PREVENTION. CARE. RECOVERY.

Te Kaporeihana Āwhina Hunga Whara

Sensitive Claims Unit (SCU) Clinical Pathway - Frequently Asked Questions

1. ***Are the changes ACC is making really just about saving money?***
   No, the driver for these changes has always been to provide survivors of sexual abuse or assault who have a mental injury with a better level of assistance, and to help them achieve a more timely and successful recovery. An important focus is ensuring that clients receive treatment which:
   - reflects the latest evidence, and
   - improves their rehabilitation to everyday life, and work where applicable.

   To achieve these goals, we are strengthening the clinical focus of the SCU.

2. ***After filling in the ACC290 with the client, can I continue treatment once the claim has been accepted, or will the client be referred to someone else?***

   The treatment for a client with an accepted claim will depend on their specific needs, context and injury. That may mean they are referred to another provider, as we want to match clients with the most appropriate health professional for their needs. We also want clients to have a say in who provides their treatment, so wherever possible we will offer them a choice of appropriate providers in their region.

3. ***Am I expected to complete an ACC290 assessment in two sessions?***
   Under the new Clinical Pathway, only those Providers who can provide us with a DSM-IV diagnosis need to complete an ACC 290.
   It's our understanding that generally, two sessions will be sufficient to complete most assessments. We will pay for the report for these assessments.
   If additional time is required for assessment, this can be agreed on a case-by-case basis, by making a phone application to the triage psychologists employed by ACC's SCU.

4. ***Can I assess and treat the same client?***
   This is certainly possible within the following guidelines, which will be applied to most cases:
   a) If the Provider who completes the ACC290/ACC45/DSM-IV is appropriately qualified to undertake the agreed treatment plan, and the client chooses them, then they can go ahead once ACC has sent authorisation. The Treatment Conclusion Review and Recommendations (TCRR) assessments will be completed by an independent person.
   b) Where the Provider only lodges the ACC45 and they are qualified to complete the treatment and the client chooses them to do so, then they

can go ahead once ACC has sent the relevant authorisation. However the Initial Assessment and Recommendations for Treatment (IART) and TCRR assessments will be completed by another Provider.

We will agree to waive these guidelines in exceptional circumstances (such as for geographical considerations, or because a specialist service is required).

A Provider can be an assessor for some clients and a treatment provider for others.

5. ***What information will be required in the four-weekly progress reports?***
We require:
   - the planned dates of treatment
   - treatment given
   - progress against the treatment goals.

   At some providers' request, the reports also include a formal means of seeking a change to the treatment plan and for asking questions of ACC.

6. ***What additional payment will I receive for the four-weekly progress reports?***
There won't be any extra payment. This is because the reports are only brief, and are intended to be completed as part of the client's treatment session and with the client's input.

7. ***What benefits will the 4-weekly reports have?***
The four-weekly reports will deliver many benefits. For example, they will:
   - provide a record of progress towards rehabilitation/recovery which can be easily monitored by ACC
   - allow easy identification of any barriers that may be preventing clients from attending treatment
   - reduce interruptions to busy providers from ACC staff following up treatment progress
   - enable pre-planning of the TCRR report appointment, which will reduce breaks in treatment for clients
   - provide information for the TCRR report (up-to-date and structured towards the achievement of goals)
   - remove the requirement for a comprehensive ACC291 report at the end of treatment
   - provide a formal mechanism for Providers to communicate treatment changes or ask questions of ACC.

8. ***Will the report still need to be submitted every four weeks if sessions are held fortnightly or monthly?***
There will be some flexibility based on the needs of the client and achieving the best outcome for them. Where four-weekly reporting is not required, this will be by arrangement as part of a confirmed treatment plan.

9. ***What goals will be expected to be outlined on the self-management plan?***
Goals which define the treatment pathway to recovery and rehabilitation, ie SMART goals - Specific, Measurable, Achievable, Realistic and Time-framed.

The focus is on successfully rehabilitating clients into everyday life, and reducing the likelihood of them needing follow-up care in the future.

10. What is the approach for children and young people?

It's critical that children are appropriately assessed and, if treatment or therapy is required, that this is offered by appropriately qualified health practitioners. We're about to start work on enhancing specific treatment and support processes for children. It's likely children will require specialised assessment to ensure ACC has sufficient information to reach a claim and treatment decision. Children's and young people's claims will be given high priority at triage and will be fast-tracked wherever possible.

11. Is my client expected to wait for treatment after the initial two assessment sessions, until a claims decision has been made?

No – if your client is having treatment or therapy, this can continue. However, ACC can only fund treatment delivered from the date a claim is accepted. Clients can seek funding from other sources or continue with funding arrangements already in place. Similarly, having an ACC claim lodged does not prohibit assistance from other funding or support groups - ACC clients are still entitled to support from local DHBs and other health agencies.

12. What is being done to accommodate Maori cultural needs?

We are working on enhancing specific treatment and support processes for Maori. The ethical codes, standards of competence and the HDC code all put the responsibility for effective counselling of Maori on the counsellor - ACC trusts the ability of registered counsellors to provide appropriate services.

The professional associations are responsible for ensuring counsellors adhere to these codes, not ACC. ACC does want more Maori counsellors and welcomes advice on therapy including Maori models of counselling - we have begun discussions to advance this and will be holding a hui to discuss this later in 2009.

13. What does ACC spend on counselling each year?

The costs of counselling are approximately $19 million per year. This amount is just one component of the total costs for treatment, therapy and intervention, which exceed $56 million per year.

14. Why is ACC asking clients to see a range of Providers before a claim decision is reached and during treatment, when this could re-traumatise the client?

ACC appreciates that sensitive claims need to be handled with the utmost care and sensitivity. Every effort will be made to minimise the number of health professionals that a client needs to see during their assessment and treatment. However, this will be balanced against ensuring clients receive the assistance they need to make a successful recovery.

The existing processes mean many clients see more than three assessors without any claim decision being made. The emphasis of the new Pathway is wherever possible to have the same assessor for the one client, completing the IART and TCRR assessments.

15. Why is ACC asking for more information to support claims and ongoing treatment?

Information gathering is critical to delivering better outcomes for clients. We ask for information for many reasons, including:

- to enable a timely and appropriate claim decision to be made
- so that ACC can be sure the therapy proposed is appropriate for the client, their context and their injury.

We also need to understand what other support is needed beyond counselling, and whether therapy is helping the client recover from their injury. If we don't receive this information, assistance may be delayed and the client's recovery potentially impaired.

Regular feedback on a client's progress enables more timely and informed decision making. We aren't seeking additional reporting on top of what was required before, and some previous reports have been removed.

16. Why is ACC insisting there must be a mental injury before approving cover?

This is because ACC has to operate within the framework of the appropriate legislation. The legislation says that ACC can only accept claims from people with a diagnosed mental injury resulting from sexual abuse or assault, ie we cover the mental injury, not the event per se.

We accept we may not have communicated this distinction sufficiently or consistently in the past. As a result, some people think ACC is making a major change in the absence of a change in legislation, when this is not the case.

Currently ACC frequently gets insufficient information to reach a claim decision, which results in unacceptably long delays for clients who may have been led to believe they will get ACC cover for the abuse, even though they do not meet the criteria to have these claims accepted.

We hope this won't be the case in the future, following these changes and greater education about ACC's cover for mental injury resulting from sexual assault or sexual abuse.

17. Is a DSM-IV diagnosis necessary?

Yes. ACC has to operate within its legal framework and ACC can only assist clients once a diagnosis has been made. Section 27 of the IPRC Act 2001 defines mental injury as 'a clinically significant behavioural, cognitive, or psychological dysfunction'. The dysfunction must:

- be assessed as clinically significant by a suitably qualified and experienced health professional, and
- require treatment typically provided for such injuries, over and above certification.

The DSM-IV is an internationally recognised tool which clinicians use to make a diagnosis on mental injury.

We recognise that survivors of sexual abuse or assault will be distressed from the event, and we will work to ensure all agencies, public and private, can support them. However, our responsibility is to cover treatment for those with a mental injury caused by a sexual assault.

18. Why is ACC limiting initial treatment to 16 sessions?

There is no treatment cap. However, the latest research shows that clinically-based treatment over a shorter timeframe achieves the best outcomes for adult clients. A client needing longer-term support will continue to have access to this. Any therapy or other support packages provided will be in keeping with the injury and the context of the client. The research reports taken from the background to the Massey Guidelines, (particularly technical report 6) found that the optimum duration of treatment for most adults undergoing counselling is fewer than 16 sessions. As such, ACC will provide initial counselling of up to 16 sessions before making an assessment of progress.
The Massey Guidelines are clear: short-term, focused, directional counselling is best for most adults with a mental injury arising from a sexual assault.

19. Will ACC evaluate the changes as it has promised?

Yes, we will certainly be evaluating these changes. In fact, the current changes are themselves based on research evidence, and feedback from providers, clients and staff.
Our ongoing evaluation will involve reviewing factors such as ACC's performance and client outcomes, and we will assess the impact of any changes with a view to making continuous improvements. Such improvements could be making quicker and better decisions, or using all information at hand to make an informed decision.

20. Will changes has ACC made to the new Pathway as a result of feedback from providers?

We've made the following changes based on providers' feedback:

- ACC will only receive the ACC290 from providers qualified to provide a DSM-IV diagnosis, along with the detail necessary to support the diagnosis – this will reduce the number of people clients must see and answer questions from
- Clients returning for additional therapy will be referred via letter to the SCU
- children, young people and those with an intellectual disability will be given priority at triage, with their claim considered the same day it's received
- the multidisciplinary panel may now make a recommendation on the claims decision
- timeframes for the period from claim lodgement to decision have been included - one week for 'fast-tracked' claims (when ACC receives sufficient information with the claim) and six weeks for all other claims
- direct access to long-term treatment and case management will be initiated at claim time for those clients who clearly require long-term intervention for their particular clinical needs.

For more information on the new Clinical Pathway, please call 0508 222 233 between 8.30am and 5.00pm Monday to Friday, or email sensitive claims@acc.co.nz