PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

Integrated Services for Sensitive Claims (ISSC) Operational Guidelines

December 2022

Contents

Introduction to this guide

These Operational Guidelines have been designed to help Suppliers, Providers and other relevant stakeholders to understand and implement the Integrated Services for Sensitive Claims (ISSC) contract. They can be a point of reference and be used to help clarify differences of interpretation of various aspects of the services. It's important to note that where there is a conflict or inconsistency between these Operational Guidelines and the Service Schedule, the provisions of the Service Schedule take precedence.

This is a living document. Updated versions will be made available as the need arises and published on the ACC website https://www.acc.co.nz/resources/#/. We are committed to ongoing service improvement and changes may be made from time to time to reflect these.

These Guidelines are not intended to provide the user with specific clinical advice. In 2008, ACC produced the 'Sexual Abuse and Mental injury: Practice Guidelines for Aotearoa New Zealand', known as the Massey Guidelines. These Operational Guidelines should be read alongside the Massey Guidelines, which provide clinical and therapeutic guidance.

Introduction to the ISSC Service

Purpose

The purpose of the ISSC is outlined in Part B, Clause 1 of the ISSC service schedule.

Service objectives

The service objectives for the ISSC are set out in Part B, Clause 2 of the ISSC service schedule.

In practice, we want:

The service to:

- support Providers to deliver the right service at the right time and collaborate with other parties involved in Client recovery.
- respond to cultural diversity.
- be responsive to individuals and provide for various levels of intervention based on need.

Our Clients to:

- have access to services when they need them.
- have the opportunity to develop early therapeutic relationships with the Provider that best suits their individual needs.
- receive services at a pace that works for them.

This means that:

Suppliers and Providers will:

- be able to tailor therapy for their Clients.
- have support from ACC.
- deliver an end-to-end service for Clients.

ACC will:

- have effective working relationships with Suppliers and Providers.
- enable streamlined services that ensure timely recommendations to support the Client.

For all of us it means an opportunity to work together effectively, supporting the Client every step of the way.

At the service level, the following principles underpin the ISSC contract:

- Client-centricity: Suppliers, Providers and ACC are expected to deliver individually tailored services collaboratively, with the Client at the centre.
- Flexibility: Clients are offered options and choice in how they access and engage with services, and how they progress through the service.

- Diversity: The service acknowledges and accommodates the diversity of Clients, and the influences of factors such as culture, ethnicity, gender, age, etc., as well as the needs of their family and whānau.
- Appropriate services: Our legislation also requires that services are both necessary and appropriate.
- The model ensures provision of services is both clinically necessary and appropriate as well as being appropriate for the Client at that time.
- Responsivity: Services must acknowledge, support, and be responsive to the Client's need for immediate access and their changing needs over time.
- Safety: The service will recognise that the safety of the Client and relevant others is paramount throughout the therapy process.

Service overview

An overview of the ISSC process is outlined in Appendix 3 of the ISSC service schedule.

There are three key phases to the service:

- Pre-cover services;
- Assessment to determine eligibility and supports; and
- Post-cover services.

We want Clients to feel supported to engage with recovery services at a time and pace that works for them.

Details on operationalising each component of the ISSC are outlined in these Guidelines.

Your relationship with ACC

We want to work with our Suppliers and Providers so that Clients gain maximum benefit from the ISSC Service. This is supported through timely and open communication between ACC and Suppliers and Providers wherever possible.

Key relationship contact points are outlined in Part A, Clause 4 of the ISSC service schedule. Individual Client queries or issues should be resolved with the ACC Recovery Team or Team Member supporting the Client and/or their Leader in the first instance. If unable to be resolved, issues should be raised with your local Engagement and Performance Manager https://www.acc.co.nz/for-providers/provide-services/provider-relationship-team/#find-an-engagement-and-performance-manager.

Roles and Responsibilities of ISSC Suppliers and Providers

Service Schedule	Supplier	Provider
Capacity and referrals: Refer to Part B, Clause 18 (Appendix 1)	• Manage and understand the capacity of all Named Providers at any given time • Ensure that contact details on www.findsupport.co.nz are correct at all times • Complete applications to add new Named Providers to ISSC contract or to extend the services a Named Provider is approved for • Remove from your Contract Named Providers that you no longer have a contractual relationship with	• Keep Supplier informed of current capacity • Advise Supplier when unavailable due to planned or unplanned leave (e.g. holidays, away due to injury or illness) and identify continuity plan for current clients.
Invoicing and payments: Refer to Part B, Clauses 5,15 and 17.2.5	• Receive Purchase Orders (POs) directly from ACC (Providers will be copied into purchase order approvals by ACC). • Manage all Provider queries regarding invoicing, PO dates, how many sessions have been used and timeliness of reporting • Submit invoicing to ACC • Ensure that providers are paid in a timely manner	• Manage timeliness of sessions and reports as per the PO • Direct any PO queries to the Supplier – not ACC
Reports: Refer to Part B, Clauses 5 and 12	• Ensure that all reports submitted to ACC meet the criteria for content and quality as per the service schedule and Operational Guidelines • Ensure Providers are submitting reports to ACC within the timeframe of the approved purchase order • Ensure that reports are only invoiced for once they have been submitted to ACC	• Submit all reports on ACC approved templates • Submit reports to: sensitiveclaimsproviderreports@acc.co.nz • Ensure all sections within a report are completed as per the requirements set by the service schedule Operational Guidelines and the outline attached to the Supported Assessment report template.
Escalation of risk and privacy issues: Refer to Part B, Clause 12.2	• Inform your Engagement and Performance Manager immediately of any privacy issues • Ensure Client risks have been raised with ACC	• Inform Supplier and ACC immediately of any identified risks
Training and communications: Refer to Part B, Clauses 12; Appendices 1 and 2	• Attend ISSC annual Supplier training • Train new Providers on the contract	• Inform Supplier of any training requirements • Review and implement the communications received from ACC and contact the

Service Schedule	Supplier	Provider
	• Ensure that all relevant communications from ACC are disseminated to Providers	Supplier directly with any questions

Health and Safety

Maintaining the safety of all parties (including but not limited to the Client, Supplier, Provider, ACC staff) is the highest priority.

Client safety:

Suppliers and Providers have a responsibility to identify risks and assist the Client in maintaining their safety. Providers should ensure that the Client has a risk management plan where risks have been identified and that appropriate referrals have been made (e.g. to Police, acute mental health services, Oranga Tamariki).

Providers need to notify ACC of risk management plans and the details of any referrals that have been made. Reporting health and safety risks and incidents including notifiable events (as defined by WorkSafe) is a requirement in the ISSC Service Schedule (refer to Part B, Clause 12). Threats and other health and safety risks must be reported to ACC using the procedure and online form on our website www.acc.co.nz/for-providers/report-health-safety-incidents.

Working with Clients who may pose a health and safety risk:

Any session with the Client should be terminated if the Client, or their representatives, cause you to feel threatened or unsafe. If you decide that a security guard is required because of concern about your own or your employees' safety, please contact ACC to arrange the security guard. Guards can be arranged at any initial or subsequent appointment.

Clients who meet any one of the following more serious criteria are also considered a health and safety risk and will also have a Care Indicator activated:

- Have been or are physically violent (this unacceptable behaviour may not have occurred directly towards ACC employees)
- Have a history of violence or aggressive behaviour, have known convictions for violence
- Made threats previously against ACC, ACC employees or agents acting on ACC's behalf
- Intimidated an employee through written abuse or verbal abuse (face-to-face or over the telephone) to the extent they felt unsafe
- Exhibited homicidal ideation.

ACC Clients who meet two or more of the following criteria are considered to pose a potential risk to safety, and will have a Care Indicator activated by ACC:

- Have continued to demonstrate intimidating and/or offensive behaviour (e.g. body language and verbal dialogue has made employees feel unsafe)
- Been abusive, verbally or in writing
- Made racist or sexist comments
- The current actions being undertaken on their claim by ACC are known to have caused or are expected to cause a significantly negative response from the Client. For example, Prosecution, Fraud Investigation, cessation of Weekly Compensation, etc.

ACC may not always have access to detailed information concerning a Client's history, but if a Client has been identified to ACC as posing a risk, we will provide relevant information to help you mitigate health and safety risks to service providers and others.

Communication regarding Care Indicated Clients:

The ACC team member supporting a Client with a care indicator will advise you in writing or via the telephone, either:

- Prior to your initial contact with the Client, or
- If you are already providing services to the Client, as soon as possible when ACC becomes aware of you seeing the Client; or receives new information about the Client and this risk.

Please report any threatening behaviour to the police immediately if you feel that it is warranted in the circumstances and advise ACC and any other parties that are at risk as soon as possible.

All threats by ACC Clients or their representatives must be reported to ACC in writing using the online form on our website www.acc.co.nz/for-providers/report-health-safety-incidents. We ask that you report these to us so that we can do our part to protect the safety of our staff and other providers that are working with the Client.

Stopping a Client session:

If you would like to stop seeing a Client due to safety concerns, please notify ACC as soon as possible and fully document the reasons for the termination of the treatment or assessment in your report. Please report to ACC in writing using the online form on ACC's website https://www.acc.co.nz/for-providers/report-health-safety-incidents/.

Health issues for Suppliers and Providers which may impact on the safety of Clients:

Providers have the responsibility to inform their Supplier and their own clinical supervisor of any significant personal or health issues that have the potential to impact their ability to work safely and effectively with Clients. Such issues might include physical health problems, significant stressors, or mental health difficulties significant

enough to require treatment. They should also inform their treating clinician of the nature of their work so that any treating clinician can factor this into their treatment advice.

Where the Supplier is the provider, they are responsible for informing their own clinical supervisor and treating provider of any significant personal or health issues that have the potential to impact on Client care as noted above.

Suppliers have the responsibility to ensure that where such issues are identified, there is a plan in place via the Provider's clinical supervisor or any treating clinician to ensure that ongoing Client and provider safety is monitored and ensured. Further, the Supplier will need to ensure that obligations in relation to the professions covered under the Health Practitioners Competency Assurance Act (HPCA) are met; or that the appropriate professional association is contacted regarding the appropriate complaints process.

Concerns about the work of another provider:

A provider may become concerned about the work of another provider, regarding the safety of a client. It is the responsibility of the concerned provider to raise these points directly with that provider and, if necessary, to notify that provider's Supplier, supervisor or professional body if the issue is considered sufficiently significant. Suppliers/providers should consult with their own supervisor and professional body's ethical requirements when considering such notifications.

Providing services for children and adolescents:

Appendix 2 of the ISSC service schedule outlines the qualifications and experience for all disciplines. Suppliers will need to ensure that Providers maintain the required specifications. Only those Suppliers and Providers who have specific expertise and experience in working with children and adolescents, and their whānau may work in this area. Registration boards and professional associations maintain that practitioners should practise only within their areas of competency.

Providers working with children/young people with a disability must be aware of the services which are most appropriate. While ACC may not be responsible for particular physical and cognitive disabilities which a child/young person may present with, the impact of these disabilities should be included in the proposed assessment and treatment and discussed with ACC.

Before agreeing to working with a child or adolescent, the Supplier must be able to confirm that the proposed Provider has completed the legally required training and documentation and has a robust understanding of their responsibilities with regards to statutory reporting requirements when a child or adolescent's safety is threatened or compromised.

ACC and Service Concepts

Definitions and Interpretations

Please refer to Appendix 2

ACC Cover

Under the Accident Compensation (AC) Act 2001, a mental injury is defined as a clinically significant behavioural, cognitive or psychological dysfunction.

A claim for mental injury caused by sexual abuse or assault is called a sensitive claim. ACC can provide cover for a sensitive claim where:

- There has been an event of sexual abuse or assault(s), or 'certain criminal acts', as listed in sections of the Crimes Act 1961 and Schedule 3 of the AC Act 2001, and;
- there is a mental injury and the sexual abuse / assault event(s) is a material or substantial cause of that mental injury, and
- the event occurred in New Zealand or, if the event occurred outside of New Zealand, the Client was ordinarily resident in New Zealand when the event occurred.

Unlike most physical injuries, cover for a sensitive claim is not provided immediately when lodging the claim as each of the factors listed above need to be determined. The ISSC ensures that support and assistance is provided 'pre-cover' and throughout the cover determination process. For some Clients, immediate assistance and support may be all they need, and they may choose to withdraw their claim without having cover determined.

Why is Cover important?

Once a mental injury is covered under a claim, ACC can provide treatment for that injury that is determined to be 'necessary and appropriate' and of the quality and frequency required to help the Client. Under the ISSC this includes the services available under Support to Wellbeing and Maintaining Wellbeing.

If a Client requires access to social rehabilitation, vocational rehabilitation or financial compensation, they must have a 'covered' claim. For definitions on what a 'covered' claim is please refer to the definitions in Appendix 2 of this document.

It is important that if a Client needs to access ACC supports, such as financial compensation or social rehabilitation services, they progress through the initial pre-cover process in a safe and timely manner.

Many supports have eligibility criteria of their own and it is therefore important to liaise with ACC to determine whether a Client may be eligible to receive a specific support.

Refer to Appendix 1 for some frequently asked questions related to ACC funding and eligibility.

Cover status

The status of a Client's claim at ACC can be

- Held (where we have not yet made a decision on whether to accept or decline the claim and we often refer to these claims as 'pre-cover')
- Accepted (where the claim has met our criteria for cover and ACC has issued a decision accepting cover)
- Declined (where the claim has not met our criteria for cover and ACC has issued a decision declining cover).

More about declined claims

Claims are declined when they do not meet our criteria for cover under the AC Act 2001. However, in some cases we decline claims because we do not have enough information to make a decision as to whether the claim meets the criteria. We will work with Suppliers and Providers as much as we can to ensure we have all the right information to assist with this decision.

When a Client chooses to withdraw their claim before cover is determined we also must make a decision on their claim. This will result in a declined claim on our system; however, the decision reason will be noted as withdrawn. When we write to the Client advising them of this decision, we will explain the reasons.

Another example is when the Client chooses to go to Support to Wellbeing (short term) instead of progressing for a Supported Assessment. We will decline the claim as the Client has chosen not to have cover determined via a Supported Assessment and therefore, we do not have sufficient information to make a decision on cover.

We will work together with Suppliers and Providers to help Clients understand our decisions and to support them through this process. It is important that the Supplier, the Provider, and our Clients understand that if we decline claims in these circumstances, we can re-open their claim if they re-engage or decide they need further support at a later stage.

Cover time frames

Sensitive Claims are considered 'complicated' claims and ACC has an extendable amount of time in which to make the cover decision. There are some specifics around this that are important to note:

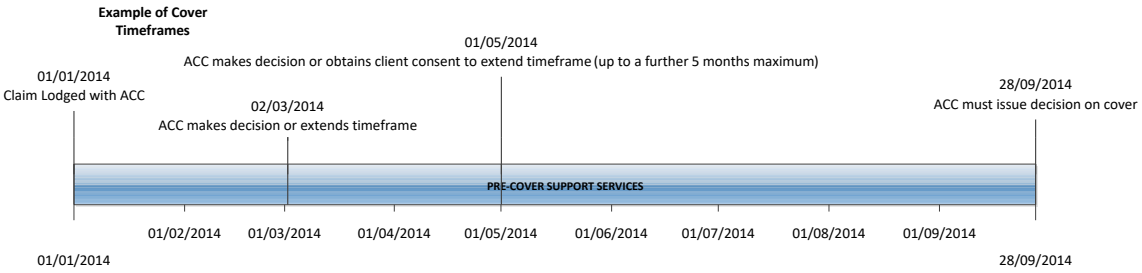
- Under Section 57 of the AC Act 2001, we have two months (60 days) from the time of a new claim being lodged to make a decision as to whether we accept or decline a claim.
- **First Extension**: We may extend this time to four months if we notify the Client that we require more time, which we will do if the Client is still engaged in pre-cover services.
- **Second Extension:** If we need to extend the timeframe further, we must ask the Client's permission to apply a further extension to their claim. This can allow

ACC up to nine months from the date the claim was lodged to issue a final decision. If the Client declines to extend the decision timeframe, ACC must, under legislation, issue a decision based only on the information we have at the time. The Client has the right to review any decision that ACC makes.

- To make this easier, we've attached the relevant permission forms to the Early Planning documentation (ACC6242 or the ACC6422). Clients can choose to give us a total of nine months to make a decision, or an extension length of their choosing, or no extension.
- ACC may request the Lead Provider to submit the ACC6242 or ACC6422 prior to the completion of the Early Planning Report. ACC would ask this of the Lead Provider where cover time frames are due to expire sooner than the Early Planning report is submitted. This would normally take place where the Client has lodged a claim via an alternative provider, such as a General Practitioner, prior to engaging in the ISSC.

The diagram below illustrates sensitive claim cover timeframes

These cover time frames only apply if the claim is a new one. If the claim has been previously declined and has now been reopened, these time frames do not apply, and the Client does not need to complete that section of the confirmation form (ACC6242 or ACC6422).



Authority to collect Client information

Client and ACC authority

We collect a Client's information to help determine whether we can accept a claim and, if the claim is accepted, what services and/or financial compensation may be provided. The Client's authority for us to collect this information must be obtained before any information can be collected.

ACC applies the following principles when collecting a Client's information. We will:

- obtain the authority we need, when we need it
- specify what information we need and why we need it
- return or destroy information we receive that we did not request
- use information solely for the purposes we specified when we requested it.

A Client's authority is obtained at the following stages:

1. At Getting Started, when the electronic engagement form is completed and submitted to ACC.
2. When the Client and Service Provider have determined that a Supported Assessment is required, and an ACC6300 'Authority to collect medical and other records' is completed and sent to ACC.
3. ACC may obtain the Client's authority directly at other stages too if the previously obtained authority is no longer considered valid.

Engagement form authority

The engagement form cannot be submitted without the Client's authority. In keeping with the principles above, the engagement form offers the Client two authority options:

If they decide they don't want any further support after 'Getting Started'

- They only need to give their authority for the therapist to lodge the engagement form with ACC.
- ACC will contact them to let them know we will not do anything further with their claim, including collecting any other information about them and the claim will be declined at this time and a decision letter will be issued to the Client.
- We will let them know they can come back for further support at any time.

If they decide they would like to receive further support (i.e. beyond 'Getting Started'):

- They will need to give their authority for the therapist to lodge the engagement form with ACC and for ACC to collect medical or other records (this includes engaging in conversations with medical providers as well as actual medical records).
- This allows for information to be gathered during the period of the Client's Early Planning sessions. Only information that is directly relevant to informing the Early Planning can be gathered at this stage.
- If the Service Provider or ACC need to speak to any other individuals or organisations, they must contact the Client to obtain their verbal or written agreement.

The service provider's role

The Service Provider completes and submits the engagement form on behalf of the Client. The Service Provider is responsible for explaining the engagement form, including the authority options, to the Client.

ACC6300 'Authority to collect medical and other records'

If a Client requires longer-term support and treatment and/or financial compensation, then an ACC6300 'Authority to Collect Medical and Other Records' form must be completed and signed by the Client and returned to us. The ACC6300 authority allows

for the collection of information to help inform the Supported Assessment and/or Incapacity Assessment. ACC expects the Provider to talk with the Client about the ACC6300 and facilitate this being sent into ACC with the Early Planning Report.

If the Client is unwilling to complete and sign the ACC6300, they have the option of agreeing a personally tailored authority with ACC. The Client will need to contact ACC directly to discuss this option.

Complying with the legislation

ACC will comply with the Privacy Act 2020, the Health Information Privacy Code 2020 and the Accident Compensation Act 2001 when collecting, using and managing the Client's information.

Under the Privacy Act 2020 and Health Information Privacy Code 2020, the Client has the right to access any information ACC holds about them. The Client can also ask ACC to correct any information they deem to be incorrect and if this is a report from a Provider, ACC can ask the Provider whether they are willing to modify any factually incorrect information contained in the report. Providers would not typically alter their clinical opinion unless this has been based on incorrect information. ACC's privacy notice can be found at www.acc.co.nz/privacy.

Entering the service

Clients can access the service directly or they can be referred by someone else such as:

- their family or whānau
- a general practitioner
- a victim support agency
- another Supplier
- ACC
- Government agencies e.g. Oranga Tamariki.

You need to ensure that you identify ISSC Clients at the initial point of contact, so that you won't need to discuss funding and can work with them to determine the most appropriate Provider. It is important to establish what kind of Provider or support they are looking for and that they understand what a "sensitive claim" is.

If the referral comes from a Client who has accessed www.findsupport.co.nz and has identified a preferred Provider, it is still the Supplier's responsibility to establish what kind of Provider or support they are looking for and that they understand what a "sensitive claim" is.

If you have a "waitlist" of Clients you need to ensure the Client is informed of the waitlist, and that they have the option to visit the www.findsupport.co.nz website to engage with another Supplier. Refer to 'Managing Waitlist' below for more details.

If you decline a referral, you should help the Client find a suitable alternative Supplier. If you can't find a suitable alternative Supplier, please contact ACC. Refer to 'Declining referrals' below for more details. If the referral comes from ACC, you must accept or decline the referral within two business days. Please send your response via email.

At the first point of contact with the Client, you should attempt to ascertain whether the Client has engaged with the ISSC or ACC sensitive claims in the past. If they have, once you have submitted the Engagement Form you should confirm with ACC what that engagement involved and whether they have an existing claim, a covered claim, or whether they have been declined cover in the past and why. Refer to "Returning Clients" below for more details.

ACC Provider web search – www.findsupport.co.nz

Potential Clients or referrers with Clients seeking to use the ISSC service may use the web-search function to identify a Provider that is likely to meet their needs.

Clients using the Search Tool can filter against criteria which identifies a Provider that will best meet their needs. For example, if a Client is looking for a Provider that is female, speaks Te Reo Māori and provides services in Wellington City, the web search will return the names of those Providers with each of these characteristics and skills.

The Client will be directed to contact their preferred Provider's Supplier in the first instance.

Managing waitlists

Suppliers may choose to have a waitlist given possible capacity issues in their local area. If you do choose to hold a waitlist, it is important that prospective Clients are informed of their options.

1. If you are intending to direct a client to a waitlist:

    - a triage conversation will be used to understand the Client needs and complete a risk assessment
    - the triaging practitioner must decide whether it is appropriate for the client to go on a waitlist e.g. risk issues, acuity etc.
    - the client must be made aware that there is a waitlist (and the estimated wait time)
    - if possible, the first appointment should be tentatively booked
    - if there are immediate needs to be addressed, refer to the appropriate organisation or agency.

2. If the wait is likely to exceed six weeks, you should decline the referral (please see below for more details on declining referrals), unless you are able to provide support services outside of ISSC services to support Clients while they are waiting;

3. Ensure the person understands that they can continue to search for an alternative Provider while they are on a waitlist, and refer them to www.findsupport.co.nz; and

4. Provide information about https://safetotalk.nz/.

Returning Clients

Where a Client has presented to an ISSC Supplier to access services under a previously lodged claim, they are regarded as a 'returning Client'. The Client may have:

- never received any therapy, support or assessment from ACC for their sensitive claim – they would proceed to Getting Started as if they were a new Client
- completed a course of treatment – check the cover status (including what cover is for) with ACC. This will determine whether the client needs to proceed directly to Supported Assessment (no cover, or cover for a mental injury that is different from current presenting symptoms), Support to Wellbeing (cover for a mental

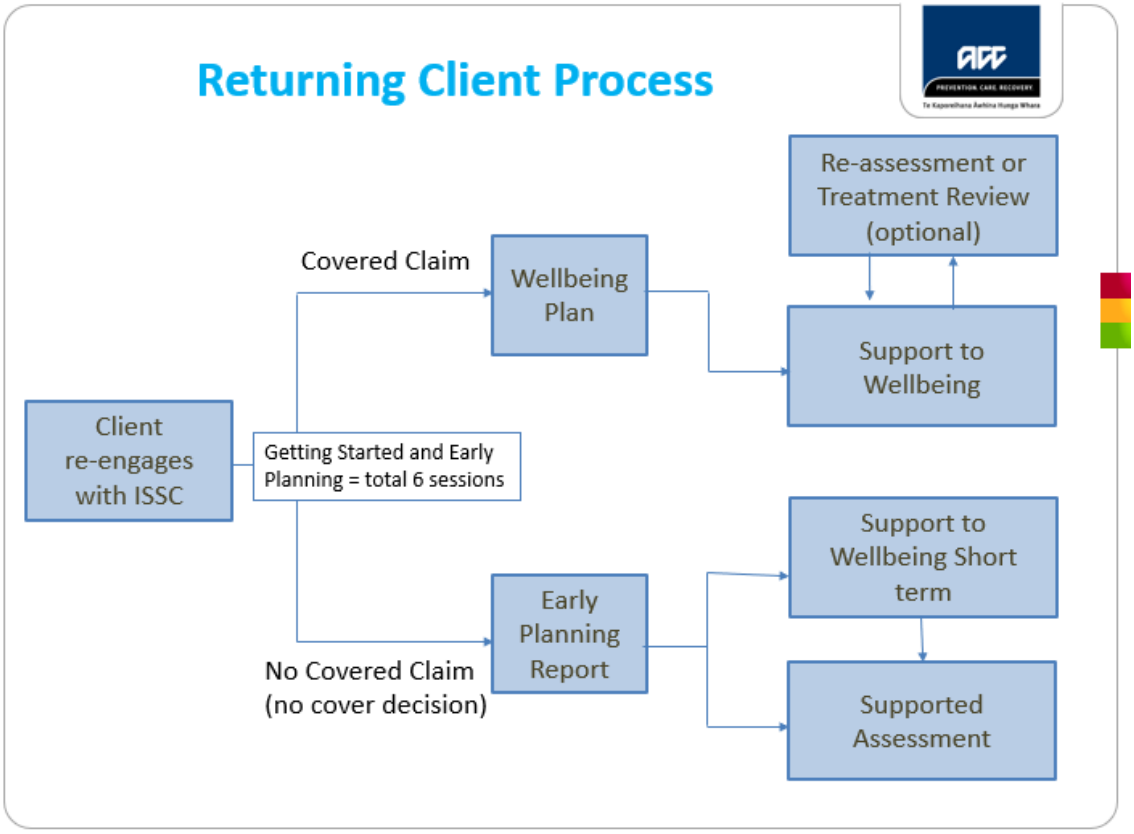
injury that is consistent with the current presenting symptoms) or Getting Started (no cover).

- been declined. ACC will determine which pathway needs to be followed.

To activate a new 'period of engagement', the Provider will complete a new engagement form as part of the Getting Started service (refer to Getting Started section). At this point, ACC may direct a pathway, based on the history of the claim.

If the Client is returning to a different Supplier, the new Supplier may invoice for the Administration and Management Fee.

This diagram below illustrates the process for returning clients:



Summary of time frames

To ensure Clients receive timely services, the following timeframes apply:

Action	Response Time frame

Supplier accepts or declines the referral and lets ACC know	Within two business days from receipt of referral (when ACC refers) or from the initial contact of the Client (when Client contacts directly)
Supplier allocates referrals to a Provider	Within one business day of acceptance by the Supplier
The first appointment arranged between the Provider and Client	Within five business days from receipt of referral by the Supplier (unless otherwise requested by the Client)
First Getting Started appointment with the Client	As soon as possible

Please let us know if you cannot provide the service according to the above time frames.

Declining referrals

You may decline a referral

- where a conflict of interest exists
- where you have no capacity; or
- where the Client's needs would be better met by another ISSC Supplier, for example a specialist child and adolescent Provider.

If you decline a referral, you should help the Client find a suitable alternative Supplier. If you can't find a suitable alternative Supplier, please contact ACC.

You must keep a record of all declined referrals and the reasons for declining. This information needs to be included in your quarterly reports.

Capacity Issues

It is important that Clients are seen in a timely manner. While it is your responsibility to ensure ongoing capacity to respond to referrals, we need to know when this is becoming a problem so that we can work together to look at options for increasing capacity or plan for the best way to manage incoming referrals.

In the first instance, notify your local Engagement and Performance Manager, and provide details of how many Clients are on your waitlist, the average wait time for an appointment, how the waitlist is being managed and whether there are any plans to increase capacity by adding new named providers onto the contract.

Delivering services outside of your Territorial Authority (TA) to address capacity issues

As specified in the Service Schedule Part B, Clause 4, Suppliers may provide services outside of their approved TA as agreed with ACC for the purpose of addressing capacity and capability constraints in other areas. Examples of this exception include:

- Where a prospective Client would otherwise be waiting for more than six weeks to engage with an appropriate Lead Provider or Assessment Provider, or

- Where a TA has no Providers with the specialty skills needed to support a client.

It is anticipated that requests to provide services outside of a Supplier's TA will most often be made by ACC to the Supplier when it has not been possible to access a suitable and appropriate Provider within the Client's local area in a timely manner.

If a Supplier requests approval from ACC to deliver services outside of their approved TA, consideration will be given to determining:

- absolute certainty that a Supplier within the TA is not able to accept the referral as outlined above in "Managing Waitlists"

- That there is not a Supplier with an appropriate provider available who is geographically closer to the client. ACC will always look to neighbouring TAs in the first instance and work outwards from the local region

- That inter-regional travel is the most effective use of time and resource to address capacity and capability gaps and would not create additional capacity constraints within a Suppliers or Service Providers TA or Region.

- The current risk status and suitability for the Client to engage in long term therapy by Telehealth

- Connectivity to available local support and/or crisis services if needed

- The nature of the service to be delivered and what other options there are for service delivery i.e. engaging an Assessment Provider from outside of the Client's TA may be a straight forward decision to make, while considering referring a Client to a Lead Provider outside of the Client's TA would require more robust rationale and a clinically appropriate and sustainable service delivery plan.

- The Supplier and Service Provider must have sufficient knowledge of the heath and non-health services available in the Client's TA to facilitate and coordinate additional services and support. This includes but is not limited to local ISSC Suppliers, Emergency Services and Government Agencies such Ministry of Social Development.

It is expected that where services are provided outside of the Client's TA via Telehealth as the dominant mode of delivery, steps to mitigate risks associated with the use of Telehealth will be considered throughout the delivery of services and addressed in reporting requirements. Services delivered via Telehealth must be delivered in a manner consistent with Part B, Clause 4.3 of the ISSC Service Schedule.

Note that the AC Act 2001 stipulates that all ACC (including ISSC) services must both be delivered from and received in New Zealand, regardless of mode of delivery.

Primary Services

There are seven different service items:

1. Getting Started
2. Early Planning
3. Support for Next Steps
4. Support to Wellbeing (Short Term)
5. Supported Assessment
6. Support to Wellbeing
7. Maintaining Wellbeing

Getting started

Service name	Getting Started
Objective of the service	The objectives of this service are to: • help determine what type of Provider could best deliver services to meet the Client's needs. • let the Client know what ACC-funded services are available. • help Clients feel comfortable and validated for seeking assistance and to establish rapport between the Provider and Client. • enable the Provider and Client to complete an engagement form, allowing them to lodge a claim with ACC or re-enter the ISSC service and initiate other support applications if relevant. • give Clients an opportunity to decide whether they wish to proceed with ACC services. • give Clients a chance to meet and feel comfortable with the Service Provider without pressure that they must continue with that Provider. • let returning Clients know about any changes to ACC-funded services since they last received services. • provide ACC with the most up to date information on the Client and their current circumstances, including but not limited to contact details (including safe contacts for children and adolescents), current risks or concerns and services they are currently engaged with.
Who is this service for?	This service is for anyone who has experienced sexual assault or sexual abuse and who engages with an ISSC Supplier. To enable ACC to fund this service, Clients must either have an existing claim or agree to lodge a claim (via an engagement form). Clients accessing this service include: • new Clients who have never lodged a sensitive claim with ACC.

	• Clients who are unsure as to whether they have ever lodged an ACC claim. • Clients who have been referred from another Provider or Supplier. • Clients who have self-referred to another Provider under the same Supplier, where the Client believes an alternative Provider would be a better match. • returning Clients who have previously received sensitive claim services funded by ACC but disengaged from those services (whether with the same provider or a different provider). • a relocating Client who is currently in service but needs a Supplier close to their new location.
Who performs this service?	An approved ACC Treatment Provider with the intent of becoming the Client's Lead Provider.
Incoming information	Referral
Information submitted to ACC	Sensitive claims engagement form
Process	1. The Provider will contact the Client to arrange an appropriate appointment time. 2. The Provider will meet with the Client up to a maximum of two hours to provide the Client with the opportunity to engage with ACC-funded services. 3. The Provider needs to advise ACC of the Client's decision as to whether to progress with ACC-funded services using the Engagement Form. This is required to get the purchase order for the Getting Started sessions issued. 4. Where the claim status differs from what the Provider has stated, ACC will contact the Provider to discuss this. 5. Where the Provider believes there may already be an existing claim for the Client, the Provider will contact ACC directly to obtain the claim number, and to clarify the event dates. 6. Where the Provider has raised any concerns or asks to be contacted by ACC, ACC will contact the Provider

	within two working days of the engagement form being submitted. 7. The Provider may utilise Support Services to provide immediate support and remove barriers to a Client's ongoing engagement in therapy. 8. ACC will automatically issue a purchase order for the Supplier named on the engagement form. 9. Where the Client has indicated that they do not want further assistance the purchase order will be for the 'Getting Started' service only. Otherwise, the purchase order will be for 'Getting Started' and 'Early Planning' services under the vocation type of the Provider who submitted the engagement form. 10. Where the Client has indicated that they do not want further assistance, ACC will decline the claim at this time. Note: Following submission of the engagement form to ACC, the Client will be contacted directly by ACC for a 'Welcome Conversation'. The Welcome Conversation is intended to help ACC understand the Client's situation, including immediate barriers to access treatment (e.g. travel), and an opportunity for the Client to tell us what they need, and ensure they understand ACC's role in their recovery. Where the Provider has selected 'No' to ACC contacting the Client, the Recovery Partner will call the Provider to determine why (if it has not been specified on the Engagement Form) and how best to engage with the Client to ensure that they can access all supports.
Service requirements	1. The Provider meets with the Client for up to two hours and discusses the ACC process with the Client, what services they can offer the Client, and what the options are for the Client. 2. The Provider ensures that they complete an engagement form. The engagement form should be submitted to ACC in a timely manner following the last face to face session. 3. The Provider ensures that all relevant information is provided to ACC via the engagement forms (or by alternate means where this is not appropriate). 4. Where a Client does not wish to proceed further with the claim at this time, the Provider should ensure that the claim form specifies 'No Assistance Required'. ACC will contact the client and issue a decline letter.

	5. Providers explain the ACC Authority to Collect Information principles to ensure the Client understands what information we need and why we need it. 6. The Provider ensures that the correct Supplier has been entered onto the engagement form before submitting to ACC. 7. The Provider ensures that the correct dates are entered in the date fields “First Date of Consultation” and “Second Date of Consultation” – if a second date of consultation was required to provide the engagement form.
Next Stage	Early Planning or End of Engagement with the Provider
SPECIAL NOTE ABOUT THIS SERVICE	If the Provider does not intend to follow through with the full course of treatment, they should not engage with a Client in the first instance. If the Lead Provider is a Psychiatrist, they should refer the Client back to their Supplier if they believe that the Client is unlikely to need long-term treatment.

Early Planning

Service name	Early Planning
Objective of the service	The objective of this service is to identify the current needs of the Client and work with the Client to determine the most appropriate service(s) to address those needs.
Who is this service for?	Clients who have completed a Getting Started service: • New Clients who have recently lodged a claim with ACC, and do not have a covered claim. • Clients who have completed sensitive claim services funded by ACC but need to return to Getting Started to access longer-term support. • Returning Clients who have previously received sensitive claim services funded by ACC but disengaged from those services (whether with the same Supplier or a different Supplier). • A relocating Client who is currently receiving services elsewhere but has engaged via a new Service Provider. • Existing Clients who have had a significant enough change in need that the type of services they are receiving, needs to be revised.
Who performs this service?	An approved ACC Service Provider who is the Client's Lead Provider. (Input may be required from other Providers who may be involved in delivery of further services.)
Incoming information	Relevant clinical records that may help in the planning of onward services.
Information submitted to ACC	• *ACC6426 Early Planning Report* • *ACC6242 Client Confirmation* **or** *ACC6422 Guardian Confirmation* (this is only required for claims where ACC has not made a cover decision yet). **Note:** ACC may request the submission of the ACC6424 **or** ACC6422 form prior to the completion of the Early

	Planning Report. See 'Cover time frames' above, for more details. • *ACC6300 Authority to Collect Medical and other Records* (where appropriate)
Process	1. The Supplier and the Provider will receive a purchase order from ACC which will include the claim cover status. 2. The Provider meets with the Client for a maximum of four hours to establish the Client's needs, agree the next steps and to complete the Early Planning Report. 3. The Provider will contact ACC if the Client may require ACC funded services outside of ISSC, or if they have any questions about access to other ACC entitlements. 4. Any services not itemised in the Early Planning purchase order require approval from ACC. 5. On completion of the face-to-face sessions, the Early Planning Report will be submitted to ACC. 6. To avoid disruption to the Client receiving services, the Provider will help in obtaining agreement for the cover time frame to be extended by the Client or the collection of authority where this is necessary (see "Cover time frame" and "Authority to collect information" sections of this document) 7. The Supplier will invoice ACC for the Administration and Management Fee at the end of Early Planning. This fee is payable only to the Supplier who is administering the claim. Unless ACC requires further clarification, ACC will then provide a purchase order for the recommended ongoing services.
Service requirements	1. The Provider identifies the initial Client needs (for example: Cultural Support and Advice, Whānau Support, school, co-morbidity, work situation or other Client specific need) in enough detail to identify the next service, and provides this information including which Provider will provide the service, how many hours and the rationale within the Early Planning Report. 2. The Provider clarifies and confirms that the claim event or events meet the criteria of events specified under Schedule 3 of the AC Act 2001. 3. The Provider confirms that the event(s) happened in New Zealand, or if overseas the Client was ordinarily

	resident in New Zealand when the event(s) occurred as specified in the AC Act 2001. 4. In the case of a child, the Provider should determine guardianship, safe contact details and who has the right of access to the claim information and ensure that this information is sent to ACC – this information should also be provided within the Engagement Form. 5. The Provider discusses the ACC process with the Client, including the services the Provider can offer the Client and the options for the Client based on their needs. 6. The Provider submits the Early Planning Report to ACC within 10 Business Days following the last face-to-face session with the Client. 7. If the Client chooses to proceed to a Supported Assessment, the way the assessment will be carried out and what clinical records are required should be discussed with the Client and documented in the Early Planning Report. 8. Any Support Services used prior to the submission of the Early Planning Report and required ongoing must be outlined in the report, for example Whānau Support sessions, Cultural Support and Advice, Active Liaison, Social Work or the collection of notes and records relevant for the Supported Assessment. 9. The Personal Wellbeing Index (PWI) must be completed during the Early Planning sessions and the results included in the Early Planning Report. 10. Where the Client chooses to proceed to Supported Assessment, the Provider should request a signed ACC6300 'Authority to collect medical and other records' on ACC's behalf. 11. If the Client is proceeding to a Supported Assessment, ACC will contact them directly to discuss the collection of notes. 12. Where the Client is choosing to progress with Supported Assessment, but has a held claim, the Provider should ask the Client or the guardian to complete the 'Cover time frame extension' part of the Early Planning Client or Guardian Confirmation forms. 13. Unused hours do not roll over into the next recovery stage.

Next Stage	Depending on the Client's needs, eligibility and preference:
	
	1. Clients with a new claim who are deemed to meet ACC eligibility criteria for consideration of cover may consider:
	  o Supported Assessment
	  o Support to Wellbeing (short term)
	2. Clients with a new claim who are not considered to meet ACC eligibility criteria can access:
	  o Support for Next Steps
	3. Clients with a previously covered (accepted) claim can move on to the following services:
	  o Supported Assessment (as required to identify treatment needs)
	  o Support to Wellbeing
	  o Maintaining Wellbeing (following completion of Support to Wellbeing)
	4. Clients with a claim that has been previously declined by ACC because the Client chose not to progress can consider:
	  o Supported Assessment
	5. If the Client has a claim that has been previously declined by ACC due to criteria not being met, the Provider should discuss this with ACC as soon as possible.
	
	The services above are described in the relevant sections of these guidelines. If there is any doubt about what options are available to the Client, please contact ACC.

Support for Next Steps

Service name	Support for Next Steps
Objective of the service	The objective of this service is to support Clients who are not eligible for ACC funding to find and transition to another non-ACC Provider.
Who is this service for?	Clients who have had their claim declined by ACC due to not meeting eligibility criteria.
Who performs this service?	An approved ACC Treatment Provider who is the Client's Lead Provider.
Incoming information	None
Information submitted to ACC	Closure Notice
Process	1. Confirmation from ACC that the claim has been / will be declined. 2. ACC will approve up to a final two hours for the Support for Next Steps service. 3. ACC will discuss with the Client and advise them in writing that their claim has been declined. No further services can be funded beyond Support for Next Steps. 4. The Provider will work with the Client to identify and transition to an alternative service if required. 5. The Service Provider will signal that Support for Next Steps service is complete by submitting a Closure Notice to us. 6. Support Services are not available in this service
Next Stage	None

Support to Wellbeing (Short Term)

Service name	Support to Wellbeing (Short Term)
Objective of the service	The objective of this service is: • To provide short-term intervention as identified by the Client to support their safety and wellbeing. • to support the Client to self-manage by the completion of this service.
Who is this service for?	This service is for Clients who are expected to be able to achieve recovery with self-management within eight sessions and: • have recently lodged a new claim with ACC. • Have previously lodged a claim with ACC but never continued passed Early Planning services. *This service is not for returning Clients who have previously accessed Support to Wellbeing Short Term. They are required to progress to 'Support to Wellbeing" via the Supported Assessment process.*
Who performs this service?	An approved ACC Treatment Provider who is the Client's Lead Provider.
Incoming information	The goal(s) of Support to Wellbeing as documented in the Early Planning Report.
Information submitted to ACC	Completion Report at the end of services **Or** Updated Early Planning Report (for which ACC will pay up to 30 minutes) if the Client decides to proceed to Supported Assessment during this service.
Process	1. ACC will contact the Client and advise them in writing that they will not be eligible for cover with this service choice and that ACC is unable to approve their claim at this time. The Provider may want to discuss this with the Client when selecting this service.

	2. The Provider will work with the Client over a maximum of eight hours to achieve the goal(s) outlined in the Early Planning Report. 3. The service provision may also include Whānau Support, Cultural Support and Advice, Social Work, and Active Liaison where it supports the goal(s) outlined in the Early Planning Report. 4. The Provider will re-administer the Personal Wellbeing Index (PWI) tool in the last face-to-face session. 5. At the completion of the service the Provider will provide a Completion Report to ACC in a timely manner. 6. ACC will use the report to confirm the Client's personal goals for the service have been achieved. 7. ACC will contact the Client to confirm that they have the support they need for now. 8. When the Client's needs have been met, ACC will 'close the claim'.
Next Stage	None
Support Services	Whānau Support Cultural Support and Advice Active Liaison Social Work
Service requirements	1. This service item is comprised of a maximum of eight hours of face-to-face time. 2. The Completion Report will be submitted in a timely manner following the face-to-face session of Support to Wellbeing (Short Term) 3. The Support to Wellbeing (Short Term) service will include the administration of the Personal Wellbeing Index (PWI) at the end of therapy, and the results of this will be included on the Completion Report. 4. Submission of the Completion Report is the end of this service item. No further services will be funded after this service has been provided. However, the Client may choose to return for a Supported Assessment at a later stage.

Supported Assessment

Service Name	Supported Assessment
Who is this service for?	• New Clients who are likely to need treatment that exceeds eight hours or returning Clients who do not already have a covered mental injury. • Returning Clients who would like to access, and are eligible for, further support but have a declined a claim as the result of not progressing to assessment previously. • Returning Clients who have a covered mental injury but are presenting with new symptoms where a re-assessment is clinically indicated. • Clients who would like to be assessed for Lump Sum or Independence Allowance compensation by ACC but do not yet have a diagnosed mental injury. • Clients who are struggling to perform their normal work or commence work (in the case of a young person) and who ACC has indicated would be eligible for Weekly Compensation. (The Provider should contact ACC to discuss eligibility requirements).
Who performs this service?	It may be delivered by either: • Two Providers: a qualified and approved ACC assessor and the Client's Lead Provider, working collaboratively to support the Client through a process of assessment (this may be an independent assessor where ACC requests this). • By the Client's Lead Provider, if they are also an approved ACC assessor and they deem it appropriate to do so. (See Assessment Types below)
Incoming information	• Relevant clinical records (see section on relevant clinical records). • Relevant school / Oranga Tamariki reports (for children and adolescents). • A request for assessment from ACC that is particular to the Client's situation.
Information submitted to ACC	<u>For adults:</u>

	The ACC6429 Supported Assessment: Adults and supporting clinical records. <u>For children and adolescents:</u> The ACC6424 Supported Assessment: Child and Adolescent and supporting clinical records.
Service delivery	1. During Supported Assessment, Providers must ensure that Clients are appropriately supported, particularly where the assessment is carried out by an independent assessor (Assessment Provider). Support may include; attendance by the Lead Provider, Whānau Support, Social Work, Cultural Support and Advice or Active Liaison as appropriate. The Lead Provider must also provide the Assessment Provider with all the relevant background information. 2. Where a single Provider carries out this service the maximum number of face-to-face hours is 10 (using service code SCSA). These may be used as follows: o Up to two hours pre-assessment sessions, whilst waiting for any required clinical records to be obtained, for the Client to be informed about and prepared for the assessment. o Up to five hours supported assessment sessions. o One hour Client assessment report review session. o Up to two hours post-review support sessions while awaiting ACC's decision. 3. Where this service is provided by the Lead Provider and an Assessment Provider working collaboratively, the following maximum sessions apply: o The Lead Provider can use up to 10 hours as per section 2 above (using service code SCSAL). o The Assessment Provider can use a maximum of six hours (using service code SCSA). This is comprised of up to five hours of face-to-face assessment time and up to one hour to review the assessment report with the Client. 4. The Assessment Provider will administer the WHODAS 2.0 as part of this assessment and will report this data as part of the Supported Assessment report. 5. The assessment review appointment will include the Client and any others thought to be necessary (with Client consent)

	unless there are concerns around Client or Provider safety, or if this is deemed clinically inappropriate. 6. If the Assessment Provider is not the Lead Provider and has had to travel outside of their TA to assess the Client (due to capability and capacity constraints), the Assessment Provider may deliver the assessment appointment and any other necessary follow up appointments via Telehealth (with the Client's consent).
Process	1. Once ACC is satisfied by the Early Planning Report and Confirmation Form that Supported Assessment is required, we will advise the Supplier and the provider of: o The approved assessment hours for all Providers. o The areas to be covered as part of the assessment including where ACC has purchased services from other Suppliers (where assessment is required outside of the ISSC contract). o Clinical notes that ACC holds which are relevant for the assessment. 2. The Lead Provider will coordinate the assessment between the Client and any additional Providers including provision of support services. 3. After the relevant face-to-face sessions, the assessor will complete the Assessment Report. 4. The Assessment Report will be reviewed with the Client before it is sent to ACC. 5. The report will be sent to ACC in a timely manner following the Client assessment report review session, and support will continue to be provided until ACC has reviewed the report and made any required cover/entitlement decisions. 6. The assessment report must be received by ACC before it can be invoiced for. 7. Unused hours do not roll over into the next recovery stage.
Next Stage	Support to Wellbeing Support for Next Steps (if the claim is declined) Client sent for assessment for other ACC entitlements No further services required

Support Services	Whānau Support Social Work Active Liaison Cultural Support and Advice

When to use a Psychiatrist

Psychiatrist involvement would typically be decided within the Early Planning service as part of preparation for the Supported Assessment Service (or as early as possible). The Lead Provider should take the following factors into consideration when determining the need for a psychiatrist:

- Where the Client requires an Incapacity Assessment as they may be unfit for work due to their mental injury (to access entitlements, such as Weekly Compensation or Loss of Potential Earnings (LOPE)). Please note, if a psychiatrist is not available to do the assessment within four weeks, a suitably qualified Clinical Psychologist can complete the Incapacity Assessment, with ACC approval.
- Recent discharge from a Psychiatric Inpatient Unit.
- History of serious mental health disorders such as bipolar affective disorder or schizophrenia.
- Comorbid physical health issues that may be influencing mental state, such as:
    - poorly controlled diabetes,
    - HIV,
    - severe traumatic brain injury, or
    - evidence of gynaecological and/or hormonal conditions that may be causing mood instability.
- If Early Planning or obtained clinical records indicate the Client will benefit from a review of medication at the same time as the assessment. Indications of this include polypharmacy indicated in GP notes, as some medications and/or prescribing regimes can produce symptoms that mimic other mental health problems.
- In cases where pharmacotherapy is likely to be complex, for example treating pain concurrently with mental disorder.

Note that a referral to a psychiatrist can be made at any time should the Lead Provider consider this is prudent. Review or follow-up by a psychiatrist following a Supported Assessment may be indicated where:

- Previous indicators for involvement were identified at Supported Assessment, and/or where the cover assessment identified:
    - pharmacotherapy is likely to be complex (for example, treating pain concurrently with mental disorder)
    - complex diagnostic issues which require clarification
    - serious or long-standing alcohol and drug use issues

Where a psychiatrist has been deemed the most suitable Lead Provider for a client to engage with, the following should be considered before commencing services:

- If long-term treatment is unlikely to be required, the Client should be referred back to their Supplier to engage with an alternative Provider.

- Psychiatrist may provide Support to Wellbeing Short Term, where it is the most suitable option for the client. Psychiatrists are primarily reserved for clients to determine diagnosis and who specifically require psychiatric input as a result of a covered injury.

If the ISSC Supplier doesn't have a psychiatrist as part of their ISSC Service and a psychiatrist is needed, the Supplier has two options:

Establish a relationship with psychiatrists within the TA that you provide services in who hold the Psychiatric Services Service Schedule and directly refer to them. The Supplier needs to contact ACC to discuss which psychiatrist will be used. This enables ACC to generate two purchase orders, of which one allows the psychiatrist to invoice ACC directly for their part in the Supported Assessment. Where a Supplier does not have a network established, the Supplier can contact ACC directly to request names of suitable psychiatrists. The Supplier will contact the psychiatrist and follow the process as above.

When to use a Clinical Psychologist

Clinical Psychologists should be considered in preference to counsellors approved to deliver assessment to assess Clients with complex presentations, especially those with multiple diagnoses or where psychometric assessment may assist with diagnosis.

Support to Wellbeing

Service Name	Support to Wellbeing
Objective of the service	The objective of this service is to provide the Client with a personalised treatment plan developed with the Client and informed by the Supported Assessment to achieve recovery from, or the self-management, of their covered mental injury.

Who is this service for?	Clients with a covered mental injury who require therapeutic intervention.
Who performs this service?	Lead Provider.
Incoming information	Clinical notes from previous Providers and information from the Supported Assessment (Supported Assessment Report and any related discussions).
Outgoing information	Wellbeing Plan Wellbeing Progress Report Case Conferences Completion Report
Process	1. ACC will confirm cover for a mental injury to the Provider and the Client and approve four hours for the creation of the Wellbeing Plan. 2. The Supported Assessment Reports and any related discussions can provide input to the plan. 3. For returning Clients who have not recently been assessed, WHODAS 2.0 and PWI should be administered as part of the Wellbeing Plan development for a baseline WHODAS 2.0 and PWI score. 4. The Provider will coordinate the development of the plan with input from the assessor and all Providers (ACC and non-ACC) that have a role in forming the plan. 5. The Provider will complete the documentation of the plan and submit it to ACC for approval. 6. ACC will check that the plan demonstrates appropriate goals and treatment plan for recovery or self-management for the covered mental injury. 7. ACC will approve the plan by issuing a further purchase order for up to 44 hours of Support to

	Wellbeing for 12 months from the start date of the initial purchase order. 8. ACC will continue to coordinate other entitlements as required to support the Client. 9. The Provider will deliver therapy as per the Wellbeing Plan, informing ACC of any significant changes. 10. Case Conferencing will align to the milestones set in the Client's Wellbeing Plan or at additional times as agreed with ACC. Refer to 'Case Conferencing' below for further information. . 11. Progress reports will be due three months before the end of each Purchase Order for this service. 12. The WHODAS 2.0 and PWI will be re-administered at the point the Progress Report is due. If applicable and necessary, the Provider may re-engage with the Provider who administered the baseline WHODAS 2.0 to do this. 13. ACC will issue a new purchase order for up to a maximum 48 hours over the next 12-month period, or shorter, as outlined in the progress report. This will start from the end date of the current purchase order to ensure continuity of support. 14. The Wellbeing Plan should be updated to reflect any significant changes to the Client's goals or circumstances, or to include rationale when requesting additional supports. ACC will approve up to 30 minutes for this. 15. At any time during Support to Wellbeing either the Provider or ACC may determine that it is clinically appropriate for an updated assessment to be undertaken. The Provider may signal this need in the Progress Report. 16. Where the Client has successfully achieved recovery or self-management the Completion Report should be completed and submitted to ACC. 17. The WHODAS 2.0 and PWI will be re-administered at the completion of service. If applicable and necessary, the Provider may re-engage with the Provider who administered the baseline WHODAS 2.0 to do this.

	18. ACC will use the completion report to confirm the Client's personal goals for the service have been achieved. 19. ACC will also contact the Client to confirm that they have all they need for now. 20. Where the Client's needs have been met, ACC will advise the Client that Maintaining Wellbeing sessions are available. 21. ACC will issue a purchase order for the first year of Maintaining Wellbeing and then 'close the claim'.
Next Stage	Maintaining Wellbeing
Support and Secondary Services	Group-based Therapy Group-based Therapy – Dialectical Behaviour Therapy Whānau Support Cultural Support and Advice Active Liaison Social Work
Service requirements	1. The Support to Wellbeing service item will be delivered up to a maximum of 48 hours: up to four hours to develop the Wellbeing Plan and up to 44 hours over the first 12-month period. Subsequent 12-month periods of approval for services will be delivered up to a maximum of 48 hours, as outlined in the progress report. 2. This service item must be approved by ACC. 3. This service item is only available to Clients with an accepted claim. 4. The Provider will use up to four hours at the start of this service item to develop a Wellbeing Plan in collaboration with the Client. 5. The Provider will deliver treatment services that are "necessary and appropriate, and of the quality required, for that purpose" and "performed only on the number of occasions necessary for that purpose" (Accident Compensation Act 2001, Schedule 1, Part 1, clause 2 (1) (a) and (b)). 6. Progress Reports will be provided to ACC three months out from the end of the Purchase Order. If at this point it is determined that the Client will require

	additional services, the Provider will discuss this with ACC and, in place of the Completion Report, will request additional services via the Progress report. The Service Provider will be required to administer the WHODAS 2.0 and PWI as part of the Progress Report. 7. Case Conferencing will align to the milestones set in the Client's Wellbeing Plan or at additional times as agreed with ACC. Refer to 'Case Conferencing' below for further information. 8. If a Client does not complete the Support to Wellbeing service for any reason, including actively disengaging, the Provider will complete and submit a Closure Notice, unless the Provider has enough information to submit a completion report to ACC. 9. Unused hours do not roll over into the next year or recovery stage, and ACC cannot extend the Purchase Order past 12 months. 10. Near the completion of active therapy under this service, the Service Provider is required to administer the WHODAS 2.0 and the PWI. 11. At the completion of this service item the Completion Report will be submitted to ACC in a timely manner following the final face-to-face Support to Wellbeing Service. 12. Submission of the Completion Report defines the completion of therapy and the termination of this service item.

Maintaining Wellbeing

Service Name	Maintaining Wellbeing
Objective of the service	To provide support as required for a Client who is self-managing their mental injury but may need some brief assistance from time to time.
Who is this service for?	Any Client who has successfully completed the Support to Wellbeing Long Term service.
Who performs this service?	An approved ACC Treatment Provider who is the Client's Lead Provider.
Process	1. On completion of the Support to Wellbeing service, ACC will issue a purchase order for four Maintaining Wellbeing hours over the next 12 months with the Client's same Provider. 2. The Client may access these sessions whenever support is required. 3. If the Client wants to access support in year 2 or year 3, the Supplier will need to contact ACC for them to issue a subsequent purchase order. 4. If the Client requires more than four hours in a year or it is evident that the Client is no longer able to self-manage, this should be escalated to ACC via the 'Returning Client' process as described in this document.
Next Stage	None
Support Services	No support services apply for this service; these can only be requested via the Returning Client process.
Service Requirements	1. This service item provides for up to four hours of face-to-face sessions per year for three years commencing from the completion of therapy (i.e. completion of Support to Wellbeing service, submission of Completion Report and Client transition to self-management). 2. This service item must be approved by ACC.

	3. This service item is only available to Clients with accepted claims who have completed the Support to Wellbeing service. 4. Unused hours do not roll over into the next year and a DNA cannot be invoiced if a Client does not attend a session. 5. Where a Client presents for Maintaining Wellbeing with service needs outside of the scope of this service item the Provider must: o Advise ACC of this escalation as soon as practicable, but no later than the completion of the final approved Maintaining Wellbeing session. o Complete an engagement form (Getting Started). See section: Returning Clients

Support Services

Support services can be provided as part of a Client's primary ISSC services following Getting Started, where specific needs are identified and able to be met through the delivery of these services. These include:

- Whānau Support
- Social Work
- Cultural Support and Advice
- Active Liaison

The first annual (12-month) allocation of Support Services does not require prior approval from ACC. Where additional hours are required beyond the first 12-month allocation, prior approval from ACC is required before delivery. All requests and notification of hours used should be accompanied by appropriate rationale. Rationale should include the outcome that will be achieved by using the support service and how many hours are being requested or have been used and who will be completing the support service. Where required, ACC will issue a purchase order once these services are approved.

The Supplier would usually apply for these services through:

- Early Planning, Supported Assessment, and Support to Wellbeing plans and progress reports.
- Case Conferencing.
- Contacting ACC by email.

The Lead Provider will be required to document the progress and outcome of support services in relevant reports.

Whānau Support

Whānau Support is used to support a Client's recovery through provision of early education and support to whānau about the effects of sexual assault and abuse.

The support provided focuses on how whānau can support the rehabilitation goals of the Client. Services of up to 20 hours per claim, per 12-month period can be requested. Whānau support is intended to occur without the Client present, but the Client should be aware these sessions are occurring, with the Provider considering the age of the Client.

Whānau support may include but is not limited to:

- education about the effects of sexual abuse,

- strategies to deal with behavioural or emotional issues of the Client
- coping strategies to ensure the stability of the home environment.

There are situations where this service is not appropriate. This could include where a court case is pending and some of the whānau may be used as witnesses, or when family conflict or abuse means the service would not be beneficial or could potentially even be dangerous. It is important that you consider a Client's situation and safety when deciding whether to use this service.

Services which are excluded and not funded:

- Treatment of issues not directly related to the Client's recovery
- Relationship Counselling
- Resource Teachers; Learning and Behaviour (RTLBs) or special education assisting with issues related to school. However, ACC may be able to help with accessing these agencies
- Reimbursement of costs of attendance, although some assistance with travel costs in special circumstances may be available as per ACC policy
- Treatment of whānau members wishing to deal with their own sexual abuse or assault trauma. A separate claim will need to be lodged for this

Whānau Support may either be delivered by the Lead Provider or a separate Named Provider (for example, a Social Worker).

Where possible, requests for Whānau Support should be made as part of the request for a Primary Service item and be for the number of hours required for the duration of that service. Progress should be reported in the relevant Client reports although personal details of specific whānau should not be included.

Social Work

This service is for when the Client may need support outside of primary services to support their recovery and rehabilitation. The focus of this service is on managing and/or removing any social barriers that prevent or compromise a Client's ability to engage in ISSC treatment or Supported Assessment Services. It may be used to:

- Advise Clients and connect them into other services that are available in their communities.
- Assist Clients to access other services.
- Introduce the Client to other services and ensure effective engagement and reduce barriers to engaging in their therapy.

The social worker will plan and facilitate this service. Only social workers who are a named provider under an ISSC contract can provide social work services. They do not have to be with the same ISSC Supplier as the Lead Provider.

Examples of where Social Work may be appropriate are:

- When Clients are not entitled to weekly compensation and need support connecting to MSD
- When Clients are being released from prison and need to connect with their community
- Where Clients need support connecting to community social services.

Service Requirements

1. Up to 10 hours per claim, per 12-months of Social Work support may be requested for each Client. If there are circumstances where a Client requires more than the 10 hours in the 12-month period, this should be discussed with ACC. ACC will determine whether Social Work should be provided via another ACC contract.
2. This service item must be pre-approved. Wherever possible, requests for Social Work should be made as part of the request for a Primary Service Item.
3. Requests for Social Work must include the rationale and goals for the service.
4. The Lead Provider will document delivery of this service item in the Client's service records and record progress in the relevant ACC reports.

Cultural Support and Advice

The provision of Cultural Support and Advice acknowledges the cultural diversity of Aotearoa New Zealand and the importance of culture in the delivery of and effective engagement in therapy.

The Lead Provider can request funding for Cultural Support and Advice to engage an appropriate person in the community determined to have the right level of stature within that community and expertise necessary to facilitate the removal of cultural barriers to a client's recovery.

The removal of cultural barriers will be different for different people and may include:

- Facilitating access to culturally relevant social services and supports
- Facilitating connectivity to cultural community networks
- Addressing the culturally specific spiritual or holistic aspects of healing.

Only Cultural Support and Advice provided by an appropriate third party can be funded. The Lead Provider cannot be funded to deliver Cultural Support and Advice themselves.

Examples of who might be an appropriate third party are:

- Kaumatua, or community elder

- Faith leader
- Community leader (for example Rainbow or Disability communities)

For those Clients without an accepted claim, a Rongoā Māori (see below) practitioner may be an appropriate third party to approach to deliver Cultural Support and Advice. Cultural Support and Advice may incorporate elements considered to be Rongoā Māori, however, the two are considered different services for ACC clients, with Cultural Support and Advice focussed on the removal of cultural barriers and alignment to treatment goals to increase the effectiveness of therapy.

Cultural Support and Advice requires prior approval. The Lead Provider must consult with ACC when determining the need for Cultural Support and Advice. The Lead Provider will need to provide the following information to ACC:

- Relevant background information on the proposed provider of Cultural Support and Advice, including why they are suitable to provide Cultural Support and Advice.
- Rationale for requiring Cultural Support and Advice, including details of the cultural barriers to be overcome and alignment to any treatment goals.

Service Requirements

Refer to Part B, Clause 5.7.6 in the Service Schedule for the requirements of this service item. Additionally:

1. The Lead Provider will need to consult with the Client and obtain their agreement before seeking Cultural Support and Advice. The Client's agreement will also need to be obtained if it is determined that the provider of Cultural Support and Advice should attend the Client's therapy sessions.
2. Where possible, requests for Cultural Support and Advice should be made as part of the request for a Primary Service item and be for the number of hours required for the duration of that service.
3. Progress should be reported in the relevant Client reports.
4. The Third Party identified to deliver Cultural Advice and Support is subject to the same vetting as all Named Service Providers and are the responsibility of the supplier. Refer to Part B, Clause 6.1.4.4 of the Service Schedule.

Note that Cultural Support and Advice is not intended to replace Cultural Supervision for a Provider. The distinction between Cultural Supervision and Cultural Support and Advice is:

1. Cultural Supervision is intended to increase a Provider's cultural competency in general
2. Cultural Support and Advice is relevant to a specific Client and focusses on the removal of cultural barriers and alignment to treatment goals to increase the effectiveness of therapy.

Rongoā Māori

Clients with an accepted ISSC claim can access Rongoā Māori (traditional Māori healing) by approaching their ACC Recovery Partner or Assisted Recovery for approval. This is managed outside of the ISSC and is funded separately. ACC does not refer for this service. Instead, Clients or their Lead Provider should identify which Rongoā practitioner they would like to seek care from in their request to ACC.

For more information about Rongoā Māori, including a list of practitioners who are registered to deliver services for ACC Clients, refer to our website Using rongoā Māori services (acc.co.nz)

Active Liaison

Active Liaison is used by the Lead Provider to coordinate key activities that support the Client's rehabilitation and recovery. This may include:

- Telephone discussions with Oranga Tamariki or a school to ensure that the necessary supports are in place at a Client's home or school that supports the ISSC treatment programme.
- Connecting with the Client's General Practitioner (where appropriate and this has been discussed first with the Client) to ensure they are on the same page and working together.
- Coordinating external agencies and/or family and whānau or caregivers to support the Client's attendance at meetings.
- Leading and participating in cross sector inter-agency meetings, including recording and follow-up of actions
- Helping the family and whānau with connecting with other agencies involved with the Client (with the Client's permission) e.g. courts, NZ Police, Oranga Tamariki.
- Time spent with a provider who has been engaged to deliver Cultural Support and Advice.

Service Requirements

1. This service requires pre-approval and up to 10 hours per claim, per 12-month period can be requested. Active Liaison services will always be delivered by the Lead Provider.
2. Up to two hours of the 10 hours per claim, per 12-month period in total for Active Liaison time can be requested for the Lead Provider to liaise with a Supported Assessor to determine if there are any supported assessment needs for a Client e.g. may be a discussion with the Assessor to determine if assessment is the right path for the Client at this stage. Where this is required, the ISSC Lead Provider should complete and submit the Early Planning report which identifies that Active Liaison hours have been used during the Early Planning stage. This

will then activate the requirement for ACC to create and send you a related purchase order referral for Active Liaison.

3. Under clause 5.5.1.2 of the Service Schedule states: for Support to Wellbeing, a Lead Provider will use up to four sessions at the start of this service to develop the Wellbeing Plan in collaboration with the Client and in consultation with the Assessment Provider. The Assessment Provider can access Active Liaison to be remunerated for this consultation. The Active Liaison hours available for this must come from the 10 hours available per claim over a 12-month period. Remuneration for an Assessment Provider being consulted on the development of a Wellbeing Plan should be negotiated and managed between the Supplier/Lead Provider and the Assessor. This should be requested a part of the Wellbeing Plan by the Lead Provider. Where possible, requests for Active Liaison should be made as part of the request for a Primary Service item and be for the number of hours required for the duration of that service.
4. The Lead Provider should update ACC on how the Active Liaison time has been used in progress reporting and case conferences

Active Liaison hours are not for:

- The Lead Provider to liaise with other service providers when they are both with the same ISSC Supplier – except for the two hours available to determine the need for Supported Assessment (see point 2 above).
- The Lead Provider to attend court with the Client. In this circumstance, Active Liaison should be requested for the Lead Provider to liaise with and connect the Client to the Court Victims Advisor or appropriate support service.
- Advocating for the Client.
- Active Liaison cannot be requested for time spent engaging with ACC.

Secondary Services

Group-based Therapy

This service is focused on helping Clients to develop the specific skills which are the focus of that group. For example, an anger management group will focus specifically on the development of anger management skills. Clients would only be included in a group if they required the specific skills being addressed by that group. Support groups and unstructured group therapy are not included in this service and are not included as part of the ISSC.

Group-based Therapy is planned and delivered as part of Support to Wellbeing and is only available for Clients with an accepted claim. Group-based Therapy needs to be easily accessible to the Client and is delivered face-to-face (either via in-person or Telehealth channels).

- The type and nature of Group-based Therapy proposed for the Client should be documented in the Client's Wellbeing Plan.
- The service must be delivered by either two Named Providers approved by ACC to deliver Group-based Therapy, or one Named Provider approved by ACC to deliver Group-based Therapy and a specialist in a field relevant to the kind of Group-based Therapy being delivered. For example, if the group is a Trauma Sensitive Yoga (TSY) group, the specialist should be trained in TSY. These specialists are subject to the same vetting as all Supplier-approved people and are the responsibility of the Supplier.
- The specialist may not conduct the group session without the Named Provider being present.
- The Named Providers approved to deliver Group-based Therapy are required to keep the Lead Provider updated. The Lead Provider is responsible for documenting progress and achievement of outcomes in the reporting associated with the Support to Wellbeing service.

- The hours provided for this service include non-face to face contact time, so that Providers may be remunerated for time taken to prepare and conclude sessions. Please keep the Client's annual hourly allocation in mind when deciding how long sessions will run.

- DNA is not applicable to this code. ACC expects that clients are aware that if they do not attend a session, it will be charged for and be deducted from the Client's annual allocation (32 hours). Where a Client actively disengages partway through Group-based Therapy, the Group-based Therapy Provider will notify the Lead Provider as soon as practicable. Where this indicates the Client does not wish to proceed with the Group-based Therapy, the Lead Provider will notify ACC to close off the purchase order for that service item.
- If Group-based Therapy Providers need to hire a room specifically to facilitate the group, the Remote Clinic Room Hire code may be considered

- Further requests for Group-based Therapy can be made by submitting an updated Support to Wellbeing Plan to ACC. Upon approval, the Supplier will receive a purchase order from ACC confirming what has been agreed.

Establishing endorsement to run a specific group

Providers wanting to start a therapy group for ISSC Clients should follow the process below:

- Supplier submits a group proposal to their Engagement and Performance Manager.
- The Group proposal is evaluated by ACC.
- Approval or feedback is sent to the Supplier by the Engagement and Performance Manager.

This process will take two to four weeks depending on the level of detail in the proposal and availability of staff to evaluate.

The following information should be included in the proposal:

- Objectives and rationale for the group, including an outline of the content and focus,
- Names and Provider IDs of the facilitators (if Named Providers), the Named Providers must also be approved for groupwork as they would for treatment or assessment.
- Name, qualifications, CV and/or written reference and relevant experience of specialist (if applicable),
- Group duration (specific dates and confirmation of client facing and non-client facing time),
- Location (including whether in-person, or online)
- Measure for ensuring Client safety,
- An outline of how outcomes will be evaluated.

Only groups that have been approved to be delivered via Telehealth may be delivered in this way. A group may not change mode of service delivery without seeking ACC's approval, via the Engagement and Performance Manager.

Approval must be given for each round of group-based therapy. This means that approval is needed each time a group is set up and run (even if the content and process is the same as previously approved groups). This is to ensure that ACC is aware of when and where groups are run. For groups that have already been approved for content and clinical suitability, approval for further rounds can be done quickly by contacting the Performance and Engagement Manager (EPM). Alternatively, Suppliers may provide this information annually if they are able to stipulate the dates for the

groups. Should anything change during that time (e.g. providers, dates or venue), then Suppliers should contact their EPM to advise them of these changes.

Service Requirements

1. The service requirements are outlined in Part B, Clause 5.6.1 of the service schedule.

2. Clients may participate in more than one group service if the different groups focus on different skills as identified in their Wellbeing Plan and approved by ACC, as long as this does not exceed the Client's annual hourly allowance for this service.

Group-based Therapy – Dialectical Behaviour Therapy (DBT)

This is a specific form of therapy designed primarily (but not exclusively) for Clients with Borderline Personality Disorder, or for Clients who have similar traits, for example, they may experience significant mood swings, have difficulty in tolerating distress, react with extreme emotion to changing life circumstances, and require support for basic problem-solving.

The programme is long term and structured and is delivered by two approved Service Providers with specific training in DBT. A Client may participate in more than one form of Group-based Therapy programme such as an anxiety management group and a resilience group as well as a DBT group. Group-based Therapy (SCGW/T) and Group-based Therapy (DBT) (SCGWL/T) are not mutually exclusive. Group-based Therapy (DBT) must meet the same requirements as set out above in Group-based Therapy, with some additional requirements:

- This service item must be delivered within a maximum of two hours per week over a 12-month period.

This service item must be delivered by two ISSC Named Group-based Therapy Providers.

Triage

One hour of funding (per Client, per Group) is available to allow planning and engagement with prospective Clients for Group-based Therapy (refer to Part B, Clause 5.1.9 of the Service Schedule).

ACC Continuity Sessions

There may be situations where we are not able to make a cover decision within the agreed timeframes or we need additional time to consider reports and requests for services. To ensure therapy continues without interruption a conversation needs to be had with ACC and the Supplier, or the Service Provider on behalf of the Supplier, to discuss the expected timeframe for decision making and agree the number of continuity sessions required. It is important that this happens well before the approved hours under each primary service expires.

If there are unanticipated delays that ACC is not aware of, it is important that the Supplier contacts ACC to inform of the delays. Where appropriate, ACC may choose to proactively provide continuity sessions if we identify a delay.

Incapacity Assessment

This is usually done after a Supported Assessment, but in some cases can be done at the same time if clinically appropriate and if the Assessor is approved to deliver the service. An Incapacity Assessment assesses the impact of the mental injury on the Client's capacity to work in their pre-injury role or to commence work in roles deemed suitable by reason of experience, education or training, or any combination of these. This assessment is used to inform vocational rehabilitation or training and for determining Weekly Compensation where clients are unable to work due to their injury.

The assessment should be completed by a psychiatrist or where a psychiatrist is not available within four weeks of the referral, it may be completed by another appropriately qualified assessor (such as an occupational physician). Please contact ACC to discuss further.

Treatment Review

Service Name	Treatment Review
Who is this service for?	• Clients who have been receiving treatment for a long time (at least 12 months) and where ACC has concern that treatment is not progressing as expected. A Treatment Review may be considered when: • ACC has concerns about treatment progress as evidenced by factors such as a lack of overall improvement in the Client's day to day functioning, • there has been no change in treatment goals over time, • there has been a deterioration in functioning over time, • there is no clear explanation by the treating provider for any lack of progress, • reports or case conference contacts appear to indicate that the presentation being treated no longer arises from coverable events (e.g. the treatment appears to be focused on issues secondary to problems such as a relationship break up), or • ACC becomes aware of new information that might indicate that the current treatment is counterproductive or not required at the current time.

Who performs this service?	• Service providers who are approved to deliver Supported Assessments can complete Treatment Reviews. • The Treatment Review can't be completed by the Client's Lead Provider and where possible shouldn't be delivered by a Provider within the same Supplier network. This is because the Treatment review is designed to be an independent review of the Client's treatment and progress.
Incoming information	Supported Assessment Report Wellbeing Plan Support to Wellbeing Progress report(s) Case Conferencing
Information submitted to ACC	*ACC7420* Treatment Review report
Service delivery	1. This service is initiated by ACC and the service item must be pre-approved. 2. This service is designed to review treatment to date and gains (or otherwise) made in treatment. It is not a full diagnostic assessment, although a review of current covered diagnoses and an opinion on any potential changes to these (improvements, deterioration) is required. The assessment will inform ACC about the Client's current presentation, how a Client is progressing in therapy, evaluate the extent to which the current intervention is on track to be effective for the Client given their unique presentation, identify current issues, including any changes to circumstances, and provide recommendations for ongoing treatment if any further treatment is required. Recommendations may include changes to treatment or additional treatment that is required. It may also include a recommendation for a diagnostic reassessment if it appears the client's diagnosis may have changed. 3. The service item is for up to a maximum of 16 hours, including but not limited to face-to-face sessions with the Client, review of all relevant documentation, liaising with the lead provider about current treatment, writing the report, and provision of feedback to the Client and/or their treatment provider. 4. The Service Provider will administer the WHODAS 2.0 as part of this review and will report this data as part of the Treatment Review report.

	5. The Treatment Review report and any other supporting documents will be submitted to ACC within ten Business Days following provision of feedback to the Client and/or their Lead Provider.
Process	1. ACC will refer into this service following recommendations from a Psychology Advisor that a treatment review is considered necessary. This may also be requested by the Lead Provider where they have concerns that treatment has stagnated or there are barriers to progress that are not easily identifiable. 2. ACC will contact the Lead Provider to advise of the referral and discuss whether ACC or the Lead Provider are better suited to discuss the Treatment Review with the Client. 3. The Assessment Provider will work closely with the Lead Provider to complete the Treatment Review and make decisions around what face-to-face sessions with the Client are required and whether the Lead Provider should be present at these sessions. 4. The relevant background information required for the Treatment Review Report can be taken from previous reports and case notes and doesn't need to be discussed with the Client again. 5. Section 4 of the Treatment Review Report form regarding the events only needs to be completed where new information comes to light during the review process. The assessor is not required to discuss the events with the client, if this is not clinically indicated. 6. ACC will ensure that the lead provider receives a copy of the Treatment Review Report.

Assessments under other ACC contracts

Assessments for other mental injuries

There are comprehensive assessment services available under our Psychological Services contract for Clients, who may have suffered a mental injury caused by physical injury or a treatment injury, or who might have a work-related mental injury.

Assessments are completed by Psychologists or Psychiatrists who have been approved by ACC to provide these services.

ACC should be contacted for advice if the Lead Provider wishes to recommend a neuropsychological assessment for a Client.

Neuropsychological/ Cognitive testing

A neuropsychological assessment evaluates the Client's cognitive functioning, where a Client is suspected to have significant or relevant cognitive deficits which are interfering with their recovery. A neuropsychological assessment may also be required where a Client has a history of a traumatic brain injury and it is felt that a more complete assessment of the Client's functioning is indicated to assist with accessing or designing suitable treatment.

A neuropsychological or cognitive assessment should only be requested where there is evidence that the Client's functioning may be impacted by cognitive difficulties and that the Client may require access to specialist support services or specific treatment adaptations. Given the nature of such an assessment and the demands on Clients, it is not recommended where the results are unlikely to add anything of significance to treatment or access to services or benefits.

Alternatively, a cognitive assessment may be conducted by a psychologist competent in psychometric assessment as part of the Supported Assessment. This may be applicable to children who have suspected cognitive deficits/developmental disabilities which may have an influence on the way therapy is delivered. While these assessors may not be specialised in neuropsychological assessments, they have the required expertise and familiarity with the psychometric tools to use the appropriate measures to determine a Client's cognitive functioning. It is possible that a full neuropsychological assessment may be requested following a cognitive assessment.

ACC should be contacted for advice on the appropriateness of, and how, to refer a Client for a neuropsychological assessment.

Specialty Assessors

Where special assessments are required that are not available within the ISSC contract or the Client's normal Supplier agency, these can be brought in. The Lead Provider will still need to work collaboratively to support the Client through the process of assessment.

For example, if the Provider identifies that psychiatric assessment is necessary but the Client's Supplier has no named psychiatrist on their contract, ACC, the Lead Provider, and the Client will agree on an appropriate assessor. ACC will raise an additional purchase order to pay for that assessor. The Treatment Provider will then work with the psychiatrist to determine how the assessment will be carried out to best suit the Client's needs.

Medicine Reviews

Before referring for a medicine review, it is important to ensure both the Client and primary care prescriber (ie GP) are part of the referral process.

The provider for a medicines review should assess the whole medicine regime, client adherence/beliefs about their regime and work collaboratively with the primary care prescriber and other providers involved in client care to improve medicines outcomes.

All medicine review referrals **must** identify specific questions to be addressed to ensure:

- The whole medicine regimen is assessed
- Adverse events and medicines interactions are minimised
- Adherence improves
- Client medicine use is optimised
- The client has an improved understanding of how their medicines work
- The client achieves the expected recovery goals

Before agreeing to a referral for medicine review, the ACC Recovery Team Members will check that the Client:

- has multiple comorbidities; **and/or**
- is taking multiple medicines; **and**
- The treatment provider (eg. lead provider or other provider who requests a medicine review) has liaised with the client and primary care prescriber to ensure:
    i. Comorbidities impacting on wellbeing have been addressed by the primary care prescriber and
    ii. Social factors impacting on wellbeing have been addressed by the treatment provider or other provider and
    iii. Adherence to taking medicines or complying with treatment is identified by the treatment provider or other provider and
    iv. Medicines (for both mental health and non-mental health conditions) are reviewed; and
    v. the primary care prescriber, treatment provider and client agree the whole medicine regimen will be reviewed and outline any specific questions they want the review to address; and
    vi. the primary care prescriber, treatment provider and client record the medicine history/ outcomes to date and the current medicine list and have sent this information to ACC; and
    vii. the primary care prescriber, treatment provider and client identify whether a medical specialist (eg. psychiatrist) or a clinical pharmacist[1] or other specialist should undertake the medicines review

If ACC agrees to a medicine review referral, ACC will make a referral to the medicine review provider with the specific questions from the treatment provider, primary care prescriber and client into the referral. The referral will include a history and outcomes to date and a list of the medicine. The report and recommendations will help the primary care prescriber, lead provider and client to:

- Improve therapeutic effectiveness

[1] The GP or treatment provider can find a clinical pharmacist to do medicine reviews through their PHO or clinical networks

- Minimize adverse effects
- Minimize interactions
- Educate the Client about the purpose/s of their medicines
- Enable the primary care prescriber to stop and/or start medicines.

The medicine review will be asked to send a copy of their report and recommendations to the lead provider, primary care prescriber, client and ACC.

The following are the responsibility of the various providers who receive the medicines review report:

- Prescribing changes are the responsibility of the primary care prescriber
- Adherence support is the responsibility of the treatment (Lead Provider) provider
- Medicines education is the responsibility of the primary care prescriber (or medicine reviewer in collaboration with the primary care prescriber)
- Integration of the medicine review recommendations into the Wellbeing Plan or rehabilitation plan is the responsibility of the case owner and/or lead treatment provider

Supporting service delivery for the Client

This section encompasses:

1. Engagement Form
2. Case Conferencing
3. Client reporting and monitoring requirements
4. Outcome measures
5. Obtaining clinical and other records
6. Other ACC entitlements
7. Managing non-attendance
8. Clients leaving the service
9. Notifying ACC of Closure
10. Transitioning Clients

Engagement Form

Providers under ISSC contracts are required to lodge a claim for a client using the electronic Engagement Form. This form is only submitted electronically and requires Providers to have a RealMe login and Internet access.

RealMe Login

ACC plans to deliver all future ACC online services on the MyACC site using the RealMe login service. RealMe is a service co-created by the Department of Internal Affairs and NZ Post which enables external users to use one sign-on to access all ACC online services as well as other government websites.

All Approved ISSC Providers will need to provide us with their individual email address (this needs to be provided to ACC using the ACC24 or ACC6244). We'll use this email address to send an invitation to access MyACC so that a Provider can use the engagement form. If a Provider does not already have a RealMe login, (some people might already have one, if for example they have recently requested a passport online), they will be guided to create a RealMe login and then be directed to the Engagement Form on MyACC.

We recommend that Providers complete the RealMe sign-up process prior to having a session with a Client so they can complete Engagement Forms without delay and as needed during Client sessions.

Technical requirements

ACC recommends the Engagement Form and MyACC site will best be viewed using the following operating systems and browsers:

Form factor	OS	Browser	Versions supported
Desktop	Windows 7,8.1,10	Internet Explorer	Manufacturer supported (Currently 11) *
Desktop	Windows 10	Edge	Current*
Desktop	Windows 7,8.1,10	Mozilla Firefox	Manufacturer supported (Currently 70.0.1) *
Desktop	Windows 7,8.1,10	Chrome	Manufacturer supported (Currently 51) *

Desktop	OSX 10.9-10.11	Safari	Manufacturer supported (Currently 9.1) *
Tablet	Android 4.4.2+ *	Chrome	Current
Tablet	Android 4.4.2+ *	Android System	Current as per OS
Tablet	IOS8+ *	Safari	Current as per OS
Tablet	IOS8+ *	Chrome	Current

Printing the form

Once the Provider has submitted the form, a confirmation number - the equivalent of an ACC45 number - is assigned to the form. A PDF of the form is generated, and copies can be printed for the Provider's records and to be given to the Client.

Case conferencing

Case conferencing is a means of updating ACC on progress against the Wellbeing Plan.

The Provider, Client, and ACC collectively discuss progress and the Client's ongoing needs. Other parties, for instance GP, Social Worker, Oranga Tamariki case coordinator, may attend the case conference as appropriate and with the Client's consent.

Providers must indicate tentative case conference dates in the Wellbeing Plan based on the milestones identified. ACC will contact the Provider three weeks prior to this date to confirm a date and time for the case conference. This can normally be incorporated into the scheduled face-to-face session. The agenda of the case conference may be agreed between the Provider and ACC at that time. Case Conferences can be requested sooner if it is determined the Client's treatment is not progressing as expected, additional support and services are required or a milestone has been achieved sooner than identified. ACC may discuss whether a Client is ready to transition to a different Recovery Team as part of Case Conferences and will be agreed through the conversation.

If the Provider has concerns about the Client participating in the case conference, they can talk to ACC about this.

Any adjustments to the Wellbeing Plan that are discussed as part of the case conference will be reflected in an updated purchase order sent to the Supplier after the

case conference. The Lead Provider can utilise up to 30 minutes to make the necessary adjustments to the Wellbeing Plan.

Client reporting and monitoring requirements

All Client reports are word documents that can be downloaded from acc.co.nz/resources. Please note that ACC will not accept reports that are handwritten or submitted on the incorrect templates. Once completed, please send reports to sensitiveclaimsproviderreports@acc.co.nz.

Providers must send ACC their Client reports in a timely manner. Progress monitoring dates should be based upon expected Client milestones detailed within the Client's Wellbeing Plan.

The Provider is required to keep to these time frames to ensure the Client experiences a seamless service.

Client reports that do not meet our quality standards will be returned to the Supplier for resubmission. We will provide information to the Supplier as to what aspects of the report we need them to address or provide more clarity on. When completing these reports, the Providers should ensure:

- They are written in plain language.
- They are written, where possible, in a way that non-clinical staff can understand and use to make decisions.
- All required fields are completed.
- Information reflects the Client's current situation and demonstrates planning with the Client.
- Answers to questions are succinct.
- The Provider's name is entered in the signature field in lieu of a signature and the report is dated. This also applies to electronic signatures.
- The date of the last face to face session with the Client is included.
- Any evidence required to support clinical opinions is included or appended (e.g. relevant clinical records).

All forms and reports should be completed in partnership with the Client. The Client needs to be given the opportunity to review completed reports if it is appropriate.

The table below provides a summary of forms and reports:

Form Number	Client Forms and Reports	Inclusions	Guidance
ACC6425	Client Engagement Form	Initial authority	• Ensure the contact details provided on this form are suitable for ACC to use to contact the Client. • Include whether the Client requests contact with ACC to be direct or via the Provider. If this should be made via the Provider, please indicate this on the Engagement Form within the contact fields and if applicable include a reason for this request in the free text notes. • In the free text notes field of the Engagement Form, please indicate any barriers to engagement (e.g. childcare or transport needs) that ACC may help with and any indication of urgency (e.g. need for an expedited assessment). This field also allows you to provide any information that you feel is important for ACC to know about. This could also include details for other agencies involved with the Client. • Clients are able to request a Recovery Partner from another part of the country if they prefer. This can be done by filling out the free text notes on the Engagement Form.
ACC6426	Early Planning Report	PWI scoring Client needs	• Guardian and/or Enduring Power of Attorney (Welfare) details required if relevant. • ACC6300 Authority to Collect Medical and Other Records Form will need to be completed and appended to the Early Planning

Form Number	Client Forms and Reports	Inclusions	Guidance
			Report for any Client moving forward to a Supported Assessment. • If a Client does not complete Early Planning including Active Disengagement submit partially completed Early Planning Report and Closure Notice.
ACC6429 or ACC6424	Supported Assessment Report	WHODAS 2.0	• All sections are completed. • Provide the assessment findings and do not include detailed treatment recommendations.
ACC6428	Wellbeing Plan	PWI scoring WHODAS 2.0 scoring	• Includes treatment recommendations. • Includes recovery goals. • Includes progress monitoring milestones. • Provides ACC with information to make decisions for additional support. • PWI and WHODAS 2.0 are only required if they haven't been completed within the last 3 months.
ACC6427	Wellbeing Plan Progress Report	PWI scoring WHODAS 2.0 scoring	• Provide the achievements or progress against the goals set in the Wellbeing Plan Report rather than the details of therapy sessions delivered. • PWI is only required if it hasn't been completed within the last 3 months.
ACC7420	Treatment Review Report	WHODAS 2.0 scoring	• Treatment Reviews can't be completed by the Lead Provider and where possible shouldn't be delivered by a Provider within the same Supplier Network. This is

Form Number	Client Forms and Reports	Inclusions	Guidance
			designed to provide ACC with an independent review of the Client's treatment and progress. • WHODAS 2.0 score is required. • Provide assessment findings, including a summary of treatment to date and recommendations for on-going treatment.
ACC6430	Closure Notice		• Must be completed if the Client has actively disengaged (the Provider has had no contact with the Client for a period of four weeks). • Also used to signal the completion of Support for Next Steps. • Note – there is an option to notify ACC of closure via an email. See "Clients Leaving the Service".
ACC6423	Completion Report	PWI scoring WHODAS 2.0 scoring	• PWI and WHODAS 2.0 scores are required (these need to be administered toward the end of ACC service delivery). • The Client cannot progress to Maintaining Wellbeing until the Completion Report (Long Term) has been submitted to ACC. ACC will then issue a purchase order for Maintaining Wellbeing. • Support to Wellbeing (Short Term) Completion Report plus PWI scoring.

Please note: There are no reporting requirements for Maintaining Wellbeing.

Outcome measures

The Personal Wellbeing Index (PWI) and World Health Organisation Disability Assessment Schedule (WHODAS 2.0) are subjective disability and quality of life measures which we have incorporated into the assessment, planning and progress reporting services of the ISSC service.

These outcomes measures are not used to measure the performance of individual Providers or the progress of the Client but are in place so that we can measure the overall effectiveness of the service that is being provided.

The PWI is completed as part of Early Planning and again within Support to Wellbeing Services. The WHODAS 2.0 is used as part of the Supported Assessment and again when the Client nears completion of the Support for Wellbeing service.

Both the PWI and WHODAS 2.0 results have been integrated into the report required within the service stage.

A summary of these measures is below:

Personal Wellbeing Index (PWI)

This quality of life outcome measure assesses subjective wellbeing. The PWI Scale contains eight items of satisfaction (eight questions), each corresponding to the following domains:

1. Spirituality/Religion
2. Standard of living
3. Personal health
4. Achieving in life
5. Personal relationships
6. Personal safety
7. Community connectedness; and
8. Future security

There is also a global question which asks about Client satisfaction with life as a whole. This is not used in the scoring, but it adds useful clinical information. Parallel forms of the PWI have been created to be used with population sub-groups. The parallel forms are:

- PWI-A Designed for use with the general adult population, aged at least 18 years
- PWI-SC Designed for use with school-age children and adolescents
- PWI-ID Designed for use with people who have an intellectual disability or other form of cognitive impairment.

The scale can be administered in either a verbal or written format and is completed by the Clients themselves. A zero (no satisfaction at all) to 10 (complete satisfaction) defined response scale is employed. The completing clinician should read the manual carefully.

Manuals for PWI's can be located at the following website:

- http://www.acqol.com.au/instruments#measures

An instructional video for how to collect information, administer the PWI and calculate the scores can be found here:
https://www.youtube.com/watch?v=tJpInGgxNwk&feature=youtu.be

Tips related to completing PWI:

- Read the administration instructions.
- Check to ensure that responses are varied and not all the same (response set). Consistently maximum or minimum scores should be eliminated as lack of variation will distort data analysis.
- For each domain score convert the score out of 10 to one out of 100, e.g. 7 becomes 70% or 6.5 becomes 65%. To obtain the Personal Well Being Index add the percentages for the eight items that comprise this (Spirituality/Religion, Standard of living, Personal health, Achieving in life, Personal relationships, Personal safety, Community Connectedness, and Future Security). This should give you a number between 0-800. Divide this number by 8 and you will have the Personal Wellbeing index score.

Example:

Domain	Raw Score (0-10)	Percentage (0-100)
Spirituality/Religion	6	60
Standard of Living	5	50
Personal Health	6	60
Achieving in life	7	70
Personal Relationships	8	80
Personal Safety	2	20
Community Connectedness	4	40
Future Security	3.5	35
Personal Wellbeing Index	Add the percentage scores, divide by 8, and round to one decimal place)	Total=415/8=51.88=**52**

- Qualitative Data: Report any difficulties or concerns/observations made during the completion of this measure.

PWI – A

This measure is to be used as part of the Adult Early Planning. Of note:

- The test is self-completed either in written or verbal (interview format) as described.
- The Likert scales are marked by the Client (18 years or over) indicating scores of 0 to 10 (No satisfaction at all through to completely satisfied).

PWI- ID

This is only for Clients who have an intellectual disability or other form of cognitive impairment. Of note:

- The administration of this scale needs to be restricted to psychologists who are experienced in the administration of psychometric instruments.
- Others must not answer “on behalf” of anyone but only the Client themselves as the former will render the results invalid.
- The PWI-ID differs from other tests in that it incorporates a very detailed “pre-testing” protocol to determine whether, and to what level of complexity, the person can use the scale.
- Attention to the testing environment is needed. While the manual says the caregiver must not be present, ACC considers that it is appropriate for a Client to have the person of their choice in the room.
- The Likert scales are marked by the Client indicating scores of 0 to 1 (2-point scale), 0 to 2 (3-point scale) or 0 to 4 (5-point scale).

PWI- SC

This is for school-age children and adolescents. (Note the PWI-PS (Pre-school) will not be used). Note that the Likert scales are marked by the young person indicating scores of 0 to 10 (Very Sad through to Very Happy).

WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)

This measure was developed by the World Health Organisation as a generic instrument for assessing disability in everyday functioning. It takes approximately 20 minutes to administer the 36-item simple version. Forms can be downloaded from the World Health Organisation (WHO) website: http://www.who.int/classifications/icf/whodasii/en/ along with the manual. It is important that the completing clinician has read the manual carefully.

There are several different forms of this test. We require the Client to complete the 36-question simple version at the Supported Assessment and at the conclusion of treatment. The 12-item version can be used to monitor progress during treatment. There is a:

- Self-administered form for adults over 18 years.
- A fully structured interview administered form for people with literacy issues.
- Proxy version for friends, relatives or carers.

The WHODAS 2.0 measures six domains across a 5-part Likert scale ranging from “None” to “Extreme or cannot do” **over the previous 30 days**. Ratings need to be averaged over the 30-day period:

- **Cognition**: understanding and communicating
- **Mobility**: moving and getting around
- **Self-care**: hygiene, dressing, eating and staying alone
- **Getting along**: interacting with other people

- **Life activities:** domestic responsibilities, leisure, work and school
- **Participation**: joining in community activities

There are two forms of scoring, complex or simple.

Use the 36-item simple scoring method:

1. The scores assigned to each item should be selected from “none” (0), “mild” (1), “moderate” (2), “severe” (3) and “extreme” (4). Please note that the WHODAS manual lists the scoring as (1) to (5). However, to better reflect a “none” rating where there are no limitations to functioning in a particular area, we ask that you apply the scoring (0) to (4) accordingly.
2. Sum the score for the items in a domain and then divide by the number of items in that domain. Some domains have four, five, six or eight items, so ensure that you are dividing by the correct number of items to reach the average for a particular domain.

For an example see the table below:

Domain	**Number of items**	**Add the scores for each item**	**Divide by the number of items for that domain and round to the nearest decimal place**
Understanding and Communicating	6	1+1+2+2+1+3=10 Minimum score possible=0, maximum score possible =24)	10/6=1.666=1.7
Getting around	5	4+4+4+4+3=19 Minimum score possible=0, maximum score possible =20)	19/5=3.8
Self-care	4	4+4+3+3=14 Minimum score possible=0, maximum score possible =16)	14/4=3.5
Getting along with people	5	1+2+3+4+4=14	14/5=2.8

		Minimum score possible=0, maximum score possible =20)	
Life activities-household	4	2+2+2+2=8 Minimum score possible=0, maximum score possible =16)	8/4=2
Life activities-work/school	4	3+3+3+4=13 Minimum score possible=0, maximum score possible =16)	13/43.25=3.3
Participation in Society	8	1+2+3+4+3+2+1+4=20 Minimum score possible=0, maximum score possible =32)	20/8=2.5

Use the “36-item Instrument Scoring Sheet, Simple Scoring Calculation” live scoring template on the WHODAS website (http://www.who.int/classifications/icf/whodasii/en/) or on the ACC website which generates a Total Disability Score (Overall score) as a percentage in the purple strip as you add the item ratings into the template. You will see it recalculating as you add more items in.

An instructional video for how to collect information, administer the WHODAS 2.0 and calculate the scores can be found here:
https://www.youtube.com/watch?v=Jee3qwEsbSQ&feature=youtu.be

Qualitative Data: Report any difficulties or concerns/observations made during the completion of this measure.

Obtaining clinical and other records

Where a Provider requires records such as clinical records from another party, they should request ACC to obtain the records for them. This should be done via the Early Planning report.

If a Provider wishes to collect a Client’s clinical records directly, they must obtain the Client’s written consent using their own agency’s form. In some cases, this option may expedite the receipt of records as the request does not need to go via ACC. In this case, the records would not become the property of ACC and the Provider would become responsible for this information.

If the Provider wishes ACC to obtain records on their behalf, an ACC6300 'Authority to Collect Medical and Other Records' form will need to be completed and signed by the Client and returned to ACC (see "Authority to Collect Client Information").

- Ensure the Client or their legal representative is aware that records are being requested and why.
- There needs to be a clear rationale for requiring the information and the process followed needs to be consistent with the Privacy Act 2020 and Health Information Privacy Code 2020.

Examples, where records may be required, are shown in the table below:

Record type	**Reason for obtaining**
DHB Mental Health records	The Client was recently discharged, and a copy of the discharge summary would help the Provider to inform their clinical decision making, to help manage risks identified at discharge. There are previous assessment reports associated with the Client's mental health history that will assist a current assessor to understand the Client's presenting symptoms and previous treatment.
DHB Clinical Records	The Client received care in the Emergency Department and a copy of the Emergency Department record would help the Provider in obtaining further information about the injuries sustained and history taken by clinical staff about the event.
GP notes	The Client has been regularly attending the GP with symptoms of depression that may be related to the sexual abuse or assault even if the GP has not known about it. The Provider wants to review the treatment plan commenced by the GP as this will have a bearing on the Client's clinical management within the ISSC Service.
Child's school records	The Client has had behavioural issues since being sexually abused or assaulted. The parents have told the Provider this has been well documented by the school, which has tried several strategies to manage the behaviour. The Provider wants to review the behavioural plan as this will provide valuable information relevant to any new strategies which may be tried. If there is a requirement for ACC to consider funding for educational support, it is recommended that the Provider contacts ACC.

Oranga Tamariki records	Oranga Tamariki has had a long involvement with a Client and their family. There is a current social worker involved and the Provider has spoken with the social worker. The social worker suggested requesting the records as there is such a long history with information relevant to the Provider to help them to determine how they would proceed.
Another therapist's records	The Client has switched Suppliers and/or Providers part way through the Support to Wellbeing service. The new Provider holds a copy of reports submitted to ACC by the prior Supplier. However, the Provider feels it would be beneficial to review the clinical records made by the previous Provider, as this will provide detailed clinical information the Provider needs.

If a Client is applying for other ACC supports the Provider is required to liaise with ACC. This may change the type of medical and other relevant information we need to determine whether a Client is eligible for the supports. Ensure that the correct information is gathered as early as possible to avoid any unnecessary delays in Clients receiving entitlements from ACC.

Other ACC supports

Under ACC legislation, Clients can be considered to receive supports if they have a "covered" claim (refer to definitions Appendix 2). Entitlements fall under broad categories such as Treatment, Social Rehabilitation and Vocational rehabilitation.

All ACC supports have specific eligibility criteria that Clients must meet to receive them. These criteria are documented within ACC legislation.

If the Client has or develops any specific needs that fall outside the scope of the ISSC, the Provider should speak to ACC to discuss whether the Client may be eligible for ACC help to address these needs. ACC will discuss any eligibility directly with the Client and can give general eligibility information to Providers where needed.

Providers should not discuss specific ACC supports directly with the Client. All supports are dependent on individual circumstances of the Client, so it is important that these conversations occur between ACC and the Client. Providers are also cautioned against leading Clients to expect a financial pay out, since if this does not occur, this may damage the relationship between Clients and ACC and impact negatively on the Client's recovery.

If the Client currently has an incapacity to perform employment activities, they may be eligible for financial assistance from ACC in the form of either Loss of Potential Earnings (LOPE) or Weekly Compensation (WC). We need to consider these applications quickly to ensure that these can be provided as soon as possible to eligible

Clients. This may mean we have to collect information from sources other than the GP or other health providers. If we do, we will discuss it with the Client first.

Some Clients who experience a permanent loss of functioning may be eligible to receive Lump Sum compensation for a permanent impairment. These supports will require other assessments outside of the ISSC service and it is recommended that ACC is made aware as early as possible if a Client wishes to apply for these supports.

Managing non-attendance

Clients should be reminded that if they can't attend an appointment for any reason, they should let the Provider know at least two working days in advance, and that a new appointment can be easily scheduled.

Processes should be in place to help the Client to maintain their engagement in ISSC services. These may include:

- Text message or phone reminders for appointments.
- Appointment cards.
- Social worker involvement.
- Ensuring transport and childcare needs have been considered.
- Location or venue preferences for the Client should be considered.

Clients may occasionally miss an appointment without giving sufficient notice. In these instances, the Provider should consider the Client's safety and take appropriate action if they are concerned.

In recognition of the partial loss of productive time when Clients miss appointments (i.e. they did not give at least two working days' notice) you may claim for up to five non-attendance or DNA (Did Not Attend) fees per Client over a 12-month period. These five DNAs are only available to be shared across primary services, with the exception of Maintaining Wellbeing.

In the case of more than 2 DNA's per 12-month period, the Provider must contact ACC within one business day of the DNA to discuss why the Client didn't attend and discuss an action plan to help ensure the Client remains engaged in the service.

When Clients change Suppliers part way through services, the new Supplier can obtain DNA information about the Client from ACC. This Supplier can use this to develop processes to potentially improve engagement with the Client.

Non-attendance fee for secondary and support services

One DNA fee is available across Secondary and Support Services (with the exception of Group-based Therapy and Group-based Therapy (DBT)), per 12-month period. It is up to the Supplier to manage provider expectation around the availability of this fee, as it may have already been used before a particular provider begins work with a client.

Charging the Client for non-attendance

If you have in your terms of engagement a provision to charge the Client for non-attendance once the ACC covered DNA provision has been exhausted, the Supplier is able to charge the Client.

You should let the Client and their supporting representative (if applicable) know both verbally and in writing at the start of the service about the possibility of being charged for non-attendance.

ACC expects you will not charge more than the agreed ACC fee and will take the Client's financial situation into consideration.

Clients leaving the service

The term active disengagement is used to describe a range of situations where the Client has chosen to leave the service by withdrawing or is no longer wanting to access services.

Examples include:

- The Client failing to attend an agreed appointment and not responding to repeated attempts to contact and reschedule.
- The Client not making any further appointments when part way through a service.
- The Client choosing not to contact the Supplier to make an appointment after referral to that Supplier and unsuccessful follow-ups by the Supplier to make an appointment.
- The Client contacting the Supplier or Service Provider stating they don't want to continue at this time.

Active disengagement can happen at any time. Where a Client doesn't yet have cover for their claim, ACC typically declines claims for Clients who actively disengage during short-term services. This does not in any way restrict their ability to re-enter the ISSC service at a later date. Refer to "Returning Clients" above.

Notifying ACC of closure

Remaining in therapeutic services can be difficult for some Clients, and Clients may leave the service at any point. It is important that Clients know that they can leave and return at a later date if they wish, and that ACC is told when Clients leave the service. The provider can do this by either:

- Submitting an ACC6430 Closure Notice
- Sending an email to sensitiveclaimsproviderreports@acc.co.nz. The email should specify the following:
    - Client's name

- Claim number
- ACC team or name of ACC team member supporting the client
- Date of last face to face session with the Client
- Reason the Client disengaged
- Any safety concerns that ACC needs to be aware of.

If the Provider holds sufficient information to partially complete a Service Report (e.g. Early Planning Report or Supported Assessment) they should provide this along with the closure notice.

Providers have four weeks from the last contact with the Client to get back in touch with the Client and re-engage them. If they can't contact the Client, they must send a Closure Notice to ACC. Providers should take appropriate action where they have concerns about the Client's safety.

If we become aware that the Client has moved to another Supplier or has told the Lead Provider they no longer wish to receive services, ACC will let you know and ask for a Closure Notice if the client has actively disengaged, along with any other partially completed reports.

Transitioning Clients

Between Providers

The Client must be involved when it is necessary to choose an alternative Provider (and/or Supplier). There needs to be a handover process or meeting between the two Providers to ensure a seamless process for the Client. Active Liaison should be used to remunerate both Providers in this case.

If the new Lead Provider is with a different Supplier, the original Supplier must also consent to the intervention.

Note that under either scenario, no extra Support to Wellbeing sessions will be issued, ACC must be notified, and no further action needs to be taken.

In the event of an unexpected departure of a Provider that results in discontinuity for a Client which the Supplier is not able to rectify, the Supplier needs to notify ACC as quickly as possible. ACC will work with the Supplier to implement the Supplier's business continuity and transition plan.

Between Suppliers

There may be circumstances where a Lead Provider changes Suppliers, and transfers Clients with them. In all circumstances, continuity of service provision for the Client is paramount.

The Provider requesting the transfer must confirm that the following criteria are met:

- Each Client is fully informed and agrees to the change of ISSC Supplier
- The original Supplier agrees to the transfer
- ACC is contacted via email requesting the transfer, confirming that the requirements above have been met and advising the date when the transfer needs to occur

The new Supplier may invoice for the Administration and Management fee.

Service administration

This section encompasses:

1. Invoicing
2. Purchase orders
3. Making a prior approval request
4. Paying others
5. Changing Supplier/Provider details
6. Quarterly Supplier reporting
7. Troubleshooting

Invoicing

Our business relationship with you will be faster, easier and more efficient if invoicing is done electronically. The following table describes what you need to do:

What to do	Website page: www.acc.co.nz
How to work online with ACC	Home Page>Health and Service Providers>Getting set up online Also on this page: • Apply for a digital certificate • FAQs for working online • Where to get more information
How to set up electronic invoicing	Home Page>Health and Service Providers>Invoicing Us >How to Invoice Us
How to invoice ACC	Home Page>Health and Service Providers>Invoicing Us >How to Invoice Us
Enquire about a payment	Home Page>Health and Service Providers>Invoicing Us >Sort Out a Problem with a Payment
How to complete your invoice with ACC's purchase order information	Home Page>Health and Service Providers>Invoicing Us >How to Invoice Us

Refer to the ISSC Service Schedule for service items and charges (Clause 3). The Service Schedule can be found on https://www.acc.co.nz/resources/#/ by entering ISSC on the search function.

A named Provider must be referenced against every service item when billing.

Examples:

a. Example one: A counsellor Level 6 providing Primary Service Early Planning combines the prefix (SCGS) and suffix (1) to create a pricing code (SCGS1).

b. Example two: A psychiatrist providing Primary Service Support to Well-being combines the prefix (SCSS) and suffix (5) to create a pricing code (SCSS5).

c. Example three: A social worker providing Support Service Liaison with Community combines the prefix (SCAL) and suffix (6) to create a pricing code (SCAL6).

d. Example four: A Supplier invoices for Cultural Support and Advice (SCCA). No suffix is required for this service code and the full-service item code is SCCA

Purchase orders

Purchase orders are issued by ACC allowing the Supplier to invoice for services rendered. Note that:

- Purchase orders are raised retrospectively for Getting Started once the Client Engagement Form has been submitted to ACC.
- Purchase orders are raised for onward services when reports are submitted to ACC which include details of Providers and an estimate of hours required for onward services.
- The following Services do not require prior approval, however onward services shouldn't be started until written confirmation is received or a purchase order has been received by the Supplier:
    - Getting Started and Early Planning and Support to Wellbeing Short Term
    - Support Services (first annual (12-month) allocation)
    - Completion Report and Closure Notice
    - Administration and Management Fee
- The ISSC purchases services on actual time spent. Actual hours delivered should be invoiced up to the maximum hours available for the service purchased. In most cases the hours charged will be fewer than those approved in the purchase order.
- Where you use another ISSC Supplier's Group-Based Therapy Provider a separate purchase order is raised for that ISSC Supplier.
- Invoicing should not be submitted for reports until ACC has received and is satisfied with the report.
- Purchase orders are generated with in-person codes and, if applicable, Telehealth "alias" codes can be used on invoices. This allows ACC to measure the uptake of Telehealth. Refer to the Service Schedule (Clause 3) for applicable Telehealth codes.

Making a prior approval request

Most ISSC services require a prior approval before a Provider starts that service. Where prior approval is required, the request for prior approval is usually associated with the completion of an ACC report, which triggers the request for onward services. The exception to this is the Getting Started service.

This purchase order will be provided to you retrospectively.

Onward service required	Prior Approval Triggered by:	Request will be actioned by ACC within:
Support to Wellbeing (short term)	Early Planning Report	Five business days
Support for Next Steps	Early Planning Report	Five business days
Supported Assessment	Early Planning Report	Five business days
Support to Wellbeing	Supported Assessment Report and if the Client's claim is accepted by ACC	10 business days
Continuance of Support to Wellbeing	Wellbeing Plans, Progress Report (or Case Conference)	10 business days
Maintaining Wellbeing	Completion Report	n/a

The completion and submission of the Client Engagement Form will result in a purchase order being issued for the Getting Started service, as well as Early Planning if the Client is progressing past Getting Started.

If you urgently need prior approval you can request a purchase order for a prior approval service by contacting ACC via phone or email.

Paying others

You are responsible for having a process in place for paying:

- your approved Providers
- any individuals engaged to deliver Cultural Support and Advice

Costs incurred for individuals engaged to deliver Cultural Support and Advice should be on-invoiced for the actual costs incurred or up to the maximum price paid as per the Service Schedule.

Do not add a margin or premium to the costs incurred for Cultural Support and Advice, social work or group-based therapy.

The Supplier is not responsible for paying a Psychiatrist providing services under the Psychiatric Services (CPSA) contract as the Psychiatrist will invoice ACC directly.

Changing Supplier and Provider details

You have an obligation to ensure your Approved Provider list remains accurate with ACC as:

- The web search needs to be updated to reflect changes.
- ACC needs to ensure the Supplier is meeting its obligations under the ISSC Service agreement.
- ACC may need to notify other Suppliers who use the same Provider if there is a performance issue that resulted in another Supplier removing a Provider from its list.

There are different forms to use depending on the details that need to be changed.

Change required	Form	How to access form	When to use this form
Inform ACC of changes to your business	ACC5930 ACC111	acc.co.nz>Resources enter the relevant form number in the search function	If there are legal changes to your business including a change of ownership (novation).
Change of your details	ACC1534	acc.co.nz>Resources enter the relevant form number in the search function	Change any Supplier contact details or request access to the eBusiness Gateway for electronic invoicing.
Add new Provider	Integrated services for sensitive claims named Provider application form	Request from Health Procurement at health.procurement@acc.co.nzmailto:ACChealthtenders@acc.co.nz	If the Provider has never been registered with ACC before, you will also need to complete an ACC24 Application for ACC Health Provider registration. If the Provider is already a registered Provider with ACC, their details may need updating using the ACC6244.
Change of Provider details – no impact on contract	ACC6244	acc.co.nz>Resources enter the relevant form number in the search function	If one of your Providers has a change to any of the following details that does not affect the contract: • name • physical address

			Note: If this is a change of facility address it could affect the terms of your ISSC contract. In this instance please use the Integrated named Services for Sensitive Claims Provider application form. • postal address • email address • work phone number • mobile phone number • preferred contact method.
Change of Provider details – impact on contract	Integrated services for sensitive claims named Provider application form	Request from Health Procurement at health.procurement@acc.co.nz	If there is a change in any of the following details for one of your Providers that may potentially affect the terms of your ISSC contract: • applying to provide another service type • adding a competency • adding other skills and experience • adding or removing a service location • changing named Provider information on ACC website • changing a Provider's name. You'll also need to include relevant supporting documentation.
Removing an Approved Provider	No form		This requires a formal letter signed by a duly authorised signatory advising that you want a Provider removed from your contract. You need to include the reason for removal. You should ensure that Clients are appropriately supported if their existing Provider ceases

			providing services under your contract. You may need to find a new service Provider or transition a Client to another Supplier.

In all cases completed forms and any supporting documentation will need to be sent via the Supplier to Health Procurement at health.procurement@acc.co.nz

If you have any queries regarding the use of these forms, contact health procurement at health.procurement@acc.co.nz

To add a new Provider to your ISSC contract you need to complete an ISSC Named Provider Application Form (request from Health Procurement email: health.procurement@acc.co.nzmailto:ACChealthtenders@acc.co.nz). Relevant supporting documentation will need to be provided. Applications will be accepted throughout the year.

Quarterly Supplier Reporting

As part of measuring the overall performance of this service we require a quarterly report to be completed by ISSC Suppliers. We will contact you by email to provide access to the quarterly report form. This report will include: number of referrals in/out and declined, confirmation that capacity and coverage is maintained, and any emerging trends and issues.

This will be part of the basis of ACC's monitoring and reporting for this service. We will not disclose commercially sensitive information to other Suppliers. Once the information has been compiled, we will extract the data from our systems, in conjunction with the Supplier's data, and analyse and report on it.

The following table describes the Supplier reporting periods and due dates:

Period start	Period finish	Submitted by	Summarised by
24 November	28 February	20 March	ACC will produce summarised reports when the data is sufficient for robust analysis.
1 March	31 May	20 June	
1 June	31 August	20 September	
1 September	30 November	20 December	

Troubleshooting:

Query	Who to contact	How to contact them
Client and/or claim related concerns or queries	Supplier or Provider needs to contact ACC	If contact details not known, then email sensitiveclaimsproviderreports@acc.co.nz
If a query is not claim related, or relates to another incident such as breach of contract or media attention	Supplier needs to contact the Engagement and Performance Manager (EPM) directly	Regional EPM contact details are available online https://www.acc.co.nz/for-providers/provide-services/provider-relationship-team/#find-an-engagement-and-performance-manager
Content questions when completing any forms	Engagement and Performance Manager	Regional EPM contact details are available online https://www.acc.co.nz/for-providers/provide-services/provider-relationship-team/#find-an-engagement-and-performance-manager
Technical issue with logging in to RealMe	DIA RealMe 24/7 Help Desk	0800 664 774 or help@RealMe.govt.nz
Technical issues about registering and completing engagement form	eBusiness Support Team	0800 222 994 or ebusinessinfo@acc.co.nz
Invoicing issues - manual	Provider Helpline	0800 222 070 or providerhelpline@acc.co.nz

Invoicing issues - electronic	eBusiness Support Team	0800 222 994 Or ebusinessinfo@acc.co.nz

Please note: To help provide support in the above two situations, the eBusiness Support Team sometimes needs remote access to the user's computer. They do this using Team Viewer see http://www.teamviewer.com/. This is a software package for remote access. While not mandatory, it is something Providers might want to investigate for prompt resolution of any technical issues they may experience.

Reference documents

The following documents provide useful references for the ISSC Service and are available online at https://www.acc.co.nz/resources/#/:

- Service Schedule for Integrated Services for Sensitive Claims - https://www.acc.co.nz/resources/#/
- 'Sexual Abuse and Mental injury; Practice Guidelines for Aotearoa New Zealand' (known as the Massey Guidelines) - https://www.acc.co.nz/resources/#/
- ACC1625 Guidelines on Māori cultural competencies for Providers - https://www.acc.co.nz/resources/#/
- Accident Compensation Act 2001 - http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM99494.html
- Accident Compensation (Definitions) Regulations 2019 - http://www.legislation.govt.nz/regulation/public/2019/0194/8.0/LMS89656.html#d12932986e52
- List of Schedule 3 crimes - http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM105476.html

Appendix 1: ACC funding and eligibility FAQs

This is a list of frequently asked questions that may help ISSC Suppliers and Providers in understanding ACC funding and eligibility as it applies to sensitive claims; please refer to the Definitions and Interpretation section where required.

1. **What constitutes a claim and what does ACC have to do to respond when a claim is lodged?**

   ACC legislation does not specify what is considered to be a claim but states a person must lodge a claim in a manner specified by the Corporation. ACC has a standard form, the ACC45, which is the standard mechanism to lodge a claim.

   When a 'claim' has been lodged, ACC must make a decision on whether to "cover" the claim and where cover has been established, to make a decision to provide entitlements to the Client, according to the Act.

   Under ISSC, a new sensitive claim can also be raised through an Engagement Form. This is the way Providers under the ISSC contract lodge a sensitive claim with ACC.

2. **Once a claim has cover what is the criteria for covering treatment costs?**

   ACC is required to pay for treatment when the purpose of the treatment is to restore the Client's health to the maximum extent practicable, and the treatment is:

   - necessary and appropriate,
   - of the quality required,
   - performed for the necessary number of occasions,
   - performed at times and places that are appropriate,
   - provided by a suitably qualified and approved Provider, and
   - provided only after ACC has agreed to that treatment (where required).

   When deciding on a Client's treatment, ACC must consider:

   - the nature and severity of the injury,
   - the generally accepted methods of treatment in New Zealand, and
   - other options available in New Zealand, and the cost in New Zealand of both, compared to the benefit the Client is likely to receive.

   ACC generally determines the above criteria are being met from the reports sent to us by the treating Provider.

3. **How does Client eligibility for other ACC-funded services work?**

   If a Client requires access to other ACC supports, they must have “cover” i.e. an accepted claim. For definitions on what a “covered” claim is, please refer to the definitions section of this document.

   It’s therefore important that if a Client needs to access other services such as financial compensation or social rehabilitation services, the Client is progressed through the initial pre-cover support in a safe, but timely manner. This will ensure that Clients are able to access other ACC supports in a timely way.

   Many supports have eligibility criteria of their own, so it is important to liaise with ACC, who will determine whether a Client is eligible to receive a specific support.

4. **Who can assess for mental injury?**

   ACC assesses mental injury using assessors who meet the criteria in the ISSC Service Schedule and who have been approved to do this. The injury must be diagnosed by a mental injury assessor who meets ACC’s criteria which includes:

   - qualification,
   - training,
   - experience in mental health and with survivors, and
   - ongoing requirements (i.e. Annual Practicing Certificate, Continuing Professional Development, supervision).

5. **Why does ACC need to know some of the details of the Client’s experiences of sexual abuse or assault?**

   For Clients to be eligible for cover under their claim, ACC needs to determine that the Client has experienced an event of sexual abuse or assault, or ‘certain criminal acts’, as listed in sections of the Crimes Act 1961 and Schedule 3 of the Accident Compensation Act 2001 (see Links above).

   Secondly, ACC can only consider cover for injuries relating to events of sexual abuse or assault that occurred in New Zealand, or overseas but whilst the Client was classified as ordinarily a resident of New Zealand. Please note that there is no requirement for the perpetrator to be charged with a crime for the Client to be considered for cover under an ACC claim.

   When issuing a decision whether to accept or decline a claim for a mental injury, ACC determines whether the sexual abuse or assault event (or events) is a substantial or material cause of a clinically significant injury. This is usually established within a mental injury assessment (the Supported Assessment service under the ISSC).

6. **How does an assessor determine the injury is clinically significant?**

To be clinically significant the injury may be diagnosed using:

- Diagnostic and Statistical Manual of Mental Disorders (DSM IV or 5), or
- International Classification of Diseases (ICD10), or
- Psychodynamic Diagnostic Manual (PDM), or
- Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3R).

Appendix 2: Definitions and interpretations

In these Operational Guidelines when we use the terms listed in this section (or those listed in Part B, Clause 16 of the ISSC Service Schedule), they have the meaning given below, or as contained in the ISSC Service Schedule.

Approved Service Provider

An Approved Service Provider refers to a suitably qualified and experienced therapist, or practitioner who:

- delivers services, usually of a therapeutic nature, to Clients;
- has a professional relationship with the Supplier; and
- is named in Appendix 1 of the ISSC Service Schedule;

Approved Service Providers will meet the criteria and qualifications for one or more aspects of service delivery, and these are detailed in Appendix 2 of the ISSC Service Schedule. An Approved Service Provider will be approved to provide one or more of the following services depending on their qualifications and experience:

- Assessment
- Treatment
- Group-based therapy (in addition to treatment)
- Incapacity assessment (in addition to an assessment)
- Social work (separate from treatment).

Child, Adolescent and Young Person

Child – defined by the Children, Young Persons, and Their Families Act 1989 as a person under the age of 14 years. ACC defines a child as anyone under the age of 18 years.

Adolescent – the World Health Organisation identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19.

Young Person – defined by the Children, Young Persons, and Their Families Act 1989 as a person of or over the age of 14 years but under 17 years.

Cisgender

Cisgender (often abbreviated to simply cis) is a term for people whose gender identity matches their sex assigned at birth.

Claim

The name given to an application made by the Client (or made by someone on behalf of the Client) under ACC legislation for cover of a personal injury.

Cover

When ACC refers to a Client who has cover it means that the Client has cover for a personal injury under ACC legislation.

Cultural barrier

When a person of a particular culture encounters the context of another culture, a clash can occur, resulting in barriers to achieving treatment goals. In the context of the ISSC, this could be a Māori client being treated by a Tauiwi Provider using a Tauiwi clinical framework rather than from a Te Ao Māori worldview. This meeting of two different cultural contexts may inhibit the effectiveness of therapy for the client.

Given that any client from a non-dominant culture (the dominant culture of Aotearoa New Zealand is Pākeha, heterosexual and cisgender) is encountering the context of another culture every day, it may be that the barriers inhibiting therapy from being successful are multifaceted and complex. For Māori, this may include the impact of intergenerational trauma due to colonisation, forced assimilation, and subsequently, urbanisation and disenfranchisement.

Decline

An action ACC takes when making a decision not to provide cover or supports under a Client's claim, and is issued in writing with review rights.

Supports

The supports provided under ACC legislation include: rehabilitation (comprising of treatment, social rehabilitation and vocational rehabilitation), weekly compensation (which includes first week compensation in some circumstances) and Lump Sum compensation for permanent impairment. Although these are the main supports available to sensitive claims Clients, other supports are listed under ACC legislation.

Personal injury

Personal injury means:

(a) the death of a person; or

(b) physical injuries suffered by a person, including, for example, a strain or a sprain; or

(c) mental injury suffered by a person because of physical injuries suffered by the person; or

(d) **mental injury** suffered by a person in the circumstances described in section 21 of the AC Act 2001; or

work-related mental injury that is suffered by a person in the circumstances described in section 21B AC Act 2001; or

(e) damage (other than wear and tear) to dentures or prostheses that replace a part of the human body.

Pre-cover

The term ACC uses to describe the period from when a Client lodges a claim, to when ACC issues a decision on whether to accept or decline the claim.

TAs

Territorial Authorities: TAs are areas defined by government. ACC uses TAs within the ISSC service to define what Suppliers cover what areas. Suppliers need to have Providers based in all TAs for which they hold the contract.

Milestones

A milestone is a marker in therapy where the treatment provider expects that change would occur in a Client's presentation, where signs of this change should be evident. Milestones may indicate either a positive or negative shift in recovery. These may include review points based on known or expected change markers in therapy (towards the end of therapy initiation and relationship-building, such as the 6-session marker); or where significant events in the client's life have occurred and their response to this is becoming evident (e.g. 6 weeks after returning to work). We would anticipate milestone reviews to be set when a change in treatment may be required due to lack of progress, realisation that treatment is no longer effective, or where additional or different support is required.

Region

Regions have been identified based on the TA's that make up a particular region. A copy of the Regions we have highlighted are identified through the following document:

Tauiwi

A person or people who are not Māori.