Aotearoa New Zealand Association of Social Workers Inc

Aotearoa **N**ew **Z**ealand **A**ssociation of **S**ocial **W**orkers (ANZASW)

Submission to the

Independent Clinical Review of the ACC Sensitive Claims Clinical Pathway

Lucy Sandford-Reed
Chief Executive
ANZASW
DX Box WX33 484
Christchurch

DDI: 03 349 0190 x 4
Mobile: 027 349 0190
Lucysandford-reed@anzasw.org.nz
www.anzasw.org.nz

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Introduction

The ANZASW welcomes the opportunity to comment on the operation of the Sensitive Claims Clinical Pathway.

The principle of social justice and human rights are the foundations of New Zealand social work practice. In dealing with clients, social workers take a holistic approach, recognising the complexity of interactions between human beings and their environment. Identifying the capacity of people to be affected by and to alter the multiple influences upon them, (including bio-psychological factors), social workers seek to empower and liberate people to enhance their well-being. Counselling is an identified social work intervention.

Following a membership wide consultation the following comment and evidence has been provided.

General

Sexual abuse is a criminal act. The clinical pathway requirement that an applicant must have a clinical diagnosis of a mental illness associated with the historical abuse is in itself a further institutional abuse. It continues the victimization of these individuals, potentially labelling them for their lifetime. It is not considered helpful in their rehabilitation.

The introduction of Clinical Pathway brought a period of unpredictability and has had a detrimental effect on clients accessing treatment/services and providers in determining their level of service provision. There has been uncertainty as to whether existing treatments would continue to be funded. Greater concern exists that the much needed counselling for victims of sexual abuse is now difficult to access. The evidence provided points to a protracted process, becoming lengthy with many reporting delays at different stages. These would appear to arise from difficulties in timely access to the clinical workforce required to undertake assessments.

Enabling claimants and clients to seek appropriate assistance from ACC

The new pathway places unreasonable barriers on clients accessing the assistance that is clearly advocated in the Massey Guidelines and further severely limits client choice.

ACC's reliance on a clinical DSM IV diagnosable mental illness as the access criteria is a considerable barrier. It is considered too narrow and inappropriate. Limiting access to services to those clinically diagnosed with a mental illness due specifically to sexual abuse raises a number of issues.

It will exclude many that have suffered such abuse but who may not necessarily present with these symptoms. Examples include children requiring psycho-educative work on issues of shame etc. Similarly adults are overcome by guilt, shame, lack of self esteem and are not able to function but do not present with a mental illness and are also excluded under the Pathway yet have a very real need that is related to an episode/s of sexual abuse.

Evidence indicates that the presence of a dysfunctional family background at childhood, or the existence of co-morbidities such as drug abuse, have been cited as reasons for declining application as their existence deters establishing a direct causal link between the mental health illness and the sexual abuse.

This is a complex area and such an approach is too simplistic. It acknowledges that exposure to factors such as sexual abuse in childhood increases the incidences of risk behavior by the individual in adulthood.[1].

Box 1: Access to appropriate assistance

Background: 25 years – currently in prison – 2 single incidents of abuse – age 6/7 and 14. Unstable family background – lack of care and protection. Coped with affects of the abuse through escalated drug use since 14 years old. In prison due to drug related offences.
29/9/09 – cover report sent to ACC
10/12/09 – letter from ACC – internal panel decided to decline claim – 'SA (not) material cause of the current presentation but most likely causes are the other life stressors that were present in this client's life' noted 'long history of disordered behaviour, a dysfunctional family environment, a history or alcohol and drug use starting at an early age'
23/12/ 09 –client applied for review
Feb 2010 – ACC (phone call to client) asked her to withdraw application for review and offered a psychiatric assessment. Client declined to withdraw the application and when I rang ACC on her behalf was told that she would be assessed within 1 month. When last seen at the end of April 2010 she had not received any notification of a review.

Source: Counsellor, Canterbury

The need to undertake such a psychiatric assessment will deter some applicants. A private counsellor (Canterbury) relays a case about "*a 14 yr old boy sexually abused by his older brother - when he found out he needed to have psychiatric assessment, he refused to carry on. The Mother was devastated as it took her a month of encouragement for the14 year old to present for counselling in the first place*".

[1]Mullen PE et al. Childhood sexual abuse and mental health in later life. The British Journal of Psychiatry 163: 721 – 732 (1993)

The reluctance to be labeled with such a diagnosis is real. An example given is women who have experienced sexual abuse and recognise behaviours that are re-triggered when with the birth of a newborn. Of the many concerns they may have at this time, one is that they would not wish to have a psychiatric assessment made that would potentially enable others to challenge their fitness to parent properly.

The use of the DSM IV diagnosis is further detrimental as it will impact on other parts of the client's life. Once such a mental health diagnosis is recorded, clients are likely to encounter difficulties in terms of job opportunities, accessing mortgages, insurance etc.

The reported sharp drop in accepted new cases following the introduction of the pathway (between October '09 – January '10 where only 9 claims were accepted from 152 applications)[2] is echoed in evidence submitted to ANZASW which show disquieting reductions in referral rates to providers (Box 2). These providers reflect a similar trend to that of the Ashburn Clinic (Dunedin) as highlighted by Hon Annette King in a Parliamentary debate (06/05/10).

Box 2: Referral rates decreasing

The Catholic Social Services (Invercargill) has seen referrals reduce from 10 new referrals in the period Jan – June 2009 to only 2 new referrals in the same period in 2010.

A long-serving ACC approved counsellor has seen her referrals fall from averaging 2-3 referrals a week for the last 7 years, to only receiving 1 referral since October 2009. As a result, ACC is losing the services of an experienced counsellor as it is no longer viable for her to offer this service to ACC. (Otago)

In summary, the use of this diagnostic tool acts as a deterrent for some seeking appropriate treatment and is an inappropriate tool to use to identify those who have experienced sexual abuse and require treatment. In essence it continues the victimization of the individual.

It is important also to emphasize that in order that claimants feel safe in participating in the process, appropriate training and cultural awareness must be assured across the assessors and the clinicians that they may see.

[2] Martin van Beynen. Review of ACC sexual-abuse claims The Press newspaper (08/01/10)

Timely triage of new and reactivated claims

Given lack of timeliness in other areas highlighted in this submission, we would expect there to be a similar situation in this area.

Timely collection of Clinical and other relevant information relating to the event and the mental injury from sexual assault/abuse

It is reported that a large number of applications are delayed due to being referred for additional information or assessment. This further extends the delay between application and commencement of treatment which is considered to be clinically unsafe for clients. The range of information requested is considered to be too wide and often in relation to unrelated conditions.

Timely assessments for clients who require this

The ACC's preference that assessments are undertaken by clinical psychologists and psychiatrists is in itself causing many of the delays. Evidence has been provided that assessments are being significantly delayed due to an inability to access such clinicians. Despite requests, ACC has repeatedly refused to provide centers with lists of local psychologists or psychiatrists who are willing to conduct assessments.

The exclusion of allowing appropriately trained social workers with qualifications in this specific area to undertake assessments is therefore disadvantaging applicants. Appendix 1 illustrates the pathway for Registered Social Workers to be recognised a health professionals
Box 3 provides examples of where delays in accessing a psychological assessment are occurring

Box 3: Delays in undertaking assessment

My client submitted a claim in December 2009 and still has not been seen by a psychologist (04/06/10). Not only is this detrimental to my client but it is also particularly damaging for her children. We became involved with the family as there were serious care and protection concerns over her ability to parent the children without physical and verbal abuse. Professional opinions were sought from counsellors she had seen before and a psychiatrist she was assessed by and their opinion was that before she could begin to parent appropriately, she would need to deal with the effects of the sexual abuse she had suffered as a teenager. To date, she has not heard from ACC about seeing a psychologist to assess her claim (even though she had previously been assessed as eligible some years before). When I made enquiries I was informed that there were no psychologists available at that time in the area.

Source: Social Worker, Wairarapapa

Client – wanted to return to counselling
6/11/09 – sent letter to ACC to return to counselling
26/11/ 09 – letter from ACC – referred to be reviewed by internal psychologist
June 2010 – rang ACC – client referred for DATA assessment (clinical psychologist) – was advised that this should be happening shortly!! (Source: Counsellor, Canterbury)

Client – wanted to return to counselling
18/1/10 – sent letter to ACC requesting to return to counselling
27/1/10 – letter sent to client informing her she will be reviewed by clinical psychologist
Client has not informed me of any further progress since then (06/06/10) (Source: Counsellor, Canterbury)

Client – wanted to return to counselling
12/2/10 - sent letter to ACC to request a return to counselling
Client was informed that she was referred to psychiatric assessment –
4/6/10 - client still awaiting assessment (06/06/10) (Source: Counsellor, Canterbury)

Client – wanted to return to counselling
29/3/10 - letter sent to ACC requesting a return to counselling
27/4/10 - letter sent to client – to be reviewed by clinical psychologist
So far client is still awaiting further progress (06/06/10) (Source: Counsellor, Canterbury)

Source: Counsellor, Canterbury

Box 4: **ACC applicants seeking reviews to declined applications**

Background: 52 year old women – multiple SA during her teenage years. After leaving her alcoholic husband of 31 years (married when she was in her late teens), she became involved with an abusive man – she was referred to counselling due to disclosure at the sex health clinic – displaying a lifelong coping pattern (adapting to the previous abuse)
1/10/09 - Cover report sent to ACC
13/11/09 - letter to client stating 'events over 40 years ago have not caused clinically significant mental injury …'other current life stressors play a significant role in your current presentation.'
December 09 - client sent letter asking ACC for review.
09/03/10 - we rang ACC as there had been no response to application for review. ACC stated application was never received. Client applied again. Client rang me on 25/3 as ACC had asked her to withdraw the application (ACC rang her) and offered a psychiatric assessment instead. Client decided not to withdraw the application and take the offer of an assessment. When last in contact in April 2010 there had been no further progress.

Background: 25 years – currently in prison – 2 single incidents of abuse – age 6/7 and 14. Unstable family background – lack of care and protection. Coped with affects of the abuse through escalated drug use since 14 years old. In prison due to drug related offences.
29/9/09 – cover report sent to ACC
10/12/09 – letter from ACC – internal panel decided to decline claim – 'SA (not) material cause of the current presentation but most likely causes are the other life stressors that were present in this client's life' noted 'long history of disordered behaviour, a dysfunctional family environment, a history or alcohol and drug use starting at an early age'
23/12/ 09 –client applied for review
Feb 2010 – ACC (phone call to client) asked her to withdraw application for review and offered a psychiatric assessment. Client declined to withdraw the application and when I rang ACC on her behalf was told that she would be assessed within 1 month. When last seen at the end of April 2010 she had not received any notification of a review.

Source: Counsellor – Canterbury

Timely claims decisions once information is available (and clinically and legislatively appropriate decisions)

This, too, is an area where there are delays as evidenced above.

Access by clients to appropriate therapies, treatment or interventions including entitlements

Delays between approval and access to service are also occurring. A private counsellor (Otago) reported that their latest client waited 5 months between their appointment with the clinical psychologist to being able to access the counsellor – this is clearly unacceptable.

There is concern at the limited access and client choice when it comes to selecting a clinician.

Regular monitoring of progress against treatment and rehabilitation goals

The use of diagnostic assessments and increased frequency of treatment reports to four weekly, causes unnecessary impediments to treatment and interferes with the building of the therapeutic relationship, universally shown in research (including the Massey Guidelines) to be the primary clinical factor in treatment of the mental injuries caused by sexual abuse/ assault.

Provision of self management and relapse prevention plans

Thoughtful and planned discharge, including plans for self-management were evident prior to the introduction of the Guidelines. The term 'relapse' is inappropriate for this work as clients heal in stages. It infers that either the client or therapist have "failed' to rehabilitate the client. ACC expects an explanation for the 'relapse' under the new pathways, when in reality it is in the nature of the work.

Other comments

Prisons

There is concern that no process is in place to provide assessments for the prison population – a population in which it is recognised that historical sexual abuse is a potential contributing factor to their offending behavior. A prison social worker has highlighted his frustration stating that:

> '*New assessment processes have meant it is impossible for a prisoner to be assessed and any enquires to ACC are met with silence….. So far ACC have failed to provide a list of any psychologists willing to come to the prison and assess the prisoners or provide written documentation to the prisoner as to who and when this assessment will take place. ……. We no longer have any ACC counsellors working at Auckland Prison due to the new mandate of declining all referrals until further assessment.*

Cases were also presented where prisoners' applications have been declined due to ACC not being able to contact the client or the client not responding (Box 5).

Box 5: **Prisoner applications rejected**

Client – wanted to return to counselling
13/01/2010 – letter to ACC to request return to counselling
May 2010 – client informed me in passing that she was going to be seen by clinical psychologist (in prison).
4/6/10 – on ringing ACC counsellor informed that case declined as ACC been waiting to be contacted by client to arrange assessment.

Client – wanted to return to counselling
4/6/10 rang ACC and was informed that client did not contact to arrange a psychiatric assessment – case declined – apparently ACC had a note on file that unsuccessful attempt was made to contact client

Client – new claim
27/1/2010 – information on new claim posted to ACC
4/6/10 rang ACC and was informed that client did not contact to arrange an assessment with a clinical psychologist – apparently ACC had a note on file that unsuccessful attempt was made to contact client – then claim was declined –
I have raised this issue with the prison's social worker, who subsequently tried to contact ACC on the prisoner's behalf. She commented that after waiting for 10min on the phone she gave up waiting for a response from ACC

Source: Counsellor, Canterbury

Clearly, given the restrictive movements and limited freedoms of prisoners, the expectations of ACC are unrealistic in this situation.

The inability to contact the client who is in prison is an unacceptable reason to decline their application -the prisoner has nowhere to go. Similarly, an expectation that clients need to contact ACC to arrange an assessment in such instances fails to recognize that there are no time restraints for prisoners – so there is no need for this. Also prisoners have only limited access to phones and are not able to wait in a phone queue for long.

Payments

Many counsellors are experiencing problems getting payment from ACC for work undertaken for the pathways. A counsellor (Canterbury) "*ACC, under the new pathways, pay for 1 session for a returning client. I have put in 2 such claims recently and both times have not been paid as*

'no decision has been made' – which is irrelevant. Counsellors spend too much time chasing up non-payments".

Summary

It is clear from the evidence that the pathway is not delivering timely and appropriate access to services. Instead of helping these vulnerable people it merely adds to their distress and victimization.

ANZASW considers counselling to be a cost effective treatment which is able to restore survivors enabling them participate effectively in their family, whanau and community and build their resilience. The costs of undertaking assessments, under the current model would be better spent on providing counselling by trained therapists.

Enabling people, adults, children and young people, who have been victims of sexual abuse to access timely and effective interventions, facilitates the building of resilience. This in turn enhances problem solving and coping skills so as they have better control over lives, providing them with voice, choice and hope.

Lucy Sandford-Reed
ANZASW
Chief Executive
17th June 2010