NHS Greater Glasgow & Clyde
Mental Health Service
Management of Insomnia Guideline

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NHS GG&C Mental Health Services
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Revision Information

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	Apr 2015	Consultation Draft	P Davies
2.0	Apr 2018	Title of guideline changed from Hypnotic Prescribing to Management of Insomnia Page 2,4,6. NICE CKS 2015 Insomnia added as reference Page 3. Sleep hygiene advice tabulated and updated Page 3. Choice and medication Insomnia guide and sleep hygiene handy fact sheet added Page 4. Potential adverse effects (including falls risk) and long term complications of hypnotics added under general principles Page 4,6. NICE CKS Benzodiazepine and Z-drug withdrawal 2015 added as reference Page 5,6. GG&C formulary site added as reference Page 5 Diazepam and nitrazepam not recommended due to their long half lives	L Templeton L Burns
3.0	Jan 2022	Page 5. Addition of melatonin prescribing information	S Burke
4.0	May 2025	Page 5: Add statement regarding promethazine use. Update formulary status of melatonin. Page 6: Add prescribing information for chronic insomnia.	S Burke

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Introduction & Background

Insomnia can often be poorly managed therefore this guideline describes best practice around the promotion of sleep hygiene and appropriate pharmacological intervention. This guideline was originally produced by consolidating the best practice from the existing set of guidelines in use within NHS GG&C. This guideline has been updated to take into account NICE CKS Insomnia 2015[1] and NICE Technology Appraisal No77, 2004[2], Guidance for the short term management of insomnia.

Scope

Application – all clinical settings across Mental Health Services, NHS GG&C.

Non-pharmacological Interventions

Before treating insomnia with drugs, prescribers should consider:

- Managing any underlying cause for insomnia
- Substance misuse or dietary issues
- Ensure appropriate timing of potentially stimulating drugs
- Ensure realistic expectation of sleep and sleep duration
- Encourage sleep hygiene approaches, as indicated within the table below;

Sleep Hygiene Advice * Sleep hygiene is a variety of different practices and habits intended to promote better quality sleep
Maintain a regular sleep-wake schedule. Go to bed and rise at the same time each day
Avoid sleeping in after a poor night
Do not nap, especially close to bedtime
Keep the environment dark, quiet (use earplugs if necessary) and at a comfortable temperature
Avoid using backlit screens e.g. smart phones, tablets, computer screens, television for an hour before bedtime
Avoid watching the clock
Do not lie in bed for prolonged periods awake. If unable to fall asleep (or back to sleep) within 20 minutes, get out of bed. Engage in relaxing activity until drowsy then return to bed and repeat this action as necessary
Avoid excessive liquids or heavy evening meals
Minimise or avoid caffeine (N.B. contained in many soft drinks), alcohol, tobacco, stimulants, especially after noon
Warm milk-based drinks before bed can help. Milk contains tryptophan, a precursor to serotonin, which aids sleep.
Exercise regularly but not within 3-4 hours of bedtime
Go outside for at least half an hour each day (especially late afternoon). Exposure to natural light helps restore circadian rhythm

For further information on sleep hygiene and handy fact sheets for patients please refer to the Choice and medication website hosted via the NHS Inform portal[3]:

http://www.choiceandmedication.org/nhs24/condition/insomnia/
Sleep hygiene handy fact sheet

If these approaches fail or are impractical, a pharmacological intervention may be appropriate.

Pharmacological Interventions

1) *General Principles*

<u>Hypnotic use is for short term use only</u>

- Be aware of (and advise patients of) interactions with alcohol and other drugs (prescribed and non-prescribed)
- Be aware of potential 'hangover' effects of hypnotics
- Potential adverse effects of hypnotics include daytime sedation, poor coordination, cognitive impairment, and related concerns about the increased risk of driving accidents and falls especially in the elderly
- Avoid hypnotics in patients at risk of respiratory depression
- Avoid hypnotics in patients with a severe hepatic impairment
- Avoid hypnotics in addiction-prone individuals
- As required hypnotics should not be administered routinely and ideally not at a fixed time. A clear need should be evident e.g. patient fails to sleep despite an adequate time in bed
- Long-term use of hypnotics can lead to the development of tolerance, physical or behavioural dependence, adverse effects on withdrawal, rebound insomnia, and increased mortality [1]

2) *New presentation of a sleep disorder*

- Use the recommended formulary option [4] i.e. zopiclone unless an alternative is clinically indicated
- Use the lowest effective dose
- Use intermittent dosing e.g. alternate nights or lower frequency of use
- Prescribe as an 'as required' medication. The prescribing and administration of regular hypnotics at a fixed time is inappropriate
- Prescription should be for short term use (no more than four weeks duration)
- Prescriptions must be reviewed regularly (at least weekly)
- If a hypnotic is commenced as an inpatient, this must be discontinued prior to patient's discharge if possible

3) *Pre-existing prescription of a hypnotic for a sleep disorder*

- Assess the current requirement for a hypnotic;
    - Evidence of an existing sleep disorder
    - Consider factors contributing to a sleep disorder
    - Appropriate dose and duration of treatment
    - Appropriate timing of dose
- If the prescription is no longer appropriate, discontinue slowly to minimise the risk of rebound insomnia and withdrawal symptoms. For further information, refer to the NICE CKS on benzodiazepine and z-dug withdrawal[5] or seek advice from a specialist mental health pharmacist
- If a hypnotic is still required
    - Ensure formulary choice
    - Switch if necessary and optimise dose
- Prescriptions must be reviewed regularly (at least weekly)
- At resolution of sleep disorder, consider slow withdrawal of treatment

Choice of Hypnotic

From NICE Technology Appraisal No77 2004[2];

> *"It is recommended that, because of the lack of compelling evidence to distinguish between zaleplon, zolpidem, zopiclone or the shorter-acting benzodiazepine hypnotics, the drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be prescribed."*

Patients who have not responded to one of these hypnotic drugs should not routinely be prescribed any of the others. Although, consideration may be given to alternatives in situations where there is an incidence of z-drug or benzodiazepine abuse, where alternatives may be appropriate.

The Formulary Preferred List hypnotic in NHSGG&C is zopiclone.[4]

If zopiclone is inappropriate, another formulary hypnotic should be prescribed.[4,6] Diazepam and nitrazepam are not recommended because their long half-life commonly gives rise to next day residual effects, and repeated doses tend to be cumulative.[1] Promethazine is licensed for short-term treatment of insomnia but is not a formulary option. Consideration needs to be given to the cholinergic burden and risk of QTc prolongation before prescribing.

Melatonin

Melatonin is included within the GGC adult formulary but is restricted to initiation on recommended of secondary care and in concordance with the NHSGGC 'Melatonin for acute and chronic insomnia in adults' treatment guideline. Zopiclone remains the first line choice within Adult MHS. Where melatonin is prescribed it should be part of a package of sleep hygiene and altered sleep behaviour as detailed above.

Maximum duration of treatment is 13 weeks or until sleep pattern normalizes (unless used for REM sleep disorders).

Dosing advice in GGC shared care guidelines for melatonin	**MR 2mg tablets**		**Immediate release 3mg tablets**		**Oral solution**	
	Adults	**Children**	**Adults**	**Children**	**Adults**	**Children**
Recommended starting dose	2 mg	2 mg	3 mg	3 mg	2 mg	2-3 mg
Titration (depending on response)	Increase by 2 mg every 7-14 days	Increase by 2 mg every 7-14 days	Increase to 6 mg after 7-14 days	Increase to 6 mg after 7-14 days	Increase to 6 mg after 7-14 days	Increase to 4-6 mg after 7-14 days
Maximum dose	12 mg	8 mg	12 mg but additional benefits above 6-9 mg are uncertain	12 mg but additional benefits above 6-9 mg are uncertain	8 mg	10 mg but additional benefits above 6-9 mg are uncertain

Chronic Insomnia

Daridorexant is the only licensed treatment for chronic insomnia and is an orexin OX1- and OX2-receptor antagonist that blocks the action of orexin neuropeptides, thereby decreasing wakefulness. Chronic insomnia is defined as symptoms present for 3 nights a week for at least 3 months with considerable impact on daytime functioning. Treatment should only be considered if cognitive behavioural therapy for insomnia (CBTi) has been tried but not worked, or CBTi is not available or is unsuitable.

This product may be initiated in Primary Care without referral to specialist services. Diagnosis and treatment of chronic insomnia should be managed within Primary Care and considered independently of co-morbidities. For patients who present to mental health services with insomnia in addition to other mental disorder prescribers can recommend initiation to GP if deemed clinically appropriate. Initiation within acute admission wards is not deemed appropriate.

Management of Insomnia Guideline: Audit Criteria

Criterion Statement	Standard	Exceptions
Is there a documented assessment indicating a sleep disorder	100%	None
Non-pharmacological interventions have been attempted	100%	None
Where a hypnotic is indicated, zopiclone is prescribed	100%	Intolerance or previous/potential misuse of zopiclone Prescriber has documented rationale for alternative choice of hypnotic.
Evidence of regular (weekly) review	100%	None
New hypnotic prescriptions are discontinued prior to discharge if commenced as an inpatient	100%	None

References

1. National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summaries (CKS). Insomnia. March 2021 https://cks.nice.org.uk/insomnia Accessed online 17th June 2021.

2. National Institute for Health and Care Excellence (NICE) Technology Appraisal No 77. Guidance on the use of zaleplon, zolpidem and zopiclone for the short-terms management of insomnia. April 2004 (reviewed 2010) https://www.nice.org.uk/guidance/ta77 Accessed online 21st February 2018.

3. NHS Choice and Medication http://www.choiceandmedication.org/nhs24/

4. NHS GG&C Formulary. http://www.ggcmedicines.org.uk/

5. National Institute for Health and Care Excellence (NICE) Clinical Knowledge

Summaries (CKS). Benzodiazepine and Z-drug withdrawal. January 2019 https://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal Accessed online 26th June 2021

6. British National Formulary (BNF) eBNF