

## Why is patient taking a BZRA?

If unsure, find out if history of anxiety, past psychiatrist 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  $\geq 65$  years of age: taking BZRA regardless of duration (avoid as first line therapy in older people)  
For those 18-64 years of age: taking BZRA > 4 weeks

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

**Engage patients** (discuss potential risks, benefits, withdrawal plan, symptoms and duration)

## Recommend Deprescribing

## Continue BZRA

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

## Taper and then stop BZRA

(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)

- For those  $\geq 65$  years of age (strong recommendation from systematic review and GRADE approach)
- For those 18-64 years of age (weak recommendation from systematic review and GRADE approach)
- Offer behavioural sleeping advice; consider CBT if available (see reverse)

## 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

Use behavioral approaches and/or CBT (see reverse)

If symptoms relapse:

Consider

- Maintaining current BZRA dose for 1-2 weeks, then continue to 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. See BZRA deprescribing guideline for details.

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Pottier K, Thompson W, Davies S, Grenier J, Sadowski C, Welch V, Holbrook A, Boyd C, Swenson JR, Ma A, Farrell B (2016). Evidence-based clinical practice guideline for deprescribing benzodiazepine receptor agonists. Unpublished manuscript.



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## BZRA Availability

BZRA	Strength
Alprazolam (Xanax®) <sup>T</sup>	0.25 mg, 0.5 mg, 1 mg, 2 mg
Bromazepam (Lectopam®) <sup>T</sup>	1.5 mg, 3 mg, 6 mg
Chlordiazepoxide (Librax®) <sup>C</sup>	5 mg, 10 mg, 25 mg
Clonazepam (Rivotril®) <sup>T</sup>	0.25 mg, 0.5 mg, 1 mg, 2 mg
Clorazepate (Tranxene®) <sup>C</sup>	3.75 mg, 7.5 mg, 15 mg
Diazepam (Valium®) <sup>T</sup>	2 mg, 5 mg, 10 mg
Flurazepam (Dalmane®) <sup>C</sup>	15 mg, 30 mg
Lorazepam (Ativan®) <sup>T,S</sup>	0.5 mg, 1 mg, 2 mg
Nitrazepam (Mogadon®) <sup>T</sup>	5 mg, 10 mg
Oxazepam (Serax®) <sup>T</sup>	10 mg, 15 mg, 30 mg
Temazepam (Restoril®) <sup>C</sup>	15 mg, 30 mg
Triazolam (Halcion®) <sup>T</sup>	0.125 mg, 0.25 mg
Zopiclone (Imovane®, Rhovane®) <sup>T</sup>	5mg, 7.5mg
Zolpidem (Sublinox®) <sup>S</sup>	5mg, 10mg

T = tablet, C = capsule, S = sublingual tablet

## BZRA Side Effects

- BZRAs have been associated with:
  - physical dependence, falls, memory disorder, dementia, functional impairment, daytime sedation and motor vehicle accidents
- Risks increase in older persons

## Engaging patients and caregivers

Patients should understand:

- The rationale for deprescribing (associated risks of continued BZRA 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 BZRAs reduces incidence of withdrawal symptoms or is more effective than tapering shorter-acting BZRAs
- 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

## Behavioural management

Primary care:

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

Institutional care:

- Pull up curtains during the day to obtain bright light exposure
- Keep alarm noises to a minimum
- Increase daytime activity & discourage daytime sleeping
- Reduce number of naps (no more than 30 mins and no naps after 2 pm)
- Offer warm decaf drink, warm milk at night
- Restrict food, caffeine, smoking before bedtime
- Have the resident toilet before going to bed
- Encourage regular bedtime and rising times
- Avoid waking at night to provide direct care
- Offer backrub, gentle massage

## Using CBT

What is cognitive behavioural therapy (CBT)?

- CBT includes 5-6 educational sessions about sleep/insomnia, stimulus control, sleep restriction, sleep hygiene, relaxation training and support

Does it work?

- CBT has been shown in trials to improve sleep outcomes with sustained long-term benefits

Who can provide it?

- Clinical psychologists usually deliver CBT, however, others can be trained or can provide aspects of CBT education; self-help programs are available

How can providers and patients find out about it?

- Some resources can be found here: <http://sleepwellns.ca/>

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