ISSUES FACED BY ACC CLAIMANTS

April 2021

A Report for the Royal Commission of Inquiry on issues facing survivors of abuse in care when seeking cover, compensation and rehabilitation from the Accident Compensation Corporation.

By John Miller & Brittany Peck

JOHN MILLER LAW
Barristers & Solicitors

Authors

JOHN MILLER founded John Miller Law in 2001. He is one of New Zealand's leading ACC law experts and a former senior law lecturer at Victoria University. John Miller has represented injured people, including many sensitive claimants, for the last 40 years. He is a tireless campaigner for ACC claimant rights and a sought-after media commentator and author on personal injury law. His firm has taken key cases affecting the rights of sensitive claimants such as *Murray v ACC*[1], *W v ACC*[2], and *KSB v ACC*[3]. It is also one of the few firms in New Zealand training young lawyers in how to be effective advocates in the complex area of ACC law.

John has been awarded many accolades for his work, including the Millennium Human Rights Award (2000) and Wellingtonian of the Year (2002), for his long-term efforts on behalf of injured claimants. In 2006, Victoria University of Wellington dedicated an annual John Miller Community Service Award for law students demonstrating an outstanding contribution to the community. In 2006 he was made an Honorary Fellow of the Royal Society of Physician of Ireland for his work on occupational health claims.

BRITTANY PECK has a BA/BSC and LLB and has been working at John Miller Law since 2012. She practices in the areas of criminal law, mental health law, and ACC law. She specialises in treatment injury and mental injury cases.

Acknowledgements

The authors acknowledge their clients who have shared their experiences of the ACC claims process with them and taught them about the issues they face. These clients have informed this opinion and as such it is written very much from a claimant point of view. The nature of the authors' work means that they are familiar with claimants who are struggling with the ACC process, but whom do have sufficient agency to seek advocacy.

The authors are not medically trained and have not sought medical expertise in preparing this report. Any reference to psychological impacts is informed by reports from their clients, rather than from an expert perspective.

[1] *Murray v ACC* [2013] NZHC 2967.
[2] *W v ACC* [2018] NZHC 937.
[3] KSB v ACC [2012] NZCA 82.

Contents

Scope of report

1. On 23 February 2021 the authors were instructed by The Royal Commission of Inquiry into Abuse in Care ("the Inquiry") to provide an expert opinion on the following matters listed as (a) – (h):

    a) Any significant issues you consider are faced by survivors of abuse in care (as defined in the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018) when applying for cover under ACC, including in relation to causation and disputes about cover. This may include as relevant issues with legal aid.

    b) Any significant issues you consider are faced by survivors who have cover under ACC (e.g. access to weekly compensation, lump sum compensation, and independence allowance entitlements, including assessment procedures, quantum, and timeframes for decision-making by ACC on entitlements).

    c) To the extent not covered by the above, your opinion on whether or not there are any significant gaps in the ACC legislation for survivors.

    d) Whether compensation for pain and suffering is available under ACC now.

    e) Whether compensation for pain and suffering was available through ACC in the past, and if so how much was available.

    f) Any key reforms which in your view need to be made to ACC to address any significant issues or gaps which you consider exist.

    g) Any areas in which you think ACC performs well, assists or otherwise provides a good service for survivors.

    h) Any other significant matters relating to ACC and survivors of abuse in care which you consider should be drawn to the Inquiry's attention.

2. This report starts with a brief overview of how the accident compensation scheme works, and then addresses each of these eight matters in turn.

3. It must be noted that the current accident compensation scheme consists of five Acts of Parliament, frequent amendments, as well as a large body of complex case law. As such the answers provided to these eight queries are not all-inclusive of every issue. However the authors are happy to provide more detailed information on any aspect that the Inquiry is interested in.

Overview of ACC processes

4. To understand the issues faced by survivors as ACC claimants, an understanding of how the scheme works is first needed.

5. Under the ACC scheme there are two key concepts: cover and entitlements.

6. Cover is what claimants receive when their personal injuries are accepted as falling under the 'umbrella' of the scheme. Cover is the 'gateway' to the scheme.

7. For each type of injury that the scheme covers, there are different criteria (legal tests) that have to be met for cover to be accepted. An acceptance of cover is simply that – the person does not automatically receive any rehabilitation or compensation upon acceptance of cover.

8. The types of injuries that are covered under the scheme include:

    - Physical injury caused by accident (which includes intentional injuries such as assault)
    - Mental injury caused by sexual abuse
    - Mental injury caused by physical injury
    - Work-related mental injury
    - Work-related gradual process
    - Treatment injury (previously medical misadventure)

9. The first three of these heads of cover are the most likely to be relevant to survivors of abuse.

10. Claims for cover are generally made by a General Practitioner or other health practitioner, but can also be made by an advocate or the claimant themselves.[4] The Accident Compensation Corporation ("ACC / the Corporation") investigates claims received and issues a decision. The investigation process can involve: obtaining the claimant's relevant records; seeking advice from internal ACC employees (such as a Psychology Advisor or a Clinical Advisory Panel); and seeking external advice from experts (such as a psychiatrist).

11. Once cover is accepted, a claimant can apply for entitlements.[5] These include: a lump sum or independence allowance; weekly compensation at 80% of lost earnings; loss of potential earnings ("LOPE") at 80% of minimum wage; treatment and rehabilitation.

12. Just as with the different types of cover, each entitlement has its own legal test that has to be satisfied.

13. A similar process of investigation applies to a request for entitlements, which may be made by a treatment provider or by the claimant themselves. ACC obtains information, which may include requiring the claimant to attend assessments, and then issues a decision.

[4] Accident Compensation Act 2001, s 48 – 49.
[5] Accident Compensation Act 2001, s 67 and 69.

14. When a person has cover and is accessing entitlements, they are allocated a case manager – also now referred to as a "Recovery Partner". The case manager is their point of contact and helps process the claim.

15. The Corporation must issue decisions on any request for cover or an entitlement in a timely manner.[6] For decisions on cover for 'complex claims', which includes mental injury caused by sexual abuse, the Corporation has nine months to issue a decision.[7] A failure to issue a decision within the legislated time frame results in 'deemed cover'.[8] There is no provision providing time frames for issuing a decision on entitlements, or for deemed entitlements.

16. All decisions carry rights of review.[9] A review must be lodged within three months unless there are extenuating circumstances.[10] A claimant can also lodge a review for unreasonable delay in processing a claim for entitlements.[11]

17. The Corporation must send a claimant's review application along with the ACC file to an independent reviewer. The Corporation contracts two organisations to perform this service for them: Fairway Resolution Ltd and Independent Complaint and Review Authority ("ICRA").

18. A recent initiative has taken the handling of reviews away from case managers. ACC has set up review units, manned by Review Specialists, who act as ACC's representative in review proceedings. In some instances, it is unclear how much authority Review Specialists have. Some seem to have a lot of power to correct errors and take positive steps towards resolution. Others seem bound by internal advisory comments and processes in the same way that case managers are.

19. ACC will also sometimes instruct external counsel to act at review. For unrepresented claimants this could be very daunting.

20. Both parties have an opportunity to obtain further evidence prior to the review hearing. Whilst this can be very beneficial in terms of allowing the claimant to counter the evidence from the ACC experts and advisors, and even lead to a settlement, it can also take months due to expert availability and workload. Further, it can be very expensive and beyond the means of many to obtain.

21. Inevitably the Corporation is given the chance to consider the claimant's evidence, and as part of doing so obtains its own further evidence, either internally or externally. Although as the applicant there is a right to have the final reply in evidence, many claimants will not have the resources to do so. This means the Corporation often has more evidence 'on its side' leading to an 'inequality of arms'.

22. A reviewer must issue a decision within 28 days of the review hearing[12], although there is provision to enforce this. Reviewers can award costs and expenses to a claimant, even

[6] Accident Compensation Act 2001, s 54.
[7] Accident Compensation Act 2001, s 57.
[8] Accident Compensation Act 2001, s 58
[9] Accident Compensation Act 2001, s 134.
[10] Accident Compensation Act 2001, s 135.
[11] Accident Compensation Act 2001, s 134(1)(b).

when their review is dismissed.[13] The maximum amounts are prescribed by regulation,[14] and will often not cover the full cost of legal fees and expert reports.

23. A reviewer can dismiss the review application, quash the ACC decision and replace it with their own, or they can make directions.[15] For example, directing ACC to investigate further and to issue a further decision with review rights.

24. Review decisions can be appealed to the District Court and proceed as a *de novo* hearing, meaning that parties can file further evidence.[16] The same 'inequality of arms' referred to above is often then played out again here. The legislation provides the power for the court to appoint an assessor.[17] However these powers do not appear to ever have been used, possibly due to the issue of funding and the delay it would cause.[18]

25. Appeals of District Court decisions to the High Court and Court of Appeal can only be on a question of law and leave to appeal has to be granted first.[19] ACC claimants can only appeal as far as the Court of Appeal.[20]

26. Claimants can also lodge complaints for breaches of the Claimant Code of Rights[21] and can lodge reviews of decisions on these.[22] However they cannot appeal the review decision.[23]

27. The above outline hopefully gives a sense of the long and arduous journey that many claimants face to obtain ACC cover and entitlements. The authors agree with the observation that:

> Originally, the scheme was principle-based with a community focus largely constructed around broad discretion rather than rigid procedure. Now, however, the scheme is individually focused: it is managed through "claims" made by injured people and "decisions" made by ACC. This has taken on a highly legalistic and procedural character.[24]

28. We will now address each of the specific queries (a) – (h) raised by the Inquiry.

---

[12] Accident Compensation Act 2001, s 144.
[13] Accident Compensation Act 2001, s 148.
[14] Accident Compensation (Review Costs and Appeals) Regulations 2002.
[15] Accident Compensation Act 2001, s 145.
[16] Accident Compensation Act 2001, ss 149 – 156.
[17] Accident Compensation Act 2001, s 157 – 158.
[18] See *Green v ACC* [2014] NZACC 67.
[19] Accident Compensation Act 2001, ss 162 – 163.
[20] Accident Compensation Act 2001, s 163(4).
[21] Injury Prevention, Rehabilitation, and Compensation (Code of ACC Claimants' Rights) Notice 2002.
[22] Accident Compensation Act 2001, s 134(1)(c).
[23] Accident Compensation Act 2001, s 149(3).
[24] Warren Forster, Tom Barraclough, and Tiho Mijatov *Solving the problem: causation, transparency and access to justice in New Zealand's personal injury system* 22 May 2017 at p 6.

a) Significant issues faced by survivors of abuse in care when applying for cover under ACC, including disputes in relation to causation and disputes about cover and legal aid

29. As above, the heads of cover which survivors of abuse may be eligible to apply for are:

    - Physical injury caused by accident (which includes intentional injuries such as assault)
    - Mental injury caused by sexual abuse
    - Mental injury caused by physical injury

30. Survivors face a number of issues when applying for cover for these injuries. The most significant of these, in the authors' opinion, are outlined below.

Issue 1: Date of injury deeming provision denies access to key entitlements

31. The fixing of date of injury by the Corporation can be a major problem for survivors who suffer from mental injuries caused by childhood abuse. The authors consider this is the most significant injustice facing survivors of abuse accessing the ACC scheme.

32. To qualify for weekly compensation or Loss of Potential Earnings ("LOPE") a claimant either has to be an earner at their date of injury and their date of incapacity; or they have to be under the age of 18 at their date of injury.[25]

33. ACC says that the date of a mental injury caused by sexual abuse, for the purposes of LOPE or weekly compensation, is deemed under s 36(1) of the 2001 Act. Section 36(1) deems the date of injury as the date of receiving treatment for the mental injury. Whereas the date of injury for a physical injury, or a mental injury from a physical injury (e.g. depression from leg fractures), is the date of occurrence of the physical injury.[26]

34. For example, a person who suffered sexual abuse in 2000 when they were 8 years old, but who first received treatment at age 20 for the mental injury in 2012, is precluded from accessing LOPE. Furthermore, if at age 20 the abuse survivor is not in employment, then there is no entitlement to weekly compensation either.

35. Previously ACC usually required that when receiving the treatment there was disclosure of the sexual abuse. However in 2013 the case of *Murray*[27] made it clear that this was not required. Rather, a broad interpretation should be taken. For example, a call to Lifeline could qualify. Occasionally we do still see ACC failing to apply this aspect of *Murray* when

[25] See Accident Compensation Act 2001, s 6(1): definition of "potential earner". There is a small extension for claimants whose date of injury is during full-time study which began before they turned 18 and continued uninterrupted after they turned 18.
[26] This leads to attempts by applicants to attempt to find a qualifying physical injury that the mental injury can be ascribed to instead of the sexual abuse. See *TF v ACC* [2020] NZACC 173; *KL v ACC* [2017] NZHC 1870.
[27] *Murray v ACC* [2013] NZHC 2967.

analysing a claimant's medical records for the purpose ascertaining the deemed date of injury under s 36(1), including defending this approach in the District Court.[28]

36. The widely recognised reality is that survivors of sexual abuse can take years to seek help, let alone actually receive treatment, and many of them will be over the age of 18 when they do so. The current application of the law punishes them for this, even though the reasons for delay in seeking help are easily understood, and indeed even acknowledged by ACC.[29]

37. Minors and incapacitated persons are dependent on their legal guardians for their wellbeing. This wellbeing includes seeking medical attention for them, protecting them from harm, and ensuring their legal rights are respected. Negligent caregivers, or caregivers who are responsible for the abuse, are unlikley to fulfill these duties. Due to the lack of capacity and immaturity of a child, as well as cultural, societal,[30] and personal factors such as fear and shame, many childhood sexual abuse victims do not disclose or seek help for many years even once they are adults and no longer subject to a caregiver. The court in *HB v ACC* [2019] NZACC 55 recognised this reality:

> [29] The appellant, along with the majority of rape victims was slow to seek help in the aftermath of her rape trauma. The delay in disclosure of this trauma to her GP or anyone else is commonplace. [31]

38. Indeed, the very nature of the trauma suffered, often inhibits the seeking of help. This was recognised by the majority of the Court of Appeal recently (with reference to expert psychiatric evidence), when examining the lack of reference to the mental distress or sexual assault in the victim's medical records:

> [196] … the scenario where a person is psychologically unable to engage with traumatic events (until some trigger event) would be more likely to manifest itself in a state of affairs where the anxiety was suppressed, and the trauma swept under the carpet.[32]

39. The agreed facts in another recent case, *TN v ACC*[33], also provide a stark example of these barriers:

> [1] The appellant was the victim of multiple Schedule 3 offences at the hands of family members, as well as an associate of the family. The abuse was severe and protracted lasting from ages 2 to 15.

---

[28] See *HB v ACC* [2020] NZACC 55 where a sensitive claimant represented herself against experienced ACC counsel to seek a finding that she received treatment for her PTSD when she was under the age of 18. ACC counsel submitted that she had not disclosed the abuse until after she turned 18 (at [23]). The Judge appropriately took a broad and generous approach in finding that she had received treatment for 'stress' prior to disclosing the abuse and this was sufficient to deem the date of injury as being at a GP appointment when she was 17.

[29] See https://www.acc.co.nz/newsroom/stories/sarahs-story-breaking-the-silence-on-rape/ .

[30] For example in *UT v ACC* [2019] NZACC 152 the court noted at [43]: "As is tragically so often the case the appellant's parents felt it was the appellant's fault and nothing was done about it."

[31] Compare to *B-Q v Accident Compensation Corporation* [2019] NZACC 19 where the District Court Judge stated at [205]: "I do not accept the criticism made by Ms Peck at both the appeal hearing and in her submissions, that it is "common knowledge traumatised young victims of sexual or physical assault do not raise it with anybody for years, due to shame and fear of disclosure".

[32] *Taylor v Roper* [2020] NZCA 26.

[33] *TN v ACC* [2020] NZACC 132.

> [2] At age 35 the appellant laid criminal charges against her grandfather and uncle. Both men were incarcerated for the crimes they committed against her.
>
> [3] The appellant's evidence is that she disclosed the abuse to her parents as early as age 7 but was told to "shut up" about the abuse and was not allowed to discuss it with others. Her family did not allow her to visit medical professionals unaccompanied.
>
> [4] At age 16 the appellant ran away from home. She was brought back by a man who her father then invited to stay in her room for several months. On one occasion the man forced her to have sex with his younger brother. The appellant's evidence is that she conceived from that rape.
>
> [5] The appellant's evidence is that she would have disclosed the abuse or the mental injuries resulting from the abuse when she visited her GP in relation to her pregnancy when she was 17 years old. She states in her affidavit:
>
> [i] Had her mother not been present at that consultation she would have discussed the abuse with the GP as "it was causing (her) distress".
> [ii] She was feeling deeply depressed, sleeping all day and rarely leaving the house.
> [iii] Her pregnancy "was a reminder of the abuse that had occurred, as it was a product of the abuse".
>
> [6] The Corporation granted the appellant cover for mental injuries of post traumatic stress disorder and major depressive disorder resulting from her abuse. But only from the date she sought treatment at age 35 thus she did not qualify for LOPE or weekly compensation as she was not in employment at the date of injury.

40. Despite these facts, the District Court Judge considered that as there had been no mention at all of the abuse or mental injury at the doctor's appointment when TN was 17, the date of injury under s 36(1) remained at age 35. This approach is in line with all other recent District Court decisions addressing the s 36(1) issue.[34]

41. John Miller Law is awaiting a decision on leave to appeal the *TN* judgment to the High Court on a question of law. However, it is clear that on the current application of s 36(1) by the Corporation and the courts, survivors of sexual abuse who do not receive treatment at an early age, through no fault of their own, are punished by the legislation

42. The authors consider that this restriction on entitlement is the antithesis of justice and the principles of a no-fault social insurance scheme, as well as being out of step with the nature of sexual abuse trauma.

43. Ironically, the injustice seems to have arisen from an attempt by Parliamentarians to avoid a hard limitation provision that was introduced in the 1992 Act.[35] Based on the case law, it

[34] Compare with *Welch v ACC* [2020] NZACC 40 where the Judge did feel able to take a purposive approach to create an artificial deemed date of injury in a mesothelioma injury case, where the issue was whether the claimant was 'ordinarily resident' at the date of injury.

[35] See the Parliamentary Debates for the 1992 Act, where the opposition raised concerns that the new Act would prevent sexual abuse victims from receiving cover due to a new limitation provision stating that claims must be lodged within 12 months of the injury being suffered. The issue went to Select Committee. At the second reading the Hon. Bill Birch for the Government was clear that sexual abuse victims would still get full cover by virtue of a new clause deeming the date of injury as being when treatment was first received for the

seems it was only years later during the tenure of the 2001 Act that ACC started using s 36(1) to deny LOPE to survivors of sexual abuse. Prior to that ACC appears to have continued to use the date of the abuse, as had been the practice under the 1972 and 1982 Acts.[36]

44. There are also major problems with date of injury for abuse survivors who are physically injured. For example if a claimant has a back injury at age 8 in 2000 due to physical abuse, but then at age 20 in in 2012 has to cease their employment and lose earnings because of a flare up of the childhood injury, they do not get any weekly compensation based on their employment earnings as they were a non-earner at the time of injury at age 8 in 2000. They can only receive LOPE which is set at 80% of the minimum wage, whereas they may have been earning double that from their employment.[37]

45. Thus the ACC loss of earnings compensation situation for abuse survivor is complex and unjust. Despite this being pointed out by the courts, no attempt has been made to change the legislation by Parliament. As the High Court noted in 2013:

> The outcomes under the present Act are unquestionably anomalous… No Judge could frame common law duties in such an inconsistent and erratic a fashion. Nor could insurers achieve such outcomes in an informed market.[38]

46. Therefore a legislative remedy is much needed.

Issue 2: Cover criteria are too complex and ungenerous

Claims covered by the 2001 Act

47. The 2001 Act centers around complex tests of causation for each head of cover and entitlement, which the Corporation is obligated to manage. This complexity and its concomitant management is often the cause of the distress and delays experienced by claimants.[39]

Physical injuries

48. Cover is available for physical injuries caused by accident, which would include physical assaults by caregivers. However it would not cover things such as malnutrition caused by a neglectful caregiver, as the definition of accident requires an external application of force.[40]

---

personal injury. The National Party (governing party at the time) policy document, also implies that there was no intention to derive people injured as children from being able to access LOPE.

[36] The authors are awaiting an Official Information Act response requesting clarification on exactly when this policy change occurred.

[37] See *Murray v ACC* [2013] NZHC 2967

[38] *Murray v ACC* [2013] NZHC 2967 at [69].

[39] This is extensively covered in: Warren Forster, Tom Barraclough, and Tiho Mijatov *Solving the problem: causation, transparency and access to justice in New Zealand's personal injury system* 22 May 2017.

[40] Accident Compensation Act 2001, s 25.

Mental injuries

49. Cover is available for mental injuries sustained by people abused while in care in two ways:

    a. Under section 21, cover is available for mental injuries "*caused by*" criminal acts listed in schedule 3 (sexual abuse) if they occurred in New Zealand.

    b. Under s 26(1)(c) cover is available for mental injury suffered "*because of*" physical injury suffered by the person.

50. Notably, this means that unless a person has suffered physical injury or sexual abuse, there is no ACC cover available. Survivors of abuse in state care that were subject to emotional abuse, psychological abuse, or neglect, whom have a mental injury condition/s that was caused by this abuse and trauma, with no contribution from physical injury or sexual abuse, would have no access to the accident compensation scheme.

51. For example in a recent case the claimant disclosed abuse whilst in state care. However it seems that the ACC simply proceeded to consider and decline his claim for mental injury from sexual abuse[41]:

> [27] … the Corporation does not dispute that the appellant suffered mental and psychological abuse while in state programmes as a child but that the abuse was not sexual abuse. Accordingly, she submits there is no evidence of mental injury following sexual abuse.

52. "Mental injury" is defined as a a clinically significant behavioural, cognitive, or psychological dysfunction.[42] As such, any consequences of abuse that do not reach this threshold will not be compensated by ACC.

53. Although not required, the authors rarely see the Corporation cover anything other than a DSM[43] diagnosis. Thus, despite the Disley report[44] and judicial comment[45], it would seem that the threshold of what qualifies as a mental injury is often still being applied at that level, when the legislative wording could support a wider scope. It is noted that the current *Guideline* for ACC mental injury assessors[46] does allow for other clinical diagnostic tools to be used. However, the authors consider that "clinically significant" should not mean that diagnostic tools should be rigidly adhered to and every criterion met. Rather, the focus should be on whether there are dysfunctions impairing a person to a clinically significant level.

54. Even with a wider approach, the current definition in s 27 means that survivors who may be badly affected but who do not develop 'significant dysfunctions' as a result of the abuse, will have no access to compensation or rehabilitation from ACC.

---

[41] ***NJ v ACC*** [2020] NZACC 133.
[42] Accident Compensation Act 2001, s 27.
[43] Diagnostic and Statistical Manual of Mental Disorders.
[44] Dr Barbara Disley et al. "Clinical Review of the ACC Sensitive Claims Clinical Pathway", September 2010.
[45] See for example: *Baker* v ACC [2012] NZACC; *Smith v ACC* [2018] NZACC 35 at [170]; *K v ACC* [2015] NZACC 42 at [54] – [58].
[46] ACC6429, November 2019. Attached at appendix "A".

55. Establishing a causal link to the abuse is often difficult, because survivors may have a background where they suffered a range of traumas or adversities that contributed to their mental health conditions. For example, an ACC assessor may find that the claimant was impacted by the separation from whanau when placed in care, or by the poor mental health of their parents, or by the neglect of a caregiver. The assessor may find that the mental injury condition is caused by these impacts, rather than the sexual abuse. This means the mental injury is not coverable. It is a sad irony that the circumstances that often make a child more vulnerable to things such as sexual abuse, such as caregiver neglect, are then the reason used to deny them ACC cover.[47]

56. Once a causal link to Post Traumatic Stress Disorder ("PTSD") is established by the assessor, the Corporation invariably grants cover for PTSD. The nature of this condition makes establishing a causal link more straightforward. However the authors often see the Corporation requiring an unreasonably high level of rationale to cover other conditions such as personality disorders, eating disorders, and pain disorders. For example, we see assessors or ACC psychology advisors making the following findings in their reports:

- A statement that substances are used in a self-medicating way by the claimant (i.e. sniffing glue to block out the traumatic abuse memories) followed by a conclusion that there is no causal link between the trauma and the substance use.
- A statement that the covered PTSD (relating to the abuse) caused the eating disorder, followed by a conclusion that there is no causal link between the abuse and the eating disorder.
- A statement that the person suffers from depression and anxiety, which could be viewed as part of the PTSD condition, followed by a conclusion that the depression and anxiety do not meet the criteria for cover.
- A statement that the claimant turned to drugs after the abuse as a coping mechanism, and that the drugs caused them to develop a psychotic disorder, followed by a declined of cover for the psychotic disorder.

57. It is vitally important that the full scope of coverable mental injuries is ascertained, as it has a direct bearing on the already meagre entitlements for people suffering mental injury. If conditions are not covered, then the claimant will have their Lump Sum payment reduced[48], or a finding may be made that their incapacity to work is due to non-covered conditions leading to a decline of weekly compensation.

58. The wording "because of" in s 26(1)(c) (concerning cover for mental injury caused by physical injury) has been the subject of a number of court decisions, however the leading authority is currently *W v ACC* [2018] NZHC 937.

59. In this decision Justice Collins undertook a thorough review of the previous divergent case law and reinforced some key principles:

[47] See *IM v ACC* [2020] NZACC 90 at [62].
[48] See for example *UT v ACC* [2019] NZACC 152.

- A direct link between the physical injury and the mental injury is not required.[49]
- Development of the mental injury need not be contemporaneous with the physical injury.[50]
- The physical impacts of the injuries need not be permanent or ongoing.
- Not remembering the abuse happening to you (for example because you were an infant, suffer from cognitive impairment, were drugged at the time, or have blocked the memory) is not a barrier to cover.
- The "but for" test may assist as a screening test for assessing causation, but there will be some circumstances not apposite to this.
- Multifactorial causation is not a barrier to cover;- what is required is a *material contribution* from the physical injury to the mental injury. That is what the focus of the enquiry should be.
- A *material contribution* in this context means a cause that is genuine and meaningful, rather than just trivial or minor. It does not need to be a substantial cause.[51]

60. Although dealing with mental injury because of physical injury, Justice Collins noted that the principles outlined would also likely be applicable to sexual abuse mental injury claims, albeit this comment was obiter.[52]

61. It is pleasing to see that the most recent *Guideline for completing mental injury assessments*[53] that ACC sends to its mental injury assessors now includes an explanation of 'material contribution' in line with *W v ACC*. Previous versions of the Guideline required a substantial cause.[54] However contrary to the obiter comment of Justice Collins, the Guideline seems to limit this to mental injury caused by physical injury claims under s 26(1)(c). The authors still see many instances of ACC Psychology Advisors and report writers requiring a direct link.

62. With regard to physical injuries, the Corporation seems to require contemporaneous medical evidence of these to accept cover. This is the case whether the claim is for a mental injury caused by the physical injury, or for the downstream physical consequences such a chronic pain or other post-traumatic conditions. This is a barrier to survivors who were unable or actively prevented from seeking medical care at the time of their physical injuries. The authors had to take one case to review (successfully) where despite the retrospective evidence from the treating orthopaedic surgeon, the Corporation did not accept that the knee injury was due to a brutal gang rape at a young age. Not all reviewers would have found in favour of such a claimant, in the absence of contemporaneous medical records.

63. Often revelations about the physical abuse sustained by a claimant are made in the context of a mental injury assessment for a sexual abuse claim. Indeed, the assessor may find that there is no material contribution to a condition because other *coverable* causes including

[49] See [86].
[50] See [74].
[51] At [65] and fn 75.
[52] At footnote 79.
[53] Appendix "A".
[54] One version dated June 2013 required that the injury is a 'substantial cause'.

physical abuse injuries have contributed. The authors are yet to see a case where the Corporation has of their own initiative recognised that physical abuse was part of the causal matrix and instructed the assessor to make a finding on whether that, either in and of itself, or in combination with the sexual abuse, was making a material contribution to the causation of the mental injury.[55] This is concerning given both types of trauma are covered by the legislation.

64. Such revelations in a report commissioned by the Corporation should be treated, with the claimant's consent, as an application for cover under s 26(1)(c). That would be in line with the directions of the Court of Appeal to take an investigative approach.[56] The authors wonder how many claimants miss out on ACC cover due to the Corporation not taking an active approach to facilitate such claims. Many claimants would not be aware this was another option for them, unless they had access to legal advice.

Claims covered by previous legislation

65. It is not uncommon for a claim to have been lodged under previous legislation[57],where the claimant received only a basic entitlement such as a few sessions of counselling. However later in life they may seek advice or further assistance from ACC, either due to increased stability, a relapse, or awareness of what they can claim for.

66. For example, we encounter clients in our work in the mental health and criminal justice courts who disclose their abuse as part of those processes. We often find they already have a generic 'sensitive claim' approved. We are then able to advise them on what they could apply for from ACC. They are mostly unaware of the availability of LOPE in particular.[58]

67. Some of these claimants have been on social welfare benefits for significant periods of time due to their mental injuries, with the impediments and struggles that living on such a low income entails. It is quite a surprise to many that they could have been living on significantly higher income (80% of the minimum wage), as well as accessing vocational rehabilitation from ACC for all those years.

68. Because of the expansion and contraction of the scheme over the years, the legislative criteria applicable to a particular claimant will depend on when they lodged their claim. This means some claimants have advantage over others in accessing entitlements – those who have cover under the more generous 1972 and 1982 Acts.

69. Under s 2 of the 1982 Act, an accepted claim for a "personal injury by accident" included the physical and mental consequences of the injury or of the accident event itself.[59] This meant that, unlike the current legislation, a claim accepted under the 1982 Act could

[55] See *NJ v ACC* [2020] NZACC 133 where the claimant mentioned physical abuse while in state care, however ACC appears to only have considered whether there is a claim for mental injury due to sexual abuse.
[56] See *ACC v Ambros* [2007] NZCA 304 at [64].
[57] There are 5 ACC Acts: 1972,1982,1992, 1998, and 2001.
[58] Section 50 of the 2001 Act requires ACC to facilitate access to entitlements. However could certainly be done proactively by the Corporation.
[59] The 1972 Act definition of personal injury is essentially the same as the 1982 Act.

extend to any mental consequences arising purely from the accident event and without the need to link them to a physical injury or sexual abuse.[60]

70. The level of connection required between an accident event and a physical or mental consequence is also more generous in that such a consequence can only be declined if caused *exclusively* by disease, infection, or the ageing process. A meagre connection was all that was required.[61] This is materially different to the current "wholly or substantially" test under the 2001 Act.

71. Furthermore, the term "mental consequences" itself had a wider meaning than "mental injury" in that it simply required there to be some emotional or psychological effect from the injury or accident.[62]

72. Another significant advantage is that under the 1982 Act the date of the mental injury from sexual abuse is the date of the abuse. This means that access to LOPE is much easier, as the claimant does not encounter the problems created by s 36(1), as outlined above from paragraph 31.

73. Such advantages for some claimants over others, who have suffered similar traumas, results in an inequity that is hard to justify.

74. The Corporation does not always appreciate the significance of ascertaining the correct Act before assessing cover and entitlements.[63] The authors often review claimant files to find that the 2001 Act criteria have been applied (by the Corporation and the medical assessors), when more advantageous 1972/1982 Act criteria of 'physical and mental consequences' applies. This is a level of legal complexity which should be eliminated. The authors see the only fair means of doing this would be making the more generous cover criteria under the 1972 and 1982 Acts, applicable to all mental injury claimants across the board, no matter when the claim was lodged.

75. Concerningly, we have recently seen the Corporation attempt to limit access to the more generous 1972 and 1982 Acts for claimants who are lucky enough to have had cover accepted during their tenure.

76. In *Wilson*[64]*,* the Corporation successfully argued that the wider definition of 'mental consequences of the accident' in s 2 of the 1982 Act did not apply, as the claimant had not sought treatment for the mental consequences until the tenure of the 2001 Act. Therefore, the more difficult mental injury criteria applied.[65]

---

[60] *Accident Compensation Corporation v E* [1992] 2 NZLR 426 (CA) at 433: "We see no other construction than that mental consequences of the accident are included within the term personal injury by accident whether or not there is also physical injury."
[61] *Prince v Accident Compensation Corporation* [2005] NZACC 161 at [9].
[62] *Green v Matheson* [1989] 3 NZLR 564 (CA) at 572: "[Once] there is a personal injury by accident within the scope of the Act, all the emotional or psychological effects fall within the statutory words 'The physical and mental consequences of any such injury or of the accident'."
[63] See for example *Gray v ACC* [2003] NZAR 289 where the Corporation accepted that they had wrongly applied the 1998 Act test when the 1982 Act test should have been applied, which was materially different.
[64] *Wilson v ACC* [2020] NZACC 71.
[65] John Miller Law has sought leave to appeal and is presently awaiting the District Court decision on this.

77. The Court of Appeal made some interesting observations recently in *Taylor v Roper*[66] in this regard, suggesting that a person is covered from the date of the abuse, regardless of whether they made a claim at the time. If this means they are covered by the legal criteria in force at the time, this would give many more claimants who suffered abuse in the 1970s and 1980s access to the more generous criteria that existed under the 1972 and 1982 Acts. John Miller Law is currently seeking leave to be heard in the High Court to test this argument. However clear legislative amendment would of course be preferable to litigation.

Issue 3: Legal Aid

78. There are many problems with legal aid for abuse survivors. The main issues are:

i. Legal aid is available but only when an adverse ACC decision has been made. Many claimants require much more assistance well before that stage. This includes when proceedings have been successful, following which the claimant may be waiting for the directions of the Reviewer to be actioned on investigating cover, or paying entitlements. However because the proceedings have finished, legal aid ceases. Many claimants need significant support and advocacy to get the outcome for the successful proceedings actioned by ACC in a timely and fair manner. This is not funded by legal aid and will have to be done pro bono or at cost to the claimant.

ii. The legal aid available for ACC cases is set at restrictive levels that do not cover the work required to do justice to a claimant's case and the complex law governing their claim. This reduces the appeal of specialising in ACC law, and the building and maintaining of a strong personal injury bar to give ACC litigants choice in qualified representation. John Miller Law is one of the few ACC specialist practitioners who still accept ACC clients who require legal aid funding.

iii. Even those claimants on low incomes or social welfare benefits are often required to repay legal aid whether they win or lose, and will have to use some their meagre entitlements gained to pay back legal aid.

iv. For claimants who have managed to buy a house but nevertheless may be on a pension or low income, the approval letters from legal can be so outputting, mentioning possible six figure sum repayments, that claimants refuse legal aid and the only option is to continue on a pro bono basis to ensure justice is done.

v. The low amounts available for legal aid give an unfair advantage to ACC in any dispute as they have unlimited funds and regularly employ corporate law firms and QC's to fight the claims.

79. Our firm assists clients with write off applications to legal aid. However these are done after the proceeding has been finalised, so there is still the stress of proceeding with a legal

[66] *Taylor v Roper* [2020] NZCA 268 [1 July 2020]; the majority (Brown J and Clifford J).

challenge with a fear of ending up in debt. For claimants on a low income this can be off-putting and hence create access to justice issues.

b) Significant issues faced by survivors who have cover

80. Once a claimant has secured cover, there may still be issues in accessing entitlements. Issues with accessing some of the main ACC entitlements are addressed below.

Issue 1: Access to Weekly Compensation and Loss of Potential Earnings

81. The main issue with access to this entitlement is the way date of injury is deemed, as set out from paragraph 31 above.

82. As an additional affront, if a claimant is able to find a date of mental injury which qualifies, possibly after a lengthy legal proceeding, the assessment process and resulting payment can take many months if not years.

83. Although these claimants would have likely already attended recent comprehensive cover and impairment assessments, they then usually have to attend three further assessments for LOPE. This can be daunting and off-putting for claimants who, by virtue of the need for the entitlement, may be easily triggered or destabilised. Indeed they may still be recovering from the cover assessment process.

84. The authors are not aware of whether or how often ACC waives the need for these assessments, or allows them to be done as a file review, in cases where it is patently obvious that a person who for example has chronic complex PTSD, would not be able to sustain work in any occupation. It is the authors' opinion that such waivers should be utilised more often to reduce re-traumatisation.

85. Perhaps a 'traffic light' system could be used. The cover assessor could indicate in an amendment report once cover has been accepted, whether it is clear (on balance of probabilities) that the person could not work in any job for 30 hours per week[67] due to their covered injury; whether this was possible; or whether it was unknown. The former should not have to proceed with the two or three LOPE assessments, if they confirm that they wish to apply for this entitlement.

86. The authors see significant delays in the area of processing backdated LOPE and weekly compensation once entitlement has been established. Although some of these cases are complex as they involve decades of backdating, and require ACC to request information from WINZ, it is essentially just a calculus that needs to be determined. One of our clients has been waiting since April 2020 (after a review decision in her favour) for her complete backdating to be received. ACC advised:

[67] In *Allen-Baines v ACC* [2011] NZACC 308 the court found that the s 105 test for LOPE should be based on a 30 hour working week.

> *My apologies for the delay in completing this task which has come about because we have disabled the old payments system which would normally have been used to calculate the payments. We are in the process of finalising manual calculations which once done will enable us to advise MSD of the gross weekly compensation rates for the period concerned.*

87. It is not clear whether a new system is going to be, or has been installed to reduce the manual workload of the team and decrease delays. It is clear that 12 months to process backdated LOPE is not acceptable. At the very least, more staff should be employed ot undertake the manual calculations. The only recourse a claimant has is to lodge an unreasonable delay review. However a reviewer is not equipped to undertake these calculations as a remedy, so it s a somewhat hollow recourse.

88. The low level of interest payable on delayed payments[68] available does not adequately recompense for these delays in the authors' opinion.

89. In cases where a successful claim has resulted in backdated LOPE or weekly compensation being paid out in one year, people are then penalised by having the highest tax rate applied to them. Provision should be made so that people are only taxed at the rate they would have been taxed at, if they had received the payments in real time.

Issue 2: Access to Lump Sum and Independence Allowance

90. This is a payment which recognises the permanent impairment caused by a personal injury. The payment is calculated based on the percentage of impairment caused by the injury, determined by an ACC appointed assessor.[69]

91. The AMA 4 Guide[70] which the legislation requires assessors use, is antiquated and does not provide a good tool for measuring the impact of injury on a person, although this seems to vary somewhat depending on the assessor. It is particularly problematic with assessing the impact of mental injury. Indeed, the AMA states that it should not be used to calculate financial awards.[71]

92. It is noted that in 2009 ACC found that ratings were even lower under the 6th edition of the Guide.[72] One answer therefore may be for New Zealand to develop its own ACC specific guide to rating impairment.[73]

93. In the author's experience it is rare to see lump sum ratings for mental injuries go as high as 40%, which equates to a payment of around $28,000.00. Most will be rated lower than this. If a person is rated at 9% or less they will receive nothing.

---

[68] Accident Compensation Act 2001, s 113.
[69] Accident Compensation Act 2001, sch 1, Part 3.
[70] American Medical Association's Guides to the Evaluation of Permanent Impairment, Fourth Edition (AMA 4).
[71] At p 1/5.
[72] https://www.acc.co.nz/assets/oia-responses/AMA-guidelines-for-medical-assessors-GOV-005254-response.pdf .
[73] The Corporation does provide a handbook for assessors, but the predominant tool is still the AMA 4.

94. Many claimants feel aggrieved that they cannot choose whether to receive a lump sum or an independence allowance, as this is based on date of injury or date of sexual abuse. The Corporation does have discretion to pay a five year advance on an independence allowance, but does not always exercise this.

95. Backdating an independence allowance often results in a significant payment for the claimant, before their quarterly payments start. Recently we have seen a number of cases in which ACC are proceeding to review simply to avoid backdating claimant's independence allowance to the date they lodged the claim for cover.

96. In one such case, in a review of a first assessment decision (based on a 0% rating for sensitive claim PTSD), ACC argued that decision had been revoked by a subsequent decision approving an independence allowance (based on a 14% rating) and there was no jurisdiction for the Reviewer to consider the first assessment decision. No backdating was provided in the new decision. After technical advice, the Corporation later agreed there was jurisdiction and the new decision was actually based on a reassessment. However, the Reviewer found there was no jurisdiction because the first decision had been revoked. No appeal was lodged. The new decision was reviewed due to the lack of backdating. In submissions for the review of the new decision, the Corporation continued to argue the first assessment with the revoked decision remained valid, arguing that the new decision was merely the "first decision" and the new decision was based on both assessments. This was all to avoid backdating.[74]

97. In another such case, all prior independence allowance decisions had been quashed. A 2018 assessment of sensitive claim PTSD was thus the first assessment and backdating paid. The claimant later received additional cover and rather than assessing her again, ACC agreed to have the assessor simply amend her report. As a result of the amended report, the claimant's rating went up by 5%. ACC then determined that a reassessment should have been undertaken instead and refused to issue a decision on the amended report. The applicant lodged a review and ACC issued a decision on the amended report but without the additional backdating of the increase. The applicant lodged a review due to the lack of backdating. ACC proceeded on the basis the amended report constituted a reassessment despite the claimant not being seen since 2018 and ACC's earlier acknowledgement that the amended report was not a reassessment. Counsel prepared to proceed to review to argue why an amended report for a first assessment does not constitute a reassessment. ACC settled the matter the day before the hearing.

98. Challenging impairment assessments can be very difficult. Because it is not a standard medical tool, the only people trained in using the AMA 4 are those contracted to do impairment assessments to ACC. This makes obtaining a competing independent assessment, which some reviewers and court decisions seem to require, nigh impossible.

99. Other issues with this entitlement are covered in the below sections (d) and (e) on pain and suffering.

[74] The matter proceeded to review and was successful. ACC was also asked to investigate further cover - it has been over six months with no decision or update.

Issue 3: Access to Treatment

100. Our clients could use more help finding treatment providers. Wait lists appear to be long with insufficient choice of counsellors.[75] Provision of addiction rehabilitation can be similarly problematic due to shortage of providers.

101. ACC can also be too slow to respond urgent requests. For example when extra sessions are needed during periods of stress, which may include when ACC requires the claimant to attend further assessments. Claimants who do not attend such assessments are at risk of losing their entitlements for non-compliance.[76]

102. Clients who request 'non-standard' rehabilitation are often declined, or are required to provide extensive rationale for the request. Examples include assistance dogs and self-defence courses. These can be empowering and helpful to people recovering from trauma. However there seems to be an unwillingness to consider such requests, let alone suggest them to claimants, even though there is a scope under the legislation to fund alternative approaches.

103. It would seem beneficial and appropriate if ACC funds were used in improving the quality and quantity of the counselling and rehabilitation workforce, to try an reduce some of these barriers.

Issue 4: Disentitlement of self-inflicted injuries or suicide

104. Survivors of abuse may self-harm or even take their own lives as a result of their mental injuries.

105. Prior to 2010 the legislation had at least allowed entitlements to be paid any to dependents of the deceased. However in 2010, s 119 was introduced to prevent claimants and any dependents from receiving entitlements other than treatment costs, where the injury was the result of self-infliction or suicide unrelated to a covered injury.

106. The authors consider this provision is inconsistent with the purpose of the scheme to reduce the impact of injury on whanau and communities.[77]

c) Significant gaps in the legislation

107. The following are significant gaps in the Accident Compensation which affect survivors of abuse:

---

[75] See the comments of the claimant at [100] of *IM v ACC* [2020] NZACC 90. Recent media has also highlighted this: https://www.nzherald.co.nz/nz/wellington-sexual-assault-victim-told-wait-for-acc-therapy-could-near-nine-months/2S3WJBAHLHFJTDITL3KFLOSDD4/ .

[76] See for example Accident Compensation Act 2001, s 117(3).

[77] Accident Compensation Act 2001, s 3.

i. A claimant needs to have suffered the effects of the abuse to a level that means they have a 'clinically significant dysfunction', usually in the form of a DSM diagnosis. The dysfunction then also has to be sufficiently causally linked to either a physical injury or sexual abuse. This means some survivors of abuse will not have any access to ACC compensation and rehabilitation.

ii. For claimants covered under the 1992, 1998 or 2001 Act, the application of the date of injury provisions often means that there is no access to weekly compensation or LOPE.

iii. The provisions assessing the level of compensation for permanent impairment (lump sum or independence allowance) are not generous enough, especially in relation to mental injuries.

108. Other gaps exist, but for conciseness we have focused on these three.

d) Whether compensation for pain and suffering is available under ACC now; and

e) Whether compensation for pain and suffering was available through ACC in the past, and if so how much was available.

109. The short answer is that compensation for pain and suffering was available in the past but is not available now. Nor can abuse survivors sue for such compensation, as the Accident Compensation legislation bars damages claims in a New Zealand court for personal injury in New Zealand.[78]

110. A significant component in such damages claims against the wrongdoer had always been compensation for pain suffering and loss of amenities. Amenities covered such matters as the inability to see, smell, play the piano etc.

111. The 1967 Woodhouse Report, which eventually led to the Accident Compensation legislation five years later, did not recommend including any lump sum for this loss.

112. However due to submissions from the New Zealand Law Society and Unions during the five years, it was recognised in Justice Department submissions to the 1969-1970 Select Committee that this form of compensation was "too deeply embedded in our legal system to abolish at the present time".

[78] The exception is that exemplary damages are still available, however that is a high threshold to meet. See *McGougan v DePuy International Ltd* [2018] NZCA 91; [2018] 2 NZLR 916.

113. Consequently, the Accident Compensation Act 1972 which came into force on 1 April 1974, provided under s 120 for the sum of $5,000.00 (later increased to $10,000.00) to be paid for:

    a) Loss suffered by the person of amenities or capacity for enjoying life, including loss from disfigurement and pain; and

    b) Mental suffering, including nervous shock and neurosis.

114. This lump sum was in addition to another lump sum in s 119 of $5,000.00 (later increased to $7,000.00) for permanent loss or impairment of bodily function. This was based on percentages set out in Schedule 2 to the 1972 Act. Such a schedule had been used in the now repealed Workers Compensation Act 1956. For example the loss of an arm was set at 80%, the loss of a thumb at 28%.

115. The two lump sums were carried over into the 1982 Act which came into force on 1 April 1983.

116. Section 79 of the 1982 Act continued the pain and suffering lump sum using the same wording as in the 1972 Act. However, the amount was increased to $10,000.00.
117. Section 78 of the 1982 Act also continued with the percentage based assessment for loss or impairment of bodily function. The schedule of percentages was expanded, but the basic losses remained. For example, the loss of an arm was set at 80%, the loss of a thumb at 28%. The maximum amount of this lump sum was increased to $17,000.00.

118. These two lump sums continued until 1 July 1992, when they were replaced by the "meaner and leaner" Accident Rehabilitation and Compensation Insurance Act 1992.
119. The lump sum of $10,000.00 for pain suffering and loss of amenities under s 79 of the 1982 Act was completely abolished.

120. The schedule percentage impairment lump sum of $17,000.00 under s 78 of the 1982 Act was replaced with what was described as an independence allowance ("IA") of a maximum of $60.00 per week, payable quarterly.

121. Instead of a schedule as in the 1982 Act with percentage impairments already set out, assessments were to be made by assessors using the American Medical Association guides to the evaluation of permanent impairments ("AMA")[79].

122. Thus, from 1 July 1992 onwards there was no compensation at all for pain and suffering and loss of amenities under the Accident Compensation legislation.

123. The Accident Insurance Act 1998 replaced the 1992 Act from 1 July 1999 and continued the independence allowance instead of a lump sum. It added a further complication in that private insurers were allowed back into providing ACC cover. The AMA guides continued to be used for assessment.

[79] There were different assessment procedures initially.

124. On 1 April 2002 the Accident Compensation Act 2001 came into force and reintroduced a lump sum, but not for pain, suffering and loss of amenities. The lump sum of up to $100,000.00 was for permanent impairment only, and again the AMA guides were to be used to calculate the level of payment. The maximum lump sum award has increased periodically and is now around $134,000.00.

125. There was a further limitation in that no lump sum was payable if the act (in the case of sexual abuse) happened before 1 April 2002.[80]

126. This of course affects many historical sexual abuse claims, so that even if the date of injury is set by s 36 after 1 April 2002 when treatment is received, no lump sum is payable if the sexual abuse happened before 1 April 2002. Instead, an independence allowance (IA) is the only option available.

127. This means that many sexual abuse victims no longer have any lump sums for pain and suffering, and are also denied the permanent impairment lump sums. Instead, they have to rely on the meagre independence allowance payable quarterly.[81]

128. Injuries are assessed at the 'snapshot in time' of the assessment. Low amounts of the lump sum will be awarded if the sexual abuse survivor has, despite the trauma, managed to make some success of their lives, or is in a relatively good place at the time of the assessment. This means the payment may be based on a rare level of functioning.

129. For example, one of our clients is so impaired by her covered addictions and PTSD, that she cannot maintain stable housing and is frequently before the courts for crimes committed whilst she lives on the street. Her functioning is so impaired that getting her to attend an impairment assessment was impossible in these circumstances. With ACC's cooperation we were able to arrange for an assessment to be undertaken while she was remanded in custody for a brief period. However, whilst in custody she is comparatively less impaired, as she is sober and returns to a higher level of functioning including eating regular meals, partaking in activities, doing laundry etc. As such, her resulting impairment rating does not reflect how she actually functions the majority of the time.

130. This all leads to a confusing picture, as given the five different Accident Compensation Acts, and the fact that injuries and events may occur when different Acts were in force, there are many problems in working out whether a lump sum or independence allowance is payable and from when.

131. Further, when there are previous and subsequent injuries, working out what deductions (if any) are to be made for any previous lump sum or IA payments can be complicated.

132. A major injustice is that percentages assessed under the 1972 and 198 Acts were much higher that the percentages now assessed under the AMA guides. Deducting a previous lump sum award percentage from the current percentage assessment under the AMA guides means that often no further award is made for a subsequent injury.

[80] Accident Compensation Act 2001, sch 1, cl 55.
[81] There is a discretionary provision for the ACC to make a five year advance of the independence allowance.

133. For example, the loss of an arm was assessed at 80% under the 1972 and 1982 Acts, whereas an assessment of 80% in the AMA guides is given for tetraplegia. Thus, any assessment of new injury now, to someone who has a previous 1972/1982 lump sum for the loss of an arm, means that very little (if any) compensation is awarded.

134. The AMA guides also use the confusing concept of whole person impairment ("WPI") for assessments which limits the amounts awarded for injuries. This concept of WPI is explained in the *ACC v Fenemor*[82] case where John Miller Law argued that deductions based on the higher awards under the previous Acts were unfair. We succeeded in the High Court but lost when the ACC appealed to the Court of Appeal. However the Court of Appeal did provide a succinct explanation of the Whole person Impairment concept:

> **The whole-person impairment assessment**
>
> [14] Mr Fenemor suffered a back injury in 1990 for which he received a lump sum bodily impairment payment assessed at 10 per cent under the First Schedule of the 1982 Act. Eight years later he suffered a very serious leg injury. He was then reassessed as having a 28 per cent impairment from his leg and a 5 per cent impairment from his previous back injury. Together they gave a combined assessment of 32 per cent. One could be excused for thinking that 28 plus 5 equals 33 per cent. But in the world of accident compensation it does not. This is because under s 441(3)(c) and s 442(2)(a), the assessment had to be done on a "whole-person impairment" basis.
>
> [15] The way the whole-person impairment assessment operates is as follows. That term was previously found in s 54(5)(a) of the 1992 Act (as applicable from 1 July 1997). Reg 3 of the Accident Rehabilitation and Compensation Insurance (Independence Allowance Assessment and Rates of Payment) Regulations 1997 then required that assessment of a person's whole-person impairment to be carried out using the AMA's Guides to the Evaluation of Permanent Impairment (4ed). (The prior s 54 referred to the second edition of the same Guides at s 54(15).) That method of assessment continued under the 2001 Act, which was in force when Mr Fenemor applied.
>
> [16] The chart in the AMA Guides shows how two injuries are assessed by taking the greater percentage and then working out the combined percentage from the chart. That combined percentage is described in these terms:
>
> > The values are derived from the formula, A + B(1-A) = combined value of A and B, where A and B are the decimal equivalents of the impairment ratings.
>
> [17] The reasoning behind such a formula is to be found in the ACC User Handbook (expressly referred to in Reg 4(2) of the Injury Prevention, Rehabilitation, and Compensation (Lump Sum and Independence Allowance) Regulations 2002) (at 13):
>
> > **Combining: How it works**
> >
> > This is how "combining" works:
> >
> > - If we take an individual with no impairment, and they lose their leg (the impairment value for which is 40%), they now only have 60% of their whole person remaining.

[82] *ACC v Fenemor* [2008] NZCA 241.

- If they then suffer a further loss of (say) the other leg, that second impairment is deemed to be on the 60% whole person remaining. That is, the whole-person impairment for the second leg is 24% (40% of 60%).
- The total impairment for the loss of both legs is 64% (40% for the first leg, plus 24% for the second).
- The remaining whole person is now 36%. (Any further impairments should be applied to 36% of the whole person.)

The method guarantees that the total impairment rating for an individual can't exceed 100%, and can be expressed mathematically as:

Percentage impairment = A + B(1-A)

Where A and B are the two impairment values being combined.

[18] Thus, "whole-person impairment" assessments take the person's existing state of impairment into account when assessing the impact of any subsequent injury (whether related or not). The wording of the Handbook makes no reference to the injuries being related and the sense of the passage quoted is that the injuries do not need to be related. The Guide also recognises that a person cannot be impaired more than 100 per cent whether or not the injuries are related"

135. These and other lump sum problems can be further detailed if required, but as the question we are asked is on pain and suffering and loss of amenities it is clear that compensation for that ceased when the 1982 Act was replaced with the 1992 Act.

136. While it may be pointed out that the AMA guides do have provision (chapter 15) to consider pain, the ACC have in effect prevented its use by instructing assessors that: pain is not separately rateable, except where specifically noted in AMA 4 because in general, the AMA4 percentages for the various organ system already make allowance for accompanying pain.

137. This instruction is invariably repeated in all assessments by assessors and is used to deny any greater percentage being awarded for a painful injury unless it is chronic pain from a physical injury. For that to be considered the ACC require a psychiatric evaluation to assess whether the pain can be labelled as a mental injury.

138. We successfully challenged this approach in *Bryan v ACC*[83] but the ACC practice still continues.

f) Key reforms which need to be made to ACC to address any significant issues or gaps

139. The authors believe, along with many others, that the time has come for a comprehensive Royal Commission looking into the operation of the current ACC scheme, and how it should

[83] [2013] NZACC 16.

intersect with the health and social welfare systems. Consideration should be given to how resources used on policing the complex legal criteria could be better channelled into rehabilitation, treatment and compensation.

140. Some commentators believe that more piecemeal reform to the scheme should be set aside in favour of waiting for this comprehensive overhaul. It is acknowledged that high level aspects of ACC such as how it is funded and the operation of the board, have an impact on how claims for victims of abuse in state care and are in need of review. However the reform recommendations of this report are necessarily narrower in scope.

> **Recommendation 1**: Amend s 36 of the legislation so that it is clear that survivors of sexual abuse are not to be penalised for coming forward to receive treatment when they are/were ready and able to do so. The person should be able to elect LOPE or weekly compensation – whichever is the most appropriate and beneficial to them. The authors consider this is the most significant injustice affecting sexual abuse survivors accessing the ACC scheme, and the easiest to remedy.
>
> **Recommendation 2**: Amend the cover requirements to allow for a more consistent, simple, and generous assessment of cover for the consequences of abuse, no matter when suffered and when the claim is lodged.
>
> **Recommendation 3:** Replace the AMA 4 with a more appropriate assessment tool and increase the amounts that claimants can receive as lump sums.
>
> **Recommendation 4:** Amend the tax law that applies to backdated weekly compensation and LOPE so that claimants are not taxed at the highest rate.
>
> **Recommendation 5:** Remove the disentitlement in cases of self-inflicted injuries or suicide in s 119.
>
> **Recommendation 6:** Amend Legal Aid requirements to increase access to good quality advocacy.

141. Other recommendations can be made, however for conciseness the authors have focused on these six as being particularly important.

g) Areas where ACC performs well, assists or provides a good service for survivors

Treatment and rehabilitation

142. Generally when a claimant seeks counselling funding from ACC this is approved. The authors encounter few decline decisions for this entitlement. We see many of our clients engaging in therapeutic, even life-saving, counselling and psychiatric treatment as a result of ACC funding.

143. The initial approval with 'no questions asked' of some hours of counselling for new claimants, as recommended by the Disley report, reduces the stress of deciding whether to enter into the ACC scheme.

144. The rehabilitation provisions are appropriately wide[84] and ACC seems to be increasingly open to other rehabilitative and therapeutic options. For example the authors understand that now all approved sensitive claims can access (at least) five Trauma Sensitive Yoga classes.

145. The authors also understand that ACC will fund a number of sessions with a social worker. This has a significant impact in terms of giving claimants support to deal with basic needs such as housing. This in turn allows them to reach a place where they are better placed to attend ACC assessments and rehabilitative appointments such as counselling, and vocational training.

146. The authors consider that this type of practical assistance should be more readily funded by the ACC given the difference it can make to alleviating consequences of the abuse. It could also help in integrating the different services and support the person is accessing. The public and NGO sectors are often overwhelmed in this space. More ACC funding (including for funding training of more social workers and navigators) could make a significant impact.

Not requiring evidence of a prosecution or police complaint

147. In the majority of cases ACC appropriately does not require any corroborative evidence that sexual abuse was suffered, or that there were criminal convictions for it.[85] However some ACC report writers use "alleged" in their reports, which can suggest to the claimant that they are not believed, which has a re-traumatising effect on them.

148. The authors also note that many claimants need reassurance when they contact us that they do not need to provide proof such as criminal convictions that they did suffer abuse. This is often based on a misunderstanding that this is the reason their cover or entitlements were declined, when the issue was usually ACC not accepting a causal link between the abuse and the mental injury, as outlined below.

Lump Sum and Independence Allowance payments not affecting WINZ payments

149. Per s 197(5)(b) of the Social Security Act 2018, lump sum and independence allowance payments do not affect a person's receipt of a social welfare benefit. This is appropriate given the low level of social welfare benefits and the fact that lump sum or independence allowances are a type of compensation which recognises long term impairment, rather than work capacity.

[84] Accident Compensation Act, Part 1.
[85] Accident Compensation Act 2001, 21(5).

Allowing claimants to request gender of assessor, reviewer, case manger

150. Having control over this is an important aspect to reducing the stress and re-traumatisation aspects of the claim's process. When counsel is involved this is often specifically asked. However it is not clear if claimants without advocacy are always given this option unless they initiate the request themselves.

Improvements to instructions to assessors

151. Recent improvements to the *Guideline for completing mental injury assessments*[86] that ACC sends to its assessors are pleasing to see. This is now much more in line with the legal criteria. If this embeds and is carefully applied by the assessors alongside training as to the right legal thresholds, then this could decrease the number of people inappropriately being declined cover. However, people whose assessments took place before these changes and did not have advocacy may have missed out on cover, or on the appropriate scope of cover.

Contribution to costs

152. The costs that can be awarded by a Reviewer, even if the claimant is unsuccessful, assist in allowing people to challenge adverse decisions. However the maximum award for a specialist report is $1094.84, even if their case is successful. As most specialist reports would cost more than this, there will still be a cost that needs to be covered by the claimant or legal aid.

153. Occasionally when the claim is successful, or is settled prior to hearing, ACC does agree to cover the full cost of a report obtained by the claimant. The Corporation is also often agreeable to paying for joint instructions to an agreed expert, which can be useful in reducing the cost to claimants without funding. This can result in ACC settling the matter or the claimant withdrawing the review without so much legal aid debt.

h) Other significant matters relating to ACC and survivors of abuse in care

Delays in assessing and making decisions

154. There are often delays in getting cover and entitlement assessments underway due to the availability of assessors. After the assessment report is written it then goes through an

[86] The most recent version seen by the authors is dated November 2019 and is attached to the ACC6429 template for Supported Assessments.

internal process at ACC which can delay a decision for further weeks.[87] Whilst ACC would say this is justified to ensure robust decisions are made, as set out above the authors consider that the scrutiny applied is overly rigorous and not apposite to a social insurance scheme, especially one responsible for dealing with the effects of childhood abuse.

155. Claimants have little power when it comes to delays. The legislation gives the Corporation a lot of leeway in this regard.[88] Essentially ACC can simply issue a decline decision to avoid a deemed cover decision under s 58 (usually on the basis that they have insufficient information to approve cover), then continue to slowly investigate.

156. There are no provisions that provide timeliness requirements for entitlement decisions in the 2001 Act.[89] Proving that the Corporation should have issued a decision earlier in order to claim interest can be difficult, and only relates to weekly compensation and LOPE entitlements.

157. Claimants can lodge reviews claiming unreasonable delay in providing an entitlement.[90] This is something that the authors as counsel will often do, but many self-represented claimants may not know about this. If the review goes to an effective Review Specialist, they can often use their specialist help in removing any roadblocks in the responsible unit at ACC and speeding up a decision. If there is not an effective or willing Review Specialist assigned to the review, then things may have to progress to a hearing. The earliest a hearing would usually proceed is three months from lodgment, due to reviewer availability and because ACC requires time to prepare the file.

158. Often reviewers feel too hamstrung to fully use their power under s 145 to make the decision themselves in an unreasonable delay review, given that the legal test relating to the entitlement may require medical or other evidence that is not yet available. By the time any District Court appeal is lodged a decision has usually been issued. If the decision is a decline, the person has to go start the process of challenging it by lodging a review again.

159. However the District Court recently criticised the Corporation for cynically issuing a decline decision the day before an unreasonable delay hearing to try and nullify jurisdiction.[91] ACC did not appeal the decision. The authors hope this means that the Corporation is taking note of these judicial findings and instigates measures to reduce such occurrences.

160. In summary, more powerful mechanisms for holding the Corporation to account for unreasonable delays would make the scheme fairer to claimants. The time and resources it takes to investigate and issue decisions could also be reduced by a more generous approach to cover, as set out above.

---

[87] See this media report on this issue: https://www.tvnz.co.nz/one-news/new-zealand/sexual-assault-survivor-says-accs-complex-compensation-process-made-him-want-give-up-so-many-times .
[88] See sections 54, 56, and 57.
[89] Compare to the 1998 Act ss 56-57 setting timeliness requirements that applied to cover and entitlement decisions.
[90] Accident Compensation Act 2001, s 134(1)(b).
[91] *Meehan v Accident Compensation Corporation* [2020] NZACC 125.

Late claims creating evidential barriers

161. Delays in lodging claims or accessing entitlements can create evidential barriers, as counselling or other records that could support the claim, date of injury, or incapacity period have been destroyed or lost. ACC is often quick to remind claimants that the onus is on them to prove their entitlement. This is particularly galling when claimants had ACC claims accepted in past decades but entitlements were not facilitated at the time and the original ACC file with this information has since been destroyed.

162. Counsel may be able to undertake the work required to track down documents or provide corroborative evidence such as affidavits. ACC often does not go further than requesting GP and Hospital records. Many claimants are not up to contacting agencies such as Police, Corrections, Oranga Tamariki, or schools to ask for their records. It is somewhat of a double-edged sword as these records may reveal uncoverable traumas that could make establishing a material contribution to coverable traumas even less straightforward, as explained above.

Re-traumatisation

163. Sensitive claimants inevitably have to tell their story to a number of people, which can be difficult especially if they have trust and other issues associated with their conditions.[92]

164. For a claimant to access cover, a lump sum, and LOPE, they will have to go to a number of assessments with at least four different assessors. If the claimant chooses to challenge any of these decisions, lawyers are usually forced to advise them that to increase their prospects it would be good to get a competing evidence – i.e. another assessment with yet another new face.

165. The Court in *K v ACC* [2015] NZACC 42 captured this problem well:

> [44] Included in the appellant's issues is the constant referral of her to assessments and reassessment, and to review, the effects of which mean she has had to relive the trauma. Further, the appellant has had to deal with confusing terminology applying to her claim; the poor co-ordination of the claim of physical injury considered in isolation from mental injury, resulting in review, and then followed by revocation of a primary decision. These processes have caused severe distress. All of these issues in relation to claimants who have suffered sexual abuse are addressed in Dr Disley's report, with sensible and constructive recommendations made for resolution.
>
> ...
>
> [48] As noted in the comprehensive report by Dr Barbara Disley, the assessment processes, in the case of sexual abuse victims, can exacerbate their injuries. The *Disley Report* stated at 18:
>
> > The assessment processes must be tailored to the needs of sexual assault victims, be appropriate for use by those with expertise in working therapeutically with the psychological impacts of sexual abuse and assault, be safe and acceptable to Māori,

[92] See for example the comments made by the claimant in *IM v ACC* NZACC 90 [2020] at [27].

> people from diverse cultures and children and young people. While the assessment process will contribute to the determination of cover, it must also contribute to the recovery process.
>
> [49] It is not difficult to understand the appellant's anguish.

166. This re-traumatisation can impact whether claimants choose to challenge an ACC decision, no matter how justified, because it means that a Review Specialist, Reviewer, and other people in those units will then have access to their very personal information. Counsel can try and mitigate this when they are involved. For example we recently requested the same Reviewer/Mediator and Review Specialist as had been involved in a previous mediation. ACC and the review unit accommodated this request. This allowed the sensitive claimant client to feel less stressed and hence more able to engage in what was a productive mediation proceeding. Often this will not be an option however.

167. A high turnover of case managers in the sensitive claims unit is something our clients often advise causes distress. It can take time for a case manager to build rapport and gain an understanding as to what is particularly important to that client (i.e. being involved in every communication about them versus only wanting to know the essentials).

168. To facilitate rapport and assist any necessary transfer of case manager, new claimants could be asked for their preferences in terms of gender of assessors and case managers, preferred means of contact and times, advocates or family they would like included, and any other aspects that would make communication as claimant friendly as possible. This could be recorded at the front of the file to assist in the absence of the usual case manager, or in any necessary transfer of case manager. Obviously the claimant should be able to update this at any time. The Sensitive Claims Unit ("SCU") are generally good at allowing claimants to change case managers when the relationship is not working.

169. Case managers recently had their title changed to 'Recovery Partner'. Whilst acknowledging the significant contribution a good case manager can make, the authors feel that this wording is not appropriate given that case managers are often involved in communicating declines of entitlements and cover, and are not actively involved in the rehabilitation services. The title implies a level of shared experience that does not exist. More careful thought from the perspective of claimants should be given to such terms.

170. The authors are not privy to the internal workings of the SCU. However it would seem that a strong effective SCU would have case managers well trained in the effects of trauma, how to communicate with people with a history of trauma, and good workplace culture with robust support and remuneration for its staff so that there is less staff turnover.

171. The SCU should not be limited to sexual abuse – it should also include claimants who have sustained physical injury due to childhood physical abuse. Similar considerations apply in these circumstances meaning they should be treated differently by ACC to injuries sustained in accidents.

High standard of evidence applied by Corporation

172. Whether evidence meets the relevant threshold is of course an area where parties to disputes often disagree. However, the authors consider that the Corporation, usually via its assessors and instructed experts, often tends towards applying a higher level of evidence, above balance of probabilities and closer to certainty. It is reluctant to 'join obvious dots' when there are gaps in the records, or where the expert may not have spelt things out explicitly.

173. For example the majority in the Court of Appeal in *Taylor v Roper*[93] noted in assessing Ms Taylor's history:

> [196] French J makes the point at [106] that the medical records clearly demonstrate intermittent concerns, not of continual suffering such as said to be required by s 24. However, we do not consider that it is necessary in order to establish a s 24 disability that there be a "picture of consistent psychiatric problems". On the contrary, the scenario where a person is psychologically unable to engage with traumatic events (until some trigger event) would be more likely to manifest itself in a state of affairs where the anxiety was suppressed, and the trauma swept under the carpet.

174. It is notable that the *Guidelines*[94] sent to mental injury assessors do not mention balance of probabilities at all, let alone under the section asking for comment on the causal relationship between the sexual abuse and the diagnosed conditions. As such, it is likely that the practitioners providing these reports are applying a higher level of certainty than is required. This is particularly likely given the report writers are often doctors who are more familiar with medical certainty, as opposed to balance of probabilities. Possibly the assessors are instructed elsewhere on this, however it is rare to see the ACC assessors state their findings on the basis of 'more likely than not'.

175. When the authors instruct experts, we are always very clear that we are asking their opinion of what is more likely than not. It is thus unsurprising then that often our experts often find more conditions have a causal link to the abuse, or to the incapacity to work, than the ACC instructed assessor. It also means that we almost always have to obtain second opinions when representing claimants in cover disputes, as we can have no confidence in how the ACC expert was instructed.

176. The Corporation sometimes does not adequately take into consideration the impacts of trauma on memory, and on causing people to act in an unexpected way when assessing whether the evidential thresholds are met. In *PQ v Accident Compensation Corporation* [2019] NZACC 60 the court commented on this:

> [48] It is a truism to say that those with mental health challenges are often not the most methodical, ordered, or reliable reporters of their own history, and it is therefore not at all surprising that evidence of early childhood sexual abuse, as well as the rape in 1988, has emerged in a somewhat haphazard fashion. In 1988 it may well have been overshadowed, so far as the appellant was concerned, by the breakup with her de facto partner, at least in her own mind.

[93] Above n 66.
[94] Appendix "A".

177. The authors consider ACC could improve its approach to claimant evidence to be more in line with the above judicial comment.

Access to Justice and Appeal rights

178. Issues around access to justice have been extensively covered in a report by Acclaim Otago[95] and subsequent Miriam Dean QC report ("the Dean Review"). A further report has analysed the impact of the changes arising from the Dean Review.[96]

179. Following the Dean Review ACC introduced a Navigation Service. There are two providers: Wayfinders and Wanau Ora. It is not yet clear how successful this has been.[97] Navigation support does not extend to legal advice on whether an ACC decision is correct or should be challenged.

180. The impact of legal aid restrictions on access to justice is covered above from paragraph 78.

181. Due to access to legal aid or capacity of lawyers who specialise in ACC, many claimants are forced to self-represent or may be represented by advocates who do not have a legal qualification. This is concerning given the complexity of some of the law, as set out in this report. Further, advocates cannot access legal aid funding, meaning that their clients would have to pay for any evidence (above what can be claimed back at review) themselves. As outlined above, evidence is often crucial to winning a case as many of the disputes centre around medico-legal causation, and most reports cost more than the $1094.18 claimable at review.

182. There can also be significant delays in having appeals heard. As the District Court recently noted:

> [10] At the present time the widespread practice in the District Court jurisdiction as it relates to ACC appeals of advocates representing clients is not itself the subject of regulation either under the District Court Rules specifically or under the ACC Act itself. Recent estimates are that advocates who are not barristers or solicitors with a current practicing certificate represent appellants in close to 50% of cases.
>
> [11] Appeals in this jurisdiction are frequent and currently there is a backlog of over 600.
>
> [12] The question then arises as to what standard advocates in this jurisdiction should be held to when performing their advocate's role.

[95] Acclaim Otago "Understanding the Problem: An Analysis of ACC Appeals Processes to Identify Barriers to Access to Justice for Injured New Zealanders" (9 July 2015).
[96] Ibid.
[97] Appendix "B" is an OIA request by ACC Futures to try and ascertain this.

183. Appeal from the District Court is only available on a question of law and first leave has to be granted. If leave is declined by the District Court then an application for special leave has to be made to the High Court, with the attendant High Court fees.

184. Unfortunately if the District Court Judge frames the decision as a finding of fact it creates difficulty in appealing. One judge in the District Court found against claimants in around 95% of her decisions. As the decisions often had a factual issue at their heart it was often difficult to obtain leave to challenge the decision.

185. Even when leave is granted, the time and expense in taking matters to the High Court and Court of Appeal is daunting to many claimants, especially when there are well resourced corporate law firms and Queens Counsel instructed by ACC to defend its decisions.

186. The authors also consider that s 163(4) preventing access to the Supreme Court needs to be removed. Issues of law arising from a complex piece of legislation, which affect crucial rights of New Zealanders to access rehabilitation and compensation, such as those abused in state care, should have the benefit of the highest court in the land. The fact that people have access to a review process is not a sufficient reason. Section 74 of the Senior Courts Act acts as a sufficient bar to unnecessary appeals.

187. Similarly the authors support the suggestion of removing the leave to appeal process and replacing it with a general right of appeal. A lot of time and resources are wasted by having to go through the leave process.

Differential outcomes

188. The Inquiry recognises that a significant number of those abused in care were from Māori and Pacific communities.[98]

189. Given the advantages of being under the ACC scheme, as opposed to the public health system, differential access to ACC likely contributes to the overall health and wellbeing differential outcomes in New Zealand.

190. In 2015 John Wren wrote a comprehensive report outlining the differential access and outcomes that Maori faced in relation to the ACC scheme.[99]

191. The authors acknowledge that they are not experts in this area and there will be those who can more appropriately advise on this aspect. Allowing assessments, review processes and other aspects of ACC to operate with respect to tikanga when requested by the client, could improve access and outcomes. These preferences could also be noted on the claimant communication preferences record suggested above. It is noted that in June 2020 ACC and the Health Research Council of NZ announced funding for research proposals that

[98] Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018.
[99] John Wren *Evidence for Māori Under-utilisation of ACC Funded Injury and Rehabilitation Support Services: Māori Responsiveness Report 1* ACC Research, Wellington, August 2015

address health inequity in ageing Māori.[100] Similar research on inequity of access for survivors of abuse could be commissioned.

192. The ACC Board should also be more representative of key stakeholders, and should include Māori and Pasifika members.

Conclusion

193. Survivors of abuse in care face significant hurdles when accessing the ACC scheme. Some of those hurdles are inherent in the legislation and require Parliament's attention to rectify them. Other barriers are inherent in the way that the Corporation operates, and others still are due to systems outside of ACC such as the level of counsellor availability and access to legal aid.

194. Survivors who have access to good quality legal representation and advocacy may be able to overcome some of these hurdles. However even when successful, the limited compensation they may receive is often neither substantial nor life-changing.

[100] 2020 Achieving equity for aging Māori: Injury prevention, service access and injury rehabilitation.

ACC6429

Supported Assessment - adults

Mental injury assessors carrying out the Supported Assessment service should complete this form after you have completed a mental injury assessment with an adult client. If you are new to providing these assessments, please make sure you obtain supervision or peer consultation from an experienced ACC mental injury assessor. This form is for adults; if the client is a child or young person use the *ACC6424 Supported Assessment – child and young person* form.

The guidelines at the end of this form provide detailed information on how to complete in each section. Please read these to familiarise yourself with the specific requirements of this assessment report. We also have more supporting information at 'Providing therapy for sensitive claims' and 'Integrated Services for Sensitive Claims Supported Assessments'.

When you've finished, please return this form to sensitiveclaimsproviderreports@acc.co.nz

1. Client details		
Client name:	Claim number:	
Date of birth:	Address:	
Contact details / Safe contact where appropriate:		
☐ Female	☐ Male	☐ Other
Ethnicity:		

2. Assessor and supplier details	
Supplier name:	Supplier number:
Supplier address:	
Assessor name:	
Assessor email address:	Assessor phone number:
☐ Psychiatrist	☐ Psychologist
☐ Psychotherapist	☐ Counsellor

3. Introductions	
Dates of consultations:	Duration of consultations:
Sources of information:	
Client capability: This refers to the client's ability to understand the purpose of the assessment and their ability to provide valid information.	

4. About the event
Briefly describe the event or events, the date range of the events, frequency of the events, and the age of the client at the time of each event identified as the basis of this mental injury claim. Please outline the meaning

ACC6429 Supported Assessment - adults

and emotional impact of the event for the client at the time of the event and after.

5. Background client information

A) Summary of relevant background information. Please refer to relevant medical history (illnesses, operations, hospitalisations), developmental history, education or employment history, alcohol and drug history (if relevant), family history, cultural and spiritual background, and forensic history (if relevant):

B) Past psychiatric or psychological history including treatment for the presenting problems:

C) Current situation and presenting problems:

D) Summary of previous clinical and psychometric assessments:

E) Current medications and dosages, including the names of prescribers:

If this client has received any treatment from another health provider(s) for this condition, please provide a contact name and email (phone number) for each provider.

Contact name:	Contact email:

6. Diagnosis

Please refer to the guidelines at the end of the form when completing this section.

A) Personality assessment:

B) Client strengths and protective factors. Please describe factors such as relationships, family connectedness, cultural/spiritual identity.

C) Areas of vulnerability:

D) Mental state examination:

E) Psychometric testing (if relevant):

F) Results of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0):

ACC6429 Supported Assessment - adults

Domain	Score	Domain	Score
Understanding and communicating:		Getting around:	
Self-care:		Getting along with people:	
Life activities – household:		Life activities – school or work:	
Participation in society:		Total disability score:	
Qualitative data:			
☐ A copy of the form is attached.			
G) Diagnosis (and classification system used): If the diagnosis is not made using the ICD9 or ICD10 classification systems, please enter the ICD9 or ICD10 diagnostic code that corresponds to the diagnosis you are making here:			
H) Formulation and summary:			
I) Risk assessment:			
J) Symptom validity:			

7. Opinion

A) Relationship between the sexual abuse or sexual assault and the diagnosed mental conditions:

B) Relationship between other life events and the diagnosed mental conditions:

8. Treatment

Please provide any broad recommendations for treatment derived from your assessment:

9. Prognosis

What is your prognosis for this client's mental injury?

10. Other information

Please provide any other information that you consider relevant, eg genograms. You may attach additional

ACC6429 Supported Assessment - adults

pages if required and expand this section as much as you need.

11. Provider declaration and signature	
By entering my name in the signature field, I confirm the information contained in this report is accurate, and I have followed the standards explained in the ISSC Operational Guidelines.	
Signature:	Date:
Date of last face-to-face meeting with client:	
List other providers who contributed to the assessment.	
☐ I have explained to the client that the information collected during the assessment will be sent to ACC and obtained their authority for this.	
☐ I have explained to the client that a copy of this report will be sent by ACC to their Lead Provider (if relevant)	
☐ The client would like a copy of this report to be sent to them by ACC.	
☐ I have explained to the client that they have the opportunity to participate in a feedback session prior to this report being submitted to ACC.	
The client: ☐ wants to participate in the feedback session ☐ doesn't want to participate in the feedback session (please provide reasons)	

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.

ACC6429 Supported Assessment - adults

Guidelines for completing Supported Assessments

Use these guidelines when you assess ACC clients who have lodged a claim for a mental injury caused by a sexual abuse event. Part A discusses key terms and Part B provides guidelines for completing the *ACC6429 Supported Assessment – adults*.

You should also refer to "'Integrated Services for Sensitive Claims Supported assessments' for further guidance.

Part A – Key terms and guidelines for assessment of sexual abuse related mental injury

These guidelines have been informed by clinicians from the mental health field, who were brought together by ACC to provide clinical advice on the cover process and these guidelines.

Cover

Deciding cover for mental injury involves establishing that the sexual abuse event, as defined by Schedule 3 of the Accident Compensation Act 2001 (AC Act 2001), has caused the client to develop a clinically significant behavioural, cognitive or psychological dysfunction (i.e. a 'mental injury') as defined in the AC Act 2001.

Deciding cover for a sexual abuse-related mental injury requires establishing that the event meets the criteria for a Schedule 3 event. For these claims, this does not mean the client has to have proof that the event occurred. The event does not have to have been witnessed by others, does not have to have resulted in formal charges against or conviction of the perpetrator and need not have been previously disclosed by the client.

Sexual abuse event

To be considered a sexual abuse event, the event(s) must meet all of the criteria. The event must have:

- occurred in New Zealand or occurred while the client was an ordinary resident of New Zealand temporarily travelling overseas
- involved the occurrence of any one or more of the events listed as Schedule 3 events under the AC Act 2001. Whilst it is acknowledged that other events of a sexual nature might have been very distressing for the client, only those events that clearly meet the definitions under the AC Act 2001 can be considered as sexual abuse events.

Clinically significant mental injury

To be considered a clinically significant mental injury, ACC requires a diagnosis based on a diagnostic framework that supports the concept of clinical significance. Acceptable diagnostic frameworks are:

- DSM IV
- DSM-5
- Psychodynamic Diagnostic Manual (PDM)
- ICD-10
- DC:0-3R.

Your mental injury assessment must differentiate between a normal distress response and a persisting response, which is associated with dysfunction or disability.

ACC6429 Supported Assessment - adults

Please include the following items in the assessment:

- **Collateral information about the signs and symptoms and resulting impairment.**

Collateral information can be in the form of past medical records from a general practitioner (GP) or other mental health providers, records from other agencies such as Child Youth and Family (CYF), or accounts from family/whānau, friends, educational providers or employers (if older adolescent and relevant), pre- and post-injury. This information might help to provide a more accurate and fuller picture of pre- and post-injury presentation, the course of any impairment over time and any non-abuse related factors that might have contributed to the overall presentation. Examples of such factors include exposure to domestic violence, exposure to bullying, poor attachment, serious physical health problems, family history of other mental health or behavioural problems. It might also help to assist in determining the clinical significance of any impairment resulting from injury in the client's social, educational and other relevant environment.

- **Use of standardised instruments to provide supportive information for the clinical formulation where appropriate**

Psychometric instruments can help you determine what symptoms the client is experiencing and can assist in focusing the interview. Consider using both qualitative and quantitative data without relying exclusively on one or the other. Using psychometric instruments that help determine the consistency of the reported symptoms can inform an objective evaluation and can help in setting a baseline for measuring any treatment progress. Where a significant inconsistency arises, consider the options to investigate this further.

- **Diagnosis of mental injury and its relationship to the sexual abuse event**

In the mental injury assessment, you should demonstrate that the onset or development of symptoms was caused by the sexual abuse event. Provide a careful inquiry of pre-injury symptoms and behaviour where this is possible. Where this is not possible, (eg if there is little information about pre-injury functioning), you should carefully consider the development and progression of the mental injury and the client's wider context to identify and fully consider all factors that have contributed to the presentation.

The sexual abuse must have materially contributed to the condition diagnosed as clinically significant. However, it does not have to be the only material contribution to the condition.

It's important that you distinguish whether the sexual abuse materially contributed to the mental injury, instead of being a trigger or the final straw in a succession of stressful events. You should also determine whether the presenting issues have arisen at times where this might be better accounted for by other factors in the client's life, circumstances or development.

You should examine GP notes, DHB notes or other notes from relevant health professionals or other agencies to help provide supporting discussion and documentation. These will be particularly important in assessing claims where the sexual abuse event occurred some time ago.

Key terms

Below are the relevant legislative terms and phrases used by ACC to determine cover for this type of claim.

Term	Definition and explanation
Mental injury	A clinically significant behavioural, cognitive, or psychological dysfunction (defined in section 27 of the AC Act 2001). ACC considers that a psychological dysfunction is considered clinically significant if it meets the diagnostic criteria specified in currently available diagnostic tools. All diagnostic formulations must be made with reference to the diagnostic

	tool used.
Materially contributed	To satisfy s 26(1)(c) of the Act, the physical injury or work-related event must be a cause of the mental injury in some genuine or meaningful way, rather than just in a trivial or minor way.
Schedule 3 event	Cover for mental injury caused by certain acts dealt with in the Crimes Act 1961. A full list of these acts is available on our website.
Occurring in New Zealand or while an ordinary resident of New Zealand	The sexual abuse event occurred in New Zealand or, if occurring outside of New Zealand, occurred while the client was ordinarily resident in New Zealand. A person is an ordinary resident in New Zealand if New Zealand is their permanent place of residence and one of the following applies: • they are a New Zealand citizen • they hold a residence class visa granted under the Immigration Act 2009 • they are exempt from any requirement to hold a resident class visa under the Immigration Act 2009 • they are a spouse, partner, child or dependant who generally accompanies a person who fits one of the above criteria

Part B – Guidelines for completing the ACC6429 Supported Assessment – adults form

Sections 1 and 2:

Please complete all sections.

Section 3: Introductions

Sources of information

Please list and number all sources of information used in completing the assessment. Identify the nature of the information (eg document, interview or phone contact), the origin or author of the information, and the date of the information. If undated, please note this.

You should also note any information that you know to be available yet wasn't available to you.

Client capability

Client capability refers to the client's ability to understand the purpose of the assessment and also to their capacity to provide valid information.

If appropriate, please acknowledge any concerns about the client's capability to participate in such an assessment.

Section 4: About the event

Briefly describe each event. Include details such as the circumstances, location, memory and reaction at the time, and injuries caused. Explicit details are not required but brief details of the events, sufficient to establish that they represent Schedule 3 events should be included. For each event please give the following details:

- date of event

- age of the client at the time
- relationship between the client and perpetrator (if any)
- age and gender of the perpetrator
- frequency of events and time period over which this occurred
- brief details of the events.

Please outline the meaning and emotional impact of the event for the client at the time of the event and after.

Section 5: Background information

A. Summary of relevant background information

Please include a note of relevant medical history (illnesses, operations, hospitalisations), developmental history, alcohol and drug history if relevant, family history, cultural and spiritual background, education or employment related issues and forensic history if relevant. The following list is a guide to information that may be included in the assessment report where relevant:

- **Medical history**
  Include any past medical history relevant to this assessment.

- **Personal history**
  A general summary of the client's personal history is important. If you identify any mental health disorders or significant behavioural problems, please record a more comprehensive account of the personal history. Please take care to only record clinically relevant personal information. Possible information includes developmental history, relationship history, and social history. Obtain a history of any physical or emotional abuse.

- **Family history**
  You should record a summary of family relationships and functioning, including any family history of mental health, alcohol or drug problems. Note family of origin and current family composition and relationships, the nature of the family environment, the client's relationships with family, friends and any past and present partners or spouses. To protect privacy, refer to third parties using their relationship to the client, rather than their names.

- **Cultural and spiritual background (if relevant)**
  Summarise the client's relevant cultural and spiritual background and outline any particular cultural needs that need to be considered when working therapeutically with the client. Please note there are Māori cultural competencies guidelines for providers – see ACC1625 Guidelines on Māori Cultural Competencies.

- **Education or employment-related issues**
  Record any relevant issues the client has in their study or workplace environment that could influence their presentation. Include details of any occupational functioning over time.

- **Alcohol, drug and gambling history (if relevant)**

Please record a full alcohol, drug and gambling history if relevant. Include the nature, frequency, and pattern of use or behaviour over time, and amounts of any alcohol and substances that might be used. Record whether the client describes any symptoms or signs of abuse or dependence, what problems their alcohol or drug use or gambling behaviour may have caused them, whether they have accessed previous treatment or rehabilitation programmes, and whether these were successful. It is particularly important to record the current pattern of use and behaviour, and what difficulties this might be causing the client in areas that might be important for occupational rehabilitation. If you diagnose any alcohol, drug or gambling related problem, please include the raw data to support your diagnosis.

- **Forensic history (if relevant)**
  Please record any pattern of misdemeanours and list any convictions and imprisonments.

B. Past psychiatric or psychological history including treatment for the presenting problems (if relevant)

Please summarise any past psychological and/or psychiatric history. Describe any pre-event experience of symptoms, behavioural problems and/or psychosocial difficulties. Give a clear account of the identified problems, times that treatment was received, what the treatment was, and effects or outcomes of treatment. Please also note the details of previous treatment providers if known.

C. Current situation and presenting problems

It's important that you identify problems described by the client and give a comprehensive account of any clinical signs or symptoms you describe. Describe the original onset and progression of symptoms, including dates of onset of particular symptoms, and note effects of the trauma on thinking, cognition, and behaviour.

It's also important that you record any resulting impairment or disability, and the extent to which each impedes full rehabilitation for the client. We require that the World Health Organisation Disability Assessment Schedule (WHODAS 2.0) be filled in by the client for this purpose. ACC uses the WHODAS 2.0 as an outcome measure for all clients.

D. Summary of previous clinical and psychometric assessments

It can be helpful to comment on any other assessments that have been previously completed and identify where, if at all, the client's account of the mental injury, symptoms or events differs. Please reference information outlined in this section clearly and accurately.

This is also a good opportunity to identify other tests or assessments that may be helpful in further clarifying aspects of the client's presentation. It can also be helpful to comment on any other assessments that have been previously completed, and to identify and discuss any differences between earlier findings and reports regarding symptoms or events if any.

E. Current medications and dosages including the name/s of prescriber(s)

List all current medications and dosages and any relevant past medication.

Section 6: Diagnosis

A. Personality assessment

ACC6429 Supported Assessment - adults

You should undertake formal clinical assessment of personality and/or standardised personality testing, if indicated, to identify relevant aspects of personality function. Please resist making premature comments about personality function before you have obtained sufficient supporting evidence.

B. Client strengths and protective factors

Please describe protective factors such as relationships with others, family connectedness, cultural/spiritual identity.

C. Areas of vulnerability

Please describe any areas of vulnerability for the client.

D. Mental state examination

Undertake a full mental state examination (MSE) and record relevant findings in each report. Include all areas of an MSE using an accepted format with a comprehensive account of any relevant abnormal phenomena.

You should also include a comment on apparent cognitive function and assessment of insight and judgement.

E. Psychometric testing (if relevant)

Please indicate any other tests or assessments that you used to further clarify aspects of the client's presentation.

F. WHODAS 2.0 World Health Organization Disability Assessment Schedule 2.0

Use the 36-item version, self-administered by the client. If necessary, there is a proxy-administered version if the individual is of impaired capacity and unable to complete the form. Both of these forms are available on http://www.who.int/classifications/icf/whodasii/en/ . Please request that the client reads all instructions carefully.

Use the qualitative data section to comment on/explain the ratings and make observations about the client's functioning in everyday contexts.

G. Diagnosis (and classification system used)

Please outline any formal psychiatric or psychological diagnoses that you think are appropriate and reference them clearly to the classification system used. Consider the following questions:

- In your opinion, does the client have a clinically significant mental condition?
- If so, what factors indicate this?
- What is the diagnosis? Please define precisely and outline the classification system used.

If in your opinion your diagnosis differs from previous diagnoses, please give reasons for the difference.

If you haven't used the ICD9 or IDC10 classification systems, please enter a ICD9 or IDC10 code as well.

H. Formulation and summary

ACC6429 Supported Assessment - adults

Please provide a clear formulation explaining how the client has developed any presenting difficulties. 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. The formulation does not need to be long but should succinctly encompass aspects of the individuality of the client. Please do not simply copy and paste previous sections, but rather summarise key information that contributed to the client's current presentation.

There is some helpful information on formulation in the document 'Integrated Services for Sensitive Claims Supported assessments'.

I. Risk assessment

You should include a comment on any suicide risk, risk of other self-harm and any risk of harm to/from others. The assessment should formulate risk and identify any particular situations in which the client may present issues of risk, and you should include ways in which these risks can best be monitored and mitigated.

You need to ensure that there is an adequate risk management plan for the client if necessary. If there are significant concerns it is your responsibility to make any necessary notifications (eg, to police, acute mental health services, CYFS). If you have made any notifications, please record them here.

The following aspects of safety and risk need to be considered in the assessment: internal risks to the client such as suicidality, self-harm, medical and extended mental health needs; external risks to self, such as substance abuse and unsafe sexual practices, risks from others such as further sexual or physical abuse and neglect; and risks to others, including abuse or neglect of children.

J. Symptom validity

Please record your evaluation of symptom exaggeration during the assessment process, including any tests this client has taken as part of your evaluation. Please refer to the earlier section of these guidelines (PART A: Consideration of symptom exaggeration and how it affects the diagnosis) for fuller details.

We've provided some useful material to help you to consider and report on symptom validity in the 'ISSC Supported Assessments' document.

Section 7: Opinion

A. Relationship between the sexual abuse or sexual assault and the diagnosed mental conditions

Please answer the question "Have the sexual abuse event(s) materially contributed to the diagnosed mental condition(s)?" If there is more than one diagnosis, consider each diagnosis separately and provide a rationale for your conclusion(s). Consider the guidelines provided.

If there is not a specific diagnosis but the client is considered to have a clinically significant behavioural, cognitive or psychological dysfunction, please indicate how the sexual abuse event(s) is a material contribution to the clinically significant dysfunction.

For definitions of 'event' and 'mental condition' see Part A.

B. Relationship between other life events and the mental condition

ACC6429 Supported Assessment - adults

If applicable, please outline what other issues, separate from this event(s), that may have contributed to the client's current mental condition or emotional and/or behavioural problems.

Please indicate what effect these are having on the client's mental state and/or behaviour.

Section 8: Treatment

Please provide any broad recommendations for treatment derived from your assessment

While this report is for you to provide us with your assessment of our client's mental injury we understand that the determination of treatment recommendations is a routine part of assessment. Please provide any broad recommendations for the treatment of this client here derived from your assessment. These might include some broad goals such as behavioural regulation, skills acquisition for anxiety management or increased engagement in social activity, or broad recommendations for how a treatment provider might approach these issues such as graded exposure, or trauma processing. We ask that you don't complete a detailed treatment plan for another provider to follow.

It is expected that this section will be developed in discussion with the treatment provider and that the broad recommendations of the assessment report will continue to allow the treatment provider to develop their own specific Wellbeing Plan within any broad recommendations made by the assessor.

Section 9: Prognosis

What is the prognosis for this client?

If applicable, please indicate your prognosis for this client's mental injury(s) and the severity of the client's condition(s).

Section 10: Other information

Please provide any other relevant information that may help ACC to determine whether the client has suffered a mental injury as a result of a Schedule 3 event.

Section 11: Provider declaration and signature

Please complete, sign and date this section. Please also note the date of your last face-to-face meeting with the client.

"B"

10 August 2020

Hazel Armstrong
hazel@armstrongthompson.co.nz

Tēnā koe Hazel

Your Official Information Act request, reference: GOV-005408 & GOV-005790
Thank you for your email of 22 June 2020 asking for the following information under the Official Information Act 1982 (the Act):

Re: Navigation Services: Wayfinders and Whānau Ora In respect of each of the two navigation services:

1. *What information is ACC collecting from the services?*
2. *How many individuals have contacted the service broken down on a month by month basis?*
3. *How many individuals have been provided with advice by the service?*
4. *What are the categories of advice that is being sought?*
5. *How many referrals are made to legal services providers? (legal aid providers?)*
6. *How many face to face meetings? broken down by month*
7. *How many of the advice services are provided by phone? broken down by month*
8. *How many of the advice services are by email only? broken down by month*
9. *What are the demographics of those making inquiries: male/female/pakeha/Maori/Pacific/other, age?*

On 14 July 2020, we contacted you to advise of our need to extend this request to 18 August 2020, to allow us sufficient time to consult with Way Finders and Whānau Ora.

On 15 July 2020, you requested the following information be added to your request:

10. *What proportion of cases have been navigated successfully to the satisfaction of the ACC Claimant?*
11. *What has been the average time of response to initial enquiries by the Navigation Service?*
12. *What is the average length of time that ACC Claimants cases are being managed through the Navigation Service?*
13. *What is the result of client surveys being conducted by the Navigation Services?*
14. *How often has an ACC claimants use of the navigation service resulted in a better outcome for the claimant?*
15. *How many times has the Navigation Service provided advocacy/representation for the ACC Claimant with ACC?*
16. *What steps are ACC taking to promote the navigation services?*

Our response
Please find our response to both of your requests below. The information provided is from 2 September 2019 (when the Navigation Service began) to 30 June 2020, unless stated otherwise.

Question 1: What is ACC collecting from the services?
As is outlined in the contract with ACC, Way Finders and Whānau Ora provide the following information to ACC:

- Number of new clients accessing the service
- Contacts resolved
- Commentary on cases that remain open over 30 days

- Ethnicity information
- Issue Type: Cover (Personal Injury Caused By an Accident, Work Related Gradual Process, Disease or Infection, Treatment Injury, Mental Injuries, Sensitive Claims, Hearing Loss, Dental, Fatal) Entitlements (Social Rehabilitation, Treatment (including Elective Surgery), Ancillary Services, Vocational Independence, Independence Allowance/Lump Sum, Weekly Compensation), Cessation and Disentitlement (Suspension, Criminal Disentitlement, Non-compliance, Section 103 decisions) as well as Reviews, Levy, Debt and general queries on Navigations Services, Customer Service & Claims Management issues).
- Trends
- Successes

Question 2: How many individuals have contacted the service broken down on a month by month basis?

The table below provides the numbers of individuals who have contacted Way Finders or Whānau Ora from 2 September 2019 (when the service began) to 30 June 2020, broken down by month.

Provider	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	March 20	April 20	May 20	June 20
Way Finders	75	74	100	92	92	103	115	43	67	127
Whānau Ora	9	23	32	17	20	21	24	6	22	25

Question 3: How many individuals have been provided with advice by the service?
Navigation Service providers have responded to all enquiries made to the service as per the numbers above. However, not all callers to the service have sought advice, for example some callers may be seeking forms or contact information only.

This information is not specifically collected and therefore this part of your request is refused under 18(g) of the Act as the information requested is not held by the providers or ACC.

Question 4: What are the categories of advice that is being sought?
Please see the information listed under 'issue type' in our response to question 1.

Question 5: How many referrals are made to legal services providers? (legal aid providers?)
Way Finders: Any approach to Way Finders regarding an appeal requires the involvement of legal services. Way Finders will advise the caller that they are not a legal service and will provide information regarding options for obtaining legal services.

Way Finders do not follow up once information is provided to clients and are therefore not privy to the number of clients who eventually engage legal services. This part of your request is therefore refused section 18(g) of the Act as the information is not held by Way Finders or ACC.

Whānau Ora: No direct referrals have been made to legal service providers. As part of the service, Whānau Ora encourage whānau to seek advice (including legal advice) from an appropriate third party, such as Community Law, and the Citizens Advice Bureau.

Question 6: How many face to face meetings (broken down by month), Question 7: How many of the advice services are provided by phone (broken down by month & Question 8: How many of the advice services are by email only (broken down by month)?

Way Finders: The service provided by Way Finders is a phone and email based service and therefore face-to face meetings do not occur between individuals and Way Finders, though video conferencing is also offered.

While the total number of clients who engage with Navigation Service providers is collected by providers, these numbers are not separated into the type of interaction eg phone, email or video conference. This part of your request is therefore refused under section 18(g) of the Act as the information is not held by Way Finders or ACC.

Whānau Ora: Whānau are supported to engage with the service in the manner in which best suits their needs. However, services are set-up to be provided via telephone or email in most instances. The table below shows the numbers and types of contacts made to Whānau Ora:

Month		Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Face to face		0	0	1	2	0	0	0	0	0
Phone		6	20	29	17	20	21	22	6	20
Email		3	3	3	0	0	0	2	0	2

Question 9: What are the demographics of those making inquiries?

Way Finders: The following information has been collected since April 2020.

Ethnicity	April	May
Māori	12%	7%
Pākehā	58%	49%
Other European	7%	10%
Middle Eastern	0%	1%
Indian	0%	5%
Other	0%	5%
Not Specified	23%	23%

Gender	April	May
Male	55%	58%
Female	48%	42%

Whānau Ora: The following tables provide a breakdown of whānau by ethnicity, age group and gender between 2 September 2019 and 30 June 2020.

Please note that the information provided is not required to be reported through to ACC. ACC only receives reports of the percentage of Māori clients on a quarterly basis. The following information has been received directly from Whānau Ora for the purpose of responding to your request.

Ethnicity	Total
Māori	130
NZ European	32
Pacific	4
Other	16
Unknown	17

Age Group	Total
18 – 24	8
25 – 44	38
45 – 64	68
65 +	6
Unknown	79

Gender	Total
Female	107
Male	89

Question 10: What proportion of cases have been navigated successfully to the satisfaction of the ACC claimant?

Way Finders: Way Finders deals with a wide variety of queries of differing complexities. These queries can require a range of responses from a single email response providing step by step instructions or guide for a client to follow, access to or understanding an entitlement, through to directly engaging with ACC on behalf of the client.

Way Finders have noted that anecdotal feedback from ACC clients has been positive. However, the number of ACC clients who have reported a successful outcome is not specifically collected by Way Finders. This part of your request is therefore refused under section 18(g) of the Act as the information requested is not held by Way Finders or ACC.

Whānau Ora: Of the whānau who have engaged with Whānau Ora, 82 percent have reported a successful outcome.

Question 11: What has been the average time of response to initial enquiries by the Navigation Service?
Way Finders: Way Finders' internal policy requires all initial emails and calls to the service be responded to no later than two working days from date of receipt.

Whānau Ora: Whānau Ora responds to whānau within 24 hours.

Question 12: What is the average length of time that ACC Claimants cases are being managed through the Navigation Service?
Way Finders: As outlined in question 10, Way Finders deals with a wide variety of queries each with different complexities, and different support needs.

The length of time taken to support ACC claimants is not specifically collected by Way Finders. This part of your request is therefore refused under section 18(g) of the Act as the information requested is not held by either Way Finders or ACC.

Whānau Ora: The average length of time taken to support all whānau is 35 days. For whānau who are supported for more than six days, the average support time becomes 48 days.

Question 13: What is the result of client surveys being conducted by the Navigation Services?
Way Finders: Way Finders do not currently collect this data in any formal manner, and only collect anecdotal feedback in the form of an email. They are currently in the process of developing a formal customer satisfaction programme. For this reason, this part of your request is refused under section 18(g) of the Act as the information is not held by either Way Finders or ACC.

Whānau Ora: Whānau Ora undertakes an annual whānau satisfaction survey. Some verbatim feedback has been collated by Whānau Ora and provided at Appendix 1 to highlight the impact of whānau experience with Whānau Ora.

Question 14: How often has an ACC claimant's use of the navigation service resulted in a better outcome for the claimant?
Please see our response to question 10.

Question 15: How many times has the Navigation Service provided advocacy/representation for the ACC claimant with ACC?
As stipulated in Schedule 1 of the service contracts held by Way Finders, Whānau Ora and ACC, the Navigation Service is not intended to be an advocacy service, but instead to provide ACC clients with knowledge, empowerment and confidence in order for the client to make informed choices in relation to their ACC claim.

There are some instances where providers may seek the permission of a client in order to liaise with ACC on their behalf so that sufficient advice may be provided.

These instances are not recorded by Way Finders, Whānau Ora or ACC. This part of your request is therefore refused section 18(g) of the Act as the information requested is not held by either organisations or ACC.

Question 16: What steps are ACC taking to promote the navigation service?

Clients:

- Information regarding ACC's Navigation Service can be found in the 'Get independent support' section of ACC's website (https://www.acc.co.nz/im-injured/claim-help/get-independent-support/).
- An information sheet is provided to ACC clients every time they receive a decision. The information sheet provides the client with an outline of their rights and responsibilities, and details of where they may obtain support, including Navigation services.
- ACC case management and resolution staff are also aware of the service and able to discuss it with clients where they feel is appropriate.

Providers:

- Articles have previously been placed in provider publications to promote and provide information on the service.

Internal:

- Since the launch of the service there have been a number of internal communications across ACC regarding the service ie what it is, who is involved, what it means for our clients and who to contact.

If you have any questions

If you have any questions regarding this response, you can email me at GovernmentServices@acc.co.nz.

For any questions specifically relating to the Navigation Service, please contact Lucy McKimm, Senior Resolution Specialist at Lucy.McKimm2@acc.co.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

Nāku iti noa, nā

Sasha Wood
Manager Official Information Act Services
Government Engagement & Support