Neuropsychiatry

Neuropsychiatry is the speciality that provides for the mental health needs of persons with brain and nervous system disorders. Clinical neuropsychiatry is a subspecialty of psychiatry devoted to the assessment and management of mental and behavioural problems in nervous system as well as unexplained neurological symptoms[1].

Access to specialist psychiatry services with multidisciplinary team members for those with neuropsychiatric and neurobehavioural difficulties is vital to decrease the psychiatric burden in this population, provide education and support to caregivers and family members and to support colleagues in the general adult services who may be struggling to care for these individuals.

Neuropsychiatry is a Tertiary care level service. It is generally situated in specialist Neurological/Neurosurgical centers. The coordination of such Neuropsychiatry services with the Rehabilitation services enables integrated care across the acute and recover phases of the patient's care journey and enhances the expert management, particularly of ABI. This should be organized at a National/Regional level.

Multidisciplinary teams should include neuropsychology, physiotherapy, occupational therapy, speech and language therapy, dietetics/nutrition, social work, nursing and clinical nurse specialists who help these individuals and their families navigate their difficult journey to finding locally based, specialised services if possible.

There is considerable overlap between the medical disciplines of neurology, rehabilitation medicine and psychiatry. Patients may be referred from one specialty to another as clinical symptoms develop, best practice would be for a tertiary, collaborative model of care with joint clinical commitments e.g. outpatient clinics or consult service teams.

Typical clinical presentations requiring the specialist skills of neuropsychiatry services include;

- **Major Neurocognitive disorder** (previously termed dementia)
- M**ild Neurocognitive Disorder (**Substantially congruent with previous definitions of mild cognitive impairment)
- **Acquired Brain Injury (ABI)**
    - Individuals with TBI may have changes in emotional function, reduced control over aggression, mood disorders, anxiety, personality changes, physical disturbances and reduced tolerance to medications.
    - Vascular neurocognitive disorders: Psychiatric sequellae of stroke includes neurocognitive disorders, changes in personality, depression and bipolar disorders. Similar symptoms can occur in other vascular conditions.
- **Movement disorders**
    - Psychiatric features may present in a number of movement disorders including parkinsonism, huntingtons etc.
- **Other Neurological Conditions which may present with Psychiatric Features include (but are not limited to);**
    - Multiple sclerosis
    - Neurofibromatosis

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- Normal pressure hydrocephalus

- **Somatic Symptom and related disorders**
  - Conversion disorder (functional neurological symptom disorder)
  - psychogenic non-epileptic seizures

Mental Health Comorbidity in Epilepsy

  - Peri-Ictal Psychosis, Interictal Psychosis, Mood disorder

Current service provision

Services for those with neuropsychiatric needs are limited throughout the country. Services are generally delivered in a consultation liaison model of care within general hospitals. Consultation Liaison colleagues around the country may provide an ad hoc service as possible.

Consultants in the voluntary sector may also contribute with a cognitive disorders clinic and specialist services for those with Huntington's disease, early onset cognitive disorders and their caregivers and family members.

The National Rehabilitation Hospital has an in-patient Neurobehavioural Unit as well as a Neurobehavioural out-patient clinic (NBC). Both services are multidisciplinary and support those with significant behavioural/emotional needs following an acquired brain injury. These are tertiary services, as similar services do not currently exist within the hospital group or CHO structures. Considering this, demand on these services far outweigh capacity, both for the in-patient unit and out-patient clinic.

It is recognised that psychiatric complications of TBI interfere with rehabilitative interventions and, more importantly, affect survivor's abilities to function autonomously following their discharge from structured medical rehabilitative settings (Kim, E et al, 2007)[2]. The unfortunate outcome for many of these patients, who are not supported appropriately, is placement in residential services, many of which are inappropriate i.e. in-patient psychiatric institutes, placement in intensive residential behaviour management programmes, many of which are only available outside of Ireland or through private organisations at great cost to the state.

Considering the incidence of psychiatric symptoms following ABI (20% of those presenting with catastrophic psychiatric symptoms, *Dilley M. & Fleminger S. 2007*) it is strongly felt that all clinicians working in the area of ABI should be provided with the opportunity to develop further neuropsychiatric expertise particularly as the neuropsychiatric consequences of ABI can out weight neurological sequelae as predictors of functional outcome. This would be also supported by experts in the field including David B. Arciniegas, MD who writes 'developing further neuropsychiatric expertise of physicians and other specialists providing care to persons with TBI in such (rehabilitation) settings is an important objective'.

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[2] Kim E, Lauterbach EC, reeve A, Arciniegas DB, etc al. the Journal of Neuropsychiatry and Clinical Neurosciences 2007; 19:106-127).

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Development of neuropsychiatry services and supports for people with neurobehavioural challenges are crucial as existing services are inadequately resourced to meet the ever increasing demand on services. These supports should be multidisciplinary, ideally with input from Neuropsychiatry, Neuropsychology and Rehabilitation Medicine clinicians with access to wider multidisciplinary teams with appropriate training as necessary.

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