Australian Centre for Posttraumatic Mental Health

Australian Government Mental Health Lifecycle Package

A Study into the Barriers to Rehabilitation

Phase One Final Report, June 2009

THE UNIVERSITY OF MELBOURNE

Note

This document is a progress report for the Government's Mental Health Lifecycle Package "Study into the Barriers to Rehabilitation". It is the Final Report on Phase One of the project.

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Contents

Contents 3
Executive Summary 5
Introduction 15
Section 1: DVA client interviews 17
Introduction 17
Methodology 17
Findings 20
General overview of participating clients 20
Understanding and expectations of rehabilitation 20
Experience of rehabilitation 23
Facilitators & barriers to rehabilitation 24
Suggested areas for improvement 28
Summary 31
Section 2: DVA staff focus groups 33
Introduction 33
Methodology 33
Findings 34
Key components of rehabilitation 34
Experience working with rehabilitation service providers 36
Determining successful rehabilitation outcomes 39
Facilitators & barriers to rehabilitation 41
Suggested areas for improvement 45
Summary 47
Section 3: Survey of rehabilitation service providers 49
Introduction 49
Methodology 49
Findings 50
Organisational profile 51
Contact with DVA 53
Contact with other service providers 55
Standardised outcome measurement 57
Rehabilitation services delivered and assessment process 60
Perceived barriers to rehabilitation 63
Summary 66
Section 4: Key stakeholder interviews 68
Introduction 68
Methodology 68
Findings 70

Changes in approach to rehabilitation over time 70
Perspectives about 'successful' outcomes in rehabilitation 73
Standardised outcome measures 78
Barriers to rehabilitation 82
Facilitators to rehabilitation 87
Summary 90
Discussion 93
Key themes from phase one 93
Phase two of the project 95
Appendices 98
Attachment A: DVA Client Interview Documentation 99
Attachment B: DVA Staff Focus Group Documentation 108
Attachment C: Survey of rehabilitation service providers documentation 112
Attachment D: Letter of invitation sent to key stakeholders 157
Attachment E: Background documents provided to key stakeholders prior to interview 158
Attachment F: Questions for interviews with key stakeholders 164

Executive Summary

INTRODUCTION

The *ADF Mental Health Lifecycle package* and the initiative to *"Make community mental health care 'ex-service friendly'"* ("Training for Mental Health workers") were announced in "Labor's Plan for Veterans' Affairs" policy document (November 2007) prior to the 2007 Federal Election. One of the projects specified in the Lifecycle package was a Study into Barriers to Rehabilitation.

There are two objectives of the Barriers to Rehabilitation project. The first objective is to determine whether there are systematic barriers (particularly those that DVA may be able to redress) to successful rehabilitation for DVA clients. A second objective of the project is to develop and trial mechanisms for ongoing collection of relevant data to allow accurate monitoring of rehabilitation outcomes by DVA. To explore these two objectives in detail, it was proposed that new data would be collected and relevant existing data and information would be analysed. Furthermore, the project would be divided into two phases with phase one focusing on the first objective and phase two concentrating on the second objective. This report provides a summary of the findings from phase one of the study.

The aim of phase one was to use the results from a range of data sources to increase understanding of the rehabilitation process, explore how rehabilitation outcomes are currently being measured, examine how 'success' in rehabilitation is conceptualised by different stakeholders and identify perceived barriers to achieving successful rehabilitation outcomes. It involved data collection from a range of sources including:

1. Interviews with DVA clients;
2. Focus groups with DVA staff;
3. An online survey of rehabilitation service providers;
4. Interviews with key stakeholders; and
5. A review of a sample of DVA case files.

This Executive Summary provides an overview of the findings from each of the key methods of phase one data collection outlined in sections 1-4 of the report. Greater detail including quotes from various participants as well as tables and charts elaborating on these themes are presented in the main body of the report. The report concludes with a discussion of the key results from each of the components of phase one of the project and the relevance of the findings for the proposed direction of phase two of the study.

SECTION 1: DVA CLIENT INTERVIEWS

The first component of phase one of the Barriers to Rehabilitation study involved interviews with DVA clients. The purpose of the client interviews was to hear from a range of DVA clients regarding their personal experiences of being assessed for rehabilitation needs, their experience of accessing rehabilitation services through DVA, whether they felt it was successful and if there were any barriers to accessing rehabilitation. The intention was that the information supplied by DVA clients would be provided to DVA to support the Department to ensure that the rehabilitation services and programs available are of a high

quality and better serve the needs of eligible current and former serving ADF members. Furthermore, it was hoped that the information would inform what would be an appropriate routine measure of success in rehabilitation for clients. Overall, 20 DVA clients based in Adelaide, Sydney and Melbourne who had accessed rehabilitation services within the past 12 months participated in phone and face-to-face interviews during March-April 2009.

The interviews with clients covered questions focusing on four main areas:

1. Understanding and expectations regarding rehabilitation
2. Experience of rehabilitation and whether it was perceived to have been successful
3. Perceived facilitators and barriers to rehabilitation
4. Suggested areas for improvement

The feedback from DVA clients regarding the barriers to rehabilitation and suggested areas for improvement can essentially be categorised under three key themes, which are briefly summarised in turn below.

Communication

Communication, at various points during the client's contact with DVA, was a central theme. An important barrier to accessing rehabilitation raised by clients was a lack of awareness about the rehabilitation services available through DVA. It was pointed out that if clients were not provided with the necessary information to begin with (in terms of knowing what they could access, what the process would involve, who to contact etc.), it was unlikely that they would be able to achieve the best rehabilitation outcomes as this lack of awareness has ramifications in terms of early and appropriate intervention. Clients made a number of suggestions to overcome the current information barrier including the distribution of an information pamphlet to all ADF members during transition and ensuring that there is a user-friendly website available for clients to refer to for further information. Better communication between DVA staff and their clients was also suggested as an area which could be improved particularly in terms of DVA staff being more proactive in communication with clients as well as adopting a more client-focused approach.

Need for a flexible and holistic approach to rehabilitation service delivery

Another major area that clients felt was important to address was the need for a flexible and holistic approach to rehabilitation. It was pointed out that rehabilitation service provision needs to focus on addressing physical, psychological, social and vocational needs as well as providing support to the client's family. Related to this point, some clients felt as though there was more of a focus on providing financial compensation rather than relevant services to assist in improving a client's overall level of functioning and quality of life. Clients also suggested that it was vital that DVA's approach to rehabilitation is flexible so that each individual case is assessed on its merits and there is flexibility in the provision of services depending on the needs of the client.

DVA administrative processes

The other major barrier to accessing timely, quality and relevant rehabilitation raised by clients was DVA's administrative processes. A number of clients suggested that the rehabilitation process was more effective when there was early intervention and the provision of immediate services. However it was pointed out that this was often affected by the time it takes from making a claim through to acceptance of liability, assessment, approval and provision of services. Clients felt it would be beneficial if it was possible to speed this process up as clients would be able to access the assistance when they need it the most – immediately when they make a claim.

SECTION 2: DVA STAFF FOCUS GROUPS

Around the same time that the interviews were conducted with DVA clients, a number of focus groups were also carried out with DVA staff involved in rehabilitation service and delivery based in Adelaide, Sydney and Melbourne. Drawing on the knowledge and advice provided by DVA staff, the purpose of the focus groups was to use the information to assist the Department to gain a better understanding of what DVA staff believe successful rehabilitation involves, what measures they use or believe should be used to measure rehabilitation outcomes and their views on the barriers and facilitators to rehabilitation for DVA clients. In total, 18 staff across the three states participated in the focus groups: 5 from South Australia, 7 in NSW and 6 in Victoria. This included a mix of staff who worked with MRCA, SRCA and VEA clients, those who work in the area of household services, incapacity payments as well as rehabilitation.

Complexity of rehabilitation process and work with rehabilitation service providers

It is interesting to note the similarities and differences in the feedback received from DVA staff across the three states compared with the feedback from DVA clients. Similar themes were raised by both groups but with the DVA staff placing stronger emphasis on the role of the rehabilitation service provider in the rehabilitation process. There was consistency in responses regarding the key components of rehabilitation with staff placing a strong emphasis on defining a successful rehabilitation outcome as one where the client returns to work. The staff pointed out the importance of others recognising the complexity of the rehabilitation process for them given that a staff member may manage a range of different clients who fall under each of the three Acts as well as clients who may have been recently injured or those who were injured decades prior to their current rehabilitation experience. In terms of contact with rehabilitation service providers, the staff reported a number of factors that influence their decision regarding which provider to refer a client to. This included the geographic location of the provider, reputation, whether the provider specialises in a particular aspect of rehabilitation and also whether they are client-focused in their service delivery. It was apparent that the staff saw their role as more administrative in nature whereby they monitored a client's case based on feedback supplied by the provider whilst the provider was seen as the 'expert' who provided the services and managed the client on a more personal level. It should be noted, however, that there were differences reported across the three states in terms of processes in place for maintaining contact with rehabilitation providers as well as in the direction, training and feedback supplied to providers.

Barriers/facilitators to rehabilitation for DVA clients

Some of the barriers to rehabilitation described by the staff included lack of client motivation to participate in rehabilitation, the difficulties encountered when a client resides in a regional or remote area, inconsistency in expectations regarding the purpose and expected outcomes of rehabilitation, poor communication amongst parties (particularly DVA staff and rehabilitation service providers), staff turnover and getting clients to commence rehabilitation early in the process but the difficulties experienced when clients are reluctant to report their problems and lodge a claim with DVA in the first place. On the flip side, DVA staff felt that that because DVA has a system in place that is flexible and not very restrictive in terms of what can be provided to clients, this acts to facilitate the client's recovery from injury or illness.

Suggestions for improvement

Across all three states, staff indicated they were generally satisfied with how rehabilitation was delivered by DVA and felt that rehabilitation had improved over time in terms of processes and flexibility in the range of services that can be provided to clients. There were, however, some aspects that they believed could be addressed. Consistent with feedback from DVA clients, the staff suggested that improvements could be made in relation to raising awareness about rehabilitation with DVA clients as well as in the communication amongst different parties but particularly between DVA staff and the rehabilitation service provider. Another focus was on getting clients into rehabilitation as quickly as possible and staff felt that better communication and procedures to aid the transition between ADF and DVA would assist this process. Staff in all three states also agreed that the guidelines given to rehabilitation providers are too vague (e.g. currently defined as the approval of whatever is considered 'reasonable' in relation to injury) and that rehabilitation providers do not have a clear understanding of what DVA rehabilitation staff want them to provide to the clients. A suggestion was to improve the referral documentation supplied to rehabilitation providers and develop an information pack that is sent out when referring all new clients. Staff from Victoria also felt that DVA's administrative systems could be improved to assist staff to easily locate relevant information about a client and view clients in a holistic manner.

SECTION 3: SURVEY OF REHABILITATION SERVICE PROVIDERS

Rehabilitation service providers currently certified to provide rehabilitation to DVA clients were invited to complete an online survey. The purpose of the survey was to gain a better understanding of the rehabilitation process delivered by DVA-contracted service providers, how rehabilitation outcomes are measured by providers and their opinions regarding perceived barriers to achieving successful outcomes in rehabilitation for DVA clients.

The results reported in this section were based on information provided through the survey of rehabilitation service providers conducted between March-April 2009. The 27 organisations who participated in the survey represented a range of different rehabilitation service providers in terms of geographic location, organisational size, amount of time their organisations have been providing rehabilitation for DVA clients and in terms of the number of DVA clients they provide rehabilitation to. All organisations reported providing

vocational/employment support, the majority provided psychosocial and self-care services but less than half reported delivering medical and allied health treatment.

Contact with DVA and other service providers

The rehabilitation service providers were asked to specify the frequency of their contact with DVA as well as with other service providers in relation to work with DVA clients and to indicate their level of satisfaction with this contact. Overall, the majority of providers reported being in contact with both DVA and other service providers on at least a monthly basis but a greater proportion reported being in contact with DVA staff (compared to other service providers) on at least a weekly basis. In terms of the types of other service providers that the organisations reported contact with, this was mainly in relation to the medical and allied health needs of DVA clients and so contact was predominantly with general practitioners, psychologists and psychiatrists. The respondents seemed to be generally satisfied with their contact with DVA and other service providers. In both instances, however, it was found that providers were generally less satisfied about the timeliness in dissemination of DVA reports and ensuring that these reports are provided to all relevant stakeholders.

Use of standardised outcome measures

The majority of rehabilitation service providers reported using standardised outcome measures, however a wide range of outcome measures were utilised by the respondents and it was pointed out that the outcome measures used depends on the needs of the client. Most participants felt that use of standardised outcome measures was very important to evaluate the effectiveness and efficiency of rehabilitation and to a slightly lesser extent, to demonstrate accountability. In particular, using outcome measures to assess whether individualised rehabilitation goals identified by the client have been achieved was seen as very important along with using the measures to assess the success of rehabilitation in providing the client with the capacity to manage their own condition (20 of 23 organisations – 87% respectively). Slightly fewer organisations (17 of 23 organisations – 74%) reported return to work outcomes as being very important to assess the success of rehabilitation for DVA clients.

Rehabilitation and assessment process

Survey participants were also asked to comment on the rehabilitation and assessment process followed by their organisations. Responses indicated the complexity of this process, which depends on the injury/illness of the client, the goals of the client and the importance of adjusting the assessment process and services delivered depending on client needs. Furthermore, there was variation in the extent to which the providers reported undertaking various types of service evaluation activities, with most ‘always’ evaluating progress towards rehabilitation goals and objectives, but relatively few organisations ‘always’ evaluating system-wide service provision to ensure services are meeting the needs of clients.

Barriers to rehabilitation for DVA clients

As was the case in the interviews with DVA clients and focus groups with DVA staff, rehabilitation service providers were asked to comment on perceived barriers to rehabilitation for clients. Individual client level barriers were perceived to have most impact on the ability to deliver successful rehabilitation to DVA clients followed by organisational barriers and system level barriers. The most common barriers mentioned at the individual client level included a lack of understanding and support provided to the client, the difficulty experienced by the client in adjusting to their injury or condition, unrealistic expectations on behalf of the client and tension between rehabilitation and financial/compensation entitlements. At the organisational level, the most common barrier was the difficulty in finding alternative suitable duties for the client and a perceived lack of support for the client from their employer. System level barriers to rehabilitation included a lack of flexibility in developing rehabilitation programs for individual clients, barriers in relation to the administrative and reporting processes and some confusion regarding the rehabilitation legislation and process.

SECTION 4: KEY STAKEHOLDER INTERVIEWS

The final component of data collection for phase one of the Barriers to Rehabilitation study involved phone interviews with key stakeholders involved in the area of rehabilitation. The aim was to interview a range of different stakeholders from various organisations considered to have expertise in the area of rehabilitation. This included stakeholders working in rehabilitation delivered to military veterans, stakeholders involved in rehabilitation and advocacy for clients in the community, as well as recognised experts working in academic and applied areas. Essentially, the goal was to interview key stakeholders grouped under five main categories: DVA senior management personnel; ADF Rehabilitation Directorate personnel; key organisations currently providing psychosocial services to the broader community; key experts in the applied and academic fields; and DVA service delivery staff in location offices. Given that DVA service delivery staff participated in focus groups at the time of the interviews with DVA clients, it was considered unnecessary to re-interview additional service delivery staff. The questions asked participants to comment on the essential components of rehabilitation, their use of rehabilitation outcome measurement tools, their view about what a successful outcome in rehabilitation involves and their opinion about possible barriers and facilitators to successful rehabilitation outcomes. Twelve stakeholders from a variety of organisations participated in phone interviews in April/May 2009.

Changes in approach to rehabilitation over time

Almost all participants believed there had been changes in the way rehabilitation is perceived and delivered in recent years. Most of these were positive changes in terms of cultural changes amongst DVA staff and the community, with greater emphasis on engagement in rehabilitation and the reduction of stigma; however, it was noted that further work was needed to continue in these areas. Many of the key experts and stakeholders representing community based organisations focused on changes in service delivery such as the provision of discrete services and an emphasis on rapid job search strategies. Another change noted by

several participants was a greater focus on building on the capacities of the client during their rehabilitation rather than focusing on their incapacities.

Definitions of 'successful' outcomes in rehabilitation

All participants were asked to describe what they believed constitutes a 'successful' outcome in rehabilitation service. Many of the participants focused on return to work outcomes, particularly stakeholders from DVA, however there were some differences in terms of what 'return to work' means (e.g. competitive employment, full-time versus part-time, voluntary work etc.). The most successful outcome would be where a client has returned to competitive employment, but it was noted that the number of hours worked would be dependent on the abilities of the client and as such, full-time work is not always the goal. Some participants defined a successful outcome in rehabilitation more broadly than return to work. This included a focus on improvement in quality of life outcomes and successful transition into the community, with a few participants also indicating that a successful outcome is where all of the goals outlined on a client's rehabilitation plan have been achieved. Clearly, defining 'success' in rehabilitation is a complex task. It is important that any definition of success is able to address the complexities of client rehabilitation cases where there can be a focus on different return to work outcomes as well as broader outcomes such as improved independence and quality of life. Furthermore, it was suggested that ongoing monitoring and evaluation of client outcomes both during and after formal closure of a case is important to ensure that these positive outcomes are maintained for the client over time.

Due to the complexity of defining a successful outcome in rehabilitation, some participants suggested that it would be beneficial to examine a number of different sources of information to determine whether a client has achieved a successful outcome in rehabilitation. This included using some of the information generated by rehabilitation providers, conducting exit interviews or client satisfaction surveys and 'thinking outside of the square' by examining some of the information available on DVA's administrative systems that could act as indicators of success or function as warnings that clients may require further assistance or follow-up. Most importantly, many of the key experts and interviewees from community organisations pointed out that the easiest way to determine whether a successful outcome has been achieved is to speak directly with the client.

Standardised outcome measures

When asked about use of standardised outcome measures, some participants focused on the types of administrative measures used to monitor and evaluate progress and success in rehabilitation, whilst a small number discussed the use of measurement tools to assess client needs (e.g. physical, psychological, social and vocational). For those organisations involved in the delivery of rehabilitation to clients, indicators were used to assess return to work outcomes, costs and case duration at the consultant level and to measure client and staff performance via surveys. A number of stakeholders suggested that it is important to measure a broad range of client outcomes but that the types of outcomes measured really need to be determined on a case by case basis. Some of the suggested areas of importance to measure included quality of life, self-esteem, social connectedness, empowerment and job tenure. All of the interview

participants from DVA agreed that improvements are required to monitor and evaluate client and system outcomes.

All participants were asked about the benefits and limitations of using standardised outcome measures. Some of the benefits to using these measures included that they provide objective information to enable organisations to compare changes between clients and over time; they formally document and track client outcomes in a consistent manner; and they can assist staff in measuring performance and identify areas which may need to be addressed. However, across the board there was consensus amongst the participants that information obtained from outcome measures should not be exclusively relied upon to assess success in rehabilitation. Most participants recommended that quantitative measures be used in conjunction with qualitative measures, particularly in direct communication with clients. Some of the limitations to using outcomes measures included that they often only focus on particular types of outcomes and can neglect other important issues of relevance for a client and they can be inflexible when applied to populations with different needs or issues. Many participants suggested that outcome measures are most useful as broad indicators of success and in identifying where further information is required.

Barriers/facilitators to rehabilitation for DVA clients

Some of the barriers to rehabilitation mentioned by the key stakeholders included:

- The tension for clients between receiving financial compensation/entitlements and engagement in rehabilitation;
- Culture among DVA staff where rehabilitation may not always be promoted;
- Defence culture where ADF members may be reluctant to lodge a claim for their injury for fear of being perceived as weak or the potential impact it may have on their career;
- Difficulty in delivering effective rehabilitation to all groups including those with complex needs;
- The complexity of the DVA administrative system;
- Lack of flexibility in development of rehabilitation plans;
- Regional and remote issues;
- Implications of the global financial crisis for engaging clients in employment; and
- Stigma in the community in relation to mental health.

Some of the main factors believed to facilitate rehabilitation included early intervention, goal setting, working with a multidisciplinary team and ensuring the client is engaged in the rehabilitation process along with all other key stakeholders. Successful communication amongst all parties was the overwhelming factor that stakeholders believed contributed to a successful rehabilitation experience for clients. An important aspect recognised in the continuity of care for DVA clients was ensuring a smooth transition process from the ADF to DVA. A number of participants also felt that the resources and support networks available for current and former serving veterans assists in the achievement of successful rehabilitation outcomes, but some stakeholders suggested that better engagement of veterans in the community could aid this process further.

DISCUSSION

Through collecting data from each of the four data sources in phase one (client interviews, focus groups with DVA staff, survey of rehabilitation service providers and interviews with key stakeholders), the aim was to capture information that would be used to provide direction for the second phase of the project. It is interesting to note that a number of the key themes identified in one component of data collection during phase one of the study often emerged in the context of other components of data collection. These key themes are described and discussed in reference to direction for phase two of the project.

Communication was one of the key themes emerging from all four areas of data collection during phase one. Firstly, it was noted that for a number of DVA clients there is a general lack of support and awareness regarding the rehabilitation process and available services. Related to this point was the need to improve general communication between DVA staff and clients during their rehabilitation. Thirdly, information from all data sources indicated the importance of communication between DVA staff and rehabilitation service providers. A number of suggestions were made by various parties to overcome these communication barriers.

Another key theme was the importance of a holistic and flexible approach to rehabilitation where the focus is on addressing the needs of individual clients rather than a generic approach to rehabilitation. Some participants discussed the tension between the provision of financial compensation to DVA clients and the engagement with relevant rehabilitation services. There was the belief amongst some clients that there is a greater focus by DVA staff in providing compensation rather than rehabilitation for clients, whilst several key stakeholders, DVA staff and rehabilitation service providers felt that, at times, clients are more motivated by the financial entitlements they can access from DVA rather than rehabilitation to recover from their injuries or conditions.

Improvement of DVA's administrative processes was another area identified as a barrier to successful rehabilitation for clients due to a lack of timeliness in liability determination, assessment and the provision of rehabilitation services. It was pointed out that this inevitably impacts on DVA's ability to provide early intervention. Further investigation of DVA's administrative processes was conducted via a review of a small sample of 40 closed DVA client rehabilitation files. It became apparent from this review that phase two of the study would need to involve a data collection rather than a data capture as there was a mix in terms of the forms included in the case files and the quality of the information. The other noticeable finding was that no needs assessment forms were included in the paper-based case files.

It became clear by the completion of phase one that defining 'success' in rehabilitation is a complex task and in many cases can be subjective as it can differ from client to client. It was pointed out that whether a client achieves a successful rehabilitation outcome depends on what their initial goals were and therefore addressing client expectations via goal setting is important in this respect. It is important that any definition of success is able to address the complexities of client rehabilitation cases where there can be a focus on different return to work outcomes as well as broader outcomes such as improved independence and quality

of life. Furthermore, a successful outcome can be dependent on a number of other factors such as the age of the client, their injuries/conditions, their location (e.g. rural versus metropolitan) and the legislation they fall under. It was suggested that ongoing monitoring and evaluation of client outcomes both during and after formal closure of a case is important to ensure that positive outcomes are maintained for the client over time.

When asked about use of standardised outcome measures, some participants focused on the types of administrative measures used to monitor and evaluate progress and success in rehabilitation, whilst a small number discussed the use of measurement tools to assess client needs. A number of stakeholders suggested that it is important to measure a broad range of client outcomes but that the types of outcomes measured need to be determined on a case by case basis. The DVA staff pointed out that they relied on the reports supplied by rehabilitation service providers regarding client progress and outcomes and therefore did not implement any outcome measures of their own. The survey of rehabilitation service providers revealed a lack of consensus regarding the best standardised outcome measures to use as different measures were utilised depending on the client's circumstances. However, there was agreement that use of standardised outcome measures is important in demonstrating effectiveness, efficiency and accountability and that they can be a useful in formally documenting and tracking client outcomes in a consistent manner. Some of the suggested areas of importance to measure when assessing clients included quality of life, self-esteem, social connectedness, empowerment and job tenure. All key stakeholders interviewed from DVA agreed that improvements are required to monitor and evaluate client and system outcomes.

Direction for phase two of the study

Based on the findings described in this report, it is proposed that phase two of the project will include two studies with different foci:

- Study one will aim to explore the implementation of the Needs Assessment process by staff to look at how different factors can impact on this process. The purpose would be to review the compliance and quality of information documented in the electronic Needs Assessment forms. It would also provide an opportunity to examine the types of needs and services required by clients who have different injuries or conditions. An additional aspect of this study will involve exploring how staff experience, staff ratios and turnover at different DVA offices impacts on the quality of the Needs Assessment forms completed.
- Study two will involve a trial of the routine adoption of an outcome measure that would be relevant to apply in all rehabilitation cases. This would provide an indication of success in non-return to work related outcomes, which are not currently measured by DVA. Goal attainment scaling, where clients work with consultants to develop goals across relevant domains (e.g. education, isolation, depression, work etc.), has been suggested as the method of measurement.

Introduction

The *ADF Mental Health Lifecycle package* and the initiative to *"Make community mental health care 'ex-service friendly'"* ("Training for Mental Health workers") were announced in "Labor's Plan for Veterans' Affairs" policy document (November 2007) prior to the 2007 Federal Election.

The *Mental Health Lifecycle package* included "nine strategic mental health initiatives targeted across the four stages of an ADF member's lifecycle". The stages were described as "recruitment, service, transition or discharge, and rehabilitation and resettlement into civilian life". The aim of the package of initiatives is to achieve four outcomes across the ADF 'lifecycle':

- Enhanced psychological resilience among serving personnel.
- Better early intervention and mental health surveillance.
- Successful transition from defence to civilian life for the member and their family.
- Effective rehabilitation and support, and timeline mental health treatment.

One of the projects specified in the Lifecycle package was a Study into Barriers to Rehabilitation. This project is one of several in the Lifecycle package in Labor's Plans for Veterans that is led by and funded through the Department of Veterans' Affairs (DVA), but is "implemented as a partnership between the Department of Defence, DVA and the Australian Centre for Posttraumatic Mental Health (ACPMH)". The Study into Barriers to Rehabilitation is a two-year project focusing on rehabilitation provided to MRCA and SRCA clients. The project runs from September 2008 through to September 2010.

Essentially, there are two objectives of the Barriers to Rehabilitation project. The first objective is to determine whether there are systematic barriers (particularly those that DVA may be able to redress) to successful rehabilitation for DVA clients. A second objective of the project is to develop and trial mechanisms for ongoing collection of relevant data to allow accurate monitoring of rehabilitation outcomes by DVA. To explore these two objectives in detail, it was proposed that new data would be collected and relevant existing data and information would be analysed. Furthermore, the project would be divided into two phases with phase one focusing on the first objective and phase two concentrating on the second objective. This report provides a summary of the findings from phase one of the study.

The aim of phase one was to use the results from a range of data sources to increase understanding of the rehabilitation process, explore how rehabilitation outcomes are currently being measured, examine how 'success' in rehabilitation is conceptualised by different stakeholders and identify perceived barriers to achieving successful rehabilitation outcomes. It involved data collection from a range of sources including:

- Interviews with DVA clients
- Focus groups with DVA staff
- An online survey of rehabilitation service providers
- Interviews with key stakeholders

- A review of a sample of DVA case files

The objective of phase two is to develop and trial mechanisms that DVA can use for ongoing collection of relevant data to allow accurate monitoring of rehabilitation outcomes. Findings from phase one have been used to guide the direction of phase two of the project in terms of the focus, mode and feasibility of data collection. Phase two will involve a pilot study to develop and trial methodology for the routine collection of data that will assist DVA in monitoring rehabilitation outcomes for clients and assessing overall success in rehabilitation policy and practice.

This progress report outlines the findings from phase one of the project. It is divided into four sections reflecting each of the key methods of phase one data collection.

Section 1 details the findings from the interviews conducted with DVA clients based in Adelaide, Melbourne and Sydney who were identified by DVA as having accessed rehabilitation services within the previous 12 months.

Section 2 describes the results from focus groups conducted with DVA staff based in Adelaide, Melbourne and Sydney.

Section 3 summarises the results from an online survey of rehabilitation service providers currently certified to provide rehabilitation to DVA clients.

Section 4 outlines the key themes from interviews conducted with key stakeholders regarding best practice in rehabilitation, particularly psychosocial rehabilitation.

The report will conclude with a discussion of the key results from each of the components of phase one of the project (DVA client interviews, focus groups with DVA staff, survey of rehabilitation service providers, key stakeholder interviews and the review of a sample of DVA client case files). The findings from phase one will then be discussed in terms of the relevance and direction for phase two of the Barriers to Rehabilitation study.

Section 1: DVA client interviews

Introduction

The first component of phase one of the Barriers to Rehabilitation study involved interviews with DVA clients. The purpose of the interviews was to hear from a range of DVA clients regarding their personal experiences of being assessed for rehabilitation needs, their experience of accessing rehabilitation services through DVA, whether they felt it was successful and if there were any barriers to accessing rehabilitation. The intention was that the information supplied by DVA clients would be provided to DVA to support the Department to ensure that the rehabilitation services and programs available are of a high quality and better serve the needs of eligible current and former serving ADF members.

The interviews with clients covered questions focusing on four main areas:

1. Understanding and expectations regarding rehabilitation
2. Experience of rehabilitation
3. Perceived facilitators and barriers to rehabilitation
4. Suggested areas for improvement

Methodology

There were a number of steps involved in the process of identifying, inviting and conducting the interviews with DVA clients. These steps are outlined below and the relevant documentation (letter of invitation, participant information sheet, consent form and interview questions) can be found in Attachment A. The DVA Human Research Ethics Committee approved the research involving interviews with DVA clients in February 2009. Under ethics, it was agreed that the names and contact details provided by DVA state offices to ACPMH would only be used to contact veterans and invite them to participate in the study and that all data acquired through the focus groups would be reported at a de-identified and aggregated (to the state) level. All aspects of the research were developed in consultation with staff from the DVA Rehabilitation Policy Section.

The first step involved identifying relevant DVA clients to contact and invite to participate in the study. This involved DVA service delivery staff identifying relevant DVA clients. DVA staff were provided with a description of the type of client that ACPMH was seeking to participate in the study. The focus was on MRCA and SRCA clients who had received rehabilitation services within the past 12 months. The interviews were limited to clients based in New South Wales (NSW), South Australia (SA) and Victoria (VIC) due to the smaller number of MRCA and SRCA clients who had received rehabilitation in the previous year across the other states and territories in Australia. DVA were asked to identify approximately 30 clients in each of the three states and these 30 clients were to be divided into two categories: 15 clients for whom the rehabilitation process and experience was considered to be successful and 15 clients for whom the rehabilitation process and experience was considered to be unsuccessful. ‘Success’ was defined as a ‘positive’ outcome as perceived by the client, DVA and the provider. It should be noted that in the final

breakdown, an equal split in the number of clients considered to have experienced successful and unsuccessful rehabilitation outcomes was not achieved with the majority of clients identified as having achieved successful outcomes.

The total number of clients identified to participate (i.e. to be sent the letter of invitation) in each of the three states is provided in Table 1. The table also provides a breakdown of the number of clients considered to have experienced a successful or unsuccessful rehabilitation outcome.

Table 1: Number of DVA clients identified in each state broken down by whether they were considered to have experienced a 'successful' outcome

	Successful outcome	Unsuccessful outcome	Total
New South Wales	14	7	21
South Australia	13	4	17
Victoria	15	1	16*
Total	*42*	*12*	*54**

* It should be noted that three of the identified clients from Victoria (all classified as having experienced a successful outcome) were not sent the letter of invitation as they were identified by DVA as having postcodes which were located within areas having been affected by the Victorian bushfires in early February. It was agreed by DVA and ACPMH that under the circumstances, it would not be appropriate to ask these clients to participate in the interviews. Therefore, the adjusted total number of clients invited to participate in Victoria was 13 with the total number of clients across all states reduced to 51.

Once relevant clients had been identified, DVA sent a letter of invitation via post to all identified clients in mid-February. The letter of invitation was on a DVA letterhead and was signed by DVA Commissioner Brigadier Rolfe. Along with the letter, clients were sent a factsheet of frequently asked questions which provided additional information about why the client had been contacted and how the interviews would be conducted. The letter indicated that if clients were not interested in participating, they were to contact the local DVA staff representative whose contact details were supplied in the letter. A small number of clients called to opt out of the research (1 from NSW and 3 from VIC).

For those who did not opt out of the interview, DVA passed on the names and contact details to ACPMH who then contacted the client by phone approximately two weeks later. The clients were provided with further information about the interviews and details regarding date/time and location for potential focus groups. The focus groups were to be held in late March/early April at the DVA state offices in each of the three states with one focus group offered at 10:30am and another at 5pm. If clients were unable to attend the focus group, they were asked if they were willing to participate in a phone interview covering the same questions.

Originally it was anticipated that those who agreed to participate would participate in focus groups in each of the three locations, however it turned out that almost all participants were unable to attend the focus group either due to work commitments or were unable to make it into the DVA office as some clients were living in regional areas or were unable to make it due to their physical injuries. However, the majority of those who were contactable agreed to participate via a phone interview. Of the 47 clients who were on the list to be contacted (excluding those who called DVA staff to opt out and those located in the Victorian bushfire zone), a small number of clients in each state also chose to opt out of the study after being contacted by ACPMH (5 in NSW, 3 in SA and 2 in VIC). An additional 17 clients were unable to be contacted via phone after numerous attempts (9 in NSW, 6 in SA and 2 in VIC). Of those unable to be contacted, in several cases this was due to clients having disconnected phone numbers.

A total of 20 clients participated in the study. The total number who elected to participate in an interview is outlined in Table 2 and is broken down by state, whether the client participated in a phone or face-to-face interview and the number classified as having experienced a successful versus unsuccessful outcome.

Table 2: Number of DVA clients who participated in the interview broken down by state, phone versus in person interview and classification of successful/unsuccessful outcome

	Successful outcome		**Unsuccessful outcome**		**Total**	
	Phone	**In person**	**Phone**	**In person**	**Phone**	**In person**
New South Wales	5	1	0	0	5	1
South Australia	5	1	2	0	7	1
Victoria	5	0	1	0	6	0
Total	*15*	*2*	*3*	*0*	*18*	*2*

The phone and face-to-face interviews were conducted between mid-March and early April. Participation in the interview was completely voluntary. Clients were ensured that none of the information provided in the interview would be used to identify them and would not in any way affect any pension or benefits to which they were receiving or may be entitled. A participant information sheet was provided to clients who participated in face-to-face interviews and they were asked to sign a consent form. Those who participated via a phone interview were read all of the information outlined on the participant information sheet by the interviewer as well as the information on the consent form and were asked to provide verbal consent. The two interviews conducted in person with the client were audio-recorded with the consent of the client whilst the discussion from the phone interviews was typed up as the interview was conducted.

Overall, there were five main questions asked of all clients (see Attachment A); however, the interviewer probed clients for further information where necessary. Participants were also asked to complete a short questionnaire to provide some basic demographic information. This also provided participants with the opportunity to supply further details regarding their experience of rehabilitation. It was originally anticipated that the clients would complete the questionnaire and return it during the focus groups, however because the majority of participants participated via a phone interview, participants were asked to return the survey

via email. As a result, not all participants completed the questionnaire (12 of the 20 participants). Given the small number of clients who elected to participate in face-to-face interviews, the results from both face-to-face interviews and phone interviews will be discussed in combination.

Findings

The results from the interviews conducted with DVA clients are broken down into the four main areas listed in the introduction (understanding and expectations of rehabilitation, experience of rehabilitation, perceived facilitators and barriers to rehabilitation, and suggested areas for improvement). The key themes emerging from the interviews with clients are discussed within each of these four areas and where relevant, a number of quotes have been provided to offer further illumination of the themes. This section will conclude by summarising the key themes and describe the implications for DVA rehabilitation programs and services from a client perspective.

General overview of participating clients

Nineteen of the 20 clients who participated in the interview were male. Based on the 12 clients who completed the questionnaire, two clients were aged between 15-24 years, three between 25-34, three between 35-44, two between 45-54 and two clients were aged over 55 years. Three clients indicated they were still serving members of the ADF at the time of interview. Participants were asked to estimate how long it was between the time they were injured and the time they accessed rehabilitation. Responses ranged from immediate access to rehabilitation up to 2-3 years, with half of the clients indicating that it was up to 4 months between the time of injury and rehabilitation.

Understanding and expectations of rehabilitation

The first section of the interview asked DVA clients to describe how they heard about the rehabilitation services provided by DVA and to detail what expectations they had regarding the treatment and rehabilitation they may be able to access through DVA.

Sources of information

The majority of clients reported that they had heard about the rehabilitation available from DVA either through the discharge process (n=8), during the process of making a compensation claim or accessing incapacity payments (n=7) and/or through their local GP/army medical base (n=5). A few clients (n=3) also mentioned that they heard about the rehabilitation services they may be able to access through DVA via a friend or colleague. Two clients mentioned hearing about rehabilitation services through their local RSL (both clients were aged over 45 years).

Quality of information

More than half of the DVA clients (n=11) felt that they had not received adequate information from DVA regarding the rehabilitation process in terms of what they may be able to access and what it would involve. A few of the clients (n=4) who said that they did receive some information felt that it was disjointed, too

broad or not easily available/accessible. This theme emerged in interviews with clients across all three states. Some of the comments made by clients include:

DVA client (SA) *"When I was medically discharged I had to do a medical discharge course. As part of the course, I was told about rehabilitation services and the possibilities of accessing it if need be. The course only provided a very general overview and had a contact number if you wanted additional information."*

DVA client (SA) *"There is not a lot of information out there and it's not widely disseminated. A lot of people don't know where to go and they don't know what information they can get."*

DVA client (SA) *"If you want to find out about it, it's up to you to ask the questions."*

DVA client (SA) *"My primary understanding was that the assistance would revolve around compensation for my injury such as lump sum payments. I didn't know that you could get help with household services/equipment and workplace assistance."*

DVA client (NSW) *"I was given information about what it would involve but even with the information sheets I received, I would read through them but they didn't give you an idea about what to expect as they covered very broad areas. I just didn't know where I fit into the puzzle."*

In contrast, there were a small number of clients who were satisfied with the information that had been provided to them by DVA or the ADF regarding the rehabilitation services to which they may be entitled and the process involved. It was evident that the clients who were satisfied were those whose experience had involved greater personal contact with DVA staff at the very beginning of the process and where this occurred either immediately or not long after their injury. For example, one client from Victoria said that he had been provided with a lot of literature about the types of assistance he could access after he had been discharged. He said that he had an appointment with DVA prior to being discharged where they spent a few hours going through the information and discussing his claim in terms of what he was or was not entitled to. He commented that "the way they went about it was good."

Expectations and goals for successful outcomes

However of those clients who felt that they had not received adequate information, the majority went into their rehabilitation without any expectations about what services they could access, what the process would involve or expectations about what they wanted to achieve. Those who did have expectations simply felt that by accessing services through DVA, they would be provided with support and would be "looked after". When probed about their expectations, the majority focused on having their medical needs addressed in terms of recovering or managing their injuries or conditions. For many, this was linked with being able to return to work (either to their previous role or to a new position post-discharge). An example demonstrating this point was made by one client from South Australia. His expectation was that DVA would help him to find a new job because his previous focus had been on a career in the ADF. He indicated that he did not require any further assistance but then went on to say that he did not really know what else he could get assistance with as he did not know how the system worked. Comments from some of the other participants are provided below.

DVA client (SA) *"I had very high expectations that after rehabilitation I would be able to return to my previous duties without a problem. However this was not the case…I now recognise that my injury was severe but I was in denial about it and once I realised this, I changed my expectations."*

DVA client (SA) *"I hoped that the rehabilitation would provide me with a means to be able to get back up to a reasonable fitness level."*

DVA client (NSW) *"I was of the belief that it would focus on addressing my injury to allow me to overcome the injury and return to my previous work role."*

DVA client (VIC) *"I expected that rehabilitation would focus on vocational retraining but retraining me for a more sedentary role. I also thought it would cover any medical assistance required."*

Some clients had differing expectations regarding what they would be required to do as part of the rehabilitation and what role DVA staff would play. There was a general expectation that DVA staff would be more hands on in the assistance and handling of a client's case. For some clients, this was desirable whereas for a small number, they preferred to handle their own medical needs (e.g. appointments with GPs and surgeons). For example:

DVA client (SA) *"It's not clear-cut who looks after what and that's why people get frustrated. I get frustrated because I do all the running around and chasing things up – it's me doing all the work."*

DVA client (NSW) *"Because I knew what I needed to get done, they said they were more than happy to let me handle it. So I mostly do everything myself. I could have accessed help from them but prefer to do it myself."*

DVA client (NSW) *"I didn't think I would have to be in as frequent contact as I am. I usually write to DVA once per month to chase up medical certificates, referrals and arrange assessments. This gets a bit wearing after awhile."*

DVA client (VIC) *"I understood that there would be other people involved [in the rehabilitation process] but I thought that my DVA case manager would get to know me on a more personal level but it was mainly all done through the post and occasional phone call where it was me calling DVA."*

DVA client (VIC) *"When they said they would provide rehabilitation, I thought it would be more hands on rather than just getting me to handle things myself and fill out lots of paperwork."*

It was apparent that the clients saw the role that DVA played in their rehabilitation and what they wanted to get out of it differently as a result of how long ago they were injured and their age. Some focused on wanting to participate in rehabilitation as this would provide a means to get back to their previous fitness levels and/or previous work duties, whilst for other clients the emphasis was on DVA providing a means to assist with the recovery from their medical injury/condition and provide ongoing services or support where required. For example:

DVA client (NSW) *"Even though the vocational rehabilitation they provided was good, it probably wasn't as productive for me as would be the case for a lot of clients because my aim was always to get back into the army so I wasn't interested in finding another job."*

DVA client (VIC) *"[My rehabilitation] consisted primarily of providing physiotherapy and hydrotherapy to get my knee movement back. I'm very grateful about the rehabilitation I received as I was back running*

and able to resume normal duties again within 3 months."

DVA client (VIC) *"I decided to make contact with DVA because I wanted to get help for the position that I'm in…mainly for medical assistance. I also wanted to know what would happen in the future, as I got older and it became likely that I would require more assistance."*

Experience of rehabilitation

Participants were asked to describe their experience of the rehabilitation accessed in the previous 12 months. It should be pointed out that although asked to focus on the rehabilitation they had accessed in the past year, a number of clients had been accessing rehabilitation services through DVA over a considerable period of time (ranging from within the past year up to 50 years). Therefore some clients had difficulty in separating out their experiences from the previous 12 months from the remainder of their rehabilitation experience. Furthermore, some clients compared their experience of rehabilitation in the past year with their previous experiences of rehabilitation over time and where this was the case, it was generally suggested that there had been an improvement over time. Some comments include:

DVA client (SA) *"I have been happy with the services and processes over the past 12 months as I have changed to a new case worker. Since changing to the new case worker, any requests for services have been processed more quickly than has been the case over the past 10 years."*

DVA client (SA) *"Over the past 5 years, particularly within the last 18 months, my rehabilitation needs have been more adequately addressed."*

DVA client (VIC) *"Even though I'm very thankful for the medical assistance I have received over the past 50 years, I have become increasingly unhappy with my contact with DVA."*

When describing the services they had accessed in the previous 12 months, almost all clients (n=17) indicated that their rehabilitation had focused on their medical needs – attending GP appointments, surgery, physiotherapy, hydrotherapy etc. The other main area covered in rehabilitation was the provision of household services, modifications and aids. Three-quarters of clients said that they had either been assessed or were provided with household services including regular gardening services, household cleaning and aids such as beds, specialised chairs and bathroom modifications such as guard-rails and shower stools. As some clients had been accessing rehabilitation through DVA for several years, not all clients indicated they had recently accessed vocational rehabilitation. However, seven clients indicated that they had accessed vocational rehabilitation either participating in training, university courses or attending job skills training. Some comments about rehabilitation services accessed include:

DVA client (SA) *"I have been receiving household and garden services over the past year. I get reimbursed for the cost of my medication. In the past I have also accessed physiotherapy but not within the last year."*

DVA client (SA) *"I have been provided with a personal physiotherapist who comes to my house and takes me to a pool to do hydrotherapy. I have been provided with exercise equipment. I have been provided with financial assistance to attend courses to find a new trade. As part of this, I was also given a new laptop to use for TAFE. The only negative side is that I have not been able to do any housework*

since my last surgery but I have not received any assistance or offer of assistance."

DVA client (NSW) *"They have covered my medical expenses and paid for me to complete the remaining university subjects I had as part of the course I started in the ADF. When they did a household assessment, numerous recommendations were made. I received a few aids [for his computer] and someone mows my lawns once per month but none of the other recommendations were followed up."*

DVA client (VIC) *"I get regular massages, visit the podiatrist and do hydrotherapy as a way to keep my body mobile."*

Approximately a quarter of the clients commented that they were satisfied with their experience of rehabilitation through DVA. Clients based in South Australia were slightly more likely to have commented on their satisfaction compared with clients from New South Wales or Victoria. Some quotes include:

DVA client (SA) *"Overall, I had no problems with DVA as it is good to know that there is someone there to help."*

DVA client (SA) *"Overall, I was pretty impressed with DVA once you get over the information barrier."*

DVA client (NSW) *"I got everything I needed straight off the bat and I was offered a lot more than what I needed."*

DVA client (VIC) *"During my rehabilitation, DVA and my rehabilitation provider kept in contact on a weekly basis to see how things were going. The support and everything they offered was good."*

Facilitators & barriers to rehabilitation

Clients were asked to reflect on their rehabilitation experiences and identify the factors (both positive and negative) that affected their access to quality, timely and relevant rehabilitation services. The majority of clients focused on factors that hindered their access to rehabilitation and most of the barriers to rehabilitation mentioned by the clients were at the organisational or system level.

Inadequate or untimely information

The main barrier that emerged from the discussions was that clients did not feel they received the necessary information at the beginning of the rehabilitation process in terms of knowing who to talk to and what they could get assistance with. Some clients commented that they way they discovered the relevant information was via networking with other people. Lack of client awareness surrounding what rehabilitation was, how the DVA rehabilitation process worked and what services they may be able to access was a clear barrier. Some clients felt that being unaware of the rehabilitation services available to them contributed to them not being offered services which may have helped and not being in an informed position to ask for assistance so that when assistance was offered, it was often not at the time when it was needed the most. Some comments include:

DVA client (SA) *"The system seems to be like a big fog. As you push your way forward, you may come across somebody who might point you towards an area so you go over there but that is not the information you need and so they point you towards somebody else. So you seem to be doing a lot of digging and searching through the fog to find what you actually need."*

DVA client (SA) *"Unless you ask, you don't know what you can get. Unless you talk with other veterans you don't know what you can get."*

DVA client (NSW) *"It is usually via speaking with a friend and finding out what services she has accessed that I hear about the possible rehabilitation services available. I then phone up DVA to ask whether I may be able to access similar services."*

DVA client (VIC) *"Speaking to someone face-to-face who understood my needs [through his local RSL] because they had also been in the army and been medically injured was a lot more helpful than DVA because they hadn't been in the army and didn't know what it was like."*

In the survey that clients were asked to complete, they were asked to rate their level of satisfaction with DVA in relation to the information provided to them about the rehabilitation process and what it would involve. Eight of the twelve clients who answered the survey indicated that they were either dissatisfied or very dissatisfied, one client indicated they were very satisfied and three clients were neither satisfied nor dissatisfied.

Communication with DVA

Lack of communication or inconsistency in the information communicated among DVA staff and those involved in the rehabilitation process (rehabilitation provider, GP, employer, DVA compensation area and the client) was mentioned by over a quarter of clients (n=6) as a barrier to rehabilitation. This was particularly the case for one currently serving NSW client who said that he was very confused regarding his rehabilitation because there "didn't seem to be any consultation between the army hierarchy and the medical and rehabilitation staff in relation to my injury and what I could/couldn't do." He said that there was a tension between the medical staff who felt he required further rehabilitation and the army who felt he was fit enough to return to full duties. He said that it was usually left to him to try to mediate between the different parties but when he did, he was often looked down upon for interfering. Comments from other clients include:

DVA client (SA) *"The left hand doesn't know what the right hand is doing. If you're a serving member you have to go down one path, if you're a civilian, you have to go down another. The information gets chopped and changed from one person to another."*

DVA client (NSW) *"The two areas (rehabilitation and compensation) obviously don't talk to each other which isn't easy to manage."*

DVA client (VIC) *"There is a lack of organisation between MCRS departments and the medical centre."*

Timeliness of administrative processes

Almost three-quarters of clients mentioned the DVA approval process acted as a barrier in terms of the length of time it takes to get services approved. Clients indicated that this was related to the perceived 'red tape' involved with the paperwork and administrative processes in place. One client from Victoria commented that the "structures in place and time waiting for official decisions to be made is a nightmare". He was of the belief that a lot of this has to do with the duplication of documentation such as letters going back and forth between the client, DVA and medical advisors. Another client from Victoria spoke about his experience where he has been seeing his local GP and a chiropractor for more than 12 months but has never been reimbursed for the costs of the visits. He said that even though he has sent in numerous forms

to DVA, he is told that he has sent the wrong form but no-one is able to tell him which form he needs to complete. Some comments from other clients include:

DVA client (SA) *"It's mainly the time it takes before you actually find out what is going on. I know there's a lot of red tape and people can't help that sometimes because there are checks and balances that need to be in place but it draws things out for a long time before something happens."*

DVA client (NSW) *"There seems to be no correspondence handling methods. I don't know how many times I have tried to contact somebody and they say they can't do anything because my file is somewhere else. There needs to be one individual who manages all components of a client's file."*

DVA client (NSW) *"DVA are just concerned with saving money – they put off providing assistance at the time when it is needed the most and instead waste time assessing whether you have an injury claim or not".*

DVA client (VIC) *"The time it takes from when you put in the claim to when you get it…it takes too long and it's too late by the time you get the help. You need the support when you're hurt and down and out…that's when people put in the compensation claims…they don't put them in when they are better."*

DVA client (VIC) *"I have had the same DVA contact for years so the need to continually get approval in writing for everything is frustrating given that they are familiar with the details of my case."*

DVA client (VIC) *"The only thing that frustrates me is having to put everything in writing, which then has to go to someone in DVA for approval and this takes time. It would be good if the process was more stream-lined."*

A few clients mentioned that they felt as though DVA staff put up barriers to them accessing some services/aids because of the money it would cost to provide the service/aid. In particular, this theme was raised by a number of clients based in South Australia.

DVA client (SA) *"I had the sense that they were just trying to push me towards the cheapest means possible rather than what best suits my needs." [In relation to a specialized chair for work]*

DVA client (SA) *"DVA staff seem to have an idea that if they provide the information and services to clients, clients will take advantage."*

DVA client (SA) *"There seems to be a culture where you are entitled to certain things but you feel like you always have to re-justify why you should be able to access things before they will be approved."*

DVA client (SA) *"They seem concerned with saving cash rather than helping out clients."*

DVA client (NSW) *"I was made to feel as though I was asking too much."*

Inflexible models of rehabilitation

The perceived lack of adaptability of vocational rehabilitation policy was mentioned by about a quarter of clients (n=6) in terms of the need for vocational rehabilitation to be more flexible in catering to the individual needs of the client both in relation to training courses and future career direction. This point was raised mainly by clients in South Australia and New South Wales. Some comments are included below:

DVA client (SA) *"In terms of retraining and getting assistance with job searches, I managed this. DVA tried to provide some assistance but it was not of high quality. I went to some counselling sessions and*

spoke with some employment guidance counsellors. However, I knew I needed to complete a university degree and I would need to do this on my own as it took years rather than months which is what they are after."

DVA client (SA) *"I told DVA I would like training to learn a trade or do an apprenticeship. However, DVA said that they could not cover that type of training because the courses were too long. They would only provide financial assistance for short-term courses. I asked why this was a case and was told that in the past, other clients had not completed the longer term courses (e.g. 4 years) so they only allowed people to do short term courses. I was basically told that most clients do a security course so that was recommended."*

DVA client (NSW) *"They are good if you need a basic job but not if you are looking to do something different. They are not good at tailoring their services to individual cases such as those who may be looking at different employment options other than trade-related careers."*

DVA client (NSW) *"DVA seem more attuned to people becoming a truck driver and other similar trade-related vocations. They don't seem to be able to cope with people from slightly different backgrounds or people working for themselves."*

Rural issues

Only two clients (both from Victoria) mentioned living in a regional or remote area as a barrier to accessing rehabilitation. However, both clients indicated that it was a significant barrier to being able to access quality, relevant and timely rehabilitation. For example, one client (who lived approximately 350km from Melbourne) said that he is required to pay for any medical expenses upfront, send the bill to DVA and wait to get reimbursed because there are no doctors approved in his local area where DVA can be billed directly. He said that this causes significant problems because he does not have "money to throw around" so as a result, he often has to "pick and choose what I can access and if I can't afford it, I go without." He said that he was told that he was ineligible for a white or gold card. For the other client, the issue was more about a lack of contact with DVA: "even talking over the phone to someone you still have that distance and can't relate to them as well as if you were meeting in person".

DVA staff

A theme that emerged as both a barrier and a facilitator to rehabilitation was DVA staff. Almost half (n=8) of the clients directly commented on the role their case managers played in their rehabilitation. Some clients mentioned that they were very helpful and efficient whilst others mentioned that they felt as though some staff members hindered their rehabilitation. Related to this, over a quarter of clients (n=7) mentioned that changes in the DVA staff managing their cases over time impacted on their rehabilitation experience. Some comments in relation to DVA staff are provided below.

DVA client (SA) *"The process was very "bureaucratic", however the DVA staff seemed to handle and support the medical rehabilitation needs of clients reasonably well (e.g. surgeries, physiotherapy and hydrotherapy). They were not as helpful with providing other forms of rehabilitation assistance such as access to household services and workplace assistance but this has improved in more recent years."*

DVA client (SA) *"Staff always seemed to be changing and this can be difficult for the client to keep track of who their case worker is and can lead to confusion both for the client and the staff who have to keep track of the needs of their clients."*

DVA client (NSW) *"The two DVA staff members were easy to deal with. I didn't need to give them my life story each time. It was efficient. It was really quick and they knew what they were doing."*

DVA client (NSW) *"One of the biggest problems was every time I spoke to someone there was a new person I would have to deal with. There was no continuity between what one person would say and what the next would say in relation to approval for services. Everyone seemed to have a different view on how they would apply the guidelines. This was very frustrating."*

DVA client (VIC) *"If I ever needed anything, I just called up and it got sorted out for me."*

DVA client (VIC) *"They are very good with provision of aids, services etc. but not good with the 'nitty gritty' of assessments or appointments - that's where they fall down. The process is okay but there are too many chiefs and not enough Indians. Nobody will make a decision and when somebody does, someone else usually counters it."*

DVA client (VIC) *"I have had six different case managers over a 2 year period. This causes a problem because no-one gets to know my case properly."*

Suggested areas for improvement

The last section of the interview focused on the key areas that clients felt DVA needed to improve in order to deliver appropriate rehabilitation services for clients. The majority of areas for improvement outlined below extend on the key themes discussed in the previous sections of the report.

Awareness about rehabilitation

One of the major areas that clients felt could be improved was ensuring that clients are provided with information about rehabilitation to increase awareness about their options. A number of interviewees indicated that the best outcomes are most likely to be achieved when clients are provided with detailed information at the beginning of the rehabilitation process to increase awareness about what the process would involve, who would be involved and the services a client may be able to access. Several clients suggested that the development of an information pamphlet to be distributed to ADF members during transition would be useful in this respect. This could also provide a way to ensure that there is consistency in the information provided to clients (both current and discharged members). A related point was the need to think about when clients are provided with this information. For those clients who were still serving ADF members, this posed further difficulties as to when they would be provided with such information if they were not discharged. Some suggestions included having an electronic newsletter that was distributed to all DVA clients and having a user-friendly website that included access to relevant information about how to submit claims, types of services clients may be able to access and who to contact. Four clients suggested that it would be useful if there was an information pamphlet that was given out to everyone. Some of the suggestions made by participants regarding raising awareness about rehabilitation are provided below.

DVA client (SA) *"It would be useful if there was somebody permanently embedded at major defence bases in the area of health, where this person could act as a point of contact where ADF members could go to*

talk to about discharge or about claims they may be able to submit".

DVA client (SA) *"It would be really helpful if DVA produced a booklet and provided it to all individuals who experience an injury in the ADF which details a list of services etc. that you may be entitled to. It would be beneficial for the client's family members to receive the same or a similar booklet."*

DVA client (SA) *"The first 12 months of rehabilitation for a client is important. DVA need to make more regular contact with clients and provide them with more information as this would make the transition of coping with the injury so much easier."*

DVA client (VIC) *"It would be useful if DVA knew when a client was being medically discharged so they could provide a package to the client explaining what they were entitled to. The information could be tailored to the needs of the client, e.g. their type of injury, their years of service in the ADF and explain what they are entitled to. This way, the person can go back to the family, look at what they can access and what they really need and go back to DVA better informed."*

Communication

Another area for improvement that was raised by clients revolved around contact and communication between DVA staff and clients. Half of the clients mentioned that DVA staff need to be more proactive and take the initiative in their communication with clients as a number said that any communication about their case was always self-initiated. Some comments include:

DVA client (SA) *"DVA staff should be doing regular checks on people to see how they are going and whether they require any services or help."*

DVA client (SA) *"I was left to drift…DVA should have an obligation to follow up on things with clients."*

DVA client (SA) *"I was never contacted. Contact was always self-initiated. This really made me feel alone."*

DVA client (NSW) *"There should be a point in time that acts as a red flag showing that a file is still active but there has been no client contact and so DVA staff should follow up on it."*

Client-focused rehabilitation

Related to the suggested need for greater focus on communication with clients was the suggestion that DVA staff need to become more 'client-focused'. A number of DVA clients (n=7) said that they felt like they were treated like a 'case number' and not as an individual. Therefore, individualised service delivery and adaptability/flexibility depending on each client's needs were highlighted as areas of importance for good rehabilitation. Comments from some clients include:

DVA client (SA) *"DVA need to treat people as individuals rather than grouping them together according to what they can/can't do and what they can/can't access."*

DVA client (NSW) *"I didn't get the feeling that they [DVA and my rehabilitation provider] were listening to what I wanted. It seemed as though it was expected that one size would fit all clients."*

DVA client (NSW) *"DVA staff need to recognize that they are providing customer service to the clients."*

DVA client (VIC) *"The process of handling my case wasn't very personal at all. There was no human contact. I wasn't even a name on a piece of paper – I just felt like a reference number."*

Provide a broader range of services

It was also suggested that DVA would benefit from reviewing the range of services it provides to clients and ensuring that there was consistency in the understanding and approach to rehabilitation. In particular, the importance of a holistic approach to rehabilitation was raised by some clients who felt that rehabilitation needed to focus on addressing physical, psychological, social and vocational needs as well as providing support to the client's family where required. More than a quarter of clients mentioned the need to focus more on the mental health needs of clients. Several clients pointed out that clients are reluctant to ask for help in relation to their mental health needs and therefore it was really important for the DVA case manager to ask the client how they were feeling. This point was raised by clients across all three states. Some comments regarding the need for a holistic approach towards rehabilitation are provided below.

DVA client (SA) *"I'm pretty happy with the physical and medical side of the rehabilitation I have received. However DVA need to look more closely at their advice/assistance with psychological issues experienced by clients."*

DVA client (SA) *"I would have liked some psychological help to assist with coping with my condition. It also would have been good if my wife had been provided with some assistance with helping me cope with my behaviour. The whole family needs to be provided with assistance to deal with and understand what is happening."*

DVA client (NSW) *"Rehabilitation should be targeted at the whole of person both their physical and mental health needs."*

DVA client (NSW) *"It's important that DVA are conscious of the fact that their decision doesn't just impact on the client but also the client's family."*

DVA client (VIC) *"It's about feeling like they care. Being injured, it wasn't just the physical side, it was mentally tough. When you're injured, you feel as though you don't have anyone to talk to about what you're going through…you have your family and friends but they can't offer that extra support and let you know what to expect. It would be good if your case manager called you up to talk about things."*

Focus on function

Following on from the above point focusing on a holistic approach to rehabilitation, approximately a quarter of clients mentioned that, going forward, the focus of DVA needs to be on provision of relevant services rather than on providing compensation or financial aid. This point was raised more by younger clients. They said that their first priority was to be able to attain the best possible level of functioning. Again, this point was raised by clients across all three states. Some comments include:

DVA client (SA) *"They pay your bills but don't actually do anything to help you".*

DVA client (NSW) *"It's my opinion that DVA are simply concerned with processing cash flow. No one in DVA or the navy are there to give you a hand when you actually need it. You're caught in bind between of being good enough to go to work and being sick or unfit enough to warrant help."*

DVA client (VIC) *"It's all about accepting liability and not about trying to help."*

DVA client (VIC) *"DVA need to understand that even though the financial assistance is of a great help, it is also important for there to be recognition of how injuries impact on a person's life."*

Timeliness of processes

The final area for improvement raised in discussions with clients relates to the timely approval and provision of rehabilitation services. It was outlined above that more than half of the clients commented directly on the administrative processes in place for approval of rehabilitation services for clients and the fact that some believed that the time taken for services to be approved was too lengthy and impeded their recovery. Most of these clients felt that the approval process needs to be sped up to respond to the immediate rehabilitation needs of the client so rehabilitation is provided as early as possible. Some comments include:

DVA client (SA) *"It would be beneficial for staff to look at what injury a client has and pre-empt what kind of services they are likely to need (e.g. physiotherapy) and in a way 'pre-approve' the provision of those services so that the client does not need to wait around for DVA approval (which can be timely) before they can access rehabilitation and treatment."*

DVA client (NSW) *"The DVA process is all about acceptance. Once they have accepted the injury, then they can offer you things such as treatment and services, but until then you're left to your own devices. What DVA need to focus on immediately is the recovery of the client to ensure they are getting the things they need to get better. Whilst processing a client's claim, clients should be getting some kind of assistance."*

DVA client (NSW) *"As long as it was relevant, there was no problem in getting things approved."*

Summary

The feedback from DVA clients regarding the barriers to rehabilitation and suggested areas for improvement can essentially be categorised into three areas: communication/information, DVA's approach to rehabilitation service delivery, and DVA's administrative processes. These are briefly summarised in turn below.

Communication, at various points during the client's contact with DVA, was a central theme. An important barrier to accessing rehabilitation raised by clients was a lack of awareness about the rehabilitation available through DVA. It was pointed out that if clients were not provided with the necessary information to begin with (in terms of knowing what they could access, what the process would involve, who to contact etc.), it was unlikely that they would be able to achieve the best rehabilitation outcomes as this lack of awareness has ramifications in terms of early and appropriate intervention. Clients made a number of suggestions to overcome the current information barrier including the distribution of an information pamphlet to all ADF members during transition and ensuring that there is a user-friendly website available for clients to refer to for further information. Better communication between DVA staff and their clients was also suggested as area which could be improved in terms of DVA staff being more proactive in communication with clients as well as adopting a more client-focused approach.

Another major area that clients felt was important to address was the need for a holistic approach to rehabilitation. It was pointed out that rehabilitation service provision needs to focus on addressing physical, psychological, social and vocational needs as well as providing support to the client's family. Related to this

point, some clients felt as though there was more of a focus on providing financial compensation rather than relevant services to assist in improving a client's overall level of functioning and quality of life. Clients suggested that it was vital that DVA's approach to rehabilitation is flexible so that each individual case is assessed on its merits and there is flexibility in the provision of services depending on the needs of the client.

The other major barrier to accessing timely, quality and relevant rehabilitation raised by clients was DVA's administrative processes. A number of clients suggested that the rehabilitation process was more effective when there was early intervention and the provision of immediate services. However it was pointed out that this was often affected by the time it takes from making a claim through to acceptance of liability, assessment, approval and provision of services. Clients felt it would be beneficial if it was possible to speed this process up as clients would be able to access the assistance when they need it the most – immediately when they make a claim.

Section 2: DVA staff focus groups

Introduction

Around the same time that the interviews were conducted with DVA clients, a number of focus groups were also carried out with DVA staff involved in rehabilitation service delivery based in Adelaide, Sydney and Melbourne. Given their experience working in the area of rehabilitation with DVA clients and rehabilitation service providers, it was believed that the staff would be in a ideal position to comment on aspects of the rehabilitation process that work well and aspects that could be improved. Drawing on the knowledge and advice provided by DVA staff, the purpose of the focus groups was to use the information to assist the Department to gain a better understanding of what DVA staff believe successful rehabilitation involves, what measures they use or believe should be used to measure rehabilitation outcomes and their views on the barriers and facilitators to rehabilitation for DVA clients. The themes emerging from discussions with DVA staff surrounding barriers and facilitators to rehabilitation also provide an opportunity to compare the barriers and facilitators raised by DVA clients in the previous section. This will be examined in further detail in the 'Discussion' chapter of this report.

The interviews with staff covered questions focusing on five main areas:

1. Key components of rehabilitation
2. Experience working with rehabilitation service providers
3. Determining successful rehabilitation outcomes
4. Facilitators & barriers to rehabilitation
5. Suggested areas for improvement

Methodology

The managers of the rehabilitation sections in each state (South Australia, New South Wales and Victoria) were asked to identify DVA staff to participate in the focus groups. Nominated staff were those who were involved in the process of assessing and/or managing clients through the rehabilitation process, those who have regular contact with providers delivering rehabilitation to DVA clients, or those who have worked in this role in the past. The respective managers emailed through the list of nominated staff to participate along with their contact details. Nominated staff members were then sent an email with a letter of invitation to participate in the focus group. The documentation relevant to the focus groups with staff (letter of invitation, participant information sheet, consent form and interview questions) can be found in Attachment B.

The consent process for the staff focus groups was the same as that conducted in the face-to-face interviews with DVA clients. Each staff member was provided with a participant information sheet at the beginning of the focus group and asked to sign a consent form indicating whether they were happy to participate and whether they were happy for the discussion to be audio-recorded. Participants in all states agreed.

In total, 18 staff across the three states participated in the focus groups: 5 from South Australia, 7 in NSW and 6 in Victoria. This included a mix of staff who worked with MRCA, SRCA and VEA clients, those who work in the area of household services, incapacity payments as well as rehabilitation.

Findings

The themes emerging from the focus groups conducted with DVA staff are discussed in terms of the five main areas listed in the introduction (key components of rehabilitation, experience working with rehabilitation service providers, determining successful rehabilitation outcomes, perceived facilitators and barriers to rehabilitation, and suggested areas for improvement). As in the previous section, the key themes emerging from the focus groups across all three states are discussed within each of these five areas and where relevant, a number of quotes have been provided. This section will also contrast the perspectives of staff from across the three states regarding the key themes and rehabilitation processes adopted in the respective states.

Key components of rehabilitation

Each focus group commenced by asking participants to describe the key components of rehabilitation for DVA clients. Across all states there was consistency in the perceived key components of rehabilitation that were described. This included addressing the medical and psychosocial needs of clients including improving quality of life, providing vocational rehabilitation with a focus on return to work as well as the provision of aids, modifications and appliances. It was agreed that the aim was to restore the client's capacity to what it was prior to injury.

Broad range of DVA clients

Across all three states the staff pointed out that they see a broad range of clients including recently discharged ADF members as well as clients who finished serving many years ago. They also noted that clients can enter the DVA system via a range of avenues including self-referral, referrals from GPs as well as through the discharge process from the ADF. The staff felt that it was important to recognise the range of clients who are managed by DVA as they often have different expectations regarding the purpose of DVA, the outcomes they would like to achieve as well as how they would like their needs to be addressed.

Generally the staff felt that the DVA rehabilitation process works well in achieving positive results for clients although a number of factors can impact on clients achieving different outcomes. These included:

- Early intervention with clients (in terms of client awareness about DVA rehabilitation services as well as ensuring DVA are informed of clients discharging from the ADF);
- Client motivation;
- Severity of the client's injury, illness or condition; and
- The rehabilitation service provider to whom the client is referred.

Outcomes were also seen to differ depending on which Act the client falls under – VEA, SRCA or MRCA. Staff from South Australia felt that for MRCA and SRCA clients, there was a more proactive approach towards clients in terms of early intervention – "you get them early, get them young and get them rehabilitated". Whereas for VEA clients, staff felt the process was more reactive as it was "up to the client to identify that they have an issue", which DVA would then attempt to address. It was pointed out that for VEA clients the focus is more about maintenance and ensuring positive quality of life outcomes rather than rehabilitation and return to work per se.

Early intervention

When asked whether they felt the current rehabilitation process was working well, staff from all states emphasised the importance of early intervention. Staff from Sydney felt that outcomes were very dependent on the length of time between injury and access to rehabilitation services: "the case is usually more difficult if the client was injured years ago but is only now accessing rehabilitation as they may have been unemployed for a long period of time and therefore their motivation to return to work and/or get better may not be as high as for clients who receive early intervention." Similarly, staff from South Australia and Victoria seemed satisfied with the range of services available to provide to DVA clients but wondered whether there were ways to make sure that those who can access rehabilitation are aware of this. One staff member from Victoria raised an example of a client who had been receiving incapacity payments for two years but who was unaware that he could access any other services including rehabilitation. Some comments included:

DVA staff (SA) *"By and large the system works well, but DVA is aware that it is not a perfect system. It relies on people being referred. If they don't come into the system in the first place, DVA's ways of attracting them or making them aware of their existence are not great."*

DVA staff (VIC) *"There are not people out there who are dealing with the younger clients. The WWII clients have people out there who they can go to for advice but it has only been since MRCA came on board that there has been a push in getting information out there [for younger clients]. But for those on SRCA, that is not helpful and they are not aware of the information and that makes up a large proportion of the clients."*

Changes in rehabilitation over time

There was general agreement amongst staff that the rehabilitation provided to DVA clients has improved over time. It is now more targeted at the whole of person and not just the short-term goal of getting the client into employment. However, it was evident that the staff felt that return to work remained the primary focus of rehabilitation but more so in terms of ensuring that clients find sustainable employment options rather than simply getting the client into employment and then closing their case.

One interesting point raised by staff from Victoria in relation to changes in thinking about rehabilitation was that staff are now encouraged to "think yes rather than no" when providing services to DVA clients. In other words, they are now encouraged to take a more flexible approach when dealing with clients and approving rehabilitation services. For example, one staff member commented that they "took the position that if we

have paid X amount for a program to date and the next step is a little bit uncertain as to how beneficial or necessary it is, given that we have invested so much already, if we can get the person back to work or an outcome that is beneficial, for the sake of spending a few extra dollars, it is worth it in the long run." Furthermore, "older staff members seem to be very firm in their interpretation of the legislation but this seems to be changing with the newer staff who come on board. It's all about trying to do the right thing for the client. It's about getting the best outcome for the client - it's okay if staff are more flexible in their approach to this." Staff explained that they were told if you "need to hold off and get a few extra pieces of information that might change the outcome in a decision and result in a possible 'yes' decision, they should do this."

Experience working with rehabilitation service providers

The next section of the focus group discussions asked staff to provide feedback on their experience working with rehabilitation service providers. It was apparent from the discussions that staff viewed their role as more administrative in nature whereby they managed the high-end administrative decisions and monitored the progress on each case, whilst the role of the rehabilitation service provider was to manage clients on a more personal level in terms of assessing need, delivering the necessary services and feeding back information to the DVA rehabilitation staff. The rehabilitation providers were viewed as the 'experts' for whom the DVA staff relied upon for advice. Some comments from staff are provided below.

DVA staff (SA)	*"You just have to be guided by what the provider says."*
DVA staff (NSW)	*"We mostly focus on the information from the provider to determine whether a successful outcome has been achieved."*
DVA staff (VIC)	*"Realistically, DVA staff rely on the rehabilitation providers to set the goals etc. DVA's role is to monitor and ensure they are achieving the goals – their role is administrative."*
DVA staff (VIC)	*"We trust the rehabilitation provider to be the medical professionals in these situations because DVA staff are not qualified."*

Approach to referring clients to service providers

When asked how they determine who to send a client to, the main factors that influenced the decision were:

- The availability of providers in the regional area where the client lives;
- Ensuring the provider is client-focused in service provision;
- Depending on the needs of the client, whether there is a provider who is a specialist in that area;
- Client preferences (e.g. if they have previously participated in rehabilitation through a specific provider); and
- Reputation and previous experience working with the provider.

Some quotes demonstrating the above approach to referring clients to rehabilitation service providers are provided below. It was evident that staff from South Australia placed a strong emphasis on ensuring that rehabilitation providers provide a client-centred and individualised rehabilitation service. For staff from NSW, a factor that was important in determining which provider they referred a client to was the geographic

location of providers and their proximity to clients. For example, it was noted that "many clients are from regional areas…if a rehabilitation provider is not available from the area where the client lives, we usually refer the client to one of the national providers such as CRS". Similarly, Victorian staff mentioned that "we have used CRS a lot in the past because they had the geographical spread."

DVA staff (SA)	*"We need to be satisfied that they are client-focused. We don't like the tick & flick approach and they should follow up with clients."*
DVA staff (SA)	*"An underlying concept in the rehabilitation is that the client should be involved and participate in the rehabilitation, not just be directed. So to be client-focused, they need to involve the client."*
DVA staff (NSW)	*"In cases where there are multiple providers a client could be referred to, the decision is usually based on which provider would be able to best address the needs of the client."*
DVA staff (VIC)	*"Depending on where the person lives, if we have service providers we have previously worked with who have done a fantastic job (provided the necessary reports etc.), we will use them primarily over the other providers."*
DVA staff (VIC)	*"Sometimes the clients have a preference for which provider they are sent to (e.g. they may have previously participated in rehabilitation through a particular rehabilitation provider)."*

There was agreement across all three states that providers tend to specialise in particular areas such as addressing the vocational needs of clients, medical and physical needs and psychosocial needs. For example, one staff member from South Australia commented, "one company may be particularly good at job search skills, others may be good at getting a client through the medical phases so they are ready for job searching. Even though they are both approved providers under the Comcare scheme, we would try to pick the company that is most appropriate for the person at that time." Staff from NSW made a similar point regarding specialisation: "some rehabilitation providers are better than others and some specialise in particular areas such as vocational rehabilitation or mental health issues." However, it was pointed out that once a client has been referred to a particular provider to be assessed and participate in rehabilitation, they try not to involve or move them to another service provider as it is important that the provider builds up rapport with the client. It is only if DVA or the client is very unsatisfied that DVA would refer the case to another provider.

Communication between DVA and service providers

In all states, the staff agreed that communication between DVA staff and rehabilitation providers is mostly made via progress reports and closure reports. However in some cases, there can be daily communication between rehabilitation consultants and DVA rehabilitation coordinators. It was evident that the processes in place for maintaining contact with rehabilitation providers as well as the direction, training and feedback provided to providers varied widely across the three states. For example, staff from South Australia indicated that they have face-to-face meetings with providers on a semi-regular basis. Similarly, staff from Victoria reported recently introducing regular case conferences whereby DVA staff meet face-to-face or via phone or video hook-up every 4-6 weeks to discuss expectations, case progress and feedback regarding service delivery, case management and reporting to DVA. Furthermore, the Victorian staff reported conducting training sessions where both providers and DVA rehabilitation staff discuss the DVA

rehabilitation framework and expectations regarding case management, expected outcomes and quality of reporting to DVA. Both states saw this process as beneficial to ensure that both DVA staff and rehabilitation providers are 'on the same page' regarding expectations.

In contrast, staff from NSW did not report any formal mechanisms whereby regular contact and feedback is supplied to providers. Staff were of the belief that such formal feedback and regular conferencing was "not feasible" because of the large number and wide geographic dispersion of providers across the NSW/ACT region. However, it is worthwhile noting that staff discussed the process in Townsville where rehabilitation providers and DVA staff do meet on a more regular basis and it was acknowledged that "good providers are usually those who have sat down with DVA and spent time understanding the rehabilitation process and DVA's expectations and the provider's role in the process." Some comments include:

DVA staff (SA) *"We sit down with the providers to start with to explain the standards, expectations, the DVA framework, process, perceived outcomes for different types of cases etc. We don't just cold refer. Then we try them out. If it's not working, we sit down with them again. However we have regular meetings with all providers – this is a good thing from a business perspective both for them and DVA as it allows the opportunity to provide feedback on what works well and doesn't work well."*

DVA staff (NSW) *"We're not aware of any scheduled face-to-face meetings between DVA and the contracted rehabilitation providers, however these do happen from time to time. There is no formal process for this feedback to occur."*

DVA staff (VIC) *"Often we will go through each of the clients DVA has with the particular provider, outlining where the provider is at with the client, where DVA is at and what we need from the client and provider at that point in time. It is about moving the case along and making sure that nothing is missed. It is in their best interest to do what DVA wants because they want the business."*

Expectations and understanding of DVA's rehabilitation framework

Perhaps related to the above point regarding communication with rehabilitation providers, staff from NSW raised concern in relation to the perceived unrealistic expectations of clients and impractical recommendations made by some providers, particularly in the provision of household aids and modifications as well as in terms of vocational rehabilitation. For example, one staff member commented that "if the client can get the swimming pool, they'll ask for a diving board too." It was also pointed out that some clients are provided with unrealistic expectations regarding their vocational employment possibilities or they start off with unrealistic expectations which are never addressed by the rehabilitation provider. For example, it was pointed out that one client who had been discharged from the ADF wanted to become a helicopter pilot and their rehabilitation provider led them to believe that this was feasible when it was not given their medical injury/condition (they were suffering from posttraumatic stress disorder and had issues with drug/alcohol use).

Amongst staff in NSW, there was the belief that this problem regarding unrealistic expectations usually stems from a lack of understanding of DVA's rehabilitation system by rehabilitation providers. When asked how they thought this could be addressed, the staff agreed that the guidelines given to rehabilitation

providers are too vague (particularly in relation to guidelines for approval of whatever is considered 'reasonable' in relation to injury) and rehabilitation providers do not have a clear understanding of what DVA rehabilitation staff want them to provide to the clients. Although staff from South Australia and Victoria did not mention a specific problem with rehabilitation providers making unrealistic requests on client rehabilitation plans, they did raise the question of what is 'reasonable' to provide to clients regarding rehabilitation in terms of a lack of definitional clarity surrounding this concept. Staff from NSW in particular believed that providers are unclear about this concept and seem to be of the understanding that DVA will approve any services or aids in relation to the client's injury/condition. It was acknowledged that the interpretation of what is 'reasonable' can differ from person to person and this is also the case amongst DVA staff and rehabilitation providers. For example, one staff member from NSW asked the question, "what if you have a wheelchair dependent client who resides in a split level home: Is it reasonable to install a lift in their home so they can reach the second floor?" Some other comments regarding approval of services and the concept of 'reasonable' rehabilitation are provided below.

DVA staff (SA) *"Therapists know that it's a pretty broad approval process and that as long as it's a reasonable request, it's more than likely that DVA will cover it."*

DVA staff (SA) *"It is pretty broad in terms of what is 'reasonable'. It comes down to an individual delegate to decide, however this is an appealable decision from the client's point of view."*

DVA staff (NSW) *"Clients need to have realistic expectations about what to expect from their rehabilitation and be realistic about the services and aids they can receive. There is a need to balance the needs of the clients against their wants."*

DVA staff (VIC) *"There is a need for a clearer definition of 'reasonable' and this is important for consistency across DVA offices nationally. You can set guidelines and the delegate can still go outside them depending on the circumstances. It's not right that different clients can access different services depending on which delegate they get. What's reasonable for one person may be totally unreasonable for another person."*

Determining successful rehabilitation outcomes

All staff agreed that it is difficult to determine success because it is subjective and can differ from client to client. It was pointed out that whether a client achieves a successful rehabilitation outcome depends on what their initial goals were. For example, a staff member from South Australia discussed a current client he had who was suffering severe posttraumatic stress disorder symptoms, which had resulted in the client refusing medical attention and practically living as a recluse. For this client the staff member felt that a successful outcome would be ensuring that the client has a support network in place to assist him and noted that "each time he leaves the property and accesses treatment is a small victory."

Staff perceptions about success in rehabilitation

Staff from NSW indicated that successful outcomes are determined on the basis of a hierarchy of outcomes outlined on a client's rehabilitation plan. It was agreed that outcomes where a client returns to work in a position that is satisfactory from their point of view as well as sustainable are considered most successful. In cases where the goal is not a return to work outcome, improved quality of life and ensuring the client has

undertaken steps to assist themselves in the treatment of their condition were seen as successful. One participant from NSW commented that as long as the client has been provided with the services or aids outlined in their rehabilitation plan, then the outcome should be considered successful regardless of whether they achieve their overall rehabilitation goal (e.g. attended re-training but did not get a job). It should be noted, however, that in asking staff a number of the focus group questions, such as to describe what a successful outcome in rehabilitation looks like, the first response of the majority was to focus on return to work cases and outcomes (e.g. rehabilitation should get the client back into sustainable employment). In some cases, the staff had to be explicitly asked what would be considered successful in non-return to work cases, which may suggest the need to increase understanding about holistic approaches to rehabilitation which also focus on psychosocial interventions.

Information used to assess clients and monitor success in rehabilitation

When questioned about use of formal outcome measures to monitor and determine success in rehabilitation, staff indicated that they do not use formal outcome measures as this was the role of rehabilitation providers in their work assessing and monitoring the progress of individual clients. For example, one staff member from South Australia commented: “there are standardized reporting systems. But we expect the providers to use the standardized outcome measures.” Staff were then asked what information sources they use to monitor progress in client cases and to determine successful outcomes. In the vast majority of cases, the staff mentioned relying on the initial rehabilitation assessment reports, rehabilitation plans, progress reports and case closure reports supplied by rehabilitation service providers to identify the goals of rehabilitation and outline progress and success in achieving these goals. There were differences across the states, however, with staff from NSW reporting that they do not conduct or use information collected via the Needs Assessment or Rehabilitation Assessment. The NSW staff generally felt that these forms were “too cumbersome” to use and that most staff have their own way of doing things and it usually comes down to how much time the staff have to focus on those types of reporting mechanisms. The staff commented that they usually monitor client’s progress through reviewing provider progress reports and conducting informal discussions with clients, which may or may not be documented as “this often comes down to the individual discretion of the delegate, how many notes they take and the time they have to write up the discussion.”

It was also noted that the information used to determine success differs depending on whether it is a return to work or non-return to work case in terms of the ongoing monitoring of client outcomes. Staff reported that in return to work cases, there is a 6 month and 12 month follow up to look at the sustainability of employment. For example, one staff member commented “we try to ring the client to see if they are still in employment but if you can’t make contact, you just assume that everything is okay.” However, some staff mentioned that there were other methods by which to monitor how clients are going post-closure of their rehabilitation case. In non-return to work cases, the staff indicated there is no formal measure but that you usually hear from the client if they did not consider their rehabilitation to be successful. Staff from Victoria also indicated that cases can be monitored by yearly household services reviews and medical and incapacity payments. For example, if the client is no longer receiving incapacity payments, “in most

cases…that means it's a successful outcome as they are back at work." Furthermore, through the regular reviews of household services provided to a client, staff can monitor the client's situation and conduct reviews to see whether the client's circumstances have changed and whether they require any further assistance including rehabilitation. Generally, staff in all states felt confident that clients would make contact with DVA if they required further assistance after case closure. Some comments are provided below.

DVA staff (SA) *"We are reasonably confident that if they have an ongoing problem that they would come back to us because we tell the client and provider that if they have future issues to make contact."*

DVA staff (NSW) *"Although there is not a formal feedback mechanism, the client will call up if they are unhappy or require more assistance."*

DVA staff (VIC) *"If an ADL has been done, the client is aware that they can call DVA up if they need anything else. We try to keep the communication lines open."*

Client satisfaction surveys

In South Australia, the staff who worked with VEA clients mentioned using client satisfaction surveys to assess positive outcomes. Staff from Victoria indicated that introducing client satisfaction surveys at case closure would be useful to provide feedback on the rehabilitation provider's performance as well as that of DVA. One staff member commented that "realistically, the only way that you know something is falling down is if you get feedback." The staff from Victoria acknowledged that from a client's point of view, there would invariably be aspects that could be improved. Another staff member said "we do a lot of training with staff and providers but we don't sit down with clients and ask what we can do to make things easier for them. DVA is the one who is putting the client through the process but we don't get any feedback from the clients about what they thought of the process." However, the staff pointed out that caution would need to be exercised in terms of implementing such a survey. The surveys would need to be voluntary, anonymous and seek targeted feedback rather than adopting a blanket approach. The reason being that "the older VEA clients are generally happy with what they get whereas in the military compensation area, we deal with younger clients who may not be as happy (a lot of them have psychological or anger issues) and are just looking for someone to blame. DVA are still seen as an off-shoot of Defence and because they tend to be angry at Defence as they can no longer work there, they are more likely to blame DVA." Furthermore, it would also need to be made clear that the responses would in no way affect any pension, benefits or health services they currently receive or may receive in the future from DVA.

Facilitators & barriers to rehabilitation

Consistent with the interview questions asked of DVA clients, DVA staff were also asked to describe perceived barriers and facilitators to rehabilitation for DVA clients. It is noteworthy that in contrast to the majority of barriers mentioned by clients that were described as organisational or system level barriers, a number of the barriers mentioned by DVA staff focused on barriers to rehabilitation at the individual client level.

Client motivation

At the individual client level, a barrier mentioned by staff was the level of client motivation. Staff from Victoria noted that "most clients are motivated to return to work but then you get some who are not motivated." Staff from both NSW and Victoria noted that for some clients there is a tension between accessing DVA compensation payments and motivation to participate in rehabilitation to enable them to return to employment. They mentioned that some clients appear to feel a sense of entitlement to financial compensation above other types of support and believed that ex-service organisations can sometimes play a role in this. For example, one staff member from Victoria commented: "ESO representatives fixate on getting client's a TPI pension and gold card as that is seen as the goal but this is a dead end if you're only 25. Some have the perception that because they have been thrown out of the military, DVA owe them a living and should pay them."

When asked what the staff do if a client is not motivated to participate in rehabilitation, an incentive mentioned by staff was that if clients do not participate in rehabilitation, they will not be able to access their incapacity payments. For example, one staff member from Victoria commented that "the client has their rights and obligations information so they know that if they don't comply with their rehabilitation, they won't get their incapacity payments – so that makes them comply." Similarly, staff from South Australia spoke about the perceived "magic stick" that client's feel DVA staff can hold over them if they do not participate in rehabilitation: "the only reason my client is participating is that he thinks we have some kind of stick. I haven't got a stick but I'm not going to tell him I don't."

However staff from NSW pointed out that there are differences in what action can be taken if a client is not participating in their rehabilitation depending on whether the client falls under MRCA or SRCA: "Under SRCA, if a client is not actively participating, the delegate can suspend their compensation payments/services. Under MRCA, this is more difficult because the delegate needs to have more evidence that the client has been provided with assistance and offered a reasonable job but that they don't intend to work." On the whole though, staff commented that most clients want to get better and get back into employment. It is usually in longer-term cases where the client has not been working for several years where they come across problems. Therefore, getting the client into rehabilitation as early as possible is important to keep them motivated and interested in returning to work.

Another barrier that staff from NSW mentioned in terms of return to work was a belief by some clients that if they return to full-time employment, they will be unable to continue participating in rehabilitation and undergoing medical treatment, which will enable them to become "cured of their condition". Staff pointed out that there was sometimes a reluctance to work because the client would "prefer to continue attending their medical appointments and accessing treatment (such as physiotherapy) instead of working because if they are working, they would not have as much time to attend the medical appointments to get better."

Unrealistic client expectations about rehabilitation

A further barrier identified at the individual client level was the unrealistic expectations that many clients have regarding rehabilitation services and outcomes, particularly in terms of vocational rehabilitation outcomes. The staff pointed out that most DVA clients have been medically discharged and will rarely get back into the ADF but for some, that is all they want. When the client comes to the realisation that they will not be able to rejoin the ADF, this can lead to problems with motivation and a reluctance on the behalf of the client to look at other vocational rehabilitation options. For example, one staff member highlighted that a common client comment is "all I ever wanted to do was be in the army. If I can't be a soldier, I don't want to be anything else." When asked how they ensure that the client's expectations are realistic regarding what they would like to achieve from their rehabilitation, the staff indicated that the methods employed differ depending on DVA staff but most have an informal discussion with the client before referring them to a provider. Rehabilitation service providers also play an important role in addressing client expectations and maintaining motivation.

Early intervention and transition out of the ADF

In all states, another significant barrier to rehabilitation mentioned by staff is getting clients to commence rehabilitation early in the process. Related to this barrier is the belief that those still serving are reluctant to make a claim for their injury, illness or condition for fear of being discharged, which results in clients delaying the onset of rehabilitation. One staff member from South Australia commented that "some of them also associate submitting a claim with 'it's not the done thing'. This has to do with the Defence culture and stigma, particularly around mental health conditions. Often we are asked by clients 'if I submit a claim, it means my discharge, doesn't it?'" The staff pointed out that unless a client has made a claim for their injury, illness or condition which is then accepted by DVA, there will inevitably be "a gap between the time they get out of the ADF to when DVA processes their entitlements to determine whether their injury or condition is as a result of their service." Staff from Victoria believed that clients often feel that they have been "dumped by Defence" and when DVA do not engage with them early after their discharge, they can feel as though DVA is also abandoning them. The staff felt that clients had an expectation that they could put in a claim a few days prior to medical discharge and have it accepted in a few days time. Staff felt that this process could be facilitated a lot better than is currently the case: "to be left out there with nothing and the perception of no support, then having to deal with a bureaucracy (which is how they see DVA), is very difficult for the client. There is some support and assistance during the transition process in terms of knowing what to expect about the claims process but not in terms of the rehabilitation process."

Furthermore, staff pointed out that if the client is administratively discharged, often DVA will not be aware of the client and so they will fall through the cracks. Staff from South Australia pointed out that for ADF members who are medically discharged, DVA has a transition service whereby DVA staff engage with the ADF member prior to discharge to discuss claims and entitlements. It was believed that making contact with ADF members prior to discharge and during their transition out of the ADF facilitates the quick transition from the ADF into DVA rehabilitation which is most beneficial for the client. One staff member from South Australia commented that "this has been one of our goals in more recent years – trying to capture those

members who are not leaving on medical grounds to be more aware of the services." It was pointed out that just because an ADF member is being administratively discharged rather than medically discharged does not necessarily mean that they do not have injuries or conditions that they could claim and get assistance with. Staff from NSW felt since MRCA had been introduced more has been invested in this area, with clients generally commencing rehabilitation earlier than was the case with previous clients. However it was pointed out that to get clients into rehabilitation early, there could still be improvements in the communication processes in place between ADF rehabilitation staff and DVA staff to improve the speed and smoothness of the transition process for clients. Similarly, staff from Victoria emphasised the theme of timeliness in the transition process: "the longer the client is without structure in their life, the more detrimental this can be for the client in terms of their quality of life."

In particular, where the client has a mental health problem, the barrier is often getting the client to report the condition and make a claim in the first place. Staff in all three states felt that the 'Defence culture' perpetuated this problem whereby ADF members are reluctant to lodge a claim for a mental health condition due to the perceived stigma associated with this – "it looks wimpy". The staff felt that more could be done to improve this because as one staff member from South Australia commented "at the end of the day, we can't help them unless they put the paperwork in." However, it was also pointed out that by not reporting the mental health problems at the time they occurred, this can hinder the claims process for the client in the long run due to a lack of evidence on the aetiology of the condition. It was also acknowledged that sometimes the mental health condition of an ADF member may actually impact on their ability to make a claim and therefore, it is important that staff are more lenient and flexible with these clients.

Rural issues

For clients living in regional or remote areas, a barrier can be getting them in contact with a rehabilitation service provider and also in terms of getting them back into competitive employment due to the shortage of appropriate employment opportunities typically available in regional or remote areas. Staff from Sydney pointed out that even if there are jobs available in regional areas, the jobs "often involve physical work that the client is incapable of doing due to their injury."

Consistency of DVA staff

Whilst staff from South Australia pointed out that they had a reasonably stable staff working in the rehabilitation area over the past few years, staff from NSW and Victoria acknowledged that there have been a lot of staff changes in the DVA rehabilitation section recently and this probably acted as a barrier to rehabilitation for DVA clients. It was pointed out that such staffing changes result in the need to re-educate DVA staff about the rehabilitation framework and what is reasonable to expect from rehabilitation providers and clients. Staff from the Victorian office indicated they are now responsible for also managing DVA clients from the Tasmania and ACT regions. In addition, the staff indicated that the process of handling DVA clients has recently changed in Victoria due to the increased number of new staff members – there is now a separation of roles so that different staff deal with client incapacity payments and another staff member handles the rehabilitation aspects of a client's case. It was believed that this separation of roles would make

it easier for staff to learn their rehabilitation role in it's entirety before moving on to handle incapacity payments. The staff indicated that taking over clients from the other state offices had been a "big learning curve in terms of the approval process and consistency in decisions" but that the separation of roles allows DVA to "do what best suits the client but also what best suits the staff based on their skills". One staff member commented that "it appears to be working well at the moment because we have had a stable staff group. You also get to know your clients." Furthermore, it was pointed out that separating these roles was seen as beneficial as the two roles essentially have a different focus with incapacity payments focusing on the short-term whereas rehabilitation is about long-term outcomes. Staff noted that now "there is more of an emphasis on getting the client to participate in rehabilitation" rather than simply "getting somebody their money."

Facilitators to rehabilitation

In terms of aspects of the DVA system that facilitate rehabilitation for DVA clients, the staff felt that DVA has a system that is very flexible and not very restrictive in terms of what can be provided to clients, which ultimately acts to facilitate their recovery from injury or illness. Although it was mentioned by staff as a barrier to rehabilitation, early intervention and the transition of clients between the ADF and DVA was believed to be improving under MRCA. Staff from South Australia also commented that cases work well when all of the parties involved (client, employer, rehabilitation provider and DVA) communicate with one another.

Suggested areas for improvement

During the course of the focus groups, staff raised a number of areas where they believed there was room for improvement.

Continuity of service provision

Staff from all states mentioned that continuity of service provision and early intervention are important, particularly for those transitioning out of the ADF. Therefore, communication between the ADF and DVA in terms rehabilitation provided to clients, previous rehabilitation service providers used and discharge dates for clients was highlighted as critical and an area which could be improved. Staff from South Australia mentioned that the referral system between ADF and DVA works well most of the time but not in cases where the person has been administratively discharged. Some comments are provided below.

DVA staff (SA) *"If the individual is administratively discharged, they try to get them out of the system quickly on grounds of non-medical issues even if they do have medical issues and so they fall through the cracks. If they are medically discharged, there is a network to catch them."*

DVA staff (SA) *"It can be quite difficult if the client has to revisit their stories multiple times with different providers. Therefore continuity of service is important, particularly in mental health cases."*

DVA staff (VIC) *"There's a gulf between when someone is transitioning out of Defence to when DVA take over. There's no handover or continuity especially for those who have already received rehabilitation assistance through Defence. There's not really a program in place that says that the client should*

put a claim in, that DVA will accept liability, to explaining the incapacity and rehabilitation process – this should all start before the client transitions out of Defence and it should be much more thorough in terms of providing information on the client's history and their needs. Basically, we are just told that a person is discharging in 6 weeks."

Information pack to be sent to providers with every client referral

Staff from NSW indicated it would be beneficial to develop an information pack that could be sent out with each new referral to a rehabilitation provider for a client. This would ensure uniformity in the information sent to each provider and ensure consistency in the expectations amongst all parties (client, rehabilitation provider and DVA staff) regarding goals and expected outcomes in each case. Furthermore, the staff felt that it would be beneficial if the referral template used to refer clients to rehabilitation providers was improved to enrich the quality of the information supplied to the provider but it was also noted that it should not take too long to complete this paperwork. Staff were of the belief that such documentation was not currently in use but would be beneficial, particularly for new rehabilitation providers or providers who have not been referred a DVA client for a long time period and therefore may not be as familiar with DVA's rehabilitation framework.

Improve education and information for clients and other stakeholders

Another area identified for potential improvement by staff from NSW and Victoria was improving the education and information available for clients and those out in the community such as family members, ex-service organisations, RSLs and the media. In particular, the DVA website and fact sheets were suggested as key areas for improvement by staff from Victoria. It was pointed out that the information should be more targeted at those under different compensation Acts as there are currently a lot of information resources available for VEA clients but not as much readily accessible information for clients who fall under SRCA. Comments made by staff included:

DVA staff (NSW) *"It would be beneficial if the client was provided with a pamphlet that explained to them what they are likely to be able to access and what they can't access as it's not supposed to require a master's degree. It would also be useful if this covered a checklist of questions regarding expectations about rehabilitation."*

DVA staff (VIC) *"People don't understand that there are VEA, SRCA and MRCA. Even internally there isn't enough information and training about what the differences are between the different schemes. SRCA is just missed."*

DVA staff (VIC) *"The DVA fact sheets are very sub-standard compared with VEA fact sheets. The DVA military compensation website is appalling. It's not user-friendly but should be as the clients are younger and therefore more likely to be computer literate."*

Improve communication between DVA and service providers

Improving communication between DVA staff and rehabilitation service providers was also mentioned as an area of improvement in all three states. In particular, staff highlighted the importance of improving this communication to allow for closer monitoring of long-term rehabilitation and compensation cases in terms of

progress and outcomes. One staff member from South Australia commented that "in most cases, the providers want to see the client resolve the situation, their condition and move on. It's not in their interest to prolong the process." However, it was acknowledged that prolonged cases do occur and closer monitoring by DVA could assist in ensuring these clients receive the necessary rehabilitation services early in the process to maximise client motivation and the potential for successful outcomes rather than unnecessarily prolonging the case by not addressing client expectations and providing services earlier in the process.

Improve DVA administrative systems

Staff from Victoria indicated that it would be very useful for staff if there was one system where they could easily find out information about a client such as their incapacity payments, accepted conditions, updates on their rehabilitation as well as any other relevant information. It was pointed out that such a system exists for VEA clients (the VIEW system) and that staff who had worked on this system in the past had found it to be very user-friendly. One staff member commented that "in supporting clients, the systems DVA have don't actually support the rehabilitation process" because staff are required to "click on multiple screens to find the information so they are not seeing the client holistically in one snap-shot." Another staff member noted that "it's hard for staff to give information to clients because it takes so long to find information on the system. As a holistic client service, you want your staff to be able to look at a client's case file and immediately understand what is happening whereas at the moment this is not possible when a timely response is needed." The staff felt that having such an integrated system would be extremely beneficial in terms of improving case management and efficiency and would also reduce the amount of paperwork required and make it less likely that paperwork gets lost as it can be registered on the system.

Summary

It is interesting to note the similarities and differences in the feedback received from DVA staff across the three states compared with the feedback from DVA clients. Similar themes were raised by both groups but with the DVA staff placing stronger emphasis on the role of the rehabilitation service provider in the rehabilitation process. There was consistency in responses regarding the key components of rehabilitation with staff placing a strong emphasis on defining a successful rehabilitation outcome as one where the client returns to work. The staff pointed out the importance of recognising the complexity of the rehabilitation process for them given that a staff member may manage a range of different clients who fall under each of the three Acts as well as clients who may have been recently injured or those who were injured decades prior to their current rehabilitation experience. In terms of contact with rehabilitation service providers, the staff reported a number of factors that influence their decision regarding which provider to refer a client to. This included the geographic location of the provider, reputation, whether the provider specialises in a particular aspect of rehabilitation and also whether they are client-focused in their service delivery. It was apparent that the staff saw their roles as more administrative in nature whereby they monitored a client's case based on feedback supplied by the provider whilst the provider was seen as the 'expert' who provided the services and managed the client on a more personal level. It should be noted, however, that there were

differences reported across the three states in terms of processes in place for maintaining contact with rehabilitation providers as well as in the direction, training and feedback supplied to providers.

Some of the barriers to rehabilitation described by the staff included lack of client motivation to participate in rehabilitation, the difficulties encountered when a client resides in a regional or remote area, inconsistency in expectations regarding the purpose and expected outcomes of rehabilitation, poor communication amongst parties (particularly DVA staff and rehabilitation service providers), staff turnover and getting clients to commence rehabilitation early in the process but the difficulties experienced when clients are reluctant to report their problems and lodge a claim with DVA in the first place. On the flip side, DVA staff felt that that because DVA has a system in place that is flexible and not very restrictive in terms of what can be provided to clients, this acts to facilitate the client's recovery from injury or illness.

Across all three states, staff indicated they were generally satisfied with how rehabilitation was delivered by DVA and felt that rehabilitation had improved over time in terms of processes and flexibility in the range of services that can be provided to clients. There were, however, some aspects that they believed could be addressed. Consistent with feedback from DVA clients, the staff suggested that improvements could be made in relation to raising awareness about rehabilitation with DVA clients as well as in the communication amongst different parties but particularly between DVA staff and the rehabilitation service provider. Another focus was on getting clients into rehabilitation as quickly as possible and staff felt that better communication and processes to aid the transition between ADF and DVA would assist this process. Staff in all three states also agreed that the guidelines given to rehabilitation providers are too vague (approval of whatever is considered 'reasonable' in relation to injury) and that rehabilitation providers do not have a clear understanding of what DVA rehabilitation staff want them to provide to the clients. A suggestion was to improve the referral documentation supplied to rehabilitation providers and develop an information pack that is sent out when referring all new clients. Staff from Victoria also felt that DVA's administrative systems could be improved to assist staff to easily locate relevant information about a client and view clients in a holistic manner.

Section 3: Survey of rehabilitation service providers

Introduction

Rehabilitation service providers currently certified to provide rehabilitation to DVA clients were invited to complete an online survey about rehabilitation processes, outcome measurement and barriers to rehabilitation. The providers invited to participate were identified by DVA as an organisation (or branch of a large organisation) contracted to provide rehabilitation to DVA clients. It was believed that these organisations would be in the perfect position to comment on services provided to DVA clients and non-DVA clients as well as best practice in psychosocial rehabilitation more broadly.

The purpose of the survey was to gain a better understanding of the rehabilitation process delivered by DVA-contracted service providers, how rehabilitation outcomes are measured by providers and their opinions regarding perceived barriers to achieving successful outcomes in rehabilitation for DVA clients. The survey covered questions on the following areas:

- Organisational profile
- Contact with DVA
- Contact with other service providers
- Assessment and use of standardised outcome measures
- Nature of the organisation's service provision and rehabilitation process and policies followed
- Barriers to successful rehabilitation outcomes

The questions asked in the survey covered topics of interest for both the Barriers to Rehabilitation project as well as another project in receipt of DVA Research funding (Psychosocial Rehabilitation for Veterans study) which is interested in exploring best practice in rehabilitation. This section will report findings of relevance for the Barriers to Rehabilitation project in terms of providing background information on the profiles of the organisations that participated in the survey, reported contact with DVA and other service providers, use of outcome measurement tools and barriers to rehabilitation for clients. More detailed findings from the survey in relation to rehabilitation processes followed by the rehabilitation providers and the types of services provided will be available in the report delivered as part of the Psychosocial Rehabilitation project later in 2009.

Methodology

The DVA Rehabilitation Policy Section sent ACPMH a spreadsheet with the names and contact details (email and postal addresses) for all service providers certified to provide rehabilitation for DVA clients. This spreadsheet included details for 109 organisations from around Australia: 53 from NSW, 12 from Queensland, 9 from Western Australia, 8 from Victoria, 8 from Tasmania, 7 from the ACT, 6 from the Northern Territory and 6 from South Australia. It should be noted that these were not all unique organisations – for example, in Western Australia, three rehabilitation providers from CRS Australia were

invited to participate but these were providers located in three different regions of the state. Although working for the same organisation (CRS Australia), these providers were still invited to participate because of the possible differences in policies/practice adopted by different branches within the same organisation.

The rehabilitation providers identified in the spreadsheet were sent a letter of invitation (including instructions on how to access the survey) via email in mid-March 2009 (see Attachment C). Emails bounced for 18 of the identified organisations and so the invitation letter and instructions were posted out to these respective organisations. Two of these letters were subsequently returned to sender. The online survey went live on the 16th of March and participants were given until the 27th March to complete and submit the survey. All rehabilitation providers were sent a follow-up email on the 30th March with details regarding the survey and reiterating the importance in completing the survey in terms of the opportunity to provide feedback to DVA. The survey was subsequently extended for a further two weeks to maximise the number of possible respondents.

Over the two month period, 27 organisations submitted the online survey, although only 20 organisations completed the entire survey. Of the 27 participating organisations, 16 were located in NSW/ACT, 4 in Queensland, 3 in South Australia, 3 in Western Australia and 1 in Tasmania. None of the organisations from Victoria or the Northern Territory submitted a survey. It should be pointed out that a few of the organisations who were invited to participate reported to ACPMH that they had never been referred a DVA client or had not had a DVA client for several years and therefore they elected not to complete the survey. In addition, two of the organisations that did participate in the survey reported that they had not had any contact with DVA clients since working with DVA (both had been working with DVA for less than 5 years). DVA subsequently reiterated that the list provided included all eligible rehabilitation providers rather than those who were known to provide services to DVA clients.

In the instructions supplied to providers, it was suggested that the survey should be completed by a member of senior management within the organisation, however, it was recommended that the person who completed the survey should consult other staff members to ensure that the responses provided were reflective of the organisation's position and practice as a whole. A copy of the documentation (letter of invitation and instructions) as well as the survey are available in Attachment C.

Findings

The findings reported below are those from the survey of rehabilitation service providers that are relevant for the Barriers to Rehabilitation study. The survey sought to capture information at the organisational level; in other words, information on the processes, practices and perspectives regarding the organisation as a whole rather than information about individual rehabilitation consultants within the organisation who respond to the survey. Respondents from national organisations were asked to answer the questions based on their state or regional branch profile. Due to the relatively small number of participants completing the survey, the findings will be reported in terms of frequencies with percentages reported where helpful.

Organisational profile

The first section of the survey asked respondents to provide some information about the organisation they represent. Geographically, 21 of the 27 organisations described the location where they provide services as being a 'mixed metropolitan/rural' area. The length of time the participating organisations had been providing rehabilitation services for DVA clients varied widely. One-fifth of the organisations (5 out of 25 organisations) reported having been providing rehabilitation for DVA clients for more than 20 years whilst two organisations had been doing so for less than one year. The majority of organisations had been providing rehabilitation for DVA clients for between 1-5 years (9 out of 25 organisations) and 6-10 years (5 out of 25 organisations).

Respondents were also asked to estimate how many clients (including both DVA and non-DVA clients) access their organisation or branch for rehabilitation in an average year. Organisations reported up to 3,000 clients accessing their organisation but this varied widely across respondents. Eleven respondents reported fewer than 500 clients accessing their organisation for rehabilitation in an average year, 5 respondents reported between 500-1000 clients and eight respondents reported more than 1,000 clients accessing their organisation for rehabilitation in an average year. Participants were asked to estimate what proportion of their clients would be DVA clients (0-19%, 20-39%, 40-59%, 60-79% or 80-100%). The majority of organisations reported that less than 20 percent of their clients are DVA clients (22 out of 25 organisations – 88%). In terms of the clients that do access the organisation, this was reported to be a mix of MRCA and SRCA clients and to a much lesser extent, VEA (VVRS) clients.

Staff numbers and profile

Participants were asked to indicate the number of staff employed by the organisation or branch. Responses ranged from one staff member up to 500 staff with an average of 81 staff. However, this number should be interpreted with caution given the small number of organisations reporting large numbers of staff which inflated the average number of staff employed per organisation. A breakdown of the number of staff employed by the organisations is provided in Table 3. More than half of the organisations reported having a staff of 20 or less and more than three-quarters had 50 or less staff working for the organisation.

Table 3: Breakdown of the number and percentage of organisations reporting staff employment numbers

Number of staff employed by organisation	Frequency	Percent
1 – 10 staff	7	26
11 – 20 staff	9	33
21 – 50 staff	5	19
51 – 100 staff	2	7
More than 100 staff	4	15
Total	*27*	*100*

Respondents were also asked to identify the areas in which their rehabilitation consultants were qualified. The majority of organisations reported employing rehabilitation consultants with qualifications in psychology (24 out of 27 organisations – 89%), occupational therapy (23 out of 27 organisations – 85%) and vocational training (20 out of 27 organisations – 74%). The other common areas of qualifications for staff included rehabilitation counselling (17 out of 27 organisations – 63%) and social work/counselling (16 out of 27 organisations – 59%). Nine organisations (33%) reported employing rehabilitation consultants with qualifications in exercise physiology/physiotherapy, eight (30%) reported employing consultants with qualifications in the area of drugs and alcohol and five (19%) reported employing consultants with qualifications in psychiatry. Two (7%) organisations also reported employing a nurse.

In addition to information on the qualifications of staff employed by the organisation, respondents indicated a range of methods by which current staff members remain up-to-date with the latest information regarding rehabilitation needs, programs and services for DVA clients (see table 4). The most common method was to read the information provided by DVA, however two organisations commented that it would be beneficial if DVA could run more regular seminars or training sessions for service providers. Approximately two-thirds of organisations also rely on in-house training, mentoring and reading publications about rehabilitation.

Table 4: Method used by organisation to stay up-to-date with information regarding rehabilitation for DVA clients (number and percentage)

Method used to stay up-to-date with information for DVA client	Frequency	Percent
Read information provided by DVA	17	68
In-house training	16	64
Mentoring	16	64
Read the latest publications in the area (e.g. journal articles)	16	64
Attend seminars and conferences run by others (not DVA)	15	60
Attend seminars and conference run by DVA	11	44
Participate in professional discussion boards	7	28
Total	*25*	*100*

Area of service delivery

Respondents were asked to indicate which category the majority of rehabilitation referrals received by the organisation would fall into (see Table 5). Approximately three-quarters of respondents describe the majority of rehabilitation referrals received by the organisation as being musculoskeletal in nature. Fifteen organisations reported receiving a lot of referrals for clients with mental health issues and ten reported receiving referrals for clients with chronic medical conditions. It is noteworthy that the type of rehabilitation referral received by the organisation does not appear to be dependent on the size of the organisation with organisations reporting employment of a smaller number of staff being just as likely to report receiving referrals in each of the areas.

Each organisation was asked to indicate what service(s) they provided (vocational/employment support, psychosocial and self-care and medical and allied health treatment). All respondents reported providing vocational/employment support, almost three-quarters reported providing psychosocial and self-care services (18 out of 25 organisations) and 10 of the organisations reported providing medical and allied health treatment (40%).

Table 5: Breakdown of the number and percentage of organisations reporting rehabilitation referrals across different areas

Type of rehabilitation referral received	Frequency	Percent
Musculoskeletal	19	76
Mental health	15	60
Chronic medical conditions	10	40
General debility	7	28
Spinal injury rehabilitation	4	16
Amputee rehabilitation	2	8
Neurorehabilitation	2	8
Elderly rehabilitation	1	4
Other	2	8
Total	*25*	*100*

Contact with DVA

Participating organisations were asked a series of questions about their involvement and satisfaction with their contact with DVA regarding rehabilitation service provision for clients. Three-quarters of the respondents (19 out of 25 organisations) reported having at least monthly contact with DVA in relation to their work with DVA clients whilst almost half (12 out of 25 organisations) reported at least weekly contact. Only the two organisations who reported no DVA clients accessed their organisation said that they had no contact with DVA. These two organisations did not answer the subsequent questions about satisfaction with contact with DVA staff.

Satisfaction with DVA

Respondents were asked to rate their level of satisfaction (using a 5 point Likert scale ranging from 'very satisfied' through to 'very dissatisfied') with DVA in relation to issues such as timeliness, communication, quality and dissemination of reports and documentation (Table 6). Generally, the rehabilitation service providers who answered the question were satisfied with their contact with DVA staff. Twenty of the 22 organisations (91%) reported being either 'very satisfied' (6 organisations – 27%) or 'satisfied' (14 organisations – 64%) with the quality of the referral documentation provided by DVA. Seventeen of the 22 organisations (77%) reported being either 'very satisfied' (9 organisations – 41%) or 'satisfied (8 organisations - 36%) with the general communication between the organisation and DVA staff. Only one of the 22 organisations reported being dissatisfied with their contact with DVA and this was in relation to the timeliness of referrals. This organisation was from the NSW/ACT region. The two main areas where it

appears that respondents are not as satisfied are in relation to the timely dissemination of DVA reports and ensuring that these reports are provided to all relevant stakeholders. The results are presented in Table 6.

Table 6: Number of organisations reporting satisfaction with various aspects of contact with DVA

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Appropriate use of referrals	7 (32%)	12 (55%)	3 (14%)	0	0
Quality of referral documentation	6 (27%)	14 (64%)	2 (9%)	0	0
Timeliness of referrals	3 (14%)	12 (55%)	6 (27%)	1 (5%)	0
Timely approval of rehabilitation plans	7 (32%)	10 (46%)	5 (23%)	0	0
General communication with DVA	9 (41%)	8 (36%)	5 (23%)	0	0
Timeliness of communication	8 (36%)	9 (41%)	5 (23%)	0	0
Reports produced by DVA provided in a timely manner	5 (23%)	7 (32%)	10 (46%)	0	0
Appropriate dissemination of all documentation to relevant stakeholders	4 (18%)	8 (36%)	10 (46%)	0	0

When broken down by state, all three organisations located in South Australia reported being either 'very satisfied' or 'satisfied' with all aspects of their contact with DVA reported in the above table, aside from one organisation that reported feeling 'neutral' in relation to the reports produced by DVA being provided in a timely manner. Similar results were reported by the three organisations located in Western Australia. In comparison, of the 11 organisations from the NSW/ACT region, the majority reported being either 'satisfied' or 'neutral' in relation to their contact with DVA. Rehabilitation providers in Queensland and Tasmania reported being generally satisfied with their contact with DVA.

A few of the respondents commented on aspects of their contact with DVA staff. One provider from the NSW/ACT region reported that "at times it is difficult to contact case coordinators due to staff movements" whilst another provider from Queensland commented that there was "excellent collaboration with rehabilitation coordinators in determining ways to address barriers and provide advice regarding relevant legislation relating to DVA clients."

Organisations were also asked to indicate how satisfied they were with the monitoring of clients by DVA after initial assessment and referral. Almost all respondents reported monitoring to be either 'very satisfactory' (7 out of 22 respondents – 32%) or 'satisfactory' (14 of 22 respondents – 64%). Only one respondent (from the NSW/ACT region) reported that monitoring of clients by DVA after initial assessment and referral was 'not very satisfactory'. When asked to explain why this was the case, the respondent commented "client case loads are high and case managers cannot keep up with the same level of intensity required by the service delivery agent."

Contact with other service providers

In addition to the questions about satisfaction with contact with DVA, the rehabilitation providers were asked a series of questions about their involvement and satisfaction with the contact they have with other service providers in relation to service provision for DVA clients. Responses indicated that level of contact with other service providers was not quite as frequent as the contact with DVA staff. Eighteen of the 24 organisations (75%) reported at least monthly contact with other service providers, however this was mostly comprised of organisations who reported their level of contact as being 'a few times per month'. One-third of organisations reported contact on at least a weekly basis whilst two organisations (8%) reported no contact with other service providers in relation to their work with DVA clients. These two organisations did not answer the subsequent questions about contact and satisfaction with other service providers.

Contact by type of other service provider

Those organisations who reported contact with other service providers in relation to their work with DVA clients were asked to indicate who they have contact with. The most common providers with whom the organisations indicated working with in relation to DVA clients included general practitioners, psychologists and psychiatrists. It is noteworthy that the three most common providers that the organisations worked with in relation to DVA clients provide medical and allied health services – for example, all but one organisation (from the NSW/ACT region) reported contact with general practitioners. A smaller number of organisations reported contact with vocational specialists, drug & alcohol workers and social workers or counsellors. No organisations reported contact with nurses. The nature of the contact for which these organisations worked with the other service providers was not specified. An overview of the number and proportion of organisations reporting contact with other types of service providers is listed in Table 7.

Table 7: Breakdown of the number and percentage of organisations reporting contact with other types of providers in relation to their work with DVA clients

Type of service provider	Frequency	Percent
General Practitioner	20	95
Psychologist	16	76
Psychiatrist	12	57
Occupational Therapist	8	38
Vocational Specialist	6	29
Drug & Alcohol Worker	6	29
Rehabilitation Counsellor	4	19
Social Worker	4	19
Counsellor	2	10
Pharmacist	2	10
Nurse	0	0
Other*	5	24
Total	*21*	*100*

*Other types of service providers mentioned included physiotherapists/exercise physiologists, orthopaedic specialists and unspecified treatment specialists who may need to be involved to assist with the case.

In terms of classifying the purpose of this contact with other service providers, 18 of 21 organisations (86%) categorised this in relation to 'medical and allied health needs' and 16 of 21 organisations (76%) categorised it as covering 'vocational/employment needs' as well as 'psychosocial and self-care needs' respectively. The high proportion of respondents reporting contact with other service providers in relation to the medical needs of DVA clients is not surprising given that less than half (40%) reported their organisation provides medical and allied health treatment. What is surprising is that more than three-quarters of the organisations reported contact with other service providers in relation to the vocational/employment needs of DVA clients when all organisations reported providing vocational/employment support. Similarly, the same proportion reported contact with other providers in relation to psychosocial/self-care needs when 72 percent reported providing psychosocial and self-care services. Given that further information about the nature of these services was not specified, it can only be speculated that whilst all organisations are in a position to provide these types of support for DVA clients, perhaps these organisations are in contact with other providers who specialise in particular aspects of this vocational or psychosocial rehabilitation support such as providing job seeking skills or homecare assistance.

Satisfaction with other service providers

As with the questions in relation to contact with DVA staff, the respondents were asked to rate their level of satisfaction with other service providers in relation to issues such as timeliness and quality of services delivered, timeliness and clarity in communication, and dissemination of reports and documentation. Respondents seemed generally satisfied or 'neutral' regarding their contact with other service providers and their provision of service, although perhaps not as satisfied with their contact with DVA as only one organisation indicated being 'very satisfied' with the various aspects of service provision. Consistent with the results in relation to contact with DVA, it was in the areas of timely production and dissemination of reports that the respondents indicated lower satisfaction levels. The results are outlined in Table 8.

Table 8: Number of organisations reporting satisfaction with various aspects of contact with other service providers

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Quality of services performed	1 (5%)	15 (71%)	5 (24%)	0	0
Timeliness of services performed	1 (5%)	12 (57%)	8 (38%)	0	0
Appropriate identification of needs	1 (5%)	14 (67%)	6 (29%)	0	0
Clarity of information provided	1 (5%)	13 (62%)	7 (33%)	0	0
Appropriate use of referrals	1 (5%)	14 (67%)	6 (29%)	0	0
Communication about shared clients	0	11 (52%)	9 (43%)	1 (5%)	0
Timeliness of communication	0	12 (57%)	7 (33%)	2 (10%)	0
Reports produced in a timely manner	0	11 (52%)	7 (33%)	3 (14%)	0
Appropriate dissemination of all documentation to relevant stakeholders	0	9 (43%)	9 (43%)	3 (14%)	0

Respondents were then given the opportunity to provide any additional comments about their contact and satisfaction with other service providers. Five organisations made comments which are provided below.

- *"[We] have developed a database of allied health and similar providers that we know to provide excellent services for DVA clients; therefore our satisfaction with quality of services is high."*
- *"These factors are dependent on the availability of the other providers and their ability to provide feedback reports etc. The rehab provider is the only one that is expected to report on a regular basis and it is often difficult to obtain reports from other service providers."*
- *"Communication with treating GP's and specialists can be difficult and a source of delay in progressing rehabilitation programs."*
- *"[We] would not refer to service providers who were unable to provide a satisfactory service for our clients."*
- *"Depends on the provider and the service in which they provide."*

Standardised outcome measurement

Another section of the survey asked respondents about use of standardised outcome measures. Standardised outcome measurement was defined as "the measurement of individual change that results from participation in a program or service, or after receiving treatment or an intervention. An outcome measurement tool usually consists of a test or scale which is considered to be reliable, valid, and sensitive to change." Nineteen out of 23 organisations (83%) reported currently using standardised outcome measures to assess need or determine DVA client outcomes. The four organisations who reported not using outcome measures were small in size (employing less than 20 staff) but were from a range of states (NSW, Queensland and South Australia). Given the range of instruments available to measure the mental health status and needs of a client, it is interesting to note that three of the four organisations who reported not using outcome measures categorised the majority of their rehabilitation referrals as falling under the 'mental health' banner. The organisations that did not use standardised outcome measures were asked to indicate their reasons for this. Three of the four organisations reported they were in the process of evaluating the measure best suited to their client group, one organisation reported not using standardised outcome measures because it was not a DVA requirement to do so and one organisation commented that "DVA utilise their own outcome measures".

Types of standardised outcome measures used

The respondents who did report using standardised outcome measures were asked to list the measures utilised by the organisation to assess rehabilitation needs and outcomes. A wide range of different outcome measures (29 in total) were referred to by the respondents and it should be pointed out that some clients indicated that they did not list all measures used by the organisation due to the sheer number utilised. It should also be noted that a number of respondents pointed out that the outcome measures used depends on the needs of the client, perhaps explaining the reason for the high number of outcome measures utilised. For example, one rehabilitation service provider from the NSW/ACT region commented: "We tailor the outcome measure per client (e.g. English as a second language and dependent upon injury type etc.). It is important to measure change over time and address goals of rehabilitation (and possible treatment options)

to the needs of the client. We ensure all parties are aware of the measures, to ensure it is a team approach to the client's rehabilitation."

A list of the outcome measures mentioned by respondents is provided in Table 9. The most commonly used standardised outcome measure was the Orebro Musculoskeletal Pain Questionnaire (OMPQ) with almost half of the organisations reporting use of this measure (9 out of 20 organisations – 45%). Six of the nine organisations were from the NSW/ACT region with single organisations from each of Queensland, South Australia and Western Australia also using the measure. The OMPQ is a screening questionnaire that is used to predict long term disability and failure to return to work due to personal and environmental factors. The other most commonly used measures include monitoring of return to work outcomes, the Depression Anxiety Stress Scales (DASS), the Fear-Avoidance Beliefs Questionnaire (FABQ), the Kessler Psychological Distress Scale (K10), Visual Analogue Scale (VAS) and review of case duration and costs. Given that 60 percent of the organisations reported handling rehabilitation referrals in the area of mental health, it is surprising that a higher number of respondents did not report using psychosocial outcome measures. One respondent commented that it was difficult to "identify a standardised measurement tool which captures the complexity of chronic psychological injuries." Furthermore, another provider from the NSW/ACT region felt that there was limited available training in the use of outcome measures.

Table 9: List of all outcome measures used by service providers and the number who reported using the measure

Outcome measure	Number of organisations who reported use of the measure
Orebro Musculoskeletal Pain Questionnaire (OMPQ)	9
Return to work outcomes	5
Case duration	3
Case costs	3
Depression Anxiety Stress Scales (DASS)	3
Fear-Avoidance Beliefs Questionnaire (FABQ)	3
Kessler Psychological Distress Scale (K10)	3
Visual Analogue Scale (VAS)	3
Barthel Index	2
Client outcome and satisfaction follow-up	2
Disability, Arm, Shoulder and Hand (DASH) questionnaire	2
Functional capacity assessments	2
Needs Assessment/goal attainment screening	2
Neck Disability Index	2
Other*	17

*Other included where only one respondent mentioned each of the respective measures: Domestic Activities of Daily Living Plans; Factor Web; FRI; Oswestry; Pain screens; Patient Specific Functional Scale; Peer reviews; Physical Work Performance Evaluation Differential Aptitude Test; Quebec; Reduction in income maintenance; Rothwell Miller Values Inventory; Timeliness of services; Whiplash disability scale; WHO QoL; and Yellow Flag Questionnaire.

Benefits of using standardised outcome measures

Respondents were then provided with a list of some of the possible benefits of using standardised outcome measures. All organisations (regardless of whether or not they currently used standardised outcome measures) were asked to indicate how important they believed the use of standardised outcome measures were based on several different statements. The majority of organisations felt that standardised outcome measures were 'very important' to evaluate the "effectiveness" and "efficiency" of rehabilitation (18 of 23 organisations – 78%) and to a slightly lesser extent, "to demonstrate accountability" (14 of 23 organisations – 61%). Respondents felt that outcome measures were not as important in terms of providing the opportunity to "make comparisons with normative samples" with only nine of the 23 organisations (39%) believing this to be a 'very important' reason for using standardised outcome measures. Table 10 presents the results from this question.

Table 10: Number of organisations reporting importance of various benefits to using standardised outcome measures

	Very important	Quite important	Somewhat important	Not at all important
To ensure standard practices across clients and the organisation	13 (57%)	7 (30%)	3 (13%)	0
To evaluate effectiveness of rehabilitation	18 (78%)	4 (17%)	1 (4%)	0
To evaluate efficiency of rehabilitation	18 (78%)	4 (17%)	1 (4%)	0
To make comparisons between programs	12 (52%)	7 (30%)	3 (13%)	1 (4%)
To make comparisons over time	13 (56%)	8 (35%)	1 (4%)	1 (4%)
To make comparisons with normative samples	9 (39%)	11 (48%)	2 (9%)	1 (4%)
To demonstrate accountability	14 (61%)	5 (22%)	4 (17%)	0

In addition, respondents were asked to indicate how important they believed various outcomes were when assessing the impact/success of rehabilitation for DVA clients. Overall, respondents felt that all of these outcomes were important to a greater or lesser extent. Almost all organisations (20 of 23 organisations – 87%) felt that outcome measures were 'very important' in assessing whether individualised rehabilitation goals identified by the client have been achieved and also in assessing the success of rehabilitation for the client in providing them with the capacity to manage with own condition (both in terms of physical and mental health needs).

Interestingly, given the focus on return to work outcomes for DVA clients, this outcome ranked third (after ensuring individualised rehabilitation goals have been achieved and in providing the client with the capacity to manage their own condition) in importance based on the number of organisations who reported the outcome as being 'very important' when assessing the success of rehabilitation. Approximately three-quarters of rehabilitation providers (17 of 23 organisations - 74%) perceived return to work to be a 'very important' outcome to assess the success of rehabilitation for DVA clients. "Reducing risk factors" and "improving social connectedness" were also endorsed as 'very important' by between 60-70 percent of

rehabilitation providers. In comparison, assessing whether the DVA client is "no longer diagnosed with an illness or injury" is not perceived to be as important. One provider qualified this response by commenting that "all our DVA clients continue with life long conditions, illnesses and injuries. Therefore, reduced symptoms and nil diagnosis questions are not relevant to our DVA clients. However, effective management of conditions is very important in our outcomes." Two other comments made by the respondents are provided below and the findings in relation to this question are presented in Table 11.

- *"All [of these outcomes] are vital for assisting clients return to a normal life style when returning from injury or illness. Also creates routine, purpose to life and self satisfaction."*
- *"Outcome is always dependent upon the goal, and if the agreed goal was met, then it has been a successful program."*

Table 11: Number of organisations reporting importance of various outcomes when assessing the impact/success of rehabilitation for DVA clients

	Very important	Quite important	Somewhat important	Not at all important	Don't know
Return to work	17 (74%)	4 (17%)	2 (9%)	0	0
Return to study/training	12 (52%)	8 (35%)	3 (13%)	0	0
Improved social connectedness	14 (61%)	8 (35%)	1 (4%)	0	0
Capacity to manage own condition (physical & mental health)	20 (87%)	2 (9%)	1 (4%)	0	0
Reduced risk factors	16 (70%)	6 (26%)	1 (4%)	0	0
Enhanced protective factors	11 (48%)	7 (30%)	3 (13%)	0	2 (9%)
Reduced symptoms	10 (44%)	8 (35%)	4 (17%)	0	1 (4%)
No longer diagnosed with illness of injury	9 (39%)	4 (17%)	6 (26%)	3 (13%)	1 (4%)
Individualised rehabilitation goals identified by the client are achieved	20 (87%)	2 (9%)	1 (4%)	0	0

Rehabilitation services delivered and assessment process

The survey included a series of questions regarding rehabilitation services delivered and the assessment process implemented by the organisation. It should be noted that not all of the findings in relation to this section of the survey will be included in this report. Readers are referred to the Psychosocial Rehabilitation for Veterans report which will be available from the DVA Rehabilitation Policy Section later in 2009.

Principles and goals of service delivery

Each organisation was asked to list the principles and goals guiding their service delivery in an open-ended question. Consistent with literature on best practice in rehabilitation, some of the common principles referred to by organisations were providing individualised service, maximising client involvement in the development of their rehabilitation plan and goals, as well as maximising participation in the program with a focus on achieving the goals set out in the rehabilitation program (with an emphasis on return to work outcomes). Some of the common goals mentioned focused on achieving return to work outcomes,

maximising quality of life and the independence of the client, and providing timely and cost-effective service provision. In commenting on the rehabilitation process followed by the organisation, respondents were given the opportunity to provide additional comments. Several comments related to the difficulty for rehabilitation service providers in providing early intervention for clients. These comments are listed below.

- *"Early intervention can only be provided when the referral is early."*
- *"Early intervention and timeliness of service provision is dependent upon timing of referral and approvals from DVA."*
- *"We always received referrals very late in the process."*

Assessment process

Participants were asked to indicate whether the assessment process was the same for DVA and non-DVA clients. Thirteen of the 21 organisations (62%) reported that they applied the same assessment process for both DVA and non-DVA clients. Of those organisations who indicated that the assessment process differed for DVA compared with non-DVA clients, comments included that the assessment process is dependent on the injury/illness of the client (e.g. physical/psychological) and the rehabilitation goals of the client (e.g. return to work versus non-return to work), therefore it was noted that the process could be adjusted depending on the clients' needs. One organisation commented that "a more comprehensive assessment process is undertaken with DVA clients" and another organisation felt that DVA were "more flexible and encourage longer term programs with training to support longer career objectives at higher rates of pay and will often support additional services for close family members to ensure employment goals are achieved."

Seventy-five percent of rehabilitation providers reported that the same process was also followed regardless of whether the assessment was for a client with a mental health or physical condition. Organisations reporting a different approach for clients with mental health and physical conditions indicated that different screening tools may be used (depending on their relevance) and that more emphasis may be placed on particular aspects of the assessment dependent on the client's condition. For example, "a FCE may be utilised for a physical assessment and DASS may be used for psychological assessment." Almost all organisations reported undertaking situational assessments to determine a client's level of functioning (19 out of 21 organisations – 91%), however it was pointed out that these are not 'always' done as it is dependent on the circumstances of the case.

In an open-ended question, respondents were asked to list the aspects of client functioning assessed by rehabilitation consultants during assessments with DVA clients. The majority of organisations mentioned assessing the physical/medical conditions of the client, social/Activities of daily living (ADL) tasks, psychological functioning and work history/assessment. A few organisations mentioned assessing psychosocial needs. It is noteworthy, given the findings from the DVA client interviews and focus groups with DVA staff, where comments were made about different expectations regarding rehabilitation goals amongst different parties, that all 21 organisations reported 'always' fully examining the preferences and goals of the client when conducting a vocational assessment. Perhaps this could suggest that whilst

providers do discuss rehabilitation expectations and goals with clients, these are not being sufficiently documented or clearly communicated to all parties.

Engagement of client's family in rehabilitation

Given that one of the suggested areas for improvement emerging from the interviews with DVA clients was for greater engagement of the client's family in their rehabilitation, it is interesting that approximately two-thirds of the respondents (14 out of 21 organisations – 67%) reported that their organisation provides services and support to both the client and their family. However, of the respondents who did report providing services and support to the client and their family, only one respondent reported 'always' involving the family in treatment and rehabilitation planning and four respondents (29%) 'always' explored the family member's expectations regarding treatment and rehabilitation. When asked to comment on the responsiveness of DVA's rehabilitation approvals process in allowing rehabilitation consultants to provide support and services to the client and their family, the respondents were generally satisfied with DVA's approach. Some comments are provided below.

- *"Approval processes could be more responsive, particularly to the needs and involvement of family members."*
- *"With the inception of MRCA legislation this has made it easier for DVA to provide support of this nature."*
- *"There is some reluctance by most insurers (including DVA) for rehabilitation services for client's family members."*
- *"Very [responsive as] not many insurers do provide such support for the families."*

Evaluation of service delivery

Rehabilitation service providers were asked whether their organisation undertakes evaluation and assessment of the services it provides. Almost all respondents (20 out of 21 organisations – 95%) reported undertaking evaluation and assessment of service provision. However, when asked to comment on the extent to which staff undertake a number of different evaluation activities that are described as best practice in rehabilitation service provision, there was wide variation in the extent to which the organisations reported that such activities were 'always' implemented. For example, 16 of the 21 organisations (80%) reported 'always' evaluating progress towards rehabilitation goals and objectives and 7 organisations (35%) reported undertaking an evaluation of system-wide service provision to ensure services are adequately meeting the needs of service populations. Table 12 presents these results.

Table 12: Number of organisations reporting extent of various evaluation activities

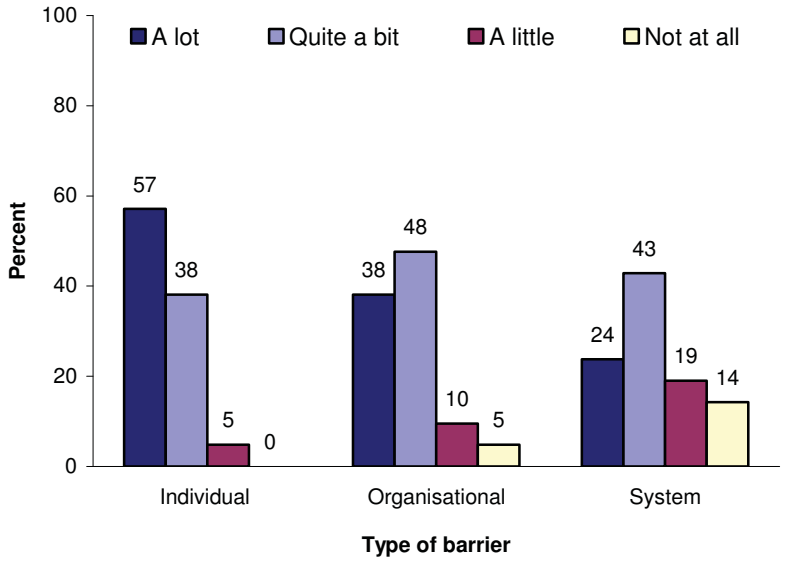
	Always	Often	Sometimes	Rarely	Never	Don't know
Evaluate outcomes of individual interventions included in rehabilitation plans	11 (55%)	6 (30%)	2 (10%)	1 (5%)	0	0
Evaluate the progress towards rehabilitation goals and objectives	16 (80%)	4 (20%)	0	0	0	0
Evaluate service-user satisfaction of service provision	11 (55%)	4 (20%)	4 (20%)	1 (5%)	0	0
Undertake an evaluation of system-wide service provision to ensure services are adequately meeting the needs of service populations	7 (35%)	7 (35%)	4 (20%)	1 (5%)	0	1 (5%)
Evaluate service provision to determine whether the overall goals of the organisation are being met	12 (60%)	8 (40%)	0	0	0	0
Actively respond to outcomes of the evaluations	14 (70%)	6 (30%)	0	0	0	0

Perceived barriers to rehabilitation

The final section of the online survey with rehabilitation service providers asked participants to describe the factors perceived to be the most influential barriers to successful rehabilitation. Based on the research literature where barriers have been described at the individual client level, organisational level and system level, participants were first asked their opinion regarding barriers to rehabilitation in relation to each of these levels. They were also asked to indicate the extent to which these barriers impact on the organisation's ability to provide successful rehabilitation to veterans and current and former serving ADF members.

Figure 1 displays the extent to which the rehabilitation providers believe that the barriers at each of the three levels impact on their ability to provide successful rehabilitation to DVA clients. It is interesting that the organisations perceived individual client level barriers to have the most impact on their ability to deliver successful rehabilitation to DVA clients, followed by organisational barriers and lastly system level barriers. All organisations indicated that individual level barriers impact at least 'a little' on their ability to deliver successful rehabilitation to DVA client with 12 of the 21 organisations (57%) believing these individual level barriers to impact 'a lot'. By comparison, 8 of the 21 organisations (38%) perceive organisational barriers to impact 'a lot' and 5 of the 21 organisations (24%) believe system level barriers to impact 'a lot' on their ability to deliver successful rehabilitation to DVA clients. Across the three levels, system level barriers were perceived to have the least influence of the ability to provide successful rehabilitation to DVA clients.

Figure 1: Extent to which organisations report different barriers impact on their ability to provide successful rehabilitation to veterans and current & former serving ADF members



Individual client level barriers

At the individual client level, the client's motivation and expectations regarding participation in rehabilitation, particularly in terms of return to work goals, was the most common barrier mentioned by almost half of the participants (10 out of 21 organisations – 48%). Another barrier to rehabilitation at the individual client level included a lack of understanding and support provided to the client both in terms of social support in the home, support from the employer, and support from those involved in the treatment and rehabilitation of the client (9 out of 21 organisations – 43%). Difficulty by the client in terms of adjusting to their injury or condition and the limitations that it poses was another significant barrier mentioned by eight organisations particularly in relation to how it will impact on their future career choices. Related to the previous barrier, five organisations reported that the client's expectations regarding the rehabilitation process and outcomes can act as a barrier, with one respondent noting that this is related to a "lack of education about their injury". The other main barrier was the tension in getting a client to engage in rehabilitation when their focus is on financial/compensation entitlements (mentioned by four organisations). Some comments made by participants in relation to individual level barriers for veterans and current and former serving ADF members are provided below.

- *"Personal psychological distress as evidenced by depression, anxiety, PTSD, mental illness and multiple injuries. Clients looking for financial gain through legislation, fear of re-injury, treatment not being appropriate and work factors including dissatisfaction or conflict."*
- *"Client expectations upon discharge (i.e. earning potential, inappropriate expectations regarding re-training) and medical limitations (significant ongoing limitations which may be stable however significantly reduce employment options)."*
- *"Support at the workplace, social isolation and long periods away from work or participating in community activities, lack of confidence and poor experience with previous rehabilitation."*

Organisational level barriers

Respondents were also asked to comment on perceived barriers to successful rehabilitation at the organisational level. The most common barrier to rehabilitation mentioned by participants was the difficulty in finding suitable and alternative duties for the client. Rehabilitation providers pointed out that employers need to be flexible in meeting client needs as often the client is only able to perform a certain range of duties that are within the medical restrictions based on their injury or condition. The other main barrier to successful rehabilitation related to a perceived lack of support provided to the client. This lack of support was mentioned in relation to support and cooperation from the client's employer or direct supervisor. Two respondents commented that a barrier to rehabilitation was when the organisation failed to refer the client for early intervention. One respondent indicated that "unlimited entitlement to compensation despite resolution of the initial injury" also acts as a barrier to successful rehabilitation. One respondent also commented that a barrier is "when the client is not happy with DVA and the relationship has already proven difficult and where rehabilitation is used as a means of compliance." Some comments in relation to organisational level barriers are listed below.

- *"Client not perceiving support from organisation/employer, where reasonable accommodation in the workplace is not being offered."*
- *"Degree to which DVA clients feel powerless in dealing with a large bureaucracy. Degree to which DVA clients interpret that the Defence Force 'don't care' about their situation."*
- *"Failure to refer client for early intervention. Lack of meaningful work options and suitable duties available. Manager/supervisor not responsive to supporting a return to work. No contact made with client during their time off work."*
- *"Supportive services, flexible strategies that meet the client needs, a willingness to support re-training when required, longer term job goal planning and not quick fixes or placements into dead end jobs."*
- *"Rehabilitation Consultants working across many areas under different legislation at the same time find it is difficult to juggle competing priorities."*
- *"Failure to provide suitable alternative duties; negative experience of previous management of the clients rehabilitation."*
- *"Hierarchy within the current ADF, time taken for a MEC determination (members become very frustrated while waiting), communication with hierarchy, culture, availability and perception of suitable duties within ADF units."*

System level barriers

The third level was identified as system level barriers to rehabilitation. A number of different system level barriers were mentioned by the rehabilitation service providers but the main barrier was the lack of flexibility in developing rehabilitation programs for individual clients and the use of generic programs. Another barrier to rehabilitation related to the administrative and reporting processes. Two respondents also indicated that there was some confusion regarding rehabilitation legislation and policies which acted as a barrier. One respondent mentioned that the downturn in the economy would act as another barrier to rehabilitation for clients stating that "greater unemployment and higher competition for jobs is going to be a major obstacle to career transition over the next few years. We will need to focus on longer term training strategies for clients

and perhaps a series of work experience placements to build skills and work routine." Some of the other comments made by rehabilitation service providers included:

- *"Individualised programs - meeting clients' individual needs rather than slotting into a spot."*
- *"Use of generic groups and programs."*
- *"No policy or procedure to maintain contact with injured client whilst off work. No suitable duties options available. Lack of manager/supervisor training for assisting injured workers to return to work. No tailoring of return to work plans to individual clients. Lack of resources to manage the return to work."*
- *"Time lag with process."*
- *"Understanding of the compensation and rehabilitation process."*
- *"Suitable qualifications of RTW service providers, appropriate QA procedures, suitable evaluation and monitoring processes in place."*
- *"Confusion between different legislation, inability for family to access rehab services (including psych counselling)."*
- *"Early identification of issues and prompt referral to the appropriate service (i.e. early intervention). The new system implemented by Department of Defence in conjunction with DVA has prevented many members 'falling through the cracks' and not gaining access to relevant services."*

Summary

The results reported in this section were based on information provided through an online survey of rehabilitation service providers conducted between March-April 2009. The 27 organisations who participated in the survey represented a range of different rehabilitation service providers in terms of geographic location, organisational size, amount of time their organisations have been providing rehabilitation for DVA clients and in terms of the number of DVA clients they provide rehabilitation to. All organisations reported providing vocational/employment support, the majority provided psychosocial and self-care services but less than half reported delivering medical and allied health treatment.

The rehabilitation service providers were asked to specify the frequency of their contact with DVA as well as with other service providers in relation to work with DVA clients and to indicate their level of satisfaction with this contact. Overall, the majority of providers reported being in contact with both DVA and other service providers on at least a monthly basis but a greater proportion reported being in contact with DVA staff on at least a weekly basis. In terms of the types of other service providers that the organisations reported contact with, this was mainly in relation to the medical and allied health needs of DVA clients and so contact was predominantly with general practitioners, psychologists and psychiatrists. The respondents seemed to be generally satisfied with their contact with DVA and other service providers. In both instances, however, it was found that providers were generally less satisfied about the timeliness in dissemination of DVA reports and ensuring that these reports are provided to all relevant stakeholders.

The majority of rehabilitation service providers reported using standardised outcome measures, however a wide range of outcome measures were utilised by the respondents and it was pointed out that the outcome measures used depends on the needs of the client. Most participants felt that use of standardised outcome measures was very important to evaluate the effectiveness and efficiency of rehabilitation and to a slightly

lesser extent, to demonstrate accountability. In particular, using outcome measures to assess whether individualised rehabilitation goals identified by the client have been achieved was seen as very important along with using the measures to assess the success of rehabilitation in providing the client with the capacity to manage their own condition. Slightly fewer organisations reported return to work outcomes as being very important to assess the success of rehabilitation for DVA clients.

Survey participants were also asked to comment on the rehabilitation and assessment process followed by their organisations. Responses indicated the complexity of this process, which depends on the injury/illness of the client, the goals of the client and the importance of adjusting the assessment process and services delivered depending on client needs. Furthermore, there was variation in the extent to which the providers reported undertaking various types of service evaluation activities, with most 'always' evaluating progress towards rehabilitation goals and objectives, but relatively few organisations 'always' evaluating system-wide service provision to ensure services are meeting the needs of clients.

As was the case in the interviews with DVA clients and focus groups with DVA staff, rehabilitation service providers were asked to comment on perceived barriers to rehabilitation for clients. Individual client level barriers were perceived to have most impact on the ability to deliver successful rehabilitation to DVA clients followed by organisational barriers and system level barriers. The most common barriers mentioned at the individual client level included a lack of understanding and support provided to the client, the difficulty experienced by the client in adjusting to their injury or condition, unrealistic expectations on behalf of the client and tension between rehabilitation and financial/compensation entitlements. At the organisational level, the most common barrier was the difficulty in finding alternative suitable duties for the client and a perceived lack of support for the client from their employer. System level barriers to rehabilitation included a lack of flexibility in developing rehabilitation programs for individual clients, barriers in relation to the administrative and reporting processes and some confusion regarding the rehabilitation legislation and process.

Section 4: Key stakeholder interviews

Introduction

The final component of data collection for phase one of the Barriers to Rehabilitation study involved phone interviews with key stakeholders involved in the area of rehabilitation. The aim was to interview a range of different stakeholders from various organisations considered to have expertise in the area of rehabilitation. This included stakeholders working in rehabilitation delivered to military veterans, stakeholders involved in rehabilitation and advocacy for clients in the community, as well as recognised experts working in academic and applied areas. Essentially, the goal was to interview key stakeholders grouped under five main categories:

- DVA senior management personnel.
- ADF Rehabilitation Directorate personnel.
- Key organisations currently providing psychosocial services to the broader community.
- Key experts in the applied and academic fields.
- DVA service delivery staff in location offices.

Given that DVA service delivery staff participated in focus groups at the time of the interviews with DVA clients, it was considered unnecessary to re-interview additional service delivery staff.

As was the situation with the online survey of rehabilitation service providers, information collected via the interview was to be used to inform both the Barriers to Rehabilitation study and the Psychosocial Rehabilitation for Veterans project. Therefore, the focus of this section will be on the key stakeholder interview findings of relevance for the Barriers to Rehabilitation study. Aspects regarding best practice in psychosocial rehabilitation which are relevant to the Psychosocial Rehabilitation for Veterans project will be documented in a report which will be available from the DVA Rehabilitation Policy Section later in 2009.

The purpose of the interview was to gain an understanding of how different stakeholders view rehabilitation, including what it should involve, what works well and how the rehabilitation process involving different stakeholders might be strengthened to improve rehabilitation outcomes for DVA clients. The questions asked participants to comment on the essential components of rehabilitation, their use of rehabilitation outcome measurement tools, their view about what a successful outcome in rehabilitation involves and their opinion about possible barriers and facilitators to successful rehabilitation outcomes. Based on their experience working in the area of rehabilitation, it was believed that the key stakeholders would be in a good position to comment on the types of services provided to veterans as well as best practice in psychosocial rehabilitation more broadly.

Methodology

A range of different people were consulted to obtain their opinions regarding relevant stakeholders to invite to participate in the interview. This included Professor Mark Creamer (ACPMH), Dr Lynda Matthews (The

University of Sydney), Dr Geoff Waghorn (The Queensland Centre for Mental Health Research (QCMHR)) and staff from the DVA Rehabilitation Policy section. In total, 13 key stakeholders were identified to invite to participate in an interview. A breakdown of the key stakeholders identified to participate (based on the five groups described above) is presented in Table 13.

Table 13: Breakdown of key stakeholders identified to participate in an interview

Category	Name
DVA senior management personnel (n=3)	• Barry Telford • Sandy Bell • Margaret Jenyns
ADF Rehabilitation Directorate personnel (n=1)	• Jim Porteous
Key organisations currently providing psychosocial services to the broader community (n=5)	• Jenny Thomas (Konekt) • Helen Knottenbeld (CRS Australia) • Liz Hudson (NEPS – BreakThru) • Kim Koop (VICSERV) • Steve Morton (MIND)
Key experts (n=4)	• Dr Geoff Waghorn (QCMHR) • Caroline Crosse (Social Firms Australia) • Barbara Hocking (SANE) • Dr Philip Morris (Psychiatrist)
Service delivery staff in location offices	• Participated in staff focus groups in Adelaide, Sydney and Melbourne

In mid-April 2009, each of these key stakeholders was sent an invitation via email to participate in a phone interview (see Attachment D). Participation in the interview was voluntary and incentives to participate were not offered. All but one organisation (involved in providing psychosocial services to the broader community) responded over subsequent days to confirm their interest in participating. It should be pointed out, however, that in some instances the stakeholders identified in Table 13 nominated a colleague to participate in their place. A total of 12 stakeholders were interviewed. All phone interviews were conducted in late April/early May by staff from ACPMH. Interview dates and times were set up at mutually convenient times with the phone interview taking approximately 45 minutes to complete.

To make the interviews most useful to DVA, those who agreed to participate were sent some background material as well as a copy of the interview questions at least a few days prior to their interview. In addition to providing some background information about DVA's rehabilitation framework, it was hoped that the interview participants would reflect on the information contained in these documents during the course of the interview in terms of the models and results regarding service delivery for DVA clients. The documents provided to the key stakeholders and their brief descriptions are outlined below and copies can be seen in Attachment E.

- *"DVA Rehabilitation Model"*: This document represents an overview of the processes and procedures that constitute the intended service delivery model for rehabilitation for DVA Clients. It was developed in consultation with DVA as a tool to help guide the research.
- *"Best practice in rehabilitation flowchart (with survey data)"*: This document represents a flowchart overview of the elements of "best practice" in rehabilitation services based on a comprehensive literature review. The flowchart was used to develop a survey that was sent to accredited rehabilitation service providers eligible to provide services to DVA clients. The flowchart includes a summary of the number of survey respondents who indicated they provide certain services or adopt particular practices.
- *"Summary of provider survey"*: This document provides further summary information about the responses to the survey outlining the nature of the services being purchased by DVA.

The interview questions covered three main topics of relevance to both projects: models of rehabilitation, definitions of success in rehabilitation and use of outcome measures, and barriers to rehabilitation. Slightly different questions were asked of the participants depending on their background, with a standard set of questions for DVA staff (believed to have more intimate knowledge about the DVA rehabilitation framework) and another version for non-DVA stakeholders (who in addition to being asked to comment on DVA's rehabilitation framework, were also asked to reflect on how it compares to their own rehabilitation framework). The list of questions asked of DVA and non-DVA stakeholders can be viewed as Attachment F.

All participants were asked for verbal consent for the phone interview to be audio-recorded – all agreed. The information provided by participants has been de-identified and will only be reported in terms of the four stakeholder categories listed in Table 13 (DVA senior management personnel, ADF Rehabilitation Directorate personnel, community organisations providing psychosocial rehabilitation and key experts).

Findings

The findings reported below are from all key stakeholders who participated in a phone interview. Information provided by DVA service delivery staff during the focus groups has not been replicated in this section and the reader is referred to Section 2. Again, only the findings of relevance for the Barriers to Rehabilitation study have been included here. The first series of interview questions focused on rehabilitation models and practice within DVA as well as in the community – only selected aspects of the information collected from these questions have been included in this report due to the relevance of these questions for the Psychosocial for Veterans project. As in the previous sections outlining findings from interviews with clients and DVA staff, the key themes emerging from the key stakeholder interviews will be discussed and where relevant, a number of quotes will be provided.

Changes in approach to rehabilitation over time

All key stakeholders were asked to comment on whether they believed there has been a shift in recent years in the way DVA, the community and service providers think about and approach rehabilitation. All except one participant agreed that there have been changes in the way rehabilitation is perceived and

delivered. However when describing how rehabilitation has changed, the participants focused on a number of different aspects.

Cultural shift in focus

DVA senior management personnel felt that there had been a general cultural shift amongst the organisation and staff (particularly within the past three years) in terms of there now being a greater focus on rehabilitation for clients. However one DVA participant questioned the extent to which this cultural change had filtered through to staff at all levels of the organisation: "we could work more effectively in developing that greater shift amongst our own staff in terms of rehabilitation but also a greater understanding of what rehabilitation is really about." Another DVA participant felt that the biopsychosocial aspects of rehabilitation are not currently examined, adequately addressed or measured under DVA's rehabilitation model. However this participant noted that "we are building in a lot of cultural shifts and programs, moving the emphasis from processing the claim to looking after the client." Similarly, the other DVA interview participant pointed out that whilst there has been "a huge shift in our intent and in what we're actually delivering", they did not believe that there had been the same dramatic improvement in the delivery or focus on psychiatric needs but noted that "we're working on it."

The DVA stakeholders felt that the organisation's rehabilitation framework constitutes a good model. However, there were questions raised about the extent to which the model works in practice. For example, one participant commented that "it's a matter of theory versus practice. I think that the theory, framework and model that we have is pretty hard to dispute in many ways – it's all there and is based on evidence-based research." This group also commented on the improvement in administrative processes in place to now handle rehabilitation cases and the "greater clarity around what we require of providers". Similarly, one of the participants from a community organisation that has contact with DVA rehabilitation staff noted that DVA's rehabilitation model "is great in theory but it's definitely not happening in practice" particularly due to the inconsistency in the way rehabilitation is delivered across different states.

However, the participants from DVA pointed out that whilst there is greater awareness and emphasis on rehabilitation needs amongst DVA staff, this has not necessarily filtered down to the clients and other stakeholders such as Ex-Service Organisations where some interviewees perceived there is still an emphasis on compensation and accessing a TPI pension. One DVA staff member commented "we have to try to sell the rehab message far better in terms of the benefit to the individual without necessarily taking away any of the financial support and independence they gain from the financial supports we have given them. So I think there is work to do in the community." These stakeholders were conscious of the impact that different legislation (VEA, SRCA and MRCA) has regarding awareness of and emphasis on rehabilitation: "we have a large volume of clients that are not interested and who have never been exposed to rehabilitation…there is quite a challenge in the old VEA system where rehabilitation was just a minute part."

Change in type of service delivery

Whilst non-DVA stakeholders also felt that there had been a general shift in the approach towards rehabilitation in recent years, the factors that these stakeholders felt had generated this change were different to those focused on by DVA stakeholders. The participant from the ADF noted that the change in legislation has had an impact on the way rehabilitation is conceptualised and pointed out that it aims to provide greater consistency in rehabilitation regardless of which state a client is treated in.

One participant from a community organisation noted that with other funding bodies/organisations (such as insurance companies) there is more of a focus on providing discrete services (short, fixed interventions) whilst for DVA there is still an emphasis on providing case management services. Similarly, another participant was of the belief that there had been a pendulum swing where "it's gone from 'it doesn't really matter about the disability issues, we'll just get them into a job and they can be rehabilitated in the workplace' to 'we'll do everything prior to the person even thinking about a job that we can possibly imagine that this person could ever need in their entire life and then we'll think about getting them the perfect job that is their dream job' to a more pragmatic approach now where…it's about providing as much as is needed but not much more than that so it is not excessive."

Several stakeholders from community based organisations as well as key experts discussed a key change in the area of vocational rehabilitation with greater focus on rapid job search strategies. One stakeholder commented: "the focus used to be that you had to have pre-employment training and preparation before you started job seeking but now this evidence-based research is indicating that rapid job search helps recovery." This focus on rapid job search is consistent with literature on best practice in rehabilitation.

Another noted change in rehabilitation in community-based services is a greater emphasis on intensive case management where there is "one case manager who has a very low caseload of about 8 clients" who aims to assist the client to connect into the community in a range of different ways. It was acknowledged that this change was particularly beneficial for clients with complex needs, particularly those with a severe mental illness. Commenting on their experience working for a rehabilitation service provider more than a decade ago, one key expert reiterated that "no matter what people say, you can't provide a very individualized form of assistance with caseloads that high [30-40 clients per consultant]" and so this change was seen as a move in the right direction.

Focus on client capabilities rather than inabilities

There was the belief that there is now a greater focus on examining clients in terms of their capacities rather than incapacities which is perceived to be a result in the shift of focus from litigation to rehabilitation. One stakeholder pointed out that this shift is happening across society more broadly so that rather than institutionalising people with mental health issues who are not considered 'normal', there is more emphasis on integration into the community and a greater acceptance and normalisation of mental illness. Another interviewee felt that service providers are "moving toward a less medicalised model so that recovery or rehab is not just about symptom reduction. It is focused much more on the person and what they want for

their life than what it used to be" (community organisation). By focusing on the abilities of the person rather than what they are unable to do, there was a belief that this helps to "break down a lot of the stigma in the community". One key expert felt that by focusing on getting clients into competitive employment "after a while, employers get to know the people on their staff that have psychiatric disabilities and learn about other disabilities and health conditions…they also learn that these types of people can be good workers. But if you keep them out of the mainstream and in sheltered workshops and non-competitive employment, the wider community never gets to know about them and never gets to know that vocational rehabilitation is feasible and effective."

Perspectives about 'successful' outcomes in rehabilitation

All participants were asked to describe what they believed constitutes a 'successful' outcome in rehabilitation. They were prompted to think about how this may differ depending upon the viewpoints of those involved such as the client, rehabilitation service provider, health provider, DVA staff member and family member.

Focus on return to work outcomes

The majority of stakeholders focused on return to work when describing success in rehabilitation. It was pointed out by some participants familiar with DVA's rehabilitation framework and legislation that a successful outcome depends on the legislation a client falls under as they have different purposes. One DVA participant noted that "return to work is an issue that is very big on our agenda. If they are unemployed, we are certainly aiming to get those capable of it back into work." Another stakeholder from DVA commented that "my gold standard is always return to full-time, paid work – that is what we should always be aiming for with all of our clients." Some other comments are provided below.

ADF personnel	*"I think the whole focus generally, whether it's civilian (WorkCover, Comcare) rehab or rehab through DVA or Defence, is on return to work."*
Community organisation	*"You can do a lot of interventions or the best program in the world but in the end if the person does not get a job at the end of it, they are really no better off in a lot of ways and you have built up their hope."*
Community organisation	*"If you apply the principles of recovery being best achieved through employment, then a successful employment outcome in the long-term would be a measure of a successful outcome."*
Key expert	*"The purpose of the program is gaining competitive employment, let's not be wishy-washy about this. The other biopsychosocial outcomes are only relevant if you don't achieve competitive employment…If anything, a biopsychosocial outcome should be a side benefit from the program because those things should be addressed along the way by the provider. Employment itself should lead to increased social inclusion opportunities and social support."*

However, a key expert pointed out that whilst a successful rehabilitation outcome should be defined in terms of return to work, it should be a return to competitive employment and needs to be achieved within a reasonable timeframe. They pointed out that the industry average is to have the client engaged in

"satisfactory competitive employment within 100 days" but it was noted that competitive employment does not necessarily mean working "30-40 days a week – it's just about what the client thinks they can manage."

Defining success more broadly

Some participants defined a successful outcome in rehabilitation more broadly than return to work. This included a focus on improvement in quality of life outcomes and successful transition into the community. Some stakeholders simply defined a successful rehabilitation outcome as being where "all of the goals that are developed and put into the plan are met". However, this participant did then go on to focus on return to work outcomes as being seen as the most successful outcome. Some comments are provided below.

Community organisation	*"From the client's point of view, it's more around being able to transition into civilian life, being able to operate in the civilian environment, have all of those support services and structures in place such as paid employment, appropriate medical services and appropriate support structures."*
Community organisation	*"Where [return to work] is not a realistic goal, it is about assisting the client to identify meaningful alternative activities to ensure they don't become isolated and depressed by not participating in any activities."*
Community organisation	*"Anything that the client feels has changed for them that they wanted to change. No matter how big or small."*
Key expert	*"A successful outcome would be reflected in having a routine and attaining some of the goals that you'd been working towards, and not being so reliant on the support services that may have had a more dominant role in your life when you were unwell. A successful outcome is being engaged with the community, having a place in the community, and not thinking about your mental illness, but having other things in your life going on."*
Key expert	*"There is a focus on mental health and as a result, the client is able to make their own decisions regarding their life, they display independence in functioning, they have improved skills and the support they require."*

Differences in perspectives on success

Interestingly, the DVA interview participants had different perspectives on what constitutes a successful outcome in rehabilitation. One interviewee was very clear on what a successful outcome involves whilst the two other interview participants were less clear noting that it was difficult to measure due to the complexity of needs among DVA clients. One interviewee commented: "every month when I look at my monthly report and it reports on return to work and non-return to work, I say to myself, what does that mean?" Another DVA participant noted that "we don't really measure success. The fact of life is we don't really have enough time to be able to get back to people in 6 months to see how they're going. We're not putting as much emphasis on that as we should be because our resources don't allow it. So we need to be resourced to be able to do that because I think that's quite important." Comments from each of the participants from DVA in relation to successful outcomes and measurement of these outcomes are provided below.

DVA management	*"Where DVA sees it's outcomes as being successful is around some measures such as when you have someone fully rehabilitated and they are able to work again for whatever period of time, a good outcome would be that we are able to say that they remain a reservist."*
DVA management	*"A happy client - that's the number one successful outcome."*
DVA management	*"We can't afford to measure just at the individual level. We need to measure at the organizational or outcome level. Whether one of those outcomes is return to work, which is obviously important based on everything I have read about rehabilitation, but is that the only thing we need to measure? I think we're a bit flaky at the moment in terms of understanding what biopsychosocial rehabilitation actually means because for a lot of clients just because they go to a community centre and actually talk to others given their chronic mental health conditions is a good thing."*

However one participant from DVA pointed towards the need to differentiate between different clients when looking at successful rehabilitation outcomes depending on their age: "the only difference I would see in terms of the veteran and non-veteran community is the issue of the different needs of what we call the 'career group' of veterans and the 'repatriation group'." Similarly, the participant from the ADF noted that defining a successful outcome for clients with more complex needs is usually less straight-forward and success should be determined according to the client's initial goals.

Definition of success for others involved in rehabilitation cases

Interviewees did not perceive there to be much difference in the way 'success' is conceptualised by rehabilitation and other healthcare providers depending on whether the client is from a military or non-military background. A successful outcome would be where the provider has done the best possible job to enable the client to meet their goals and ideally "to get to the stage where they are not requiring assistance any more" (ADF personnel). Similarly, a stakeholder from a community organisation noted that for a rehabilitation provider, a successful outcome is where they are "able to achieve the goals that were originally outlined in the return to work plan."

One key expert believed that rehabilitation providers would see success for a client where they have "more connection with the community, employment, and less reliance on the rehabilitation provider" but noted that the support from the provider could be reactivated if the "person was experiencing some instability." Although one participant noted that the concept of success for healthcare providers may depend on "whether their motivation is repeated visits or good outcomes", it was assumed that most providers would be looking for improvement for the client and return to work was seen as optimal, as "those who return to work tend to require less ongoing health intervention". One key expert did not believe there were any major differences in the way the different parties involved in a rehabilitation case conceive of success. They pointed out that whilst "there may sometimes be differences between what clients want and what professionals see as appropriate and this can lead to differences in perceived 'success', on the whole I don't think this is an issue."

From the point of view of families, success was generally defined as involving improved connection and morale amongst family members and reduced burden of responsibility on carers. However, one participant from a community organisation suggested that family members may have mixed feelings about success in rehabilitation for their relative. For example, where a person recovers to the point where they are able to return to full-time employment, whilst seen as successful, this may place additional pressure on the family where the person was previously at home and responsible for baby-sitting duties but no longer able to assume these duties when at work.

Type of information to measure success

Participants were asked to comment on the type of information they use or would like to use to determine whether a client has achieved a successful outcome in rehabilitation. One key expert felt that motivation was a key indicator of whether a client would achieve a successful outcome in rehabilitation: "all the other client characteristics are useful in working out how challenging or costly the service may be but nothing beats client motivation as a predictor of successful engagement and outcome."

One interviewee from DVA commented that they would like to have more information about the different pathways into rehabilitation that impact on a successful outcome for clients. In particular, how do rehabilitation outcomes differ depending upon factors such as the client's injury or condition, where they served under the ADF, as well as the process, quality and timeliness of the rehabilitation process? Another DVA stakeholder noted that because it is difficult to define what success in rehabilitation is, the question of what information should be used to measure whether a client has achieved a successful rehabilitation outcome is complicated to answer. This stakeholder commented that DVA has had rehabilitation providers asking "What do you want us to do? What do you want to measure us on? What do you want us to report on?" but that this was difficult to answer when "I don't know what success means". Furthermore, this participant noted that "we aren't able to say 'this is the improvement' or see how we are improving the lives of people when they come to us." Therefore, going forward it will be important for all parties involved in rehabilitation for DVA clients to clarify their expectations and definitions regarding successful outcomes for clients and discuss the most appropriate methods of capturing this information on a case by case basis.

Some participants highlighted the need to think outside the square in terms of the information that could be used to provide information on rehabilitation outcomes for clients. A few participants suggested that because DVA clients receive unique case file numbers, these could be used to examine other information (aside from rehabilitation services accessed) that is available on DVA's system. This could include looking at a client's marital status (a change from married to single may indicate possible problems at home for the client), monitoring medical bills and where the client receives a pension or benefit, looking at their income earnings to get an indication of the client's work status. One interview participant from a community organisation commented that a successful outcome from DVA's perspective would be that they are able to reduce the benefits paid to the member. Comments from some participants are provided below.

DVA management	*"We need to be a bit more horizontal in our information gathering rather than just vertical in respect to what the rehabilitation program is showing."*
DVA management	*"We can see from the bills that a client is taking $3000 worth of pain killers per month, but there is not a process in place where we can say 'there is clearly a problem here'. In some critical instances we do, but as a general process we don't have the facilities to interrogate some of that stuff and say 'there is obviously a looming problem here'."*
Community organisation	*"I think that DVA has a real failure in utilizing providers to the best of their ability in terms of using reporting outcomes and service provision, making providers provide information each year on objective measures – they just don't do it."*
Community organisation	*"[We have told DVA that] with the ability of our system to generate reports, every month we'll generate a report for you of clients that we have previously completed an ADL assessment for, to say 'here's a reminder, from a legislative point of view, we need to reassess them' and do you want us to go back out and reassess them. They haven't engaged with that."*

Several stakeholders indicated that the easiest way to obtain information, and potentially the most useful information, is by talking directly with clients or via client satisfaction surveys. One key expert felt that it would be beneficial to involve the client's family in these discussions and surveys. One DVA interviewee suggested that it would be useful to conduct professional exit interviews with DVA clients. This respondent noted that the information required to determine whether someone has experienced a successful rehabilitation outcome is to a large extent already collected, however "you need the resources and people to talk them through it." Furthermore by conducting these types of exit interviews drawing on the information already collected in medical reports and rehabilitation plans, DVA can show the client "where we started, this has been our journey and this is where we're ending, so that they can see that they've been through a journey, and see and understand what's been done for them." Similarly, some stakeholders from community organisations suggested that the most useful information to be able to determine whether a client has achieved a successful outcome would be available by conducting client satisfaction surveys or feedback sessions which would be facilitated by someone external to the organisation. One key expert felt that these types of feedback sessions could be conducted by DVA staff with individual clients but needs to be "more structured than just a two minute phone conversation" as they should be documented in a standardised way. He went on to suggest that similar questions could be asked of the employer.

Ongoing monitoring of rehabilitation outcomes

Ongoing monitoring and evaluation of client outcomes was pointed out as important for ensuring that successful outcomes, particularly in terms of employment, are maintained over time rather than cutting off all assistance "at an artificially determined time-point" (key expert). Several stakeholders felt that rather than simply following up with clients after six months to assess whether they have sustained outcomes (such as employment), the amount of follow-up support required should be determined on a case by case basis and needs to be flexible in the amount that can be provided over time. It was suggested that the most useful information in this respect is speaking directly with the client and their employer on a periodic basis to assess whether there are "any ongoing needs the client may have."

Several participants noted that client outcomes really need to be measured and assessed on an ongoing basis. One stakeholder from DVA felt that follow-up with clients via ongoing Needs Assessments would be beneficial to ask a client "how are you dealing with the change in your wellbeing now that you are an injured person?" compared with how the client was prior to participating in rehabilitation. Another DVA stakeholder commented that it "is critical for any model to have the capacity for continually updating the outcomes that have been achieved. Quite often we see the outcomes down at the beginning of the assessment and when understanding their needs and capacities when going forward but those outcomes and those capacities need to be reassessed over time but often I think that is not the case. I think we have tried to build that into our new arrangements so that if the outcome you want to achieve hasn't been achieved after 3 months (or whatever time period it is) then it's a matter of not just looking at why the client hasn't achieved the outcome but looking at whether the outcome needs to be reviewed and do we need to set stretchable but realistic goals. That requires detailed and comprehensive discussions with the individual about where they are going." Another stakeholder from a community organisation agreed: "during the whole program, re-evaluating if things seem to be going off track should also occur."

Standardised outcome measures

Use of standardised outcome measures

When asked about use of standardised outcome measures, some participants answered in terms of administrative measures used to monitor and evaluate the progress and success in rehabilitation for clients. For those organisations involved in the delivery of rehabilitation to clients, measures were used to assess return to work outcomes, costs and case duration at the consultant level and to measure client and staff performance. For example, participants mentioned examining time durations to reach different outcomes and the numbers who return to work. One key expert suggested some measures that DVA could use to measure success in rehabilitation: "time from referral to formulation of the plan, time from formulating the plan to job search, time from commencing job search to commencing employment, time from commencing employment to stability in employment and program closure." It was also noted that it is important to differentiate between clients under different rehabilitation legislation when examining these types of administrative outcomes. Some organisations also reported conducting client satisfaction surveys in relation to the execution of service delivery, satisfaction with staff and effectiveness of case management.

By comparison, relatively few participants discussed the types of standardised outcome measures used to assess a client's rehabilitation needs in terms physical and mental health needs or when asked about these measures were of the belief that they would be used by staff from their organisation but they were unable to identify the specific measures used. One participant from a community organisation commented: "whilst we have a standard process for completing assessments in terms of a whole swag of questions we ask and testing using different instruments and tools, it varies so significantly and that's why evaluation really needs to be done on a case by case basis." However, some did use measures including WHO QoLs which are completed every six months. Another tool used by one community organisation was the 'Recovery Enhancing Environment Measure' – this participant noted that whilst the measure is not well validated at the moment, it has been designed by a consumer academic and examines important aspects for clients "in their

recovery and gets them to rate how well the organization is supporting them in those aspects." A key expert pointed out that "most providers are good at measuring things informally. They only need a little bit of structure to assess things a bit more comprehensively." Some suggested areas of importance to measure included quality of life, self-esteem, social connectedness, empowerment and job tenure. Furthermore, it was noted by one key expert that it's just as important to look at mental health amongst those who are undergoing rehabilitation for physical injuries as one would for clients presenting with obvious mental health symptoms.

Interviewees recognised that there are significant differences between administrative measures and measures that assess quality of life outcomes: "Satisfaction with DVA and satisfaction in terms of quality of life are different measures and you can't compare like with like" (DVA stakeholder). One stakeholder from the community who has contact with DVA pointed out that there is "a lack of monitoring and evaluation of outcomes. They might be doing it but not communicating it with us." Some other comments regarding the need for a clear concept of success in rehabilitation and agreed tools to measure these outcomes are provided below.

DVA management	*"I don't think we have a quality of life measure that is used routinely across the organization but I think it would be very helpful."*
DVA management	*"It would still be relevant to see what the costs are over a period of time in supporting people and whether, given we don't put a halt on the amount of intervention that can be provided to someone, do we get value for money?"*
DVA management	*"Appropriate monitoring of outcomes is where we need more help…we're not good at measuring what we have done."*
Community organisations	*"There seems to be a lack of understanding around what is a good outcome. They obviously need to determine what effective rehab is from a modelling point of view to then be able to measure effective outcomes...I appreciate that this is difficult because they are not dealing with a standard model in terms of this is how you measure costs, duration, these are the outcomes which is how we are measured by a lot of other corporate clients...because return to work may not be the right vocational option so they are presented with some unique challenges."*

Benefits of using standardised outcome measures

All respondents were asked to comment on the possible benefits of using standardised outcome measures. Most stakeholders could see positive aspects to using outcome measures. The majority of participants believed that the utility of standardised outcome measures lies in the ability to collect objective information to compare changes over time and between clients. It was also noted that use of these measures assists staff in measuring performance to ensure that what they are doing is having an impact or suggest where additional work needs to be done. A small number of stakeholders pointed out that a benefit of using outcome measures is that you have documented information that tracks client outcomes. Some comments from participants are provided below.

DVA management	*"It is really timely now with numbers starting to increase and it is the future, to say that if we are*

	going to take rehabilitation seriously, then we need to set some benchmarks."
ADF personnel	*"I think if you are using standardized measures you can get much better quality and understanding of where there is a need for improvement in terms of what's going well and what is not going well."*
Community organisation	*"At least we know what we are looking at and how we can measure our own performance… It also allows us to train and mentor our staff more closely. It allows us to build processes and systems to make sure we are delivering services in accordance with client needs."*
Community organisation	*"Where you are comparing provider to provider you can use some type of standardized basis to compare their performance. I think that if people know what the performance outcome measures are, they can work towards them."*
Key expert	*"It's about being able to identify problems earlier than you would otherwise."*

Limitations of using standardised outcome measures

Across the board there was consensus amongst the participants that information obtained from outcome measures should not be exclusively relied upon. It was pointed out that only using standardised outcome measures can lead to organisations neglecting to examine other issues they may be important in determining whether a successful outcome has been achieved but which are not measurable using quantitative instruments. In addition, it can lead to particular outcomes being regarded more highly than others which may be important in a different context: "some of the social interventions could make an enormous impact on someone's life but may not score very highly on an employment based outcome measure." One stakeholder felt that outcome measures should be viewed as useful "starting points rather than the finishing point". Similarly, another DVA interview participant commented that "measures are never the 'be all and end all'." Both of these participants agreed that the information collected via standardised outcome measures should only ever by used as broad indicators of success or point towards areas where additional information is required. Some comments from the participants are provided below.

DVA management	*"I think that the trap is that this type of data really only shows us indicative information. I don't think we can ever read too much into standardised information because often by itself, there is always some noise behind it, in my view."*
DVA management	*"It's simply an indicator on where you might have to dig for more information."*
Community organisation	*"[For some measures] such as returning to full functioning (socially, emotionally, integrating into society), it's very difficult to measure this because it will vary from client to client."*
Community organisation	*"People are complex so unless you have a very complex standardized outcome measure, lots of things can be overlooked or dismissed as not important, that may actually be of incredible importance for a particular individual."*
Community organisation	*"I think if you use them in a limited way, there's a problem and if it stands on its own rather than there being a good follow up done, it can be an issue too."*
Key expert	*"I describe them as necessary but not sufficient but you could also describe them as neither necessary nor sufficient."*
Key expert	*"[There needs to be] an awareness/recognition that standardized measures are only going to capture so much and the things that don't get captured somehow get forgotten, because there's an expectation that outcome tools tell the whole story."*

Need to collect quantitative and qualitative information

Some participants felt that is was important to collect both quantitative and qualitative information to obtain a complete picture about the client and gain an idea of whether rehabilitation has been successful. One stakeholder commented that the types of measures used depends on the type of information you wish to collect and the purpose for which it is intended to be used. This participant suggested that to know whether rehabilitation achieved a successful outcome for a client, qualitative information is probably more important because you need to know more about how the client is feeling. However if measuring outcomes for rehabilitation providers, the focus would be on whether they have delivered their services in a timely manner and been cost-effective and therefore quantitative measures would be most appropriate. A few participants noted that outcome measures usually focus on whether a client has returned to work but it is important to measure beyond this to look at sustainability in employment for up to 2 years or even beyond this, as well as examining mental health recovery. Participants noted that in these instances, integration between mental health teams and employment consultants is important to generate accurate information across these two areas. Some comments are provided below.

ADF personnel	*"I think that if the goal is not met or if the quantitative information doesn't really say why the client did not reach their goal or even if you have 89% returning to work, is that saying that it is a positive outcome? I just think it is flawed. It's really important to know whether the process was a positive experience or not. Even if the client has returned to work and they have met all of their goals and your figures look good, if it was not a positive experience for the client you need to learn from that and improve."*
Community organisation	*"[You could look] at the number of times they need to access services and whether independence is gained over the longer term. You could measure the number of times of entry into hospital due to mental health incidents in terms of whether these are reduced over time. It's about a long-term focus and not just focusing on employment in isolation but also mental health recovery."*
Key expert	"*You need both [quantitative and qualitative] measures because you need to have a fair process that the client is engaged in but they need to feel empowered and benefit from the program in lots of other ways too. So if people have an employment goal and they still have it but don't have a job, then that has got to be recorded as a failure. But it's also not sufficient for a person to have a job they don't like or doesn't have any career relevance for them."*

Another limitation to using standardised outcome measures is knowing whether you are using measures that will collect the information of most relevance. It was noted that standardised outcome measures do not always fit the population you are treating and are generally not flexible. One stakeholder from a community organisation commented "you could have some templates but they don't allow for anomalies or individual responses. I guess they could be overcome by having alternative questions or assessment measures to assist in those cases where there are anomalies but this is difficult to balance." One key expert commented in relation to tools to measure success in return to work outcomes: "because each job is so different…it can be difficult to use the same measure for different jobs. If you have a basic core measure - something that measures a person's knowledge, skills and attitude for a particular job at the task and social interaction levels, we think that can help a lot." Furthermore, two key experts pointed out that it is important that the

measures are interpreted in context (e.g. funding for the program, impact of issues such as the economic situation on job availability) but the risk is that this does not always happen. Lastly, one key expert felt that a barrier to use of standardised outcome measures can be the time it takes to use them.

Barriers to rehabilitation

Tension between compensation and rehabilitation

Amongst the stakeholders who worked for DVA or who worked with DVA clients, one of the major barriers to rehabilitation was the perceived tension between financial/compensation entitlements for clients and engagement in rehabilitation. One stakeholder even went so far as to state that there is a "long standing culture of rewarding illness." One of the key experts was aware of the legislative changes in recent years which sought to tackle this but felt that it had not adequately addressed the problem: "if people are waiting for a lump sum or some kind of financial reward for their condition/disability, that is a major counter-motivator to participation because for financial reasons, people will try very hard to maximize their disability." Another participant felt that for some individuals this mindset is difficult to change because if they "have an injury or illness that is work-related, they believe they are owed something and there are a small percentage that feel compensation is what they are owed, not return to work. I do think they want to get better but they still focus on the litigation part of it." This participant suggested that a possible way to overcome the focus on compensation is for the media to focus to a greater extent on the positive aspects for veterans in participating in rehabilitation such as looking at how people have improved and been able to return to work rather than emphasising the negative aspects of their experience which is more commonly the case.

In this respect, one key expert suggested that providing financial counselling for clients describing the financial implications of non-participation could be very beneficial to "help them to understand that whilst they may gain another $20,000 if they are still unemployed at the time they get their compensation settlement, they may actually be giving up higher income over X number of years, which may equate to several times more than that."

One key expert was of the opinion that too much emphasis is placed on the vocational side of rehabilitation when it is clear that there are quite a few ADF members who will not re-enter the workforce and would most benefit from rehabilitation focusing on other components such as medical/psychiatric/psychological needs, social aspects to improve a person's networks as well as spirituality. This participant commented that in these cases "the vocational and other aspects of rehabilitation should be directed to the non-paid workforce goal."

Culture among DVA staff

Another barrier to rehabilitation was the perceived culture amongst DVA staff where rehabilitation is not always the focus in the first instance, nor understood in terms of its intended purpose and benefits for all involved (e.g. the client, their family and DVA). This barrier was predominantly reflected on by participants

from DVA, although it was also commented on by other stakeholders who have contact with DVA. One stakeholder from the DVA senior management personnel group commented that there are differences in the extent to which the culture of psychosocial rehabilitation has filtered down to staff located in different locations and also based on the personality, skills and experience of the staff: "I think there are some locations and some people who are brilliant and understand rehabilitation fundamentally and for other staff, they go through a motion of filling out a form." However it was noted that DVA is implementing structural changes to improve this. A comment from a non-DVA stakeholder reflects this: "I think that DVA has changed some of their practices in terms of what their expectations are and what needs to be provided by a member to make a claim. Once liability has been accepted, I found that generally the DVA staff were very helpful and some were very knowledgeable."

Evaluation of service delivery was seen as a supporting factor important to achievement of successful rehabilitation outcomes for clients, as this enables all involved to gain an appreciation of whether the services are meeting the needs of clients. One key expert pointed out that the focus of rehabilitation should be based on recovery rather than simply the provision of relevant services: "it's important to look at whether the client is better after having received those services" because if they are not then their rehabilitation should continue.

Defence culture

One DVA stakeholder also felt that the Defence culture amongst current serving ADF members where there is perceived to be a widely held "belief that you are weak unless you have an obvious physical injury" acts as a barrier to ensuring that members submit a claim for their injury or condition – "it's a strong, Aussie, blokey culture." The participant representing the ADF also pointed out that some ADF members are reluctant to lodge a claim because they "do not want to admit they have a problem because it's seen as a weakness…because then they will know I'm unwell and think I'm a failure." Therefore, client motivation and expectations are critical. In terms of whether there are differences in the barriers for veterans compared with other clients in the community, some stakeholders felt that there was more anger amongst veterans and a perception that injured personnel are not looked after. Some, not all, also believed that veterans were a more complex group of clients to manage as many have both physical and psychological injuries and conditions.

Clients with complex needs

Both DVA and non-DVA interviewees reported mixed opinions regarding the efficacy of current rehabilitation service delivery for clients presenting with complex needs such as mental health conditions or complex physical injuries. One participant felt that this "complex end of the market" was a key area for DVA but one which had only recently been recognised and so DVA were in the process of implementing "business processes that are quite different to what we have now to support that end of the market." It was noted that clients with mental health conditions in particular can be difficult to engage in rehabilitation. In contrast, another DVA stakeholder felt that DVA "do a really good job" with clients who are "at the apex of

cases" – those who have severe injuries or suffer trauma or diagnosed mental health conditions. However, this participant felt that DVA clients at "the bottom of the apex (the hidden wounded group)" tend to "slip through the cracks" because their rehabilitation needs are not as obvious.

Some participants noted that because discharged veterans often have a range of different problems compared with the average client in the community, this can act as a barrier to successful reintegration into the civilian community. One participant from a community organisation commented that "where your average person loses their job, they still have their networks, live in the same houses, can still do the same social activities that are meaningful; for a lot of DVA clients, their network of friends were all fellow military people so when they are out of the military they don't have that same kind of compatibility anymore…that is a really big loss in their life."

DVA administrative system

Another barrier was the complexity of the DVA administrative system. One DVA stakeholder commented "it's so hard to actually make a claim, let alone get the claim determined in your favour, everything is shrouded in mystery so it doesn't set up trust at the beginning." Another DVA participant did not believe that the "message is getting out" to potential clients and felt that DVA's "bureaucratic processes" deter potential clients who do not want to go through "the drama" of making a claim. It was noted by one of the non-DVA stakeholders that the time taken to process claims and determine liability acts as a significant barrier to engaging clients in early intervention; however, it was acknowledged that this is improving over time. One key expert felt that it is "really important to have a single database of all injured and serving members in terms of where they are up to with healthcare and vocational rehabilitation so someone can start tracking them from day one so you can look at how long they are in the system before they get any serious help. Then it's about devising system solutions to rapidly provide either serving members or veterans with whatever assistance they require."

Another DVA interview participant commented on how the system in place creates barriers to rehabilitation due to various factors including "a lack of resources" and an inability to "measure what we need to measure" which results in DVA being unable to "record and report" on different aspects of the rehabilitation process. A participant from a community organisation who has contact with DVA noted that staff have "really high caseloads" which can impact on the timeliness of service delivery and communication with all parties involved in rehabilitation cases.

However, when commenting on the implementation of the DVA Needs Assessment form, there was the general belief that this assists the process but it was acknowledged that there was further room for improvement as it is not applied by staff across locations in a consistent manner. Comments made by some of the interview participants in relation to the Needs Assessment process are provided below.

DVA management *"As a process, I think it is a good process with the client as it is generally conducted on the phone so it is a good opportunity for communication. You can also ask how the client is travelling at the*

same time."

DVA management *"The needs assessment identifies needs and referral, but it also provides a really good opportunity to be able to explain to the client exactly what the process is and what they're entitled to. It's our first real contact where we're explaining "here's what we might be able to do", and the needs assessment is an important part of our client relationship."*

ADF personnel *"You're looking at the member holistically – whether in their home environment or work environment and looking at everything across the board in terms of what their difficulties are, how they participate in their everyday living tasks, whether they can get to work, or what are the barriers to get them back into work. So it looks at what their needs are and then what you can put in place to enable them to move forward…I think that when it is completed it certainly identifies what the needs of a client are."*

Lack of flexibility in development of rehabilitation plans

At the systems level, a perceived barrier to rehabilitation was the use of generic rehabilitation processes but it was felt that rehabilitation providers have the skills and experience to "work within the structure of the system whilst still providing individualized programming for clients" (community organisation). Another stakeholder from a community organisation noted that the perceived inability to tailor rehabilitation plans to the needs of individual clients could act as a potential barrier to successful rehabilitation but felt that according to DVA's rehabilitation framework, this ability had been built in but needed to be reinforced amongst staff. Similarly another stakeholder noted that it is important that clients feel a sense of agency and ownership in their recovery because "if there's a 'one size fits all' model, then that is a big barrier." Commenting on the importance of individualised rehabilitation programs and client involvement in this process, one key expert pointed out that "if the client doesn't want the help, you have to wonder how much benefit they are going to get from it if they didn't want it in the first place."

One key expert suggested that the rehabilitation approach needs to be flexible as the "nature of psychiatric illness is different from the nature of other physical illness in that it is more prone to relapse rather than being stable." As such, this participant was of the belief that rehabilitation should involve a graduated, step-wise approach. In contrast, another key expert felt that rehabilitation providers need to move away from the traditional approach to rehabilitation (particularly in the context of vocational rehabilitation) where services are provided in a "gradual and step-wise" fashion to instead engage in rapid job search strategies.

Rural issues

Residence by clients in regional or remote areas was raised by a few stakeholders as another system level barrier to rehabilitation. One DVA interviewee pointed out that this "means they are difficult to contact, if they need treatment they are difficult to get into a plan and if they are capable of work it is difficult to find work for them." It was noted that this was not uncommon because "a lot of our clients head for more remote areas to get away from the stresses of life." Focusing on this theme but from a different perspective, another stakeholder noted that whilst there are "some really good rehabilitation programs, they may not be in the area where the person lives. So in order to access that rehab process the person would have to be disengaged from their support network. Even though the program may provide really good rehab, the client

might not actually do well because they don't have their support networks around them." Therefore, it was suggested that it is important to recognise what facilities are available, where they are located and the quality of the personnel working in those facilities as these are all factors that can impact on the quality of the rehabilitation experience for clients residing in regional or remote areas.

Global financial crisis

The impact of the global financial crisis in terms of the increasing unemployment rate was mentioned by several participants as a growing barrier to rehabilitation in terms of finding and engaging clients in suitable employment. Related to and exacerbated by this point, some stakeholders noted that a barrier for clients where the goal is to return to work is the inability to provide alterative duties in existing workplace situations. Two comments are provided below.

Community organisation	*"In the broader economic situation with the global financial crisis, employers are in a situation where they can become choosier about who they select. Their willingness to make compensations and workplace adjustments, well, there is not as much incentive for them to do so."*
Key expert	*"If focusing on return to work numbers at the moment, it is important to look at the impact of the global financial crisis on the number of jobs available and the impact this has for clients who are trying to find a job."*

Stigma in the community

Several interview participants noted that a significant barrier to rehabilitation that can often be overlooked is the level of stigma in the community in relation to mental health. It was suggested that due to the stigma associated with having a mental illness, a lot of clients are reluctant to come forward to seek help. Commenting on this, one key expert reported that "people who have been in the services do not easily acknowledge that they have been damaged, or they are denied and don't come for treatment until later in the course of the illness." One stakeholder from a community organisation commented on the ramifications of this stigma for the client: "sometimes people in the community can misunderstand that and this makes it difficult to integrate into employment situations but also into social and educational environments." Improved education and awareness around mental health issues out in the community and amongst employers was suggested as the way to overcome this. This could include training about mental illness in the workplace or establishing mentors within the workplace and community where a mentor is linked with a client to assist them in dealing with the stigma. One key expert recommended coaching for the broader community in providing support and was of the belief that "the community would be happy to take responsibility for those, who through no fault of their own, are in need of support." Another participant felt that engaging clients with a mental illness in the employment sector provides "better opportunities for role modelling". One participant was of the belief that some people (particularly those from non-English speaking backgrounds) would have difficulties in even identifying that they have a mental illness.

Facilitators to rehabilitation

A number of different facilitators to rehabilitation were mentioned by those interviewed. This included early intervention, goal setting, working with a multidisciplinary team and ensuring the client is engaged in the rehabilitation process along with all other key stakeholders. One participant from a community organisation involved with DVA commented that "it's certainly a very holistic comprehensive and client-centred rehabilitation framework."

Communication was the overwhelming factor that stakeholders believed led to a successful rehabilitation experience for clients. Communication between the client and DVA staff but also other people involved in the rehabilitation process, such as the rehabilitation and healthcare providers and family members, was noted as critical. Those engaged in the delivery of rehabilitation to clients also noted the importance of communication with rehabilitation service providers:

Community organisation	*"It would be beneficial if DVA make sure that everyone is clear around their expectations for service delivery. It's more the provision of information from DVA and making sure they are partnering with us in terms of getting the outcome from the client."*
Community organisation	*"It's also about being very clear about what DVA want and having skilled and experienced staff at DVA who are managing the programs and referrals."*
Key expert	*"There needs to be some constraints on the role of the rehab coordinator so that they are a facilitator and not a barrier to the program. That doesn't mean that the rehab coordinator role isn't important. It just means that they need to step back and let the providers get on with it and have processes that have a minimum impact on the delivery of services."*

All three DVA senior management personnel commented on the way that expectations of different parties, particularly the client, can impact on the success of rehabilitation. It was also pointed out that by sitting down with clients, providers and DVA staff can actually hear what their goals and expectations are so everyone is clear about the purpose of rehabilitation. One DVA stakeholder commented "we actually talk with the providers and connect with them in terms of working in partnership – that seems to be working well." Another DVA interviewee noted that "there needs to be greater consistency in the way they [providers] sit down with their client and talk about goal setting. One thing that we need to ensure is that the client's goals and preferences are fully examined with a maximum of client involvement in planning and decision making." This is consistent with literature regarding best practice in rehabilitation.

However, one stakeholder from DVA questioned the feasibility of DVA staff and rehabilitation providers having these types of conversations with clients as it would involve a complex and lengthy consultation which is not possible given the way the current funding structure works. Another DVA participant noted there is inconsistency in the level of contact with rehabilitation providers and it would be beneficial if a memorandum of understanding was developed to improve consistency and formalise aspects such as charging rates and reporting. One of the stakeholders from a community organisation noted that this type of contract is commonplace when working with other agencies: "agencies are also becoming more sophisticated in the way they secure services – they will set up a panel, put contracts in place, have

deliverables and make sure that there is that accountability and transparency in quality service provision whereas I think that government agencies are much slower in engaging that kind of procurement methodology."

Continuity of care

Continuity of care was another area perceived to be important in delivering successful rehabilitation. One stakeholder commented that clients, particularly those with mental health conditions, want to remain with the same treatment provider as "the last thing a client wants to do is tell their story over and over again to different people."

An important aspect of continuity of care for DVA clients was ensuring a smooth transition process from the ADF to DVA. One stakeholder from DVA felt that this process could be facilitated to a much greater extent by improving the communication between the ADF and DVA regarding members transitioning out of the ADF, particularly in terms of getting current serving members to lodge reports immediately after an incident occurs so rehabilitation can be provided as early as possible. It was pointed out that the level of support from the serving member's direct ADF unit can be an important factor facilitating the willingness of the individual to make a claim and engage in rehabilitation.

In line with comments made by DVA staff during the focus groups, one interview participant from DVA noted that members who are administratively discharged are "really problematic" and often "lost totally to DVA" even though they will often be in "situations where there could be substance use or similar problems which may mask a whole range of other issues." However, another participant from DVA felt that the process had improved so that rehabilitation is continuous and DVA links in better with the ADF. The interview participant representing the ADF commented on the effectiveness of the transition model in place in Townsville where the ADF member, ADFRP, DVA and transition cell "work together to get the best possible outcome for the member." Comments from some of the other key stakeholders are listed below.

Community organisation	*"The earlier they know about members needing to discharge and go through that process, the more they can be proactive with cases and probably the cases are much easier to manage and are much more open and shut. But because of that delay you end up having cranky clients, much longer and protracted cases, you're dealing more with chronic injury as opposed to acute injury and the cases are much more complex because of that lack of immediacy surrounding intervention. Therefore, I think that integration into the ADFRP is really critical for DVA to be successful."*
Key expert	*"We actually need people to have very individualized plans whilst they are still serving and if there is a reasonable chance that they will be discharged in the foreseeable future, they need to be rapidly moved into a DVA type program so they can get assistance to find a job outside the military. Those pathways need to be opened up. How to do that, I'm not sure because the system is mostly designed for people who want to stay in and don't want to get out."*

Engage the client in the community

One stakeholder from DVA was of the belief that DVA could "link in with the mainstream" to a greater extent to access the wide range of services available for those out in the community. Several key stakeholders felt that engaging the client in employment or in services provided out in the community facilitated a more efficient recovery. A suggested method to accomplish this was to engage the client in rapid job search because "grafting people back into the community through employment or volunteer programs makes a huge difference." One key expert felt that getting clients involved in rapid job search strategies facilitates rehabilitation. He commented: "the best way to get a person started in employment is to get them job searching as early as possible so that anything else they are provided as part of their vocational rehabilitation in terms of health interventions can be done in parallel with the rapid job searching principle." Another key expert felt that a lot of people have the idea that "vocational rehabilitation is something that you do when you are well and recovered" but that it should be "part and parcel of the process" from the beginning.

Support for veterans

Some stakeholders felt that there were very good support networks set up for military veterans relative to those in the community – e.g. VVCS, VAN and RSL advocates. There was the belief that compared with clients in the community, there are more resources available for veterans and some suggested a greater sense that veterans deserve assistance because they were injured whilst 'serving their country'. In contrast, one key expert felt that veterans should not be treated any differently than other people who are injured at their place of work: "We have got to think about the ADF as just one employer amongst lots of others out there. Sure, there is a lot of information out there about serving your country and being injured during the course of service and that puts more responsibility on the employer for the damage they have done to the person, but other than that, it is not different to having an accident or injury in any other workplace." Some other comments are provided below:

Community organisation	*"Where I see the biggest difference between DVA clients and general welfare recipient clients is that DVA clients tend to have better resources available to them."*
Community organisation	*"Veterans might have a more known and dignified label for their illness because they have done something for their country and as such, they receive a very specific resource allocation compared with other groups."*
Key expert	*"Veterans have a lot of support from other veterans [in terms of] advocacy services."*
Key expert	*"For a DVA client who had to have his left leg amputated, this is seen as a result of his military service and so he is 'entitled' to good rehabilitation. However, for someone in the community who has mental health problems, there is no identifiable cause and so the person is viewed as though there is something wrong with them."*
Key expert	*"If you had two people standing side by side where one was a soldier who had his leg blown off whilst serving overseas and the other was just a member of the community who had problems with alcohol, the person with the physical injury where the cause was seen to be their employment, they would be seen as more deserving of rehabilitation every time."*

Summary

Twelve stakeholders from a variety of organisations participated in a phone interview about rehabilitation. Almost all participants believed there had been changes in the way rehabilitation is perceived and delivered in recent years. Most of these were positive changes in terms of cultural changes amongst DVA staff and the community, with greater emphasis on engagement in rehabilitation and the reduction of stigma; however, it was noted that further work was needed to continue in these areas. Many of the key experts and stakeholders representing community based organisations focused on changes in service delivery such as the provision of discrete services and an emphasis on rapid job search strategies. Another change noted by several participants was a greater focus on building on the capacities of the client during their rehabilitation rather than focusing on their incapacities.

All participants were asked to describe what they believed constitutes a 'successful' outcome in rehabilitation service. Many of the participants focused on return to work outcomes, particularly stakeholders from DVA, however there were some differences in terms of what 'return to work' means (e.g. competitive employment, full-time versus part-time, voluntary work etc.). The most successful outcome would be where a client has returned to competitive employment, but it was noted that the number of hours worked would be dependent on the abilities of the client and as such, full-time work is not always the goal. Some participants defined a successful outcome in rehabilitation more broadly than return to work. This included a focus on improvement in quality of life outcomes and successful transition into the community, with a few participants also indicating that a successful outcome is where all of the goals outlined on a client's rehabilitation plan have been achieved. Clearly, defining 'success' in rehabilitation is a complex task. It is important that any definition of success is able to address the complexities of client rehabilitation cases where there can be a focus on different return to work outcomes as well as broader outcomes such as improved independence and quality of life. Furthermore, it was suggested that ongoing monitoring and evaluation of client outcomes both during and after formal closure of a case is important to ensure that these positive outcomes are maintained for the client over time.

Due to the complexity of defining a successful outcome in rehabilitation, some participants suggested that it would be beneficial to examine a number of different sources of information to determine whether a client has achieved a successful outcome in rehabilitation. This included using some of the information generated by rehabilitation providers, conducting exit interviews or client satisfaction surveys and 'thinking outside of the square' by examining some of the information available on DVA's administrative systems that could act as indicators of success or function as warnings that clients may require further assistance or follow-up. Most importantly, many of the key experts and participants from community organisations pointed out that the easiest way to determine whether a successful outcome has been achieved is to speak directly with the client.

When asked about use of standardised outcome measures, some participants focused on the types of administrative measures used to monitor and evaluate progress and success in rehabilitation, whilst a small number discussed the use of measurement tools to assess client needs (e.g. physical, psychological, social

and vocational). For those organisations involved in the delivery of rehabilitation to clients, measures were used to assess return to work outcomes, costs and case duration at the consultant level and to measure client and staff performance via surveys. A number of stakeholders suggested that it is important to measure a broad range of client outcomes but that the types of outcomes measured really need to be determined on a case by case basis. Some of the suggested areas of importance to measure included quality of life, self-esteem, social connectedness, empowerment and job tenure. All of the interview participants from DVA agreed that improvements are required to monitor and evaluate client and system outcomes.

All participants were asked about the benefits and limitations of using standardised outcome measures. Some of the benefits to using these measures included that they provide objective information to enable organisations to compare changes between clients and over time; they formally document and track client outcomes in a consistent manner; and they can assist staff in measuring performance and identify areas which may need to be addressed. However, across the board there was consensus amongst the participants that information obtained from outcome measures should not be exclusively relied upon to assess success in rehabilitation. Most participants recommended that quantitative measures be used in conjunction with qualitative measures, particularly in direct communication with clients. Some of the limitations to using outcomes measures included that they often only focus on particular types of outcomes and can neglect other important issues of relevance for a client and they can be inflexible when applied to populations with different needs or issues. Many participants suggested that outcome measures are most useful as broad indicators of success and in identifying where further information is required.

Some of the barriers to rehabilitation mentioned by the key stakeholders included:

- The tension for clients between receiving financial compensation/entitlements and engagement in rehabilitation;
- Culture among DVA staff where rehabilitation may not always be promoted;
- Defence culture where ADF members may be reluctant to lodge a claim for their injury for fear of being perceived as weak or the potential impact it may have on their career;
- Difficulty in delivering effective rehabilitation to all groups including those with complex needs;
- The complexity of the DVA administrative system;
- Lack of flexibility in development of rehabilitation plans;
- Regional and remote issues;
- Implications of the global financial crisis for engaging clients in employment; and
- Stigma in the community in relation to mental health.

Some of the main factors believed to facilitate rehabilitation included early intervention, goal setting, working with a multidisciplinary team and ensuring the client is engaged in the rehabilitation process along with all other key stakeholders. Successful communication amongst all parties was the overwhelming factor that stakeholders believed contributed to a successful rehabilitation experience for clients. An important aspect

recognised in the continuity of care for DVA clients was ensuring a smooth transition process from the ADF to DVA. A number of participants also felt that the resources and support networks available for current and former serving veterans assists in the achievement of successful rehabilitation outcomes, but some stakeholders suggested that better engagement of veterans in the community could aid this process further.

Discussion

As was outlined in the introduction section of this report, the Barriers to Rehabilitation project involves two phases of data collection. This report presented the findings from phase one, which involved interviews with DVA clients, focus groups with DVA staff, an online survey of DVA-contracted rehabilitation service providers, and phone interviews with key stakeholders (both DVA and non-DVA) involved in psychosocial rehabilitation. Through collecting data from each of these sources, the aim was to capture information that would be used to provide direction for the second phase of the project. This included increasing understanding about the key aspects of DVA rehabilitation service delivery; examining perceptions of 'success' in rehabilitation; use of standardised outcome measures in rehabilitation; and perceived barriers and facilitators to successful rehabilitation. It is interesting to note that a number of the key themes identified in one component of data collection during phase one of the study often emerged in the context of other components of data collection. These key themes are described below and then discussed in reference to determining the direction for phase two of the project.

Key themes from phase one

Communication, in a number of different respects, was one of the key themes emerging from all four areas of data collection during phase one. Firstly, it was noted that for a number of DVA clients there is a general lack of support and awareness regarding the rehabilitation process and available services. A number of DVA clients and DVA staff members pointed out that some clients do not receive the necessary information at the time of their injury to make informed decisions about their rehabilitation needs and goals for recovery. Related to this point was the need to improve general communication between DVA staff and clients during their rehabilitation, as it was believed that DVA staff could be more proactive in their communication and follow-up with clients. Thirdly, information from all data sources indicated the importance of communication between DVA staff and rehabilitation service providers. Some of the suggestions made by various parties in the earlier sections of this report about ways to overcome these communication barriers have included:

- The distribution of an information brochure to all ADF members during transition to increase awareness about rehabilitation;
- Development of a user-friendly website for clients;
- The development of an information brochure to be sent out to service providers with all client rehabilitation referrals to clarify guidelines and expectations; and
- Increased communication between DVA staff, rehabilitation service providers and clients to confirm rehabilitation needs, goals and expectations.

Another key theme, consistent with literature on best practice in rehabilitation, was the importance of a holistic and flexible approach to rehabilitation where the focus is on addressing the needs of individual clients rather than a generic approach to rehabilitation. This includes addressing physical, psychological, social and/or vocational needs, where required, on a case by case basis. There was recognition of the need for all parties to focus on client abilities rather than inabilities when managing rehabilitation cases. However,

it was evident that DVA staff and a number of key stakeholders who participated in the study placed a stronger emphasis on vocational rehabilitation and achieving return to work outcomes compared with other aspects of rehabilitation.

Across all four data sources, some participants discussed the perceived tension between the provision of financial compensation to DVA clients and the engagement with relevant rehabilitation services. There was a belief amongst some clients that there is a greater focus by DVA staff on providing compensation rather than rehabilitation for clients. At the same time, several key stakeholders, DVA staff and rehabilitation service providers felt that, at times, clients are more motivated by the financial entitlements they can access from DVA rather than rehabilitation to recover from their injuries or conditions. Once again, communication was identified as an area that could be improved in this respect to increase understanding of the benefits of rehabilitation for clients (both in the short- and long-term) and to address client motivation.

A number of participants in the study felt that DVA's administrative processes can act as a barrier to successful rehabilitation for clients due to a lack of timeliness in liability determination, assessment and the provision of rehabilitation services. It was pointed out that this inevitably impacts on DVA's ability to provide early intervention. All groups reported that more work could be done to better facilitate the transition of clients between the ADF and DVA. Again, this was related to improved communication between all parties.

Further investigation of DVA's administrative processes was conducted via a review of a small sample of closed DVA client rehabilitation files. In total, 40 rehabilitation case files (20 MRCA and 20 SRCA) that had been closed within the past year were reviewed. The purpose was to obtain an indication of the documents included in the files and the possibility of analysing the information contained within these documents through a trial database set up by ACPMH, including whether there would be information that could be used to examine 'success' in rehabilitation client outcomes. It became apparent from this review that phase two of the study would need to involve a data collection rather than a data capture as there was inconsistency in the forms included in the case files and the quality of the information. The other noticeable finding was that no needs assessment forms were included in the paper-based case files. It is unclear whether the needs assessments were conducted for these clients or whether they were stored elsewhere. The importance of the needs assessment process was raised in interviews with key stakeholders and the focus groups with DVA staff, however it was evident that this process was applied differently across the states.

It became clear by the completion of phase one that defining 'success' in rehabilitation is a complex task and in many cases can be subjective as it can differ from client to client. It was pointed out that whether a client achieves a successful rehabilitation outcome depends on what their initial goals were and therefore addressing client expectations via goal setting is important. It is important that any definition of success is able to address the complexities of client rehabilitation cases where there can be a focus on different return to work outcomes as well as broader outcomes such as improved independence and quality of life. Furthermore, a successful outcome can be dependent on a number of other factors such as the age of the client, their injuries/conditions, their location (e.g. rural versus metropolitan) and the legislation they fall

under. It was suggested that ongoing monitoring and evaluation of client outcomes both during and after formal closure of a case is important to ensure that positive outcomes are maintained for the client over time.

When asked about use of standardised outcome measures, some participants focused on the types of administrative measures used to monitor and evaluate progress and success in rehabilitation, whilst a small number discussed the use of measurement tools to assess client needs (e.g. physical, psychological, social and vocational needs). For those organisations involved in the delivery of rehabilitation to clients, indicators were identified to assess return to work outcomes, costs and case duration at the consultant level and to measure client and staff performance via surveys. A number of stakeholders suggested that it is important to measure a broad range of client outcomes but that the types of outcomes measured need to be determined on a case by case basis. The DVA staff pointed out that they relied on the reports supplied by rehabilitation service providers regarding client progress and outcomes and therefore did not implement any outcome measures of their own. The survey of rehabilitation service providers revealed a lack of consensus regarding the best standardised outcome measures to use, as different measures were used depending on the client's circumstances. However, there was agreement that use of standardised outcome measures is important in demonstrating effectiveness, efficiency and accountability and that they can be useful in formally documenting and tracking client outcomes in a consistent manner. Some of the suggested areas of importance to measure when assessing clients included quality of life, self-esteem, social connectedness, empowerment and job tenure. All key stakeholders interviewed from DVA agreed that improvements are required to monitor and evaluate client outcomes and system performance.

Phase two of the project

Based on the findings described in this report, it is intended that phase two of the project will include two studies with different foci:

- Study one will aim to explore the implementation of the Needs Assessment process by staff to look at how different factors can impact on this process.
- Study two will involve a trial of the routine adoption of an outcome measure that would be relevant to apply in all rehabilitation cases. This would provide an indication of success in non-return to work related outcomes, which are not currently measured by DVA.

An ethics application in relation to these two studies was submitted to the DVA Human Research Ethics Committee at the end of May 2009 for approval. The two projects are described in more detail below.

Study one: National implementation of the Needs Assessment process

There is consensus among DVA Rehabilitation Policy staff regarding the importance of the Needs Assessment process, however there is some concern as to how this process is being implemented in practice by DVA service delivery staff. This was evident in the focus groups conducted with DVA staff based in three different states as well as feedback from key stakeholders during the phone interviews. It is believed that the implementation of the Needs Assessments consistently across staff and locations will act

as a way to improve the initial communication between DVA staff and clients to confirm that all needs and expectations are discussed and to ensure that the information obtained from these discussions is documented in a standardised manner.

The DVA Rehabilitation Policy Section is currently in the process of introducing an electronically-based record of the Needs Assessment. Study one would involve a review of a sample of Needs Assessment forms completed at different DVA offices (office locations still to be determined). The purpose would be to review the compliance and quality of information documented in the Needs Assessment forms. It would also provide an opportunity to examine the types of needs and services required by clients who have different injuries or conditions. An additional aspect of study one would involve obtaining information from each DVA office participating in the study in relation to the DVA staff involved in the completion of the Needs Assessment forms (e.g., staff experience and qualifications, staff ratios and staff turnover). This would allow the quality of the Needs Assessment forms to be reviewed in relation to the experience and workload of the respective staff in the DVA office.

Study two: Trial introduction of rehabilitation outcome measures to support DVA

Findings from phase one of the project identified that DVA staff did not utilise standardised outcome measures but believed it was the role of rehabilitation service providers to implement such measures in their work with clients and to monitor and report on these outcomes back to DVA staff in their administrative reports (e.g. progress reports and case closure reports). However, there was a lack of consensus amongst the rehabilitation service providers surveyed as well as key stakeholders interviewed regarding the most effective standardised outcome measures to be used by consultants to assess rehabilitation needs and determine the success of rehabilitation. It was pointed out by the participants that rehabilitation consultants need to use outcome measures that are flexible enough to capture information depending on the client's needs and injuries/conditions and therefore a variety of measures tend to be used depending on the circumstances of the case. Furthermore, whilst return to work outcomes were noted as being important, it was generally agreed that it is important to have an indication of success in achieving non-return to work outcomes that may be just as relevant for a client.

Therefore, the purpose of study two is to conduct a trial of the routine adoption of an outcome measure that would be relevant for all rehabilitation cases, which would provide an indication of success in non-return to work related outcomes that are not currently measured by DVA. Goal attainment scaling, where clients work with consultants to develop goals across relevant domains (e.g. education, isolation, depression, work etc.), has been suggested as the most appropriate method of measurement to trial. In consultation with DVA, ACPMH will develop modified versions of the current Rehabilitation assessment report, Rehabilitation Plan, Rehabilitation progress report (6 months only); and Rehabilitation closure report. These forms will include the minimum number of additional fields possible that would allow providers to indicate the goal or intended outcome of the rehabilitation service to be provided. ACPMH will analyse the usability of the data, including the most appropriate way to represent it in summary form for DVA's monitoring and reporting needs.

It is believed that the use of goal attainment scaling to measure outcomes, where outcomes are defined in consultation with clients so they are relevant to individual client goals, but which can then be analysed using a standardised scoring system, may help overcome some of the limitations of using outcome measures mentioned by the participants during phase one (e.g. a focus on particular types of outcomes over and above other rehabilitation outcomes). Furthermore, by formally documenting the communication between rehabilitation consultants and clients regarding rehabilitation goals and expected outcomes, some of the barriers to successful rehabilitation mentioned by participants in phase one may be overcome. By ensuring that all parties have the same understanding of each client rehabilitation goal and consistent expectations from the very beginning through formal documentation and dissemination, DVA may be able to better assess the extent to which rehabilitation is meeting the needs of its clients.

Appendices

Attachment A: DVA Client Interview Documentation

DVA Description of "successful" clients

Clients eligible for services under MRCA or SRCA will be invited to participate in focus groups in which they will discuss their experiences of the biopsychosocial rehabilitation provided by DVA including identification of rehabilitation needs, formal needs assessment, plan development and implementation and outcomes. Two focus groups will be held in each of Melbourne, Sydney and Adelaide. Each of these groups will contain two sub-groups of people who have received rehabilitation services in the past 12 months.

You have been asked to identify approximately fifteen clients of two categories;

a) those for whom the rehabilitation process and experience was considered to be successful. Clients should be receiving rehabilitation as part of MRCA, have received the support within the last twelve months and have mental health problems primarily but not necessarily as their initial presenting problem. "Success" is defined as a "positive" outcome as perceived by the client, DVA and the provider.

b) those for whom the rehabilitation process and experience was considered not to have been as successful as expected as perceived by the client, DVA and the provider. It is important that no clients who are considered to be distress, have expressed anger about their experience, or who are known to have made any complaint to or about DVA are included in this group.

Letter of invitation template (Victorian version)

Telephone 131 254
Facsimile (02) 6289 6257

{Title}{Name}{Surname}
{Address}
{SUBURB STATE CODE}

Dear {Title}{Surname}

I am writing to invite you to participate in a focus group about veterans' experiences of rehabilitation provided by the Department of Veterans' Affairs (DVA). This focus group is being conducted by the Australian Centre for Posttraumatic Mental Health (ACPMH), University of Melbourne. The research is funded by DVA and is being conducted to ensure rehabilitation services and programs produced by the Department are of a high quality and better serve the needs of eligible veterans, former and serving ADF members.

Questions that will be asked focus on your experience of being assessed for possible rehabilitation needs, your expectations of the rehabilitation services, your experiences in receiving services from rehabilitation providers and your views on the factors that made your experience of rehabilitation good or bad.

If you choose to participate in the focus group, none of the information gathered from the focus group will be used to identify you. The answers you provide will not in any way affect any pension, benefits or health services which you are entitled to from DVA, or to which you may become entitled in the future. Your participation in the focus groups is voluntary and you can discontinue your participation in this study at any time.

If you do not wish to participate in the focus groups, please contact Ms Danielle Van Leeuwen from DVA Victoria on (03) 9284 6420 to remove your name from the list. If you have any questions about this survey please contact Associate Professor Virginia Lewis from ACPMH on (03) 9496 2922. Unless you advise DVA that you do not wish to participate in the focus groups, ACPMH will be in contact with you in the next two weeks with more details.

A factsheet of frequently asked questions about the focus groups is attached to this letter and may provide additional information. Your contribution and participation in the focus group is appreciated.

Yours sincerely

Brigadier W Rolfe AO (Rtd)
COMMISSIONER

PILOT STUDY INTO BARRIERS TO REHABILITATION

DVA Client Participant Information Sheet

1. The Department of Veterans' Affairs has commissioned the Australian Centre for Posttraumatic Mental Health (ACPMH) to undertake research into the barriers to rehabilitation for DVA clients. Dr Virginia Lewis is the principal investigator on the study.

2. In order to begin to gain a better understanding of veterans' experiences of rehabilitation provided by DVA, ACPMH is conducting a small number of focus groups and phone interviews in Melbourne, Sydney and Adelaide.

3. Questions that will be asked focus on your experience of being assessed for possible rehabilitation needs, your expectations of the rehabilitation services, your experiences in receiving services from rehabilitation providers and your views on the factors that made your experience of rehabilitation good or bad.

4. Your participation in this phone interview is voluntary. During the interview, you may decline to answer questions and you are free to withdraw from the interview at any time without negative consequences. Your decision to participate and the answers you provide through your participation will not in any way affect any pension, benefits or health services which you are entitled to from DVA, or to which you may become entitled in the future.

5. The questions are not intended to bring up personal or challenging experiences and are not intended to be upsetting to you. However, we understand that you may experience distress. Should you have any concerns, please remember that you can call your local VVCS during business hours (see contact details below), or the Veterans Line at any time including after hours on **1800 011 046**.

Adelaide VVCS	Melbourne	Sydney
99 Frome Street Adelaide SA 5000	Level 4, 440 Elizabeth Street Melbourne VIC 3000	88 Philip Street, Ground Floor Parramatta NSW 2150
(08) 7422 4500	(03) 8640 8700	(02) 9761 5029

6. The Research Team will protect your confidentiality and privacy of responses to the fullest extent possible, within the limits of the law. Your individual responses to specific questions will not be linked to you by name in any report provided to DVA.

7. Should you have any questions, at any stage, regarding the conduct of this study you are most welcome to contact a member of the Research Team or the DVA Human Research Ethics Committee Coordinator on (02) 6289 6204.

Thank you for your help with this research. This study is one part of a broader research project that is exploring barriers to rehabilitation for DVA clients. DVA will be using the results to support continuing efforts to ensure that Rehabilitation is meeting the needs of current and former serving members of the ADF.

Dr Virginia Lewis
(03) 9936 5140 vjlewis@unimelb.edu.au

PILOT STUDY INTO BARRIERS TO REHABILITATION

CONSENT FORM

Name of Participant: _____

Name of Investigator (s): Associate Professor Virginia Lewis, Dr Ruth Parslow, Dr Francine Hanley, Kerryn Adams
Australian Centre for Posttraumatic Mental Health (ACPMH)

1. I consent to participate in the project named above, the particulars of which - including details of the focus group - have been explained to me. A written copy of the information has been given to me to keep.

2. I acknowledge that:

   (a) The possible effects of the focus group have been explained to me to my satisfaction;

   (b) I have been informed that I am free to refuse to answer any specific questions without any negative consequences;

   (c) I have been informed that the confidentiality of the information I provide will be safeguarded within the limits of the law;

   (d) I have been informed that my individual responses to specific questions will not be linked with my name in written or verbal reports;

   (e) If a specific comment or issue is to be reported, any potentially identifying information (e.g., names of people or places) will be removed

3. Consent

   (a) I consent to the focus group being audio recorded YES ☐ NO ☐

   (c) I understand that, if I consent to the focus group being recorded, the minidisk will be destroyed 6 months after completion of the study.

Signature Date

(Participant)

Focus Group Facilitator Date

DVA CLIENT INTERVIEW QUESTIONS

1. Opening questions – break the ice and encourage everyone's participation. They are not expected to contain data for the analysis.

   "How did you first learn about the rehabilitation services provided by DVA?"

2. Introductory question – begins to focus the discussion. They are open ended so as to encourage people to bring the topic to the surface.

   "Can someone begin by describing the expectations you had about treatment or rehabilitation when you first began to access rehabilitation services?"

3. Transition question – moves the discussion toward the key question. They help the group to bring the topic into a larger context; linking the introductory question with the key question.

   "It might be good at this point for someone to begin to describe their actual experience of getting access to rehabilitation during the last 12 months? Everyone is free to add to the description as we go along".

4. Key question – is the heart of the interview and focus on the main areas of concern

   "Thinking back to your own experiences, what would you identify as the factors, either positive or negative, that affected your access to quality, timely and relevant rehabilitation services?

   Let's start with the positive factors first?

   ….and the factors that had a negative affect on your access?"

5. The ending question – is the 'insurance question' that attempts to make sure that all critical information has been obtained.

   "We are here to explore what barriers there are to getting access to rehabilitation. As a group, what would you identify as the key areas needing close attention in order to deliver appropriate rehabilitation services?"

Focus Group Survey

The purpose of this survey is to obtain some basic demographic information about those who participated in the focus groups and some information about your experience of being assessed for rehabilitation.

Please bring this completed survey along with you to the focus group. None of the information you provide in this survey will be linked to you in any way.

1. Are you male or female?
   - ☐ Male
   - ☐ Female
2. What age group do you belong to?
   - ☐ 15-24 years
   - ☐ 25-34 years
   - ☐ 35-44 years
   - ☐ 45-54 years
   - ☐ 55-64 years
   - ☐ 65-74 years
   - ☐ 75+ years
3. When you joined the ADF for military service, did you join the…?
   - ☐ Army
   - ☐ Navy
   - ☐ Air Force
   - ☐ Other (please specify) _____
4. What year did you first join the ADF? _____
5. Are you still a serving member of the ADF?
   - ☐ Yes
   - ☐ No
6. If no, what year did you leave? _____
7. How long was it between the time you were injured and the time you accessed rehabilitation? _____
8. Why did you access rehabilitation? [Tick all that apply] (OPTIONAL)
   - ☐ Concern/deterioration in health
   - ☐ Physical injury
   - ☐ Suggestion by family member
   - ☐ Suggestion by ADF
   - ☐ Suggestion by friend
   - ☐ Required by DVA to undergo assessment in order to get compensation
   - ☐ Other (please specify) _____

9. Briefly describe your most recent experience of accessing and undertaking rehabilitation through DVA (this could include describing who assessed you, what the assessment involved, what areas the assessment covered such as vocational or medical needs, your rehabilitation goals and whether these were achieved). If you require further space, please use the space provided on the next page.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

10. What types of services did you access as part of your rehabilitation plan?

_____
_____
_____
_____
_____
_____
_____

11. Overall, how would you rate your level of satisfaction with DVA in relation to the information provided to you about the rehabilitation process and what it would involve?

☐ Very satisfied
☐ Satisfied
☐ Neutral
☐ Dissatisfied
☐ Very dissatisfied

12. Overall, how would you rate your level of satisfaction about the timing and frequency of contact with the rehabilitation provider?

☐ Very satisfied
☐ Satisfied
☐ Neutral
☐ Dissatisfied
☐ Very dissatisfied

13. If you have any other comments about your rehabilitation experience please feel free to provide these below or contact ACPMH after the focus group. If you require further space, please use the space provided on the next page.

_____
_____
_____

If you require any further space to expand on any of the answers provided above, please use the space below.

Thank-you for completing the survey!

DVA CLIENT INTERVIEW KEY THEMES AND PROMPT QUESTIONS

Need to distinguish whether the participant is referring to ADFRP or DVA rehabilitation services when describing their experiences etc.

Theme	Question	Prompt questions	Covered in focus group?
Understanding of rehab (10 mins)	*How did you first learn about the rehabilitation services provided by DVA?*	• Who told you?	
		• What was the context?	
Expectations of rehab (15 mins)	*Can someone begin by describing the expectations you had about treatment or rehabilitation when you first began to access rehabilitation services?*	• What were your expectations regarding what it would involve (program components)?	
		• Who it would involve?	
		• Frequency/amount of contact with provider?	
		• What you would be required to do?	
Rehab experiences (20 mins)	*It might be good at this point for someone to begin to describe their actual experience of getting access to rehabilitation during the last 12 months? Everyone is free to add to the description as we go along.*	• Who assessed you? What was their role?	
		• Where did the assessment take place?	
		• What did the assessment involve?	
		• What were the key areas covered in the assessment?	
		• What did you think of the process?	
		• What services did you access as part of your rehabilitation plan?	
		• Was there continuity of services both pre and post-discharge?	
Facilitators/Barriers to rehab (20 mins)	*Thinking back to your own experiences, what would you identify as the factors, either positive or negative, that affected your access to quality, timely and relevant rehabilitation services*	• Individual level factors	
		• Organisational level factors	
		• System level factors	
Suggested areas of improvement (20 mins)	*We are here to explore what barriers there are to getting access to rehabilitation. As a group, what would you identify as the key areas needing close attention in order to deliver appropriate rehabilitation services?*	• Individual level	

Attachment B: DVA Staff Focus Group Documentation

Letter of invitation template (Victorian version)

<<DATE>>

Dear {Title}{Surname}

I am writing to invite you to participate in a focus group about the rehabilitation process for current and former serving ADF members accessing rehabilitation provided by the Department of Veterans' Affairs (DVA). This focus group is being conducted by the Australian Centre for Posttraumatic Mental Health (ACPMH), University of Melbourne as part of research into the barriers to rehabilitation for DVA clients. The research is funded by DVA and is being conducted to ensure rehabilitation services and programs produced by the Department are of a high quality.

You have been identified by Dannielle Van Leeuwen in DVA Management in Victoria as someone who is involved in the process of assessing and/or managing clients through the rehabilitation process, or you have regular contact with providers delivering rehabilitation to veterans. Due to this experience, it was proposed that you would be in an ideal position to respond to queries about aspects of the rehabilitation process that work well and aspects that could be improved. Your knowledge and advice will assist all involved to gain a better understanding of what DVA staff believe successful rehabilitation involves and the measures that are used/should be used to measure outcomes.

Through participating in the focus groups DVA staff have the opportunity to provide the Department with their views about aspects of the rehabilitation process that work well and aspects that could be improved.

The focus group will take place in the VIC Room (Meeting Room 2) on level 13 of the DVA office in Melbourne from 2.00pm to 3.00pm on Wednesday, 8 April. Refreshments will be served during the focus group. A facilitator from ACPMH will coordinate each group and lead the discussion. The focus group will run for approximately one hour depending on the amount of discussion from participants.

If you choose to participate in the focus group, ACPMH will not report information that identifies you in connection with your views. Your participation is voluntary and you can discontinue your participation in the study at any time.

If you have any questions about the research or participation in the focus groups, please contact Associate Professor Virginia Lewis from ACPMH on (03) 9936 5140.

Your contribution and participation in the focus group is appreciated.

Yours Sincerely

Virginia Lewis, PhD
Associate Professor / Director of Research

PILOT STUDY INTO BARRIERS TO REHABILITATION

DVA Staff Participant Information Sheet

1. The Department of Veterans' Affairs has commissioned the Australian Centre for Posttraumatic Mental Health (ACPMH) to undertake research into the barriers to rehabilitation for DVA clients. Dr Virginia Lewis is the principal investigator on the study.

2. In order to begin to gain a better understanding of veterans' experiences of rehabilitation provided by DVA, ACPMH is conducting a small number of focus groups and phone interviews with DVA clients as well as DVA staff based in Melbourne, Sydney and Adelaide.

3. Through participating in the focus groups, DVA staff have the opportunity to provide the Department with their views about aspects of the rehabilitation process that work well and aspects that could be improved. Your knowledge and advice will assist all involved to gain a better understanding of what DVA staff believe successful rehabilitation involves and the measures that are used/should be used to measure outcomes.

4. Your participation in this focus group is voluntary. During the focus group, you may decline to answer questions and you are free to withdraw from the focus group at any time.

5. If all members of the group consent, the focus group will be audio-recorded. The intent of audio-recording the focus group is to allow for a review of comments to ensure all issues and themes are identified. In the event that a direct quote would be used, all identifying information will be removed.

6. The Research Team will protect your confidentiality and privacy of responses to the fullest extent possible, within the limits of the law. Your individual responses to specific questions will not be linked to you by name in any report provided to DVA.

Thank you for your help with this research. This study is one part of a broader research project that is exploring barriers to rehabilitation for DVA clients. DVA will be using the results to support continuing efforts to ensure that Rehabilitation is meeting the needs of current and former serving members of the ADF.

Dr Virginia Lewis

(03) 9936 5140

vjlewis@unimelb.edu.au

DVA STAFF FOCUS GROUP QUESTIONS

Models of rehabilitation

We will start by asking a few questions about what you perceive rehabilitation for military veterans to involve.

1. *Can someone begin by describing what they see as the key components of rehabilitation for DVA clients?*

Service providers

All of you have been invited to participate in the focus group because you either work directly or indirectly with service providers currently providing rehabilitation to DVA clients. We are now interested in hearing about your experiences working with service providers.

2. *Firstly, what factors do you take into account when choosing which service providers to send clients to?*

3. *How satisfied are you with the level of services provided by DVA contracted service providers?*

Rehabilitation outcome measures

An important aspect of rehabilitation is determining at whether a client's rehabilitation needs have been met.

4. *In your opinion, what would you classify as a "successful outcome" in rehabilitation service?*

    a. *What do you think this would look like for different people such as clients and their families, rehabilitation providers and health providers?*

Barriers and facilitators to rehabilitation

We are now interested in hearing what you perceive to be the barriers and facilitators to successful rehabilitation for DVA clients.

In the research literature, barriers and facilitators have been described at the individual client level (e.g. dissatisfaction with pre-injury work), as organisational level factors (e.g. failure to provide suitable alternative duties), and as system level factors (e.g. utilisation of generic rehabilitation plans and process or lack of tailoring to suit individual workers).

5. *Thinking about these 3 different levels, what factors do you perceive to be the most influential barriers and facilitators to quality, timely and relevant rehabilitation?*

    Let's start with the barriers first?

    …and the facilitators?

Suggested areas for improvement

6. *We are here to understand how the rehabilitation process currently works and how it may be improved to maximise successful outcomes for DVA clients. In an ideal situation, what information would you want to determine whether a successful outcome has been achieved for a particular client?*

DVA STAFF FOCUS GROUP KEY THEMES AND PROMPT QUESTIONS

Theme	Question	Prompt questions	Covered in focus group?
Components of rehab	*What would you describe as the key components of rehabilitation for DVA clients?*	• Do you think there has been a shift over time in the way the community, DVA and service providers conceive of and approach rehabilitation for DVA clients?	
		• How satisfied are you with the current model of rehabilitation employed by DVA (good/bad aspects)?	
Service providers	*What factors do you take into account when choosing which service providers to send clients to?*	• Is the client load distributed equally across providers?	
	How satisfied are you with the level of services provided by DVA contracted service providers?	• What works well?	
		• What could be improved?	
		• How satisfied are you with the level of communication between DVA staff and service providers?	
Outcome measures	*In your opinion, what would you classify as a "successful outcome" in rehabilitation service? What do you think this would look like for different people such as clients and their families, rehabilitation providers and health providers?*	• How do you determine what a successful outcome is? ○ Do you use standardised outcome measurement tools? If yes, what?	
		• What are the benefits/limitations of using outcome measurement tools?	
Facilitators/Barriers to rehab	*What factors do you perceive to be the most influential barriers and facilitators to quality, timely and relevant rehabilitation? Let's start with the barriers first…and the facilitators?*	• Individual client factors • Organisational level factors • System level factors	
Suggested areas for improvement	*In an ideal situation, what information would you want to determine whether a successful outcome has been achieved for a particular client?*	• Is this information currently available/being collected? • How would you suggest it should be collected and/or used?	

Attachment C: Survey of rehabilitation service providers documentation

«Date»

«AddressBlock»

«GreetingLine»

I am writing to invite you to participate in a survey about the provision of rehabilitation services for veterans and current and former serving ADF members accessing rehabilitation through the Department of Veterans' Affairs (DVA). You have been identified by DVA as an organisation (or branch of a large organisation) that is contracted to provide rehabilitation to DVA clients and would therefore be in the ideal position to comment on services provided and best practice in psychosocial rehabilitation. The online survey is being conducted by the Australian Centre for Posttraumatic Mental Health (ACPMH), University of Melbourne as part of research into the barriers to rehabilitation for DVA clients. The research is funded by DVA and is intended to map the nature of rehabilitation services and programs purchased by the Department and to ensure they serve the needs of veterans and current and former serving ADF members.

The purpose of the survey is to gain a better understanding of the rehabilitation process delivered by DVA-contracted service providers, how rehabilitation outcomes are measured and perceived barriers to achieving successful outcomes in rehabilitation for DVA clients. The questions will focus on your organisational profile and experience working with veterans and current and former serving ADF members, your contact with DVA, your organisation's use of rehabilitation outcome measurement tools, the nature of your service provision, and your views on possible barriers and facilitators to successful rehabilitation outcomes.

Only ACPMH will see each organisation's responses to the survey. Although we do ask you to identify your organisation at the beginning of the survey so we know which organisations have participated in the study, your responses will not be linked to your organisation. The results of the survey will be reported in summary form at the level of states/territories to DVA and we anticipate publishing a journal article summarising the results at the national level. Your participation is voluntary and you can save the survey at any point and return to it at a later date or discontinue the survey at any time.

To access the online survey, please click on the link below:
https://www.surveymonkey.com/s.aspx?sm=ZrWCsN3RwBHxB9eznOHGUg_3d_3d .

The survey will take approximately 30-45 minutes to complete but this will depend on the detail of the responses you wish to make. Please note that you must submit the survey by COB Friday 27 March 2009 for your responses to be included. Further information and instructions about completing the survey are provided on the next page. If you have any questions about the research or survey, please contact Associate Professor Virginia Lewis from ACPMH on (03) 9936 5140.

Your contribution to this research is appreciated.

Yours Sincerely

Virginia Lewis, PhD
Associate Professor / Director of Research

Instructions and Frequently Asked Questions

Who should complete the survey?
The survey should be completed by a member of senior management at your organisation. However, it is recommended that the person who completes the survey should consult other staff members to ensure that the responses provided are reflective of the organisation's position and practice as a whole.

Alternatively, you may choose to have different staff members complete different sections of the survey depending on the questions asked and the staff member's knowledge or experience in the area. This is possible by having the different staff members use the same survey link, complete the relevant section of the survey, then click on the 'next' button within the survey. The staff member would then close the survey link and all responses will automatically be saved. When the next staff member re-opens the survey, they will be able to see the staff member's saved responses and enter responses for the other sections. The survey will not be closed to you until you click on the final "submit" button at the end of all questions.

How do I access the survey?
The survey is now open. To access the survey, click on the following link (or copy and paste it to your web browser): https://www.surveymonkey.com/s.aspx?sm=ZrWCsN3RwBHxB9eznOHGUg_3d_3d

The survey should automatically open on the first page providing background information about the survey.

Please note that only one survey should be submitted on behalf of your organisation. However as noted above, you may have different staff members answer different sections of the survey. Please note that only one person may have the survey open at any one time.

Do I have to complete the survey in one sitting?
No. There is a progress bar at the top of each page which shows the respondent how far into the survey they have progressed. If for some reason you are unable to complete the survey in one sitting, by clicking on the next button at the bottom of the page and then closing the survey link, the responses you have provided up until that point will be saved until you next open the survey link.

You may flick between different sections of the survey to edit your responses, however once you click on the submit button, you will not be able to access or change your responses.

When is the closing date for the survey?
All surveys must be submitted by COB Friday 27 March 2009 to be included in the study. If you have only partially completed the survey but have not clicked on the submit button by this date, your responses will not be included.

Is it confidential?
Yes, the answers provided in the online survey will be confidential. Individual responses supplied by organisations will not be seen by DVA and feedback will only be provided to DVA in the form of a report of the main themes emerging from the data. The results of the survey will be reported in summary form at the level of states/territories to DVA and we anticipate publishing a journal article summarising the results at the national level. DVA and ACPMH are bound by the Privacy Act 1988 (Cth) to ensure that your privacy is protected.

Who should I contact if I have any questions?
If you have any questions about the research or survey, please contact Associate Professor Virginia Lewis from ACPMH on (03) 9936 5140.

About this survey

In the Australian Government's policy "A new approach to mental health and well being in the Australian Defence Force and ex-service community" (2007), a range of initiatives were identified that are intended to enhance the wellbeing and mental health of both current and serving members of the Australian Defence Force and the Veteran community.

The Australian Centre for Posttraumatic Mental Health (ACPMH) has been contracted by the Department of Veterans' Affairs (DVA) to conduct a "Study into Barriers to Rehabilitation". This project is primarily focussed on DVA clients who receive services under the Military Rehabilitation and Compensation Act (MRCA) or the Safety, Rehabilitation and Compensation Act (SRCA). It will consider whether there is evidence of systematic barriers (particularly those that DVA may be able to redress) and individual barriers to successful rehabilitation for DVA clients.

The study will investigate veterans' attitudes and expectations about returning to work and examine current barriers preventing participation in social and community activities.

The purpose of this survey is to gather detailed information about the types of services that you provide to DVA clients, determine the rehabilitation outcome measures currently utilised by rehabilitation consultants and to identify possible barriers to successful rehabilitation.

By completing this survey, you will have the opportunity to provide DVA with confidential, in-depth feedback on the barriers and facilitators to providing quality and timely rehabilitation for DVA clients.

Instructions

There are five sections in the survey.

Section A is concerned with your organisational profile.

Sections B and C ask about your contact with the Department of Veterans' Affairs and other service providers.

Section D relates to specific outcome measures utilised by your organisation to determine rehabilitation success.

Section E asks about the types of services you provide and the processes in place to guide your rehabilitation consultants in delivering these services.

Section F is concerned with perceived barriers to successful rehabilitation.

Please take the time to fill out the survey. On average, this survey will take approximately 30-45 minutes to complete but this will depend on the detail of the responses you wish to make.

Only ACPMH will see each organisation's responses to the survey. Although we do ask you to identify your organisation at the beginning of the survey so we know which organisations have participated in the study, this is optional and your responses will not be linked to your organisation. The results of the survey will be reported in summary form at the level of states/territories to DVA and we anticipate publishing a journal article summarising the results at the national level.

Your participation is voluntary and you can save the survey at any point and return to it at a later date or discontinue the survey at any time.

There is a progress bar at the top of each page which shows you how far into the survey you have progressed. If for some reason you are unable to complete the survey in one sitting, by clicking on the next button at the bottom of the page and then closing the survey link, the responses you have provided up until that point will be saved until you next open the survey link.

Questions marked with an asterisk are mandatory and you will not be permitted to continue to the next section of the survey until you provide a response.

You may flick between different sections of the survey to edit your responses, however once you click on the submit button, you will not be able to access or change your responses.

We have provided space for additional optional comments throughout the survey as we welcome your thoughts on all issues raised in the survey. Please note that you are able to cut and paste text from other documents into the comment boxes provided or alternatively, you can simply type your response directly into the comment field.

NOTE ABOUT LANGUAGE: Members of the veteran and defence community to whom you provide services are described as "clients" in this survey. We appreciate that people use or prefer different terms (e.g. consumer or patient); however, for the sake of simplicity we have used the term "clients" throughout.

If you are uncertain about any aspect of this survey, please contact Associate Professor Virginia Lewis at ACPMH on (03) 9936-5140.

Section A: Information about your organisation

The following section asks you to provide some information about the organisation you work for. For national organisations, please answer the survey questions based on your state or regional branch profile.

1. Name of organisation (Optional)

2. What is your role within the organisation?

* **3. In what geographic region does your organisation or branch provide services?**

- o NSW/ACT
- o NT
- o QLD
- o SA
- o TAS
- o VIC
- o WA

* **4. Geographically, how would you categorise the location where your organisation or branch provides services?**

- ☐ Exclusively metropolitan
- ☐ Urban fringe
- ☐ Mixed metropolitan / rural (where rural refers to areas with urban centres with between 5,000 and 100,000 residents)
- ☐ Rural
- ☐ Remote
- ☐ Mixed rural / remote (where remote refers to areas with less than 5,000 residents

* **5. How many staff does your organisation or branch employ?**

* **6. How many (number) of the rehabilitation consultants in your organisation or branch are qualified in the following areas?**

Social Work/Counselling	
Rehabilitation Counselling	
Psychology	
Psychiatry	
Drug & Alcohol	
Vocational Training	
Occupational Therapy	
Other (please specify)	

Section A continued

* **7. How would you categorise the majority of rehabilitation referrals received by your organisation or branch?**

- ☐ Amputee rehabilitation
- ☐ Chronic medical conditions
- ☐ Elderly rehabilitation
- ☐ General debility
- ☐ Other (please specify)
- ☐ Mental health
- ☐ Musculoskeletal
- ☐ Neurorehabilitation
- ☐ Spinal injury rehabilitation

* **8. What service(s) are provided by your organisation or branch? [Tick all that apply]**

- ☐ Vocational/employment support
- ☐ Psychosocial and self-care
- ☐ Medical and allied health treatment
- ☐ Other (please specify)

* **9. How many years has your organisation or branch been providing rehabilitation services for DVA clients?**

- ○ Less than 1 year
- ○ 1-5 years
- ○ 6-10 years
- ○ 11-15 years
- ○ 16-20 years
- ○ 21 years+

* **10. In an average year, approximately how many clients would access your organisation or branch for rehabilitation (please include DVA and non-DVA clients)?**

* **11. What proportion of all clients accessing your organisation or branch for rehabilitation would be DVA clients?**

- ○ 0-19%
- ○ 20-39%
- ○ 40-59%
- ○ 60-79%
- ○ 80-100%

* **12. What proportion of all DVA clients accessing your organisation or branch for rehabilitation would be funded under the following schemes?**

	Proportion of clients
MRCA	
SRCA	
VEA (VVRS)	
Don't know	

* **13. How do the staff at your organisation or branch stay up-to-date with the latest information regarding rehabilitation needs, programs and services for DVA clients? [Tick all that apply]**

- ☐ Attend seminars and conferences run by DVA
- ☐ Attend seminars and conferences run by others (not DVA)
- ☐ In-house training
- ☐ Participate in professional discussion boards
- ☐ Read the latest publications in the area (e.g. journal articles)
- ☐ Read information provided by DVA
- ☐ Mentoring
- ☐ Other (please specify)

14. Any other comments? (Optional)

Section B: Contact with Department of Veterans' Affairs (DVA)

The following questions ask about your involvement and satisfaction with contact you have with DVA regarding rehabilitation service provision for DVA clients.

* **15. How would you describe your level of contact with DVA in relation to your work with DVA clients?**

- ○ Daily
- ○ 3-4 times per week
- ○ 1-2 times per week
- ○ A few times per month
- ○ Less than monthly
- ○ No contact

Section B continued

* **16. What is the role or position of the person within DVA with whom you have the most contact?**

* **17. Overall, how would you rate your level of satisfaction with DVA in relation to the following?**

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Appropriate use of referrals	○	○	○	○	○
Quality of referral documentation	○	○	○	○	○
Timeliness of referrals	○	○	○	○	○
Timely approval of rehabilitation plans	○	○	○	○	○
General communication with DVA	○	○	○	○	○
Timeliness of communication	○	○	○	○	○
Reports produced by DVA provided in a timely manner	○	○	○	○	○
Appropriate dissemination of all documentation to relevant stakeholders	○	○	○	○	○

18. Any additional comments? (Optional)

* **19. How satisfactory is the monitoring of clients by DVA after initial assessment and referral?**

- ○ Very satisfactory
- ○ Satisfactory
- ○ Not very satisfactory
- ○ Very unsatisfactory

Section B continued

* **20. Please explain why you believe the monitoring of clients by DVA after their initial assessment and referral is not satisfactory.**

Section C: Contact with other service providers

The following questions ask about your involvement and satisfaction with contact you have with other service providers regarding rehabilitation service provision for DVA clients.

* **21. How would you describe your level of contact with other service providers in relation to your work with DVA clients?**

- ○ Daily
- ○ 3-4 times per week
- ○ 1-2 times per week
- ○ A few times per month
- ○ Less than monthly
- ○ No contact

Section C continued

*** 22. Aside from DVA staff, who else do you have contact with when working with DVA clients?**

- ☐ Social Worker
- ☐ Counsellor
- ☐ Rehabilitation Counsellor
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ General Practitioner
- ☐ Nurse
- ☐ Drug & Alcohol Worker
- ☐ Vocational Specialist
- ☐ Occupational Therapist
- ☐ Pharmacist
- ☐ Other (please specify)

*** 23. For what purpose do you have contact with other service providers for DVA clients? [Tick all that apply]**

- ☐ Vocational/employment needs
- ☐ Psychosocial and self-care needs
- ☐ Medical and allied health needs
- ☐ Other (please specify)

*** 24. Overall, how would you rate your level of satisfaction with other service providers in relation to the following?**

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Quality of services performed	○	○	○	○	○
Timeliness of services performed	○	○	○	○	○
Appropriate identification of needs	○	○	○	○	○
Clarity of information provided	○	○	○	○	○
Appropriate use of referrals	○	○	○	○	○
Communication about shared clients	○	○	○	○	○
Timeliness of communication	○	○	○	○	○
Reports produced in a timely manner	○	○	○	○	○
Appropriate dissemination of all documentation to relevant stakeholders	○	○	○	○	○

25. Any additional comments? (Optional)

Section D: Assessment

The following section asks whether your organisation uses standardised outcome measures to assess rehabilitation needs and determine the success of rehabilitation provided to the DVA client. This section also asks you to list the types of standardised outcome measures used by your organisation.

Standardised outcome measurement is defined as the measurement of individual change that results from participation in a program or service, or after receiving treatment or an intervention. An outcome measurement tool usually consists of a test or scale which is considered to be reliable, valid, and sensitive to change.

* **26. Does your organisation currently use standardised outcome measures to assess need or determine DVA client outcomes?**

- ○ Yes
- ○ No

Section D continued

* **27. Please indicate why you have decided not to use standardised client outcome measures. [Tick all that apply]**

- ☐ Time constraints
- ☐ Financial constraints
- ☐ Lack of consensus among staff on which measures to use
- ☐ In the process of evaluating measure best suited to your client group
- ☐ Against using standardised outcome measures altogether
- ☐ DVA do not require this to occur
- ☐ Other (please specify)

28. Any additional comments about standardised outcome measures or non-standardised outcome measures you may use? (Optional)

Section D continued

* **29. Please list below which standardised outcome measures your organisation currently utilises to assess rehabilitation needs and outcomes and specify in what situation / for what purpose you use each of the outcome measures.**

Section D continued

* **30. Listed below are some of the possible benefits of using standardised outcome measures. How important do you believe each of the statements is as a reason for using standardised client outcome measures?**

	Very important	Quite important	Somewhat important	Not at all important	Don't know
To ensure standard practices across clients and the organisation	○	○	○	○	○
To evaluate effectiveness of rehabilitation	○	○	○	○	○
To evaluate efficiency of rehabilitation	○	○	○	○	○
To make comparisons between programs	○	○	○	○	○
To make comparisons over time	○	○	○	○	○
To make comparisons with normative samples	○	○	○	○	○
To demonstrate accountability	○	○	○	○	○

Other (please specify and indicate how important it is)

31. Any additional comments? (Optional)

Section D continued

* **32. How important do you believe each of the outcomes listed below are when assessing the impact / success of rehabilitation for DVA clients?**

	Very important	Quite important	Somewhat important	Not at all important	Don't know
Return to work	○	○	○	○	○
Return to study / training	○	○	○	○	○
Improved social connectedness	○	○	○	○	○
Capacity to manage own condition (physical & mental health)	○	○	○	○	○
Reduced risk factors	○	○	○	○	○
Enhanced protective factors	○	○	○	○	○
Reduced symptoms	○	○	○	○	○
No longer diagnosed with illness or injury	○	○	○	○	○
Individualised rehabilitation goals identified by the client are achieved	○	○	○	○	○

Other (please specify and indicate how important it is)

33. Any additional comments? (Optional)

Section E: Rehabilitation process

The purpose of this section is to gain a better understanding of the process followed by your organisation at different points in the rehabilitation process.

* **34. What are the principles guiding your organisation's service delivery (e.g. individualised services, maximum client involvement etc.)?**

* **35. What are the goals of your organisation's service delivery (e.g. rehabilitation, return to work etc.)?**

* **36. Does your organisation develop rehabilitation plans for DVA clients?**

- ○ Yes
- ○ No

Section E continued

* **37. Do you have organisational policies in place that guide your staff as to what should be covered when developing rehabilitation plans for clients?**

- ○ Yes
- ○ No

* **38. When developing a rehabilitation plan with a DVA client, to what extent do your staff undertake the following activities?**

	Always	Often	Sometimes	Rarely	Never
Provide the client with sufficient information to ensure they are fully informed about their treatment and rehabilitation options	○	○	○	○	○
Ensure the client's preferences and goals are fully examined	○	○	○	○	○
Involve the client in decision making and planning	○	○	○	○	○
Focus on individualised service	○	○	○	○	○
Ensure maximum client involvement in goal setting	○	○	○	○	○
Focus on the client's strengths and abilities	○	○	○	○	○
Use situational assessments to gain information on functioning	○	○	○	○	○
Integrate required treatment with rehabilitation activities	○	○	○	○	○
Provide early intervention	○	○	○	○	○
Ensure interventions are time-framed and evaluated	○	○	○	○	○
Involve a multidisciplinary team in rehabilitation	○	○	○	○	○

39. Any additional comments about development of rehabilitation plans for clients (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

*** 40. Does your organisation conduct rehabilitation assessments of DVA clients?**

- ○ Yes
- ○ No

Section E continued

* **41. Please list all aspects of a client's functioning that are assessed in a rehabilitation assessment.**

* **42. Do you have organisational policies in place that guide your staff as to what should be covered in the rehabilitation assessment of clients?**

- ○ Yes
- ○ No

* **43. Is the rehabilitation assessment process for clients, including the areas of functioning that are assessed, the same for all clients (DVA clients and non-DVA clients) accessing your service?**

- ○ Yes
- ○ No

Section E continued

* **44. Please explain how the rehabilitation assessment process can differ according to the client's status (i.e. DVA client or non-DVA client).**

* **45. Is the rehabilitation assessment process for DVA clients, including the areas of functioning that are assessed, the same regardless of whether assessing a client with a physical health condition or a client with a mental health condition?**

- ○ Yes
- ○ No

Section E continued

* **46. Please explain how the rehabilitation assessment process can differ according to whether assessing a DVA client with a physical health condition or a mental health condition.**

Section E continued

* **47. Does your organisation undertake situational assessments (e.g. work, home and functional capacity evaluation (FCE)) to determine a DVA client's current level of functioning?**

- ○ Yes
- ○ No

48. Any additional comments about rehabilitation or situational assessments (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

*** 49. Does your organisation provide vocational rehabilitation?**

- ○ Yes
- ○ No

Section E continued

* **50. Do you have organisational policies in place that guide your staff as to what should be covered when conducting a vocational assessment?**

- ○ Yes
- ○ No

* **51. When conducting a vocational assessment for DVA clients, to what extent do you believe your staff undertake the following activities?**

	Always	Often	Sometimes	Rarely	Never
Obtain the client's work history	○	○	○	○	○
Fully examine the preferences and goals of the client	○	○	○	○	○
Provide the client with an opportunity to become fully informed about their options and entitlements	○	○	○	○	○
Evaluate the client's work-readiness	○	○	○	○	○
Obtain a functional capacity evaluation	○	○	○	○	○
Obtain a situational functional capacity evaluation	○	○	○	○	○
Ensure continuous and comprehensive assessments	○	○	○	○	○
Explore how environmental modifications and supports can promote functioning	○	○	○	○	○

52. Any additional comments about vocational assessments (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

*** 53. Do you provide a vocational service for people with mental health / psychiatric conditions?**

- ○ Yes
- ○ No

Section E continued

* **54. For DVA clients with mental health / psychiatric conditions, to what extent do your staff engage the client in the following vocational strategies?**

	Always	Often	Sometimes	Rarely	Never	Don't know
Assistance with job seeking	○	○	○	○	○	○
Training in job seeking skills	○	○	○	○	○	○
Preparation of a resume	○	○	○	○	○	○
Rapid job search and placement into paid employment	○	○	○	○	○	○
Individual placement and support	○	○	○	○	○	○
Job Clubs	○	○	○	○	○	○
Transitional employment	○	○	○	○	○	○
Use of job coaches	○	○	○	○	○	○
Work trials	○	○	○	○	○	○
Volunteer options	○	○	○	○	○	○
Clubhouse / peer support initiatives	○	○	○	○	○	○
Enclave / work crew	○	○	○	○	○	○
Time unlimited support after placement	○	○	○	○	○	○

55. Any additional comments about vocational assessment and strategies (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

*** 56. Does your organisation conduct workplace assessments?**

- ○ Yes
- ○ No

Section E continued

* **57. Do you have organisational policies in place that guide your staff as to what should be covered when conducting a workplace assessment?**

- ○ Yes
- ○ No

* **58. When conducting a workplace assessment with a DVA client, to what extent do your staff undertake the following activities?**

	Always	Often	Sometimes	Rarely	Never	Don't know
Assess the compatibility of the employment placement to the client	○	○	○	○	○	○
Evaluate the potential training needs of the client	○	○	○	○	○	○
Assess the potential educational gaps within the workplace culture regarding the rights of the client and the responsibilities of the workplace	○	○	○	○	○	○
Assess the ability of the workplace to provide a progressive or partial increase in client duties	○	○	○	○	○	○
Ensure that any modifications, relevant accommodation and natural supports for the client are available within the work environment	○	○	○	○	○	○
Ensure the employer is providing a work environment conducive to the client's return to work	○	○	○	○	○	○
Ensure that the client's workplace has been provided with relevant education where necessary	○	○	○	○	○	○

59. Any additional comments about workplace assessments (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

*** 60. Does your organisation provide services and support to both the client and their family?**

- ○ Yes
- ○ No

Section E continued

*** 61. Do you have organisational policies in place that guide your staff as to the types of services and support that should be provided to the client and their family?**

- ○ Yes
- ○ No

***62. When providing support and services to the DVA client and their family, to what extent do your staff do the following?**

	Always	Often	Sometimes	Rarely	Never	Don't know
Obtain written permission from the client to have open communication with family members	○	○	○	○	○	○
Explore the client's expectations of treatment and rehabilitation	○	○	○	○	○	○
Explore the clients' family member's expectations of treatment and rehabilitation	○	○	○	○	○	○
Maintain a supportive and collaborative relationship with the client and help resolve family conflict	○	○	○	○	○	○
Involve families in treatment and rehabilitation planning	○	○	○	○	○	○
Provide crisis planning	○	○	○	○	○	○
Assess the limits of the family's ability to provide support to the client	○	○	○	○	○	○
Provide structured problem solving techniques (training) to the family	○	○	○	○	○	○
Encourage and assist family members to improve their support networks	○	○	○	○	○	○
Be flexible in meeting the family's needs	○	○	○	○	○	○

*** 63. In your opinion, how responsive is DVA's rehabilitation approvals process in allowing your staff to provide the support and services to the client and their family as outlined in the above question?**

64. Any additional comments about working with families (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

*** 65. Does your organisation provide psychosocial interventions?**

- ○ Yes
- ○ No

Section E continued

* **66. What does your organisation do if you have a DVA client who requires psychosocial interventions?**

Section E continued

* **67. Do you have organisational policies in place that guide your staff as to what should be covered when providing psychosocial interventions to clients?**

- ○ Yes
- ○ No

* **68. When providing rehabilitation services for DVA and non-DVA clients, does your organisation routinely provide the following psychosocial interventions? Please tick each box depending on whether your organisation provides the intervention with DVA clients and/or non-DVA clients. If you do not provide the intervention to DVA clients or non-DVA clients, please tick the box 'Do not provide to any clients'.**

	DVA clients	Non-DVA clients	Do not provide to any clients
Psycho-education	○	○	○
Medication adherence	○	○	○
Social skills training	○	○	○
Skills of daily living	○	○	○
Personal relationship counselling	○	○	○
Attendant care services	○	○	○
Social networking	○	○	○
Illness self-management	○	○	○
Relapse prevention techniques	○	○	○
Assistance coping with symptoms	○	○	○
Leisure programs	○	○	○
Financial counselling	○	○	○
Counselling and psychotherapy	○	○	○
Support for further education	○	○	○
Cognitive training	○	○	○
Lifestyle programs	○	○	○
Drug and alcohol / substance management	○	○	○
Anger management	○	○	○
Housing / residential support	○	○	○
Transport support	○	○	○
Family education strategies	○	○	○

Other (please specify and indicate whether you provide the intervention to DVA and/or non-DVA clients)

* **69. In your opinion, how responsive is DVA's rehabilitation approvals process in allowing your staff to provide the psychosocial interventions listed in the above question to DVA clients?**

70. Any additional comments about psychosocial interventions (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

✱ **71. Does your organisation provide case management services?**

- ○ Yes
- ○ No

Section E continued

72. Do you have organisational policies in place that guide your staff as to what should be covered when providing case management services to clients?

- ○ Yes
- ○ No

***73. What are the tasks and responsibilities of case managers in your organisation?**

Section E continued

*** 74. Does your organisation undertake evaluation and assessment of the services it provides?**

- ○ Yes
- ○ No

Section E continued

75. Do you have organisational policies in place that guide your staff as to what should be covered when undertaking an evaluation and assessment of services provided to clients?

- ○ Yes
- ○ No

***76. To what extent do your staff...?**

	Always	Often	Sometimes	Rarely	Never	Don't know
Evaluate outcomes of individual interventions included in rehabilitation plans	○	○	○	○	○	○
Evaluate the progress towards rehabilitation goals and objectives	○	○	○	○	○	○
Evaluate service-user satisfaction of service provision	○	○	○	○	○	○
Undertake an evaluation of system-wide service provision to ensure services are adequately meeting the needs of service populations	○	○	○	○	○	○
Evaluate service provision to determine whether the overall goals of the organisation are being met	○	○	○	○	○	○
Actively respond to outcomes of the evaluations	○	○	○	○	○	○

Section E continued

Assertive community treatment (ACT) is a community care model suited to a small percentage of clients with the most serious and persistent mental illness: severe symptoms and functional impairments or frequent or prolonged hospitalisation. They are designed to serve those who are not effectively engaged with treatment and are frequent users of acute care systems including psychiatric hospitals, substance abuse detoxification centres, jails, shelters and other facilities. It is an approach providing most or all of the treatment, rehabilitation and support needed by the individual in a home-based design.

* **77. Does your organisation engage clients in intensive case management (also known as assertive community treatment (ACT))?**

- ○ Yes
- ○ No

Section E continued

78. Do you have organisational policies in place that guide rehabilitation providers as to what should be covered when conducting assertive community treatment?

- ○ Yes
- ○ No

*** 79. Are the ACT team actively involved with clients prior to or immediately following discharge from psychiatric inpatient services?**

- ○ Yes
- ○ No

*** 80. Does the ACT team evaluate the treatment plan and tailor modifications to the needs of clients?**

- ○ Yes
- ○ No

***81. Does the ACT team provide assistance with acute medical care?**

- ○ Yes
- ○ No

***82. Does the ACT team assess the housing needs of clients?**

- ○ Yes
- ○ No

***83. Does the ACT team provide the client with counselling and psychotherapy?**

- ○ Yes
- ○ No

84. Any additional comments about assertive community treatment (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section E continued

*** 85. Does your organisation provide crisis intervention?**

- ○ Yes
- ○ No

Section E continued

* **86. What procedures does your organisation have in place to guide staff in situations where a significant mental health crisis occurs with a DVA client?**

* **87. Do clinicians liaise closely with the assertive community treatment teams?**

- Yes
- No
- Not applicable

88. Any additional comments about crisis intervention (e.g. innovative approaches, program or service initiatives, concerns regarding service provision to veterans and current and former serving ADF members)? (Optional)

Section F: Perceived Barriers to Rehabilitation

Among the barriers that have been described by previous research are individual level factors (e.g. dissatisfaction with pre-injury work), organisational level factors (e.g. failure to provide suitable alternative duties) and system level factors (e.g. utilisation of generic rehabilitation plans and processes/lack of tailoring to suit individual clients).

* **89. Please list which individual level factors you perceive to be the most influential barriers to successful rehabilitation.**

* **90. To what extent do you believe these individual level factors impact on your ability to provide successful rehabilitation to veterans and current and former serving ADF members?**

- ○ A lot
- ○ Quite a bit
- ○ A little
- ○ Not at all

* **91. Please list which organisational level factors you perceive to be the most influential barriers to successful rehabilitation.**

* **92. To what extent do you believe these organisational level factors impact on your ability to provide successful rehabilitation to veterans and current and former serving ADF members?**

- ○ A lot
- ○ Quite a bit
- ○ A little
- ○ Not at all

* **93. Please list which system level factors you perceive to be the most influential barriers to successful rehabilitation.**

* **94. To what extent do you believe these system level factors impact on your ability to provide successful rehabilitation to veterans and current and former serving ADF members?**

- ○ A lot
- ○ Quite a bit
- ○ A little
- ○ Not at all

Any other comments

95. We appreciate the time you have taken to complete this survey and realise that we may have missed an important aspect of your service delivery about which you would like to provide comment. We welcome your additional comments in this section and thank you again for your valued input to our project.

Attachment D: Letter of invitation sent to key stakeholders

«Date»

Dear {Title}{Surname},

I am writing to invite you to participate in an interview that seeks your views on best practice in rehabilitation, particularly psychosocial rehabilitation. The interviews will be conducted via telephone in late April/early May 2009 by the Australian Centre for Posttraumatic Mental Health (ACPMH), University of Melbourne as part of research into psychosocial rehabilitation being delivered to Department of Veterans' Affairs (DVA) clients. The research is funded by DVA and is being conducted to ensure rehabilitation services and programs purchased by the Department are of a high quality. We are conducting approximately 13 interviews with a range of stakeholders.

You have been identified as someone who has considerable expertise in the area of rehabilitation and we believe you would therefore be in the ideal position to comment on the types of services provided to veterans, and best practice in psychosocial rehabilitation more broadly.

The purpose of the interview is to gain an understanding of how different stakeholders view rehabilitation, including what it should involve, what works well and how the rehabilitation process involving different stakeholders might be strengthened to improve rehabilitation outcomes for DVA clients. The questions will focus on your thoughts about the essential components of rehabilitation, your use of rehabilitation outcome measurement tools, your view about what a successful outcome in rehabilitation involves, and your opinion about possible barriers and facilitators to successful rehabilitation outcomes.

In order to make the interviews most useful to DVA, we would like to send you a brief summary of the results of an on-line survey of some current providers of services to DVA clients. This will provide some background context for the interview. We will also provide you with a list of the questions that will be asked so that you can consider your responses beforehand if need be.

The information you provide through the interview will not be linked to you or your organisation in reporting the findings to DVA. The report will describe the key themes and range of opinions that come from key stakeholders.

We anticipate that the interview will take approximately 45 minutes. Your participation is voluntary and you can choose to discontinue the interview at any time.

It would be appreciated if you could please respond via email to Kerryn Adams from ACPMH to indicate whether you are interested in participating in the research (adamskm@unimelb.edu.au). Kerryn will then contact you to confirm your participation and arrange a convenient time to conduct the interview. If you have any questions about the research that Kerryn cannot answer, please contact Associate Professor Virginia Lewis from ACPMH on (03) 9936-5140 or at vjlewis@unimelb.edu.au.

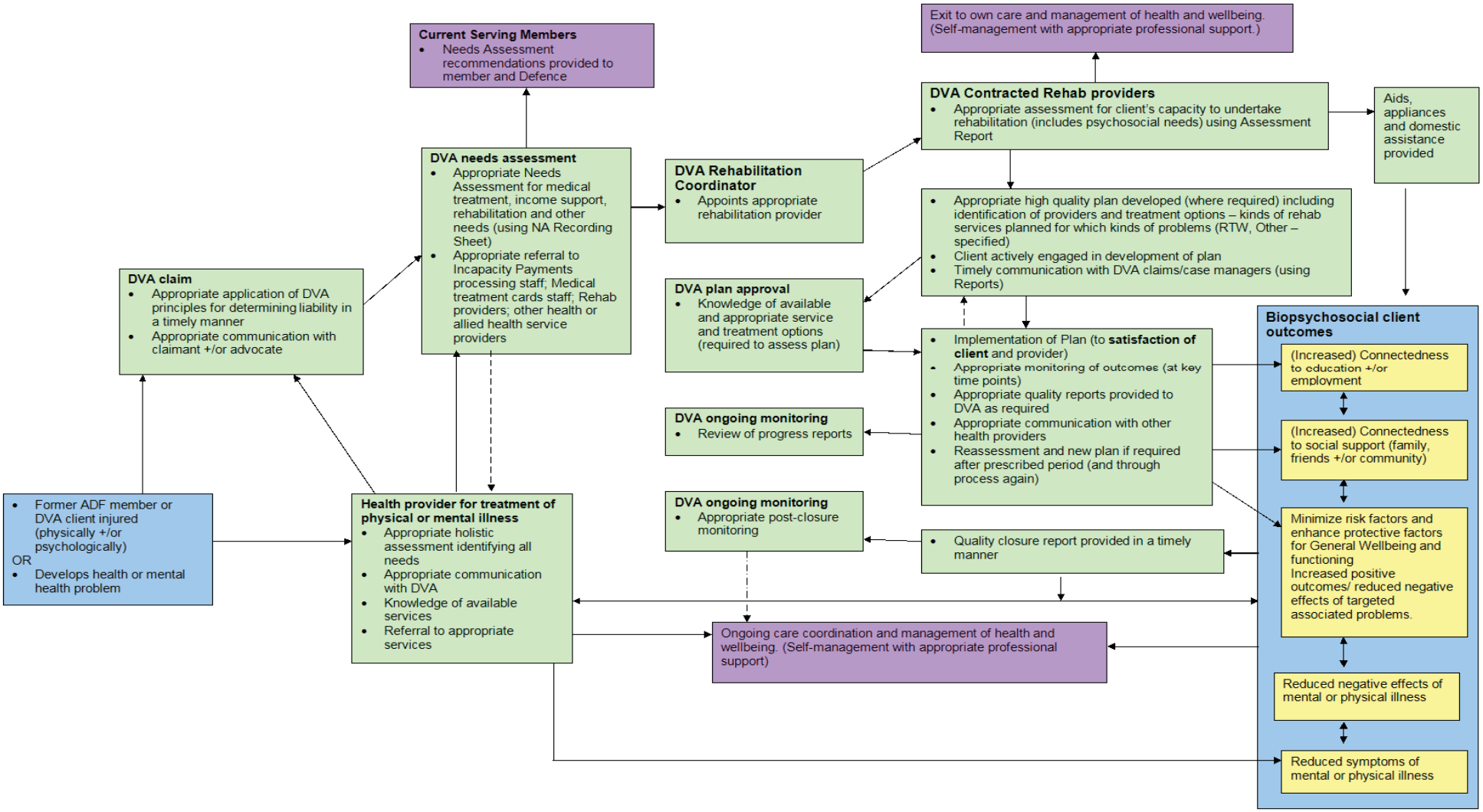
Your contribution to this research is appreciated.

Yours Sincerely

Virginia Lewis, PhD
Associate Professor / Director of Research

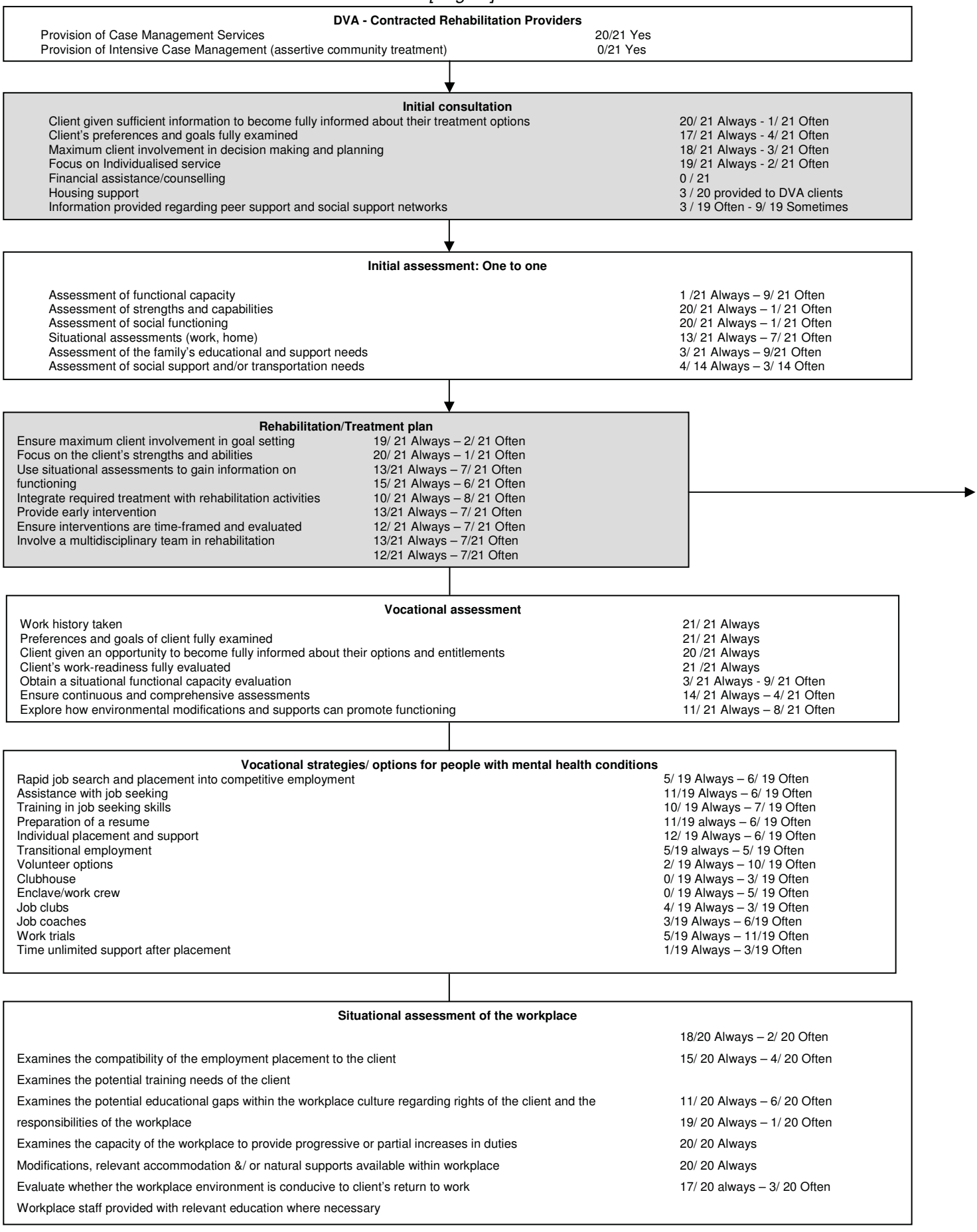
Attachment E: Background documents provided to key stakeholders prior to interview

DVA Rehabilitation Model



Best practice in rehabilitation flowchart (with survey data)

[Page 1]



[Page 2]

Family services and support	
Secure written permission from the client to have open communication with family members	11/14 Always – 2 /14 Often
Explore client's expectations	13/ 14 Always – 1/ 14 Often
Explore families member's expectations	4/ 14 Always – 3/ 14 Often
Maintain support and collaborative relationships, help resolve family conflict	4/ 14 Always – 4/ 14 Often
Involve families in treatment planning	1 /14 Always – 6/ 14 Often
Provide crisis planning	0 / 14 Always – 4/ 14 Often
Assess the limits of the family's ability to provide support to the client	4/ 14 Always – 3/ 14 Often
Provide structured problem solving techniques (training) to the family	0/ 14 Always – 3/ 14 Often
Encourage and assist family members to improve their support networks	2/ 14 Always- 2/ 14 Often
Be flexible in meeting family's needs	7/ 14Always – 4/14 Often

Psychosocial/ Educational interventions	
Psycho-education (Client and/or family)	14/ 20 Yes
Medication adherence	6 / 20 Yes
Skills of daily living	12/ 20 Yes
Personal relationships counselling	8/ 20 Yes
Illness self-management	12/ 20 Yes
Attendant care services	2/ 20 Yes
Relapse prevention techniques	12/ 20 Yes
Assistance coping with symptoms	16/ 20 Yes
Financial counselling	0 / 21 Yes
Cognitive training	11/ 20 Yes
Social networking	7/ 20 Yes
Leisure programs	6/ 20 Yes
Counselling & Psychotherapy	14/20 Yes
Support for further education	15/ 20 Yes
Lifestyle Programs	7/ 20 Yes
Drug & alcohol/ substance use management	1/ 20 Yes
Anger management	6/ 20 Yes
Housing/ residential support	3/ 20 Yes
Transport support	3/ 20 Yes
Family education strategies	6/ 20 Yes

Crisis Intervention	
Crisis intervention provided	5/ 21 Yes
Liaises closely with case management/ community treatment teams	1/ 5 Yes

Physical/psychiatric treatment	
Direct provision of medical and allied health treatment	9/24 Yes
Contact with other service providers re medical and allied health treatment	18/24 Yes

Evaluation – rehabilitation plan	
Evaluate outcomes of individual interventions included in rehabilitation plan	11/ 20 Always – 6/ 20 Often
Evaluate the progress towards rehabilitation goals and objectives	16/ 20 Always – 4/ 20 Often

Evaluation – service provision/organisation	
Evaluate service-user satisfaction of service provision	11/20 Always – 4/20 Often
Undertake an evaluation of system-wide service provision to ensure services are adequately meeting the needs of service populations	7/ 20 Always – 7/ 20 Often
Evaluate service provision to determine whether the overall goals of the organisation are being met	12/ 20 Always – 8/ 20 Often
Actively respond to outcomes of the evaluations	14/ 20 Always – 6/ 20 Often

Survey of Rehabilitation Service Providers - Summary

In March/April 2009, 25 organisations completed a survey about the provision of rehabilitation services for current and former serving ADF members accessing rehabilitation through the Department of Veterans' Affairs (DVA). The organisations approached to participate were identified by DVA as those who are currently certified to provide rehabilitation to DVA clients. It should be pointed out that a few of the organisations who were invited to participate reported to ACPMH that they had never been referred a DVA client or had not had a DVA client for several years and therefore they elected not to complete the survey. Of the 25 participating organisations, 14 were located in NSW/ACT, 4 in QLD, 3 in SA, 3 in WA and 1 in TAS.

The number of staff employed by the respective organisations ranged from one to 500, with the majority comprising less than 50 staff. Eighteen of the organisations (75%) reported that the majority of rehabilitation referrals received by the organisation are musculoskeletal in nature, with 14 organisations (58%) reporting they also receive a lot of referrals focusing on mental health needs. Each of the organisations were asked whether they had contact with other service providers in relation to their work with DVA clients. The most common providers with whom the organisations indicated working with in relation to DVA clients included GPs (95%), psychologists (76%) and psychiatrists (57%) with smaller numbers of organisations reporting contact with vocational specialists (29%) or drug/alcohol workers (29%). The nature of the contact was not specified.

Each organisation was asked to list the principles and goals guiding their organisation's service delivery. Some of the common principles referred to by organisations were providing individualised service, maximising client involvement in the development of their rehabilitation plan and goals, as well as maximising participation in the program with a focus on achieving the goals set out in the rehabilitation program (with an emphasis on return to work outcomes). Some of the common goals mentioned focused on achieving return to work outcomes, maximising quality of life and the independence of the client, and providing timely and cost-effective service provision.

Some of the findings in relation to the reported rehabilitation process followed by the organisations are outlined below.

- When developing a rehabilitation plan, most organisations reported involving the client in the planning, determination of client preferences and goals, focusing on client strengths, and providing individualised services (>80% 'always'). There was a wider distribution of responses in regards to using situational assessments (62% 'always'), involving a multidisciplinary team (57% 'always'), ensuring interventions have time frames and are evaluated (62% 'always') and using early intervention (48% 'always').
- Nineteen out of 23 organisations (83%) reported currently using standardised outcome measures to assess need or determine DVA client outcomes.
    - It was pointed out that the outcome measures used depend on the needs of the client. Some of the most commonly used outcome measures were the Orebro Musculoskeletal Pain Questionnaire (OMPQ), K10, DASS, and monitoring of return to work outcomes.
- All organisations dealing with DVA clients reported developing rehabilitation plans for clients and all of these organisations reported conducting rehabilitation assessments.
    - Thirteen of the 21 organisations (62%) reported that the assessment process was the same for both DVA and non-DVA clients. Of those organisations who indicated that the assessment process differed for DVA compared with non-DVA clients, comments included that the assessment process is dependent on the injury/illness of the client (e.g. physical/psychological) and that the process could be adjusted depending on the clients needs. One organisation commented that "a more comprehensive assessment process is undertaken with DVA clients".
    - Seventy-five percent reported that it was the same process regardless of whether the assessment was for a client with a mental health or physical condition. Organisations reporting a different approach for clients with mental health and physical conditions indicated that different screening tools may be used depending on relevance and that more emphasis may be placed on particular aspects of the assessment dependent on the client's condition

(e.g. "A FCE may be utilised for a physical assessment and DASS may be used for psychological assessment").

- When asked what aspects of a client's functioning are assessed, the majority of organisations mentioned physical/medical conditions, social/ADL tasks, psychological functioning and work history/assessment. A few organisations mentioned assessing psychosocial needs.

- Nineteen out of 21 organisations (91%) indicated that their consultants undertake situational assessments (e.g. at work, home and functional capacity evaluations (FCE)) to determine a client's current level of functioning.
- All organisations reported providing vocational rehabilitation.
  - When conducting a vocational assessment for DVA clients, only one organisation (5%) reported 'always' undertaking a functional capacity evaluation and only three organisations (14%) 'always' conduct a situational capacity assessment.
- Participants were asked to identify vocational strategies they employed when working with a client with a mental health/psychiatric condition. Individual placement and support was most common, followed by assistance with job seeking, training in job seeking skills and preparation of a resume. Strategies involving clubhouse/peer-support initiatives or enclave/work crew were least commonly implemented.
  - Sixty-three percent (n=12) 'rarely' or 'never' provided time unlimited support following placement in a job and only one service provider 'always' provided this.
- Fourteen out of 21 organisations (67%) reported providing services and support to both the client and their family, however only one organisation indicated that they 'always' involve the family in the client's treatment and rehabilitation planning.
- Organisations were asked to indicate whether they routinely provide particular psychosocial interventions to DVA clients, non-DVA clients or neither. If providing the intervention, they were most likely to provide it to both DVA and non-DVA clients. The main differences were for personal relationship counselling, counselling and psychotherapy, cognitive training, drug and alcohol management, anger management and family education strategies, which were more likely to be provided to non-DVA clients. A summary list of the psychosocial interventions and the number of organisations providing these interventions is provided:

Response options	Number of organisations providing intervention to…		
	DVA clients	Non-DVA clients	Do not provide to any clients
Psycho-education	14	13	5
Medication adherence	6	5	14
Social skills training	11	11	7
Skills of daily living	12	13	5
Personal relationship counselling	8	10	8
Attendant care services	2	0	18
Social networking	7	8	11
Illness self-management	12	11	8
Relapse prevention techniques	12	13	6
Assistance coping with symptoms	16	16	2
Leisure programs	6	6	13
Financial counselling	0	0	20
Counselling and psychotherapy	14	16	4
Support for further education	15	13	4
Cognitive training	11	14	6
Lifestyle programs	7	7	11
Drug and alcohol / substance management	1	3	16
Anger management	6	9	10
Housing / residential support	3	3	16
Transport support	3	3	16
Family education strategies	6	10	10

- The organisations were asked how responsive they perceived DVA's rehabilitation approvals process to be in allowing staff to provide psychosocial interventions. Overall, the majority of organisations felt that DVA were responsive and supportive, however a few mentioned that DVA was responsive as long as there was appropriate justification to provide the intervention.
- All but one organisation (95%) reported providing case management services.
    - Participants were asked to describe the tasks and responsibilities of case managers in their organisation. Responses included regular liaison with the client and stakeholders involved in the case to coordinate the treatment approach, conduct client assessments, deliver rehabilitation and review outcomes.
- All but one organisation (95%) reported it undertakes evaluation and assessment of the services it provides.
    - All organisations 'always' or 'often' evaluate progress towards rehabilitation goals.
    - However only 11 organisations (55%) reported 'always' evaluating outcomes of individual interventions in rehabilitation plans.
    - Only 11 organisations (55%) 'always' evaluate service user satisfaction of the service.
- None of the organisations reported engaging clients in intensive case management (also known as Assertive Community Treatment (ACT)).
- Sixteen out of 21 organisations (76%) do not provide crisis intervention services.
- Organisations were also asked what individual, organisational and/or system level factors act as barriers to successful rehabilitation. Some of the barriers mentioned were:
    - Individual level barriers included client motivation and expectations (particularly return to work goals), social/workplace support and adjustment to injury/condition.
    - Barriers at the organisational level included failure to refer the client for early intervention, difficulties with finding alternative duties for the client and a perceived lack of support from client's employer.
    - System level barriers included lack of flexibility in developing rehabilitation programs for individual clients (use of generic programs) and some confusion regarding rehabilitation legislation and policies.

Attachment F: Questions for interviews with key stakeholders

DVA staff only

Section A: Models of rehabilitation

We will begin by asking a few questions about rehabilitation models and practice generally and within DVA.

1. What would you describe as the key components of good rehabilitation generally?
2. To your knowledge, are the components you mentioned currently provided to veterans?

We have provided you with a copy of a logic map that provides an overview of the processes and procedures that constitute the intended service delivery model for rehabilitation for DVA Clients. We have also sent a flowchart overview of the elements of "best practice" in rehabilitation services based on a comprehensive literature review. The flowchart includes a summary of the number of survey respondents who indicated they provide certain services or adopt particular practices.

3. Based on the above documents as well as your experience, how satisfied are you with the current model of rehabilitation employed by DVA?
    a. Are there aspects that you think work particularly well?
    b. Are there aspects that you think could be improved?
    c. How do you think it rates/ranks with other rehab provided in the community?
4. Do you have contact with DVA contracted rehabilitation service providers?

IF NO to Q4, go to Q7

IF YES to Q4, go on to Q5

We have sent you a summary of some of the results from a recent survey of rehabilitation service providers certified to provide rehabilitation to DVA clients. This includes an overview of the processes and types of services delivered by the rehabilitation providers.

5. Based on the survey summary as well as your experience working with contracted rehabilitation providers, how satisfied are you with the level and kind of services provided by DVA contracted service providers?
    a. What do you think they do that works particularly well for DVA clients?
    b. Are there aspects of the level or kind of services that you think could be improved?
6. What is the level and nature of communication between DVA staff and service providers?
    a. Would you change anything about communication between DVA staff and service providers?
7. Do you think there has been a shift in the way DVA, the community and service providers think about and approach rehabilitation in recent years?
    a. *If yes* – What aspects in particular have changed, and are the changes positive? What do you think has caused this change?
    b. *If no* – Do you think there should be changes? What do you think would help generate change?

Section B: Rehabilitation outcome measures

This next section asks about measurement of rehabilitation outcomes.

1. What does a "successful outcome" of rehabilitation look like from the point of view of the…
    a. Client?
    b. Rehabilitation provider?
    c. Health provider?
    d. DVA?
    e. Families?
    f. Others?
2. In an ideal situation, what information would you need to determine whether a successful outcome has been achieved for a particular client?
    a. Is this information currently available/being collected by DVA?
    b. How would you suggest it should be collected and/or used?
3. What do you see as the benefits of using standardised outcome measures for determining outcomes of rehabilitation for DVA clients?
4. Are there any limitations to using standardised outcome measures? Can these be overcome?
5. There is concern that quantitative measures of success, such as changes to financial and/or employment status of clients and numerical outcomes such as number of clients returning to work, do not provide the most comprehensive, inclusive or thorough analysis of the effectiveness of rehabilitation services.
    a. What is your opinion on this?

Section C: Barriers and facilitators to rehabilitation

We are now interested in hearing what you think the barriers and facilitators to successful rehabilitation are for military veterans.

In the research literature, barriers and facilitators have been described at the individual client level (e.g. dissatisfaction with pre-injury work), as organisational level factors (e.g. failure to provide suitable alternative duties), and as system level factors (e.g. utilisation of generic rehabilitation plans and process or lack of tailoring to suit individual workers).

1. What factors do you think are the biggest barriers to successful rehabilitation for veterans? (*Interviewer to consider whether barriers are in the three categories and prompt if a category is missed: Are there other [Individual client/ Organisational level/ System level] factors?)*
    a. How do you think these barriers could be overcome?
2. What do you think are the most helpful factors in achieving successful outcomes of rehabilitation for veterans?
    a. Are these currently available to veterans?
    b. How could they be made available to veterans?
3. Do you have any other comments regarding current rehabilitation being provided to veterans, outcome measurements used in rehabilitation, and barriers/facilitators to rehabilitation for military veterans?

Non-DVA staff only

Section A: Models of rehabilitation

We will begin by asking a few questions about what you perceive good rehabilitation to involve.

1. What would you describe as the key components of good rehabilitation?
2. How familiar are you with the current model of rehab employed by DVA? (*Clarify if necessary: Does your knowledge of DVA rehab predate the information sent prior to this interview?)*

We have provided you with a copy of a logic map that provides an overview of the processes and procedures that constitute the intended service delivery model for rehabilitation for DVA Clients. We have also sent through a flowchart overview of the elements of "best practice" in rehabilitation services based on a comprehensive literature review. The flowchart includes a summary of the number of survey respondents who indicated they provide certain services or adopt particular practices.

3. Based on the logic map provided and any knowledge you have regarding the model of rehab employed by DVA, are the components of good rehabilitation that you mentioned currently included in what is provided to veterans?
4. Based on your knowledge of the current model of rehabilitation employed by DVA…
    a. Are there aspects that you think work particularly well?
    b. Are there aspects that you think could be improved?
    c. How do you think it rates/ranks with other rehab provided in the community?
5. Are you involved in providing or brokering rehabilitation services for clients (either veterans or non-veterans)?

IF NO to Q5, go to Q7.

IF YES to Q5, go on to Q6:

6. Thinking about the model of rehabilitation that is used in your organisation…
    a. Are there aspects that you think work particularly well?
    b. Are there particular aspects of the model that you think could be applied to military veterans?
7. Do you think there has been a shift in the way the community and service providers think about and approach rehabilitation in recent years?
    a. If yes – What aspects in particular have changed, and are the changes positive? What do you think has caused this change?
    b. If no – Do you think there should be changes? What do you think would help generate change?

Section B: Rehabilitation outcome measures

This next section asks about measurement of rehabilitation outcomes.

1. How would you describe a "successful outcome" in rehabilitation service?
    a. What does it look like from the point of view of the…
        i. Client?
        ii. Rehabilitation provider?
        iii. Health provider?
        iv. The insurer or funding body?
        v. Families?
        vi. Others?
2. In an ideal situation, what information would you need to determine whether a successful outcome has been achieved for a particular client?
    a. How would you suggest it should be collected and/or used?
3. Do you or your organisation currently measure the outcomes of rehabilitation for clients – either as part of service delivery or part of research?

IF NO to Q3, go to Q5.

IF YES to Q3, go to Q4.

4. Do you / Does your organisation use standardised outcome measures?
    a. If yes, which measures do you use? (In what situation?)
5. What do you see as the potential benefits of using standardised outcome measures?
6. Are there any limitations to using standardised outcome measures? Can these be overcome?
7. There is concern that quantitative measures of success, such as changes to financial and/or employment status of clients and numerical outcomes such as number of clients returning to work, do not provide the most comprehensive, inclusive or thorough analysis of the effectiveness of rehabilitation services.
    a. What is your opinion on this?

Section C: Barriers and facilitators to rehabilitation

We are now interested in hearing what you think the barriers and facilitators to successful rehabilitation are, particularly for military veterans. In the research literature, barriers and facilitators have been described at the individual client level (e.g. dissatisfaction with pre-injury work), as organisational level factors (e.g. failure to provide suitable alternative duties in the workplace), and as system level factors (e.g. utilisation of generic rehabilitation plans and processes or lack of tailoring to suit individual workers).

1. What factors do you think are the biggest barriers to successful rehabilitation for clients generally? (*Interviewer to consider whether barriers are in the three categories and prompt if a category is missed: Are there other (Individual client/ Organisational level/ System level) factors?)*
    a. How do you think these barriers could be overcome?
2. Are there differences in the barriers for veterans compared with other clients in the community generally?
3. What factors do you think are the most helpful factors in obtaining successful rehabilitation for clients generally?
4. Are the same facilitators currently available to veterans?
    a. If NOT, how could they be made available to veterans?

5. Do you have any other comments regarding current rehabilitation being provided to veterans, outcome measurements used in rehabilitation, and barriers/facilitators to rehabilitation for military veterans?