Welcome to MHPN's webinar on supporting a young woman struggling with insomnia, depression and anxiety.

We will begin at 6:45pm AEDT.

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- **Interested in hearing more about the face to face MHPN network meetings in your area?**
- **Thinking about joining, or starting a special interest mental health network?**
- **Do you live in a remote or rural area and would like to discuss options for virtual networking with your mental health peers?**

Contact us after the webinar at **contactus@mhpn.org.au** or ring us on **1800 209 031** for more information on these and other MHPN networks.

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We are always looking at ways to improve our service to you

If you have any suggestions about future webinar topics or ways we can improve our webinar format, please provide them in the exit survey at the webinar's completion

Welcome to MHPN's webinar on supporting a young woman struggling with insomnia, depression and anxiety.

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Tonight's panel discussion will be based on the case study, Natalie. If you have not read it yet you can access it via the link in our emails to you regarding this webinar

Mental Health Professionals Network Ltd

Tel. 03 8662 6600
Fax. 03 9639 8936
Add. Emirates House,
Level 8 251-257 Collins St
Melbourne VIC 3000
Email. info@mhpn.com.au
Web. mhpn.org.au

mhpn
Mental Health Professionals Network

Webinar

An interdisciplinary panel case study discussion

Working together, working better to support a young woman struggling with insomnia, depression and anxiety

Monday 22nd October 2012

"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

This webinar is presented by

mhpn
Mental Health Professionals Network

Panel

- Dr Alex Bartle (GP)
- Dr David Cunnington (sleep physician)
- Dr Stuart Armstrong (health psychologist)

Facilitator

- Associate Professor Shantha Rajaratnam (psychologist)

Learning Objectives

At the end of the session participants will be better equipped to:

- Identify the role of different disciplines in contributing to the screening, diagnosis, assessment and treatment of sleep disorders and mental illness
- Explore tips and strategies for interdisciplinary collaboration in supporting people with sleep disorders and mental illness

GP perspective

Role of the GP:

1. **Commonly first port of call for medical complaints (along with pharmacists)**
2. **Likes to be considered the 'hub' of medical care**
3. **Historically, would have information concerning the patients past history and family history**
4. **Has considerable knowledge of many aspects of medicine, and treatments (except sleep!)**
5. **Time poor, therefore tends to rely on medication to 'fix' problems**
6. **Should be aware of their limitations, and when to refer**

Dr Alex Bartle
GP/Director of Sleep Well Clinics, New Zealand)

GP perspective

Natalie – Assessment:

1. **Take a history (already aware of past history and family history)**
2. **Brief superficial examination. Note dress, affect, and check BP**
3. **Investigation**

    ***In view of the history of depression, request a K10 or Hamilton D questionnaire**

    ***Arrange bloods: CBC, iron/ferritin, thyroid function tests, fasting blood sugar**

Dr Alex Bartle
GP/Director of Sleep Well Clinics, New Zealand)

GP perspective

Natalie – Preliminary diagnosis:

1. **Anxiety concerning upcoming exams**
2. **Underlying depression resulting in the poor sleep**

Dr Alex Bartle
GP/Director of Sleep Well Clinics, New Zealand)

GP perspective

Natalie – Management:

1. ***Citalopram*** **10mg for 4 days, increasing to 20mgs, for the depression and anxiety**
2. ***Melatonin*** **(Circadin 2mg SR) 1hr before bedtime to help with getting to sleep**

   (I would previously have prescribed *Lorazepam* to help sleep and reduce anxiety, but nervous of addiction, despite no history of addictive behaviour)
3. **Arrange to review in 2 weeks**

All in 15 minutes!

Dr Alex Bartle
GP/Director of Sleep Well Clinics, New Zealand)

Sleep physician perspective

What is a sleep physician?

- Specialist physician –
  - minimum 7 years post-graduate training
  - with at least 1 year specifically in sleep
- Manages a range of sleep problems
- Historically focus has been on sleep apnea
- Evolving into broader practice
  - New curriculum / training
  - Demand

Dr David Cunnington
Sleep Physician & Director, Melbourne Sleep Disorders Centre

Sleep physician perspective

Natalie - Assessment:

- **Clinical history**
- **Physical examination**
- **Investigations**
  - **Sleep Diary**
  - **Wouldn't do blood tests or sleep study**

Dr David Cunnington
Sleep Physician &
Director, Melbourne
Sleep Disorders
Centre

Sleep physician perspective

Natalie – Formulation:

- **Probable:**
  - **Circadian rhythm disorder – delayed sleep phase**
- **Possible:**
  - **Insomnia co-mordid with depression**
  - **Anxiety**

Dr David Cunnington
Sleep Physician &
Director, Melbourne
Sleep Disorders
Centre

Sleep physician perspective

Natalie – Management:

- **Ensure she is 'safe'**
- **Circadian rhythm management – aim to advance phase**
  - **Light / activity / scheduling / melatonin**
- **If ongoing symptoms once circadian phase corrected**
  - **CBT – target most prominent symptom**
    - **Mood / anxiety / insomnia**
- **Possibly a role for CBT anyway to consolidate gains / prevent relapse**

Dr David Cunnington
Sleep Physician &
Director, Melbourne
Sleep Disorders
Centre

Psychologist perspective

INSOMNIA ICSD #2:

1) **Psychophysiological insomnia**
2) **Idiopathic insomnia**
3) **Paradoxical insomnia**
4) **Circadian insomnias**
5) **Inadequate sleep hygiene**
6) **Adjustment insomnia**
7) **Insomnia secondary to mental disorder**
8) **Insomnia secondary to medical condition**
9) **Insomnia due to substance abuse**
10) **Behavioural insomnia childhood**
11) **Psychophysiological insomnia unspecified**
12) **Insomnia nos**

Dr Stuart Armstrong
Health Psychologist

Psychologist perspective

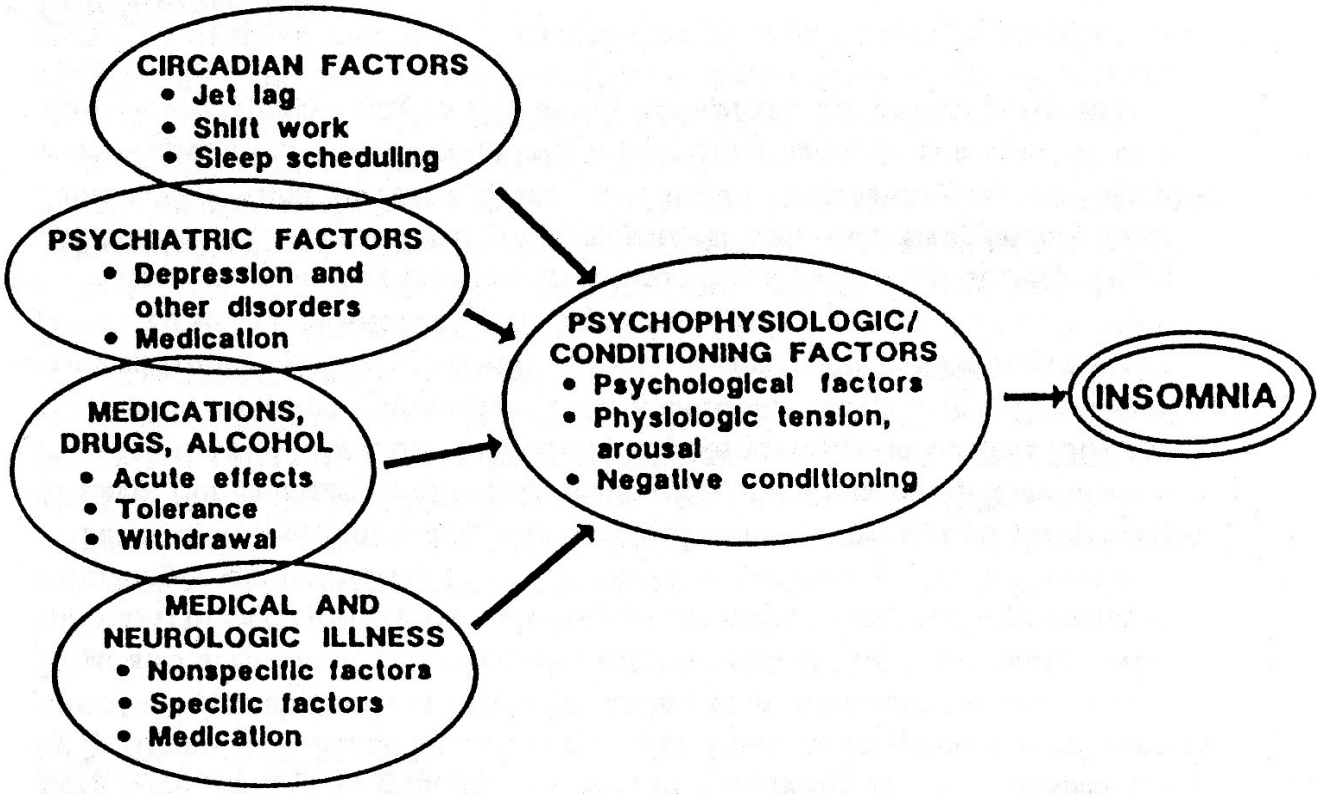
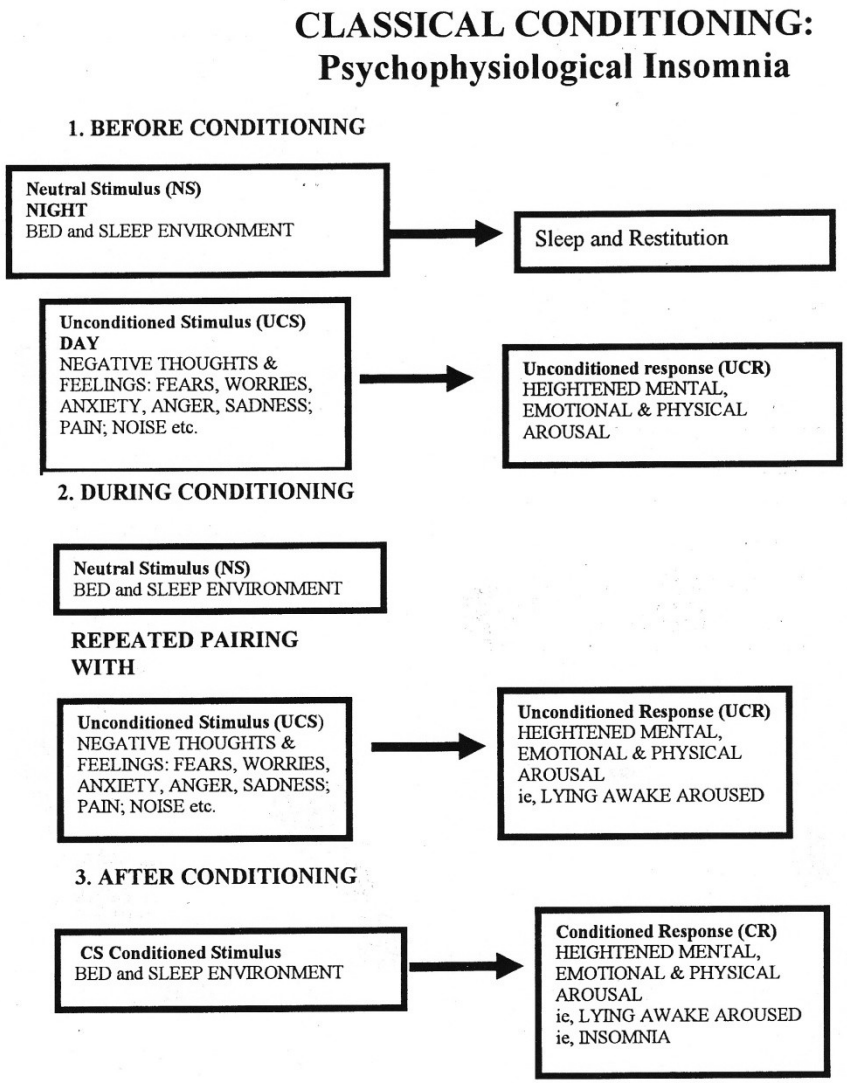


FIGURE 1 Several etiological factors may contribute to the development of insomnia. Psychophysiological and behavioral factors often perpetuate an insomnia which had its origins in a medical, psychiatric, or circadian disturbance.

Dr Stuart Armstrong
Health Psychologist

Psychologist perspective



Dr Stuart Armstrong
Health Psychologist

Psychologist perspective

CBT- i
(Cognitive Behaviour Therapy- Insomnia)

1. **Sleep hygiene education** ((P. Hauri, 1982).

   Emphasizes: environmental factors, physiological factors, behaviours, habits that promote sound sleep.

2. **Stimulus Control Therapy** (R. Bootzin et al 1972).

   If not asleep within 15-20mins, get up, go into another room, engage in quiet waking activity, don't go back to bed until sleepy. Repeat as often as necessary.

3. **Paradoxical Intent**

   Like Stimulus Control, emphasises staying awake but practice worrying (preferably by writing out ones worries) for the whole night.

4. **Bed (Sleep) Restriction Therapy** (A. Spielman et.al 1987):

   Restrict time in bed (TIB) to estimated mean TST. When Sleep Efficiency is 90%, progressively increase TIB by 15 mins weekly.

5. **Cognitive Therapy** (C.Morin 1988 etc.; C.Espie):

   Challenges, refutes and replaces dysfunctional beliefs and attitudes towards sleep.

6. **Relaxation Therapy**

   Physical component- relaxation exercises, yoga postures, breathing, biofeedback etc
   Mental component- visualization, meditation, self-hypnosis/hypnosis.

Evidence Based

Dr Stuart Armstrong
Health Psychologist

Psychologist perspective

Insomnia is a Risk:

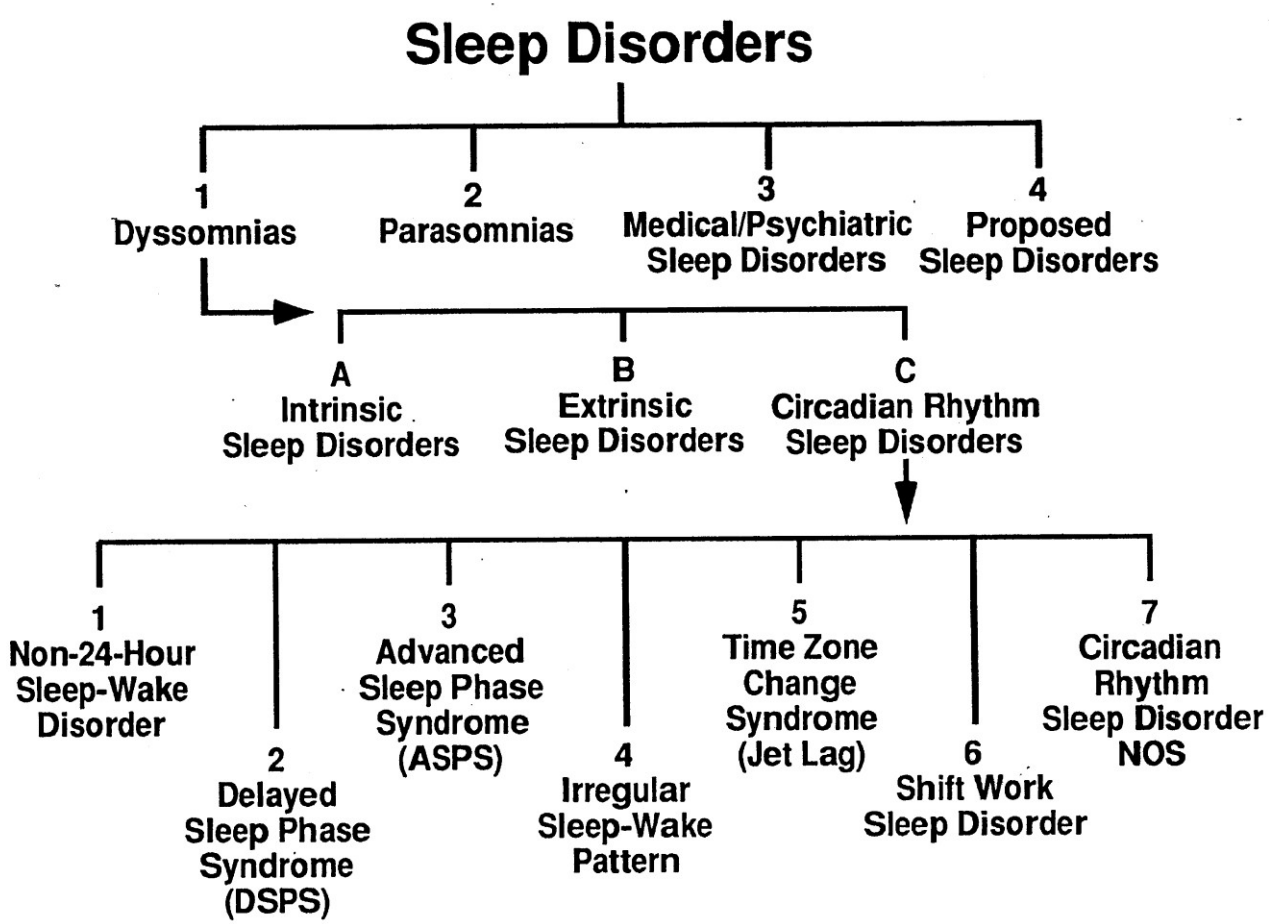
- **Pre-existing insomnia is the highest attributable, potentially treatable, risk factor for first episode depressive disorder**

Riemann & Voderholzer (J. Affect. Dis. 2003; 76: 255-259)

Cole & Dendukuri (Am. J. Psychiatry. 2003; 160: 1147-1156)

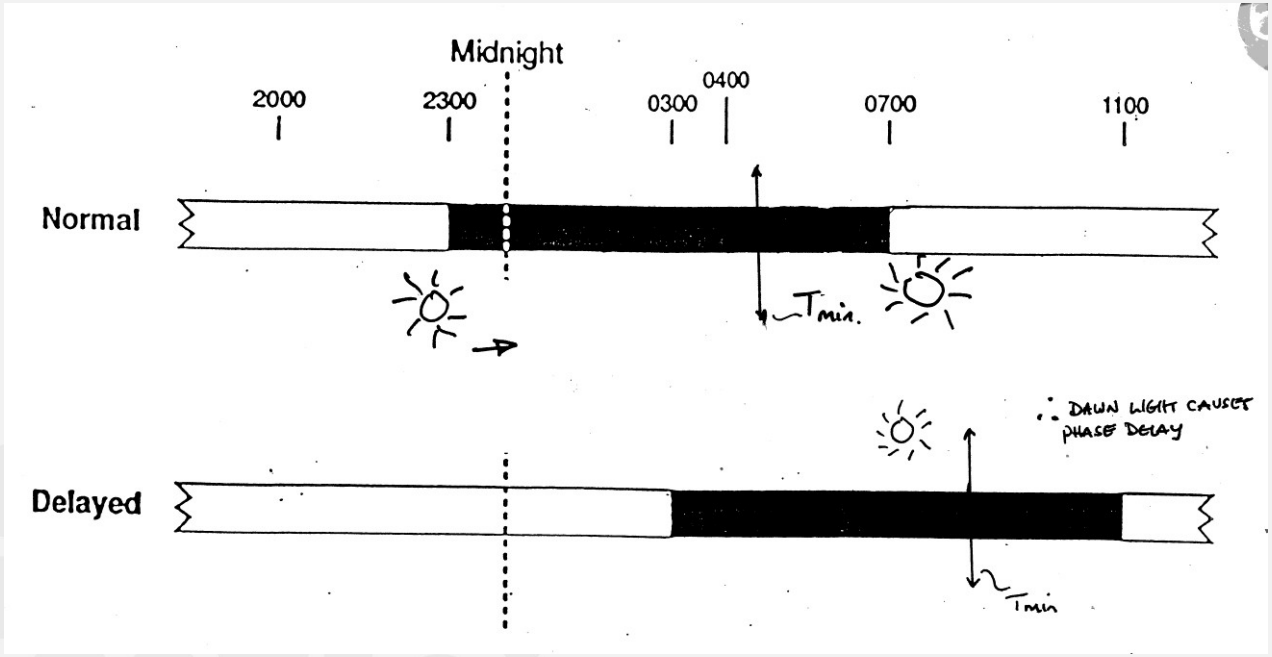
Dr Stuart Armstrong
Health Psychologist

Psychologist perspective



Dr Stuart Armstrong
Health Psychologist

Psychologist perspective



Diagnosis: LTBT (Late To Bed Test)

1. Sleep ad libitum for four consecutive nights (minimum)
2. Don't go to bed until you are sleepy/ drowsy, i.e., as distinct from tired or fatigued
3. Stay in bed as long as capable of sleeping (but not just lying there awake resting)

One can't trust the first 2 nights; Nights 3 and 4 should reveal the real sleep phase.

Dr Stuart Armstrong
Health Psychologist

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Q & A session

Thank you for your participation

- Please ensure you complete the *exit survey* before you log out (under the 'resources library' tab at the bottom of your screen). Certificates of attendance for this webinar will be issued in 4-5 weeks

- To continue the interdisciplinary discussion please feel free to stay online and utilise the chat box

- Each participant and registrant will be sent a link to online resources associated with this webinar within 2-4 days

- The next MHPN webinar will be '*Working together, working better to support a young woman struggling with bulimia and depression*' on Tuesday December 4th 2012

- MHPN acknowledge the support of the *Australasian Sleep Disorder Association* (ASA) in planning and developing this webinar. For more information about ASA visit http://www.sleep.org.au/

Thank you for your contribution and participation

Don’t forget to fill out the exit survey (in the ‘resources library’ tab at the bottom of your screen)!