REPORT

Centre for Mental Health

Welfare advice for people who use mental health services

Developing the business case

Michael Parsonage

with a foreword by Martin Lewis

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Foreword

Navigating through the welfare system can be difficult and stressful even at the best of times. Yet for those who have a serious mental illness, the anxieties can be even greater and the risk to their health and wellbeing far more pressing.

This has been a personal passion of mine for many years. I started my career preaching that a company's job was to make money; our job to stop them. Yet after meeting many mental health workers and those with mental health issues, I realised how crucial it is that we help and protect those can't always take responsibility for themselves.

Sadly financial problems and mental health are a marriage made in hell. Each ride off the back of the other. The net result is that a hugely disproportionate number of people with mental health problems face severe debt crisis. Not just because poor money management, impulse and emotional control are often symptoms of mental health problems – but because these health issues hit income too.

For too many people, mental illness and debt come together in a spiral of distress that can carry a heavy cost. Therefore it is crucial we examine all elements to ensure that someone with temporary mental health problems doesn't experience permanent financial distress. That's why access to the right advice and support is critical when people are struggling to deal with life itself.

That's why I'm delighted to support the subject raised by the Centre for Mental Health. Its view that welfare advice should be a standard feature of any good mental health service is tough to disagree with. Not only is high quality welfare advice good for mental health service users, in the long run it could end up saving the NHS, and the country, money.

More importantly, it increases options and gives practical solutions for dealing with the problem - such as preventing expensive hospital admissions and helping people keep their homes. In some cases it may be possible to prevent relapses of mental illness and stop the spiral of debt and ill health from getting out of control.

It's important every mental health service considers the financial impact of mental health. It should be seen as a core issue, not an add-on, as it is at the centre of life's functionality.

Breaking the link between mental illness and debt will make a dramatic difference to people's lives.

Martin Lewis

Moneysavingexpert.com

Executive summary

Poor mental health is frequently linked with the experience of welfare problems such as unmanageable debt and difficulties with housing and benefits. This link is particularly strong for those with a severe mental illness and the cost of these problems can be very high, including to the NHS and to social care.

This report, funded by the Baring Foundation, finds that specialist welfare advice for people using secondary mental health services can be very good value for money. Drawing on an analysis of one such service, the Sheffield Mental Health Citizens Advice Bureau, and a review of relevant literature, we have concluded that specialist welfare advice can cut the cost of health care in three main ways:

1. **Reductions in inpatient lengths of stay**: for example, an advice service may resolve a complex housing problem such as possible eviction or repossession and so enable a patient to be discharged from hospital more quickly than would otherwise be possible. At the national level the average cost of an inpatient stay is £330 per day.
2. **Prevention of homelessness**: people with severe mental illness are at much higher risk of homelessness than average and an advice service can help to prevent this, for example by negotiating directly with landlords and creditors in cases of rent arrears. A number of studies suggest that the costs of homelessness to the public sector, including the NHS, are in the range £24,000 to £30,000 a year.
3. **Prevention of relapse**: severe mental illnesses such as schizophrenia and bipolar disorder are long-term conditions, with acute episodes of illness being interspersed with periods of remission. Relapse is common and very costly. For example, in the case of schizophrenia, the probability of relapse is around 40% a year, at an estimated cost to the NHS of over £18,000 per episode. The widely accepted vulnerability-stress model of mental illness suggests a number of ways in which a welfare advice service can help to reduce the risk of relapse, most obviously by directly acting on an immediate cause of acute stress which threatens to trigger relapse but also by reducing the vulnerability of clients to future problems through the development of improved coping mechanisms.

The Sheffield Mental Health Citizens Advice Bureau is one of only two services in the country specifically dedicated to the advice needs of people with severe mental illness. Based in the hospital grounds, each year it supports about 600 people with severe mental illness throughout the city. The average cost of its advice is around £260 per client. Just under half of these seen are inpatients, with the remainder living in community settings. The service focuses on complex welfare problems involving legal or other issues that are beyond the capacity or expertise of staff working in mental health services to resolve.

"Being able to secure appropriate housing and stabilise Jane's finances while she was in hospital helped to reduce Jane's anxiety and put her back in control of her life. She was able to return to a new home with her children and has continued to make progress."

In contrast to the small per capita cost of specialist welfare advice, severe mental illness can be very costly to those affected and to the services that support them. **In any one year about a million adults of working age are seen by the secondary mental health services and on average the annual cost of mental health care for this group is around £6,600 per head.**

There is wide variation around this average. For example, only about 7% of all people receiving secondary mental health care spend any time in hospital during the course of a year, but among those who do require such treatment the average cost of inpatient care is around £23,000 a year. **The lifetime societal cost of schizophrenia could be as high as £1.5 million per person.**

These very high costs imply that interventions that reduce the severity of illness or prevent its deterioration may be able to generate significant savings.

More detailed research is needed to establish the frequency with which an advice service can generate these favourable outcomes and their associated cost savings. However, one clear conclusion from the analysis to date is that **only a small number of successful interventions are needed for an advice service to generate sufficient savings to be good value for money** - this is because the costs of severe mental illness are so high relative to the costs of the advice. These savings are over and above any direct benefits to clients in improvements in their wellbeing and quality of life which are the fundamental justification for the service.

Recommendations

1. All providers of secondary mental health services should review how they ensure that service users are given consistent access to effective welfare advice as part of the care pathway.
2. This review should particularly focus on the scope for early intervention in the provision of welfare advice, including improved access for young people experiencing or at high risk of first onset of severe mental illness.
3. Mental health service providers should recognise the important role of welfare advice in helping to achieve improved social outcomes such as secure incomes and stable housing. This should be embedded in the 'recovery' approach to mental health care.
4. All NHS and local authority commissioners with responsibility for mental health care should ensure that the need for specialist welfare advice is included in the planning and funding of mental health services.
5. All health and wellbeing boards should ensure that joint strategic needs assessments (JSNAs) capture information on the prevalence of welfare problems among people with mental health problems and that the associated need for welfare advice is incorporated in strategic planning decisions.

"Being able to deal with the issues in hospital, where Angie was safe and being cared for, meant that she was able to get things resolved quickly with the support of a dedicated worker from the advice team."

6. The Department of Health, NHS England, Public Health England and the Association of Directors of Social Services should promote greater awareness of the need for welfare advice in secondary mental health services and encourage best practice by means of national guidance.
7. The Department of Health should also explore the scope for incorporating relevant indicators relating to welfare problems and welfare advice in the public health, NHS and social care outcomes frameworks.
8. The Care Quality Commission (CQC) should incorporate assessments of the availability and quality of welfare advice in its inspections of mental health services and also in its annual surveys of mental health service users.
9. The National Institute for Health Research (NIHR) and other research funders should commission research to establish the effectiveness and cost-effectiveness of welfare advice for people with mental health problems and to identify the best models of service delivery.

"Early intervention may have prevented deterioration in Jim's mental health and a possible need for hospital admission."

1. Introduction

This report sets out the findings of a small exploratory study, funded by the Baring Foundation, which seeks to analyse the business case for the provision of expert welfare advice to people in receipt of specialist mental health care. It looks particularly at the argument that such advice, for example on social security benefits, debt and housing problems, may generate cost savings in the NHS.

This focus is not meant to imply that saving money in the NHS is the main aim of providing welfare advice. On the contrary, the fundamental objective in this area is the same as with any other form of help or support which is provided for people with severe mental illness, namely to improve their wellbeing and quality of life. At the same time, financial constraints in the NHS and elsewhere in the public sector cannot be ignored and all services which receive public funding or subsidy are under pressure to demonstrate not only that they are effective but also that they are good value for money. Making a case for the provision of more help with welfare problems for mental health service users is unlikely to get far unless this agenda is at least acknowledged and the main aim of the report is to take a first step in this direction.

Three linked pieces of work have been undertaken:

1. a review of the published research literature on the links between welfare problems, welfare advice and mental health;
2. second, a description and analysis of the Sheffield Mental Health Citizens Advice Bureau, one of only two such services in the country which is dedicated specifically to the advice needs of people with severe mental health conditions; and
3. quantitative analysis of the possible impact of welfare advice on mental health service costs.

On the basis of this work, the main elements of a business case are described below, but more information is needed to put flesh on the bones. Good quality quantitative evidence on the costs and benefits of welfare advice is in short supply and in consequence the main findings of this report should be regarded as suggestive rather than definitive.

2. The link between welfare advice and mental health

Introduction

This chapter provides a short and selective review of the published evidence on welfare advice for people with mental health problems. Most of this evidence relates to people with so-called common mental health problems such as depression or anxiety rather than to those with severe and enduring mental illness who are the main focus of this report. A general review of the published literature is nevertheless useful as a starting point, both because it provides a relevant backdrop and framework for more detailed subsequent analysis relating specifically to people with severe mental illness and also because it is of interest and importance in its own right. Where the published evidence does touch on people with severe mental health problems, this is highlighted below.

As noted in the introduction, **the main aim of this report is to assess a possible value-for-money or business case for the provision of welfare advice for people with severe mental health problems**, i.e. those in receipt of specialist or secondary mental health care. The development of such a case, whether for those with severe mental illness or for the wider population suffering from any kind of mental health problem, requires evidence on three linked propositions:

- **first, that welfare problems such as unmanageable debt or the threat of homelessness have a damaging impact on mental health;**
- **second, that by helping individuals to resolve these problems or preventing them from reaching a critical point, welfare advice services can contribute to improvements in mental health; and**
- **third, that better mental health should in turn lead to reduced use of the NHS and other public services, with associated savings in public expenditure.**

The following review of the published evidence is organised around these three themes.

Welfare problems and mental health

A substantial body of evidence demonstrates that poor mental health is frequently associated with the experience of welfare problems. Some of this evidence is derived from surveys of the general population, some from surveys which focus on specific sub-groups such as young people, and some from studies which look at a particular type of welfare problem such as debt. Taken as a whole, such **evidence shows very clearly that mental ill health is much more common among people facing welfare problems than among those who have no such problems, and equally that welfare problems are much more common among people who have poor mental health than among those who enjoy good mental health.**

As an example of evidence derived from a survey of the general population, reference may be made to a recent analysis of information collected in the English and Welsh Civil and Social Justice Survey (CSJS) of 2006-09, a large nationally representative survey of over 3,000 adults (Balmer *et al.*, 2010). The CSJS provides information both on the incidence of a wide range of welfare rights problems and on mental health, where the latter is based on responses to a version of the General Health Questionnaire (GHQ-12), which is a widely used screening tool for the detection of common mental illnesses in the community and in non-psychiatric clinical settings. High GHQ-12 scores may be interpreted as a measure of 'caseness', i.e. clinically diagnosable mental disorder, without necessarily indicating a specific condition such as depression or anxiety.

Key findings from this analysis of the 2007 CSJS are as follows:

- the prevalence of welfare rights problems was found to increase with the level of psychiatric morbidity; in other words, people with poorer mental health were more likely than others to experience welfare rights problems, and they were also more likely to report multiple problems;
- in more detail, 56% of all 'cases' (i.e. people with scores above the threshold for diagnosable mental illness) reported one or more welfare rights problems, compared with 36% among people below the threshold;
- among those with the maximum GHQ-12 score, indicating severe mental illness, no fewer than 83% reported welfare rights problems;
- the average number of problems per person was twice as high among 'cases' of mental ill health as among 'non-cases' (1.2 against 0.6);
- concerning different types of welfare problem, the prevalence of money/debt problems was 2.3 times as high among 'cases' as among 'non-cases', the prevalence of welfare benefits problems was 2.4 times as high, and the prevalence of problems relating to homelessness was 2.8 times as high;
- finally, it was found that the likelihood of inaction by an individual in the face of welfare problems increased with the level of psychiatric morbidity.

Also drawing on data collected in the CSJS, a recent report published by Youth Access has analysed the links between welfare rights problems and mental health specifically for young people (Sefton, 2010). A focus on this age group is particularly relevant in the context of severe mental illness, as it covers a peak age for first onset of schizophrenia and bipolar disorder. The study found that:

- among 18-24-year-olds, welfare rights problems are reported much more often by those who experience mental health problems (44%) than by those who have no such problems (16%);
- nearly a third (31%) of all young people with welfare rights problems also have mental health problems, compared with only 9% among those not reporting any welfare rights problems;
- a link with homelessness is particularly strong, with 62% of those reporting homelessness also having mental health problems;
- among all young people with welfare rights problems, 36% said that they worried "all or most of the time" and 22% said that their problems had led to stress-related illness.

Building on such evidence, Youth Access subsequently commissioned a survey looking specifically at young people who were seeking help in youth advice settings (Balmer & Pleasence, 2012). Again using GHQ-12 scores as a measure of mental health status, this found very high levels of mental ill health in the sample, with 66% reporting scores indicating 'caseness', which compares with a figure of around 18% in the general population. The survey also found that 17% of clients using youth advice services had GHQ-12 scores that indicated severe mental illness, compared with less than 3% in the general population. Nearly half the overall sample (45%) reported that their welfare problems were having an adverse impact on their health.

Concerning the evidence on specific types of welfare problem, the area most frequently studied is debt, with a recent systematic review identifying 50 relevant studies presenting primary empirical data (Fitch *et al.*, 2011). Some of the key findings are as follows:

- **around half of all people with debts have a mental health problem, compared with 14% of the population without debts (Jenkins *et al.*, 2009);**

- people with a mental health problem are roughly three times as likely to be in debt as those without such a problem and the likelihood rises to four times among people with severe mental illness (Jenkins *et al.*, 2009);
- people with debt problems are twice as likely to subsequently develop major depression as those without debt problems and having a debt problem reduces the likelihood of recovery from depression (Skapinakis *et al.*, 2006);
- the more debts people have, the more likely they are to have some form of mental illness; for example, those with five or more separate debts have a six-fold increase in mental disorder (Jenkins *et al.*, 2009);
- many studies have shown an association between low income and poor mental health, but the mechanism for this is not well understood; it now appears that debt plays an important mediating role; in other words, if debt is separately taken into account, the strength of the relationship between low income and mental ill health is substantially reduced (Jenkins *et al.*, 2008);
- there is some evidence that unmanageable debt is a risk factor for self-harm (Taylor, 1994) and suicide (Hintikka *et al.*, 1998);
- a survey of problem debt in a sample of people with mental health problems, most of whom were in contact with secondary mental health services, found that 78% had been threatened with legal or court action, 51% had been contacted by bailiffs or debt collectors, and 2.4% had lost their homes through repossession or eviction (Mind, 2008); and
- only about half of all people with debt problems seek advice and without intervention almost two-thirds of those with unmanageable debt will still face such problems 12 months later (Pleasence *et al.*, 2004).

All of the evidence summarised above confirms the existence of a strong association between welfare problems and mental ill health. Less clear-cut is the nature of this relationship in terms of underlying causation. Do welfare problems such as indebtedness cause mental illness or is it rather the case that having a mental health problem increases the likelihood that people will fall into debt? Or is it indeed possible that both welfare problems and mental illness are themselves primarily consequences rather than causes, each being the result of some common underlying determinant such as job loss or relationship breakdown?

In practice all these explanations are likely to have some validity, with the causal links between welfare problems and mental illness running in both directions and each being influenced by other factors such as unemployment. Particularly important is the likelihood that welfare problems and mental ill health interact with each other, one problem aggravating the other and leading to a downward spiral into crisis. An illustrative chain of events might be as follows: an individual loses his or her job and falls into debt because of the sudden reduction in income; the combination of job loss and indebtedness results in mild depression and this in turn reduces the capacity and motivation of the individual to resolve their debt problem; the continuing non-repayment of debt leads to threats of legal action, visits from the bailiffs and other highly stressful experiences which in turn deepen the severity of the depression, thus reducing still further the likelihood that the problem will be resolved. Such cumulative interactions between welfare problems and mental health highlight a need for effective early intervention in order to prevent any such downward spiral from reaching a critical point.

The impact of welfare advice

A substantial number of mostly small-scale local studies have sought to assess the impact of welfare advice on mental (and physical) health and the key findings from this body of evidence are summarised in various reviews (see for example: Greasley & Small, 2002; Adams *et al.*, 2006; and Allmark, 2011). Most of the evidence relates to the effects of welfare advice provided in healthcare settings, particularly GP surgeries.

First, there is widespread agreement that welfare advice services can substantially increase the take-up of social security benefits and so deliver significant financial gains for clients. It has long been established that for various reasons, including the complexity of the social security system and lack of knowledge among potential claimants, the take-up of many benefits is well below 100%. Rates of non-claiming are particularly high among people with mental health problems, not least because the design of the benefits system has never been well adapted to the specific characteristics of this group, such as the episodic or fluctuating nature of many mental illnesses (Cullen, 2004).

Advice on benefit entitlement accounts for a high proportion of the workload of most advice services and is undoubtedly effective. According to one review of the evidence, "welfare rights advice delivered in healthcare settings leads to worthwhile financial benefits with a mean financial gain of £1,026 per client seen in the year following amongst those studies reporting full financial data" (Adams *et al.*, 2006). In today's prices this is equivalent to a gain of around £1,360 a year. This is an increase averaged over all clients of advice services, not just those specifically seeking help with benefit entitlement.

Particularly relevant to this report is a study of a welfare benefits outreach project run in Croydon specifically for people with severe and enduring mental illness (Frost-Gaskin *et al.*, 2003). Benefit assessments were offered to a total of 153 people using community mental health services and all those who were identified as under-claiming were offered help in pursuing claims. Only a third (34%) of people seen were getting their correct entitlement and all of the other two-thirds (66%) were under-claiming. Those found to be under-claiming who accepted help gained additional benefits of an average annual amount of £3,079 each (just over £4,000 in today's prices).

As well as highlighting the very high level of under-claiming among mental health service users and the corresponding advantages of expert advice, the Croydon study also found that a number of clients in the sample had previously been given wrong or inadequate advice on their benefit entitlement by social workers or other mental health professionals. This presumably reflected a lack of expert knowledge among the staff concerned and supports a case for a specialist advice service.

Less evidence is available on the immediate effects of other types of advice given by welfare rights advice agencies, though some studies do report successful outcomes. For example, in the case of debt, there is evidence that contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable (Williams & Sansom, 2007), while telephone services achieve a success rate of 47% (Pleasance & Balmer, 2007). In comparison, only around a third of debt problems will be resolved without any intervention. Building on these studies, there is also evidence from economic modelling that debt advice services for people with mental health problems are cost-effective (Knapp *et al.*, 2011). In the case of housing, two-thirds of those who reported housing problems in the Youth Access survey of young people in advice settings said that their housing situation had improved as a result of advice received (Balmer & Pleasance, 2012).

Such findings indicate that welfare advice services can achieve a significant measure of success in helping clients resolve the immediate problems on which they are seeking help. Given the evidence reviewed earlier that the experience of these problems has an adverse impact on mental health, it would seem reasonable to conclude that effective welfare advice should have a positive offsetting effect and so be associated with better mental health. A similar link with physical health has also been posited, mainly based on the argument that because there is a clear association between economic deprivation and poor health, so any significant improvement in clients' incomes that results from welfare advice should lead to better physical health.

Published evidence on the impact of welfare advice lends some support to this line of argument in the case of mental health but very little in the case of physical health. Only one or two studies are able to report statistically significant improvements in physical health where use is made of reliable quantitative measures of health status and in the present state of knowledge the case for a beneficial effect on physical health must rest largely on qualitative information. The absence of a clear measurable impact on physical health is, however, not entirely surprising, given certain limitations of the existing evidence base. These include: small sample sizes in nearly all studies; a lack of control or comparison groups in the majority of cases; and very short follow-up periods in all cases. The last of these weaknesses is particularly important, as it is inherently unlikely that any improvements in physical health linked to welfare advice will be realised at all quickly. As a number of commentators have noted, the absence of evidence in this area should not necessarily be taken as evidence of absence of a positive effect.

There is more support in the literature for the proposition that welfare advice leads to some improvements in mental health. On the other hand, these changes, while statistically significant, are generally small in scale. Again this may partly reflect the methodological limitations in the research base just described.

A final conclusion, and one which very much follows on from the previous findings, is that little evidence has so far been found of any significant impact of welfare advice on the use of health services. One or two studies report that welfare advice provided in a primary care setting leads to a reduction in the numbers of GP appointments and drug prescriptions for mental health problems (see for example Krska *et al.*, 2013), but beyond this little change has been observed. This is not surprising, given the lack of sizeable observed effects on health status, whether these relate to mental or physical health.

Evidence from another area of welfare advice

Welfare advice is provided to many people other than those with mental health problems and there is now a growing body of research which seeks to measure the impact and effectiveness of such support in a variety of contexts. It is not proposed to summarise or review this evidence here but rather to highlight a specific example which – for reasons to be explained in more detail below – has some relevance to the analysis of welfare advice specifically for people with severe mental illness.

Family Rights Group (FRG) is a small national charity that advises families whose children are involved with, or require, local authority services because of welfare needs or concerns. Among other things FRG runs a confidential telephone advice line staffed by paid professionals which helps families to understand their situations

and the options available to them. Many of those using this service are distressed parents calling to seek advice on how to avoid losing their child to state care. In some circumstances taking a child into care is a necessary step, but with appropriate support it can be avoided in many cases, with substantial benefits both for the family and child (for example, because of the poor long-term outcomes associated with state care) and for the public sector (because of the very high costs of care).

A recent report sets out a cost-benefit analysis of the FRG advice service, based on an analysis of all calls received in 2010 (Corry & Maitra, 2011; see also a follow-up report by Featherstone *et al.*, 2012). On the cost side, it is estimated that the telephone service cost £0.3 million in 2010, supporting 6,000 callers at an average cost of £50 per caller. Against this needs to be set the financial saving to the public sector that resulted from all cases of children being kept out of care where this outcome could plausibly be attributed to the work of the advice service. In all, 101 such cases were identified, leading to total savings of £3.4 million, based on the following assumptions: first, the average cost to the public sector of keeping a child in care is £25,000 a year; second, on average a child taken into care stays in the system for 12 months (40% of all children in care stay for less than six months and only 13% stay for more than five years); and third, the average number of children taken into care per family is around 1.5.

Based on these figures, the FRG advice service is clearly extremely good value for money, with financial benefits outweighing costs by a factor of around 11 to one. As the authors of the study readily admit, some of the figures used in the analysis are subject to wide margins of error. On the other hand, because the estimated financial surplus is so large, the service would remain good value even under much more restrictive assumptions about the scale of likely benefits, particularly the claimed number of children kept out of care.

Another way of looking at these numbers is in terms of a break-even analysis: how many children need to be kept out of care for the FRG service to cover all of its own costs? Given that the cost of the service is £50 per caller and the saving from keeping a child out of care is £25,000, it can readily be calculated that for full cost recovery the service needs to prevent just one child being taken into care for every 500 callers. In practice the estimated success rate was much higher than this, at around one in 60.

The unit cost of taking a child into care is very high, while the unit cost of providing advice aimed at preventing this outcome is very low. As a result, the advice needs to be successful in only a very small number of cases to pay for itself. As will be argued below, this line of argument has clear parallels in the analysis of welfare advice for people with severe and enduring mental illness.

3. The Sheffield Mental Health Citizens Advice Bureau

Background

The Sheffield Mental Health Citizens Advice Bureau (SMHCAB) was established as long ago as 1976 in the grounds of a local psychiatric hospital, Middlewood Hospital, in the north of the city. It was the initiative of a forward-thinking social worker at the hospital and was originally set up as an outreach service from a local high street CAB. However, it rapidly became established as an independently constituted organisation and has expanded considerably since then, both in scale and in range of activity. Originally staffed by one full-time mental health advice worker and three volunteers, the service now has eight full-time-equivalent paid staff and a similar number of volunteers. Its services are available to all people in Sheffield who suffer from severe mental health problems, whether as hospital inpatients or living in the community.

The Sheffield service was the first CAB in the country to be specifically dedicated to people with mental health problems and remains one of only two CABs nationally to retain this status, the other being Salford Mental Health CAB. As part of the wider Citizens Advice organisation, the service is required to have an audit every three years. This is undertaken by Citizens Advice auditors and includes both a review of the quality of advice and a systems audit. The most recent such review was in March 2012 and a score of 89% was recorded for quality of advice, putting the Sheffield Mental Health service in the top six CABs in the country for quality.

Purpose

The Sheffield service was originally set up to provide welfare advice to patients at Middlewood Hospital on the basis that they were geographically isolated, with many of them legally detained under the Mental Health Act, and therefore unable to make use of the advice services available to the general population, as well as having complex mental health needs which would have acted as a further barrier to access. This broad rationale remains the same today as it was in 1976 and indeed in some ways offers more of a challenge, as **larger numbers of people with complex mental health needs are now supported in the community, requiring the availability of more – and more complex – pathways in order to ensure access for all.**

As seen in the previous chapter, people with severe mental illness are at particularly high risk of experiencing welfare problems, often in multiple forms. Because very few are in work, most depend largely if not wholly on state benefits which are far from generous even when claimed, leaving many exposed to persistent poverty and the associated risk of serious financial problems including accumulating debts and arrears. Severe mental illness reduces the ability of people to manage their everyday affairs and may indeed aggravate problems, for example if someone with bipolar disorder goes on a spending spree during the manic phase of their illness.

The combination of severe mental illness and persistent low income often results in extreme social isolation and many sufferers lack the networks of family and friends that would otherwise be a source of help and support when financial or other problems arise. Severe mental illness may also lead to problems of capacity and communication, often compounded not only by stigma and discrimination but also by

Case study: Elli

Elli was admitted to hospital under the Mental Health Act after she had tried to commit suicide and regularly heard voices that told her to self-harm. She was diagnosed with schizophrenia, psychosis and severe depression. She spoke little English and also had a learning disability and a number of physical health problems, including being on dialysis. She was in hospital for four months, during which time the SMHCAB dealt with a wide range of issues to help Elli get back on her feet and managing her life again.

Elli was living in a private rented flat and while she was in hospital the landlord increased the rent to an amount above the local limit for housing benefit and also issued an eviction notice saying he wanted the property for his own purposes. The SMHCAB adviser worked with the council homelessness section to get Elli re-housed under the priority housing route into social housing and she was awarded a new tenancy before she was discharged.

When Elli was admitted to hospital, she had no income and was in debt. The adviser applied for disability living allowance (DLA) and employment support allowance (ESA). ESA was initially turned down on the grounds that Elli did not have a 'right to reside'. The adviser challenged this and the benefit was finally awarded following an appeal. Elli also receives full council tax benefit, child tax credit and free school meals. A pre-payment meter has been installed to enable Elli to budget for her fuel consumption.

Elli's debts included: rent, council tax, water charges and electricity arrears. Direct debits for these had stopped when she became unemployed, having previously worked for her brother, and there was no money going into the account. A liability hearing for council tax had been issued, bailiffs had called at the house to recover goods and bank charges were accruing due to an un-agreed overdraft. While she was in hospital, the SMHCAB secured a discretionary housing payment (DHP) to pay off council tax and rent arrears and backdated payments of ESA which helped to pay off the water charges arrears. The interest and bank charges were also written off.

Elli's eight-year-old son stayed with Elli's mother while Elli was in hospital. Elli also wanted her mother to look after her benefits for her. Elli's mother had been to the local advice centre for help, but was told that they could not help her because there was a 'conflict of interest' with Elli's husband, who was also their client. The SMHCAB hospital team were able to see Elli regularly and provide consistent, on-going support and liaise with her mother. They were able to build up a relationship of trust with Elli and also access an interpreter through the hospital to help Elli communicate. They set up an 'appointeeship' for Elli's mother so that she could help Elli manage her money when she was discharged.

The advice team were able to provide dedicated, on-site support. Without this, Elli would have been discharged without the support and stability she needed and may have continued to self-harm and be a risk to herself. It required intensive interventions including 19 interviews in the hospital and 11 home visits after discharge, and 25 letters and 126 contacts with third parties. The work was done primarily by one adviser but with the support of a second worker and the advice team.

a pervasive failure in the wider community to understand the particular difficulties faced by people with severe mental illness. Such lack of knowledge may limit the ability of conventional high street advice centres to provide appropriate support even if these services are accessed in the first place. Equally, clinical and other staff working in mental health services have the requisite knowledge of severe mental illness but generally lack expertise in welfare rights problems, particularly when these raise legal issues.

In short, **people with severe mental health problems are among those most in need of welfare advice but at the same time least able to access it effectively.** The Sheffield Mental Health advice service is designed to bridge this gap and is based on the premise that the provision of advice to this client group requires expertise not only in welfare rights but also in the understanding of severe mental illness; in other words, a specialist rather than generic service. Another way of expressing this is to see the Sheffield service as part of a stepped care model of support, in which the intensity of support given to different groups of clients is matched to the severity and complexity of their needs. For example, case workers in the Sheffield MHCAB typically spend much more time with their clients than is the case in a typical high street CAB and have correspondingly smaller caseloads (around 25 clients per case worker at any one time). This is appropriate, given the greater complexity of their work which results from the interaction of welfare problems and severe mental illness.

Service delivery model

Those people with the most complex mental health needs are patients in inpatient units (or related settings such as crisis houses and step-down accommodation) and those engaged with statutory mental health services in the community. These groups make up the great bulk of referrals to the Sheffield service, though some support is also provided to people engaged with voluntary mental health services and, on the basis of self-referral, people with mental health needs who are not currently engaged with any statutory or voluntary services.

Mental health inpatient care is currently provided at two units in Sheffield run by the Sheffield Health and Social Care NHS Foundation Trust and both of these are supported by the advice service. The delivery model for welfare advice in these units has been co-designed with the hospital staff, based on a model of intervention originally developed for homeless patients at University College Hospital in London which had demonstrated cost savings to the NHS, and is integrated into the acute care pathway. All patients are screened on admission by ward staff and referred to the advice service using a screening tool developed by the SMHCAB and ward managers. Patients who are referred are then assessed by a specialist adviser to determine the appropriate type and level of support, which may take various forms including signposting or referral to other services, information, advice and case work.

About two-thirds of referrals result in case work, provided by specialist case workers. Where appropriate, these workers arrange for other specialists such as immigration solicitors to visit the ward to see clients and they are also trained to work with interpreters. In some instances patients will be discharged from hospital while case work is still on-going and where there are such needs, e.g. to complete a benefit claim or support an appeal, the case worker will maintain continuity by providing support in other settings such as step-down accommodation or at the patient's own home.

For people with severe mental problems living in the community, engagement is based on the development of close relationships between the advice service and partners in both statutory and voluntary mental health services, who are then responsible for identifying potential clients and referring them directly to the mental health advisers at the inpatient units. Screening takes place according to the same criteria as described above for inpatients.

In addition to direct welfare rights work with individual clients, the SMHCAB provides money management training sessions to individuals and groups of service users and also briefings and talks about benefit changes to staff working in mental health services.

Back in 2004, the national Citizens Advice service published a report on mental health and social exclusion, based on the organisation's response to the Social Exclusion Unit's 2003 consultation on how people with mental health problems could be helped back into work and what could be done to increase their social participation and access to services (Cullen, 2004). This included a chapter on advice services which identified the following list of core features of a good service:

- face-to-face contact with clients to build trust
- continuity of adviser contact to retain trust and confidence
- holistic advice and support – tackling many problems
- long and repeated interviews
- good access
- workers with experience of benefit issues and mental health problems to advise and represent their clients.

All of these features are embedded in the Sheffield model of service delivery. Other noteworthy characteristics of the model include:

- **early intervention**, as incorporated in the design of the inpatient pathway which seeks to identify patients in need of welfare advice and support as soon as they are admitted to hospital;

Case study: Jim

As part of a Sheffield pilot to deliver outreach services, the Sheffield Mental Health CAB provided a weekly session at a local GP surgery. The practice manager was keen to refer clients with complex social and welfare needs in order to reduce the amount of clinical time spent by GPs in dealing with these and also in recognition of the impact of poor housing, low income and debt on mental health and wellbeing.

Jim was referred to the SMHCAB by one of the GPs for help with benefits, housing and debts. Jim was suffering from depression and had been having suicidal thoughts. He had been sleeping rough for several weeks, having come to Sheffield from another city to be near friends. He had previously run his own business and was in the process of bankruptcy proceedings.

The adviser supported Jim with his claim for ESA and completed a homelessness application. The adviser explained the bidding process for properties and directed Jim to the relevant housing office. The adviser explained the bankruptcy process and offered to help Jim with this.

Having received support and knowing that he could return to the adviser if he got into further difficulties, Jim was able to deal with some of the issues himself. After a few weeks he told the adviser that he had not had suicidal thoughts for some time and that he had a better understanding of how to help himself. Early intervention at the GP surgery may have prevented deterioration in Jim's mental health and a possible need for hospital admission.

- **close working with mental health service staff**, to provide a comprehensive intervention addressing both health and welfare needs; this is strongly consistent with the widely endorsed 'recovery' approach to mental health care, which identifies the key objective of mental health services as being to help every individual with severe mental health problems to lead a satisfying and rewarding life on their own terms even with the limitations caused by illness; in many cases this means giving at least as much weight to social outcomes as to narrowly defined health ones; and
- **education and empowerment of clients**, enabling them to deal better not just with their current welfare problems but with potential futures ones as well, certainly to the extent of knowing how and where to seek advice if difficulties arise.

The impact of welfare reform

The welfare benefits system has always presented challenges for people with mental health problems and recent reforms have exacerbated these in a number of respects, leading to increased demands for welfare advice. Key changes noted by the Sheffield MHCAB include the following:

- The transition from incapacity benefit (IB) to employment and support allowance (ESA) has been a particular source of concern and anxiety, as the work capability assessment which determines whether claimants are judged fit for work is not well designed for people with mental health conditions; in Sheffield as elsewhere a significant number of decisions have been overturned on appeal.

Case study: Jane

Jane was admitted to the general hospital after taking an overdose in a suicide attempt and was then transferred to the psychiatric unit where she was referred to the SMHCAB. She had been working part-time but had accrued several thousands of pounds worth of debts including four with pay day loans. She also had council tax and rent arrears. She was due for a court appearance in relation to the council tax and had received an eviction notice from her private rented flat as a result of the rent arrears.

She was a 57-year-old single parent with two children living at home, one a non-dependent. Her only income for the last four months had been child benefit and part-time wages.

During her three months on the ward, the SMHCAB advisers worked with Jane to restructure her debts, stabilise her housing and sort out the employment issues. They established that she was not eligible for statutory sick pay and put in a claim for ESA as well as backdated housing benefit (HB), council tax benefit (CTB) and personal independence payment (PIP). Working with the discharge facilitator, new accommodation was found and new claims for HB and CTB made.

Jane was unable to return to work but wanted to start a course in science. The adviser is currently helping her to apply for this. 115 contacts have so far been made on behalf of the client over a four month period and the case is on-going.

Jane's financial and housing situation had contributed to her suicide attempt. Being able to provide dedicated support on-site to secure appropriate housing and stabilise Jane's finances while she was in hospital helped to reduce Jane's anxiety and put her back in control of her life. She was able to return to a new home with her children and has continued to make progress with her college application.

Client characteristics

Summary information for 2012/13 on the characteristics of clients supported by the Sheffield service and the issues on which they sought advice is as follows.

- **The service supported 622 clients presenting with 1,725 issues**
- On average there were **eight contacts with each client and a further five contacts per client with third parties** (benefits offices, housing providers etc.)
- **64% of clients required case work**, with most of the remainder being given advice or information
- **60% of inquiries related mainly to benefits, 16% to debt and 4% to housing**; in practice, there is a good deal of overlap between these categories and many clients seek advice on more than issue at the same time
- **48% of clients were inpatients** and the majority of the remainder were clients living in the community who were in receipt of statutory mental health services
- **50.5% of clients were male and 49.5% were female**; in terms of age, 7% of clients were between 17 and 24 years old, 87% were 25-64 years old and 5% were 65+ years old
- 19% of clients were from black and minority ethnic (BME) communities
- **45% of clients were on an income of less than £4,800 a year and only 6% had an income of more that £12,000 a year**
- **113 clients were helped to increase their income by £4,274 a year on average**
- 18% of clients were married or co-habiting and 82% were single, separated, divorced or widowed
- **21% of clients were homeless or living with friends or relatives**, while 18% were owner-occupiers; most of the remainder were council housing or social housing tenants.
- Based on responses to a feedback questionnaire, **84% of clients said they were satisfied with the overall service they received from the SMHCAB, 96% found the staff informative and 95% said they were treated fairly.**

- Disability living allowance (DLA) is being replaced by the personal independence payment (PIP), with stricter eligibility criteria. The reassessments and medical questionnaires are again generating anxiety and stress among people with mental illness, who struggle to articulate their conditions and symptoms and fit them into the medical criteria.
- The replacement of council tax benefit with local council tax support has significantly reduced the overall level of financial support for council tax payments which is available for people on low incomes in Sheffield, including those with mental health problems.
- The under-occupancy rules, which reduce the amount of housing benefit for working-age tenants who have more rooms than they are deemed to need (the 'bedroom tax'), have had a disproportionate effect on people with mental health problems because of the high numbers who live alone. The SMHCAB report that the stress of having to move from her family home into single-bedroom accommodation had a serious adverse effect on the mental health of one of their clients.
- The 'digital by default' programme which is moving government services online has been a major improvement for some mental health service users in terms of claiming benefits, but has created a significant barrier on inpatient wards where there is no general access to the internet.

Many of these changes have had an impact on the pattern of Citizens Advice work throughout the country. For example, national statistics show that problems relating to ESA increased by 50% in 2012/13 compared with the previous year, due to appeals and the work capability assessment (Citizens Advice, 2013).

In addition to changes in the social security system, cuts in funding for some third sector organisations have led to reductions in the availability of non-statutory services and support. These services can be particularly important to people with severe mental illness because of their social isolation.

Organisational change

Since its inception in 1976 the Sheffield Mental Health CAB has a record of good practice in service delivery for people in the city with severe mental health problems and has been nationally recognised for its good practice in social inclusion. It is currently in the process of merging, along with 13 other local advice services, into a single CAB in Sheffield. This will mean considerable change and offers both opportunities and risks.

In the current economic climate the larger organisation offers some protection and economies of scale. It is an opportunity to share good practice across service outlets and develop a strong evidence base for social policy work. Maintaining the focus and resource on the mental health community will be crucial in maintaining the service that Sheffield has provided for this vulnerable group over the past 37 years.

Case study: Angie

Angie has long-standing mental health problems and has been unable to work for a number of years. She was admitted to hospital after physical and financial abuse from her partner and was referred to the Sheffield Mental Health CAB adviser by the Sheffield Outreach Team (SORT).

While Angie was in hospital the adviser dealt with her debts, benefits and housing issues.

Angie had a number of debts which had been accrued as a result of undue pressure from her partner. The SMHCAB were able to pay the fee for a debt relief order, which was then handled by a local solicitor. Over £8,000 of debt was managed by the order.

The adviser worked with the hospital discharge officer to make sure that Angie's rent arrears did not mean that she was prevented from applying for a new tenancy. This is complex work that the discharge officers don't do and the SMHCAB works closely with them to speed up the process of rehousing in situations like Angie's.

Angie had been 'migrated' from incapacity benefit (IB) to employment support allowance (ESA) and had been refused benefit. The adviser submitted a supersession to get Angie's benefit re-instated and made sure that she had some income. There was regular liaison with the SORT team member over this issue. The latter collected letters from Angie's house while she was in hospital and delivered them to the SMHCAB so that the advice worker in the hospital could contact Angie quickly on the ward and keep up the momentum to get things sorted out. If there had been no worker at the hospital, this would have been unlikely to have been resolved and Angie would have been in hospital for longer.

Resolving Angie's debts and arranging alternative housing away from an abusive partner, as well has making sure that Angie had enough money to pay her bills when she was discharged, helped to ensure that Angie would not relapse when she went home. Being able to deal with the issues in hospital, where Angie was safe and being cared for, meant that she was able to get things resolved quickly with the support of a dedicated worker from the advice team.

4. Welfare advice and the scope for cost savings

Introduction

It was noted in Chapter 2 that published research has so far failed to provide any clear evidence that welfare advice for people with mental health problems has a significant impact on health service use. In part this may be because of shortcomings in the research design of most studies in this area, but it may also be because, almost without exception, these studies have focused on people with mild-to-moderate mental health problems such as depression or anxiety. This chapter seeks to explore whether the provision of welfare advice for those with more severe mental illness offers greater scope for cost savings. The main focus is on savings in expenditure on health and social care, but cost savings elsewhere in the public sector and in the wider economy are also noted where there is evidence that these are at all significant.

The costs of severe mental illness

Total spending on secondary or specialist mental health services for people of working age amounted to £6.6 billion in 2011/12 (Mental Health Strategies, 2013). About 80% of this expenditure was funded by the NHS and the remaining 20% by local authority social services departments. The overall number of people having any contact with these services during the course of the year was around 1 million (NHS Information Centre, 2013), implying that on average the annual cost of mental health care for people with mental illnesses which are sufficiently severe to require secondary care was around £6,600 per person. There is, of course, a high degree of variation round this average, with some individuals having only a single contact (e.g. for an assessment following a GP referral) and others having frequent contact including lengthy stays in hospital.

The majority of those receiving secondary services suffer from schizophrenia or bipolar disorder. These conditions are combined with drug or alcohol misuse in a significant proportion of cases. For example, data from the European Schizophrenia Cohort study found an overall rate of substance dependence of 42% among people with schizophrenia in London and 28% among those in Leicester (Carra *et al.*, 2012). Such dual diagnosis can significantly increase the complexity and cost of care. One study of a sample of mental health service users with and without dual diagnosis in south London found that over a six-month period mental health service costs were nearly 150% higher in the dual diagnosis group than among other patients (McCrone *et al.*, 2000).

The average annual cost of healthcare is much lower among people with anxiety or depression, the great majority of whom are treated wholly within primary rather than secondary care. According to estimates produced by the King's Fund in 2008 (McCrone *et al.*, 2008) and uprated to today's prices, the annual cost of care for this group averages around £920 per person. One reason why the cost is so much lower is that a majority of those with diagnosable common mental health problems are not currently receiving any treatment at all (McManus *et al.*, 2009), while for most of the remainder the unit costs of the services they do receive, such as prescriptions or short courses of talking therapy, are relatively modest. As a matter of simple arithmetic, the scope for NHS cost savings at the individual level is inherently limited among those with mild-to-moderate mental health conditions.

At the other end of the scale, again using costs per head by type of illness as an indicator, the greatest scope for savings is to be found among people with schizophrenia. Estimates of costs for this group are set out in an economic report (Andrew *et al.*, 2012) prepared for the Schizophrenia Commission, an independent commission which was established by the charity Rethink Mental Illness and reported in November 2012 (Schizophrenia Commission, 2012).

Overall, according to these estimates, **schizophrenia costs English society £11.8 billion a year and the public sector £7.2 billion a year. Given that the number of people with schizophrenia is put at around 200,000, this amounts to an annual average cost to society of £60,000 for each person with this condition and a cost to the public sector of £36,000 per case**. An earlier study has suggested that the lifetime rather than annual societal cost of schizophrenia could be as high as £1.5 million per case of enduring illness, measured in today's prices (Davies & Drummond, 1994).

A significant proportion of these costs arise because **only about 7% of people with schizophrenia are in employment, compared with a rate of 71 % among all adults aged 16-64**. This very low level of employment implies a huge loss of productive capacity and also has adverse effects on the public finances because of reduced tax receipts and increased spending on social security benefits. The annual costs of public services for people with schizophrenia – mainly health and social care – are estimated at nearly £20,000 per person. The very high level of these costs measured in absolute terms implies that even relatively small percentage reductions will represent significant savings.

Savings pathways

Discussions with members of the Sheffield Mental Health CAB and staff at the Sheffield Health and Social Care NHS Foundation Trust suggest that there are a number of routes or pathways by which the provision of welfare advice for mental health service users may lead to cost savings in the NHS and elsewhere. In some cases the link is fairly direct, for example as when the resolution of a welfare problem allows a patient to leave hospital more quickly than would otherwise be the case. In others it operates less directly and over a longer time frame, with the causal chain running from:

successful advice
↓
improved financial or housing stability
↓
better mental health
↓
reduced use of services.

Three such pathways were identified by SMHCAB and Trust staff as the most important in terms of their likely impact on service use.

1. Quicker discharge from hospital

It was noted in Chapter 3 that discharge planning in the two Sheffield inpatient units starts almost as soon as patients are first admitted to hospital, including screening for welfare problems by ward staff as a precursor to possible referral to the advice service. The availability of suitable accommodation in the community is often a critical factor in enabling prompt discharge and in most cases the responsibility for ensuring this falls to discharge facilitators employed by the Trust. In some instances, however, the involvement of the advice service is also required, particularly when this involves legal issues such as the settlement of rent or mortgage arrears or repossessions, and in these cases the SMHCAB case workers will negotiate directly with creditors or other third parties to ensure that a patient's occupancy rights are maintained. Negotiations may also be undertaken with local benefits offices in cases where hospital inpatients cannot easily be rehoused in the community because they do not currently have a valid benefit claim including eligibility for housing benefit. Given the high cost of psychiatric inpatient care, advice work which facilitates quicker discharge from hospital is likely to have a high return.

2. Preventing homelessness

About 40,000 people are homeless at any one time, although significantly larger numbers, estimated at around 100,000, cycle in and out of homelessness over the course of a year (Department of Health, 2010). People with severe mental illness, particularly when this is combined with drug or alcohol abuse, are heavily over-represented in this population. For example, a recent study found that as many as 33% of a sample of people with schizophrenia drawn from London and Leicester had been homeless at some stage, compared with an average population risk of less than 1% (Bebbington *et al.*, 2005).

Over and above its damaging impact on individuals, homelessness is a very costly problem both for society as a whole and for the exchequer. **Only about one in seven homeless people is in any kind of employment** (Crisis UK, 2012) and being homeless creates significant barriers to finding work, e.g. having no fixed address for post and not being able to open a bank account.

Various studies, reviewed in a recent government report (Department for Communities and Local Government, 2012), put the annual costs of homelessness to the public sector at between £24,000 and £30,000 per person, or around £1 billion a year in total. (It should be noted that these are gross costs. Net costs, i.e. costs over and above those that would have been incurred if the person had not become homeless, are somewhat lower.) About a third of the total cost is attributable to spending by local authorities on homelessness including temporary accommodation, while the remainder is spread across a range of departmental budgets including those run by the Department for Work and Pensions, the Department of Health, the Department of Education (which is responsible for spending on children who are taken into care because they are homeless) and the Ministry of Justice.

A recent report by the Department of Health puts the gross costs of homelessness to the NHS at around £85 million a year (Department of Health, 2010). This is equivalent to about £2,100 a year per homeless person, which is four times the average amount spent on someone aged 16-64 in the general population. Costs of hospital inpatient care are eight times higher per head than the population average and account for the great bulk of expenditure. Net costs are estimated at £64 million a year, or around £1,600 per homeless person.

Chapter 2 of this report presented evidence on the costs and benefits of an advice service for families whose children are at risk of being taken into care and it was argued that because the costs of the care system are so high relative to the costs of advice, only a small number of successful interventions by the advice service are needed for the service to be good value for money. Interventions to prevent homelessness have similar characteristics; in particular, the annual public sector costs of homelessness are much the same as the costs of taking a child into care, at around £25,000 per case. An advice service for mental health service users thus needs to prevent only a small number of cases of homelessness to be self-financing in public expenditure terms.

3. Preventing relapse

Schizophrenia and bipolar disorder are severe and enduring mental illnesses which are characterised by frequent relapse, defined as a significant increase in symptom severity, a significant decrease in social functioning or a major change in the pattern of care such as hospitalisation. Initial onset of illness is usually at a relatively young age for both conditions, with the majority of first episodes being experienced before age 30. In the case of schizophrenia, less than 20% of people recover fully after an initial episode, with the remainder at high risk of experiencing multiple episodes of severe illness extending over many years and with varying degrees of long-term disability (Wiersma *et al.*, 1998). Similarly, only about a fifth of people with bipolar disorder experience only one episode; for the remainder, there is wide variation between individuals in the number of subsequent episodes experienced, but the average is about ten (Mackin & Young, 2005).

The cost of relapse

At 2011/12 prices, the net cost of relapse to the NHS is

£13,773 in the **Leicester** study,

£23,571 in the **London** study and

£18,650 on average per case.

It is estimated that the rate of relapse in people with schizophrenia is approximately 3.5% a month, or more than 40% in the course of a year (Csernansky & Schuhart, 2002). Bipolar disorder is similarly characterised by high rates of episodic recurrence; after a manic episode, there is typically around 50% recurrence within 12 months (Tohen *et al.*, 1990).

Relapse is not only a major clinical event but also a very costly one. To quantify this, use may be made of two recent studies of the costs of relapse in schizophrenia, one based on a sample of patients in Leicester (Almond *et al.*, 2004) and the other on a sample in south London (Munro *et al.*, 2011).

The Leicester study used a patient sample which was randomly drawn from active psychiatric caseloads in the city and then divided into two groups: those patients who had experienced a relapse in the previous six months and those who had not. Detailed data showed that over a six-month period service costs for those who had relapsed were over four times higher than for those who had not relapsed (average service costs per head of £8,212 compared with £1,899, measured in 1998/89 prices). Nearly all of the difference was accounted for by increased inpatient care. The figures imply that the net cost of relapse, i.e. over and above the costs that would have been incurred anyway in the patient's usual care, was £6,313 (£8,212 minus £1,899).

The south London study collected information on the costs of treating a sample of 71 patients, all of whom suffered a relapse and were admitted to hospital. Only hospital costs were covered and these were collected for the full duration of each patient's stay, irrespective of length. On this basis, the average gross cost of relapse was estimated at £25,852 in 2005/06 prices.

A number of adjustments can be made to put these two cost estimates on a comparable footing:

- the Leicester study shows that the net cost of relapse is 77% of the gross cost. Using this percentage, the net cost of relapse in the London sample may be estimated at £19,874 per case;
- in the Leicester study costs are rather arbitrarily truncated after six months and data reported in the London study show that costs incurred after this cut-off increase the total by 37%; on this basis the net cost of relapse in the Leicester study may be adjusted upwards to £8,635;
- finally, putting both sets of figures on a common 2011/12 price base, it can be calculated that the net cost of relapse comes to £13,773 in the Leicester study and £23,571 in the London study.

There remain differences between the two studies; for example, it appears that the London sample had more severe illness than the Leicester group, including a higher incidence of co-morbid substance misuse. However, in the absence of further information it is not possible to make any further changes and it is proposed to take a simple average of the two adjusted figures given above. On this basis the net cost of relapse to the NHS is estimated in round figures at £18,650 per case.

This estimate relates to the cost of relapse in schizophrenia. Less information is available on the equivalent cost for bipolar disorder, though reference may be made to a French study which collected information on service use among a sample of 137 patients with bipolar disorder who were hospitalised for a manic episode (Olié & Lévy, 2002). Average length of stay in hospital was 47 days, which implies a cost per episode of around £15,050, based on the current cost of a psychiatric bed-day in England. This is a gross cost and adjustment using the ratio of net to gross cost found in the Leicester study of schizophrenia (77%) suggests a net cost of around £11,600. It should be noted that this estimate relates to the cost of a manic episode sufficiently severe to require hospitalisation and should therefore be regarded as an upper limit, as not all such episodes lead to hospital admission.

Relapse in severe mental illness is therefore costly to the NHS and indeed the bulk of all spending on secondary mental health care can be attributed to dealing with its consequences. Frequent relapse worsens the long-term prognosis for severe mental illness and so leads to increased expenditure on treatment over the longer term.

There are also wider consequences and associated costs. For example, acute illness is associated with a significant increase in the risk of suicide, which accounts for around 10% of all deaths among people with schizophrenia (NICE, 2010) and a similar proportion among those with bipolar disorder (NICE, 2006). For people with schizophrenia and co-morbid substance misuse, acute psychosis also appears to be associated with an increased risk of criminality, including acts of violence to others. According to a recent review of the evidence, individuals with schizophrenia and co-morbid substance misuse are 4.4 times more likely to commit a violent crime than the population average, even though the absolute level of risk remains very low (Fazel *et al.*, 2009). For all these reasons a major goal of treatment for patients with severe mental illness is to prevent or least limit the severity of relapse. For the possible causes of relapse, see box below.

The vulnerability-stress model

A widely accepted framework for analysing and explaining both the onset of severe mental illness and its subsequent progression, including relapse, is provided by the so-called vulnerability-stress model (Nuechterlin & Dawson, 1984). This builds on evidence: first, that episodes of mental illness, including first episodes, are often preceded by negative or stressful life events; but second, that while stress plays an important role, other factors must also be at work, as only a proportion of all people experiencing the same negative or stressful life events go on to show evidence of mental disorder. The model thus proposes that individuals possess different levels of vulnerability or susceptibility to mental illness and that it is the combination of vulnerability and stress, rather than one or the other in isolation, that is the key determining factor. If vulnerability is high, relatively low levels of stress may be sufficient to cause diagnosable mental health problems; conversely, if vulnerability is low, such problems may only develop with higher levels of stress.

The vulnerability-stress model is consistent with a wide variety of possible causes of the initial onset of mental illness and subsequent relapse. For example, in explaining vulnerability to severe mental illness, it is generally accepted that both schizophrenia and bipolar disorder have a high heritable element, but there is also evidence that severe or prolonged psychosocial stress during childhood, particularly resulting from neglect or abuse, plays an important role in increasing susceptibility to illness in later life.

Much work has been undertaken on improving the definition and measurement of stress, including the ways in which different individuals perceive and react to stressful events, and on investigating the impact of a range of social and environmental factors as causes of stress. Among other things, this research has confirmed that adverse or stressful life events often precede the onset of an episode of severe illness both for schizophrenia (Norman & Malla, 1993) and for bipolar disorder (Joffe *et al.*, 1989). These stressful life events may take a variety of forms but clearly include some of the critical situations confronting individuals as a result of welfare problems, such as unmanageable debt and its consequences, including visits by bailiffs, legal proceedings and the threat of eviction and homelessness.

Assessment

Information on the overall costs and caseload of the Sheffield advice service indicates that on average the cost of advice works out at about £260 per client. (This is based on an average of costs over the last two years and includes an imputed cost for office accommodation and related services provided without charge by the Sheffield Health and Social Care NHS Foundation Trust.) In comparison, the national average cost of psychiatric hospital inpatient care is around £330 per day. To cover its own costs from an NHS perspective, an advice service for mental health service users thus needs to make annual savings equivalent to around 0.8 hospital bed-days per client.

As an alternative comparison, it was noted earlier that on average the total annual cost of mental health care among people using secondary mental health services is around £6,600 per head. The cost of advice is equivalent to 3.9% of this total. In practice, the true percentage is lower than this, as the typical patient seen by the SMHCAB is more severely ill and therefore more costly than the national average. The main reason for this is that roughly half the clients supported by the Sheffield advice service are inpatients, whereas at the national level only about 7% of all people receiving secondary mental health care spend any time in hospital during the course of a year (NHS Information Centre, 2013). Among those who do have such stays, the average amount of time spent in hospital is 70 days over the year, equivalent to an annual cost of inpatient care of around £23,000. The cost of advice corresponds to 1.1% of this figure.

These calculations are of course purely hypothetical but are intended to illustrate the general point that, because the costs of advice are very low relative to the costs of health and social care for people with severe mental illness, only small savings in proportionate terms are needed for an advice service to represent good value for money. In practice, how realistic is it that such savings can be realised? In the absence of detailed quantitative information, it is not possible to give a precise answer to this question, but some progress can be made through further analysis of the key sources of potential saving discussed above, combined with professional judgement as derived from discussions with staff at the SMHCAB and the Trust.

Pulling together the threads, the main components of a value-for-money case are as follows.

First, it is clear that people with severe mental illness are at very high risk of encountering welfare problems. As noted earlier, evidence from one survey suggests that the proportion experiencing such problems is over 80% (Balmer *et al.*, 2010). The reasons for this are several: people with severe mental illness are often vulnerable, isolated, lacking support networks, living on the margins of poverty and handicapped by their illness in dealing with aspects of everyday life. Many not only encounter welfare problems but also are in particular need of welfare advice because of incapacity resulting from their illness.

Not all these cases require the input of a specialist service such as the SMHCAB, as many problems can be resolved by social workers and other staff working in mental health services. The screening system used to regulate the flow of referrals to the Sheffield advice service ensures that only the most complex cases are seen, particularly those involving legal or other issues that are beyond the capacity or expertise of mental health staff to deal with. A specialist service such as the SMHCAB thus meets a need that in many cases would otherwise not be met. This prioritisation of complex cases is an important ingredient of good value for money, as it ensures that the advice service focuses its work where it is likely to have the biggest net impact.

In some instances the work of the SMHCAB produces an outcome that is directly beneficial not only to the client but also to the NHS in terms of its impact on mental health service use. The main such example is the resolution of a housing-related problem that enables a patient to be discharged from hospital more quickly than would otherwise be possible. Staff working in the SMHCAB and in the Trust were able to identify a number of specific instances where this was achieved. In resource terms the value of quicker discharge is given by the national average cost of psychiatric inpatient care, currently around £330 per bed-day (Department of Health, 2012). On this basis, every reduction of 50 bed-days in a year achieved by the SMHCAB would generate savings equivalent to around 10% of the service's total cost.

People with severe mental illness are at much higher risk of homelessness than the population average and in some cases this can be prevented by the work of an advice service, for example by negotiating with housing providers to stop evictions as a result of rent arrears. It is clearly difficult to assess in any particular case what the outcome would have been without the intervention of the advice service, but the high costs of homelessness mean that even a single success represents a worthwhile saving. From a public spending perspective, these costs fall on a wide range of agencies including the NHS and are estimated at £24,000 to £30,000 a year per case measured on a gross basis, somewhat less if measured net of the costs incurred if homelessness had not occurred.

National data shows that Citizens Advice Bureaux around the country dealt with around 500,000 housing-related problems in 2010/11, of which 18% concerned actual or threatened homelessness, while follow-up research on housing outcomes for a sample of over 1,000 clients indicated that two out of five clients who sought help relating to threatened homelessness recorded a positive outcome (Citizens Advice, 2012). If similar proportions applied to the housing problems dealt with by the SMHCAB, the service could prevent up to six cases of potential homelessness in a year.

Severe mental illnesses such as schizophrenia and bipolar disorder are, in most cases, long-term conditions, with acute episodes of illness being interspersed with periods of remission of varying length. Relapse is common and also very costly. For example, in the case of schizophrenia, the probability of relapse is around 40% a year, at an estimated cost to the NHS of over £18,000 per episode. Preventing ten such episodes in a year would more than cover the full costs of the Sheffield mental health advice service.

The vulnerability-stress model of mental illness proposes that both the onset of illness and its subsequent course including relapse result from the interaction of stressful life events and a predisposition or vulnerability to illness stemming from heredity and/or severely adverse experiences in early life such as physical or sexual abuse. High levels of anxiety or stress caused by acute welfare problems such as the threat of losing one's home can clearly act as a trigger for relapse among those already suffering from severe mental illness.

The vulnerability-stress model suggests that there are two different ways in which interventions such as welfare advice can serve to limit the frequency or severity of relapse: first, by reducing stress, and second, by reducing vulnerability or – put another way – increasing resilience.

In the first case, the risk of relapse may be diminished by directly acting on an immediate cause of acute stress, for example by negotiating debt write-offs or repayment schedules so as to prevent a debt problem from reaching a crisis point such as legal action. Staff at the Sheffield Health and Social Care NHS Foundation Trust identified a number of individual cases where, in their judgement, the intervention of the advice service had prevented a relapse in such circumstances. These examples of prevention are most likely to occur among clients of the advice service who are currently living in the community, where there is more scope for early intervention than among clients in inpatient settings. Those living in the community represent just over half the caseload of the SMHCAB.

Welfare advice may reduce the risk of relapse not only by resolving an immediate cause of stress but also by improving the general stability of their clients' financial or housing circumstances in such a way that the likelihood of future crises – and hence future relapses - is reduced. For example, advice work which enables clients to receive previously unclaimed benefits raises their regular income and makes them less vulnerable to unexpected expenses which might otherwise push them into a cycle of debt and worsening mental health.

As well as diminishing stress, both now and in the future, welfare advice can reduce the risk of relapse by strengthening the resilience of clients, particularly by helping them to develop improved coping mechanisms for dealing with everyday problems. Case workers in the Sheffield mental health service seek to empower their clients to do things for themselves and to learn lessons from a current problem or crisis on how they should respond to a similar event in the future, including seeking advice at an early stage. Continuity of support is also emphasised, with clients receiving advice from the same case worker, whether in or out of hospital. These features are intended to increase both the confidence of clients and their knowledge of how to approach problems in the future.

The potential for an advice service to reduce the risk of relapse in the future as well as in the present clearly increases the likelihood that the service will be good value for money, as the current costs of the service need to be compared not just with benefits arising this year but also with a flow of benefits accruing over time.

Taken together, these various sources of saving set against the low unit cost of advice constitute a strong argument that the specialist provision of welfare advice for mental health service users will be good value for money, both for the NHS and from a wider public sector perspective. These savings are over and above any improvements in the health, wellbeing and quality of life of the immediate beneficiaries of an advice service.

5. Conclusions and recommendations

Published research shows that poor mental health is frequently associated with the experience of welfare problems such as unmanageable debt. The association is particularly strong for those with severe mental illness.

Causation is likely to run in both directions Because most live on low incomes, people with poor mental health are more likely than average to run into financial or housing difficulties and their capacity to deal with such problems is often compromised by their illness. At the same time, **welfare rights problems are a major cause of stress which can precipitate or worsen diagnosable mental health conditions.** A particular risk is that welfare problems and mental illness interact with each other, one problem aggravating the other and leading to a downward spiral into crisis.

Existing research shows that welfare advice is often effective in helping clients to resolve their rights problems but has so far failed to provide any compelling evidence that such support for people with mental health problems has a marked impact on their mental health or their use of the NHS. This is partly because of shortcomings in the design of most research studies in this area, but also because these studies almost invariably focus on people with mild-to-moderate mental health problems rather than those at the more severe end of the spectrum, where the scope for cost savings is much larger.

Most people with mental health problems are managed by GPs and other primary care services, and only those with severe illness receive support from the secondary or specialist mental health services. In any one year about a million adults of working age are seen by the secondary services and on average the annual cost of mental health care for this group is around £6,600 per head.

There is wide variation round this average. For example, only about 7% of all people receiving secondary mental health care spend any time in hospital during the course of a year, but among those who do require such treatment the average cost of inpatient care is around £23,000 a year.

The specialist advice service in Sheffield supports people with severe mental illness throughout the city, most of whom are served by the Sheffield Health and Social Care NHS Foundation Trust. The service helps about 600 people a year, with the cost of advice averaging around £260 per client. Just under half of those seen are inpatients, with the remainder living in community settings. The service focuses on complex welfare problems involving legal or other issues which are beyond the capacity or expertise of staff working in mental health services to resolve.

The experience of the Sheffield service, supported by the professional judgement of staff working in the Trust, indicates that **welfare advice generates cost savings in a number of ways. The main examples are:**

1. **reductions in inpatient lengths of stay:** for example, the work of the advice service may resolve a complex housing problem such as possible eviction or repossession and so enable a patient to be discharged from hospital more quickly than would otherwise be possible. At the national level the average cost of an inpatient stay is £330 per day.
2. **prevention of homelessness:** people with severe mental illness are at high risk of homelessness and the advice service can help to prevent this, for example by negotiating directly with landlords and creditors in cases of rent arrears. A number of studies suggest that the costs of homelessness to the public sector including the NHS are in the range £24,000 to £30,000 a year.
3. **prevention of relapse:** severe mental illnesses such as schizophrenia and bipolar disorder are long-term conditions, with acute episodes of illness being interspersed with periods of remission of varying length. Relapse is common and also very costly. For example, in the case of schizophrenia, the probability of relapse is around 40% a year, at an estimated cost to the NHS of over £18,000 per episode. The widely accepted vulnerability-stress model of mental illness suggests a number of ways in which a welfare advice service can help to reduce the risk of relapse, most obviously by directly acting on an immediate cause of acute stress which threatens to trigger relapse but also by reducing the vulnerability of clients to future problems through the development of improved coping mechanisms.

Further, more detailed research is needed to establish the frequency with which an advice service can generate such favourable outcomes and their associated cost savings. However, one clear conclusion emerging from the analysis to date is that **because the costs of severe mental illness including relapse are so high relative to the costs of welfare advice, only a small number of successful interventions are needed for an advice service to generate sufficient savings to be good value for money**. These savings are over and above any direct benefits to clients in terms of improvements in their wellbeing and quality of life which are the fundamental justification for the service.

Recommendations

1. **All providers of secondary mental health services should review how they ensure that service users are given consistent access to effective welfare advice as part of the care pathway.** In most cases this is likely to require a dedicated advice service, working closely with clinical teams in both hospital and community settings.
2. **This review should particularly focus on the scope for early intervention in the provision of welfare advice**, including the availability of improved access for young people experiencing or at high risk of first onset of severe mental illness.
3. **Mental health service providers should recognise the important role of welfare advice in helping to achieve improved social outcomes such as secure incomes and stable housing. This should be embedded in the 'recovery' approach to mental health care being developed in many mental health service providers.**

4. **All NHS and local authority commissioners with responsibility for mental health care should ensure that the need for specialist welfare advice is included in the planning and funding of mental health services.**

5. **All health and wellbeing boards should ensure that joint strategic needs assessments (JSNA) capture information on the prevalence of welfare problems among people with mental health problems and that the associated need for welfare advice is incorporated in strategic planning decisions.**

6. **The Department of Health, NHS England, Public Health England and the Association of Directors of Social Services should promote greater awareness of the need for welfare advice in secondary mental health services and encourage best practice by means of national guidance.**

7. **The Department of Health should also explore the scope for incorporating relevant indicators relating to welfare problems and welfare advice in the public health, NHS and social care outcomes frameworks.**

8. **The Care Quality Commission (CQC) should incorporate assessments of the availability and quality of welfare advice in its inspections of mental health services and also in its annual surveys of mental health service users.** In the latter case, the surveys should seek information from service users on their experiences of welfare problems and their satisfaction with the advice and support provided on these issues.

9. **The National Institute for Health Research (NIHR) and other research funders should commission research to establish the effectiveness and cost-effectiveness of welfare advice for people with mental health problems and to identify the best models of service delivery.** There is a particular need for quantitative studies using high quality research designs such as randomised controlled trials.

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