IMPACT

THE INTERNATIONAL HEALTH IMPACT ASSESSMENT CONSORTIUM

Final Report

A Desktop Health Impact Assessment of the Speke "Paylink Project"

August 2010

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impact

Acknowledgements

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1. Executive Summary

1.1 Liverpool City Council, through the Speke Customer Focus Centre wished to assess the impacts of the pilot "Paylink Project" that ran with funding for six months in 2009, but offering ongoing unfunded support to some clients, in order to ascertain whether or not it is an appropriate model to roll out across the City.

1.2 The agreed scope of this HIA was a desktop HIA, but there was an opportunity to add richness with evidence gathered from a group of organisational stakeholders familiar with the project and client group.

1.3 The assessment was undertaken using a robust and validated model of health impact assessment. Policy context was described relative to recent publications focussing on health inequalities and equity in health. A profile of South Liverpool Area Committee available in the public domain was appended with the permission of the editor. A purposive search of the secondary literature was undertaken to examine research evidence on the effectiveness of debt advice on improving health and wellbeing and reducing inequalities. Organisational stakeholders contributed evidence, gathered using a validated tool designed for the purpose, in a half day workshop setting. A number of evidence based recommendations were made, based upon analysis of the evidence from all sources and this report prepared for the commissioners.

1.4 The main finding is that it is probable that the model of intervention in the "Paylink Project" improves the mental wellbeing of those clients who completed or continue to receive support. There is evidence in the literature of similar models resulting in reduced levels of indebtedness, increased take up of welfare benefit entitlements, more favourable and less onerous levels of repayment achieved through supported negotiation, reduced stress and feelings of control regained for clients. Perhaps the strongest circumstantial evidence comes from organisational stakeholders demonstrating the substantial commitment of providers in continuing unfunded to maintain longer term support for clients from the pilot.

1.5 There is as yet insufficient evidence in the literature concerning those who are lost to these types of interventions, although long term studies are in progress.

1.6 It is possible that this model could be utilised elsewhere in the City, but the literature suggests that due to the wide range of vulnerable groups, "one size" is unlikely to fit all. The training and participation of specialist advisers is crucial and there are potentially substantial resource implications if sufficient capability is to be developed to meet the current exponential increase in demand. This could affect cost effectiveness of the model, but further research is needed to investigate this against the benefits of reduced indebtedness, ability to sustain employment and thus increase economic activity.

1.7 There is evidence from Scotland that such is the scale of the problem of financial exclusion and indebtedness, that there is a burgeoning market for

commercially provided for profit debt advice. It is speculated that should there be insufficient capacity for not for profit debt advice provision coupled with a raised expectation of access to such services, either in the Speke area or across the City, a market for commercial advice could be unintentionally created. Since low income exacerbates the debt experience of all of the vulnerable groups, seeking support and resolution at (probably) premium rates is likely to be a potential negative impact and could increase financial and social exclusion.

Table 1. Table of Recommendations

Health impact	**Direction**	**Likelihood**
4.16. Prior to consideration of any future roll out of the Paylink Project more widely across the City, the commissioners will wish to establish links with this FI initiative, through the Greater Merseyside Champions (Lydia Plackett 01772 530 763 lydia.plackett@lancashire.gov.uk and Paula Skinner 01772 530 762 paula.skinner@lancashire.gov.uk	+	probable
4.18. Wherever possible, individual local programmes should be aware of other initiatives targeting specific population subgroups and how they may relate to them, in order to make best use of scarce resources and better advise clients on the most appropriate support for their circumstances. This should be achieved through undertaking a mapping exercise to establish the nature of services existing elsewhere in Liverpool.	+	possible
4.20 At City level, or City region level, the commissioners may wish to investigate establishing closer working relationships with the Courts and Community Legal Services, to offer early interventions that may mitigate clients' experience of the legal system, reduce the severity of their repayment obligations and help manage the burden of debt related legal action through the courts.	+	possible
6.3.8 Further research, perhaps on a city wide, or city region wide, national or regional level, is required to better understand the nature of support for specific groups, or different types of debt, as a "one size" approach may not adequately support particular population subgroups, especially if the Paylink scheme is to be rolled out across the city.	+	possible
6.3.9 Interventions that empower clients to successfully manage their debt recovery should be developed, as there is evidence that repeated, or long term support is often sought by those who	+	possible

maintain contact with debt advice agencies.		
6.4.5. Further research (or at least further searching of the research evidence presently on going), on the sociological aspects of interventions could enhance the effectiveness of interventions in seeking how best to foster the self esteem, confidence and skills needed to implement and maintain self management.	+	possible
6.5.11. At national, or City wide level, regulation of the fee charging advice sector, along the lines of that for independent financial advisers, should be considered, with the finance industry contributing appropriately.	- and +	speculative
7.3.4. Should a City-wide programme be implemented, appropriate links should be established with the courts to raise awareness and enable access to ongoing support.	+	possible
7.3.7 There is no shared intelligence between the agencies that could usefully help local evaluation and possibly streamline systems. Despite data protection concerns, the group felt it would be possible for each of the local actors to contribute to a clearer picture of referral and support in the area.	- and +	possible
7.3.15. It is estimated that a single part-time (2 days a week) trained CAB specialist caseworker supported the 120 families in the pilot project. Increased demand for CAB debt advice since the end of the pilot suggests that further medium to long term resource would be needed to restore the project in Speke and that this will be replicated across the City.	-	possible
7.3.18. The Paylink Project should be brought to the attention of the Greater Merseyside Financial Inclusion Champions and considered as an appropriate approach for use in the financial inclusion strategy and as such resourced for further research and evaluation.	+	speculative
9.7. It is recommended that the programme be considered for a sustained re-introduction in Speke, with careful monitoring and resource management initiated and more in depth assessment undertaken to inform decisions about further expansion elsewhere in the City.	+	probable

2. Background

2.1. In 2009, Liverpool City Council, through the Neighbourhood Management Service and Speke Garston Ward Members, funded a 6 month pilot project undertaken by the Citizen's Advice Bureau (CAB) in Speke, providing enhanced debt advice with Riverside Credit Union, incorporating access to their 'Paylink' service. The pilot covered some 120 families in the Speke and Garston areas of the city. The pilot project ended in June 2009, although it has continued to provide ongoing unfunded support for just over 28% of existing clients under the auspices of the CAB.

2.2. The "Paylink Project" consists of specialist debt advice from Speke CAB caseworkers, negotiation and agreement of repayment programmes on behalf of clients by CAB, with Riverside Credit Union accepting client deposits, managing and processing payments for clients, using Paylink technology.

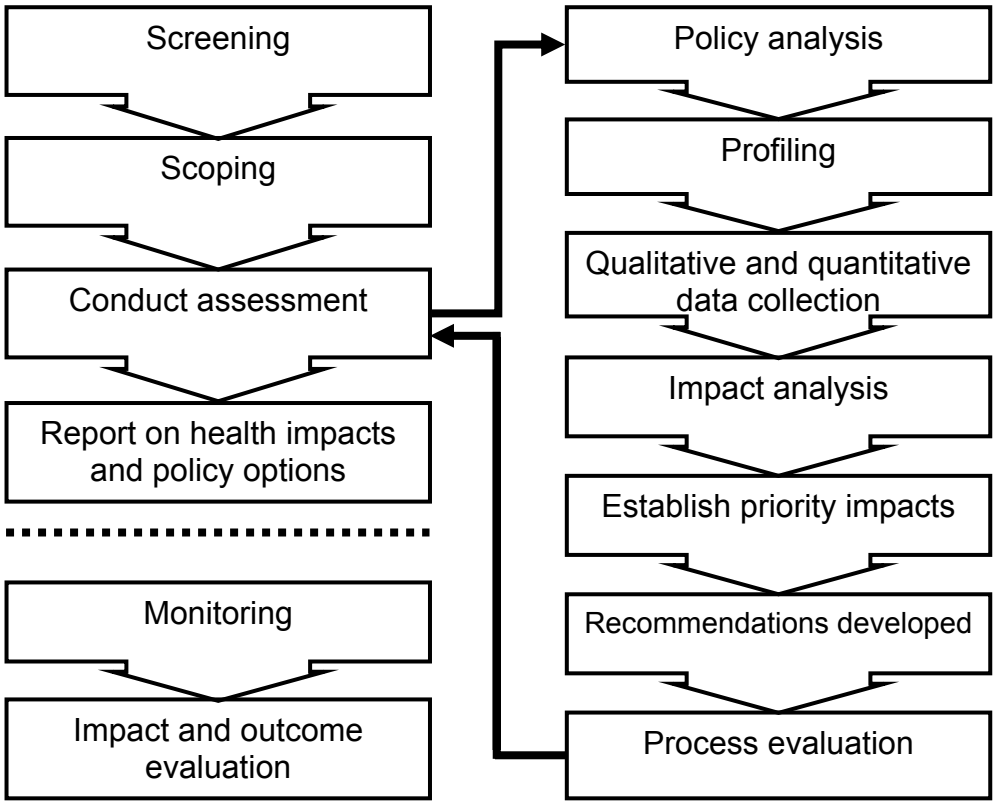
2.3. The essence and added value of the pilot project is the negotiation of the repayment programme with creditors and ongoing support in ensuring that sufficient funds are regularly deposited with the Credit Union, CAB acting in support of clients, that is an independent "safety net" of support.

2.4. This "safety net" joint advocacy role is not part of the usual work of CAB, whose trained workers offer both general and specialist levels of debt advice to clients, the implementation of which then has to be self-managed. Nor is it part of normal practice for the Credit Union, whose clients self refer and utilise the Union as a means of accessing reasonable credit facilities and stabilising money management when they are unable to access high street banking and may be targets for loan sharks.

3. HIA Methodology

3.1. The methods used were based on a validated generic HIA methodology (below), adapted to the requirements of the scope of the HIA. As principally a desktop piece of work there was no Steering Group, with the scope and progress of the work agreed with the lead officer of Neighbourhood Agreement Co-ordinator, South Liverpool Neighbourhood Team, on behalf of the commissioners. The process was undertaken between March and May 2010.

Figure 1 A Generic Model of Health Impact Assessment.



Source: Abrahams et al (2004) EPHIA Guide. www.ihia.org.uk

3.2. The agreed scope of this HIA was a desktop HIA and follows the methods shown on the right side of the figure above, but is necessarily constrained to secondary literature and data available in the public domain, examined within the time available.

3.3. Gathering evidence from community stakeholders and key informants is beyond the scope of a desktop HIA, but there was an opportunity to add richness with evidence gathered from a group of organisational stakeholders familiar with the project and client group.

4. Policy Context

4.1. This section sets out only the most recent principal key policy publications concerned with the reduction of health inequalities and improving mental health and well-being.

4.2 Inequalities: Progress and Next Steps (2008). This Department of Health publication summarised progress on tackling inequalities first described in the 1980's Acheson Report, particularly reviewing progress in the five years since the publication of Tackling Health Inequalities: A Programme for Action (Department of Health, 2003).

4.3. Progress and next steps recognised that despite some initial success, there was a need to re-invigorate policy action with targeted interventions and undertake assessment of the impacts of policy on health inequalities. Given a reduced rate of effect of government policies to reduce inequalities since 2003 (Hills et al, Joseph Rowntree Foundation, 2009) this brought a renewed impetus to reduce the social gradient in health inequalities.

4.4. The Commission on the Social Determinants of Health (World Health Organisation, 2008) brought together the evidence on what can be done to promote health equity and to foster a global movement to achieve it. Partner countries and agencies have started to frame policies and programmes across the whole of society that influence the social determinants of health and improve health equity. It recognises that achieving health equity within a generation is achievable, on the grounds of social justice is the right thing to do and that now is the right time to do it.

4.5 Three principles for action underpin the recommendations of the commission. These are:

- Improve daily living conditions
- Tackle the inequitable distribution of power, money and resources
- Measure and understand the problem and assess the impact of action.

4.6. The Commission was chaired by Sir Michael Marmot for the World Health Organisation. He and other U.K. contributors published in 2009 a new review, capturing the U.K. evidence submitted, brought together and independently reviewed by members of a number of task groups, each focussing on a social determinant of health within the UK.

4.7. Colloquially known as the Marmot Review, this updates the Acheson Report. There are nine key actions emerging from the findings and recommendations of the report, shown in Box 1, over.

4.8. New Horizons: A Shared Vision for Mental Health (2009) is a cross government programme of action to improve the mental health and well-being of the population and the quality and accessibility of services for people with poor mental health, with a view to reducing risk factors and enabling Strategic Health Authorities (SHAs) to deliver their regional visions for mental health.

4.9. New Horizons for the first time takes a population approach to mental health and well-being, rather than a reductionist, medicalised approach to individual mental ill-health, advocating a life course approach with specific actions to address specific risks. It notes that many interventions (citing those concerned with homelessness and debt) that reduce the risk of mental and related physical illness and speed recovery in vulnerable groups and individuals may reduce some of the well-known health and social inequalities.

Box 1 Marmot Review – Nine Key Messages

The nine key messages of the Marmot Review are:

1. **Reducing health inequalities is a matter of fairness and social justice.** In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.

2. There is a social gradient in health – the lower a person's social position, the worse his or her health. **Action should focus on reducing the gradient in health.**

3. Health inequalities result from social inequalities. **Action on health inequalities requires action across all the social determinants of health.**

4. Focussing solely on the most disadvantaged will not reduce health inequalities sufficiently. **To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.**

5. **Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.**

6. **Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.**

7. **Reducing health inequalities will require action on six policy objectives**:
   - Give every child the best start in life
   - Enable all children young people and adults to maximise their capabilities and have control over their lives
   - Create fair employment and good work for all
   - Ensure healthy standard of living for all
   - Create and develop healthy and sustainable places and communities
   - Strengthen the role and impact of ill-health prevention

8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. **National policies will not work without effective local delivery systems focused on health equity in all policies.**

9. **Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities**

4.10. The UK government has given debt/indebtedness a high priority as a cross government policy even prior to the "global credit crisis". Whether this

remains the case after the General Election is as yet unknown, although the size of the problem (albeit perhaps slightly slowing in early 2010) suggests that interventions are likely to be necessary, albeit in other policy manifestations.

4.11. The Treasury set up a Financial Inclusion Fund in 2004, a large proportion of which was earmarked for funding debt advice.

4.12. There are clearly a substantial number of interventions and support programmes run through a number of sectors and government departments intended to address the problem of financial inclusion, money and debt management. For example, The Department of Work and Pensions has recently funded an initiative "now let's talk money".

4.13. Lancashire County Council Trading Standards Service is leading a time limited (2009 to 2011) strategic financial inclusion (FI) programme across West Lancashire and Greater Merseyside. This programme has three high level objectives:

- Helping people manage their money day-to-day
- Helping people to plan for the future and cope with financial pressure
- Helping people to deal with financial distress

4.14. A Liverpool Seminar was held in the Autumn of 2009, the purpose of which was to examine the scale of the problem in the City, highlight the good work already taking place and encourage closer working together.

4.15. The programme includes the establishment of a network of Financial Inclusion (FI) Champions who are intended to develop support infrastructure locally, to

- Develop the role of local authorities and LSPs in financial inclusion
- Disseminate findings from financial inclusion beacon local authorities
- Develop local networks, building on the work initiated by programme Stakeholder Mangers
- Develop and implement regional and sub regional action plans, particularly in areas with high levels of financial exclusion
- Develop partnerships with other FI and housing and Insurance Champions
- Work with local stakeholders and partners (including local authorities, housing associations, banks, commercial lenders, third financial sector and other stakeholders) to establish steering groups to develop credible proposals for establishing new provision of affordable credit, saving and banking in areas of currently low levels of provision.

4.16. Recommendation: Prior to consideration of any future roll out of the Paylink Project more widely across the City, the commissioners will wish to establish links with this FI initiative, through the Greater Merseyside Champions (Lydia Plackett 01772 530 763 lydia.plackett@lancashire.gov.uk and Paula Skinner 01772 530 762 paula.skinner@lancashire.gov.uk)

4.17. A dedicated benefits and money advice service for the Serving and ex-Serving community and their dependants was established in 2007 by four

leading national charities, with third sector caseworkers in (at that stage) thirty eight CABs, including North Liverpool, Wirral and Chester, as well as other Royal British Legion (TRBL) locations. While CAB specialist advice is offered to some 16% of caseload, for this specific subgroup, 80% of the support is required at specialist level. Similarly, there is an overrepresentation of clients with disability and long term health problems at 48% compared to 21% of CAB caseload. At 2009, this service had achieved £15.7 million in benefit gain, debt write off, grants and other funds received for 7,500 clients, an average gain of £2093.

4.18. Recommendation: Wherever possible, individual local programmes should be aware of other initiatives targeting specific population subgroups and how they may relate to them, in order to make best use of scarce resources and better advise clients on the most appropriate support for their circumstances. This should be achieved through undertaking a mapping exercise to establish the nature of services existing elsewhere in Liverpool.

4.19. Debt is a key area for the Ministry of Justice, who are responsible for Community Legal Services (CLS) through which legally aided debt advice is given. The costs to the criminal justice system of dealing with offences related to debt (such as possession orders) are not inconsiderable and debt advice is viewed as an upstream intervention that could “save the system money”, in much the same way that stopping smoking and other public health interventions are, it could be argued, perceived as ways of reducing the burden of treatment of disease on the NHS. Both will contribute to improved health and wellbeing, reduction of health inequalities and increasing equity in health, but sometimes this is not expressed as the primary objective.

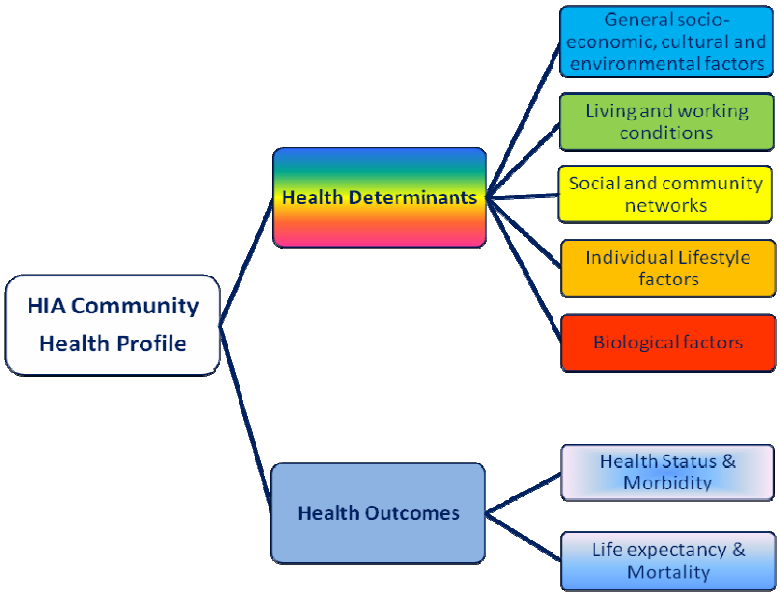
4.20. Recommendation: At City level, or City region level, the commissioners may wish to investigate establishing closer working relationships with the Courts and Community Legal Services, to offer early interventions that may mitigate clients’ experience of the legal system, both criminal and civil, reduce the severity of their repayment obligations and help manage the burden of debt related legal action through the courts.

5. Profile

5.1. The purpose of a health profile in HIA is to give a picture of the health and socio-demographic context of the population of the area under consideration in order to better understand potential health impacts and any population sub groups that may be affected.

5.2. The structure of a HIA health profile is based upon the main determinants of health described in 1991 by Dahlgren and Whitehead in their now ubiquitous socio-environmental model of health. This model of health underpins HIA methodology. Figure shows the range of health determinants and outcomes that are considered in HIA profiling, but this is dependant upon the availability and quality of data in the public domain at the required level of analysis. As a desktop HIA, existing profile sources have been sourced.

Figure 2 Community Health Profile



Source: Haigh,F, et al (2009) A prospective rapid HIA of Liverpool PCT Outside of Hospital Strategy. IMPACT, University of Liverpool.

5.4. A profile based upon this model for Liverpool City was produced by IMPACT for the prospective rapid HIA of the Liverpool PCT Outside of Hospital Strategy in March 2009. This can be accessed at www.healthimpactassessment.co.uk

5.5. South Liverpool District Committee (2009) have also prepared a local profile, using lower levels of geographical analysis, lower super output areas. The profile may be accessed on the City Council website at http://www.liverpool.gov.uk/Images/tcm21-154561.pdf

5.6. NHS Liverpool has also published key demographic and Health Statistics for Neighbourhood Areas (2009). The information may be accessed at http://www.liverpoolpct.nhs.uk/Library/Needs/NMA%20Profile%202009.pdf

Summary

5.7. Speke has for many years experienced high levels of deprivation and social exclusion, described using a wide range of indicators. The area continues to figure consistently among the most deprived areas nationally.

5.8 Apart from any demographic profile compiled from data available in the public domain that shows the high degree of deprivation experienced in Speke, it is interesting to note that in the run-up to the General Election 2010, Liverpool Riverside has been identified as having the lowest electoral turnout in the country in the last two General Elections. Vox pop comments in a recent Radio 4 programme (18 April, Broadcasting House) note that "because nothing has changed" and they "vote Labour or nothing", non-voting is self-perpetuated – "I don't vote because my mum doesn't", with poverty a fact of life across several generations.

5.9. This starkly illuminates the long standing and embedded challenges and potential barriers to engagement and civic participation that the CAB Paylink Project is seeking to address.

5.10. The literature indicates that there are "profile attributes" of those most at risk of indebtedness, not necessarily geographical, but with likelihood increased or exacerbated in areas of deprivation. It may be then possible to define social identity groups/equality target groups/vulnerable groups, e.g. BME for mental health problems, middle-aged adults rather than young or old, that may be over represented among the population of Speke and Garston.

5.11. For consideration of future roll-out across the city, it might be useful to better recognise social identity groups such as disabled, welfare benefit clients, workless and those in low quality, low paid and/or insecure jobs, impairments, chronically sick and those engaged with the criminal and civil justice system.

5.12. While the "Paylink Project" is necessarily reactive, being in response to CAB enquiries, a better understanding of the distribution of these groups would assist estimates of the capacity required for restoration of the project and infrastructure needed should it be rolled out across the city.

6. Evidence from the Literature

6.1. Introduction

6.1.1. There is considerable documentation looking at “debt” through many lenses.

6.1.2. For the purposes of this desktop exercise, an initial search for review level literature was undertaken using the search terms debt; debt advice; indebtedness. Subsequent searching of the literature was purposive.

6.1.3. Limitations of the search and resource constraints meant that a wider and more in-depth, systematic search of the secondary and grey literature regarding for example poverty, income, offenders, mental health, employment, benefits and other related topics was not possible. Terminology seems to be crucial, as the terms financial inclusion and money management revealed a policy stream with associated evidence from the literature late in the search.

6.1.4. While it was not possible to consider specifically the evidence base regarding the effectiveness of CAB and Credit Union interventions in reducing health inequalities, there is sufficient breadth in those reports examined to suggest that these are “a good thing”, since these organisations figure largely as providers of neutral, well-respected, high quality, specialist advice in several government policy initiatives. Other providers of reputable free to face debt advice services are not examined here.

6.1.5. It is clear from the literature that despite being beset by variances in definition, both on the “financial” side of the literature and the “mental health” side of it, debt is a complex, multifactoral issue of huge and exponentially increasing importance since the global credit crunch and recent recession.

6.1.6 Many of the studies examined were necessarily of small numbers of participants and qualitative in nature. There seems as yet to be little comparable empirical evidence about the impact of debt advice (Williams and Sansom, 2007), rather than debt or indebtedness, but due to the plethora of recent guidance publications many of which are jointly produced by experts from the medical and third sectors (particularly since the events associated with the “global credit crisis”), it is possible to draw a clear picture of the main factors prompting various groups to seek advice and the pattern of support that has been found to assist them.

6.1.7. There is evidence from a randomised control trial (Pleasance et al, 2007) that debt advice has a positive impact, with improvements in clients’ financial circumstances greater where advice has been provided. Better understanding of personal finances, levels of anxiety, general health, relationships and housing stability benefited from debt advice.

6.1.8. It is clear from the literature that different groups of people experiencing debt problems seek or utilise advice from different sources. For example, older

people with long term chronic health problems who benefited from welfare benefits advice in a primary care setting would not have thought to approach organisations such as CAB for support (Abbott and Hobby 1999), whereas working age adults requiring debt management advice were more likely to seek repeated support from organisations such as CAB.

6.1.9 It is clear that the trigger for seeking support from whatever source is the degree of worry, rather than the size of the debt incurred.

6.2 Financial Inclusion

6.2.1. Mitton (2008) in her review of financial inclusion policy and practice in the UK defined financial inclusion as the inability, difficulty or reluctance to access appropriate “mainstream” financial services, with two main elements, namely good decision making and access to suitable products and services. Her review covered services including money and debt advice, financial capability, banking, affordable credit and insurance.

6.2.2. Particularly vulnerable groups include:

- Housing association tenants(now either with registered social landlords (RSLs) or Arms Length Management Organisations (ALMOs)
- NEETS, ie young people not in employment, education or training
- Those leaving care
- Lone parents and divorced people
- Disabled people
- Those with mental health problems and carers
- People living in isolated or disadvantaged areas
- Prisoners, ex-offenders and families of prisoners
- Members of minority ethnic groups
- Migrants
- Asylum seekers and refugees
- Homeless people
- Older people
- Women
- People with a post office card account or basic bank account
- People with low incomes

6.2.3. Those outside the mainstream services suffer disadvantages including higher-interest credit, lack of insurance, no account into which income can be paid and higher cost utilities. Those with bank accounts may barely use them, preferring to withdraw all their money each week and manage it as cash. There will continue to be people who, for a range of reasons that vary between vulnerable groups, all of which are exacerbated by low income, cannot take full advantage of bank accounts and other financial services.

6.2.4. In an increasingly cashless economy, the consequences of not holding a bank account are ever more exclusionary. For example, lack of access to affordable loans leaves little option other than high interest credit; lack of insurance and savings leaves families vulnerable to financial crises following

unexpected events such as burglary or flooding; employers may only pay into bank accounts; cheque cashing charges may be up to 9 % of the value, plus a transaction fee ; lack of access to direct debit facilities results in higher utility charges for using methods such as pre-payment meters, paypoint cards in convenience stores, postal orders or cash.

6.2.5. Having identified a number of vulnerable groups, the review found that so great is the need, that all of them were likely to remain vulnerable to financial exclusion in the future. Low income is an exacerbating factor for all groups, but particularly for disabled and older people. The gap between those making best use of financial services and those unable to do so looks likely to widen.

6.2.6. With such a wide range of vulnerable groups, it is unsurprising that there is a very wide range of initiatives taking place – it is clear that what helps one group of clients may not help another. Considerable work remains to be done to identify what is effective for different types of client. Successful initiatives do share several common features:

- The intervention happens when the client was ready to receive advice or looking for help
- The intervention is on-going, with continuity of funding
- Trained staff provided the intervention, either training money advisers about vulnerable groups, or vice versa
- The service was effectively marketed to potential clients
- The service is seen as independent and trusted
- Partnerships with other relevant organisations were developed

6.2.7 Recommendations made in the review included

- Assuring long term funding to projects in order to retain experienced staff who recognise the long term nature of clients needs
- Continued investment in financial training for advice workers, especially those working with vulnerable groups
- Target generic financial advice, since the most successful services are tailored to clients needs

6.3. Criminal Justice System

6.3.1 Williams (2004) discussed the historical stigma attached to debt and noted that the perception of those who get into debt (or certainly the use of credit and unsecured borrowing) as inadequate people requiring help is no longer a truism.

6.3.2. Investigating the literature for evidence of the economic benefits of money advice given through the legal services, Williams found little quantitative evidence, although he found that positive impacts on health were widely reported at that time.

6.3.3. In relation to the courts and their workload, he found several benefits of money advice:

- Reducing the burden on the courts, for example by removing those who cannot pay, diverting them to more appropriate services to negotiate with their creditors and help prepare the necessary paperwork associated with court procedures
- Maintaining family stability, reportedly reducing costs of breakdown, re-housing and repossession.
- Maintaining people in employment and thus economically active, reducing the impact of debt as a disincentive to work.
- Avoiding stress related problems (particularly money worries), which in turn may result in mental and physical ill health, again maintaining economic activity and reducing the costs of treating ill health
- Avoiding criminality. Some 50% of those entering custody may have problematic financial circumstances and advice on release is thought to reduce the risk of re-offending.
- Avoiding homelessness, by virtue of proper representation in court procedures for repossession orders leading to continued payment rather than eviction which removes the incentive to continue to do so.

6.3.4. Not withstanding some rather arcane language and the legalistic standpoint, Williams reports the work of Abbott and Hobby (1999) in seeking to quantify health impacts in their research with Garston CAB. More recent long term qualitative research studies are in progress, for example at Warwick University Institute for Employment Research, with interim reports published (Orton 2008, 2009) building on this and other similar approaches, many of which have run under the auspices of CAB (Kennerley, 2009).

6.3.5 There are now many summary estimates in the literature of the wider economic costs and benefits sought by Williams, for example in terms of additional income generated for clients by CAB services (Kennerley 2009), average household debt (Forum for Mental Health in Primary Care, 2009), reductions in levels of debt (Williams and Sansom, 2007; Pleasance et al 2007; Buck et al 2009), costs of outreach advice services (Buck et al 2009).

6.3.6 Williams also found evidence of equity and tackling social exclusion as non-economic benefits of debt counselling, but defined these within purely legal service parameters, noting that those who received advice achieved a greater degree of equity in the system by securing lower levels of repayment to their creditors and were better able to respond to and participate in court procedures.

6.3.7. In consideration of tackling social exclusion, he reported evidence of a “revolving door” scenario, where schemes where least helpful for those most likely to benefit from them because recipients lacked the necessary legal skills to take action for themselves.

6.3.8. Recommendation: Further research, perhaps on a city wide, or city region wide, national or regional level, is required to better understand the nature of support for specific groups, or different types of debt, as a “one size” approach may not adequately support particular population subgroups, especially if the Paylink scheme is to be rolled out across the city.

6.3.9. Recommendation: Interventions that empower clients to successfully manage their debt recovery should be developed, as there is evidence that repeated, or long term support is often sought by those who maintain contact with debt advice agencies.

6.4. Minimum Income Standard

6.4.1. There is evidence from the literature (Hirsch, Davis & Smith 2009) indicating that while there have been modifications to the way in which it is estimated, the cost of everyday living has increased by at least 5% in the last year, putting severe pressure on those on low incomes and exacerbating indebtedness.

6.4.2 Some people losing their jobs are still having to survive on less than half of what members of the public think is needed to achieve an acceptable standard of living. This is in the region of £13,900 per year, a wage above the minimum wage of £5.73 an hour for most family types with one full-time worker. Benefits fall well short of providing a minimum acceptable income on this measure, although pension credit brings pensioners to the standard.

6.4.3. Eventual rethinking about the definition of a “necessity” may occur, but people hold robust views of what it means to have the things you need to participate fully in society. Increasingly vulnerable incomes have increased the risk of falling below this norm.

6.4.4. There is evidence, not least the high drop out rates in some longer term research studies and those who attempt self management resulting in defaulting, that despite clients recognising the excellent support given to them that does reduce their level of indebtedness or improve their income they continue to lack the confidence, life skills, or control of their lives to act for themselves.

6.4.5. Recommendation: Further research (or at least further searching of the research evidence presently on going), on the sociological aspects of interventions could enhance the effectiveness of interventions in seeking how best to foster the self esteem, confidence and skills needed to implement and maintain self management.

6.5. Advice in a range of settings

6.5.1. Williams (2009) commented upon the success of client-focussed interventions, tailored to the requirements of particular groups. Buck et al (2007) identified five location types – family and children centres; credit unions; housing offices; community centres and prisons – and described the characteristics of advice service users in each in their evaluation.

6.5.2. All locations reported low household incomes, with the lowest in credit unions, the highest in family and children centres. There were high percentages of limiting long term illness, the highest found at credit unions. In prisons, credit unions and housing offices, low levels of educational qualification were

common. Unemployment was frequently reported, being highest among prisoners and lowest at family and children centres. Many recipients lived in rented social accommodation and with the exception of prison, lone parenthood was commonplace.

6.5.3. Prisons and credit unions had the highest proportion of clients with low incomes, fewest educational qualifications and highest unemployment rates. Re-offending was very common among those receiving advice in prison, together with the youngest people and significant numbers with long term illness or disability. Unsurprisingly, in family and children centres, there was a high proportion of female visitors who cared for home and family, attending with children, although lone parents were less common in this setting. In housing offices, credit unions and community centres, lone parenting was twice as common as in family and children centres. Housing offices and community centres served the oldest visitors, with community centres a source of social interaction. All non-prison locations were thought easily accessible and visited often, with the exception of the housing office.

6.5.4. Aznar (2009) undertook an analysis of new CAB clients in response to a 100% increase in debt enquiries over the previous decade. Debt is now the primary issue in bureaux, accounting for one in three of all enquiries. Nationally, advisers deal with nearly 7000 new debt problems each working day.

6.5.5. Lone parents with children, minority ethnic groups, family members with disability or long term illness and renting accommodation were all over represented among the client profile.

6.5.6. Over 50% had four or more priority debts (mortgage or rent, fuel bills, council tax). 10% had ten or more credit debts. 45% of homeowners had mortgage or secured loan arrears, an increase of 15% in four years. Two thirds of these were in priority need for rehousing. A third of homeowners spent at least half of their monthly income on housing costs. 43% of clients were defined as in fuel poverty, with half defined as in water poverty. Nearly two thirds had no spare money to pay their credit debts.

6.5.7. Abbott and Hobby (1999) identified the client group for welfare advice in a primary care setting as elderly, with as might be expected high levels of long term illness.

6.5.8. There is evidence from Scotland (Gillespie, 2010) that such is the scale of the problem of financial exclusion and indebtedness, mainly due to adverse financial shocks, persistent low income, poor money management and over-commitment and over-spending (especially credit), overlapping and cumulatively, there is a burgeoning market for commercially provided for profit debt advice. Since low income exacerbates the debt experience of all of the vulnerable groups, seeking advice at (probably) premium rates is likely to be a potential negative impact and could increase financial and social exclusion.

6.5.9. Gillespie cites evidence that financial mismanagement may be a greater problem than has been reported; that people on low incomes often have good

budgeting skills out of necessity; that macro-economic factors (inflation, interest rates, employment and falling house prices, for example) have a strong influence on peoples' ability to maintain repayments; there is often a negative differential impact from financial shocks such as rising fuel bills for those on low incomes, aged over 60 years, social tenants, single adults living alone and lone parents; there is a strong link between levels of financial stress and whether people think they would be able to manage to make ends meet following loss of the main wage.

6.5.10. The raised likelihood of debt among low income groups, including those with learning disabilities or mental health problems for whom lack of knowledge, capacity or confidence to manage their affairs, can lead to a reliance on sources such as home credit and doorstep loans, mail order, sub-prime credit cards, pay day advance and cash converter lenders.

6.5.11. Gillespie suggests that regulation of the fee charging advice sector, along the lines of that for independent financial advisers, should be considered, with the finance industry contributing appropriately. **Recommendation:** This should be considered at national or City wide level.

6.6. Wellbeing and Mental Health

6.6.1. The most recent summary of the evidence concerning mental wellbeing has been undertaken by Friedli, as part of the revision of the Mental Well-being Impact Assessment (MWIA) Toolkit (Cooke & Stansfield, 2009). This was launched on-line on 21st May 2010 (http://tinyurl.com/2u9ezjq).

6.6.2. The tool, to which IMPACT has been a key contributor, aims to identify the specific influence of a project or development on mental wellbeing. It uses HIA methodology to consider whether a proposed development or project has a positive or negative effect on four core protective factors for mental well-being:

- Enhancing control
- Increasing resilience and community assets
- Facilitating participation
- Promoting inclusion

6.6.3. Deacon et al (2009) brought together important definitions of mental health and well-being from both the World Health Organisation (2001) and the Foresight Mental Capital and Wellbeing Project Progress Report (Government Office for Science, 2008) in their survey of mental well-being in the North West.

"a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" WHO, 2001

"a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relations with others and contribute to their economy. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a purpose in society" Foresight, 2008

6.6.4. They observe that feeling good and functioning well are the two main elements of mental well-being, including how we feel about ourselves, our future and the world around us and our ability to have positive relationships, a sense of control and purpose in life.

6.6.5. They note that mental health and well-being influences a wide range of outcomes for individuals and communities, including better physical health, financial and personal security, relationships with friends and family and improved quality of life. In return, many of these factors may determine levels of mental well-being and have been the focus of researchers attempting to capture the domains and evidence base for mental well-being.

6.6.6. The survey uses a shortened form of the validated Warwick-Edinburgh Mental Well-being Scale (WEMWBS), which focuses on measuring only positive mental health, to measure well-being. As the profile would suggest, NHS Liverpool area has the lowest mean score (25.69) in the North West (range 25.69 – 31.79, mean 27.70). It also had the greatest proportion of respondents with low mental well-being (30.3%) and smallest proportion of respondents with high mental well-being (5.7%).

6.6.7. The survey looked at feelings; relationships; health; lifestyle and life events; place and the characteristics of respondents. Overall, no difference was found between women and men in levels of mental well-being, but there were differences by age group, deprivation and ethnic grouping. High levels of mental well-being were more likely to be found among 25-39 year olds; those living in less deprived areas and non-white adults.

6.6.8. A number of determinants for each category is examined, but financial matters are mentioned a number of times. For example, 8% of respondents stated that they could not afford to meet friends and family as often as they wanted to. Although 75% were able to rely on others if they were in financial difficulties, those over 55 years felt less able to rely on someone for financial help. Women felt slightly more able than men to ask for help in a personal crisis. A significantly higher proportion of non-white adults than white adults felt able to ask for help in financial difficulty.

6.6.9. 49% of people said they were coping on their present income, but nearly 20% said they were finding it difficult or very difficult on their present income. People with low mental well-being were five times more likely than people with high mental well-being to be finding it very difficult on their present income. There were no gender differences. Over 25% of adults in the most deprived areas were finding it difficult or very difficult on their present income, with significantly more non-white individuals than white individuals were finding it difficult on their present income.

6.6.10. Over 30% of respondents said they had worried about money quite often or almost all the time, with a further 34% reporting worrying about money sometimes. Nearly half of those with low mental well-being had been worried about money almost all the time, or quite often in the past few weeks, two and a half times the proportion of those with high mental well-being in these

categories. More women than men and more than twice as many people living in the most deprived areas compared with the least deprived had worried about money almost all the time over the past few weeks.

6.6.11. More people with low mental well-being lived in households classified as unemployed, retired, or inactive for either domestic, sickness or disability reasons.

6.6.12. Those experiencing redundancy in the last twelve months, either voluntarily or involuntarily and not currently working or receiving training were significantly more likely to have low mental well-being.

6.6.13. Significantly more people with low mental well-being were living in supported or assisted housing, were most likely to be female, over 65 years and non-white adults. More people with low mental well-being lived in households classified as unemployed, retired or inactive for either domestic, disability or sickness reasons.

6.6.14. MIND focussed particularly on aspects of debt for those with mental health problems in their 2008 report “In the Red”. Although in their survey, the levels and experience of individual debt do not seem significantly different to those described elsewhere in the literature, the effect on the living standards of respondents seems to be greater. Nearly half were living on the poverty line of £200 per week; 56% had gone without food and 56% without heating due to lack of money. 87% needed to borrow money or use credit to buy food or everyday items. 71% ran out of money every, or most, weeks. 92% reported not being able to socialise.

6.6.15. Two thirds of respondents did not tell their creditors they had a mental health problem and among those who did, harassment, lack of sympathy and lack of consideration of their problems were reported on the part of creditors.

6.6.16. Since one in four people will experience a mental health problem during their life, this is a significant issue, since living with a mental health problem increases the likelihood of falling into debt and being in debt can negatively affect a persons’ mental health.

6.6.17. MIND makes a number of recommendations, including regulation of doorstep lenders and private finance companies; access to affordable credit; systems for banks, utilities and other creditors to be improved to help improve awareness of the issues; training for brief debt advice and signposting to support among health professionals; access to advisory services to be provided in health settings and finally improved access to debt advice services in the community.

6.6.18. In 2009, reflecting the research programme undertaken for them, some of which has been referred to elsewhere in this report, the Legal Services Research Centre published a useful factsheet summarising the evidence base regarding civil law, social problems and mental health.

6.6.19. This identifies the complex problems likely to be presented by those with mental health problems, such as domestic violence, discrimination, relationship breakdown, homelessness, debt, employment, benefits and children. They are less likely to be able to resolve their problems on their own, or seek help to do so. If they do try to resolve their problems, they are more likely to seek help.

6.6.20. Around a third of civil law problems are reported as leading to stress-related ill health, commonly concerning homelessness, mortgage and rent arrears, domestic violence and relationship breakdown. Stress-related ill-health is more common for recession related problems. Only just over half of those reporting stress-related ill-health seek medical help.

6.7 Ethnicity

6.7.1. Deacon et al note that the WEMWBS measure may not be sufficiently culturally sensitive to adequately describe differential distribution of mental well-being among ethnic minority groups. Mental health problems are known to be more prevalent among some minority ethnic groups, but are ubiquitous across all sections of society.

6.7.2 In 2007, the Joseph Rowntree Foundation (JRF) published four reports reviewing the literature relating to poverty and ethnicity.

6.7.3. Salway et al researched the links between ill health and poverty and why the consequences appear to be worse among ethnic minority groups. Many respondents lacked coping skills and felt little control over their situation. There are strong societal pressures to be “normal” resulting in concealment of ill health, leading to refusal or delay in seeking help. Long term ill health further reduces chances of employment, something almost accepted by older Bangladeshis and Pakistanis. Younger people and men found it harder than older people and women to accept alternatives to paid work. Employment mattered for some, but for others, conflicted with their health needs or undermined other roles, such as child care.

6.7.4. The need for substantial flexibility in employment conflicted with employers need for reliability. Low income (often the consequence of long-term ill health) and caring reduced social contact, this being stressful for those with long term conditions.

6.7.5. Financial hardship was common, particularly where benefits were not received. Reluctance to be labelled as disabled or incapacitated made some unwilling to claim entitlements. The system also seems to present barriers to taking up “sickness” benefits for these groups. Effective professional support was generally lacking, especially for those with limited English (some older ethnic group members have literacy difficulties in their own first languages) leading to feelings of exclusion from society and services.

6.7.6. Platt reviewed the literature on poverty and ethnicity in the UK, finding that there are stark differences in poverty rates according to ethnic group. Risks of poverty are highest for Bangladeshis, Pakistanis and Black Africans and

above average for Caribbean, Indian and Chinese people. Muslims face higher poverty risks than other religious groups. Over half of Pakistani, Bangladeshi and Black African children are growing up in poverty. There is evidence that the reasons for lower sources of income vary between ethnic minority groups and in numbers likely to need support from low income. Factors affecting poverty rates include educational qualifications, employment sector, labour market experience, discrimination, location, disability, ill health and family form and structure.

6.7.7. There appears to be an “ethnic penalty”, for example, highly qualified Black Africans experience high rates of unemployment and poor occupational outcomes. This effect extends also to access to benefits and other financial support. The author recommends a greater focus on take up of benefits, analysis at household level to monitor improved employment policy and investigation of the experience of poverty between different ethnic groups.

6.7.8. Palmer and Kenway noted that while the income poverty rate for all ethnic groups seems to have fallen at a roughly similar pace over the last decade, there are still substantial differences. For all ages, family types and family work statuses, those from ethnic minority groups are much more likely to be in income poverty than white British people, especially for families where at least one adult is in paid work.

6.7.9. In Northern England and other English regions, minority ethnic groups experience higher income poverty rates than elsewhere. Differences in age, family type and work status account for just half of the “excess” income poverty experienced by minority ethnic groups compared to white British people. Family work status is the biggest factor, because of the high proportions of working age Bangladeshis and Pakistanis, especially women, who are not in paid work. Lone parenting in an ethnic group is an important factor for both black Caribbean and black African groups.

6.7.10. Clark and Drinkwater looked at the labour market experience of ethnic minorities between 1991 and 2001. While employment rates improved overall, there were continuing employment gaps for black African, Caribbean, Pakistani and Bangladeshi men. Women did not close the gap with white women to the same extent, with rates remaining very low, less than 30%.

6.7.11. Educational qualifications improved job prospects for everyone, but this was most pronounced among ethnic minorities. The effect of living in a deprived area reducing employment prospects was larger for ethnic minorities.

6.7.12. Self-employment, highly concentrated in sectors such as retail, restaurants and taxi-driving remained largely unchanged. British-born Indian and Chinese appear to have better employment prospects.

6.7.13. Educational qualifications lead to improved occupational attainment (social class), although graduate women from ethnic minorities were finding similar advancement harder to achieve.

6.7.14. Individuals from all ethnic minorities earned on average less than white people, but the differences were smaller for women than men. The deficits were highest in professional and managerial occupations.

6.8. Summary

6.8.1. This brief examination of the evidence from the literature demonstrates that there is a complex, but clear, relationship between the many manifestations of “money problems”, however they are defined and the mental well-being of a large and possibly increasing proportion of the population.

6.8.2. Deprivation, with or without the additional factor of mental health problems, seems to exacerbate the problems of financial exclusion, with debt an exponentially increasing issue for a number of “new” population sub-groups, or those not previously identified or regarded as target groups.

6.8.3. However defined, problem debt is not a “minority group” matter and there is evidence that societal change in the way credit and debt are perceived, particularly at a time when large sections of society have been encouraged to financially over-commit and access credit is going to result in significant increases in demand for assistance and advice for those who find themselves affected by adverse financial shocks, unemployment, mortgage or rent arrears and so on, for some time to come.

6.8.4. There is anecdotal evidence that impending and future “financial cuts” and job reductions may lead to an increasing reliance by authorities and agencies on e-commerce to save money. For financially excluded groups and those unused or unable to access and utilise such systems, this is a clear risk of potential negative impact, likely to widen inequalities.

6.8.5. There is evidence from the literature that the worry about indebtedness, rather than the actual amount of debt, is the trigger both for mental health impacts (in terms of stress related ill health) and seeking help for several population subgroups.

6.8.6. There is also evidence that demand (that is, costs) on “systems and services”, for example the courts, could perhaps be mitigated and managed by making debt advice more widely available in a wide range of settings, to adopt an upstream approach likely to prevent or delay engagement with the judicial system wherever possible.

6.8.7. Closely linked to this is advice to optimise utilisation of benefit entitlements, for example for the elderly and disabled and other groups such as prisoners, although this may not bring them to an adequate minimum income standard for acceptable day to day living.

7. Organisational Workshop

7.1. Introduction

7.1.1. HIA methodology, with its flexible and iterative nature captured in the terms of reference for each assessment, is not reproducible scientific research. The “added value” of HIA, particularly in rapid and comprehensive forms, comes from garnering stakeholder evidence in the form of community participation.

7.1.2. In scoping this concurrent desktop HIA, the nature of the small project of 120 families, the sensitive nature of the topic and time and resource constraints mitigated against service user engagement, which would have been desirable in a larger rapid HIA.

7.1.3. There was an opportunity to add richness to the desktop HIA by undertaking a short workshop for organisational stakeholders, that is a group of people with knowledge of both the “Paylink Project” and its users.

7.2. Method

7.2.1. The workshop was planned for a half day session, using a valid and robust methodology (Barnes and Scott-Samuel, 2003) designed for the purpose [Appendix A].

7.2.2. Ten stakeholders were identified by the commissioners and invited by IMPACT to attend the workshop, held at the end of April. They represented Speke CAB, Riverside Credit Union (RCU), Five Childrens’ and Family Centre, South Liverpool JET, Job Centre Plus, NHS Liverpool (Public Health Neighbourhood Management). Six invitees were able to attend on the day, with apologies due to prior commitments from the other four.

7.2.3. Following introductions and questions to ascertain the understanding of the group of the wider determinants of health, the group described in greater detail the nature of the “Paylink Project”, the age range and gender profile of those who took part in the pilot project, positive and negative impacts and evidence of effectiveness (in qualitative terms), going on to make a number of recommendations. These were at several levels, for example with regard to the restoration of the programme in Speke/Garston, potential roll out across the city, identification of the need to communicate better across organisations and the need for wider ranging anonymised data collection.

7.3. Findings

7.3.1. For the six months of the pilot project, CAB clients with debt problems were seen by a caseworker who helped asses their situation and prioritise debts, e.g. council tax arrears. All were offered ongoing CAB support through membership of Riverside Credit Union, using Paylink technology. CAB maintains and administers a client list, liaising with creditors and the Credit Union on behalf of the clients they are supporting for the duration of their

agreed repayment programme. For some 34 of the 120 families taking up the offer of the pilot project, CAB support and advocacy for their repayment programme continues despite cessation of the project funding.

7.3.2. For those unable to access the pilot programme, or who declined the offer, or those who defaulted on their repayment programme, their only option is to entirely re-refer themselves and set up an entirely new negotiation of a repayment programme outwith the pilot project. The group felt that there was a degree of leeway, particularly with difficult creditors, for those taking part in the pilot project, the "safety net" and active support and advocacy creating a level of trust that was perhaps not usual between individuals and creditors.

7.3.3. The group included input from elsewhere in the City, where CAB worker debt support often resulted in onward referral for specialist advice to Speke/ Garston CAB offices. Reflecting on debt as a barrier to a return to, or sustaining of, employment and clients experience of debt over a long period of time before seeking advice (perhaps over several years) leading to engaging with bailiffs and the criminal justice system, stakeholders thought that if such a programme was made available, the establishment of upstream links with the courts could possibly divert or bring earlier support for clients, reducing barriers to future employment.

7.3.4. Recommendation: Should a City-wide programme be implemented, appropriate links should be established with the courts to raise awareness and enable access to ongoing support.

7.3.5. In terms of impacts upon health and well-being, examples were described where the support of the project had enabled a victim of domestic violence who had as a consequence lost her home and work, suffered a bereavement and as a result inherited debt, to return to work and take a positive view of how her life had been set-up, making things manageable once more. Stress and a feeling of being overburdened are common, with people stopping eating and affects on their emotional wellbeing.

7.3.6. Despite pathways of referral existing from primary care and support in the form of a series of sessions on money management at the childrens' centre for parents of young children, offers of support are often declined despite indebtedness being a common problem – "leading horses to water, but can't make them drink" and "preferring to try to buy their luck (spending on scratch cards and on-line gambling)".

7.3.7. Discussion around understanding who does and doesn't take up referral from the childrens' centre for CAB advice, particularly the Paylink Project, revealed that **Recommendation:** there is no shared intelligence between the agencies that could usefully help local evaluation and possibly streamline systems. Despite data protection concerns, the group felt it would be possible for each of the local actors to contribute to a clearer picture of referral and support in the area.

7.3.8. The age range of participants in the pilot project was wide, from grandmothers, mothers in their forties to teenage and school age mums. Debt is often collective, a family rather than individual matter. Reflecting evidence from the literature, accounts with the Credit Union are mainly held by females.

7.3.9. Deposits lodged with the Credit Union range for example from nearly £400 to less than £5 pounds per month. Given that in any HIA there may be potential unanticipated impacts, it is interesting to note that the source of the money is never questioned.

7.3.10. Focussing particularly on what would help re-establish the programme, i.e. accentuate a positive impact, the group felt that the pilot infrastructure worked well, but that CAB capacity, especially in terms of appropriately trained and specialist caseworkers was a barrier.

7.2.11. The interview undertaken by CAB trained caseworkers includes questions intended to discreetly ascertain if the client may have mental health issues, in which case they are flagged up and actions taken to ensure that benefit entitlements are utilised.

7.3.12. While signposting and assistance with single debt advice were agreed as appropriate actions for general advisers and partners such as health professionals, specialist advising on multiple debts requires additional training, although experienced volunteers may have such knowledge.

7.3.13. In light of the current economic situation, it was noted that the calibre of Future Jobs Workers applicants has risen dramatically, many of whom it was thought might be suitable for developing as debt advisers for CAB.

7.3.14. Regardless of the potential need for restoration and expansion of the Paylink Project, it was noted that there has been a recent significant increase in requests for debt advice at CAB offices in the City, with capacity presently not sufficient to meet demand. Requests are never refused, but referrals are either re-routed to other offices with shorter waits to see caseworkers, or have to wait up to six weeks to see a specialist adviser.

7.3.15. Recommendation: It is estimated that a single part-time (2 days a week) trained CAB specialist caseworker supported the 120 families in the pilot project. Increased demand for CAB debt advice since the end of the pilot suggests that further medium to long term resource would be needed to restore the project in Speke and that this will be replicated across the City.

7.3.16. The stakeholder group articulated their belief that the added value of the pilot programme was the strength of relationships and trust that was built up, coupled with the partnership between CAB and the Credit Union, creating a “safety net” of advocacy and support unique to the scheme. Such a model does not appear to have been researched as an intervention in the literature examined.

7.3.17. While the profile of those approaching the two organisations may usually be somewhat different, the pathway created from CAB to Credit Union and the additional Paylink service available through the Credit Union appear to bring differential benefits to those who participated in the pilot, characterised by the commitment to continuing unfunded but ongoing support for remaining participants.

7.3.18. Recommendation: The Paylink Project should be brought to the attention of the Greater Merseyside Financial Inclusion Champions and considered as an appropriate approach for use in the financial inclusion strategy and as such resourced for further research and evaluation.

8. Impact Analysis

8.1. This brings together the evidence from all the data collected from different sources and using different methods; in this case, the literature and evidence of organisational stakeholders. Where possible, it describes the potential impacts:

Health impacts	health determinants affected and the subsequent effect on health outcomes;
Direction of change	health gain (+ve) or health loss (- ve);
Scale	severity (mortality, morbidity and well-being) and magnitude (size/proportion of the population affected)
Likelihood of impact	definite, probable, possible or speculative based on the strength of the evidence and the number of sources;
Latency	when the impact will occur.

8.2. For the purpose of systematic impact analysis, a hierarchy of evidence from level I to V has been defined describing the relative strength of evidence for an association or causal relationship between health determinants and health outcomes; this includes evidence from the literature, key informants and stakeholders.

Level I	Reviews of (systematic) reviews or meta analyses
Level II	Systematic reviews; reviews of several HIAs
Level III	Single studies or HIAs
Level IV	Expert witnesses (key informants)
Level V	Stakeholders.

8.3. Where evidence collected from multiple research methods converges, this adds extra strength to the evidence and the likelihood of impact. Definition of the likelihood of the impacts is described using the following qualitative terms. The likelihood of the impact is based on the assessed strength of evidence. For clarity throughout the impact analysis section, the potential impacts are in **bold** and the likelihood of an impact is <u>underlined</u>.

<u>Definite</u>	=	Will happen. Overwhelming strong evidence from a range of data sources collected using different methods (level I)
<u>Probable</u>	=	Very likely to happen. Direct strong evidence from a range of data sources collected using different methods (levels II/III)
<u>Possible</u>	=	More likely to happen than not. Direct evidence but from limited sources (level IV)
<u>Speculative</u>	=	May or may not happen. No direct evidence to support (level V)

8.4. It is **<u>probable</u> that the model of support provided in the Speke CAB Paylink pilot project has a positive impact upon the mental wellbeing of**

the client group. There is evidence from the literature, supported by stakeholder evidence that such models allow clients to feel they have regained control over their debt problems and management of their repayments.

8.5. **It is <u>speculated</u> that should there be insufficient capacity for not for profit debt advice provision coupled with a raised expectation of access to such services**, either in the Speke area or across the City, **a market for commercial advice could be unintentionally created.** Since low income exacerbates the debt experience of all of the vulnerable groups, **seeking support and resolution at (probably) premium rates is likely to be a potential negative impact and could increase financial and social exclusion.**

8.6. The number of reports of debt advice service interventions in the literature, particularly those offered by CAB, the evidence regarding the exponential increase in enquiries to bureaux regarding debt and the (unanticipated) substantial evidence from the legal sector, provide strong evidence that **it is <u>possible</u> that** both general, and in particular **specialised debt advice will have a positive impact in the medium and long term on the well-being of families engaging with the Paylink Project in Speke** and elsewhere in the City.

8.7. Given potential increased demand for not for profit debt advice services against a background of lack of regulatory control of, for example, access to door step credit, for profit debt advice and lifestyle choices such as online gambling, it is not possible to assess the overall impact on health inequalities of the Paylink Project upon the population of Speke.

9. Conclusions and Recommendations

9.1. It would seem that this is the first time that HIA methodology has been applied to the topic of debt advice and to this specific model that combines the expertise of both specialist CAB advisers and the Credit Union, utilising Paylink technology.

9.2. There is a very recent, wide and burgeoning literature, little of which as yet shows causal relationships or strong associations between debt, debt advice, mental well-being and reduction in health inequalities. That there is so much widespread interest demonstrating the complexity of the picture suggests that in HIA terms, this is a significant determinant of health alongside poverty, employment, housing, transport, environment and, for example, lifestyle factors, social and community factors, including access to services and wider socioeconomic, cultural and environmental factors.

9.3. The potential impacts of debt and debt advice on health inequalities lend themselves to further investigation using robust impact assessment tools, not least in light of the key messages of the Marmot Report and findings of the Commission on the Social Determinants of Health.

9.4. A key tenet of impact assessment, be it either health, mental well-being, equality, or equity focussed, is to ensure that there are no unanticipated negative impacts of a policy, programme or project, while seeking to optimise positive and mitigate negative impacts.

9.5. Although it is probable that the Paylink Project model has a positive impact upon the mental well-being of the client group in Speke and it is possible that it may transfer well for individual families to other areas of the City, it is speculated that resourcing and developing sufficient capacity in the third sector and the costs of expansion to meet increasing demand may mitigate against it contributing significantly to reducing health inequalities across the City.

9.6. There is however, demonstrable commitment and real-time evidence that the project model works locally on the ground, since it continues unfunded for those whose repayment programmes have extended beyond the funded pilot programme.

9.7. It is recommended that the programme be considered for a sustained re-introduction in Speke, with careful monitoring and resource management initiated and more in depth assessment undertaken to inform decisions about further expansion elsewhere in the City.

Table 2 Table of Recommendations

Health impact	**Direction**	**Likelihood**
4.16. Prior to consideration of any future roll out of the Paylink Project more widely across the City, the commissioners will wish to establish links with this FI initiative, through the Greater Merseyside Champions (Lydia Plackett 01772 530 763 lydia.plackett@lancashire.gov.uk and Paula Skinner 01772 530 762 paula.skinner@lancashire.gov.uk	+	probable
4.18. Wherever possible, individual local programmes should be aware of other initiatives targeting specific population subgroups and how they may relate to them, in order to make best use of scarce resources and better advise clients on the most appropriate support for their circumstances. This should be achieved through undertaking a mapping exercise to establish the nature of services existing elsewhere in Liverpool.	+	possible
4.20. At City level, or City region level, the commissioners may wish to investigate establishing closer working relationships with the Courts and Community Legal Services, to offer early interventions that may mitigate clients' experience of the legal system, reduce the severity of their repayment obligations and help manage the burden of debt related legal action through the courts.	+	possible
6.3.8. Further research, perhaps on a city wide, or city region wide, national or regional level, is required to better understand the nature of support for specific groups, or different types of debt, as a "one size" approach may not adequately support particular population subgroups, especially if the Paylink scheme is to be rolled out across the city.	+	possible
6.3.9 Interventions that empower clients to successfully manage their debt recovery should be developed, as there is evidence that repeated, or long term support is often sought by those who maintain contact with debt advice agencies.	+	possible
6.4.5. Further research or at least further searching of the research evidence presently on going, on the sociological aspects of interventions could enhance the effectiveness of interventions in seeking how best to foster the self esteem, confidence and skills needed to implement and maintain self management.	+	possible

6.5.11. At national, or City wide level, regulation of the fee charging advice sector, along the lines of that for independent financial advisers, should be considered, with the finance industry contributing appropriately.	- and +	speculative
7.3.4. Should a City-wide programme be implemented, appropriate links should be established with the courts to raise awareness and enable access to ongoing support.	+	possible
7.3.7. There is no shared intelligence between the agencies that could usefully help local evaluation and possibly streamline systems. Despite data protection concerns, the group felt it would be possible for each of the local actors to contribute to a clearer picture of referral and support in the area.	- and +	possible
7.3.15. It is estimated that a single part-time (2 days a week) trained CAB specialist caseworker supported the 120 families in the pilot project. Increased demand for CAB debt advice since the end of the pilot suggests that further medium to long term resource would be needed to restore the project in Speke and that this will be replicated across the City.	-	possible
7.3.18. The Paylink Project should be brought to the attention of the Greater Merseyside Financial Inclusion Champions and considered as an appropriate approach for use in the financial inclusion strategy and as such resourced for further research and evaluation.	+	speculative
9.7. It is recommended that the programme be considered for a sustained re-introduction in Speke, with careful monitoring and resource management initiated and more in depth assessment undertaken to inform decisions about further expansion elsewhere in the City.	+	probable

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APPENDIX A RAPID HIA TOOL

1. Using the social model of health shown below as a general background and Table 1 as a guide, identify the key health issues relating to your group's policy / project and try to reach a consensus within your group about which are the most important.
2. Think about the population groups whose health is most likely to be affected by the policy / project (e.g. elders; people in poverty; men; ethnic minorities) and record these in column 1 of the framework for rapid HIA (Table 2).
3. In column 2 of the framework, list the elements / activities of the policy / project which are likely to impact on these population groups.
4. Discuss and record the potential health impacts – the beneficial and adverse effects - of the policy / project in columns 3 and 4 of the framework.
5. Where possible, assess the measurability and the probability of impacts. The following codes can be used for this purpose:

   Measurability:
   - Q = qualitative
   - E = estimable / quantitative
   - C = calculable / quantitative

   Probability:
   - D = definite
   - P = probable
   - S = speculative

6. In the final column, list any recommendations which arise from your discussions. These might include, for example,

   - ways in which the proposed project could be changed to maximise the positive health impacts, to minimise the negative ones or to reduce inequalities between population groups (e.g. between affluent and poor; elders and adults; men and women; black and white people)
   - ways in which local partnerships could be strengthened to benefit health; or
   - ideas about further work or information which is needed in order to inform future developments.

A Social Model of Health

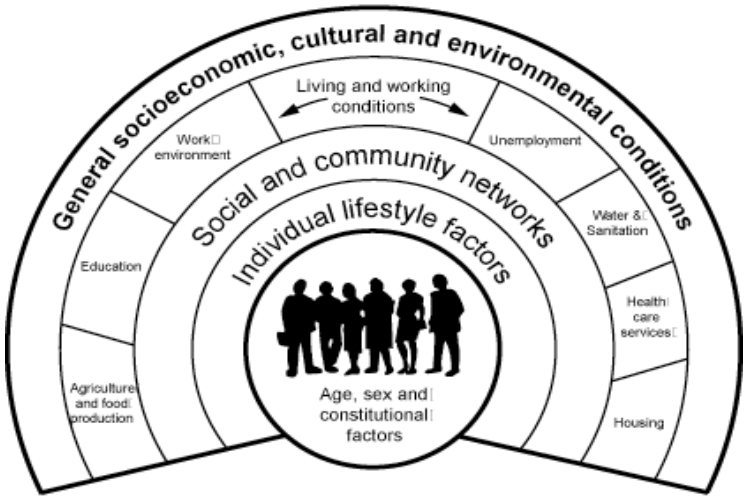

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Table1: Key Areas Influencing Health

Categories of influences on health	Examples of specific influences (health determinants)
Biological factors	age, sex, genetic factors
Personal / family circumstances and lifestyle	family structure and functioning, primary / secondary / adult education, occupation, unemployment, income, risk-taking behaviour, diet, smoking, alcohol, substance misuse, exercise, recreation, means of transport (cycle / car ownership)
Social environment	culture, peer pressures, discrimination, social support (neighbourliness, social networks / isolation), community / cultural / spiritual participation
Physical environment	air, water, housing conditions, working conditions, noise, smell, view, public safety, civic design, shops (location / range / quality), communications (road / rail), land use, waste disposal, energy, local environmental features
Public services	access to (location / disabled access / costs) and quality of primary / community / secondary health care, child care, social services, housing / leisure / employment / social security services; public transport, policing, other health-relevant public services, non-statutory agencies and services
Public policy	economic / social / environmental / health trends, local and national priorities, policies, programmes, projects

TABLE 2: FRAMEWORK FOR RAPID HEALTH IMPACT ASSESSMENT

(1) Population group	(2) Activity	Predicted health impacts		(5) Comments / recommendations
		(3) Positive – beneficial effects	(4) Negative – adverse effects	

Measurability: Q = qualitative; E = estimable; C = calculable **Risk of impact:** D = definite; P = probable; S = speculative

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