

Why Are More Older People Dying After Falls?

Medications such as benzodiazepines, opioids and antidepressants can increase the risk of falling.

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For a while, walking the dog felt hazardous.

Earl Vickers was accustomed to taking Molly, his shepherd-boxer-something-else mix, for strolls on the beach or around his neighborhood in Seaside, California. A few years ago, though, he started to experience problems staying upright.

“If another dog came toward us, every single time I’d end up on the ground,” recalled Vickers, 69, a retired electrical engineer. “It seemed like I was falling every other month. It was kind of crazy.”

Most of those tumbles did no serious damage, though one time he fell backward and hit his head on a wall behind him. “I don’t think I had a concussion, but it’s not something I want to do every day,” Vickers said, ruefully. Another time, trying to break a fall, he broke two bones in his left hand.

So in 2022, he told the oncologist who had been treating him for prostate cancer that he wanted to stop the cancer drug he had been taking, off and on, for four years: enzalutamide (sold as Xtandi).

Among the drug’s [listed side effects](#) are higher rates of falls and fractures among patients who took it, compared with those given a placebo. His doctor agreed that he could discontinue the drug, and “I haven’t had a single fall since,” Vickers said.

Public health experts have warned of the perils of falls for older people for decades. In 2023, the most recent year of data from the Centers for Disease Control and Prevention, more than 41,000 Americans over 65 died from falls, an [opinion article](#) in JAMA Health Forum pointed out last month.

More startling than that figure, though, was another statistic: Fall-related mortality among older adults has been climbing sharply.

The author, Thomas Farley, an epidemiologist, reported that death rates from fall injuries among Americans over 65 had more than tripled over the past 30 years. Among those over 85, the cohort

at highest risk, death rates from falls jumped to 339 per 100,000 in 2023, from 92 per 100,000 in 1990.

The culprit, in his view, is Americans' reliance on prescription drugs.

"Older adults are heavily medicated, increasingly so, and with drugs that are inappropriate for older people," Farley said in an interview. "This didn't occur [in Japan](#) or in Europe."

Yet that same 30-year period saw a flurry of research and activity to try to reduce geriatric falls and their potentially devastating consequences, from hip fractures and brain bleeds to restricted mobility, persistent pain, and institutionalization.

The American Geriatrics Society adopted updated [fall prevention guidelines](#) in 2011. The CDC unveiled a program called [STEADI](#) in 2012. The United States Preventive Services Task Force recommended exercise or physical therapy for older adults at risk of falling in 2012, 2018, and again [last year](#).

"There've been studies and interventions and investments, and they haven't been particularly successful," said Donovan Maust, a geriatric psychiatrist and researcher at the University of Michigan. "It's a bad problem that seems to be getting worse."

But are prescription drugs driving that increase? Geriatricians and others who research falls and prescribing practices question that conclusion.

Farley, a former New York City health commissioner who teaches at Tulane University, acknowledged that many factors contribute to falls, including the physical impairments and deteriorating eyesight associated with advancing age; alcohol abuse; and tripping hazards in people's homes.

But "there's no reason to think any of them have gotten three times worse in the past 30 years," he said, pointing to studies showing [declines in other high-income countries](#).

The difference, he believes, is Americans' increasing use of medications — like benzodiazepines, opioids, antidepressants, and gabapentin — that act on the central nervous system.

"The drugs that increase falls' mortality are those that make you drowsy or dizzy," he said.

Problematic drugs are numerous enough to have acquired an acronym: FRIDs, or "fall-risk-increasing drugs," a category that also includes various cardiac medications and early antihistamines like Benadryl.

Such medications play a major role, agreed Thomas Gill, a geriatrician and epidemiologist at Yale University and a longtime falls researcher. But, he said, "there are alternative explanations" for the increase in death rates.

He cited changes in reporting the causes of death, for instance. “Years ago, falls were considered a natural consequence of aging and no big deal,” he said.

Death certificates often attributed fatalities among older people to ailments like heart failure instead of falls, making fall mortality appear lower in the 1980s and 1990s.

Today’s over-85 cohort may also be frailer and sicker than the oldest-old were 30 years ago, Gill added, because contemporary medicine can keep people alive longer.

Their accumulating impairments, more than the drugs they take, could make them more likely to die after a fall.

Another skeptic, Neil Alexander, a geriatrician and falls expert at the University of Michigan and VA Ann Arbor Healthcare System, argued that most doctors have come to understand the dangers of FRIDs and prescribe them less often.

“Message delivered,” he said. Given the alarms sounded about opioids, about benzodiazepines and related drugs, and especially about opioids and benzos together, “a lot of primary care doctors have heard the gospel,” he said. “They know not to give older people Valium.”

Moreover, prescriptions for some fall-related drugs have already declined or hit plateaus, even as death rates because of falls have risen. Medicare data shows [lower prescription opioid use](#) beginning a decade ago, for example. Benzodiazepine prescriptions for older patients have slowed, Maust said.

On the other hand, the [use of antidepressants](#) and of [gabapentin](#) has increased.

Whether or not medication use outweighs all other factors, “nobody disputes that these agents are overused and inappropriately used” and contribute to the troubling increase in fall death rates among seniors, Gill said.

Thus, the ongoing campaign for “deprescribing” — stopping the medications whose potential harms outweigh their benefits, or reducing their dosage.

“We know a lot of these drugs can increase falls by 50% to 75%” in older patients, said Michael Steinman, a geriatrician at the University of California-San Francisco and co-director of the [US Deprescribing Research Network](#), established in 2019.

“It’s easy to start meds, but it often takes a lot of time and effort to have patients stop taking them,” he said. Harried doctors may pay less attention to drug regimens than to health issues that seem more pressing, and patients can be reluctant to give up pills that seem to help with pain, insomnia, reflux, and other common age-related complaints.

The Beers Criteria, a directory of drugs often deemed inadvisable for older adults, recently [published recommendations](#) for alternative medications and nonpharmacological

treatments for frequent problems. Cognitive behavioral therapy for sleeplessness. Exercise, physical therapy, and psychological interventions for pain.

“It’s a real tragedy when people have this life-altering event,” Steinman, co-chair of the Beers panel on alternatives, said of falls. He urged older patients to raise the issue of FRIDs themselves, if their doctors haven’t.

“Ask, ‘Do any of my medications increase the risk of falls? Is there an alternative treatment?’” he suggested. “Being an informed patient or caregiver can put this on the agenda. Otherwise, it might not come up.”

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