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Feature

Epilepsy and mental health disorders: current challenges and potential solutions

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Summary

Epilepsy affects ~50 million people worldwide and is associated with increased psychiatric comorbidities, including depression, anxiety, psychosis and suicidality. Despite this, current epilepsy management primarily focusses on seizure control, potentially overlooking mental health concerns. This article explores the challenges of integrating psychiatric care into epilepsy treatment and proposes solutions for a more holistic approach. Using a consensus development panel method, a multidisciplinary team of neurologists, psychiatrists and a lived-experience expert identified key challenges to optimising the mental health of people living with epilepsy, such as healthcare system fragmentation, underdiagnosis of mental health conditions and inadequate resources. Among the proposed solutions, the need for routine mental health screening, interdisciplinary support and collaboration, and increased research into the neuropsychiatric aspects of epilepsy were highlighted. A shift from a seizure-centric model to a patient-centred approach is advocated, emphasising biopsychosocial care and improved access to psychiatric services. We also discuss prospective practical strategies to tackle the issues identified, including collaborative care models, structured decision trees and AI-driven screening tools, to enhance diagnosis and treatment. Addressing these challenges through systemic change, research investment and service innovation should significantly improve the care and quality of life for individuals with an epilepsy and co-occurring mental health disorders.

Keywords

Epilepsy; psychosis; depression; suicide; anxiety.

Affecting around 50 million people globally,[1] epilepsy is associated with elevated disability and mortality.[2] Its definition traditionally focuses on seizure activity,[3] but people with epilepsy often experience several other adverse conditions, especially higher rates of psychiatric and behavioural disorders such as depression, anxiety, psychosis and completed suicide.[4] Current care for people with epilepsy still prioritises seizure control, though from a patient's perspective, improving quality of life requires a much broader focus.[5] Despite the clear need for better interdisciplinary work between neurology and psychiatry, many barriers seem to prevent such holistic care. The available scientific literature relating to neuropsychiatric symptoms in epilepsy, for example, focuses almost entirely on children and adolescents,[6,7] on people in specific geographical areas[8] or special populations.[9] The aim of this Feature Article is to identify challenges and propose potential solutions for the healthcare across the breadth of people with epilepsy and co-occurring mental health illness.

Method

We used the consensus development panel approach[10] as recommended by the National Institutes of Health[11] and the World Health Organization.[12] This method is regarded as particularly effective for identifying challenges and potential solutions in broad areas of clinical need[13] involving a multidisciplinary group of international experts (hereafter, 'the expert group') and a separate panel of non-expert participants with a mix of early- and mid-career researchers, clinicians and individuals with lived experience (hereafter, 'the panel').

Pre-consensus meeting procedures and literature review

Before the consensus meeting, the panel conducted a literature review of the evidence available over the last five years on PubMed/MEDLINE, relevant to the themes previously suggested by the experts: (a) general psychiatric comorbidities in epilepsy, (b) epilepsy and psychosis, (c) functional dissociative (or non-epileptic) seizures, (d) epilepsy and suicidality, (e) treatment-resistant epilepsy and the role of the neuropsychiatrist, (f) epilepsy and depression, (g) epilepsy and cognitive impairment, (h) epilepsy care pathways and (i) patient and public involvement and engagement perspectives on epilepsy and mental illness. The panel used a broad search strategy to screen for papers relevant to epilepsy and psychiatric comorbidities. The search was updated until 4 September 2024, using the following terms: ('mental disorders'(MeSH Terms) AND 'epilepsy'(MeSH Terms)) AND (2019:2024(pdat)). From 3033 records initially identified and 18 suggested by the expert group, 162 papers met the inclusion criteria; of these, 23 were further selected as essential reading by the panel and shared with all the panellists, while the remaining 139 records were listed as supplementary reading material for consultation purposes (Fig. 1; Supplementary Material S1 available at https://doi.org/10.1192/bjp.2025.10455). This preliminary work identified areas of recent development, uncertainties or debate that formed the opening agenda for the enquiries to be addressed in the face-to-face meeting.

Consensus-meeting procedures

We convened a meeting in Rome, Italy, on 8–9 October 2024, to discuss the complexities of formulating diagnosis, collecting data, delivering treatment and the ethical implications in epilepsy and

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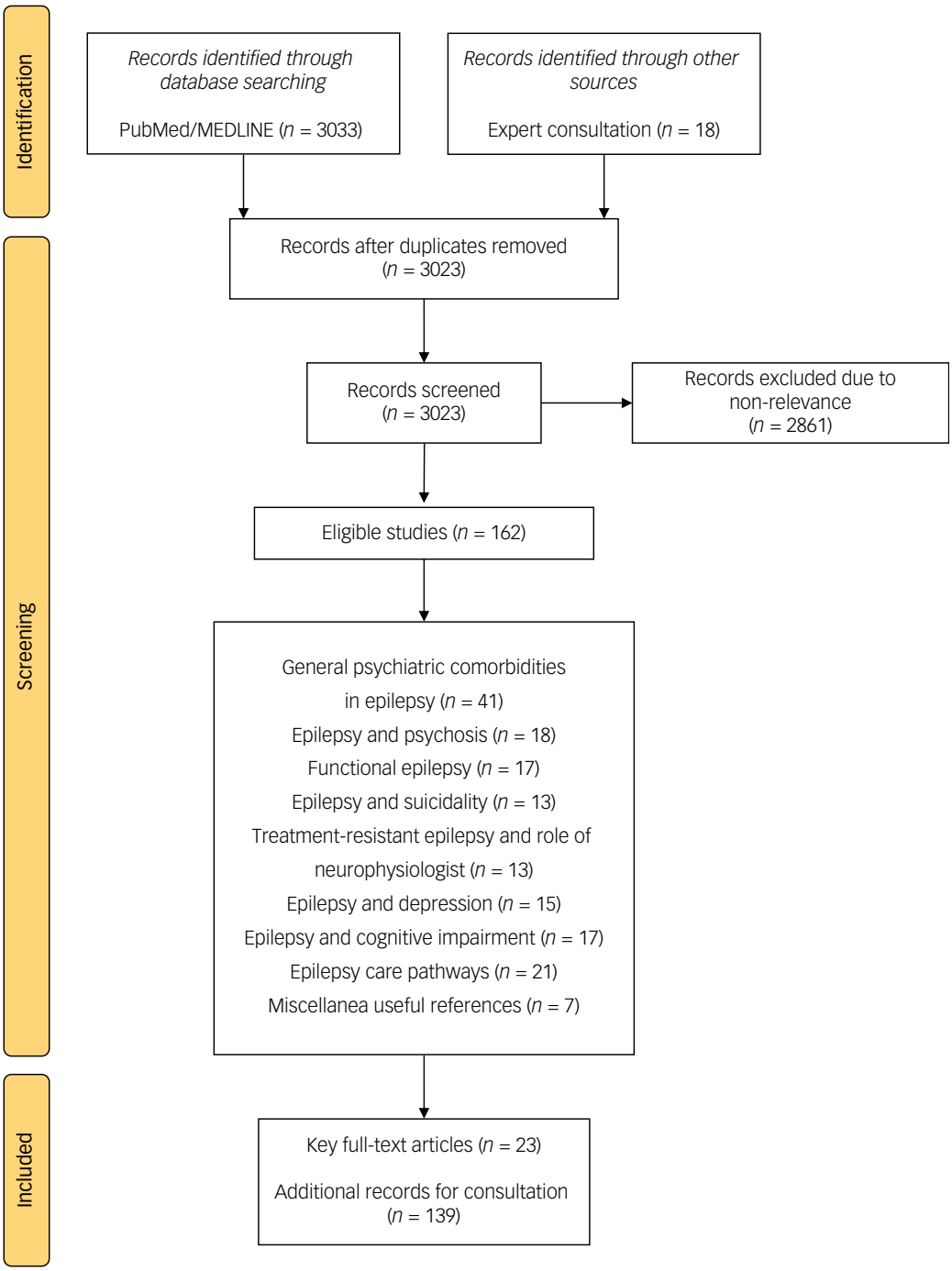

Fig. 1 Flow chart of the literature review.

mental health. The logistics of the meeting were supported externally by Angelini Pharma. Angelini Pharma did not have any involvement in the design of the meeting, identification or selection of the expert group or panel, agenda of the meeting, discussions, consensus or output. Consensus was defined as either fully met or not met, with outcomes being transparently reported.

The expert group and the panel

Eight international experts (A.S., B.T.B., C.M., G.A., J.P.-C., M.Y., S.F. and S.L.) encompassed expertise in a variety of specialist areas within neurology and psychiatry (including epilepsy, mood disorders, psychosis, functional dissociative seizures, neuropsychiatry, experimental medicine, evidence synthesis and epidemiology) and lived-experience of epilepsy and psychiatric comorbidities (T.R., representing the Patient and Public Involvement, Engagement and Participation (PPIEP)). The panel was composed of nine members (C.R.d.R., E.F.O., E.V.A., P.A.C., R.D.G., R.K., R.Y., T.B. T.L.), including early- and mid-career medical researchers and clinicians in neurology and psychiatry. Their role was twofold: summarising the best evidence on the nine topics selected and opening the group discussion to facilitate equal contributions from members of the expert group and the panel. The group and panel's composition were gender-balanced, with members from both academic and clinical settings across Germany, Ireland, Italy, Spain and the UK.

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Table 1 Summary of challenges and potential solutions for the healthcare of people with epilepsy and co-occurring psychiatric illness

Challenges	Potential solutions
High burden of unmet psychiatric need in people with epilepsy	• Moving epilepsy care **beyond a narrow focus on seizure control and SUDEP** to include routine screening of mental health difficulties including mental health side effects of anti-seizure medication. • **Increased research efforts** in understanding psychiatric disorders in people with epilepsy.
Need for holistic care approach	• Foster **a biopsychosocial approach** to patient care, not forgetting social aspects such as support structures and considering cultural, ethnic and gender-specific aspects in service improvement and delivery.
Healthcare system divide between mental health and physical healthcare	• Foster **collaborative care models**, where for example psychiatrists and neurologists work together to provide integrated care for people with epilepsy with significant mental health needs. • Support the **expansion of existing neuropsychiatry services** aimed at people with neurological disorders, modelled on existing ones. • **Effective communication and information sharing** between neurologists and psychiatrists.
Barriers to accessing mental healthcare for people with epilepsy *(including mental health needs falling onto non-specialised mental health services)*	• Establish **channels between neurology and mental health services**, including a clear pathway for people with functional dissociative (non-epileptic) seizures. • Increase **education and training programmes for healthcare staff** (e.g. epilepsy nurses, epileptologists) in primary and secondary care around better identification and management of co-occurring psychiatric illness in epilepsy. • Develop artificial intelligence **tools** (i.e. screening and risk assessment tools) to support staff in recognising people with epilepsy who may require more specialised mental health care support.
High rates of suicide in people with epilepsy	• Increase education in staff around the elevated risk of completed suicide and in the **identification and assessment of suicide risk**. • Improve **research efforts in suicide in people with epilepsy** and in the development of supportive artificial intelligence tools (including suicide risk assessment tools).
Practical barriers to providing holistic care	• Develop **MDTs involving neurologists/epileptologists, epilepsy nurses and mental health professionals** (psychiatrists, psychologists and mental health nurses) **and primary care physicians**. • Develop **appropriate infrastructure for MDT** working including clinic time, space and setting. • Clearly identify **healthcare staff's role in the MDT** (e.g. who case-manages; who is responsible for starting first-line antidepressant therapy and the infrastructure to support this). • Clearly identify the **role of primary versus secondary healthcare**. • Ensure staff have **appropriate access to both mental and physical health records** in order to provide holistic care.
Improving the development of services	• Involve people with lived experience in the design of services (**co-production**). • Use **Patient Reported Outcome Measures**.
Resource limitations	• Develop **'decision trees' for pathways of care**, to identify people with epilepsy for whom holistic care may be critical, such as those with severe mental illness, or treatment-resistant epilepsy.
Research gaps	• Clear **identification of research priorities** to attract funding. • **Collaboration** of mental health and epilepsy specialists **in epilepsy research**. • **Co-production** with people with epilepsy and PPIEP made mandatory **in funding applications**.

MDT, multidisciplinary team; PPIEP, Patient and Public Involvement, Engagement and Participation; SUDEP, sudden unexpected death in epilepsy.

Ethical considerations

Ethical approval was not required. All attendees offered contributions to the research topic voluntarily in an open environment.

Results

Challenges, potential solutions and implications for practice

The group achieved full consensus on all the outputs of the meeting, encompassing four broad, interconnected themes detailed below. Challenges, potential solutions and clinical implications for each theme are reported in detail here and a succinct summary is also listed in Table 1.

Multiple long-term conditions in people with epilepsy

In line with the recommendations from the UK National Institute for Health and Care Research, we advocate for the use of the term multiple long-term conditions to describe the co-existence of two or more chronic conditions in an individual, rather than 'multimorbidity' or 'comorbidity.' This terminology is preferred by people with epilepsy, carers and the public, as it is more intuitive and better understood.[14]

Psychiatric disorders, cognitive deficits and functional dissociative seizures are disproportionately prevalent in people with epilepsy. One in three individuals with epilepsy has a lifetime psychiatric diagnosis, and the risk of developing a psychiatric illness is two to five times higher than in the general population. This increased burden is linked to poorer treatment response, higher morbidity and elevated mortality.[15] The pooled prevalence of anxiety and depression is greater in people with epilepsy compared to those without (9.2 *v.* 2.4%).[16] The risk of psychosis is also markedly higher, with an almost eight-fold increase and a prevalence of approximately 5.6%.[17] Additionally, individuals with epilepsy face a substantially heightened risk of suicide, with a two- to three-fold increase in completed suicides compared to those without epilepsy.[18] This risk is exacerbated by co-occurring depression, as demonstrated by a Swedish population study, which reported an absolute suicide rate of 3% over an average nine-year follow-up.[19]

The underlying mechanisms driving this increased mental health burden in epilepsy remain an area of active investigation. A bidirectional relationship between epilepsy and mood disorders has been proposed.[20] The localisation of epileptic activity within the brain may influence the psychiatric manifestations observed. For instance, temporal lobe epilepsy, which affects the hippocampus and mesial temporal structures, is frequently associated with anterograde memory deficits, depression and anxiety.[21] Clinical evidence, however, indicates that psychiatric manifestations in epilepsy are not always predictable and may extend beyond these expected patterns.[21] Shared neurobiological mechanisms have been

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implicated, including disruptions in brain development, accelerated brain ageing and a range of neurological conditions such as traumatic brain injury and autoimmune encephalitis. Additionally, epilepsy's psychosocial impact – often affecting employment, social interactions, transportation and autonomy – can further contribute to psychiatric distress.[21]

A fundamental challenge in addressing psychiatric disorders in epilepsy lies in their recognition. Neurologists may underdiagnose depression owing to a misconception that depressive symptoms are a natural consequence of living with epilepsy.[22] A review of integrated care pathways recommends routine mental health screening for people with epilepsy to facilitate early identification.[23] However, even when psychiatric disorders are identified, evidence on treatment efficacy remains limited. Randomised controlled trials assessing antidepressant use in people with epilepsy and depression are scarce,[24] and no trials have evaluated the use of antipsychotics in epilepsy-related psychosis.[25] Medication choices require careful consideration from both neurological and psychiatric perspectives, as they can have beneficial or adverse effects on both seizure and psychiatric components. For example, anti-seizure medications, such as lamotrigine and carbamazepine, can be effective in bipolar disorder,[26] whereas certain antipsychotics, such as clozapine and haloperidol, are known to lower the seizure threshold.[27] Specific educational trajectories are needed (both during medical school and specialist training) to properly address this highly specialised field of brain health.

Holistic care

A key theme that emerged from the consensus discussions was the need to adopt a biopsychosocial approach to epilepsy care – one that fully addresses the diverse needs of individuals living with the condition. Social determinants, such as the presence of strong support networks, play a crucial role in shaping patients' coping strategies and overall well-being. Additionally, cultural, ethnic, age, gender-specific and socioeconomic factors significantly influence healthcare-seeking behaviours, treatment engagement and care provision.[28] The importance of fostering trusting therapeutic relationships and promoting shared decision-making was also underscored as critical for improving patient outcomes.

A major challenge in delivering holistic care is the longstanding divide between mental and physical health services. In England, for example, specialised mental healthcare is typically provided by separate NHS Trusts from those delivering secondary physical health services. Similar structural separations exist across Europe, often creating barriers to interdisciplinary collaboration. In response, healthcare systems are increasingly shifting towards collaborative care models, which integrate mental and physical health professionals to better address the needs of individuals with chronic conditions, including epilepsy.[29] Promising initiatives have emerged in epilepsy care,[23] including specialised clinics where neurologists and mental health professionals work together to provide integrated treatment. These models have shown positive outcomes, particularly in improving mental health outcomes.[23] Crucially, effective communication and knowledge-sharing between psychiatrists and neurologists are essential for delivering comprehensive care. Ongoing cross-disciplinary education and training can help professionals better understand each other's approaches and facilitate more seamless collaboration.

Access to mental health services also remains a significant hurdle. Pathways to care are obstructed by a range of structural and systemic barriers, including fragmented electronic health record systems, organisational silos between healthcare settings and overstretched mental health services. Information-sharing between neurologists and psychiatrists may also be hindered by privacy concerns, institutional policies or the absence of formal mechanisms for interdisciplinary communication. These barriers often leave epilepsy professionals – who may not have adequate mental health training – managing psychiatric concerns by default.[30] One potential solution is to enhance mental health training for epilepsy clinicians while simultaneously improving access to mental health services and establishing clearer referral pathways.

Practical aspects to healthcare delivery (including co-production)

Achieving holistic care in epilepsy requires structured collaboration across specialities and the formation of a multidisciplinary team (MDT) comprising neurologists/epileptologists, epilepsy specialist nurses, mental health professionals (psychiatrists, psychologists, mental health nurses and care coordinators) and primary care representatives. Practical considerations include: ensuring adequate clinic space, optimising appointment structures (including scheduling and follow-up logistics), establishing clear protocols for case management and referrals and including any caregivers/family members/partners, as appropriate. A key issue raised was the need to define roles and responsibilities within the MDT. For instance, in cases of moderate depression, should the neurologist/epileptologist initiate first-line antidepressant treatment, or is a comprehensive psychiatric evaluation required beforehand? Clarifying such responsibilities, which may vary across settings, is critical for ensuring efficient and effective care.

A particularly pressing challenge in epilepsy care is the lack of a well-defined treatment pathway for functional dissociative seizures. Functional dissociative (or non-epileptic) seizures are at least as prevalent as multiple sclerosis[31] and are more common in individuals with epilepsy than in the general population. Many people experience both functional and epileptic seizures concurrently.[32] Despite this, access to appropriate treatment remains inadequate. People with epilepsy are often referred to mental health professionals, yet specialised psychological therapies for functional seizures are frequently unavailable.[33] This gap in care persists despite the significant morbidity[34] and mortality risk[35] associated with functional seizures. Addressing this issue is imperative to improving outcomes for this neglected patient group.

There is growing recognition of the importance of co-production in healthcare service development, ensuring that services are designed in partnership with patients to better meet their needs.[23] Involving people with epilepsy in service design is essential. Additionally, the use of Patient-Reported Outcome Measures, such as the Quality of Life in Epilepsy Inventory-10[36] and CORE-10,[37] can help ensure that patient-centred outcomes – such as quality of life and mental well-being – are systematically measured and prioritised in clinical care.

While ideal models of holistic epilepsy care exist, pragmatism is required given real-world resource limitations. Many people with epilepsy worldwide still struggle to access even basic anti-seizure medications,[38] underscoring the need for realistic, evidence-based approaches to resource allocation, particularly in low-resource settings. Even in high-income countries, epilepsy care remains inadequate, with significant barriers to accessing psychiatric support.[39]

To balance the ideal of holistic care with resource constraints, structured decision trees for epilepsy care pathways could be developed. These could help identify people with epilepsy for whom comprehensive, multidisciplinary care is particularly critical. For example, holistic approaches may be most urgently needed for individuals with pharmacoresistant epilepsy or those experiencing severe medication side effects. In such cases, adjunctive non-pharmacological interventions – including psychotherapy, psychoeducation, mindfulness and lifestyle modifications – may provide significant benefits. Similarly, people with epilepsy and severe

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mental illness may require direct psychiatric involvement within an MDT, whereas those with mild anxiety or depression may be effectively managed in primary care or by their neurologist. Certain subpopulations, such as individuals undergoing presurgical epilepsy evaluations or those with treatment-resistant epilepsy, may also require dedicated mental health input to ensure accurate diagnosis and long-term optimal management.

For people with epilepsy who do not meet criteria for specialised psychiatric care, enhancing mental health training for frontline epilepsy professionals – such as epilepsy specialist nurses and primary care physicians – could improve outcomes. Education on recognising and managing mental health difficulties, including suicide risk, should be prioritised. Such efforts, though, must be complemented by accessible care pathways to ensure that individuals requiring higher levels of support can seamlessly transition to appropriate services. Both neurologists and psychiatrists operate under heavy workloads and resource constraints, making sustained interdisciplinary collaboration challenging. A shortage of mental health professionals in many healthcare systems exacerbates these difficulties.[40] In low- and middle-income countries (and rural areas of high-income countries), where specialist psychiatric services are even more limited, integrating mental health support into primary care and epilepsy services may be particularly crucial.[23] Future innovations, including the use of artificial intelligence and digital screening tools, may offer practical solutions. Artificial intelligence-driven assessments could assist clinicians in identifying mental health disorders, screening for and/or augmenting clinical evaluation of suicide risk[41] and guiding decisions on anti-seizure medication prescribing. Such tools may help streamline care by identifying people with epilepsy who would benefit from psychopharmacological treatment or more intensive mental health interventions.

Recent advances in biological aspects of epilepsy, evidence gaps and research priorities

There is an urgent need for greater research at the intersection of mental health and neurology to deepen our understanding of the mechanisms underlying disorders that span both fields. Addressing these knowledge gaps can foster enhanced collaboration and, ultimately, improve patient care. Recent advances in our biological understanding of the neuropsychiatric aspects of epilepsy, including cognitive impairment and functional dissociative seizures, offer promising insights into potential therapeutic avenues. For instance, anti-seizure medications such as levetiracetam have demonstrated potential for treating disorders of neuronal hyperexcitability beyond epilepsy, including Alzheimer's disease.[42] However, potential adverse psychological effects of anti-seizure medications, for instance the higher incidence of treatment-emergent neuropsychiatric symptoms, should be acknowledged.[43] This suggests that bidirectional associations between these conditions might pave the way for combined, effective treatments.

In the context of functional seizures, emerging research has highlighted differences in interoceptive accuracy and awareness among affected individuals.[42] Interoception refers to the ability to perceive and accurately interpret visceral signals. People with functional seizures exhibit poorer objective scores of interoception while paradoxically reporting higher levels of interoception compared to individuals without functional seizures.[44] These findings offer valuable insights into the underlying mechanisms, potentially leading to more accurate diagnostic and therapeutic approaches.

Despite these promising developments, significant research gaps remain. Epilepsy, one of the most prevalent neurological disorders, has long faced chronic underfunding.[45] Other key issues within epilepsy research include a high degree of heterogeneity in evidence synthesis, a pressing need for more rigorous methodological approaches and the failure to integrate joint input from both neurologists and psychiatrists when investigating epilepsy and co-occurring neuropsychiatric disorders (Box 1). This issue is especially pertinent when phenotyping and characterising mental health disorders that co-occur with epilepsy. In some research projects, psychiatrists are notably absent from the investigative teams. Critical evidence gaps identified include the need for more collaborative approaches, rigorous statistical testing of the bidirectional relationship between epilepsy and comorbid mental health conditions and better evaluation of treatment efficacy.

Box 1 Specific knowledge gaps in epilepsy research highlighted from the consensus meeting and literature review

- Understanding co-existing epilepsy and functional dissociative seizures.
- Stratification of people with epilepsy to inform treatment and prognosis.
- Suicide and related risk prediction tools.
- Evidence-base for treatment of co-existing psychiatric disorders.
- Non-pharmacological treatments for epilepsy (e.g. psychoeducation, biofeedback, mindfulness, physiotherapy, physical exercise and sleep management/hygiene/quality).
- Understanding monogenic and polygenic underpinnings of epilepsy and mental disorders.
- Artificial intelligence and digital healthcare (e.g. artificial intelligence support tools, digital psychoeducation, healthcare data collection, and digital biomarkers).
- Improving objective measures of seizure activity (instead of heavy reliance on seizure diaries in out-patient clinic settings) and mood fluctuations.

Incorporating patients and the public into research is essential. One potential solution is to make PPIEP mandatory in funding applications, with a requirement for a co-applicant role, as is already the case for several major funding agencies.

A recent publication by Norton et al[45] identified the top ten research priorities in epilepsy, as determined by over 5000 members of the 'epilepsy and associated conditions' community. These priorities resonate with key issues raised during the consensus meeting: (a) enhancing our understanding of the impact of epilepsy, seizures and anti-seizure medications on mental health; (b) investigating the causes and contributory factors of epilepsy-related deaths and their prevention and (c) adopting a 360-degree approach to epilepsy care, particularly with regard to improving the quality of life for people with epilepsy and their families/carers. Notably, any study of epilepsy-related mortality must address suicide and other premature causes of death. Moreover, the role of risk stratification requires further exploration to support clinicians in targeting resources more effectively and augmenting clinical decision-making in the management of co-occurring psychiatric conditions.

Discussion

Epilepsy is a prevalent neurological disorder affecting approximately 50 million people worldwide and is associated with increased psychiatric comorbidities, including depression, anxiety, psychosis and suicidality. Despite this, current epilepsy management does tend to primarily focus on seizure control, potentially overlooking mental health concerns. In this article, we explore the challenges of integrating psychiatric care into epilepsy treatment and propose solutions for a more holistic approach. Using a consensus development panel method, a multidisciplinary team of neurologists, psychiatrists and a lived-experience expert identified key challenges to optimising the mental health of people living with epilepsy. These included healthcare system fragmentation,

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underdiagnosis of mental health conditions and inadequate resources. Among the proposed solutions, the need for routine mental health screening, interdisciplinary support and collaboration, and increased research into the neuropsychiatric aspects of epilepsy were highlighted. A shift from a seizure-centric model to a patient-centred approach is advocated, emphasising biopsychosocial care and improved access to psychiatric services. We also discuss proactive practical strategies to tackle the issues identified, including collaborative care models, structured decision trees and artificial intelligence-driven screening tools, to enhance diagnosis and treatment. Addressing these challenges through systemic change, research investment and service innovation should markedly improve the care and quality of life for individuals with epilepsy and co-occurring mental health disorders.

The focus of this paper is around the challenges and solutions of the healthcare management of epilepsy and mental health comorbidities. Epilepsy is a specific example in an intentionally narrow clinical area, but we think it is important to expand this approach to the interface between neurology and psychiatry more broadly. Psychiatry and neurology, two closely intertwined disciplines focused on the brain and nervous system, have historically faced challenges in working together. A primary issue arises from the distinction between psychiatric and neurological disorders. While some conditions clearly fall into one category or the other, many exhibit overlapping symptoms – some more neurological, others more psychiatric – making classification difficult. This overlap is particularly evident in conditions like epilepsy and functional dissociative seizures, which straddle both fields.

Psychiatrists and neurologists, though both experts in brain-related disorders, often receive different training. Psychiatrists primarily address the mental, behavioural and emotional dimensions of illness, focusing on conditions where structural brain lesions are not typically present. Neurologists, in contrast, specialise in disorders that affect the structure and function of the nervous system, such as motor or sensory disturbances. These differing perspectives can create barriers to effective collaboration and prevent effective patient care.

The longstanding stigma surrounding psychiatric disorders has further complicated this dynamic, as some neurologists may view psychiatric conditions as less 'objective' or deserving of attention compared to neurological diseases. This bias can hinder joint efforts between the fields and reduce patients' willingness to seek integrated care. Additionally, treatment approaches differ: psychiatry often utilises medication, psychotherapy and psychosocial interventions, while neurology tends to focus on medications, lifestyle adjustments and surgical interventions. These distinctions can make it difficult to integrate care for patients with complex, overlapping conditions.

The benefits of closer collaboration are clear. When both fields recognise the interplay between brain function and mental health, their expertise becomes complementary. Neurologists who consider emotional and behavioural factors, and psychiatrists who acknowledge the structural and functional aspects of brain disorders, can provide more holistic, effective management. In particular, conditions such as epilepsy that exhibit both neurological and psychiatric components, exemplify the need for interdisciplinary approaches that integrate the strengths of both psychiatry and neurology.

Our methodological approach to consensus development has some limitations. Although we conducted a systematic literature review, we limited our search to PubMed/MEDLINE and to papers published over the last five years, which may have excluded prior relevant studies. The purpose of this search, however, was to provide the most recent scientific information that could then be discussed at the expert meeting. To reduce the risk of selection bias, we did not rely exclusively on these references for the consensus development. This issue was further mitigated by the later addition of key references provided by the expert group and by running an updated search before the final submission of our manuscript, which confirmed that no relevant articles had been missed.

Additionally, as with all consensus meetings, there are no standardised guidelines for selecting experts, and a degree of subjectivity in the experience and knowledge of the participants and the selection of topics is to be expected. To minimise this, we aimed to include a broad range of perspectives: our expert panel represented diverse fields at the interface between epileptologists and psychiatrists and we also involved one expert with lived experience of mental illness in epilepsy. Nevertheless, this article is not meant to exhaustively address all challenges and potential solutions across the large spectrum of co-occurring epilepsy and mental disorders. Some important areas, often seen in epilepsy, such as autism, attention-deficit hyperactivity disorder, learning difficulty, intellectual disability or movement disorders, were not covered.

In conclusion, the current focus of epilepsy care – both clinically and within research – remains largely centred on seizure control and reducing the risk of sudden unexpected death in epilepsy (SUDEP).[5] While these are crucial priorities, comparatively little attention is paid to the co-existence of co-occurring psychiatric and behavioural disorders in people with epilepsy, and the associated adverse outcomes such as suicide. Seizure control alone does not always correlate with improved quality of life; mental health disorders, treatment side effects and broader psychosocial factors often play a more decisive role. A more holistic approach to epilepsy care must, therefore, extend beyond seizure management and SUDEP prevention to fully address the broader determinants of patient well-being.

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Supplementary material

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Data availability

The data that support the findings of this study are available from the corresponding author, A.C., upon reasonable request. The materials supporting the findings are available to other researchers upon reasonable request to the corresponding author.

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Author contributions

A.C. and A.A.-S. formulated the overarching research goals and aims, and acquired funding. A.C., R.D.G. and A.A.-S. were responsible for the management and coordination of the research planning and execution. A.C. and A.A.-S. supervised the whole project. R.D.G., T.L. and A.C. composed the first draft of the manuscript. C.M., E.V.A., E.F.O., T.B., A.S., S.F., B.T.B., R.K., R.Y., J.P.-C., S.L., P.A.C., C.R.d.R., M.Y., G.A. and T.R. critically revised the first draft of the manuscript. A.C. had final responsibility for the decision to submit for publication. All authors reviewed, edited and approved the final manuscript.

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