

Sleep

Dear [Dr ____],

Advice and guidance response pertaining to [Patient name].

Primary sleep disorders are very rare (<4%) – whereas sleep problems are common (50% of all children as reported by parents). Sleep problems are more common among children with neurodevelopmental differences.

Sleep problems usually fall into one of three groups:

insufficient sleep (e.g. insomnia, night waking): Reports of insufficient sleep are very common especially in infants and young children

excessive sleepiness (including daytime somnolence): Commonly caused by insomnia, or sleep disordered breathing. History should distinguish between somnolence and fatigue/ lethargy

sleep disturbances/parasomnias (e.g. night terrors, sleepwalking)

Sleep problems are often a symptom, rather than a primary problem. History should cover sleep habits and impact on daily life, but also potential causal factors such as anxiety, mood and activity levels.

All sleep problems will benefit from improvements in sleep hygiene (e.g. a regular sleep routine, dark and quiet sleep environment, reduced screen time (especially an hour before bedtime) – refer parents and patients to resources such as [Children - The Sleep Charity](#).

Most children with sleep problems do not require referral. Sleep hygiene is the mainstay of management. If referral is still indicated (see below), refer to general paediatrics in the first instance as most tertiary sleep clinics do not take direct referral from primary care.

Insomnia: Refer children who continue to have significant insomnia impacting daily activities despite rigorous implementation of sleep hygiene measures at home; and children with significant neurodevelopmental differences (who may benefit from earlier pharmacological intervention).

Excessive sleepiness: The commonest causes for daytime somnolence are insomnia, and sleep disordered breathing (which may be better reviewed by ENT; features include history of snoring with breathing pauses; early morning fatigue, associated headaches). Refer if there are concerns over rare causes such as narcolepsy (may be associated with cataplexy, sleep paralysis, sleep attacks, family history).

Parasomnias: referral is not required or helpful for the majority of parasomnias, which are managed conservatively and with safety advice only, and resolve over time (>95% by adolescence). Refer to general paediatrics if significant safety concerns (e.g. physical danger associated with sleepwalking), or if diagnosis is in doubt (e.g. suspicion of nighttime epilepsy).

Any underlying causal factors requiring intervention (e.g. behavioural or mental health problems, obstructive sleep apnoea) should be referred to the relevant specialist service as needed.

Melatonin: melatonin may be prescribed to support sleep initiation and can be particularly helpful for those children with neurodevelopmental differences. Long term use can lead to reduced responsiveness, and regular breaks from treatment (“drug holidays” for 7-14 days annually) can sometimes be more helpful than repeated dose increases. Melatonin is usually prescribed in primary care on a shared care basis, but this is dependent on local policies. It is important to review usage regularly e.g. ongoing treatment and cessation, regular review of indication and dosage, drug holidays etc.

Information for families and patients:

[Healthy Sleep: Healthier Together](#)

[How to sleep well for teenagers | Evelina London](#)

[Children - The Sleep Charity](#)

[Baby Sleep Advice for Parents & Kids | Pediatric Sleep Council](#)

[ATN/AIR-P Strategies to Improve Sleep in Children with Autism | Autism Speaks](#)

If referring back, please state that the referral has already been through Advice and Guidance and include a copy of the previous correspondence, to ensure we don't duplicate advice.

With kind regards,

[Clinician name and role]