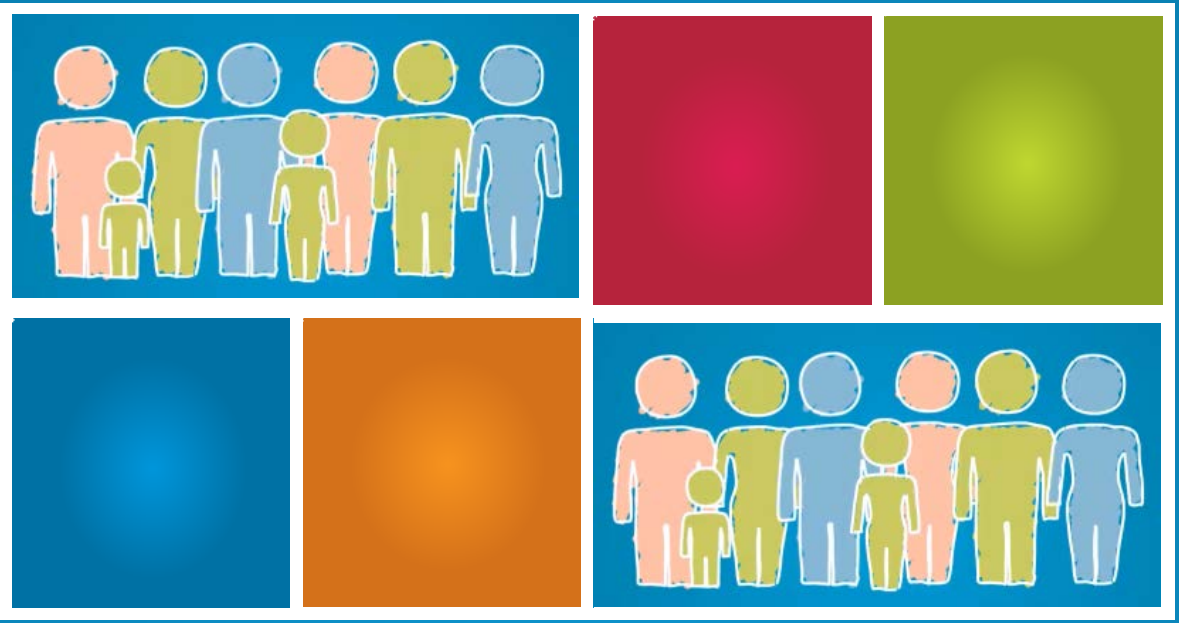
Integrated Services for Sensitive Claims

Supported Assessments



Contents

Introduction

Approved assessors reported in the tender process that they have the academic qualifications, skills and experience to carry out comprehensive psychological/psychiatric assessments. Specifically, approved assessors stated that they are knowledgeable, skilled and experienced in

- Assessment, classification and formulation
- Abnormal Psychology
- Skills in one or more models of therapeutic intervention
- Human development
- Knowledge and skills in using psychometrics (if using psychometrics)

Therefore, the information provided here is not aimed at teaching providers how to carry out mental injury assessments, but rather to clarify those aspects of the assessment which are relatively unique to ACC, and the administration and scoring of the WHODAS 2.0 and the Personal Wellbeing Index. This information should be read in conjunction with the guidelines attached to the ACC6429 Supported Assessment – Adults and ACC 6424 Supported Assessment – Child and Young Person.

Assessors new to doing mental injury assessments are required to have one-to-one supervision from ACC experienced assessors for the first two years post awarding of the supported assessment component of the ISSC contract. Some people who have been accepted as assessors may now feel that they do not have the requisite skills. If this is the case, it is important to inform ACC as ACC does not want providers to be practicing outside their areas of competency and it is important that clients receive high quality services.

What is a mental injury?

Mental injury is a legal concept associated with environments where establishing that psychological problems experienced by an individual are linked to specified events will result in the individual being entitled to some kind of compensation or other entitlements.

ACC is an example of this kind of environment.

Accident Compensation Act 2001

A mental injury is defined as:

"a clinically significant behavioural, cognitive or psychological dysfunction" (s27).

Causal Links

Within the Sensitive Claims Unit, for a client to receive cover and entitlements, the mental injury must be significantly linked to specific sexual offences described in the Crimes Act 1961. There does not need to be a physical injury for a mental injury of this type to be covered. However, **there must be a mental injury** and that **mental injury must be significantly linked to the sexual abuse events. The requirement for cover is that the sexual abuse is a significant (material) cause of the diagnosed mental injury (ies)**

Mental injuries, causal links and the supported assessment

The purpose of the supported assessment is to establish:

1. A comprehensive assessment of a client's cognitive, psychological and behavioural functioning from which appropriate intervention can be planned and delivered

2. The nature of any clinically significant behavioural, cognitive or psychological dysfunction experienced by the client.

3. The extent to which there is any causal link between the sexual abuse event (s) reported and the clinical dysfunction assessed as being present.

You will need to consider:

- The onset or development of the presenting symptoms and how soon after the sexual abuse events these developed.
- How the client's difficulties have developed and progressed within the client's wider context to be able to identify and fully consider all factors that have contributed to the presentation.
- Whether or not there are/were other developmental or environmental factors that might explain the development or severity of any presenting symptoms

(e.g., attachment issues often result in personality difficulties regardless of whether sexual abuse has occurred).

- Whether the extent and severity of the difficulties experienced is greater or lesser than you would expect given the sexual abuse events reported and to what extent other non-sexual abuse related factors have contributed to this.

Formulation

Formulation is different than diagnosis in that if diagnosis provides the answer to the question “what mental injury(ies) is the client experiencing?”, formulation provides the answer to the questions “why has the client developed these difficulties” and “what is maintaining them?”

The formulation requires a narrative summary of all of the factors, both positive and negative, specific to an individual client that clearly explains why and how the client has developed the difficulties they are currently presenting with and why these difficulties have persisted. It should also include discussion of any barriers to recovery that might exist.

Formulations will likely range from simple to complex depending on specific client circumstances and should provide an explanation for all of the presenting difficulties such that it is clear which have been caused by the sexual abuse, which have not, and which act as rehabilitation barriers.

Below are some examples of simple and complex formulations for adults and children.

Example One:

“Ms C reported no early childhood difficulties, abuse or trauma and positive parental attachment and sibling relationships. Throughout her life she has been high functioning having achieved well academically and occupationally with no evidence of any mental health, relationship, or behavioural difficulties up until the rape that occurred in her work car park in late 2014. Since that time she has experienced strong intrusive imagery and thoughts of the rape, has sought to avoid any activities or situations that remind her of this event, and has experienced intense anxiety and panic attacks when she has been unable to do so. As a result she has avoided returning to work, has avoided sexual intimacy with her partner and has increasingly managed symptoms of anxiety via benzodiazepines prescribed by her GP. Additionally she is feeling increasingly hopeless about her situation and capacity for recovery. It is considered that the avoidance via actual avoidance and avoidance via the anxiolytics is acting to maintain the intensity of all current symptoms.”

This formulation would support a diagnosis of PTSD significantly linked to sexual abuse in the Section 7 Opinion section of the Supported Assessment report.

Example Two:

"James is a four year old Pakeha male who was referred by ACC for an assessment as to whether contact with an alleged sexual offender had resulted in a mental injury secondary to a sexual assault. James 's mother noted his increased difficulty regulating his emotions and sexualised behaviour and this heightened her concern that James had been sexually assaulted. James did not disclose sexual abuse when interviewed in April 2014. The assessment included an interview with James's mother, an observation of James, interviews with early childhood teachers and James's ACC counsellor, and completion of psychometric questionnaires.

James lives with his mother, his mother's partner and his two older brothers and one older sister. His parents separated a year ago and he has regular contact with his father and his father's new partner although there has been acrimony between the two sets of parents, and inconsistencies in their approach to parenting the children. The family have experienced considerable stress and change over the last 12 months including the parental separation, moving house, a change in care giving arrangements as James's mother returned to work, and the introduction to and ultimately living with his mother's new partner. At the time of the referral to ACC, James's mother was concerned about his frequent tantrums, non-compliance, social withdrawal and reports of sexualised behaviour. These issues resolved with counselling support and intervention. Over the last three or four months, there has reportedly been a regression in his behaviour at home but not in any other settings. James's mother continues to be concerned that the recent regression is directly related a sexual assault by the alleged perpetrator.

The current assessment suggests the behaviours reported are an age appropriate response to the stressors and considerable change the family and James have experienced over the last 12 months. While concerning for the family, these behaviours do not meet the threshold of a mental injury. James's positive response to the counselling and support provided to date would suggest that if there has been any sexual assault, the support and intervention received to date has enabled the resolution of any difficulties associated with the experience. James will likely benefit from any ongoing efforts by his parents and step-parents to resolve the issues that underlie some of the stressors impacting on the family. These efforts would be supported by attendance of a parenting programme that focuses on strengthening relationships and helping children to better manage their feelings and behaviour."

This formulation would support an opinion of no mental injury significantly linked to sexual abuse in the Section 7 Opinion section of the Supported Assessment report.

Example Three:

"Mrs X is a 47 year old mother of three teenage children and reports poor relationships with all three who she lost custody of at various points in their childhoods. She presents with a history of severe neglect and abuse by her parents who were substance dependant and heavily involved in gangs and an offending lifestyle. In this context she was subject to and witnessed severe acts of physical violence throughout her childhood and early adolescence when she was "passed around" her parents and wider family and at times coming to CYFS attention. She was also subject to frequent sexual abuse involving three discrete episodes by three perpetrators when she was aged 4-5 years, a single event when aged 7 years, and ongoing abuse when aged 7-12 years.

Mrs X noted that she had become sexually active on a consensual basis in her early teens, had spent a period working in the sex industry when aged 13-15 years, and had been introduced to cannabis by cousins when aged approximately 10yrs and had used this more or less ever since to manage negative affect, calm herself and as a recreational activity. She also noted that she had been drawn to "bad boy" partners who had been violent but not sexually abusive. In this context she noted three significant violent relationships. Her most recent relationship has been with a cannabis dealer and, although he has not been violent, they argue often and she considered that she had often sought to "goad him" into hitting her to prove that he cared. His responses had been to simply leave the house which in turn provoked increased emotional dysregulation and some episodes of self-harm. She reports strong anxiety at the thought of losing him.

Ms X reported symptoms of PTSD with strong visual and auditory intrusive symptoms that almost exclusively arise from an incident when she was quite young and witnessed her father and three other men beat a man to the point of unconsciousness with softball bats and then beat the victim's dog to death with the bat.

The current assessment supports diagnoses of PTSD, cannabis dependence, and borderline personality disorder. It is the assessor's opinion that the PTSD is not significantly linked to the sexual abuse but is clearly and significantly linked to the childhood experience of violence and has been exacerbated by subsequent exposure to violence. Similarly the cannabis use is not considered to be linked to the sexual abuse and appears to have developed and been maintained as a combination of familial propensity for substance abuse, parental and familial modelling, the pleasurable effects associated with use, and the distress and agitation associated with not using. With regard to the borderline personality disorder it is considered that the sexual abuse is a significant factor in the development of this albeit that it is not the only significant factor with the violence, neglect, and poor attachment also acting as important causal factors. Although neither the PTSD or cannabis use is linked significantly to the sexual abuse, both act as barriers to treatment for the personality issues and will likely need some addressing as part of treatment for this."

Example Four:
"Ms S is a 15 year old girl who presents as the oldest of three children with a history of having been raised in an environment where her father was demanding and verbally abusive, highly critical of her mother, her and the younger children; and her mother was supportive but passive and modelled and encouraged the children to try their hardest not to upset their father. Ms S is reported to have been an anxious child who nevertheless excelled academically and had a number of good friends. At age 11 she appears to have withdrawn socially and exhibited clear symptoms of depression following an incident in which she was raped by the teenage son of a family friend. She does not appear to have ever fully recovered from this with sub-threshold symptoms of depression present ever since but has been prone to more severe episodes of depression whenever things have gone wrong. (e.g., after the separation of her parents when she was aged 12 years, and when she did not achieve the grades she was expecting at the end of last year).

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

The current assessment supports diagnoses of Persistent depressive disorder, anorexia nervosa-restricting type, and obsessive compulsive personality traits. The persistent depressive disorder is opined to be clearly and significantly linked to the sexual abuse event albeit that the discrete episodes of major depressive disorder may not be. The obsessive compulsive personality traits that appear to be developing and the anorexia-nervosa are not considered to be significantly linked to the sexual abuse event reported. Rather they appear to have arisen out of the low self-esteem and anxiety about negative evaluation that have developed as a result of her father's critical and demanding interpersonal style and her mother's modelling and encouragement of unhelpful perfectionistic strategies for responding to this. Both disorders appear to be the result of her use of over-controlling, perfectionistic strategies to avoid anxiety and negative outcomes such as failure or criticism by controlling her environment."

Symptom Validity

Symptom validity should be considered in any and every assessment. Issues to consider are:

- whether or not there are any inconsistencies/differences between the various sources of information obtained from third parties, from self-report by the client, from psychometrics, from your own observations of the client,
- explanations for these inconsistencies/differences,
- unusual presentations or unusual amounts of distress/lack of distress given the reported difficulties.

Reporting on symptom validity

When you have no concerns:

It is not best practice to simply say “There were no symptom validity issues”. Appropriately you might say:

> “There were high levels of consistency between Ms X’s presentation during the current assessment, her self-reported description of symptoms and their history, the collateral information provided by her GP and counsellor, and the information from the psychometric assessment. Additionally the DAPS validity scales did not indicate any areas of concern associated with under or over reporting of symptoms. On this basis there did not appear to be any basis for current concerns about symptom validity.”

When some concerns are noted:

Clearly note the nature of the concerns:

> Example:
> “There were some inconsistencies noted between Ms X’s presentation during the current assessment, her self-reported description of symptoms and their history, the collateral information provided by her GP and counsellor, and the information from the psychometric assessment. In particular her self-report at assessment indicated events that were significantly more intrusive, and occurring over a significantly longer time period than previously reported. Similarly she reported significantly higher levels of distress than was evident from the previous reports to her GP and previous providers.”

Note any discussion of the inconsistencies with the client and their explanation for these if any:

> Example:
> "When asked about the differences between her descriptions of the events at the current assessment as compared with the reports at earlier assessments Ms X noted that over the years, and as she has felt more angry and less ashamed about the events, she has found it easier to disclose the full extent of the abuse and its impact on her life".

> Example:
> "When asked about the differences between her descriptions of the events at the current assessment as compared with the reports at earlier assessments Ms X became upset and angry stating that she felt that her personal integrity was being questioned. The matter was not pursued further by the assessor".

Be cautious about offering black and white opinions about the causes for symptom validity issues as it is typically difficult to establish clearly that symptom validity issues arise out of deliberate attempts to mislead (e.g., malingering, factitious disorder), rather than out of unconscious symptom production (e.g., somataform disorder), personality characteristics, or "cries for help". Instead consider all the possibilities and outline your hypotheses regarding factors/processes other than the index injury/event that may be contributing to the client's current presentation and behaviour.

> Example:
> "It is noted that Mr X reports significant distress arising from his perception that over the years others have not believed his reports of the abuse, or have been dismissive of the impact that this has had on his life noting that he has even had responses that consider he had "got lucky" at an early age and that other adolescents may have been jealous of his early sexual activity. On this basis although it is possible that the symptom validity issues noted reflect deliberately exaggerated reports of his abuse and its impact, it is considered more likely that these arise from his expectation that no one will listen, believe him or assist him unless he is able to persuade them of how bad and damaging the abuse was."

Outcome Measures

Two outcome measures are being used with the Integrated Services for Sensitive Claims (ISSC) contract

1. World Health Organisation Disability Assessment Schedule – Second Edition WHODAS 2.0
2. Personal Wellbeing Index – PWI

Purpose of Using Outcome Measures

- To design and evaluate the impact of therapeutic interventions.
- To offer additional services that might be useful where this is possible (e.g., transport assistance, social work, whanau support).
- For better understanding of the client, their situation and pressures.

Both of these outcome measures are appropriate to use with clients regardless of their circumstances (e.g., they can be used with prisoners or hospital in-patients). This is because they are holistic measures that do not consider the cause or reason for the client's difficulties with functioning but are simply a means of establishing that there ARE difficulties. It is also important that administrating clinician does not make any assumptions about whether any particular item will be relevant for a client based on their circumstances. For example it would be easy to assume that some WHODAS 2.0 items about community participation or the PWI item "how satisfied are you with feeling part of your community?" are irrelevant for many prisoners yet, in fact, many will continue to/begin to participate in community activities with community agencies around activities such as education, cultural and religious activities while they are imprisoned. It is recommended that all questions are put to all clients so that they can decide themselves how best to respond to each item.

World Health Organisation Disability Assessment Schedule – Second Edition WHODAS 2.0

The WHODAS 2.0 was developed by the World Health Organisation and based on the International Classification of Functioning, Disability and Health (ICF). It is an instrument for assessing disability in everyday functioning in adults aged over 18yrs. The WHODAS 2.0 assesses the activity limitations and participation restrictions experienced by an individual irrespective of medical diagnosis – physical or mental. This instrument was developed and tested in a variety of different cultural settings

and health populations. The WHODAS 2.0 has been found to be psychometrically robust. A children and young person's version is in the process of being developed.

The WHODAS 2.0 measures six domains with items within domains being rated on a five-point scale ranging from "none" to "extreme" difficulty relating to the last 30 days

- Domain 1: Cognition – Understanding and communicating
- Domain 2: Mobility – moving and getting around
- Domain 3: Self-care – attending to one's hygiene, dressing, eating and staying alone
- Domain 4: Getting along – interacting with other people
- Domain 5: Life activities – domestic responsibilities, leisure, work and school
- Domain 6: Participation – joining in community activities, participating in society

Administration

The version we are asking providers to use is the 36-item self-administered version. The 36-item interviewer-administered version can be used if the client has literacy or fine-motor problems. When a client has a cognitive disability which prevents them from filling out the form, the proxy-administered version can be used.

Self administration takes on average five minutes and the interviewer-administered version takes about 20 minutes. These times are approximate as there is the expectation that the assessor would enquire further if the client reported experiencing significant problems in particular areas.

The WHODAS 2.0 should be administered first in the Supported Assessment or when developing the Wellbeing Plan for those who have not had a Supported Assessment within the last three months. It should also be administered at the completion of treatment.

To administer the WHODAS 2.0, it is highly important that the assessor has **read the manual** and knows how to respond if clients ask questions about particular items. The manual has been distributed to all suppliers but can also be accessed via the following link

http://www.who.int/classifications/icf/whodasii/en/

Scoring

- **Total Disability Score**

There are two forms of scoring: simple or complex

Please use the simple method – the 36-item instrument scoring sheet, simple scoring calculation to obtain the Total Disability score which is expressed as a percentage.

This can be obtained using the above link

- **Scoring each Domain**

Each of the six domains needs to be scored separately

The scores assigned to each of the items within each domain

- None (0)
- Mild (1)
- Moderate (2)
- Severe (3); and
- Extreme (4)

need to be summed and averaged for each domain.

Some domains have four, five, six or eight questions, so ensure that you are dividing by the right number of questions to obtain the average score for that domain.

Please record the average score for each domain and place in the appropriate boxes on the report forms.

Example:

if the item scores on the Understanding and Communicating Domain are 4, 3, 2, 2, 1 and 1, the total is 13.

Because there are six items, you divide this score by the number of items in the domain (6) to get the average score for this domain

13/6 = 2.166 which is rounded up to 2.17.

Qualitative data needs to be provided in reports. What we are asking is for you to describe the quantitative data obtained especially when the client reports having significant difficulty in areas of functioning. It is very important that qualitative data is obtained as otherwise the scores lack meaningfulness for the reader of the report.

Example:

On the Mobility Domain, if a client who is physically healthy reports that he has 'extreme difficulty' in getting out of his home, this may not make a lot of sense unless it was explained by the assessor that the reason he has problems leaving his home is that he has fears that he might be triggered by seeing someone who looks like his abuser outside of his home environment.

Personal Wellbeing Index (PWI)

This quality of life outcome measure assesses subjective wellbeing. The PWI Scale contains seven items of satisfaction, each corresponding to the following domains:

- Standard of living
- Personal health
- Achieving in life
- Personal relationships
- Personal safety
- Community connectedness; and
- Future security

There is an optional spiritual/religious domain item. This item is optional because it did not make any unique contribution in the Australian population but clinically it may have relevance for the New Zealand population.

There is also a global question which asks about Client satisfaction with life as a whole. This is **not** used in the scoring but it adds useful clinical information.

Parallel forms of the PWI have been developed for population sub-groups.

- **PWI-A**
  Designed for use with the general adult population, aged at least 18 years

- **PWI-SC**
  Designed for use with school-age children and adolescents. If a child is developmentally incapable of completing the PWI-SC, this should be noted and the scale should not be administered.

- **PWI-ID**

Designed for use with people who have an intellectual disability or other form of cognitive impairment. The administration of this scale is restricted to psychologists who are experienced in the administration of psychometric instruments. The PWI-ID differs from other versions in that it incorporates a very detailed “pre-testing” protocol to determine whether, and to what level of complexity, the person is able to use the scale

Note the PWI-PS (Pre-school) will not be used.

It is important that the respective manuals are read carefully. Manuals and the forms for PWI versions have been provided to suppliers but can also be obtained from Deakin University website

http://www.deakin.edu.au/research/acqol/iwbg/wellbeing-index.php

These scales can be administered in a verbal or written format. Significant others must not respond on behalf of the client as it is important that the client assesses his/her own subjective well-being.

While the manual says the caregiver must not be present, ACC considers that it is appropriate for a client to have the person of their choice in the room.

Scoring

When scoring, convert the score out of 10 to one out of 100 by moving the decimal point to the right – e.g. 7 becomes 70% or an average score of 6.56 becomes 65.6%. Data can be reported at the level of individual domains and averaged to form the Personal Wellbeing Index (PWI). However, the **Happiness with Life as a Whole** and **Spirituality or religion** is not used to calculate the PWI and is reported separately. The seven items that follow **Happiness with Life as a Whole** are totalled and divided by 7, 135/7 = 33.57.

Please provide qualitative data to explain and/or elaborate on the quantitative information obtained.

Getting specialist BAP support/advice

The Branch Advisors Psychology/Psychotherapy (BAP's) are always happy to be contacted to provide support and answer questions. It is useful to know that all of the BAP's are engaged in other clinical work outside of ACC and all work part-time as a result. If there is a specific BAP you wish to talk to the best way of doing this is to ring the help desk number 0800 735 566 and ask to be put through to that person. You may need to ask to be put through to leave a message if you have rung on a day that the person doesn't work. If you don't mind who you talk to then you can simply ask to be put through to any of us.