Guidance For NHS Grampian Clinicians On The Management Of Insomnia And The Use Of Hypnotics

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Guidance For NHS Grampian Clinicians On The Management Of Insomnia And The Use Of Hypnotics

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Guidance For NHS Grampian Clinicians On The Management Of Insomnia And The Use Of Hypnotics

1. Introduction

This guidance is intended for use by all clinicians involved in the management of insomnia in NHS Grampian to provide consistency in practice across the Health Board area.

2. Classification Of Insomnia

2.1. Transient insomnia may occur in those who normally sleep well and may be due to extraneous factors such as noise, shift work and jet lag. If a hypnotic is indicated one that is rapidly eliminated should be chosen and only one or two doses should be given.

2.2. Short-term insomnia is commonly related to an emotional problem or serious medical illness. It may last for a few weeks (generally less than 4 weeks\(^1\)) and may recur. Short-term use of a hypnotic may be useful. For further information see: http://cks.nice.org.uk/insomnia#!backgroundsub

2.3. Chronic insomnia is commonly associated with psychiatric disorders such as anxiety, depression and misuse of drugs and alcohol. Hypnotics are **not recommended** as they are rarely beneficial. Instead focus should be given to treating the underlying cause. For further information see: http://cks.nice.org.uk/insomnia#!scenario:1

2.4. Secondary Causes of Insomnia

Other medical co-morbidities and/or prescribed medications can affect sleep. Resolution of these secondary conditions is often necessary to resolve symptoms of insomnia. For further information see: http://cks.nice.org.uk/insomnia#!backgroundsub and click on “Causes”.

3. Management of Insomnia

Insomnia can be caused by a number of underlying conditions, including the use of illicit drugs. Alcohol consumption is also common and can impact on sleep, but is often understated.

3.1. Hypnotics do not treat the underlying causes of insomnia

Non-pharmacological measures should be considered first line in the management of insomnia. A sleep diary can be used to identify underlying causes of insomnia (see Appendix 1). Self help guides are also available an example of which can be found on the Mood juice website: http://www.moodjuice.scot.nhs.uk/sleepproblems.asp
3.2. **Sleep Hygiene**

**Advice for Patients**

Sleep hygiene aims to make people more aware of behavioural, environmental and temporal factors that may be detrimental or beneficial to sleep. Advise the person to:

(i) Establish fixed times for going to bed and waking up (and avoid sleeping in after a poor night's sleep).
(ii) Try to relax before going to bed.
(iii) Maintain a comfortable sleeping environment: not too hot, cold, noisy, or bright.
(iv) Avoid napping during the day.
(v) Avoid caffeine, nicotine and alcohol within 6 hours of going to bed. Consider complete elimination of caffeine from the diet. Bear in mind any stimulant drugs such as cocaine, amphetamines and new psychoactive substances will affect quality of sleep and should be avoided.
(vi) Avoid exercise within 4 hours of bedtime (although exercise earlier in the day is beneficial).
(vii) Avoid eating a heavy meal late at night.
(viii) Avoid watching or checking the clock throughout the night.

See also Appendix 2 sample patient leaflet.

Refer to [http://cks.nice.org.uk/insomnia#!scenario#](http://cks.nice.org.uk/insomnia#!scenario#)

4. **Pharmacological Management**

Before prescribing a hypnotic, non-pharmacological measures should be considered and recommended. Hypnotics carry a risk of tolerance and dependence, and danger in overdose, particularly when combined with alcohol and other respiratory depressants. If a patient is under the care of a substance misuse CPN or doctor please discuss with them prior to considering prescribing in primary care.

4.1. Hypnotics must only be considered when insomnia is disabling to the patient as physical and psychological dependence can occur after even short-term use.

4.2. Hypnotics should be prescribed at the **lowest effective dose, for the shortest period of time necessary, to re-establish a regular sleep pattern** and in strict accordance with each manufacturer's licence as the risk of dependency increases with dose and duration of use. It is recommended that, if necessary, hypnotics are prescribed for a **maximum period of 14 days and then reviewed and if necessary continued for up to 4 weeks**.

4.3. There is no evidence that intermittent or "pulse" regimens prevent dependence and should be avoided.

4.4. Temazepam and the Z-drugs, zopiclone and zolpidem are currently recommended as first line choice for use in NHS Grampian (April 2016). Hypnotics should however be avoided in the elderly wherever possible. The elderly are at risk of becoming ataxic, confused and so liable to fall and injure themselves. Current “street” value and issues with misuse or diversion should be considered when prescribing for substance misuse patients.
Zopiclone is a short acting, non-benzodiazepine hypnotic which acts at benzodiazepine receptors (schedule 4 part 1 controlled drug). It has a recommended dose of 7.5mg at bedtime (elderly initially 3.75mg).

Zolpidem is also a short acting, non-benzodiazepine hypnotic which acts at benzodiazepine receptors (schedule 4 part 1 controlled drug). It has a recommended dose of 10mg at bedtime (elderly or debilitated 5mg).

Temazepam is a short-acting benzodiazepine (schedule 3 controlled drug) with a recommended dose of 10-20mg at bedtime.

4.5. With specific reference to patients receiving methadone, current UK guidance\[^2\] states that “insomnia in patients receiving prescribed methadone may be best alleviated by reviewing methadone dose, encouraging cessation of any stimulant misuse and guidance on management of sleep disturbance”.

4.6. Sedative drugs other than hypnotics (such as antidepressants, antihistamines, choral hydrate, clomethiazole, and barbiturates) are not recommended for the management of insomnia. Expert opinion from reviews suggests that there is insufficient evidence to support their use and that the potential for adverse effects is significant.

4.7. For patients undergoing opioid detoxification, prescribing symptomatically may reduce some of the physical effects of withdrawal although there is no supporting evidence which suggests that this will improve the outcome. For agitation, anxiety and sleeplessness experienced during opioid detoxification current guidance\[^2\] recommends “diazepam (oral) up to 5-10mg three times a day or when required (or zopiclone 7.5mg at bedtime for patients who have been dependent on benzodiazepines). In severe cases of anxiety and agitation, obtain suitable psychiatric advice from an addiction psychiatrist or the on-call duty psychiatrist”.

4.8. Prescribing of the 10mg diazepam tablets should be avoided where possible due to the higher street value these can have on the illicit market.

4.9. Switching between hypnotics is not recommended where the patient has not responded to treatment and is only recommended where the patient has experienced an adverse effect to treatment.

4.10. It is recommended that patients are not prescribed more than one benzodiazepine, or combination of Z-drug and benzodiazepine, concurrently. Where combinations are prescribed it is advisable to convert the doses of each to the equivalent dose of diazepam.

Table 1: Anxiolytic and hypnotic doses equivalent to diazepam 5mg

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam</td>
<td>5mg</td>
</tr>
<tr>
<td>Nitrazepam</td>
<td>5mg</td>
</tr>
<tr>
<td>Temazepam</td>
<td>10mg</td>
</tr>
<tr>
<td>Zaleplon</td>
<td>10mg</td>
</tr>
<tr>
<td>Zopiclone</td>
<td>7.5mg</td>
</tr>
<tr>
<td>Zolpidem</td>
<td>10mg</td>
</tr>
</tbody>
</table>
Nitrazepam and zaleplon are not recommended, they are included in the equivalent table should a patient need to be converted to an appropriate therapy.

4.11. Reduction of Sedative Hypnotics [2]

Where patients have been prescribed a hypnotic for the recommended, limited period of time (2 - 4 weeks or less) dependence should not be an issue and the hypnotic merely stopped. Gradual withdrawal may be required for those patients who have received a long term prescription and/or dependence is suspected. Refer to local NHS Grampian guidance below:

Guidance For The Community Management Of Benzodiazepine And Z-Drug Dependence And Withdrawal In NHS Grampian

4.12. Contraindications, cautions and side effects

A full list of contraindications, cautions and side effects for each drug can be found in the Summary of product characteristics or the British National Formulary.

5. Driving

Advise the person not to drive if they feel sleepy (although it is not necessary to inform the Driver and Vehicle Licensing Agency [DVLA] unless a primary sleep disorder is confirmed).

For more detailed guidance, see the DVLA 'At a Glance' guide.

6. Overdose

General supportive measures should be instituted including close monitoring of respiratory and cardiac status. If the patient vomits care must be taken to prevent aspiration of the vomitus. Activated charcoal can be given within one hour of ingestion of significant quantities of benzodiazepines and Z-drugs to reduce absorption. Sedating drugs should be withheld even if excitation occurs.

Flumazenil (licensed for use as an antagonist for central and respiratory depression) may be considered where serious symptoms are observed. Treatment using flumazenil should only be undertaken under specialist supervision as administration can be hazardous and may contribute to the appearance of neurological symptoms such as convulsions.

7. Consultation

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CPN Clinical Leads  NHSG Substance Misuse Service
CPN Team Leads  NHSG Substance Misuse Service
HSCP lead Pharmacists  NHS Grampian
NHS Grampian Mental Health Operational Medicines Management Group

8.  References


(vii)  Appendix 1 “Sample Daily Sleep Diary” and “10 Rules for Improved Sleep Hygiene” adapted with permission from Loughborough Sleep Research Centre.
# Sample Daily Sleep Diary

Complete the diary each morning ("Day 1" will be your first morning). Don’t worry too much about giving exact answers, an estimate will do.

Your Name: ___________________________  The date of Day 1: _______________

<table>
<thead>
<tr>
<th>Enter the day of the week e.g. Mon, Tues, etc</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   At what time did you go to bed last night?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2   After settling down, how long did it take you to fall asleep?</td>
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<td></td>
</tr>
<tr>
<td>3   After falling asleep, about how many times did you wake up in the night?</td>
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</tr>
<tr>
<td>4   After falling asleep, for how long were you awake during the night in total?</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5   At what time did you finally wake up?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6   At what time did you get up?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7   How long did you spend in bed last night? (from first getting in, to finally getting up)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>8   How would you rate the quality of your sleep last night?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9   List the drugs or medicines that you have taken each day (both prescribed and non-prescribed drugs. Include Alcohol.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1      2      3     4     5
V. Poor → → → → V. Good
Suggestions for Improved Sleep Hygiene

Appendix 2

If you have problems sleeping, then it is important that you practise good sleep hygiene. This means doing things which are known to improve sleep and avoiding those things which are known to disturb sleep. Here are 10 things you should know about getting better sleep; each of these points is based on scientific research and could help you to get the most out of your sleep. Remember, this advice applies only if you have a sleep problem:

1. Products containing caffeine (tea, coffee, cocoa, chocolate, soft drinks) should be avoided at least 6 hours before bedtime. Caffeine is a stimulant and can keep you awake. Stimulant drugs have the same effect.

2. Avoid nicotine (including nicotine patches or chewing gum, etc) an hour before bedtime and when waking at night. Nicotine is also a stimulant.

3. Avoid alcohol around bedtime because although it can promote sleep at first, it can disrupt sleep later in the night.

4. Avoid eating a large meal immediately before bedtime, although a light snack may be beneficial.

5. Try to do regular (even mild) physical exercise if you are able, but avoid doing this 4 hours before bedtime.

6. Keep the bedroom calm and tidy. Select a mattress, sheets and pillows that are comfortable.

7. Avoid making your bedroom too hot or too cold.

8. Keep the bedroom quiet and darkened during the night, but try to spend some time in daylight (or bright artificial light) during the day.

9. Keep your bedroom mainly for sleeping: try to avoid watching television, listening to the radio, or eating in your bedroom.

10. Try to keep regular times for going to bed and getting up.