

**Psychiatry · Educational evidence summary**

Anticholinergic burden in older adults with psychiatric illness

This psychiatry article focuses on anticholinergic burden in older adults with psychiatric illness.

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Two histories need to be visible

An older adult with psychiatric illness has both a psychiatric treatment history and a current medical context. A medication that helped maintain recovery may now be considered alongside changing function, additional conditions, or a more complicated regimen. An anticholinergic review is useful when it brings these histories together without reducing either to a score.

This article explains the role of source classifications and supplemental geriatric criteria in that discussion. It does not presume that every concern is medication-related or that a criterion determines a treatment decision. The central task is to state which evidence applies and what additional clinical information is needed.

The scale and the geriatric criterion answer different questions

A burden scale assigns a source-specific classification. The 2023 AGS Beers Criteria address potentially inappropriate medication use in older adults and include different types of criteria, some qualified by clinical context. The criterion should be read with those qualifications rather than treated as another ordinal scale. [AGS Beers Criteria, 2023](#)

On a medication page, the source-native observations should remain the primary evidence table. A supplemental geriatric panel can explain a relevant criterion, but it should not alter the original value or imply that the value itself was developed for the person's current situation. A medicine absent from the selected overlay has not thereby been shown safe.

Read the psychiatric history before judging the regimen

Document the reason each psychiatric medicine is used, the benefit observed, and the history of previous treatment changes. These facts matter because the burden table cannot estimate the consequence of altering an effective regimen. An adjunct's present role may need clarification, but uncertainty about its role should be recorded rather than replaced by an assumption that it has none.



It is also important to distinguish a medicine continued for a psychiatric indication from one used for another condition. The same ingredient may appear in more than one specialty's records. The review should identify the actual product and exposure, then assign responsibility for resolving any discrepancy.

Age is not a complete description of the person

An age category can determine whether a geriatric criterion is relevant, but it does not specify the person's cognitive status, function, current symptoms, or treatment priorities. Those need individual assessment. A source classification should not be used to infer frailty or incapacity from age alone.

Similarly, a finding from an older-adult study should be read with its population and outcome attached. A medication-cognition association is not automatically a prediction of falls, delirium, or loss of independence in a particular person. Each outcome requires evidence and an appropriate clinical context.

Reconcile the whole regimen across care settings

A psychiatric medication list may omit medicines prescribed for bladder, gastrointestinal, allergy, sleep, or other concerns. Include the relevant current products and actual occasional use. Retain route and formulation where known. A complete ingredient list is a starting point; the use pattern and treatment purpose still matter.

When the person has recently moved between care settings, distinguish the current regimen from old orders. A change in a source total may reflect reconciliation rather than altered exposure. Report that distinction so that a later reviewer does not mistake improved documentation for an intervention effect.

Let the clinical question determine the clarification

If a criterion depends on dose, route, indication, or a condition, ask for the detail that would change applicability. An ingredient-level tag should not be treated as a completed clinical assessment. For example, an unknown total daily dose should remain unknown until clarified; the tool should not infer it from a brand or a usual-use assumption.

The concern prompting review should also be explicit. An account of what changed and when is more useful than "high burden in an older patient." That account can include competing explanations and the person's own priorities, giving the prescribing team a basis for deciding what deserves further assessment.

What a balanced review can conclude

The review may identify a source-supported concern while also recognizing a substantial treatment benefit. It may conclude that more history is needed before interpreting a criterion. It may correct an obsolete medicine entry without changing treatment. Each is a legitimate outcome when accurately described.



If the team changes the care plan, follow the clinical concern and the treatment goal separately. A lower source category does not itself prove improved function or preserved psychiatric stability. Those outcomes should be observed rather than assumed.

Continuity can be especially useful when a new clinician sees a long-standing regimen without its original rationale. The record should explain what benefit has been maintained, which previous changes were unsuccessful, and which current concern is being investigated. Those facts do not exempt a medicine from review. They define the decision that review must inform and prevent a newly visible classification from being mistaken for newly discovered evidence that the entire treatment history was inappropriate.

Limits

This article does not convert geriatric criteria into a psychiatric treatment algorithm. It does not establish that the magnitude of an association in one age group applies to every older adult. The useful output is a treatment-aware, criterion-specific evidence summary whose uncertainty remains visible.

References

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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.