Beers Criteria: psychiatric meds

2023 AGS Beers-flagged psychiatric medications for adults 65 and older, with safer alternatives. Reviewed against current guidelines as of June 8, 2026.

Three concepts dominate geriatric psychiatric prescribing: anticholinergic burden, fall risk, and CNS or orthostatic effects. If you avoid tertiary TCAs, paroxetine, benzodiazepines, Z-drugs, first-generation antihistamines, and reserve antipsychotics for BPSD only when nonpharmacologic approaches have failed, you're most of the way there. Trazodone low dose and mirtazapine are the pragmatic picks for insomnia and depression here.

Beers-flagged psychiatric medications

Drug or class	Recommendation	Reason	Safer alternatives
Tertiary TCAs (amitriptyline, imipramine, doxepin above 6 mg, clomipramine)	Avoid	High anticholinergic, sedation, orthostasis	SSRIs (sertraline, escitalopram), mirtazapine, SNRIs
Secondary TCAs (nortriptyline, desipramine)	Use with caution	Less anticholinergic but still orthostatic and cardiac	Same as above; occasionally appropriate for neuropathic pain
Paroxetine	Avoid	Most anticholinergic SSRI, sedation, discontinuation	Sertraline, escitalopram
Benzodiazepines (all)	Avoid	Falls, fractures, cognitive decline, delirium, dependence	CBT-I; SSRIs for anxiety; melatonin for sleep
Z-drugs (zolpidem, zaleplon, eszopiclone)	Avoid	Complex sleep behaviors, falls, cognitive effects	CBT-I; ramelteon; low-dose doxepin; low-dose trazodone
Antipsychotics for BPSD in dementia	Avoid unless nonpharm fails or danger	Boxed mortality warning, stroke, EPS, sedation	Nonpharmacologic first: pain, constipation, environment, caregiver approach
First-gen antihistamines (diphenhydramine, hydroxyzine, chlorpheniramine)	Avoid	Strong anticholinergic, sedation, delirium	2nd-gen antihistamines for allergy; low-dose doxepin for sleep
First-gen antipsychotics (haloperidol, chlorpromazine, perphenazine) chronically	Avoid	EPS, tardive dyskinesia, mortality signal	Second-gen if antipsychotic truly needed
Meperidine	Avoid	Neurotoxic metabolite accumulates	Other opioids as needed
Barbiturates (phenobarbital, butalbital)	Avoid	High dependence, sedation, overdose risk	Any modern anticonvulsant
Chlordiazepoxide	Avoid	Long half-life, active metabolites, falls	Lorazepam-based protocols for withdrawal in older adults
Diazepam	Avoid	Long half-life, accumulation	Same as chlordiazepoxide
Muscle relaxants (cyclobenzaprine, methocarbamol, carisoprodol)	Avoid	Anticholinergic, sedation, questionable efficacy	PT, topical agents, acetaminophen

Safer picks for common presentations

Presentation	First-line	Second-line	Avoid

Depression	Sertraline; escitalopram (max 10 mg over 60)	Mirtazapine (if sleep and appetite), bupropion (if no seizure risk)	Paroxetine, tertiary TCAs
Anxiety	SSRI (sertraline, escitalopram); CBT	Buspirone adjunct	Chronic benzos, hydroxyzine
Insomnia	CBT-I, sleep hygiene, melatonin 1 to 3 mg	Ramelteon; doxepin 3 to 6 mg; low-dose trazodone	Benzos, Z-drugs, diphenhydramine
BPSD in dementia	Nonpharm first (pain, infection, environment)	Low-dose risperidone, quetiapine, olanzapine, or brexpiprazole	Chronic haloperidol; unmonitored antipsychotic
Bipolar	Lithium (target 0.4 to 0.6, watch renal)	Lamotrigine; aripiprazole or quetiapine adjuncts	Carbamazepine when possible
Psychosis (non-dementia)	Risperidone, aripiprazole, or olanzapine at lower doses than younger adults	Adjust for metabolic and EPS profile	

STOPP additions worth remembering

- Long-term (more than 4 weeks) benzodiazepines or Z-drugs for insomnia or anxiety.
- Antipsychotics as long-term hypnotics (excluding sub-therapeutic doxepin and modest trazodone).
- SSRI use in patients with current or recent hyponatremia without close monitoring.
- Any anticholinergic drug in patients with dementia or cognitive impairment.

Not medical advice.