

Assessment and treatment of functional neurological disorder in a community rehabilitation service: The Tower Hamlets Model

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Introduction

Functional Neurological Disorder (FND) is a common neurological condition, with an incidence of 4–12 per 100,000 per year, and an estimated 6% of neurology clinic appointments in the UK recording FND as a primary presenting diagnosis. The impact on those living with the condition is equal to other common neurological disorders, and associated UK healthcare costs total between £13.5 million and £40.4 million per year.

Assessment and treatment of FND is within the remit of the Tower Hamlets Community Neurology Team (THCNT), a multidisciplinary service based in London. Noting an increasing frequency of referrals for FND, the service began to develop a pathway for this population, based upon best-practice recommendations. This paper outlines the development and implementation of the pathway within THCNT.

Aim

In Tower Hamlets, there was an increase in referrals for patients presenting with FND (2019: 5 accepted referrals, 0.3% of total team referrals; 2023: 15 accepted referrals, 1.2% of total team referrals; 2025: 25 accepted referrals, 1.5% of total team referrals).

Prior to the pathway’s conception, staff in THCNT reported reduced confidence in supporting the rehabilitation needs of this population and described increased levels of stress related to clinical complexity. Treatment was often not coordinated between disciplines, resulting in variable patient experience and diminished outcomes.

The project aimed to more effectively meet the clinical needs of patients, whilst developing staff confidence and expertise.

Method

A working group was set up to review the literature and develop the pathway. As part of this process, staff attended training provided by a tertiary level FND service and feedback was obtained from stakeholders, including neurologists, experts by experience and referring therapists. No additional funding was available for implementation of the pathway, and, as such, active input from neurology or neuropsychiatry was not available. To mitigate for this, local links were established with neurology and psychiatry services. These links, and an outline of the pathway, can be seen in Figure 1.

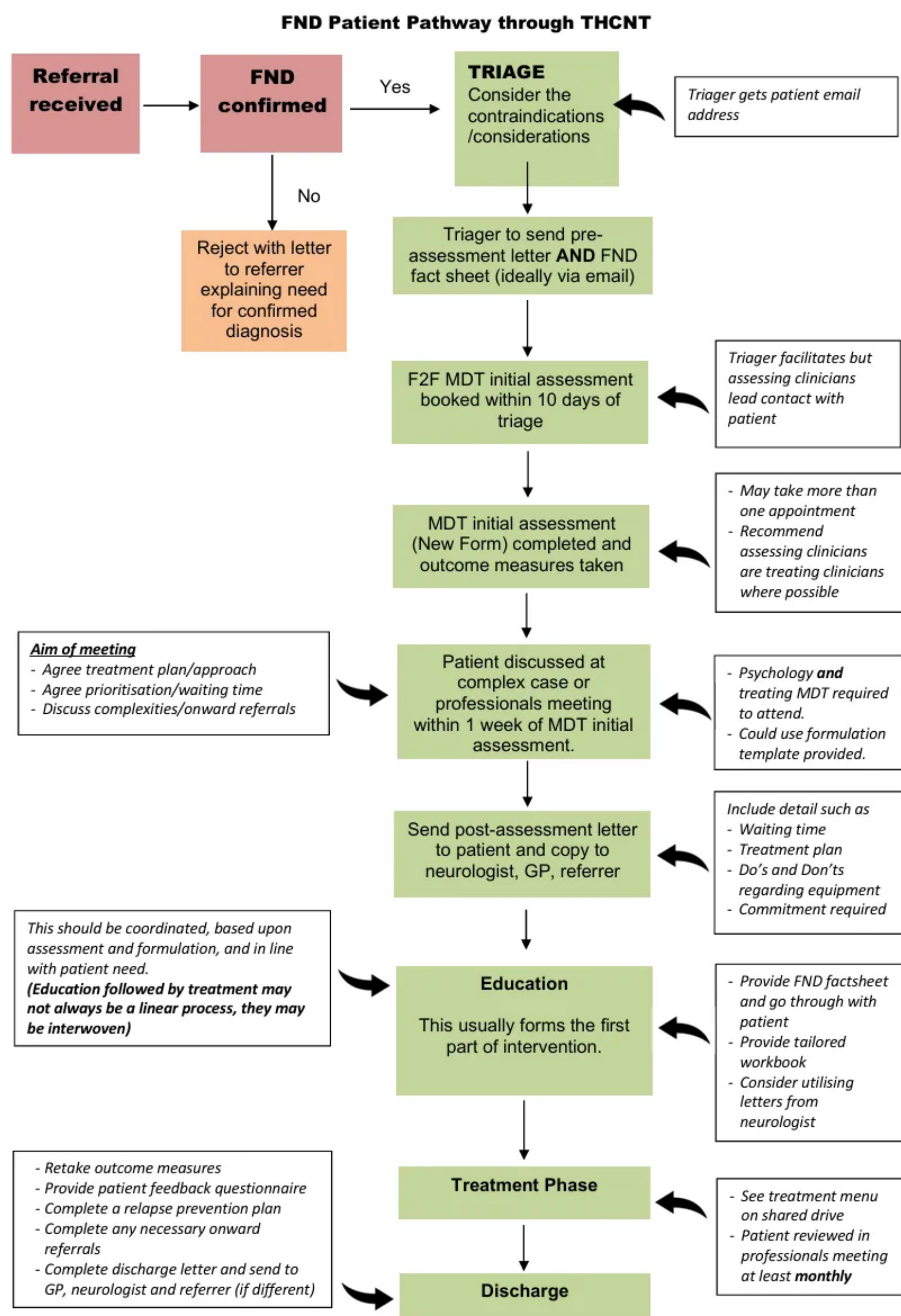


Figure 1: The Tower Hamlets Model.

Results

Patient feedback: Feedback from patients has been encouraging. Patients have highlighted the importance of receiving care from a team with a good understanding of FND, as well as the value of receiving education regarding the factors which may have precipitated the onset of their symptoms, and the factors which perpetuate them. Patients have found the flexibility of the service beneficial. Wait times have not typically been an issue for patients.

Staff feedback: Staff generally feel more skilled in working with patients with FND and highlight the importance and value of consistent MDT working. There are some practical considerations in respect of health literacy, significant physical and psychiatric comorbidities, and the lack of neurology follow-up for some of our patients. We also do not have routine access to either neurology or neuropsychiatry within the team. Our patients typically present with systemic and psychosocial complexities, including housing, finance, and immigration issues, and many have PTSD or complex PTSD, all of which can be a barrier to their participation in rehabilitation. Our observation is that patients who receive good education at the point of diagnosis tend to make better gains.

Measuring success: The collection of outcome data has proven challenging: there are few measures suitable for this population. We are currently piloting our own patient- and clinician-rated outcome measures. From a qualitative perspective, we have observed improvements in patients’ understanding of FND, in their function, and in symptom management. Some of our patients have been able to return to work or to leisure activities. Some have been able to participate more in family life and parenting. We have observed a reduction in A&E attendance in some patients who have been through the pathway. We have also worked with patients who progressed from being PEG fed to eating and drinking normally.

Peer learning: There have been considerable opportunities for peer learning. Pathway development was precipitated by a peer-led multidisciplinary study day, sharing best practice principles and considering liaison between neuro-therapies, neuropsychology, and neurology. As part of the establishment of the pathway the team has embedded in-service training provision as part of induction; systemic learning via fortnightly complex case discussions; and provision of peer learning to therapists in acute settings. In January 2026 the team held a study day entitled ‘Community Neurorehabilitation for FND: An Integrative Approach’, which included sessions on pathway design and trauma-informed approaches, and presentation of a novel biopsychosocial model to facilitate formulation and treatment. Patient feedback was presented, as were sessions on interdisciplinary working, and case-based workshops. Feedback was positive, with the sessions on FND psychoeducation and biopsychosocial formulation rated as particularly valuable.

Challenges: As awareness of the pathway has improved, referrals have increased, resulting in longer waiting times. There is significant psychiatric complexity in the caseload, leading to longer episodes of care and difficulties balancing the rest of the caseload. Joint working with adult mental health has sometimes been challenging.

Conclusion

This project demonstrates that it is feasible to implement a specialist pathway for patients with FND within an NHS community neurorehabilitation team, even in the absence of additional funding.

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