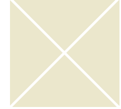
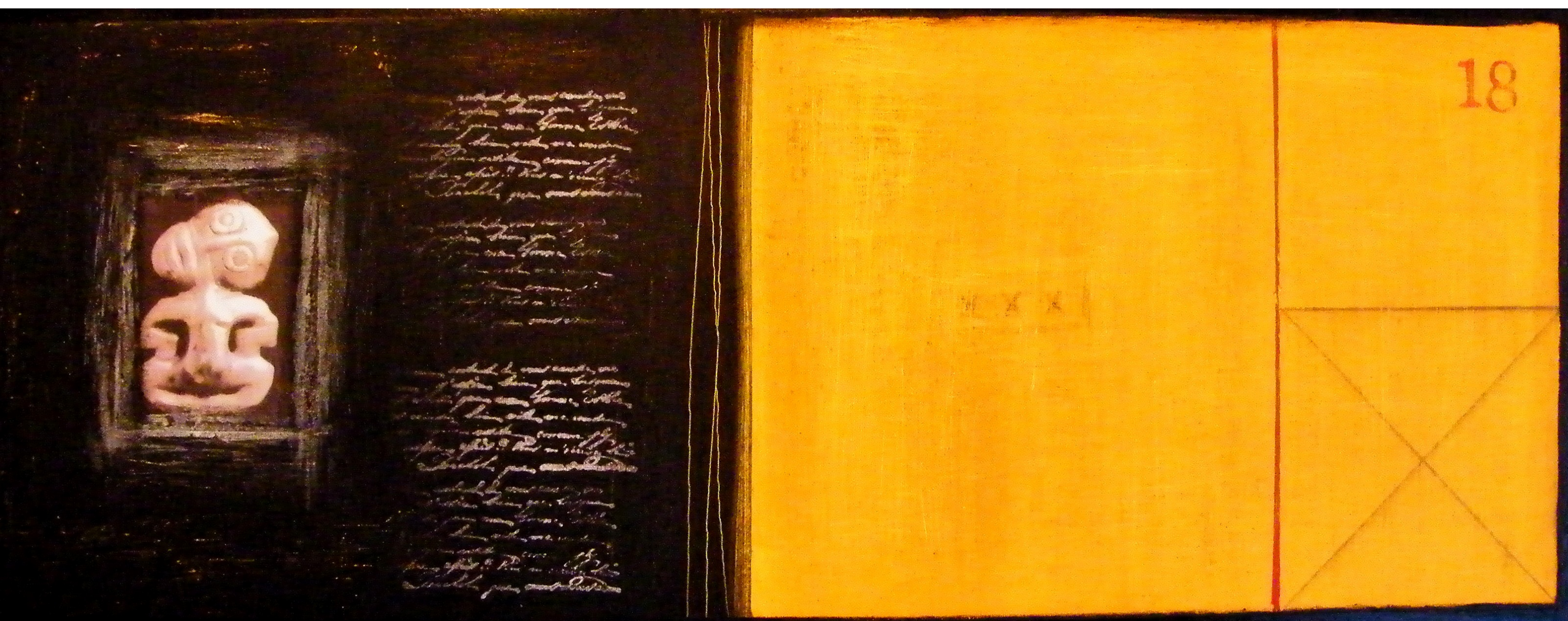
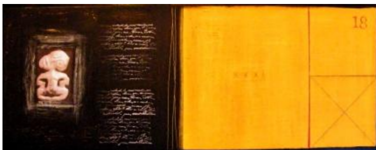


CLINICAL REVIEW OF THE ACC SENSITIVE CLAIMS CLINICAL PATHWAY



Sensitive Claims Pathway Review Panel

September 2010



Cover Artwork

The inspiration for Tiki Girl came from an old road sign that I have at home. The colours and the use of a sign to mark a point in time or a place in your life developed into this piece. She's about personal growth, a coming of age, a growing awareness of my Maori culture, previously ignored and unacknowledged by me. It's all been a bit buried under a muddle of other "stuff". My own "work in progress" otherwise known as therapy is digging out "the real me". Tiki Girl is a marker peg of where I'm at in my journey. She's very joyful, she has a voice, dignity and soul and I have am very attached to her!

I am pleased to provide the use of this image to the ACC review board, it is a way of giving something back to the process that has enabled me to continue on my own journey. She is subject to copyright and cannot be reproduced or used for any other purpose. I hope you will enjoy her while respecting the copyright in place.

Jillaine Murray

LETTER OF TRANSMITTAL

Honourable Dr Nick Smith
Minister for ACC
Parliament Buildings
Wellington

September 2010

Dear Minister

Re: Report of the Sensitive Claims Pathway Review

I am pleased to provide you with the report of the Panel set up to review the Sensitive Claims Pathway. The Panel has been meeting since May 2010 to respond to your request that we assess the implementation and impact of the new Clinical Pathway for clients who have a mental injury caused by sexual assault or abuse. You asked us to identify any changes to policies, procedures, guidelines and clinical pathways to ensure ACC delivers timely decision making and services to these clients.

The Panel was provided with a range of information from ACC, received a large number of submissions from organisations and individuals, and met with survivors, provider groups, and government agencies. We also reviewed files and the Sensitive Claims data base to assess the impact of the new Pathway.

Once the Panel had the opportunity to review evidence and hear submissions we conveyed to you our concern about the delays for clients in accessing services. The Panel are of the view that it is important all survivors have access to immediate support and that for those who need ongoing treatment for a mental injury the pathway to and through treatment should be smooth and supportive of survivors' recovery.

ACC responded to this interim feedback by providing new claimants and those already in the Pathway with up to 16 sessions of immediate therapeutic assessment and recovery support. The Panel are supportive of this initial response from ACC. There are indications this has been welcomed as a positive sign by the sector.

The Panel have made recommendations to you that will result in changes to the current Pathway. It is important that ACC work closely with survivor representatives, service providers and relevant government agencies to agree how these changes will be put into practice. We believe the initial changes can begin to take effect immediately but also recognise that implementing all the recommendations in our report and making ongoing improvements to the sensitive claims processes will take time.

We suggest that you establish a process to independently monitor the implementation of the changes recommended by the Review Panel to give the survivors, the service providers and the public confidence that our findings are being appropriately addressed.

Yours sincerely

Dr Barbara Disley, Chair | Clive Banks | Ruth Herbert | Graham Mellsop

ACKNOWLEDGEMENTS

The Panel gratefully acknowledges those survivors of sexual abuse who courageously shared their thoughts and experiences with the Panel.

The Panel is also grateful for the verbal and written submissions it received from a wide range of individuals, organisations and agencies in the government and non-government sectors.

The Panel thanks ACC staff for their assistance in providing information and briefings, answering requests, providing administrative support to the Panel, and commenting on drafts. In particular, the Panel recognises that a number of the findings of this report present challenges for ACC and the Panel acknowledges and is encouraged by the positive changes that ACC has willingly and rapidly implemented.

The Panel is grateful to Debra Fraser, who analysed the submissions and undertook the file review, and John Marwick, of Sky Blue House Limited, who was the report writer.

The Panel also gratefully acknowledges Jillaine Murray, who freely contributed the artwork on the cover of this report.

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EXECUTIVE SUMMARY

In April 2010 the Minister for ACC established a Panel to review the clinical Pathway for sexual abuse claims (the Pathway) which ACC introduced in October 2009. The four person review Panel worked independently from ACC. It received written submissions from sexual abuse survivors and the sector (Appendices III and IV), met with 32 organisations including relevant central government agencies (Appendix V), and with approximately 50 sexual abuse survivors. The Panel analysed anonymised data provided by ACC about the status of all claims lodged since the Pathway began up to the end of June and undertook a detailed review of 68 files selected randomly from claims submitted in November 2009 and February 2010. In addition the Panel commissioned a legal opinion on certain legislative questions (Appendix IX) and has referred to various relevant reports, documents, articles and papers (see References page 76).

There had been some years of problems with the way that ACC managed sexual abuse claims and in 2009 ACC saw the need to develop what it described as 'a strengthened clinical model'. Its objectives in doing so were to improve outcomes for clients, tailor the approach to specific client needs, shift from a claims management to a clinical management approach, and improve timeliness, accuracy and consistency of decisions. ACC stated that another motivator for change was their concern that they were operating outside their legislative mandate and providing cover to people who did not meet ACC's legislative criteria. The new Pathway was seen as providing ACC with greater assurance that they were operating within their legislative mandate and processing claims with greater accuracy and consistency of decisions (section 2, page 5).

The Accident Compensation Act 2001 ('the Act') provides for ACC cover for people who have a mental injury ('a clinically significant behavioural, cognitive or psychological dysfunction') caused by a sexual offence listed in Schedule 3 of the Accident Compensation Act 2001. One of the major changes under the Pathway is that ACC put new processes in place to examine clinically whether all claims meet this legislative mandate. In the light of its interpretation of both the Act and of a number of court decisions, ACC says that mental injury means a diagnosable psychiatric disorder. Under the Pathway up to the beginning of July 2010 ACC had only accepted claimants who have been given a diagnosis from the DSM-IV diagnostic system by a registered health professional specifically qualified to give such a diagnosis. As the test of whether the mental injury was caused by a Schedule 3 event, ACC operational policy says it must be possible to show that "on the balance of probabilities ... the mental injury must be more likely than not the direct result of the abuse/assault rather than any other factors that are also present" (section 3, page 7)

The Panel received a legal opinion about the legislative position, and also learned about the effect of these interpretations of the legislation from many submissions and from ACC's data. The Panel concludes that the Act allows the use of a DSM-IV diagnosis as one way of recognising mental injury but it should not be the only way of determining whether such an injury exists. ACC stated that they are open to using alternative standardised ways of recognising mental injury and have asked the sector to propose alternatives but none had been offered. The Panel has found that the way in which ACC operationalised the Pathway resulted in approvals being limited to those with DSM-IV diagnoses. This resulted in the sector believing that a DSM-IV diagnosis was always required (paragraph 55, page 11).

In respect of causality the Panel concludes that if there is reason to think that the sexual abuse was a substantial or a material cause of the mental injury the claim could be accepted under the Act. ACC stated that they agree with this interpretation. However, the Panel considers that ACC's current operational processes are not supporting this (paragraph 54, page 11).

In April 2008 ACC published a set of practice guidelines for sexual abuse and mental injury that it had commissioned from Massey University. ACC used these as part of the rationale for the subsequent ACC Framework and Pathway. The Panel concludes that in general these Massey Guidelines are well-researched and well-accepted. Links between the Pathway and the Guidelines are not strong. In a number of ways the Pathway aligns poorly with key Massey Guidelines principles particularly safety, the importance of the therapeutic relationship, and client focus (paragraph 67, page 14).

The Panel is of the opinion that the Pathway was planned and implemented with too much haste. ACC did not adequately consult with the relevant government and non-government agencies, with the sector, or with its own Sensitive Claims Advisory Group (section 5.2, page 17).

The Pathway has resulted in a precipitous drop in the number of claims submitted (close to a 50 percent reduction comparing the first three months of 2009 and 2010 – see Table 1, page 21). The Panel concludes that the Pathway requirements are discouraging sexual abuse victims from lodging a claim. It is reasonable both clinically and legally for ACC to require the use of standardised systems to show that a person has a mental injury meeting the legislated requirements before making a decision about cover. However, there are no good legislative or clinical reasons to restrict access to cover to only those who have a DSM-IV diagnosis (paragraph 113, page 24).

The Pathway introduced a 'triage' step where all claims are initially considered by a clinical psychologist. Claims submitted for children and adolescents are supposed to be triaged in one day, but in the 32 files for this group amongst the Panel's random file review the median time to triage was five weeks with shortest being two days and the longest 10 months. The Panel concludes that triage is not meeting ACC's own standards of timeliness and delays at this stage can result in further trauma for survivors (section 24, page 24).

Under the new Pathway ACC is requiring extra information and/or initial assessments on three quarters of all claims before any claim decision is made or approval given for treatment to commence. 31 percent of claims declined were because of lack of information. The Panel concludes that information collection and assessments are causing significant delays for many people and there are concerns about privacy and appropriateness (section 6.4, page 28).

Comparing claims lodged in January 2009 with those in January 2010 the proportion of people waiting 91 days or more for a decision is twice as high this year. The data show that claims processing time is systematically getting worse each month under the new Pathway. 66 percent of claims lodged in November and December 2009 took longer than 90 days for a claims cover decision to be made. By February and March 2010 this figure had grown to 82 percent. The Panel concludes that these delays do not meet ACC's own expectation of all decisions being taken within six weeks and they are inconsistent with the Massey Guidelines' principles (section 6.4, page 28).

The Pathway separates assessment and treatment planning from the actual treatment process. This is a further cause for delay and is likely to cause more harm than help. The Pathway is also causing delays and difficulties for clients who were already in the system or who are re-entering for further counselling (paragraph 151, page 32).

Many sexual abuse victims have a need for expert support at the vulnerable time soon after they first disclose sexual abuse. The Pathway has had adverse effects on the provision of such support. The changes that ACC implemented from 16 August should help ensure that immediate support is again available (Section 7.1, page 33).

ACC's communications with sexual abuse victims and providers have often been inappropriate and inadequate. These need to be improved as a matter of urgency taking a client perspective and working with survivors and providers in the process (section 7.2, page 34).

The Pathway has aggravated the situation for certain groups of sexual abuse survivors with particular needs including Māori, children, adolescents, people with mental illness, and people who have problems with addiction or substance abuse (paragraph 166, page 35).

Before the introduction of the Pathway there were concerns about the quality of care given by some providers. The regulations that are designed to ensure that ACC-registered treatment providers offer quality care depend largely on self-regulation by their professional bodies and, to be effective, they require close cooperation between ACC and those organisations. Relationships between ACC, treatment providers and the various bodies representing treatment providers have been damaged. The Pathway and the way that it has been introduced and implemented have led to a reduction in available workforce and this has contributed to restriction in claimants' access to care. (see paragraph 178, page 38).

A number of submissions to the Panel raised questions about whether having the treatment of sexual abuse victims covered under ACC is the most appropriate arrangement. For some the issue is that sexual abuse is not accidental, for others ACC's insurance model was not the appropriate model, and other submitters thought that the arrangements sometimes made integrated care more difficult. The Panel concluded that these points merit further consideration. While it is outside the scope of this review, the Panel notes that ACC is involved in the government response to the Taskforce on Sexual Violence, which may provide a useful whole of government perspective (section 7.5, page 38).

Overall the Panel concludes that the Pathway is effectively a claims management pathway which has significantly reduced timeliness and appropriate access. It has not improved outcomes for individual clients nor for groups with particular needs (section 8, page 41).

In the process of developing this report, the Panel shared their findings and recommendations with ACC who worked with the Panel to discuss options going forward for changes that will enable clients to have more timely access to appropriate interventions within the context of ACC's legislative mandate. The Panel recommends a range of immediate and longer-term changes to the design and operation of the Pathway. These must be developed and implemented with appropriate expert advice from people with skills and experience of working in the sexual abuse treatment area and with other relevant government agencies.

As an immediate measure the Panel proposes that all sexual abuse survivors should immediately be able to access up to 16 hours of therapeutic assessment and recovery support. The Panel welcomes ACC's move to action this proposal for new clients and those already in the system from 16 August 2010 – and notes that this has already received some favourable response from a number of treatment providers. ACC's action and the response from the sector are both positive signs for further future improvements.

Many clients will be able to self-manage before the end of these 16 sessions but some will not. Clients who will need ongoing therapy or who are applying for earning related compensation will need to have a decision made about ACC cover. The Panel proposes that ACC work with the sector to review how this is arranged. This assessment for cover process could use one of a number of approved standardised systems for recognising mental injury and should be designed to identify whether sexual abuse was a material cause of the mental injury. Where possible the client's current treatment provider will be involved in the process.

RECOMMENDATIONS

Recommendation 1 That ACC ensures that all aspects of their Pathway(s) and associated claims processes are in line with the Massey Guidelines by seeing that they:

- are developed and implemented in ways that recognise and protect client safety and the importance of the therapeutic relationship;
- take a client focus; and

recognise the special needs of particular groups including children, adolescents, people with mental illness, people with intellectual disabilities, Māori, and Pacific peoples.(page 14)

Recommendation 2 That future changes to the Pathway and associated processes are planned, managed and implemented with meaningful engagement and consultation with the sector and relevant government agencies. (page 18)

Recommendation 3 That, as a priority, ACC commence work with relevant sector experts to agree additional standardised systems for determining mental injury – including ones that would be appropriate for children and for Māori – and discuss how they should be used to confirm that a claimant has a mental injury for ACC when making cover decisions under its legislation. (page 24)

Recommendation 4 That, in determining whether a mental injury has been caused by a Schedule 3 event, the test should be that the sexual abuse was a substantial or a material cause of the injury. (page 24)

Recommendation 5 That all ACC communications with survivors of sexual abuse need to be reviewed as a matter of urgency taking a client perspective and using survivor and expert provider assistance in the process. (page 34)

Recommendation 6 That ACC establish an appropriately constituted working party involving professional groups to examine credentialing or other means of ensuring that the workforce for treatment and assessment, including the new therapeutic assessment and recovery support process, is fit for purpose and meeting quality standards. (page 38)

Recommendation 7 That, in order to ensure processes around the Pathway(s) are of good quality, safe and effective for ACC, clients, and providers, ACC work with the sector, survivor representatives and relevant government agencies to develop and implement a comprehensive quality framework including strengthened processes for:

- provider approval and auditing
- appropriate service standards and monitoring
- workforce training and development
- ongoing professional development, and
- continuous service improvement.

(page 38)

Recommendation 8 That ACC move to improve access for survivors by introducing 16 hours of immediate therapeutic assessment and recovery support from a registered ACC treatment provider for new claimants, those currently under consideration under the Pathway, those who have had a claim declined and those who have chosen to withdraw their claim under the Pathway. (Page 45)

Recommendation 9 That these initial changes are planned, managed and implemented quickly and effectively – giving priority to claims for children – with input and/or oversight from relevant sector experts and relevant government agencies. (page 45)

Recommendation 10 That ACC work with sector representatives to evolve the Pathway(s) based on the Massey Guideline principles and the proposals and principles in section 9 of this report giving particular attention to the needs of children and adolescents. The amended Pathway(s) must clarify how cover for treatment according to need will be available to those needing more than the initial 16 sessions recognising that this will be particularly important for adult survivors of child sexual abuse. (page 45)

Recommendation 11 That a proportion of claimants may be required to undergo an assessment for cover from an assessor who is not their treatment provider before a decision about cover is taken or to review ongoing therapy. These assessors should themselves be experts who have worked with sexual abuse victims and, wherever possible and desired by the client, the client's usual treatment provider should also be involved in the formal assessment process and in determining appropriate treatment goals and plans. (page 45)

Recommendation 12 That ACC ensure that any assessment for cover processes for all claims requiring a treatment decision have occurred and a decision has been made within 6 weeks of being notified that a decision on cover will be needed. If this is not possible for any reason outside the client's control then further two weekly therapeutic assessment and recovery support sessions should continue to be funded until the assessment is completed and a decision on further cover is taken. The assessment and cover decision must be taken at the latest within nine months of the claim being lodged – and preferably sooner. (page 45)

Recommendation 13 That ACC provide mechanisms for involving families/whānau in therapy especially for children and adolescents. (page 45)

Recommendation 14 That a process be established to independently monitor the development and implementation of actions recommended in this report. (page 45)

ACC RESPONSE TO THIS REPORT

As required in its Terms of Reference the Panel shared a draft copy of this report with ACC and have met with ACC to discuss the findings and recommendations. ACC has already responded to a number of the Panel's proposals and concerns. ACC asked the Panel to include the following statement.

The Panel has identified some serious issues which ACC is responding to with urgency, and they make a number of important and strong recommendations for change. Overall, ACC endorses the Panel's recommendations. ACC has found the process of developing the recommendations helpful and has sought, where possible, to make immediate changes to address the Panel's concerns consistent with the intent of the recommendations and within ACC's legislative mandate.

Specific examples of this include:

- The urgent introduction of 16 hours of support sessions during the assessment phase for new clients and those new clients currently in the Pathway.
- The commencement of meaningful re-engagement with the sector (through an expanded Sensitive Claims Advisory Group (SCAG) including client and other representation, which has already met and will now meet on a more frequent basis). SCAG and ACC are firstly developing the practical implementation parameters for the 16 hours of support sessions for the initial group of clients and then considering the extension of this to others, e.g. relapse, reactivated declines and those who have previously been declined in the Pathway. And secondly, SCAG and ACC have started to identify an annual programme of work on issues arising from the Review and from sector feedback. This is likely to include as a priority the development of the Pathway variation for children, and a broader workforce development plan for counsellors (considering, for example, capability, capacity, sustainability, quality, standards and monitoring). This is also likely to include the further development of ancillary pathways, e.g. for Maori and others, and work on identifying standardised systems for determining mental injury in addition to DSM-IV.
- ACC will shortly meet with relevant government agencies to similarly seek their input into current and proposed changes.

ACC considers the above initiatives will go a long way towards implementing the majority of the Panel's recommendations.

1 INTRODUCTION

1.1 PURPOSE OF THIS REVIEW

1. On 26 April 2010 the Minister for ACC, Hon. Dr Nick Smith, appointed a four person panel (the Panel) to undertake an independent clinical review into ACC's new approach to managing sensitive claims from victims of sexual abuse or assault (the Pathway).

2. When the Minister announced the review (Smith, 2010) he referred to ACC having "changed its approach to managing sensitive claims in response to more than four years research work from Massey University into best practice clinical guidelines." He noted that "these changes have never been about costs savings." He said "that the focus must be on delivering to victims of sexual abuse or assault that have a mental injury the best help available to achieve a timely and successful recovery." He explained that he had "been very hesitant as a politician to interfere in clinical decisions" but went on to "acknowledge the changes have caused controversy." For this reason he established the independent review.

3. The Terms of Reference for the Review are set out in Appendix I. The Panel is asked to "assess the implementation and impact of the new Clinical Pathway for clients who have a mental injury caused by sexual assault or sexual abuse."

1.2 THE PROCESS FOR THE REVIEW

4. The four Panel members (see Appendix II) worked independently from ACC with the assistance of a contracted analyst and a report writer. ACC provided logistical support, some documentation and responded to the Panel's requests for information.

5. The Panel called for written submissions and received 177 from a range of sector individuals and organisations as well as a written submission from ACC (see Appendix III). In Auckland, Wellington and Christchurch it met with representatives from 14 organisations (see Appendix V) and approximately 50 survivors of sexual abuse (most of whom had been covered by ACC under the previous pathway). Relevant government agencies briefed the Panel. ACC made its own submission and various ACC staff members also briefed the Panel and were available to answer queries.

6. ACC provided the Panel a data set of all claims lodged since the new Pathway and the status of those claims as at 30 June 2010. The Panel analysed these raw data and prepared some summary tables of the status of all claims; ACC checked the accuracy of these tables. The Panel also accessed a range of other statistical tables from ACC and other sources. The Panel undertook a detailed review of 68 files of claims lodged under the new Pathway which had been chosen randomly from November 2009 and February 2010 (see Appendix VI). In addition the Panel commissioned an independent legal opinion on certain legislative questions (see Appendix IX) and has referred to relevant reports, documents, articles and papers (see References page 76).

7. The Panel was to report by the end of July. In early July the Panel met with the Minister for ACC. At that meeting the Panel alerted the Minister to significant concerns about the adverse impacts that the Pathway was having on clients. Despite the fact that ACC's stated purpose was to "ensure clients receive timely and appropriate assessment and intervention" the Panel was finding overwhelmingly from its initial file review, statistical analysis, written submissions and confidential presentations that access to and delays in receiving appropriate care has significantly worsened since the Pathway was introduced. As well as alerting the Minister to these urgent concerns the Panel requested an extension of time to complete a full report in order to do justice to the high number and depth of submissions it had received.

8. In response the Minister extended the time for completion of the report to September 2010. He brought the Panel's interim findings to the attention of ACC and suggested they consider urgent changes some of which have now been implemented. The Panel comments about and makes recommendations for change throughout the report but particularly in sections 9 and 10.

1.3 SEXUAL ABUSE AND ASSAULT IN NEW ZEALAND: VICTIMS, IMPACTS AND RESPONSES

1.3.1 TERMINOLOGY

9. In its widest sense **sexual abuse** is a term used to describe "any act which is sexual in nature that someone does not, or cannot consent to" (Rape Prevention Education, 2010).

10. According to the guidelines commissioned by ACC from Massey University School of Psychology ('the Massey Guidelines'), **childhood sexual abuse** "has come to mean the experience of sexual abuse during childhood in the history of adult clients who are seeking treatment for emotional distress" (ACC, 2008).

11. **Sexual assault** generally refers to rape and other forced physical acts. A Ministry of Justice publication refers to sexual assault as "a physical assault of a sexual nature, directed toward another person where that person:

    - does not give consent; or
    - gives consent as a result of intimidation or fraud; or
    - is legally deemed incapable of giving consent because of youth or temporary/permanent incapacity." (Segessenmann, 2002, p. 14)

12. As discussed further below (section 3.2) under its legislation ACC covers mental injury suffered as a result of certain criminal acts dealt with in the Crimes Act 1961 and listed in Schedule 3 of the Accident Compensation Act 2001 (see Appendix VIII).

1.3.2 HOW COMMON IS SEXUAL ABUSE AND ASSAULT AND WHO ARE THE VICTIMS?

13. A recent report for the Ministry of Women's Affairs (Mossman, Jordan, MacGibbon, Kingi, & Moore, 2009, p. 7) refers to the 2006 New Zealand Crime and Safety Survey which found a 12-month prevalence rate of 3 percent for individuals aged 15 years or older who had experienced one or more occurrences of sexual victimisation in 2005. This equated to 6.4 incidents per 100 adults (9 per 100 women, 3 per 100 men) that year.

14. The same Ministry of Women's Affairs report notes that women are twice as likely to be victims as men. Māori women were twice as likely to be victims as non-Māori women. A third of adult victims are aged between 16 and 20 when first assaulted; two thirds are under 29. Women who were sexually assaulted as children, adolescents or adults are more likely to be sexually assaulted as adults. People with physical, intellectual or psychiatric disabilities have a higher risk of sexual violence. Three quarters of offenders were known to their victims. Only nine percent of the offences reported in the 2006 survey were reported to the police (Mossman, Jordan, MacGibbon, Kingi, & Moore, 2009, pp. 8-11).

15. A 2007 study on childhood sexual abuse involved face to face interviews with 2,855 randomly selected women aged 18 to 64 years old from the Auckland and Waikato regions (Fanslow, Robinson, Crengle, & Perese, 2007). The study found that the overall prevalence rate for historical childhood sexual abuse was 23.5 percent for women from the urban region (Auckland) and 28.2 percent for those from the rural region (Waikato). Māori women reported higher rates of abuse than both European women and those of other ethnic groups (Urban 30.5 percent vs. 17.0 percent and rural 35.1 percent vs. 20.7

percent). The study noted that these rates are higher than those of any of the ten countries studied in the World Health Organisation Multi-Country Study (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005).

1.3.3 WHAT IS KNOWN ABOUT THE IMPACT OF SEXUAL ABUSE?

16. The Massey Guidelines state that “sexual abuse always affects the person abused in some way” (ACC, 2008, p. 31). There is a wide array of effects which may be temporary, discontinuous, or ‘sleeper’ effects that remain undetected but may emerge at key times in later life. The effects will differ between individuals according to the nature of the abuse and the abuser; the age at onset, frequency and chronicity of abuse; and variables such as family support, resiliency and experience of disclosure. For children the developmental stages of the child at the time of abuse and of disclosure are also very important elements.

17. The Ministry of Women’s Affairs commissioned a report based on interviews with 75 adult survivors of sexual violence (Kingi & Jordan, 2009). This showed that the effects of sexual violence are not confined to the survivors but also affect family, whānau and friends. Impacts for survivors were listed under the following headings:

    - Life overall
    - Mental and emotional health
    - Intimacy and relationships
    - Behavioural impacts
    - Cognitive impacts
    - Personal and social impacts
    - Physical impacts.

1.3.4 RESPONDING TO SEXUAL ABUSE

18. Individual responses to sexual abuse and assault vary greatly. Most victims of childhood sexual abuse do not tell anyone at the time and many may never do so. Dr Kim McGregor’s PhD thesis based on survivor interviews estimated only four percent did so immediately and the average time to initial disclosure was 16.3 years (McGregor K. , 2003).

19. Many adult victims will also not disclose the sexual abuse or assault to anyone. When people do disclose sexual violence they usually do so first to a family or whānau member or a close friend – only a small number go first to police or a victim service. Family and friends constitute informal support systems but, while some members of such systems are able to respond well to victims’ needs, others are less well equipped to do so, or were unable or unwilling to help or even to accept the problem (Kingi & Jordan, 2009).

20. The Ministry of Women’s Affairs report on sexual violence makes the following conclusions about the importance of formal support systems for survivors of sexual abuse.

> *Access to high quality and culturally appropriate services is essential for meeting survivors’ crisis and longer-term needs and for promoting recovery. Results from the environmental scan drew attention to the limitations of existing services in meeting the needs of Pākehā survivors, as well as survivors from diverse social and cultural groups. In particular, service providers indicated that the following groups of survivors might experience the most difficulty in having their needs met: Ethnic communities; Pacific peoples; people with disabilities; Māori; men; and sex-workers.* (Ministry of Women's Affairs, 2009)

21. New Zealand uses its no-fault accident compensation arrangements to fund support for victims of sexual abuse who have suffered mental injury. The Panel heard directly from survivors of sexual abuse who were very grateful for the support that had been made available to them by way of ACC funding.

> *"It was ACC-funded counselling that turned my life around from being a bum to being a productive member of society"*
>
> A survivor of sexual abuse

2 ACC'S OBJECTIVES IN DEVELOPING THE PATHWAY

22. This section of the report deals with ACC's reasons for changing the way that it dealt with sensitive claims and for developing the Pathway. The report returns to these objectives in section 8 – the Panel's overall conclusions about the Pathway.

23. ACC has accepted claims for personal injury following sexual abuse since the scheme's inception in 1974. When the Accident Rehabilitation and Compensation Insurance Act 1992 changed the general interpretation of "personal injury by accident" to narrow cover for mental consequences of accidents, provisions were added to specifically provide cover for "mental or nervous shock" as a result of "any act that is within the description" of one of a list of sexual offences. "Mental or nervous shock" was replaced by "mental injury" in the Accident Insurance Act 1998. This history and the current legislative provisions are further considered in section 3.2 below.

24. At the time of the 1992 Act, ACC developed a special unit to deal specifically with sexual abuse claims which is called the Sensitive Claims Unit (SCU). In an initial briefing to the Panel ACC explained that there had been some years of problems in its SCU. By August 2008 there were rapidly growing volumes and costs, increasing delays, poor communications, poor internal management and leadership, growing workloads, poor staff morale and increasing vacancies, and growing adverse media attention. An action plan was instituted between August 2008 and February 2009 and by March 2009 significant administrative and organisational improvements were noted. Further action was planned between March and June 2009 and an internal presentation in March 2009 noted that future moves included a 'strengthened clinical model.'

25. This 'strengthened clinical model' was the Pathway and associated Clinical Framework (ACC, 2009). ACC advised the Panel that the decision to develop the model was an internal one. The Panel has been given a range of stated objectives and goals for the development of the Framework and Pathway.

26. In its initial briefing to the Panel ACC stated that the primary objectives developed in 2009 were to:

    - Develop and implement an evidence based clinical framework including clinical pathways which will support good client outcomes as well as effective management of scheme liability
    - Introduce new purchasing arrangements and policies which align with the adopted clinical approach
    - Plan and implement changes in approach in a methodical, timely and structured manner.

27. In its submission to the Panel in July 2010 ACC listed the following objectives for the Framework and Pathway:

    - Improve rehabilitation outcomes for clients by ensuring clients received evidence-based treatment that empowered clients to manage their own lives and return to full functioning as quickly as possible
    - Shift from taking a claims management approach to a clinical management approach for sensitive claims by increasing the number of clinical staff and involving them in decision making
    - Improve the timeliness, clinical basis, accuracy and consistency of ACC decision making within its legislative mandate
    - Move from a 'one size fits all' approach to tailoring the Pathway and services for clients with specific needs (for example children and adolescents, Māori, people with substance abuse issues)
    - Build the required capability within the Sensitive Claims Unit to deliver high quality rehabilitation to people with a mental injury as a result of a sexual abuse/assault event

- Improve the quality of data to build an evidence base for improving client outcomes in the future.

28. ACC amplified the third point's reference to "accuracy and consistency in decision making within its legislative mandate" by advising the Panel that one of the problems it had identified was that entitlements were being provided "outside ACC's legislative mandate (90% of clients did not have a diagnosis before receiving treatment and ACC was accepting the claim on the basis of the sexual abuse/assault event without diagnosing a mental injury or establishing a causal link)[1]".

29. ACC's written submission to the Panel and verbal briefings also noted that the Pathway's purpose was to ensure that clients receive timely, appropriate assessment and intervention which is evidence based, goal oriented and focused on recovery and rehabilitation. ACC noted some concerns about quality including that the length of counselling for many clients was inconsistent with the evidence based guidelines and that there was feedback from some clients who were not satisfied with the service they were getting and were also not making any progress to recovery from their injury.

[1] From ACC's written submission to the Panel.

3 THE LEGISLATIVE FRAMEWORK RELEVANT TO THE PATHWAY

30. This section refers to relevant international and domestic legislation, describes ACC's interpretation of its legislative mandate, explains what the Panel found in respect of the legislative questions, and then gives the Panel's conclusions. The impact of ACC's interpretation of its mandate and how this has been operationalised is further considered in section 6.1: Access to ACC cover and lodging a claim.

3.1 INTERNATIONAL LEGAL OBLIGATIONS

31. New Zealand is party to a number of relevant international resolutions and conventions including those listed below. These are further discussed in Appendix VII.

- United Nations General Assembly Resolution 62/134, Eliminating Rape and other forms of sexual violence in all their manifestations, including in conflict and related situations (General Assembly, 2008)
- the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- the United Nations Convention on the Rights of the Child 1989 (General Assembly, 1989).

3.2 DOMESTIC LEGAL OBLIGATIONS

32. ACC operates under the Accident Compensation Act 2001 ('the Act'). Section 21 of the Act provides that a person has cover for a mental injury that is caused by one of the major sexual offences listed in Schedule 3 of the Act (see Appendix VIII). These offences include sexual violation (including rape), incest, indecent assault, sexual connection with a child or young person, and female genital mutilation. Section 27 of the Act says that mental injury means "*a clinically significant behavioural, cognitive, or psychological dysfunction.*"

> *Mental Injury: A clinically significant behavioural, cognitive or psychological dysfunction*
>
> Accident Compensation Act 2001

33. Other legislative requirements closely associated with ACC's management of sensitive claims are:

- Injury Prevention, Rehabilitation and Compensation (Code of ACC Claimants' Rights) Notice 2002. Statements of particular relevant to this review include:
  - You have the right to be treated fairly, and to have your views considered (Right 2)
  - We will be respectful of, and responsive to, the culture, values and beliefs of Māori (Right 3)
  - We will keep you fully informed (Right 6)
  - We will respond to your questions and requests in a timely manner (Right 5)
  - We will inform you about options available for resolving problems and concerns (Right 8)
- Victims' Rights Act 2002. Clause 11 of this Act states:

  A victim must, as soon as practicable after the victim comes into contact with an agency, be given information by the personnel of the agency about programmes, remedies, or services available to the victim through the agency.
  In this section agency means –

  (a) the Accident Compensation Corporation

- The Health Information Privacy Code 1994.

3.3 HOW ACC INTERPRETS AND IMPLEMENTS ITS LEGISLATION THROUGH THE PATHWAY

3.3.1 ACC'S INTERPRETATION OF MENTAL INJURY

34. ACC's policy document on the diagnosis and assessment of mental injury from sexual assault or sexual abuse states that

> *to come within the definition of mental injury the mental trauma has to be something that would be recognised as a psychiatric condition and also that the condition requires some form of intervention. If the mental trauma is less than this, for example, transient feelings of anger, humiliation, fear, embarrassment, shock, then it will not be considered a mental injury under the Act. (ACC, 2009)*

35. The policy document goes further to state that in order to be assessed as clinically significant

> *a suitably qualified health professional must both diagnose the mental injury and consider whether the injury was caused by the event(s)... In effect, only psychiatric conditions are covered and then by reference to an established means of diagnosis and assessment such as the American Psychiatric Association's Diagnostic and Statistical Manual of mental Disorders (DSM-IV).*

36. The policy states that only the following providers are able to provide a DSM-IV diagnosis and assessment of potential mental injury:

- registered psychiatrists and clinical psychologists, and
- registered psychotherapists, other registered psychologists, registered medical practitioners (such as general practitioners), and registered advance practice mental health nurses who affirm they have training and experience in the use of DSM-IV (which should involve a post-graduate level paper followed by continuing use in practice).

37. ACC told the Panel on 5 July that up to that point no claims had been approved without a DSM-IV diagnosis. The Panel understand that subsequently there may have been two claims accepted using an ICD-10 diagnosis. ACC advised the Panel that, while they considered a DSM-IV diagnosis to be a good guide to the existence of mental injury and one which had been recognised as authoritative by the courts, it is not prescribed by law and ACC would consider other authoritative sources. ACC's written submission to the Panel advised that ACC have asked the sector to identify other suitable diagnostic systems as an alternative to DSM-IV but that none had so far been suggested. In response to a draft of the Panel's report ACC have advised that they plan, in the medium term, to work with the sector on identifying other standardised systems for determining mental injury (see paragraph 101 - 106).

3.3.2 ACC'S REQUIREMENTS IN ESTABLISHING A CAUSATIVE LINK TO A SEXUAL ABUSE EVENT

38. Section 21 of the Act provides that the mental injury must have been "caused by" one of certain acts listed in Schedule 3 of the Act (see Appendix VIII). ACC have pointed out to the Panel that it is factually often quite complex to determine the causation of the mental injury and the extent to which it is 'caused by' the sexual abuse. In many cases there are pre-existing conditions, co-morbidities and other events or aspects of a person's environment that may also have contributed to the injury. In advice to practitioners who provide initial assessments, ACC says that the test for causation is the 'balance of probabilities': "the mental injury must be more likely than not the direct result of the abuse/assault rather than any other factors that are also present. Indirect causes such as aggravating or precipitating

an underlying mental disorder cannot be accepted" (ACC, 2010, p. 3). ACC explained to the Panel in its written submission that this interpretation is based in part on various court decisions notably the case of *Hornby v ACC* in 2009.

39. ACC advised the Panel that, in order to ensure that it is not acting outside the legislation by providing cover for mental injuries where sexual abuse was not the substantive cause, it has been seeking detailed information about the event(s), their history and their circumstances. Providers are asked to

> *clearly demonstrate the causal link between the mental injury sustained through the sexual abuse event(s), with due regard to other life factors and psycho-social stressors present in the client's life which may be responsible for the current presentation of psychological disorders (ACC, 2010).*

3.3.3 TIMEFRAMES UNDER THE LEGISLATION

40. Claims for mental injury caused by sexual abuse are one of four categories of claim that are described in the Act as 'complicated claims.' Section 57 of the Act requires ACC to investigate such claims as soon as practicable and no later than two months after lodgement. Before two months ACC must either give notice of its decision about cover or within a further two months seek further information and make a decision. ACC and the claimant may subsequently agree to further extensions but ACC's decision on cover must always be made within nine months of the claim first being lodged.

3.4 FINDINGS IN RESPECT OF THE LEGISLATION

41. The Panel commissioned independent legal advice from Joanna Manning, Associate Professor in the University of Auckland's Faculty of Law. Manning's full report is attached as Appendix IX. It discusses the definition of mental injury under the Act, establishing a causative link with a Schedule 3 offence, and some privacy issues. The following paragraphs are based upon Manning's legal advice. A recent High Court decision by Justice Mallon also refers to the definition of mental injury and although it is not a decision directly involving ACC it is relevant (P v Attorney-General, 2010). Refer to section 6.1 for a discussion of the impact of ACC's interpretation of its legislative mandate on access.

3.4.1 THE LEGISLATIVE HISTORY AND INTERPRETATION OF 'MENTAL INJURY'

42. The term 'mental injury' was first introduced into ACC legislation in the Accident Rehabilitation and Compensation Insurance Act 1992 where it was used in respect of mental injuries as an outcome of a physical injury to a person.

43. The term 'mental disorder' rather than 'mental injury' was used in the 1992 Bill as first introduced to Parliament when it applied to both victims of sexual abuse and to other accident victims. The term was defined as a "clinically significant behavioural or psychological disorder." The accompanying Government Explanatory Note indicated that the term had been taken from the definition of mental disorder in DSM-III.

44. In the course of Select Committee consideration of the 1992 Bill three relevant changes were recommended. The first of these was to use the term 'mental injury' rather than 'mental disorder.' This change was in line with a number of submissions to the Select Committee which expressed concerns about inappropriately labelling victims of sexual abuse as having a mental disorder. Secondly, the definition of mental injury was broadened to include cognitive dysfunction. Finally, as a result of a considerable number of submissions to the Select Committee, it was determined that the definition of mental injury was inappropriate when applied to sexual abuse victims. Instead, for sexual abuse victims, a broader definition of 'mental or nervous shock' was included in section 8(3) of the 1992 Act as passed.

45. The Accident Insurance Act 1998 removed the reference to 'mental or nervous shock' and moved to a single definition of 'mental injury' applicable to both sexual abuse victims and to general accident victims. Manning could find no discussion or explanation about this change and concluded that it is unclear whether the change was a deliberate narrowing of cover for sexual abuse victims or done without appreciating the potential narrowing effect; the legislative history is inconclusive.

46. Manning found nothing in the legislative history to indicate that Parliament intended the definition of 'mental injury' to be confined to diagnoses referred to in DSM. However, DSM, as the original source of part of the definition of 'mental injury', could be taken to indicate recognition of the utility and status of DSM as *a* source in determining the existence of mental injury.

There is nothing in the case law to suggest that a DSM-IV diagnosis is required for a finding of mental injury

47. Manning also examined whether the courts have subsequently required a DSM-IV diagnosis before making a finding of mental injury. Commenting on several relevant cases the advice was that

> *there is nothing in the case law to suggest that a DSM-IV diagnosis is required for a finding of "mental injury," nor that it be used as the sole means of diagnosis for determining its existence.*

48. Manning considers that the law's interpretation of mental injury "obviously contemplated that expert clinical evidence from relevant health professionals would be required to establish a mental injury; hence the reference to clinically significant dysfunction." However the advice also states that "there seems to be nothing in the legislation ... which would restrict ACC from accepting a clinician without a DSM-IV qualification, as having the necessary clinical training and expertise to provide expert advice on the existence or otherwise of 'clinically significant behavioural, cognitive, or psychological dysfunction.'"

49. As well as the advice discussed above, the Panel also received comment on legal aspects of the Pathway in some of the submissions and presentations it received. The TOAH-NNEST submission states that there is no legislative requirement for DSM-IV and also points out that ACC had previously advised its treatment providers that it requires:

> *A detailed description of the significant features of the mental injury and, as far as you are professionally able, a diagnosis of it, for which you may use a DSM-IV diagnosis, an ICD code or a Read Code (ACC, 2009, p. 86).*

3.4.2 FINDINGS IN RESPECT OF PROVING CAUSATION

50. Manning considered the legislative and case law issues around causality. She noted that the statutory language used in describing the causative link between mental injury and ACC cover is different in the two sections of the Act. Section 21, in relation to victims of a scheduled sexual offence says that the mental injury has to be 'caused by' the act. Section 26, however, refers to accident victims generally and says that the mental injury has to be 'because of' physical injuries suffered.

51. The courts have taken different approaches and applied different levels of proof to these two terms. As mentioned above the case of *Hornby v ACC* is one that ACC has used in setting the level of causality that it requires. This case was about mental injury following a physical injury (s26 of the Act) and the High Court held that a higher level of proof of direct causation was required such that it should be shown that the mental injury "results from" the physical injury[2].

[2] The Court of Appeal has subsequently questioned whether this is the right test – but no definitive answer.

52. The *Hornby* case was about a s26 mental injury in relation to a general accident victim. Manning advises that it cannot be taken as a warrant for applying the stricter test of 'direct causation' to the causal requirement of s21 – including mental injury 'caused by' sexual abuse. Manning advises that the most relevant case in respect of a s21 mental injury is the 2008 case of *Ambros v ACC.* This was a medical misadventure case and the Court of Appeal took a pro-claimant stance.

> *We agree that the question of causation is one for the courts to decide and that it could in some cases be decided in favour of a plaintiff even where the medical evidence is only prepared to acknowledge a possible connection.*
>
> *…*
>
> *The generous and unniggardly approach referred to in Harrild [v Director of Proceedings] may, however, support the drawing of 'robust' inferences in individual cases. It must, however, always be borne in mind that there must be sufficient material pointing to causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice. (NZLR, 2008, p. 69 & 70)*

53. After considering these cases Manning noted that ACC would have to exercise considerable care in declining claims on the basis that the claimant has not proved on the balance of probabilities that the sexual abuse constitutes the sole or exclusive cause of the mental injury. Manning notes that if the *Ambros* case applies to sexual abuse cases then it may be that a *possible* link would be considered enough. Even if *Ambros* does not apply Manning suggests that a balanced approach would be to apply a test of 'substantial cause' or 'material cause'.

54. After receiving this advice and considering its findings the Panel shared them with ACC. ACC accepted that a DSM-IV diagnosis is not the only way to establish a mental injury. ACC also accepted that it was reasonable that the test for causation should be that the sexual abuse event was a substantial or a material cause of the mental injury. This appears to be a change to the operational policy that has been used within the sensitive claims unit so far.

55. **Panel Conclusions about ACC's Interpretation of its Legislative Mandate**

- The Act allows the use of a DSM-IV diagnosis as one way of recognising mental injury but it should not be the only way of determining whether such an injury exists.
- Although ACC is open to using alternative standardised ways of recognising mental injury the way in which ACC operationalised the Pathway resulted in approvals being limited to those with DSM-IV diagnoses. This meant that unless a claimant had a DSM-IV diagnosis provided with their claim they were referred for a further assessment.
- If there is reason to think that the sexual abuse was a substantial or a material cause of the mental injury the claim could be accepted under the Act.

4 THE EVIDENCE GUIDING THE PATHWAY

56. This section looks at the evidence that ACC says it used in developing the Pathway. Over the last eight years there have been a number of guidelines and developments related to ACC's approach to sensitive claims and the operation of the Sensitive Claims Unit. These include Dr Kim McGregor's 2002 publication for ACC "Guidelines for Therapists working with Adult Survivors of Child Sexual Abuse" (McGregor K. , 2001); an Auckland University Review of the Sensitive Claims Process in 2003; and the 2008 report "Sexual Abuse and Mental Injury: Practice Guidelines for Aotearoa New Zealand" which ACC commissioned from Massey University ("the Massey Guidelines") (ACC, 2008). The Massey Guidelines are the most widely researched and up to date guidelines developed in New Zealand for this area and they are the principle evidence that the Panel has considered.

4.1 ACC'S USE OF THE MASSEY GUIDELINES AND OTHER EVIDENCE

57. As well as the Massey Guidelines ACC gave the Panel a list of some other sources of evidence to which it has referred (some of which have also been cited in the Massey Guidelines work). These include:

- an August 2009 overview of evidence from the Health Services Assessment Collaboration showing that inpatient therapy for adult victims of childhood sexual abuse can be effective (Ali & Smart, 2009)
- a Cochrane Collaboration review showing that cognitive-behavioural interventions may have a place in treating children who have been sexually abused but that the quality of evidence is poor (Macdonald, Higgins, & Ramchandani, 2006)
- guidelines from the UK and Australia about management of Post-Traumatic Stress Disorder which note that various approaches can help reduce symptoms and improve quality of life, emphasise the importance of working at the client's pace and building a therapeutic relationship especially when trauma has been prolonged, note that medication should not be routinely used as first line treatment, and that evidence is lacking for some modalities such as supportive counselling and hypnotherapy (National Institute for Clinical Excellence, 2005) (Australian Centre for Posttraumatic Mental Health, 2007)
- several other more general reviews of evidence about broader mental health services in New Zealand and elsewhere.

58. During and since the development of the Pathway ACC have quoted the Massey Guidelines as providing the justification for many of the changes brought about by the Framework and the Pathway. However, ACC has also advised the Panel that the Guidelines are focused on treatment provision whereas the Pathway is focused on the pre-treatment claims approval processes.

4.2 FINDINGS IN RESPECT OF THE EVIDENCE AND ITS USE IN THE PATHWAY

59. The Panel met with the principal authors of the Massey Guidelines and sought comment from a range of providers and professional bodies on their appropriateness, usefulness and the extent to which they have been reflected in the Pathway.

60. In general there is widespread respect for the Massey Guidelines. It is recognised that they cover the area well and there is support for their twelve principles:

- Safety
- Client focus
- Therapeutic relationship
- Culture – Identity and diversity

- Effects
- Assessment
- Goals
- Rationale and Process
- Monitor and Feedback
- Opportunities and Challenges
- Context
- Therapy completion.

61. The Panel heard from many of the written and oral submissions it received that parts of the Pathway were based on selective extracts from the Massey Guidelines that had been used out of context. For example the New Zealand Psychological Society's submission says:

> *ACC has claimed that its clinical pathway for sensitive claims was justified by commissioned research, conducted by a team at Massey University, to develop practice guidelines for sexual abuse and mental injury. However, having read this research, we believe that the recommendations made for the new clinical pathway are not supported by the research that was specifically intended to develop knowledge about best practice in the sensitive claims area. Instead ACC has clearly ignored some recommendations and has quoted selectively from others to justify their own position. This is a significant issue, insofar as it sheds doubt on the evidence base for the new clinical pathway.*

62. ACC has cited the Massey Guidelines as the basis for setting 16 sessions of therapy as the initial standard length of therapy for all new clients[3]. Many commentators stated that when the Massey Guidelines identified up to 16 sessions as an appropriate length of therapy they were referring to victims of a single episode of rape or sexual assault (ACC, 2008, p. 80). However, the Massey Guidelines also say that the evidence shows that "many adult survivors of child sexual abuse did well with medium-duration therapy (10-16 sessions)" but also that "the duration of therapy will depend on the complexity of the client's range of effects. For example, time-limited may mean up to 20 sessions for most clients, while other clients may require a more long-term approach to attain a sufficient degree of wellness" (ACC, 2008, p. 80). The evidence for these statements came from a number of meta-analytic reviews of various studies, none of which had been conducted in New Zealand. The Massey University team cautions "Another limitation of meta-analysis and examining treatment outcomes studies is that the types of client commonly seen in practice may be excluded from research studies because they present with multiple difficulties or have issues beyond the scope of the study." Also "....these issues limit the findings of meta-analysis reviews for therapy practice" (ACC, 2008, p. 81).

63. The Panel reviewed the Massey Guidelines, the Framework and the Pathway and found discrepancies and contradictions between these three documents. Whilst individually these may be of little consequence, cumulatively they have contributed significantly to confusion in the sector and the view that the Pathway cannot be justified by the Massey research.

64. Many submissions point out that the first principle in the Massey Guidelines is safety. These submissions state that the Pathway process can be unsafe for clients because of the delays in treatment while waiting for a decision on ACC cover[4], enforced breaks in therapy while waiting for ACC to approve further sessions, and the requirement that many claimants undergo an independent

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[3] Although the Pathway is meant to differentiate clients who are expected to need long term therapy, ACC advised that no such clients have been approved under the new Pathway so far.

[4] For new, decline reactivated or relapse clients

assessment at an early stage. Often these delays occur at a point when claimants have disclosed sexual abuse for the first time or they are at a critical time in the therapeutic process and they may therefore be very vulnerable.

65. The second principle in the Massey Guidelines is client focus. This emphasises that individual tailoring of therapy is important; for example, therapy should be planned in the light of the client's age, culture, and the type, frequency and severity of abuse. The Guidelines point out that the complexity of sexual abuse and its affects mean it is impossible to say in advance what therapy will best suit an individual. The Panel heard from various submissions that the Pathway is perceived as imposing a rigid, externally driven, closely monitored and defined system that makes it less able to be flexible and responsive to individual client needs.

66. Several submissions point to the fact that the Massey Guidelines lay considerable emphasis on the importance of the therapeutic relationship between client and therapist (the third principle). These submissions state that the Pathway is in conflict with this principle since clients are frequently asked to see new practitioners to undergo assessments and sometimes are required to choose a new therapist because an ACC assessment has determined that a different therapeutic approach is needed. The New Zealand Psychological Society submission said this:

> *To insist that sexual abuse survivors disclose the details of their abuse not once, but as many as three times (GP-initial assessor-treatment provider) is likely to be experienced as distressing by survivors and will negatively impact on the development of a trusting relationship with a service provider. This relationship with a service provider was recognised in the Massey University guidelines to be a key element of successful treatment.*

67. **Panel Conclusions about the Massey Guidelines**

- The Massey Guidelines are well-researched, are a generally good reflection of the evidence, and are well-respected by New Zealand's provider community.
- Links between the Massey Guidelines and the Pathway are not strong. ACC had not recognised that the Guidelines are relevant to the whole Pathway including claims processing and assessment for cover rather than just to treatment. The Panel are of the view that all engagements with clients should support recovery and be consistent with the Guidelines.
- Under the Pathway delays in access to therapy, enforced breaks in therapy, and requirements that many clients must undergo an early and independent assessment do not align with the Massey Guidelines' principle of safety or of the importance of the therapeutic relationship.
- The Pathway aligns poorly with the Massey Guideline's principle of client focus since it does not adequately allow for differences in client age, gender, culture and the nature of the abuse.
- The Pathway's setting of 16 sessions as the standard length of initial short-term therapy is an arbitrary limit. The Massey Guidelines did not find definitive evidence about the best length of therapy indicating that this should be flexibly based on each client's progress.

Recommendation 1. That ACC ensures that all aspects of their Pathway(s) and associated claims processes are in line with the Massey Guidelines by seeing that they:

- are developed and implemented in ways that recognise and protect client safety and the importance of the therapeutic relationship;
- take a client focus; and
- recognise the special needs of particular groups including children, adolescents, people with mental illness, people with intellectual disabilities, Māori, and Pacific peoples.

5 THE DEVELOPMENT AND IMPLEMENTATION OF THE CLINICAL FRAMEWORK AND PATHWAY

68. In this section the Panel describes the processes that ACC followed in developing and implementing the Clinical Framework and the Pathway, and reports on its findings and conclusions about these processes. This is an area that the Panel has heard a lot about. The Panel addresses it here because changes in ACC processes going forward are particularly relevant to meeting the Panel's requirement (in its Terms of Reference) to focus on finding practical solutions to address issues that are identified.

5.1 ACC'S PROCESSES

5.1.1 THE DEVELOPMENT OF THE CLINICAL FRAMEWORK

69. On 16 July 2009 ACC released its Clinical Framework for the Sensitive Claims Unit (ACC, 2009) to "provide a set of guiding principles for the provision of treatment services (and other entitlements) for clients, health professionals, treatment providers and ACC staff" (ACC, 2009, p. 3). The Framework was developed internally without any external consultation. The nine principles in the Framework are:

   - Principle 1: We support the rehabilitation of injured clients
   - Principle 2: Treatment must focus on empowering the client to manage their injury
   - Principle 3: Measurable treatment effectiveness must be demonstrated
   - Principle 4: Goal setting is a means of improving function and return to work
   - Principle 5: Treatment must be based on the best evidence available
   - Principle 6: Decisions about claims are made within the bounds of legislation
   - Principle 7: We share responsibilities for injured clients with the wider community
   - Principle 8: We will develop the capabilities of staff members to support the rehabilitation of injured clients
   - Principle 9: We will use all the available expertise in making decisions.

70. Although the Framework develops each of these principles a little further it gives no details of how they might be operationalised or what the impact might be of putting them into action. No response was sought or received from the sector about the Framework.

71. At the same time as the Framework was released ACC distributed its July sensitive claims provider newsletter (ACC, 2009). This newsletter announced the release of the Framework but made no mention of the upcoming Pathway even though internal modelling of the Pathway had commenced in June 2009 and it was first released for comment in the following month. The newsletter did, however, have a first section entitled "A change in how we work." This section began with an explanation that "At the first meeting of the new ACC Board in April this year, the Board signalled that it expects us to keep a close eye on expenditure for all parts of the state sector." The section went on to describe ACC's new Health Purchasing Framework and concluded by saying "our team is keen to find areas of innovation within the treatment of sensitive claims clients. You can expect to hear more about this from us over the next few months."

5.1.2 THE DEVELOPMENT OF THE PATHWAY

72. ACC stated in its submission to the Panel that:

> *ACC developed the Clinical Framework and Pathway to respond to a large number of issues with the treatment and rehabilitation of clients, including services that were being provided outside of ACC's legislation. While this was an urgent response and ACC moved quickly to implement far reaching change, feedback was sought from the sector and proposals were refined before the Pathway was introduced at the end of October 2009.*

73. The initial version of the Pathway was drafted internally by ACC between June and August 2009. ACC advised the Panel that it invited over 700 providers to attend one of eight workshops at which the draft Pathway was released and discussed. Following some amendments a revised Pathway was released to over 900 recipients in September 2009. At this stage meetings were held with various sector groups notably:

    - the Sensitive Claims Advisory Group
    - Te Ohaaki a Hine - National Network Ending Sexual Violence Together (TOAH-NNEST)
    - New Zealand Association of Counsellors
    - New Zealand Association of Psychotherapists
    - Psychology Society
    - College of Clinical Psychologists
    - Psychotherapists Board of Aotearoa New Zealand
    - New Zealand Psychologists Board
    - Royal Australia and New Zealand College of Psychiatrists
    - Royal New Zealand College of General Practitioners.

74. In terms of government agencies ACC noted in its submission to the Panel that it attended meetings by invitation with the Health and Disability Commission, the section of the Ministry of Health dealing with primary mental health, and the Children's Commission.

75. The Panel has heard both from ACC and in numerous submissions and from many presenters that at the workshops and during subsequent discussions there was considerable concern expressed from many quarters (including clients and providers). These concerns included that the Pathway would:

    - markedly reduce client access to therapy
    - be stigmatising and potentially re-traumatising
    - be difficult to implement
    - create gaps in therapy
    - be more costly.

76. Significant numbers of providers said that they thought it was unethical to begin work with survivors under the Pathway because it would involve starting work around disclosure of the abuse and then not being able to continue to support and 'hold' clients at a time when they are most vulnerable.

77. Others expressed the concern that the Pathway would not be suitable for specific groups particularly children, adolescents, people with mental illness, Māori, and Pacific peoples. It was argued that separate pathways were needed for such groups.

78. There were a small number of changes made to the initial Pathway design as a result of comments made at the workshops and its introduction was delayed by several weeks. The Pathway came into effect on the 27th October 2009 some five months after ACC first began to develop it with the key features of the original Pathway retained.

79. ACC has briefed the Panel about a number of changes that have been implemented since the Pathway was initially introduced and about future plans for development and further change (including, for example, developments for Māori and for children).

80. In its initial briefing to the Panel ACC noted that one of the challenges in managing the implementation of change to the Pathway was "managing involvement and feedback in the timeframe available." ACC also advised that another key issue in introducing the Pathway was "overcoming provider resistance to change."

5.2 FINDINGS ABOUT THE DEVELOPMENT AND IMPLEMENTATION OF THE PATHWAY

81. The State Services Commission's 2005 Guidance to Crown Entities about planning change (Treasury and State Services Commission, 2005) advises that there should be a credible intervention logic or evidence as to how the objective of any new policy or programme will address the identified need. Intervention logic is defined as the 'systematic and reasoned evidence-based description of the links between outcomes and outputs [of an intervention]' (State Services Commission, 2010). The Panel asked ACC for a copy of the programme or intervention logic underpinning the Pathway. ACC's response was that the one page claims processing pathway diagram is the programme logic. The Panel does not consider the pathway diagram constitutes an intervention logic.

82. In light of its purpose to "assess the implementation and impact[5]" of the Pathway the Panel asked ACC whether there was an implementation project plan for the development and introduction of the Pathway. ACC said that an initial project management plan and communications plan had been prepared for the Steering Group but further said "ACC will not be providing this information, as it's believed that it is not relevant to the [Panel's] terms of reference[6]".

83. The Panel found no evidence of formal planning for implementation in any of the documentation provided to it. To the contrary, evidence obtained from presentations and submissions was that implementation was poorly planned without adequate consideration of the impact on clients and the Pathway was introduced prematurely and precipitously.

84. As described above (paragraph 72) ACC initially developed the Pathway internally. Sector groups had no involvement in this phase of development which started in May 2009 and they only heard about the proposed radical changes at the series of workshops in August. The Panel has heard from most of the groups that ACC met with and they have made it clear that they think they were not adequately consulted, that their contributions and opinions were sought too late, and that ACC did not adequately hear or respond to the many general or specific concerns that they raised. For example, the Royal New Zealand College of General Practitioners' submission to the Panel stated,

> *We consider the process required more attention, particularly in areas of early consultation and development. It appears that there was too much speed and not enough haste.*

85. In 2002 ACC established a Sensitive Claim Advisory Group (SCAG). The Terms of Reference for this group state "The primary goal [of SCAG] will be to ensure appropriate processes and outcomes for the services provided to ACC claimants." One of the principles included in the Terms of Reference states: "provide input and advice on the development and implementation of, and receive feedback on, the most effective best practice processes for sensitive claims." The Panel met with, and received submissions from, many of the non-government sector members of SCAG and they unanimously told

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[5] Panel's Terms of Reference

[6] From ACC response to Panel's request for information

the Panel that at no stage in the lead up to the August workshops had ACC advised them of the proposed new Pathways or sought their advice. The SCAG met in March 2009 and not again until October 2009. The notes of the SCAG meeting held 2 October 2009 (three days before the Pathway was originally due to come into force) state "There was disappointment and surprise from the SCAG members on the announcement of the new clinical pathway and the lack of involvement from the SCAG."

86. The Panel understands that the 2004 amendments to the Crown Entities Act were intended to create a clear obligation on Crown entities (including Crown agents) for them to act in concert with other agencies in the achievement of whole-of-government outcomes. The general belief at the time and since was apparently that, whilst allowing their necessary independence in relation to certain matters, it is also important that, in relation to policy, they coordinate and consult with other departments (including ministries) and agencies on matters where their outcomes and strategies overlap in planning and delivery. Guidance produced by central agencies, for example the Treasury and State Services Commission document on the preparation of Statements of Intent (Treasury and State Services Commission, 2009, pp. 5-6 & 10-11), is quite explicit. Sometimes this consultation should occur with the Responsible Minister through the monitoring department (in the ACC case, the Department of Labour). Other times, it should occur directly with the agencies concerned.

87. This indicates an expectation that any agency making a change in policy that is likely to impact on the well-being of client groups covered by the outcomes of other agencies and departments, would need to consult with them during the planning and implementation stages.

88. ACC's 2010-2013 Statement of Intent (ACC, 2010, p. 36) says, "To achieve its outcomes, ACC must work with a number of other agencies. This collaboration ensures that services are well aligned and meet the needs of New Zealanders. ACC will continue to engage with its partners to achieve quality outcomes." The SOI lists Department of Labour, Ministry of Health, Ministry of Social Development, the injury prevention sector, rehabilitation and treatment providers and the business community as the agencies (and sectors) that are particularly relevant for ACC to work closely with.

89. The Panel met with representatives from key central government agencies affected by the Pathway changes including the Ministry of Health, NZ Police, the Ministry of Social Development, the Ministry of Justice, Child Youth and Family, the Ministry of Women's Affairs, the Department of Labour and the Commissioner for Children. None of these agencies reported being consulted by ACC prior to the introduction of the Pathway and several stated that had they been consulted they would have raised concerns about the impact of the changes.

90. **Panel Conclusions on Development and Implementation of the Pathway**

- ACC implemented the Pathway hurriedly without sufficient intervention logic, planning or sector involvement.
- ACC failed in its duty to adequately consult with relevant key central government agencies.
- While ACC communicated its proposed changes to the sector this did not amount to meaningful or timely consultation and it paid insufficient attention to the problems that were foreseen by many in the sector.

Recommendation 2. That future changes to the Pathway and associated processes are planned, managed and implemented with meaningful engagement and consultation with the sector and relevant government agencies.

6 PROBLEMS IDENTIFIED WITH MAIN PARTS OF THE PATHWAY

91. This section looks at the key parts of the Pathway in turn. For each the key features are described with an explanation of what has changed compared to the previous system. Then the Panel's findings from data analysis, file review (see Appendix VI) and submissions (see Appendices III and IV) are described and the Panel's conclusions stated.

6.1 ACCESS TO ACC COVER AND LODGING A CLAIM

92. ACC systems distinguish several groups of people whose claims need to be considered under the Pathway: new claims, relapse claims, decline reactivated claims and extension of cover claims.

- **New** claimants are people who are making a new sensitive claim for a mental injury arising from an episode (or episodes) of sexual abuse (sexual abuse events may be recent or historical).
- **'Relapse'** claimants are people who have previously had a claim accepted and have completed their treatment but who at a later date has experienced a setback and are applying to return to counselling. The Panel prefers to describe these claims as 'return to counselling'.[7]
- **'Decline reactivated'** claimants are people who, for a variety of reasons, have previously had a sensitive claim declined or an earlier claim that did not require a treatment decision and are now reapplying for cover usually because their situation has changed or new information about the mental injury or the causative link to sexual abuse has become available. These declined cases fall into two main categories and a number of sub categories:
  - Claims declined which are coded as:
    - Client declines service (this code includes claimants who actively withdraw but is mostly people who do not respond to ACC communications or where ACC has lost contact)
    - Insufficient information received
    - Mental injury not clearly attributable to Schedule 3 event
    - No evidence of mental injury
    - No schedule 3 event
    - Not a clear mental injury
    - A number of other sundry reasons
  - Claims not requiring a treatment decision. None of these claims had treatment cover approved when they were first lodged. Between 1 November 2009 and 31 May 2010 there were 912 claims not requiring a treatment decision. The Panel recommends that these people should not be treated as claimants at all and hence if or when they do lodge a claim requiring a treatment decision it would be dealt with as a new claim :

[7] The Massey Guidelines (ACC, 2008, p. 123) note that for children and adolescents "the effects of sexual abuse can be discontinuous in that they are likely to re-emerge in situations due to changes or stressors in the environment .... for example the onset of puberty; they go on (pg 146) to describe similar variability in effects over time for adults and point out that 'the re-emergence of maladaptive functioning can be triggered in which a person can feel vulnerable." The Massey Guidelines suggest when such setbacks occur clients should 'seek reassurance or short-term help, or revisit therapy before a crisis situation develops.'

    - SAATS claims are registered in the ACC system because they are receiving early treatment through the SAATS programme (see section 7.1) but who may never choose to make an ACC claim. However, when someone who has attended the SAATS service subsequently lodges a claim for ongoing treatment the system recognises them as a previous 'decline' and hence their treatment claim is registered as a 'reactivated decline'
    - Department Allocation - No further Action,
    - Duplicate Claim - No further Action
    - No Client Contact/Response: No further Action
    - Physical Claim Only - No further Action
    - Returned to Registration Unit
- **'Extension of cover'** claimants are those who had had a treatment claim approved and have been undergoing treatment, have come to the end of these allocated sessions and are applying for additional sessions to be allocated so they can continue their treatment.

93. Unless stated otherwise all data provided in this report will include new, relapse and decline reactivated claims (but exclude claims not requiring a treatment decision). Extension of cover claims are not identified in the dataset provided to the Panel and hence cannot be reported on quantitatively.

94. In the seven months from November 2009 to May 2010 2,325 claims requiring a treatment decision[8] were lodged as shown in Figure 2.

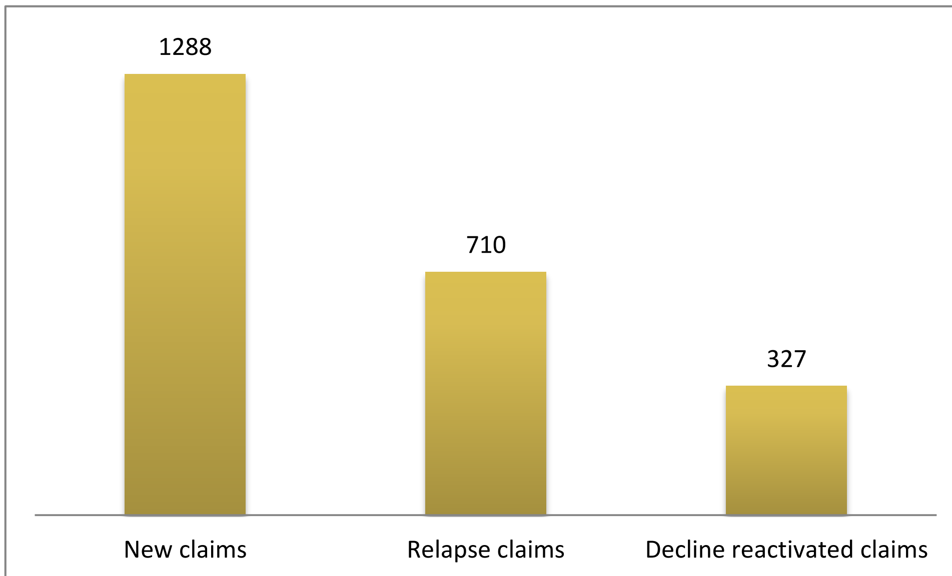

Figure 1 Claims requiring treatment decision
Source: ACC sensitive claims dataset

[8] This excludes SAATs claimants (see paragraph 153) and duplicate claims.

95. Under the Pathway ACC will only accept claims if the client has a diagnosed mental injury using DSM-IV (or an equivalent diagnosis using a comparable diagnostic system) and if there is evidence that the injury was caused by a Schedule 3 event. ACC documentation states that sensitive claims should ideally be lodged through the Pathway by someone who is capable of making such a clinical diagnosis (see paragraph 36 above); ACC will pay such a person to see the client for up to two hours and a fee for completing the ACC290 form (cover determination report). Providers who do not have the required training to make a DSM-IV diagnosis can lodge the claim using an ACC45 form and are asked to include any other information including a clinical summary of symptoms and the event; they are not funded by ACC to do this. Previously any ACC registered sexual abuse treatment providers were funded for up to four sessions to complete an initial assessment and lodge a claim.

96. In recent years before the introduction of the Pathway ACC received between 6,000 and 6,500 sensitive claims per annum. The number of claims that have been lodged has dropped precipitously since the Pathway was introduced. ACC's own data show that new claims have dropped by nearly 50 percent in the first three months of 2010 compared to the same months a year earlier (see Table 1).

Table 1 Comparison of Sensitive Claims lodged January – March 2009 & 2010

	2009	2010	Difference	Reduction
January	407	230	-177	43.5%
February	508	294	-214	42.1%
March	647	303	-344	53.2%

Source: ACC data provided to the Panel in June and July 2010
Note: The above numbers are only new claim notifications i.e. they include claims requiring a treatment decision and claims not requiring a treatment decision (e.g. SAATS) but exclude 'decline reactivated' and 'relapse'` cases.

97. The Panel has heard various explanations for this immediate reduction in claims. ACC advised the Panel that it has concerns that clients may be being told that ACC no longer funds therapy for sexual abuse claims and that some providers may be advising clients not to make an ACC claim in order to bring pressure to bear against the Pathway arrangements.

98. The Panel also heard from a number of sexual abuse survivors and from many providers who said that the Pathway was intimidating and unsafe for survivors. In particular providers told the Panel that some clients were deterred from lodging a claim by the requirement for a DSM-IV diagnosis. This they saw as a requirement to be labelled with a mental illness that might adversely affect them in future. One claimant wrote "We are victims of crime, not psychiatric patients."

"We are victims of crime, not psychiatric patients."

A survivor

99. The Panel also heard from many providers and provider organisations who think that DSM-IV is a limited tool in some circumstances for defining mental injury for sexual abuse victims. For example the submission from Doctors for Sexual Abuse Care (DSAC) said:

> *DSM-IV diagnoses are unsuitable in the immediate aftermath of an acute sexual assault, and are also only one among many diagnostic tools recommended in the Massey Guidelines. It is not a suitable tool for the mental injury that may be evident by other criteria immediately after a sexual assault. In addition, DSM-IV has significant limitations with children, adolescents and Māori and Pacific claimants.*

100. The Mental Health Commission submission stated:

> *With regard to establishing mental injury the requirement for formal diagnosis of mental disorder according to a classification system (such as the DSM-IV) may have unintended consequences… There is good evidence of the association between sexual abuse and mental illness even if criteria for PTSD are not necessarily evident on presentation.*

101. ACC has an obligation to ensure that it stays within its legislative mandate by only covering people who have suffered a “clinically significant cognitive, behavioural, or psychological dysfunction.” The Panel acknowledges that it is reasonable for ACC to require the use of standardised systems to help make a decision about cover. Standardised systems have a degree of reliability that can be used to improve decision-making. They also need to be seen to have some degree of validity and practicality for use in this context.

102. While understanding why ACC has emphasised the use of DSM-IV, it being historically popular with the New Zealand mental health sector and frequently referred to in judicial processes, the Panel does not support its use as the exclusive measure for determining the existence of a clinically significant behavioural, cognitive or psychological dysfunction. DSM-IV is particularly questionable for determining mental injury in children. The exclusive use of this tool appears likely to have been a major reason for the reduction in claims submitted because of the reluctance of clients to be seen as mentally ill and because only a limited number of practitioners can use the tool.

103. The Panel has briefly considered other possibly relevant diagnostic systems. Although DSM-IV is widely used by psychiatrists and clinical psychologists in New Zealand and in a few other countries (in particular the U.S.A., Australia and Canada), the International Classification of Diseases (ICD-10), developed under the auspices of the World Health Organisation, is the official diagnostic system for New Zealand (and indeed for all countries in the world) and its use should be accepted.

104. A standardised system for recognising mental injury does not necessarily have to involve a diagnostic label. There are a number of standardised tools that can be used to identify and document clinically significant dysfunction by focusing on symptoms and levels of functioning. The DSM-IV and ICD-10 are examples of standardised ‘categorical’ systems: people either meet the diagnostic criteria or they do not. Others are ‘dimensional’ systems: a person gets scored on a scale for each symptom and agreement is required on the score that is needed to meet the definition of the diagnosis. For example, the Health of Nations Outcome Scale (HoNOS) (Royal College of Psychiatrists, 1996) is a scale originally developed in the UK and specifically directed at measuring the health and social functioning of people with mental illness. This tool specifically rates a person’s complaints or symptoms or behaviours as to whether or not they are “clinically significant”. There is also a version for children and adolescents (HoNOSCA) as well as one specifically for older people (HoNOS65+). In New Zealand all DHBs are required by the Ministry of Health to collect HoNOS, HoNOS65+ and HoNOSCA., and all clinical staff will be trained in its use (Te Pou, 2009).

105. A simpler (dimensional) tool used increasingly for assessing depression, anxiety and general psychological health in primary care is the Kessler 10 Item Psychological Distress Scale (Kessler, 2003). The Massey Guidelines list 22 other formal assessment tools from the international literature that may be relevant (ACC, 2008, p. 114). Work with relevant experts to examine these and other possible tools could identify whether they would be suitable for determining and documenting mental injury. Work with relevant Māori experts may also allow similar use of a tool such as Hua Oranga developed in the Te Whare Tapa Whā model (Durie, 1994).

106. If other systems for identifying and documenting mental injury are considered one important aspect is how difficult they are to learn and to use. At present the ACC rules around which practitioners are qualified to give a DSM-IV diagnosis are quite restrictive. They present a further source of delay and often mean survivors have to undergo a difficult further assessment by a new practitioner. Systems that could be reliably applied by a wider range of approved practitioners would help expedite claims cover decisions.

107. The other major barrier to access under the Pathway is ACC’s requirement to have information to show that “the mental injury must be more likely than not the direct result of the abuse/assault rather than any other factors that are also present.” (ACC, 2010, p. 3). Although ACC acknowledges that the

causation of mental injury in sexual abuse survivors is complex and that there are often multiple factors involved, this approach to causation narrows ACC's mandate to situations where the sexual abuse is considered to be *the* most important factor. The impact of the Pathway's current approach to causation is that many claims are delayed while further information is sought (see section 6.3 below) and many are declined because it is assessed that, on the balance of probabilities, the mental injury is not the main cause (see Table 5, page 30).

108. Research shows that there is a "confluence of vulnerability factors" for victims of sexual assault (Ministry of Women's Affairs, 2009, p. 11) and that most survivors have a history of repeat sexual victimisation as well as being victims of other violence. The Massey Guidelines state:

> *People who experience CSA [child sexual abuse] are more likely to be sexually assaulted. The severity of earlier abuse is often related to an increase in the risk of experiencing sexual violence later in life. Those who experience multiple sexual abuse events are also at increased risk of developing severe and long-term difficulties. (ACC, 2008, p. 106)*

109. There is also a clear association with physical, intellectual or psychiatric disability. However, the Panel heard multiple examples of cases being declined because of an ACC decision that other factors were considered to be more important than the sexual abuse in the claimant's mental condition. The New Zealand Association of Psychotherapists give the following example in their submission to the Panel:

> *Not approved – quote: "considerable time has elapsed between the reported events and seeking assistance at this time. ACC is of the opinion that other life factors and psycho-social stressors present in your life may be responsible for the current presentation of psychological disorders" (client raped by father at 9, uncle at 10, and later gang raped).*

110. As discussed in section 3.4.2 this approach appears to narrow cover further than Parliament intended and the Panel thinks that the appropriate test should be that the sexual abuse was a 'substantial cause' or a 'material cause' (see paragraph 55).

111. The Panel also heard that many survivors are choosing not to submit a claim to ACC because they are likely to have to undergo an independent assessment – particularly at the stage when they are vulnerable because they have recently suffered a sexual assault or disclosed historical abuse for the first time. The impact of these assessments is discussed further in section 6.3 but they are clearly an important reason for claims not being submitted. Another quote from the New Zealand Association of Psychotherapists' submission:

> "The thought of having to go to a psychologist to determine whether counselling is needed by yet another person is off putting"
>
> A survivor

> *It's hard enough having to trust one person to open up with to deal with the effects of rape...the thought of having to go to a psychologist to determine whether counselling is needed by yet another person is off putting.*

112. The Panel found from its analysis of ACC data on claims received since the Pathway commenced (see Table 5, page 30) that of the 688 cases declined as at 30 June, 10 percent are declined because there is 'no evidence of mental injury' or 'not a clear mental injury' and 13 percent because 'mental injury not clearly attributable to Schedule 3 event.' A further 31 percent were declined because of 'insufficient information received' and most often the information sought is in order to show the causal link with a Schedule 3 event. As discussed in paragraph 140, the single biggest category of claims declined are coded as 'client declines service' and these are mostly people who fail to respond to ACC communication or people with whom ACC has lost contact.

113. **Panel Conclusions about access**

- ACC's emphasis on a DSM-IV diagnosis, on proof that the sexual event is the most substantial cause of the injury, and on early independent assessments have all inappropriately discouraged many claimants from lodging a claim and thus have made it more difficult for sexual abuse survivors to get appropriate assistance.
- It is reasonable for ACC to require the use of standardised systems to show that the claimant has a clinically significant behavioural, cognitive or psychological dysfunction which meets the legislated requirements before a decision about cover is made.
- However, there are no good legislative or clinical reasons to restrict access to cover to only those people who have had a DSM-IV diagnosis. There are a number of possible alternative standardised tools that could be used.

Recommendation 3. That, as a priority, ACC commence work with relevant sector experts to agree additional standardised systems for determining mental injury – including ones that would be appropriate for children and for Māori – and discuss how they should be used to confirm that a claimant has a mental injury for ACC when making cover decisions under its legislation.

Recommendation 4. That, in determining whether a mental injury has been caused by a Schedule 3 event, the test should be that the sexual abuse was a substantial or a material cause of the injury.

6.2 TRIAGE

114. Under the Pathway every claim is examined ('triaged') by a clinical psychologist in the ACC Sensitive Claims Unit who either makes a recommendation about the decision for cover to a case manager, or seeks further information and/or an independent assessment. Previously case managers made claim decisions without clinical involvement other than the report from the clinician who saw the client.

115. Triage does not involve face-to-face contact with the client. In order for the claim to proceed to the claims cover[9] decision point there needs to be:

- a DSM-IV diagnosis given by a practitioner qualified to give such a diagnosis[10] (see paragraph 36), and
- sufficient information for the triage psychologist to assess whether or not the mental injury was caused by a Schedule 3 event (as discussed in paragraph 107 above).

116. The Panel's Terms of Reference specifically ask whether the Pathway has achieved "timely triage of new and reactivated claims[11]." Under the Pathway claims for Priority 1 clients are supposed to be triaged on the same day that the claim is lodged regardless of who the referral comes from. Priority 1 clients are:

- Children
- Intellectually disabled people
- Adolescents.

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[9] 'Claims cover decision' refers to all claims that need a decision about cover to be taken under the Pathway – it excludes SAATS claims which are described in paragraphs 153 and 157.

10 Although ACC states that it would consider alternatives to a DSM-IV diagnosis no guidelines have been issued about what alternatives are acceptable or whether only certain practitioners would be eligible to use them.

11 A reactivated claim is one that has previously been declined for any reason but which has been reactivated because of new information.

117. There were 32 Priority 1 clients (children and adolescents) among the Panel's review of files from November 2009 and February 2010. None of these clients (including new and reactivated clients) were triaged within one day. The median time to triage was about five weeks with the shortest being two days and the longest 10 months (see Appendix VI).

118. Claims are often submitted and triaged soon after the person first discloses recent or historical abuse to a treatment provider. The Panel has learned from survivors, providers and the literature that this is a time when abuse survivors are particularly vulnerable. Delays in decision making are often interpreted by survivors as a sign that they are not being believed. Since for many survivors this has been a feature of family and friends' responses to earlier disclosure too, any delay at this stage can be experienced as further trauma.

> *"There are no rules – once you let the genie out of the bottle you need immediate care or you're history"* a male survivor.

"There are no rules – once you let the genie out of the bottle you need immediate care or you're history"

A male survivor

119. **Panel Conclusions about Triage**
- ACC processes under the Pathway are not meeting ACC's expectation for triage of priority 1 cases within one day (children, adolescents and people with an intellectually disability).
- Triage of all claims is taking too long and any delay at this stage can result in further trauma for survivors.

6.3 FURTHER INFORMATION COLLECTION AND ASSESSMENT

120. If there is insufficient information to allow the triage psychologist to make a recommendation about mental injury or the causal link with a Schedule 3 event then further information is sought (from various sources including the client, general practitioners, district health boards, Child Youth and Family, mental health providers, police and schools). Of the 1,288 new claims[12] requiring a treatment decision lodged between 1 November 2009 and 31 May 2010 ACC requested additional external information for 1059 of them (82 percent) and an Initial Assessment and Recommendations for Treatment (IART) or a psychiatric assessment for 812 (63 percent). As at 30 June 2010, 186 of these claims were declined because the required information was not forthcoming.

121. The Panel has heard a number of concerns about ACC's information gathering including concerns about the extent of information that is gathered, the suitability of the consent process, and privacy issues. Once a claim is lodged with ACC, claimants are sent an ACC167 form asking that they give authority for information to be released. The form asks the claimant to declare that they understand that "this consent applies to all aspects of my claim, and includes external agencies and service providers such as general practitioners, specialists, employers etc from whom ACC asks for information." As pointed out to the Panel this in effect states that ACC may gather information that it considers relevant from an unlimited range of sources. In respect of this Doctors for Sexual Abuse Care (DSAC) submission to the Panel said:

> *This entitles ACC to make contact with employers, friends and family members (whom the claimant may have elected not to inform of the event) including potential inadvertent contact with offenders such as a parent or partner.*

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[12] Excluding reactivated declines and relapse claims. For both these groups the triage psychologists requested additional external information.

122. Manning addresses legal issues about information gathering in her report to the Panel (see Appendix IX). ACC has a statutory right under the Act to ask for and receive information from and about clients. This right, however, only covers information that is “relevant to the claim” and ACC is required to act “reasonably” in requesting the client’s authority to the release of their information.

123. The Panel has heard of difficulties that are liable to arise when ACC is trying to collect information that may be relevant to the causative link between an event and a mental state. The Panel has heard that sometimes ACC asks general practitioners or district health boards for all information that may be relevant – but it is quite unclear how the GP or DHB is expected to determine which parts of the client information they hold is relevant. In some cases, particularly where the sexual abuse is historic, there could be a lot of potentially related matters that have occurred in the interim and it may be unreasonable to expect that these can be extracted from medical records. On the other hand, the GP or DHB could be in breach of the Health Information Privacy Code if they release the whole of a person’s records since much of the record will be irrelevant to the claim. These problems are likely to be a major cause of delays and, in cases where no information is forthcoming, they may lead to the claim being declined altogether.

124. The data indicated that in 62 percent of all cases[13], even after receiving more information, ACC still does not feel they have sufficient information about diagnosis or cause, or has uncertainties about the appropriate treatment[14]. In these cases the client will either be asked to be assessed by a separate ACC-contracted clinical psychologist (an IART), attend a psychiatric assessment or advice will be sought from the Sensitive Claims Unit’s multi-disciplinary assessment panel (MDAP). If an IART process results in a recommendation that the client’s claim should be accepted the independent assessor also specifies a treatment plan but is generally not involved in providing therapy.

125. Awaiting an IART or psychiatric assessment is another very common reason for delays. 677 of the 1,337 claims lodged under the Pathway up until 31 May 2010 were still awaiting decision as at 30 June 2010.

Table 2 Claimants waiting for IART or psychiatric assessment at 30 June 2010

Process	**Status of claim**	**Number**
Psychiatric Report	Referral Sent: Waiting Response from Provider	32
Psychiatric Report	Referral to be made	28
IART – Report	Referral Sent: Waiting Response from Provider	173
IART – Report	Referral to be made	119
Sub-total		**352**
Client Contact - Psychiatric Assessment	Client to be Contacted	68
Client Contact - Psychiatric Assessment	Waiting for Client Response	36
Client Contact – IART	Client to be Contacted	78
Client Contact - IART	Waiting for Client Response	143
Sub-total		**325**
TOTAL		**677**

Source: ACC sensitive claims dataset

126. The Panel has heard from survivors who have had to wait several weeks or months while arrangements are made to find an assessor. Often claimants have to travel considerable distances for an assessment and sometimes an assessor has to be brought from another town. Delays of this magnitude are very significant and are a new feature that has occurred because of the Pathway.

[13] 69% of reactivated declines claims, 63% of new claims and 58% for relapse claims

[14] The practitioner who completes the ACC290 cover determination report is asked to include a rehabilitation plan including detailed and measurable goals for the immediate treatment.

127. The Panel also heard many concerns from survivors and providers about the assessment processes: 24 percent of all issues raised in survivors' written submissions are about the negative impact of the assessment process, and 17 percent of all the issues raised by individual providers. In addition, as mentioned earlier many survivors are put off submitting a claim because of the need for independent assessment and some decline further service rather than have the assessment. As well as the delays and need to travel, the Panel heard about clients for whom the independent assessment process was traumatic, for example, because of the assessor's gender[15] or because the assessment took place in an inappropriate venue such as a hotel bedroom. Comments about independent assessments include the following:

> *"It's very hard to get an idea of how I am in two hours."* A survivor

> *"I'm terrified, can't speak, can't put a sentence together"* A survivor

> *"The main thing is to be believed and trusted."* A survivor

> *"It feels as if you're in the court system and you've done something wrong and you're going up before a judge and jury and they're picking through everything they can so they don't have to help you. I'll be locked up and they'll throw away the key and no help"* A survivor.

> *"Client very angry about the idea that she could be assessed by anyone else, as it was shameful enough to tell me. Said that another assessment would mean she would refuse to have counselling"* A psychotherapist.

"Client very angry about the idea that she could be assessed by anyone else, as it was shameful enough to tell me"

A psychotherapist

128. Principle 6 of the Massey Guidelines is about assessment and emphasises the importance of assessment as an integral part of the therapeutic process. The recommended approach is to balance informal and formal assessment methods and to make assessment an ongoing process. By way of interviews over a number of occasions assessment gathers information from the client on various domains including the history of the abuse, perception and insights, thoughts and feelings, coping behaviours, insight and so on (ACC, 2008, p. 34). Assessment should be used to guide therapy and as a marker of change for both the client and the practitioner.

129. ACC have pointed out that many of the delays in information gathering and assessment are caused by waiting to receive information from various external sources or the difficulties imposed because of a shortage of clinical psychologists and psychiatrists prepared to provide the IARTs and psychiatric assessments. ACC also point out that there are some examples of provider services where a clinical psychologist works closely with sexual abuse counsellors and in these cases the ACC290 form can be completed in a way that reduces delays.

130. The Panel received a written submission from such a centre. The service confirmed that most of their ACC290 forms have been accepted usually with minimal delays. Clients see a counsellor for four initial visits and during this time the clinical psychologist meets with the client to carry out an assessment and complete the ACC290. While this service is meeting the ACC requirements to get cover for their clients the providers stated that the ACC requirements added considerable extra demands, delays and costs.

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[15] Many sexual abuse victims find it traumatic being assessed by someone of the same gender as their abuser.

The centre is currently considering whether it can afford to continue to provide ACC funded services. The written submission said:

> *The design of the Pathway itself causes us serious concern however there is another parallel concern: ACC appear unable to make their Pathway work in practical terms. If the goal of the Pathway was to enable efficient and effective service provision we have countless examples of this not transpiring.*

131. ACC has pointed out that sexual abuse claims fall under the provisions for complicated cases in its legislation as described in paragraph 40 above. The delays reported by ACC so far fall within the maximum nine months allowed under the provisions of the Act when claimants agree to an extension[16]. However, providers and abuse survivors gave evidence to the Panel of the adverse effects both of the delays associated with information gathering and the barriers that are posed by knowing that ACC is likely to want considerable amounts of information about people's medical and social history.

132. The data for March and April 2010 were examined. Of all new claims[17] lodged in these two months requiring a treatment decision additional information was sought for 80 percent and 68 percent of claims had been deemed to require either an IART or an assessment by a psychiatrist.

133. **Panel Conclusions about Information Gathering and Assessment**

- The Pathway's requirement for extra information and initial assessments affects three quarters of all claims submitted.
- Information collection and assessments are not timely: many clients wait for several months for information to be collected or assessment arranged.
- The extent and breadth of information requests and the difficulty in determining which information might be relevant is causing considerable problems of timeliness and raises questions about breaches of privacy.
- The number of assessments requested and a shortage of assessors is causing significant concerns about delays, difficulty in meeting client needs, and other processes around these assessments.

6.4 DECIDING ABOUT CLAIMS

134. To examine timeliness of decision making the Panel examined ACC data on all 2,325 claims lodged in the seven months Nov 2009 to May 2010 inclusive. As shown in Figure 3 at 30th June 2010 over half of these claims were still awaiting a decision.

[16] Claimants often face a difficult choice between agreeing to an extension of time or having their claim declined for lack of information.
[17] Excluding relapse or decline reactivated claims

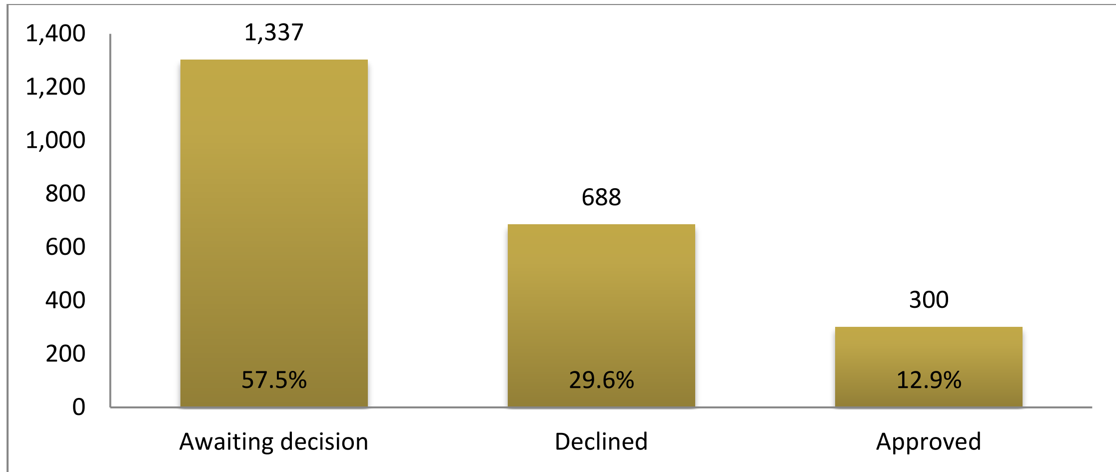
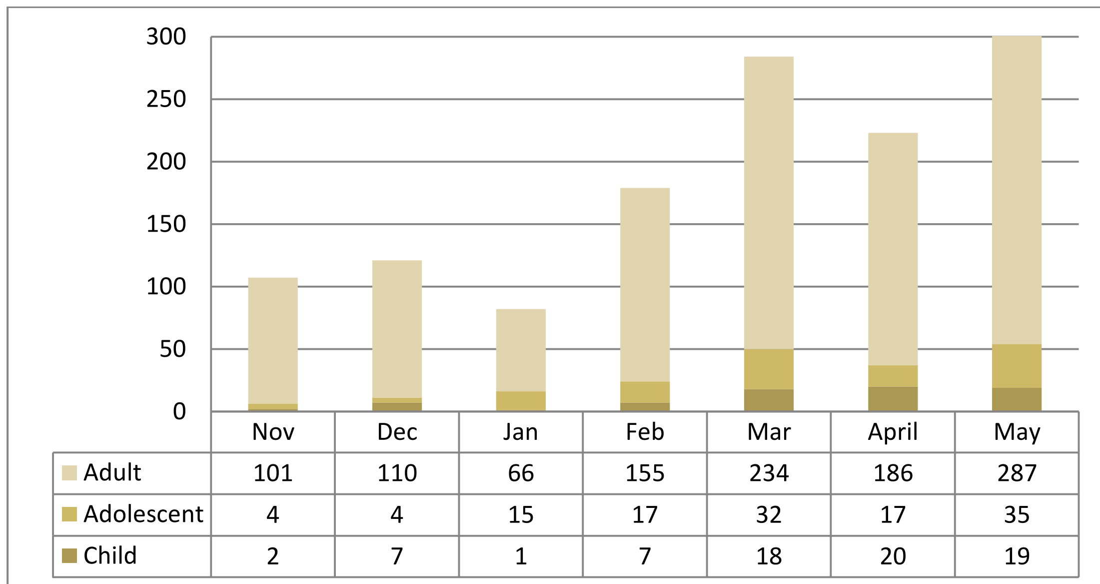


Figure 3 Status of all claims lodged between 1/11/2009 and 31/5/2010 as at 30 June 2010
Source: ACC sensitive claims dataset

135. Figure 4 shows the breakdown of the 1,337 claims lodged between 1/11/09 and 31/5/10 that were still awaiting a decision as at 30/6/10. There are 773 cases that have been waiting longer than three months for a claims cover decision (those lodged up to and including March 2010). Of particular concern are the 211 adults, 8 adolescents and 9 children who have been waiting longer than six months to have a decision made regarding their claim (claims lodged in November and December 2010). 30 percent of all claims lodged in Nov and Dec 2009 had not had a decision made as at 30 June 2010.



	Nov	Dec	Jan	Feb	Mar	April	May
Adult	101	110	66	155	234	186	287
Adolescent	4	4	15	17	32	17	35
Child	2	7	1	7	18	20	19

Figure 4 Claims 'awaiting decision' as at 30 June 2010 by months initially lodged
Source: ACC sensitive claims dataset

136. Table 3 examines the time taken to decide claims under the Pathway for claims lodged in January 2010 compared with 12 months previously, before the Pathway was introduced. For all claims lodged in January 2009 only 5.9 percent were dealt with in under a month while 24.3 percent took longer than 3 months (91 days) for a claims cover decision to be made. In contrast, of all claims lodged in January 2010, 31.6 percent were dealt with in one month[18], but the figure for longer than 3 months for a claims cover decision jumped to 51.4 percent. This is a two-fold increase in the number of claimants waiting

[18] The majority of these were SAATS claims and hence not part of the Pathway.

longer than 3 months for a claims cover decision – even though the total number of claims cover decisions had dropped by 45 percent[19].

Table 3 Time taken for decision on claims lodged in January 2009 & January 2010

	January 2009		January 2010	
Time taken for cover decision	**Number**	**Percentage**	**Number**	**Percentage**
30 days or less	24	5.9%	67	31.6%
31 -60 days	243	59.7%	30	14.2%
61 - 90 days	41	10.1%	6	2.8%
91 days or greater (1)	99	24.3%	109	51.4%
TOTAL	**407**		**212**	

Source: ACC data provided to the Panel in May 2010

137. ACC 's processing timeframe goals for sensitive claims are:

- Where sufficient information is received at lodgement the decision will be made within 7 days
- Where insufficient information is received at lodgement the goal is 6 weeks to allow for collection of further information from the referrer and from other providers or through an IART or other assessment.

However of 1,959 claims lodged between 1 November 2009 and 30 April 2010 for which a treatment decision was required only 1.4 percent had a decision made within 7 days and only 8.8 percent had a decision made within 6 weeks.

138. The situation appears to have been getting progressively worse. Table 4 shows a decline in the percentage of all claims requiring a treatment decision that were processed in 30 days or less and a steady increase in the percentage of claims taking over 90 days for a claims cover decision to be made.

Table 4 Time taken to make claim decision for claims lodged November 2009 to March 2010

	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
30 days or less	6.9%	12.5%	6.9%	4.2%	2.8%
31 -60 days	16.0%	13.3%	12.0%	8.1%	10.6%
61 - 90 days	12.1%	7.2%	5.2%	6.3%	3.1%
91 days or greater (1)	64.9%	66.9%	76.0%	81.3%	83.6%

Source: ACC sensitive claims dataset

139. Of the 2,325 claims lodged between 1 November 2009 and 31 May 2010 requiring a treatment decision 988 (42 percent) had reached a final decision (approve or decline) by 30 June 2010. 70 percent of the decisions were to decline the claim. Table 5 shows the reasons these 688 claims were declined.

[19] These figures do not provide the full picture because they exclude relapse and decline reactivated claims. The data in Table 3 includes SAATS cases which do not require a treatment decision as they are only registered in the sensitive claims database in order to initiate payment to the SAATS service. It is therefore somewhat erroneous to count these cases as 'time taken for decision' but as the Panel did not have access to source data for 2009 we were unable to extract the SAATS cases from this table. For these reasons the only inference drawn from Table 2 should be the difference in claims processing time between the two years.

Table 5 Reasons for ACC declining claims

	New	Relapse	Decline reactivated	Total	Percent
Client declines service	165	44	27	236	34.3%
Insufficient information received	186	8	17	211	30.7%
Mental injury not clearly attributable to Schedule 3 event	67	11	10	88	12.8%
No evidence of mental injury	44	1	7	52	7.6%
No schedule 3 event	31	1	7	39	5.7%
Not a clear mental injury	16		3	19	2.8%
No new mental injury	12		1	13	1.9%
Other sundry reasons	25	4	1	30	4.4%
TOTAL	**546**	**69**	**73**	**688**	**100%**

Source: ACC sensitive claims dataset

140. During these seven months 236 clients are coded as 'client declines service' (see paragraph 92). Most of these claims represent clients who do not respond to ACC communications or with whom ACC has lost contact. In about a quarter of cases the client actively withdraws their claim. The shortest time a client for a claim to be categorised as 'client declines service' was 5 days and the longest was after the claim had been in the ACC system for 203 days.

141. The shortest time it took ACC to decline one of the 211 claims declined due to insufficient information was 2 days and the longest was 5 months.

142. **Panel Conclusions about Claims cover decisions**

- Under the Pathway decision-making processes substantially fail to meet ACC's own timeframes. Less than 10 percent of decisions are taken within the expected six week maximum and timeliness appears to be deteriorating rather than improving.
- 30 percent of claimants from November and December have waited longer than six months for ACC to make a decision on their claim and 57 percent of all claimants since the Pathway began up to the end of May were still awaiting a decision at the end of June.
- These delays are largely due to ACC's new requirements for extra information and/or an independent assessment by a psychologist or psychiatrist and these delays can be harmful for many of these claimants.
- Although delays of this magnitude are within the maximum allowed for in ACC legislation, they are inconsistent with the spirit of the legislation and with the Massey Guidelines' principles.

6.5 LATER PARTS OF THE PATHWAY

143. The Panel was asked to review whether the Pathway has achieved access for clients to appropriate therapies and to entitlements, whether there is regular monitoring against goals and whether there is provision of self-management and relapse prevention plans.

144. As already described there is a very significant drop in the number of claims submitted and an equally large reduction in the number of claims accepted. The evidence received from many quarters is that this is likely to mean clients are missing out on appropriate therapies – and potentially entitlements as well.

145. A significant change that the Pathway instituted is that in many cases treatment plans and goals are now approved independently from the practitioner who will be providing the therapy. As described above, if a claim is submitted by a practitioner who is not qualified to undertake a DSM-IV assessment then the triage psychologist will usually refer the claimant for an IART or psychiatric assessment. Part

of the assessment process is to determine treatment goals and a plan – but the assessor does not carry out the therapy. The Panel received submissions from survivors and providers that this separation of assessment and treatment was not sensible. For example, the New Zealand Psychological Society submission says "Most clinicians prefer to conduct their own assessments because it provides them with a stronger foundation of understanding on which to base their intervention." As noted in paragraph 128 above the Massey Guidelines emphasise that routine assessment is an ongoing component of therapy.

146. Because of the steep reduction in numbers of claims accepted ACC was unable to report to the Panel about how useful the four-weekly monitoring reports are proving to be. Providers reported that they thought such frequent reporting would pose a considerable extra administrative burden without any clear gain (since providers generally work with clients to regularly monitor progress towards agreed goals).

147. So far very few clients have moved through the Pathway to the stage of completion of treatment and provision of self-management plans so the Panel is unable to comment on this aspect of the Pathway.

148. Similarly, it is difficult at this stage to comment on how well the Pathway is working for clients who apply for extension of cover beyond 16 sessions since very few clients have progressed through the Pathway to that point. Providers have expressed concern that this is likely to be another time when delays could be created and have noted that forced interruptions to therapy at any stage has the potential to damage a client's recovery.

149. The Panel heard from many survivors who had claims approved before the Pathway was introduced but who are now experiencing lengthy periods without treatment while ACC consider whether to grant them more counselling sessions i.e. extension of cover.

150. Indications from the survivor stories and by examining the ACC dataset are that clients who are applying to re-enter the system for more treatment (described as 'relapse' clients – see paragraph 92) are experiencing even greater delays that the new claimants. 89 percent of relapse claims lodged between 1 November 2009 and 31 March 2010 took longer than 90 days for a claims cover decision to be made compared to 73 percent for reactivated decline claims and 66 percent for new claimants.

151. **Panel Conclusions about the later parts of Pathway**

- For most clients the Pathway's separation between assessment and treatment is liable to add delays and to be more harmful than helpful.
- Four weekly progress reports are a burden for providers with little benefit to the client.
- As well as the impact on new claimants the Pathway is also adding delays and difficulties for clients already in the system who are applying for extension of therapy, who are re-entering the system because of a need for further therapy, or are resubmitting a claim that had previously been declined.

7 OTHER PROBLEMS ASSOCIATED WITH THE PATHWAY

7.1 PROBLEMS IMMEDIATELY AFTER ASSAULT OR AT THE TIME OF INITIAL DISCLOSURE

152. Although not strictly part of the Pathway, the Panel heard about problems that the Pathway has reputedly caused in the period immediately after a sexual assault or at the time when a person first discloses that they have suffered historic sexual abuse.

153. ACC, along with NZ Police and the Ministry of Health, is involved in the sexual abuse assessment and treatment service (SAATS) which provides victims with immediate medical assessment and treatment, forensic examination and crisis support through contracts covering 15 DHB areas. This programme was initiated following concerns expressed by Doctors for Sexual Abuse Care (DSAC) in 2006. Since the introduction of the Pathway DSAC has withdrawn from the working party that oversees SAATS because of concerns about the effects of the Pathway. The Panel heard from NZ Police about their significant concerns that in many parts of the country the crisis support component of SAATS was no longer available. This they noted was because the effects of the Pathway meant the groups who usually provided the service (Rape Crisis, Auckland Sexual Help and others) are finding it increasingly difficult to fund and supply this assistance because of the increased burden imposed by picking up victims who had previously qualified for ACC funded therapy.

154. In its written submission ACC advised the Panel that it had been made aware of the issues about support for claimants at this stage and during any subsequent delays before a decision was made about cover under the Pathway. ACC proposed extending the SAATS contract to include 'psychological first aid' to reduce distress, provide information, identify acute risks and refer people to clinically appropriate services. ACC also talked about offering 'Supported Assistance' through GPs or Primary Health Organisations (PHOs) to enable contracted providers to "spend time with the client to explain about the ACC process and provide them with information and support while they wait for a decision on their claim."

155. The Panel heard from survivors, providers, experts in sexual abuse care, the Police and DSAC about this issue. It is clear that for most people the immediate aftermath of a sexual assault or the time when they first disclose historical sexual abuse is a time of great vulnerability. The Massey Guidelines state that safety is the first principle of care and that various aspects need to be considered including internal and external risks to self and risks from and to others. Neither the concept of offering 'psychological first aid' through SAATS nor 'supported assistance' through GPs and PHOs appear to be supported in the sector. The changes that ACC announced it will implement from 16 August should help ensure that immediate help is more readily accessible again.

156. **Panel Conclusions about problems immediately after assault or disclosure**

- Many people need psychological assistance and support immediately after a sexual assault or at the time of initial disclosure of sexual abuse and this is best supplied by a specialist sexual abuse treatment provider.
- The Pathway has had an adverse effect on the ability of specific crisis support agencies to provide this specialist crisis support and assistance.
- The support that is needed requires specific expertise and is more than psychological first aid. Few GPs are trained to provide the support that is needed and contracting through PHOs would add unnecessary expense with little gain.
- The changes that ACC announced it will implement from 16 August should help ensure that immediate help is again available.

7.2 ACC COMMUNICATIONS IN CONNECTION WITH THE PATHWAY

157. The Panel heard a number of concerns about damaging effects that some of ACC's letters and other communications under the Pathway are having on clients. ACC asks doctors who provide a service under the SAATS programme to complete an ACC45 lodgement form for all clients even if the doctor has not assessed the person in terms of mental injury or ascertained whether or not the person wishes to make a claim for ACC cover. ACC asks for the ACC45 form as a way of collecting information and triggering payment for the SAATS service and in order that the event will be known about in case a claim is made at a later date. However, when such a form is received and is entered on the ACC database, ACC then sends the person a letter which is headed "Your initial consultation has been paid for – however, we can't approve your ACC claim." The letter goes on to say "Although we recognise that this is a difficult time for you, from the information provided, we've determined that you do not currently have a physical or diagnosable mental injury."

158. The Panel has heard from survivors and providers that this letter is at best very confusing to clients and at worst can add to their already distressed state given that many receive it within days of having been raped or sexually assaulted. ACC have recently informed the Panel that they have adjusted their system so it no longer automatically sends a decline letter to SAATS clients. The Panel supports this change.

159. The Panel has also received submissions about the confusing, inappropriate and sometimes threatening tone and content of other communications to clients. ACC state that they have been working to implement "a number of customer service improvements (for example phoning clients to explain the process following IART) to be more responsive to the needs of clients."

160. Many claimants and providers have told the Panel about considerable difficulties in contacting case managers or others in the Sensitive Claims Unit to follow up on the progress of their claims. The Panel heard numerous complaints that multiple phone messages and emails have never been answered. This is in breach of ACC's Code of Claimant's Rights (New Zealand Government, 2002) that states 'We will keep you fully informed' (Right 6) and 'We will respond to your questions and requests in a timely manner' (Right 5). Given that at the end of June 1,302 claims still had a status of 'pre-decision' it is not surprising that these requests for information are frequent or that the sensitive claims unit staff have struggled to keep in contact with all these claimants.

Recommendation 5. That all ACC communications with survivors of sexual abuse need to be reviewed as a matter of urgency taking a client perspective and using survivor and expert provider assistance in the process.

7.3 THE NEEDS OF PARTICULAR CLIENT GROUPS

161. The Panel heard from survivors, providers and organisations that the special needs of particular client groups are not met under the Pathway.

162. Māori are disproportionately represented amongst victims of sexual abuse. The Panel heard from Māori survivors and provider organisations that the Pathway fails to reflect Te Ao Māori, has increased barriers for Māori accessing services, and fails to provide for services based on Māori tikanga. In particular the Pathway is based on an individualised rather than a whānau approach although for many Māori the latter is more appropriate and effective. Some submitters suggested that there are Māori approaches to assessment that would be more appropriate than DSM-IV for describing and determining mental injury (as discussed in paragraph 105). Another effect of the Pathway has been to reduce the number of skilled Māori treatment providers available to provide ACC services.

163. The Panel heard from a number of families and several experts that the Pathway and the way that it has operated are inappropriate for children. There are particular difficulties associated with recognising mental injury in children, the assessment of child victims, establishing causative links, and finding appropriate therapeutic options. The Pathway's requirements are not tailored to children's needs and can make the process threatening or damaging. The Panel heard from the New Zealand Association of Child and Adolescent Psychotherapists that of the 15 child psychotherapists providing services to ACC at the start of 2009 only five continue to do so.

164. Other groups who have particular needs that are not adequately addressed in the Pathway include adolescents, people who have mental illness, people who have problems with addiction or substance abuse, other ethnic groups and prisoners.

165. ACC told the Panel that they recognise these special needs groups and plan to adopt new approaches in response. However, the Panel also heard from submitters and sector commentators that so far little progress has been seen on these alternative Pathways.

166. **Panel Conclusion about the Needs of Particular Client Groups**

- The Pathway has aggravated the situation for certain groups including Māori, children and adolescents, people with mental illness, and people who have problems with addiction or substance abuse.

7.4 QUESTIONS ABOUT QUALITY AND WORKFORCE

167. Although not explicitly listed among objectives for the Pathway, in presentations before and after the Pathway was instituted ACC pointed out concerns about the quality of some treatments and of some practitioners in the workforce. Questions were raised, for example, about whether it was appropriate that 27 percent of clients received more than 50 therapy sessions and there were over 800 clients who have received more than 100 sessions spread over many years. The concern (largely unspoken) seemed to be that some therapy was inappropriate and ineffective and that some therapists were encouraging prolonged and unhelpful dependency in clients.

168. As already discussed the Massey Guidelines did not find definitive evidence about the best length of therapy and state that therapy needs to be matched to the needs of the individual. While the Guidelines note that "many adult survivors of child sexual abuse did well with medium-duration therapy" they also go on to say that "with a small group of clients with confirmed complex presentations, longer-term therapy may be appropriate in some situations" (ACC, 2008, p. 80). They also say the therapist should prepare for and manage completion of therapy carefully, should emphasise that it is not the end of the client's journey, and should help clients to prepare for any set-backs and understand that sometimes a return to counselling is appropriate.

169. The Panel heard overwhelmingly positive comments from survivors about the value and importance of the therapy they received and their praise for the quality of their therapists.

170. However, a small number of the submissions and presentations to the Panel address the question of poor quality therapy and poor quality treatment providers. A very few comments raised wider concerns.

> *By all means tighten up the system, if there are counsellors under-performing, and I am sure there will have been some, get rid of them, have robust reporting and ensure as has been in the past that approved therapists are fully qualified, belong to a recognised national body* (a counsellor).

We have a lot of patients who have ended up with a prolonged unhealthy mutual dependency relationship with ACC counsellors because of funding anomalies and loose definitions of harm (a GP).

I have been appalled to hear some of my colleagues' absolute sense of entitlement to provide ACC counselling as they alone see fit for as long as they see fit… I must also add that many of my colleagues are completely professional and have only the well-being of clients as their concern (a counsellor).

I have also observed numerous instances where the counsellor has lied or exaggerated the nature of the sexual abuse and the claimant adamantly denies that what the counsellor wrote in the report ever occurred. I have drawn this to the attention of ACC in every case in my reports but, to my knowledge, nothing has ever been done about it (a psychiatrist).

171. The Panel also heard a number of complaints from survivors and providers raising issues about the quality of clinical psychologists and psychiatrists who do assessments.

I was with him for exactly one hour. I was traumatized through the whole experience. I started crying after about the third or fourth question and continued to cry through the whole session. He didn't stop to allow me to compose myself and some questions were asked and I had no chance to explain the answers. This caused me more stress. He did not ask me if I had a safe person with me or if I would be safe getting home. It was very clinical and very stressful. If I was a survivor who had not been to therapy before this it would have put me off ever going to see a therapist again!! (A survivor).

172. The Panel heard from ACC and from submitters that many treatment providers who previously provided ACC-funded counselling have ceased to do so since the Pathway was introduced. ACC has 995 registered counsellors[20] and advised the Panel that only one of these counsellors had formally withdrawn since the Pathway began. However, several counsellor associations told the Panel that more than half of their members had indicated that they were no longer doing ACC-funded counselling under the Pathway. Most of the counsellors who have stopped providing ACC-funded counselling to victims are private counsellors many of whom told the Panel that this sort of counselling was only a small portion of their work. On the other hand, this has meant a significant increase of work for specialised sexual abuse counselling services such as Rape Crisis and Auckland Sexual Abuse HELP Foundation. These organisations have seen a significant increase in demand for counselling this year and are struggling to cope.

Most of the agencies interviewed had experienced a dramatic increase in referrals since the implementation of the pathway. Agencies reported that more people were phoning the service and more people were being referred to them by other agencies as private counsellors were no longer taking up clients due to the ethical and viability challenges created by the ACC pathway (TOAH-NNEST submission).

173. Under the Accident Insurance (Counsellors) Regulations 1999 ACC approves treatment providers to provide and be paid for services to clients whose claim has been accepted by ACC (i.e. to act as treatment providers). The Regulations set out the criteria that ACC must use in approving counsellors as treatment providers under the Act. These include that the counsellor must:

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[20] ACC-registered counsellors cover a range of practitioners who provide counselling services – including counsellors, social workers, clinical psychologists and psychiatrists.

- hold a qualification which means education and training covering and being assessed on knowledge and skills in at least two models of counselling, human development, family dynamics, abnormal psychology, dealing with injury and trauma (the length of the qualification is unspecified in the regulations)
- have had at least one year of supervised work experience as a counsellor
- have an understanding of the influence of age, beliefs, culture, gender, sexual orientation, and disability on responses to injury and trauma
- have an understanding of, and be able to respond to, the cultural values and beliefs of Māori
- not have been disbarred from membership of an organisation or body or had employment terminated for disciplinary reasons or been convicted of a sexual offence
- be a paid up member of one of a number of named counsellor bodies (including bodies covering psychiatrists, psychologists and psychotherapists as well as counsellors)
- be covered by the body's code of ethics, complaints procedure, disciplinary procedure, and requirements for compulsory peer supervision, continuing education, and professional development.

174. ACC also requires practitioners who are applying to be approved as counsellors and who are not registered professionals under the Health Practitioners Competence Assurance Act 2003 (HPCA) to submit two case studies showing their experience with treating mental injuries of sexual abuse victims and a report from their professional supervisor.

175. There has been discussion in the past about counsellors becoming a regulated profession under the HPCA – possibly along with psychotherapists who have been a regulated profession under that Act since 2008. ACC has also consulted about the possibly of making changes to the Counsellor Regulations in order to make them more closely aligned to the HPCA Act but at this time no change to the regulations is proposed. It also seems that, following a government review of the HPCA Act, self-regulation rather than regulation under that Act is likely to be the preferred route for ensuring safe and high quality counselling and assessment services without adding considerably to the costs.

176. The Panel sees it as critical that survivors get access to services that meet their needs. It is important that all providers are actively involved in continuous quality improvement and provide services that are based on the best available evidence. ACC is right to be interested in the quality of the services it funds and needs to work closely with providers to ensure a process of ongoing quality audit is in place. This process should not impact on client access to services (i.e. the client should not have access denied or delayed because the provider is not submitting a quality plan). The audit process should be sufficiently robust to ensure that the providers who are not appropriately responsive are identified and not registered to provide ACC services.

177. While the quality of the workforce is important all aspects of the Pathway should be the subject of quality assurance processes and continuous quality improvement. Suitable measures, standards and ways of gathering information would need to be discussed with the sector. Aspects of quality that need to be developed include:

- Client outcomes (suitable outcome measures should be discussed and developed)
- Survivor and provider surveys as part of assessing the quality of treatment, communications and client experience of the Pathway(s) and its associated processes
- The clinical appropriateness of the type and length of treatment especially for complex or prolonged treatment
- The timeliness, reliability, validity and consistency of all parts of the Pathway(s)
- Quality of data

- The currency of the evidence on which the Pathway(s) is based.

178. **Panel Conclusions about Quality and Workforce**

- Before the introduction of the Pathway aspects of ACC-supported therapy for mental injury suffered by victims of sexual abuse gave cause for concern including in some cases concerns about the length, effectiveness and appropriateness of therapy given by some treatment providers.
- Relationships between ACC, treatment providers and the various bodies representing treatment providers have been damaged.
- The Pathway and the way that it has been introduced and implemented have led to a reduction in available workforce and this has contributed to restriction in claimants' access to care.

Recommendation 6. That ACC establish an appropriately constituted working party involving professional groups to examine credentialing or other means of ensuring that the workforce for treatment and assessment, including the new therapeutic assessment and recovery support process, is fit for purpose and meeting quality standards.

Recommendation 7. That, in order to ensure processes around the Pathway(s) are of good quality, safe and effective for ACC, clients, and providers, ACC work with the sector, survivor representatives and relevant government agencies to develop and implement a comprehensive quality framework including strengthened processes for:

- provider approval and auditing
- appropriate service standards and monitoring
- workforce training and development
- ongoing professional development, and
- continuous service improvement.

7.5 FINDINGS IN RESPECT OF ACC'S ROLE IN COVERING SURVIVORS OF SEXUAL ABUSE

179. Several of the written and oral submissions to the Panel raised questions about whether having the treatment of sexual abuse victims covered under ACC was the most appropriate arrangement. A number of submissions made the point that sexual abuse is not accidental and does not therefore fit easily within arrangements designed to provide for no-fault accident compensation and treatment.

180. In their submission TOAH-NNEST state

> *We would like to suggest that the taxpayer funding of this part of the non-earners account, be redistributed to a different funding agency, probably MSD, so that the medically based insurance model can be replaced with a model more appropriate to solving this significant social problem. One way to do this would be to fund kaupapa Māori services and agencies providing survivors of sexual violence with specialist services. The previous ACC funding system provided relatively good geographical coverage, so funding would need to be at a rate which allowed them to subcontract the work to experienced providers in areas in which they could not provide service.*

181. Other submissions point out that significant problems can arise from treating mental injuries caused by sexual abuse in isolation from the social, cognitive, behavioural dysfunctions caused by other life events, for example, by family violence without a sexual dimension. Child, Youth and Family's submission to the Panel pointed out that around 65 percent of all children in care have a diagnosable

emotional or behavioural problem and 15 percent have a known and substantiated history of sexual abuse. The submission stated that the causation of mental health problems is usually complex and that services need to be better integrated rather than the effects of sexual abuse being managed in isolation from other issues.

182. Several submitters called for a 'whole of government' approach to the problem. For example the New Zealand Medical Association said

> *"Regardless of where the bar is set it is critical that those claimants who do not meet the bar still have their needs cared for by the health system. In particular there needs to be a whole of government approach to those people with sensitive claims with one government department taking the lead role in providing access to services for people with sensitive claims. This is currently not the case."*

183. The Panel also learned that at present the service specifications for mental health services funded via Vote:Health through district health boards specifically exclude mental health injuries as a result of sexual abuse – presumably because it is expected that these will be covered by ACC-funded care. Various submitters pointed out that this exclusion meant that where clients could no longer access ACC-funded care they often had no alternative source of funded care.

184. These questions are mostly outside the scope of this review. However, the Panel thinks they merit further consideration. Parliament clearly wanted ACC to cover people who have been mentally injured by sexual abuse but, because ACC is not a universal scheme covering all illness and injury, there will always be issues at its boundaries. In some circumstances there may be a place for a more integrated service model for people who have suffered mental injury from sexual abuse.

185. **Panel Conclusions about ACC covering Sexual Abuse Survivors**

- ACC is involved with the Ministries of Justice and Social Development in responding to the Taskforce on Sexual Violence (Ministry of Justice, 2009) and this may provide a useful mechanism for ACC to work closely with other government agencies in ensuring that any changes in access to ACC-funded care are considered from a whole-of-government perspective.

8 OVERALL CONCLUSIONS ABOUT THE PATHWAY

186. This section will consider the Panel's overall conclusions against ACC's objectives in introducing the Pathway. These objectives were to:

    - improve outcomes for clients
    - shift from a claims management to a clinical management approach
    - improve timeliness, accuracy and consistency of decisions within ACC's legislative mandate
    - tailor the approach to specific client needs.

187. Are outcomes for clients improved? When looking at outcomes the Panel is unaware of any objective, evidence-based measure of outcomes for clients and, moreover, there are few, if any, people who have completed therapy under the Pathway. However, it is relevant to note that the number of claims submitted for cover has reduced by nearly 50 percent and only 13 percent of submitted claims have been approved. From these figures and from all the preceding findings it is likely that the overall result will be a worsening of outcomes for sexual abuse survivors.

188. Has the Pathway shifted to a clinical rather than a claims management approach? Under the Pathway all the claims are initially considered by an ACC clinical psychologist rather than only by a case manager as previously. In addition, many clients are required to be assessed by an independent clinical psychologist or psychiatrist before a decision is made on their claim. While it may be argued that this introduces a higher level of clinical oversight into the process, the outcome for clients is that these steps have resulted in more extensive information and assessment requirements which have again led to significant delays in processing. The Panel acknowledge the importance of ACC ensuring that there is a mental injury and that the mental injury is as a result of a Schedule 3 event before a claim for cover is accepted. However, the reliance on DSM-IV and the operational policy around determining causality have resulted in a narrowing of the way that mental injury and causality are interpreted. Despite the additional clinical oversight the Pathway is largely a claims management pathway and entry to therapy is more closely restricted than it was before.

189. Has the Pathway improved timeliness, accuracy and consistency of decision-making? The Pathway has severely worsened timeliness of decision making; 80 percent of all claims requiring a treatment decision are taking over 90 days to process and timeliness is getting worse. While the new processes are likely to have increased consistency, the approach taken by ACC to determine mental injury and causality are likely to have resulted in less accurate decision making.

190. Does the Pathway meet specific client needs? The Pathway has been developed and implemented poorly. Not only does it fail for those groups with particular needs such as children, adolescents and Maori and discriminate against people with co-existent and pre-existent problems but the Panel has also found no evidence that it is better tailored to meet individual client needs.

191. The Panel's detailed and overall conclusions are strengthened by the multiple sources of evidence available for this review. Traditional qualitative triangulation techniques have been used to compare data from multiple sources namely the submissions, personal presentations, documentation, file review and the ACC dataset of all claims.

192. **Panel Overall Conclusions about the Pathway**

- The Pathway is effectively a claims management pathway which has significantly worsened timeliness, reduced appropriate access, and not improved outcomes for individual clients nor for groups with particular needs.
- The Pathway was poorly planned and hurriedly implemented without adequate consultation with the sector or relevant central government agencies.

9 PROPOSALS FOR CHANGE

193. In the process of developing this report, the Panel shared their findings and recommendations with ACC. ACC discussed with the Panel options for changes to enable clients to have more timely access to appropriate interventions within the context of ACC's legislative mandate. This section outlines some general points that the Panel thinks should form the basis for future changes to the way that ACC manages its responsibilities under the Act. These points must not, however, be implemented without considering all of the Panel's recommendations.

194. The Panel does not see a need to change the Act in respect of mental injury caused by sexual abuse. The Panel sees advantages for claimants, providers and ACC in having one or more Pathways that give a clear set of expectations about ACC's processes and the steps and times involved.

195. Future arrangements must ensure that people who have been sexually abused are safe and can get timely access to support. Survivors are particularly vulnerable in the days and weeks immediately after sexual assault or when they have disclosed historical sexual abuse. It is at this time that they need to be able to get high quality support from a provider whom they can trust and there is a great opportunity to intervene to promote early recovery. Each survivor's needs will vary but there is evidence that safe and appropriate therapy at an early stage is likely to reduce the overall time taken for rehabilitation and recovery. As described in the Massey Guidelines, therapy at this stage must be safe, client focused, build a relationship of trust, and begin the process of assessing needs and matching therapy to the individual. This is described here as 'therapeutic assessment and recovery support' to distinguish it from 'assessment for cover' that ACC may need to ensure that it is operating within its legislative mandate.

196. While ACC needs processes to ensure that it only approves cover within its legislation, these assessments for cover processes take time and can be potentially harmful especially if they involve the person being questioned by assessors with whom they have no relationship. Such processes should not be imposed early in the recovery process.

197. The Panel proposes that ACC should fund therapeutic assessment and recovery support services for up to an initial 16 one hour sessions for all new and reactivated declined sensitive claims and should not require an early formal decision on cover. The Panel welcomes ACC's move to action this proposal for new clients and those already in the system from 16 August 2010 – and notes that this has already received some favourable response from a number of treatment providers. ACC's action and the response from the sector are both positive signs for further future improvements. People who have had a claim declined under the Pathway should also be able to apply for reconsideration and in general[21] should be treated in the same way as new claimants.

198. Claims should be able to be lodged by a GP or an ACC-registered treatment provider using an ACC45 form. Within 3 days of such a claim being lodged ACC should tell the client (and the treatment provider if one is already involved) that a formal decision on the ACC claim has not yet been determined and that ACC will fund up to 16 one hour sessions with an ACC-registered treatment provider of the client's choice for therapeutic assessment and recovery support. The 16 sessions should be provided at a pace that meets the client's needs but should, at the latest, be completed within nine months[22]. During

[21] There may be a small proportion not eligible because, with good information, the claim was declined on grounds other than a lack of a mental injury or a causative link – for example the date or place of the injury was not covered by ACC.

[22] This aligns with the legislated requirement for ACC to make claims cover decisions within at most nine months.

these sessions the treatment provider should, as part of the clinical process and being aware of safety and the importance of maintaining a client focus, gather information about the sexual abuse event(s) and impact on the person using appropriate formal and informal assessment methods (as discussed in Principle 6 of the Massey Guidelines).

199. It can be expected that many or most clients will be able to self-manage sometime within 16 sessions of therapeutic assessment and recovery support (historically the average number of sessions is approximately 10). Where indications are that the client will not need more than 16 sessions the treatment provider will work with the client to document progress achieved and to develop and document a self-management plan. In consultation with the sector a formal completion report format should be developed for submission to ACC. This should include sufficient details to make it useful for any clients who in the future may need to lodge a claim for treatment and hence require a later cover decision.

200. If at any stage it seems likely the client will need longer than 16 sessions or wishes to apply for loss of earnings payments or a lump sum payment then ACC will need to take a decision on cover. In this situation the treatment provider (with the client's approval) will submit a cover determination report (ACC should work with the sector to develop a suitable form). In order to allow adequate time for a decision on cover, ACC must be notified by the latest at the 12th of the 16 therapeutic assessment and recovery support sessions. The treatment provider must ensure that this notice is given to ACC in time to allow for any assessment and claim decision to be completed within a total of nine months since the ACC45 was initially lodged.

201. The process for cover determination needs to be reviewed in discussion with sector experts. It should take into account the Panel's findings and recommendations about the use of standardised systems for the determination of mental injury and about the need to show that a Schedule 3 event was a material or a substantial cause of the mental injury.

202. The Panel expects that a redeveloped system for cover determination or extension of cover for relapse claims will still involve at least a proportion of clients being required to undergo an assessment for cover from an assessor who is not their treatment provider before a decision about cover is taken or to review ongoing therapy. It will be important that the Massey Guidelines principles of safety, client focus, and the therapeutic relationship are considered when developing the assessment process. The assessors should themselves be experts who have worked with sexual abuse victims. There will need to be a sufficient workforce so that clients can be assessed without undue delay. Wherever possible and desired by the client the client's usual treatment provider should also be involved in the formal assessment process and in determining appropriate treatment goals and plans. The assessor's report (which should include recommendations about any ongoing therapy or rehabilitation) is sent to ACC where it should be clinically reviewed and form the basis for a claims cover decision.

203. ACC should ensure that any assessment for cover processes have occurred and a decision has been made within 6 weeks of being notified that a decision on cover will be needed. If this is not possible for any reason outside the client's control then further two weekly counselling support sessions should continue to be funded until the assessment is completed and a decision on further cover is taken. The assessment and cover decision must be taken at the latest within nine months of the claim being lodged – and preferably sooner.

204. The changes proposed above will assist clients who are newly entering the system. However, ACC will also need to work with the sector to develop processes for other clients and situations including:

- clients who already have a claim accepted but who may need review for approval of further treatment
- clients who may need to return to counselling (relapse claims).

205. The Panel is of the view that the same principles outlined above for new claimants should apply to these cases:

- In line with the Massey Guideline principles the process should be safe, flexible, client focused, enable client choice and build on a relationship of trust that recognises the central importance of the client/therapist relationship.
- There should be little or no delay between a claim being lodged and counselling support being available.
- There should be continuity of care throughout i.e. if there is a delay due to the requirement for assessment or any other claims processing activities counselling support should be provided during this time.
- Wherever possible and desired by the client the client's usual treatment provider should also be involved in any independent assessment process and in determining appropriate treatment goals and plans.
- The client and the therapist should be free to determine the pacing and timing of the counselling sessions.

10 RECOMMENDATIONS FOR CHANGE

Recommendation 8. That ACC move to improve access for survivors by introducing 16 hours of immediate therapeutic assessment and recovery support from a registered ACC treatment provider for new claimants, those currently under consideration under the Pathway, those who have had a claim declined and those who have chosen to withdraw their claim under the Pathway.

Recommendation 9. That these initial changes are planned, managed and implemented quickly and effectively – giving priority to claims for children – with input and/or oversight from relevant sector experts and relevant government agencies.

Recommendation 10. That ACC work with sector representatives to evolve the Pathway(s) based on the Massey Guideline principles and the proposals and principles in section 9 of this report giving particular attention to the needs of children and adolescents. The amended Pathway(s) must clarify how cover for treatment according to need will be available to those needing more than the initial 16 sessions recognising that this will be particularly important for adult survivors of child sexual abuse.

Recommendation 11. That a proportion of claimants may be required to undergo an assessment for cover from an assessor who is not their treatment provider before a decision about cover is taken or to review ongoing therapy. These assessors should themselves be experts who have worked with sexual abuse victims and, wherever possible and desired by the client, the client's usual treatment provider should also be involved in the formal assessment process and in determining appropriate treatment goals and plans.

Recommendation 12. That ACC ensure that any assessment for cover processes for all claims requiring a treatment decision have occurred and a decision has been made within 6 weeks of being notified that a decision on cover will be needed. If this is not possible for any reason outside the client's control then further two weekly therapeutic assessment and recovery support sessions should continue to be funded until the assessment is completed and a decision on further cover is taken. The assessment and cover decision must be taken at the latest within nine months of the claim being lodged – and preferably sooner.

Recommendation 13. That ACC provide mechanisms for involving families/whānau in therapy especially for children and adolescents.

Recommendation 14. That a process be established to independently monitor the development and implementation of actions recommended in this report.

APPENDIX I. TERMS OF REFERENCE

PURPOSE

The Minister for ACC has requested an Independent Clinical Review to assess the implementation and impact of the new Clinical Pathway for clients who have a mental injury caused by sexual assault or sexual abuse.

These terms of reference outline the scope of the Independent Clinical review of the Sensitive Claims Clinical Pathway.

BACKGROUND

Since 1993 SCU has managed all claims and access to treatment for survivors of sexual abuse with a mental injury caused by the abuse.

Various approaches were used to manage the claims in part to respond to legislative changes. In 2002 ACC commissioned Massey University to research and develop best practice guidelines for the management and treatment of mental injury following sexual abuse. These were released in March 2008.

The opportunity existed for the improvement of care according to the current evidence (The Massey Guidelines); the development of a clear framework and defined pathways to reduce variations and enable the best management of clients through better faster decision-making with a more proactive approach to recovery and rehabilitation and streamed to the client's clinical needs, age and context.

PURPOSE OF THE REVIEW

To independently review and identify any changes to policies, procedures, guidelines and the clinical Pathway to ensure that ACC is delivering timely decision-making and services to clients with a mental injury caused by sexual assault or sexual abuse (a Schedule 3 event) in accordance with its governing legislation.

GOALS

To review and determine if the clinical pathway implemented in October 2009 has achieved the following aspects of the Clinical Framework and Clinical Pathway;

- Enabling claimants and clients to seek appropriate assistance from ACC,
- Timely triage of new and reactivated claims,
- Timely collection of Clinical and other relevant information relating to the event and the mental injury from sexual assault/abuse,
- Timely assessments for Clients who require this,
- Timely claims cover decisions once information is available (and clinically and legislatively appropriate decisions),
- Access by clients to appropriate therapies, treatment or interventions including entitlements,
- Regular monitoring of progress against treatment and Rehabilitation goals, and
- Provision of self management and relapse prevention plans.

PROCESS

The Independent Reviewers will carry out the Review in accordance with the following principles:

- The Review will seek (where appropriate) input from relevant parties as identified and determined by the Review Group,
- The parties to the Review will make available relevant material and information as requested, and
- The Review will focus on finding practical solutions to address any issues that are identified.

This group will seek to sample feedback from Clients who have been through the new Pathway and may review a sample of anonymous claims information/look at declines, reviews and complaints.

The review will be clinically focussed.

The Review Group will be appointed/determined by the Minister for ACC.

The Review is expected to commence at the end of April 2010 and will be completed by the end of July 2010. The draft report will be provided to ACC for comment.

The final report will be provided to the Minister for ACC.

APPENDIX II. INDEPENDENT REVIEW PANEL MEMBERS

DR BARBARA DISLEY

Ph D

Dr Disley has worked extensively in the areas of mental health and education. She was the Chief Executive of the Mental Health Foundation (1991 - 1996 and Deputy CEO from 1989 - 1991). As Executive Chair of the Mental Health Commission (1996 - 2002), Dr Disley reported directly to the Minister of Health, providing advice and monitoring the provision of mental health services in New Zealand.

In her role as Deputy Secretary, Ministry of Education (2002-2007), Dr Disley was responsible for the results, budget and overall management of the Group Special Education, a special education service for children and young people aged between 0-21 years.

A Churchill Fellow and a Fellow of the New Zealand Institute of Management, she was made a life member of the New Zealand Association of Adolescent Health and Development for her outstanding contribution to the promotion of healthy development of rangatahi/young New Zealanders.

In 2005 Dr Disley received The Mental Health Services (THEMHS) individual award for exceptional contribution to Mental Health Services in New Zealand.

CLIVE BANKS

BA (Sociology and Psychology), MA (Clinical Psychology), PGDipClPs, FNZCCP

Clive Banks is a clinical psychologist of Ngati Porou iwi and his interest and expertise lies in Māori mental health. He is a Fellow of the New Zealand College of Clinical Psychologists and the Cultural Advisor on their National Executive.

His clinical experience covers most mental disorders, with a particular interest in the effects of trauma symptoms and trans-cultural psychology.

Mr Banks' background includes the training of students in cognitive behavioural interventions, the use of Māori models with Māori, providing assessments, second opinions of complex cases and supervising and training other clinicians.

He worked as a clinical psychologist at Te Ware Marie (1996-2004) and was a consultant clinical psychologist with the Regional Personality Disorder Service in Capital Coast Health (2005-2006).

In his current position as site manager and consultant clinical psychologist of Tu Te Wehi: a primary mental health service, he is able to focus on helping Māori and Pacific peoples.

RUTH HERBERT

MPP

Ruth Herbert's background is in community work and community development. Under the nom de plume of Lorraine Webb) she led a high profile public campaign and wrote the book "Cot Death in New Zealand" in the 1980s.

In the early 1990s Ms Herbert had a lead role in the implementation of consumer focused initiatives recommended by the 'Cartwright inquiry'.

Since 1995, Ms Herbert has run her own consultancy specializing in strategy, implementation and evaluation in the public sector. She is recognized as a leader in two fields: domestic violence and public health.

Ms Herbert was awarded the Victoria University School of Government 2008 Holmes Prize in Public Policy for "the best research thesis on an issue of public policy or public management of importance to New Zealand" for her evaluation of New Zealand's family violence strategies.

PROFESSOR GRAHAM MELLSOP

MB, ChB (Otago), DPM, MD (Melb), FRANZCP

Professor Mellsop's expertise in mental health is based on 40 years of experience in the field of psychiatry. He has special interests in classification of psychiatric disorders, outcomes, culture and mental health service design. Currently working for Waikato Clinical School of Auckland University as Professor of Psychiatry he has authored more than 150 research papers and publications on psychiatric disorders.

His professional background includes providing expert advice at Board/Committee level for mental health services, hospitals and at psychiatric units in Australia, New Zealand, a variety of Asian Pacific countries and to the World Health Organisation.

APPENDIX III. SUMMARY OF SUBMISSIONS FROM TREATMENT PROVIDERS, ORGANISATIONS, AND OTHERS

Of the 177 submissions received 129 were from individual treatment providers, organisations and other interested parties (as detailed in Table 6). A further 48 submissions were received from sexual abuse survivors. These are summarised in Appendix IV.

Table 6 Submissions received

Individual Treatment providers	67
Organisations (refer Appendix V)	37
Concerned public and others	25
TOTAL	**129**

Two submissions were supportive of the Pathway. 127 submissions were critical about the Pathway. The points made in these critical submissions were analysed in 15 categories. Within those 15 categories there were 812 comments made as shown in Table 7. The most common issue for treatment providers, organisations and others was the Pathway's assessment and treatment process. Interestingly this was also the most common issues raised in the survivor submissions. Time delays were third on the most frequently mentioned issue for this group and second most important issue for survivors (see Appendix IV). Lack of choice and the wider effects on society were also featured categories for both groups.

Table 7 Areas of concern

	# of comments	**% of all comments made**
Assessment and treatment process	117	14%
Best Practice	106	13%
Time delays	105	12%
Safety	97	11%
Wider social impacts	61	7.5%
Unethical	66	8%
Relationship/communication skills	45	5.5%
Culturally inappropriate	40	5%
Lack of choice	76	9%
Children, adolescents and special groups	21	3%
Solutions	22	3%
Lack of consultation	20	3%
Is ACC Best agency to manage sexual abuse cases	7	1%
Legality	7	1%
Other issues	22	3%
TOTAL	812	100%

Table 8 Organisations that made submissions

ACC Pasifika Counsellors
Action for Children & Youth Aotearoa
Abuse & Rape Crisis Support, Manawatu
Ashburn Clinic
Auckland Sexual Abuse Help
Citizens Commission on Human Rights
Commissioner for Children
Confidential listening Service
Child, Youth & Family
Doctors for Sexual Abuse Care (DSAC)
Family Works, Tairawhiti
Homeworks Trust
Male Survivors of Sexual Abuse Trust (MSSAT)
Manawatu Abuse Intervention Network
Mental Health Commission
Monarch Centre
Ngā Kaitiaki Mauri o TOAH-NNEST (*Te Ohaakii a Hine – National Network Ending Sexual Violence Together)*
NZ Assoc of Counsellors
NZ Association of Counsellors Ethics Committee
NZAC Wellington Branch
NZ Assoc of Psychotherapists
NZ Assoc of Social Workers
NZ Christian Counsellors Assoc
NZ College of Clinical Psychologists
NZ College of GP
NZ Medical Association
NZ Nurses Organisation
NZ Police
NZ Psychological Society
Personal Advocacy Trust
Rape Crisis Dunedin Inc.
Relationship Services
Roundtable on Violence Against Women
START Inc
TOAH-NNEST
Wellington Sexual Abuse HELP Foundation
Women's Health Action

APPENDIX IV. SUMMARY OF PRESENTATIONS AND SUBMISSIONS FROM SURVIVORS OF SEXUAL ASSAULT/ABUSE

PRESENTATIONS

The Panel met with approximately 50 adult sexual abuse survivors, in Auckland, Wellington and Christchurch. All were current or past claimants from ACC, most had claims lodged prior to the Pathway and their experiences with the Pathway were primarily related to extend their allocation of counselling sessions and when they sought to re-activate an earlier claim (cases ACC call 'relapse').

- The survivors were from a wide variety of ages and ethnicities.
- By and large the survivors thought that the 'old' ACC system had worked well.
- They were grateful to ACC for the often life-saving value of the therapy they had received.
- They particularly valued the ongoing relationship with a counsellor over time – though sometimes it took time to find the right therapist and sometimes they saw a number of therapists over several years.
- Where ACC had declined claims or refused to extend their cover we heard various examples of survivors funding their own therapy, providers discounting treatment, or WINZ or other funding sources being used in order that survivors could continue needed care.

The main issues raised by these survivors relating to the Pathway were (in no particular order):

- The trauma they experienced when having to tell their story to multiple people and how this makes them feel disbelieved.
- Long waits with clients 'left hanging' while ACC process their claims or applications to extend cover with no systems in place to keep the client safe while they wait.
- Barriers to clients trying to re-enter the system if they needed further treatment.
- Lack of flexibility – clients noted that the normal healing process for sexual abuse victims is to do the treatment in blocks but the ACC process doesn't allow then to easily stop and start treatment.
- The assessment process, in particular: the need to see an independent psychiatrist or clinical psychologist soon after the sexual assault or the disclosure of historic abuse; having no choice of assessor[23]; assessments being conducted in situations where the client felt unsafe; Maori and Pacific victims not having access to culturally appropriate assessments; not being supported through the assessment process; some assessors appearing to have minimal experience in working with sexual abuse victims.
- ACC communications. Clients often waited months with no communication from ACC regarding their claim. When they tried to contact the Sensitive Claims Unit their enquiries were repeatedly unanswered. Many survivors reported feeling re-traumatised by the tone and content of ACC communications.
- Intrusive information requirements. Clients felt coerced into signing the consent form giving ACC open access to all their personal information.
- Where victims had been in foster care or come from dysfunctional families this was being used as reasons to decline their claims.

[23] Sexual assault and abuse victims are often particularly traumatised if there are similarities between their assessor or treatment provider their abuser for example the same gender

- Labelling - while all survivors acknowledged they had suffered mental injury they mostly did not see themselves as mentally ill and rejected the notion that they could only get ACC cover if they had been diagnosed with a mental disorder.

SUBMISSIONS

Of the 177 submissions received, 48 were from sexual abuse survivors. Table 1 lists the main issues raised in the survivor submissions and the frequency with which these matters were commented on. The issues contained in the written submissions were closely aligned to those conveyed in the face-to-face presentations.

The 48 submissions were analysed in eight categories. Within those eight categories there were 156 comments made as shown in Table 9. 24% of all comments pertained to the negative effect of the assessment process. The next most common issue for survivors was time delays with 17% of comments regarding this issue. Interestingly these were also the two of the three most common issues raised in the 129 submissions from treatment providers, organisations, and others (refer Appendix III).

Table 9 Issues raised by Survivors

	Number of comments	% of all comments made
Negative effect of assessment process	37	24%
Time delays	26	17%
Effects of labelling	25	16%
Lack of choice	22	14%
Fear and mistrust of ACC	16	10%
Fighting and battling ACC	10	6%
Wider effects on society	6	4%
Other Issues	14	9%
TOTAL	156	100%

APPENDIX V. ORGANISATIONS THAT PRESENTED TO THE REVIEW PANEL

- Auckland Sexual Abuse Help Foundation
- Australia and New Zealand Association of Social Workers
- Child Youth and Family Service
- Children's Commissioner
- Department of Labour
- Doctors for Sexual Abuse Care
- Male Survivor of Sexual Abuse Trust
- Massey University Department of Psychology
- Ministry of Health
- Ministry of Justice
- Ministry of Social Development
- Ministry of Women's Affairs
- New Zealand Association of Child and Adolescent Psychotherapists
- New Zealand Association of Counsellors
- New Zealand Association of Psychotherapists
- New Zealand Christian Counsellors Association
- New Zealand Police
- Pasifica Counsellors
- Rape Prevention Education - Whakatu Mauri
- Royal Australia and New Zealand College of Psychiatrists
- Sexual Abuse Therapy and Rehabilitation Team Inc (START)
- Te Ohaaki a Hine - National Network Ending Sexual Violence Together (TOAH-NNEST)

APPENDIX VI. FILE REVIEW SUMMARY

The sample consisted of a mix of child, adolescent, adult acute and adult historic cases as shown in Table 10. In both months the selected files were the first received in each category in that month for example the first four child claims received in November 2009 with a 'pre-decision' status as at 31 May 2010 and so on.

Table 10 Claims selected for file review

Status at 31 May 2010	Month claim lodged	Child	Adolescent	Adult	Total
Pre-decision	Nov-09	4	3	10	17
Pre-decision	Feb-10	8	5	8	21
Approved	Feb-10	1	1	13	15
Declined	Feb-10	5	5	5	15
TOTALS		**18**	**14**	**36**	**68**

INFORMATION REVIEWED

The file review assessed the length of time taken for the claim to be triaged (see Figure 5), total time each case had been in the system, and the reasons for problems and delays in processing claims (where evident).

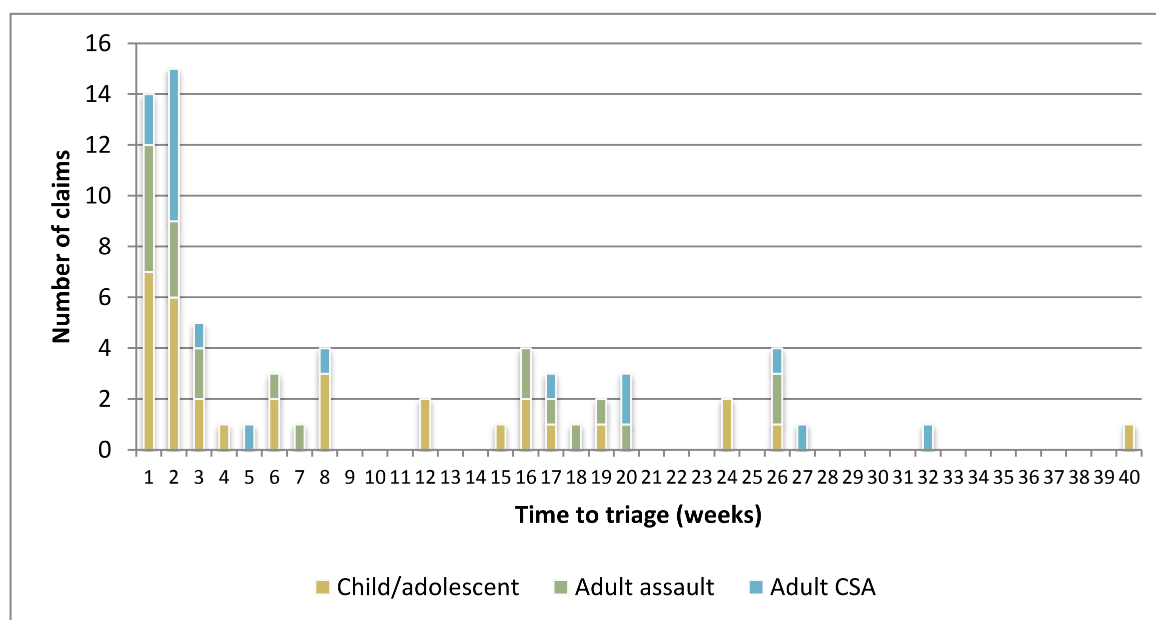

Figure 5 Time to triage

APPENDIX VII. RELEVANT INTERNATIONAL CONVENTIONS AND RESOLUTIONS

ELIMINATING RAPE AND OTHER FORMS OF SEXUAL VIOLENCE

New Zealand is party to United Nations General Assembly Resolution 62/134, *Eliminating Rape and other forms of sexual violence in all their manifestations, including in conflict and related situations* (General Assembly, 2008). This resolution affirmed "the need to provide all necessary assistance to victims, including children born as a result of rape" and, in article 1(c), urged all member states:

> *To provide victims with access to appropriate health care, including sexual and reproductive health care, psychological care and trauma counselling, as well as to rehabilitation, social reintegration and, as appropriate, effective and sufficient compensation, in accordance with relevant international and national law.*

CEDAW

Because sexual abuse is perpetrated on women much more frequently than men, the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (General Assembly, 1979) is also relevant when addressing sexual abuse. Here is what the Australian Government says about this issue:

> *Gender-based violence is a serious form of discrimination. While CEDAW does not contain an explicit reference to violence against women, the CEDAW Committee has issued a General Recommendation which states that violence directed against a woman because she is a woman or violence that affects women disproportionately is recognised and addressed as discrimination under the convention. Parties to CEDAW therefore have an obligation under CEDAW to take positive steps to eliminate all forms of violence against women. The CEDAW Committee asks countries to provide information in their regular reports about legislation and other measures it uses to protect women from violence, as well as the support services available to women. (Department of Families, Housing, Community Services and Indigenous Affairs, 2010)*

CONVENTION ON THE RIGHTS OF THE CHILD

New Zealand has specific international obligations to children as a signatory to the United Nations Convention on the Rights of the Child 1989 (New Zealand ratified the Convention on 6 April 1993). For present purposes it suffices to refer to articles 19(1) and 39 of the United Nations Convention on the Rights of the Child 1989 which have obvious implications for ACC (General Assembly, 1989).

> *Article 19 (1) "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."*

> *Article 39 "States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child"*

APPENDIX VIII. ACCIDENT COMPENSATION ACT 2001, SCHEDULE 3 S 21(2)

Cover for mental injury caused by certain acts dealt with in Crimes Act 1961

Section	
128B(1)	Sexual violation
129(1)	Attempted sexual violation
129(2)	Assault with intent to commit sexual violation
129A(1)	Inducing sexual connection by threat
129A(2)	Inducing indecent act by threat
130	Incest
131(1)	Sexual connection with dependent family member
131(2)	Attempted sexual connection with dependent family member
131(3)	Indecent act with dependent family member
132(1)	Sexual connection with child under 12
132(2)	Attempted sexual connection with child under 12
132(3)	Indecent act on child under 12
134(1)	Sexual connection with young person under 16
134(2)	Attempted sexual connection with young person under 16
134(3)	Indecent act on young person under 16
135	Indecent assault
138(1	Exploitative sexual connection with person with significant impairment
138(2)	Attempted exploitative sexual connection with person with significant impairment
138(4)	Exploitative indecent act with person with significant impairment
142A	Compelling indecent act with animal
194	Assault on a child, or by a male on a female. For the purposes of this schedule, section 194 of the Crimes Act 1961 must be regarded as relating only to situations where a female sexually assaults a child under 14 years old.
201	Infecting with disease
204A	Female genital mutilation
204B	Further offences relating to female genital mutilation

APPENDIX IX. REPORT ON LEGAL ISSUES FOR CLINICAL PATHWAY REVIEW PANEL

Joanna Manning
Associate Professor
Faculty of Law, The University of Auckland

The Clinical Pathway

Page 1 of the Pathway states "DSM-IV diagnosis required by ACC."

The Clinical Pathway provides for Clinical Triage. If the information provided at that stage is "sufficient", the claim will be referred to claims management for an acceptance decision. Sufficient information is defined in the Pathway as follows:

"For information to be sufficient for decision-making on a claim it requires:

- DSM-IV diagnosis/diagnoses — mental injury

…"

Thus, where there is a DSM-IV diagnosis, a claim will be more quickly and readily accepted. Claims without such a diagnosis are placed in a category where the information is "not sufficient", and a lengthy process of assessment and information gathering is then required.

Page 1 of the Pathway states that the health practitioners "qualified to give a DSM-IV diagnosis are psychologists, psychiatrists, psychotherapists with a DSM-IV qualification, and medical practitioners (for example GPs) with a DSM-IV qualification."

You have asked that I consider and provide legal advice on the following questions:

1. Overall purpose of the ACC Act in respect of sexual abuse/assault

"Mental injury" is defined in s 27 of the Accident Compensation Act 2001 (ACA 2001) as meaning "a clinically significant behavioural, cognitive, or psychological dysfunction." The term and the definition made its first appearance in s 3 of the Accident Rehabilitation and Compensation Insurance Act 1992 (ARCIA 1992), and these have remained the same since (see s 30 Accident Insurance Act 1998 or AIA 1998, and s 27 Accident Compensation Act 2001, or ACA 2001).

The Legislative History:[24] Definition of mental injury; separate cover for the mental consequences suffered by victims of sexual offences

When the ACA 1972 came into force on 1 April 1974, there was separate legislation (the Criminal Injuries Compensation Act 1963) providing for a compensation scheme for the victims of crime.

[24] The term "legislative history" refers to evidence as to what Parliament intended to achieve when it passed a particular statute or statutory provision, gleaned from statements made by MPs, especially Ministers responsible for a measure, during its passage into legislation, in debates in the House or in Select Committee reports.

"Injury" under that Act meant actual bodily harm and included "pregnancy and mental or nervous shock." Compensation was payable for some pecuniary loss and pain and suffering of the victim.[25] The scheme was funded from general taxation, and a schedule listed offences from the Crimes Act.

When the ACA 1972 was passed, criminal injury compensation was merged into the general accident scheme. The Criminal Injuries Compensation Act 1963 was repealed on 1 April 1975. Under the ACA 1972 there was cover for "personal injury by accident" (s 5(1)(a) and (b)).[26] The phrase was undefined in the legislation.[27] Since 1974 the scheme has covered physical injury suffered by the victims of crime. ACC generally rejected claims for mental consequences of crime, such as the bank teller traumatised in a hold-up but not physically harmed. But later courts held that personal injury extended to mental consequences of an accident, unaccompanied by physical injury, which would have meant that the victims of crime suffering only mental consequences were covered under the legislation, until passage of the 1992 Act.[28]

The notable exception has been the victims of sexual abuse without physical injury, who received counselling and lump sums without the need to show physical injury. There is no logical basis in the 1972 Act for this difference in treatment. It has been suggested that it has its origins in "public abhorrence of these particular offences."[29] There was no separate provision in the ACA 1972 providing cover for the victims of sexual assaults, as in the later ACA 1982. But it was held by the courts from very early on after the scheme came into force, that the victim of a rape was covered as having suffered a "personal injury by accident" in respect of the deterioration in her physical and mental health, see *G v Auckland Hospital Board* [1976] 1 NZLR 683.[30] As a result, cover under the ACA 1972 extended to the physical and mental injuries of victims of sexual offences.

The ACA 1982 did not make major change to the ambit of cover under the scheme. It was largely a consolidating piece of legislation, gathering together various amendments since 1972 for convenience. But it did include a partial definition in s 2 of "personal injury by accident, of which the relevant part is:

Personal injury by accident —

(a) Includes —

(i) The physical *and mental consequences* of any such injury or of the accident:

Note that both "physical" and "mental consequences" of the accident or the injury were covered. "Mental consequences" is a term of unknown origin. Courts would later consider whether "mental consequences," without any physical injury, suffered as a result of an accident would be covered as

[25] There were caps on payments for pecuniary loss and for pain and suffering.
[26] A fuller version of s 5 was substituted by the ACA Amendment Act 1974.
[27] Except to include "incapacity resulting from occupational disease" as covered in ss 65-68 of the ACA 1972.
[28] See *ACC v E* [1992] NZAR 182 (CA); *Kennedy v ACC* [1992] NZAR 107.
[29] See Background Paper for Labour Select Committee: Victims of Crime and Mental Disorder 9 March 2992 L/92/719.
[30] The High Court held that "accident" had to be judged from the perspective of the victim, and so an "accident" included an event, though intended by the perpetrator, was not intended by the person who suffered the misfortune. It was irrelevant that the acts were also a breach of the criminal law.

"personal injury by accident", and the meaning of "mental consequences" i.e. how serious the mental consequences would have to be to attract cover.

Separate provision for the cover for the personal injury suffered by the victims of sexual offences dates from the 1982 Act. It included for the first time a specific provision in paragraph (a)(iv) of the definition of "personal injury by accident" (and so within cover): "actual bodily harm (including pregnancy and mental or nervous shock) arising from any act or omission of any other person … within the description of any of the offences" specified in s 128 (sexual violation), 132 (sexual conduct with a child under 12), and 201 (infecting with disease) of the Crimes Act 1961. The reference to "pregnancy and mental or nervous shock" came from the Criminal Injuries Compensation Act 1963. "Mental or nervous shock" was undefined. It is a non-scientific term used in the judge-made law (common law). Thus there was cover for the mental sequelae of sexual abuse sustained by a victim, where s/he had not suffered physical, bodily injury from the sexual assault. But the mental injuries of the victims of crime generally were not considered covered if they had suffered no physical injury.

The incoming National Government in 1990-1 was concerned about what it perceived as the unacceptable rises in the cost of the scheme, partly from what it considered were "extensions to the boundaries of the scheme over the years" by the courts "to cover situations which most people would have difficulty in reconciling with the common view of what an accident is."[31] One of the decisions that the Government was keen to reverse was the Court of Appeal's decision in *ACC v E*, which held that there was cover under the definition of "personal injury by accident" for mental consequences alone suffered by a person, unaccompanied by any physical injury suffered by them.[32] In addition, in *Green v Matheson* the Court of Appeal indicated that the term "mental consequences" was not limited to those identifiable by some medical or psychiatric condition, but was capable of including lesser states such as humiliation and emotional distress and more transient states.[33] The Government was concerned about a risk from these decisions of opening the door to workplace stress claims, a source of cost escalation in overseas schemes.

Government announced in the policy document *A Fairer Scheme* its intention to define injury conditions covered by the scheme more closely and to repeal cover for mental injury not attributable to physical injury. This was motivated by an attempt to hold the line against extending the scheme to cover an increasing stream of bystander/secondary victims claims, and to prevent extensions to the scheme which might allow for cover for workplace stress. Physical injury should be present before mental injury was covered. The mental consequences of accidents, unless arising out of a claimant's physical injury, should be excluded from cover.[34] In addition it was considered that to the extent that mental consequences were covered i.e. arising out of physical injury, they should be restricted to non-trivial mental consequences. Hence the insertion of the definition of "mental injury" in the 1992 Act.

This would exclude the mental consequences suffered by the victims of criminal offences generally in respect of non-physical injury. Government also foreshadowed an intention to repeal cover for mental injuries of sexual abuse victims. This provoked considerable public and political controversy,

[31] See W Birch, Accident Compensation: A Fairer Scheme (1991), p 31.
[32] See [1992] NZAR 182 (CA).
[33] [1989] 3 NZLR 564 (CA), p 572. "The words personal injury by accident are all-embracing as regards effects in the person."
[34] The 1992 Act only covered mental injury which was "the outcome of those physical injuries" (s 4(1)), whereas the 1998 and 2001 Acts used the expression mental injury suffered "because of" physical injuries" (s 29(1)(c)).

and in the result Government was persuaded to reverse the policy and to continue to include cover for the victims of sex crimes. And so, the Bill as introduced continued to provide cover for them.

ARCIA 1992

The Bill as introduced

In the first version of the ARCI Bill, as introduced, there was a definition for "mental disorder", as follows:

Means, in relation to any person, a clinically significant behavioural or psychological dysfunction.

The Explanatory Note to the Bill indicates that the definition of "mental disorder" "was based on the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association)."[35] "Mental disorder" was relevant for the purposes of the definition of "personal injury" (clause 3), which included mental disorders arising out acts in the nature of the Scheduled offences performed on the claimant:

3. Definition of personal injury — (1) For the purposes of this Act, "personal injury" means —

(a) The physical injuries to the person; and

(b) Any mental disorder suffered by that person which is an outcome of those physical injuries to that person; and

(c) Any mental disorder suffered by a person which is an outcome of any act of any other person performed on, with, or in relation to the first person … which is within the description of any offence listed in the First Schedule to this Act.

Thus, as introduced, the Bill contained a *single* definition of "mental disorder", drawn from the DSM, relevant for the purposes of both cover for mental disorder suffered by sexual abuse victims and all other accident victims.

The Bill reported back from the Select Committee

The Bill was referred to the Labour Select Committee. Unfortunately the Select Committee report back to the House was merely *pro forma*, and so is unavailable to shed light on the changes made.[36] Various submissions before the Select Committee had argued for the inclusion of mental disorder/injury suffered by primary victims of crime, and some argued for the inclusion of secondary

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[35] See Accident Rehabilitation and Compensation Insurance Bill No 103 — 1, introduced on 19 November 1991. The phrase and definition were taken from the DSM — III (1987), p 6, according to Brookers Commentaries to the ACA 2001.

[36] There is no extensive Select Committee report on the ARCI Bill 1992, as the Report from the Labour Select Committee on the Bill was only a *pro forma* one (i.e. without any discussion of the content of the Bill or any changes made by the Select Committee, simply referring it to the House with a recommendation that it be passed in the form sent from the Committee), notwithstanding that this was a controversial Bill, see AJHR 1991-93 vol. XXIV I.9, p.14. There is no indication of reasons for the name change, apart from a simple reference to fact of the name change, in the debates on the Bill.

victims (cover for the mental injury suffered by witnesses of a crime). Although sympathetic to cover in the criminal injuries context, the Committee rejected this, wanting to hold the line that mental injury was only compensatable if it was attributable to physical injury. Thus, it decided not to seek a better deal for crime victims in the scheme, but to recommend to the House that the Government conduct an urgent review of ways of dealing with victims of crime outside of the accident compensation scheme.[37]

Max Bradford, on presenting the Select Committee report to the House, stated:[38]

A considerable number of submissions commented on the *two major definitions in the Bill* determining what is mental injury by accident. The definition of mental disorder — now changed to mental injury in the Bill — *is inappropriate when applied to sexual abuse victims*. The test for sexual abuse victims is now that *of mental or nervous shock* — a test with a long history in criminal injury schemes.

The italicised words suggest agreement with submissions that the (then) DSM-III definition of "mental disorder" was inappropriate when applied to sexual abuse victims, and that a broader definition was required for them. Bradford does not elaborate on why submitters considered the DSM-III definition of "mental disorder" was inappropriate when applied to sexual abuse victims. Some submitters had expressed concerns about the "labelling" propensities of the term. Perhaps there was an acceptance that the requirement for a "mental disorder" defined in terms of the DSM-III would be inappropriately narrow in relation to sexual abuse victims, cutting out some deserving survivors from access to counselling assistance, and of the need for a looser definition; and that the Select Committee, at least, accepted that there should be less reliance on the DSM in relation to sexual abuse victims.

As a result, there are changes in the Bill reported back from the Select Committee. The term "mental disorder" was changed to "mental injury". The reform paper *A Fairer Scheme* had used the term "mental injury". The term did not excite comment from groups representing victims of crime, but substantial criticism came from psychiatrists and allied health professionals, who argued for a definition of "mental disorder" linked to the DSM.[39] By contrast, submissions from consumer groups objected to the term "mental disorder" as involving "labelling."[40] Workers compensation schemes overseas also tended to use the term "mental injury", though they all required a medical certificate with a specific diagnosis. Thus the term "mental injury" was preferred "in an attempt to cater for the justifiable concerns of consumer groups, but at the same time [to] ensure that an injury was a prerequisite to compensation." Thus it seems that the reason "mental injury" was preferred to

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[37] New Zealand Parliamentary Debates (Hansard), 19 March 1992, p 7062.

[38] New Zealand Parliamentary Debates (Hansard), 19 March 1992, p 7061.

[39] The submission of the Royal Australasian and New Zealand Society of Psychiatrists apparently fluctuated between requesting cover for mental injury, mental disorder, and mental consequences. It suggested that in order for mental injury to be covered, there would need to be (a) an identifying accident involving the claimant: (b) a diagnostic psychiatric disorder according to internationally accepted operational criteria; and (c) a causal link between the accident and the disorder. The New Zealand Psychological Society and the New Zealand College of Clinical Psychologists also supported the requirement of a diagnostic mental disorder. The principal concern of all three was the extension of cover to all victims of crime. See Background Paper for Labour Select Committee: Victims of Crime and Mental Disorder 9 March 2992 L/92/719, paras 36-37. I have not accessed separate submissions in the time available to prepare this advice, but have relied on descriptions of submissions from the Background Paper referred to. They will be available from the Parliamentary Library in Wellington.

[40] See Background Paper for Labour Select Committee: Victims of Crime and Mental Disorder 9 March 2992 L/92/719, para 38.

"mental disorder" was that the former was considered somewhat less stigmatising and so more acceptable. The definition was also widened to include "cognitive dysfunction" as well.[41]

The definition of "personal injury" set out above was struck out, and a new definition inserted, which was applicable only to accident victims generally, and did not apply to sexual abuse victims:

3. Definition of personal injury — (1) For the purposes of this Act, "personal injury" means the death of, or physical injuries to, a person, and any mental injury which is the outcome of those physical injuries to that person.

There was separate cover for sexual abuse victims in a new clause 7 of the Bill:

7 (3). Cover under this Act shall also extend to personal injury which is physical injury or **mental or nervous shock** suffered by a person as an outcome of any act of any other person performed on, with, or in relation to the first person … which is within the description of any offence listed in the First Schedule to this Act.

Thus, in the Bill as reported back, there were *two* different mental injury requirements: a separate, undefined but broader one ("mental or nervous shock") appropriate for and specifically applicable to sexual abuse victims; and a different, narrower, statutorily defined term "mental injury", based in part on the DSM-III, applicable to all other accident victims. The phrase "mental or nervous shock", applicable to sexual abuse victims, is replicated from the 1982 Act and has its origins in the criminal injuries legislation. It was a broader term taken from common law case law in the negligence field. At this time (1992), the common law did not necessarily confine "mental" or "nervous shock" to a recognisable or diagnosable psychiatric illness or condition. "Nervous shock" was not defined restrictively as meaning a psychiatric or psychological illness or condition in New Zealand until 2000, when the Court of Appeal so confined it later in *van Soest v RHMU.*[42]

These two definitions of mental consequences were passed into law in the ARCIA 1992. For general accident victims, "mental injury" was not covered and compensatable unless it was suffered by the claimant and was "the outcome of" physical injuries the claimant had also suffered, see s 4(1). "Mental injury" was restrictively defined in s 3, based in part on the DSM definition of "mental disorder", as set out above.

For sexual abuse victims, however, there was separate cover under s 8(3):

8. (3) Cover under this Act shall also extend to personal injury which is *mental or nervous shock* suffered by a person as an outcome of any act of any other person performed on, with, or in relation to the first person … which is within the description of any offence listed in the First Schedule to this Act.

Imagine that the Clinical Pathway was brought into effect during the period that the 1992 Act was in force. Under it, separate cover for the "mental" or "nervous shock" suffered by sexual abuse victims (in contrast to more narrowly defined "mental injury" applicable to general accident victims) would

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[41] This came from an individual submitter, who identified the need to include cognitive dysfunction as well, see Background Paper for Labour Select Committee: Victims of Crime and Mental Disorder 9 March 2992 L/92/719, para 41.
[42] [2000] 1 NZLR 179 (CA).

have been inconsistent with the Clinical Pathway, which requires (or at least favours) a DSM-IV diagnosis of a psychiatric disorder as a prerequisite to cover, at least in terms of the then current definitions and understanding of "mental" and "nervous shock" at common law.

Accident Insurance Act 1998; Accident Compensation Act 2001

The critical change came in the AIA 1998. Unaccountably, the reference to "personal injury which is mental and nervous shock" in s 8(3) of the 1992 Act, taken from the criminal injuries compensation scheme, was dropped from the legislation. There was a move to a *single* definition of "mental injury", applicable to *both* sexual abuse victims and to general accident victims, with the same definition as that in the 1992 Act. The head of cover applicable to sexual abuse victims used the expression "mental injury" throughout. The AIA 1998 provided:

29. Personal Injury. (1) "Personal injury" means —

…

(d). *Mental injury* suffered by an insured in the circumstances described in section 40.

40. Cover for mental injury caused by certain criminal acts — (1) An insured has cover for a *personal injury that is a mental injury* if —

(a) He or she suffers *the mental injury* inside or outside New Zealand on or about 1 July 1999; and

(b) *The mental injury* is caused by an act performed by another person; and

(c) The act is of a kind described in subsection (2).

The definition of "mental injury" was replicated from the 1992 Act (s 30).

What is the explanation for the disappearance from the Act of "mental and nervous shock" as the test for the mental injury in s 21 cases? Was it deliberate, designed to narrow cover for sexual abuse victims to "mental injury", as defined?

I have been unable to find any discussion during the passage into law of the AIA 1998 to cast light on the reasons for the change. The Accident Insurance Bill was referred to a special Select Committee stuck to consider it. The key purpose of the Bill was to introduce competition into delivery of accident compensation for workplace injuries, and discussion in the Select Committee Report is largely devoted to that issue.[43] The change to s 40 is discussed nowhere in the Report, including in the Minority View of Labour, Alliance and New Zealand First. The Report states that the intention was to preserve the extent of cover provided for under the 1992 Act, and the Bill essentially restates the existing law on cover. There were some definition changes, which are specifically discussed in the Report. But the change in the definition of the mental consequences covered where caused by scheduled sexual offences from "mental or nervous shock" to "mental injury" is not one of them. There is similarly no discussion of the issue that I could find in the debates in the House on the Bill.

[43] See (1998) vol LXV AJHR p 909. The Explanatory Note to the Bill reproduces the Select Committee Report, without the Minority View.

As a result it would be largely speculation to proffer an opinion as to whether the change was deliberate, designed to narrow the ambit of cover for the mental consequences covered in respect of "sexually abused" claimants to "mental injury" as defined, and perhaps even to DSM-based diagnoses, or accidental, done without appreciating the careful inclusion in the 1992 Act of separate tests for cover for the mental consequences in relation to general accident victims and sexual abuse victims and the potential narrowing effect of including the term "mental injury" in s 40.

The ACA 2001 simply replicated the terms of the AIA 1998, referring to "mental injury" in s 26(1)(d), "personal injury that is a mental injury" throughout s 21, and using the same definition of "mental injury" in s 27.

Conclusion:

When Parliament first moved in 1992 to narrow cover for mental injury to that causally linked to physical injuries suffered by the claimant, it deliberately provided for a separate, broader test for cover for mental consequences suffered as a result of sexual abuse. That test was intended to cover mental injuries that were not confined to those based on the DSM. In 1998 there was a move to a single test for "mental injury", applicable both to cover for sexual abuse victims and to cover for mental injury in respect of all other claimants.

It could be argued that this was a deliberate decision to narrow cover for "mental injury" suffered by sexual abuse victims to diagnoses referrable to the DSM, since the definition of "mental injury" was initially taken from the DSM definition of "mental disorder". But it is perhaps as likely that the change was made without appreciation of the potentially narrowing effect it could have. Accordingly, it is suggested that not too much weight should be placed on the change in 1998. Ultimately, the safest conclusion would appear to be that the legislative history should be considered inconclusive on the point.

In addition, there is nothing in the legislative history to indicate that the definition of "mental injury" was intended by Parliament to be confined to diagnoses referred to in the current version of the DSM. The change in the definition from "mental disorder" to "mental injury", because of concerns about the labelling and stigmatising potential of a diagnosis of "mental disorder" could be seen as signalling the merits of a somewhat broader approach to "mental injury" under the scheme than exclusive reliance on the DSM. But the partial definition of the term in terms of the definition of "mental disorder" from the DSM-III does, however, indicate recognition of the utility and status of the DSM as *a* source in determining the existence of mental injury.

Questions 3 and 4: Does the Act require use of a particular tool or diagnosis methodology? Case Law on "mental injury": Geerders v ACC; Foley v ACC

Leaving aside efforts to cast light on the interpretation of "mental injury" from statements made relevant to the intentions of the Act's drafters, the Act says nothing about how mental injury shall be determined. It was obviously contemplated that expert "clinical" evidence from relevant health professionals would be required to establish a mental injury; hence the reference to "clinically" significant dysfunction. The definition indicates that evidence is necessary to establish a "dysfunction" that is clinically "significant" i.e. as opposed to "insignificant" dysfunction. So relatively trivial mental injuries, lesser emotional trauma, and transient emotions, such as anger or humiliation, will not be covered, although the issue is one of degree based on assessment and judgment. There is a spectrum of seriousness and permanence of the injury; whether a particular instance is "significant" is left to expert clinical assessment and judgment. A useful way to think about this is that the dysfunction has

to be significant enough to be considered an "injury." The definition directs the clinician to consider the claimant's functioning in three relevant fields, being whether s/he exhibits signs or symptoms of "behavioural", "cognitive", and "psychological" dysfunction. Beyond that, the Act itself provides no further guidance.

I would take issue with the following statement in the Brookers Commentaries on the Act:[44]

In effect, only psychiatric conditions that would appear in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, now in its Fourth Edition, would be covered.

The statement seems based simply on the fact that the definition of "mental injury" was originally based on the DSM-III, but the conclusion does not follow from that fact. The legislation has never specified that clinicians assessing a claim for cover for "mental injury", including cover for mental injury under s 21, use a particular tool or diagnosis methodology, such as the DSM-IV, or make a DSM-IV diagnosis as a prerequisite to the existence of "mental injury." There seems to be nothing in the *legislation* which restricts "mental injury" to DSM-IV diagnoses, or which would prevent ACC from accepting a clinician without a DSM-IV qualification, as having the necessary clinical training and expertise to provide expert advice on the existence or otherwise of "clinically significant behavioural, cognitive, or psychological dysfunction."

I fully endorse the next sentence in Brookers' Commentaries to that quoted: "This publication [the DSM-IV] is widely used in New Zealand by psychiatrists to diagnose psychiatric conditions." A DSM-IV diagnosis by a psychiatrist is clearly *one* acceptable means of producing the expert evidence required to establish a mental injury, but is not the only acceptable clinical evidence. There is nothing in the legislation to privilege DSM-IV alone as capable of amounting to mental injury. Other methodologies or diagnostic tools commonly used by responsible and reputable members from other "mental health" professions would seem able to be used and accepted by ACC to assist it to make a determination on a claim for mental injury. Some of these are referred to in Graham Mellsop's paper, *Dealing with the DSM-IV Dilemma*, see pp 2-3.

Have the courts *required* a DSM IV diagnosis before being prepared to make a finding of "mental injury"? I am advised that ACC apparently relies on *ACC v Geerders*[45] as authority for a requirement that clinicians use the DSM-IV to determine "mental injury" under s 27 of the Act, and that a DSM-IV diagnosis is a prerequisite for the existence of "mental injury." ACC might also rely on *ACC v Foley* for the same principle.

The claimant in *Geerders* claimed he suffered incapacity in the form of mental injury (persistent depressive illness), which he said was suffered because of a back injury in 1997, and so the ACC was wrong to suspend his entitlements. The issue in the case was not whether there was sufficient medical evidence of a "mental injury", but whether the necessary causal link between the covered physical injury and his depression was established in terms of s 26(1)(c). The District Court concluded that the direct causation required between the physical injury and mental injury was not established. His depression arose directly out of brooding and worry; any relationship between the physical injury

[44] See AC 27.03. See also the statement at para AC21.04: "It has to be something that would be recognised as a psychiatric condition."
[45] DC Wellington, Dec No 188/2004, 8 July 2004, Cadenhead DCJ.

and mental injury was indirect. Judge Cadenhead records ACC's submissions, including the following:[46]

This definition [mental injury] accords with the terminology in DSM IV which is the standard text used universally providing the diagnostic criteria of mental disorder. A depression is not recognised as a mental injury, i.e. is not a clinically significant behavioural, psychological or cognitive dysfunction. A diagnosis of a depression which accords with the definition of "mental injury" is a 'major depression."

ACC went on the argue that there was no evidence of a diagnosed major depression before the review officer i.e. that any psychological dysfunction was not 'clinically significant." In his decision the Judge appears to accept the existence of a "mental injury" in the form of depression, but allows ACC's appeal on the basis that he was not satisfied that the depression was directly caused by the physical injury he had suffered. Thus, while the Court provides some support for the principle that a DSM-IV diagnosis is *one* authoritative means of establishing "mental injury", it is stretching the decision beyond its capacity to argue that it supports a legal principle that a DSM-IV diagnosis is the *only* means of establishing "mental injury."

Likewise in decision in *Caroll v ACC*, a case under s 21, the issue was whether the claimant's mental injury (DSM-IV diagnosis of Schizoaffective Disorder) was caused by an incident of sexual abuse when she was aged 7 years.[47] The Court concluded that it could not be attributable to the sexual assault. It was more likely to have a biological or genetic origin. Again the Court accepted a DSM-IV diagnosis made by two psychiatrists as proof of the existence of "mental injury", but there is nothing to suggest a judicial finding that it is a requirement or the sole means of establishing "mental injury."

In *Simmonds v ACC* the issue was whether the claimant's mental injury (diagnosed PTSD), suffered as a result of sexual abuse suffered at a boys' home in his teenage years, was responsible of his incapacity to work, or whether other mental health problems, not attributable to the sexual abuse for which he had cover, were the reason for his inability to work. A diagnosis of Schizoaffective Disorder was disputed by the claimant. The Court considered reports from a number of psychiatrists who had treated or reviewed the claimant, two of whom disagreed about the appropriate diagnoses. The Court stated:[48]

Often the fact of whether or not a claimant is suffering from a mental injury has been an issue requiring to be determined. In that regard the Court is aware that the psychiatrists, who are the experts in the field, have almost invariably adopted as their reference the publication from the American Psychiatric Association known as the Diagnostic and Statistical Manual of Mental Disorders, usually referred to as DSM-IV. It is notable that many of the reports on this appellant refer to the criteria in DSM-IV for establishing diagnoses …

The Court went on to prefer the evidence of one expert psychiatrist and found that the claimant's PTSD was the prime cause of his incapacity for work. Again, because the evidence adduced to the Court was expert psychiatric and the diagnoses were based on the DSM-IV, the Court accepted these as authoritative. But there is no suggestion that this is a required methodology or that a diagnosis of "mental injury" could not be based on another diagnosis methodology.

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[46] Para 23.
[47] DC Tauranga, Dec No 77/2009, 19 May 2009, Beattie DCJ.
[48] DC Wellington, Dec No 87/2007, 7 May 2007, Beattie DCJ, para 18-19.

The strongest case for ACC's position is *Foley v ACC*.[49] The claimant had suffered a physical assault at work in July 2004, from which he suffered mild head injury. He claimed that he had developed mental injuries of post-concussional syndrome, PTSD, and major depressive disorder as a result of the physical assault. ACC did not accept the existence of the first two asserted mental injuries, and, although all the experts agreed that he suffered from depressive illness, argued that it was not causally linked to the physical injuries suffered. The psychiatric evidence was opposed. The Court rejected one psychiatric opinion and accepted the other, principally because one relied on statistics and generalisations in reaching his diagnoses, and the other more closely addressed the DSM-IV criteria for the diagnoses he considered and considered their presence or absence in respect of the claimant's mental state. This is a normal judicial process for assessing expert evidence. Given that the experts were psychiatrists purporting to base their diagnoses on the DSM-IV and they disagreed with each other's conclusions, the Court felt required to assess their evidence so as to be satisfied that, *if* that the DSM-IV was being used as the diagnostic tool, the expert had made a careful clinical assessment based on it. It does not mean that *only* the DSM-IV will be accepted as authoritative for the purpose of diagnosing mental injury.

The answer to the question posed above is that, although courts have accepted the DSM-IV as authoritative and have accepted DSM-IV diagnoses based on specialist psychiatric evidence for the purposes of establishing "mental injury" in respect of both s 21 and 26(1)(c), there is nothing in the case law to suggest that a DSM-IV diagnosis is *required* for a finding of "mental injury", nor that it be used as the sole means of diagnosis for determining its existence. Although most of the expert evidence in the cases is psychiatric and therefore refers to the DSM-IV, courts have on occasions referred to other diagnostic methodologies. For instance the Court referred to and stated that it was assisted by input from a neuropsychologist using other evaluation methods testing for cognitive dysfunction and assessing the claimant's depression in *Foley*, and accepted that evidence of the absence of cognitive impairment.[50] ACC appears to be attempting to elevate references to the DSM-IV in judicial decisions and findings of the existence of "mental injury" on the basis of DSM-IV diagnoses, accepted by courts based on expert psychiatric evidence, into a requirement for a DSM-IV diagnosis before a finding of "mental injury" can be made. The decisions support no such conclusion.

It is true that for the purposes of a common law action for "nervous shock", a majority of the Court of Appeal held in *van Soest v RMHU* that a civil claim by a secondary victim for mental suffering caused by awareness of death or injury to a primary victim through a defendant's negligence could not succeed unless there is proof that the effect on the mind of the secondary victim constitutes a "recognisable psychiatric disorder or illness".[51] But this case is distinguishable as decided under the common law of negligence, not under the specific statutory definition of "mental injury" under the accident compensation legislation. The specific issue relevant to the Clinical Pathway, whether a psychiatric diagnosis based on the DSM is a requirement, was not being considered. Rather the issue in *van Soest* and *Surrey v Speedy* was whether lesser mental states were recoverable in a civil damages action in negligence. (As to that the statutory definition provides that the dysfunction must be "significant", so the need to restrict damage to a psychiatric diagnosis does not arise under the ACA 2001). And, in any event, the Court also suggested in *van Soest* that the psychiatric profession's two internationally recognised diagnostic classification systems, the DSM and the International

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[49] DC Wellington, Dec No 76/2008, 8 April 2008, Beattie DCJ.
[50] Para 15.
[51] [2000] 1 NZLR 179 (CA), paras 65 and 69. See also *Surrey v Speedy* [2000] NZFLR 899.

Classification of Diseases and Related Health Problems, might be considered authoritative, and stated that "the courts should be prepared to take a receptive attitude to medical evidence."[52]

Questions 6 and 7 - Causality

Where a claimant is claiming that "mental injury" is covered by the scheme, the issue of causation in respect of that mental injury arises under the scheme in two scenarios:

(1) In relation to victims of a scheduled offence, s 21. In their case, mental injury has to be "caused by" an act performed by another person, which is within the description of a Schedule 3 offence (s 21(1)(b)).
(2) In relation to other accident victims generally. In order for mental injury to be covered, the mental injury has to be suffered "because of physical injuries suffered by" the claimant (s 26(1)(c));

The statutory language describing the causative link between the mental injury and either the physical injuries (s 26(1)(c)) or the act which constitutes the offence (s 21) is *different*. The test in (1) is "caused by, whereas in (2) it is "because of." Because of the Court of Appeal decision in *Hornby v ACC* in 2009, it is now unsettled whether these two statutory descriptions of the causative link have different meanings.[53]

There is a recent, important decision of the Court of Appeal in *Ambros v ACC*,[54] which considers the causation requirement in a medical misadventure case. In *Ambros* Mrs Ambros, a 36-year old woman, was admitted to hospital with chest pain less than a week after the birth of her first child. Six days after admission she was found dead in her hospital bed as a result of what was discovered at post-mortem to be a spontaneous coronary artery dissection, a rare, often fatal complication of pregnancy. The High Court had found the physician responsible for her care negligent in various respects (in diagnosis and treatment and in not booking her for an urgent angiogram), and negligence was accepted for the purposes of the appeal. The causation issue was whether Mrs Ambros' death was "caused by" medical misadventure (s 20(2)(b) and s 32(1)), or whether her death was the result of the rare condition from which she suffered. The High Court had indicated that Mrs Ambros' death was only possibly avoidable,[55] but had nevertheless found causation proven on the basis of a special, novel test of causation it developed. The Court of Appeal, in a judgment by Glazebrook J, confirmed previous case law that the onus of proving the causal link between the medical misadventure and the personal injury is on the claimant, and s/he is required to do so to a standard of the balance of probabilities.[56]

The importance of *Ambros*, however, lies in Glazebrook J's consideration of the common law developments in causation principles and their potential applicability to proving causation in Medical Misadventure cases under the scheme. Her Honour noted that dissatisfaction with the results of the traditional common law "but for" test of causation has led to calls for modifications to it to ameliorate

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[52] See paras 65 and 67.
[53] [2009] NZCA 576.
[54] [2008] 1 NZLR 340 (CA).
[55] The High Court stated that the evidence suggested that, but for these negligent failures, her death may "possibly" been prevented.
[56] The Court confirmed an earlier decision of its own, *Atkinson v ARCIC* [2002] 1 NZLR 374(CA), which had rejected a suggestion of reversing the onus of proof and placing it on the ACC where proof of causation is difficult for a claimant to establish, or of permitting proof of causation by proof of an increased risk of harm. The Court considered whether it should now depart from *Atkinson*, concluding that it was correctly decided.

the difficulty of proving causation for victims of personal injury. The significance of *Ambros* is twofold: first is the Court's implicit recognition that normal causation principles are productive of injustice to patients in some cases of causal uncertainty, so that a judicial technique is needed to assist them in overcoming an otherwise insuperable barrier to proving causation; and second is its determination that, of the various approaches in the common law adopted overseas making it easier for plaintiffs to overcome difficulties in establishing a causal link between negligence and injury, the preferred one for use in Medical Misadventure (now Treatment Injury) under the New Zealand accident scheme is the Canadian approach of a shifting "tactical" burden and the drawing of an inference of causation, where there is some evidence of a "possible connection" between the negligence and the injury.[57]

Put simply, the approach is this: once the plaintiff produces some, even though perhaps only slight, affirmative evidence suggesting a causal link between an accident (here, negligent treatment) and personal injury, an inference of causation may (not must) be drawn by the court in favour of a plaintiff. If medical science is prepared to say that there is a *possible* connection between the events and the injury or death, a court *may* draw a robust inference and decide that causation is probable. The only time a court cannot draw an inference is when medical science says that there is *no* possible connection between the events and the injury.[58] An inference can be drawn where the expert evidence is inconclusive or even conflicting. It would be for the defendant (the ACC) to point to other evidence suggesting that no causal connection exists at the risk (though not the certainty) of losing on the causation issue. The Court concluded:[59]

We agree that the question of causation is one for the courts to decide and that it could in some cases be decided in favour of a plaintiff even where the medical evidence is only prepared to acknowledge a possible connection.

…

The generous and unniggardly approach referred to in *Harrild* [*v Director of Proceedings*] may, however, support the drawing of 'robust' inferences in individual cases. It must, however, always be borne in mind that there must be sufficient material pointing to causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice.

In my view, the implications of *Ambros* have yet to be fully appreciated. The Court of Appeal indicated that ACC should fully investigate claims in a non-adversarial fashion taking the approach outlined in the decision.[60] It is a pro-claimant decision, designed to relax the strictness of normal causation principles with the aim of assisting claimants to establish the causal link where there are difficulties of proof. It indicates a general approach of not being as strict as previously about proof of causation.

Unanswered questions remain after *Ambros*. While it clearly applies to proof of the causal link between personal injury and "treatment" in medical cases, it is unclear whether this pro-claimant approach applies to proof of causation generally under the accident compensation legislation. Relevantly here, does *Ambros* apply to the issue of proof that a claimant's mental injury "is caused by" an act performed by another person which is within the description of a schedule 3 offence in terms of s 21? It might be argued that *Ambros* is restricted to Treatment Injury cases, where

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[57] [2008] 1 NZLR 340, para 63.
[58] [2008] 1 NZLR 340, paras 68-69.
[59] [2008] 1 NZLR 340, paras 69 & 70.
[60] [2008] 1 NZLR 340, para 64.

difficulties in proving causation are notoriously difficult. Note, however, that the same statutory language ("caused by") is used in s 21 as in the provisions relating to Medical Misadventure, so that there is a good argument that *Ambros* is applicable to the interpretation of "caused by" in s 21(1)(b). And the *Hornby* case appears to contemplate more widespread application of the *Ambros* approach.[61]

Coming to scenario (2) above, there is substantial case law interpreting "because of" in s 26(1)(c). As indicated, since ARCIA 1992 the legislation has provided that mental injury is covered only if it is suffered "because of physical injuries suffered by the person" (s 26(1)(c)).[62] Case law has required a closer causal link between mental and physical injury for the purposes of s 26(1)(c), than for causation generally under the scheme.

The leading case on the meaning of "because of" in s 26(1)(c) was the High Court decision in *Hornby v ACC*, which held that "because of" in s 26(1)(c) is governed by a stricter test of *direct* causation.[63] A line of District Court cases had interpreted the statutory requirement of causation as meaning *direct* causation. An *indirect* causative link was insufficient. The legal principle was stated in the cases, as follows:[64]

In all three statutes the [claimant] has the burden of proof on a balance of probabilities, of showing that on the facts of the case, there was a causal relationship between the physical injury suffered and the mental injury that is now alleged as its outcome. There has to be a direct causal link between a physical injury and the mental condition alleged. An indirect link is not sufficient.

These courts took into account various relevant factors to the assessment of the evidence relevant to the causal link. One is the nature and circumstances of the accident and injury as "an important measuring rod".[65] As Ongley DCJ stated, "Cases where mental injury is available fall along a spectrum, at the upper end of which are serious injury or brain injury cases, and at the lower end minor injury cases accompanied by significant psychological trauma."[66] Where, for example, the accident and/or the physical injury was relatively trivial, such as a fracture from tripping in the gutter or a soft tissue injury whose effects resolved reasonably quickly, it was considered to point away from a finding of a direct causal link between the physical and mental injury.[67] This was particularly the case where there were other psychological stressors present at the same time in the claimant's life, to which the mental injury could be attributed.[68] If, on the other hand, the incident causing the physical injuries was exceptionally dramatic or life-threatening, or there was a significant physical assault

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[61] [2009] NZCA 576, para 38.

[62] The phrase used by ARCIA was slightly different, requiring that any mental injury suffered was "an outcome of" physical injuries suffered by the person. The courts have indicated that the changed wording was not material so as lead to different outcomes.

[63] HC Wellington, CIV 2008 485 763, 10 September 2008, Dobson J.

[64] See *Hornby v ACC* DC Wellington, Dec No 214/2007, 10 September 2007, Cadenhead DCJ, para 53.

[65] See *Hornby v ACC* DC Wellington, Dec No 214/2007, 10 September 2007, Cadenhead DCJ, para 72.

[66] *ACC v Griffith* DC Wellington, Dec No 84/2009, 19 May 2009, Ongley DCJ, para 19.

[67] See for example, *Geerders v ACC* DC Wellington, Dec No 188/2004, 8 July 2004, Cadenhead DCJ, para 50, where the injury was a "seemingly minor back strain"; *Robinson v ACC* DC Wellington, Dec No 230/2003, 17 September 2003, Cadenhead DCJ (fracture to foot and soft tissue injury of lower back)

[68] See *Geerders v ACC* DC Wellington, Dec No 188/2004, 8 July 2004, Cadenhead DCJ (relatively minor physical injury; mental injury directly caused by loss of employment, marital separation, and brooding and worry over perceived mishandling of ACC claims); *Gable v ACC* DC Wellington, Dec No --/2003, date 2003, Cadenhead DCJ (weak evidence of PTSD, other stressful experiences meant causative link between physical assault and mental injury unproven); *ACC v Griffith* DC Wellington, Dec No 84/2009, 19 May 2009, Ongley DCJ (ongoing psychological stress in employment was real cause of mental injury, rather than physical injury sustained in the assault).

accompanied by violence or reasonably substantial physical injuries, the courts determined that it was artificial to sever the physical injuries from the surrounding circumstances of the assault and that the physical injuries were a direct cause of the mental injury suffered.[69] Another relevant factor was the claimant's pre-accident emotional or mental health history.[70] Where the claimant had a pre-accident history of significant mental health difficulties that have been aggravated or exacerbated by the physical injury, the court sometimes decided that the direct causal link between the claimant's physical injuries and mental injury was not established.[71]

In *Hornby* the High Court held that the District Court's test of *direct* causation for s 26(1)(c) was correct as a matter of law:[72]

I respectfully adopt the phrase "results from" as used in the Court of Appeal decision in *Harrild* as the appropriate mode of testing the connection [between physical injury and mental injury in s 26(1)(c)]. That is consistent with the approach adopted here, and I am accordingly satisfied that the test as to whether the mental injury was suffered because of the physical injuries of March 2000 has been correctly addressed. The specific question of law posed on this further appeal is answered in the negative, namely that a finding of indirect causation is not sufficient to satisfy the requirements for cover.

The High Court decision was, however, appealed to the Court of Appeal. Although upholding the decision declining cover on the facts, the Court of Appeal in *Hornby* cast doubt on whether the test of direct causation was the correct test after the *Ambros* decision for the causal link for the purposes of s 26(1)(c). "That turns to some extent on the scope of *Ambros*."[73] Frustratingly, the Court of Appeal declined to resolve this question, leaving it open for decision in a later case. Thus, it is not settled whether the broader approach to causation in *Ambros* governs the term "because of" in s 26(1)(c), or whether the pre-existing line of District Court decisions, which developed a stricter test of direct causation, remains good law applicable to s 26(1)(c).

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[69] See for example, *Greenland-Tangipo v ACC* DC Wellington, No 282/03, 6 March 2003, Middleton DCJ (PTSD arising from serious domestic assault; no pre-accident stressors); *Woodd v ACC* DC Wellington, No 54/03, 2 April 2003, DCJ (victim of life-threatening pharmacy burglary; no pre-accident history of emotional difficulties); *Foley v ACC* DC Wellington, Dec No 76/2008, 8 April 2008, Beattie DCJ (victim's Major Depressive Disorder accepted as direct consequence of head injury suffered in assault, despite presence of other ongoing precipitants which had no direct connection with the physical injury but were part of wider consequences of the assault); *Robertson v Attorney-General* HC Palmerston North, CP16/01, 12 August 2002, Gendall J (Plaintiff's PTSD could not be separated from physical injuries including head injury occurring in accident).

[70] See *Hornby v ACC* DC Wellington, Dec No 214/2007, 10 September 2007, Cadenhead DCJ, para

[71] See *Hornby v ACC* DC Wellington, Dec No 214/2007, 10 September 2007, Cadenhead DCJ (major depressive illness that pre-dated the physical injury, arm fracture and nerve injury relatively minor), upheld on appeal HC Wellington, CIV 2008 485 763, 10 September 2008, Dobson J, para 26, citing *Cochrane v ACC* [2005] NZAR 193, in which it was held that causation cannot be established by showing that the injury triggered an underlying condition to which the claimant was already vulnerable or that the injury accelerated a condition that would have been suffered anyway. See also *Robinson v ACC* DC Wellington, Dec No 230/2003, 17 September 2003, Cadenhead DCJ (mental injury held to be caused by long term struggle with ACC over claims, rather than physical injuries suffered from three injuries to knee and calf); *Geerders v ACC* DC Wellington, Dec No 188/2004, 8 July 2004, Cadenhead DCJ (persistent depressive illness substantially caused by other life events and interactions with AC, rather than back strains in 1990, 1993 and 1995).

[72] See HC Wellington, CIV 2008 485 763, 10 September 2008, Dobson J, para 29.

[73] [2009] NZCA 576, para 38.

One matter, however, *is* clear. There is no warrant for applying the stricter test of "direct causation", developed in relation to the phrase "because of" in s 26(1)(c), to the causal requirement in s 21. The uncertainty sounded in *Hornby* surrounds only whether the stricter causal requirement of direct causation continues to be *applicable to s 26(1)(c)* after *Ambros*, not whether it applies to s 21. Because of the different statutory language used, it is clear that the stricter, direct causation test, applied previously to s 26(1)(c), most certainly does *not* apply to the phrase "caused by" in s 21. I suggest that the preferable approach to the meaning of "caused by" for the purposes of causation in the scheme generally, including in s 21, is the Court of Appeal's decision in *Ambros v ACC*. The latter takes a less restrictive approach to causation than the cases interpreting s 26(1)(c).

As a result, ACC will have to exercise considerable care in declining claims on the basis that the sexual abuse was not the exclusive or sole cause of the mental injury; or that the claimant came from a dysfunctional childhood background and that the sexual abuse was part of that context, and it is therefore not possible to assign a causal link between the sexual abuse and the current mental injury. The Court of Appeal in *Ambros* approved suggestions that ACC should not generally be declining claims in reliance on the lack of evidence produced by the claimant so that the onus of proof is not discharged onus, because of its duty to investigate a claim.[74] Because very little in the experience of life has an exclusive or single cause, it is unrealistic, and seems unduly restrictive and unfair in the context of multiple causes of a claimant's mental injury, for it to be a requirement that the claimant prove on the balance of probabilities that the sexual abuse constitutes the *sole* or *exclusive* cause of the claimant's mental injury. This seems especially so in the context of childhood sexual abuse, where there is a high likelihood of a generally dysfunctional environment, of which the sexual abuse forms a significant part. It is well established in common law cases of causation that exclusive causation is not required to be proved, and that often a "material contribution" to the injury or a showing of "substantial cause" is sufficient to establish the causal nexus. by the Defendant's negligence is sufficient.[75] The cases on the causal link between physical and mental injury in s 26(1)(c) and in other cases on causation in the accident compensation legislation have not required the physical injury to be the sole cause either, requiring it "in line with the usual principles of causation" to be the "a real and substantial cause."[76] And an approach based on proof that the sexual abuse is the *sole* cause of the subsequent mental injury is inconsistent with *Ambros*, which suggests that in cases of causal uncertainty a *possible* causal link between the sexual abuse and the mental injury may be enough. Even if the *specific* approach of drawing an inference of proof of causation in the presence of proof of a *possible* causal link from *Ambros* is not applied to s 21 and is restricted to medical cases, suggestions of ACC latching on to "excuses" based on causation to decline claims is inconsistent with the general philosophy of *Ambros*.

I would suggest that a more balanced approach is to apply an approach or test of "substantial cause" or "material" cause in these sorts of situations i.e. to determine on the basis of the claimant's statements and expert clinical evidence whether the sexual abuse was a "substantial" or "material" cause of the subsequent mental injury, or whether other factors such as those mentioned were substantially responsible. I suggest that this is more consistent with the broader approach to causation generally indicated by *Ambros*, which, it is to be remembered, may even permit proof of causation based on a possible causative link.

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[74] [2008] 1 NZLR 340, para 64, approving Cochrane v ACC [2005] NZAR 193.

[75] See Bonnington Castings v Wardlaw (1956) AC 613(HL).

[76] See for example, *ACC v Griffith* DC Wellington, Dec No 84/2009, 19 May 2009, Ongley DCJ, para 18 ("a real and significant cause"); *McDonald v ARCIC* HC Christchurch, AP 2/02, 29 May 1992, Panckhurst J ("substantial cause").

Question 3: Some notes on the privacy/waiver issue

Rule 11 of the Health Information Privacy Code states that a health agency (such as a DHB or GP) that holds health information must not disclose the information unless the agency believes on reasonable grounds, that — (b) the disclosure is authorised by the individual concerned.

There is a provision in the ACA 2001, s 55 which states that a person lodging a claim "**must**, when **reasonably required** to do so— … (b) give the Corporation any ... **relevant** information that the Corporation requires; (c) **authorise the Corporation to obtain medical and other records that are or may be relevant to the claim**; (d) undergo a medical assessment by a registered health professional specified by the Corporation.

This provision, being a statutory provision, would prevail over anything inconsistent in the Health Information Privacy Code. Note that it is restricted to information "relevant to the claim". So a GP who released irrelevant information, for example about a claimant's termination of pregnancy, would breach the Health Information Privacy Code, because the authorisation does not extend to information which is not relevant to determining a claim for cover and entitlements.

The other constraint on ACC is that the requirement to give the particular authorisation must be reasonable. This is vague, but suggests that requirements to give over-broad or unnecessarily searching authorisations might be inconsistent with the reasonableness limitation in s 55(1). The Panel could provide expert comment on the extent to which it considers the authorisation form (ACC 167) meets the statutory test of reasonableness.

There is a no provision specifying an offence or penalty for the failure **by the claimant** to give the authorisation for the ACC to obtain the information referred to in s 55. It is just that a claimant is unlikely to get their claim accepted for lack of information, if they fail to provide the authorisation.

But it is an offence (see s 309) for someone who has sought or received any payment in respect of a claimant to refuse or fail to provide information requested by ACC for the purpose of facilitating decisions about cover and entitlements. The claimant has to have authorised the request for information first. A treatment provider treating a claimant covered by ACC could be caught by this, if they failed to provide information requested.

The Code of Claimants' Rights states in Right 7 — You have the right to have your privacy respected. And there are three sub-rights:

(a) We will respect your privacy;
(b) We will comply with all relevant privacy legislation;
(c) We will give you access to your information, in accordance with legislation.

The Code provides for a complaints mechanism for breaches of the Code.

I have had a look at the ACC 167 form. It is legal for ACC to require a claimant to grant this authorisation, because of s 55. But the claimant is not **required by s 55** to give authorisation for information to be collected about the second and third bullet points (help with the evaluation of ACC's services and performance; and help with research into injury prevention and effective rehabilitation), as these are not relevant to deciding a claim. A claimant could choose to give such authorisation, but I would argue that s 55 only requires the claimant to give authorisation for the purposes of deciding the claim for cover and any entitlements. Disclosure of this other information would be subject to the limitations of the Health Information Privacy Code. In addition, the

information that ACC requires a claimant to provide authorisation for must meet an overall test of reasonableness.

Joanna Manning
23 July 2010

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