

# Good Practice Awareness Guidelines

For Consumers with  
Mental Health Problems  
and Debt

Money Advice Liaison Group

Second edition  
Autumn 2009



**Strategist and communications expert Alastair Campbell, Mind champion of the year, also supports these Good Practice Guidelines.**

*“One in four of us will directly experience mental illness during our lifetime. For many, those problems are exacerbated by financial problems, sometimes in part caused by the mental health problems. It cannot be entirely a coincidence that the word depression has an economic as well as a health meaning. According to Credit Action, personal debt in the UK stands at £1,457bn. These Guidelines will go a considerable way to assisting all the relevant organisations to work together to ensure that both mental health and financial difficulties are identified so appropriate support can be provided.”*



**Comedian and writer Stephen Fry applauds the 2nd edition of The MALG Mental Health Good Practices Guidelines.**

*“My own bipolar condition has caused me to go on many giddy spending sprees so I have first hand experience of the difficulties of debt brought on by poor mental health. I fully support the work being undertaken by the Money Advice Liaison Group in this complex and sensitive area and believe this has the potential to be a very beneficial resource for creditors, debt collection companies and advisers attempting to assist the consumer suffering serious mental health problems.”*

# Foreword by Anthony Sharp

## Chair of the Money Advice Liaison Group



The Money Advice Liaison Group (MALG) is delighted to publish this second edition of the Mental Health Good Practice Awareness Guidelines for the industry concerned with consumer credit and debt.

The first edition of these Guidelines was published

in November 2007 and was the result of two years of concentrated work by a MALG Mental Health Working Party. The original and current membership of the Working Party is listed at Appendix 3 of the Guidelines.

This second edition does not add to, subtract from, or substantively amend any of the Guidelines, but simply brings the document up to date. This is an exercise I hope you will agree is important, as we are dealing with a working document. In tandem with this exercise, in July 2009, we published a redesigned version of the Debt & Mental Health Evidence Form, originally launched in August 2008.

In order to assist you in understanding the background to the Guidelines, I would draw your attention to the Introduction of this document, which lays out the need and rationale for the work and the extent of MALG's involvement with it.

This important document contains fifteen robust recommendations that should enable creditors and advisers to understand each other's positions, in order to better support consumers with mental health problems to resolve their debt issues and thus assist everyone to work towards good practice in this sensitive area.

MALG is a non-policy making body, so we cannot impose these Guidelines on either the advice or the creditor sector. On the other hand, we can and do now place them in the public arena, and would encourage trade organisations within the industry to adopt and build the Guidelines into their respective

Codes of Practice/Statements of Good Practice and/or recommend them to their members as a positive step towards best practice.

The Guidelines have recently been promoted in the White Paper issued by the Department for Business, Innovations & Skills entitled "*A Better Deal for Consumers-delivering real help now and change for the future*". Also The Office of Fair Trading's Guidance on Irresponsible Lending, due to be published in the Spring of 2010, strongly recommends the use of the Debt & Mental Health Evidence Form, an integral part of the Guidelines themselves, as an appropriate means of obtaining evidence from consumers experiencing mental health problems.

I commend these valuable Guidelines to you, and fervently hope that they will go a long way to improving understanding and communication among all parties. The Guidelines have only come about through the hard work, skill, generosity, and dedication of the contributing organisations and their representatives, who believe in the principles of MALG and who wish to assist people less fortunate than themselves.

Finally, I wish to offer the sincere thanks of The Money Advice Liaison Group to Charis Grants which has so generously funded the production of this second edition and to all those who have participated and continue to participate in the MALG Mental Health Working Party.

A handwritten signature in black ink that reads "Anthony Sharp". The signature is written in a cursive style with a period at the end.

**Anthony Sharp**

Chair of the Money Advice Liaison Group

# Foreword by Joanna Elson

## Chief Executive of the Money Advice Trust



Experts indicate that over ten million people in the UK experience some form of mental illness at some time in their lives, and in happiness ‘guru’ (Lord) Richard Layard declared that mental health issues had overtaken unemployment as the number one problem in the UK.

Employers consider how best

to cope with and support employees with mental health problems, the media seize on happiness classes in schools as a metaphor for our times, and the cost to the economy of mental health problems is estimated at around 2% of GDP in lost output.

Given the high percentage of people in the general population experiencing mental health problems, it is not surprising that a proportion of those in debt come from this group – in fact it would be surprising if they didn’t.

When Elaine Kempson, the last but one reviewer of the Banking Code, wrote her recommendations back in the summer of 2004 about how the Code should be changed, she wrote:

*“The debt problems faced by people with mental health difficulties have only recently begun to be acknowledged. There are particular difficulties where mental health conditions impair people’s ability to maintain repayment schedules. I recommend that Code sponsors work with the national money advice associations listed in the Codes to agree guidance on the most appropriate ways for subscribers to assist people who have diagnosed mental health problems that impair their ability to handle money.”*

Mike Young, the most recent reviewer, also recommended that Code sponsors should consider importing MALG’s mental health guidelines into their codes of practice.

Robert Skinner, my predecessor as Chief Executive of the Money Advice Trust and now Chief Executive of the Banking Code Standards Board (soon to be the Lending Standards

Board), chaired a piece of work on mental health and debt, which we now call ‘phase 1’ of the project, to develop guidelines for creditors and the advice sector to take note of.

I was asked late in 2006 to chair the working party in taking that piece of work on to the next phase, and specifically to:

- review recommendations from the previous working party in the light of the feedback from consultation
- produce an illustrative list of types of mental health conditions and medications that might affect contracting or payments of debts, in order to assist all parties in understanding better this very complex area
- explore practical ways of building greater trust between advisers, creditors and debt collecting agents when handling cases involving consumers with mental health problems, ie, who should be considered to be a trusted agency as far as creditors and people in debt are concerned
- refine the Guidelines, so that they are in a proper state to be placed in the public arena for trade bodies, wherever possible, to consider including them in their respective Codes of Practice

These activities resulted in the production of the first edition of these Guidelines, which were published in November 2007. I am indebted to members of the working party, drawn from creditors, the advice world and the mental health profession for their sterling input

We have tried to be pragmatic in this work, and it is our hope that it will help advisers in seeking to achieve the optimal situation for their clients, for creditors in offering the most appropriate range of options for consumers (including via inclusion of relevant guidelines into industry codes), and, above all, for people who are in debt and have mental health problems.

A handwritten signature in black ink that reads "Joanna Elson". The signature is written in a cursive, slightly slanted style.

**Joanna Elson**

Chief Executive, Money Advice Trust

# Contents

<b>Introduction</b>		<b>6</b>
<b>Guidelines and supporting guidance</b>		<b>11</b>
<b>Appendix 1</b>	<b>Selected Glossary of terms used when describing mental health problems</b>	<b>21</b>
<b>Appendix 2</b>	<b>Different types of health and social care professionals</b>	<b>24</b>
<b>Appendix 3</b>	<b>Membership of the MALG Mental Health Working Parties</b>	<b>25</b>
<b>Appendix 4</b>	<b>Items tabled by the MALG Mental Health Working Party for further discussion and potential exploration and progress so far.</b>	<b>26</b>
<b>Appendix 5</b>	<b>A list of those mental health organisations that have endorsed these Guidelines</b>	<b>28</b>
<b>Bibliography</b>		<b>30</b>

A pdf version of these Guidelines is available at [www.malg.org.uk](http://www.malg.org.uk), [www.moneyadvicetrust.org](http://www.moneyadvicetrust.org) and [www.rcpsych.ac.uk/debt](http://www.rcpsych.ac.uk/debt).

Paper copies are available on request from Marie Coles, Secretary to MALG: [info@malg.org.uk](mailto:info@malg.org.uk)

# Introduction

## Some parameters and assumptions

### General points

MALG is a non-policy making body, and as such cannot impose these Guidelines on either the creditor or advice sector. However, we believe that the Guidelines indicate good practice in the treatment of consumers with mental health problems, and hope that they will result in a greater awareness of the difficulties such people face.

Creditors operate within a highly regulated environment and it should be understood that compliance with statute, case law, regulatory requirements and principles takes precedence over these Guidelines.

The Guidelines deal with best practice in the management of debt, ie recommendations regarding what can be done when a consumer is already in financial difficulty.

At the time of going to print, these Guidelines do not include guidance for best practice in relation to lending decisions, but in due course MALG intends to explore this area as a separate but related piece of work – See Appendix 4 for further comment.

### Which mental health conditions are covered by these Guidelines?

Mental health problems can be caused, or result, from a range of factors. There can be direct or underlying biological or organic, psychological, and social causes.

This guidance does not distinguish between mental health problems resulting from these factors. In other words these conditions are regarded as being in scope of the Guidelines, to the extent that their impact on consumers is such that it will affect their financial/debt management skills.

In particular, it is worth noting that biological or organic mental illnesses are covered by this guidance. These refer to those conditions either caused, or resulting from, disease of the

Central Nervous System. For example, dementia, Alzheimer's, amnesiac disorders, and Parkinson's disease are all organic mental illnesses.

Furthermore, there will be situations where physical health problems can cause or result in the development of mental disorders. For example, brain tumours or head injuries are neurological conditions, but can cause psychosis, depression, mania, and anxiety. Similarly, depression could be 'caused' by HIV or cancer (eg, following initial diagnosis, or the trials of living with the condition etc).

Psychiatrists and other health or social care professionals provide care and treatment for mental health problems. In doing so, they will consider the biological, psychological, and social factors underpinning the condition, and will devise an appropriate programme of care. Where there is doubt about a customer's mental health problem, appropriate evidence and guidance can be sought from these professionals.

### Mental capacity

The Guidelines do not deal with mental capacity issues.

### Collections and recoveries

These Guidelines do not distinguish between collections that seek payments out of income and recoveries that seek payments out of security. It is acknowledged that different approaches may well apply to different products and that, notably, where there is a secured asset involved, practice may differ. In particular, delay in the sale of a secured asset may cause further hardship to the borrower, which is clearly not the intention of this guidance.

### Joint and several liability

It is worth clarifying that in cases involving issues of joint and several (separate) liability, ie, where a person has taken out a loan jointly with another consumer and the terms of the loan are not being adhered to, the party who is not experiencing mental health problems would continue to be regarded as liable for the debt, both in law and from the 'everyday'

perspective of the creditor. In other words, the fact that one of the two borrowers was experiencing mental health problems that affected their ability to manage their financial commitments would not necessarily be grounds for the creditor to take account of these Guidelines.

### Scottish law

Please note that references to Scottish law are made, where relevant, in the body of the text.

### Some key definitions

In this report, the term “*mental health problem*” is used to refer to the range of mental experiences that can limit a consumer’s ability to cope with day-to-day living.<sup>1</sup> Being mentally healthy means having the ability to adapt and cope with change and to make the best of any situation you may find yourself in.

Unless otherwise specified, the term “creditor” is used in this document as a ‘catch-all’ to include both original lenders and third parties such as debt collection agencies/companies, and refers to any organisation to which a person owes money.

### The catalyst for these guidelines

There is considerable international evidence of a relationship between indebtedness and mental health problems. The Royal College of Psychiatrists and Rethink have published a comprehensive report that reviews this evidence, a piece of work that was made possible by financial support from the Finance & Leasing Association and the Money Advice Trust.<sup>2</sup>

In the UK, for example, consumers with mental health problems are nearly three times more likely to be in debt than others.<sup>3</sup> It is unsurprising, therefore, that advisers have become increasingly concerned to ensure that creditors have greater awareness of the impact of mental health problems and are able to respond in an appropriate way to consumers’ circumstances when they are made aware of such problems.

Whilst the diagnosis, care, or treatment of someone with a mental health problem is not the responsibility of creditors, they should nonetheless ensure that they have procedures in place to take account of the experiences and needs of the consumer and respond sensitively and positively.

Improvements can also be achieved in the approach taken by advisers and health and social care professionals to support consumers and the way they work with creditors in these circumstances, an aspiration that is particularly reflected in Guidelines 2 and 3. As a general principle, we seek a joined-up approach and encourage a dialogue between health and social care professionals, the advice sector, and the creditor sector.

### Objectives of the Money Advice Liaison Group (MALG) Mental Health Working Party

The aims of the Working Party are to make recommendations (“the Guidelines”) on good practice to the creditor sector and, where appropriate, to the advice sector and health and social care sector, and to highlight the Guidelines as representing key principles that we believe should be incorporated into consumer Codes of Practice.

The Guidelines are intended to be proportionate, practical, and applicable to a commercial environment. They also assume a desire by creditors to improve the services they provide, beyond the legal minimum requirements. Equally, the recommendations for advice agencies assume a willingness to (a) introduce greater standardisation in the way they interact with the creditor sector and (b) provide guidance and training to advisers regarding how to better support their clients.

The Guidelines do not seek to turn staff working in creditor companies into experts in mental health. However, we do hope that they will result in a greater awareness of the difficulties faced by some consumers, and encourage the implementation of policies and procedures to enable creditors to respond appropriately when they are made aware of a consumer’s mental health problem(s).

1 Mind, 2007.

2 Fitch C, Hamilton S, Bassett P, Davey R. Debt and mental health. What do we know? What should we do? Royal College of Psychiatrists, 2009

3 Office for National Statistics, 2002(a). A higher proportion of consumers with mental health problems report debt on every single indicator than those without similar conditions.

## The extent and impact of mental health problems

The Office for National Statistics estimates that one in six people is living with a mental health problem at any one time, roughly over seven million people between the ages of 16 and 74.<sup>4,5</sup>

The most common problems are anxiety and depression, which affect almost one in ten adults.<sup>6</sup> Rarer mental health problems such as schizophrenia and bipolar condition occur in around one in every 100 people.<sup>7</sup> Some conditions tend to affect particular social groups disproportionately – dementia, for example, affects 6% of people over 65, and 20% of those over 80.<sup>8</sup> We should also note that consumers may have more than one mental health problem.

The 'social invoice' associated with mental health problems is huge. In 2003, the Sainsbury Centre for Mental Health estimated the economic cost of mental illness for England to be around £77 billion.<sup>9</sup>

## Financial difficulty, debt, and mental health

The financial difficulties experienced by people with mental health problems can be caused by a range of factors, including:<sup>10</sup>

- Lack of money management skills
- Reliance on benefit income
- Fluctuations in income or an inability to work
- Unmet housing, care, or treatment needs
- Difficulties with communication
- Relationship breakdown

There is no one definition of financial difficulty. However, it is clear that in this context at least, it could be assessed according to both objective and subjective measures. These might include some of the indicators listed below.

## Objective measures

- A high proportion of income spent on servicing debt
- Arrears on credit commitments and domestic bills
- Variable and/or low income

## Subjective measures

A person might:

- Regard their financial situation as unmanageable or out of control
- Be unable to fully assess their financial situation
- Feel that their financial situation has become oppressive

Without monitoring or intervention, people with mental health problems who experience debt are at risk of falling into a problem debt spiral. Furthermore, in terms of consumer health, research indicates that debt is associated with anxiety and stress, depression, self harm or suicidal thoughts, and relationship strain and social isolation.<sup>11</sup>

There are numerous reasons why people with mental health problems experience higher than average levels of debt and arrears. These include:

- The fact that people with mental health problems often live on low incomes, and experience high levels of unemployment<sup>12</sup> – debt disproportionately affects those on low incomes.<sup>13</sup>
- The influence of (a) given mental health problem(s). The onset of mental illness, a consumer's condition exacerbating spending (eg, mania and spending sprees), or communication difficulties/withdrawal, can all contribute to personal debt.
- Low levels of awareness and intervention. There are relatively few training programmes or other resources for creditor sector staff dealing with how to work effectively either with consumers with debt and mental health problems themselves, or with the health and social care professionals who support them.

4 Office for National Statistics, 2000.

5 Office for National Statistics, 2000.

6 Office for National Statistics, 2000.

7 National Institute for Clinical Excellence, 2002; Royal College of Psychiatrists, 2006.

8 Social Services Inspectorate, 1996.

9 Sainsbury Centre for Mental Health, 2003.

10 It is acknowledged that not all mental health problems will lead to financial difficulties and not all personal borrowing will lead to debt problems.

11 Fitch C, Hamilton S, Bassett P, Davey R. Debt and mental health. What do we know? What should we do? Royal College of Psychiatrists, 2009.

12 Labour Force Survey 2002, 2003.

13 Department of Trade & Industry, 2005.

## Resources for the Health and Social Care Sectors

Major challenges exist for health and social care professionals who wish to engage with issues relating to debt and mental health. These problems arise in relation both to the extent to which professionals feel able to discuss debt-related issues with patients during routine assessments, and the degree to which they can access the knowledge, support and confidence to ask about patient finance in the first place. While it is a sound aspiration that professionals should receive basic 'debt first aid' training (knowing how to talk with patients about debt; knowing to whom they should be referred for further help etc) without being expected to become 'debt experts' themselves, how can this be achieved in practice?

One attempt to address these issues is the *Final Demand* pocket guide, the product of a collaboration between the Royal College of Psychiatrists and Rethink, and available at [www.rcpsych.ac.uk/debt](http://www.rcpsych.ac.uk/debt). Currently in its second edition (supported by the Financial Services Authority, with the first edition being funded by the Finance & Leasing Association), *Final Demand* is a guide for health and social care professionals, which deals with debt and mental health-related matters, and includes guidance on working with money advice services.

A fact sheet for health and social care professionals has also been produced by a coalition of organisations, led by the Money Advice Trust in partnership with the Royal College of Psychiatrists, Royal College of General Practitioners, Faculty of Public Health and Mind. This fact sheet discusses the relationship between debt and mental health, and outlines the benefits for mental health practitioners and people with mental health problems of working with money advice services. The fact sheet is available at [www.moneyadvicetrust.org/section.asp?sid=12](http://www.moneyadvicetrust.org/section.asp?sid=12).

## The Debt and Mental Health Evidence Form

A significant number of the recommendations in the Guidelines deal with collecting evidence to help demonstrate the impact of consumers' mental health problems on their capacity to deal with debt issues. It was agreed by all MALG stakeholders that there was a need for a tool that would enable advisers and creditors to request clear, relevant and comprehensive information in a standard format from health and social care professionals, as appropriate to each given situation.

As such, the Royal College of Psychiatrists, with financial support from the Money Advice Trust (MAT), was commissioned by MALG to develop a standard Debt and Mental Health Evidence Form (DMHEF). The DMHEF covers the following key areas:

- The identification of whether a consumer has a mental health problem that either (i) currently affects their ability to deal with money or (ii) means they will experience difficulties in being contacted by telephone, letter, or in person.
- A description of the person's mental health problems relevant to (i).
- Information about how any treatment or support a person is receiving for their mental health problems might affect their ability to manage money and debt matters.
- A summary history of the person's mental health problems that currently affect their ability to deal with money.
- An assessment of the general impact of the person's mental health problems on their life overall.
- A description of whether, and if so how, the person's mental health problems would affect their ability to manage money and debt matters.
- The estimated effects of different forms of debt recovery contact by third parties.

# Introduction (continued)

In order to ensure that it would meet the needs of all involved, the tool was rigorously tested with a variety of user groups and other stakeholders, including:

- Members of MALG's national forum
- Mental health service users and their carers
- Medical professionals
- Consumer creditor agencies
- Creditor trade associations
- Advisers
- The Information Commissioner's Office

Version 1 of the DMHEF for use by creditors and advisers, was launched in August 2008. Version 2, for use by advisers only, was launched in July 2009 and is available by downloading from either the Money Advice Liaison Group (MALG) website [www.malg.org.uk](http://www.malg.org.uk), The Money Advice Trust website [www.moneyadvicetrust.org](http://www.moneyadvicetrust.org) or the Royal College of Psychiatrists website at [www.rcpsych.ac.uk/debt](http://www.rcpsych.ac.uk/debt).

MALG will be considering the creation of a self help/creditor version of this Form later in 2009.

## Evaluation of The Guidelines & DMHEF

As of Summer 2009, The Royal College of Psychiatrists and The Money Advice Trust began work on a collaborative programme of research with creditors and debt recovery companies. Funded by the Friends Provident Foundation, the research will review the impact of existing initiatives such as these Guidelines and The DMHEF, with a view to supporting organisations to enhance their services for people with debt and mental health problems.

## Further information

Appendix 1 of this document provides a glossary of terms used to describe selected mental health problems.

Appendix 2 describes the different types of health and social care professionals who work with people with mental health problems.

Appendix 3 provides details of the membership of the two MALG Mental Health Working Parties that originally produced the Guidelines and of the current Working Party membership.

Appendix 4 summarises and provides an update report on a number of issues proposed by the MALG Mental Health Working Party for further discussion with the wider MALG membership. Any resulting initiatives taken forward would be designed to further help to broaden access to information and skills development and address other related points of practice, as appropriate.

A selection of other mental health and debt-related information resources is available on the following three websites – [www.malg.org.uk](http://www.malg.org.uk), [www.moneyadvicetrust.org](http://www.moneyadvicetrust.org) or [www.rcpsych.ac.uk/debt](http://www.rcpsych.ac.uk/debt).

# Mental Health Awareness Guidelines and Supporting Guidance

## Guideline 1

### **Creditors should have procedures in place to ensure that consumers in debt with mental health problems are treated fairly and appropriately.**

- 1.1 Creditors should consider their processes and systems to ensure that they can be responsive to a consumer<sup>14</sup> in financial difficulties, from the point at which the creditor is made explicitly aware of (a) mental health problem(s).
- 1.2 The creditor will need to take steps to establish whether the mental health problem affects a consumer's ability to manage money and debt, based on relevant testimony to be provided by the consumer and/or their representative. Guidelines 12 and 13 below provide further guidance regarding the collection of relevant evidence.
- 1.3 The creditor will also need to establish whether the mental health problem will affect a consumer's ability to deal with telephone, letter, or face-to-face communication, based on relevant testimony to be provided by the consumer and/or their representative.
- 1.4 It is important to remember that the fact a consumer has a given mental health problem, formally diagnosed or otherwise, is not of itself an indicator of their relative inability to manage money and debt. The issue is the effects of the consumer's condition (and/or associated medication). These effects will differ from one consumer to another, and may vary over time.
- 1.5 The appropriate response from creditors will differ in each case, and could involve a range of approaches, including:
  - Working positively with an advice agency
  - Promptly carrying out agreed actions
  - Being flexible in responding to offers or schedules of repayment
  - Sensitively managing communications with the consumer (for example preventing unnecessary and unwelcome mailings)

- 1.6 Version 1 of the DMHEF was launched in August 2008. and is available by downloading from either the Money Advice Liaison Group (MALG) website [www.malg.org.uk](http://www.malg.org.uk), The Money Advice Trust website [www.moneyadvicetrust.org](http://www.moneyadvicetrust.org) or the Royal College of Psychiatrists website at [www.rcpsych.ac.uk/debt](http://www.rcpsych.ac.uk/debt). Creditors who wish to contact health/social care professionals directly (with the consent of the person in debt) can continue to use version 1, available on all three of the above websites.
- 1.7 Of key importance is the need for creditors to be mindful of mental health issues and ensure that they have systems in place to be able to respond appropriately. Such a high-level commitment should be enshrined in relevant codes of practice. By way of example, the Finance & Leasing Association (FLA) Code states:

#### ***“Health problems***

*We will take particular care if you are suffering from health problems, including mental health difficulties, when we are made aware of this.*

*This includes:*

- *Appropriately training staff to handle accounts, including those dealing with complaints and collecting debts for us; and*
- *Being sensitive to your condition and responding appropriately when dealing with you or someone authorised to act on your behalf.*

*In order to do this we may need to ask for appropriate evidence of your health problem and may need your permission to record this information on our system.”<sup>15</sup>*

- 1.8 It is also recommended that creditor agencies publicise and share examples of good practice from within their own organisations with colleagues across the industry.

<sup>14</sup> Unless otherwise specified, the term “consumer” is used to refer to a consumer who is in debt.

<sup>15</sup> Section IC.5 of the FLA Code.

# Mental Health Awareness Guidelines and Supporting Guidance (continued)

## Guideline 2

**Relevant staff should be trained on the reciprocal impact of mental health problems and people's ability to manage money and debt.**

### *Creditor agency staff*

- 2.1 Once procedures have been developed, it is important to ensure that staff have the ability to implement them where necessary. For example, if collections staff are more sensitive to the issues, it is likely that this will improve their communication with consumers experiencing mental health problems, and will assist the overall management of those consumers' accounts.
- 2.2 It is important that volumes, types and levels of training should be proportionate both to the structure and staffing arrangements of collections agencies/ departments and to the role profiles and daily activities of consumer workers.
- 2.3 Creditor agencies that use specialist teams to work with consumers with mental health problems should also consider how the expertise that members of these teams possess can be shared with other colleagues via informal/semi-formal cascading, in-house training courses etc.

### *Advisers and health and social care professionals*

- 2.4 Adequate skills and knowledge are not a concern for the creditor sector alone. Advisers may well need to be trained on the relationship between mental health problems and debt and, conversely, practitioners in the health and social care fields may benefit from training on debt advice issues, whether to act as initial problem noticers or more.
- 2.5 Across all sectors, training should ensure clarity about the need for workers to recognise the limits of their competence and refer on to specialist colleagues or other agencies as appropriate.

### *Working towards a training strategy*

- 2.6 The Money Advice Trust (MAT) has offered training sessions on mental health and debt to all Financial Inclusion Fund (FIF) advisers.

A one-day course on the subject is now included within MAT's wiseradviser branded portfolio of courses in England and Wales.

- 2.7 MAT's partners in Scotland are now adapting these materials for advisers working in Scotland and, with funding from MAT, will provide a series of one-day courses. The materials will also be made available to MAT's partners in Northern Ireland should they wish to add the course to their programme.

In addition a number of lenders have approached MAT and the Institute of Advisers (who are working in partnership) to request training on debt and mental health for their teams.

All the above materials will be amended to incorporate the second edition of the Guidelines, and supporting information/documents will be available on [www.wiseradviser.org](http://www.wiseradviser.org)

## Guideline 3

**Creditors, advice agencies and health and social care professionals should work in a joined-up way.**

- 3.1 It is important that members of each agency helping to resolve a person's debt problems work together, exchange information (with clients' consent), and explain what might be unfamiliar working practices to each other. Better dialogue overall may lead to potential financial difficulties being addressed at an earlier stage.
- 3.2 Developing relationships at local and regional level via mechanisms such as the MALG Regional Fora,

Community Mental Health Team contacts etc, will help to join up the 'three points of the triangle'. In particular, advisers would need to work closely with health and social care professionals in relation to people whose mental health problems have a significant impact on their ability to manage money.

- 3.3 There is also a need to develop and maintain high-level links at a national level between and among creditors, advice sector bodies, and health and social care agencies to ensure ongoing commitment to and promotion of the principles enshrined in these Guidelines.

## Guideline 4

### **Creditors should have procedures in place to accurately record relevant information on client files and manage accounts appropriately.**

#### *Case management and recording*

- 4.1 Information relating to a consumer's physical or mental health or condition is termed "sensitive personal data" under the Data Protection Act 1998, and can only be processed if the consumer concerned has given his or her explicit consent to that processing taking place. In addition, any organisation that intends to process sensitive personal data must first ensure it is included on the register of data controllers maintained by the Information Commissioner's Office ie is the organisation properly registered under the Data Protection Act 1998.
- 4.2 "Explicit consent" is not defined in the Data Protection Act, but the giving of such consent should be absolutely clear. The creditor should give the consumer an adequate explanation of why the information is being collected, how it will be used, and to whom (if anyone) it will be disclosed.
- 4.3 While explicit consent does not necessarily have to be provided in writing, there should be clear evidence

that the steps required to ensure the fair and lawful obtaining of such sensitive data have been taken. It may be enough to ask for consent over the phone, but it is suggested that such calls should be recorded wherever possible. Routines designed to obtain consent to the processing of non-sensitive data cannot be assumed to be sufficient where sensitive data are concerned.<sup>16</sup>

- 4.4 Creditors should follow the Act's requirement that information must be accurate and, where necessary, kept up to date. Some further information regarding the Act and issues of relevance and currency is provided in the guidance to the Debt and Mental Health Evidence Form, referred to in the introduction to the Guidelines, which is available at any of the following three websites:- [www.malg.org.uk](http://www.malg.org.uk), [www.moneyadvicetrust.org](http://www.moneyadvicetrust.org), or [www.rcpsych.ac.uk/debt](http://www.rcpsych.ac.uk/debt).
- 4.5 It is very important, that once relevant information about the effects of a consumer's mental health problem(s) has been notified, an accurate note is kept on the consumer's file, which is shared across relevant parts of an organisation.
- 4.6 In terms of general good case management and client liaison, we recommend that:
- Procedures are put in place to record sensitive personal data
  - Sufficient and appropriate training is provided to staff (please refer to Guideline 2)
  - Maximum possible flexibility is applied at first points of contact in relation to referring consumers on for specialist assistance
  - Appropriate levels of discretion/authority are conferred on frontline staff in order to enable them to make account management decisions wherever possible
  - Supporting/covering letters from third parties such as advisers, which may provide detailed explanatory

<sup>16</sup> We are grateful to Diane Williams of The Capital Partnership and to Stephen Weeks of the Mail Order Traders' Association for their expert assistance in the drafting of these paragraphs.

# Mental Health Awareness Guidelines and Supporting Guidance (continued)

information about a consumer's circumstances, should not be separated from budget forms, repayment proposals, or other correspondence

- Creditors should seek to avoid over-reliance on scripted responses or, more generally, use of rigid account management and communication procedures
- 4.7 Where necessary, procedures covering the key areas of consumer services, account management, and collections should be reviewed to ensure that notified information is recorded, stored with other account information and correspondence, and is readily available to consumer-facing members of staff, who in turn should be trained to examine client records adequately.
- 4.8 The following further case management recommendations are also made:
- The requirement to keep account records up to date is particularly relevant in the case of consumers who have accrued debt as the result of the onset of a mental health problem (which may have been temporary), or where the mental health problem fluctuates over time.
  - Instances of original correspondence being destroyed and replaced by a generic note to the effect of 'letter received' with no further detail must be avoided. In particular, evidence supplied by health and social care professionals must be kept on file, not least because such information can be costly and difficult to obtain.
  - Creditors may wish to consider whether to 'flag' the files of consumers who have notified relevant mental health information as an 'early notifier' device for staff, and may also wish to diarise dates to review these files as standard practice.
- 4.9 Advisers should assist their clients in ensuring that only necessary and relevant information is supplied to creditors, ie, information that explains the effects of

given mental health problems on money management and debt issues.

## *Voluntary notification of relevant mental health problems*

- 4.10 Consumers may decide to voluntarily add information about their mental health problem(s) to the credit files held by credit reference agencies (CRAs) in a 'Notice of Correction'. In doing so, a consumer indicates that they want this information to be known to creditors, although it will only be accessed when a credit search is made.
- 4.11 It needs to be clearly understood that it is the responsibility of the consumer (or that of their representative appointed under Power of Attorney) to update such a Notice. Information on how to file a Notice of Correction can be found on the websites and in the consumer literature of CRAs. No unauthorised person can view a person's file or put on a Notice of Correction unless they hold a Power of Attorney.
- 4.12 The three major CRAs, Experian, Equifax and CallCredit, have agreed a standard form of words that consumers (or those holding Power of Attorney on their behalf)<sup>17</sup> might choose to add to their credit record to flag up relevant mental health problems – please refer to paragraph 4.16 below.
- 4.13 Please note that no CRA can prescribe what a consumer writes in these circumstances. Also, the consumer would need to contact each of the three CRAs separately and request that a Notice be added.
- 4.14 A Notice can be up to 200 words in length, and must not be "frivolous, defamatory, factually incorrect or scandalous". If the CRA concludes that a suggested Notice from a consumer should not be added to a report, the consumer can ask the Office of the Information Commissioner, as the administrators of the Data Protection Act 1998, to arbitrate.
- 4.15 A Notice can be added or removed as required by the consumer or a person who holds Power of Attorney

<sup>17</sup> As a general point, it is worth pointing out that there should be no direct or indirect discrimination in any dealings relating to consumers who appoint third parties to represent them via Power of Attorney.

on their behalf, and will leave no 'footprint' of any kind once it has been removed.

4.16 The agreed form of words is as follows:

*"I, John Smith, wish anyone checking my credit report to be aware that I currently have mental health problems that might affect my ability to manage my credit commitments."*

**or**

*"As the person who holds legal Power of Attorney for John Smith, I, Mary Jones, wish anyone checking this credit report to be aware that John Smith has mental health problems that might affect his ability to manage credit commitments."*

4.17 It is important to ensure both that any information on creditors' own files regarding such Notices is current and that future lending decisions should always be made with fresh reference to the consumer's credit record, in order to establish the current existence or otherwise of a Notice.

## Guideline 5

**Creditors should establish referral mechanisms to ensure targeted help is offered to consumers with mental health problems or those acting on their behalf.**

- 5.1 Creditors should ensure that they have procedures in place to refer consumers, where necessary, to more targeted forms of support. For example, if it becomes clear that because of a mental health problem, standard processes are not appropriate, the consumer (or someone acting on their behalf) should be referred to a specialist team trained to help consumers with more complex issues, where such a team exists.
- 5.2 It would be regarded as good practice for larger companies to have specialists in place as a matter of course. The

cost benefit of specialist teams may well work in creditors' favour, as such teams would have the skills and experience to process cases more efficiently and effectively.

- 5.3 Any specialist team should have the ability and discretion to manage an account on its own terms, and to coordinate (or prevent) activity from other departments. This is particularly important in larger companies where automated processing may lead to inappropriate referrals to debt collection agencies, standard mailings etc.
- 5.4 Companies that lack the resources to support a specialist team should ensure that members of staff who have relevant experience and the necessary level of authority are able to assist consumers with notified debt and mental health problems.
- 5.5 A key method of enhancing communication and contributing to continuity of consumer care on the part of creditors would involve all companies nominating a dedicated first point of contact for third parties working with consumers with relevant mental health problems. Advisers' communication with such contacts should be monitored by their managers to avoid these channels being used as an all-purpose route to discuss all/any cases.

## Guideline 6

**Where a mental health problem has been notified, creditors should allow a reasonable period for advisers to collect relevant evidence and present it to the creditor. This period could be extended by negotiation if necessary, in order to accommodate delays in gathering particular items of evidence.**

- 6.1 Advisers should do everything reasonable within their power to collect relevant evidence as promptly as possible and present it to the creditor. It is suggested that 28 days/one month would be a reasonable point at which to review the situation if necessary and for

# Mental Health Awareness Guidelines and Supporting Guidance (continued)

- advisers to produce a progress report for creditors in the event that not all evidence has yet been collected.
- 6.2 When a relevant mental health problem is identified, an adviser will typically try to establish the nature of the problem and how it affects their client. This can involve:
- Gathering and reviewing relevant correspondence and documentation
  - Liaising with health and social care professionals currently working with the client and obtaining evidence of how the client's mental health problem and/or associated medication impacts on their ability to manage money and resolve/avoid debt
  - Assessing the client's overall financial, housing and care situation
  - Agreeing a course of action with the client
- 6.3 It can sometimes take considerable time to obtain evidence regarding the effects of a consumer's mental health problem(s), particularly where a consumer has been admitted for care under the Mental Health Act or a longer-term prognosis is awaited. As such, there may be situations in which advisers would need to request a moratorium on their client's account.
- 6.4 Where a health or social care professional has been approached (and has agreed) to provide evidence, the adviser should ask the professional to send a copy of any resulting letter or completed DMHEF to the advisers' client. The only exception to this would apply in situations where the health/social care professional who has provided this evidence indicates that sharing such information with their patient would incur a serious risk to the individual's health or safety, or that of others.
- 6.5 Where the DMHEF is being used, clients are given 21 days to (i) review the information provided, (ii) to make an optional statement on what has been written about them (in the space provided in the DMHEF), and (iii) sign and return this back to their adviser. They are told that the 21 days starts on the date that the health professional signed the DMHEF. The 'small print' on the DMHEF will allow for this 21 day period, plus an additional week for the client to post it back to the adviser. This is important for the patient as well as the adviser. Otherwise it will unnecessarily delay contact with a creditor.
- 6.6 When requesting that a creditor manages an account in a particular way, it is good practice for the adviser to specify the following:
- The action that is requested from the creditor and how it will benefit the client
  - The specific reason for the request
  - Any relevant information the adviser has obtained to date and their assessment of it
- 6.7 Creditors may not be aware that a consumer has a mental health problem and may not receive notification of this until a late stage, for example after the account has entered into the collections phase.
- 6.8 When creditors are notified, they should be responsive to third parties working with the consumer, and actively work with the adviser or consumer to agree appropriate courses of action, assuming of course that the consumer has given their consent for the third party to act on their behalf.
- 6.9 Appropriate courses of action might include agreeing to impose a stay of action, not charging default interest and/or charges for unauthorised borrowing while information is being gathered by an adviser.
- 6.10 It is recommended that creditors adopt a sympathetic attitude to the application of interest or other charges to the accounts of consumers in prison or hospital, and particularly in cases where the consumer has no third-party support to manage their correspondence/affairs.
- 6.11 It would be sensible for creditors to conduct a review of a consumer's account and circumstances at the end of any agreed moratorium period, and to discuss with the adviser any progress in collecting evidence, if this has not already been supplied.

## Guideline 7

### **Creditors who outsource debts to debt collection agencies should ensure they are satisfied that such action is consistent with the intentions of these Guidelines and relevant Codes of Practice.**

- 7.1 In some circumstances, it may be helpful to pass debt on to third parties for collection, depending on the track record and reputation of particular third parties. For example, some companies may specialise in dealing with cases of hardship and/or vulnerability or have developed relationships with the health sector.
- 7.2 Equally, there may be circumstances where it would create more confusion to a consumer if a creditor were to recall a debt from a third party with whom the consumer was engaged in a reliable and appropriate repayment arrangement.
- 7.3 It can be distressing for consumers with mental health problems to receive correspondence from new debt collection companies, irrespective of how such correspondence is worded. The creditor therefore needs to make a positive decision in these circumstances about where best such accounts should be managed. If it is within a specialist team in their own company, they may wish to call the account back once they are notified of the consumer's mental health problem(s).
- 7.4 Alternatively, the creditor might choose to either leave the debt with a debt collection company that specialises in working with vulnerable consumers or recall the account in order to forward it on to a further debt collection company to administer with optimal expertise. The expectation is that the account will quickly move to the appropriate agency so that any changes do not destabilise the consumer's mental health further.
- 7.5 The creditor should also give due regard to advisers' recommendations in this area. Hence, if the adviser

notifies the creditor or debt collection company that no further correspondence should go directly to the consumer (because of the distress this might cause), then systems will need to be updated across all collection agencies working on an account in default to make sure this happens.

## Guideline 8

### **Where the debts of people with notified mental health problems are sold, the vendor (ie the creditor) should, wherever possible, endeavour to ensure that the purchaser complies with the intentions of these Guidelines and relevant Codes of Practice.**

- 8.1 Problems often arise when, as part of re-structuring or for some other reason, a debt is sold on or transferred to another business. A common frustration for consumers or their advisers in this situation stems from the need to provide information more than once. Often in these cases, information about a consumer or their circumstances is lost, which can cause distress to the consumer and difficulties for the person acting on their behalf.

## Guideline 9

### **Where a creditor is made aware that a consumer has a mental health problem, they should only initiate court action or pursue enforcement through the courts as a last resort, and when it is appropriate and fair to do so.**

- 9.1 In making a decision about whether to initiate action, a creditor should take into account the appropriateness of taking that action in the light of any relevant evidence they might have.
- 9.2 Decisions should seek to prevent:
  - Unnecessary action that might further harm vulnerable consumers

# Mental Health Awareness Guidelines and Supporting Guidance (continued)

- Action that exacerbates problems arising from temporary financial difficulties
- Action where other alternatives have not been considered

9.3 The creditor should make every effort to reach a reasonable negotiated settlement with the consumer before proceeding to court action or enforcement through the courts.

## *An issue of Scottish law*

- 9.4 In Scotland, save for 'low income, low assets' cases, known as LILAs, "apparent insolvency" must be established before a debtor can apply for their own bankruptcy. This is generally established with service of a Charge for Payment by a lender once they have obtained a Decree (Judgment), and is contingent on a person in debt having total debt(s) in excess of £1,500.
- 9.5 If court action is restricted as set out in this recommendation, it may prevent people in debt from declaring themselves bankrupt, where it would be appropriate to do so. This requirement for apparent insolvency does not exist in England as a pre-requisite for a person in debt to petition for their own bankruptcy.

## Guideline 10

**Creditors should consider writing off unsecured debts when mental health problems are long-term, hold out little likelihood of improvement, and are such that it is highly unlikely that the person in debt would be able repay their outstanding debts.**

10.1 The issues of severity of the effects of mental health problem making repayment highly unlikely, and the likely duration of the problem, including likelihood or otherwise of improvement, would need to be supported by appropriate evidence. Please refer to recommendations 12 and 13 below for more guidance on evidence.

## Guideline 11

**It should be recognised that the issue of whether at all, and if so how much of, a person's Disability Living Allowance (DLA) or Attendance Allowance (AA) award should be added towards disposable income for the purposes of paying off debt will be the consumer's choice alone.**

- 11.1 As the introduction to these Guidelines clarifies, the recommendations made in this document apply solely to the circumstances of consumers who are already in debt, and not to those prevailing at the time an application for credit is made. As such, this Guideline does not apply to the presentation of income information, including the 'disposability' or otherwise of DLA or AA, at the point of entering into a contract.
- 11.2 DLA and AA are specifically awarded to compensate for the extra costs associated with the (mobility and) care needs of people with disabilities. As such, a consumer in debt who is in receipt of one or other of these benefits would be perfectly entitled to treat their entire award as non-disposable income. Equally, however, some claimants might feel that the quality-of-life benefits of using a proportion of their award to pay off debts would be of sufficient magnitude to justify them doing so.
11. In situations where priority debts are involved a discussion between the creditor, the consumer and/or their adviser regarding the use of DLA/AA monies might be appropriate, given the additional risks associated with non payment of priority debts.
- 11.4 DLA/AA awards can be revised downwards or removed by the Department for Work and Pensions (for reasons that may not have anything to do with any variations to the effects of mental health problems), which if a claimant has been using some of their award to repay debt, will mean that income and expenditure and debt repayment levels will need to be re-assessed.

## Guideline 12

**Advisers will provide creditors with evidence to confirm a client’s debt and mental health status that is proportionate to the type of action requested from the creditor.**

12.1 Evidence needs to be:

- Sought as early in the debt identification and management process as possible
- In writing, and wherever possible compliant with the format adopted by the MALG Debt and Mental Health Evidence Form (DMHEF)
- Comprehensive enough to reassure the creditor of its validity and to demonstrate the relevant effects of the mental health problem(s) on the consumer’s ability to manage money and debt
- Proportionate to what the adviser is asking the creditor to do

12.2 It should be acknowledged that staff in creditor agencies will not necessarily have the expertise to interpret medical evidence presented and/or representations made by third parties acting on behalf of consumers. Third parties should therefore be aware of the need for patience and clarity when attempting to progress a consumer’s case.

12.3 It should also be noted that such evidence constitutes “sensitive personal data” and should be handled accordingly. Please refer to Guideline 4 for guidance on the data protection requirements relating to the handling of sensitive personal data, and also to the guidance to the DMHEF, available at any of the following three websites – [www.malg.org.uk](http://www.malg.org.uk), [www.moneyadvicetrust.org](http://www.moneyadvicetrust.org) or [www.rcpsych.ac.uk/debt](http://www.rcpsych.ac.uk/debt).

## Guideline 13

**Creditors will accept evidence provided from an agreed list of practitioners.**

*Debt and mental health evidence*

13.1 Creditors should be prepared to accept debt and mental health evidence from a range of health and social care professionals who may be able to help a consumer to prove they have particular mental health problem(s) that may prevent them from being able to manage their financial affairs or pay their debts. Creditors also need to be aware of the variety of organisations and consumers who may be involved in the care of someone with a mental health problem.

13.2 Relevant practitioners who may be working with consumers with mental health problems include:

- Care coordinators
- Clinical psychologists
- General Practitioners (GPs)
- Mental Health Nurse/Psychiatric Nurse
- Occupational therapists
- Psychiatrists
- Social workers
- Other approved mental health professionals

An explanation of the respective roles of these practitioners is provided at Appendix 2 of this document.

13.3 The crucial issue to consider is the nature of a particular practitioner’s professional relationship with their client/patient, and the degree to which that relationship might inform the practitioner’s ability to make judgements about a consumer’s money and debt management behaviour.

# Mental Health Awareness Guidelines and Supporting Guidance (continued)

- 13.4 It is important that creditors give appropriate weight to the perspectives of the particular health or social care practitioner(s) best equipped to comment on the effects of a consumer's mental health problem(s) on a case-by-case basis.
- 13.5 Multi-disciplinary teams, in which knowledge is shared across a range of practitioners, are common in the mental health field. The assumption that there is a hierarchy of knowledge where, for example, the testimony of a psychiatrist might be accorded more weight than that of a nurse, should be avoided.
- 15.2 Relevant stakeholders should continue to engage in dialogue at policy level within the health and social care fields regarding the case for providing evidence at no cost wherever possible and appropriate.
- 15.3 Because payment is usually requested in advance, creditors might have understandable concerns about how to ensure the appropriate level of quality or comprehensiveness of what they will receive in return for a fee. Use of the MALG Debt and Mental Health Evidence Form will support the consistency, clarity and relevance of evidence collected.

## Guideline 14

**Advisers should be encouraged to use the Money Advice Trust/British Bankers' Association/Finance & Leasing Association's Common Financial Statement (CFS), or a statement format that conforms to the general principles of the CFS, when they prepare financial information in support of client repayment offers or other forms of negotiation.**

## Guideline 15

**If a creditor requires evidence that is only available on a charging basis, they should be prepared to consider payment proposals made by health or social care practitioners on a case-by-case basis.**

- 15.1 As a general rule applicable to any party seeking evidence from a health or social care professional, an unsolicited offer of payment is not advisable, as this practice risks creating expectations that fees can be charged as standard.

- 15.4 It is possible that the creditor policy bodies may in the future explore the potential for agreeing protocols regarding standard charges with the relevant health and social care professions.
- 15.5 In some cases, creditors may choose to rely solely on the information provided in Appendix 1 to these Guidelines, ie without reference to external, individualised evidence, in order to confirm that a consumer's mental health problems will adversely affect their ability to manage their finances, including debt. However, in cases where a creditor is not simply using this information to positively corroborate such an assertion, ie where they remain to be convinced, they should seek third-party evidence.

## MALG Mental Health Working Party

Autumn 2009

# Appendix 1

## A selected glossary of terms used when describing mental health problems

**Affective Disorder** is a term used for any disorder of mood such as depression, hypomania, bipolar disorder and seasonal affective disorder.

**Alzheimer's Disease** is a condition causing loss of memory, intellectual decline, changes in personality and behaviour, and an increased reliance on others for activities of daily living. It is a form of dementia.

**Anorexia nervosa** is an illness involving an intense fear of being fat, distorted body image, under-eating and excessive weight loss.

**Anxiety** is a feeling of unease, apprehension or worry. It may be associated with physical symptoms such as rapid heartbeat, feeling faint, or trembling. It can be a normal reaction to stress or worry or it can sometimes be part of a bigger problem.

**Auditory hallucination** means hearing a voice or sound when there is nothing there.

**Binge eating** involves uncontrollable episodes of eating very large quantities of food over a short period of time. It occurs in bulimia.

**Bipolar disorder** is a condition in which people have mood swings that are far beyond what most people experience in the course of their lives. These mood swings may be low, as in depression, or high, as in periods when we might feel very elated. These high periods are known as 'manic' phases. Many sufferers have both high and low phases, but some will only experience either depression or mania. Bipolar disorder used to be referred to as 'manic depression'.

**Bulimia** is an eating disorder characterised by binge-eating, vomiting, purging by making oneself sick, or abusing laxatives.

**Capacity** is the ability to understand and take in information, weigh up the relative pros and cons, and reach a sensible decision about a given issue.

**Dementia** is a condition in which there is a gradual loss of brain function. The main symptoms are usually loss of memory, confusion, problems with speech and understanding, changes in personality and behaviour, and an increased reliance on others for activities of daily living. There are a number of causes of dementia. Alzheimer's disease is the most well-known form of dementia.

**Depression** is a common condition. The main symptoms are feeling low, sleep problems, loss of appetite, concentration, and energy. There are a number of treatments that can help.

**Hypomania** is state of high mood that is not quite as severe as mania.

**Mania** is a state of extreme and persistent over-activity and high mood. It is regarded as the opposite of depression.

**Obsessive compulsive disorder** is a fairly common problem, where people experience 'obsessions', ie, recurring unwanted thoughts that are difficult to stop, and 'compulsions', ie, rituals of checking behaviour or repetitive actions that are carried out in an attempt to relieve the thoughts.

**Panic attacks** are intense and sudden feelings of fear and anxiety. They are associated with many physical symptoms such as rapid heart beat, trembling, rapid shallow breathing, pins and needles in the arms, and feeling faint. Many people who have a panic attack fear that they will collapse or die. These attacks are not harmful and usually go away within 20-30 minutes.

**Paranoid psychosis** is a condition whose major symptoms are hallucinations and delusions, often with a change of mood. It is very similar to schizophrenia.

**Personality disorder** describes someone who has severe disturbances of their character and behaviour. Personality disorders usually appear in late childhood or adolescence and continue into adulthood. The thought patterns and behaviours cause distress to the person or to those around them.

# Appendix 1

## A selected glossary of terms used when describing mental health problems (continued)

**Phobia** is an irrational and intense fear of a situation or object.

**Postnatal depression** is a mental illness that occurs within the weeks or months after childbirth.

**Psychosis** is a condition in which a person is not in contact with reality. Symptoms can include sensing things that aren't really there (hallucinations), having beliefs that aren't based on reality (delusions), having problems in thinking clearly, or not realising that there is anything wrong with oneself (called 'lack of insight').

**Puerperal psychosis** is a mental illness that can affect women after childbirth. The symptoms are usually severe depression or mania, often with psychotic features.

**Schizophrenia** is a mental illness whose main symptoms are hallucinations (hearing voices), delusions (a firm belief in something that isn't true) and changes in outlook and personality.

**Self-harm** occurs when people feeling sad, desperate, angry or confused, hurt themselves. Some people harm themselves by taking an overdose or other poisonous substances, others by injuring themselves (usually by cutting parts of the body).

## Box 1 – Types and extent of mental health problems

### Overall extent

The Office for National Statistics estimates that one in six British adults at any one time is experiencing a mental health problem (ONS, 2000).

### Combined anxiety and depression

Depression with anxiety is experienced by just over 9% of adults in Britain (ONS, 2000).

### Anxiety

Main symptoms are intense and debilitating feelings of unease, apprehension or worry.

Just under 5% of adults report generalised anxiety disorders (ONS, 2000).

### Depression

Main symptoms are feeling low, sleep problems, loss of motivation, concentration and energy.

Just under 3% of adults report depression on its own (ONS, 2000).

### Phobias

Fear and avoidance of situations/things that aren't dangerous and which most people don't fear.

Just fewer than 2% of adults in Britain experience phobias (ONS, 2000).

### Eating disorders

Anorexia nervosa (extreme body shape anxiety; dieting, vomiting, or excessively exercising).

Bulimia nervosa (extreme anxiety about body shape, cycle of eating and vomiting).

1% UK women aged 15-30 have anorexia nervosa, and 1-2% bulimia nervosa (MHF, 1997).

### Dementia

Brain disorder resulting in memory loss, language and decision-making difficulties, and problems controlling movements of the body.

20% of those over 80 in UK, and 6% of those over 65 (SSI, 1996).

### Bipolar Disorder (Manic Depression)

Periods of mania (prolonged extreme happiness or irritability) and periods of depression.

1% of people experience bipolar disorder (RCP, 2006).

### Schizophrenia

Experience of hallucinations and beliefs that others don't agree with (delusions).

Around 1% of the population will experience schizophrenia (NICE, 2002).

### Personality disorders

Severe and enduring disturbances of character and emotion falling outside accepted patterns.

The concept of personality disorder is controversial and estimates of extent vary.

### Obsessive compulsive disorder

Experience of recurring unwanted thoughts, 'compulsions', rituals, or repetitive actions.

Just over 1% of British adults have obsessive compulsive disorder (OCD).

### Self harm

Consumer response to sadness, anger or confusion expressed by people overdosing or injuring themselves (usually by cutting).

Around 10% of young people report self-harm (RCP, 2007).

### Post-natal depression (PND)

Depression following child-birth.

Around 10% of women have PND after having baby (RCP, 2006).

# Appendix 2

## Different types of health and social care professionals

The following list of definitions is intended to help inform creditors about the respective roles of various types of health and social care professionals. People with mental health problems who are under the care of the Health Service and/or Social Services, may be in contact with one or a number of these professionals at any one time, depending on their circumstances and their needs.

It is also worth reiterating that multi-disciplinary team working is common in the mental health field, meaning that different professionals may be dealing with or primarily specialising in particular aspects of a person's treatment or care, but may also at the same time be in regular contact/liaison with colleagues as part of an overall package of support.

### Social workers

Most mental health social workers are based in multi-disciplinary community mental health teams. They can deal with social problems, such as those associated with housing, money, and employment, and may also control access to appropriate social and community sector support services.

### Care coordinators

A care coordinator is someone named as the main point of contact of support for a person who needs ongoing care. The care coordinator can be a nurse, social worker, or other mental health professional.

### Clinical psychologists

Clinical psychologists use their understanding of human emotions, thinking and behaviour to assess people's mental health and social needs, plan care and deliver evidence-based psychological therapies and interventions. Clinical psychologists work both in hospitals and community settings but, unlike psychiatrists, do not prescribe medication.

### Community psychiatric nurses

A community psychiatric nurse (CPN) is a registered nurse with specialist training who works in the community. Some are attached to GPs' surgeries, community mental health centres or psychiatric units.

### Nurses in psychiatric hospitals

These nurses work in hospital settings and assess the needs of all patients on in-patient wards. Often, a nurse will take responsibility for a patient on the ward and will liaise with community-based colleagues regarding the care that will be provided when the patient is discharged.

### General practitioners (GPs)

Although GPs can deal with most mental health problems without referring the patient elsewhere, they often work in teams with other professionals, such as health visitors, nurses and mental health practitioners.

### Psychiatrists

Psychiatrists are qualified medical doctors who look after patients with mental health problems. Working both in hospital settings and community teams, psychiatrists work with other professionals to address patients' health and social needs. Psychiatrists are able to prescribe medication.

### Occupational therapists

Occupational therapists work in hospitals and community settings, and help people to adapt to their environment and cope with daily life. They may also take part in therapeutic and rehabilitative activities with patients.

# Appendix 3

## Membership of the two MALG Mental Health Working Parties

### Membership of the 2005-6 Mental Health Working Party

**Robert Skinner** Money Advice Trust, Chair

**Paul Ross /Joanna Elson** British Bankers' Association

**Peter Tutton/Sue Edwards** Citizens Advice

**Marie Coles** Credit Services Association

**Karen Bennell** Finance & Leasing Association

**Colin Trend** Money Advice Association  
and Money Advice Plymouth

**Yvonne Gallacher** Money Advice Scotland

**Jane Guy** MALG Secretary  
and Secretary to the Working Party

### Membership of the 2007-8 Mental Health Working Party

**Joanna Elson** Money Advice Trust, Chair

**Helen Banks/Paul Ross/Stewart Dickey**  
British Bankers' Association

**Peter Tutton** Citizens Advice

**Marie Coles/Claire Aynsley** Credit Services Association

**Liz Denyer** Finance & Leasing Association

**Colin Williams** Manic Depression Fellowship

**Brian Rogers** Mental Health Nurses Association

**Colin Trend** Institute of Advisers  
and Money Advice Plymouth

**Yvonne Gallacher** Money Advice Scotland

**Jim Fearnley** Money Advice Trust

**Chris Fitch** Royal College of Psychiatrists

**Rob Chaplin** Royal College of Psychiatrists

**Jane Guy** MALG Secretary  
and Secretary to the Working Party

### Membership of the current Mental Health Working Party

**Joanna Elson** Money Advice Trust, Chair.

**Marie Coles** Secretary.  
Secretary to the Money Advice Liaison Group

**Jim Fearnley** Money Advice Trust

**Claire Aynsley** Credit Services Association

**Elizabeth Denyer** Finance & Leasing Association

**Paul Ross** British Bankers Association

**Colin Trend** Independent adviser

**Sallie Johnson** The Institute of Advisers

**David Delooze** Council of Mortgage Lenders

**Peter Tutton** Citizens Advice

**Yvonne Gallacher** Money Advice Scotland

**Chris Fitch** Royal College of Psychiatrists

**Rob Chaplin** Royal College of Psychiatrists

**Colin Williams** Manic Depression Fellowship

**Brian Rogers** Mental Health Nurses Association

# Appendix 4

## Items tabled by the MALG Mental Health Working Party for further discussion and potential exploration and an update report

The following issues emerged as areas of interest or concern in the course of the first edition of the Guidelines being prepared. MALG is in the process of exploring each issue with a view to determining what might be the best course of action on a case-by-case basis.

### 1 Lending decisions

It was acknowledged by the Mental Health Working Party that money problems can be compounded by fresh offers of credit being made to people already in debt. However, it was agreed that the specific issues raised by any 'fresh' credit applications and offers, such as squaring the respective implications of the Disability Discrimination Act and Mental Capacity Act, meant that this area should be dealt with separately.

At the time of going to print the Office of Fair Trading is finalising a Guidance document relating to the overall issue of Irresponsible Lending (as required by the Consumer Credit Act 1974 as amended by the Consumer Credit Act 2006). As of the date of the publication of this edition of The Guidelines there a positive indication that specific account will be taken of the needs of consumers with mental health problems within this Guidance. It was thought sensible to wait for this work to be completed before exploring this area further.

The EU Consumer Credit Directive that will come into effect in the UK in June 2010 will contain a specific area on assessment of the credit worthiness of the consumer applying for credit.

### 2 Extending the scope and content of the Guidelines to other creditors, eg utility providers

Both the Energy Retail Association and Water UK have fully endorsed the Guidelines on behalf of their members.

### 3 Amending the Guidelines to support people with physical disabilities

After much careful discussion it has been agreed that as The Disability Discrimination Act 2005 adequately covers behaviour towards physically disabled people, separate Guidelines or amendments to these existing Guidelines would not be appropriate.

Physical disability as such is not generally a direct cause of people getting into debt although we acknowledge the strain that physical disability can put on household budgets. Likewise debt is not of itself a cause of people becoming physically disabled. It could well be that many physically disabled people also experience mental health problems that cause them difficulties in handling their financial affairs and paying their debts. If this is the case, these Guidelines will naturally cover such consumers and how they should be treated.

#### **4 Developing and maintaining a database of nominated creditor mental health contacts**

Work towards the production of a database of nominated creditor mental health contacts is in progress and MAT will provide an update in due course.

#### **5 Developing a national mental health and debt training strategy to meet the respective needs of the creditor, advice, and health and social care sectors**

The Working Group has identified a common desire to expand the scale, format and content of the work currently being undertaken by MAT/ IMA and, we understand, Advice NI in this area. In due course, the intention is that interested parties will (a) scope levels and types of demand for training and (b) explore effective methods of joint working amongst training provider bodies.

#### **MALG Mental Health Working Party**

Autumn 2009

# Appendix 5

A list of those mental health organisations who have endorsed these Guidelines

## The Royal College of Psychiatrists



## Mind



## British Association of Social Workers



## Rethink



## British Psychological Society



The  
British  
Psychological  
Society

**The Royal College of General Practitioners**



Royal College of  
General Practitioners

**The Royal College of Nursing**



Royal College  
of Nursing

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