

Out of the picture

CAB evidence on mental health and social exclusion

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Executive Summary

1. When people suffer mental health problems, they lose part of themselves, a way of being. For some, this may be like a bereavement. Their ability to work, to manage their everyday affairs and to look after themselves falters and sometimes fails completely.
2. The scale of the problem is huge. The Office of National Statistics estimates one in six people suffer from a mental health problem at any one time¹, roughly over 7 million people between the ages of 16 and 74. The Sainsbury Centre recently estimated the economic and social costs of mental illness for England to be around £77 billion². The most recent Welsh Health Survey indicated that 9.4 per cent of adults suffered from depression and 7.3 per cent had suffered from anxiety³.
3. Society's response should be to support people through this difficult time. CAB evidence suggests that far from this happening, people with mental health problems often experience discrimination and are not adequately supported. These two themes run through the evidence from Citizens Advice Bureaux in this report. These issues create difficulties for people that reinforce the isolation their illness creates.
4. This report draws on evidence, views and experience from over 350 CABx throughout England and Wales, 64 responses to a Social Exclusion Unit questionnaire on mental health and social exclusion and information from interviews and discussions with specialist workers from some of over 100 CAB mental health projects around the country.
5. Widespread discriminatory behaviour and failures to understand the difficulties people with mental health problems face makes raising awareness about mental illness a central issue. This is not a new message. The Government has begun to take steps to educate young people and employers about mental illness but CAB evidence suggests this has not yet had real impact. This is a challenge for all of us. It calls for action across all sectors of society. All those who come into contact directly or indirectly with people with mental health problems need to be better equipped to identify and help them whether they be in the public, private or independent sectors. Institutions need to review their procedures to avoid discriminatory outcomes. In addition, there is a need to break down the barriers of discrimination by raising awareness about mental health issues among the general population.
6. This report outlines CAB evidence on the stigma, discrimination and difficulties people with mental health problems face in the work

¹ *Psychiatric Morbidity among adults living in private household in Great Britain, 2000*, National Statistics. Other surveys have put the figure at 1 in 4 including the *mind out for mental health* campaign. Depression occurs in 10 per cent of the population.

² *The Economic and Social Costs of Mental Illness, 2003*, Sainsbury Centre for Mental Health.

³ *Welsh Health Survey, 1998*, National Assembly for Wales. Fieldwork for a new combined survey began in October 2003 and will be carried out over a 2 year period.

environment, the benefit system and dealing with consumer affairs such as financial services. These are just some of the areas in which people experience exclusion. Working, welfare and personal finance are key to maintaining a regular income. When something goes wrong, security and the daily routine is lost. A large part of the work of Citizens Advice Bureaux involves helping these clients with employment, benefit and consumer problems as illustrated with case studies throughout the text.

7. Many people with mental health problems want to work. We describe some of the barriers to their achieving this. The work environment too often seems to discard people who are ill, for lack of understanding and knowledge about the kind of help that people need. Sometimes there is overt discrimination. The Government is piloting changes to help people on incapacity benefit back into the workplace but we have yet to see how these will work out in practice.
8. Loss of work and failure to get back into employment after illness means that mental health service users have the lowest employment rate of all disabled groups. Only 18 per cent⁴ are employed. Most are dependent on benefit income and are some of the poorest people in the UK. Poverty is linked to poor health and people with mental health problems are trapped in poverty for longer periods than most.⁵ Persistent low incomes reduce people's ability to afford to participate in activities and services that might help reduce their isolation.
9. Work is one avenue by which people with mental health problems may be made to feel less socially excluded but it is not the whole answer in addressing social exclusion. A number of broader based issues need to be tackled if those with mental health problems are to be helped into a 'work-ready' state. Major changes in the benefit system and in consumer protection are urgently needed. Unfair discrimination in these sectors is undermining people's confidence and their ability to cope financially and creates conditions in which they are least likely to get better.
10. The benefit system should underpin people's security but it often fails to recognise and make allowance for their illness. The forms that have to be completed and the procedures used for assessing capacity to work do not make appropriate provision for mental health problems. People with mental health problems have full responsibility for complying with procedures and time limits and failure to do so can mean benefits are stopped. When people are unwell, their capacity to function normally may be reduced, yet the benefit system makes no allowance for this.
11. High pressure selling and the ease of obtaining credit are problems for many people. But those with mental health problems are particularly vulnerable when unwell. Many face difficulties in being effective consumers and understanding the full implications of consumer contracts or credit

⁴ *Labour Force Survey*, 2002, National Statistics, Department for Education and Employment

⁵ *Poverty, Social Exclusion and Mental Health: a resource pack*, 2001, Davis, Ann & Phil Hill, The Mental Health Foundation.

agreements they may not be able to afford. They are directly discriminated against when insurance providers apply blanket exclusions of people with mental illness and when payment protection insurance fails to cover breaks in their income.

12. Low income and illness make managing finances difficult and debt is common. The anxiety and stress that accompanies debt is known to impair health. Support and independent advice demonstrably contribute to reducing anxiety and health problems and debt needs to be addressed early if it is not to become insurmountable and make people's condition worse.
13. When unwell, large numbers of people with mental health problems are very much on their own. They need support to cope with their illness and advice and help to deal with the benefit system, debts, social activities and moves into work. Aside from the statutory agencies, a wide range of supportive work is undertaken by a number of voluntary organisations. But these do not have the resources to cater for all needs.
14. This report argues for a programme of action to tackle discrimination in behaviour and in institutional procedures across the public and private sectors. It calls for more support for people with mental health problems to help create positive experiences both in and outside work, building blocks that may help them to recover more quickly and prevent their domestic situation deteriorating. The report makes recommendations in the following key areas:
 - **for action to improve awareness and understanding of mental health throughout the public, private and independent sectors. This should be underpinned by monitoring and reviews of how services impinge on people with mental health problems and backed up by changes to the Disability Discrimination Act 1995. The National Institute for Mental Health England should take responsibility for establishing a cross departmental programme to combat discrimination on grounds of mental health and promote social inclusion for people with mental health problems in the public, private and voluntary sectors. The Welsh Assembly Government should build on the progress it has made for a multi-agency approach to address these issues**
 - **for a comprehensive review of the benefit system and its impact on people with mental health problems**
 - **for the National Institute for Mental Health England to work with the Department of Trade and Industry to raise awareness about mental health issues and achieve changes in working practices which reflects this awareness**
 - **for ready access to support for people with mental health problems when they are not well, where and when they need it**

- **for statutory bodies, voluntary agencies and private companies to exercise due care and responsibility towards vulnerable people who may not be able to look after their own interests. This should be underpinned with amendments to the Mental Incapacity Bill to improve consumer protection rights and remedies. Training on mental health awareness should be a requirement in industry codes of practice. The OFT should develop guidance on responsible lending and dealing with customers in financial difficulties.**

1 Introduction

'I think one of the hardest things to deal with is the fact that you have an illness. It's not always something you can see, it's in your head. You know you don't feel right but you don't know why. I didn't want it, it just happened. Why me? I don't know the answer to that, I wish I did. One thing I know is I will never be the same person that I used to be. The little problems that could so easily be solved are like huge mountains that have to be climbed. But why do I keep falling down before I reach the top?

It could be that my mind has blown a fuse but my thinking is not the same as it was before. Now I can't think too far ahead... Sometimes I'm confused. Sometimes people talk to me and words don't make any sense. It hurts to think, it hurts not to think. All I do know is I'm different.⁶

- 1.1 The Office of National Statistics estimates one in six people suffer from a mental health problem at any one time⁷, this is approximately 7 million people between the ages of 16 and 74. The Sainsbury Centre recently estimated the economic and social costs of mental illness for England to be around £77 billion⁸. They suggest that about 70 per cent of the cost of mental illness falls on the people who experience it and about 30 per cent on the rest of the population.
- 1.2 This report builds on Citizens Advice's response to the Social Exclusion Unit's 2003 consultation on how people with mental health problems could be helped back into work and what could be done to increase their social participation and access to services⁹. It outlines CAB evidence on the exclusion and barriers experienced by people with mental health problems as they struggle to engage with the workplace, the benefit system and consumer affairs.
- 1.3 In 2002/3 bureaux dealt with almost 6 million new enquiries of which over half a million were about employment problems, over one and a half million about benefits and over one million about consumer and utility issues. More than 100 bureaux run special projects for people with mental health problems and CABx regularly give advice and help in 707 GP surgeries and health centres, 79 general hospitals and 69 psychiatric care centres and 20 healthy living centres. Many people with mental health problems turn to the CAB when they cannot manage and have been unable, or not known where, to get help. A few bureaux have indicated to us that they estimate more than half of their clients have or have had a mental health problem.

⁶ A former CAB client and contributor to *Marooned*, a magazine produced by and for users of the mental health system in Salford and supported by social services community care worker services.

⁷ *Psychiatric Morbidity among adults living in private household in Great Britain, 2000*, National Statistics. Other surveys have put the figure at 1 in 4 including the *mind out for mental health* campaign. Depression occurs in 10 per cent of the population.

⁸ *The economic and social costs of mental illness, 2003* The Sainsbury Centre for Mental Health, Policy Paper 3.

⁹ In March 2003, the Deputy Prime Minister launched Mental Health and Social Exclusion, asking the Social Exclusion Unit (SEU) to consider what more could be done to reduce social exclusion among adults with mental health problems. The Social Exclusion Unit's information gathering included a consultation exercise.

- 1.4 This report draws on evidence, views and experience from:
- Over 350 bureaux throughout England and Wales who have submitted client case examples to Citizens Advice since January 2002
 - CAB advisers' responses to a Social Exclusion Unit questionnaire¹⁰ on mental health and social exclusion (35 from special projects for people with mental health problems and 29 from generalist bureaux)
 - information from interviews and discussions with specialist workers in CAB mental health projects.
- 1.5 This introduction outlines the two themes that run through CAB evidence on mental health issues. They are that:
- people with mental health problems face discrimination
 - inadequate support is available for people with mental health problems.

These create fundamental barriers to inclusion that pervade people's experiences in the work place, with the benefit system and how they are treated as consumers, particularly when accessing insurance and financial services. They create further difficulties that reinforce the isolation illness creates. This introduction also discusses the care given to people with mental health problems and actions being taken by the Government to address mental health issues.

- 1.6 Chapter 2 outlines the barriers to working. Chapter 3 looks at whether the benefit support for returning to work helps people back into employment. Chapter 4 describes the general problems people with mental health problems have with the benefit system and looks in detail at how disability benefits may undermine people's confidence and security and Chapter 5 examines how people lose out on means-tested benefits. Chapter 6 outlines consumer, debt and credit issues and how debt affects people's mental health and Chapter 7 describes how CAB projects that work with people with mental health problems are organised to help them. Broad recommendations, with some specific suggestions towards achieving the overall objective of inclusion, are summarised at the end of the report. Textual references throughout to 'people' should be read as 'people with mental health problems'.

Discrimination

- 1.7 There is a general lack of knowledge and understanding about different kinds of mental illness such as anxiety, panic attacks, phobias, depression, manic depression and schizophrenia. Attitudes based on fear stigmatise

¹⁰ circulated to projects and bureaux in June 2003.

and stereotype people with mental health problems, exposing them to prejudice, discrimination and sometimes harassment¹¹. Discrimination leaves them feeling ashamed, excluded and marginalized even after recovery.

- 1.8 The difficulties people face are not understood and so do not elicit sympathy.

'They can feel judged by others and feel excluded because no-one understands how their illness affects them.'¹²

People with mental health problems suffer low self-esteem and lack confidence and motivation and talk about a 'battle' or 'fight' to be understood by others. They see allowances made at work and in the benefit system for people who are physically ill but not the same allowance made for mental illness. They believe it is not they who have to come to terms with their illness but others. To cope, they may lie about it on forms, not tell their colleagues at work and not tell the people they socialise with, fearing disclosure will mean harassment and prejudice.

- 1.9 The Disability Discrimination Act 1995 (DDA) does apply to people who have a mental impairment that is 'clinically well-recognised by a respected body of medical opinion', and where the impairment has a 'substantial and long-term adverse effect on his ability to carry out normal day-to-day activities'. Long term is defined as lasting at least 12 months, though if an illness is likely to recur this can be treated as a substantial effect.
- 1.10 But it can be very difficult for people with mental health problems to use the law to assert their right to be treated fairly as is demonstrated by the extent of case law on this issue¹³. There are three obstacles to be overcome when people consider taking action under the Act.¹⁴ First is that 'normal day to day activities' are mostly defined in physical terms; yet physical activities may not be affected for a person with mental health problems. As currently defined, the 'normal day to day activities' fail to take sufficient note of the kinds of difficulties people with mental health problems face, such as psychiatric impairment affecting behaviour, social interaction, relating to strangers and communication. A second difficulty is mental impairment must be 'clinically well-recognised', a stipulation that doesn't apply to physical disability. It is not clear why there is a higher threshold of proof for mental disability beyond a GP diagnosis of mental impairment. Finally, the emphasis on 'long term' does not seem to encompass mental conditions that may be short term, fluctuating or recurrent in nature such as trauma or reactive depression, which for their duration can be mentally incapacitating and people with these conditions experience discrimination. CAB advisers indicate that it can be very difficult with all these obstacles to bring cases under the Disability Discrimination Act.

¹¹ Read and Baker describe community harassment in *Not Just Sticks and Stones*, 1996, Mind.

¹² CAB adviser

¹³ for example, see *Goodwin v The Patent Office*, 1999, IRLR 4, Employment Appeal Tribunal.

¹⁴ See Chapter 6, paragraph 6.41 and 6.42 for further discussion of this.

- 1.11 **To help challenge the unacceptable discrimination faced by people with mental health problems, Citizens Advice recommends that definitions of mental disability in the Disability Discrimination Act should be broadened. 'Normal day to day activities' should be broadened to include the effects of mental disability on day to day living, such as communication or social interaction. The term 'clinically well recognised' should be dispensed with and recognition given to a wider range of mental health problems so that the same level of protection for people with mental disabilities is provided as for people with physical disabilities.**
- 1.12 Citizens Advice is not alone in identifying the need for the DDA to be changed in this way. Mind has noted the limited definition excludes many people with mental health problems¹⁵. The Disability Rights Task Force has recommended the DDA definition should be reviewed with a view to extending it¹⁶ and this remains the view of the Disability Rights Commission¹⁷.
- 1.13 The Royal College of Psychiatrists has reported¹⁸ that 40 per cent of people who present to their GP with mental health problems feel stigmatised and discriminated against by their GPs. It too argues that anti-discrimination and disability legislation must be seen to operate effectively for those disabled by mental illnesses and that NHS trusts should treat mental illness in all policy and procedures as they presently treat such issues as race, gender and age. It argues that the Medical Royal Colleges and British Medical Association (BMA) should formally adopt anti-discriminatory policies and awareness campaigns in relation to people with mental health problems.
- 1.14 However, the Government has so far been reluctant to act on evidence of the inadequacy of the DDA in this respect¹⁹. Regrettably government proposals to amend the act²⁰ are missing an opportunity to address these important issues and if they are not addressed, it will remain very difficult for people with mental health problems to bring and prove cases of discrimination.
- 1.15 More widely tackling discrimination on grounds of mental health is a major challenge. CAB evidence points to **the need for all those working in statutory and voluntary agencies and public and private bodies that deal with the public to undergo mental health awareness training which includes information about the difficulties illness creates for**

¹⁵ *Creating Accepting Communities*, 1999, p.124, Mind.

¹⁶ *From Exclusion to Inclusion*, 1999, Disability Rights Task Force, Final Report.

¹⁷ *Disability Rights Commission Response to the Social Exclusion Unit Consultation*, 2003

¹⁸ *Mental Illness: stigmatisation and discrimination within the medical profession*, 1999, Council Report 91, Royal College Psychiatrists, Royal College Physicians of London, British Medical Association

¹⁹ see for example the Ministers response to Lord Ashley of Stoke. Disability Discrimination (Amendment) Bill, 6 Mar 2002, Col 347, Hansard.

²⁰ *Draft Disability Discrimination Bill*, 3rd December 2003, Cm 6058, DWP.

people. Organisations should underpin this by reviewing and regularly monitoring their systems and procedures to ensure that people with mental health problems are not put at a disadvantage.

- 1.16 The National Institute for Mental Health England and the Department of Health, Social Services and Public Safety in Northern Ireland should be given lead responsibility for establishing a cross departmental programme for combating discrimination on grounds of mental health and promoting social inclusion for people with mental health problems in the public, private and voluntary sectors.**
- 1.17 The Welsh Assembly Government should build on the progress for a multi-agency approach to combating discrimination, promoting social inclusion and tackling stigma as laid down in the NSF (Standard 1) for Wales. The Assembly Government has adopted a multi-agency approach to delivering services.**

Inadequate support

- 1.18 CAB advisers have identified lack of support as one of the most significant issues to be tackled if we are to make an impact on the social exclusion experienced by people with mental health problems. If people do not have support with basic tasks such as claiming benefits and paying bills, they enter a downward spiral to poverty and exclusion as well as having to deal with the stigma of mental health.
- 1.19 For the majority of sufferers, illness causes them to withdraw socially. Wary of people, they can find it difficult to get information, seek help or go out of the house. They may have problems communicating and being understood. Depression and the side effects of medication can lead to extreme fatigue. When people are not able to manage appointments and arrangements, this can be interpreted as 'not bothering'. Problems with communication extend to concentration and coping with written material. When ill, people are unable to work, less able to claim benefits, complete forms, manage money and other daily matters; sometimes they cannot manage their own personal care.
- 1.20 It is often erroneously assumed that family and friends can help but advisers report that a significant number of clients who have been referred to the mental health system are without the family or friendship networks we might assume they have. If people are to be helped to recover, support needs to be substantially improved and increased.
- 1.21 CAB advisers report that people need advocacy in the community that is readily accessible to help them articulate their needs when they have difficulty doing so themselves. The Durham CAB Representative Advocacy Service is an example of working with people in the community to help them articulate their needs.

- 1.22 Citizens Advice welcomed the positive proposals in the Draft Mental Health Bill (2002) to strengthen patients' rights and improve advocacy and hopes these will be taken forward. However, we very much regret that in the new Mental Capacity Bill, the Government has rejected the 'essential role' of a comprehensive system of advocacy as recommended by the Joint Committee²¹. **It is important that patients' rights to advocacy are translated into more resources on the ground to help people with mental health problems challenge discrimination and access their civil and consumer rights when these are being denied them.**

Treatment and care for people with mental health problems

- 1.22 People receive very different levels of support to manage their illness and cope with the consequences of illness, such as losing a job. The kind of help given seems to depend not only on the nature of their illness but where they live.
- 1.23 People who are referred on to the mental health services for specialist help from a psychiatrist and/or a Community Psychiatric Nurse (CPN) and the Community Mental Health Team (CMHT) are a minority. Such referrals tend to be made when people's conditions deteriorate or become critical. This means a substantial number of people do not receive help beyond that which their GP can give them, unless they buy it privately.
- 1.24 90 per cent of mental health problems are dealt with in primary care²². These people are in particular need of more support. Mind have noted that when people with mental health problems were treated by their GP, the majority (94 per cent) had been prescribed medication²³. Other options for GPs are often limited because the focus of treatment currently remains with secondary rather than primary care, so a GP is unlikely to be in a position to refer these people for the 'effective support' in the early stages of their illness that the Government would like them to have²⁴.

'Fewer people are getting diagnosed ... so a client can go in and out of hospital with severe panic attacks and then come out with no CPN or psychiatric referral. We have lots of clients like that. With border personality disorder basically you cannot get treatment and no one wants you, yet it is one of the most common mental health problems and a result of neglect and abuse with people really marginalised and unable to cope. Because no one is interested, they get little support or help. They're told it is untreatable and a lot of the people

²¹ *Government's Response to the Scrutiny Committee's Report on the Draft Mental Incapacity Bill*, Cm 6121, February 2004, Department for Constitutional Affairs.

²² *Fast-forwarding Primary Care Mental Health: justification for a permanent separate strand for primary care within NIMH(E)*, 2001, Department of Health.

²³ *The hidden costs of mental health*, 2003, Mind.

²⁴ *Pathways to Work: Helping people into employment*, 2002, p.14, Department of Work and Pensions, Cm 5690.

I see are at the bottom of the pile and they often turn to drugs or drink to self-medicate²⁵.

- 1.25 It is possible some GPs do not refer on clients who could benefit from specialist help because they know services are over-stretched. Social services often purchase special services or activities to help clients up to a financial limit for any one individual. Also, the support and activities that are accessed through referrals may have limited places and restricted opening times. Some people find their CPNs and social workers difficult or impossible to reach. When professionals have moved away to other jobs or for training, clients' files have been closed without informing the client who has then had to go back to her/his GP for a new referral.

A CAB in Hertfordshire is helping a client who cannot read or write and who has serious mental health problems. The client went to social services to try and get help with benefits and with her mental health. There was a 'violent incident' and she was banned from the premises. She then approached the Women's Resource centre who referred her to the CAB who sorted out her benefit entitlements and tried to get help for her mental health problem. Social services stated that as she had a personality disorder she did not come within their remit. The client's state of mind deteriorated and she tried to harm herself and then to murder her husband. She has now been sectioned.

- 1.26 People who are not ill enough to be referred by their GP to the mental health services help may fall through the net in spite of skilled services and advice given by organisations such as Mind, Rethink, SANE, MACA, CABx and others. CAB advisers describe many people who feel they are totally lacking in support to manage their illness and their everyday lives. Without such support, they are unlikely to find their way into work.
- 1.27 Ethnicity also affects access to services. There are noticeable differences between white majority and minority ethnic groups experience of mental health services and the Government has recently produced a consultation document²⁶ with proposals to address this issue. Rates of compulsory admission are higher for black and minority ethnic groups, this may be associated with a more frequent involvement of the criminal justice system in their referrals. This group of people are also more likely to be assessed as requiring a greater degree of control and security and are more likely to be admitted to secure environments²⁷. Some bureaux, such as Leytonstone, provide services in day centres for people with mental health problems from black communities. More work of this kind needs resources to help minority ethnic groups realise their rights.

²⁵ CAB project worker.

²⁶ *Delivering Race Equality: a framework for action*, October 2003, Consultation Document, Mental Health Services, Department of Health.

²⁷ *Inside Outside: improving mental health services for black and minority ethnic communities in England*, 2003, National Institute for Mental Health in England.

- 1.28 Ways need to be found to ensure everyone with mental health problems can access appropriate services, activities and the practical help they need to manage their lives until they recover from illness. CAB evidence shows that more support and practical help is needed in particular when people go into hospital and are discharged or when they move into and out of employment.

Government action

- 1.29 The Department of Health (DoH) has recently undertaken a number of welcome initiatives to raise awareness about mental health issues. These include publishing The National Service Framework for Mental Health (NSF, 1999) which sets standards and service models to address the mental health needs of working age adults up to 65 years, together with a significant investment²⁸. The first of the NSF's standards addresses promoting mental health and tackling discrimination and social exclusion associated with mental health problems²⁹. However, the NSF is concerned with the treatment and care which people will be entitled to expect and will be a guide to investment. It does not address work and benefit issues, nor consumer issues such as access to insurance, that form the basis of this report.
- 1.30 The National Institute for Mental Health in England (NIMHE) was set up in July 2001 to implement the NSF and to raise the profile of mental health and to improve services. Also in 2001, the *'Mind out for mental health'* campaign, commissioned by the DoH and NIMHE, was launched to help change the way people think about mental illness, especially young people, employers and the media³⁰.
- 1.30 Over the same period (1998-2003) the Royal College of Psychiatrists conducted a *'Changing minds'* campaign to raise public and professional awareness and change attitudes. Its report³¹ addresses stigmatisation by doctors and makes recommendations for reducing it.
- 1.31 In spite of these developments, statistics prepared for the DoH on attitudes to mental illness show that between 2000 and 2003, adult attitudes became slightly worse³², throwing doubt on the effectiveness of the *'Mind out for*

²⁸ *National Service Framework for Mental Health modern standards and service models*, 1999, Department of Health. The needs of older people and young people and children are being addressed separately. There is £700 million over three years from 2000 to reshape mental health services in line with the NSF, to address gaps, to create a comprehensive service for people with severe and enduring mental illness and where this has been achieved, to develop services for people with common mental health problems.

²⁹ *Ibid*, p.14-15

³⁰ The campaign is being run by the communication consultancy, The Forster Company

³¹ *Mental Illness: stigmatisation and discrimination within the medical profession*, 2001, Council Report 91, Royal College Psychiatrists, Royal College Physicians of London, British Medical Association

³² *Adults' Attitudes to Mental Illness in Great Britain*, 2003, National Statistics. Respondents were asked to say to what extent they agreed or disagreed with various statements and responses for different years were compared.

mental health' campaign and indicating that a great deal remains to be achieved in terms of reducing discrimination against people with mental health problems.

- 1.32 Mental health remains one of the government's three key clinical priorities, along with cancer and coronary heart disease. The priorities and planning framework for 2003 reaffirmed this³³.
- 1.33 The Welsh Assembly Government has listed the improvement of mental health services as one of its 5 priorities for health gain targets for 2002-2007³⁴. The most recent Welsh Health Survey indicated that 9.4 per cent of adults suffered from depression and 7.3 per cent had suffered from anxiety³⁵. The Health and Social Services Committee of the National Assembly for Wales has confirmed the key actions it is taking forward within its National Service Framework for Mental Health following a recent review and set new targets in January 2004. The Minister for Health and Social Services has already acknowledged the need for a national multi-agency initiative in order to address these key action points across Wales.
- 1.34 In Northern Ireland, a cross-departmental strategy led to the 'Promoting Mental Health Strategy 2003-2008'³⁶, with the aim of improving the incidence of emotional and mental distress and raising knowledge and awareness. Research indicates the serious impact the "Troubles" continue to have on psychological well being with an estimate that Northern Ireland mental health needs are at least 25 per cent greater than England³⁷.
- 1.35 Such government actions are welcome and demonstrate a recognition of the scale of the task. However, this report based on CAB evidence shows that people with mental health problems continue to face discrimination and social exclusion in the workplace, in the benefit system and in consumer affairs. Too often they are left out of the picture with their needs neither recognised nor understood. Much work beyond the outlined government programme remains to be done if we are to create building blocks of positive experience for this group of people so that they feel included.

³³ *Improvement, expansion and reform, the next three years: priorities and planning framework for 2003-2006*, 2002, Department of Health.

³⁴ *Targeting Health Improvement for All*, 2002, National Assembly for Wales. Specified five priority areas for target setting – coronary heart disease, cancer, mental health, older people, and children.

³⁵ *Welsh Health Survey 1998*, National Assembly for Wales. Fieldwork for a new combined survey began in October 2003 and will be carried out over a two year period.

³⁶ *Social Services and Public Safety*, January 2003, Northern Ireland Department of Health.

³⁷ *Priorities for Action: planning priorities and actions for the health and personal social services, 2003-4*, 2003, DHSSPS.

2 Barriers to working

- 2.1 This chapter outlines the difficulties people with mental health problems have staying in work when not well and getting back into work after illness. It shows that discrimination and lack of support and understanding in the workplace, are foremost among their problems. It argues for the Government to take a lead in bringing about change in working practices.
- 2.2 CAB evidence indicates that many people with mental health problems want to work because they expect to feel better for doing so and they want to make a contribution to society. Work can have a significant and beneficial impact on people's lives, giving their day structure, raising income and broadening social contacts. Work confers confidence and self-esteem and a sense of social inclusion. However, people with mental health problems have the lowest rate of employment among people with disabilities at 18 per cent.³⁸
- 2.3 For some people with severe and enduring difficulties, the option of work may not be feasible or appropriate and for them, work will not represent social inclusion. There are other people who can realistically manage only supported or part-time work for a few hours a week and this is important for their sense of well-being.

Discrimination in the workplace

- 2.4 CAB advisers³⁹ working with people with mental health problems cite workplace experience and in particular, stigma, prejudice and discrimination from both employer and colleague employees as the main reason for people with mental health problems giving up work and the main problem when trying to get work (Table 2). Advisers believe employers' attitudes represent a significant hurdle over which people with mental health problems have no control or influence. Employers are criticised for their reluctance to employ people with mental health problems and their lack of understanding when people are in work and not well. There seems to be little point in encouraging people with mental health problems back into work unless the prejudices and discrimination of the workplace are effectively addressed. The stress of harassment and unsympathetic treatment will make their condition worse and lead to a breakdown of the work arrangement, possibly leaving them in a worse situation than when they started.

³⁸ *Labour Force Survey*, National Statistics, 2002, Department for Education and Employment.

³⁹ Responding to the Social Exclusion Unit's questionnaire

Table 2
Reasons reported by advisers for people with mental health problems giving up work

Reasons	Percentage of advisers
Stigma, prejudice, discrimination in the workplace	60
Lack of support for & from employers for working practice	39
Lack of support	36
Lack of confidence	34
Pressure and stress in the workplace	20
Fear of consequences for benefit if work fails	19
Lack of qualifications / need for training / poor prospects	16
Benefit poverty trap	12
Problems with benefit administration / delays	6
No work opportunities	6

Base: responses from 64 advisers

- 2.5 Advisers also report that previous employment experiences can act as a deterrent to returning to work. Taking time off for treatment at hospital or as sick leave can be misunderstood by employers and lead to dismissal or people being encouraged to resign. Research undertaken by The Work Foundation shows that 75 per cent of line managers don't think that, or don't know whether, their organisation has adequate policies or procedures to deal with mental health issues and 70 per cent don't have adequate information about mental health⁴⁰. The same research revealed that whilst nearly half (46 per cent) of all employees would go to their line manager with a mental health problem, but only four per cent thought their manager would be able to provide practical support.
- 2.6 People have to cope with a lack of understanding that at its worst is manifested as discrimination, intimidation and derision. They fear admitting to the nature of their illness, are reluctant to seek help and may ignore early symptoms until there is a crisis. People feel isolated when there is no flexibility or support at work and they are left unassisted. CAB advisers observe that people don't know where to find supportive work environments and need help to tackle the lack of awareness and understanding among employers.

A CAB in Worcestershire helped a client whose former store manager had breached her trust and confidentiality. The client had been employed for a year as a part-time sales adviser when she had to take sick leave. Her GP diagnosed depression and signed her off work for two weeks. The client's mother handed the GP's certificates into the store. Later the client learned that the store manager had joked with colleagues about her illness and had

⁴⁰ *Managing Mental Health: research into the management of mental health in the workplace and the information and guidance available to managers*, 2003, Diffley, Ceri, The Work Foundation. Research carried out for the Mind Out for Mental Health campaign.

displayed her sickness certificate on the staff notice board; a colleague took photographs of it. The client felt humiliated by this invasion of her privacy and it adversely affected her condition. At a grievance procedure the client's allegation concerning the manager's breach of confidentiality was refuted verbally and then in a letter. Later when the client was able to produce the photographic evidence to support her complaint, the company agreed to set up another meeting but by this time the client had resigned because she felt she couldn't go on working for the company.

A CAB in Yorkshire advised a client whose employer pressed him to return to work to the point of harassment. The client who managed a petrol station had been held up at gun point two months previously and had since been off work with stress. The employer who had a doctor's sick notes for the client did not believe he was ill.

Colleague employees

- 2.7 Other employees' lack of understanding can make life difficult for people, isolation and derision are not uncommon. A client at one of the CAB projects described in Chapter 7 regularly takes medicine that enables him to manage his symptoms. He has a small pension which just pays his rent, this means he cannot get housing benefit or council tax benefit. He has debts and can only afford a limited diet. He has not told the people he socialises with during the day about his illness in case they start to treat him differently.

"I was diagnosed a schizophrenic in 1980. I did various things to get work and put my name down on a list and got a flat. A friend of someone I met at hospital told me of a job and I took it and stayed for over 12 years and got promoted.

This condition of mine makes it difficult because you think people are saying things about you. The job was going quite well – I used to see the staff counsellor regularly. Then I started having difficulties with people because my illness had become common knowledge and I got remarks like 'the men in white coats will be coming in a minute'. I foolishly took the option of medical retirement and have regretted it ever since. My pension just pays the rent.

I find it extremely difficult getting jobs. It's not so difficult if I've got an interview following a phone call because it is one-to-one but when forms are involved and Human Resources, as soon as you write schizophrenic, it's no go. You can put 'well controlled by medication' but you don't stand a chance. They always write back and say we had a large number of high calibre applicants. I have thought about not putting it in but then I leave myself open to charges of fraud and sacking. You're between a rock and a hard place, where being honest goes against you."

Getting a job

2.8 When people with mental health problems experience constant refusals for jobs, it is a deterrent to applying. They sometimes wonder if it is worth being honest about their history and condition, knowing full well that if they lie and the lie is discovered, they could lose their job. A client in Lancashire was doing just that. She had failed to tell her future employers about her long-term depression and two breakdowns but she was starting work shortly. She was both excited and terrified by the prospect and worried about whether she would cope on her first day. What she felt she couldn't do was share the nature and reason for her anxieties with her work colleagues, as other workers might if they had a physical problem.

A CAB in Lincolnshire advised a man with a history of mental health problems who has on-going psychiatric support. He obtained full time employment in October 2002 and was subsequently asked to sign an employment contract containing the clause 'The employer may end the employment ... if ... (the employee) becomes of unsound mind or a patient under the Mental Health Act 1983.'

A CAB in Cumbria described a client who has been on incapacity benefit because of post-natal depression whose condition was beginning to improve and she wanted to work again. She applied at a local shop that was advertising for part-time staff but when she disclosed why she had not been working, the shop said they didn't wish to employ her.

2.9 Employers are frequently accused of closing their doors on applicants who have or have had a mental illness. CAB advisers say that giving help and support when people with mental health problems are looking for jobs is the best way to help them find and keep work. People's lack of confidence and skills need to be addressed before they begin looking and they need clear guidelines on the support and training they can expect from employers. Advisers report that provision of schemes to help people back into work is patchy. Some areas are well provided for and others are not. More resources need to be directed to developing a wider range of training options and supportive schemes for people with mental health problems who are considering returning to work.

2.10 Citizens Advice believes the Department for Trade and Industry should work with the National Institute for Mental Health England to encourage employers to:

- **separate the interviewing process from an applicant's disclosure of information about any medical conditions. Disclosure could be made in a separate process, such as after the selection procedure or when employers ask for a medical reference.**

- **publicise to job applicants that they have arrangements to accommodate people with mental health problems.** Potential employees can then be re-assured about their move into work and know that they will be appropriately supported and where necessary have training.
- **make clear to employees the help that people can anticipate through confidentiality, flexible working arrangements, understanding about their illness, reasonable adjustments and one to one support if it is needed.**

Keeping a job

- 2.11 Under the Disability Discrimination Act, there is a duty on employers that employ 20 or more people⁴¹ to make reasonable adjustments to the workplace and working conditions so that disabled people can work. However, not all employers will be aware of this and many people who have mental health problems will not be aware of it either.
- 2.12 The Disability Discrimination Bill⁴², recently issued in draft form, will introduce a general duty on public authorities to remove barriers to disabled people's access to goods, services and employment opportunities. This is very much welcomed. However, if there is to be change in the workplace, people's employment security and protection against discrimination needs to be fully backed in legislation. Without changes to the Disability Discrimination Act to broaden the range of recognised mental illness under the Act, it will remain difficult for people with mental health problems to challenge employers about discrimination at work and recruitment practice⁴³.

A CAB in Avon is helping a client who worked for a large aeronautical company for over 10 years, during which time he had bouts of depression which he felt were not adequately treated. In 1997 he had a year off sick and returned to work part time and then full time. In 2000 he was being badly treated at work and the client's manager was formally warned about this. In 2002 the client's job was changed from engineer to Environmental Health and Safety Officer. The client felt his promotion prospects were compromised and his prospective earnings significantly reduced by this change. After several meetings with the company in 2002, the client was told he was not capable of doing his job and unless they were able to find him an alternative position in two weeks, he would be made redundant under the terms of his contract. He is not a member of a union.

⁴¹ Small firms under 20 people will be subject to the Disability Discrimination Act from October 2004.

⁴² *Draft Disability Discrimination Regulatory Impact Assessment*, December 2003, DWP.

⁴³ See paragraphs 1.8, 1.9 and 1.10 in Chapter 1 for more information.

- 2.13 People will only keep their jobs if the prevailing cultural attitude is tackled and becomes one of support rather than derision so that when people are ill they do not feel misunderstood to the point of having to resign. When people with mental health problems leave work or are dismissed this is usually because of a crisis in their health. They often surrender their jobs rather than risk being sacked because 'following relapse, they totally lose confidence in their ability to continue handling the regular demands of their job, at whatever level'⁴⁴ and there is little or no support from their employer.
- 2.14 Acute phases of some illness can last between three to six months and long periods of absence may be difficult for employers who have to meet targets and need continuity at work. Employers may not understand or sympathise with erratic behaviour, poor time-keeping, recurring absences, lack of concentration and failure to attend meetings to resolve difficulties. Advisers point out that some large employers seem to cope better and can absorb the extra costs of making adjustments more easily than smaller companies.
- 2.15 Citizens Advice welcomes the Government's intention to 'create an environment where health at work is properly managed, effective occupational health support is provided and individuals are appropriately encouraged by employers to stay in, and return to, work when health problems arise'⁴⁵. To do this, employers will need to be fully aware about mental health problems and the difficulties they create for people in the workplace. They need advice and guidance about how they as employers might support people with mental health problems in the work environment.
- 2.16 Recent research⁴⁶ for the anti-stigma campaign *mind out for mental health*, indicates that mental health problems in the workplace are widespread and that most line managers are ill-equipped to deal with them. Citizens Advice welcomes the launch of a free guide for managers, the '*Line Managers' Resource*'⁴⁷ in the hope that this will help employers identify signs of distress, take early action to prevent problems escalating and support employees who are off sick and planning a successful return to work. This document needs wide publicity and circulation. The document could be part of the Department of Trade and Industry's (DTI) '*Work-Life Balance*' campaign to encourage employers to implement policies and practices over and above the legal requirements but it is not clear how it is being promoted and distributed, particularly to small employers.
- 2.17 CAB advisers often quote work itself as a source of stress causing people to leave their job. It undermines people's confidence and stressful

⁴⁴ CAB adviser

⁴⁵ *Pathways to work: Government's response and action plan*, p.18, DWP.

⁴⁶ *Managing Mental Health*, 2003, Ceri Diffley, The Work Foundation.

⁴⁷ *Mind out for mental health, The Line Manager's Resource: a practical guide to managing and supporting mental health in the workplace*, Department of Health, September 2003.

experiences can be a deterrent to seeking work after illness. Research⁴⁸ has indicated that about one in five workers were 'very stressed' by work and this is likely to represent a major potential occupational health problem. The Institute for Public Policy and Research has highlighted the need to prevent mental health problems arising in the first place, as well as supporting people back into work.⁴⁹

A CAB in London helped a client who had worked for over five years for a marketing firm. A new management and work structure was introduced, the client was demoted and told he was not meeting targets. The client disputed this and said the difficulty was really about personality conflicts. The client became more and more stressed and eventually left his job because of mental distress and illness. Part of his treatment for recovery included time in a psychiatric hospital.

2.18 There needs to be wider publicity about the nature of mental illness and the difficulties illness creates for people in the workplace. This should be accompanied by information about the way work itself can contribute to stress and create some mental illness. The National Institute for Mental Health England should work with the Department of Trade and Industry to raise awareness about these issues and back this with support for employers and employees to achieve change in working practices. Such support might include:

- **active promotion and distribution of documents such as *The Line Manager's Resource* with guidance on phasing people into work, flexible working, supervision and support for people when they are ill and for assisting their return to work.**
- **encouraging flexible working by giving employees with mental health problems the same right as parents, to a new right to flexible working⁵⁰, namely:**
 - **to apply to work flexible hours,**
 - **to have their application for such properly considered and responded to and**
 - **for the right of appeal at tribunal.**
- **giving help to some smaller employers to support people with mental health problems such as the subsidies and training grants sometimes given by the DWP in the new deal programmes for the first 6 months of employment.**

⁴⁸ *The Scale of Occupational Stress: the Bristol stress and health at work study*, 2000, A Smith et al, HMSO. The pros and cons of addressing work related stress are explored in *Making it Happen: a guide to delivering mental health promotion*, 2001, Mentality, DH.

⁴⁹ *The missing million: supporting disabled people into work*, 2003, pp 14-15, Stanley, K and S. Regan, IPPR.

⁵⁰ *Flexible Working: the right to request and the duty to consider*, 2003, Department of Trade and Industry.

Conclusions

- 2.19 Roughly 2.5 million of the adult working population suffer from mental health problems at any one time. This is a significant number of people, many of whom are not in employment but want to work. Employers, managers and other employees need to be shown how to support people with mental health problems in the workplace and how to avoid the workplace contributing to or creating mental health problems. Guidance needs to be vigorously promoted and backed with mental health awareness training. Changes need to be made to the Disability Discrimination Act so that employees can feel secure in pursuing their rights when challenging discrimination at work.

3 Benefits – support for going back to work

- 3.1 This chapter outlines what the Government is doing to help people with mental health problems who are on incapacity benefit back into work and the difficulties and concerns people have when they try to make the move into work.
- 3.2 People suffering from mental/behavioural disorders make up 35 per cent of those receiving incapacity benefit and the majority have depression, anxiety or other neuroses with only a small number having more severe conditions. Incapacity benefit already allows people to take on 'permitted work' but CAB advisers report that the rules are not sufficiently flexible to be of real help to many people with mental health problems. The allowance and tax credit systems mean that many people who would return to low paid employment are unable to escape the worst effects of the poverty trap; they are little better off in work than when on benefits.
- 3.3 People with mental health problems have to balance working against the insecurity they associate with employment, such as loss of earnings because of sickness or losing their job. There is also the fear of losing eligibility for benefit if they break a benefit claim.

Linking rules

- 3.4 When work fails, evidence indicates people may not be treated sympathetically by the benefit system, in spite of the linking rule⁵¹ allowing people back onto incapacity benefit. This is a realistic fear based on experience. In practice, people with mental health problems have difficulty getting benefits reinstated. People also fear disability living allowance will stop if they begin work.

A CAB in Yorkshire is helping a young British Bengali woman who has severe mental health problems and is managing with the help of a Community Psychiatric Nurse at the hospital. The client was in work for a month but left because she couldn't manage it. The client was in receipt of income support before taking the work but now the Jobcentre has sanctioned her for giving up the work voluntarily although they are fully aware of her mental health problems.

- 3.5 The Department for Work and Pensions should ensure:
- people considering moving back into work are always and clearly advised about linking rule entitlements and how to secure them,
 - people need not fear the consequences for their benefit income should their move back into work fail

⁵¹ If a person starts work or training, provided they meet certain conditions, a linking rule allows them to return to their incapacity-related benefit at the same rate as before, should they become incapable of work within 52 weeks.

- re-instatement to benefit entitlement under the linking rules is prompt.
- 3.6 People with mental health problems need encouragement at every stage yet, CAB advisers report that when people have joined training courses, it has sometimes been taken as an indication that they are capable of work and they have been recalled to have their benefits re-assessed. Joining and completing training courses as a first step to work should not affect people's entitlement to benefits.

A CAB in Surrey helped a client who has been incapacitated by mental health problems for some time and receives incapacity benefit and disability living allowance (DLA). He is hopeful of returning to work and signed up to a 52 week 'welfare to work' course through the Jobcentre but had to drop out after six weeks because he was not well enough to continue. While on the course he received jobseekers allowance and returned to incapacity benefit when he left the course. The incapacity benefit office notified the DLA office that the client had 'returned to work' which prompted a review of the client's DLA. DLA forms were sent to the client to complete and he didn't understand why and his community support worker was unable to understand the explanation given her by the DLA helpline. The CAB discovered that incorrect information provided by the incapacity benefit office had prompted the forms which were later withdrawn.

Permitted work

- 3.7 For people who cannot return directly to full time work, and this is the case for many people with mental health problems, undertaking permitted work whilst continuing to claim benefits is a route back to employment. Permitted work allows people who receive incapacity benefit or income support on the basis of being incapable of work, to work without losing entitlement to their benefit. The rules and 'in work' benefit entitlements are complicated and clients depend on advice and help to understand and use them⁵².
- 3.8 Citizens Advice believe the principle of allowing people on benefits to work is positive and helpful but that it could be improved. Permitted work rules

⁵² *Welfare Benefits Handbook*, 2002/3, Child Poverty Action Group, CPAG

- for an unlimited period as long as the person does not earn more than £20 per week – '*permitted work lower limit*'.
- for an unlimited period as long as the person is '*supported*' and does not earn more than £72.00 a week. Supported means supervised by someone in a public, voluntary or local authority.
- for up to 26 weeks as long as the work averages less than 16 hours a week and the person does not earn more than £72.00 a week. This can be extended to 52 weeks with evidence that extending the period will help people to undertake full time work – '*permitted work higher limit*'.

are rigid and fail to allow for the many difficulties that can face people and which can tip them over the permitted work allowance.

A CAB in Surrey supported a client getting permitted work through a job-broker project. She worked 13-14 hours a week in a nursing home. One of the client's working days was Monday and several Bank holidays fall on Monday when she and her colleagues were paid time and a half. This tipped her over the earnings limit in the month in question. Her income support was stopped and because her disability living allowance was paid on the same order book, that was effectively stopped too. It took the local DWP office six weeks to give the DLA office the correct dates and the client had no benefit for these weeks. She was also told that she had to make a fresh income support claim because she was not covered by the eight week linking period because the DWP and not the client, had closed the claim. There was no leeway for this client who can negotiate with her employer not to work Mondays or opt to be paid normal rates on Bank Holidays.

- 3.9 Permitted work rules assume that people will move into full or part time work after 52 weeks. After a year, an individual has to take on sufficient work to meet their income needs or reduce their work to something paying less than £20 per week, the permitted work lower limit, perhaps losing out on any progress they have made. CAB advisers say many people with mental health problems need much longer periods of such employment. Making the transition to full time work too quickly unnerves people and creates stress that is likely to undo achievements in getting better. Work placements may then fail making it less likely that a person will eventually move back into work, whereas allowing for a slower process with support in the workplace might be more successful.
- 3.10 Permitted work rules also fail to recognise that some people will never be able to move into full-time work and would benefit from doing a small amount of work on a part time basis indefinitely. The DWP might consider making permitted work rules into transitional arrangements that are not finite and which allow people to earn up to the limit for a two year period after which they could apply for a one year extension at a time. People who can gradually move into full time employment could be allowed to earn above the limit and have their incapacity benefit income tapered to take account of earnings.
- 3.11 Finally, the permitted work rules lock people into returning to work via very low paid work. Thought needs to be given to helping people back to part time skilled work with higher rates of pay.
- 3.12 Citizens Advice recommends the Department for Work and Pensions undertakes a comprehensive review of rules and procedures for the transition from benefits to work. This should be done in co-operation with mental health service users and providers to:**

- **create greater flexibility and simplicity**
- **permit a more gradual transition from benefits to work**

in a system which is sufficiently simple to meet a variety needs.

Tackling financial incentives for work

- 3.13 When they lack skills and work continuity, people with mental health problems are more likely to stay at lower rates of pay without prospects of getting onto higher pay in a year or so. CAB advisers point out that this can influence decisions people make about returning to work as will concerns they may have about coping with discrimination and the risks of work making their illness worse.
- 3.14 The Government recognises that financial incentives for people on incapacity benefit returning to work can be poor and that significant numbers of people would gain only a small amount of extra money. For example only 25 per cent of people on incapacity benefit would be at least £40 a week better off if they moved into work of 30 hours or more a week⁵³. People with mental health problems are more likely to work part time and so less likely to benefit by this amount. These small gains have to be balanced against their concerns about security and returning to benefit should work fail.

A CAB in Sussex described a client with mental health problems working for three hours a week and receiving long term incapacity benefit (IB). She has the chance to take up employment for 13 hours per week but will lose her IB and have reductions in her housing and council tax benefits. She will have a very small increase in income for considerably more hours of work.

- 3.15 The way tax credits and earnings interact with benefits should make it financially worthwhile for people with mental health problems to do as much work as they can comfortably cope with, without putting pressure on people who are not yet able to cope with full time paid employment. However, current arrangements are complicated and do not offer sufficient incentives to overcome the concerns of people with mental health problems. For example:
- people moving into work from income support lose a number of passported benefits such as free prescriptions, other free health provision and free school meals which they need to take into account when making a decision.
 - earnings disregards, the sum of money that is ignored before earnings are deducted from benefit entitlement, are too low to offer

⁵³ *Pathways into Work: Government's response*, 2003, p.16, DWP.

real incentives to people on benefit to take on part time work of less than 16 hours a week.

- working tax credits (WTC) are only open to people working 16 hours or more and CAB advisers describe them as too complicated with many people not meeting the eligibility criteria⁵⁴.

3.16 Because of the way it interacts with housing benefit, WTC offers little practical incentive to people with mental health problems who are on low pay that is unlikely to increase significantly. In such cases, it is virtually impossible to escape the poverty trap created by the fact that any gain in WTC is counted as income and therefore 'clawed back' by a reduction of housing benefit and council tax benefit.

A client with long term mental health problems (a schizo-affective disorder) and living on income support and disability living allowance was completing a computer course and considering returning to work. She came to a CAB in Middlesex for advice about her likely income if she worked part time and if she worked full time. She had previously been paid £5 an hour at work, so this figure was used to estimate her disposable income, following benefit adjustments for housing and council tax. Her disposable income when out of work and living on benefits is £108.25 per week. If she worked part time, she would have £126.26 disposable income per week. If she worked full time, she would receive WTC but would have only £25.00 more income, £154.06 disposable income per week. Working full-time she would also no longer be eligible for free prescriptions and she would have bigger expenses for travel and food.

3.17 More needs to be done to help people who are ill for a long time and unlikely to qualify for WTC. Substantial numbers of people cannot consider full-time work because of the variability of their condition but they could perhaps manage 12-15 hours a week. A possible course would be for the Government to consult with user groups about how the hours' threshold for Working Tax Credit could be reduced to below 16 hours per week for disabled people.

3.18 As part of a comprehensive review of the benefit system, the DWP should review earnings disregards and tax credits to create a simpler system that makes it more financially worthwhile for people with mental health problems to do as much work as they can.

⁵⁴ working for 16 hours or more; having a physical or mental disability which puts people at a disadvantage in getting a job (this means passing a disability test); receiving a qualifying benefit such as higher rate short term Incapacity Benefit, long term incapacity benefit or Severe Disability Allowance or if entitled to claim under a fast track procedure.

Unpaid work

- 3.19 Work has its own value and ‘if you are recovering from illness, it is not only paid work that is important, it is a meaningful occupation, something worthwhile to do that is valued’.⁵⁵ When people undertake voluntary work it is sometimes interpreted as indicating they are capable of work and therefore not entitled to benefit. One adviser reported that even when doing the right thing, taking advice from a GP and notifying the DWP of voluntary work to be undertaken, a client had been called to an interview ‘under caution’ with threats of criminal prosecution. This can be totally unnerving to anyone. People with mental health problems should be allowed to undertake voluntary work without risk that this may affect their entitlement to benefits.
- 3.20 A survey of volunteering by people with mental health problems found that the overwhelming majority of respondents said that volunteering had been a positive experience and helped them to develop confidence and self-esteem, social networks and friends, skills that were useful in gaining employment and a sense of purpose after a period of difficulty in life⁵⁶.
- 3.21 Citizens Advice experience is that volunteering can be a useful means of bridging the gap between benefits and work. For example, Sheffield Mental Health Citizens Advice Bureau and Advocacy Service is an example of a service that actively recruits mental health service users and ex mental health service users to work both as volunteers and paid staff. Similarly, Debt Advice Within Northumberland works closely with a local user group, Northumberland Voice, to train and use mental health service users as volunteers. They give financial literacy support in a CAB context to clients with mental health problems. Supported by paid workers, these volunteers also develop and deliver workshops on money management and give sessions to advice and health care workers on how to support people with mental health problems.

Pilot schemes to help people back to work

- 3.22 Work remains the best option for helping many people out of social exclusion and the Government is piloting a number of schemes around the country to help more people on incapacity benefit back to work. It is for people with less severe illness that the Government believes ‘the prospects of an eventual return to work, with the right forms of support, should be good’ and to whom the following pilot changes are mostly directed⁵⁷:
- *work-focused interviews* – at which clients receive specialised help to find work. Failure to attend can lead to a reduction in benefits

⁵⁵ CAB adviser.

⁵⁶ *Volunteering for Mental Health*, 2002, Sherry Clark, The National Centre for Volunteering.

⁵⁷ for all new incapacity benefit claimants in a number of Jobcentre Plus areas from October 2003 until April 2006. *Pathways to work: the Government’s response*, June 2003 p. 12, Cm 5830, DWP.

- *Personal Advisers* will conduct work focused interviews to draw up a voluntary *action plan* to consider how and when people might return to work, the kind of work and the programmes available to help. They will assist with benefits and offer *in-work support* to clients who move back to work
- *rehabilitative support*, delivered through the NHS will help people manage their condition⁵⁸.

3.23 The Government acknowledges⁵⁹ that people with mental health problems will often have the greatest difficulty returning to and seeking work. Citizens Advice welcomes the extra support for people in these schemes but is concerned about how some of the proposals may affect people with mental health problems. Citizens Advice believe that proposed support may not go far enough and recent CAB evidence suggests work-focused interviews may intimidate people.

Work focused interviews

3.24 People with ‘a severe mental illness’⁶⁰ are exempt from work focused interviews. However, these interviews are likely to create substantial difficulties for people with less severe mental health problems. CABx advisers say that, when they are unwell, clients with mental health problems have trouble travelling distances, tend to be withdrawn, afraid of meeting strangers, wary of contacts and don’t expose themselves to situations, such as an interview, that could highlight their problems with communication and concentration. They sometimes do not open post, find it difficult to keep to deadlines and may be unable to attend interviews on the appointed day. It may be difficult for them to cope with compulsory attendance at an interview and to grasp the difference between having to draw up an action plan and the voluntary option of fulfilling the listed activities in that action plan.

3.25 People who fail to attend work focused interviews will face a reduction in their benefit. There are safeguards to ensure that clients ‘with a stated mental health problem’ are not sanctioned when they are unable to comply but these do not appear to be enshrined in the regulations⁶¹. Jobcentre personal advisers applying sanctions and safeguards will have a lot of discretion over the income of incapacity benefit recipients. This is of concern in a climate of much misunderstanding and stigma associated with mental illness and highlights the importance of appropriate training. Should safeguards not be operated properly, there is no comeback for clients.

⁵⁸ people with non-severe mental health problems, cardiovascular and musculo-skeletal conditions. *Pathways to work: the Government’s response*, June 2003, DWP.

⁵⁹ Para. 27, *The Social Security (incapacity benefit work-focused interviews) Regulations*, 2003, Explanatory Memorandum to the Social Security Advisory Committee, DWP

⁶⁰ as defined in *A Guide to incapacity benefit – the personal capability assessment*, IB214, DWP

⁶¹ *Social Security (incapacity benefit work-focused interviews) Regulations*, 2003, Explanatory Memorandum to the Social Security Advisory Committee, DWP

A CAB in Wales are helping a client in a pilot area with mental health problems who has been in receipt of incapacity benefit (IB) and disability living allowance for several years, so is not a new recipient of IB. The client has been entitled to but not received, income support (IS) for two years. The bureau requested an IS form from the Jobcentre and were told it would only be issued on the understanding that the man attend the Jobcentre for a work focused interview. The CAB explained that the client would find it extremely stressful to attend but the Jobcentre insisted he do so.

A CAB Yorkshire is advising a Somali mother of four children aged between 5 – 11 years. She is unable to read or speak English, is diagnosed with schizophrenia and depression, relies on income support and lives in local authority accommodation. Her personal allowance has been reduced by 20 per cent because she did not attend a mandatory work focused interview after three written interview invitations. The client is unable to deal with her personal affairs and correspondence; she does not open letters. She is being penalised for her inability to comply. Despite the existence of discretion, the CAB was told no home visits would be made.

A CAB in Derbyshire helped a client who had been off work for six months with mental health problems. The client came to the bureau following a telephone call from Jobcentre Plus to arrange for an interview with his Personal Adviser in town, saying he felt pressurised into agreeing. He suffered from anxiety, panic attacks and phobia of visiting the town. The CAB telephoned the Jobcentre to try and arrange for another venue but was told by the supervisor that this was not possible. The CAB arranged to send a representative to accompany the client.

- 3.26 Benefit sanctions may only serve to confirm for people with mental health problems that their illness is not understood by the agencies that profess to be helping them and add to their difficulties of coping on a low income. The Department for Work and Pensions needs to recognise the stress that work focused interviews can cause. The advice of a GP or other mental health professional should be sought and interviews made discretionary. Sanctions should be waived for those people with mental health problems who are not currently exempt.

The role of Jobcentre Personal Advisers

- 3.27 Citizens Advice particularly welcomes the extra in-work support for clients in the pilot schemes who successfully manage the transition back to work. Many CAB advisers have noted that support which people are accustomed to is frequently withdrawn too soon, as people take up a place on a training course or find work and so undermines the prospect of a successful transition.

- 3.28 However, it is not clear whether personal advisers will give the right kind of support to people with mental health problems. CAB advisers point out that these clients need practical help finding appropriate work, help coping with changes to their benefit entitlements as well as help from prospective employers.
- 3.29 If these various support mechanisms are to work, the Department for Work and Pensions needs to ensure there is formal and ongoing liaison between all the agencies and employers that support people prior to, during and following a move into work and that personal advisers are appropriately trained to work with people with mental health problems.

Financial changes in pilot schemes

- 3.30 Citizens Advice very much welcome the additional financial help that will be offered to people in the pilot schemes including:
- immediate access to the Adviser Discretion Fund for help up to a sum of £300 with items to facilitate a return to work;
 - a new Return to Work Credit (payable for 52 weeks to anyone leaving incapacity benefit for paid work of at least 16 hours a week) which will be disregarded for tax, national insurance, housing benefit and council tax benefit purposes;
 - extension of the four week housing benefit run on to cover people in receipt of incapacity benefit from April 2004⁶².
- 3.31 Low benefit income means people with mental health problems usually have no spare funds to cushion themselves through the transition back to work and the gap between benefits ending, which are paid on a weekly basis, and work pay starting, usually on a monthly basis. The piloted Adviser Discretion Fund, will help with travel costs and buying clothes but it will not help address the difficult interim period between benefit payment and employment income. Similarly, the Return to Work credit, which adds to the complexity of arrangements, does not help people who need help to cover the transitional period from benefits to employment income, which a run-on of benefit would achieve. Furthermore, it offers no benefit to people who continue working beyond 52 weeks and who have little prospect of higher rates of pay because they lack training and skills, which may be the case for many people with mental health problems.
- 3.32 Citizens Advice recommends that the Department of Work and Pensions should consider maintaining incapacity benefit payment for people with mental health problems for a month during their move back into work.**

⁶² *Pathways to Work: Government response*, 2003, DWP.

Conclusions

- 3.33 The changes encompassed within the pilot schemes do not address permitted work arrangements and the interaction between income and benefits both of which create difficulties for people with mental health problems who try to move back into work. People with mental health problems need greater security and more gradual and flexible procedures to help them back into work which are backed by arrangements that mean extra work always pays.
- 3.34 It is important to help people back into work but not at the cost of their failing in work. People with mental health problems need both financial and practical help to manage the change. Practical help means assistance with finding appropriate work, help with the transition from benefits, and the knowledge that, should it all fail people can return to their former benefit entitlement. To achieve this, careful and detailed collaboration between helping agencies is needed throughout the process so that people do not feel quickly abandoned by the services upon which they have come to depend.
- 3.35 To achieve this there should be a comprehensive review of the benefit support for helping people with mental health problems back to work which should be part of a major review of the benefit system.**

4 Barriers to claiming benefits and disability benefits

- 4.1 The benefit system exists to provide people with financial support when they are unable to support themselves. It should provide security so that people with mental health problems can live their lives with as little stress as possible and as much support as they need during recovery.
- 4.2 This chapter outlines the most common difficulties people with mental health problems experience when engaging with all parts of the benefit system and then looks specifically at the problems people have claiming disability and incapacity benefits.
- 4.3 The catalogue of difficulties experienced by people with mental health problems calls for a thorough and all embracing review by the Department of Work and Pensions (DWP) of every part of the benefit system. The review should examine the effects and outcomes of the benefit system for people with mental health problems so that appropriate changes can be made to reduce social exclusion.

A complex system

- 4.4 The complexity of the benefit system highlights the need for people with mental health problems to know about their entitlements and the services available to them so that they can feel as secure as possible. This work is often provided by generalist CABx and specialist CAB projects and by many other voluntary organisations.
- 4.5 CAB advisers helped people with over 1.8 million benefit and tax credit problems in 2002/03. The most common difficulties for applicants were complex forms, administrative issues and delays. Even clients who are well can find the tasks and processes associated with successfully claiming benefit challenging⁶³. It can be considerably more difficult for people with mental health problems and benefit issues form the bulk of CAB work with this group.
- 4.6 People with mental health problems' experience of the benefit system is often negative because:
- the forms that have to be completed to claim disability benefits do not recognise their illness in the same way that physical illness is recognised
 - frequent changes in benefit status, form filling and delays in processing lead to breaks in income which create insecurity and possible debt
 - if they cannot understand the application forms, it undermines their ability to manage their affairs.

⁶³ *Riding the Benefits Roller-coaster: CAB clients' experiences of claiming sickness and disability benefits*, December 2003, Citizens Advice Scotland.

- 4.7 The stress caused when claiming benefits and challenging decisions are often described as a contributory factor in making people's health worse. This undermines their confidence and their capacity to manage. One client had his income support suspended as fraudulent simply because he stuck airmail stickers on the envelope. In another instance, the DWP was requested not to send a copy of a disability living allowance (DLA) application to a client suffering from paranoia and schizophrenia for the client's own protection; the agency nevertheless did so, aggravating his condition.
- 4.8 People have been discharged from hospital with no guidance about benefit entitlements, some have lost their job and some have lost a benefit and have to reapply for it. They depend on the help of others when they cannot cope.

Poor service

- 4.9 Poor administration and poor co-ordination, in and between departments in the DWP when dealing with clients benefit applications creates considerable difficulties for people. CAB advisers describe long telephone waits, lost forms, lost evidence (even when registered post is used), forms waiting for months to be processed, summonses for medicals sent to the wrong address, failure to reply to clients' representatives and appointees and losing 'DLA for life' files. All this leads to loss of income and delays (in one case reported by a CAB, there was a seven month delay in paying DLA to a client following award at appeal) which contribute to stress that frequently makes people's symptoms worse.
- 4.10 When they are unwell, people with mental health problems can experience withdrawal and have problems with communication. They may fail to report changes in circumstances, fail to respond to post or not even open post. Some people are so disturbed they will not claim, or will not give evidence for a claim and when presented with questions, have run away. They may not have the focus to pursue their entitlements, for example asking doctors for sick notes or employers for wage slips and they forgo backdating their claim. Advisers have described some clients as easily agitated by small difficulties, leading them to panic and overdose. People, who for whatever reason, fail to co-operate with set procedures have had their benefits stopped.
- 4.11 When the administration of the benefit system is falling down, people with mental health problems are unlikely to be able to pursue the details of their claims and can be left with no income.

A CAB in Wiltshire described a client who failed his personal capability assessment and incapacity benefit was stopped. The client appealed this decision and submitted medical certificates to the DWP who initially denied receiving them, announced them lost and eventually found them. The certificates were with the incapacity

benefit section but had not been recorded nor passed onto the income support section. The client's health suffered considerably during this period. He eventually won his incapacity benefit appeal with backdated benefits.

A CAB in Sussex described a client who returned his pension book to the DWP, with one un-cashed payment still in it, so that income support could be added. The book was not returned and because of his mental health problems, the client failed to realise this or that he had no pension coming in. He lived off his small building society savings and came to the bureau when down to his last £2. The DWP acknowledged their mistake and immediately rectified the situation which had arisen because a case control should have been entered on the computer system to remind staff that further action was required.

A CAB in Oxfordshire helped a client with mental health problems living on incapacity benefit. He found a few hours of work to do a week and the bureau wrote to the DWP at the beginning of October with a note from the client's GP. There was no response and a further letter was sent with a copy of the original. At the end of October a questionnaire was sent to the client with questions that had been answered in the letter. This was returned at the beginning of November. Because there was no reply, the CAB rang the DWP who had no record of the letters and said to ring another day when the staff who were dealing with it would be in. The GP also needed to complete a questionnaire. After the long-winded cumbersome system was completed, the job was gone.

- 4.12 Jobcentre Plus staff can be very helpful. However, they have also been described by advisers as giving inappropriate or wrong advice (for example about the Social Fund and permitted work rules), giving out the wrong forms, failing to advise or assist with applications and even sometimes being abusive. Clients with depression who cannot read or write have been sent away without help. One office wanted medical evidence that a client could not understand a form before giving them help. Advisers describe a general lack of awareness and inflexibility among Jobcentre Plus staff when assisting people with mental health problems.
- 4.13 People's illness can sometimes make working with them quite difficult challenging but the consequences of loss of engagement can be devastating for the individual.

A CAB in Merseyside helped a client with a history of mental health problems and who receives incapacity benefit and income support (including mortgage interest payments). The client has had no money for six months because of his challenging behaviour and inability to co-operate with the DWP. He has cashed in an

endowment policy to live on but has now received a possession claim because no mortgage interest has been paid for 6 months.

- 4.14 CAB advisers have also drawn attention to the difficulties facing clients who have been banned from the offices of statutory agencies. Open plan offices, lack of privacy, crowds and long waits can present very real difficulties for people who are vulnerable to emotional or mental difficulties and who on occasion exhibit challenging behaviour. Clients sometimes go without money rather than subject themselves to this, a lack of privacy deters people when they have to talk about their illness. Jobcentre Plus have failed to make adjustments even when forewarned of a vulnerable client.

A CAB in Hampshire helped a woman with mental health problems who lived of income support and disability premium. She attended a pre-arranged interview at Jobcentre Plus with her caseworker. The Jobcentre had been pre-warned that she was a vulnerable client but they made no preparations and moved the client around from counter to counter and from staff to staff. The client became increasingly agitated, eventually sweating, dribbling, crying and lying on the floor.

- 4.15 Ways need to be found to address these difficulties rather than excluding people. Some Jobcentre Plus offices have enquiry bells for people to draw attention to their needs but they are not generally known about. One client didn't see the notice about the bell because she was so focused on 'controlling her feelings of anxiety and panic'⁶⁴.

- 4.16 The way forward for all organisations and in this case for the Department of Work and Pensions and its agencies must be to make mental health awareness and training about the problems it creates for people who are unwell a central requirement for all staff, especially those working directly with clients.** In this context, Jobcentre Plus should review reception procedures for vulnerable people so that clients who may have extreme difficulties are not simply banned from premises.

Rural areas

- 4.17 People living in rural areas can be placed at a unique disadvantage accessing specialist help, Jobcentre Plus or community services. Travelling distances presents difficulties because of the lack of transport, its intermittent nature and costs.

A CAB in Hampshire advised a client who was living rough in a shed on National Trust land and had been signed off sick with depression. He made a successful claim for income support but had to travel to the DWP every 2 weeks to collect his benefit because he was of 'no fixed abode'. There is no public transport going directly to or near

⁶⁴ CAB adviser

the DWP that is 8 miles from the CAB and about 11 miles from the client's home. Anyway, the client had no money to pay the fare and an adviser from the CAB eventually took him to the DWP to discuss the problem. They admitted that they had a number of claimants who were having difficulty getting to their office.

A single man with mental health problems living in a council flat in an isolated village sought advice from a CAB in Cheshire. His disability living allowance claim had been turned down and he lived on incapacity benefit. Without care and dependent on friends to take him shopping or to GP appointments in the nearby town, his limited income particularly affected his ability to travel and conduct any kind of social life. He missed several medical appointments when he ran out of money. His GP does not book medical appointments in advance so he has to take a chance that his GP is available on the days his benefit is paid and that he has the money to go to town. He failed to attend a recent medical examination in connection with his benefit claim because he could not afford to travel. His community psychiatric nurse (CPN) established that he was ineligible for local transport concessions.

- 4.18 The difficulty clients may have attending appeals is being helped with initiatives such as video conferencing that is being successfully experimented with in the Wirral between Bebington CAB and the Appeals Service. But so far, such projects are fairly limited in impact. As part of its rationalisation programme, Jobcentre Plus is closing Jobcentres in smaller towns and concentrating the administration of the Social Fund into fewer offices. There are often inadequate local facilities for emergency help and people are required to travel considerable distances (on low income) to make application for crisis loans, especially in rural areas.

A CAB in Devon helped a client who was bulimic and agoraphobic and had been dismissed from her job. The client had no money until her first income support payment arrived but she was unable to get a crisis loan because she was mentally unfit to cope with the journey across country to the town.

- 4.19 As part of the broad review of how services are experienced by people with mental health problems which we advocate the DWP undertake, **Jobcentre Plus needs to address the important question of accessibility for claimants who have difficulty travelling because of their illness and/or who live in rural areas. Jobcentre Plus should report annually to the DWP what steps it is taking to tackle this difficulty and how successful they are.**
- 4.20 Clients being interviewed can ask to be examined in their own home if they are too ill to get to the Medical Examination Centre and will need to ask their GP to indicate they are unable to travel. However, doing this doesn't guarantee them a home visit. Some people have been required

to travel as far as 60 miles for assessments. Long distance travel is a particular problem in rural areas, especially for people who are insecure or agoraphobic.

A CAB in mid Wales reported that a woman with obsessive compulsive disorder was forced to travel to a hospital in Aberystwyth rather than go to the local hospital which is 4 miles away. This entailed a 90 mile round-trip for a DWP medical service examination in connection with her claim for incapacity benefit and income support. When this was queried, DWP Medical Services said that although they do have a room available at the client's local hospital every six to eight weeks, they have a schedule of appointments which means the client must go to Aberystwyth. The Medical Service said they will reimburse the client if she uses a 'country cab' but the client would have to pay the cab and then wait two to three weeks to get her money back.

- 4.21 In 2000 the House of Commons Select Committee⁶⁵ called for Medical Services⁶⁶ to take action to reduce distress to claimants and attend to customer care. **Medical Services should report annually to the DWP about how it is addressing the difficulties faced by people with mental health problems in rural areas. Medical Services are responsible for making clear to people who are being examined that they can be accompanied to medical examinations and that they can claim travel expenses for themselves and their companion. Arrangements should be made so that clients are able to use this service.**

Direct payment of benefits

- 4.22 A further difficulty that is becoming apparent is with direct payment of benefits into a bank or similar account which the Government began in April 2003 and is to be completed by 2005. People with mental health problems sometimes have great difficulty using cards and remembering pin numbers. People with memory problems are not able to cope with payment into any sort of account and those who are currently dependent on a third party for help may need to make other arrangements.

A CAB in Hertfordshire reported that a man suffering from mental health problems sought advice about the difficulties he was having accessing his benefit at the Post Office now it was paid into an account. He told the CAB he found it difficult to remember his PIN and kept forgetting where he put his card.

A CAB in Northern Ireland reported that the manager of a housing association which caters primarily for adults with learning needs and

⁶⁵ *Report on Medical Services*, Chapter iv, Session 1999/2000, House of Commons 183, Cm 4780, Reply by the Government to the Third Report of the Select Committee on Social Security, DSS.

⁶⁶ The DEP has contracted a private company, Atos Origin, formerly known as Schlumberger Sema, to provide a medical service for benefit purposes.

other vulnerable people, wanted to know how the tenants would be able to cope when their benefits were paid into accounts. Currently he was the appointee for all the residents and cashed their order books for them every week. However, many of the residents had received letters from the Northern Ireland Social Security Agency (NISSA) urging them to open an account for their benefit. The manager was concerned that as all the residents were vulnerable, they were not able to manage their financial affairs. He told the CAB he had not been consulted during the payment modernisation process and was unaware what steps could be taken to protect vulnerable people who were tenants and residents of the association.

A CAB in Cornwall was consulted by a 52 year old man on behalf of himself and his brothers. They lived with their parents and all had mental and physical disabilities. The client told the CAB that he and his brothers felt they would find it difficult to manage if their benefits were paid into accounts of any kind. They could not remember PIN numbers, write cheques, request amounts of money or know how much they had in their account. They had come to the CAB because they had received an unsolicited phone call from the Jobcentre Plus Direct Payments Centre asking to speak to them.

- 4.23 The DWP has always recognised that there will be a need for an alternative payment option for immediate payments and for those who cannot cope with any sort of account. They have begun to consult informally on the details of the Exceptions Service, as the alternative payment system will be called. So far the DWP have stated that the service will be very much a last resort where the claimant could not manage any kind of account and that the service is likely to be cheque-based⁶⁷. However, there is little information available to benefit claimants about the Exceptions Service and how to request to be paid this way.
- 4.24 The Disability and Carers Service of the DWP needs to work with the Exceptions Service to address further the particular needs of vulnerable people such as those with memory problems or people who are dependent on the help of a third party to manage their affairs, when accessing their benefits. In particular, these people need to know about and have easy access to the proposed Exceptions Service.

Claiming incapacity and disability benefits

- 4.25 Among all disabled groups, people with mental health problems are most likely to be unemployed. A government survey⁶⁸ showed that 71% of those giving mental health problems as their main disability receive state benefits. Incapacity benefit and disability living allowance help people

⁶⁷ *People, Pensions and Post Offices*, July 2003, Trade and Industry Select Committee Report, Department of Trade and Industry.

⁶⁸ *Labour Force Survey*, Autumn 1999, National Statistics.

when they cannot work and when their disability hampers their managing to look after themselves on a daily basis. People suffering from mental health problems constitute 35 per cent of those on incapacity benefit and the majority of this group have depression, anxiety or other neuroses with only a small number having more severe conditions.

- 4.26 The first 28 weeks of incapacity are assessed under the 'own occupation test' which looks at a person's ability to do their usual job and is based on medical certificates from a GP. After this time, the personal capability assessment (PCA) applies which involves completing an incapacity questionnaire (IB50) that assesses ability to do any work.

Application forms

- 4.27 The complexity of these benefit application forms is the first difficulty for people with mental health problems. The National Audit Office has noted that 'filling in forms is one of the most frequent ways that they (citizens) interact with departments and agencies. Forms are therefore crucial in shaping citizens' perceptions of public services.' Well designed and easy to handle forms would lead to fewer errors, better access, greater efficiency and targeting better-designed forms at specific groups of people should mean shorter forms⁶⁹.
- 4.28 Not only are forms difficult to understand and complete, advisers describe what amounts to 'institutional bias' against clients with mental health problems in the incapacity benefit questionnaire which does not establish information about fluctuating conditions. The DWP uses a system that allocates points to certain activities and tasks, with 10 points needed to determine a person's eligibility on grounds of mental incapacity. Mental health descriptors are not itemised in the same detail as physical descriptors and a client is therefore less likely to answer in the way most helpful to a successful outcome in their case⁷⁰.

A client with mental health problems did not know where to start with his incapacity benefit and disability living allowance forms. He was referred by his Community Psychiatric Nurse to a CAB in North Wales for help.

A bureau in London describes a client who was sent the personal capability form to complete. He did so, failed the test and incapacity benefit was stopped. He suffers from anxiety and depression and

⁶⁹ *Difficult Forms: How government agencies interact with citizens*, 2003, National Audit Office, Stationery Office

⁷⁰ For example, after 10 pages of detailed questions about physical needs, the IB50's questions on mental illness ask whether treatment is being received, the date of a client's last appointment and then to 'tell us about any problems you have with your nerves or any other mental health condition and the type of treatment you receive. Include things like problems you have with normal day-to-day activities because of your mental health condition and problems you have dealing with other people'. IB50 questionnaire, p.16

found the exercise very stressful. He was assisted in appeal with representation and had his claim re-instated.

A CAB in London is helping a client who applied for incapacity benefit because of mental illness. He asked staff at the Jobcentre to help him because he had trouble understanding the form. No one would. A friend finally helped him and he supplied the documents requested. He was later asked for further proof of his illness, then the form was returned to him to complete one line. The delay has put him in debt.

- 4.29 Mental health problems can be difficult for a person to describe at the best of times; it is unlikely they will describe their condition with clarity in relation to the current descriptors used. Some clients also do not understand the significance of calling on medical evidence to support their application. When clients are helped, they are better able to describe their condition.

A CAB in Berkshire helped a client who in receipt of incapacity benefit and income support for many years. On renewal of his application he was deemed capable of work. A revision confirmed the decision and the client then came to the CAB who helped with his appeal. A letter from the client's psychiatrist shows the client has long-term mental health problems. However, the cut in his benefit income and worry about the appeal led to a relapse of his condition and his being admitted to hospital under Section 2 of the Mental Health Act.

- 4.30 Citizens Advice recommends that the incapacity benefit questionnaire (IB50) should be redesigned to ask specific questions on mental health problems.**

Medical examinations

- 4.31 People are not found to be capable of work and denied incapacity benefit simply on the basis of their answers on the IB50 form. They will always be offered a medical examination with a chance to talk to the doctor in person about how their condition affects them.
- 4.32 In 2003, nearly 48 per cent of appeals by all claimants against incapacity benefit (PCA) decisions were successful⁷¹. The failure of so many cases that are later found to have good ground is not acceptable and throws doubt on the quality of all assessments. For clients with mental health problems, Citizens Advice believe this happens partly because some medical services⁷² doctors display a poor understanding of the difficulties

⁷¹ *Quarterly Appeal Tribunal Statistics*, June 2003, DWP. For all claimants.

⁷² The DWP has contracted a private company, Atos Origin, formerly known as Schlumberger Sema, to provide a medical service for benefit purposes.

faced by people, how these difficulties bear on people's ability to work⁷³ and the fragility of their mental state.

A central England CAB described a client who was on incapacity benefit because of a nervous breakdown. He was suffering from depression that was being treated by his GP, a psychologist and a psychiatrist. All three professionals recommended that the client should not return to work but incapacity benefit ceased following a personal capability assessment at which the client was awarded 9 points out of a possible 10. It was a brief interview which the client, who was fragile, found patronising, offensive and humiliating because he was not listened to.

A bureau in Cleveland described a client with severe depression, compulsive disorder and displaying suicidal behaviour who received a personal capability assessment examination less than 10 months after being deemed exempt from the test for 3 years. A physical examination was carried out which lasted less than 10 minutes and was made worse by the manner and comments made by the doctor who conducted the examination. An appeal is pending.

4.33 Citizens Advice evidence is that the problems clients face with personal capability assessments conducted by Medical Services fall into the following areas:⁷⁴

- doctors not listening to clients
- poor recording of clinical findings
- incorrect assumptions based on information from the client and from the medical examination
- effects of mental illness not appropriately taken into account
- difficulties in arranging home visits for some clients.

4.34 The House of Commons Select Committee on Social Security has highlighted the importance of improved training on mental health issues for Medical Services doctors who conduct PCAs⁷⁵. **Citizens Advice believes regular training should be a priority for medical services.** The Select Committee has also recommended the DWP's Chief Medical Adviser should instigate a full review of the Medical Services' treatment of claimants with mental health problems. The Government's response in 2000⁷⁶ was that such a review would delay work that was being undertaken to improve services and was not needed at that time. **Citizens Advice believe that such a review should be instigated**

⁷³ *Response by Citizens Advice*, July 2003 to Consultation by Social Security Advisory Committee on the Draft Social Security (incapacity benefit Work-Focused Interviews) Regulations 2003

⁷⁴ *Response by Citizens Advice*, February 2003 to Pathways to Work: Helping People into Employment

⁷⁵ *Medical Services*, 1999/2000, Third Report, Chapter IV, House of Commons Select Committee on Social Security.

⁷⁶ *Report on Medical Services*, Reply by the Government to the Third Report of the Select Committee on Social Security, Session 1999-2000 (HC 183) Cm4780, DSS.

without delay to assess the impact of changes and in particular how the outcome of services affect people with mental health problems. The DWP should develop a system for monitoring the quality of all reports on mental health issues by doctors working for Medical Services.

Constant scrutiny and instability

- 4.35 Too often it seems as if “people are in a constant trail of revisions, appeals and renewals”⁷⁷. This is particularly stressful for people with mental health problems. Clients are often under constant scrutiny because of the frequency with which they are faced with medical examinations and renewal applications for their incapacity and disability benefits. Disability living allowance (DLA) can be awarded for fixed periods or indefinitely and the DLA award will indicate how long the award is for⁷⁸. For incapacity benefit, a medical services doctor suggests a date when incapacity for work should be considered again. Even when a person’s illness does not change they are nevertheless subjected to regular reviews to avoid fraud. For example, following a failed PCA, an appeal may take 9 – 12 months. The next renewal claim form is then often sent to the client within three months of the appeal decision, possibly triggering the entire process again.

A CAB in Middlesex described a single Kenyan woman aged 45 with physical and mental health problems. The client has suffered from depression and post traumatic stress disorder since the assassination of her father in front of her in Kenya in 1994 and the death of two other close family members. Following a PCA, her incapacity benefit claim was rejected and she received 80% income support pending appeal. The appeal was heard and incapacity benefit reinstated. She contacted the CAB for help completing a new IB50 form 7 months later. The whole process may be repeated.

A bureau in Wales described a claimant aged 52 with long standing mental health problems including anxiety and obsessive-compulsive disorder being asked to complete an IB50 form every year in spite of his chronic condition where no change was expected. There is no exemption and the stress and anxiety caused for a person with long standing mental health problems is considerable.

- 4.36 This constant scrutiny results in significant breaks and fluctuations in income and puts people under inordinate stress. Such difficulties increase people’s feelings of not being understood, undermines their confidence in the assessment process and increases nervousness about future assessments.

⁷⁷ CAB adviser

⁷⁸ The common fixed period for DLA is two or three years.

4.37 To help reduce the degree to which people's condition is aggravated by constant re-assessment, Citizens Advice believes there should be:

- **no call for re-assessment within an award period for incapacity benefit or disability living allowance**
- **no further assessment of disability living allowance or incapacity benefit within 12 months of an appeal decision.**

Appeals evidence

4.38 The success of an application or appeal for incapacity benefit or DLA frequently depends on the input of a GP, community psychiatric nurse (CPN) or psychiatrist but the importance of their evidence is not always appreciated by the professionals supplying evidence nor given appropriate attention by decision makers. Health professionals may also not appreciate the difference that security of income can make to a client's sense of well being and inclusion in society. They often do not understand the significance of time limits for appeals and the consequences for clients if these are missed. To be useful, their informed view needs to be related to the criteria used by the appeal process.

A CAB in the Midlands helped a woman with paranoid delusional disorder who was living on benefits. The client's DLA was being reviewed and the client approached her psychiatric consultant to provide evidence on her behalf but was told that evidence would only be supplied on payment of £100.

4.39 The National Audit Office has stated that 'ensuring good quality medical evidence is an essential part of assessing eligibility for these benefits'⁷⁹. Claimants with mental health problems do not always understand the significance of professional input to their application for benefit. Unless they are advised about this and have help, they are therefore likely to be at a disadvantage. Clients often have great difficulty explaining their condition and needs. The DWP should seek the most appropriate advice on a client's illness. Yet, on occasions, decision makers are said by advisers to have ignored reports from the CPN or the psychiatrist and asked the GP, whom the client has not seen as frequently, for a factual report and as a result, DLA has been denied. Sometimes the psychiatric report has been 'overlooked'.

4.40 People who have more frequent contact with clients, such as care workers and CPNs, are often in a better position to answer questions about how that person copes with daily living and to comment on the intermittent nature of a condition. In the following case the Medical

⁷⁹ *Progress in improving the medical assessment of incapacity and disability benefits*, 2003, National Audit Office.

Services' doctor's report was contradictory to advice from other professionals who knew the client's needs better.

A CAB in Warwickshire is helping a client with schizophrenia who receives disability living allowance. His mother is his appointee and this was clearly noted on his review pack with a request not to write to the client but to his appointee. The review decided to reduce the client's DLA without contacting his psychiatrist – whom he sees on a monthly basis – or his psychiatric nurse whom he sees regularly. A decision to reduce DLA was made on the basis that the client's medication had been reduced, although in fact it had not; it had been changed to injections and this information was in the review pack. Notification of reduced DLA was sent to the client and not his appointee and caused him great agitation and concern about debt.

4.41 The impact on a client when the decision is not made on the basis of all the evidence available can be catastrophic.

A bureau in Yorkshire described a client with a long history of physical and mental health problems including self harm. Her award for DLA which she used to pay for daily help, was reduced from higher rate care and higher rate mobility to lower rate care and lower rate mobility as a result of the medical services doctor's report. The client requested a revision with the assistance of the bureau adviser who in mid May asked for the revision not to go ahead until supporting information was received. This information was sent at the end of May. A decision was made at the beginning of June without regard to the new information and without following the usual procedure of warning the representative that they were about to make the decision. It was decided not to amend the rate of benefit. The bureau was informed by the client's partner that the client committed suicide as a direct result.

4.42 Medical Services should:

- **ensure that doctors carrying out assessments take sufficient time to deal with complex cases appropriately**
- **instigate checks to review whether this is being done and report to the DWP on this annually.**

4.43 Citizens Advice believes that as part of an overall review of services, the Department for Work and Pension needs to ensure:

- **there is appropriate training on mental health issues for all those involved in making decisions on applications and for members of independent appeals tribunals**
- **all evidence that is relevant to a PCA is considered in applications. This should include information from community psychiatric nurses, care workers and**

psychiatrists, equally with the reports of medical services doctors.

4.44 Professionals who work with people with mental health problems should be made fully aware about:

- **the importance of a secure income to the health of people with mental health problems**
- **their role in contributing relevant and timely evidence in securing this income.**

Refusals and client's difficulties

4.45 When people with mental health problems appeal a decision, the system makes it difficult for them to manage with daily living, contributing to their sense of exclusion. Pending a PCA appeal, they are entitled to only reduced income support and the lower income creates practical difficulties that increase the likelihood of debt. For people who have been in receipt of incapacity benefit for more than 12 months, a drop in income can be from £79.35 per week⁸⁰ to £44.52 per week – a loss of £34.83 in weekly income. This is a huge sum to lose when planning weekly outgoings for anyone. It is a particular difficulty for people with mental health problems who can find financial management very difficult, with many clients only just coping when their income is stable.

4.46 In view of the fact that 45 per cent of failed PCAs succeed at appeal, Citizens Advice has for a long time recommended that incapacity benefit should not be withdrawn immediately on notification of a failed medical but instead allowed to run until appeal. It should at least run for a limited period such as 3- 4 weeks in cases where a person has been incapable of work for a year. This would allow time for people to initiate a review of the decision if they wanted to and to explore work options while not immediately losing their income.

4.47 At present, people who have failed their PCA to have to manage on 80 per cent of personal allowance (reduced income support) pending appeal. This is wholly unfair and **at a minimum people should be entitled to full income support without disability premium until their appeal is settled.**

4.48 The adverse effect of appeals on people's condition coupled with the high success rate of appeals makes a strong case for improving initial assessments. The appeals process can be very distressing causing anxiety and adversely affecting people's health; one woman had to be admitted to a psychiatric hospital two days after a very inquisitorial hearing. The stress sometimes puts people off making an appeal even

⁸⁰ Incapacity benefit plus income support disability premium top up

when they have access to representation to help them cope. Such help is not always available and when it is not, the message is that their illness is generally not understood.

4.49 The DWP should ensure that people with mental health problems always have access to representation at appeal should they want it, both because of the nature of their illness and the difficulties they may have communicating about it.

4.50 Following a failed PCA, the transition from incapacity benefit to jobseekers allowance is sudden with no intermediate support. People can be under treatment from their GP and sometimes also by psychiatrists, psychologists and CPNs and be quite ill and yet be notified that they have failed their medical assessment and are expected to work. This is an abrupt change for a client group that is known to lack confidence. 'Clients in this situation often feel a mixture of confusion and terror'⁸¹. It may be compounded by a lack of understanding from Jobcentre Plus staff. The stress sometimes exacerbates people's condition, inhibiting any kind of recovery or rehabilitation, so increasing their social exclusion in the short and long term. A slower transition for moving people with mental health problems who have failed their medical assessment into work needs to be explored. An intermediate stage with continuing benefit would allow people time to consider work options and could help their adjustment.

Conclusions

4.51 The benefit system must support people financially when they are unable to support themselves. It should contribute to security so that it facilitates people's recovery from illness. In practice complexity, rules, poor administration, the nature of forms and procedures often conspire to create outcomes that undermine people's security because of a lack of awareness and understanding about mental health issues and a failure to recognise the difficulties mental illness creates for people who are unwell.

4.52 A consequence is frequent and sudden drops in benefit that can result in debt and adversely affect people's health at a time when the system should be increasing their chances of recovery and living independently. It means people with mental health problems are very much dependent on help to manage their affairs when they are ill. Yet that help may not be readily available. Low and uncertain income also contributes to social isolation by limiting people's opportunities and capacity to join communal activities because they are already cutting back on essentials and struggling with debt.

4.53 If the Government is to effectively address the social exclusion of people with mental health problems, the difficulties outlined in this

⁸¹ CAB adviser

chapter call for a major review of the whole benefit system and its impact on people with mental health problems. Such a comprehensive review should assess how performance at every level affects experiences and outcomes for people with mental health problems when they are ill.

5 Losing out on means-tested benefits

- 5.1 When they cannot work and disability hampers their managing to look after themselves, people receive disability benefits. Other benefits including means tested benefits can provide them with assistance at times of extreme hardship so that people are able to keep a roof over their head and pay for the essentials of daily living. This chapter looks at those benefits geared to provide help with basic essentials - housing benefit, the social fund, income support and prescription charges - and the difficulties people with mental health problems have accessing them.

Housing Benefit

- 5.2 Poor administration is a common feature of people's experience of claiming Housing Benefit. The consequences of administrative failure can be catastrophic. Lengthy delays in processing claims (six months is not unusual) feed straight into rent arrears, and tenants of both private and social landlords can find themselves facing possession action and even eviction as a direct consequence. For people with mental health problems such experiences are hugely stressful and damaging to their health.

A CAB in Hampshire described a woman with severe mental health problems who has been admitted to hospital several times in the last three years. Her housing association started possession action because of rent arrears of £1,317.52. The main reasons for arrears were delays in processing income support and housing benefit applications. The landlord withdrew proceedings on the last working day before the court hearing when benefit paid had reduced arrears to £197.72.

- 5.3 The complexity of the housing benefit scheme also creates major obstacles for people with mental health problems. The relationship between housing benefit and income support can result in people either facing gaps in their claim, or being over-paid housing benefit without their knowing it and then finding themselves in debt. When income support stops, housing benefit has to be re-claimed, although a person's entitlement may continue. This is particularly a problem for people on incapacity benefit when they move in and out of entitlement to income support.
- 5.4 In these circumstances, if the client does not reapply for housing benefit immediately, this can lead to loss of income, arrears and debt. Much adviser time is then spent trying to get benefit backdated. However backdating is discretionary and councils often appear reluctant to recognise mental illness as 'good cause' for not making or renewing a claim on time.

A CAB in Hertfordshire described a client suffering from severe depression with drug and alcohol problems. The client's incapacity

benefit went up from short-term lower rate to short term higher rate so her income support stopped but she was not informed until eight weeks afterwards. Even then she did not realise that this affected her housing benefit and council tax benefit and that she needed to make a new application until she had notification of housing arrears and the CAB explained why. Eventually the housing benefit department agreed to backdate her housing benefit but there is an 8-week backlog in dealing with claims. This caused the client great anxiety because although her landlord, a housing association, knew about the housing benefit department's backlog, they started possession proceedings after five weeks of arrears.

- 5.5 Similarly the complexity of the system can prevent people with mental health problems maximising their income. Once people are on long-term incapacity benefit for example, they are also entitled to apply for the disability premium. If awarded, this puts them back on income support and again entitled to full housing benefit and council tax benefit.

A CAB in Surrey described a client with long term physical and mental health problems, who received short-term lower rate of incapacity benefit (IB) and income support top up as his IB was less than the applicable amount for a single person. When he moved to short-term higher rate Incapacity Benefit, he lost his income support as his IB is now more than the applicable amount. When he moves on to long-term rate Incapacity Benefit, he will again be entitled to income support but will have to claim afresh and will not be invited to do so by DWP. The client's health is such that he will not understand or remember to reclaim when the time comes.

- 5.6 Benefit notifications should be more proactive in encouraging people with mental health problems to seek further advice from a Jobcentre Plus office, CAB or other agency to ensure entitlement to benefit is maximised.
- 5.7 The requirement for regular renewals of housing benefit claims, at least annually, has proved particularly difficult for people with mental health problems. The repercussions of not renewing a claim promptly can mean rent arrears, hardship and financial loss. Citizens Advice welcomes the fact that requirements for annual reviews will cease from April 2004⁸². However, periodic reviews will remain and it seems likely that these will continue to cause difficulties for people with mental health problems.

Supporting housing benefit claimants and the landlords role

- 5.8 People with mental health problems are unlikely to be able to successfully make and maintain a housing benefit claim without support.

⁸² Chancellor's Budget statement, 9th April 2003

The rules and procedures are not designed to accommodate the difficulties people face, as is illustrated in the following case.

A CAB in Yorkshire advised a client with severe and enduring mental illness who was detained in a secure unit and who had recently lost his entitlement to incapacity benefit, severe disablement allowance and disability living allowance. Now on income support he was claiming housing benefit and council tax benefit but was unable to take proof of his income to the housing office and no one could do this for him. The housing benefit office and area housing office refused to visit the client in hospital and offered no solution. The CAB wrote to the DWP for a breakdown of changes in the client's benefits but the DWP initially refused to provide this information, saying the housing benefit services should contact them directly for it. The housing benefit service, when asked, refused to do so. The information eventually came to the CAB from the DWP and was sent to the housing benefit service. This took from the beginning of February to July by which time the client had significant rent arrears.

- 5.9 The difficulties people with mental health problems experience with housing benefit highlight the need for agencies dealing with tenants - landlords, housing benefit officers and floating support providers - to ensure all their staff are adequately trained about mental health issues and to ensure their policies and procedures are appropriate to meet the needs of people with mental health problems. A secure home is of paramount importance for the well being of people with mental health problems. It is therefore essential that this should not be put at risk because of an inability to manage a housing benefit claim.
- 5.10 There is a recognition of these issues in the DWP HB Performance Standards⁸³, which identify as "good practice" mental health awareness training for staff and safeguards to ensure benefit is not stopped without additional checks such as a home visit. However the evidence on the ground shows that these measures are often not in place. **These good practices should be given a higher profile by being clearly incorporated into the HB Performance Standards themselves, to which all housing benefit departments have to work.**
- 5.11 Providers of social housing know that substantial numbers of their tenants are vulnerable and that many have mental health problems. A repeated theme of CAB evidence is that tenants who are vulnerable are not identified by housing officers for additional support to help sustain their tenancy. People with mental health problems can be particularly at risk of rent arrears and its consequences. Recent research carried out by mental health researchers in Northumberland found that the most common type of debt for service users was rent arrears.⁸⁴ (Sharpe and Bostock, 2002).

⁸³ *HB/CTB Performance Standards*, 2002, DWP.

⁸⁴ *Supporting People with Debt and Mental Health Problems: research with psychological therapist in Northumberland*, 2002, Sharpe J and J Bostock.

- 5.12 Social landlords should ensure that maximum use is made of the Supporting People funding scheme in order to provide floating support for this client group. **Citizens Advice believe that social landlords should have a duty of care to be pro-active in ensuring people with mental health problems have access to help and advice to deal with their benefit and other financial issues.**
- 5.13 Effective liaison between social landlords and housing benefit departments, as set out in the DWP HB performance standards⁸⁵, is essential to ensure tenants successfully claim housing benefit, and are not subjected to inappropriate rent arrears enforcement action.
- 5.14 In addition, all social landlords should sign up to the common code of practice recommended in *Possession Action – the last resort?*⁸⁶. This calls on landlords to adopt tenancy sign-up procedures that identify vulnerable tenants, to ensure rent payment and recovery procedures are tailored to their particular needs and that ongoing additional support needs are met.**

Hospital and discharge

- 5.15 People need practical help and support when they are admitted to hospital, during their stay and when discharged. Extra care and help is needed for people who live alone to ensure their affairs are properly managed.

A CAB in Merseyside described a homeless client with serious mental health problems. He was finally offered a council flat and applied for housing benefit. In the meantime he had a breakdown in health and was admitted to psychiatric care. For the last few weeks of his stay, the hospital sent the client out on home leave for short periods. He had to walk the five miles because he had insufficient money for public transport. Returning home he found that he did not have any gas or electricity but did have a letter seeking possession due to rent arrears. No help was offered by the hospital before the client was sent home.

- 5.16 Discharge is a crucial time for people with mental health problems. People's financial and home circumstances need to be checked to ensure they have the help they need when moving back into the community.
- 5.17 The NHS should ensure there is practical advice and assistance about benefits and housing for everyone with mental health problems when entering hospital, during their stay and on discharge.** A number of different agencies, such as the CAB projects

⁸⁵ *HB/CTB performance standards*, 2002, see section on Working with Landlords, DWP.

⁸⁶ *Possession action – the last resort?* 2003, Citizens Advice.

outlined in Chapter 7, give such help but services are neither widespread nor standard.

Financial support in hospital

- 5.18 Since May 2003, people entering hospital are entitled to full rate incapacity benefit or income support for 52 weeks before these benefits are reduced. People are also entitled to their usual housing benefit and council tax benefit for up to 52 weeks. These recent changes to down rating rules and benefit entitlement in hospital are welcomed and will ease the difficulties of many who have previously found themselves in debt and hardship as a consequence of a hospital stay because their benefit was reduced.
- 5.19 However, people who are in hospital for longer than 52 weeks are still affected by benefit down-rating and it is very difficult for them to manage. Mind warn that 9,000 people every year in England and Wales are being forced to live on a total of £15.50 a week after 52 weeks or more in hospital because of mental health problems⁸⁷. It is even more difficult if people are allowed out into the community for days at a time and have many of the expenses of daily living in the community but no income.

A woman with long-term mental health problems who has been in hospital for 2 years, is being helped by a CAB in Surrey. It is proving difficult to find suitable accommodation for her. She gets reduced benefit income of £15.50 per week out of which she needs to buy clothes (including underwear), toiletries (soap, toothpaste, toothbrushes, combs, shampoo, sanitary towels etc,) which are not provided in hospital and washing powder (not provided). She cannot afford things like make-up, sweets, snacks to supplement hospital meals, cigarettes, birthday cards for family and friends, newspapers and the other little things that may be considered non-essential but which add up to a normal life. The advice worker describes it as humiliating for the client to have to beg and borrow from other patients and staff for money for these things. The ward staff described the client as 'poverty personified'. Loss of self esteem is hindering her recovery. Her consultant psychiatrist is making an application to a local charity on her behalf.

- 5.20 The level of benefit down rating for long stay hospital patients should be reviewed to take into account reasonable hospital living costs. Where long stay patients are spending part of their time in the community, they should receive full entitlement to benefit such as DLA.**

⁸⁷ *Mind Mental Health Charity: Press release, 8th December 2003, MIND.*

The Social Fund

- 5.21 The absence of help or of a proper discharge plan can mean people are left homeless and without money when they leave hospital. In such circumstances, they are forced to rely on the Social Fund which often proves inadequate to deal with the crisis. Bureaux report that it can be very difficult to secure quick access to funds and Jobcentre staff sometimes put the onus on applicants to know what type of payment they should ask for⁸⁸.
- 5.22 Eligibility rules leave many people with mental health problems without recourse to the Social Fund. People who receive only incapacity benefit cannot apply for a community care grant or for a budgeting loan; only if people receive income support or income-based jobseekers allowance can they do so. Some CAB advisers report that people with mental health problems often do not have family or dependents who would entitle them to income support and thereby access to community care grants and budgeting loans. Even when eligible, people may not be considered a priority.

A CAB in Hampshire is helping a young man who receives income support and disability living allowance. He has depression and on-going mental health problems and was living in institutional care, followed by a care home and is now returning to independent living. He has no furniture or furnishings and his clothes and shoes are second hand and not suitable for interviews. His application to the Social Fund for a community care grant was turned down.

- 5.23 Citizens Advice has called for extensive reform of the Social Fund to provide help to people when they need it most and to combat social exclusion⁸⁹. Community care grants can be given to help people establish themselves in the community 'following a stay in institutional or residential accommodation' in which they received care, but people whose sole income is incapacity benefit cannot apply. **People whose sole income is a contributory benefit such as incapacity benefit should be eligible for Social Fund loans and grants. All applications for community care grants for people coming out of hospital should be fast-tracked.**
- 5.24 DWP statistics indicate that a significant number of people who receive help from the Social Fund are disabled but we do not know what proportion of these people have mental health problems. The proportion of successful awards made to people with mental health problems should be separately monitored.

⁸⁸ The question of not advising or giving misleading advice is examined in more detail in *Unfair and underfunded: CAB evidence on what's wrong with the Social Fund*, 2002, Citizens Advice.

⁸⁹ Ibid.

- 5.25 It can be very difficult to demonstrate how a moderate mental health problem is likely to become worse if a person does not have help to see them over a crisis or to settle back into the community and to avoid debt. As well as widening eligibility rules, there needs to be broader recognition of such need and resources allocated to meet it. If the Social Fund is to play its part in tackling social exclusion, **the Social Fund budget needs to be substantially increased to give people access to grants and loans at times of extreme difficulty and need. One option might be transforming and extending the loan element of the Social Fund into a 'social lender' as outlined in *Beyond Bank Accounts*⁹⁰.**

Prescription charges

- 5.26 Current policy on prescription charging⁹¹ undermines the Government's wider policy on care in the community⁹². Taking medicine is often a means of stabilising a person's condition, so enabling them to live in the community. But prescription costs mean that some people are neglecting this. As a result their health may deteriorate and they are more likely to need more expensive hospital care. People on incapacity benefit are not automatically entitled to free prescriptions. Many people are moved from income support (which entitles them to free prescriptions) to incapacity benefit for reasons of mental health and although they may be getting only a few pounds more per week, they then lose their entitlement to free prescriptions⁹³.

A CAB in Worcestershire described an 18 year old female who lives alone and receives Incapacity Benefit. She has suffered from manic depression, anxiety and panic attacks for three years. She claims she cannot afford her medicine and so is not buying it. This has an adverse effect on her health and her capacity to mix socially. One reason she is foregoing her medicine is that she has rent arrears of over £300 which she is paying off at £15 per week.

- 5.27 The extent of the problem is influenced by whether a person's medical condition requires multiple prescriptions and thereby higher prescription costs. The length of time for which a drug is prescribed also affects cost. Patients requiring long term medication can find the price they pay increases three fold if the GP moves from a three month to a one month prescription routine. Clients in danger of overdosing may even have to collect prescriptions weekly or fortnightly which significantly increases the cost. Clients can find themselves facing further expense because of their

⁹⁰ *Beyond Bank Accounts: full financial inclusion*, 2003, Sue Regan and Will Paxton, Institute for Public Policy Research and Citizens Advice.

⁹¹ From April 2004, prescription charges in England are £6.40 per item

⁹² This is looked at in some detail in *Unhealthy Charges*, 2001, Chapter 2, Citizens Advice.

⁹³ Some people on incapacity benefit may be entitled to free prescriptions if they claim under the health benefits low income scheme but this is not promoted and involves a cumbersome claiming process.

mental health if they require special dispensing packs. Patients who, even mistakenly, assume they are exempt from charges, are issued with a penalty notice.

A CAB in Lancashire is helping a client with mental health problems who receives incapacity benefit and disability living allowance care component. He is prescribed medication for a two week period rather than a month because of his condition. Not entitled to free prescriptions, he cannot find the money for a prepayment certificate. He is paying £12 per week for medicine, sometimes more, out of a weekly income of £117.

A CAB in Surrey described a client with severe and enduring mental health problems who receives incapacity benefit (long term higher rate) with the age addition and so is not entitled to income support. Not realising she was not entitled to free prescriptions she has, for many years, ticked the back of her prescription to indicate she is entitled. Unable to provide proof when asked for it, she was issued with a penalty notice while in hospital and recently received a Notice of Issue of a Warrant of Execution for a county court judgement for £96.85. She came to the CAB who has established she has £2000 of priority debts and £3000 of non-priority debts. The CAB understand that if this client had an injection at the Community Health Team it would be free, but if the same medicine is given in tablet form, the client has to pay.

A CAB in Lincolnshire described a client who had a weekly dispensed prescription involving a complex number of tablets which are dispensed in a daily formula pack. The client cannot work out the daily selection of tablets to take so the chemist puts each day's supply in a pill organiser, for which the client pays £3 per week out of her income support and disability living allowance. The client is in debt and the mental health team are in too infrequent contact to help with this.

- 5.28 It is not acceptable that patients should face increased charges as a direct result of their illness and inability to manage their medication. If people who need long term medication cannot be given it through injections of controlled release drugs in health centres, **there should be the option of 'instalment dispensing' making three monthly prescriptions with controlled release of drugs from chemists on a weekly or fortnightly basis.**⁹⁴
- 5.29 Pre-payment certificates are intended to be helpful for heavy prescription users as they effectively cap the cost of prescriptions. However, people

⁹⁴ as the Department of Health is introducing for dispensing tranquillisers. Pharmacists will receive extra payments under the new arrangements.

managing on limited budgets find it difficult to pay a lump sum of £91.80 for 12 months in advance.

5.30 At a minimum, help with paying prescription charges should be extended to people with incomes above the exempt levels, by pricing the pre-payment certificate on a sliding scale, depending on a person's income.

5.31 There is also a strong case for more fundamental reform, perhaps as is happening in Wales, where there are to be phased moves towards free prescriptions from October 2004⁹⁵.

Conclusions

5.32 People with mental health problems lose out on entitlement to a number of benefits because regulations state they are ineligible if they receive only incapacity benefit. Yet many people's income is so low they cannot pay for the basics or for their prescriptions. They lose out further when, as with housing benefit, they are unable to understand the system and comply with its procedures and time limits without advice and help.

5.33 The role of the Social Fund, prescription charges, housing benefit and income support for people with mental health problems in hospital and the community should all be reviewed as part of a major review of the whole benefit system to create better support and outcomes for people with mental health problems when they are ill.

⁹⁵ *Welsh Assembly Government Press Release, October 2003*

6 Vulnerable consumers, credit and debt

- 6.1 This chapter outlines CAB evidence on the problems people with mental health problems experience as consumers, particularly of financial services. One in six of people face mental health problems at any one time, representing a significant market share. Businesses therefore cannot afford to ignore their needs. People also need adequate protection if they are to avoid being excluded from mainstream society because of an intermittent inability to look after their own interests and if they are to avoid the consequences of serious debt. Citizens Advice considers that the current level of consumer protection is failing people with mental health problems.

Recognising the problem

- 6.2 People with mental health problems often find it difficult to be effective consumers, as they tend to withdraw when they are unable to cope. Lack of awareness about the effects of poor mental health can mean that communication may be a problem and misunderstandings can occur.
- 6.3 Businesses also find it difficult to deal with people with mental health problems. In particular they may not be aware that individual customers have mental health problems and may respond inappropriately. For example, lack of communication may be interpreted as the consumer being difficult or even fraudulent. There may be a straight misreading of the situation where the customer is labelled as a nuisance without the company investigating and dealing with the customer's enquiry. For example:

A CAB helped a client with a mental health problem deal with a debt to a fuel company of £214. There were 48 entries in the fuel company's log of contacts concerning the setting up and maintaining of a prepayment arrangement and many approaches from the consumer reporting problems using the equipment which occasioned home visits that indicated the equipment to be in working order. The fuel company's record shows a degree of irritation with a difficult customer who could not be relied upon to give an accurate version of events or to behave responsibly. The CAB record of contacts with the client revealed that the customer was a mentally ill man living on income support and in debt⁹⁶.

- 6.4 Clearly staff training is one way of addressing this problem. **Citizens Advice recommends that providers of consumer goods and services should ensure their staff are trained on awareness of mental health problems and how to respond appropriately.** A model for this training could be a recent initiative by Lloyds TSB to ensure that bank branch staff are aware of and respond appropriately to people with basic skills needs. The initiative involves bank branch staff watching a video specially produced by the Basic Skills Agency for financial services staff on helping people with basic skills problems. The bank then ensures that staff

⁹⁶ *Striking a Deal: negotiations by CAB clients over debts for gas and electricity*, 2001, University of Leicester Centre for Utility and Consumer Law and Chesterfield CAB.

respond appropriately to people with basic skills needs by conducting regular mystery shopping exercises in branches.

- 6.5 The Office of Fair Trading (OFT) have recognised the need for companies to be more responsive to vulnerable consumers, such as those with mental illnesses. Their core criteria requirements for business-to-consumer codes of practice⁹⁷ include that code subscribers make additional efforts to help vulnerable consumers who may, for example, be at risk of making incorrect or inappropriate decisions if they are not given the correct advice in the most helpful and appropriate manner. **Citizens Advice recommends that such training should be required in relevant industry codes of practice.**

Sales Practices

- 6.6 Given the significant number of people will have a mental health problem at any one time, providers of goods and services should be encouraged to ensure that their sales practices are fair to all consumers, simply from a market share perspective. Businesses have much to gain from policies that enable people to resolve problems when their mental health results in them making inappropriate purchases.
- 6.7 CABx report that people with mental health problems are particularly vulnerable to high pressure sales techniques and may make inappropriate purchases during a period of illness. As a result they may end up with goods or services which are of little or no use to them and which may result in debt:

A Wiltshire CAB described the sale of gym membership to a woman with mental health problems who could not afford the subscription and for whom the facilities were inappropriate. Her mother was shocked that the gym had accepted the membership and sought advice about how to sort this out.

A West Midlands CAB reported their client, a woman with mental health problems, had approached the bureau for help when she received bills totalling over £82 for mobile phone calls and charges, despite having no mobile phone. She had been persuaded to sign a mobile phone contract by a salesman in her local shopping centre, despite having explained she was receiving income support. No phone had ever been supplied and in this case the bureau negotiated the cancellation of the contract as well as the incorrect bill.

A CAB in Cleveland reported that a retired man suffering from schizophrenia had had an alarm fitted by a local company. This was financed by a linked credit agreement. A year later the company contacted the client to offer an “updated” alarm system. They told

⁹⁷ *Core Criteria for Consumer Codes of Practice – guidance for those drawing up codes of practice*, May 2002, OFT.

the client that they would cancel the existing credit agreement and arrange a new one for the second system.

- 6.8 There appear to be particularly acute problems in the sale of utility supplies, such as fuel and telecoms, where competition has led to a more complex marketplace. Sales of utility supplies often occur either at the doorstep or on the telephone. Agreements to change supplier can result from a simple failure on the part of the consumer to clearly voice a refusal. As we illustrated in our evidence report on doorstep selling, *Door to Door*⁹⁸, the resulting contracts are often difficult and time consuming to unravel and frequently result in debts. Because of the discrimination often experienced by consumers with poor mental health, resolving these problems can be challenging:

A Lancashire CAB client with mental health problems found herself being chased for debts owed to her electricity supplier. A rival company had approached her and, despite her refusing their offer, had transferred her direct debit. The original fuel company had blocked the transfer, due to debts, so they remained her suppliers. The client did not realise payments were going to the wrong fuel company for several months. The bureau had to discover who her supplier really was and then help her to reclaim the direct debits drawn by the company who were not her supplier.

A Wiltshire CAB reported their mentally frail client had found the only way he could get rid of a fuel company salesman who had cold-called on him at home was to sign a contract. He did not find out about the seven day cooling off period for doorstep sales until it was too late. He was eventually transferred back to his original supplier through an erroneous transfer charter agreed within the domestic fuel industry. But the bureau commented that the fuel company had been insensitive to their client's position and that the transfer would have made his fuel more expensive because he would lose a discount for buying gas and electricity from one supplier.

A client of a CAB in Wales with manic depression was approached by a telephone company canvassing representative nearly two years ago and persuaded to sign up for a land line. Although the client received regular bills for line rental, she actually had no telephone. No telephone calls had been made over the past two years and no one from the company had queried why. The problem only came to light when she sought debt advice from the CAB for the bills.

- 6.9 Consumers have a number of rights to cancel consumer contracts, and protection through sector specific and self-regulation. The protection of all consumers is an essential remit for government through the OFT, sector specific regulators⁹⁹ and consumer bodies.

⁹⁸ *Door to Door - CAB clients' experience of doorstep selling*, September 2002, Citizens Advice.

⁹⁹ Bodies such as the Office of Gas and Electricity Markets (OFGEM), created by statute to regulate the activities of businesses in a specific sector.

However, the present legal framework does not provide an adequate focus on the protection of vulnerable consumers, such as people with mental health problems.

- 6.10 First, where legislation does provide for cancellation rights¹⁰⁰, the period when the consumer is legally entitled to cancel varies. Consumers are often uncertain of their rights. And for people with mental health problems something more is needed. These consumers need a right to cancel when there is clear evidence that the contract has not been understood, due to mental capacity.
- 6.11 Secondly, current legislation allowing contracts to be challenged because they have been made during a period when a consumer with mental health problems is ill, is unclear and inaccessible. At present the High Court does have some jurisdiction to intervene in contracts where a person's mental capacity is in question but this is a complex and expensive process and places much reliance on case law. This means that people with mental health problems can be taken advantage of.
- 6.12 Thirdly new European wide protection¹⁰¹ designed to stop unfair commercial practices will take at least another two years to reach the statute book. The draft directive outlaws unfair commercial practices and enables enforcement action to be taken against firms who behave unfairly to consumers. It is welcome that the powers in the directive could be used where a trader takes advantage of vulnerable consumers, including those with 'mental or physical infirmity'. It is not yet clear how this will work in practice and the directive does not offer individual redress, it is only an enforcement tool.
- 6.13 The Mental Incapacity Bill, currently in draft form, sets out to reform the law to protect the interests of people who are unable to make decisions for themselves. However, the Bill as currently drafted has only limited application to contract and consumer protection law. Indeed, in some circumstances, consumers without mental capacity are not protected from unscrupulous trading because of the inclusion of the 'necessaries rule'¹⁰², which allows traders to claim the cost of goods and services they can argue the person needed. This means that where a person who lacks capacity has been persuaded to enter into a contract for fuel supplies or another everyday service, the 'necessaries rule' prevents the

¹⁰⁰ The Consumer Protection (Cancellation of Contracts Concluded Away from Business Premises) Regulations, and the Distance Selling Regulations and consumer credit law are designed to allow consumers a brief time to consider the purchase away from the sales person and cancel if necessary (seven days, seven working days and five days respectively).

¹⁰¹ Proposal for a Directive of the European Parliament and of the Council concerning unfair business-to-consumer practices in the Internal Market (compromise text), 20 February 2004, Council of the European Union

¹⁰² Clause 33 of the Draft Mental Incapacity Bill states that "if necessary goods are supplied to, or necessary services provided for, a person who lacks capacity to contract, a reasonable price must be paid for them by that person or a person acting for that person". Necessary means "suitable to a person's condition in life and to his actual requirements at the time when the goods are supplied or the services provided".

consumer from invalidating the contract on the grounds that they did not have capacity at the relevant time. This leaves the door open to overpricing or locking consumers into contracts they were pressurised into.

6.14 Citizens Advice recommends that the draft Mental Incapacity Bill is amended to improve consumer protection rights and remedies, so that all consumer contracts may be challenged where they have been made during a period when a consumer with mental health problems is ill and cannot reasonably be expected to enter into contractual relationships on the same basis as somebody with full mental capacity. This would involve:

- clarifying and strengthening the Court of Protection's powers in respect of consumer contracts, to make remedies more accessible
- ensuring that the definition of incapacity can also apply to a consumer's capacity to enter into a contract
- allowing the burden of proof to shift in cases of unfair sales practice so that it is up to the business to prove that the person was able to understand the nature and effect of their actions in making the contract, where their capacity is in doubt
- the introduction of a proactive duty on business to take account of a person's vulnerability, such as recognised signs of mental ill health, in considering the suitability of and entering into the contract; and
- abolishing the 'necessaries rule' in all consumer protection legislation, in respect of mental incapacity so that contracts made when a consumer does not have capacity to contract can be invalidated.

6.15 But there is no clear indication of when the draft Mental Incapacity Bill might be enacted. In the absence of clear legislation to redress the imbalance in access to consumer protection for vulnerable consumers with mental health problems, there is a need for better recognition of the problems these consumers face.

6.16 Further, consumer protection bodies such as the OFT, Department of Trade and Industry (DTI) and regulators need to examine how consumers with mental health problems can be afforded better access to consumer protection. The OFT initiated a useful inquiry into vulnerable consumers and financial services¹⁰³ which built on work that identified certain groups as vulnerable, such as those suffering from a long term illness or disability¹⁰⁴. The Office of Fair Trading could take this work forward.

¹⁰³ *Vulnerable Consumers and Financial Services*, 1999, OFT.

¹⁰⁴ *Vulnerable Consumer Groups: Quantification and Analysis*, 1998, Research Paper 15, OFT.

- 6.17 Citizens Advice believes that there is a lot more that the various organisations with responsibilities for consumer protection could offer vulnerable consumers with mental health problems by using their statutory functions and influence over firms' policies and practices to secure changes and fair treatment. These organisations include the OFT, the sector regulators and consumer bodies, particularly OFGEM, OFWAT, Postwatch and OFCOM, local consumer protection and trading standards services and statutory consumer bodies. The regulatory bodies not only have enforcement powers but produce guidance and, in the case of the OFT, give approval to business-to-consumer Codes of Practice. It would seem to us that the overriding case for regulation in consumer markets must be to protect those consumers who are unable to exercise effective power in the market due to income or mental capacity and it is for the most vulnerable consumers that regulation should be tilted.
- 6.18 The DTI is also very important in driving forward policy and practice in this area and is presently developing a forward looking consumer strategy. **Citizens Advice would like to see a commitment in the forthcoming Department of Trade and Industry consumer strategy that consumer protection bodies will work together to develop and publish a shared strategy on the use of their powers to the maximum benefit of vulnerable consumers including people with mental health problems. This strategy should set out in particular how they will challenge discrimination and unfair treatment towards and improve protection of people with mental health problems in the markets they are concerned with. The Office of Fair Trading, in their role of co-ordinating UK enforcement could be asked to take the lead in developing this.**

Borrowing

- 6.19 CAB evidence points to the ease of obtaining credit as a major problem for people with mental health problems. Most lenders now use an automated process to score credit applications, using sophisticated computer modelling. However they do not check whether credit repayments are actually affordable by examining the borrower's income and expenditure. Instead they mainly rely on the information held in their credit reference file which includes payment records of past credit and loans. So someone with no past record of default will be regarded as good credit risk, whatever their current income and number of outstanding credit commitments.
- 6.20 This issue affects all people with limited means taking out credit, but those with mental health problems seem to be particularly adversely affected by lack of checks on ability to repay new credit agreements. Firstly it is CAB experience that this group is likely to be on low incomes or benefits and may have little available income to afford the repayments:

A man with schizophrenia necessitating regular admission to the local psychiatric hospital sought debt advice from a CAB in Staffordshire. The client told the CAB that on one occasion he had visited his bank branch to withdraw his benefit from his basic bank account, when a member of the bank staff asked him whether he

wanted an overdraft. When the client refused, the bank suggested that he could have a credit card to buy 'things he wanted but did not have the cash for'. The client accepted the credit card with a £3,000 limit. He spent up to the limit but did not realise the implications of having to pay the money back. The bank knew that the client was living on income support.

A single woman came to a CAB in Sussex in great distress about debt problems. The client told the CAB that during a period when she was taking heavy doses of medication for her mental health problems, she went to her bank and obtained a loan for £1,000, even though her only income was benefits. The client went back to the bank for more loans and now owed £7,000 which she could not afford to repay. The client admitted that due to the nature of her illness, she could not recollect how she spent the money, but asked the CAB to ring the bank to tell them not to lend her any more. When the bureau contacted the bank to make this request, the bank explained they could not discriminate against a customer on benefit income and pointed out that they were unable to judge someone's mental capacity to understand the terms of the agreement. The bank went on to say that even now they had information about the client's state of health and level of income, they would not necessarily stop lending her more money.

A CAB in Yorkshire reported that a client with severe mental health problems arranged for his income support and disability living allowance to be paid into his bank account. Without consulting the client, the bank immediately increased his overdraft limit from £600 to £1,100. The client came to the bureau when his overdraft reached the new limit.

- 6.21 Secondly a client's illness can exacerbate the situation. A feature of manic behaviour is spree spending; people can get themselves into severe debt with catalogue purchases or by going on spending sprees having secured easy credit to do so:

A man with bi-polar disorder sought debt advice from a CAB in Staffordshire. The client told the CAB that during the manic phases of his condition he experienced delusions of grandeur and lost all inhibition, especially with regard to money. On one occasion he put £1,000 in a charity box. Subsequent awareness of his actions and their consequences has contributed to a very depressed state. To the best of his knowledge, all his current debts of £9,400 arose from behaviour during his manic phase.

A woman with severe mental health problems and compulsive disorder approached a CAB in the East Region for debt advice. The client told the CAB that her illness manifested itself in spending on credit cards which she could not afford. As a result she got into considerable debt and was at the point of suicide. Since the CAB started to negotiate reduced payments with her creditors, one of

them, a credit card company, gave the client a new card and increased her credit limit. The client was so upset she had to ring the Samaritans before coming to the bureau.

- 6.22 Any policies for dealing effectively with inappropriate lending to people with mental health problems need to take account of two issues. Firstly the lender is unlikely to be aware of the borrower's mental health problems at the time of an application for credit. The borrower is unlikely to reveal this information to the lender, because of the stigma of having mental health problems, and the difficulties people often experience with ability to concentrate, with communication and with social interaction¹⁰⁵. Secondly any policy solution must not close off access to credit and other financial services for people with mental health problems. Not only could this breach the Disability Discrimination Act, but it is also not what people with mental health problems, or the organisations that speak for them want.
- 6.23 We therefore consider that broader initiatives, which promote responsible lending and marketing to all consumers, have the most potential to resolve the problems CAB debt clients with mental health problems experience. In particular if lenders did more to check ability to repay by analysing the borrower's income and expenditure, and ensuring that their marketing encourages responsible borrowing, this could help to prevent problems of over commitment arising for all consumers including those with mental health problems.
- 6.24 It is therefore very welcome that the Government's recently published White Paper on Consumer Credit stated that they intended to support a legal duty for lenders to lend responsibly, both in forthcoming EU and UK legislation¹⁰⁶. However, it will be some years before the proposed EU Consumer Credit Directive and the new Consumer Credit Act reach the statute book. **In the meantime Citizens Advice considers that it is vital that interim measures are put in place to ensure responsible lending, marketing and borrowing and to protect vulnerable consumers, particularly those with mental health problems.**
- 6.25 **The Banking and Finance and Leasing Association (FLA) Codes, two key financial services codes of practice, should incorporate commitments to use the rule-of-thumb indicators of overindebtedness recommended by the second DTI Overindebtedness Task Force report.** In relation to the Banking Code there is an opportunity for this to happen in the current review of the Code. It is disappointing that the recently revised FLA Code which came into effect on 1st January 2004 does not incorporate such a commitment.
- 6.26 **The Banking and FLA Codes should emphasise the importance of assessing a borrower's income and expenditure before lending and should encourage consumers to consider for themselves the**

¹⁰⁵ These are described in further detail in Chapter 1

¹⁰⁶ *Fair, Clear and Competitive – The consumer credit market in the 21st century*, December 2003, paras 3.37 and 5.67, DTI.

affordability of loans. This could be by way of guidance for subscribers to the Codes. There is already guidance in place for Banking Code subscribers, but not for those to the FLA Code.

- 6.27 The OFT should draw up guidance for consumer credit licence holders on credit marketing and responsible lending. Alternatively it could rework its existing guidance on non-status lending to cover all credit lending, whether secured or unsecured.**¹⁰⁷ The OFT non-status lending guidance is out-of-date, and it is unclear to what extent it applies to high-street lenders' lending practices. The OFT have indicated that they will consult on the content of the non-status guidance this year.¹⁰⁸

Insurance

- 6.28 Insurance is an important consumer purchase, ranging from car, holiday and home insurance to mortgage and loan payment protection. In some circumstances there is an expectation that consumers will have obtained insurance cover to protect themselves. For example under the current benefits system housing costs for owner occupiers are usually only available after a waiting period of up to 39 weeks because the Government expects consumers to have made their own provisions for these periods, by obtaining payment protection insurance. And for everyday activities such as holidays, tour operators commonly require evidence of insurance as a condition of accepting a booking.
- 6.29 It is CAB experience that access to effective insurance is frequently more difficult for people with mental health problems for a number of reasons. Firstly, the terms and conditions of many insurance policies can exclude any claim relating to mental health. This problem appears to particularly affect payment protection insurance, which is designed to help consumers meet their credit and loan commitments when they experience an unexpected reduction in or loss of income, due to ill health or redundancy. Redcar & Cleveland CAB¹⁰⁹ monitored their enquiries to identify examples of mental health exclusions in insurance policies and gathered evidence from CABx around the country. They found a significant number had 'blanket exclusions' in their policies for claims resulting from mental health problems.

A CAB in Essex was helping a lorry driver deal with £9,000 of debts. Although all the debts were covered by payment protection insurance, the policy did not provide cover for events caused by mental health problems. The client had just been diagnosed with clinical depression and as his income was reduced to income support, he had no means of paying his debts.

¹⁰⁷ *Non-status lending: guidance for lenders and brokers*, November 1997, OFT.

¹⁰⁸ *OFT annual plan, 2004/5* consultation paper

¹⁰⁹ reported in *'Evidence, Getting Insured'*, July 2002, Lorraine Bowden, Redcar and Cleveland CAB, Citizens Advice.

A CAB in Greater Manchester reported that a client who had originally successfully claimed on payment protection insurance due to a back problem, later developed depression. The insurer stopped payments under the policy because a clause in their policy stated that no payments would be made for psychiatric illnesses. The client, whose only income was incapacity benefit and disability living allowance, was facing financial difficulties as a result.

A CAB in North-East Wales reported that a client who was off work due to stress (caused by harassment from his neighbours) had claimed on payment protection insurance on a loan for a car. His claim was rejected under a clause excluding “disability caused or aggravated by any psychiatric illness or any mental or nervous disorder”.

- 6.30 Secondly, because of these blanket exclusions, insurance may often be sold to people with mental health problems who cannot benefit from the cover. The cost of some payment protection insurance premia can substantially increase the amount of credit: many payment protection insurance premiums are one-off lump sums added to a loan; the consumer then pays interest on the amount for the loan and the premium over the term of the loan:

A lone parent with mental health problems sought debt advice from a CAB in Essex. She had over £13,000 worth of debt with one bank, through her current account, a personal loan and a credit card. Despite these debts and the fact that the client has not been able to pay anything towards them, the bank persuaded her to take out another loan for £2,000, plus £585 payment protection insurance for which she was ineligible, because she was not working. At the time of seeking advice her debt had risen by over £1,200.

A CAB in Hertfordshire reported that they were helping a woman unable to work, due to manic depression, and in receipt of benefits. The client told the CAB that she had taken out a bank loan for £3,000 about six months earlier. The bank persuaded her to take out a £600 payment protection insurance policy, which they claimed would pay out if her benefits stopped. When the CAB investigated, the bank agreed that the cover had not been appropriate for the client as it only covered cessation of wages, and they knew that the client was not employed. The policy also excluded claims relating to mental illness.

A woman who had suffered mental health problems for many years sought debt advice from a CAB in Surrey. Her debts included a £15,000 bank loan, which was used to repay catalogue debts. The client, who was in receipt of benefit at the time the loan was taken out, was persuaded by the bank to buy

payment protection insurance on the grounds that her children would otherwise have to pay off the debt if she died.

- 6.31 Finally, where cover is provided, people are often expected to provide medical evidence from a consultant psychiatrist for their claims to be successful. This requirement means that the majority of people with mental health problems are effectively excluded from cover, as 90% are treated by their GP¹¹⁰.

A Cleveland CAB reported that a couple were unable to claim on their holiday insurance when they had to cancel their holiday because the wife was diagnosed as suffering from depression. An exclusion clause in the contract did not allow for any claim for mental illness unless the claimant was an in-patient in hospital. They had already paid an extra premium to ensure cover due to the husband previously suffering from cancer.

A CAB in Hampshire reported that a client who had claimed on payment protection insurance following an accident later had his claim stopped when the insurance company asked for additional information from his GP. The GP wrote confirming both the injury and that the client suffered from depression, which had been made worse by the injury, preventing him from working. Subsequently the insurer asked for a consultant psychiatrist's report, which the GP completed himself. The insurer then stopped payments under the policy as it excluded cover for psychiatric illnesses unless diagnosed by a consultant.

- 6.32 It is unreasonable for insurers to exclude consumers from access to insurance through the use of blanket exclusion clauses. It is also of great concern that many consumers are paying premia when the policy will not in practice cover them.
- 6.33 The Financial Services Authority (FSA) will regulate the sale and administration of general insurance from 14 January 2005. The rules¹¹¹ cover consumers being provided with the information they need about insurance, including **any significant or unusual exclusions from cover** and this is very welcome. What is less clear, however, is how this will be translated, by those selling insurance, into the information consumers will be given when they purchase insurance. Exclusions that are commonly used to exclude any claims that relate to mental health may not be considered to be 'unusual', so will not necessarily be drawn to the attention of consumers when they purchase. Further, blanket mental health exclusions are not uncommon and there is a danger they may not be considered as being 'significant' information to be pointed out to a consumer who has no history of mental ill health, despite their significant effect. But any such clause will certainly become significant to the insured

¹¹⁰ *Fast-Forwarding Primary Care Mental Health*, 2001, Department of Health.

¹¹¹ *Insurance selling and administration: the FSA's final conduct of business rules*, January 2004, FSA

consumer if they go on to develop a mental illness, which will then be excluded when they need to make a claim under the policy. These interpretations of the FSA rules are in danger of failing to ensure the provision of the very information that might prove to be of vital significance to consumers when they suffer mental ill health.

- 6.34 FSA rules also require that claims made under an insurance policy are dealt with promptly and fairly. Where consumers dispute the insurers' response to their claim, and cannot resolve this with the company, they can approach the Financial Ombudsman Service (FOS) whose decision will be binding on the company involved. The FOS's decisions take account of what consumers should expect from the wording of the policy and from what they were told when the insurance was sold. FOS takes into account the full range of regulatory rules, relevant, industry codes and best practice.
- 6.35 What FOS cannot challenge and is not covered in FSA rules, is the right of insurers to decide on the extent of the cover they provide. So, whilst the FOS can address mis-selling of insurance to consumers with mental health problems, it cannot challenge the presence of blanket exclusions. This is because whilst it is illegal, under the Disability Discrimination Act 1995 (DDA) for insurers to discriminate against a person because they are mentally ill, it is not illegal for insurers to discriminate against mental illness, through the use of blanket exclusions.
- 6.36 It is not yet clear how the FSA will develop their approach to the handling of issues affecting particular groups of consumers, such as those with mental health problems, who are taken advantage of. **Citizens Advice suggests that the FSA should produce a policy statement setting out how their approach to regulation of general insurance will ensure that consumers with mental health problems are treated fairly.**
- 6.37 The Disability Discrimination Act 1995 (DDA) provides that it is unlawful for insurers to adopt a general policy or practice of refusing to insure disabled people or people with particular disabilities. The Code of Practice, which supplements the legislation, permits insurers to treat consumers with mental health problems less favourably in certain circumstances.¹¹² Although this can only happen where all four "conditions" set out in the Code are satisfied¹¹³ these provide very broad permission to firms to discriminate with the only challenge arising from an aggrieved consumer taking out a civil action under the DDA.
- 6.38 Although the FSA is taking over regulation of general insurance from January 2005, self regulation will continue to play an important role in setting standards for the insurance industry. For example, the FSA regime

¹¹² *Disability Discrimination Act, Code of Practice*, paragraph 8, 2002, Disability Rights Commission

¹¹³ The four conditions are:

- It is in connection with insurance business carried on by the service provider;
- It is based on information which is relevant to the assessment of the risk to be insured
- The information is from a source on which is it reasonable to rely; and
- The less favourable treatment is reasonable having regard to the information relied on and any other reasonable factors.

will not apply to all general insurance; travel insurance sales are outside the FSA's scope. Also, FSA rules do not deal specifically with some matters and there is continued scope for the industry to set out best practice guidelines. The Association of British Insurers (ABI) provides guidance to insurers on the Disability Discrimination Act¹¹⁴. In the guidance, insurers are encouraged to recognise the opportunity for business and to re-examine their process and procedures, so that cover is offered wherever possible. But the guidance is insufficiently demanding on insurers and consequently fails to meet the needs of people with mental health problems.

6.39 Citizens Advice recommends that the Association of British Insurers review their good practice guidance on compliance with the Disability Discrimination Act to ensure that people with mental health problems are not unreasonably excluded from obtaining insurance. The review should examine:

- **The use of blanket mental health exclusions that serve to unreasonably reduce access to cover**
- **The acceptance of medical evidence from GPs about the insured's state of mental health as evidence in the event of a claim; and**
- **How the industry could be encouraged to provide a better deal for people with mental health problems.**

6.40 This would help alleviate the current gaps in disability discrimination legislation. But ABI models its guidelines on the Disability Discrimination Act. To ensure that consumers with mental health problems are not discriminated against when they claim under an insurance policy, Citizens Advice believes the core requirements within the DDA will need to be changed. These lie within Clause 1 and Schedule 1 of the Act.

6.41 The Clause 1 definition of disability includes physical and mental impairment but goes on to require the impairment to be 'long term'. Long term is further defined in Schedule 1 and the Code of Practice produced by the Disability Rights Commission as an impairment that has lasted, or is likely to last, for at least a year. This serves to exclude people whose mental health problems are, by their nature, short term, such as depression caused by reaction to pressure, trauma or severe stress. Reactive depression can respond positively to medication and therapeutic interventions within a few months; however, for the duration of depression or a depressive episode, a person may be totally physically and mentally incapacitated.

6.42 The Act goes on, at Schedule 1, to specify that 'mental impairment' must be linked to 'clinically well recognised' mental illness. This has the effect of creating a higher threshold of proof of mental disability than that required for

¹¹⁴ *An insurers to Discrimination Disability Act 1995*, January 2003 ABI

physical disability. This Schedule also specifies, at sub-section 4, a list of the everyday activities that must be affected for a disability to be included within this important consumer protection. These activities are predominantly physical in nature and may not be affected by mental ill health. To protect the mentally ill from discrimination, these definitions need to be substantially amended, to cover conditions that may be short term, hidden or fluctuating and affecting social interaction.

- 6.43 As outlined in Chapter 1¹¹⁵, Citizens Advice recommends that the definitions applied to disability under the Disability Discrimination Act 1995 be amended to provide the same level of protection for those with mental disabilities as are currently provided for those with physical disabilities.**

Coping with unmanageable debt

- 6.44 Unmanageable debt is a common and pervasive issue for CAB clients with mental health problems. For example, enquiries about debt comprise approximately half of the Cambridge CAB Project's work, 73% of the mental health enquiries between April and June 2003 in Derwentside and nearly 20% of Leytonstone's clients' problems in 2001/2. In County Antrim, a third of the specialist money advice worker's debt clients have mental health problems.
- 6.45 Research on the interrelationship between debt and health shows that debt can cause crises for people's health and that illness in turn reduces people's capacity to handle their finances and contributes to debt¹¹⁶. Recent research on CAB debt clients found that a quarter of CAB debt clients had already sought treatment or counselling through their GP for feelings of stress, anxiety and depression before seeking CAB advice¹¹⁷. Over half of these reported that they were already receiving medical treatment for their depression before their debt problems arose. The recent Consumer Credit White Paper also outlined the substantial costs to the government and the UK economy as a whole of mental ill-health and overindebtedness.¹¹⁸

¹¹⁵ See paragraph 1.10

¹¹⁶ *Income, Poverty and Mental Health*, March 2003, M. Plumpton & J. Bostock, Department of Psychological Services and Research Newcastle, North Tyneside & Northumberland NHS Mental Health Trust.

¹¹⁷ *In too deep: CAB clients' experience of debt*, May 2003, Citizens Advice.

¹¹⁸ *The Costs of Over-indebtedness - Fair, Clear and Competitive – The consumer credit market in the 21st century*, Annex C, December 2003, DTI.

Unfair debt collection practices

- 6.46 The use of unfair and heavy-handed debt collection practices can only exacerbate mental health problems. This results from the collection processes many lenders and debt collection firms use. The aim of most lenders' debt collection departments is to get defaulting customers back on track with their contractual payments as soon as possible. This is a cost-effective way of dealing with the majority of defaulting customers who will only be in financial difficulties for a short while. Most lenders use a highly automated process, including power-dialling systems which automatically call up contact details of customers in default, and standard computer generated letters. Individual collections staff have financial targets to meet, which may include minimum levels of payment on debts. If these do not generate contact or a payment arrangement which is acceptable to the creditor, the debt may be passed out to a third party debt collection firm who will continue the contact and possibly arrange to visit the customer. Debt collectors are likely to view debtors who do not respond or who break unaffordable repayment arrangements as deliberately avoiding payment.
- 6.47 Such processes do nothing to help resolve those whose financial difficulties are going to be long-term, like the majority of people with mental health problems. If debt collectors are under pressure to meet their targets, they are likely to pressurise defaulting customers to agree to pay their target minimum, whatever their personal situation and means. Because of this some debt collectors put unacceptable pressure on individuals to pay up, for example, frequent phone calls, threats to send in the bailiffs to seize their belongings even where there is no court order, and telling neighbours or work colleagues about the customer's debt problems. These are only a very few of the many case examples Citizens Advice receives every month about unfair and heavy handed debt collection practices:

A man suffering from schizophrenia contacted a CAB in the East region for debt advice. He had not worked for two years and was not able to make repayments on his debts. The client told the CAB that persistent and heavy-handed contact from debt collectors had adversely affected his mental health. The client was so worried by the threats of the debt collectors that he had destroyed all his possessions so that bailiffs could not seize them.

A CAB in Sussex reported that they had been helping a couple with their debts of £30,000 for over a year. The wife had been admitted to a clinic following a nervous breakdown as a result of severe post-natal depression, and the husband was suffering from stress trying to cope. During the course of the year their financial circumstances fluctuated greatly and had deteriorated. As a result their ability to pay creditors had reduced to the point of not being able to make payments at all. However, many of the creditors, including a major credit card company, two high street banks and a supermarket bank, had taken a more aggressive approach to collection of the debts, refusing to suspend interest charges and insisting on contacting the clients directly. This had happened even though the CAB had

requested that they deal directly with the bureau due to the clients' precarious state of mental health.

A CAB in East London reported that they had helped a man with severe mental health problems petition for bankruptcy, as it appeared to be the best option for dealing with his unmanageable debts. Although the Official Receiver had notified all the client's creditors that he was now bankrupt and all further enquiries about his debts should be made to the Official Receiver's office, a firm of solicitors collecting a storecard debt continued to send the client letters demanding immediate payment or they would seize his belongings. The client was extremely upset by the continuing contact with this creditor following his bankruptcy, which was exacerbating his mental health.

Ability to repay

- 6.48 Another issue which particularly affects people with mental health problems in debt, is that they are often unable to make offers of payment, as they are on low or volatile incomes. Furthermore, those with long-term mental health problems may never see an improvement in their financial circumstances. Consequently payment moratoria or debt write-offs are often the only realistic options for dealing with their debt problem. However, such strategies are often unacceptable to creditors and debt collectors who want their minimum payment, and continue with collection action and sometimes court action:

A CAB in Gloucestershire reported that they had been trying to negotiate for 18 months with a debt collection agency collecting a credit card debt. The CAB was asking for a write off, as the client, a former soldier, was suffering from post-traumatic stress disorder, requiring frequent hospitalisation. However the debt collection agency would only hold the account for two months at a time and then threaten the client and his wife with further action, at which point the CAB would have to write again to tell them that the client's circumstances had not changed. After no contact for 6 months, the client received a letter from a different debt collection agency threatening court action for the debt. When the CAB rang the new collection agency to ask if they could hold further action for seven days to enable the CAB to write to the company explaining the client's background, medical and financial situation, the debt collector said, "this company never holds action", and put the phone down.

A CAB in County Durham reported that they had been helping a lone parent with severe long-term mental health problems with her debts. At the time of seeking advice, the client's youngest child had recently died, and two of her other children had health problems. The CAB wrote to all creditors explaining her current personal and financial circumstances, and requested that all future contact with the client should come through the CAB, due to her state of health. Nevertheless one creditor continued to send people around to her

house to demand payment. Following a complaint from the CAB, the creditor agreed as a gesture of good will to write off the debt. However, six months later, a third party debt collector apparently collecting this debt called at the client's house. When the CAB rang the debt collection company for further clarification, the debt collector insisted that it was not possible to write off debts.

A CAB in Nottinghamshire was helping a couple both of whom suffered from bi-polar disorder. They had entered into a credit agreement to buy double glazing for £10,000 at a time when their main income was incapacity benefit, and it should have been clear to the creditor at the time that the clients could not afford the repayments on top of their mortgage. The clients could not afford the repayments and fell into arrears. The credit company insisted on taking court action for the debt, and when they got the county court judgment, applied to enforce it by means of a charging order, and threatening the clients with an order for sale of their home. Although the CAB were able to persuade the creditor's solicitors to withdraw the application for the final charging order, the solicitors continued to contact the clients asking for increased payments.

6.49 Protection for people in financial difficulties is currently provided by various voluntary codes of practice to which creditors subscribe, and by the consumer credit licensing system policed by the Office of Fair Trading. Although many codes of practice require subscribers to treat people in financial difficulties "positively and sympathetically", there is no practical definition of this phrase in most of the codes, with the exception of the Banking and Mortgage Codes. These codes have associated guidance which describes in detail how subscribers can demonstrate compliance.

6.50 In our recent report *In too deep: CAB clients' experience of debt*, Citizens Advice called for all creditor trade associations to adopt guidance on dealing with customers in financial difficulties, including a commitment to train their staff on awareness of mental health problems. However, to date none of the creditor trade bodies have adopted such detailed guidance. **Citizens Advice therefore recommends that all creditor trade associations, including the Finance and Leasing Association, Consumer Credit Association, Consumer Credit Trade Association, Mail Order Trade Association and Credit Services Association, adopt guidance on dealing with customers in financial difficulties by the end of 2004.** The model for the guidance should be the guidance to the Banking Code. **Citizens Advice further recommends that the guidance should contain the following to ensure that customers with mental health problems in debt are treated fairly and sympathetically:**

- **To provide training for all collections staff on awareness of the needs of people with mental health problems**
- **To ensure that vulnerable people whose debt problems are likely to be long-term are identified at an early stage in the collection process, and are dealt with by special units who can**

provide a more focused service. This would not just help those with mental health problems, but also other vulnerable people in debt. The 2002 OFGEM guidance on preventing debt and disconnection¹¹⁹ expects fuel companies to do this

- **To be willing to write-off debts where the customer's mental health problems are long-term and their financial circumstances are unlikely to improve.**

6.51 It is unacceptable that court action to recover and enforce non-payment of debts is taken before other solutions, such as negotiation have been fully explored. It is welcome that the Department for Constitutional Affairs (DCA) is now developing pre-action guidance for debt cases to encourage creditors to engage in dialogue with debtors before entering the court process. Research commissioned by DCA found that people with mental health problems were “can't pay” and all too often facing court action for debt which was completely inappropriate due to their income and state of health.¹²⁰ **Citizens Advice therefore recommends that the pre-action guidance should require creditors to take a holistic approach to debt recovery, which tailors their response to the debtor's circumstances and ensures that court action is not taken against debtors with long-term mental health problems.** In order to ensure that this happens in practice, the guidance must be binding.

Support for people in debt from health professionals

- 6.52 Debt compounds social exclusion because if people are on benefits they lose control of the very little money they have for debt repayments. Advisers find that some social workers and mental health care workers give insufficient attention to people's income and financial commitments and how income security contributes to maintaining people's health and stability. They may not be aware of their clients' debts and the help available. Financial literacy is described by advisers as a central issue; ‘many clients have never been shown how to manage their money and for us it is an education issue, teaching them what it is all about’¹²¹.
- 6.53 Help promotes health. Surveys of care managers in Northumberland showed that ‘engaging with debt advice ameliorated mental health problems’¹²² and Abbot and Hobby found that mental health scores improved significantly over a 12 month period among clients who received new benefits.¹²³

¹¹⁹ *Preventing Debt and Disconnection*, 2002, OFGEM

¹²⁰ *Can't pay or won't pay? A review of creditor and debtor approaches to the non-payment of bills*, 2003, Kempson, Elaine, Lord Chancellors Department.

¹²¹ CAB project worker

¹²² *Income, Poverty and Mental Health*, p.5, March 2003, M. Plumpton & J. Bostock, Department of Psychological Services and Research Newcastle, North Tyneside & Northumberland NHS Mental Health Trust,

¹²³ *Evaluation of the health and advice project: its impact on the health of those using the service*, 1999, Abbott S & Hobby L, Health and Community Care Research Unit, Liverpool.

- 6.54 It is crucial that professionals and other workers understand the importance of addressing debt early to minimise health problems, and the need to ensure people are referred to specific agencies for help. **Citizens Advice recommends that all social workers, community psychiatric nurses, psychiatrists and GPs should receive training to raise their awareness to the importance of advice and help on income maximisation for people with mental health problems. Social Services and the NHS should develop procedures for prompt referral of clients who need financial help or advice to specific agencies to ensure that all clients, as part of their care programme, are fully informed about benefit entitlements and have help to maximise their income and deal with debts.**

Conclusions

- 6.55 If the one in six of the people who may suffer from mental health problems at any one time are to be able to engage with the everyday purchase of goods and services, there must be better recognition of their needs by businesses. CAB evidence illustrates that discrimination arises through a lack of knowledge of the symptoms of mental ill health that is frequently reflected in the way in which people with mental health problems are dealt with in the consumer market. Staff training is clearly one way to prevent this, as long as it is backed up by compliance checks.
- 6.56 CAB evidence shows that people with mental health problem are particularly susceptible to pressurised sales techniques, and so may end up with unaffordable goods and services, which may be unsuitable for their needs. They also experience difficulties at a disproportionate level in trying to set aside contracts that have been entered into during a period when, due to mental ill health, they temporarily lacked the capacity to contract. These problems need to be recognised in the new Mental Incapacity Bill. In addition, consumer protection bodies should look at strategies for better access to consumer protection for vulnerable consumers with mental health problems.
- 6.57 The ease of access to credit can pose problems for people with mental ill-health who are likely to be on low incomes. In particular the lack of checks by the credit industry on the borrower's income and expenditure means it is easy for those exhibiting manic behaviour to go on spending sprees using credit they cannot afford to repay. Although government proposes to introduce a duty to lend responsibly, legislation is some way off, and regulatory guidance is needed to ensure responsible lending.
- 6.58 In contrast, insurance protection can be inaccessible to people with mental health problems under the current provisions of the Disability Discrimination Act. The guidance from the Association of British Insurers needs to be improved to tackle the issue of fair access and terms and the Financial Services Authority should produce a statement of how new regulatory powers can ensure that consumers with mental health problems are treated fairly. And crucially, the DDA needs to be reformed to fully encompass

discrimination against people with mental health problems in the provision of goods and services.

- 6.59 There is a clear link between mental ill-health and debt. CAB evidence shows that heavy-handed debt collection practices exacerbate the problem. Creditors fail to be realistic in their expectations of the ability of those with severe mental health problems to repay their debts. Credit industry codes of practice should recognise the problems faced by people with mental health problems in debt, and provide detailed and realistic guidance for their subscribers. Finally health professionals need training to recognise when patients require debt advice, and access to appropriate referral procedures in order to alleviate the levels of stress associated with debt.

7 Advice work – making a difference

7.1 This chapter describes how CAB projects take account of the special needs of people with mental health problems and offer help and support. It illustrates the importance of inter-agency co-operation and sustained funding for all services for this group of people if clients are to receive the best possible service and support.

7.2 There are over 100 CAB mental health projects around the country. This chapter focuses on seven which have been selected because they demonstrate the range and different kind of work undertaken:

- Abraham Cowley Unit Mental Health Project
- Cambridge CAB Mental Health Project
- Derwentside CAB Mental Health Project
- Durham CAB Representative Advocacy Service
- Gwynedd CAB and De Ynys Mon CAB Mental Health Service Provision
- Leytonstone CAB Mental Health Project
- Salford Mental Health Services CAB

Responding to need

7.3 Previous chapters have outlined some of the support which people with mental health problems need if they are not to be excluded from their rights and participation in the wider community. Some CABx report that as many as 50 per cent of their clients have or have had a mental health problem; some of the projects referred to in this chapter emerged in response to this level of client need. For example:

In Derwentside the bureau manager noticed a significant number of clients were not able to control their budgets and were missing appointments. A short questionnaire elicited 100 replies from people who said they had mental health problems, 70 per cent of whom had been referred by their GP to mental health services for help. The project secured funding in 1999 and sees clients at the bureau, at home and in mental health groups in the community.

In Cambridge, CAB workers who were visiting family members in the local psychiatric hospital realised there was a lack of information for people there who needed help with benefits, debt, housing, immigration, consumer affairs, treatment, safety and security in the hospital and contraventions of the Human Rights Act. With only one telephone for patients, there were many practical things that could not be sorted out from the hospital. The service began by sending volunteers to the hospital to give advice. The project was set up in 1997 when funding was found for a worker who sees clients at the CAB and during a weekly session at the Fulbourn Hospital. Help is

also given by the manager of a nearby CAB who can undertake home visits.

- 7.4 All these CAB projects except Derwentside help clients who have been referred to mental health services¹²⁴ who may be in hospital or in the community. When the Abraham Cowley Unit started in 1988, most of its clients were in-patients; now about 50 per cent come from the Community Mental Health Team and outreach sessions are given at day centres on alternate Tuesdays. In Derwentside, the CAB project began by helping clients with a mental health problem who had come to the bureau; it now also takes referrals from psychiatrists, psychologists, social workers, GPs and community psychiatric nurses.

Advice and Advocacy

- 7.5 The kind of help CABs give varies. Most give generalist advice, the bulk of which relates to benefits and debt, with specialist help for benefit reviews and appeals.

At the Abraham Cowley unit, advice workers help with representation and advocacy.

The Durham Representative Advocacy service provides advocacy¹²⁵ for adults who are community based and receiving continuing care. People with mental health problems constitute a third of their clients. Many are not connected to any kind of social network and may go from week to week seeing only health care professionals. Most of the work is with the client so that their voice is heard in care plans, relationships with social, health and housing services, treatment plans and through complaint procedures.

Salford Mental Health Services CAB offer both generalist advice and advocacy services at a number of outreach locations. Advocacy is provided as a full-time service to people in hospital (in secure and acute units). At the Meadowbrook acute unit for example, advocacy is in its sixth year and available five days a week. The service initially focused on discharge and aftercare packages. Now, increasingly, they also address care and treatment issues, legal rights and housing problems. It gives people general support, accesses information, makes contact with staff and other agencies via telephone, letters and face to face meetings and represents clients at ward rounds, pre-discharge meetings, managers hearings, review tribunals and independent review panels. Information about the service is given to every patient on arrival at the unit in a Patients Book. The worker, who introduces herself on the ward, can be reached through a 24 hour telephone line.

¹²⁴ Derwentside helps both clients who have and those who have not been referred to mental health services.

¹²⁵ The local CAB service is accessed for help for issues other than advocacy.

7.6 Without these special projects, there would not be sufficient time for CABx to give clients the level of support and help they need. CAB services stop clients' difficulties mounting to a point where they become so stressful they might cause a return to hospital or delaying discharge. CAB services also stop clients having to turn to debt management companies and leaving issues until the last minute, such as 'coming to the bureau at the 'nth hour with their court papers or when the bailiff was at the door.'¹²⁶ Outcomes are very positive with high success rates in securing benefit payments for clients and resolving debt issues. This can have a tremendous impact on peoples' lives. Unsolicited comments from users to the Leytonstone project, such as the following, illustrate this.

'Since my case was taken on by yourselves it has allowed me to concentrate on my treatment and well being.'

'X has been extremely professional and concerned in her dealing with me. She has been a major factor on my road to recovery.'

'I was frightened by all the paper work as I'm dyslexic. X was kind, efficient – nothing was too much trouble. She cares about her clients and pursued matters and made me feel worthwhile.'

Service features

7.7 CAB projects have developed a range of core features which break down barriers of distrust and overcome people's lack of confidence.

- Face to face contact with clients to build trust
- Continuity of adviser contact to retain trust and confidence
- Holistic advice and support– tackling many problems¹²⁷.
- Long and repeated interviews
- Good access. Location is part of this. But so is accessibility over the phone. For example, the Durham advocacy project and Salford mental health CAB advocacy services have 24 hour telephone lines to take messages.
- Workers with experience of benefit issues and mental health problems to advise and represent their clients.

7.8 CAB projects working to support and help people with mental health problems tend to need to give long interviews to individuals and to be flexible. Clients frequently fail to attend interviews and it takes a lot of time to amass information and evidence from people when they are ill.

7.9 People with mental health problems need face to face advice that allows time to build trust and confidence. This needs to be

¹²⁶ Project worker.

¹²⁷ It can take a great deal of effort for someone with a mental health problem to come into a bureau or other voluntary organisation. If they are then referred to other agencies such as specialist debt services, they may well be lost to help.

recognised and planned for in service provision. Funding should provide for trained workers and advocates.

Appropriate location

- 7.10 Services need to go to the client, which may mean offering them in new and accessible environments. Projects helping people in hospital and following their discharge are often located in or near a hospital unit so they are well placed for inpatients to get to and for people returning on a weekly or regular basis. The Abraham Cowley Unit Mental Health Project, a specialist outreach service of Runnymede CAB and Salford Mental Health Services CAB are such projects. They, Leytonstone, and Gwynedd and De Ynys CABx run regular outreach sessions to reach clients in care and day units. For example:

Leytonstone runs weekly sessions at two Mental Health Locality centres and at a drug and alcohol drop in¹²⁸ and monthly sessions at a mental health day centre for black people.

Gwynedd and De Ynys Mon CAB run six outreach services across rural locations from Dolgellau to Bangor, a distance of approximately 70 miles. These bilingual services take referrals from psychiatric wards and community mental health teams, helping clients from very different communities, in hospital day units and drop in centres.

- 7.11 These projects focus on helping people who have been referred to the mental health services by their GP. However, there are many people in the community with mild to moderate mental health problems who are treated only by their GP and who get little if any further help. They may have no support network to turn to and some come to CABx and other voluntary organisations for help.
- 7.12 Locating services in or near GP surgeries may be best for catching people in the early stage of their illness so they can be advised early about benefit entitlements and financial management should they need it. Academic research¹²⁹ demonstrates both health improvement and economic benefit for people using CAB services in primary healthcare settings. It reduces anxiety, has direct effects on financial benefits and housing and indirect benefits of well-being and self-esteem which come from the support of advice and advocacy. For example:

The Birmingham CAB Health Unit runs advice sessions in 45 GP practices. Amongst its services it has 6 advice workers based in the social services community mental health teams.

¹²⁸ Separately funded from the main project.

¹²⁹ *Evaluation of the health and advice project: its impact on the health of those using the service*, July 1999, Research by Abbott S and Hobby L, Health and Community Care Research Unit (HACCRU), Liverpool University; *What do you advise doc? A CAB in Primary Care in the West Midlands*, 2000, Emanuel J and Begum S, Sandwell District CAB and Faculty of Education, University of Manchester.

Targeting people via GP surgeries is one of the approaches being used in the strategy for *'Better Health - Better Wales'*. In this programme, each area has at least one specialist advice worker who is based at a Citizens Advice Bureau taking referrals from primary care teams, CPNs and mental health organisations. This benefits advice pilot scheme has seen over 6,000 clients and generated £3.5 million in confirmed benefits¹³⁰.

7.13 Support and practical help are needed when people become ill, when they go in and out of hospital, when they move into and out of employment and when in debt. It is also important to get help to the majority of people with mental health problems who are not referred on to the specialist mental health services. Advice and help need to be focused where it is quickly and easily accessed, that is:

- in or near hospital and treatment centres for people in the mental health system
- in GP surgeries for people who have not been referred to the mental health system, in order to reach people at an early stage.

Inter-agency working

7.14 Clients often have complex problems involving a number of inter-relating issues. Projects need to work closely with mental health services and other agencies to address multiple needs and provide appropriate support. For example, Salford Mental Health Services CAB works closely with day services and secure units to offer a number of outreach advice sessions and advocacy services on site for clients. It has also been heavily involved in organising the North West Mental Health and Welfare Rights Group which provides support for benefit workers in the mental health field and in the work of the Northern Mental Health Forum. The Abraham Cowley Unit, as well as working closely with the hospital with which it is associated, is part of a well integrated network of agencies in its community across which there is good communication. It refers clients directly to Project 18, a local voluntary service job-broker, if clients are in a position to consider returning to work. Housing issues tend to be picked up early and there is good input from the Community Mental Health Team to support clients looking for housing and established protocols to help the council liaise with the Community Mental Health Team when clients have rent arrears.

7.15 Inter-agency co-operation does not always work well. CAB workers need time to build good working relationships with professionals in and outside hospitals to secure the co-operation of doctors and nurses for their specialist input to benefit applications or appeals. One CAB project shows dramatic differences between two specialist care units in the amount of

¹³⁰ The Health and Social Services Minister Jane Hutt has endorsed the schemes' successes with a commitment to provide £700,000 a year to Citizens Advice Cymru to continue the initiative.

time the project worker has to invest on behalf of clients for the same good results. A particularly good working relationship at one care unit reflects the professionals' understanding about the importance of benefits to the lives and well being of clients. The kinds of information that is needed, how it should be presented and the importance of time limits.¹³¹ Doctors supply accurate and relevant information quickly for benefit applications and appeals. The project reports that far more time and work is required for clients at a second care unit where the professionals, in spite of being given help, are slow to respond, may supply incomplete or irrelevant information and where clients may have no allocated worker.

- 7.16 Inter-agency co-operation on planning and development is needed so that agencies develop common objectives, minimise referrals and offer joined up services and holistic support. A number of the healthcare locations involved in the partnership between Citizens Advice Cymru and the National Assembly of Wales for the '*Better Health - Better Wales*' programme¹³² are specifically for people with mental health problems.
- 7.17 However, some CABx report that they are not included in local forums and planning strategies to develop services for people with mental health problems. If people are to have an holistic service, full inter-agency co-operation is essential for planning and development. **Citizens Advice recommends The National Institute for Mental Health England should take the lead in developing comprehensive strategies for providing appropriate support to people with mental health problems between local agencies that include CABx.**

Funding for sustained support

- 7.18 The system fails clients with mental health problems who need help and representation and do not get it. Bureaux do not always have the resources or skill needed to do the work that is required and clients are sometimes passed between agencies in an effort to help them. Resources are needed for trained workers in outlets that can readily reach people in the early stage of their illness.
- 7.19 Some areas have a good range of services but even then workers comment that 'most if not all of them are in constant need of funds to prevent closure'. Sustained funding for special schemes is rare. Advisers observe that money is often available for new projects but not for ongoing work despite the fact that clients need stability. Continuity of services and of personnel is an issue for concern as many projects describe themselves as expected to plan without knowing whether they will be funded. The successive closure of projects for lack of funds can generate a sense of betrayal amongst users.

¹³¹ The project has developed standard letters to help professionals focus their knowledge and input on relevant criteria for clients' claims or appeals.

¹³² *Better Health – Better Wales*, 1998, Cm 3922, Greenpaper, National Assembly for Wales,

7.20 Even when there is demonstrable need, funding is not guaranteed. In Derwentside the project is currently funded on a year by year basis, making planning difficult; yet in 2002 the programme had 1,827 enquiries. The Leytonstone project was funded jointly by social services and the health authority when it started in 1997. It later faced the prospect of losing its funding, until a local user group called 'Together' lobbied very effectively on its behalf and the project won partnership funding up to 2005, administered by the Primary Care Trust. Even so, Leytonstone's funding does not cover the full spectrum of needs; the project is funded to provide welfare, benefit and debt advice but help with housing can only be given in so far as it relates to debt.

7.21 Established projects need to be able to rely upon long term and sustainable funding to create stability and allow for planning and development of their work.

Conclusions

7.22 Advice services play an important role both for people with mental health problems who are in the formal mental health system and for the many with mild to moderate illness who are treated by GPs. Services need to be located where the clients are and they need to incorporate certain key features which take account of the difficulties facing people with mental illness. Projects referred to in this Chapter are a few amongst the many that fulfil a vital function in the network of service provision for people with mental health problems.

8 Conclusions and Recommendations

- 8.1 The CAB evidence in this report clearly demonstrates the extent of social exclusion faced by people with mental health problems, in consumer affairs, the benefit system and the workplace. Citizens Advice believes it is crucial that this exclusion is addressed in all its forms.
- 8.2 This means tackling the core issues of discrimination and people's need for support. The aim should be to enhance their sense of inclusion and security and to facilitate their recovery so that they can move forward with their life and, if they can cope with it, work.
- 8.3 There is no point in broadening people's social contacts and opening up opportunities for work if, by doing so, we are exposing them to more discrimination. A concerted effort needs to be directed to educating everyone in the public, private and voluntary sectors who meet and deal face to face with people with mental health problems. For a significant number of people with mental health problems these contacts may be the bulk of their social network. Such education needs to be anchored in a general push for greater public awareness.
- 8.4 For this reason Citizens Advice calls for a wide ranging campaign to promote mental health awareness. Because discrimination against people with mental health problems is often endemic to institutions this report also calls for a cross-cutting review of the benefit system and for significant changes in how insurance companies, banks and credit agencies relate to vulnerable customers and people with mental health problems.
- 8.5 It is important to tackle institutional procedures and systems that perpetuate inequalities, either directly by not recognising people's illness or indirectly by practices that lead people into debt, if we are to help broaden people's sense of security.
- 8.6 People with mental health problems need positive experiences and help with managing their affairs if they are to get better and be able to work. It is therefore crucially important that they are helped to tackle discrimination when they experience it and are given help to manage their lives when they need it.
- 8.7 The report's main recommendations are summarised below under the headings:
- Discrimination and mental health awareness
 - Changes to working practices
 - Overhauling the benefit system
 - Addressing insurance, consumer and debt issues
 - Supporting people when they are ill

Discrimination and mental health awareness

- 8.8 The Government has a lead role to play in raising the profile of mental health awareness training and in ensuring discrimination legislation sets a baseline for good practice, as this determines how the market responds.
- **The National Institute for Mental Health England (NIMHE) and the Department of Health, Social Services and Public Safety in Northern Ireland should be given lead responsibility for establishing a cross departmental programme for combating discrimination on grounds of mental health and to promote social inclusion for people with mental health problems in the public, private and voluntary sectors. (paragraph 1.16)**
 - **The Welsh Assembly Government should build on the progress for a multi-agency approach to combating discrimination, promoting social inclusion and tackling stigma as laid down in the NSF (Standard 1) for Wales. (paragraph 1.17)**
 - **All those working in statutory and voluntary agencies and public and private bodies dealing with the public should undergo mental health awareness training which includes information about the difficulties illness creates for people. Organisations should underpin this by reviewing and monitoring their systems and procedures, to ensure that people with mental health problems are not put at a disadvantage. (paragraph 1.15)**
 - **To help challenge the unacceptable discrimination faced by people with mental health problems, definitions of mental impairment in the Disability Discrimination Act should be broadened. 'Normal day to day activities' should include the effects of mental disability on day to day living, such as communication or social interaction. The term 'clinically well recognised' should be dispensed with and recognition given to a wider range of mental health problems so that the same level of protection is provided for people with mental disabilities as is for those with physical disabilities. (paragraphs 1.11, 6.43)**

Changes to working practices

- 8.9 Helping people with mental health problems back into work will only help reduce their social exclusion if the difficulties they encounter in recruitment and holding onto jobs when they are ill are vigorously tackled. **The National Institute for Mental Health England should work with the Department for Trade and Industry to:**
- **raise awareness about mental health issues and widely disseminate publicity for employers about the nature of mental illness and the difficulties it creates for people in the workplace. This should be accompanied by information about the way work**

itself can contribute to stress and create some mental illness. (paragraph 2.18)

- **back this up with guidance about best practice for employers and employees and support for achieving change in working practices which might include:**
 - **active promotion and distribution of documents such as *The Line Manager's Resource* with guidance on phasing people into work, flexible working, supervision and support for people when they are ill and for assisting their return to work. (paragraph 2.18)**
- **encourage flexible working by giving employees with mental health problems the same right as parents, to a new right to flexible working¹³³, namely:**
 - **to apply to work flexible hours**
 - **to have their application for such properly considered and responded to**
 - **for the right of appeal at tribunal. (paragraph 2.18)**
- **separate the interview process from an applicant's disclosure of information about any medical conditions (paragraph 2.10)**
- **publicise to job applicants that there are arrangements to accommodate people with mental health problems and making clear to employees the help they can anticipate through flexible working arrangements, reasonable adjustments, confidentiality, understanding about their illness and one to one support if it is needed. (paragraph 2.10)**

Overhauling the benefit system

- 8.10 The benefit system's failure to acknowledge the particular circumstances and requirements of people with mental health problems prevents them from claiming their full benefit entitlement, deters moves into work and restricts access to financial help at times of hardship. This must be addressed if there is to be a more positive and helpful response to people's illness and the difficulties they face when not well.
- 8.11 **The Department of Work and Pensions and its agencies should undertake a major review of the whole benefit system and its impact on people with mental health problems. Such a comprehensive review should assess how performance at every level affects experience and outcomes for people with mental health problems**

¹³³ *Flexible Working: the right to request and the duty to consider*, 2003, DTI.

when they are ill. Mental health awareness and training about the problems it creates for people who are unwell should be a central requirement for all staff (paragraph 4.53). Some of the issues a review should pay attention to are:

- **revising rules and procedures for the transition from benefits to work in co-operation with mental health service users and providers to:**
 - **simplify and create flexibility for a more gradual transition from benefits to work (paragraphs 3.12, 3.35)**
 - **create a simpler allowance and tax credit system that makes it financially worthwhile for people with mental health problems to do as much work as they can (paragraphs 3.18, 3.35)**
- **reviewing all stages of incapacity benefit and disability living allowance assessment and how the claiming process affects people with mental health problems, addressing issues such as:**
 - **redesigning the incapacity benefit questionnaire (IB50) and reducing the constant re-assessment which can aggravate people's condition (paragraphs 4.30, 4.37)**
 - **ensuring there is appropriate training on mental health issues for everyone involved in making decisions on benefit applications and for members of independent appeals tribunals (paragraphs 4.16, 4.43)**
 - **ensuring evidence relevant to a personal capability assessment, such as information from community psychiatric nurses, care workers and psychiatrists, is considered equally with the reports of medical services doctors. Professionals must be fully aware of their role in contributing relevant and timely evidence for securing benefit income and of its importance to people's health and recovery (paragraphs 4.43, 4.44)**
 - **acting immediately on the Select Committee's call for a full review of Medical Services' treatment of claimants with mental health problems¹³⁴ with attention to regular training and monitoring the quality of doctors reports on mental health issues (paragraphs 4.34, 4.42)**

¹³⁴ *Third Report, Chapter IV, 1999/2000, Select Committee on Social Security, House of Commons*

- **Jobcentre Plus should report annually to the Department for Work and Pensions on the steps it is taking and with what success, to tackle the problems of claimants accessing offices when they have difficulty travelling because of their illness and/or because they live in rural areas. Medical Services should report annually to the Department for Work and Pensions on how it addresses the difficulties faced by people with mental health problems in rural areas (paragraphs 4.19, 4.21)**
- **examining difficulties in review and appeal processes faced by claimants with mental health problems. Particular attention should be paid to representation and not financially penalising people who appeal (paragraphs 4.46, 4.47, 4.49)**
- **amending benefit rules and procedures to ensure that people with mental health problems do not lose out on help at times of need. This means:**
 - **housing benefit departments and social landlords should support tenants with mental health problems with housing benefit applications and renewals (paragraphs 5.10, 5.12, 5.14)**
 - **reviewing the benefit rules for long stay hospital patients (paragraph 5.20)**
 - **extending the scope of the Social Fund and reviewing eligibility for Social Fund loans and grants (paragraphs 5.23, 5.25)**
 - **reviewing the dispensing of prescriptions and help with prescription charges (paragraphs 5.28, 5.30)**

Addressing insurance, consumer and debt issues

- 8.12 People with mental health problems who lose their job may also find they have no payment protection insurance because their illness is not recognised. They can face further difficulties when credit is given without reasonable checks on their ability to pay and they may have to struggle with unmanageable debt and heavy handed inappropriate debt recovery practices, which only aggravate their condition. For these reasons, Citizens Advice makes the following recommendations.
- 8.13 **Providers of consumer goods and services should ensure their staff are trained on awareness of mental health problems and how to respond appropriately. Training on mental health awareness should be required in relevant industry codes of practice. (paragraphs 6.4, 6.5)**

- 8.14** The draft Mental Incapacity Bill should be amended to improve consumer protection rights and remedies, so that contracts may be challenged where they have been made during a period when a consumer with mental health problems is ill and cannot reasonably be expected to enter into contractual relationships on the same basis as somebody with full mental capacity. (paragraph 6.14)
- 8.15** Citizens Advice would like to see a commitment in the forthcoming new DTI consumer strategy that consumer protection bodies will work together to develop and publish a shared strategy on the use of their powers to the maximum benefit of vulnerable consumers and consumers with mental health problems. This strategy should set out in particular how they will challenge discrimination and unfair treatment towards and improve protection of, people with mental health problems in the markets they are concerned with. OFT, in their role of co-ordinating UK enforcement could be asked to take the lead in developing this. (paragraph 6.18)
- 8.16** The Banking and Finance and Leasing Association Codes should introduce interim measures until the Government's proposals to support a legal duty for lenders to lend responsibly come into force. (paragraph 6.24)

They should:

- incorporate commitments to use the rule-of-thumb indicators of overindebtedness as recommended by the second Department of Trade and Industry Overindebtedness Task Force report (paragraph 6.25)
 - emphasise the importance of assessing a borrower's income and expenditure before lending and encourage consumers to consider for themselves the affordability of loans (paragraph 6.26)
- 8.17** Further action on responsible lending should include:
- the Office of Fair Trading should draw up guidance for consumer credit licence holders on credit marketing and responsible lending. Alternatively it could rework its existing guidance on non-status lending to cover all credit lending, whether secured or unsecured (paragraph 6.27)
 - all creditor trade associations, including the Finance and Leasing Association, Consumer Credit Association, Consumer Credit Trade Association, Mail Order Trade Association and the Credit Services Association, should adopt guidance on dealing with customers in financial difficulties by the end of 2004 to provide for:

- **training for all debt collection staff on the needs of people with mental health problems**
- **ensuring vulnerable people whose debt problems are likely to be long-term are identified at an early stage and dealt with by special units who can provide a more focused service**
- **writing off debts where the customer's mental health problems are long-term and their financial circumstances unlikely to improve (paragraph 6.50)**
- **the Department for Constitutional Affairs should draw up pre-action guidance requiring creditors to take a holistic approach to debt recovery, which tailors their response to a debtor's circumstances and ensures court action is not taken against debtors with long-term mental health problems. (paragraph 6.51)**

8.18 The Financial Services Authority should produce a policy statement setting out how their approach to regulation of general insurance will ensure that consumers with mental health problems are treated fairly. (paragraph 6.36)

8.19 The Association of British Insurers should review their guidance on compliance with the DDA to ensure people with mental health problems are not unreasonably excluded from obtaining insurance and making claims. The review should examine:

- **the use of blanket mental health exclusions that serve to unreasonably reduce access to cover**
- **the acceptance of GP medical evidence about the insured's state of mental health as evidence in a claim**
- **how the industry could be encouraged to provide a better deal for people with mental health problems. (paragraph 6.39)**

Supporting people when they are ill

8.20 The interlinking of problems of illness with, for example, debt, substance misuse and homelessness emphasises the importance of helping people with all their problems and early on, to minimise the risks of aggravating their illness. This is best done through a co-operative and inter-linked agency approach to provide services and help. CABx mental health projects demonstrate the effectiveness of advice and advocacy where people can easily access it.

8.21 The National Institute for Mental Health England should take the lead in developing comprehensive strategies for providing all round

support to people with mental health problems between local agencies that include CABx (paragraph 7.17). This strategy should include:

- **training social workers, community psychiatric nurses, psychiatrists and GPs about the importance of advice and help on income maximisation for people with mental health problems (paragraphs 4.44, 6.54)**
- **developing procedures for prompt referral of clients who need financial help to specific agencies so that, as part of their care programme, they are fully informed about benefit entitlements and have help to maximise their income and deal with debts (paragraphs 5.17, 6.54)**
- **Established projects need to be able to rely upon long term and sustainable funding to create stability and allow for planning and development of work that includes trained workers and advocates, face to face advice and time to build trust. (paragraphs 7.9, 7.21)**

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Appendix 1

CABx that responded to the Mental health and social exclusion questionnaire**EAST**

CAB Service in
Hertsmere
Dacorum District*
Fenland
Hertford
Ipswich
Leiston, Saxmundham &
District
Stevenage*
Welwyn Hatfield*
Waltham Abbey
Wymondham*

LONDON

Chelsea*
Eltham
Hampton
Harrow*
Romford*

MIDLANDS

Burton upon Trent
Daventry & District
Dudley District
Lincoln & District*
Malvern Hills District*

Northampton & District*
Rugeley & District*
South Shropshire
Walsall*
Worcester*

NORTH

Blyth Valley
Boothferry District*
Derwentside*
Gateshead*
Hartlepool*
Keighley & District*
North Kirklees
Redcar & Cleveland*
Ripon & District
Sheffield*

NORTH WEST

Chester
Crew & Nantwich*
Macclesfield, Wilmslow
& District*
Salford*

SOUTH

Alton

Crowborough*
Dorking*
Dover & District*
Eastbourne
Epsom & Ewell*
Fareham*
Godalming
Guildford*
Heathlands/Rushmoor*
Medway
Runnymede*
Thanet*
Waterside
Winchester*
West Berkshire*

WALES

Gwynedd
Llanelli
Powys
South Denbighshire*

WEST

Gloucester & District*
North Cornwall
North Devon
Taunton & District

* CABx with mental health outlets

Appendix 2

CABx that submitted evidence between January 2002 and December 2003

EAST REGION

Abbots Langley
 Billericay
 Bishop's Stortford District
 Braintree & District
 Brandon & Mildenhall
 Broxbourne
 Bury St Edmunds
 Cambridge & District
 Castle Point
 Chelmsford
 Colchester
 Dunstable & District
 Ely
 Epping
 Fenland (Main)
 Great Yarmouth
 Harlow
 Haverhill
 Dacorum District
 Hertford
 CAB service Hertsmere
 Huntingdonshire
 Ipswich & District
 Kings Lynn & District
 Leighton Linlade
 Leiston & Saxmundham
 Lowestoft
 Maldon
 Mid-Suffolk (Stowmarket)
 Newmarket
 North Herefordshire
 Norwich & District
 Norwich Money Advice
 Oxhey & District
 Peterborough
 Rickmansworth
 Rochford & Rayleigh
 St Albans
 Southend-on-Sea
 Stevenage
 Sudbury
 Thetford & District

Uttlesford (Saffron Walden)
 Waltham Abbey
 Ware & District
 Watford
 Welwyn Hatfield
 Wickford
 Witham
 Wymondham & District

LONDON REGION

Barking & Dagenham
 Barnet
 Bexley
 Brent
 Bromley
 Camden CAB Service
 Croydon
 Ealing
 Enfield
 Fulham
 Greenwich District
 Hackney (Mare Street)
 Harrow
 Havering
 Hillingdon
 Hounslow
 Kensington & Chelsea
 Lewisham
 Merton
 Newham Docklands
 Redbridge
 Richmond Borough
 Royal Courts of Justice
 Sheen
 Southwark
 Sutton
 Tower Hamlets
 Waltham Forest
 Wandsworth Borough
 Service
 Westminster CAB Service

MIDLANDS REGION

Ashfield
 Bassetlaw (Retford)
 Bedworth & District
 Birmingham
 Bromsgrove & District
 Burton-upon-Trent
 Cannock
 Charnwood
 Chesterfield
 Daventry & District
 Derby
 Dudley
 East Lindsey
 East Northants
 Eastwood & District
 Harborough District
 Hinckley
 Lichfield
 Lincoln & District
 Lutterworth
 Malvern Hills District
 Mansfield
 Melton Mowbray
 Mid Derbyshire
 Newark & District
 Newcastle Under Lyme
 Northampton
 North Warwickshire
 Nottingham & District
 Nuneaton
 Ollerton & District
 Redditch
 Rugby
 Rugeley
 Rutland
 Sandwell
 Shirley
 Sleaford
 Small Heath
 Solihull
 South Derbyshire
 South Holland
 South Kesteven
 South Shropshire

Stoke-on-Trent (District)
Stafford & Stone
Straford-on-Avon
Tamworth
Telford & The Wrekin
Uttoxeter
Walsall
Warwick District
West Lindsey
Wolverhampton District
Wyre Forest

NORTHERN IRELAND

Armagh
Callender Street
(Central Belfast)
Carrikfergus
Dungannon
Holywood
Lisburn
Londonderry

NORTH REGION

Berwick
Blyth Valley
Boothferry District
Bradford (West
Yorkshire)
Calderdale
Craven (Skipton)
Debt Advice within
Northumberland
Derwentside
Doncaster
Durham
Easington & District
East Yorkshire
(Bridlington)
Grimsby Cleethorpes &
District
Hambleton
Hartlepool
Hull
Keighley & District
Leeds
Middlesbrough
Newcastle City
North East Doncaster
North Kirklees

North Tyneside (The
Valley)
Redcar & Cleveland
(Guisborough)
Ripon
Rotherham
Ryedale
Scunthorpe
Selby District
Sharrow (Sheffield)
Sheffield Debt Support
Unit
Sheffield Mental Health
South East Sheffield
South Kirklees
(Huddersfield)
Stockton & District
Information & Advice
Service
Wakefield District
Washington
Wear Valley
York

NORTH WEST REGION

Altrincham
Bebington
Birkenhead (Charity) Ltd
Blackpool
Bolton & District
Bradford (Gtr
Manchester)
Bootle
Burnley
Bury District
Carlisle
Chester
Chorley South Ribble &
District
Citizens Advice Allerdale
Combined Hospitals
Crewe & Nantwich
Crosby
Eden
Garston
Halton District
Heswall
High Peak
Knowsley & District
Lancaster

Liverpool Central
Lytham St. Annes
Macclesfield Wilmslow &
District
Manchester District
Morcambe & Heysham
Netherly
North Liverpool
Old Trafford
Oldham District
Ribble Valley
Rochdale District
Rossendale
Sale
Salford
Skelmersdale (West
Lancs)
South Lakeland
Southport
St Helen's
Stockport District
Stretford
Swinton
Toxteth
Wallasey
Warrington District
West Kirby
Whitehaven
Wigan Borough
Wychavon

SOUTH REGION

Abingdon
Alton
Andover
Ash
Aylesbury
Basingstoke
Bexhill & Rother
Bicester
Bishop's Waltham
Bognor Regis
Bracknell
Brighton & Hove
Buckingham, Winslow &
District
Camberley
Canterbury
Chichester & District
Chiltern

Crawley
 Dartford
 Deal
 Didcot
 Dorking
 East Grinstead
 Eastbourne
 Eastleigh
 Edenbridge &
 Westerham
 Epsom & Ewell
 Esher & District
 Fareham
 Farnham
 Faversham & District
 Godalming and District
 Gosport
 Gravesham
 Guildford
 Hailsham
 Haslemere & Cranleigh
 Havant & District
 Henley & District
 High Wycombe &
 District
 Horsham
 Kent Probation Service
 Lancing & Sompting
 Leatherhead & District
 Littlehampton
 Lymington
 Maidstone
 Malling
 Medway District
 Milton Keynes District
 New Forest North
 New Milton & District
 Oxford
 Petersfield
 Portsmouth District
 Reading
 Reading Community
 WRU
 Redhill Reigate &
 Banstead
 Romsey & District
 Runnymede
 Rushmoor
 Sevenoaks
 Shoreham & Southwick

Sittingbourne & Isle of
 Sheppey
 Staines (Spelthorne)
 Swanley & District
 Tenterden
 Thanet District
 Tonbridge
 Triple Four
 Tunbridge Wells
 Uckfield
 Walton, Weybridge &
 Hersham
 Waterside
 West Berkshire
 Whitehill & Bordon
 Wigan
 Winchester
 Woking
 Wokingham & District
 Worthing & District

WALES

Abergavenny
 Ammandford
 Bridgend
 Caerphilly County
 Caldicot
 Caradon
 Cardigan
 Conwy
 Flintshire District
 Gwynedd & De Ynys
 Mon
 Maesteg
 Merthyr Tydfil
 Montgomeryshire Neath
 Newport
 North Denbighshire
 Pontypridd
 Port Talbot
 Powys
 Swansea
 Torfaen
 Vale of Glamorgan
 (Barry)
 Wrexham & District
 Ynys Mon (Holyhead)

WEST REGION

Barnstaple (North
 Devon)
 Bath & District
 Bournemouth
 Bristol
 Bude Holsworthy &
 District
 Christchurch
 Cirencester
 Dorchester & District
 East Dorset
 Exeter
 Forest of Dean
 Frome & District
 Gloucester & District
 Kennet
 Kingswood District
 Mid Devon
 Mid Somerset
 North Cornwall (Bodmin)
 North East Somerset
 North Wiltshire
 Plymouth
 Poole
 Purbeck
 Salisbury & District
 Saltash
 Sedgemoor
 South Gloucester
 South Hams
 (Dartmouth)
 South Somerset
 Stroud & District
 Teignbridge
 Torquay (Torbay)
 West Devon
 West Wiltshire Wide
 Weymouth & Portland