



MONEY AND
MENTAL HEALTH
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THE MISSING LINK

How tackling financial difficulty can boost recovery rates in IAPT
Rose Acton

"The stress from my financial position is making my illness worse making recovery unlikely."

"The additional worry of how I'm going to pay the debts back is holding me back from recovery."

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Publication

The Money and Mental Health Policy Institute,
October 2016

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Acknowledgements

We would like to thank all those we spoke to throughout
the project, who have informed and enriched our
thinking. In particular, Andy Bell from the Centre for
Mental Health and Joseph Surtees from StepChange
have both kindly given their time to share their expertise
and have provided valuable input.

A special thank you goes to all the 435 people with
lived experience of mental health problems who
shared their experiences of NHS talking therapy,
your contribution has been invaluable in allowing us
both to understand the current system and to design
recommendations for the future.

I would also like to thank all the team at Money and
Mental Health who have provided intellectual support
and challenge throughout the project. In particular,
Katie Evans has provided valuable support with the
economic modelling and analysis.

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Executive summary

What is the problem?

- This paper sets out the case for tackling financial difficulty in the Improving Access to Psychological Therapy programme (IAPT).
- The relationship between financial difficulties and mental health problems is alarmingly strong: half of British adults with a debt problem have a mental health problem. People with debt are twice as likely to develop a serious depression and the more debts a person has the more likely they are to develop a mental health problem.
- A quarter of people experiencing common mental disorders are also in problem debt, three times more than people without. There is no reason to think that users of the IAPT programme are less likely to be in financial difficulty.
- Money and mental health are intricately linked. Mental health problems make it harder to recover from financial difficulty, and financial difficulty can both worsen and prolong periods of poor mental health.
- Currently the IAPT programme does not formally recognise this damaging link and therefore does not adequately identify patients in financial difficulty or refer them on to help.
- Our new survey revealed that just 6% of people who experienced financial difficulty while receiving treatment through IAPT were referred on to specialist help.

The benefits of tackling financial difficulty:

• Improve recovery rates

The IAPT programme hasn't yet achieved its objective of 50% recovery. Our new analysis shows that financial difficulty is dragging down recovery rates across the programme. The IAPT recovery rate for people experiencing both depression and financial difficulty is likely to be just 22%, compared to 55% for people without financial difficulties. For anxiety, the IAPT recovery rate is likely to be just 38% among those with financial difficulties, while over half (52%) of patients without financial difficulties recover through IAPT.

We find that an intervention on financial difficulty boosts the likelihood of recovery for an individual with depression and financial difficulties from 22% to 48%. For an individual with anxiety and financial difficulties, meanwhile, the likelihood of recovery increases from 38% to 50%.

Across the programme overall, an intervention on financial difficulty would likely improve the recovery rate for depression to 53%, and would raise the recovery for anxiety disorders to 52%. **Addressing financial difficulties could lift IAPT over its 50% recovery target.**

- **Deliver patient centred care**

Tackling financial difficulty will create a service that truly responds to individual needs and will improve patient satisfaction.

- **Tackle stigma**

Encouraging people to talk about financial difficulty in a healthcare setting will help break down stigma and feelings of shame, embarrassment and fear.

- **Promote greater social inclusion**

Tackling financial difficulty will also promote greater social inclusion, helping people to join in with day-to-day social activities and enjoy a fulfilling life.

A cost-effective intervention

- **An intervention that will pay for itself**

Our cost-benefit analysis shows how even if the NHS wholly funded a financial difficulty intervention, it would not only pay for itself but would also boost the cost-benefit ratio of the IAPT programme.

- **Reduce healthcare costs**

Increasing recovery rates through tackling financial difficulty would generate healthcare savings of at least £2.4 million.

- **Increase employment and economic participation**

Tackling financial difficulty would decrease barriers to work, increase productivity and generate at least £105 million in additional economic benefits.

This takes the total savings to £108 million, with savings of £61 million for people with depression alone.

How to tackle financial difficulty in IAPT - recommendations

First step

Develop national Positive Practice Guidance for healthcare professionals and commissioners on people in financial difficulty.

Positive Practice Guidance already exists for drug and alcohol addiction, offenders and other particularly vulnerable groups. This guidance helps healthcare professionals both to understand the additional needs of these groups and to identify opportunities for external referral to third sector organisations or others who can provide specialist support.

Introducing Positive Practice Guidance on financial difficulty will increase understanding among IAPT professionals of the ways in which money worries can affect mental health and undermine recovery, and will enable IAPT services better to support the quarter of patients who are in financial difficulty.

Next steps

Basic one-question screening by IAPT practitioners on financial difficulties to guide referral to specialist help, tackle stigma and monitor outcomes.

Adding a single question on financial difficulty to the IAPT data set will first of all identify those who need specialist help. But it will also nudge people to talk about their financial situation in a healthcare setting, breaking down stigma and overcoming feelings of shame, embarrassment and fear experienced by many people in financial difficulty. It would build on the existing IAPT outcome measurements, such as the employment questions, and would be asked at every appointment session. Once collected, this data can be used to understand the scale of the issue and, to monitor outcomes. This will improve understanding of the interaction between financial difficulty and mental health problems and inform future interventions.

Onward referral to specialist advice services for those with financial difficulties.

Debt advice services, which can resolve the vast majority of problem debts, are available across the UK, free of charge to consumers and in many cases funded by the financial services industry. But to benefit from these services, people have to know how to find them.

IAPT could play an important role by systematically referring people in financial difficulty on to help. Referring people on to specialist advice will mean these advice services are reaching those whose needs are the greatest.

Debt advice services are currently undergoing structural reform, with the Government announcing the creation of a single public financial guidance organisation. Given the importance of financial security, the Government are committed to making it as easy as possible for people to access advice. This represents an opportunity for IAPT to play a key role in ensuring that people with mental health problems reach the help they need, while at the same boosting the effectiveness of the IAPT programme.

Action point: This package of recommendations should be tested and evaluated in a number of local IAPT services to establish the impact on recovery and performance rates, before national roll-out.

Longer term

Fully embed and fund money advice in IAPT.

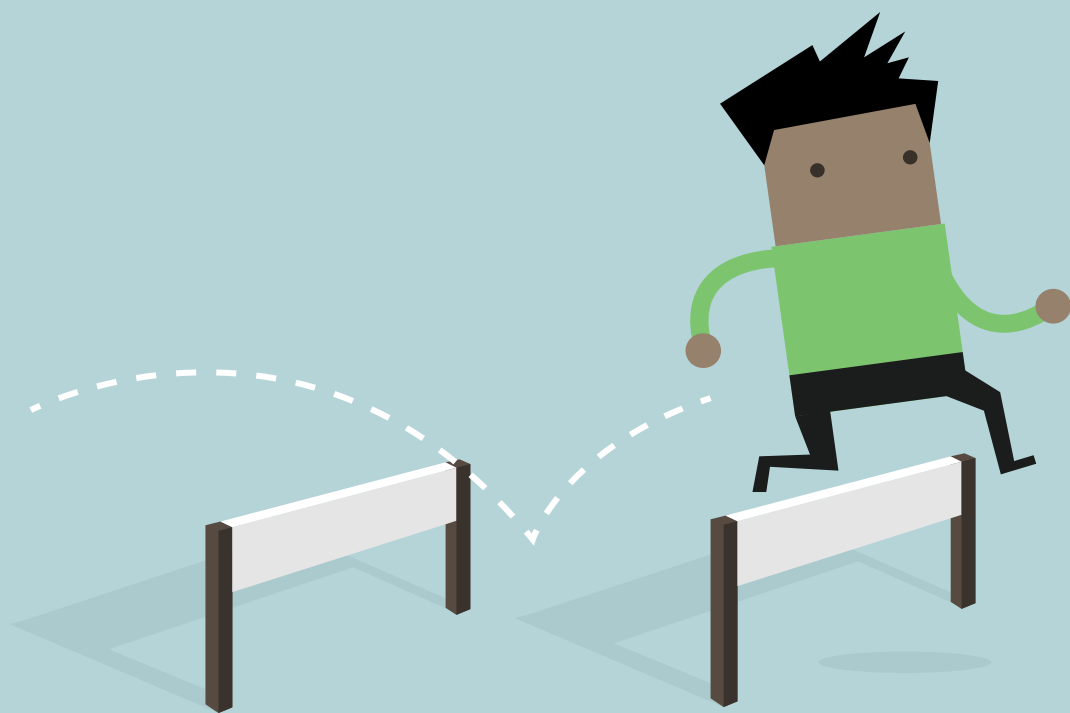
Once the beneficial impact on recovery and performance rates is established, programme managers may explore the potential benefits of embedding and funding money advice. As with embedded employment advisers in IAPT, our hypothesis is that the best results and patient outcomes would be achieved via embedded money advice.

Embedded money advice in IAPT could be achieved by a number of different models such as employing specialist money advisers or contracting out to existing local specialist providers. An embedded model would allow for continuity of service provision, an integrated referrals process and an information sharing agreement.

This would make it easier for patients to access financial advice; when mental health problems and financial difficulty are more severe, a patient may need greater support to access financial advice - for example, the reassurance of a personal referral, and the knowledge that they won't need to repeat their whole story.

Although embedding and funding money advice in IAPT is a more costly intervention than signposting to existing services, our analysis suggests that the cost of advice would be fully recouped in later health care savings, driven by a significantly improved recovery rate. NHS funding would ensure that debt advice could be provided alongside therapy in an integrated way, ensuring that the practical side of financial difficulty is dealt with allowing therapy to focus on emotional and behavioural support. This should maximise the effectiveness of IAPT therapy, boosting recovery rates and unlocking savings that would more than cover the cost of the investment.

Action point: Test and evaluate the benefits of different embedded delivery models across a number of local sites. This would build on the evaluation of the impact of signposting to existing services, and would test the hypothesis that embedded services would be more effective.



Section One - Money and Mental Health

The relationship between financial difficulties and mental health problems is alarmingly strong. A quarter of people experiencing common mental disorders are also experiencing financial difficulty, three times more than people without.¹ Living in financial stress can harm your mental health, and mental health problems can make it harder to manage your finances. Half of British adults with a debt problem have a mental health problem. People with debt are twice as likely to develop major depression.² The more debts a person has the more likely they are to develop a mental health problem, even after adjustment for income and other sociodemographic variables.³

Improving Access to Psychological Therapies (IAPT) is the main programme of treatment for people with common mental disorders in England; nearly one million people enter treatment each year.⁴ There is no reason to think patients with financial difficulties are less likely to seek treatment, and indeed the additional stress caused by money troubles may specifically lead patients to seek treatment for their mental health problems. As such, it is fair to assume that at least a quarter of patients in the IAPT programme have financial problems. At present, however, the IAPT programme does not formally recognise the damaging link between mental health problems and financial difficulty and as a result, the programme does not adequately identify patients in financial difficulty or refer them onto specialist help.

The most recent IAPT annual report finds the most deprived areas have the highest number of referrals and the lowest recovery rates.⁵ While financial difficulty and deprivation often go hand in hand, there is evidence to suggest that the link between poverty and mental health is largely contingent on problem debt.⁶ In this report, we examine the impact of financial difficulty on the chance of an individual's recovery from a mental health problem and, the subsequent impact on recovery rates across the IAPT programme. We find that financial difficulty worsens and prolongs mental health problems and acts as a significant drag on IAPT recovery rates.

This report therefore puts forward the case that the IAPT programme should seek to recognise, and develop ways to mitigate, the impact of financial difficulty. Tackling financial difficulty in IAPT could improve recovery rates substantially, and, by reducing healthcare spending on those with both mental health problems and financial difficulty, pay for itself.

Definitions:

In this report we use "problem debt" and "financial difficulty" interchangeably as they are defined using similar parameters, namely being in arrears and unable to meet payment obligations when they are due. Problem debt is often defined as being behind on two or more consecutive payments with a bill or repayment,⁷ and 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.⁸ Key indicators of financial difficulty include consecutively failing to meet minimum repayments on credit, inability to meet repayments out of disposable income, evidence of non-payment of essential bills (such as utility bills), having to borrow further to repay existing debts, evidence of seeking debt advice, the agreement of a debt management plan or other debt solution.⁹

1 Jenkins R, Bhugra D, Bebbington P, et al. Debt, income and mental disorder in the general population. *Psychological Medicine* 2008; 38: 1485-1494.

2 Skapinakis P, Welch 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.

3 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.

4 NHS Digital. *Psychological Therapies: Annual report on the use of IAPT services - England, 2015/16*. October 2016.

5 Ibid.

6 Jenkins R, Bhugra D, Bebbington P, et al. Debt, income and mental disorder in the general population. *Psychological Medicine* 2008; 38: 1485-1494.

7 Mind. *Still in the red: Update on debt and mental health*. 2011.

8 National Statistics. *Psychiatric morbidity among adults living in private households, 2000: Technical Report*. 2002.

9 Financial Conduct Authority. *CONC 1.3 Guidance on financial difficulties*. Version of the handbook as at 27 October 2015.

Common mental disorders are defined as depression and anxiety disorders (including generalised anxiety disorder, panic disorder, phobias and obsessive-compulsive disorder).¹⁰

1.1 How does financial difficulty lead to mental health problems?

"My financial situation causes stress every day. It's like a black cloud hanging over me every day. It never goes away... I never thought I would be unwell this long. I don't know when or how I will ever get on top of it."

"Being made bankrupt and having my home repossessed had a terrible effect on my mental health and I don't think I will ever feel secure again."

Living under financial stress can trigger, worsen and prolong episodes of poor mental health: 86% of the 5,500 people with mental health problems who responded to a survey conducted by Money and Mental Health in April 2016 said their financial situation had made their mental health problem worse.¹¹ Figure 1 demonstrates the direct effect that financial difficulties can have on mood and mental health.

1.2 How do mental health problems lead to financial difficulty?

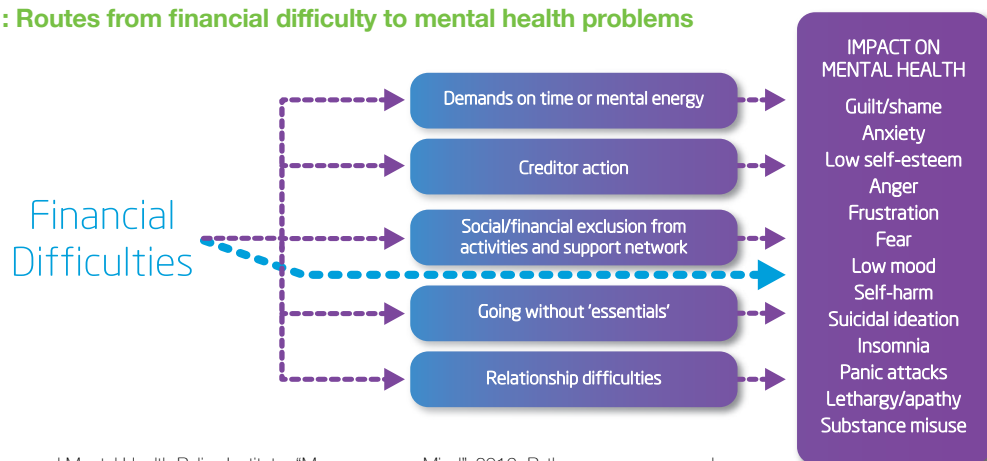
"Anxiety affects my ability to deal with often quite simple situations. I forget passwords and then have too much anxiety to contact organisations to sort the problem out."

"I comfort shop. When I feel down, depressed or low I shop to cheer myself up. Buying things gives me a high, cheering me up, but is very short lived hence a lot of debt."

Periods of poor mental health can also lead to financial difficulty. One in four British adults with a mental health problem has problem debt.¹² 72% of respondents to our survey said their mental health problems had made their financial situation worse.¹³ Mental health problems make it harder to recover from financial difficulty for a variety of reasons, including loss of income and finding it difficult to communicate with debt collection professionals.¹⁴

93% of survey respondents told us that during a period of poor mental health they spent more than usual and 92% found it harder to make financial decisions during periods of poor mental health. 74% put off paying bills and 59% took out a loan they wouldn't otherwise have taken out.¹⁵ Figure 2 maps how living with a mental health problem can negatively affect your finances.

Figure 1: Routes from financial difficulty to mental health problems



Source: Money and Mental Health Policy Institute, "Money on your Mind", 2016. Pathways were mapped from the qualitative accounts of financial difficulty from 2,911 people with mental health problems.

10 Stansfeld S, Clark C, Bebbington P et al. Common mental disorders: Adult Psychiatric Morbidity Survey 2014 Chapter 2. September 2016.

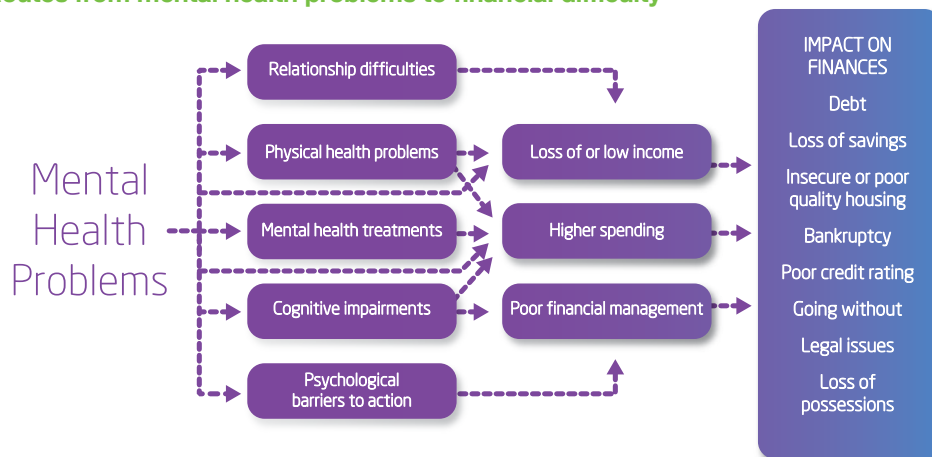
11 Holkar M, Mackenzie P. Money on Your Mind. Money and Mental Health Policy Institute. 2016.

12 Jenkins R, Bhugra D, Bebbington P, et al. Debt, income and mental disorder in the general population. Psychological Medicine 2008; 38: 1485-1494

13 Holkar M, Mackenzie P. Money on Your Mind. Money and Mental Health Policy Institute. 2016.

14 Fitch C, Trend C, Chaplin R. Lending, debt collection and mental health: 12 steps for treating potentially vulnerable customers fairly. London. 2015.

15 Holkar M, Mackenzie P. Money on Your Mind. Money and Mental Health Policy Institute. 2016.

Figure 2: Routes from mental health problems to financial difficulty

Source: Money and Mental Health Policy Institute, "Money on your Mind", 2016. Pathways were mapped from the qualitative accounts of financial difficulty from 2,911 people with mental health problems.

1.3 How financial difficulty slows recovery from a mental health problem

Whether financial difficulties lead to mental health problems or emerge as a consequence of poor mental health, we know they have a compounding and devastating effect. People with depression and financial difficulties are 4.2 times more likely to 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 be experiencing anxiety 18 months later than if your finances were sound.¹⁶ Ongoing financial difficulty is therefore likely to be dragging down recovery rates for people with common mental disorders.

Happily, some simple changes to the IAPT programme could begin to tackle this link, raising recovery rates and improving patient outcomes.

1.4 A growing problem

UK households are increasingly financially vulnerable. UK household indebtedness is high by both historical and international standards, and is on the rise. In the first quarter of 2016, UK households on average owed 132% of their annual income.¹⁷ This rise in indebtedness has corresponded with a growth in lending to households, with a particularly strong growth in consumer credit lending such as credit cards and overdrafts. To put this in context, lending to households is now at its highest level since 2008.¹⁸

Rising debts as a proportion of income means households are more vulnerable to falling into arrears and problem debt. Problem debt frequently arises when people lack the financial resilience to deal with an income shock, such as redundancy or relationship breakdown, or face an unexpected, unavoidable or unaffordable bill -

for example when a car or boiler breaks down. This can mean people are unable to service their existing debt repayments or that they start borrowing to cover daily living expenses.

The ability of many households to service their debts will be challenged if, as expected, there is a coming period of weaker employment and income growth. The Bank of England's August 2016 Inflation Report predicts unemployment will rise and that wages will stagnate.¹⁹ Given we know the more debts a person has the more likely they are to have a mental health problem,²⁰ the growing unsustainable debt burden on households is a cause for concern.

'[I'm] constantly worrying about making payments. The embarrassment. Not being able to provide for my family. Constantly stressed.'

The risk of falling into financial difficulty is increasing for users of the IAPT programme, too. As the number of service users experiencing financial difficulties increases, IAPT's recovery rate and programme performance could be adversely affected.

16 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.

17 Financial Policy Committee, Financial Stability Report, July 2016. London. 2016. Issue No. 39

18 Ibid.

19 Bank of England, Inflation Report August 2016. London.

20 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.



Section Two - Financial difficulty - the missing link in IAPT

Currently, there is no formal recognition of the link between financial difficulties and mental health in the IAPT programme. Service users experiencing financial difficulty are not being systematically identified, or referred on to specialist advice. Our survey of more than 400 people with experience of NHS talking therapies found that over half (54%) of those in financial difficulty suffered in silence by not discussing their financial situation with their healthcare professional. Just 6% of those experiencing financial difficulties received a referral to specialist advice services.²¹

The benefits and impact of debt advice are well established. The most recent evaluation of Money Advice Service funded face-to-face debt advice found that in 94% of cases clients were able to agree actions with their advisers to address their debt issue, and 93% of clients who agreed actions went on to progress at least one of them. 80% agreed reduced payments with their creditors, 80% set up a repayment plan and 81% set up a budget. These actions often directly reduce the pressure placed on people by creditors, provide some breathing space and prevent people from going without daily essentials. Advice also increases the client's confidence to manage finances beyond the advice session: 84% agreed that they were more likely to open their post and 83% felt more confident with creditors. In the period following the advice (c. 3-6 months) 76% had already reduced or cleared at least some of their debts. This reduction in debts meant 80% felt more in control of their financial situation, 71% were less stressed about their debts, and 67% were sleeping better.²²

Our analysis shows how tackling financial difficulty through specialist advice, in the context of the IAPT programme, will boost recovery rates, improve patient care, tackle stigma and improve employment outcomes. Furthermore, cost-benefit analysis of this intervention suggests that the cost of advice would be recouped through lower healthcare costs and productivity benefits within 12 months.

2.1 Improve recovery rates

The IAPT programme is yet to achieve its recovery rate target of 50%. The most recent annual IAPT report (2015/16) shows that 46% of people who ended treatment moved to recovery.²³ Our new analysis shows that financial difficulties, affecting approximately one in four IAPT service users, may be the barrier which is preventing the programme from achieving this goal.

How financial difficulty is currently impacting recovery rates

Existing research shows that among people with depression, those also experiencing financial difficulties are 4.2 times more likely to still be experiencing depression 18 months after first being assessed, compared to those without financial difficulty. Among people with anxiety, those also experiencing financial difficulty are 1.8 times more likely to still be symptomatic 18 months later.²⁴

²¹ Money and Mental Health survey of 435 people with experience of NHS talking therapy, carried out online between 16 September and 3 October 2016. See Appendix A for further detail on the methodology of the survey.

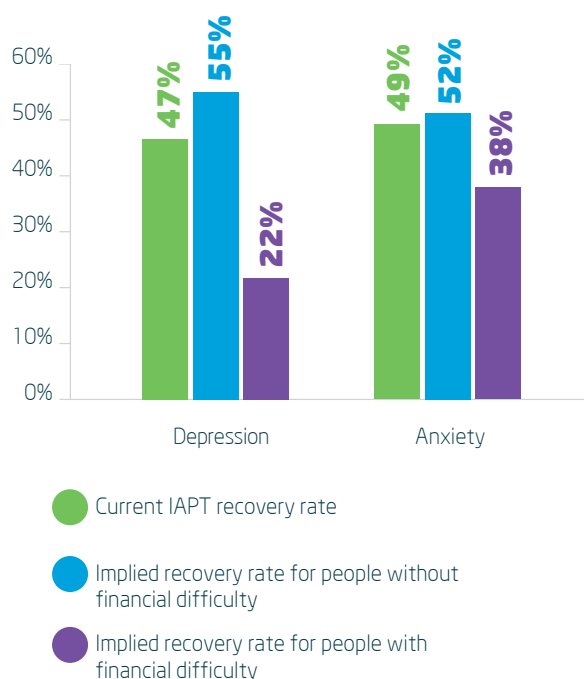
²² O'Brien C, Willoughby T and Levy R. The Money Advice Service Debt Advice Review 2013/14. August 2014.

²³ NHS Digital. Psychological Therapies: Annual Report on the use of IAPT services - England 2015/16. October 2016.

²⁴ 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.

Extrapolating from this,²⁵ we find that the 25% of IAPT service users who are experiencing financial difficulty are likely to be dragging down recovery rates across the programme. This is most significant for people with depression. While the recovery rate for depression across all IAPT users in 2015/16 was 47%, our analysis predicts that the recovery rate for people experiencing both depression and financial difficulty is likely to be just 22%. For people without financial difficulties, by contrast, the recovery rate is expected to be around 55% - comfortably exceeding the target. The recovery rate for anxiety disorders across all IAPT users in 2015/16 was 49%, this equates to recovery rates of just 38% among those with financial difficulties. The recovery rate for those without financial difficulties, meanwhile, is 52%. Figure 3 demonstrates the magnitude of the impact financial difficulty has on recovery rates.

Figure 3: Impact of financial difficulties on IAPT recovery rates



How an intervention on financial difficulty could improve recovery rates

Our analysis suggests that an intervention on financial difficulty could transform the success rate of the programme and help IAPT to meet its 50% recovery target.

Specialist debt advice is proven to help resolve people's financial difficulties and get them back on track. We model the potential impact of an intervention on financial difficulty on recovery rates, using the measure that 80% people who receive debt advice feel more in control of their finances. We assume that having regained control of your financial situation reduces the psychological distress caused by financial difficulties, and that the removal of this additional pressure moves an individual with financial difficulties back towards a normal likelihood of recovering from their mental health problem. For the 20% of those with financial difficulties for whom debt advice is ineffective (at least in resolving the emotional burden of debt and feeling of inefficacy which we assume is a cause of the ongoing psychological burden), the recovery rate remains significantly lower.

²⁵ See Appendix A for a description of the methodology used to complete this analysis.

This complex conditional probability modelling allows us to reflect the fact that debt advice is helpful in many cases, but can't completely solve all problems. In practical terms, this means the modelled recovery rate for those with financial difficulty remains lower than for those without financial difficulty. However, our analysis suggests that even adjusting for the 20% of cases where financial advice isn't effective, tackling financial difficulty through IAPT would increase recovery rates substantially as illustrated in Figure 4.

This is particularly striking for depression - a condition where IAPT has continually struggled to meet its recovery target. For an individual with depression and financial difficulties, receiving debt advice boosts the likelihood of recovery from 22% to 48%. For an individual with anxiety and financial difficulties, meanwhile, the likelihood of recovery increases from 38% to 50%.

Across the programme overall, we find that offering service users struggling with financial difficulties debt advice through IAPT would likely improve the recovery rate for depression to 53%, and would raise the recovery for anxiety disorders to 52%. Addressing financial difficulties could lift IAPT over its 50% recovery target.

"I suffered from panic attacks, anxiety and depression...I think that owing all of that money is adding to my stress and anxiety and is slowing down my recovery."

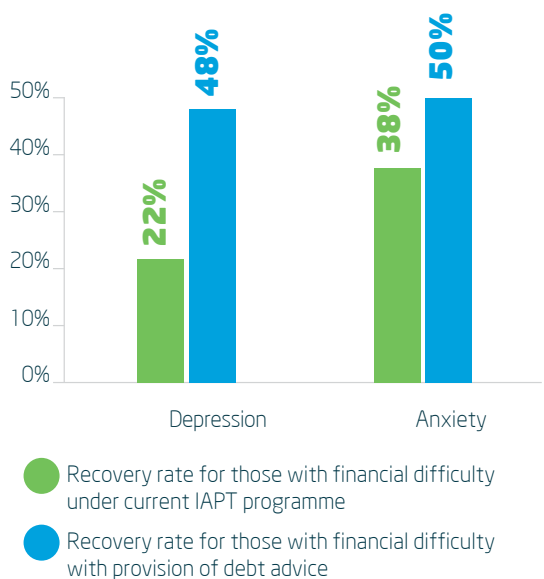
"Mental health recovery from an episode goes hand in hand with recovering my financial stability."

"The stress from my financial position is making my illness worse making recovery unlikely."

"The additional worry of how I'm going to pay the debts back is holding me back from recovery."

"I believe if I wasn't so worried about our debt then my recovery...would be more controlled and I would be able to see a future for me and my husband."

Figure 4: Modelled recovery rates for people with depression or anxiety and financial difficulty, with and without provision of advice



Source: Money and Mental Health Analysis

2.2 Deliver patient-centred care

As well as boosting recovery rates, tackling financial difficulty will enable IAPT to deliver patient-centred care to those whose needs are the greatest.

People who struggle with both mental health and financial problems are more disadvantaged, since they have to cope with both simultaneously. A key component of commissioning world-class IAPT services is that current and future commissioned services address and respond to the needs of the whole population, especially those whose needs are greatest - those affected by both mental health and money problems fall into this latter category.²⁶

The IAPT for Adults Minimum Standards state that during treatment patients should receive patient-centered assessments (on problems and goals, employment issues) as they provide the basis for effective and efficient clinical care and the delivery of an appropriately focused course of therapy.²⁷ User-led evaluations of IAPT show that service users are most satisfied with therapy when they feel that therapists are able to respond to their individual needs and circumstances.²⁸ In contrast, service users are dissatisfied with therapy when their therapists deliver 'textbook' CBT and are not flexible and responsive in their approach.²⁹ People want therapy that is addressed to them as an individual, not simply a set process followed in a set way.³⁰ While there may be a balance to strike between personalisation and scalability, the current lack of recognition of the link between financial difficulty and mental health is constraining the ability of IAPT to deliver patient-centred care.

Our survey of over 400 people with experience of NHS talking therapies found that although 46% of those in financial difficulty did discuss their situation with their healthcare professional, half this group (51%) said the advice they received wasn't helpful.³¹ The words of people who filled out the survey demonstrate how the programme is currently failing to meet individual needs around financial difficulty:

"They didn't really want to know - despite the huge impact on my mental health."

"No... she did seem to understand but wanted to focus on more positive actions."

Some therapists did try to provide some practical advice, such as:

"Yes, I was advised to check bank statements regularly."

"We talked through reasons for the financial issues."

"She suggested talking to my bank."

While it is important that therapists understand and engage with the relationship between money and mental health and can offer support around the emotions of managing money, dealing with the practical aspects of financial difficulty uses therapists' time on issues they are not expert in and reduces available therapy time. Identifying people in financial difficulty and referring them on to specialist advice will create a more flexible service that truly responds to individual needs, and will therefore improve patient outcomes and satisfaction.

26 Department of Health. Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit. April 2008.

27 IAPT. IAPT for Adults Minimum Quality Standards. <http://www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-quality-standards.pdf> (last accessed 11 October 2016)

28 Rethink. A user-focused evaluation of IAPT services in London. March 2011.

29 Ibid.

30 Ibid.

31 Money and Mental Health survey of 435 people with experience of NHS talking therapy. 16 September - 3 October 2016.

2.3 Tackle stigma

In our survey of people with experience of NHS talking therapies, over half (54%) of those in financial difficulty suffered in silence and did not discuss their financial situation with their healthcare professional.³² Our survey reveals that shame or embarrassment, finances not being brought up, and not seeing financial difficulties as relevant were the most common reasons for this. Yet over two thirds (69%) of those who didn't discuss their financial situation said they would have found a discussion about their financial difficulties helpful.³³ Encouraging people to talk about financial issues in a healthcare setting would help break down the stigma, shame, embarrassment and fear people feel when disclosing they are in financial difficulty.

"It didn't come up, so I just didn't mention it. It's humiliating to admit that we had to borrow £80,000 from family to cover my out-of-control spending."

"I felt too embarrassed to talk about my financial difficulties plus I also felt that the subject of financial difficulties was something the therapist wouldn't be interested in hearing about as she was only there to hear about how I was feeling and coping with my mental illness."

"I wasn't asked, and it didn't seem relevant, and I felt ashamed and guilty."

"I was ashamed to admit it and I didn't know at the time spending was linked to depression."

"Scared, didn't want to admit there was a problem even though there was."

2.4 Promote social inclusion

IAPT aims to increase social inclusion through employment, including help for people to retain employment, return to work, improve their vocational situation, and participate in the activities of daily living.³⁴ Financial difficulties also often lead to social exclusion, with people being excluded from activities, social groups, or behaviours that are known to support mental health and wellbeing - including taking a break or reducing hours at work, joining a gym or social club. Often people go without essentials such as food or heating, which can create a sense of worthlessness. Exclusion can be caused by financial difficulties or by psychological barriers, such as feelings of shame.³⁵

"I felt I had to make excuses for not attending family social occasions and meals out because of embarrassment over having no money. This leads to further isolation and a sense of worthlessness."

"I am currently having one of my bad days. This stems from having a nil balance in my account, limited food in my house, no toilet roll, two school trips to pay for and my daughter needs new school trousers."

It is therefore not sufficient for IAPT to promote social inclusion solely through employment. Tackling financial difficulty alongside employment will lead to higher social inclusion for those receiving therapy through IAPT, and will complement the existing role of the employment outcomes.

³² Ibid.

³³ Ibid.

³⁴ NHS Digital. Psychological Therapies: Annual Report on the use of IAPT services - England 2014/15. November 2015.

³⁵ Holkar M, Mackenzie P. Money on Your Mind. Money and Mental Health Policy Institute. 2016.



Section Three - The business case

3.1 An intervention that will pay for itself

Our cost-benefit analysis shows how even if the NHS funded the additional face-to-face debt advice needed, recovery rates would be improved without additional cost. Our analysis calculates the potential for a small surplus of health care savings of £2.4 million as well as a much greater gain of £105 million in additional economic benefits, by decreasing barriers to work and increasing productivity. This brings the total savings to £108 million.³⁶

These additional savings would be generated through the increase in recovery rates that would follow from tackling financial difficulty. In some cases financial advice will not succeed and ongoing financial difficulties will continue to reduce the likelihood that a patient will successfully recovery through IAPT. However our analysis suggest that even adjusting for the 20% of cases where financial advice isn't effective, tackling financial difficulty through IAPT would increase recovery rates substantially. Our analysis suggests that for an individual with depression and financial difficulties, receiving debt advice and regaining control of their finances changes their individual likelihood of recovery from 22% to 48%. For an individual with anxiety and financial difficulties, meanwhile, the likelihood of recovery increases from 38% to 50%.

Overall, tackling financial difficulty through IAPT would likely improve the recovery rate for depression to 53%, and would raise the recovery for anxiety disorders to 52%.

Increasing the recovery rate for people experiencing both a common mental health disorder and financial difficulty would result in long term savings in primary care costs and increased economic participation. This is set against the cost of providing specialist debt advice of £169³⁷ (for face-to-face advice; other advice delivery methods would be even cheaper), and results in an intervention would both pay for itself, yield long-term savings for the NHS and boost the cost-benefit ratio of the IAPT programme.

³⁶ See Appendix A for a description of the methodology used to complete this analysis.

³⁷ National Audit Office. Money Advice Service: Helping consumers to manage their money. December 2013.

3.2 Reduce physical health care costs

In addition to driving mental health problems, financial difficulty can also be a compounding factor for physical health problems. 47% of StepChange clients said they had visited their GP as a result of their debts, a further 6% said they had visited hospital and 5% had visited the Accident and Emergency. When asked about the impact of their debt, 71% reported experiencing insomnia, 70% experienced low energy and 66% experienced headaches.³⁸

On average people with ongoing mental health problems cost £1,200 more in physical health care than people without mental health problems.³⁹ Improving recovery rates through tackling financial difficulty will mean fewer outpatient sessions; fewer hospital admissions; and fewer appearances at Accident and Emergency.⁴⁰

Our modelling shows that the improvement in recovery rates among those with financial difficulties would generate healthcare savings alone of £2.4 million.

3.3 Increase employment rates and economic participation

Improving recovery rates would also generate additional savings through improved employment rates and higher economic participation. The average annual cost of lost working time, through both unemployment and sickness absence, for a person with depression is £7,226. For a person with anxiety, the equivalent figure is £6,850.⁴¹ Our modelling shows that tackling financial difficulty would therefore generate at least £105 million in added economic benefits. Adding this to the healthcare savings brings the total savings generated to £108 million, with savings of £61 million for people with depression alone.

There is a complex relationship between financial difficulty, mental health problems, employment and economic participation. Managing financial scarcity carries a cognitive load that affects people's capacity to think about processes or other information. Similarly, mental health problems impair cognitive function, making it harder to budget, fill out forms, make decisions and remember important information.⁴² In a workplace context, this cognitive impairment commonly leads to a lack of concentration and high levels of stress, resulting in lower productivity and time off work.

Unemployment among people with mental health problems remains unacceptably high. 43% of all people with mental health problems are in employment, compared to 74% of the general population and 65% of people with other health conditions.⁴³ People experiencing both mental health problems and financial difficulty face additional barriers to regaining work and are less productive when they are in work. People experiencing financial difficulties may leave work entirely as a result of pressures around debt repayment. Financial difficulty also acts as a barrier and a disincentive to getting back into work, as people worry that any additional earnings will be eaten up by higher repayment demands rather than leading to a higher disposable income.⁴⁴ Nearly half (48%) of StepChange clients who had fallen out of work were worried about unaffordable debt repayments if they took a new job and 76% say they would worry about taking on an insecure job in case it makes their income unreliable.⁴⁵

38 StepChange. Statistics Yearbook: Personal Debt 2014.

39 Layard R. A New Priority for Mental Health. May 2015.

40 Ibid.

41 McCrone P, Dhanasiri S, Patel A et al. Paying the Price: The cost of mental health care in England to 2026. London. 2008.

42 Holkar M, Mackenzie P. Money on Your Mind. Money and Mental Health Policy Institute. 2016.

43 Mental Health Taskforce. The Five Year Forward View for Mental Health. February 2016.

44 Hartfree Y and Collard S. Poverty, debt and credit: An expert-led review. March 2014.

45 StepChange. Held Back By Debt: How Britain's lack of financial resilience is tipping people into a debt trap. https://www.stepchange.org/Portals/0/documents/Reports/Held_back_by_debt_2015.pdf (last accessed 11 October 2016).

Mental health problems and financial difficulty also decrease workplace productivity. Analysis of Understanding Society, a longitudinal survey of 40,000 households across the UK, shows that in 2013/14 poor mental health resulted in more than one in three workers achieving less than they would like and a third of workers carrying out their jobs less carefully.⁴⁶ Four in ten workers said money worries have made them feel stressed over the last year and a quarter lost sleep over money worries. This affected the ability of one in eight workers to concentrate at work and one in twenty workers missed work in the last year. Similarly, 15% of StepChange clients said their debt worries led to them arriving late for work or taking more time off and 43% said that being in debt has led to them being unable to concentrate at work.⁴⁷

"Worrying about the amount of money coming in vs what is needed to pay money owed, household bills, feed and clothe three children and ourselves exacerbated my anxiety levels making it impossible for me to think rationally or logically about budgeting. My mind became almost paralysed and I was unable to make even simple decisions e.g to have cereal or toast at breakfast."

Tackling financial difficulty will therefore improve the employment outcomes of the IAPT programme, increase employment rates and improve productivity for those in work - increasing overall returns for the Treasury.

⁴⁶ Evans K. Working Well: How employers can improve the wellbeing and productivity of their workforce. January 2016.

⁴⁷ StepChange. Held Back By Debt: How Britain's lack of financial resilience is tipping people into a debt trap.





Section Four - A feasible, pragmatic and necessary next step for IAPT

4.1 The programme design

The founding principles, setup and reach of IAPT mean the programme is uniquely placed to test and respond to the link between financial difficulty and mental health.

IAPT was introduced in 2008 with the aim of ensuring widescale access to effective evidenced-based psychological therapy for common mental disorders, where medication had traditionally been the only treatment available. The programme was initiated on the basis that the lack of access to evidence-based treatment was unjust and that improved mental health would bring social and economic benefits. Treating mental health problems was expected to reduce public costs (such as welfare benefits and medical costs) while also helping people to find or stay in employment, boosting both national productivity and government revenues.⁴⁸ As a result, an increase in access to psychological therapies was expected largely to pay for itself.

Supporting people with mental health problems to remain in or return to employment was seen as integral to the success of the IAPT programme from the beginning, both because employment is widely accepted as good for mental health and because of the role of increased employment in mitigating costs and building the economic case for IAPT. Our arguments for the inclusion of financial difficulty in the IAPT pathways follow a similar logic. Just as being out of work is bad for mental health, so is being in financial difficulty. The longer people are out of work, the more likely they are to experience depression and anxiety.⁴⁹ Likewise, people with debt are twice as likely to develop major depression and the more debt a person has the more likely they are to develop a mental health problem.^{50, 51} Our cost-benefit analysis also shows how funding face-to-face debt advice would cost nothing due to the savings from reduced healthcare and economic costs. Tackling financial difficulty is therefore a vital next step for IAPT.

4.2 Consistent data collection

An integral part of the IAPT programme design is the continuous recording of clinical outcome data, achieved by therapists working with patients to record and track scores on clinical measurement tools, including questions on employment. These scores are used to demonstrate the effectiveness of treatment and also form a central feature of the therapeutic relationship. Collecting data on financial difficulty through these channels would provide further proof of the impact of financial difficulty on recovery rates, and would allow researchers to properly evaluate the impact of any intervention aiming to resolve financial difficulty.

4.3 A unique centrally-designed programme

IAPT services are now widely available across England: nearly one million people enter treatment each year. In 2014 one in three people with a diagnosable common mental disorder reported current use of mental health treatment. This is a substantial increase from one in four in 2007 and is largely attributed to the roll out of IAPT.⁵² As IAPT is a large scale, standardised programme, an intervention on financial difficulty could be rolled out consistently and systematically. This intervention could be tested at a number of local sites, and would then be scalable and replicable at a national level. The reach of the IAPT programme means this would have a large impact.

48 Department of Health. IAPT three-year report, the first million patients. 2012.

49 IAPT employment website, <http://www.iapt.nhs.uk/commissioning/employment/> (last accessed 10 October 2016).

50 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.

51 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.

52 McManus S, Bebbington P, Jenkins R, Brugha T. Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital. 2016.

4.4 Looking ahead - the future of IAPT

The Five Year Forward View for Mental Health commits to expand access to IAPT services to an additional 600,000 adults with anxiety and depression each year by 2020/21, with a focus on people living with long-term physical health conditions and those who are unemployed.⁵³

IAPT was specifically encouraged to focus on support for people with long term conditions and medically unexplained symptoms in 2011.⁵⁴ The focus on people living with long-term physical health conditions is part of a wider commitment in the Five Year Forward View to integrate mental and physical health support.⁵⁵ Tackling financial difficulties remains vital in this context. People with long-term physical health conditions and comorbid mental health disorders disproportionately live in deprived areas and have access to fewer resources of all kinds.⁵⁶ The evidence points to a three-way interaction between social conditions, mental health, and physical health, where the relationship between multiple long-term conditions and psychological distress is exacerbated by socio-economic deprivation.⁵⁷ The latest IAPT annual report finds that recovery rates are lower in deprived areas and among those with long-term health conditions.⁵⁸ Therefore in order to improve care and recovery rates for both people with long-term conditions and those living in deprived areas it is vital to tackle the causes of socio-economic deprivation, a key part of which is tackling financial difficulty.

The decision to focus on expanding access to IAPT among the unemployed is driven by the continuing low employment rate among people with mental health problems and builds on the existing work of the IAPT programme to boost employment levels. The NHS Five Year Forward View views both stable housing and employment as contributing to good mental health and as important outcomes for recovery from a mental health problem.⁵⁹ Our new evidence on the impact of financial difficulty on recovery rates shows how financial difficulty is a key factor in recovery, and is the missing link in this narrative on the social determinants of mental health.

⁵³ Mental Health Taskforce. The Five Year Forward View for Mental Health. February 2016.

⁵⁴ Department of Health. No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. London. February 2016.

⁵⁵ Mental Health Taskforce. The Five Year Forward View for Mental Health. February 2016.

⁵⁶ Naylor C, Parsonage M, McDaid D et al. Long-term conditions and mental health: The cost of co-morbidities. February 2012.

⁵⁷ Ibid.

⁵⁸ NHS Digital. Psychological Therapies: Annual Report on the use of IAPT services - England 2015/16. October 2016.

⁵⁹ Mental Health Taskforce. The Five Year Forward View for Mental Health. February 2016.



Section Five - Summarising the benefits

Tackling financial difficulty not only improves recovery rates but also brings a number of economic, social and healthcare benefits, as illustrated by Figure 5. We quantify that in economic terms improved recovery rates would lead to healthcare savings of £2.4 million and employment and productivity savings of £105 million, taking the total savings to £108 million. It would also result in improved healthcare services and increased social and economic inclusion for individuals.

Figure 5: A summary of the benefits of tackling financial difficulty

Improved recovery rates		
Economic benefits	Social benefits	Healthcare benefits
Increased workplace productivity	Reduced financial difficulty	Services commissioned for those whose needs are greatest
Increased incentives to work	Potential for early intervention in cases of financial difficulty	Improved patient satisfaction
Reduced spending on healthcare	Increased social inclusion	Decreased health inequality
	More open conversation about financial difficulty, reduced stigma	Increased awareness and patient-centered care



Section Six - Recommendations

6.1 First step

Develop national Positive Practice Guidance for healthcare professionals and commissioners on people in financial difficulty. This guidance should cover:

- The issues people with mental health problems and financial difficulties face
- How best to engage with people in financial difficulty
- Understanding their needs and any barriers to accessing support
- Best practice on referring onto help and which services are most appropriate

Positive practice guidance already exists for drug and alcohol addiction, offenders and others. This guidance both helps healthcare professionals to understand the additional needs of these particularly vulnerable groups and to identify opportunities for external referral to third sector organisations or others who can provide specialist support.

Introducing Positive Practice Guidance on financial difficulty will increase understanding among IAPT professionals of the ways in which financial difficulties can affect mental health and undermine recovery. This will enable a more informed conversation about the patient's needs and for IAPT services to better support the quarter of patients who are in financial difficulty.

6.2 Next steps

Basic one-question screening by IAPT on financial difficulties to guide referral to specialist help, break stigma and monitor outcomes.

Adding a single question on financial difficulty to the IAPT data set will first of all identify those who need specialist help. But it will also nudge people to talk about their financial situation in a healthcare setting, breaking down stigma and overcoming feelings of shame, embarrassment and fear experienced by many people in financial difficulty.

Like the other IAPT outcome measurements this would be asked at every appointment session and would form part of the therapeutic relationship. The question needs to be asked at each appointment for two reasons:

1. It will enable a person who does not feel comfortable disclosing their financial difficulty at the first appointment session, to disclose once they have built up a trusting relationship with their healthcare professional. As one of our research panel members said, 'asking once isn't enough' as people may be overwhelmed or embarrassed and need time to process the question.
2. It will enable to IAPT to identify people whose financial difficulties develop during treatment as a consequence of their poor mental health. This allows for an early intervention in emerging financial difficulty via specialist advice and is likely to be the most effective, helping people with their debt before it spirals out of control.

Finally, collecting this data will allow IAPT to assess the scale of financial difficulty across IAPT patients, and to properly consider the extent to which financial difficulty is hindering recovery, and what additional measures may be required to prevent this.

Onward referral to specialist advice services for those with financial difficulties.

Debt advice services, which can resolve the vast majority of problem debts, are available across the UK, free of charge to consumers and in many cases funded by the financial services industry. But to benefit from these services, people have to know how to find them and have the confidence to ask for help.

IAPT could play an important role by systematically referring people in financial difficulty onto help. Referring people to specialist advice will mean these advice services are reaching those whose needs are the greatest. Being able to refer people in financial difficulty to accessible specialist advice also means therapists are also not spending valuable therapy time on issues they are not an expert in.

Debt advice services are currently undergoing structural reform, with the government announcing the creation of a single public financial guidance organisation. Given the importance of financial security, the government is committed to making it as easy as possible for people to access advice. This represents an opportunity for IAPT to play a key role in ensuring that people with mental health problems reach the help they need, while at the same boosting the effectiveness of the IAPT programme.

Action point: This package of recommendations should be tested and evaluated in a number of local IAPT services to establish the impact on recovery and performance rates, before national roll-out.

6.3 Longer term

Fully embed and fund money advice in IAPT.

Once the beneficial impact on recovery and performance rates is established, programme managers may explore the potential benefits of embedding and funding money advice. As with embedded employment advisers in IAPT, our hypothesis is that the best results and patient outcomes would be achieved via embedded money advice.

Embedded money advice would enable patients easily to access advice and allow the complementary roles of advice and therapy to be fully realised.

Embedded money advice would also create a continuity of service provision, an integrated referrals process and the ability to seamlessly share information. This would make it easier for patients to access financial advice and would mean patients are less likely to fall through the gaps due to the lack of continuity in services. Especially when mental health problems and financial difficulty are more severe, a patient may need greater support to access financial advice - for example, the reassurance of a personal referral, and the knowledge that they won't need to repeat their whole story.⁶⁰

NHS funding would ensure that debt advice could be provided alongside therapy in an integrated and efficient way. Otherwise patients seeking advice may find they have to wait for an appointment, and this delay may undermine the ongoing benefits of IAPT therapy as patients continue to experience sustained stress and anxiety as a result of their financial distress. Integrated and NHS-funded specialist services should make it easier for patients to obtain the right advice and would enable the practical side of financial difficulty to be dealt with, while therapists focus on the emotional and behavioural support. Healthcare professionals would also be able to track whether advice has been sought and seek feedback. Evaluations of IAPT Employment Advisers found that employment advice and therapy were complementary, with the Employment Adviser providing practical employment advice and the therapist providing emotional and behavioural support.⁶¹ Specialist money advice and therapy would similarly complement each other.

By commissioning these specialist services, IAPT managers could ensure that patients are seen within an acceptable timescale, with continuity of services and in a suitable physical environment.

⁶⁰ Dobbie L and Gillespie M. The Health Benefits of Financial Inclusion: A Literature Review. May 2010.

⁶¹ Department for Work and Pensions. Evaluation of employment advisers in the Improving Access to Psychological Therapies programme. January 2013.

Embedded money advice in IAPT could be achieved by a number of different models, for example by employing specialist money advisers or contracting out to existing local specialist providers. Although embedding money advice in IAPT is a more costly intervention than signposting to existing services, our analysis shows how even if the NHS funded this advice the cost would be recouped in health care savings within 12 months driven by a significantly improved recovery rate. A single face to face appointment, at a cost of £169, allows the majority of people to feel more in control of their finances and therefore reduces the burden of financial strain.

Embedded money advice in IAPT would therefore maximise the effectiveness of IAPT therapy, boost recovery rates and unlock savings that would more than cover the cost of the investment.

Action point: Test and evaluate the benefits of different embedded delivery models across a number of local sites. The IAPT programme it is well placed to do a comparative study given the setup and structure of the programme. This would build on the evaluation of the impact of signposting, and would test the hypothesis that embedded services would be more effective than signposting.



Appendix A - Research Methods

A.1 Survey of IAPT users

Recognising the importance of involving people with lived experience of mental health problems and the IAPT programme, we commissioned a survey on talking about money during IAPT therapy.

The survey was sent out to the Money and Mental Health research panel on 16 September 2016. At this point, our research panel consisted of approximately 1,000 people with lived experience of mental health problems. 187 panel members completed the survey between 16 September 2016 and 3 October 2016. The survey was also circulated across social media channels to broaden the sample. Between 24 September and 3 October, the survey received 395 responses from social media. In total we received 582 responses.

Respondents who said they had not received NHS talking therapy, or had not received talking therapy through IAPT were excluded from the analysis. This left a total sample of 435 respondents, of whom 144 specifically reported receiving talking therapies through IAPT, and 291 who could not say for sure that their treatment was through IAPT but had received NHS talking therapies since 2008. Sampling methods mean the survey will not be representative of all IAPT users, but the sample of over 400 people is sufficiently large to provide a reasonable insight into experiences.

Respondents were asked if their mental health problems affected their ability to manage their finances (74%), and if they were in financial difficulty during the course of their therapy (62%). We then asked those who had experienced financial difficulty or struggled to manage their finances for more information about their experiences in IAPT; specifically, if a healthcare professional had asked about their financial situation during treatment, if they had discussed their financial difficulties with a healthcare professional during treatment,

and if so whether they received advice. Free-text verbatim answers were used to explore in greater detail why patients did not disclose their financial difficulties, and what advice they received if they had a discussion about money with their therapist.

A.2 Verbatims

Unless otherwise referenced all verbatims in this report are from people with lived experience of mental health problems who have contributed to Money and Mental Health's research.

A.3 Modelling current recovery rates

Our modelling brings together several independent pieces of evidence to consider the likely rates of recovery from common mental disorders (specifically depression and anxiety) for those with and without financial difficulty.

Our assumptions and their sources are listed below:

1. 47% of IAPT patients recover from depression following treatment, as do 49% of patients with anxiety and stress-related disorders - Source: IAPT Annual Report 2015/16 data tables, table 7c.
2. 25% of people with a common mental disorder also experience financial difficulty - Source: Jenkins R et al. Debt, income and mental disorder in the general population. *Psychological Medicine* 2008; 38: 1485-1493.
3. Of people with depression, those who also experience financial difficulties are 4.2 times more likely to be experiencing depression 18 months later than those who do not experience financial difficulties. Of people with anxiety, those who also experience financial difficulties are 1.8 times more likely to experience anxiety 18 months later than those who did not experience financial difficulty. Source 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.

We use the odds ratios presented in assumption 3 to calculate predicted recovery rates for those with and without financial difficulty across IAPT, within the constraints of the total recovery rates and prevalence of financial difficulty expressed in assumptions 1 and 2.

This calculation provides us with the implied recovery rates described in the report. We find that 22% of people with depression and experiencing financial difficulty will be symptom free in 18 months, compared to 55% of those without financial difficulties. For anxiety, we find that 38% of those with financial difficulties will be symptom free 18 months after first being surveyed, while 52% of those without financial difficulty will have recovered.

The odds ratios presented in assumption 3, which give the likelihood that an individual will have recovered 18 months after their first interview, do not control for treatment. In the modelling described above we assume that as IAPT currently doesn't treat the underlying causes of financial difficulty, the distribution of recovery across those with and without financial difficulty is determined by this odds ratio.

A.4 Cost-benefit analysis

From the recovery rate modelling described above, we undertook a brief cost-benefit analysis of funding debt advice with NHS funds.

This analysis is based on the following assumptions, in addition to the recovery rates derived through the analysis described above:

1. Four out of five people (80%) felt more in control of their financial situation following face-to-face debt advice. We assume that a feeling of greater efficacy resolves the psychological distress associated with financial difficulty - source: Optimisa research, The Money Advice Service Debt Advice Review 2013/14, August 2014 <https://mascdn.azureedge.net/cms/optimisa-final-quant-report-jul-2014.pdf>, p.4.

2. Face-to-face advice costs £169 for a single appointment, which is usually sufficient to provide a solution - source: National Audit Office, Money Advice Service: Helping consumers to manage their money, HC879, Session 2013/14, December 2013, <https://www.nao.org.uk/wp-content/uploads/2013/12/10278-001-Helping-consumers-to-manage-their-money.pdf>, p.20.
3. The average annual cost per person of increased physical healthcare use due to ongoing mental health problems is £1,200. Source: Richard Layard, A New Priority for Mental Health, Centre for Economic Performance 2015 Election Analyses Series, Paper EA035, 2015 <http://cep.lse.ac.uk/pubs/download/ea035.pdf>, p.5.
4. The average annual cost in lost productivity/employment for a person with depression is £7,226, and the equivalent figure for a person with an anxiety disorder is £6,850. Source: McCrone et al, Paying the Price: The cost of mental healthcare in England to 2026, King's Fund, 2008.

http://www.kingsfund.org.uk/sites/files/kf/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf
5. 121,743 people with depression completed IAPT treatment in 2015/16, as did 244,967 people with anxiety disorders. - Source: IAPT Annual Report 2015/16 data tables, table 1b.

Applying the assumption that debt advice resolves financial difficulty in 80% of cases to the recovery rates modelled above, we find that the provision of debt advice to all those in financial difficulty would raise recovery rates for those with depression and financial difficulty from 22% to 48%, and for those with anxiety and financial difficulty from 38% to 49%. This raises the IAPT recovery rate across all patients with depression to 53% from 48%, and amongst those with anxiety to 52% from 49%.

From here we isolate the improvement in the recovery rate attributed to the receipt of debt advice, and use this to calculate savings across the population of IAPT patients with depression and anxiety in 2015/16. In the depression case, for example, we assume that 78% of the £1,200 healthcare costs need to be attributed to each patient (given the 22% recovery rate) in the world without provision of advice, and that this falls to 52% when debt advice is provided and the recovery rate improves to 48%. The same calculation is carried out with regards to employment and productivity losses to identify gross potential savings per patient with depression and anxiety respectively if debt advice is provided and successfully resolves financial difficulty in 80% of cases. The cost of providing a single face-to-face debt appointment is then subtracted to provide gross savings per person. This figure is then summed across the IAPT patient population, assuming that 25% of those with depression and 25% of those with anxiety disorders are in financial difficulty, to provide headline cost-benefit figures.

The assumptions used in this analysis are purposefully conservative. Firstly, we limit our modelling to patients who currently complete IAPT (those who complete two or more sessions). In practice, dealing with financial difficulties may improve IAPT compliance rates by reducing stress on patients and improving their ability to comply with treatment. Secondly, we assume that all debt advice is provided face-to-face, when in practice in many cases assistance could be provided over the phone or online at a lower cost and be just as effective. Cost assumptions around health are also relatively conservative, given that evidence suggests that people with financial difficulties consume more health care, suggesting that people with financial difficulty may make even greater use of physical health services than the average person with a mental health problem. StepChange finds that 47% of their clients had visited their GP as a result of their debts, a further 6% said they had visited hospital and 5% had visited the Accident and Emergency.

For further details on the methods used in this report and a copy of data tables please email

contact@moneyandmentalhealth.org



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