# INSOMNIA (Difficulty Sleeping)

Though many people in nursing homes *complain* of insomnia, *very few* actually have sleeping problems requiring medication. Here are some simple facts that may help explain the discrepancy, especially since using sleeping pills in this population is considered potentially dangerous and is highly regulated.

*What is a "normal" sleep pattern?* It is **not** 8 hours of sleep as a solid block and only at night! Any person who lives long enough…

- will take longer to fall asleep (*sleep latency*);
- will sleep 4-6 hours, then wake with trouble falling back asleep (after several hours, they are likely to sleep for another 1-3 hours);
- has less REM and DEEP sleep time (when most healing takes place); and
- will nap periodically throughout the day

*Do sleeping pills help?* The average sleeping pill…

- Decreases the time to fall asleep by less than10 minutes, and
- Increases the total amount of time slept by about 20 minutes a day

*What steps can be taken to improve sleep?*

- Avoid stimulants (e.g., tobacco, caffeine, soft drinks) for >2 hours before bedtime
- Adjust temperature and light to levels that will be conducive to sleep
- Reduce environmental noise
- Make sure pain and depression are being adequately addressed
- Make plans for middle of the night activities for those with normal sleep patterns of aging, such as reading, writing letters, folding linens, watching TV

*What if the patient, family, night nurse and / or provider really want sleeping pills?* Common sense and Federal Regulations in nursing homes have us *compulsively* track hours of sleep residents get (all day) for 3-4 days. Here's how it is done:

- Record how much sleep the patient gets *each hour* for 72-96 hours
- Make sure to include accurate estimates of naps, sleeping at the table, etc.
- If they get >7 hours sleep over 24 hours, they do **not** need sleeping pills!

Federal regulations require that everyone on sedating medications undergo dosage reductions and try to discontinue them frequently. Having noted that, they should **not** be abruptly stopped in persons who have been on them for an extended period of time. Providers should safely taper them.

The *psychologic dependence* on these agents (by patients and those caring for them) is significant. As a result, anxiety, agitation or insomnia for the first few weeks is *very common*, but can be overcome with comfort, reassurance and encouragement by providers, nurses, families and friends who accept that promoting the healthiest alternative for the patient (ie, no sleeping pills) is more important.

**ALL** sleep medications – prescription, homeopathic, natural and over-the-counter – are associated with an increase in falls, fractures and other unwanted side effects. **Education, recognition, and acceptance of normal changes in sleep patterns with aging coupled with an increase in physical activity during the day** is the healthiest way to get a good night's sleep, reduce fatigue, restore alertness and maintain health.

Insomnia in the NH

*The evidence and guidelines are written for younger, healthier adults than our typical population.* First ask… is it?

- Major Mental Illness (MMI)
- Dementia

MMI – Some YOUNGER residents with chronic psychotic illnesses, especially BPAD – in a current manic episode, CAN require intermittent hypnotics. Typically, BZD's are used. Rarely – chronic use is required. Remember, both psychological and physical dependence occurs regardless. SO, it is still best to taper/stop intermittently.

- NEVER alprazolam
- Lorazepam cleanest, clonazepam next – temazepam has indication but long half-life and often deliriogenic
- Trazodone is popular but does not work well, is psychologically addicting and causes orthostatis in elderly (studies show that after two weeks – it stops helping with sleep onset – which is only about 10 minutes greater than placebo anyway!)
- Make sure all sedating psychotropics (antipsychotics, AED's) are given at night, to exploit the side effect of sedation

Dementia – The sleep/wake cycle in dementia is almost always affected as a byproduct of the primary illness. Sleeping exclusively at night is NOT a realistic goal. The BEST option is to live in a setting where residents can safely be awake, wander, eat, etc. at will. The best way to encourage nighttime sleep is DAYTIME activity.

- BZD's often DISINHIBIT – use only in most extreme circumstances (NO documented sleep for several days with disruptive behaviors)
- OK to try melatonin at 1mg for use as "supplement" – limited data on efficacy and is unregulated. Circadian rhythm disruption most likely to respond (blindness and jet lag)

Determine *acute vs. chronic* insomnia and identify whether it is primarily a *sleep onset or sleep maintenance* problem. Rule out depression, SUD, sleep apnea.

CBT-Insomnia (focus on stepped sleep restriction) has proven efficacy and is SUPERIOR to medications, for chronic insomnia.

- **Never use PRN hypnotics. If you decide you must RX, do so for 1-2 weeks SCHEDULED and then stop and re-evaluate. 6-8 weeks max. Explain this UP FRONT to family and staff. PRN dosing reinforces the focus on insomnia.**

TABLE 2.

## US Food and Drug Administration (FDA)-Approved Medications for Insomnia[a]

| Category | Medication, Generic (Trade) | FDA Indication | Recommended Initial Geriatric Dose (mg) | $T_{max}$ (h) | Half-Life (h) | Most Common Adverse Effects[b] |
|---|---|---|---|---|---|---|
| Benzodiazepine receptor agonists | Temazepam (Restoril; Mallinckrodt, Bethlehem, PA) | Short-term treatment of insomnia (7-10 days) | 7.5 | 1.5 | 3.5-18.4 | Drowsiness, fatigue, lethargy, dizziness, hangover, anxiety |
| | Triazolam (Halcion; Pfizer, New York, NY) | Short-term treatment of insomnia (7-10 days) | 0.125 | 2 | 1.5-5.5 | Drowsiness, headache, dizziness, nervousness, lightheadedness, ataxia, nausea/vomiting |
| | Eszopiclone (Lunesta; Sunovion, Marlborough, MA) | Insomnia (no time limitation) | 1 | 1 | 9 | Headache, unpleasant taste, dyspepsia, pain, diarrhea, pruritus, dry mouth, abnormal dreams, neuralgia, urinary tract infection |
| | Zaleplon (Sonata; Pfizer, New York, NY) | Short-term treatment of insomnia (up to 30 days) | 5 | 1 | 1 | Abdominal pain, somnolence, eye pain, paresthesia, tremor, amnesia |
| | Zolpidem (Ambien; Sanofi-Aventis, Paris, France), also available as sublingual (Edluar; Meda, Solna, Sweden) and oral spray (Zolpimist; ECR, Bridewater, NJ) | Short-term treatment of sleep onset insomnia (up to 35 days) | 5 | 1.6 | 1.4-4.5 | Drowsiness, dizziness, diarrhea |
| | Zolpidem ER (Ambien CR; Sanofi-Aventis, Paris, France) | Sleep onset and/or maintenance insomnia | 6.25 | 2 | 1.6-5.5 | Headache, somnolence, dizziness, nasopharyngitis |
| | Zolpidem, sublingual (Intermezzo; Sanofi-Aventis, Paris, France) | Sleep maintenance insomnia with at least 4 hours of sleep time remaining | 1.75 | 0.5-1.25 | 1.4-3.6 | Drowsiness, dizziness, diarrhea |
| Melatonin receptor agonists | Ramelteon (Rozerem; Takeda, Deerfield, IL) | Sleep onset insomnia | 8 | 0.75 | 1-2.6 | Dizziness, somnolence, nausea, fatigue, exacerbation of insomnia |
| Antidepressants | Doxepin (Silenor; Pernix, Morristown, NJ) | Sleep maintenance insomnia | 3 | 3.5 | 15.3 | Somnolence, upper respiratory tract infection, gastroenteritis, nausea, hypertension |
| Orexin antagonists | Suvorexant (Belsomra; Merck and Co., Kenilworth, NJ) | Sleep onset and maintenance insomnia | 10 | 2 | 10-22 | Headache, somnolence, dizziness, diarrhea, dry mouth, upper respiratory tract infection, abnormal dreams, cough |

*Abbreviation: $T_{max}$, time to maximum concentration.*

*[a]Additional FDA-approved medications for insomnia include flurazepam (Dalmane; Roche, Branchburg, NJ) and quazepam (Doral; Meda, Solna, Sweden), which were excluded here due to significantly long half-life.*

*[b]Excluding adverse effects for which reported incidence for the placebo was equal to or greater than that for the medication.*

*Adapted from FDA prescribing information (package inserts).[31]*