

Honourable Nick Smith  
Minister of Accident Compensation Corporation  
Parliament Buildings  
Wellington

22 October 2009

*Dear Minister,*

The Mental Health Foundation is writing in regard to the proposed implementation of the Accident Compensation Commission's Sensitive Claim Unit Clinical Framework to take place on October 27 2009. We acknowledge that abuse in any form affects the mental health and wellbeing of individuals and communities and even more so when it happens to a child. We therefore share the Government's concern to find the best possible response to a widespread problem.

Victims of sexual abuse need to have access to help that takes a non-pathological, 'whole of life' approach which emphasizes respect for the experience of the victim and their right to determine their path to recovery. Some of our concerns are set out below.

1. Payment from ACC will be conditional on a diagnosis of 'mental injury' as a result of sexual abuse

The Mental Health Foundation is concerned that the new emphasis on a requirement for a diagnosis of 'mental injury' which must be linked to the DSM-IV will lead to many, mainly women, not accessing the free counselling they need.

Sexual abuse both in childhood and adulthood can have a far-reaching and complex traumatic impact on a person's life. It can lead to a range of difficulties such as forming relationships with others, having a positive sense of self and feeling secure. Because sexual abuse is done in secret and blamed on the victim, the latter can spend years feeling guilty or choosing forms of self-medication such as alcohol and drugs. A recent British study asserts that based on their findings, if sexual abuse were not to exist, the rate of suicide attempts during a lifetime would drop by 28% for women and by 7% by men<sup>1</sup>. MHF, recognizes the clear link between sexual abuse and increased risk of suicide. Given victims may have more barriers to receiving counselling support they need, MHF are identifying increased suicide risk amongst this group.

The traumatic impact of abuse often involves the whole life of the person and a non-pathological, client-centered assessment and treatment approach is more beneficial than a diagnostic framework such as DSM-IV. Indeed, a medical diagnosis can unfortunately lead to individuals believing they are personally responsible for the impact of trauma because of a deficit in their individual make-up.

A clinical assessment must be done within the first two sessions by an approved counselor and then referral to a psychiatrist

The Mental Health Foundation has concerns with ACC's new Clinical Framework which will mean that a diagnosis must be reached within the first two sessions of counselling. A sense of safety is the starting point for a client who may have come to counselling with much hesitation and a sense of fear and exposure. Part of building a sense of safety is respecting the autonomy of the client and their right to lead the interaction. The pressure to form a clinical diagnosis is likely to be counter-productive in this situation.

There seems to be a lessening of flexibility in the proposed system. Clients' circumstances have to now be exceptional to affect the proposed duration of therapy. Many people could fail, or not feel able to apply under the stricter requirements for counselling help. Instead of receiving counselling as an early intervention, some will then develop more serious mental conditions such as depression, and post-traumatic stress disorder. Children's development could continue to be affected negatively.

It is important to offer victims who need specialist help an appropriate referral path to mental health services. In fact, research shows 50%-80% of clients in that system currently have abusive backgrounds<sup>2</sup>, although this trauma is often unacknowledged. However, the first and most important step is the provision of widely accessible user-friendly counselling.

The counselling help provided will be of a shorter length, usually 16 sessions

The new Clinical Framework emphasizes a shorter length of counselling to be provided – 'we'll also ensure you receive clinically-based treatment, usually over a shorter term, as research shows this leads to the most successful outcomes' (ACC Advertisement in the Herald 17.10.09). The focus of counselling then becomes 'empowering the client to manage their injury'. (In contrast, the Massey Guidelines<sup>3</sup> states as an example the goal for Maori clients may be 'their connection with personal and cultural identity'.) Even some of the objectives of the Guidelines, as opposed to those of the current ACC changes, appear to be at variance.

Current statistics of clients' use of counselling shows 53% find 30 sessions sufficient and 14% require more than 100<sup>4</sup>. This would suggest that clients (and their therapists) might feel pressured with only 16 sessions available. There is an additional requirement for a review at 16 sessions to see whether more are required, with the possibility of the client being told they need to see another professional for any further sessions. There may be a reluctance by the counsellor to take up more traumatic themes with the client, if the sessions will be curtailed or the client is likely to be 'transferred' to a new counselor. It is well-known that the relationship between therapist and client is a key dynamic in successful outcomes. It is important that the client can choose, or change to an appropriate therapist but again, that should be a client-initiated step.

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We believe the current proposal to be a significant tightening of the support available to victims. The suffering of sexual abuse victims if not healed remains as part of the community, with a range of negative consequences for generations.

*Yours sincerely*  
*Judi Clements*

Judi Clements  
**Chief Executive**  
**Mental Health Foundation**

#### References

(1) Bebbington P et al (2009) *Suicide Attempts, Gender, and Sexual Abuse: Data from the 2000 British Psychiatric Morbidity Survey* Am J Psychiatry 2009 166: A 28

(2.) *Child Abuse and Severity of Disturbance Among Adult Psychiatric Inpatients.* Read, J. 5, s.l.: Child Abuse and Neglect, 1998, Vol. 22; 16. *Staff responses to Abuse Histories of Psychiatric Inpatients.* Read, J., & Fraser, A. 2, s.l.: Australian and New Zealand Journal of Psychiatry, 1998, Vol. 32.;17. *Trauma History Screening in a Community mental health Center.* Cusack, K. J., Frueh, B. C., & Brady, K. T. 2, s.l. Psychiatric Services, 2004, Vol. 55. 157-162.; 33. *Asking About Abuse During Mental Health Assessments: Clients' Views and Experiences.* Lothian, J., & Read, J. 2, s.l.: New Zealand Journal of Psychology, 2002, Vol. 31. 98-103.

(3.) ACC Sensitive Claims Newsletter – July 2009

(4.) ACC (2008) Sexual abuse and Mental Injury: Practice Guidelines for Aotearoa New Zealand