Original Scientific Paper

Sexual abuse counselling:

Treatment rates provided by psychiatrists, psychologists and counsellors under ACC funding

Felicity Goodyear-Smith MBChB MGP FRNZCGP, Senior Lecturer, Department of General Practice and Primary Health Care, University of Auckland; Brenda Lobb PhD, Lecturer, Department of Psychology, University of Auckland, and James Mansell BA (Hons), Senior Analyst, Child Youth and Family, Wellington

ABSTRACT

Objective

To compare treatment rates provided to Accident Compensation Corporation (ACC) sexual abuse claimants by professional provider categories of psychiatrist, psychologist and counsellor.

Method

Data on total numbers of claims per provider and claimant visits to each provider were analysed for all ACC-funded providers of sexual abuse counselling services in 2003. Visits/claim for each provider were estimated as total number of treatment visits divided by total number of new claimants in 2003. Providers were classified as psychiatrists, psychologists or counsellors. The data were analysed using nonparametric Kruskal-Wallace and Mann-Whitney U tests to determine differences between professional categories in visits/claim.

Results

Sexual abuse counselling services were provided by 647 professionals to 8676 claimants over 107 685 visits during 2003. Most were counsellors (89.4%) rather than higher qualified professionals. On average, counsellors had 12.87 visits/claim, registered psychologists 9.11; psychiatrists 8.89. Counsellors provided significantly more visits/claim than psychiatrists or psychologists (χ^2=33.53, df=2, p<.000).

Conclusions

To determine whether psychiatrists and registered psychologists work more effectively than counsellors, we recommend additional data collation/analysis, including diagnosis at onset of treatment and frequency, duration and nature of treatment modalities. We recommend both initial and final Diagnostic and Treatment Assessments. Although qualified professionals have higher fee structures, correct initial diagnosis and instigation of optimum treatment may be cost-effective.

Key words

Sex offenses, child abuse, sexual, psychology, applied, psychotherapy, counselling

(NZFP 2005; 32:389–393)

Introduction

The Sensitive Claims Unit of the Accident Compensation Corporation (ACC) works with people dealing with the mental effects of sexual abuse or sexual assault (called 'sensitive claims' due to the sensitive and confidential nature of the injury). ACC can accept a sensitive claim if *'there is evidence of a diagnosable mental injury and that this mental injury was caused by sexual abuse events.'* Mental injury is defined as a clinically significant behavioural, cognitive or psychological dysfunction (such as acute stress disorder, post-traumatic stress disorder, anxiety disorder, depression, dissociative identity disorder) that is more than an immediate reaction to the event and requires treatment.[1] The sexual abuse act must be one of the criminal acts described in Schedule 3 of the Injury Prevention, Rehabilitation and Compensation Act 2001 (sexual violation or other sexual offence). This applies to NZ residents and also to overseas visitors if the event occurred and treatment is being sought within NZ.

ACC-funded treatment for mental injury caused by sexual abuse events is provided by ACC Recognised Sexual Abuse Counsellors, although claimants may have to pay a surcharge to cover the full fee of the provider. Low-income patients can apply to Work and Income NZ (WINZ) for a disability allowance to cover a surcharge.[2-8] Recognised counsellors may be psychiatrists (who are registered medical practitioners), registered psychologists (who are members of the New Zealand College of Clinical Psychologists and/or the Institute of Clinical Psychology) and other psychologists, counsellors and psychotherapists (who are neither psychiatrists nor registered psychologists but possess qualifications and/or recognised experience in clinical psychology, psychology, psychotherapy, or counselling). For the professional bodies recognised by ACC for counsellors see Table 1. New Zealand general practitioners are not recognised by ACC as sexual abuse counsellors. Previously GPs were required to complete the ACC 45 Injury Claim form for referral to an ACC counsellor, but current legislation now allows for counsellors to complete these forms without the need for GP referral.

Table 1. Professional bodies of ACC registered counsellors

New Zealand Association of Counsellors	NZAC
New Zealand Association of Psychotherapists	NZAP
Aoteoroa New Zealand Association of Social Workers	ANZASW
New Zealand Psychological Society	NZPsS
New Zealand College of Clinical Psychologists	NZCCP
The Institute of Australasian Psychiatrists Incorporated	IAPI
New Zealand Association of Child & Adolescent Psychotherapists	NZACAP
New Zealand Christian Counsellors Association	NZCCA
Auckland Sexual Abuse HELP Foundation	ASAHF
Waitakere Abuse and Trauma Counselling Service Incorporated	WATCS

No data are available to determine whether specific criteria are applied that result in patients being referred to a psychiatrist, psychologist or counsellor. However in many cases they self-refer using lists of recognised providers available on an ACC 0800 number and on the website. The implicit assumption in the use of different professional groups as ACC counsellors is that all are equally effective in providing this service, achieving equally successful outcomes and undertaking on average the same number of treatment visits per claimant. Given the range of qualification levels involved, we hypothesise that more highly-qualified professionals (psychiatrists and registered psychologists) are expected to achieve better outcomes and/or similar outcomes with fewer treatment visits per claimant.

Treatment modalities shown to be effective in treating the types of mental injury that can result from sexual abuse events (such as depression and anxiety) are primarily pharmacotherapy, cognitive behavioural therapy (CBT) and interpersonal therapy (IPT).[2-8] It is reasonable to assume that more qualified professionals will be cognisant of evidence-based treatment and will be more likely to be trained in these psychological interventions. CBT and IPT are active and goal-oriented therapies which generally are not of long duration.[9]

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Registration of a claim by ACC automatically entitles a claimant to up to three initial assessment sessions with a recognised counsellor. This allows the counsellor to gather the relevant information to supply to ACC to establish whether the claim will be covered. ACC accepts a claim on the basis of a narrative description of a Schedule 3 crime reported by the complainant and the diagnosis of the mental injury suffered as a consequence. If the claimant's claim is accepted, the Sensitive Claims unit will provide for up to ten hours of counselling.[1] If the claimant is deemed to require more treatment, the counsellor can provide a progress report (ACC 291-progress) and then have up to 20 more hours of treatment approved. If counselling is not concluded, a further 20 sessions may be recommended. After 52 hours of counselling the claimant is required to have an independent Diagnostic and Treatment Assessment (DATA) by a clinical psychologist or psychiatrist qualified in the use of the DSM IV manual.[10] After every three months or twenty counselling sessions, a further progress report is required.

ACC does not have information concerning treatment outcomes but it does have data on the total number of claimants seen by each provider over each quarter year and the total number of claimant visits to each provider over the same period, enabling estimation of the treatment rate (visits per claimant) per provider. The aim of the present study, therefore, was to test at least part of the hypothesis by comparing the treatment rates provided to ACC sexual abuse

Table 2. Service provider types, claimants and numbers of claimant visits

Provider type	N	%	No claimants	% claimants	No of visits	%
Psychiatrists	8	1.2	60	0.7	441	0.4
Reg. Psychologists	106	16.4	1095	12.7	10,941	10.2
Counsellors	533	82.4	7521	86.6	96,303	89.4
TOTAL	**647**	**100**	**8682**	**100**	**107,685**	**100**

claimants by practitioners in different professional categories.

Method

Data on the total number of claims per provider and the total number of claimant visits to each provider were obtained from ACC for all providers whom it had paid for counselling services for sexual abuse claims during the 2003 calendar year. The data set included cases where a single provider had billed as a registered psychologist on some occasions and as a counsellor on others. For the purposes of this study, where a provider had billed for services under more than one provider class then the more senior classification was taken as being representative. It was assumed, for example, that all services provided by a person trained as a registered psychologist reflected this training regardless of the fact that sometimes their bill was coded as coming from a 'counsellor'.

The number of treatment visits per claim was estimated as follows: for each provider the total number of treatment visits provided within the year was divided by the total number of new claimants seen within the year, giving the visits per claim for that provider. The average value across all providers within each professional category was then calculated. This is a simple method making use of recent data. It is likely to capture the number of visits per case independent of time constraints and, moreover, reflects the total workload of visits that a provider was undertaking on behalf of ACC – including, potentially, visits belonging to very old cases. Providers undertaking a higher workload are not over-emphasised. A potential limitation is that the method assumes a stable rate of new claims per year per provider and that there is no systematic bias driven by different rates of change in the number of new claims seen by each provider class.

These data were then analysed to determine whether there were significant differences between the professional categories in visits per claim.

Table 3. Number of claimant visits by provider type

Provider type	N	%	Visits / claimant / provider type		
			Range	Mean	SD
Psychiatrists	8	1.2	1–33	8.89	10.23
Reg. Psychologists	106	16.4	1–26	9.11	5.26
Counsellors	533	82.4	1–84	12.87	8.19

Results

ACC sexual abuse counselling services were provided by 647 professionals to 8676 claimants over 107 685 visits during 2003. Table 2 shows the number and percentage of professionals in each category; the number and percentage of claimants seen by providers of each category; and the number and percentage of total visits to providers in each category. As can be seen, most of the counselling was provided by counsellors rather than by more highly qualified professionals.

Table 3 shows the number of each provider type, and the range, mean and standard deviation of visits/claim for each professional category of ACC-registered sexual abuse counsellor, during 2003. Although there was wide variability in the number of visits per claim within each professional category, on average counsellors had the highest number of visits per claim, registered psychologists had the next highest number while psychiatrists had the least.

To determine whether these differences were statistically significant,

Table 4. Tests of normality of distribution of visits per claim for each provider type

Provider type	N	%	Test of normality	Statistic	df	Sig.
Psychiatrists	8	1.2	Shapiro-Wilk	0.694	8	0.002
Reg. Psychologists	106	16.4	Kolmogorov-Smirnov*	0.112	106	0.002
Counsellors	533	82.4	Kolmogorov-Smirnov*	0.141	533	<0.001

** Lilliefors significance correction*

firstly the distributions of visits per claim for each professional category were scrutinised. Normality (p>.05) was not found for any group, as shown in Table 4.

Therefore the nonparametric Kruskal-Wallace test was used to determine whether the number of visits per claim differed between the three professional groups. The results showed that there was a significant difference (χ^2=33.53, df=2, p<.000). Mann-Whitney U tests revealed that counsellors had significantly more visits per claim than psychiatrists (U=1083.00, 2-tailed p=.017) and than registered psychologists (U=18920.00, 2-tailed p=.000). There was no significant difference in visits per claim between psychiatrists and registered psychologists.

When professionals within each category were ranked in order of number of visits per claim, for the last two of the 533 counsellors and for the last one of the eight psychiatrists there was a noticeably greater increase in the number of visits per claim compared to the increases between preceding providers. These providers could therefore be regarded as outliers, atypical of the remainder of this category of provider with respect to visits per claim. However, when these were excluded from the analyses, the results were fundamentally unchanged: there was a significant difference between groups (Kruskal-Wallis χ^2=37.133, df=2, p<.000). Mann-Whitney U tests revealed that counsellors had significantly more visits per claim than psychiatrists (U=563.50, 2-tailed p=.002) and than registered psychologists (U=18920.00, 2-tailed p=.000). As before, there was no significant difference in visits per claim between psychiatrists and registered psychologists.

Discussion

This study aimed to compare the treatment rates provided to ACC sexual abuse claimants by practitioners in different professional categories during 2003. It was found that there was a small but statistically significant difference: although there was considerable variability within each group, on average psychiatrists and registered psychologists provided fewer visits per claim than the less qualified counsellors.

However, in order to determine from this whether the psychiatrists and registered psychologists were working more effectively than the counsellors, a number of issues must be taken into consideration for which data were not available in the present study. These include the nature of the reported sexual crime, the diagnosis of the mental disorder deemed caused by it, the treatment modality selected and applied for this disorder, and outcome measures of the effectiveness of the treatment. These will be discussed briefly below.

Diagnosis of mental disorder

Firstly, accurate diagnosis is fundamental to appropriate and effective treatment. The vast majority (89%) of ACC-funded sexual abuse counselling sessions in 2003 were provided by counsellors other than psychiatrists and clinical psychologists. These counsellors can see claimants for up to 52 hours before a Diagnostic and Treatment Assessment (DATA) according to DSM IV is required by a qualified professional. This raises potential concerns about accuracy of the initial diagnosis (type of mental injury), appropriateness of the treatment selected and best use of available funds.

There is a need for accuracy of diagnosis of the mental disorder deemed caused by the sexual assault event or events. Given that some mental disorders may require psychopharmacology as well as psychological intervention, it would appear prudent on these grounds for a formal DATA to be conducted prior to the onset of any counselling and, where necessary, medication prescribed by a GP or psychiatrist. Some patients referred by a GP may have concurrent pharmacological therapy, but patients may also self-refer to counsellors.

Data should also be examined regarding the length of time between the sexual crime and the mental disorder diagnosis, given that ACC accept a sensitive claim where there is evidence of a diagnosable mental injury caused by sexual abuse events that is more than an immediate reaction to the event.

Nature and effectiveness of treatment modalities

Secondly, evaluation of the relative effectiveness of the different professional groups providing counselling to ACC sexual abuse claimants requires consideration of the treatment modality selected. It should be noted that sexual abuse is an event and hence treatment is for any specific mental injury resulting from it, not 'sexual abuse' per se. A range of mental disorders is covered under the ACC system, each requiring different treatment modalities which may require varying durations and/or frequencies of visits to the service provider to be effective. For example, recommended best practice for treatment of depressive illness involves use of anti-depressant medications and/or empirically supported psychotherapy (particularly cognitive behavioural therapy (CBT) and interpersonal therapy).[11] Anti-depressant medication and CBT are effective in treating general anxiety disorder.[2, 6,8] From an evidence-based perspective, CBT is currently the treatment of choice for anxiety and depressive disorders in children and adolescents.[4] On the other hand, a systematic review showed that acute debriefing of victims of trauma did not reduce the short-term (three to five months) risk of developing PTSD and appeared to significantly increase the risk of PTSD at one year.[12] A recent meta-analysis also concluded *'claims that single session psychological debriefing can prevent development of chronic negative psychological sequelae are empirically unwarranted'*.[13] This form of treatment is therefore not recommended and, given the potential risk of rapid de-

briefing, some delay between the traumatic event and the counselling would seem appropriate.

Assessment of treatment outcome

Finally, it is axiomatic that awareness of the outcome of treatment, considered in relation to the diagnosis and expected outcome, is necessary. This knowledge, together with the findings of the present study concerning relative treatment rates of the three professional groups providing counselling, could be used to inform the best deployment of practitioners in terms of both benefit to patients and cost-effectiveness. ACC has recently revised its Cover and Treatment Report (#1276) and Follow-up (#1277) forms so that more data should be available in future to determine the effectiveness of ACC-funded sexual abuse counselling.

Recommendations

We recommend that as well as the provider type and number of treatment sessions, the following data set should be collated and analysed:

- Duration between the reported traumatic event and the onset of counselling.
- Nature of the sexual crime suffered.
- Diagnosis at onset of treatment (mental injury suffered as a result of the sexual crime) according to DSM IV criteria.
- Treatment modalities provided.
- Frequency and duration of sessions.
- Results of a DATA at the conclusion of the treatment.
- Whether the provider or the claimant concluded the treatment.

Given the serious nature of the mental injuries treated by ACC-funded providers, it may be appropriate for the initial and final assessments at the least to be conducted by a professional qualified to perform a DATA according to DSM IV criteria – i.e. a psychiatrist or clinical psychologist. Although these professionals have a higher fee structure, their use may still be cost-effective if their assessment assures that a correct diagnosis is made and optimum treatment provided from the outset.

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