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RESEARCH PAPER

Barriers to discontinuing benzodiazepine receptor agonists in older adults: a survey of older adults across Europe

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Abstract

Background: Various factors hinder older adults from discontinuing benzodiazepine receptor agonists (BZRAs). Identifying and prioritising these barriers is essential for designing effective interventions to discontinue BZRAs.
Objective: To identify barriers to BZRA discontinuation among older adults and factors associated with their willingness to reduce or stop use.
Methods: A cross-sectional survey was conducted among adults 65+ using BZRA for sleep problems, recruited from hospitals across six European countries. Barriers were identified via a 27-item questionnaire grounded in the Theoretical Domains Framework (TDF), which systematically identifies individual and contextual determinants of behaviour. Responses were

analysed using descriptive statistics. Multivariable logistic regressions identified factors associated with patients' willingness to reduce or stop BZRA.

Results: Among 183 participants, 59.1% were willing to reduce and 42.7% to stop BZRA if recommended by their doctor. Half understood why discontinuation is necessary. Barriers were present for most participants across multiple TDF domains. They included: high satisfaction with BZRA, perceived low risk of side effects, limited coping skills or ability to stop, fear of discontinuation and lack of support from physicians or social networks. Higher scores in the TDF domains of Goals, Emotion and Social Influences were associated with greater willingness to reduce BZRA. These domains and Reinforcement, Environmental context and resources were also linked to a greater willingness to stop.

Conclusions: These findings highlight the opportunities and challenges of discontinuing BZRA in older adults. While half know the need to discontinue and are willing to try, future interventions must address pervasive barriers across many behavioural domains.

Keywords: benzodiazepines; z-drugs; deprescribing; medication safety; older adults

Key Points

- Patients across Europe face overall similar major barriers to BZRA deprescribing, yet more than half are willing to reduce BZRA intake.
- Patients often lack information about BZRA, motivation and support from healthcare professionals and their social network.
- Interventions should target both reflective (e.g. goals) and automatic (e.g. emotions) processes.

Introduction

Sleep problems are highly prevalent in later life. A recent meta-analysis reported that up to 38% of community-dwelling older adults experience insomnia [1], which is associated with increased risks of adverse outcomes such as cardiovascular disease and depression [2, 3]. Current clinical guidelines recommend cognitive behavioural therapy for insomnia (CBT-I) as the first-line treatment [4], and its effectiveness in older adults is well established [5–7]. In contrast, the use of benzodiazepine receptor agonists (BZRAs) in older adults is strongly discouraged [8, 9]. BZRAs are linked to dependence, falls, fractures and cognitive impairment and substantial societal and healthcare costs [10–16]. Despite these risks, BZRA use remains common among older adults in Europe [17, 18], with prevalence rates of 18.2% in Belgian adults aged $\geq$ 65 years (up to 50% in nursing homes), 25.8% among Swiss adults aged $\geq$ 80 years and 33.5% in Spain [17, 19–21].

Patient-related factors may contribute to persistent BZRA use. Systematic reviews have identified several factors, referred to as barriers, including older patients' perceived benefits of BZRAs, limited awareness of associated risks and the absence of clear goals for reducing or stopping BZRA [22–24]. However, most of the included studies were qualitative in nature. Quantitative data could help prioritise these barriers and support the development and evaluation of targeted interventions. Weir et al. conducted a meta-analysis of patients' general attitudes toward discontinuing medications, focusing primarily on older adults, although not specifically on BZRA [25]. Additional research gaps include limited data on the relationship between patient-related barriers, patients' willingness to reduce or stop using BZRA and their prior experiences with discontinuing BZRA.

The present study is part of the European BE-SAFE project, which aims to identify barriers and subsequently develop and evaluate an intervention to increase BZRA discontinuation. The primary objective of the present study was to identify barriers to discontinuing BZRAs from the perspective of older adults currently using it for sleep problems. Secondary objectives were to examine associations between barriers and patients' willingness to reduce or stop BZRA and to explore differences in behavioural factors based on patients' previous attempts to reduce or discontinue BZRA.

Methods

Study design

We conducted a multicentre, cross-sectional survey in six countries participating in the BE-SAFE project: Belgium, Greece, Norway, Poland, Spain and Switzerland. The BE-SAFE project aims to enhance patient safety by promoting the discontinuation of BZRAs used for sleep problems in older adults and implementing a theory-informed deprescribing intervention initiated in hospitals. Its initial phase focused on identifying and prioritising barriers to discontinuing BZRA from the perspectives of multiple stakeholders, to inform the development of a targeted intervention. This intervention is evaluated in an ongoing cluster-randomised controlled trial (clinicaltrials.gov NCT06584513). We previously reported barriers from the perspectives of physicians and nonphysician healthcare professionals [26, 27].

The findings of this study were reported following the Consensus-Based Checklist for Reporting of Survey Studies (CROSS) and the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines [28, 29].

Sample

We surveyed older adults who used BZRA for sleep problems. Participants were eligible if they met the following criteria: (i) aged 65 or older and (ii) using BZRA for sleep problems at least thrice weekly over the past 3 months. The exclusion criteria were refusal to provide informed consent and inability to answer the questionnaire.

Patients were recruited from hospitals in the six participating countries. Recruitment details are provided in Appendix 5. We aimed to recruit 40 patients per country, totalling 240 participants. This sample size was considered feasible within the project timeline and suitable for cross-country comparisons.

The study was conducted in accordance with the Declaration of Helsinki [22], approved by local ethics committees, except in Switzerland, where it was exempt. All participants provided written informed consent before enrolment.

Survey questionnaire

The targeted behaviour was defined using the AACTT framework (Action, Actor, Context, Target, Time) [30] as follows: gradual discontinuation of sleeping pills within 6 months in adults aged 65 and older who use BZRA for sleep problems.

The questionnaire was developed using the Theoretical Domains Framework (TDF), a comprehensive framework grounded in 33 psychological and organisational behaviour change theories [31, 32].

We used 13 items adapted from the revised Patients' Attitudes Toward Deprescribing (rPATD) questionnaire [33], which has been previously validated for use with older adults [34]. We used these items to identify barriers to discontinuing BZRA and mapped each item to relevant TDF domains (see Appendix 1). To capture factors not addressed by the attitudes questionnaire, we supplemented our questionnaire with 13 items from a TDF-based questionnaire [35]. These items captured barriers in the TDF domains: Knowledge and Skills, Memory, Attention and Decision Processes, Environmental Context and Resources and Social Influences. Additionally, we included one item assessing awareness of alternative sleep approaches. Additional data on the psychometric properties are available in Appendix 4.

The final questionnaire included 40 questions: nine sociodemographic questions (including one question on previous attempts to deprescribe), 27 statements linked to 11 TDF domains (Knowledge; Skills; Memory, Attention and Decision processes; Beliefs about Capabilities; Beliefs about Consequences; Reinforcement; Goals; Intentions; Emotion; Environmental Context and Resources; and Social Influences). Three TDF domains—Behavioural Regulation, Optimism and Social/Professional Role and Identity—were excluded, as no relevant items were identified for these domains. In addition, the questionnaire included two questions about where it was completed and whether help was needed to complete it, as well as two open questions on additional barriers to and enablers of BZRA discontinuation.

Translation and piloting

The questionnaire was translated from English into six languages (French, German, Greek, Norwegian, Polish and Spanish) following the forward/backward translation procedure [36, 37]. We pilot-tested the questionnaire with at least two older adults per country to ensure clarity, comprehensiveness and acceptability. After completing the questionnaire, participants took part in a brief interview to provide feedback on clarity, wording and comprehensibility. We also measured the time taken to complete the questionnaire (average time: 14 minutes) and asked participants to comment on the questionnaire's length, which they found acceptable. Based on this feedback, minor corrections were made. The study protocol and questionnaire are available on the Open Science Framework (OSF) website: https://osf.io/xu4h8/?view_only=9bfd650bdd3b413aabe04d3781c6e695.

Survey procedure

Data collection began in December 2022 after approval from each Ethics Committee. We distributed paper-based questionnaires at hospitals to eligible patients in inpatient and outpatient settings. Additionally, sites could distribute questionnaires by mail or collect data by phone. Regardless of the collection method, local research team members entered data into Qualtrics version 09.22. Data collection continued until the target sample size of 40 participants per country was reached or until the survey closed in May 2023.

Statistical analysis

Participants who completed only background questions or less than half of the TDF questionnaire were excluded. Among the 183 included participants, the overall missing response rate was low (1.45%) and assumed to be missing completely at random (MCAR); missing values were not imputed, and means were calculated from available data.

Appendix 2 maps instruments to the three target constructs and describes their use in the analysis. The rPATD and TDF-based items were rated on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree); negatively worded items were reverse-scored so that lower scores consistently reflected greater barriers. Responses were summarised using percentages, and means were used to compare items.

We conducted two mixed-effect ordinal logistic regression models to assess variables associated with willingness to reduce (model 1) or stop (model 2) BZRA use. The country was included as a random effect. Potential associated variables included background variables (age, sex, education, place of residency, duration and amount of BZRA intake,

previous attempts to stop) as confounders and TDF domains as explanatory variables, with domain scores computed as the average of their items. Variables with a *P*-value <.15 in the univariate analyses (see Appendix 7) were included in the multivariable model.

A *post hoc* power analysis using the 'popower' function (Hmisc package, R) indicated that with 183 participants and $\alpha = 0.05$, the study had 83% power to detect a proportional odds ratio of 2.2. Therefore, we emphasise effect sizes and confidence intervals rather than dichotomous statistical significance.

We also compared responses to TDF items based on patients' previous attempts to discontinue BZRA (never tried to reduce, reduced/reducing or failed) using the standardised mean difference.

All analyses were conducted in R (version 4.2.1) using the 'tidyr', 'ordinal' and 'Likert' packages. Statistical significance was set at $P < .05$.

We analysed responses to the open questions using NVivo version 14.23.2 (Lumivero). Two researchers (V.S. and P.E.) trained in TDF coding independently coded answers into the TDF framework. All disagreements were resolved through consultation with a senior researcher (A.S.).

Patient and public involvement

A Patient Partnership Advisory Council (PAC) was established to represent patients and caregivers in the BE-SAFE project. Each participating country has a local PAC composed of approximately five members—patients, caregivers or patient advocates interested in BZRA discontinuation.

For this study, a PAC member in each country reviewed the draft patient questionnaire and consent form before pilot testing with other older adults. Their feedback improved the clarity of the questionnaire instructions and items for the target population. In addition, one PAC member reviewed the current manuscript.

Results

Participant characteristics

The final sample consisted of 183 older adults: 41 (22.4%) participants from Belgium, 40 (21.9%) from Switzerland, 34 (18.6%) from Greece, 32 (17.5%) from Spain, 29 (15.8%) from Poland and seven (3.8%) from Norway. Nearly half of the respondents, 78 (42.6%), were aged 65–74, and the majority were women, 124 (67.8%). Most participants, 113 (61.7%), reported taking six or more medications daily, and 39 (21.3%) reported taking more than one BZRA. Regarding previous attempts to discontinue BZRA, 67 (36.6%) participants never tried to stop their BZRA, 67 (36.6%) tried but returned to the initial dose, and 39 (21.3%) had reduced or were reducing their BZRA at the time of the survey.

More details are presented in Table 1.

Table 1. Background characteristics of surveyed participants

Characteristics	Total (*N* = 183) *n* (%)
Country	
Belgium	41 (22.4)
Greece	34 (18.6)
Norway	7 (3.8)
Poland	29 (15.8)
Spain	32 (17.5)
Switzerland	40 (21.9)
Age, y[a]	
65–74	78 (42.6)
75–84	66 (36.1)
≥85	38 (20.8)
Gender[b]	
Men	52 (28.4)
Women	124 (67.8)
Other	2 (1.1)
Education	
Never been to school	19 (10.4)
Primary education	46 (25.1)
Secondary education	61 (33.3)
Higher education	57 (31.1)
Place of residence[c]	
At home alone	62 (33.9)
At home with someone else	105 (57.4)
Other[g]	12 (6.6)
Health condition: self-reported[d]	
Excellent	19 (10.4)
Good	54 (29.5)
Fair	65 (35.5)
Bad	42 (23.0)
Number of medications taken daily[e]	
2–5	62 (33.9)
≥6–9	76 (41.5)
≥10	37 (20.2)
Number of BZRA taken daily[c]	
1	140 (76.5)
2	23 (12.6)
≥3	16 (8.7)
Duration of BZRA intake[f]	
<1 year	23 (12.6)
≥1 year	153 (83.6)
Previous attempts to discontinue BZRA[c]	
Never tried	67 (36.6)
Tried, but returned to the previous dose	67 (36.6)
Tried, and reducing now	18 (9.8)
Reduced but still taking it	21 (11.5)
Other	6 (3.3)

[a]1 missing value (0.5%), [b]5 missing values (2.7%), [c]4 missing values (2.2%), [d]3 missing values (1.6%), [e]8 missing values (4.4%), [f]7 missing values (3.8%), [g]8—lived in a nursing home; 4—undefined.

Barriers to discontinuing BZRA

Items in the TDF domains of Knowledge, Goals and Intentions scored higher than items in other domains: 59.1% and 42.7% of respondents expressed willingness to reduce their BZRA, if their doctor recommended it (Intentions), 49.2% reported knowing why to consider stopping their BZRA (Knowledge) and 53.9% indicated that their goal is no longer to need BZRA (Goals).

However, 75.9% reported satisfaction with their BZRA (Beliefs about Consequences), 71.5% stated that they had

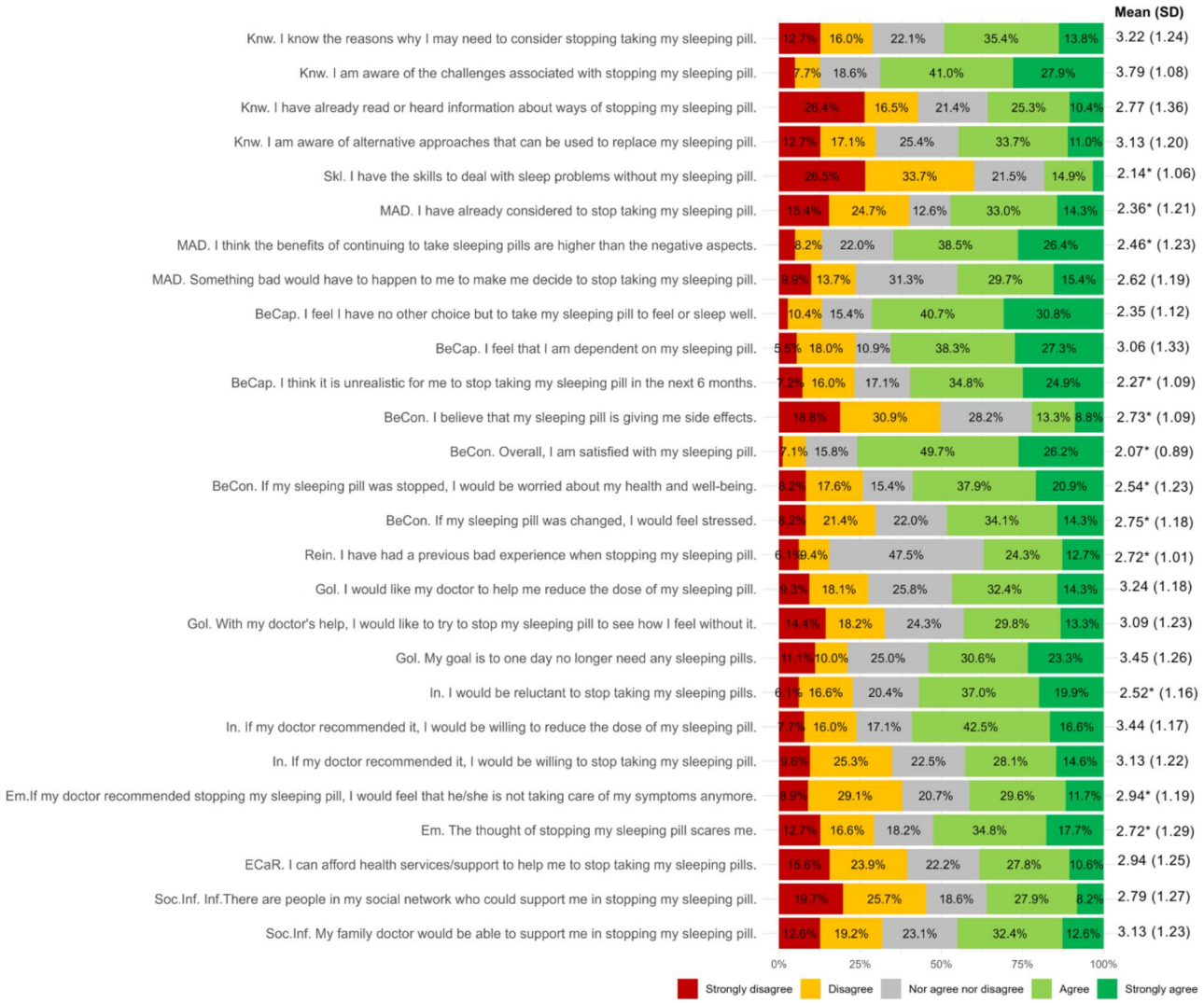

Figure 1. Participants' answers to the TDF-based questionnaire items. *Reversed scorings; SD, standard deviation; items are measured on a five-point Likert scale from 1 ('Strongly disagree') to 5 ('Strongly agree') *TDF domains:* Knw., Knowledge; Skl., Skills; MAD, Memory, Attention and Decision Processes; BeCap., Beliefs about Capabilities; BeCon., Beliefs about Consequences; Rein., Reinforcement; Gol., Goals; In., Intentions; Em., Emotion; ECaR, Environmental Context and Resources; Soc.Inf., Social Influences.

no choice but to take a sleeping pill to sleep well (Beliefs about Capabilities) and only 22.1% believed their BZRA caused side effects (Beliefs about Consequences). Additionally, 64.9% felt benefits of continuing BZRA outweighed harms (Memory, Attention and Decision Processes), 18.2% reported that they have the skills to manage sleep without medication (Skills), 35.7% had read or heard information about BZRA discontinuation (Knowledge) and 36.1% could identify people in their network who could help them discontinue BZRA (Social influences).

More details are in Figure 1.

Subgroup analysis according to the previous attempt to stop BZRA

Figure 2 illustrates the trends observed across the three predefined subgroups. Standardised mean differences show that participants who failed to reduce or never tried have lower means than those who reduced or are currently reducing in the following domains: Memory, Attention and Decision Processes; Beliefs about Consequences; Goals; Intentions; and Emotions.

Factors associated with willingness to reduce and stop BZRA intake

Several factors were significantly associated with participants' willingness to reduce BZRA intake (Table 2): Participants with primary education (OR, 0.27; 95% CI, 0.09–0.78) and those not living in their own home (OR, 0.18; 95% CI, 0.03–0.92) showed significantly lower odds of being willing to reduce BZRA (OR, 0.18; 95% CI, 0.03–0.92). Three TDF domains were associated with higher odds of

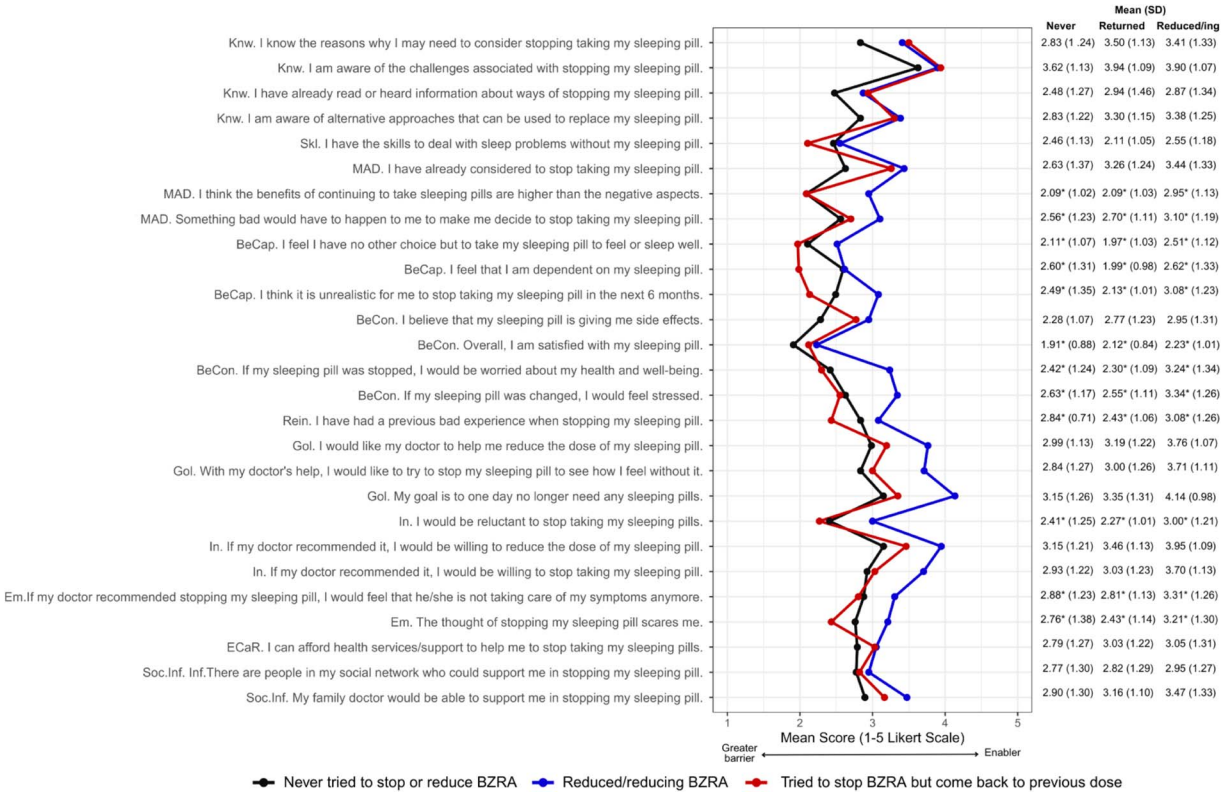

Figure 2. Participants' answers to the TDF-based questionnaire items according to the previous attempt to stop BZRA. *Reversed scoring; SD, standard deviation; Items are measured on a five-point Likert scale from 1 ('Strongly disagree') to 5 ('Strongly agree') TDF domains: Knw., Knowledge; Skl., Skills; MAD, Memory, Attention and Decision Processes; BeCap., Beliefs about Capabilities; BeCon., Beliefs about consequences; Rein., Reinforcement; Gol., Goals; In., Intentions; Em., Emotion; ECaR, Environmental Context and Resources; Soc.Inf., Social Influences.

participants' willingness to reduce BZRA intake: Goals (OR, 4.69; 95% CI, 2.95–7.45), Social Influences (OR, 2.60; 95% CI, 1.68–4.03) and Emotion (OR, 1.55; 95% CI, 1.00–2.40).

No background characteristics were associated with patients' willingness to stop BZRA. Four TDF domains were significantly associated with higher odds of being willing to stop BZRA: Goals (OR, 5.05; 95% CI, 3.06–8.36), Reinforcement (OR, 1.73, 95% CI, 1.15–2.61), Emotion (OR, 1.58; 95% CI, 1.00–2.51), Environmental context and resources (OR, 1.41, 95% CI, 1.01–1.97) and Social Influences (OR, 1.66; 95% CI, 1.11–2.47).

More details are in Table 2.

Open-ended responses

In the free-text answers, most participants expressed barriers falling under the Beliefs about Consequences domain. Older adults were convinced that they could not sleep without their sleeping pills and believed that, at their age, there was no point in discontinuing. Additionally, some participants were unaware of the harms associated with BZRA. Several participants expressed willingness to reduce or stop BZRA if their doctor provided a valid reason or helped them explore alternative approaches. Detailed citations are available in Appendix 6.

Discussion

Older adults face numerous barriers in BZRA discontinuation, with the lowest-rated items in Knowledge, Skills, Beliefs about Consequences, Beliefs about Capabilities and Emotion. Goals, Emotion and Social Influences were significantly associated with both a higher willingness to reduce or stop BZRA. These insights highlight key areas for developing a theory-driven intervention to support BZRA discontinuation.

Barriers and implications for interventions

The TDF enabled us to classify responses and identify where major barriers occurred—whether they stemmed from lack of awareness, contradictory beliefs about deprescribing or external factors such as negative social influence.

The proportion of patients willing to stop BZRA if recommended by their doctor (42.7%) was lower than the willingness to stop any medication reported in a recent meta-analysis (84%) [25]. This aligns with other studies showing

Table 2. Factors associated with 1) willingness to reduce BZRA and (2) willingness to stop BZRA in a multivariable, ordinal, logistic regression for patients (country as a random effect)

1) Willingness to reduce BZRA (*N* = 173)			
Variables	**ORs**	**95% CIs**	***P*-value**[a]
Background characteristics			
Age (reference 65–74)			
75–84	0.84	0.39–1.82	.66
85-more	0.96	0.36–2.55	.94
Education (reference 'Higher education')			
Never been to school	0.30	0.07–1.26	.10
Primary	**0.27**	**0.09–0.78**	**0.02**
Secondary	0.47	0.18–1.21	.12
Health condition: self-reported (reference 'Poor')			
Excellent	0.71	0.19–2.64	.61
Good	1.42	0.55–3.69	.47
Fair	2.18	0.84–5.64	.11
Residency (reference 'At home alone')			
At home, with someone else	0.52	0.24–1.09	.08
Other	**0.18**	**0.03–0.92**	**0.04**
Previous attempt to stop BZRA (reference 'Never tried')			
Returned to the previous dose	1.53	0.68–3.46	.31
Reduced/ing	1.54	0.55–4.34	.42
TDF-variable[b]			
Knowledge	0.95	0.58–1.55	.83
Skills	1.11	0.81–1.58	.48
Memory, attention and decision processing	0.70	0.38–1.32	.27
Beliefs about capabilities	0.85	0.38–1.32	.55
Beliefs about consequences	0.58	0.30–1.11	.10
Reinforcement	1.12	0.50–1.44	.59
Goals	**4.69**	**2.95–7.45**	**<.01**
Intentions	1.30	0.88–1.93	.19
Emotions	**1.55**	**1.00–2.40**	**0.05**
Environmental context and resources	0.98	0.71–1.35	.88
Social influence	**2.60**	**1.68–4.03**	**<.01**
2) Willingness to stop BZRA (*N* = 171)			
Background characteristics			
Sex			
Male	1.32	0.57–3.08	.52
Education (reference 'Higher education')			
Never been to school	1.52	0.26–8.85	.64
Primary	1.25	0.39–4.01	.71
Secondary	1.01	0.39–2.63	.98
Residency (reference 'At home alone')			
At home, with someone else	1.37	0.60–3.15	.45
In a nursing home	1.72	0.35–8.50	.50
Duration of BZRA intake (reference '< 1 year')			
More than a year	2.66	0.83–8.50	.10
Previous attempt to stop BZRA (reference 'Never tried')			
Returned to the previous dose	1.06	0.45–2.48	.90
Reduced/ing	1.01	0.33–3.12	.98
TDF-variable[b]			
Knowledge	1.36	0.83–2.22	.22
Skills	0.93	0.67–1.30	.69
Memory, attention and decision processing	0.85	0.44–1.65	.64
Beliefs about capabilities	1.59	0.93–2.75	.09
Beliefs about consequences	0.58	0.30–1.09	.09
Reinforcement	**1.73**	**1.15–2.61**	**<.01**
Goals	**5.05**	**3.06–8.36**	**<.01**
Intentions	1.54	1.00–2.36	.05[c]
Emotions	**1.58**	**1.00–2.51**	**.05**
Environmental context and resources	**1.41**	**1.01–1.97**	**.04**
Social influence	**1.66**	**1.11–2.47**	**.01**

[a]*P*-value < .05 was considered statistically significant. Text, highlighted in bold, indicates statistically significant associations. [b]TDF domains are summarised by averaging item scores**.** [c]The number is rounded, and the actual value is below 0.05.

that willingness to stop varies by type of medication [38]. Despite the greater reluctance, our findings offer compelling reasons for physicians to initiate conversations about BZRA discontinuation. First, more than half of older adults in our study would consider reducing BZRA use if advised by their doctor; clinicians may underestimate this willingness [39]. Second, our regression analysis showed that perceived support positively correlates with willingness to reduce or stop BZRA use. This echoes findings from qualitative studies, where a lack of support—summarised as 'I haven't discussed anything with anyone'—emerged as a major barrier [40–42]. Initial discussions might benefit from focusing on dose reduction rather than complete cessation, as patients may be more open to tapering.

Beyond physician support, perceived support from patients' social networks was also low, despite evidence highlighting its importance [43–45]. In the Sleepwell study [45], the authors suggested that the impact of the intervention on discontinuing BZRA may have been lowered by a lack of behaviour change techniques addressing social support. Future interventions should consider incorporating these elements, such as involving caregivers or leveraging the social support components of CBT-I. Additional resources (brochures, informational videos) could also be beneficial, since only one-third of participants had previously read or heard about stopping BZRA.

Our data suggest that even when patients understand BZRA harms, their willingness to stop is outweighed by beliefs in BZRA effectiveness and dependence. This tension reflects a conflict between reflective motivation, driven by conscious thought processes, and automatic motivation, which involves needs, impulses and reflex responses [46, 47]. In our regression analysis, willingness to stop was associated with TDF domains from reflective (i.e. Goals, Environmental context and resources) and automatic (i.e. Reinforcement, Emotion) processes. Therefore, interventions should target both. Increasing awareness of BZRA risks (used in EMPOWER, D-PRESCRIBE and Sleepwell [48–50]) may strengthen reflective motivation. However, strategies to address automatic processes such as habit and emotional reliance may have been underused and warrant further development.

Although exploratory, our data suggest that barriers differ by patients' prior discontinuation experience. Those who had attempted to reduce but returned to their initial dose showed similar patterns to those who had never tried. Conversely, patients who were currently reducing or had reduced successfully in the past displayed higher scores across several items and domains, indicating fewer perceived barriers. Interpretation is limited because item-wise tests would likely be underpowered and not representative of the whole domains. Domain-level or latent-score analyses would be appropriate in future work.

Strengths and limitations

This is the first multinational, multicentre, multi-language survey to assess patient-perceived barriers to discontinuing BZRA. Using a theoretical framework enabled a structured barriers' evaluation. Importantly, the association analysis between TDF domains and willingness to stop adds a novel and valuable perspective for informing intervention design. Previous studies have largely focused on sociodemographic predictors of willingness, with limited attention to underlying behavioural constructs. In parallel to the present survey, we also surveyed physicians, using a similar approach. Although the questionnaires differed, patients rated all TDF domains lower than physicians [26]. Ultimately, successful discontinuation requires physician involvement and targeted efforts to enhance patient education, motivation and emotional readiness. These findings were used to develop the BE-SAFE deprescribing intervention [51].

This study has several limitations. First, recruitment occurred in a limited number of hospitals and wards. The sample size was modest and lower than anticipated, and recruitment challenges at some sites resulted in an unbalanced distribution across countries. These factors may limit the power to detect differences between groups and reduce generalisability. Second, self-report bias is a recognised limitation of survey-based research. Third, we combined items from two validated questionnaires, each with inherent limitations, and did not conduct additional psychometric evaluation; however, this approach was considered a pragmatic solution. Additionally, items from Pétein et al. were not originally developed using the TDF and were mapped to the framework retrospectively. Fourth, the cross-sectional design precludes insight into how barriers may change over time or in response to intervention. This will be addressed in the upcoming BE-SAFE trial.

Conclusion

Approximately half of the participants understood the need to discontinue BZRA and were willing to reduce or stop use. This is encouraging given the high prevalence of BZRA use among older adults in Europe. However, barriers emerged across all TDF domains, involving both reflective and automatic behavioural processes. Interventions should therefore address this wide range of barriers to support discontinuation in older adults.

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Supplementary Data: Supplementary data are available at *Age and Ageing* online.

Declaration of Conflicts of Interest: None.

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Data Availability: The data dictionary and de-identified data are made available to others. The data dictionary for patients is accessible on the Open Science Framework (OSF) platform via the following link: https://osf.io/xu4h8/files/osfstorage/690dc46aeab562e3d5be2b19 The data can be obtained by contacting the researchers at vladyslav.shapoval@uclouvain.be or anne.spinewine@uclouvain.be. The data will be provided to anyone who requests it and specifies the purpose of their data analysis. There will be no restrictions on the type of analysis for which the data can be used, nor any other limitations on access.

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