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Positives from the Forum

- Good to hear other mbrs input
- Broad range
- Exceptional – open discussion passing on experiences
- Good cross section of mbrs
- It was interesting to see the difference in units
- People could relate to each other
- Good to know that your not the only one going through things

DECISION BRIEF FOR CA (THROUGH DCA AND DGPERS-A) ON THE OUTCOMES OF THE 2016 WIIDF

1. **Purpose.** To **update** on the outcomes of the 2016 WIIDF.

2. **Recommendations.** It is recommended that you:

a. **note** the content of the Post Activity Report (PAR) (**Flag A**).

NOTED / PLEASE DISCUSS

b. **endorse** release of the PAR to stakeholders.

ENDORSED / NOT ENDORSED / PLEASE DISCUSS

c. **sign** the covering Minute distributing the PAR (**Flag B**).

SIGNED / NOT SIGNED / PLEASE DISCUSS

3. **Background.** The 2016 WIIDF was conducted at the QT Hotel in Canberra. The activity was attended by stakeholders from the Department of Veterans' Affairs and across Defence, as well as s47E(d) and s47E(d) family members/support persons. The theme of the WIIDF was 'Rehabilitation and Return to Work'. A PAR outlining the conduct of the WIIDF along with the key issues identified is at **Flag A**.

4. **Forum outcomes.** As a result of the plenary and syndicate sessions conducted at the forum, three broad areas for improvement were identified. These were:

a. Continuity of care, covering both medical and unit domains

b. Meaningful engagement and employment within units during rehabilitation

c. The medical waiver system.

5. Similar issues have been identified at previous WIIDF.

5. A more detailed table of issues identified and recommendations to remediate these problems is provided in Annex C to the PAR (**Side Flag A1**).

6. **Way ahead.** It is recommended you endorse the circulation of the PAR to key stakeholders participating in the WIIDF 2016 (**Flag B**). DAH through DGPERS-A will work with relevant stakeholders to action the recommendations.

7. **Conclusion.** The 2016 WIIDF was a successful activity; however the requirement for an annual forum is not extant.

Drafted by: s47E(d)
Cleared by: s47E(d)

MNGR A-SWIIP s47E(d)
DAH s47E(d)

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Flags:

- A. R27676170 - Post Activity Report – 2016 WIIDF
- B. R27976020 - CA Minute - Army Wounded Diggers Forum 2016 - Post Activity Report

Side flag:

- A1. Annex C- Outcomes and Recommendations



AUSTRALIAN ARMY
Director General Personnel–Army

DGPERS-A/OUT/2026/R27981976

COFS HQ 1 DIV
COFS HQ FORCOMD
COFS SOHQ
DGCM-A

For information:

DGDCO
DGGHO
DGMHP&R

2016 WOUNDED, INJURED AND ILL DIGGER FORUM – OUTCOMES

1. Thank you for your recent support in conducting the Wounded, Injured and Ill Digger Forum. Participants, facilitators and subject matter experts all provided valuable input and contributed to a successful event. The Post Activity Report has now been completed and is with CA for review - a copy of the report will be provided in due course.
2. Notes and observations from all syndicate discussions and the plenary session have been analysed and summarised into the synopsis at Enclosure 1. In order to progress the recommendations, suggested areas of responsibility have been allocated. I now seek your engagement to further develop and action these recommendations in 2017.
3. My point of contact is the Acting Manager, Army – Support to Wounded, Injured and Ill Program, s47E(d) [REDACTED], who can be contacted via email, s47E(d) [REDACTED] or tel: s47E(d) [REDACTED].


LS Wilton
BRIG
DGPERS-A

Mar 26


Enclosure:

1. WIIDF 16 - Tabulated Outcomes, Recommendations and Responsibilities


s47E(d)




s47E(d)



s47E(d)



s47E(d)



OCA/OUT/2026/R28885109

See distribution

ARMY WOUNDED INJURED AND ILL DIGGERS FORUM 2018

1. The 2016 Army Wounded Injured and Ill Diggers Forum (WIIDF) was held in Canberra over the period 18 - 19 Oct 16. WIIDF have proved very useful in providing feedback to me on one of my top priorities for Army, namely support to our wounded, injured and ill (WII) personnel. It was apparent at the 2016 Forum, however, that most of the significant WII issues at the soldier level have been well canvassed over the last six years. I therefore believe we should explore new opportunities to use alternative Forum formats to expand Army's effectiveness in this priority area. Rather than focus at the tactical level, I wish to lift the outlook to broader issues in order to create the philosophical framework within which to draw together a range of lines of effort related to resilience, wellness, wellbeing, treatment, rehabilitation and transition.

2. I do not anticipate the attendance of a large number of WII personnel at the next WIIDF. Instead, I intend to bring together the necessary expertise required to develop and deliver a coherent framework for managing the physical, mental and spiritual health of our people throughout their career and especially during periods of ill-health, whatever the cause. In line with a recommendation from the 2015 WIIDF for future Forums to be held in the first half of the year, I have endorsed the next WIIDF to be held in Canberra during the second quarter of 2018. My staff will forward details to you in due course.

3. Beyond 2018, my intent is that WIIDF continue in a three yearly cycle. In the first year I plan to bring WII soldiers together, as in the past, to help Army's leadership identify problems from a soldier's perspective. In the other two years, I will bring together the necessary subject matter experts and those with the necessary authority to develop and guide our enduring programs for the care of our wounded, injured and ill personnel.

4. My POC for this issue is the Director Army Health, s47E(d), who can be contacted on s47E(d) or via s47E(d).

AJ Campbell
LTGEN
CA

Mar 26

Distribution:

VCDF

CJHLTH

DCA

COMD FORCOMD

SOCAUST

COMD 1 DIV

COMD 2 DIV

RSM-A

DGNP

DGPERS-A

DGPERS-AF

DGCMA

DGAHS

DGDCO

DVA - Assistant Secretary, Mental & Social Health

ANNEX D to R27676170

FEB 17



Chief of Army
Wounded, Injured and Ill Digger Forum 2016

Closing Session



Health Care

- JHC is under-resourced
 - Wait times
 - Fragmentation of care
 - Poor clinical handover
- Preference to see uniformed doctors
 - Education of contract doctors/clinical staff
- Access to service in remote locations
- Alternative therapies
- Alternative treatment pathways



Medical Employment Classification System

- Understanding of process
 - Assumed knowledge
- Understanding of classifications
- Restrictions couched in the affirmative
- Waiver process
 - Poorly understood
 - Bureaucratic
 - Risk averse



Rehabilitation

- Excessive optimism
 - Goal 1 to Goal 3
 - Is rehab always the best first answer?
- Clarification of roles
 - Unit Welfare Officer
 - Rehabilitation Coordinator
 - Member Support Coordinator
- Capabilities of SRC
 - Segregation vs. outcome



Employment and Engagement

- Maintaining engagement with unit
- ‘linger’ culture/stigma
- Poor employment
- Lack of visibility for non-unit employment
 - In Defence
 - External placement
- Family engagement



Employment and Engagement

- Limitations of trade transfer & retention
 - Higher rank
 - Greater use of MEC J42
- Options for training and education
- Unrealistic expectations



Unit Management & Welfare Management

- Leadership
 - Engaged leadership = good outcomes
- Use of unit vs individual welfare board
- Communication of WB outcomes
- Governance & compliance



Empowerment & Trust

- Trust rises with rank
- Empowerment rises with rank
- Education facilitates empowerment
- Ownership is not required for empowerment and trust



Actions

- Review waiver system
- Mock MECRB
- Communication (up, down, sideways)
- Examples of good family engagement in rehabilitation
- Identifying and sharing best practice
- Training and mentoring
- Reducing the policy blizzard



Actions (cont.)

- Engagement with JHC on issues raised
- Treatment of medical professionals by Command and patients
- ‘linger’ culture needs to be addressed (is it a stigma rather than a culture?)
- Employability vs deployability



Key outcomes/issues

- 1. Continuity of care – unit & medical**
- 2. Meaningful employment/engagement**
- 3. Waiver system**



- Communication & education**
- Governance & compliance**
- Policy improvement**
- Sharing and embedding excellence**

1. Stigma

- WII reluctance to report / seek medical attention due to fear of
 - Being labeled as malingerer,
 - Being medically downgraded
 - Extended absence from the workplace having an adverse impact on career and employment opportunities
 - Not fully understanding the medical process

Cause - fear instilled during ab itinio and reinforced through trng / unit

Fix - early education on importance of self-medical mgmt and process

2. Education / Experience / Support

- WII unfamiliarity of process /avail resources / tools / insufficient education
 - UWB / MECR / Corps Trade tfr / UWO / Rehab Consultant / ESO
- CoC and Medical staff inconsistencies applied to policy and process
 - Not advising WII of UWB or welfare plan / no rehab plan or engagement during rehab / incorrect application of Goal 1/2/3
 - Extreme disparity and inequity by management / CoC micro mgmt, no evidence of trust / inappropriately demanding in confidence info

Cause – absence of awareness / ownership / responsibility / info at unit level

Fix – on-going education and trng for UWO / CoC, Unit notice board poster/brochure (similar to Equity Officer) advising unit HWO/HWWO, USO, APS Rehab Coordinator POC, UWO responsible to educate WII members prior to initial WB and remain single POC until mbr fully recovered

3. UWB

- WII unaware / not involved / not debriefed on WB outcomes or welfare plan
- WII attending UWB felt intimidated and overwhelmed by process

Cause – WII not being fully informed and inadequate engagement by CoC

Fix - on-going education and trng for UWO / CoC, UWO providing info resources

4. Employment during rehab and RTW

- WII not being gainfully employed during RTW programs
- Blanket restrictions being applied depending on medical diagnosis
- Inconsistencies between Offr / OR mgmt

Cause – workplace assessment not undertaken and CoC expectations

Fix – RTW workplace assessment involving WII spvr, TTO, OT and WDR is undertaken

5. Feedback

- Regardless of understanding / experience, WII generally felt empowered and believed they had ownership of their rehab
- WII expressed gratitude to be given the opportunity to attend forum and that it was a positive experience providing an opportunity to share stories and recognise they are not alone

- ~~WII expressed appreciation for the opportunity to attend forum and that it was a positive experience providing an opportunity to share stories and recognise they are not alone~~
workplace

MINISTER FOR DEFENCE PERSONNEL SPEAKING NOTES

WOUNDED INJURED AND ILL DIGGER FORUM

18 November 2016

- 262 ADF personnel deployed to Afghanistan have been wounded in action since 2002*

**NB as at 1 Feb 2014 as per Defence website.*

- Military service as an occupation makes unique demands upon members of the ADF. Defence continues to improve the support available to wounded, injured and ill members and their families.
- Whether ADF members become wounded, injured or ill on operations or at home, they should feel confident that they will be supported through their journey of rehabilitation and recovery.
- The Army - Support to Wounded Injured and Ill Program (A-SWIIP) was established in 2009 to meet the needs of an increasing number of wounded, injured and ill personnel resulting from Service, including operational deployments in East Timor, Iraq and Afghanistan.
- The Wounded Injured and Ill Digger Forum, established by the Chief of Army, has been held annually in Canberra since 2010.
- This forum is a positive example of the Army continuing to learn from their members own experiences, while continuing to improve the support services available to wounded injured and ill personnel.
- This process of obtaining constructive feedback is essential to improving access to support services and to connect with those members and their families who can assist us to continue to provide the best care available for those in the future.
- Over the years, the Army has specifically established new initiatives, and streamlined processes through feedback from the Chief of Army's wounded injured and ill digger forum. This includes building closer ties with Department of Veterans Affairs, changes to policies and support services, establishing stronger communication platforms such as the wounded digger website and smart phone apps.
- Other initiatives that have improved outcomes for wounded, injured and ill members includes the establishment of Soldier Recovery Centres as centers of excellence for rehabilitation and recovery.
- The implementation of Health Care Coordination Forums and the Intensive Rehabilitation Team by Joint Health Command targeting members with complex conditions or at risk of poor health outcomes. Adoption of the Meaningful Engagement program, trialed under the Simpson Assistance Program, as business as usual.
- Looking forward Defence has committed to continuing to improve Mental Health support by introducing uniformed Psychiatrists and implementing the next iteration of the ADF Mental Health Strategy.
- It is important to note that every ADF member who becomes wounded, injured or ill has different circumstances, which means Defence has an obligation to ensure each member has tailored support services available to meet their individual needs.

- The tailoring of individual support is best achieved through a member focused approach, with Joint Health Command, the Defence Community Organisation, Command and other stakeholder synchronized to ensure the right support at the right time.
- In previous years, this forum has covered physical injuries as a result of operations, mental health and transition as key topics of discussion. Today we are here to talk about support to wounded injured and ill members through their rehabilitation and return to work, whether this be in the same role or a different role elsewhere in Defence.
- Involvement of the wounded, injured and ill member and their support network, family, friends and peers is vital to a successful recovery. Today, the Chief of Army has asked specifically for your thoughts on how individuals can be best supported to lead their own recovery journey
- Workforce engagement is an important aspect of an individual's ongoing rehabilitation and recovery, and provides a range of psychosocial, health, independence and financial benefits.
- How Defence can keep members actively engaged in the military work environment whilst facilitating recovery is an ongoing challenge. The Soldier Recovery Centres are one method to achieve this, however there are likely other innovative ways. Today is about thinking outside the boundaries you know and how things could be done differently.
- Sharing areas of best practice and opportunities to improve existing programs will be the key for Defence in retaining more of our soldiers and officer, in whom so much is invested, following wounded, injury and illness.

Drafted	Name	Appointment	Date and Time
<i>TPs drafted by</i>			

Clearance	Name	Appointment	Date and Time
<i>Subject Matter Expert</i>			
<i>DGPERS-A</i>	s47E(d)	<i>A/DGPERSA</i>	
<i>DAC</i>	s47E(d)	<i>DAC</i>	

Summary of Common Themes / Discussion

1. Stigma

- WII reluctance to report / seek medical attention due to fear of
 - Being labeled as malingerer,
 - Being medically downgraded
 - Extended absence from the workplace having an adverse impact on career and employment opportunities
 - Not fully understanding the medical process

Cause - fear instilled during ab initio and reinforced through trng / unit

Fix - early education on importance of self-medical mgmt and process

2. Education / Experience / Support

- WII unfamiliarity of process /avail resources / tools / insufficient education
 - UWB / MECR / Corps Trade tfr / UWO / Rehab Consultant / ESO
- CoC and Medical staff inconsistencies applied to policy and process
 - Not advising WII of UWB or welfare plan / no rehab plan or engagement during rehab / incorrect application of Goal 1/2/3
 - Extreme disparity and inequity by management / CoC micro mgmt, no evidence of trust / inappropriately demanding in confidence info

Cause – absence of awareness / ownership / responsibility / info at unit level

Fix – on-going education and trng for UWO / CoC, Unit notice board poster/brochure (similar to Equity Officer) advising unit HWO/HWWO, USO, APS Rehab Coordinator POC, UWO responsible to educate WII members prior to initial WB and remain single POC until mbr fully recovered

3. UWB

- Prior to injury/illness not familiar or aware of what a UWB / IWB / IWP or UWO were
- WII unaware / not involved / not debriefed on WB outcomes or IWP
- Some WII attending UWB felt intimidated and overwhelmed by board attendees and the process

Cause – WII not being fully informed and inadequate engagement by CoC

Fix – early intervention, on-going education and trng for UWO / CoC, UWO engaging WII member prior to initial WB to provide info, resources and expectations of the WB

4. Employment during rehab and RTW

- WII not being gainfully employed during RTW programs
- Blanket restrictions being applied depending on medical diagnosis
- Inconsistencies between Offr / OR mgmt
- Continuity of medical management during rehab

Cause – possible a workplace assessment has not undertaken in conjunction with CoC expectations and WII medical restrictions

Fix – RTW workplace assessment involving WII spvr, TTO, OT and WDR is undertaken to determine medical restrictions and how a WII can be gainfully employed during the rehab process.

5. Other

- **Consistency of medical mgmt** and the requirement to continually having to explain their situation on posting or appointment of new CoC and medical staff
- **Lengthy delays** being experienced in the MECRB process (now resolved)
- Misdiagnosis of injury/illness with mbrs relying on 'google' to identify and treat
- Regardless of understanding / experience, most **generally felt empowered** to manage rehab, with some seeking external medical treatment
- Some concerns raised around **medical confidentiality** with supervisors demanding / inappropriately questioning what the injury/illness and treatment / rehab program were
- Request for a **single unit SME (UWO)** to approach in the event of injury/illness and 'what next' to assist through the WB process
- **Deployable vs Employable** and whether a member who may not be considered deployable still can still be gainfully employed. Further if a member who is not considered deployable but could be gainfully be employed as a reservist with a medical classification raised to indicate as such (J50 – suitable for employment as a reservist, however may not be suitable for deployment but could be presented for medical clearance)
- **Common/standard defence medical management** system to ensure Army WII are not mis-managed (lost) in the system in tri-service, NAG postings
- **Care for the carer program** to ensure those who are caring for the WII are receiving support for the work they do IOT prevent own medical/mental health concerns
- WII expressed **preference for civilian psych** due to confidentiality and confidence their discussions would not be shared with CoC
- **PCC mock MECRB** misses the independent sub-unit commanders. Suggest this also be included in All Corps Majors Course CMLT
- WII expressed gratitude to be given the opportunity to attend forum and that it was a positive experience providing an opportunity to share stories and recognise they are not alone

WIIDF Points – s47E(d) Health and Wellbeing

s47E(d) the facilitators in some of their discussion, but highlight some points that s47E(d) throughout. There are also comments here that s47E(d) . s47E(d) not to repeat points raised by all the groups – s47E(d) offer points in regard to them.

1. **Messaging.** This is a theme that was identified in two groups. This was apparent in the MH space:
 - a. Something that was identified as a restriction to seeking help was the impact on security clearances. This goes against the AGSVA response to CDF(?) which states that it is seen as a proactive measure in personal health care and awareness.
 - b. There is a requirement for positive outcomes to be identified to show it is not all doom and gloom.
2. **Blanket Restrictions.** Driving restrictions and weapon handling once a MH condition is identified seem strange in that an individual can drive to work but then not drive a service vehicle. When people are covered for liability if they have an accident while commuting – it seems a double standard – or is it something that has not been discussed?
3. **Stigma.** Does a stigma develop due to treatment during training? One of the issues identified was that of self-reporting of an injury during basic training. s47E(d))
s47E(d)
s47E(d) . People are not as good mates with those who report sick, so they therefore have an ingrained fear of doing it. People who report sick 'disappear' is the association that people have with going to the medical centre. Is this enhanced by removal to DJs? s47E(d)
s47E(d) .
4. **UWB/IWB.** This is confusing the issue. People no longer know the 'qualification' criteria for presenting to the two types of WB as they are contradictory. s47E(d)
s47E(d) .
That is – Chain of Command and individual involved in the process and covers WB for Admin purposes. The CO can then change the composition as required for individuals to include MO / ADFRP / Chaplain / DCO / psychologist / psychiatrist / etc as per their (and the Mbr's requirements). s47E(d)
s47E(d) paragraphs from the new WII management policy.
 - a. The nomenclature is confusing in that you can conduct a UWB which is made up of many IWBs. Running WB based on requirements for each individual in the unit may give greater flexibility for commanders, but also remove confusion.

- b. There is no requirement for IWP any more because every single person at the WB or on the SharePoint system has a record with agreed action points on it.
 - c. Most people highlighted the requirement for a Mbr to be present at the WB – then we reinforce that in policy as that is the key differentiation between the two types of WB at present.
 - d. s47E(d) engage with HWO to get comment on this prior to submitting a proposal prior to the Army Health Services Steering Group meeting.
5. **Alternative treatments.** s47E(d) do not get involved enough in the use of pre-injury physiotherapy or chiropractic (or the like) treatment. Civvies get that as part of their health fund. It is an investment in the prevention of injury. Athletes do it so they can maintain performance throughout a season. Why do s47E(d) not? Maybe trial it in the ready Bde as they should be the people who are operating at the peak of their performance cycle?
6. **Physio-led PT.** This should be included in RLA/SLA/GHS agreements if appropriate.
7. **Employment mismatch.** Negative mental affect and loss of skills. s47E(d) this is linked to the driving and weapon issue. If people lose skills on the tools through the application of their restrictions, then let's get the Chain of Command to actively engage with the MO:
- a. Can we re-write restrictions to enable them to conduct activities under one on one supervision? Then they can work on tools / or do TOETs and stay current as they want to be doing, through one-to-one supervision.
 - b. This is a command issue – they should be looking at innovative ways to enable the individual rather than to restrict them as per the PM101 – it's a recommendation? If the PM101 is too vague, then request clarification.
8. **Knowledge of the AD092 HCCCF.** People need to know about it and use it if they are not content with anything they are subjected to – but also use to compliment as well. JHC units cannot take action against ineffective treatment without building a case against a provider, which is enabled through the AD092.
9. **Perspective.** The point came up about the MDRM process. "s47E(d) [REDACTED]." It might seem risk averse – but there might also be some very good reasons why the unit did not complete / endorse the MDRM waiver for an individual. They might see the bigger picture, which the member may not. The CO is the one wearing the risk – that is why they command.
10. **RSL Messaging.** "s47E(d) [REDACTED]." s47E(d) this is confusion between RSL pokies and RSL organisation. They need engagement with contemporary veterans. Can Army drive this ethically by nominating or endorsing or recommending individuals?

11. **Training.** There are lots of training requirements that came out:
 - a. The mock MECRB at ACSC could benefit from a mock WB beforehand.
 - b. Training should be for MOs as well. MOs should be held accountable for referral to ADFRP Rehabilitation Consultants.
 - c. Chain of Command engagement with MOs. People seem to sit back and complain about restriction detail or MOs not having knowledge of the unit. MOs and ADFRP Case Manager can be invited to the unit to see what the unit does. This will enable them to tailor their 'service'.

12. **SRC knowledge.** Two of the groups mentioned that hardly anyone knew about what the SRC were there for and believed they were there for separation. The participants in those groups (s47E(d) [redacted]) were predominantly not from s47E(d) [redacted] locations

13. **J33 Issue.** One of the participants from s47E(d) [redacted] raised interesting points about engagement with J33 personnel before returning to work. s47E(d) [redacted]
[redacted]
[redacted] ? To be discussed with Hlth CAG.

14. **Spouse engagement.** Policy used to enable unit duty vehicles to be used to get spouse/family to WBs – this has been changed in the new (Draft) WII Manual (para 2.12). s47E(d) [redacted]
[redacted]
[redacted].

15. **Attendees.** It is important to remember that there are significant success stories in the WII management space, which is testament to the individuals and the chain of command work to support them.