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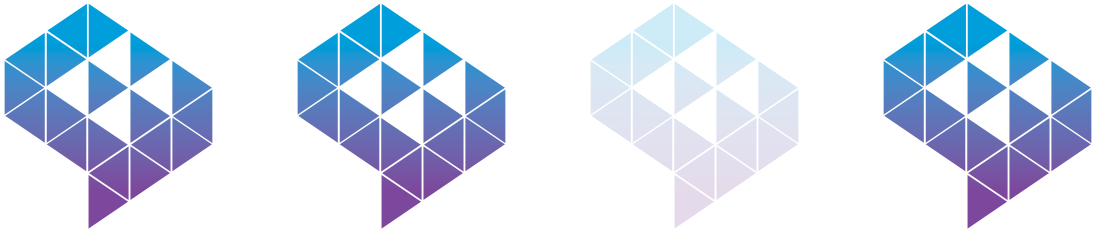

THE OTHER ONE IN FOUR

How financial difficulty is neglected in mental health services

Tasneem Clarke, Rose Acton and Merlyn Holkar

Contents

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DEBT

Executive summary

What is the problem?

- Mental health services are under severe financial pressure. Historic and continuing underfunding have led to services in crisis. 40% of mental health trusts experienced reductions in income in 2013/14 and 2014/15.[1]
- At the same time, the number of people at risk of problem debt is rising. The latest Bank of England figures find that UK households on average owe 132% of their income and lending to households is at its highest level since 2008.[2] The ability of people to service their debt will be challenged by the predicted coming period of weaker employment and income growth.[3]
- Living in financial stress can lead to mental health problems. The more debts a person has, the more likely they are to develop a mental health problem, even after adjusting for income and other factors.[4] As the number of people in problem debt rises, so too will the number of people needing to use mental health services, which are already operating at maximum capacity in most cases.[5]
- Financial difficulty can also worsen and prolong mental health problems. People with depression who are also in financial difficulty are 4.2 times more likely to still have depression when contacted 18 months later than people without financial difficulty. One in four people using existing mental health services are also in problem debt. This group are likely to need greater support for a longer period of time.
- More people facing financial insecurity will put further pressure on mental health services which are ill-prepared to cope, both by increasing demand and by reducing recovery rates.
- Tackling financial difficulty is an issue of both prevention and treatment:
  - Reducing the number of people in financial crisis will have a public health benefit by helping to prevent the onset of poor mental health.
  - For people with existing mental health problems helping them to overcome their financial difficulty is a form of treatment, improving both recovery rates and patient outcomes.

How the link between financial difficulty and mental health problems is currently being tackled

A new Freedom of Information (FoI) exercise by the Money and Mental Health Policy Institute has found that while there are some pockets of good practice, tackling financial difficulty is falling between the cracks in the health systems of the United Kingdom. Without a systematic approach, support to address the financial difficulties that can both cause and perpetuate mental health problems is patchy and its impact limited.

1. The King's Fund. Briefing: Mental health under pressure. November 2015.
2. Financial Policy Committee, Financial Stability Report, July 2016. London. 2016. Issue No. 39.
3. Bank of England, Inflation Report August 2016. London; Office for Budget Responsibility. Economic and Fiscal outlook: November 2016. November 2016.
4. Fitch C, Hamilton S, Bassett P, et al. The relationship between personal debt and mental health: A systematic review. Mental Health Review Journal 2011; 16, 4: 153-166.
5. The King's Fund. Briefing: Mental health under pressure, November 2015.

- **Lack of a systematic approach**

We found that only 4% of Clinical Commissioning Groups (CCGs) had a systematic approach to tackling financial difficulty in England. Across the devolved nations, 33% of Northern Irish Health and Social Care Trusts and 10% of Scottish NHS Trusts dealt with financial difficulty systematically, and no Welsh Local Hospital Boards did so. There is clearly a way to go across the UK before financial difficulty is considered consistently and thoroughly throughout its health systems.

Our criteria for a systematic approach is that the health system recognises the link between financial difficulty and mental health problems in strategic planning, provides an intervention designed to meet this need, including through partnerships with other organisations, and collects data on the extent to which people are affected by financial difficulty to inform this strategic planning and commissioning. Within each of these areas we also find a lack of consistency of approach between nations and areas.

- **No joined up assessment of local need**

A systematic approach starts with recognising the link between financial difficulty and mental health in strategic planning. Only 22% of CCGs in England said they considered financial difficulty in their local health needs assessment, as did only 14% of Welsh Local Hospital Boards, 25% of Northern Irish Health and Care Trusts and 45% of Scottish NHS Trusts.

However, four in ten (40%) Public Health teams told us they consider financial difficulty in their local needs assessment. Local authorities and CCGs in England have equal and joint duties to prepare Joint Strategic Needs Assessments (JSNAs) and the Joint Health and Wellbeing Strategies through which these needs should be met, through the Health and Wellbeing Board. It is, therefore, concerning that Public Health teams and CCGs differ so significantly in their views on whether financial difficulty is considered as part of their local needs assessment.

It may be that Public Health teams are exploring this in their own independent needs assessments. While this is encouraging, this insight should be integrated with the wider JSNA. Worryingly, a quarter (26%) of CCGs in England directed us to ask elsewhere about recognising financial difficulty in needs assessments, most commonly the local authority, suggesting they do not consider this to be a health need, or consider it only a matter for public health rather than treatment services. Assessing this issue solely from the perspective of prevention will not meet the needs of people who already have a mental health problem and financial difficulties.

- **Patchy coverage of specialist services**

The provision of specialist services to tackle financial difficulty is patchy geographically, meaning the care available to people experiencing both mental health problems and financial difficulties depends on where you live.

We found that nearly half of CCGs and NHS Trusts that provide mental health services in England either commission or work with an external organisation to provide a specialist service for people experiencing both mental health problems and financial difficulty. In the devolved regions these specialist services are even more common: every Welsh Local Hospital Board told us they had some form of specialist provision, as did 91% of Scottish NHS trusts and three quarters of Northern Irish Health and Social Care Trusts. But this still leaves large areas, of England in particular, without appropriate provision.

- **Existing services not consistently reaching those who need them**

For the specialist services that exist to reach those who need them, health services must routinely screen service users for financial difficulty. Encouragingly, more than half (57%) of NHS trusts in England ask people with mental health problems if they are also experiencing financial difficulty. The devolved nations are even further ahead with three-quarters (75%) of Northern Irish Health and Social Care Trusts, 71% of Welsh Local Hospital Boards and 73% Scottish NHS Trusts routinely screening service users. But only 17% of CCGs make sure that providers ask service users about their financial situation, showing a lack of prioritisation of this issue at the commissioner level, or for primary care services, despite the potential improvement in outcomes it could bring.

Only 34% of NHS Trusts and 9% of CCGs in England both screen for financial difficulty and provide a specialist service. This means that there are services who are screening for financial difficulty but who can't address this need: a particularly damaging message to someone who may already be feeling hopeless due to a mental health problem. Again, the devolved nations are further ahead with 75% of Northern Irish Health and Social Care Trusts, 71% of Welsh Local Hospital Boards and 64% of Scottish NHS Trusts both asking the question and meeting the need.

- **Poor data collection**

Out of those who offer a specialist service or have a working relationship with someone who does, in England only 17 CCGs (17%) and one NHS Trust (4%) were able to provide a figure for how many people use the service. Without this information, health services cannot understand the level of need for these services, or the extent to which this need is being met. The devolved nations lead the way on this, with 30% of Scottish NHS Trusts and 67% of Northern Irish Health and Social Care Trusts able to tell us how many people used the services. Although all seven Welsh Local Hospital Boards provide a specialist service for people with mental health problems experiencing financial difficulty, none of them collect data on how many people make use of these services.

How to effectively tackle the link between financial difficulty and mental health problems

Advice services are enormously effective in resolving financial difficulty.[6] But for people with mental health problems, taking the first step and asking for help can be enormously difficult. Many people wait up to 12 months before seeking help, experiencing the stress and strain of financial difficulty for longer as a result.[7]

Although there is a lack of systematic provision for people experiencing both mental health problems and financial difficulty, innovative services in some areas are proving that addressing financial difficulty in clinical settings can reduce pressure on mental health services and improve outcomes for patients. These services are most effective when they are provided in a location which is familiar and accessible to people with mental health problems, by a trusted provider and by advisers who have been trained in mental health so they understand the specific barriers this client group faces.

Most importantly, specialist services for people experiencing both mental health problems and financial difficulty must be well integrated with other services, such as housing or welfare advice. A timely and warm referral,[8] information sharing, and link workers or peer supporters to help people with mental health problems to access support all significantly improve the likelihood of engagement with debt advice, and the chances that financial difficulty can be resolved.

6. O'Brien C, Willoughby T and Levy R. The Money Advice Service Debt Advice Review 2013/14. August 2014; Ellison A and Whyley C. Debt Advice Channel Strategy Research: Volume one – The client experience of channel choice, use and outcomes. 2012; Citizens Advice. The impact of debt advice. 2015.
7. StepChange. Statistics Yearbook: Personal Debt 2013.
8. A warm referral takes place when there is a direct interaction between the organisation who is referring the client on and the advice provider, and the client details and relationship are directly passed on. This is distinct to signposting, where the client is only provided with the contact details of the advice provider and it is their responsibility to make contact. Warm referrals minimise the risk that people will fall through the gap in the signposting process and therefore increase the likelihood of the uptake of advice. For more information see Citizens Advice. The Referral Gap. January 2016.

The case for more systematic provision of support for people with both mental health problems and problem debt

Initial evidence suggests that providing debt advice in healthcare settings can reduce GP appointments and prescriptions for some medicines used to treat mental health problems, as well as decreasing clinical workload.

However, there is a lack of evidence of the clinical impact of debt advice for those experiencing financial difficulty and a mental health problem. This appears to be creating a gap, meaning that financial difficulty falls off the radar of healthcare commissioners and providers, even though initial evidence suggests that debt advice can reduce levels of anxiety and improve sleeping patterns, general health and relationship stability, in additon the evidence of the potential cost savings to the health system is strong.

Next steps

Money and Mental Health will begin work in 2017 to build the clinical evidence base for the provision of financial advice in mental health settings. However, there is sufficient existing evidence to justify more urgent action from the health system. Our recommendations include:

- **Routinely screen service users for financial difficulty and refer them on to help**

  People with mental health problems are significantly more likely to be in problem debt, which in many cases will be aggravating their mental health problems. They are also likely to struggle to access advice services without support. Simply by asking about financial difficulty and signposting to local advice services, healthcare providers could help to raise awareness of debt advice and increase the numbers receiving help.

- **Train mental health practitioners to improve understanding of the link between money and mental health.**

  Improved understanding of financial difficulty among mental health practitioners should also boost their confidence to break the taboo of talking about money, increasing the effectiveness of screening and helping service users to overcome the stigma of talking about debt.

- **Consider financial difficulties in local needs assessments.**

  Financial difficulties pose a separate risk to mental health, independent of income, and are not only found among deprived populations. Actively considering levels of problem debt locally and the impact it has upon mental health would enable commissioners to provide more effective services to people with mental health problems.

- **Provide tailored financial advice to people experiencing both mental health problems and financial difficulties.**

  Providers should consider setting up or extending specialist financial advice services, to increase the likelihood that people will access help. These services could be commissioned (and funded) specifically for particular patient groups, or developed in partnership with existing local advice provision to ensure services are well-integrated with local mental health services and meet the specific needs of people with mental health problems.

- **Evaluate specialist advice services.**

  To ensure that specialist advice services are properly meeting the needs of people experiencing both mental health problems and financial difficulty, service use should be monitored and provision evaluated to ensure it is delivering the desired impact.


FINANCE

Section One - Why should healthcare providers be thinking about financial problems?

1.1 The links between money and mental health

There is a well-established link between mental health problems and financial difficulties. More people have anxieties and fears about money, finances and debt than about any other issue[9] and, in some cases, these anxieties can spiral into a mental health problem. People with problem debt are twice as likely to develop major depression as those not in financial difficulty.[10] The correlation between problem debt and mental health problems is overwhelmingly strong: about half of people with problem debts (45%) have a mental health problem, compared with 20% of people not experiencing financial difficulty.[11] The more debts a person has, the more likely they are to develop a mental health problem, even after adjusting for income and other factors.[12]

The causation appears to go both ways. While fewer than one in ten (8%) people without mental health problems are in problem debt, this rises to nearly one in four (24%) for people experiencing depression or anxiety, and one in three (33%) for people experiencing psychosis.[13] People with severe mental illness are 2.3 times as likely to experience money or debt problems; 2.4 times as likely to experience welfare benefits problems; and 2.8 times as likely to experience problems relating to homelessness. Yet the poorer someone's mental health, the greater the likelihood that they will not be able to resolve problems like these, especially without help and support.[14] People with mental health problems are therefore more likely to be in debt, and less likely to be able to resolve it. This has significant implications beyond finances; those in problem debt are twice as likely to think about suicide as those not in financial difficulty, even after controlling for other factors.[15]

Definitions

Throughout this report "problem debt" and "financial difficulty" are used interchangeably. In both cases we mean people who are in arrears and unable to meet payment obligations when they are due. Most of the existing research on the link between mental health and problem debt is based on the 2000 British Adult Psychiatric Morbidity Survey which asked people whether they had been seriously behind in paying their bills in the past year.[16] The Financial Conduct Authority's guidance on financial difficulties states that indicators of financial difficulty include consecutively failing to meet minimum repayments on credit, an inability to meet repayments out of disposable income, evidence of non-payment of essential bills (such as utility bills) and having to borrow further to repay existing debts.[17]

9. Mental Health Foundation. In the face of fear: How fear and anxiety affect our health and society, and what we can do about it. April 2009.
10. Skapinakis P, Weich S, Lewis G, et al. Socio-economic position and common mental disorders: Longitudinal study in the general population in the UK. British Journal of Psychiatry 2006; 189: 109-17.
11. Jenkins R et al. Mental disorder in people with debt in the general population. Public Health Medicine 2009; 6, 3: 88-92.
12. Fitch C, Hamilton S, Bassett P, et al. The relationship between personal debt and mental health: A systematic review. Mental Health Review Journal 2011; 16, 4: 153-166.
13. Jenkins R et al. Debt, income and mental disorder in the general population. Psychological Medicine 2008; 38: 1485-1493.
14. Balmer N and Pleasance P. Psychiatric morbidity and people's experience of and response to social problems involving rights. Health and Social Care in the Community 2010; 18, 6; 588-597.
15. Meltzer H et al. Personal debt and suicidal ideation. Psychological Medicine 2011; 41, 4; 771-778.
16. National Statistics. Psychiatric morbidity among adults living in private households, 2000: Technical Report. 2002.
17. Financial Conduct Authority. CONC 1.3 Guidance on financial difficulties. Version of the handbook as at 27 October 2015.

1.2 Counting the cost of financial difficulty to the NHS

Mental ill health is the largest single cause of disability in the UK, contributing almost 23% of the overall burden of disease, compared to about 16% each for cancer and cardiovascular disease. Receiving only 13% of NHS health expenditure,[18] mental health services currently face a huge challenge in attempting to provide care with shrinking resources.[19] 40% of mental health trusts experienced reductions in income in 2013/14 and 2014/15.[20] Under such pressure, it is ever more vital that opportunities to reduce reliance on costly NHS services are not missed. Tackling the relationship between financial difficulties and mental health problems represents one such opportunity.

Mental health problems created or worsened by financial difficulty impose a dual cost on the health system. Firstly, financial difficulty generates additional demand for services which are already stretched. Nearly half (47%) of respondents to a StepChange survey reported that they had visited their GP about health conditions caused by their debt. A further 6% said they had visited hospital, and 5% had visited Accident and Emergency.[21] GPs spend almost a fifth of their time on social issues, including financial difficulty, that are not principally about health, at a cost of almost £400 million a year.[22]

Secondly, financial difficulty drastically reduces recovery rates for common mental health conditions. People with depression and problem debt are 4.2 times more likely to still have depression when contacted 18 months later compared to people without financial difficulty. For those with anxiety, having financial difficulties means you are 1.8 times more likely to still be experiencing anxiety 18 months later than if your finances were sound.[23] Our analysis suggests that financial difficulty is significantly reducing recovery rates across the NHS Improving Access to Psychological Therapies programme[24] - meaning service users will require further clinical intervention, more appointments and medication for a longer period of time. Both the human and financial costs quickly add up.

Meanwhile, debt levels are rising, and with the economy expected to slow in coming years, financial difficulty is likely to become even more common. The latest Bank of England figures find that UK households on average owe 132% of their income, lending to households is at its highest level since 2008,[25] and the latest Office for Budget Responsibility forecast predicts this will rise to 148% by the start of 2021.[26] The ability of people to service their debt will be challenged by the predicted coming period of weaker employment and income growth.[27] The latest Office for Budget Responsibility forecast also predicts a higher unemployment rate and a fall in real earnings from the second half of 2017, due to the cost of consumer goods being driven up by higher inflation and lower income growth.[28]

Healthcare providers are therefore likely to find themselves seeing more people who are experiencing both mental health problems and financial difficulty. Health services must act now to make sure they can tackle this toxic link to provide the best possible patient care and ensure services are not overwhelmed by an increase in demand driven by a worsening economic situation.

18. The Centre for Economic Performance's Mental Health Policy Group. How mental illness loses out in the NHS. June 2012.
19. Mental Health Strategies. 2011/12 National survey of investment in adult mental health services. August 2012.
20. The King's Fund. Briefing: Mental health under pressure. November 2015.
21. StepChange. Statistics Yearbook: Personal Debt 2014.
22. Citizens Advice. A very general practice: How much time do GPs spend on issues other than health? May 2015.
23. Skapinakis P, Weich S, Lewis G, et al. Socio-economic position and common mental disorders: Longitudinal study in the general population in the UK. British Journal of Psychiatry 2006; 189: 109-17.
24. Acton R. The Missing Link: How tackling financial difficulty can boost recovery rates in IAPT. October 2016.
25. Financial Policy Committee, Financial Stability Report, July 2016. London. 2016. Issue No. 39.
26. Office for Budget Responsibility. Economic and Fiscal outlook: November 2016. November 2016.
27. Bank of England, Inflation Report August 2016. London.
28. Office for Budget Responsibility. Economic and Fiscal outlook: November 2016. November 2016.

1.3 How healthcare can help

The link between mental health and deprivation is rightly acknowledged by NHS and public health commissioners. The core data for Joint Strategic Needs Assessments, for example, contains a significant volume of information about local deprivation levels. There is not, however, the same recognition that financial difficulties have a separate and significant relationship with mental health problems.

Moreover, there is relatively little that healthcare providers can actually do to tackle deprivation - which is a consequence of lack of economic opportunity, poor housing stock and other systemic issues. Financial difficulty and problem debt, by contrast, are eminently solvable problems. Debt advice[29] is widely available at no cost to the consumer, funded through a levy on financial services providers. Four out of five people feel more in control of their financial situation after receiving debt advice, which reduces the emotional burden imposed by problem debt. Initial evidence suggests that this can reduce reliance on mental health services and medication, and although there is a lack of quantitative, clinical evidence that advice can improve mental health, qualitative evidence suggests service users benefit.[30]

Yet, like mental health problems, financial difficulty is a source of stigma. Often feelings of embarrassment and shame mean service users will not tell medical professionals that this is a contributing factor to their mental health problems. In a large-scale survey, four in ten people experiencing both a mental health problem and financial difficulty do not tell their mental health professionals about their financial difficulties, even when they acknowledge these are making their mental health worse.[31] Furthermore, it is very difficult for people with mental health problems to take the first steps to resolving problem debt on their own. It can be challenging even for someone in good mental health to take the first steps to address their financial difficulties, but for someone struggling with anxiety, depression or other mental health problems it can be next to impossible. Yet with help and support that specifically takes into account these barriers, people can regain control of their finances and thereby also improve their mental health, creating savings for mental health providers.

To reduce the strain that financial difficulty is placing on NHS mental health services, we need to take a systematic approach. Healthcare providers need to ask service users if they are experiencing financial difficulty, and then need to know where to direct people if they disclose. Specialist support services can be commissioned in their own right, or provided through partnerships with existing local advice providers like local Citizens Advice. Given the significant emotional and psychological barriers that people experiencing both financial difficulty and mental health problems face in seeking help, support is most effective when it is well coordinated with mental health services, even if the funding for the intervention comes from elsewhere.

By building an understanding of the relationship between problem debt and mental health problems into service provision, mental health commissioners and providers across the UK can help to reduce the burden that financial difficulty places on health services, and vastly reduce the human suffering which results from the toxic combination of problem debt and poor mental health.

29. O'Brien C, Willoughby T and Levy R. The Money Advice Service Debt Advice Review 2013/14. August 2014.
30. Dobbie L and Gillespie M. The Health Benefits of Financial Inclusion: A Literature Review. 2010.
31. Money and Mental Health survey of 5,413 people with lived experience of mental health problems. 4 March -15 April 2016.

1.4 Outline

In July 2016, Money and Mental Health published a consultation paper, 'In Control', which explored ways to break the link between mental health problems and problem debt, including the role of mental health services. There, we set out the aspiration to strengthen the clinical and business case for specialist interventions which help people with mental health problems to overcome financial difficulties and manage their money more effectively. In responses to that consultation, prominent representative bodies for medical professions told us that they recognised the issues we raised, but that provision to tackle them was patchy.

> "Those mental health nurses that work with individuals who have remitting illnesses with periods of poor mental health will be aware of the potential for financial problems. Typically in situations such as periods of hypomania spending can be erratic and problematic. Similarly in periods of low mood there is the potential for exploitation … However, [at present] this may be an area of practice where the skills acquired have developed due to experience rather than specific educational preparation."
>
> *Royal College of Nursing response to In Control, October 2016.*

> "GPs act as gatekeepers to the health services as well as to a wider system of care, which can include social care, local authorities and voluntary sector support. They are therefore well placed to support people who are concerned about the impact their mental health has on their spending as they can signpost service users in difficulty to the most appropriate care setting, for example to the Citizens Advice… We are aware of instances where GP practices have had an in-house debt counselling service which has been in high demand. This suggests that where local services are available they are used and valued, however, we do not have any knowledge of more widespread schemes."
>
> *Royal College of General Practitioners response to In Control, October 2016.*

In this report, we assess the extent to which mental health services systematically recognise and respond to this relationship between financial difficulty and mental health problems. We explore where there are gaps in existing provision to indicate where better coordination could improve services for people with mental health problems who are experiencing financial difficulty. From 2017, we will build on this initial mapping exercise to strengthen the case for interventions in clinical settings to make sure people with mental health problems and financial difficulty get all the help they need.

The rest of this paper is as follows:

- Section 2 sets out the results of a national review of current practice within the NHS
- Section 3 describes existing interventions that help people with mental health problems to resolve financial difficulties, and explores why a systematic approach remains uncommon
- Section 4 makes recommendations about how commissioners and providers of health services can most effectively meet this growing need.

Section Two - Mapping money and mental health

2.1 Our Freedom of Information request exercise

In this exercise we attempted to go beyond existing mapping work, which has focused on identifying best practice, to provide a complete picture of the approach NHS and public health services across the UK take to financial difficulty linked to mental health problems.

Using Freedom of Information requests,[32] we have mapped the degree to which CCGs, NHS Trusts and Public Health teams in England and Scottish NHS Trusts, Welsh Local Hospital Boards, Northern Irish Health and Social Care Trust and the Northern Irish Health and Social Care Board:

1. Recognise the link between financial difficulty and mental health problems in strategic planning
2. Provide an intervention designed to meet this need, including through partnerships with other organisations
3. Monitor and evaluate services to ensure effectiveness

Who did we ask about money and mental health?

To provide the fairest picture of current provision of public services meeting the needs of people experiencing both mental health problems and financial difficulties, Money and Mental Health sent Freedom of Information requests to commissioners and public sector providers of mental health and public mental health services, all of whom could have a role to play in breaking the link between mental health problems and financial difficulty.

Primary care commissioners have the ability, through feeding into their local needs assessments, to assess the local prevalence of financial difficulty and ensure appropriate provision is made. They can also specify that service providers should screen people with mental health problems to assess if financial difficulty is a factor in their condition, and a potential barrier to recovery. They may also commission specialist services for those with both mental health problems and financial difficulty, to ensure service users are able to access appropriate help, or work with external partners, like advice agencies or charities, to make sure suitable provision is available locally. Problem debt is not, in itself, a medical problem, so it may not always be appropriate for commissioners to spend NHS resources on specialist services. However, people with mental health problems may face substantial additional barriers in seeking support to tackle problem debt. Putting support in place to help them access these services could promote recovery, so it is likely to be worth investing in building pathways which make it easier for people with mental health problems to get the financial support they need.

Providers of mental health services need to take into account the extent to which financial difficulty is a factor in the mental health problems experienced by service users, and help them to access support. This may require asking the question routinely rather than relying on service users to bring the subject up. It may also involve signposting or working in partnership with other organisations to ensure appropriate services are available - for example, bringing a local Citizens Advice service into a mental health inpatients unit.

32. See chapter 5 for a summary of the methodology, the full methodology is published on the website alongside this report.

Public Health teams should ensure that appropriate debt advice is available in their local area, given that financial difficulty is a significant risk factor for mental health conditions. The provision of advice could play a role in preventing poor mental health, and generate significant savings on health and social care.[33]

The precise organisations contacted varied across the UK as commissioning structures vary by region, as illustrated in the table.

England	Clinical Commissioning Groups (Primary care) NHS Trusts (secondary care) Public Health teams (Prevention)
Scotland	NHS boards
Wales	Local Health Boards
Northern Ireland	Health and Social Care Boards Health and Social Care Trusts

2.2 Recognising the need

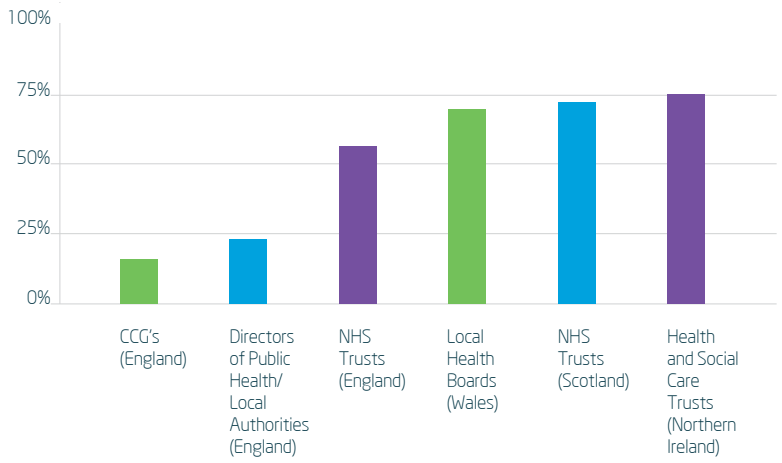
NHS Trusts are more likely to recognise the link between financial difficulty and mental health problems than CCGs, as illustrated in Figure 1 - perhaps because they gain first hand experience of this issue through their contact with service users.

> "Practical finance issues are pivotal in community mental health work and in the 30 years I have worked [in] mental health it has ALWAYS been the first thing to cause deterioration."[34]

Six in ten (57%) NHS trusts in England reported that they routinely ask service users if they are experiencing financial difficulty, as shown in Figure 1.

33. Knapp M, McDaid D and Parsonage M. Mental Health Promotion and Prevention: The Economic Case. 2011.
34. Quote from an independent living advisor in response to a survey sent to members of Money and Mental Health's professionals network working in mental health 18 November - 23 November.

Figure 1: Are your mental health service users (for both primary and secondary care) routinely asked about their financial circumstances?



Money and Mental Health Policy Institute analysis of Freedom of Information Request responses.

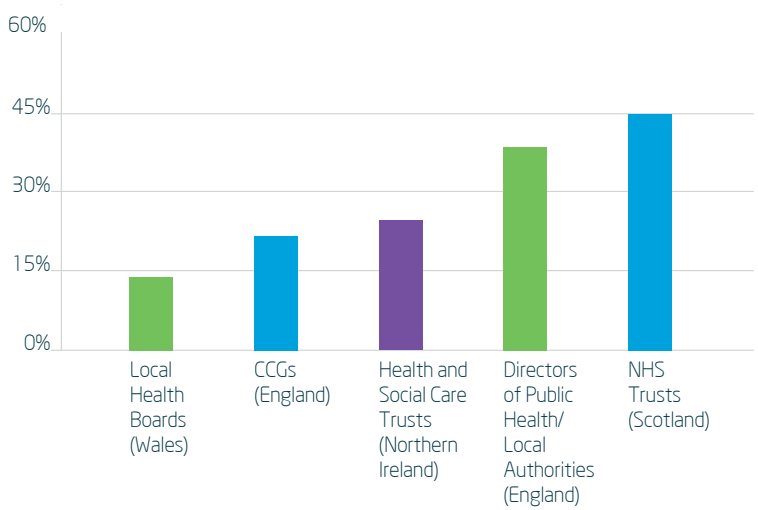
By contrast, only one in six CCGs (17%) said their service providers are expected to routinely screen people experiencing mental health problems for financial difficulties.

People in secondary care are more likely to be asked about their financial circumstances, due to processes like the Care Programme Approach, which ensures that a service user's social situation is taken into account.[35] However, 90% of people receiving treatment and care for their mental health problem are solely under primary care,[36] where there are no such processes. 81% of people first come into contact with mental health services through their GP,[37] so asking about financial difficulty in a primary care setting could represent a real opportunity for early intervention.

It is not surprising that most CCGs do not specify that providers should screen service users for financial difficulties, given that many CCGs do not take financial difficulty into account when assessing local needs and planning services. Only a fifth (22%) of CCGs refer to financial difficulty in their Joint Strategic Needs Assessment, as illustrated in Figure 2.

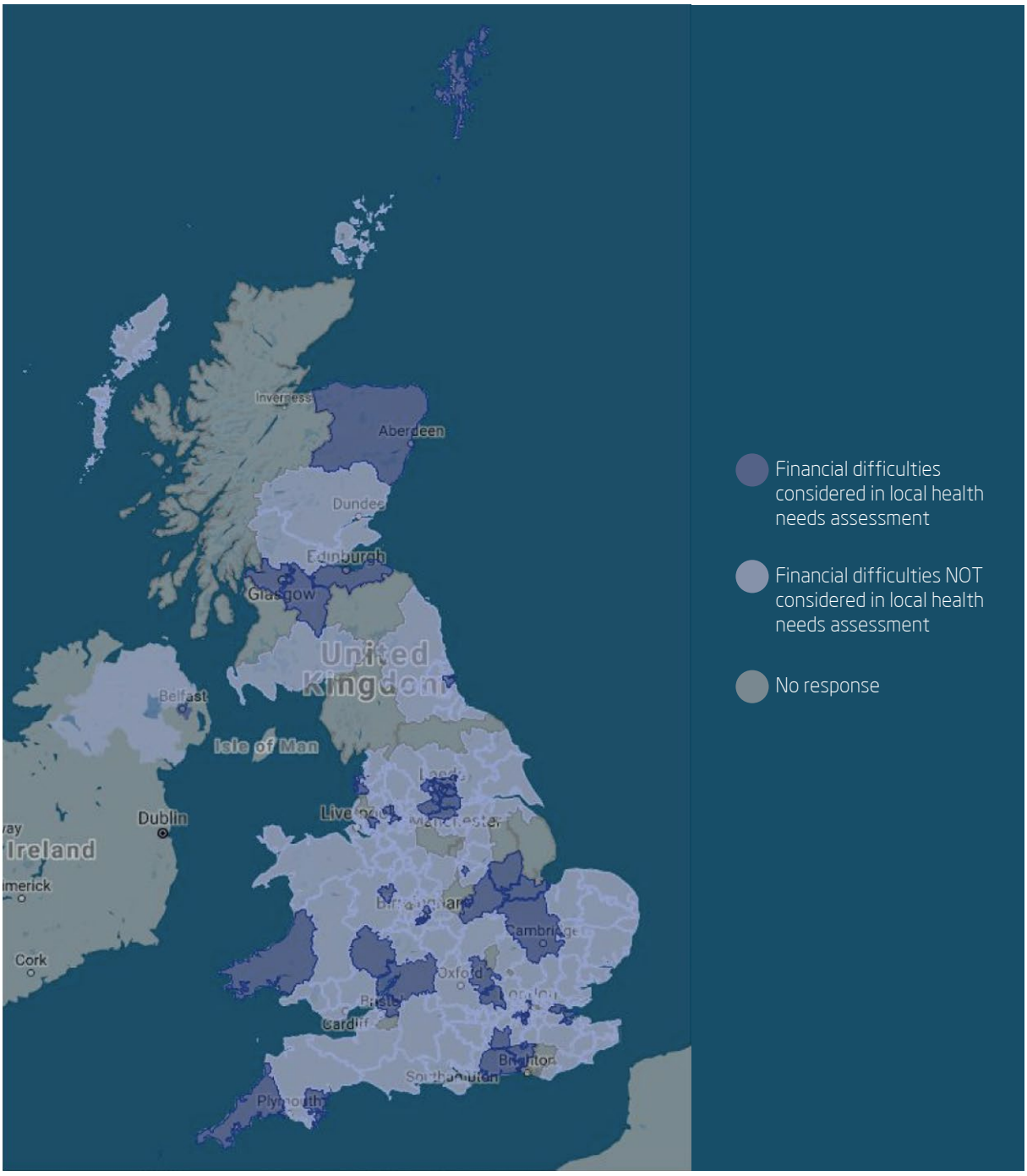
35. Rethink Mental Illness. Care Programme Approach: Factsheet. Last updated September 2015.
36. Mind. Better equipped, better care: Improving mental health training for GPs and practice nurses. November 2016.
37. Ibid.

Figure 2: Are financial difficulties considered in your local needs assessment?



Money and Mental Health Policy Institute analysis of Freedom of Information Request responses.

Figure 3: Map showing where financial difficulties are considered as part of local needs assessments.



Map Data ©2016 Google, Money and Mental Health analysis of Freedom of Information request responses from Clinical Commissioning Groups (England), NHS Trusts (Scotland), Local Hospital Boards (Wales) and Health and Social Care Trusts (Northern Ireland).

Recognition of the fact that financial difficulty has an impact on mental health need is higher in Scotland, where joint commissioning of services has progressed further than in England. 45% of Scottish NHS Trusts referred to financial difficulty in their needs assessment (compared to 22% in England, 25% in Northern Ireland and 14% in Wales). While Northern Irish Health and Social Care Trusts and Welsh Local Hospital Boards did not score so highly on planning for needs related to financial difficulty, they scored highly on ensuring that service users are asked about their financial circumstances. Three quarters (75%) of Northern Irish Health and Social Care Trusts routinely ask their service users about financial difficulties, as do 73% in Scotland and 71% in Wales.

In England, Public Health teams show a greater awareness than CCGs of the specific needs associated with financial difficulty. Four in ten Public Health teams (40%) told us they mention financial difficulty in their local needs assessment. It is concerning that Public Health teams and CCGs differ so significantly in their views on whether financial difficulty is mentioned in local needs assessments, which should be coordinated through the Health and Wellbeing Board.

While relatively few commissioners in England, Wales and Northern Ireland specifically consider financial difficulty in their local needs assessment, many reported that they consider related issues, such as poverty, deprivation, housing and employment. While important, these factors can also be a red herring for commissioners and providers, allowing them to think that the issue of household finances has been covered. In fact financial difficulties pose a separate risk to mental health, independent of income, and can affect people who are not in poverty or deprived - for example, people who experience an income shock as a result of bereavement or a serious health condition which prevents them from working. Existing initiatives to ensure that poverty and deprivation are assessed when planning to meet local healthcare needs are a big step forward, but cannot be used as an alternative to considering financial difficulty.

It is encouraging that there is some recognition of the issue at a preventative level. However, commissioning designed to prevent mental health problems will not meet the needs of people who already have a mental health problem alongside financial difficulties, who have specific support needs. This brings to light a more deep-seated problem: a quarter (26%) of CCGs directed us to ask elsewhere about recognising financial difficulty in needs assessments, most commonly a local authority. Relying on public health commissioners to think about these issues on behalf of the general population does not reflect the fact that people who need mental health services have a specific vulnerability to financial difficulty, which in turn is known to significantly affect the clinical recovery rates that are core NHS business.

2.3 Meeting the need

Just over a third (36%) of CCGs and 16% of NHS Trusts in England said that they commission or provide a specialist service for people who have both financial difficulties and mental health needs. In Wales, one in three (29%) of Local Hospital Boards provide such a service, as do 27% of Scottish NHS Trusts. One of the four Health and Social Care Trusts in Northern Ireland also told us they commission specific support for this group of people.

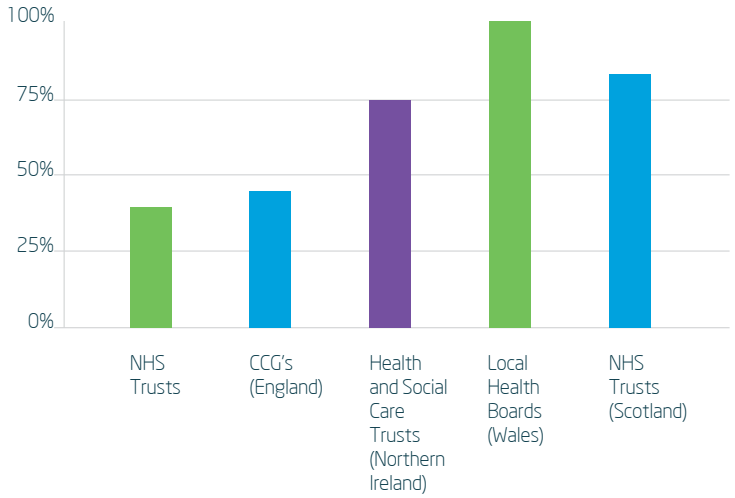
Formally commissioning services for people experiencing both mental health problems and financial difficulties clearly has a cost implication. Fortunately, many healthcare commissioners and providers have found ways to work in partnership with other local agencies, both formally and informally, to ensure that the needs of this population are met. In England, four in ten NHS Trusts and 43% of CCGs have at least an informal link to a local provider of debt advice, rising to 82% of Scottish NHS Trusts, three of the four Northern Irish Health and Social Trusts who responded to our request, and all Welsh Local Hospital Boards. Once again, provision for this group proved better in devolved nations.

Put together, we find that around half of CCGs (52%) or NHS Trusts (45%) providing mental health services in England either commission or work with an external organisation to provide a specialist service for people experiencing both mental health problems and financial difficulty. In the devolved regions these specialist services are even more common, as illustrated in Figure 4: every Welsh Local Hospital Board has some form of specialist provision, as do 91% of Scottish NHS Trusts and three quarters of Northern Irish Health and Social Care Trusts. Figure 5 demonstrates the geographical distribution of this provision, and shows that large areas of England, in particular, remain without appropriate provision.

2.4 Evaluating the need and following through

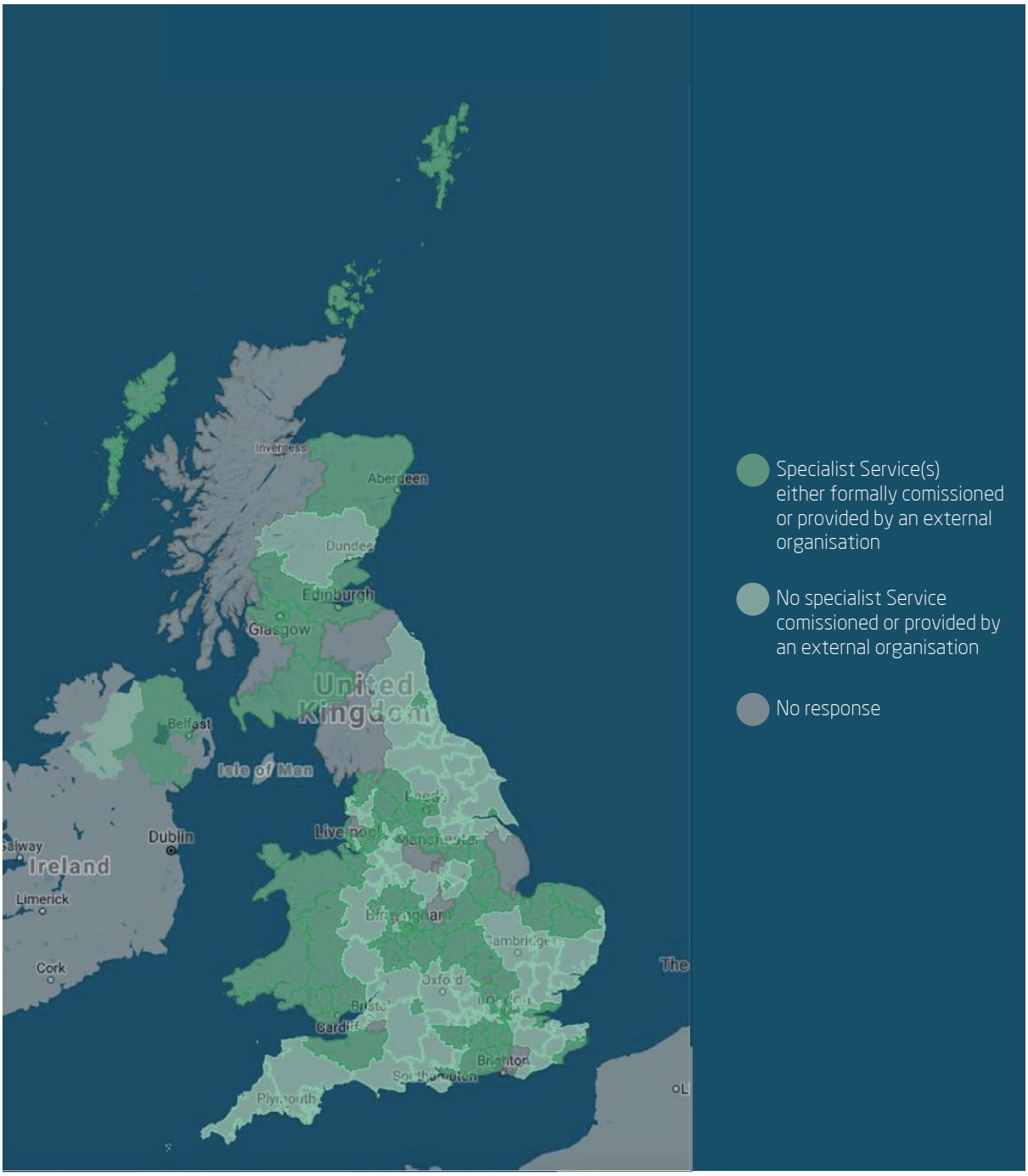
Although many healthcare providers are offering a service for those experiencing both financial difficulty and mental health problems, we find that very few are keeping track of how many people use these services. Of the 99 CCGs in England who report that they offer a specialist service, only 17 (17%) were able to provide a figure for how many people access it. Regarding NHS Trusts, only one Trust in the whole of England (4%) reported that they both offer specialist services and collect access figures. In Wales, although all seven Local Hospital Boards offered a specialist service, none could say how often it was used. The situation was only only moderately better in Scotland, where fewer than a third (30%) of NHS Trusts could quote useage figures, as illustrated in Figure 6. Northern Ireland had significantly better coverage, as two out of their three Health and Social Care Trusts who provided specialist services did measure access to them.

Figure 4: Proportion of healthcare commissioners and public sector providers who either commission a specialist service for people experiencing both mental health problems and financial difficulty or partner with an external organisation to deliver such a service



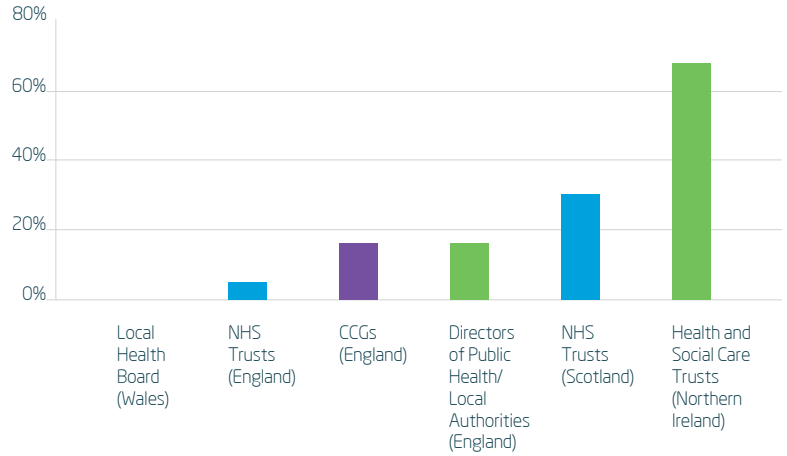
Money and Mental Health analysis of Freedom of Information request responses, November 2016.

Figure 5: Map showing the distribution of specialist services for people experiencing both mental health problems and financial difficulty



Map Data ©2016 Google, Money and Mental Health analysis of Freedom of Information request responses from Clinical Commissioning Groups (England), NHS Trusts (Scotland), Local Hospital Boards (Wales) and Health and Social Care Trusts (Northern Ireland).

Figure 6: Where a specialist service is available, was any information made available about how many people are referred?



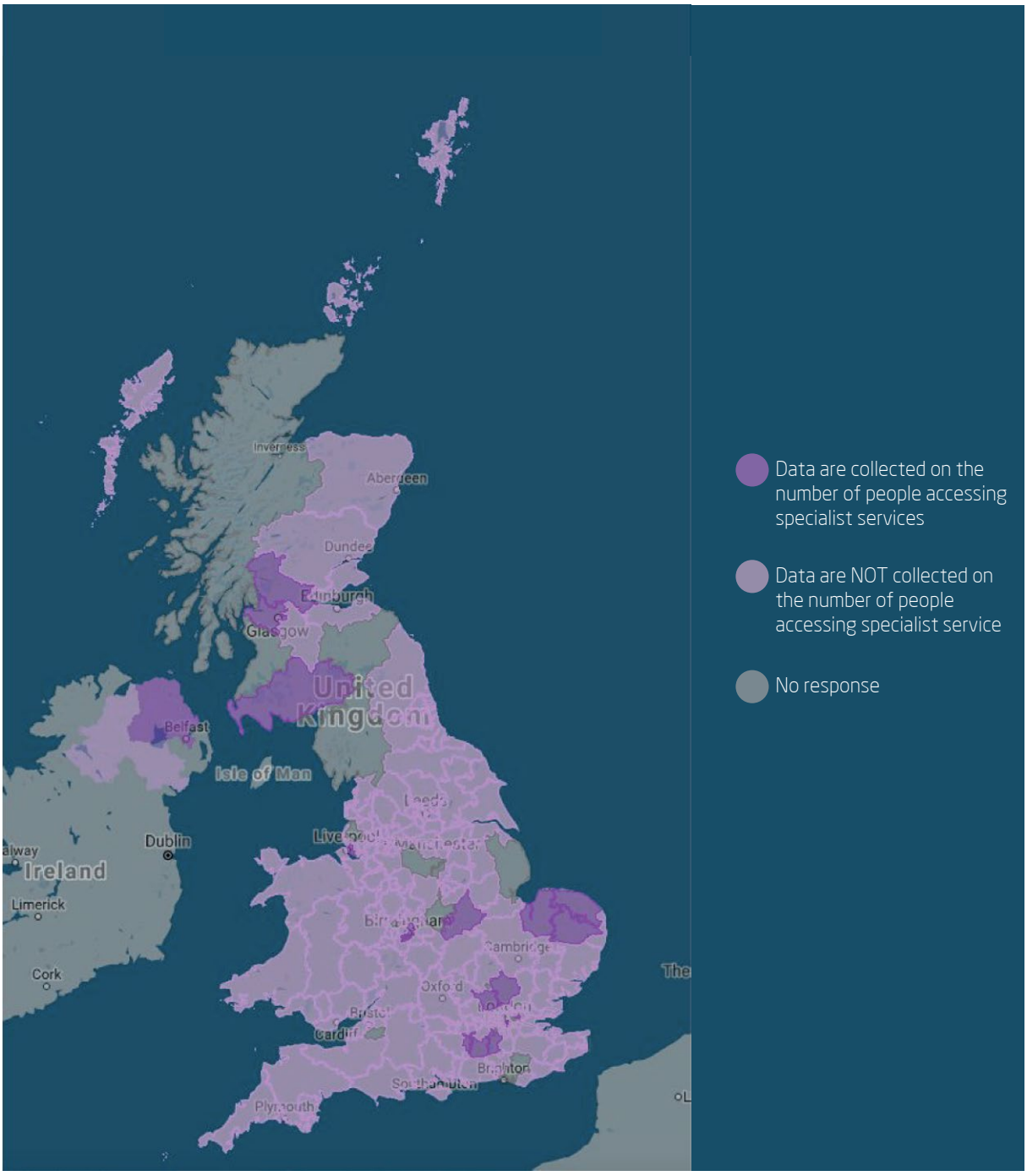
Money and Mental Health analysis of Freedom of Information responses, November 2016.

Some responders told us they could not provide these numbers without accessing personal health records, indicating that this information is not seen as something that needs to be systematically recorded. Yet without measuring referral and uptake numbers, commissioners and providers are left unaware of the level of need for such services and whether current provision is sufficient. They are also unable to assess how accessible their current provision is to practitioners and service users or how effective it is in resolving financial difficulty and treating mental health problems. Without such evaluation, the ability of the service consistently to address the social contributors to poor mental health is undermined, and there is a higher risk of financial difficulties being missed at both a strategic level and by individual practitioners.

Similarly, not all of those who routinely ask their service users about financial need provide a service to meet it. Just half (53%) of the CCGs in England who do consider financial difficulty in their needs assessment provide a service to meet this need. Similarly, only half (52%) of CCGs who have asked their providers to regularly screen for financial difficulty offer a service that providers can refer those who disclose difficulties to. The relationship is only slightly stronger among service providers in England - 60% of NHS Trusts who screen for financial difficulty also offer a specialist service to help. If the question is asked but access to a solution is not provided, the message given to both service users and practitioners is that they are helpless to address this particular need: a particularly damaging message to someone who may already be feeling hopeless due to a mental health problem. Figures are higher in Scotland (88%), Wales (100%) and Northern Ireland where all three Health and Social Care Trusts who screened service users also provided a specialist service. The good practice seen in Scotland and Wales suggests that where commissioning and provision is combined pathways are smoother.

At the strategic level, these figures show an uncoordinated approach that is unreliable in recognising need, acting on it once it is identified, and evaluating how effective such actions have been in order to feed back into the next needs assessment.

Figure 7: Map showing the distribution of healthcare commissioners and public sector providers who collect data on the number of people accessing specialist services for people experiencing both mental health problems and financial difficulty



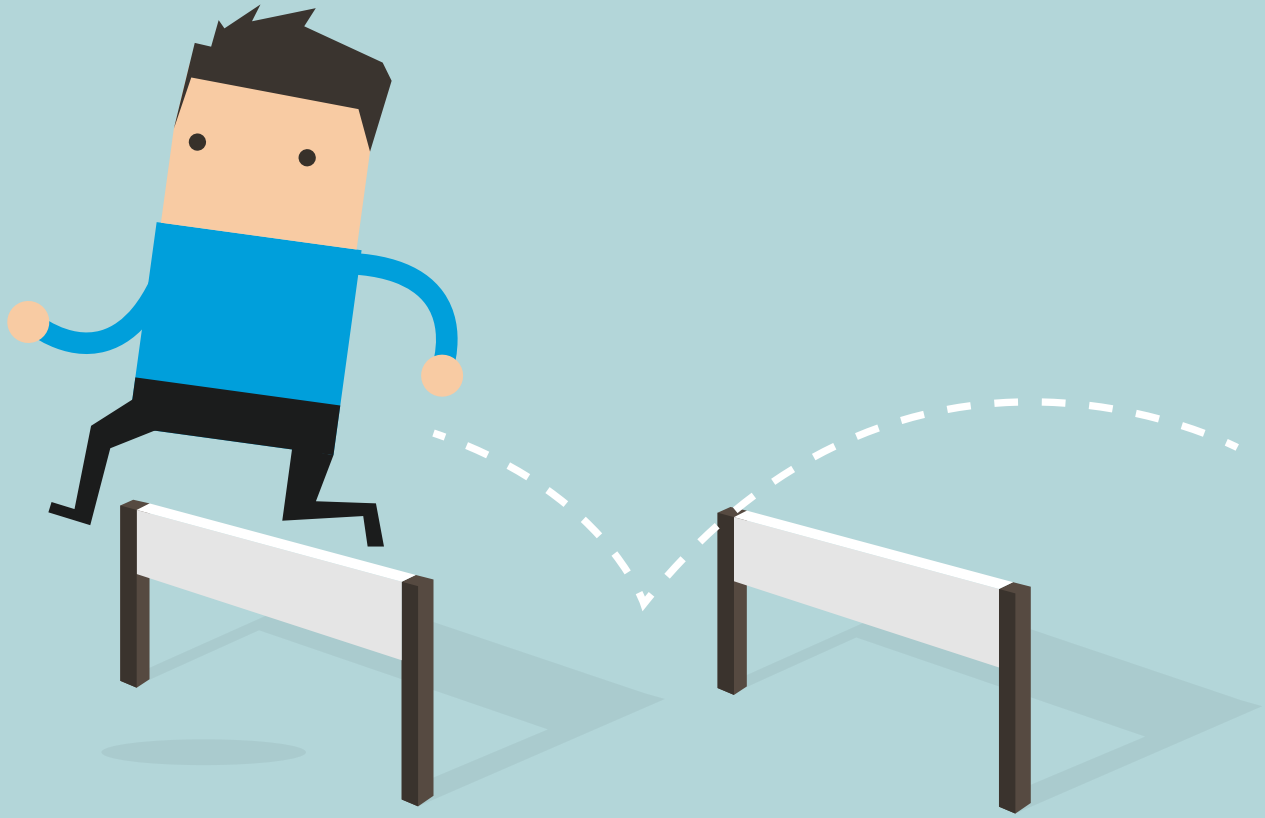
Map Data ©2016 Google, Money and Mental Health analysis of Freedom of Information request responses from Clinical Commissioning Groups (England), NHS Trusts (Scotland), Local Hospital Boards (Wales) and Health and Social Care Trusts (Northern Ireland).

2.5 Conclusions

It is encouraging that significant numbers of commissioners and providers of mental healthcare recognise the link between mental health problems and financial difficulty. However, the inconsistency with which they do so points toward a systemic problem. Coverage is patchy geographically, meaning the care available to people experiencing both mental health problems and financial difficulties will depend on where you live.

Beyond this, many areas fail to join the dots between different parts of the process. The overwhelming conclusion of our exhaustive data analysis is that many places fail to see financial difficulty as having a direct, clinical impact on mental health. As a result, very few areas are systematically assessing need, screening, providing appropriate services and evaluating them. Only 10% of Scottish NHS Trusts, 4% of CCGs in England, and one Health and Social Care Trust in Northern Ireland were able to answer yes to all the questions we asked. No Local Hospital Board in Wales was found to be systematically addressing financial difficulty. Worryingly, this means that the vast majority of commissioners and providers may be reliant on individual commissioners (sometimes in a separate department such as public health), providers, practitioners and even service users themselves to address this need on an ad hoc basis. The reliance on "care as usual" to pick up any issues and refer means that the response to financial difficulty is not systematic and misses the point that people may not feel able to volunteer information about their own financial difficulties to a mental health professional.

Lacking a systematic approach, our mental health system is full of gaps into which people experiencing both mental health problems and financial difficulty can slip. If such a significant contributor to mental health problems continues to be overlooked, people will be more unwell for longer, leaving individuals and services paying the price in ongoing healthcare costs and productivity losses.



Section Three - The case for further consideration of financial difficulty in clinical settings

Our mapping exercise demonstrates a rudimentary understanding of the links between money and mental health among CCGs and NHS Trusts in England, and a slightly more advanced understanding in the devolved nations and among public health teams. However across the board there is a lack of strategic planning around this critical issue which means services are unlikely to be joined up the most effective way. But, for people with mental health problems, this coordination is essential to effective service provision.

3.1 The challenge of building effective services

Although the lack of a systematic approach to financial difficulty within mental health services is worrying, innovative services in some areas are proving that addressing financial difficulties alongside mental health problems can make a transformational difference to people's mental health. Some of these interventions are run by local authorities and NHS providers, but many of the most promising attempts to date have been run by third sector providers such as local Citizen's Advice and Mind.

To be effective, services to tackle financial need alongside mental health must be responsive to the particular needs of people with mental health problems. Barriers like stigma and fear that inhibit the general public from getting help with finances are exacerbated for people who have mental health problems. For example, they may be terrified of going outside,[38] may struggle to visit unfamiliar places, cope with public transport, or waiting for attention in busy agencies,[39] or may have particular needs regarding literacy and confidentiality.[40] It is vital that commissioners and providers bear this in mind when designing services to help people experiencing both mental health problems and problem debt.

Numerous, mainly qualitative, evaluations of existing advice services in healthcare settings give us a good idea of how best to design services to meet the needs of people experiencing both mental health problems and financial difficulty.

For service users:

A. **Location:** Advice is more accessible when it is available somewhere local and familiar like a GP surgery or drop in centre, to minimise barriers to attending.[41]

B. **Training in mental health:** Those delivering support around money need to be expert in the subject they are advising on but also to have knowledge about mental health conditions.[42] This gives them a better understanding of the additional barriers clients experiencing mental health problems face, equips them to provide support in the most effective way and enables them to advocate more effectively on the client's behalf.

C. **Trust:** Trust is key in engaging people with the support being offered. Sometimes this means using a link worker or peer supporter to engage someone with advice services,[43] or asking their existing key worker to attend appointments with them.[44] For others, GP surgeries are seen as trusted advocates providing a non-stigmatising environment.[45]

38. Sharpe J and Bostock J. Supporting People with Debt and Mental Health Problems: Research with Psychological Therapists in Northumberland. 2002.
39. Greasley P and Small N. Establishing a welfare advice service in family practices: views of advice workers and primary care staff. Family Practice 2005, 22; 513–519.
40. NHS Health Scotland. Social prescribing for mental health: background paper. December 2015.
41. Dobbie L and Gillespie M. The Health Benefits of Financial Inclusion: A Literature Review. 2010.
42. Ibid.
43. Social prescribing for mental health: background paper NHS Health Scotland, December 2015.
44. Dobbie L and Gillespie M. The Health Benefits of Financial Inclusion: A Literature Review. Report for NHS Greater Glasgow and Clyde, Scottish Poverty Information Unit. 2010.
45. NHS Health Scotland. Social prescribing for mental health: background paper. December 2015.

D. Reliable quality and long-term availability: successful interventions are seen as independent, good quality and reliable.[46] Continuity of funding to enable an ongoing service is important, since without this people lose trust in the service, and may find it difficult and distressing to repeat their story multiple times to a new set of strangers.[47]

E. Available at the right time: timing interventions to moments when the client is ready to receive advice makes it more effective.[48] Most people in problem debt wait around a year before seeking help:[49] reaching people early could help to reduce the toll on mental health.

For healthcare providers:

F. Reliability: Loss of funding for advice services means that professional links with healthcare services are lost and healthcare providers are less likely to refer service users to specialist advice services.

G. Practitioner buy-in: Levels of enthusiasm from healthcare staff are important to referral numbers and uptake. Evidence to date suggests co-location models, where advisors become an integral part of the health unit are most successful, partly by allowing trust to develop between advice providers and healthcare staff, and improving healthcare staff's awareness of who can be helped by advice.[50]

Joining forces

Most importantly, to maximise impact, specialist services for people experiencing both mental health problems and financial difficulty must be effectively linked to other services. People with poorer mental health often need advice on a complex set of financial issues, potentially including housing, employment or welfare rights.[51] Furthermore, these financial issues often need to be addressed at the same time as a pressing mental health issue, for example when someone experiences a manic episode and spirals into debt. Addressing either issue in isolation could be ineffective, and potentially even worsen the situation.

Effective links can be achieved through central coordination, partnership working, co-commissioning, or social prescribing, which connects people to non-medical sources of support that improve wellbeing. Programmes like prescriptions for adult learning, supported referrals to information and advice, or linking schemes where a link worker or peer supporter helps the client to access support, are all good examples of how coordination can make accessing advice easier for service users with the most severe needs.[52] Such initiatives improve the efficiency and effectiveness of a service compared to relying on signposting or simple referrals in a variety of ways, illustrated in Figure 8.

Figure 8: The benefits of joint working to provide specialist services to tackle mental health problems and financial difficulty

Primary Care Advice Liaison - Wirral

This service, run jointly by Citizens Advice Wirral and Advocacy in Wirral (a mental health charity), provides advice situated within GP surgeries on issues such as welfare rights, debt and housing. A full evaluation of its impact is pending, but the results from the existing qualitative evaluation are encouraging:

- 85% of GPs noticed a decrease in referrals to other specialist mental health services
- 43% of GPs and 22% of practice managers reported a reduction in GP appointments for clients who had been assisted by the PCAL service
- 8% of GPs confirmed that they had reduced the amount of medication for their patients
- 76% of clients indicated that the PCAL intervention had reduced their levels of anxiety and/or depression
- 85% of clients agreed that the PCAL Service intervention had supported them in resuming their day to day activities

"Previously I would advise people to attend the Wallasey office, but the initiative required to phone, book an appointment and go, was too much for almost all the patients with mental health issues. Now I give the patient an appointment...and they almost invariably attend. I have had many patients whose life and health have been transformed by having this service in the surgery and my workload has been greatly eased."
- A GP commenting on the service

The Centre for Labour Market Development. Report into the added value of Wirral CAB. 2012.

Pennywise project - Bristol

The Pennywise project is run by a social housing provider, teaching people how to be more financially savvy with activities like budgeting, borrowing, saving and getting online. 42% of beneficiaries have common mental health issues, and a further 32% disclosed a more serious issue. In many cases, mental health problems were found to be limiting the effectiveness of the programme, by reducing people's ability to keep appointments and carry out agreed actions. To overcome this, the project trained workers in mental health and identified appropriate strategies to help including:

- home appointments to increase engagement
- active listening to build rapport before collecting data or using a computer
- reassurance that progress can be made
- goal setting to build self-esteem
- breaking down actions into manageable steps
- use of tools such as calendars, payment planners and action plans
- suggestions of well-being steps

"Trust and confidence in a strong brand from both beneficiaries and referring partners have been vital in achieving successful engagement and delivery of outcomes."
- Pennywise Project Summary

"Overall, I'm much more organised now. I'm much more relaxed and don't worry about money as much. It's surprising how a few little tweaks and useful everyday tools can make a real difference. Life is a lot easier and I am looking forward to the future."
- Pennywise client

Pennywise project evaluation.

46. Ibid; Mitton L. Financial inclusion in the UK: Review of policy and practice. 2008; NHS Health Scotland.
47. Dobbie L and Gillespie M. The Health Benefits of Financial Inclusion: A Literature Review. 2010.
48. Mitton L. Financial inclusion in the UK: Review of policy and practice. 2008.
49. StepChange. Statistics Yearbook: Personal Debt 2013.
50. Dobbie L and Gillespie M. The Health Benefits of Financial Inclusion: A Literature Review. 2010.
51. Balmer N and Pleasance P. Psychiatric morbidity and people's experience of and response to social problems involving rights. Health and Social Care in the Community 2010; 18, 6; 588-597.
52. NHS Health Scotland. Social prescribing for mental health: background paper. December 2015.

3.2 The barriers to more strategic interventions

From pioneering local services like those described above, we have a fairly good idea of what effective interventions to address financial difficulty among people with mental health problems should look like. And, in responses to our Freedom of Information requests, a substantial number of providers and commissioners of healthcare demonstrated an interest in the links between mental health problems and financial difficulty, and a willingness to tackle it on some level. So why do we not see more widespread, systematic efforts to break the link between financial difficulty and mental health in clinical settings?

The evidence base for debt advice is overwhelmingly strong; it can resolve the vast majority of problem debts and have a transformative effect on a household's finances. In nearly all cases (94%) clients are able to agree actions to resolve their debt issue with their advisor, and 93% of clients who agree an action go on to make some progress towards it. Eight in ten people who receive debt advice agree reduced payments with their creditors and the same proportion set up a repayment plan. Debt advice also increases financial capability, reducing the likelihood that households will end up in problem debt again in future: 81% of clients set up a budget and the vast majority feel more able to deal with creditors (83%) and open post (84%), avoiding some of the issues that can escalate problem debt in the first place.[53] It is also well accepted that people experiencing a mental health problem may be in particular need of advice services, as they are at higher risk of financial difficulty, and may require greater support to access advice services. We know, to a reasonable level of certainty, that specialist advice services located in clinical settings improve the likelihood that people with mental health problems will take up debt advice.

There is also some initial evidence that providing advice in healthcare settings can reduce the numbers of GP appointments and prescriptions for anxiolytics/hypnotics (medications for anxiety).[54] Qualitative evaluations suggest that this decreases workload for clinical staff and improves patient care at the same time.[55] And the benefits would be spread more widely: economic modelling has shown that £3.50 could be saved for every pound spent on debt advice through not only reduced health and social care spending, but also lower legal costs and higher productivity.[56]

However, unfortunately, to date there have not been any high quality studies which demonstrate statistically significant improvements in mental health as a result of the provision of advice services across the population,[57] partly due to methodological difficulties.[58] Most studies have had small sample sizes, not included control groups, or struggled with follow-up - either covering too short a time period to capture the impacts of advice, or seeing serious reductions in sample size as a result of sample dropout.

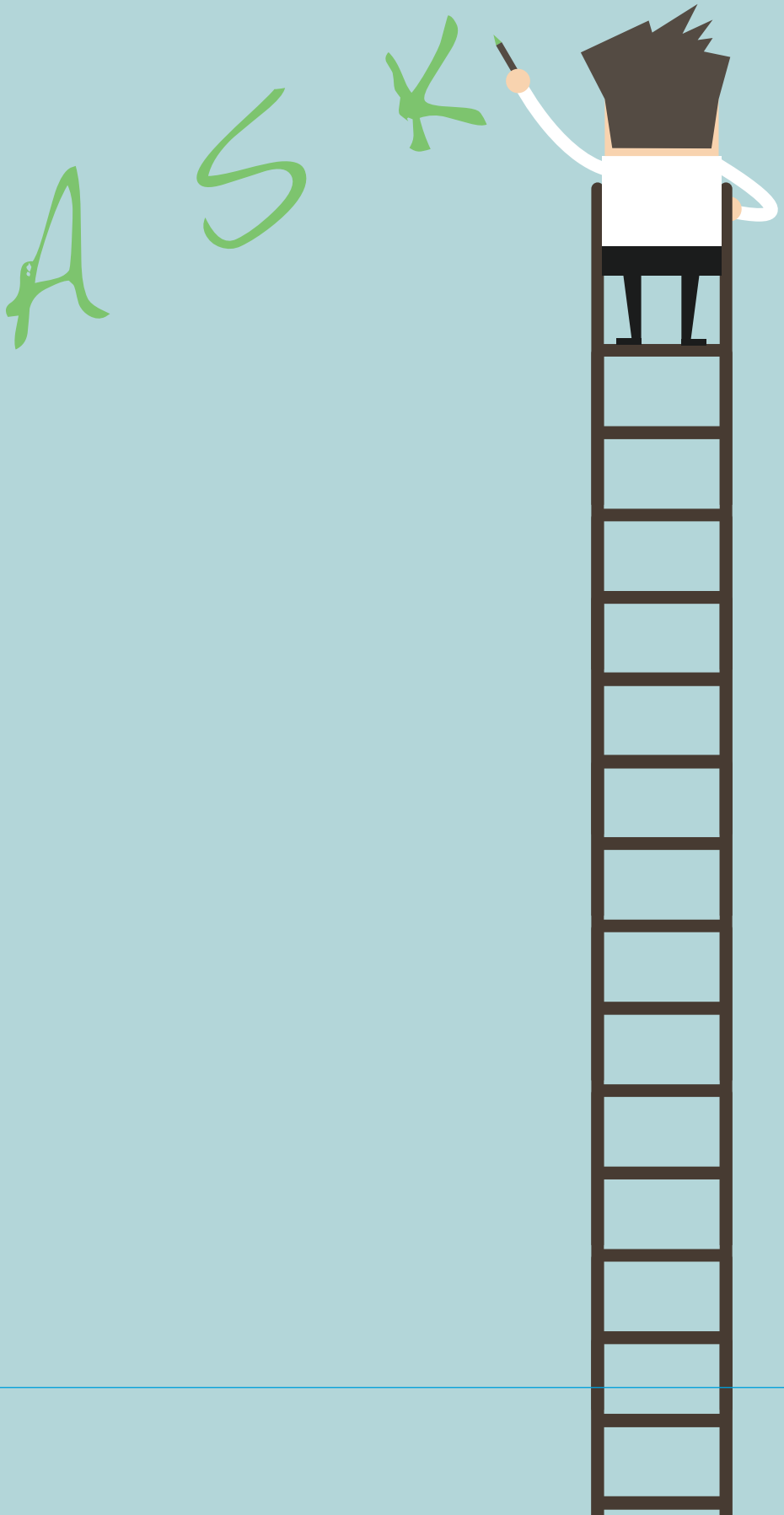
53. O'Brien, C, Willoughby T and Levy R. The Money Advice Service Debt Advice Review 2013/14, August 2014.
54. Krska J, Palmer, S, Dalzell-Brown A and Nicholl P. Evaluation of welfare advice in primary care: effect on practice workload and prescribing for mental health. Primary Health Care Research and Development 2013, 14, 3; 307- 314; Dobbie L and Gillespie M. The Health Benefits of Financial Inclusion: A Literature Review. 2010.
55. Adams J, White M, Moffatt S, Howel D, Mackintosh J, A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings, BMC Public Health 2006, 6:81.
56. Analysis of Knapp M, McDaid D, Evans-Lacko S, Fitch C, King D, Mental health promotion and mental illness prevention: the economic case, 2011. Spending £151,512 on advice for a hypothetical population of 100,00 people, (with NHS paying 1/3rd of costs) could provide gains of £539,501 over five years in reduced health and social care spend, legal savings and reduced productivity losses.
57. Parkinson A and Buttrick J. The Role of Advice Services in Health Outcomes: Evidence Review and Mapping Study. Advice Services Alliance / The Low Commission, June 2015.
58. Pleasance P and Balmer N. Changing fortunes: results from a randomized trial of the offer of debt advice in England and Wales. Journal of Empirical Legal Studies, 4; 651-673.

This leaves a gap, whereby it is unclear who should pay for specialist financial advice for people with mental health problems. Should health services invest, as it reduces demand, even if they can't demonstrate clinical outcomes? Or should it fall on third sector providers of debt advice, or public health, as a preventative measure? Without a straightforward answer to these questions, services tend to be funded on an ad-hoc basis at a local level where small funding pots are available, and often cease to exist when funding runs out, even if successful. This makes joining up interventions to create the systematic treatment pathways we were looking for in our Freedom of Information exercise very difficult.

Initial evidence, however, suggests that this topic is worthy of further investigation. Evaluations of existing debt advice services in healthcare settings, mostly qualitative in nature, suggest that the provision of advice can improve patient wellbeing and decrease costs for healthcare services. There are indications that debt advice can reduce levels of anxiety and improve sleeping patterns, general health and relationship stability.[59] Most promisingly, recent research has demonstrated that advice has a significant impact on the mental health of young people (albeit in a relatively small trial of just 100 people).[60]

Through 2017, Money and Mental Health will be working to develop the clinical evidence base for financial advice for people with mental health problems, to increase our understanding of what works and ensure that everyone is able to access the support they need. In the next chapter, we present some brief recommendations as to how this can be achieved.

59. Pleasence P, Buck A, Balmer N and Williams K. A Helping Hand: the Impact of Debt Advice on People's Lives, Legal Services Research Centre, 2006; Parkinson A and Buttrick J. The Role of Advice Services in Health Outcomes Evidence Review and Mapping Study. June 2015.
60. The Baring Foundation. Health Outcomes from Advice: Interim Report. 2015.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Section Four - Recommendations

Bearing in mind the current financial constraints faced by healthcare commissioners and providers, we are not recommending that they should be the sole funders of interventions to tackle financial problems alongside mental health. Our recommendations, even when developing best practice, focus instead on low cost, strategic changes that can be made to ensure that financial difficulty is understood throughout the system and appropriately tackled for people with mental health problems.

4.1 First steps - making sure help reaches those who need it

- **Mental health services to routinely screen service users for financial difficulty and refer them on to help in both primary and secondary care**

Often feelings of embarrassment and shame mean people will not tell medical professionals that their financial difficulty is making their mental health problems worse. We therefore cannot rely on service users to raise the issue proactively, so mental health practitioners need to ask the question. Given that the vast majority of people receive care for their mental health problem solely in primary care, it is vital that this question is asked consistently in this setting, not just in the most complex cases in secondary care (such as under the Care Programme Approach). 81% of people first come into contact with mental health services through their GP,[61] so asking about financial difficulty in a primary care setting could also represent a real opportunity for early intervention and to raise awareness of the availability of debt advice across the population.

In the absence of specialist services for people with mental health problems and financial difficulty it is important that mental health service providers are aware of existing generic advice provision in their local area, and how their service users can access this.

4.2 Medium term - building the clinical evidence base and training practitioners

- **Train mental health practitioners in understanding the link between money and mental health**

Training mental health practitioners will help them to understand the additional needs of people in financial difficulty and to identify opportunities for external referral. Without expecting practitioners to be experts in finance, training in how best to recognise the issues and offer support could improve practitioners' confidence to ask the question, and therefore increase the effectiveness of routine screening by enabling practitioners to have an informed and open conversation.

- **Building the clinical evidence base**

The biggest barrier to wider adoption of debt advice in clinical settings appears to be a lack of clarity about the clinical benefits, and thus how it should be funded. Money and Mental Health will work with external partners to understand what works and to build the clinical evidence for tackling financial difficulty and the impact on health outcomes, from 2017 onwards. We welcome support from partners in the NHS and advice sector in this work.

61. Mind. Better equipped, better care: Improving mental health training for GPs and practice nurses. November 2016.

4.3 Long term - building best practice and a systematic approach

- **Consider financial difficulties in local health needs assessments**

Joint Strategic Needs Assessments (JSNA) have made great progress in recognising the impact of the wider determinants of poor mental health. Our research showed that many local health needs assessments considered issues related to financial difficulty such as poverty, deprivation and homelessness. But financial difficulties pose a separate risk to mental health, independent of income, and can affect people who are not in poverty or deprived - for example, people who experience an income shock as a result of bereavement or a serious health condition which prevents them from working. In order to fully assess the mental health needs of their local community, JSNAs must include analysis of financial difficulty. This is important both for the commissioning of services for people with existing mental health problems, but also to target a cause of poor mental health at a much earlier stage.

- **Provide tailored advice to people experiencing both mental health problems and financial difficulties**

Often mental health problems will mean that people face additional barriers to accessing debt advice, and are more likely to need support and guidance to access it. There are many different pathways that could be set up to refer people on to advice. One basic and easy way to ensure that appropriate help will be accessible to people with mental health problems is to invite external advice agencies to co-locate some of their face-to face-services within a healthcare setting.

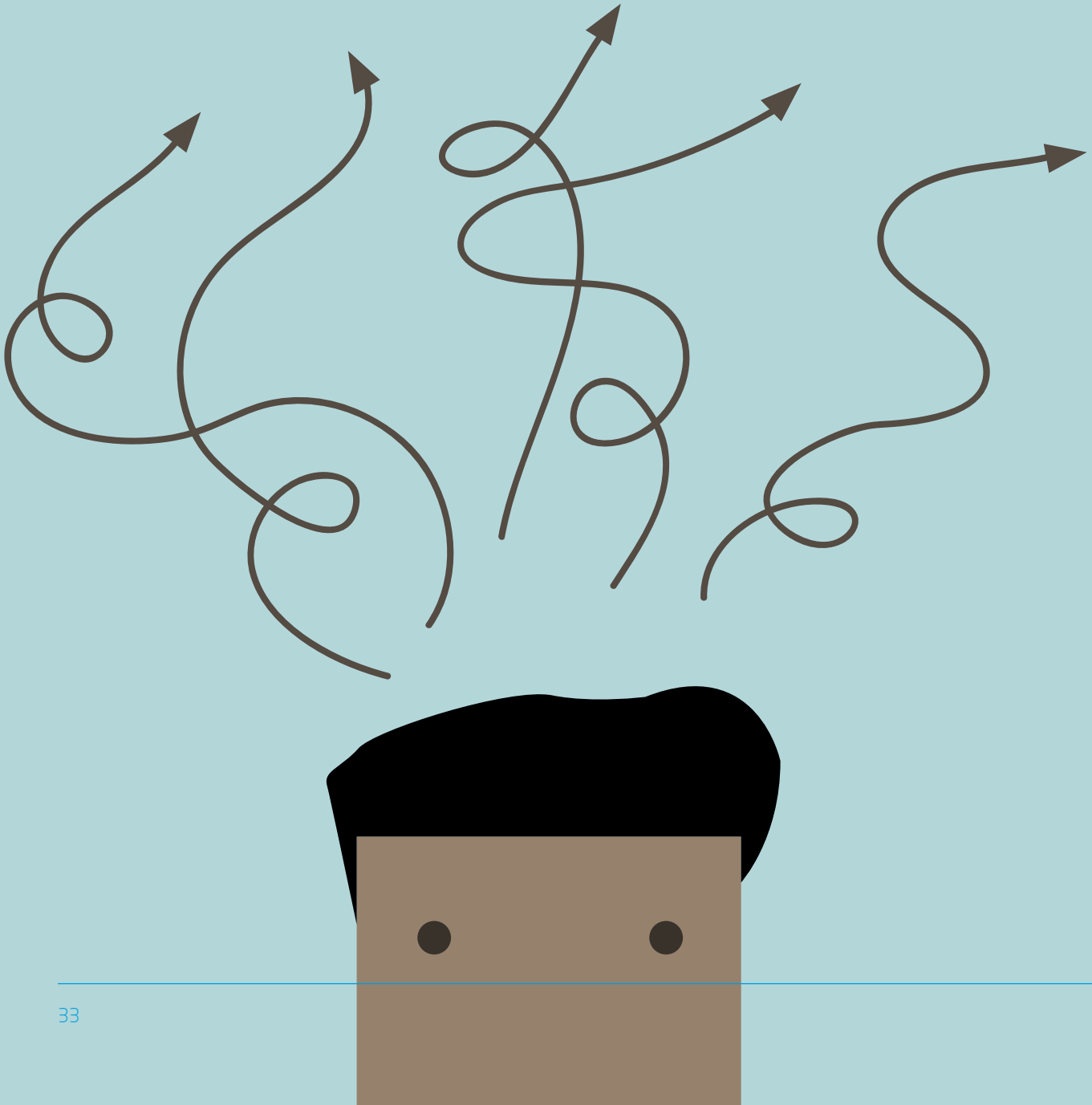
Even if not co-located, advice will be most effective if mental health awareness training is given to the advice providers. Similarly, the likelihood of engagement would be increased by a referrals process that is quick, easy and well-promoted to practitioners, and that allows a 'warm handover'. Waiting times for advice should be kept to a minimum for people with mental health difficulties, and financial advice provision should be able to continue regardless of where the person is in their mental health care pathway, for example if initially located in an inpatient setting but the person is discharged.

- **Evaluate the service provided**

Currently, the majority of mental health service providers are unable to tell us the number of people who used a specialist service, even when they commissioned it. Collecting data on the number of people who used a specialist service is just the first step to properly evaluating an intervention. Understanding the usage of a service and evaluating the clinical impact on service users is vital for a number of reasons:

- Understanding the need for the service, to both feed into future local need assessments and future commissioning decisions.
- Ensuring the service is delivering its desired outcomes, especially when services have been commissioned.
- Understanding the clinical impact on clients, to build an understanding on the impact of financial difficulty on mental health and put forward the case for further investment.
- Developing an understanding of what interventions work, to build best practice.

We believe that this package of recommendations will allow the health system to tackle financial difficulty systematically, driving improved recovery rates and better patient outcomes while also helping to prevent the onset of poor mental health.



Section Five - Methodology Summary

5.1 Time scale and scope

Money and Mental Health sent out the Freedom of Information (FoI) request on 29 and 30 September 2016 and accepted all responses up until 7 November 2016. This gave the authorities 26 working days to respond, in excess of the 20 working days statutory time limit.

FoI requests were sent to all Clinical Commissioning Groups in England,[63] NHS Trusts in England, Public Health teams in England, Local Hospital Boards in Wales, NHS Trusts in Scotland and Health and Social Care Trusts and the Health and Social Care Board in Northern Ireland. This allowed us to capture commissioning and provision of most mental health services at primary and secondary level, along with public health initiatives, across the UK.

5.2 Response rate

We received a high response rate: 97% of CCGs, 87% of NHS Trusts, 67% of Public Health teams, 100% of Welsh Local Hospital Boards, 71% of Scottish NHS Trusts and the Northern Irish Health and Social Care Board and 80% of Northern Irish Health and Social Care Trusts.

5.3 Questions asked

1. Whether you consider financial difficulties in your local health needs assessment?

2. Whether your mental health service users (for both primary and secondary care) are routinely asked about their financial circumstances or difficulties?

3. Whether you commission, either solely or in partnership with any other agency, any specialist services for people who have both financial difficulties and mental health problems?

4. Whether you have a formal and/or informal working arrangement with any external organisations providing financial, welfare or debt advice, and if so which one(s)?

5. How many people using your primary and secondary mental health services are referred to or provided with a specialist service that addresses financial needs?

Organisations were provided with a list of the types of intervention that we were interested in, including specialist advice, financial capability, support into employment, integrated care pathways and peer support.

5.4 Coding

We developed a coding system in order to analyse and quantify the qualitative responses received. These codes were applied consistently across all authorities for each question. We then used the codes to identify those who provided a positive answer to the question. We calculated the proportion of those who provided a positive answer to the question, as a proportion of all those who provided a response, excluding those who responded solely to inform us that they do not offer mental health services.

For further detail on the methodology and codes used, please see the full methodology published alongside the report at **www.moneyandmentalhealth.org**
For any further questions please email **contact@moneyandmentalhealth.org**

63. FoI requests were sent to all NHS Mental Health Trusts and all NHS Trusts and Foundation Trusts where we couldn't validate that they did not provide mental health services.

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