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**STAGE 2**  
**REPORT**

**Department of Veterans' Affairs**

**Service Needs of Contemporary DVA Clients**

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Roger West/ Sue Warth

WestWood Spice

21A Elliott Street

Balmain NSW 2041

Ph: 02 9555 4429

Fax: 02 9352 3443

Email: [rogerwest@westwoodspice.com.au](mailto:rogerwest@westwoodspice.com.au)

[suewarth@westwoodspice.com.au](mailto:suewarth@westwoodspice.com.au)

Website: [www.westwoodspice.com.au](http://www.westwoodspice.com.au)

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## Acronyms

The following acronyms have been used in this report.

Acronym	Meaning
ADF	Australian Defence Force
CASO	Casualty Administration Support Officer
DHA	Defence Housing Australia
DVA	Department of Veterans' Affairs
MRCA	Military Rehabilitation and Compensation Act 2004
OT	Occupational Therapist
PTSD	Post-traumatic stress disorder
SRCA	Safety, Rehabilitation and Compensation Act 1988
VEA	Veterans' Entitlements Act 1986
VVCS	Veterans and Veterans Families Counselling Service
WWS	WestWood Spice



## 1. Background to the project

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The context in which the Department of Veterans' Affairs (DVA) operates is changing. Younger clients, changing demographics, differing needs and expectations, and technological advances mean new ways of doing business. As part of its overall strategic planning, DVA is presently developing a number of improved models of service delivery focused on meeting the needs of current client target groups.

This work involves four specific program projects:

1. Dependants Service Model
2. Wounded/ Injured Service Model
3. Complex/ Multiple Needs Service Model
4. Mass or Multiple Casualty Service Model

It is anticipated that all four models will have a firm grounding in sound case management and be designed to respond flexibly to individual needs and circumstances, service planning and the provision of potentially long-term support.

An early task for the development of the *Wounded / Injured Service Model* is an exploration of the views of a sample of contemporary clients about their current experiences and their ideas about desired features in advance of the development of detailed model specifics.

WestWood Spice was engaged by DVA to conduct consultations with current DVA clients who would fit the target group for the *Wounded / Injured Service Model*.

A key focus of the WestWood Spice research was on exploring client views about preferred approaches to case management but it also covered the provision of DVA services more generally.

The project was divided into two stages:

- a. Stage 1 - An exploratory pilot stage which explored the views of five clients and tested the methodology for the research. The consultations for Stage 1 were held in late October 2011; and
- b. Stage 2 - Interviews with a larger cohort of 15 clients to broaden the pool of views which were gathered, and to identify themes in the responses. Stage 2 interviews were conducted from late November 2011 to late January 2012.

A Stage 1 report summarised the pilot findings and implications for the conduct of Stage 2. This report presents the detailed findings of the research from both Stage 1 and Stage 2 and the implications of these findings for the development of a new service model. A list of recommendations is also provided to guide the further work of DVA on the model.

The DVA Human Research Ethics Committee gave approval for the project in June 2011.



## 2. Methodology

Following ethics approval, DVA undertook activity to identify and recruit potential participants to be interviewed for the project. In late October 2011, five clients were selected and interviewed for the Stage 1 pilot consultations. The DVA project officer attended all Stage 1 interviews. Four of the five interviews were conducted face-to-face (in Townsville and in Sydney) with one interview completed by telephone. While the face-to-face interviews provided a richness of context and ease of communication, the pilot phone interview also worked successfully and this confirmed that it would be appropriate to utilise telephone interviews for Stage 2.

Subsequently, a further 15 individuals were identified for Stage 2. Consultations with these participants took place in the period November 2012 - January 2012. Three were face-to-face (in Sydney and Adelaide) and the remaining 12 were conducted by phone. DVA were also represented in Stage 2 consultations and one interview was also attended by the First Assistant Secretary, Client and Commemorations Division. The involvement of DVA personnel in the consultations allowed for the immediate follow-up of any current issues or difficulties which were raised.

Following each consultation, the WestWood Spice consultant prepared a summary of the key points from each interview and this document was provided to the participant via email. This gave an opportunity for participants to confirm that their views had been accurately recorded and to make any additional comments triggered by the consultation. Feedback from participants confirmed that they appreciated this step of the project. Only minor amendments were received.

### Participant characteristics:

Table 1: Gender & participation of partners

Stage	Male	Female	# Partners	Total
Stage 1	5	0	1	6
Stage 2	13	2	1	16
TOTAL	18	2	2	22

As can be seen from Table 1 above, the majority of people consulted were men. Two men were interviewed with their spouses. There were two women in the sample and some discussion of gender-specific issues has been included in Section 4 below.

### Geographic Distribution:

As can be seen from Table 2 below, there were people in the sample from all states and territories of Australia with the exception of Tasmania and the ACT. Some individuals who had received their injuries during overseas deployment had initially returned to military rehabilitation facilities, mainly in Queensland, but had subsequently relocated to their home state to be close to family. Section 3.5 touches on some issues which have arisen as part of relocation.

**Table 2: Geographic distribution**

State	Stage 1	Stage 2	Total
NSW	1	5	6
VIC	-	1	1
QLD	3	3	6
SA	-	2	2
WA	-	2	2
NT	1	2	3
TOTAL	5	15	20

**ADF Membership:**

As can be seen from Table 3 below, the majority of participants were members of the Army. There were two members of the Navy in the Stage 2 sample and one of the Stage 2 participants had served in both the Army and the Air Force.

**Table 3: ADF membership**

Service	#	%
Army	17	85%
Navy	2	10%
Air Force	0	0%
Army and Air Force	1	5%
TOTAL	20	100%

**ADF Service Status:**

More participants were currently serving members of the ADF than former members.

**Table 4: ADF service status**

ADF service status	#	%
Currently serving member	12	60%
Separated from ADF	8	40%
TOTAL	20	100%

**Time since Injury:**

There was some variation in the time since injury, with time since injury relatively short for most people. Sixty five per cent of participants were injured or wounded less than four years ago. One person had acquired their injury more than 10 years ago.

**Table 5: Time since injury across both Stage 1 & Stage 2**

Time	#	%
Under 12 months	2	10%
1 - 4 years	11	55%
5 - 10 years	6	30%
More than 10 years	1	5%
TOTAL	20	100%

**Nature of Injury:**

The nature of the injuries or impairment of all participants meant that they could generally be considered to have been seriously injured or wounded. As well as a wide range of multiple physical injuries, some in the Stage 2 sample also had a diagnosis of post-traumatic stress disorder (PTSD) or other mental health condition. Across the sample, there was a mixture of people who had injuries caused on operation or in peacetime service. This is shown in Table 6 below.

**Table 6: Injury/ wound related to operational/ peacetime service**

Service type	#	%
Operational	13	65%
Peacetime	4	20%
Operational + Peacetime	3	15%
TOTAL	20	100%

**Coverage under DVA legislation (VEA/ MRCA/ SRCA):**

As can be seen from Table 7 below, there was a wide variation of legislative cover for individual's injuries/ wounds.

**Table 7: Coverage under VEA/ MRCA/ SRCA**

Legislative coverage	#	%
One Act (MRCA)	12	60%
One Act (SRCA)	0	0%
Two Acts (MRCA/ SRCA)	5	25%
Two Acts (VEA/ SRCA)	1	5%
Three Acts	3	15%
TOTAL	20	100%



**Consultation topics:**

An interview schedule was developed for the project and this was included in the materials presented to the DVA Human Research Ethics Committee together with an appropriate client consent form. (A copy of the interview questions can be found at Appendix A.) The interview schedule guided the conduct of a semi-structured interview. Thus, not all questions were asked of all participants. The case management questions in particular were used as prompts or checks to ensure the comprehensiveness of discussions. Each of the broad areas in the guide was covered.

The duration of most consultations was in the range of 45-60 minutes.



## 3. Findings

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The findings from the consultations have been grouped under the headings below. Each is then discussed in greater detail and where appropriate, commentary is provided about the implications of the findings for the development of a new *Wounded / Injured Service Model*.

- Prior awareness of DVA
- Experiences on entry to DVA services
  - DVA/ Department of Defence interface
  - DVA claims processes
  - Accessing information
- Case management
  - Rehabilitation support - experience with external providers
  - Preferred contact channels
  - Case manager characteristics
  - Case manager turnover
- Transition
- Moving interstate
- The perspective of the female veteran
- Supporting families and family relationships
- Specific services and supports
  - Home modifications
  - Motor vehicles
  - Equipment
  - Domestic services

### 3.1. *Prior awareness of DVA*

There was a varied level of awareness of DVA services across the sample of people consulted, prior to their becoming a client of DVA. Some of the influencing factors included whether or not the person had participated in pre-deployment briefings which contained information about DVA and/or involved DVA guest speakers; prior family relationships with DVA such as experience with Legacy or a grandparent in WWII; and general community perceptions.

*"I thought DVA was for Vietnam Vets."*

Many respondents reported that they had limited familiarity with the work of DVA and the role DVA could play in providing assistance to them prior to the occurrence of their accident or injury.

*"It's all new to me."*

Even those with some familiarity with DVA reported that it took time to understand how the system worked.

*"It's taken 18 months to get my head around the process."*

A few of those consulted raised the issue of a poor image or reputation of DVA. However, actual DVA experience was often described as very positive, in contrast to rumour. Good early DVA responsiveness allayed misconception, but slow decision-making and time delays in delivering agreed outcomes e.g. items of equipment added to reputational problems.

#### **Implications for a new service model:**

A key message from the consultations was the need for an increased level of knowledge about DVA services amongst serving military personnel. An important channel of communication is the “pre-deployment” briefings which are organised. It is suggested that a joint DVA/ Defence approach to the dissemination of information about the respective roles which both parties play in the case of serious injury would enhance both veteran (and family) confidence and the smooth management of support should a serious injury eventuate. It was further suggested that pre-deployment information about DVA should be undertaken throughout the preceding 12 months, perhaps with a series of ½ to one hour briefings both open to families and as well as handing out information designed to be passed on to families. Another suggestion was for the provision of a comprehensive folder of information and copy of presentations in the same way as information is provided about Defence Housing Australia (DHA). One person emphasised the importance of letting people know that they should be maintaining good medical records as a matter of course.

### **3.2. Experiences on entry to DVA services**

In the aftermath of experiencing a severe trauma, respondents spoke about the challenges of their situation. With priorities of focusing on becoming well, adjusting to the level of injury and reduced capacity to take in day-to-day information, factors which caused difficulty included the numbers of people involved and understanding what their role was as well as the volume of information presented. Sometimes, the timeframe in which people were expected to make decisions was too fast.

*“It was hard to know who was who and what they were responsible for.”*

*“Don’t rush the process, give people time to get over their injuries.”*

In the early days, some individuals reported that they were very reliant on family members to make decisions on their behalf as they found the amount of information overwhelming and difficult to comprehend. Some mentioned the difficulties of trying to process their situation and options against the backdrop of post-traumatic stress disorder (PTSD) or a brain injury. A service model which is welcoming and inclusive of family involvement is universally important, but particularly in these circumstances.

#### **3.2.1. DVA/ Department of Defence interface**

The consultations painted a picture of some confusion about the ownership of responsibilities for different elements of the recovery/ rehabilitation process for veterans who are seriously wounded/ injured but are still serving members of the military. It was said that good Defence and DVA connections need to be in place from the outset.

*“All the groups should get together at the point of injury. Each case is separate. There is a need to work out what will work best.”*

There was strong support for the on-base DVA advisor role in beginning this process.

For some, links to their Unit played a very important part in their support network, source of information and progress. There was a suggestion that a DVA representative be employed within the Unit or that there be direct communication between DVA and the Unit level to make for easier management of matters. Alternatively, it could be that right from the point of hospitalisation there is a case manager appointed for the individual from within the military who understands the whole system and is there to help get the best for the individual and to ensure that all liaison happens across the different organisations involved. It is important that this is the primary role of the person, not a secondary add-on role and it would be preferable if they were a familiar person from the Unit.

It was further suggested that DVA should participate in Welfare Boards - this would assist with planning for the future and creating better vocational continuity.

It was noted that Defence have made very good endeavours to keep people within Defence over the 2/3 years that their injuries may take to stabilise. Introduction of some form of shared DVA case management could streamline and better manage any subsequent transition out.

Lack of harmonisation of entitlements meant for confusion in the transition period prior to discharge with variations in both the supports available and the mechanisms for their access, depending on whether Defence or DVA were responsible. A particular example given was differing provision of transport support to attend university lectures (cabcharges vs a booked car and driver).

#### **Implications for a new service model:**

Better alignment of Defence and DVA entitlements.

A coordinated DVA/ Defence approach from the time of injury including the concept of a joint case manager.

#### **3.2.2. DVA claims processes**

A number of very positive initial experiences were reported. Good features included:

- Early acceptance of claim;
- Pre-completed paperwork;
- Initial contact at the hospital bedside;
- A sense that the person's case was being 'fast-tracked'.

This provided a strong sense of reassurance for the person and was reported to contribute to a person's ability to focus on recovery early on with a sense of "I don't have to worry". Having a claim in and accepted and provision of initial support quickly following a serious injury would seem to be key ingredients for the commencement of a sound working relationship with the wounded or injured person.

Most of the individuals consulted had made use of an external advocate to assist with claims processes and navigating the DVA system. There was a view that it would have been good to have had access to a person who had such knowledge and skills but who was a DVA employee. As well as



the opportunity to develop a longer-term customer relationship, this would also improve individual confidence in the advice being received and develop a sense of being on the same team.

Nevertheless, the vast majority of those who had used advocates found them very helpful. One person mentioned that the independence from DVA made it easy to establish trust and that an advocate also provided good direction to help with the person's own research. There was only one mention of advice subsequently shown to not be in the person's best interests.

A range of difficulties with claims processes were mentioned including:

- A different DVA officer for each function;
- Part-time contact people with no one briefed as a back-up able to answer queries when the contact person is not at work;
- No proactive contact to the person to let them know where things are up to, or to reassure that work is still happening, even when there is no progress to report.

*"It's faceless. You are dealing with no one in particular."*

It was suggested that education needed to be provided to medical personnel who are providing information to DVA to ensure they provide the correct information e.g. by way of examples of paperwork. This would help in not disadvantaging the veteran through the failure of the medical personnel to provide the right information which had been the experience of two of the participants.

#### **Implications for a new service model:**

A speedy DVA response to a serious incident/ accident can set a good foundation for the development of a positive relationship with the client. The claims process as the first point of contact can make or break the relationship which is to follow. It is important that the expectations set up at this stage are able to be maintained.

One suggestion which was made was for the creation of a small team of people who are dealing specifically and only with serious injury claims. This would have the advantages of:

- Allowing them to become specialists;
- Giving the client a small group of named people to deal with who all know your situation;
- Fostering the development of positive relationships.

As mentioned above, another preference was for a single consistent DVA person (similar to the RSL advocate system, but internal to DVA).

A proactive approach to communication can help create a sense of "we're going to look after you" and facilitate a message that "DVA want to do these things for me". This is more beneficial than the onus being on the person with the severe injury or disability to feel like they always have to ask to get help. Several participants commented that they were quite reluctant to ask for help.

#### **3.2.3. Accessing information**

Access to information, especially in the absence of an advocate, presented challenges with people not knowing what they didn't know or what they should be asking. It was said to be difficult to understand "How the facts sheets apply to me". The suggestions above for a single point of contact within DVA could be linked to a process of individual explanation to each veteran related to their

particular circumstances. There could be provision of a comprehensive information booklet/ flow chart which explains everything and is available at the time of injury – tailored for each person.

Another information gap appeared to be in accessing a directory and/or information about appropriate health care professionals who are accredited with DVA, particularly in rural locations. A possible solution could be a DVA service provider on-line directory.

Another suggestion was using Wounded Diggers website as a portal (individuals who are still ADF employed can access the site at work both through the internet and the intranet).

- Have all forms available for download;
- Re-title/ re-organise fact sheets so content is clear.

It was noted that a recent Wounded Digger forum had been very useful with every Defence agency represented, but only one DVA representative.

Other information suggestions were:

- An information pack for discharge which included contact numbers and an entitlement list and information about 5 year pension reviews/ what to expect/ what happens/ who to call;
- Making DVA information/ marketing materials widely available e.g. in stands in waiting rooms on bases, in the pharmacy etc.

### **3.3. Case management**

All the consultations covered individual's experiences with case management and their suggestions for improvements in the future.

It was apparent that the concept of case management included a variety of somewhat fragmented roles which were undertaken in the provision of support to a seriously wounded/ injured veteran. Amongst these were:

- Casualty Admin Support Officers (CASO) – an Army position;
- Rehabilitation Coordinator – a DVA position which co-ordinates DVA rehabilitation matters;
- Case Coordinator – a DVA position provided as a single point of contact for clients who are identified as "at risk" and/or having complex needs to assist in navigating all DVA services and benefits; and
- ADF Rehabilitation Program Contracted Case Manager (external providers e.g. Konekt, CRS Australia).

Some individuals reported that they did not know who was their current case manager. There appeared to be some possible explanations for this. For example, staff turnover with a previous case manager leaving and a replacement either not assigned or the new person not having made any contact with the participant; infrequent communications leading to a loss of the relationship.

There was a suggestion that there should be a checklist/ role description of the support which a case manager is expected to provide - available both to the veteran and put on the website. This would demonstrate the comprehensiveness of the service delivery offering and also detail when there would be proactive intervention/ contact by the case manager. Irrespective of which of the various case management roles listed above is being discussed, it is critical that there is a foundation of empowerment of the person and their involvement in the decision-making process.

The consultations heard of one instance of a veteran being (mistakenly) called and told that he was being discharged when no such discussions had taken place. A single joint case manager as suggested above would help to coordinate these various functions and provide a more person-centred and seamless experience for the veteran.

### **3.3.1. Rehabilitation support - experience with external providers**

There was experience with contracted external case managers from both currently serving and discharged participants. Best practice appeared to have been those situations where an individual had been able to retain the same person as their rehabilitation case manager pre and post discharge. However, this was reported to have been organised at the request of the individuals concerned, rather than proactively offered to the seriously wounded/ injured person as an automatic choice. There would seem to be considerable benefit in smoothing the transition pre and post discharge through the maintenance of case manager relationships where these have been working well and there is a strong relationship in existence.

Some individuals had very positive experiences with contracted rehabilitation providers, whilst others reported poor experiences.

In addition to a general concern about lack of understanding of Defence processes, particular concerns mentioned included:

- Failure to keep in touch or repeatedly not being available when client has a query;
- Lack of appreciation of the impact of delays on the person and their family. One instance quoted was the impact of delays in house modifications on the timing of discharge from hospital to return home;
- Lack of confidence in the clinical decisions of providers. An example was failure to consult a neurological physiotherapist in decision-making about the suitability of exercise equipment for someone who had received a brain injury;
- The insecurity of short-term rehabilitation plans (3 months duration) for someone who has a whole of life/ long-term disability.

Another theme which recurred was a questioning of the cost and decision-making processes of outsourced rehabilitation. In the views of one participant, many meetings and consultations attract high fees, but produce little in the way of outcomes.

*“It’s just another firewall between DVA and the veteran.”*

### **3.3.2. Preferred contact channels**

There was strong support for the foundation of any case management relationship to be based on face-to-face contact.

*“One delegate requested a face-to-face meeting with us as he felt he could better explain the issues we were to discuss. This was excellent.”*

With respect to DVA relationships, the concept of a single point of contact was appealing. Indeed, some of the individuals consulted had effectively created a single point of contact structure for themselves by choosing to channel queries through a particular individual with whom they had

developed strong rapport. In some cases this was the continued use of an advocate who had assisted with initial claims processes, in others, an external rehabilitation case manager/ company and in others still, a DVA Rehabilitation Coordinator.

The second key message about contact was the desirability of proactive initiation of contact and associated follow-up on the part of officials. A regular touch-base, by phone (preferably) or email if need be was welcomed. Phone communication was described as preferable to letter as it sets up a two-way dialogue and "can put out fires."

### 3.3.3. Case Manager characteristics

*"It was clear that she cared about her job." (description of a DVA Rehabilitation Coordinator)*

Individuals consulted suggested that the new model needed a constructive approach with people in case management who are committed to their role in helping the injured veteran and their family, who are easily to approach and who recognise the uniqueness of each person.

*"On the same team."*

*"Wanting to help."*

*"All they want to do is stuff for us."*

The issue of choice in selection of case manager was raised during the consultations. Some supported the notion of the veteran having an initial role in the selection of a case manager; others felt it was more important to have the opportunity to change case managers if the relationship was not working, with some individuals reporting that they believed the current system was sufficiently flexible so that they could ask for a change if needed.

Some individuals reported that they had "sacked" their case manager; achieving this outcome for some appeared to be by force of personality, for others, electing to do without.

It was recommended that case managers have both case manager skills and social work skills. They should be well-networked and know other relevant health professionals who can be used. One suggestion was that DVA should cease outsourcing and employ their own dedicated rehabilitation coordinators to work in tandem with DVA case managers, thus developing good rapport and teamwork within the DVA office and with the veteran while saving money and improving service delivery.

Another characteristic mentioned was the need for the case manager to have the required experience and access to up-to-date information when providing advice on possible options so that sound advice could be provided e.g. in advising on options for hand-controlled motor vehicle modifications.

An important point to recognise is that some individuals will prefer to take a very active role in their own case management and processes should facilitate the person's desired level of autonomy/ self-management and provide support and back-up as necessary.



### 3.3.4. Case Manager turnover

Case managers may change because of staff turnover or because a person is returning to their home state or territory.

Sound hand-over processes were important and contributed to continuity of care and the development of a sound relationship with the new case manager. There were reports of good handovers with previous case managers introducing the new case manager and having a number of weeks of handover. However, some new case managers attracted particular criticism because of their failure to ensure that they organised an early opportunity to meet with the person face-to-face and to introduce themselves. Processes needed to be in place so that there was no need for an individual to "retell their story" or to re-provide medical proof.

### 3.4. Transition

A number of the individuals consulted were young people whose only vocational aspirations and experience was with the military and they were just beginning their careers.

*"I am currently being pushed to pick a career path. This is very difficult when you are young and all you know is the army."*

*"I felt safe under the Defence umbrella - the prospect of transitioning out was very daunting."*

Others who were still serving were concerned about their future income prospects.

The experiences of those consulted whose injuries had occurred less recently were instructive here. Key ingredients included:

- Reassurance that the costs of all care would be met;
- Encouragement and support to explore alternative vocational choices. This might mean for example, flexibility to undertake a (say 2 year) TAFE course and then to decide that this is not the career direction that you want to take ; options to sample a variety of work placements to get a better idea of potential vocational interests; organisation of on-the-job work experience to assist in securing employment; and
- Linkages with other younger veterans who have made the journey/ could take on a mentor role.

Amongst those consulted for this project, it was evident that there had been some contact and sharing of information amongst some people who have been seriously injured more recently. DVA could potentially play a role in creating a sense of sharing of experiences and greater proactive fostering of linkages amongst younger seriously wounded/ injured veterans. A systematic approach to this would be superior to ad hoc contact depending on who you know. Possible mechanisms could include:

- Face-to-face briefings/ information seminars;
- Video clips of ADF member's stories.

### 3.5. Moving interstate

Those who had returned to their home states spoke of the importance of returning home following their injury. It was noted however, that there are pockets of particular expertise amongst case managers with more extensive experience with seriously wounded soldiers e.g. in Brisbane and that there could be a place for mentoring of interstate case managers with less experience or possibly even assignment/ maintenance of an original case manager after the person has moved interstate.

One person reported a delay when their case file was closed in one state and needed to be restarted with all information resubmitted in the new state.

*“There was a two months delay. It felt like I had to start all over again. It was too much red tape.”*

Some issues around the movement of equipment with an interstate transfer were raised. The particular example was a hoist to assist with bed transfer which had been specifically acquired for the person, but could not be transferred with them. Factors appeared to be lack of clarity around who owned the equipment (Military Compensation or DVA) and whether it was “loaned” or given to the person.

## 4. The perspective of the female veteran

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Two of the seriously wounded/ injured veterans who were included in the consultations were female. This provided an opportunity to explore any gender-specific issues which should be taken into account in the development of a new service model. The key finding was a lack of a female-friendly focus.

*"I felt alone in getting better."*

This could contribute to a sense of isolation. An important element should be a choice for a female veteran to access a female rehabilitation coordinator/ case manager (in the same way as some women have a preference for female doctors). It was also suggested that the threshold for a female veteran to be able to access a case manager could possibly be lower/ more automatic.

*"It's really helped that she (Rehabilitation Coordinator) is female."*

Female isolation was also reinforced in the situation of services such as support groups or counselling sessions which were male-dominated. There appeared to be no courses specifically designed for women.

*"All the counselling groups are male counselling groups."*

*"I was embarrassed as a professional. It couldn't be happening to me."*

It was noted that the literature which was provided was written from a male member perspective. It was suggested that DVA awareness of females in combat zones could be acknowledged by the rewriting of literature to reflect both male and female perspectives. Another need was for information material to be developed which specifically addressed family and spouse concerns and was tailored to recognise that the injured person is female and the impact that this may have on family and domestic responsibilities.

It was hypothesised that some female veterans may be more reticent about reaching out for help and assistance than their male counterparts. A female may already have concerns about being seen as "weaker" than her colleagues and this could result in greater reluctance to ask for help and/or indicate that there may be a health problem. This could also be contributed to by broader cultural thinking in the ADF that may not necessarily be gender-specific – where a person may not feel like admitting they have an injury if they believe that there is a chance it could hold them back from advancement.

This further underscores the point made elsewhere in this report about the need for proactive support and follow-up on the part of all those involved in the delivery of DVA services.

### **Implications for a new service model:**

There should be a choice of female rehabilitation coordinator/ case manager for female veterans should they wish.

Information materials need to reflect the possibility that the wounded/ injured veteran is female and be written appropriately.

## 5. Supporting families and family relationships

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There needs to be recognition of family and the importance of family relationships and the role which they play in the recovery of someone who has had a major injury. Not everyone will have a partner, but it is reasonable to assume that almost without exception, people will have family.

For those with a partner, from the time of the initial injury, inclusion of a partner is a key ingredient to give existing relationships every chance to survive. For everyone, inclusion of family can avoid the situation where family members feel left out and helpless.

Family members may also need their own support e.g. to be able to access counselling.

*“There should be liaison with the spouse too and checking up on the kids.”*

*“It can be even harder as a spouse to ask for support.”*

In the case where the injured veteran is the sole breadwinner, there may be extra stress on the partner. In another example, the consultations heard of the beneficial outcomes of the provision of weekly Defence support groups for the children of some of the wounded veterans.

Information provided to family members should “demystify” some of the Defence/ DVA jargon which may be very new and confusing in a time of uncertainty.

*“A spouse information session would be good. It would help to prepare you mentally.”*

*“You need to have all the pieces of the puzzle in place.”*

It was suggested that letters advising of meetings with DVA/ CRS etc were addressed to both the person and their partner, specifically welcoming the spouse to attend.

Support with childcare both in a practical and financial sense can free family members to provide support to the injured veteran. Here the age demographics of the group of people who were consulted were instructive. Some had very young children of their own, while others were of an age where there were other younger siblings in the family who were still in the care of the veteran's parents. Support to meet these responsibilities could enable increased visits during hospitalisation through to making it possible for veterans to attend lifestyle weekends and similar events as needed.

Feedback from a member who had acquired their injury some time ago highlighted the need to review the levels of care able to be accessed. This is particularly relevant where a family member does not wish to take on a care provision role, or wishes to reduce their responsibilities for providing care.

### **Implications for a new service model:**

There may be a number of ways in which a spouse could be involved as part of the new service model. Examples could include:

- Encouraging connection to counselling services like Veterans and Veterans Families Counselling Service (VVCS) if a need is identified;
- Specific inclusion of information materials especially for families;
- Support with childcare to facilitate spouse participation in rehabilitation activities.

## 6. Specific services and supports

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As part of the consultations, participants were also invited to comment more generally about their other DVA services and experiences. While equipment and property maintenance experiences are not within the scope of the model development work for the *Wounded / Injured Service Model*, some useful comments were made and these are included in this section.

### 6.1. Home modifications

There were a variety of experiences reported with the organisation of home modifications. Some people recounted really good experiences; some had begun well, but were plagued by delays which impacted on the timing of the return home from hospital/ moving house. Some had an excellent initial experience but this was not repeated when they were posted or moved interstate.

In one instance there had been no follow-up to ensure that work had been satisfactorily completed, but incompetent work had subsequently been rectified after the client contacted DVA.

### 6.2. Motor vehicles

Motor vehicles and the independence this can provide the person were seen as very important and for many, an area which had been well-managed.

*"My DVA car was specially designed and has been brilliant. It gives me my own independence."*

Others had mixed experiences, including one person who described how they did their own research on options available and developed their own expertise about new alternatives (in this case, for hand-controls). This raises a concern that external providers may not always have the technical expertise/ latest information about the best technology which is available e.g. hand control options for motor vehicles, wheelchair options which will best suit younger, fit individuals. There were also reports of considerable delays in organising subsidies for car conversions.

### 6.3. Equipment

It was clear from the consultations that fitness was of major significance to this client group. Support for activities to maximise independence and wellness was welcomed. Some individuals reported good timely provision of home exercise/ gym equipment. This assisted with recovery and ability to train 24/7, at times convenient to them.

*"It was exactly what I needed."*

Others described difficulties in accessing home exercise equipment because they did not request it at the outset of their rehabilitation. This is another example where a proactive approach in suggesting options for individuals is preferable to a reactive system or to having someone go without because they don't know what they are entitled to.

One person mentioned that the cost of an assessment to access approval for a gym membership outweighed the actual cost of the membership.



It can be frustrating when small pieces of equipment which can add greatly to a person's independence take a long time to arrive. Larger items were also sometimes slow, for example a specialised bed which took 18 months before delivery. On the other hand, it was also reported that DVA approvals for a custom wheelchair to be built were very quick and the veteran concerned noted that this greatly aided in his recovery and positive mindset in dealing with his disability.

A sound suggestion which was made was for DVA to work together with the seven or eight major rehabilitation equipment providers to develop a number of packages of products suitable for particular levels/ types of disability e.g. provide a basic kitchen pack with appropriate knives, non-slip mats, one-handed tools/ implements; perhaps an enhanced pack for people doing a lot of cooking. (The packages could be described on the internet with choice options.) This would have a number of advantages:

- Significant cost savings as it avoids the expense of multiple reports from a case manager to justify acquisition of low cost items e.g. \$10 knife;
- Proactive - doesn't rely on the individual having to keep coming back to ask for help and accommodates those who are reluctant to ask for assistance;
- Needed items have already been identified and can be made available promptly.

There were reports of bills for equipment which had been approved and supplied being received at the veteran's home address.

#### **6.4. Domestic services**

Domestic, gardening and personal care services provided valuable supports to some people.

A gardener who assisted with tall hedges was reported to take a load of the mind of a veteran. An interesting example to foster independence was the suggestion of the purchase of a ride-on lawn mower in lieu of paying for a lawn mowing service.

For persons who are seriously wounded/ injured, DVA may like to consider making proactive contact as the time for renewal of domestic services entitlements approaches. This could be a simple check with the person to confirm that the supports were still needed and if so, streamlining their continuity. This appeared to be in place, through a proactive Occupational Therapist for one individual whose injury had occurred a number of years ago.

Information was given about unacceptable delays in the payment of gardening services and domestic cleaning which caused the cleaners to leave. Removal of lengthy delays in payments could be achieved by conversion from a reimbursement system to a prepayment option and/or introduction of an internet claim reimbursement system or preloaded "smart card".

## 7. Recommendations

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### 7.1. General principles

It is recommended that the following general principles underpin the new *Wounded / Injured Service Model*:

#### **Person-centred**

The seriously wounded/ injured veteran is at the centre of planning and support which is then organised to assist the person to achieve their maximum level of independence and autonomy. This means decision-making with the person at the centre of determining their life direction and support providers in a partnership relationship to assist with the achievement of identified and agreed goals.

#### **A proactive approach to the provision of support**

The framework for the provision of support is grounded in the notion that the DVA system takes the initiative for support offerings in consultation with the seriously wounded/ injured veteran and their family. This would range from early claim acceptance and pre-completed paperwork at the hospital bedside, through the offering of equipment packages matched to the person's disability and needs to pre-emptive renewal of domestic support services as appropriate.

#### **Valuing family relationships**

This means that the needs of families and the support of family relationships are considered in everything which is done.

#### **Single point of contact**

There is a designated person who is the primary contact point for the seriously wounded/ injured veteran. This could be someone in a case management or case coordination role.

#### **Defence/ DVA partnership**

Roles and responsibilities of the two agencies are clearly identified and made explicit to all stakeholders at the outset and a team approach taken to the planning of support on a person-centred basis.

### 7.2. Information provision

#### **Generic information**

1. Consider the development of a unified Defence/ DVA presentation/s which outlines the roles taken by each agency in the management of a serious injury. This could include development of a standardised presentation template and/or DVD to ensure a consistent message and/or the inclusion of a segment in pre-deployment briefings about DVA which feature presentations by injured veterans as guest speakers.

2. Open up attendance at pre-deployment information sessions about DVA to family members.
3. Review information materials for "female veteran-friendliness" and introduce specific materials as appropriate.
4. Distribute DVA information widely on bases.

### **Post-injury**

1. Develop a comprehensive written hard-copy information pack (and downloadable web-version) made available to the client and family at the time of injury outlining both information needed at the outset as well as an outline of the journey/ pathways which are likely.
2. Ensure communications are "family-friendly" and invite the participation of partners as appropriate.
3. Consider an on-line directory which provides information about location of relevant health care professionals who are accredited with DVA.
4. Investigate possible use of the Wounded Diggers portal or DVA website as an entry point for access to information and downloadable forms.
5. Consider use of social networking vehicles to facilitate, but not supplant, face-to-face client contact.
6. Consider mechanisms to harness the experiences of younger seriously wounded/ injured veterans who could act in support/ information sharing roles for others e.g. through:
  - a. Face-to-face briefings/ information seminars;
  - b. Telephone/ email/ social-networking contact;
  - c. Video clips of soldiers' stories.

### **7.3. Defence/ DVA interface**

1. Institute a joint Defence/ DVA planning process to plan the provision of cohesive support to a seriously wounded/ injured veteran based on the principle of person-centred planning from the time of injury.
2. Strengthen linkages between DVA and the Unit level within Defence.
3. Maintain and expand the on-base DVA advisor role.
4. Explore the scope for DVA to participate in Welfare Boards.
5. Explore the potential for harmonisation of entitlements between Defence and DVA.

### **7.4. Case management**

1. Develop a framework of support which could enable a seriously wounded/ injured veteran and/or family member to take on a self-managed case co-ordination role if they choose/ prefer.
2. Consider a joint DVA/ Defence appointment of a case manager from the time of injury.
3. Reinforce system flexibility so that a veteran may either choose their case manager and/or change case manager.
4. Ensure that female veterans can access a female case manager if preferred.



5. Provide a written checklist/ role description which details the support which a case manager is expected to provide.
6. Provide continuity of care across transition from Defence to discharge through maintenance of the same case manager/ access to same health professionals e.g. counsellors.
7. Provide continuity of care through relocation to a person's home state or territory through sound case manager hand-over processes and/or mentoring from a more experienced case manager.
8. Consider if there is a need for access to increased specialist skills for dealing with situations of limb loss injuries.

### **7.5. Communication**

1. Endeavour to provide all initial communication with a seriously wounded/ injured veteran on a face-to-face basis.
2. Provide proactive communication about expected timeframes and transition points and notification or feedback where there are to be changes or delays in these.
3. Provide a clear written rehabilitation plan which has both short (3 month) and longer term (12-24 month) goals.

## APPENDIX 1 – Interview Question Guide

# Research Project: The Service Needs of Seriously Injured/ Wounded DVA Clients

### Client interview questions

#### Introduction:

DVA is developing improved models of service delivery to better meet the needs of its contemporary clients.

WestWood Spice (WWS) is meeting with a number of current DVA clients such as yourself, to find out from you what service model features would suit you and your family best, both now and in the future.

We are particularly interested in finding out about what would make for good case management. What have been your experiences to date? What things do you think should be not-negotiable/ you must have? What features would help for flexible responses to be made to your individual needs and changing circumstances? We are also keen to gain a sense of the views/ interactions of family, if this is relevant to your circumstance.

#### What were your first experiences with DVA like?

1. What did DVA do well in terms of service delivery when you first became a client?
2. What about things that could have been done better by DVA in terms of service delivery?
3. Was there anything you would have liked done that you did not experience?

#### What have been your experiences to date?

1. Do you have a case manager at present? Have you had one in the past (i.e. at any time since your injury/ prior to this? [Clarify if the case manager was a Defence force person vs DVA case manager - while person in ADF?]

If person has had no experience of case management ... ask:

- a. How desirable do you think it would be to have case management?
  - b. How do you think it should work? Then move to ask any specific questions from the "How could case management work?" section which haven't been covered.
2. Based on your experience to date with case management, what things have you found to be particularly helpful, for either yourself or your family? [Anything in the way case management has operated/ been delivered?]
  3. And what things would you say have been missing from your experience to date which would improve case management? Do you think should be in place in a new model of support?



## How could case management work?

1. Frequency of contact:
  - a. How often would you like your case manager to be in touch with you? (Probe for:
    - i. As a matter of course/ minimum level of contact e.g. wouldn't like a month to go by without hearing from them?
    - ii. When your circumstances change e.g. change in residential arrangements? Change in employment/ daily activities? Change in health care needs?
    - iii. What contact should they have with members of your family?
  - b. Are there any circumstances in which you would feel that there is too much contact?
2. Type of contact:
  - a. What are your preferred types of contact?
    - i. Face-to-face
    - ii. By phone
    - iii. By email
    - iv. By Skype/ video-conference
  - b. Are there any particular circumstances in which one type of contact is preferable over another? Does it make a difference if the case manager is contacting you or you are contacting them?
3. Content of case management communications
  - a. What information do you think needs to be channelled through a case manager?
  - b. Should they be your primary point of contact? Do you need any other points of contact? For what sorts of information?
4. Where does the primary responsibility for contact lie?
  - a. Is it with you/ with the case manager/ with members of your family?
  - b. Is it different for different circumstances?
5. Decision-making processes about case management
  - a. Choice of case manager: How should the decision be made about who is your case manager? [Probe: should you be able to change case managers?]
  - b. What characteristics do you think are essential/ desirable for a good case manager?

## DVA services more generally?

1. Are there any other things which you would like to see more generally as part of DVA support? [Probe for assistance with child care for attending appointments, other possibilities?]

## Any other suggestions?

1. Are there any other things which you would like to see happen in a new model of case management/ new model of support for people in a similar situation to yourself which we haven't already discussed?