

**Psychiatrists’ delivery of Standardised Medical Care (SMC)**

Psychiatrists’ provision of SMC of patients begins after diagnosis with an outpatient appointment around 3 months of the neurological assessment. This will be held before the patient can be consented for the randomised controlled trial.

Key points:

The initial pre-randomisation clinical psychiatric assessment will include the following components and partly have a psychoeducational function:

1. Reiteration of all of the points covered by the neurologist at diagnosis including checking the patient has received the information leaflet from the study that was delivered by the Neurologist and direction to self-help information;
2. Provision of a more detailed leaflet “Dissociative Seizures” (Factsheet (Psychiatry)) ;
3. Acknowledge fears about a psychiatric label;
4. Clinical assessment of relevant axis 1 (e.g. depression, anxiety) and axis 2 (personality disorder traits) psychiatric disorders including an assessment of the risk of self-harm/suicide;
5. Explanation and treatment of any psychiatric comorbidity. This may include provision of psychopharmacological treatment (for example antidepressants) or general treatment as required;
6. Explanation of any other functional somatic symptoms, general advice about management and referral to physiotherapy if appropriate for mobility problems or fatigue;
7. Discussion of factors emerging from the clinical history that seem to have aetiological significance: relevance of predisposing, precipitating and perpetuating factors in their case if apparent;
8. General information provision about any warning symptoms and distraction but not specific techniques and not discussed repeatedly so that this does not become therapy;
9. Liaison with other mental health professionals involved in the patient’s case as appropriate but no referral for other psychotherapeutic input (including use of CBT techniques) specifically for dissociative seizures. The emphasis should be on psychoeducation and management of comorbid psychiatric conditions in the normal way;
10. Involvement of family or friends in the above steps as required;
11. Encouragement in social activities, return to college/work as appropriate. This may require liaison with work / school / college to explain disorder and assist in correct management of dissociative seizures in these environments if appropriate;
12. Completion of forms from DVLA or Department of Work and Pensions if requested by those agencies.
13. If the patient is still being followed up at 12 months after they have been randomised to either receive CBT+ SMC or SMC along it will be necessary to complete a very brief rating scale about how their seizures are. Information about how to do this will be provided by the research team.

Further SMC by psychiatrists will include support, consideration of psychiatric comorbidities and any associated drug treatment and general review but no CBT techniques for dissociative seizures.

Following the initial psychiatric assessment session (up to 90 mins), despite some local variation we then anticipate 3-4 psychiatry SMC sessions (costed on the basis of up to 30 minutes per appointment) after randomisation but there will be no mandatory number.

*Withdrawal of anti-epileptic drugs:*

We anticipate that neurologists will, as part of delivering the diagnosis, explain that AED withdrawal should be gradual but that AEDs are not treating dissociative seizures and may make them worse. The exception would be for someone with a previous history of epilepsy. Subsequent SMC by neurologists would include supervision of AED withdrawal and overall progress review. This is an approach that should also be emphasised during the psychiatric assessment and follow-up since remaining on AEDs conveys to the patient that they have epilepsy rather than a psychiatric disorder. However, it would be emphasised that AED withdrawal would be undertaken in a measured and collaborative way and that during that process side effects (including changes in the nature or number of seizures) would be monitored. A gradual reduction in drug dose would be recommended to avoid adverse reactions (e.g. mood changes, anxiety or withdrawal seizures) and this would be communicated to the patient’s general practitioner to ensure that AEDs are not re-prescribed. There is evidence that a measured approach to AED withdrawal, undertaken soon after diagnosis is safe and potentially beneficial in improving seizure control and reducing health service use. We would document any concerns patients have about their medications at each SMC appointment.