The Royal College of Psychiatrists and the Money Advice Trust

Debt collection and mental health: an evaluation of the Debt and Mental Health Evidence Form

A briefing for creditors and money advisers

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RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

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Authors

This report was written by Ryan Davey[1] and Chris Fitch[2]

[1] Research Worker, Centre For Quality Improvement, Royal College of Psychiatrists
[2] Research Fellow, Policy Unit, Royal College of Psychiatrists - cfitch@rcpsych.ac.uk

Ryan Davey was a Researcher at the Royal College of Psychiatrists when he co-led the first-ever research on the experiences of around 1300 UK frontline debt collection staff when working with customers who report a mental health problem (www.rcpsych.ac.uk/recovery). Prior to joining the Royal College of Psychiatrists, Ryan worked in the financial services sector as a collector for a major high street bank in their credit card arrears department, as well as the mental health charity Mind and undertook research on the mental health service user movement. Ryan is now based at the University of Cambridge where he is undertaking research on vulnerable consumers and money advice services.

Chris Fitch is a Research Fellow at the Royal College of Psychiatrists where he leads a programme of work on indebtedness, financial services and mental health. He was a member of the Money Advice Liaison Group's working party on their mental health guidelines, led the development of the Debt and Mental Health Evidence Form, and in 2010 (with Ryan Davey) undertook the research on which this report is based. This study won the Credit Today 2011 award for Money Advice Initiative of the Year. Prior to this, Chris worked in international HIV prevention for Imperial College Medical School, the World Health Organisation, and the United Nations Programme on AIDS.

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1 Introduction

This report presents the findings from research on the use of the Debt and Mental Health Evidence Form (DMHEF) among debt collection staff and money advisers.

What is the DMHEF?

The DMHEF is a standardised form containing seven basic questions which creditors or money advisers can use when:

- an individual discloses a mental health problem to a creditor or money adviser;
- the individual reports that the mental health problem has negatively impacted on their ability to repay or manage their debts;
- creditor or money adviser staff have asked for clarification on exactly how this impact affects their ability to repay or manage their debt;
- but unresolved issues, complex circumstances, or doubts remain;
- where additional information – or what is usually referred to as *medical evidence* - from a health or social care professional who knows the customer is needed to decide the action creditors should take;
- and where the customer gives their informed consent for such an approach to be made.

The DMHEF has been developed by the Royal College of Psychiatrists and the Money Advice Liaison Group (MALG is a forum that brings together creditors and money advisers), in collaboration with creditors, money advice agencies, and health organisations.

Why was it developed?

During the drafting of guidelines by MALG in 2007 on working with indebted customers with mental health problems, money advisers and creditors reported that when attempts were made to collect information from health or social care professionals:

- poor-quality, irrelevant, or just 'difficult to understand' information was often returned;
- refusals, delays, or payment requests from health professionals were not uncommon;
- which ultimately made it difficult for creditors to take better informed action, or avoid heightening customer distress at an already difficult time.

The final MALG guidelines therefore called for a standardised approach to overcome these difficulties, while also meeting legal requirements regarding the communication and processing of sensitive personal data detailed in the UK Data Protection Act 1998.

The first version of the DMHEF was subsequently launched in 2008, with a second revised version being produced in 2009 (see TIMELINE 1).

What does the DMHEF 'ask'?

The seven DMHEF questions are outlined in BOX 1, while APPENDIX 2 contains the full set of DMHEF forms.

What is its status?

The DMHEF has been used by money advisers and creditors since its launch in 2008:

- it is recognised by the major trade membership bodies within the creditor and collections sector, as well as the major money advice organisations;
- subscribers to the Lending Code 2011 are required to *"consider the DMHEF if it is presented by the customer or (with the customer's consent) their adviser or medical practitioner"* (this therefore applies to all members of the British Bankers' Association, The UK Cards Association, and the Building Societies Association);
- the OFT Irresponsible Lending Guidance also requires creditors to consider the DMHEF;
- while there are no data – to our knowledge - on the number of creditors and money advisers using the DMHEF, estimates do exist on the collection of medical evidence among creditors (see TIMELINE 1).

This report

Despite this progress, attempts to improve the DMHEF continue. In this report, we attempt to contribute to this, by addressing a key gap in current knowledge: *how do money advisers and creditors actually use (or decide not to use) the DMHEF?*

To achieve this, this report combines data from qualitative interviews with 24 money advisers and creditor staff, and quantitative data from a three-month audit of the collection and use of medical evidence at one creditor site (see BOX 4, page 6).

Taken together, it provides a previously unavailable insight into how well the DMHEF 'fits' the needs and processes of everyday creditor and adviser practice.

BOX 1 The seven DMHEF questions

Q1. Does the person have a mental health problem?

Q2. Does the person have a mental health problem that currently affects their ability to deal with money? Does this mental health problem have a name? Please provide the main diagnosis in plain English. How does this mental health problem affect the person's ability to deal with money?

Q3a. What was the approximate date of the:
(i) first onset of this mental health problem
(ii) first treatment given for this
(iii) most recent episode of this mental health problem

Q3b. Is this episode currently ongoing?

Q4. If the person is receiving treatment or support for this mental health problem, is there any aspect of this that affects their ability to manage money?
Please explain how that treatment or support affects their ability to deal with money.

Q5. Are there any other relevant impacts/effects that the person may experience in their everyday life due to their mental health problem? What other relevant effects are there?

Q6. Does the person have any difficulties with communication due to their mental health problem?

Q7. Can the information provided in this form be shared with the person it is about?

TIMELINE 1 History of the development of the DMHEF

2008 - Following a recommendation in the MALG guidelines, the first version of the DMHEF was launched in 2008. This was designed for use by both creditors and money advisers.

2009 - An evaluation was undertaken by the RCPsych of the views of creditors, money advisers, health professionals, people with mental health problems and their carers on the questions contained within the DMHEF, (Fitch, Chaplin and Tulloch, 2010).

Following this, significant changes were made to the DMHEF's questions and design. Separate versions were also produced for creditors and advisers. These contained *exactly* the same questions, but contained different 'introductory information' which reflected the slightly different uses that creditors or advisers would make of information in completed DMHEFs returned by health or social care professionals.

This second version of the DMHEF was launched in 2009 for money advisers only. The creditor version was placed 'on hold' due to discussions about the administrative process creditors needed health or social care professionals to follow. However, it is anticipated that a creditor version will be launched in 2012/13.

2010 - A survey of nearly 1300 frontline debt collection staff was undertaken by the RCPsych and Money Advice Trust. This found that frontline staff (a) reported being confused about whether their role allowed the collection of medical evidence; (b) only collected medical evidence once a month, and then (c) only used medical evidence about once every five months. However, (d) eighty-four percent of frontline staff surveyed agreed that the medical evidence influenced the decisions they made; (e) fifty-seven percent agreed that the information was easy to understand; (f) three-quarters (76%) agreed that the information was relevant; and (g) nearly a quarter (24%) agreed that using medical evidence had helped them recover the debt.

2011 - The Lending Code 2011 (which applies to all members of the British Bankers' Association, The UK Cards Association, and the Building Societies Association) was published. This required all subscribers to *"consider the DMHEF if it is presented by the customer or (with the customer's consent) their adviser or medical practitioner"*

2 Background

What is 'medical evidence'?

The term 'medical evidence' is used in this document to refer to written information (a) provided by a health or social care professional about (b) an individual that they know in a professional capacity.

What is it used for?

Where an individual has mental health problems as well as debts, creditors may wish to gather further information to address unresolved issues, complex circumstances, or remaining concerns and doubts. The decision to collect such further information should always be in proportion to the type of decision or course of action that is likely to be taken.

Who *collects* medical evidence (and why)?

In terms of mental health conditions, medical evidence is already collected by a range of organisations (and for a range of purposes). These include:

- *government bodies* – for example, in relation to 'fit to drive' assessments by the Driving Vehicle Licensing Authority; mental capacity issues; as well as substantiating claims for Disability Living Allowance and Incapacity Benefit;
- *commercial organisations* – for example, reports requested by insurance companies will often address the issue of mental health conditions;
- *voluntary agencies* – medical evidence may also be requested by agencies in relation to housing, debt, and other welfare issues.

Who *provides* medical evidence?

As noted in the MALG Guidelines, a *range* of health and social care professionals can provide equally robust medical evidence in relation to an individual's reported mental health condition.

In practice, however, requests for medical evidence have often been directed at doctors. In particular, General Practitioners are often approached to provide such evidence, due to the fact that many people will be registered with a GP.

How should medical evidence be collected?

In addition to our 2010 report on creditor practice (Fitch and Davey, 2010) there is existing guidance on the principles and procedures underpinning the collection of medical evidence where an indebted customer reports a mental health problem (BOX 2, opposite).

What does previous research tell us?

Previous research has focused on:

- *the DMHEF* – in 2009, an evaluation of the DMHEF with 92 creditors/advisers, mental health professionals, and service users/carers found the DMHEF scored acceptable levels of clarity and relevance (Fitch, Chaplin and Tulloch, 2010). However, concerns existed about (a) the sharing of diagnostic information between the creditor and health sectors, and (b) the difficulties in providing a prognosis about the likely future course of an individual's mental health problem.
- *the collection of medical evidence* – in 2010, a survey of nearly 1300 frontline debt collection staff found that staff (a) reported being confused about whether their role allowed the collection of medical evidence; (b) only collected medical evidence once a month; and (c) then only used medical evidence about once every five months. (Davey and Fitch, 2010)

Charges for medical evidence?

There have been informal reports by creditors and advisers that General Practitioners often charge for medical evidence. One reason for this may be that GPs (and GP practices) are not normally employed *by* the NHS, but instead have a contract *with* the NHS to provide specific primary care services. Consequently, any services 'falling outside' of this contract are likely to be charged for. Further, General Practitioners are used to charging for report-writing (e.g. insurance reports) and may view requests for medical evidence in a similar manner.

To our knowledge, the National Health Service does not have any central guidelines on charging for medical evidence. However, while the British Medical Association (which represents the interests of individual doctors who are members) do not provide specific guidance on fees for providing mental health evidence, they do provide general guidance on fee-charging and also operate a Professional Fees Committee (which sets tariff levels for different forms of activity including report-writing).

BOX 2 Codes of practice relating to the collection of medical evidence about mental health conditions

MALG guidelines (MALG, 2009b)

1.3 The creditor will need to take steps to establish whether the mental health problem affects a consumer's ability to manage money and debt, based on relevant testimony to be provided by the consumer and/or their representative.

3.1 It is important that members of each agency helping to resolve a person's debt problems work together, [and] exchange information (with clients' consent).

6. Where a mental health problem has been notified, creditors should allow a reasonable period for advisers to collect relevant evidence and present it to the creditor.

6.9 Appropriate courses of action might include agreeing to impose a stay of action, not charging default interest and/or charges for unauthorised borrowing while information is being gathered by an adviser.

13.2 Creditors will accept evidence provided from an agreed list of practitioners [including] care coordinators, clinical psychologists, GPs, mental health nurses/psychiatric nurses, occupational therapists, psychiatrists, social workers, and other approved mental health professionals.

Lending Code (sponsored by BBA, The UK Cards Association, and BSA, 2011)

238. Where it is appropriate and with a customer's consent, subscribers should work with advice agencies and health and social care professionals in a joined-up way to exchange information and ensure an effective dialogue.

241. If a customer informs a subscriber that they have a mental health problem that is impacting on their ability to manage their financial difficulties, the subscriber should allow the customer a reasonable period (e.g. 28 days) of time to collect and submit relevant evidence to the subscriber. This evidence will help the subscriber to work with the customer, advice agencies and health/social professionals where appropriate to determine the most appropriate action to deal with the customer's financial difficulties.

242. The Money Advice Liaison Group (MALG) has produced a Debt and Mental Health Evidence Form (DMHEF) which provides a standardised methodology for advisors and creditors to share relevant information about the customer's condition from health and social care professionals.

243. Subscribers should consider the DMHEF if it is presented by the customer or (with the customer's consent) their adviser or medical practitioner.

244. If a subscriber has received appropriate and relevant evidence of a customer's mental health problems they should consider whether it is appropriate to pass or sell the customer's debt to a third party debt collection agency.

Lending Code (FLA, 2006)

1C Lending you money - We will take particular care if you are suffering from health problems, including mental health difficulties, when we are made aware of this ... In order to do this we may need to ask for appropriate evidence of your health problem and may need your permission to record this information on our system.

1D4. If we are aware you have a long-term health difficulty [we will] make sure that we accept appropriate evidence of your condition when considering your financial difficulties and the options available to you.

Debt Collection and Default Guidelines (CSA, 2009)

L) Have due regard and deal sensitively with individuals where evidence has been given, or is apparent, that the individual is incapacitated by mental or physical disability.

P) Take into consideration before determining whether to enforce repayment, all information supplied in relation to the reason for nonpayment.

OFT Guidance on Irresponsible Lending

7.4 [& 7.13] In the OFT's view, creditors should consider reducing or stopping interest and charges when a borrower evidences that he is in financial difficulty and is unable to meet repayments.

MALG = Money Advice Liason Group **BBA** = British Bankers' Association **BSA** = Building Societies Association
FLA = Finance & Leasing Association **CSA** = Credit Services Association **OFT** = Office of Fair Trading

3 Methodology

In simple terms, the study aimed to answer the question: *how do money advisers and creditors actually use (or decide not to use) the DMHEF?* To help answer this:

- qualitative interviews were undertaken with a total of 24 money advisers and creditor staff;
- an audit was undertaken over a three month period on the collection and use of information using the DMHEF (and other forms of evidence) in a large creditor organisation.

This ran from between December 2010 to April 2011.

Qualitative interviews

The aim of the qualitative interviews was to explore the participants' views, experiences, and decision-making processes when collecting and using medical evidence. Such insights are invaluable to ongoing efforts to improve the utility of the DMHEF.

We asked participants to specifically focus on the DMHEF, although comparisons with other forms of medical evidence were welcomed. We also encouraged them to reflect on the perceived weaknesses and benefits of using the DMHEF, as well as the extent this 'fitted' the needs and processes of everyday creditor and adviser practice.

Sampling

A total of 24 participants were spoken to over the course of 12 semi-structured interviews including:

- 10 staff working in collections and recoveries in the creditor sector in England (n=4 worked in high street banks, n=6 worked for debt collection agencies, and n=9 were in 'specialist teams');
- 14 money advice staff/ volunteers, all based in England (n=9 worked on specific mental health projects, n=1 made home visits to 'harder to reach' clients, including those with mental health problems).

Participants were recruited through existing contacts within the creditor sector and the advice sector. Creditor and advice organisations were asked to nominate staff who had experience of using medical evidence in relation to customers with mental health problems.

Audit

The aim of the audit was to consider – in the real-life setting of a collection department in a large creditor - whether the DMHEF improves (a) the perceived quality of information available to creditors about customers with debt and mental health problems; (b) the time and resources needed to collect this evidence; (c) and the decisions made on the resulting course of action.

To achieve this:

- data were collected prior to the audit beginning – with interviews documenting existing practice, creditor/adviser expectations, and perceived obstacles/facilitators to implementation.
- each time a DMHEF was sent to a health/social care professional, information was logged on the date sent and other indicators, and also on return (to calculate completion time). These data were stored by collections staff in a central database, with regular updates sent to the research team.
- following the audit, interviews were held with creditor/adviser staff about using the DMHEF.

Sampling

The creditor site was recruited through the RCPsych's network of existing contacts. Over three months, 58 items of medical evidence were collected (**BOX 4**).

Analysis

All qualitative interview data were subjected to a content analysis of key themes using the software package Atlas.ti. Quantitative data from the audit were compiled into a central database. These data were analysed using the SPSS software package.

Limitations

Originally, the research had intended to also undertake an audit of the DMHEF in a money advice provider. Although official agreement had been reached with a money advice provider to do this, shortly before field-work was to begin the Coalition Government began significant cuts in funding to this sector. Consequently, the agency was unable to participate, and a substitute could not be found.

In addition, we had intended to survey health and social care professionals who completed/returned a DMHEF to the creditor organisation. However, the creditor site could only participate if the research was *purely observational*, and did not 'interfere' with normal communications or practice. A similar objective of surveying money advice clients was not possible, due to the withdrawal of the money advice site.

BOX 3 Who is involved in the collection of medical evidence?

'Specialist teams'

Specialist teams within creditor organisations are teams that aim to support customers who have (a) serious difficulty engaging with the mainstream collections and recovery operation or (b) setting up payments with them. With names like 'Sensitivity and Hardship', 'Vulnerability', 'Mental Health and Money Advice Support', 'Long-term Payment Arrangements' and 'Third-Party Debt Management', these teams are constituted in various ways (e.g. addressing different types of customer vulnerability or having different thresholds for referral).

Money advisers

A money adviser is trained in providing debt/money advice and support. They can help clients manage their debt, negotiate with creditors to establish an acceptable repayment schedule; and advise clients on other sources of help and options. The money advisers we interviewed worked face-to-face, in debt advice centres (n=12) as well as in clients' homes (n=1), and also by telephone (n=1). Advice sessions could last around an hour, and a large part of the work involved clarifying exactly what an individual owed and to whom, given that many clients had left letters unopened and calls unanswered – a process one adviser described as like "unravelling spaghetti". Debt advice projects targeted at clients with mental health problems tended to have the capacity to provide extra support to those clients; under some sources of mainstream advice funding, some advisers felt that targets and other pressures made it difficult to provide an adequate service to clients with mental health problems.

Health and social care professionals

Creditors should accept evidence provided from an agreed list of practitioners including care coordinators, clinical psychologists, General Practioners, mental health nurses/psychiatric nurses, occupational therapists, psychiatrists, social workers, and other approved mental health professionals.

BOX 4 Quantitative audit

Presented below are data from the three-month audit of all requests and receipts of medical evidence at the specialist team of one major creditor organisation. Over the course of the three months, a total of 58 pieces of medical evidence were received.

Overall, the majority of medical evidence received was DMHEF forms, rather than letters or medical reports:

Type of evidence	n
DMHEF form	40
Letter	16
Both a letter and a DMHEF form	1
Medical report	1
TOTAL	58

However, if we look more closely by comparing submissions following the creditor requesting evidence vs unprompted submissions, there were about as many letters and DMHEF forms submitted among the medical evidence submitted unprompted; among the medical evidence submitted after the creditor's request, the vast majority were DMHEF forms. (This is due to the company's policy of sending out blank DMHEFs to customers.)

Type of evidence	Unprompted	After Request
DMHEF form	11	29
Letter	12	3
Both a letter and a DMHEF form	0	1
Medical report	0	1
TOTAL	23	34

Notes: Data were unavailable from one case, so the lower table has a total of 57 items of evidence (rather than 58).

4 Results

In this section, we combine qualitative interview and quantitative audit data to present the key results of the study. These are grouped into six key themes:

A. medical evidence: importance of quality
B. getting medical evidence: return rates
C. acceptability: health and social care professionals
D. acceptability: credibility of source
E. money advisers: awareness and range of use
F. outcomes: what do creditors do?

Presentation of results

Selected quotes from the interviews are presented below, alongside quantitative audit data from our creditor field-site. Each quote is accompanied by a participant code (either 'Ad' for an adviser, or 'Cr' for a creditor) and a participant number. APPENDIX 1 contains further general details on the type of participants interviewed.

A. Medical evidence: importance of quality

The quality of the information provided in the Debt and Mental Health Evidence Form (DMHEF) is crucial when considering the form's effectiveness. We therefore examine quality of information in depth by considering first creditors' views, then advisers' views, before finally attempting to disentangle the assorted concerns and priorities that both groups raised.

Creditors' views: overall quality

TABLE 1 shows creditors' comments about what information they felt to be relevant, including but not limited to the existing DMHEF questions.

The creditors interviewed reported that generally speaking the DMHEF provided the information they needed, and that they preferred this to receiving an 'ad hoc' letter from a health or social care professional:

"There's no need to change the DMHEF, it works perfectly." [Cr4]

Some creditors commented that when completing the DMHEF, GPs (and sometimes psychiatrists) often provided irrelevant, technical, or generically clinical information. It was thought this was *because such health care professionals didn't know the patient well enough to provide the information the DMHEF required*, and therefore 'compensated' by providing other forms of information.

However, two creditors commented that the DMHEF did provide better and more relevant information than 'ad hoc' letters from doctors, which often had unclear or unnecessary information. Another two creditors felt the questions in the DMHEF could be made more specific to dealing with debts. Finally, one creditor said that the text boxes in the DMHEF were often left blank.

Creditors' views: effects of treatment

There was confusion among creditors about Question 4 (on the effects of treatment). Some creditors felt this question duplicated Question 2 and they could not distinguish between them. Of more concern was that two creditors reported if there was a 'no' to Question 4, they would conclude that the customer did not need support from the creditors – which is a misinterpretation. One creditor thought Question 4 meant that if the treatment did have an impact on a customer's mental health, then that impact could only be a positive one and hence a 'yes' to this question might be a reason not to give concessions to that individual. One creditor thought it was important to know what treatment the customer was getting (rather than the impact of this on their ability to manage money). The distinction between the effects of a mental health problem and the effects of treatment is salient to the individual, and to tackling stigma around mental health, but this distinction may be irrelevant at best, and confusing at worst.

RECOMMENDED AMENDMENT TO THE DMHEF: Remove Question 4.

Creditors' views: prognosis

All creditors wanted a likely prognosis for customers with mental health problems, and to know how long the mental health problem would last. More specifically, it appeared that creditors wished to know the likelihood of an improvement in the customer's condition over the course of up to two years. This concern is echoed in industry guidelines and regulation. For example, the MALG Guidelines state the likely duration of mental health problems as a key consideration when creditors are deciding to write off debts (as the guidelines note, creditors should consider writing off unsecured debts when mental health problems are long-term, hold out little likelihood of improvement, and are such that it is highly unlikely that the person in debt would be able to repay their outstanding debts; MALG, 2009b, Guideline 10).

TABLE 1

What do creditors want to know?

Existing DMHEF questions (full list in Box 1)	Creditor comments
Q1 Existence of mental health problem	Essential
Q2 Impact of mental health on ability to manage money	Highly relevant "The key piece of information"
Q3 Dates of onset, first treatment and recent episode	Relevant
Q4 Effects of treatment	Creditors were confused about the purpose of this question.
Q5 Other impacts on everyday life	"Generic" "What we really want to know is whether they can work"
Q6 Difficulties communicating	"A bit irrelevant because it's not specific enough" "It's useful to know if they have communication problems or are withdrawn"
Q7 Sharing information	Important
Items suggested by creditors	**Creditor comments**
Impact of mental health on ability to manage their *debts* and deal with creditors	Highly relevant
Likelihood of recovery from mental health problem	Extremely relevant. All creditors mentioned this. See comments under '**PROGNOSIS**', overleaf.
Ability to work	Highly relevant
Likelihood of ability to return to work	Highly relevant
What (if anything) the customer can afford to pay	Essential, but beyond the scope of medical evidence.
Treatment, hospitalisation and breakdowns	Details of treatment, rather than impact of this on money management, were felt to be useful.
Health/social care professionals' suggestions for creditor action	Primarily, would they recommend: (a) a temporary hold, or (b) a write-off? Also suggested could be smaller items like (c) how to contact the customer (phone, writing, home visit, in branch) (d) what help is needed to set up payments (setting up standing orders, going to a branch)
Items considered irrelevant	**Creditor comments**
"Emotive statements"	For example, from relatives or carers, about banks bullying or pressurising customers; or people describing their personal or emotional tie to the customer
Items whose relevance was disputed	**Creditor comments**
Impact of debts on customer's mental health	One creditor said they would assume debts had a negative impact on mental health for all debtors, and so did not need to be told this. Another creditor wanted to know what impact continued debt collection might have on the customer's mental health, so as to avoid causing harm.

Creditors' rationale for wanting a prognosis varied. In most cases creditors wished to know the prognosis in order to identify how long it might be appropriate to cease collections for – until a customer was well enough to be contacted again, or well enough to work so as to increase their income. That is, many creditors were willing to suspend collections activity for up to six months if they felt there was some prospect of the customer being in a better position to pay thereafter.

Two creditors also reported an additional dimension in which prognosis was relevant: the collections and recoveries industry works on the assumption that older debts are more expensive to 'service' (i.e. to pursue). So it can come down to a simple cost-benefit question for a creditor about how long it is worth hanging on to a particular debt before its value decreases too much. The problem, according to one creditor, is that this principle – that older debts are less likely to generate a return (in other words, that patience is costly) – is "a bit one-size-fits-all" and doesn't necessarily apply to all people with mental health problems, whose health may fluctuate over time.

The relevance of prognosis, as with any other information about mental health, was dependent on the customer's financial situation, as one creditor illustrated:

> *"If a customer has a mental health problem but he has assets (like owning a house), then the bank would wait as long as we like to get the money back. But if the customer is on benefits, and lives in social housing, we'd wait a maximum of two years, but we'd analyse the book every so often." [Cr6]*

Creditors were prepared to wait for a matter of years for customers who were almost certain to be able to pay once their mental health improved (for example, because they had equity on a house). In contrast, the prospects of payment from a customer who had no assets and had a low income were much less certain, even if they did recover from their mental health problem. The second type of customer would, accordingly, be more likely to get their debt passed over to a debt collection agency or written off.

Creditors' views: confirmatory information

In perhaps a majority of cases where creditors request medical evidence, they are looking simply for *confirmation* that the customer indeed has the mental health problem they claim to have.

In only limited circumstances do creditors appear to require full details of the impact of the mental health problem on the customer's ability to deal with money and debt. As two creditors explained:

RECOMMENDED AMENDMENT TO THE DMHEF:

Despite creditors' understandable interest in prognosis, we do not believe it is practical to include a question in the DMHEF asking for this.

There are four reasons for this:

- making a useful and accurate prognosis can be very difficult – consequently, health and social care professionals may be reluctant to make a statement about the likely progression of a person's mental health problem. This may particularly be the case if they do not know the patient (or their wider medical or social circumstances) well.
- individuals often experience mental health problems in different ways – for example, even though clinical guidelines might indicate that depression usually lasts up to a certain number of months, with the chance of repeated episodes afterwards, there will be large numbers of people who do not have this experience.
- the inter-relationship between mental and physical health can complicate reaching an accurate prognosis – this adds an additional factor to the consideration. It also could involve an examination of the patient (which would require time, resources, and possibly payment).
- there will be other social and economic factors (often unknown to the health or social care professional) that will impact on a person's recovery from a mental health condition, and which are difficult to incorporate into a prognosis.

Overall, making an accurate and useful prognosis can be very challenging for health and social care professionals. Furthermore, there is the probability that such a prognosis could be inaccurate, which would not help the creditor recover the debt, or the customer get on top of their financial and mental health situation.

> *"We ask for either the DMHEF or a letter from your doctor. We're happy to accept either. We'd even mention copies of prescriptions, if that gives us an indication, with the date on it. To be honest, the DMHEF is useful, but it's easier from a customer perspective to just obtain a letter from their doctor to say 'Look, this is their condition. It is affecting their health.'" [Cr5]*

> *"The main value of the DMHEF is as back-up." [Cr1]*

Three advisers echoed this, with one saying that simply sending in confirmation of the client's diagnosis and date of onset was sufficient to get a response from creditors:

> ***"It's useful to submit written evidence from a psychiatrist or doctor if we're asking the creditor to put a hold on activity for say 6 months while they're in hospital. Nothing specific is required, just confirmation." [Ad3]***

Given this, there was a sense among several advisers that some creditors used the DMHEF to make them "jump through hoops". We explore the issue of over-reliance on the DMHEF in SECTION B2. 'WHEN IS EVIDENCE GATHERED?'

In a related way, several creditors suggested that the advantage of a full DMHEF compared to a "sick note" or care plan was its credibility rather than the content of the information it contained. Creditors sometimes appeared to have difficulty in drawing on the specific information in the DMHEF when making decisions, whereas the financial statement was generally the pivotal information in creditor decision-making:

> ***"I do read through the information on the DMHEF, rather than just thinking 'oh we've got it, that's that'. It gives me a better idea of their ability to pay back their debt. It's not so much what's in the Debt and Mental Health Evidence Form it's mainly, say, you know, for instance here [shows letter] they might have been asking for a write-off and they've provided this DMHEF form back but on the financial statement it says they can afford one pound." [Cr3]***

We make recommendations about when to request evidence at the end of SECTION B.

Advisers' views: quality of information

While creditors were generally satisfied with the quality of information provided by the DMHEF, money advisers had a number of distinct concerns.

In particular, some advisers felt that the protection of vulnerable customers and the prevention of harm to customers' mental health should be the priority.

> ***"It's not so much their ability to manage money as the stress of the debt that's the problem." [Ad3]***

Other advisers felt the DMHEF should sharpen its focus such that it asks about (a) dealing with being in debt rather than managing money and (b) communicating with creditors rather than communication skills per se.

Two advisers criticised Question 2 ("ability to manage money") saying:

> ***"It doesn't ask about the aftermath of spending money. It only talks about what he does when he's on a high." [Ad4]***

In relation to Question 6 ("difficulties with communication") one adviser said:

> ***"I don't think GPs understand what you're trying to get at. They think 'Can he speak? Do words come out?' because the DMHEF doesn't say 'Do they have any problems communicating about money issues, or with debt collection agencies?'" [Ad4]***

In relation to Question 5, about "other relevant impacts", one adviser commented that it may be very difficult for a GP to know what might count as relevant. They therefore felt that this is either a redundant question, or could be broken down into specifics such as setting up payments, leaving the house, and so on.

Advisers suggested a number of possible alternative questions, focusing on four areas:

- dealing with debts - how does the individual cope with being in debt? Would the individual be able to maintain regular payments under a debt management plan? Can the individual put together a statement of income and expenditure on their own?
- communicating with creditors - can the individual talk to creditors on the phone? Can the individual negotiate with creditors on their own? Are they able to open and respond to letters from debt collection agencies?
- impact of debt on mental health - is the individual's mental health worsening because they are worried about their creditors? Could the debt lead to a relapse in their mental health?
- quasi-prognosis - as things stand with the debt, can you see an improvement in the patient's condition within the next two years? Are they likely to be able to return to work in the foreseeable future?

However, other advisers disputed the relevance of any information beyond confirming the individual's diagnosis, the date of onset, and that the individual was unable to work.

While advisers felt that the information in the DMHEF was often vague or generic, they

acknowledged this to be a general problem of gathering information from health and social care professionals.

While we note earlier comments about both the likelihood that health and social care professionals could provide such detailed information about a patient they may not know that well, and also the wider difficulties of providing a prognosis, we explore this issue in more detail in SECTION C 'ACCEPTABILITY: HEALTH AND SOCIAL CARE PROFESSIONALS'.

Finally, most advisers preferred to write a personalised letter to the health or social care professional, rather than (or as well as) using the DMHEF. In particular, advisers felt the separate consent form for the DMHEF made the process more cumbersome. Lots of advisers simply didn't complete it, or consent for medical evidence was covered by the agency's standard consent form. One creditor reported that the consent form was never completed or returned by customers.

Other concerns about the DMHEF

Participants had different views on what information should be considered relevant when gathering medical evidence, related to divergent priorities about when and why to be lenient or sensitive to customers. These fell into three broad, but overlapping groups: customer responsibility, cost-effectiveness, and customer safety.

Customer responsibility

Most creditors said that knowing when the mental health problem first developed, or its history, was relevant. It became clear that creditors sometimes made a decision about a customer's liability or responsibility for their debts based on whether their mental health problem pre-dated (1) taking out credit and/or (2) entering into debt.

First, some creditors suggested that mental health is most relevant to questions of the enforceability of contracts (due to the customer's capacity to enter into a credit agreement). For example, one creditor would consider write-offs if the customer was "of unsound mind" at the time of taking out credit or if their condition was now "uncontrollable". Second, other creditors said that if the mental health problems pre-dated and were a cause of entry into debt, then the customer was less culpable for their debt. (This position is echoed by Dominy & Kempson (2003), who argue that customers should not be held responsible for debt problems brought on by an inability to manage money associated with mental illness, because the onset of debt would have been beyond the customer's control.)

As a consequence of this preoccupation with customer responsibility and the onset of mental health problems, there was sometimes less sympathy for debtors whose mental health problems had arisen since being in debt.

Cost-effectiveness

Aside from questions about the customer's responsibilities and obligations being voided by a mental health problem, many creditors stated that their main concern was the cost-effectiveness of collections and recovery activity. In other words, was it worth the time and resources to pursue a debt from a given individual:

One adviser said:

> ***"You have to show that it's in the interests of the creditor to write the debt off, because the cost they're going to incur by chasing the chasing debt is not worthwhile." [Ad4]***

While also adding:

> ***"Creditors will always be less concerned about exercising compassion and more concerned about categorising the client as 'Yes, we can get our money back because she's got equity in her property.'" [Ad4]***

While cost-effectiveness is a universal concern, different creditors have different models of what constitutes cost-effective collections. Many creditors have adopted the position that the most cost-effective collections result from being flexible and responsive to each customer's circumstances, and from emphasising the long-term sustainability of payment arrangements and customer relations. The business case for best practice is discussed in MacDermott (2010) and Fitch & Davey (2010).

Customer safety

To a degree, all creditors and advisers felt it was important to protect the safety of customers. However, some advisers argued it should be the primary concern, given that any further debt collection could cause distress and potentially put that individual at risk of relapse, hospitalisation or harm. They therefore felt a simple statement of the client's diagnosis and inability to work should be enough to obtain sensitive or concessionary treatment from creditors:

"If the creditor knows the client is poorly, they should be sympathetic regardless of what is making them poorly ... particularly because most mental health problems have an element of anxiety or paranoia.. It's not so much their ability to manage money as the stress of the debt that's the problem.... We have seen cases where people have made suicide attempts simply because of their debts – the letters, the phone calls." [Ad3]

While cost-effectiveness was naturally a concern for creditors, it was clear that customer safety was of importance to all creditors. All creditors expressed their concerns about the risk of customers taking their own lives because of the stress of their debts. Many expressed a desire to become better able to safeguard those customers at risk of suicide. Several creditors acknowledged that customer safety extends beyond the prevention of suicide:

"We do want to act in the interests of the customer, and also of collecting debts where appropriate. We don't want to make the customer's situation any worse." [Cr6]

"It can be difficult deciding whether to send a chaser letter when customers don't return the DMHEF. You have to make a judgement call: will it harm the customer to send this out?" [Cr1]

Creditors varied in how they managed their concerns about customer safety. For example, one creditor commented that knowing a customer's mental health was being affected by their debts would lead to the customer being removed from the collections dialler (i.e. where they might receive multiple calls per day), but it would not influence the eventual decision made about the customer's account: that is, it would influence the process but not the outcome of collections. Another creditor (a debt collection agency) took steps to inform their client (the lender) of a customer's mental health problem, even if that customer was unable to submit medical evidence, to prevent that customer being returned to mainstream collections or passed on to another debt collection agency.

Overall, it seemed that many creditors were unsure how to balance their concern for customer safety with the need for cost-effectiveness, and did not always find it straightforward to do so.

Discussion

Confusion or inconsistency among creditors about how the DMHEF is intended to be used may lead to inconsistent treatment, or even the DMHEF being used inadvertently to withhold sensitive or concessionary treatment from customers who need it (or conversely to grant it to those who do not). Further, while many creditors are committed to protecting the safety and well-being of customers and are aware of the business benefits of this, other creditors have not adopted this stance. It seems that clearer guidance about how to use it, and when and why to grant concessions would be of use to them.

How well does DMHEF address these concerns?

Advisers raised concerns that the current wording of the DMHEF question 'raises the bar too high' and risks excluding some vulnerable individuals from sensitive or concessionary treatment.

Advisers said that the DMHEF's questions on money management and communication skills seemed to be geared towards customers whose mental health problems were severe, or had developed before they took out credit. They were concerned that Question 2 instructs professionals not to fill in most of the form if the customer's mental health problem does not affect their ability to manage money. One adviser felt that the current wording of Question 2 almost gives creditors an excuse to carry on pursuing debts for people who can manage their money when they are relatively well, but who may be extremely distressed by their debts during an episode:

"The DMHEF questions seem to fit better with people who are hospitalised, whereas out in the community, someone who's signed off work with depression or anxiety has no problem managing their money, they just haven't got any. And the fact that they haven't got any is impacting on their health." [Ad3]

Two advisers raised concerns that the DMHEF in its current form perpetuated the misunderstanding that mental health was relevant to creditors primarily in terms of the enforceability of contracts. One adviser remarked that Question 2 (about ability to manage money) and Question 3 (about first onset) seem geared towards questions of enforceability, rather than whether that person could currently repay their debts. They felt it seemed plausible that the information about onset and money management could be used by creditors as a justification not to be lenient to customers.

RECOMMENDED AMENDMENT TO THE DMHEF:

- Amend Questions 1 and 2 – incorporate the name of the mental health problem/main diagnosis from Q2 into Q1.
- Review whether the current DMHEF strikes the right balance between (i) simply confirming that a customer has a mental health problem that affects their ability to manage their money and (ii) the need for creditors to receive more detailed information about that mental health problem.
- In light of the above point, review whether Question 5 ("...any other relevant impacts/ effects that the person may experience in their everyday life due to their mental health problem") can be removed from the DMHEF.
- Streamline and simplify the process through which advisers/creditors obtain consent from customers to use the DMHEF to collect medical evidence.

ORGANISATIONAL RECOMMENDATIONS

- Individual creditor and collection organisations have reported for some time that they would benefit from their staff having the basic skills and strategies to work more effectively with indebted customers who report a mental health problem. In response to this, the Royal College and Money Advice Trust are now offering e-learning and face-to-face training on mental health for collection and recoveries staff (www.rcpsych.ac.uk/recovery).
- Regardless of whether the DMHEF or another means is used to collect medical evidence (e.g. a letter), advisers and creditors should review whether the information they are requesting from health and social care professionals will be practically useful and relevant to making a decision about a customer's account.
- Creditor and advice agencies who are concerned about contract enforceability (where a customer is reported to have had limited mental capacity at the time they entered into an agreement), should consult recent Office of Fair Trading guidance for relevant advice.

B. Getting it back: return rates

Three factors seemed to impinge upon what proportion of requests for evidence resulted in customers submitting evidence and how long this tended to take:

- how evidence is requested, in terms of the process and manner used;
- when evidence is requested;
- and whether it is relied upon too much.

Another factor was, of course, the acceptability of the DMHEF to health and social care professionals. This is considered in greater detail in SECTION C 'ACCEPTABILITY: HEALTH AND SOCIAL CARE PROFESSIONALS'.

General response rate and timeliness

Creditors generally had a low 'return rate' on DMHEFs sent out to customers, and reported that the evidence-gathering process could become very protracted. In the quantitative audit conducted at our creditor field-site:

- the return or response rate for evidence submitted upon request within the maximum time allowed by that creditor (74 days) was 41%.
- the average time for completion of DMHEFs was 39 days (median), from initial request to date received.
- however, the longest time taken was 166 days – almost six months.

Other creditors reported that their average time from the initial date requested to date received was 6 to 8 weeks. However, they emphasised that it could take much longer if, for example, customers did not understand why the information was needed; or if a financial statement of income and expenditure was still needed after medical evidence had been submitted. (In our creditor fieldsite, this was the case with nearly a quarter (13 out of 58) of the DMHEFs that were sent in.) However, most creditors were willing to hold accounts pending the submission of evidence for up to 3 months.

B1. Process and manner of request

In TABLE 2 (opposite) we compare the approaches of three creditor organisations who provided information on their response rate for medical evidence. As it shows, creditors had varying approaches to the following:

- how medical evidence was initially requested, and who by;

TABLE 2

Comparing response rates with how creditors gather evidence

	Creditor A	Creditor B	Creditor C
Estimated response rate	95-100%	40%	20%
When is evidence requested?	Only when needed: • write-offs • very low settlements • very occasionally, when doubts exist about what customer says they have. Not for: Token payments Repayment arrangement Stopping phone calls	Most of the time: • where it seems unlikely that a customer can propose a payment arrangement in short-term (3 months). • some token payments. Not for: 1-3 month hold Repayment arrangement	All of the time: • every customer who discloses a mental health problem to frontline staff.
Who requests it?	Specialist collections mental health worker.	Specialist team (3rd Party Debt Management and Mental Health)	Frontline collections.
How do they request it?	DMHEF is sent after 1 or 2 conversations with the same specialist worker, if worker feels that customer can "handle it all". Otherwise, no evidence is requested at that stage.	On initial call with customer, specialist staff decides whether evidence is needed. If so, they will tell customer about the form and why it is needed.	Issued automatically by admin team after frontline keys in 'mental health' code. "This is an automatic process, with no further probing from the collector."
Do creditors explain what the DMHEF is to customers?	Yes, over the phone. 'Chaser' phone call checks-in with customer after 1 or 2 weeks to see if they've understood the process and identified a suitable health/social care professional.	Yes, over the phone. "When people don't respond, we have said to them, it's to help them get out of debt."	No explanation given to customer while on phone of reasons for or benefits of completing evidence. Cover letter on DMHEF advises customer to seek help from relative, money adviser and/or mental health professional.
Confidence in staff dealing with mental health	Very good.	Reported some discomfort about asking for evidence. Confidence had improved with familiarity.	The above process means that discussion of the customer's mental health problem is side stepped.
When is it followed up?	Call after 2 weeks to check progress and see if there are any difficulties. Thereafter call every few weeks.	Yes. After 1 month, DMHEF is re-sent with explanatory letter. After 2 months, DMHEF pack is sent again. Finally, after 2½ months DMHEF pack is sent for a fourth time.	Uncertain – seems to be down to frontline discretion or awareness.
Alternatives to DMHEF	Offer to contact doctor directly. Can accept a range of evidence (care plans etc).	Not stated.	None; returned to Collections.
Maximum time for completion	None – flexible.	2½ months.	45 days before it has to be returned to Collections.

Note: The table is based on interview data with staff at each of three separate creditor organisations – two creditor organisations and one debt collection agency. Response rates were estimated as follows: for Creditor A an estimate was calculated by referring to a log of all evidence requested and received back over the previous 12 months; Creditor B was the field-site in which our quantitative audit was undertaken, and an estimate was calculated based on this; for Creditor C, the specialist team manager made an estimate based on his supervision of his company's use of the DMHEF. Each of the three organisations dealt with different types of debt. The table is intended primarily for an approximate comparison of how response rates of the DMHEF may be related to different aspects of how creditors go about gathering evidence.

- how much time was allowed for the customer to respond, and whether 'chasers' were sent;
- how much the creditor explained and reassured the customer about the reasons for gathering medical evidence.

As can be seen in **TABLE 2**, where explanation was given to customers about the reasons for, and benefits of, completing a DMHEF, this seemed to make it more likely that evidence would be returned. However, two creditors reported that their staff felt uncomfortable or lacked confidence when discussing mental health with customers and asking for evidence. In these cases, less of an explanation was given as to the benefits (to the customer) of sending in evidence; in both cases there was a low response rate; and in one case it seemed that the DMHEF process could have been used to side-step the issue of mental health and avoid the anticipated awkwardness of discussing it altogether.

> *"I'd suggest we looked at improving our initial interaction with the customer, because this is what sets the tone. There's no explanation at this stage of 'I'll send this form out so we can figure out the best solution.'" [Cr6]*

Conversely, one creditor emphasised the fact that customers could become overwhelmed by forms being sent to them and that the likelihood of getting medical evidence therefore hinged on building a good bond with that customer and being flexible:

> *"On the first call, I don't discuss payment, I just introduce myself, give them National Debtline number and my direct line. I build up a relationship with people so they're not overwhelmed..*
>
> *I really think it's just about making that bond with them, and then once they've heard your voice a few times they do open up a bit more." [Cr3]*

In the main, participants reported that the vast majority of customers were happy for evidence about their mental health to be sent to their creditors, so long as they understood the reasons for this. Three creditors reported that, where they had spoken directly to a social worker or mental health nurse, who had been sitting with the customer at the time, these professionals were able to submit evidence much quicker – within a week or two – as they could print out the DMHEF and complete it immediately.

As can be seen on **TABLE 2**, sending out DMHEFs routinely appears to be counterproductive: it leads to a low response rate and the creditor not getting even basic information about how the customer's mental health problem impacts on their ability to repay their debts. This can make many customers into 'unknown quantities' for creditors.

ORGANISATIONAL RECOMMENDATIONS

- Collections and money advice staff should be clear on their organisation's policy on when and how medical evidence is collected.
- Collections and money advice staff should give a reassuring and clear explanation to customers about the reasons medical evidence is needed.
- Collections and money advice staff should have the necessary skills to be able to discuss basic information with customers about their reported mental health problem.
- Where a specialist team is present, frontline staff should be instructed to refer customers to this team once a mental health problem is disclosed, and specialist staff should be responsible for requesting evidence. As well as providing vulnerable customers with the support they need to engage with their creditors, this will also mean customers receive a fuller explanation of the reasons medical evidence is being sought which in turn could boost response rates.

B2. When is evidence gathered?

Our data on how frequently and how routinely creditors request medical evidence suggest that there may be an optimum degree of reliance on medical evidence that generates the best response rate.

One creditor said:

> *"To begin with, I used to ask for DMHEF with everyone who said they had a mental health problem, but I think sometimes it's too much for them to be dealing with, along with the financial statement. So we basically only request the Debt and Mental Health Evidence Form if it's really needed." [Cr3]*

It is very encouraging that more and more creditors are recognising the relevance of mental health and, in particular, medical evidence to their work. However, we found that many

creditors risked over-relying on medical evidence – requesting it as a matter of routine, rather than based on a need for the information. In three of the six creditors we interviewed, evidence would be requested of every customer who claimed to have a mental health problem, regardless of the customer's ability to pay or the severity of their mental health problem.

Advisers' views on over-reliance on evidence
As the above creditor reports suggest, the DMHEF is less effective when relied on too routinely. Advisers gave two other reasons why over-reliance on medical evidence may present problems for creditors, advisers and customers alike:

- a possible 'backlash' from health and social care professionals in terms of payment requests or refusals;
- preventing customers from receiving the support necessary to resolve their debt problems.

Advisers expressed concerns about increased reliance on medical evidence:

> *"What worried me was when you said that one creditor was sending the DMHEF to every customer who disclosed a mental health problem. That seemed a bit excessive to me." [Ad3]*

First, increased circulation of the DMHEF was expected to lead to a 'backlash' from health and social care professionals, meaning in effect that fewer indebted customers could receive leniency or concessions from their creditors. One adviser reported that GPs locally were starting to charge for completing medical evidence, because the advice agency had begun to request it more frequently.

Second, aside from any backlash, some advisers felt it would also mean there would be greater barriers to customers being able to access the support they need.

> *"A lot of people would have difficulty getting this form filled in by anyone. And if that's all the creditor will accept, then they're going to have difficulty getting their accounts on hold." [Ad3]*

They reported reasons why customers might understandably be unable to provide evidence of their mental health problem, such as professionals refusing or taking a long time to complete it; reduced provision of secondary mental health services; poor relationships with psychiatrists or GPs; concerns about providing health information to creditors, for example because of concerns about access to future credit.

ORGANISATIONAL RECOMMENDATIONS

- It is in creditors' interests not to rely on evidence for measures that they might take for any customer in financial difficulty, such as being flexible with repayments, allowing written contact only, accepting token payments if that is all the customer can afford, or allowing a temporary hold. Creditors should understand the reasons evidence might not be available.
- Rather than collecting medical evidence on a routine basis whenever a mental health problem is disclosed by a customer, creditors should consider only collecting medical evidence only when it is absolutely required. This is important given both the cost-implications of collecting evidence (e.g. some health and social care professionals may request a fee), and the additional time often required to collect evidence.
- Creditors may therefore consider placing a temporary hold on collections activity, interest and charges on the basis of receiving credible information from a customer. Some interviewees observed this 'hold' could range from 3-6 months.
- Creditors should not consider collecting medical evidence where it is not critical to the decision being made. Some interviewees observed this could include accepting a low monthly payment offer, referring customers to a specialist team, or allowing customers to remain with a specialist team if they have agreed a repayment plan.

C. Acceptability: health and social care professionals

Although we were not able to interview any health and social care professionals directly (see page 5), most of the creditors and advisers interviewed reported that getting such professionals to complete the DMHEF could be problematic. A range of reasons were suggested:

- the DMHEF form took too long to complete;

- the introductory guidance notes (pages 1 and 2 of the DMHEF) made the DMHEF appear more complicated than it was;
- professionals might not have the necessary information, knowledge or insight to answer some of the questions;
- such professionals are generally pressed for time and so might be put off completing the DMHEF by its length and apparent complexity (one creditor commented, "For them it's time. They have a huge amount of paperwork – requests, insurance, benefits. I know my GP has.").

One adviser reported getting not one response out of three separate requests for medical evidence from GPs. Another adviser, whose agency was based in a psychiatric hospital, said it could take up to six weeks to get even a short letter from one of the psychiatrists working on-site, because they were busy (rather than being unwilling).

Charging

All advisers and creditors reported that GPs sometimes requested a charge to complete the DMHEF. Staff working in secondary mental health services (psychiatrists, mental health nurses and social workers) were never reported to request a charge and were generally described to be very co-operative with providing evidence.

Adviser and creditor staff gave several solutions to the problem of charging. One creditor agreed to pay the fee (while all others ruled this out). One adviser "veered away from" GPs, preferring mental health nurses. Two advisers pre-empted fees by stating on their cover letter: "I am from a charity and unable to make payment." Most creditors were willing to accept existing medical documents as proof of the customer's mental health problem – ranging from prescriptions and care plans to a brief medical report from a doctor.

Translating medical knowledge into relevant information for creditors

Advisers and creditors acknowledged that it was not always an easy task for health and social care professionals – particularly clinicians such as GPs and psychiatrists – to provide relevant information based on their medical knowledge of the individual.

Several advisers mentioned the difficulty of "getting the GP on the same page as you" – not so as to influence them, but to help them to understand the potential consequences of the evidence they gave:

> *"Whichever professional you're dealing with – GP, CPN, social worker – they haven't been trained in our area of work. You've got to coach them to put it in a way that's going to be beneficial for our clients." [Ad4]*

> *"I had to use the DMHEF, and the doctor had to call me and then say 'I'm not sure what you are asking me'. So I had to explain exactly what I wanted her to do." [Ad2]*

Most advisers stated that mental health nurses and social workers – "people who are more directly involved in the client's day to day life" – provided better quality information than GPs, who may only see an individual for ten minutes every few months.

> *"What if that client doesn't have a CPN [community psychiatric nurse]? I think a lot of GPs would have trouble filling in the questions, unless they've got very in-depth knowledge of the personal life of their patient." [Ad3]*

Two creditors echoed the comments of these advisers, saying that information from GPs was often too generic, technical or clinical. It appeared that, in order to answer the DMHEF questions satisfactorily and to provide relevant information, clinicians (i.e. GPs and psychiatrists) had to translate their medical knowledge of their patients into grounded knowledge about how that individual dealt with their debts. Such a shift in mindset involved a degree of effort on the part of the clinician. It was often reported that good quality evidence was generated when individuals were able to sit with their health or social care professional while the form was being completed.

RECOMMENDATIONS:

- The DMHEF should be revised to encourage health and social care professionals to provide relevant information. This could, for example, include removing the first two sides of notes and instructions, and reducing the amount of introductory information.
- A review should be undertaken by MALG on the issue of fees being charged by GPs for providing medical evidence. Consideration should be given to the reasons why GPs decide to charge for evidence, and whether agreeing a standard fee for evidence (with the British Medical Association – see page 3) is either practical or desirable.

D. Acceptability: credibility of source

Reliability of social workers and nurses

It was of primary importance to creditors that the person filling out the DMHEF was qualified to do so. Many creditors reported being unsure whether to accept social workers' testimony, or in some cases that of mental health nurses, because of concerns they were not medically qualified. Further, most creditors preferred the testimony of GPs and psychiatrists. (Advisers, on the other hand, reported that nurses and social worked were better placed to provide the relevant information as they had a better knowledge of the individual's personal life.) Creditors were not aware when informed that social workers and nurses nowadays work in multidisciplinary teams with psychiatrists and psychologists, and are adequately qualified to provide evidence.

Self-help

All but one of the creditors interviewed were already effectively using an assisted 'self-help' version of the DMHEF (i.e. posting a DMHEF direct to customer upon the disclosure of a mental health problem, and the customer then taking responsibility for liaising with the health or social care professional). In contrast, only one creditor reported sending a DMHEF form directly to a health or social care professional – and this was done only when necessary. In terms of current discussions within MALG about developing either a creditor-initiated or a self-help version of the DMHEF – particularly some creditors' concern that customers could forge the evidence – a self-help version of the form appears to have evolved of its own accord in current creditor practice, perhaps indicating that this could be a more suitable way to gather evidence.

General credibility

The DMHEF was generally considered by creditors to be the most credible form of medical evidence, especially when it bore the official stamp of the health and social professional's organisation.

E. Money advisers: awareness and range of use

Advisers had two further reservations about the DMHEF: its narrow range of use; and low awareness among advisers.

Among our adviser interviewees, one had completed six DMHEF forms in a year (having seen around a hundred clients); one misunderstood the purpose of the DMHEF and had never used it; the vast majority wrote letters to health and social care professionals if evidence was needed, rather than using the DMHEF.

RECOMMENDATIONS:

- MALG, creditor trade bodies, and the Lending Standards Board should emphasise the credibility of social workers and mental health nurses as sources from which to gather medical evidence.
- The MALG Working Party, when considering whether to develop a creditor version of the DMHEF, should consider the creation of a single DMHEF which is shorter, easier to complete, and that both advisers and creditors can use.

E1. When do advisers use the DMHEF?

Advisers would generally only gather medical evidence in order to request a write-off or temporary hold from creditors, in cases where insolvency solutions were not appropriate.

> *"I only use the Debt and Mental Health Evidence Form as the last chance saloon." [Ad6]*

> *"Write-offs and token payments often entail a long-winded process of negotiation." [Ad5]*

From an adviser's point of view, the DMHEF would only come into play very rarely. It was reported that this is potentially because of the wide range of insolvency solutions available, ways of "getting rid" of all an individual's multiple debts with a single application, that do not rely on the creditor's approval: bankruptcy, IVAs (individual voluntary arrangements), DROs (debt relief orders) and administration orders. Most advisers reported that it was only when these measures were not available or appropriate that they would turn to negotiate with the client's creditors. In most cases where an adviser negotiates with creditors, they complete an Income & Expenditure sheet and make an offer of monthly payment (as low as £1 per month). Creditors often accept this when it comes from an advice agency. If the client can't afford this, and the debt solutions above aren't appropriate, the adviser might then ask for:

- a write-off, or
- a temporary hold on collections activity, say for 3-6 months. However, three advisers commented that creditors would often rely on an adviser's word for something like a temporary hold.

These are the two main situations where an adviser would gather medical evidence. Unlike insolvency solutions (bankruptcy, IVAs, DROs and admin orders), write-offs and temporary holds depend on creditors' goodwill, and require a separate application with regard to each debt. This makes them much more time-consuming for advisers, who often already faced targets and tight timeframes in their work. Write-offs were also felt to be less satisfactory because creditors could technically re-commence collections or sell the debt on to a debt purchaser after months or years have elapsed.

Other possible uses of the form reported by advisers:

- where the adviser seeks to dispute the enforceability of the credit agreement, for example by arguing that the customer lacked capacity at the time of borrowing;
- to seek a reasonable response from creditors, in cases where the creditor refuses to do something that they should do with any customer, regardless of the customer's health, such as accepting a low monthly payment arrangement or being lenient if a customer misses an occasional payment. Some advisers might consider medical evidence in this situation, but it was generally not thought to be worth the effort.
- requesting a very low settlement.

E2. Adviser awareness

It was reported that advisers have low awareness of the DMHEF – even some of those in this sample, who self-selected because of some interest in mental health, were unfamiliar with the form or had never used it.

There was reportedly low use of the DMHEF. Advisers reported that it could take a lot of time and effort to get to grips with it. However, when asked about the Adviser Flowchart that accompanies the DMHEF, two advisers felt it was unnecessary and that the DMHEF process follows common sense.

Two advisers reported that most generalist advisers or debt advisers probably do not consider mental health to be particularly relevant to their job, or would feel uncomfortable about discussing it. Three advisers suggested that promoting (a) mental health and (b) medical evidence in particular among advisers would be beneficial. Possible channels for publicising the form included Adviser magazine, Quarterly Account (IMA newsletter), Arian, and other Citizens Advice bulletins. Another four advisers suggested giving guidance to advisers on what questions to ask doctors in their letters, rather than publicising or amending the DMHEF.

"There's no real problem with advisers filling in the form itself. It's more about getting the word out there among advisers." [Ad2]

F. Outcomes: what do creditors do?

Those creditors who were interviewed varied enormously in terms of how receptive they were to mental health and to medical evidence. Some responded positively, sympathetically and flexibly when mental health was raised or when medical evidence was submitted, whereas some did not respond at all.

RECOMMENDATIONS:

- Organisations including the Money Advice Trust, Advice UK, and Citizens Advice should raise awareness among advisers about the importance of collecting the right and relevant medical evidence, and the potential use of tools such as the DMHEF.

Creditor reports

In the quantitative audit undertaken in the single creditor fieldsite, we gathered data on the action or outcome that followed submission of medical evidence, out of a total of 58 submissions.

As can be seen in **TABLE 3**, about two-fifths of DMHEF forms submitted in the creditor fieldsite led to the debt being written off. About a third

TABLE 3

Outcome / action	n	%
Write-off	**25**	43
Write-off declined (because customer had equity on property)	1	-
Repayment arrangement agreed	**11**	19
Of which token payments	7	-
Temporary hold in collections	**18**	31
Income & Expenditure requested	13	-
DMHEF sent back because no signature/stamp	2	-
Breathing space / moratorium granted	3	-
Miscellaneous	**4**	7
DMHEF was sent out (erroneously) after receipt of doctor's letter	3	-
Charges refunded as per request	1	-
Total	**58**	100

of DMHEF forms submitted led to a temporary hold in collections, and a fifth led to a repayment arrangement being agreed.

In our interviews, one creditor stated that they would very rarely write-off a debt as such, but they may sometimes inform the customer that no further action would be taken. Another creditor reported that many customers with mental health problems were able to agree and keep to realistic payment arrangements once they had been placed with the specialist team – i.e. that simply this shift in approach and tone had enabled effective collections, and that medical evidence was often not required. Another creditor specialist team reported that far more customers offered to make payments than was expected (and fewer requested write-offs than expected). This suggests that a key benefit for creditors of specialist teams is to allow vulnerable customers to set up payment arrangements, where they may have struggled to do so if dealing with mainstream collections, rather than their primary function being write-offs.

Adviser reports

Advisers reported a very mixed response from creditors, ranging from creditors failing to respond to – or repeatedly claiming not to have received – medical evidence that had been submitted, to creditors agreeing to write-off debts based on DMHEF forms received. It seems that some creditors respond positively and sympathetically, while others (not any of the creditors we interviewed) are unsympathetic or do not know how to respond to medical evidence about a customer's mental health problem. In one case, the adviser's submission of medical evidence appeared to precipitate that customer's account being passed over to a debt collection agency. In the positive cases, advisers reported that getting a write-off or agreement on a token payment arrangement was "always a battle" for them, entailing much back-and-forth with creditors. Advisers said that creditors would often suspend activity but not definitively write-off the debt, leaving customers unsure of their status. One adviser questioned whether creditors read the DMHEF forms in full or knew what to do with them.

While some advisers reported a generally poor response from creditors, many advisers reported that creditors were generally sympathetic to mental health and that creditor practice was improving over time. There were numerous anecdotes of creditors writing off debts, granting temporary holds, or accepting token payments.

5 Conclusion

In conclusion, three 'groups' or sets of recommendations can be made:

- changes to the DMHEF
- changes to organisational practice
- actions for other parties

A. Recommended changes to the DMHEF

The following amendments are suggested.

- Amend Question 2 (ability to deal with money) – incorporate the diagnosis name into Question 1;
- Remove Question 4 (receiving treatment or support) – incorporate this into Question 2.
- Review whether the current DMHEF strikes the right balance between (i) simply confirming that a customer has a mental health problem that affects their ability to manage their money and (ii) the need for creditors to receive more detailed information about that mental health problem.
- In light of the above point, review whether Question 5 ("...any other relevant impacts/effects that the person may experience in their everyday life due to their mental health problem") can be removed from the DMHEF.
- Streamline and simplify the process through which advisers/creditors obtain consent from customers to use the DMHEF to collect medical evidence.

Prognosis

Earlier in this report, we considered some of the difficulties that many health and social care professionals have with providing a prognosis about how an individual's mental health condition is likely to develop in the future.

While we feel that it is not consequently practical to include a question on prognosis within the DMHEF, we do recognise the importance of explaining the reasons to creditors why such information cannot usually be collected.

We will therefore incorporate a short note into the DMHEF explaining why such a line of questioning has not been included.

Acceptability

The DMHEF should also be amended to improve its acceptability to health and social care professionals and help them provide relevant information. This could include removing the first two sides of notes and instructions (leaving simply space for the advice agency's and the health professional's details), reducing the amount of introductory information, or making these detachable so the health or social care professional does not need to see them. Instead, the form should launch into the main questions sooner.

The adviser version of the DMHEF can be amended to account for the fact that all advisers reported that they attach a cover letter when sending the DMHEF to health and social care professionals.

Consent

Consideration should also be given to the way in which customer consent is obtained with the DMHEF. This is because few or none of the advisers interviewed completed it, and no creditor reported receiving a completed consent form.

Fees

A review should be undertaken by MALG on the issue of fees being charged by GPs for providing medical evidence. Consideration should be given to the reasons why GPs decide to charge for evidence, and whether agreeing a standard fee for evidence (with the British Medical Association – see page 3) is either practical or desirable.

B. Recommended changes to practice

Initial decision to collect evidence

Collections and money advice staff should be clear on their organisation's policy on when and how medical evidence is collected.

It is in creditors' interests not to rely on evidence for measures that they might take for any customer in financial difficulty, such as being flexible with repayments, allowing written contact only, accepting token payments if that is all the customer can afford, or allowing a temporary hold. Creditors should understand the reasons evidence might not be available.

Regardless of whether the DMHEF or another means is used to collect medical evidence (e.g. a letter), advisers and creditors should review whether the information they are requesting from health and social care professionals will be practically useful and relevant to making a decision about a customer's account.

Creditors may therefore consider placing a temporary hold on collections activity, interest and charges on the basis of receiving credible information from a customer. Some interviewees observed this 'hold' could range from 3-6 months.

Creditors should not consider collecting medical evidence where it is not critical to the decision being made. Some interviewees observed this could include accepting a low monthly payment offer, referring customers to a specialist team, or allowing customers to remain with a specialist team if they have agreed a repayment plan.

Routinely requesting evidence

Rather than collecting medical evidence on a routine basis whenever a mental health problem is disclosed by a customer, creditors should consider collecting medical evidence only when it is absolutely required. This is important given both the cost-implications of collecting evidence (e.g. some health and social care professionals may request a fee), and the additional time often required to collect evidence.

Training

Individual creditor and collection organisations have reported for some time that they would benefit from their staff having the basic skills and strategies to work more effectively with indebted customers who report a mental health problem. In response to this, the Royal College and Money Advice Trust are now offering e-learning and face-to-face training on mental health for collection and recoveries staff (www.rcpsych.ac.uk/recovery).

Specialist teams

Where a specialist team is present, frontline staff should be instructed to refer customers to this team once a mental health problem is disclosed, and specialist staff should be responsible for requesting evidence.

As well as providing vulnerable customers with the support they need to engage with their creditors, this will also mean customers receive a fuller explanation of the reasons medical evidence is being sought which will in turn could boost response rates.

Mental capacity

Creditor and advice agencies who are concerned about contract enforceability (where a customer is reported to have had limited mental capacity at the time they entered into an agreement), should consult recent Office of Fair Trading guidance for relevant advice.

C. Recommended actions for other parties

MALG, creditor trade bodies, and the Lending Standards Board should emphasise the credibility of social workers and mental health nurses as sources from which to gather medical evidence.

There is currently a MALG Working Party which is reviewing the content and use of the DMHEF, with an updated DMHEF potentially due in 2012. This should consider all the recommendations in this report, as well as whether a single version of the DMHEF is created which is shorter, easier to complete, and which advisers and creditors can both use.

MALG and creditor trade bodies should continue to promote medical evidence among the creditor sector. This should emphasise getting the balance right between being responsive to evidence and relying on it to put customers off from requesting leniency. It should form part of a broader promotion of mental health among the creditor sector.

Citizens Advice and the Money Advice Trust should continue to promote medical evidence among the advice sector, given low levels of awareness. This could include a one page, user-friendly guide on when and how to get medical evidence, making it as simple as possible for advisers to get to grips with medical evidence. The DMHEF should be promoted via Adviser, Arian, Quarterly Account, the MAT website and perhaps advice sector conferences. This could form part of a broader promotion of good practice with clients with mental health problems among the advice sector.

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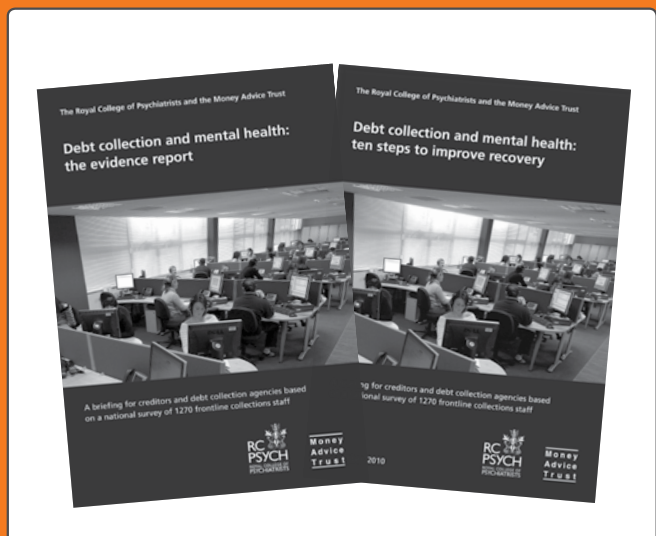
Read more...

Other reports in this series can be downloaded at **www.rcpsych.ac.uk/recovery**



Appendix 1: interview participants

Each quote in this report is accompanied by one of the following participant code, where 'Ad' indicates an adviser and 'Cr' a creditor. The codes refer to specific interviews rather than individual interviewees, and so are used to indicate one or several individual participants in some instances.

[Ad1] A money adviser who worked specifically on a Mental Health Outreach Project.

[Ad2] Four money advisers, one working on a Mental Health Outreach Project, another dedicated to people with learning difficulties.

[Ad3] Three money advisers working exclusively with mental health patients.

[Ad4] Four money advisers: two generalist debt advisers, two Mental Health Outreach workers.

[Ad5] One telephone-based adviser dealing exclusively with people with mental health problems.

[Ad6] One adviser who visited "harder to reach" clients in their own homes.

[Cr1] Two members of a large creditor's specialist team.

[Cr2] One mainstream debt collection employee.

[Cr3] A Mental Health Specialist employee based at a debt collection agency.

[Cr4] Four debt collection agency employees: three specialist workers, one manager.

[Cr5] One specialist team member based at a debt collection agency.

[Cr6] One manager of a creditor's specialist team.

Appendix 2: Debt and Mental Health Evidence Form

For completion by the health or social care professional.

Debt and Mental Health Evidence Form (advice version 2)

Agency ref:

Date:

Contact details: health or social care professional

To:

Fax:

Email:

A We are an advice agency. Our details are:

Agency name:

Adviser's name:

Fax:

Email:

B We are working for the person below. They have asked for your help.

Person's name

Date of birth

(see consent form for full personal details)

Why do they need help?

First, they are in debt to one or more creditors. Second, they have told us that they have a mental health problem that affects their ability to manage or repay this debt.

Why your help?

The person has identified you as a health or social care professional who knows them, and can comment on their mental health.

What information is needed?

The person has given their written consent (see enclosed form) to ask you eight short questions.

How will this information help?

As an advice agency, we will use this information to help negotiate with creditors on the person's behalf.

C How to help

First

Please complete the Debt and Mental Health Evidence Form

☑ Tick the boxes

Tell us your reasons

Second

Please tell us if any information should NOT be shown to the named person.

Third

If the person CAN see the information, please photocopy the form.

Fourth

Please sign and return the photocopy in the envelope marked 'client'.

Fifth

Please sign and return the original in the envelope marked 'adviser'.

More about this form

- **The person named on this form has told us:**
  - they owe money to one or more creditor organisations
  - they have a mental health problem
  - this mental health problem is affecting their ability to deal with their debts.
- **The named person has given their written consent for us to collect appropriate information about their mental health problem:**
  - from a nominated health or social care professional who knows them
  - to use and share this information with the organisations they owe money to
  - in order to negotiate with these organisations, and reach an acceptable solution.
- **The Debt and Mental Health Evidence Form:**
  - contains eight brief questions
  - these questions provide basic information which will allow us as an advice agency to corroborate and understand the named person's reported situation
  - in accordance with Data Protection Act, the information will be kept for as long as it is believed to be up-to-date, accurate, and relevant. It will be stored securely.

Statement by the Information Commissioner's Office

The Information Commissioner's Office (ICO) is responsible for regulating and enforcing access to and use of personal information in the UK.

"It is important that creditor organisations and money/debt advisers have up-to-date, relevant and accurate information about consumers who have mental health problems."

"It is equally important that users of such information remain aware of the sensitivity of the data they are collecting, keep it secure, and use it only for the stated purpose."

"The DMHEF is a tool that enables the collection of this information, and it is clear that careful thought has gone into its design.
We welcome the opportunity to have reviewed the form and accompanying guidelines, and we are sure that the form can be used in a manner consistent with the principles of good data handling as set out in the Data Protection Act 1998."

Other useful resources

www.rcpsych.ac.uk/debt
The Royal College of Psychiatrists website for tools and guidelines.

www.moneyadvicetrust.org/section.asp?sid=12
Key resources on debt and mental health from the Money Advice Trust.

www.nationaldebtline.co.uk
Free specialist advice and guidance.

www.mind.org.uk/money
Resources for people with experience of mental distress and debt.

Copyright statement

The Debt & Mental Health Evidence Form is copyright of MALG and the Royal College of Psychiatrists. However, you are encouraged to use, photocopy, or disseminate the Debt & Mental Health Evidence Form in its entirety, for non-profit making purposes only. You neither need to seek permission nor pay to use, photocopy or disseminate the Debt & Mental Health Evidence Form, on the understanding that your use of the form will not be for commercial purposes. However, if you wish to revise, alter, or partially reproduce questions from the Debt & Mental Health Evidence Form for any purposes, you will need to obtain the permission of MALG and the Royal College of Psychiatrists.

About the person

QUESTION 1

Does the person have a mental health problem?

Yes No

No If you answer 'No', then please go to Question 8.

QUESTION 2

Does the person have a mental health problem that currently affects their ability to deal with money?

Yes No

No If you answer 'No', then please go to Question 6.

Does this mental health problem have a name? Please provide the main diagnosis in plain English.

How does this mental health problem affect the person's ability to deal with money?

Notes:
Please provide examples of this (e.g. the person has concentration difficulties, or receives assistance with money management from another person such as someone with power of attorney, or another third party).

QUESTION 3

a What was the approximate date of the:

(i) first onset of this mental health problem — Month / Year

(ii) first treatment given for this — Month / Year

(iii) most recent episode of this mental health problem — Month / Year

b Is this episode currently ongoing?

Yes No

Notes:
If there is more than one diagnosis, please refer to all relevant mental health problems, using the space in this margin.

QUESTION 4

If the person is receiving treatment or support for this mental health problem, is there any aspect of this that affects their ability to manage money?

Yes No

Please explain how that treatment or support affects their ability to deal with money.

Notes:
Please provide examples (e.g. medication side-effects mean the person may have memory or concentration difficulties; or the individual is often away from home whilst being cared for as a hospital in-patient, which makes it difficult to manage finances).

QUESTION 5

Are there any other relevant impacts/effects that the person may experience in their everyday life due to their mental health problem?

Yes No

What other relevant effects are there?

Notes:
Please provide examples in non-clinical language (e.g. cannot leave their home; has difficulty in understanding information/making decisions).

QUESTION 6

Does the person have any difficulties with communication due to their mental health problem?

Yes No

What difficulties do they have?

Notes:
For example, do they have difficulties in being contacted by telephone, letter, or in person? Which is the best method?

QUESTION 7

Can the information provided in this form be shared with the person it is about?

Yes No

Notes:
The person named on this form may wish to see the information that has been collected about them. However, if seeing this information could (a) result in serious physical or mental harm to the named person or (b) to others, then please tick the ‘No’ box opposite.

About you

QUESTION 8 - Your contact details

☐ **Tick here if your details on the front page of this form are already correct. If any details aren't correct, please provide any corrections below.**

Your name:

Your address:

Your telephone number: Your mobile number:

Your email address:

Your relationship with the person named on this form:

☐ Social Worker ☐ Clinical Psychologist ☐ General Practitioner

☐ Mental Health Nurse ☐ Psychiatrist ☐ Occupational Therapist

Other (please specify) ____________________

☐ Tick here if you are also the Care Coordinator

Finally

Please sign, date and stamp this form

We greatly appreciate your assistance in completing this form.
This will help inform our decision about the best course of action to take.

Signature:

Date:

Service/organisation stamp

Not for completion by the professional

Optional statement by the named person only

This section allows the person named on this form to provide an optional short written statement.

This statement can be about what the health or social care professional wrote about that person, or it can be used to provide additional information.

If you wish to make a statement, then:

- you have 21 days to write, sign and return the statement
- the 21 day period starts from the date on which the health or social care professional signed page 5 of this form
- you should carefully read what has been written in the Debt and Mental Health Evidence Form
- you can write your statement in the box below

Name of person:

Signature of person:

Date:

Please sign and then return to the advice agency. The return address is provided in 'Box A' on Page 1.

For completion by the client.

Debt and Mental Health Evidence Form

(advice version 2)

Personal Consent to share information

Agency ref:

Date:

Contact details: client

To:

Mob:

Fax:

Email:

We are an advice agency working on your behalf. Our details are:

Agency name:

Adviser's name:

Fax:

Email:

1. What you've already told us

You've told us:

- about your debts
- and your mental health problems.

You've asked us to:

- tell the organisations you owe money to about your mental health problems, and to explain how these affect your ability to repay the debt.

2. What *we* need to do next

To help, we need your written consent to:

- collect information about your mental health from a health or social care professional who knows you
- present this information to the people you owe money to
- negotiate with these people, and use this information to reach an acceptable solution.

3. *What you need to do now*

First

Please read the information on the next two pages. This will explain how we will collect, share and store information about you.

Second

If you don't understand anything, please ask us any questions you have.

Third

If you want to give consent, please complete and sign the form on page 4.

Fourth

Please take a copy of the form for your records.

Fifth

Please return the form in the envelope provided.

Please read this information carefully

Q: What information will be collected?

- First, your adviser will ask you to nominate a health or social care professional to provide the information.
- This professional will then be contacted. They will be asked 8 questions about your mental health, and how it may affect your ability to repay your debts.
- If you want further information, ask your adviser for a copy of the Debt and Mental Health Evidence Form, or visit www.rcpsych.ac.uk/debt

Notes

These 8 questions are:

- whether a person has a mental health problem
- whether (and how) that mental health problem currently affects that person's ability to deal with money, and the name of that mental health problem
- the approximate date of the first onset of the mental health problem, the first treatment given for this, and the most recent episode of the mental health problem
- if the person is receiving treatment or support for the mental health problem, whether (and how) this affects their ability to manage money
- whether there are other relevant impacts/effects that the person may experience in everyday life due to their mental health problem
- whether the person experiences any difficulties in communication due to their mental health problem, and if so what are these
- whether information provided by the professional can be shared with the person it is about
- the health or social care professional's contact details.

Q: How will the information be used?

- We will use the information to understand your situation better.
- When we make contact with the people you owe money to, we will show the information to them. We will do this for two reasons:
  - improve their understanding of your situation
  - to request that your situation is taken fully into account when they make decisions about what action to take.

Q: Who will see the information?

- We will see the information provided by the health and social care professional.
- In most situations, you will be able to see the information (see below).
- The people you owe money to will see the information.
- The people you owe money to may share the information with their 'agents'. Agents are companies that are employed by creditors to collect debts.

Q: Can I see the information?

- In most situations, the answer is 'yes'.
  - in most cases, the professional will automatically send you a copy of the completed form
  - when you receive the form, please read it carefully
  - you have 21 days to make an optional statement about the information in the form
  - the 21 day period starts from the date on which the health or social care professional signed page 5 of the completed Debt and Mental Health Evidence Form
  - if you do make a statement, please sign the form, and then return it to your adviser.
- In a small number of situations, the answer may be 'no':
  - if the professional feels that seeing the information could cause serious physical or mental harm to you or others.

Please read this information carefully

Q: How will the information be stored?

- The law requires that any personal information held about you is securely stored.
- The law requires this information is also destroyed when no longer relevant.
- The law requires that any information held about you is accurate, up-to-date, and relevant.
- The main law about this is called the Data Protection Act.

Q: Can the information be used in the future to make decisions about my applications for credit?

- This answer to this question only applies to creditors with whom you shared information about your mental health.
- The answer to this question depends on whether the information you gave the creditor could still reasonably be considered as being:
  - up-to-date
  - an accurate description of your current situation
  - relevant to the decision that is being made.
- All creditors should be aware that mental health problems can fluctuate over time. They should also know that people can recover from periods of poor mental health.
- Therefore if your circumstances change, you are entitled to instruct the creditor to change the information they hold, OR to securely destroy this information.
- To do this, you should:
  - instruct the creditor that they need to take action (the preferred method is by a letter sent via the post or email)
  - tell them what action to take (which information needs revision, or should be securely destroyed)
  - keep a copy of the letter and any correspondence from the creditor
  - For further information on how to do this, please visit: www.ico.gov.uk/what_we_cover/data_protection/your_rights.aspx

Any further questions?
Please contact us if anything is not clear, needs explaining, or isn't covered.

Have you decided to give consent to share information? If so please complete the form below.

Your details

☐ **Tick here if your details on the front page of this form are already correct. If any details aren't correct, please provide any corrections below.**

Your name:

Your address:

Your telephone number:

Your mobile number:

Your email:

Your consent – please sign

Authorisation to health or social care professional:

I authorise you to provide information about my health to the advice agency named on this form.

I authorise the advice agency named on this form to store information about me on the basis that (a) this information will be securely stored and (b) will be destroyed when it is no longer relevant.

I authorise the advice agency sending this form to share information about my health with relevant creditors (including their agents) to improve their understanding of my health situation.

Signature: Date:

Once you have signed the form, please return it in the envelope provided.