Good afternoon. On behalf of the Department for Veterans Affairs I'd like to thankyou for coming to this session. My name is Geoff Madden and I've just closed my Sat morning surgery early to dash up from Beenleigh to talk to you. When I'm not in General Practice I'm a medical adviser to the department in Brisbane. My job there is basically to explain admin things to doctors and medical things to admin types.

We are here as part of a response by the department to the problems of mental health in the veteran community. In the Policy and Strategic Directions document you will thrilled to know that you are here as part of Strategic Direction 1.2. - so you know where your place in life is – at least for the next few hours.

This aims to: "Strengthen the mental health role of primary health care."

Why is this important?

You can't fault the department on research –they went looking – and found out lots:

- The veteran community uses more mental health services than the general community.
- But still a large number of those with a mental health disability are not accessing specific mental health providers. (actually the consultants said that they were getting no mental health treatment.)
- They are seeing their GPs however – we know that because they are on prescription medication for their problems – someone had to prescribe it.

- In other words an awful lot of mental health treatment is being done by GPs – even in a group where there is no payment problem for the other services.
- In the general community
    - 1 in 5 over 18 have a mental disorder
    - 1 in 3 seek help
    - 3 in 4 see their GP only

Now you could argue that you could have all told us this without the research but that is not how things are done in government.

The next question is "Is that a problem?"

Well it is – and I'm sure you could all tell me what the barriers are to providing this treatment. I recently heard at a talk on GPs and mental health treatment of a doctor who no longer asks anything about the patients mood – because they knew that it would take too long to handle and they would not have any assistance in dealing with whatever came up. It was almost as if you actually listened to one depressed patient the word might get out and hoards would descend upon you.

- Time
- Remuneration
- Skill base
- Lack of support

The federal government is addressing some of these issues and it will be interesting to see how that pans out. DVA is addressing the question of a skill

base for our LMOs, which means not just opportunities to learn more about treatment, but also what other assistance is available to you as you co-ordinate the patient's mental health treatment.

As an introduction to the afternoon I thought it might be useful to apply some CBT to ourselves.

If we look for the cognitive basis for maladaptive thinking they have been usefully defined as

- Negative view of self (I don't have the skills)
- Negative view of the world (No one will help me)
- Negative view of the future (It's just going to get worse)

(The Cognitive Triad)

Cognitive errors Evidence

- All or nothing thinking – never give time for the situation to arise!
- Overgeneralisation – I can't help these people
- Mental filter
- Disqualifying the positive - discounting the good that's already being done
- Jumping to conclusions
- Magnification or minimisation
- Emotional reasoning
- Should statements
- Labelling and mislabelling
- Personalisation – this is my fault for not being a better doctor

What are the positive actions we could take?

- Continue to try and help
- Continue to learn more
- Embrace what is useful to you out of the new initiatives when they come out
- Eg Why not do CBT yourself ?