Insomnia and its treatment should be given more importance

Progress has been made in the UK in addressing the lack of parity of esteem between mental and physical health. However, chronic insomnia, one of the most common mental disorders,[1] appears to have been side-lined. The launch of the Improving Access to Psychological Therapies (IAPT) programme in 2008 increased treatment of common mental disorders but, despite its prevalence, insomnia is not included in that list.[2]

Chronic insomnia is a persistent, subjective disturbance in initiating or maintaining sleep, despite adequate opportunity, which results in daytime impairment or clinically significant distress. Transient sleep disturbances have the potential to develop into chronic insomnia, and various factors increase the risk of this progression. These factors include physical illness, mental health disorders, shift-work, social deprivation, being from an ethnic minority background, being female, and advancing age.[3]

IMPORTANCE OF DIAGNOSING AND TREATING INSOMNIA

Chronic insomnia is common, with a worldwide prevalence of around 10% in the general population and 50% in primary care patients.[1] This is at least as common as illnesses that receive a larger share of healthcare resources in many countries. Insomnia impacts quality of life as severely as major depression and heart failure do.[4] It increases the risk of developing new mental illnesses such as depression in people with no psychiatric history, exacerbates the severity of other psychiatric disorders, and reduces the efficacy of their treatment.[5] It can persist long after the comorbid mental illness has resolved and later precipitate its relapse.[5] Insomnia also contributes to road traffic accidents and increases the risk of developing physical illnesses such as hypertension, diabetes, obesity, and heart failure, with greater health risks in minority populations.[6] It also carries a high economic impact due to lost productivity and increased healthcare utilisation.[7] Once insomnia becomes chronic, spontaneous improvement without treatment is unlikely.[3]

> *"Studies have repeatedly demonstrated its* [cognitive behavioural therapy for insomnia {CBT-I}] *high effectiveness, with 60%–80% of individuals undertaking CBT-I experiencing acute therapeutic improvement and durable gains long term …"*

EFFICACY OF TREATMENT

Cognitive behavioural therapy for insomnia (CBT-I) is recommended by bodies such as the National Institute for Health and Care Excellence and the American College of Physicians as the first-line treatment for chronic insomnia, or for insomnia that is likely to become chronic. The treatment goes well beyond sleep hygiene and focuses on techniques to modify beliefs and behaviours around sleep. Studies have repeatedly demonstrated its high effectiveness, with 60%–80% of individuals undertaking CBT-I experiencing acute therapeutic improvement and durable gains long term,[3] making it one of the most effective treatments in mental health care. Research consistently shows it to be effective in patients with wide-ranging comorbidities, including depression, anxiety disorders, bipolar affective disorder, psychosis, post-traumatic stress disorder, chronic pain, obstructive sleep apnoea, cancer, and alcohol dependence.[3] CBT-I also improves and reduces the relapse rate of other mental illnesses,[5] for example, it is as effective at treating depression as CBT for depression, where there is comorbid depression and insomnia.[8] It has even been found to improve asthma outcomes.[9] Treatment is highly cost-effective,[7] can be provided with low burden on resources (via 1-day workshops, five once-weekly groups, or, where appropriate, self-help applications),[5,10,11] and can successfully be delivered by people who have received only brief CBT-I training without specialist CBT or psychology training.[11]

AN UNMET NEED

In the UK, clinicians in primary and secondary care usually provide psychoeducation on sleep hygiene, despite research showing this is ineffective as a monotherapy for most people with chronic insomnia.[12] Sleep hygiene was originally developed only for mild, transient insomnia or for prevention of insomnia and, because of its poor efficacy, is usually used as the control condition for clinical trials of insomnia treatments.[12] Evidence-based CBT-I provision is limited by a lack of services and professionals trained to deliver it. Some UK IAPT services provide CBT-I as an 'extra treatment', but this is a postcode lottery. A handful of sleep clinics provide CBT-I; however, since CBT-I is cheap and simple to learn and provide, provision by only specialist clinics is not cost-effective. Furthermore, most patients never get referred. While digital therapies may improve access, they are not universally available or accessible, nor are they appropriate for all patients. In other countries such as the US, similar issues with undertreatment have been reported.[7]

WHY IS INSOMNIA NOT BEING GIVEN MORE VALUE?

Given the high burden of insomnia and the cost-effectiveness of CBT-I, one must wonder: why is insomnia not considered as important as other health conditions that similarly affect quality of life, health, and functioning? Why is it not seen as a modifiable risk factor for illnesses in a similar way to diet, exercise, and smoking? And why is no meaningful training on insomnia included in the UK medical school and speciality training curricula?

In the authors' experience, there are several likely explanations. First, a lack of parity of esteem persists between mental

> *"… why is insomnia not considered as important as other health conditions that similarly affect quality of life, health, and functioning?"*

"... in the UK, insomnia should be included in the IAPT [Improving Access to Psychological Therapies] manual of national service requirements so that it becomes a core treatment that all IAPT services are required to provide ..."

and physical disorders, and insomnia treatment still suffers from the lack of regard previously afforded anxiety and depression. Second, sleep is not adequately valued by society or the medical establishment. Third, insomnia was previously considered merely a symptom of other disorders, not requiring treatment in its own right. This belief has not been updated despite the significant body of research over the past two decades, including high-quality longitudinal data demonstrating that insomnia is commonly a primary disorder, has a bidirectional relationship to other mental and physical illnesses (and is a modifiable risk factor for many illnesses), and that CBT-I has high efficacy regardless of whether insomnia is primary or secondary. Finally, in stretched, underfunded healthcare systems, commissioners may be reluctant to add to the list of conditions for which services are funded, and healthcare providers may expect fines for long waiting lists if they introduce a new, popular service.

RECOMMENDATIONS

Insomnia should be afforded the importance it deserves. For it to be successfully identified and treated, clinician awareness is vital. As with any intervention, the first step on the treatment pathway involves identifying the disorder and any other disorders that might be contributing to the issue (such as, in this case, sleep apnoea, restless leg syndrome, or circadian rhythm disorders). Since insomnia is so common, all clinicians, but particularly primary care clinicians, play an essential role in this and require education. As such, sleep medicine, including identifying insomnia and other sleep disorders and basic CBT-I techniques, should be included as a key part of the medical student syllabus and specialty training curricula, especially for psychiatry and general practice. Training could also be facilitated by attending courses and webinars.

Appropriate services considering equitable access should be commissioned locally, and patients with chronic insomnia should be referred. CBT-I training for those delivering services could be facilitated by attending brief courses (for example, the Royal London Hospital for Integrated Medicine runs a 2-day course [janet.joseph1@nhs.net]; Edinburgh Sleep Consultancy runs 2- and 3-day courses [https://www.sleepconsultancyltd.co.uk]; and Newcastle upon Tyne Hospitals NHS Foundation Trust runs a 1–2-day course [https://www.newcastle-hospitals.nhs.uk/services/sleep-service]). As with other common mental disorders, a stepped-care approach should be used,[7] including large-scale self-help interventions, therapist-led group/individual treatments, and specialist sleep services for those with higher complexity, such as those with comorbid sleep disorders, comorbid severe psychiatric illness or suicidality, or for whom previous treatment has failed.

Additionally, in the UK, insomnia should be included in the IAPT manual of national service requirements so that it becomes a core treatment that all IAPT services are required to provide, eliminating the national postcode lottery and reserving treatment in specialist sleep clinics for patients with a higher degree of complexity.

Lauren Waterman,
(ORCID: 0000-0002-9963-4008), Consultant Psychiatrist, Camden and Islington NHS Foundation Trust; Health Education England-funded Population Health Fellow, North Central London integrated care board, London.

Hugh Selsick,
(ORCID: 0009-0002-7511-6369), Consultant in Psychiatry and Sleep Medicine, University College Hospitals NHS Foundation Trust, London.

Provenance
Freely submitted; externally peer reviewed.

Competing interests
Lauren Waterman initiated and runs a cognitive behavioural therapy for insomnia (CBT-I) service for existing patients at South London and Maudsley NHS Foundation Trust, but receives no extra funding or payment for doing so. She has been awarded a Health Education England-funded Population Health Fellowship, for which she has conducted a population health needs assessment on insomnia for North Central London Clinical Commissioning Group. Hugh Selsick runs an NHS Insomnia and Behavioural Sleep Medicine Clinic that also provides training in CBT-I. He does not receive any additional payment for this training.

ADDRESS FOR CORRESPONDENCE

Lauren Waterman
St Pancras Hospital, Pancras Road, London NW1 0PE, UK.

Email: laurenzwaterman@doctors.net.uk

Acknowledgements
The authors would like to thank Felicity Waite and David O'Regan for their expert insights that contributed towards this article.

DOI: https://doi.org/10.3399/bjgp23X734421

REFERENCES

1. Perlis ML, Posner D, Riemann D, *et al.* Insomnia. *Lancet* 2022; **400(10357):** 1047–1060.
2. National Collaborating Centre for Mental Health. *The Improving Access to Psychological Therapies manual, version 6.* 2023. https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf (accessed 28 Jun 2023).
3. Fatima Y, Bucks RS, Mamun AA, *et al.* Sleep trajectories and mediators of poor sleep: findings from the longitudinal analysis of 41,094 participants of the UK Biobank cohort. *Sleep Med* 2020; **76:** 120–127.
4. Katz DA, McHorney CA. The relationship between insomnia and health-related quality of life in patients with chronic illness. *J Fam Pract* 2002; **51 (3):** 229–235.
5. O'Regan D. Cognitive behaviour therapy for insomnia in co-morbid psychiatric disorders. In: H Selsick, ed. *Sleep disorders in psychiatric patients: a practical guide.* Heidelberg: Springer: 149–171.
6. Matias T, Dominski FH, Marks DF. Human needs in COVID-19 isolation. *J Health Psychol* 2020; **25(7):** 871–882.
7. Koffel E, Bramoweth AD, Ulmer CS. Increasing access to and utilization of cognitive behavioral therapy for insomnia (CBT-I): a narrative review. *J Gen Intern Med* 2018; **33(6):** 955–962.
8. Blom K, Jernelöv S, Kraepelien M, *et al.* Internet treatment addressing either insomnia or depression, for patients with both diagnoses: a randomized trial. *Sleep* 2015; **38(2):** 267–277.
9. Luyster FS, Ritterband LM, Sereika SM, *et al.* Internet-based cognitive-behavioral therapy for insomnia in adults with asthma: a pilot study. *Behav Sleep Med* 2020; **18(1):** 10–22.
10. Freeman D, Sheaves B, Goodwin GM, *et al.* The effects of improving sleep on mental health (OASIS): a randomised controlled trial with mediation analysis. *Lancet Psychiatry* 2017; **4(10):** 749–758.
11. Cape J, Leibowitz J, Whittington C, *et al.* Group cognitive behavioural treatment for insomnia in primary care: a randomized controlled trial. *Psychol Med* 2016; **46(5):** 1015–1025.
12. Irish LA, Kline CE, Gunn HE, *et al.* The role of sleep hygiene in promoting public health: a review of empirical evidence. *Sleep Med Rev* 2016; **22:** 23–36.