

**Psychiatry · Educational evidence summary**

Anticholinergic burden in first-episode psychosis

This psychiatry article focuses on anticholinergic burden in first-episode psychosis.

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Capture the starting point while it is still recoverable

Near a first episode of psychosis, medication exposure and clinical state may both change quickly. A later review can become difficult if the record contains only the final regimen and a burden category. The distinctive opportunity is to document the starting point, the reason for each addition, and the timing of actual use so later concerns can be interpreted against a meaningful history.

This guide proposes a documentation approach. It does not claim that a first-episode-specific burden threshold has been validated, and it does not advise delaying treatment to obtain an untreated cognitive baseline. Clinical care takes priority; the record should state what information was realistically available.

Distinguish baseline information from retrospective reconstruction

If a symptom or functional concern was recorded before treatment, preserve that account with its date and source. If it is reconstructed later from memory, label it accordingly. Both can be useful, but they are not the same measurement. A retrospective description should not be presented as a standardized baseline test.

Likewise, record whether the initial medication history includes prior nonpsychiatric medicines or products used outside the formal care setting. “First episode” does not automatically mean no prior exposure to any relevant medication. The exposure definition must come from the history rather than the label of the episode.

Track why each addition occurred

Separate the primary treatment from medicines used for an acute symptom or another condition. Record the intended purpose, whether use is scheduled or occasional, and whether the indication is expected to be revisited. NICE’s psychosis guidance emphasizes documenting the therapeutic trial and the reasons for treatment decisions. [NICE CG178](#)

A timeline makes it easier to distinguish a medicine introduced in response to a symptom from one that preceded the symptom. It also prevents the final regimen from being treated as though every



component had been present throughout the episode. This is a basic requirement for fair causal interpretation.

Keep acute orders distinct from maintenance use

An admission order set may contain treatments that were never administered or were used only briefly. A discharge list may retain an occasional medicine whose later use is unknown. These records answer different questions. A review should identify which one supports the exposure description and avoid assuming continuity across them.

If the question concerns school, work, or concentration after discharge, current use and the relevant period of follow-up matter more than the mere existence of an earlier order. Where the history is incomplete, describe the uncertainty instead of filling the gap with a presumed daily frequency.

Use source classifications without changing their meaning

Look up the exact medication and retain source version, value, and missingness state. An ingredient-level category does not encode the person's age, dose, duration, or current illness phase unless the source method explicitly does so. Those clinical details should be documented alongside the category rather than inserted into new arithmetic.

A source disagreement can be reported honestly without resolving it into one value. The aim is to know what evidence is available, not to make a regimen appear to meet a target that has not been validated for early psychosis. Supplemental geriatric criteria do not become applicable simply because the same ingredient appears in a younger person's regimen.

Follow outcomes that matter to early recovery

Clinical follow-up may involve symptoms, treatment tolerability, participation, and practical goals. Record those outcomes separately. A source total is an exposure description, not a complete measure of recovery. A lower classification cannot establish that the person is functioning better, and improved functioning cannot establish that every medication concern has disappeared.

If cognition is assessed, preserve the instrument and testing conditions. A later score may reflect several changes, including the illness course and the conditions under which testing occurred. The burden category does not provide a correction factor for those differences.

What a later reviewer should be able to reconstruct

- The information available at the beginning of care and its source.
- When each medicine was introduced and the reason documented at the time.
- Which occasional medicines were actually used during the relevant period.
- Which outcomes were followed and whether they were measured consistently.
- Which source versions were used in the exposure summary.



Limits of extrapolation

The broader psychosis literature does not automatically establish the size of a causal anticholinergic effect in first-episode care. Treatment histories, populations, and timing differ. A careful timeline does not eliminate those limitations, but it prevents avoidable ambiguity and provides a firmer basis for future clinical discussion or a properly designed study.

References

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4. National Institute for Health and Care Excellence. Psychosis and schizophrenia in adults: prevention and management. CG178. Recommendations. [Source](#)

Explore the evidence

[Ask UnifiedACB](#) about a medication or source, browse the [Medication Library](#), or read the [methodology](#).

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Educational evidence summary. This content does not provide patient-specific medical advice and does not replace clinical judgment, medication reconciliation, or prescribing guidance.