

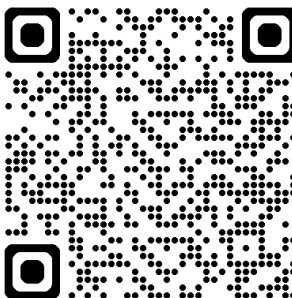


Beyond Sleep Apnea: Addressing the Most Common Sleep Disorder Among Drivers

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Overview



01 Definition of Insomnia



02 Cognitive Behavioral Therapy for Insomnia (CBT-I)



03 Medications



04 What Motor Carriers and Drivers Can Do



05 Resources

Reminders, please



- 1 Consult your medical provider before following any lifestyle recommendations or if you feel any discomfort**
- 2 You are responsible for any consequences of following any recommendations provided
- 3 Be aware of, and work to eliminate, the stigma sometimes associated with sleep, metabolic diseases, substance abuse and mental health
- 4 Do not allow any recommendations to cause you to worry or become obsessed with a toxic wellness culture

What share of adults will run into insomnia at some point in their lives?

A About 1 in 10

B About 3 in 10

C About 6 in 10

D About 9 in 10

About 9 in 10

- Between 5% and 10% of adults have it right now: months of poor sleep, distress and daytime impact
- Roughly 30% to 35% of adults have a bout of temporary insomnia in a given year
- About 10% meet the criteria for chronic insomnia disorder
- Closer to universal than to rare, which is exactly why the stigma keeps drivers quiet

Elevated Crash Risk



~300%

higher crash risk with shift work sleep disorder in real-world driving data

27.5%

of 949 truck drivers screened positive for insomnia

3.4x

higher odds of a near miss for truck drivers with insomnia, after adjusting for sleep apnea

The safety threat

Research links driver insomnia and sleep disorders to highway crashes and near misses

The Cost to Well-Being and Retention



Driver Well-Being

Severe mental
health decline



Preventable Errors

Critically delayed
reaction times



Fleet Turnover

Accelerated driver
burnout

Operational impact

Untreated sleep disorders cascade into systemic operational failures



Proactive sleep wellness protects drivers

Diagnosing and treating insomnia reduces liability and
strengthens retention

01 Definition of Insomnia



Insomnia Definitions



**ICSD-3-TR | AMERICAN ACADEMY OF SLEEP
MEDICINE**

Difficulty initiating or
maintaining sleep despite
adequate opportunity, leading
to daytime impairment

**DSM-5-TR | AMERICAN PSYCHIATRIC
ASSOCIATION**

Dissatisfaction with sleep
quantity or quality, associated
with difficulty initiating or
maintaining sleep

One diagnosis, three categories



1

Chronic insomnia disorder

Symptoms at least three nights a week for at least three months, with daytime consequences

2

Short-term insomnia disorder

The same picture lasting less than three months, and with no frequency threshold

3

Other insomnia disorder

Real complaints that do not fit either box, used sparingly

Chronic insomnia has three numbers



3

SYMPTOMS

Trouble falling asleep, trouble staying asleep, or waking earlier than intended

3

NIGHTS A WEEK

The frequency threshold for a diagnosis, not an occasional rough night

3

MONTHS

At that point it is chronic insomnia disorder rather than short-term insomnia

Plus the two conditions that decide everything

It happens despite an adequate opportunity to sleep, and it causes daytime consequences

Treatment by Insomnia Type



Insomnia Type	First-Line Treatment Strategy	Role of CBT-I	Role of Medications / Supplements
Short-Term Insomnia <i>(under 3 months)</i>	Identifying and removing the trigger plus structured sleep hygiene	Preventative role Full CBT-I is rarely used, but core components (like stimulus control) keep it from turning chronic	Short-term use is common Doctors may prescribe brief courses of sleep aids (under 2 weeks) to bridge a crisis
Chronic Insomnia <i>(3+ months)</i>	Full, structured CBT-I	Primary treatment Multi-component CBT-I actively fixes the "learned" bad sleep behaviors	Discouraged for long-term use Guidelines recommend tapering off medications as CBT-I takes effect

Which test confirms that a driver has insomnia?

A An overnight sleep study

B Blood work

C A wearable sleep score

D None of these

None of these: insomnia is a clinical diagnosis

- There is no blood test, and a night in a sleep lab does not diagnose insomnia
- It is built from the history plus a seven-day paper sleep diary the driver fills in each morning
- A sleep study answers a different question: what else is going on, such as apnea or restless legs
- Wearables usually make it worse, which is why trackers come off during treatment

Three things insomnia is not



Not a short sleep opportunity

Five hours of sleep because the schedule allowed five hours in the berth is insufficient sleep

That is a dispatch problem, not a diagnosis



Not the body clock alone

Sleep that falls apart on nights may be circadian misalignment or shift work disorder

Different mechanism, different fix



Not a character flaw

Nine in ten adults hit it at some point, and treatment works on behavior rather than willpower

Stigma is why drivers stay quiet

How insomnia takes hold and stays



PREDISPOSING

Traits that make a person vulnerable: a light sleeper, or someone who reacts strongly to stress



PRECIPITATING

The event that starts it: a crash, a divorce, a death, a job loss, a switch to nights



PERPETUATING

The coping habits that outlive the event: the Benadryl, the naps, extra hours in the bunk, the clock watching

Treatment targets the third column only

A driver does not need to know what broke his sleep in order to fix it

Four systems behind every sleep problem

1

Sleep pressure

The drive that builds the longer you are awake, and that napping bleeds off

2

Circadian timing

Whether the body clock is lined up with the light and dark cycle

3

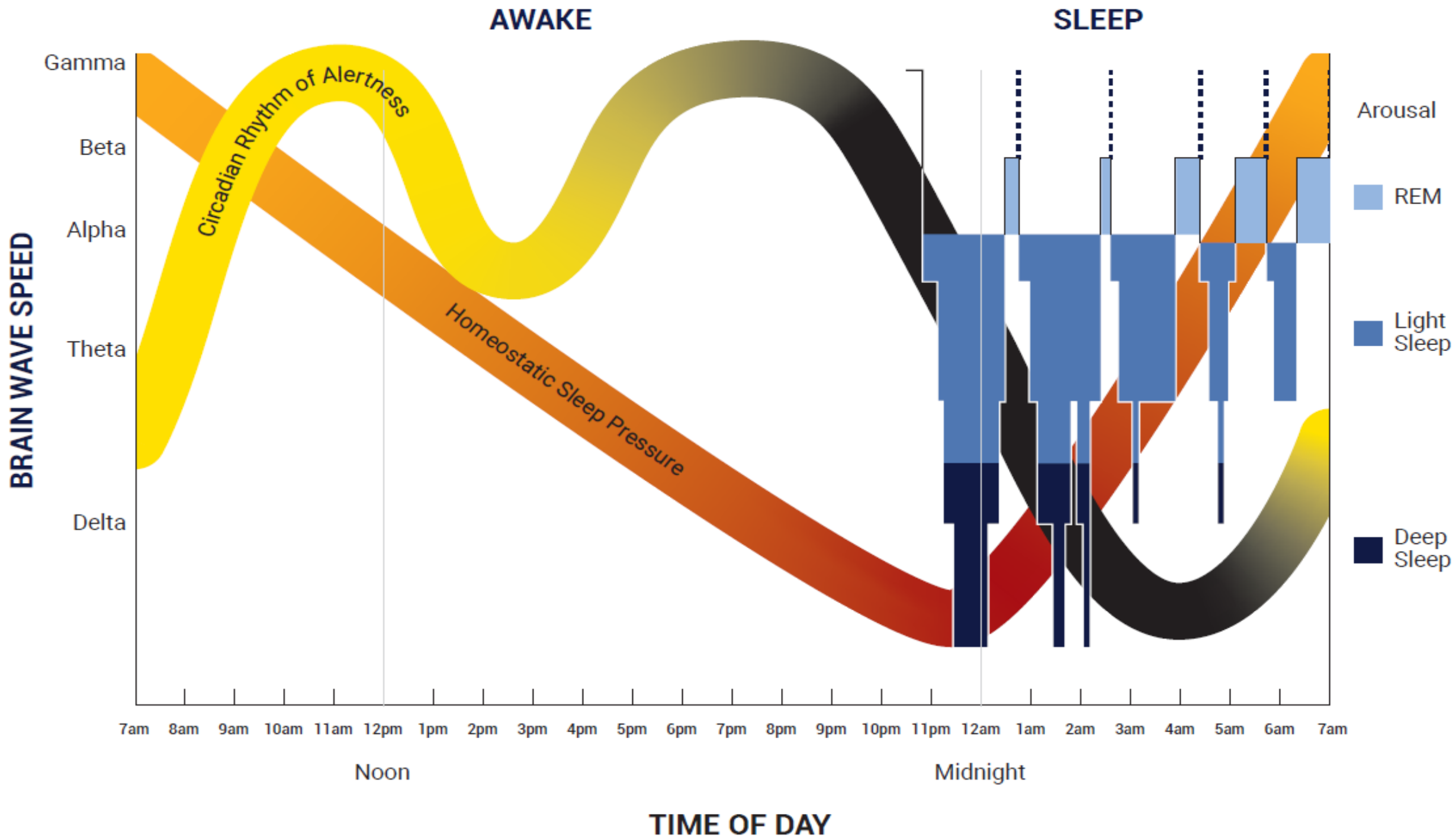
Hyperarousal

The brain holding the gas pedal down at the moment you are trying to sleep

4

Sleep architecture

The structure of the sleep you do get: deep sleep, REM and the repair work they do



A driver sleeps five hours because the schedule allowed five hours in the berth. What is it?

- A** Chronic insomnia
- B** Short-term insomnia
- C** Insufficient sleep, not insomnia
- D** Shift work disorder

Insufficient sleep, not insomnia

- The definition requires an adequate opportunity to sleep, which this driver never had
- Calling it insomnia sends a dispatch problem to a clinician, and it will come back unchanged
- If the schedule is fixed and he still cannot sleep, the diagnosis becomes a live question
- Both can be true at once, which is why the sleep diary records time in bed as well as time asleep

A driver cannot stay on CPAP. Which reason is most often missed?

- A** Mask fit
- B** Body weight
- C** Untreated insomnia
- D** Motivation

Untreated insomnia

- 30% to 50% of people with sleep apnea report clinically significant insomnia symptoms
- Drivers with both conditions use PAP therapy fewer hours per night than apnea patients alone
- In a randomized trial, CBT-I before CPAP added 61 minutes of nightly use and lifted acceptance from 89% to 99%
- Screen the insomnia and the apnea treatment you already pay for starts working

Insomnia is not sleep deprivation



Insomnia

- The opportunity to sleep is there
- The ability to generate sleep is not
- Treatment is behavioral, and it works
- Time in bed usually has to come down

Sleep deprivation

- The ability to sleep is intact
- The opportunity is missing
- The fix is the schedule, not the driver
- Time in bed has to go up

A driver who gets five hours because the run allowed five hours is sleep deprived, and no amount of therapy will fix a dispatch problem

When the body clock is the problem



Shift work disorder

Insomnia or sleepiness tied to working through the biological night, common in night and rotating operations

Delayed sleep phase

The clock runs late, so a normal bedtime is simply too early for that person

Advanced sleep phase

The clock runs early, producing evening sleepiness and waking hours before the alarm

Jet lag and time zones

A temporary mismatch that resolves as the clock catches up

Different mechanism, different treatment

These respond to light, timing and schedule design, not to the sleep window alone

When something else is doing it



Sleep apnea

Snoring, gasping, unrefreshing sleep, headaches

Restless legs

An urge to move the legs at rest in the evening

Mood and anxiety

A quarter of adults a year, and insomnia runs with it

Drugs and substances

Stimulating antidepressants, steroids, decongestants, alcohol, caffeine

Screen first, treat second

These are ruled out before insomnia treatment starts, and apnea is the one most likely to be sitting underneath

When both are present



30% to 50%

of people with sleep apnea also report clinically significant insomnia symptoms

30% to 40%

of people with insomnia also have sleep apnea

COMISA is its own category in practice

People with both have worse sleep, worse health and worse quality of life than people with either alone, and they use PAP therapy fewer hours a night

The one that is a choice



Insomnia

- The door is locked
- The person wants to sleep and cannot
- Arousal and conditioning keep it going
- Treatment is CBT-I

Bedtime procrastination

- The door is unlocked
- The person delays sleep to reclaim the evening
- Phones and low control over the day drive it
- Treatment is habit design, not therapy

It produces the same sleep debt and the same next-day risk,
and it is the most fixable thing

Signs worth a conversation



He cannot sleep in the truck

Complaints about the berth, the noise, the parking, the heat

The caffeine is climbing

Energy drinks stacked on the dash, coffee at 9 p.m.

A sleep aid gets mentioned

A pill, a nightcap or a bottle from the truck stop shelf

The edges are fraying

Irritability, short fuse with dispatch, small mistakes

None of these diagnoses anything: they are prompts for a conversation and a referral

Which treatment do ACP, AASM and VA/DoD all put first? For chronic insomnia

- A** A prescription sleep medication
- B** Melatonin
- C** Cognitive behavioral therapy for insomnia
- D** Sleep hygiene education

Cognitive behavioral therapy for insomnia

- Strong recommendation from ACP, AASM and the 2025 VA/DoD guideline, ahead of any medication
- Trial data: 19 minutes faster to sleep, 26 fewer minutes awake at night, roughly 10 points of sleep efficiency, sustained at follow-up
- In clinic: remission for 50% to 60% of patients and meaningful improvement for about 70%
- Sleep hygiene by itself is specifically not recommended as a stand-alone treatment

The type changes the first move



What you see

What it usually is

First move

Five hours in the berth

Insufficient sleep opportunity

Fix the schedule

Cannot sleep on night runs

Circadian misalignment

Light and timing plan

Wakes at 3 a.m., mind racing

Chronic insomnia

CBT-I referral

Snoring and unrefreshing sleep

Sleep apnea, maybe both

Sleep study

Legs will not settle at night

Restless legs syndrome

Medical workup

02 Cognitive Behavioral Therapy for Insomnia (CBT-I)



What CBT-I is not



A structured, multicomponent behavioral treatment delivered over four to eight sessions

It is not counseling

Sessions follow a protocol built on data the patient collects, with homework between them

It is not sleep hygiene

Hygiene advice supports the work but does not treat the disorder on its own

It does not need a cause

Treatment targets what keeps insomnia going now, not the event that started it

It outlasts treatment

The patient leaves with skills rather than a prescription that has to be renewed

A driver sleeps five and a half hours and is exhausted. What does CBT-I have him do first?

A Go to bed two hours earlier

B Take an afternoon nap

C Spend less time in bed

D Start a sleep aid

Spend less time in bed

- Time in bed is matched to the sleep actually produced, which rebuilds sleep pressure and consolidates the night
- A fixed wake time comes first, before any bedtime is set, and the naps come out
- Sleep efficiency is calculated weekly: above 85%, the bedtime moves 15 minutes earlier
- Four good weeks in a row is an extra hour of sleep opportunity every night

What CBT-I actually is



1

Time in bed restriction

Match time in bed to the sleep the body is producing, then open it back up

2

Stimulus control

The bed is for sleep, so the bunk stops meaning frustration

3

Cognitive work

Take apart the catastrophic thought and replace it with an accurate one

4

Relaxation

Progressive muscle relaxation, the one technique with direct evidence

5

Sleep hygiene

Light, temperature, caffeine and alcohol, supporting the rest

Four to eight sessions

Take out stimulus control or time in bed restriction and it stops working

What comes before treatment



1

Rule out the mimics

Apnea, restless legs, circadian disorders and mood disorders are screened and referred before CBT-I starts

2

Ask the apnea question

Has anyone who has slept near you said that you snore loudly or that you stop breathing

3

Review every medication

All drugs have circadian effects, and a stimulating antidepressant at bedtime is a fixable problem

4

Stabilize what is in play

Sleep aids are settled to one drug at one dose, and alcohol is cut back, before the data can mean anything

Your driver asks whether to keep wearing his sleep ring during CBT-I. What do you say?

- A** Yes, the data helps the clinician
- B** Yes, but only check it weekly
- C** No, take it off for the duration
- D** It makes no difference either way

Take it off for the duration

- The clinician works from the paper diary, not from a consumer device, and the two rarely agree
- A nightly score tells an anxious sleeper every morning that he slept badly, which raises the arousal driving the problem
- Patients who waited more than a year for treatment should remove the tracker on day one

The sleep diary runs the treatment



What it records each morning

- Time into bed, and lights out
- How long it took to fall asleep
- Awakenings, and how long each was
- Wake time, out of bed, quality rating

How it is used

- Seven days minimum, one day misleads
- Average sleep time sets the window
- Sleep efficiency recalculated weekly
- One change at a time, two weeks each

Precision is not the point

The clinician needs the difference between five minutes and fifty, not a stopwatch reading

Component 1: Time in bed restriction



How the window is set

- Diary sleep time, plus about 30 minutes
- Anchored to a fixed wake time
- Rarely set below five and a half hours
- Naps come out, they bleed off sleep pressure

How it opens back up

- Sleep efficiency recalculated weekly
- Above 85%, the bedtime moves 15 minutes earlier
- Four good weeks is an extra hour a night
- Patients are warned it gets worse first

The engine of the treatment

Two independent component analyses rank sleep restriction among the most effective pieces of CBT-I

The wake time comes first



- You cannot make a person fall asleep on command, but you can wake him at a fixed time every day
- Set the wake time from diary evidence rather than patient preference
- Week one is wake time and no naps, with no bedtime assigned at all
- One or two of every eight patients improve substantially on the wake time anchor alone
- Only in week two does true time in bed restriction begin

After treatment, the rule that keeps it

Never sleep in two days in a row, and choose which day you will feel bad on

Component 2: Stimulus control



The rules

- The bed is for sleep and sex only
- Go to bed only when sleepy
- Get up when awake and frustrated
- Same wake time daily, no napping

The 2 a.m. reset

- Get up, do something mildly boring
- Nothing to look forward to at 3 a.m.
- No email, no load board, no scrolling
- Return when sleep feels close

Component 3: Cognitive restructuring



1 Name the thought

If I do not sleep tonight, I cannot work tomorrow

2 Weigh the evidence

What actually happened the last time, on both sides of the question

3 Build a balanced thought

I will not be at my sharpest, and I will get through the day

4 Track the belief

Rate how strongly you believe the 1 a.m. thoughts at intervals the next day

Scheduled worry time, and a surprise in the data

An hour a day set aside for worrying keeps it out of the night, and a 2024 analysis ranked this component highest of all

Components 4 and 5



Relaxation

- Progressive muscle relaxation is the tested one
- Permitted in bed, unlike everything else

Sleep hygiene

- Light, temperature, caffeine, alcohol
- Cool room, warm feet, fewer fluids
- Supports treatment, never replaces it

**A patient is sleeping five and a half hours.
What time in bed does the clinician prescribe?**

- A** Eight hours, to catch up
- B** Seven hours, as a compromise
- C** About six hours
- D** Whatever the patient prefers

About six hours

- The window matches the sleep the body is producing, plus roughly thirty minutes, and not the sleep the patient wishes he were getting
- The floor is about five and a half hours, so nobody is restricted below that
- The wake time is fixed first, and the bedtime is calculated backwards from it
- The window widens by 15 minutes a week once sleep efficiency passes 85%

What five weeks looks like



Intake

Screening, referrals if needed, medications stabilized, diary started

Week 1

Fixed wake time, naps out, no bedtime assigned yet

Week 2

Time in bed restriction begins, calculated from the diary

Week 3

Cognitive work starts: thought records and scheduled worry time

Weeks 4 and 5

Window widens by 15 minutes a week, relapse prevention, follow-up

The access problem



Why drivers do not get it

- Waiting lists run months to over a year
- Certified clinicians number in the hundreds
- Many private providers take no insurance
- Weekly appointments fight an OTR schedule

What closes the gap

- Telehealth, licensed in the driver state
- Group visits, eight patients at a time
- Prescription digital programs and free VA apps
- A workbook, finished before the intake

A carrier can buy access

Telehealth coverage, paid time for sessions and predictable scheduling are the three levers a fleet controls

In the first weeks of sleep restriction, what happens to daytime sleepiness?

- A** It improves right away
- B** It stays about the same
- C** It gets worse before it improves
- D** It varies with no pattern

It gets worse before it improves

- In a laboratory study, Epworth scores rose in weeks one through three and returned to baseline by three months
- Objective total sleep time fell and vigilance was measurably impaired during that acute phase
- One 2025 trial of mobile sleep restriction excluded truck drivers, train drivers and pilots outright for this reason
- For a CDL holder this is a scheduling decision as much as a clinical one, and it argues for home time or lighter dispatch

The safety catch for drivers



Sleepiness goes up before it goes down

In a laboratory study, Epworth scores rose in weeks one through three of sleep restriction

Clinician led

Restriction is guided by a clinician, never self-prescribed

Tell them the job

A behavioral sleep specialist can soften the protocol for a CDL holder

Time the hard weeks

Home time, local work or a lighter dispatch during the acute phase

Keep 392.3 open

A penalty-free way to say today is not a day they should drive

Adapting it for drivers and shift workers



What the evidence says

- Limited effect in shift workers so far
- Adapted versions add dark sleep periods
- A digital version helped shift nurses
- Attrition often tops 20% in these trials

What to change for a CDL holder

- Anchor wake time to the run pattern
- Plan naps, do not ban them
- Sequence restriction into home time
- Keep a penalty-free way to stand down

The honest position

CBT-I was built for people who sleep at night, and the adaptation work is still young

Who responds, and who does not



The numbers

- Remission for 50% to 60%
- Improvement for about 70%
- Four sessions beat one or two

The harder cases

- Short measured sleep may blunt it
- Undiagnosed apnea or RLS caps it
- Non-responders see a specialist

Adherence is the variable that matters most

The treatment works when patients do it, which is why the protocol explains the science first and warns people about the first two weeks

Five things to take back about CBT-I



- 1 CBT-I is first line in every guideline, and starting there beats starting with a pill a year later
- 2 It works by rebuilding sleep pressure and lowering arousal, which is why sleep hygiene alone does not
- 3 The behavioral core carries the effect, and shorter nurse-delivered versions get most of the result
- 4 For a driver, the first three weeks raise sleepiness, so treatment has to be sequenced with dispatch
- 5 It is also the safest route off a sleep medication, roughly doubling successful discontinuation

Getting drivers to the treatment



Telehealth

CBT-I by video is no less effective than in person, which puts it within reach of an over the road driver

Digital programs

Somryst and SleepioRx are FDA cleared, and the VA CBT-i Coach and Insomnia Coach apps are free

Group sessions

Group, ninety minutes a week, at least five weeks, the same protocol for everyone

A workbook

Quiet Your Mind and Get to Sleep workbook walks a driver through the same treatment on his own

03 Medications



Benzodiazepines and Z-drugs



Benzodiazepines

- Deep sleep and REM go down
- Dependence, rebound insomnia, falls
- Respiratory risk with alcohol or opioids, especially with untreated apnea
- Labels say two to four weeks, average use approaches a decade

Z-drugs

- More than 40% of U.S. sleep prescriptions, and zolpidem is nearly 90% of those
- FDA boxed warning for complex sleep behaviors, including sleep driving
- Impair motor function, balance, attention and processing speed
- More than half of users take another sedating drug as well

Both erase the memory of waking, so the pill feels like it worked when the sleep did not improve

Match the drug to the problem



Medications are not the foundation of good sleep

Sedation is not sleep

Most sleep drugs create unconsciousness and flatten sleep architecture rather than supporting it

Different problems, different drugs

Trouble falling asleep, trouble staying asleep and early waking run on different mechanisms

Half-life is the driver issue

A long-acting drug taken at 11 p.m. is still working at the pre-trip inspection

A bridge, not a crutch

Best used short term, alongside the behavioral work that makes the far side reachable

The better tolerated options



Orexin blockers

suvorexant, lemborexant, daridorexant

- Turn wakefulness down instead of forcing sedation
- Preserve deep sleep and REM, and outperform older drugs on sleep efficiency
- Half-lives of 6 to 19 hours, so morning impairment is the driver question
- On-road studies at standard doses look reassuring, first doses less so

Trazodone

off label, not a controlled substance

- Increases total sleep time and deep sleep rather than suppressing it
- Guidelines suggest against it while many clinicians favor it, so expect disagreement
- Morning grogginess and low blood pressure on standing matter on cab steps
- Cheap, and safer in overdose than the older hypnotics

CBT-I and coming off a sleep aid



40% to 80%

discontinuation success rises from roughly 40% with a taper alone to about 80% when CBT-I runs alongside it

73% vs 59%

benzodiazepine discontinuation at six months with a masked taper plus CBT-I against a standard supervised taper

- Stabilize on one drug at one dose before any reduction begins
- Run the taper with the prescriber, not around him, and pace it to the anxiety rather than the pharmacology
- Deliver the behavioral work during the taper, not after it, so the hardest nights have tools behind them

In a driving simulator, which impaired driving more: Benadryl or alcohol at 0.10%?

- A** Alcohol
- B** Diphenhydramine, the antihistamine in Benadryl
- C** About the same
- D** Neither impaired driving

The antihistamine

- Diphenhydramine produced the poorest driving performance of every condition tested, including legal intoxication
- Drivers own drowsiness ratings did not predict how impaired they actually were
- Tolerance to the sleep effect builds within days, so the benefit fades while the risk stays
- Both AASM and VA/DoD advise against it for chronic insomnia

Melatonin works mainly by doing what?

- A** Sedating the brain
- B** Telling the body when night has started
- C** Deepening slow wave sleep
- D** Lowering stress hormones

Telling the body when night has started

- It is a timing signal, not a sleeping pill: it fires the starting gun, it does not run the race
- Best use is circadian realignment, so jet lag and shift changes rather than general insomnia
- One meta-analysis put the useful dose near 4 mg, while shelves are stocked with 5 and 10 mg
- Beta blockers suppress the body own melatonin, so a driver on metoprolol who cannot sleep should ask about it

Six rules for a driver on a sleep aid



- 1 Tell the medical examiner and every prescriber everything, including OTC medications
- 2 Make sure the prescriber knows the job before writing for a scheduled drug
- 3 Ask how long it lasts, and take it only when a full night in the bunk is available
- 4 Ask whether to start the first doses during home time rather than the night before a run
- 5 Count every sedating substance, because alcohol and other drugs stack on top of it
- 6 Report sleepwalking or unexplained night activity right away and stop the drug

Coming off a sleep medication



1 Stabilize first

One drug, one dose, one time every night, agreed with the prescriber, and no middle of the night top ups

2 Work with the prescriber

Most physicians want the patient off, and most failed attempts moved too fast

3 Size the steps to the anxiety

The difference between 12.5 and 12 mg is not pharmacology, it is confidence

4 After the behavioral work

Stabilize during CBT-I, taper afterward, and hold the taper when life gets hard

Slow and steady wins the race, and a driver in a careful taper is a safer driver than one stuck on the drug

04

What Motor Carriers and Drivers Can Do



Fatigue Management Program



Safety Culture

- Education
- Training
- Continuous communications – including partnerships

Fatigue Risk Management System

- Operations
- Identify risks with processes and controls
 - Predictive, proactive, reactive
 - Sound scheduling, sleep disorders management program, fatigue detection technologies
- Risk assessment
- Measures and countermeasures
- Evaluation

What motor carriers can do



Train beyond apnea

Put insomnia, over the counter sleep aids and next day impairment into driver and dispatcher training

Screen confidentially

Offer the ISI through the wellness program, kept away from the personnel file

Pay for CBT-I

Check the health plan for coverage, including telehealth and digital programs

Protect the hard weeks

Predictable start times or home time while a driver is in treatment

Fix what you control

Schedules, notice of changes, secure parking, and a cooler darker bunk

Screen your apnea program

The drivers who cannot tolerate CPAP may be the ones with insomnia

And partner with your medical examiner: ask them to ask every driver about sleep aids

What drivers can do tonight



- Anchor the wake time, not the bedtime
- Never sleep in two days in a row
- Cool bunk, warm feet, eye mask, tape over the lights
- Move the caffeine earlier, do not cut the amount

- Stop the fluids well before sleep
- If you are awake and frustrated, get up and reset
- Put the sleep tracker away while you are struggling
- Ask your doctor about CBT-I, not just a prescription

And the one that is regulation, not advice

If you are impaired, do not start, and if you already have, shut it down

05 Resources



Where to send a driver



Find a CBT-I provider

behavioralsleep.org | cbti.directory

Free VA apps

[CBT-i Coach](#) | [Insomnia Coach](#)

Other digital programs

Somryst and SleepioRx are FDA cleared

Accredited sleep centers

sleepeducation.org

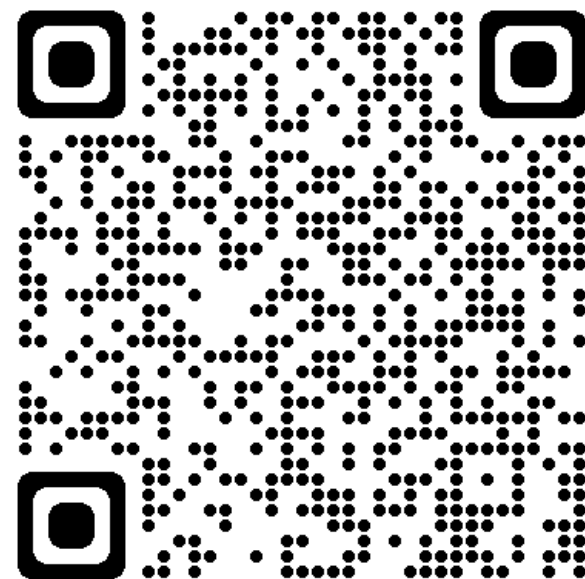
Five things to take back



- 1 Insomnia is the most common sleep disorder in your workforce, and your apnea program will not find it
- 2 It is a clinical diagnosis: three symptoms, three nights a week, three months, despite a real chance to sleep
- 3 It roughly doubles crash odds and triples near miss odds in truck drivers, after adjusting for apnea
- 4 CBT-I is first line everywhere, works for most drivers who finish it, and now reaches them by video
- 5 Medications are a bridge: matched to the problem, disclosed to the examiner, with a plan to come off



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NAFMP Website Free Resources



Tools

- FMP Template
- Implementation Manual
- ROI Calculator



Courses

- eLearning Platform
- PowerPoints with and without audio
- For carrier's executives, safety managers, dispatchers, instructors, drivers, driver's families, shippers and receivers



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Questions



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