Sedative/Hypnotic Deprescribing Algorithm

Why is patient taking a sedative/hypnotic?

If unsure, find out if history of anxiety, past psychiatric consult, whether may have been started in hospital for sleep, or for grief reaction.

- Insomnia on its own OR insomnia where underlying comorbidities managed
  For those ≥ 65 years of age: taking sedative/hypnotic regardless of duration (avoid as first therapy in older people)
  For those 18-64 years of age: taking sedative/hypnotic > 4 weeks

Engage patients

- Discuss potential risks, benefits, withdrawal plan, symptoms and duration

Recommend deprescribing

Taper and then stop sedative/hypnotic

- Taper slowly in collaboration with patient, for example ~25% every two weeks and, if possible, 12.5% reductions near end and/or planned drug-free days

Monitor every 1-2 weeks for duration of tapering

Expected benefits:

- May improve alertness, cognition, daytime sedation and reduce falls

Withdrawal symptoms:

- Insomnia, anxiety, irritability, sweating, gastrointestinal symptoms (all usually mild and last for days to a few weeks)

- Use non-drug approaches to manage insomnia

If symptoms relapse:
Consider

- Maintaining current sedative/hypnotic dose for 1-2 weeks, then continue taper at slow rate

Alternate drugs

- Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this algorithm.

- Other sleeping disorders (e.g., restless legs)
- Unmanaged anxiety, depression, physical or mental condition that may be causing or aggravating insomnia
- Alcohol withdrawal

Continue sedative/hypnotic

- Minimize use of drugs that worsen insomnia (e.g., caffeine, alcohol etc.)
- Treat underlying condition
- Consider consulting psychologist or psychiatrist or sleep specialist
- Use lowest possible effective dose

Sedative/Hypnotic Deprescribing Advice

Engaging patients and caregivers

Patients should understand:

- The rationale for deprescribing (associated risks of continued sedative/hypnotic use, reduced long-term efficacy)
- Withdrawal symptoms (insomnia, anxiety) may occur but are usually mild, transient and short-term (days to a few weeks)
- They are part of the tapering plan, and can control tapering rate and duration

Tapering doses

- No published evidence exists to suggest switching to long-acting sedatives/hypnotics reduces incidence of withdrawal symptoms or is more effective than tapering shorter-acting sedatives/hypnotics
- If dosage forms do not allow 25% reduction, consider 50% reduction initially using drug-free days during latter part of tapering, or switch to lorazepam or oxazepam for final taper steps

Behavioral Management

1. Go to bed only when sleepy
2. Do not use bed or bedroom for anything but sleep (or intimacy)
3. If not asleep within about 20-30 min at the beginning of the night or after an awakening, exit the bedroom
4. If not asleep within 20-30 min on returning to bed, repeat #3
5. Use alarm to awaken at the same time every morning
6. Do not nap
7. Avoid caffeine after noon
8. Avoid exercise, nicotine, alcohol, and big meals within 2 hrs of bedtime

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This information sheet and other resources can be found at **KnowMyMeds.org.**
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