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Anticholinergic burden in older psychiatric inpatients

Dear Sir

Lee et al.[1] reported a study to explore the prescribing patterns in a geriatric psychiatric inpatient unit and found that anticholinergic burden of medication was rarely considered. Also, from admission to discharge, the proportion of patients on any anticholinergic medication increased. Furthermore, only 10% of patients were free of anticholinergic medication upon discharge. These findings highlighted some points with implications for clinical practice.

First, older patients are more vulnerable to anticholinergic burden. Quality of care has several dimensions, including safety, effectiveness, and efficiency.[2] As the authors pointed out, 'there were no evidence of anticholinergic burden review in the form of electronic documentation,' future studies should evaluate the utility of incorporating an anticholinergic medication scale as part of the electronic health record. Reviewing such red flags may improve the quality of care and prevent iatrogenic complications amongst older inpatients.

Second, Lee et al.[1] found that the proportion of patients on at least one anticholinergic medication increased from admission to discharge, and suggested that clinicians should be vigilant when prescribing anticholinergic medications to older psychiatric patients. Past studies additionally pointed out that multidisciplinary teams utilizing interdisciplinary geriatric psychiatric and medicine care teams may decrease overuse of inappropriate medications in the elderly, including anticholinergic medications.[3-5] As such, quality care requires a multidisciplinary approach for older patients.

Third, polypharmacy is recognized as a major contributor to anticholinergic burden, and is associated with functional decline.[4] The current study demonstrated that a majority of older patients at discharge suffered from definitive anticholinergic burden.[1] Since older psychiatric patients are frequently treated with anticholinergic medications, clinicians should monitor the anticholinergic burden carefully as a potential risk factor for decline in daily functioning.

Anticholinergic burden may cause psychiatric exacerbations and decline in functioning. The present study provided insight into the frequency and nature of anticholinergic burden in hospitalized older mental health inpatients. Clinicians should respond to the question raised by the authors, 'do we care [about anticholinergic burden],' with a resounding yes. Since older psychiatric inpatients have increased sensitivity to anticholinergic burden, clinicians should further explore the use of technology and interdisciplinary teams to improve the quality of care provided to this vulnerable population.

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Enabling interagency collaboration in providing comprehensive mental health care: the rise of the care coordinator

Dear Sir

Individuals with severe and persistent mental illness (SPMI) have multiple needs such as support to access general medical services, housing, community and domiciliary services, and employment services.[1] Recovery can be achieved only when all or most of these needs are met. Case managers tend not to have the time to support the non-clinical needs of their clients.[2]

Multiple needs of individuals with SPMI can be addressed by interagency collaboration, which has shown to have better outcomes for clients and services.[1] However, barriers such as competition for funding, conflicts related to areas of responsibility and integration strategies make collaborative efforts quite challenging.[1] As a result, individuals

with SPMI do not receive the support they need and eventually fall through the cracks in the system.

The care coordination role of the support facilitator (SF) designed as part of the Partners in Recovery (PIR) initiative appears to provide a solution to enable interagency collaboration.[2] In the PIR initiative, the SF serves as a single point of contact for all the different services supporting the client. With a focus on recovery and patient-centred care, the SF coordinates a care team made up of representatives from each service that could meet the different needs of the client. According to a care plan developed by the client and the care team, each service provider takes responsibility to deliver their component of the plan.[3] In this way, different agencies are able to collaborate without the challenges described above.

This model of care is recommended by both service providers and clients. Advantages highlighted by services include that an unmet need has been addressed and that there is a team approach to patient care with no duplication of services.[3] Apart from better access to services, clients report feeling valued and having more confidence in managing their illness as well as improved hope and better quality of life.

The care coordination role could hence be a possible solution to overcoming the barriers to interagency collaboration for the benefit of individuals with SPMI.

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