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Implementing the ACP CBT-I recommendation: outcomes, assessment, referral, and training

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Conflict of Interest: Dr. Perlis is author of a CBT-I manual and is instructor for two not-for-profit courses on CBT-I. Dr. Posner is author of several CBT-I educational products

TO THE EDITOR:

The ACP's recommendation that CBT-I be the first line indication for all adults suffering from chronic insomnia is to be applauded (1). The guideline highlights the paradigmatic shift that has occurred with the DSM-5 reclassification of insomnia as a disorder in its own right. Further, the recommendation highlights the contrast between the use of hypnotics and CBT-I. While producing comparable acute outcomes (2), hypnotics are not ideal for true maintenance therapy and they do not produce durable gains following treatment discontinuation. In contrast, CBT-I is a short term intervention (usually 4-12 weeks) where up to 70% of subjects exhibit a treatment response and nearly 40% recover average or good sleep (3). More than this, when CBT-I is applied to patients with related comorbidities (e.g., depression, chronic pain, etc.) there is evidence that targeted treatment for insomnia influences the course of the related comorbidities. The best data of this type show that CBT-I, when applied concurrently with antidepressants, doubles responder and remitter rates (4) and reduces suicidal ideation by up to 65% (5). Given these considerations, the question is no longer "what treatment should be the first line therapy for chronic insomnia", the question is "how can the recommendations of the ACP be implemented? Within the context of primary care, the first step is assessment and the second step is referral. Assessment could be as simple as "how are you sleeping". Those that endorse sleep problems could be further assessed using a short general screening questionnaire (two presently exist; the GSAQ (6) or the SDS-CL-25[†]). Those that endorse trouble falling and/or staying asleep may be further evaluated for their insomnia using the ISI (7). Once these data are obtained, the primary care clinician can utilize an algorithm for questionnaire cutoff scores to make treatment/referral decisions. Treatment may be provided in the primary care setting or by referral to specialists. In either case, treatment should be conducted by an experienced CBT-I provider who can dedicate the 4-12 hours (over 4-12 sessions) typically required for evidence based treatment. Specialists may be identified via provider directories^{††}. Finally, primary care clinicians that wish to add to their existing skill set by taking dedicated CE or CME courses in CBT-I, may avail themselves of the training opportunities exist through the VA, the DoD, the SBSM, University of Pennsylvania, University of Massachusetts, and/or Ryerson University.

Respectfully,

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[†] The SDS-CL-25 is in development and may be found on line at <https://redcap.upstate.edu/surveys/?s=DNT8PL7PNA>

^{††} CBT-I Provider directories may be found at <http://www.behavioralsleep.org/index.php/society-of-behavioral-sleep-medicine-providers>
http://www.med.upenn.edu/cbti/provider_directory.html

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