DEBT AND MENTAL HEALTH EVIDENCE FORM
(VERSION FOUR)

ADVISER USER GUIDE (ASSISTED SELF-HELP)
1st October, 2019

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What is the DMHEF?

- The DMHEF is a form that health and social care professionals complete.
- It can be used when an indebted person needs evidence to confirm that they have a mental health condition.
- The health and social care professional can use the DMHEF to:
    - confirm whether a person has a mental health condition
    - give the name of this condition
    - and - if they choose to - provide further information (e.g. how the mental health condition might affect the person's ability to manage their money).
- The indebted person chooses the health or social care professional – ideally, this will be a professional who already knows the person and their situation.
- The completed DMHEF is used by the organisation that requested it to decide what action to take next. This organisation could be a firm that a person owes money to. Or it could be a debt adviser helping the person with their finances.

The consent form

- Health or social care professionals will not complete the DMHEF without the explicit consent of the indebted person whose information is about to be shared.
- The DMHEF consent form should therefore be completed by the indebted person. The consent form and DMHEF can be given to the professional at the same time.

What the DMHEF isn't for

- The DMHEF *is not* the only type of evidence that organisations should accept – there are other evidence types that should be considered first (page 5).
- The DMHEF *is never* automatically used for every individual who discloses a mental health condition – instead it is selectively and carefully used.

How should I use the DMHEF?

- A guide to using the DMHEF is provided on page 4.
- The full set of DMHEF resources can be found at:

    www.moneyadvicetrust.org/DMHEF

This is a new version of the DMHEF – what is different?

- This is the fourth version of the DMHEF. It replaces all previous versions.
- This version of the DMHEF is simpler and shorter for health and social care professionals to complete than previous versions.
- A range of health and social care professionals are eligible to complete the DMHEF – ranging from social workers to mental health therapists.
- The front side of the DMHEF now simply asks for the professional to confirm if the client has a mental health condition, and to give the name of this condition.
- The reverse side of the DMHEF provides a short space for the professional to provide further information about the client – including, for example, how the mental health condition might affect the person's ability to manage their money.
- For those familiar with version three of the DMHEF, we provide a more detailed explanation of the changes to the form (and rationale for these) on pages 9-10.

Professionals who request payment

- One reason for creating version four of the DMHEF was to end the practice of some General Practitioners (GPs) in England requesting such a payment.
- **If the GP is working in England** and they agree to complete the DMHEF, then they must do so without charge. This is part of their contract with NHS England, and is required under the following regulatory document: National Health Service (General Medical Services Contracts and Personal Medical Services Agreements) (Amendment) Regulations 2019.
- **If the GP is working in Northern Ireland, Scotland or Wales,** they can ask for payment to complete the DMHEF. This situation may, however, change in the future.
- However, please remember that most health and social care professionals will not request payment to complete the DMHEF.

Who created this version of the DMHEF?

- This version was created by the Money Advice Trust and Money and Mental Health Policy Institute in partnership with the British Medical Association, Credit Services Association, Department of Health and Social Care, Money Advice Liaison Group, Royal College of Psychiatrists, and UK Finance. Prior to this, the DMHEF was overseen by the Money Advice Liaison Group. More information on the DMHEF (including its development) can be found at: www.moneyadvicetrust.org/DMHEF.

USING THE DMHEF: AN ELEVEN STEP-GUIDE

- There are eleven steps that need to be followed when completing the DMHEF through assisted self-help.

ADVISER: WHETHER TO COLLECT EVIDENCE	**Step 1.** **A mental health problem is disclosed** **Step 2.** **The adviser finds out more about this** **Step 3.** **The adviser asks themselves…** a) whether further evidence is *actually needed*? b) what *alternatives* to the DMHEF could be accepted? c) whether the client *is able* to collect this evidence? **Step 4.** **The adviser sends the client the 'DMHEF pack'** ▪ blank DMHEF ▪ blank Consent Form ▪ stamped addressed envelope (with adviser's address on it) ▪ a covering letter pack
CLIENT: PACK & PROFESSIONAL	**Step 5.** **The client receives the DMHEF pack – they read, complete and sign the Consent Form** **Step 6.** **The client approaches a health or social care professional of their own choosing to complete the DMHEF**
PROFESSIONAL	**Step 7.** **The health or social care professional completes the DMHEF, and returns this to the client**
CLIENT: PHOTOCOPY	**Step 8.** **The client receives and photocopies the completed DMHEF and Consent Form for each creditor** **Step 9.** **The client prepares a standard letter for each creditor to be sent with a copy of the completed DMHEF and signed consent form** **Step 10.** **The client sends the letter and a copy of the completed DMHEF and signed Consent Form to each creditor** **Step 11.** **Each creditor receives a copy of the completed DMHEF and Consent Form, with a corresponding covering letter and acts upon it**

ADVISER: WHETHER TO COLLECT EVIDENCE

Step 1. A mental health problem is disclosed

The client tells the adviser that they have a mental health problem that is affecting their ability to manage their money.

Step 2. The adviser finds out more about this

Before deciding to use the DMHEF, the adviser will always talk to the client about their situation, with the aim of developing a good understanding of this.

The adviser will ask questions such as how the mental health problem affects their ability to manage money; how the mental health problem affects their ability to communicate with their advisers; and whether anyone helps the client manage their finances (such as a family member).

This conversation can provide the adviser with all the information that is needed – meaning that the collection of further evidence is not required at all, or that evidence is needed but it might be collected using an *alternative* to the DMHEF (see below).

Step 3. The adviser asks themselves…

a) …whether further evidence is *actually needed*?

The adviser should have now spoken with the client to establish how their ability to manage money has been impacted by the reported mental health problem.

If unanswered questions, concerns or doubts remain, or the individual's situation is complex and needs further exploration, only then should the adviser suggest the further collection of evidence to assist with this.

However, advisers will be aware that it may not be necessary to collect further evidence to achieve some actions. For example, most creditors are obliged to offer a breathing space, consider reasonable offers, and not harass a client regardless of *whether or not* the client has a mental health condition.

b) …what *alternatives* to using the DMHEF could be accepted?

If further evidence is needed, the adviser should begin by considering alternatives to issuing a blank DMHEF. Where available, these can save time for everyone.

Firstly, the adviser should check whether the client has already recently completed a DMHEF for another organisation – if so, this provides a potential option.

Secondly, if this is not the case, the adviser should consider whether an alternative to the DMHEF would work equally as well. This could include copies of prescriptions, patient letters, or other materials that confirm the client's mental health situation (and following this confirmation, assist with a further client conversation).

The rationale for considering alternatives is purely practical. Clients may have equally valid forms of evidence to hand (which they might be able to share more easily than having to physically get a DMHEF completed). On another level, using alternative forms of evidence to the DMHEF could reduce demand on the time of already busy health and social care professionals.

c) whether the client *is able to* collect evidence using the DMHEF?

If the adviser feels they have no option but to use the DMHEF, they should establish whether the client will be able to take the assisted self-help option.

It is essential that a discussion is held with the client about exactly what taking responsibility for liaising directly with the health or social care professional actually means. It is also important that similar discussions take place with the client about liaising directly with their creditors. If the client understands and is willing, steps 4-10 describe how the client and adviser should work together in order for evidence to be collected from a health or social care professional

If the client is **unable** to collect the evidence in this way, then the client should be advised to get help from a third-party who will help them do this. If the DMHEF cannot be used to collect further evidence, then the client should be referred to or linked into face-to- face debt advice, where they will receive the support they need.

If the adviser decides to record any information about the client's health on an organisational file, then they will need to need to explain to the client (i) how the evidence collected from the health and social care professional will be used (this includes an explanation of why the adviser wishes to collect this data, what the data will be used for, who the evidence might be shared with, how it will be securely stored, and how long it will be stored for. Without this explanation, the client cannot know what they are consenting to, and consent therefore cannot be properly obtained); (ii) the adviser will need to ask the client if they understand this explanation, and allow them to ask questions if necessary to clarify any points; and (iii) after doing this, the adviser should ask the client for their *explicit consent* to process their information in this way. There may be additional steps or actions that your organisation requires you to take to record this *explicit consent*.

ADVISER: EXPLAIN TO CLIENT WHAT TO DO

Step 4. The adviser sends the client the 'DMHEF pack'

The adviser will need to send the client the following:

- a blank DMHEF version 4
- a blank Consent Form (adviser version)
- a *pre-paid* envelope with the adviser's address on it (so the completed DMHEF can be returned to the adviser without any cost to either the client or health and social care professional).

You may wish to draft your own covering letter to accompany these materials.
You should then send the DMHEF pack to the client.

Step 5. The client receives the DMHEF pack – they read, complete and sign the Consent Form

By reading, completing, and signing the Consent Form the client is now ready to approach a health or social care professional to complete the DMHEF.

Unless the Consent Form is completed and signed by the client, the health or social care professional should not complete the DMHEF.

It is important for advisers to remember that the Consent Form can also be completed and signed by a third party authorised to act on their behalf.

Step 6. The client approaches a health or social care professional of their own choosing to complete the DMHEF

The client should decide which health or social care professional of their own choosing to approach to complete the DMHEF. This should be someone who knows the client in a professional capacity such as a general practitioner, psychiatrist, nurse, psychologist, occupational therapist, social worker or another worker.

The client should provide this health or social care professional with a completed and signed Consent Form, a blank copy of the DMHEF to complete, and a stamped addressed envelope with the client's address on it.

PROFESSIONAL: COMPLETION AND RETURN OF THE DMHEF

Step 7. The health or social care professional completes the DMHEF, and returns this (and the Consent Form signed by the client) in the stamped addressed envelope back to the client

Step 8. The client receives and photocopies the completed DMHEF and Consent Form for each of their creditors

Upon its receipt, the client should check they have received all the necessary information from the health or social care professional.

The client should then make sufficient photocopies of the DMHEF and Consent Form to send to all their creditors.

ADVISER: DECIDE ON THE ACTION TO TAKE

Step 9. The client prepares a standard letter for each creditor to be sent with a copy of the completed DMHEF and signed consent form

Step 10. The client sends the letter and a copy of the completed DMHEF and signed Consent Form to each of their creditors

The client sends the standard covering letter and a photocopy of the completed DMHEF and signed Consent Form to each creditor.

Step 11. Each creditor receives a copy of the completed DMHEF and Consent Form, with a corresponding covering letter and acts upon it

The creditor decides what action should take place in light of the collected evidence. The creditor should advise the client of their decision/enter into discussion.

FREQUENTLY ASKED QUESTIONS

Q: What are the differences between Version 3 and 4 of the DMHEF?
The major difference is there are fewer questions.

Version 3 of the DMHEF asked health and social care professionals to answer eight separate questions and provide 14 different pieces of information.

Version 4 of the DMHEF asks professionals to answer two questions and to provide three different pieces of information.

A comparison of Version 4 and Version 3 is provided in Box 1 (overleaf).

Q: Why was Version 4 of the DMHEF created?
The main reason for creating version 4 of the DMHEF was to end the practice of some General Practitioners in England requesting payment to complete the form.

If the GP is working in England and they agree to complete the DMHEF, then they must do so without charge. This is part of their contract with NHS England, and is required under the following regulatory document: National Health Service (General Medical Services Contracts and Personal Medical Services Agreements) (Amendment) Regulations 2019.

If the GP is working in Northern Ireland, Scotland or Wales, they can ask for payment to complete the DMHEF. This situation may, however, change in the future.

However, please remember that most health and social care professionals will not request payment to complete the DMHEF.

Q: Does the new DMHEF ask how a person's money management is affected?
As seen in Box 1 overleaf, professionals are asked to provide information on how a person's mental health problem might affect their ability to manage their money.

Our experience from the three previous versions of the DMHEF, is that some health and social care professionals choose not to answer this question (often on the basis that professionally they do not know the person well enough/have enough contact to answer), while other professionals are often able to provide detailed information.

When a health and social care professional is unable to provide this information, we would obviously recommend talking with the client about this impact, but also consulting wider sources of information about the impact of mental health problems on a person's ability to manage money (including www.moneyandmentalhealth.org).

If this does not suffice, then advisers may consider asking the client to obtain further evidence from a different health or social care professional (who can provide this information).

Box 1 Comparison: Version 3 and Version 4 of the DMHEF

Version 3 of the DMHEF	Version 4 of the DMHEF
Q1. What is your relationship with the person reporting the mental health problem? **Q2. Does the person have a mental health problem?** **Q3. What is this mental health problem?** If it has a name or diagnosis, what is it? **Q4. Does the person have a mental health problem that affects their ability to manage their money?** **Q5. If the person is receiving treatment or support for this mental health problem, does the treatment or support affect their ability to manage their money?** **Q6. When communicating with the person, are there any special circumstances that a creditor needs to take into account?** **Q7. What was the approximate date when** (a) this mental health problem first started, (b) the first treatment was given, (c) the most recent episode took place, and (d) is the episode on-going? **Q8. Is there anything else we should know about the person?**	**Q1. Does the person have a mental health problem?** [Write the name of the mental health problem(s) below.] **Q2. Relationship to the person named above (please tick box).** **Supplementary info. (optional):** If you are able to, please do provide further information about the person's situation. For example: - how the mental health problem affects their ability to manage money. - how the person's ability to communicate with their creditor might be affected. - any other information that may help the person (e.g. the severity or duration of the condition; any relevant treatment the person is receiving; or whether the person is in a situation of mental health crisis).

Q: What should happen if the client refuses to give their *explicit consent*?

If a client is unwilling to give their *explicit consent* (including *explicit consent* to complete the Consent Form), then the process cannot continue.

The only exception may be if a third party is legally authorised to give consent on the behalf of a client (for example, in cases where the client lacks the mental capacity to make such a decision).

Health and social care professionals should not complete the DMHEF unless the consumer has given their explicit and written consent for this to happen.

Q: Why doesn't the DMHEF contain a question asking the health or social care professional to estimate when an individual is likely to recover/return to work?

We understand that information about when a client is likely to recover from their mental health problem/return to work would be valuable to some advisers/ creditors.

However, estimates or 'prognoses' of such recovery/return to work are extremely difficult for health and social care professionals to provide:

1. Making a useful and accurate prognosis can be very difficult – consequently, health and social care professionals may be reluctant to make a statement about the likely progression of a person's mental health problem. This may particularly be the case if they do not know the patient (or their wider health or social circumstances) well.

2. Individuals often experience mental health problems in different ways – for example, even though clinical guidelines might indicate that depression usually lasts up to a certain number of months, with the chance of repeated episodes afterwards, there will be many people who do not have this experience.

3. The inter-relationship between mental and physical health can complicate reaching an accurate prognosis – this adds an additional factor to the consideration. It also could involve an examination of the patient (which would require time, resources, and possibly payment).

4. There will be other social and economic factors (often unknown to the health or social care professional) that will impact on a person's recovery from a mental health condition, and which are difficult to incorporate into a prognosis.

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

Consequently, the DMHEF does not include a 'prognosis question'.

Q: What about people with debt and mental health problems who are not in contact with a health or social care professional?

The DMHEF relies on information being collected from a health or social care professional. However, not every client may be in contact with such a professional.

In these situations, a adviser may wish to recommend that an individual either registers or re-establishes contact with a General Practitioner.

It is important to remember that although an individual does not have contact with a health or social care professional, they may still have a mental health problem.

If a client needs urgent assistance, or is in crisis as a direct result of the current state of their mental health, they (or the person working with them) should contact the Samaritans (see page 14). If they, or anyone else, are in immediate danger of harm, the police emergency number (999) should be called.

If the need is less urgent, the individual concerned or the person working with them can still call the above organisations or call NHS Direct. Alternatively, the person can visit their General Practitioner.

Advisers should also consult and become familiar with their own internal policies on dealing with such emergencies.

Q: It is possible that the client could receive a request for the completion of the DMHEF from a number of organisations and at different times - how could this be avoided?

Advisers should check with the client concerned whether any evidence about their mental health problem has (a) already been recently collected or (b) is about to be collected for another adviser, a creditor, or a different organisation.

The adviser is always strongly recommended to remind their client to send a copy of the completed DMHEF and the signed Consent Form to all their creditors. However, this may not happen in reality.

Q: What happens if the client, having sight of the completed DMHEF from their health or social care professional, wishes to make a personal comment or statement about the information given?

The client can write a personal comment or statement that they supply to their creditors or supporting adviser.

There is no longer any actual space allowed for such comments on the DMHEF, but this should not discourage individuals to comment if they wish.

USEFUL SOURCES OF INFORMATION

Mental Health:

- **Mind** – for information and support on mental health http://www.mind.org.uk/information-support/
- **NHS Choices** – for a range of advice on issues relating to mental health http://www.nhs.uk/livewell/mentalhealth/Pages/Mentalhealthhome.aspx

Suicide and self-harm:

- **Mind** – for guidance on supporting someone who feels suicidal please go to http://www.mind.org.uk/information-support/types-of-mental-health-problems/suicide-supporting-someone-else
- **Samaritans** – The Samaritans are there to talk to at any time, in your own way, and off the record. Call them free at any time on 116 123 or visit their website at http://www.samaritans.org/how-we-can-help-you
- **NHS Choices** – http://www.nhs.uk/Conditions/Suicide/Pages/Getting-help.aspx

NHS Helplines:

- **England & Scotland** – NHS 111: is the non-urgent number for out of hours care and information http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx

  http://www.nhs24.com/111/
- **Wales** – NHS Direct: 0845 46 47 www.nhsdirect.wales.nhs.uk/
- **Northern Ireland** http://www.hscni.net/

Debt advice:

- **National Debtline** – 0808 808 4000 https://www.nationaldebtline.org/
- **Business Debtline** – 0800 197 6026 https://www.businessdebtline.org/
- **Citizens Advice** – 03444 111 444 https://www.citizensadvice.org.uk/
- **StepChange** – 0800 138 1111 https://www.stepchange.org/
- **Christians Against Poverty** - 01274 760720 - https://capuk.org/