NATIONAL OPTIMAL PATHWAY FOR FUNCTIONAL NEUROLOGICAL DISORDER (FND)

Pathway for adults aged 16 and over

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FOREWORD

The National Optimal Pathway (NOP) for Functional Neurological Disorder (FND) aims to highlight the impact of FND on people and healthcare services, and guides the best practice delivery of co-ordinated, evidence-based care across Wales. It supports timely and efficient diagnosis, the need for holistic, person-centred interventions, and continuity across services for adults age 16 and over. The FND NOP is intended for use by clinicians overseeing the care of people living with FND, intended to support health boards in guiding their service delivery and service improvement, and identify, acknowledge and fulfil gaps in care for people living with FND.

GROUP CONSULTATION

The pathway development was led by the FND Task and Finish Group hosted by the National Strategic Clinical Network for Neurological Conditions, chaired by Dr Tanya Edmonds (Consultant Neuropsychologist, Swansea Bay University Health Board), Dr Craig Roberts (Consultant Neuropsychologist, Betsi Cadwaladr University Health Board) and Professor Robert Powell (Clinical Lead, Neurological Condition Network, NHS Wales Performance & Improvement). The FND Task and Finish Group was established in 2024 and comprised of a variety of individuals to reflect a wider Multidisciplinary Team (MDT) who are involved in supporting people living with FND across their pathway. This group included representation from Allied Health Professionals (AHPs), medical and neuropsychology colleagues and people with lived experience. The priority of the group was the design of the FND NOP for Wales, which was then circulated for consultation between August and October 2025, and approved by the National Clinical Framework Board in March 2026.

Contents

Wales FND Pathway Overview

1**.** The pathway for FND is holistic and person-centred. The person typically presents with symptoms to their GP or emergency department, although may already be within a service or already diagnosed with FND. If FND is suspected, a referral should be made to a neurologist for diagnosis*.

2. Diagnosis should be based on *positive clinical features* (e.g., Hoover's sign, entrainable tremor)*, and clear communication, validation, and referral to appropriate therapy services are essential[6]. Reviewing patient-recorded videos for seizures, gait and movement disorders are also an important part in the positive identification of FND.

3. Where appropriate, individuals should be managed in outpatient or generic community-based therapy settings, with access to Physiotherapy, Psychology, Occupational Therapy (OT), Speech and Language Therapy (SALT), and Dietetics. Staff should be provided with training and professional development opportunities to enhance their knowledge, skills and confidence in assessing and treating FND.

4. Those with more complex or uncertain presentations require referral to a specialist neurology-led FND multi-disciplinary team (MDT). It is likely that these MDTs will be regional and based in centres where the services exist, but with access to all patients within that region, similar to the way MS services are currently set up in Wales.

5. Services at all levels should focus on enabling recovery, self-management, and reintegration into community roles. Psychoeducation, supportive relationships, and flexible access to services underpin successful outcomes.

6. In some cases, the person living with FND will need a navigator/link worker to advocate on their behalf to enable them to access services. This does not need to be a new role but can be undertaken by an existing team member deemed best placed to act as an advocate for the individual.

******In some cases, the referring service/clinician may feel they have the relevant knowledge and expertise to confidently diagnose FND, e.g., Memory Clinics.*

FND Symptoms and Presentation

The term FND describes symptoms which resemble the effects of disease or damage in the nervous system but arise from physiological and psychological effects and in the absence of structural pathology. FND may co-exist with other diagnoses but is distinctive in the complexity of its symptoms and its superficial similarity to diseases that require entirely different treatment. By its nature, FND is difficult to define and subject to misunderstanding, both by service users and professionals, and its complexity means that expert involvement is often crucial to ensure access to services and to promote a return to health.

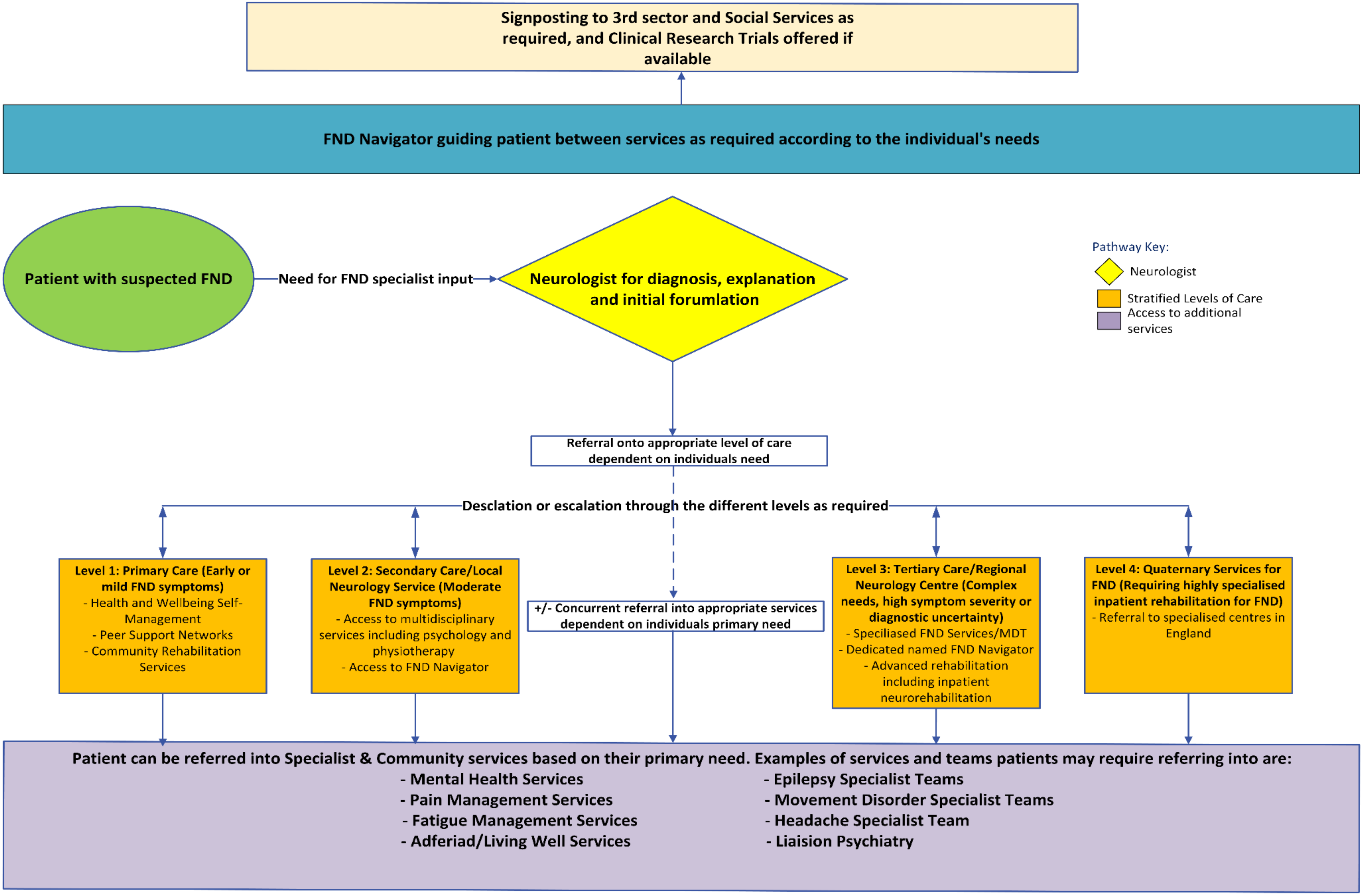
- FND encompasses a wide range of neurological symptoms, such as seizures, limb weakness or paralysis, movement disorders (e.g., tremor, impaired gait and jerking), sensory disturbances (e.g., dizziness), functional cognitive symptoms (e.g., memory, information processing) as well as a range of other visual, language and swallowing problems that do not have an identifiable structural cause.
- The minimum UK prevalence of FND has been estimated at 80–140 per 100,000 people[1], suggesting between 2,500 to 5,000 people living with FND in Wales. This is comparable to the prevalence of conditions like Multiple Sclerosis and Parkinson's Disease.
- FND is often misunderstood, leading to delayed diagnoses, a lack of intervention, or inadequate treatment strategies.
- It may co-occur with conditions such as anxiety, depression, fibromyalgia, chronic fatigue or pain, although these are distinct diagnoses[2,3,4]. In addition, people living with other neurological conditions can suffer from functional symptoms, making diagnosis and treatment especially challenging[5].
- FND can affect individuals of all ages, though it is most common in women aged 35-60[2], and the proportion of men affected increases as the age of onset increases[6]. Misdiagnosis and lack of access to appropriate treatment exacerbate symptoms, reduces quality of life, and contributes to avoidable healthcare costs[7,8,9,10].

- For many people with FND, the journey through health services is fragmented, stigmatising and frustrating, with many therapy services either not accepting referrals for people with FND or lacking in service provisions, which in turn can be actively traumatising for people with FND and lead to an exacerbation of symptoms. The clinical heterogeneity and multi-morbidity, along with the absence of a structured care pathway leads to frequent hospital visits, attendances in primary care, over-investigation, inappropriate prescribing, prolonged treatments, and inefficiencies in the delivery of care[7,8]. These adverse experiences and service inequities can lead to healthcare avoidance, further widening health inequalities. People with FND are approximately five to six times more likely to use emergency services compared to the general population[11].

FND National Optimal Pathway

This pathway provides a structured, severity-based model for triaging and delivering care for individuals with FND. Care is matched to clinical need, and movement between levels should be dynamic, recognising the inherent fluctuation, relapse, and recovery often seen in FND. People with FND and their families should be at the centre of decision-making, supported by proactive care navigation. Services should be available and equally accessible across the spectrum of FND presentations.

FND National Optimal Pathway for adults aged 16 and over



Signposting to 3rd sector and Social Services as required, and Clinical Research Trials offered if available

FND Navigator guiding patient between services as required according to the individual's needs

Patient with suspected FND

Need for FND specialist input

Neurologist for diagnosis, explanation and initial forumlation

Pathway Key:

◆ Neurologist

🟧 Stratified Levels of Care

🟪 Access to additional services

Referral onto appropriate level of care dependent on individuals need

Desclation or escalation through the different levels as required

Level 1: Primary Care (Early or mild FND symptoms)
- Health and Wellbeing Self-Management
- Peer Support Networks
- Community Rehabilitation Services

Level 2: Secondary Care/Local Neurology Service (Moderate FND symptoms)
- Access to multidisciplinary services including psychology and physiotherapy
- Access to FND Navigator

+/- Concurrent referral into appropriate services dependent on individuals primary need

Level 3: Tertiary Care/Regional Neurology Centre (Complex needs, high symptom severity or diagnostic uncertainty)
- Speciliased FND Services/MDT
- Dedicated named FND Navigator
- Advanced rehabilitation including inpatient neurorehabilitation

Level 4: Quaternary Services for FND (Requiring highly specialised inpatient rehabilitation for FND)
- Referral to specialised centres in England

Patient can be referred into Specialist & Community services based on their primary need. Examples of services and teams patients may require referring into are:

- **Mental Health Services**
- **Pain Management Services**
- **Fatigue Management Services**
- **Adferiad/Living Well Services**
- **Epilepsy Specialist Teams**
- **Movement Disorder Specialist Teams**
- **Headache Specialist Team**
- **Liaision Psychiatry**

Stratified Levels of Care

Level of Care	Target Group	Clinical/Functional Criteria	Key Components	Threshold for Escalation
Level 1: Primary Care/ Community / Local Neurology Service	Early, mild FND symptoms	*Milder or intermittent symptoms with limited impact on daily functioning; no significant psychiatric or physical co-morbidities; first presentation or early-stage symptom development.*	• Single point of access for initial neurology diagnosis and explanation. • Referral to local generic community or rehabilitation services with knowledge of FND, e.g., Adferiad/Living Well Services. • Following assessment, services should facilitate access to education on FND and supported self-management, including digital tools, guided self-help, third sector resources, peer support networks and group-based community well-being programmes. • Navigation to Open Access Mental Health or other relevant services. • Services should follow *"what matters to them"* principles, supporting individuals with FND and their families to co-produce and shape their care. • People with FND should be encouraged to co-ordinate their own care when able or supported by a navigator or key contact provided by local services if needed.	**Threshold for Escalation to Level 2**: • Increasing frequency or persistence of symptoms despite supported self-management. • Emerging psychiatric or physical comorbidities requiring coordinated input. • Diagnostic uncertainty or non-response to low-intensity interventions.
Level 2: Secondary care/	Moderate FND symptoms	*Persistent symptoms causing moderate*	• Single point of access for neurology diagnosis and explanation.	**Threshold for Escalation to Level 3**:

Local Neurology Service/ Outpatient Therapies/ Community Rehabilitation Services		*disruption to function; co-occurring mental health or physical conditions complicating management; partial response to previous interventions; needs coordinated input from multiple services (e.g., physiotherapy and psychology)*	• Capacity to offer at least one follow-up appointment, and longer-term follow-up where required[12]. • Referral to relevant outpatient therapies and/or community rehabilitation services with knowledge, skills and experience in FND. Access to physiotherapy and psychologists to shape structured interventions and patient education programmes[10]. • Processes to discuss patients and access advice from a regional (Level 3) FND subspecialty team e.g. via regular FND multidisciplinary team meetings[12]. • Self-management and education remain a focus, including third sector/ living well community group programmes and digital supports etc. • Provision of a navigator/ key worker/ advocacy for complex presentations, including liaison with mental health and voluntary sector services. • Services responsive to symptom relapse or exacerbation, and ready to step care up or down accordingly.	• Severe or escalating symptoms. • Multiple failed treatment attempts in community setting. • Risk of long-term disability. • Diagnostic uncertainty or suspected complex/mixed presentations (e.g., FND with epilepsy or other neurological/neurodevelopmental disorder). • Requirement for neurology-led/specialist FND multidisciplinary formulation or rehabilitation coordination beyond local services.
Level 3: Tertiary/ Regional	Complex needs, high symptom	*Severe symptoms affecting single (e.g., frequent*	• Single point of access to neurology-led diagnosis and explanation.	**Threshold for Escalation to Level 4**:

Neurology Centre	severity or diagnostic uncertainty	*and/or severe functional seizures) or multiple domains (e.g., mobility, cognition, speech, self-care); complex psychiatric comorbidities (e.g., PTSD, dissociation); prior unsuccessful community interventions; diagnostic clarification required; risk of chronicity or disengagement*	• A specialist FND service (run by clinicians in an appropriate specialty e.g. neurology, psychiatry, neurorehabilitation) through which further assessment, formulation and treatment planning can be carried out for patients who have not benefited sufficiently from first line management[12]. • Access to a specialist FND multidisciplinary team, including neurology, neuropsychiatry, neurophysiotherapy, neuropsychology, and other relevant specialists, who can assess and manage second line treatment in an outpatient and/or inpatient setting as required - delivered remotely and/or with technology in more rural areas[12]. • Access to advocacy and/or dedicated FND navigator/key worker. • Inpatient intervention in complex cases. • Integrated working with mental health and social care services. • Care planning should anticipate and proactively address relapse, embedding step-down and re-engagement mechanisms.	• Severe functional dependency and inability to engage with outpatient MDT due to complexity. • Failure of structured outpatient MDT programmes despite access and engagement. • High-carer burden, safeguarding issues, or frequent unplanned admissions. • Need for time-intensive, specialist inpatient rehabilitation not available in Wales.
Level 4: Quaternary Services for FND	Persons requiring highly specialised inpatient rehabilitation for FND	*Complex, treatment-resistant FND with profound disability; severe multi-domain dysfunction (e.g.,*	• Referral to specialist centres (only in England) for inpatient, time-limited multidisciplinary rehabilitation. • Regional commissioning and cross-border referral protocols should be developed to facilitate timely access.	**Not applicable.**

		non-ambulant, non-verbal, high dependence for ADLs); entrenched disengagement, repeated admissions, or severe psychological distress	• Goals should be clearly defined and include stabilisation, functional gains, and improved engagement with local services post-discharge.	

Core Framework & Recommendations

Core Framework & Recommendation	Principle	Recommendation
1. Timely, Positive Diagnosis, and Early Intervention	*People with FND should receive a timely, explanatory diagnosis based on positive clinical signs, not by exclusion. This fosters understanding, trust, and engagement in treatment.*	• Neurological diagnosis based on application of standardised positive diagnostic criteria. • Provide early access to psychoeducation and high-quality information about FND. • Support self-management and signpost to community and peer-led resources. • Delivered according to Welsh Government waiting times guidance.
2. Coordinated Multidisciplinary Care	*Care should be matched to the individual's symptom severity, complexity and needs, delivered via a*	• Embed FND Navigators to facilitate access to appropriate services and monitor transitions[12]. • Ensure timely access to multi-disciplinary care with professionals who have knowledge and skills that include FND.

	multi-disciplinary approach, and proactively coordinated to avoid fragmentation.	• Provide a clearly defined care plan with a flexible re-access point for individuals with recurrent or fluctuating needs.
3. Equity and Accessibility of Services	*Specialist, multi-disciplinary FND services must be equitable and available to individuals regardless of geography, using technology and regional networks to close service gaps.*	• Develop a hub-and-spoke model linking local primary/ community/ rehabilitation providers to a specialist neurology-led multi-disciplinary FND service[12]. • Use digital technologies to support assessment, therapy, and follow-up, especially in rural areas. • Monitor service provision and access disparities through regular audits.
4. Lived Experience and Family Involvement	*People with FND and their families should be active partners in shaping services and evaluating their effectiveness.*	• Include individuals with lived experience in service design, governance, and training activities. • Provide family education and opportunities for involvement in care planning and review. • Establish user feedback mechanisms to inform continuous improvement.
5. Workforce Education and Service Development	*Improving outcomes for FND requires ongoing health care professional education, public awareness, and systematic evaluation of services.*	• Deliver targeted FND training for clinicians in primary, secondary, and tertiary care. • Develop a community of practice in FND (locally, regionally and across Wales/UK). • Promote public and professional understanding of FND to reduce stigma and improve the quality and safety of the care delivered. • Support research and service evaluation as part of standard care development.

Best Practice Guidance

Service Interfaces and Implementation	FND services must work collaboratively with mental health, pain, neurodevelopmental, and physical health services. It is important that there are no barriers to people with FND accessing appropriate local treatments, and professionals should receive training in FND to ensure individuals are not excluded solely due to having a functional diagnosis. Where a service declines input, clear escalation and referral routes must be in place. People with FND should have timely access to re-engage services if they relapse. A patient-initiated follow-up (PIFU) mechanism is essential. Pathways must be dynamic, trauma-informed, and uphold person-centred principles such as continuity, shared decision-making, and the care is matched to individual needs. Person-centred care - including shared decision-making, proactive coordination, and matched care based on "*what matters*" to the individual - must underpin each level of the pathway. Flexibility across levels is essential: static or exclusionary care models risk exacerbating symptoms, increasing crisis presentations and inflating long-term healthcare costs[13]. Regular service mapping, review processes, and cross-sector collaboration are essential to implement this pathway effectively and equitably across Wales.
Navigator Role in FND	The concept of case management and care coordination is one of the key principles for delivering networked care in the NHS England service specification for Specialised Neurology Services[12]. A care coordinator or navigator role is provided by a team member to provide a single point of access to specialised care for people with complex needs requiring multi-professional input[12]. Navigators support individuals whose complexity prevents them from coordinating their care independently. They facilitate access to appropriate services, support MDT communication, and link with other sectors (e.g., primary

	care, mental health, vocational rehab, third sector etc). Continuity, navigation and advocacy are central to achieving positive outcomes in FND, particularly during relapse or service transitions[12]. The recommendation is to introduce a tiered navigator model, with foundational support at Level 2 and specialist roles at Level 3. *The role involves:* • Collaborating with and supporting the person with FND and their family, promoting self-management and engagement with services. • Liaising closely with the MDT to ensure clear and timely communication between all involved professionals and helping the person access other services across the network. • Building connections across the pathway, including with primary care, community health services, mental health, third sector, vocational rehabilitation, and tertiary services. At any point in the care pathway, individuals may reach a period of stability or enter a maintenance phase where active treatment is reduced or no longer required. However, relapses are common, and if not managed promptly, can result in unplanned re-presentations to emergency or frontline services. For this reason, establishing a single point of access or patient-initiated follow-up (PIFU) pathway for individuals with FND is essential to enable timely support during periods of deterioration.
Specialist FND Multi-Disciplinary Team (MDT)	Owing to the complex and multifaceted nature of FND, a subset of individuals with moderate to severe symptoms require specialist MDT intervention to improve outcomes[12]. The concept of a clinically led regional MDT, coordinating specialist care with local and community services is also highlighted in the NHS England Specialised Adult Neurology Service Specification[12]. The specialist MDT for FND should include as a minimum:

	• Neurologist • FND navigator • Practitioner Psychologist with expertise/Neuropsychologist • Neurophysiotherapy • Access to liaison psychiatry/neuropsychiatry, speech and language therapy, occupational therapy and dietetics Throughout the pathway, access to self-management programmes, interactive technology, third sector/ community resources, and peer support initiatives enable people to better manage their symptoms and improve their quality of life. Access is also needed to emerging evidence-based therapies that address the complex, multifactorial nature of FND, integrating both physical and psychological approaches to treatment.
Education and Training	Effective care requires psychoeducation and training for health and social care providers in FND and people with lived experience of FND play a key role in contributing to training programmes. Primary care and emergency service practitioners (including paramedics) would also benefit from training to enhance their ability to recognise and understand the need for FND assessment and person-centred skills. Early and accurate diagnosis, timely referrals, and appropriate treatment depend on clinicians having foundational knowledge[14]. Developing a community of practice in each health board area will widen the knowledge base and people with lived experience, and relevant third sector organisations, need to be at the heart of this development.

	Neurology and multi-disciplinary professionals should support and work closely with patient mentors to disseminate knowledge and encourage shared learning across specialities and the wider network (e.g., including employers, schools, and colleges). Developing a community of practice will help to improve clinical outcomes, promote staff collaboration, reduce professional isolation, and enhance overall job satisfaction. Given the complexity of FND and emerging evidence base, continuous updates to clinical knowledge are essential[14]. FND training programs should focus on diagnosis, pathophysiology, psychosocial factors and management, with particular emphasis on psychological and rehabilitative models. Interventions focus on rehabilitation and living well with FND symptoms, rather than solely eliminating symptoms[15,16]. Service models also need to be trauma-informed and focus on engaging empathetically without stigma. Professionals must be equipped to address misconceptions, to clarify the roles of both neurological and psychological factors in symptom presentation, and to foster trust and engagement through clear, supportive communication[17]. A compassionate and person-centred ethos builds understanding and respect. Recent studies show that continuous professional development through case studies, simulation, and role-playing exercises enhances the ability of clinicians to improve their skills[18]. This not only improves the quality of person-centred care but also reduces clinician burnout by fostering a collaborative and supportive environment. As a major part of primary care is to manage multiple structural and functional symptoms over time, and bridge the mental/ physical divide, it is essential to include general practitioners (GPs) in the development and delivery of education and training. One option might be to develop and extend the role

	of GPs to enable them to have greater opportunities to contribute to the management of FND, especially as cases often involve a broad spectrum of other co-morbid somatic and structural disease symptoms.
Education for the person with FND and their family	Psychoeducation is an important component of the pathway as it empowers the individual to understand their symptoms; reduces anxiety and misconceptions and enhances engagement in treatment. Online resources offer easy access to psychoeducation materials, self-management strategies, and online support groups, which can be particularly beneficial for people living in rural or underserved areas. The support of an FND navigator to self-management strategies, such as relaxation techniques, symptom tracking, and goal setting encourages the use of practical tools to manage symptoms, reduce stress, and enhance functional independence. Thereby, reducing the need for hospital admissions and improves quality of life, reduces distress, promotes positive coping strategies, and encourages long-term recovery[19,20]. FND Hope UK - FND Hope International FND Dimensions Home Page - FND Dimensions Homepage | Neurology Academy Functional Neurological Disorder (FND) – A Patient's Guide to FND FND Action - Home
Research and Continuous Education	Continuous Professional Development (CPD) is necessary to ensure professionals remain up to date with the latest research, clinical guidelines, and treatment strategies. This is key to delivering effective care. Clinical research collaboration with academia and research institutions ensures that the latest evidence is integrated into clinical practice.

	Investment to promote opportunities for split clinical and research posts is recommended. In other specialities, this has been shown to lead to clinically relevant research that progresses our understanding of community rehabilitation and service models in Wales[21].
Standardised Outcome Measures	Developing and implementing standardised outcome measures across the pathway allows for the assessment of treatment efficacy and ongoing quality improvement[19,13]. Measures should be co-produced, Value-Based and focused on the outcomes that matter to the patient. This guides the most equitable and sustainable use of available resources. Education and public awareness initiatives designed to reduce the stigma encourage more people to seek care and actively engage with treatment. Collaboration with FND-focused charities and patient organisations can amplify this message.
Governance and Funding	Sustainable funding for specialised roles, clinical co-ordination and research is essential. A national network of FND professionals would be able to capture data, monitor, and implement the pathway, ensuring consistency and quality control. Developing a national database for the registration of FND cases in Wales would improve understanding of the severity and impact of FND, as well as targeting the allocation of resources and education. Regular audits are essential to gather feedback from people with FND, their families and staff, and to identify areas for improvement, for example, use of patient-reported outcome measures (PROMS/PREMS) to monitor effectiveness[22]. People with lived experience, their families and communities need to be central to designing, evaluating, and co-delivering services. Access to telehealth/virtual treatment requires further research, and there is

	a need to explore proactive outreach to Black, Asian and Minority Ethnic and Welsh-speaking communities.
Community Rehabilitation Best Practice Standards	The All-Wales Community Rehabilitation Best Practice Standards (September, 2023)[24] have been designed to; support professionals working in rehabilitation services to understand and deliver standardised rehabilitation; allow rehabilitation services to benchmark their service against others, look at ways to improve their own service provision, and help identify quality improvement projects; ensure anyone who needs rehabilitation can access these services and receive holistic treatment with them at the centre, while also giving them guidance on what they can expect.

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