Guideline Summary NGC-9480

Guideline Title

Clinical practice guidelines for the management of patients with insomnia in primary care.

Bibliographic Source(s)

Guideline Development Group for the Management of Patients with Insomnia in Primary Care. Clinical practice guidelines for the management of patients with insomnia in primary care. Madrid (Spain): Health Technology Assessment Unit, Laín Entralgo Agency, Ministry of Health, Social Services and Equality (Spain); 2009. 159 p. [207 references]

Guideline Status

This is the current release of the guideline.

Scope

Disease/Condition(s)

Acute and chronic primary insomnia

Guideline Category

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Psychiatry

Psychology

Sleep Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Social Workers

Guideline Objective(s)

To help professionals working in primary care (PC), firstly in the diagnosis of insomnia in adults (over 18 years), and secondly, in the choice of recommendations, based on available scientific evidence on treatment and care interventions for the management of either acute or chronic primary insomnia in a PC environment

Target Population

Adult patients (over 18 years of age) suffering from insomnia who present to primary care

Interventions and Practices Considered

1. Assessment interview, identifying:
   - Potential trigger situations
   - Precursor factors
   - Sociodemographic factors
2. Sleep diary
3. Self-administered questionnaires
   - Insomnia Severity Index
   - Pittsburgh Sleep Quality Index
4. Health education
5. Sleep hygiene education
6. Behavioural therapy and cognitive behavioural therapy
7. Pharmacological interventions
   - Hypnotics, including benzodiazepine and non-benzodiazepine
   - Other drugs (e.g., antidepressants)
8. Bibliotherapy
9. Treatment for the elderly
10. Patient information and adherence

Major Outcomes Considered

- Patient's subjective report about the quality of night time sleep
- Sleep parameters (see Appendix 7 in the original guideline document)
- Sleep quality
- Daily functioning
- Quality of life
- Frequency of side effects

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Literature search in Medline, EMBASE, PsycINFO, CINAHL, Cochrane Plus, Database of Abstracts of Reviews of Effectiveness (DARE), Health Technology Assessment (HTA), Clinical Evidence, INAHTA, National Health Service Economic Evaluation Database (NHS EED), CINDOC in Spanish, English and French (from 1999 to 2009). Studies in adults over 18 years. Publication year limitation: only for primary studies (those that use original data).

Firstly, a search was performed to find clinical practice guidelines (CPG), and their quality assessed using the Appraisal of Guidelines Research and Evaluation (AGREE) instrument. Four CPGs are included as a secondary source of evidence to answer specific sections of the guide (diagnostic and therapeutic strategies, patient information/communication). The guides included are: "Prise en charge du patient adulte se plaignant d'insomnie en médecine générale. Recommandations pour la pratique clinique. Argumentaire", 2006, Haute Autorité de Santé (HAS); "Insomnie: Recommandation en première ligne de soins. Recommandations de Bonne Pratique", 2005, Société Scientifique de Médecine Générale (SSMG); "Clinical guideline for the evaluation and management of chronic insomnia in adults", 2008, American Academy of Sleep Medicine (AASM); "Clinical Practice Guidelines Adult Insomnia: Diagnosis to management", 2007, Alberta Medical Association.

The second phase was to carry out a search for systematic reviews, meta-analyses and evaluation reports in the aforementioned databases. Thirdly, an extended search was made of primary studies (clinical trials, observational studies, diagnostic and prognostic test studies).

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

1++ High quality meta-analyses, systematic reviews of clinical trials or high-quality clinical trials with very low risk of bias

1 + Well-conducted meta-analyses, systematic reviews of clinical trials, or well-conducted clinical trials with little risk of bias

1- Meta-analyses, systematic reviews of clinical trials or clinical trials with high risk of bias

2++ High quality systematic reviews of cohort or case-control studies. Cohort or case-control studies with very low risk of bias and with high probability of establishing a causal relationship.

2+ Well conducted cohort or case-control studies with a low risk of bias and a moderate probability of establishing a causal relationship

2- Cohort or case-control studies with a high risk of bias and a significant risk that the relationship is not causal

3 Non-analytic studies such as case reports and case series

4 Expert opinion

Qualitative research*

*This category includes qualitative methodology studies and is not covered by the Scottish Intercollegiate Guidelines Network (SIGN). Studies incorporated have been evaluated at a methodological level, including more rigorous studies in this category.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Assessment of the quality of the studies and summary of evidence for each question following the Scottish Intercollegiate Guidelines Network (SIGN) recommendations (see Appendix 1 in the original guideline document)

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

- Forming the guide development group composed of professionals in: primary care (general practice, nursing, social work), specialist care (psychiatry, neurophysiology, geriatrics, psychology and nursing) and researchers in the Health Technology Assessment Unit (UETS). In addition, and within the development group itself, a patient with insomnia has been involved in preparing this guide from the early stages.
- Forming a subgroup, with members of the guide group and another patient, for the production of patient information.
- Establishing the scope and objectives of the guide, including the social vision of the disease with the use of qualitative research. Firstly, contact was made with health care professionals (physicians in primary and specialist care) and the resources of participant observation and in-depth interviews via a questionnaire were used. Thus, social, demographic, health treatment and care information was collected on patients with insomnia after being cared for by these professionals. Subsequently, patients with insomnia were involved in a discussion group to freely discuss their experiences, interests and concerns in the management of their condition.
- Formulation of clinical questions using the Patient/Intervention/Comparison/Outcome (PICO) format.
- Formulation of recommendations based on "considered judgment" by the Scottish Intercollegiate Guidelines Network (SIGN). Any controversial recommendations or those lacking evidence were resolved by consensus of the development group (see Appendix 1 in the original guideline document).
- Detailed information with the clinical practice guideline (CPG) methodological process (description of the techniques used in qualitative research, search strategy for each clinical question, evidence tables) are available at www.guiasalud.es.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation*

A: At least one meta-analysis, systematic review, or clinical trial rated as 1++ directly applicable to the target population of the guide; or a body of evidence consisting of studies rated as 1+ and showing overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population of the guide and showing overall consistency of results; or evidence extrapolated from studies rated as 1++ or 1+

C: A body of evidence consisting of studies rated as 2+, directly applicable to the target population and showing overall consistency of results; or extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+

Q: Evidence taken from relevant, good quality qualitative studies. This category is not included in the Scottish Intercollegiate Guidelines Network (SIGN).

Good clinical practice: Recommended best practice based on the clinical experience and the consensus of the editorial team.**

*Studies classified as 1- and 2- must not be used in the process of developing recommendations due to their high potential for bias.

**Sometimes the development group wishes to highlight an important practical aspect for which there is no supporting evidence. In general, these cases are related to an aspect of treatment generally accepted to be good clinical practice, and is evaluated as a point of good clinical practice. These messages are not an alternative to the recommendations based on evidence, but should be considered only when there is no other way of highlighting that aspect.

Cost Analysis

- Some studies have reported benefits in terms of cost-effectiveness of implementing interventions carried out by trained nurses, in group therapy or with self-help materials to supplement intervention directed by a therapist (psychologist or psychiatrist).
- In reviews carried out, non-benzodiazepine hypnotics have not proven cost-effective compared to benzodiazepines.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

An external review of the guide was performed by a group of professionals selected for their knowledge of the methodology of Guidelines development, the pathology addressed and its scope.

Various scientific societies collaborated in preparing the guide to address this health problem in different areas: the Spanish Society of Family and Community Medicine (SEMFYC), Spanish Society of Primary Care Physicians (SEMERGEN), Spanish Psychiatry Society (SEP), Spanish Association of Neuropsychiatry (NEA), Spanish Union of Scientific Nursing Societies (UESCE), Spanish Society of Sleep (SES), Spanish Society of Geriatrics and Gerontology (SEGG), Spanish Society of Clinical Neurophysiology (STDF) and the Spanish Patients Association for Sleeping Disorders (ASENARCO). All societies are represented by a member of the development group or external reviewers.

Recommendations

Major Recommendations

Levels of evidence (**1++** to **4**) and grades of recommendation (**A** to **D**, **Q** and **good clinical practice points**) are defined at the end of the "Major Recommendations" field.

Diagnosis of Insomnia

Evaluation of Insomnia

Good clinical practice: In *acute insomnia*, an interview to assess the clinical onset and course of insomnia and its relationship with potential trigger situations is recommended. In addition, possible precursor factors of chronic insomnia (vulnerability and poor sleep habits) must be identified.

Good clinical practice: In *chronic insomnia*, the interview should include sociodemographic factors and detailed characteristics of the complaint, as well as the psychiatric, sleep and substance use history. Information provided by the family and anyone who sleeps with the patient must also be taken into account.

Good clinical practice: Key questions are recommended to help detect insomnia, and to rule out other sleep problems or other disorders (see Appendices 3 and 4 in the original guideline document).

D - It is recommended to use a 2-week sleep diary to get to know the sleeping and waking times of the patient to differentiate primary chronic insomnia from other conditions. It can also be used to assess the treatment and monitor the patient's progress if kept for at least 2 months.

C - To assess the severity of insomnia, it is recommended to use the self-administered questionnaire Insomnia Severity Index (ISI) (see Appendix 6 in the original guideline document).

C - The self-administered questionnaire Pittsburgh Sleep Quality Index (PSQI) is recommended to assess the quality of sleep in insomnia or the presence of other sleep disorders, as it includes information from the person with whom the patient sleeps (see Appendix 6 in the original guideline document).

Treatment of Insomnia

Health Education

Q - The ideas, concerns and expectations of the patient regarding sleep complaints should be discussed with the patient, in order to be able to give further information and correct any misconceptions.

D - Health education for insomnia should be based on: the structure of sleep, influence of age, the number of hours required and individual variations, prevalence of insomnia, sleep as a reflection on daytime functioning and vice versa, the importance of conditioning and mental processes that lead to a vicious circle, the place of medication in treatment, the effect of certain substances and the clarification of treatment goals to adjust to expectations.

Sleep Hygiene Education

A - Sleep hygiene education is recommended in the treatment of chronic insomnia as an adjunct to other psychological and pharmacological therapeutic interventions.

A - To achieve greater sleep efficiency, a combination therapy is recommended, that includes one of the following techniques in addition to sleep hygiene education: stimulus control, relaxation therapy, or sleep restriction.

Psychological Therapies

Treatment with Behavioural Therapy and Cognitive Behavioural Therapy (CBT) for Insomnia, Aimed at Primary Care (PC)

B - In PC general practitioners, nurses and social workers can perform both individual and group approaches for patients with insomnia, using techniques based on the principles of behaviour therapy and CBT, provided that they have received adequate training.

B - Behavioural interventions for insomnia should include at least stimulus control and/or sleep restriction. Other CBT interventions that may be recommended are breathing and relaxation therapies, paradoxical intention and cognitive

restructuring.

Good clinical practice: *First choice* psychological techniques in PC* to reduce the symptoms of insomnia are: relaxation therapies, stimulus control and sleep restriction (see Appendix 9 in the original guideline document for details).

Good clinical practice: *Second choice* psychological techniques in PC to reduce the symptoms of insomnia are: paradoxical intention techniques and cognitive restructuring.

Good clinical practice: Psychological interventions in PC should be performed by trained professionals and have the following common features in their application: to be structured, simple and easy to implement, short, with set times, well targeted and with described effectiveness.

*Appendix 9 in the original guideline document provides information for the PC practitioner and patient on the main interventions: relaxation therapies, stimulus control and sleep restriction.

Pharmacological Interventions

Benzodiazepine (BZD) and Non-Benzodiazepine Hypnotics

B - If hypnotics are to be used for treating insomnia, it is recommended that treatment is short-term (not more than 4 weeks) and at the lowest possible dose.

C - Long-term use of hypnotics is not recommended. If doing so, it should always be monitored, with a diagnosis and at a specific regimen.

B - To prevent dependence on BZDs, it is recommended that use be restricted to acute insomnia, at the lowest dose possible and for no longer than 2 to 4 weeks.

B - As first choice hypnotics for insomnia, either a BZD or non-benzodiazepine can be chosen, as no significant differences in clinical or adverse effects have been demonstrated between the two types.

B - If a patient does not respond to treatment with a hypnotic, it is not recommended to change to another, unless there are side effects directly related to a specific hypnotic drug.

B - It is recommended to use the hypnotic which is most efficient and responsive for the patient, unless side effects directly related to the chosen hypnotic are observed.

B - If a BZD is needed during pregnancy, it should be used at the lowest effective dose and for the shortest time possible to avoid the risk of birth defects.

B - The new discontinuous zolpidem treatment regimens, either intermittent or on demand according to the patient's needs, supported by stimulus control techniques, can be used in the short term as an alternative to continuous dosing.

Good clinical practice: When prescribing hypnotics, patients should be informed of the therapeutic objectives, the duration of treatment and possible side effects, including tolerance and dependence problems associated with their use, as well as the lack of studies reporting long-term efficacy.

Good clinical practice: When prescribing hypnotics, the following parameters must be considered: age, previous treatment, tolerance, potential pregnancy, side effects, patient preferences and costs of equally effective choices.

Other Drugs in the Treatment of Insomnia

Antidepressants

B - There is enough evidence to recommend the use of antidepressants for insomnia associated with depressive disorder, but not for primary insomnia.

B - There is insufficient evidence to recommend the use of trazodone and doxepin until results from long-term studies are obtained.

B - There is insufficient evidence to recommend the use of the antidepressants amitriptyline and mirtazapine in the treatment of insomnia.

Others

B - More long-term comparative studies are needed to recommend the use of ramelteon in the treatment of insomnia.

Not Recommended

B - The use of chloral hydrate, meprobamate and barbiturates is not recommended for the treatment of insomnia.

Other Treatments

Treatment with Melatonin

B - There is insufficient evidence to recommend the use of melatonin in the treatment of insomnia until good quality methodological trials demonstrate its effectiveness.

B - There is not enough evidence to recommend the use of melatonin for the interruption of prolonged use of BZDs.

Acupuncture Treatment

B - There are no studies of enough methodological quality to recommend the use of acupuncture in the treatment of primary insomnia.

Treatment with Herbal Medicines

B - There is not enough evidence to recommend the use of valerian alone or in combination with hops for the treatment of insomnia.

Good clinical practice: Professionals should ask patients about any herbal product they are taking or have taken.

Self-Help Treatments

B - The application of bibliotherapy based on CBT principles via self-help manuals and guided by professionals is recommended in health centres.

Treatment of Insomnia in the Elderly

Good clinical practice: Any concurrent conditions, the possibility of modification of lifestyle factors affecting sleep quality and the contribution that some drugs can have on insomnia must first be taken into account.

B - Either behaviour therapy or CBT is recommended in older people with insomnia; especially stimulus control and sleep restriction, supported with sleep hygiene education.

Good clinical practice: The use of hypnotics in older people is generally not recommended, due to the unfavourable risk/benefit ratio.

B - There is enough evidence to recommend the use of antidepressants for insomnia associated with depressive disorder, but not for primary insomnia.

Good clinical practice: There is insufficient evidence to recommend the use of clomethiazole in the treatment of insomnia in older people.

B - The use of barbiturates, antipsychotics or antihistamines, such as diphenhydramine, hydroxyzine, and doxylamine, is not recommended for older people with insomnia.

Good clinical practice: When prescribing any hypnotic in the elderly, it is recommended to start with half the usual adult dose.

B - For elderly long-term users of hypnotics, a gradual reduction of the drug combined with CBT is recommended, to help slow or stop the consumption of BZDs.

B - Slow-release melatonin* may be used in patients aged 55 or over with primary insomnia, as it improves sleep quality and daytime sleepiness.

B - More long-term comparative studies are needed to generalise the use of exercise in the treatment of elderly patients with insomnia.

*Melatonin is approved for use in Spain for people over 55 with insomnia, however, it is not commerically available.

Patient Information and Adherence to Treatment in Insomnia

D, Good clinical practice: It is recommended to provide information for patients with insomnia, including general information about the problem and effective interventions (see Appendix 11, "Patient Information" in the original guideline document).

D, Good clinical practice: To improve treatment adherence and facilitate shared decision-making, patient experiences, expectations and preferences regarding treatment decisions must be taken into account.

D, Good clinical practice: It is recommended to encourage the patient to acquire a certain degree of motivation to carry out the clinical recommendations of health professionals regarding sleep hygiene education, stimulus control, sleep restriction and relaxation therapies.

D, Good clinical practice: Patients must be informed of the barriers they need to overcome and the effort involved in compliance with certain psychological interventions, in connection with the adoption of new patterns of behaviour, (e.g., keeping the same sleep timetable every day, getting out of bed until feeling sleepy again and stopping certain habits-tobacco and alcohol.

Definitions:

Levels of Evidence

1++ High quality meta-analyses, systematic reviews of clinical trials or high-quality clinical trials with very low risk of bias

1 + Well-conducted meta-analyses, systematic reviews of clinical trials, or well-conducted clinical trials with little risk of bias

1- Meta-analyses, systematic reviews of clinical trials or clinical trials with high risk of bias

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team.***

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Clinical Algorithm(s)

The original guideline document contains the following clinical algorithms:

- Diagnostic algorithm
- Management of primary insomnia in PC

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

This guideline is intended to improve the quality of care for patients with insomnia and thereby increase their quality of life.

Potential Harms

- Side effects observed with the use of *benzodiazepines (BZDs)* include: daytime drowsiness, headache, dizziness, nausea, fatigue, and others. After 2 weeks of using a BZD, there is an increased risk of development of tolerance, physical and psychological dependence, and long-term use has been associated with increased risk of traffic accidents. In case of abrupt termination or stopping treatment, signs of withdrawal are produced. Moreover, effects such as memory loss and the risk of falls are also important as they mostly affect older people, who are major consumers of drugs and more sensitive to side effects. Clinically significant interactions with other drugs and with alcohol have also been reported. In advanced stages of pregnancy or during lactation, BZDs may cause adverse effects in newborns (neonatal hypotonia, withdrawal syndrome, sedation and hypothermia).
- The adverse effects of *non-benzodiazepine hypnotics* are: daytime drowsiness, dizziness, fatigue, headache, hallucinations, nausea, disorientation and confusion, anxiety or panic attacks, weakness, trembling, palpitations, and tachycardia. Some studies have also described rebound insomnia, withdrawal syndrome (at both supratherapeutic and normal doses) and the danger of dependence, especially after prolonged use. As with BZDs, zopiclone was recognised as a potential replacement for alcohol in people addicted to it, even with standard daily doses. Some studies also suggest an increased risk of traffic accidents with the consumption of these drugs (zopiclone, zolpidem).
- When prescribing any *hypnotic* in the elderly, it is recommended to start with half the usual adult dose.
- Potential toxicity of *antidepressants*

Qualifying Statements

Qualifying Statements

- The clinical practice guideline (CPG) is an aid to decision making in health care. Compliance with it is not compulsory nor does it replace the clinical judgment of health care professionals.
- Since this guideline is focused nationally, it does not cover organizational questions, but rather tries to establish a basic circuit for patients between the two levels of health care – primary care and specialized care – so it will also be distributed among the other professionals involved in providing patient care in an effort to provide integrated care of patients.

Implementation of the Guideline

Description of Implementation Strategy

Dissemination and Implementation Strategies

The clinical practice guidelines are useful for improving the quality of care and patient outcomes. The big challenge now is to get professional adherence to the recommendations of these guidelines. This calls for an implementation strategy aimed at overcoming the barriers in the field of application.

The plan for implementing the guide for the management of insomnia in patients in primary care (PC) includes the following interventions:

- Presentation of the guide to the media by the health authorities.
- Presentation of the guide to Primary Care and Specialised Care management in the various Regional Health Services

- Presentation of the guide to Primary Care and Specialised Care management in the various Regional Health Services.
- Institutional presentation of the guide in collaboration with the Quality Agency of the Ministry of Health and Social Policy to the various scientific and professional organisations involved.
- The information produced for the patient will be highlighted in all its forms to facilitate its distribution to all health personnel, and thus in turn to patients with this health problem.
- Effective and targeted distribution to the professional groups involved (PC physicians, nurses and social workers, psychiatrists, psychologists and specialists in mental health) to facilitate its dissemination.
- Interactive presentation of the guide in health centres by local opinion leaders.
- Posting of the guide in electronic format on the websites of the Ministry of Health and Social Policy of the Health Guide, the Health Technology Evaluation Unit (UETS) and companies involved in the project.
- Publication of the guide in scientific journals.
- Establishment of criteria for good care of patients with insomnia for the programme and clinical management contracts, as provided for in the guide.
- Evaluating effectiveness of implementation, establishing systems of clinical decision support, integrating the guide and the indicators selected in the software used in PC.

Proposed Indicators

The authors of this clinical practice guideline (CPG) have designed a series of indicators that must be measurable, through the information system in PC, to evaluate both health care for patients with insomnia and the potential impact of the implementation of the guide. It was not the purpose of the authors to design a comprehensive and detailed evaluation involving the use of all proposed indicators. The intention was to provide a tool for those practitioners and managers concerned, which may be useful in the specific design of the evaluation of care for patients with insomnia in primary care.

Two types of indicators are proposed:

- **Monitoring indicators**: This set of indicators would monitor the distribution of patients according to the use of the treatments and tools suggested in the guide.
- **Compliance indicators**: These are based on the recommendations proposed in this guide and therefore the available scientific evidence and consensus of the profession. Although the proposed compliance standards should be 100%, the reality of the PC field must be taken into account when establishing such standards.

Refer to the tables in Chapter 11 of the original guideline document for additional information on these indicators.

Implementation Tools

Audit Criteria/Indicators

Chart Documentation/Checklists/Forms

Clinical Algorithm

Foreign Language Translations

Mobile Device Resources

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Guideline Development Group for the Management of Patients with Insomnia in Primary Care. Clinical practice guidelines for the management of patients with insomnia in primary care. Madrid (Spain): Health Technology Assessment Unit, Laín Entralgo Agency, Ministry of Health, Social Services and Equality (Spain); 2009. 159 p. [207 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2009

Guideline Developer(s)

GuiaSalud - National Government Agency [Non-U.S.]

Health Technology Assessment Unit, Laín Entralgo Agency - State/Local Government Agency [Non-U.S.]

Ministry of Health (Spain) - National Government Agency [Non-U.S.]

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Guideline Committee

Guidelines Development Group for the Management of Patients with Insomnia in Primary Care

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

All members of the Development Group have made a declaration of interest as reflected in Appendix 13 of the original guideline document.

Guzmán Artiach Geiser, Mª Isabel del Cura González, Mª Jesús de la Puente, Julio Fernández Mendoza, Ana García Laborda, Alicia González Avia, Pedro José González Gil, Susana Martín Iglesias, Pablo Pascual, Mª Teresa Rubio Moral, Violeta Suárez Blázquez, Antonio Vela Bueno have declared no conflict of interest.

Mª Isabel Villalibre Valderrey has participated in a research project funded by Sanofi-Aventis.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in English and Spanish from the GuíaSalud Web site.

Availability of Companion Documents

The following are available:

- Quick reference guides are available in several dialects from the GuíaSalud Web site.
- The Spanish version of the guideline is also available via a mobile application from the GuíaSalud Web site.
- A summary version is available in Spanish from the GuíaSalud Web site.
- A methodology document is available in Spanish from the GuíaSalud Web site.

The appendices to the original guideline document contain interview questions, a sample sleep diary, insomnia measurement questionnaires, and outcome measures. In addition, proposed monitoring and compliance indicators are available in the original guideline document.

Patient Resources

Appendix 11 in the original guideline document contains information on learning to recognize and cope with insomnia for the patient.

Patient information in Spanish is available from the GuíaSalud Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them

better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on January 9, 2013. The information was verified by the guideline developer on February 5, 2013.

Copyright Statement

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