Insomnia in Adults

On-the-spot management

INFORMATION FOR HEALTH PROFESSIONALS

Sleep Health
Primary Care
Resources

Definition

Insomnia is the most common sleep disorder. It is defined by self-reported difficulties initiating sleep, maintaining sleep, and/or waking too early on ≥3 nights/week, with associated daytime feeling or functional impairment. At any given time, approximately 30-50% of adults in the general population have acute insomnia (< 3 month duration) and 10-15% meet criteria for chronic insomnia (≥ 3 months duration). Insomnia reduces quality of life, decreases mental health and wellbeing, and increases risk of psychiatric conditions.

Short-term insomnia (0-2 weeks) is often associated with an obvious underlying cause, such as family / relationship / financial / workplace / physical stressors or jetlag. Most short-term insomnia improves after these underlying causes have subsided. However, in some people, insomnia can develop independence from these initial triggers and become a self-maintaining acute (< 3 months) or chronic condition (≥ 3 months).

Chronic insomnia is maintained by underlying psychological and behavioural factors, such as spending excessive time in bed awake, development of a 'learned' relationship between the bed and feelings of alertness, anxiety and a conditioned insomnia response, as well as mal-adaptive cognitive and behavioural responses to sleep loss and the anticipated consequences of insomnia. For this reason, Cognitive Behavioural Therapy for insomnia (CBT-i) is the recommended 'first line' treatment. In addition to improving sleep, CBT-i also improves co-morbid mental and physical health conditions.

Typical scenario and clinical presentation

- Insomnia can occur throughout the lifespan; therefore any age group can be affected.
- The patient is dissatisfied with the quantity or quality of their sleep.
- Many people have attempted to self-treat their insomnia before presenting to GPs.
- Patients often present as being "wired & tired" (fatigued and anxious during the day and night).
- Patient may indicate that they are a "light sleeper" with sensitivity to environmental light exposure or sound cues.
- Patients often present with daytime fatigue, lethargy, and/or poor mood but rarely daytime sleepiness. However, the difference between feelings of sleepiness and fatigue may have to be teased out from the patient.
    - **Sleepiness** refers to a feeling that your eyes are heavy, and you could easily fall asleep if you laid down to rest, or fall asleep without meaning to.
    - **Fatigue** refers to mental or physical exhaustion (e.g., after a long meeting or physical activity) without necessarily feeling like you could fall asleep.
- Insomnia often occurs with other sleep, mental health, and physical health conditions. It should be viewed as a 'co-morbid disorder' to encourage targeted insomnia treatment, rather than expecting insomnia to resolve as the co-morbid condition is treated.

Insomnia assessment and management

Numbered sub-headings correspond to the Flow diagram in **Figure 1**.

1 Patient identification

Insomnia can be identified relatively easily by asking patients simple questions about their sleep pattern and perceived impact on daytime feelings and functioning. Patients can also be identified via;

- Auditing electronic records to identify patients recently prescribed sleeping pills, or
- Focussing assessment on patients with a high risk of insomnia (e.g., older adults, those with symptoms of depression/anxiety, chronic pain, cardiac or respiratory disease). www.sleepprimarycareresources.org.au/insomnia/assessment-sleep-history

2 Insomnia assessment

After identifying a patient with sleeping difficulties, confirm insomnia with simple screening tools;

- If patient has initially presented for management of other issues, a separate longer consultation many be required for insomnia assessment.
- The **Sleep Condition Indicator** (SCI) maps onto DSM-5 criteria for Insomnia Disorder: www.sleepprimarycareresources.org.au/insomnia/questionnaires

  Scores ≤16 indicate probable insomnia disorder.

  - Patients that do not have insomnia can be provided information about sleep patterns (www.sleepprimarycareresources.org.au/insomnia/basic-sleep-and-sleep-hygiene-education), and good sleep habits (www.sleephealthfoundation.org.au/sleep-topics/sleep-hygiene-good-sleep-habits).
  - Most cases of sub-clinical and short-term insomnia (0-2 weeks) do not transition to chronic insomnia. Sleep education and healthy sleep practices should be provided to prevent the development of chronic insomnia.

(Optional) GPs and nurses with an interest in further assessment may provide a **one-week sleep-wake diary** to assess sleep and wake patterns: www.sleepprimarycareresources.org.au/insomnia/assessment-sleep-history

3 Screen for co-morbid sleep, mental and physical conditions

Patients with a suspected co-morbid sleep disorder can be referred for concurrent management by specialist sleep physicians, in addition to management of insomnia. Consider the presence of excessive sleepiness and co-morbid sleep disorders:

- ☐ Screen for excessive daytime sleepiness which may indicate the presence of a co-morbid sleep disorder (see below).
- ☐ Sleep Apnoea: Loud snoring, witnessed choking/gasping during sleep, daytime sleepiness,
- ☐ Restless Legs Syndrome,
- ☐ Circadian Rhythm disorders,
- ☐ Central disorder of hypersomnolence (Narcolepsy, Idiopathic Hypersomnia).

GPs can refer patients with a high-risk of sleep apnoea on questionnaire measures for a home-based or laboratory sleep study with MBS items introduced in 2018 (Aus), or refer to sleep physicians (Aus), or through local regional health pathways (NZ). www.sleepprimarycareresources.org.au/osa/investigations-and-referral

Consider co-morbid mental and physical health disorders, symptoms, and treatments, and other lifestyle factors that can share bi-directional relationships with insomnia;

- ☐ Depression, anxiety, stress
- ☐ Acute/chronic pain
- ☐ Peri/post-menopausal
- ☐ Respiratory conditions
- ☐ Cardiovascular conditions
- ☐ Use of illicit or non-illicit substances that can impact sleep
- ☐ Alcohol consumption
- ☐ Travel between time zones, jet-lag, circadian disruption

4 Assess insomnia duration and development of perpetuating factors

- CBT-i is the recommended 'first line' treatment for chronic insomnia. It aims to identify and treat the underlying psychological and behavioural perpetuating factors that maintain chronic insomnia, and is effective in 70-80% of patients.
- However, CBT-i does not provide immediate therapeutic benefit and may not be appropriate in a minority of patients with severe short-term insomnia (<2 weeks) that is causing significant distress or impaired functioning.
- For short-term insomnia caused by an obvious underlying precipitant (e.g., work stress, bereavement, physical pain) that is causing significant distress or impairment, consider a short-term medication prescription with documented follow-up tapering advice and CBT-i.
- Sleeping pills (e.g., benzodiazepines, 'z-drugs') should be prescribed for the shortest possible duration to reduce dependence risks, and a documented structured withdrawal plan should be developed from the outset.

  See RACGP's Benzodiazepine guidelines: www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/drugs-of-dependence/part-b

  See Reconnexion's online resources: www.reconnexion.org.au/resources
- Evidence is lacking regarding the efficacy and safety for medications such as antidepressants, antipsychotics, antihistamines, and nutritional substances including valerian for the management of insomnia disorder and should therefore not be prescribed to manage insomnia disorder.

5 Assess for suitability for CBT-i in general practice

- Cognitive Behavioural Therapy for Insomnia (CBT-i) can be accessed/delivered via;
  - Self-guided programs - reading and interactive online programs supported by scientific research,
  - In general practice settings - by general practitioners and nurses,
  - By psychologists - Insomnia is an eligible condition for a Mental Health Treatment Plan in Australia. CBT-i can be delivered through support of a MHTP by 'sleep' psychologists or GPs with Focussed Psychological Strategies training in most capital cities, or via tele-health when local clinicians are not available.
- Consider referral to a clinician that specialises in the management of sleep disorders such as a 'sleep' psychologist, sleep physician, GP, or nurse with specialist sleep expertise, for **management of insomnia** in the context of:

  ☐ Patient preference for management by a sleep specialist

  ☐ Epilepsy

  ☐ Perinatal period

  ☐ People that drive or operate heavy machinery for work

  ☐ Excessive daytime sleepiness (consider sleep physician referral)

  ☐ Shift workers

  ☐ Co-morbid sleep disorder (consider sleep physician referral)

  ☐ Severe psychiatric condition (e.g., Bi-polar, schizophrenia)

  ☐ History of sleepiness-related accidents.

6 Digital CBT-i and general practice CBT-i

Digital CBT-i

- Digital CBT-i may be preferred by people that are not able to attend clinical appointments during standard work hours, and those that are motivated to access and enact treatment recommendations without clinician support.
- Digital CBT-i may be completed with or without motivational support from clinicians.
- Australian digital CBT-i options: www.sleepprimarycareresources.org.au/insomnia/cbti/referral-to-digital-cbti-programs
- New Zealand digital CBT-i: www.justathought.co.nz/insomnia and www.justathought.co.nz/clinicians

CBT-i delivered in general practice

GPs and practice nurses can provide a brief CBT-i during general practice consultations.

- **Step-by-step guide** https://doi.org/10.31128/AJGP-04-20-5391
- **Sleep education** www.sleepprimarycareresources.org.au/insomnia/basic-sleep-and-sleep-hygiene-education
- **Stimulus Control Therapy** www.sleepprimarycareresources.org.au/insomnia/bbti/insomnia-stimulus-control-therapy
- **Bedtime Restriction Therapy** www.sleepprimarycareresources.org.au/insomnia/bbti
- **Relaxation Therapy** www.sleepprimarycareresources.org.au/insomnia/bbti/insomnia-relaxation-techniques

7 Follow-up Assessment and Future Management

- Schedule follow-up consultation after CBT-i to assess treatment response and determine whether specialist care is required in relation to persistent insomnia, other sleep disorders, or sleep anxiety or stress.
- Set realistic expectations: Short-term sleep problems will occur in the future, but patients can use CBT-i strategies to improve sleep and prevent the development of chronic insomnia.
- Patients that have not experienced improvement in insomnia despite adherence to treatment recommendations may be considered for referral to a specialist sleep clinician (e.g., a 'sleep' psychologist or sleep physician).
- Sleeping pills (e.g., benzodiazepines, 'z-drugs') are not the recommended 'first line' treatment for insomnia, but may be appropriate for patients with short-term insomnia that is causing significant distress/impairment, or if CBT-i is not effective. Sleeping pills should be prescribed at the lowest effective dose for the shortest possible duration. If used for longer periods, sleeping pills can result in increased risk of side-effects, adverse events, and patterns of dependence. Sleeping pills should be tapered gradually (i.e., over several weeks/months) to reduce rebound insomnia and withdrawal symptoms.

Patient information

Sleep Health Foundation, fact-sheets: www.sleephealthfoundation.org.au/all-sleep-factsheets-a-z

NZ resources: www.justathought.co.nz

RACGP Prescribing drugs of dependence resource:
www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/drugs-of-dependence/part-b

Reconnexion, Benzodiazepine dependence service (VIC): www.reconnexion.org.au

Adapted from: Sweetman et al., (2023).
General practitioner assessment and management of insomnia in adults.
Australian Journal of General Practice. 52(10).
www1.racgp.org.au/ajgp/2023/october/general-practitioner-assessment-and-management-of

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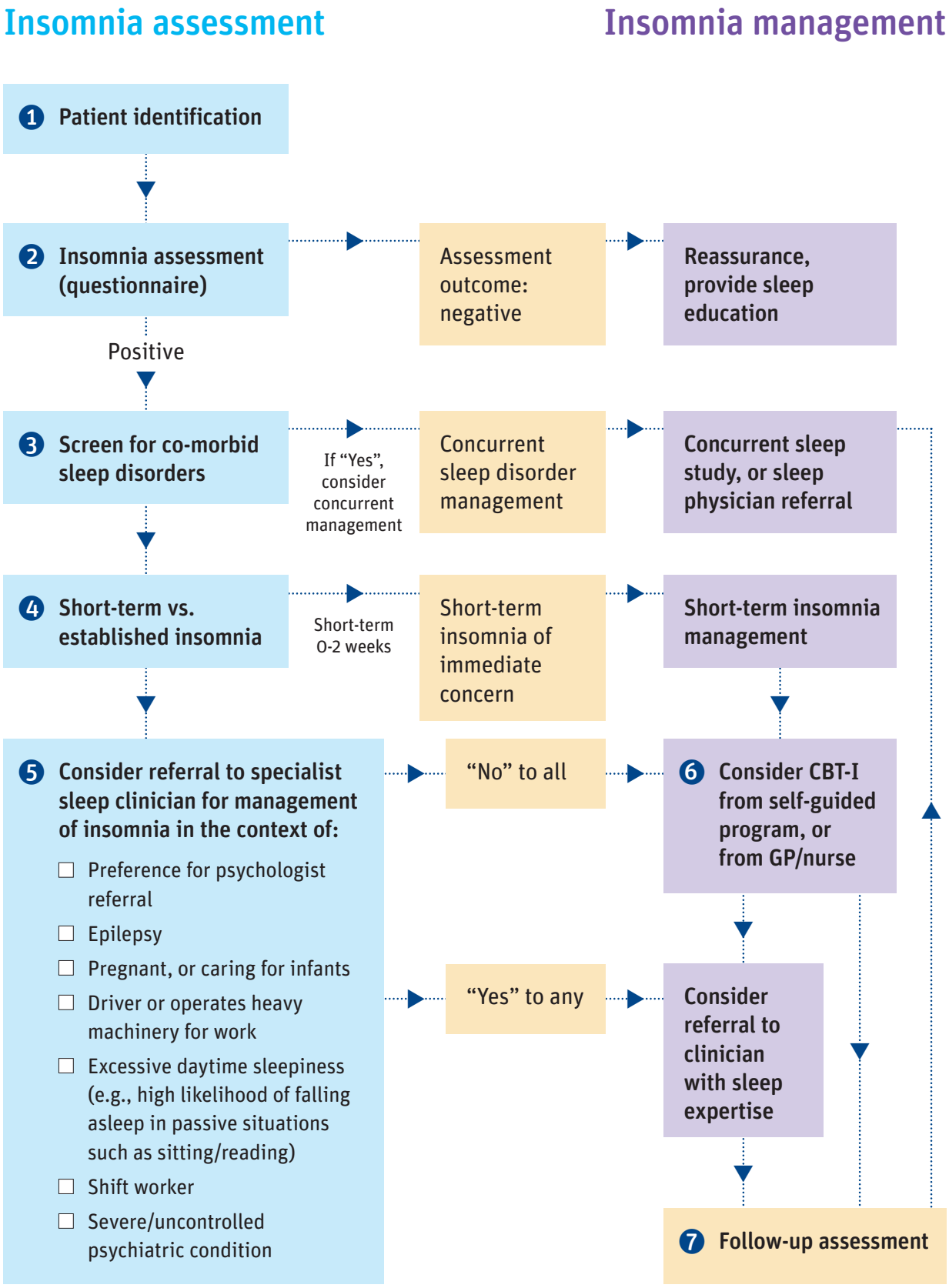

Figure 1. Insomnia assessment and management flow diagram.
Numbered boxes correspond to numbered sub-headings in text.