Mind over Money

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

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List of frequently used Abbreviations:

AiB:	**Accountant in Bankruptcy**
BMA:	**British Medical Association**
CAB:	**Citizens Advice Bureau**
CAS:	**Citizens Advice Scotland**
CONC:	**Consumer Credit Sourcebook**
CPN:	**Chartered Psychiatric Nurse**
DMHEF:	**Debt and Mental Health Evidence Form**
FCA:	**Financial Conduct Authority**
GP:	**General Practitioner**
MALG:	**Money Advice Liaison Group**
MAS:	**Money Advice Scotland**
MMHPI:	**Money and Mental Health Policy Institute**
RCP:	**Royal College of Psychiatrists**

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Introduction and Background:

Debt is amongst the most prominent issues for which citizens across Scotland sought help from their local Citizens Advice Bureau (CAB). In the 2017/18 financial year the Scottish CAB network is known to have given 765,882 pieces of advice, 133,593 (17%) was for debt. After welfare benefits (43%) debt is the next most common matter for which citizens sought advice (Citizens Advice Scotland, 2018). Perth figures mirror national trends. For 2018/19 benefit issues counted for 39% of advice given by Perth CAB. Debt came in second at 24%.

17% of known advice provided by Scottish CAB network in 2017/18 was for debt issues

24% of advice given by Perth CAB in 2018/19 was for debt

At this stage it is important to differentiate between households in 'debt' and 'problem debt'. An immeasurable percentage of households across the UK are currently in debt, though it may not necessarily be causing them hardship. Debt becomes 'problematic' when households fall behind with payments, endure harassment from creditors and face penalties such as court action (Glasgow Centre for Population Health, 2018, 06). Contrary to popular belief it is not just low-income households and/or those with poor budgeting skills that experience problem debt. Unexpected and abrupt changes to household finances, known as 'income shocks' including loss of employment, termination/reduction of welfare benefit payments, illness, bereavement, loss or damage to possessions/property, relationship breakup etc. can force even the most financially stable households into problem debt (StepChange, 2019). Figures from the Money and Mental Health Policy Institute (MMHPI) informed by the 2014 Adult Psychiatric Morbidity Survey (APMS) state that 7% of the adult population in England[1] (1 in 14) are living with problem debt (Bond and Holkar, 2018, 13). Unfortunately, vulnerable citizens such as those with mental health issues are amongst the most susceptible. According to NHS Scotland a quarter of those using mental health services are known to be struggling with problem debt (NHS Scotland, 2017, 05).

1 in 14 adults in England are living with problem debt (7% of the adult population)

It is already well known that the needs of citizens with mental health issues are often highly complex, which can make engagement extremely difficult for both the debtor and creditor. Complicating the situation further is the growing belief that creditors do not adequately comprehend how mental ill health can impede the capacity of indebted citizens to repay debts and are generally unsympathetic to their needs. This small-scale qualitative study strives to assess the factual accuracy of this perception. Problem debt

[1] This survey does not include Scotland, Wales or Northern Ireland

without doubt is potentially damaging to mental health, however, its impact reaches beyond individual debtors. Health professionals both primary and secondary, including General Practitioners (GPs), Community Psychiatric Nurses (CPNs), Psychiatrists amongst others, will confront the psychological fallout attributed to problem debt. This research focuses exclusively on a specific angle. In pursuit of remedial solutions to problem debt, debt advisers often approach health professionals to request medical evidence to justify how mental health impairs financial capacity. Colleagues have noted inconsistency in the quality of the evidence. The report provides a detailed illustration of this issue, the problems it causes before considering some possible factors which account for why inconsistency occurs.

These remits will be satisfied by answering the following research question:

- How are creditors and health professionals responding to the needs and circumstances of indebted citizens with mental health issues

The findings and discussion will be used to inform recommendations for addressing gaps in knowledge and weaknesses in policies and protocols.

Problem debt and mental ill health, a relationship of mutual reinforcement:

Problem debt and poor mental health exist in a relationship of 'mutual reinforcement'

Problem debt and poor mental health exist in a relationship of 'mutual reinforcement' (Jenkins et al, 2009, 90, Mind, 2011, 08, NHS Scotland, 2017, 05). The stress and anxiety of being in debt can either damage the mental wellbeing of someone with initially sound mental health or exacerbate chronic problems including Depression and Obsessive Compulsive Disorder (OCD). An analysis of the 2000 UK wide National Survey of Psychiatric Morbidity by Jenkins et al, (2009, 90) revealed that relative to those without problem debt, the level of neurotic and psychotic illness amongst indebted citizens was consecutively two and four times higher. Of greatest concern by far is the link between debt and suicide. Sociological research from the Royal College of Psychiatrists (RCP) identifies increased personal debt, along with unemployment and housing insecurity, as issues, which have elevated the risk factor for suicide across Western Europe and North America in the aftermath of the 2007/08 Financial Crisis (Reeves et al, 2014, 02). The mixed-method study by MMHPI cited earlier, makes further use of the 2014 Adult Psychiatric Morbidity Survey and highlights that amongst citizens with problem debt in England, 1 in 8 admitted to having suicidal thoughts, whilst 3% of those sampled had actually attempted suicide (Bond and Holkar, 2018, 14).

Mutual reinforcement a 'two-way' street

Mutual reinforcement is a two-way street as mental health conditions may cause or exacerbate problem debt. Debtors unable to cope frequently avoid engaging with creditors, either by not opening letters, emails or answering the phone. In most cases avoiding contact causes arrears to build up and in the long-term may lead to injurious penalties including earnings arrestment, bankruptcy, seizure of possessions, repossession of property or even eviction. Many end up in problem debt by taking on credit or signing up for financial products i.e. loans, etc. when their mental capacity is compromised by a condition, meaning that they have not fully comprehended terms and conditions. For others, compulsive and/or impulsive spending is tied into their illness, meaning that during bad phases they can easily overspend what cannot readily be paid back (Mind, 2011, 08). This is especially true for those living with disorders such as agoraphobia, where it is probable a sufferer feels estranged and isolated. According to Murray (2017, 02) these feelings are what drive many to gamble online. The same logic can be applied to other injurious behaviours such as excessive online shopping and/or catalogue purchases.

Credit and Mental Capacity:

'Mental capacity' and 'mental ill health' related but are separate concepts

The Consumer Credit Sourcebook (CONC) produced by the Financial Conduct Authority (FCA) contains explicit guidelines creditors, including lenders, etc. should adhere to when they are concerned about a customer's 'mental capacity'. The former term is used to describe an individual's ability (or capacity) to process and retain information upon which they can make a decision (FCA, 2019). The FCA (2019) recognise that whilst imperfect mental capacity and mental ill health frequently overlap, they remain separate concepts, given that many of those living with mental illness remain perfectly capable of making sound financial decisions. There is no space to provide a detailed outline all FCA mental capacity guidelines. However, the central premise is that firms should be vigilant for shortfalls in mental capacity amongst prospective and existing customers, yet the default position is to award credit on the understanding that the customer comprehends. This is to avoid unfair discrimination, as refusal on the basis of mental capacity may breach the 2010 Equality Act (FCA, 2019, Law, 2015, 226). This said, the guidelines state that if an agent suspects mental capacity limitations, they must support the customer to make an 'informed decision' as to whether or not to proceed. They must ensure terms and conditions of agreements are clear and lucid and that recovery practices are sensitive to the customer's mental disposition (FCA, 2019). If guidelines are discarded and credit is awarded inappropriately, the firm have not

committed a crime; however, they will face penalties imposed by the FCA (AdviserNet, 2019).

Creditor responses to debtors will mental health issues:

A report published by mental health charity Mind in 2011, noted that in comparison to findings of earlier research conducted in 2008, there was a clear improvement in how creditors treated indebted citizens with mental illnesses. More specifically, a greater percentage of informants acknowledged that creditors showed empathy and sympathy when engaging with them. Moreover, creditors appeared to be responding proactively to good practice guidelines for dealing with mentally ill customers formulated by bodies including the RCP. Increased signposting of indebted customers to debt advice agencies was also noted (Mind, 2011, 10). Sadly, improvements were not universal. Inconsistency was observed in creditor attitudes towards mental health. In addition, reports of harassment by multiple creditors remained relatively static amongst informants (Mind, 2011, 10).

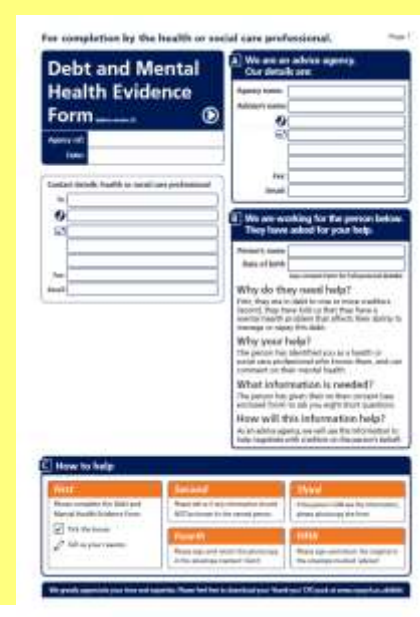
Creditor attitudes towards mental health inconsistent

Research published last year by the Personal Finance Research Centre at the University of Bristol, revealed similar trends to the Mind (2011) study. By the authors' own admission, this quantitative study was amongst the first focusing exclusively on attitudes of debt collectors towards mental health. By 'debt collector' they mean those employed specifically to liaise with customers with outstanding balances and negotiate repayments. This included collectors employed within credit agencies and third-party debt purchase/collection companies (Evans et al, 2018). Comparing the findings from two surveys conducted in 2010 and 2016, participants in the latter acknowledged, on the whole, that they felt more confident engaging with mentally ill customers. A favourable shift in attitudes was also noted, most significantly less suspicion about mental health being used an excuse to avoid paying off debts. Another positive development was a notable increase in collectors routinely enquiring about a debtor's mental health and if they needed to take it into consideration when negotiating payments (Evans et al, 2018, 500). Whilst clearly grounds for optimism, the authors rightly concede that their sample represents a mere fraction of the wider UK debt collection industry (Evans et al, 2018, 502). This strongly implies that inconsistency remains an ongoing problem.

The role of health professionals and medical evidence:

It is impossible to know for sure how many citizens in problem debt are also living with undiagnosed mental health conditions. Given that 1 in 6 people (NHS Health Scotland, 2019) are thought to be living with mental health issues, the number is likely to be high. Nevertheless, it is quite probable that those with formally diagnosed mental health problems experiencing problem debt will be seeking or undergoing treatment from their GP and/or specialist mental health practitioner such as a psychiatrist. As stated at the onset, alongside treating mental illnesses, health professionals both 'primary' i.e. GPs and 'secondary' i.e. psychiatrists, community psychiatric nurses, etc. play an active role within debt remedies. In Scotland the three main 'statutory' debt remedies are the Debt Arrangement Scheme (DAS), Trust Deeds and Sequestration (bankruptcy). These are administered either by the Accountant in Bankruptcy (AiB) a Scottish Government department, third sector organisations or private insolvency practitioners. Going solely on the experiences of Perth CAB debt advisers, it appears not to be standard practice for AiB decision makers to make routine enquiries about an applicant's mental health and consequently request medical evidence from health professionals. This said, there are occasions, albeit rare, when they will.

Medical evidence is used most frequently by debt advisers liaising with creditors on behalf of mentally ill debtors. An adviser may use the evidence to justify why a creditor should freeze interest, accept payments, reduce or write off the debt entirely (Davey and Fitch, 2011, 18). Amongst resources available to advisers is the Debt Advice and Mental Health Evidence Form (DMHEF). Produced by The Money Advice Liaison Group (MALG) in collaboration with the Money Advice Trust (MAT) and RCP, the DMHEF is (presently) an eight question form completed by health professionals to provide a coherent overview of a debtor's mental health issues with specific emphasis on how they affect financial capacity. The DMHEF is also used to highlight any matters, which creditors/collectors should take into consideration when corresponding with the debtor (Money Advice Liaison Group, 2015, 09). The idea behind the DMHEF was initially conceived in 2007 and with input from numerous sources including mental health professionals and creditors on the content and wording, a final draft was completed and put into service in 2008. Following its launch the DMHEF was formally recognised by organisations regulating the credit industry; both creditors and collectors. These



included the former British Bankers Association, British Building Societies Association and UK Cards Association (in 2017 these amalgamated to form UK Finance). Official guidelines including the voluntary Standard of Lending Principles (previously the 2011 Lending Code) and the Office for Fair Trade (OFT) Irresponsible Lending Guidance state that creditors/collectors should afford a DMHEF due consideration should a customer submit one (Fitch et al, 2010, 96, Davey and Fitch, 2011, 01). Much of the OFT guidance has since been incorporated into the FCA CONC, although the narrative of the latter has become more generic, employing the term *"vulnerable customers"* to include those with mental health problems (FCA, 2019). The evidence utilised in this research is concerned chiefly (though not exclusively) with issues surrounding the use of the DMHEF.

Existing social policy research across Scottish CAB network focusing on medical evidence and social security, not debt

Referring solely to the Citizens Advice Network in Scotland (CAS and local Bureaux), medical evidence has been the focus of recent campaigns, though not in the context of debt. Research on the role of medical evidence in the UK Social Security system by Stirling CAB and CAS revealed numerous mutual issues. Of most concern were DWP decision makers appearing to disregard supporting medical evidence when approached to reassess a claim via the Mandatory Reconsideration (MR) process (Citizens Advice Scotland, 2017). Instances of health professionals plainly refusing to supply evidence for MRs and appeals were also revealed. Not having time was amongst the most widely cited reasons (Scobie, 2015, CAS, 2017). Health professionals are legally obligated to supply evidence to DWP personnel if approached. The same obligation does not apply to patients or third parties representing them. What is more they are permitted to charge for evidence, GPs especially, given that many work in practices that are private businesses contracting their services to the NHS. A review of evidence charges amongst local GP practices in Stirling District revealed significant variation in fees, whilst some charged nothing others requested as much as £200 per letter (Scobie, 2015). Whilst the topics are different, similar themes were uncovered between this research and the aforementioned studies.

At the time writing of this report commenced, the British Medical Association (BMA) officially announced that from 1st October English GPs will no longer charge patients and advisers for completion of DMHEFs and/or provision of alternative evidence. This change came about after lobbying from MMHPI. In their most recent *Evidence Base* publication for 2017/18 Money Advice Scotland (MAS) openly supports MMHPI's campaign, but they gave no indication of whether similar initiatives were afoot in Scotland (Money Advice Scotland, 2018). Email correspondence between the author and the BMA on 19th July confirmed that Scottish GPs remain at liberty to charge for evidence provision, but the MMHPI are presently campaigning for fees to be abolished in Scotland too.

GP practices in Scotland are still able to charge for evidence utilized in debt remedies

Data Collection:

After careful deliberation the team decided to take a qualitative approach to data collection. From January 2018 to March 2019 the social policy team worked in partnership with the debt advisers to compile a series of micro-case studies from clients seeking debt advice. Case details of all clients accessing Perth CAB are written up in a specially designed software package. The package allows advisers to highlight (flag up in CAB jargon) cases where a specific policy, protocol, etc. is clearly having a negative impact on a client and/or their household. The debt advisers were asked to 'flag up' cases where debt was an arguable catalyst for a client's poor mental health and where debt was exacerbated by mental illness. Speaking technically, sampling was 'purposive' given that only cases meeting these criteria were included. This said no restrictions or quotas were set on client demographics. Initially the criteria were applied loosely, but as the data collection progressed it was narrowed to focus principally on problematic lending practices and issues surrounding the DMHEF. These matters were raised most frequently. Furthermore, the team agreed that an in-depth exploration of restricted subject matter would produce stronger and ultimately more useful research. It should be acknowledged that debt caused by problem gambling has not been included. Whilst Perth CAB recognises both gambling addiction as a mental disorder in its own right and impulsive gambling as a potential co-morbidity of an underlying mental health condition, a vast body of literature already exists on the psychological and financial consequences of problem gambling.

Researching citizens with mental health issues is challenging both practically and ethically. Though many successfully make first contact with the debt team, doing so can be extremely wearing psychologically. Maintaining contact thereafter can be exceptionally difficult for both the client and caseworker. Likewise the latter must exercise discretion and treat mentally unwell clients sensitively so not to cause any distress. The same applies to research. Various methods, both quantitative and qualitative were assessed for suitability. A 'tick-box' client survey was drafted but not used. It can be expected that talking about their debts to an adviser would be emotionally draining for any client, let alone one with mental health issues; hence it would be inappropriate to ask them to complete a survey at the end. Practically speaking, engagement difficulties would make an abnormally high rate of non-completion likely if not inevitable. The chosen approach was compatible as no extra correspondence with the client was required, nor were the team in any way dependent on them returning data to the bureau.

Findings:

Problematic lending and collecting practices:

As can be anticipated a recurring matter was companies awarding credit to customers whose mental capacity was compromised by their mental health. Ultimately they were unable to repay the credit, causing grief to the debtor and their family:

Case study 1

Client with severe and highly complex mental health issues, which caused them to spend compulsively, was able to obtain five different credit cards, the average spending limit on each being approximately £10,000. By the time they approached the bureau the collective arrears to the credit cards was over £30,000. Their income was already low and the prospect of it increasing was scant, meaning that they would not be able to repay the debt. Client advised that a DMHEF completed by a health professional could be sent to the credit card companies, the best outcome being that the debts were written off. Sequestration also proposed as an option.

Client obtained 5 credit cards and over time accumulated arrears of over £30,000

Case study 2

Client concerned that a relative living with bi-polar disorder that excessively spends and shows virtually no capacity for financial reasoning, including how they will repay credit, was able to take out numerous high-interest loans from various lenders. They could not provide an exact figure, yet the client estimated that their relative likely owed thousands of pounds, which they could not pay back. The debtor was living at the client's address when the bulk of the credit was awarded. Client worried that as the creditors still have their address on record they are partially liable for the debts and will face recovery action. Client reassured that unless their signature was on the credit agreements they were not liable.

Case study 3

Another client living with bi-polar disorder and also spends erratically, had the spending limit on their credit card increased without them asking. Consequently, they spent more and went into further debt.

Client did not ask for credit card limit to be increased

Creditor collection practices also had potentially detrimental implications:

Case study 4

Bi-polar client, who makes excessive catalogue purchases when their condition is affecting them adversely, approached the bureau with debts of approximately £10,000. At least half of this was owed to catalogues. The catalogue companies had started sending them regular payment request letters. Included with some of these, were leaflets advertising new products and promotional items. It makes no sense that a creditor should pursue repayment, whilst at the same time, all but encourage an indebted customer to spend more and increase their debt.

Creditor's behavior sending conflicting message to indebted client with bi-polar disorder

Case study 5

Client struggling to manage severe anxiety, for which we had been prescribed anti-depressants, acknowledged that they were receiving numerous phone calls and texts from one of their creditors on a daily basis. This 'harassment' exacerbated their anxiety.

Harassment from creditors exacerbating anxiety

Inconsistency in responses to medical evidence:

The case study review revealed inconsistency between creditors concerning responses given to a DMHEF. When asked, some creditors agreed to write off debts on the basis of medical evidence. Others would not write it off but instead: agreed to take no further action, offered to suspend recovery and/or freeze interest, in some cases for up to 12 months. Some simply refused to put anything in place or did not engage at all. In terms of justification for action/inaction certain creditors explained why whereas others did not:

Case study 6

Debt purchasing company refused to write off a client's debt in response to DMHEF completed by psychiatric nurse. When adviser contacted them to enquire why, they would not divulge the reasons. Adviser challenged the company via their complaints procedure on the grounds that the refusal to explain why lacked both transparency and fairness. Prior to this, the DMHEF had been submitted to four credit card companies. One agreed to write the debt off whilst another declined. The latter justified their refusal on grounds that the debtor's surplus income was too high. The debtor is unable to work due to mental ill

Income of debtor living off benefits viewed as too high to write their debt off

health and is dependent on benefits. There was nothing to suggest that the creditor considered the evidence provided when reaching this decision. The remaining companies also would not write off the debts. Instead they offered to suspend recovery action for 30 days and 6 months sequentially, one requesting that the client provide periodic updates on their condition, whilst the debt was on hold. Though preferable to no action, this request was incompatible with the client's mental capacity, suggesting that the creditor had disregarded the evidence provided in the DMHEF.

Case study 7

DMHEF completed by clinical psychologist sent to credit card company by adviser seeking a write off. Client has various and highly composite mental health problems including Post-Traumatic Stress Disorder (PTSD) and a dissociative disorder, both of which impede their mental capacity and therefore, their ability to manage finances. In spite of evidence, the creditor flatly rejected a write off and did not state why. Adviser concerned that this refusal would exacerbate the client's mental health problems further.

Case study 8

Adviser submitted a DMHEF completed by psychiatric nurse for a client with severe mental health problems, for which they were being treated on and off as an inpatient. Credit card company offered to put the debt on hold for 6 months, but not to write it off. This increased the client's stress at an already difficult time. A further DMHEF form completed by client's psychiatrist was sent to challenge the decision. This was accompanied by a letter of complaint regarding the handling of the initial evidence. The outcome was favourable for the client in that they agreed to write the debt off.

Case study 9

DMHEF sent to credit card company for a client with mental health issues, including severe anxiety, asking if they would consider writing off the debt. The creditor did not respond. The bureau later received correspondence saying that they debt had been passed to a collection firm. Subsequently the DMHEF was sent to the collector. They did not engage either. This lack of engagement worsened the client's anxiety.

Medical evidence being of poor quality:

Though some were stronger than others, the DMHEFs acknowledged in cases 5 to 8 were on the whole, of a satisfactory standard. Unfortunately, the same could not be said for others. In some cases the quality was so poor the form was essentially useless:

Case study 10

Client approached their clinical psychologist to complete a DMHEF. The form was returned sparsely completed and did virtually nothing to demonstrate how the client's mental health issues impaired their financial capacity. Client advised to ask their GP to complete a fresh DMHEF, if they thought there was a chance the latter would make a better job. Client ended up changing psychologists the new one filling in a fresh DMHEF, which was of a much higher quality.

DMHEF returned sparsely completed and contained virtually no evidence

Case study 11

DMHEF poorly completed by psychiatrist, providing very little information. To make matters worse, the form contradicted itself, stating that the client's mental health did not affect their financial decision making. It then went on to say that their decision making was hindered by poor concentration. Subsequently, the adviser decided not to use the form, as it would be of no help. Specialist support worker from mental health advocacy group agreed to provide a written statement, which was submitted as an alternative to another DMHEF. The statement was used to support a request that debt be written off. It was successful.

DMHEF contradicting itself

Case study 12

Client's GP completed DMHEF on their behalf. The quality was dreadful. Testimonial evidence provided scant details of how client's mental health affected financial aptitude. Client was advised to approach the practice and ask that another be filled in. The second was even worse. Asides from ticking boxes, no testimonial evidence was provided at all. If that was not bad enough, whilst the initial completer ticked 'yes' that the client's mental health affected their money management skills, the new one ticked 'no' rendering it completely and utterly useless. Client decided to use the first form to support a write off request. As anticipated the creditor refused.

Only boxes ticked, no testimonial evidence provided in DMHEF

Case study 13

Psychiatric nurse filled in DMHEF for client with bi-polar disorder. Yet again, whilst they ticked 'yes' that their money management skills are affected by a mental health problem, meagre details were given as to how. The testimony made a superficial reference to systematic overspending when their mind-set was erratic, but provided no other information. Another point to note is that, at the time they approached the bureau the client was being constantly harassed by phone calls and letters from their creditors, causing them great anxiety. The completer ticked the 'no' box asking if there were

special circumstances to take into account when communicating with the client. It stands to reason that 'yes' should have been selected as a reduction in phone calls and letters would be highly beneficial to the client whilst they were waiting for a remedy to be put in place.

Case study 14

DMHEF completed quite thoroughly by a GP in handwriting that was almost illegible. Fortunately adviser was able to decipher what was written but could not be fully certain. This puts the client at a disadvantage as if the bureau struggled to read it, a creditor would too, and what is more, they would be less inclined to spend time deciphering the text. A misinterpretation could result in vital evidence being overlooked.

Miscellaneous:

The MMHPI are currently trying to persuade GP practices in Scotland to follow England and scrap fees for DMHEF completion and evidence provision. The following case does not concern a DMHEF or the submission of evidence to a creditor. Nevertheless it remains in the report to reiterate why developments down south are a timely intervention and why Scotland should take similar action:

Case study 15

Client with numerous mental and physical health issues applied to the AiB for sequestration. She was informed that she would need to provide medical evidence, as her expenditure exceeded the 'trigger figures'. Without it the application could not go further. They had approached their GP who agreed to the write the letter, but would be charging a fee – which they had not specified. The uncertainty around the fee increased the client's anxiety at a time when their mental wellbeing was already fragile.

Discussion:

As identified in case studies 1 to 3, consumers whose mental health issues compromise their ability to make appropriate decisions regarding their finances are accessing credit when by all sensible logic they should not be. This is despite FCA safeguarding efforts via the Consumer Credit Sourcebook (CONC) Guidelines. Observers can be forgiven for thinking the CONC is not fit for purpose as creditors appear to ignore it. Sustaining a fair balance between safeguarding and discrimination prevention is extremely difficult; a problem to which there are no evident or straightforward solutions. Complicating this further is the fact that the bulk of agent-customer interaction does not take place in person but over the phone or webchat, email, etc. The recent and highly publicised cull of local bank branches by Royal Bank of Scotland (RBS), Santander and Clydesdale Bank is but one example of socio-economic processes including automation, digitalisation and globalisation, which have greatly de-personalised the credit industry. Inevitably, it will be more difficult, even impossible in some situations, for agents to detect potential shortfalls in mental capacity and implement CONC recommendations. At the consumers' end a paradoxical outcome of de-personification is the increased accessibility of credit, which is something of a double-edged sword. More readily available credit will likely be helpful to some consumers. For those more disposed to problem debt, this study is but one piece of a large evidential jigsaw.

Automation, digitalization and globalization de-personalizing the credit industry

As implied by cases 4, 5 and 13, even with existing research including Mind (2011) and Evans et al, (2018) confirming increased creditor/collector competence in handling mental health and FCA good practice guidelines available for reference, recovery practices, to quite an extent, remain somewhat injurious to mentally unwell debtors. Case study 4 requires careful handling. It goes without saying that creditors' dispatching frequent letters demanding payment is not conducive to the mental welfare of a bi-polar sufferer, as is enclosing new product flyers with said letters when the individual in question is prone to unwarranted spending on part of their illness. This aside we cannot know if the creditors were aware of the client's condition. Even if the collection agents did, it is unlikely that this information would have filtered down to administrative staff handling outward mail. Readers may note that none of the case studies professed to having contemplated or attempted suicide on part of mental ill health exacerbated by problem debt. This would only be known if the clients choose to share this, therefore it cannot be ruled out that case study participants may have pondered taking their own lives at some point or another.

MALG recognise writing off debt as the *"last resort"* with regards to non-statutory debt remedies for citizens with mental health issues (Money Advice Liaison Group, 2015, 30). Taking care not to overgeneralise, this position is mutual across money advice services, advisers only pursuing if it is realistic a creditor(s) may agree. It may have required some extra persuasion; still it is encouraging that in case studies 6 and 8 the creditors did ultimately write the debt off. This reinforces the validity of the findings of Evans et al, (2018) given that the evidence supports the premise that debt collection agents are accommodating mental health issues to a greater extent. Even where write offs were denied, the same line of reason applies to offers to suspend recovery. Unfortunately, proactive creditor/collector responses to DMHEFs or alternative evidence were not universal. Positive connotations aside, the generic rationale behind suspended recovery is to allow a creditor to wait and see if a debtor's mental health will improve (Davey and Fitch, 2011, 09). Whether this expectation is realistic or practical varies greatly. Merely holding recovery for 30 days will be of no notable benefit to a debtor with mental health issues, who will likely take longer to consider their options. If mental capacity is diminished by mental illness, it is unrealistic for a creditor to expect regular updates on a debtor's condition. It is improbable that a severe chronic mental illness will improve within a month or similarly short time space. Secondly, heavy correspondence in pursuit of updates will result in debtors feeling harassed, aggravating their condition. Those of greatest concern are individuals already being harried by other creditors. As justified by case studies 6, 7 and 9 creditors not taking medical evidence into consideration, refusing to account for decisions, providing nonsensical reasons or not engaging altogether is unacceptable and causes undue stress and anxiety. These cases represent the worst excesses and are not representative of the credit industry as a whole. Likewise, we do not know exactly why these creditors responded as they did. As stated by Davey and Fitch (2011, 10) creditors will take a DMHEF into consideration, but may ultimately make a decision based on the debtor's financial statement, if they believe the former can afford to make minuscule regular payments. This could explain why one of case study 6's creditors refused a write off on the basis of income. Yet again the realism of this practice, especially for those on very restricted incomes is highly debateable. Another plausible explanation could be that a firm has a policy prohibiting write offs. Debt advisers at Perth CAB have seen creditors refuse write offs as they believe doing so *"encourages misuse of credit"*. Agents may lack the knowledge, experience or authority to make an informed

Is it realistic for a creditor to expect that a debtor's mental health will improve within a matter or mere weeks or months?

Cases studies represent the worst excesses and not representative of credit industry as a whole

judgement and/or a decision on the basis of DMHEF evidence. It may also be that they do not have the time or resources to give them due attention.

Shifting the focus from creditors to health professionals, inconsistency is a common discernible theme. Appraisal of case studies 10 to 13 reveals disparity between health professionals, regarding the quality of completed DMHEFs. Potentially, this is highly disadvantageous to debtors with mental health issues, especially in cases where a coherent DMHEF is crucial for convincing a creditor to write off debt or suspend recovery. Additionally, as witnessed in case studies 10 and 12, it is not practical or convenient for a debtor or adviser to bid the original author or a different health professional to complete a new DMHEF, though as 10 (and 8) indicate, it can be fruitful. Comparison of DMHEF quality amongst differing types of health professional is not an explicit remit of this study, still it is worth noting that within this sample no occupation appeared to have a monopoly on either meagre or strong completion. This contrasts somewhat with Davey and Fitch (2011, 17) whose research revealed that advisers deemed DMHEFs completed by CPNs and social workers to be a higher quality than GPs, given that their engagement with a patient is more rigorous. Case study 12 may well be an example of this, but of course that cannot be known for sure. A further observation made by Davey and Fitch (2011, 18) was creditors affording greater kudos to DHMEFs completed by GPs and psychiatrists over those done by CPNs and social workers (rather ironic given those from the latter are typically deemed to be of a higher quality). Regardless of irony, in case study 8 the creditor only agreed to write of the debt after receiving a new DMHEF from a psychiatrist, having only put it on hold after a psychiatrist nurse submitted the original form. The complaint letter from the debt adviser accompanying the new form undoubtedly strengthened the conviction of the second attempt to write off the debt, still, it remains plausible to speculate that the testimony of a psychiatrist was favoured over a psychiatric nurse and inevitably would have influenced the positive outcome. On par with the appraisal of case study 4, 14 must be treated fairly. The borderline illegible handwriting was not a malicious act and it is very possible the GP in question overestimated the legibility of the text. However, this does not change the fact that this constitutes a significant and highly avoidable hurdle to both the debtor and adviser.

This evidence paints quite a grim picture of how health professionals are responding to the needs of indebted clients with mental health issues. This said the study does not set out to apportion blame. The mechanics of the sampling process mean that only the worst cases are recorded, further exemplifying the need not to overgeneralise. Still, it is vital that the possible causes of poor practice are discussed so that solutions can be devised. Davey and Fitch (2011 19) assert that unfamiliarity with the DMHEF was a recurring problem amongst debt advisers. A colleague who frequently engages with

health professionals regarding DHMEF completion suggested that the aforementioned may have the same problem. Despite the part played by the RCP and similar institutions in designing the DMHEF, the informant stressed that health professionals, more specifically those operating within Perth and Kinross, will seldom encounter a DMHEF. Perth CAB excluded, it is quite doubtful that other local agencies use them. Without regular encounters, health professionals cannot be expected to know what is required and why methodical completion is so important. It cannot be escaped that this testimony is based on informed speculation instead of hard fact. Nonetheless, it is sufficient both as a foundation upon which to construct a potential research objective for a future study.

Alongside familiarity, demands and workloads could also explain fluctuations in evidence quality from health professionals. It is well documented that health professionals in NHS primary care and mental health services, are overwhelmed with their current workload. For example, a study published last month by the Royal College of GPs highlighted that almost 40% of Scottish GPs admitted that at least once a week they felt inundated by their workload and on average could only spend a maximum of 10 minutes on each patient appointment (BBC News, 2019). The situation is similar for mental health professionals. Both Davey and Fitch (2011) and Scobie (2015) acknowledge the heavy clinical workload of psychiatrists, which leaves them with little time for administrative tasks including evidence provision. The latest official statistics from NHS Scotland on waiting times for Psychological Therapies revealed that as of March this year, nearly 18,000 patients commenced treatment, an increase of over 1,200 since December. In addition, approximately 2 out of 10 patients waited longer than the Scottish Government's 18 week maximum waiting time threshold to start treatment (NHS Scotland, 2019). Both services are clearly working at capacity, which accounts in part for scant completion of DMHEFs, due to there being insufficient time to provide ample detail.

Another possible explanation for GPs is that in practices where patients are seen on a communal basis instead of being allocated a doctor, completing a DMHEF will be more difficult. Davey and Fitch (2011, 07) note that some creditors received DMHEFs from GPs (and psychiatrists) which were either filled with irrelevant information or full of technical medical jargon, which could not be easily interpreted. Unfamiliarity with the patient's case was proposed as a possible justification. This could also account for a form being completed sparsely.

Conclusion:

To reiterate, the research question sought to examine how creditors and health professionals are responding to the needs and circumstances of indebted citizens with mental health issues. There is no clear cut answer for either.

Regulatory bodies such as the FCA are clearly knowledgeable of how mental ill health can diminish consumers' mental capacity and consequently their ability to manage their finances. Protocols have been devised and implemented so their needs are better accommodated. This said, the scale and scope of the credit industry in the UK is so vast and varied, ensuring that *all* firms adhere to these is akin to herding cats. This is made all the more difficult by the ongoing shift from face to face to digital engagement between consumers and the creditors. The cases in this report are the 'best of the worst' and are not wholly representative of generic practice across the board. Yet, they reinforce the point that while top-down measures may be in place, there certainly is further work to do at grassroots level.

In this research there were no recorded incidents of a health professional refusing to complete a DMHEF or provide alternative evidence to assist an indebted patient. Unfortunately since its completion cases of this have been flagged up in the bureau – see Appendix A. Also disappointing are the numerous incidents of badly completed DMHEFs recorded by the bureau. Without doubt this is not conducive to the needs of citizens with mental health conditions with problem debts, and is potentially very harmful to their short and long-term well-being. Clearly action is needed to rectify this issue; however, knee-jerk reactions are neither helpful nor practical. Solutions must be devised with discretion and empathy, especially given the difficulties primary care and mental health professionals are currently facing.

Knee-jerk reactions neither helpful nor practical

Finding concrete long-term solutions to the shortfalls identified is greatly outwith the scope of this small-scale study. The following section lists recommendations informed by the research findings for both national and local initiatives to provide mitigation and perhaps refine some existing protocols. As things stand from this study's perspective, creditors and health professionals are willing to support citizens with mental health issues to resolve problem debt. Unfortunately, existing measures are meeting with mixed success. Improvements are very possible and should be pursued.

Recommendations:

Some of these recommendations may already be in place. If so their preservation is encouraged highly.

National:

- On par with England, GPs in Scotland should agree not to charge for DMHEF completion and/or evidence provision for debt remedies (note: some surgeries may have already done so)

- The exchange of good practice by the FCA and other agencies is already underway and should be continued. It is particularly important that staff in firms interacting directly with consumers should have the opportunity to share *their* experiences, concerns and ideas and for these to shape future guidelines

- Customers themselves should be invited to impart their experiences of what works best for them and what does not. These should also be used to formulate and modify guidelines. At the end of June MMHPI launched the Mental Health Accessible Initiative (MHAI), which aims to streamline accessibility of banks and utility services for consumers with mental health issues. Amongst the methods by which providers will be assessed against MHAI access criteria, are customer surveys and interviews with the former and staff (MMHPI, 2019). As well as being a most timely initiative, this is an invaluable opportunity to observe how feasible this recommendation is in practice

- Opportunities for mental health awareness training must be available for creditors and collectors wanting to improve their knowledge and understanding of mental health and how best to engage with customers who may have mental illnesses. This is particularly important for those tasked with making decisions on the basis of DMHEFs and/or alternative evidence as to whether or not debt is written off

- Fresh research is required into the relationship between health professionals and debt advice/remedies. Organisations such as CAS which have investigated medical evidence issues in the social security system should, with support from local bureaux, extend their focus to debt. Research could possibly be done in partnership with fellow third sector organisations including StepChange, Mind, Scottish Association for Mental Health (SAMH) etc. perhaps with support from NHS Scotland, local authorities, The Scottish Government and UK Government

- Financial wellbeing should be incorporated into nationally implemented protocols for assessing new patients with mental health issues. Where appropriate health professionals should signpost those acknowledging debt issues to sources of support, either national or local

Local:

- Citizens with mental health issues are legally entitled to access credit should they wish and cannot be stopped from doing so. This aside, if a money adviser, support worker or health professional is concerned that poor mental health is undermining mental capacity; they should provide the appropriate support to ensure to the greatest possible extent that the individual in question understands how the repayment process will work and what can happen if they fall behind with payments. Inter-agency signposting and referring should be available if a worker/health professional does not have the knowledge to undertake this independently

- As the credit industry digitalises further more local bank branches will be lost from high streets, particularly in rural and smaller settlements. Larger branches, which have absorbed customers from closed outlets, should ensure that they retain some local presence such as a regular mobile bank. It cannot compensate for the lack of a local branch, nevertheless, in tandem with the previous recommendation, preservation of interpersonal communication should ultimately be beneficial for users with mental health issues

- Local mental health and money forums could be established. Amongst those invited to participate could be debt advisers, GPs, CPNs, psychiatrists and representatives from local banks, local authorities, etc. This would allow for topics such as completion of DMHEFs to be discussed and for examples of good practice to be exchanged. Geographically individuals forums could operate in each local authority, or on a 'regional' basis i.e. Tayside incorporating Angus, Dundee City and Perth and Kinross

- Mental health strategies including service delivery plans devised by local authorities and/or regional health boards must include debt and financial wellbeing amongst the underpinning prerequisites for good mental health. Also, they should ensure that local organisations providing money advice such as CAB and credit unions are incorporated or at the very least consulted. This recommendation is not confined to generic service delivery and should be applied to locally delivered initiatives to reduce and prevent suicides

Appendix A: Postscript:

Between the completion and publication of this report, the debt team flagged up some further pertinent cases. It was decided not to include them in the results section as they were outside the sample timeframe. Nevertheless, they have been added as an appendix as they provide further evidence, illustrating the complexities encountered by indebted citizens with mental health issues when engaging with third parties. Furthermore, they add reinforcement to the recommendations:

Case study 1:

GP refused to complete a DMHEF until the client had paid a £40 charge up front. Client was living on a very restricted income and did not have money available to pay. Adviser approached local charities to see if client could apply for a 'grant' to pay the fee

Case study 2:

Client with complex mental health issues, exacerbated by substance addiction approached his GP practice, asking if they could write a letter detailing his health problems, which could be dispatched to his creditors. He expressed a willingness to pay if needed. Request was refused downright, the practice stating "they don't do that". They suggested that he ask his creditors to write directly to them to request information. Adviser not confident that the creditors would cooperate, however, it was agreed that they would try

Case study 3:

Client had asked their CPN to complete a DMHEF; however they had refused for no clear reason. Client advised to approach either their GP or their support worker as they are also eligible to complete the form

Case study 4:

Well completed DMHEF sent to creditor. The refused to accept it as it had not been stamped. The form had been completed by a support worker who does not have an official stamp as they are employed through Self-Directed Support. Adviser considered this unfair, as stamping is becoming an increasingly archaic practice. Client facing the choice of challenging the refusal via the creditor's complaints procedure or approaching their GP to request a ask for a new DMHEF be completed and stamped

Bibliography:

AdviserNet (2019) *13.3.4.7 Entering into a credit agreement* [Online] Available at

https://www.citizensadvice.org.uk/scotland/advisernet/debt-and-money/getting-credit/entering-into-a-credit-agreement/ (Accessed 25th April 2019).

BBC News (2019) *Patients should get 15-minute appointments with GPs* [Online]

Available at

http://www.bbc.co.uk/news/uk/uk-scotland-38512297 (Accessed 05 June 2019).

Bond, N. Holkar, M. (2018) *A Silent Killer, Breaking the link between financial difficulty and suicide* London, Money and Mental Health Policy Institute

Braverman, R. Holkar, M. Evans, K. (2018) *Informal Borrowing and Mental Health Problems,* London, Money and Mental Health Policy Institute

Citizens Advice Scotland (2017) *Burden of Proof, The role of medical evidence in the benefits system,* Edinburgh, Citizens Advice Scotland

Citizens Advice Scotland (2018) *Citizens Advice Service Statistics 2017-18* [Online]. Available at

https://www.cas.org.uk/system/files/publications/scotland_2.pdf (accessed 08 February 2019)

Davey, R. Fitch, C. (2011) *Debt collection and mental health: an evaluation of the Debt and Mental Health Evidence Form,* London, Royal College of Psychiatrists

Evans, J. Fitch, C. Collard, S. Henderson, C. (2018) 'Mental health and debt collection: a story of progress? Exploring changes in debt collectors' attitudes and practices when working with customers with mental health problems, 2010-2016' *Journal of Mental Health*, Vol. 27, No. 6, pp. 496-503

Fitch, C. Chaplin, R. Tulloch, S. (2010) 'The Debt and Mental Health Evidence Form A tool for health professionals and lenders dealing with customers with self-reported mental health problems' *The Psychiatrist,* Vol. 34, pp. 95-100

Financial Conduct Authority (2015) *Occasional Paper No. 8 Consumer Vulnerability February 2015,* London, Financial Conduct Authority

Financial Conduct Authority (2019) *Consumer Credit Sourcebook,* London, Financial Conduct Authority

Glasgow Centre for Population Health (2018) *Briefing Paper 54, The Public Health Implications of Rising Debt, October 2018* [Online] Available at

https://www.gcph.co.uk/assets/0000/6995/BP54_Public_health_implications_of_rising_debt.pdf (Accessed March 2019).

Jenkins, R. Bebbington, T. Bhugra, D. Farrell, M. Coid, J. Singleton, N. Meltzer, H. (2009) 'Mental Disorder in People with Debt in the General Population' *Public Health Medicine*, Vol. 6, No. 3. pp 88-92.

Law, J. (2013) *Oxford Dictionary of Law 8th Edition,* Oxford: OUP

Mind (2011) *Still in the red, Update on debt and mental health,* London, Mind

Money Advice Liaison Group (2015) *Good Practice Awareness Guidelines for helping consumers with mental health conditions and debt* [Online] Available at

http://malg.org.uk/wp-content/uploads/2017/03/MALG-Debt-and-Mental-Health-Guidelines-2015.pdf (Accessed June 2018).

Money Advice Scotland (2018) *Evidence Base 2017/18* [Online]. Available at

https://www.moneyadvicescotland.org.uk/sites/default/files/MAS%20Evidence%20Base%2017-18_1.pdf (Accessed 14 July 2019).

Money and Mental Health Policy Institute (2019) *Mental Health Accessible, why do we need to think about accessibility for mental health?* [Online] Available at https://www.moneyandmentalhealth.org/wp-content/uploads/2019/06/Mental-Health-Accessible-standards-summary.pdf (Accessed 09 July 2019).

Murray, N. (2017) *Policy Note 11 Know the odds: the link between mental health problems and gambling* [Online] Available at

https://www.moneyandmentalhealth.org/wp-content/uploads/2017/11/Know-the-odds-Gambling-policy-note.pdf (Accessed June 2018)

National Debt Helpline (2017) *Debt and mental health Fact sheet no 53 SCOT Debt and mental health* [Online]. Available at

https://www.nationaldebtline.org/S/factsheets/PDFs/debt-and-mental-health-scotland.pdf (Accessed 22 June 2018).

NHS Scotland (2017) *Inequality Briefing 10: Mental health* [Online] Available at

http://www.healthscotland.scot/media/1626/inequalities-briefing-10_mental-health_english_nov_2017.pdf (Accessed 15th February 2019).

NHS Scotland (2019) *Psychological Therapies Waiting Times in NHS Scotland* [Online] Available at

https://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2019-06-04/2019-06-04-WT-PsychTherapies-Summary.pdf (Accessed 10 July 2019).

NHS Health Scotland (2019) *Mental health and wellbeing* [Online]

http://www.healthscotland.scot/health-topics/mental-health-and-wellbeing/overview-of-mental-health-and-wellbeing (Accessed 02 September 2019).

Reeves, A. McKee, M. Stuckler, D. (2014) 'Economic suicides in the Great Recession in Europe and North America' *The British Journal of Psychiatry*,

Rowe, B. Holland, J. Hann, A. Brown, T. (2014) *Vulnerability exposed: The consumer experience of vulnerability in financial services,* London, Financial Conduct Authority

Scobie, A. (2015) *Under Pressure, A research report into medical evidence,* Stirling, Stirling Citizens Advice Bureau

StepChange (2018) *Scotland in the Red, the latest debt statistics from StepChange Debt Charity Scotland,* Glasgow, StepChange

StepChange (2019) *Scotland in the Red, The Impact of problem deb in Scotland* [Online] Available at

https://www.stepchange.org/Portals/0/documents/Reports/scotland-in-the-red-2018-stepchange-debt-charity.pdf (accessed 10 April 2019)

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To ensure that individuals do not suffer through lack of knowledge of their rights and responsibilities, or of the services available to them, or through an inability to express their needs effectively

and equally:

To exercise a responsible influence on the development of social policies and services, both locally and nationally.

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