ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

I wanted to experience as much breadth as possible within the field of Psychiatry during my time on elective at the Prince of Wales hospital in Sydney. I am extremely interested in pursuing Psychiatry as a career and have had minimal exposure to the different subspecialties during my time at medical school. I spent a week in Old Age Psychiatry at the Euroa Centre, a week in the Mood Disorders Unit on Kiloh ward, a week at the Langton Drug and Alcohol Addiction Centre, and a week at the Early Psychosis Unit at the Bondi Junction Centre.

During my time at the Langton Centre I spent some time shadowing Dr Mark Montebello in his outpatient clinic. The first thing to come to my attention was the difference in patient demographics and also the availability of different street drugs between Australia and the UK. London is an extremely ethnically diverse city with a large number of immigrants and non-English speakers, however the majority of patients in Australia that I was exposed to were English speaking, and either originally from Australia or neighbouring Pacific islands. The main drugs of abuse in Australia are alcohol, cannabis and methamphetamine. Methamphetamine abuse is quite uncommon in the UK, whereas heroin is quite uncommon in Australia but is quite prevalent in London, along with cocaine and crack cocaine (these are very commonly abused in London and virtually non-existent in Australia).

Dr Montebello also informed me of an initiative called IDAT (Involuntary Drug and Alcohol Treatment Program) which has been implemented in Australia which is designed to protect patients with substance dependence that is so severe that they are at risk of serious harm, and they are not deemed to have capacity due to their substance abuse. In the UK, it is not possible to section someone under the Mental Health Act due to addiction, as it is considered that even if they were to receive treatment they are likely relapse as soon as they are released if they receive the treatment involuntarily. Whilst this is true, we discussed a case where a patient was being admitted to A&E on a weekly basis due to a severe alcohol addiction, and how in this case the patient was at a huge risk to himself unless he were to be detained, and if not he may overdose. I have heard of similar cases in the UK in which patients did go on to overdose, and so this difference in systems highlighted to me a need for something similar to be implemented back home.

During my time in the Mood Disorders Unit, the Early Psychosis Unit, in the in-patient unit in Old Age Psychiatry, and also at the Addiction Centre, I saw a number of patients with anxiety and depression of varying degrees. Although my clinical experience in this area during my time at medical school has been limited, it struck me how common both anxiety and depression are across the board, and that they can affect anyone from any walk of life, and at any age.

Pharmacological treatment for anxiety and depression is much the same as it is in the UK; RANZCP (Royal Australian and New Zealand College of Psychiatrists) guidelines suggest SSRI's and SNRI's as first line for anxiety, and in the UK the NICE (National Institute for Health Care Excellence) guidance states that an SSRI should be tried first and if this is ineffective, a different SSRI or SNRI can be used. NICE guidance also recommends SSRI's as first line for depression, but suggests that treatment should be tailored to the individuals needs based on

the side effect profile of the medication. For example, mirtazapine is often used if patients are also suffering from lack of sleep as it is also sedating, but is less likely to be used in elderly patients due to the risk of falling. The RANZCP has similar recommendations.

CBT (Cognitive Behavioural Therapy) is suggested as the first port of call for both mild to moderate anxiety in both Australia and New Zealand, before using medication. Due to the structure of the healthcare system in Australia, however, a lot of treatment is private and so in practice, a lot of patients receiving free treatment through Medicare are unable to access psychological treatment due to limited funding meaning that it is not widely available. People with private health insurance are more able to access CBT and other psychological therapies, however even with insurance patients are only entitled to receive 12 sessions which may not be adequate in severe cases. Patients would then need to pay for further sessions, which a lot of patients may be unable to afford. In the UK, CBT is recommended as first line and the NHS is available to everyone and this type of treatment so is much more widely available.

Electroconvulsive therapy (ECT) is offered for severe depression and treatment resistant Schizophrenia in Australia as it is in the UK, and the Prince of Wales Hospital is a centre of excellence for ECT treatment, and it is used with a lot of success. I learned a lot about this as a form of treatment during my time here, which will be very useful for me in terms of my future career in Psychiatry.

I spent a week working in Old Age Psychiatry and saw a number of both in-patients and out-patients experiencing cognitive decline and dementia. Patients eligible for Medicare are covered for inpatient hospital treatment and dementia medication, but only up to 100 days of skilled nursing home care under limited circumstances. Medicare also covers hospice care delivered in the home for patients determined to be palliative. People who are unable to cover the costs of additional longer term care are able to apply for government assistance, which is similar to the services available in the UK under the NHS.

During my time in the Early Psychosis Unit at Bondi Junction, I saw a number of young patients having recently presented with a psychotic illness. The patient demographic highlighted the highly familial and organic nature of Schizophrenia, as the patients that I saw came from all socioeconomic backgrounds and were all of a similar age; males in their late teens and females in their early twenties. Speaking with the Psychiatrist Dr Julia Lappin, she informed me that prognosis is very much dependent on the clinical picture (people with florid symptoms often do a lot better than people with an insidious onset of symptoms or negative symptoms), but that family support and socioeconomic status also play a role in long-term outcomes.

I spent a day at the International Conference Centre at a conference on early psychosis. One point that was mentioned that stood out to me was that in Australia, indigenous Australians with severe mental illness experience poorer prognoses than the rest of the population, due to disproportionate levels of educational, employment and social disadvantage. Whilst mental health services in Australia are very good overall, there is still a large disparity in the quality of treatment received by different socioecomonic groups, which is a problem that needs to be addressed. During my time venturing out in Sydney I was shocked by the levels of homelessness in the city, and also during my time in the Addiction Centre as it highlighted the levels of poverty and poor health that large numbers of people experience here. Should I move to Sydney to work as a registrar once I have completed my 2 years foundation training

in the UK, I would be very keen to do some work in public health in order to help address these issues.

Overall, I have thoroughly enjoyed my elective and my time in Sydney. I have enjoyed working with the healthcare professionals here and felt very welcome throughout. I would be very keen to come back and work at the Prince of Wales Hospital in the future.