Causation in mental injury

Clinical appraisal of causation and "material contribution"

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Psychology Advisor Forum

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He Kaupare. He Manaaki. He Whakaora.

Prevention. Care. Recovery.

Haere mai Karakia

Whāia, whāia
Whāia te tika
Whāia te pono
Whāia te aroha
Mō te oranga tāngata
Kia puta ki te whai ao
Ki te ao mārama
Haumi e, hui e, tāiki e!

Striving to do what is right
Undertaking to act justly
Being considerate of everyone
That it may improve the lives of all

Housekeeping

Please do not record this session as it is an open discussion forum and participants have not consented to being recorded.

If you’re using AI to transcribe the content, please switch this off once the formal presentation section is over, and keep the transcription for your personal use only.

Important: This session is designed to support your clinical thinking. It is not an explanation of ACC policy or procedures. ACC psychology advisors are not decision-makers, the guidance given today is general only, and every claim is decided on a case-by-case basis.

Causation in mental injury at ACC

By the end of the presentation part of today's session, you should be able to:

- Explain what "causation" means in the ACC context
- Apply the material contribution test
- Understand the role of triggers, risk, and vulnerabilities
- Weigh up forms and quality of evidence
- Identify common errors in appraisal of causation

What “causation” means in the ACC context

A legal test, not a clinical one

The role of mental injury assessors

Contribute **clinical** understanding and knowledge relating to:

- *General* principles (epidemiology, risk, vulnerability, incidence, prevalence) – *apply as background knowledge, only discuss if necessary*
- *Specific* principles (specific causes unique to the individual – this person, this time, this place, this way) - *essential*

The role of advisors at ACC

ACC clinical and technical advisors integrate clinical information and knowledge with ACC policies, procedures, and medicolegal considerations to provide advice to ACC.

ACC

The primary test of causation

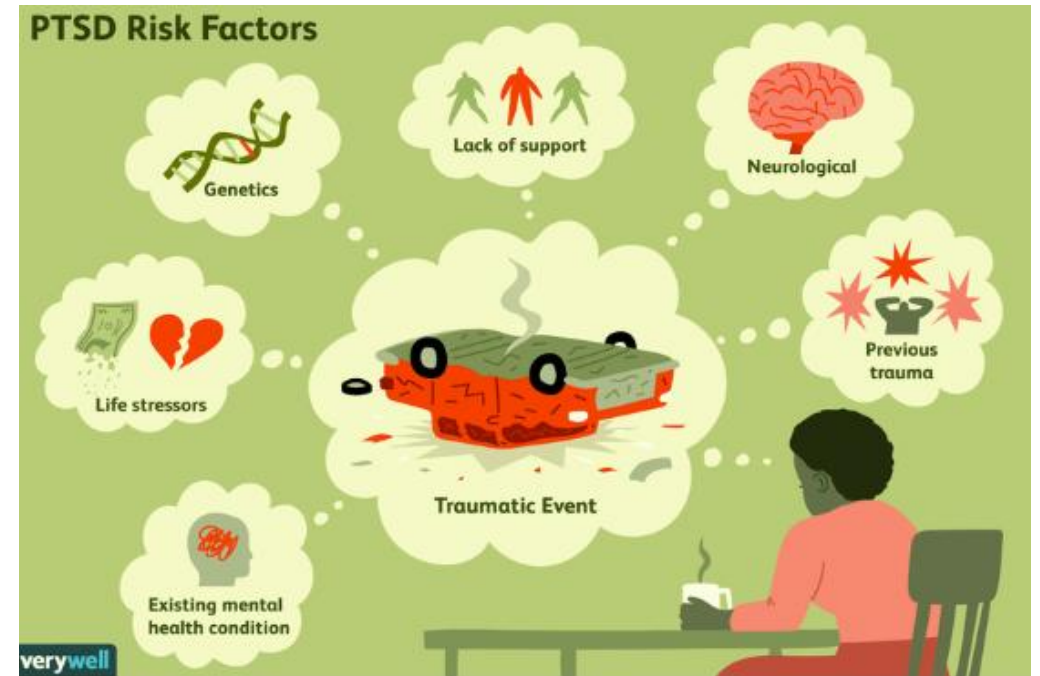
“Material contribution”

The covered injury or event does NOT need to be the only or even the main cause

BUT

It must be a **material** cause, meaning:

- Real and meaningful
- More than minor or trivial



Clinical considerations

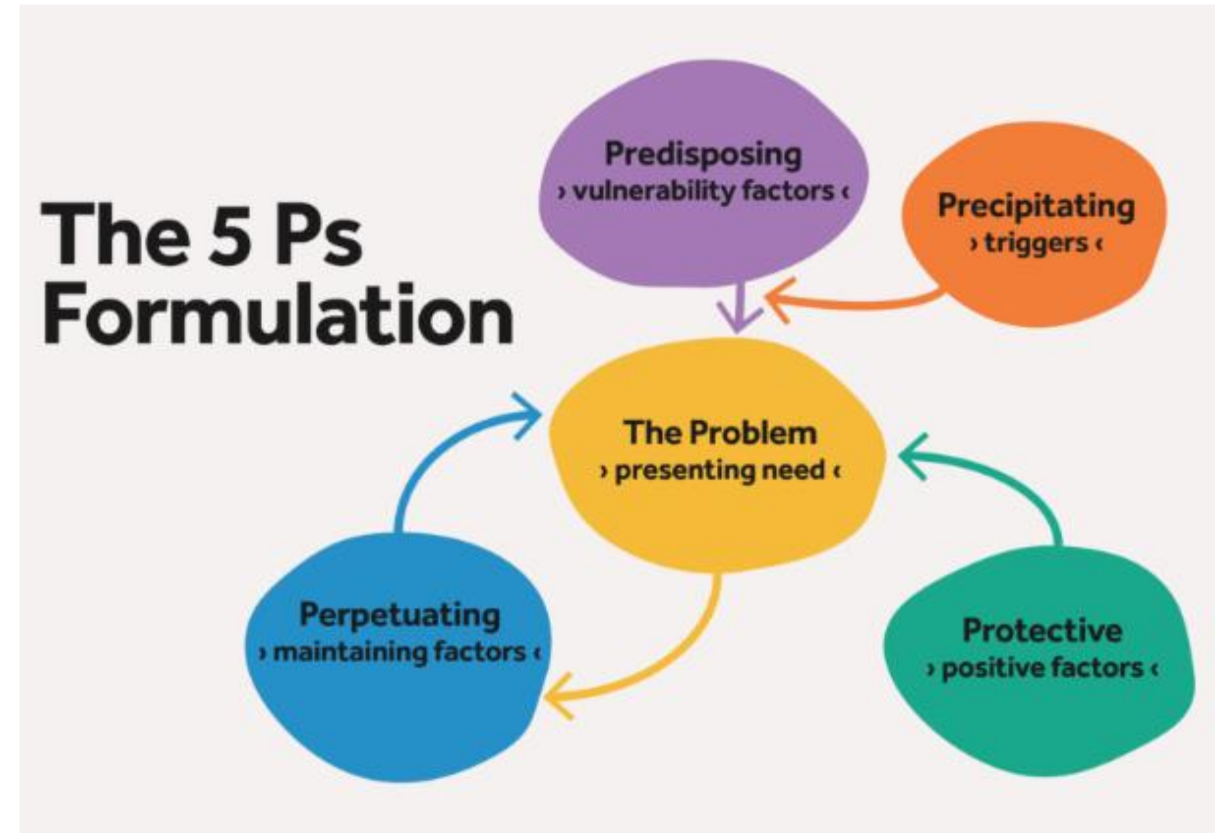
Mental injury is almost always multifactorial

Common contributors include:

- Biological and genetic vulnerability
- Past trauma or adversity
- Personality and coping style
- Social and occupational stressors
- The injury/event and its context

“5-P” framework can be useful

Formulation is important in weighing relative contribution of different factors



“Trigger” vs “cause”

When is a precipitating factor a material contributor?

ACC case law:

A trigger may reveal, unmask, render symptomatic, or accelerate an underlying condition (ie. “final straw”, poised to happen):

= NOT a material contribution

A trigger may be significant, real, or meaningful in its own right:

= IS a material contribution

- Terminology is relevant: Explain what you mean by “trigger”
- Ask: Was the trigger incidental or material?

Considerations

Temporal relationship ≠ causation

Temporal proximity is relevant but not determinative.

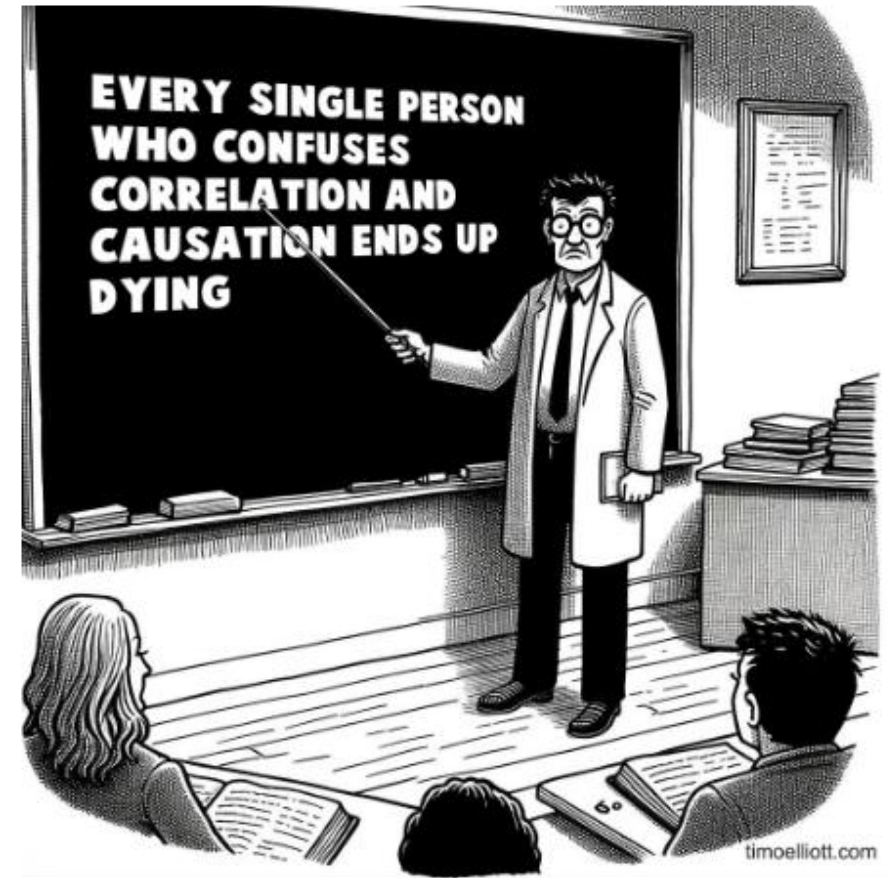
Timing must be considered alongside:

- Symptom development
- Mechanism plausibility
- Intervening events
- Alternative explanations

Questions to consider:

What is the causal chain?

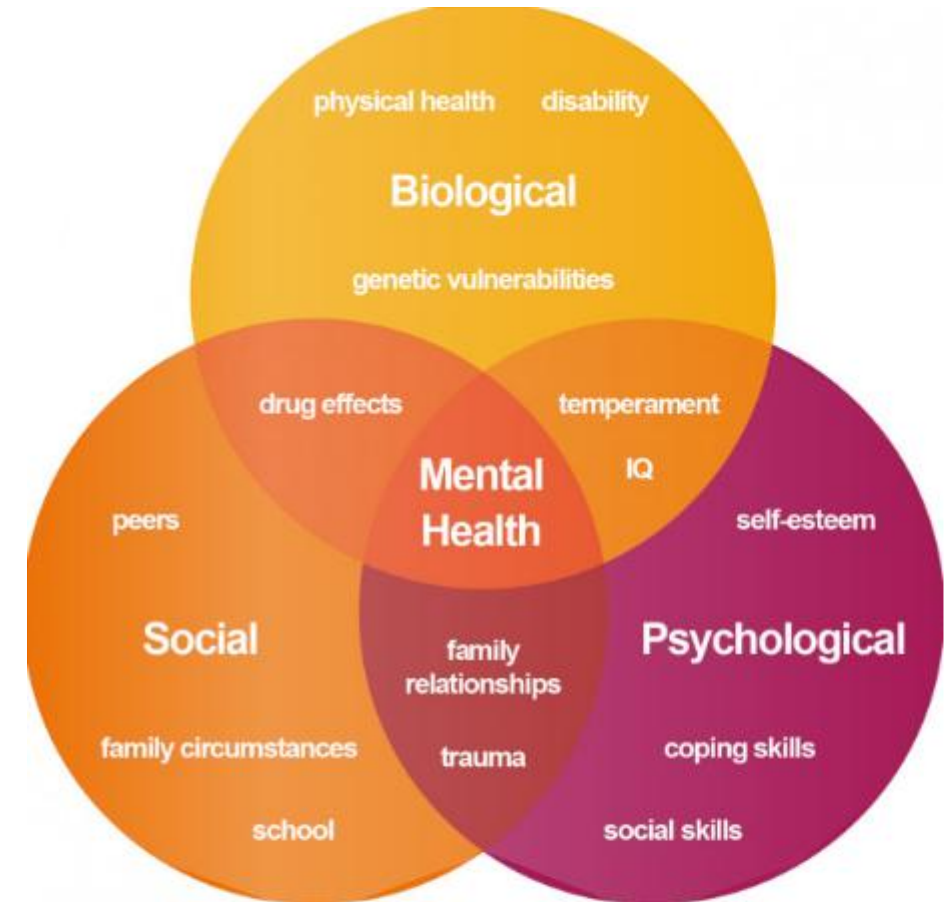
What could break the causal chain?



Considerations

Risk factors ≠ causation

- Vulnerability (predisposing factors) alone does not establish causation
- Number and severity of risk factors is relevant to weighting
- Significance of injury/event is also relevant



Previous diagnoses? Pre-existing condition?

Consider:

- Is this a recurrent condition or just a single episode?
- Resolved or in remission?
- Historical vs recent diagnosis?
- Similar/overlapping symptoms/diagnoses?
- Thematic links, presenting concerns?
- Treatment needs?

ACC

The quality of your evidence matters

Good causation analysis relies on:

- Multiple information sources
- Contemporaneous records
- Clear symptom development
- Plausible psychological mechanisms
- Self-report important but often insufficient
- Memory is fallible and subject to bias

Be alert to:

- Retrospective reconstruction
- Discrepancies between recent and contemporaneous information
- Overreliance on claimant narrative without corroboration
- Compensation context

ACC

Vignettes

MICSA 1

Mr Jones submitted a sensitive claim while serving a prison sentence for the rape of a child. He reported Schedule 3 events as having occurred at approximately age 3 by an unknown perpetrator. Mr Jones had no clear memories of sexual abuse but felt this may have occurred due to a change in his behaviour at that age and memories of "shadows, pain, fear" and a sense of "intrusion" occurring at around that time. He identified the possible perpetrator as being an adult male relative who was living with them at the time. Neither he nor family members could provide any further details that would shed light on the nature of any sexual abuse he may have experienced, although his mother said that the uncle in question had been a bit "touchy" with the children and as a result she was reluctant to leave young children alone with him.

He presented to MH services during the criminal investigation with depression and suicidal ideation, but had no previous contact with MH services. He was raised in a difficult family environment characterised by parental conflict and alcohol abuse, emotional coldness, poor attachment and physical abuse. There is a family history of mental illness. At the time of assessment he was being treated under the specialist Corrections programme for sexual offenders.

ACC

Vignettes

MICSA 2

Ms Pink is a 17 year old girl who presents as the oldest of three children with a history of having been raised in an environment where her father was demanding and verbally abusive, highly critical of her mother, her and the younger children; her mother was supportive but passive and modelled and encouraged the children to try their hardest not to upset their father. Ms Pink is reported to have been an anxious child who nevertheless excelled academically and had a number of good friends. At age 13 she appears to have withdrawn socially and exhibited clear symptoms of depression following an incident in which she was raped by the teenage son of a family friend. She does not appear to have ever fully recovered from this with sub-threshold symptoms of depression present ever since but has been prone to more severe episodes of depression whenever things have gone wrong (e.g., after the separation of her parents when she was aged 14 years, and when she did not achieve the grades she was expecting at the end of last year).

Most recently Ms Pink has increasingly developed high levels of anxiety about her academic performance and her weight, has become very rigid in her habits and very distressed when there are unexpected disruptions to her routine, and has developed restrictive eating patterns with significant weight loss. There have been similar concerns expressed by her school and the GP confirms problematic weight loss.

The assessment supported diagnoses of Persistent Depressive Disorder (PDD), Anorexia Nervosa - restricting type (AN), and obsessive-compulsive personality traits.

ACC

Vignettes

MICSA with overseas events

Scenario 1: Aisha and her family moved to NZ when she was 13 years old. When she was 19, she started working fulltime as a sales assistant and moved out of the family home. She sought counselling for abuse by her older brother which started in her home country when she was six, and only ended when she left home. The ACC Specialist Assessment diagnosed PTSD in relation to the sexual abuse.

Scenario 2: Annie grew up in New Zealand but moved to Australia at the age of 18, where she met and married her husband. She returned to New Zealand with her husband and two children at the age of 32. At the age of 40, she separated from her husband and sought counselling for issues relating to abuse in the marital relationship. She reported that her husband had started abusing her physically, emotionally, financially, and sexually shortly after their marriage, and that she had encouraged them to move back to NZ in the hope that being closer to her family would help her muster the courage to leave him. She was diagnosed with PTSD, which the assessor considered was due to the multiple forms of abuse in her marriage, symptoms of which were evident prior to her arrival in NZ.

Vignettes

MICPI

Mr Black is a 27 year-old man who sustained a mild traumatic brain injury (mTBI) during a home invasion when he was struck on the head with a hammer. He was treated by the Concussion Service who found that his cognitive symptoms were resolving well but that he was presenting with symptoms of posttraumatic stress. He was discharged after a month, but later re-referred by his GP who thought he may have post-concussion syndrome and a likely coexisting PTSD.

Mr Black has a history of being badly bullied at school, and historical notes from CAMHS refer to an earlier diagnosis of PTSD in relation to this. GP records do not indicate any presentations for mental health concerns in the last two years prior to the injury.

Dr White’s neuropsychological assessment report concluded that Mr Black did not appear to be experiencing residual cognitive effects of the concussion. He noted that Mr Black’s presentation is consistent with a diagnosis of mild intellectual disability (ID), and found that he further met criteria for a diagnosis of PTSD in the context of emotional distress caused by the trauma of the home invasion, with other contributing factors being the intellectual disability, past trauma which had been triggered by the assault, and initial concussion symptoms which led him to believe that his brain had been damaged.

Vignettes

WRMI

Mark is a 42-year-old firefighter. Throughout his 18-year career, he has regularly attended serious emergencies, including suicides, and numerous fatalities in car accidents and house fires. Mark describes these experiences as distressing, and occasionally experienced transient distress following the worst of these, but overall reports that he remained psychologically well, continued to work without restriction, and did not seek mental health treatment until recently. Six months prior to lodging his claim, Mark attended a single-vehicle crash involving a family whose car caught fire after impact. He was directly involved in the extrication and resuscitation efforts. Two children were deceased at the scene, and an adult died during prolonged rescue attempts. Mark reports being acutely aware of the surviving parent's distress throughout the response. He describes this incident as particularly confronting and emotionally overwhelming. Following this event, Mark began experiencing intrusive memories of this event, as well as memories of other events in which children had died, nightmares involving trapped children, heightened physiological arousal, emotional numbing, and increasing irritability. He found himself avoiding certain call-outs and withdrawing from family and colleagues. Over the following months, these symptoms persisted and worsened, leading him to seek psychological treatment. He was subsequently diagnosed with PTSD by a clinical psychologist, and an ACC WRMI claim was lodged. The assessment noted Mark's long history of exposure to traumatic incidents as part of his occupation and raised the question of whether his presentation reflected cumulative occupational stress rather than a qualifying WRMI event.