

Mental Health Commission

THE HUMAN COST

An overview of the evidence on economic adversity and mental health and recommendations for action

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September 2011

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Glossary

ASIST	Applied Suicide Intervention and Skills Training
CCMA	Code of Conduct on Mortgage Arrears
DALYS	Disability Adjusted Life Years
DMHEF	Debt and Mental Health Evidence Form
FETAC	Further Education and Training Awards Council
FRC	Family Resource Centre
GDP	Gross Domestic Product
GNP	Gross National Product
GMS	General Medical Services
GP	General Practitioner
HSE	Health Service Executive
IBF	Irish Banking Federation
MABS	Money Advice and Budgeting Service
MALG	Money Advice Liaison Group
MARP	Mortgage Arrears Resolution Process
NHS	National Health Service
OECD	Organisation for Economic Cooperation and Development
PCRS	Primary Care Reimbursement Scheme
WHO	World Health Organisation

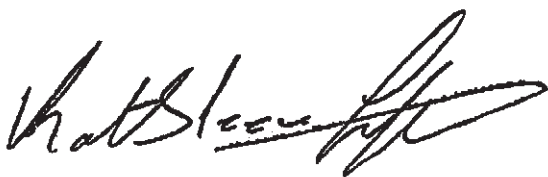
Foreword

As Minister of State with responsibility for Mental Health it gives me pleasure to launch *The Human Cost* a research paper from the Mental Health Commission which provides us with unequivocal evidence that economic adversity impacts negatively on mental health. The report represents a very good analysis of the situation on the ground and includes many practical recommendations on what we can do to help people who are experiencing difficulties.

The reality is that an increasing number of people are suffering stress and anxiety as a result of the recession. We cannot ignore the fact that the economic slowdown is having an affect on our mental health and consequently there will be greater demand for mental health services. Coping with unemployment, debt and poverty understandably puts pressures on individuals and families, and as a society, we must recognise this and try in whatever way we can to support people through the crisis. At the same time it is vitally important that we attempt to build emotional resilience within our communities which will enable us to cope better with the stresses that life throws up. We must also be careful to watch out for those around us who may be in trouble and encourage them to seek help where necessary. For the services, the challenge is to ensure that when people seek help that they will find timely, sensitive and effective support. For the Government, the challenge is to provide a person-centred, recovery oriented, mental health service in the face of scarce and reducing health resources.

A Vision for Change requires that mental health services be characterised and led by a partnership between all stakeholders. I believe that the time has now come for us all to step up to the plate. This report from the Mental Health Commission is part of the solution and will, if implemented, go a long way to ease the pressures on those in difficulty. I urge those organisations to which recommendations are directed, to respond positively, proactively and as early as possible.

I extend my thanks and gratitude to the Mental Health Commission and in particular to the Mental Health Services Committee and Dr Fiona Keogh, for the preparation of this informative and timely paper.



Kathleen Lynch, T.D.

Minister for Disability, Equality, Mental Health & Older People

“We should not be surprised or underestimate the turbulence and likely consequences of the current financial crisis... It should not come as a surprise that we continue to see more stresses, suicides and mental disorders.”

Margaret Chan, Director General of the World Health Organization
World Mental Health day October 2008 Geneva

1. Introduction

The current economic recession represents a time of high stress for individuals, organisations and society as a whole. Research evidence presented here suggests that components of economic adversity such as unemployment, debt and poverty have a significant impact on mental health. The Mental Health Commission is concerned about this impact on the mental health of the wider population and on those with pre-existing mental health conditions in particular. The resultant increased pressure on mental health services is also of concern. Several initiatives have already been taken by Government and these are very welcome¹. This paper outlines the Commission's position and proposes a series of actions informed by evidence, to help alleviate the human cost of the economic crisis. The paper first considers the wider context in terms of the recession itself, the economic impact of mental health problems and the public health context for action in mental health, then goes on to examine the evidence documenting the effect of economic adversity on mental health and actions proposed in other jurisdictions, and finally suggests a series of actions to be considered in the Irish context.

2. The wider context

2.1 The recession

In common with many other countries, Ireland has been in a 'severe recession'² since 2008. It could be argued that the perceived effects of the recession have been even more marked in Ireland because of the rapid and steep decline from a period of unprecedented growth which saw living standards increase by one-third in ten years³.

The recession has had a variety of economic effects. From a historically low level of unemployment; an average of 4.5% in 2007; unemployment has increased to 14.7% by the end of 2010⁴. In terms of public finances, a General Government Surplus of 3% was recorded in 2006, declining to an estimated General Government Deficit of almost 12% in 2009. National debt was 65% of GDP in 2009, up from 12% in 2007⁵.

The Organisation for Economic Cooperation and Development (OECD) believes that economic recovery will be weak and a "*protracted period of readjustment will be needed to resolve economic imbalances built up during the expansion*"⁶. Analysis of previous recessions has shown that unemployment rates tend to increase quickly in recessions, but take much longer to return to pre-recession levels – perhaps as long as 14 years (even longer for those who are long-term unemployed i.e. 12 months or more)⁷.

¹ For example, the recommendations of the Final Report of the Mortgage Arrears and Personal Debt Expert Group (2010) are very helpful <http://www.merrionstreet.ie/wp-content/uploads/2010/11/Mortgage-Arrears-and-Personal-Debt-Group-Report-17th-November-2010.pdf> as are the changes to the Review of the Consumer Protection Code Consultation Paper CP47 by the Financial Regulator on including a category of 'vulnerable consumer' <http://www.financialregulator.ie/consultation-papers/Documents/CP47%20Review%20of%20Consumer%20Protection%20Code/CP47%20Review%20of%20Consumer%20Protection%20Code.pdf>

² Organisation for Economic Cooperation and Development (2009) *Economic Survey of Ireland 2009*. Paris: OECD

³ Angel Gurria (2009) *Launch of OECD Economic Survey of Ireland 2009*.

⁴ Central Statistics Office Quarterly National Household Survey http://www.cso.ie/releasespublications/documents/labour_market/current/qnhs.pdf

⁵ http://www.esri.ie/irish_economy/ and Central Statistics Office

⁶ Ibid. OECD 2009

⁷ Mental Health Commission Canada (2009) *International Roundtable: Impact of the Recession in the Mental health of Workers and their families: Summary Report*.

Some key factors differentiate this recession from past recessions;

- Personal debt levels are much higher than ever before^{8,9};
- The combination of high personal debt with dramatic reductions in property values and investment values can result in significant negative impacts on individuals and families¹⁰;
- The benefit structure and state supports have changed to the detriment of people on low incomes.

Essential steps are being taken in this and other jurisdictions to drive economic recovery by supporting the financial system and supporting the economy. However, responses to support people through the crisis are also required¹¹. In what has been described as a “human crisis”, researchers who analysed suicide rates in Europe from 2007 to 2009 noted that “there is likely to be a long tail of human suffering following the downturn”¹². This paper highlights the importance of considering the impact of the recession on the mental health of individuals and the wider population, and possible actions that can ameliorate that impact.

2.2. Economic impact of mental health problems

The economic impact of mental health problems is considerable. The overall economic cost of mental health problems in Ireland has been estimated at just over €3 billion in 2006¹³, which is equivalent to 2% of GNP. The bulk of the costs are located in the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement. Costs to the health care system account for less than one quarter of overall costs¹⁴.

To put these costs into context, in England the costs of mental illness are greater than the costs of crime and are projected to double over the next 20 years¹⁵. A measure of the dual effect of chronic illnesses; both premature death and years lived with illness (the Disability Adjusted Life Year or DALY), shows that neuropsychiatric conditions account more than twice the DALYS of all cancers¹⁶, that depressive disorders were third among the leading causes of disease in 2004 and are projected to be the leading cause of DALYS by 2030¹⁷.

⁸ Oireachtas Library and Research Service (2010) Spotlight: Debt Part 2: Personal Debt and Consequences No. 3 http://www.oireachtas.ie/parliament/media/housesoftheoireachtas/libraryresearch/spotlights/Personal_Debt_and_Consequences.pdf

⁹ Russell, H., Maitre, B. and Donnelly, N. (2011) *Financial Exclusion and Over-indebtedness in Irish Households*. Dublin: ESRI. <http://www.esri.ie/UserFiles/publications/bkmnext184.pdf>

¹⁰ Mental Health Commission Canada (2009) *International Roundtable: Impact of the Recession in the Mental health of Workers and their families: Summary Report*.

http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/ev_20090427_co05_en.pdf

¹² Stuckler, D., Basu, S., Suhrcke, M., Coutts, A. and McKee, M. (2011) Effects of the 2008 recession on health: A first look at European data. *Lancet*, 378, 124-125. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61079-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61079-9/fulltext)

¹³ O’Shea, E. and Kennelly, B. (2008) *The Economics of Mental Health Care in Ireland*. Dublin: Mental Health Commission

¹⁴ Ibid. O’Shea, E. and Kennelly, B. (2008)

¹⁵ McCrone, P., Dhanasiri, S., Paterl, A. et al. (2008) *Paying the Price. The Cost of Mental Health Care in England to 2026*. London: King’s Fund

¹⁶ World Health Organisation (2008) *The Global Burden of Disease 2004 Update*. Geneva: WHO. http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_AnnexA.pdf

¹⁷ Ibid. p. 51 WHO 2008

2.3. Who is affected?

The recession affects everyone, to a greater or lesser extent. For people with pre-existing mental health problems the impact of the recession, and factors such as debt and unemployment, is likely to be more pronounced for several reasons. People with mental health problems have much higher rates of unemployment than the general population¹⁸. This results in a reliance on state benefits and a low income. One in four adults with a pre-existing mental health problem is also in debt¹⁹. These are all risk factors for poor mental health. Features of specific disorders may result in excess spending (e.g. mania and spending sprees) and other features such as withdrawal and communication difficulties can all contribute to personal debt. A high proportion of people with mental health problems who are in debt choose not to tell creditors because they think creditors won't understand or will not believe them²⁰. Finally, the presence of a mental health problem represents an existing vulnerability and the person may not have the emotional and psychological resources to cope with the extra stress of concerns in relation to debt and unemployment.

In addition to the effect on people with pre-existing mental health problems, people with no previous history of mental health difficulties can be affected. Some of these individuals may have little previous experience of coping with hardship (some may have been quite well off materially) and may be at greater risk of mental health problems than others who are 'inured' to financial insecurity²¹. While the majority of clients of the Money Advice and Budgeting Service (MABS) are social welfare recipients; almost 70% in 2010; the remaining 30% were people not in receipt of social welfare²². MABS experienced a 10% increase in the number of people accessing their service in 2010 compared to 2009 and figures for 2011 show a further increase²³. The increased awareness of the MABS service is very welcome but does lead to increased pressure on the finite resources of this service.

Poor mental health is associated with significant financial strain²⁴, debt and unemployment, although it is difficult to determine a causal relationship from the research. An English study has found that in the general population, half of those with debt have a mental disorder, compared to only 14% of people with no debts²⁵. A recent report from the Economic and Social Research Institute found associations between financial exclusion and households at risk of poverty, headed by a person unable to work due to illness/disability and a range of other indicators of social exclusion²⁶. Similar associations were also found for over-indebtedness, and that income inadequacy is a key factor in over-indebtedness in Ireland; "*The risk groups identified, such as lone parent households, the unemployed and the ill/disabled, also highlight the role of a persistent lack of resources in over-indebtedness*" (p.15)²⁷.

¹⁸ Perkins, P. and Rinaldi, M. (2002) Unemployment rates among patients with long-term mental health problems. *Psychiatric Bulletin*, 26, 295-298

¹⁹ Jenkins, R., Fitch, C., Hurlston, M. and Walker, F. (2009) Recession, debt and mental health: challenges and solutions. *Mental Health in Family Medicine*, 6, 85-90.

²⁰ MIND (2008) In the Red: Debt and Mental Health. http://www.mind.org.uk/assets/0000/9121/in_the_red.pdf

²¹ Fitch, C., Hamilton, S., Basset, P. and Davey, R. *Debt and Mental health: What do we Know? What should we do?* [http://www.rcpsych.ac.uk/pdf/Debt%20and%20mental%20health%20\(lit%20review\).pdf](http://www.rcpsych.ac.uk/pdf/Debt%20and%20mental%20health%20(lit%20review).pdf)

²² O'Connor, A. (2011) Debt and Mental Health – The MABS Perspective. Presentation to MHC workshop.

²³ www.mabs.ie

²⁴ Weich, S. and Lewis, G. (1998) Poverty, unemployment and common mental disorders: population-based cohort study. *British Medical Journal*, 317, 115-119

²⁵ Jenkins, R., Fitch, C., Hurlston, M. and Walker, F. (2009) Recession, debt and mental health: challenges and solutions. *Mental Health in Family Medicine*, 6, 85-90.

²⁶ Russell, H., Maitre, B. and Donnelly, N. (2011) *Financial Exclusion and Over-indebtedness in Irish Households*. Dublin: ESRI. <http://www.esri.ie/UserFiles/publications/bkmnext184.pdf>

²⁷ Ibid. Russell, H., Maitre, B. and Donnelly, N. (2011)

While urban poverty is often to the fore, rural poverty is also a significant problem. A study by the Vincentian Partnership for Social Justice has highlighted rural poverty and the higher costs for many associated with rural living²⁸. Two of the household types examined in the study are characteristic of risk factors for poor mental health (a female pensioner (70+) living alone and a single male (40-55) living alone).

2.4 The impact on mental health services

At the same time as the need for support is increasing, the Irish Government and its associated agencies (such as the HSE) are faced with cutting expenditure on public services in order to address the budget deficit. The cuts in mental health services are taking an insidious form in that staff who leave or retire are not replaced. It is estimated that approximately 10% of psychiatric nursing staff left the mental health services in 2009²⁹. Delays in recruiting health and social care professionals also occur as a cost saving measure. The Inspector of Mental Health Services notes that *“unfortunately and ironically, when cuts are made, it is the progressive community services which are culled, thus causing reversion to a more custodial form of mental health service”* (p.82).

This scenario for service providers has been characterised as a *“double-edged sword...whereby service providers confront the prospect of diminishing resources together with increased demand.”*³⁰ This is particularly the case for mental health in comparison to other parts of the health service, where debt and unemployment have been shown to have such a direct negative impact on mental health.

2.5 Mental health and public health

Debt and mental health problems interact so that each set of issues can cause or exacerbate the other³¹. However, it is important not to “medicalise financial, economic and social problems”³². In terms of addressing the impact of unemployment, debt and poverty, the most effective remedial action is that which will change the social circumstances of those affected, rather than the provision of individual treatment or therapy³³. In essence this describes a public health approach to the issue, with an emphasis on building mental capital and improving the general wellbeing of the population. This is a long-term, investment approach rather than a reactive, interventionist approach designed to build mental capital in the general population. Adopting a social policy of supporting wellbeing to increase social capital is argued strongly by the Commission on the Social Determinants of Health³⁴ and a recent publication on mental health, resilience and inequalities³⁵. While this present paper focuses on the effects of the recession on mental health, the evidence for both the effects and possible actions are embedded within this wider context.

²⁸ <http://www.svp.ie/Files/Documents/VINCENTIAN-FULL-DOCUMENT.html>

²⁹ Mental Health Commission (2010) *Annual Report and Report of the Inspector of Mental Health Services 2009*. Dublin: Mental Health Commission

³⁰ The National Centre of Mental Health Information and Workforce Development: Mental health and the recession. <http://www.tepou.co.nz/page/823-Factsheets+Mental-health-and-the-recession>

³¹ The Forum for mental health in primary care (2009) *Primary Care Guidance on debt and mental health. Factsheet* <http://malg.org.uk/Primary%20care%20guidance%20on%20debt%20and%20mental%20health%20July%202009.pdf>

³² http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/ev_20090427_co07_en.pdf

³³ Whelan, C., Hannan, D and Creighton, S. (1991) *Unemployment, poverty and psychological distress*. Economic and Social Research Institute. General Research Series Paper No. 150.

³⁴ World Health Organisation (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health* Geneva: WHO.

³⁵ Friedli, L. (2009) *Mental health, resilience and inequalities*. WHO Regional Office for Europe

3. Research evidence

While it is difficult to create a causal link between an event that occurs over a period of time, such as a recession, and direct effects on health, there is a wide-ranging and reliable body of evidence which documents a strong negative association between poverty, debt, unemployment, and mental health.

These several strands of research are all relevant to a consideration of the impact of an economic recession on mental health, and all are inter-related;

1. *Poverty and its impact on mental health:* there is strong evidence of a direct negative relationship between poverty and mental ill health;
2. *Unemployment and its impact on mental health:* the impact of unemployment can take place in at least two ways; firstly, unemployment results in a lower income which in turn influences mental health; secondly, the experience of unemployment itself can have a negative impact on mental health ;
3. *Debt/economic hardship and its impact on mental health:* there is an increasing body of evidence documenting the negative effect of debt on mental health;
4. *Pathways to mental ill health, specifically childhood adversity:* there is strong evidence concerning the impact of childhood adversity on the mental health of children and subsequently as adults. Components of childhood adversity including economic hardship;
5. *Suicide:* there is a strong, long-term body of evidence showing increased suicide rates in recessionary times and an increased risk of suicide among the unemployed.

Each of these areas will be briefly considered and some pointers to possible action will be highlighted. It should be noted that there is a dearth of Irish data, information and research in many of these areas. While Irish data and studies are used wherever available, the research evidence draws heavily from the UK and other similar jurisdictions where experiences are assumed to be largely similar.

3.1 Poverty, unemployment and mental health

There is a strong inter-relationship between poverty, unemployment and mental health. The effect of poverty on mental health occurs largely in three ways. Firstly, poverty itself is associated with psychological distress. The deprivation of basic necessities has a particularly strong impact³⁶. Secondly, poverty arising from certain economic stressors such as unemployment is more likely to precede mental health difficulties such as anxiety and depression, thus making it an important risk factor for mental illness^{37,38}. Thirdly, people with a serious mental disorder, such as schizophrenia, have high levels of unemployment and many are reliant on state payments and are thus at risk of poverty^{39,40}.

³⁶ Whelan, C., Hannan, D and Creighton, S. (1991) *Unemployment, poverty and psychological distress*. Economic and Social Research Institute. General Research Series Paper No. 150.

³⁷ Canadian Mental Health Association (2007) *Poverty and Mental Illness* http://www.ontario.cmha.ca/admin_ver2/maps/cmha_poverty_backgrounder.pdf

³⁸ Murali, V. and Oyebode, F. (2004) *Poverty, social inequality and mental health*. *Advances in Psychiatric Treatment*, 10, 216-224.

³⁹ Keogh, F., Finnerty, A., O'Grady-Walshe, A., et al. (2003) *Meeting the needs of people with schizophrenia living in the community: a report from a European collaboration*. *Irish Journal of Psychological Medicine*, 20, 45-51.

⁴⁰ Expert Group on Mental Health Policy (2004) *What we heard. Consultation report on long-term service users*.

A large-scale Irish study (over 3,000 households) was carried out in the late 1980s, when unemployment was very high in Ireland and economic growth had been low for a significant period of time⁴¹. This study showed that poverty in terms of basic necessities (primary deprivation⁴²) had the strongest impact on mental health, with a more than four-fold difference in psychological distress in those in poor versus non-poor households. The effects of unemployment and poverty are cumulative, i.e. they combine to increase the levels of distress. The unemployed in poor households were five times more likely to be psychologically distressed than those living in non-poor households. Levels of psychological distress were also found to significantly increase rates of health service utilisation, such as GP visits and prescription rates. There is a ten-fold difference in admissions to psychiatric hospitals and units in Ireland, between employers and managers and those in the 'unspecified' socio-economic group, which is likely to contain a disproportionate number of unemployed and low income individuals⁴³.

Unemployment itself is strongly associated with psychological distress not just because of the effects on income but because of the loss of status, self-esteem and purpose which are all associated with being employed. For the individual, access to work is associated with higher levels of autonomy, health and well-being and social networks⁴⁴. Participation in work also has wider benefits for the community, contributing to the economic and social development of local communities and the country as a whole.

3.1.1 Policy implications

The evidence clearly shows that *"a great deal of psychological distress could be ameliorated, in principle, by remedial actions arising from social policy"* (p.6) and that those who experience re-employment or are removed from poverty regain their mental health⁴⁵. Social support also has the effect of ameliorating the impact of poverty and unemployment. Measures to increase social support can be an important intervention.

A recent UK report on *Mental Health and the Economic Downturn*⁴⁶ recommended keeping people with mental health problems at work (for example through support for employers) and getting people back to work (for example making available supports to people with mental health problems to return to work) as priorities for Government and health service action.

3.2 The effect of debt on mental health

The Psychiatric Morbidity Survey in the UK showed that one in 11 British adults was in debt (being 'seriously behind with at least one bill or commitment'). One in two adults in such debt has a mental disorder⁴⁷. Recent research on debt has also shown a clear relationship between debt and mental ill health. A large scale study in the UK in 2007 (8,185 participants) found that housing arrears negatively impacted on mental health among men (if arrears occurred in the last year) and among women (if arrears were long term)⁴⁸. A study on consumer debt (2,193 participants) reported a statistically significant relationship

⁴¹ Whelan, C., Hannan, D and Creighton, S. (1991) *Unemployment, poverty and psychological distress*. Economic and Social Research Institute. General Research Series Paper No. 150.

⁴² Primary deprivation was defined as the enforced absence of socially defined necessities of a very basic kind relating to food, clothing and heat.

⁴³ Daly, A., Walsh, D. and Moran, R. (2007) *Activities of Irish Psychiatric Units and Hospitals 2006*. Dublin: Health Research Board.

⁴⁴ Wynne, R. and McAnaney, D. (2004) *Employment and disability: Back to work strategies*. European Foundation for the Improvement of Living and Working Conditions. Luxembourg: Office for Official Publications of the European Communities.

⁴⁵ Ibid. Whelan et al. 1991

⁴⁶ Royal College of Psychiatrists, Mental Health Network, NHS Confederation and London School of Economics (2009) *Mental Health and the Economic Downturn: National Priorities and NHS Solutions* http://www2.lse.ac.uk/LSEHealthAndSocialCare/PSSRU/pdf/mental_health_downturn121109.pdf

⁴⁷ Jenkins, R., Fitch, C., Hurlston, M. and Walker, F. (2009) Recession, debt and mental health: challenges and solutions. *Mental Health in Family Medicine*, 6, 85-90.

⁴⁸ Taylor, M.P., Pevalin, D.J. And Todd, J. (2007) The psychological costs of unsustainable housing commitments. *Psychological Medicine*, 37, 1027-1036

between debt and mental well-being, although the effect size (i.e. the impact on mental health) was small⁴⁹. Debt has also been found to be significantly associated with major depression⁵⁰. A large scale review of the evidence concluded that there is evidence of an association between debt and mental health problems, although there was no conclusive evidence of a causal relationship. An important conclusion of this review captures the wider, insidious effect of debt which “may have indirect effects on household psychological wellbeing over time, as it impacts on feelings of economic pressure, parental depression, conflict-based family relationships and potential mental health problems among children”⁵¹ (p.3).

3.3 Longer term impacts on mental health

Children with good mental health are able to develop emotionally, intellectually and creatively and have the resilience to cope with problems they might encounter. They are able to form satisfying relationships and live life to the full. Poor mental health in childhood, or the presence of factors which adversely affect mental health in childhood, can have significant and long-term impacts on the child, affecting the possibility of future achievements and relationship and family formation.

Economic adversity or poverty is one such factor which has a strong association with mental health problems in childhood. For example, a large-scale survey in Great Britain (over 12,000 participants aged between 5 and 16 yrs) found that 16% of children from families with a weekly household income of under £100 had mental health problems, compared to 5% with a weekly household income of more than £600⁵². This study also found that children in Local Authority Care and refugee and asylum seeker children were also at high risk of mental health problems⁵³.

Preliminary findings from the Children's Longitudinal Study in Ireland have shown substantial differences in the level of emotional and behavioural problems depending on the mother's educational level, with the lowest levels of problems in children whose mothers were graduates and the highest levels among children whose mothers completed low secondary or less⁵⁴. Level of educational attainment is known to be strongly associated with income and an extrapolation of these findings could indicate higher levels of emotional and behavioural problems with lower income levels. Of the 11% of 9 year olds in the study who were reported as having a chronic illness or disability, 17% of this cohort had a mental or behavioural condition. Chronic illness or disability was more concentrated in those with semi-skilled/unskilled backgrounds. More detailed analysis of future data from this longitudinal study may shed more light on these interpretations.

The effects of poverty on adolescent mental health are several and cumulative. Chronic exposure to poverty increases adolescents' risks for disorders such as depression, and behavioural risks such as substance use, early sexual activity and criminal activity⁵⁵. The awareness of financial difficulties in their families has also been found to negatively impact adolescent's mental health; being associated with depression and adolescent girls and drinking to the point of intoxication in boys. The awareness of familial economic difficulties was also associated with a sense of helplessness, and feelings of shame and inferiority in adolescents⁵⁶.

⁴⁹ Brown, S., Taylor, K. And Price, S. (2005) Debt and distress: evaluating the psychological cost of credit. *Journal of Economic Psychology*, 26, 642-663

⁵⁰ Drentea, P. (2000) Over the limit: the association among health, race and debt. *Social Science and Medicine*, 50, 517-529

⁵¹ Fitch, C., Hamilton, S., Basset, P. and Davey, R. (2009) *Debt and Mental Health. What do we know? What should we do?* [http://www.rcpsych.ac.uk/pdf/Debt%20and%20mental%20health%20\(lit%20review\).pdf](http://www.rcpsych.ac.uk/pdf/Debt%20and%20mental%20health%20(lit%20review).pdf)

⁵² Office for National Statistics (2005) *Mental Health in Children and Young People in Great Britain 2004*. London: HMSO

⁵³ Office for National Statistics (2005) *Ibid.*

⁵⁴ Williams et al. (2009) Growing Up In Ireland: National Longitudinal Study of Children. The lives of 9-year-olds. http://www.esri.ie/Childrens_Longitudinal_Study/news_publications/Growing_Up_in_Ireland_-_The_Lives_of_9-Year-Olds_Exec_Summary.pdf

⁵⁵ Dashiff, C., DiMicco, W., Myers, B. and Sheppard, K. (2009) Poverty and Adolescent Mental Health. *Journal of Child and Adolescent Psychiatric Nursing*, 22, 23-32.

⁵⁶ Frojd, S., Marttunen, M., Pelkonen, M. et al. (2006) Perceived financial difficulties and maladjustment outcomes in adolescents. *European Journal of Public Health*, 16, 542-548

Adversity itself also tends to be cumulative, with a large scale US study⁵⁷ reporting childhood economic adversity in 11% of the sample, 84% of whom experienced at least one other childhood adversity. The study also suggests that multiple childhood adversities are associated with up to 45% of all childhood-onset mental disorders⁵⁸.

3.4 Suicide and economic adversity

Economic adversity and recession specifically has been shown to result in an increase in suicide rates⁵⁹. Studies have also shown that factors in the current economic crisis, such as falling stock prices, increased bankruptcies and housing insecurity (including evictions and the anticipated loss of a home), and higher interest rates are all associated with increased suicide risk^{60,61}. People who are unemployed are two-three times more likely to die by suicide than people in employment⁶². A recent Irish study has shown that during the boom years of the 'Celtic Tiger' male and female rates of suicide and undetermined death were stable during 1996-2006, while suicide among unemployed men increased. Unemployment was associated with a 2-3 fold risk of suicide in men and a 4-6 fold increased risk in women⁶³.

A recent analysis of European suicide rates and unemployment increases following the economic crisis showed that the steady downward trend in suicide seen in European countries before 2007 "reversed at once in 2008" with a small increase in 2008 and a further increase in suicide rates in 2009⁶⁴. This increase in rates corresponds with "a swift increase in unemployment rates" in 2009 to a rate that was 35% above the 2007 level in Europe. The researchers also note that "the countries facing the most severe financial reversals of fortune, such as Greece and Ireland, had greater rises in suicides (17% and 13%, respectively) than did the other countries".

In late 2008 the Samaritans were warning of the risk the deepening financial crisis posed to mental health and the increase of suicide in particular⁶⁵;

"Economic recession, especially when it is sudden and severe, can lead to an increase in suicide rates. This is not only because more people become unemployed and, as a result, more psychologically vulnerable, but also because those in employment feel threatened too. The fear of losing one's job and pressures caused by a downturn in business, demotion or pension plan cutbacks can be bad for mental health and therefore increase suicide risk."

Stephen Platt, Professor of Health Policy Research at the University of Edinburgh and Samaritans' Trustee⁶⁶.

By mid 2010 one in ten calls to the Samaritans in Ireland were described as 'recession-related' and in June 2010 some 50,000 calls were received, up from an average of 35,000 in other months⁶⁷. The suicide rate in Ireland increased from 424 in 2008 to 527 in 2009, an increase of 24%. This followed a small but continued

⁵⁷ The National Co-morbidity Survey Replication was carried out in the US on over 9,000 people between 2001 and 2003.

⁵⁸ Grief Green, J. et al. (2010) Childhood Adversities and Adult Psychiatric Disorders in the National Comorbidity Survey Replication I: Association with first onset of DSM-IV disorders. *Archives of General Psychiatry*, **67**, 113-123

⁵⁹ Stack, S. (2000) *Work and the Economy*, in *Comprehensive Textbook of Suicidology*, R.W. Maris, A.L. Berman and M.M. Sliverman, Eds. New York: The Guildford Press

⁶⁰ Viren, M. (2005) Suicide and business cycles: new empirical evidence. *Applied Economics Letters*, **12**, 887-892

⁶¹ Stack, S. And Wasserman, I. (2007) Economic strain and suicide risk: A qualitative analysis. *Suicide and Life-Threatening Behaviour*, **37**, 103-112

⁶² Platt, S. (2003) Suicide and Work. *Psychiatry*, **25**-28.

⁶³ Corcoran, P. and Arensman, E. (2009) Suicide and employment status during Ireland's Celtic Tiger Economy. *European Journal of Public Health*, <http://eurpub.oxfordjournals.org/content/early/2010/01/27/eurpub.ckp236>

⁶⁴ Stuckler, D., Basu, S., Suhrcke, M., Coutts, A. and McKee, M. (2011) Effects of the 2008 recession on health: A first look at European data. *Lancet*, **378**, 124-125. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61079-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61079-9/fulltext)

⁶⁵ http://www.samaritans.org/media_centre/latest_press_releases/samaritans_suicide_crisis.aspx

⁶⁶ Ibid.

⁶⁷ Eithne Donnellan, 1st July 2010, Irish Times, One in 10 calls to Samaritans relates to recession.

reduction in the number of suicides over the previous years. The Director of the National Office for Suicide Prevention noted; *"The impact of the economic downturn in 2008, and particularly in 2009, has led to substantial increases in both self harm and suicide numbers."*⁶⁸

4. The consequences for the wider 'mental health system'

The 'mental health system' incorporates the framework described in A Vision for Change which includes; the community-level response to mental health difficulties, such as through support groups and other voluntary groups; mental health interventions at primary care level – usually in the form of contact with a GP or other primary care professional; and interventions at the specialist mental health service level, through contact with community mental health teams and other parts of the mental health service.

4.1 Community level

At the community-level, organisations such as the Samaritans have reported a significant increase in calls and that approximately 10% of calls are related to the recession. A report by the Family Resource Centre National Forum reported a large increase in the numbers of unemployed accessing their centres; "In 2009, Family Resource Centres (FRCs) had an influx of service-users experiencing stress, financial management difficulties and mental health problems, mostly as a direct consequence of the recession and the rise in unemployment"⁶⁹. A number of additional services and supports are now being provided by FRCs within existing resources to address the needs of the 'new unemployed'.

4.2 Primary care level

The evidence described so far shows that financial strain is strongly associated with both the onset and maintenance of common mental health problems. The majority of common mental health problems are treated at primary care level which means it is likely that in times of economic hardship there will be an increase in the number of individuals attending GPs for mental health problems.

Unfortunately, there are no centrally collected statistics on GP visits and so it is not possible to establish increased visits due to mental health difficulties. However, statistics from the Primary Care Reimbursement Scheme (PCRS) show increased levels of demand, particularly from 2007 to 2008, the year the effects of the recession were beginning to be felt within the system⁷⁰. In 2008 an additional 75,942 persons were granted medical cards, an increase of 6% over the 2007 figure. Figures for 2009 are not yet available.

Table I shows a selection of drugs used to treat mental health difficulties from the top 100 most commonly prescribed products on the General Medical Services (GMS) scheme. The number of prescriptions

⁶⁸ http://www.nosp.ie/annual_report_09.pdf

⁶⁹ <http://www.familyresource.ie/documents/1280151290.pdf>

⁷⁰ Health Service Executive (2009) Primary Care Reimbursement Service Statistical analysis of claims and payments 2008. http://www.hse.ie/eng/staff/PCRS/PCRS_Publications/

increased for all products except one; prescriptions for Temazepam showed a decrease of 2.3%. The most marked increase was seen for the antidepressant Mirtazapine, an increase of over 19% in prescriptions between 2007 and 2008. Other products showed an increase in prescription rates of over 10%; the benzodiazepine Alprazolam and the anti-depressants Venlafaxine and Amitriptyline. Smaller increases were seen in numbers of prescriptions for the anti-psychotic drugs, which are probably due to the overall increase in the numbers of people on the GMS scheme which occurred in the time period.

While it is difficult to make concrete attributions, the increases in rates of prescription for anti-depressants in particular, are greater than the 6% increase in medical cards which occurred from '07 to '08. The PCRS report noted that "increasing numbers on the Live Register...presents an unprecedented challenge for services in the future" and that "in line with the current economic situation and growth in Live Register numbers...this sharp growth in numbers eligible for services is expected to continue throughout 2009".

Table 1: 100 most commonly prescribed products on the General Medical Services Scheme (GMS): Selection of the products used for mental health problems 2007 and 2008.

Product	Broad classification	2007	2008	% change
Diazepam	Benzodiazepine*	455,352	479,305	5.3
Alprazolam	Benzodiazepine	346,130	382,291	10.4
Citalopram	Anti-depressant	255,930	268,062	4.7
Venlafaxine	Anti-depressant	243,124	267,656	10.1
Temazepam	Benzodiazepine	218,625	213,631	-2.3
Flurazepam	Benzodiazepine	179,965	181,576	0.9
Olanzapine	Anti-psychotic	165,875	174,560	5.2
Mirtazapine	Anti-depressant	135,737	161,981	19.3
Amitriptyline	Anti-depressant	139,467	154,067	10.5
Fluoxetine	Anti-depressant	129,367	132,370	2.3
Carbamazepine	Mood stabiliser	130,508	131,244	0.6
Risperidone	Anti-psychotic	128,249	131,179	2.3
Prochlorpromazine	Anti-psychotic	122,116	126,107	3.3
Sertraline	Anti-depressant	116,237	124,791	7.4

*Benzodiazepines are used to treat anxiety and also have a sedative effect

4.3 Mental health service level

Primary care services are the gateway to mental health services, thus an increase in attendances at primary care level for mental health problems is likely to lead to an increase in referral rates to mental health services. The evidence also suggests that poverty and unemployment serve to maintain and prolong episodes of mental disorders which might otherwise have resolved more rapidly. This may also act to increase the rates of referral from primary to secondary mental health care.

There is no detailed data on mental health service use in Ireland, apart from inpatient services. Data from the inpatient database in the HRB shows small year on year changes is unlikely to show substantive changes in inpatient bed use which could be reliably attributed to the recession.

An increase in presentations of self harm have been recorded on the National Registry of Deliberate Self Harm Ireland for 2007, '08 and '09, whereas numbers for the three years previous had shown slight decreases. Of the 11,966 presentations of self harm in 2009, close to 10% were admitted to a psychiatric unit. This figure is acknowledged to be an underestimate of cases that end up in psychiatric care as cases admitted initially to general wards are subsequently referred to the mental health services or admitted to a psychiatric ward. Thus, over 1,100 admissions were made to psychiatric inpatient care following self harm. The Director of Research at the National Suicide Research Foundation has attributed the 11% rise in the rates of self harm in young men in 2009 directly to the economic downturn; *“an obvious increase was seen in men aged between 25 and 34 – a time in life when people are either in the workforce or looking for jobs” and that “the increase in deliberate self harm among men that started in the middle of last year because of unemployment and financial cutbacks is expected to intensify this year”* (i.e. 2010)⁷¹.

Specific demands may also be seen on other services such as child and adolescent mental health services, particularly as time passes and families are in economic hardship for longer periods and with increased hopelessness regarding change or resolution. Longitudinal data on mental health services use will be required to determine such patterns.

⁷¹ Evelyn Ring, 20th July 2009, *Recession blamed for 11% rise in self-harm*. Irish Examiner: <http://www.examiner.ie/ireland/recession-blamed-for-11-rise-in-self-harm-96797.html>

5. Current actions in Ireland and other jurisdictions

The *Foresight*⁷² *Review of Mental Capital and Wellbeing* in England convened a workshop of representatives from health and social care, money advice, banking and government agencies to address the challenges to mental health posed by the recession⁷³. This workshop proposed a useful framework for action across three areas; actions within sectors to support people experiencing debt and mental health difficulties; action across sectors to coordinate activity and changes to government policy and practice.

5.1 Current actions within sectors

5.1.1 Health and social care

The evidence shows that people with mental health difficulties and disorders are experiencing significant levels of debt. The Foresight workshop recommended that:

- all health and social care professionals should ask service users about financial difficulties in routine assessments
- where debt is reported, primary care professionals should assess for depression and other common mental health difficulties;
- health and social care professionals should receive basic 'debt first aid' training; knowing how to refer to and support debt counsellors, but without having to become experts in debt and money management themselves.

A guide on debt and mental health has been produced in the UK which may be a useful resource for health and social care professionals in Ireland⁷⁴. This guide is based on a programme of research on debt and mental health undertaken by the Royal College of Psychiatrists. It acknowledges that health professionals are not debt experts and outlines eight steps a health professional can take when working with a person with a mental health problem. These steps are summarised by the acronym CARE;

- C – Consider debt as a possible underlying determinant of ill health – physical or medical
- A – Ask about debt – the person may be too embarrassed to bring it up
- R – Refer consenting clients to a money adviser
- E – Engage with financial advisers

One of the important potential roles a health care professional may have is to share information with the appropriate agencies with the consent of the service user. A tool has been developed in the UK to facilitate this (see Section 5.2.1 below).

⁷² Foresight is a group under the UK Government Office for Science which uses the latest scientific and other evidence to tackle complex issues and help policy makers make decisions about the future <http://www.bis.gov.uk/foresight>

⁷³ <http://www.bis.gov.uk/foresight/our-work/projects/published-projects/mental-capital-and-wellbeing>

⁷⁴ Fitch, C., Fearnley, J., Trend, C. And Williams, S. (2009) *Final Demand: Debt and mental health*. London: Royal College of Psychiatrists.

The provision of general information about mental health and how it can be supported is one of the actions recommended in the combined report of the Royal College of Psychiatrists, the NHS and the London School of Economics. The HSE has taken action under this heading in Ireland with the launch of the programme *Looking after your mental health in tough economic times*⁷⁵. A pocket-sized information card and leaflets have been rolled out which have the contact details of support agencies.

5.1.2 Financial services

Adults with mental health difficulties and debt are “customers and consumers who purchase goods and services, enter into contracts and borrow money”⁷⁶(p87). However, there is often little or no acknowledgement of this fact, and there is evidence that financial and other agencies view a declaration of mental health difficulties as an ‘excuse’ to get out of payments⁷⁷. The Foresight workshop recommended that financial sector codes of practice should, at a minimum, recognise the existence of customers with mental health difficulties and should define ‘best practice’ in working with such customers.

A review of the Consumer Protection Code is currently underway and a consultation paper has been issued by the Financial Regulator for comment⁷⁸. This paper has introduced the concept of a vulnerable consumer, defined as “a consumer that is vulnerable because of mental or physical infirmity, age, circumstances or credulity...”. This concept is potentially very helpful in recognising the diverse client group of financial institutions, some of whom will have vulnerabilities, and in clarifying responsibilities on the part of such institutions for this group of consumers.

The Irish Banking Federation (IBF), in consultation with the Money Advice and Budgeting Service (MABS), has developed a Consumer Guide to Dealing with Mortgage Repayment Difficulties⁷⁹. While this guide contains helpful information for consumers, it makes no mention of personal difficulties the consumer may have.

A key recommendation from the Mortgage Arrears and Personal Debt Group is that lenders must develop a Mortgage Arrears Resolution Process (MARP) to provide a framework for handling arrears and pre-arrears cases⁸⁰. MARP has the potential to encourage a change in culture in how financial institutions deal with customers in arrears as it is based on a process of engagement and communication with the goal of resolving arrears in a non-adversarial way. A potentially very helpful development for those in difficulty is the recommendation that lenders must establish a centralised and dedicated Arrears Support Unit to manage pre-arrears under the MARP. It is also recommended that a Standard Financial Statement be developed for use by all lenders and MABS. This would provide a common core of information for all involved to assess a borrower’s financial position and to identify a best course of action.

⁷⁵ http://www.yourmentalhealth.ie/pdf/suicide_brochure.pdf

⁷⁶ Jenkins, R., Fitch, C., Hurlston, M. and Walker, F. (2009) Recession, debt and mental health: challenges and solutions. *Mental Health in Family Medicine*, 6, 85-90.

⁷⁷ MIND (2008) In the Red: Debt and Mental Health. http://www.mind.org.uk/assets/0000/9121/in_the_red.pdf

⁷⁸ Financial Regulator (2010) Review of Consumer Protection Code. Consultation Paper CP 47 <http://www.financialregulator.ie/consultation-papers/Documents/CP47%20Review%20of%20Consumer%20Protection%20Code/CP47%20Review%20of%20Consumer%20Protection%20Code.pdf>

⁷⁹ <http://www.helpinghomeowners.ie/>

⁸⁰ Final Report of the Mortgage Arrears and Personal Debt Group (2010) <http://www.merriestreet.ie/wp-content/uploads/2010/11/Mortgage-Arrears-and-Personal-Debt-Group-Report-17th-November-2010.pdf>

The Final Report of the Mortgage Arrears and Personal Debt Group also made important recommendations around personal debt and bankruptcy. Reform of Ireland's personal insolvency regime was recommended, and that this should happen in two parts; new and modernised bankruptcy legislation with a less punitive approach, and a non-judicial debt settlement and enforcement system which would be an alternative to bankruptcy in most cases⁸¹. A range of other positive recommendations are made throughout the *Final Report of the Mortgage Arrears and Personal Debt Group* which should prove very helpful to those experiencing financial difficulties and potentially, mental health difficulties. The recommendations from this group have also fed into the revised Code of Conduct on Mortgage Arrears (CCMA) which came into effect on 1st January 2011 and applies to borrowers in arrears and pre-arrears.

Good Practice Mental Health Guidelines have been produced by Money Advice Liaison Group (MALG) for those working in the creditor sector in the UK (such as lenders and debt collection agencies). The Money Advice Liaison Group is a not-for-profit association which acts as a Discussion Forum with members from a wide range of voluntary agencies, private organisations and public sector bodies, all of whom have an interest in personal credit and debt⁸². The MALG produced the Good Practice Mental Health Guidelines in response to the challenge of increasing debt problems and mental health conditions. This document provides guidance to creditors on good practice when dealing with customers with mental health problems. The Guidelines acknowledge that they do not seek to turn staff in creditor companies into 'mental health experts', rather they provide proportionate, practical guidance and create awareness of the specific difficulties faced by some consumers.

5.2 Current actions across sectors

5.2.1 Sharing information

One of the main barriers to good understanding in financial organisations of mental health problems among their consumers is difficulties in accessing information about a customer's mental health condition. Even where the person consents to sharing such information in creditors, several difficulties have been identified⁸³:

1. variability in the type and amount of evidence requested
2. ambiguous instructions or unrealistic expectations concerning what information professionals should provide
3. delays, refusals or payment requests from professionals to provide evidence
4. poor quality and irrelevant information for decision making being returned.

⁸¹ Ibid. Final Report of the Mortgage Arrears and Personal Debt Group (2010)

⁸² Money Advice Liaison Group (2009) Good Practice Awareness Guidelines for Consumers with Mental Health Problems and Debt. <http://www.malg.org.uk/about.html>

⁸³ <http://www.bis.gov.uk/foresight/our-work/projects/published-projects/mental-capital-and-wellbeing>

A standardised Debt and Mental Health Evidence Form (DMHEF) has been developed in England to help health professionals provide clear and relevant information when a creditor requests such information and the service user consents. The DMHEF has been recognised by major UK creditor and advice membership organisations and has also been approved by the Information Commissioner's Office.

5.3 Current action by government

Actions at Government level can focus on improving financial service practice. The establishment of the Mortgage Arrears and Personal Debt Expert Group by the Minister for Finance in 2010 was an important action to address the concerns of those in debt and the resultant report and recommendations from the group are positive and progressive.

The combined report of the Royal College of Psychiatrists, the NHS and the London School of Economics recommended a series of actions for Government including supporting employers to keep people with mental health problems in work and ensuring appropriate supports are available to people with mental health problems to return to work. Advice for the commissioners and providers of services was to keep a long-term perspective and essentially to avoid short-term gain for long-term pain. It is noted that the difficulty of measuring the quality and value for money of mental health services in a performance framework can leave mental health services more vulnerable to funding reductions. The report notes a number of approaches to avoid such as letting waiting lists grow, diluting quality, 'slash and burn' and 'salami slice' (i.e. top slicing a percentage) savings "are all to be avoided"⁸⁴. Approaches to dealing with constrained resources must involve proper planning and have an evidence base or thought-through rationale. The report warns that disinvestment in mental health services would "*without doubt deliver immediate, medium- and long-term pain for the NHS and other public services. Most importantly, it would have a negative impact on people experiencing mental distress and illness, as well as their carers and families. Such shortcut commissioning would not only increase their burden but would ultimately result in a larger economic burden for the nation*" (p.9)⁸⁵.

In order to address concerns regarding over-indebtedness and the severe social and health consequences that can often follow as a direct result of debt problems, the Council of Europe made a series of recommendations to assist policy makers to deal with over-indebtedness⁸⁶. The recommendations focused on preventive, remedial and rehabilitative measures which national governments needed to take in order to address over-indebtedness. A report by the Combat Poverty Agency highlighted the lack of a policy framework in Ireland for dealing with over-indebtedness⁸⁷. The recommendations of the Final Report of the Mortgage Arrears and Personal Debt Group have addressed several of the policy-level measures recommended by the Council of Europe and the Combat Poverty Agency report.

⁸⁴ Royal College of Psychiatrists, Mental Health Network, NHS Confederation and London School of Economics (2009) Mental Health and the Economic Downturn: National Priorities and NHS Solutions http://www2.lse.ac.uk/LSEHealthAndSocialCare/PSSRU/pdf/mental_health_downturn121109.pdf

⁸⁵ Ibid. 2009

⁸⁶ Council of Europe (2007) *Legal solutions to debt problems*. http://book.coe.int/EN/ficheouvrage.php?PAGEID=36&lang=EN&produit_aliasid=2342

⁸⁷ Stamp, S. (2009) *A Policy Framework for Addressing Over-Indebtedness*. Dublin: Combat Poverty Agency

6. Recommendations

As the review of the evidence shows, many of the factors contributing to mental health problems occur within a much broader context than health. Therefore actions are required within a public health or wider societal context, as well as at the level of mental health and associated services.

In order to formulate recommendations for actions which are relevant, practical and of maximum benefit to people with mental health problems and financial difficulties, a workshop was convened in February 2011, with an invited audience of key stakeholders in the financial, mental health and voluntary/advice sectors. Practitioners and front-line staff with direct experience of the issues were invited to ensure a focus on actions that will be of most assistance at the interface between staff in all sectors and clients with financial and mental health difficulties. The workshop was structured to elicit relevant, practical and resource neutral actions/solutions and which would build capacity across the sectors. It is not expected that health professionals become financial experts or that financial services employees become mental health experts. However, an increased awareness of mental health difficulties in the context of indebtedness can only serve to improve the situation for those who are in this situation.

6.1 Outcomes of the workshop

The actions that were proposed at the workshop came under three broad headings; training, communication and production of resources. There were also other suggestions and areas for action that were much broader than the scope of this exercise (i.e. require multi-partner action over a long period) or were about the availability of resources within the health/mental health system. For example, the requirement for a change in culture and approach by financial institutions was noted, particularly a move away from an adversarial to a supportive, engaging approach; and the need for the greater availability of mental health support at community/primary care level (such as counselling and psychological support) were two such issues. While these are important issues, concerted action is required by agencies outside of the remit of the Commission to bring about such changes. The focus in the workshop was on the formulation of practical, easily implemented and resource-neutral/low-resource actions that have the potential to have a significant impact. These actions will be outlined under the three headings.

6.2 Training

A number of groups were identified who would require or benefit from training and support;

- Frontline workers in financial services organisations (banks, building societies, credit unions and similar organisations, particularly those staff in Arrears Management Units in banks);
-

- Frontline workers in charities/voluntary agencies;
- Frontline workers in other organisations who may encounter individuals in financial distress such as utility companies;
- Frontline workers in the Department of Social Protection.

At the simplest level, mental health awareness training could be provided to frontline workers. Mental health awareness training is widely available in Ireland. Such training can range from the structured use of widely available resources on the internet, linking with organisations with experience (examples of useful organisations and resources are provided in Appendix 1) through to FETAC level 6 Mental Health Awareness Training which is a three day course to provide participants with an understanding of mental health difficulties and apply this knowledge to support people who have mental health difficulties in a positive way.

Agencies such as MABS provide more specific training for their staff such as that available in the ASIST and safeTALK programmes. These programmes were recommended in the workshop as suitable for the frontline workers described above.

ASIST (Applied Suicide Intervention Skills Training) is a two-day interactive workshop in suicide first-aid. It has been designed to be suitable for a wide range of people in the community such as health workers, teachers, community workers, Gardai, youth workers, volunteers, people responding to family, friends and co-workers.

safeTALK is a half day training programme that prepares participants to identify persons with thoughts of suicide and connect them to suicide first aid resources. These specific skills are called suicide alertness and are taught with the expectation that the person learning them will use them to help reduce suicide risk in their communities. Following a safeTALK workshop you will be more willing and able to perform an important helping role for persons with thoughts of suicide. ASIST and safeTALK programmes are available through the HSE Suicide Prevention Resource Offices and partner agencies throughout the country.

Recommendation: A programme of appropriate training should be provided on a regular basis to staff in contact with people experiencing serious financial difficulty. The majority of training courses in this area are provided by the HSE/partner organisations and other agencies. Priority for training staff in financial institutions should be given to staff in Arrears Management Units.

6.3 Resources

There are several resources currently available which provide information and describe processes and codes which are in place to protect consumers and those in debt:

1. Leaflet and wallet card produced by the National Office for Suicide Prevention and the HSE entitled *Look after your mental health in tough economic times*⁸⁸. This could be made more widely available through financial services outlets, MABS and utility companies.
2. Leaflets from Mental Health Ireland such as *Managing your mental health*⁸⁹.
3. A Revised Consumer Protection Code from the Financial Regulator is in development and should be available by the end of 2011.
4. The Code of Conduct on Mortgage Arrears (CCMA), a statutory code of the Central Bank.
5. There is now a Mortgage Arrears Resolution Process (MARP) within lending institutions for dealing with customers in arrears and pre-arrears. Lending institutions are also required to establish an Arrears Support Unit to assess arrears and pre-arrears cases.
6. The Irish Banking Federation and MABS have developed a joint *Consumer Guide to Dealing with Mortgage Repayment Difficulties*.

Recommendation: It is recommended that there is greater promotion and availability of existing information resources and codes by all relevant parties such as MABS, financial institutions, Citizen Information Offices, Offices of the Department of Social Protection and others.

In the course of the workshop, a number of resources were identified which could be developed to facilitate greater awareness of the issues and better communication among the various stakeholders. These resources are listed below along with suggested organisations/agencies which could be involved in developing them:

1. A leaflet with basic information on mental health (including definitions/descriptions of different disorders) for the financial services sector. As well as imparting information this could be used as a training resource in mental health awareness courses.

Action: HSE/Mental Health Ireland

⁸⁸ [http://www.yourmentalhealth.ie/images/uploads/Mental_Health_Tough_economic_times_Brochure\(1\).pdf](http://www.yourmentalhealth.ie/images/uploads/Mental_Health_Tough_economic_times_Brochure(1).pdf)

⁸⁹ <http://www.mentalhealthireland.ie/publications/downloads/finish/1/5>

2. The development and adoption of a Standard Financial Statement (SFS) for use by all lenders and MABS. This should be used to assess a borrower's financial position and to identify a best course of action. This echoes recommendation 26 made by the Mortgage Arrears and Debt Expert Group⁹⁰.
Action: Dept. of Finance/Central Bank/Financial Regulator
3. A form similar to the Debt and Mental Health Evidence Form (DMHEF) developed in England which would enable the transfer of agreed information between the mental health and financial services sectors in a way that protects the person
Action: MHC/Irish College of Psychiatrists/others
4. A guide on debt and mental health for health and social care service providers, primary care service providers, frontline staff in the Department of Social Protection and others.
Action: MHC/ICGP/Irish College of Psychiatry/others
5. The production of Good Practice Guidelines for the financial sector in dealing with vulnerable consumers – similar to the Guidelines produced in the UK by the Money Advice Liaison Group (MALG)
Action: Financial Regulator/MABS/Irish Banking Federation/Irish League Credit Unions/others

Other resources such as manpower are an issue for agencies such as MABS which are facing increased pressure in the current environment. One suggestion to assist in this was that internships/a volunteer scheme be developed for graduates in the financial area or others who are currently not working. These individuals with appropriate training and induction could be a valuable resource to MABS. It was also suggested that the Psychological Society of Ireland (PSI) and other relevant associations be approached to offer pro-bono consultations to MABS clients. MABS has formed relationships with professionals in other sectors (such as law and accountancy) to whom they can refer clients for limited pro-bono specialist advice and information.

Action: MABS to link with relevant agencies

6.4 Communication

The need for improved communication across sectors was emphasised throughout the workshop. Many of the resources described above are aimed at facilitating *informed* communication, i.e. a greater level of awareness of mental health difficulties among customers of financial institutions so that account can be taken of relevant issues. Training will also be central to improving awareness and equipping staff with appropriate and helpful communication skills. The development of Arrears Support Units in financial

⁹⁰ Final Report of the Mortgage Arrears and Personal Debt Group (2010) <http://www.merrionstreet.ie/wp-content/uploads/2010/11/Mortgage-Arrears-and-Personal-Debt-Group-Report-17th-November-2010.pdf>

institutions (as and from 1st January 2011) will provide a locus for expertise and training within banks which can cascade through the rest of the organisation as appropriate.

Suggestions which could be taken up by relevant agencies/organisations included:

1. To establish secondment schemes to share expertise and create awareness across the sector. For example, a worker from MABS could be seconded to a financial institution (e.g. the Arrears support unit) and vice versa to share expertise and knowledge and create greater awareness of the challenges facing each side as well as the people with mental health difficulties (an example was given of another sector where a similar scheme works well).
2. The possibility could be explored with the Financial Regulator of a third party being permitted to engage with a lender on behalf of vulnerable person – at the moment banks can only deal with the person directly. The Mortgage Arrears Resolution Process is potentially very helpful but only works if the person engages with the financial institution. Some people with mental health difficulties find this type of engagement particularly challenging and the possibility of an advocate or other person engaging on their behalf would be very welcome.
3. Encourage the media to provide information and case studies that promote the positive developments in the Code of Conduct on Mortgage Arrears (CCMA) and the Mortgage Arrears Resolution Process (MARP) to create greater awareness of these new measures.
4. Very simple, low cost measures to facilitate awareness and spread information included the following:
 - a. Customers falling behind with repayments on loans, credit cards, utility bills etc. to be sent a leaflet on MABS and the CCMA enclosed with demands for payment. This is already happening with some companies but needs to be adopted throughout the financial and utility sector.
 - b. Banks and utility companies to include details of MABS and others in their call waiting phone messages and on websites include direct links to MABS and other agencies such as the Samaritans
 - c. Use a variety of organisations to get relevant information out such as Trades Unions, Irish National Organisation for the Unemployed etc.
 - d. Information on debt management, MABS and the CCMA could be included in packs for those who are made redundant

Appendix I: Resources and useful websites

Financial Regulators Office

www.financialregulator.ie

Money Advice and Budgeting Service

www.mabs.ie

Mental health websites

www.yourmentalhealth.ie

www.samaritans.ie

www.mentalhealthireland.ie

National Office for Suicide Prevention Resources

www.nosp.ie

http://www.nosp.ie/not_alone_directory.pdf

<http://www.letsomeoneknow.ie/>

MIND UK organisation resources:

<http://www.mind.org.uk/money>

http://www.mind.org.uk/assets/0000/5653/tax_and_mental_health.pdf

http://www.mind.org.uk/help/social_factors/looking_after_your_personal_finances

Royal College of Psychiatrists resources:

<http://www.rcpsych.ac.uk/pdf/FinalDemandcf.pdf>

<http://www.rcpsych.ac.uk/pdf/MALGb%202009.pdf>

<http://www.rcpsych.ac.uk/mentalhealthinfo/debtmentalhealthcontents.aspx>



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ISBN 978-1-907399-10-7