MAYO CLINIC

Benzodiazepine Use in Older Adults: Dangers, Management, and Alternative Therapies

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Abstract

Several major medical and psychiatric organizations, including the American Geriatrics Society, advise against using benzodiazepines or nonbenzodiazepine hypnotics in older adults. Despite these recommendations, benzodiazepines continue to be massively prescribed to a group with the highest risk of serious adverse effects from these medications. This article summarizes legitimate reasons for prescribing benzodiazepines in the elderly, serious associated risks of prescribing them, particularly when not indicated, barriers physicians encounter in changing their prescription patterns, and evidence-based strategies on how to discontinue benzodiazepines in older patients. Although more research is needed, we propose several alternatives for treating insomnia and anxiety in older adults in primary care settings. These include nonpharmacological approaches such as sleep restriction—sleep compression therapy and cognitive behavioral therapy for anxiety or insomnia, and as well as alternative pharmacological agents.

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The American Geriatrics Society (AGS) placed benzodiazepines on a list of medications that should be avoided in patients over 65 years of age.[1] Several major psychiatric associations also advise against using benzodiazepines for generalized anxiety disorder and insomnia in the elderly.[2] Despite these recommendations, benzodiazepines

continue to be prescribed to a group with the highest risk of serious adverse effects from these medications.[3] In the United States, more than 10% of women and 6% of men aged 65 to 80 years filled at least one prescription for benzodiazepines in a 1-year period, approximately one-third of them receiving benzodiazepines for longer than 120 days in a year.[3] This widespread prescription of benzodiazepines in a population for which they are generally contraindicated has the potential for important public health consequences because benzodiazepine use is associated with risk of dependence, cognitive deficits, falls resulting in fractures, motor vehicle accidents, and overall mortality.[1]

Primary care physicians prescribe the largest absolute number of long-term benzodiazepines, likely because they see the greatest number of elderly patients.[3] However, in relative numbers, primary care physicians do not prescribe benzodiazepines at a higher rate than psychiatrists.[4] There are several interdependent reasons why doctors are unable to change their benzodiazepine prescription patterns. Some are intrinsic to physicians, including insufficient recognition of adverse effects, conviction that the risk to benefit ratio favors the latter, perceived lack of skills and training on how to respond to problems that occur during a taper, resource constraints such as limited time and a resultant decision to focus on other important medical issues in this population, fear of jeopardizing the doctor-patient relationship or fear of push-back leading to patients finding other doctors, unwillingness to question other colleagues' prescription rationales, and opinion that discontinuation could be too stressful for an elderly user with a limited life expectancy.[5] Other reasons are external to physicians, such as patients' resistance to change, health systems with insufficient reimbursement for the invested time and effort, limited availability of psychotherapists, absence of scheduled medication reviews, or inability to access support from psychiatrists in a timely fashion.[5] Importantly, older adults are a very heterogenous group because this population ranges from 65-year-olds to centenarians, and not all older adults are affected equally by the aforementioned factors. For example, elderly patients in residential care facilities are at a higher risk of being exposed to benzodiazepines, and pressure from the nursing staff to prescribe psychotropics seems to play an important role in that setting.[5] This and other factors have likely contributed to the prevalence of benzodiazepine use remaining unchanged in the elderly population over the past decade.[1,6]

This article reviews the literature on the risks of prescribing benzodiazepines to older adults, problems associated with benzodiazepine use in the elderly, ways to reduce their use, and alternatives to benzodiazepines for anxiety and insomnia.

PRESCRIBING BENZODIAZEPINES

AGS Guidelines and Clinical Practice

In 2015, the AGS published the fourth update of the so-called Beers criteria. These criteria are meant to be evidence-based recommendations by the AGS to guide decision making for prescribing to elderly patients by listing medications that have an unfavorable risk to benefit ratio. The criteria should be used to support clinical judgment and not to prohibit the use of the listed medications.[1] The AGS recommendations are intended for use in all clinical settings for people older than 65 years in the United States, outside of palliative or hospice care.[1] The 2015 update was authored by an interdisciplinary panel of 13 experts in geriatric care.[1] Each published recommendation was labeled as either "strong" or "weak" depending on the quality of available evidence, potential for harm, and availability of safer alternatives.[1] Most of the recommendations regarding benzodiazepine use are based on evidence of "moderate" quality and are given with a "strong" recommendation.[1] Two notable exceptions are (1) use of benzodiazepines in elderly patients with a history of falls and (2) use in elderly patients who are already receiving 2 or more drugs that act on the central nervous system.[1] The recommendation to avoid benzodiazepines in these 2 situations is based on "high" quality of evidence.[1] An important update in the new criteria is that nonbenzodiazepine receptor agonists (such as eszopiclone, zalpelon, and zolpidem) are unambiguously to be avoided regardless of duration of use, whereas the 2012 recommendations were more permissive of their use.[1] These drugs possess minimal efficacy in treating insomnia beyond acute periods measured