

CHAPTER 9

MENTAL HEALTH

INTRODUCTION

9.1 Mental health is a key aspect of a member's overall health status. A member can be completely healthy in other respects, but if they are not mentally fit, their ability to function and perform their military duties may be partially or totally impaired. 'Mental disorders account for a large proportion of all chronic ill health, and people's mental capabilities determine, to a large extent, their ability to protect their health and to achieve the maximum benefits from the health services that are available.'¹ As this quote indicates, mental health is closely linked with physical health. The importance of mental health can be seen in its selection as one of the five top National Health Priority Areas in Australia.² Not only must Australian Defence Force (ADF) members be mentally healthy to carry out their day-to-day roles, but also they must be able to effectively operate in the extremely physically and mentally stressful environments that are often associated with military operations.

9.2 'Individuals differ in their sense of wellbeing and their behavioural functioning. However, in some people there are symptoms and behaviours which are distressing to them or others and which impair their social functioning. These can be classified into different types of mental disorders. Mental disorders may require treatment to alleviate symptoms and to provide rehabilitation of impairment. In some cases the severity of a disorder warrants hospitalisation.'³ Until very recently data on the mental health status of Australians have been minimal. However, during the period from 1993–98, initiatives by the Commonwealth, States and Territories under the National Mental Health Strategy have led to a number of improvements in the development and collection of data on a range of mental health issues.

9.3 This chapter will seek to discuss relevant data available in the ADF related to mental health. This will include data covered in a more general sense under other chapters related to deaths (ie suicides); hospital admissions; invalidity retirements; workplace injury and illness reports and compensation claims; PULHEEMS data, etc. An attempt has been made to pull all relevant mental health data together from a variety of different sources.

SUICIDES

9.4 As discussed in [chapter 7—'Mortality'](#), suicide and self-inflicted injuries are a major cause of death among personnel in each of the Services. During the period from 1994 to 1998 an average of 1.6 Royal Australian Navy (RAN) personnel committed suicide (a rate of 1.1 per 10 000 personnel per year) and suicide accounted for 19 per cent of all RAN deaths. In the Army an average of 3.8 suicides and deaths from self-inflicted injuries occurred over the period from 1994 to 1998 (1.5 per 10 000 per year), accounting for 15 per cent of all deaths. From 1994 to 1998 there were an average of 1.8 suicides in the Royal Australian Air Force (RAAF) per year (1.0 per 10 000 per year) and suicides accounted for 18 per cent of all deaths. Although suicide rates in the ADF are lower than the population at large, they still warrant special attention not only because of the loss of the victims, but also because of the detrimental impact of suicides on the organisation and on the victims' associates. [Chapter 7](#) also refers to preventive measures.

1 J.M. Last, Ed., *Public Health and Preventive Medicine*, 11th edition, 1980, Appleton-Century-Crofts, page 1304.

2 Australian Institute of Health and Welfare (AIHW), *Australia's Health 1998*, pages 103–08.

3 AIHW, page 102.

INVALIDITY RETIREMENTS

9.5 As discussed in [chapter 2—'Invalidity retirements'](#), mental diseases were the second leading cause of medical invalidity retirements in the ADF in Financial Year 1997-98 (FY 97/98). The definition of medical retirements is found in chapter 2, [paragraph 2.2](#). In FY 97/98, 35 Class A and B retirements under Military Superannuation and Benefits Scheme (MSBS) were due to mental diseases. This represented 16 per cent (35 cases) of all Class A and B retirements under MSBS. In addition, 11 per cent of Class C retirements (25 cases) under MSBS were also related to mental disease. Under Defence Force Retirement and Death Benefits (DFRDB) there were 12 Class A and B retirements and two Class C retirements for mental disorders representing 19 per cent of all invalidity retirements. A total of approximately 11 per cent of all invalidity retirements were related to mental diseases. [Table 9-1](#) is a summary of all ADF retirements for mental diseases.

	MSBS Retirements ADF		DFRDB Retirements ADF		Total Retirements ADF	
	Class A & B	Class C	Class A & B	Class C	Class A & B	Class C
No.	35	25	12	2	47	27
%	47	34	16	3	64	36
Total	60 (81%)		14 (19%)		74 (100%)	

Table 9-1: Invalidity retirements for all Australian Defence Force retirements for mental disease (Military Superannuation and Benefits Scheme and Defence Force Retirement and Death Benefits)

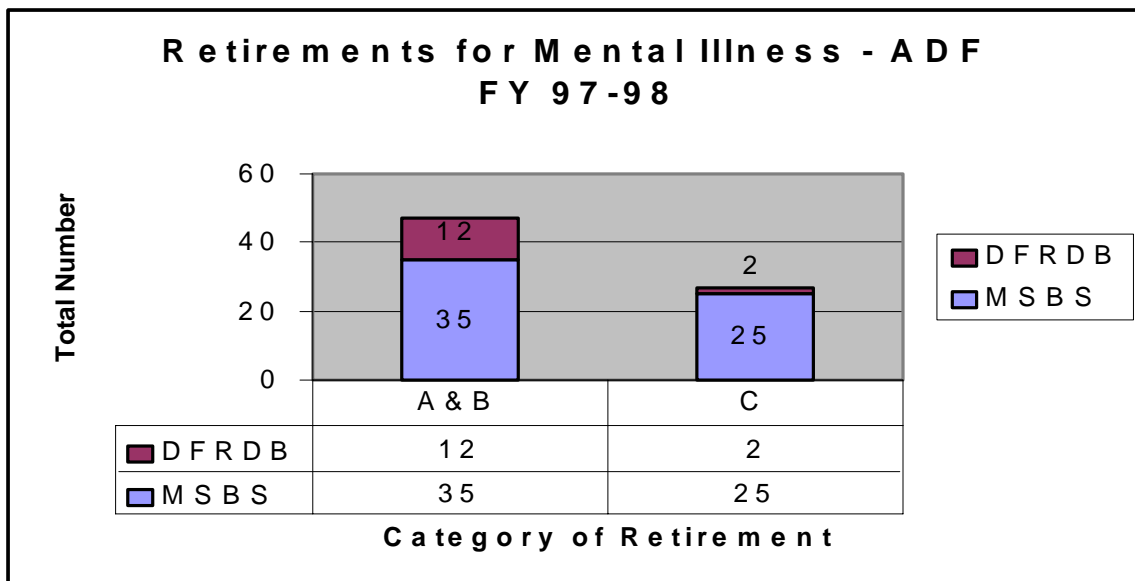


Figure 9-1: Retirements for mental illness—Australian Defence Force FY 97/98

WORKERS COMPENSATION CLAIMS

9.6 The number of workers' compensation claims related to stress from FY 92/93 to FY 96/97 ranged from 66 to 179 with an average of 122. The number of claims climbed steadily from FY 92/93 to FY 95/96 and then decreased the following year. Claims for stress accounted for an average of 2.3 per cent of all workers' compensation claims received with a range of 1.9 to 2.8 per cent. The average rate of stress-related workers' compensation claims was 82 per 10 000 full-time equivalent personnel per year with a range of 43 to 122. The overall outstanding liability estimate other than incapacity payments determined by the Australian Government Actuary for stress-related claims was

\$9.1 million as at 30 June 1997. The breakdown of the estimate is shown in [table 9-2](#). Stress-related claims account for 2.8 per cent of outstanding liability other than incapacity payments and four per cent of total outstanding liability.

Injury Group	Permanent Impairment	Non-Economic Loss	Medical Expenses	Rehabilitation	Other	All
Stress Related	\$2.8M	\$2.1M	\$3.2M	\$0.2M	\$0.8M	\$9.1M

Table 9-2: Stress-related Workers' Compensation outstanding liability claims estimate at 30 June 1997 for non-incapacity payments

WORKPLACE CASUALTY REPORTS

9.7 In FY 97/98 a total of 33 casualty reports to DEFCARE were related to mental disorders among full-time ADF personnel. These casualties resulted in eight days spent in hospital, 248 sick days and 81 light duty days for a total of 337 working days lost. Of the casualties reported, 19 were related to 'other anxiety conditions', 12 were related to 'acute reaction to stress', and one each was related to 'mental disorders' and 'neurotic disorders with underlying psychological conditions'.

HOSPITAL ADMISSIONS

Royal Australian Navy

9.8 Mental disorders were the fourth leading International Classification of Diseases (ICD) grouping associated with working days lost related to admission of RAN personnel to hospitals, accounting for an average of 8286 working days lost (WDL) per year or 12.7 per cent of WDL from FY 95/96 to FY 97/98. The number of WDL associated with admission to hospital for mental disorders has increased by a total of 39.2 per cent over the period studied. The average WDL per admission related to mental disorders was 31.4 with a range of 29.5 to 33.2. In terms of the number of admissions, mental disorders was the sixth leading ICD grouping associated with admission to hospital with an average of 264 admissions per year or a rate of 18 per 1000 personnel per year. The number of admissions increased by approximately 32 per cent over the three-year period from FY 95/96 to FY 97/98. Mental disorders represented an average of 6.5 per cent of admissions of RAN personnel to hospital over the period from FY 95/96 to FY 97/98.

9.9 The top 12 mental disorders associated with admission of RAN personnel to hospital from FY 95/96 to FY 97/98 are shown in [table 9-3](#). The number of admissions due to 'alcohol dependence syndrome', 'neurotic disorders' and 'depressive disorder, not elsewhere classified' has increased steadily over the three-year period. Admissions related to 'alcohol dependence syndrome' increased by over 84 per cent over the three-year period while admissions due to 'neurotic disorders' increased by over 56 per cent and admissions due to 'depressive disorders not elsewhere classified' increased by 130 per cent. The number of admissions due to 'acute reaction to stress' and 'adjustment reaction' has fluctuated, but has also shown a generally increasing trend with each increasing by over 25 per cent during the three-year period. Although this data only represents a trend over three years, it does indicate that additional analysis of data on mental disorders in the RAN is warranted.

Army

9.10 Form PM 38—*Monthly Statistical Summary of Causes of Admission to Hospital* includes four 'psychiatric' categories of admission to Army hospitals. The data for FY 97/98 are summarised in [table 9-4](#). 'Transient Situational Disturbances' were by far the most common mental disorders resulting in admission of Army personnel as reported on Form PM 38. An analysis of 'other admissions' data from Lavarack Medical Centre indicated that there were three admissions associated with alcohol rehabilitation and two associated with alcohol withdrawal.

Reason for Admission	No of Admissions				Average Rate (per 10 000 per year)
	FY 95/96	FY 96/97	FY 97/98	Average	
Alcohol dependence syndrome	45	47	83	58.3	39.8
Neurotic disorders	32	45	50	42.3	28.8
Depressive disorder, NEC	20	36	46	34.0	23.1
Acute reaction to stress	24	45	30	33.0	22.4
Adjustment reaction	27	37	34	32.7	22.2
Nondependent use of drugs	22	24	10	18.7	12.7
Affective psychoses	19	10	14	14.3	9.8
Special symptoms or syndromes, NEC	12	10	11	11.0	7.5
Other non-organic psychoses	2	6	5	4.3	2.9
Personality disorders	5	1	3	3.0	2.1
Physiological malfunction resulting from mental factors	4	2	1	2.3	1.6
Schizophrenic disorders	3	2	1	2.0	1.4

Table 9-3: Most common mental disorders associated with admission of Royal Australian Navy personnel to hospital

Reason for Admission	No of Admissions	Rate per 10 000 per year
Transient situational disturbances	185	65.8
Personality disorder	6	2.1
Psychosis	3	1.1
Psychoneurosis	1	0.4

Table 9-4: Most common mental disorders associated with admission of Army personnel to hospital

Royal Australian Air Force

9.11 A summary of the total number of admissions related to mental disorders for RAAF personnel is provided in [table 9-5](#). There was an average of 132 admissions to hospital among RAAF personnel for mental disorders from FY 92/93 to FY 95/96, accounting for 2.1 per cent of all admissions. With the exception of FY 93/94 when the admissions rate dropped considerably, the admissions rate for mental disorders in the RAAF has remained relatively constant with an overall decrease of 9.8 per cent from FY 92/93 to FY 95/96.

ICD Grouping	FY 92/93	FY 93/94	FY 94/95	FY 95/96	Avg.	Avg. Rate per 10 000 per year
Mental Disorders	162	98	139	129	132	71.9

Table 9-5: Admissions of Royal Australian Air Force personnel to hospital for mental disorders from FY 92/93 to FY 95/96

ARMY PULHEEMS DATA

9.12 The Army PULHEEMS system of medical classification provides some information that may be useful in assessing mental health for Army personnel. More specifically, the PULHEEMS quality S (Stability) reflects a member's psychiatric stability in the military environment. A summary of data on this PULHEEMS quality as of February 1999 is presented in [table 9-6](#). Given that all personnel would enter active duty with a degree of 2 for 'Stability', any changes would reflect a diminishment of capacity based on a consultant psychiatric examination. As of February 1999, 65 personnel had experienced some diminishment in psychiatric stability, 15 had experienced markedly diminished stability, and 11 were medically unfit for any form of service due to psychiatric instability. A further four personnel were under medical care and unfit for duty based on psychiatric instability. Tracking PULHEEMS data over time may provide useful information on trends in mental fitness related to deployability. The majority of personnel with a history of mental illness are considered deployable.

PULHEEMS Degree	0 or 0R	2 or 2R	3 or 3R	7 or 7R	8 or 8R
No of full-time personnel	4	23 415	65	15	11
% of personnel	0.0	97.0	0.3	0.1	0.0

Table 9-6: Summary of PULHEEMS quality 'stability' for full-time Army personnel as of February 1999

INSERVICE ASSESSMENTS AND CASELOADS

General

9.13 The Directorate of Psychology—Navy produced a summary of Caseloads and Assessments for the period from 01 January to 31 December 1997 that may provide useful information for assessing the mental health of Navy personnel. Part 2 of this report provides summaries of inservice caseloads and assessments conducted primarily at Naval establishments. This data may serve as a useful indicator of potential mental health problems.

Summary of psychological caseloads and assessments

9.14 Total. Table 9-7 provides an abbreviated summary of psychological assessment and caseload information and includes rate calculations and the ratio of female to male rates of cases/assessments.⁴ The leading source of cases/assessments among Navy personnel was anxiety/stress/adjustment with a total of 1029 cases and a rate of 700 per 10 000 personnel per year. Training problems and relationship issues accounted for over 400 cases each in 1997. Disciplinary/suitability assessments and medically related cases each accounted for over 300 cases over the same period. Depression/grief and other counselling each accounted for over 200 cases per year. There were 125 cases related to critical incident stress management (CISM) or Post-Traumatic Stress Disorder (PTSD). A further 87 cases were associated with drug and alcohol problems and 33 cases were related to suicide gestures or attempts. Data was not available to allow an assessment of trends in rates over time. Future health status reports would benefit from a discussion of trends, as more data becomes available.

9.15 Differences by gender. Overall, females presented for psychological assessment/counselling at a rate 2.5 times that of their male counterparts. With the exception of clinical assessments, females had higher rates of cases/assessments for all reported categories in table 9-7. Rates of cases/assessments for sexual harassment and assault; suicide attempt or gesture; depression/grief; anxiety/stress/adjustment; medically related counselling; and relationship issues among female personnel, all occurred at over twice the rate for male personnel. *Australia's Health 1998* noted that there is a marked difference in mental wellbeing reported by young men compared with young women, with the difference between the sexes narrowing with age.⁵ During 1997 the Australian Bureau of Statistics (ABS) conducted the National Survey of Mental Health and Wellbeing as part of the National Mental Health Strategy. Using the Composite International Diagnostic Interview (CIDI) to measure mental disorders, the ABS reported that women were more likely to experience anxiety disorders and affective disorders than men. The female to male ratio for anxiety disorders and affective disorders was 1.7 and 1.8, respectively. However, men experienced an incidence of substance use disorders over twice that of women, and the overall prevalence of mental disorders was 17.4 per cent in men and 18 per cent in women.⁶ Further research into differences between rates among men and women for various mental health indicators discussed in this report would provide a more comprehensive picture of whether or not differences in mental health exist between men and women in the ADF and could determine potential reasons for these dissimilarities.

VETERANS COMPENSATION CLAIMS FOR MENTAL DISORDERS

9.16 A total of 4422 disability compensation claims accepted by the Department of Veterans' Affairs (DVA) in FY 97/98 were related to mental disorders, which represents 11.9 per cent of all claims accepted. Table 9-7 summarises claims information from DVA for mental disorders from July 1997 to June 1998. Over 2500 claims for PTSD were accepted by DVA in FY 97/98. PTSD was the most common mental disorder for which claims were accepted in FY 97/98, and accounted for 6.8 per cent of all claims accepted. Overall, PTSD was the sixth most common condition for which claims were received by the DVA in FY 97/98. Other mental disorders with a large number of claims accepted by DVA included psychoactive substance abuse or disorder (794), generalised anxiety disorder (638), and affective psychoses (322). These disorders were the 15th, 18th and 22nd leading conditions for which claims were received by DVA between June 1997 and July 1998. In addition, there were 86 claims accepted for anxiety due to general medical condition and 66 claims accepted for adjustment disorder. Thus,

4 A. Backhouse, M. McNamara, and A. Twomey, Caseloads and Assessments 01 January to 31 December 1997, Directorate of Psychology—Navy, page 19.

5 AIHW, page 103.

6 AIHW, page 104.

mental disorders are seen to have a significant impact on veterans' health as measured by DVA claims accepted. Since only claims that are considered to be service-related are accepted by DVA, this points out the potential long-term mental health impact of military service and the importance of prevention efforts. Although average cost figures were not available for each category of claim, the cost in terms of monetary compensation is likely quite high. This would be in addition to the substantial effects on the quality of life of many veterans.

Mental Disorder	Claims Accepted	Claims Rejected	Total Claims	Rank in Terms of Overall Claims Frequency
PTSD	2506	220	2726	6
Psychoactive substance abuse or disorder	794	306	1100	15
Generalised anxiety disorder	638	330	968	18
Affective psychoses	322	358	680	22
Anxiety due to a general medical condition	86	25	111	71
Adjustment disorder	66	71	137	66
Panic disorder	4	7	11	140
Personality disorder	2	55	57	96
Acute stress disorder	2	1	3	181
Bipolar disorder	2	30	32	109
Schizophrenia	0	12	12	138
Psychalgia/Tension Headache	0	191	191	50
Dementia pugilistica	0	7	7	156
Suicide or attempted suicide	0	1	1	217

Table 9-7: Claims received by Department of Veterans' Affairs related to mental disorders for July 1997 to June 1998

Service Provided Assessments	Male	Rate (M) (per 10 000 per year)	Female	Rate (F) (per 10 000 per year)	Total Cases	Total Rate (per 10 000 per year)	Female/Male Rate Ratio
Anxiety/stress/adjustment	651	522.8	378	1680.7	1029	700	3.2
Training problems	362	290.7	74	329	436	296.6	1.1
Relationship issues (family: marriage, etc)	290	232.9	125	555.8	415	282.3	2.4
Disciplinary/suitability assessments	333	267.4	59	262.3	392	266.6	1
Medically related (eg eating disorders)	214	171.9	101	449.1	315	214.3	2.6
Depression/grief	139	111.6	106	471.3	245	166.7	4.2
Other Counselling	119	95.6	87	386.8	206	140.1	4
Voluntary discharge assessments	114	91.6	40	177.9	154	104.8	1.9
CISM, PTSD	97	77.9	28	124.5	125	85	1.6
Clinical assessments	107	85.9	17	75.6	124	84.3	0.9
Sexual harassment/assault	27	21.7	84	373.5	111	75.5	17.2
Drug/alcohol problems	70	56.2	17	75.6	87	59.2	1.3
Suicide gesture or attempt	14	11.2	19	84.5	33	22.4	7.5
Total	2537	2037.4	1135	5046.7	3672	2458.6	2.5

Table 9-8: Number and rates of psychological cases and assessments for the Royal Australian Navy for FY 96/97

COMPARISON TO RELEVANT BENCHMARKS

Mental health in Australia

9.17 The 1995 National Health Survey collected information on general health and wellbeing using the SF-36 instrument. The Mental Component Summary of the SF-36 is derived from a subset of items that ask respondents about their general mental health (eg the amount of time spent feeling nervous or happy) as well as any role limitations due to emotional problems (eg lack of care in performing activities), their vitality (eg the amount of time spent feeling 'full of pep'), and their social functioning (eg the impact that emotional problems might have in curbing social activities). An ADF-wide health survey might provide useful information on the overall health of ADF personnel, including mental health. The benefits and costs of conducting such a survey should be assessed. Using the SF-36 instrument would allow direct comparisons to the general Australian population. Similarly, a survey using the CIDI to measure mental disorders similar to the National Survey of Mental Health could be considered to provide a source of broad-based epidemiological data on the mental health status of the ADF.

9.18 A summary of hospital separations related to mental disorders in Australia in 1995-96 is summarised in [table 9-9](#), which was extracted in abbreviated form from *Australia's Health 1998*.⁷ Comparing [table 9-9](#) to [table 9-3](#) it can be seen that the Navy appears to have higher rates of admission to hospital for alcohol dependence syndrome, nondependent use of drugs, neurotic disorders, depressive disorder, not elsewhere classified, and other non-psychotic mental disorders than the general Australian population. The higher RAN rate for neurotic disorders may be at least partially explained by the fact that civilian patients are rarely admitted to hospital for neurotic disorders since their management is nearly totally done on an out-patient basis. On the other hand, conditions of service in the Navy account for why members are admitted for these problems (eg if a member has claustrophobia they are removed from the ship/submarine where they are experiencing the problem). The RAN had an overall rate of admissions for mental disorders that was 1.7 times that of the Australian population at large. However, the RAN had lower rates of admission than the general population for dementia, other organic psychotic conditions, schizophrenic disorders, affective psychoses, personality disorders, and drug dependence. It is important to note that better comparisons could be made if the data were age-standardised, and the period covered (three years) is relatively short to draw definitive conclusions. However, the data presented in this report would suggest that further research is warranted.

9.19 Similarly, by comparing [table 9-9](#) to [table 9-4](#) it can be seen the Army has a far higher rate of admission for transient situational disturbance than the general population. Among RAAF personnel the rate of admissions for mental disorders was 68 per cent of that for the Australian population. Additional analysis is required to determine the rates of specific mental disorders for RAAF personnel. Given the fact that the RAN and Army conduct psychological screening as part of their overall recruit screening processes, these results may seem somewhat surprising. However, service in the military, particularly during operations,⁸ can be very stressful. Given the large amount of time that many Navy personnel spend at sea, the impact of operational stress factors may have a more profound effect on the RAN. Another factor may be a lower threshold for admission of single personnel in each of the Services.

9.20 Interpretation of these comparisons is difficult due to the unreliable nature of the data and potential inconsistencies in reporting. The data is likely to be inconsistent across different reporting group and locations due to the differing systems across the ADF, differing levels of diagnostic capacity amongst reporting personnel and the likelihood of under-reported co-morbidity amongst patients. Mental illness diagnostic categories commonly occur together in the same patient, for example a chronic illness may be exacerbated by an acute event or as in often the case in mental illness, the patient may present with symptoms of multiple syndromes. The incidence of co-morbidity could not be determined for this report, but may be the reason for the differences between RAN and Australian Regular Army (ARA) data.

7 AIHW, page 106.

8 ADFP 714—*Operational Stress Management*, chapter 2, page 2-2.

Mental Disorder	ICD-9-CM Code(s)	% of All Mental Disorders	Separations per 10 000 population
Dementia	290, 294.1, 331.0	5.93	6.3
Other organic psychotic conditions	291-294	5.78	6.1
Schizophrenic disorders	296.2-296.3	15.46	16.4
Other affective psychoses	296	6.78	7.2
Paranoid states	297	0.91	1.0
Other psychoses	298-299	2.24	2.4
Neurotic disorders	300	9.93	10.5
Personality disorders	301	4.06	4.3
Sexual deviations and disorders	302	0.12	0.1
Alcohol dependence syndrome	303	6.90	7.3
Drug dependence	304	3.06	3.2
Non-dependent drug use disorder	305	3.09	3.3
Depressive disorder, nec	311	4.54	4.8
Other non-psychotic mental disorders	306-310, 312-316	15.15	16.0
Total mental disorders		100.0	100.6 ^(a)

Note

(a) Calculated value.

Table 9-9: Hospital separations for mental disorders in Australia in 1995-96

PREVENTION OF MENTAL ILLNESS AND PROMOTION OF MENTAL HEALTH

9.21 As previously mentioned, mental health is one of Australia's five National Health Priority Areas. Though limited in many ways, the data in this report suggests that mental health should also be a major health priority area in the ADF. Using the National Mental Health Strategy as a guide, the ADF is developing an ADF Mental Health Strategy. Such a strategy will include appropriate mental health indicators, mechanisms for uniform data collection, and strategies for the promotion of mental health and the prevention of mental disorders. It will also incorporate a suicide prevention strategy. The development of an effective strategy would require the efforts of a multi-disciplinary team of psychiatrists, psychologists, social workers, chaplains, medical personnel, etc with input from commanders. Personnel with expertise in health promotion, health surveillance, and other related disciplines would also be important.

9.22 Psychological screening occurs prior to enlistment for all ADF personnel. It may be possible through further study to determine the adequacy and accuracy of the selection criteria, in what circumstances these criteria can be waived and whether the results of this testing could contribute to predictive factors for the development of mental illness in the ADF.

9.23 Current data available to assess the mental health status of the ADF is fragmented and incomplete. This data is likely to be inconsistent across different reporting group and locations due to the differing systems across the ADF, the differing levels of diagnostic capacity amongst the reporting areas, and the likelihood of under-reported co-morbidity amongst patients. Efforts should be made to determine which mental health indicators are useful for the ADF and to seek to develop uniform schemes of data collection throughout. Implementation of the ADF Health Surveillance System⁹ will allow for uniform capture of some primary care data on mental health during peace and operations.

CONCLUSIONS

9.24 Data on mental health in the ADF is fragmented and inadequate to assess the overall mental health status of the Force.

9.25 Although suicide rates in the ADF are lower than for the general population, suicide is a leading cause of death among ADF personnel and warrants continued vigilance.

9.26 Mental disorders were the second leading cause of invalidity retirements in FY 97/98.

9.27 Claims for stress accounted for 2.3 per cent of all workers' compensation claims from FY 92/93 to FY 96/97. The overall outstanding liability claim estimate other than incapacity payments for stress was \$9.1 million as of 30 June 1997.

9.28 In terms of psychological assessments and caseloads, women in the RAN received services at a considerably higher rate than men for most categories of service. This may reflect similar trends in the Australian population.

9.29 A total of 11.9 per cent of all claims accepted by DVA in FY 97/98 (4422 total) were related to mental disorders. Post traumatic stress disorder was the most frequently accepted claim among mental disorders and the sixth highest category of claim received by DVA.

9.30 The report highlights the requirement for a more effective integrated program to prevent, detect and treat mental illness across the ADF. A comprehensive ADF Mental Health Strategy is required and is currently under development.

