Health Inequalities
National Support Team

LOW INCOME, DEBT AND HEALTH

Includes Potential Key Actions for Reducing Ill Health and Mortality (Appendix 1)

Identifying strengths and effective practice and making tailored recommendations on how to address gaps in service delivery

DH INFORMATION READER BOX

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Management	IM & T
Planning /	Finance
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Description	This Low Income and Debt workbook was developed by the Health Inequalities National Support Teams (HINST) with 70 local authorities covering populations in England. Local areas could use this approach when analysing whether a population level improvements could be achieved from a set of best-practice and established interventions. This is offered as useful resource for commissioners: use is NOT mandatory.
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For Recipient's Use	

Contents

Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, 'diagnostic' visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People's Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

Executive Summary

This workbook is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels disadvantage and poorest health. These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learning from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

The topic of this workbook – *Low Income, Debt and Health* - was selected for its potential impact on health and wellbeing, and on mortality and life expectancy in the short, medium or long term. Poverty, relative deprivation and social exclusion have a major impact on health and premature death, and the chances of living in poverty are loaded heavily towards some social groups.

More debt equates to more mental ill health, even after adjustment for income and other socio-demographic variables. While both low income and debt are associated with mental illness, the effect of income on mental health appears to be mediated by debt (Jenkins et al, 2008); For example:

- Half of all people with debt in the general population have a mental disorder, compared to 14% of people with no debts and 15% of the general population (Jenkins et al, 2009)[1].
- Being in debt is associated with 2-3 fold increased risk of anxiety and depression (Jenkins et al, 2009; Meltzer et al, 2010), 3 fold increased risk of psychosis, more than 2 fold increased risk of alcohol dependence and 4 fold increased risk of drug dependence compared to people not in debt (Jenkins et al, 2009).
- Being unable to adequately heat the home in winter was associated with an almost doubled risk of anxiety or depressive disorder (Harris et al, 2010[2]).
- *Suicide and debt*: Change in financial status is associated with suicidal ideation and difficulty repaying debt is a risk factor for suicide (Turvey et al, 2002)[3].

In addition, increased mental ill health increases the likelihood of debt. While 8% of those without mental disorder have problems with debt, the rates are 24% for those with depression and anxiety, 33% for those with psychosis, 25% for those with alcohol dependency and 24% for those with drug dependency even after adjusting for income and other socio-demographic variables (Jenkins et al, 2008). One in six British adults lives with a mental health problem. One in four adults with a mental health problem – 1.75 million British adults - reports being seriously behind in paying a bill or making a repayment in the last 12 months, which is three times the rate of indebtedness in the wider 'mentally healthy' British population.

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[1] Jenkins R, Bebbington P, Brugha T et al (2009) Mental disorder in people with debt in the general population. Public Health Medicine, 6(3), 88-92

[2] Harris J, Hall J, Melzer H, *et al* (2010) *Health, Mental Health and Housing Conditions in England*. Eaga Charitable Trust, National Centre for Social Research.

[3] Turvey C, Stromquist A, Kelly K, Zwerling C, Merchant J (2002) Financial loss and suicidal ideation in a rural community sample. Acta Psychiatr Scand, 106, 373- 80.

This workbook seeks to explore the relationship between low income, debt and health. This is considered from the perspectives of:

- In general terms, the *health and wellbeing impacts* of lifting the burden of personal debt and increasing personal income
- The *specific links* between welfare benefits that are geared to address physical and mental functional ability and health, and the relationship between debt and mental health

This workbook – which is recommended for use either to carry out a local stocktake or to run a facilitated workshop – provides advice on achieving best outcomes at **population level**, and for identifying and recommending changes that could be introduced locally. Recommendations are provided on potential workshop invitees.

Central to the HINST approach is a diagnostic framework – *Commissioning Services to Achieve Best Population Outcomes* (see p11), which focuses on evidence-based interventions that produce the best possible outcomes at population level. Part of the framework addresses delivery of **service** outcomes in the most effective and cost effective manner. This is balanced by considerations of how the population uses services, and is supported to do so, to aim for **optimal population level** outcomes that are fairly distributed.

The framework points to the following areas of intervention:

A CHALLENGE TO PROVIDERS

1. Known intervention efficacy
2. Local service effectiveness
3. Cost effectiveness
4. Accessibility
5. Engaging the public

B POPULATION FOCUS

6. Known population needs
7. Expressed demand
8. Equitable resourcing
9. Responsive services
10. Supported self

11. Adequate service volumes
12. Balanced service portfolio
13. Networks, leadership and coordination

The workbook is made up of sets of detailed questions in the above categories. They provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done in relation to low income, debt and health** (including interventions to prevent people getting into debt in the first place such as financial capability interventions) to further improve population health and wellbeing, capitalising on evidence-based interventions. How these improvements will best be achieved in a given locality will be for local participants to decide. The workbook signposts good practice and guidance where this may be helpful. Appendix 1 outlines Potential Key Actions for successful interventions in this area.

Introduction

This is one of a series of diagnostic workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. The programme finished work in March 2011, but the Department of Health is publishing its key outputs for local commissioners and providers to use if they so wish. Each workbook topic was selected for the importance of its potential impact on health and wellbeing, and also on mortality and life expectancy in the short, medium or long term.

At the core of each workbook is a diagnostic framework – Commissioning Services to Achieve Best Population Level Outcomes' (see p12). The diagnostic focuses on factors that contribute to a process in which a group of evidence-based interventions produce the best possible outcomes at population level. Part of the structure addresses delivery of **service** outcomes in the most effective and cost effective manner. However this is balanced by considerations of how the population uses services, and is supported to do so, to help achieve **optimal population level** outcomes that are fairly distributed.

The framework is made up of a set of detailed, topic-based questions. These provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done** to further improve population health and wellbeing, capitalising on evidence-based interventions. **How** these improvements will best be achieved in a given locality will be for local participants to decide. The workbooks signpost good practice and guidance where this may be helpful.

The resource represented by this workbook can make a significant contribution during a period of transition for the NHS, as responsibility for commissioning of health and health related services transfers to the NHS Commissioning Board, GP Commissioning Consortia and aiming for delivery passing to the Health and Wellbeing Boards. Changes are also in progress within local government, social care and the voluntary sector. Current policy in relation to public services highlights the centrality of engaging people – as individual service uses and patients, and as whole communities, in their own health and wellbeing and that of the wider community.[4] The workbook will support the newly emerging organisations and networks as an aid to understanding commissioning processes to achieve population level outcomes. Key processes that should significantly influence local commissioning priorities as part of the development of Joint Strategic Needs Assessment and Health and Wellbeing Strategies, will be highlighted through the use of the workbooks. The skills and knowledge embedded within the realigned local Public Health teams will be critical in development and coordination of these key processes.

The workbook is designed and tested to help areas identify which factors are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

[4] See for example NHS Constitution: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx and Localism Bill: http://services.parliament.uk/bills/2010-11/localism.html
And NHS and Social Care Bill: http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the government protected the NHS, with cash funding growth of £10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency savings of up to £20bn by 2014/15 for re-investment. This means that considerations of the affordability, and evidence on the cost-effectiveness and cost-benefit of the interventions presented should be of central consideration. Where possible priority should be given to interventions which are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base. Some of the relevant evidence has been referenced through the workbook.

Local facilitators and participants will be aware of changes that may be outside the scope of this workbook and of any detail in the workbook that may have been superseded. These should be taken into account. To facilitate this, a generic workbook - *A Generic Diagnostic Framework for Addressing Inequalities in Outcome from Evidence-based Interventions* - has been produced that could be used to guide the diagnostic questions and discussion during the workshop, with this detailed workbook being used alongside the generic one for reference

How to Use this Workbook – a guide for facilitators

This workbook provides a diagnostic, which can be used in three ways:

1. For taking stock of the set of interventions to check their potential for delivering optimal population level outcomes that are fairly distributed and will have an impact on inequalities in mortality
2. With a group of commissioners and providers to develop a systematic approach to commissioning and delivering the set of evidence based interventions using this stock take approach.
3. In a workshop setting as described below

The objective of the workbook, used in a workshop setting, is to gain a picture of the local strengths and gaps in services in relation to the objective of achieving best outcomes at **population level**, and to identify and recommend changes that could be introduced.

The workbook is best used in a **facilitated** workshop setting for a **minimum of 8 and a maximum of 25 participants**. **Allow 4 hours for the workshop.** The participants in the workshop should include key individuals who are involved in planning, commissioning and delivering services and interventions in relation to the workbook topic through a partnership approach. The make-up of the group will vary according to local situations but the suggested attendee list for this workbook is set out below:

Advice sector

1. *Citizens Advice Bureau (CAB[5])*
2. *Welfare Rights Service (County and/or District Council, and/or CAB)*
3. *Money Advice / Debt Counselling Service (County and/or District Council, and/or CAB)*
4. *Local Law Centre* (if there is one)

[5] The registered office of national Citizens Advice Bureau is: Citizens Advice, Myddelton House, 115-123 Pentonville Road, London, N1 9LZ. Tel. 020 7833 2181, Fax 020 7833 4371 (admin only)

Regulatory sector

5. *Legal Services Commission (LSC) – representative for the Community Legal Service* (regional contacts in Appendix 2).
6. *Department of Work and Pensions (DWP) representative*
7. Inland Revenue representative
8. Trading Standards representative (County/Unitary Council – regulation of the creditor sector)

Health and social care sector

9. Adult Social Care (County or Unitary Council)
    - *Commissioning* - and/or -
    - Social workers dealing with physical disability - and/or -
    - Mental Health social workers
10. Mental Health Trust
    - Community Psychiatric Nurses
    - Occupational Therapists
11. *Mental health commissioning*
12. *Practice Based Commissioning*
13. PPI/PALS or LINks
14. GPs

Local authority

15. *Policy unit particularly if responsible for an Anti-Poverty Strategy*
16. Data analyst
17. *Housing Benefits representative*
18. *Council Tax Benefits representative*

Voluntary sector

19. Citizens Advice Bureau (mentioned above)
20. Council for Voluntary Service – a CVS representative or from a Voluntary, Community or Faith agency with particular interest in welfare rights and/or debt.

Other

21. Credit unions or community development financial institutions

Where there is more than one organisation (for example, hospital trust) providing local services, it is advisable to invite senior representatives from each.

Provide a copy of this workbook to each participant at the workshop. It is suggested that the participants do not see the workbook in advance, but are informed that the workshop will be an opportunity to explore their knowledge of approaches to the issue with others who will bring differing perspectives. This will mitigate against any participants over-preparing, becoming defensive or being resistant to discussing – and finding solutions for – local issues.

The facilitator should be familiar with the workbook questions and the model described below, which help to achieve a population level perspective is taken. It is suggested that facilitators introduce the participants to this model and approach. Following the introduction, it is useful to look at section 13 first as this gives an overview of the situation in the area for this topic and enables all participants have an opportunity to contribute at the beginning. Finish by working through each sections 1-12 of the model.

Group discussions about all of the questions in each section allow strengths, best practice and gaps to be identified, and the group to begin to think about where improvements could be made. A separate publication contains a facilitator's recording book, which can be used during the workshop to record this discussion. This need not be copied for workshop participants.

Key actions and lead stakeholders to take these actions forward can be identified during the workshop. The greatest impact is likely to result if summaries of these key actions and of the recognised strengths and recommendations from the workshop are produced and circulated to attendees and key accountable stakeholders within the partnership, following the workshop.

There is a list of potential key actions summarised in Appendix 1. It is sensible to emphasise these questions during the workshop.

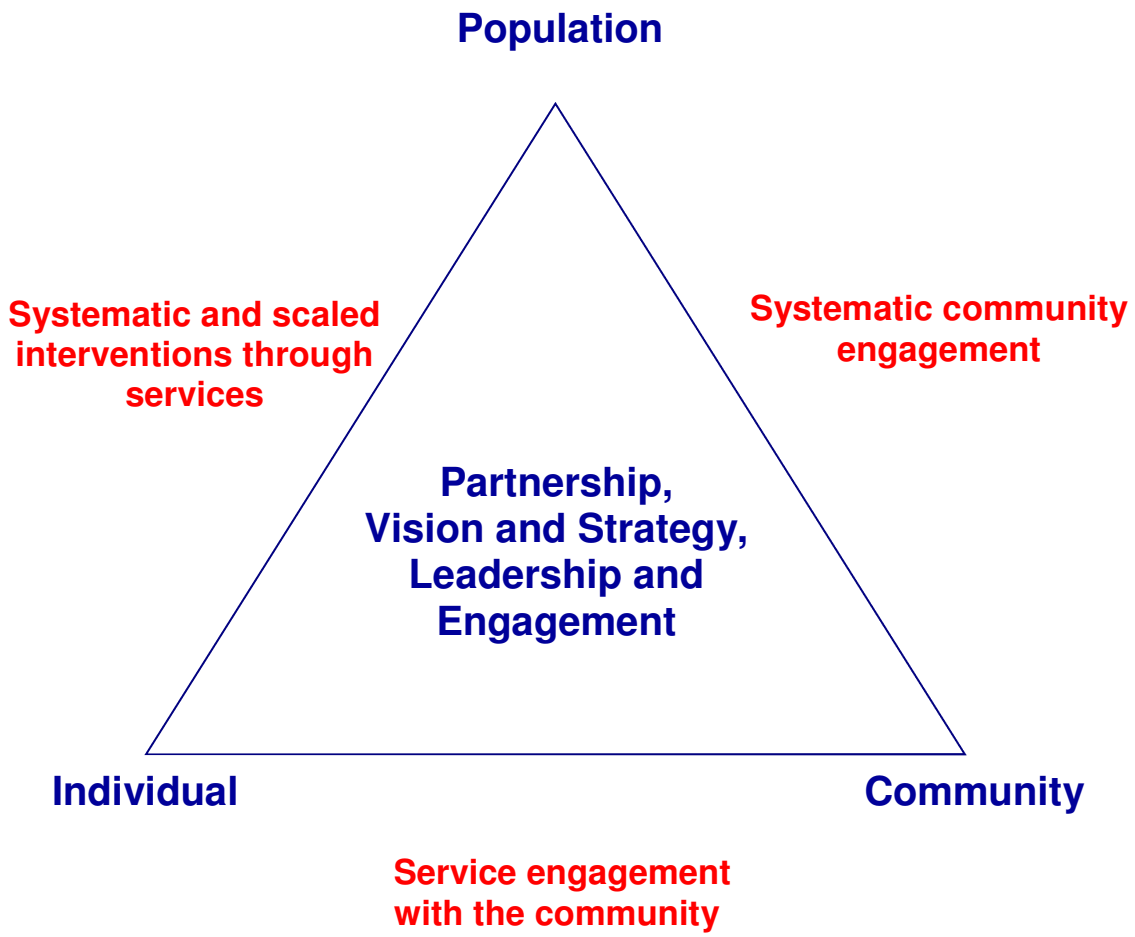
Background to Population Level Interventions

Challenging public health outcomes, such as achieving significant percentage change within a given population by a given date, will require systematic programmes of action to implement interventions that are known to be effective, and reaching as many people as possible who could benefit.

Programme characteristics will include being:

- **Evidence based –** concentrating on interventions where research findings and professional consensus are strongest
- **Outcomes orientated –** with measurements locally relevant and locally owned
- **Systematically applied –** not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately –** 'industrial scale' processes require different thinking to small scale projects or pilots ('bench experiments'**)**
- **Appropriately resourced –** refocusing on core budgets and services rather than short bursts of project funding
- **Persistent –** continuing for the long haul, capitalising on, but not dependant on fads, fashion and changing policy priorities

Interventions can be delivered through three different approaches to drive change at population level, illustrated by the following diagram:



Producing Percentage Change at Population Level

C. Bentley 2007

Population Approaches
Direct population level interventions will include developing healthy public policy, legislation, regulation, taxation and public funding strategies. These elements should support making 'healthy choices easy choices' for individuals and communities.

The impacts of such population level interventions, however, will not automatically 'trickle down' to all, often in particular missing those who are socially excluded for various reasons. Strategies for targeted communication and education, service support and even enforcement will be required to achieve full impact.

Individual Approaches through Services
Some interventions taken up at individual level, such as support for environment and behaviour change, therapies, treatments and rehabilitation, can change individual risk significantly, in some cases by 30-40%. The challenge is to achieve so many of those individual successes that it adds up to percentage change at population level. This will be achieved only if services take into account issues of system and scale to enable this to happen, and work to address population level outcomes as well as those for individual service users.

Improvements in health and wellbeing will require some reorientation of health and other services to take a more holistic view of individual circumstances, with regard to any

personal characteristics/sub-population group status or socio-economic status and to focus on development of personal skills of staff and service users, so promoting healthy choices and actions.

Community Approaches
Individuals will only choose to use and benefit from certain behaviours and actions if those behaviours fit with the cultural and belief system of their own community. Communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith) and others (disability, sexual orientation). Community development is one way of facilitating communities' awareness of the factors and forces that affect their wellbeing, health and quality of life.

Community engagement is often patchy, favouring those communities that already have leadership, organisation and some resources. Instead, it needs to be systematic in bringing top-down and bottom-up priorities together into plans. This will strengthen community action to create more supportive environments and develop knowledge and skills of community members.

Service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary, community and faith sector as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.

Commissioning for Population Level Outcomes

Substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, extra attention is given here to extracting maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition there is a deliberate emphasis wherever possible, on improving access to services of a scale that will impact on bringing about a population level improvement in mortality and life expectancy within a two to three year period.

The detail is illustrated in the attached diagram on Page 12 with the title 'Commissioning for Best Population Level Outcomes', otherwise known as the 'Christmas Tree' diagnostic, with an accompanying description of its component principles. The framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

The right hand side of the diagram (1 to 5) - a challenge to providers: links the factors that will influence health *service* outcomes, that is, how can we construct the most effective service.

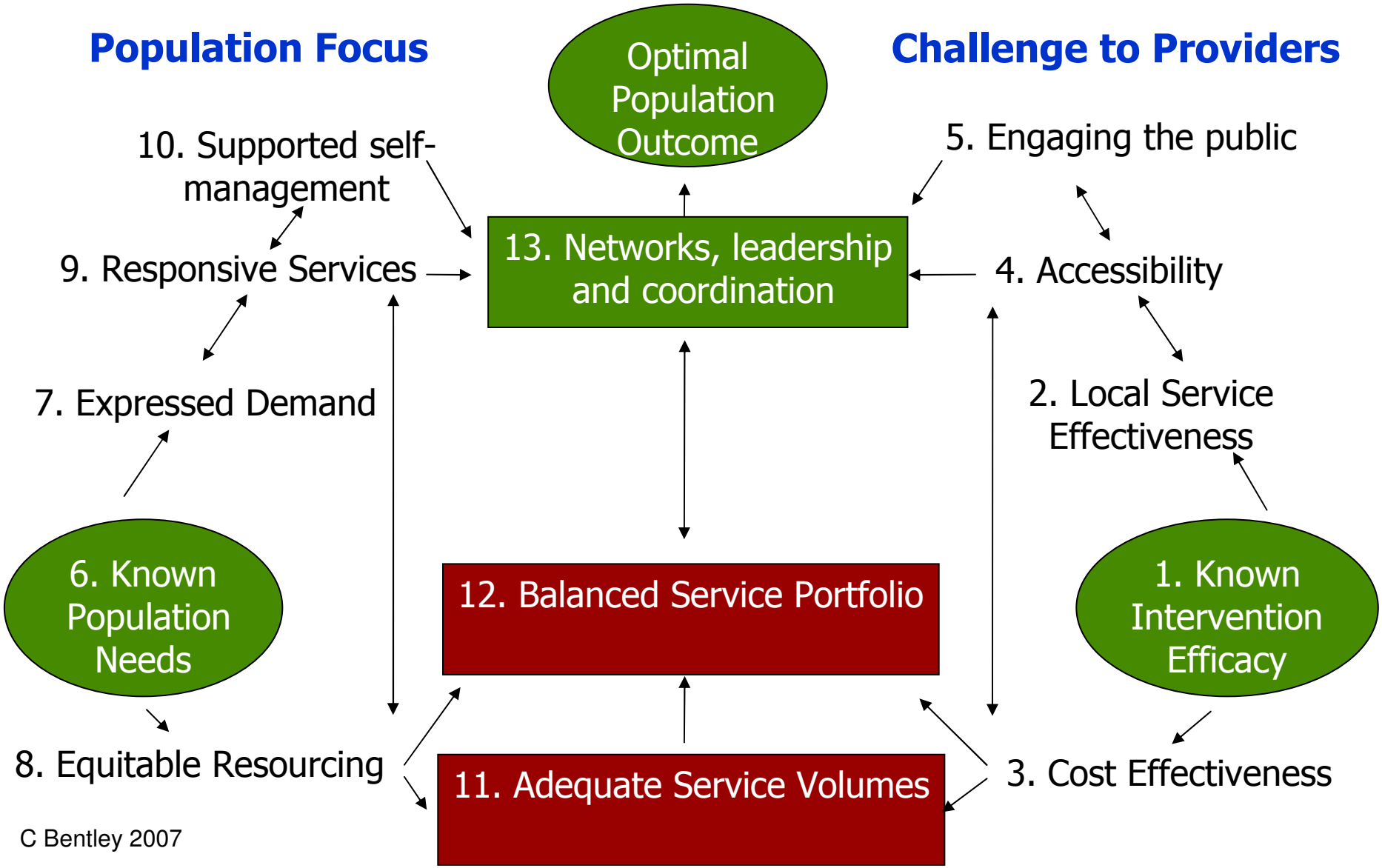
However, optimal outcomes *at population level* will not be obtained without the following:

The left hand side of the diagram (6 to 10) - a population focus: identifies those factors that determine whether a community makes best use of the service provided – for example, whether the benefits of personalised improvements to services are having a systematic impact on reducing health inequalities at the population level.

The balance between the two sides of the diagram - the commissioning challenge: Working towards equality of outcome, not just equality of access to service provision and support, is a significant and crucial challenge for commissioners. The 'Christmas Tree' diagnostic, is a tool to help achieve this. The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider whether services commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help all services to be effective **and** engaged with and used by all of the diverse communities in the area they serve.

The central elements of the diagram are concerned with aiming for the scenario that when the most effective services/interventions are identified that are fully acceptable, accessible and effective in terms of take-up and compliance, there is adequate capacity to meet the need. Effective leadership and networks are needed to keep all these elements under review to aim for continuous improvement and equality of morbidity and mortality outcomes.

Commissioning for Best Population Level Outcomes



C Bentley 2007

Commissioning for Best Population Level Outcomes

A CHALLENGE TO PROVIDERS

1. **Known Intervention Efficacy:** Looks at life saving interventions, for which there is strong evidence, and that are implemented equitably and made available to as many people who could benefit as possible.

2. **Local Service Effectiveness:** Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

3. **Cost Effectiveness:** Aim for programme elements that are as affordable as possible at population level

4. **Accessibility:** Aim for services to be designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of those services.

5. **Engaging the Public:** Working with service users and communities to aim for their needs and requirements to be at the centre of service provision, and for quality assurance systems to be in place that makes the services acceptable to service users

B POPULATION FOCUS

6. **Known Population Needs:** Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.

7. **Expressed Demand:** Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.

8. **Equitable Resourcing:** Aim for the distribution of finance and other resources to support equitable outcomes according to need.

9. **Responsive Services:** When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

10. **Supported Self Management:** Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

11. **Adequate Service Volumes:** Commissioning adequate service volumes to aim for acceptable access times.
12. **Balanced Service Portfolio:** Aim for balance of services within pathways to avoid bottlenecks and delays.
13. **Networks, Leadership and Co-ordination:** Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

Whilst the service design elements are an immediate concern to providers, all sections of the 'Christmas Tree' diagnostic are of direct relevance to commissioners

Equality

Equalities perspectives need to be built into all whole population approaches. The Equality Act 2010 set out the public sector equality duty:

> *(1) A public authority must, in the exercise of its functions, have due regard to the need to:*
>
> > *(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
> >
> > *(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
> >
> > *(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The Act identifies a number of "protected" population groups/characteristics where specific elements of the legislation apply. These groups/characteristics are:

- *age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.*

Although socioeconomic inequalities are not specifically included in the Equality Act, there are a range of duties in relation to tackling inequalities included at different levels in new health and social care legislation, and for all key structures and partners involved in the commissioning and delivery of health and social care, in new health and social care legislation. The Health and Social Care Bill 2010 proposes new legal duties on health inequalities for the Secretary of State and the NHS. Subject to Parliamentary approval:

- The Secretary of State for Health must have regard to the need to reduce health inequalities relating to the NHS and public health.
- The NHS Commissioning Board and GP consortia must have regard to reducing inequalities in access to, and outcomes of, healthcare.

In order to carry out these duties effectively an emphasis on socioeconomic disadvantage will be essential as it is recognised as a major driver in relation to inequalities of access to, and outcomes of, health and wellbeing services.[6]

[6] The Marmot Review (2010) *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England post 2010* http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

Why this Topic has been Chosen

Poverty, relative deprivation and social exclusion have a major impact on health and premature death, and the chances of living in poverty are loaded heavily towards some social groups. Absolute poverty – a lack of the basic material necessities of life – continues to exist, even in the richest countries of Europe. Unemployed people, many ethnic minority groups, guest workers, disabled people, refugees and homeless people are at particular risk. People living on the streets suffer the highest rates of premature death.

Fair Society, Healthy Lives: The Marmot Review

Health-adverse effects of being on a low income have been shown in several studies. But the relation is a graded one, not confined to those on the lowest incomes. There is evidence that income has a direct impact on parenting and on children's health and wellbeing. For example, according to Gregg *et al*,

> Holding constant other types of parental capital, income is strongly associated with types of maternal psychological functioning that promote self esteem, positive behaviour and better physical health in children[7].

The graded nature of the relationship between income and health is consistent with the fact that a person's relative position on the social hierarchy is important for health. Given that the majority of people in England live above the level of absolute deprivation, it is likely that relative position on the income scale is having a determining effect on the kinds of influences this Review covers.

However, income inequality is not just about material deprivation. There is evidence that the degree of inequality in society has a harmful effect on health, not only of the poor, but of society as a whole. Countries and areas within countries that are marked by greater inequality have not only worse health but a higher rate of crime and other adverse social outcomes. Both poverty and inequality may be important for social cohesion, life opportunities and health. Social protection schemes are designed to smooth income flows across the life course and act as a buffer against those times when it is harder to obtain and maintain secure employment or adequate pay.

Ideally, a social protection system offers people the opportunities to maintain a decent standard of living while aiming to:

- give assistance and encouragement to people to remain in work when they experience poor health or other life-changing events such as divorce or new caring responsibilities and facilitates the transition into work or self-employment as their health improves or other responsibilities change
- enable and incentivise people to move into retirement at a pace that reflects their health and wider capabilities
- create opportunities for people to prepare for alternative careers through access to training and re-skilling

[7] Marmot, M (2010) *Fair Society, Healthy Lives; The Marmot Review. Strategic review of health inequalities in England post-2010.* www.ucl.ac.uk/marmotreview

- provide the support required by families when bringing up their children.

However, most current social protection systems, fail to fulfil the above criteria. A first important difficulty is that benefits are inadequate to provide a healthy standard of living or fail to reach those in need. A second key difficulty is that they tend to create a 'black and white' distinction between being reliant and non-reliant on various components of support. The distinction between being in work and out of work is too distinct, leading to a 'cliff edge'. This cliff edge may discourage people from seeking work or from staying in work with, say, reduced hours if they could otherwise be signed off as ill.

In high-income countries where evidence is available, more generous social protection systems are shown to lead to better population health outcomes and to increased life expectancy. Welfare regimes may also differ with regard to their ability to provide a buffer against the adverse health effects of economic crises and substantial job instability

Relative poverty means being much poorer than most people in society and is often defined as living on less than 60% of the national median income. It denies people access to decent housing, education, transport and other factors vital to full participation in life. Being excluded from the life of society and treated as less than equal leads to worse health and greater risks of premature death. The stresses of living in poverty are particularly harmful during pregnancy and to babies, children and old people. In some countries, as much as one quarter of the total population – and a higher proportion of children – live in relative poverty.[8]

The effect of debt on mental health

More debt equates to more mental ill health, even after adjustment for income and other socio-demographic variables.

- Higher level of debt are associated with greater mental ill health even after adjustment for income and other sociodemographic variables (Jenkins et al, 2008)[9].
- Half of all people with debt in the general population have a mental disorder, compared to 14% of people with no debts and 15% of the general population Jenkins et al, 2009[10].
- Being in debt is associated with 2-3 fold increased risk of anxiety and depression (Jenkins et al, 2009; Meltzer et al, 2010[11]), 3 fold increased risk of psychosis, more than 2 fold increased risk of alcohol dependence and 4 fold increased risk of drug dependence compared to people not in debt (Jenkins et al, 2009).
- People with more than 5 separate debts have on average a 6-fold increase in mental disorder (Jenkins et al, 2008).
- Utility disconnection and cutting down on utility usage are associated with 3-4 times and twice the average rates of mental disorder respectively (Jenkins et al, 2009.

[8] World Health Organisation (2003) *Social Determinants of Health: The Solid Facts*. Edited by Richard Wilkinson and Michael Marmot, 2d ed.

[9] Jenkins R, Bhugra D, Bebbington P, Brugha T, et al (2008). Debt, income and mental disorder in the general population. Psychological Medicine 38, 1485-1494.

[10] Jenkins R, Bebbington P, Brugha T et al (2009) Mental disorder in people with debt in the general population. Public Health Medicine, 6(3), 88-92

[11] Harris J, Hall J, Melzer H, *et al* (2010) *Health, Mental Health and Housing Conditions in England*. Eaga Charitable Trust, National Centre for Social Research.

- Being unable to adequately heat the home in winterwas associated with an almost doubled risk of anxiety or depressive disorder (Harris et al, 2010).
- *Suicide and debt*: Change in financial status is associated with suicidal ideation and difficulty repaying debt is a risk factor for suicide (Turvey et al, 2002)[12].
- *Debt as the mediator*: Although both low income and debt are associated with mental illness, the effect of income on mental health appears to be mediated by debt (Jenkins et al, 2008);

A Civil and Social Justice survey found that 44% of the debt problems reported "led to physical or stress-related ill-health [and that] the average cost to the NHS of 'difficult-to-solve' debt problems that caused such ill-health was around £50 (£20 per debt problem in general)"[13].

Effect of mental health problems on debt

One in six British adults lives with a mental health problem. One in four adults with a mental health problem reports being seriously behind in paying a bill or making a repayment in the last 12 months[14].

- This is three times the rate of indebtedness in the wider 'mentally healthy' British population.
- These issues affect 1.75 million British adults.

In a survey of more than 8000 people, higher levels of debt were associated with mental health problems (Jenkins 2008)[15]

- 8% of people with no disorder
- 24% with depression and anxiety (common mental disorder)
- 3% with psychosis
- 25% with alcohol dependency
- 24% with drug dependency

Analysis of the 2007 Adult Psychiatric Morbidity Survey found that suggests that, compared to those not in debt, being in debt is associated with:

- 2-3 fold increased risk of anxiety and depression
- 3 fold increased risk of psychosis
- more than 2 fold increased risk of alcohol dependence
- 4 fold increased risk of drug dependence compared to people not in debt (Jenkins et al, 2008)
- 2 fold increased risk of suicide ideation (Meltzer et al 2010)[16].

These results adjusted for income and other socio-demographic variables,

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[12] Turvey C, Stromquist A, Kelly K, Zwerling C, Merchant J (2002) Financial loss and suicidal ideation in a rural community sample. Acta Psychiatr Scand, 106, 373- 80.

[13] Royal College of General Practitioners and Royal College of Psychiatrists (2009) *Primary Care Guidance on Debt and Mental Health http://www.rcpsych.ac.uk/pdf/mat_14_07_09.pdf*

[14] Royal College of General Practitioners and Royal College of Psychiatrists (2009) *Primary Care Guidance on Debt and Mental Health*

[15] Jenkins R, Bhugra D, Bebbington P, Brugha T, et al (2008a). Debt, income and mental disorder in the general population. Psychological Medicine 38, 1485-1494.

[16] Meltzer, H., Bebbington, P., Brugha, T.S., Jenkins, R., McManus, S., Dennis, M. (2010) Personal debt and suicidal ideation. *Psychological Medicine* 16:1-8.

The more debts people had, the more likely they were to have some form of mental disorder, even after adjustment for income and other socio-demographic variables.

Analysis of the Adult Psychiatric Morbidity Survey 2007 found that risk of common mental disorder was almost double in those fuel related debt (Harris et al, 2010).

- 6% of those with CMD were seriously behind paying for fuel bills and/or at risk of being disconnected in the last 12 months compared to 2% of those without CMD.(Harris et al 2010)[17]

Income inequality increases risk of mental illness

Income inequality is a principle underlying determinant of mental illness with mental disorder several times more common in those from bottom 20% household income compared to top 20% household income except alcohol dependence (McManus et al, 2009)[18].

- Children from families with gross weekly income of less than £100 have 3 fold increased risk of mental disorder compared with those children from families with gross weekly income of £600 or more (Green et al, 2005)[19].
- Common mental disorder is 2.7 times more common in men and 1.4 times more common in women from lowest 20% household income compared to highest 20% household income (McManus et al, 2009).
- 23% of men and 26% of women in the lowest 20% household income had a high score on the GHQ12 compared with 10% of men and 11% of women in highest 20% household income (HSE, 2009).
- Post-traumatic stress disorder is 3.3 times more common in men and 2.3 times more common in women from lowest 20% household income compared to top 20% (McManus et al, 2009).
- Self-harm is 3.2 times more common in men and 2.5 times more common in women from the lowest 20% household income compared to the highest 20% (McManus et al, 2009).
- Suicide attempts are 5.0 times more common in men and 3.2 times more common in women from the lowest 20% household income compared to the highest 20% (McManus et al, 2009).
- Psychotic disorder is 9 times more common in adults from the lowest 20% household income compared to the highest 20% (McManus et al, 2009).
- Eating disorder in past year is 1.7 times more common in men and 1.2 more common in women from the lowest 20% household income compared to the highest 20% (McManus et al, 2009).
- Alcohol dependence in past 6 months is 1.4 times more common in men and 2.0 more common in women from the highest 20% household income compared to the lowest 20% (McManus et al, 2009).
- Dependence on any drug is 4.6 times more common for men and 33 times more common in those from lowest 20% household income compared to top 20% (McManus et al, 2009).

This workbook seeks to explore the relationship between low income, debt and health. This is considered from the perspectives of:

[17] Harris et al (2010) Health, mental health and housing in England. NATCEN

[18] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England 2007. Results of a household survey. The Health & Social Care Information Centre, Social care Statistics.

[19] Green H, McGinnity A. Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. ONS.

- In general terms, the *health and wellbeing impacts* of lifting the burden of personal debt and increasing personal income
- The *specific links* between welfare benefits that are geared to address physical and mental functional ability and health, and the relationship between debt and mental health

These are elaborated as follows:

- *Health and wellbeing impacts*: The link between low income /debt and health is best explained, initially, by reference to Maslow's hierarchy of needs (see diagram below). Low income and debt frequently places people in a low position on Maslow's hierarchy. More extreme poverty and debt can create a raft of problems of great immediacy, and viewed from a health perspective, only medical emergencies will compete for priority with these problems.

  Health-seeking behaviour is likely to be allied to a longer-term perspective on health and life expectancy. People are unlikely to seek healthy lifestyles until their lives are stabilised at a higher level of Maslow's hierarchy.

- *Specific links*: The second focus of the workbook is the specific linkages:
  - Between welfare benefits geared to address physical and mental functional ability, and health. For example:
    - lack of (physical) ability to: walk (e.g. on level ground, on stairs), sit comfortably, stand unassisted, rise from a sitting position, bend or kneel, use hand/s for a range of tasks, lift and carry, reach, speak, hear, see, maintain continence, maintain consciousness
    - lack of (mental) ability to: complete of a range of tasks, undertake activities of daily living, cope with pressure, interact with others

The framework for provision of advice services

There are a number of interventions to be found ranging from financial capabilty work to debt advice and a number of resources that can be helpful to those services, for example the fact sheet on financial capability for those with mental health problems. Also the rcpsych work on providing debt advice for those wht mental illness.[20]

The welfare benefits system is a claims-based system - entitlement is dependent upon claiming. Debt advice is part of a network of advice provision. However, there is no comprehensive statutory provision or funding for advice services. The provision is partial, and cast in different ways. For example:

- *There is statutory provision for aspects of advice giving*: For example, the Housing Act 1996 'General functions in relation to homelessness or threatened homelessness' specifies a duty under S179 for a local housing authority to provide advisory services:

[20] http://www.rcpsych.ac.uk/mentalhealthinfo/debtmentalhealthcontents.aspx

> Every local housing authority shall secure that advice and information about homelessness, and the prevention of homelessness, is available free of charge to any person in their district.

- *There is comprehensive advice service provision outside a statutory framework*: The Citizen's Advice Bureau service, as a voluntary sector provider, provides advice across the country, albeit not necessarily to a level that includes a legal advice and representation service.

- *There is central funding for advice, but this is not (as yet) comprehensive:* The Community Legal Service (CLS) is a network of Legal Services Commission (LSC) funded advice providers. This civil legal aid scheme helps people to protect their rights. Civil law is the section of the law that deals with disputes between individuals or organisations. Rather than any sentence, custodial or otherwise, the end result is usually financial compensation.

  People experiencing social problems often need legal advice in areas such as relationship breakdown, debt, housing, domestic violence and benefits. Help is also available for asylum and immigration; education, employment, mental health and community care issues. This type of help might be providing information leaflets or directing people to other services such as debt counselling or mediation. Civil legal aid is also available for specialist advice and taking cases to court where necessary.

  Civil legal aid can fund:

  - initial advice and assistance with any legal problem
  - a solicitor who can speak on someone's behalf at court hearings without formally representing them
  - help and advice on family disputes, including assistance with family mediation
  - legal representation in court proceedings.

- *There is a vision for the future*[21]*:* On 29 May 2008, Richard Collins, Director of Policy and Planning at the Legal Services Commission, said:

  > It is common for people needing help to have several problems. Community Legal Advice services are designed around the needs of clients, enabling them to get legal help for a range of social welfare problems.
  >
  > For example, someone returning from maternity leave and forced to take a lower paid position than they left will need advice on their employment rights. In addition they may be facing debt and welfare benefit problems as their reduction in income has made it difficult to pay the rent and bills. Their receiving of advice on all the aspects of the problem will help prevent essential utilities like gas being cut off or the potential loss of the family home.
  >
  > Our aim is for clients to be able to access a seamless service, from basic advice to specialist representation in the highest courts. This will be either via a single centre, or a network of service providers delivering advice in a more joined up way.

[21] Legal Services Commission website: http://www.legalservices.gov.uk/

In addition to providing advice, Community Legal Advice services will take action to resolve the causes of common local problems and will also help educate people about their legal rights. If the service is not able to help, it will refer the person to other local sources of help, arranging appointments where possible.

The LSC and local service providers, funders, decision-makers and users will all work together to shape each service. In particular by working with local authorities we will be able to combine council expertise in identifying local needs with our expertise in aiming for service quality and value for money. This will enable budgets to be pooled and better integration of local services.

In areas where Community Legal Advice centres and networks are not established the LSC will take steps to commission services covering all five social welfare law categories[22] and related public law, under a single contract in each procurement area. This will help to increase the number of clients who will be able to benefit from integrated services. As at December 2010, the LSC had developed and opened Community Legal Advice services in 10 local authority areas.

Workshop participants also need to be aware of the cuts to the legal aid budget announced in the Comprehensive Spending Review in 2010 which at the time were expected to amount to £350 million by 2014-15. The cuts within the Proposals for the Reform of Legal Aid in England and Wales, Consultation Paper CP12/10, November 2010, would remove from the Legal Aid scheme:

- Debt –other than where the debtor's home is at risk,
- Welfare Benefits advice,
- Housing advice –other than in cases of homelessness or serious disrepair.

It is also understood that the government is thought to be considering taking social welfare law 'out of scope' for civil legal aid.

On the other hand, the cross-government outcomes strategy 'No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, 02 February 2011' states "Broadening the approach taken to tackle the wider social determinants and consequences of mental health problems. One example of this approach is providing face-to-face debt advice. Evidence suggests that this can be cost-beneficial within five years. The upfront cost of debt advice is more than offset by savings to the NHS, savings in legal aid, and gains in terms of employment productivity, even before taking into account savings for creditors."

The Department of Work and Pensions – Financial Inclusion Champions

Work at DWP has been to support local delivery partnerships to do more to address financial exclusion. Their work supported delivery of the UK Government objectives across three high level goals for financial inclusion policy, which were as follows:

[22] The five categories of social welfare law are community care, debt, employment, housing and welfare benefit

- helping people to manage their money day-to-day;This needs to link with the national financial capability work of the FSA. Some of their work is highlighted in the outcomes document of the mental health strategy. This work is important in preventing getting into debt and needs to be directed at those at higher risk of getting into debt including those with mental health problems
- Improving financial capability has wider social benefits and is associated with psychological well-being (Taylor et al, 2009)[23]. Moving from low to average financial capability:
    - improves psychological well-being by 5.6%
    - improves life satisfaction by 2.4%
    - reduces risk of anxiety/ depression by 15%.

- helping people to plan for the future and cope with financial pressure; and
- helping people to deal with financial distress.

DWP created teams of financial inclusion Champions who worked to build and co-ordinate partnerships with Local Authorities, social landlords and other potential financial inclusion intermediaries to promote financial inclusion issues. In particular, they aimed to stimulate the demand for, and where possible and desirable, to increase the supply of, basic financial services for financially excluded people. The objectives that Champions aimed to progress through their activities, supported the Financial Inclusion Task Force objectives to increase access to banking, saving, debt and money advice, affordable credit and home contents insurance (HCI). The Champions have developed a range of products including Financial Inclusion Toolkits (see link below)[24].

DWP are currently evaluating their work and early indications are that they have been successful.

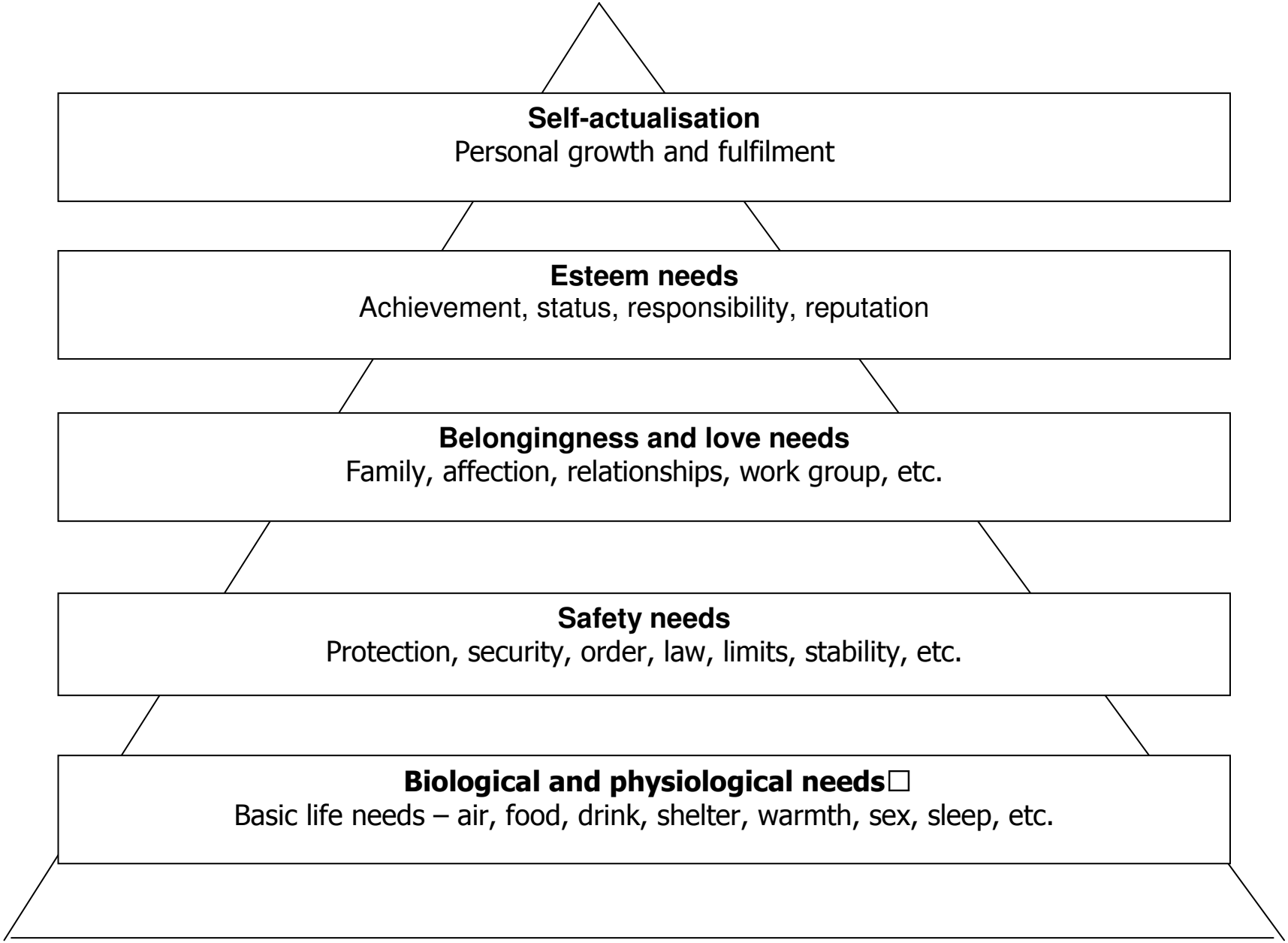
The Champions were instrumental in the creation of Financial Inclusion Forums that are made up of a number of your suggested invitees. Those groups will have experience of creating anti-poverty strategies. The local authority delegate should have local details.

Workshop facilitators will need to check current policy at national and local levels at the time of facilitating the workshop.

[23] Taylor M, Jenkins S, Sacker A (2009) Financial capability and wellbeing: Evidence from the BHPS. Financial Services Authority, Occasional Paper Series 34.

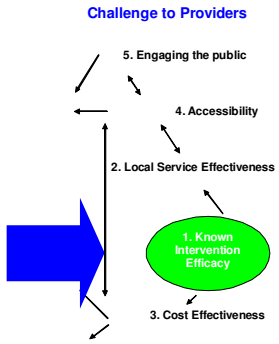
[24] http://www.fichampions.com/index.php?option=com_content&view=article&id=215:local-authority-financial-inclusion-toolkit&catid=88:la-lsp&Itemid=286

MASLOW'S HIERARCHY OF NEEDS



The Workbook

Low Income, Debt and Health



1. Known intervention efficacy

Looks at life saving interventions, for which there is strong evidence, and that are implemented equitably and made available to as many people who could benefit as possible.

1. Welfare benefits

The Benefits system is characterised by complex eligibility criteria. It is divided in many categories – between means tested, non-means tested and universal benefits, between different categories of need (e.g. ill-health and disability), and between methods of funding and claim (e.g. tax credits).

Broadly, the types of benefits include:

Administered by the Dept of Work and Pensions

- Bereavement benefits *
- Carers Allowance
- Child benefit
- Disability living allowance and attendance allowance *
- Employment and support allowance *
- Guardian's allowance
- Health benefits (e.g. prescriptions, dental treatment and dentures, sight tests and spectacles, fares to hospital) *
- Incapacity benefit *
- Income Support
- Industrial Injuries Benefits *
- Jobseekers allowance
- Maternity allowance
- Pension credit
- Retirement pensions
- Severe disablement allowance *
- Social Fund – discretionary and regulated payments
- Statutory maternity, paternity and adoption pay
- Statutory sick pay *

Administered by local authorities

- Council tax benefit
- Housing benefit and discretionary housing payments

Administered by the Inland Revenue

- Child Tax Credit
- Working Tax Credit

Those benefits asterisked (*) have a specific relationship to ill-health and disability. However, other benefits make allowance for ill-health and disability in the form of 'premiums' – additional allowances geared to reflect differing levels of ill-health and disability. The following benefits allow for enhancement through premiums:

- Income Support
- Income-based Job Seekers Allowance
- Housing Benefit
- Income-related Employment and Support Allowance (ESA)
- Council Tax benefit

The premiums that relate to ill-health and disability include the Disabled Child Premium, Disability Premium, Enhanced Disability Premium and Severe Disability Premium; however, the rules are complex.[25]

The principle behind welfare rights advice is to enhance personal income – in the knowledge that this should create a raft of health and social benefits.

2. Debt

Whereas Welfare Rights advice is more 'static' in terms of identifying and claiming the benefits to which an individual should be entitled, debt counselling or money advice is framed around a process. Broadly, this involves:

- dealing with emergencies
- drawing up a financial statement – listing existing income and existing expenditure
- maximising income – the process above
- establishing the level of indebtedness
- dealing with priority debts
- dealing with non-priority debts
- revising the financial statement following the action above.

Dealing with specific debts might include negotiation with bailiffs, and dealing with enforcement by creditors through the County or Magistrates Court.

Pro-actively seeking a resolution of the individual's indebtedness might include:

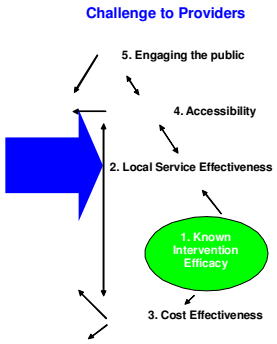
- Applying for bankruptcy
- Seeking a voluntary arrangement with creditors
- Seeking an enforceable arrangement with non-priority creditors through an 'Administration Order' via the County Court.

More recent reforms include Debt Relief Orders (DROs) administered by the Official Receiver for the 'can't pay' debtors (introduced April 2009)

The principle behind debt counselling or money advice is to both enhance personal income and relieve the burden of debt – in the knowledge that this should alleviate the negative health (especially mental health) and social effects of debt, and create a raft of health and social benefits.

The following sections of the workbook examine how in practice this might be achieved in terms of improvement of service and enhancement of 'reach'.

[25] Child Poverty Action Group (2010) *Welfare Benefits and Tax Credits Handbook, 2009-2010*. 11th Edition



2. Local service effectiveness

Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

1. Regulation of advice and support agencies

- Is there a regularly updated register of agencies providing:
  - Welfare benefits advice
  - Debt counselling and support
- Which of these agencies are commissioned under the auspices of the Legal Services Commission?

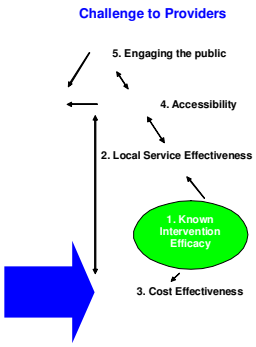
2. Quality assurance

The LSC Quality Profile has been developed to indicate how providers perform over time.

- Are the Quality Profiles of LSC-commissioned providers published and known to:
  - Alliance partners
  - The public
- For services delivered outside the LSC specification, what alternative methods of quality assurance are used?
- Are the results of quality assurance publicly available, and accessible to encourage client choice?
- To what extent are local approaches based on effective practice guidelines (e.g. Money Advice Quality Model [MAQM] from the Money Advice Trust)?
- What mechanisms are available to support improvements in quality of provider agencies? How are components of locally provided training accredited?

Useful materials[26]

[26] Legal Services Commission (2007) *Assuring and Improving Quality in the Reformed Legal Aid System*. Money Advice Trust website: www.moneyadvicetrust.org



3. Cost effectiveness

Aim for programme elements that are as affordable as possible at population level

The LSC audits contracts (both solicitor and not-for-profit) to provide assurance that contract work:

- is in line with the reasons why legal aid was granted
- is being carried out according to the contract rules
- is properly evidenced on the file
- costs incurred are reasonable

The LSC audits also check for

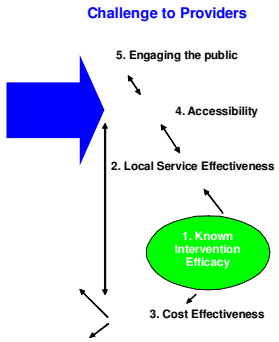
- evidence that Specialist Quality Mark requirements are met
- objective evidence to support all items claimed

1. Is there a local cost/benefit system of audit that extends to non-LSC commissioned services?

2. Has the cost of a range of forms of benefits and debt service provision been measured against the impact of increased income and reduced debt within the local economy?

3. What precautions are in place to ensure best value is obtained out of contracts for provision of debt and welfare rights advice?

4. Has the cost/effectiveness of different forms of delivery of income and debt advice been assessed – Law Centres, Advice Centres, CAB, assessment by frontline health and social care staff, assessment by frontline staff from other agencies (e.g. Fire and Rescue), advice services hosted by GP surgeries, etc?



4. Accessibility

Aim for services that are designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of those services

1. Planned pattern of geographical access

- Is there a planned pattern of services, commissioned to achieve integrated access for clients with complex needs? (As well as welfare benefits and debt, integrated commissioning should also include employment, housing and community care.)

- What parts of the district are covered by:
  - Community Legal Advice Centre with associated network
  - Multiple services covered by a single contract for a given procurement area
  - Uncoordinated services

- ***Is there a thought-out strategic approach to the local provision of advice services? For example:***
  1. ***Hospital-based welfare rights aimed particularly at benefits that alter after 4/12/52 weeks in hospital – Attendance Allowance, Disability Living Allowance, Child Benefit, Income Support, Job Seekers Allowance, Housing Benefit (temporary absence from home)***
  2. ***A town centre walk-in law centre or advice centre,***
  3. ***Satellite provision in townships/districts/neighbourhood clusters, or (in rural shires) market towns***
  4. ***Neighbourhood access to welfare rights and debt advice based at community venues; GP surgeries etc.***

- What debt and welfare rights services are offered as an emergency service (i.e. offered as a 'walk-in' service)? Do walk-in services offer facility for a range of purposes, for example:
  - 'front desk' quick enquiry service
  - interview rooms for sensitive and complex issues
  - 'back office' caseworkers handling caseload of more complex cases

- Is there telephone advice provision – for income and debt emergencies in particular?

- Which of the following are deployed as *systematic strategies* to promote access in neighbourhoods:
  - Neighbourhood services such as a Children's Centre or Healthy Living Centre that may provide signposting, advice and assistance

- Neighbourhood facilities such as a GP surgery, community centre or Learning and Skills Access Point that may host Welfare Benefits and Debt advice services
- Staff groups /domiciliary services such as health visitors, district nurses, social workers, health trainers who may provide signposting, advice and assistance.
- VCF Sector outlets that may provide any of these

- Is there a Customer Access Strategy offering a menu of options for accessing services, with 'social marketing' segmentation of groups?

2. Access for communities of equity and interest

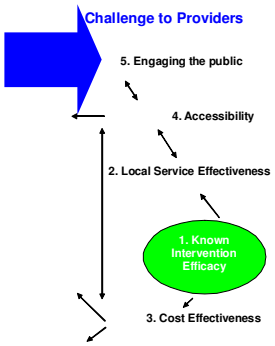
- What are the specific arrangements for accessible income and debt advice for BME communities?
  - How does this advice align with immigration advice?
  - Are there readily accessible interpretation services?

What considerations for specific access to welfare and debt advice have been given to people from the most marginalised communities (including those with protected equality characteristics).[27]:

- Street homeless; 'sofa surfers'[28], hostel and B & B residents (including hostels for homeless people, women's refuges, bail hostels, Foyers)
- Refugees, asylum seekers and newly arrived immigrants
- Prisoners, ex-offenders, offenders serving community sentence
- Gypsy/Traveller communities
- Care leavers, NEETs, Employment and Support Allowance non-optants
- Drug and alcohol misusers

[27] **"The Equality Act 2010 sets out 9 protected characteristics. These are Age, Disability, Gender Reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion and belief, Sex and Sexual orientation. See the Equality and Human Rights Commission website for further information on the protected characteristics** http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/protected-characteristics-definitions/ **and on the purpose of equality information http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSED/information_guidance.pdf.**

[28] Term used to describe people who move around friends' and acquaintances' houses sleeping on sofas and floors



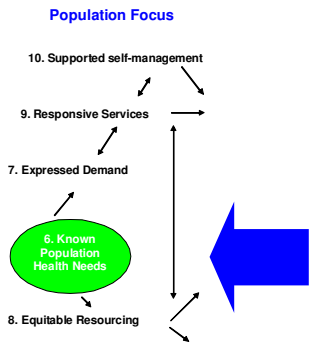
5. Engaging the public

Working with service users and communities to aim for their needs and requirements to be at the centre of service provision, and for quality assurance systems to be in place that make the services acceptable to service users

1. How are access issues to welfare and debt advice for recognised equity groups (i.e. gender, age, disability, ethnicity, faith, sexual orientation) addressed within the LSP:
   - An LSP theme group or task group (e.g. an Older People's Partnership or a Disability Group)
   - A representative Voluntary/Community/Faith (VCF) sector organisation

2. Are mental health services engaged in the service design of debt services? Do they commission debt services for their patients/clients?

3. Are services for physical disability and health engaged in service design for supporting welfare rights?



6. Known population needs

Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.

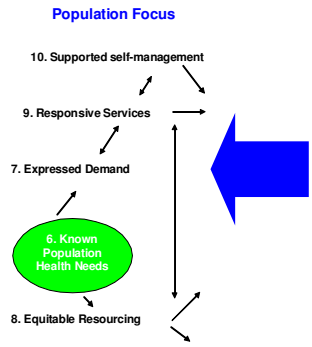
1. ***What mechanisms are in place to assess need/eligibility at population level for welfare benefits by individual agencies/sectors:***
   - ***Department of Work and Pensions***
   - ***Inland Revenue***
   - ***Local Authority Housing/Council Tax***
   - ***Social Care***
   - ***Health***
   - ***Other***

2. ***Has information on debt been analysed at population level, drawing in anonymised data from provider and enforcement agencies? For example:***
   - ***Local Authority Services***
   - ***Courts***
   - ***Utilities***
   - ***Mortgage lenders***
   - ***Credit referencing agencies (Experian, Equifax, CallCredit)***

3. ***Is the information applicable through Geographical Information Systems? Can common geographical building blocks be used?***

4. What equality monitoring is possible across the range information sources?

5. Has information from the range of sources:
   - been shared
   - been pooled
   - been jointly analysed
   - formed part of a joint strategic needs assessment



7. Expressed demand

Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.
To include:

- *as many indebted people as possible are afforded money advice, and as many eligible people as possible are enabled to claim the relevant benefits*
- *health groups disproportionately affected by debt problems (notably mental health) are helped with money advice*
- *people with medical conditions - that automatically qualify them for benefits - apply for those benefits*

Welfare rights are universally available, but since they are dependent upon making a claim, to what extent are local services effective in helping people to claim the benefits to which they are eligible?

1. Identifying gaps in uptake

- ***At a strategic level, is there a mechanism for comparing actual take-up of a range of benefits (or welfare rights) against an 'expected' number based on modelling of potential eligibility?***
  - ***Which components of the benefits system does this apply to? (employment, income, age, disability/medical condition)***
  - ***Is the information***
    - ***pooled/cross-referenced - or -***
    - ***jointly analysed***
  - ***Is there an analysis of any major discrepancies, for example:***
    - ***geographically***
    - ***by ethnic group***
    - ***by other category (enduring mental health; physical or learning disabled)***

- Is there a mechanism to generate action plans, in response the 'uptake versus eligibility gaps', to target substantial increases in uptake?
  - Is there a track record of success in this?
  - Has action been taken in a coordinated way across agencies in recognition of common areas of concern (e.g. placement of generic walk-in/advice centres in areas of poor uptake)?

- Is access to services specifically geared to disadvantaged communities known to be in greatest need, such as:

- young and older people, people with disability or medical conditions, BME communities, religious communities, LGBT communities
- people with mental health conditions (particularly in relation to debt)
- deprived neighbourhoods

2. Signposting to services

- ***Is there an effective system (such as a Single Assessment Process [SAP] / Common Assessment Framework [CAF]) for making referrals for benefits or debt advice, with particular reference to key service providers? For example:***
  - ***mental health professionals referring for debt advice?***
  - ***health and social care professionals – GPs, PCT provider services, social workers – referring for benefits advice?***

- ***Are there electronic systems in operation that automatically trigger referrals for debt and benefits advice (e.g. by GPs, SAP, CAF)?***

- Is a guide available showing which medical conditions/forms of disability are likely to qualify for which benefits?

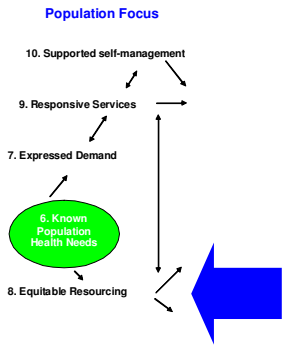
- Which frontline services systematically provide training for staff on eligibility for benefits and how to access them? Which do not and where it would be preferable for them to do so?

- Are there targeted screening arrangements in place? For example:
  - the Courts screening for debt /the need for debt advice
  - creditors screening for mental health problems

- Is there recognition of lack of income and debt as a social emergency? What debt and welfare rights services are offered as an emergency service (i.e. offered as a 'walk-in' service)?

- Can walk-in self-referral be accommodated initially at a range of access points?

- Are local advice services coordinated, with arrangements as to how clients will obtain legal/tribunal representation if needed?



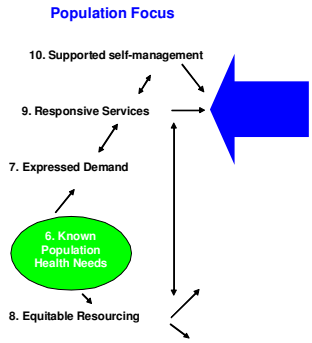
8. Equitable resourcing

Aim for the distribution of finance and other resources to support equitable outcomes according to need

1. What mechanisms are in place to consider whether funding is equitable according to need for provision of:
   - advisory and support services for access to welfare benefits
   - counselling and support for debt management

2. Do these mechanisms reflect the disproportionate costs of meeting need in the most deprived circumstances?

3. Is resource allocation for the costs of service provision decided on an agency-by-agency basis, or is it coordinated across the partnership?



9. Responsive services

When people present to services,aim to make sure they are afforded equal access to timely beneficial interventions according to need

1. Income maximisation

- What is the extent of schemes to maximise people's incomes through benefit entitlement checks, debt screening and benefits take-up campaigns?

- Since some benefits 'passport' to other benefits, how actively are local people helped to claim passporting benefits? 'Passported' benefits include: health benefits, free school means, Surestart maternity grant, Social Fund funeral expenses, Social Fund cold weather payment, community care grant and budgeting loan.

- Are charitable sources accessed to provide income in emergency need?

- Is assessment and referral activity of frontline staff in target communities audited?

2. Debt

- ***What proportion of people taken through the County or Magistrates Courts systems are afforded debt advice prior to appearing in Court?***

- ***Is there a casework approach for debt problems, including a legal representation service for all levels of County, Magistrates and High Court, and with the capacity to deal with bailiff action and personal insolvency?***

- ***Is there a duty advice and representation service at the relevant Courts – at least County Court?***

- ***Is Debt advice commissioned by mental health services?***

3. The creditor sector[29]

- ***Does the creditor sector accept mental health / health evidence from health and social care professionals?***

- ***Do creditors work with advisors and health and social care professionals on specific debt cases?***

- ***Are there local arrangements for dealing with 'loan sharks'?***

[29] Money Advice Liaison Group (2009) *Good Practice Awareness Guidelines, For Consumers with Mental Health Problems and Debt* 2nd Ed

- ***Is debt collection that is outsourced to debt collection agencies covered by Codes of Practice for dealing with mental health / health?***

- ***Has the creditor sector procedures for dealing with mental health /health cases – handling sensitive personal data and stopping inappropriate enforcement action?***

- ***Does the creditor sector undertake training on mental health?***

- ***Do enforcement agencies screen for vulnerability (age/health /disability) before taking enforcement action?***

4. Income and benefits

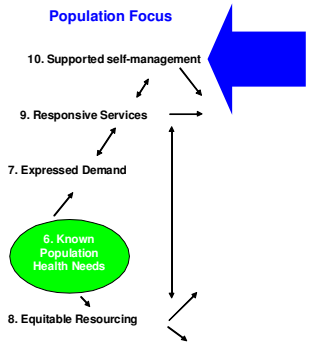
- Do advice services seek to negotiate with Department of Work and Pensions/Inland Revenue to resolve benefit eligibility problems?

- Is there a casework approach for benefit problems, including a tribunal representation service?

- Is there a tribunal representation service, including capability to appeal to the Social Security Commissioners?

- What proportion of people refused benefits are offered benefits advice, including tribunal representation?

- Are housing management and tenancy support workers able to deliver effective advice on Housing Benefit?



10. Supported self-management

Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

1. Assistance

- ***Are there systems for providing appropriate assistance (e.g. helping people fill in complex benefits application forms, or helping people fill in the income and expenditure parts of a financial statement) while giving advice on future management of personal finances, in relation to the following:***
  - ***illiteracy, poor literacy, low confidence and self-esteem***
  - ***learning or physical disability***
  - ***mental health problems***
  - ***no English, or English as a second language***

- Are systems for delivering 'managing your money' advice generally available, including:
  - budgeting
  - knowing where to obtain benefits health checks
  - understanding different forms of credit
  - understanding the financial and health benefits of smoking cessation
  - knowing how to eat healthily at low cost

2. Debt

- Is there a 'self-help guide' to dealing with personal debt?

- ***Is there an organised system of assistance (e.g. helping clients to prepare financial statements)?***

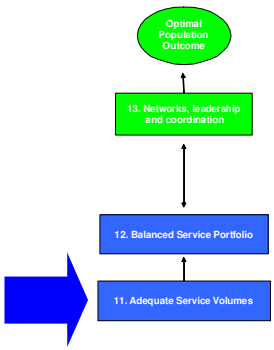
- Are there arrangements for accompanying indebted clients to Court as a 'Mackenzie friend[30]'?

- Are there arrangements for brief interventions e.g. the health and financial benefits of stopping smoking?

- ***Does the help in the preparation of financial statements involve contact with creditors?***

- Has social marketing identified likely forms of indebtedness amongst particular segmented groups?

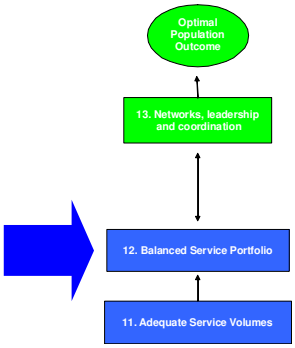
[30] A McKenzie friend – who need not be legally qualified - assists a litigant in person in court.



11. Adequate service volumes

Commissioning adequate service volumes to aim for acceptable access times

1. Is the capacity of advisory and support services sufficient to prevent delays in urgent access? Where in the system are there unacceptable delays in access?



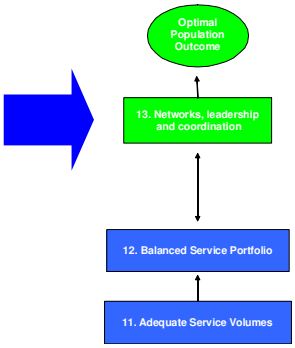
12. Balanced service portfolio

Aim for balance of services within pathways to avoid bottlenecks and delays

1. Where in the system are there delays or complexities following referral that may result in clients failing to get access to support?

2. Signposting and referral can fail. Practical assistance can make sure they do not. What mechanisms are in place in terms of:

- ***benefits, assistance to the less-than-literate with form filling (particularly Disability Living Allowance and Attendance Allowance claim forms) and speaking to benefits agencies on a client's behalf***
- ***debt, helping fill in financial statements and speaking to creditor agencies on a client's behalf.***



13. Networks, leadership and coordination

Designating leadership and co-ordination to aim for services to be commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

1. Partnership

Q

- ***Is there a Healthy Living Standard/Anti-Poverty Alliance within the LSP? If so, does its remit include:***
  - ***Welfare rights advice, service provider awareness and related health issues across the LSP***
  - ***Debt advice, enforcement, and related health issues across the LSP***

- Is the Alliance formally constituted within the LSP organisational and governance structures:
  - Linked in to the LSP as a theme group or task group
  - Linked through to the Economic block of the LSP

- Does the membership reflect all relevant partners, particularly:
  - Key Commissioners
    - Legal Services Commission
    - Social care
    - Housing
    - Health: PCT/mental health trust
  - Benefits Agencies
    - Department of Work and Pensions
    - Local Authority Housing Benefits/Council Tax
    - Inland Revenue
  - Advice services
    - Citizens Advice Service
    - Welfare Rights
    - Money Advice/Debt Counselling Service
  - Enforcement Agencies
    - Courts
    - Utilities
    - Mortgage lenders
    - Trading Standards
  - User and community representatives, with ‘equity group’ links

2. Strategy and action plan

- ***Is there a Strategy and Annual Action Plan that:***

- ***Is linked directly to the LAA***
- ***Is reflected in separate agency documentation (e.g. LA Corporate Plan, PCT Operational Plan)***
- ***Is there dedicated officer support with day-to-day responsibility for taking forward and coordinating action within the Plan? Is there dedicated officer support with day-to-day responsibility for taking forward and coordinating action within the Plan?***

- Is covered by governance and performance management arrangements for the LAA?

- Has the Overview and Scrutiny Committee reviewed delivery of welfare rights and debt services – in the context of an anti-poverty strategy?

3. Commissioning[31]

- Is there a common framework for commissioning debt and welfare rights advice services?

- ***Are health and social care services involved in the commissioning of these services:***
  - ***PCT***
  - ***Primary care***
  - ***Mental health trust (one third of people with enduring mental health problems have substantial debt)***
  - ***Adult social care services***
  - ***Children's trust***

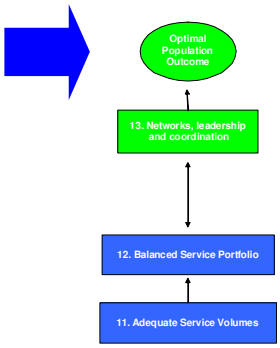
4. Data sharing

- ***Has a data sharing protocol been negotiated between the alliance partners? Does this form part of the commissioning specifications?***

- As part of the process, have signatories to the data sharing protocol been required to achieve Caldicott Guardian status? If so, what data is shared with whom?

	Data shared?	Health	Social Care	Advice sector
Single Assessment Process (SAP)	Health info.			
	Social Care info.			
	Advice agency info.			
Common Assessment Framework (CAF)	Health info.			
	Social Care info.			
	Advice agency info.			

[31] Michael Bell Associates Research & Consultancy (2009) *Their Patients, Our Clients, Our Patients, Their Clients: Developing effective partnerships between the NHS & the Advice Sector in England; The Evidence Report for advice UK*



Optimal Population Outcome

Aim for service outcomes to be meaningful locally, and drive the programme

1. What goals and outcomes will be used to measure the impacts of:

- Services to optimise the delivery of welfare benefits and maximise income to those in disadvantageous circumstances?
- Services to reduce indebtedness and its consequences?

Appendix 1: Low Income, Debt and Health: Potential Key Actions to reduce ill health and mortality

Introduction

To mitigate the worst impacts of low income and debt and their adverse impact on health, it is important to move from targeting services at individuals to targeting whole populations. However, a population-based approach cannot be achieved by a patchwork quilt of services.

It means tackling issues around service provision: service efficacy, service cost and effectiveness, service accessibility and engaging the public. It also means tackling issues around assessing and meeting need and demand: assessing need, meeting expressed and latent demand, equitable resourcing – of responsive services, and supported self-management where appropriate.

This is further explained in the above workbook on low income, debt and health, including the 'Christmas Tree' model on page 11.

The following recommended changes are aimed to achieve that population level change in the area of low income and debt and their relationship to health.

To achieve 'population level' change, the NST recommends:

1. Partnership and Strategy

The development of a **Poverty, Low Income and Debt Partnership**:
- clearly situated within the structure of the LSP
- possibly reporting to the Theme Group /Partnership for Economy and Prosperity
- with the partnership drawn to include key agencies (i.e. advice services including the CAS); benefits agencies (e.g. the DWP, Inland Revenue and local authority Housing Benefits and Council Tax Benefits); also key enforcement agencies – the Courts, utilities, mortgage lenders; and stakeholders such as the voluntary sector, PCT and mental health trust.

The development of an **Anti-Poverty Strategy**:
- under the overview of the Poverty, Low Income and Debt Partnership,
- with responsibility for relevant National Indicators and LAA targets e.g. take-up of benefits

The establishment of an **Anti-Poverty Unit**:
- operating with day-to-day responsibility for the Anti-Poverty Strategy and Action Plan

2. Commissioning advice services

Commissioning advice services will sustain their provision. In terms of health and social care, there is potential mutual benefit from:
- Health and social care agencies commissioning benefits advice for their services users in disadvantaged groups – in low income/workless groups, for children and older age, and for disability/medical condition
- Mental health services commissioning debt advice - for the one-third or more of people with diagnosed mental health problems who have substantial debt problems.

3. Mapping expected need for services

Mapping would show the expected take-up of benefits in terms of population groups/ communities of interest (e.g. employment status, age, disability/medical condition and carer status). Information could be sought from the DWP, Inland Revenue and local authority Housing Benefits and Council Tax Benefits, and from health services.

Mapping would show the proportion of people needing advice and assistance on debt, and in terms of the likely coincidence of mental health issues and debt (approximately one in three people with a serious mental health problem are in debt). Information could be sought from key enforcement agencies – the Courts, utilities, mortgage lenders and credit referencing agencies (Experian, Equifax, CallCredit) as well as health services.

4. Mapping actual take-up of services against expected need

Mapping can show the expected take-up of benefits against the actual, and the proportion of people obtaining advice and assistance on debt against known levels of indebtedness as supplied by creditors and/or Court information, in terms of:

- whole Borough population
- population groups (e.g. against employment status, age, disability/medical condition [physical and mental] and carer status)
- deprived neighbourhoods.

5. Information sharing as a means of cross-referencing need

A data sharing protocol would be the vehicle to maximise data sharing between the major stakeholders, including:

- Advice services
- Benefits agencies (e.g. the DWP, Inland Revenue, and local authority Housing Benefits and Council Tax Benefits)
- Enforcement agencies – the Courts, Utilities, mortgage lenders; and debt collection agencies /bailiffs,
- Health and Social Care agencies – the PCT and Mental Health Trust, Adult (and Children's) Social Care and the voluntary sector.

Appropriate levels of sharing (for example, in relation tosharing sensitive and personal data) would be a matter for the stakeholders to agree.

6. Information sharing as a means of stimulating take-up of services

Systems for information dissemination, signposting and making referrals can be greatly enhanced by assessment frameworks and processes (Common Assessment Framework [CAF], and/or Single Assessment Process [SAP]) being shared across the stakeholders, and, assuming the relevant personal information is collected, designed to trigger referrals for benefits and/or debt advice.

7. Advice and assistance services

Signposting and referral can fail. Practical assistance can make sure they do not.

- In terms of benefits, assistance to the less-than-literate with form filling (particularly Disability Living Allowance and Attendance Allowance claim forms) and speaking to benefits agencies on a client's behalf.

- In terms of debt, helping fill in financial statements, and speaking to creditor agencies on a client's behalf.

8. Representation services

Given that complete resolution of a client's problems can in many cases only be achieved by representation at Court or Tribunal, these services need to be geared to representation at

- Appeal Tribunals and appeals to the Social Security Commissioners
- County, Magistrates and High Court
- With a duty advice and representation service, at least at the County Court.

9. Delivery

9a. 'Front end' delivery in health settings – **Hospital**: Some benefits alter after 4/12/52 weeks in hospital – Attendance Allowance, Disability Living Allowance, Child Benefit, Income Support, Job Seekers Allowance, Housing Benefit (temporary absence from home).

Other people not claiming any benefits may leave hospital with a residual disability and newly qualify, for example, for Disability Living Allowance. Hence, there is a clear need for hospital-based benefits advice tied into hospitalisation beyond 4 weeks and into discharge arrangements.

9b. 'Front end' delivery through 'walk-in' service provision: 'Late presentation' is a characteristic experienced not only by health services, but also by the advice sector. Walk-in centres, frequently located in town centres, can afford immediate access and immediate assistance in cases of urgent need ('no money', 'due in Court in 5 minutes' etc.) They can combine health and advice services, suggesting an issue for the LSP or commissioning body to consider.

Moreover, in a different way from appointment-based systems, walk-in centres can gear themselves to demand by providing a 'front desk' quick enquiry service, interview rooms for more sensitive and complex enquiries, and 'back office' caseworkers handling a caseload of more complex cases.

9c. 'Front end' delivery through neighbourhoods: Neighbourhood based service delivery may be through neighbourhood services, neighbourhood facilities, staff groups / domiciliary services, or voluntary and community sector outlets. The manner of service delivery may be signposting, advice and assistance (all requiring training), or hosting a service.

- Neighbourhood services such as a Children's Centre or healthy living centre may provide signposting, advice and assistance.
- Neighbourhood facilities such as a GP surgery, community centre or Learning and Skills Access Point may host welfare benefits and debt advice services.
- Staff groups /domiciliary services such as health visitors, district nurses, social workers or health trainers may provide signposting, advice and assistance.
- Voluntary and community sector outlets may provide any of these.

9d. 'Front end' delivery through 'communities of interest': Equalities related communities of interest (i.e. gender, age, disability, ethnicity, faith, sexual orientation) may be represented by:

- An LSP theme group of task group (e.g. an Older People's Partnership or a Disability Group)
- A representative voluntary/community/faith sector organisation.

Either of these may be able to access specific groups to target signposting, advice and assistance (e.g. mental health groups for targeted debt advice, and disabled groups for targeted benefits advice).

Consideration should be given to delivery of advice and assistance to the most marginalised communities. Some of these communities include street homeless people, 'sofa surfers', residents of hostels and B&B (including hostels from the homeless, women's refuges, bail hostels, Foyers), people excepted/exempted from QOF registers, refugees and asylum seekers, newly arrived Black and minority ethnic communities, prisoners, offenders serving on community programmes and ex-offenders, Gypsy/ Traveller communities, carers, care leavers, drug and alcohol misusers, NEETs, Employment and Support Allowance 'non-optants' (i.e. self-excluded from the Pathways to Work Programme), etc.

10. The creditor sector

It is important to:

1. Establish with all major creditors whether:
   - They accept mental health/health evidence from health and social care professionals
   - They are willing to work with advisors and health and social care professionals on specific debt cases
   - Debt collection outsourced to debt collection agencies is covered by Codes of Practice for dealing with mental health/health
   - They have procedures for dealing with mental health/health cases –preventing inappropriate enforcement action.
   - They undertake training on mental health.
2. Encourage the development of this approach
3. Identify the most cooperative agencies as potential partners in a Poverty, Low Income and Debt Partnership.

11. The Courts

The enforcement roles of both the Magistrates and County Courts in relation to debt have enormous potential to embed good practice in debt cases by:

- hearing evidence from health and social care professionals
- ensuring debt enforcement agencies adhere to Codes of Practice for dealing with mental health/health
- ensuring defendants have been offered appropriate advice and representation before court hearings.

This might take the form of a review process whereby these factors are checked prior to setting a date for a court hearing.

Appendix 2: LSC Regional Offices

LONDON & SOUTH EAST REGION	NORTH WEST REGION	NORTH EAST REGION	MIDLANDS REGION	SOUTH & WEST REGION
(National) Central Customer Services Unit 11th Floor Legal Services Commission Exchange Tower 2 Harbour Exchange Square London E14 9GE Tel: 020 7718 8025 Fax: 020 7718 8021	**Liverpool Office** 2nd Floor Cavern Court 8 Mathew Street Liverpool L2 6RE Tel: 0151 242 5200 Fax: 0151 242 5394	**Newcastle Office** 2-8 Star House Fenkle Street Newcastle-upon-Tyne NE1 5RU Tel: 0191 244 5800 Fax: 0191 244 5998	**Nottingham Office** 1st Floor Fothergill House 16 King Street Nottingham NG1 2AS Tel: 01159 084 200 Fax: 01159 084 397	**Bristol Office** 33 -35 Queen Square Bristol BS1 4LU Tel: 011 7 302 3000 Fax: 011 7 302 31 98
London Office 12th Floor Legal Services Commission Exchange Tower 2 Harbour Exchange Square London E14 9GE Tel: 0845 602 14 00	**Manchester Office** 2nd Floor, Lee House 90 Great Bridgewater Street Manchester M1 5JW Tel: 0161 244 5000 Fax: 0161 244 5196	**Leeds Office** Harcourt House Chancellor Court, 21 The Calls Leeds LS2 7EH Tel: 0113 390 7300 Fax: 0113 390 7484	**Birmingham Office** Centre City Podium 5 Hill Street Birmingham B5 4UD Tel: 0121 665 4700 Fax: 0121 665 4899	**Reading Office** 80 King's Road Reading RG1 3BJ Tel: 011 89 55 8 600 Fax: 011 89 55 8 780
Brighton Office 3rd/4th Floor Invicta House Trafalgar Place, Cheapside Brighton BN1 4FR Tel: 01273 878800 Fax: 01273 878991			**Cambridge Office** 62-68 Hills Road Cambridge CB2 1LA Tel: 01223 41 7 800 Fax: 01223 41 7 982	

Appendix 3: Acronyms and abbreviations

AO	Administration Order
B+B	Bed and breakfast
BME	Black and minority ethnic
CAB	Citizens Advice Bureau
CAF	Common Assessment Framework
CLS	Community Legal Service
DROs	Debt Relief Orders
DWP	Department for Work and Pensions
EROs	Enforcement Restriction Orders
IVAs	Individual Voluntary Arrangements
LINks	Local Improvement Networks
LSC	Legal Services Commission
MAQM	Money Advice Quality Model
NEET	Not in education, employment or training
SAP	Single Assessment Process
SIVAs	Simple Individual Voluntary Arrangements
VCF	Voluntary, Community and Faith Sector