

Eric Medcalf to Dr Peter Jansen (ACC Clinical Pathways)

I write in response to the draft clinical pathway promulgated by ACC on 4th September.

I am a registered psychotherapist, with some 25 years of post-qualification practice. Apart from my psychotherapy qualifications I am also a qualified social worker and have a business degree. I have worked most of my life in the public sector, including 5 years as a Clinical Advisor to the Sensitive Claims Unit. I have been in private practice for 8 years and, although not “approved” by ACC for ACC funded work I supervise ACC approved counsellors, who are, by training, counsellors, psychotherapists and clinical psychologists. I am a member of the NZ Association of Psychotherapists and sit on their Council; and also of the NZ Association of Counsellors, of which I am the Convenor of their Ethics Committee. This, however, is my personal submission.

As a preamble to this submission I would like to say that I think that the ACC system of support for survivors is the envy of the world. Although poorly researched, anecdotal evidence is that the work has huge benefits for the mental health of individuals, their families, workplaces and communities. An example would be services to inmates. A large proportion of inmates of prisons are survivors of sexual abuse and the ACC –funded work with the few inmates who receive it has considerable benefits – not just for the mental health of the inmates but also for the prison community (less impulsive behaviour, more realistic reflection on offending) and for the community generally.

I would also like to say that my experience of the Sensitive Claims Unit is that it performs best when staffed by mature people from professional backgrounds. Historically the bureaucracy has broken down when the pressure of work is combined with the personal reactions of the staff in dealing day in day out with often horrific stories of abuse. Any new system MUST be operationalised by a unit which is properly staffed and supported, administratively and professionally. I don't believe that ACC has ever been comfortable with having to deal with sexual abuse and its consequences. Bureaucratic and system failures add the strain of the work, both within ACC and in the communications with health providers and claimants. Lost files, issues about codes that do not exist, wrongly posted files, delays in approvals, delays in payments are administrative problems, these, and providers' reactions to these, fuel mistrust and bad feeling between ACC staff and providers.

Sexual abuse is about a betrayal of trust – any systems that exist to support work that treats the effects of such abuse need to be permeated by trust.

At present there are clear issues of inequity in ACC's provision of services to sexual abuse survivors. This is particularly so in the area of services to Māori and to children, where there is a paucity of ACC approved counsellors with the necessary skills and cultural knowledge. For many years the professional associations represented on the “Sensitive Claims Advisory Group” (SCAG) have lobbied to make a difference. A set of Māori Competences has sat gathering dust on ACC's shelves since the early 1990s. These had the potential to enable many more Māori counsellors

to be approved to do sexual abuse work. Proposals to improve services to children have risen and fallen as personnel change and ACC have diverted to new (bureaucratically and politically driven) priorities.

I have several points to make about the new system.

1. I do not believe that a DSM IV diagnosis is necessary. My reading of the law is that the injury has to be **diagnosable**, not that there is a diagnosis. The description used in the Act is taken from the definition of mental disorder in the DSM, it is not a list of diagnoses. This is a parallel to the “accident” needing to be covered by the **description** of a Crimes Act crime (as listed), not that a crime has to have been committed (which can only be determined in a court). If a counsellor just provided the Crimes Act description that would be the same as providing just a diagnosis. I cannot imagine ACC accepting a claim on the basis of a single Crimes Act section and a DSM diagnosis without more detail. So it is the description of the event (“accident”) and its mental consequences that are important. Diagnosis is notoriously unreliable in the field of mental health, with researched inter-rater disagreement (.59 for PTSD, .38 for Dysthymia – Fliess’s Kappa see: Hersen, M., Hilsenroth M.J., and Segal, D.L. (2004): Comprehensive Handbook of Psychological Assessment: Personality Assessment. Wiley.)
2. Two hours is insufficient for the initial contact. Often first contact will be after a long period of anxiety for the client, they may find that the mental consequences have become too much for themselves, and their relationships. This may be the first time that they have told about the abuse, and such telling may be accompanied by defence reactions such as dissociation, which the counsellor must manage in a clinically and ethically appropriate form. For some even four sessions might not be enough. I remember a client who, after telling, sat with her back to me for four sessions before she could continue. I had to help her to contain the affect that emerged on telling – it would have been abusive for me to push her to tell more or to undertake a formal diagnostic examination.
3. I understand the need for ACC to know that there is an “injury” as defined in the act. I also understand that some counsellors may not be very good at communicating their conclusions to ACC. I have a few suggestions:
 - a. That ACC identify those counsellors whom they feel they can trust to understand ACC’s rules about acceptance of a claim and allow them to accept referrals and work with the client, only communicating with ACC after, say, 20 sessions – at that point their conclusions about acceptability of the claim would be randomly monitored.
 - b. That ACC undertake a round of training for their providers in the requirements for cover and the ways in which information should be communicated to ACC. (I am aware that some counsellors may provide more than ACC require whilst others provide less)

- c. Once trained these latter counsellors are gradually given “trusted” status.
 - d. This would potentially reduce the costs to ACC of over-processing claims at the beginning of the path to recovery. It would also reduce the emotional cost of ACC workers having to read the details of, often disturbing, sexual abuse.
4. **Assessing outcomes.** ACC do not have ways of gaining useful information about the outcomes of the work they fund. Traditionally a good outcome for ACC is when a claimant is “off the scheme”, that is they are no longer claiming an entitlement (like weekly compensation) or requiring ACC funded treatment. Although counsellors provide completion reports I suspect that these are never analysed. **The potential for valid outcome measures to be formulated by ACC in conjunction with practitioners and researchers has yet to be utilised.** Because of this ACC are not really able to distinguish between counsellors with different levels of skill and work preferences. (Although the recent survey of counsellors has given some information it does not relate to outcomes). This is especially important for work with children and Māori, but also for work with those survivors who have more deep seated issues that may require longer term work by a counsellor/psychotherapist who has the necessary skills to do that work. Work with people with a Dissociative Identity Disorder is a case in point. If ACC had an awareness of who were the best counsellors to work with particular clients or presentations then they might be able to give clients better information on who would best meet their needs, more than just a list of “Approved” counsellors. There are risks at present that ACC may make these decisions on poorly derived evidence, whether of a counsellor’s skill or on mistaken conclusions from research.
5. **Triage.** I am concerned that a small number of staff will be expected to review all claims. There are serious risks of secondary traumatising. **THIS IS A HEALTH AND SAFETY ISSUE.** I am also concerned on the emphasis on Clinical Psychology. Clinical Psychologists are often poorly trained in longer term work with sexual abuse survivors. In NZ the dominant methodology is Behavioural (CBT etc), an approach which has only limited use in sexual abuse recovery (research supports its use with otherwise healthy victims of single episodes of abuse as adults; not childhood sexual abuse). If the triage system survives this process of consultation I believe that it should be done by practitioners who have experience of work with survivors. Psychotherapists, as well as Psychologists, have to show competence in diagnosis for their professional memberships and registration. This is beginning to become part of Counsellor training also.
6. **Independent assessment.** I think that it is potentially traumatising for a claimant to be asked to present themselves to another person early on in their therapeutic path. If the issue is making sure that people are referred to competent and appropriate counsellors then surely this can be achieved by providing information in the community about counsellors and their respective competences. This could be based on outcome research funded by ACC. If not, on the counsellors’ own statements as to their competence. Just being “ACC approved” is not sufficient – potential clients, and their referrers, need to know who is good at what. Some counsellors will do really good short term

work, others might be psychotherapists and be trained in working with the long term effects of serious child abuse, with its distortions in personality and brain development. If an independent assessor has to refer on then surely they must have a basis on which to make that referral; knowledge of the counsellors. If this knowledge exists then surely it can be made available to consumers. If it doesn't exist how is the referrer going to make a decision?

7. **Assessments** are best carried out by the practitioners who know their clients, they should be ongoing and inform work which, over time, will have to change in order to meet the changing face of the mental disorder (see Judith Herman's 3 stages to recovery).

8. **Four weekly reports.** This is a burden on the practitioner. There are many senior and/or experienced and skilled practitioners who choose not to take ACC referrals, often because of the bureaucratic demands. This is a risk to ACC, losing their most competent and experienced providers. The rationale for this requirement is not clear. At least it is regular communication between the counsellor and ACC - but is this necessary? **WHY? What problem is this trying to solve?**

9. **IARTS:** This appears to be an alternative to the DATA reports. I think that in some situations it can be helpful to a counsellor have an independent overview of their work – however, this process ignores the contribution of professional supervision. Supervisors are usually experienced practitioners who can bring this experience to aid the work of their supervisee.

10. If independent assessments are used then the assessors should be drawn from across a range of professional groupings and modalities, Psychotherapists, Psychologists, Psychiatrists and Counsellors. Assessors should be sufficiently experienced to not be methodologically dogmatic and to be able to assess the wide range of appropriate research. The Massey Guidelines make valid points about the limits of applying results of research with one client group onto another. A case in point is the application of randomised control trials of Cognitive Behavioural Therapy (usually with highly screened subjects with single episodes of adult sexual assaults by strangers) onto people who have suffered repeated assaults as children from family members. **To make clinical decisions on the basis of misinterpreted research data is unethical; this is an issue for practitioners, assessors and health professionals in ACC.**

11. **Multi-disciplinary Assessment Panel.** I welcome this in principle and expect it would only be used in situations where the work is long term, probably around 10-15 % of claims. The panel should consist of professionals with recent experience of work in the treatment of mental injury from sexual abuse.

It would be a useful contribution to the clinical centre of gravity of the Sensitive Claims Unit. Debates amongst professionals can inform ACC as a whole. This takes the onus away from ACC staff without clinical experience.

- 12. TCRR.** These have the potential to be useful indicators of outcome. Assessors need to be able to make assessments both from their own clinical perspective and also to gain the perspective of the client. I believe that a structured assessment instrument is just as able to be used by the primary therapist than by an external assessor.

- 13.** Any eventual new process will be destabilising and thus should be embarked upon with care. The Treaty of Waitangi principles of **Protection, Participation and Partnership** can be fittingly applied to this situation. ACC should communicate with its providers in a spirit of partnership; it should listen and enable participation in the development of new processes. Any processes should offer protection to the most vulnerable of our society, and not further traumatise.

- 14. Evaluation.** There is a paucity of good, research-based information in the operation, efficiency and effectiveness of ACC-funded counselling – both the clinical outcomes and the processing of claims. Any changes must have built-in evaluation. **You can't shout "evidence-based" on one day and then not properly evaluate on the next.**