

Non-pharmacological management of chronic insomnia in primary care

One-fifth of patients consulting in primary care have insomnia¹ and prevalence in the population ranges from 10–12% to over 20% in older adults.² It is the most common symptom of mental illness, regardless of age, sex, or ethnic group.³ Insomnia is more common than worry, and twice as common as anxiety or depressive symptoms. Typically, insomnia is associated with reduced daytime alertness and productivity, poorer quality of life, impaired relationships, and increased ill health.⁴ It is the largest, potentially treatable, risk factor for depression⁵ and is a major cause of accidents.⁶

Persistent insomnia presents a challenge for most GPs. The problem is often unrecognised and management is generally unsatisfactory.⁷ Many doctors manage the condition with 'off-label' prescribing of hypnotic or sedative antidepressant drugs, neither of which have demonstrated more than marginal efficacy.⁸ There is little evidence that the new generation of hypnotics has improved the management of persistent insomnia.⁹ Adverse effects of hypnotics are common¹⁰ and an investigation of drug-associated hospital admissions among older patients has shown that up to 10% may be due to benzodiazepines.¹¹ Despite the fact that many would prefer a non-pharmaceutical approach if an effective one were available, hypnotics are nevertheless often requested by patients and withdrawal often poses difficulties for doctors and patients as a result of physical and psychological dependence. It is therefore important to offer an alternative.

Faced with a complaint of chronic insomnia, potentially reversible causes such as pain, menopausal symptoms, or restless legs syndrome should be addressed. We should also always consider prescribed and non-prescribed stimulants such as caffeine, steroids, and decongestants, as well as illicit drugs such as amphetamines. Other drugs such as β -blockers, alcohol, and nicotine can also interfere with sleep. Depression and anxiety may contribute to and result from insomnia. They should be considered and appropriate management strategies discussed. Nevertheless, for a significant number of patients, even when all potential contributory causes are excluded or

managed, insomnia will remain a problem.

The most common non-pharmaceutical approach for GPs faced with such a patient is to promote 'sleep hygiene'. This involves encouragement to establish a regular sleep habit, not going to bed too early, not staying in bed if unable to get to sleep in a reasonable time, having fixed routines and rituals at bedtime, and avoiding daytime napping. Vigorous exercise, heavy eating, and caffeine and alcohol consumption prior to bedtime are discouraged. However, there is little evidence that this approach is effective¹² and, somewhat perversely, people with insomnia often have better sleep hygiene than good sleepers. In common with many traditional — and ineffective — health promotion approaches, sleep hygiene largely involves giving people advice that they already know, without giving them the wherewithal to make crucial behavioural and attitudinal changes. Such behavioural and attitudinal changes are central to the approach of cognitive behavioural therapy (CBT).

Promising results have been achieved by combining some of the elements of sleep hygiene with CBT. CBT is a validated and evidence-based therapy comprising behavioural and mental strategies that can elicit substantial change in the whole approach to sleep. Insomnia often arises from psychological factors such as conditioned arousal (for example, from lying in a bed that is associated with sleeplessness) and sleep preoccupation,¹⁰ regardless of whether the sleep problem is primary or presenting in the context of psychiatric problems.¹³ Although meta-analyses have demonstrated clear benefit,¹⁴ most CBT efficacy trials have been conducted among media-solicited participants, perhaps excluding patients with the type of complex presentations and comorbidities seen in general practice. Furthermore, the CBT interventions in these trials have generally been delivered by qualified clinical psychologists, a scarce resource in the NHS.¹⁵

In a recently published randomised controlled trial,¹⁶ we showed that health visitors could be trained to deliver an effective CBT-based treatment for chronic insomnia to

small groups of patients. The health visitors received 12 hours of small-group training delivered over 2 days by a clinical psychologist. The training was followed by 'apprenticeship' support where the health visitors were first-participant observers in an ongoing treatment group and then took responsibility for their own group.

In 19 general practices, 201 patients were assigned at random to receive the CBT programme or treatment as usual. Half of the participants were taking hypnotic medication and most had mental health problems associated with their insomnia — usually anxiety or depression. The CBT programme was delivered to 19 groups of 4–6 patients over five 1-hour evening sessions. The course included general information, advice on sleep hygiene, scheduling, and developing cognitive approaches to recognise and avoid intrusive thought patterns. The programme came in the form of a manual and comprised therapist notes, presentations using PowerPoint® (15 slides per session), worksheets for 'break-off' times, and take-home notes with implementation guidelines. Clinical psychologists provided mentoring support to the health visitors but they took no part in the delivery of the programme.

This relatively inexpensive intervention, requiring 1 hour of health visitor time per patient, resulted in significant improvements in self-reported sleep latency (the time it takes to fall asleep once the lights are out), subsequent wakefulness after falling asleep (a reduction of 60 minutes), and an 11% greater improvement in sleep efficiency (the proportion of total sleep time in bed) compared with participants receiving treatment as usual. Benefits were not restricted to sleep alone. On the SF-36 scale, significant health-related quality of life improvement was observed among the CBT group in domains reflecting mental health and vitality. Improvements were generally sustained at follow-up at 6 months. The study was not powered to detect reductions in hypnotic use but other recent work has demonstrated that CBT can be effectively applied to hypnotic reduction as a primary outcome.¹⁷

The cost-effective delivery of CBT

interventions for problems such as depression anxiety, eating disorders, and schizophrenia has received much recent attention and is now clearly a health service priority. However, even with a sizable increase in current resources it will be hard to meet the potential demand. The expansion of training in the technique to professionals whose work is not exclusively focused on mental health problems seems a logical development. The health visitors who took part in the study enjoyed the training and delivery of the intervention and they found the techniques they had learned transferable to their other work. The use of a manual ensured standardised treatment, and alongside training, supervision, and case review, provided a robust model of service delivery. Development of alternative strategies for delivering CBT — such as supported self-help¹⁸ or computerised¹⁹ approaches — might merit further research and could further expand our therapeutic options.

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Regulation: appraisal alone is not enough

Until now, the ultimate goal of medical training has been to achieve the right to independent medical practice. The prime benefit of this has been the professional ability of a doctor to think, speak, and act objectively, purely in the interest of clinical benefit, and free from corporate constraint. The noxious side effect has been a litany of medical scandals, well documented elsewhere, where doctors, both misguided and malicious, have become the agents of harm. The challenge for a new regulatory process is to eliminate the latter while preserving the former.

The introduction of appraisal for all NHS doctors was an excellent first step in addressing this challenge for several reasons. Firstly, it is a universal process following a standard format. Secondly, it has broadened the remit of professional

development to include all aspects of good medical practice, not just maintenance of knowledge. And thirdly, it has begun with the premise that most doctors are diligent and honest, and will voluntarily bring the important issues to their appraisal.

This is not to say that appraisal has solved the problem. Although universal, there is inconsistent implementation. The dawning of realisation that professional development goes beyond knowledge has been slow, so that there remain too few learning resources around subjects such as teamwork and probity. And, partly because we choose what we present in appraisal by way of evidence, and partly because at its heart appraisal is a developmental activity, there remains the question of how we assure that individual doctors meet acceptable

standards of practice.

These contradictions are part of the reason why researchers such as Colthart *et al* end up with the results they have.¹ In a postal survey to which 671 GPs responded, 47% thought that appraisal had altered their educational activity. Asked about the value of appraisal, around 40% reported their perception that appraisal is valuable, around 40% that the value is marginal, and the remainder that it has no value. Appraisal has the potential to succeed, but also to fail. The optimists see the former, the sceptics the latter.

This divergence of opinion is healthy. The sceptics should consider the optimists' view that the process is worth further development and the optimists should recognise the gaps that appraisal fails to address. Both groups need to accept that, valuable as the