

Chapter 6

VOCATIONAL REHABILITATION OF THE COMBAT AMPUTEE

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INTRODUCTION

Vocational rehabilitation (VR) refers both to the overarching goal of returning an individual to gainful employment after he or she acquires a disability, and to a complex process of assessment, counseling, support services, and retraining that should begin, at least conceptually, shortly after the onset of disability. Cultural values of independence, self-sufficiency, and the importance of being able to contribute to the community provide a strong incentive for individuals to return to employment, and both local and national communities recognize the financial and humanitarian value of maximizing employment. In today's rapidly changing world, service members with amputation are more likely than ever to remain on active duty status in the same or a modified position, or to seek

a job or retraining for competitive employment in the civilian sector.

This chapter summarizes the basic components of VR of the combat amputee, describing both the general process of preparing an individual with amputation to return to work and the issues related to vocational success specific to combat amputees. The structure and opportunities of Department of Veterans Affairs (VA) vocational rehabilitation are outlined. The chapter concludes with a description of a model system developed over several years via collaboration between the vocational rehabilitation service of the James A Haley VA Hospital and the Veterans Benefits Administration (VBA) staff at the St Petersburg, Florida, regional office.

BACKGROUND

Legislation

In the United States, systems of VR have been initiated primarily in response to wartime casualties, then mandated and broadened for civilian populations afterwards via federal legislation. The Soldiers Rehabilitation Act was passed in Congress in 1918 to require vocational education for returning World War I soldiers with disabilities. Additional legislation broadened the scope of VR services to individuals with blindness, mental retardation, and mental illness. World War II resulted in the 1943 Disabled Veterans Act, which authorized vocational support, and the 1944 Servicemen's Readjustment Act, which provided vocational training and education for those whose careers were cut short by military service. The 1952 Veterans Readjustment Assistance Act provided vocational education to Korean War veterans. Additionally, the shortage of traditional employees in World War II created an opportunity for individuals with disabilities to demonstrate their ability to participate competitively in the workforce, resulting in additional legislation broadening VR and education for civilians. The 1973 Rehabilitation Act resulted in significant infrastructure growth for VR; 25 years later the 1998 WorkForce Investment Act brought dramatic changes to the field.

Vocational Rehabilitation Professionals

VR services, particularly in terms of initiating support and developing employment plans, have primarily been provided in both the VA and the public sector by the discipline of rehabilitation counseling.

The field of rehabilitation counseling was developed as master's level education of professional counselors with specialty training in disability, medical aspects of disability, advocacy, career guidance and vocational assessment, and rehabilitation systems. Rehabilitation counselors have a national credential, the Certified Rehabilitation Counselor (CRC), and in many states are licensed as master's level counselors. Rehabilitation counseling is defined by recognized competencies expected of a CRC; some of these identified in the CRC Scope of Practice include career counseling, assessment and appraisal, case management, referral and service coordination, job analysis, job development, placement services including assistance with employment and job accommodations, and interventions to remove environmental, employment, and attitudinal barriers.¹

The national credentialing body for master's programs in rehabilitation counseling, the Council on Rehabilitation Education, also specifies competencies for all graduates of rehabilitation counseling programs. A brief review of these competencies confirms that training and expertise in VR are essential aspects of rehabilitation counseling. Competencies include the following:

- utilize career and occupational materials and labor market information with the consumer to accomplish vocational planning;
- evaluate work activities through the use of job and task analyses and utilize the evaluation in facilitation of successful job placement;
- establish follow-up procedures to maximize an individual's independent function through the provision of postemployment services;

- use computerized systems for consumer job placement assistance; and
- identify and arrange educational and training resources that can be utilized by consumers to meet job requirements.

Other rehabilitation professions may also be involved with VR in some settings, particularly occupational therapy, psychology, or social work. Some aspects of the rehabilitation counseling profession may overlap with psychology and social work, particularly in the areas of individual or group counseling services, discharge planning, case management, and treatment team coordination. Occupational therapists, in particular, often participate in evaluation of return-to-work status through a work hardening trial or a functional capacities evaluation that operationalizes fitness and safety for specific occupational tasks.

Rehabilitation engineers often play essential roles in VR, identifying assistive technologies and providing training on how best to implement the technologies as an accommodation for either training or on the worksite. Rehabilitation engineers may also be involved with making worksite modifications, making recommendations for ease of computer accessibility, or prescribing and setting up an environmental control unit that allows the employee to remotely control numerous appliances or other electronic devices.

Outcomes

The professional literature describes vocational and psychosocial outcomes in individuals with amputation, although the heterogeneity of amputation and differences between the civilian population and the combat amputee render most findings unlikely to generalize to this group of individuals. Vocational rehabilitation has played an essential role in the rehabilitation and community reentry of other disability groups.

Vocational Rehabilitation and the Combat Amputee

VR is tailored to the characteristics of each individual who has experienced a disability. Given their active duty status before injury, combat amputees tend to be young, fit, healthy, and oriented to physical activity, competition, and independence. These individuals, at least since the end of the draft in 1973, have chosen a career path in the military knowing of its increased level of risk, as well as uncertainty about living conditions, job duties, and an ongoing need to reestablish new peer relationships. These preinjury characteristics imply a set of values and expectations for employment

and independent living that may differ significantly from other groups of amputees, such as sedentary, elderly persons with chronic medical conditions, who make up the largest group of amputees. In general, the characteristics of combat amputees imply significant motivation to return to employment and strength of character to tolerate the ambiguity of VR. However, these same characteristics may present some obstacles to VR. Many service members have had a hiatus from their academic discipline and may find it difficult to reengage in academics, reducing their interest or confidence in their ability to succeed in vocational retraining programs.

A unique characteristic of military service members is a shift in primary identity from an “I” to a “we” upon joining the military, placing service to the country and protection of fellow service members over their individual needs. This value greatly facilitates success in combat, but may be inconsistent with planning for individual goals; the combat amputee may need to reprioritize the self and personal needs over group needs to successfully engage in the VR plan. Many veterans maintain this core value for their entire lives.

An additional component of VR is to plan pragmatically for employment. In today’s military population, some service members may have learned English as a second language, and may not have been formally educated in English. Concurrently, some service members may have joined the US armed forces from another country in the hopes of facilitating US citizenship for themselves, and are not currently US citizens. Both of these issues need to be considered in light of the demands of academically oriented vocational training programs, the requirements for employment, and the long-term opportunities for employment if the service member chooses to return to the home country to be closer to family and friends.

A third tenet of VR is evaluation of the individual’s strengths and limitations, taken as a whole, after injury has stabilized. For combat amputees, the mechanism and context of amputation is therefore a significant factor for future VR. The current etiology of limb loss due to explosions and motor vehicle accidents often includes numerous additional injuries such as spinal cord injury, burns, orthopedic injuries, and head trauma (and resultant cognitive or other dysfunction). These additional injuries greatly challenge the VR process and may supersede amputation as the primary limitation or consideration in identifying future employment opportunities. However, the context of combat limb loss in the system of care provided by the Department of Defense (DoD) acutely and postacutely differs significantly from typical civilian amputee care. In the DoD, active duty personnel are very likely to be

recuperating in the company of other service members with similar injuries, providing a built-in support network and an organizational structure oriented to optimal rehabilitation and access to cutting-edge prosthetics.

A fourth basic issue to consider in VR is the feasibility of transferring past work experience to future employment options. The employment circumstances of active duty personnel differ dramatically from civilians both in overall format and frequently in specific job duties. Although many of the tasks completed by service members have a parallel in civilian settings, other duties are much more specific to military needs and have no clear parallel position in civilian employment. However, some resources are available to assist in generalizing from military to civilian employment, which will be discussed in the next section.

In addition, many individuals with a combat amputation are young and may have joined the military due to a lack of other vocational direction; often they have not had other types of work experience. This group may require more evaluation and exploration to determine a future employment direction. Although the opportunity to remain on active duty has greatly increased and a formal return-to-duty process exists, some service members may be unwilling to pursue this route if they are unable to return to their previous military occupational specialty.

Finally, the VR process must include consideration

of long-term needs and outcomes in determining type, location, and characteristics of employment. As previously stated, the literature on long-term outcomes for individuals with combat amputations has been scarce; however, individuals with amputations resulting from the current conflicts represent a unique population in which the complexity of injury mechanism along with polytrauma, access to rapid medical and rehabilitation services, and access to state-of-the-art prosthetics all combine to produce an individual with significantly greater opportunities for functional recovery than previously seen.

The vast majority of service members with amputations are rated by the VA system as having some level of disability, or percent of "service connection" for the amputation. This commits the VA healthcare system to lifelong medical and rehabilitative care for the service member for any needs related to the disability. Therefore, many service members with limb loss find proximity to a VA hospital or a military medical treatment facility (MTF) that offers these services, in addition to the ongoing needs for rehabilitation, therapy, and modifications with a VA prosthetics service, to be an important factor in choosing a location for long-term employment. For individuals considering retraining in new career fields, additional consideration will therefore need to be given to the "transferability" of employment from a current home to areas with access to VA rehabilitation services.

THE VOCATIONAL REHABILITATION PROCESS

This section summarizes various VA and DoD systems and potential paths to access VR services. For the service member with amputation as the primary injury, medical and rehabilitation services are most likely to be provided in an MTF with specialized amputee care resources. Military MTFs now have access to VR professionals, who may establish preliminary rapport with service members and determine when to make formal referral to initiate the VR process. Particularly for those service members who express interest and are likely to remain on active duty status, consultation with VR specialists occurs after stabilization and transfer to outpatient rehabilitation, when functional status is better known and return to employment ability can be assessed and discussed in a realistic manner.

The VA incorporates VR specialists in some hospital settings and in VBA offices. For service members sustaining polytrauma, transfer to a VA polytrauma center may occur early in rehabilitation. These individuals are treated by a transdisciplinary team that includes VR. The VR team member can begin to provide education

to family members and to the service member about VR options. Depending on severity of disability, some of these individuals may become veterans and may in fact need access to VA VR benefits to assist in transition to community-based services upon discharge from the military.

For medical professionals working with a combat amputee, a brief overview of the basic components of VR is offered here. VR begins early in the rehabilitative process and must be understood, reinforced, and supported by all professionals providing services to the combat amputee. VR steps discussed below include assessment and career exploration, rehabilitation plan development, intervention and training, and ongoing follow-up.

Assessment and Career Exploration

VR involves a process of intake and referral to services within DoD, VA, and community settings that will ultimately support future efforts toward return to employment, as well as a process of individually

oriented assessment and intervention. Both intake and preliminary assessment can begin early in the rehabilitation of the combat amputee, but these initial steps must lead to a rehabilitation plan developed in conjunction with the individual service member. It is critical to include an overall assessment of strengths that might contribute to future employment, not just an evaluation of ambulation or other motor and sensory skills presumed to have changed after amputation. Assessment should be conducted after the service member has had ample time to adapt to prostheses or any other compensatory strategies.

Individually oriented assessment uses a variety of interviews, observations, standardized questionnaires and tests, and techniques, not all of which are necessary or relevant for every individual. In general, the process follows this sequence: interview and background gathering, evaluation of transferability of previous employment, tests or other data gathered on current ability level, determination of current interests, functional or situational assessment to assist the individual in exploring fit to a position, matching of current personal attributes to potential jobs, and finally a market study to determine utility of career choices.

Assessment in VR includes current abilities and aptitudes, interests and preferences in type of work, and transferability of skills from previous employment or training to other jobs. Abilities and aptitudes may be identified via formal testing of intellectual, academic, motor, and sensory abilities; through informal interviews; and by observation in real world environments as the individual attempts various tasks. Numerous interest inventories, such as the Self-Directed Search, are available as written exercises.² Data on interests is gained in interviews with veterans about hobbies, avocational interests, and past successes, as well as interviews focused on why they have chosen previous employment and their subsequent subjective experiences with the work environment and work tasks. In determining transferable job skills, it may be useful to acquire a formal job description of the military occupational specialty as well as to conduct detailed interviews about daily function.

Numerous Internet-based programs are available to assist with career guidance, particularly to gain detailed information about the demands of specific jobs, educational requirements, and job prospects. These programs are often best used initially under the guidance of a VR counselor, but lend themselves well to further independent exploration by veterans. The most comprehensive Internet resource is ONET, available at www.onetcenter.org (previously available in hardcopy as the *Dictionary of Occupational Titles*³).

Several online resources can assist in comparing military occupational specialty with civilian sector employment, including a “crosswalk” page on ONET and Transition Assistance Online (at www.TAOnline.com). In addition, the American Council on Education offers a Web site that describes military training programs and compares them to educational training, assigning college credits to past military training (www.militaryguides.acenet/edu).

Development of the Rehabilitation Plan

Depending on residual abilities, interests, and the demands of employment, there are typically four possible directions for VR, in the following order of preference: (1) return to previous employment in active duty status; (2) remain in the military, but in another military occupational specialty; (3) leave the military and seek civilian employment using current skills; or (4) leave the military and seek retraining for new skills or a new environment. Each combat amputee may have specific opinions and preferences about which of these directions to pursue, but will also need to abide by military decisions and policy regarding retention of active duty personnel with limb loss.

As an individual moves closer to a specific vocational choice, an assessment of the impact of disability characteristics as he or she interacts with the environment is critical. This process of functional assessment can take many forms, but ultimately must address the day-to-day realities of employment and identify compensatory strategies and accommodations that the amputee may use to meet the demands of competitive employment.

Baseline Function

As an initial step in the rehabilitation plan, the service member must reestablish and achieve a baseline level of independent function that is robust enough to remain secure in the face of the demands of return to work or participation in retraining. For many service members, particularly those with comorbid conditions, this will entail the development and description of a “prevocational” phase of therapy and supports tailored to their specific needs. Areas to evaluate and support include basic activities of daily living, such as personal hygiene, dressing, and self-feeding; home and nutritional management; finances; ability to negotiate medical and rehabilitation appointments; and medication management.

A particular point of concern is the ability to maintain attention and endurance equivalent to a work-oriented daily schedule, and then return home

to attend to other requirements of independent adult life. Emotional status is also a critical component of baseline coping—the demands on emotions escalate with increased responsibilities—and the attainment of adequate coping strategies may require ongoing counseling services, support groups, family education, or other supports. To address these issues, the VR plan often details a list of prevocational therapeutic activities involving ongoing outpatient medical rehabilitation, professional counseling, or participation in community-based reentry programs. These services are typically funded under VA independent living services.

Functional Assessment

A second aspect of developing a VR plan is functional assessment, to determine the veteran's current abilities in the everyday world.⁴ This assessment may include functional capacity evaluations by occupational or physical therapists to identify specific levels of physical ability as related to work demands, work hardening programs that require individuals to return gradually to the demands of employment, functional interviews, and situational assessments (discussed below).

Interviewing individuals and collateral informants is another way of obtaining information about functional abilities and competencies in the everyday environment. Spouses, housemates, employers, coworkers, caregivers, and adult children can provide rich information on an individual's ability to perform a certain task, how an individual goes about performing a task, how the individual's environment is structured, what obstacles he or she encounters, and the supports the individual needs and has access to.

A functional interview is an extension of the information-gathering process that starts with collecting background information. The functional interview differs from the traditional clinical interview in its emphasis on the individual's current environment and relationships between that environment and current problems. It also differs in its emphasis on exploring the interface between cognitive strengths and limitations and everyday life. Its purpose is not to provide a historical view of social, vocational, educational, medical, or familial background; to conduct an interview that elicits truly functional information, it is critical to keep these two agendas separate. The goal of a functional interview is to provide specific information on what individuals can or cannot do. Examples of what might be obtained include a specific picture of daily life schedule and activities; statements detailing the impact of problems

on everyday life experiences; or a list of previously attempted remedies.

The manner of questioning is important because it may influence the response. For example, asking an informant whether an individual "can" perform a task may produce a different (and perhaps less accurate) response than asking if the person regularly "does" a task. Asking about *how* an individual goes about a task (the approach, strategies, and accommodations used) can provide the rehabilitation counselor with information to make generalizations about other functional skills and future behaviors. Systematic collection of information from both veterans and informants using rating scales or questionnaires may shed light on the problems that may not be apparent from test results. There are often dramatic differences in how individuals rate themselves versus how family or caretakers rate executive function.

Simulations and role-playing of real-life activities can be used to determine how an individual utilizes interpersonal and cognitive skills to resolve problems.⁵ These activities require the individual to deal with multiple priorities, unforeseen circumstances, and interpersonal interactions—the real tests of effective executive function. Situational assessments are completed by putting the individual in a real-life environment and observing how he or she functions over a period of time. These short-term real-life experiences can be arranged through temporary employment, often through the use of a temporary personnel agency. Volunteer work or short-term employment arranged through family or friends can also be considered. Large institutional settings such as a VA hospital or MTF offer a protected setting to establish a wide variety of short-term employment-oriented simulations, given the wide range of professions and environmental demands in such places and the relative facility an inside employee may have in developing such a simulation.

Situational assessments can be arranged to match the demands of training environments if the individual's vocational goals include training. Arrangements can be made for individuals to sit in on classes on a time-limited basis, or they can attend professional seminars or continuing education courses to assess their response to training at this level. In any context, a situational assessment permits evaluation of executive function across time and in the face of real-life demands and conflicts that closely parallel the employment or educational settings in which the person will need to function.

Cognitive endurance, ability to adjust to new demands and learn from the environment, social interactions with coworkers and supervisors, and problem-

solving with transportation can all be observed during a situational assessment, even in a field unrelated to the individual's expressed vocational goal. The individual's ability to perform in his or her own environment may be markedly different than performance in other settings would predict, and should be assessed through direct observation. Observations can be completed at the individual's job site, in the classroom, or in his or her home, depending on the individual's level of functioning

Individual Choice

A third aspect of career guidance and exploration is the issue of consumer choice, or empowerment, especially in relation to vocational goals and choices about future employment and training. An individual may not spontaneously propose a vocational path that a professional deems most feasible, or may decline to participate in formal VR efforts when initially approached. It may be tempting to impose vocational goals on an individual that from an outside perspective appear to be a good fit. Ultimately however, each individual will need to maintain the motivation and commitment to the training and employment outlined, and will not be able to do so unless the choice was made freely. These issues have been detailed in a 2005 Institute on Rehabilitation Issues paper.⁶

Intervention and Training

In general, opportunities for intervention in VR fall broadly into three categories: (1) enhance the person's abilities; (2) change or modify the environmental demands; or (3) both. In terms of ability, VR may provide funding for a training or educational program to prepare the veteran for a new career. VR may also provide counseling or learning supports to assist veterans with the challenges of the new learning environment, particularly if the disability has a cognitive or emotional component. VR may also make environmental modifications, such as purchasing modified work stations, assistive technology, or other strategies in an environment that facilitates employment.

VR uses numerous strategies to support veterans as they return to employment. Among these are assistance in finding employment (job development), on-the-job coaching that diminishes over time as the veteran becomes more capable (job coaching), temporary employment positions that provide an opportunity to improve work skills (transitional employment settings), and on-the-job development of compensatory strategies and accommodations that allow the veteran to work competitively. The concept

of supported employment using some version of a job coach has been a part of VR for individuals with significant disabilities since the 1980s.^{7,8} Concurrent with outpatient rehabilitation, institutional settings such as warrior transition units (or medical holding companies) offer an opportunity to initiate return to work in a supported, safe environment without demands on the client to meet the level required of competitive employment.

The current use of structured and supervised employment with professional support in VA hospital settings, or compensated work therapy (CWT), is one version of a supported employment program. CWT is a recovery-oriented model of VR to assist veterans with disabilities in gaining prevocational and vocational skills through employment opportunities throughout the VA and with local businesses based upon the individual's goals. CWT offers supported employment services while providing vocational assistance and counseling for a predetermined amount of time. Veterans work a specified number of hours each week as part of the therapeutic process to develop appropriate work habits and to facilitate the transition into full-time employment. Some CWT programs also have a CWT/transitional residence program to offer additional support with housing while the veteran is using CWT services.⁹ Service members with complex acquired disability, however, may need professional support on the job over an extended period of time, and the psychosocial model of CWT may not be able to provide the full complement of vocational supports necessary.

Follow-Up Services

The "endpoint" for successful VR is controversial. Each program involved in VR is likely to have defined for itself a measure of successful outcome, but in the interests of serving the combat amputee, successful rehabilitation should better be conceptualized as a path rather than an endpoint. Work environments are dynamic, with ongoing and unpredictable changes in supervisory practices, coworker relationships, and intensity of workload; concurrently, physical status and stamina after amputation may also change over the years due to chronic pain, prosthesis comfort and tolerance, or prosthesis functionality. It is critical that any time a service member is referred for some aspect of VR, follow-up contact is maintained to ensure that the requested services are provided and that they result in the intended consequence. Frequently, multiple barriers arise unexpectedly, and medical professionals working with a combat amputee may need to reassess or redefine the VR plan.

SUPPORTS AND SYSTEMS FOR VOCATIONAL REHABILITATION OF THE COMBAT VETERAN

Psychosocial Adaptation to Amputation

Early in the rehabilitation of the combat amputee, it is critical to facilitate psychosocial adaptation to disability. It is much less important who intervenes to accomplish this, and much more relevant that all medical professionals providing services to the combat amputee have a basic orientation to possible psychological responses and changes after amputation.

It is important to communicate to the combat amputee that rehabilitation is a learning process, requiring rehearsal of new skills and a willingness to try new ways to accomplish old tasks. Neither acute rehabilitation nor eventual return to employment comes without attention, effort, and motivation to acquire new strategies, sequences of movement, and new attitudes and values. At times, the VR process may seem distant or unclear, and in fact it requires tolerating a high degree of ambiguity. This rehabilitative process involves ongoing change and modifications to the individual's overall level of function. Consequently, amputees cannot rapidly make an internal determination about their ultimate level of function.

One goal of rehabilitation professionals is to facilitate coping with amputation. Livneh et al¹⁰ examined coping responses in a group of 61 amputees, noting that coping styles of amputees are similar to other groups of people dealing with a variety of illness or other life stressors. Generally, individuals chose between active coping/problem-solving perspectives versus denial, optimism versus pessimism, and seeking external support (talking to others, asking advice) versus internally oriented acceptance.

A wide variety of personal factors may be involved in psychosocial changes after amputation. Shifts in body image and personal identity, phantom pain or residual limb pain, and emotional changes related to depression or anxiety have all been noted in other amputee populations as potential areas complicating recovery. Horgan and MacLachlan¹¹ reviewed a wide range of published studies on psychosocial outcomes after amputation, concluding that better adjustment was associated with active coping, optimism, good social support, increased time since amputation, and less pain. These characteristics make intuitive sense, but are often lost in considering a specific individual and where professional intervention may fit at the current stage of the rehabilitation process.

Service members with amputations will encounter a wide range of professionals as they traverse their rehabilitation paths, most of whom have an opportunity to provide some aspect of psychosocial support that

ultimately will facilitate return to independence and employment. General themes that may appear in any contact with service members include distress over appearance, a shift in personal values and goals, and identifying personally relevant goals to maintain motivation and stamina throughout the long rehabilitation process. Professionals may also be able to support service members as they begin to compare strengths and limitations of their "new self" in comparison to their "old self," offering a sounding board as amputees rehearse new ways to explain their current circumstances and changes to others. Veterans are also faced with the need to rapidly absorb complex medical information, synthesize it with family needs and personal values, and make weighty decisions about return to active duty, surgical and other treatment options, and use of prosthetics. These topics are all best addressed in a supportive, nonconfrontational manner, with repeated discussion until the veteran has become comfortable with a decision.

The Veterans Affairs Vocational Rehabilitation System

The VBA and DoD now operate a complex and detailed system of benefits that support VR for service members with a service-connected disability. An overview is provided here along with a description of VR services that may also be found in some VA healthcare facilities. An excellent summary is also offered at www.vetsuccess.gov. It is critical to note that funding and overall direction of VR occurs not within the hospital system but in the veterans' benefits system.

The primary vehicle in the VA system to implement rehabilitation plans is in the VBA Office of Vocational Rehabilitation and Education (VR&E). The VR&E employs rehabilitation counselors, housed under the VBA in regional offices, to develop and implement rehabilitation plans for veterans with disabilities. Typically, veterans with at least a 20%-level of service-connected disability are eligible to apply for VR under Chapter 31 of Title 38 of the US Code. For many veterans with significant disabilities, however, prevocational programs including ongoing therapy and community reintegration are required as the initial step in the VR process. The VA system may provide these services under an independent living program.

VR&E rehabilitation counselors assist veterans in applying to the program using Form 1900. Once the veteran is found eligible, VR&E may provide services under a rehabilitation plan for extended evaluation, independent living, or education and training. The VA

process includes significant opportunities to ensure that veterans with a disability are fully prepared before initiating a formal education/training process.

Services for VR within VA hospitals currently vary widely from facility to facility. Those with the greatest emphasis on rehabilitation, particularly the polytrauma centers, are best equipped to provide face-to-face direct VR evaluation and career guidance. Increasingly, VA hospitals also have implemented the CWT program.

The Public Vocational Rehabilitation System

Each state is required by the federal government to establish and maintain a public VR system for citizens with disabilities. Established in 1920, the funding

stream for public VR is now a mix of federal and state monies. Eligibility for VR services is based on documentation of disability and the decision that the disability represents a significant obstacle to competitive employment. The public VR system can provide a wide variety of resources and supports for an individual, including counseling, assessment, job development, and job coaching, as well as financial support for tuition and other fees associated with vocational training programs. The public VR system defines itself as the "payor of last resort," meaning that services should always be funded first by any other resource. Hence, the veteran who incurred an amputation in combat may more likely receive VR services under the VA, but may still be eligible for some public benefits, such as reimbursement of transportation.

A MODEL SYSTEM FOR VETERANS WITH DISABILITIES

VR services for veterans under Chapter 31 involve an exchange of information and collaboration between the VBA VR&E counselor and a contractor. A model program to facilitate rapid entry into the VBA VR system and timely deployment of a rehabilitation plan has been developed and disseminated by the joint efforts of the VR service of the Tampa, Florida, VA and the local regional benefits office in St Petersburg.¹² An outline of this model is provided here.

The Tampa model requests consultation from all programs that serve veterans likely to qualify for or need VR services upon admission; this ensures that the veteran will be identified as a potential VR candidate early in the rehabilitation process. The model includes ongoing collaboration between a VA VR specialist, a VBA VR&E counselor, and the assigned contractor in the community brought in to facilitate the rehabilita-

tion plan. This collaboration includes face-to-face meetings and participation, when feasible, in client staffing. The VA hospital staff facilitates any necessary medical appointments for evaluation, triaging the requests. VA staff initiate vocational evaluations with veterans when relevant and appropriate, and maintain ongoing cross-training between the two entities. Notably, the VR&E staff are considered primary stakeholders in the VR process, sharing common outcome measures in client satisfaction and effectiveness measures. The regional office also maintains an out-stationed VR&E counselor at the hospital, greatly facilitating the partnership. For service members who participate in inpatient rehabilitation services in a VA setting, this approach is critical to timely and coordinated benefits and access to appropriate services as they transition home or to other services.

SUMMARY

This short overview of the VR process for the combat amputee has reflected the complex nature of returning to employment after limb loss. The process requires assessment and involvement of the service member as well as knowledge, access, and coordination across numerous systems of support and institutional bureaucracies. Even for those individuals who

experience a rapid and successful return to competitive employment, education, training, and follow-up to anticipate and manage changes in the work environment successfully are critical to long-term retention of employment. Initiating discussions and referrals related to VR is one of numerous preliminary steps in the rehabilitation of the combat amputee.

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