Deprescribing Communication Tool: Benzodiazepines and Z-drugs for insomnia

SUPPORT Meds

TO: PRESCRIBER INFORMATION

Name:

Phone: Fax:

Email:

FROM: SENDER INFORMATION

Name & profession:

Phone: Fax:

Email:

PATIENT INFORMATION

Name: Medicine & dose:

DOB: Date:

Why deprescribe medicines for insomnia?

Cognitive behavioural therapy for insomnia (CBTi) is first-line therapy for insomnia because it is safer and more effective over time than medicines.[1]

Benzodiazepines and Z-drugs for insomnia are:

» not first-line therapy and not recommended for more than 4 weeks because **the effect wears off, yet the risk of adverse events remains**[1]

» associated with an increased risk of **motor vehicle accidents**[2]

» potentially inappropriate for adults 65 years or older[3-5]

5 × ↑ risk of cognitive impairment

4 × ↑ risk of daytime sedation

2 × ↑ risk of falls and fractures*

* even with PRN use and especially if other CNS-active drugs are prescribed

How to deprescribe medicines for insomnia

Tapering should occur **gradually** and be **individualised** to the person's clinical characteristics, treatment goals and preferences. Tapering recommendations in guidelines vary from 5 to 25% dose reductions every 1 to 4 weeks, with slower or faster tapers depending on dose and duration of use.

Closely monitor and regularly review patients during tapering, and adjust tapering plan if needed.

Do not substitute other sedative medicines (e.g. quetiapine), as these have been associated with similar risks of harm.[6]

For more information and a tapering calculator, see www.monash.edu/mips/support-meds.

REFERRING HEALTH PROFESSIONAL REPORT

- ○ To the best of my knowledge, there is no indication other than insomnia.
- ○ Provided and discussed with patient education brochure on benzodiazepines and Z-drugs for insomnia, which includes information about cognitive behavioural therapy for insomnia (CBTi).

Additional comments:

PRESCRIBER REPLY

(Optional)

References: 1. Riemann D, et al. J Sleep Res 2023;32(6):e14035 **2.** Wolff K, et al London: UK Department for Transport; 2013 **3.** American Geriatrics Society Beers Criteria® Update Expert Panel. J Am Geriatr Soc. 2023:71(7): 2052-81 **4.** Glass J, et al. BMJ. 2005;331(7526):1169. **5.** Donnelly K, et al. PLoS One. 2017;12(4):e0174730 **6.** Iaboni A, et al. Drugs Aging. 2016;33(7):523-33.

Adapted from the D-PRESCRIBE trial (doi: 10.1001/jama.2018.16131) with permission from Professor Cara Tannenbaum.

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Deprescribing Algorithm: Benzodiazepines and Z-drugs for insomnia

SUPPORT Meds

Why is the person taking a benzodiazepine or Z-drug (BZRA)?

If unsure, find out if history of anxiety, past psychiatrist visit, started in hospital for sleep, or grief reaction.

An indication other than insomnia, e.g.:

- other sleeping disorders
- unmanaged anxiety, depression, physical or mental condition that may be causing or aggravating insomnia
- anxiety disorder where the BZRA has been effective
- alcohol withdrawal
- seizure disorders
- end-of-life care.

Continue BZRA

- Minimise use of substances that worsen insomnia (e.g. caffeine, alcohol).
- Treat underlying condition.
- Consider consulting psychologist, psychiatrist or sleep specialist.

Insomnia in a person 65 years or older [NB1]

Engage person

(discuss potential risks and benefits of deprescribing, and the plan for tapering, support and monitoring)

Recommend deprescribing

Taper and then stop BZRA

(strong recommendation from systematic review and GRADE approach)

- Taper slowly in collaboration with patient, for example 5 to 25% dose reductions every 1 to 4 weeks, with slower or faster tapers depending on dose and duration of use. [NB2]
- Offer behavioural sleeping advice; consider CBTi. [NB3]

Monitor and regularly review during tapering

Expected benefits:

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

Withdrawal symptoms:

- Sleeplessness, nightmares, anxiety, restlessness, irritability, sweating, tremors, high blood pressure, fast heartbeat (last for a few days to weeks, usually mild, but can be distressing)

- Use non-pharmacological approaches to manage insomnia.
- Use behavioural approaches and/or CBTi.

If symptoms relapse, consider:

- Maintaining current BZRA dose for 1 to 2 weeks, then continue to taper at a slow rate.
- Alternative medicines to manage insomnia. Assessment of safety and effectiveness of other insomnia medicines is beyond the scope of this algorithm.

BZRA = benzodiazepine receptor agonist; CBTi = cognitive behavioural therapy for insomnia
NB1: Recommendations for people younger than 65 years have been omitted from this version of the algorithm.
NB2: Recommendations for BZRA tapering rate have been modified from the original algorithm.
NB3: See the Sleep Central CBTi directory for help finding a local provider or digital applications.

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Pottie K, Thompson W, Davies S, Grenier J, Sadowski C, Welch V, Holbrook A, Boyd C, Swenson JR, Ma A, Farrell B. Evidence-based clinical practice guideline for deprescribing benzodiazepine receptor agonists. Can Fam Physician 2018;64:339-51 (Eng), e209-24 (Fr)

Version 1, July 2026

Algorithm modified from the deprescribing.org original version by SUPPORT-Meds in accordance with the deprescribing.org Team's Modification Policy. Wording, visuals, and recommendations on this version of the algorithm have been modified from the original version. Several elements have been removed for the purposes of this modification.

Original materials available at https://deprescribing.org/resources/deprescribing-guidelines-algorithms

deprescribing.org