All,

Three items on addressing the opioid epidemic, America's major medical challenge:

A] This month's J of AAC&AP suggests the following considerations:
1] Motivational enhancement therapy
2] Adolescent community reinforcement approach
3] Cognitive behavioral therapy
4] Family-based treatments

Although the evidence base is limited medication-assisted treatments such as extended release naltrexone, buprenorphine-naloxone or methadone should also be considered.

B] A major resource on prescribing opioids from Maryland's Office of Legislative Oversight: OLO Report 2017-11 June 20, 2017: Prescribing Opioids: Prescriber Education and the Maryland Drug Monitoring Program.

C] For those wanting a review of potential new approaches to the opioid epidemic now under study, July 27's NEJM: "The Role of Science in Addressing the Opioid Crisis."

NY Times, 25 July:

A] Describes England's efforts to offer free counseling and therapy for anxiety or depression. Usually an hour phone intake takes place within 24 hours, then a wait of about a month before therapy begins via phone, face-to-face individual therapy or group therapy depending on the intake's findings. While cognitive therapy dominates the approaches, intra-personal therapy and short-form of psychoanalysis is available. Medications are not mentioned. I gather that the primary-care physicians provide medications.

B] Article on a conference on procrastination, "procs," defined as "the purposive and frequent delay in beginning or completing a task to the point of experiencing subjective discomfort." DSM-5 would prefer "clinically significant distress," not "subjective discomfort." Article said that the incidence is about 20% from country to country, a surprise that it would not vary from country to country. Not in the article and not in DSM-5, but I assume that if treating procs and needing a code: "F60.89, Procrastination Personality Disorder."

JAMA Psychiatry, August: An editorial on modern electroconvulsive therapy says:

A] Recovery time used to be hours, now 15 minutes for bilateral, 10 minutes for right unilateral.

B] There used to be retrograde memory lost and sometimes other cognitive problems, now no cognitive deficits are found.

C] For geriatric depression, a 62% remission rate is seen.

D] Editorial champions ECT followed by pharmacological treatment, e.g., lithium or venlafaxine as most successful approach.

From Lakphy desk:

A] Use of nonsteroidal anti-inflammatory medications (e.g., ibuprofen) during vigorous exercise could overtax the kidneys and reduce muscles' ability to recover afterwards [NY Times, 11 July].

B] Physical activity and diet for individuals not at high risk for cardiovascular disease result in consistent modest benefits across a variety of important intermediate health outcomes across 6 to 12 months, including blood pressure and cholesterol levels with evidence of a dose response effect, with higher-intensity interventions conferring greater improvements [JAMA, 11 July, p175].

C] From Tufts Health and Nutrition Letter: Persons who increased number of steps/day from 1,000 to 3,000 reduced their mortality risk 12%. Those who increased to 10,000/d decreased their risk 46%. Higher aerobic fitness is linked to better cognitive functioning.

D] TIME magazine, 7 Aug, has a nine-page article championing ketamine for treating depression. On the tenth page, "treatments backed by science":

1] Physical exercise
2] CBT
3] Behavioral-activation therapy
4] Mindfulness Activation Therapy
5] Transcranial magnetic stimulation.

From 1975, the Washington Psychiatric Society has set the American Psychiatric Association agenda more than the other 73 District Branches -- not because WPS folks are smarter, but because WPS has been a strong supporter of the APA being a representative democracy, and thus make the most use of that governance. So, what would we suggest to WPS as to motions [Action Papers] that we would like to see on APA's agenda? I would welcome ideas.

Roger