep cycle. You know, it makes things worse. I think Benzo, is similar to treating your sleep with

			booze, which many people do. You know and get sleepy with booze, but then it wrecks the sleep cycle. So then over time they get more tired and over time they may get more depressed. Participant 1 I am slightly – I call it crazy – I hate [Z]-drugs, and usually when patients talk to me about insomnia, they want a Z-drug…. I think I've seen such terrible consequences for my patients and for family members on Z-drugs that I'm very hesitant about it. … I think all of these drugs to treat insomnia sometimes mask the problem. Participant 3 So, on one hand, you need to balance an unsafe mixture of GABAergic medications with, you know, your risk of seizure if you disrupt kind of the balance that's been struck with long-term tolerance. So, in a situation like that, I guess social and medical stability is probably my biggest consideration. I would not want to make any medication changes that are going to disrupt a medically stable for the time being situation. With that being said, that status quo doesn't sound very acceptable from a risk standpoint to me. And so, the very frank discussion that I would have would be, look, mixing, you know, alcohol and benzos is not safe, these are the potential risks. You know, there's not – going cold turkey on either one of those is not a good way of tapering down and is quite dangerous. This is where it's really important to kind of assess where the patient's at first before trying to make any kind of recommendations. Participant 4 I also try and get them to not jump to medication as kind of a first line. And if they're going to take kind of a medication route, to just be aware of the breadth of different options. Participant 4

			So we all know that it's not our go-to strategy, but we also accept that there is a role in certain situations and that we'd be willing to meet our patients sort of half-way with that. And then we do lots of counselling around potential adverse effects and consequences of using things like Z-drugs. Participant 7 Ah, this is your classic difficult patient. We have many red flags in this story, the chronic pain, the alcohol, the benzodiazepine use, etc., the early refills. These are all red flags and dangers and cautions with that medication. So really, you're thinking in the back of your mind we need to get this guy off of this medication because he's either subverting it, so selling it to somebody else, or he's taking too much himself, highly risky in a person drinking alcohol. Participant 4 This guy can kill himself if he's not careful, and you could be a participant in that, which you don't really want to be. So I think – and then you can't, if he's been on it a long, long time, you don't want to suddenly pull it and withdraw from benzodiazepine, you know. He'll get delirious and seize or shaking and sweating and anxious, and, you know, in being off it, so there's not an easy way. Participant 8 I'm not a huge one in favour of medications. I don't believe in medications. If we do use them, try not to use the benzos, use the tricyclic or something else, depending on the patient, whether it's safe or not. Participant 8 So Z-drugs, I use very, very sparingly – very, very sparingly. Participant 9

			Benzos seem to be pretty taboo right now. Or like in the past few years, they've really gotten a really bad rap. Participant 10
		Balancing and breaking rules	You have to be really comfortable with uncertainty. Participant 2 Just because something is not first line in long-term use doesn't mean that it's not appropriate in specific situations. real life medicine isn't kind of a black and white, that guidelines that say, you know, you should try not to use certain medications in situations doesn't mean that you can ever use them and that it's not ever appropriate to use them. Participant 4 insomnia treatment in general, and it's that it's very challenging, it's something that I think often you need to balance compassion for the patient's experience, much like, I think, you know, depression or anxiety. It's – it affects different people in different ways. And so, you can never really make an assumption bout how debilitating someone's – or bothersome someone's insomnia is. But that's something that always needs to be balanced with the fact that a lot of the treatments and a lot of the most common treatments that people have been on or exposed to or heard about are quite dangerous or risky when misused. Participant 4 You're trying to balance risks and benefits for a patient. Participant 7
		Give and take	I always say like I'm not saying you can't have your meds, I will give you your meds if that's what you want. But I just want to talk about some other options just to know if you're aware of them. Participant 2

			I am not taking this away from you. This is not – today we are not taking this away from you. But I do want to make sure that we're using the best methods for you to sleep the most efficient and to feel the best you can feel, especially after a good night's rest. And would you be open to other options, if there are better options? Participant 9 My approach usually, when a patient requests for something, is the first thing I say to them is like, yeah we can totally get you something like that. Like I just kind of agree with them. And then I go on to explain, and we also have some other options so let's discuss kind of what all the options are and then we can decide what would be best for you. Participant 10
	Establishing therapeutic alliance	Establishing trust – showing compassion	You just have to stop judging, and you have to keep them safe. Participant 2 I try really hard to come at it from, like, not a point of judgment, like, I don't want them to feel embarrassed or ashamed of whatever the reasoning behind the early dispensing or the early refill request is, but just to understand. Participant 3 I think that this case has a lot of room for judgment. Right? And it's hard to be non-judgmental. And I learned it really hard, because I used to work at [cups] downtown, right? And so, you saw – I saw a lot of, you know, street-involved or homeless or [unintelligible 00:55:58] dependent and alcohol and drugs and, like, there's so much more complexity to their social circumstance that I had to learn to be non-judgmental. Participant 3

			Because, like, grief is hard. Like, I don't know that I would necessarily, like, wag my finger at her about it. Participant 3 It takes patient buy-in, and that alone also takes time in hearing and validating their experiences and trying to develop a bit of a therapeutic alliance before stepping into your management plan. Participant 4 I think that one thing that I try to emphasize is the centrality of that patient trust and validating that patient experience, and not just being focused on kind of a single minded de-prescribing paradigm. Participant 4 being able to suggest and offer alternatives to that, there needs to be that understanding that they know that you understand what they're going through. And sometimes that can happen on the first visit, and sometimes that's something that's built with time. Participant 4 I think that one thing that I try to emphasize is the centrality of that patient trust and validating that patient experience, and not just being focused on kind of a single minded de-prescribing paradigm. Participant 4 I tend not to be hard-nosed about that [laughs] because it doesn't really help. Participant 5 Don't focus too much on the sleep and realise you have somebody who's grieving, and that's your first thing is to listen to this person and offer support. Participant 8

			I'd have them be very cautious about how you approach them, because they're having a difficult time and you're being a support for these people. Participant 8 So, then I'll have to be a little more sensitive around talking about that medication. Because they don't have the established relationship with me. Participant 9 I would hope it's somebody that I know already, that I have a bit of a therapeutic relationship with. I guess I would like to understand just where she's, like just how things are affecting her. Participant 10
		Shared decision-making	You know, and depending on how that went, if the patient was not open at all – like it's – I mean it's a bit like stages of change in motivational interviewing, if they were totally pre-contemplative, then you handle it like that. …. And if they're totally pre-contemplative, you leave it open, like you know, that's totally fine, it's your health. It's your choice. Participant 2 You're much more likely to be successful and engaging with the patient and keeping them on side if you are a collaborator. Participant 5 Look for opportunities to see if they're in that contemplative phase. Participant 7 Like, This is – I'm not telling you this is how we're going to do things. This is – we're going to decide as a, as a team. Participant 9
		Sharing evidence	**exception battling: either I have the conversation or I have the battle about me not prescribing. Participant 3

			It was a beautiful study but it was like 40% improvement using credible rating scales. Participant 5 I have a really good hand-out. Participant 6 I usually have like my RxFiles with me. Because most of them know Zopiclone. Most of them know, like Melatonin. So, I'll have that with me so that we can go through the RxFiles together to see, "OK. Well how does it work? What's the evidence for it? Participant 9 Like I'll do a little bit of the top guidelines with them maybe. Participant 9 I'll say, This is the evidence. Like this is the evidence for and against. This is where I'm coming from. Participant 9
Deviations from standard care	Valid exceptions		[…] So it's just a matter of knowing when patients are the exception and when you have to work with these drugs smartly and safely to help your patients. Participant 2 So, there are definitely significant exceptions regarding Z-drugs, I have easily, like, five patients I can think of that I do prescribe without question for…..There are totally reasonable exceptions, but I won't understand if a person meets my reasonable expectation or exception criteria if I don't have this conversation with them. So, you know, with an acute stressor like this, I think that we had come up with this a little bit in, like, talking about some of my past examples, I automatically see a lane into my exception pathway. Participant 3

			There is a difference between somebody who's had the occasional Z-drugs for flying and stuff like that and then somebody who's regularly on it. Participant 5 I think I am a little less hesitant to use sedatives because I feel comfortable in choosing patients that I'm going to be able to get off of them once we get them through whatever. Participant 7
		Short duration Acute stress	prescriptions listed but like they're for five days. Participant 2 And so, for a very, very brief period of time, I prescribed for him. Participant 3 based on it's a short period of time. Participant 6 And I think I justify that based on it's a short period of time, it's an extremely stressful period of time. Participant 6 You're seeing someone who's more in acute distress and you may be more willing to give them a simple temporary solution. Participant 7 I don't believe in medications. If we do use them, ….I use it very short term. I set that expectation very early, But in the short-term, it could potentially help. Participant 8
	Caring for a colleague's patient	Can't step into another providers shoes	Bring it up, but, again, not my patient, don't have a relationship with them. Participant 3 Something that I've – in my own personal practice – realized over the course of locum-ing for several physicians is that you can't step into another provider's

			shoes and expect to change, you know, a multi-decade treatment plan over the course of a week. And so, there's always a bit of a balance there, and I think a lot of that depends on how the interaction goes with the patient and how responsive the patient is. There's no sense in fragmenting or – a relationship with a patient or making the patient feel either nervous or discriminated against or anything like that when, you know, you're not the one that's going to be able to really speak into that patient's treatment plan on an ongoing basis, or deal with the symptoms if your proposed alternative doesn't work. Participant 4 So I approach it from a perspective of this isn't my patient, I want to respect the fact that I don't know their history, I don't know what they've been – like what the decisions are that have been made by their previous physician, or their regular physician I should say in this case. So I'll approach it from a perspective of I'm probably not going to change things today, and I shouldn't, maybe, because this is not my patient, I'm not responsible for their ongoing care, but with the same knowledge that I can take an opportunity to do some education with a patient. Participant 6 You don't know how that all ended up like that, so rather than focusing on that, it's just how do we go from here and making suggestions. Participant 8 I mean if somebody's been on zopiclone and I can see from the record it's been pretty stable and that's what they've been using, usually I'm not, I don't really like being another chef in the kitchen, I don't like adding to

			something or like I don't know the history so maybe she's tried a lot of things. Participant 10
		Don't step on toes	There are some of our colleagues that if you were to try and suggest some alternative strategies would be [pause] a little sensitive. Participant 5 You're not wanting to step on the toes of the primary doctor but trying to maintain some consistency with the messaging between the primary doctor and you. Participant 7 You don't want to offend our colleague, and we all live in a glasshouse and we don't want to throw rocks. Participant 8
		Balancing 2 (navigating uncertainty); bridge, band aid, patchwork, planting a seed	I think about that, this is not my patient, this is not my patient to have that discussion with. I am covering for a colleague to some extent. But I'm still responsible for prescribing. So, it's balancing those two things. I will bridge you until then, these are the reasons I'm not giving you a long prescription, because I am uncomfortable, these are not how these drugs are meant to be used, and there's maybe more work that needs to be done. Participant 3 And it's this really fine balance, because I really believe that I have to take responsibility for every prescription I write, and I can't hide behind this idea of, well, if somebody else does it, so I'm just covering for them. Right? Because that's a little bit of that horrible locum practicing or that horrible, like, walk-in medicine style, where, "Oh, this person's been on it for ages, I don't need more history, just keep going." Like, I have to be responsible for what I prescribe. Participant 3

			I will bridge you until then, these are the reasons I'm not giving you a long prescription, because I am uncomfortable, these are not how these drugs are meant to be used, and there's maybe more work that needs to be done. Participant 3 of how do you manage a treatment plan that you maybe don't personally agree with, but that has been initiated by another prescriber? And so, the idea of sort of immediate patient safety being a number one consideration and then not trying to kind of go off and do your own thing, but involve, you know, their provider in whatever you want to do or whatever you think needs to be done as a long-term plan. Participant 4 I would probably probe the patient a little bit, time permitting, and just get a sense of, first of all, whether there's any significant, like, immediate red flags, you know, like, escalating doses of Zopiclone or early refills or things like that. Something like that, I would probably flag – I would refill, you know, a short course and ask them to follow-up with their primary provider and probably send them a message. If it doesn't seem like there's anything like that, then I would probably throw out a bit of a prompt to the patient and just say, you know what, there could be some alternatives here that might work better for you. Participant 4 So then do I put a bit of a patchwork plan together to get him to the primary doctor so that he can fix the problem. That's I think the ideal scenario, so I don't want him to go into withdrawal, I want to set some limits though, so I may not give him – I wouldn't like to give him his usual dosing, but I might give him enough to just keep him out

			of the emergency room until his primary doctor can see him. Participant 6 I might just give them a shorter prescription. Participant 6 To summarise, my approach to these patients is always what's your stage of change. Because if their stage of change is like pre-contemplative then you're definitely not going to make a change, and I'm definitely not going to make a change if I'm not their primary care physician. But if I can provide – it's like smoking cessation, and like, you know, even if I was seeing somebody who's a smoker who's not my patient, I'm still going to say where are you at with being ready to quite, you know, quitting smoking is the best thing you can do for your health, et cetera, et cetera. So I might try to fit in a little education there. But if I get a lot of resistance from the patient then I'm not going to push it. Participant 6 Again, this is one of those things, it's not my patient, I have to sort of Band-Aid the situation, to plant the seeds and have them follow up in the short term, because there's going to need to be a discussion here about everything, about how to treat alcohol abuse disorder, about how to taper off benzodiazepines, and the signs of, you know, the early refills, etc, combined with alcohol, are a very risky business and inappropriate. And so yeah, there's going to have to be some discussion about that. Participant 8 And then to start the conversation of, "Well, maybe this is the medication that – like do we need it or can we do better with something else for it?" And I won't take it

			away necessarily from them, not at the first visit of interacting with them. Participant 8 But something that I would flag as, “Hey, this is something important that maybe you want to discuss with your family doctor, or you’re welcome to come back and talk to me about it, if you’re comfortable doing so.” But I would talk to them about the risks and benefits with something like this, with long-term use. Participant 9
Strategies Used			I try to focus first on non-pharmacological interventions whenever possible. Participant 2 I try to avoid medication wherever possible or at least build it into a more comprehensive plan. Participant 4 CBTI Sleep hygience Body Scan Reground how they view sleep Mindfulness Sleep doctor Journalling Sleep diary