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NCL-Wide / Borough(s)	NCL-Wide
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North Central London Integrated Care Board

Insomnia in adults Clinical Pathway

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Key

- Pi — **"Must do" actions for GP's / (Triaged by RSS)**
- B — **Recommendations for Primary Care**
- R — **Red flag / urgent referral**
- O — **Routine referral**
- P — **Public health intervention**
- G — **Audio-visual aids for patients and GP**
- **Click icon for clinical evidence**
- **Right-click to use hyperlink**

Note: Alpha-numeric step references are to aid printing in black & white and colour blindness

Investigations must be within 6 months of date of referral

1.0 (B) Patient presents with sleep problems

2.0 (B)
History:

Duration and frequency of symptoms

- Sleep schedule – time to bed, time taken to get to sleep, awakenings, rise time
- Sleep environment
- Possible triggers – stress, shift work etc
- Behaviours during sleep
- Past medical history/presence of co-morbidities
- Impact of insomnia – on concentration, quality of life, ability to drive, employment, relationships, mood. Patient must be warned not to drive or operate heavy machinery if insomnia impacts daily functioning
- Medications and substance misuse – including caffeine, nicotine

3.0 (B) Sleep difficulties without functional impairment

6.0 (B) Offer sleep hygiene and non-pharmacological management advice

4.0 (B) Functional impairment or significant distresss and symptoms present for less than 3 months

7.0 (B) Short term insomnia

8.0 (B)
Offer advice on sleep hygiene
Address circumstances associated with onset of insomnia
Optimise management of co-morbid conditions where appropriate

Effective

10.0 (B) Offer sleep hygiene and non-pharmacological management advice

Not effective

11.0 (B) Sleep hygiene measures not effective, daytime impairment or causing significant distress

12.0 (B) Insomnia likely to resolve soon

14.0 (B) Consider a short course (e.g. 3-7 days) of zopiclone 3.75-7.5mg ON or zolpidem 5-10mg ON or temazepam 10-20mg ON

13.0 (B) Insomnia NOT likely to resolve soon (e.g. symptoms lasted ≥ 1 month with no improvement)

5.0 (B) Functional impairment or significant distress and symptoms occur on ≥ 3 nights per week for ≥ 3 months

9.0 (B) Chronic/long term insomnia

15.0 (Pi)
Is the patient appropriate for CBT-I?
Patients are NOT appropriate if:

- Unable to engage in and attend individual or group sessions in person or remotely
- Unwilling to change their sleep-related behaviours.
- Have drug or alcohol use that would affect ability to engage in therapy
- Have significant cognitive impairment or significant comorbidity (discuss suitability of CBTI or sedative medication with specialist team)
- Have severe active psychosis or who are currently in crisis.
- Have uncontrolled epilepsy

Suitable

16.0 (B)
Do any of the following apply?

- comorbid severe or complex mental illness
- moderate or high risk of harm to self
- a possible comorbid sleep disorder such as parasomnia, restless legs or sleep apnoea?
- already completed a course of CBT-I
- Epilepsy or chronic fatigue syndrome

Yes

18.0 (O)
Refer to local specialist sleep clinic

- Respiratory for sleep apnoea
- UCLH insomnia clinic for patients with insomnia and no other sleep disorder
- Guy's hospital or UCLH sleep clinic for patients with insomnia and other sleep disorder

No

19.0 (O)
Refer to local provider of talking therapies (iCOPE or digital solution if available) for CBT-I:

iCope for Camden and Islington

Local specialist sleep clinic for Barnet, Enfield and Haringey (e.g. UCLH)

Digital CBT-I may be available in some areas

Not suitable

17.0 (B)
Consider longer-term sedative medication, with regular review for the need to continue this and re-offer/reconsideration of CBT-I. Consider referral to local specialist sleep clinic if indicated.

First-line sedative medication for chronic insomnia in under 55 years is daridorexant 50mg ON. Daridorexant or modified release melatonin 2mg tablets can be considered in those over 55 years*

**melatonin can be initiated in primary care for patients >55 years old with primary insomnia for max 13 weeks*

20.0 (B)
Review within 3 months
Refer to **Appendix 1** for further prescribing information and review criteria for daridorexant

22.0 (B)

- Review efficacy, continue medication if effective.
- Review suitability for CBTI on a regular basis
- If CBTI becomes available or patient becomes suitable continue prescribing whilst awaiting therapy
- Long term use should be reviewed periodically
- Discontinue medication if not effective or tolerated or new contraindications. Consider trial of alternative medication.

21.0 (B)
Is pharmacotherapy needed whilst awaiting CBT-I? (Consider the current impact on their health, quality or life or functioning if they are not prescribed a sedative medication in the meantime)

No

23.0 (B) **Await CBT-I**

Yes

24.0 (B)
Consider prescribing sedating medication while they await CBT-I. This should be a shared assessment/decision with the patient.

Daridorexant 50mg ON or melatonin 2mg modified release tablets ON or short course of z-drug or other sedative medication**. Choice dependent on assessment and patient individual factors.

*Chronic insomnia is defined as a difficulty in initiating or maintaining sleep, despite adequate opportunity, at least 3 nights per week for 3 months, which results in daytime impairment or significant distress.

**Sedative medication considerations – refer to Appendix 1- sedative medicines:

- **DO NOT prescribe sedating antihistamines e.g. promethazine for management of insomnia due to high anticholinergic burden.** Promethazine is not recommended by the British Association for Psychopharmacology for the treatment of insomnia. May be considered in pregnancy.
- If another comorbidity is present (e.g. depression), consider starting a sedating antidepressant/increasing a dose of their current sedating antidepressant.
- Consider if there are any indicators that the patient may be at risk of developing misuse of sleeping tablets (e.g. past misuse on sleeping tablets or benzodiazepines, or past/current dependence on other substances). This would influence the weighing up of risks and benefits.
- Note that needing ongoing sleeping tablets does NOT always indicate dependence/'addiction'. Risk vs benefit should be assessed considering insomnia may be a chronic condition.

Appendix 1 – Sedative medicines

Sedative medicines

Zopiclone	3.75-7.5mg ON. For short term insomnia. First choice 'z' drug in NCL. Should be used at lowest effective dose for short courses (e.g 3-7 days, 2-4 weeks maximum) for short term insomnia Advise patients not to drive or operate heavy machine until the effects of the medication on them are known.
Temazepam	10-20mg ON. For short term insomnia First choice in NCL. Should be used at lowest effective dose for short courses (e.g. 3-7 days, 2-4 weeks maximum) for short term insomnia
Zolpidem	5-10mg ON. For short term insomnia. Second choice 'z' drug in NCL. Should be used at lowest effective dose for short courses (e.g 3-7 days, 2-4 weeks maximum) for short term insomnia Advise patients: • not to drive, operate machinery, or work at heights until at least 8 hours after taking zolpidem • not to take zolpidem with alcohol, illicit drugs, or other central nervous system suppressants • not to drive, operate machinery or work at heights if they are still drowsy after taking Zolpidem Use with caution in the elderly and those with liver impairment – max dose 5mg ON
Melatonin	2mg once daily, 1-2 hours before bedtime and after food. Prescribe the 2mg MR tablet as preference (prescribe generically) Can be initiated in primary care for licensed indication: • as monotherapy for the short-term treatment of primary insomnia characterised by poor quality of sleep in patients who are aged 55 or over for up to 13 weeks For other indications approved for use in NCL see NCL factsheet
Promethazine and other sedating antihistamines	Not recommended for the management of insomnia due to the risk of potential side-effects and anticholinergic burden. May be considered for pregnant patients although non-pharmacological measures are preferred
Daridorexant	Indicated in insomnia in adults with symptoms lasting for 3 nights or more per week for at least 3 months, and whose daytime functioning is considerably affected only if: • cognitive behavioural therapy for insomnia (CBTi) has been tried but not worked, or • CBT-I is not available or is unsuitable. 50mg ON See appendix 2 for further daridorexant information
Antidepressants e.g. mirtazepine	If an antidepressant indicated for management of depression, consider a sedating antidepressant which can help with sleep
Antipsychotics e.g. olanzapine and risperidone	If an antipsychotic indicated for management of a co-morbid mental health condition, consider a sedating antipsychotic which can help with sleep

Appendix 2 - Daridorexant tablets (Quviviq®▼) prescribing information

Daridorexant is is a dual orexin receptor antagonist. Orexin neuropeptides act on orexin receptors to promote wakefulness. Daridorexant antagonises the activation of orexin receptors and thereby decreases the wake drive, allowing sleep to occur, without altering the proportion of sleep stages.

Daridorexant is licensed for the treatment of adult patients with insomnia characterised by symptoms present for at least 3 months, and considerable impact on daytime functioning.

NICE technology appraisal (TA) 922 recommends daridorexant as an option for treating insomnia in adults with symptoms lasting for 3 nights or more per week for at least 3 months, and whose daytime functioning is considerably affected only if:

- cognitive behavioural therapy for insomnia (CBTi) has been tried but not worked, or
- CBT-I is not available or is unsuitable.

Prescribing information – refer to the SmPC for full prescribing information

Dose and administration

- The recommended dose for adults is 50 mg ON, taken orally in the evening within 30 minutes before going to bed.
- Daridorexant can be taken with or without food but taking it after a large meal may reduce its effect on sleep onset.
- Dose adjustment will be required taking moderate CYP3A4 inhibitor or who have moderate hepatic impairment (recommended dose 25mg ON). Not recommended for those with severe hepatic impairment.
- The maximum daily dose is 50 mg.
- Limited data are available in patients older than 75 years. No data are available in patients older than 85 years.

Contraindications

- Hypersensitivity to the active substance or to any of the excipients
- Narcolepsy
- Concomitant use with strong CYP3A4 inhibitors including clarithromycin, ketoconazole, itraconazole, nelfinavir, ritonavir, saquinovir, posaconazole, voriconazole, grapefruit juice

Warning and Precautions

- As grapefruit and grapefruit juice inhibit CYP3A4, the manufacturer of daridorexant recommends against consuming grapefruit or grapefruit juice in the evenings.
- Because of the general risk of falls in the elderly, daridorexant should be used with caution in this population.
- Patients should be warned about engaging in potentially hazardous activities, driving, or operating heavy machinery unless they feel fully alert, especially in the first few days of treatment. A period of approximately 9 hours is recommended between taking daridorexant and driving or using machines.
- Caution should be exercised when prescribing concomitantly with CNS-depressant medicines – potential for additive effects. Other hypnotic medicines should be reviewed prior to starting daridorexant
- Patients should be counselled on the possibel side-effects of treatment prior to starting treatment including possible sleep paralysis or hypnagogic/hypnopompic hallucinations
- Patients should be warned about drinking alcohol during treatment (additive effects on psychomotor performance).
- Administer with caution in patients exhibiting symptoms of depression. Isolated cases of suicidal ideation have been reported in subjects with pre-existing psychiatric conditions and/or stressful living conditions.
- Daridorexant should be used with caution in patients with severe obstructive sleep apnoea (OSA) and/or severe COPD.

Assessment/review of treatment

- The length of treatment should be as short as possible.
- Response to treatment should be assessed within 3 months of starting and treatment should be stopped in people whose long-term insomnia has not responded adequately.
- At each review, reassess the patients suitability for CBT-I
- Check tolerability/presence of side-effects at each review
- If treatment is continued, assess whether it is still working at regular intervals.
- Clinical data are available for up to 12 months of continuous treatment. Treatment can be stopped without down-titration

Changing between other sedative medications and daridorexant

At the time of producing this pathway, formal guidance on how and when to change between other sedative medications and daridorexant is not yet available. Supporting information will be included once this is available.