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Patients' and clinicians' experiences and perceptions of the primary care management of insomnia: qualitative study

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Abstract

Background Insomnia is common leading to patients with sleep problems often presenting to primary care services including general practice, community pharmacies and community mental health teams. Little is known about how health professionals in primary care respond to patients with insomnia.

Aim We aimed to explore health professionals' and patients' experiences and perceptions of the management of insomnia in primary care.

Design We used a qualitative design and thematic approach.

Setting Primary care in Nottinghamshire and Lincolnshire.

Method We undertook focus groups and one-to-one interviews with a purposive sample of health professionals and adults with insomnia.

Results We interviewed 28 patients and 23 health professionals. Practitioners focused on treating the cause of insomnia rather than the insomnia itself. They described providing stepped care for insomnia, but this focused on sleep hygiene which patients often disregarded, rather than cognitive behavioural therapy for insomnia (CBT-I). Practitioners were ambivalent towards hypnotic drugs but often colluded with patients to prescribe to avoid confrontation or express empathy. Patients sometimes took hypnotics in ways that were not intended, for example together with over-the-counter medication. Practitioners and patients were sometimes but not always concerned about addiction. Practitioners sometimes prescribed despite these concerns but at other times withdrew hypnotics abruptly without treating insomnia. Both patients and practitioners wanted more options and better training for the management of insomnia in primary care.

Conclusion A better understanding of the current approaches and difficulties in the management of insomnia will help to inform more therapeutic options and health professional training.

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Introduction

Insomnia affects up to 30 percent of the adult population in the UK and the United States in any one year.[1,2] It is associated with increased health-care utilization[3] and costs.[4] Poor sleepers are as follows: more likely to have had a consultation with a health-care professional in the past year[5]; slower to recover from acute illnesses; more often hospitalized[6]; and at risk of increased overall mortality.[7]

National guidance for insomnia management recommends sleep hygiene advice, access to non-pharmacological treatments, such as cognitive behavioural therapy for insomnia (CBT-I) and finally short-term prescribing of hypnotic drugs in cases of severe insomnia that interferes with daily life.[8] Hypnotics are only licensed on a short-term basis because of tolerance, dependency and withdrawal effects.[8] Nonetheless, there is also evidence to suggest that longer-term hypnotic prescribing occurs on a regular basis.[9]

Previous research has shown that prescribers are generally cautious about initiating benzodiazepines, most of which are now prescribed as hypnotics.[10] Most practitioners are aware that hypnotics should be used only in the short-term and for acute situations, such as bereavement.[11] Despite this, long-term prescribing is common,[9] because of prescribers' (usually doctors') hesitance to disrupt patients' established sleep patterns; patient reluctance to discontinue therapy and dependence on hypnotics.[12] Other factors influencing longer-term prescribing include the following: prescribing previously established by another doctor; practitioners' high workload; and time constraints dealing with patients who have insomnia comorbidity with multiple long-term conditions and complex psychosocial problems.[11,13]

The aim of this research was to understand the current experiences and views of patients and the wider primary care health team, including general practitioners (GPs), pharmacists and community mental health teams (CMHT) on the treatment for insomnia.

The research questions were as follows:

1. What treatment strategies did primary care practitioners use for patients with insomnia?
2. What were patients' views about primary care treatments for insomnia?
3. In what ways could treatment for insomnia be improved?

Methods

Design

We used a qualitative design and a thematic approach. We conducted focus groups (FGs) and one-to-one interviews lasting between 40 and 60 min with people who had suffered with insomnia and health professionals involved in treating insomnia, to understand the range of experiences, actions and intentions and the meanings associated with them. We chose to incorporate both individual interviews and FGs to gather individual and collective responses because these give rise to different forms of data. FGs tend to offer consensus alongside contentious views, while individual interviews tend to offer more introspective data. The responses generated in FGs allow participants to explore and clarify views in ways that would be less easily accessible in a one-to-one interview; they also have the potential to trigger ideas, which help participants to think, clarify thoughts and then respond.[14]

Participants

We interviewed 28 patients (for ease of terminology, both patients and service users are referred to as patients in this paper) and 23 health professionals between January and July 2011; these included 17 individual and three randomly allocated FG interviews with patients. We offered patients the chance to be interviewed alone or as part of a FG. There were two single sex (female) FGs ($n = 3 \times 2$) and a mixed sex FG ($n = 5$). Eight individual interviews and three profession-based FGs with a total of nine GPs, two primary care nurses, five pharmacists and seven mental health professionals were conducted. Participants were

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recruited from Lincolnshire and Nottinghamshire, UK. Patients were recruited through posters in public places and family practice waiting rooms. Health professionals were recruited from direct mailing to practitioners or via clinical leads. We stopped recruiting patients and professionals to the study when lines of enquiry in relation to the research questions were exhausted (Tables 1 and 2).

Interview schedule

Separate semi-structured topic guides were used for patients and practitioners to elicit participants' beliefs about current treatments for insomnia, although these were similar for FGs or face-to-face interviews. We asked patients about their sleep problems, what they had tried to resolve them and where they had found useful advice (if indeed they had). For professionals, we explored their current treatment practices for a patient presenting with insomnia and what their perceptions of patients' expectations were.

Analysis

All interviews were transcribed verbatim. Interview data were managed using NVivo 8 (QSR International Pty Ltd, Doncaster, Victoria, Australia). We used thematic analysis; analysing data concurrently with collection allowed us to explore new avenues of enquiry during the fieldwork. This process included the following: familiarization with the data; generating initial descriptive codes; and searching for

Table 1 Participants: health professionals

Study ID	Gender	Profession	Length of time practicing
General practitioners			
GP Prof. Int. 03[1]	Man	GP	10 years
GP Prof. Int. 04	Man	Salaried GP	2 ½ years
GP Prof. FG. 17[2]	Man	GP Principal	23 years doctor, 5 years GP
GP Prof. FG. 22	Man	GP Principal	34 years
GP Prof. FG. 23	Woman	GP Principal	5 years
GP Prof. FG. 24	Woman	GP Principal	<1 year
GP Prof. FG. 25	Woman	GP Trainee 3rd year	5 years
GP Prof. FG. 26	Man	GP Principal	18 years
GP Prof. FG. 27	Woman	SPST	On-going
Nurses			
N Prof. Int. 18	Woman	Nurse Practitioner	5 years
N Prof. Int. 21	Woman	Practice Nurse (PN)	17 years nurse, 7 years PN
Community pharmacists			
CP Prof. Int. 12	Man		20 years
CP Prof. FG. 13	Woman		31 years
CP Prof. FG. 14	Man		24 years
CP Prof. FG. 19	Woman		9 years
CP Prof. FG. 20	Woman		35 years
Community Mental Health Team (CMHT)			
CMHT Prof. Int. 02	Woman	Doctor Adolescents/children	15 years
CMHT Prof. Int. 07[3]	Woman		20 years
CMHT Prof. Int. 08	Man		2 years
CMHT Prof. Int. 09	Woman		15 years
CMHT Prof. FG. 01	Woman		2 ½ years
CMHT Prof. FG. 10	Woman		2 years
CMHT Prof. FG. 11	woman		3 years

[1]Int, individual interview.
[2]FG, focus group.
[3]Community mental health team were either CBT therapists or psychological wellbeing practitioners.

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Table 2 Participants: patients

Study ID	Gender	Age	Perceived/diagnosed cause of insomnia
Pt. Int. 01[1]	Woman	62	Mental health condition, physical condition (pain)
Pt. FG. 02	Woman	45	Mental health condition
Pt. Int. 03	Woman	53	Physical condition (pain)
Pt. Int. 04	Woman	60	Mental health condition, physical condition
Pt. Int. 05	Woman	70	Caring responsibilities, mental health condition, physical conditions including pain
Pt. FG. 09	Woman	52	Mental health condition
Pt. Int. 10	Woman	66	Undisclosed
Pt. Int. 11	Man	36	Insomnia, caring responsibilities, bereavement
Pt. Int. 12	Woman	32	Bereavement
Pt. Int. 15	Man	20	Bereavement
Pt. FG. 18	Man	50	Mental health condition environmental issues
Pt. FG. 19	Woman	69	Mental health condition
Pt. FG. 20	Woman	45	Physical condition (pain)
Pt. Int. 21	Woman	56	Undisclosed
Pt. FG. 22	Woman	43	Mental health issues, relationship issues
Pt. Int. 23	Man	23	Bereavement
Pt. Int. 26	Man	35	Physical condition, mental health condition, relationship issues
Pt. Int. 27	Man	55	Physical condition, mental health condition, caring responsibilities
Pt. Int. 28	Woman	64	Physical conditions
Pt. FG. 29	Woman	23	Undisclosed
Pt. FG. 30	Woman	51	Physical conditions
Pt. Int. 31	Man	38	Mental health conditions
Pt. FG. 33	Woman	22	Mental health condition, Socio-environment issues
Pt. FG. 34	Man	28	Caring responsibilities, mental health condition, socio-environmental issues
Pt. FG. 35	Man	54	Undisclosed
Pt. Int. 36	Man	51	Physical conditions
Pt. Int. 39	Man	36	Mental health condition, social issues
Pt. Int. 40	Man	57	Stress-related issues

[1]Pt, patient.

underlying themes, reflecting on deeper notions and conceptualizations.[15,16] Codes were both theory- (deductive) and data-driven (inductive). The process involved each of the authors developing initial codes, two of the authors continuing to code data to generate new codes and potential themes. All three authors then reviewed the codes and themes together iteratively to generate the final themes and choose the quotations, which best illustrated these.

Ethical approval

Leicestershire, Northamptonshire & Rutland Research Ethics Committee Reference 10/H0406/78. Research Governance approvals were sought and gained from both Nottinghamshire and Lincolnshire Primary Care Trust and Mental Health Trusts.

Results

Four main themes emerged (Box 1):

Box 1 Themes

Responses to insomnia
Prescribing and drug taking
Addiction and withdrawal
More options, better education and training

Responses to insomnia

General practitioners and patients often described a stepped-care approach to treating insomnia, starting with a psychosocial assessment, followed by advice on sleep hygiene which often consisted of a single sheet of

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information printed out at the consultation. Following this, medication was considered. The psychosocial assessment consisted of: a mental health review for depression or anxiety and screening for physical (e.g. pain, sleep apnoea), occupational (variable shift patterns) and social (relationship or financial difficulties) causes. GPs often focused on treating causes before insomnia itself, and their perception of causation was often influenced by consideration of patients' socio-economic status, particularly in areas of high social deprivation.

> We try to explore the reasons why they are not sleeping, so after finding out those reasons, treatment depends on what the causes are. Most of them are [due to] social [problems]. (GP Prof. Int. 04)

According to most of the GPs interviewed, they tried to match treatment to individual patients and the perceived cause of their insomnia. If a mental health issue, such as depression, was suspected, then an antidepressant and/or a referral to the CMHT was offered. Some CMHT practitioners suggested that they only accepted patients with comorbid insomnia linked to depression or anxiety of sufficient severity which encouraged some GPs were to cite mental health issues rather than insomnia on referral letters, in order for their patient to access CMHT services. This sometimes led to patient and CMHT confusion about the reason for referral where GPs sent referral letters stating a diagnosis of depression or anxiety when the patient thought that their referral was for insomnia.

Despite patients agreeing that their insomnia may have been connected to physical, psychological, social or a combination of these, *their* main concern was lack of sleep. The following quotation reflects many patients' views about the frustration they felt when their insomnia was not prioritized:

> I would like them [clinicians] to say, right let's look into it. But I know there is such a wide number of reasons why people don't sleep that it would be too expensive, to look into everybody that doesn't sleep, but it isn't taken seriously, it is a health problem I think and it isn't taken seriously enough. (Pt. Int. 03)

A few patients also expressed confusion about why a GP would prescribe drugs for depression when they were presenting with a sleep problem:

> I don't want to be on anti-depressants for a sleep problem. (Pt. Int. 11)

It was clear from the way some GPs and some community mental health professionals talked about insomnia that they believed; in the case of potential mental health issues, it was these that were the cause of insomnia as the following quotation shows:

> If there's a realisation that there is a mental health issue, for that patient, they should see somebody far more expert in that field as soon as possible because for some people their medical condition is having a major impact upon their sleep pattern. (CP Prof. Int. 12)

Most professionals described how they first explored lifestyle issues contributing to insomnia, gave advice and provided a sleep hygiene leaflet. Some GPs said that while they discussed sleep hygiene with patients, they did not believe that many of their patients would even attempt to try it.

> Most of them already have a mindset, as soon as you start talking about sleep hygiene being the way to go, they switch off. That may be a prejudice of mine but that's my observation. (GP Prof. Int. 04)

Although GPs offering sleep hygiene felt that patients 'switched-off' to this advice, many pharmacists, in contrast expressed that patients seeking help for insomnia at a pharmacy were often satisfied, at least on their first visit, to receive lifestyle advice about their sleep patterns, rather than purchase an over-the-counter remedy. This suggested that patients tried various strategies to combat their sleep problems prior to the next step of seeking medication from their GP. This was evident in a number of patients' recollections, when they said that they knew all about sleep hygiene. In some cases, if sleep hygiene strategies were suggested

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by a health professional, patients perceived this to be a too simplistic and even a dismissive intervention for the severity of their insomnia.

> Yes I've been through all that. I don't have a television in the bedroom. I don't have anything like that in the bedroom. I've been through all the sleep hygiene stuff side of it, I do all that yeah. (Pt. Int. 03)

Rarely, if ever, was referral or access to CBT-I offered as a treatment for primary or comorbid insomnia by either GPs or CMHT members indicating that this was seldom used for insomnia treatment in the regions. Although GPs knew about CBT, they were less familiar or convinced with it as a potential treatment for insomnia. As one GP stated:

> I can't remember having specifically referred patients to a specific CBT website. I know I have given people lists of various mental health websites which includes modules on CBT (GP Prof. Int. 03).

Moreover, GPs suggested that, before they would consider using CBT-I, they would have to see positive evidence of benefit to patients, implying that they had little or no personal experience of patients using or benefitting from CBT-I. Many pharmacists and all the patients were also unaware of the utility of CBT-I.

There was a complex array of psychological, social and physical scenarios GPs had to contend with in relation to insomnia sufferers following the initial assessment, attempts at sleep hygiene strategies and patient demands for hypnotics (see below). The tension between prescribing hypnotics, which most GPs suggested they did not want to do long-term, was due to their perception of potential harms and widespread recommendations of short-term treatment. This was complicated by the GP–patient interaction, where feelings were engendered in the GP by patients' stories of distress.

Prescribing and drug taking

General practitioners stated that they would prescribe a one-off, short course of hypnotics when patients asked for these, particularly in situations of bereavement or where sleep hygiene had not worked, to avoid confrontation. They also suggested that they did so reluctantly, warning patients that it was a short-term solution which would not be repeated.

> Some people do come in and ask if they can have a sleeping tablet. The wrong thing to do is just to say 'no'. You automatically get into this confrontational situation. So I usually say 'yes that's okay, but let's talk about what's been going on', and then we can go through everything else [...] If they do insist on that, then I would do what [name of another GP in practice] does, a very short course of benzodiazepine type medication. (GP Prof. FG. 17)

Despite some doctors wishing to prescribe hypnotics only short-term, others conceded that they often behaved differently in practice, when faced with a patient who had severe insomnia. They felt empathetic towards their patient who was undergoing life stresses and colluded in prescribing hypnotics by arguing that the benefits outweighed potential disadvantages.

> I think you know there will be doctors who say I never prescribe hypnotics because it's wrong. Why is it wrong? Well it's just wrong. The answer is in my view, the correct view, is that we are here to help patients and if somebody has to have a benzodiazepine occasionally to make their lives tolerable then that's not a bad price to pay and if that helps them to get through life and to survive their job, their marriage or their financial crisis then so be it. You've got to be humane about these things, not be an intellectual purist [...] I think you will never ever avoid prescribing something like that, because if you won't prescribe it, then people will turn to alcohol or turn to illicit substances to use instead. (GP Prof. FG. 22)

This GP felt hypnotics were a short-term crisis intervention and a humane practice that would benefit patients with insomnia.

According to many of the GPs interviewed, patients often requested hypnotics and repeatedly returned to the surgery for more. Interestingly, GPs said that they tried to dissuade patients, who they thought were only 'drug seeking', from short-term hypnotics. However, the pharmacists we interviewed also suggested

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that long-term repeat prescribing was more common and they observed GPs hypnotic prescribing practices which contrasted with their stated short-term approach, a conclusion which they derived from the prescriptions being presented and medicine review meetings with GPs.

> It is perfectly normal for a 28-day prescription of zopiclone from day one and I think the patient's perception is that once they've got the prescription they can then take one tablet every night. (CP Prof. FG. 13)

Pharmacists observed that acute prescriptions often led to long-term prescribing of hypnotics.

> We do sadly have the scenario where it [sleep medication] was prescribed when they've lost a loved one, maybe a year ago and it was on repeat then and they still carry on taking it, and that sadly is still, in my experience, quite common [...] I work with a very good group of doctors who are very patient conscious, yet, it still happens. (CP Prof. FG. 19)

Some patients, particularly those who had suffered with insomnia for many years, wanted to manage their own insomnia and wanted hypnotics repeatedly prescribed. They felt best placed to self-medicate and described how they had learned to actualize their goal of accessing medication.

> I went to see one of the lady doctors who's no longer there and all she gave me was a load of bumph about insomnia which y'know I knew what it was and what happens, but she didn't give me the tablets that time, so I went back to see the doctor I am actually registered with and he was a lot more helpful, he always is. (Pt. Int. 10)

From these data, we can see that prescribing was longer-term and more widespread than just short-term and contextual as some GPs suggested. Our data suggest that GPs and by default patients considered two main treatment options, sleep hygiene and hypnotic drugs, perhaps because of the general acceptance of these as viable care for insomnia.

Some patients developed creative, but unlicensed, ways to stockpile hypnotic drugs or enhance their effects. For example, to tailor a bespoke regimen for themselves they said that they were splitting the medication and taking half a tablet when they woke at night, taking drugs on alternate nights or mixing them with over-the-counter remedies.

> I'm on zopiclone from the GP [...] I use it as and when [...] I use only half a tablet. There are times when I use it every night for a couple of weeks, then other times where I take Kalms night-time, Nytol. I've tried Phenergan, just because nothing works for long. (Pt. Int. 03)

One patient suggested:

> Following my bereavement [...] I found that taking one tablet wasn't enough. I had to take at least two [...] two was fine for a short while, but then that became not enough so I had to take three, to even get relaxed [...] When I explained this to the doctor he wouldn't prescribe me any more, because that was an addictive way of taking them. (Pt. Int. 15)

Sometimes doctors took a hard line, when potentially dangerous use of hypnotics was reported and refused to prescribe further drugs. This required patients to 'play the system' to obtain prescriptions. GPs rarely considered that patients might modify their drug regimen. There was little evidence of support involving patients and GPs discussing the safety issues or appropriate doses of hypnotics use if they were being used in such *ad hoc* ways. Disclosures of these kinds by patients to GPs were not common, which may have contributed to GPs' inability to understand exactly how patients were using prescribed hypnotics and their sometimes unfounded assumption that patients would take hypnotics as prescribed.

Addiction* and withdrawal

Contrary to those patients who were sporadically self-medicating, a number of other patients were concerned about long-term use

*We have retained the concept 'addiction' to represent the data expressed by patients, GPs and pharmacists in this study. While the clinical definition of 'addiction' seems to suggest a compulsive dependence on a behaviour or substance, we understand that 'dependency' is the term that may better reflect contemporary understandings of patients' use of hypnotics.

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and addiction to hypnotics. This was evident in accounts offered by patients and some pharmacists. For instance, a community pharmacist said:

> "Will I be addicted to these" I think is the most common question [from patients]. I think there's a lot of medication [hypnotics] collected that isn't taken, that sits on shelves. (CP Prof. FG. 13)

General practitioners often discussed the addictive potential of hypnotic drugs with patients but varied in their attitude and response to potential dependence; some were much less concerned about addiction, particularly in relation to different patient groups, for example older patients.

> Yes, I suppose quite often [I prescribe hypnotics], but not to everybody. I just warn them that it can be addictive to take it [...] often with older people or where there is a risk of addiction, it's not going to be the end of the world if they do get addicted to them. (GP Prof. Int. 03)

Patients, GPs, pharmacists and CMHT frequently stated the need to discontinue long-term hypnotics but withdrawal was sometimes *ad hoc* or unplanned.

> If one of their [patients'] goals is to be able to come off medication they need to be motivated to actually put that in place, because there's no point doing one or two days then having a tablet and then non the next day. So that's where it would depend on their motivation, if they want to change it. But for some, if GPs, if they are just going to carry on prescribing, they [patients] are getting a good night's sleep, so they're going to carry on taking the medication. (CMHT Prof. Int. 09).

Mental health practitioners and GPs differed in the way they thought withdrawal of hypnotics should be organized.

> So with a few people who maybe have tried sleeping tablets for a while, I'll try stopping them for a while or just having them periodically. (GP Prof. Int. 03)

However, patients felt withdrawal from hypnotics needed to be handled sensitively with alternative support offered for insomnia, rather than simply withdrawing drugs.

> The last time I went [to the GP], he said to me, 'you know we are not supposed to prescribe these anymore' and he had a training doctor with him actually. I said 'yes but I've got so many problems'. I said 'there's nothing you can do?' and he said 'no'. [...] His comments were, 'you should be trying to do without them', without any other kind of help. (Pt. Int. 05)

Nonetheless, some patients described how GPs just stopped hypnotic medication without their insomnia being treated; this was based on length of time that drugs had been taken, rather than whether the insomnia had improved.

> Just to be told you should come off the zopiclone is not what you want to hear [...] It is a health problem I think, and it isn't taken seriously enough [...] I do think there ought to be more things available through the GP. (Pt. Int. 03)

Practitioners sometimes explored patients' readiness to stop hypnotics and discussed the importance of gradual withdrawal.

> 'Once I'm on it I can't come off', is quite a common concept and its talking it through with them [patients] and saying, 'Well actually, yes you can, we're not going to stop immediately and we're going to work down'. (CP Prof. FG. 13)

Withdrawal interventions were not widely used and reasons behind the reluctance of practitioners to implement gradual withdrawal in conjunction with a patient's readiness to reduce long-term hypnotic therapy was often not clear. However, fear of addiction to hypnotics, which for some patients had become a reality, was also evident. GPs and pharmacists were also concerned about patients' long-term use. Worryingly, GPs in this study were sometimes reported to stop prescribing hypnotics abruptly rather than tailing these off, because of concerns about addiction. While CMHT professionals suggested that patient motivation coupled with complete withdrawal from medication use was a better option for patients.

More options, better education and training

Many practitioners perceived a lack of options for patients presenting with insomnia and

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welcomed more training and a wider range of treatment options.

> I have got a patient that we just can't do anything, there's nowhere else or nothing else I can offer and he's still got insomnia problems [...] I don't know where else to go from there, when things don't work. (N Prof. Int. 18)

Patients, particularly those who were dissatisfied with drug treatment for sleep problems, also agreed that GPs would benefit from education in managing insomnia.

> Anything that can help a GP and educate them [about insomnia] rather than giving out antidepressants has got to be good. (Pt. Int. 11)

> Because what you don't get when you go and see a GP, in my opinion, is very good advice because they haven't had proper training [...] so they're not up to speed, and they've got 10 minutes to talk to you if you're lucky. (Pt. FG. 18)

Practitioners who had attended specific insomnia training felt that they had benefitted:

> Well I went to have a one day course on insomnia [...] there was a lot of useful information [...] so that when a patient comes in, I can identify the severity of the insomnia, a bit of background around it, some general discussion and then they [patients] go away with some ideas and background reading of what the condition entails. (N Prof. Int. 18)

Patients and all the health practitioners concur that more options should be available for treatment and that health professionals should have better training in treating insomnia.

Discussion

We have shown that health professionals' approach to insomnia primarily focused on assessment and treatment of comorbidities, particularly social problems, anxiety, depression and physical disorders, as established in other studies.[17,18] Similarly, patients, while understanding the importance of their insomnia being connected to physical, psychological, social problems or a combination of these, felt that these often took precedence in clinical consultations. This detracted from the treatment for insomnia itself,[17,19] which if provided could lead to improvements in symptoms and quality of life, even in comorbid insomnia.[20] The tension here is the position of insomnia in GPs' perception in which insomnia is treated as an effect of underlying psychosocial or physical ill-health manifestations rather than it contributing to them. There is some evidence in this study that GPs more readily recommended psychological treatments for anxiety and depression, whereas hypnotics were often prescribed early for insomnia,[21,22] despite CBT-I being recommended first-line.[8,23] GPs or CMHT rarely considered CBT-I as a viable option for insomnia itself and patients rarely asked about this as a treatment option.

Although practitioners described a stepped-care approach, care provided was often inadequate because it did not involve the most effective psychological treatment, CBT-I, either self-administered or delivered in primary care.[24] Instead they focused on sleep hygiene advice which, although a prerequisite for other elements of CBT-I, has little evidence of effectiveness by itself.[25,26] Sleep hygiene advice was not always well received or used by patients, because they were sceptical about its effectiveness, a finding which is evident in other studies.[19] Indeed, older people with sleep complaints often report little difference in sleep hygiene practices, other than daytime napping, than those without sleep complaints.[27]

It is well established that GPs prescribe hypnotics for a variety of reasons: patients ask directly for sleeping tablets when they are distressed and GPs feel under pressure to prescribe to avoid confrontation,[11,19,28] or to maintain a good doctor–patient relationship.[29] Many feel that drugs work, particularly for acute situations.[12,30] Drugs are also prescribed in the face 'of insolvable psychosocial problems'[31] to show empathy[10] or to prevent alcohol or drug abuse.[29] Sometimes drugs are used because another doctor began prescribing them,[31] or to meet actual and perceived patient expectations or to save time.[32]

Our data support the diverse contextual influences on hypnotic prescribing but we

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have also shown that patients sometimes want to self-medicate and continue to receive prescriptions as and when they need them. This leads patients, especially long-term users of hypnotics, to strategically negotiate prescriptions to support their self-medication practices. We found little evidence, except in a few cases, where GPs and patients used a concordance approach to hypnotic drug regimens involving honest information sharing about their use. According to Weiss and Britten, this would balance the doctor–patient relationship, enabling GPs to help patients determine appropriate drug doses until they are ready to try alternative treatments or cease taking medication.[33] After all, as Pound *et al*.[34, pp. 50] suggest, the doctor 'maybe in control during the consultation but [is] oddly powerless once the person has left the surgery' with a prescription.

A small minority of practitioners in our study, who prescribed long-term hypnotics, saw their prescribing habits as being appropriate and defensible, which has also been found in other studies.[10,30,31] Fear of addiction to hypnotics was common among patients and practitioners in our study, but for a minority of doctors, addiction was not perceived to be a problem for some groups, such as the elderly or terminally ill. Some previous studies have highlighted that patients are concerned about addiction and try to stop hypnotics, often without success,[9,35] whereas others show that patients and their physicians are often reluctant to discontinue these drugs.[36,37] Patients did express concerns about hypnotics, centred on addiction and side-effects, to community pharmacists in our study, but there was little communication of this to GPs.

Limited communication and professional barriers between pharmacists, GPs and community mental health practitioners can often lead to lack of coordination of care and absence of a much needed interprofessional approach to the problem of insomnia.[38] Studies have shown a reluctance of behalf of pharmacists to get more involved in hypnotics due to concerns about undermining patient confidence and a fear of inappropriately challenging prescribers.[39]

Other studies have highlighted limited time and poor access to mental health services to be barriers to effective management of insomnia.[10,13] Although programmes such as Improving Access to Psychological Therapies[39] now provide better access to non-pharmacological therapies for conditions, such as anxiety and depression, CBT-I is still not widely used or available, mainly because of the lack of trained providers.[40,41] We add to this by showing that CBT-I is rarely considered by health professionals and patients as a stand-alone option for insomnia, due to lack of awareness about the evidence and poor knowledge of the technique.

Strengths and limitations

The strengths of this study were as follows: the wide range of perspectives gleaned from patients and health professionals; the triangulation of different views; divergent case analysis; and rigorous analysis and interpretation of data. This was a multidisciplinary study involving academics from general practice; nursing and social science. We recruited from two large counties in one area of the UK. Although this may not completely reflect experiences elsewhere and we acknowledge that qualitative studies are not generalizable to the entire population in the traditional sense, we are confident that our methods generated conceptual generalizability.[42]

Implications for further research or clinical practice

The failure to treat insomnia effectively may be explained, at least in part, by lack of undergraduate or postgraduate clinical education and training. A previous study of UK medical education found that practitioners received an average of five minutes training on insomnia during undergraduate medical education.[43]

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Better education and training for management of sleep problems is needed and should incorporate better understanding of the clinicians' role, more accurate sleep assessment and training in CBT-I.[19] Improved training for health professionals in managing insomnia, a recognized primary care pathway for insomnia including GP, pharmacists, and CMHT, as well as increased public awareness of non-pharmacological approaches to treatment for insomnia is needed. Further research looking at the role and communication between community pharmacists and prescribers of hypnotics is warranted.

Conclusion

This study has elicited GPs', CHMTs', pharmacists' and patients' beliefs about the treatment for insomnia. There were important differences between perceptions of treatment. Current treatment for insomnia is contextual and influenced by practitioners' and patients' perceived understanding about underlying psychosocial, physical and psychological causes of insomnia. It was clear that the patients wanted to have their insomnia treated, while practitioners understood that the underlying causes needed exploring. Nonetheless, hypnotics were prescribed, sometimes long-term, creating a situation where patients' often self-managed their hypnotic intake as and when needed. CBT-I was rarely offered or requested as a solution to insomnia. There is evidence for the efficacy of CBT-I[23]; therefore, there needs to be consistently better management of insomnia in primary care, including use of non-pharmacological approaches for patients presenting with insomnia for the first time as well as those on long-term hypnotics. This would be helped by improving training for health professionals caring for patients with insomnia.

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