Factsheet

Insomnia

british society of pharmacy sleep services

Definition

Insomnia is a condition characterised by difficulty in getting to sleep, maintaining sleep, or early morning awakening, despite adequate opportunity to sleep. This inability to sustain good quality, restorative sleep results in impaired daytime functioning and performance.

- Short-term insomnia:
  - Symptoms of poor sleep for less than 3 months duration (typically a few days or weeks),often after a period of stress or bereavement.
- Chronic insomnia:
  - Sleep disturbance on at least 3 nights per week for three months or more.

Symptoms

- Difficulty with sleep initiation (getting to sleep), sleep maintenance (staying asleep) or early morning waking.
- Poor concentration, mood disturbance, and daytime fatigue.
- A lack of daytime impairment alone is not considered to be insomnia disorder.

Prevalence

- 33-40% of the UK population are reported to experience insomnia disorder
- More females than males have insomnia (Ratio:1.5-2) and it is widely accepted that the COVID-19 pandemic has seen a significant rise in the rates of insomnia, although exact figures are yet to be released. While insomnia is more common in older adults, it can occur at any age.

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Assessment of insomnia disorder in primary care

The below information is provided to help you assess, inform and guide the patient. We recommend undertaking our free online education https://bspss.org in order to improve patient outcomes.

Social / environmental history

Age and gender of patient - You may need to set realistic expectations for people in their advancing years, as sleep will commonly fragment as part of the normal ageing process. Waking on average around 6 times a night is part of the normal sleep cycle. Sometimes the knowledge of this can help to allay anxiety.

Environmental considerations: noise, outside light, neighbours, bed partner disturbing their sleep, caring responsibilities, child/pet in the bed?

Work routine? Shift work? Late nights/irregular working patterns.

Do they exercise? What time? Exposure to morning light?

Past / present medical history

Underlying physical health conditions that could contribute to their sleeplessness? (e.g: pain in bed? Menopause/perimenopause? Allergies? Diabetes?)

Underlying mental health problems such as anxiety, depression etc?

Medications - generally and/or for insomnia? OTC or prescribed (? side effects etc)

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Sleep history

- When and how did the sleep issue start? Is the issue continuous or periodic?
- Can they identify a trigger or cause? Stress, shift work or jet lag can trigger insomnia.
- Evening routine. Are they using screens excessively, hyperalert by watching the TV or distressed by the news? Do they use alcohol as a sleep aid, or caffeine to stay awake during the day?
- How long does it take for the patient to get to sleep, on average (sleep latency)? (within 30 minutes is within normal limits)
- Can they describe their sleeping and waking patterns on an average day/week? How often and at what time does the patient wake in the night?
  Are they woken by the need to use the toilet? How long are they awake?
- Activity during wakings? Lie in bed? Get up? Do jobs? Check emails etc?
- What time do they wake in the morning? How long do they stay in bed after waking? Is it the same time every day or does it vary at weekends?
- Given the opportunity, could the patient nap during the day? (Clients with insomnia are usually "tired but wired" and unable to nap, whereas those with sleep disorders such as obstructive sleep apnoea suffer from excessive daytime sleepiness and could easily sleep in the day)
- How does their sleep difficulty impact their mood and relationships?
- Does the patient get sleepy when driving? Have they ever fallen asleep in an inappropriate or public space, or had an uncontrollable episode of sleepiness? (These are symptoms of other sleep disorders)
- What have they tried to resolve the problem? Is there anything they have done or taken that has worked so far?

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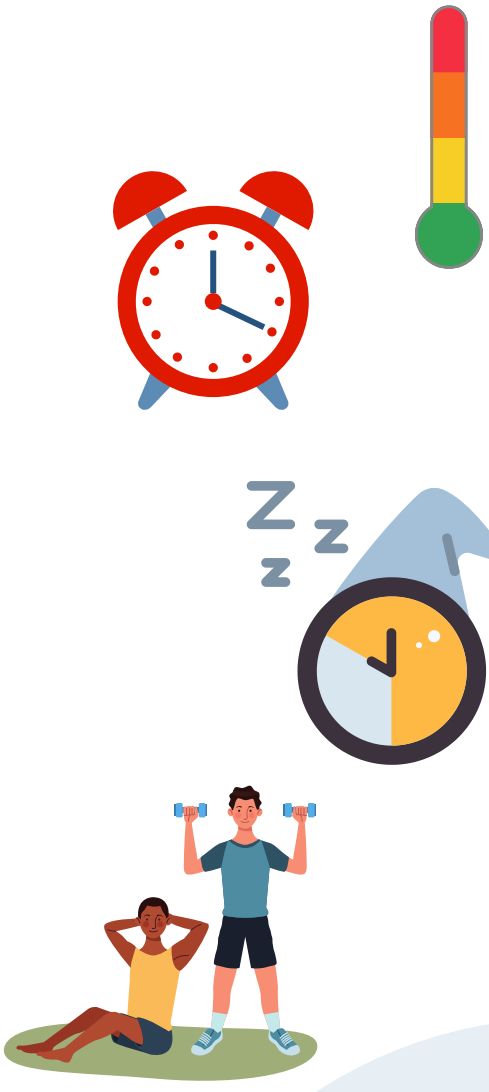
Possible treatments for Insomnia disorder

Good sleep hygiene is an important first-line course of action to treat short-term insomnia, as per NICE guidelines, and is a great place to start with patients, but it should be explained to the patient that it is not a treatment for chronic insomnia.

Sleep hygiene can be compared to dental hygiene. It is effective in maintaining good dental health, but it will not treat a dental abscess, for example!

- Is the bedroom not too hot, cold, noisy or bright? - the environment must be right
- Are they using a bedtime routine?
- Waking at the same time every day, 7 days a week, helps the body expect sleep at night, by giving a regular opportunity to build the sleep drive (need for sleep).
- Only going to bed when sleepy, not just because it's "bedtime" will ensure that there is a high sleep need. Good sleep initiation (getting to sleep) and sleep maintenance (staying asleep) are therefore more likely.
- Avoid lie-ins, naps and early nights, as this will reduce the need for sleep and reduce the quality of sleep. This is a very common cause of sleep disturbance.
- They are not exercising near bedtime, ideally 4 hrs or more pre-bedtime - reduce hyperarousal
- Avoid having a noticeable clock and "clock-watching"



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Possible treatments for Insomnia disorder (contd.)

- Avoid using devices at least 2 hours before bed - instead read a book, or have a bath. Bedrooms should be strictly for sleep and intimacy.
- Caffeine should ideally only be consumed in the morning
- Limit alcohol, nicotine and large meals and at least 2 hours before bedtime
- Get some bright light each morning, especially if they had a poor night's sleep - helps establish circadian rhythm
- Avoid napping - break any vicious cycle that could be contributing to a lack of nighttime sleep
- Relaxation and mindfulness techniques

CBT-I - Cognitive Behaviour Therapy for Insomnia should ideally be employed over a 5-week period of time and gains around 80% success rate.

However, GPs often resort to short-acting benzodiazepines or the z-drugs such as zopiclone, etc. This should be for no longer than 2 weeks at a time.

OTC options (first-generation sedating antihistamines e.g. diphenhydramine and promethazine) are explicitly not recommended by current NICE guidelines. Tolerance to sedating antihistamines can develop with long-term use meaning higher doses are required to achieve sedation. This increases the risk of side effects such as prolonged daytime drowsiness, and can lead to a vicious cycle of needing higher doses to achieve night-time sedation yet increased drowsiness during the day which can impact activities such as driving.

There is no evidence base to support the use of herbal remedies.

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Follow-up / prevention of regression

If you do sell OTC sedatives in any form, we would advise keeping a record of the sale, with a description of the purchaser. If possible, follow up the sale after a week or two, in order to confirm the effectiveness of the sleep hygiene measures and medication (if used).

If there is no resolution AND there is distressing daytime impairment refer the patient to their GP who should follow the NICE guidelines for short-term insomnia:

- If sleep hygiene fails and likelihood of a resolution soon (not elderly or pregnant) - Z-drug* for 3 to 7 days
- If no resolution likely then refer to CBT-I plus when required z-drug* for acute distress prevention only, or melatonin if >55 years old

**Lowest dose possible and max 14 days, < 7 days preferably. If no response to z-drug, do not re-prescribe that or another z-drug. The patient must understand the role of the z-drug.*

Case Study

George from Birmingham, (55 yrs old) reported getting less than 5 hours of sleep per night over the last 2 months after starting a new working pattern.

After implementing the pharmacist's recommended sleep hygiene measures George reports being able to sleep for 7 hours every night and feels like a new man.

Stock image - not the real George!

About The British Society of Pharmacy Sleep Services

Our independent research established that the general public 'often' to 'very often' consult a community pharmacist about suspected sleep disorders.

We aim to empower the community pharmacist to assess, screen and recognise these individuals in order to help patients progress rapidly to appropriate care.

The BSPSS was established in 2021 to plug the disconnect between sleep expertise and the public, and in 2022 we became a registered charity.

We recognise the community pharmacist as the front-line healthcare professional.

Click here to take your learning further with free BSPSS membership, training and support