

SUBMISSION

to the

TRANSPORT AND INDUSTRIAL RELATIONS SELECT COMMITTEE

in relation to the

Injury Prevention, Rehabilitation, and Compensation Amendment Bill

From

THE COUNCIL

OF THE



NEW ZEALAND ASSOCIATION OF PSYCHOTHERAPISTS
(Te Roopu Whakaora Hinengaro)

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The New Zealand Association of Psychotherapists (NZAP) presents this submission for the consideration of the Parliamentary Select Committee. We wish to be able to present this in person. Persons presenting will be:

Eric Medcalf and Suzanne Johnson, both members of the Council of NZAP.

1. Preamble

- 1.1. The New Zealand Association of Psychotherapists is a professional organisation which sets, examines and maintains specific standards for the safe and ethical practice of psychotherapy in Aotearoa, New Zealand. It is organised at national and regional levels with an elected Council. It has a membership of 435. The Association provides a qualification process within which provisional members progress to full membership via a programme of supervision, tutorship and guided learning.
- 1.2. This submission is made after consultation within the NZAP Council, with members of the Association and officers and members of other professional bodies. It specifically has the official support of the Aotearoa New Zealand Association of Social Workers and the New Zealand Association of Counsellors.

2. Summary of concerns

- 2.1. The Council of the New Zealand Association of Psychotherapists is concerned about recent changes in the policies of the Accident Compensation Corporation in relation to the acceptance of claims for mental injury for persons suffering mental injury as the result of sexual crimes. **ACC now requires a full psychiatric diagnosis of mental illness** for a claim to be accepted. This pathologises the trauma of sexual abuse and will deter many victims of sexual crime from seeking help.
- 2.2. ACC claims that these changes have been brought about by a legal judgement (Judge Cadenhead in ACC v Geerders; decision number 188/2004) on the definition of mental injury. **Their interpretation is that this judgement requires that mental injury is diagnosed as a mental illness** according to a diagnostic manual used in the field of psychiatry.
- 2.3. In October 2009 ACC decided that it would insist that survivors of sex crimes would have to undergo an assessment and psychiatric diagnosis prior to their claim being considered, **even though this is against their own “Practice Guidelines” (ACC, 2008)**, produced by Massey University Psychology Department (the so-called “Massey Guidelines”).

2.4. It is the assertion of the NZAP that this interpretation of the term “mental injury” as a diagnosed mental illness is against the intentions of Parliament when it defined the term in the Accident Rehabilitation and Compensation Insurance Act 1992. The recent judgement and ACC interpretation has serious consequences for those survivors of sexual abuse and assault who suffer significant impairment as a consequence of criminal acts.. It will severely restrict access to the treatment they need to recover from the psychological effects of sexual assaults.

2.5. **NZAP therefore asks the Select Committee, as it discusses changes to the Injury Prevention, Rehabilitation, and Compensation Act 2001, to clarify the definition of mental injury so that it does not constrain the Accident Compensation Corporation in ways that limit the availability of professional treatment for psychological trauma arising from sex crimes.**

3. Sexual Abuse in New Zealand

3.1. Unacceptably large numbers of New Zealanders have been subject, at some time in their lives, to some form of sexual abuse, or sexual assault. A study by the University of Auckland indicates that about one in four New Zealand women have been victims of child sexual abuse before the age of 15. 23% of women in urban areas and 28% in rural areas experienced some form of sexual abuse as a child. In the majority of cases one perpetrator was involved, usually a male family member, and around half of the women had experienced the abuse on more than one occasion. The average age of the victim at the start of the abuse was nine years old, with the average age of the abuser being 30. (Janet Fanslow et al 2004; Ian Hassall and Fanslow 2006)

3.2. On census night in 2006 the population of New Zealand was 4,027,947, of whom 2,062,326 were female and 561,567 were under 15 years of age. Using the above estimates one can estimate that 488,792 New Zealand women have been subject to childhood sexual abuse. Although statistics have yet to be obtained this is likely to far exceed the total number of claims to ACC for mental injury from sexual crimes.

3.3. “There is an urgent need for the implementation of programmes for the primary prevention of child sexual abuse, and the provision of support and treatment for women who have experienced child sexual abuse.....” says Dr Janet Fanslow of the Auckland University Faculty of Medical Sciences.

3.4. Reporting of sexual abuse is understandably difficult for survivors. Less than 40% of New Zealand survivors of sexual abuse are likely to disclose the abuse (Mullen, 1991), another New Zealand study (Anderson, J. et al., 1993) found that only 7.5% of cases of child sexual abuse were ever officially reported. Other New Zealand research conducted by Dr Kim McGregor (2003) of 191 women with histories of child sexual abuse found that they took 16 years on average before they told anyone about the abuse.

4. Historical Context

4.1. The Accident Compensation Scheme was introduced in 1974 based on the report of the 1967 Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand under the chairmanship of Mr Justice Woodhouse (subsequently the Rt Hon Sir Owen Woodhouse), commonly referred to as the “Woodhouse Report”. That report proposed a “no fault” system based on five basic principles:

- Community Responsibility
- Comprehensive Entitlement
- Complete Rehabilitation
- Real Compensation, and
- Administrative Efficiency

4.2. Although initially excluding “mental shock” in the 1980s the scheme introduced cover for this in respect of victims of sexual crimes and in relation to the mental consequences of physical injury. Initially this was termed “Mental and Nervous Shock” (ARCI Act, 1992), but this was replaced by a consistent use of the term “Mental Injury” (IPRC Act 2001).

4.3. The basis of the ACC scheme is that there is an “accident” and an “injury”, without injury the accident is not covered by the scheme; and an injury, without an accident is similarly not covered.

4.4. In the case of mental injury from sex crimes Parliament decided that one of a number of events included in the Crimes Act as sexual crimes would constitute the “accident”. These crimes are listed in Schedule 3 of the IPRC Act 2001. It was decided that it was not necessary that the assault be reported or prosecuted, nor that there be a successful conviction of the perpetrator; only that the event met the *description* of one or more of these crimes. This was in acknowledgement of the distress and uncertainty of a report to the police, making treatment and rehabilitation available to as wide a group of New Zealanders as possible.

4.5. The New Zealand Association of Psychotherapists asserts that this same principle should apply to a compulsory investigatory assessment process, (by a stranger, not of the claimant’s choice), which has as its aim the proof, or otherwise, of a mental illness. **It is the view of NZAP that the injury should meet the *description* of a mental disorder (in relation to the types and degrees of impairment) in order for an ACC claim to be accepted; not that it has to be actually diagnosed.**

- 4.6. The recognition of mental injury from sexual assaults and abuse as falling within the ACC scheme produced a need for appropriately qualified professionals to be able to assess and provide treatment for mental and nervous shock. Parliament thus created a Counsellors Approval Committee, appointed by the Minister, to appoint people with training in Social Work, Counselling, Psychotherapy and Psychology; together with specialist expertise in sexual abuse recovery, to a list from which survivors could select an acceptable treatment provider.
- 4.7. Initially all claims for mental and nervous shock had to be made via a registered medical practitioner (usually a GP). In the late 1990's ACC allowed claims to be made directly through a counsellor approved as competent under the Accident Rehabilitation and Compensation Insurance (Counselling Costs) Regulations 1992. This was in recognition of the intense distress often experienced by survivors of sexual crimes and the need for appropriately qualified professionals to be able to manage what was often the first disclosure of the abuse to a professional. It also recognised the importance of the relationship with the counsellor and the distress caused by having to disclose to more than one person in the beginning stage of the path to recovery.
- 4.8. **The ACC funding of services to victims of sexual crimes has been the envy of the world. It meets a demand for professional psychological and psychotherapeutic interventions that would not normally be provided in a mental health system that caters for a small proportion of mental health issues in the New Zealand population.**
- 4.9. Until October 2009 ACC accepted claims for mental injury from sexual crimes on the basis of the description of significant impairment by a person described in the regulations as a "Counsellor" (under the regulations this could be a counsellor, psychotherapist, psychologist, social worker or psychiatrist). A diagnosis was only required for claims where the mental injury was severe enough to warrant longer term therapy, and that diagnosis was usually provided by the treatment provider as part of a full assessment and treatment plan, requested after 20 hours of treatment.
- 4.10. This process whereby the injury met a *descriptive* rather than *diagnostic* test recognised the dangers of using a western style diagnostic framework within a bicultural society. It allowed for counsellors using Tikanga Māori frameworks of therapy to avoid compromising their culture by forcing western models on their clients. They could then use Māori models of treatment.
- 4.11. Even in the in the case of physical injury, where diagnosis is an essential step, health providers have been at pains to deliver assessment and treatment interventions within a culturally appropriate framework. In the case of mental injury, particularly when due to sexual abuse, the event is of such an intrusive and disruptive nature that the person's sense of self and identity is profoundly affected. This effect clearly bears on cultural identity - the nature

of sexual contact, the sense of sexual identity, the meaning of sex as well as the significance of sexual organs and other body parts involved in sexual assault are all culturally bound. The equation of this disruption with mental illness compromises recovery rather than assisting it, making culturally appropriate intervention even more crucial. Thus a descriptive rather than categorical account is helpful.

4.12. In October 2009 ACC decided that it would insist that survivors of sex crimes would have to undergo an assessment and diagnosis prior to their claim being considered. It made this decision on the basis of the judgement of Judge Cadenhead in ACC v Geerders (decision number 188/2004) that ACC must have a diagnosis in cases of mental injury, **in contradiction to their own Clinical Guidelines.**

4.13. **The ACC commissioned “Massey Guidelines” (ACC 2008) argues that sexual abuse is a complex life experience, not a diagnosis or disorder.** These guidelines created “Principles of Good Practice” which include the following:

Principle 1: Safety – The safety of the client and relevant others is paramount throughout the therapy process. Aspects of safety include risk to self, risk from others, and risk to others (including abuse or neglect of children). Cultural safety is also important, including ethnicity, religion, gender, age, sexual orientation, gender identity, and (dis)ability (p. 21).

Principle 2: Client focus – A client focus emphasises the importance of tailoring therapy to the client on the basis of a detailed assessment. The most appropriate therapy depends on several factors, including the victim/survivor’s age, culture, type of sexual violence, and the frequency and severity of the abuse. Complex need can be identified early in the process through assessment so that the relevant services are accessed for the client (p. 23).

Principle 3: Therapeutic relationship – The guidelines state that the therapeutic relationship is one of the foundations on which successful therapy rests, and the quality of the therapeutic environment will influence the outcome of therapy. The therapeutic relationship should be evaluated in a cultural context as cultural preferences may be pivotal in developing a positive therapeutic relationship (p. 25).

Principle 4: Culture, identity and diversity – Considerations of culture, identity and diversity emerge as a strong principle for inclusion in the guidelines as culture impacts on therapy. A lack of knowledge and respect for differing cultural world views, systems of belief, social customs and ways of being can undermine the therapeutic relationship. The guidelines state that where possible and favoured by the victim/survivor, a therapist and client match is preferable whether this is ethnic, religious, gender or otherwise. Practitioners also need to have a good understanding of the impact of their own culture as well as that of the victim/survivor (p. 27).

Principle 5: Effects – Sexual violence always affects the victim/survivors in some way, and there is a vast array of emotional, behavioural, social, cognitive, physical, and environmental effects of sexual violence, which differ with each individual. There is a close interplay between coping strategies and effect. Effects may be expressed in a cultural context and may refer to tapu, tikanga, whakapapa, and identity issues. Sexual abuse is a complex life experience, not a diagnosis or disorder, and those who have experienced sexual violence can display a variety of effects at any point in time (p. 31).

Principle 6: Assessment – Assessment is an essential process for understanding the victim/survivor and formulation of a therapy approach. Assessment should use a variety of approaches and sources and is an ongoing process. Important areas to assess include safety, risk, and physical and mental health, as well as relationships, family/whānau, identity and self-esteem (p. 33).

(Summary from Dept.of Women’s Affairs, 2009).

5. Mental Injury and “Clinical Significance”

- 5.1. The 1992 ARCI Act refers to “Mental or Nervous Shock”. It then goes on to define “Mental Injury” as “a clinically significant behavioural, cognitive or psychological dysfunction”. This definition has survived the various changes to ACC legislation (see S 27, IPRC Act 2001) to the present day.
- 5.2. The word “injury” is derived from the Latin “iniurius”, which means “wrong” or “injustice”. In more modern language it can be defined as: “physical harm or damage” or “a wrongful action or treatment” (Concise Oxford Dictionary).
- 5.3. The definition used in the 2001 Act appears to be drawn from the American Diagnostic and Statistical Manual’s (“DSM IV”) definition of a *Mental Disorder*. The Concise Oxford Dictionary defines “disorder” as a “minor ailment or disease”: The full DSMIV definition is as follows:

“...a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (eg., a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.”

- 5.4. There is a clear emphasis here on the *level* of dysfunction, the distress and the loss of freedom.
- 5.5. The Accident Compensation Scheme in New Zealand bases its provision of rehabilitation and compensation on the existence of a degree of *impairment* that has arisen from an injury; impairment that affects a person's functioning in their work, personal and social lives. This impairment will be both an observable and subjectively experienced phenomenon. For the purposes of accepting a claim, ACC require that this impairment is verified by a suitably qualified professional.
- 5.6. **The recognition and description of impairment is not the same as a diagnosis.** Whilst the observable impairment may meet the requirements for a diagnosis of mental disorder it is our contention that it need not necessarily be **actually diagnosed** in order to meet the requirements of the law, only that the professionally observed impairment is of sufficient severity that it is generally recognised as significant.
- 5.7. An example of a professionally accepted measure of impairment is the "Global Assessment of Functioning", or GAF, which forms part of the "multi axial" diagnostic scheme of the DSM IV. This *in itself* it could be sufficient to act as an assessment of severity and as such this kind of assessment should be enough for an injury to be considered "clinically significant" for the purposes of the ACC scheme.
- 5.8. NZAP is not opposed to diagnosis as such, it has its place as long as the consequences are understood and ethically justified. Diagnosis is only one of a range of tools available to the clinician. In the field of mental injury the process of *formulation* is important. This is the process of making sense of a person in terms of their presenting symptoms, causative factors, expectations for treatment and potential outcome. Diagnosis may be part of this. This process often takes place in an early phase of the treatment process, **but only once sufficient trust has been established** for the client to be able to talk openly about their abuse.
- 5.9. It is **trust** that is the cornerstone of effective treatment of mental injury from sexual crimes. **The establishment of a *therapeutic alliance* is consistently the most significant predictor of treatment success in research studies.**

6. The consequences of insisting on diagnosis

- 6.1. The ability to diagnose specific syndromes, illnesses or disorders varies across health professionals. Whilst a general practitioner will have a wide range of skills from which to draw, both in the process of diagnosis and the ability to form accurate diagnoses, they may sometimes refer to a specialist in order to be more accurate. **In the field of mental health there is often disagreement over the exact diagnosis.** Research on diagnoses using the DSM IV has shown that this might be as much as only 1 in 3 agreeing on the same diagnosis (Hersen, M. et al , 2004) ,
- 6.2. Psychotherapists will often have had training in diagnostic processes, whether as part of their formal tertiary training or in their progression to full membership of the New Zealand Association of Psychotherapists, via our “apprenticeship route” (a scheme of professional development through supervision, tutorship and guided education) . This may not necessarily be restricted to the American “DSM”, but may also include the World Health Organisation International Classification of Disease (the “ICD”) and the use of various assessment tools (for example the Beck Depression Inventory and the Trauma Symptom Inventory created by John Briere, a world expert in this field).
- 6.3. The place of diagnostic assessment in the process of treatment of mental injury can be important, most especially where the mental injury is severe and requires long and complex therapy. However, the first task of the clinician is to establish trust. The survivor of sex crime, whether as an adult or as a child, will frequently have had their trust in others severely damaged. Most sexual abuse (particularly in childhood) occurs in situations where the abuser is known and trusted.
- 6.4. NZAP asserts that to require a diagnosis in the first stages of disclosure and seeking help is both **inhumane** and a deterrent to engagement in a therapeutic journey; **NZAP therefore asks Parliament to change the definition of mental injury.**
- 6.5. A diagnosis of mental illness has repercussions. Whilst we wish that it were otherwise; a diagnosis of mental illness is still a stigma that has consequences in employment, for insurance and socially. **To be forced to have a diagnosis in order to receive help is in itself a form of injury, mirroring the process of coercion that is central to sex crimes.**
- 6.6. Reports from members of NZAP, other professional bodies and community agencies of the first weeks of ACC’s new policy are that the number of claims has dropped considerably, with victims of sexual crimes being reluctant to face a process where they have to be given a diagnosis of mental illness in order for them to receive the support and treatment they need.

6.7. We also understand that there is a crisis of availability, with both ACC and claimants finding it difficult to find suitably qualified clinicians (who should be both qualified in psychiatric diagnostic skills and have significant recent experience in the recognition and treatment of sexual abuse psychological trauma).

6.8. We also understand that ACC has a publically declared policy to reduce the number of so called “Sensitive Claims”. **This is not via their statutory duty to promote prevention; it is by a deliberate policy of making it more difficult for people to gain treatment and rehabilitation.**

7. Proposed change

7.1. NZAP suggests that the definition of Mental Injury be changed to:

7.1.1. A significant impairment in everyday cognitive, behavioural, emotional, psychological or social functioning that has been described by, and is amenable to treatment from a suitably qualified health provider; and which, following treatment, would normally improve to a degree that is over and above any improvement that would be expected to occur naturally over time.

7.2. This would enable a *description* of the impairment to stand as a sufficient proof of mental injury; in the same way that a description of the criminal act is sufficient, rather than a prosecution.

7.3. Whilst the ACC processing of sexual abuse claims has not been perfect this change would at least, once again, enable easy access to a process of treatment and rehabilitation for victims of sexual crimes who suffer psychological trauma.

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