Mind over Money

A study of Third Party responses to the needs of debtors with mental health issues

Executive Summary

October 2019

Introduction and Background:

This qualitative study conducted by Perth Citizens Advice Bureau set out to explore how third parties; more specifically creditors and health professionals are responding to the needs and circumstances of indebted citizens with mental health issues.

Problem debt and mental health exist in a relationship of mutual reinforcement. Stress and anxiety caused by debt can either exacerbate chronic mental health problems or damage the mental wellbeing of someone with generally sound mental health. Alternatively, mental health may create or worsen problem debt. Mentally unwell debtors often avoid engaging with creditors by not opening post, emails or answering the phone. Avoiding correspondence frequently results in arrears building up, the consequences of which can be highly detrimental, especially in the long-term. Many sign up for financial products i.e. credit cards and loans despite their 'mental capacity' being compromised by a mental health condition; consequently they may not fully comprehend terms and conditions. For others, impulsive borrowing and spending is tied into their illness, meaning that during bad phases they can easily overspend what cannot readily be paid back.

Specific guidelines for creditors in handling customers with suspected shortfalls in 'mental capacity' including those with mental health issues is provided in the Consumer Credit Sourcebook (CONC) produced by the Financial Conduct Authority (FCA).

Whilst there has been a notable improvement in how creditors treat indebted citizens with mental health problems, inconsistency in terms of their attitudes remains an ongoing issue.

Medical evidence can play a pivotal role in debt remedies. Amongst the resources available to health professionals is the Debt and Mental Health Evidence Form (DMHEF).

Previous research conducted across the Scottish Citizens Advice Network into medical evidence and benefit entitlement revealed various pitfalls including GPs charging for evidence, DWP decision makers appearing to disregard evidence and health professionals refusing to provide it in the first instance. These are also applicable to the use of medical evidence in addressing problem debt. From 1st October GPs in England will no longer charge for medical evidence, although those in Scotland currently remain at liberty to do so.

Key Findings:

The following findings were taken from 15 micro case studies collected by the Perth CAB debt team from January 2018 to March 2019.

- Citizens with diminished financial capacity on part of mental illness being able to take out multiple pay-day loans, credit cards and/or make excessive catalogue purchases, their total debt reaching levels, which could not be easily paid back (if at all). In one case a credit card spending limit was increased without the debtor asking, resulting in them spending even more and going into further debt.

- Collection practices being potentially harmful, this includes creditors phoning and texting debtors multiple times in a single day, causing distress and anxiety. In a (hopefully) isolated case, a catalogue company put promotional leaflets for new products in with recovery letters destined for a bi-polar debtor prone to excessive spending.

- Inconsistency in creditor responses to medical evidence recurred frequently. Some agreed to write off a debt, not take any further recovery action, or suspend recovery (time ranging from 30 days to 6 months). Others refused downright to write off debts or postpone collection. Some did not engage with letters. It is worth mentioning that although postponement was better than no action, 30 days has virtually no practical benefits for debtors with chronic mental health issues as the chances of their condition improving within such a short space of time are slim in the extreme.

- Typically creditors did not provide any justification for their decisions. One did confirm that they deemed a debtor unable to work and living of benefits as having too high an income and refused to write the debt off.

- The quality of DMHEFs completed by health professionals varied greatly. Examples of poor completion included forms contradicting themselves i.e. stating that poor concentration affected decision making but ticking the box to say that financial capacity was not affected. Completers merely ticking boxes and providing no or very superficial testimonial evidence on how a mental health condition affected ability to manage money. In other instances, health professionals refused to complete a DMHEF. In the event of an unhelpful form or refusal, debtors were required to request another be completed or alternative evidence i.e. a letter being sent in its place. Regrettably, this was not a guarantee that the new one would be of a higher quality.