The New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

Submission
to the
Independent Clinical Pathway Review
on the
new clinical pathway for sensitive claims

Prepared by the New Zealand Psychological Society

17 July 2010

Introduction
As a number of our members are involved in sensitive claims service provision, we welcome the opportunity to comment on the new clinical pathway for this area. This submission has been prepared by Executive member, Dr Kerry Gibson and Executive Director, Dr Pamela Hyde in consultation with New Zealand Psychological Society members who have a particular interest in this area.

The Society has a number of concerns which are highlighted below for the Independent Clinical Pathway Review Panel which has been appointed to assess the implementation and impact of the new clinical pathway:

The justification for the clinical pathway
ACC has claimed that its clinical pathway for sensitive claims was justified by commissioned research, conducted by a team at Massey University, to develop practice guidelines for sexual abuse and mental injury (Rāranga Whatumanawa, 2008). However, having read this research, we believe that the recommendations made for the new clinical pathway are not supported by the research that was specifically intended to develop knowledge about best practice in the sensitive claims area. Instead ACC has clearly ignored some recommendations and has quoted selectively from others to justify their own position. This is a significant issue, insofar as it sheds doubt on the evidence base for the new clinical pathway.

Split between assessment and provision of services
The new clinical pathway recommends that assessment and intervention for those seeking ACC support be conducted by two different practitioners. While we are aware that this is a strategy commonly used by the insurance industry, we believe that this is unsuitable for the client group in question for a number of reasons. Research has indicated that one of the most significant barriers to sexual abuse survivors obtaining assistance is their difficulty in disclosing the abuse (Paine & Hansen, 2002). To insist that sexual abuse survivors disclose the details of their abuse not once, but as many as three times (GP-initial assessor-treatment provider) is likely to be experienced as distressing by survivors and will negatively impact on the development of a trusting relationship with a service provider. This relationship with a service provider was recognised in the Massey University guidelines to be a key element of successful treatment (Rāranga Whatumanawa, 2008). Furthermore, this process is liable to create unnecessary disruption in the important link between assessment and intervention. Most clinicians prefer to conduct their own assessments because it provides them with a stronger foundation of understanding on which to base their intervention. Finally, the process for referring someone for an initial assessment and then re-referring for the intervention is liable to be slower and more administratively cumbersome than the previous system which allowed a flow through from assessment to intervention with the same practitioner. This may create dangerous delays in offering services to a vulnerable client group.

Requirement for a DSM diagnosis

The new clinical pathway prescribes a DSM diagnosis as a basis for ascertaining 'mental injury' as a result of sexual abuse. This has the effect of limiting the professional groups who can perform the initial assessment to those who have had specific tertiary training in this diagnostic system. We have at least two concerns about this recommendation; the first is in relation to workforce issues and the second in relation to the appropriateness of this diagnostic system for the client group.

Psychologists generally have a background in DSM diagnosis, as do psychiatrists and some psychotherapists. This diagnostic system is less commonly used by counsellors who make up the major proportion of the sensitive claims workforce. Implementation of this recommendation is likely, therefore, to result in a situation where clinical psychologists (and only a minority of other professional groups) have responsibility for initial assessments of sensitive claims clients. As a result of this, a large number of very skilled counsellors who have developed their expertise in this area over time may be lost to this area of practice. Furthermore, as there is generally a shortage of psychologists and only a relatively small number of these working in the sexual abuse field, there are unlikely to be sufficient resources to meet the need.

We also have other concerns about the requirement for a DSM diagnosis of sexual abuse survivors. It is important to note that the use of this diagnostic system was never a recommendation of the Massey University guidelines (Rāranga Whatumanawa, 2008). It is well recognised that the DSM diagnostic system is not capable of capturing the array of problematic responses to sexual abuse and the review of research contained in the Massey University guidelines notes that the effects of sexual abuse do not, in fact, generally match any existing DSM diagnosis. DSM diagnosis is also particularly weak in accounting for psychological problems experienced by children and adolescents (Beauchaine, 2003). Significantly, this diagnostic system is also not recognised to be sufficiently culturally sensitive to allow for its use in our bicultural society (Durie, 1999). Finally, a formal psychiatric diagnosis may have stigmatising effects for survivors of sexual abuse (Dios & Stevens, 2004).

Other 'diagnostic' systems (including that recently used by ACC itself) which emphasise responses to difficult circumstances across a range of areas (cognitive, behavioural, social, and psychological) may be more appropriate and sufficiently flexible to reflect a range of different responses to sexual abuse without unnecessarily pathologising the client.

Allocation of counselling hours

The clinical pathway suggests 15 sessions as a guideline for an appropriate number of counselling hours, although it is recognised that there may be exceptions to this. This suggestion appears to have been drawn from research evidence quoted in the Massey University guidelines which related to the treatment for a single sexual assault (Rāranga Whatumanawa, 2008). Current research, however, recognises that it is very difficult to assume any homogeneity in experiences of sexual abuse (Goldman & Padayachi, 2000) and therefore also in its effects (DiLillo, 2001). In many cases interventions would need to take account of the much more complex set of problems that arise in relation to repeated experiences of abuse or those that date back to childhood. Given the array of experiences of abuse, it is very difficult to make claims about any particular length of therapy being recommended for all (or even most) cases. Even if this recommendation were used in the lightest sense as a 'guideline' – it may inadvertently foster inappropriate

expectations for rapid improvement where this is not to be expected. This is likely to re-victimise clients who may blame themselves for their lack of progress. It is worth noting that the Massey University guidelines recommended that the length of therapy be guided by the monitoring of progress rather than any external criteria (Rāranga Whatumanawa, 2008).

Current feedback on the implementation of the pathway:
We have reports from our members that the new clinical pathway is already having some detrimental impacts on their work in this area. Several have reported that referrals have decreased significantly and also that the general efficiency of response to sensitive claims reports is poor. Some believe that the change process has been chaotically implemented and without sufficient concern for the rights and well-being of clients. Some of our members also feel that they have been treated disrespectfully and dismissively by ACC in the change process.

We also hear from a number of our members that they are disappointed by ACC's lack of responsiveness to their and other professional's concerns and that they are opting to withdraw from the sensitive claims services rather than be involved in a system with which they have serious issue. Some of our members have also told us that while they have strong negative feelings about the new pathway they do not feel safe to voice their dissatisfaction for fear of being labelled as 'trouble makers' by ACC.

Recommendations
On the basis of the concerns raised in this submission we would like to recommend a complete overhaul of the new clinical pathway for sensitive claims. We would strongly recommend a more honest use of the Massey University guidelines (Rāranga Whatumanawa. 2008) together with consultation with sensitive claims service providers to ensure a strong foundation for a pathway that

a) Allows the client to decide whether they wish the intervention to be provided by the same service provider who conducted their assessment

b) Utilises a flexible diagnostic system capable of reflecting the diverse ways in which 'mental injury' may manifest amongst survivors of sexual abuse

c) Allows a flexible number of sessions to be allocated dependent on the needs of the client.

Contacts in relation to this submission

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