

**Psychiatry · Educational evidence summary**

Anticholinergic burden and adherence complexity

This psychiatry article focuses on anticholinergic burden and adherence complexity.

UnifiedACB · Published October 3, 2026 · Updated October 4, 2026

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A question about taking medicine is not just a question about pharmacology

When someone finds a regimen difficult to follow, an anticholinergic review may reveal a concern worth discussing. It cannot establish why doses are missed or whether the prescribed regimen describes actual exposure. These questions examine the boundary between a medication classification and a person's experience of taking treatment.

Is a high burden category an adherence score?

No. It does not measure whether medicines are taken, whether instructions are understood, or whether products are available. A prescription-based classification describes a proposed regimen unless actual use has been established. It should not be presented as a measurement of adherence.

The distinction works in both directions. A low classification does not establish that a regimen is easy to follow, while a high classification does not establish that the person is taking it inconsistently. The history must answer those questions separately.

Can unwanted experiences affect willingness to continue treatment?

They can be relevant to the discussion, but the person's own explanation is needed. A clinician should not assume that an anticholinergic category is the reason for difficulty when the person identifies another problem. NICE's psychosis guidance places the person's experience and tolerability preferences within the treatment discussion. [NICE CG178](#)

A useful question asks which part of the regimen is difficult and why. The answer might concern the effects experienced, the schedule, remembering instructions, access, or another issue. The source table cannot infer those reasons from the ingredient names.



Does a complex regimen necessarily have high anticholinergic exposure?

The number of products and their source classifications are different descriptions. Several medicines may create a complicated schedule without each being assigned a high category. One strongly classified contributor may matter to the exposure review while the schedule itself is simple.

Keep both descriptions if they are useful: how the regimen is organized and what each source reports. Combining them into a new “complexity burden” number would require a separate, defined method and evidence. UnifiedACB does not create that measure.

What if the prescription record and actual use disagree?

Record both and clarify the relevant time period. An order can remain active after the person stops using it, or an occasional product can be used more often than the record suggests. Those discrepancies change the exposure question and should not be hidden by an apparently precise total.

Avoid describing uncertainty as nonadherence without context. A discrepancy may reflect unclear instructions, an outdated list, a change made by another clinician, or another explanation. The review should establish the facts before assigning a label to the person’s behavior.

Can simplifying the list prove an anticholinergic benefit?

A simpler regimen and a lower source-specific total are separate outcomes. A simplification may help the routine without changing the anticholinergic classification. A lower total may occur without addressing the difficulty the person identified. Follow the actual goal rather than assuming that all forms of improvement move together.

If a clinical team makes a change, document what was changed and why. A later improvement in taking treatment should be described as an observed outcome, not automatically attributed to an anticholinergic mechanism. Other aspects of the intervention may have mattered.

Which source details belong in the review?

Keep the exact medicine, formulation, source version, and evidence state. A medication missing from a source remains missing; it cannot be assigned zero merely because completing the calculation would be convenient. Separate any geriatric criterion from the scale observations.

Those details make the evidence traceable. They also show when a change in the summary resulted from a corrected identity or source update rather than from different medication use.

What is the useful next step?

Identify the practical problem in the person’s own terms, reconcile actual use, and bring the source evidence to the clinician responsible for the regimen. Choose a follow-up outcome that matches the



problem: understanding the schedule, resolving an access issue, or reassessing an unwanted experience, for example.

The limitation is central: the cited cognition literature does not validate anticholinergic burden as an adherence predictor. A medication review can be helpful without claiming that one pharmacologic category explains every difficulty in following treatment.

References

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Explore the evidence

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

Disclosure

Funding: None. Conflict of interest: None declared for the UnifiedACB educational project.

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