



THE UNIVERSITY OF
**WESTERN
AUSTRALIA**

WESTERN AUSTRALIAN CENTRE FOR
HEALTH X AGEING



**CENTRE FOR
OPTIMISATION
OF MEDICINES**



HYPNOTICS AND SEDATIVES

**Deprescribing in older people:
A clinical practice guideline**

dRx[™]

HYPNOTICS AND SEDATIVES

Benzodiazepine derivatives

Flunitrazepam, midazolam, nitrazepam, temazepam*

Benzodiazepine related drugs:

Zopiclone, zolpidem

*Common Pharmaceutical Benefits Scheme medicines

Note: Please refer to the antiepileptics section for benzodiazepine derivatives used as antiepileptics (clonazepam, nitrazepam) and anxiolytics section for benzodiazepine derivatives used as anxiolytics (alprazolam, bromazepam, clobazam, diazepam, lorazepam, oxazepam).

Type	Recommendation
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WHEN TO DEPRESCRIBE

CBR We suggest deprescribing be offered to older people taking long-term (beyond four weeks) benzodiazepines for insomnia as the risk of dependence and other potential harm (e.g. falls, fractures, impaired cognition) generally outweighs the potential benefits, except in special circumstances (e.g. terminal care).

GPS Deprescribing decisions should be made in consultation with the individual, their carer/family members, GP and/or specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).

ONGOING TREATMENT

CBR Given the harms of long-term use are likely to outweigh the benefits in most cases, we generally suggest **against** the use of long-term benzodiazepines for insomnia in older people and trial on-demand or intermittent use at the lowest effective dose in addition to appropriate investigation to identify and subsequently treat a cause.

If symptoms are chronic and persistent, we suggest considering appropriate non-pharmacological therapies and/or safer alternatives for symptoms, provided this aligns with the individual's goals and preferences, following informed consent.

CBR, consensus-based recommendation; GPS, good practice statement

HOW TO DEPRESCRIBE

CBR We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 25% every one to four weeks, ensuring the absence of withdrawal symptoms or reduced sleep quality before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.

GPS Healthcare providers should consider and offer adequate non-pharmacological management options (e.g. good sleep practices) as appropriate (ungraded good practice statement).

MONITORING

CBR We suggest closely monitoring for withdrawal symptoms and/or symptoms indicative of relapse, including worsening sleep quality, changes in psychological or physical health status (e.g. anxiety, and agitation) and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

If in-person visits are impractical, we suggest advising people to report symptoms as needed.

CBR, consensus-based recommendation; GPS, good practice statement

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

