

COMMENTARY

Insomnia in Primary Care: Misreported, Mishandled, and Just Plain Missed

Commentary on Ulmer et al. Veterans affairs primary care provider perceptions of insomnia treatment. *J Clin Sleep Med*. 2017;13(8):991–999.

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Insomnia is likely the most common sleep disorder, with population estimates generally showing that approximately 10% of the United States population meets criteria for an insomnia disorder.¹ This prevalence is even higher in the Veteran population with an estimate of 26%.² Insomnia is a major risk factor for neuropsychiatric disorders,³ suicide,⁴ cardiometabolic disease risk,⁵ and all-cause mortality.⁶ It is frequently comorbid with psychiatric, chronic medical and addictive disorders, conditions commonly reported in the Veteran population. Fortunately, efficacious and effective treatments exist, most notably cognitive behavioral therapy for insomnia (CBT-I),⁷ which is the recommended first-line treatment for the disorder,⁸ even in the context of comorbidities.⁹ Efficacious medication regimens also exist when CBT-I is not available.¹⁰

Although other sleep disorders such as sleep apnea and narcolepsy are typically referred for treatment by sleep medicine specialists, insomnia is often neglected or dealt with in the context of primary care. This can potentially lead to problems, because primary care clinicians often lack training regarding importance, screening, assessment, and management of insomnia. The Veterans Affairs (VA) network is an especially salient context to examine the diagnosis and treatment of insomnia in the context of primary care. As an organization, the VA has made efforts and allocated resources to recognize the importance of mental health in the context of primary care, including those for insomnia. In addition, the VA has engaged a nationwide training and education program focused on insomnia diagnosis and treatment.¹¹ It is with this information in mind that the paper by Ulmer and colleagues in this issue of *Journal of Clinical Sleep Medicine* explores the beliefs, attitudes, and behaviors of VA primary care clinicians regarding insomnia.¹²

Overall, the results of this study show that insomnia is frequently misreported or not reported in the medical record, on many occasions mishandled through provision of suboptimal care, and often just plain missed—not discussed or brought up at all. Ulmer and colleagues report that the plurality of clinicians surveyed believed that insomnia symptoms were experienced by 20% to 39% of their patients. Prior work by this group has shown that the prevalence of poor sleep quality may

be greater than 70% among those without a mental health diagnosis and even higher among those with a mental health diagnosis.¹³ This discrepancy is troubling.

What is also disturbing is that Ulmer and colleagues report that even within the VA system, recommended first-line treatments are not used.¹² When clinicians were asked how they responded to insomnia, the most common response was counseling on healthy sleep hygiene, which is known to be ineffective for treating insomnia.¹⁴ Also common were prescription of hypnotic medication and adjusting medications that may contribute to insomnia. These are also suboptimal strategies that may also increase the risk of complications from falls in patients, many of whom are elderly health care recipients within the Veterans Health system.¹⁰ Although 82% of primary care clinicians had heard of CBT-I, 43% indicated that they did not know whether it was even offered at their facility. This is surprising as the Veterans Health Administration has invested in the national rollout of CBT-I as well as the telehealth-based treatment programs for the assessment of sleep disorders and the conduct of CBT-I.

When insomnia was encountered, only slightly more than half (53%) indicated that they routinely document it and fewer than half (39%) routinely include it in the problem list. Of those who did not routinely include it, many seemed to still consider insomnia as a symptom or secondary condition rather than a comorbid diagnosis, reflecting an attitude that is inconsistent with current nosologies^{15,16} and unsupported by scientific evidence.¹⁷ Of particular concern was the belief reported by 100% of respondents that sleep difficulties were expected to remit following successful treatment for conditions such as depression and posttraumatic stress disorder. This belief is contradictory to the available scientific evidence,^{18,19} and neglecting insomnia may only worsen the prognosis for those comorbid conditions.²⁰

Interestingly, providers were often supportive of the importance of insomnia, another important finding of this investigation. Most of the providers (80%) thought that insomnia was as important as other health concerns, and two thirds (67%) believed that treating insomnia was as important as treating sleep apnea.

The results of this study show that although insomnia is considered an important concern in primary care, its prevalence may be underestimated, its documentation unreliable, and its treatment suboptimal, despite access to standard treatment interventions. Also, it appears that primary care clinicians' beliefs about insomnia and its treatment reflect outdated nosologies and misunderstandings about sleep hygiene. This represents an important opportunity for the sleep medicine field to develop strategies for improved screening and management protocols for insomnia in primary care settings. Although sleep apnea and other sleep disorders usually require referral to a sleep specialist, insomnia treatment still often remains in primary care, leading to underdiagnosis as well as perpetuation of this disorder. In addition to recommending referral, we need to better educate primary care clinicians about how to recognize and treat insomnia, and when to refer for specialized care.

Recently, the National Institutes of Health and the Sleep Research Society jointly held a workshop focused on dissemination and implementation science in sleep research. A report from that meeting highlights that a major goal of the field should be to increase sleep health literacy among not only patients but providers as well.²¹ This goal is also part of the Healthy People 2020 program. The article by Ulmer and colleagues in this issue further focuses on this problem specifically at the level of primary care providers. There are several strategies that can help ameliorate this problem.

First, health care systems such as the VA need to continue to develop comprehensive insomnia screening and treatment protocols that are consistent with published guidelines. Devising standard protocols for the assessment and management of insomnia is an important goal, but several major obstacles exist, including lack of knowledge among providers, lack of screening resources, lack of access to CBT-I, and unclear guidelines for hypnotic prescriptions. Health services research in the context of insomnia care is critically needed to better understand how to overcome these obstacles and deliver optimal care to patients.

Second, increased recognition of the difference between CBT-I and sleep hygiene is clearly needed at the provider level on an intramural basis. Although both approaches are behavioral, only CBT-I has demonstrated efficacy as a treatment for insomnia disorder. Sleep hygiene is considered an adjuvant intervention and sometimes allocated as a control condition in insomnia clinical trials. Even worse, many patients may spend time and effort with sleep hygiene and end up with a bias against trying CBT-I because of a belief of lack of possible efficacy.

Third, there is an urgent need for more access to efficacious insomnia treatment options. Although the VA CBT-I rollout has resulted in many individuals trained to provide services, there is still a very large unmet demand. Addressing this need may include broadening existing training programs to include CBT-I. In addition, brief behavioral treatments for insomnia based on CBT-I have proven effective.²² This goal may also include developing training programs for nondoctoral-level providers (such as nurses, masters-level therapists, and social workers) who may be able to see patients in larger numbers. Online CBT-I programs (which are rapidly growing in number) may be effective, especially for less complex cases.

Insomnia is a prevalent and important sleep disorder, especially within the Veterans health care system, and patients with insomnia routinely present to primary care providers. The article in this issue by Ulmer and colleagues highlights that despite providers being generally supportive of the importance of insomnia, many problems hamper effective identification and management. Given current dissemination and implementation priorities within the sleep medicine field, it is imperative that the field address the unmet need for access to care, sleep health literacy among providers, and models of care that can be implemented within health systems.

CITATION

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