Neuropsychiatry Updates December 2024

The newsletter of the Neuropsychiatry Faculty

Contents

Editorial: Welcome to Neuropsychiatry Updates

Dr Maytal Wolfe and Dr Killian Welch

Dear Neuropsychiatry Faculty members, and friends of the Neuropsychiatry Faculty,

Welcome to Neuropsychiatry Updates, the relaunch of the Neuropsychiatry Faculty Newsletter. We hope that this will be a place to showcase high quality research, case reports, and quality improvement from our members and others involved with the Faculty. We hope for future editions to have a greater weighting towards this content, but this is dependent on receiving submissions. Please support the newsletter by submitting your work!

You'll notice some new features. With each issue we'd like to bring you information about the state of neuropsychiatry in different regions across the UK (starting with a Postcard from Edinburgh in this issue). We hope that this will encourage strengthening of regional networks across the UK, even outside of the main centres of neuropsychiatry.

Given the important work that third sector organisations are doing for services, patients, and carers, we hope to have a regular section spotlighting the work of charities. In this issue, you can read about the work of Head for Change, who were represented at our annual conference this year by Sally Tucker and Alix Popham.

As a faculty, we are keen to support psychiatry trainees, and we know that trainees can struggle to find their way to quality neuropsychiatry training experiences (depending on the location of their training). We aspire to support the next generation of neuropsychiatrists with the latest curriculum developments and top tips on accessing training.

Finally, please note the call for submissions for the annual conference 2025. The academic team would love to hear your proposals!

Meet the Faculty: Faculty Chair, Dr George El-Nimr

It gives me great pleasure to introduce our membership to the Faculty publication in its new format. In this edition, I am particularly pleased to launch a 'Meet the Faculty' section, where you will hear from different executive colleagues about their experience and particular areas of interest.

From my clinical perspective, I have been working as a full-time neuropsychiatrist in North Staffordshire for over 20 years, providing care in various inpatient and community settings. Over the years, I have not only witnessed the development of various service models but also encountered many challenges and even missed opportunities. Some of my experience was formalised as I co-authored a 'neuropsychiatry service models' chapter for the Oxford Textbook of Neuropsychiatry. You will appreciate that our speciality is quite unique and can be perceived differently by different groups of clinicians, commissioners and even service users. Having been involved in planning and delivering over 15 national / international conferences and teaching at various institutions, this has brought to light how little understood and even encountered neuropsychiatry is as a speciality. This can present itself as a real challenge from both service and training perspectives.

One thing that I learned over the years is the importance of involving patients in both service development and teaching junior colleagues. Working with families and voluntary organisations has therefore been a real privilege for me. I also believe that supporting our working groups will ensure that effective forums are available to discuss and develop specific areas of neuropsychiatry. Addressing the issue around patients with neurological conditions having erratic access to mental health services is certainly one of my top priorities. This work will need to include not only developing neuropsychiatry and its commissioning strategies but also empowering colleagues from other specialities in providing care to patients with neuropsychiatric conditions where specialist services are unavailable. I believe that working collaboratively with various stakeholders is key to changing the world of neuropsychiatry and ensuring that our patients have equitable access to high quality care, especially for historically disadvantaged groups.

I have always had a particular passion for training and education, and have completed a Masters Degree in Medical Education a few years ago. I believe that looking after future neuropsychiatrists would be of particular importance that needs to be achieved through developing mentoring schemes, clear training pathways and credentials, along with fully engaging with relevant national forums.

I have been supporting the educational activities of the GMC and our College, engaging in research as well as contributing to the educational programmes of other universities for many years. I believe that effective communication by disseminating key messages to families and professionals is central to improving understanding and facilitating collaborative working. I have published a number of educational papers and video materials and reviewed scientific papers for high impact medical journals. I have co-developed a couple of CPD online modules for our College. Since 2012, I have been serving as an Executive member for our Faculty and as the Academic Secretary since 2014, until this year when I took up the role of Chair. In the past, I took the lead to represent the Faculty at the Public Engagement Committee.

Another priority for me is to ensure that neuropsychiatry continues to flourish across the whole of the UK including devolved nations. I believe that our Faculty should also take the lead in strengthening international relations which would certainly be of mutual benefit. This work has already started and manifested itself in the context of our highly regarded annual conferences and other activities.

I look forward to working with all of you over the coming years and would love to invite you to make contact if you would like to contribute to the work of the Faculty at any level.

Quality Improvement

STEPS-ID: Meeting the epilepsy training needs of psychiatry of intellectual disability trainees in Scotland

Dr Jennifer Mutch

Background

Epilepsy is the most common serious chronic comorbidity in people with intellectual disability (ID). People with epilepsy are commonly seen within ID services and by psychiatrists working within these services. Epilepsy, and the treatment of epilepsy, may impact behaviour, and can affect long-term mental and physical healthcare outcomes. Knowledge in the assessment and management of epilepsy is therefore essential for psychiatrists working with people with ID.

Historically, there has been a lack of clarity regarding the role of the psychiatrist in the management of epilepsy, and there is variation in how services are set up across the country. The current curriculum for higher trainees in psychiatry of intellectual disability includes 'an understanding of the assessment and treatment of epilepsy in patients with intellectual disability' as a key capability. There had not however been any formalised training in epilepsy for ID higher trainees offered in Scotland, with most addressing this competency through 'special interest sessions' of varying duration, variety and intensity depending on trainee interest and local service arrangements, and attendance at conferences.

In May 2017, The Royal College of Psychiatrists (RCPsych) published College Report 203, "Management of Epilepsy in Adults with Intellectual Disability"(1). This document acknowledged the lack of clarity around not only training standards, but also pathways to achieving competency and the expected roles of psychiatrists working within ID services. The report clarified the RCPsych position on the role of the ID psychiatrist in the management of epilepsy and proposed a tiered model of competencies.

Aim and Methods

The aim of our work was to understand and address the epilepsy training needs of higher trainees in psychiatry of intellectual disability in Scotland. We established a working group with representation from epilepsy specialist psychiatrists from across Scotland as well as a higher trainee in psychiatry of ID. In December 2019, higher trainees in ID psychiatry from across Scotland (n=13) were invited to complete an online survey based on the competencies outlined in RCPsych College Report 203. Trainees were asked to rate how strongly they agreed or disagreed with statements relating to different areas of capability in epilepsy. They were also asked for free text responses in relation to their experience of epilepsy special interest sessions to date and any perceived gaps in their knowledge or training, as well as any challenges encountered in obtaining competency in this area. The baseline survey results, alongside the College guidance, shaped the development of the Scottish Training in Epilepsy for Psychiatry Specialty Trainees in Intellectual Disability programme (STEPS-ID). Following the establishment of the programme, and a period of programme delivery, we invited trainees to complete a follow-up online survey in April 2023 (with further invites sent in May 2024) to collect early evaluation data.

Results

Twelve trainees responded to the baseline survey. Ten responded fully and two only to Part 1 of the survey (up to and including Question 10). Questions elicited a wide range of responses indicating varying levels of confidence within the trainee group, likely in part reflective of the varying stages of training represented within the group. Despite this however, only 22% of trainees agreed that they'd had opportunities in their training to date to gain the necessary skills in epilepsy management required as a consultant psychiatrist working in ID. Generally, trainees agreed that they would like more training in epilepsy (70% strongly agree).

The working group agreed on relevant capabilities on which to base the training programme, informed by the College Report (Box 1).

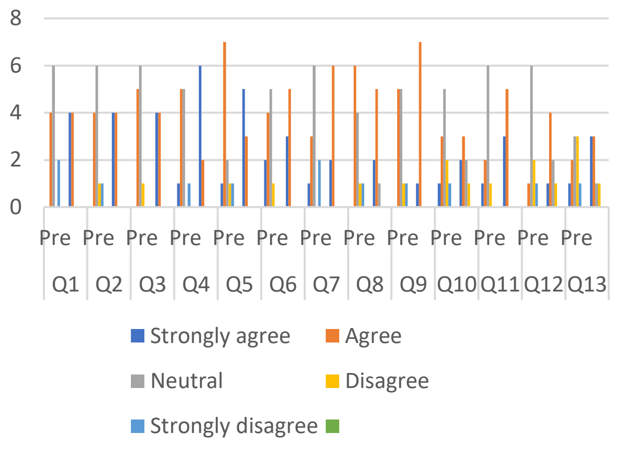
Box 1: Capabilities:
1. Have the basic skills to take a relevant epilepsy history
2. Have knowledge of differential diagnoses including non epileptic attack disorder (NEAD)
3. Knowledge of indications and limitations of the relevant tests
4. Have knowledge of the psychiatric co-morbidities in epilepsy
5. Have an appreciation of the association between challenging behaviour, epilepsy, psychiatric illness and ID
6. Be able to diagnose, address and treat any associated mental illness or challenging behaviour occurring alongside epilepsy
7. Have a basic knowledge of indications and side effects of first line anti-epileptic drugs (AEDs)
8. Have a knowledge of the psychiatric side effects of AEDs
9. Be aware of the interactions between AEDs and other drugs, especially psychotropic drugs
10. Have an ability to scrutinise a rescue medication protocol and ensure one is in place if needed
11. Know the risks associated with epilepsy and have a knowledge of epilepsy risk assessments
12. Manage sudden unexpected death in epilepsy (SUDEP) discussions with patients and carers
13. Be familiar with the local or regional pathway for epilepsy management

These capabilities, supported by the baseline survey results, informed the development of the STEPS-ID programme. The programme consisted of the following:

- a national epilepsy teaching day for all trainees with input from psychiatry, neurology, epilepsy specialist nursing, occupational therapy;
- shadowing experience at The William Quarrier Scottish Epilepsy Centre;
- time with epilepsy specialist nurses, neurologists, neurophysiologists and psychiatrists working in epilepsy;
- signposting to epilepsy educational resources; and
- quarterly case-based discussion sessions on MS Teams.

Of the eight respondents to the follow-up survey, seven had experience of the STEPS-ID programme. Responses indicated positive experiences of the programme and increased confidence and self-reported competence in the RCPsych epilepsy framework areas (see Figure 1).

Figure 1: Survey responses pre- and post-STEPS-ID



Question Key: ***Q1.*** I feel confident in my ability to take a relevant history of epilepsy. ***Q2.*** I have knowledge of indications and limitations of investigations relating to epilepsy. ***Q3***. I have knowledge of differential diagnoses, including non-epileptic attack disorder (NEAD). ***Q4.*** I have knowledge of the psychiatric co-morbidities in epilepsy. ***Q5.*** I have an appreciation of the association between challenging behaviour, epilepsy, psychiatric illness and intellectual disability. ***Q6.*** I am able to diagnose, address and treat any associated mental illness or challenging behaviour occurring alongside epilepsy. ***Q7.*** I have a basic knowledge of indications and side effects of first line anti-epileptic drugs (AEDs). ***Q8.*** I have knowledge of the psychiatric side effects of AEDs. ***Q9.*** I am aware of the interactions between AEDs and other drugs, especially psychotropic drugs. ***Q10.*** I am able to scrutinise a rescue medication protocol and ensure that one is in place if needed. ***Q11.*** I know the risks associated with epilepsy and have knowledge of epilepsy risk assessments. ***Q12.*** I am able to manage discussions about sudden unexpected death in epilepsy (SUDEP) with patients and carers. ***Q13.*** I am familiar with the local or regional pathway for epilepsy management.

Discussion and conclusions

It is well established that psychiatrists working with people with ID should have knowledge and skills in epilepsy assessment and management. Survey of trainees in psychiatry of ID in Scotland revealed what was suspected; that they felt there were gaps in their knowledge and skills in relation to epilepsy assessment and management and that they felt there was a need for more training. Through drawing on the expertise available nationally and the formation of a working group, we were able to combine efforts and resources to develop the STEPS-ID programme. This programme has proven, in early evaluation, to support higher trainee psychiatrists to meet their expected competencies and increase confidence in this area of their practice. Further evaluation and development of the programme is planned. We would encourage those working in other areas of the UK to consider developing a similar programme for epilepsy and to consider which additional areas of trainee curricula may be addressed with a similar national or regional approach.

References

1. Royal College of Psychiatrists. Management of epilepsy in adults with intellectual disability. Good Psychiatric Practice CR203: College Report. 2017.

Bursary for Psychiatrists from LAMI Countries

Knowledge, Attitudes, and Practices about Psychogenic Nonepileptic Seizures (PNES) Among Neurologists and Neurology Trainees Across India: A Cross-sectional Survey

Dr Harkishan Mamtani

Introduction

Knowledge, attitudes, and practices (KAP) about Psychogenic Non-epileptic seizures (PNES) have been studied among general practitioners and physicians only. However, neurologists encounter a large number of patients with PNES.

Aims

To assess the KAP of practicing neurologists and neurology trainees in India about PNES

Methods

A questionnaire assessing the KAP about PNES was validated by a panel of expert neurologists and psychiatrists. After validation, the questionnaire was circulated among 3091 practicing neurologists and neurology trainees using a Google form link through electronic mail.

Results

Of 281 responses (9.1% response rate), 268 were valid. Respondents most commonly referred to PNES as "non-epileptic seizure" and "pseudoseizure," with "hysteria" being least common. Majority (84%), induced seizures at least sometimes, however 35.4% always obtained consent for the same. In contrast, 38% reported never using noxious stimuli to abort PNES. Malingering by PNES patients was perceived by 65.2%, with 70.5% viewing them, at least sometimes, as attention-seekers. Empathy with PNES patients is difficult for the majority (61.2%), but 68.8% believed psychotherapy to have largest evidence in managing PNES. Additionally, 42% believed, at least sometimes, that PNES patients burdened neurological services. A significant majority (88.1%) believe that the long-term prognosis of PNES is either "good" or "very good." Interestingly, 3% of participants manage PNES patients without referring them to mental health professionals.

Conclusion

This study indicates a discordance in KAP of PNES among neurologists. Reasonable knowledge did not appear to adequately influence attitude and practices, reflected in large proportion perceiving PNES as malingering, attention-seeking with low empathy and burden on services. Bridging gaps in knowledge by adopting clinically oriented best practices may enhance translation of knowledge to attitude, and thereby practices. This, in turn, could ensure effective care.

Winning medical student systematic review

Brief CBT-based psychological interventions to improve mental health outcomes in refugee populations: A systematic review and meta-analysis

Nadia A. Daniel*, Xin Liu*, Elizabeth T. Thomas, Emily Eraneva-Dibb1, Al-Maz Ahmad, and Carl Heneghan

*Joint first authors: Nadia A. Daniel and Xin Liu.

Background

Refugees, asylum seekers, and internally displaced people experience a high burden of mental health problems owing to their experiencing traumas and stressful events.

Objective

To summarise the available evidence and analyse the efficacy of brief psychological interventions (< 3 months) on improving mental health outcomes, including depression, anxiety, and post-traumatic stress disorder (PTSD)-related symptoms in refugees.

Method

We searched Medline, EMBASE, PsycINFO, CINAHL, and Global Index Medicus from inception to 19 December 2023. We included controlled studies using any cognitive behavioural therapy (CBT) or CBT-based therapies delivered over a short time (< 3 months), which reported mental health outcomes pre-and post-intervention. We conducted meta-analyses using random effects to derive pooled summary statistics. The quality of the evidence was assessed with the Cochrane Risk of Bias (RoB2) and ROBINS-I tools. This study is registered on the Open Science Framework, DOI 10.17605/OSF.IO/9CXU4.

Results

34 eligible studies across 37 publications were retrieved for analysis, and 33 studies with 4479 participants were included in the meta-analysis. There was an overall improvement in immediate mental health outcomes for all three domains, with analysis of 13 studies on anxiety outcomes (SMD -1.12, 95% CI -1.72 to -0.52), 20 studies on depression (SMD -1.04, 95% CI -1.97 to -0.11), and 24 studies on PTSD (SMD -0.82, 95% CI -1.20 to -0.45). At 3 to 6-month follow-up, however, analysis of mental health outcomes shows no significant change from baseline, with a SMD of 0.24 (95% CI -0.94 to 1.42) across 4 studies, -0.73 (95% CI -2.14 to 0.68) across 9 studies, and 0.29 (95% CI -0.94 to 1.53) across 12 studies for anxiety, depression, and PTSD respectively.

Conclusion

Low-quality evidence shows brief psychological interventions have a positive immediate effect on refugees and internally displaced people's mental well-being. However, these effects do not persist in the short-term follow up. Heterogeneity was high, even among subgroups, impacting our findings' generalisability.

KEYWORDS: Refugees, asylum seekers, internally displaced persons, CBT, brief psychological intervention, anxiety, depression, PTSD, systematic review, meta-analysis

HIGHLIGHTS

- We analysed the evidence on the use of brief CBT-based psychological interventions to improve mental health outcomes in forcibly displaced persons.

- These interventions had a positive effect on anxiety, depression and PTSD, though there was high heterogeneity between studies.

- Positive effects on mental health disappeared at long-term follow-up

Conference 2024 Prize winners

Oral presentation prize winner

DNMT1-related Disorder with Psychiatric Manifestations: A Case Report

William Thomas, medical student, and Dr Bethan Brace, CT3, North Staffordshire Combined Healthcare NHS Trust

Aims and hypothesis

This report aimed to analyse the psychiatric manifestations associated with the DNMT-1 gene mutation in inherited peripheral neuropathies through a case report and comparison with the literature. The objective was to evaluate the contribution of the case study to newly emerging evidence of psychosis and hallucinations reported to be associated with this DNMT-1 related neurological disorder. This was through the case of a patient with hereditary sensory and autonomic neuropathy with dementia and hearing loss (HSAN1E) and DNMT1 mutation associated with visual and tactile hallucinations, cognitive decline and self-injurious behaviour leading to the autoamputation of all digits.

Background

The DNMT1 variant is one of uncertain clinical significance, however has been suggested to be a contributor to hereditary peripheral neuropathies. Mutations in DNMT1 have been linked to an expanding spectrum of phenotypes that is now being termed DNMT1-related disorder. DNMT1-related phenotypes published include several psychiatric manifestations; namely cognitive decline, visual and auditory hallucinations and non-organic psychosis.

Methods

The case of one patient, a 55 year old Caucasian male with the c.1288T>C, p.(Cys430Arg) variant in the DMNT1 gene was reported. His childhood, developmental, genetic, neurological and psychiatric history was analysed along with features identified in affected family members including a sibling, father and paternal grandfather. Psychiatric manifestations were analysed and compared with current evidence found through literature review.

Results

The patient discussed experienced the three accepted core symptoms of HSAN1E which include sensory dominant neuropathy and sensorineural hearing loss from the second decade and cognitive decline from the 5th decade. Psychotic symptoms were reported in later life in the patient, his father and paternal grandfather. In the 7 year period 2017-2024, the patient experienced a rapid cognitive decline and gradually worsening digital autoamputations, exacerbated by two years of biting and chewing on the wounds associated with visual and tactile hallucinations. The patient was commenced on Aripiprazole and a moderate response was observed in psychotic symptoms, however these features were initially unexplained by the medical history and genetic diagnosis. The literature review showed a limited amount of evidence however a key theme identified was hallucinations and psychotic symptoms which reinforced the findings of this case.

Conclusion and next steps

The rapid deterioration in cognition, mental state and physical health illustrated in this case highlight the importance of understanding the diagnoses and disease process associated with DNMT1-related disorders in order to improve quality of life and management of these patients.

Poster: trainee/SAS winner

Pilot Functional Seizures Clinic for Young People at Queen Alexandra Hospital in Portsmouth

Dr Naomi Phillips

Aims and hypothesis

Aim: To set up a pilot clinic at Queen Alexandra Hospital (QAH) in Portsmouth for young people with functional seizures.

Hypothesis: A clinic providing detailed formulation assessments plus 2-4 additional sessions can improve young people's level of functioning and reduce hospital admissions.

Background

Young people with functional seizures often fall in the gap between physical and mental health services. During my CAMHS (Child and Adolescent Mental Health Services) liaison post I piloted the first functional seizures clinic for young people at QAH.

Methods

I met with the epilepsy team and joined their clinic. I visited Professor Isobel Heyman's Mind-Body clinic at Great Ormand Street to observe her approach. I reviewed relevant literature including, 'Treatment of Functional Seizures in Children and Adolescents: A mind-body manual for health professionals' by Kasia Kozlowska et al., and 'Explaining dissociative seizures: a neuropsychological perspective' by Claire Rockliffe-Fidler and Mark Willis.

The pilot clinic I designed offered an extended formulation assessment during which I worked with the young person and their family to understand their functional seizures in the context of their life experiences. I explained functional seizures using the fight/flight/freeze and pressure cooker models. I then offered 2-4 additional sessions aimed at recognising and reducing triggers, recognising early warning signs, teaching strategies to avert seizures, and offering guidance for parents. I also liaised with other professionals (community CAMHS, school, social services) to ensure a joined-up approach. After this piece of work was completed, I signposted to other services to address ongoing triggers.

Results

I saw 7 young people (3 boys, 4 girls) for an average of 4.6 sessions. Outcomes for 5 of the 7 were positive: functional seizures were completely resolved in 2, while 3 had a large decrease in the frequency of functional seizures and improved functioning. The remaining 2 continued to have seizures at the same rate. Feedback from young people and their families was largely very positive and the epilepsy team reported a reduction in hospital admissions.

Conclusion and next steps

The outcomes for the pilot clinic suggest that meaningful functional improvement and a reduction in hospital admissions can be achieved through this relatively short intervention.

After leaving the team I ensured the continuation of the clinic by working closely with the incoming trainee. We are developing a business case for a commissioned service.

Poster: medical student winner

A systematic review of studies of attitudes and beliefs of healthcare professionals towards non-epileptic attack disorder (NEAD) in adults

Amelia Townsend

Aims and hypothesis

The aims of this study were to review the existing literature on the attitudes of clinicians towards non-epileptic attack disorder (NEAD), and any differences that exist between professional groups.

Background

Non epileptic attacks (also referred to as psychogenic non-epileptic seizures, functional seizures or dissociative seizures) are similar in appearance to epileptic seizures but are not accompanied by ictal electroencephalographic (EEG) discharges. NEAD is classified as either a conversion or dissociative disorder in DSM-V and ICD11 respectively, and is often associated with significant long-term disability. People with NEAD often access care across many different specialties and healthcare settings. Their experiences of doing so are frequently negative, based both on interactions with clinicians and integration of care.

Methods

The study followed PRISMA 2020 guidelines and was registered on the international prospective register of systematic reviews (PROSPERO). Three electronic databases (MEDLINE, EMBASE and PsycInfo) were searched for studies of clinician attitudes towards NEAD using pre-developed terms. These terms were optimised following familiarisation with the literature. Specific inclusion and exclusion criteria were applied, and studies were selected if they included data regarding the attitudes of healthcare professionals from any group towards NEAD. A data extraction template was used to synthesise study characteristics and outcomes. The Mixed Methods Appraisal Tool was used to appraise methodological quality of the included studies. Two reviewers independently completed the selection process and data extraction.

Results

The search strategy yielded 508 citations, of which 80 were selected for review of the full publication based on the title and abstract. A further 12 papers were identified from reference list searching. Inclusion/exclusion criteria were applied to full texts. 24 texts met criteria for inclusion in the review. The literature mainly included clinicians from general practice, neurology, emergency department and psychiatry. There was general negative stereotyping of people with NEAD and a lack of confidence in management. Attitudes differed between professions, particularly with respect to aetiology.

Conclusion and next steps

The literature highlighted that many clinicians held a negative attitude towards people with NEAD, and there was evidence of a general lack in confidence towards NEAD across all healthcare professional groups. There was a difference between healthcare professional groups, mostly related to views on aetiology. The review highlights the need for specific education related to NEAD with a focus on understanding aetiology and greater transparency in interdisciplinary working.

Conference Update 2024

Dr Killian Welch

The conference began with Professor Willie Stewart and Dr Thomas McCabe discussing brain injury in sport. Neuropathologist Prof Stewart integrated epidemiological findings from the FIELD study, reporting increased risk of neurodegenerative disorders in certain former sports professionals, and histopathological findings from post-mortem studies of deceased sportsmen. He discussed the characteristic pattern of tau deposition reported in chronic traumatic encephalopathy (CTE). He emphasised the need for prospective studies (indeed, the writers note that epidemiological studies to date have struggled to control for some potentially important confounders, such as years of education), but as Dr McCabe went on to report, this research has already had success in prompting guidance to reduce 'heading' exposure in amateur and professional football. Professor Stewart also emphasised the deficiencies in proposed consensus diagnostic criteria for diagnosing CTE in life. Given the profile of these concerns, and presumably the high levels of anxiety about the potential consequences of sports participation, this is clearly a field in which more of the high quality research he is undertaking is greatly needed.

This was followed by a very personal account from Miss Sally Tucker of the effect on patients and families living with CTE. She and Alix Popham described the important work Head for Change is doing in educating, promoting good practice in professional and amateur sports, and in supporting families. The conference was really grateful that they were able to attend to provide this insight which highlights the importance of the research.

Dr Mahinda Yogarajah and Dr Susannah Pick followed the opening session, expanding on the 'bio' and the 'psychosocial' in the biopsychosocial model of FND.

Session 1 speakers, left to right: Miss Sally Tucker, Dr Willie Stewart, Dr Thomas McCabe and Dr Peter Trimble.

Dr Yogarajah built on established findings, such as poorer interoceptive accuracy in patients with certain FND presentations, with imaging findings showing state changes in association with experience of episodic FND symptoms (reduced heartbeat evoked potential during the prodromal phase of dissociative seizures); such findings are beginning to give us an understanding of processes underpinning the reduced body awareness which is such a core component of these conditions. These studies clearly advance the field, helping to disentangle trait and state features associated with these conditions. Functional imaging findings identifying reduced activity in the temperoparietal junction during functional seizures further suggests that disturbances in sense of body ownership and agency is central in the episodic generation of these symptoms. There followed a lively philosophical discussion with plenty of audience participation. After the workshop sessions the day concluded with talks discussing two intriguing paediatric neuropsychiatric conditions. Dr Ashley Liew discussed developmental regression. He focussed on autism, certain single gene disorders and some devastating childhood epilepsies. It was interesting to hear of abnormalities of the 22q chromosome again being discussed in relation to neuropsychiatric disorders (Phelan-McDermid syndrome was discussed in association with 22q13 deletions, but of course we are also familiar with 22q11 deletions and velo-cardio-facial syndrome). The day concluded with Dr Osman Malik discussing Intense Imagery Movements and associations with adult maladaptive daydreaming. I was left rather envious of the rich imaginary life some children and adults seem to have, the talk bringing to mind the film Billy Liar, a forgotten classic of 1960s British cinema.

Day two maintained the high standards set by day one. Professor Vaughan Bell and Dr Norman Poole explored Capgras syndrome and delusional misidentification syndromes more generally. By the end we were persuaded that the alluringly neat hypothesis that Capgras syndrome rests on dissociation of facial recognition and emotional sense of familiarity (the delusion being generated by facial familiarity not being accompanied by its expected emotional correlates) was convincingly debunked. It seems we don't have a complete replacement model, but an erudite discussion of possible explanations was provided (albeit with some imperious scepticism from Professor Kopelman). Dr Clare Eddy and Dr Quiton Deeley followed, with a deep dive into social cognition. Dr Eddy made a strong case for the basal ganglia as central in social cognition, with dopamine expected to have an important role in signalling salience of social cues. Dr Deeley explored abnormalities of social cognition in autism, personality disorder and FTD. The talk was full of fascinating insights, but key messages I took were the profound heterogeneity of ASD and that decreased amygdala responsiveness to distress cues in psychopathy may be because they 'attend away' from these stimuli (and importantly if you do require them to attend then brain activity does increase in the relevant networks). Old British films again came to mind, recalling the attempts at aversion therapy in 'A Clockwork Orange' when Alex is forced to view scenes of violence in association with medication-induced nausea.

This was followed by a very powerful account from Jane Allberry on the experience of caring for someone with a traumatic brain injury and Francoise Balfe's experience of FND and her journey through services. Attendees were very grateful to have lived experience accounts represented at the meeting, and open discussion about the state of services and what needs to change.

After lunch Dr Nathan Huneke and Dr Matt Butler delivered a masterful session on placebo effects. This spanned underlying mechanisms, the implications of placebo effects for RCTs of psychoactive drugs (where expectation effects may be particularly strong and it is impossible to blind participants to whether they receive active agent or placebo), and the costs to patients (in terms of reducing treatment efficacy and tolerability) when we openly discuss the possibility potential treatments may not help and be associated with various side effects. An audience member speculated if we have anything to learn from the approaches of alternative therapists. Placebo effects can be so large in psychiatry that these do seem to be considerations which are of more importance to us than many other doctors (if you are treating colorectal cancer, of course, they will be negligible in tumour response - though the conditioned associations patients report of nausea with site of chemotherapy delivery are often striking). The conference ended with a practical session on the implications of certain conditions (TBI, FND and sleep disorders) for driving. There were many learning points, but I certainly will not have any hesitancy in requesting driving assessments in the future.

The conference was given added depth by moving patient and carer sessions and two high quality trainee presentations. The considerable global attendance was heartening, and it was a pleasure to chat with Dr Mamtani, winner of the international bursary award. He has been undertaking a broad range of neuropsychiatric research in India.

Lived experience session speakers, left to right: Francoise Balfe, Professor Anthony David and Jane Allberry.

We thank our new Faculty of Neuropsychiatry Chair, George El-Nimr, for his wonderful work in programming this conference (with of course the very able support of Emma George, Rukiyat Babajide, Kitti Kottasz and the IT team) and look forward to next year! Of note, recordings of the talks discussed above are still available on the college website (for conference attendees).

Postcard from... Edinburgh!

Dr Killian Welch

Neuropsychiatry in Edinburgh began with the appointment of Professor Alan Carson in a split role between the Robert Fergusson Unit and the Department of Clinical Neurosciences in 2000. He had already established himself as a trailblazer in the 'rediscovery' of FND and together with Jon Stone, Neurologist, made Edinburgh a major centre for FND research. Neuropsychiatry in Edinburgh expanded substantially over subsequent years, the three additional consultant neuropsychiatrists now in post having trained under him. He and Laura MacWhirter now split a post covering the acute brain injury service and Department of Clinical Neurosciences (Royal Infirmary of Edinburgh). Laura is an active researcher in FND, with a particular interest in functional cognitive disorder. Ally Rooney works in the Robert Fergusson Unit, is local lead for ECT, and has research interests including the neuropsychiatric morbidity associated with brain tumours. Killian Welch also works in the Robert Fergusson Unit, with interests in behavioural modification post-brain injury and psychological approaches to the treatment of FND. Lorna Langrell, Associate Specialist in Neuropsychiatry has worked for many years in medical and neurobehavioural rehabilitation, but will retire in January 2025. We don't know how we will manage without her! All four consultant neuropsychiatrists run mixed neuropsychiatry outpatient clinics.

In terms of service structure, the acute brain injury service was started in September 2021 as part of the development of a major trauma centre. All traumatic brain injuries requiring admission in South East Scotland are transferred to the regional neurosciences centre and managed jointly between neurosurgeons and a medical team comprising neurologists and neuropsychiatrists (Alan and Laura). The purpose was to facilitate early specialist assessments and intensive early rehabilitation from the day of admission. The team is staffed with physiotherapy, OT, SLT, psychology and dietetics at a level that allows for 3 hours of rehabilitation a day for patients. Most patients are discharged to home with some, with most severe needs, transferring on to inpatient neurorehabilitation in one of the 4 units in South East Scotland. The Robert Fergusson Unit is a neurobehavioural rehabilitation unit providing care to patients from around Scotland whose challenging behaviour means it is not possible for them to be cared for in standard rehabilitation settings. Patients often have substantial psychiatric comorbidity, care being delivered by a broad MDT with a strong emphasis on positive approaches.

Edinburgh's reputation in FND research and treatment means clinicians from around the world come to Edinburgh to obtain training in management of these conditions. Local psychiatry and rehabilitation medicine trainees can undertake formal training in neuropsychiatry/neurobehavioural rehabilitation, and trainees from around Scotland have attended neuropsychiatry clinics. Alan has created a strong Neuropsychiatry base in Edinburgh and we hope to be able to sustain this into the future!

Charity Spotlight: Head for Change

Anna Allan
Head for Change

Head for Change is a charity created for sports people suffering from neurodegenerative disease. It was founded in 2021 by Dr Sally Tucker and Mel and Alix Popham.

Sally is an NHS surgeon whose father is a former professional footballer diagnosed with dementia, secondary to repetitive head injury sustained during his career.

Alix was diagnosed with probable Chronic traumatic encephalopathy (CTE) and early onset dementia as a result of traumatic brain injury suffered in his rugby career.

Head for Change has three primary objectives:

1. Pioneering positive change for brain health in sport. Promoting education and understanding of the effects and risks of head impacts in sports. They have participated in the DCMS inquiry into head injury in Sport. Their work also involves working with schools, clubs, sports' governing bodies and players' representative organisations, supporting them to actively promote player welfare and protect the future of the sports.

2. Supporting independent research to provide answers to the more nuanced questions in order to make sports safer for brain health.

3. Supporting ex-players who are affected by neurodegenerative disease as a result of their sporting career in football or rugby and providing practical support to them and their families.

Head for Change is funded entirely by donations and the events organised are aimed at raising awareness as well as funds for future projects.

Neuropsychiatry PsychStar

The Northern Star/Where Medicine Seeps

Namira Patel

Dr Czarina Kirk and Namira Patel

I'd always been sceptical of committing to psychiatry as a speciality. During medical training, we spend so much time learning about and interacting with physical health that it almost feels a waste to turn away from it. As important as the connection between psychological and physical health is, unfortunately, the UK model of medicine is still widely under representative of it- at least from the student perspective.

We're lectured on the presentations and managements of depression and psychosis, but pathophysiology is largely undertaught- likely partially due to the uncertainty of it.

So, the discovery of neuropsychiatry, was like the sighting of the Northern Star.

I discovered the sub-speciality when applying to be a PsychStar- an initiative run by the college to give access to mentorship and funds for students interested in psychiatry.

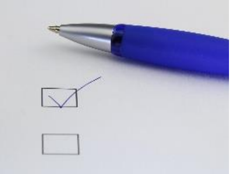
During my fourth year (2023-2024) at medical school- I was fortunate enough to be the NeuroPsychitary Faculty PsychStar. Because of this, I had the opportunity to attend the 2023 Faculty Conference. There, I learnt about the relationship between acquired brain injuries (ABIs) and criminal behaviour which inspired an essay, with help from my PsychStar mentor, for a competition run by the Forensic Faculty. Following which, I was invited to give a presentation at their annual conference with three other students. The conference was in Italy! ~~(I'm pretty sure a lot of the consultants were just there for the holiday)~~

I was very anxious- my voice shook and I tried to avoid eye-contact, but I'm so grateful that I had the opportunity to do something like this. I was able to attend my first conference, meet students with similar interests, have regular meetings with mentors that helped me set goals for the year and learn more about the role of physicians in sub-specialities like NeuroPsychiatry.

The PsychStar programme opened a whole new side of psychiatry for me - one where the medicine I was so reluctant to leave behind seeped into the speciality that interested me from before I had even decided to apply to medical school. It was a wonderful experience- thank you.

Top Tips for Trainees

Dr Maytal Wolfe



As a higher trainee in a city with no formal neuropsychiatry training, I had start to find my way to high quality training experiences. Now that I'm a consultant in the same city (in liaison psychiatry and with an interest in neuropsychiatry), I am continuing to find my way!

Here are some of my top tips for trainees in the same position:

- Mentorship – find a neuropsychiatrist who can support you to be involved in clinical experience and research. If you aren't sure where to start, email the Neuropsychiatry Faculty: neuropsychiatry@rcpsych.ac.uk
- Local opportunities – Ask what is happening in your area: Maybe there is a stand-alone Huntington's clinic, a Tourettes working group, or some neurology colleagues crying out for psychiatry involvement. A good mentor can help with this.
- Teaching weekends – The British Neuropsychiatry Association and the ILAE British Branch both have excellent teaching weekends for SpRs.
- Become a member of the Global Neuropsychiatry Group – it's a great forum for networking, education, and collaboration.
- Neuropsychiatry Faculty Annual Conference – If you can attend in person, don't be shy! Get talking to other attendees and you will find the Faculty members are a friendly bunch who are keen to help.

Faculty Prizes and Bursaries

Neuropsychiatry Faculty: Medical Student Systematic Review Prize
2025 title: *How can the mental health of people with neurological conditions be improved in the UK? Discuss the best evidence for different service models for the delivery of mental healthcare in neuropsychiatric conditions*
Deadline: 30 April 2025
Prize: £250 and subsidised attendance at the faculty conference
Eligible: medical students in the UK

Neuropsychiatry Research Prize
Deadline: 30 April 2025
Prize: £500 and subsidised attendance at the faculty conference
Eligible: Medical students, foundation doctors, specialty trainees (CT1-CT3 and ST4-ST6) including non-psychiatry trainees, or consultants in psychiatry (within three years of their first consultant appointment), based in the UK.

Neuropsychiatry Faculty educational bursary
Deadline: available throughout the year
Bursary: up to £200
Eligible: medical students, foundation doctors, junior psychiatric trainees (CT1-3, ST4-6), SAS doctors, based in the UK

Neuropsychiatry Faculty: Bursary for psychiatrists from LAMI countries
Deadline: 30 April 2025
The Neuropsychiatry Faculty has established an annual bursary to enable a psychiatrist from a low- and middle-income (LAMI) country (defined as World Bank classification C and D) to attend the Faculty Annual Residential Meeting (usually held in September) in order to give an oral or poster presentation or deliver a workshop.

Contact: kitti.kottasz@rcpsych.ac.uk if you have any queries.

Announcement: Psychopharmacology newsletter

Introducing the first RCPsych Psychopharmacology Committee Newsletter!

Calling all members with an interest in psychopharmacology!

Sign up now to receive it and learn about:

Why Trainees Should Be Interested in Psychopharmacology, Prescribing Wisely: Using Existing Treatments Better, A Lived Experience Prospective, KarXT a new FDA approved drug for schizophrenia and much more!

Our goal is to create an essential psychopharmacology resource for all psychiatrists, with relevant updates, insights, and learning opportunities, and to keep members informed on the latest Psychopharmacology hot topics and the activities from the committee.

Each issue, **expected once a year**, will feature a range of engaging topics, including:

- Why psychopharmacology is vital for psychiatry trainees and sources of educational opportunities
- A "Prescribing Wisely" section updating members on latest treatment guidance
- Latest news from the Prescribing Observatory for Mental Health (POMH) and the Medicines and Healthcare products Regulatory Agency (MHRA)
- Summaries of groundbreaking research findings
- Lived experience perspectives
- Other recent work from our Psychopharmacology Committee

Call for Submissions

RCPsych Neuropsychiatry Conference, 11-12 September 2025

We would also like to remind you that we are looking for suggestions for sessions at our conference in September 2025. If you have ideas please **submit the ATTACHED FORM.** **The deadline is 22 March 2025.**

We look forward to hearing from you.

Killian Welch, Academic Secretary and Newsletter Editor
Maytal Wolfe, Deputy Academic Secretary and Newsletter Editor

Dates for the Diary

- Brain Conference
  7 March 2025
- BNPA
  13 – 14 March 2025, London
- Functional Neurological Disorder Masterclass, Fetal Medicine Research Institute, Denmark Hill, London, 26 March 2025.
  Contact: khpneurosciences@kcl.ac.uk
- Neuropsychiatry Faculty Annual Conference
  11 – 12 Sept 2025, London
- ILAE British Branch
  15 – 17 Sept 2025, Bournemouth