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THE AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS

POSITION STATEMENT

SEPTEMBER, 1972

Child Psychiatric Services in Australia and New Zealand

COLLEGE MEMORANDUM

SEPTEMBER, 1972

~~Hallucinogenic Drugs~~

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CHILD PSYCHIATRIC SERVICES IN AUSTRALIA AND NEW ZEALAND

SUMMARY

Child psychiatry is concerned with the disturbances and development of 4,000,000 children in Australia and 1,000,000 in New Zealand.

Some ten per cent of these require professional services, and a survey of services provided, made by The Australian and New Zealand College of Psychiatrists, reveals gross inadequacy of facilities and trained personnel.

There is an urgent need for the training of child psychiatrists.

There is also need for the training of clinical psychologists, psychiatric social workers and other professional workers in this field.

Adequate finance is required.

Various service modalities including consultative and other services are required in the community.

Preventive mental health measures to deal with emergent problems are essential.

An immediate programme to treble present services is technically possible and financially practical.

The Section of Child Psychiatry of The Australian and New Zealand College of Psychiatrists, which has prepared this Report, is available for consultation at all times to clarify these issues and work towards their solution.

1. The medical specialty of child psychiatry is concerned with treating children, adolescents and their families who evidence signs of irregular or uneven development, emotional disturbances or behaviour which the community regards as anti-social. Child psychiatrists work with paediatricians, general practitioners, obstetricians and other physicians, psychologists, social workers and educators. Child psychiatry is also concerned with basic issues in the community related to the welfare of children, and child psychiatrists have contributed substantially to the formation of professional and public opinion in key issues such as drug trafficking and drug abuse, child minding centres, admission of mothers to hospital with their young children and other subjects. The child psychiatrist is the only professional trained to integrate all these crucial services impinging on the mental health of children.

2. In Australia we are concerned with the care of some 4,000,000 and in New Zealand 1,000,000 children and adolescents. Surveys in Europe, the United States of America and Canada agree with surveys in Australia in showing that approximately one-tenth of these children have psychiatric symptoms which require specialist assessment. Research studies in Victoria of both urban and rural populations have been made (Krupinski *et al.*, 1967; Krupinski and Stoller, 1971) and a summary of worldwide research is given in a recent article published in Australia (Buckle, 1971).

3. The Section of Child Psychiatry of The Australian and New Zealand College of Psychiatrists has, for the past 7 years, worked towards an adequate estimation of child psychiatric needs. The survey has produced opinion from all Australian States, the Australian Capital Territory and New Zealand. The data collected, estimated requirements and recommendations may be examined on application to the Secretary, Section of Child Psychiatry, A.N.Z.C.P., "Maudsley House", 107 Rathdowne Street, Carlton, Victoria, 3053. The College has formulated technical programmes of education in child psychiatry. These two areas, provision of service and training, are intimately connected.

4. There is gross insufficiency of all child psychiatric services throughout Australia and New Zealand.

Among the deficient services, there is a serious lack of in-patient services. The routine hospitalization of children needing psychiatric in-patient care in a psychiatric hospital for adults, an institution for the mentally retarded, or a centre for convicted delinquents may not only be inappropriate but potentially dangerous. Paediatric hospitals without specialized in-patient services are inappropriate for the hospitalization of these children.

Geographic surveys show that services reach but a limited proportion of the popula-

tion at risk. In New Zealand, one-half of the population has no child psychiatric services available to it. Throughout the whole of Australia, there are practically no services available outside capital cities.

The provision of services specifically for the mentally retarded is not covered by this Report, as these services are usually administratively independent.

5. The number of child psychiatrists in active clinical work is extremely limited. As estimates of local need agree with more precise surveys in countries of comparable economic and cultural status, the conclusion is drawn that there should be a minimum of one child psychiatrist, together with supporting specialists, available for work with children and their families for each 50,000 population. Estimates have shown that in New Zealand there should be at least 60 child psychiatrists. Only 6 are available. In Queensland, there should be at least 35. Only 20 are available. In New South Wales, the requirement is 75. There are 21 available. In Victoria the minimum requirement is 60 where 20 are available, and so on.

6. In order to increase the number of child psychiatrists up to this level, training programmes must be instituted. These require the provision of subsidized training posts. The Child Psychiatry Section of the College has developed suitable programmes, but these programmes cannot be implemented without the provision of adequate finance for the maintenance of trainees, their educational needs and individual clinical supervision by experienced tutors. **This is the most important recommendation which has arisen from this study — the key to the whole development of child psychiatry.**

7. With the possible exception of Western Australia, there are not enough adequately trained professional workers in the disciplines of clinical psychology, psychiatric social work, child psychotherapists (non-medical), speech therapy and remedial teaching. The provision of extensive training programmes and the establishment of posts in these disciplines is complementary to the provision of programmes of training and service in child psychiatry.

8. Consultation to schools and services to preschool children is most important. Developmental problems may be detected and dealt with at an early stage; suitable environments may be arranged to facilitate development. In addition to children and adolescents showing frankly psychiatric disturbances, there is a further ten per cent of children in the community whose various handicaps, motoric and sensorial, impede their capacity to learn and for whom psychiatric consultation is mandatory.

9. The future development of child psychiatric services can be foreseen as a widening of the existing medical and mental health services in each community. Not only should existing mental health services through Government agencies, general and special hospitals and private psychiatric services be expanded and multiplied, but also new forms of child psychiatric services need to be developed to meet community needs.

10. Estimates show that current services should be trebled to meet minimal requirements.

11. Immediate action is required. This is the opinion of The Australian and New Zealand College of Psychiatrists which, through its Section of Child Psychiatry, is prepared to provide consultative advice at any time at any administrative level to clarify these issues and work towards their earliest solution.

REFERENCES

Krupinski, J., Baikie, A. G., Stoller, A., Graves, G., O'Day, D. M. and Polke, P. (1967). Community health survey of Heyfield, Victoria. *Med. J. Aust.*, **1:** 1204.

Krupinski, J. and Stoller, A. (1970). Psychological disorders, In: Krupinski, J. and Stoller, A. (Eds.) The Health of a Metropolis. Heinemann, Melbourne.

Buckle, D. (1971). The changing tasks of child psychiatry. *Aust. N.Z. J. Psychiat.*, **5:** 167.

HALLUCINOGENIC DRUGS

A Subcommittee was appointed by the Victorian Branch of the College in 1970, consisting of three members of the Branch who had had extensive experience with the use of hallucinogenic drugs. Expert scientific evidence was called in relation to the genetic, biological and biochemical aspects of these substances, and these opinions were incorporated into the

findings of the Subcommittee.

Hallucinogenic drugs were defined for the purposes of the Subcommittee as being those substances which fell within the meaning of the *Poisons (Hallucinogenic Drugs) Regulations, 1967,* being part of the *Poisons Act 1962* (Victoria). For this purpose therefore, these substances were dimethyltryptamine, lysergic acid diethylamide, mescaline, psilocybin and psylocin. The Subcommittee unanimously recommended that these substances be used strictly in accordance with the Regulations set out under the *Poisons Act, 1962,* and promulgated on the 24th January, 1967, under the heading of Statutory Rules, copies of these Rules and Regulations being available from the Government Printer. The Subcommittee agreed that it was mandatory that only those persons holding a warrant within the terms of the above Regulations should be allowed to use such substances.

The overall findings of the Subcommittee were therefore based on a survey of the literature, the taking of expert evidence, and the results of a questionnaire sent to psychiatrists, nineteen in all, who had considerable experience in the use of such substances and held warrants to use them within the meaning of the Regulations.

It is pointed out that all aspects of the use of such substances in Victoria were thoroughly investigated. The findings of the Subcommittee therefore can be summarized under two headings.

1. Clinical Justification for their Continued Use. The continued clinical and therapeutic use of these substances would appear to be justified. Difficulties and dangers are fully recognized, and it is felt that there is a distinctive place for the use of these substances in the treatment of neurosis, particularly intractable anxiety neurosis, hysteria, mixed neurosis, character disorders and psychosexual disorders including frigidity, impotence and paraphilias. It is emphasized that these drugs are not seen as a panacea or complete answer to difficult psychiatric problems, but are emphasized as facilitators of skilled psychotherapy. The overall conclusion reached is that having regard to all the medical, psychiatric and biologic evidence, there would not seem at this time to be any real justification for complete restriction on the use of hallucinogenic drugs by skilled and qualified persons.

2. Moral and Ethical Considerations. It is particularly emphasized that this is a serious responsibility for the practitioner, and that there must be thorough, careful documentation of the previous case history and intensive knowledge of the individual psychopathology. (These matters are fully covered in the Appendix B of the full report of the Victorian Subcommittee.) The Subcommittee is emphatic and emphasizes that the use of these substances in any non-therapeutic sense whatsoever was regarded as unethical, immoral and illegal. It is further stressed that the use of such agents is regarded as a privilege and trust, and that any misuse would reflect gravely on the integrity of individual therapists, the College, and the profession in general.

CONCLUSION

It should be stated that, although at this time these findings support the recommendation that continued use be allowed under the conditions prescribed, it is felt that should further evidence become available as to adverse reactions or serious contraindications, their findings could be subject to revision. The Convenor's view is that the Subcommittee should meet again within two years to re-evaluate the situation.