

Understanding Sleep Medications

A Guide for Patients, Families & Caregivers

Sleep problems are common, especially with aging, chronic illness, and dementia. Medication can sometimes help, but the safest choice depends on the cause of poor sleep, other medications, fall risk, and overall health.

What should happen before starting a sleep medication?

- Identify the pattern: trouble falling asleep, waking often, early awakening, or a reversed day–night schedule.
- Look for treatable causes: pain, nighttime urination, sleep apnea, restless legs, depression, anxiety, medications, caffeine, and environmental disruption.
- For chronic insomnia, cognitive behavioral therapy for insomnia (CBT-I) is the preferred first-line treatment for most adults.
- In dementia, review daytime activity, lighting, naps, nighttime discomfort, delirium, and caregiver safety before considering a sedative.

What benefits can medications offer?

- Some help people fall asleep faster; others help them remain asleep.
- Benefits are often modest and may not persist after the medication is stopped.
- Better sleep may improve daytime functioning, but sedation is not the same as restorative sleep.

Sleep medication categories: a quick comparison

Category	Examples (generic / brand)	Key points
Orexin receptor antagonists	suvorexant / Belsomra; lemborexant / Dayvigo; daridorexant / Quviviq	Reduce wakefulness signaling; may cause next-day sleepiness, vivid dreams, sleep paralysis.
"Z-drugs"	zolpidem / Ambien, Edluar, Intermezzo; eszopiclone / Lunesta; zaleplon / Sonata	Can help sleep onset or maintenance; risks include falls, confusion, dependence, and complex sleep behaviors.
Benzodiazepines	temazepam / Restoril; triazolam / Halcion; estazolam / Prosom; flurazepam / Dalmane; quazepam / Doral	Sedating; generally avoid for insomnia in older adults due to falls, cognitive effects, and dependence.
Melatonin-receptor agents	ramelteon / Rozerem; melatonin (OTC supplement)	Often considered for sleep-onset/circadian problems; melatonin product quality and effects vary.
Low-dose antidepressant	doxepin / Silenor (3–6 mg)	For sleep maintenance; higher antidepressant doses have more anticholinergic effects.

Brand availability and formulations change. This is an educational reference, not a prescribing list.

Other medications sometimes used for sleep

Medication / group	Important considerations
Trazodone (Desyrel; Oleptro)	Commonly prescribed off-label; may cause dizziness, low blood pressure, falls, and daytime sedation. Evidence for chronic insomnia is limited.
Mirtazapine (Remeron)	May be considered when depression or poor appetite also needs treatment; sedation and weight gain are common.
Hydroxyzine (Atarax; Vistaril), diphenhydramine (Benadryl), doxylamine (Unisom)	Sedating antihistamines; anticholinergic effects can cause confusion, constipation, urinary retention, and falls. Generally avoid in older adults.
Gabapentin (Neurontin)	Sometimes used when pain or restless legs contributes; may cause sedation, dizziness, and unsteadiness; kidney dose adjustment may be needed.
Quetiapine (Seroquel) and other antipsychotics	Not recommended solely for routine insomnia; carry significant risks, particularly in dementia, including a boxed warning for increased mortality.
Clonidine and other off-label sedatives	Limited insomnia evidence; may cause low blood pressure, dizziness, or other adverse effects.

Common side effects and safety concerns

- Morning grogginess, slowed reaction time, impaired driving, and difficulty concentrating.
- Dizziness, falls, fractures, and worsening confusion—especially in older adults.
- Sleepwalking, sleep-driving, or other complex behaviors while not fully awake (particularly with Z-drugs); stop the drug and contact the prescriber immediately if this occurs.
- Tolerance, dependence, rebound insomnia, and withdrawal with some medicines; do not abruptly stop a long-used benzodiazepine without a supervised taper.
- Dangerous additive sedation or breathing suppression when combined with alcohol, opioids, or other sedatives.
- Some medicines worsen untreated obstructive sleep apnea or other breathing disorders; review respiratory conditions with the clinician.

Important differences in older adults

The American Geriatrics Society Beers Criteria recommends avoiding benzodiazepines and Z-drugs in most older adults because harms often outweigh the small average sleep benefit. First-generation antihistamines also carry substantial anticholinergic risks. A medication that is suitable for one person may be unsafe for another.

Sleep medications and dementia

Sleep disturbances in dementia may arise from disrupted circadian rhythms, pain, medication effects, sleep apnea, nighttime anxiety, environmental triggers, or delirium. Treating the underlying cause is often more useful than adding a sedative.

What families should know

- Sedatives can worsen confusion, gait instability, daytime sleepiness, and fall risk. Some may cause paradoxical agitation.
- Melatonin has not consistently shown meaningful benefit for sleep in Alzheimer's disease in clinical trials.
- Suvorexant has trial evidence of improved total sleep time in people with mild-to-moderate Alzheimer's disease and insomnia, but it still requires careful individual risk assessment.
- Antipsychotics should not be used simply as sleeping pills for people with dementia.
- Sudden nighttime behavioral changes, fluctuating attention, or new confusion require evaluation for delirium or a medical problem.

What to expect when starting treatment

- Discuss a clear target (such as fewer prolonged nighttime awakenings) and a plan for reassessment.
- Review all prescriptions, OTC products, supplements, alcohol use, sleep apnea, fall history, and kidney/liver disease.
- Take medicine only as directed, when enough time remains for a full night of sleep; specific timing differs by drug.
- Track sleep and next-day alertness for 1–2 weeks; watch for new confusion, falls, or unusual nighttime behavior.
- Ask whether the medication is intended for short-term or longer-term use, and how it will be discontinued safely.

Practical nonmedication strategies

- Keep a regular wake time; seek daylight and gentle physical activity during the day.
- Limit late-day caffeine, alcohol, and long afternoon naps.
- Use a quiet, dark, comfortable sleep environment; address pain and toileting needs.
- For dementia, offer predictable evening routines, orientation cues, and caregiver support.
- Ask about CBT-I, which can be adapted for older adults; caregivers may need help implementing routines.

Questions to ask the prescriber

- ☐ What is causing the sleep problem, and are there nonmedication treatments we should try first?
- ☐ What specific improvement should we expect, and how soon?
- ☐ How does this medication affect falls, memory, breathing, and next-day alertness?
- ☐ Could it interact with the person's other medicines or alcohol?
- ☐ How long should it be taken, and what is the plan to taper or stop it?
- ☐ What changes should prompt an urgent call or emergency evaluation?

Family sleep and safety tracker

Date	Bedtime / awakenings	Morning alertness / falls	Notes / medication changes

When to get urgent help

Call 911 for trouble breathing, inability to awaken the person, a serious fall with injury, or other immediate danger. Contact the treating clinician promptly for new or worsening confusion, complex sleep behaviors, severe dizziness, or marked daytime sedation. For suicidal thoughts or emotional crisis in the U.S., call or text 988.

Trusted educational resources

- National Heart, Lung, and Blood Institute (NHLBI): Sleep Health — nhlbi.nih.gov/health/sleep
- American Academy of Sleep Medicine: patient sleep education — sleepeducation.org
- National Institute on Aging: A Good Night's Sleep / Alzheimer's sleep changes — nia.nih.gov
- MedlinePlus: Sleep Medicines and Insomnia — medlineplus.gov
- FDA: Medication Guides and boxed warnings — fda.gov/drugs
- American Geriatrics Society: Health in Aging medication safety — healthinaging.org

Educational information only. Not all listed medications are FDA-approved for insomnia, and availability may vary. Medication decisions should be individualized with a licensed clinician; do not start, stop, or change a prescription based on this handout.