He Kaupare. He Manaaki. He Whakaora.
prevention. care. recovery.

08 April 2022

[redacted]

Kia ora [redacted]

Your Official Information Act request, reference: GOV-016995
Thank you for your email of 28 February 2022, asking for the following information under the Official Information Act 1982 (the Act):

- *2010 Review of the ACC sensitive claims pathway*
- *The first, second and any subsequent Monitoring Reports on the Implementation of the Recommendations from the Independent Panel's Review of the ACC's Sensitive Claims Clinical Pathway.*

We are releasing the information requested
Please see the attached report to the Hon. Nick Smith, Minister for ACC in 2010 and subsequent reports provided to the ACC Board.

- *Clinical Review of ACC's Sensitive Claims Clinical Pathway – September 2010*
- *Monitoring Report on the Implementation of the Recommendations from the Independent Panel's Review of the ACC's Sensitive Claims Clinical Pathway – 30 April 2011*
- *Monitoring Report on the Implementation of the Recommendations from the Independent Panel's Review of the ACC's Sensitive Claims Clinical Pathway: 18 Months Follow up – 1 July 2012*
- *Progress on the Recommendations of the Clinical Review of the Sensitive Claims Clinical Pathway – October 2014*

ACC is working to evolve its Integrated Services for Sensitive Claims (ISSC)
ACC implemented the recommendations in the report, with the ISSC going live in 2014. We are now looking at how we can continue to evolve the ISSC and strengthen the delivery of services to support clients with a sensitive claim.

You can read details about the key information and updates on the evolution of the ISSC on ACC's website at www.acc.co.nz/for-providers/provide-services/sensitive-claims/evolving-integrated-services-for-sensitive-claims/, and if you have any questions or feedback about ISSC's evolution, you can contact ACC by emailing isscevolution@acc.co.nz.

As this information may be of interest to other members of the public
ACC may decide to proactively release a copy of this response on ACC's website. All requester data, including your name and contact details, will be removed prior to release. The released response will be made available https://www.acc.co.nz/resources/#/category/12.

If you're concerned about this response, please get in touch
You can email me at GovernmentServices@acc.co.nz.

Ngā mihi

Sara Freitag
Acting Manager Official Information Act Services
Government Engagement & Support

CLINICAL REVIEW OF THE ACC SENSITIVE CLAIMS CLINICAL PATHWAY

Sensitive Claims Pathway Review Panel

September 2010

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

[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

[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.

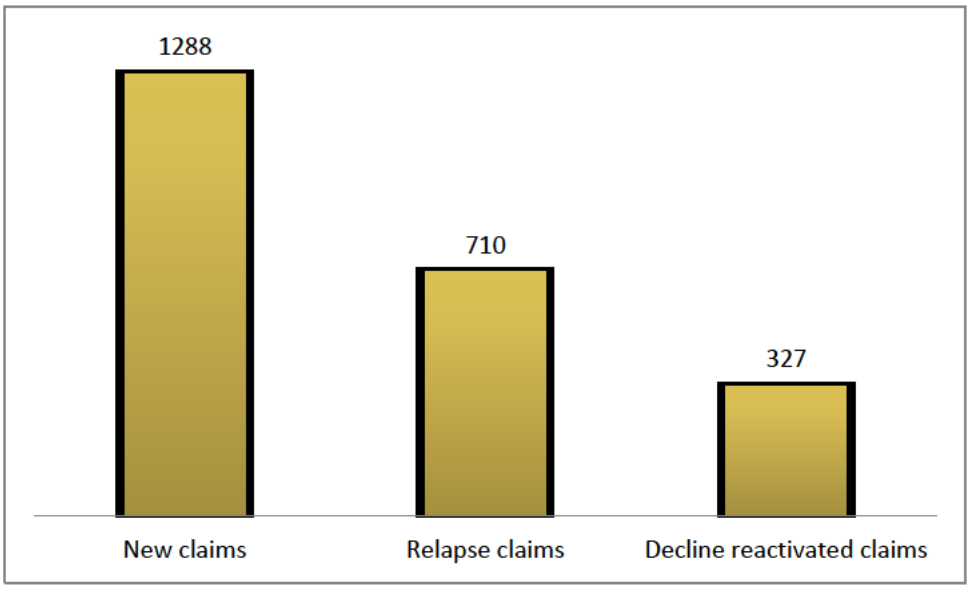


Figure 1 Claims requiring treatment decision
Source: ACC sensitive claims dataset

[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:

> *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.*

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

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.

[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.*

[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.

[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

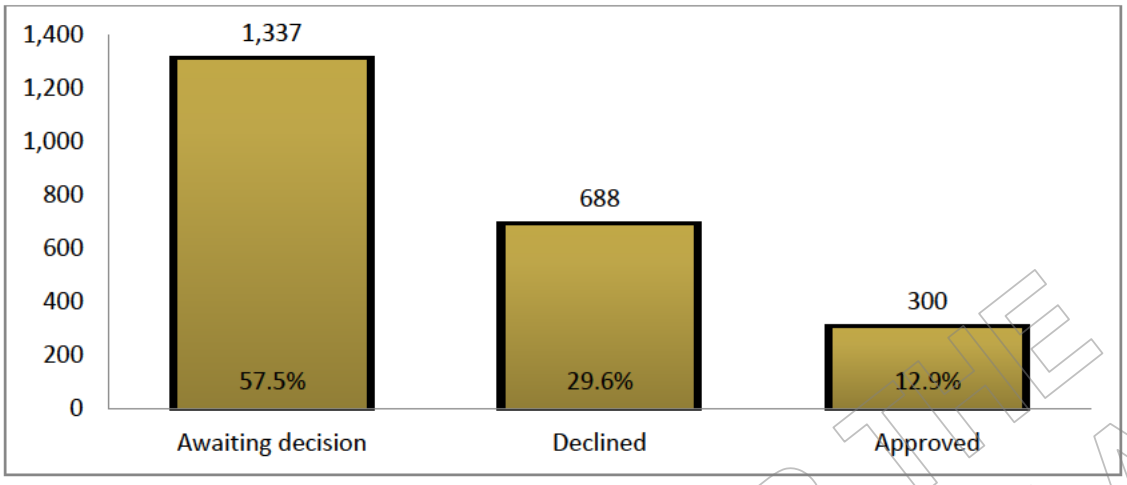
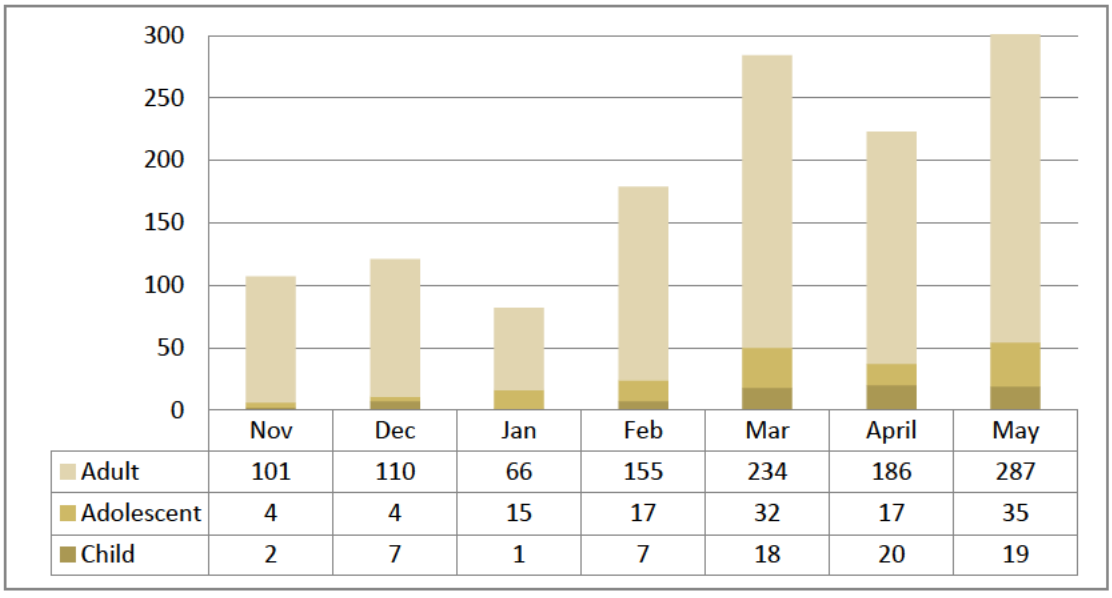


Figure 3 Status of all claims lodged between 1/11/2009 and 31/5/2010 as at 30 June 2010

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:

[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).

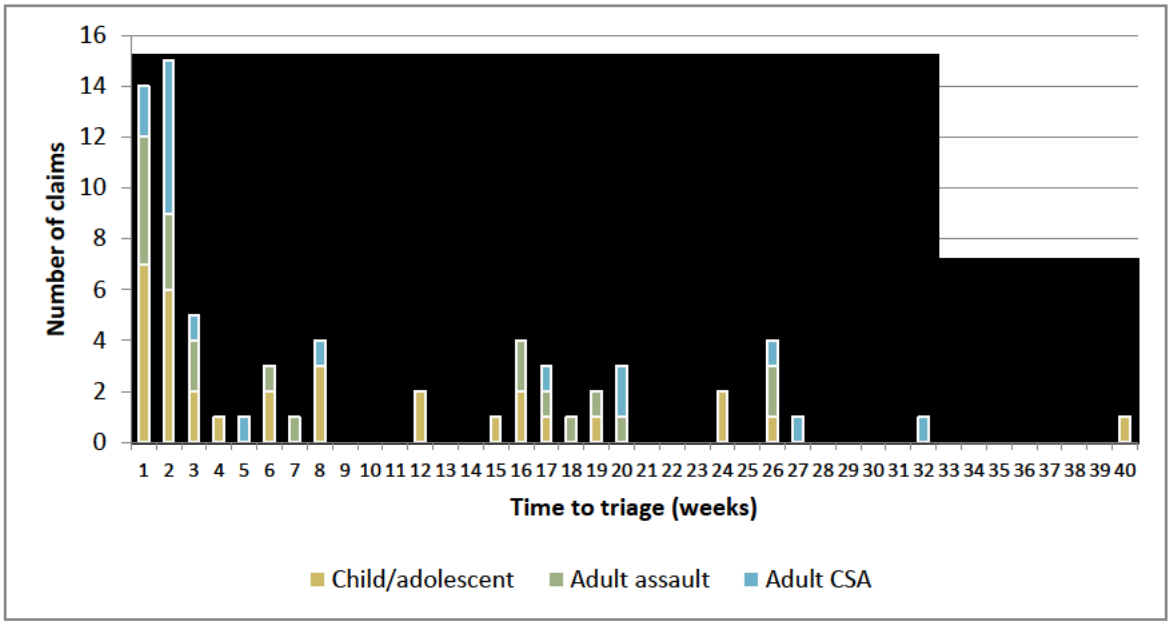


Figure 5 Time to triage

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

[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

[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

[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.

[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

[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

[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

[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

[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).

[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.

[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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Monitoring Report on the Implementation of the Recommendations from the Independent Panel's Review of the ACC's Sensitive Claims Clinical Pathway

Report prepared for ACC Board

Dr Barbara Disley NZOM

30 April 2011

This report provides an overview of the response of ACC to implementation of the fourteen recommendation made by the Review Panel in the Clinical Review of ACC Sensitive Claims Clinical Pathway. This is the first progress report.

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Executive Summary

1. In April 2010, The Honourable Dr Nick Smith, Minister for ACC, requested an independent review of the introduction of the new Sensitive Claims Clinical Pathway.

2. The independent panel[1] provided its report to the Minister in September 2010. The report was developed from a range of information sources including ACC, submissions from organisations and individuals, survivors, provider groups and Government agencies. The panel made 14 recommendations based on the outcomes of the review.

3. The fourteenth recommendation was that a process be established to independently monitor the development and implementation of actions recommended in the report.

4. In response to this recommendation, the ACC Board engaged the reviewer, Barbara Disley, to undertake an independent review at six months and eighteen month periods.

5. ACC provided the reviewer with a report and supporting documentation on actions taken to address the recommendations. Face to face interviews were conducted with a small number of ACC senior managers and staff with responsibilities for implementing the recommendations. The reviewer attended a meeting of the Sensitive Claims Advisory Group (SCAG) and received four written submissions from members.

6. In presenting this report it is acknowledged that there has not as yet been adequate time to implement all the review recommendations as ACC has needed to strike a balance between ensuring immediate access to support for victims of sexual abuse, re-establishing relationships and building trust, engaging the sector in the changes, and undertaking complex pieces of work to ensure that the end-to-end processes for victims of sexual abuse are safe and therapeutic.

7. The Review Report acknowledged that addressing its concerns would require a well planned long term approach. ACC has developed an explicit plan to systematically address in a comprehensive way, the issues raised in the Review report.

8. ACC identified four key focus areas for the first six months:

    a. To ensure client safety

    b. Introduce 16 hours of immediate support for all new clients

    c. Conduct thorough planning and

    d. Establish and/or rebuild necessary working groups and relationships within the sector

[1] Dr Barbara Disley (Chair), Clive Banks, Ruth Herbert and Graham Mellsop

9. ACC has made good progress in implementing processes to ensure that survivors of sexual abuse have access to support quickly. Relationships with the sector have improved and SCAG members reported that they have appreciated the responsiveness and openness which senior managers with responsibility for implementing the Review Panels recommendations have approached their tasks. Communications with clients are more client-focused and appropriate. Internal SCU processes are improved, management practices have been enhanced and there is greater focus on providing quality services.

10. The review report looks at each of the Review Panel recommendations and presents commentary on progress to date.

11. ACC made substantial changes to its processes to quickly implement claimants' access to 16 sessions of support. Implementation of this recommendation is seen as a positive first step by SCAG and the sector.

12. Implementation of the support sessions has substantially reduced the time taken for clients to receive initial support.

13. ACC has re-established positive working relationships with SCAG. In addition, working parties to revise children and adolescent and Māori client processes have been established.

14. These working parties are in their infancy and in the early stages of influencing the end to end claims, assessment and treatment processes. However, ACC is optimistic that these working groups will make a significant contribution to the work programme.

15. There remains a high level of sector concern that the independent assessment still required for a claimant to move through the claims process does not align with the Massey Guidelines. ACC is aware of these concerns and sees that the child and adolescent and Maori working groups will allow input and feedback into these key issues.

16. ACC needs to effectively engage the sector to work through the claims assessment, return to counselling and reactivated claims processes to ensure that every aspect aligns with the Massey Guidelines. ACC have noted that these issues require robust discussion as there are very differing views and approaches within the sector.

17. While there is acknowledgement of ACC's focus on improved communication and stronger relationships, there is scepticism that the core decisions around the thresholds and mechanisms for determining mental injury and causation will be made by ACC without adequate engagement or consideration of the SCAG, Māori, or child and adolescent working parties' views.

18. In order to allay these fears, ACC would be wise to reiterate the roles, relationships and decision making responsibilities of ACC itself, the SCAG and the working parties, particularly in regard to the advisory role of Mental Health Sector Liaison Group (MHSLG).

19. Work on recommendations 6 or 7 which relate to credentialing of the workforce and quality standards is in its infancy with ACC in the early stages of consultation. ACC's reported focus to date has been on improving its own internal claims processing. Finalising this aspect of the work programme is unlikely to happen until the substantive work on the assessment and treatment frameworks has been completed.

20. ACC has set up working groups for children and adolescent and Māori to ensure that end-to-end claims processes are appropriate and deliver to the needs of these client groups and while SCAG supports these initiatives, there remains concern that progress in developing the post 16 session claims and treatment processes is slow. On the other hand, ACC is keen to ensure that its engagement processes and the work on new frameworks are robust. The overall work programme is 12-18 months in duration and to date ACC's priorities have been to re-establish relationships and to implement access to immediate support.

21. High levels of concern remain about the independent assessment processes. The pool of ACC identified assessors with experience of treating victims of sexual abuse, particularly for children is small.

22. ACC must reiterate its processes of engagement with sector groups over these key issues and reinforce how the existing working groups will contribute to the final frameworks.

23. ACC has made internal changes that have contributed to more streamlined clinical review processes and faster decision making however, there remain significant delays in the provision of external assessments and this is impacting on claims decision timeframes. Delays are sometimes exacerbated by clients and /or counsellors not indicating sufficiently early in the supports sessions of their intentions to progress to a claim.

24. Processes have been put in place to ensure clients have access to support while cover decisions are being made.

25. The Review Panel Recommendation 13 that ACC provide mechanisms for involving family/whanau in therapy especially for children and adolescents has yet to be fully addressed. ACC endorses the need for family involvement and are in the early stages of consulting with the Child and Adolescent Working Group the best way to achieve this. Ensuring these options are appropriate for Māori is also an ACC future priority

26. In conclusion, at the six month review point, ACC has made substantial changes to its internal processes to improve the quality and responsiveness of the SCU. This is acknowledged and appreciated by the sector. Newly presenting clients have immediate access to support and communication and relationships with claimants and the sector have improved. Priority must now be given to working with SCAG and other sector experts on developing processes for determining mental injury and causality. These two aspects of the claims process are of considerable concern to SCAG members, to Māori and to providers working with children and young people.

Background[2]

27. ACC introduced a new Sensitive Claims clinical pathway in October 2009 to apply a strengthened clinical model to the way it managed sensitive claims.

28. The introduction and implementation of the clinical pathway created significant public/media and stakeholder issues.

29. In April 2010, The Honourable Dr Nick Smith, Minister for ACC, requested an independent review of the introduction of the new Sensitive Claims Clinical Pathway.

30. The independent panel: Dr Barbara Disley (Chair), Clive Banks, Ruth Herbert and Graham Mellsop, provided its report to the Minister in September 2010. The report was developed from a range of information sources including ACC, submissions from organisations and individuals, survivors, provider groups and Government agencies. The panel made 14 recommendations based on the outcomes of the review.

31. Recommendation 14 suggested that a process be established to independently monitor the development and implementation of actions recommended in the report.

32. The ACC Board requested that Dr Barbara Disley be engaged to conduct the independent monitoring at 6 and 18 month intervals post the release of the Panel's report (i.e. March 2011 and March 2012).

In Scope

33. This review monitored ACC's progress in the development and implementation of each of the recommendations in the report of the Independent Panel. The recommendations are set out in Appendix 2.

34. The review was limited in its approach and relied heavily on ACC reporting and feedback from the SCAG. Assessment of the quality, timeliness and adequacy of progress made to implement the recommendations is therefore heavily based on perceptions and ACC provided evidence.

Out of Scope

35. This work was confined to looking at the progress ACC had made with implementing the Independent Panel's Recommendations and did not include making new recommendations, except where these relate solely to improving progress with the original recommendations.

36. The review is based on written information provided by ACC and interviews with key staff and on interviews with Sensitive Claims Advisory Group (SCAG). Four SCAG

2 Adapted from the Monitoring the Implementation of the Recommendations from the Independent Panel's Review of the ACC's Sensitive Claims Clinical Pathway - Terms of Reference :January 2011 developed by ACC (See Appendix 1)

members provided additional written submissions. As set out in the terms of reference for the review, it did not include interviews with clients or external stakeholders other than the Sensitive Claims Advisory Group.

37. The reviewer was commissioned to produce a short written report that set out the actions ACC has taken to implement the recommendations and any suggestions for improving progress with the implementation of the recommendations.

38. The findings of the Review were presented to the ACC Board.

The Review Methodology

39. ACC provided the reviewer with a detailed written report[3] providing commentary and evidence of progress made in implementing the Sensitive Claims Review Panel Report recommendations. In addition, face to face interviews were held with a small number of senior ACC staff.

40. The reviewer met with SCAG members at a regular meeting on 24th March 2011. A small number of individual SCAG members provided independent submissions.

The Review Findings

ACC's Approach to the Independent Panel Report

41. In the six months since the initial review, ACC report that it has given priority to the following four focus areas:

    a. A client-centric approach to decision making with client safety of paramount importance

    b. Implement support sessions that are easily accessed by clients and easily delivered by providers

    c. Thorough scoping and planning to deliver improvements that will enjoy long term success

    d. Establish/Re-establish stakeholder relationships seeking to "engage and agree".

42. ACC has established a project team to:

    a. Implement the key deliverables of the 14 recommendations made by the independent review

    b. Gain stability of internal processes and improve timeliness for clients from lodgement through to cover decisions

[3] Clinical Review of ACC Sensitive Claims Clinical Pathway: Implementation of Independent Review Recommendations – Progress report. March 2011

c. Maximise knowledge and visibility of sensitive claims client groups, trends, their needs and research best practice to achieve client recovery through outcome

d. Align sensitive claims treatment services, providers and the service delivery model to meet clients' needs and drive client recovery

e. Introduce outcome measures in a model of recovery.

43. ACC's change management planning reflects the seriousness with which they have approached the Review Panel's recommendations. A comprehensive prioritised plan has been developed and is guiding the work programme.

44. In line with its own stated objectives (paragraph 41) ACC has taken a client focused approach to its planning. Internally, there is greater focus on the client and their recovery.

45. Internal processes have been streamlined and attention paid to ensuring more timely access to support.

46. Good progress has been made in re-establishing sector relationships and trust within the sector. Where possible ACC has taken a client centred approach to its planning.

47. Each of the Review Panel recommendations will be presented with commentary on progress to date.

Recommendation 1

48. 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*

Evidence and Views on Progress

49. ACC acknowledge that this recommendation is far reaching and that it applies to all aspects of a client's end-to-end experience from initial presentation through all stages of the therapeutic relationships.

50. The implementation of the 16 hours support has been an ACC priority. The support is seen as a major initiative to enhance safety of clients, along with an enhanced risk assessment process that has been implemented by the Sensitive Claims Unit (SCU).

51. In consultation with SCAG priority has been given to Māori and children and adolescents services client processes. Working groups were re-constituted in November 2010.

52. Initiatives within the SCU have been to increase training and support to dedicated teams; to enact an early response approach to communities/schools where situations of widespread abuse have occurred and additional support to Christchurch clients as a result of the February earthquake.

53. Data from the SCU shows that following the introduction of the Support Sessions on 16 August 2010 there was an increase in the number of new claims lodged. In addition, the average number of days between the lodgement and first service lodgement for all Sensitive Claims reduced from 192.2 days in November 2009 (the first month data after the introduction of the Clinical Pathways) to 7.1 days in March 2011. The data indicates that more claimants have access to initial support and that the waiting times for this support are dramatically reduced. It is as yet too early to comment on the numbers moving through to a full claims process.

54. SCAG members are supportive of the introduction of the Support Sessions by ACC and see this as enhancing client safety. However, the SCAG members remain concerned about the requirement for independent external assessment including the need for a DSM IV diagnosis.

55. ACC acknowledge that this is an area of challenge as a number of current treatment providers do not have the necessary qualifications to utilise the psychometric instruments available to determine mental injury. ACC are working with the Child and Adolescent Working Group on approving alternative classification methods. ACC also report that they will accept other methods of classification although they require more than a narrative description of injury.

56. The importance of a supportive therapeutic relationship across all stages is a primary consideration. There remains concern within the SCAG that clinicians with expertise in diagnosis may not necessarily have expertise in sexual abuse counselling. There is a view that this has the potential to compromise the therapeutic process.

57. SCAG are concerned that the processes for clients returning to counselling or those wanting to pursue a claim have not been aligned with the Massey Guidelines. Clients returning to counselling report to providers that they are sent for an independent assessment which many find traumatising at a time when they are highly vulnerable.

58. SCAG is supportive that working groups have been set up to review claims processes and services for children and young people and Māori. The working group processes however, takes time. ACC is aware of the balance that needs to be struck between ensuring opportunity for the sector to contribute and more quickly progressing the changes. Engagement with these groups must be appropriate, effective and lead where possible, to changes that the working parties can endorse.

59. The needs of children and young people are particularly pressing given the recent UN Committee on the Rights of the Child's recent Concluding Observations on New Zealand[4] that that recommended that the State party "provide access to adequate services for recovery, counselling and other forms of reintegration in all parts of the country."

[4] http://www2.ohchr.org/english/bodies/crc/crcs56.htm

60. SCAG members are concerned that while access to immediate support has been addressed, there has been no change to the "Clinical pathway processes" for clients returning to counselling or reactivating a claim.

61. ACC have a detailed plan it is progressing to address the needs of returning clients. The delivery date for this work is 7 June 2011.

Reviewer's Conclusions and Recommendations

62. The introduction of the Support Sessions has enhanced client safety by enabling access to immediate support. The number of days taken for clients to access support has dramatically decreased.

63. Setting up working groups to review claims processes for children, young people and Māori, is positively viewed. However, there remains concern about the independent assessment process and how it can be implemented in a way that aligns with the Massey guidelines and provide claimants with an end-to-end process that is safe and acknowledges the importance of the therapeutic relationship. ACC is aware of this concern and plans to consult more widely with the researchers who produced the Massey Guidelines, the Werry Centre and the faculty of child and adolescent psychiatry within the Royal Australian and New Zealand College of Psychiatry. To ensure integrity an open dialogue between ACC, SCAG, other sector experts and the working parties must underpin the change process.

64. The Māori working group was established in January and has met a number of times. There are raised expectations that future end-to-end processes for Māori will be culturally appropriate and effective. This includes the cultural dimensions of building rapport, time, process, cultural safety at the initial stage and throughout the full claims and therapeutic processes. ACC will need to ensure that there is internal SCU capability to deliver on these expectations.

65. ACC needs to ensure that all aspects of its claim assessment processes are safe for claimants and align with the Massey guidelines or there is a risk that the same concerns raised in the original Panel report in respect of the narrow gateway that was introduced with the original introduction of the Sensitive Claims Clinical Pathway in October 2009 will remain.

66. ACC quickly and effectively engage the sector to develop return to counselling and reactivated claim processes that quickly and effectively address clients' need for support and intervention.

67. This recommendation included recognition of the special needs of particular groups including people with mental illness, people with intellectual disabilities and Pacific peoples. ACC needs to develop forward plans to ensure that the needs of these groups are addressed.

68. **Overall assessment – Some Progress Made.** Working groups have been established to advise on the revised processes. ACC has introduced access to support for all victims of sexual assault. This was done in an efficient and timely manner. However, the comprehensive work programme will take time to ensure that all aspects of the pathway align to the Massey Guidelines. Child and adolescent and Māori working groups have been established to being addressing the special needs of particular groups.

Recommendation 2

69.	*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.*

Evidence and Views on Progress

70. Enhancing sector relationships is a stated priority at all levels within ACC with a high level of effort being channelled into developing effective working relationships and to establishing clear roles and responsibilities within working groups.

71. ACC has developed explicit plans to implement the Review Panel's recommendations. The plans reflect both immediate and longer term actions. It is acknowledged that addressing all aspects of the recommendations with effective sector engagement will take twelve to eighteen months.

72. ACC plans have detailed extensive communication and relationship management priorities. ACC report that they have improved engagement and networks through:

    a. Extending the membership of SCAG

    b. Re-establishing connections with members of TOAH-NNEST, government sector agencies, and Doctors for Sexual Abuse Care (DSAC) discussing and seeking advice and feedback on the work of the service improvement project and taskforce

    c. Re-establishing the Māori, and Children and Adolescent working groups

    d. Including SCU staff in working groups to sit alongside sector representatives in developing solutions

    e. Developing a dedicated sensitive claims section on the ACC website

73. SCAG has appreciated ACC's increased attention to relationships and to communication. SCAG members are very positive about the way in which ACC senior managers with direct responsibility for implementing the Review Panel's recommendations have engaged with them. However, there remains concern that consultation has yet to be reflected in changes to overall processes. There is a sense that there remains a "glass door" with relationships in front of the door being stronger and more respectful while at the same time decisions are being made behind the door that do not adequately engage SCAG or the sector. There is fear that decisions around the independent assessment processes and the thresholds regarding the definition of mental injury will continue to restrict the number of clients who will move on to treatment interventions.

74. As noted earlier, finding acceptable mutual ground on the key issues of independent assessment processes and the thresholds of mental injury are a challenge. ACC has indicated that it is willingly exploring options with SCAG and the working groups but that progress is at times constrained by the time it does take to consult and engage. ACC has also indicated that they are committed to open and robust engagement and consultation.

75. There is unease that ACC continues to progress work that will significantly affect the treatment of sensitive claimants without adequate engagement with SCAG. Cited as an example is the work of the Mental Health Sector Liaison Group (MHSLG). This group is not seen to have adequate representation from the SCAG and the relationship between advice and decisions made within the two differing groups not transparent. In response to this concern, ACC have advised that while MHSLG views have been sought, final decision making does not rest with them.

76. While there is support for the specific working groups for Māori and child and adolescents, there remains apprehension about the way in which these two groups work will be conveyed to and considered by SCAG as a whole. This concern needs discussion and clarification with SCAG. ACC communications to community groups about the working parties does reflect that the working parties provide an opportunity for more focus on specific issues in relation to these two particular groups and that there will be opportunity for SCAG to provide feedback to the groups on their deliberations.

77. SCAG reinforced that engagement with Māori must be authentic and that the time to adequately develop responses allowed. Questions were raised about ACC's internal capability to adequately support the working group deliberations. The view was expressed that ACC Māori staff advising and developing new processes must also have experience and understanding of sexual abuse treatment within a Māori context.

Reviewer's Conclusions and Recommendations

78. ACC has recognised that it needs to re-establish and strengthen effective working relationships with survivors of sexual assault and providers of support and intervention services.

79. More positive relationships, while constructive, will of themselves not be sufficient to ensure that future changes to the Pathway are planned, managed and implemented with meaningful engagement and consultation.

80. ACC will need to clarify the advisory roles of the MHSLG and SCAG and the working groups to avoid confusion. Ultimately, ACC is the decision making body and it has undertaken to make decisions in consideration of the advice provided to it by SCAG and the working groups.

81. ACC has begun a journey by establishing the Māori working party and it is now important that the views and deliberations of this group and their perspectives on how decisions are made and processes changed, adequately reflected into ACC's internal decision making. ACC's stated approach is to allow Māori specific approaches to overlay mainstream approaches as is the intention with the approaches that will be developed for children and other special needs groups. This process will require careful management and communication to ensure that the overall approach is well understood within the sector. ACC is taking the time to consult on changes. While in some areas this may mean slower progress it is pleasing to see that ACC is engaging with the sector on changes in an attempt to ensure that it does not repeat the mistakes made with the rapid introduction of the original Clinical Pathway

82. **Overall Assessment – Good progress made.** Initial changes to the pathway have been made and consultation and engagement with the sector initiated. This foundation provides a base for ACC to begin to address the complex changes required to ensure that all aspects of the claims process reflects the principles of the Massey Guidelines.

Recommendation 3

83. 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.

Evidence and Views on Progress

84. ACC and SCAG have agreed that this recommendation is a priority and that it will take time to develop robust and long term solutions that are fit for purpose, meet the needs of all groups and are supported by appropriate processes and tools.

85. In its approach to the matter of determining mental injury, ACC has reinforced the view that a mental injury is defined as a 'clinically significant behavioural, psychological or cognitive dysfunction' that must be capable of being assessed and classified.

86. ACC also agree that there are a range of tools which can be used to demonstrate clinically significant dysfunction and both formal and informal measures must be used. ACC are of the view that any changes to assessment of determination of cover for mental injury need to be applied consistently across all areas (subsequent to physical injury, subsequent to sexual abuse, subsequent to work related trauma).

87. ACC agree with SCAG that determining alternatives to the DSM-IV is a priority action although they also acknowledge that there are challenges surrounding differing views amongst provider groups as to the methodology for assessing mental injury, the interpretation of 'clinically significant' and which groups are qualified to complete assessments.

88. ACC has also invited providers to provide alternatives means of classification when doing mental injury assessments and indicated a willingness to consider alternatives.

89. ACC has sought SCAG views on the diagnosis of mental injuries but as yet, it is unclear to members as to the impact their views have had or the plans that ACC has for clarifying entitlements.

90. There is worry that the work of the child and adolescent and Māori working groups will be subjugated to the decisions of the MHSLG. The incompatibility of the operating paradigms of the various groups (SCAG, child and adolescent and Māori working groups, MHSLAG) is seen as a major barrier to ACC reaching a decision on the determination of mental injury that will be acceptable to all. SCAG are concerned that failure to resolve this issue will undermine future working trust.

91. ACC re-iterate that in working through this complex area it will seek the advice of SCAG, the Child and Adolescent and Māori Working Groups as well as other relevant experts and researchers.

Reviewer's Conclusions and Recommendations

92. There is the potential for the various working and advisory groups to take a variety of differing approaches to the assessment of mental injury. ACC needs to clarify the processes of developing tools for determining mental injury and ensure that the working groups are engaged and aligned in these processes. This includes ensuring that where advice is sought (i.e. from SCAG) members are clear about the impact of this advice.

93. At the same time, ACC is charged with the ultimate responsibility for making the final decisions around coverage. Working closely with the sector and providing case studies and opportunities for discussion will help clarify the criteria and decision making rationale.

94. ACC accepts that assessment processes must align with the Massey Guidelines and be safe and contribute to an ongoing therapeutic environment as they are an integral part of the end-to-end experience of claimants.

95. In addition, the assessment processes must be tailored to the needs of sexual assault victims, be appropriate for use by those with expertise in working therapeutically with the psychological impacts of sexual abuse and assault, be safe and acceptable to Māori, people from diverse cultures and children and young people. While the assessment process will contribute to the determination of cover, it must also contribute to the recovery process.

96. **Overall Assessment – Early stages so minimal progress.** Working groups for children and young people and Māori have been formed, and consultation on assessment tools and processes is in the early stages.

Recommendation 4

97. 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.

Evidence and Views on Progress

98. ACC accepts the test of causation set out in Recommendation 4 and has provided increased training to staff including assessors, as well as increasing legal representation and advice during panels. ACC report that operational guidelines for assessing mental injury are being developed along with case studies to demonstrate its application.

99. Team managers now review decline decision letter for all children and adolescents to ensure that decisions align with the accepted legal test.

100. There is a perspective among SCAG members that the interpretation of "substantial" and "a material cause" is too high and that ACC decisions are highly influenced by the independent assessments. These assessments are generally undertaken by

clinical psychologists or psychiatrists who have not usually provided initial support. There are deep difference in terms of approaches within the sector and a strong view by SCAG that a deep understanding of the treatment of sexual abuse survivors is a prerequisite for being able to effectively make these determinations.

101. Despite training there is a view that for clients progressing from "support" to a claim, the processes around determination of injury and causality have not substantially changed from prior to the Review Panel's report.

Reviewer's Conclusions and Recommendations

102. ACC has accepted the Review Panel's interpretation of the test for determining causation, and provided training and developed some internal quality monitoring processes. Mental injury assessment guidelines will be developed and implemented.

103. These changes are internal to ACC processes and have not substantially involved engagement or communication with SCAG although ACC report that they were discussed at the Child and Adolescent Working Group meeting in March.

104. The determination of mental injury and causation are two key areas of continuing worry to SCAG given that both rely heavily on independent assessments. It is likely that the thresholds around both determination of causation and mental injury assessment will remain contentious and will require ongoing discussion between ACC and the sector.

105. Given ACC and SCAG members' priority for ensuring that all aspects of the claims process are safe and therapeutic for claimants, there would be value in higher levels of engagement with SCAG on the criteria being used by ACC and discussion around case studies to utilise the experience that exists within the SCAG on these matters.

106. ACC could enhance understanding by engaging with SCAG representatives in the development of guidelines for assessors and key staff.

107. **Overall Assessment – Good progress on internal processes to ensure consistency.** ACC has provided initial training and more legal representation to ensure more consistent interpretation of causality. There remains unease within SCAG that the threshold for interpreting "substantial" and "a material cause" remains too high. ACC will need to continue to engage with the sector so there is a growing collective understanding of rationale for coverage and decline decisions.

Recommendation 5

108. 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.

Evidence and Views on Progress

109. ACC report that client communication was an initial and ongoing area of focus within SCU with a move to more proactive and appropriate communication with clients and providers.

110. Survivor advocates for Tau Iwi caucus of TOAH-NNEST were consulted by ACC to assist them to develop a set of core client communication principles and to support the development of training packages for use with ACC staff.

111. ACC have also changed their processes around phone calls and timing of these in an attempt to enhance client contact.

112. It is widely acknowledged by SCAG members that overall communication with clients and providers has been more timely, more respectful and appropriate.

Reviewer's Conclusions and Recommendations

113. ACC has substantially improved its communications with survivors of sexual abuse and involved survivors in ensuring more effective processes.

114. It is recommended that these processes continue with ongoing engagement and review.

115. **Overall Assessment – Good progress has been made on this recommendation.** ACC communications with survivors of sexual abuse have been reviewed and improved. This will require ongoing attention.

Recommendation 6

116. 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.

Evidence and Views on Progress

117. ACC reports that SCAG has endorsed ACC's need to review credentialing requirements for service providers and to introduce defined but flexible criteria for providers. ACC report that initial planning for the credentialing review has commenced.

118. Counsellors have been asked to confirm their details for inclusion on the ACC external website.

119. SCAG members report that to date there has been little visible progress on this recommendation.

Reviewer's Conclusions and Recommendations

120. Aside from internal planning, little progress has been made on this recommendation. ACC does accredit assessment and treatment providers but these processes need to be strengthened. As set out in the original Review Panel recommendations, ACC should establish an appropriately constituted working party to begin this work as it is important to ensuring the ongoing quality of services for claimants.

121. Engaging with SCAG and other professional groups will be important to ensure high levels of "buy in" to the final credentialing and quality processes. All professional groups who provide assessment and treatment services to victims of sexual assault will need to be consulted and engaged in the process of setting service and credentialing standards.

122. Credentialing will be influenced by the overall assessment, support and treatment processes that are developed as a result of the various work streams ACC has underway. It is therefore unlikely to be able to be completed until these other components are determined.

123. **Overall Assessment – Not progressed**. An appropriately constituted working party involving all professional groups to examine credentialing or other means of ensuring that the workforce for assessment and treatment, including the new therapeutic assessment and recovery support process is fit for purpose and meets quality standards is yet to be established.

Recommendation 7

124. 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.*

Evidence and Views on Progress

125. ACC reports that it implemented a range of internal quality initiatives that impact on:

- Recruitment
- Reporting
- Performance management
- Process improvement
- Communication

126. ACC has also extended the use of the "Guidelines for Performance Management of ACC Providers" to (medical/mental health contractors) to mental health providers working under the regulations, including counsellors.

127. ACC notes that this is a major piece and that the quality framework components will be built once the new processes have been determined. This is unable to be achieved until completion of key programme components.

128. SCAG report that they are not aware of any consultation or progress on this recommendation.

Reviewer's Conclusions and Recommendations

129. The changes to the internal processes of claims management and client engagement have improved the working environment within the SCU.

130. ACC will need to engage the sector, survivor representatives and relevant government agencies to progress this recommendation. It includes substantial work on provider approval and auditing, service standards and monitoring, workforce training and development, ongoing professional development and continuous service improvement. These are important aspects of ensuring a robust and reliable quality service in respect of claims processing, assessment and treatment. Implementation of this recommendation is dependent on the development of the new processes.

131. **Overall Assessment – Not progressed as timing requires this be done after support, assessment and treatment processes are agreed.** ACC has initiated a number of quality improvement processes to improve the performance of the SCU. However, the wider intent of this recommendation is yet to be achieved. A process for widely consulting and developing and implementing 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 will need to be initiated once the end to end support and claims processes have been determined.

Recommendation 8

132. 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.

Evidence and Views on Progress

133. ACC immediately implemented the support sessions to new clients and those already on the pathway following the Minister's announcement of this change on 16 August 2010.

134. Careful attention was also paid to the processes around offering support to those clients who had declined or withdrawn under the clinical pathway (27 October 2009 – 16 August 2010).

135. A priority for ACC has been to provide training to SCU staff and guidelines to ensure the intent of this recommendation was well implemented.

136. ACC data provide evidence that time to first counselling or support has decreased and client numbers have increased since the changes were introduced.

137. SCAG agrees that implementation of the support session has been a priority for ACC and that it has made a difference to accessibility to immediate support for clients.

138. Concerns still remain however about the number of counsellors/organisations available to support people given the number who had left the sector and the impact that introducing the earlier clinical pathway had on organisations' ability to now provide effective support services.

139. SCAG members are reporting clients who are reaching the end of their sessions and needing to progress to a full claim remain highly concerned about the assessment processes and the thresholds for accessing ongoing support and treatment.

140. SCAG members also report that some clients are concerned that claims may not be determined within the nine months period and extensions requested, or they may not have been aware that a medical professional may have lodged an ACC45 form earlier that will have set the official start of the claim period without full claimant knowledge.

141. ACC report a commitment to reducing claims processing times. Clients are contacted around the 12th support session to confirm if a claim needs to be initiated. ACC is also keen to ensure that counsellors have the information needed to adequately support clients to move through the claims process.

Reviewer's Conclusions and Recommendations

142. Implementing the 16 support sessions has been a priority for ACC and they have worked quickly and effectively to ensure clients have access to immediate support.

143. As clients reach the end of the 16 sessions and a decision made to lodge a claim, procedures will need to be quickly put in place that ensure that the claims processes do not lead to a disruption in client support and care. Support providers and ACC both have roles to play in ensuring that the pathway for client is smooth.

144. ACC will need to ensure that there are adequate numbers of quality providers to provide the immediate support services.

145. Attention will need to be given to ensuring that actions taken by medical or treatment professionals on behalf of the clients do not inadvertently reduce the clients claim period of 9 months.

146. **Overall Assessment – Excellent progress made.** The changes to provide immediate support were implemented quickly by ACC and with engagement with SCAG. The working parties ACC has established will advise on changes to ensure the processes work effectively for children and Māori.

Recommendation 9

147. *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.*

Evidence and Views on Progress

148. ACC report they implemented the 16 support session changes quickly and in a planned way with internal and external consultation. Their priority was to ensure that there was immediate access to support for all new clients.

149. Consultation with SCAG has continued to refine the support sessions package and to develop operational guidelines for service providers.

150. SCU have implemented higher levels of contact with clients to support them through the processes including proceeding to cover where this is required.

151. SCAG report that while the changes have been implemented, and a working group established for children and adolescents and Māori that the work to ensure a smooth transition that leads to an ongoing therapeutic and safe environment for clients going through the claims processes and progressing to treatment has yet to be changed.

152. ACC reinforced that the overall change programme has a timeframe of 12-18 months and that their priority was to put the 16 support sessions in place in a quick and efficient way.

153. There are high levels of disquiet that the claims process remains unchanged and that the "gate" has been merely transferred to a later stage in the claims pathway process. The independent assessment processes, the concerns around continued requirement of a DSMIV diagnosis, the availability of assessors with sexual abuse treatment experience and the determination of causality are reported by SCAG and providers as areas needing clarification.

154. ACC acknowledge this concern but reiterate that a comprehensive assessment is required to determine cover and that this assessment needs to be done by a professional who has the requisite skills, knowledge and experience. Where a provider has the assessment capability they can fulfil the assessment role. In addition, there is the opportunity for the provider of the support sessions to input into and attend (if the client wishes) the Cover Assessment.

155. ACC has also clarified that following the Cover Assessment, there will be a therapeutic assessment by the treatment provider where more specific therapy goals will be set.

Reviewer's Conclusions and Recommendations

156. ACC has balanced the need to move quickly with the initial changes with the requirement to consult.

157. Priority has been given to quickly implementing access to the sixteen support sessions. ACC is now consulting with the Child and Adolescent Working group as a priority to consideration alternative ways of assessing mental injury that are more appropriate for children and young people.

158. Determining alternative ways to assess mental injury for children and adolescents and for Māori will set the context for broader mental injury determination with other claimants.

159. High levels of engagement with relevant sector experts (people with experience of providing treatment to survivors of sexual abuse) and with relevant government agencies must be a priority to ensure that changes are both planned and effective in the longer term.

160. ACC will need to quickly work out the processes for decision making around the determination of mental injury as there is confusion around the role of the MHSLG and SCAG.

161. **Overall Assessment - Good progress made**. ACC's priority in the first six months was to implement the changes to provide immediate support. These were implemented quickly and with engagement with SCAG. The working group to ensure processes are effective for children has been initiated as has the Māori working group.

Recommendation 10

162. 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.

Evidence and Views on Progress

163. ACC has set up working groups for children and adolescents and Māori to begin the processes of developing an end-to-end claims processes that is appropriate and delivers to the needs of these client groups.

164. Internally ACC has established a dedicated child and adolescent team to work with children and families; developed draft guidelines for assessors completing mental injury assessments for children and adolescents and draft credentials for assessors for consultation as well as developing a set of principles for providers working with children.

165. The role of Chief Māori Advisory (ACC) has been strengthened and a stronger working relationship established between SCU staff and ACC's Māori Cultural Advisor. Terms of references and a scoping paper for the work to be undertaken by the group have been developed for consultation and ratification.

166. SCAG is supportive of the working group approach for children and adolescents and Māori. However, some members are unhappy that progress in developing the post 16 sessions claims and treatment processes is slow. ACC while mindful of this concern, responded that there is a plan for developing the claims and treatment processes and will engage SCAG and the sector in this work. ACC also reiterate that the speed at which changes can be put in place depends on both the sector and their capacity to engage and consult. It is more appropriate from ACC's perspective that changes are well planned, consulted and robust prior to their implementation. This takes time.

167. There is a strong expectation that the approaches taken for children and young people and Māori will set the context for other claims groups.

Reviewer's Conclusions and Recommendations

168. ACC has begun to implement this recommendation with the establishment of the working groups. It is now imperative that work quickly progress on developing claims processes that are based on the Massey Guidelines and the principles that were set out in Section 9 of the original Review Panel Report[5]. ACC reiterated that its priority over the next six month will be to develop process that align with the Massey Guidelines for cover determination and treatment. This work is complex and ACC will need to work closely with the sector to ensure expectations and priorities are understood and aligned.

169. It is also important that ACC keep all sector groups well informed of progress and change and that it clearly plans how the decisions and advice from one group will be conveyed and influence the overall process frameworks. If the relationships and processes around the working groups are not explicit or managed well there is danger that the sector or parts of the sector will become disenfranchised or lose trust in the engagement process.

170. **Overall Assessment – Not yet progressed** The work with sector representatives to evolve the Pathway(s) giving particular attention to the needs of children and adolescents has recently been initiated but as yet an amended pathway that clarifies how cover for treatment according to need will be available to those needing more than the initial 16 sessions has not been developed. In the first six months, ACC has rightly given priority to ensuring access to the support sessions and to re-establishing working relationships. In the next six months, progress on this recommendation will be a priority.

Recommendation 11

171. *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*

[5] Sensitive Claims Pathway Review Panel (September 2010). Clinical Review of the ACC Sensitive Claims Pathway. Section 9: Proposals for Change.
These principles intended that all changes should be in line with the Massey Guidelines and that all processes 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. In addition, the process must ensure there is little or no delay between a claim being lodged and counselling support being available and that continuity of care should be available throughout the process. The client's usual treatment provider should be involved in any independent assessment process and in determining goals and plans.

Evidence and Views on Progress

172. ACC report that the primary change that has been made to the assessment for cover process has enabled the sexual abuse victim's usual treatment provider to attend assessment processes and engage in determining the appropriate treatment goals and plans.

173. ACC acknowledge that the SCU predominantly uses the Diagnostic and Treatment Assessment (DATA) Service to purchase cover assessments, through the Initial Assessment and Recommendations for Treatment (IARTS) service and that this service is delivered by clinical psychologists.

174. While some treatment providers are able to complete the ACC290 determination report, the majority of clients are referred to an assessment provider who is not their usual treatment provider.

175. ACC recognise that the pool of assessors who ACC has determined can deliver these services has narrowed. They also acknowledge that independent providers are not best placed to set specific therapy goals for clients.

176. In its high level objectives and goals for implementation of this recommendation ACC state that priorities will be to:

    a. Review assessors credentials to reflect and endorse provider experience and training

    b. Broaden the scope regarding which disciplines can undertake assessments

    c. Review current assessment, treatment planning processes and reporting against the Massey Guidelines – principles of safety, therapeutic relationships, assessment and client focus

177. SCAG members welcome the changes that allow the regular treatment provider or support counsellor to attend the assessment processes.

178. Feedback from SCAG members on the progress in respect of this recommendation reflects a level of frustration that many still feel about the time taken to progress through IARTS processes and the impact that an independent clinical assessment can have on clients.

179. There remains a perception that claimants are still being assessed by clinicians who lack experience of treating victims of sexual abuse, particularly children. There remains a small pool of ACC approved assessors with experience to work with both children and victims of sexual abuse.

180. As noted earlier in the report, the concerns around the independent assessment processes remain high. ACC acknowledge this concern. ACC has recently consulted with the Child and Adolescent Working Group on a set of child and adolescent assessment and intervention principles. Draft assessment for mental injury guidelines have also been prepared for assessors.

Reviewer's Conclusions and Recommendations

181. ACC must clarify its processes of engagement with sector groups in respect of input into determining changes to the assessment processes.

182. ACC has a work plan to achieve the high level objectives and goals (set out in paragraph 176 above) in respect of this recommendation.

183. Decisions must be made to broaden the pool of assessors and ensure that all assessment processes align with the Massey Guidelines. The draft assessment and intervention principles and the mental injury guidelines for assessors are initial steps in this process.

184. Given the importance of this area to the whole claims and treatment process ACC must continue to engage effective with assessment providers, SCAG and the Child and Adolescent and Māori working groups it has established to advise it. Developing forums for the different professional groups who work across both the assessment and treatment arenas to discuss their perceptions and differences and gain better understandings of the contribution that each make to the client's recovery may be valuable.

185. **Overall Assessment – Some progress.** ACC has made changes to enable the client's usual treatment provider to attend assessment for covers sessions. However the processes to support the usual treatment provider being "involved in the formal assessment process and in determining appropriate treatment goals and plans" are yet to be fully clarified with either the providers of treatment or the independent assessments. There are some delays in clients moving through to cover. These delays are caused by insufficient assessors available that are experts who have worked with sexual abuse victims leading to delays in client assessments and at times client and/or support provider notification that progress to cover is required.

Recommendation 12

186. *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*.

Evidence and Views on Progress

187. ACC is focused on reducing timeframes for assessment and cover decisions to meet the 6 week target.

188. Changes with the SCU have contributed to more streamlined clinical review processes and to faster decision making once a client has indicated that they wish to proceed to cover determination.

189. ACC has processes in place to provide further support for clients for whom ACC has not reached a decision within the 6 weeks timeframe.

190. SCAG report that there has been a decrease in delays with regard to processing of reports for clients seeking cover determination. However, SCAG members also report that there are significant delays in the provision of external assessments.

191. It has also been acknowledged that clients and support providers may not be aware of the timeframes as an ACC45 form may have been lodged by an earlier provider and this lodgement becomes the official point for determination of the nine month claims period. This means that timeframes from the client's perspective are sometimes compressed.

Reviewer's Conclusions and Recommendations

192. ACC has put in place processes to reduce the timeframes for cover decisions and to ensure that treatment is not disrupted while claims decisions are being processed.

193. However, processes need to be clarified to ensure that all parties (ACC, claimant, provider) are aware of the nine month timeframe and when officially that timeframe has started. Clarifying whether an initial medical assessment (i.e. DSAC consultation) initiates the start of the timeframe for cover decisions would be helpful.

194. As noted in Recommendation 11 extending the pool of available assessors must be a priority.

195. **Overall Assessment – Good progress made.** ACC has implemented internal changes to streamline clinical review processes and to make faster decisions. The sector report fewer delays in processing of reports however there are still delays in provision of external assessments and these have yet to be addressed with revised assessment processes.

Recommendation 13

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

Evidence and Views on Progress

197. ACC currently approves primary caregiver sessions with treating therapist "where appropriate" on a case-by-case basis.

198. It intends to develop family/whanau forms as part of the child and adolescent working group's brief and to invite their working group's input to a guideline for providers and families.

199. SCAG report that they have yet to be involved in discussions around this issue and that providers have not been provided with any information or instructions in respect of providing support or services to family/whanau.

200. ACC advises that the Child and Adolescent working group have been invited to provide feedback on the draft guidelines and that this will be progressed.

Reviewer's Conclusions and Recommendations

201. While ACC has begun work on this recommendation, the full intent of this recommendation is yet to be addressed.

202. ACC acknowledge that family/whanau involvement in therapy must be viewed more broadly than the approval of "one off" or case-by-case sessions.

203. ACC will need to effectively engage the child and adolescent and Māori working groups as well as the SCAG in developing appropriate mechanisms for the involvement of families/whanau.

204. **Overall Assessment – Project initiated and in early stages.** ACC provides for primary caregivers to be involved therapy sessions but the full intent of this recommendation which was to provide a mechanism for involving families/whanau in therapy. A comprehensive approach to this is being developed with initial consultation with the Child and Adolescent working Group

Recommendation 14

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

Evidence and Views on Progress

206. ACC developed the Terms of Reference (Appendix 1) for this review and commissioned Dr Barbara Disley to undertake the review.

207. The review was prepared on the basis of:

a. A written report from ACC with supporting review material

b. Key informant interviews with selected ACC senior managers and staff

c. A feedback workshop with SCAG members

d. Written submissions from some SCAG members

Reviewer's Conclusions and Recommendations

208. The scope of this six month review was restricted to evidence from ACC and SCAG members. This has limited the perspectives on progress and therefore the report.

209. Consideration may need to be given to extending the Terms of Reference for the final review to ensure that wider evidence is collected from various sector groups including survivors of sexual abuse, families of children and young people, Māori, and providers of services.

210. **Overall Assessment – Achieved.** ACC has commissioned this initial report six months after the presentation of the Review Panels Report.

Summary of Progress on Recommendations

Recommendation 1 - Reasonable progress made on planning and working groups

211. **Overall assessment –** Working groups have been established to advise on the revised processes. ACC has introduced access to support for all new victims of sexual assault. This was done in an efficient and timely manner. However, the comprehensive work programme will take time to ensure that all aspects of the pathway align to the Massey Guidelines. Child and adolescent and Māori working groups have been established to being addressing the special needs of particular groups.

Recommendation 2 – Good progress made

212. **Overall Assessment** - Initial changes to the pathway have been made and consultation and engagement with the sector initiated. This foundation provides a base for ACC to begin to address the complex changes required to ensure that all aspects of the claims process reflects the principles of the Massey Guidelines.

Recommendation 3 – Early stages so minimal progress

213. **Overall Assessment –** Working groups for children and young people and Māori have been formed, and consultation on alternative assessment tools and processes is in the early stages.

Recommendation 4 – Good progress on internal processes to ensure consistency

214. **Overall Assessment –** ACC has provided initial training and more legal representation to ensure more consistent interpretation of causality. There remains unease within SCAG that the threshold for interpreting "substantial" and "a material cause" remains too high. ACC will need to continue to engage with the sector so there is a growing collective understanding of rationale for coverage and decline decisions.

Recommendation 5 – Good progress

215. **Overall Assessment –** ACC communications with survivors of sexual abuse have been reviewed and improved. This will require ongoing attention.

Recommendation 6 – Not Progressed

216. **Overall Assessment –** An appropriately constituted working party involving all professional groups to examine credentialing or other means of ensuring that the workforce for assessment and treatment, including the new therapeutic assessment and recovery support process is fit for purpose and meets quality standards is yet to be established.

Recommendation 7 – Not Progressed

Overall Assessment – ACC has initiated a number of quality improvement processes to improve the performance of the SCU. However, the wider intent of this recommendation is yet to be achieved. A process for widely consulting and developing and implementing 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 will need to be initiated once the end to end support and claims processes have been determined.

Recommendation 8 – Excellent progress made

217. **Overall Assessment –** The changes to provide immediate support were implemented quickly by ACC and with engagement with SCAG. The working parties ACC has established will advise on changes to ensure the processes work effectively for children and Māori.

Recommendation 9 – Good progress made

218. **Overall Assessment –** ACC's priority in the first six months was to implement the changes to provide immediate support. These were implemented quickly and with engagement with SCAG. The working group to ensure processes are effective for children has been initiated as has the Māori working group.

Recommendation 10 – Initial progress made

219. **Overall Assessment –**The work with sector representatives to evolve the Pathway(s) giving particular attention to the needs of children and adolescents has recently been initiated but as yet an amended pathway that clarifies how cover for treatment according to need will be available to those needing more than the initial 16 sessions has not been developed. In the first six months, ACC has rightly given priority to ensuring access to the support sessions and to re-establishing working relationships. In the next six months, progress on this recommendation will be a priority.

Recommendation 11 – Some progress

220. **Overall Assessment –**ACC has made changes to enable the client's usual treatment provider to attend assessment for covers sessions. However the processes to support the usual treatment provider being "involved in the formal assessment process and in determining appropriate treatment goals and plans" are yet to be fully clarified with either the providers of treatment or the independent assessment. There are some delays in clients moving through to cover. These delays are caused by insufficient assessors that are experts who have worked with sexual abuse victims leading to delays in client assessments and at times client and/or support provider notification that progress to cover is required.

Recommendation 12 – Good progress made

221. **Overall Assessment** - ACC has implemented internal changes to streamline clinical review processes and to make faster decisions. The sector report fewer delays in processing of reports however there are still delays in provision of external assessments and these have yet to be addressed with revised assessment processes.

Recommendation 13 – Initiated

222. **Overall Assessment** – ACC provides for primary caregivers to be involved therapy sessions but the full intent of this recommendation which was to provide a mechanism for involving families/whanau in therapy is yet to be realised. A comprehensive approach to this is being developed with initial consultation with the Child and Adolescent working Group.

Recommendation 14 - Good progress

223. ACC has commissioned this initial report six months after the presentation of the Review Panels Report.

Conclusions

224. ACC has made good progress in implementing processes to ensure that survivors of sexual abuse have access to support quickly. Relationships with the sector have improved and SCAG members reported that they have appreciated the responsiveness and openness which senior managers with responsibility for implementing the Review Panels recommendations have approached their tasks. Communications with clients are more client-focused and appropriate. Internal SCU processes are improved, management practices have been enhanced and there is greater focus on providing quality services.

225. Working groups to provide advice on changes to the claims processes for children and young people and Māori have been initiated. The groups are being consulted and over the next six months progress should be made on developing end to end processes that are safe and effective for children and adolescents and Māori.

226. SCAG remains apprehensive that following the sixteen support sessions, clients who move through the claims process will be subjected to the same assessment processes that were put in place in the original Sensitive Claims Clinical Pathway that was introduced in October 2009.

227. While much more open and positive relationships have been established by ACC with SCAG, there is some confusion within SCAG as to their role and how they will influence the way in which new assessment tools will be developed and assessments undertaken. This is exacerbated by fears around the role that the MHSLG will have in determining the final outcomes. ACC is clear that MHSLG does not have a decision making role so this needs to be clearly conveyed to SCAG.

228. ACC has developed a work plan that will take 12-18 months to fully implement. While the sector is impatient for change, this must be balanced with the need to ensure adequate consultation around the changes so that they are both appropriate and effective. ACC will need to continue to effectively engage the working groups, SCAG and the wider sector in its work programme and communications.

Appendices

Appendix 1: Terms of Reference: January 2011

Monitoring the Implementation of Recommendations from the Independent Panel's Review of ACC's Sensitive Claims Pathway

Background

229. ACC introduced a new Sensitive Claims clinical pathway in October 2009 to apply a strengthened clinical model to the way it managed sensitive claims.

230. The introduction and implementation of the clinical pathway created significant public/media and stakeholder issues.

231. In April 2010, The Honourable Dr Nick Smith, Minister for ACC, requested an independent review of the introduction of the new Sensitive Claims Clinical Pathway.

232. The independent panel: Dr Barbara Disley (Chair), Clive Banks, Ruth Herbert and Graham Mellsop, provided its report to the Minister in September 2010. The report was developed from a range of information sources including ACC, submissions from organisations and individuals, survivors, provider groups and Government agencies. The panel made 14 recommendations based on the outcomes of the review.

233. Recommendation 14 suggested that a process be established to independently monitor the development and implementation of actions recommended in the report.

234. The ACC Board has requested that Dr Barbara Disley be engaged to conduct the independent monitoring at 6 and 18 month intervals post the release of the Panel's report (i.e. March 2011 and March 2012).

In Scope

235. This work will monitor ACC's progress in the development and implementation of each of the recommendations in the report of the Independent Panel. The recommendations are set out in Appendix 1.

236. This work will assess the sufficiency (quality, timeliness and adequacy) of progress made to implement the recommendations and may make suggestions to improve progress where this is required.

Out of Scope

237. This work will be confined to looking at the progress ACC has made with implementing the Independent Panel's Recommendations and will not include making new recommendations, except where these relate solely to improving progress with the original recommendations.

238. This work will not include interviews with clients or external stakeholders other than the Sensitive Claims Advisory Group.

Procedure/Deliverables

239. In conducting the Independent Monitoring Review, Dr Barbara Disley ('the Monitor') will:

- Access relevant records and conduct a small number of meetings (up to 5 per phase) with relevant ACC staff (listed in Appendix 2) to determine progress with the implementation of the recommendations. Will it be possible for your data people to provide information that is already collated? It would be helpful if I could look at some of the information on timeliness of responses etc as we did in the initial review report and assess progress.

- Meet twice (once at 6 months, and again at 18 months) with the Sensitive Claims Advisory Group as part of that group's regular meeting schedule to discuss SCAG's opinion of progress with the implementation of the recommendations.

- Produce a short written report that sets out the actions ACC has taken to implement the recommendations and any suggestions the Monitor may have for improving progress with the implementation of the recommendations.

- Present the findings of the Review to the ACC Board.

Appendix 2: Recommendations of the Independent Review Panel

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, Maori, and Pacific peoples

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.

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 Maori – 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.

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.

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.

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

Monitoring Report on the Implementation of the Recommendations from the Independent Panel's Review of the ACC's Sensitive Claims Clinical Pathway: 18 Months Follow up

Report prepared for ACC Board

Dr Barbara Disley NZOM

1 July 2012

This report provides an overview of the response of ACC to implementation of the fourteen recommendations made by the Review Panel in the Clinical Review of ACC Sensitive Claims Clinical Pathway. This is the second progress report undertaken 18 months following the initial Review Panel Report.

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Executive Summary

1. In April 2010, The Honourable Dr Nick Smith, Minister for ACC, requested an independent review of the introduction of the new Sensitive Claims Clinical Pathway.

2. The independent panel[1] provided its report to the Minister in September 2010. The report was developed from a range of information sources including ACC, submissions from organisations and individuals, survivors, provider groups and Government agencies. The panel made 14 recommendations based on the outcomes of the review. The fourteenth recommendation was that a process be established to independently monitor the development and implementation of actions recommended in the report.

3. In response to this recommendation, the ACC Board engaged the reviewer, Barbara Disley, to undertake an independent review at six months and eighteen month periods. This is the second monitoring report undertaken eighteen months after the Independent Review Panel report was released.

4. Many of the changes made by ACC have been positively received by the sector. This is particularly the case in respect of:

    a. The provision of the sixteen sessions of early intervention and support to clients
    b. The management of the claims processes for children and young people
    c. ACC's approach to sector engagement, communication and relationships
    d. The more timely processes to support re-entry of clients to counselling

5. There is widespread sector support for the way in which ACC has worked with the sector to develop the claims processes for children and adolescents. The SCU itself is better staffed and more able to manage the responses for this group. In addition, the SCU worked with the Child and Adolescent working Group to develop a claims process that more effectively met their needs. This process allows a broader range of tools for assessing mental injury and it has enabled a wider group of professionals to undertake these assessments. These improved processes have enhanced the responsiveness of ACC to this client group and ensured more timely access to support and treatment.

6. ACC is well placed to extend the model utilised to improve the processes for children and adolescents to other client groups. Priority must be given to Māori as to date progress made has been slower than expected to ensure the processes are culturally responsive and effective for this group.

7. The Independent Review Panel report also expressed concern about the processes for adults who had experienced childhood sexual abuse. This group often present with complex symptoms and existing experience of mental illness and alcohol and substance abuse. A specific focus on the needs of this group needs to be now initiated. The model of an expert panel working with SCU members to develop appropriate processes is required.

[1] Dr Barbara Disley (Chair), Clive Banks, Ruth Herbert and Graham Mellsop

8. Concern remains within the sector in respect of the processes around independent assessment for cover. While there have been improvements including the ability of the support counsellor to attend these assessments with the client, the narrow range of tools applied to determining mental injury and the limited number of professional groups who can administer these tools leads to bottle necks and delays in cover determination. ACC needs to urgently review the assessment processes within the adult claims coverage context and broaden the range of tools and professional groups capable of undertaking these assessments. As with the child and adolescent area this needs to be done with input from sector experts who provide therapeutic interventions with this client group.

9. The number of clients moving through the cover assessment process is low. It could be that access to the sixteen support sessions is sufficient for the majority of client and that because their needs are met they do not need to progress through the cover determination process. However, ACC needs to be assured that this is the case and that the process of cover determination itself is not a deterrent to people moving through this process.

10. Minimal progress has been made in respect of credentialing of the workforce or in ensuring that the workforce is fit for purpose and that there are sufficient skilled people available to meet the range of the diverse client group who will access this service. While ACC is not accountable for credentialing or workforce development it can play a facilitative role in ensuring that there is a workforce capable of meeting the needs of its clients. There are major gaps in the capability and capacity of the sector to respond to the needs of Māori or Pasifikā people. In addition, the needs of adults who experienced childhood sexual abuse and who now present with mental health or drug and alcohol issues requires a skilled and effective workforce who can respond appropriately to their needs.

11. While ACC has made considerable progress in addressing the recommendations raised by the Panel, the sector is concerned that without an on-going external monitoring process the imperative to continue to implement the Independent Review Panel's recommendations could diminish. ACC needs to put a process of on-going monitoring and quality assurance in place that provides the sector with confidence that progress in improving the quality of services continues.

Recommendations

12. ACC has made considerable progress in the past eighteen months in implementing the recommendations of the Independent Review Panel Report. There is however, still much to be done to ensure that the service meets the needs of all clients and that there is capacity both within the SCU and the sector to respond appropriately to the needs of all client groups. The following recommendations are made to ensure continued progress in implementing the original recommendations of the Independent Review Group.

13. ACC needs to take the model of review developed in the child and adolescent area to ensure the support and claims process was appropriate for children and adolescents and apply it to other needs areas. In particular this model needs to be applied to ensure enhanced responsive to Māori and Pacific peoples, and adults who experienced childhood sexual abuse and those who have experience of mental illness or drug and alcohol abuse.

14. ACC needs to engage the appropriate range of sector experts to ensure that changes to the processes for all client groups are well planned, managed and implemented with meaningful engagement with the sector. ACC did this in the review of the child and adolescent area and now needs to apply this model more widely.

15. The assessment for cover processes must be safe, client focused and therapeutic as well as providing ACC with the information it needs to make a cover determination. ACC needs to develop their processes to ensure that:

    a. The range of tools available to determine mental injury is broadened and there are sufficient assessors available to undertake these assessments so that bottle necks do not occur

    b. Support, claims assessment and intervention services can effectively meet the needs of Māori clients

    c. Clients have a choice of assessor where this is possible

    d. All parties (client, assessor and counsellor) understand that the client's regular support counsellor can attend and provide information into the assessment process if the client wishes this

    e. Independent assessments are organised in a timely manner and clients continue to be well supported while a cover determination assessment is being made

    f. The use of assessment tools other than the DSMIV is given practical expression

16. ACC take steps to better understand why a large number of clients are not engaging in support sessions and why the numbers going through to a claims assessment are low.

17. Continued engagement with the sector is required to ensure sound understanding by all parties in relation to the application and interpretation of the test for

determining causation. This is particularly important in relation to clients who experience poor mental health or drug and alcohol abuse as this group is seen to sometimes be denied cover because of a pre-existing condition when these conditions could have developed in response to childhood sexual abuse. These issues need greater discussion and resolution.

18. ACC has improved its communication processes with client and providers. The SCU is taking a much more proactive client management role. ACC need to continue to seek feedback on the appropriateness of their client management practices and continually improve these. Clients need to have the opportunity to determine their preferred means of contact with ACC.

19. As set out in the original Independent Review recommendations, ACC needs to establish an appropriately constituted working party to address the issues of provider credentialing and quality improvement processes.

20. While ACC has considerably improved its internal processes within the SCU for managing children and adolescents, and some of these changes have influenced other needs groups, continued improvements need to be made in the adult area including reducing the client case management loads of staff working with adults. In particular, the unit needs to enhance its capability to work with Māori clients and clients who have complex needs including those who experienced childhood sexual abuse.

21. ACC will need to engage the sector, survivor representatives and relevant government agencies to effectively address the substantial work programme that improving provider approval, monitoring and auditing, service standards, workforce training and development, on-going professional development and continuous service improvement. Changes across these areas may impact on the way that services are contracted in the future.

22. ACC moved quickly to implement the sixteen support sessions with a minimum of bureaucracy. Care now needs to be taken to ensure that a balance is struck between ACC's need for information and the compliance costs this imposes.

23. Ensuring that there are adequate numbers of quality counsellors and assessors to provide immediate support and assessment to the diverse range of clients remains a challenge. ACC needs to review its contracting approaches and develop effective ways to provide support to clients that assures clients of access and quality.

24. ACC has developed a policy for enabling family/whānau to access support in the absence of the primary client if this is appropriate. ACC needs to ensure this new policy is well communicated and implemented with the sector.

25. ACC needs to develop a mechanism for ensuring the momentum for change is maintained. This could be done by commissioning a final review in another twelve/eighteen months or by developing an on-going quality improvement, audit and reporting process that assures all that the recommendations of the Independent Review Panel have been fully implemented.

26. Consideration is given to reviewing whether ACC is the most appropriate agency to continue to fund the support, assessment and intervention services for survivors of

sexual assault given the emergence of more integrated whole person and community service responses in the primary mental health care and social service sectors.

Background[2]

1. ACC introduced a new Sensitive Claims clinical pathway in October 2009 to apply a strengthened clinical model to the way it managed sensitive claims. The introduction and implementation of the clinical pathway created significant public/media attention and stakeholder issues. In April 2010, The Honourable Dr Nick Smith, Minister for ACC, requested an independent review of the introduction of the new Sensitive Claims Clinical Pathway.

2. The independent panel: Dr Barbara Disley (Chair), Clive Banks, Ruth Herbert and Graham Mellsop, provided its report to the Minister in September 2010. The report was developed from a range of information sources including ACC, submissions from organisations and individuals, survivors, provider groups and Government agencies. The panel made 14 recommendations (Appendix 1) based on the outcomes of the review.

3. Recommendation 14 suggested that a process be established to independently monitor the development and implementation of actions recommended in the report.

4. The ACC Board requested that Dr Barbara Disley be engaged to conduct the independent monitoring at 6 and 18 month intervals post the release of the Panel's report (i.e. March 2011 and March 2012). The Terms of Reference for this review are set out in Appendix 2.

5. A six month follow up review report was submitted to the Board of ACC in March 2011. The Executive Summary of the first review is attached in Appendix 3.

In Scope

6. This review monitors ACC's progress in implementing each of the recommendations in the report of the Independent Panel.

7. The task of this review is to assess the sufficiency (quality, timeliness and adequacy) of progress made to implement the recommendations and make suggestions to improve progress where this is required. The report will pay particular attention to aspects of Recommendations 1 (recognising the special needs of particular groups, including children and Maori), 3 (additional systems for determining mental injury), and 7 (counsellor capability).

8. The review was informed by an in-depth report provided by ACC on their progress in implementing the recommendation. An on-line survey of provider's perspectives on progress was completed by 188 providers and the reviewer met with the Sensitive Claims Advisory Group (SCAG). Interviews were conducted with representatives from a number of professional bodies whose members provide counselling services to sensitive claims clients. The review was also informed by the findings of an online survey conducted by the New Zealand Association of Psychotherapists that was returned by 146 providers and 72 clients. A number of other individuals were

2 Adapted from Monitoring the Implementation of Recommendations from the Independent Panel's Review of Sensitive Claims Clinical Pathway –Stage 2 March 2012 (See Appendix 2)

interviewed who provided services and feedback on changes was sought from the Department of Child Youth and Family.

Out of Scope

9. The review was confined to looking at the progress ACC has made with implementing the Independent Panel's Recommendations and did not include making new recommendations, except where these relate solely to improving progress with the original recommendations.

10. Information was not sought directly from clients but feedback from clients was available through the online survey conducted by the Association of Psychotherapists and via the survivors of sexual abuse representatives on SCAG.

The Deliverables

11. The reviewer was commissioned to produce a short written report that set out the actions ACC has taken to implement the recommendations, perspectives on progress and any suggestions for improving progress with the implementation of the recommendations.

12. The findings of the Review were presented to the ACC Board.

The Review Methodology

13. In conducting the Independent Monitoring Review, the reviewer:

- Accessed relevant documents and conducted a small number of meetings with relevant ACC staff to determine progress with the implementation of the recommendations.
- Utilised survey feedback provided by ACC that canvassed the views of:
    - members of SCAG
    - ACC registered providers
    - representatives of a sample of professional authorities(e.g. NZ Psychological Society, NZ College of Clinical Psychologists, NZ Association of Psychotherapists, NZ Association of Counsellors, Royal Australian and NZ College of Psychiatrists)

  The survey was facilitated by ACC using Qualtrics web-based methodology.
- Met with SCAG as part of that group's regular meeting on 27th March 2012 to discuss SCAG's opinion of progress with the implementation of the recommendations; and interviewed representatives of professional bodies.
- Reviewed the findings of a survey undertaken by Kyle MacDonald on behalf of the New Zealand Association of Psychotherapists. Findings from this survey are referred to within the report. However it is important to note that the survey methodology and the process for selection of the survey sample will have a bearing on the validity of the survey responses.

- Produced a short, written report for ACC that set out the reviewer's assessment of the progress ACC had made in the implementation of the recommendations and provided suggestions for improving progress.
- Presented the draft findings to ACC for review of factual accuracy.
- Presented the findings to the ACC Board.

14. ACC provided the reviewer with a detailed written report[3] providing commentary and evidence of progress made in implementing the Sensitive Claims Review Panel Report recommendations. In addition, face to face interviews were held with a small number of senior ACC staff and with staff working in the Sensitive Claims Unit.

The Review Findings

ACC's Approach to the Independent Panel Report

15. In the 18 months since the initial review, ACC report that significant changes have been made to the way that it deals with sensitive claims. In particular, ACC reports that:

    a. The framework is now characterised by flexibility of process, with barriers to re-entry removed.

    b. The focus of the Sensitive Claims Unit is on client safety, the needs of the client and supportive communication with the client, their family and providers.

    c. Policies, procedures and guidelines have been developed to reflect the framework and change of focus.

    d. There are more tools for measurement of mental injury, and a lower threshold for causal link with sexual abuse or assault.

    e. Changes have been communicated and education/training provided to internal and external stakeholders.

16. Each of the Review Panel recommendations will be presented with commentary on progress to date.

[3] Sensitive Claims Monitoring Review Report March 2012

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, and people with intellectual disabilities, Maori, and Pacific peoples.*

Evidence and Views on Progress

17. ACC report that its priority has been on ensuring that the sensitive claims framework is safer, more client focused and enables a more effective therapeutic relationship to be established and maintained for clients. The introduction of the 16 counselling support sessions, enhanced flexibility to enable support sessions to continue if there are delays in cover determination, the involvement of the counsellor in the Diagnostic and Treatment Assessment(DATA) process and the reduced timeframes for supporting clients to return to counselling have enabled clients to access support quickly and minimised breaks in support.

18. In its feedback the sector indicated that the changes have been in a positive direction but that more still needs to be done to ensure that ACC's approaches across all groups are fully in line with the Massey Guidelines. It is acknowledged by the sector that changes in the last six months have led to a more client focused approach by ACC. However, there is a strong view that the needs of adults who experienced sexual assault and particularly those who experienced sexual assault as children are still not well understood and responses to needs are not always timely or appropriate. In addition, ACC's figures would indicate that only small numbers of clients are successful in moving through to the claims process. Most either do not progress or are declined. The reasons for the low claims levels are not well understood. It could be that clients are choosing not to go through the process due to their concerns about the independent assessment process, the requirement that they allow ACC to access all their previous mental health related medical records, or in fact whether as a result of the 16 support sessions they no longer require on-going support.

19. Good progress has been made in the smooth management of claims for children and adolescents. A specialist team with reduced case-loads has been set up to manage these claims. ACC worked closely with a Child and Adolescents' Working party to develop more appropriate approaches to the determination of mental injury and to advise on more child centred claims processes. Sector feedback has been supportive of both the working party approach and the outcomes that have been achieved by the Sensitive Claims Unit in their management of both support and cover for children. Claims for people with intellectual disabilities are also being managed by the specialist child and adolescent team within SCU. The sector report that the changes put in place to ensure a more client centred approach to children and adolescent claims have been positive and that the model of change developed in the child and adolescent area could be more positively utilised to address the gaps that remain in the adult client and Māori service areas.

20. A Māori Working group was established to ensure more effective responses to Māori, however, the outcome of this process has yet to translate into specific changes to better meet the needs of Māori. The concerns identified by the initial panel review about the appropriateness of the mechanisms for determining mental injury, access to Māori assessors and counsellors and the engagement with whānau remain. While the SCU has access to Māori cultural advice the unit does not have sufficient Māori staff to enable Māori clients who would prefer to be supported by a Māori case worker to do this.

21. While changes have been made to the independent assessment process, counsellors remain concerned that the process for many adults, in particular those adults who were victims of childhood sexual abuse and those who now present with drug and alcohol or mental health concerns, can be more problematic. Concerns were raised that some assessors are not suitable for some clients because they do not adequately understand their needs or have the ability to be culturally responsive. While some concern was raised that at times assessments are conducted in unsuitable places (i.e. motel rooms) it is likely that these concerns are based on past rather than present experiences. ACC has indicated that assessment contracts stipulate that services must be conducted at the assessor's premises and approval must be sought from the case manager if services are to be delivered elsewhere.

22. ACC has set up a dedicated team to process return to counselling claims for clients who have previously been granted cover. These claims are now processed within 48 hours so that clients can access more immediate support.

Reviewer's Conclusions and Recommendations

23. The most far reaching change for clients has been the introduction of the 16 Support Sessions and this has enhanced client safety by enabling access to immediate support. The number of days taken for clients to access support has dramatically decreased as a result. The support sessions provide an opportunity for a counsellor to build a therapeutic relationship with the client and to support them through the claims process.

24. ACC has made progress in taking a client focus particularly in relation to the management of clients and client communications. Again the child and adolescent team appear to be able to take a stronger client focus. There was feedback both internally and externally that the higher client loads in the adult areas mean that while there are now good intentions to be client focused, this is not always possible. Frequent client contact is not always indicative of a client focus and there is a fine balance between regular contact and a client feeling they are being pursued particularly if the client manager has not the time to adequately develop a positive relationship with the client or his/her provider. Considerable effort has also been made by SCU to improve client communication. Written communication is now more "client" friendly and ACC has made changes to "decline" letters to help clients better understand the rationale for the decisions.

25. ACC has worked with the Child and Adolescent Working Group to review the support and claims process and developed more responsive ways of assessing mental injury and providing support to both the primary client and their family/whānau. The model of a working group that was actively engaged by SCU in determining the claims process worked well. This model could well be applied to other client groups

for example, adults who were sexually abused as children and adults recently sexually assaulted. Engaging survivor representatives and experts in the provision of services to these two groups could facilitate higher levels of sector engagement and satisfaction in processes going forward.

26. While there has been a Māori working party, this has yet to result in more acceptable mechanisms for determining mental injury or more effective ways of engaging this client group. The Māori working group has met over the past year and there are expectations that future end-to-end processes for Māori will be culturally appropriate and effective. This includes the cultural dimensions of building rapport and ensuring cultural safety at the initial stage and throughout the full claims, assessment and therapeutic processes. To date there has been no real change to the processes for Māori clients. ACC will need to determine a more effective way of undertaking the work required to ensure culturally appropriate and effective processes. Consideration needs to be given to strengthening ACC internal or contracted capacity to ensure that this work is undertaken quickly and effectively. The nature of the changes required is such that it is very unlikely that they can be quickly progressed through the current working party approach.

27. There have been changes to the way in which independent assessment process work. The client's regular counsellor can now attend these assessments and there is an expectation that the independent assessor and the counsellor will share information to support the assessment. However, there is feedback from the provider sector that while this works well at times it is dependent on the assessor and their willingness to engage with the counsellor. While for some clients the independent assessment is therapeutic, this is not always the case. There remains concern about the independent assessment process and how it can be implemented in a way that aligns with the Massey guidelines and provides claimants with an end-to-end process that is safe and acknowledges the importance of the therapeutic relationship. Further work with the sector to develop assessment processes that are safe and aligned to the Massey Guidelines is required. In addition, bottlenecks to accessing independent assessments still exist. Clients preferences in respect of having access to an assessor that can meet their specialist needs (child and adolescents, cultural groups, disability groups, those with experience of mental illness); their gender preferences or locally accessible are often unable to be met in a timely way.

28. ACC has ensured a smoother process for clients returning to counselling and reactivating claims. This has led to reduced time delays and more immediate access to support for this group.

29. This recommendation included recognition of the special needs of particular groups including people with mental illness, people with intellectual disabilities and Pacific peoples. Clients with intellectual disabilities are now being handled by the Child and Adolescent teams and this leads to higher levels of client management and support for this group. Considerable concern was expressed about the client management of people with mental illness or drug and alcohol abuse as it was felt that this group often has difficulty proving their support needs are due to their original sexual abuse. It is recommended that ACC set up a consultation process with people who are experienced in providing sexual abuse counselling and support to people with

mental illness or drug and alcohol abuse to ensure that the claims processes do not discriminate against them.

30. As noted above only a small numbers of clients progress through the full claims processes. ACC would be well advised to better understand the needs of clients who do not seek to go through the claims process and ensure that there is a better understanding of the outcomes for these clients. Clients could be accessing other means of support through the Ministry of Social Development rather than pursue a claim through ACC. Without fully understanding the reason for the low claims figures, ACC may be inadvertently shifting costs to another government agency or clients may not be having needs met. ACC have indicated that introduction of provider reporting into the 16 hours of support will enable them to better understand whether the sessions are meeting needs and where clients go following the completion of their sessions.

31. **Overall assessment – Some Progress Made.** Good progress has been made in respect of the initial support and claims process for children and young people. The opportunity for a broader range of professional groups to undertake claims assessments, the wider range of acceptable assessment tools and the higher level of skill and expertise within the SCU have contributed to this more satisfactory state. A similar approach to that taken in the child and adolescent claims area now needs to be taken with the other groups who have particular needs. The original Independent Review Panel report identified that people with mental illness, people with intellectual disabilities, Māori and Pacific people as well as adults who had experienced sexual abuse as children needed more focused attention.

Recommendation 2

32. *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.*

Evidence and Views on Progress

33. ACC report that it has used multiple approaches over the last 18 months to inform developments in the sensitive claims areas, to include stakeholders in a meaningful way and to communicate changes to policies and processes. The SCU report that it has:

a. Proactively engaged with clients and providers in managing claims
b. Met with organisations providing support to clients
c. Sent out regular newsletters updating providers on the changes and seeking feedback
d. Provided detailed responses to questions raised by providers
e. Presented at conferences of professional organisations whose members provide services
f. Regularly updated the ACC website
g. Continued to engage with the Sensitive Claims Advisory Group(SCAG), the Māori and Child and Adolescent Working groups
h. Met with other relevant government and professional agencies

i. Hosted provider "road shows" to foster higher levels of engagement and consultation with the sector and to gather direct feedback from people who are engaged in service provision.

34. Both SCAG and the wider sector acknowledge the increased attention that ACC has paid to establishing and maintaining more effective communication and relationships. SCAG in particular appreciated the way in which senior managers within ACC and the unit have met with them and engaged on aspects of the changes being put in place.

35. However in respect of the degree that changes have been planned and implemented with *meaningful* engagement, the sector and SCAG members identify that there is room for improvement. Where there has been meaningful planning and engagement, as in the child and adolescent area, there has been a higher level of satisfaction with the outcomes.

36. While a Māori working party has been established, the processes to date have not resulted in effective changes for Māori. Both ACC and the Māori working group acknowledge the slower than expected progress. ACC need to develop a mechanism for quickly ensuring that the support, assessment and claims process work effectively for Māori. To date, the progress made using a Māori working party has not led to enhanced outcomes for Māori. ACC have ultimate responsibility for ensuring the processes work do work for all and it therefore needs to consider other mechanism for driving change such as contracting in appropriate Māori expertise to develop a diverse range of Māori approaches to the sensitive claims process.

Reviewer's Conclusions and Recommendations

37. ACC particularly the SCU has worked hard to re-establish and strengthen effective working relationships with survivors of sexual assault and providers of support and intervention services. It has done this through regular meetings, road-shows and newsletters.

38. ACC has worked constructively with the child and adolescent working group and this has led to changes that have been planned, managed and implemented with meaningful engagement with the sector and relevant government agencies. ACC would now be well advised to use this approach more widely with other needs groups.

39. ACC needs to review the role of the SCAG and the way in which it works with this group so that expectations within both parties are aligned. There is still considerable work to be done to ensure that the processes are effective for all needs groups and this will require much more intensive engagement with survivor representatives and sector specialists within these groups. A series of more targeted consultation mechanisms may lead to more effective progress across specific needs groups.

40. Changes to the processes for Māori have been slow and ACC needs to determine a more effective mechanism for developing support, assessment and claims processes that are effective for Māori.

41. **Overall Assessment – Some progress made.** ACC has engaged more effectively with the sector and in particular in the child and adolescent area made changes that were planned and consulted with relevant sector experts. However, this process now needs to be expanded to ensure that changes for other needs groups are planned, managed and implemented with meaningful engagement and consultation with the sector.

Recommendation 3

42. 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.

Evidence and Views on Progress

43. ACC report that considerable work is nearly completed that proposes a suite of changes to, and classification of, mental injury operational policy and the assessment tools and process that will be used by ACC to make mental injury cover decisions. While ACC acknowledge that it may take some time for the impact of these changes to be realised in practice, they reiterate that they have been open to the use of classification tools other than the DSMIV although few providers have taken up this option. One reason for this could be the narrow range of professional groups who undertake the assessments, i.e. psychiatrists and psychologists who are trained to use the DSMIV. The changes being worked on by ACC are expected to improve the timeliness and quality of mental injury cover decisions and they will:

a. Define criteria for "clinically significant"
b. Introduce minimum standards for assessor qualification and experience
c. Define criteria for mental injury assessment tools
d. Lead to changes in the Diagnostic and Treatment Assessment (DATA) contracts (and over time other contracts) that enable a range of classification tools to be used for adults and children. ACC report that changes have already been made to the DATA contracts.

44. The Child and Adolescent Working Group had a significant role in supporting ACC to develop a revised assessment process for children and adolescents. ACC report that the current practice of the SCU Child and Adolescent Team is to consider whether clinical information available from treatment providers already involved with the young person can be used to accept the claim, thus reducing the need for further assessment. Claims have also been accepted for behavioural changes and sexualised behaviour, and support funded to address these areas. These changes have been widely conveyed and well received.

45. SCAG and sector feedback are supportive of the changes in the child and adolescent area in respect of the determination of mental injury however, there remains dissatisfaction with the continued reliance on a DSMIV diagnosis for adults. While it is acknowledged that a more culturally appropriate approach to determining mental

injury is required for Māori, little progress on this has been made by the Māori Working Party and ACC.

46. There remains widespread concern that in the absence of clear guidelines on alternatives, claims cover in the great majority of cases is dependent on an independent DSMIV assessment. The survey of providers found that 55% reported no experience of ACC using a wider range of tools to assess mental injury.

Reviewer's Conclusions and Recommendations

47. ACC has shown through its approach to the child and adolescent area that it is possible to work with the sector to develop a broader and more acceptable range of tools to agree standardised systems for determining mental injury. It now needs to do this for Māori and for all adults. While ACC states that a broader range of tools are acceptable, the reality is few options other than the DSMIV are deemed to meet ACC's assessment criteria.

48. While there have been improvements in the management of the claims cover assessments, there are still bottlenecks and delays in client accessing assessments, and the process for some may remain daunting.

49. In addition, the finding reported in the six monthly review report[4] continues to remain true at the time of this report and ACC needs to work with sector experts to ensure a broader range of professional groups can undertake assessments using a variety of assessment tools.

50. **Overall Assessment – Some Progress.** Progress made for children and young people but more needed to achieve similar results for other needs groups.

Recommendation 4

51. 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.

Evidence and Views on Progress

52. ACC accepts the test of causation set out in Recommendation 4 and has provided increased training to staff including assessors, as well as increasing legal representation and advice during panels to ensure correct interpretation of the legislation. New wording has also been incorporated into the DATA variation contract. All decline decisions are reviewed by a technical claims manager, a team manager or both to ensure that mental injury and causation tests have been correctly applied.

[4] Paragraph 95: …the assessment processes must be tailored to the needs of sexual assault victims, be appropriate for use by those with expertise in working therapeutically with the psychological impacts of sexual abuse and assault, be safe and acceptable to Māori, people from diverse cultures and children and young people. While the assessment process will contribute to the determination of cover, it must also contribute to the recovery process. P16

53. Within the sector there is recognition that ACC is applying the test of causation more appropriately and consistently. However, there are concerns that for adults who report childhood sexual abuse there is a greater likelihood that additional evidence will be sought from them. It was noted that this is more likely with adults who now present with mental health or drug and alcohol concerns and that these factors impact on the determination of whether or not the mental injury was caused by a Schedule 3 event. In addition, there was feedback that causation is often assessed as being linked to overall family dysfunction for adults who experienced childhood sexual abuse rather than to the Schedule 3 event. It is also noteworthy that clients report more concern with the determination of mental injury and the interpretation of the test. This may be linked to clients feeling that they have to "prove" the event and recount their stories a number of times.

Reviewer's Conclusions and Recommendations

54. ACC has accepted the Review Panel's interpretation of the test for determining causation, and has provided training and developed internal quality monitoring processes in respect of assessor determinations.

55. ACC is applying the test of causation more appropriately and consistently. However, as noted in the six monthly follow up report, the determination of mental injury and causation are two key areas of continuing worry to the sector and SCAG. Concern remains around the implementation of the test of causation with clients who have a previous experience of poor mental health or who have experience of drug and alcohol problems. Continued engagement with the sector and communications that reinforce the accurate application of the test of causation could help improve understanding and consistency.

56. **Overall Assessment – Good progress on internal processes to ensure consistency.** ACC has provided initial training and more legal representation to ensure more consistent interpretation of causality. Further work needs to be done to ensure consistent interpretation for people with experience of mental illness or drug and alcohol concerns and to support sector wide understanding and interpretation of the causation test.

Recommendation 5

57. *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.*

Evidence and Views on Progress

58. ACC report that client communication has been an on-going area of focus within SCU with a move to more proactive and appropriate communication with clients and providers. ACC has taken the following specific steps to improve its communication processes:
    a. Client communication principles were developed in 2010/11 with survivor advocates and the tau iwi caucus of TOAH-NNEST
    b. All written communication with clients has been updated regarding the support sessions

c. Letters have been modified to accommodate claims of children and adolescents in consultation with the Child and Adolescent Working Group
d. Staff within SCU receive initial and on-going training regarding engagement with clients
e. Internal ACC quality improvement monitoring of staff member communications to ensure they are client focused and appropriate
f. Recruitment of SCU staff has been refocused to prioritise communication skills and capability.
g. Processes have been introduced within the Child and Adolescent team to establish who the safe contact for the clients

59. Provider feedback indicates that communications by ACC with survivors of sexual abuse and providers has improved with over 83% of providers noting improvement in the past six months. However, the feedback from clients through the NZ Association of Psychotherapists survey showed that for the majority, communication with ACC continues to require improvement.

60. It was reported that the increased direct communication processes between ACC case managers and clients may at times be intrusive for the clients. Providers also conveyed concerns that at times clients expressed their anxiety about unsolicited phone calls arriving at inappropriate times.

61. It is widely acknowledged by SCAG members that overall communication with clients and providers has been more timely, more respectful and appropriate.

Reviewer's Conclusions and Recommendations

62. ACC has substantially improved its communications with survivors of sexual abuse and involved survivors in ensuring more effective processes. However, for some clients the formal communications around their claims can be confusing.

63. ACC may need to build into its client engagement processes a recurring question for clients about their preferred method of contact and communication and ensure that wherever possible clients' wishes drive both the frequency and style of communication.

64. **Overall Assessment – Good progress has been made on this recommendation.** ACC communications with survivors of sexual abuse have been reviewed and improved. This will require on-going attention particularly in relation to ensuring that communications with individual clients are appropriate for them.

Recommendation 6

65. *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 meets quality standards.*

Evidence and Views on Progress

66. Over the last year, ACC has met with professional groups to look at means of ensuring that the workforce for support, treatment and assessment can meet the specific needs of sensitive claims clients. However, this has not developed to the point of implementing a credentialing or standards process. ACC has also met with all relevant government agencies regarding workforce issues and to assure alignment between the mechanisms these agencies might use to ensure the quality of their counselling provider workforce.

67. Psychiatrists, psychologists, social workers and psychotherapists are covered by the Health Practitioners' Competency Assurance Act have their own professional mechanisms for ensuring competence. For counsellors who are not registered under the HPCA, the assurance of standards is through their registration with the NZ Association of Counsellors or the NZ Association of Christian Counsellors. ACC requires all counsellors registered with them to have a current registration under the HPCA Act or an Annual Practicing Certificate issued by their Counselling Association.

68. The SCAG members report that to date there has been little visible progress on this recommendation other than the preliminary discussions with professional bodies around credentialing.

69. There has been considerable change in the provision of primary mental health care services since the initial panel review. Primary healthcare providers are being encouraged to work more collaboratively with a range of community based providers to provide more effective integrated interventions at a local level. While outside the scope of this review it may be timely for ACC to investigate the feasibility of developing sensitive claims services that are more closely connected to primary health care and other community based services. Services could be developed in ways that enable a more integrated approach to be taken to the support, assessment and interventions for clients by enabling them to be able to access services from one place. Such moves could lead to more connected professional communities working together and enable more effective quality improvement processes.

Reviewer's Conclusions and Recommendations

70. As was noted at the six months review, limited progress has been made on this recommendation. ACC has met with professional bodies to better understand the processes these bodies have for accrediting members. As set out in the original Review Panel recommendations, ACC should establish an appropriately constituted working party to begin this work as it is important to ensuring the on-going quality of services for claimants.

71. Engaging with sector experts, professional groups, and the current provider workforce will be important to ensure high levels of "buy in" to the final credentialing and quality processes.

72. It may be timely for ACC to explore more integrated mechanisms for providing support, assessment and intervention services. Some of the emerging primary health care services could enable a more integrated, flexible approach to be taken to

meeting an individual's range of mental health needs. This could support more effective communities of practice and stronger quality improvement mechanisms.

73. **Overall Assessment – Limited progress**. ACC has initiated some consultation with professional bodies but limited progress has been made on developing or implementing credentialing or standards processes.

Recommendation 7

74. *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*
- *monitoring*
- *workforce training and development*
- *on-going professional development, and*
- *continuous service improvement.*

Evidence and Views on Progress

75. ACC reports that it implemented a range of internal quality initiative including ensuring that through regular, training monitoring, updates and reminders that all staff is aware of the profession requirements and standards for processing all claims. All staff is required to attend 8 sessions of professional supervision in their first 18 months of working in the SCU. There are clearer processes for monitoring and checking consistency of practice across staff and a new ACC consistency checking tool is used by staff and management to focus on particular areas for improvement. In addition a new tool allows caseloads to be monitored more effectively. Additional staff has been employed within the unit including a Business Analyst. All clinicians are now permanent or fixed term employees and the clinicians are fully integrated into operational teams supporting their greater engagement.

76. ACC report that they have around 560 providers currently providing services for sensitive claims. Counselling requirements are set out on the website and explicit criteria are set out on the Service Schedule. ACC have undertaken road shows, sent out newsletters and attended conferences to support wider sector communication around changes. Initial discussions have been held with DSAC, the Werry Centre and Te Pou about professional development and training specifically in the areas of trauma and working with survivors of sexual abuse.

77. There is widespread acknowledgement from providers that the internal changes within the SCU have led to improvement for both them and clients. These changes have led to improved morale, competency and engagement across teams. The establishment of a specific Child and Adolescent Team within SCU, the increased skills within team members in respect of child and adolescent issues and the lower case loads were all viewed positively and seen to have contributed to higher and more consistent performance by this team. Changes have been made to enable clients with high and complex needs to be supported into return to counselling and

senior case managers are appointed to work with clients who have higher levels of needs. However, there is a strong provider view that while improvements have been made that in general, adult team members have high case loads and this is reflected in lower levels of satisfaction with service by both clients and providers.

78. While initial work has been done on standardising provider approval and auditing a much stronger focus is required to ensure that all providers are meeting appropriate service standards, are well monitored and continually improving service provision. Workforce training and development is inconsistent across professional groups.

79. In the provider survey suggestions for improving the quality of the workforce included:
    a. On-going professional development for all ACC staff
    b. Strengthening provider approval and auditing processes
    c. Developing service standards
    d. Monitoring client outcomes
    e. Providing professional training and development within the provider sector

80. Other suggestions of note to improve quality reinforced the importance of ACC supporting and developing the expertise of its own staff including increasing the clinical knowledge and leadership within the teams; ACC promoting regional peer supervision groups and communities of practice and providing professional development opportunities for providers. There was also feedback from providers that ACC needed to develop closer relationships with the professional bodies and better understand the processes that already exist across these bodies for ensuring professional competence of members. It was noted by providers that at times there was insufficient understanding of the mechanisms already in place to ensure practice competence. ACC report that they have run three workshops with professional body representatives on workforce issues to ensure better understanding of issues and requirements by all parties.

81. The workforce is aging and there is concern that the remuneration levels for counselling and support sessions may be insufficient to sustain a well-trained, consistently available counselling and support workforce.

82. As noted above, it may be timely for ACC to also investigate more flexible and integrated contracting arrangements with primary health care providers to build more effective hubs where clients can have access to a range of sexual abuse and other mental health support and interventions that treat needs in a holistic and integrated way.

Reviewer's Conclusions and Recommendations

83. There has been substantial improvement since the original Panel Review Report in respect of the working environment, culture and practices within the SCU. The child and adolescent team in particular appears to be able to provide a better level of case management to clients due to the increased staffing levels and the knowledge that staff have about the needs of this client group. Higher staff client management numbers in other parts of SCU appear to hinder the ability of these teams to provide the same level of service to clients. Despite this, it was evident that the morale in the SCU as a whole is much improved and that staff do strive to provide a good service.

84. As noted in the six month review report, ACC will need to engage the sector, survivor representatives and relevant government agencies to effectively address this recommendation. It includes substantial work on provider approval and auditing, provider contracting, service standards and monitoring, workforce training and development, on-going professional development and continuous service improvement. These are important aspects of ensuring a robust and reliable quality service in respect of claims processing, assessment and treatment. The fact that many of the providers of services are independent practitioners presents particular challenges to the on-going professional development and support of the workforce. ACC may need to take a more proactive role in contracting for and supporting the development of stronger provider options and networks and creating more effective communities of practice for learning and development.

85. **Overall Assessment – Good progress internally within SCU but limited progress at a sector level.** ACC has initiated a number of quality improvement processes to improve the performance of the SCU. However, the wider intent of this recommendation is yet to be achieved. A process for widely consulting, developing and implementing a comprehensive quality framework including strengthened processes for provider and development; on-going professional development and continuous service improvement is yet to be initiated.

Recommendation 8

86. 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.

Evidence and Views on Progress

87. ACC immediately implemented the support sessions to new clients and those already on the pathway following the Minister's announcement of this change on 16 August 2010. Clients now have immediate access to support sessions after the lodgement of a claim. ACC report that counsellors are now expected to support their client through the cover assessment and to engage with the assessor and prepare the client for the assessment. There is now also provision for the counsellor who has provided initial support sessions to support their client at the cover assessment and up to two hours are available for this. There is increased flexibility for clients as they move through the claims process and they can opt out of the process and re-engage at a later time. Enhanced client management processes within ACC also support closer monitoring of client movement through the process to ensure that support is provided in a timely manner.

88. ACC report that the number of new claims lodged monthly has increased by 33% since the period of the clinical pathway. Of the 5799 claims lodged in the period of 16 August 2010 to 3 March 2012 and for which a decision has been made, 2984 (51%) accessed support sessions and 2815 (49%) did not. ACC note that the uptake of support sessions has been less than may have been expected. This may be because a large number of claims are initially lodged by General Practitioners (54%)

or SAATS (Sexual Abuse Assessment and Treatment Services) so ACC now contacts these claimants quickly to offer support sessions. Clients may choose not to engage in these at this time.

89. Since the introduction of the 16 sessions, ACC has introduced two reporting requirements for providers. Since 28 November 2011, providers have been required to submit a short report after four sessions, outlining their clients presenting issues and indications of the support required. The next report is required after 12 sessions and this includes a self-management plan for clients who choose not to proceed to cover assessment. The final four sessions are then approved under a purchase order.

90. SCAG and providers note that the introduction of the 16 support sessions has meant that clients can access support more immediately and this has been seen as the most significant change since the review panel's initial report. SCAG reported that generally ACC staff move quickly to ensure that clients are not left unsupported and that if claims cover decisions are not able to be made prior to the 16 support sessions running out additional sessions are approved. This leads to less gaps in support should there be delays in getting assessment or claims cover decisions. However, providers expressed concern that the additional reporting requirements (4 weeks and 12 weeks) and the need to seek two purchase orders for the provision of the 16 sessions is beginning to introduce unnecessary bureaucracy into what was a streamlined and simple process. While there is some support within the sector for the reporting sessions, the process of needing to seek approval under a purchase order for additional sessions makes it more onerous and complex and takes time from client support sessions. In addition, clients receive confirmation early in the process that they are entitled to 16 sessions of support and many do not then understand why progress within the sessions is dependent up provider reports and approval processes.

91. In response to these concerns, ACC report that the additional reporting was introduced to:

    a. Enable a clear, consistent and timely way for counsellors to communicate a client's choice to proceed to cover or not

    b. Capture reasons for the withdrawal

    c. Provide information regarding client's needs for cover assessment

    d. Ensure clients accessing the support are entitled to it

ACC also clarified that approval is not required for clients to access further support sessions based on the content of the support session report. Purchase order numbers are used to better manage the tracking and monitoring of payments for new claims from a business perspective. ACC also acknowledge that a balance needs to be struck between provider ease of doing business and ACC requirement for information and tracking systems. ACC has indicated that reporting will be a subject for future road shows and that it will provide an opportunity to talk to the sector about the processes and any possible changes for improvement.

92. The reason for the high number of people not engaging in the support sessions is not well understood and ACC should examine this issue to be assured that the entitlement and claims processes are well understood by people who have been the victims of sexual assault.

Reviewer's Conclusions and Recommendations

93. ACC quick response to implementing the 16 support sessions enabled survivors of sexual assault to quickly access support. However, just fewer than 50% do not access support, it would be wise for ACC to better understand the reason for this to ensure that everyone who is entitled to ACC support is informed and adequately supported to initiate the process.

94. ACC has introduced additional reporting requirements on providers. While ACC do need to have good information on clients' needs and their support and treatment requirements, care will need to be taken to ensure that the reporting processes do not become bureaucratic and cumbersome.

95. ACC will need to ensure that there are adequate numbers of quality providers to provide the immediate support services and that clients are well supported should they wish to progress to a cover decision. This is particularly the case for Māori and people presenting with complex needs.

96. As over 50% of initial ACC45 claims for sensitive claims are lodged by General Practitioners it is important that ACC ensure that all providers are well informed about entitlement and access to the support sessions and that there is a smooth pathway for clients to progress from a GP surgery to a support counselling provider.

97. **Overall Assessment – Excellent progress made.** The changes to provide immediate support were implemented quickly by ACC. Care will now need to be taken to ensure that the process of accessing the support sessions remains impediment free and that all survivors of sexual assault are aware of their entitlement to support. Ensuring a range of support providers who can meet the diverse needs of clients also requires more work.

Recommendation 9

98. 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.

Evidence and Views on Progress

99. ACC report that change has been both internal (how claims are managed by ACC) and external (apparent to clients and providers). The 16 support sessions were introduced quickly following the independent review of sensitive claims. There have been on-going changes within SCU to enhance the capability of the unit to respond quickly and effectively and these have continued. Working groups to guide changes for children and young people and Māori were established. The changed processes for children and young people have been implemented. Changes to the processes for Māori are yet to be put in place.

100. ACC has increased its communication and engagement with the sector and broadened the input that it seeks from survivors, providers and other government agencies. There is also realisation within the sector that changes have been made as quickly as possible and that change has been balanced with the ability of the unit itself and the sector to engage and respond to it.

101. There is however, less satisfaction with the level of input and/or oversight from relevant sector experts to the change process. The child and adolescent area is the exception to this where in the main, there is acknowledgement that the working group was actively engaged in the process of developing new assessment tools and in ensuring the processes worked as well as possible for this client group. The internal SCU changes in terms of a dedicated team with higher levels of expertise in working with children and young people were also viewed positively and interpreted as ACC actively committing to the change process. The SCAG in particular believe that this model needs now to be applied to the adult area with specific focused attention being given to the needs of Māori, adults who have been recently sexually assaulted and adult survivors of childhood sexual abuse. There is concern that this later group's needs are not as well understood within ACC as they might be and that the complexity of many of the people who present to providers and ACC requires a high level of expertise. Working through the complex issues of determining mental injury for this group requires a coordinated and focused approach that considers the range of views and expertise available.

Reviewer's Conclusions and Recommendations

102. ACC has balanced the need to move quickly to ensure appropriate change with the requirement to consult.

103. Priority was given to quickly implementing access to the sixteen support sessions with these changes being implemented within one month of the report of the Independent Review of Sensitive Claims. ACC has also worked closely with the Child and Adolescent Working group as a priority to implement changes to the claims processes for this priority group.

104. Changes to the processes for Māori have yet to be undertaken.

105. More effective processes for clients returning to counselling have led to this group being able to access support more quickly.

106. ACC has continued to engage with the sector and improve its working relations with SCAG and other agencies. Using the model provided by the Child and Adolescent Working Group across other specific needs groups could enhance future changes and outcomes.

107. **Overall Assessment - Good progress made**. ACC's priority in the first six months was to implement the changes to provide immediate support. These were implemented quickly and with engagement with SCAG. Good progress has also been made in developing more appropriate claims processes including assessments for children and young people. Greater priority must now be given to ensuring the needs of Māori clients and other high needs groups including those who present with complex needs are met.

Recommendation 10

108. 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.

Evidence and Views on Progress

109. ACC reports that the introduction of the 16 hours support prior to cover determination has changed the process from a claim lodgement to a cover decision. Once a claim is lodged a claimant is able to receive 16 hours of support. At any stage the individual can proceed to a cover assessment for determination of claims cover. They can also withdraw from the process at any time. ACC note that the following changes have also been made:

    a. Unnecessary steps have been removed from the process such as triage (clinical input) at lodgement
    b. An initial risk assessment is carried out by the team manager for each newly lodged claim to identify to identify duplicate claims and to allocate the claim to the appropriate team
    c. Individuals are entitled to the 16 support sessions
    d. There is more flexibility for example, in choice of assessor; claims can be re-opened at a later stage for further investigation;
    e. A new return to counselling process means that clients with an accepted claim are not required to go through a cover assessment if ACC holds enough information to make decisions but instead can start appropriate treatment process and receive four sessions from a counsellor to determine their therapeutic needs and set treatment goals. Approval for the "returns to counselling" occurs within 7 days of receipt of the Therapeutic Assessment and Planning Report.

110. Changes to the claims process for Māori have not progressed as ACC report that changes have been delayed pending the completion of research initiated by the Māori Working Group.

111. ACC data indicate that the percentage of claims that go through to be accepted following a cover assessment has declined dramatically since 2007 through to 2011. This is not surprising given that there have been changes to ACC's processes over this time period. Prior to August 2010 clients did not receive any support until they had a claim accepted. Since this date, clients have been able to access 16 sessions of support prior to going through a claims process. Table 1 set out the percentage of clients who lodged a claim who had a claim accepted. The clinical pathway process was introduced in 2009 which led to the decrease at that time. Since August 2010 clients have been able to access the support sessions and it is possible that as a result of being able to access support, the majority of clients do not want or need to go through the cover claims process. It is possible, and reported by providers, that some clients do not progress their claim due to their concerns about the cover assessment process. Providers also indicated that the 16 sessions are sufficient for

many clients and they therefore choose to not continue with the claims cover process.

112. Given that the reporting sessions for those who do access the support sessions have only recently been introduced, there is limited evidence to enable the reasons for withdrawal from support or the claims process to be well understood.

Table 1: Number of Sensitive Claims Lodged Between 2007 and 2012 and the status of these claims as of 5 May 2012

	Calendar year of lodgement					
Claim Status	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Held				0	115	1026
Decline[5]	1928	2313	2995	191	100	250
Accept	3991	3540	2062	403	135	49
Total claims lodged	**5919**	**5853**	**5057**	**3112**	**3782**	**1325**
Number claims with paid cover assessment	**NA**	**NA**	**NA**	**594**	**350**	
Total claims where cover decision made	**5919**	**5853**	**5057**	**594**	**235**	**299**
% claims accepted in relation to number lodged where decision made	**67%**	**60%**	**41%**	**13%**	**3.6%**	**16%**
% claims accepted with paid cover assessment (where decision has been made)	**NA**	**NA**	**NA**	**68%**	**57%**	

Notes:
Excludes duplicates and accredited employers
- Data is based on calendar year
- Cover Assessment is defined as either DAIART, LEST, CPS3, CPS1, CPS2, PSY35
- The codes CPS3, CPS1, CPS2, PSY35 were counted only if the days between lodgement and date of service were within 273 days (9 months) as these codes can be used for post cover assessments.
- Data is updated as of 5 May 2012.

113. ACC data indicates that 46% of people for whom an ACC45 form is submitted and a claim decision had been made do not access the support sessions. 23% of the total group access less than 8 sessions and 30% of the total group access 8 or more sessions. In 2010 594 clients had a cover assessment with 68% being accepted for cover. In 2011 350 clients had a cover assessment with 57% accepted.

114. It is important that ACC put in place processes to better interrogate its own data and extend these to include broader client views on the services they receive in relation to their needs. While the 16 sessions has enabled clients to quickly access counselling support, there may be other needs, including employment cover, that remain unmet in aftermath of a sexual assault or its disclosure. These issues are not currently dealt with unless there is a full claims cover yet in the immediate aftermath of sexual abuse disclosure clients may need other forms of support. ACC acknowledges the importance of providers understanding the requirements for accessing other entitlements and will continue to provide information and update them through FAQs and road shows. .

[5] Declines include those clients for whom cover is declined as well as those clients who withdraw from the process or choose to **not** proceed with a cover claim following their 16 sessions of support

115. Overall SCAG and the sector are happy with the speed of change. There is also recognition that the processes for children and adolescents in respect of access to immediate support and movement through the cover process are much improved. However, there remain concerns within both groups about the process for moving from the 16 sessions through to the full claims processes for adults and in a particular for the adult survivors of child sexual abuse. While there is acknowledgement that the processes have improved particularly in relation to counsellors being able to attend assessments and the opportunity for more comprehensive information to be provided to the independent assessors, there remain concerns that the independent assessment process can still be daunting for some clients. The impact of the independent assessment on clients appears to depend on the way in which the independent assessors conduct the session. Where these are done well with a strong client focus, clients report the assessments were informative and supportive. Feedback through the Association of Psychotherapist provider and client survey indicates that the majority of providers and clients are unclear about what the processes entail. There is also feedback that the processes for cover for adults do not show an understanding of the needs of survivors of childhood sexual abuse. There remains concern from both providers and survivors of the requirement to be effectively "labelled" as having a psychiatric disorder in order to substantiate a "mental injury". This step does have other implications for individuals. Discrimination toward people who experience psychiatric disorders remains strong and those so labelled can be discriminated against in terms of future insurance cover, travel restrictions and employment.

Reviewer's Conclusions and Recommendations

116. ACC has begun work on the cover determination processes. It has developed more appropriate process for children and adolescents and these have been welcomed by providers who work with this client group. ACC has also implemented changes that allow the clients' support provider to be involved in the cover assessment process and to support them through this. ACC still needs to fully meet its responsibility to fully developing claims processes that are based on the Massey Guidelines and the principles that were set out in Section 9 of the original Review Panel Report[6]. In particular, the cover assessment process remains problematic in that there are still limited numbers of assessors and clients do not always have access to assessors that meet their specific requirements or needs. This is particularly important for adult survivors of child sexual abuse as the needs of this group are often complex and require specialist knowledge and management both within ACC itself and by those who provide support, assessment and treatment services.

[6] Sensitive Claims Pathway Review Panel (September 2010). Clinical Review of the ACC Sensitive Claims Pathway. Section 9: Proposals for Change.
These principles intended that all changes should be in line with the Massey Guidelines and that all processes 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. In addition, the process must ensure there is little or no delay between a claim being lodged and counselling support being available and that continuity of care should be available throughout the process. The client's usual treatment provider should be involved in any independent assessment process and in determining goals and plans.

117. ACC needs to quickly and comprehensively investigate why so few clients progress to claims cover. While the implementation of the 16 support sessions may have met many clients' needs, it is possible that some clients decide not to continue through the claims gateway due to their concerns about the process. There is feedback that many clients are unhappy about the requirement to hand over access to all their medical records to ACC and to participate in what in most instances is a psychiatric assessment to determine mental injury.

118. **Overall Assessment – Some progress made.** Good progress has been made by ACC in consultation with the Child and Adolescent working group on developing a pathway that is appropriate for children and adolescents. Further work to ensure the processes work well for Māori and other needs groups now needs to be progressed.

Recommendation 11

119. 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 on-going 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

Evidence and Views on Progress

120. ACC report that under the new claims process, clients have some choice around how soon assessment for cover will commence. In addition, counsellors are paid for two support sessions to assist clients with the assessment and treatment goals and plans following an assessment are developed by the treatment provider, not the assessor. This change supports the direction of the recommendation that the client's usual treatment provider should be involved in the formal assessment process and in determining appropriate treatment goals and plans.

121. In respect of the requirement that the assessors should be experts who have worked with sexual abuse victims, ACC report that most clients are referred to an assessment providers who is not their usual treatment provider because the majority of treatment providers are not qualified to diagnose mental injury and determine causal links. Assessors must have a minimum of 12 months post graduate experience in sensitive claims and have knowledge and experience in working in the area of Sensitive Claims. Psychotherapists who are registered under the HPCA Act may complete the ACC290 Mental Injury from Sexual Abuse Assessment Report form if they meet the criteria for use of the assessment tools. ACC also note that the proposed new mental injury assessment contract may expand the range of assessors.

122. The process for returning clients has also been modified with the client and their provider being informed if an assessment is required and their preference of assessor sought. The time frame from submission of the ACC720 for returning clients to a decision has reduced to 3.6 days with a target set to be under 7 days.

123. The feedback from the survey of providers conducted by the Association of Psychotherapists indicated that fewer than 50% had experienced assessors who they believed were either "expert" or "showed some knowledge" in sexual abuse and childhood sexual abuse trauma and its effects. Approximately 50% of providers responding to the survey reported that they had been involved in the assessment process with their clients. The ACC survey of all providers indicated that 50% of respondents thought the recommendation relating to assessment had been satisfied or mostly satisfied with another 34% indicating that there had been some shift in the direction of the recommendation. However, the area of assessment of mental injury still remains the area of greatest concern to both providers and clients.

124. There is acknowledgement that the independent assessment processes for children and young people are much improved and that the broadening of the assessment tools to identify mental injury has contributed to this improvement.

125. SCAG members welcome the changes that allow the regular treatment provider or support counsellor to attend the assessment processes. There is also positive feedback about the improved processes for clients who are returning to treatment. However, concerns still exist about the availability of independent assessors, the lack of assessors with the cultural knowledge and skills to work effectively with Māori, and the narrow range of tools that are used in practice for the assessments and the limited range of professional groups who are deemed to be able to undertake them.

126. While the move to include regular counsellors in the process is widely welcomed, there was feedback this process still is not widely understood by some of the assessors or by clients and there remains confusion around the role of the counsellor in the assessment process.

127. As noted earlier in the report, despite the changes, concerns around the independent assessment processes remain high. ACC acknowledge the concerns.

Reviewer's Conclusions and Recommendations

128. ACC has put changes in place to ensure the independent assessment processes are more appropriate and acceptable for children and adolescents.

129. The pool of professional groups who can undertake an assessment has been slightly widened and the range of assessment tools increased particularly for children. However, while the assessment process has been made more supportive of clients by enabling the support counsellor to attend assessments, for some clients the process remains daunting. Appropriate changes to the process for Māori have yet to be developed.

130. **Overall Assessment – Some progress.** ACC has made changes to enable the client's usual treatment provider to attend assessment for covers sessions. However, it remains unclear to many support counsellors and assessors as to the role the usual therapist plays in the assessment process with much depending on the approach taken by the assessor. There are some delays in clients moving through to cover. ACC needs to further investigate why the number of clients who have cover claims approved has reduced so substantially.

Recommendation 12

131. *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*.

Evidence and Views on Progress

132. In its update on progress against this recommendation, ACC reports that the lodgement of an ACC45 form is still the starting point for counting the days for the purpose of a decision within the nine months and that this has been clarified for providers in the Provider Update newsletters. For claims lodged where either no treatment or support is required or where the client engages with the 16 support sessions, there are no time delays as the support can start immediately.

133. For the clients who have lodged a claim and proceed to cover assessment, (5799 lodged between the period 16 August 2010 to 3 March 2012), ACC has paid for cover assessments for 509 (or 8.8%). Of these claims, 53% were accepted and 39% declined. ACC also report that for all these clients the time taken from lodgement of a claim to a cover decision is still much longer than the recommended 6 weeks. The median number of days taken for a cover determination request to a decision is 93 days.

134. In reviewing a sample of client files to determine the factors that impact on timeliness ACC found the following factors were instrumental in decision delays:
    a. Availability of assessors
    b. Suitability of assessors for the client
    c. Client non-attendance
    d. Client needing to be assessed over multiple sessions
    e. Gathering the necessary medical evidence from various sources to support the assessment

135. ACC reports that a number of steps have been taken within the SCU to improve cover timeliness. These include:
    a. Increasing the capacity and capability of the SCU although high turnover rates continue to impact and present challenges
    b. Setting us two dedicated staff with SCU to arrange clinics and appointments for clients which has reduced waiting time for appointments
    c. Assisting with funding of transport for clients to attend support sessions or assessments
    d. Removal of the triage system, the introduction of the 16 support sessions and return to counselling processes have reduced delays into support and counselling
    e. The introduction of an information gathering process during the 16 support session in November 2011 in an effort to bring forward cover assessment and provide another source of information for the assessors

f. The introduction of a new system of monitoring timeliness also introduced in November 2011 to enable delays to be better understood and addressed
g. More active communication processes between the assessors and SCU including a dedicated staff member to follow up on referrals. Assessors are now required to advise the SCU within 48 hours of a referral as to their availability with an expectation that assessments will be undertake within 10 days of the referral
h. Setting up of team dedicated to the needs of clients returning to ACC for cover assessment

136. As noted earlier, providers still have serious reservations about the ability of clients to receive timely cover decisions. SCAG reports that while there has been some improvement in the independent assessment processes, there are frequently delays due to the lack of available assessors. While client support sessions are usually extended to ensure that there is not a break in support to the client, the cover assessment process is still viewed by both providers and clients as not meeting timeliness criteria.

137. Again the processes for children and adolescents around assessment and the timeliness of these have improved and are seen as a model for improvement across the adult claims context.

138. While the timeframes from lodgement of claims to a decision are longer than all parties regard as acceptable, decisions are generally made within the legal timeframes.

Reviewer's Conclusions and Recommendations

139. ACC has put in place processes to reduce the timeframes for cover decisions and to ensure that treatment is not disrupted while claims decisions are being processed. Support sessions are extended if delayed decisions mean that support would be interrupted.

140. Good progress has been made in reducing delays for children and adolescents. This has been possible due to the increased staff within the SCU available to manage children and adolescent clients and to the broadening of the professional groups who can undertake the cover claims assessments.

141. Applying the strategies that have been successful in reducing delays for children and adolescent to adults and other specific needs groups is recommended. Increasing the pool of assessors for adults and reducing the client case-loads for case managers within the SCU could reduce current timeframes.

142. **Overall Assessment – Good progress made particularly in relation to services to children and adolescents.** ACC has implemented internal changes to streamline case management processes and to make faster decisions. There are still delays in provision of external assessments and these have yet to be addressed by revising assessment processes and increasing the pool of assessors.

Recommendation 13

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

Evidence and Views on Progress

144. ACC report that family and whānau may access services as part of attendance at therapy with a young client and that this was possible prior to the independent review, however what is less clear is the ability of family and whānau to access assistance in the absence of the client. This issue also raises aspects of client and family/whānau confidentiality and the scope of ACC legislation.

145. ACC have been working on a new policy that is expected to be implemented in May 2012 that includes:
    a. The ability of family/ whānau to access services as part of attendance with their young client (no change)
    b. Family/ whānau may access support in relation to a young client during the initial support sessions period whether or not the client is present
    c. Family/ whānau may access short term support/therapy in relation to a young client after cover whether or not the client is present; further support/therapy will be available according to the client's treatment plan.

146. The Child and Adolescent Working Group and SCAG were consulted on the new policy and contributed to its development. ACC is aware that this issue is important to Māori clients.

147. The ability to include family/ whānau in sessions for children and young people is viewed positively by providers. However, there remain concerns that the 16 session limit of support sessions may create competing priorities between the primary client and family/ whānau.

Reviewer's Conclusions and Recommendations

148. Family/whānau is able to attend support sessions for children and adolescents as was the case prior to the panel review.

149. Implementation of ACC's new policy will enable family/whānau to access support in the absence of the primary client if this is deemed to be appropriate.

150. **Overall Assessment – Good progress made.** ACC provides for family/whānau to be involved in support sessions. A comprehensive new policy has been developed and once launched should support higher levels of support and engagement of families/whānau.

Recommendation 14

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

Evidence and Views on Progress

152. ACC developed the Terms of Reference (Appendix 1) for this review and commissioned Dr Barbara Disley to undertake the reviews at six and 18 months after the release of the Independent Review Panel's recommendations.

153. The review was prepared on the basis of:
    a. A written report from ACC with supporting review material

    Key informant and team interviews with selected ACC senior managers and staff
    b. A feedback workshop with SCAG members
    c. Written submissions from some SCAG members including the findings of a provider and client survey undertaken by the New Zealand Association of Psychotherapists
    d. A survey of Sensitive Claims providers undertaken by ACC in consultation with the reviewer

154. ACC reports that changes have been made over the 18 month period to support implementation of all of the recommendations set out in the Independent Review Panel's Report. While progress is still to be made on a number of recommendations to fully implement them, ACC has confirmed that they have an on-going work plan and a number of projects underway to continue to improve processes.

155. The SCAG and survey respondents expressed concern that while there have been improvements in the claims processes that has enabled more timely support for clients, there is still considerable work to be done within ACC to fully implement the Review Panel recommendations. Given this, many recommended that there be some form of independent monitoring of progress going forward. It was suggested that SCAG could be involved in determining an effective mechanism for this to occur.

Reviewer's Conclusions and Recommendations

156. The scope of this 18 month review was broader than the initial six month review in that it included a survey of providers; there was limited input from clients themselves.

157. It is recommended that ACC determine a mechanism for continued follow up on the Review Panel recommendations and a process for monitoring and assuring that there is on-going quality review of processes.

158. **Overall Assessment – Achieved.** ACC commissioned the initial report six months after the presentation of the Review Panels Report and report eighteen months after the review report. A mechanism for ensuring that the momentum for change is maintained needs to be developed. It could be that a final review or an on-going quality improvement and reporting process needs to be developed to provide assurance at all levels that all recommendations have been fully implemented.

Additional Reviewer Observations

159. While outside the scope of the review the following matters have come to the reviewer's attention while undertaking the review and they are set out in this section for ACC's consideration.

The appropriateness of an insurance model for sexual assault

160. Throughout the review, the question was raised as to the appropriateness of an insurance driven model for the provision of assessment, support and intervention services for people who are recovering from the aftermath of sexual assault. While it could be argued that compensation for the legacies of a sexual assault event and claims related to loss of income and on-going disability should be managed by ACC, there is considerable justification for the initial support, assessment and intervention services to be managed through under a primary health or a social services umbrella.

161. The legislative requirement for survivors of sexual assault to have a determined "mental injury" or psychiatric diagnosis is seen by many survivors and providers as being at odds with a paradigm focused on providing individuals with an integrated, safe and supportive environment following a traumatic life event that considers their whole mental and physical health needs. It is acknowledged that ACC has to balance its legislative requirements for determining cover with the provision of support prior to the cover being determined.

162. Given that sexual abuse survivors now have access to 16 sessions of support prior to going through a claims determination process, it may be timely for ACC to consider whether it is the most appropriate agency to manage this part of the process. The current approach requires ACC to take a relatively intensive case management approach to clients. This process may be more effectively managed by providers who could be contracted to case manage clients and provide them with the full range of integrated services they require, making referrals for assessment and more specialised treatment where this is required. More active case management of clients that is located closer to them could reduce current duplication, reduce bureaucratic overheads, move more resource into direct client services and promote better outcomes.

163. Primary healthcare and social service provision has also changed considerable over the past ten years with client centred approaches that ensure more integrated approach to the care and support of the whole of a person's needs. It could be timely for ACC to consider developing some new models of contracting that enable integrated case management and care response to be developed and outcomes evaluated.

Contracting for Quality

164. While there are many excellent providers, questions were raised through the review about the mechanisms for assuring that all clients have access to high quality services provided by well qualified professionals. The individual client contracting model that exists within the provider sector does mean that there are a large number of individual practitioners operating in single person practices. There are limited mechanisms for supporting practitioners to be constantly improving their skills, operating to consistent service standards or building and sharing expertise and knowledge. There are not explicit pathways that ensure clients are referred to or

matched with providers who can meet their individual needs. It may therefore be timely for ACC to trial some new models of service contracting and provision that support stronger provider organisations and collectives. Again the developments that have occurred within health to bring individual general practitioners into independent practitioners organisations where there are agreed service standards, opportunities for supportive professional communities to grow and enhanced professional development opportunities may be worthy of consideration.

Summary of Progress on 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, Maori, and Pacific peoples

165. **Overall assessment – Some progress made.** Good progress has been made in respect of the initial support and claims process for children and young people. The opportunity for a broader range of professional groups to undertake claims assessments, the wider range of acceptable assessment tools and the higher level of skill and expertise within the SCU have contributed to this more satisfactory state. A similar approach to that taken in the child and adolescent claims area now needs to be taken with the other groups who have particular needs. The original Independent Review Panel report identified that people with mental illness, people with intellectual disabilities, Māori and Pacific people as well as adults who had experienced sexual abuse as children needed more focused attention.

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.

166. **Overall Assessment – Some progress made.** ACC has engaged more effectively with the sector and in particular in the child and adolescent area made changes that were planned and consulted with relevant sector experts. However, this process now needs to be expanded to ensure that changes for other needs groups are planned, management and implemented with meaningful engagement and consultation with the sector.

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 Maori – 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.

167. **Overall Assessment – Some Progress.** Progress made for children and young people but more to achieve similar results for other needs groups.

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.

168. **Overall Assessment – Good progress on internal processes to ensure consistency.** ACC has provided initial training and more legal representation to ensure more consistent interpretation of causality. Further work needs to be done to ensure consistent interpretation for people with experience of mental illness or drug and alcohol concerns and to support sector wide understanding and interpretation of the causation test.

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.

169. **Overall Assessment – Good progress has been made on this recommendation.** ACC communications with survivors of sexual abuse have been reviewed and improved. This will require on-going attention particularly in relation to ensuring that communications with individual clients are appropriate for them.

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.

170. **Overall Assessment – Limited progress**. ACC has initiated some consultation with professional bodies but limited progress has been made on developing or implementing credentialing or standards processes.

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
- on-going professional development, and
- continuous service improvement.

171. **Overall Assessment – Good progress internally within SCU but limited progress at a sector level.** ACC has initiated a number of quality improvement processes to improve the performance of the SCU. However, the wider intent of this recommendation is yet to be achieved. A process for widely consulting, developing and implementing a comprehensive quality framework including strengthened processes for provider approval and auditing; appropriate service standards and monitoring; workforce training and development; on-going professional development and continuous service improvement is yet to be initiated.

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.

172. **Overall Assessment – Excellent progress made.** The changes to provide immediate support were implemented quickly by ACC. Care will now need to be taken to ensure that the process of accessing the support sessions remains impediment free and that all survivors of sexual assault are aware of their entitlement to support. Ensuring a range of support providers who can meet the diverse needs of clients also requires more work.

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.

173. **Overall Assessment - Good progress made**. ACC's priority in the first six months was to implement the changes to provide immediate support. These were implemented quickly and with engagement with SCAG. Good progress has also been made in developing more appropriate claims processes including assessments for children and young people. Greater priority must now be given to ensuring the needs of Māori clients and other high needs groups including those who present with complex needs are met.

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.

174. **Overall Assessment – Some progress made.** Good progress has been made by ACC in consultation with the Child and Adolescent working group on developing a pathway that is appropriate for children and adolescents. Further work to ensure the processes work well for Māori and other needs groups now needs to be progressed.

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 on-going 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

175. **Overall Assessment – Some progress.** ACC has made changes to enable the client's usual treatment provider to attend assessment for covers sessions. However, it remains unclear to many support counsellors and assessors as to the role the usual therapist plays in the assessment process with much depending on the approach taken by the assessor. There are some delays in clients moving through to cover. ACC needs to further investigate why the number of clients who have cover claims approved has reduced so substantially.

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.

176. **Overall Assessment – Good progress made particularly in relation to services to children and adolescents.** ACC has implemented internal changes to streamline case management processes and to make faster decisions. There are still delays in provision of external assessments and these have yet to be addressed with revised assessment processes and increasing the pool of assessors.

Recommendation 13

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

177. **Overall Assessment – Good progress made.** ACC provides for family/whānau to be involved in support sessions. A comprehensive new policy has been developed and once launched should support higher levels of support and engagement of families/whānau.

Recommendation 14

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

178. **Overall Assessment – Achieved.** ACC commissioned a review six months after the presentation of the Independent Review Panel's Report and this review at eighteen months. A mechanism for ensuring that the momentum for change is maintained needs to be developed. It could be that a final review or an on-going quality improvement and reporting process needs to be developed to provide assurance at all levels that all recommendations have been fully implemented.

Conclusions

179. The introduction of the sixteen support sessions and the changed return to counselling processes have meant that ACC has made good progress in ensuring that survivors of sexual abuse have access to quick support. Relationships with the sector have continued to improve and SCAG members reported that they have appreciated the responsiveness and openness that senior managers with responsibility for implementing the Review Panels recommendations have approached their tasks. Communications with clients are more client-focused and appropriate. Internal SCU processes have continued to improve, the setting of up a child and adolescent focused team and the higher staffing levels within it have contributed to better morale and much higher levels of external satisfaction with the unit. There is within the whole unit a much greater focus on providing quality services to clients and engaging more effectively with providers.

180. Internally within SCU there have been positive changes to the climate and morale. This is particularly evident in the Child and Adolescent team where the client case-loads have been reduced; people with experience of working in relevant child and adolescent service areas have been recruited and the ability of this group to more effectively engage with clients and providers has led to higher levels of staff satisfaction. While morale has improved across the whole group, case-loads in the adult area are high, clients often present with complex needs and staff struggle to respond in as timely and effectively a manner as they would want. To ensure continued progress, ACC will need to address these pressures.

181. The Unit has engaged effectively with the Child and Adolescent Working Group to develop and implement changes to the claims processes for children and young people. This has led to a widening of the pool of tools and assessors for determining mental injury. The internal unit has a staffing level that had enabled more effective client management and provider engagement.

182. While a Māori Working Group was set up at the same time, the same levels of progress have not been achieved. Given the weight the original Independent Review Report placed on ensuring that the claims processes were appropriate for Māori, ACC must review the current working group arrangement and processes to quickly progress this work. The model utilised by ACC in the child and adolescent service areas could be applied to Māori client services. The unit needs to enhance its capability to respond appropriately to Māori by ensuring that there is staff that has the skills and knowledge to engage with Māori and support the on-going professional development of all unit staff.

183. There remains a strong sector view that the needs of adult clients who experienced sexual abuse as children are not well understood or effectively managed. This group

often present with highly complex needs and many have already have past diagnosis of mental illness or drug and alcohol concerns. It is recommended that ACC engage sector experts who work with this group of clients to ensure that their needs are well understood both within the unit and the provider sector. This client group needs access to assessors that have deep understanding of the impact of sexual abuse that has occurred in childhood. Care needs to be taken that within the ACC claims process that this group is not discriminated against because of their prior history of a mental illness diagnosis.

184. While the changes to the determination of mental injury processes have been made for children and young people, high levels of sector concern remain about the assessment process and the narrow range of tools and still used to make this determination for other groups. ACC would be advised to quickly implement a process like that used for children and adolescents to determine other tools and to widen the pool of people available to undertake the assessments. Providers continue to express concern that some clients are sent for an independent assessment unnecessarily when the information to inform a claims decision is already held or available from their regular support provider.

185. ACC needs to better understand the reason for the unexpected low uptake of support sessions and the low numbers who move through the claims cover process.

186. While new or returning clients can more easily access immediate support, there are concerns that the reporting processes take time and that these should be streamlined where possible. There remain delays in cover decisions. There are a number of causes of the delays including the lack of available assessors. ACC needs to examine the cover decision process and take action to ensure more timely decisions.

187. ACC is yet to implement the recommendations around credentialing and quality improvement. These must now be given greater priority. Concerns have been raised by the sector in the context of this review that the workforce remains depleted as a result of both dissatisfaction with ACC provider processes and the sessional costs paid by ACC. The workforce is also aging. Ensuring a competent, robust assessment, support and treatment workforce is available to meet the needs of survivors is critical to ACC's ability to ensure effective responses to this group.

Appendices

Appendix 1: Recommendations of the Independent Review Panel

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, Maori, and Pacific peoples

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.

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 Maori – 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.

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.

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
- on-going professional development, and
- continuous service improvement.

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 on-going 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 2: Updated Terms of Reference: January 2012

Background

27. ACC introduced a new Sensitive Claims clinical pathway in October 2009 to apply a strengthened clinical model to the way it managed sensitive claims. The introduction and implementation of the clinical pathway created significant public/media and stakeholder issues. In April 2010, The Honourable Dr Nick Smith, Minister for ACC, requested an independent review of the introduction of the new Sensitive Claims Clinical Pathway.

28. The independent panel: Dr Barbara Disley (Chair), Clive Banks, Ruth Herbert and Graham Mellsop, provided its report to the Minister in September 2010. The report was developed from a range of information sources including ACC, submissions from organisations and individuals, survivors, provider groups and Government agencies. The panel made 14 recommendations based on the outcomes of the review.

29. Recommendation 14 suggested that a process be established to independently monitor the development and implementation of actions recommended in the report. The ACC Board requested that Dr Barbara Disley be engaged to conduct the independent monitoring reviews at 6 and 18 month intervals post the release of the Panel's report (i.e. March 2011 and March 2012). These Terms of Reference apply to the second monitoring review.

In Scope

30. This work will monitor ACC's progress in the development and implementation of each of the recommendations in the report of the Independent Panel. The recommendations are set out in Appendix 1.

31. The task is to assess the sufficiency (quality, timeliness and adequacy) of progress made to implement the recommendations and may make suggestions to improve progress where this is required. The report will pay particular attention to aspects of Recommendations 1 (recognising the special needs of particular groups, including children and Maori), 3 (additional systems for determining mental injury), and 7 (counsellor capability).

32. Information will be sought from some stakeholders, including ACC staff, providers, representatives of professional authorities, and the Sensitive Claims Advisory Group (SCAG).

Out of Scope

33. This work will be confined to looking at the progress ACC has made with implementing the Independent Panel's Recommendations and will not include making new recommendations, except where these relate solely to improving progress with the original recommendations.

34. Information will not be sought directly from clients but feedback from clients may be arranged through the Sensitive Claims Unit.

Procedure/Deliverables

35. In conducting the Independent Monitoring Review, Dr Barbara Disley will:

- Access relevant documents and conduct a small number of meetings with relevant ACC staff (listed in Appendix 2) to determine progress with the implementation of the recommendations.
- Survey the following:
    - members of SCAG
    - ACC registered providers
    - representatives of a sample of professional authorities(e.g. NZ Psychological Society, NZ College of Clinical Psychologists, NZ Association of Psychotherapists, NZ Association of Counsellors, Royal Australian and NZ College of Psychiatrists)

  This will be facilitated by ACC using Qualtrics web-based methodology.
- Meet with SCAG as part of that group's regular meeting schedule to discuss SCAG's opinion of progress with the implementation of the recommendations; and meet with the professional authorities (as agreed) as well as survey them.
- Produce a short, written report for ACC that sets out her assessment of the progress ACC has made in the implementation of the recommendations and any suggestions for improving progress.
- Present the draft findings to ACC for review of factual accuracy.
- Prepare a presentation and deliver it to the ACC Board.

Timeline

36. The review will be delivered against the following timeline:

Early March 2012	Information and documents provided by ACC
Mid-March 2012	Commencement of Independent Review (Internal meetings scheduled for 13 March; SCAG meeting scheduled for 27 March 2012)
Mid April 2012	Draft report provided to ACC
Early May	Finalisation of report
Mid May 2012	Presentation to ACC Board

Appendix 3: Executive Summary First Six Month Monitoring Report

1. In April 2010, The Honourable Dr Nick Smith, Minister for ACC, requested an independent review of the introduction of the new Sensitive Claims Clinical Pathway.
2. The independent panel[7] provided its report to the Minister in September 2010. The report was developed from a range of information sources including ACC, submissions from organisations and individuals, survivors, provider groups and Government agencies. The panel made 14 recommendations based on the outcomes of the review.
3. The fourteenth recommendation was that a process be established to independently monitor the development and implementation of actions recommended in the report.
4. In response to this recommendation, the ACC Board engaged the reviewer, Barbara Disley, to undertake an independent review at six months and eighteen month periods.
5. ACC provided the reviewer with a report and supporting documentation on actions taken to address the recommendations. Face to face interviews were conducted with a small number of ACC senior managers and staff with responsibilities for implementing the recommendations. The reviewer attended a meeting of the Sensitive Claims Advisory Group (SCAG) and received four written submissions from members.
6. In presenting this report it is acknowledged that there has not as yet been adequate time to implement all the review recommendations as ACC has needed to strike a balance between ensuring immediate access to support for victims of sexual abuse, re-establishing relationships and building trust, engaging the sector in the changes, and undertaking complex pieces of work to ensure that the end-to-end processes for victims of sexual abuse are safe and therapeutic.
7. The Review Report acknowledged that addressing its concerns would require a well-planned long term approach. ACC has developed an explicit plan to systematically address in a comprehensive way, the issues raised in the Review report.
8. ACC identified four key focus areas for the first six months:

    a. To ensure client safety

    b. Introduce 16 hours of immediate support for all new clients

    c. Conduct thorough planning and

    d. Establish and/or rebuild necessary working groups and relationships within the sector

9. ACC has made good progress in implementing processes to ensure that survivors of sexual abuse have access to support quickly. Relationships with the sector have improved and SCAG members reported that they have appreciated the responsiveness and openness which senior managers with responsibility for implementing the Review Panels recommendations have approached their tasks. Communications with clients are more client-focused and appropriate. Internal SCU processes are improved, management practices have been enhanced and there is greater focus on providing quality services.

[7] Dr Barbara Disley (Chair), Clive Banks, Ruth Herbert and Graham Mellsop

10. The review report looks at each of the Review Panel recommendations and presents commentary on progress to date.

11. ACC made substantial changes to its processes to quickly implement claimants' access to 16 sessions of support. Implementation of this recommendation is seen as a positive first step by SCAG and the sector.

12. Implementation of the support sessions has substantially reduced the time taken for clients to receive initial support.

13. ACC has re-established positive working relationships with SCAG. In addition, working parties to revise children and adolescent and Māori client processes have been established.

14. These working parties are in their infancy and in the early stages of influencing the end to end claims, assessment and treatment processes. However, ACC is optimistic that these working groups will make a significant contribution to the work programme.

15. There remains a high level of sector concern that the independent assessment still required for a claimant to move through the claims process does not align with the Massey Guidelines. ACC is aware of these concerns and sees that the child and adolescent and Maori working groups will allow input and feedback into these key issues.

16. ACC needs to effectively engage the sector to work through the claims assessment, return to counselling and reactivated claims processes to ensure that every aspect aligns with the Massey Guidelines. ACC have noted that these issues require robust discussion as there are very differing views and approaches within the sector.

17. While there is acknowledgement of ACC's focus on improved communication and stronger relationships, there is scepticism that the core decisions around the thresholds and mechanisms for determining mental injury and causation will be made by ACC without adequate engagement or consideration of the SCAG, Māori, or child and adolescent working parties' views.

18. In order to allay these fears, ACC would be wise to reiterate the roles, relationships and decision making responsibilities of ACC itself, the SCAG and the working parties, particularly in regard to the advisory role of Mental Health Sector Liaison Group (MHSLG).

19. Work on recommendations 6 or 7 which relate to credentialing of the workforce and quality standards is in its infancy with ACC in the early stages of consultation. ACC's reported focus to date has been on improving its own internal claims processing. Finalising this aspect of the work programme is unlikely to happen until the substantive work on the assessment and treatment frameworks has been completed.

20. ACC has set up working groups for children and adolescent and Māori to ensure that end-to-end claims processes are appropriate and deliver to the needs of these client

groups and while SCAG supports these initiatives, there remains concern that progress in developing the post 16 session claims and treatment processes is slow. On the other hand, ACC is keen to ensure that its engagement processes and the work on new frameworks are robust. The overall work programme is 12-18 months in duration and to date ACC's priorities have been to re-establish relationships and to implement access to immediate support.

21. High levels of concern remain about the independent assessment processes. The pool of ACC identified assessors with experience of treating victims of sexual abuse, particularly for children is small.

22. ACC must reiterate its processes of engagement with sector groups over these key issues and reinforce how the existing working groups will contribute to the final frameworks.

23. ACC has made internal changes that have contributed to more streamlined clinical review processes and faster decision making however, there remain significant delays in the provision of external assessments and this is impacting on claims decision timeframes. Delays are sometimes exacerbated by clients and /or counsellors not indicating sufficiently early in the supports sessions of their intentions to progress to a claim.

24. Processes have been put in place to ensure clients have access to support while cover decisions are being made.

25. The Review Panel Recommendation 13 that ACC provide mechanisms for involving family/whānau in therapy especially for children and adolescents has yet to be fully addressed. ACC endorses the need for family involvement and are in the early stages of consulting with the Child and Adolescent Working Group the best way to achieve this. Ensuring these options are appropriate for Māori is also an ACC future priority

26. In conclusion, at the six month review point, ACC has made substantial changes to its internal processes to improve the quality and responsiveness of the SCU. This is acknowledged and appreciated by the sector. Newly presenting clients have immediate access to support and communication and relationships with claimants and the sector have improved. Priority must now be given to working with SCAG and other sector experts on developing processes for determining mental injury and causality. These two aspects of the claims process are of considerable concern to SCAG members, to Māori and to providers working with children and young people.

30 November 2014

Paula Rebstock
Chair
ACC
Justice Centre – Level 7
19 Aitken Street
Wellington, 6011

Dear Paula

RE: Progress on the Recommendations of the Clinical Review of the ACC Sensitive Claims Clinical Pathway

Thank you for the opportunity provided to meet with the board and to discuss the above review findings. I have enclosed the final report. It is pleasing to see the progress that has been made in addressing the concerns of the initial report. Such change would not have been possible if there had not been the shift in focus and culture within ACC. This positive shift is evident at all levels including at the Board level. You have provided the leadership necessary for the organisation to make these changes.

If there is any further information you require please do not hesitate to contact me.

Yours sincerely

Barbara Disley
Consultant

Progress on the Recommendations of the Clinical Review of the ACC Sensitive Claims Clinical Pathway

Report to the ACC Board

Dr Barbara Disley
October 2014

Executive Summary

The original 2010 Clinical Review of ACC Sensitive Claims Pathway review panel made 14 recommendations for improvement. The author conducted an interim review in 2011 and a follow-up review in 2012 and reported to and met with the ACC Board and discussed progress. At the time of the 2012 review ACC had made progress in addressing a number of the recommendations including providing claimants with quick access to sixteen sessions of early intervention and support. However the sector continued to hold concerns about the processes for cover assessments and minimal progress had been made on ensuring the workforce was fit for purpose or that there were robust quality systems in place.

The findings of the current review are that ACC has made substantial progress on the recommendations and the relationship with the sector is much improved. Much of the positive change by was perceived by key stakeholders to have been as a direct result of ACC accepting the recommendations of the 2010 Review Panel and taking a proactive response to re-establishing relationships and building trust with claimants and providers.

There are some areas where current feedback indicated the need for improvement. These included the provision of culturally appropriate service options for Māori and the responses to adults who were victims of childhood sexual abuse.

There continues to be sector concerns about the overall suitability of the ACC "insurance model" to the support of people who have been victims of sexual assault and abuse. This concern centres primarily on the requirement that there is a "mental injury" and the heavy reliance on a psychiatric diagnosis as the mechanism for determining a "mental injury". A psychiatric diagnosis is not the only way of determining a "mental injury" and it can lead to discrimination against the individuals in other aspects of their lives.

There is general support for the changes to the procurement of future services with the provision of suppliers and providers of services through the Integrated Services for Sensitive Claims (ISSC) project currently being rolled out.

ACC has developed a quality assurance framework for monitoring progress against its own strategy and the new contracting approach has also built in requirements that will allow monitoring of the quality of service provision. A reporting mechanisms now needs to be confirmed and regular reports made to the management, board and key stakeholders of ACC. Having a robust internal monitoring and reporting mechanism will allow ACC to move to a system of self-monitoring, review and reporting. This will remove the need for continued external monitoring.

This review has proposed a number of recommendations that if implemented will address the above concerns and support ACC to continue to develop the quality and timeliness of the support available to people who are victims of sexual abuse and assault.

Background

The original review of ACC sensitive claims area was initiated in 2010 by the Minister of ACC Honourable Nick Smith. It was undertaken by an independent panel following widespread sector concern about the difficulties many clients were experiencing in accessing timely support. The review panel made 14 recommendations for improvement. Dr Barbara Disley conducted an interim review in 2011 and a follow-up review in 2012 and reported to and met with the board and discussed progress. At the time of the 2012 review, ACC had made good progress in addressing the recommendations. Of positive note was:

- The provision of the sixteen sessions of early intervention and support to clients
- The improved management of the claims processes for children and young people
- ACC's approach to sector engagement, communication and relationships
- The more timely processes to support re-entry of clients to counselling

There was sector support for the way in which ACC had worked with it to develop the claims processes for children and adolescents. There was a view that the process used for children and young people should be extended to Māori as progress had been slower than expected to ensure the processes were culturally responsive and effective. A specific focus on meeting the needs of adults who were survivors of childhood sexual abuse was also seen as necessary.

The sector had continuing concerns about the processes for cover assessments and there was a view that clients were avoiding going to a cover assessment due to anxiety about the process. Minimal progress had been made on ensuring the workforce was fit for purpose or that there were robust quality systems that would ensure all clients received support from skilled and competent practitioners. There were gaps in the provision of support to Māori and Pacific people and people with complex presentations (often due to childhood sexual abuse) and those with mental health, drug and alcohol presentations. ACC also needed to ensure a robust process for monitoring and review so that the sector could be assured of progress.

Review of Progress in 2014

In August 2014, ACC management commissioned this review to provide an independent view on progress in order to report to the Board of ACC with an update on progress since the 2012 review. This review is limited to a review of papers, reports and information provided by ACC and interviews with selected sector stakeholders.

It is pleasing to see the degree of progress that has been made by ACC in implementing the recommendations of the original report and to hear from the sector their positive views about the changes that have been made. In summary the sector feedback was positive about:

- The working relationship and greater trust that had been rebuilt between ACC, clients and providers of support. This was strongly attributed to the approach taken by ACC management and the team in the Sensitive Claims Unit (SCU).
- The higher level of engagement ACC has with the sector and the enhanced communications

- The focus the SCU has on supporting claimants and the smoother processes to enable people to have immediate support through access to 16 sessions
- The changes to the claims processes for children and the growth in understanding within ACC of how children's needs can be better met
- The greater flexibility that has been built into ACC processes to allow for people to return to support or intervention quickly and without having to participate in onerous assessments
- The improved cover assessment processing including the ability of the support therapists to accompany claimants to assessments and the increase in professional groups deemed to be able to undertake the assessments
- The enhanced status of the Massey guidelines in driving changes and client experiences
- The shorter timeframes in which cover decisions are made and the extension of support sessions if decisions take longer
- The inclusion of family/whānau in therapy for children where this is deemed to be in the interest of the claimant

Much of the positive change is perceived by key stakeholders to be as a direct result of ACC accepting the recommendations of the review panel and being proactive in re-establishing relationships and building trust with claimants and providers. It was heartening to hear the increased positive regard the sector has for ACC and the sensitive claims unit and the view that the changes were as a result of ACC being prepared to ask for advice, listen and take on board sector views.

There are some areas where feedback indicated the need for improvement. These included the provision of culturally appropriate service options for Māori. It was acknowledged that while ACC had done some work to on the development of service models that might be more culturally appropriate but moving these ideas into service provision options has proved challenging. In addition, there was considerable feedback that the responses to adults who were victims of childhood sexual abuse were still not as smooth or effective as these could be. It was recognised that this was a complex area and it was suggested that this might be enhanced by the SCU having a dedicated team with the appropriate expertise and skills to support this specific client group. The needs of this group of clients can be very complex as many people also present with mental health, drug and alcohol and personality disorders.

There continues to be sector concern about the overall suitability of the ACC "insurance model" to the support of people who have been victims of sexual assault and abuse. This concern centres primarily on the requirement that there is a "mental injury" and the heavy reliance on a psychiatric diagnosis as the mechanism for determining a "mental injury". The requirement for a psychiatric diagnosis for someone who has been a survival of rape or sexual assault seems incongruent with the overall concept of limiting the trauma of such an event. Given the discrimination that still exists toward people with mental health concerns and the implications this has for some aspect of health insurance and the requirement of some countries for declaration of mental illness when entering their borders, going through the ACC assessment process can leave unintended legacies. Early intervention and good

therapeutic support can in some cases ensure that trauma is minimised and a diagnosis of post-traumatic stress disorder avoided. Currently intervention without a diagnosis is limited to nine months even when good progress is being made.

This is a very complex area and it is recommended that ACC initiate a review to determine whether changes could be made through policy or whether legislative change is necessary to enable a broader range of approaches to be taken to the determination of mental injury.

There was general support for the changes to the procurement of future services with the provision of suppliers and providers of services through the Integrated Services for Sensitive Claims (ISSC)project currently being rolled out. The opportunity for greater self regulation and networked provision were viewed as strengthening the provider sector and providing greater flexibility to meet the needs of clients. Where concerns were expressed they generally related to the tendering process, the onerousness of this and the reduced communication that has occurred between the unit and stakeholders while the tenders were sought. While there was recognition that this may be as a result of the need for an independent tendering process, care needs to be taken to ensure that the approach does not inadvertently fracture the trust that has been built up by ACC. Some providers have not joined the tendering process and have adopted a "wait and see" approach. There was concern that the reduction in providers in some geographic patches may be a concern as some existing providers have narrowed their geographic coverage. It is apparent that the change to suppliers and providers is a large programme of work. While there is acknowledgement from the sector that the general direction is appropriate and the sector has been involved in determining the model, there is some anxiety that it may result in ACC stepping back and the suppliers taking on much of the responsibility that has until now been taken by the SCU.

ACC will need to focus on keeping service providers well informed and ensuring that clients' needs continue to be well met throughout the change timeframe. In addition, ACC will need to be explicit about how it is going to monitor and evaluate the success of the change programme and ensure that the benefits of the changes are realised.

Appendix 1 sets out a more detailed review of each of the original recommendations. The table provides a self review update by ACC on its progress, a commentary by the reviewer and accompanying recommendations.

Recommendations to the ACC Board

The following recommendations are made to ensure continued progress is made in implementing the original recommendations made in 2010 by Review Panel.

ACC has a well-planned ongoing work programme that aims to address the issues raised within this review. It is therefore recommended that ACC:

Continues to:

1. Gather regular client and key stakeholder feedback:

- Following the implementation of the current ISSC and contract changes to ensure that the pathways and process are safe and foster and maintain a therapeutic relations at all points
- On the effectiveness of communication and engagement mechanisms with all groups and across all parts of the ACC pathway and the support it provides to enable clients to more effectively navigate the system
- To monitor the ongoing satisfaction with the services (Clients, suppliers, providers, other relevant agencies)

2. Review its processes to ensure:
    - Communications are appropriate to the full range of special client groups
    - That special needs groups (e.g. children and Māori) are able to access support and interventions that are appropriate
    - That the causation test for materiality is being observed
    - More effective responses to adult victims of childhood sexual abuse

3. Maintain a high level of communication and engagement with the sector particularly through the implementation phase of the new Integrated Services for Sensitive Claims (ISSC) and through any future change processes

4. Explore options for appropriate support for Māori and work with providers to ensure adequate capability and capacity to respond appropriately

5. Review the evidence base on effective practices in supporting people through recovery from the impact of sexual abuse and assault and ensure that future service changes align with this evidence

Implements:

6. The monitoring framework that has been developed as part of the move to ISSC. It is recommended that the monitoring programme be fully implemented to allow ACC to fully monitor, report and review its performance and assure its stakeholders and the Board that it can:

    - Effectively gauge the impact of the change process and ensure that there is adequate geographical and special group coverage by suppliers and providers.
    - Assess the impact of the ISSC changes on client access and outcomes
    - Ensure that all clients, family and whānau have access to immediate support
    - Ensure the capability of suppliers and providers to effectively respond to the needs of adult survivors of childhood sexual abuse
    - Ensure that the ISSC contracting approach delivers a more integrated approach to assessment and support for all clients and that there are no gaps in geographic coverage or access to support by an groups
    - Ensure arrange of options are available to adequately support family/whānau in therapy particularly for children
    - Assure the Board and ACC stakeholders that needs are well met in a timely and efficient way

Initiates:

7. A review of the mechanisms and process used to determine mental injury including the requirement that claimants have a psychiatric diagnosis. It is recommended that ACC consult with sector experts including consumers and providers of ACC services and the professional bodies including the Australian and New Zealand College of Psychiatrists to review its policy and if necessary legislative requirements and approaches to the determination of mental injury including:

    - A review of international models for the determination of support to victims of sexual assault
    - A review of policy and legislative requirements (if necessary) for cover for victims of sexual assault and abuse including that of the definition of mental injury and the mechanisms for determining this
    - The development of an approach to assessment for cover that is therapeutic, culturally sensitive, meets the needs of children and adults and ensures timely and ongoing access to support

8. An investigation of an independent audit mechanism that will assure clients (and ACC) of provider quality

9. Regular six monthly reports to the Board from management that include sector feedback, on the implementation of ISSC so that it can be assured that adequate progress is being made

Appendix 1: Recommendations of the Clinical Review of the ACC Sensitive Claims Clinical Pathway, Update of Actions from ACC and Commentary and Recommendations by Barbara Disley

Summary of actions taken by ACC to meet recommendations	Commentary on ACC Progress by Reviewer	Recommendations
Recommendation 1: The sensitive claims pathway and process must embody client safety and the therapeutic relationship, be client focused and recognize the needs of special groups		
• Full redesign of all support, assessment and treatment services for sensitive claims resulting in the Integrated Services for Sensitive Claims (ISSC) service and contract (scheduled to go live in late 2014) • Full redesign of all supporting operational processes and service collateral • Move to a higher trust model between ACC and suppliers/providers, which seeks to uphold therapeutic alliance between the client and their service provider • Development of a purpose-built electronic engagement form to replace the ACC45 Injury Claim form for sensitive claims clients • Reorganisation of the Sensitive Claims Unit (SCU) (currently underway), including full training and development packages and a competency framework to align to the new service model • Full transition plan to support all clients, service providers and staff to the new service model by June 2015 • ISSC features a Cultural Advice service type, delivered by cultural advisors, Kaumatua, etc., to support the provision of culturally appropriate responsive services • Introduction of identified areas of experience, reflected in the contracting process for service providers and built into the online search tool,	• The Sensitive Claims Unit has made good progress on this recommendation. In particular there is sector recognition that the approach taken by the SCU has served to rebuild trust between the unit, claimants and providers of services. While there is still a way to go before all clients report that the process and pathway for them was as smooth and safe as they would like, the redesign of the support assessment and treatment services is predicated on ensuring a smoother pathway through the process of support, assessment and treatment and a more client centric approach. • The recognition of the needs of special groups has led to practice changes. The greater awareness of differing needs has mean that SCU communications are more sensitive and there is a greater awareness that approaches must consider the context and characteristics of the clients receiving them. • The changes to ACC processes to more effectively accommodate the needs of children and young people and their whānau/families have been particularly well received. • The reorganisation process has not been completed and while plans incorporate the needs of specific groups it will be important to ensure that these are fully reflected in the new practices and approaches and that client feedback is systematically sought from across the diverse client base to ensure that clients report their needs are being met	• That ACC gather client and key stakeholder feedback following the implementation of the current ISSC and contract changes to ensure that the pathways and process are safe and foster and maintain a therapeutic relations at all points • That ACC continue to review their processes to ensure that they are appropriate to the full range of special client groups (e.g. children and Māori)and they are able to access support and intervention from providers who are acceptable to them

Summary of actions taken by ACC to meet recommendations	Commentary on ACC Progress by Reviewer	Recommendations
i.e.clients will be able to search for service providers with experience working with male survivors, lesbian, gay, bisexual, transgender and intersex survivors (LGBTI), etc.		
Recommendation 2: Future change to the pathway and process should be with meaningful engagement and consultation with sector and Government agencies		
• Significant sector engagement, including service provider road shows, service provider and client focus groups, dedicated website, regular stakeholder email updates, professional body meetings, surveys to obtain feedback and measure level of support for ACC's direction	• Key Stakeholders report that ACC has improved its engagement and consultation with the sector • Stakeholder report a positive lift in the relationship between the SCU and the sector and express appreciation at the significant effort that has been made by ACC staff to engage more effectively and consult on major changes	• That ACC continue to maintain a high level of communication and engagement with the sector particularly through the implementation phase of ISSC and through any future change processes • That ACC obtain regular feedback on the effectiveness of communication and engagement mechanisms
Recommendation 3: Engage sector experts in developing additional systems for determining mental injury that are appropriate for special groups (i.e. children and Māori) when making cover decisions		
• Additional classification systems and tools identified and now in use • ACC policy changes made to reflect the use of additional systems and tools	• ACC has made initial welcome changes to the classification systems and to the tools that can be utilised to determine "mental injury" for children. The progress in respect of classification systems that may be appropriate for Māori is less advanced. • There remains dissatisfaction within the sector that the determination of mental injury still relies heavily on a psychiatric diagnosis. Stakeholder feedback indicates that for many clients this is stigmatising and discriminatory. • ACC could engage in a more inclusive approach that engages sector experts and key stakeholders in developing additional classification systems and tools for determining cover. • Change to the legislation may be required specifically for the area of sexual abuse and assault. The specific focus of the current legislation on a "mental injury" is not a comfortable fit for many victims of sexual violence. This is particularly	• That ACC review international models for the determination of support to victims of sexual assault • That ACC review the legislative requirements of a mental injury and the mechanisms for determining this • That ACC engage widely with sector experts including the Australian and New Zealand College of Psychiatrists as part of this review

Summary of actions taken by ACC to meet recommendations	Commentary on ACC Progress by Reviewer	Recommendations
	the case when a psychiatric diagnosis is required for determination of coverage. • ACC will also need to engage appropriate legal expertise to determine if there are policy and/or legislative changes required to support other cover determination mechanisms	
Recommendation 4: The test for mental injury must be that the sexual abuse was a substantial or material cause of the injury		
• Causation test adopted, trained and implemented throughout the SCU	• Stakeholders report that the causation test training throughout the unit has led to more acceptable decision making	• That ACC continue to regularly review sector feedback to ensure that the causation test for materiality is being observed
Recommendation 5: Communications need to be revised, taking a client perspective and using survivor and expert assistance in process		
• Full redevelopment of client communications including contact scripts, letters, pamphlets and staff training • Development of new, standalone website for clients, Support Access, developed and tested with survivors, service providers and wider public, includes a search tool to help clients locate a provider	• ACC has substantially reviewed its client communications and its mechanisms for engaging with survivors	• That ACC continue to seek feedback from clients and make changes as to the appropriateness of its communication practices and the support that it provides to enable clients to more effectively navigate the system.
Recommendation 6: (Use a working group to) ensure providers are fit for purpose and meet quality standards		
• Development and procurement of ISSC contract, introducing a new supplier-based service model with enhanced accountability and qualifications, training and experience requirements. • Supplier-based service model allows ACC to contract with specialist agencies and small and large groups, as well as individuals who can demonstrate the required skills and experience • High level of response to ISSC tender from the service provider market, with responses from 173 suppliers, comprising over 1,300 service providers. Approximately 70% of successful service providers are currently ACC registered. • ISSC tender set out criteria to be able to deliver services and service quality and performance requirements	• ACC has made considerable progress is developing a procurement system for providers • This system is currently being implemented. The scale of the changes is considerable and to a large extent the sector has engaged with the intent and direction of the change. That said, there are some existing providers who have not engaged with the new arrangements and are adopting a "wait and see" approach. • ACC will need to ensure that it has adequate providers available to ensure full geographical coverage and within its supplier and provider networks adequate capability to meet the needs of special groups • ACC will need to maintain a high level of oversight of the	• That ACC have a high level of engagement with the sector through the ISSC implementation period and seek feedback to ensure the expected outcomes are achieved • That ACC monitor the impact of the change process and ensure that there is adequate geographical and special group coverage by suppliers and providers.

Summary of actions taken by ACC to meet recommendations	Commentary on ACC Progress by Reviewer	Recommendations
• Additional supplier manager resources dedicated to managing supplier/provider performance.	new supplier/provider arrangement to ensure that the new system is and remains fit for purpose and does lead to improved quality and better client outcomes.	• That ACC develop a mechanism for monitoring the impact of the ISSC changes on client access and outcomes
Recommendation 7: Work with sector, survivors and Government agencies to develop a framework for provider approval, audit, monitoring and service standards and workforce training, professional development and continuous improvement		
• ISSC tender set out criteria to be able to deliver services and service quality and performance requirements • Development and implementation of a service assurance framework including quality indicators and reporting requirements	• ACC has identified through the tender process service supply performance criteria and set service quality and quality performance requirements however it will need to develop effective contract monitoring mechanisms to be assured the desired changes in terms of service standards, workforce capacity and capability and continuous service improvement are achieved. • Implementation of the service assurance framework and effective monitoring of quality standards has remained a challenge in other areas of health service provision so ACC may need to set up an independent mechanism that enables regular audit of providers. This could be at a service rather than an individual practitioner level where presumably professional standards and credentialing mechanisms will operate.	• That ACC develop effective contract monitoring mechanisms following the implementation of ISSC • That ACC investigate an independent audit mechanism that will assure clients of provider quality.
Recommendation 8: Provide 16 hours support (including pre-cover)		
• Implemented in August 2010 • ISSC features enhanced immediate support, including dedicated sessions for clients' family and whānau and social work and active liaison, as required	• As reported by ACC this recommendation was implemented.	• That ACC continue to monitor that all clients, family and whānau have access to immediate support
Recommendation 9: Change must be implemented quickly and effectively with input from sector and Government agencies		
• 16 hours of support implemented immediately following Clinical Review in August 2010 • Changes made in 2011 to improve access for clients seeking to return to services, moving away from re-assessment to providing immediate support and counselling	• The degree of change required by ACC was considerable and overall good progress has been made. The implementation of the 16 hours of support and the changes to enable people returning to services has facilitated a smoother pathway for clients. • Progress in addressing the needs of children has been given	• That ACC continue to explore options for appropriate support for Māori and work with suppliers and providers to ensure adequate capability and capacity to respond

Summary of actions taken by ACC to meet recommendations	Commentary on ACC Progress by Reviewer	Recommendations
	priority and good progress has been made in this regard. • More still needs to be done to effectively meet the needs of Māori and adult victims of sexual abuse as children. This latter group often has complex presentations and ensuring smooth pathways into care with people who have the skills and knowledge to adequately respond to needs requires increased sector capability and careful ongoing monitoring.	appropriately • That ACC continue to monitor the access and capability of suppliers and providers to effectively respond to the needs of adult survivors of childhood sexual abuse
Recommendation 10: Work with the sector to evolve pathways to Massey Guidelines with special attention to needs of children and adolescents. Clarify how clients in need can get more than 16 support sessions		
• Full service redesign developed with focus groups, including a client experience group, and road tested with the sector, the sensitive claims advisory group and professional bodies • New service clearly details: o Getting Started o Early Planning o Support to Wellbeing (Short-term) o Supported Assessment o Support to Wellbeing (Long-term) • Maintaining Wellbeing (pre-approved maintenance sessions for up to 3 years)	• Good progress has been made by ACC in evolving the pathways. • ACC has paid appropriate attention and made good progress on ensuring that the needs of children and young people are better met.	• That ACC continue to review the evidence base on effective practices in supporting people through recovery from the impact of sexual abuse and assault and ensure that future service changes align with this evidence
Recommendation 11: Clients should be able to be assessed with the usual counsellor attending and contributing to treatment goals and plan		
• Introduction in 2011 of funded sessions for counsellors to attend the assessment, at the client's discretion • ISSC contracting process has increased the pool of assessors, applied broader criteria for who can perform the assessment and developed a Supported Assessment service type • Under the ISSC, the Supported Assessment is an integrated combination of assessment and support sessions managed by the same service provider or providers (within the same supplier arrangement). Time is allowed for a post-assessment debrief and to agree the assessment report content with the client • The Supported Assessment is not intended to offer a snapshot view of the client but is intended to support and enhance the	• The change in policy to enable counsellors to attend the assessment processes has been positively received by all concerned including the assessors. • ACC has made changes that support a more supportive and therapeutic approach to the assessment processes however this does remain an area of concern for some therapists as the level of engagement does depend on the assessors • Ensuring robust shared treatment goals and plans will be an ongoing requirement for effective intervention and ACC will need to monitor that the integrated supplier context adequately supports integrated assessment and support sessions.	• That ACC monitor that the ISSC contracting approach delivers a more integrated approach to assessment and support for all clients

Summary of actions taken by ACC to meet recommendations	Commentary on ACC Progress by Reviewer	Recommendations
client's recovery		
Recommendation 12: Make cover decisions within 6 weeks where possible; continue support sessions until cover decision is made		
• The Service Level Agreement under the ISSC gives ACC maximum of 10 working days to make a cover decision • Sessions are built into the Supported Assessment to allow for the continuous provision of support while the cover decision is pending • Additional continuity sessions can be provided where ACC requires more time to make a cover decision • Claims management process and system changes will help ensure timely responses	• Excellent progress has been made in ensuring access to immediate support • ACC is continuing to explore ways of making early cover decisions where this can be done • ACC has provided a range of mechanisms for ensuring that support continues while cover decisions are being made	• That ACC monitors the impact of the ISSC implementation to ensure that no gaps in cover and access to support occur
Recommendation 13: Provide means of including family and whānau in therapy especially for children		
• Since the introduction in 2010 of support sessions, ACC has promoted the inclusion of family and whānau in support sessions, at the client's discretion, via operational guidelines and service provider training • ISSC features a Family and Whānau service type, which provides up to 10 sessions of support for clients' family, whānau and support people. • ACC policy has allowed for this entitlement since 2012	• The inclusion of family/whānau in treatment sessions with young people was introduced early and has had a positive impact within the sector • The introduction of Family and Whānau services has been positively received	• That ACC continue to monitor that providers ensure a range of options are available to adequately support family/whānau in therapy particularly for children
Recommendation 14: Independent review and monitoring on progress of implementation		
• ACC has developed: o Service Assurance Framework o Sensitive Claims Outcomes Framework (DoView) o Full systems reporting o Regular, on-going engagement with suppliers and service providers o Regular, on-going engagement with the sector and Government agencies o Client satisfaction survey o Clear, long-term sensitive claims governance structure and lines of accountability	• ACC commissioned independent monitoring and reporting on the progress made on implementing the recommendations of the Review Panel • ACC has built regular feedback and review into its approaches • ACC has increased it engagement with the sector and the range of feedback mechanism available to clients	• That ACC continue to strengthen its client and sector feedback mechanisms • That the ACC board receive regular six monthly reports that include sector feedback, on the implementation of ISSC so that it can be assured that adequate progress is being made