JMA ELECTIVE REPORT

Judaism in Melbourne

During my first week in Melbourne I decided to visit the Jewish Museum in St Kilda, in order to learn about Jewish history in Australia, and more specifically in Melbourne. While much of the museum was informative about Judaism in general, the exhibition on a 'Timeline of Jewish History' was what I found the most interesting. Learning about how Jewish people first came to Australia to how they later then became an integral part of society educated me on Melbourne's Jewish story, and felt very relevant to myself as someone who was new to the city.

Whilst in Melbourne, I also had the privilege of spending Friday night dinners at Rabbi Mendy's house, who leads Chabad on Campus across the Melbourne universities. This not only gave me the opportunity to feel connected to my Jewish heritage while abroad, but also to meet fellow Jewish students and to experience a Chabad in a different country. Although there were notable differences between Chabad on Campus in Leeds and Melbourne, mainly that in Melbourne the evening was far more intimate, I was touched and amazed by how even on the other side of the world the Chabad family were able to create a home away from home for me that evening.

The Alfred Hospital and Monash Psychiatry Alfred Research Centre

The Alfred Hospital, Melbourne, is a public hospital with over 500 beds[1]. It is the centre for multiple services across the state of Victoria, including the Victorian Adults Burns Service, and the largest Intensive Care Unit in the state[2].

The Alfred also has specialised community and inpatient psychiatry services. The psychiatry unit consists of 58 beds split over two wards, each with a High Dependency Unit (HDU) for more acutely unwell patients, and a Low Dependency Unit (LDU) for more clinically stable patients. On the ward, each patient benefits from a varied multi-disciplinary team, including doctors, occupational therapists, social

workers, psychologists and nurses. The average length of stay on the ward is 12 to 16 days, but some patients may stay for several months depending on how complex their needs are[3].

The Alfred's Department of Psychiatry includes the Monash Alfred Psychiatry research centre (MAPrc), run by Professor Jayashri Kulkarni, who was my supervisor for the duration of my elective. At the MAPrc Professor Kulkarni runs a Women's Mental Health Clinic, which focusses on helping women whose mental health problems partly stem from sex hormone imbalances. As this area is so sub-specialised, the waitlist to be seen in this clinic is over one year.

Aims and objectives

- Explore the similarities and differences between the UK and Australian psychiatric services and their Mental Health Acts.
- Improve my consultation skills within Psychiatry, particularly performing mental state examinations.
- Further explore Psychiatry as a potential career.

Clinical Attachment

For one day each week I participated in Professor Kulkarni's Women's Mental Health Clinic, both observing and leading consultations, and producing medical letters afterwards. The remainder of my week was spent on the psychiatry inpatient ward taking histories, reviewing patients, and participating in management discussions where appropriate. Whilst on the ward I interviewed patient CM, whose case study I have included in this report.

<u>Presenting complaint</u>

CM is a 44-year-old male who was admitted to the inpatient ward on an Assessment Order, having been taken to the Emergency Department by the police. CM was attempting to break down his neighbour Toby's door due to a delusional belief that his fiancée was having an affair with him, despite her staying at her mother's house at the time**.**

According to The Mental Health Act, 2014[4], Australia, an Assessment Order authorises the compulsory assessment of a person within 24 hours of detainment in order to determine whether involuntary treatment, including an inpatient stay, is necessary[4].

Following an initial assessment, the consultant decided to admit CM as in involuntary patient under an Inpatient Temporary Treatment Order (ITTO). This allows a psychiatrist to administer compulsory treatment for a mental illness for up to 28 days. Within that time, a Mental Health Tribunal may authorise either an Inpatient Treatment Order, which lasts for six months, or a Community Treatment Order (CTO), which lasts for 12 months, to allow for compulsory treatment of a mental illness by a psychiatrist[4]. Following his Mental Health Tribunal, CM remained an involuntary patient on an Inpatient Treatment Order.

History of Presenting complaint

CM has extensive and longstanding paranoid delusions about Toby and a man called Chris. While he names these men he has never met them. He describes being able to hear these two men talking about him while he is in his house, believes that they have installed cameras in the house to spy on him, and that they have threatened to hurt him. CM also believes that they have been breaking into his house and stealing personal objects, cars and documents pertaining to his business plans.

Past psychiatric history

CM has had five previous hospital admissions for his mental health. He had one episode of self-harm where he cut his arms 10 years ago but denies any current suicidal ideation or plans to self harm.

Drug History

CM has previously taken Risperidone, but this resulted in hyperprolactinaemia and lactation, and Olanzapine. He stopped taking these medicines as he does not believe he needs them.

On admission, CM was started on Zuclopenthixol 10mg BD PO, and switched to a depot injection during his stay. He was also prescribed Lorezapam 1mg PRN, and Olanzapine 10mg TDS PO.

Family History

CM is estranged from his family. No known family history.

Social History

CM was a truck driver but has not worked since 2016 when he experienced a traumatic incident where a woman attempted suicide by jumping in front of his truck. He recently started a diploma in Business Communications in order to aid his business venture of starting a family support company.

CM lives in a privately rented apartment building and owns two houses that have been repossessed due to failure to make mortgage payments. He lives with his dog and his fiancée of two years. Shortly before his admission he assaulted her, and she has taken out an Intervention Order against him. He also has an estranged nine-year-old son from a previous relationship.

He smokes one packet of cigarettes a day, smokes ICE (methamphetamines) regularly, and smokes marijuana on a daily basis. CM was previously dependent on alcohol.

Forensic History

CM has been to prison three times for charges including assault, burglary and damage to property.

Mental State Examination on admission

Appearance and behaviour: Caucasian man of large stature who looks his stated age. CM was casually dressed. CM engaged throughout, forming a good rapport with the medical team. He became tearful at points.

Speech: Some pressure of speech. Appropriate volume, rhythm and tone.

Mood: Subjectively and objectively low in mood. Reactive affect.

Thought form: Tangentiality apparent.

Thought content: Paranoid delusions and preoccupations that Toby and Chris are trying to steal his life, breaking into his property, spying on him through hidden cameras, and having an affair with his fiancée. He believes these men are taking on his identity and multiple other identities, consistent with Fregoli syndrome. CM denies any thoughts to hurt himself or others, including Chris, Toby or his fiancée.

Perception: No auditory hallucinations during the interview and CM was not responding to unseen stimuli. He experienced auditory hallucinations at home prior to admission, stating he could hear Toby and Chris talking about him while at home.

Intelligence/Cognition: Orientated to time, place and person. Not formally assessed.

Insight: CM has no insight into his condition, he disagrees with his diagnosis of schizophrenia, does not wish to take medication, and became very distressed at being admitted as an involuntary patient.

Diagnoses

Schizophrenia.
Antisocial Personality Disorder
Polysubstance abuse

Reflection

I chose this case as it highlighted some of the similarities and differences between the laws and applications of the Mental Health Acts in the UK and in Australia. While initially the process of an Assessment Order, converted to an ITTO for 28 days, before being changed to a Treatment Order seemed very different to the UK system. However, on further reflection this was very similar to the UK process of a patient being detained by the police under Section 135/136, before being admitted under Section 2, and then changed to a Section 3 when this expired[5]. However, In Australia the legal system plays a greater role in the involuntary admission of patients due to the necessity of a Mental Health Tribunal before a long-standing Treatment Order is put in place[4]. Therefore, the Australian system appears to offer more fixed opportunities for involuntary patients to appeal any decisions.

One difference I found striking was that in order to place a patient under a Section in the UK, they must be assessed by two doctors and an approved mental health professional (AMHP)[5], whereas the decision to make a patient involuntary in Australia lay purely with the psychiatrist. While this gives the psychiatrist a greater role in sectioning a patient, I felt that this power was somewhat mitigated by the necessity of a Mental Health Tribunal in maintaining any long-term compulsory treatment.

When discussing the ongoing management of CM with my consultant, she informed me that CM would likely be placed on a CTO when discharged in order to allow him to lead as independent a life as possible whilst minimising his risk of relapse and his forensic risks. Prior to this elective, I was unaware that CTOs also exist in the UK to allow for the compulsory treatment of mental illness outside of hospital, although in the UK a CTO lasts for six months rather than up to one year. On hearing about

CTOs in Australia, this inspired me to read more about our own Mental Health Act in the UK[5], and thus deepened my understanding of psychiatric services both in the UK and Australia.

In conclusion, I feel my time at The Alfred has allowed me to successfully meet the aims and objectives of my elective. In particular, this elective furthered my understanding and interest in psychiatry as a career. As much of my psychiatric placement in Leeds was spent in Old Age Psychiatry, this elective has offered me opportunities to further explore psychiatry in an inpatient setting, particularly increasing my knowledge of schizophrenia, bipolar disorder and personality disorders, and their management.

I am incredibly grateful to the Jewish Medical Association for granting me this scholarship which has enabled me to undertake this fantastic elective and experience Jewish life on the other side of the world.

References

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3) The Alfred: Adult Inpatient Mental Health [Internet]; [posted 2019; cited 2019 August 15]. Available from: https://www.alfredhealth.org.au/the-alfred/services/adult-inpatient-mental-health

4) *Mental Health Act 2014* (Victoria), [Internet]; [cited 2019 August 15]. Available from: http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/ltobjst10.nsf/DDE300B846EED9C7CA257616000A3571/0EE6BAC8A81034C2CA25842600190181/$FILE/14-26aa020%20authorised.pdf

5) *Mental Health Act 1983* (UK), [Internet]; [cited 2019 August 15]. Available from: https://www.legislation.gov.uk/ukpga/1983/20/pdfs/ukpga_19830020_en.pdf