Rehabilitation Services
An overview of the Department of Veterans’ Affairs rehabilitation program expectations for new and existing rehabilitation providers

INFORMATION PACK
OCTOBER 2015

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Disclaimer and Clarification of Terms

Australian Government
Department of Veterans’ Affairs

FURTHER INFORMATION
RING 133 254
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DVA encourages you to check with us if you have any concern about the information on the website.

DVA is aware that some examples contained in this document may not be applicable in all circumstances and are developed with the intention of educating and informing rehabilitation service providers.

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CLARIFICATION OF TERMS
Where the term DVA or Department is used in this document, this may also refer to a decision made by either the Military Rehabilitation and Compensation Commission or the Repatriation Commission.

Where the term client is used in this document, this may refer to members of the veteran and Defence Force communities who are eligible for rehabilitation services. Furthermore, the term encompasses members of the Australian Federal Police who have participated in peacekeeping operations.

FURTHER INFORMATION
For further information please contact DVA on 133 254 or go to the DVA website at http://www.dva.gov.au/health-and-wellbeing/rehabilitation
1—Rehabilitation in DVA

DVA’s rehabilitation approach is aimed at maximising quality of life after an injury or illness. DVA aims to do everything possible to improve the client’s wellbeing and assist them in adapting to, and recovering from, any injury or illness related to their Australian Defence Force (ADF) service.

DVA’s rehabilitation approach is different from a traditional workers compensation approach which is largely focused on return to work. Our whole-of-person rehabilitation approach is focused on physical, social and mental recovery. We use medical, allied health, psychological, social, educational and vocational resources to assist and support the client as they move forward from their injury or illness. DVA aims to ensure that rehabilitation will be coordinated, integrated and adequately resourced to achieve positive outcomes for the client.

DVA provides rehabilitation assistance to entitled serving and former ADF members, declared members’, part-time and continuous full-time reservists, ADF cadets, cadet instructors and some members of the Australian Federal Police. These programs are administered under three distinct legislative acts:

- Military Rehabilitation and Compensation Act 2004 (MRCA);
- Safety, Rehabilitation and Compensation Act 1988 (SRCA); and
- Veterans’ Entitlements Act 1986 (VEA).

DVA clients can have eligibility under one or more of these Acts depending on their type of service and when they served: http://www.dva.gov.au/reservist/eligibility

DVA has adopted the MRCA rehabilitation philosophy to drive policy and administrative protocol for all DVA rehabilitation clients. This is a whole-of-person approach which focuses on the client’s medical, psychosocial and vocational needs to deliver an individually tailored program. DVA rehabilitation programs are designed to assist clients who are injured or become ill as a result of their service in the ADF to, wherever possible, move towards self management of their conditions. The focus and extent of the client’s rehabilitation will depend on the nature and severity of the injury or illness and the client’s individual circumstances.

This Guide aims to provide an overview of:

- the principles that underpin DVA’s rehabilitation approach;
- the sorts of issues that DVA clients may be experiencing, particularly if they are discharging from the ADF;
- the role of the DVA Coordinator and how they work with rehabilitation providers;
- the reporting documentation that rehabilitation providers are expected to use;
- DVA and Defence responsibilities for treatment and rehabilitation for serving members of the ADF and
- services and benefits that DVA can provide to members who have discharged from the ADF.

Declared members are persons who are determined to have performed activities which are similar in nature to those performed by members of the ADF.
Key Stakeholders

Client: The client is the key player in providing feedback on their progress towards rehabilitation goals, their satisfaction with the rehabilitation process and their involvement with other stakeholders.

Significant People in the Client’s Life: This group of people must be actively involved in the development of an appropriate rehabilitation plan/program to ensure sufficient support for the client.

DVA Rehabilitation Coordinator: The rehabilitation coordinator takes prime responsibility for the overall progress and the direction the case is taking; input is sourced from all parties from progress reports, case correspondences, phone calls or conversations. Communication is vital to ensure a client understands the rehabilitation processes, is satisfied with their progress and to ensure that any concerns or issues raised can be addressed quickly, in consultation with key stakeholders.

Rehabilitation Service Providers: Rehabilitation service providers play a critical role in providing a case management approach, providing ongoing support to the client and the rehabilitation coordinator, monitoring recovery of health, client behavioural and personality issues, social reintegration, client coping skills and return-to-work matters. It is expected that providers will regularly document and report progress to the rehabilitation coordinator (every four weeks for the life of the client’s rehabilitation plan or as agreed to following negotiations with the rehabilitation coordinator). They are also responsible for the collection of authorities relating to the rehabilitation process.

Specialists, Treating Practitioners and Allied and Mental Health Providers: These providers contribute to the rehabilitation of the client by providing evidence-based interventions, preparing regular medical reviews/reports which provide a record of progress from a medical perspective, facilitate treatment to promote recovery and monitor its effectiveness and actively participate in the process of the client achieving optimum psychological and/or physical function.

Other Service Providers: Deliver services in line with an agreed plan for the client and provide reports on progress or results such as course progress at training institutions, fitness, and work preparation programs.
2—Guidelines for Rehabilitation in DVA

The Australian Government introduced the MRCA legislation to cover Defence service rendered on or after 1 July 2004. This legislation differs from a traditional workers compensation approach, and provides a whole-of-person model of rehabilitation service provision.

The following legislated requirements drive and inform rehabilitation practice in DVA:

- 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 a 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;
- a person can be considered for rehabilitation where DVA has accepted liability for an injury or disease, which causes incapacity for work, or caused impairment that requires rehabilitation;
- once DVA has accepted liability for a person’s injury or disease, an assessment must be completed to identify the person’s needs, including their financial, medical and whole-of-person rehabilitation needs;
- if a person requests a rehabilitation assessment, that request must be complied with;
- DVA can determine that a person who has an injury or illness resulting in an incapacity for work should undertake a rehabilitation program;
- when determining that a person will undertake a rehabilitation program, the following issues must be considered:
  - any written report or assessment about the person,
  - whether a rehabilitation program may lead to a reduction in the future liability of the Commonwealth to pay compensation to the person;
  - the cost of the rehabilitation program;
  - any improvements in the person’s opportunity to gain suitable and sustainable employment after completing the program;
  - the person’s attitude to the program;
  - the relative merits of any alternative rehabilitation program; and
  - any other matter the Department considers relevant.

Written reports and assessments may include reports provided from the client’s principal treating practitioner or other health providers. Other reports relating to the client’s capacity for rehabilitation and the development and focus of the rehabilitation program may also be considered.

If the client is eligible for incapacity (income replacement) payments, these will continue while the client is undertaking a rehabilitation program, completing rehabilitation activities or treatment, is restricted in work hours, ability to undertake shifts or undertake certain elements of their job or is unfit for work. More information about incapacity payments can be found in Chapter 12 of this pack.
3—DVA Rehabilitation Framework

DVA is committed to providing rehabilitation services based on best practice principles. These principles are:

- care and respect for the client is paramount;
- early intervention processes and practices must operate;
- whole-of-person rehabilitation needs must be addressed;
- the client and, where appropriate, other significant people in their life, must be actively involved in, and at the centre of, the development of an appropriate rehabilitation plan/program with realistic and achievable goals;
- all key stakeholders must be actively involved in an effectively coordinated plan/program of activities; and
- rehabilitation plans must be focussed on outcomes.

DVA and the rehabilitation providers it works with will achieve this by:

- adopting best practice rehabilitation provisions to drive policy development and practices for all DVA rehabilitation clients;
- using the expertise of the joint DVA/Defence Rehabilitation Advisory Committee as a consultation mechanism with industry to guide our best-practice decision making processes;
- applying nationally consistent standards, best practice frameworks and principles that focus on achieving the best possible outcomes for clients;
- promoting excellence in service delivery and case management as the norm;
- challenging existing practices and reviewing and revising current approaches and policy to address emerging issues;
- adopting a robust structure to measure success for rehabilitation activities;
- developing a supportive and collaborative environment which shares knowledge and experiences and embraces the whole-of-person model of rehabilitation service provision;
- promoting the importance of rehabilitation as a positive opportunity to assist clients move forward from injury and illness; and
- acknowledging the role of significant others in the client’s life in achieving long term positive outcomes in the rehabilitation process.


DVA Best Practice Principles

DVA Best Practice Principles are driven by the broadening of rehabilitation services introduced by the MRCA. At the time of its development, the MRCA drew on two distinct bodies of research in the fields of rehabilitation and mental health:

2. International Association of Psychosocial Rehabilitation Services – Principles of Psychosocial Rehabilitation (Cnaan et al, 1998).

We continue to draw on current research and best practice through:

1. The joint DVA/Defence Rehabilitation Advisory Committee;
2. Research conducted through DVA’s research programs;
3. Strong collaboration with DVA’s Mental and Social Health sections;
4. Utilising Comcare’s national standards and best practice frameworks; and
5. Developing positive working relationships with the rehabilitation industry.

DVA’s whole-of-person rehabilitation approach is represented in Chapter 4.
To aid recovery and wellbeing, three elements must be considered when working with a client to identify their rehabilitation needs.

**MEDICAL MANAGEMENT**
The use of a managed process to restore or maximise the client’s physical and psychological functioning.

As an adjunct to treatment, a medical management rehabilitation plan may also be developed to assist a client who is having difficulties in managing their treatment or has high support needs.

Assistance may be focused on helping the client navigate through their medical appointments, treatment regimes, medical information, self care needs, requirement for aids and appliances and other related activities.

**PSYCHOSOCIAL**
The use of rehabilitation measures aimed at helping a client to adjust to changes in their life, restoring or maximising the client’s functioning and maintaining appropriate behavioural and social skills for living in their communities.

The aim of a psychosocial rehabilitation plan is to assist a client in accepting, adapting and moving forward following an injury, by improving functioning, recovery, community participation and quality of life. Interventions are aimed at helping people address potential barriers to recovery and rehabilitation.

Clients may benefit from a psychosocial rehabilitation program in conjunction with the medical management and vocational aspects, to address issues of loss and help with accepting the changes in their life, before they move into considering a return to work. This approach may support a more sustainable return to employment.

**VOCATIONAL**
The managed process that provides an appropriate level of assistance, based on assessed needs, necessary to achieve a meaningful and sustainable employment outcome.

The aim of a vocational rehabilitation program is to return a client to the workforce to at least the level of their pre-injury employment.

Broadly, services may include vocational assessment, guidance or counselling, functional capacity assessments, work experience, vocational training and retraining, further education and job seeking assistance.

Whilst returning to paid employment may be the primary goal to work towards, other forms of ‘employment’ including voluntary employment should not be ruled out as a successful vocational outcome.

It should be considered if this is more appropriate for a client’s individual circumstances and assisting them to better manage their health and wellbeing in a sustainable way.

**WHOLE-OF-PERSON REHABILITATION**

4—DVA’s Whole-of-Person Rehabilitation

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This section will discuss in detail the possible range of unique circumstances, impacts and issues associated with rehabilitation clients with military service and likely impacts on rehabilitation broad outcomes. This section is intended to cover potential impacts and effects from military service in a broad and generalised way. It is written to provide rehabilitation practitioners with a background of the impacts of military service on the range of potential requirements across vocational, psychosocial and medical rehabilitation.

Those who have served in the ADF have been exposed to a unique culture and system during their service. Their experiences in the ADF mean they may have a number of attitudes and issues different from other rehabilitation clients. Subsequently, it is necessary for rehabilitation service providers to understand these unique attitudes and issues in order to better appreciate the context for rehabilitation for DVA clients. The section thus provides a general overview of the ADF military culture to assist with this understanding. It should be stressed that some aspects of military culture may not be applicable to all ADF personnel.

Joint Health Command (JHC) provides health care to ADF members. JHC is responsible for health policy, strategic health advice and technical control of health services. JHC is also responsible for delivering comprehensive garrison health care to entitled personnel. JHC uses an integrated workforce to deliver garrison health care. The workforce comprises uniformed members of the ADF, Australian Public Service employees and contractor personnel.

5.1 The ADF Military Culture

The Australian Defence Force (ADF) has a long and honourable history of service in the defence of the nation and support of its interests. In doing so, they have won Australians’ admiration and respect over many decades. Core to much of their success has been the strength of their culture, collectively and within each of the Services. Their culture binds them as an organisation and shapes the way that they operate every day.

ADF members belong to one of the three Services of the ADF –

- Royal Australian Navy (RAN),
- Australian Army and
- Royal Australian Air Force (RAAF).

The Navy, Army and Air Force share a common primary purpose and commitment, which is to defend Australia, our people and national interests. The personnel of all three Services are members of the Profession of Arms that confers upon them unique roles and responsibilities within Australian society. Members are trained to do things far and beyond anything else people in the broader community may be required to do, they may have to face death and may have to take lives.

However, each Service is unique, which is reflected in and by their culture. Each culture stems from a different set of technologies, the way they fight in a combat environment, and their individual history and heritage. In turn, a Service’s culture frames the unique way in which its members think and act, and exerts a significant effect on what they believe, and in how they view and understand themselves, and the other Services.

continued next page
Military training is geared to producing a quick thinking individual with solid leadership and team building skills, a strong appreciation of processes along with the ability to use and rapidly adapt new technologies. All this is created within a highly disciplined and structured work environment. Military personnel pride themselves on their responsiveness, problem-solving skills, ability to work in high-pressure environments and cross cultural skills.

However, this high level of training and responsiveness may lead to issues for members when exiting the ADF. After years of operating in environments of escalated threat, having to downgrade perceptions of a threat and manage their responses can be difficult. Ex-members are also known to experience difficulty in appreciating the need for balance in arriving at a decision, especially where security is involved or where decisions are arrived at over a long period of time. Where leadership structures and systems are fluid and less well defined than the military norm, ex-members may be challenged and frustrated. Where decisions are arrived at through processes of negotiation, input and consensus, ex-members may have difficulties with these inclusive approaches as this contrasts strongly with expectations of compliance with orders within the ADF.

Not all members of the ADF experience direct combat activities as a result of their service. However, they will generally have experienced the same training and preparation for a potential role during deployment.

These generalisations are designed to provide areas of potential rehabilitation red and yellow flags for practitioners during the assessment and plan development phases of a rehabilitation intervention.

5.2 Psychosocial Factors

The ADF system is renowned for its highly trained, equipped and supported workforce – a level of training, provision of equipment and services not normally found in the civilian sector. Ties they had in the ADF may be lost. This could result in little or no social support if they are unable to depend on family members due to location/poor relationships/lack of family understanding of their ADF experiences. Therefore, some military personnel discharging into a new community, location and employment may find difficulty with adapting to providing for their own retraining, securing accommodation, negotiating medical treatment, applying for health insurance and other basic life needs.

Successful adjustment to a new life in a civilian world will depend on an individual’s capacity to recognise and acknowledge their military transferable skills and forgo those elements of the military culture that could detract from adjustment to civilian and community life.

5.3 The ADF System

As discussed at §1, ADF training is unique and unlike what most people encounter. It is important to be aware of what Service the individual is from to understand their experiences of daily work within the ADF. These experiences will be influenced by their Service, training, postings, deployment, circumstances of their exit (voluntary or involuntary), and their experiences of Service life. Following are some general considerations.

5.3.1 Training

As their careers develop members of the three Services undertake lengthy training on the job, individually and collectively, to enhance their effectiveness as individuals and
as sub-units and formations. This training usually takes place on exercises, within the area they are posted, interstate or overseas. Training for career development purposes is also a feature of service life. Career development courses are conducted by each of the Services, so that individuals have the opportunity to advance within their occupation and their service. Attendance at career development training is usually by selection and is rarely “automatic”. Describing these courses is beyond the scope of this document given the complexity of the occupations and career matrices in each Service. Individuals do have the scope to negotiate their career development plan with their career managers and the chain of command, but performance on the job, relative seniority, availability of positions, and the needs of the Service are also important factors which will have an influence.

5.3.2 Skills

Many ADF members will have gained recognition for civilian professional or trade qualifications (e.g. health professionals, carpenters, mechanics, drivers, and clerks) on the basis of training undertaken in the Services. Some ADF members have skills, which are specific to their military employment (e.g. infantry riflemen, artillery gunners, RAAF fighter controllers) which are not accredited by civilian organisations. Others need further training to achieve civilian qualifications.

ADF personnel develop skills such as leadership, management, timelines discipline and the capacity to follow orders through their service.

5.3.3 Postings

Upon completion of their induction and initial occupation, ADF personnel are posted to a unit or ship. Their living circumstances may be with or in very close proximity to their workmates especially early in their career. Postings are generally for two to three years, but this can vary considerably. Because of the nature of their service it is likely that they will work and socialise largely with workmates or service people, as will their families. The typical posting cycle for most officers is two years. In contrast, personnel posted to artillery, armoured or infantry units may be in the same location for several years, whereas those posted to administrative, workshops or logistics units are likely to have shorter posting cycles. For RAN and RAAF personnel, depending on their occupation, their posting flexibility may be limited to a few bases, and may have served in only two or three regions of Australia over a lengthy career. Some postings require members to work mainly with civilians (e.g. clerks and health professionals), some do not have any contact with civilians (e.g. infantry, those deployed on ships). Members who have worked with civilians are likely to have acquired skills and knowledge of civilian work practices not usually experienced in the military work environment.

All three Services post their personnel to capital cities as well as to remote parts of Australia with significant time spent in the field or at sea. This can require constant adjustment to being in the family home and being away from home, because extended time away precludes involvement in day-to-day responsibilities and activities.

5.3.4 Deployment

RAN personnel are usually deployed in ships based at Fleet Base East (Garden Island, Sydney) or Fleet Base West (Garden Island, Perth). Other ports from which ships deploy regularly are Darwin and Cairns. RAAF personnel are more likely to
have been deployed if they have been posted to bases in the north of Australia. Army personnel have experienced a high level of operational tempo in the last 15 years with some members deploying as quickly as within 12 months of their enlistment. It is not uncommon for Army personnel to have deployed multiple times to numerous theatres in the past 15 years including Timor-Leste, Solomon Islands, Iraq and Afghanistan. These operations have seen largely combat elements deploy (Infantry and Armoured (Calvary) units, as an example) with support from the ‘enablers’ such as logisticians, workshops, medical and administrative personnel. Additionally, humanitarian deployments to Fiji, Banda Aceh and Pakistan have also seen a number of logistical and health elements of the Army deploy. While the large majority of deployed personnel are male, many females have also been deployed and have worked ‘outside the wire’. These can include medics, aviation crew, cooks and in Afghanistan, those who volunteer to be part of the Female Engagement Teams (FET). The FET conduct outreach primarily through interaction with local women and children to learn about and report information on the local population. It should not be assumed that female veterans have not been exposed to potentially traumatic events.

Army has moved to a 36 month deployment window, known as the Force Generation Cycle, consisting of 12 month phases, specifically the Readying (preparing to deploy), Ready (deployment) and Reset (post deployment) phase. These phases include all aspects of preparing to deploy, from personnel, administration, equipment and corporate governance. While this 36 month cycle may work for the three manoeuvre Brigades (1, 3 and 7 Brigades who are comprised of combat arms such as Infantry, Artillery, Armoured etc.), the enablers will often move much quicker through the Force Generation Cycle and thus will often have a reduced Reset phase in which they can take leave, undertake compulsory promotion courses (which has a significant impact on the trajectory of their career) and spend time with family and friends. In recent years many reservists (from all three Services) have been deployed, serving alongside their full-time colleagues and returning to their civilian jobs and reserve roles on completion of the deployment.

On deployment, in addition to the hazards and dangers of operational service, the living conditions can be quite demanding. The environmental conditions, sleeping arrangements, the food, meal times, and recreational activities and so on are very different to what people are normally used to. The environmental conditions can be quite basic at the start of a deployment, for example tents, stretcher beds and ration packs at the start of the ADF’s involvement, to a base with hardened facilities (to provide cover from rocket attacks) that includes air conditioning/heating and wi-fi facilities. Depending on the location of where an ADF member is deployed too, there can be vast differences in environmental conditions that can cause friction. For example, Infantry personnel may spend the majority of their deployment at a Forward Operating Base where they are on constant alert of rocket attacks, there may be only two ‘welfare’ homes to call home, no wi-fi and meals are dependent on what fresh and tinned rations can be flown in. This is in comparison to personnel who may be deployed to the rear of the theatre where there is no threat of rocket attacks, wi-fi and welfare phones are freely available and R&R (rest & relaxation) days can be taken every two weeks to a major tourist town. Culture shock can also set in,
especially where travelling or working in developing countries. This is particularly so for those who have never travelled overseas before. Living and working with military personnel from other nations can also be very demanding and stressful.

Whilst there is generally some notice prior to being deployed, there are many anecdotes about members only having limited notice, sometimes only days, to deploy. Prior to deployment there are many protocols to be followed and there is always a period of intense activity prior to departure. Often the preparation required for the deployment is such that there is only limited time to be spent with family and friends. This can increase stress, particularly where children are involved.

The Defence Community Organisation is involved in supporting the families of deployed personnel.

5.3.5 Rank and Command Structures

ADF members work within the structure of the chain of command. This requires members to communicate either up or down the chain. The structure consists of Commissioned Officers, Non-Commissioned Officers and other ranks.

Significant career focus is placed on achieving the role and status that goes with each of the successive ranks. In order to progress through the ranks, members have to have been on certain postings, completed mandatory as well as recommended courses, and achieved consistent and high ratings on annual written reports.
Increased responsibility, pay and prestige is attached to each rank. Some ranks are seen as key milestones. Not achieving these requirements, or moving to the next available rank can and does present significant career and psychosocial setbacks for individuals.

Under normal circumstances in the military environment, respect for rank, and communication through chain of command, would not see members from a mixture of ranks in the same setting calling each other by first name. Respect for rank is a key consideration in how people communicate with each other in the military context, and may also influence how ADF members communicate with others in a civilian context.

### 5.3.6 Discharging or Leaving the ADF

Discharge from the ADF can be either voluntary or involuntary, depending on the reason for discharge and the person’s individual circumstances.

- Voluntary discharge can occur as a result of:
  - career-related reasons such as wanting a change;
  - personal reasons such as fulfilling long-term plans;
  - family reasons such as their partner’s employment or children’s schooling.

Increasingly people are signing up for only a specified period (say 4-6 yrs) and are not inclined to stay in beyond this fixed initial period. This decision may be influenced by family circumstances, for example, because children are established in a particular high school or because of a partner’s career prospects. It is likely that these people would have a sense of control of
the process of discharge and considered plans for employment after their discharge.

Medical discharge occurs as a result of injuries or illness which prevents the member being able to meet the requirement for all military personnel to be fit for deployment. This does not occur without extensive prior treatment and rehabilitation. Administrative discharge occurs as a result of a determination by defence command that the member is no longer suitable to continue service. This may occur for a variety of reasons including disciplinary reasons, related to the inability to meet the service demands on behaviour (e.g., being involved in fighting, drug usage, or having difficulty forming part of the team), in training (inability to meet specified training objectives) or on the job performance (sometimes this may be as a result of clashes about job standards and expectations). An assessment of psychological unsuitability for retention in the ADF can influence an administrative discharge because it may reveal some of these difficulties.

Members who involuntarily discharge may experience denial, anger and betrayal according to the degree to which they have identified with their role as a military member. Other factors that impact on negative emotions include separation from friends and lifestyle, inability to achieve goals (e.g., promotion to a certain rank, to achieve a particular deployment or posting and the associated social standing or prestige attached to these) and capacity for transferring work skills.

5.3.7 Transition Services

Defence provides a range of support services to assist ADF members and their families planning to leave Defence to make the transition to civilian life as smooth and successful as possible. Transition Support Services are delivered through ADF Transition Centres located at major military establishments across Australia. More information can be found in the ADF Transition Handbook, a helpful guide for transitioning members, which can be accessed via the Defence website or via the following link: http://www.defence.gov.au/transitions/documents/ADF%20Transition%20Handbook.pdf

The Defence administered Career Transition Assistance Scheme (CTAS) is a potential benefit available to members and offers a wide range of assistance measures to facilitate the transition to civilian employment. Under CTAS, eligible members may access a suite of tools and services, depending on how many years served and the reason for leaving the ADF. More information on CTAS can be found on the Defence website at the following link: http://www.defence.gov.au/transitions/support/ctas/ctas.htm

5.3.8 Impact on Employment

Most ex-members effectively manage their discharge into the civilian workforce, sometimes in new locations and often into entirely new types of employment. For those who experience service related health issues, the quality of their work, their ability to apply themselves and their capacity to face challenges such as redundancy, declining physical health or work pressures (real or perceived) can be impaired, leading to frustration, anxiety, depression and poor work relationships.
Most ex-members experiencing service-related health conditions would prefer to remain in the workforce because of psychosocial and financial benefits in doing so. Leaving the workforce for whatever reason can therefore have a significant impact on the ex-member and requires quite an adjustment. This obviously involves a period of adjustment for significant others in the client’s life, including the ex-member’s partner, family and friends.

5.3.9 Circumstances Common to Medically Discharging ADF Members with Accepted Military Compensation Claims

The circumstances of a medically discharging ADF member, with accepted military compensation claims, are often very different to that of their contemporary civilian workforce members with a workplace injury. This adds to the complexity involved in the rehabilitation management process. The medically discharging ADF member often:

- has multiple injuries and accepted military compensation claims due to the physical demands of their ADF employment;
- may have already undertaken, or is currently undertaking, a rehabilitation program through the ADF;
- is highly skilled but may be unable to readily transfer their skills directly into the civilian workforce;
- has no guarantee of future employment;
- may have to find new civilian medical service providers;
- may have to geographically relocate;
- has a family who also requires relocation and support to adapt to the new location and requirements (schools, work, training etc) and change in security and stability;
- experiences the loss or close contact of their social support networks and activities such as sporting and cultural activities;
- requires assistance in securing accommodation and other essential services such as health and other community services, which are normally provided for them while serving within the ADF;
- experiences a significant loss of identity as they move from ‘military culture’ into civilian life; and
- experiences major difficulty adjusting to their new circumstances, resulting in anger and frustration.

For more information about the potential impact of a client’s military experience, you may like to access the Understanding Military Culture course, available through DVATrain and can be accessed from this page: [http://www.dva.gov.au/providers/online-training-health-providers](http://www.dva.gov.au/providers/online-training-health-providers)
6—In Summary—Typical Issues Faced by DVA Clients

Some of the major issues which may be experienced by DVA clients and need to be addressed by rehabilitation intervention include:

- changes in location/residence;
- rural clients may move back to an area of low employment opportunities and limited services;
- impacts on family (for example children having to change schools);
- the need to re-establish support/social networks in a new home location;
- the medical discharge process can affect attitudes to rehabilitation;
- a loss of identity associated with rank, unit, role;
- expectations may be based on Defence culture which may create barriers to moving to self management of their injuries or illness;
- being used to receiving allowances and pay, now on compensation payments until employment income resumes;
- unreasonable expectations of what DVA is able to provide;
- lack of civilian or non-military skills and experiences, particularly for younger clients;
- ex-serving members may have specific skills that don’t “fit” easily into work in the civilian world;
- difficulties with civilian employers recognising the skills that ex-serving members have developed over their military career and how they transfer to the civilian workforce;
- multiple injuries/conditions which may complicate treatment and rehabilitation;
- a loss of physical function which could subsequently impact day to day activities such as self-care, sleep, home maintenance etc.; and
- associated psychological issues that may create barriers to rehabilitation and recovery.
This section describes a typical DVA rehabilitation client who may be an existing or former member of the ADF who has become injured or ill as a result of their service in the ADF. While injury can occur during active operations, a large number of injuries are a result of non combat operations or training. Please note that the following chapter is intended as a general guide only, and does not reflect the diversity within the ADF. It is included to provide some context for the clients that may be referred to you.

7.1 Demographics
- Generally tends to be young, male, married with family.
- More typically of Anglo-Saxon background, English speaking at home and identifies with dominant Australian cultural characteristics.
- Interruption to earning capacity for the family unit as a result of injury.
- The need to relocate from Defence housing after discharge from the ADF.
- Female veterans are a growing client group, reflecting the changing demographics of the ADF.
- Reservists provide an important resource of skills and personnel that is drawn on for operational requirements.

7.2 Injury Pattern
- For those injured while on deployment, multiple physical injuries along with secondary conditions, such as mental health conditions, are common.
- Clients may under-report injury whilst serving (including during training) and discharge with a range of poorly treated and poorly managed musculoskeletal and other injuries.
- Clients may report injuries or conditions to DVA many months or even years after discharging from the ADF.
- There is a greater awareness of post traumatic mental health conditions which can arise from a range of issues, including deployments (single or multiple).
- May have undergone some form of rehabilitation while serving – most commonly medical management rehabilitation or occupational rehabilitation with a focus on returning to ADF duties.
- Those particularly at risk of a secondary condition are clients who find the rate of recovery slower than expected, the transition to civilian life difficult or settlement of their compensation claims is prolonged.
- Sometimes lower levels of perceived pain while serving, and an attitude that it’s important to keep going despite pain, can often disguise an underlying injury or condition.
- Clients may have higher expectations of recovery/ functioning and return to work which can create barriers to longer term recovery if these expectations are not met, especially as they transition out of the ADF.

7.3 Attitudes and Expectations
- Clients may exhibit high levels of anger and resentment at ‘losses’ experienced – these include the loss of their military career as well as functional or lifestyle losses as a result of their illness or injury.
- The medical discharge process can affect attitudes towards rehabilitation and DVA particularly where clients feel unhappy about being discharged.
- Unreasonable expectations of what DVA is able to provide are common – some of these expectations are a result of differences between the structure of military culture and the uncertainty of civilian life.
- After having all medical/rehabilitation provided for in the ADF, regardless of whether their condition is related to
service or not, creates a strong culture of entitlement to benefits and the expectation that DVA will provide more than it can.

- DVA staff confirm that some clients demonstrate a limited ability to self-motivate and take responsibility for their own health and rehabilitation, due to a strong conditioning to a command and control structure while in the ADF.
- Some clients experience a significant loss of identity, confidence, self-esteem and connection (associated with rank, unit, role) following discharge.
- Some clients may be dealing with many issues in their domestic situation as a result of the many changes enforced on the entire family unit as a result of disruption to their military career (for example, relocation, loss of connection to the ADF community for all members of the family and changes in their employment situation).
- Reservists may see themselves as a unique group within the ADF, which may impact on the way they seek information about their entitlements and access and engage with rehabilitation support.
- Reservists may also experience disruptions to their civilian career which has the potential to compound the impact of their service related injury or illness.

### 7.4 Social Support and Geographic Issues

- Clients typically experience high levels of social support and engagement while serving.
- Clients may need to set-up new support/social networks post discharge at a time when they are feeling vulnerable.
- Younger men often have difficulty dealing with the transition process leading to medical discharge from the ADF.
- Clients with family post discharge may be more successful in developing social networks away from the ADF. This can have ramifications on the client’s outlook and mental health status.
- Change of social and family dynamics can impact on clients’ self-esteem, confidence and mental health status after discharge.
- Change in location/residence is common following discharge which can lead to disruption and an inability to effectively participate in any rehabilitation.
- Relocation of family into new communities and schooling is commonly required.
- Clients commonly experience relocation issues related to housing availability and cost of living issues in capital cities.
- Sourcing and establishing of health service providers may be required. This can be a big change to clients who were able to access health services on base whenever they needed it (for example, many ADF members may not have a Medicare card as they do not need one to access health services while serving).
- Rural/remote clients may move back ‘home’ to an area of low employment opportunities and limited services once they discharge from the ADF.

### 7.5 Skills, Training and Work

- Most former ADF members are highly trained and exhibit positive work attitudes.
- Most former ADF members possess a team oriented work style but can experience difficulty in accepting loss of control post injury and post discharge.
- Some former ADF members will be able to return to their previous type of work with some retraining.
- Some former ADF members may have unrealistic goals for return to work such as wanting a full-time high paying role even though their condition restricts the hours they can work and/or they lack the relevant qualifications/experience.
- Some former ADF members may have highly transferrable skills which are highly desirable in civilian settings.
- Some former members may have limited scope to transfer their military skills to civilian jobs (i.e. infantry trained personnel) without some retraining/vocational rehabilitation.
- Skills recognition by civilian employers may be an issue due to lack of understanding about the skills that ADF members have developed over their career.
- Some former members will need to deal with loss of identity (associated with rank, unit, and role).
- Client’s military experience may result in issues fitting into an inclusive decision making workplace as this is in marked contrast to the military culture in which they have previously worked.

### 7.6 Finance and Legal Matters

- Clients are accustomed to receiving allowances to supplement their military pay.
- ADF personnel receive significant financial injection through allowances and tax incentives when on deployments.
- Cost of living is insulated whilst serving through entitlement to allowances and subsidies for meals, beverages, accommodation etc and comprehensive health care coverage that is provided to serving members.
- Financial issues can arise when clients are in the process of discharge for many reasons including:
  - changed support for day to day living expenses by employer;
  - relocation and/or readjustment costs for family and individual; and
  - difficulties in decision making about the future and the best options for management of compensation payments.
7.7 Veterans’ Vocational Rehabilitation Scheme (VVRS) Comparisons

The VVRS is a free and voluntary rehabilitation program to help eligible veterans under the VEA. Help can be provided with specific vocational issues, such as those transitioning from military to civilian employment and those who may experience difficulty in obtaining and/or holding civilian employment. Eligible veterans who have been out of the workforce for some time and require support and pension protection while attempting to retrain and re-enter paid employment are suitable candidates for this vocational rehabilitation scheme. The VVRS may provide vocationally oriented services such as:

- an assessment to determine work opportunities,
- advice on job seeking or support to secure a job at risk, or
- assistance in finding work or upgrading skills.

Through DVA’s comprehensive rehabilitation assessment process clients with other non-vocational and more general rehabilitation needs may be referred to appropriate DVA or community services.

7.8 Experience of Part-Time Reservists

- Part-time reservists may be required to switch between civilian and military employment;
- Tension may arise between reservists and civilian employers to obtain time off work to partake in ADF training and exercises;
- A part-time reservist’s civilian career and employment may be in jeopardy due to the impact of a service related injury or illness;
- The same support mechanisms available to full-time service members are not accessible to reservists. For example, access to health care and support while transitioning out of the ADF may differ.
- Part-time reservists may not identify as regular serving members, which can impact on the way they access information about their rehabilitation entitlements and seek help.
8—The Role of the DVA Rehabilitation Coordinator

The DVA rehabilitation coordinator is a link between the client, their treating medical practitioners, allied health workers, service providers, training organisations and the managing rehabilitation provider.

DVA rehabilitation coordinators are committed to ensuring that a client’s rehabilitation will be coordinated, integrated and adequately resourced to achieve positive outcomes. DVA rehabilitation coordinators will therefore work closely with rehabilitation providers to achieve these goals.

In order to ensure consistency in rehabilitation and treatment directions, interventions, and outcomes, key stakeholders involved in an individual’s rehabilitation need to be advised of the activities and plans that have been identified to improve functioning, return to work, or social engagement and ultimately contribute to that individual’s improved quality of life.

The DVA rehabilitation coordinator organises the program of activities for the individual involved in the rehabilitation process so as to aim to return the client to, as much as possible, the same social, vocational and educational status as he or she had before the injury or disease.

The typical focus of this role involves:

- ensuring a client centred approach is used throughout the rehabilitation process;
- ensuring that early intervention occurs;
- establishing and maintaining contact with the client and other key stakeholders and ensuring the client has access to appropriate information and services;
- researching and gathering information on the circumstances of the client;
- referring the client to approved external rehabilitation providers for assessments and development of a rehabilitation plan;
- formalising, approving, monitoring and reviewing rehabilitation plans and activities (including resource allocation and finances) up to and including plan closure;
- liaising with other business areas within the Department to ensure that the client is receiving their correct entitlements to compensation payments, treatment, transport support and other related benefits,*
- ensuring the client is aware of their rights and responsibilities under the relevant legislation, and documenting activities, decision making processes and maintaining appropriate rehabilitation case records;
- ensuring progress with the rehabilitation process, that momentum is maintained, and delays are minimised; and
- liaising with all key stakeholders and confirming that all activities and steps are implemented according to the recommendations of the treating practitioners or allied health providers.

It is expected that rehabilitation service providers will work closely with DVA rehabilitation coordinators and will be in regular contact with them, particularly if a client’s circumstances change, there are barriers to them participating in rehabilitation activities or they request further assistance. The underpinning principle is that DVA encourages rehabilitation providers to communicate with DVA rehabilitation coordinators at any time, regarding any aspects of a client’s rehabilitation plan.

*Further information about the interactions between rehabilitation and compensation can be found in chapter 12 of this pack.
As part of DVA’s Best Practice Principles, we encourage case conferencing for a range of circumstances, including:

- to enable reviews of rehabilitation cases;
- to focus on cases where some significant issues need to be resolved or there are barriers hindering the progress towards agreed rehabilitation goals; and
- to involve key stakeholders in monitoring and progressing rehabilitation goals and activities.

Case conferencing generally involves:

- a lead person to be identified prior to the meeting;
- the development of an agenda with clear objectives;
- the briefing of key individuals prior to the meeting, and
- ideally face to face discussions or, where this is not possible, the use of teleconferencing or video conferencing facilities.

Case conferences are usually initiated by either the rehabilitation provider or the DVA rehabilitation coordinator because of issues associated with the progress of the program/plan.

Rehabilitation providers are expected to use a range of reporting documents to ensure that rehabilitation coordinators are kept informed about a client’s progress. More information about these documents can be found in chapter 10 of this document.
9—DVA Rehabilitation Referral Process

9.1 Enhanced Early Intervention in DVA
DVA strives for more effective rehabilitation services and improved outcomes in rehabilitation through best practice. This includes:
- initial needs assessment screening by DVA staff*;
- early referral to service providers;
- appropriate and timely services based on assessed needs identified by rehabilitation providers, and
- improved reporting processes from assessment to closure.

*this assessment addresses all of the client’s rehabilitation needs, not just vocational.

9.2 Case Management Pathway
The following diagram, the DVA Rehabilitation Case Management Pathway, provides an overview of the processes and procedures that are taken as a client progresses through the DVA claims and rehabilitation system from the submission of a claim to closure of a rehabilitation plan.
9.3 The Rehabilitation Referral Process

It is the role of the DVA rehabilitation coordinator to assist recovery and enable the best possible rehabilitation outcomes for a client. One of the most positive steps in assisting with a client’s recovery is making a referral to an approved rehabilitation service provider for a rehabilitation assessment.

Under our legislation, a comprehensive rehabilitation assessment is required for all DVA rehabilitation clients, and assessments must be completed with recommendations for a rehabilitation program before any rehabilitation services can be approved.

An internal DVA screening process (needs assessment) covering rehabilitation and other needs is an important first step in understanding where the client is at. This needs assessment is undertaken by a designated DVA staff member, normally within 14 calendar days of acceptance of liability for a service related injury or illness. If the client is still a serving member of the ADF, a needs assessment review will also be conducted when they discharge from the ADF. This assessment helps to provide an overview and understanding of a client’s current circumstances and needs. If the client’s circumstances change, a needs assessment can be done at any time.

Once the decision has been made to refer a client, an approved rehabilitation service provider is sought to undertake the assessment of the client’s rehabilitation needs and capability to undertake rehabilitation. Once a referral is made, the rehabilitation provider is required to acknowledge receipt and acceptance of the referral by return fax within 24 hours.

The DVA rehabilitation coordinator is expected to provide the rehabilitation service provider with a case summary and attach copies of relevant and appropriate information sourced from the client’s file such as medical reports and any relevant information from the needs assessment.

The following mandatory timeframes apply:

- seven calendar days for the service provider to contact the client and begin the assessment process; and
- twenty-one calendar days for completion of the assessment report and provision of the report to the DVA rehabilitation coordinator.

These timeframes are outlined in DVA rehabilitation reporting guidelines.

The DVA Rehabilitation Coordinator is expected to ensure that:

- the client is to be kept informed of the referral process, both directly and in writing;
- all relevant discharge information is included with the referral to allow the rehabilitation process to be streamlined – eg. plans for vocational options, training completed, services required, whether an Activities of Daily Living assessment was completed before discharge, results from Vocational/Functional Assessments undertaken whilst in the ADF;
- client confidentiality is maintained; and
- the client’s progress is monitored through the referral process to completion of the assessment.

9.3.1 Identifying Rehabilitation Clients

DVA identifies potential rehabilitation clients in a number of ways:

- through a needs assessment, following acceptance of liability for a service injury or disease. The needs assessment must consider medical management, psychosocial and vocational rehabilitation needs;
- an ADF rehabilitation coordinator may identify that a serving member is considering separating from the ADF because of ongoing medical issues. This would impact on the member’s ability to fulfil the duties of their position, and may therefore lead to them being medically discharged;
- the medical discharge process and any transition management intervention readily identifies clients leaving the ADF who may need rehabilitation assistance from DVA;
- through a review of the client’s needs and current circumstances, once they have separated from the ADF;
- clients with an accepted claim for liability may request a rehabilitation assessment, or other assistance, at any time;
- a person with eligible service under the VEA may make an application for assistance under the VVRS;
- Ex-Service Organisation advocates or other legal representatives may refer a client for rehabilitation assistance;

continued next page
• clients with an accepted claim for liability may request assistance with activities of daily living that may include aids and appliances or assistance with household services. Any rehabilitation assessment arranged to consider these needs should also consider the broader rehabilitation needs of the client;
• any claim for incapacity payments should trigger consideration of the need to refer for a rehabilitation assessment to consider a client’s rehabilitation needs;
• SRCA clients who receive incapacity payments are referred for rehabilitation automatically once they have been in receipt of incapacity payments for three consecutive pay periods;
• medical reports from treating doctors, or independent specialists assessing permanent impairment or incapacity, may identify rehabilitation needs.

In each of these cases a referral to a rehabilitation provider for a rehabilitation assessment is expected to be made as soon as possible to facilitate early intervention.

Further information about incapacity and permanent impairments payments can be found in chapter 12.

Mental Health and Rehabilitation

There is an increasing body of research and knowledge in the rehabilitation and mental health sectors about issues associated with addressing a client’s mental and physical wellbeing. DVA believes that the biopsychosocial philosophy to injury management that provides programs tailored to an individual’s needs has the best chance of maximising recovery and return to work outcomes.

Military service involves a wide variety of domains in which mental and physical injury and illness can occur. The increased level of operational tempo and the nature of deployments experienced by the ADF since late 1999 (commencing with our involvement in East Timor and later in areas including the Persian Gulf and Afghanistan) have had a strong impact. Higher expectations and pressures have been placed on ADF personnel from all Services. The increased operational involvement meant a reduction in downtime between operational cycles and the reality of multiple deployments experienced by many personnel has impacted on physical and mental wellbeing. A flow on effect of this, combined with general service, is a growing percentage of DVA clients with a greater potential for physical and mental health issues being referred for rehabilitation.

DVA requires providers to be aware of the unique nature of military service and how this influences a client’s rehabilitation journey.

DVA’s approach to rehabilitation ensures that the necessary investigations are sought and issues are identified from the outset and as early as possible. DVA supports comprehensive assessments and seeks to ensure whole-of-person responses are provided in rehabilitation plans for those in the workforce, seeking to return to work, or those unable to work.

Assessment of mental health needs in the context of rehabilitation must seek to address the client’s recovery and assist in maintaining their general functioning in the home, the community and the workplace.
CHAPTER 10—MONITORING OF REHABILITATION ACTIVITIES AND PROGRESS

10—Monitoring of Rehabilitation Activities and Progress

DVA seeks to ensure best practice is achieved in monitoring progress towards rehabilitation goals and benchmarks and liaison and communication with all stakeholders. At each step in the process the client should be made aware of the rehabilitation activities and their rights and obligations in a clear and succinct manner.

Once a client has been accepted into a rehabilitation program, they work collaboratively with their rehabilitation provider to develop a plan that addresses their needs. Plans are developed taking into consideration the individual needs of the case. Therefore, these plans can run from only a few months to years. Regardless of the length of any rehabilitation plan it is important that the rehabilitation provider maintains regular contact with the client and the DVA rehabilitation coordinator. Plan reviews are completed at least every three months, or prior to the expiration of the plan, whichever comes first. This ensures that the costs and circumstances of the case are monitored on a regular basis. Progress reports must be completed every month to ensure effective monitoring of client contact and how the plan is progressing.

Rehabilitation providers have an important role in monitoring rehabilitation activities and progress towards rehabilitation goals. DVA’s expectation is that effective monitoring of rehabilitation activities and progress will involve:

- assisting a client to recover and return to capacity and functioning as quickly as possible;
- on-going communication with all stakeholders;
- being aware of the psychological factors impacting on the rehabilitation process*;

DVA's expectation is that effective monitoring of rehabilitation activities and progress will involve:

- considering the provision of structured counselling sessions to address psychosocial factors and the return to work process;
- exploring community programs available to assist the client;
- considering the inclusion of financial management sessions if this is impacting the client and the rehabilitation process;
- continuous reviews of strategies with stakeholders, in particular the client, treating doctors/specialists and allied health providers;
- observing, reporting, guiding and coordinating approved rehabilitation activities and sound recording of information that is passed on to stakeholders as appropriate (case notes are a vital source of updating events, developments and conversations);
- actions which ensure all rehabilitation activities are on track and achieving the planned outcomes of the program;
- actions which are vital in assisting a client to recover and return to capacity and functioning as quickly as possible;
- having regular review points with all rehabilitation activities;
- application of critical skills including organising and analytical skills, time management, communication skills, problem solving, documentation/case notes and reporting, technology application in order to access data and update case file records; and
- all parties involved in the client’s rehabilitation contributing to the monitoring of a client’s progress.

*Being aware of the psychological factors impacting on the rehabilitation process can mean that people may bring psychological overlay to rehabilitation, or that being in the rehabilitation process may result in stress and (additional) psychological consequences for the client.
10—Monitoring of Rehabilitation Activities and Progress continued from previous page

10.1 Goal Attainment Scaling Process and Reporting Documents

Goal Attainment Scaling (Scaling) is a model used in DVA's rehabilitation programs to determine appropriate individual goals for our rehabilitation clients, measure those goals against tailor made scales and, importantly, measure change and progress in our clients' functioning, employment, social and wellbeing outcomes. DVA provides instructions on using Scaling in Chapter 15 of the Rehabilitation Library in DVA's Consolidated Library of Information and Knowledge (CLIK). You can access CLIK here: http://clik.dva.gov.au/
rehabilitation-library

The following information relates specifically to DVA's expectations of each reporting document from rehabilitation assessment to plan closure.

The following documents are to be used for all DVA clients undertaking rehabilitation:
• Life Satisfaction Indicators (LSI)
• Rehabilitation Assessment Report;
• Rehabilitation Plan
• Rehabilitation Plan Amendment;
• Rehabilitation Plan Progress Report;
• Rehabilitation Closure Report;
• Return to Work Rehabilitation Rights and Obligations; and
• Non Return to Work Rights and Obligations.

Note: Refer to Chapter 15 in CLIK throughout this process. Further, all links to forms with Scaling can be found on DVA's provider webpage at http://www.dva.gov.au/health-and-wellbeing/rehabilitation/rehabilitation-service-providers#rd

Assessment Report

After accepting a referral, providers are expected to provide a Rehabilitation Assessment Report to the DVA rehabilitation coordinator. The report is expected to:
• determine the client’s capacity to undertake rehabilitation and appropriate whole-of-person rehabilitation activities;
• address ALL headings and matters raised in the template. Where an item does not apply to the client, the report should provide brief reasons as to why the heading is not relevant. The points highlighted in the comment boxes attached to each of the headings are to be used to guide the assessment process;
• identify the client–agreed expectations of, and barriers to, rehabilitation, and their level of motivation to participate in the process;
• include results from the client's completed LSI;
• acknowledge the general environment in which the client is living, socialising and working;
• include a comprehensive analysis of the client’s medical condition(s), current treatment and possible limitations and restrictions – evidence of input from the current treating practitioner(s) is essential;
• provide a detailed review of the client’s psychosocial status, including daily functioning needs;
• identify the client’s employment status;
• recommend rehabilitation interventions and actions that have been determined with the client and that are Specific, Measurable, Achievable, Realistic within a given Timeframe (SMART) which cover:
  - medical management, vocational and psychosocial interventions;
  - work conditioning to improve function, confidence and support a suitable and sustainable return to work;
- aids, appliances or modifications to the home or workplace required; and
- other items which may be relevant to addressing the individual's needs;
- identify immediate or urgent needs requiring advice to the rehabilitation coordinator by telephone contact;
- be completed within a 21 calendar day timeframe following the referral (unless an independent assessment is required for inclusion in the final report) and where required include the following provisions:
  - client contact will need to be established and the first assessment review meeting undertaken within 7 calendar days from the date of referral;
  - a Functional Capacity Evaluation, or vocational and/or psychosocial assessment will ONLY be undertaken at the time of the assessment following the recommendation and approval of the Rehabilitation Coordinator;
  - where urgent or immediate client needs are identified during the assessment process, phone contact should be made with the rehabilitation coordinator to discuss possible action required; and
  - negotiation with the rehabilitation coordinator is required to extend this timeframe where necessary, in exceptional circumstances.
- include the client’s name and claim number in the footer of the document;
- include all necessary supporting documents and reports,
- be signed-off by the rehabilitation service provider.

Rehabilitation Plan/Rehabilitation Plan Amendment
The Rehabilitation Plan or Plan Amendment is expected to:
- be numbered in consecutive order;
- ensure the case management process is documented clearly;
- be concise and not relay every action but provide a summary of essential detail;
- reflect the recommendations from the Rehabilitation Assessment Report;
- define the rehabilitation goals and timeframes;
- define the rehabilitation outcomes;
- identify all services or activities to be provided, specifying the timeframes for each;
- clearly identify who is responsible for the service and the expected outcomes;
- indicate the importance and challenge in achieving each goal;
- specify the costs involved, separating rehabilitation provider costs from third party rehabilitation costs;
- include the client’s name and claim number in the footer of the document;
- indicate expected dates for reviewing the progress of the plan;
- be signed off by the key parties identified on the form, and
- be distributed by the rehabilitation coordinator to key stakeholders following final sign-off.

Note: Refer to Chapter 15 in CLIK throughout this process.

Working Plan/To Do List
Where greater detail of the services or stages involved in the plan is required a working plan or to do list can be attached to the Rehabilitation Plan. Where a working plan or to do list is used, clear reference will need to be made in the related plan or amendment to ensure the linkage between the two documents is clearly established.

Copies of the working plan or amendment are to go to the treating practitioner(s), employer (if appropriate) and other key players (including parent or guardian for ADF cadets).
### Progress Report

The Progress Report is expected to:
- be submitted to the DVA rehabilitation coordinator monthly;
- include results from the client’s completed LSI at six monthly intervals;
- re-state agreed goals and objectives identified in the client’s rehabilitation plan or amendment;
- detail the current barriers to achieving the goals;
- score the goals in accordance with the Scaling information in CLIK;
- document plan objectives and interventions in the plan details table provided so that they progressively accumulate over time. This allows the reader to easily identify outcomes and status of interventions in chronological order;
- document developments or activities undertaken during a set period of the rehabilitation plan;
- be succinct and not provide a documentary on all actions but provide necessary detail;
- not be the rehabilitation coordinator’s sole source of information. It is important that major or significant developments are to be communicated to the DVA rehabilitation coordinator by the provider at the time of the incident or event, rather than waiting for the progress report;
- be provided every four weeks of the life of a plan or as agreed following negotiations between the rehabilitation provider and the rehabilitation coordinator;
- be numbered consecutively;
- include the client’s name and claim number in the footer of the document;
- be distributed by the rehabilitation provider to all stakeholders, identified by the rehabilitation coordinator;
- be signed by the rehabilitation provider; and
- accompany the monthly service provider invoice (which is to be attached to the progress report).

### Closure Report

The Closure Report is expected to:
- document all goals and objectives in the rehabilitation plan;
- include results from the clients’ LSIs;
- clearly state the reason(s) for the closure such as goals fully achieved or further rehabilitation services would not be beneficial, or the client has withdrawn from the rehabilitation program;
- score the final goals in accordance with the Scaling information in CLIK;
- include any final invoices for payment;
- be prepared after the client has demonstrated a sustainable outcome by achieving a functioning status at the post goal level for four weeks or as specified by the rehabilitation coordinator;
- include the client’s name and claim number in the footer of the document; and
- be distributed to all stakeholders by the DVA rehabilitation coordinator.

**NOTE:** Separate advice from the rehabilitation coordinator will be sent to the client confirming that receipt of the closure report does not mean the closure of their DVA claim, and that they are still entitled to claim ongoing medical and incapacity payments and other benefits.

### Managing Conflicts of Interest

DVA has revised its policy regarding conflict of interest matters relating to clients, DVA staff and DVA rehabilitation providers. Providers are required to adhere to their professional and/or organisational codes of conduct with these matters and are requested to inform DVA should they become aware of a conflict relating to them with key stakeholders.
11—Rehabilitation and Treatment Responsibilities for Serving and Discharged ADF Members

11.1 Health Care and rehabilitation in the ADF

Defence requires fit and healthy personnel who are ready to deploy on operations. Defence provides health services to ensure the ongoing physical and mental wellbeing of eligible personnel.

High quality health care contributes to the morale and confidence of troops, as well as acting as a public statement of assurance to families, the public and the international community. There is an expectation that ill or injured personnel will have access to the best health care that Australia can provide. Defence instructions and health policies stipulate the standard of health care expected for ADF personnel.

Defence provides comprehensive health care to entitled personnel. Health care encompasses preventive care, management of acute and chronic illness or injury, occupational fitness assessments and rehabilitation.

The ADF approach to rehabilitation and recovery is a comprehensive one aimed at restoring an individual member’s satisfaction with daily life following their wounding, injury or illness. This includes their psychological and physical needs as well as social, economic, employment, relationship and other needs. In the Defence approach, this includes a strong focus on activities that promote and maintain their physical, cognitive and emotional health, including ongoing contact and support with their Unit.

Defence uses the best practice rehabilitation biopsychosocial approach in the provision of workplace-based rehabilitation services to improve recovery outcomes. The model focuses on the dynamic interaction between biological, psychological and social dimensions of an individual’s overall health, wellbeing and capacity to function.

Rehabilitation services in the ADF are provided within a continuum of care from primary health care, specialist clinical rehabilitation services through to occupational rehabilitation services. Primary health care is important in the ADF care continuum because it represents the first point of contact that an ADF member is likely to have with the ADF health care system. It is at this level that most personnel will receive their first diagnosis and assessment of treatment required and it provides an important link to ongoing care management and more specialised secondary or tertiary treatment and rehabilitation services.

Defence, through the Australian Defence Force Rehabilitation Program (ADFRP), provides rehabilitation services for permanent force members of the ADF and reserve force members on continuous full-time service (CFTS) irrespective of whether a member’s injury or illness is related to work. The ADF is also responsible for providing rehabilitation to non-CFTS reservists who have an injury or illness that is related to their ADF service.

Defence delivers member-centric occupational rehabilitation services to assist ADF members to return to a state of readiness as soon as practicable after injury or illness. The ADFRP includes a thorough assessment and the management of the diverse biological, psychological and social factors involved in rehabilitation.
Occupational rehabilitation services focus on the following:

- Optimal physical and mental recovery of ADF members
- Returning ADF members to suitable work as soon as possible
- Returning ADF members to a deployable level of fitness
- Reducing human and economic costs of disability to members, the ADF and the community.

Defence works closely with DVA in a number of areas including rehabilitation case management practice, shared provider services and policy related matters.

DVA retains responsibility for some specific rehabilitation services for ADF members who are still serving. As a general rule, the need for these services will have been identified through a rehabilitation assessment conducted by an ADFRP provider.

The following paragraphs summarise DVA and Defence responsibilities for treatment and rehabilitation.

### 11.1.1 Full-Time Serving Members

**Defence Responsibilities for Full-Time Serving Members**

For serving members on an ADFRP, including full-time ADF members and reservists on CFTS, Defence carries the overall responsibility to provide for their member’s assessed rehabilitation needs including:

- medical treatment;
- medical aids and appliances;
- rehabilitation assessment;
- work related rehabilitation aids and appliances;
- non clinical aids and appliances (for example, showering equipment, grab rails, non slip mats);
- alterations and modifications to Defence Housing Australia (DHA) accommodation; and
- delivery of occupational rehabilitation programs.

**DVA Responsibilities for Full-Time Serving Members**

DVA can provide the following rehabilitation assistance to serving members:

- assistance through DVA motor vehicle assistance schemes to enable the client to drive in safety and reasonable comfort (includes vehicle modifications, or where specific criteria are met and a client is severely injured, provision of a new vehicle);
- household services (services of a domestic nature to assist a client to manage the proper running and maintenance of their household);
- attendant care services (services that are required for the essential and regular personal care of the client); and
- household alterations of private (non DHA) accommodation (alterations to a client’s place of residence, education or work to enable freedom of access and movement, and the safe use of facilities).

DVA may also provide certain aids and appliances in specific circumstances. The DVA Rehabilitation Coordinator will be involved in negotiating with the ADFRP to enable this to happen.

### 11.1.2 Part-Time Reservists

The ADF has overall responsibility for rehabilitation for part-time reservists while they are still serving. However, DVA retains responsibility for some treatment and rehabilitation services...
once liability has been accepted for the person’s service related injury or illness. Once the person discharges from the ADF, DVA becomes responsible for their rehabilitation. Further details are provided below.

**Defence Responsibilities for Part-Time Reservists Still Serving in the ADF**
Defence provides early intervention treatment and is responsible for coordinating occupational rehabilitation for part-time reservists with a Defence service related injury or illness until their successful rehabilitation or their medical discharge from the ADF. Once DVA accepts a part-time reservist’s claim for liability for a service related injury or illness, DVA becomes responsible for covering all ongoing treatment costs.

**DVA Responsibilities for Part-Time Reservists Still Serving in the ADF**
Once DVA accepts liability for a service related injury or illness, DVA is responsible for the funding and provision of the following assistance:

- medical treatment for the client’s service related injuries or illness;
- assistance through DVA motor vehicle assistance schemes;
- attendant care services;
- household services; and
- household alterations.

In order to gain access to services from DVA, an ADF serving member with an accepted claim must have undergone a specific assessment by an ADFRP Rehabilitation Consultant.

All requests for vehicle modifications, or where specific criteria are met, a new vehicle, must be supported by an assessment and report from a Driver Trained Specialist Occupational Therapist. All assessments must be detailed enough to provide clear evidence of the clinical need for the services that are being recommended or requested.

If you are experiencing difficulties in accessing support for serving ADF members, reserve force members on CFTS or part-time reservists, please discuss this with the DVA rehabilitation coordinator.

**11.2 Discharged ADF Members**
Once an ADF member is discharged, DVA is responsible for all components of their rehabilitation. This includes psychosocial rehabilitation, medical management rehabilitation plans and vocational rehabilitation aimed at returning a client to sustainable employment.

DVA is also responsible for providing the following services where there is clear evidence of clinical need, and where the need results from the client’s serving related injury or illness:

- household services;
- attendant care services;
- assistance through DVA motor vehicle assistance schemes to enable the client to drive in safety and reasonable comfort (this must be supported by an assessment from a Driver Trained Occupational Therapist);
- provision of aids and appliances to assist a client to reach rehabilitation goals; and
- alterations to a client’s place of residence, education or work to enable freedom of access and movement, and the safe use of facilities.

Policy and procedural information about the services and benefits that are available to DVA’s rehabilitation clients are published in the Rehabilitation Library in DVA’s Consolidated Library of Information and Knowledge (CLIK) at: http://clik.dva.gov.au/rehabilitation-library

continued next page
12.1 Treatment
DVA rehabilitation clients who have had liability accepted for a service related injury or illness may also be eligible for treatment at the Department’s expense and for a range of compensation payments. Specific eligibility criteria must be met before clients can access these benefits. These treatment benefits may include:

- a repatriation card for all conditions (Gold Card) which entitles the card holder to treatment for all of their health conditions at DVA expense, or
- a repatriation card for specific conditions (White Card) which entitles the card holder to treatment for specific conditions related to their Defence service at DVA expense; or
- a White Card for treatment of non service related medical conditions including diagnosed post traumatic stress disorder, anxiety and depression, malignant cancer and pulmonary tuberculosis at DVA expense. There is no requirement for a client to lodge a compensation claim in order to access this assistance.

More information about the types of health services eligible DVA clients can access is found in factsheet HSV01 Health Services Available to the Veteran Community, available through the DVA website at factsheets.dva.gov.au/factsheets/

In addition to support available through repatriation health cards, DVA offers a range of assistance for clients with mental health issues including:

- the Veterans and Veterans Families Counselling Service (VVCS) – the VVCS provides counselling and group programs to Australian veterans, peacekeepers, their families, eligible current serving ADF members and F-111 workers and their families. It is a specialised, free and confidential Australia wide service;
- on line access to information and support through the DVA At Ease website http://at-ease.dva.gov.au/
- PTSD Coach Australia – a mobile app to help client’s learn about and manage symptoms that commonly occur after trauma – for more information see http://at-ease.dva.gov.au/veterans/resources/mobile-apps/ptsd-coach/
- High-Res – a mobile app to help client’s learn how to manage stress and build psychological resilience – for more information see http://at-ease.dva.gov.au/veterans/resources/mobile-apps/high-res-app/

12.2 Financial Support
The following compensation payments may also be available to DVA rehabilitation clients where specific eligibility criteria are met:

- incapacity payments – economic loss compensation payments due to the inability (or reduced ability) to work, because of a service injury or illness; and/or
- permanent impairment payments – compensation payments for impairments that are likely to continue indefinitely because of a service injury or illness.

The interactions between compensation payments and rehabilitation can be complex. For example, a client may continue to receive incapacity payments while they remain on an approved rehabilitation program, or are receiving treatment for their service related injury or illness, even if they are no longer incapacitated for employment or able to engage in work at the same level as their previous employment.
If a client fails to undertake a rehabilitation assessment or program without reasonable excuse their right to compensation (but not treatment) may be suspended. Compensation payments include both incapacity payments and permanent impairment payments. It is therefore important that the DVA rehabilitation coordinator is advised as soon as possible if a client stops participating in their approved rehabilitation activities or attending scheduled appointments. More information about incapacity payments and permanent impairment payments can be found in the following factsheets available from the DVA website at http://factsheets.dva.gov.au/factsheets/:

- MRC08 Benefits for incapacity for service or work
- MRC07 Permanent impairment compensation payments

### 12.3 Transport/Travel and Accommodation Assistance

DVA can provide rehabilitation clients with assistance with transport, travel and accommodation in particular circumstances.

Decisions about eligibility for assistance are generally made on a case by case basis. However, the sorts of assistance that could be provided may include:

- reimbursement of reasonable travel and accommodation costs where a client is required to travel to attend a rehabilitation assessment, or
- reimbursement of reasonable travel and accommodation costs where a client is required to travel to attend treatment for their service related injury or illness; or
- payment of travel or accommodation costs for a carer to accompany a client with severe disabilities to enable them to attend approved activities under a psychosocial rehabilitation plan; or
- payment of reasonable travel expenses to and from a workplace, where a client is undertaking unpaid work experience and there is clear evidence that the client is experiencing financial hardship.

It is important that requests for assistance with transport, travel or accommodation are discussed with the DVA rehabilitation coordinator in the first instance in order to manage client’s expectations.
13—Some Useful Organisation Contacts

You can find the details for some of the major ex-service organisations in the link provided below.

http://www.dva.gov.au/contact_us/Pages/eso.aspx

Support can also be provided by the following more recently formed not for profit charity organisations:

http://mates4mates.org/

http://soldieron.org.au/

14—The Last Word

This pack is a living document and will be amended from time to time to better meet your needs. Changes may also be made if policy and/or procedures change. It is therefore important that you check this pack from time to time to make sure that you have the most current version. The date of the last amendment is be clearly identified on the pack.

More detailed information can be found in DVA’s Rehabilitation Library in its Consolidated Library of Information and Knowledge (CLIK) at: http://clik.dva.gov.au/rehabilitation-library

We welcome your feedback or any comments you might have on the information in this pack. If you’d like to make any comments, please don’t hesitate to contact rehabilitation@dva.gov.au.