Proposed changes to streamline and update ACC regulations: Submission from the New Zealand Psychological Society

Introduction

The New Zealand Psychological Society Rōpū Mātai Hinengaro o Aotearoa (NZPsS) is the largest professional association for psychologists in Aotearoa New Zealand and is committed to supporting quality practice, education, and research in psychology. The NZPsS represents more than 2500 members and students and encompasses a broad range of practice in psychology in Aotearoa New Zealand, including clinical, counselling, health, organisational, and educational. As an organisation we have a strong commitment to Te Tiriti o Waitangi.

Contact

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For the New Zealand Psychological Society Rōpū Mātai Hinengaro o Aotearoa
31 August 2026

Note: As requested for Official Information Act purposes, we confirm there is no sensitive information in this submission that needs to be withheld.

Member Consultation Process

In gathering feedback from members, we undertook the following:

- Advised our members of the ACC consultation via email and included a direct link to ACC's consultation document.
- Provided multiple opportunities for members to provide NZPsS with feedback (email, online form, online meeting).
- Held an in-person meeting to discuss the proposed changes at our annual conference in Auckland from 26–29 August 2026. MBIE agreed to extend the submission deadline to 31 August 2026 to accommodate this conference discussion; this submission is made within that extended timeframe.

This submission integrates all feedback received from members. Most respondents provide services for clients who are funded by ACC.

Overview of Responses

The proposed changes to the ACC Regulations provide a valuable opportunity to streamline administration and expand access. We consider that while expanding access is a valid goal, having low minimum standards risks client safety rather than setting a standard that lifts all providers. We are also concerned that adopting AMA6 for mental injury assessment would reduce impairment ratings and compensation for claimants with injury-related mental health conditions. The NZPsS considers that retaining and refining ACC's existing mental injury assessment framework is a preferable path.

Alongside these central concerns, we recommend that any expansion of the provider workforce be paired with differentiated funding rates, an explicit cultural competency requirement, and a post-implementation review, so that improved access does not come at the cost of quality, equity, or consistency.

Our more detailed response follows, with a list of recommendations at the end. Our submission focuses on the changes proposed under Package 2: Modernising and streamlining the Counsellor Regulations and Package 3: Updating the Lump Sum Regulations.

We have no substantive concerns regarding Package 1 (designation of pharmacist prescribers) or Package 4 (technical update to the Hearing Assessment Regulations). In relation to Package 1, we note only that coordination between prescribing and psychological treatment should be considered where ACC clients are receiving both types of care concurrently, to support integrated, safe treatment planning.

Proposal 2.1: Clarify and update the Counsellor Regulations

Question 2.1.1: Do you agree with the proposed technical updates?
We support clarifying definitions and aligning with the Health Practitioners Competence Assurance (HPCA) Act and Clean Slate Act.

However, 2.1(b) creates critical risk: our members feel strongly that a Level 6 qualification is not sufficient to provide the knowledge and skills required to support ACC clients, particularly those with complex presentations.

We support the setting of a minimum qualification level, in order to provide clarity in these decisions. However, this should be, at minimum, a Level 7 qualification. This threshold aligns the Counsellor Regulations with the qualification and complexity standards already applied under ACC's own Sensitive Claims Service contract, which recognises that trauma-related and complex presentations require postgraduate-level training.

Question 2.1.2: For proposal 2.1(a), does the proposed definition of "counselling" adequately capture the activity and provision of counselling? Why or why not? If not, how could it be improved?

The definition is broadly appropriate but omits the diagnostic, assessment, and formulation role unique to registered psychologists.

We recognise that the definition is intentionally broad. However, there are additional, essential skills that are brought by psychologists as a distinct, regulated health profession with statutory authority to assess and treat mental injury. No guidance is provided in ACC's proposed changes or regulations to clarify that, where there are higher levels of complexity or severity, these must be undertaken by those with the requisite skill set, and the professional qualifications and professional experience to safely provide these more complex services.

Aligning with Responsible Authorities is an improvement, but the list still does not distinguish regulatory status or qualification level. A registered psychologist (which requires a minimum of six years full-time training, with a Masters and a PGDipPrac as minimum requirements) is treated identically to diploma-level counsellors in this regulatory framing. Doing so erodes the safeguards that have been built into the HPCA Act.

Question 2.1.3: For proposal 2.1(b), do the six listed courses of education represent the core skills and capabilities required of a provider to deliver quality counselling services?

The six listed courses do identify foundational topics. However, two core and essential topics are missing:

- recognition of cultural competence, and
- any indication of the depth, integration, or clinical application required for safe practice with complex, injury-related mental health needs.

It is essential that providers and practitioners working in Aotearoa New Zealand have a base level standard of cultural competence and cultural safety, including base level standards of understanding related to Te Tiriti o Waitangi, and specifically for working with Māori. This must be included explicitly in the requirements for knowledge and training and cannot be assumed.

This approach is consistent with the Crown's own Te Tiriti framework in health [1][2], and with responsible authorities' statutory duty under the Health Practitioners Competence Assurance Act 2003 to set standards of clinical and cultural competence [3]. It is also consistent with the explicit, registration-linked cultural safety and Te Tiriti responsiveness competencies already required of regulated health professions, including psychologists [4], physiotherapists [5], nurses [6], and doctors [7]. Notably, both bodies proposed for addition under Proposal 2.3 – the Occupational Therapy Board of New Zealand and the Nursing Council of New Zealand – already treat Te Tiriti responsiveness as a mandatory competency for their own members [8][6]. It is inconsistent for the Counsellor Regulations to leave this implicit when it is explicit and assessed elsewhere in the regulated health workforce.

The NZPB registration and annual practising certification, as currently required under existing legislation, is sufficient evidence of professional expertise and that skills and knowledge are current and up to date, and this should continue without requiring further annual documentation (see also our comments on Proposal 2.2 below).

Question 2.1.4: For proposal 2.1(c), do you think the proposed definitions are accurate?

The definition of a body is reasonable. Practising certificate would be more practically phrased as "means an annual practising certificate for full registration or a membership certificate, issued by a body as defined within these regulations".

This would ensure that membership of professional bodies who do not issue practising certificates was also recognised.

Question 2.1.5: For proposal 2.1(d), do you anticipate any issues if reference to suppliers of counselling services are removed?
No, we do not anticipate any issues with this change.

Question 2.1.6: For proposal 2.1(e), do you think the updated list appropriately captures the range of providers in the current list?

The NZPsS and its members vehemently oppose the proposal to remove professional association requirements. The role of the New Zealand Psychologists Board (NZPB) is to ensure professional standards within the profession for the protection of the public, whereas the NZPsS supports psychologists with ongoing best ethical and professional practice, including in their work as ACC providers, through peer support, access to our ethical experts, ongoing professional development opportunities and more.

While being registered with the NZPB does provide some assurance as to the practitioner's competence, it does not provide assurance that practitioners are being professionally supported, mentored, or have access to ethical advice and guidance. The NZPB does not offer this kind of advice and support to registered psychologists. The NZPB has reduced, and continues to reduce, its capacity in this regard.

The Health Practitioners Competence Assurance Amendment Bill (introduced 18 May 2026) [11] will change legal requirements under the HPCA. It will give the Minister of Health increased powers to direct workforce regulators, introduce new reporting and transparency requirements, and create a streamlined process for reviewing regulators' registration decisions. This increased ministerial direction over responsible authorities, such as the NZPB, makes it more, not less, important that practitioners retain access to an independent professional body for ethical support, professional guidance, and advice that is not subject to government overreach.

Professional associations, such as the NZPsS do offer ethical support, professional guidance, and advice that enables practitioners to offer competent, safe, culturally appropriate, and effective services to ACC clients. Psychologists are already required to be registered with the NZPB in order to work as a psychologist. Including the requirement for membership of a professional body, within ACC regulations, recognises that this type of professional membership means that practitioners are supported to maintain their professional expertise. It also recognises that these types of professional support networks are the mechanisms through which practitioners maintain and develop professional expertise.

We note this position is consistent with our comments on Proposal 2.2 below: we consider statutory registration under the HPCA Act should be sufficient evidence of core competence for the purpose of streamlined ACC registration. However, retaining a professional body requirement alongside registration provides an additional layer of ethical support and peer

accountability that benefits both practitioners and clients. Professional body membership is no substitute for statutory regulation.

We ask that ACC maintains current practice, of requiring both registration and professional body membership.

Question 2.1.7: For proposal 2.1(f), what are the benefits and/or risks of aligning with the Clean Slate Act?
Aligning the timeframe to seven years is appropriate and consistent with current legislation.

Question 2.1.8: For proposal 2.1(g), do you agree with the range of proposed range of convictions that would disqualify a provider from registering with ACC? Are there any to add or remove?
The proposed additions are reasonable, provided they apply consistently and proportionately across all provider categories.

Question 2.1.9: Is there anything else that needs to be considered in terms of these proposals?
Yes.

We recommend that any provider currently registered under the existing Counsellor Regulations be given a clear transitional period to meet updated qualification and conviction-history criteria, so that continuity of care for existing ACC clients is not disrupted.

We also recommend that ACC commit to reviewing the effect of these technical amendments after an appropriate period (for example, two years) to confirm they have not had unintended consequences for access or quality.

Proposal 2.2: Streamlining the requirements for registering as an ACC counsellor

Question 2.2.1: Do you agree with the proposed approach? Why or why not?
Streamlining via Annual Practising Certificate (APC) is a very welcome approach and one that members have asked for.

However, we seek to confirm that the CV will still be reviewed for understanding the deeper skills and experience the practitioner brings.

The fast-track approach relies on APC as proof of compliance. However, an APC merely confirms *current practice*, not the depth of initial education. It should be explicitly stated that registration with the NZPB is conclusive evidence of meeting all qualification, supervision, and ethics criteria, removing the need for providers to repeatedly submit degree transcripts or course outlines.

Question 2.2.2: Are the proposed requirements for the streamlined approach correct? Are any requirements missing, or any that could be removed?
We recommend one addition: evidence of cultural competency and cultural safety (for example, through professional development records or supervision) should be an explicit requirement of the streamlined approach, consistent with our comments on Proposal 2.1(b) above.

Without this, the fast-track process risks assuming that practitioners hold a level of cultural competence and cultural safety that an Annual Practising Certificate alone does not guarantee.

Question 2.2.3: Do you agree with the proposed list of bodies under the streamlined approach? Why or why not?
The inclusion of the NZPB is appropriate. However, excluding the Nursing Council and Occupational Therapy Board from the fast-track list, while including non-regulated counselling bodies, creates inconsistency. If a body has statutory regulatory oversight under the HPCA Act, its members should qualify for streamlined assessment.

Question 2.2.4: Is there anything else that needs to be considered in terms of this proposal?
Concern has been expressed that enabling nurses and occupational therapists to become providers was too broad, as their training would not be specific enough for the role (see below).

Proposal 2.3: Expand the types of providers that can provide ACC counselling services

Question 2.3.1: What is your preferred option and why?
The NZPsS supports Option 3 (add Nursing Council and Occupational Therapy Board) as a targeted, evidence-based expansion, but only if accompanied by the following safeguards:

- Retain explicit recognition that regulated, degree-qualified mental health professionals hold higher training standards that should be prioritised for complex cases.
- It is made explicit that being a registered member of those bodies does not automatically qualify a person to provide counselling services; they must have the requisite qualification, skills and experience as outlined elsewhere in the regulations.
- Reject Option 2 (general ACC discretion) as it removes regulatory certainty and risks inconsistent standards.
- Require members of the Nursing Council and Occupational Therapy Board to demonstrate they meet those bodies' own existing Te Tiriti o Waitangi responsiveness competencies (for example, OTBNZ's Competency 2: Responsiveness to Te Tiriti o Waitangi [8], and the Nursing Council's Te Tiriti o Waitangi Policy Statement [6]) as a condition of ACC approval. This is a safeguard that imposes no additional burden on these providers, since compliance is already required for their base registration. This is consistent with our comments on Proposals 2.1 and 2.2 above.
- Commit to monitoring claimant outcomes and complaints by provider type following implementation, with a formal review after an appropriate period.

Question 2.3.2: What do you see as the risks and benefits of the proposed options?
The key risks and benefits are set out below.

Benefits	Risks
Increases workforce supply to reduce access delays	Equating unequal training levels may lower clinical safety and consistency
Uses existing skills in the health system	Dilutes the value and recognition of advanced postgraduate qualifications
Aligns with wider health sector integration	Blurs statutory distinctions between regulated professions

We also recommend that, if new provider types are added, ACC review the Cost of Treatment consultation rates to ensure funding differentiates by qualification level and case complexity. This would give ACC an additional lever alongside registration criteria to ensure

complex cases continue to be directed to practitioners with the appropriate depth of training, without limiting overall access.

Question 2.3.3: Is there anything else that needs to be considered in terms of this proposal?
Yes. We recommend a formal, time-bound review (for example, after two years) of any expansion of provider types, examining claimant outcomes, complaints, and the complexity of cases seen by each provider type. This would allow ACC to confirm that expanded access has not come at the cost of safety or quality, and to adjust settings if it has.

Proposal 3.1: Options for updating the assessment tools

Question 3.1.1: What is your preferred option and why?
The Society supports Option 3 (adopt AMA6 for physical injury, retain and refine the existing ACC mental injury framework).

While AMA6 updates physical impairment guidance, its Chapter 14 methodology for mental and behavioural impairment has been widely criticised as producing substantially lower and more constrained ratings than earlier approaches. Independent analysis has identified structural problems in Chapter 14, including a Brief Psychiatric Rating Scale component that caps at only 50% impairment – a ceiling reached only by claimants requiring institutional care – and an arbitrary conversion of Global Assessment of Functioning scores into impairment percentages [9]. Separately, presentations to medical evaluators modelling the shift to AMA6 Chapter 14 methodology for mental impairment (in the context of Ontario's auto insurance scheme) have projected discounts in the order of 50 to 66 percent compared to prior approaches [10].

While these analyses come from other jurisdictions rather than ACC's own claims data, they point to a serious risk that adopting AMA6 for mental injury would materially reduce compensation for New Zealand claimants with injury-related mental health conditions. This is already a group that faces inconsistency and disadvantage in assessment.

We recommend that ACC commission or publish its own modelling of the impact of AMA6 Chapter 14 on a sample of past New Zealand claims before making a final decision on this proposal.

Question 3.1.2: What do you think the benefits and/or risks (clinical or otherwise) are with adopting the AMA6?

The benefits include more structured physical injury guidance and better coverage of conditions like cancer.

The risks are that AMA6's mental health framework has not been clinically validated for Aotearoa New Zealand injury contexts; it narrows functional assessment and may systematically under-rate impairment compared with the ACC-developed Mental and Behavioural Assessment Tool [9][10].

No evidence has been provided in the consultation document that AMA6 will improve fairness or consistency for mental injury claimants, and the consultation document itself acknowledges this option is likely to reduce average compensation for mental health injury clients.

We are also concerned this impact would not fall evenly: claimants who already face barriers to accessing timely, culturally appropriate mental health assessment, and in particular for Māori claimants, are likely to be disproportionately affected by any systematic under-rating of mental injury. In fact, ACC data shows Māori are more likely to experience serious life-changing injuries but are 36 per cent less likely to lodge a claim with ACC compared to non-Māori [18], and ACC legislation requires delivery of services in ways that support equitable access by kiritaki Māori when they are injured, and it is the reason for the establishment of Hāpai [18].

Our position is also consistent with New Zealand evidence that cultural identity and connectedness are associated with mental health outcomes for Māori [12][13], and with professional recognition of the significance of Te Tiriti o Waitangi in mental health practice [14].

Question 3.1.3: Is there anything else that needs to be considered in terms of this proposal?

The consultation document lacks efficacy studies regarding the use of overseas tools (e.g., those developed in America) here in Aotearoa New Zealand. None of the consultation documents appear to have considered tools that have been developed in Aotearoa New Zealand, for clients in this country, or any NZ-developed tools that are currently in use. This oversight is problematic in terms of best practice.

The consultation is void of Te Tiriti o Waitangi and the consultation documents do not acknowledge or mention cultural competencies or cultural safety.

This gap is particularly striking given ACC's own statutory obligations and existing initiatives. Since 2023, ACC has been required under the Accident Compensation Act to report annually on access disparities for Māori, Pacific peoples, Asian peoples, and disabled people [15]. ACC's own Year 2 Scheme Access Report (2026) found that these groups face financial, geographic, informational, and cultural barriers that directly affect claim lodgement pathways [15]. ACC's own published data also shows that Māori are more likely to experience serious life-changing injuries but are 36 per cent less likely to lodge a claim with ACC compared to non-Māori [16]. ACC has responded to this with its own culturally responsive initiatives, including the Hāpai service and Kaihāpai (Recovery Partner) role, which integrates tikanga Māori into recovery planning and case management [16], and Te Ara Tūhono, an independent, culturally responsive navigation service [17]. Given ACC already recognises, resources, and reports on the need for culturally responsive practice elsewhere in the scheme, it is inconsistent for this consultation on treatment provider regulations to omit any equivalent Te Tiriti o Waitangi or equity analysis.

As a result, the consultation itself does not align with current standards and competencies.

We recommend that the consultation and subsequent documents include a specific Te Tiriti o Waitangi and equity analysis. We also recommend that the consultation process going forward is informed by New Zealand-based clinical and outcomes evidence, and that any tools and modelling developed for other jurisdictions are subject to efficacy studies regarding their use in Aotearoa New Zealand.

Conclusion

We recognise and appreciate ACC's attempts to improve and streamline the process for practitioners working with ACC. This is certainly supported by our members. We note that improving access to ACC services is vital. However, this cannot come at the cost of clinical standards. It is imperative that those working with vulnerable people have the necessary expertise to do so safely and effectively, can ensure that clients have the best chance of recovery, and that ACC's funds are well-spent.

Summary of Recommendations

- Set the minimum qualification for ACC-approved counsellors at NZQA Level 7, consistent with the complexity threshold already used in ACC’s Sensitive Claims Service contract (Proposal 2.1(b)).

- Add an explicit requirement for cultural competency and safe practice with Māori clients to both the core qualification criteria (Proposal 2.1(b)) and the streamlined registration requirements (Proposal 2.2).
- Retain the requirement for membership of a relevant professional body alongside statutory registration, recognising that registration alone does not provide the ongoing ethical support and peer accountability professional bodies offer.
- Amend the definition of "practising certificate" to also recognise membership certificates from bodies that do not issue formal practising certificates.
- If Option 3 (Proposal 2.3) proceeds, make explicit that registration with the Nursing Council or Occupational Therapy Board does not, by itself, qualify a person to provide ACC counselling services; the requisite counselling-specific qualifications, skills, and experience must still be demonstrated.
- Reject Option 2 for Proposal 2.3 (general ACC discretion to approve providers), as it removes regulatory certainty and risks inconsistent standards.
- Review the Cost of Treatment consultation rates alongside any expansion of provider types, so that funding differentiates by qualification level and case complexity.
- Commit to a time-bound review (for example, after two years) of the effect of the Counsellor Regulations changes and any provider-type expansion on claimant outcomes, complaints, and case complexity by provider type.
- Retain and refine ACC's existing mental injury assessment framework (Option 3 for Proposal 3.1) rather than adopting AMA6 for mental injury, given the significant risk that AMA6 Chapter 14 would reduce compensation for claimants with injury-related mental health conditions.
- Before any decision on AMA6, commission or publish ACC's own modelling of its impact on a sample of past mental injury claims, and include a specific Te Tiriti o Waitangi and equity analysis.
- Provide a clear transitional period for existing registered counsellors to meet updated qualification and conviction-history criteria.

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