

Health Care Unhinged

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“And though she’s not really ill | There’s a little yellow pill | She goes running for the shelter of a mother’s little helper | And it helps her on her way, gets her through her busy day.”

Sir Michael Philip Jagger and
Keith Richards

To date, there exists no thermometer to measure vacillations in a person’s mental health, which is a good thing for febriphobics, and generally

speaking, neither acetaminophen nor ibuprofen can cure mental illness, especially if the diagnosis is pharmacophobia. Unlike a fractured bone or sinus infection, ailments of the mind tend to be subjective and therefore more difficult to gauge. Just as a diagnosis of schizophrenia relies on a spectrum, psychotic examples range from hallucinations to speech impediments (even for glossophobics), and bipolar affective disorder by definition alternates between periods of elevated mood and depression. While the tenth revision of the medical classification system known as the International Statistical Classification of Diseases and Related Health Problems (ICD-10) contains more than 14,400 different physical health concerns, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), still hovers around a paltry 300 disorders from which to choose.

We Know What We Do Not Know

The dearth of clearly identifiable mental disorders is a disheartening factor for the 3.1% of American adults who have presented with

serious psychological distress within the past 30 days, or the 1.5 million hospital inpatients discharged with psychosis as the primary diagnosis, the average length of stay for whom was 7.2 days (and this not fast enough for those inpatients with nosocomphoia). Add to such dismal figures some 63.3 million visits to doctors (not including iatrophobics), as well as emergency departments or other outpatient clinics, and top off the numbers by including the 41,149 suicides that took place in 2013 (which equates to 13 deaths by suicide for every 100,000 people), one does not need a PsyD to identify a serious problem.

Even when the risks have certain clarity, like the general population’s 1% at-risk status for schizophrenia, which jumps to 10% for those with a schizophrenic parent or sibling, or 50-60% with schizophrenic identical twin, the inability to test for, or even definitively diagnose such a malady sounds insane. And while medical conditions such as Ebola and Dementia continue to make headlines as being incurable, the prognosis of sufferers from Kluver-Bucy (presenting as memory

loss and the eating of inappropriate objects) and Diogenes (the hoarding of random items and pets, though not by disposophobics) remains equally dismal.

Parity Does Not Mean Clarity or Evenhanded Implementation

Notwithstanding the disparity between identifying and treating mental health and medical concerns, the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) focused on preventing health insurance agencies from imposing unequal benefit limitations upon the two. While MHPAEA had certain limitations in its initial application across health plans, the Affordable Care Act effectively eliminated any imperfections in parity. Today, a qualified health plan must include at least ten essential health benefits, although certain states require more. California, for example, mandates “chemical dependency services” must be consistent with MHPAEA, including inpatient detoxification, outpatient evaluation and treatment for chemical dependency, transitional residential recovery services or chemical dependency treatment in a residential recovery setting.

For those not quite ready to accept the changes to the mental health industry brought about by health care reform, it may be of some consolation to know that the traditional AA program now extends anonymity to those suffering from online gaming (OLGA), cluttering (CLA), underearners (UA), workaholics (WA) and spenders (SA), to name but a few. Perhaps an AA-appropriate elective should replace driver’s education in each high school curriculum

(with at least one exception for amaxophobics and possibly both for didaskaleinophobics).

Funding a public system for mental health is in many ways as complicated as diagnosing the diseases themselves. With monies from the state, counties, the federal government through Medicaid, Substance Abuse and Mental Health Services Administration block grants, and CHIP programs, one of America’s greatest challenges is to protect the integrity of these funds for the intended beneficiaries. Unfortunately, even the combined strength of MHPAEA and the Affordable Care Act cannot fully stop the payer system synapses from misfiring. Medicaid still has sizeable gaps for adults (21 to 64) seeking mental health coverage, and the payer mix for mental health and addiction treatment in particular is about as functional as a patient diagnosed with dissociative identity disorder. Left untreated, the cost of substance abuse to society is close to \$900 billion (factoring in a combination of lost productivity, increased health care costs, and the burden on the criminal justice system, as well as the further cost to victims of related crimes).

The Challenge to Provide Treatment

In antiquity, the Oracle of Delphi or “Pythia” delivered information in the form of prophecies after inhaling oleander vapors rising from the limestone at Mount Parnassus in central Greece. These seemingly epileptic advisors counseled some of ancient Greece’s best and brightest, although even Hunter S. Thompson understood how helpless and irresponsible a person in the

“depths of an ether binge” could be. As mental health disorders continue to steal center stage (except for those with topophobia), treatment options remain confusing to more than just decidophobics. Likewise, the ranks of mental health practitioners tasked with doling out diagnoses can be equally disparate, including primary care physicians, psychiatrists, psychopharmacologists, mental health nurse practitioners, psychologists, social workers, members of the clergy and counselors.

While psychotherapy and prescription medication have made great progress in the past 20 years, the list of cognitive therapy treatments still ranges from rational-based (rational emotive and rational behavior therapy as well as rational living therapy) to dialectic behavior therapy. Today disfavored by many health care professionals (and avoided by electrophobics), certain patients still undergo shock or electroconvulsive therapy. Newer brain stimulation options include transcranial magnetic stimulation, vagus nerve stimulation and deep brain stimulation, among others. Residential treatment centers provide an important alternative to psychiatric hospitalization, especially when such facilities extend treatment to an actual curriculum complete with the promotion of life skills and general functionality in an environment similar to that which may have contributed to the original condition at issue.

Though many of the treatments listed above are voluntary, sometimes personal choice is not an option. In many west coast states, involuntary psychiatric

holds may be used with a person suspected of being a danger to him or herself or others due to his or her mental illness. While able medical and mental health practitioners shepherd patients through such treatments, each temporal extension of an involuntary hold includes ways in which the patient can seek

emancipation. To be sure, mental illness is a condition, not a crime, and while there is no right to a jury trial, a writ of habeas corpus may still apply. In much the same way as mental illness is diagnosed and treated, the law of involuntary holds that was designed to protect society can be unpredictable at best.

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