

## **Executive Summary: Implementation actions for the WOREL guideline "Management of sleep disorders and insomnia in adults in primary care".**

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In Belgium, 30% of adults have symptoms of insomnia. Insomnia reduces quality of life and is also a risk factor for health problems such as hypertension, depression, diabetes, and cardiovascular disease, leading to additional personal impairment and additional costs to society.

Clinical practice guidelines prioritize a behavioral approach to sleep problems and insomnia. In Belgium, the 2018 WOREL guideline recommends a stepped-care approach focusing on the use of a sleep diary and sleep hygiene counseling. In a second step, cognitive-behavioral therapy for insomnia (CBTi, see BOX) is strongly recommended. The use of sleep medication is only appropriate in cases of acute and severe insomnia, only for a short period of time, and not in patients that are eligible for behavioral interventions or CBTi. There is no place for sleep medication in the treatment on insomnia in elderly people, mainly due to increased risk associated with sleep medication in this group.

### **BOX: What is CBTi?**

Cognitive-behavioral therapy for treating insomnia (CBTi) is a 6-8 session psychological treatment. The goal of CBTi is to treat insomnia by changing thoughts, beliefs, and behaviors related to sleep. integrates different approaches aiming, on the one hand, to help patients associate sleep with other cognitive patterns than those they already have and, on the other hand, to enable patients to adopt behaviors likely to help them apprehend sleep differently. To do this, CBTi is structured in three components: (1) sleep restriction techniques, (2) stimulus control techniques and (3) cognitive techniques.

#### **1. Sleep restriction techniques**

Sleep restriction techniques aim to increase successful sleep by delaying the time of going to bed and restricting time in bed, thereby increasing sleep drive. The paradoxical nature of the instruction "to sleep less, in order to sleep better", necessitates specific motivational skills in the therapist.

#### **2. Stimulus control techniques**

These techniques seek to limit all the stimuli interfering with sleep, by recommending the avoidance of some substances or habits (external stimuli), but also by limiting the impact of intrusive thoughts and worries (internal stimuli) through a reasoned management of such thoughts.

#### **3. Cognitive techniques**

Dysfunctional beliefs about (lack of) sleep and its consequences perpetuate sleep related anxiety and poor sleep. By discussing, challenging, and replacing dysfunctional beliefs about sleep, the vicious cycle of poor sleep and worry about sleep can be broken.

Current practice is far removed from the recommendations in these guidelines: 12% of adults are current users of sleep medication, which increases to 25% in men and 35% in women over 75 years. Furthermore, 52% of nursing home residents are using sleep medication. Pharmaceutical sales data collected by OECD, show that sales of sleep medication in Belgium are among the highest in Europe. Despite previous educational efforts aimed at GP's, pharmacists, and the general public, use of behavioral treatments for insomnia remains limited.

Different barriers contribute to poor insomnia care. These include misconceptions about sleep and treatment of sleep problems in patients and health care providers, especially the mismatch between

practitioner beliefs and patient preferences, and practitioner beliefs on the efficacy of behavioral interventions. In health care practitioners, lack of skill and self-efficacy to provide behavioral interventions, and lack of information on how to refer and treat patients with insomnia and how to aid discontinuation of sleep medication are also important barriers. Finally, environmental barriers, such as time constraints, lack of access and cost of behavioral interventions are also important.

Internationally, interventions have been carried out to address these barriers, with multifaceted active interventions leading to the best results. For example, implementation efforts focusing on providing feedback and skills training to general practitioners or interventions combining patient-directed information on discontinuation with pharmacy and general practitioner support have led to strongest improvements. For increased access to CBTi, integrated care interventions have been carried out combining training supervision of psychologists with system-level interventions to improve access and referral, and provision of brief behavioral interventions by other health care providers (nurses, pharmacists, physiotherapists) has been positively evaluated or trials are ongoing. System-level interventions restricting sleep medication prescriptions are highly effective, but have a risk of practitioners switching to other, non-recommended medications. However, many implementation interventions that are effective for other treatments (facilitation, use of local champions or change agents) have not been carried out in the context of insomnia treatment.

Based on the identified barriers and international evidence on implementation interventions, we see an urgent need for supporting health care providers in providing stepped care for patients with sleep problems. In line with the guideline, we advise to develop a care pathway supporting patients with sleep problems during health care encounters with different practitioners. A first step in the care continuum should focus on providing information and behavioral interventions to patients with sleep problems. Similar to previous education efforts by BelPEP, this support for health care providers should primarily target pharmacists and general practitioners, as they are the first point of contact of patients looking for treatment of sleep problems. Skill-based training of GP's and pharmacists should focus on the provision of behavioral interventions and consultation skills aimed at changing patient attitudes about behavioral interventions. This training should include information and hands-on experience on working with existing information materials. Skill-based training of primary care psychologists in CBTi can provide the workforce to provide access to CBTi in primary care, as well as reduce the limited reimbursement for current behavioral interventions. Furthermore, when embedded within a patient care team, primary care psychologists skilled in CBTi could provide supervision or support to other health care providers involved in behavioral treatment for sleep problems.

Furthermore, we prefer that implementation projects are supported in a way that they can be tailored to local needs. This includes supporting the role of local champions as well as providing repeated feedback to participating health care providers on their treatment behaviors (e.g. prescription behaviors, provision of behavioral interventions, referral to CBTi). There should be adequate compensation for health care providers involved in the provision of information and behavioral interventions, as well as for supervisory roles.

As with all implementation efforts, evaluation of the implementation should be ensured, with particular attention to processes involved in uptake of the different implementation interventions and the resulting provision of services, as well as their impact on prescription behaviors.