Guidelines for Treatment of Primary Insomnia
(Adults aged 18-65)
Version: 2

| Summary: | Guidelines for the treatment of primary insomnia. Insomnia can be understood as a difficulty in initiating or maintaining sleep, early waking or non-restorative, poor quality sleep. |
| Keywords (minimum of 5): (To assist policy search engine) | Primary Insomnia, Insomnia, Sleep, Sleep Problems, Hypnotic, Zopiclone, Temazepam, Zolpidem. |
| Target Audience: | Heads of Professions, Medical Staff, Nursing Staff working in Clinical areas, Pharmacists, MHPs. |
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Guidelines for Treatment of Primary Insomnia
(Adults aged 18-65)

Definition – Insomnia can be understood as a difficulty in initiating or maintaining sleep, early waking or non-restorative, poor quality sleep which occurs despite adequate opportunity and appropriate circumstances for sleep, resulting in impairment in daytime functioning (including impairment in concentration or attention, social or vocational dysfunction, mood disturbance, daytime sleepiness, headaches or gastrointestinal symptoms and worry or concern about sleep).

Assess for underlying physical or mental health problem (secondary insomnia) and treat according to relevant guideline.

Monitor sleep pattern
Measure sleep efficiency & use to monitor improvement/progress i.e. change relative to that person:
Total time the patient thinks they are asleep (mins) ÷ Total time spent in bed (mins) x 100

Provide sleep hygiene advice (see overleaf) and ‘Can’t Sleep?’ patient leaflet
Refer to self-help materials (in a written or on-line format)

If improved

If unsuccessful after 2-4 weeks

Provide CBT approach where available (see overleaf)

If improved

If no improvement and insomnia is severe, disabling or causing extreme distress

Consider Hypnotic
(see overleaf for prescribing principles)
Delayed onset – Zolpidem £
Sleep maintenance – Zopiclone £ or Temazepam (CD) £££

If improved

If unsuccessful after 2-4 weeks

Repeat once

No further treatment required

If no response, stop, review diagnosis. If partial response, continue for 2 weeks and review, repeat once. Consider alternate day long-term treatment with Z-drugs e.g. once or twice a week.

Steps 1-2
Steps 3-4
Step 5

Insomnia is a common and highly subjective complaint.
Insomnia is usually self-limiting but persistent insomnia can lead to impairment of functioning with reduced quality of life.
Initial focus should be on treating underlying causes (e.g. physical illness, mental illness, drug side effects or time of administration)
Many patients have unrealistic sleep expectations so an objective measure of sleep (sleep efficiency quotient) should be used to assess sleep pattern.
A stepped care approach should be followed with sleep hygiene advice and self-help materials first line.
Hypnotics should be used to treat insomnia only when it is severe, disabling, or causing the patient extreme distress.
An exception to the guidelines is in the case of short-term management of bereavement, in which drugs maybe considered first line. Short term use only will need emphasising to the patient.
These guidelines do not cover sleep disorders such as narcolepsy, cataplexy, sleep apnoea etc.
These guidelines should be applied regardless of setting (primary/secondary care, inpatient/outpatient).
New law on driving having taken certain drugs (July 2014) in force from 2nd March 2015. Information for Health Care Professionals can be found at www.gov.uk/government/collections/drug-driving with link to a leaflet to be given to patients.
Steps 1-2 Sleep hygiene

- Try to go to bed and rise at the same time each day—this sets your BODY CLOCK.
- Create a RESTFUL BEDROOM for sleep—cool, quiet and dark.
- EXERCISE regularly—but avoid exercising too close to bed time as it may keep you awake.
- Have a “WIND-DOWN ROUTINE” for the 30 mins when getting ready for bed.
- If you have worries, LIST them on a piece of paper so that you can tackle them in the morning.
- AVOID caffeine, nicotine, food or alcohol in the hour before bedtime or during the night.
- Be aware that reading or watching TV in bed can make some people more alert.
- DO NOT HAVE DAYTIME NAPS—to catch up on missing sleep! This will make it harder for you to sleep at night and upset your body clock.
- The more you worry about sleeping, the harder it will be for you to sleep.

Steps 1-2 Self Help/other Leaflets

“An Introduction to Coping with Insomnia and Sleep Problems” Colin A. Espie (2011)
www.patient.co.uk
http://rcpsych.ac.uk/expertadvice.aspx

Steps 3 - 5 CBT approach

Delivered by CBT-trained clinicians
4-8 sessions (group or individual)
Involves formulation of interaction between thoughts, physiology and behaviours relating to sleep.
Cognitive strategies include thought challenging, re-appraisals, behavioural experiments etc.
Behavioural strategies include relaxation, sleep restriction etc.

Steps 4 - 5 only Hypnotics

Prescribing Principles

- Hypnotics are only to be used when the insomnia is severe and disabling.
- Wherever possible hypnotics should only be prescribed for short periods (less than 4 weeks), in strict accordance with their licensed indications. However dependence is not inevitable.
- All hypnotics have the potential for misuse and abuse but this varies between hypnotic agents.
- Care should be taken when prescribing due to potential for ataxia and consequent falls, particularly in the elderly.
- When prescribing awareness should be given to sedation, hangover effect, affecting driving and performance of skills tasks.
- Ideally hypnotics should not be used every night.
- Intermittent dosing may further reduce the risk of tolerance and dependence (Wilson, 2010).
- Other medications, including OTC preparations, should be reviewed for their impact on sleep and daytime drowsiness.
- Factors which need to be taken into account when prescribing are efficacy, safety and duration of action.
- Other prescribing considerations are previous efficacy of the drug or adverse effects, history of substance abuse or dependence.
- A rational approach is to carry out periodic trials of tapering and discontinuation of medication. Concomitant CBT during tapered discontinuation improves outcome. (Wilson, 2010).
- BNF recommends use of hypnotics for short-term use only up to 2-4 weeks. However there will be some patients in whom short-term use has been tried repeatedly and has been found not to be beneficial. In this group there may be an argument for longer term use, preferably on an alternate night basis and at the lowest dose possible.
- Ensure treatment and side-effects are clarified with the patient and DOCUMENTED.

Choice of Hypnotic

- See current BNF for details of recommended dosage and adverse- effects etc
- Zolpidem has the quickest onset of action and hence is more suitable for sleep-onset insomnia
- Zopiclone or Temazepam may be more suitable for maintaining sleep.
- Switching from one hypnotic to another should only occur if a patient experiences adverse effects.
- There is evidence that dependence is not inevitable for up to one year with Zolpidem (Wilson 2010), but this is not within its Licence.
- Consideration should be given to intermittent dosing i.e. only taking a hypnotic when it is really needed. This may further reduce the risk of tolerance and dependence. A sensible prn use maybe once or twice a week.
- Hypnotics should be withdrawn gradually following chronic use because abrupt withdrawal may produce rebound symptoms of insomnia & agitation (see withdrawal advice in current BNF)
- Advice from secondary care may involve the use of other drugs.

Further Reading:

- NICE Insomnia – Newer hypnotic drugs (TA77), 2004
- 2004/021 NICE issues guidance on the use of drugs for the management of insomnia