Mental Injury and Sensitive Claims (from ACC website

What is a mental injury?

Mental injury is a legal concept rather than a clinical concept and as such is defined by legislation.

Accident Compensation Act 2001

A mental injury is defined as:

“a clinically significant behavioural, cognitive or psychological dysfunction” (s27).

ACC can provide cover for mental injury arising from:
 Sexual abuse (sensitive claims),
 A covered physical injury,
 A work related traumatic incident, and
 Treatment injury.

- Within the Sensitive Claims Unit, for a client to receive cover and entitlements, the mental injury must be significantly linked to specific sexual offences described in the Crimes Act 1961.These are referred to as Schedule 3 events.

- Schedule 3 events do not include witnessing others being abused or behaviours that would be seen as part of appropriate parenting (e.g., bathing or toileting a young child), or developmentally normal behaviour.

- The full list of schedule 3 events can be accessed via the following website:

http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM100693.html

- There does not need to be a physical injury for a mental injury of this type to be covered. However, to receive cover there must be a mental injury and the sexual abuse events must be considered to be a significant or material cause of the diagnosed mental injury(ies).

For assessors

Mental injuries, causal links and the mental injury assessment
The purpose of the mental injury assessment is to establish:

- A comprehensive assessment of a client's cognitive, psychological and behavioural functioning from which appropriate intervention can be planned and delivered.

- The nature of any clinically significant behavioural, cognitive or psychological dysfunction experienced by the client.

- The extent to which there is a causal link between the specified event(s) reported (e.g., physical injury, workplace event, treatment injury or sexual abuse event), and the clinical dysfunction assessed as being present.

You will need to consider:

- The onset or development of the presenting symptoms and how soon after the events these developed.
- How the client's difficulties have developed and progressed within the client's wider context to be able to identify and fully consider all factors that have contributed to the presentation.

- Whether or not there are/were other developmental or environmental factors that might explain the development or severity of any presenting symptoms (e.g., attachment issues often result in personality difficulties).

- Whether the extent and severity of the difficulties experienced is greater or lesser than you would expect given the nature of the events reported and to what extent other non-event related factors have contributed to this.

Cultural

ACC has produced the following document:

ACC 1625 Guidelines on Maori Cultural Competencies for Providers.

Symptom Validity

Symptom validity should be considered in any and every assessment. Issues to consider are:

- Whether or not there are any inconsistencies/differences between the various sources of information obtained from third parties, from self-report by the client, from psychometrics, from your own observations of the client,

- Explanations for these inconsistencies/differences,

- Unusual presentations or unusual amounts of distress/lack of distress given the reported difficulties.

Formulation

Formulation is different from diagnosis in that diagnosis provides the answer to the question "what mental injury(ies) is the client experiencing?", and formulation provides the answer to the questions "why has the client developed these difficulties?" and "what is maintaining them?"

The formulation requires a narrative summary of all of the factors, both positive and negative, specific to an individual client that clearly explains why and how the client has developed the difficulties they are currently presenting with and why these difficulties have persisted. It should also include discussion of any barriers to recovery that might exist.

Formulations will likely range from simple to complex depending on specific client circumstances and should provide an explanation for all of the presenting difficulties such that it is clear which have been caused by the accident/event which have not, and which act as rehabilitation barriers.

Below are some examples of simple and complex formulations for adults and children for sensitive claims, and for mental injury caused by physical injury and work-related injury claims.

Example One:

"Ms C reported no early childhood difficulties, abuse or trauma and experienced positive parental attachment and sibling relationships. Throughout her life she has been high functioning having achieved well academically and occupationally. There was no evidence of any mental health, relationship, or behavioural difficulties up until the rape that occurred in her work car park in late 2014. Since that time she has experienced strong intrusive imagery and thoughts of the rape, has sought to avoid any activities or situations that remind her of this event, and has experienced intense anxiety and panic attacks when she has been unable to do so.

As a result she has avoided returning to work, has avoided sexual intimacy with her partner and has increasingly managed symptoms of anxiety via benzodiazepines prescribed by her General Practitioner. Additionally she is feeling increasingly hopeless about her situation and capacity for recovery. It is considered that the avoidance via actual avoidance and avoidance via the anxiolytics is acting to maintain the intensity of all current symptoms."

This formulation would support a diagnosis of PTSD significantly linked to sexual abuse in the Section 7 Opinion section of the Supported Assessment report.

Example Two

"Mrs X is a 47 year old mother of three teenage children and reports poor relationships with all three who she lost custody of at various points in their childhoods. She presents with a history of severe neglect and abuse by her parents who were substance dependant and heavily involved in gangs and an offending lifestyle. In this context she was subject to and witnessed severe acts of physical violence throughout her childhood and early adolescence when she was "passed around" her parents and wider family and at times coming to CYFS attention. She was also subject to frequent sexual abuse involving three discrete episodes by three perpetrators when she was aged 4-5 years, a single event when aged 7 years, and on-going abuse when aged 7-12 years.

Mrs X noted that she had become sexually active on a consensual basis in her early teens, had spent a period working in the sex industry when aged 13-15 years, had been introduced to cannabis by cousins when aged approximately 10yrs and had used this more or less ever since to

manage negative affect, calm herself and as a recreational activity. She also noted that she had been drawn to “bad boy” partners who had been violent but not sexually abusive. In this context she noted three significant violent relationships. Her most recent relationship has been with a cannabis dealer and, although he has not been violent, they argue often and she considered that she had often sought to “goad him” into hitting her to prove that he cared. His responses had been to simply leave the house which in turn provoked increased emotional dysregulation and some episodes of self-harm. She reports strong anxiety at the thought of losing him.

Ms X reported symptoms of PTSD with strong visual and auditory intrusive symptoms that almost exclusively arise from an incident when she was quite young and witnessed her father and three other men beat a man to the point of unconsciousness with softball bats and then beat the victim’s dog to death with the bat.

The current assessment supports diagnoses of PTSD, cannabis dependence, and borderline personality disorder. It is the assessor’s opinion that the PTSD is not significantly linked to the sexual abuse but is clearly and significantly linked to the childhood experience of violence and has been exacerbated by subsequent exposure to violence. Similarly the cannabis use is not considered to be linked to the sexual abuse and appears to have developed and been maintained through a combination of familial propensity for substance abuse, parental and familial modelling, the pleasurable effects associated with use, and the distress and agitation associated with not using.

With regard to the borderline personality disorder it is considered that the sexual abuse is a significant factor in the development of this albeit that it is not the only significant factor with the violence, neglect, and poor attachment also acting as important causal factors.

Although neither the PTSD or cannabis use is linked significantly to the sexual abuse, both act as barriers to treatment for the personality issues and will likely need some addressing as part of treatment for this.”

Example Three:

“Ms S is a 15 year old girl who presents as the oldest of three children with a history of having been raised in an environment where her father was demanding and verbally abusive, highly critical of her mother, her and the younger children. Her mother was supportive but passive, tried hard

not to upset her husband, and encouraged the children to try their hardest not to upset their father. Ms S is reported to have been an anxious child who nevertheless excelled academically and had a number of good friends. At age 11 she appears to have withdrawn socially and exhibited clear symptoms of depression following an incident in which she was raped by the teenage son of a family friend. She does not appear to have ever fully recovered from this with sub-threshold symptoms of depression present ever since but has been prone to more severe episodes of depression whenever things have gone wrong. (e.g., after the separation of her parents when she was aged 12 years, and when she did not achieve the grades she was expecting at the end of last year).

Most recently Ms S has increasingly developed high levels of anxiety about her academic performance and her weight, has become very rigid in her habits and very distressed when there are unexpected disruptions to her routine, and has developed restrictive eating patterns with significant weight loss. There have been similar concerns expressed by her school and the GP confirms problematic weight loss.

The current assessment supports diagnoses of persistent depressive disorder, anorexia nervosa-restricting type, and obsessive compulsive personality traits. The persistent depressive disorder is opined to be clearly and significantly linked to the sexual abuse event albeit that the discrete episodes of major depressive disorder may not be. The obsessive compulsive personality traits that appear to be developing and the anorexia-nervosa are not considered to be significantly linked to the sexual abuse event reported. Rather they appear to have arisen out of the low self-esteem and anxiety about negative evaluation that have developed as a result of her father's critical and demanding interpersonal style and her mother's modelling and encouragement of unhelpful perfectionistic strategies for responding to this. Both disorders appear to be the result of her use of over-controlling, perfectionistic strategies to avoid anxiety and negative outcomes such as failure or criticism."

What we don't cover

Your injury must be because of an accident. We won't cover things like illness, conditions from ageing and emotional issues.

Your injury must be because of an accident. We don't cover:

- illness or contagious diseases, eg measles

- stress, hurt feelings or other emotional issues. This is unless they're linked to an injury we already cover
- conditions related to ageing, eg arthritis
- most hernias
- injuries that happen over time, unless an activity at work is causing it
- damage to items that don’t replace body parts. This includes hearing aids, glasses, pacemakers and gastric bands.

These are some of the common injuries and conditions that in most cases we don't cover:

- if you have appendicitis and need an emergency trip to the hospital
- you get skin burn from the sun, wind or snow
- you have unexplained back pain that gets worse over time.