Chapter summary

The aim of rehabilitation is to maximise the potential for a person with a service injury or disease to return to their previous physical and psychological state, with the same social and vocational status. Rehabilitation programs, formulated by approved rehabilitation providers, can include medical, dental, psychiatric, in-patient and out-patient care; physical exercise and physiotherapy; psychosocial training and counselling; aids and appliances; and modifications to workplaces, homes and cars.

Defence provides rehabilitation to all full-time serving members though the Australian Defence Force Rehabilitation Program (ADFRP), with no requirement to establish liability under any compensation scheme. There were 4,189 new referrals to the ADFRP in 2009–10. Of these 925 were assessed as not requiring a rehabilitation program and resumed duties. On completion of rehabilitation programs, 2,405 members returned to normal or alternate duties.

For part-time Reservists and former members of the Australian Defence Force (ADF), rehabilitation is provided by the Military Rehabilitation and Compensation Commission (MRCC); however liability for the injury or disease must first be established under the Military Rehabilitation and Compensation Act 2004 (MRCA) or the Safety, Rehabilitation and Compensation Act 1988 (SRCA). The Department of Veterans’ Affairs (DVA) also administers the Veterans’ Vocational Rehabilitation Scheme (VVRS), which is available to former members of the ADF who are eligible under the Veterans’ Entitlements Act 1986 (VEA). In 2009–10 DVA opened 773 non-return to work (NRTW; psychosocial) rehabilitation cases and 525 return to work (RTW; vocational) rehabilitation cases. Fifty-one per cent of RTW programs under the SRCA were successful; 63 per cent under the MRCA were successful; and 45 per cent under the VVRS were successful.

DVA has an active research program into its rehabilitation services, and some recent reviews and commissioned research have recommended that case management be improved and arrangements simplified across the relevant government agencies. The Committee recommends that this research continues, and that outcomes from the research are promptly reflected in revised policies and improved practices in the ADF and DVA.

A number of submissions to the Review related to vocational rehabilitation, including opportunities for tertiary training. Vocational rehabilitation programs are decided on a case-by-case basis, and may include tertiary training if appropriate for an individual; however, this may not be widely known. The Committee’s view is that clients and providers would benefit from an improved understanding about MRCC policies on vocational rehabilitation. This could be achieved through more details and clarity in DVA referrals to providers, and through information in pamphlets and the DVA website, including examples of successful vocational programs undertaken by former ADF members.

The Committee identified a gap between the level of psychosocial rehabilitation that DVA delivers and what clients perceive is delivered. Psychosocial rehabilitation includes referral to community support services, basic skills training, lifestyle programs, attendant care services, drug and alcohol management programs, and household aids and appliances for daily living. The Committee believes that DVA should improve the information in its pamphlets and website on the availability of psychosocial rehabilitation, in addition to vocational rehabilitation. Performance reports for the MRCC should show the volume and outcomes for subcategories of psychosocial rehabilitation.

Early intervention improves the effectiveness of vocational rehabilitation. Some submissions and comments in public consultation indicated that the need to await the
The determination of liability can delay intervention. The Committee considered the feasibility of allowing entitlements to rehabilitation assessments and limited access to programs as soon as a claim is lodged for initial liability. Another option considered was to allow reimbursement of rehabilitation-related costs between the date of onset and the date of acceptance of liability. For cases in which claims are lodged some years after service, case coordinators could be able to offer a rehabilitation assessment without the need to await determination of liability. The Committee believes that the ADF and DVA should develop further options to improve access to early intervention, and provide advice to the Government on such options.

The effectiveness of requiring people with mental health conditions to undergo rehabilitation programs has been raised as an issue of concern. However, the Committee received expert advice from the Technical Advisory Committee on Rehabilitation that participation in a rehabilitation program, including vocational rehabilitation, can benefit people with mental illness. MRCC policy is that people with mental health conditions should receive medical and psychiatric clearance before entering a vocational rehabilitation program. The Committee supports this aspect of the rehabilitation framework provided in the MRCA. The Rehabilitation Authority can suspend a member’s right to compensation if the member refuses or fails to undertake a rehabilitation program, although these provisions are used sparingly. However, this power is very rarely used.

ADF performance reports are not currently provided to the MRCC. The Committee believes that the ADFRP should provide performance reports on ADF rehabilitation assessments and program outcomes to assist the MRCC to fulfil its functions.

Lastly, the Committee recommends a long-term study of the effectiveness of rehabilitation arrangements within the ADF and DVA, reviewing the level of rehabilitation services and the link with incapacity payments. The study should cover at least 10 years, and should include mental health and physical injuries and the response by the ADF from the time of the first injury through transition to discharge and later experience in civilian life.

Introduction

6.1 Section 28 of the Military Rehabilitation and Compensation Act 2004 (MRCA) sets out the aim of rehabilitation:

The aim of rehabilitation is to maximise the potential to restore a person who has an impairment, or an incapacity for service or work, as a result of service injury or disease to at least the same physical and psychological state, and at least the same social, vocational and educational status, as he or she had before the injury or disease.

6.2 MRCA rehabilitation provides for vocational and holistic needs. It aims for recovery and re-establishment following a service injury or disease, and the services provided will vary according to individual needs.

6.3 While a member is on full-time service in the Australian Defence Force (ADF), the Australian Defence Organisation (Defence) will provide rehabilitation under the Defence Act 1903, because it is not limited in having to establish liability under the MRCA. For part-time and former members of the ADF, liability for the injury or disease giving rise to the need for rehabilitation must first be established under the MRCA. Rehabilitation assessments can be sought either by the rehabilitation authority (Service Chief or the Military Rehabilitation and Compensation Commission [MRCC]), or at the member or former member’s own request. Vocational and non-vocational programs may be provided if required.
6.4 There are specific changes recommended to the MRCA in this chapter, but the place of rehabilitation in the administration of military compensation is firmly based and well entrenched in practice. Improvements in the dissemination and content of information may result in greater understanding of the MRCC rehabilitation programs.

Background

Defence

6.5 Defence has policy directions in place under S.9A of the *Defence Act 1903* to rehabilitate ADF members, as a responsible employer with a duty of care, and to retain the investment in the capability that its people represent. Within the ADF the management of rehabilitation is the responsibility of the Commander Joint Health or Surgeon General ADF through the ADF Rehabilitation Program (ADFRP). By this means, injuries are identified and treated early, with rehabilitation programs being put in place where necessary. Cases are managed on a nationally distributed basis, and coordinated and reported upon centrally.¹

6.6 Certain provisions in the MRCA designate the Service Chief as the responsible authority, when, in fact, services are provided mainly through tri-Service arrangements. The Committee recommends changes to make the Chief of the Defence Force the responsible rehabilitation authority and believes this will have a positive impact and encourage greater progress towards consistency in administration across the services. These matters are covered in Chapter 7, because the issue gained its greatest focus when the Committee was considering transition arrangements for members proceeding through separation from the ADF and entry into civilian life.

6.7 The Directorate of Rehabilitation Services, Joint Health Command, is responsible for:
- the development, implementation and interpretation of ADF health policies, procedures and standards;
- evaluation and reporting on performance and compliance related to rehabilitation;
- procurement and delivery of rehabilitation assessments and programs within budgets; and
- management and operational support of the ADF rehabilitation coordinators.

6.8 The Directorate operates through the rehabilitation coordinators who are distributed through Garrison Health Support regions, which contract and manage rehabilitation case-management services. These coordinators provide the following key services:
- arrange and coordinate rehabilitation assessments and programs;
- procure case management service providers and monitor performance;
- review members’ progress;
- assist in developing the program;
- manage, collect, analyse and report performance data; and

¹ See the Australian Defence Force Rehabilitation Program *Annual report 2008–09.*
coordinate the provision of information between members, commanders and managers, and the Department of Veterans’ Affairs (DVA).

6.9 Rehabilitation continues until a case is closed according to one of three goals: (1) fit for duty in pre-injury duty or status; (2) fit for alternative work in the ADF; or (3) stabilisation and support out of the ADF with an optimum level of functioning.

6.10 The ADF has expanded its rehabilitation effort substantially since 2006. There were 4,189 new referrals to the ADFRP in 2009–10. Of these, 925 were assessed as not requiring a rehabilitation program and resumed duties. On completion of rehabilitation programs, 2,405 members returned to normal or alternate duties, with a return to work rate of 84 per cent, continuing the consistently high rate of durable return to work rates as compared to other Australian and New Zealand rehabilitation, compensation and insurance jurisdictions. Five hundred and eighty-eight members were unsuccessful in returning to work or were discharged. The total number of medical discharges reduced by 89 in 2009–10, compared to the previous year.

6.11 Certain issues that are outside the scope of this review have arisen in the course of consultations with regard to ADF operations. These include:

- career transition assistance officers approving vocational programs that were not consistent with the medical capability of certain individuals; and
- coordination of ADF rehabilitation activity — stakeholders in the Northern Territory observed that improvements were necessary.

These matters have been referred to Defence for further consideration.

**Department of Veterans’ Affairs**

6.12 Since the mid-1990s, DVA has administered the Veterans’ Vocational Rehabilitation Scheme (VVRS). This scheme was introduced to meet concerns that younger people were being accepted as totally and permanently incapacitated with no opportunities for vocational rehabilitation to attempt to return to work. The scheme is available under the *Veterans’ Entitlements Act 1986* (VEA) to eligible former members of the ADF. The transfer of administration of the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) for the ADF from the Department of Defence to DVA in December 1999 brought further rehabilitation expertise.

6.13 A rehabilitation policy unit was set up in DVA in 2002 and DVA has run two colloquia involving professionals, academics and commentators in the field of mental health and rehabilitation. In 2004, DVA formed a Technical Advisory Committee (TAC) on Rehabilitation, consisting of various experts in the field of rehabilitation, to advise on rehabilitation issues generally.

6.14 The introduction of the MRCA in 2004 brought rehabilitation into higher focus within Defence and DVA. An Ex-Service Organisation Working Group was established to develop Principles Guiding Rehabilitation under the MRCA, and Protocols of Rehabilitation under the MRCA, and these documents were approved by the MRCC in September 2004. These documents are currently being updated.

6.15 Greater success in rehabilitation and retention within the ADF means those who are discharged are generally in higher needs categories than they would be in any other rehabilitation or compensation scheme. The options of return to work in their original and usually preferred (ADF) workplace or a similar position elsewhere in the ADF have
been exhausted, sometimes for two years or longer. The member has to pursue new opportunities and challenges while dealing with increased incapacity. Performance data on DVA rehabilitation activities for the past four years are shown in Table 6.1.

### Table 6.1 Rehabilitation overview

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SRCA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessments completed</td>
<td>1,199</td>
<td>1,114</td>
<td>1,074</td>
<td>944</td>
</tr>
<tr>
<td>NRTW cases opened</td>
<td>648 (54%)</td>
<td>667 (60%)</td>
<td>686 (64%)</td>
<td>605 (64%)</td>
</tr>
<tr>
<td>RTW cases opened</td>
<td>363 (30%)</td>
<td>290 (26%)</td>
<td>236 (22%)</td>
<td>194 (21%)</td>
</tr>
<tr>
<td>RTW cases closed</td>
<td>379</td>
<td>289</td>
<td>190</td>
<td>189</td>
</tr>
<tr>
<td>% successful RTW</td>
<td>53%</td>
<td>54%</td>
<td>51%</td>
<td>51%</td>
</tr>
<tr>
<td>% durable RTW &gt;6 months</td>
<td>73%</td>
<td>74%</td>
<td>69%</td>
<td>67%</td>
</tr>
<tr>
<td><strong>MRCA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessments completed</td>
<td>268</td>
<td>354</td>
<td>400</td>
<td>475</td>
</tr>
<tr>
<td>NRTW cases opened</td>
<td>71 (26%)</td>
<td>128 (36%)</td>
<td>134 (34%)</td>
<td>168 (35%)</td>
</tr>
<tr>
<td>RTW cases opened</td>
<td>149 (56%)</td>
<td>175 (49%)</td>
<td>209 (52%)</td>
<td>245 (52%)</td>
</tr>
<tr>
<td>RTW cases closed</td>
<td>45</td>
<td>85</td>
<td>112</td>
<td>142</td>
</tr>
<tr>
<td>% successful RTW</td>
<td>49%</td>
<td>72%</td>
<td>65%</td>
<td>63%</td>
</tr>
<tr>
<td>% durable RTW &gt;6 months</td>
<td>100%</td>
<td>86%</td>
<td>97%</td>
<td>81%</td>
</tr>
<tr>
<td><strong>VEA (VVRS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessments completed</td>
<td>182</td>
<td>153</td>
<td>147</td>
<td>106</td>
</tr>
<tr>
<td>RTW cases opened</td>
<td>145 (80%)</td>
<td>116 (76%)</td>
<td>109 (74%)</td>
<td>86 (81%)</td>
</tr>
<tr>
<td>RTW cases closed</td>
<td>118</td>
<td>141</td>
<td>145</td>
<td>108</td>
</tr>
<tr>
<td>% successful RTW</td>
<td>42%</td>
<td>45%</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>% durable RTW &gt;6months</td>
<td>59%</td>
<td>51%</td>
<td>58%</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Total new NRTW cases</strong></td>
<td>719</td>
<td>795</td>
<td>820</td>
<td>773</td>
</tr>
<tr>
<td><strong>Total new RTW cases</strong></td>
<td>657</td>
<td>581</td>
<td>554</td>
<td>525</td>
</tr>
</tbody>
</table>

MRCA = Military Rehabilitation and Compensation Act 2004; NRTW = non-return to work or psychosocial cases; focused on providing a range of services to assist with activities of daily living (e.g. household services, aids and appliances, home modifications); RTW = return to work or vocational rehabilitation cases; SRCA = Safety, Rehabilitation and Compensation Act 1988; VEA = Veterans’ Entitlements Act 1986; VVRS = Veterans’ Vocational Rehabilitation Scheme.

6.16 The outcomes of successful return to work (RTW) programs (SRCA 51 per cent, and MRCA 63 per cent in 2009–10) are higher than might be expected given that the people involved have lost their preferred ADF employment. Durable RTW outcomes are measured after six months (consistent with long-standing SRCA practice) at 67 per cent and 81 per cent, and are understandably higher for the newer and younger MRCA group. Only 4.5 per cent of MRCA clients are aged over 55, compared with 35.4 per cent of SRCA clients and 92.3 per cent of VEA clients.

6.17 MRCA clients with serious injuries are more likely to have their complex medical needs met using the Repatriation Health Card — For All Conditions (Gold Card) and so do not require the case-management approach provided for equivalent SRCA clients, who may have many non return to work (NRTW) cases in a single year; for example, a ventilator-dependent quadriplegic with a SRCA-accepted claim could have several separate NRTW cases for various needs over the course of a year, whereas a similar MRCA client’s needs may be met through community nursing and rehabilitation appliances programs set up under the VEA for treatment card holders.

6.18 In 2009–10, only 475 rehabilitation assessments were completed out of 2,265 liability claims accepted. Of the assessments completed, 413 new MRCA
rehabilitation programs were commenced. The explanation for the large number not assessed for rehabilitation is that most claims are from serving members entitled to rehabilitation under the ADFRP. In 2009–10, the ratio of claims from serving members to former serving members was approximately 6:1. Furthermore, claims from former serving members may be for conditions that have already stabilised, and have been assessed as not requiring rehabilitation.

Veterans’ Vocational Rehabilitation Scheme

6.19 The VVRS is available under the VEA for eligible former members of the ADF. The scheme assists former members, with or without a disability, who need special assistance to obtain or hold suitable paid employment. There are no penalties for failure or inability to complete a program. The scheme assists those in receipt of the Special Rate of pension under the VEA to phase out of benefits while their work earnings increase and to return to prior benefit levels if they are forced to again leave the workforce. The VVRS managed 1,637 cases from 1998 to 2010, and completed 106 assessments in 2009–10.

6.20 There has been a gradual decline in numbers over the years due to the increasing age of the largest group in the scheme, Vietnam War veterans. There are still some Vietnam War veterans applying for assistance under the VVRS, but most applicants have later periods of service. There are still very few who apply for assistance under the VVRS because their job is in jeopardy, and this may be due to a lack of awareness in the veteran community of the availability of this assistance. In the past, the Department conducted VVRS marketing campaigns in areas with high concentrations of veterans without significant impact on intake numbers.

6.21 With the major effort on rehabilitation in DVA being addressed through the MRCA service delivery stream, it is possible that former members who only have VEA eligibility for their condition will not have the opportunity to participate in the programs relevant to their age and expectations of quality of life. It is an encouraging sign that these members are being considered through the re-write of the Rehabilitation Manual and the consistent application of principles to all three groups of clients — VEA, SRCA and MRCA. The Committee noted the decline in VVRS uptake, and the limited nature of the scheme. The Review of Veterans’ Entitlements (Clarke Review) conducted in 2003 made recommendations concerning this group and these matters are considered further in Chapter 29.

Needs assessments

6.22 The needs assessment was introduced into military compensation arrangements by sections 325 and 326 of the MRCA. The MRCC may carry out a needs assessment at any time after the acceptance of liability, but must do so before a claim for compensation is determined. The needs assessment provides the opportunity to consider whether a rehabilitation assessment is necessary, and the method by which a person’s medical needs are met.

6.23 In rare cases, a formal needs assessment may not be completed. This might occur for currently serving ADF members who lodge claims for acceptance of liability but do not proceed to payment or for those whose conditions are minor or will quickly resolve. Review of the implementation of the needs assessment process is part of the current Barriers to Rehabilitation project discussed below.
Under the MRCA, rehabilitation assessments can be required by the nominated rehabilitation authority or they can be sought voluntarily, to which the authority (Service Chief or MRCC) must respond. While serving, the assessment can be initiated by the member, a commanding officer, by medical officers, by an absence in excess of 28 days, or in response to a DVA-conducted needs assessment. Post-service, rehabilitation assessments are triggered by the conduct of a needs assessment under section 325 of the MRCA. All costs incurred in the ADF are paid by Defence for serving members, except for needs assessments, aids and appliances, and incapacity payments — which are covered by the MRCC once a compensation claim has been accepted (see below). Failure to comply with a direction to undergo an assessment can result in a claim being suspended. Equally, under section 52 of the MRCA, incapacity payments can be suspended if rehabilitation is not undertaken.

In considering the need for a rehabilitation assessment, MRCA subsection 51(2) requires the authority to take into account such things as:

- the person’s capacity for rehabilitation, and type of rehabilitation;
- any possible reduction in Commonwealth liability;
- cost of the program;
- possible improvement in employability;
- the member’s attitude to the program; and
- the merits of alternative programs.

Rehabilitation programs are formulated by approved rehabilitation providers, either Comcare approved, or others who are considered to possess the necessary skills. Pursuant to section 41 of the MRCA, rehabilitation programs can include medical, dental, psychiatric, in-patient and out-patient care, physical exercise, physiotherapy, psychosocial training and counselling. Provision is also made for aids and appliances, as well as modifications to work places, homes and cars. All rehabilitation decisions are reviewable by the Service Chiefs or the MRCC.

Also pursuant to section 41 of the MRCA, vocational assessment and rehabilitation includes assessment of transferrable skills, functional capacity, workplace assessment, vocational counselling and training, review of medical factors, resumé preparation and workplace aids.

Rehabilitation providers are also contracted to manage programs once developed, to coordinate and manage complex cases, to track progress, and to provide reports. Where those being discharged have a current program developed during service, transfer can be made to the MRCC and DVA. The timeliness of this transfer is discussed in Chapter 7.

Recent reviews and commissioned research have highlighted the need to improve case management and simplify arrangements across all government agencies involved in the lives of former ADF members. DVA has an active research program into rehabilitation services in DVA, the results of which are instructive for the purposes of this review.
6.30 The most recent research was initiated in response to the Australian Government’s election undertakings for a ‘Mental Health Lifecycle package’, which in turn prompted the reviews by Professor David Dunt. Of particular interest is the appointment of experienced case coordinators in response to the Dunt Review recommendation — ‘experienced case managers should be assigned to claims of clients having complex multiple needs claims’.

6.31 The report from phase one of a research task contracted to the Australian Centre for Posttraumatic Mental Health (ACPMH), *A study into the barriers to rehabilitation*, is now available. The study comprised a series of structured interviews and questionnaires to DVA rehabilitation clients, rehabilitation providers, senior DVA staff, and DVA operational staff. Key comments are highlighted in Table 6.2.

### Table 6.2 Key outcomes from *A study into the barriers to rehabilitation*

<table>
<thead>
<tr>
<th>Barriers to rehabilitation as seen by DVA rehabilitation clients</th>
<th>Comments by DVA staff, rehabilitation providers and other stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of awareness about the rehabilitation services available through DVA. Suggest distribution of an information pamphlet to all ADF members during transition.</td>
<td>Staff support awareness-raising, but believe some clients lack motivation to participate in rehabilitation.</td>
</tr>
<tr>
<td>Better communication needed between DVA staff and their clients. Need for a user-friendly website available for clients to refer to for further information.</td>
<td>Staff acknowledge that staff turnover is a barrier. There is poor communication between them and rehabilitation providers and the guidelines to providers are too vague. Rehabilitation providers are less satisfied about the timeliness in dissemination of DVA reports and ensuring that these reports are provided to all relevant stakeholders. DVA management observe positive changes in terms of cultural changes among DVA staff and the community, with greater emphasis on engagement in rehabilitation and the reduction of stigma.</td>
</tr>
<tr>
<td>DVA staff need to be more proactive in communication with clients.</td>
<td>Staff recommended an information pack be sent out when referring all new clients, and that DVA’s administrative systems be improved to assist staff to easily locate relevant information about a client and view clients in a holistic manner. Staff reported the difficulties encountered when a client resides in a regional or remote area.</td>
</tr>
<tr>
<td><strong>Need for a flexible or holistic approach</strong></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation service provision needs to focus on addressing physical, psychological, social and vocational needs, as well as providing support to the client’s family. Focus needs to move from providing financial compensation to relevant services to assist in improving a client’s overall level of functioning and quality of life.</td>
<td>Staff noted inconsistency in expectations regarding the purpose and expected outcomes of rehabilitation. Stakeholders reported greater DVA focus on building on the capacities of the client during their rehabilitation, rather than focusing on their incapacities.</td>
</tr>
</tbody>
</table>
Vital that DVA’s approach to rehabilitation is flexible so that each case is assessed on its merits, and there is flexibility in the provision of services depending on the needs of the client.

DVA staff felt that because DVA has a system in place that is flexible and not very restrictive in terms of what can be provided to clients, this acts to facilitate the client’s recovery from injury or illness.

**DVA administrative processes**

<table>
<thead>
<tr>
<th>More effective when there is early intervention and the provision of immediate services.</th>
<th>Staff support early commencement of rehabilitation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often affected by the time it takes from making a claim through to acceptance of liability.</td>
<td>Staff note the difficulties experienced when clients are reluctant to report their problems and lodge a claim with DVA in the first place. All the interview participants from DVA agreed that improvements are required to monitor and evaluate client and system outcomes.</td>
</tr>
</tbody>
</table>

ADF = Australian Defence Force; DVA = Department of Veterans’ Affairs

6.32 Phase two of the Barriers to Rehabilitation project completed two components, evaluating:

- a routine outcome measure relevant to all of DVA’s rehabilitation clients, using the goal attainment scaling method; and
- the trial of an electronic needs assessment process.

The final report will be published in early 2011.

6.33 ACPMH has documented existing psychosocial rehabilitation practices and models of service delivery for veterans and a best-practice model based on a literature search. The ACPMH report focuses on the more extensive rehabilitation ambition as reflected in the definition of rehabilitation in section 28 of the MRCA and discusses the way forward for the delivery of best practices in psychosocial rehabilitation for DVA clients. DVA is currently considering ways of implementing the recommendations of the report. This research aims to improve DVA’s rehabilitation responses to better address complex needs and is consistent with Professor Dunt’s recommendations.

6.34 DVA is using the results of the research and completed reviews in the development of its DVA Rehabilitation policy and procedures guide, incorporating the MRCA Rehabilitation Principles and Protocols. Given that the principles and protocols were developed in consultation with the ex-service community in 2004, the revised version should also take account of the views of the ex-service community.

6.35 The Committee notes the extensive research and reviews completed and still under way. It encourages the prompt formulation of the outcomes from this activity into revised policies and improved practices in the ADF and DVA.

**Legislative and policy issues identified by stakeholders relating to rehabilitation**

6.36 The major issues addressed in submissions relevant to rehabilitation are:

- managing high-needs clients;
- vocational rehabilitation, including opportunities for tertiary training;
- importance of holistic rehabilitation;

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4 Australian Centre for Posttraumatic Mental Health, *Psychosocial Rehabilitation for Veterans* (draft, not released), ACPMH, Melbourne.
• early identification and intervention; and
• the ‘compulsory’ nature of rehabilitation.

Managing high-needs clients

6.37 The Committee notes that several submissions highlighted the need for improved case management, particularly for high-needs clients.

6.38 In January 2010, pursuant to a recommendation by Professor Dunt, DVA appointed experienced case coordinators to provide holistic management for clients with psychological issues, including those who may be in danger of causing self harm, or harm to others. The submissions about case management, particularly for high-needs clients, are being addressed with these appointments, and a post-implementation study will be conducted in due course.

Vocational rehabilitation

6.39 Submissions from a number of ex-service organisations (ESOs)\textsuperscript{5} assert that rehabilitation should include provision for tertiary training. There is a perception that tertiary training is not possible under the MRCA. Certain other submissions are not receptive to the focus on rehabilitation under the MRCA.

6.40 The MRCA is a rehabilitation and compensation scheme directed to meeting the Commonwealth’s liability to restore people to their pre-injury condition and potential. Vocational needs are decided on a case-by-case basis, and tertiary training is underway for a number of existing cases. Consideration of applications for tertiary courses is made after considering factors including assessment of the former member’s ability to return to their previous job level and their capacity to complete a vocational course. This is explained in Protocol 9 of the MRCA Rehabilitation Principles and Protocols as follows:

• Vocational training and education is generally provided to return a person to the workforce at a level to which they are accustomed. If, to regain employment, the assessment determines that education or training to a higher level, including tertiary, is required to achieve reasonable likelihood of a return to the workforce, and such provision could reasonably be expected to be cost effective, training or education to that level will be considered.

• Matters to be considered when determining cost effectiveness include
  – cost of the training or education, including, where applicable, Higher Education Contribution Scheme;
  – additional reduction in future liability that would be attributable to the studies; and
  – improvement in work opportunities and capacity to obtain paid employment.

6.41 One submission to the Review argued there should not be any restriction on the kind of training that can be provided to a member.\textsuperscript{6} The ESO Round Table representatives made a similar contention to the Committee that all clients should be offered at least a diploma-level course of training. Both suggestions are less applicable

\textsuperscript{5} Australian Special Air Service Association, Defence Force Welfare Association and the Australian Veterans and Defence Services Council.

\textsuperscript{6} Australian Veterans and Defence Services Council.
to a rehabilitation and compensation scheme and more akin to a re-establishment scheme for all former ADF personnel, as existed after the end of the Second World War and National Service in the 1965–72 period. MRCC rehabilitation offers greater opportunities for vocational training than other compensation schemes, but does need to address individual needs within guidelines to prevent abuse and inequity between beneficiaries.

6.42 The following fictional case study demonstrates that the Department has options to consider individual capacity, potential earnings and overall cost effectiveness, and need not limit opportunities for vocational training or placements in directly equivalent roles previously held in the ADF.

**Case study**

A former infantry soldier, with an accepted back injury, had transferrable skills that would enable him to pursue a range of employment options in the security industry. However the former soldier also had prior experience, aptitude and interest to work in the information technology (IT) industry. He was very keen to pursue a four-year undergraduate degree in IT. The service provider undertook a comprehensive labour market analysis in consultation with the client. It was agreed that, given the nature of the client’s back injury, his employment and earning capacity was suited to pursuing employment in the IT industry.

The labour market analysis included a comprehensive investigation of training options, and it was subsequently agreed that the member should undertake a diploma in information technology through a privately run IT training facility. The course was 13 months in duration at a cost of $17,350. The course was available on a self-paced learning basis as soon as the client was ready to commence. An alternative two-year diploma course at a local TAFE college was also considered. The TAFE course costs were considerably less, but the member could not commence the training until the beginning of the new semester in three months’ time, and the training was going to take an additional 11 months to complete. The additional cost of the privately run course was considered justified because of the reduced timeframe, in conjunction with a job placement service the training facility provided for their graduates.

The member was assessed as medically and vocationally capable of a high performance role in the IT industry. The Department was then able to consider the potential higher and sustainable earnings as a basis for approving tertiary study at a relatively modest cost, producing a cost-effective outcome and prospects for a good quality of life.

6.43 Clients and providers would benefit from an improved understanding about the MRCC rehabilitation policies. This may be achieved through more details and clarity in DVA referrals to providers, as well as more general information in pamphlets and the DVA website. This finding is supported by ACPMH studies and in consultations by the Committee with ADF members. The DVA *Rehabilitation manual*, recently completed, should provide improved guidance for DVA coordinators.

6.44 The TAC has recommended that DVA provide examples of successful rehabilitation cases in its publicity material. This would not involve well-known high-profile cases that set too high a target for the average person. The examples should include cases where mental health issues have been a factor, and where non-vocational services have been used with beneficial timing of vocational programs and job placement assistance.

6.45 The Committee believes that the MRCA vocational rehabilitation programs offer a wide range of options for training, including tertiary levels when appropriate,
but these options are clearly not understood by some major stakeholders. DVA
rehabilitation pamphlets and websites should highlight the MRCC policies on
vocational training aimed at restoring potential based on individual abilities and
assessed capacity. Examples (de-identified) of successful vocational programs
undertaken by former ADF members should be publicised. Rehabilitation providers
should be fully briefed on the opportunities for vocational training under MRCC
rehabilitation.

Importance of holistic rehabilitation

6.46 Several submissions lament what the authors see as a low level of holistic (or
psychosocial) rehabilitation programs. The DVA fact sheet on rehabilitation refers to
‘psychosocial training’ as including ‘such things as referral to community support
services, basic skills training, lifestyle programs, attendant care services or drug and
alcohol management programs’. Table 6.3 highlights that a significant amount of effort
is going into non-return to work rehabilitation.

Table 6.3 Rehabilitation programs by type

<table>
<thead>
<tr>
<th>2009–10 rehabilitation assessment outcomes</th>
<th>SRCA cases</th>
<th>MRCA cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-return to work program</td>
<td>605 (64%)</td>
<td>168 (35%)</td>
</tr>
<tr>
<td>Return to work program</td>
<td>194 (21%)</td>
<td>245 (52%)</td>
</tr>
<tr>
<td>No program recommended</td>
<td>145 (15%)</td>
<td>62 (13%)</td>
</tr>
<tr>
<td>Total</td>
<td>944</td>
<td>475</td>
</tr>
</tbody>
</table>

6.47 As discussed previously, the older group of SRCA clients is more likely to have
been through vocational rehabilitation in past years, with the needs and focus now being
on holistic rather than work-related needs. The younger group under the MRCA has
critical vocational needs, but it is also important that these programs are timed for when
the person is ready to resume a place in the workforce. A psychosocial or holistic
program is often necessary as a precursor to vocational rehabilitation. A gap exists
between what DVA delivers and how clients view what is being delivered. DVA should
provide more stakeholder and client information on the availability of holistic services
as part of its rehabilitation programs.

6.48 Most non-return to work programs cover household aids and appliances for
daily living. Assistance is also provided with medical management and psychosocial
needs. Regular rehabilitation performance reports combine all forms of vocational
rehabilitation. These reports could be made more meaningful by reporting subcategories
of holistic rehabilitation, particularly psychosocial programs.

6.49 Phase two of the Barriers to Rehabilitation project is identifying ways to
improve needs assessments and performance measurement for non-vocational
rehabilitation. Measures will no doubt be redefined following completion of the current
research studies. In the interim, subject to the capacity of the information technology
(IT) systems, the MRCC could seek reports from DVA; for example, reporting the
completion rates for participants on non-vocational courses and satisfaction rates for
house and workplace modifications.

6.50 The Committee has identified the need for greater awareness by clients and
other stakeholders on the availability of holistic assistance, including psychosocial
services, in addition to the traditional and important role of job-related programs.
Performance reports for the MRCC should be expanded to show the volume and outcomes for relevant subcategories of holistic rehabilitation.

**Early identification and intervention**

6.51 Some submissions to the Review and comments in the ACPMH focus groups (Table 6.2 above) indicate that the need to await the determination of liability can be a factor in the timing and effectiveness of rehabilitation.

6.52 A Canadian Veterans Affairs report\(^7\) cites numerous research studies with regard to the need for timely rehabilitation programs:

- early intervention significantly improves probability of returning to work and can prevent long-term dependence on benefits;
- the probability of returning to work after sustaining a disability drops from 50 per cent after a six-month absence, to 20 per cent after one year, and 10 per cent after two years; and
- disability should not be equated with inability to work; investment in vocational rehabilitation and training can quickly pay for itself, because the average cost per capita is low compared with the average cost of disability benefits.

6.53 Currently, the MRCC delegate decision on the section 326 needs assessment may initiate a rehabilitation assessment. However, the needs assessment is only undertaken after liability is established. This may be a considerable period for a claimant to have to wait before receiving professional help in planning for life with a disability. Chapters 15 and 16 discuss the time taken to process claims and the efforts to reduce these times.

6.54 The Committee accepts the importance of early vocational rehabilitation and discusses below the feasibility of allowing entitlements to rehabilitation assessments and limited access to programs, as soon as a claim is lodged for initial liability.

**Rehabilitation during Australian Defence Force service and transition**

6.55 ADFRP provides an opportunity for early rehabilitation action, and compensability is not an issue for ADF members. Every effort is now being made to finalise compensation claims before discharge. It is important that rehabilitation programs extending through transition to civilian life are not disrupted solely due to the fact of discharge. The MRCC and the ADF need to ensure that there is no disruption in the event that discharge occurs without the claim being finalised. This matter is addressed in certain recommendations in Chapter 7 of this report, aimed at a smooth transfer of responsibility from the ADF to the MRCC.

**Veterans at risk status**

6.56 The VEA VVRS provides entitlements for ‘at-risk’ status for those with warlike or non-warlike service. There is no requirement that the need for rehabilitation arises from a compensable or service-related condition. The VVRS no longer applies to members with warlike or non-warlike service after 1 July 2004. The loss of entitlement

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of ‘at-risk’ veterans to a rehabilitation scheme was not acknowledged in papers at the time of development of the MRCA.

6.57 DVA and Defence believe there has been an unintended loss of the right of ‘at-risk’ veterans, to seek assistance with vocational rehabilitation before there being an accepted liability. Given the limited VVRS take-up from a much larger eligible population, discussed previously, the incidence of future take-up from ADF members who have served in deployments since 2004 is estimated to be very low.

**Offset savings from invalidity superannuation**

6.58 Early access to vocational rehabilitation could result in some offset savings for the Australian Government with respect to former full-time members who are eligible for disability superannuation benefits. The military superannuation schemes for the ADF do not offer the opportunity for rehabilitation, yet invalidity superannuation benefits are assessed on three levels of incapacity and ability to work. Earlier rehabilitation could mean that an invalidity retiree could improve their capacity to work and the level of income from their own efforts. There may be a lower incapacity classification level with a lower military invalidity superannuation payment. It is relevant to consider this wider issue, particularly given the willingness shown by ADF members towards rehabilitation and the view from focus groups that the delay in finalisation of the claim is a factor in delays in commencing rehabilitation.

**Reimbursement of rehabilitation costs**

6.59 A further option considered by the Committee was to allow for reimbursement of rehabilitation-related costs between the date of onset and the date of acceptance of liability. There would be considerable complexity to prescribe conditions for reimbursement for services not determined as part of a rehabilitation assessment and program. Current provisions allow for reimbursement of treatment expenses and these can cover the needs of the most vulnerable group with mental health issues.

**Late-onset cases**

6.60 Certain cultural factors, including the lack of willingness to admit to having injuries, mitigate against ensuring that all those in need of help actually have the opportunity to attend rehabilitation programs while in service. Many such people do not lodge a claim for some years after service when their condition worsens or limits their ability to engage in their civilian occupation.

6.61 If a former member has lost their civilian job and has time on their hands, this may be a vulnerable period while they await determination of their claim. As discussed in later chapters, DVA has recently appointed case coordinators for the benefit of vulnerable former members going through the claims process. Case coordinators should be able to identify where the greatest needs exist and should have the facility to offer a rehabilitation assessment without the need to await determination of liability. Given the limited VVRS take-up from a much larger eligible population, discussed previously, the incidence of such cases is estimated to be very low.

6.62 More timely assistance through a rehabilitation assessment, and, where appropriate, a limited vocational rehabilitation program, may encourage a vulnerable person to focus on returning to a normal civilian life and not to simply await the outcome of a compensation claim.

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8 See Chapter 12. Ongoing MSBS Invalidity pensions are 100% funded by the Australian Government, as all member contributions are returned to the member with interest.
6.63 In regard to early intervention, the Committee believes that Defence and DVA should develop options to further the aim of early intervention and ensure that improvements are made to the timing and effectiveness of rehabilitation, and provide advice to government as appropriate. This may include consideration of the following approaches:

- extension of the existing VVRS entitlement for former ‘at-risk’ members with warlike or non-warlike service veterans to seek assistance with vocational rehabilitation before there is an accepted liability to members with service after 1 July 2004;

- the facility for the ADF or the MRCC to make offers of vocational rehabilitation assessments in vulnerable late-onset cases while their initial liability claim is being considered, as part of the ADF’s post-discharge duty of care; and

- the provision of rehabilitation by the MRCC under the special assistance provision of the MRCA before a claim for liability is determined.

6.64 While the take-up rate for such programs would be very low, the benefit to these former members may be substantial.

**Ex-service organisation views on rehabilitation**

6.65 ESO submissions supported, in the main, the emphasis on rehabilitation in the MRCA. One expressed concern at the ‘compulsory nature’ of MRCA rehabilitation programs, which it is alleged causes delays in compensation payments and stress through veterans being forced into mandatory programs.

6.66 If a member refuses or fails to undertake a rehabilitation program, the rehabilitation authority can suspend the member’s right to compensation until the member undertakes the program. This does not affect the member’s right to treatment or compensation for treatment. These provisions are used sparingly and in accord with the principles and protocols.

6.67 In practice, most individuals who are medically discharged receive separation payments from the ADF and are soon in receipt of Invalidity Superannuation and/or MRCA incapacity payments to fund their daily living needs. Rehabilitation must be completed before eligibility for the Special Rate Disability Pension is determined.

6.68 The concerns about the effectiveness of requiring people with mental health conditions to return to the workforce are shared by administrators and stakeholders alike. It is accepted by MRCC policy that medical or psychiatric clearance should be obtained before a person could be expected to be ready for a vocational program. The Committee has sought advice from the TAC. Professional TAC members have provided papers explaining the current thinking in the field of psychiatric rehabilitation. These are summarised below in Boxes 6.1 and 6.2.

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9 Section 424 of the MRCA.
Box 6.1
A September 2000 article by Canadian researchers Joseph Marrone and Ed Golowka10 explores the notion that people with mental illness should work. The authors reject any implication that a ‘get tough’ approach works. Instead, they emphasise that sensitive handling is needed by all parties (the worker, the professionals, family and friends) to successfully leverage the potential with an appreciation of the limitations that are part of mental illness. A literature search found no clinical research studies that showed the ill-effects of employment on the mental health of people with serious mental illness. While there is a large body of data showing poor outcomes in psychiatric vocational rehabilitation, there is no information on actual ill effects. Thus a widely shared concern about negative consequences attendant to working is not based on hard data. If people with mental illness are not encouraged to work, they are further exposed to factors that exacerbate, rather than ameliorate, their problems.

The authors assert from their studies that people should work because unemployment is much worse for mental health than the stresses of employment; that getting a job quickly is more likely to lead to a career than just planning; that finding work does not get easier later on; that work is a way to meet people and expand social networks; that work gives people more status than the ‘consumer’ role; and that work provides a distraction from disability.

Box 6.2
An article entitled ‘Does competitive employment improve non vocational outcomes for people with severe mental illness?’11 examined the cumulative effects of work on symptoms, quality of life, and self-esteem for 149 unemployed clients with severe mental illness receiving vocational rehabilitation. Clients were tracked over an 18-month study period, and outcomes were compared on the basis of their predominant work activity over the study period; for those in competitive work, sheltered work, minimal work and no work.

The authors found that the competitive work group showed higher rates of improvements in symptoms in satisfaction with vocational services, leisure, finances and self-esteem than other groups.

6.69 Research shows that the probability for a sustainable return to work drops dramatically with longer periods out of the workforce. Efforts do need to be made to prevent the person from developing a victim or welfare mindset and effectively denying themselves the opportunities they had before the incident.

6.70 It is worth noting that the MRCA requires a more stringent process than the SRCA in regard to the cessation of benefits. The SRCA client may be deemed able to earn at the conclusion of a rehabilitation program, whether or not the person then goes into employment. The MRCA stipulates that incapacity payments can only be adjusted by deemed amounts once the client commences work or fails to follow through on a reasonable offer of employment. Section 62 obliges the MRCC to ‘take all reasonable steps to assist the person to find suitable civilian work’.

6.71 ADF members and former members at public consultations run by the Review have shown notably high motivation towards rehabilitation and efforts to return to a normal life. The Committee supports the rehabilitation framework provided in the MRCA with improvements as outlined in this report.

**Possible legislative and policy changes and improvements to claims administration and service delivery for rehabilitation clients**

6.72 Recommendations addressing items brought to attention in submissions to the Review are covered above. A number of other items have been referred by DVA, as discussed below.

**Evaluation of rehabilitation or return to work success rates**

6.73 The statistics shown in Table 6.1 (above) show the return to work rate for former members reported to the MRCC each quarter. Importantly, cases where return to work has been sustained for more than six months are also reported. It is noted that ADF rehabilitation statistics are not currently provided to the MRCC. Among the MRCC functions listed in section 362 of the MRCA are:

- ‘to minimise the duration and severity of service injuries and service diseases by arranging quickly under this Act for the rehabilitation of members and former members who suffered those injuries and diseases’; and
- ‘to promote the return to suitable work (defence or civilian) by persons who suffered a service injury or disease’.

6.74 The capacity of the MRCC to meet these responsibilities for current and former members would require performance reports from the ADFRP in addition to those now received from DVA.

6.75 The overall effectiveness of rehabilitation programs is difficult to test. For example, current management reports do not track the length of time that successful placements spend in the new job, changes of employers, or total costs (vocational programs and subsidising of normal earnings) for individual clients. The durability of return to work programs should be tested beyond the six-month period shown in current performance reports.

6.76 It is likely that people move through vocational programs and different jobs several times over the years. A special long-term study is recommended by the Committee to get a full picture of the effectiveness of rehabilitation arrangements within the ADF and DVA. This study would review the level of rehabilitation services and the nexus with incapacity payments. The study of a sample of individual cases should commence at the time of the first incident in the ADF that gives rise to the liability, and go forward for at least a 10-year period.

6.77 A research project undertaken in 2004 by RTK Corporate with respect to the effectiveness of rehabilitation under the SRCA indicated that the Department has been able to conduct such studies in previous years.\(^{12}\)

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\(^{12}\) RTK Corporate (2004). *A national study of effectiveness of military rehabilitation services*, report to Australian Government Department of Veterans’ Affairs, Canberra.
The RTK study was made on a random sample of 250 personnel discharged medically who were no longer capable of being rehabilitated within the ADF, from a total of 2,097 records of SRCA claimants. The objective of the RTK study was to determine what vocational rehabilitation strategies and interventions achieved durable and cost-effective return to work outcomes.

The findings of the study are interesting, but must be qualified for current relevance. The study was exclusively of discharged personnel with active rehabilitation plans, before the creation of the ADFRP and the MRCA, and with a simpler system of incapacity payments that was less generous than the MRCA model.

The study was positive about the success of rehabilitation, showing that 62.9 per cent of clients returned to work at the end of their plans. This compared favourably with Workcover NSW at 62 per cent for the same type of return to work with a new employer. Of the sample group, 53 per cent returned to work full time, 15.3 per cent part time, and 31.8 per cent had no return to work. Only 10.7 per cent were on full incapacity payments after six months. After two years, 71 per cent were still at work.

The study also showed that the most effective rehabilitation services were those of a vocational nature, and the least effective were those of a counselling nature (solely against a return to work criterion).

The Committee’s public and ADF member consultations revealed some lack of connection between the various action officers within Defence in some areas. The study should include mental health and physical injuries and the ADF’s response from the time of the first injury through 5–10 years within the ADF, transition to discharge, and later experience in civilian life under the MRCC as the rehabilitation authority.

A long-term study of the effectiveness of MRCA rehabilitation arrangements within both the ADF and DVA, with respect to the level of rehabilitation services needed and the importance of the nexus with incapacity payments, should be undertaken.

Conclusions

The Committee concludes that the MRCA approach to rehabilitation has continuing relevance, is soundly based and includes important components of vocational and non-vocational rehabilitation. Improvements can be made in information and publicity about available rehabilitation programs, and in management reporting.

There is considerable evidence that early intervention improves the effectiveness of rehabilitation. While every effort should be made to finalise claims before discharge from the ADF to provide continuous and seamless rehabilitation to members under the MRCA, this is not always possible — particularly in relation to mental health conditions and late-onset conditions. The Committee believes that Defence and DVA should develop options to ensure that improvements are made to the timing and effectiveness of rehabilitation. This would also have the potential to reduce costs in relation to former full-time members who are eligible for disability superannuation benefits, as well as improve long-term wellness and wellbeing.
Recommendations

The Committee recommends that:

6.1 research into rehabilitation, and the formulation of the research outcomes into improved policies and practices in the Australian Defence Force (ADF) and the Department of Veterans’ Affairs (DVA), be continued;

6.2 DVA rehabilitation pamphlets and websites should highlight the Military Rehabilitation and Compensation Commission (MRCC) policies on vocational training aimed at restoring potential, based on individual abilities and assessed capacity; examples (de-identified) of successful vocational programs undertaken by former ADF members should be publicised;

6.3 rehabilitation providers should be fully briefed on the opportunities available for vocational training under MRCC rehabilitation;

6.4 DVA should improve the information in its pamphlets and on the website on the availability of holistic assistance, including psychosocial services, in addition to the traditional and important role of job-related programs;

6.5 performance reports for the MRCC should be expanded to show the volume and outcomes for relevant subcategories of holistic rehabilitation;

6.6 the Australian Defence Organisation and DVA should develop options to further the aim of early intervention and ensure that the timing and effectiveness of rehabilitation are improved, and provide advice to government;

6.7 the ADF Rehabilitation Program should provide performance reports on ADF rehabilitation assessments and program outcomes to assist the MRCC to fulfil its functions under the Military Rehabilitation and Compensation Act 2004 (MRCA); and

6.8 a long-term study of the effectiveness of MRCA rehabilitation arrangements within both the ADF and DVA, with respect to the level of rehabilitation services needed and the importance of the nexus with incapacity payments, should be undertaken.