Mental Health Clinical Advisory Group

June 6, 2024 | 8:00 – 8:50 AM | Microsoft Teams

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OHA welcomes all participants. If you have any questions about accommodations or need any assistance to participate, please call or email: Andrew Gibler at: 503-878-1395 or andrew.n.gibler@oha.oregon.gov (voice/text). All relay calls are accepted.

Public comment requires the completion of a public comment form. This form is available on the MHCAG website. The form should be signed and returned to Andrew Gibler at: andrew.n.gibler@oha.oregon.gov. Each speaker is allotted 3 minutes.

Officers: Nick Kashey, MD (Chair); Kaja Wagner, PharmD (Vice-Chair).

Appointed Members: Maggie Bennington-Davis, MD; John Bischof, MD; Chris Bouneff; Don Dravis, MD; Ty Duffield, PhD; Samantha DuPont; Neil Falk, MD; Naomi Fishman, MD; Bennett Garner, MD; Bethany Higa, PsyD; Bob Joondeph, JD; Jacq Knapp, MD; Lori Martin, MSN, PMHNP; Katie Peters-Daniel, PharmD; Leah Werner, MD

Agenda subject to change

AGENDA	PAGE	TIME	FACILITATOR
Call to order Approval of May meeting minutes OHA announcements	2	8:00 – 8:05	Nick Kashey
Public comment on agenda items • *including OHA staff*		8:05 – 8:10	Nick Kashey
ADHD Drug Policy Evaluation (focus on off-label use)	3-11	8:10 – 8:20	Sarah Servid (OSU)
Management of Insomnia Draft	12-21	8:20 – 8:45	Andrew Gibler
PTSD Research Questions		8:45 – 8:50	Andrew Gibler

Next Meeting: Thursday, July 11, 2024; 8:00-8:50 AM

All 2024 Meetings: First Thursdays of each month **(**except 2nd Thursday in July) at 8:00 AM. No meeting in December.

Attendees:

Mental Health Clinical Advisory Group Committee: Maggie Bennington-Davis, MD; John Bischof, MD; Ty Duffield, PhD; Samantha DuPont; Neil Falk, MD; Naomi Fishman, MD; Bennett Garner, MD; Bob Joondeph, JD; Nick Kashey, MD (Chair); David Nagarkatti-Gude, MD; Katie Peters-Daniel, PharmD; Leah Werner, MD

OHA Staff: Jennifer Bowen; Trevor Douglass; Andrew Gibler; Sarah Servid (OSU DURM)

Public: Amy Breen, Madeline Tyler (pharmacy student)

Call to order: A quorum was present for voting purposes. The meeting was called to order by Chair Kashey at 8:01 AM.

Review of previous minutes: Minutes from the April 4, 2024, meeting were reviewed. A motion was made by Maggie Bennington-Davis to approve the minutes and was seconded by John Bischof. None opposed, and the motion passed.

OHA announcements: Four MHCAG appointments have been submitted for approval.

Public comment: None.

Antidepressant Drug Class Review. The group reviewed and discussed the antidepressant drug class review by the OSU College of Pharmacy for the state Pharmacy and Therapeutics Committee. The antidepressants are carved out in Medicaid to fee-for-service. Feedback was provided on pediatric use of tricyclic antidepressants for depression. No vote was required.

MHCAG Sleep Disorders Draft Review. The group reviewed the first draft of MHCAG treatment recommendations for insomnia in adults. Discussion involved areas to focus, with an emphasis on cognitive behavioral therapy and resources for clinicians. No vote was taken.

DRAFT

ADHD Drug Policy Evaluation with a Focus on Off-label Use

June 2024



Background/Policy Rationale

- Drugs for attention deficit hyperactivity disorder (ADHD) have been studied for a variety of conditions:
  - movement disorders (i.e., tics),
  - autism,
  - learning disabilities,
  - disruptive behavior, and
  - eating disorders.

- The Oregon Health Authority reviews requests for ADHD drugs when:
  - Dose, age, or combination therapy is not supported by current evidence and guidelines

- Prior authorization (PA) criteria supports use only for ADHD and narcolepsy.

- This analysis evaluates
  1) Common off-label indications for ADHD drugs,
  2) How off-label use impacts healthcare utilization, and
  3) The impact of recent PA changes on ADHD drug utilization for off-label conditions

People without an ADHD diagnosis (part 1)

- Population: members starting an ADHD drug who did not have an ADHD diagnosis
- Evaluation window for claims: 1/1/22 to 6/30/22

- 63% adults
- 90% enrolled in a coordinated care organization (CCO)
- Drugs paid for by fee-for-service (FFS):
  - Stimulant 8%
  - Non-stimulant: 92%
- Prescriber type:
  - General practitioner: 47%
  - Psychiatrist: 17%

Common Off-label Diagnoses

		All	
		626	%
Evidence-based diagnosis		110	17.6%
Learning disorder or intellectual disability		18	2.9%
Autistic disorder		34	5.4%
Conduct, oppositional defiant disorder, intermittent explosive disorder		41	6.5%
Tic disorders		16	2.6%
Eating disorders		16	2.6%
Narcolepsy and cataplexy		2	0.3%
Members without a diagnosis supported by evidence (most common mental health diagnoses)		516	82.4%
F41	Other anxiety disorders	207	33.1%
F43	Reaction to severe stress, and adjustment disorders	170	27.2%
F33	Major depressive disorder, recurrent	127	20.3%
F32	Depressive episode	125	20.0%
F17	Nicotine dependence	65	10.4%
F31	Bipolar disorder	60	9.6%
F10	Alcohol related disorders	44	7.0%
F15	Other stimulant related disorders	44	7.0%
F11	Opioid related disorders	42	6.7%
F12	Cannabis related disorders	38	6.1%

Health Resource Utilization

No indication based on medical claims of overt harms because of off-label prescribing for ADHD drugs.

- No change in emergency visits, pharmacy utilization, psychotherapy
- Small decline in inpatient costs in the 6 months after starting an ADHD drug
  - evidence-based diagnosis (mean decrease of $6,370 and change of 4.5% of members)
  - without an evidence-based diagnosis (mean decrease of $293 and change of 2.3% of members).

Policy Change

In January 2023, prior authorization criteria were updated to:

- limit use to FDA approved indications (ADHD, narcolepsy)
- permit ongoing use of an ADHD drug for members turning 18 years of age

Population: included people with and without ADHD, new starts and ongoing therapy

Timeframe:

- Before: 01/01/2022 to 06/30/2022
- After: 1/1/2023 to 06/30/2023

Prior authorization criteria most commonly apply to guanfacine and clonidine because they are not FDA-approved in adults.

Policy Change Results

Overall, people with an initial denied claim was similar before and after the policy

Variability in denied claims based on subgroup:

- Age < 5 years: 9% before vs. 17% after
- Ongoing treatment: 21% before vs. 31% after
- No difference in proportion of people with an evidence-supported diagnosis

90 days after an initial denial, people who had a paid claim for an ADHD drug decreased (62% before vs. 54% after).

In the after group:

- 34% had claims for a stimulant
- 21% had claims for ER guanfacine
- 25% had claims for IR guanfacine
- 10% had no subsequent paid claim and had an ADHD diagnosis

Conclusions

- Claims data indicates a small portion of patients on OHP may be prescribed non-stimulant ADHD drugs for off-label conditions.
- We did not identify harms based on claims as a result of off-label prescribing.
- Some off-label conditions do have supporting evidence and guideline recommendations for use.
- In 68% of members with an initial denied claim, there was a subsequent claim for a similar drug:
  - 34% of members were prescribed a stimulant (first-line for ADHD).
  - 25% of members were prescribed immediate-release clonidine or guanfacine.
  - 20% of members were prescribed extended-release guanfacine.

Recommendations

Management of Insomnia in Adults

Compromised sleep is an important medical problem that requires intervention. Untreated insomnia can exacerbate cooccurring mental or behavioral health disorders; likewise, untreated mental health disorders can exacerbate sleep disturbances.

Table 1. Clinical Features of Chronic Insomnia Disorder.
• Difficulty initiating sleep, maintaining sleep, or early-morning awakenings • The sleep disturbance causes clinically significant distress or impairment in important areas of functioning • The sleep difficulty occurs at least 3 nights per week • The sleep difficulty has been present for at least 3 months • The sleep difficulty occurs despite adequate opportunity for sleep • The insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder • The insomnia is not attributable to the physiological effects of a substance • Coexisting mental disorders and/or medical conditions do not adequately explain the predominant complaint of insomnia

Management of insomnia requires a stepwise approach, beginning with attempts to eliminate, or at least minimize, contributing factors and cooccurring disorders that can interfere with optimal sleep.[1] The Epworth Sleepiness Scale may be a good place to start with someone who complains of sleep disturbance.

Table 2. Differential Diagnoses.

Symptoms	Differential Diagnoses	Next steps
Difficulty with sleep onset	Restless Leg Syndrome	Check iron stores, consider iron supplementation, dopamine agonist (e.g., ropinirole, pramipexole) or pregabalin.
	Delayed sleep-wake phase disorder	Sleep log to review sleep-wake patterns on weekdays and weekends. Refer to sleep specialist. (note: actigraphy is not a covered benefit under Oregon Health Plan)
Difficulty maintaining sleep, daytime sleepiness	Obstructive sleep apnea	Calculate STOP-BANG score; confirm with home sleep apnea test or polysomnography. Refer to sleep specialist.
	Periodic limb movement disorder	Polysomnography (note: services for periodic limb movement disorder is not a covered benefit under Oregon Medicaid)
Early morning awakening	Advanced sleep-wake phase disorder	Sleep log to review sleep-wake patterns on weekdays and weekends. Refer to sleep specialist. (note: actigraphy is not a covered benefit under Oregon Health Plan)
	Depression*	Evaluate for depression*; concomitant treatment for both disorders is often necessary.
Decreased sleep quality	Insufficient sleep	Emphasize sleep hygiene and lifestyle changes to promote adequate sleep.
	Short sleep duration	Educate about range of normal sleep needs, revise expectations on duration of sleep.

*Although early morning awakening is a common symptom of depression, any insomnia complaint could trigger an evaluation for depression and anxiety.

We recommend due diligence to figure out why an individual has disordered sleep.

- **Treatment for chronic insomnia should be initiated after all contributing factors, including cooccurring mental health disorders and behavioral issues, are identified and attempts to manage them are made.**
- Treatment should focus on achieving restorative sleep, and not simply to reduce latency of sleep onset. This can best be achieved without medications.

Sleep Hygiene

- A set of general recommendations about lifestyle practices (e.g., diet, exercise, substance use) and environmental factors (e.g., light, noise, temperature).
- Offering sleep hygiene recommendations alone has not shown to be an effective treatment for insomnia disorder, but everyone with insomnia should be provided education on good sleep hygiene in combination with other prescribed therapies.

Table 3. Sleep Hygiene Guidelines.[1]

Recommendation	Details
Regular sleep schedule 7 nights per week	Having a consistent bedtime and rise time leads to more regular sleep schedules and avoids periods of sleep deprivation or periods of extended wakefulness during the night.
Avoid naps during day	Avoid napping, especially naps lasting longer than 1 hour and naps late in the day.
Limit caffeine	Avoid caffeine after lunch. The time between lunch and bedtime represents about 2 half-lives for caffeine, and this time window allows for most caffeine to be metabolized before bedtime.
Limit alcohol	Recommendations are typically focused on avoiding alcohol near bedtime. Alcohol is initially sedating, but activating as it is metabolized. Alcohol also negatively impacts sleep architecture.
Avoid nicotine	Nicotine is a stimulant and should be avoided near bedtime and at night:
Medications	Medications are often overlooked as a contributing factor of insomnia. Offending medications should be taken in the morning, or in the case of bronchodilator inhalers like albuterol, a spacer can be used to minimize systemic absorption.
Exercise	Daytime physical activity is encouraged because it may facilitate sleep. However, it should be done at least 6 hours before bedtime. Exercise within 2 hours of bedtime is discouraged because it hinders sleep onset.
Keep the sleep environment quiet and dark	Noise and light exposure during the night can disrupt sleep. White noise or ear plugs are often recommended to reduce noise. Using blackout shades or an eye mask is commonly recommended to reduce light. This may also include avoiding exposure to digital devices and other technology near bedtime, as this can have an impact on circadian rhythms by shifting sleep timing later.
Bedroom clock	Avoid checking the time at night. Checking the time increases cognitive arousal and prolongs wakefulness.
Evening eating	Avoid a large meal close to bedtime. Eat a healthy and filling (but not too heavy) meal in the early evening.

Psychotherapy

Psychotherapy can be difficult to access and sometimes difficult to complete, so it may be easy to resort to medications to manage chronic insomnia, many of which can have harmful long-term effects and do not facilitate restorative sleep.

We recommend a harm-reduction approach to steer people away from chronic use of insomnia medications whenever possible. Please review our references, which provide a concise list of recommended online CBT-I programs and apps, helpful books, and videos for both clinicians and patients.

Table 4. Psychotherapy for Adults Chronic Insomnia Disorder.[2-12]

Cognitive Behavioral Therapy for Insomnia (CBT-I) ***(multicomponent)***

- Treatment is usually 4-8 sessions, which can be provided in-person or via telemedicine.
- Upon course completion, CBT-I provides clinically meaningful long-term improvement in critical outcomes of remission, response, SOL, WASO and sleep quality (ISI, PSQI) (moderate quality evidence).
    - Multicomponent CBT-I will at least include stimulus control therapy, sleep restriction therapy, and some form of cognitive therapy.
    - CBT-I can be tailored to match each individual's clinical presentation (e.g., relaxation therapy for anxiety, pain).
    - CBT-I has significant impact on people with insomnia and cooccurring depression, PTSD, alcohol dependency and bipolar disorder.
- Clinicians play a large role helping set reasonable expectations for individuals:
    - Treatment adherence to CBT-I is correlated to treatment efficacy. Suboptimal adherence may reduce the impact of treatment.
    - CBT-I requires motivation and significant effort to change the behaviors and thinking patterns that contribute to and perpetuate insomnia.
    - Regularly follow-up with individuals to address adherence and promote patient motivation.
- Medicaid covers in-person CBT-I and, with exceptions due to lack of access to CBT-I, requires completion of at least 4 sessions of CBT-I before attempting pharmacotherapy.

CBT-I Online Programs and Mobile Apps

There are many apps and online treatment programs intended to help people with insomnia. The programs/apps listed include the most important components of CBT-I. However, they differ in a number of different ways. We recommend taking a look to see which you find most appealing.

- Some online programs, like Sleepio, are covered under some health plans. Medicaid does not currently cover online CBT-I programs.

Path to Better Sleep	CBT-I program designed by the VA for veterans but available for anyone to use. (free)
Go! to Sleep	6-week CBT-I program designed by the *Cleveland Clinic;* has demonstrated clinically meaningful improvement in insomnia.[13] ($40)
Conquering Insomnia	5-week CBT-I program that replicates a program shown to be more effective than zolpidem alone.[14] ($50-70)
Sleepio	6-week CBT-I program available online or by mobile app; recommended as an alternative to in-person CBT-I based on evidence it provides clinically meaningful improvements in several sleep outcomes.[15-17] (only accessible as a health plan benefit)
Insomnia Coach	CBT-I app designed by the VA for veterans but available for anyone to use. (free)
Sleep Ninja	App provides 6 sessions that have shown to benefit adolescents with sleep disturbances.[18,19] (free)
Drug-Free Sleep	5-week CBT-I course with access to Sleep Coaches via email. ($147)
Insomnia Solved	Self-guided educational CBT-I program. Telemedicine resources may be available in the future. ($89)

Abbreviations: CBT-I = cognitive behavioral therapy for insomnia; ISI = Insomnia Severity Index; PSQI = Pittsburgh Sleep Quality Index; PTSD = post-traumatic stress disorder; SOL = sleep-onset latency; VA = US Veterans Affairs WASO = wake after sleep onset.

Pharmacotherapy

We recommend medication be reserved after attempts to identify causes of insomnia disorder are identified and attempts to treat with CBT-I have been made.

With the exception of the dual orexin receptor agonists (DORAs), pharmacotherapy does not promote slow wave sleep (deep sleep) and rapid eye movement (REM) sleep, which is often impaired with chronic insomnia disorder. Some medications, like benzodiazepines and non-benzodiazepine sedatives may actually decrease time in restorative sleep. Duration of medication should be limited to 4 weeks.

Table 5. Pharmacotherapy for Chronic Insomnia Disorder.

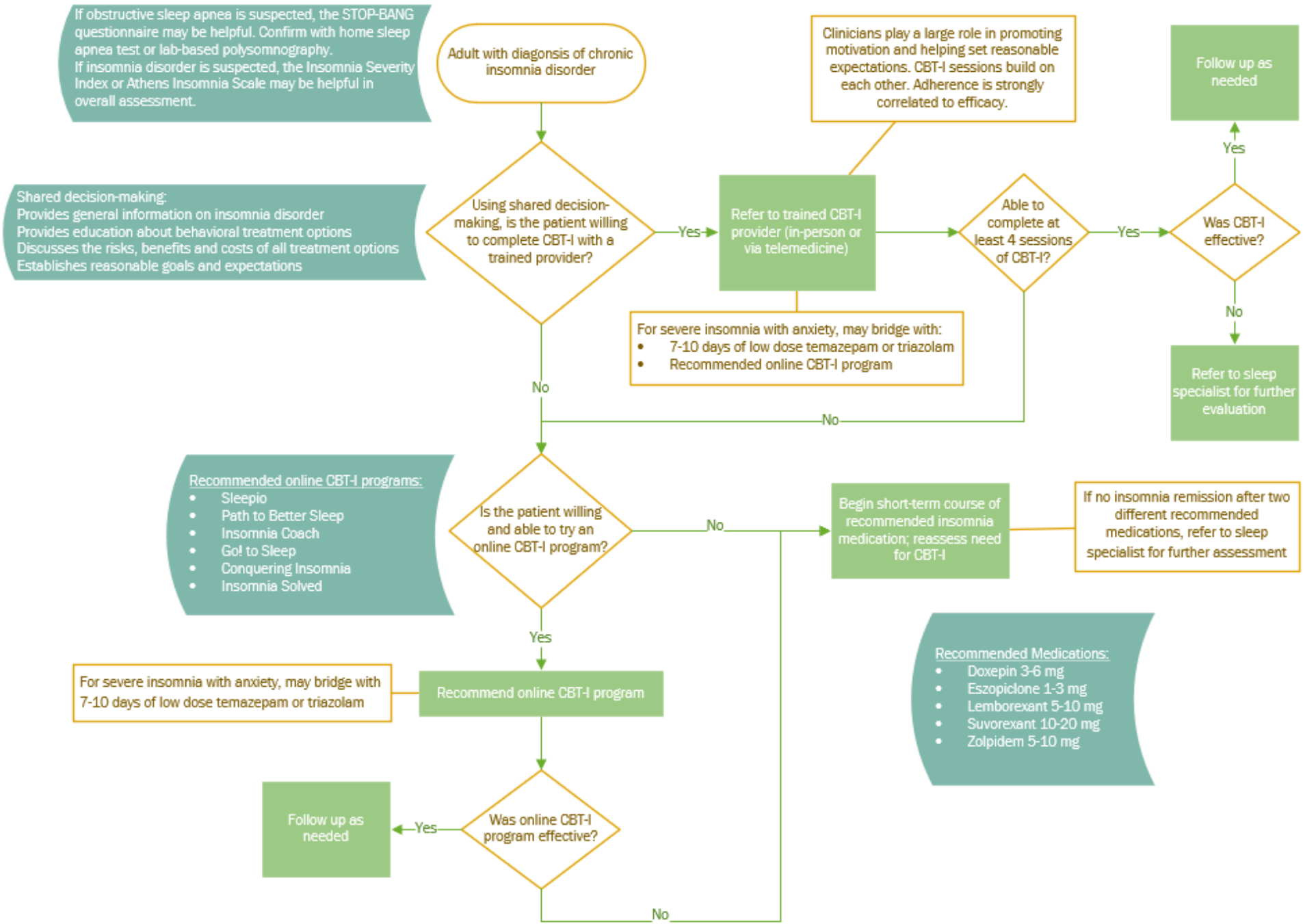
Drug Name	DEA CS	Recommendation	Evidence
Benzodiazepine Hypnotic Sedatives [2,4,20-25]			
Comments: *Unfavorable short-term tolerability and safety profiles.* *Avoid long-term use. Risks include dementia and fractures; tolerance, dependence, addiction and withdrawal effects are well recognized.* *Benzodiazepines may have deleterious effects on the sleep architecture by decreasing time in slow wave sleep (deep sleep) and REM sleep.*			
Temazepam *Restoril, generic*	C-III	Sleep onset, sleep maintenance. Limit to 7-10 days PRN.	• Original studies were of poor quality of studies and provide low-quality evidence that short-term (<4 weeks) use improves sleep outcomes. • Lack evidence for long-term efficacy. • Drugs with shorter half-lives are preferred to reduce daytime sedation.
Triazolam *Halcion, generic*	C-III	Sleep onset. Limit to 7-10 days PRN.	
Nonbenzodiazepine Hypnotic Sedatives [2-4,20-22,24,26,27]			
Comments: *Generally, they have less abuse potential and less risk for withdrawal or tolerance than benzodiazepines.* *Long-term risks include dementia and fractures.* *Rare risk for daytime memory and psychomotor impairment, abnormal thinking and behavioral changes, and complex behaviors (i.e., sleep driving, sleep walking).* *Non-benzodiazepines may have deleterious effects on the sleep architecture by decreasing time in slow wave sleep (deep sleep) without improving REM sleep.*			
Eszopiclone *Lunesta, generic*	C-IV	Sleep onset, sleep maintenance	• Improves short-term SOL, TST and WASO (moderate quality evidence). • May also be effective long-term (low quality evidence). • May be more effective than others in this class.
Zaleplon *generic only*	C-IV	Sleep onset	• May not improve TST. • May be least effective 'Z' drug.
Zolpidem *Ambien, Ambien CR, Edluar, generic*	C-IV	Sleep onset, sleep maintenance	• Improves short-term SOL and TST (moderate quality evidence). • When taken "as needed", improves global outcomes, SOL and TST (low to moderate quality evidence)

Dual Orexin Receptor Antagonists (DORA) [2-4,20,21,27-30]			
Comments: *DORAs preserve or may improve, sleep architecture in people with insomnia by increasing time in slow wave sleep (deep sleep) and REM sleep.*			
Daridorexant *Quviq*	C-IV	No recommendation	• New agent with more limited evidence compared to other DORAs.
Lemborexant *DayVigo*	C-IV	Sleep maintenance	• Improves short-term SOL and TST (moderate quality evidence). • May also be effective long-term (low quality evidence). • May be more effective than other DORAs (low quality evidence). • No evidence of detriment to next day memory or driving ability in older adults
Suvorexant *Belsomra*	C-IV	Sleep maintenance	• Improves short-term SOL, TST and WASO (moderate quality evidence). • May have better safety profile than other DORAs. • No evidence of daytime residual or withdrawal symptoms
Antidepressants [2,19,30]			
Doxepin *Silenor, generic*	No	Sleep maintenance	• Low dose tablet formulation has FDA-approved indication for insomnia. • Most effective for sleep maintenance. Improves TST and WASO without impact on SOL (moderate quality evidence). • May also improve subjective sleep quality (low quality evidence). • Caution in older adults and patients already on an antidepressant.
Trazodone *generic only*	No	No recommendation	• Off-label use • 50-150 mg may improve subjective, self-reported sleep quality (moderate quality evidence) with no impact on sleep efficiency, SOL, TST or WASO (low quality evidence). • Evidence is limited to very short-term studies only. • Limited by drug-drug interactions and adverse effects, such as morning grogginess, increased dry mouth and thirst. • May be helpful with cooccurring depression; caution advised when used with another antidepressant.
Melatonin Agonists [2,19,20,31,32]			
Ramelteon *Rozerem, generic*	No	Sleep onset	• May modestly improve SOL, TST and WASO (low quality evidence). • Poorer efficacy relative to other agents; likely reason for high dropout rates in studies. • Low risk for adverse effects.
Tasimelteon *Hetlioz, generic*	No	Avoid	• Indication limited to non-24-hour sleep-wake disorder or nighttime sleep disturbances in Smith-Magenis syndrome.
Over-the-Counter Agents and Supplements [3,4,20-22,32-34]			
Melatonin	No	No recommendation	• Dietary supplement, not regulated by FDA. Lack of oversight may lead to variability in the quality of melatonin. • Only controlled-release formulations studied.

			• Evidence in adults is mixed. Some studies showing improvement in sleep outcomes and other do not. May modestly improve SOL. In older adults, may also improve sleep efficiency (low quality evidence).
Diphenhydramine	No	Avoid	• Off-label use. • Effect on sleep outcomes not clinically significant (low quality evidence). • Increased risk of dementia in older adults.
Doxylamine	No	No recommendation	• May improve short-term sleep outcomes (low quality evidence). • More tolerable than prescription drugs with antihistamine properties that are used off-label for insomnia (e.g., quetiapine, doxepin, trazodone)
L-tryptophan	No	Avoid	• Essential amino acid dietary supplement, not regulated by FDA. • Evidence limited to patient reports of mild benefit (low quality evidence).
Antipsychotics [35,36]			
Quetiapine	No	Avoid	• Used off-label for its sedative effect. • May improve sleep quality and TST in adults, including people with GAD or MDD (low quality evidence). • Poorly tolerated with high incidence of discontinuation. • Potential for considerable harm, including increased risk of death, weight gain, diabetes, cerebrovascular AEs, gait disturbances and falls, somnolence, movement disorders. Risk is higher in older adults. • Deprescribe antipsychotic if being used for insomnia only.

Abbreviations: AE = adverse event; CS = controlled substance; DEA = U.S. Drug Enforcement Agency; FDA = US Food and Drug Administration; GAD = generalized anxiety disorder; MDD = major depressive disorder; PRN = as needed; REM = rapid eye movement; SOL = sleep onset latency; TST = total sleep time; WASO = wake after sleep onset;

Treatment Algorithm for Adults with Chronic Insomnia Disorder:


If obstructive sleep apnea is suspected, the STOP-BANG questionnaire may be helpful. Confirm with home sleep apnea test or lab-based polysomnography.
If insomnia disorder is suspected, the Insomnia Severity Index or Athens Insomnia Scale may be helpful in overall assessment.
Adult with diagonsis of chronic insomnia disorder
Clinicians play a large role in promoting motivation and helping set reasonable expectations. CBT-I sessions build on each other. Adherence is strongly correlated to efficacy.
Follow up as needed
Shared decision-making:
Provides general information on insomnia disorder
Provides education about behavioral treatment options
Discusses the risks, benefits and costs of all treatment options
Establishes reasonable goals and expectations
Using shared decision-making, is the patient willing to complete CBT-I with a trained provider?
Yes
Refer to trained CBT-I provider (in-person or via telemedicine)
Able to complete at least 4 sessions of CBT-I?
Yes
Was CBT-I effective?
Yes
No
For severe insomnia with anxiety, may bridge with:
7-10 days of low dose temazepam or triazolam
Recommended online CBT-I program
Refer to sleep specialist for further evaluation
No
No
Recommended online CBT-I programs:
Sleepio
Path to Better Sleep
Insomnia Coach
Go! to Sleep
Conquering Insomnia
Insomnia Solved
Is the patient willing and able to try an online CBT-I program?
No
Begin short-term course of recommended insomnia medication; reassess need for CBT-I
If no insomnia remission after two different recommended medications, refer to sleep specialist for further assessment
Yes
Recommended Medications:
Doxepin 3-6 mg
Eszopiclone 1-3 mg
Lemborexant 5-10 mg
Suvorexant 10-20 mg
Zolpidem 5-10 mg
For severe insomnia with anxiety, may bridge with 7-10 days of low dose temazepam or triazolam
Recommend online CBT-I program
Follow up as needed
Yes
Was online CBT-I program effective?
No

Resource Recommendations:

Overview of CBT-I for Clinicians:

- CBT-I Information Sheet for Behavioral Health Providers in Primary Care *(VA)*
- Insomnia and CBT-I community education videos *(Society of Behavioral Sleep Medicine)*
- What is Behavioral Sleep Medicine? *(Society of Behavioral Sleep Medicine)*

Books/Bibliography:

Several books have been published to guide individuals through CBT-I without a clinician. As with the apps and online courses, the books listed include the most important components of CBT-I. However, they differ in a number of different ways. We recommend taking a look to see which you find most appealing. Used copies of older books are often available at low costs. When possible, I have linked to the publisher's website or to Bookshop.org, which connects readers with independent bookstores. None of the links are affiliate links: We do not receive compensation for any purchases you make.

- Hello Sleep by Jade Wu
- The One-Week Insomnia Cure by Jason Ellis
- Goodnight Mind by Colleen Carney and Rachel Manber
- Goodnight Mind for Teens by Colleen Carney and Rachel Manber
- Sleep Through Insomnia by Brandon Peters
- The Sleep Fix by Diane Macedo
- The Women's Guide to Overcoming Insomnia by Shelby Harris
- Mindfulness for Insomnia by Catherine Polan Orzech and William H. Moorcroft
- Sound Sleep, Sound Mind by Barry Krakow
- The Insomnia Answer by Paul Glovinsky and Arthur Spielman
- Quiet Your Mind and Get to Sleep by Colleen Carney and Rachel Manber
- Say Good Night to Insomnia by Greg Jacobs
- No More Sleepless Nights by Peter Hauri and Shirley Linde
- Conquering Bad Dreams and Nightmares by Barry Krakow - out of print, used copies available, focused on treating nightmares
- Turning Nightmares into Dreams by Barry Krakow - digital download, focused on treating nightmares
- "The Sleep Book: How to Sleep Well Every Night" by Dr. Guy Meadows. This book uses ACT techniques to help with insomnia.

Delayed School Start Time:

https://www.startschoollater.net/

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