Everyone,

A bunch of Letters to the Editor in last Sunday's WS Journal included: "A big piece missing from the National Instant Criminal Background Check System puzzle is the mental health professions and their omerta philosophy." I had to look up "omerta." It refers to the Mafia value to remain silent.

The letter goes on to say, "all mental-health professionals should be required to report patients who voice homicidal ideation or lose their license." Not clear why that author wants to limit this requirement only to mental-health professionals.

Of course, it is against the law to make any threat to take the life of the president, former presidents, or presidential candidates. Maybe some might want to expand that to everyone? {Per our interest in classification, homicidal ideation code is R45.850 [not in DSM-5].}

At St Es, we used to have patients who made such threats and had later been found not guilty by reason of insanity. Not easy, as you can imagine, to decide your treatment had cured such, and the patient was ready for discharge.

In yesterday's WS Journal, quite different attitude than letter supra, was the letter:
"I Have OCD. Don't I Have Gun Rights? 'The mentally ill' is a much broader category than people often realize.. . .I am mentally ill. I won't bore you with the details, but I'm one of hundreds of thousands of Americans with a tough-to-treat, life-affecting neurosis known as obsessive compulsive disorder. . . . As it happens, I have no interest in owning a gun. But what if I did? Should society stop me? In the current debate following the Parkland massacre, there are many—including the president, moderates in Congress and even some gun-rights advocates—who say so. . . . I have to ask: How will you go about this? . . The idea of stripping rights from the mentally ill is a very slippery slope."

Today's NY Times:

1] Bring Back Asylums? page D1. As you would predicted, the Times contacted Bethesda's E. Fuller Torrey for his take on this topic. Fuller said, "No one seemed to care enough a generations ago, when so many became homeless. . . .Now they are going to prison, well, these are horrendous tragedies." Jennifer Mathis of the Bazelon Center argues against any return to asylums, saying that asylums failed badly, "its crazy and discriminating."

The article ends: "At the heart of the modern debate over new asylums are two questions awaiting answers: What is good mental health care, really? And what does its quality say about the society attempting to provide it?" We might add a third core question: Who should be the responsible agent, the feds?, the state?, the counties?, the private sector? Obviously, we want a lot from all, but it is hard to imagine a satisfactory system without clarity as to who is ultimately responsible.

This month's Psychiatric Services Journal:

Cognitive-behavioral therapy (CBT) contributes to consistently low rates of suicidal behavior among U.S. Army personnel who reported active suicide ideation or a suicide attempt, regardless of severity of suicidal intent. Nearly 41% of high-risk patients attempted suicide without receiving CBT compared with 8% of those who received CBT.

This month's American Journal of Psychiatry

1] Long-term SSRI treatment may delay progression from Mild Cognitive Impairment to Alzheimer's dementia.

2] Many questions remain and much more research will be needed to determine the effects of different types of computerized cognitive behavioral therapy [CCBT] (in person, video, tele–mental health, text, etc.) and what levels of training and credentials the support therapists must have to treat depression. As the authors point out in the discussion, so far studies of mobile apps with CBT content ***alone*** have not shown good efficacy for depression. As an additional approach, they may be quite valuable.

3] Whether for the purpose of improving general health or the possibility of improving clinical symptoms, it would be beneficial for health care providers to assess physical activity and educate patients about exercise as a treatment option. Integrating exercise as a core component of early psychosis treatment for those who wish to undertake it has a range of potential benefits for mental and physical health, including potential synergies with other treatment components.

Good to see in today's Washington Post that researchers are attempting to develop a pill that mimics the effect of exercise for those who cannot exercise, e.g. the frail.

Per our interest is classification, the following from IVD-10-CM [not in DSM-5], relate to frailty:

F43.0 Combat fatigue: DSM-5 uses this code for Acute Stress Disorder
R53.81 Malaise,
R53.82 Chronic Fatigue
R53.83 Fatigue NOS
R54 Age Related Physical Disability includes frailty

In Sentinels there may be the implication that DSM-5 is not as complete as we would like. Mea Culpa. I have been involved in the development of DSMs since 1975, and I never objected to DSMs lack of comprehensiveness.

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