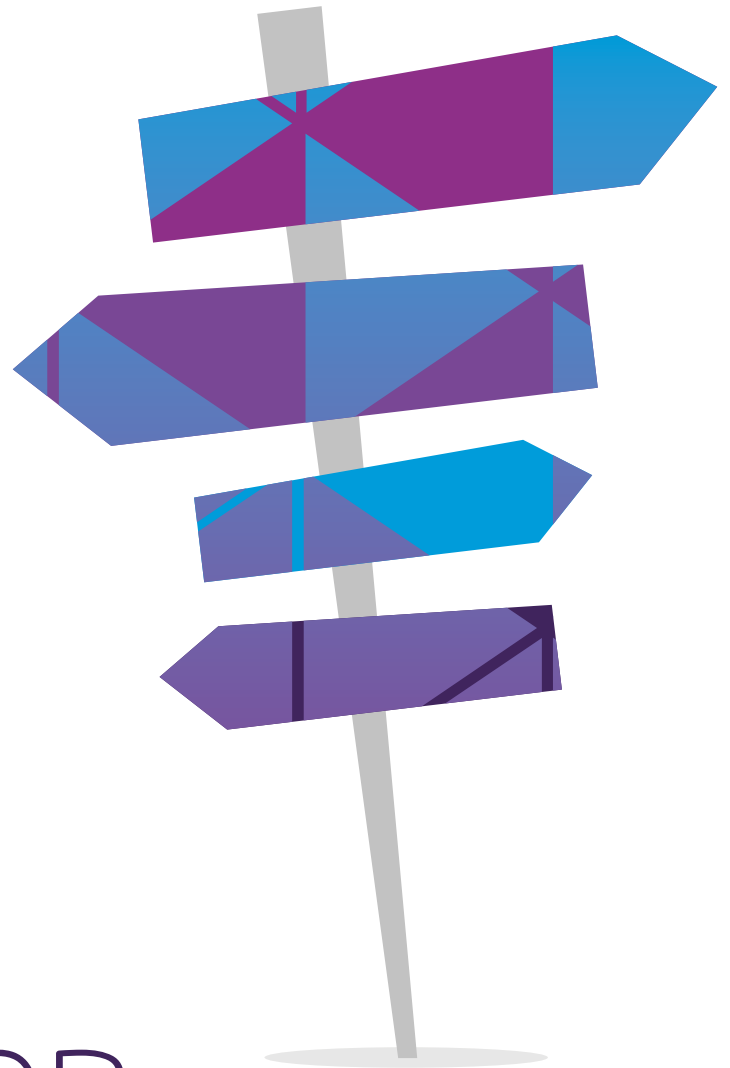




MONEY AND  
MENTAL HEALTH  
POLICY INSTITUTE



# WHOSE JOB IS IT ANYWAY?

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How mental health practitioners  
help navigate financial difficulty

Tasneem Clarke

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## About the author

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## Executive summary

Financial difficulties have a daily and destructive impact on the work of mental health professionals and support staff. One in four people with a mental health problem are also in problem debt, and mental health professionals report that these financial difficulties and resulting insecurity can undermine therapeutic interventions.

This report assesses the extent to which mental health practitioners are currently equipped to support service users experiencing financial difficulty, drawing on a new survey of 216 mental health professionals and depth interviews with 22 practitioners.

Practitioners help people experiencing financial difficulty in four main ways:

1. **Identifying financial difficulty**
2. **Supporting people experiencing problem debts to access appropriate advice services**
3. **Providing practical support where service users struggle to access other sources of advice**
4. **Offering specialist help to address the underlying psychological causes and consequences of financial difficulty.**

At each stage practitioners face challenges, as illustrated in Figure A on the next page.

### Identifying the problem

- Where it is not a requirement from service commissioners and managers to routinely ask about finances, practitioners are sometimes unnecessarily and overly cautious about raising the subject, meaning that the issue gets missed.

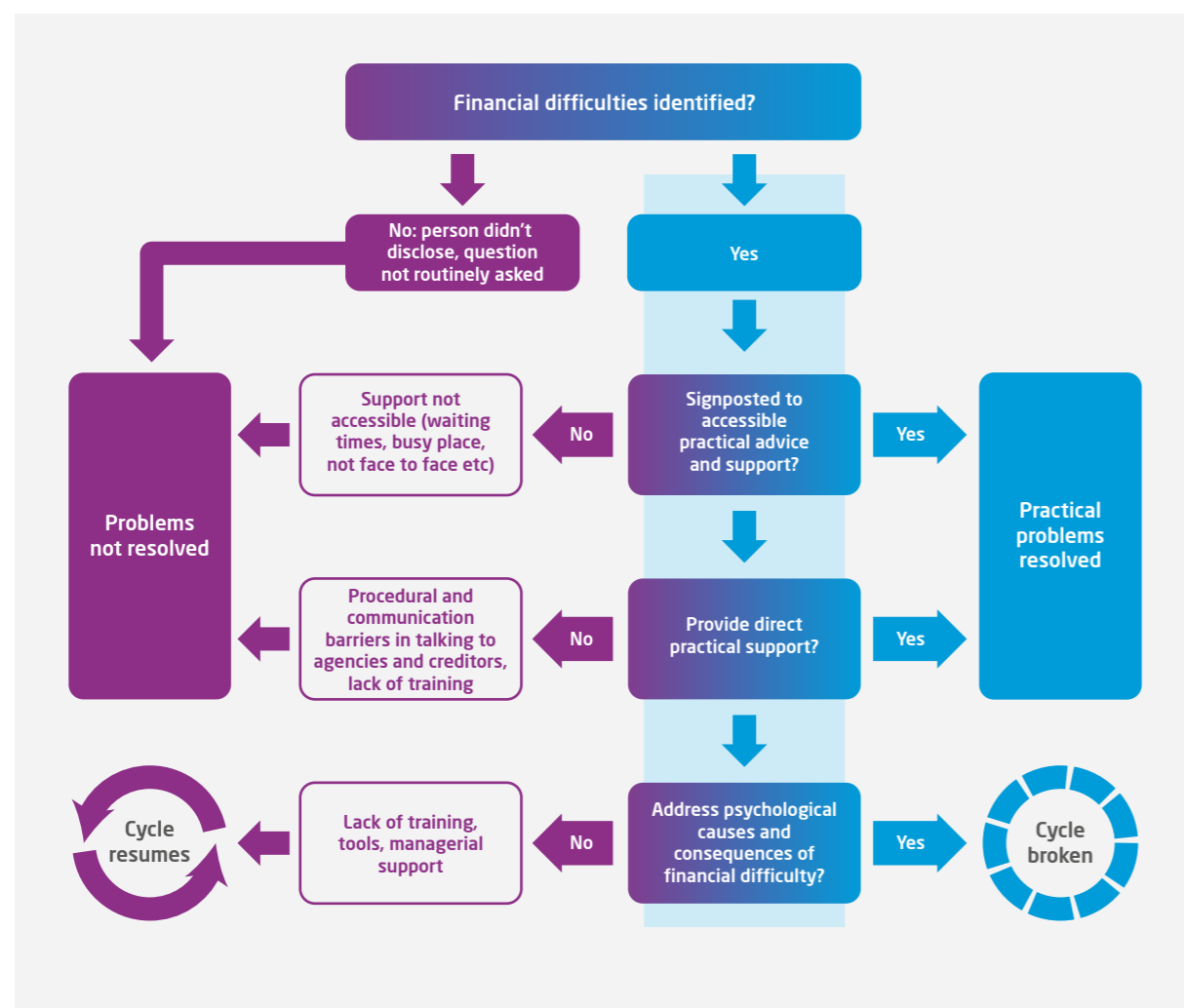
### Enabling access to advice

- Practitioners trying to signpost to appropriate support find that services are not able to meet the additional needs of some people with mental health problems, for example by offering a quick, face to face service.
- Practitioners therefore spend extra time trying to help people access these services, or helping them communicate.
- However, practitioners are uncertain about the limitations of their role when it comes to practical support, and often think someone else would be better placed to provide it.

### Providing practical support

- The limitations of existing advice provision and the complex and often urgent support needs of service users means practitioners are sometimes drawn into intervening practically on their behalf. This can involve contacting creditors, or providing practical support with forms and applications.
- Practitioners recognise that they are not well qualified for this role, but feel that in the heat of the moment there is no alternative.
- These attempts to help are sometimes hampered by the complexity of communications pathways and by data protection which is, in some cases, overzealous.

Figure A: Pathways for a service user experiencing financial difficulties



Source: Money and Mental Health, 2017.

### Offering psychological support

- Practitioners could helpfully use their specialist clinical training and skills to support people to change their patterns of thoughts and behaviours around money. This could help to provide a lasting fix to the vicious cycle of financial difficulty and mental health problems.
- In practice, however, this form of intervention seems very rare. Although a minority of practitioners are working with services users in financial difficulty in this way, they do so on an ad hoc basis, and specialist therapeutic programmes addressing this relationship are scarce.

These challenges mean the existing support provided by mental health practitioners to people experiencing financial difficulty is not as effective as it could be, or as efficient, incurring costs for both service users and service providers. To help resolve these difficulties, we recommend:

### 1. Integrated commissioning to bridge the gap

Health, public health and social care commissioners should jointly commission services that enable people with more severe mental health conditions to access financial advice. This could be done by making it easier to access existing services; improving advice services' ability to respond to people with more complex needs; or, through specialised advice services for people with the most severe needs.

### 2. Training and tools for mental health practitioners

Mental health service providers should add a module on financial difficulty to their training framework for all practitioners in mental health teams, including team managers, to provide practical tools and clarify the legitimate role for practitioners in this field. One person in each team should have particular links to local advice providers and be responsible for keeping information about how to access them up to date. Financial difficulty should also be included in initial training for all mental health practitioners, and professional bodies advising on commissioning on qualifying training should promote the inclusion of financial difficulty.

### 3. Make information sharing and communication easier

Any business, agency or authority dealing with people's finances should put procedures in place to make potential information sharing and communication in an emergency easier. This could include obtaining permission while first onboarding a customer to speak to health and social care professionals in an emergency, and holding emergency contact details.

## Introduction

### Why should mental health practitioners worry about money?

Financial problems have a daily and destructive impact on the work of mental health professionals and support staff. One in four people with a mental health problem are also in problem debt,<sup>1</sup> and the overlap between financial problems and mental health problems can cause a vicious cycle. Mental health problems can affect income; cognitive processes like short term memory or ability to process complicated financial information; and psychological factors such as motivation<sup>2</sup> all of which make it more difficult for people in a period of poor mental health to resolve financial problems on their own.<sup>3</sup> Without appropriate support, financial problems can be left to spiral out of control. The resulting stress and reduction in living standards can, in turn, undermine recovery from 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. 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.<sup>4</sup>

In this report, we assess the extent to which mental health practitioners are currently equipped to support this group of people - whether they are effectively identifying financial difficulty among service users and how they are trying to support them - drawing on detailed qualitative interviews with a range of mental health practitioners from across the UK.

The practitioners we asked clearly saw financial difficulty as something that has to be addressed in order for them to be able to do the rest of their job. In fact, eight out of ten (80%) practitioners overestimated the proportion of those with a mental health problem who also have problem debt.<sup>5</sup> This may indicate that people with more severe mental health problems, who are seen by specialist mental health practitioners, are even more likely to be in financial difficulty than headline prevalence figures suggest.

They recognise that they are not best placed to provide this support, but where financial difficulties and mental health problems are closely intertwined and a service user is too unwell to seek specialist debt advice themselves, mental health professionals are left trying to pick up the pieces.

"[Financial difficulty] definitely has a major impact, it can be a hindrance and sabotage the rest of the intervention."

– Psychiatrist<sup>6</sup>

"If you can't resolve, or at least start working on supporting somebody to resolve their debt, then you're going to struggle with improving that person's mental health and wellbeing."

– Social worker



1. Jenkins R et al. Debt, income and mental disorder in the general population. *Psychological Medicine* 2008; 38: 1485-1493.
2. Holkar M. Seeing through the fog: how mental health problems affect financial capability. Money and Mental Health Policy Institute. 2017.
3. 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.
4. 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.
5. Base 216
6. Where not otherwise attributed, all quotes are from mental health practitioners interviewed by Money and Mental Health for this research

"It's not what I've chosen to do nursing to do, but at the same time it's going to have a massive impact on their mental wellbeing. Therefore if you don't address it, it's still going to be there."

– Mental health nurse

The significant impact on recovery rates means that to be effective, mental health services must help service users to address their financial difficulties too. Despite announcements of an extra £600m of funding for mental health since 2014, only half of mental health trusts report a real-terms increase in their budgets in 2015-16.<sup>7</sup> At the same time, the number of people at risk of problem debt is expected to rise, with the latest Bank of England publications showing UK household indebtedness increasing relative to incomes<sup>8</sup> while rising inflation and stagnant wages make it harder to meet these credit obligations. As the number of people in problem debt rises, so too will the impact on mental health services. 70% of mental health trust chairs or CEOs expect a rise in demand this year, and 80% are concerned they will have too little money to provide timely, high-quality care.<sup>9</sup> In this context, failing to address the needs of those struggling with financial problems will add to the estimated £105.2bn economic and social costs of mental health problems.<sup>10</sup> It will also remain a daily frustration to professional work and a personal tragedy to the individuals involved.

At present, many people experiencing the toxic combination of mental health problems and financial difficulty appear to be falling through the gaps. A recent survey of Money and Mental Health's Research Community of people with lived experience of mental health problems found that only a third (35%<sup>11</sup>) of those who had experienced financial difficulty while accessing secondary mental health services were asked about their finances, and only one in ten (11%<sup>12</sup>) received an onward referral for help.

### State of play: a case-by-case approach

To examine the extent to which the link between financial difficulty and mental health problems is recognised within the health system, last year Money and Mental Health sent freedom of information (FoI) requests to all NHS mental health service providers and commissioners asking about how they identify and provide for cases where people are in financial difficulty. Only 17% of Clinical Commissioning Groups (CCGs) in England specified that mental health service providers must ask if service users are experiencing problem debt, and only half (52%) either commission or work in partnership with a financial advice provider to provide a specialist service for people with mental health problems.<sup>13</sup>

In England, 40% of local authorities considered financial difficulty in their needs assessment, compared to only 22% of Clinical Commissioning Groups (CCGs), suggesting that this is seen as a public health or prevention issue rather than an issue of treatment. Yet in devolved nations, where health and social care budgets are more integrated, there is greater provision of services that are specialised to enable people with mental health conditions to access money advice. Where only 45% of English mental health trusts provide some sort of specialist provision for this group, it was available in:

- All seven Welsh local hospital boards
- 91% of Scottish NHS trusts
- Three out of the four Northern Irish Health and Social Care Trusts who responded to our request.

Integrating health, public health and social care commissioning seems to have a real impact on the provision of services that take into account the complexity of a social problem which impacts on a health problem, and vice versa.

The lack of a systematic approach does not mean that mental health practitioners are not dealing with financial difficulty. Money and Mental Health's FoI responses often said that, rather than dealing with this systematically through commissioning a service or requiring service users to be asked about finances, the issue was dealt with on a case by case basis by professionals. This report continues the investigation to examine mental health professionals' experiences of doing just that. It explores their role and viewpoint, including how they deal with real life situations, and what more they need to be able to better support the people at the heart of this issue.

### Methodology and outline of the report

This report examines how mental health practitioners currently approach cases where someone is struggling with their finances. The focus is on secondary services that deal with more complex mental health needs, such as community mental health teams, crisis teams and acute hospitals. Given the strong links between financial difficulty and more severe mental health problems, the expectation is that this group of professionals should have a good awareness of the issue and be relatively well equipped to cope with it, perhaps providing learning that could be applied elsewhere in the system.

The research aimed to explore:

- How much secondary mental health practitioners know about the role of finances in mental health problems;
- How well prepared they are to deal with the financial difficulties experienced by service users with mental health problems; and
- What more they need to be confident in supporting people with this issue.

To find out, we first conducted a literature review and engaged with relevant experts in the field, including professional organisations representing psychiatrists, nurses, social workers, psychologists and psychotherapists. We then surveyed 217 practitioners working in secondary mental health services, and 425 people with lived experience of mental health problems and financial difficulty. We conducted semi-structured interviews with a total of 22 mental health practitioners, including a balanced mix of social workers, mental health nurses, support workers, occupational therapists, psychotherapists, psychologists, and psychiatrists from around the UK. Their insight forms the bulk of the research presented below.

14. More detail on methods is in Annex 1 to this report, available on the Money and Mental Health website, [www.moneyandmentalhealth.org](http://www.moneyandmentalhealth.org).

7. NHS Providers. The state of the NHS Provider Sector, July 2017.

8. Record of the Financial Policy Committee Meeting, 22 March 2017.

9. NHS Providers. The state of the NHS Provider Sector, July 2017.

10. Centre for Mental Health. The economic and social costs of mental health problems in 2009/10. 2010.

11. Money and Mental Health survey of 425 people with lived experience of accessing mental health services during a time when they were in financial difficulty. Base for this question: 329.

12. Ibid. Base for this question: 333.

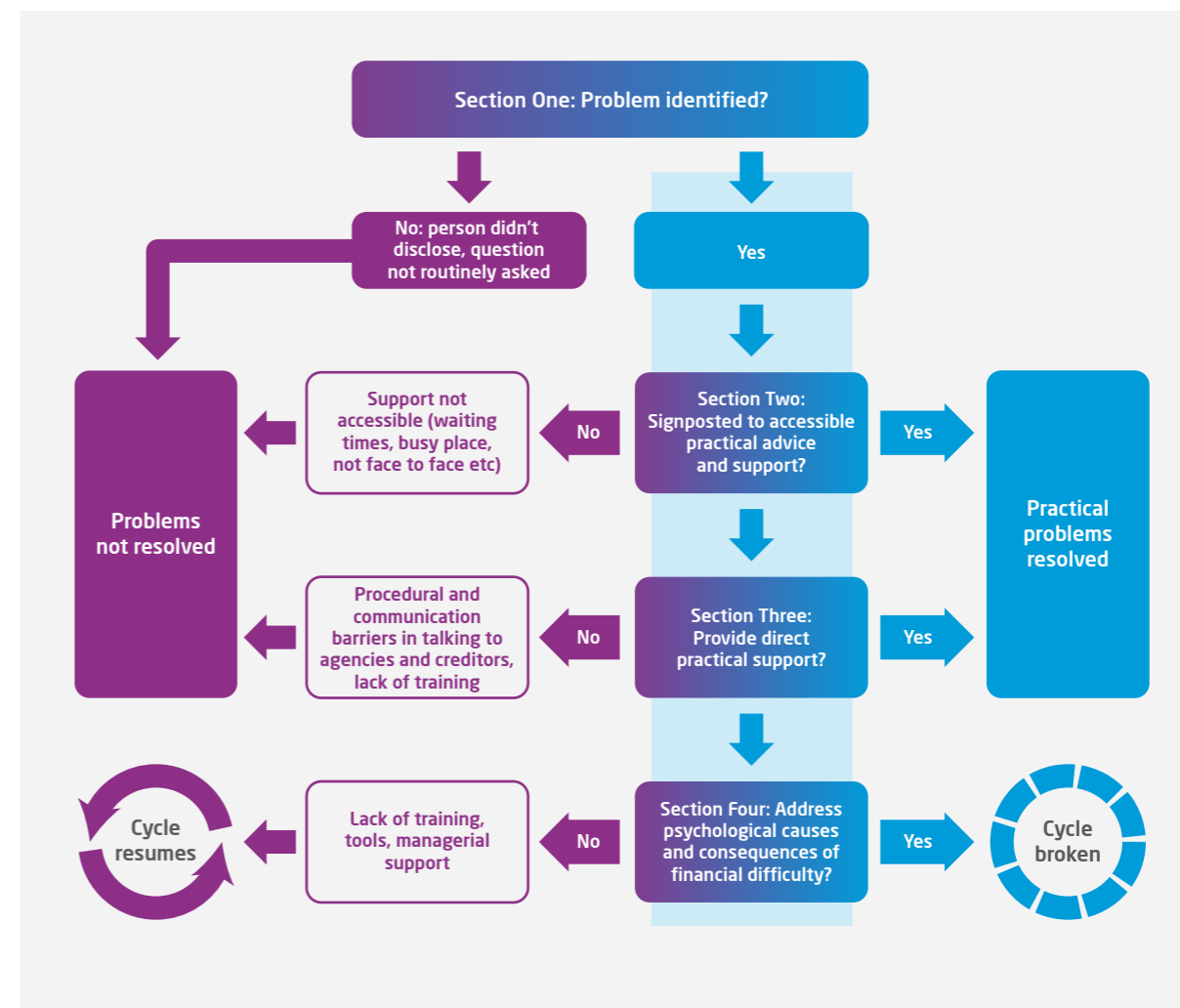
13. Clarke T, Acton R and Holkar M. The Other One in Four: How financial difficulty is neglected in mental health services. Money and Mental Health Policy Institute. 2016.

People experiencing financial difficulty while accessing secondary mental health services need support at each stage, from identifying the issue, to tackling its practical consequences by signposting or providing direct practical intervention, to addressing the psychological aspects of financial difficulty. Figure 1 gives a flowchart developed from our interview analysis, summarising how mental health practitioners currently attempt to intervene at each stage of this journey, and where support can be problematic.

- **Section one** explores how practitioners currently identify whether financial difficulty is a problem, arguing that opportunities are currently missed and that they can afford to be more assertive in doing so.
- **Section two** describes how practitioners attempt to help people access practical support for their financial difficulty, through signposting and referral processes, and the difficulties they face in doing so.
- **Section three** shows how practitioners therefore sometimes step in to try and do the job of advice services, either due to a lack of suitable advice provision or due to a person's particularly acute needs, and the issues that arise when this occurs.

- **Section four** highlights the particular skills that practitioners sometimes use to address the psychological causes and consequences of financial difficulty, to break the cycle of poor mental health and financial problems. They need support to do more in this space to maximise their chances of aiding someone towards meaningful recovery.
- Finally, **Section five** draws together the common costs of leaving unaddressed the hurdles that practitioners face, and recommends three simple solutions that could mitigate the situation: joint commissioning of specialist services, training for practitioners and managers, and better information sharing procedures from creditors and benefits agencies.

Figure 1: Current pathway for a service user experiencing financial difficulties



Source: Money and Mental Health, 2017.

## Section One: Identifying the issue

### 1.1 A softly, softly approach

The first step in tackling a problem is identifying it. Often, however, this is easier said than done. The mental health practitioners we interviewed use a variety of ways to identify whether a service user may be experiencing financial difficulties. The majority put an emphasis on establishing a trusting relationship before raising this issue, and asking questions sensitively so as not to damage an emerging rapport or scare people off:

"It's not what you say but what you don't say, so you don't talk about things they can't share. You're basically just trying to get a real overview of people, about what's going on in their lives... usually we do that by meeting people, to build up that trust with them, not get them too scared. They might say more once you get to know them."

– Support worker

Mental health practitioners know that it is hard for people to raise the sensitive issue of debt even within a trusting therapeutic relationship. They recognised that the stigma and shame around financial problems can make accessing help, such as through a debt advice agency or talking directly to a creditor, difficult or even impossible.

"If they're feeling depressed or anxious they might find it difficult to open post, maybe that triggers their anxiety, or to respond to letters or make phone calls. Perhaps they don't have the motivation due to anxiety... People avoid dealing with those sorts of problems if they're finding them quite overwhelming, or if they don't feel like there is any hope... it could just be that that's a feature of their difficulties."

– Psychotherapist

Alongside building trust, some practitioners also used other means of recognising difficulties such as observing a home environment, observing reactions in a group scenario where money was discussed, or relying on family and friends to mention problems. Worryingly, this approach tended to rest on an assumption or hope that they would happen across evidence of financial difficulty, or that the individual would raise the issue themselves.

"My natural style is to be guided by what the person brings and I would presume that if that was causing a lot of stress for them, then that would come out in our discussions. Maybe not straight way but perhaps over the course of a session or two you'd hope that that would be something we'd get to."

– Clinical psychologist

This delicate approach respects the importance of the therapeutic relationship, and recognises that money can be a sensitive and private issue for people. It also illustrates practitioners' wishes to be person-centred, or led by the service user's own priorities.

"First things first, you need to obtain his views on the situation. What does he want to do, how does he want to progress, what does he want to get out of the situation, what's the best way of working with him? It's about being quite personalised."

– Social worker





## 2.2 The need for a more assertive approach

The above approach arises out of genuine intentions to work collaboratively and sensitively. However, it could be described as being reactive: following the service user's lead and erring on the side of not pushing people too far. It does not recognise that what practitioners may think of as 'private' or 'sensitive' is sometimes actually seen by service users as being too scary or stigmatising to talk about, or simply not understood as being relevant to their mental health. It risks leaving a person continuing to struggle alone.

"I was afraid of how they would judge me and reactions they would show."

– Money and Mental Health Research Community member

Our survey of people with experience of mental health problems revealed that 61% of those accessing mental health services who were in financial difficulty were not asked about it.<sup>15</sup> Of these, only a third (33%)<sup>16</sup> talked about their financial problems with their mental health practitioners, compared to over three quarters (77%)<sup>17</sup> of those who were asked about it. The main reasons for not talking about money were thinking the mental health team couldn't help (56%) or embarrassment (48%), with a third (34% each) thinking that the mental health team either didn't have time or didn't care about financial difficulty. Only 16% referred to privacy.<sup>18</sup>

Another key reason for not raising the issue was not feeling well enough to do so, or to recognise the need to do so. Most practitioners are well aware of this.

"There's another group of people who are too chaotic or too mentally unwell or lacking capacity to really think of it as a priority... Some people have grandiose beliefs that they have lots of money and they actually have none."

– Occupational therapist

"I thought I was in control of my finances (even though I wasn't) and so I felt that I didn't need to discuss the issue with anyone. But I should have done."

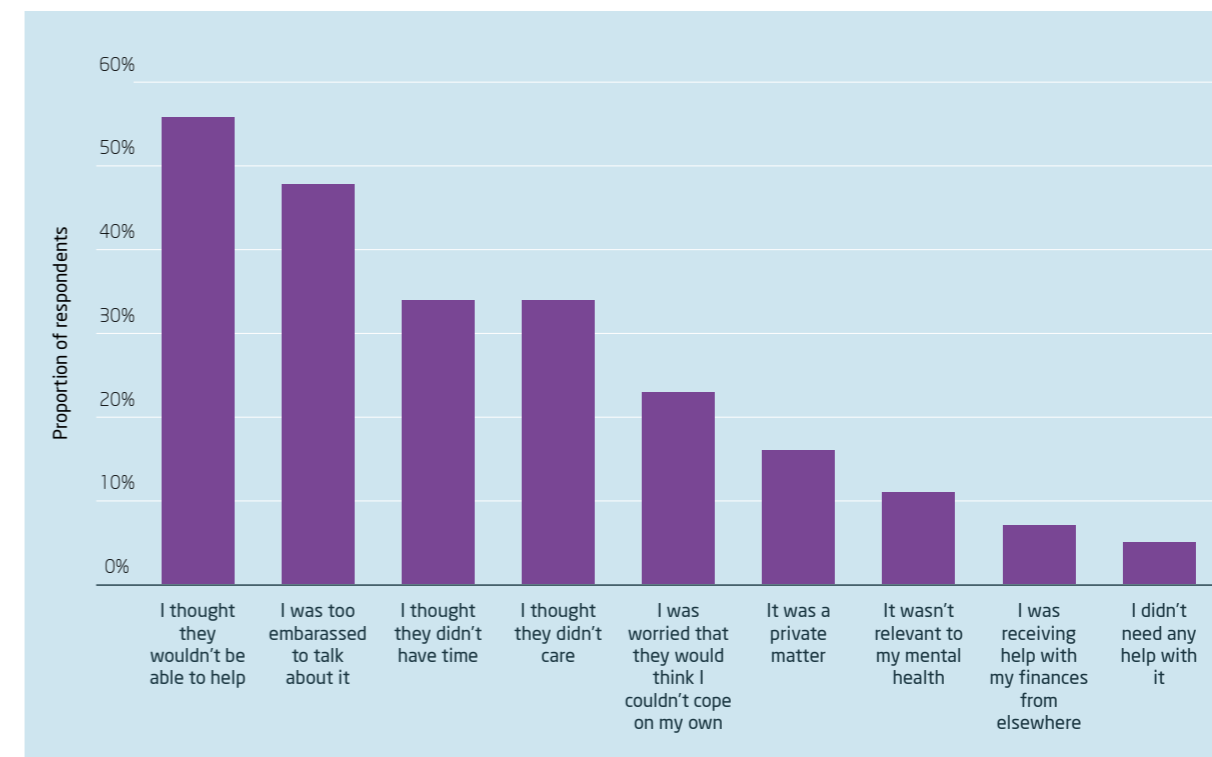
– Money and Mental Health Research Community member

Practitioners are well placed to observe problems, to challenge the stigma of being in problem debt, and to let service users know that this is a relevant and resolvable issue. Yet their very sensitivity means they don't always raise the issue, thus risking missing the problem, and allowing the person to go on without tackling it so that it continues to impact on their mental health.

"It's a very private thing for a lot of people, and there's a lot of shame and guilt with money problems... There's probably lots of patients who actually wouldn't mention it, where that's been an issue that I've never heard about."

– Clinical psychologist

Figure 2: Reasons for not talking about financial problems with a mental health practitioner



Source: Money and Mental Health survey of 425 people with experience of accessing mental health services during a time when they were in financial difficulty. Base for this question: 131

15. Money and Mental Health survey of 425 people with experience of accessing mental health services during a time when they were in financial difficulty. Base for this question: 329

16. Ibid. Base for this question: 201

17. Ibid. Base for this question: 115

18. Ibid. Base for this question: 131

### 2.3 It doesn't hurt to ask

Around half the practitioners we interviewed said that they routinely asked people about finances as part of their assessment process, and almost all struggled to think of a time someone had responded negatively to being asked. Quite the reverse:

"When you actually touch on it some people are really, really pleased to get it out... especially when you offer that support to help them with it. Because they think they're holding it alone."

– Mental health nurse

Most practitioners went on to say that even though it is a sensitive subject, it was part of their job to be able to talk about issues like this. Inevitably practitioners couldn't always be sure whether people may have not answered the question truthfully, but this was seen as no reason not to ask the question and at least provide the opportunity to address the issue. As service users told us:

"It would have been helpful to have been asked. I might have been shocked or overwhelmed at first and needed time to process the question, but once trust had been built up I would have felt more encouraged to share my problems and get help if I knew it was something they'd already asked about."

– Money and Mental Health Research Community member

Raising the question early can be valuable, even without necessarily expecting a response until a trusting relationship is later established:

"At the time I'm not sure I saw the pattern of spending was associated to my poor mental health so probing from them might have revealed that."

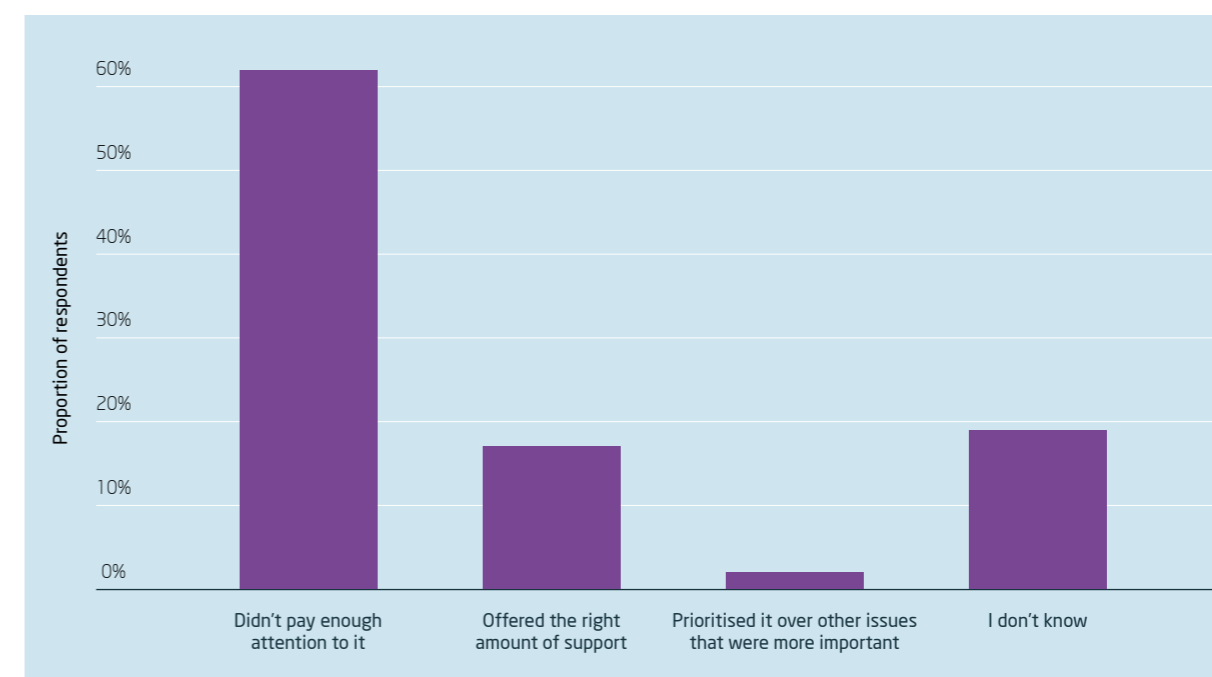
– Money and Mental Health Research Community member

"If it's very apparent that bills are on their mind, but... they've adopted a default coping strategy of avoidance, then I wouldn't bring it up on the first visit but maybe just mention: 'if there are financial difficulties maybe there are things I can help with... but I respect that's for you to decide. I don't want to overwhelm you at this stage with questions and information...' It's kind of hinting to the person that you've picked up there's something else there but you're respecting their dignity and privacy to not push too much until they're ready to disclose that information."

– Social worker

The viewpoint of those who do ask, and those who are asked about finances, is that routinely raising the subject is not damaging to trust as some practitioners may fear, and avoids the risk of relying on service users a) identifying the need to mention money, and b) feeling able to do so.

**Figure 3:** Service users' perspectives on the prioritisation of their financial situation by mental health teams



Source: Money and Mental Health survey of 425 people with experience of accessing mental health services during a time when they were in financial difficulty. Base for this question: 325

Very rarely (2%) do service users see their mental health team as having prioritised finances over other more important issues, whereas six out of ten (62%) think that their mental health team did not put enough priority on their financial situation.<sup>19</sup>

It is usually managers or service designers who decide whether to routinely ask about finances, regardless of whether an individual practitioner has recognised the importance of the issue. In our 2016 report we revealed that just over half (57%) of NHS trusts in England

require the services they commission to routinely ask people with mental health problems if they are also experiencing financial difficulty, although the proportion was higher in the devolved nations.<sup>20</sup> Yet only 17% of Clinical Commissioning Groups (CCGs) required them to do so.<sup>21</sup> In practice, practitioners report a distinct lack of understanding from service managers, commissioners, and other service providers about this aspect of the role, which has a huge impact on their ability to carry it out.

19. Ibid. Base for this question: 325

20. Clarke T, Acton R and Holkar M. The Other One in Four: How financial difficulty is neglected in mental health services. Money and Mental Health Policy Institute. 2016.

21. Ibid.

"For us it's a priority, for the service users it's a priority, because we know it's important, but for management it's not considered something that we should be doing."

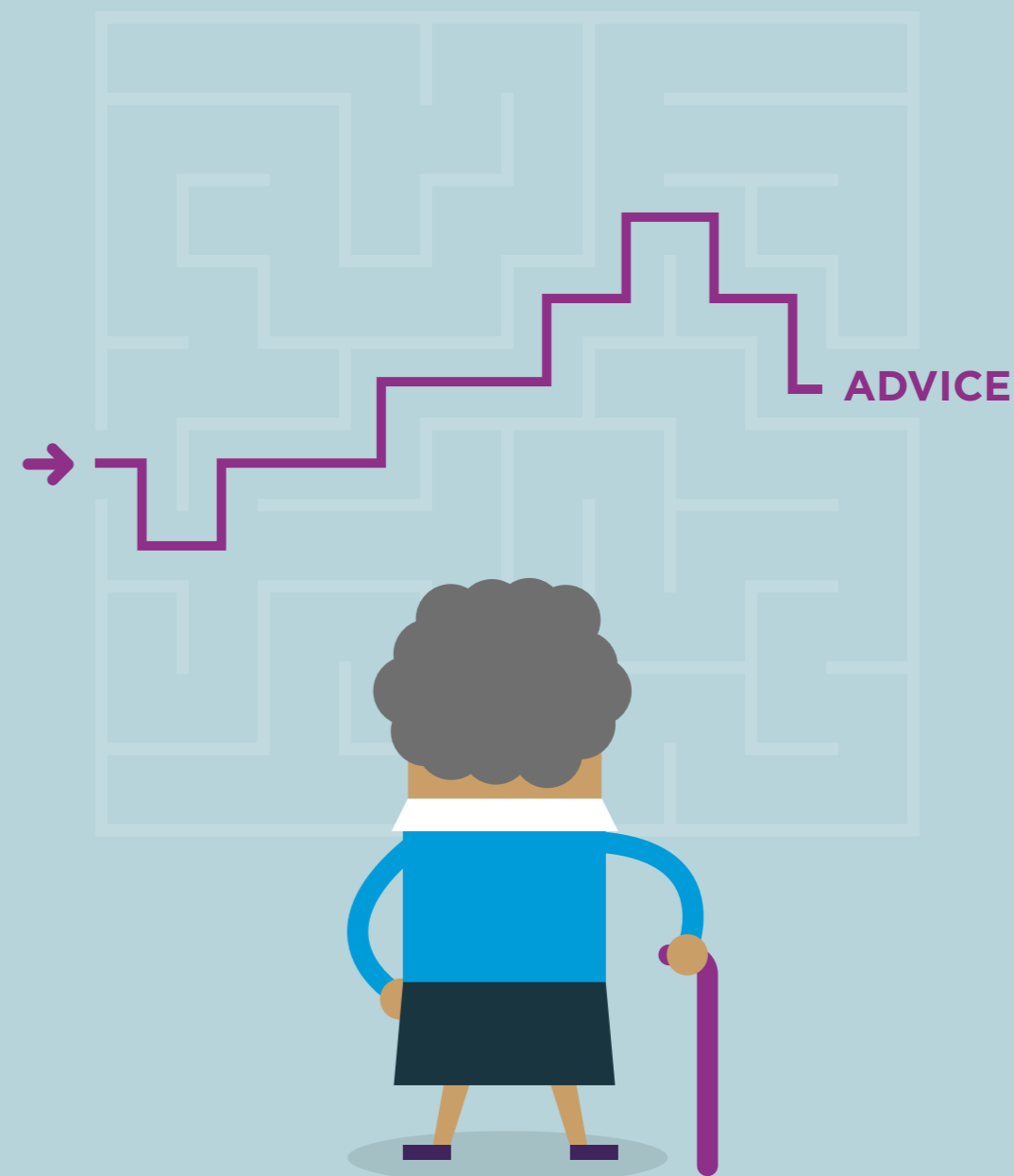
– Occupational therapist

Service designers, managers and practitioners could all afford to be more aware of the relevance of this issue and the need to be bolder in proactively raising the subject at an early stage.

### Section One summary

Where it is not a requirement from service commissioners and managers to routinely ask about finances, practitioners are sometimes

unnecessarily and overly cautious about raising the subject, meaning that the issue gets missed.



## Section Two: Enabling access to advice

Once practitioners have identified that financial problems are contributing to mental health difficulties, they turn to practicalities. This could be seen as a pragmatic or harm mitigation approach: dealing with the presenting symptoms that must be alleviated to enable longer term recovery.

Practical support is generally best provided by a dedicated money advice service with appropriate expertise and resources. Debt advice is extraordinarily effective: in nearly all cases debt advice 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.<sup>22</sup> 80% of debt advice clients report feeling more in control of their financial situation after receiving advice.<sup>23</sup> Where a service user in financial difficulty is not already accessing debt advice, a practitioner's first step is almost always try to get them to do so.

### 2.1 Basic signposting: easier said than done

Every practitioner we spoke to, and 91% of those we surveyed, said they would tell service users how to access an advice agency for practical help. This is a basic and necessary first step, and for some practitioners represents the limit of their responsibilities and abilities.

"Aside from trying to refer on to other specialist services, there isn't really a lot that I would know what to do ... I wouldn't feel very knowledgeable about what support someone might need in that situation. It's a shame."

– Clinical psychologist

Many practitioners also talked of difficulty identifying an appropriate advice service that would be truly accessible for someone with mental health problems, and talked of the limitations of what those services might really be able to provide. Charities and other advice providers, including local authorities, are seen as having had to cut back on their provision, at a time when the economic environment has actually increased the need for advice.

Advice agencies are perceived as having long waiting times and a focus on core business rather than having capacity to do extra work to support people with additional needs.

"The people and support services that used to be around are either not around at all any more or they're around for very limited hours. So the person has to be able to engage with a service at a particular time of day."

– Clinical psychologist

While accessing busy advice services may be fine for some, practitioners highlighted that it can be next to impossible for people with more severe mental health problems.

"Unfortunately there have been a lot of cuts to all these peripheral voluntary sector organisations that would usually offer something like floating support... [Some] people are incapable of going out to such places."

– Social worker

### 2.2 Enabling and warm referrals: support to access support

It's a short step from recognising people's difficulties in accessing advice to taking supportive action to enable them to do so. Many practitioners described helping service users to overcome communication barriers, by facilitating or attending appointments with someone, or making phone calls alongside someone to help them find information when they feel unable to do so alone.

"Given that [he] is clearly struggling with his mental health currently, I would be actively facilitating, not just giving information and saying get on with it. I'd be offering to make an appointment with the Citizens Advice, to accompany him there or to ask a colleague to do that."

– Social worker

Another set of support tools used were to do with helping manage a particular task:

"Just try and develop a sort of supportive relationship so the person will understand: let's be pragmatic and just do this, how can I help make it easier? I'll do the letters and you read them, agree them and sign them. Take off the pressure for that person if it's just too difficult for them to take responsibility."

– Occupational therapist

This approach fits with the social model of disability, by focusing on empowerment and enablement, and making reasonable adjustments to allow for equal access to society.

"It's about minimum intervention to keep people as independent and well as possible... Very often [forms] wouldn't get filled in because the client has either social anxiety or paranoia or whatever... they've got more reservations than reassurances if you like, and that's mainly down to mental health needs... If a bit of support from myself can help them to clarify they could be getting £50 a week on [benefits], then they're financially better off as a result."

– Social worker

### 2.3 Passing the buck: who bridges the gap?

Despite recognising that advice services are sometimes unable to reach out to those with more severe needs, practitioners gave uncertain and contradictory responses about who else should best take action to enable someone to resolve their practical situation. A majority of practitioners mentioned another health-related professional they believed was better positioned to help than them. This included:

- psychologists thinking social workers should do it;
- social workers thinking it should be support workers;
- psychiatrists thinking nurses or support workers should do it; and
- support workers thinking it should be occupational therapists or nurses.

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

23. Optimisa Research. The Money Advice Service Debt Advice Review 2013/14. 2014.

This finger-pointing does not appear to stem from professionals attempting to limit their own responsibility by defining their role narrowly; most of those we interviewed emphasised the importance of seeing a service user in their social context. Instead, it seems to be a result of genuine confusion about who is best placed to help.

Even when there is a named professional who should in theory be coordinating all the different aspects of a person's holistic care, practitioners struggle to spend time on an issue that could be seen as peripheral, focussing instead on basics like managing risk.

"Sometimes the care coordinators are a nightmare to get hold of... They feel like, 'well I've got a massive caseload... where there's high levels of risk, I'm just going to leave [the inpatient service] to get on with things...' You know this person's got a money issue, you know the care coordinator could help, but they're not responding to your phone calls or emails."

– Clinical psychologist

This tendency to try and outsource parts of the job may be because all mental health practitioners are stretched, or a result of changing roles as a result of service re-designs.

"We used to have someone that could deal with that. They could get four or five people sorted in one day, which is a big help when you've got a ward of 16... We just used to ask a person and they would take it over."

– Support worker

It is worth noting that in devolved areas of the UK, the gap in service provision for people who can't access mainstream advice is not as stark, which may be thanks to the advances made in integrating health services with social care. Integrating provision of care for this group of people might not only help bridge the service provision gap, but also clarify for practitioners where their role starts and ends.

### Section Two summary

- Practitioners trying to signpost to appropriate support find that services are not able to meet the additional needs of some people with mental health problems, for example by offering a quick, face to face service.
- Practitioners therefore spend extra time trying to help people access these services, or helping them communicate.
- However practitioners are uncertain about the limitations of their role when it comes to practical support, and often think someone else would be better placed to provide it.



## Section Three: Providing practical support

Where working alongside someone to enable them to access advice and address their financial problems isn't enough, some mental health practitioners (around half of those we interviewed) also take direct action on service users' behalves. This can include advocacy tasks like writing a supporting letter, making phone calls or other negotiations, providing direct aid for example via food banks or a staff collection, or even taking legal responsibility to act in someone's best interest when they lack mental capacity.

Information and advice were the most commonly offered types of support, but advocacy through supporting letters seemed to be more appreciated by service users. Practitioners confirmed that advocacy is particularly powerful in leveraging their professional

status, as well as their ability to identify and articulate people's needs:

"We can write a letter which explains why somebody should have access and we've been able to get decisions overturned about [benefits], which is really great... We're not saying anything that the person themselves hasn't said. But because we've got a degree of power that comes with our titles, when we say it it seems to have more influence than when the person themselves says it. We shouldn't be in the position where you have to have a psychologist to advocate for you in order to overturn unjust decisions."

– Clinical psychologist

### 3.1 A stop-gap

Such tasks however, are not necessarily best provided by a mental health practitioner. In deciding to take direct action to help someone with their finances, practitioners expressed a sense of urgency, empathy, and necessity.

"If a little bit of input from myself to the local food bank... can alleviate a crisis and temporarily, hopefully permanently, stabilise that person's life situation, and therefore their mental health as a result, to me that's a win-win situation."

– Social worker

This again demonstrates a pragmatic approach to a problem that would not otherwise go away, rather than confidence that this was necessarily the type of work they were best placed to undertake.

"The line gets drawn where my expertise ends. My expertise isn't in debt management, so I wouldn't feel that I should be phoning up a company for him or that sort of thing. I guess there are different professionals whose role that might be, so we have to draw that boundary."

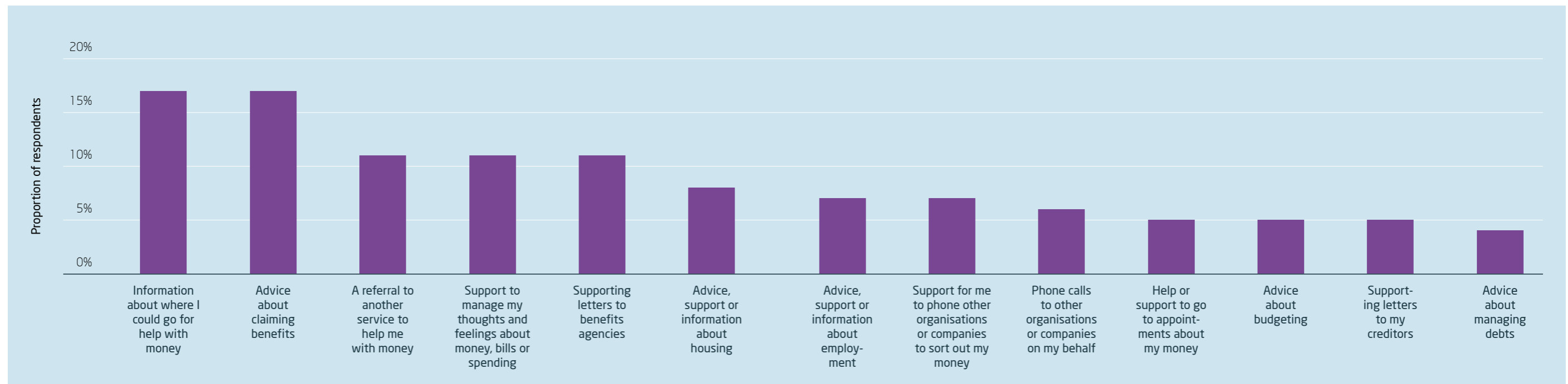
– Psychotherapist

"I'm working it out as I go along and often I don't get it quite right."

– Occupational therapist

Attempting such tasks was often in response to a perceived shortfall in service provision elsewhere. We even heard of some mental health professionals being more prepared to take action on someone's behalf than advice agencies:

Figure 4: Types of support most commonly offered



Source: Money and Mental Health survey of 425 people with experience of accessing mental health services during a time when they were in financial difficulty. Base for this question: 325

"There's a limit to where [advice agencies] can go and that's where I will jump in and see if there's anything I can help with. It can vary from that to doing a lot of the legwork that [advice agencies] would have done."

– Social worker

Despite such instances, it is unlikely that a mental health practitioner would know more on this subject than a trained and regulated debt advisor. More commonly, the urge to jump and take action is related to urgency of the problem. Where a mental health practitioner discovers financial difficulty, it is often already at crisis point and requires quick action, particularly if they are to keep the momentum achieved through a tentative engagement. Examples include benefits being sanctioned because of missed appointments during a psychiatric hospital admission, or needing to respond to a debt notice that has been ignored for too long before the debt is sold on to debt collectors, after which it is much harder to reverse any action.

At such moments, there is an urgent need to communicate with the relevant organisation. Yet, for someone with a mental health problem, taking this action can alone be impossible. In these circumstances, where time is critical, it is much harder for practitioners to successfully direct the service user to an appropriate advice agency and foster engagement with them. Because they understand the urgency and people's difficulties, because there is no-one else to do the job, and because they care, practitioners are getting pulled into directly dealing with practical situations that are beyond their training and resources.

"When they go wrong they can go wrong in quite an excessive, or quite a serious way quite quickly, or it can get quite bad before people realise the extent. That contributes to anxiety and depression and it's quite easy for them to feed into each other."

– Psychiatrist

"The process itself, with respect, it's arduous and rigorous... What works with my clientele is having a person they can get to know, be it one worker or one name, and it's very difficult to negotiate that with a big system."

– Social worker

### 3.2 Communication confusion: to share or not to share?

Unfortunately, advocacy, although valued by the service users we surveyed, is not always straightforward. Legal and procedural barriers make it difficult for practitioners to communicate effectively with other agencies and businesses on behalf of service users.

"Even as a practitioner who in theory is supposed to know some of what goes on and how to go round that process... I can't even manage it... For example, you can't ring the local job centre, you ring a call centre and you go from here to here to here... There's no real good line of communication between them and other professionals."

– Social worker

Firstly, the problems are to do with finding the right person to talk to:

"I remember sitting with a few [cases] where we're just stuck, we seem to just bounce. You're doing it online and it tells you to do it in the job-centre, and the job-centre tells you to do it online."

– Mental health nurse

Secondly, practitioners attempting to communicate on someone's behalf must contend with the issue of data protection, and consent to share information.

"You try and talk to them on someone's behalf as a social worker, you offer them the opportunity to ring you back via admin to confirm... and still they won't talk to you. You are fighting to try and support the people you're working with and the red tape from organisations like the DWP... [is] just astounding."

– Social worker

It is, of course, right that data protection laws are properly observed: this is why consent to share information is so crucial. Yet we were told of scenarios where, even when a person is present on the phone asking an agency to talk to their mental health practitioner, the agency would refuse to do so, and sometimes would not even take information that a practitioner was trying to pass on.

"It can be a bit of a nightmare to be honest because of things like confidentiality concerns. With some companies you can sort of become a named person to talk about it, but with others you have to be there with the person in order to talk about the situation. Which can be quite problematic if someone's been admitted to a mental health ward or is having acute mental health difficulties to the point that they really wouldn't be capable of maintaining a conversation on the phone."

– Social worker

"When I've phoned up credit card companies they want to speak to a professional service, they're not interested in speaking to someone who works in the health service."

– Mental health nurse

There are occasions when withholding information can be more damaging than sharing it, and these can often occur when a person's own capacity to communicate or give their consent to share information is compromised.

Procedurally, there are two main scenarios where a mental health practitioner would need to step in and act or communicate on someone's behalf.

1. **Where the person lacks mental capacity to make a decision about their finances and the practitioner has a legal duty to act in that person's 'best interests'**. In some cases there may be a legal procedure in place that enables them to do so, for example through Deputyship, Appointeeship or Power of Attorney, although these can be complicated and time-consuming to set up and not best suited to fluctuating mental health conditions.
2. **Where a person retains some mental capacity, but needs someone to speak on their behalf**, for example, if their condition means that they struggle to communicate over the telephone. This scenario is very difficult - often no-one is legally empowered to step in and make sure those communications happen, and at present there is no process by which consent is routinely gathered in advance by creditors and benefits agencies ahead of time to prepare for such a scenario.

### Are concerns about sharing data justified?

- The value of sharing personal data to support vulnerable customers has been recognised by government. The Digital Economy Act (2017) contains provisions allowing water and energy companies to share data with some government departments, so that all consumers entitled to financial support receive it.
- Official guidance about data sharing recognises that there will, at times, be a need to share personal data in an emergency, sometimes without being able to acquire the person's consent.<sup>24</sup> The decision to share data in these circumstances is expected to be made on the basis of professional judgement, in line with the 'best interests' of the person concerned.
- In practice, the wide range of ways in which this guidance could be interpreted appears to make organisations nervous of reaching a decision on when it is appropriate to share information. Our research suggests that many people who care for someone experiencing a mental health problem struggle to convince organisations to share information with them, sometimes even when a third party mandate or Power of Attorney is in place.<sup>25</sup> In particular, some organisations are keen to manage the risk of providing a third-party with access to personal data by relying heavily on written proof of incapacity or consent to share information, which can be very difficult to obtain while someone is acutely unwell.
- The Department for Work and Pensions has exclusive helplines for advice agencies, and works on the principle of implied consent to share information if the caller knows basic information about the customer, and can quote facts and recent details about the claim, or from recent correspondence with the customer, and makes enquiries that you would expect the customer to make if they were able.<sup>26</sup>
- However even advice agencies have informally confirmed that being able to talk to benefits agencies is a longstanding problem.
- From May 2018 data protection regulations will be strengthened through the General Data Protection Review (GDPR), which introduces heavier penalties for data breaches. This should be good news for consumers, who have been affected by high profile data leaks in recent years. However it may make organisations even less willing to share data in times of crisis.

### Section Three summary

- The limitations of existing advice provision and the complex and often urgent support needs of service users means practitioners are sometimes drawn into intervening practically on their behalf. This can involve contacting creditors, or providing practical support with forms and applications.
- Practitioners recognise that they are not well qualified for this role, but feel that in the heat of the moment there is no alternative.
- These attempts to help are sometimes hampered by the complexity of communications pathways and by data protection which is, in some cases, overzealous.

24. Information Commissioner's Office. Data sharing code of practice. 2011.

25. Murray N. Strength in Numbers: consumers, carers and financial services. Money and Mental Health Policy Institute. 2016

26. Department for Work and Pensions. Working with Representatives Guidance. 2015





## Section Four: A psychological approach

Beyond dealing with the practical consequences of financial difficulty, mental health practitioners also have unique skills, experience and training that allow them to tackle the psychological roots and consequences of financial difficulty. This is analogous to the way they deal with any other problematic behaviour impacting on wellbeing, such as addiction or self-harm: they must treat not only the symptoms but the causes.

Mental health problems have a concrete impact on people's cognitive abilities to deal with financial situations, for example through poor impulse control, as well as psychological factors like compulsive behaviour, avoidance of anxiety-provoking situations, or using spending to cope with difficult emotions.<sup>27</sup> Practitioners recognise this and are strategically placed to tackle these underlying problems, which otherwise continue to perpetuate the vicious cycle.

### 4.1 Emotional support and psychologically informed understanding

Firstly, many practitioners help with the psychological consequences of a difficult situation by normalising the person's experience, validating their emotional response, and encouraging hope:

"I would probably comment on how common it is to have debt or financial difficulties, and mention how challenging it can be... I guess to try and help him feel understood... [and] that he could receive help."

– Psychotherapist

Next practitioners seek a deeper understanding of the issue and its causes:

"I would use either [a cognitive-behavioural approach], or just try and talk about some of the cycles with money: if it's impulsive spending, or not being able to make phone calls to the companies... to see what is actually the problem that is making the money situation so difficult."

– Occupational therapist

Once this understanding is gained, it can shed a light not only on the financial difficulties but a person's overall mental state:

"For some people it's a real coping strategy... The internet was [my client's] access to the outside world and he got a buzz from spending. The more that I understood the link between his moods and the debt, the more I realised we need to do some work directly on these things... So if spending is a way of making yourself feel happier... OK well what other things can you put in your life that will also make you feel happier, and can you start to do some of those instead?"

– Clinical psychologist

### 4.2 Facilitating change

The crucial aspect for many practitioners is acting on this deeper understanding and sense of partnership to facilitate change. This is often to do with supporting service users to learn to manage thoughts and feelings to do with money, with the aim of preventing recurrence:

"[I would] talk through the psychological blocks for doing things. Even if somebody's got a psychosis or some thought disorder that's impacting on it, then I would gently challenge that."

– Occupational therapist

Such skills will then feed back not only into a person's longer term financial capability, but also into their overall ability to manage their thoughts and feelings:

"Sometimes I would intervene on a meta-cognitive level, so I wouldn't be thinking so much about the content of what somebody's thinking about, but I might be thinking about the pattern of their thinking. Are they always assuming that the worst will happen rather than focussing on each specific situation for its merit?"

– Psychotherapist

### Case study: Talking group for people with bipolar disorder - Solent NHS Trust

People with bipolar disorder are offered the opportunity to attend a 12-week group course with a clinical psychologist. The groups, who meet once a week, are intended to help prevent overall relapse, and did not originally have finances specifically included in their remit. However, the psychologist running the group has discovered that when talking about symptoms of mania, the issue always comes up, and has therefore informally incorporated this into the content of the group.

Techniques used include:

- Elements of CBT: when discussing ways to keep calm and stop mood going up, this can include changing behaviour to try to limit spending, for example using a basic phone rather than a smartphone.

- Elements of mindfulness: using mindfulness to 'surf the urge' to spend, thus limiting spending by delaying it.
- Practical tips: delaying ability to indulge urges to spend by freezing a credit card to prevent it being used; or not letting websites save card details.

"Our group is about overall recovery from bipolar disorder: feeling more able to manage and prevent relapses. Preventing relapses of overspending is often part of this and some clients have told me they find they are now more able to notice urges to spend before they become too strong to resist."

– Dr Thomas Richardson, clinical psychologist

<sup>27</sup>. Holkar M. Seeing through the fog: how mental health problems affect financial capability. Money and Mental Health Policy Institute. 2017.

### 4.3. Factors limiting this therapeutic role

Despite the fact that this area is the most clearly suited to practitioners' specialist training and clinical skills, it was mentioned far less often by our interviewees than the practicalities discussed in sections two and three. This may be because it is the kind of in-depth work that takes time and effort that practitioners can often scarce afford and is, in some cases, driven by the expectations of commissioners about the type of interactions practitioners should be undertaking and the time that these interventions should take. This therapeutic role may also be impeded by the pressing urgency of those practicalities.

Yet taking the time to support service users to understand the psychological factors underlying their financial problems could be seen as taking the enablement approach to its next logical conclusion. It may even prove to be the crucial step that breaks the vicious cycle between mental health problems and financial difficulty, promoting longer term recovery and preventing relapse in both areas. Neglecting this unique opportunity to facilitate change could leave mental health services acting like just another advice service:

"They just deal with the debt but don't look at the issues underneath it... It's like putting a sticking plaster onto a great big gaping hole. It's not going to sort it out for very long really."

– Mental health nurse

It certainly deserves further exploration - despite the potential of this approach, and a thorough search by Money and Mental Health, we have been unable to find many cases of therapeutic interventions being used specifically to address problematic relationships with money.

#### Section Four summary

- Practitioners could helpfully use their specialist clinical training and skills to support people to change their patterns of thoughts and behaviours around money. This could help to provide a lasting fix to the vicious cycle of financial difficulty and mental health problems.
- In practice, however, this form of intervention seems very rare. Although a minority of practitioners are working with services users in financial difficulty in this way, they do so on an ad hoc basis, and specialist therapeutic programmes addressing this relationship are scarce.



## Section Five: Costs and opportunities

Mental health practitioners bring a wealth of understanding and skills to the complex problem of financial difficulty. They identify the issue both as a critical practical barrier to recovery that needs addressing, and an area where their experience and training provides a crucial opportunity to facilitate change. However, at present, practitioners are spending precious clinical time undertaking practical tasks where they're not best suited to doing so, while deeper issues go unaddressed. The current lack of clarity about where responsibilities lie, and the lack of support and resources for practitioners trying to help services users in financial difficulty, have costly and potentially dangerous consequences for everyone involved.

### 5.1 Effectiveness: costs to the service user

A person experiencing a mental health problem is not always in a position to seek advice or negotiate for themselves, let alone challenge their own behaviour patterns, and so may have to rely on others to identify and deal with financial problems for them. In our current system, they may fall at the first hurdle if no-one thinks to ask the question at the right moment. Assuming the problem is caught, they may find that there is still a gap in advice services they can actually access. At this point practitioners may act out of urgent necessity to try and bridge the gap themselves, despite feeling under-confident and ill-equipped, knowing they face additional barriers to communication, and sometimes using inconsistent workarounds to these problems.

"We're not really meant to be the people who make those referrals [for practical support]. I never quite understand it. Sometimes I can make a referral, sometimes I can't."

– Occupational therapist

As a consequence, financial difficulty is dealt with in a haphazard and ineffective way, by people who are not trained in it. The available mechanisms to deal with problem debt and negotiate with creditors are complicated and require some expertise to apply appropriately without implicating yourself legally, or doing a 'botch job' that could actually make a bad situation worse. Mental health practitioners attempting this complex work out of necessity face a legal and practical minefield in this area, leaving them unable to properly meet service users' needs.

### 5.2 Efficiency: costs to the service provider

At a time when efficiency is needed in mental health services more than ever, the expensive time and skills of mental health professionals are being spent on attempts to meet a glaring practical need that obstructs the rest of their job, but which they are not well-placed to fulfil. Without training, resources and appropriate communication channels, the whole process remains ineffective, wasteful and frustrating.

"There's been so many sessions that have been... certainly in a clinical sense, wasted, in essence, because we've had to talk about the stress of their current situation. And that's not what people are actually coming to see me for, but obviously it's something that we have to deal with."

– Clinical psychologist

Meanwhile there is a missed opportunity for practitioners to make more appropriate use of their skills to improve recovery rates and prevent relapse, by more confidently identifying hidden needs for intervention, and facilitating longer term behaviour change.

### 5.3 Next steps

The current gap in service provision is damaging, but there are several logical ways to mitigate it.

#### Recommendation One: Integrated commissioning to bridge the gap

In some places, service commissioners and managers have recognised the gap between what people with mental health problems need to sort out their finances and what they can access, creatively and efficiently filling the service provision gap and freeing

up professionals to concentrate on their specialities. Examples include projects like the case study below, or using advocates, support workers and link workers provided by the NHS or charities such as Mind, as a link between mental health services and advice services.

#### Case study: Mental Ill-Health and Benefits Project

Run by Hertfordshire County Council, this project provides community-based advisers working alongside mental health staff to resolve money problems impacting on mental health, including by negotiating with benefits agencies and creditors. Referrals come from NHS, Community Finance Officers and voluntary organisations, though users can also self-refer. The local mental health trust does not offer funding, but provides an office when required, and reports benefits from the project.

Advisers have the specialist advocacy training you would expect, but also have mental health experience, which helps them communicate effectively with service users and advocate to DWP, using their understanding of how mental health issues affect people. Face-to-face advice on debt, legal matters and welfare benefits is provided at home or in NHS settings (including in hospital) as the service user requires.

The project reports:

- An estimated £5.4m in extra benefits or debt write-offs for the 1120 people advised in the first two years.
- A substantial average improvement in wellbeing among service users. 58% said their health had greatly improved and 33% reported at least some improvement.<sup>28</sup>
- In a survey of referrers to the project:
  - 88% say it allowed them to focus on clinical issues
  - 76% say it reduced the need for the team's involvement with the service user and
  - 32% say it has enabled them to discharge a service user.<sup>29</sup>

"Your help has made medication for panic attacks and psychological counselling unnecessary. I now sleep at night."

– Service user

"A great weight was lifted off my shoulders. Claiming for ESA was not easy and I would have given up if it wasn't for the adviser."

– Service user

28. Survey of Mental Ill-Health and Benefits Project service users, Jan-March 2017

29. Survey of staff referring to the Mental Ill-Health and Benefits Project, Jan-March 2017

Joint health and social care working is ideal to provide services that share responsibility for a problem that imposes costs on both partners. Health services are affected by lost efficiency of workforce resources, lower recovery rates, and higher prevalence of mental health problems. Local authorities face lost revenue of more than £800 million from council tax arrears, as well as the cost of dealing with correlated social problems such as impacts on child welfare, poverty, and homelessness, which can cost government between £24,000 and £30,000 per person.<sup>30</sup> Meanwhile, mental health practitioners are left attempting to bridge this gap on a case by case basis, without systematic support from their service commissioners, particularly in England where services are not as integrated as in devolved nations.

Joint commissioning to bridge this gap would also be in line with recent guidance from Public Health England that Health and Wellbeing Boards should include analysis of financial difficulty in their Joint Strategic Needs Assessments (JSNA),<sup>31</sup> which form the basis for health and wellbeing strategies. It would also meet calls from the Local Government Association for a new collective approach to mental health and wellness focussing on prevention and early intervention,<sup>32</sup> and fit neatly into the ongoing development of Sustainability and Transformation Partnerships (STPs), which aim, in theory at least, to improve broader health and wellbeing, including through healthy behaviours.<sup>33</sup>

### Recommendation

Health, public health and social care commissioners should jointly commission services that enable people with more severe mental health conditions to access financial advice. This could be done by:

- Making it easier to access existing services (e.g. using link workers from within the NHS or other agencies)
- Improving advice services' ability to respond to people with more complex needs (e.g. having staff better trained in mental health, and with time to spend on more complex cases)

- A specialised service designed for people with the most severe needs (eg co-located with health services, with quicker referral times, providing a variety of communication methods such as face to face support, online, phone etc).

As a minimum, excellent communication channels (such as a 'warm referrals' process) should exist between mental health and advice services. There is a further opportunity here to build the evidence base about the level of need for such specialised services, and what works in addressing this need.

30. Merola R. Mental health support in local communities. Citizens Advice, July 2017.

31. Public Health England. Better Mental Health: JSNA Toolkit. Understanding Place. 2017.

32. Local Government Association. Being mindful of mental health. The role of local government in mental health and well being. Local Government Association. 2017

33. Ham C et al. Delivering sustainability and transformation plans: from ambitious proposals to credible plans. King's Fund. 2017.

### Recommendation Two: Training and tools for mental health practitioners

Financial difficulty is currently inconsistently approached within mental health services, and consequently there are risks that the issue gets missed or inappropriately dealt with. Practitioners have vital opportunities that must not be missed: to identify and support with practical issues, enable and advocate for service users, and tackle underlying problems contributing to the vicious cycle. Yet, at present, practitioners are not well-equipped to fulfil this role. Our survey of 216 mental health practitioners showed that only one in ten (9%) had had any training about financial difficulty and its role in mental health, and only three in ten (31%) had had other 'relevant' training (self-defined).<sup>34</sup>

The cost of providing practitioners with tools and training to help them support service users experiencing financial difficulties will likely be offset by the recovery of time otherwise lost by practitioners attempting to find such resources by themselves.

The provision of training would be within the requirement of the Health and Social Care Act regulation 18(2), which states that providers must provide training to enable practitioners in their role. Supporting behaviour change is a key part of mental health work, and Skills for Health's National Occupational Standards for Mental Health Workers confirms that mental health workers need to know how to access support and assistance that people may need at different times and in different contexts.<sup>35</sup>

Trusts currently provide training on various issues known to correlate with mental health conditions, such as smoking and learning disability.<sup>36</sup> In terms of prevalence, these issues are often comparable to prevalence of financial difficulty, an issue which practitioners told us they would appreciate knowing more about.

Table 1: Training for mental health practitioners on particular subjects

Particular characteristic	Proportion of those with this characteristic who have mental health conditions	Proportion of those with mental health conditions who have this characteristic	Is training statutory or mandatory?
Domestic violence	Unknown	30-60% of psychiatric inpatients <sup>37</sup>	Yes
Learning disabilities	35-41% <sup>38</sup>	Unknown	Yes
Problem debt	45% <sup>39</sup>	24% <sup>40</sup>	No

Source: Money and Mental Health, 2017.

34. Money and Mental Health survey of mental health practitioners. Base 216

35. <http://tools.skillsforhealth.org.uk/competence/show/html/id/3831/>

36. Action on Smoking and Health. Fact Sheet: Smoking and Mental Health. 2016.

37. Howard L et al. Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychological Medicine 2010; 40: 881-893.

38. Cooper S et al. Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. British Journal of Psychiatry 2007; 190: 27-35.

39. Jenkins R et al. Mental disorder in people with debt in the general population. Public Health Medicine 2009; 6, 3: 88-92.

40. Jenkins R et al. Debt, income and mental disorder in the general population. Psychological Medicine 2008; 38: 1485-1493.

### Recommendations

- Mental health service providers should add a module on financial difficulty to their training framework for all practitioners in mental health teams, including team managers, to provide practical tools and clarify the legitimate role for practitioners in this field. One person in each team should have particular links to local advice providers and be responsible for keeping information about how to access them up to date.
- Training should cover:
1. Awareness: key facts about financial difficulty and its links to mental health problems
  2. How to proactively raise the issue, so that service users know it is considered relevant and not shameful, and have opportunities to talk when they are ready
  3. How to proactively signpost and enable: where best to refer to locally, how to refer in a way that enables communication and engagement with those services, and where to find up to date, effective practical resources
4. Tools for taking practical steps, but also for longer term proactive psychological interventions to improve problematic financial behaviours. When developing such behavioural tools, there is also an opportunity to build the evidence base about what works by building evaluation into any such trials.
- Education providers for mental health professionals should include a module on financial difficulty to raise awareness of the issue and how it can be addressed, ensuring all professionals have a basic level of knowledge and understanding.
  - Professional bodies advising or commissioning such qualifying training should actively promote the inclusion of such a module in the providers they endorse or commission.

### Recommendation Three: Make information sharing and communication easier

When a person is finding it difficult to cope with their finances, especially due to a mental health problem, it is vital that communicating with creditors or benefits agencies does not present another barrier to getting help. The procedural and legal barriers to communication could be addressed through better and more consistent interpretation of existing and forthcoming law. Such changes would avoid the inconsistent and potentially unsafe workarounds currently being used by people caring for someone with a mental health problem, including mental health practitioners.

The problem here is not in current data protection law, but rather in the risk averse and inconsistent way in which this is interpreted by companies. Although practitioners are usually trying to communicate with creditors or benefits agencies on behalf of a service user in an emergency, taking steps ahead of time to obtain and record consent for this could make things considerably easier both for practitioners

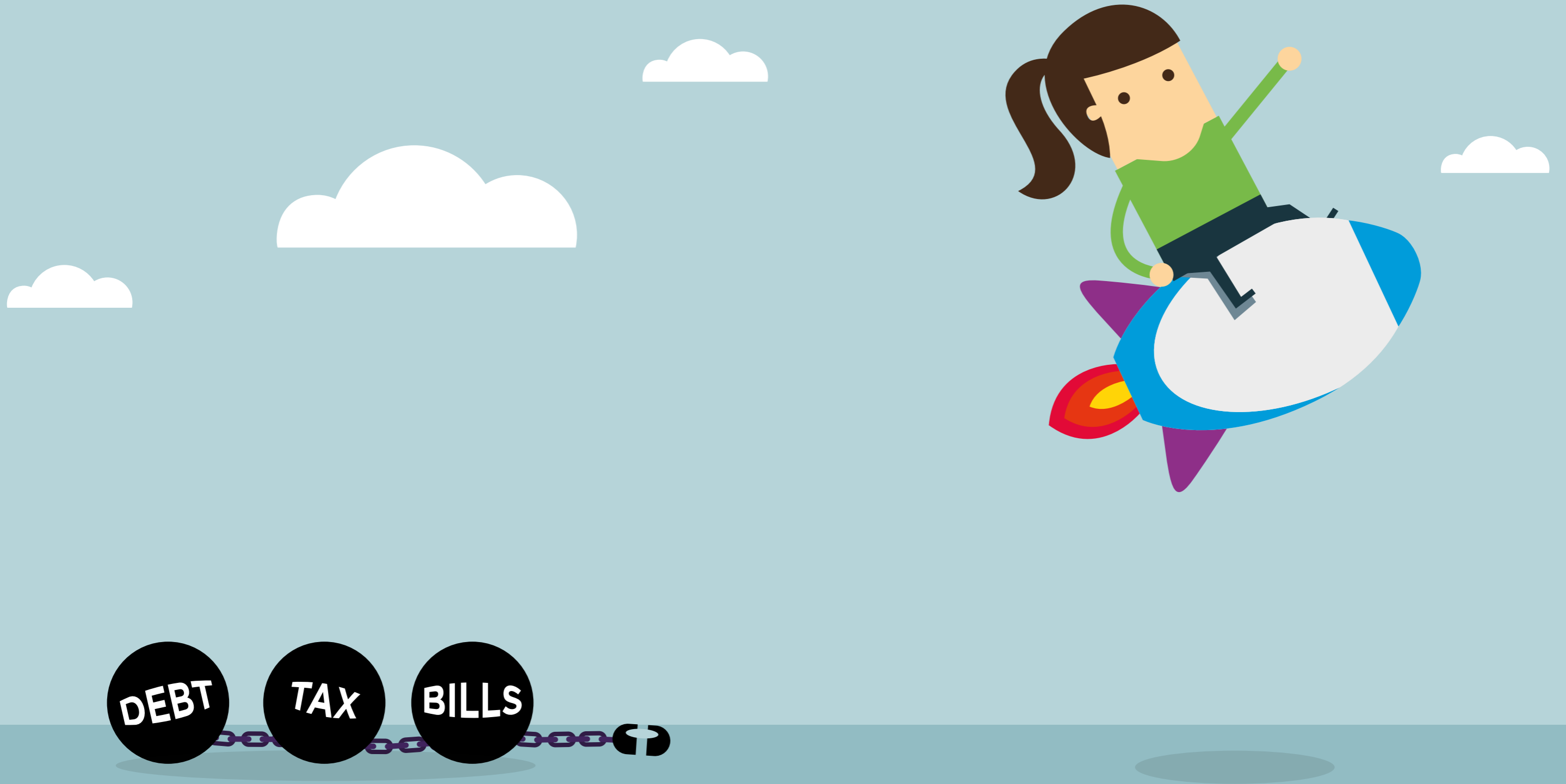
and the people they are trying to help. Developing systems of informed consent to limited data sharing in an emergency is significantly more pragmatic as an approach than expecting everyone who may ever experience a mental health crisis to set up a formal Power of Attorney or other delegation of decision-making powers ahead of time.

Customer-facing firms and benefits agencies could add simple questions to their onboarding processes, requesting emergency contact details and asking for permission to speak to medical or social care professionals in an emergency, which would avoid significant stress further down the line. These processes would benefit firms too, by reducing the likelihood that a person falls into arrears when they become unwell, and providing reassurance that while trying to do their best for a customer in a difficult situation they are not inadvertently falling foul of data protection rules.

### Recommendation

Any business, agency or authority dealing with people's finances should put procedures in place to make potential information sharing and communication in an emergency easier. This could include:

- Obtaining permission during onboarding to speak to health and social care professionals in an emergency, and ensuring contact details for an emergency contact are held on file
- Providing dedicated helplines adequately staffed by people appropriately trained in mental health awareness and data protection
- Ensuring staff have adequate flexibility to respond appropriately within the constraints of data protection legislation when they know the customers involved.





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