

COMMENT

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Bedlam Revisited and Social Care Hell

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Abstract

The long-term use of psychotropic medication in community mental health care raises important public health questions regarding patient safety, governance, and accountability. This paper presents a case-based analysis of potential iatrogenic harm arising at the intersection of mental health services and adult social care in England. Using the long-term experience of an older woman exposed to prolonged neuroleptic treatment and subsequent residential placement, the paper examines how diagnostic uncertainty, risk-based psychiatric practice, and commissioning-driven social care systems can interact to produce avoidable dependency, functional decline, and loss of autonomy. Drawing on contemporary psychiatric, neurological, and policy literature, the analysis situates this experience within wider structural challenges. These include the continuing absence of definitive biological markers for many psychiatric diagnoses, the recognised neurological risks associated with prolonged dopamine-blocking medication, and the organisational and financial pressures that shape modern health and social care provision. The cases suggest that adverse outcomes may emerge not solely from individual clinical decisions but from structural features of care delivery, including fragmented oversight between clinical services and social care commissioning. The paper argues that current frameworks can, at times, prioritise institutional risk management over patient-centred recovery. It concludes that stronger governance mechanisms—particularly clearer review structures, improved informed consent processes, and greater transparency at the mental health–social care interface—may be required to reduce the risk of long-term medication-related harm.

Keywords Long-term psychotropic medication, Medication-induced parkinsonism, Deprescribing

1 Part 1: Jean's medication history, withdrawal, and continuing clinical consequences

Jean: Patient (late 70s).

Steven: Husband, former carer, and narrator (mid-80s).

1.1 Introduction

Jean was first prescribed psychotropic medication in 2005. We contend that, over the years that followed, and particularly between April 2008 and November 2017, this pre-scribing became excessive and insufficiently reviewed. On 24 December 2019, after a



structured two-year tapering programme, Jean took her final dose. What follows is an account of her journey from first prescription to withdrawal, and of the continuing consequences and questions that remain.

1.2 Bedlam revisited?

“Bedlam”, the historic name associated with Bethlem Hospital, evokes images of coercion, institutional neglect, and mistreatment. Mental healthcare has changed profoundly since that period. Yet a difficult question remains: have older forms of physical restraint been fully left behind, or have they sometimes been replaced by quieter forms of chemical containment, particularly where mental health services intersect with social care and where integrated, person-centred support is difficult to secure?

1.3 Purpose and evidential basis of the case account

This de-identified case account draws on the lived experiences of Jean and Steven. It is supported, where possible, by contemporaneous clinical correspondence and relevant published research.

It does not claim to offer a universal explanation or a single solution. Its purpose is more limited: to document lived experience, identify systemic vulnerabilities, and encourage reflection among clinicians, commissioners, and oversight bodies.

The analysis is placed in the context of literature raising concerns about the long-term consequences of prolonged psychotropic medication exposure, inconsistent medication review, and limited access to adequately resourced non-pharmacological alternatives.

1.4 Clinical background and systemic vulnerabilities

Jean’s first diagnosed episode of bipolar mania in 2005 appears likely to have been precipitated by bereavement and the reactivation of earlier trauma. Her subsequent clinical course included several points at which systemic vulnerabilities may have influenced outcomes.

Between April 2008 and November 2017, neuroleptic and antidepressant medication were prescribed over an extended period without clearly documented evidence of regular, structured annual review. There also appears to have been limited documented discussion of the potential cumulative risks associated with long-term treatment, raising questions about the adequacy of informed consent over time.

Care was fragmented across multiple services. Neurology, psychiatry, primary care, and other clinical providers did not consistently share or integrate information. This contributed to discontinuities in care and made emerging symptoms harder to interpret.

1.5 Pharmacological mechanism: drug–drug conditioning and neurobiological adaptation

Jean’s long-term exposure, from approximately 2005 to 2019, to combined citalopram, a selective serotonin reuptake inhibitor, and olanzapine, an atypical antipsychotic, invites careful consideration through the framework of drug–drug conditioning.

Experimental work by Sparkman and Li [1] examined drug–drug conditioning between citalopram and two antipsychotics: haloperidol and olanzapine. Of relevance to Jean’s case, one of the combinations studied was citalopram and olanzapine, the same combination to which Jean was exposed for many years.

Their findings suggested that, when citalopram is repeatedly co-administered with olanzapine, citalopram may acquire conditioned properties associated with the behavioural effects of olanzapine. Through associative learning mechanisms, the central nervous system may begin to link one medication with the effects of the other.

Over time, such pairing may contribute to an adapted neurochemical state in which the medicines no longer function as entirely separate pharmacological variables. Instead, they may operate as components of an interacting system. Applied cautiously, this framework may help explain why long-term psychotropic combinations can become difficult to reduce or withdraw, particularly where exposure has continued for many years.

Experimental conditioning models cannot be assumed to translate directly into human clinical polypharmacy. However, they provide a biologically plausible framework for understanding how long-term co-administration of psychotropic medication may produce adaptive neurochemical states that complicate withdrawal and treatment response.

1.6 Clinical case review: Jean (2005–2025)

Context: Jean's clinical history involved long-term psychotropic polypharmacy, subsequent withdrawal, adverse events, and systemic communication failures. The chronology below should be read in light of the pharmacological interaction mechanism discussed above.

1. *Initial diagnosis and transfer to primary care (2005–2008)*

Jean was diagnosed with bipolar disorder in 2005 and treated within the Mental Health Trust until April 2008. At that point, she was discharged to her GP, with prescribing responsibility transferred to primary care. Approximately one month later, the GP increased the olanzapine dosage by roughly one third without re-referral to secondary care, despite the discharge correspondence suggesting that significant medication changes would normally involve specialist oversight.

A related issue emerged in February 2006, when the Trust responded to Jean's concern about possible "addiction to olanzapine." The reply stated that she was "not getting addicted" because there was "no increase in tolerance." This framed addiction narrowly in terms of craving or dose escalation, and did not address the possibility of physiological dependence or withdrawal phenomena associated with long-term neuroadaptation.

2. *Prolonged polypharmacy and emerging concerns (2008–2017)*

Between April 2008 and November 2017, Jean remained on combined olanzapine and citalopram. During this nine-year period, there is no documented evidence of regular, structured annual medication review.

In August 2017, a referral to a memory clinic confirmed that Jean's cognitive function remained intact, while also recording concern that she appeared markedly over-sedated on the olanzapine–citalopram regimen. Only at this stage were side-effect profiles discussed in detail and a supervised tapering plan agreed.

3. *Tapering, medication changes, and adverse events (2018–2019)*

Citalopram, prescribed at 40 mg daily for many years, was tapered first and discontinued by August 2018. A more accelerated medication transition then followed, involving the introduction of lamotrigine and quetiapine while olanzapine was withdrawn.

Jean reports that the specific initiation risks associated with lamotrigine, including possible behavioural disturbance or suicidality, were not fully explained.

In June and July 2019, Jean was hospitalised following two impulsive overdoses. Jean maintains that these events did not involve conscious suicidal intent. One possible interpretation is that they reflected behavioural dysregulation associated with disruption of a long-conditioned neurochemical state, consistent with the pharmacological mechanism discussed above. This interpretation cannot be proved retrospectively, but it is relevant to understanding the risks of accelerated medication change after prolonged polypharmacy.

4. Neurological complications and discontinuation (2019–2020)

In late 2019, an optometrist identified raised intra-ocular pressure and reduced visual acuity. Jean's symptoms temporarily improved following medication discontinuation, although she was later diagnosed, in 2022, with bilateral open-angle glaucoma.

In January 2020, an urgent care physician documented “advanced stages of medication-induced Parkinsonism” and advised cessation of neuroleptic medication. Jean and Steven report that this diagnosis was not clearly communicated to them by the GP practice, nor relayed to the Mental Health Trust.

Despite ongoing neurological symptoms, Jean's decision to remain off psychotropic medication was characterised by a specialist psychiatrist as “unwise,” with lithium suggested as an alternative. Jean declined lithium and was discharged to GP care on 24 January 2020.

5. Post-discontinuation course and system response (2020–2025)

Following her final psychotropic dose on 24 December 2019, after a medically supervised tapering process, Jean experienced a rapid onset of severe physical and mental-health symptoms, described by the family as arriving “like a tsunami”. These included tremor, insomnia, mood instability, temperature dysfunction, and wider neurological and autonomic disturbance. Some symptoms persisted for years, with others emerging later.

This pattern is consistent with the possibility of acute and persistent withdrawal phenomena following the reduction, discontinuation, or switching of psychotropic medication. Cosci and Chouinard [2] describe withdrawal reactions following dose reduction, discontinuation, or switching across psychotropic drug classes, including persistent post-withdrawal disorders associated with neuroleptic medication. More recent survey evidence from 585 people attempting to withdraw from antipsychotic medication also reported a high frequency of withdrawal effects, including symptoms such as insomnia, nervousness, tremor, anxiety, agitation and other physical and psychological effects [3].

A second-opinion psychiatric review in August 2021 found no evidence of active mood disorder or psychosis and recommended a multidisciplinary meeting involving all professionals involved in Jean's care. No such meeting subsequently occurred.

As of December 2025, six years after medication discontinuation, Jean has remained free of psychotropic medication and has experienced no recurrence of a diagnosed manic episode. This prolonged stability raises retrospective questions about the necessity, proportionality, and duration of the preceding pharmacological regimen.

1.7 NHS institutional response and complaint handling (2019–2023)

Concerns about prolonged psychotropic prescribing and possible medication-related harm were formally raised with the Trust during 2019. A complaint submitted to PALS on 27 August 2019 questioned whether the risks associated with long-term neuroleptic

treatment — including dependency, withdrawal phenomena, and drug-induced parkinsonism — had ever been adequately explained, reviewed, or incorporated into Jean's care planning.

Rather than triggering a clear clinical reconsideration, the complaint appears to have circulated between several internal services over an extended period. Trust records indicate that it passed through multiple administrative routes, including referral to dementia-related pathways, before an operations manager eventually agreed, on 15 October 2019, that a response would be provided. That response was not issued until 17 March 2020.

A Trust meeting held on 24 February 2020 was presented as an opportunity to address both historical concerns and future care planning. Jean was too unwell to attend, and Steven attended in her place. In Steven's account, however, the meeting appeared to function less as a forward-looking clinical review than as a means of consolidating delayed complaints and formalising the Trust's retrospective position.

That impression was reinforced by the Trust's subsequent letter of 17 March 2020, which attributed Jean's 2019 overdoses primarily to "stresses at home" and factors described as "of a social nature", while placing less weight on possible medication-related explanations. Steven regarded this as part of a recurring pattern in which clinical and pharmacological concerns were reframed within a social-context narrative, thereby reducing the likelihood of substantive medical review.

Concerns about inappropriate administrative framing arose again after Jean's discharge from hospital on 30 December 2022. Although the discharge documentation recorded "Formal diagnosis of dementia: NO" and "Increased forgetfulness in last 12 months: NO", Jean was subsequently contacted by Age UK's Dementia & Me service following discussion at a Primary Care Network hub. She declined the approach. Steven was later also contacted in relation to the same dementia service, despite there being no formal diagnosis of dementia in his case and no evidence-based cognitive assessment having been discussed with him.

Subsequent correspondence from the Primary Care Network in June 2023 referred to a "miscommunication" and included a hub note querying whether Steven himself had a formal diagnosis. To the family, this episode did not appear to be an isolated administrative error, but part of a wider pattern in which concerns were misclassified, redirected, or procedurally managed without adequate clinical foundation.

The family remained concerned that inaccurate dementia-related framing, and associated characterisations of Steven's conduct, could have lasting implications for future interactions with health and social care services. Taken together, these events gave the family the impression that complaint handling operated less as a route to substantive clinical review than as a process of administrative containment.

1.8 Language of sedation and its implications

During several consultations, the consultant psychiatrist used the phrase "to calm down" when describing the therapeutic effect of neuroleptic medication. For many years, however, Jean was prescribed both citalopram and olanzapine, a combination that may produce significant sedative effects and, according to Sparkman and Li [1], a cumulative sedative burden greater than would be expected from either drug considered alone.

In Jean and Steven's view, the phrase "to calm down" risks reducing a complex pharmacological intervention — one capable of producing neurological, metabolic, cognitive, and systemic effects — to a reassuring shorthand. Such language may obscure the cumulative risks associated with long-term exposure, particularly where medication is continued over many years without a clearly documented recovery pathway, structured review, or sustained consideration of alternatives. Their lived experience, together with the clinical and academic literature cited in this report, suggests a considerably more complex and clinically consequential reality than the phrase "to calm down" conveys.

Anticholinergic Burden and Long-Term Risk.

As outlined earlier in this report, Jean was prescribed the neuroleptic olanzapine together with the antidepressant citalopram from approximately April/May 2008 until November 2017. The available records do not demonstrate consistent annual dosage review, nor do they show regular documented discussion with Jean of the risks, benefits, and alternatives associated with continued treatment in a manner consistent with informed consent.

Olanzapine is recognised in published Anticholinergic Cognitive Burden scoring as a medication with significant anticholinergic properties. Although citalopram does not appear as an anticholinergic medication on the foundational 2012 ACB list, some later or alternative anticholinergic burden tools classify it as having possible or low-potency anticholinergic activity. For that reason, citalopram is best treated here not as the primary driver of anticholinergic burden, but as a possible additional contributor within a wider cumulative medication profile.

Anticholinergic medicines inhibit acetylcholine signalling within the central and peripheral nervous systems. In older adults, cumulative exposure to medicines with anticholinergic properties has been associated with adverse cognitive, neurological, and systemic outcomes, including confusion, sedation, falls, cognitive impairment, delirium, and increased mortality.

Cumulative exposure is commonly assessed using instruments such as the Anticholinergic Cognitive Burden scale, which estimates the combined anticholinergic effect of multiple medications. In a study of 13,004 people aged over 65, Fox et al. [4] found that 20% of those with an ACB score of four or more had died by the end of the two-year study period, compared with 7% of those with a score of zero. They also reported that each additional ACB point was associated with a 26% increase in the odds of dying.

While such findings demonstrate association rather than causation, they indicate that cumulative anticholinergic exposure is clinically significant in older populations and should form part of regular medication review. Based on published ACB scoring criteria, olanzapine alone would have contributed a substantial anticholinergic burden. Any additional medicines with anticholinergic or sedative properties would have increased Jean's overall exposure, particularly during periods of medication transition.

Jean discontinued all neuroleptic and antidepressant medication by Christmas 2019, following a gradual supervised taper. The discontinuation phase was associated with acute withdrawal symptoms, some of which, in Jean's experience, were followed by persistent functional effects that have continued to the present.

1.9 Synthesis — part 1

Part 1 has traced Jean's medication history from first prescription in 2005 through prolonged psychotropic exposure, tapering, discontinuation, and the continuing consequences that followed. The central concern is not that psychotropic medication was used at all. Medication may be necessary, beneficial, and at times protective. The concern is that, over time, treatment appears to have become insufficiently reviewed, insufficiently explained, and insufficiently integrated with a wider plan for recovery, function, and non-pharmacological support.

Jean's experience raises questions about what happens when long-term prescribing becomes the default architecture of care. The absence of regular structured review, the limited documented discussion of cumulative risk, the language of "calming down," and the later difficulty of interpreting withdrawal, neurological symptoms, and autonomic disturbance all point to the same underlying vulnerability: medication may continue to be treated as stability even when the person's functional health is deteriorating.

The evidence discussed in this section does not prove a single causal explanation for every later symptom. It does, however, make it difficult to dismiss the possibility that prolonged psychotropic exposure, accelerated medication change, withdrawal phenomena, anticholinergic burden, and fragmented clinical ownership contributed to Jean's subsequent condition. The lasting question is therefore one of proportionality: whether the duration, intensity, and review of the medication regime remained justified considering its cumulative risks and consequences.

Part 2 considers what happened when these unresolved clinical questions moved into a wider system of inter-county relocation, social-care assessment, hospital discharge, and multi-agency referral. The issue then became not only what medication had done, but how health and social care systems responded when Jean and Steven sought recognition, explanation, and an integrated medical care plan.

2 Part 2: Inter-county relocation and the persistence of unmet need

2.1 Second opinion and inter-county relocation

On 24 August 2021, Jean travelled to Surrey for an out-of-area appointment with Psychiatrist F of Mental Health Trust 2. The appointment had finally been arranged by her GP practice after repeated representations by Jean and was much appreciated by both.

Following the appointment, Psychiatrist F wrote to Jean's GP on 7 September 2021. Under the heading "Impression", she stated:

"There was no evidence of overt mood disorder, psychosis, or gross cognitive impairment in [Mrs A] despite her not being on any psychotropic medication..."

Under the heading "Recommendation", she stated:

"Because Jean is unhappy that there has been no clear care plan put in place for her treatment (a view shared by her husband), I suggested that there should be a meeting of all professionals involved in [Mrs A] care to agree a care plan which will address her physical and mental health requirements..."

Jean and Steven's meeting with Psychiatrist F had been arranged by her GP as a second-opinion appointment only. No further appointments were planned or granted by

the Mental Health Trust 2. More importantly, no multi-professional meeting took place because of Psychiatrist F's recommendation, and no agreed care plan emerged from it.

2.2 After the move: Continuing unmet need

Jean and Steven relocated to a neighbouring county in December 2021. They did so with the expectation that Jean's complex and interrelated mental and physical health needs would be reassessed, and that an integrated care plan might finally be developed.

In the previous county, despite repeated requests over approximately five years, no co-produced care plan had been agreed. The relocation therefore carried the hope that a more coordinated approach might be possible.

Jean attended her first appointment with a consultant psychiatrist at the local hospital on 11 March 2022, accompanied by Steven. In a letter to Jean's GP dated 23 May 2022, the psychiatrist recorded that Jean reported no relapse in her mental health and that Steven agreed. Steven's position was more qualified. Although Jean had not experienced a psychotic relapse, he did not consider her to be in good mental or physical health.

Between March 2022 and September 2023, a Community Psychiatric Nurse made several visits to the family home. During one discussion, Steven recalls that a question was framed as, "You do not have mood swings, do you?" He felt that this risked minimising Jean's reported experiences rather than exploring them.

Jean's second consultation with the consultant psychiatrist took place on 20 September 2023. Jean and Steven had expected the appointment to address an integrated assessment of her mental and physical health needs, with a view to supporting a future care plan. Instead, they were informed that secondary mental health services would be withdrawn.

In a letter to the GP dated 22 September 2023, the psychiatrist referred to a "management plan" rather than a "mental health care plan" and emphasised Jean's physical and social care needs. Steven considered that specialist mental health services were withdrawn without an agreed alternative framework of support, despite Jean's continuing clinical complexity.

2.3 Hospital admission: October-December 2022

Jean was admitted to hospital from 20 October 2022, via A&E, until 30 December 2022, initially following a fall and a period of general unwellness.

On 21 October, after remaining overnight in A&E, Jean telephoned Steven and asked him to attend. She reported that a nurse had, on more than one occasion, insisted that she take citalopram and olanzapine, medications that had been discontinued on 24 December 2019 following a structured two-year taper. Steven raised the matter with the duty A&E doctor, who amended the medical record. A hospital pharmacist subsequently reviewed and corrected the medication history. Despite this correction, Jean remained concerned that other NHS records, particularly following her inter-county relocation, might still contain outdated or misaligned prescribing information.

2.4 Common-interest meeting and communication failure

Prior to Jean's intended discharge, Steven requested a separate discussion with the neurologist and psychiatrist in advance of the scheduled common-interest meeting. The purpose of this request was to discuss Jean's mental and physical health, discharge

planning, and Steven's role as her primary carer. Steven was concerned that raising mental health issues in a joint meeting would cause Jean distress and potentially escalate the situation.

The request for a private discussion was refused. At the subsequent meeting, Steven raised concerns about Jean's mental health. Jean became distressed during the discussion and left the meeting.

The following day, a ward doctor telephoned Steven. Believing the call to be confidential, Steven discussed Jean's mental health and his caring responsibilities. Jean was able to hear the conversation. Following this episode, Jean did not speak directly to Steven for approximately six weeks. This sequence of events appears to have placed additional strain on an already fragile relationship and may also have contributed to prolonging Jean's hospital stay.

2.5 Supporting correspondence

A neurology letter to Jean's GP dated 8 December 2023 recorded the following:

When I asked about a care needs assessment, which is beyond the limits of my specialty, I explained that our Parkinson's disease services could assist with a referral to Social Services. However, Jean and Steven were not happy with a social services referral and stated that they would prefer a meeting for a medical needs assessment."

The same letter also recorded:

"They declined a social care assessment and explained that a physical and mental health assessment to determine the level of medical support required for nursing and social care should precede and be complemented by a social care assessment."

These passages are significant because they clarify Jean and Steven's position. Their concern was not a refusal of social care in principle, but the sequencing of assessment. They sought a medical needs assessment first, followed by integrated neurology-psychiatry coordination, with social care provision complementing rather than substituting for medical care.

2.6 Age UK referral, dementia labelling, and reputational risk

Following discharge on 30 December 2022, the discharge pathway team referred both Jean and Steven, despite Steven not being a patient, to a local Primary Care Network hub involving NHS services, social care, and Age UK.

Jean subsequently received a telephone call from an Age UK Dementia & Me coordinator inviting her to join a dementia support group. She declined. Her discharge documentation recorded that there was no formal diagnosis of dementia and no increased forgetfulness in the previous 12 months.

Several weeks later, the coordinator contacted Steven. Steven then raised concerns with Age UK and the Network Hub. Subsequent email correspondence from the PCN Lead Coordinator confirmed that the referral had occurred without Jean's consent and in error, and that it was Steven, rather than Jean, who had been referred to the Age UK dementia group.

Minutes from the Network Hub meeting dated 27 February 2023 nevertheless recorded a "query" as to whether Steven had a formal diagnosis of dementia, despite there having been no clinical assessment, diagnosis, or prior discussion with any clinician.

Steven remains concerned that informal association with dementia or cognitive impairment could have lasting implications for perceptions of his legal capacity, his engagement with health and social care services, and the credibility attached to his future communications as Jean's carer. In this context, the incident is difficult to regard as a trivial administrative error. It was experienced as carrying potential personal and reputational consequences, particularly in relation to perceptions of capacity, credibility, and future engagement with health and social care services.

The later Age UK dementia referral and PCN hub record raised a further concern: that voluntary-sector pathways may be used, however inadvertently, as instruments of containment or deflection where unresolved medical questions might not first have been properly assessed.

2.7 The need for an integrated medical care plan

Jean and Steven have consistently requested a formal medical needs assessment followed by an integrated mental-health and neurological care plan, with subsequent social care provision aligned to the complexity of Jean's medical condition. This position has sometimes been interpreted as reluctance to engage with social care services. The issue, however, concerns the sequencing of assessment.

A comprehensive medical evaluation should inform and guide subsequent social care planning, rather than social care being treated as a substitute for unresolved medical assessment and coordination.

2.8 Synthesis — part 2

Part 2 shows that Jean and Steven's move to a neighbouring county did not resolve the underlying problem identified in Part 1. The move carried the hope that Jean's complex mental, neurological, and physical health needs might finally be reassessed within an integrated framework. Instead, unresolved clinical questions continued to move between services without producing the multi-professional meeting, agreed care plan, or medical assessment that had already been recommended following the second-opinion psychiatric review.

The central issue was not a refusal of social care. Jean and Steven's position was that social care should be informed by proper medical assessment, not used as a substitute for it. The supporting correspondence is important because it records their request for a physical and mental health assessment to determine the level of medical support required, with social care then complementing that assessment. In other words, the dispute concerned sequencing, responsibility, and clinical ownership.

The hospital admission and discharge pathway then exposed the practical consequences of fragmented records and fragmented responsibility. Outdated medication information reappeared despite Jean having discontinued psychotropic medication in December 2019. Sensitive carer concerns were not heard privately. A subsequent communication failure damaged trust within an already fragile family situation. The later Age UK dementia referral and PCN hub record raised a further concern: that voluntary-sector pathways may be used, however inadvertently, as instruments of containment or deflection where unresolved medical questions might not first have been properly assessed.

What emerges is not a single isolated failure, but a pattern. Jean's needs were repeatedly recognised as complex, yet no integrated medical care plan followed. Steven's advocacy was at risk of being interpreted as reluctance, difficulty, or interference, rather than as an attempt to secure coherent assessment and care. Part 2 therefore shows how unmet medical need can become displaced into social-care process, administrative referral, and reputational risk when no single service accepts responsibility for holding the whole picture.

Part 3 turns to the clinical significance of that unresolved picture: autonomic dysfunction, movement disorder uncertainty, medication-induced or tardive mechanisms, and the need for integrated neurology–psychiatry assessment and care planning.

3 Part 3: Clinical analysis, autonomic dysfunction, and integrated care planning

3.1 Clinical analysis: autonomic dysfunction, supersensitivity, and integrated care planning

This section examines the clinical mechanisms that may help explain Jean's persistent neurological and systemic symptoms following prolonged psychotropic exposure. It considers the possible interaction between long-term pharmacological conditioning, neuroadaptive change, autonomic dysregulation, and the emergence of movement disorder features.

It also addresses the implications of diagnostic uncertainty for clinical decision-making, communication with carers, and the development of an integrated medical care plan.

1. Long-term pharmacological conditioning

Jean was exposed for approximately sixteen years to a combined regimen of citalopram, a selective serotonin reuptake inhibitor, and olanzapine, an atypical antipsychotic.

Prolonged exposure to psychotropic medication may create a conditioned neurochemical environment in which the effects of one medication become functionally intertwined with those of another. Experimental research suggests that, under repeated co-administration, an SSRI may act as a conditioned cue associated with the behavioural and sedative effects of an antipsychotic.

Although such findings originate from experimental models and should not be overstated, they provide a plausible framework for understanding how combined regimens may exert a greater functional impact than nominal doses alone would suggest.

Within this context, Jean's long-term exposure to both medications may have created a relatively stable but drug-dependent neurochemical equilibrium. The marked oversedation identified in 2017 is consistent with the cumulative impact of this prolonged pharmacological environment.

When tapering of citalopram began, the intervention did not simply remove one drug from an otherwise stable system. Rather, it may have disrupted a pharmacologically conditioned equilibrium that had developed over many years. This may help explain the significant physiological and behavioural destabilisation observed during 2018–2019.

2. Neuroadaptive change and dopamine supersensitivity

Prolonged exposure to dopamine-blocking agents may induce neuroadaptive changes within the central nervous system. One recognised mechanism involves up-regulation

and supersensitivity of dopamine D2 receptors following chronic dopamine receptor blockade [2].

These adaptations may have several clinically relevant consequences. First, they may increase vulnerability to tardive and withdrawal-related syndromes, including the emergence or worsening of neurological symptoms during dose reduction. Second, they may reduce tolerance to later pharmacological interventions, meaning that medicines introduced subsequently may produce exaggerated or destabilising adverse effects. Third, they may contribute to paradoxical responses, in which medication intended to relieve symptoms instead appears to aggravate them.

In Jean's case, her adverse response to Parkinsonian treatment with levodopa is consistent with a highly sensitised neurological system. Rather than producing straightforward improvement, treatment reportedly exacerbated tremor and triggered episodes of panic.

This does not establish a definitive mechanism. It does, however, support the possibility that prolonged psychotropic exposure left Jean neurologically vulnerable and pharmacologically unstable.

Chronic dopamine receptor blockade has been associated with compensatory dopamine receptor up-regulation and hypersensitivity, providing a plausible mechanism for tardive movement disorders and persistent motor dysfunction after neuroleptic exposure [5].

3. Autonomic nervous system dysregulation and homeostatic instability

The autonomic nervous system regulates involuntary bodily functions through the balance between sympathetic “fight-or-flight” activity and parasympathetic “rest-and-digest” activity.

Following prolonged psychotropic exposure and subsequent withdrawal, Jean developed a constellation of persistent symptoms consistent with autonomic dysregulation and impaired homeostatic control, even in the absence of demonstrable structural nerve injury.

Reported manifestations included:

- thermoregulatory disturbance, including paradoxical upper-body heat with cold extremities;
- heightened sensory sensitivity to touch, heat, and cold;
- tinnitus and sensory processing disturbance;
- abdominal pain and gastrointestinal instability;
- impaired coordination and balance;
- skin irritation and ocular pressure abnormalities.

Taken together, these symptoms suggest systemic dysregulation rather than isolated organ pathology. They are compatible with patterns of autonomic disturbance described in the psychopharmacology and withdrawal literature and should therefore be considered within a broader neurophysiological and withdrawal-related framework, rather than dismissed without assessment as merely psychosomatic.

4. Movement disorders and diagnostic uncertainty

Jean's clinical presentation involves overlapping features of movement disorder and broader neurological dysfunction.

The principal diagnostic challenge is that idiopathic Parkinson's disease, drug-induced parkinsonism, and tardive or medication-induced parkinsonian syndromes may share

similar clinical features, particularly following prolonged exposure to dopamine receptor-blocking medication.

Neurology correspondence between 2022 and 2024 did not exclude a medication-induced or tardive component. Although idiopathic Parkinson's disease was described in 2024 as the "main impression", the neurologist also acknowledged that tardive or drug-induced parkinsonism cannot be definitively ruled in or out by any specific test.

Given Jean's approximately sixteen-year exposure to dopamine-blocking medication, a medication-induced contribution remains a plausible etiology and therefore a material consideration in care planning.

In clinical practice, distinguishing between idiopathic Parkinson's disease and medication-induced parkinsonism can be particularly challenging when symptoms persist after drug withdrawal. In such circumstances, diagnostic uncertainty should not lead to therapeutic inertia. Where medication-related mechanisms cannot be excluded, the principle of beneficence supports a cautious approach that prioritises the patient's best interests and encourages supportive, integrated care.

The severity and persistence of Jean's neurological symptoms, including those relating to autonomic dysregulation and movement disorder, have contributed to the level of support now required. Since mid-2025, Jean has been living in a specialist neurological residential care setting, reflecting the complexity of her current care needs.

5. Neurology, psychiatry, and the artificial divide

In "The Wall Between Neurology and Psychiatry", Baker et al. [6] argued that advances in neuroscience make the traditional divide between neurology and psychiatry increasingly difficult to justify. Contemporary research demonstrates biological correlates across many psychiatric conditions. At the same time, long-term psychotropic treatment can itself be a significant confounding factor in interpreting such findings, since treatment may contribute to observable biological change. These considerations reinforce the importance of integrated assessment rather than siloed clinical decision-making.

6. Neuroleptics, dopamine pathways, and motor dysfunction

The substantia nigra plays a critical role in motor control as part of the basal ganglia circuitry. Long-term dopamine receptor blockade may disrupt these systems through several mechanisms, including:

- compensatory D2 receptor up-regulation and receptor supersensitivity;
- oxidative stress and mitochondrial dysfunction within dopaminergic neurons;
- disruption of normal dopaminergic signalling balance.

These mechanisms provide a plausible biological basis for tardive syndromes, including tardive dyskinesia and tardive parkinsonism, particularly following prolonged neuroleptic exposure. While the precise molecular pathways remain the subject of ongoing research, the clinical reality is well recognised: tardive movement disorders can persist after medication withdrawal and may result in substantial, and sometimes severe, functional disability.

7. Procedural failures and communication

Failure to Hear Carer Concerns in Private.

During Jean's hospital admission in 2022, Steven requested an opportunity to speak privately with clinicians regarding Jean's mental health and his role as her primary carer. This request was refused.

As a result, concerns that might otherwise have been communicated sensitively and separately were instead raised within a shared meeting format. This caused distress to Jean and contributed to strain within the family relationship.

3.2 GMC confidentiality guidance

The refusal to hear Steven's concerns privately appears inconsistent with guidance issued by the General Medical Council on confidentiality. The GMC states that, where someone close to the patient wishes to discuss concerns about the patient's health without involving the patient, clinicians "should not refuse to listen to their views or concerns on the grounds of confidentiality" (General Medical Council, [7], para. 39).

3.3 Medical uncertainty and the principle of beneficence

Drug-induced parkinsonism, medication-induced parkinsonism, tardive parkinsonian syndromes, and idiopathic Parkinson's disease may share overlapping clinical features. No single diagnostic test reliably distinguishes between these conditions in all cases, particularly following prolonged exposure to dopamine receptor-blocking agents such as olanzapine. In some individuals, more than one mechanism may coexist.

Where diagnostic certainty cannot be achieved, beneficence remains relevant: clinicians should act in ways that are intended to benefit the patient, support welfare, and reduce avoidable harm [8].

Where medication-related causes remain plausible, beneficence supports a cautious and patient-centred approach that gives appropriate weight to potentially iatrogenic factors. Diagnostic uncertainty should therefore prompt careful review, active monitoring, and supportive strategies directed toward functional recovery and symptom management.

For Jean, this issue is particularly significant because further neuroleptic treatment, and some other pharmacological interventions, appear to be limited by previous adverse reactions. In such circumstances, beneficence supports the development of non-pharmacological strategies aimed at addressing parkinsonian disability, tardive syndromes, broader neurological instability, and possible autonomic involvement.

Where established clinical pathways offer limited solutions, the ethical obligation remains to pursue reasonable and proportionate measures that support the patient's safety, function, and quality of life. Diagnostic ambiguity does not justify therapeutic inertia.

3.3.1 The hidden cost of low-cost psychotropic medication

Jean was prescribed citalopram and olanzapine concurrently for more than a decade and a half. Both are long-established, low-cost generics when prescribed in standard tablet form. At current Drug Tariff prices, even allowing for pharmacy remuneration and dispensing fees, the monthly NHS cost of maintaining this olanzapine/citalopram pharmacological pathway may plausibly fall in the range of £6–£9 per 28 days, depending on dose, formulation and tariff period [9].

Evidence from NHSBSA prescribing statistics and primary-care research indicates a sustained increase in the use of antidepressant and antipsychotic medication in England. NHSBSA reported 92.6 million antidepressant items prescribed in 2024/25 to an estimated 8.89 million identified patients, with further quarterly increases reported in

2025/26. Drugs used in psychoses and related disorders also continued to increase in items prescribed. The working-age relevance is particularly important: primary-care research on long-term antipsychotic prescribing indicates that increases have been concentrated among adults aged 18–64. This sits alongside a marked demographic shift in work-limiting mental ill-health: the Mental Health Foundation reports that, over the past decade, the number of workers aged 16–34 who say their mental health limits the type or amount of work they can do has more than quadrupled. These data examples do not prove that medication use causes work-limiting mental ill-health, but they do show that psychotropic prescribing has become an expanding and structurally significant response to mental distress within the adult working-age population.

Although many factors may explain the rise in work-limiting mental ill-health among younger workers, the parallel growth in psychotropic prescribing raises a legitimate policy concern.

Medication may, in some cases, be functioning less as one element within an integrated treatment and recovery pathway than as an administratively convenient form of containment. Where prescribing expands without equivalent investment in psychological review, rehabilitation, withdrawal support and non-pharmacological alternatives, the system risks maintaining distress rather than resolving it.

The hidden cost is therefore not the price of the tablets, but the failure to develop safer psychotropic options and to provide meaningful recovery pathways, including non-pharmacological alternatives.

3.4 Relationship to *A Triptych of Social Care in Britain*

This manuscript, *Bedlam Revisited and Social Care Hell*, is primarily concerned with medical and psychiatric care rather than adult social care alone. However, it explores structural concerns like those examined in *A Triptych of Social Care in Britain* [10]. In that article, the author argues that fragmented social care accountability may create a “public accountability shield” between formal entitlement and practical delivery. In *Triptych*, the central problem is the gap between formal statutory duties and the practical limits of delivery within underfunded and fragmented social care systems.

The comparison is not that medical care and social care operate identically. They are governed by different legal, clinical, and administrative frameworks. However, they converge in the lives of people with complex and continuing needs. In medical care, the parallel problem may be framed as the gap between formal commitments to timely, safe, and coordinated care and the practical limits of delivery within under-resourced, capacity-constrained, and institutionally fragmented health services.

In the present case narrative, this pattern appears at the interface between mental health services, primary care, hospital discharge, voluntary-sector referral, and social care assessment. Medical services may assess, treat, discharge, or refer, while social care services may assess, review, limit, or defer provision. Yet the person’s needs do not divide neatly along institutional boundaries. Responsibility is repeatedly dispersed across institutions, while no single body appears to hold continuing ownership of the whole person’s longitudinal care. In this sense, the “public accountability shield” identified in relation to social care may have an analogue within fragmented medical-social care pathways, where assessments, referrals, reviews, and risk-management processes substitute for an integrated and enforceable plan. Adverse outcomes then become difficult

to attribute, and families may be left to carry the practical consequences of systemic non-convergence.

3.5 The public accountability shield

The comparison with social care does not require medical care and social care to operate under identical legal duties. Rather, both systems may display a structural disjunction between formal entitlement, clinical need, institutional responsibility, and deliverable provision. In social care, this may appear as delayed assessment, limited packages, repeated review, or time-limited support. In medical and psychiatric care, it may appear as sequential referral, waiting lists, discharge back to primary care, signposting to other bodies, or escalation routes that place the burden of coordination on the patient or family.

This form of administrative rationing does not usually appear as explicit refusal. Instead, it may operate through delay, repeated reassessment, procedural complexity, narrow institutional remits, minimal or time-limited provision, and the deferral of decisions. These techniques may preserve the appearance of a lawful and orderly process while transferring practical responsibility onto families, carers, and individuals. Where provision is delayed, fragmented, or diluted, unpaid labour, private expenditure, persistence, and informal advocacy fill the gap.

A further difficulty is the lack of transparency within such routes of escalation. Bodies such as the ICB and the Care Quality Commission may receive concerns, intelligence, or feedback about services, but this does not necessarily mean that the complainant will receive a substantive account of what, if anything, has been done with that information. The CQC itself distinguishes between giving feedback about care and making a formal complaint; its role is not generally to resolve individual complaints, although it may use information received to inform regulatory activity.

Similarly, an ICB may have commissioning, oversight, and complaints-investigation responsibilities, but referral to the ICB does not necessarily provide the individual complainant with a clear remedial pathway. The result is a further form of procedural opacity: the complaint is heard, recorded, or redirected, but the complainant may be left without explanation, remedy, or continuing engagement. This reinforces the public accountability shield, because institutional listening is not the same as institutional answerability.

If local resolution is unsuccessful, a health-service complaint may be referred to the Parliamentary and Health Service Ombudsman (PHSO). In contrast, an adult social care complaint may be referred to the Local Government and Social Care Ombudsman (LGSCO). These routes are important, but they do not fully remove the accountability problem. Ombudsman processes are retrospective, depend on the complainant's persistence, and generally result in recommendations rather than directly enforceable orders.

They may identify maladministration and recommend apologies, financial redress, or service improvements, but they do not necessarily create immediate clinical or social care ownership of the person's unresolved needs. The danger is that accountability becomes retrospective and partly symbolic: the system may acknowledge fault after harm has occurred, while leaving the underlying structure of dispersed responsibility largely intact.

3.6 Synthesis — part 3

Part 3 brings together the clinical mechanisms that may help explain Jean's continuing neurological and systemic symptoms following prolonged psychotropic exposure. It does not assert a single definitive cause for every symptom. Rather, it identifies a cluster of plausible and overlapping mechanisms: long-term pharmacological conditioning, dopamine supersensitivity, autonomic dysregulation, movement-disorder uncertainty, and the difficulty of distinguishing idiopathic Parkinson's disease from medication-induced or tardive parkinsonian syndromes.

The central issue is diagnostic uncertainty. Jean's case sits at the intersection of neurology and psychiatry, where psychiatric medication may produce neurological consequences, neurological symptoms may be interpreted through psychiatric history, and unresolved clinical questions may be redirected into social care. In such circumstances, uncertainty should not lead to therapeutic inertia. It should require closer review, better coordination, and a more integrated approach to care planning.

The ethical principle of beneficence is therefore central. Where diagnostic certainty cannot be achieved, clinicians still have a duty to act in ways that promote the patient's welfare, minimise avoidable harm, and support function and quality of life. For Jean, this points toward active monitoring, non-pharmacological strategies, rehabilitation where possible, and an integrated care plan that takes account of medication history, neurological symptoms, autonomic instability, functional disability, and carer evidence.

The reference in Part 3 to the low cost of Jean's olanzapine/citalopram pathway illustrates a wider asymmetry: medication may be inexpensive to continue, while rehabilitation, review, withdrawal support, and integrated care planning are more difficult and costly to provide. The hidden cost is therefore not simply the price of the tablets, but the absence of a developed recovery pathway when long-term medication becomes the default response.

Part 3 also extends the manuscript's wider concern with fragmented responsibility. The comparison with *A Triptych of Social Care in Britain* is not intended to suggest that medical care and social care operate identically. Rather, it identifies a structural parallel: in both settings, formal processes may exist while no single body assumes continuing ownership of the whole person's needs. In Jean's case, medical services, psychiatric services, primary care, hospital discharge processes, voluntary-sector referral, and social care assessment each occupied part of the pathway. Yet the person's condition did not divide neatly along institutional boundaries.

The public accountability shield is therefore visible not only in delayed or limited provision, but also in the movement of responsibility between institutions and between departments within the same institution. Complaints, referrals, assessments, reviews, and escalation routes may create the appearance of process without producing an integrated remedy. Bodies may listen, record, or redirect concerns, but institutional listening is not the same as institutional answerability.

Ombudsman routes remain important safeguards, but they are retrospective and generally recommendatory. They may recognise failure after harm has occurred without necessarily repairing the dispersed structure of responsibility that allowed the failure to persist.

Part 3 therefore reinforces the central argument of the manuscript: Jean's difficulties cannot be understood safely through separated systems of responsibility. The clinical

question is not only what diagnosis best explains her condition, but who is responsible for holding the whole picture together. The existence of a Department of Health and Social Care suggests an expectation of integration between medical and social support. Jean's case illustrates the practical danger when that integration fails: responsibility becomes fragmented, services become disconnected, outcomes deteriorate, and the burden is transferred to the patient and carer.

4 Conclusion

This de-identified case account has traced Jean's journey from long-term psychotropic prescribing, through withdrawal and continuing neurological symptoms, into a wider landscape of fragmented health and social care responsibility. It does not claim to prove a single causal explanation for every later symptom. Rather, it argues that Jean's experience raises serious questions about the cumulative consequences of prolonged psychotropic exposure, the adequacy of medication review, the interpretation of withdrawal and movement-disorder symptoms, and the absence of an integrated care plan capable of holding the whole clinical and social picture together.

The central clinical concern is not that psychotropic medication was prescribed at all. Medication may be necessary, beneficial, and protective. The concern is that long-term prescribing may become the default architecture of care when regular structured review, informed discussion of cumulative risk, withdrawal support, rehabilitation, and non-pharmacological alternatives are insufficiently developed. In Jean's case, prolonged exposure to citalopram and olanzapine, followed by tapering, medication change, and later neurological deterioration, created a clinical picture in which drug–drug conditioning, dopamine supersensitivity, autonomic dysregulation, anticholinergic burden, and medication-induced or tardive mechanisms could not safely be dismissed.

The central systemic concern is that unresolved clinical complexity was repeatedly displaced across institutional boundaries. Psychiatry, neurology, primary care, hospital discharge processes, voluntary-sector referral, and social care assessment each occupied part of the pathway.

Yet no single body appeared to assume continuing responsibility for Jean's overall condition, continuity of care, or lived outcome. The family's request was not simply for more social care, but for a medical needs assessment and integrated care plan capable of informing subsequent social support. Without that clinical foundation, social care risked becoming a substitute for unresolved medical assessment rather than its complement.

The comparison with *A Triptych of Social Care in Britain* is therefore relevant but limited. Medical care and social care are not governed by identical legal or institutional frameworks. However, both may display a structural gap between formal entitlement, clinical need, institutional responsibility, and deliverable provision. At the health-and-social-care interface, this gap may appear through repeated referral, waiting lists, procedural review, signposting, complaint escalation, and the movement of responsibility between bodies. Formal processes may exist, but process is not the same as ownership.

This is the wider significance of the public accountability shield. The shield does not necessarily operate through open refusal. It may operate through delay, reassessment, narrow institutional remit, administrative redirection, and retrospective complaint handling. Bodies may listen, record, or redirect concerns without providing a substantive account of what has been done or who is responsible for resolving the underlying

problem. Ombudsman routes remain important safeguards, but they are retrospective and generally recommendatory. They may acknowledge failure after harm has occurred without necessarily repairing the dispersed structure of responsibility that allowed the failure to persist.

The hidden cost of low-cost psychotropic medication lies in this same structural asymmetry. Tablets may be inexpensive to continue, while review, rehabilitation, withdrawal support, non-pharmacological alternatives, and integrated care planning are labour-intensive and costly to provide. The danger is that medication-led care becomes administratively convenient, while the more difficult work of recovery, functional support, and coordinated long-term planning remains underdeveloped.

Jean's case therefore points to a practical and ethical requirement: diagnostic uncertainty should not lead to therapeutic inertia. Where medication-related harm cannot be excluded, and where neurological, psychiatric, autonomic, functional, and social needs overlap, the appropriate response is not institutional deflection but integrated review. Beneficence requires reasonable and proportionate efforts to support welfare, minimise avoidable harm, and improve function and quality of life.

The broader lesson is that people with complex and continuing needs cannot be safely understood through separated systems of responsibility. Their conditions do not divide neatly between psychiatry, neurology, primary care, hospital discharge, voluntary-sector support, and social care assessment. An integrated health and social care system must therefore be judged not only by whether each institution has completed its own process, but by whether anyone has accepted responsibility for the whole person. In Jean's case, that is the question that remains.

4.1 Limitations

This manuscript is based on a de-identified case account and should not be read as an empirical study or as evidence of general prevalence. It draws on lived experience, family recollection, contemporaneous correspondence, clinical records where available, and relevant published literature. The account is therefore necessarily partial and interpretive.

The manuscript does not claim to prove a single causal explanation for Jean's continuing symptoms. Prolonged psychotropic exposure, withdrawal phenomena, anticholinergic burden, dopamine supersensitivity, autonomic dysregulation, and movement-disorder uncertainty are discussed as plausible and clinically relevant considerations, not as conclusively established causes. Other explanations, including idiopathic neurological disease or interacting medical factors, cannot be excluded.

A further limitation is that the case is presented from the perspective of Jean and Steven, and from the author's analysis of the available material. The clinical teams, public bodies, and voluntary-sector organisations referred to may have held information, constraints, or interpretations not fully available to the family or reflected in the documents reviewed. The analysis therefore does not seek to assign individual blame, but to examine how fragmented systems may produce gaps in communication, accountability, and care planning.

The value of the case lies not in statistical generalisability, but in its capacity to illuminate structural vulnerabilities at the interface of psychiatry, neurology, primary care, hospital discharge, voluntary-sector referral, and social care. The conclusions should

therefore be read as case-based and conceptual: they identify risks, questions, and patterns requiring further clinical, policy, and institutional attention.

Author contributions

MP, I am the sole author and researcher of this de-identified case study that is based on personal lived experience of Jean and Steven, supported where possible by contemporaneous clinical correspondence and published research. It is not intended to propose a single universal solution; its purpose is to document lived experience, highlight systemic vulnerabilities, and prompt reflection among clinicians, commissioners, and oversight bodies. The narrative is supported by literature that questions the long-term consequences of prolonged psychotropic exposure, inadequate review, and insufficient non-pharmacological alternatives.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

Not applicable. This manuscript is a de-identified case-based policy and systems analysis written by a family member. It does not involve the collection of new research data, clinical intervention, or research involving human participants. All potentially identifying personal information has been removed or anonymised.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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