

# By providing more money without looking at how treatment is offered, Clinton's mental health agenda is a false economy.

[blogs.lse.ac.uk/usappblog/2016/09/02/by-providing-more-money-without-looking-at-how-treatment-is-offered-clintons-mental-health](https://blogs.lse.ac.uk/usappblog/2016/09/02/by-providing-more-money-without-looking-at-how-treatment-is-offered-clintons-mental-health)

9/2/2016

*This week, Hillary Clinton announced a new agenda for mental health if she wins the White House in November, which would increase funding and would create parity of mental health services within the US healthcare system. [Elizabeth Cotton](#) writes that while Clinton's new policy has promise, it does not address how mental health services are delivered, and by who. Not only is the agenda over reliant on short term behavioral interventions, but the precariousness of work in the US, combined with the private healthcare system, raises questions for those who might seek treatment and provide it under it.*



On Monday this week, Hillary Clinton release a new comprehensive [agenda](#) on mental health, which provide more funding would integrate healthcare systems. The political positioning of Clinton's agenda is pure recessionary politics and gets to the heart of the political conflict now being lived out in the US elections. The new policy builds a wall between a politics where vulnerability is equated to failure, and a humanistic understanding of what happens to human beings in the context of an economic and social crisis.

The cynical amongst us might [wonder](#) if politicians during an election campaign are experts in mental health, but this drawing of the line is of both strategic and ethical importance. In a country where in-work poverty goes up to 25 percent, racism and inequalities create escalating societal violence and the next generation of working people feel defeated even before they start this is a real battle line, rather than the fantastical geographical ones that have dominated the campaign so far. If the experience of mental illness teaches us anything, it's that we are all vulnerable to distress and whatever attempts are made to split the world into hard working people and scroungers, when it comes to the human condition we are all in it together.

The US and UK mental health climates are not so different, in part because they are parallel neo-liberal market economies which are both characterized by minimal welfare provision, high workplace insecurity and a growing inequality of opportunity.

Forty three thousand people committed suicide last year in the US, up by 25 percent since 2008. The rise in race conflict and violence in poor communities has led to the emergence of a new concept in social distress – '[suicide by cop](#)'. As the crisis deepens, societal denial is becoming harder to maintain, and there is a growing acceptance that an economic and social crisis is becoming a mental health one. This is not to pathologize poverty, rather to [recognize](#) that under certain conditions people become ill.

Clinton's new policy has promise. It involves two main elements – firstly, to create a parity of mental health services within the US healthcare system and along with it an increase in funding. The [policy](#) is evidence based, prioritizing early intervention, a growth in child and adolescent services and community teams, and a focus on rehabilitation for prisoners, veterans and addicts.

The second key area of this new policy has an important psychosocial aspect – to fund housing and employment support for people with mental health problems. This reflects the chronic discrimination people face in work. As with the UK, 80 percent of people with disabilities are unemployed and if you are diagnosed with schizophrenia you [face](#) a 95 percent chance of never working again.



The unavoidable reality is that If you want to deliver good mental health services, you have to treat the people that deliver them with the same degree of humanity as their patients.

- Elizabeth Cotton, Middlesex University Business School

One of the key problems that this new policy faces is about the delivery of these mental health services. More than the 'quasi-market' system of the NHS, and despite the reform in health insurance and creation of a [public healthcare insurance scheme](#) through the Affordable Care Act, the US has a private system of healthcare. Although the growth in private insurance, separate from company insurance schemes, is likely to lead to a greater uptake in mental health services, the problem remains that the disclosure of mental health problems that is involved is a major risk for working people in the US.

The problem is that most working people in the US, and increasingly in the UK, are [precarious](#). They do not have secure contracts of employment and with it the fear that to disclose mental health problems they will trigger a silent victimization. The US has one of the most insecure employment relations systems in the developed world – where employment 'at will' allows the vast majority of employers to terminate employment without specifying a reason. This allows employers to terminate contracts without making the link to a diagnosis for bi-polar disorder or long term sick leave due to depression. This raises significant questions over whether working people will feel secure enough to risk pursuing treatment for mental health problems, much of which is long term.

The second question is the policy's focus on 'behavioral' techniques, a specific technique for addressing individual behaviors. In the UK where the model of Cognitive Behavioral Therapy (CBT) dominates, this technique focusses on changing individual cognitions and behaviors – sometimes described as 'negative' thoughts and behaviors- rather than underlying or environmental issues. Within an underfunded system this model becomes diluted – to the extent that in the UK the largest program of Increased Access to Psychological Therapies (IAPT) is mainly a short term intervention of 4 to 6 sessions, often over the phone or manualised online. The political and clinical problem with this model is that it focusses on the individual to address systemic problems such as in-work poverty and inadequate public services.

This has led to an emerging system of downgraded sub-therapy and care and a regime of compulsory fitness founded on gaming 'recovery' data and demoralized workers. There are not many people who have experienced depression who believe that four sessions actually work in the long term to help them. This radical shift towards un-care is welcomed with wide open strategic arms by the thousands of private contractors and employment agencies waiting to negotiate the next round of health contracts.

The other problem with the policy is that it needs to address the precarity of the people delivering these services. This year I carried out the largest anonymous survey of mental health workers in the UK: one thousand five hundred

people anonymously talking about the experience of working in services in crisis. At the risk of pointing out the obvious, dealing with an increasingly distressed population is distressing. It means that the job has got harder, is increasingly low paid and insecure resulting in 60 percent of clinicians feeling depressed. The results of the survey will be published in October 2016 but this is not rocket science – you can't have vulnerable workers trying to contain the anxieties of vulnerable patients. Long term it just doesn't work.

It is a false economy to commit funding for a new mental health service in the US without looking at what treatment is offered and by whom. Learning from the mistakes of the UK, the US would do well to look at the precarious conditions and states of minds of the clinicians delivering services. The unavoidable reality – rather than the fairy stories of magic solutions and full recovery – is that if you want to deliver good mental health services, you have to treat the people that deliver them with the same degree of humanity as their patients.

*A free resource for frontline workers in healthcare has been launched by Surviving Work and the Tavistock & Portman NHS Trust here [www.survivingworkinhealth.org](http://www.survivingworkinhealth.org)*

*Featured image credit: [Hillary for America](#) (Flickr, [CC-BY-NC-SA-2.0](#))*

*[Please read our comments policy before commenting.](#)*

*Note: This article gives the views of the author, and not the position of USAPP – American Politics and Policy, nor the London School of Economics.*

*Shortened URL for this post: <http://bit.ly/2c6Pjtx>*

---

## About the author

**Elizabeth Cotton** – *Middlesex University Business School*

**Elizabeth Cotton** is a Senior Lecturer at Middlesex University Business School. Her academic background is in political philosophy and current writing includes precarious work and employment relations, activism and mental health at work. She is working on her new book, *Surviving Work in Healthcare: Helpful stuff for people on the frontline* (Taylor & Francis 2017).



- CC BY-NC 3.0 2015 LSE USAPP