

Causation in mental injury caused by sexual abuse (MICSA)

Causation and “material contribution”

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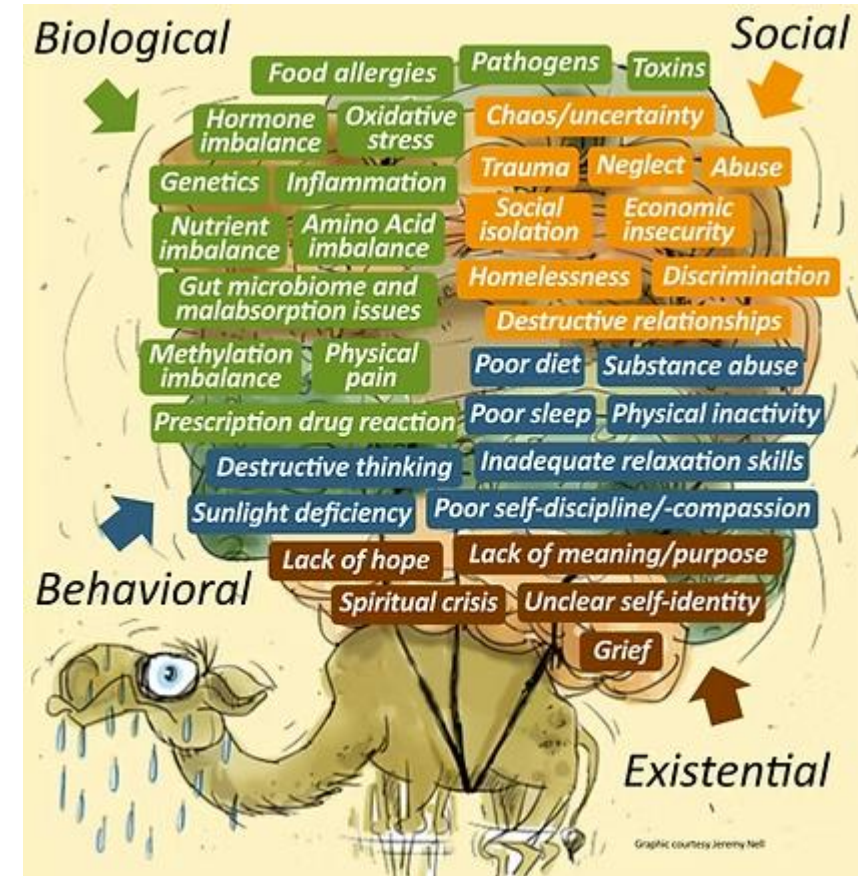


He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

Causation in mental injury at ACC

By the end of today's presentation, you should be able to...

- Explain what causation means in the ACC context
- Understand what is meant by a Schedule 3 event
- Apply the material contribution test
- Consider how to approach multifactorial causation
- Weigh the relevance and quality of clinical evidence
- Identify common errors in causation appraisal
- Understand ACC's approach to causation in specific conditions (CPTSD, SUD, ED)



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, theory) – 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

There should be a logical fit between the general and specific principles (i.e. the causal argument should make sense to any clinician familiar with the condition)

Identify clinical *evidence* to support your argument rather than speculation or theory

Critically analyse and appraise the evidence – identify and address discrepancies, omissions, contradictions, distortions, unusual aspects

Provide an objective, evidence-based, impartial opinion

The role of clinical and technical advisors at ACC

Integrate clinical information and specialist knowledge with ACC policies, procedures, and medicolegal considerations to provide advice to ACC.

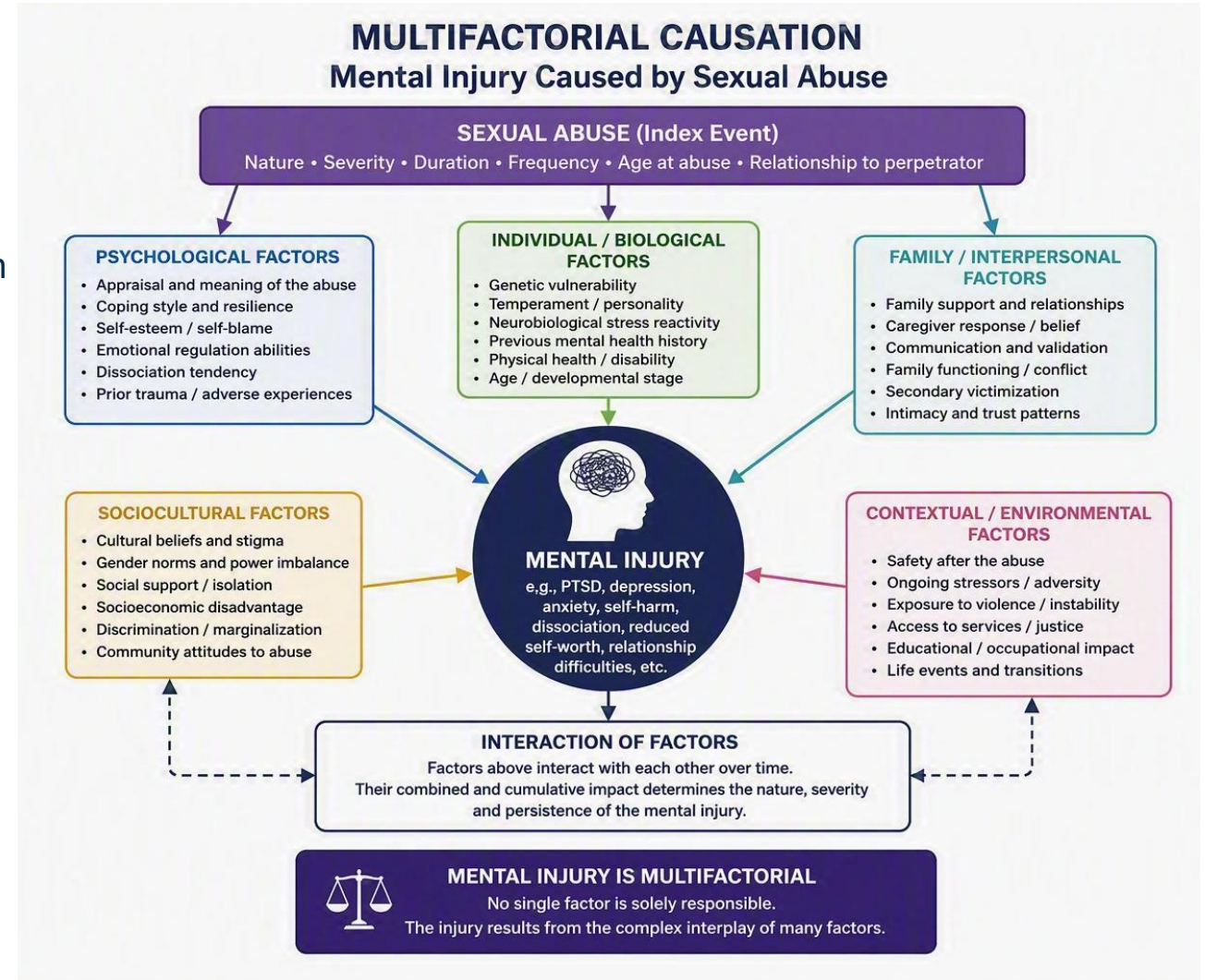
The primary test of causation

“Material contribution”

- The sexual abuse 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

Because MICSA's are usually multifactorial, “material” may be relative rather than absolute.

MICSA's are complex for many reasons: multiple contributing factors, unclear or historical injury events, late presentation...



What is meant by a Schedule 3 event?

Legal definitions

- One of the certain criminal acts under the Crimes Act 1961 that are listed in Schedule 3 of the AC Act 2001.
- This is a SPECIFIC SUBSET of criminal acts involving sexual abuse or assault.
- Not all forms of sexual abuse or assault are included, eg:
 - image-based / digital sexual harm such as recording sexual activity without consent
 - witnessing sexual abuse committed against others
 - developmentally normal sexual behaviour between children
 - appropriately conducted internal medical examinations
- Not all distressing, abusive, or traumatic experiences qualify as Schedule 3 events. The event must fit within the types of offences described in Schedule 3.
- ACC needs assessors to provide the factual and clinical information about the S3 event to help ACC determine if the event is of a kind that meets the legislative threshold.



Assessor's role in linking diagnosis to Schedule 3 events

What information about the S3 event does ACC need from assessors?

Not “proof” BUT history must be likely, plausible, contain sufficient information to assess causation, and based on more than speculation or theory.

- Provide enough relevant detail for ACC to consider whether the event is “of a kind” described by an offence listed in Schedule 3.
- Where the client cannot provide this, seek information elsewhere; BUT beware of repeating historical reports that have not been checked, validated, or updated over time.

When information is unclear:

- Address uncertainty, missing information, discrepancies, or inconsistencies.
- Distinguish between memories, suspicions, beliefs, family reports, disclosures by others, and clinical hypotheses.
- Do not fall back on speculation in the absence of evidence.
- Do not infer sexual abuse based only on recovered memories, dreams, content of psychotic phenomena, symptoms, or diagnostic presentation alone.

The quality of your evidence matters

Good causal analysis relies on:

- Multiple information sources / contemporaneous records / collateral information
- Clear symptom development
- Plausible psychological mechanisms

Self-report important but sometimes insufficient; memory is fallible and subject to bias.

Evidence quality is affected by:

- Errors in retrospective reconstruction
- Discrepancies between recent and contemporaneous information
- Uncritical acceptance of narrative (absence of critical analysis and sense-checking)
- Ignoring issues related to the compensation context

Taking a strong advocacy role weakens your argument (perceived loss of objectivity and neutrality)

Causation opinion

What a strong causation opinion looks like

- Identifies all major contributing factors
- Weighs their relative contribution
- Considers specific causal principles, not just general principles
- Explains HOW the Schedule 3 event contributed to the development of the condition
- Addresses alternative explanations and contradictory evidence
- Is objective, plausible, evidence-based, not reliant on assumptions (Occam's razor)

Causation opinion

Common errors that weaken your argument

- Concluding that the Schedule 3 event was material simply because it occurred
- Assuming a diagnosis is due to the Schedule 3 event without considering competing explanations
- Ignoring or minimising non-injury contributing factors
- Filling information gaps with assumptions or hypotheses
- Relying on theory (generalities) rather than evidence (specifics), and alignment between the two

Special considerations

Complex PTSD

- ACC is seeing significant increase in diagnoses of CPTSD
- Assessors should consider differential diagnoses
- Diagnostic confusion and issues around causation = inconsistent approaches among both providers and ACC
- Issue: Cover is problematic where DSO sx are pre-existing / clearly linked to non-injury factors but CPTSD is proposed as MICA
- Issue is usually re. what to cover, not dx accuracy
- Current preferred approach: Where CPTSD is the clinically correct diagnosis but DSO sx are not injury-related, ACC may consider granting MI cover for PTSD component only.
- ACC may seek clarification from assessors in such cases.



Credit: What is Complex Post-Traumatic Stress Disorder (C-PTSD)? — Neuro Nuance Therapy and EMDR, PLLC



Special considerations

Sexual abuse events occurring when resident overseas

- Note the client's living circumstances (residential status) in the overseas country.
- Describe and assess the abuse events occurring in both places.
- Consider cultural, developmental, and migration-related factors.
- Weigh all contributing factors in the formulation.
- Lack of clinical information for overseas clients can be challenging. Consider:
 - Is the reported symptom course consistent with what would be expected from the identified abuse?
 - Is there evidence of continuity of difficulties over time?
 - How well does the proposed formulation explain the client's current presentation compared with alternative explanations?

ACC's approach:

- ACC would not seek to automatically disentitle people who have a reasonable claim to cover for events occurring in NZ, even in the context of pre-existing trauma.
- ACC will weigh several factors in determining eligibility for cover, including (but not limited to) if the events in NZ were sufficient in their own right to give rise to the diagnosed condition



Special considerations

Maladaptive coping strategies: Substance use disorders

- Using substances to manage distress or enhance mood is common to all substance use/dependence.
- The mood-altering effects of substances are a key reason they become addictive, regardless of sexual abuse history.
- Self-medication alone does not establish that a Schedule 3 event **caused** a substance use disorder.
- Establishing causation requires consideration of:
 - family history of substance use
 - onset of substance use
 - how substances were accessed
 - who they were used with
 - in what contexts (peers, partners, employment, recreational)
 - changes in the pattern of use over time

Special considerations

Maladaptive coping strategies: Eating disorders (EDs)

Explain how ED functions as a response to the sexual abuse.

It should not be better explained by appearance ideals (body image or social factors), family factors, and/or other life experiences.

Consider:

- What is the function of the eating disorder? (emotion regulation, self-harm or self-punishment, protection from sexualisation)
- How does the client view their body? (thin ideal and appearance, shame, disgust, or self-loathing, desire to appear less sexually attractive)
- Consider the timeline (onset, evolution over time, relationship to the Schedule 3 event)
- Consider alternative contributors (family influences, bullying, mental health conditions, cultural and appearance pressures)

Summary

Specific. Balanced. Evidence-based. Explicit about uncertainty.

- **Start with the legal test.** Clinical evidence informs the opinion; diagnosis or assumption alone does not establish causation.
- **Establish the event.** Describe a plausible Schedule 3 event in sufficient detail and state any uncertainty or missing information.
- **Apply material contribution.** The effect must be real and meaningful – more than minor or trivial.
- **Weigh all causes.** Use an individual, time-linked formulation to compare vulnerability, risk, alternative explanations, and interacting factors.
- **Show the reasoning.** Explain the mechanism, relative influence of each factor, contradictions, and limits of the evidence.