

**Bangor University**

## **DOCTOR OF PHILOSOPHY**

### **A longitudinal study of the outcomes and impact of Citizens Advice Bureau advice on the lives of individuals**

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*Award date:*  
2011

*Awarding institution:*  
Bangor University

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# A Longitudinal Study of the Outcomes and Impact of Citizens Advice Bureau Advice on the Lives of Individuals

Thesis submitted in accordance with the requirements of  
Bangor University for the degree of Doctor of Philosophy

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2011

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## ABSTRACT

This three year longitudinal study of a sample of CAB clients in Wales was made possible through joint funding from the Objective One European Social Fund (ESF), Citizens Advice Cymru, and facilities provided by Bangor University, including, in particular, academic advice, supervision and support. The project was also guided throughout by a Research Steering Committee made up of representatives of all the interested parties.

The aims of the research were to measure the long-term impact of advice-giving on clients who had approached Citizens Advice with one or more problems. Citizens Advice is an independent charity operating as Citizens Advice Cymru in Wales. It is the membership organisation for 31 member Citizens Advice Bureaux (CABx) in Wales, which deliver advice services from 50 main offices and 154 secondary advice outlets, these include a range of community settings such as high street offices, GP surgeries, health centres, libraries, courts and also offering home visiting services. Each CAB also offers access to services by telephone. The Twin Aims of the service are to provide the advice people need for the problems they face and to improve the policies and practices that affect people's lives.

Adopting a quantitative longitudinal approach, this thesis provides evidence of improvements that occurred over time in clients' health, their financial and material wellbeing, and their quality of life as a direct outcome of the advice and support they received for their problems. Implications for service delivery arise from findings that highlight the complexities of the lives of many clients. Drawing on the issues raised, a number of practical and policy recommendations are provided that focus in particular on aspects of the CAB service most valued by those experiencing serious and persistent financial difficulties.

# CONTENTS

<b>ABSTRACT .....</b>	<b>II</b>
<b>CONTENTS.....</b>	<b>II</b>
<b>LIST OF TABLES .....</b>	<b>VII</b>
<b>LIST OF FIGURES .....</b>	<b>IX</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>X</b>
<b>DECLARATION.....</b>	<b>XI</b>
<b>INTRODUCTION.....</b>	<b>1</b>
 <b>PART ONE - REVIEWING THE LITERATURE</b>	
<b>CHAPTER ONE .....</b>	<b>24</b>
<b>WELFARE RIGHTS ADVICE.....</b>	<b>24</b>
The Development of Welfare Rights Advice in Primary Care.....	24
Improving Access to Advice Services.....	28
Who uses Welfare Benefits Advice? .....	30
Evidence of the Impact of Advice on Health .....	32
Welfare Benefit under-claiming and the Role of Advice Services .....	45
Evidence of Improvements to Quality of Life.....	48
Conclusions .....	51
<b>CHAPTER TWO .....</b>	<b>53</b>
<b>PERSONAL DEBT AND THE ROLE OF ADVICE SERVICES .....</b>	<b>53</b>
An Introduction to Popular Explanations of the Problem of Personal Debt .....	53
Defining Debt as a Problem .....	55
Consumer Credit Market liberalisation and its impact in the UK.....	57

The extent of Personal Debt in the UK .....	60
Socio-economic and Demographic Predictors of Debt .....	62
The Psychological Impact of Financial Hardship and Debt.....	74
The Impact of Debt Advice .....	78
Conclusions .....	82
Limitations of Research to Date .....	84

**PART TWO - RESEARCHING THE IMPACT OF ADVICE ON THE LIVES OF INDIVIDUALS**

<b>CHAPTER THREE.....</b>	<b>86</b>
RESEARCH DESIGN AND METHODS.....	86
The Research Context .....	86
Theory and Research .....	92
Longitudinal Design .....	98
Time Frame for Data Collection.....	101
Selecting the Data Collection Method.....	104
Research Support.....	110
The Question Schedule.....	113
Conceptualising Health .....	117
Open Questions .....	129
Ethics .....	131
Piloting the Study .....	134
Drawing the Sample .....	137
Data Analysis .....	143
Analysing Quantitative Data .....	146
Conclusions .....	153

<b>CHAPTER FOUR.....</b>	<b>155</b>
GETTING IN, GETTING ON, GETTING OUT AND GETTING BACK IN	155
Getting In.....	155
Getting On .....	159
Results of Sampling.....	164
Getting Out .....	167
Getting Back.....	167
Sample and Bureau Attrition .....	169
Conclusions .....	171
 <b>CHAPTER FIVE .....</b>	 <b>173</b>
OUTCOMES OF THE BASELINE STUDY.....	173
Profile of Research Subjects.....	173
Housing Status of the Sample .....	174
Personal Status of the Sample .....	177
Main Source of Income .....	178
Welfare Benefits Received by Respondents .....	179
Advice Issues.....	181
Characteristics of those seeking debt and welfare benefits advice .....	184
Breakdown of Debt Advice Issues .....	187
Breakdown of Welfare Benefits Advice Issues.....	191
Discrimination Advice Issues.....	191
Signs of Financial Difficulty and Child Poverty .....	193
Borrowing from un-regulated Sources .....	194
Signs of Individual Material and Social Deprivation at Baseline .....	195
Signs of Child Poverty .....	197
Comparing Parent and Child Deprivation .....	199

Health, Social Support and Social Isolation at Baseline .....	202
Short Form 36 (SF-36) Scores at Baseline .....	203
Social Support at Baseline.....	205
Social Isolation at Baseline .....	207
Conclusions .....	209
<b>CHAPTER SIX .....</b>	<b>210</b>
PRECIPITATING AND INTERVENING EVENTS, THE SAMPLE AT WAVE 2 AND 3, .....	210
Characteristics of Sample at Wave 2 and 3 .....	210
Respondent Issues at wave 2 and 3 .....	211
Precipitating Events, Deteriorating Health and Other Problems.....	212
The Impact of Problems on the Lives of Individuals .....	216
Health and Events in intervening period between each Wave of the Study.....	219
Conclusions .....	220
<b>CHAPTER SEVEN.....</b>	<b>221</b>
THE IMPACT OF ADVICE .....	221
Health – The Impact of Advice .....	221
Findings from SF-36 Scores .....	222
Findings from the HADS .....	226
Respondents’ Views on Improvements to Health .....	231
Financial Wellbeing – the Impact of Advice.....	233
Impact of Financial Outcomes on Material Wellbeing .....	235
Impact of Financial Outcomes on Respondents’ Children.....	240
Parents’ views of the Impact of Advice on their Child .....	243
Quality of Life - The Impact of Advice .....	244
Respondents’ Views of improvements to Quality of Life.....	246

Learning from CAB.....	247
Conclusions .....	248
<b>CHAPTER EIGHT .....</b>	<b>250</b>
PERSONAL EXPERIENCES AND SATISFACTION WITH THE CAB SERVICE .....	250
The Importance of Access to Services .....	250
Sources of Referrals at Baseline.....	251
Access to and Satisfaction with CAB Services .....	252
Experiences with CAB .....	253
Why Respondents’ followed CAB Advice .....	257
Final Comments from Respondents .....	259
Conclusion.....	261
 <b>PART THREE - CONCLUSIONS</b>	
 <b>CHAPTER NINE .....</b>	<b>262</b>
CONCLUSIONS, POLICY RECOMMENDATIONS AND FUTURE RESEARCH DIRECTIONS .....	262
 <b>APPENDIX ONE: PRE-TEST STUDY.....</b>	<b>293</b>
 <b>APPENDIX TWO: BASELINE DATA COLLECTION TABLES .....</b>	<b>294</b>
 <b>APPENDIX THREE: QUESTIONNAIRE SCHEDULES .....</b>	<b>304</b>



## LIST OF TABLES

Table 1: Sample Attrition across Bureaux .....	170
Table 2: Number of Welfare Benefits Issues per Respondent.....	191
Table 3: Health Conditions .....	203
Table 4: SF-36 Mean scores at Baseline.....	204
Table 5: HADS Interpretation.....	205
Table 6: Situations in which Individuals may need Support .....	206
Table 7: Wilcoxon Signed Rank Test –SF-36 Scores from Baseline to Wave 2.....	223
Table 8: SF-36 Outcomes at Wave 3 .....	224
Table 9: SF-36 Outcomes for 38 Respondents at Baseline and Wave 3 .....	225
Table 10: Improvements in HADS scores from Baseline to Wave 2 .....	227
Table 11: HADS findings at Wave 3 .....	228
Table 12: HADS findings for 41 Respondents at Baseline and Wave 3 .....	229
Table 13: Total Financial Outcomes: Welfare Benefits and Debt Issues .....	234
Table 14: Total Reported Additional Outcomes .....	234
Table 15: Improvements reported by Respondents .....	245
Table 16: Difference CAB Help and Advice made to Respondents.....	246
Table 17: Results of Pre-test Study Conducted February-March 2007 .....	293
Table 18: Sample Characteristics.....	294
Table 19: Household Composition and Housing .....	294
Table 20: Status of Sample .....	295
Table 21: Main source of income .....	295
Table 22: Welfare Benefits and Tax Credits Received by Respondents .....	296
Table 23: Respondent Issues.....	296
Table 24: Debt Problems .....	297
Table 25: Welfare Benefits Applications/Appeals against the Loss of Benefits .....	298
Table 26: Subjective opinion of Financial Situation.....	299
Table 27: Sources of Borrowing .....	299
Table 28: Items respondents personally went without due to shortages of money ..	300
Table 29: Items Child went without due to shortages of money .....	300
Table 30: Health Problems.....	301
Table 31: Baseline Scores SF-36 and HADS .....	301

Table 32: Wait for Appointment.....	302
Table 33: Respondent Rating Contacting CAB for an Appointment .....	302
Table 34: Respondent Rating Convenience of Location of CAB.....	303
Table 35: Respondent Rating Information about the CAB Service.....	303
Table 36: Access issues issues at Wave 2 and 3 .....	303

## LIST OF FIGURES

Figure 1: Subjective and late payment measures .....	57
Figure 2: Results of Sampling by Bureaux at Baseline .....	165
Figure 3: Welfare Benefits Received by Respondents at Baseline.....	179
Figure 4: Issues for which Respondents sought advice at Baseline.....	183
Figure 5: Household Composition and Advice Issue .....	185
Figure 6: Age group of Respondents, Debt and Welfare Benefit Issues .....	187
Figure 7: Debt Issues at Baseline.....	189
Figure 8: Respondents' view of their Financial Situation .....	194
Figure 9: Items Respondents' went without in the past year because of a shortage of money.....	196
Figure 10: Items Child went without on occasions in the last year due to a shortage of money.....	198
Figure 11: Feeling isolated or Cut off from Society .....	208
Figure 12: Items Respondents were better able to afford in wave 3.....	235
Figure 13: Comparison of items which respondents went without at baseline and could subsequently afford as a consequence of CAB advice .....	236
Figure 14: Items parents, who were better off or more secure financially, were better able to afford for their children at Wave 2.....	241
Figure 15: Items parents, who were better off or more secure financially, were better able to afford for their children at wave 3.....	242
Figure 16: Client Experiences of CAB during the Study .....	255

## ACKNOWLEDGEMENTS

Firstly, my thanks go to those Citizens Advice Bureau (CAB) clients who made up the sample, who kindly gave up their time to provide responses to the questionnaires.

A number of individuals provided expert advice, guidance, and support to the project. These include Dr David Hirst of Bangor University, who was responsible for supervising the study, and members of the Methodology Working Group. A special thank you is extended to Professor Howard Davis for his continued interest in the project and advice to the Methodology Working Group.

Members of the Research Steering Committee, chaired by Dr Gwyneth Roberts, supported the project with enthusiastic interest, active participation, and practical assistance. A special thank you is extended to Dr Gwyneth Roberts, who over the period of the study became as an inspirational mentor. Fran Targett, Director of Citizens Advice Cymru, is thanked for her interest in all aspects of the project. Delyth Owens, project manager to the Better Advice: Better Health Project, kindly facilitated communication with a number of CAB advisors and enabled the creation of vital networks within and external to CAB. The CAB staff involved in the research project are also thanked, particularly those who administered the surveys and managed the project at bureau level. Furthermore, the Citizens Advice Cymru administrative team always found time to provide practical assistance, and generously provided friendship at regional forums, conferences and other events away from home.

I have particularly valued the words of encouragement and advice received from colleagues in the School of Social Sciences and its associated Research Departments at Bangor University.

Finally, I am indebted to my husband and children for their ongoing patience, encouragement and practical support at home.

## INTRODUCTION

This thesis reports the outcomes of a longitudinal quantitative study which examined the impact of Citizens Advice Bureau (CAB) advice on the health and quality of life of a random sample of CAB clients in Wales.

The national organisation named ‘Citizens Advice’ is a registered charity. Citizens Advice Cymru makes up the Welsh arm of this organisation. It operates from two offices – one in Cardiff in south Wales and another in Llanelwy in north Wales. Citizens Advice Cymru provides training and support to Citizens Advice Bureaux in Wales, all of whom are also independent registered charities and affiliated to Citizens Advice through a membership scheme.

The Citizens Advice service has a long history. Launched one day after the declaration of War on 4<sup>th</sup> September 1939, the first 200 CABx opened to create a national network of advice centres across the UK. Staffed predominantly by volunteers, the service helped people with a wide range of issues including, for example, personal debt problems, housing issues, advice regarding pensions and other allowances, help tracing missing servicemen and advice with other problems that arise in times of conflict (Citizens Advice, 2011). The era of post-war reconstruction in the UK gave rise to the idea of free access to legal advice, although publically funded legal aid, resulting from the Legal Aid and Advice Act of 1949, was ultimately limited in reach due to its qualification criteria and restriction to civil proceedings (Legal Centres Federation, 2011). The rise of the welfare rights movement in the 1960s and 1970s resulted in more radical and enthusiastic interest in ‘rights’, as seen in the claimants union movement (Jordan, 1973). Law Centres sprang up along with a new breed of charities, motivated to campaign on policy issues and rights. The 1980s witnessed the emergence of the British law centre movement along with rapid growth of the CAB service and other independent advice services (Dean, 2002).

Today the Citizens Advice service it is one of the largest volunteer organisations in the UK, operating alongside many other organisations that have formed out of the need to find expression on particular issues of political imperative. The Twin aims of

the service are to provide the advice people need for the problems they face and to improve the policies and practices that affect people's lives through research and campaigning activity. They are not alone in this mission. Pressure groups, such as the Child Poverty Action Group have been instrumental in highlighting the failings of policy approaches through their research and campaigning activity (McCarthy, 1986), whilst the Joseph Rowntree Foundation is also a key player (Walker, 2000). Other organisations operating at the heart of the movement for fundamental rights include, for example, Liberty, Action on Elder Abuse, Age Concern, Asylum Aid, Bail for Immigration Detainees, Dial UK, Disability Law Service, Help the Aged, Justice, Mencap, Mind, Rethink, Sane, Shelter, Young Minds, and many others.

Whilst other providers generally focus on specific issues or the issues facing particular groups, a distinctive feature of the CAB service is that its advisors can provide advice on a wide range of client issues, such as those associated with welfare benefits, debt, employment, housing, legal problems, relationship and family issues, help with signposting and referral to other services, advice about consumer goods and services, financial products and services, utilities and communications, health and community care, tax, immigration, asylum and nationality, education, travel, transport and holidays, plus 'other' problems.

The scale of the service is evident from the number of client issues dealt with each year. For example, at the onset of the research in 2006-07 CABx in Wales dealt with a total of 281,219 client issues; 95,674 (34%) of these issues were benefit related, whilst 91,368 (32%) were debt related.<sup>1</sup>

These statistics relate to the number of client issues dealt with, as opposed to the number of clients. Individual clients may, and often do, seek advice for multiple issues. This is reflected in the number of issues bureaux deal with each year. Cases of

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<sup>1</sup> During the study the number of debt related problems rose and overtook welfare benefits issues as the most frequent form of advice provided. This could, however, be related to funding for debt advice acquired during this period of time, which enabled the development of additional face to face debt advice services.

this nature tend to be complex and lengthily to resolve. Consequently they are managed by a caseworker.

“In *casework* the bureau takes on responsibility for the conduct of a case and the adviser takes action on behalf of the client. This may include negotiation and representation on the client’s behalf to third parties including at appeal proceedings where necessary. The bureau drives and manages the case, generally devolving responsibility to a caseworker(s) who will have a continuing relationship with the client” (Citizens Advice, 2004: 4). (emphasis added)

At casework level, welfare benefits and debt advice are the most frequent issues for which bureaux provide advice, whilst discrimination is a small but growing area. Consequently, this study is based on a sample of clients receiving *casework* advice in relation to welfare benefits and debt issues, plus a small number of discrimination issues.

Academic interest in the outcomes and impact of advice has grown exponentially over the past twenty five years. Contributions to the literature will be discussed in detail in later chapters; however, to provide some preliminary orientation it is worth noting that these emerge from the disciplines of Sociology, Social Policy, Health, Law, Psychology, Economics, and Geography, whilst demographers and financial industry analysts have also taken an interest, particularly in relation to the problem of personal debt. Two clear spheres of interest exist within the vast body of research on the topic of advice. The dominant theme relates to the positioning of advice services in primary care settings, more specifically and frequently empirical work has been concerned with welfare rights advice in primary care. The rationale for much of this research is based on the hypothesis that increased income, gained from welfare benefit entitlements, may reduce poverty and social inequalities, which in turn may lead to improvements in the health of individuals. Long term, this may reduce inequalities in health that exist between different socio-economic groups.

Parallel literature concerned with debt advice predominantly emerges from the legal services profession, with few distinctive associations being formed with primary care advice provision. This in itself provides some interesting insights into the perceived benefits of welfare benefits advice as opposed to debt advice. Until very recently scant attention was paid to the outcomes, impact or benefits of debt advice. Instead, examining rising levels of personal debt in the UK, research has attempted to measure the extent and causes of the problem. Narrow in focus, much of this work omits to deal with broader issues of economic and social deprivation, seeing debt as a structural issue or by contrast, the outcome or consequence of individual action.

Symptomatic of the blame often placed on individuals for their predicament, bureaux sometimes face barriers obtaining funding for services deemed by some to be 'unpopular', such as debt advice and programmes to maximise income via welfare benefits uptake. Although this situation is rarely articulated explicitly, many bureaux at the onset of the project faced difficulties with Town Council and Local Authority funders regarding the provision of debt advice. Indicative of this, the Big Lottery fund recently pledged £43 million to debt advice projects targeted at helping those "...undergoing difficult transitions in their lives or experiencing isolation", claiming it will be "...unashamedly assertive in taking risks to address *unpopular* or challenging issues that have been neglected by other funders" (Guardian.co.uk, 2009) (emphasis added).

Historically, of course, this is not new. In his essay 'Der Arme' which is translated to 'The Poor Person', Simmel (1908) wrote that the generosity of welfare and poor relief depends upon the degree to which the public see the poor as being responsible for their own deplorable situation. The logic of Darwin's theory of 'Natural Selection', influenced in part by Thomas Malthus' ideas regarding irresponsibility amongst the poor, is reflected in the views of contemporary social policy moralists today (for example, Murray, 1984, 1990). Adam Smith and early influential writers speculated that poverty and starvation might be a necessary means of population control (Glennerster, 2004). Although, seeing the broader implications he wrote "No society can surely be flourishing and happy, of which the far greater part of the members are poor and miserable" (Smith, 1776: 96). Evidently, poverty, social justice responses,



and moralist views of deficient individual responsibility are topics that have a long history.

It has been said that “The very different approaches societies have taken to fighting poverty lie deep in institutional history, rather than in current economics” (Alesina and Glaeser, 2004), and it was argued by Titmuss that “The welfare state should not be studied out of context” (1958: 8). Taking this view, the legacy of early economists and writers of philosophy is relevant today and attitudes of the past influence social policy approaches in the present. Organic-mechanistic-biological constructs of society found, for example, in the writings of Herbert Spencer and Friedrich Hayek, formed the theoretical foundations of the poor laws and can be seen in the ‘the residual welfare model of social policy’, which places the private market and family as the primary sources of support. In the event that such channels of support breakdown then temporary welfare is provided (Titmuss, 1974: 30-31).

With the heritage of the poor laws, early proponents of social policy reforms in Britain aspired to redress great disparities between the rich and the poor in a vision for social reconstruction and social progress (Beveridge, 1942; 1944). With high levels of social support for a system that offered hope, dignity and respect, the grand scheme of reconstruction set to promote a new era of social progress (Jacobs, 1992). Naturally, this was debated much later. As Townsend points out in his evaluation ‘Poverty, ten years after Beveridge’ (1952), no exact definition of poverty was provided, although Beveridge did explain elsewhere that “Want is defined as lack of income to obtain the means of healthy subsistence – adequate food, shelter, clothing and fuel.” To accomplish this, measures of what constitutes ‘a subsistence minimum’ were needed (Townsend, 1952: 22).

As a result of the poverty studies of the 1960s a fuller understanding of conceptions of poverty and deprivation in relative terms is firmly established (Townsend 1962: 226). However, social issues and policy debates of this era and earlier times are still relevant today and can be seen at the forefront of contemporary social theory and policy.

David Cameron's 'age of austerity' speech provides a good example:

“Our approach is to understand why people are stuck in poverty in the first place, and help them break free by tackling welfare dependency, addiction, debt, poor schooling and above all, family breakdown” (2009).

Contextualising this thesis within more recent policy debates it is still possible to connect with underlying historical prejudices, however out of date they may at first appear. With insight, Townsend argued that “Judgements of one social class on another are notoriously untrustworthy and things which are treated as necessities by one group may not be so regarded by another” (Townsend, 1954: 133). His observations of experiences of unemployment in Lancashire showed families went without meat and fruit in order to afford visits to the pub or cinema, thus illustrating the importance of conventional community social practice.

Townsend (1954) highlighted the entrenched attitude that poor people should be held at least partly responsible for their situation, as seen in calls for moral regeneration. This is evident, for example, in policy approaches such as the ‘Transmitted Deprivation Programme’ in the 1970s and the ‘Problem Families Project’ of the 1940s to 50s. Judgements of character and the impact upon individual self worth are discussed by Gerth and Mills:

“If the upper classes monopolize the means of communication and fill the several mass media with the idea that all those at the bottom are there because they are lazy, unintelligent, and in general inferior, then these appraisals may be taken over by the poor and used in the building of an image of their selves” (1954: 88-9).

As Titmuss notes, the paradox situation in which the stereotypical idea of the welfare state for a working class, which arose as a response to the poor law, has polarised relationships between classes and he argues “... the interests of society as a whole at one extreme, and of the ‘unattached’ and dependent individual at the other, are subordinated to the interests of the group or class” (1955, published 2001: 70).

While the issue of poverty has a long history, in recent decades there has been ongoing interest in the interrelationship between poverty and poor health, and inequalities in health that prevail between socio-economic groups.

Traditionally, the scientific discipline of molecular biology influenced biomedical explanations of health, explained in terms of 'the absence of disease'. Conceptually reductionist, Engel (1977) argued that this fails to take account of biological, psychological, and sociological determinants, thus the biopsychosocial model of health emerged as a prominent force, prompting approaches that now take account of social, psychological and behavioural dimensions of illness. Sociologically, social epidemiology explanations illustrate that multiple social factors shape or determine a person's health; those most advantaged in society enjoy a health advantage (Bird, 2000: 43). 'Social selection' explanations suggest that poor health or other pre-existing attributes impair educational attainment, job opportunities and income thus causing socio-economic status; however, the literature is dominated by the reverse explanation provided by social causation theory (ibid). 'Hierarchical stress' approaches are based on the notion that those of relatively low socioeconomic status often suffer with poor health due to material conditions or the stress of living in a lower social position (Wilkinson, 1997). Additionally, Link and Phelan (1995) argue that socio-economic status and social support are likely to be 'fundamental causes' of disease because of multiple factors and mechanisms, such as access to important resources like knowledge, money, power and prestige that people use in different situations to avoid the risks of disease and death.

Morbidity and mortality have been linked historically with socioeconomic status (for example, Townsend and Davidson, 1982; Hunt et al, 1985; Davey Smith et al, 1990; Dahlgren and Whitehead, 1991; Wilkinson, 1997; Marmot and Wilkinson, 1999). The Black Report of 1980 drew attention to the failure of the National Health Service in addressing health inequalities between those in different socioeconomic groups, citing poverty as the main cause of disease with medicine outside its control. More recent studies conclude that lifetime socioeconomic factors affect health and put a person at risk of premature death. The Whitehall Studies of British Civil Servants confirmed lower socioeconomic status correlates with poor health functioning

(Hemmingway et al, 1997). They also showed that inequality is a strong predictor of life expectancy in industrialised nations; a person's relative position in society is more important for their health than their absolute level of material resources when measured per capita income. This outcome supports a hierarchy stress explanation of health that emphasises the socio-economic gradient in health that concurrently involves an association with material circumstances and hierarchical position (Wilkinson, 1997).

Thus the literature illustrates that disparity exists not only in health but also in the prospects of individuals from different socio-economic groups. For example, in terms of education, employment, income and wealth, with those in lower socio-economic groups dying sooner and experiencing disproportionate opportunities throughout the life cycle (Townsend & Davidson, 1982; Whitehead, 1992; Hemmingway et al, 1997; Shaw et al, 1999; Mitchell et al, 2000).

Recognising a broad range of factors that combine to affect the health of individuals, Dahlgren and Whitehead (1991) point to layers of influences that form 'The Main Determinants of Health'. In their model each layer sits on top of the next. Encompassing these layers are wider structural influences; these include socio-economic, cultural and environment conditions. Next inside this layer are the conditions in which people live and work. These are determined by a number of factors that include housing, health care services, water and sanitation, unemployment, the work environment, education, agriculture and food production. Labour conditions and changes within these can greatly affect those in poverty and can lead to differential outcomes for the poorer sectors of society. Living and working conditions impact on what can be bought and on a person's lifestyle generally. Those who are materially and socially the least fortunate often live in poor housing and experience poor working conditions.

The next layer of influence beneath this takes account of social and community networks, such as interaction with, and support gained from, family and friends, which is particularly important for those living in difficult circumstances.

The next layer includes individual lifestyle factors. Lifestyle can be influenced by the money a person has available to spend on food, on heating, social activities and other factors, whilst disadvantaged groups often consume poor quality and unhealthy food (Whitehead, 1995). Another example here is smoking, which is often prevalent within disadvantaged groups, but is often a means of coping with the stress resulting from living in difficult circumstances. This invariably has consequences for individual health (Graham, 1993).

At its centre, the determinants of health model places individual characteristics over which people have little control - health is influenced by age, sex and hereditary factors (Dahlgren and Whitehead (1991).

Recently ‘The Main Determinants of Health’ model can be seen as influencing an adapted version ‘The Determinants of Health and Wellbeing in a Global Ecosystem’ (Barton and Grant, 2006), which additionally takes account of the global eco-system, the natural environment and built environment, and considers other neighbourhoods and regions.

It can be concluded that the wider determinants of health model has been explicitly instrumental in informing policy approaches. Testifying to wider determinants of health discourse, the Acheson Report of 1998 made recommendations to tackle underlying causes of ill health including “Policies which will further reduce income inequalities, and improve the living standards of households in receipt of social security benefits” plus “Measures to increase the uptake of benefits in entitled groups” (items 3 and 3.3). It concluded that the “weight of scientific evidence supports a socioeconomic explanation of health inequalities” (Acheson et al, 1998). Converse to the Black Report, Acheson’s recommendations had a profound impact on policy formulation and were integrated in a broad range of Government policies, in particular the Government’s strategy *Tackling Health Inequalities* (Department of Health: 2003).

Nevertheless, research has shown that despite a plethora of government policy to reduce poverty and social inequalities, the gap between the highest and lowest social classes is growing:

“Real difference exists between the life chances, wealth and opportunities enjoyed by different classes. The effect of social class on the chances of dying has become more potent over time” (Mitchell et al, 2000: 34).

Like other areas of the UK, social and economic disparities can be found across the population in Wales. Inequalities in health occur geographically within Wales, and a high occurrence of ill health among the adult population can be observed in comparison to the rest of the UK (Kenway et al, 2005). Findings from the Welsh Health Survey of 2007 illustrate that 27% of the working age population in Wales had a limiting long term illness; this figure is in keeping with the Census of 2001. A total of 48% had an illness that was being treated.

Chronic illness is particularly prevalent. Analysis of four years of Welsh Health Survey data from 2003-2007 (Jones et al, 2010) revealed 49.6% of the whole of the sample were currently being treated for ‘any chronic condition’. This figure is much higher than previous reports for Wales which suggest one third of the adult population in Wales has at least one chronic condition (Wales Audit Office, 2008). Whilst this figure is higher than the rest of the UK, it is projected to increase by 12% by 2014 (Welsh Assembly Government, 2007: 9). Differences in statistical evidence may be due, in part, to disease categorisation and data collection methods. The Wales Audit Office statistics are based on an audit of 12 NHS trusts whereas findings by Jones et al (2010) are based on responses by individuals to the Welsh Health Survey.

Nevertheless, statistics illustrate the enormity of the problem of poor health in Wales.

Historically the South Wales Valley areas have been associated with heavy traditional industries such as mining. Economic and social deprivation followed the decline of these industries, and further polarised life chances between people in different regions of Wales. The Census of 2001 identified ten local authorities in England and Wales with the lowest age standardised rates of good/fairly good health, most were in Wales. These included the south Wales Valley’s areas of Merthyr Tydfil, Blaenau Gwent, Rhondda Cynon Taff, Caerphilly plus bordering Neath Port Talbot, (Office of

National Statistics, 2004). More recently the Chief Medical Officer (2006) reported communities known for their lower than average life expectancy, these include the aforementioned areas plus Bridgend, which is also in the south.

Relative poor health arising from social and economic inequality can also be found in north and mid Wales that include both industrial and rural areas. Poor job opportunities, low incomes and inadequate public transport compound the situation further and make it difficult for individuals in rural areas to access already limited jobs and services. Such circumstances can weaken social support and result in social isolation.

The Welsh Index of Multiple Deprivation (WIMD) is a measure of deprivation at small area level. The WIMD 2008 was developed for the Welsh Assembly Government to replace the WIMD of 2005. Of course, deprivation is a wider concept than poverty and refers to the wider problems that result from inadequate resources and opportunities. The WIMD draws on eight types of deprivation, which include income, housing, employment, and access to services, education, health, community safety and the physical environment. Put simply, multiple deprivation is a combination of specific types of deprivation. The WIMD provides ranked indicators of deprivation for Lower-Layer Super Output Areas (LSOA). Each of these geographic units is home to approximately 1,500 people (Welsh Assembly Government, 2008a).

The five most deprived LSOA in Wales include three areas in Denbighshire and one in Wrexham, both of which are in the north, plus one in Cardiff, which is in the south. Although the WIMD does not provide official local authority scores, the range of scores within some Local Authorities is broad and can be distributed along the whole spectrum of ranks from highest to lowest levels of deprivation (Welsh Assembly Government, 2008b). While the WIMD is a very useful measure, it is important to note that ranking refers to the proportion of people that are deprived in an area. It is well known that not all deprived people live in deprived areas; consequently the WIMD does not portray the full picture but it does depict a pressing case for policy responses in Wales.

The creation of the Welsh Assembly Government in 1999 forged a new epoch in Welsh Politics. Since devolution, the Government of Wales Act (Office of Public Sector Information, 2006) resulted in increased powers that allow Welsh Ministers to create Welsh laws (assembly measures) on health, education, social services and local government matters within the UK Parliamentary ‘legislative competence’ system. However, many policy areas still remain within the jurisdiction of the UK Government. These include areas such as social security, finance, employment, defence, foreign affairs, macro economic matters plus many other policy areas. Whilst the Welsh Assembly Government has regional powers its policies must fall in line with broader national (Westminster) policy and legislation that encompasses the whole of the UK.

In its strategic plan of 2003, *Wales: A Better Country*, the Welsh Assembly Government pledged to take “action on social justice that tackles poverty and poor health, and provides people and their communities with the means to help themselves and break out of the poverty trap.” However, the government cannot achieve this alone.

Reflecting the modern mantra of ‘joined up working’ a number of cross cutting policies aim to tackle personal debt, financial exclusion and social exclusion, child poverty, as well as those that improve access to services. The aim of joined up government is to promote interaction and a focus on cross cutting outcomes. Modernisation of the policy making process can be traced back to the Cabinet Office White Paper of 1999 *Modernising Government* and its vision for policy making set out in the Cabinet Office’s Strategic Policy Making Team Report of 1999 *Professional Policy Making for the 21<sup>st</sup> Century* and subsequently *Modern Policy Making* (National Audit Office, 2001). This has been equally influential to the process of devising policy solutions in Wales.

It is within this context that advice services play an important role in helping government reach their strategic objectives. For example, the Welsh Assembly Government Child Poverty Strategy *A Fairer Future for our Children* (2005)



identifies the role of CABx in reducing child poverty through a “GP scheme to refer patients to Citizens Advice Bureaux (CAB) on benefit issues.” This scheme has evolved into the ‘Better Advice: Better Health’ advice service provided by CABx in primary care settings throughout Wales.

In order to reach out to individuals and communities, the Welsh Assembly Government set out reforms for public services in Wales in its document *Making the Connections: Delivering Better Services for Wales* (2004), which include measures for greater co-ordination between service providers. Its action plan *Delivering the Connections: From Vision to Action* followed in 2005. A review of local service delivery, published in *Beyond Boundaries: Citizen Centred Local Services for Wales* (2006), concluded that service delivery was patchy and longer term transformation is needed. *Making the Connections – Delivering Beyond Boundaries: Transforming Public Services in Wales* (2006) advocates services that are flexible, so as to respond to the most vulnerable and hard to reach. The key policy framework ‘*Making the Connections – Building Better Customer Service*’ (2007) is aimed at all public service organisations in Wales. It is structured around five customer service outcomes or ‘core principles’ that aim to provide a ‘Citizen Centred Approach’. Finally, *Better Outcomes for Tougher Times: The Next Phase in Public Service Improvement* (2009) includes plans to align public services around commonly agreed priorities and develop action based approaches to social partnerships with a wide range of bodies which include the third sector.

The policy document *Making Legal Rights a Reality in Wales* was jointly published by the Welsh Assembly Government and the Legal Services Commission in 2007, a year into the research project. The document sets out the direction for the Community Legal Service in Wales over the next five years. It advocates quality assured, citizen centred advice services that provide taxpayers with value for money. The document outlines the vision for joint policy and funding approaches and means of understanding the advice needs of people in Wales. It incorporates extended telephone advice services, joint commissioning of advice services to deliver these in line with the recommendations in *Making the Connections*.

In keeping with joined up approaches and cross cutting objectives, the Deputy Minister for Social Justice's *Review of Over-indebtedness in Wales* (2005) highlighted the role that Citizens Advice services play in dealing with personal debt problems. It firmly acknowledged the impact debt problems have on health, particularly mental health. The review points out that this hinders the effectiveness of the government's economic and social policies, which also include *The Revised Adult Mental Health Service Framework and Action Plan for Wales - Adult Mental Health Services: Raising the Standard* (2005). Evidence from the Social Exclusion Unit's publication *Action on Debt* (2004) further illustrates the bearing debt has on a person's health and the remit provided to the department by the government to reduce social exclusion by producing 'joined up solutions to joined up problems' (Kempson et al, 2000). Policy approaches that recognise underlying socio-economic determinants of health are reflected in the National Assembly for Wales' commitment to tackle health inequalities as one of the key aims of its health policy - *Improving Health in Wales: A Plan for the NHS in Wales with its Partners* (2001).

At a broader level of jurisdiction that encompasses the whole of the United Kingdom, in 2001 the Secretary of State for Trade and Industry announced a review of the *Consumer Credit Act of 1974*, which led to the White Paper - *Fair, Clear and Competitive - The Consumer Credit Market in the Twenty First Century* (2003). Again reflecting a joined up approach, the paper considers how government, industry and consumer representatives and advisers can work together. Consultation for the review included a wide range of stakeholders from the credit industry, local government and consumer groups. Adopting an outward looking approach, research evidence was gathered from the USA, UK, France and Germany (DTI, 2004a). Emerging from this is the Department for Trade and Industry (DTI) and Department for Work and Pensions (DWP) paper *Tackling Over-indebtedness - Action Plan* (2004c) and *Tackling Over indebtedness Annual Reports*, plus a Bill (Consumer Credit Bill, 2004) to amend the Consumer Credit Act 1974, which extends to whole of the United Kingdom. These reforms enhance consumer rights and redress, strengthen and extend consumer credit regulation and provide debtors with new post contractual information (House of Commons Library, 2005). Citizens Advice became one of the first consumer bodies in July 2004 under the new 'super-complaints' process,

introduced in the *Enterprise Act 2002*, which allows designated consumer bodies to fast track consumer complaints (HM Treasury, 2004a).

Under New Labour's modernisation plans, the formation of evidence bases that draw on international models and practice became conventional. The need for 'outward looking' policy is reflected in the level of attention paid to 'lessons learnt' from abroad in the aforementioned consumer credit reforms.

The DTI's attempts to tackle over-indebtedness in the UK resulted in £45 million allocated from Financial Inclusion Funding to increase face to face debt advice in England and Wales between 2006-2008 (Annual Report, 2006). A total of 37 debt advisors were appointed in Wales as a result of awards to Citizens Advice Cymru under the Department for Business Enterprise and Regulatory Reform awards in association with the Ministry of Justice and DWP (2007). Additionally, the DTI worked closely with Citizens Advice, AdviceUK, the Money Advice Trust and the Advice Services Alliance, who represent the majority of existing advice providers in the UK. They also set up a sister project with the Legal Services Commission to set up pilots that would target outreach money advice to groups at risk from financial exclusion who would not normally seek help from debt advice services (HM Treasury, 2004a).

In keeping with these changes the Legal Service Commission seek to develop legal and advice services directed at those most in need. Indicative of modern policy approaches, centrally, legal advocacy should 'lift' people out of social exclusion by empowering individuals and communities and giving them a voice (Genn et al, 2004).

The new Community Legal Services Strategy for Wales *Making Legal Rights a Reality in Wales* (2007) aims to develop new networks of expertise and more joined-up legal aid services in Wales. In recognising that people often need advice for 'clusters' of problems, for example those with benefit issues often also have problems with debt or housing, the new approach should provide a seamless service that includes basic and specialist advice, plus representation and advice in the highest courts where needed. However, these services will be commissioned through an open

tendering process, which places Citizens Advice in a highly competitive environment where in future it will be tendering alongside other advice services and new operators that may be brought in from outside the area.

Clearly advice services play an important role assisting the social policy agendas of the Welsh Assembly Government, and local and national government objectives. Naturally, the key policy priorities of Citizens Advice have evolved in line with the various directives. The ‘Citizens Advice Access Strategy’ (2004-2008) aims to ensure those in greatest need receive the most appropriate help. It outlines approaches to enable the development of new and improved channels of access to the service, to increase capacity, improve efficiency and work more closely with other organisations. Since the research project began, the Citizens Advice Strategy 2008 to 2011 has been published. Its twin objectives are to continue to improve access to the service but also to play a “central role in tackling injustice, reducing poverty and social exclusion, and enabling people to realise their full potential” (Citizens Advice Service Strategy, 2008 – 2011: 3).

The modern war against poverty has been fought through campaigns based on rights strategies that differ conceptually from administrative reformism. Fundamentally, rights based reformism is rooted in the notion that those rights are a feature of a contractarian relationship between the individual and the state, and as such should empower the disadvantaged and oppressed (Dean, 2002: 204). Yet as Piven and Cloward (1977) assert, regardless of the hardships they may suffer, ordinary people usually remain acquiescent, they blame God or they blame themselves for their problems. The authors argue that “only under exceptional conditions are the lower classes afforded the socially determined opportunity to press for their own class interests” (ibid, reproduced 2008: 171). The rise of social movements, defined by Tilly (1984) as “a sustained *interaction* between a specific set of authorities and various spokespersons for a given challenge to those authorities” (reproduced 2008: 187) has created a proliferation of associations that operate as vehicles of action – as noted earlier. Yet, the erosion of funding and obligation to contractual arrangements puts many groups, particularly those at ‘grass roots’ level, in a position where their independence and existence is in jeopardy. Smaller groups are at even greater risk if

they fail to compete for funding against major charitable providers, such as Citizens Advice. Consequently, while the focus of this thesis is on the Citizens Advice service, the issues that it faces are generalizable to a much broader group of advice providers and those fighting injustice.

It seems that despite the emergence of the British Law Centre movement in the 1980s and the growth of a broad range of community initiatives, stringent eligibility criteria for legal aid has effectively reduced the number of people who qualify for assistance and gradually eroded the capacity of advice services, forcing increased reliance on funding from the Legal Services Commission. Increasingly, delivery is provided under block contracts from a mixed economy of providers from the private and not for profit sectors (Dean, 2002). By commissioning third sector organisations to deliver public services the government hopes new forms of partnership and new models of service delivery will emerge. Of course, this is not an entirely new concept. Fundamentally, Thatcher's programme of 'rolling back the state' (Hudson and Lowe, 2004) resulted in a reversal of post war reforms that had set out to increase state intervention. Continuing reconstruction of the welfare state in the UK has created transformations in managerial practices of organisational control, which have impacted significantly on advice providers, resulting in what has been characterized as quasi-market arrangements, greater emphasis on decentralisation, and a constant emphasis on the need to improve quality and meet the wishes of the customer (Clarke and Newman, 1997). Critically though, as Hudson and Lowe (2009) point out, there is little evidence to suggest 'market' philosophies and new public management practices have resulted in improvements, and despite attempts to alleviate bureaucratic control such practices appear to require even greater external regulation.

Fundamentally, the influences of contractualisation and new public managerialism give rise to a situation where advocacy groups may feel the need to 'toe the party line' in order to win contracts, or their campaigning activity may simply be curtailed due to the financial constraints placed upon them.

Whilst there is a sizable literature on the topic of resource mobilisation theory and the organisation of social movements, it is particularly pertinent that commentators from

that field propose the growth of capitalism and modern states has destroyed small solidarity groups and the autonomy they enjoyed, giving rise to larger national political arenas for protest where those organisations with bureaucratic structures are likely to enjoy more success (Jenkins, 2008). Traditionally, a situation of this kind creates advantages for larger organisations like Citizens Advice as they seek improve the policies and practices that affect people's lives through their campaigning activity. However, this inadvertently puts smaller groups at a disadvantage as they struggle to be heard and to gain funding for their activities. Nevertheless, Citizens Advice and its bureaux are not free from risk.

One immense challenge facing the service is that of funding. Citizens Advice Cymru and each of its member bureaux are reliant on funding from a wide range of sources. In their annual report of 2006/07 Citizens Advice Cymru reported that the majority of its funding was provided by government grants (£39,509,000) and a range of other grants (£2,008,000), plus public body grants (£1,346,000). However, it also received income from its trading activities (£2,391,000), training and support provision (£766,000), from donations (£30,000), bank interest (£446,000) and other incoming resources (£196,000).

In the same year, Citizens Advice Bureaux received the majority of their funding from unitary authorities (£2,969,378) and the legal services commission (£2,141,928), whilst (in order of magnitude) funding was also provided by the Financial Inclusion Fund (£809,921), the Welsh Assembly Government (£749,479), European funding (£337,190), the Big Lottery (£332,127), charitable trusts (£255,926) and other public sector sources (£158,451), Citizens Advice (£122,793), equalities sources (£113,250), Town and Community councils (£89,347), other sources (£87,187), health sources (£47,816), the corporate sector (£41,297) and trading (£5,536). It is worth noting the comparatively small sums donated by Citizens Advice to bureaux. Importantly both Citizens Advice and its bureaux are accountable to a large number of financial stakeholders.

The implications for services reliant on short term funding streams underpins the imperative for this research, which was formulated, in part, on the notion that

independent research will inform the wider public and those with a stake in the service of the value of advice in terms of its impact on the lives of individuals.

Evaluation of advice projects has increased in frequency, as the financial stakeholders of these services increasingly require evidence of the effectiveness and efficiency of projects and a return on their investment. Accordingly, advice services have recognised the importance of providing evidence on the impact and outcomes of their work in order to gain recognition and secure funding (Stone, 2006). There was undoubtedly expectation on the part of Citizens Advice Cymru that the research will help to secure future funding. This is not altogether unrealistic as the outcomes of an evaluation study by Borland in 2004 did, in fact, help to secure long term funding for the service evaluated – the Better Advice: Better Health service that now provides advice in primary care settings across Wales.

Tracking the impact and outcomes of the advice process and advice outcomes on a cohort of clients over time, patterns of change or stability in health and other aspects of an individual's life can be measured between time points. Drawing upon the experience of clients receiving CAB advice, the study plots changes over a period of twelve months beginning with data collection at baseline when clients first approached a bureau for help with their problem.

Baseline data was gathered during the first advice interview clients attended with their advisor. Baseline information is essential to the process of understanding subsequent change or non-change in key research areas. The baseline study addressed a number of key objectives:

- i. To identify how clients accessed the CAB service and their levels of satisfaction with access and information about the service.
- ii. To draw together demographic data on the cohort.
- iii. To analyse the problems for which clients were seeking advice. In the case of debt, to acquire information about the type of debts, total amount

of debts and length of time clients had been in arrears. In the case of welfare benefits problems, to gather details of welfare benefit applications or appeals against the loss of benefits.

- iv. To gain insight into any financial difficulties experienced by clients during the previous year using indicators of financial difficulty.
- v. To measure dimensions of health using the Short Form 36 (SF-36).
- vi. To measure levels of anxiety and depression using the Hospital Anxiety and Depression Scale (HADS).
- vii. To determine the incidence of long-term illness, disability, and health conditions in the cohort.
- viii. To learn about levels of social support and social isolation experienced by clients.

In summary, the base line study broadly covered three areas aimed at determining health, signs of financial and social exclusion plus information about the problem(s) for which clients were seeking advice.

Respondents were invited to participate in follow up studies, occurring at six and twelve months after the baseline study. These data collection points are referred to as wave 2 and wave 3; at these points the study addressed the following key objectives:

- i. To measure changes in dimensions of health using the Short Form 36 (SF-36) and Hospital Anxiety and Depression Scale (HADS), to determine if the health of clients improved between baseline, wave 2 and wave 3.
- ii. Report total quantifiable outcomes such as gains from welfare benefits, debts managed and other outcomes acquired for clients during the study.



- iii. To analyse how improvements in client's financial circumstances impacted on aspects of personal spending, and learn about the broader implications for their quality of life.
- iv. To analyse how improvements in client's financial circumstances impacted on aspects of spending on their dependent children, and the broader implications of these improvements for the quality of life of the child.
- v. To learn about factors that influenced the decision to pursue the advice provided CAB.
- vi. To learn about any difficulties clients may have experienced accessing the CAB service over the prolonged period of time generally associated with casework advice.
- vii. To establish if clients followed CAB advice and determine if the problem(s), for which they sought advice, was resolved.
- viii. To learn about clients personal experiences of working with CAB to resolve their problem(s).

Additionally, as a consequence of emerging research questions, at wave 3 the research sought to learn about precipitating events that may have caused or triggered the problem(s) for which clients sought advice, and to gain insights into how these problem(s) affected clients prior to them seeking advice.

### **Structure and Format of the Thesis**

This thesis is presented in three parts: Part One provides a review of the literature concerned with advice. The limitations of existing evidence are considered in order that the direction which informed this study is justified. Part Two is concerned with the research process and findings. Part Three presents the research conclusions. A summary of each chapter contained in the thesis follows.

Chapter 1 reviews the literature concerned with Welfare Rights advice. It begins by providing an outline of the historical development of services in primary care settings. The chapter discusses key aspects of the literature thematically, starting with problems of access to advice services and the characteristics of those using such services. The chapter examines a number of methodological issues that researchers have faced in attempting to measure changes in the health of those receiving advice for their problems. The extent of welfare benefit under-claiming is discussed and the financial outcomes of welfare benefits advice examined, plus the wider implications of advice for the quality of life of individuals.

Chapter 2 begins with an introduction to the literature concerned with personal debt and discusses popular definitions of debt. Debates surrounding the existence of a 'debt problem' in the UK are summarised and as evidence of the extent of the problem, statistics are provided regarding levels of personal debt in the UK. A number of multifaceted explanations of debt exist, some of which reflect historical attitudes towards the poor discussed already. The chapter ends with a review of the literature concerning the impact of debt advice, which until very recently had received little attention.

Chapter 3 begins by discussing issues which shaped the research process. It documents the conceptual underpinnings of its quantitative longitudinal design and describes all aspects of research methodology. Ethical issues and early preparatory measures, which included a baseline pilot study and training programme for CAB staff are discussed. The chapter concludes by describing techniques adopted for the analysis of data.

Chapter 4 describes the process of getting in, getting on, getting out and getting back into CABx in order to conduct the research (Buchanan et al, 1988). Drawing on excerpts from the research diary, it can be seen that this aspect of the study was particularly challenging. The results of sampling and panel attrition are provided.

Chapter 5 is concerned with the findings of the baseline study. This chapter begins with a profile of respondents and the problems for which they sought advice. It gives insights into prevalent financial difficulties reported by respondents and aspects of material disadvantage. The chapter ends with an assessment of their health and social wellbeing, and gives an outline of the reasons why some respondents felt isolated or cut off from society.

Chapter 6 compares the characteristics of those who left the study and those who remained in the latter stages to establish if particular respondent groups were more likely to withdraw from the research than others. The chapter provides a retrospective account of precipitating events that respondents attributed to triggering or causing the problems for which they sought advice. The rationale for beginning with a retrospective account is that it provides context to emerging findings and bridges a gap in the baseline study.

Chapter 7 reports the key findings from wave 2 and wave 3 of the research concerned with the impact of advice on health, financial wellbeing, and quality of life. Beginning with a focus on the impact of advice on respondents' health, the chapter sets out findings from the SF-36 and HADS questionnaires. A summary is provided of practical gains and financial outcomes acquired for respondents' during the period of the study. Improvements to financial and material wellbeing are discussed, and where relevant the impact this had on respondents' children. The chapter ends with an account of the impact of advice on their quality of life.

Chapter 8 is concerned with respondents' experiences with CAB and their perceptions of the quality of service they received.

Chapter 9 summarises and synthesises key empirical findings. The strengths and limitations of the study are reflected upon. Implications for policy are discussed, conclusions formulated and a number of recommendations made. The chapter concludes with directions for future research and some final reflections upon the journey undertaken.

# CHAPTER ONE

## Welfare Rights Advice

This chapter begins with a historical account of developments in the provision of advice in primary care. Biopsychosocial models of medical care, discussed earlier, stimulated academic interest in the role advice services can play in reducing social and economic inequalities. Whilst these models are prevalent today, their appropriateness has been challenged over the years. The growing emphasis on policy ‘evaluation’, ‘review’ and the notion of ‘learning lessons’ that emerged with the idea of modernisation of the policy making process (Cabinet Office, 1999) has been instrumental in stimulating a plethora of evaluations of primary care welfare rights advice services. Due to the extensive range of published and unpublished research on the topic, the chapter draws selectively on aspects of the literature of central importance to the thesis. It introduces a number of key theoretical and methodological issues found in the literature on welfare rights advice, which will be examined thematically; namely, the rationale for primary care advice, issues of access to advice, and the impact of advice on health, financial wellbeing and consequential improvements to quality of life.

### **The Development of Welfare Rights Advice in Primary Care**

Interest in the provision of advice in primary care as a means of reducing financial hardship and social inequality arose from an article written by Jarman, published in the British Medical Journal (BMJ) in 1985, about a computerised system developed to assist advisors providing welfare benefits advice in General Practice. Jarman argued that general practitioners (GP) and health workers are well placed to recognise financial hardship but not equipped to provide advice on such matters, it was suggested that providing advice where lack of information is detrimental to health might be the proper function of general practitioners and health centres. This early work is important as it draws attention to the relationship between poor health diagnosed by doctors, in this instance primary diagnosis using the International Classification of Diseases, and patients’ social circumstances and financial problems. Explicitly instrumental, this creates the notion that advice may alleviate some of the

physical, psychological or social symptoms thought by doctors to be due, in part, to financial stress. However, in this early work patients receiving advice from a welfare rights officer were not asked about improvements to their health, nor were measures of health taken at any point in the study. Consequently no evidence was forthcoming from the study to support the assumption that service users' health improved. Importantly though, this study provided evidence that advice in primary care is feasible, demand exists, and patients benefit financially.

In an era when the extent of welfare benefit under claiming drew attention, research revealed that patients assume their doctor will provide advice on entitlements related to their health conditions (Buckle, 1986). Highlighting the inadequacy of advice provided to patients discharged from hospital, Marks (1988) found half did not receive their full entitlements and nearly a third had debts that were causing severe financial difficulties. Noting that "Many patients are poor because they are ill or disabled; many more are likely to be ill because they are poor", Ennals (1990, 1331-2) supported the aforementioned ideas proposed by Jarman (1985) in his quest to maximise the income of disadvantaged groups, believing this to be effective in promoting health. Yet no empirical evidence was forthcoming to support their claims.

Academic interest in the impact and outcomes of advice as an intervention to alleviate social and financial inequalities gained momentum in the 1990s. Articles for doctors with information on the main areas of the benefits system were published in 1990 to enable doctors to provide patients with practical information and advice about welfare benefit entitlements (Ennals, 1990: 1322). Naturally, some questioned whether it is the function of general practitioners to engage in such activity, and if this is a burden that doctors could do without (Chagger, 1993: 261). Some revealing insights into doctors' attitudes emerged when Dowrick et al (1996) reported problems that doctors believe to be inappropriate for consultation or management by a GP, welfare rights was one of these. However, the link between high practitioner workload and underprivileged groups was already established (Jarman, 1985), as was the role of primary care in facilitating access for patients to welfare benefit entitlements (Buckle, 1986; Marks, 1988; Ennals, 1990). Yet it was Paris and Player's (1993) pioneering study of Citizens Advice services, introduced into 10 general practices in south

Birmingham in 1990, which fuelled discussion about the role of advice services in primary care settings amongst early advocates Jarman (1985) and Ennals (1993). In support Middleton et al (1993: 504) argued “This service can alleviate ill health caused by poverty and the poverty of patients and carers caused by ill health”. Putting forth a claim for future funding for the service, Veitch and Terry (1993: 261) announced the first evaluation to attempt to measure health gains was underway, thus directing attention to health outcomes as a concept of empirical interest in the field of advice.

Since the early 1990s a wide range of funding initiatives has resulted in the provision of advice services in primary care settings. In 1999 the National Association of Citizens Advice Bureaux (NACAB) received £2.million to provide welfare benefits advice in primary care settings. In 2001, Gillam et al reported 30% of primary care trusts surveyed out of a total of 69, provided funding for welfare advice projects. The Better Advice, Better Health (BABH) initiative, piloted between October 2001 and March 2002 in seven areas of Wales, is now fully operational and a key component of the CAB advice service in Wales. The BABH service provides generalist, specialist and welfare benefits advice in primary care settings. These include GP surgeries and community hospitals, home visiting services, and where physical space is limited advice services operate in other secondary outlets.

Whilst academic interest in welfare rights advice in primary care dominates the literature, as mentioned previously, CAB services deal with a litany of client issues. These include consumer rights, utilities, personal debt, money advice, taxation, employment relationships, housing, employment, discrimination and other advice issues. Innovative developments include the creation of specialist services providing advice to particular groups. For instance, Ambrose and Stone (2003) note advice services for people with HIV/AIDS; specialist services offered specifically to Chinese communities; and, specialist advice services for people with mental health problems.

More recently, academic interest has been directed towards a new trend in targeted services. For example, Reading et al (2002, also in Reading and Reynolds, 2001) refer to advice targeted at families with a child of one year in age or less. Gaskin et al

(2003) evaluated the outcomes of Welfare Benefits advice provided in community mental health services. Attention has also been paid to the needs of older age groups. For example, Toeg (2003) assessed proactive benefits advice targeted at patients of a general practice aged 80 and over. Similarly, Campbell et al (2007) studied specialist welfare benefit advice targeted at those aged 60 and over.

Recent developments include the introduction of screening models to identify and assist potential welfare benefit claimants. In a study of welfare rights services provided for people disabled with arthritis in primary care and hospital settings, Powell et al (2004) discuss this in the context of a modernized NHS. Innovative in nature, one service screened those with high levels of physical disability using the HAQ disability index, which was found this to be a good predictor of eligibility for Attendance Allowance (AA) and Disability Living Allowance (DLA) (Langley et al, 2004). The effectiveness of the HAQ as a tool for identifying patients eligible for benefits is supported by Fruin and Pitt (2008) who tested the instrument in a district general hospital rheumatology centre. Another nurse led welfare benefits screening project located in one of the largest local health care co-operatives in Glasgow found AA screening to be effective in targeting vulnerable client groups, over the age of 64 years, who would normally be excluded from money advice services because of their age, poor health, poverty and limited transport (Hoskins, 2005).

Symbolic of the recognition that they carry, standardised instruments evidently play an important role in empirical research and health practice. Still, Powell et al (2004) stress that future developments depend upon the development of an evidence base to aid the implementation of services of this nature.

Clearly the rationale for advice services in primary care is supported by user demand, and the notion that health and social services should work together to provide a seamless service for patients (Greasley and Small, 2005).

The extent to which general practitioners are consulted by their patients for advice, highlighted earlier in the literature, is supported most recently by findings from the 2004 English and Welsh Civil and Social Justice Survey (CSJS). This provides

detailed information on people's experiences of legal rights problems and their strategies to resolve them. Analysis of the survey from the year 2004 shows health professionals compared equally with Citizens Advice Bureaux and the Police, each of whom had provided advice to seven percent of respondents. Only solicitors and local authorities were consulted more frequently (sixteen and eleven percent accordingly). Three quarters of those who sought advice from a health professional said it seemed the obvious thing to do (Plesence et al, 2007a). This outcome is in keeping with earlier research and overall these findings support a model of health care that incorporates advice services. Whilst some questioned the role of advice services in primary care, these services have, with time, gained growing recognition. Most importantly many health professionals now see the service as an extension to their practice that saves them a great deal of time (Borland, 2004: 27).

### **Improving Access to Advice Services**

The principal conceptual model which influenced the positioning of advice services in primary care is based, in part, on the view that locating advice services in such settings facilitates access to people who would otherwise be excluded because of their health, age, poverty or poor transport (Galvin et al, 2000). Naturally this raises the question – are primary care services simply replacing high street provision? In answering this question, the literature provides strong evidence that many people with health problems or disabilities are unable to access high street services or simply lack knowledge of CAB services (Borland, 2004). Due to the high proportion of primary care advice users who have poor health or a disability, primary care services appear to be convenient (Coppel et al, 1999).

Access has been found to be important to patients (Borland, 2004), however, the literature provides a number of interrelated explanations. Firstly, clients feel less stigmatized using primary care advice services. Frost (1998) suggests that many people do not understand the system adequately to fill in forms and identify their entitlements but fear the stigma of seeking help from high street services. Primary care staff can dispel these worries and confusion that patients may have about making benefit claims. Secondly though, it has been noted that many patients entitled to



benefits would not see an advice worker if it were not for endorsement or referral by primary care staff (Sherratt et al, 2000). A survey of health service staff in one project found 91% had referred patients to the advice service (Bundy, 2001). Referral by a health professional can add to the legitimacy of a claim (Veitch, 1995). Toeg et al (2003) advocate taking a 'Rights' approach to welfare entitlements. Thirdly, primary care advice provision is reported as being beneficial to health care teams (Coppel et al, 1999; Galvin et al, 2000; Sherratt et al, 2000; Borland, 2004; Caiels and Thurston, 2005; Greasley and Small, 2005b). Research on practices without advice services has shown patients are more likely to approach their GP instead for advice. Harding et al (2002) argue that Welfare rights advice improves the practice's ability to meet welfare needs. Those with advice services find referral easy and say it enhances their ability to practice effectively (Harding et al, 2003). Whilst it also saves office and reception staff time, and health professional's time addressing patients' socio economic needs (Greasley and Small, 2005b).

The situation for clients in rural areas who wish to access advice services is exacerbated by cost, the inadequacy of public transport and daunting prospect of long travel distances. Bureaux in rural areas face the challenge of serving remote and scattered populations, which can manifest in many ways. Recognising their unique and idiosyncratic experiences, a study of bureau managers in rural Cornwall and Devon found these services face higher running costs, particularly in relation to travel. A good example which illustrates the extent of this cost comes from one bureau that dedicated over half their budget to travelling expenses. They also faced problems recruiting and retaining staff, sourcing suitable buildings for their services, and managing a greater number of services across dispersed locations. Most operated for short periods of just a couple of hours a week. As a consequence, potential clients found the service closed for a substantial part of the week, causing some to complain that it was inaccessible (Blackwell et al, 1990).

More recently Galvin et al (2000) conducted an illuminating evaluation of new primary care CABx services that drew data from five users of a rural service and five from those in urban settings. The size of sample necessitates some caution when interpreting the results, however, for those in rural settings transport and distances

were problematic, despite the service being located in general practice. Although all participants (rural and urban) were aware of high street CABx, none knew of the service offered in their surgery. Whilst some had used CAB in the past, the majority said they did not know how to access a CAB and until referral had coped with their problems alone.

In summary, although primary care services have to some extent improved access to advice for many people, awareness of the CAB service as a whole remains problematic. Many people do not know how to access the service or face problems doing so. Narrow in focus, the literature to date is predominantly concerned with access within a primary care setting. Little is known about the extent to which access to services may be problematic in other ways and in other settings. In the absence of comprehensive longitudinal data it is not possible to determine what barriers exist for those with complex issues that are lengthily to resolve and may require repeated communication or visits to a bureau over prolonged periods with an advisor.

### **Who uses Welfare Benefits Advice?**

The positioning advice services in primary care grew out of the logic emerging from determinants of health discourse, and in response to health and social inequalities identified in recent years across areas of the UK. In response to the mantra of evaluation, review and learning lessons (Cabinet Office, 1999) providing evidence that services do, in fact, meet the needs of the most vulnerable groups has become imperative. In recognising that advice services should be targeted at those most in need, one important outcome to emerge from recent evaluations is much needed data, notably absent from CABx and Citizens Advice, on the social characteristics of users of these services.

The literature on this topic reflects, to some extent, the prevalence of studies undertaken in primary care settings. Users of these services tend to be older; many suffer with poor health and a disproportionately high number report long term health problems or disabilities. Reflecting these circumstances a high proportion is economically inactive. It is evident that primary care advice services meet the needs

of those from lower socio-economic groups, a situation that was first documented by Paris and Player (1993). Indicative of social status, they found a high proportion of service users rented their home and a very high proportion of working age were economically inactive - only a third depended on wages as income. Similarly, Coppel et al (1999)<sup>2</sup> reported high levels of unemployment amongst service users; 91% were dependent upon social security benefits or state pension as their main source of income, despite nearly three quarters being under fifty years of age. Symptomatic of health status, a high incidence of enquiries came from new clients reporting a disability, whose claims most frequently concerned disability entitlements.

In keeping with others Abbot and Hobby (2003) reported high levels of economic inactivity and poor health despite half their sample of 345 research subjects being between 45 and 64 years of age. Three quarters had a long standing illness that limited daily activity and half reported a physical disability, related to which more than half sought advice for disability living allowance. Providing further insights into social status, approximately half the sample rented their home.

Further important contributions arise in the work of Greasley and Small (2005) who undertook an evaluation of welfare rights advice services across 30 general practices in inner Bradford. Importantly, the scale of this research suggests that primary care advice services meet the needs of those from lower socio economic groups, an aspiration based on the premise that this may in turn address social, economic and health inequalities. Illustrative of the scale of the service and degree of need for such services, advisors dealt with 2484 patients and over 4000 welfare advice issues over 24 months. The majority of patients were over 40 years and a quarter was over 60. A third was disabled, nearly as many were incapable of work and only six percent were employed full time.

Establishing how closely the social characteristics of those using primary care services reflect the users of the whole CAB service is complex. It is reasonable to hypothesise that those seeking advice from a primary care advice service are more

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<sup>2</sup> Datum was collected retrospectively from 416 clients over 11 months and prospectively from 34 over three months in an evaluation of a dedicated advice service at an inner city health centre providing welfare benefits advice.

likely to have health problems, and because of their health the likely hood of economic inactivity increases. Many services set out to target the most deprived areas. As noted earlier, the links between poor health and socio-economic status are complex but well known. It is already evident from the literature that some services actively screen or select clients most in need according to their health status. It is natural that those referred to CAB services by health professionals are more likely to have health problems.

Whilst the literature provides some helpful insights into the social characteristics of those using welfare rights services in primary care, no data exists for Wales. Despite a large scale study of the Citizens Advice Better Advice: Better Health Service in 2004, the social characteristics of those using the service was not recorded. It is understandable that Citizens Advice does not routinely publish this data. It would not be in keeping with the ethos of an organisation whose relationships with its clients relies heavily on trust and confidentiality to overtly advertise the social characteristics of its client group. However, recognising the importance of providing independent accounts, advice services increasingly require evidence that they are reaching out to the most vulnerable groups, but there is currently little evidence of this in Wales.

### **Evidence of the Impact of Advice on Health**

Utilising various theoretical perspectives and methodological approaches research has sought to illustrate the impact advice can have on a person's health. Testifying to determinants of health discourse, it is hypothesised that social and economic deprivation can be alleviated as a consequence of advice about welfare rights, money issues and personal debt. Thus, improvements in health may occur. Consequently, providing empirical evidence of health gains has been of central importance to academics, whilst policy maker and those with a financial stake in the Citizens Advice service take great interest in the subject.

In keeping with what has been discussed so far, evidence to date emerges predominantly from research conducted in health care settings. Despite a noticeable focus on welfare rights advice many services also provide advice on other issues.

Greasley (2003: 18), for example, found clients were also referred for problems with housing, immigration, debt and money, employment and other issues. This was highlighted also by Galvin et al (2000: 281) in an illuminating evaluation of Citizens Advice Bureaux in general practice, where it was found that: "The majority of consultations related to financial and social problems, they were not dominated by benefit claims alone." Health as a concept of empirical evidence has also been explored, albeit to a lesser extent, by those interested in alternative areas of advice. For instance, the impact of housing advice on health was explored by Austin et al (1993) and Blackman et al (2003).

The findings to date suggest that advice may alleviate some of the stress and anxiety associated with money worries experienced by those living on a low income and those with debt problems. There are indicators that this may result in health gains such as improvements to psychosocial health and even some aspects of physical health, hence the emergence of these concepts as of areas of empirical interest. Numerous studies have attempted to document the impact of advice on health; however, much of the evidence to date is anecdotal and inconclusive.

Whilst design and methodological approaches have varied, three strands emerge in the literature. Firstly, those employing standardised health outcome measures with self reported inventories. Within the literature, numerous standardised instruments can be found. These include for example, the Nottingham Health Profile (NHP) which was originally developed for use in epidemiology studies of health and disease (Hunt and McEwan, 1980) ; the General Health Questionnaire (GHQ) (Goldberg and Hillier, 1978); and, Short Form 36 (SF-36) (Ware et al, 2000), which all measure a number of dimensions of health. In order to measure changes in anxiety and depression the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983) has been used.

Secondly, qualitative approaches illustrate the complexity of measuring health outcomes. Studies adopting mixed methods approaches have reported discrepant findings which show many anecdotal improvements to health that cannot be verified with standardised instruments (Moffatt et al, 2006b). This has led to a growing

awareness of the subjective meaning attached to the concept of health, which provides further justification for methodological approaches that rely less upon respondent interpretation.

Thirdly and more frequently, researchers have undertaken structured interviews using in-house questionnaires administered to advice recipients at a single time point after the advice session. The outcomes of these studies have produced evidence of positive improvements in health as a result of advice intervention; however, they have also been criticised for a lack of robustness in methodology (Adams et al, 2006) as it is argued they rely heavily on questions engineered to produce positive responses. These outcomes may be interpreted as ‘health related quality of life’ outcomes and capture many of the ‘softer’ but important impacts of advice.

These three strands of evidence in the literature will be discussed in turn.

### **Measuring Health Gains with Standardised Instruments**

The first in this field to document measures of health using standardised instruments was Veitch (1995). Since then others have followed in their aspiration to track changes in the health of clients of advice services. Of central importance to this study is the work of Abbott & Hobby (1999); Emanuel & Begum (2000); Grant et al (2000); Reading and Reynolds (2001); Abbott and Hobby (2002) and Greasley (2003).

In addition to providing insights into the impact of advice on health, they provide important methodological accounts of the instruments used, the number of data collection points and time frame for data collection. In order to track changes in health over time, data was gathered at baseline plus one or two additional time points over a timeframe predominantly of up to twelve months. Naturally, longitudinal research of this kind is prone to attrition, a problem that has beleaguered studies in this field; nevertheless, final sample sizes ranging from 22 to 245 respondents have been reported. Mounting evidence suggests that a person’s health can improve as a consequence of advice but small sample sizes and methodological problems have

impacted on results, consequently to date the outcomes are inconclusive. Providing further insights is a more rigorous investigation of the literature.

Referring first to pioneering research conducted by Veitch (1995) with Birmingham District CAB, this study prompted a trend in the use of validated health outcome measures by virtue of its use of the Nottingham Health Profile (NHP). The NHP is concerned with 6 health dimensions including pain, physical mobility, emotional reactions, energy, social isolation and sleep. It also assesses daily problems (Hunt and McEwan, 1980). Having administered the NHP at baseline and in a six month follow up study, improvements were observed in the health status of the sample, but the outcomes were inconclusive. The author concluded that the sample size of 52 was too small to produce statistically significant results, the instrument lacked sensitivity and there were no controls for extraneous factors. Criticisms were also directed at the six month follow up study, which the author believed to be inadequate for any change to transpire. However, although it is necessary to consider the time required for cases to be concluded, subsequent research has found improvements in the health of respondents at six months, which provides strong support for the author's critical assessment of the NHP but highlights flaws in judgements made about the six month follow up. More recent evidence from validity assessments highlights some weaknesses with the NHP. Score distributions are prone to skew, which complicates the interpretation of extreme scores and impairs the detection of change or difference (Wann-Hansson, 2008). This highlights the importance of selecting a tool that is proven to be effective in the field in which it will be administered.

Following the introduction of health outcome measures to studies in the field, research of central relevance to this thesis can be found in the work of Abbott and Hobby (1999) who administered the Short Form 36 (SF-36) to a sample of 48 people receiving welfare rights advice. The SF-36 is a general health scale questionnaire with 36 questions grouped into eight health domains: physical functioning, role functioning, bodily pain, self reported general health, vitality, social functioning, and role emotional and mental health. Widely acknowledged, the SF-36 has a record of sensitivity that allows it to detect statistically significant changes in health in a range of settings (Ware et al, 2001). Consistent with this, the authors reported statistically

significant improvements in *Vitality, Role Emotional* and *Mental Health* domains of the SF-36 in those clients whose income had increased as a consequence of advice at the second data collection point undertaken at 6 months. Thus, claims by Veitch (1995) that six months is insufficient for improvements to health to occur were proven to be unfounded. However, Abbott and Hobby (1999) found improvements detected at six months were not sustained at a statistically significant level at twelve months, although scores did generally remain higher than at baseline. It is worth noting that statistics at the twelve month follow up are based on a sample of 24, which naturally impedes interpretation. In light of its superior properties to the NHP (Wann-Hanson et al, 2008) it is unlikely that the SF-36 instrument can be faulted. It has been suggested by Abbott and Hobby (1999) that the results may be due to chronic morbidity in the client group. In light of the social characteristics and poor health of many advice service users, it is understandable that their health may deteriorate over time. Alternatively perhaps, extra money provides little more than short lived contentment.

Contributing to the field, Emanuel and Begum (2000) administered the Measure Yourself Medical Outcome Profile (MYMOP) and the Hospital Anxiety and Depression Scale (HADS) to users of a CAB service in primary care. In contrast to earlier studies, data was collected at nine months following the baseline study. Fifty five participants were sampled, of which 32 completed the MYMOP. Forty remained in the final sample but outcomes from the HADS provide limited insights as it was only completed by 12 respondents. The HAD scale measures mild degrees of mood disorder, anxiety and depression. Scores showed a slight reduction in anxiety and depression but, not surprisingly due to the sample size, the statistics were not statistically significant. The MYMOP profile produced improvements in two areas: activity and wellbeing but results were not statistically significant. Whilst sample size is important for test statistics, there is another possible explanation for this outcome; the MYMOP is a symptom based assessment tool which requires respondents to identify symptoms that are important and then activities of daily living that are affected by illness and self reported general health. As a problem specific instrument it not suitable for people who cannot focus on a particular health problem during the assessment. In keeping with Veitch (1995), it is likely that small samples affected the



statistics, but the suitability of the MYMOP is also to be questioned. It is also relevant that like Abbott and Hobby (1999), the authors note higher levels of morbidity in the sample who received income compared to those who did not; therefore, improvements in health are less likely to occur (Emanuel and Begum, 2000).

Various frameworks for understanding the outcomes and benefits of advice can be found within the literature. Like Emanuel and Begum (2000), Grant et al (2000) administered the HADS. This time a Randomised Controlled Trial was undertaken with 161 patients identified by their GPs as having psychosocial problems. Patients were randomised between two groups, one was a liaison organisation whose aim was to facilitate contact between voluntary sector organisations and primary care, and the second randomised group were referred to general practitioner care. Respondents were also assessed for social support using the Duke-UNC functional social support questionnaire and quality of life measures, using the Dartmouth COOP/WONCA functional health assessment charts and the Delighted-terrible faces scale.

Assessment occurred at baseline, and at one month and four months after referral. One hundred and ten respondents remained in the study at the four month assessment. The group randomised to the advocacy referral group showed significant improvements in anxiety ( $n = 62$ ) compared to the group referred to their GP. No difference was found in the depression scale or perceived social support. However, other improvements were found in emotional feelings, ability to carry out everyday activities, feelings about general health and quality of life.

This research illustrates the potential benefits to mental health and wellbeing of specialist help as opposed to routine care by general practitioners, although the former was a more costly option. However, it is not possible to determine from this research the exact nature of help and advice provided by the large number of voluntary service contacts the referral agency used. Referral services included, for example, the CAB, a local Meet a Mum Association, Royal British Legion, National Schizophrenia Fellowship, Counselling on Alcohol and Drugs, Alcoholics Anonymous, Over Eaters Anonymous, Triumph over Phobia, and many more distinctly different services. Consequently it is not possible to isolate the exact nature of the intervention and

related health outcome to a specific source. Nor is it possible to determine how many respondents of the 90 randomised to the referral service received advice from services such as the CAB.

Combining the experiences of researchers in the field, it is evident that panel attrition is problematic, the implication being that health benefits cannot be demonstrated with certainty. With the exception of research by Grant et al (2000) the literature reviewed so far has focused on income maximisation advice provided by advisors in health settings. These studies draw largely on older populations and/or those in very poor health. Thus the researcher is presented with the challenge of attempting to measure improvements in health in samples with high levels of morbidity.

In light of this, Reading and Reynolds (2001) make an important contribution to the current base of evidence that exists into the impact of advice on health. Divergent in reach, they examined the impact of CAB advice provided on a range of issues, not just welfare benefits advice, to mothers with young children of less than one year of age. The sample was recruited from six urban general practices in Norwich over a nine month period between 1997 and 1998 and represented a socially diverse population representative to UK and local populations, although relatively deprived. A range of demographic, social and health data was collected which included the Edinburgh Post Natal and Depression Scale (EPDS). A reliable and sensitive tool used to screen for depression in new mothers, it has been validated for use in the community (Cox et al, 1987). The questionnaire was completed by 261 respondents at baseline and 219 six months later at wave two. Of these, 209 completed both waves. EPDS scores of 13 or more indicate a depressive illness. Importantly, it was found that scores were closely related with socioeconomic circumstances. A slight improvement was found in those who completed both waves of study but those with scores indicating depression and poor socioeconomic indicators were less likely to participate in the second wave of the study. Of those with a score of 13 or higher, 65% returned the follow up questionnaire compared with 84% of those scoring less than 13. This suggests that a different outcome may have occurred had the entire sample completed both waves of study. The authors conclude that the results support a full scale evaluation but none has been forthcoming. Whilst this thesis draws data from a full

spectrum of age groups, respondents with children will be identified, where relevant, in the hope that further insights will be gained into the broader impact of advice for those with dependent children.

Small sample sizes have plagued research and whilst a trend in health improvements is observable, due to small samples the results are rarely statistically significant. Consequently, with an initial sample of 345 respondents, research conducted by Abbott et al (2002) provides important insights into the outcomes of working with a larger sample. Building on their earlier work (Abbott and Hobby, 1999), the authors conducted a longitudinal observational study to measure change in the individual health of clients who received increased income as a result of welfare benefits advice. The initial sample of 345 declined to 245 clients at six months and 201 at twelve months. This sample is the largest of all of the key studies that directly relate to this research. The SF-36 was once again adopted but this time a quasi control group was constructed consisting of those who did not gain new income. Despite successfully retaining a good sample, the results were yet again inconclusive; although they do correlate with outcomes of an earlier study (Abbott and Hobby 1999).

Statistically significant improvements were found at the second data collection point which took place at **six months** in SF-36 scores for both groups in *Role Physical* and *Social Functioning* domains. Statistically significant improvements also occurred in *Role Emotional* and *Bodily Pain* domains for those whose income increased. Interestingly, although the *Vitality* domain did not improve significantly, improvements occurred for those receiving increased income. Conversely, *Vitality* scores decreased for those who didn't. Thus the difference between groups in the *Vitality* domain became statistically significant at six months, although this difference was not maintained at twelve months.

At the third data collection point at **twelve months**, statistically significant improvements were found between baseline scores in the domains of *Role Physical* and *Bodily Pain* for both groups. The group who received additional income also had statistically significant improvements in *Social Functioning*, *Role Emotional* and

*Mental Health* domains. Overall, the difference between groups in change over time since baseline was statistically significant in the *Mental Health domain*.

In light of these findings Abbott and Hobby (2002) suggest *Vitality* and *Mental health* appear to be most closely associated with increased income. The difference between groups at six months was most noticeable in the *Vitality* domain and at twelve months in the *Mental Health* domain.

Explicitly building upon this with a replica study and intentionally larger sample, Greasley and Small (2002) administered the SF-36 and incorporated the HADS - previously adopted by Emanuel and Begum (2000). Following Abbott and Hobby's (1999, 2002) design they incorporated three data collection points at baseline, six and twelve months at advice services located in primary care practices across inner city Bradford.

Despite intentions of acquiring a larger sample, during an eight month period where advisors saw 717 clients, only 132 (18%) had completed the initial questionnaire, 64 (48%) completed the six month follow up and 36 people participated in the third wave of the study at twelve months. At this point, respondents were discounted from the sample if they reported that the problem for which they were seeking advice had no bearing on their health or if they believed the advice had not helped them. Accordingly 22 remained in the final sample.

Nevertheless, significant improvements were reported in the SF-36 *General Health* and *Mental Health* domains when comparing scores between baseline, six and twelve months follow up surveys. Previously, Abbott and Hobby (2002) also found statistically significant improvements in *Mental Health* at **twelve months**.

Improvements in the domains of *Vitality* and *Social Functioning* were close to significant. Greasley (2003: 38), in contrast to Abbott and Hobby (2005: 6) concluded that advice cannot be expected to impact on bodily pain.

With regard to outcomes from the HADS questionnaire, a reduction (improvement) was found in the HADS anxiety scale of borderline significance. Naturally, due to the small size of this sample which stood at 22 clients the results should be treated with caution. However, this outcome supports previous research by Grant et al (2000) who reported statically significant improvements in the HADS anxiety scale in clients referred to advocacy agencies, although as stated earlier it is not possible to determine the exact nature of the intervention provided by the wide range of agencies included in their study.

With regard to improvements noted by Greasley (2003) in the SF-36 *Mental Health* domain, this outcome is in keeping with Abbott and Hobby (2002) and overall the evidence to date supports the view that gains in health are likely to be psychosocial rather than physical (Abbott and Hobby, 2000).

More recently, evidence of a positive impact on health emerged in the work of Caiels and Thurston's (2005) who conducted research with CAB general practice service users in health care settings. They administered the SF-12, a shorter version of the SF-36, which measures the same eight domains but in less detail and precision (Ware et al., 1996 cited in Bowling, 1997), however, Jenkinson et al (1997) argue it is comparable with the SF-36 whilst having the advantage of being quicker to complete. Improvements in health were reported but the results were not statistically significant, despite a relatively good sample of 96 respondents. Although there are good reasons for selecting the SF-12 it does not allow the same level of comparison with earlier research that utilised the SF-36. It appears that the authors missed a good opportunity here to build more closely on the work of others in the field.

One final contribution to the literature on this topic emerges in the work of Campbell et al (2007) in the findings of a study exploring the relationships between provision of welfare benefits advice and the health of people aged 60 and over. The authors incorporated the SF-36 and the General Health Questionnaire (GHQ-12) in questionnaires administered to 77 respondents at baseline, 52 of these participated in a follow up study conducted at five months. Results from the SF-36 revealed extremely poor health in the sample and this generally remained unchanged in the follow up

assessment, although statistically significant improvements were found in the GHQ-12 scores. Additionally, statistically significant improvements were found in those who had been newly referred for financial advice compared to those who had previously received an assessment in the SF-36 dimension Role Physical and a single question concerned with change in health

These findings illustrate that some improvements to health can be detected in older age groups. However, the authors question whether the SF-36 scales are sensitive enough to detect small changes to health, particularly as the mental health dimension of the SF-36 correlated with the GHQ-12 scores which appears to possess superior responsiveness. Overall, the results suggest that improvements to mental health can occur as a consequence of welfare benefits advice, although the statistical evidence remains inconclusive.

### **Measuring Health Gains using Mixed Methods**

A recent contribution to the literature illustrates the outcomes of using mixed methods that included a Randomised Controlled Trial (RCT) of welfare rights advice accessed via primary health care. The RCT incorporated the SF-36, HADS, Self Esteem Inventory and a range of additional indicators that were administered at baseline, six, twelve and twenty four months. One hundred and twenty six people were initially sampled, 117 took part at twelve months and 109 remained at twenty months. Additionally, a short semi structured interview was conducted with a small sub-sample of 25 research subjects at twenty four months (Mackintosh et al, 2006).

In keeping with research by Campbell et al (2007), research participants were all aged 60 and over, consequently due to its specific focus on this older age group the findings are less central to this thesis, which instead sampled the full age spectrum. However, it is of interest that mixed methods utilised by the authors resulted in discrepant findings (Moffatt et al, 2006b).

The quantitative study did not reveal any significant improvements to health; however, findings from the qualitative study illustrated many positive outcomes to

participants' quality of life. In light of the poor health and age of those participating in the study, this outcome is not altogether surprising. The authors found that using mixed methods enabled data sets to be interrogated and suggest this can increase the robustness of a study (Moffatt et al, 2006b). They put forth a number of possible reasons for the difference observed in the two strands of their research. First of all, many respondents did not receive new benefits prior to the second interview and those who did only received two months worth. Although some limitations of six month follow ups were identified earlier, research by Abbott and Hobby (1999, 2002) shows positive outcomes can emerge. Qualitative aspects of the study expand our understanding of this situation. Respondents believed due to their age no amount of increased income would improve their health, however their quality of life, independence, ability to cope better in the home, gain better access to facilities and enjoy peace of mind were evident from their accounts.

### **Accounting for Health Gains using In-house Questionnaires**

Although some commentators are critical of those using in-house questions, which it is alleged are often engineered to produce desirable outcomes, it is argued here that studies incorporating in-house questions contribute to what is known about the impact of advice on health and emphasize common methodological issues. For example, Caiels and Thurston (2005) found 78% of respondents felt less anxious after seeing an advisor but it was not possible to observe any significant improvement in health status from the SF-12 scores.

Illustrating common pitfalls associated with question wording is a study on the value of a Home and Hospital Visiting Advice Service in north Bristol conducted by Bell (2005). Forty people participated in the survey, of which ten were also interviewed. Survey results show ten percent of the sample said their health had improved even though 56% felt less stressed. In common with other research (for example, Flemming and Golding, 1997) this was the most frequent positive effect reported. Clearly reduced stress was not categorised as a 'health' improvement by the majority of Bell's sample. Interestingly, all of those participating in interviews said they 'felt better' which supports the findings from an evaluation of the BABH CAB service in

Wales, conducted by Borland (2004), in which 88% of respondents reported 'feeling better' after seeing the advisor. Respondents were not asked about any other health gains, although in a second part of the questionnaire completed by general practitioners, 63% said advice improves patients' general health, over 80% agreed that their patients' psychological health improved and 77% agreed that advice services in health care settings reduce health inequalities. Alternatively though, a deeper understanding might have been acquired if clients of the service also provided their thoughts on this matter.

### **The Challenge of measuring Health Outcomes**

The literature illustrates that isolating the effects of advice on health is challenging. Baseline health scores epitomize poor health in client groups. Despite inconclusive outcomes, these studies do provide a useful profile of the health of advice service users, of which little data exists from CAB (Abbot and Hobby, 2002). Findings from the Legal Services Research Centre's (LSRC) periodic survey of justiciable problems provide further insights. They illustrate that those with a disability are more likely to experience justiciable problems, and more likely to experience multi problems. Multifaceted experiences can impact negatively on long term health (O'Grady et al, 2004).

When interpreting the findings to date it is important to consider the age and health of respondents, many of whom represent older age groups, and those with chronic illness and disabilities (Abbott and Hobby, 1999, 2002; Greasley and Small, 2005a). Those who have suffered with chronic ill health for many years are less likely to see a significant improvement over a short six month period of time although longer term improvements may occur (Abbott, 2002). In light of what is known about causal relationship between low income and poor health (Benezeval and Judge, 2001) it may not be possible to repeal a life time of poverty and chronic illness in six or twelve months. The cumulative effect of deprivation on health over the life course is well known (Bartley et al, 1997). Illness and disabilities that develop slowly or as a result of longstanding experiences cannot easily be reversed. Consequently improvements are likely to be psychological not physical. Furthermore, causal links and causal



pathways between socio-economic status and mental health are complex and differ between individuals (Payne, 2001: 34).

Nevertheless, quantitative approaches have provided some useful insights that suggest psychosocial improvements in health can arise as a consequence of increased income. It is noteworthy that some improvements have been recorded in the health of those receiving advice but not gaining extra income, perhaps illustrating the positive effects of feeling someone cares.

### **Welfare Benefit under-claiming and the Role of Advice Services**

The dominance of welfare benefits advice in the literature is indicative of an underlying problem, which advice services seek to redress – that of benefit under-claiming. The enormity of the problem is striking; National Statistics for the United Kingdom for the year 2007-08 (published 2009) provide estimates of the level of income related welfare benefit under claiming as salient verification. The most recent information to be published estimates under-claiming between:

- £1,900m and £2,930m in relation to Pension Credit, affecting between 1.11m and 1.71m pensioners;
- £1,570m to £2,160m in Council Tax, affecting between 2.33m and 3.06m people;
- £1,350m to £2,470m in Housing Benefit, affecting between 600,000 and 990,000;
- £630m and £1,550m in Income Support affecting between 280,000 and 600,000 people;
- £870m and £1,410m in income based Jobseekers Allowance, affecting 360,000 to 490,000 entitled individuals.

It is also estimated that four out of five people on low incomes who do not have children are entitled to an average of £38.00 per week in tax credits, which they do not claim (HM Revenue and Customs, 2009).

The problem of under-claiming becomes more noticeable amongst vulnerable groups, such as older members of the population and those with mental health problems. Testifying to the extent of the problem, Pacitti and Dimmick (1996) found just over half of clients attending a mental health resource centre did not claim the benefits to which they were entitled; women were more likely to under claim than men. Similarly, Gaskin et al (2003) found 66% users of an advice services targeted at those with mental health problems were under claiming. They point out that negative outcomes on quality of life and mental health may arise if under claiming is not addressed. However, in light of the complexities of the benefits system frequently advice is needed on this matter.

The statistics provide strong justification for the provision of welfare rights advice as a means of maximising income. A growing body of research demonstrates that advice services are active in facilitating access to welfare benefit entitlements.

Supporting the notion that maximising income can reduce poverty in elderly populations, Hoskins and Smith (2002) found high levels of under-claiming, as did Toeg et al (2003) in a service targeted at those aged 80 and over. In addition to facilitating access to benefit entitlements, a holistic approach resulted in clients obtaining additional items which improved their quality of life, for example, taxi cards and special bath aids for those with mobility problems. Onward referral was also made to relevant occupational therapy services.

Making an important contribution to the literature, a systematic review of health, social and financial impacts of welfare rights advice delivered in primary care settings was published by Adams et al in 2006. The review lists thirty one studies that provide statistics on money gained for clients. Spanning a time frame of twelve years from 1993 to 2005, it demonstrates that during this period the amount of lump sum/one off payments reported in the studies included in the review amount to £1,753,843. This figure relates to claims by a total of 9,038 clients. The total amount of recurring

benefits per year was £7,864,910 for a total of 9,418 clients (Adams et al, 2006). It is important to note that this information is based on studies conducted in primary care settings that reported quantitative financial outcomes, and as such do not reflect the full picture of sums gained as a result of welfare rights advice. Nevertheless, these figures provide some insight into the extent of under claiming and the role advice services play in helping people gain their welfare benefit entitlements.

It would be laborious to take account of all financial statements herein; however, a brief précis does exemplify the accomplishments of advice services in maximising income for their clients. For example, in his evaluation of the Better Advice: Better health project in Wales Borland (2004) reported total gains for this service across Wales of £3,448, 672.70, a sum which was acquired for a total of 6,445 clients between October 2002 and September 2003. Eighty two percent were new clients who had not previously used a CAB service.

Statistics for Citizens Advice Cymru show that in the year 2006/07 bureaux in Wales helped clients with 95,674 benefit related issues which resulted in over £11,735,185 in new income for these clients. This figure relates to reports provided by 60% of bureaux, the remainder did not submit accounts. Since that time the number of clients seeking welfare benefits advice has increased steadily, seeing an 11% increase in 2008/09 and a further 16% increase the following year – equating to 114,202 welfare benefit related enquiries in 2009/10. It is not clear if these figures relate to all bureaux, as statistics are not available for the total sums gained in each year. This deficit highlights the limitations of data provided by bureaux for Citizens Advice purposes and provides further justification for independent research.

For the most part the wider literature provides strong evidence that advice services are effective in helping their clients' claim the benefits to which they are entitled, thus maximising their income.

Whilst it is generally acknowledged that the Citizens Advice service is successful in acquiring considerable sums of money for its clients from welfare entitlements, less is known about the extent to which this alleviates material deprivation. In households

with dependent children little evidence exists of the impact new income may have on spending on children within these families that may affect their material and social wellbeing. However, one important contribution exists on this topic. Reading et al (2002) provides some refreshing insights into the value of welfare rights advice for younger age groups of clients. Unique in its approach, this research evaluated advice targeted at parents with a child under the age of one year. The authors report total gains of £6,480.00 in recurring benefits and £17,857 in one off financial benefits for 23 CAB clients recruited from three advice centres involved in the study. They hypothesise that the Citizens Advice service may impact positively on the health of mothers and their children, and they argue this benefits families with young children.

### **Evidence of Improvements to Quality of Life**

It has been pointed out by Diwan (2000) that minimal concern is given to the negative effects of policy and practice that aims to increase wealth. The basic tenet of their argument is the notion that increases in material wealth beyond a certain level impinge on relational wealth. Consequently, Diwan proposes approaches that focus jointly on maximising material and relational wealth. There is some commonality here with the views of Ahuvia (2008) who argues money is a social tool that enables consumption and as such it has the most important influence on a person's desire for increased income, beyond the point where it no longer leads to increased personal happiness. People often overplay the short term outcomes and benefits that increased income brings. Shallow in focus, policy approaches often overplay the importance of increasing material wealth with little mention of the concept of 'relational wealth'. This form of wealth stems from interconnections with other people and gives us inner strength and emotional security thus defining quality of life (Diwan, 2000).

Increasingly this concept is seen emerging in academic literature. A body of which has developed in recent years to illustrate how increases in income can impact positively on subjective wellbeing. Reflecting the interrelation between underpinning concepts concerned not only with income but also 'relational' wealth is a conceptual model constructed to illustrate the perceived impact extra money has and how it is spent.

Drawing on recurrent themes that emerged from research participants' accounts in a qualitative study, Moffatt (2004) points to the material, financial and social benefits of advice that lead to choice and control over life and health. This is presented in a theoretical model for understanding the relationship between welfare benefits advice and quality of life. The authors note small increases in income can make a difference to individuals. These include reduced stress and anxiety, improved sleeping patterns, reversal of weight loss, change in medication, less contact with primary care teams, better diet and improved levels of physical activity. Some of their research subjects had given up or reduced smoking. Overall they felt a burden was removed giving them more control over their situation.

Subsequently, Moffatt et al (2006a, 2006b) conceptualise in another model the impact of gaining additional financial and non financial resources in four linked categories of outcomes. These are based on the findings from a sub-sample of 14 research subjects out of 25 participating in qualitative study embedded within a single blind Randomised Controlled Trial (RCT) who had received a financial award. The first category in the model illustrates how extra money can pay for 'necessities' such as transport, food, social activities, paying bills, heating the home, paying for extra help, and so on. The second category is 'occasional expenses'. This includes furniture, household equipment, trips and holidays, plus special equipment for illness and disability. The third category 'capacity to cope with a crisis' includes paying for emergencies and saving money. Finally, because financial worries ease, people enjoy 'peace of mind'. Conceptualising the impact of advice in this way, helps us to understand how even small increases in income can help people maintain independence and participate in society. The findings illustrate how extra money was spent on better food, which would be classed within the conceptual model as paying for 'necessities'. Money paid for 'occasional expenses' such as for house improvements, visiting people, going on holiday and for other expenses. It was also used to pay off debts and for savings, thus supporting the idea that extra money increases 'capacity to cope with a crisis'.

The rationale underpinning the model is supported by others in the field and illustrates the importance of relational wealth. With regard to 'peace of mind' for example, Bell (2005) found some people using the Home and Hospital advice service felt more secure and happier. A small number said they got more enjoyment out of life, and their life was better in other ways. Flemming and Golding (1997) note increased subjective wellbeing, self esteem, self determination and empowerment. Porter (1998) reported the outcomes of a CAB advisor working in three surgeries in north Powys. Clients appreciated help filling in forms, especially those required for disability benefits. There was some anecdotal evidence that advisors were able to provide resources for clients to deal with their problems in the long term, although no formal methods of evaluation were provided.

Contributing to the findings, Borland (2004) surveyed health care staff involved in the BABH service in Wales. High levels of agreement were reported with statements about the affect the service had on patients. Eighty four percent of health care staff agreed that it makes patients feel someone cares and reduces feelings of hopelessness. A slightly smaller percentage agreed that it increases quality of life, helps people care for others, gives them a lift, increases their feeling of effectiveness, self esteem and general health, and helps patients to deal with chronic illness. However, patients were not asked these questions so it is not possible to ascertain the accuracy of this assessment of the affects of CAB advice, although it is generally acknowledged that those who receive increased income gain greater control over their lives and subsequently this improves self esteem (Charlton and White, 1995).

However, the importance of increased material wellbeing cannot be completely dismissed. Costs associated with health or disabilities emerge regularly within the literature. For instance, Toeg et al (2003) found some recipients of welfare benefits advice were referred to occupational therapy services and received additional items to help overcome mobility problems. Similarly Bell (2005) notes that 32% of the those using a Home and Hospital Visiting Advice Service were able to receive free eye and dental tests as a result of advice.

Overall, the evidence to date illustrates that those receiving advice for their problems benefit in a number of ways. Whilst some gain independence and peace of mind, research has also illustrated that clients enjoy improvements to their quality of life, both because of increases in their income and as a consequence of the advice process itself. They benefit from knowing someone cares (Borland, 2004).

## **Conclusions**

This chapter began with an account of historical developments in the provision of Welfare Rights advice in health care settings and issues of access to services. There is good evidence that these services widen access to advice for people who would not seek help or would face barriers in doing so if these services were not provided. However, specific in focus, research to date has been predominantly concerned with access within a primary care setting. Little is known about the extent to which access to services may be problematic in other ways and in other settings. In the absence of comprehensive longitudinal data it is not possible to determine what barriers exist for those with complex issues that are lengthy to resolve and may require repeated communication or visits to a bureau over prolonged periods with an advisor.

The literature concerned with advice in primary care provides accounts of the characteristics of those using these services; principally in one setting, this omits many other services that operate from high streets, secondary outlets and those that provide home visits. In light of high levels of social and economic deprivation across Wales, little is known about the social characteristics of those using the CAB service in Wales.

This chapter looked at the problem of welfare benefit under-claiming and found as a consequence of advice many clients gain entitlements. However, assessing the impact of increased income on their health is far more complex. A range of validated measurement instruments and time frames for data collection were discussed, the optimal points for data collection being baseline, six and twelve months, as indicated in findings from Abbott (1999, 2002) and Greasley (2003). Whilst some instruments have lacked sensitivity, the Short Form 36, (SF-36) and Hospital Anxiety and

Depression Scale (HADS) has been used with some success in advice settings. Due to a number of methodological problems, unequivocal conclusions cannot be drawn from the research published to date and this consequently offers scope for further exploration, particularly in other settings and in relation to other forms of advice that improve financial wellbeing, such as debt advice.

Having reviewed the literature concerned with Welfare Rights advice, the following chapter is concerned with the topic of personal debt and research on debt advice.



## CHAPTER TWO

### **Personal Debt and the Role of Advice Services**

This chapter begins with an introduction to the topic of personal debt, followed by an explanation of definitions and indicators of personal debt. The chapter provides an outline of credit market liberalisation in the 1970s and its impact today. Drawing on academic literature, this review considers debates about structure and agency, as discussed by Deacon (2004), and looks at the psychological impact of debt. The chapter ends with a review of the literature concerned with debt advice. Until very recently, little research existed of this kind. This situation changed with the findings from a multi phased evaluation of debt outreach advice piloted across England and Wales. Published in 2009, this research contributes important and much needed evidence to the literature (Buck et al, 2009).

#### **An Introduction to Popular Explanations of the Problem of Personal Debt**

Distinctly different to what has been discussed so far, a brief introduction to the topic of personal debt is provided as direction to what follows.

Liberalisation of the consumer credit market in the mid 1970s and important macro-economic factors have contributed to current levels of personal debt (Griffiths, 2005). However, structural accounts represent just one side of the discussion. A review of the literature highlights important contemporary debates surrounding agency and structure (Deacon and Mann, 1999; Deacon, 2004; Orton, 2009a). Moralists place agency as central to cycles of deprivation, formulating the opinion that the individual behaviour of an emerging underclass is to blame (for example, Murray, 1984, 1990). The media has also played its part contributing to the moral panic (Griffiths, 2005). Although personal debt in the UK has been the focus of government policy for some time, as seen by the range of reports into over-indebtedness and social policy responses, the recent global economic crisis resulted in the problem of personal debt being highly topical.

Much of the academic research, discussed in this chapter, has sought to gain an understanding of the characteristics and experiences of those with debt problems (Kempson, 2002; Edwards, 2003; Kempson et al, 2004). Research has looked at spending habits and attitudinal factors that may contribute to a person experiencing debt problems (Boddington and Kemp, 1999; Dorminy and Kempson, 2003).

The plight of low income families is discussed extensively within social policy and academic literature and those with mental health, long term illness or disability are recognised as being particularly at risk of experiencing financial difficulties (Grant 1995, 2000; Reading and Reynolds, 2001; Kempson, 2002; Sharpe and Bostock, 2002; Davies, 2003; DTI, 2003; Burchardt, 2003; Plumpton and Bostock, 2003; Bridges and Disney, 2004; Cooke et al, 2004; Kempson et al, 2004; Pleasence et al, 2004; Griffiths, 2005; Balmer et al, 2005; Brown et al, 2005b; Gould, 2006; JRF, 2005; Phipps and Hopwood Road, 2006; Pleasence, 2006).

Some research has looked at the impact of debt advice on the lives of individuals (Mannion, 1992; Nettleton et al, 1999; Gardner and Wells, Samuel, 2001; Neuberger, 2003; Plumpton and Bostock, 2003; Kober, 2005; Pleasence et al, 2007b). However, one review of debt advice, conducted in 2004, concluded very little research exists in this area (Williams, 2004). Although some research has emerged recently, debt advice provision has received noticeably less attention compared to the literature concerned with primary care advice services. One reason for this could be that the extent of personal debt has reached record levels in recent years, particularly in the lead up to and since the economic crisis of 2007. Prior to which a social pathology discourse tended to cite individuals as having contributed to their own downfall with reckless behaviour (ibid). This may, in part, explain why few resources were previously made available for such research. In the aftermath of the recent global economic crisis, the issue of personal debt in the UK has acquired new significance, and gained much media and government attention. Despite this, no agreed definition exists as to when personal debt becomes a problem and some have questioned the existence of a personal debt problem in the UK.

These topics will be discussed in more detail throughout this chapter.

## **Defining Debt as a Problem**

For the purposes of this thesis, the definition of ‘problem debt’ provided by Citizens Advice is adopted, whilst the term ‘debt’ is generally used for simplicity. This encompasses those “*unable to pay their current credit repayments and other commitments without reducing other expenditure below normal minimum levels*” (Edwards, 2003: 48). Consequently this research adopts a definition that acknowledges debt that has become a major burden for the borrower.

Nevertheless, it is important to note that a number of alternative definitions and analytical frameworks exist in the literature and thus justify further explanation. This situation has been highlighted by the House of Lords Select Committee on European Union (2006), who notes there is no agreed definition of over-indebtedness. To complicate matters further, terms of reference differ also – ‘problem debt’, ‘bad debt’, ‘in debt’ and ‘over-indebtedness’ ‘indebted’ are terms often used to describe a similar set of circumstances.

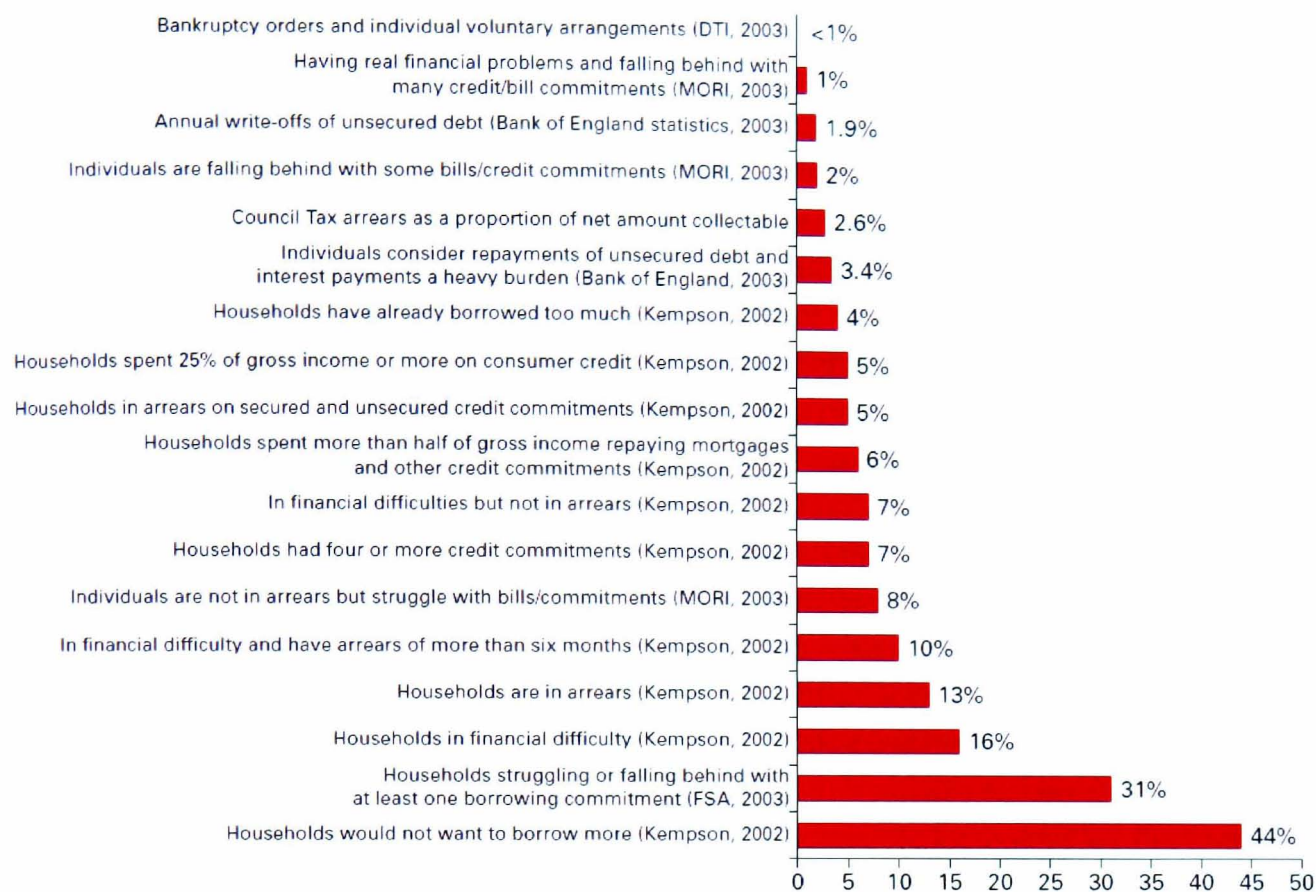
Elaine Kempson, provides some clarification - the term debt describes two different situations. Individuals ‘in debt’ or with ‘problem debt’ are those that fall behind with the payments on any of their household bills or other commitments, whilst ‘over-indebtedness’ generally refers to households experiencing financial difficulty, although they may not actually be in arrears (2004: 7). Similarly, within the financial industry, over-indebtedness has been defined as “Those households or individuals who are in arrears on a structural basis, or are at a significant risk of getting into arrears on a structural basis” (Jenkins, 2004: 3). Adopting this latter definition, individuals who intentionally refuse to repay their debts or are over-indebted temporarily should be excluded from the analysis. One widely quoted ‘analytical approach’, developed by Kempson et al (2002), includes a measure of the extent of current financial difficulties. This includes arrears plus two definitions of heavy credit use; first, spending more than 25% of gross income on consumer credit, and second, spending more than 50% of income on consumer credit and mortgages. This principle was adopted in the Consumer Credit White Paper of 2003.

Explanations are also provided by the leading UK survey company MORI Financial Services (2003), the financial services consulting group NMG Research surveys for the Bank of England (Tudela and Young, 2003; May et al, 2004), the Griffiths Report (2005), and a paper from the Centre for the Study of Financial Innovation - the CSFI - by Antony Elliott (2005) plus Citizens Advice (Edwards 2003, Phipps and Hopwood Road, 2006). Some quantitative measures incorporate debt to income ratios, others include subjective measures, such as individual assessment of the burden of debt.

More recently, in their Action Plan for Tackling Over-indebtedness, the DTI utilised indicators of current levels of over-indebtedness, such as arrears dating back three months or more, plus subjective measures, and the characteristics of the individual, plus the number of people or households exhibiting classic risk factors (2004c). In 2005 the DTI identified two more indicators - being in arrears for three months or more with a credit commitment or domestic bill, and a subjective indicator which illustrates the burden of debt. However, on its website the DTI adopts a more generalist approach: “The term over-indebtedness is used to describe debt which has become a major burden for the borrower” (2010).

Figure one below illustrates a number of definitions and analytical approaches adopted. Proportionally related to the criteria selected, it is possible to see the percentage of the United Kingdom population affected by debt problems.

Figure 1: Subjective and late payment measures



Source: Oxera, April 2004, “Are UK households over-indebted?” in a report commissioned by the Association for Payment Clearing Services (APACS), the British Bankers’ Association (BBA), the Consumer Credit Association (CCA), and the Finance and Leasing Association (FLA).

### Consumer Credit Market liberalisation and its impact in the UK

Liberalisation of the credit market in UK in the mid 1970s arose from recommendations made in the Crowther Report of 1971, which argued for an ‘open’ market in credit. At a time when a relatively small proportion of the UK population could access bank loans and overdrafts, Crowther’s proposals recognised many of the advantages that consumer credit can bring. Prior to liberalisation rigorous limits were imposed by government upon bank lending limits and strict income to debt ratio rules existed for Building society mortgages. Although instalment credit enjoyed widespread growth during the 1960s, ambiguous interest charges were widely reported and fuelled debates for greater transparency and access to a wider range of banking services (Griffiths, 2005). Indicative of the rationale surrounding the issue

Lord Airedale, in a House of Lords debate conducted in 1972, tells the story of a weary magistrate who complains:

"Too much of the time of this court is taken up by people entering into contracts which they do not understand with people whom they do not know to buy goods they do not need with money which they do not possess"  
(Parliamentary Archives, HL Deb 28 June 1972 vol 332 cc938).

Over thirty years later, this statement could originate from a current debate stimulated by concerns over rising levels of personal borrowing in the UK. Concerns have been raised over exponential growth in the number of credit cards, from just one Barclaycard in 1971 to a choice of 1,300 credit cards in 2005. A further example is debt to income ratio, which stood at 50% in the 1970s compared with 140% in 2005.

These changes occurred primarily due to changes in credit laws, which enable financial institutions to allow individuals to borrow on the basis of their lifetime earnings expectancy. In 1997 the Bank of England took ownership of monetary policy, this was followed by a period of economic stability and low interest rates, contemporaneously occurring at a time of low unemployment. During the same period the UK property boom resulted in homeowners enjoying substantial increases in the value of their homes. Research for the Bank of England illustrates an historical correlation between consumer spending and house prices, which effectively redistribute wealth and influence consumer spending patterns (Benito et al, 2006).

Consumerism, the availability of credit since liberalisation of credit controls in the 1970s, new financial products such as store credit, growth in credit cards, and low interest rates all provide structural explanations for the extent of personal debt.

In the years leading up to the economic crisis, consumer organisations, the credit industry, government and academics all debated the issue of rising consumer credit and growing levels of personal debt in the UK.

In a report on Personal debt in the UK written prior to the economic crisis of 2007, Lord Griffith warned “Debt is a time-bomb which could be triggered by any number of shocks to the economy at any time” (2005: i). He cites Ed Mayo, the chief executive of the National Consumer Council saying “Pushing credit was like pushing drugs, and the addiction was getting worse.” In support, the Church Action on Poverty, Christians Against Poverty, and all debt advice agencies consulted for the report, including Citizens Advice, Speakeasy, Community Money Advice, adviceUK, CHAS, plus numerous Credit Unions and Money advice lines agreed with the view that personal debt is a problem in the UK (In Griffiths, 2005: 7). One commentator went as far as to say the growth in credit is an ‘evil’ (Selby, 1997).

Providing strong justification for their concerns, statistics show increasing numbers of people are seeking advice for debt problems. The Legal Services Research Centre has reported money and debt problems as the third most common justiciable problem (Pleasence et al, 2008). For some time Citizens Advice warned debt had become the second most frequent problem (after Welfare Benefits) for which individuals sought advice. During the period of this study debt moved into first place as the most frequent problem reported to advisors. In 2005/6 the number of clients seeking advice for debt problems in England and Wales stood at 1,437,000 with 1,270,000 seeking debt advice from an online ‘Advice Guide’ (Citizens Advice: 2005/6). Although it is likely that additional funding for debt advice services impacted on these statistics.

Despite extensive evidence, some have challenged the existence of the problem. Griffiths (2005) cites Rodford, the Head of Policy at the Association for Payment Clearing Services (APACS) saying:

“Over the past five years, many reports have suggested over-indebtedness is a growing problem in the UK and that society stands on this precipice of a debt disaster. Yet the data we collect within our industries suggest this is not the case” (Rodford in Griffiths, 2005: 8).

Another industry expert, Dr Helen Jenkins a Director and Senior Economist at a leading economics consultancy Oxera said “Only a minority of households could be considered over-indebted” and commented that this is often a temporary problem. she went onto say “The proportion of households facing financial problems has remained

broadly stable over the last nine years”. Her concluding comment was: “We are not at the edge of a cliff” (In Griffiths, 2005: 8).

Explicitly instrumental, the recent economic crisis has effectively silenced opposition to those seeking to take action in response to rising levels of personal debt. With this shift, recent debates centre upon the impact of debt on low income families, lone parents and other groups found to be most vulnerable to debt, such as those with a disability, long term health problem, mental health problems, plus younger age groups.

### **The extent of Personal Debt in the UK**

Whilst statistical evidence illustrates the extent of personal borrowing in the UK, figures for Wales suggest that disproportionately high levels of borrowing, debt and financial difficulty exist (NACAB Cymru, 2001; Edwards, 2003). However, reliable, comparable indicators for Wales are virtually non-existent (Edin, 2001; Whyley, 2002, 2003). For this reason data for the UK is presented, supplemented where possible with evidence relating specifically to Wales.

Testifying to the existence of a ‘debt problem’ is a summary of statistical evidence from the years 2005/6, when the research commenced, to the current day:

- *Credit Card Debt*

In August 2006 credit card borrowing in the UK rose to £55.4bn (Credit Action, 2006). This figure continued to rise until, in the aftermath of the global economic crisis, credit card borrowing in the UK fell to £64bn in 2009 (Price Waterhouse Cooper, 2010). The decline continues no doubt due to the erosion of consumer confidence and unparalleled pressure on lenders. The most recent figures, for January 2010, illustrate the total figure for credit card borrowing was £61.4bn (Credit Action, 2010). Despite declining reliance on credit cards, UK consumer credit is still much higher than in Europe and the number of ‘bad’ debts has reached unprecedented levels.



- *Mortgages*

The Council of Mortgage Lenders reports statistics for mortgage possessions and arrears in the UK. Their reports show that after peaking in 1991, possessions declined until 2004 (75,500 in the year 1991 and 8,200 in 2004) but then spiralled to 14,500 in 2005 and 21,000 in 2006. In the watershed of the recent economic crisis, 46,000 properties were taken into possession in 2009, a figure much lower than the 75,000 forecast at the beginning of that year.

The pattern for mortgage arrears correlates with possessions. In 2006, 64,900 mortgages were 3-6 months in arrears; 34,900 were 6-12 months in arrears and 15,700 over 12 months in arrears. Figures for 2009 illustrate that 106,600 mortgages were 3-6 months in arrears, 88,700 were 6-12 months in arrears and 63,500 were more than 12 months in arrears.

- *Insolvencies*

The number of individual insolvencies rose to a record high of 70,000 in 2005 (Insolvency Service, 2006) indicating a trend that could continue particularly in the event of an interest rates rise (Griffiths Report, 2005). This figure hit 134,142 in 2009 (The Insolvency Service, 2010).

Currently personal debt in the UK stands at £1,457bn (Credit Action, August 2010). However, statistics represent official records that do not include debts accumulated by the poor and excluded, such as money owed to door step money lenders, loan sharks, and borrowings from family and friends.

Scant figures exist for Wales, although it is indicated that borrowing is disproportionately higher than the rest of the UK and homeowners are less likely to reduce their borrowings (The Mortgage Lender, 2003). A study of credit use in Wales conducted in 2003 provides some insights. It was found that access to and use of consumer credit and arrears is higher in Wales than the UK average and higher

proportions are heavy borrowers. Accounting for lower than average incomes, it was predicated that a debt crisis would affect more households and they would take longer to recover (Whyley, 2003). Other evidence supports this prediction. Monitoring poverty and social exclusion in Wales, Kenway et al (2005) report higher levels of credit use and borrowing in Wales. Compounding the problem, Welsh salaries are lower than the UK average and householders are more reliant upon welfare benefits. A greater proportion does not have a bank account and, perhaps not surprisingly, a greater proportion report financial problems. This is supported by data from Citizens Advice, who have found greater debt to income ratios exist in Wales (Edwards, 2003).

At the time of writing, comprehensive data illustrating the extent of debt problems in Wales since the financial crisis began to take hold in 2007 to 2008 do not exist. However, the DTI (2006) note that future trends can be forecast by looking at past economic factors and movements in levels of over indebtedness. Although forecasts and predictions can be inaccurate due to changes in the movement of contributing factors, they can provide an indication of the likely path over indebtedness will take in the future.

### **Socio-economic and Demographic Predictors of Debt**

Extensive academic evidence supports the notion that particular social and demographic characteristics place a person at higher risk of financial exclusion and a range of problems, including debt. The first study to look at credit use in Wales (Whyley, 2003) found access and use of credit is highest in younger households, divorced or separated person households, in families with dependent children, and households experiencing a drop in income in the previous 12 months. Those in lower socio-economic groups are at particular risk. The findings suggest credit is used by people in Wales to ‘make ends meet’, and in keeping with this outcome the level of household credit was linked to the likelihood of arrears.

Building on these findings, the Deputy Minister’s review of over-indebtedness in Wales (Welsh Assembly Government, 2005) drew on a number of sources of evidence including the Welsh Household Survey (2003) which illustrates that those

most at risk are households headed by women, people aged 16 –39, those that are divorced, separated or never married, those from the lowest categories of social class and those that are economically inactive.

These two sources contribute significantly to the field by virtue of their focus on Wales. They are supported by wider literature emerging from other areas of the UK. Of particular importance is a major study on the characteristics of those with debt problems and the nature of indebtedness in the UK, which was headed by Professor Elaine Kempson. The findings show those most at risk of being in arrears were young people on low incomes and low-income families with children. Illustrating the extent of the problem, more than a third of households headed by a person in their twenties were in arrears with some commitments. The risk of arrears was most strongly associated with housing tenure, age group, those experiencing a sudden drop in income, those with active credit commitments and whether a person has a current account to manage their money. Poor health also featured as a risk factor (Kempson et al, 2004). Drawing on findings from elsewhere these risk factors are discussed in turn:

### *Housing Tenure*

Providing supporting evidence in research for Citizens Advice, Phipps and Hopwood Road, (2006) found tenants were particularly vulnerable to debt problems, a disproportionate high percentage with social landlords were at risk compared to those with private landlords. These findings are supported by those from the DTI (2003) and research sponsored by the Chartered Institute of Housing and Housing Corporation (Terry et al, 2006). Providing illuminating insights, Bridges and Disney (2004) reveal distinctions between low income homeowners and tenants ability to maintain minimum credit card and catalogue payments. Their research shows, out of home owners, a greater percentage of single respondents were in arrears compared to couples. The same pattern occurred amongst tenants. However, overall the most at risk group here is the ‘single tenant’. Another feature of the tenant and homeowner is disparity in methods of borrowing. Tenants are far more likely to be excluded from mainstream financial products (Lovatt et al, 2003) and utilise less common means of

borrowing such as loans from finance companies, relatives and friends. Conversely, homeowners gain access to a wide range of borrowing options as a result of their status and tend to use mainstream sources such as credit cards, overdrafts and bank loans.

### *At Risk Age Groups*

Findings from the DTI (2005) show people between 21 and 54 years are more likely to have greater debt to income ratios than those over 55. This may be due, in part, to lower living costs in later stages of the lifecycle, as people over 55 generally borrow less money and are less likely to be financially responsible for children. However, Livingstone and Lunt (1991) suggest this difference illustrates attitudinal factors rather than lifecycle or financial needs. They found households with children took a more restrained view towards debt and tried to avoid it, although a contrary outcome was those with debt problems cited their children as the cause.

Possibly highlighting changing attitudes and consumer spending habits since the aforementioned study was conducted in 1991 (Livingstone and Lunt) the findings contradict with more recent research from the DTI (2005). Based on the DTI's indicators for over-indebtedness, the 25-44 age group are most at risk of debt to income ratios beyond the safe threshold of 25% of their income. Similarly, the 25-54 age groups are more likely to have secured and unsecured debts that are greater than 50% of their income. The latter group are also more likely to have four or more credit commitments; again this is over the safe threshold (DTI, 2005). These outcomes are consistent with other research, for example, Citizens Advice (Phipps and Hopwood Road, 2006) and the Legal Services Research Council note money and debt most frequently occur in the 25-34 age group but peak at age 32 and 33 (Pleasence et al, 2004: 17). These age groups are particularly vulnerable to additional problems relating to relationship breakdown and the costs associated with children, placing them at high risk in the case of a personal crisis.

A new category to emerge in recent years is a younger age group of individuals who experience problems with debt. Whilst this may be related to student debt it could

also be emblematic of easy access to consumer credit. Surveys collated by the Financial Services Institute (Credit Action, 2006) indicate that 29% of 16-24 year olds claim not to know how to prepare and manage weekly budgets. Debt problems were cited as one cause of withdrawal from education by some, and the cause of worry for many more.

Indicative of another new trend is recent research for Help the Aged. Whilst older age groups are the least likely age group to experience debt problems, between 1995 and 2005 those aged 55-59 and 60-64 experienced the fastest growth in outstanding debt out of all other age groups. The authors note another worrying outcome, which suggests that older people may be using credit to pay bills and purchase food (McKay et al, 2008).

#### *Low Income and Drop in Income*

Multifaceted and interrelated factors that put a person at risk of debt are underpinned by the problem of low income. Illustrative of the multiplying effect of problems, Pleasence et al, (2004) notes those in receipt of welfare benefits are more likely to report debt problems together with a range of other problems that form an economic cluster. Within the economic cluster, symptomatic of their desperate circumstances, those with debt problems are also more likely to be homeless. Supporting findings from elsewhere, additionally and illustrative of the risks associated with low income, part time workers are also at risk. In light of the popularity of part time work amongst women and their lower incomes, it is not altogether surprising that findings from the DTI (2005) show women are more than twice as likely as men to have unsecured borrowing that is a quarter or more of their income and more than three times as likely as men to have secured and unsecured borrowing that is fifty percent more than their income, plus they are more likely to be in arrears. Low income lone parents are at particular risk, they are more likely to get into arrears with their mortgage or rent (DTI: 2003, Bridges and Disney, 2004).

In circumstances where a relationship breaks down, single parents can fall into debt upon the loss of income and difficulties obtaining child support (Phipps and Hopwood

Road, 2006; Pleasence et al, 2004). However, this situation is not unique to single parents. One study found nearly a third of those with arrears attributed the problem to sudden loss of income. Generally loss of income occurs because of job loss, relationship breakdown, sickness and/or disability (McKay, 2005).

Evidently certain groups are particularly vulnerable to clusters of problems, noted by Pleasence et al (2004), for example within the economic cluster, particularly vulnerable to debt are lone parents, those with poor health or a disability, those living in rented accommodation, working part time or relying on welfare benefits. Multiple coinciding characteristics make the situation much worse for some and in the event of an unexpected drop in income they can plummet rapidly into debt or further into debt.

#### *Active Credit Commitments*

In keeping with what has been discussed so far, there is a risk that those households with high levels of borrowing and low to medium level incomes could fall into financial difficulties in the event of an unexpected personal crisis or as a result of changes in the state of the macroeconomic climate. It is estimated that 52% of the UK population could survive for 17 days in the event of a sudden loss of income. Compounding potential problems, personal saving has declined. For example, in 1979 the savings ratio was 14.1% compared with 3.1% in mid 2004 although the figure rose to 6.0% in 2006 (Credit Action, 2006).

#### *Lack of Current Account*

The situation for the poorest groups in the UK is worse still; the gap has grown over the last few decades between those with access to mainstream financial products, leaving a small but significant group of people poorer than ever and unable to access mainstream credit (Bridges and Disney, 2004). A review of financial exclusion in Britain suggested that around 1.5 million people (7%) have no financial products and a further 4.4 million (20%) have little more than a bank account, which puts them on the margins of financial services (Kempson et al, 2000). As a result of a Social Exclusion Unit Report on Neighbourhood Renewal in 1998 Policy Action Teams

(PAT 14) were developed to explore ways of widening access to financial services. Despite a range of milestones for the period 2000-2005 the problem of financial exclusion continues to concern the government, who recently announced further plans to extend access to bank accounts to financially excluded groups.

Those without access to banking facilities are more exposed to unexpected changes in their personal situation and consequently at greater risk of financial difficulty. They are more likely to become indebted to door step money lenders, pawn brokers, sale and buy back shops and mail order. It is estimated that there are approximately three million regular users of such sources of alternative credit in the UK; between 0.5 and 3 million people use door step money lending service and around 600,000 people use pawnbrokers (HM Treasury, 2004b). Extortionate interest rates and bullying tactics used by debt collectors put enormous strain on such households. Evidence from Citizens Advice (NACAB, 2000) show that extortionate credit arrangements exist across a range of financial products, one noteworthy area of evidence relates to debt consolidation loans. Low income groups – including lone parents, the long term unemployed, hostel dwellers and people living in high crime areas, and people with a poor credit record are most at risk (Kempson and Whyley (1999). Recent findings from research and evaluation of debt outreach services shows a significant percentage had limited access to mainstream banking services (Buck et al, 2009).

### *Poor Health*

It has been reported that those with a long term illness or disability are three times more likely to have debt problems (Balmer et al, 2005). These groups are the most vulnerable and report more legally justiciable problems, including debt than any other group (Pleasence et al, 2004; Phipps and Hopwood Road 2006). Interrelated with other risk factors, women experiencing social and material deprivation who have dependent children are more likely to suffer with poor health, and are at greater risk of depression (Baker & Taylor, 1997). Those with mental health problems are particularly vulnerable to experiencing debt problems (The Mental Health Foundation, 2001). Kempson et al (2004) point out that it is not possible to draw causal conclusions but there is strong evidence of links between arrears and mental

health issues. Causal pathways and explanations for the relationship between mental health and poverty are complex, as indicated in the literature. The Social Exclusion Unit (2004) has estimated that one in four tenants with mental health problems has serious rent arrears. This could result in the loss of their home, which conversely can trigger or exacerbate mental health problems (Nettleton and Burrows, 2000). Supporting the hypothesis further, analysis of the English and Welsh Civil and Social Justice Survey found a significant association between housing rights problems and mental illness (Plesence and Balmer, 2007). Whilst Harding et al (2003) highlight the magnitude of welfare rights cases with a mental health element occurring in primary care advice services.

Contributing important findings, research by Reading et al (2002), which was discussed in the previous chapter, looked at the benefits of welfare rights advice targeted at mothers with a child under the age of one year. Corresponding findings discussed in the context of debt, social disadvantage and maternal depression (Reading and Reynolds, 2001) illustrate an association between psychological distress and debt worries in mothers with young children.

The consequence for children in these households is considerable. It is estimated that 1.25 million children in England and Wales live with a parent or carer with a mental health problem, of these only 24% with long term mental health problems are in paid employment, putting many of these children at risk of poverty and households in a high risk group for debt problems (Gould, 2006). This is especially problematic for single parents (usually single mothers) who are nearly three times more likely to have a functional psychosis such as schizophrenia or bipolar affective disorder than couples with children. People with the later disorder are at additional risk of debt as sufferers can overspend during a manic phase.

People with mental health problems are at higher risk of job loss as a result of relapses in the mental health. They often experience fluctuating episodes of illness and have to deal with a complex system of benefits and rules relating to their return to work, and benefits entitlement or the reinstatement of benefits (Burchardt, 2000). The complexities of the system put these groups at high risk of financial adversity and



debt. Davis (2003) also highlighted the vulnerability of people with mental health disorders in accessing financial services, managing their incomes and dealing with the complexity of gaining benefits, a situation which can create a recipe for financial hardship. Checks are rarely made to assess the mental capacity of a person applying for credit. This is particularly problematic when that person is unable to repay the debt as there is little protection for the borrower; furthermore, people with mental health problems are often unable to purchase payment protection insurance.

### *Blame Directed at the Financial Sector*

Whilst much of the literature looks at the individual in debt, irresponsible lending and financial practice is also cited as an underlying cause of the problem. Unfair banking practices were highlighted throughout 2006 by the Office of Fair Trading. Excessive charges levied to those defaulting on loan repayments can lead to the rapid accumulation of debt (Edwards, 2003; OFT: 2006; Phipps and Hopwood Road, 2006). Kempson (2006) identifies a range of irresponsible practice by financiers, including automatic credit limits increases, reduced minimum repayments, and schemes to encourage people to use credit card cheques which encourage spending and transfer credit card balances. The Griffith Report (2005) drew attention to weak enforcement of Banking Code Standards and the Deputy Ministers Review of Over-indebtedness in Wales (2005) highlights irresponsible lending practice.

In an attempt to improve the legibility of contractual agreements of this nature, research by the DTI set out to test consumer reaction and understanding of new forms of documents. It emerged from this study that consumers often fail to fully consider the contractual agreements that they are entering into. The majority of those who had signed a credit card agreement couldn't be bothered to read much of it because the text was small and dense, and they said the agreement looked long, boring and unintelligible (DTI, 2004b). Consequently, whilst the financial services industry is held partly responsibly, individual responsibility has to also be questioned.

## Structure, Agency and Debt

One common interpretation, noted by Livingstone and Lunt (1991: 116), is that debtors are self indulgent, reckless and impatient. Drawing upon a Foucauldian social pathology discourse, it is possible to see examples from the literature that place blame on the individual for causing their own downfall. Consequently they are deemed not worthy of help as they cannot be genuinely defined as 'in need' (Watson, 2000: 74). Echoing the thoughts of some earlier philosophers' explanations of poverty grounded historically in the British welfare state, Williams (2004: 4) draws attention to recommendations by the Payne Committee on the Enforcement of Judgement Debts (1986) that a Social Service Office for Debtors should be established because "Many debtors incur and fail to pay their debts because they are inadequate personalities or irresponsible in managing their affairs."

Forming another strand to the literature are those who seek to understand attitudinal determinants of debt. Whilst certain social and economic characteristics place a person at greater risk, attitudinal factors also appear to determine the extent to which a person will get into debt and their behaviour once in debt. One of the first to contribute research findings on this topic was Livingstone and Lunt (1991), who found levels of disposable income do not factor alone in determining whether a person is in debt, although this does influence the depth of debt and is very important in determining repayments. A number of psychological factors have been found to be important in predicting the existence of debt problems and attitudes towards debt repayment. These include economic characteristics, locus of control, coping strategies, consumer pleasure and other specific economic behaviour.

Research from the US supports the evidence discussed that illustrates adverse economic conditions strongly influence the probability that a person get into debt, but also supports the notion that social and psychological factors feature in this. In keeping with research from the UK, one study found those in serious debt were from lower socioeconomic classes, they existed on lower incomes, were less likely to own their own homes (and much less likely to own them outright), they had more children and were more likely to be single parents. However, it was also found that those with

debt problems were younger and had a slightly more permissive attitude to debt. Economic resources, economic need, social support and attitude forming variables were all important predictors of whether a person was in serious debt. Those in serious debt were more likely to know others in debt and less likely to disapprove of others in debt. Thus the circumstances exist for a culture of debt to develop (Lea et al, 1993). Also in the US, Stone and Maury (2006) extend the multi-faceted explanation of the characteristics that place a person at risk of debt outlined so far, to include demographic/institutional, financial, economic, psychological, and situational aspects, each critically important to the overall explanation of indebtedness behaviour. With implications for our modern consumer society, literature from New Zealand shows highly materialistic people are more likely to view themselves as spenders and have more favourable attitudes toward borrowing (Watson, 2003).

It is argued that a number of variables are linked to the psychology of poverty; Lea et al (1995) contribute to the literature with findings that show non-debtors have more money management facilities (e.g. bank accounts) than debtors, and rate their abilities at money management more highly. Economic and demographic factors predict debt well, supporting previous results. The authors suggest that complex psychological and behavioural variables affect debt and are affected by it.

Studies on student attitudes towards debt provide useful insights. It has been found that students become increasingly tolerant as levels of borrowing increase; tolerance has been found to be more evident in those students with debts than those with small debts or none at all (Davies and Lea, 1995), thus indicating a change in ones financial circumstances can cause attitudinal change, as opposed to liberal attitudes being the cause of debt. Research has identified a correlation between increased tolerance and higher debt, but no evidence that attitudinal change preceded or occurred concurrently with increased debt (Boddington and Kemp,1999). Research from Sweden shows students that are more cautious have lower debts (Dahlbäck, 1991). However, it has also been illustrated that there is confusion over terms such as ‘interest’ amongst students with no previous experience of credit (Lewis and van Venrooij,1995). Consequently, perhaps weak financial management skills interplay with psychological factors.

Recently, attention has turned in the UK to from those who can't pay their debts due to lack of income, to those who choose not to. Using Dominy and Kempson's (2003) terms, these groups are those who 'won't pay'. Structural accounts provide one side of a debate, with agency situated as a natural alternative, although in reality the interplay between the two is complex. For the time being, further reflecting the issue of agency it is relevant here to draw upon Dominy and Kempson's (2003) categorisation of those who 'won't pay' their debts (the opposite of their aforementioned 'can't pay' group). They identify four groups that 'won't pay' despite being able to afford to. First, those who withhold payment on principle, usually because of what is perceived as a poor service – council tax and water arrears are the most common debts within this group. The second group consists of ex-partners who withhold payment for household bills on their former home. Third, are the people who work the system, this group systematically run up arrears and avoid payments wherever possible. Finally, there are those who duck responsibility. This group illustrate interesting psychological traits in behaviour. They run up large sums of credit card and other unsecured loans and then blame credit companies for lending the money, thus taking no personal responsibility. Testifying to attitudinal pro purposive action, this analysis reveals the place of agency as an alternative to structure which, drawing upon Orton (2009a), can be seen as an 'either or' rather than 'both and' approach.

However, recognising the situation whereby agency cannot be divorced from structure, it has been suggested that payment default is used as a method of managing debts in low income families. Thus individuals exercise agency within the constraints of their structural situation. Bridges and Disney (2004) note that payment default in low income families is associated with job status, age and household type together with access to benefits. They found none payment of utility bills and repayments of loans to family and friends being used as a method of managing debts and rotating non-payments, reinforcing the contribution low income makes to the occurrence of debt problems. Rather than seeing this as an example of recklessness, it could be interpreted as an example of the interplay between agency and structure. However, it

is important to consider whether a person is pro or anti debt is also an important variable (Livingstone and Lunt, 1991).

At the more extreme end of the spectrum, Kempson (2002) in her review of over-indebtedness in Britain, highlights a situation whereby some individuals know they will not be able to repay new debt or are already having difficulty with existing debt, but continue to accumulate debt by taking out consumer agreements and shopping impulsively despite their financial circumstances.

Psychological studies illustrate the dangers that this brings to individual wellbeing. Those who are overly easy with money, materialistic, or overly concerned with financial success have been found to have poor outcomes. Although, interestingly the outcomes are the same for those classed as being 'overly tight with money' (Tatzel, 2002). With individuals under pressure to purchase an ever increasing range of goods, individuals and families are under greater pressure than ever to succumb to borrowing. Sophisticated marketing campaigns, extensive purchasing options, media and celebrity endorsement of material possessions and easy credit create the ingredients that can often lead to people spending beyond their means. The Griffith Report (2005) refers to this type of consumer spending as 'pure' consumption whilst distinguishing between consumers spending on investments in the home, and so on.

Against a backdrop of a 'want it now' culture, new evidence shows that the distinction between needs and wants is not clear cut, and amongst younger borrowers it is virtually indistinguishable. Higher education students tend to see credit as a legitimate form of income or their 'right'. A small minority believe this mitigates frivolous spending. Younger people are particularly susceptible to social pressures. In this group a core minority see debt consolidation and insolvency as an easy solution. Those of family age are most likely to over-commit because of a belief that they should meet all their children's needs and wants, and because they believe future housing equity will provide for their future financial needs (Finney et al, 2007).

These findings echo those from Brown et al (2005a) who provide further insights. They identify distinctions between those with optimistic financial expectations and

those with more accurate expectations. Optimistic financial expectations can impact positively on the quantity and growth of debt at individual level, as opposed to the accuracy of predictions of financial circumstances.

Whilst the literature illustrates psychological and behavioural variables have a considerable impact on whether a person is in debt or stays out of debt. Walker (1996) provides some usual findings. First, and perhaps not surprisingly, better financial strategies are significantly associated with being less materialistic and having a more stable budget. However, a significant association has been found between feelings of coping less well and better financial management. This suggests that those who feel they are struggling may in fact adopt more rigorous financial management approaches.

Thus far, multi faceted explanations have been provided to illustrate that a range of demographic, social and economic factors interplay with psychological and situational constructs and provide significant insights into the determinants of personal debt. This chapter turns next the impact debt has on the lives of individuals.

### **The Psychological Impact of Financial Hardship and Debt**

The situation for socially excluded groups is compounded further by the multifaceted nature of problems amongst this group (Pleasence et al, 2004). Evidence from the Civil and Social Justice Survey of 2006-2009 which incorporated the GH12, a standardised health outcome instrument, provides strong evidence of the association between poor mental health and civil law problems. There is a risk that a combination of social and financial exclusion exacerbates the situation for those with mental health problems and this can result in a downward spiral of events (Davis, 2003). Related debates centre upon whether debt leads to depression or conversely whether depression leads to debt (Weich and Lewis, 1998; Reading and Reynolds, 2001). Of course, the situation is complex; poverty can create a cycle of depression caused by money worries and debt, which in turn can weaken individual coping ability. Personal debt has been linked with psychological distress and depression, and can lead to

family breakdown, poverty and social exclusion (Reading and Reynolds, 2001; Balmer et al, 2005; Brown et al, 2005b).

The literature provides strong evidence of links between socio-economic variables, debt and depression. In a study on debt, social disadvantage and maternal depression Reading and Reynolds (2001) found depression was linked with socio-economic hardship; debt worries were the strongest independent socioeconomic predictor of depression in women with young children. The situation for these women was compounded further because the depression subsequently caused them to worry more about debt.

Citizens Advice has reported that one in eight clients seeking help with debt problems began treatment after their debt problems started for stress, depression or anxiety (Edwards, 2003). Research for the DTI supports these findings; as a consequence of financial problems one quarter of households have been found to experience stress or anxiety (Kempson, 2002: section 3.9). Brown et al (2005) show how the financial burden affects key household members. Psychological distress is greater when outstanding credit is measured against the individual, primary financial decision maker rather than at household level. Household heads with outstanding individual or household debt have considerably lower levels of psychological well being than individuals with no debt, and unsecured debt is likely to have a greater negative influence on psychological well being than secured debt. Interestingly, this research found household heads with a secured mortgage loan debt did not exhibit psychological distress, whilst those who saved regularly offset the negative effects of debt but those who received one off windfalls or increased net worth failed to experience improvements in subjective well being. However, these findings are inconsistent with other studies which demonstrate that net worth has a positive increase in psychological well being (Headley and Wooden, 2004; Headley et al, 2004).

Research from the US develops our understanding of the impact of financial hardship on intra-family relationships and health. Associations between credit card debt, stress and poor physical and subjective health were reported by Drentea and Lavrakas

(2000). The quality of marital relationships has been found to be negatively affected by economic pressures, which can lead to depression and effect child – parent relationships (Lorenz et al, 1991; Conger et al, 1994). In a study of young adolescent girls, Conger et al (1993) found mothers and fathers being affected nearly equally by depression as a result of financial strain. This disrupted the early adolescent development of girls in these families. High levels of irritability between partners led to behavioural and emotional difficulties in children (Conger et al, 1994). For those already experiencing problems due to unemployment the picture is bleaker. Financial strain in US unemployed couples has been found to significantly impact on depression. Relationships deteriorate between partners leading to withdrawal of social support and increased undermining behaviour, this in turn further damages relationships (Vinokur et al, 1996).

Findings from Hatcher (1994) who studied people who poisoned themselves illustrate the serious consequences of debt. Those in debt were more likely to be diagnosed with mental illness. They harmed themselves with greater intent and exhibited greater depression and hopelessness after the suicide attempt than those without debt problems (Hatcher, 1994). The relationship between psychiatric symptoms and area deprivation has been reported by Congdon (1996), Harrison et al (1998) and Whitley et al (1999) who point to high rates of suicide and attempted suicide in socially fragmented areas where individuals are at high risk of social exclusion. Suicidal behaviour and increased psychiatric hospital admissions have been found in areas with high unemployment and deprivation (Kammerling and O'Connor, 1993).

Studies on students have also noted the relationship between higher debts and psychological distress. Ross et al (2006) conducted research on medical students. Those with higher debts worried more and performed less well in degree examinations than their peers. Some exhibited signs of mental illness. Furthermore, significant numbers who received financial assistance from their families reported the stress affected their families.

It has been illustrated that the impact of civil justice problems in general varies across age groups, also reflecting perhaps the extent of the problem among certain groups.



Data for 18-24 year old respondents to the Civil and Social Justice Survey of 2004 shows a quarter experienced a stress related health illness as a result of their problem. For socially isolated young people in this age group the situation was worse. Forty five percent reported a health illness as a result of their problem. All together the cost of civil justice problems to individuals, health and public services was estimated to amount to £13 billion over 3 ½ years (Balmer et al, 2007).

In its second annual report on over-indebtedness the UK government claim little change during the last ten years in the number of people who find their debts a 'heavy burden', the figure actually fell slightly in 2004. Despite high levels of consumer borrowing the number of people who found debt a burden or became over-indebted was considered relatively small (DTI, 2004c; Griffiths, 2005). The Bank of England and the UK government indicate that homeowners in the UK are perfectly able to service their debts, although those who are not homeowners are in a different situation (Griffith, 2005: 12). This is further verified with data from a Citizens Advice survey (Phipps and Hopwood Road, 2006), which found a much greater proportion of clients with debt problems were tenants.

It is hypothesised that those with good incomes and assets or promising financial prospects take a rational view towards borrowing; knowledge of future earnings or investment values off-set concerns. It has long been recognised that a downturn in the economy could put many people at risk. Research from the United States provides some insights into how this might impact upon subjective wellbeing. It found the negative relationship between the importance placed on money and subjective wellbeing is due to underlying motives of social comparison, power seeking behaviour, showing off, and as a means of overcoming self-doubt (Srivastava et al, 2001). Evidently the demographic profile of those affected by a debt problem is likely to have shifted considerably since the economic downturn occurred mid way through this research, and no doubt the psychological impact will be felt also.

## **The Impact of Debt Advice**

Evidence on the outcome and impact of debt advice received little attention until recently. Compared with literature on welfare rights advice, particularly in primary care, the deficit is striking. Contributing some early findings Samuel (2001) noted a decrease in criminal re-offences in those that receive debt advice; however, sample statistics were compared with criminal re-offending statistics in general. A review of the research into the impact of debt advice by The Legal Services Research Centre (Williams, 2004) identified areas where debt advice benefits the community, namely via savings to the courts, savings as a result of maintaining family stability, and as a consequence of maintaining employment. Additionally, savings from the avoidance of homelessness, criminality and stress related problems. In the US, Ellienhausen et al (2004) found borrowers improved their credit profile as a result of debt counselling over a three year period compared to similar groups in the same area. However, they note some bias in selection is probable.

Regarding the impact of debt advice on health, Gardner and Wells (2003) in a study of National Debt Line clients found recipients of debt advice felt improvements in their health and family relationships although the evidence was anecdotal. Whilst the work of Greasley (2003) was discussed in depth earlier, it is worth noting here that the author highlighted high levels of stress in those with debt problems and the impact advice may have on health and quality of life outcomes for these clients. Debt advice was cited by Plumpton and Bostock (2003) as a useful way of improving mental health problems. Importantly, they note a lack of studies into the impact of debt advice on mental health using validated health measures.

In an attempt to redress the shortfall in evidence, the Legal Services Research Centre recently published its findings from four studies that emerged from a project commissioned by the Department of Constitutional Affairs to investigate the broad Impact of Debt Advice on People's Lives. This has contributed important new evidence and supports findings elsewhere in the literature.

The four studies include a longitudinal advice agency study, which included Citizens Advice Bureaux, plus other advice services; analysis of The 2004 English and Welsh Civil and Social Justice Survey (CSJS); a qualitative follow-up study with 42 respondents reporting debt problems in the aforementioned survey; and, a Randomised Controlled Trial with 402 people with debt problems sampled from job centres (Pleasence et al, 2007b).

Findings from the studies confirm adverse changes to a person's circumstances most commonly caused their debt problems. A combination of events was often cited, but most frequently these included illness, relationship breakdown or loss of employment. In addition to changing circumstances, causes could also be attributed to poor money management and creditor behaviour. Of particular relevance, the findings highlight the distressing impact debt can have on intra-household and other family relationships, including relationships between partners, with family and friends, and between parents and their children. As a consequence of debt, the level of distress endured by individuals made it difficult for them to live their lives as normal.

Research findings from all four studies provide strong evidence of the positive impact that advice can have on a person's life. Overall, the project found evidence of improvements, although not conclusive, to levels of anxiety, general health, relationships, and housing stability. In the control trial, those receiving advice were more likely to report their financial circumstances as 'better' or 'much better' at a 20 week follow up than the control group. This difference was statistically significant. Nevertheless, whilst it was found that a third of the intervention group no longer had debt problems at the time of the 20 week follow up and were more likely to be able to see an end to their difficulties when at baseline they could not, no further statistically significant differences were found between the control and intervention groups.

Nevertheless, those receiving advice for their problems were better able to target priority debts and had a better understanding of their personal finances. Eighty four percent of those participating in the advice agency study felt more in control and of their finances and more knowledgeable. Their financial circumstances improved as a

consequence of better budgeting skills and newly acquired negotiating techniques with creditors.

In the advice agency study 26% said relationships with their children improved. The results from a 100 point self rated health index showed improvements to health occurred at six and twelve month follow up interviews. The qualitative study and control trial also reported health benefits. The advice agency findings revealed a total of 90% of respondents mentioned one or more positive benefits that occurred as a result of advice, although this was noted most frequently at six months compared to twelve months after the advice was provided. Interestingly though, as time passed by a greater percentage said they were able to carry on living normally.

As with other studies of this kind, panel attrition affected some outcomes. The study highlights yet again the challenges of researching those with serious problems, particularly relating to debt. The authors found that many of those participating in the control trial led unstable lives, moving frequently. This group is more likely to have their telephone cut off or avoid discussion on sensitive issues. However, the findings point to improvements in health, parenting, reduced family breakdown, increased economic activity, which the authors claim reduces the burden on the courts and brings about many economic benefits to society as a whole (Pleasence et al, 2007b).

In 2009 the Legal Services Research Centre published their findings from a multi-phased evaluation of debt outreach advice services located in a wide range of settings such as prisons, credit unions, community centres, housing offices and family centres in England and Wales. Legal service contracts were awarded to twenty two organisations to run pilot projects; these were mostly voluntary sector providers and included Citizens Advice. Over 40 full time debt advice posts were created in total; the projects were rolled out from January 2006 and service delivery ended in March 2008. Buck et al (2009) reported evidence from the evaluation that reveals a number of positive outcomes. Clients were able to develop payment plans and avoid crises such as the loss of their home or disconnection from utility services. In one year alone these advice services gained nearly £1.9 million as income for clients. As a consequence of the help and advice they received, clients reported a number of

additional outcomes, such as feeling less stressed. Most felt more optimistic that they could avoid debts in future, although due to their circumstances they still believed this would be difficult.

One further outcome was that their attitudes towards advice seeking behaviour changed for the better (Buck et al, 2009). This is particularly encouraging as it is known that those from socially excluded groups are less likely to try to resolve their problems (Genn, 1999; Genn et al, 2004), although if they do seek help they are more likely to seek legal advice or general advice or support (Pleasence and Balmer, 2009). Consequently, the attitudinal change observed by Buck et al (2009) is a move in the right direction. Nevertheless, there was also some indication that people who were most vulnerable had expectations of much longer term support. This clearly has implications for service delivery.

In 2007 Orton began a six year longitudinal qualitative study into the impact of debt advice on low income families. The findings contribute important new evidence of the longer term impact of debt advice. Despite initially experiencing major difficulties accessing advice services, in-depth interviews with 59 respondents in year one revealed the overwhelming majority had positive experiences of debt advice (Orton, 2008). In keeping with Borland's (2004) findings, outlined earlier, they appreciated having someone to talk to. They also appreciated the information, options, reassurance and representation provided by their advisor. They felt better able to deal with creditors themselves. They described the advice as having impacted on the control they had over their financial situation, although many still had money worries. Many said their debt problems had affected their financial confidence and they had shunned credit completely.

In year two, 30 out of 56 respondents participating in the follow up interview said their position had improved during the year, although their degree of optimistic varied (Orton, 2009b).

Findings from year three, relating to the remaining sample of 53 people who received debt advice in 2007, showed positive experiences reported by the majority of

respondents in year one remained largely unchanged three years later. Rates of indebtedness had declined for the majority of the sample, although a very small minority had increased debts. Varying levels of difficulty keeping up with repayments were reported. The financial situation for many remained unclear; low income was cited as holding people back, none appeared to have savings and over half had borrowed money between wave 2 and 3 of the study. Thus the conservative financial approach exhibited in wave 2 appears to have diminished. Nevertheless, respondents still saw the advice as being helpful. Indicative of the ongoing impact of debt advice, even where their debts were unresolved many felt better able to deal with creditors and were able to prevent their debts deteriorating. However, difficulties with creditors were still reported, most notably because of pressures to review repayment agreements or increase them. Some creditors declined payments agreed previously with advisors and others passed the debt onto other debt collection companies. Some respondents were able to act for themselves but for others longer term assistance appears to be needed. Crucially though, in keeping with Buck et al (2009), positive changes in advice seeking attitudes were observable.

Importantly, this study illustrates the much longer term impact of debt advice but it also illustrates that the financial difficulties of those living on a low income simply do not go away as a consequence of advice. Orton (2010) argues debtors cannot simply be seen as groups who 'can't pay' or 'won't pay'; a much more sophisticated understanding of debt is needed that takes account of the structural position of those living on a low income. In light of this, ongoing support may be needed for those who are most vulnerable, as indicated by Buck et al (2009).

## **Conclusions**

This chapter began with an introduction to the topic of personal debt in the UK and provided a number of definitions. Objective and subjective measures were discussed. No comprehensive data exists regarding the extent of personal debt in Wales, thus necessitating reliance on UK statistics. Debates surrounding the existence of a debt problem show that despite considerable statistical evidence of the extent of personal

borrowing and personal debt in the UK, some experts refused to acknowledge the problem.

It has been proposed that a number of critically important, multi-faceted explanations of debtor behaviour exist, which comprise of demographic, financial, economic, psychological and situational variables (Stone and Maury, 2006).

In keeping with a recent review of over-indebtedness in Wales (2005) the wider literature expands upon the causes of debt. These include low income; irresponsible lending; illegal money lending; lack of budgeting skills and financial education; lack of information about entitlements; peer pressure; modern society and the existence of a 'credit culture'. Whilst it is also acknowledged that unforeseen changes to a person's circumstances can trigger debt problems.

In terms of policy solutions, there is a clear emphasis on improving access to mainstream financial services and developing individual financial capability. However, this latter policy approach overlooks explanations that show many households get into debt because of sudden changes in their circumstances.

A number of attitudinal factors have also been discussed. Relying upon either – or explanations of structure and agency, “the social reality of agency being overlaid onto structural inequality” (Orton, 2009a: 497) has largely been ignored.

Whilst debt is acknowledged to cause psychological distress (Reading and Reynolds, 2001; Balmer et al, 2005; Brown et al, 2005b) and can result in chronic stress, it is logical that debt advice may alleviate this stress. Likewise, the hypothesis that increased income gained from benefit entitlements can improve health should apply equally to debt management as this can result in increased disposable income and greater financial stability. However, surprising little research exists to test such a hypothesis using standardised instruments. In fact, until very recently little research had been undertaken on the impact of debt advice.

## **Limitations of Research to Date**

Drawing upon the literature concerned with Welfare Rights advice and debt advice in the previous two chapters, some limitations are noted that highlight possible gaps for further research.

It is evident that a large body of research on the work of advice services emerges from the field of primary care, including an evaluation of the BABH primary care advice service in Wales. To date insufficient attention has been paid to advice provided in other settings. As one leading figure in the field notes:

“There is no reason to suppose that service users would experience fewer benefits to socioeconomic status and health if they used services in other settings” (Abbot, 2002: 310).

The literature drawn from primary care settings provide a preponderance of studies on welfare rights advice, comparably, scant attention has been paid to the impact of debt advice until very recently. Highlighting the deficit Williams (2004: 26-27) noted “There is little systematic research, even on a qualitative basis, and few resources appear to be made available for this kind of work”. Galvin et al (2000) draw attention to the potential of a study of CAB advice on a range of issues including financial matters and debt counselling in order to explore the impact of advice on health, quality of life and income. Like Abbott (2002) they also propose research should be undertaken in a broader range of settings:

“Evaluations of CAB, not only in general practices, but in other innovative settings, such as community centres, youth centres, hospitals and social services, could be undertaken” (Galvin et al, 2000: 281).

Due to its domination in health care settings, less is known about how clients learn about and access the CAB service in other settings and their satisfaction with access and information about the service as a whole in Wales. There are also a number of additional questions unanswered, for instance, little is known about factors that may



influence a client's decision to pursue the advice once it is provided. To date no recognition has been given to the role of casework or specialist advisors. Due to this deficit, little is known about clients' personal experiences of working with a CAB to resolve their problem(s) over the prolonged periods of time associated with casework and specialist advice. Focusing almost exclusively on advice services in England, little is known about the characteristics of those who use the CAB in Wales. Nor is there is any longitudinal evidence on the impact of advice on the lives of individuals in Wales.

In the legal profession, some recent long overdue research illustrates the positive impact that debt advice can have on individual's lives. Research has pointed to a significant association between debt advice and positive improvements in health but offers considerable scope for longitudinal evaluation using validated health outcome measures.

Only a few studies illustrate how improvements in clients' financial circumstances impact on aspects of personal spending and these relate specifically to money gained from Welfare Benefits advice. Opening a new avenue, research could look at how spending patterns change as financial stability improves, and this could encompass spending on the dependent children of CAB clients where applicable. To date, little is known about the impact of advice on the material, social and emotional wellbeing of dependent children of clients.

This research set out to build on previous research in the field by providing an account of advice giving in a range of settings by the Citizens Advice service in Wales – and not only within a primary health care setting. It is hoped that this will enhance what is known about the impact of advice on the lives of individuals by building on a body of existing research and exploring new areas to fill some of the gaps in the existing literature.

## CHAPTER THREE

### Research Design and Methods

According to de Vaus (2001: 9) “The function of research design is to ensure that evidence obtained enables us to answer the initial question as unambiguously as possible.” Expanding on this, research design deals with a ‘logical’ problem not a ‘logistic’ one (Yin, 1989: 29). Methodology on the other hand is concerned with techniques for collecting data (Bryman, 2004: 27). In this study, research design and methodological decisions were made within the framework of a methodology working group, and guided by a steering committee. Notwithstanding this, methodological issues dominated early discussions with the sponsoring company, and requests were regularly made for work to begin on a questionnaire before the precise aims of the research had been contemplated or agreed. It is within this context that research design and methodology is discussed.

This chapter begins with an account of issues which shaped the research process. Underlying epistemological and ontological considerations are explored with a rationale being provided for the quantitative approach taken. The process of devising measures for concepts is discussed. The chapter considers the theoretical merits of the sampling technique adopted, methods of data collection and the questionnaire schedule while also reflecting on the tenor of exchanges within and outside of the committee frameworks. Consideration will be given to ethical issues and early preparatory measures, which included a baseline pilot study and training programme for CAB staff. The chapter draws to an end with an account of procedures for the analysis of the data.

#### **The Research Context**

Long before commencement of the project, an outline of the research was developed by staff at the School of Social Sciences, Bangor University in conjunction with Citizens Advice Cymru. In summary, the research would be geared towards “tracking outcomes for a sample of clients across Bureaux in Wales” in order to “track clients’ changes over time” (Project outline, 2006.). It was envisaged that these changes

would include ‘practical gains’, such as increases in income, and ‘consequential gains’ such as improvements in health or quality of life. The researcher was to “design and conduct CAB client surveys (using postal questionnaires, telephone follow up or face-to-face interviews as appropriate) to measure outcomes of CAB advice on individuals” (ibid).

A Research Studentship Agreement was formalised at the end of May 2006, signifying commencement of the three year project. An academic supervisor and a company supervisor guided and supported research activity throughout the life of the study. Testifying to the political importance of the research, the company supervisor held the position of Citizens Advice Cymru Welsh Assembly Government Liaison Officer. This person left the company in the spring of 2008. It is reflective of the significance placed on the research at this point in time that the role of company supervisor was then taken by the Director of Citizens Advice Cymru.

A Methodology Working Group was also formed at the onset of the project to provide advice and support on issues concerned with research methods. This group comprised of two members of academic staff from Bangor University (including the academic supervisor), the company supervisor, the Chief Executive Officer (CEO) of a local CAB, and a member of the Citizens Advice Cymru Management Team.

A Steering Committee was formed to provide guidance, advice and support that would enable research objectives to be met, and to monitor the work of the Methodology Working Group. The Committee was chaired by a trustee from Citizens Advice Cymru who prior to retirement held an academic position at the School of Social Sciences, Bangor University. Steering Committee members included the head of social policy from the Citizens Advice headquarters in London, this person subsequently left the company in 2007 and was not replaced on the committee. The Director of Citizens Advice Cymru was also a member but in the earlier stages of project often deferred responsibility to the company supervisor. A local politician who was formerly a Plaid Cymru leader, a Member of Parliament and Assembly Member attended the committee until early in 2009. Some members of the

Methodology Working Group also sat on the Steering Committee; namely, the company supervisor, academic supervisor and CEO from a local CAB.

A former member of academic staff from the University was invited to join the Steering Committee. This person had previously conducted research with Citizens Advice Cymru and was involved in developing the project prior moving to another university just before it commenced. Although this person attended meetings sporadically, advice was offered informally outside the committee structure and at the first Methodology Working Group Meeting.

The project benefited in a number of ways from the expertise and experience of members of the Methodology Working Group and Steering Committee. Naturally though, differences between those from the two distinctly different organisational cultures arose at times. Academic routines and procedures seemed slow and possibly unnecessary at times to those from the sponsoring company. Each person had views about research methodology and, importantly, the aims of the research itself, which often conflicted. Meetings were not always fully attended and, as indicated previously, some members left before the research was complete.

During the period of the study the Citizens Advice service underwent a re-structuring process for which all members of staff were interviewed for the position that they held. Consequently, some members of the committee and other key contacts left the organisation and others were given new roles. Naturally, this was a time of great uncertainty for many people and understandably the research project was not always their priority.

This account of decisions regarding methodology must be considered in light of the context in which the research was conducted.

In the early weeks of the project, in July 2006, the first Methodology Working Group meeting took place, where aspects of the proposed research were discussed. Upon reviewing the research brief, a member of the Methodology Working Group raised concerns about the cost and time required to conduct an all Wales longitudinal study.

It was said that conducting face to face interviews with clients sampled from all 32 legally affiliated bureaux in Wales would dominate PhD activity; telephone interviews would be time consuming on the scale required, whilst the cost of travelling throughout Wales, in order to carry out face to face interviews, was impractical and expensive. Response rates to postal questionnaires is poor and data is more likely to be incomplete, what's more, as CAB clients often seek assistance completing forms, the idea of a postal questionnaire was deemed unfeasible and could result in bias in the sampling.

The British Sociological Association (2002, item 58) in their Statement of Ethical Practice state "A research study should not normally be undertaken where it is anticipated that resources will be inadequate." Consequently, this concern underpinned many key decisions regarding the design and methodology.

Alternative approaches were proposed and discussed during early methodology meetings and informally outside of the committee structure. The British Sociological Association (2002, item 52) stresses "Members have an obligation to ensure sponsors grasp the implications of the choice between alternative research methods." First, a qualitative approach was discussed. This appeared to be viewed by the sponsoring company as a weaker alternative to quantitative methods and there was a sense that it would deviate too much from the brief. Second, additional funding was sought to cover the cost of a longitudinal study, with the suggestion that it could be conducted as an 'add on' activity to a smaller local quantitative or qualitative study, whilst still remaining within the three year timescale. Third, the proposed longitudinal study of CAB clients across Wales could be conducted with the researcher leading and managing the research. This would involve co-ordinating data collection, which could be undertaken by CAB staff.

After several months of discussions, the request for additional funding was declined, and the option to conduct a longitudinal quantitative study as an 'add on' activity did not materialise.

It was stipulated that the research should focus upon the key policy priorities of Citizens Advice Cymru, the Welsh Assembly, UK Government and interests at bureau level, namely: over-indebtedness; child poverty; health and well-being; discrimination; and, access to services. However, the process of refining the focus of the research, formulating research questions, operationalising concepts, and reaching agreement on methodology took approximately nine months. During this time methodology was often prioritised or confused with design, and discussions aimed at gaining direction with research questions met with the same response – that the research should ‘look at everything’. It was a time of negotiation and most importantly decision making. Reflecting upon events, this was one of the more challenging periods in the three years of the project.

During the early months, the research interests of Citizens Advice Cymru moved in line with the most talked about the topic of the day – whether this was access to services, health, discrimination, housing or personal debt – and was influenced further by the personal interests and views of those who attended meetings of the Methodology Working Group and Steering Committee. For instance, one committee member wanted to ‘un-pick debt’, whilst another wanted to ‘learn about all aspects of discrimination’; and, joining the committee for the first time some seven months into the project another steering committee member announced a strong interest in ‘housing’. Conversely, those absent from meetings were not heard and subsequently had little input into the schema; although, unhelpfully, they often attempted to rectify this situation at a much a later date outside of the committee framework. Although the imperative for a quantitative longitudinal study remained unchanged throughout this period, when considering research design the first consideration should be “What kind of question is being asked?” (Bouma and Atkinson, 1995: 133), and therein lay the problem – the key decision makers wanted different things from the research. The direction the research would take was also influenced quite naturally by informal discussions and meetings where certain preferences would be emphasised and others dismissed before reaching the agenda of the next meeting. Although no malice was intended, many decisions were made with the insistence of certain committee members without full consideration being given to the scope of potential areas of study and the merits of alternative methods of conducting the research.

After several months of discussions it was agreed that the research would include clients receiving advice for welfare benefits issues and debt issues. Initially employment issues were considered for inclusion in the study, as it is under this heading that discrimination advice is often provided. However, not all bureaux operate employment contracts and so the wording was changed from 'employment' to 'discrimination' in the hope that this would 'pick up' cases from bureaux that had employment caseworkers and others that had discrimination caseworkers. Consequently, discrimination drew on a relatively small advice category compared to the more widespread problems of welfare benefits and debt for which bureaux most frequently provide advice. Critically pressing time issues resulted in the incorporation of discrimination as a category for inclusion in the study, thus enabling the project to progress, although no specific research questions were related to discrimination or specific sampling techniques adopted to draw adequate cases. The aim was simply to 'pick up' cases where they existed.

At this juncture the climate between Citizens Advice Cymru and its CABx is worthy of discussion. Whilst some bureaux affiliated to Citizens Advice exhibited strong agreement with its aims and values, some did not. These bureaux believed Citizens Advice to be a threat to their independence and source of funding. Regional meetings between the two could be tense. Bureau managers and chief executive officers often openly challenged the Director's instruction on a wide range of issues. Bureau participation in research proved to be one important area of their remit that was unclear and subsequently challenged. Several questioned whether it was their role to be involved in research at all. The complexity of the relationship between Citizens Advice and its member Bureaux was not apparent to those from the academic community at the start of the project; instead it came to light as the research unfolded.

Perhaps it is for these reasons that bureaux were not consulted about what they wanted from the research, nor were they involved in methodological decisions, with the exception of one CEO of a local bureau who sat on the Steering Committee.

Most importantly, it was deemed imperative that the study would produce statistics and hard quantitative evidence for financial stakeholders of the CAB service, a

concept coined by Gephart (1988: 9) as ‘ethnostatistics’, which is described as “The study of the construction, interpretation, and display of statistics in quantitative social research” (ibid). The main precept for research being that by use of quantification, social research provides a natural science view that is deemed legitimate and credible because of this association (McCarney, 1970). Consequently, qualitative approaches were considered of little value as, it was believed, they would be quickly dismissed by financial stakeholders of the service.

In providing a candid account there is a risk that the reader will formulate a negative opinion of those implicated. This is not the intention, for it is imperative to place events into context. In these tentative early stages the longevity of the project was a primary concern, which compounded the control the sponsoring company had over research decisions. Within the Steering Committee structure micro political interests at times drove individual lobbying. Working relationships were still being formed, and the divide between academic cultures and those of the sponsoring company took a very long time to understand and respect. Slowly, roles and boundaries were clarified and the foundations built for a positive, collaborative partnership which stood the project in good stead in ensuing turbulent stages through to a genuinely positive close.

### **Theory and Research**

This thesis is based upon a longitudinal quantitative study, which set out in broad terms to assess the impact of advice on the health and quality of life of a cohort of CAB clients seeking casework or specialist advice in Wales. From a theoretical perspective the paradigm that underpins quantitative methods is positivism. Although paradigms, which may be defined as the world views or belief systems that guide researchers (Guba and Lincoln, 1994), were of little concern beyond academic circles.

Quantitative research involves more than the quantification of aspects of social life and this is not all that distinguishes it from qualitative approaches (Bryman, 2004: 62). Consequently, the link between research and theory is not clear-cut and it would be wrong to suggest that all researchers fall neatly into one camp or another. For some, the ‘war of the paradigms’ is centred on debates such as ‘the nature of reality’



and for others issues about the possibility of ‘causal linkages’ (Tashakkori and Teddlie, 1998: 4). Although philosophical ideologies are generally concealed within the research (Slife and Williams, 1995), they influence the practice of research and this necessitates that they are identified.

Quantitative and qualitative researchers appear to be clearly orientated in a number of basic but fundamental areas. Naturally debates centre on whether it is appropriate to study society using a natural science approach, which leads to contrasting epistemological and ontological standpoints. Importantly though, the distinction between the two opposing camps is not necessarily definitive and some commonality may occur in the orientation of quantitative and qualitative researchers.

In fact, as long ago as the late 1950s, influential positivist researchers of the era acknowledged in their writings that research is influenced by the values of the researcher, inquiry may be influenced by theory, hypothesis or a framework that the researcher uses, and that our understanding of reality is constructed (Reichardt and Rallis, 1994). According to Newman and Benz, (1998) present-day research is less concerned with quantitative versus qualitative and more to do with research practices that lie along a continuum between the two. And so, shared logic is found between some quantitative and qualitative researchers.

Some support the view that quantitative approaches can tap into subjective meaning and claim that qualitative approaches do not always do so as effectively as proposed. In a critique of the qualitative position, Platt (1981) questions the notation that qualitative research is the only approach that produces studies through the eyes of the people who are studied, claiming qualitative research rarely demonstrates tapping into participants’ world views through respondent validation; in practice this is often an assumed notion. It is also argued, from a feminist perspective that:

“...the automatically laudatory designation of qualitative methods within feminist social science and other “anti-positivist” sociologies is a cause for concern, since such methods are no guarantee of equal power relations between the researcher and the researched” (Oakley, 2005: 187).

Conversely, others argue that quantitative research can (to some extent) tap into matters of 'meaning' and often does in social surveys. Participants are often asked questions about the reasons for their actions or the meaning of critical life events, and their attitudes towards certain social phenomena. Marsh (1982) argues that quantitative surveys, whilst not having a good track record at tapping the subjective dimension of behaviour, can give accounts that are adequate 'at the level of meaning'. She explains that:

“Survey research became much more exciting ... when it began including meaningful dimensions in the study design. Asking the actor either for her reasons directly, or to supply information about the central values in her life around which we may assume she is orientating her life. [This] means collecting a sufficiently complete picture of the context in which an actor finds herself that a team of outsiders may read off the meaningful dimensions” (Marsh, 1982: 123-4).

Bryman (2004: 443), argues that quantitative research can play a key role in the construction of the social world, for instance by revealing aspects of the social construction of a phenomenon. From a theoretical and conceptual standpoint, the scope and range of analytical configurations available with analysis techniques provides the researcher with a number of possibilities in not only testing pre-existing hypotheses but also exploring new avenues of exploration within the data. Thereby, the argument that quantitative research is only concerned with answering previously formulated hypotheses is diffused. Advocates of qualitative approaches generally hold the belief in the naturalistic environment in which research occurs as a route to capturing the lived experience or normal social world of the participant. In reality this is rarely the case. The researcher's presence will to some extent intrude upon that environment. Whilst for those in a more formal setting, the process of scheduling an appointment and inviting a stranger into the setting is artificial in itself. Consequently, the artificiality of quantitative research may be closer to qualitative research than initially perceived.

Therefore, qualitative research may also contain elements of the positivist epistemology, and quantitative research can contain elements of interpretivism. Furthermore, as Bryman (2004) highlights, there are a number of other influences on the conduct of social research. These include the values of the researcher – their

feelings or personal beliefs, and practical considerations. With reference to this latter point, practical considerations played a significant part in shaping the research.

Consequently, although differences exist between epistemology and ontology of the quantitative and qualitative approaches, this research is based upon the premise that these are not deterministic. Quantitative research can, to some extent, tap into the meaning of the subjects lived experiences and it can explore the data beyond previously formulated hypothesis. It is also argued that quantitative outcomes can play a role in understanding the social construction of phenomenon.

As noted in this discussion, social research is also shaped by practical considerations. In this respect, in addition to meeting the requirements of the sponsoring organisation, consideration was given to the resources available to support the research. A small budget was in place for project expenses; however, this was to be claimed by the Spring of 2008, just two years into the three year project. It is important that the commodity of time is spent wisely – how could the research track change over time in a cohort of CAB clients scattered over a large geographic area with generally poor transport links? Combined with theoretical considerations, and informed by the literature review, this is one of the many questions that were asked, which influenced the approach adopted.

### **The Advantages of Adopting a Quantitative Approach**

The key stages of quantitative research are said to sequentially begin with theory and hypothesis, followed by research design considerations. However, Aldridge and Levine (2001) point out that it is pragmatic to acknowledge that much empirical research is eclectic and rather than setting out to test a theory, most research is exploratory or developmental in that it seeks to modestly advance thinking on a topic. Nevertheless, the researcher must devise measures of concepts, selects research sites, sample research participants, administer research instruments in order to collect data, process and analyse data in order to produce their findings, and formulate conclusions. There are a number of advantages associated with quantitative research, which Bryman (2004) discusses in detail. These are outlined next.

Taking a quantitative approach, key research questions are stated specifically and measures of concepts are devised at the onset, a process referred to as operationalisation. The researcher should clearly state the hypotheses and provide a recognisable rationale for the sample and variables to be studied. However, Wall and Williams (1970) propose that:

“As well as this, a well designed longitudinal study will anticipate the possibility of spotting the unpredictable influence, the critical period – and any worthwhile definition of the process of research must include the occurrence of insight along the way, unforeseen and arising from living with the data obtained. Too restrictive a set of hypotheses may in fact produce rigidity and actually prevent the sudden illumination” (1970: 24).

This approach proved to be advantageous, as research questions and concepts were agreed within the committee structure, symbolising an end to months of discussions. This ensured the original goals of the research were followed through objectively and the project progressed, whilst retaining some flexibility to explore unplanned avenues of interest as and when the data prompted new research questions.

Quantitative research is useful where measures are to be developed. For instance, concepts to be measured in the research such as health, quality of life, social isolation, and social support, and so on, allow the researchers to delineate fine differences between the characteristics of respondents and thereby provide explanation about a particular aspect of the social world or the concept explained. More precise estimates of the degree of relationship between concepts can be given. Changes can be measured over time or in variation. This process allows new concepts to be generated, for example, explanations about improvements in health that occur over time.

Another advantage of quantitative research is that indicators can be developed for the concepts which they represent. For instance, scales were created to represent respondents level of satisfaction with aspects of the CAB service.

The researcher can distinguish variation in the concepts measured in finer detail, for example, in relation to the concept of health it was possible to delineate dimensions of health such as bodily pain, role emotional, role physical, and so on, and variations in changes that occur in each dimension. The idea that different dimensions of a concept are measured is associated with Lazarsfeld (1958, cited in Moser and Kalton, 1971) and underpinned by the expectation that theory and research informs the identification of dimensions of the concept. The rationale for measuring dimensions of a concept is that respondents may score differently across the dimensions. For example, scores may indicate improvements in dimensions of mental health but not dimensions related to physical functioning.

Measurement provides a consistent device for making distinctions; this is important when concepts are measured over time and ensures greater consistency when questionnaires are administered by different people. It allows comparisons to be made with the findings of researchers in the field.

However, it is essential in quantitative research that measures and indicators tap into their intended concepts, which raises issues of reliability and validity. Fundamentally, reliability is concerned with the consistency of a measure of a concept. A measure should exhibit stability. This means that similar results would be obtained if it was administered to a group of respondents on different occasions, assuming no unintended intervention takes place. The internal reliability of a concept can be assessed by checking whether scores or responses to indicators relate to results obtained from similar indicators; Cronbach's alpha is commonly used to test internal reliability.

Validity is concerned with whether an indicator or set of indicators effectively measures a specific concept. Several methods exist for assessing validity. Face validity can be assessed intuitively and by asking others in the field whether on the face of things a measure actually taps into a concept. It is possible for the researcher to estimate concurrent validity, whereby variation in a measure, for instance levels of satisfaction with a service or rating aspects of health, is assessed. In quantitative research the researcher will deduce hypothesis from a theory that is relevant to the

concept, this allows an estimate of construct validity. Furthermore, comparisons can be made between alternative measures of the same concept, which provides an indication of convergent validity.

From a practical perspective, incorporating validated instruments, such as health outcome measures into each wave of the study, meant the research would withstand rigorous critique from financial stakeholders of the CAB service, whom the sponsoring organisation hoped the research would influence. These include the Welsh Assembly Government, Local Authorities, Town Councils and other bodies funding Citizens Advice and their Bureaux, as identified earlier.

In essence, quantitative research can play an important role in the development and testing of sociological theory. And while it is acknowledged that not everyone likes to participate in surveys, it is argued that they give individuals a voice, particularly disadvantaged and under-privileged groups who wish their experiences, opinions or grievances to be heard (Aldridge and Levine, 2001: 15).

### **Longitudinal Design**

The ongoing commitment to a longitudinal design was underpinned by the requirement to measure change in individual clients over time, and postulate some causal relationship between advice intervention and outcomes acquired for clients. The various forms of intervention are discussed by Piesse et al (2009). Interventions that can take place at individual or group level, and may vary in uniformity, that is, intervention may vary loosely between locations. Longitudinal data is required if the intervention takes place over a long period and there is a desire to examine increasing or decreasing effects over time.

A number of critical decisions were made regarding the longitudinal design of the research. Researchers conducting longitudinal studies without a control group must defend the internal validity of their research. They must consider history and maturation issues, potential weaknesses with instruments, measurement error, panel conditioning and panel attrition. Each of these issues will be discussed in turn.

## **Overcoming the lack of a Control Group**

Randomised Controlled Trials (RCT) are often cited as the most appropriate method of measuring change or non change. The purpose of an RCT is to establish the effectiveness of a treatment or intervention; the rationale being that it is possible to assess the effectiveness of the intervention compared with alternatives or no intervention. In medicine the intervention or treatment often takes the form of a medical treatment such as a pharmaceutical drug administered to a treatment group whilst a placebo is given to a control group. Change or non change in the groups is studied over time and the groups compared so that the intervention can be evaluated. It is commonly alleged that a lack of control group creates problems with internal validity as it can be difficult to determine if any change is due to intervention or some other influence.

Despite its advocates, there are a number of problems and pitfalls associated with RCTs. Cartwright (1986) provides a good critique. The option to create groups is often limited by inadequate numbers of research participants and when it is possible there is often a lack of blindness in constructing groups and analysing outcomes. Exclusions have to be made on well defined criteria and effects should be evaluated by someone who does not know which respondents are in the treatment or control group. Due to the problems with the handling of controls and interpretation, it is only possible with certain groups that a randomised control group is appropriate and ethical and it is this latter point, which provides the grounds for most objections to control trials.

Constructing a control group would involve withholding advice from individuals within one group – the control group, and providing advice to another – the treatment group. The literature, as discussed already, clearly shows there are considerable financial benefits associated with advice; the links between poverty and poor health are well known, and there is evidence that individuals benefit in a number of ways from receiving advice on the matter of their problems. Some welfare entitlements are guaranteed in law, and it is a matter of social justice that public policy should aim to

reduce poverty and inequalities whether these are financial or concerned with health and quality of life (Abbott and Hobby, 2002: 55). Naturally, the idea of a control group is at odds with the ethos of the Citizens Advice service. Consequently, to withhold advice to individuals seeking it was totally unacceptable and practically impossible in the context of this research.

A possible alternative approach is a non-random control group, which would involve recruiting individuals with debt, discrimination or welfare benefits problems from settings other than the Citizens Advice Bureau service. However, due to practical limitations of the time and budget, and the difficulties sampling such a control group and following up individuals over a prolonged period of time, this option was deemed impractical.

Utilising variation within the panel to construct groups can alleviate some of the problems of not having a control group (de Vaus, 2001: 131). However, the literature illustrates that the scientific value of control groups is uncertain as it is virtually impossible in research of this nature to match experiment and control or quasi control groups accurately (Abbott and Hobby, 1999: 11). For instance, with relatively small samples it is difficult to match individuals by key demographic variables, and to match the type and extent of their problems, consider any precipitating events, and each person's health status.

For these reasons the study did not utilise a control group.

### **Advantages of a Multiple Point Prospective Study Design**

Despite the aforementioned considerations, the literature provides strong grounds for a multiple point prospective longitudinal study design. Mosser and Kalton (1971) argue that it is still possible and worthwhile to establish causal connections. What's more, it is possible to build on the work of others by exploring variables that are meaningful and have validity in the field (Wall and Williams, 1970).



There are many additional advantages. Piesse et al (2009) assert longitudinal surveys are valuable for evaluating the effects of interventions; bias is less likely if some data is collected before the intervention is in place, and this provides natural covariates for later analysis. Collecting data at multiple time points enables analytical techniques at baseline, and later stages of inquiry between time points (Lynn, 2009). The rationale for a multiple point prospective panel design is that it is possible to examine patterns of change or stability and to track change at both aggregate level and individual level. A basic tenet of causal reasoning is that cause must precede effect in time. Therefore, a longitudinal design allows the researcher to establish the temporal order of events. The purpose of collecting data at multiple points is to enable long and short term effects to be established and tracked, to illustrate the characteristics of any change and identify factors that precede change or non change (Piesse et al, 2009).

### **Time Frame for Data Collection**

Time between data collection is vital for a number of other reasons. Many events can take place in the life of respondents that can be difficult to isolate (de Vaus, 2001). The longer the period, over which respondents are required to recall events, the less likely they are to recall with reasonable accuracy (Cartwright, 1986: 146); although the more important an event, the more likely the respondent is to recall it (Douglas and Blomfield, 1956, cited in Cartwright, 1986: 145). It could be argued that those experiencing personal debt, discrimination and/or welfare benefit problems, will on the whole consider these as important events, particularly as this particular cohort of CAB clients had series problems, many had multiple problems and most were longstanding and complex in nature.

Nevertheless, it is wise to consider respondent recall and one way of reducing memory errors is to collect data within a reasonable timeframe. Conversely though panel conditioning and respondent burden can occur if respondents are exposed to the same question frequently, what's more this can contaminate their responses. Whilst on the topic, it is worth mentioning Sturgis et al (2009: 123) who note that the literature on panel conditioning lacks coherence and clarity regarding mechanisms

underpinning conditioning effects, and panel conditioning is often confused with many other flaws in research designs.

Therefore, a fine balance and use of judgment is required if data is to be collected at the optimal time point.

Aldridge and Levine (2001) suggest working backwards from immovable deadlines such as the delivery of the project, whilst allowing for windows of opportunity or restrictions. In practice the project was initially funded for 2.4 years and expenses for two years (project expenses to April 08, funding to end September 08). For political reasons it was important to produce some results within this period before the end of the three years of the project in May 2009. Adequate time should be allocated to each wave of data collection and time set aside for data to be collated. Time is also needed between data collection points for analysis to be undertaken, whilst it was desirable to allow some time for emerging results to be fed into some potential new avenues of exploration in subsequent survey schedules, if these looked interesting and relevant.

The nature and content of the study is crucial when considering gaps between waves of a study (de Vaus, 2001: 142). Accordingly, it was important to consider the time needed to follow clients' progress with the problems for which they were seeking advice through to resolution (where possible). In complex cases this can take many months, whilst some client issues are resolved relatively quickly. Discussions with Citizens Advice Bureau advisors, managers and relevant members of the Steering Committee and Methodology Working Group resulted in an estimated timeframe of 12 months being required to follow complex cases to resolution, although it was to be expected that a small number of client issues could take 18 months or longer to fully resolve. It was not possible to conduct 18 month interviews because of the time and funding available. Nevertheless, six and 12 month data collection points, as advocated by others in the research field, would enable changes to be tracked. Six months is long enough for respondents to forget previous responses to questions but recall important events in their lives, without being over-burdened.

Pioneering research in the field, Veitch (1995) reported that a single six month follow up interview is not long enough for change to occur, although this has since been disproven. This has been influential in subsequent comparable studies. For instance, Abbott and Hobby (1999, 2002) and Greasley and Small (2002) each collected data at three time points - a pre-test baseline data collection point and two post test data collection points, one at six months and another at twelve months after referral. This research is based on their models and the findings from their research.

Therefore, based on the literature and a number of practical considerations, the preliminary time frame for data collection was established as:

- Pilot: February - March 07
- Baseline: 1<sup>st</sup> April - 1<sup>st</sup> June 07
- Wave 2: 1<sup>st</sup> October - 1<sup>st</sup> December 07
- Wave 3: 1<sup>st</sup> April - 1<sup>st</sup> June 08

Due to the large number of CAB staff and bureaux expected to be involved in the project it was estimated that a two month time frame for data collection would adequately produce a sample of 320 clients. For instance, in 2006/07 Citizens Advice Cymru reported that their 32 member bureaux provided advice from over 200 locations in Wales.<sup>3</sup> The Citizens Advice Cymru Report of 2007, which is based on data from 60% of bureaux, provides examples of the scale of advice provided in Wales. Clearly not all bureaux provided statistics, the reason for this omission is not known although gathering data from bureaux was known to be problematic. Figures show CABx provided advice on 91,368 debt related problems and 95,674 benefit and tax credit problems, equating to 32% and 34% of advice issues respectively that year.

Based on previous research, Greasley and Small (2002) estimate that 25% of those asked to participate in research of this kind will agree. Considering the size and scale of the Citizens Advice service in Wales a two month time frame for each wave of data collection appeared to be adequate, although this time frame was later extended

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<sup>3</sup> One bureaux that did not participate in the research closed shortly after the project commenced.

because many bureaux started the project late and sampling was much slower than expected. This topic will be discussed in depth later in the thesis.

### **Selecting the Data Collection Method**

Three key methods of data collection were considered: telephone interview; self completion questionnaire; and, face to face interview. Aldridge and Levine (2001) provide a good critique of the advantages and disadvantages associated with each of these methods:

#### *Telephone Interviews*

Telephone interviews are cheaper than face to face interviews and it is feasible to survey larger samples drawn from wide geographic areas. However, telephone interviews were not viable as the sole mode in this study for a number of reasons, some of which were concerned with micro political issues operating within Citizens Advice and CAB circles.

Turning first to micro political issues, individual client data is gathered and stored at Bureau level. For the researcher to conduct telephone interviews, bureaux would need to provide clients' contact details. During the period when methodological decisions were made, bureaux were in the throes of disputes over the implementation of a computerised client case management system called 'CASE'. The software feeds key statistical data, recorded at bureau level, to the MIS system operated by Citizens Advice Cymru for the production of their annual management reports. Client data fed into the MIS is anonymous, and mainly comprises of demographic variables and details of the issues for which clients seek advice. A number of bureaux in Wales resisted adopting the new system, whilst others were suspicious of interference with data collection procedures, and it was said, would oppose access to their clients' data for the purposes of research, even with client's consent. Therefore, it was likely that the process of gaining access to clients' telephone numbers via bureaux would be problematic.

A primary concern with telephone interviewing is that socially disadvantaged groups will be underrepresented, resulting in response bias. Citizens Advice Bureau clients generally represent some of the poorest sectors of society. Many do not have a landline telephone connection and rely instead on mobile telephones, whilst others have no telephone at all. Those with mobile telephones often experience irregular connectivity because they are not always able to afford top up credit, consequently follow up interviews would be difficult with some individuals.

The telephone is widely used in telesales and it is used widely by creditors chasing clients with debt problems. For these reasons it was felt that genuine research may not be distinguished from other activities. It is also difficult to build a strong rapport and trust in telephone interviews.

Visual aids such as show cards are not possible, complex questions have to be avoided as respondents cannot be expected to remember a long list of response categories, whilst responses to open questions tend to be brief.

During the early months of the project informal discussions revealed that clients often feel confused and suffer from anxiety in the early stages of the advice process, there was a risk that clients would confuse the research interviewer with their CAB advisor and this could affect the CAB client relationship.

### *Self Completion Questionnaires*

By comparison, self completion questionnaires appear to offer a solution that was deemed acceptable to bureaux, particularly as they had previous experience of issuing self completion questionnaires in a study conducted by Borland (2004) during the evaluation of the Better Advice: Better Health Service in Wales. There are a number of benefits associated with self completion questionnaires. They are relatively cheap, and once issued by CAB staff respondents could return the questionnaire in pre-paid envelopes. It is possible to survey large samples of the populations across wide geographic areas. Importantly, interviewer bias and effects are eliminated.

Despite the obvious benefits, upon closer evaluation this option was deemed to be flawed. Advising the Methodology Working Group against postal questionnaires, Borland stressed that due to the nature of the study and characteristics of the target population, questionnaire response rates would be very low, whilst one would expect a high proportion of those returned to be incomplete.

The target population often lead a transient existence and can move address frequently. For a single researcher, maintaining contact with respondents throughout the study period could be problematic. Problems were also identified with response bias, as this target population experience literacy problems or simply find it difficult to fill in forms – this is often the reason why they approach CAB for help in the first place. What's more, those with debt problems are known to avoid opening their post, which could impact on follow up surveys.

Influential research in the field further supported the move against postal questionnaires. Greasley (2003) reported that after an eight month recruitment period in which advisors saw 717 clients, only 18% (n=132) returned the questionnaire issued at baseline in the post. At six months, 48% (n=64) of the baseline sample returned the second questionnaire, whilst at twelve months just 36 individuals remained in the study who had participated in all three waves. This equates to 27% of their initial sample, an outcome that consequently provides a solid argument against the adoption of postal questionnaires in this instance.

#### *Face to Face Interviews*

On the other hand, advantages were found to be associated with face to face interviews with the target population. First, the interviewer can build a rapport with the respondent; this helps to put the respondent at ease and ensures questions are taken seriously. With a good rapport the quality of answers improves. Due to the serious nature of some client issues and the proportion of clients suffering with severe stress or mental health problems, it was important that support was on hand should further client issues emerge or in the event of the client feeling distress. In face to face interviews the interviewer can take cues from the respondent.

It is possible to ask more questions and complex questions. Open questions can be used more freely and the interviewee can ask for clarification with more complex questions if needed. Visual aids such as show cards can be used.

It does, however, take longer to conduct face to face interviews, and consequently there is a limit to the number of interviews each individual interviewer can conduct. These problems impact on sample size. It is unfeasible for a sole researcher to sample from large geographic regions due to the time and cost involved. A solution to this problem was to utilise staff at bureaux to take on the role of interviewer, to overcome the cost and staffing problems associated with an all Wales study. The key problem associated with this particular approach is that the presence of an interviewer can influence respondents' answers. For instance, responses may reflect social norms and what is considered desirability and agreeable (De Leeuw, 1992). However, bias exists in one form or another with all modes of survey administration.

### **Rationale for Data Collection Methods**

Considering the advantages and disadvantages of each of these methods, it is clear that a universal method was not suitable in this research project. Consequently, multiple methods were adopted. Using multiple methods of data collection in longitudinal studies can threaten the accurate measurement of change between each wave of survey. Still, Dillman (2009: 137) disputes the need to completely avoid multiple survey methods, arguing that there are no alternatives but multiple modes for the conduct of longitudinal surveys.

It was agreed that CAB staff would administer the baseline survey during the first advice session with clients. One very important advantage of this method was that baseline data was gathered at the optimal time point - this is vital in longitudinal research. Alternative methods such as telephone interviews and postal surveys would involve a delay between the baseline advice session and baseline data collection point. Utilising CAB staff also helped to overcome the limitations of the budget and opened up the opportunity to sample from a large geographic area, as required by the

sponsoring organisation. This solution to the budget issue had been offered at the very first Methodology Working Group meeting but it took several months to consider all of the options before adopting this recommendation.

Clients receiving advice from a caseworker often maintain contact for up to 12-18 months, as their cases are complex and can be timely to resolve. During this time it is common for a positive rapport to develop between the advisor and client, thus facilitating a bond of trust. For these reasons, it is reasonable to hypothesise that more respondents will agree to participate in follow up interviews if their advisor or a familiar member of CAB staff conducts them. Utilising CAB staff to collect data at wave 2 and 3 also meant that bureaux would not have to share confidential client contact details with the researcher, which it was highlighted earlier, was a concern of Citizens Advice Cymru who expressed the view that bureaux would object to this.

In practice it emerged that some advisors complained of a conflict of interests and refused to administer surveys, although they were happy for another member of staff to do this on their behalf. Therefore, although the vast majority of interviews were conducted by advisors, sometimes other members of CAB staff took on this task. For example, in one bureau a CAB volunteer valiantly accompanied a casework advisor to advice sessions if the client had previously indicated (when making the appointment) that they would not mind being interviewed for a survey. Due to the rural nature of the bureau's location, most of these advice sessions took place in clients' homes. This volunteer then followed up respondents in subsequent waves of the study and, where necessary, visited them in their home to conduct the surveys. Of course, not all of those involved in the research were this enthusiastic and it was vital that the questionnaire was quick and easy to complete, regardless of who undertook this task.



In order to minimise the work load involved, the baseline questionnaire was split into two parts:

- Part One consisted of health questions, plus questions about social support and social isolation. Respondents completed this questionnaire themselves. CAB staff assisted if necessary and checked the questionnaire was complete. An interview version was developed for those unable to self complete Part One of the questionnaire; therefore, no one was excluded from participating in the survey. The interview version was administered where necessary by CAB staff, face to face, during the advice session.
- Part two of the baseline questionnaire was administered, in all cases, face to face by CAB staff. It comprised predominantly of key demographic questions and questions relating to the problem for which clients sought advice. Much of this data is gathered in baseline advice sessions for bureau records. In an attempt for consistency with CAB data and to speed up interviews, where possible, questions and response sets replicated those in the CASE system that many, but not all, bureaux operated. Show cards were developed to help speed up the process. Some bureaux later adopted these for their own interviews. Originally, in the early stages of the research it was expected that this data would be provided from bureau records contained in the CASE system, however, not all bureaux had adopted the system and many were resisting it completely.

Part One of the questionnaire included health questions that should be answered prior to other questions in the schedule. As some client's problems include a health component, for instance in relation to disability living allowance or attendance allowance, they require some discussion about the health. This could influence response to questions in the SF-36 or HADS. Consequently, guidance and training was provided on the importance of administering the first part of the questionnaire at the earliest opportunity, prior to discussing health issues relating to the problem for which the client was seeking advice.

At wave 2 and wave 3 bureau staff contacted respondents to arrange an appointment to administer subsequent survey schedules. These were administered either by telephone or face to face interviews. Many advisors used the appointments to follow progress with client issues and as part of what could be considered 'customer relationship' building exercises. For consistency, interviews were conducted by CAB staff who had previously interviewed the client. On the whole, this was not problematic and respondents who remained in the study were interviewed consistently by the same member of staff who interviewed them at baseline. Within the framework of the Methodology Working Group it was agreed that the researcher would conduct follow up interviews in cases where bureaux failed to do so. In practice respondents' contact details could not be obtained.

Questionnaires were translated into Welsh for the baseline study, however, no Welsh questionnaires were returned and it was decided that subsequent questionnaires did not need to be translated as respondents had already indicated their preference for completing the questionnaire through the medium of English.

### **Research Support**

Longitudinal studies require a heavy commitment of resources over a lengthily period of time (Wall and Williams, 1970: 30). It is vital that the strengths and potential weaknesses of the research are assessed and understood by all parties. Naturally, in longitudinal research it takes time to produce outcomes for sponsors, and for the researcher this was a concern. The project involved a large number of Citizens Advice Bureau staff located throughout Wales, and was supported by Citizens Advice Cymru staff in offices in Cardiff and Llanellwylly, north Wales. Furthermore, the project required ongoing involvement of members of the Steering Committee, and advice on occasions from key members of the Methodology Working Group.

For a sole researcher this is a considerable responsibility, which requires excellent organisational skills and project management skills. Interpersonal and communication skills are a vital prerequisite; the researcher must negotiate, influence and persuade the uncommitted whilst simultaneously encouraging, supporting and

providing feedback to those working hard to get results. In the midst of this the researcher must find the courage, motivation and the determination to see their project through to a positive end outcome, even when things are not going to plan. From the perspective of sponsors of this research, it was vital that they were prepared to wait for outcomes, and remain committed to the research over a prolonged period of time.

Training, information and guidance were provided by the researcher to bureaux throughout the period of the study. A guidance booklet was developed and distributed to bureaux in the 'survey pack'. Prior to and throughout the three waves of data collection communication was maintained via telephone and by email. This proved to be vital in monitoring and managing the project.

### **Selection and Training**

Individual bureaux selected their staff for participation in the research. This process varied between bureaux, some involved all members of the team – from administrators to advisors, whilst others asked staff if they would like to participate in the research or delegated the job to one or two advisors.

Moser and Kalton (1971) note that interviewers should possess certain desirable characteristics. They should make a pleasant impression and possess tact and social sense. They should also be able to record information accurately, be reliable, honest and able to cope with the tiring work at hand. Bureau staff are familiar and practised in all of these areas, and have a great deal of experience questioning clients in order to complete relatively complicated forms, for example, in relation to applications for welfare benefits.

Other factors outside the control of the study concerned the social background, age and sex of interviewers.

A half day training programme was developed and this took place in six locations throughout Wales. Information about training was distributed via mailings from Citizens Advice Cymru to bureau managers and at a series of presentations given at

regional and social policy forums, and the Better Advice: Better Health forums. The logistics of disseminating information to 32 independent legal entities in Wales with staff in over 200 locations was somewhat challenging. Some advisors remained unaware of the research or failed to fully understand what it would involve and when it would begin. In most instances this was because of ‘gate keepers’ or because of poor communication within bureaux. It transpired later in the study that some bureau managers routinely chose not to open mailings from Citizens Advice and as a result missed critical information and dates for the training to take place.

Nevertheless, over 50 CAB staff attended training sessions that took place in six locations around Wales. Transport costs were reimbursed by Citizens Advice Cymru, and refreshments and a buffet lunch were provided at each event as the staff were known to enjoy this aspect of training events.

The sessions followed the format advocated by Moser and Kalton (1971). An overview of the research was provided to give insights into the rationale for the study, to explain who was involved, how the results would be used and how the rest of the research would be handled, for example, aspects of the study not concerned with data collection.

The training session included practical activities to identify and discuss issues relating to interviews, such as the role of the interviewer and the respondent, the context and relationship between the interviewer and respondent and ethical considerations such as burden, distress, and confidentiality.

The role of the interviewer in survey research was explained so that CAB staff understood the importance of obtaining accurate and complete data. Guidance was given on interview techniques, for instance, the importance of asking questions verbatim, the importance of asking questions in sequential order, how to use show cards, and how to deal with questions from respondents about response choices.

Overall the training session was designed to equip CAB staff with practical skills, approaches and help them develop plans to recruit clients into the survey, administer the survey and manage the project at bureau level.

In order to achieve this CAB staff participated in trial interviews where they began by explaining the research to ‘potential respondents’, they then sought their consent, administered the questionnaire, checked it and ended the interview.

Although formal interviewing was required for the second part of the survey, clients could opt to self-administer the first part which consisted of a health questionnaire, plus questions about social support and social isolation. Nevertheless, the interviewer can determine what form the interview takes and this can lead to interviewer bias, particularly in open questions incorporated in later waves of the questionnaires. Therefore relevant information was provided at the training session and in the guidance booklet.

At the end of the session many staff commented that they had particularly enjoyed the opportunity to interview each other and saw this as a valuable opportunity for personal development. Anxieties about the study subsided and the majority of those that attended the training later proved to be the most enthusiastic advocates of the research project. It is possible, of course, that training sessions attracted somewhat more motivated individuals and bureaux, but a few attendees did say that it was the training session that won them around and caused them to ‘buy into’ the study.

### **The Question Schedule**

Longitudinal data is required when the intervention occurs over a period of time and there is a desire to examine the effects of the intervention over time (Piesse et al, 2009). In line with recommendations by Bouma and Atkinson (1995: 117) the researcher undertaking longitudinal study must:

- Select variables pertinent to the concept being studied
- Devise a method of measuring the variables

- Develop an instrument to record data
- Measure the variable on more than one occasion in the same sample of research participants.

Longitudinal research is fundamentally concerned with measuring change or non-change over time. This involves collecting data at multiple time points. Therefore, more than one question schedule is required.

The first question schedule was designed to capture baseline data whereas follow up question schedules were designed to examine the individual's experience, the impact of the intervention and any practical outcomes. Some questions within the question schedule were repeated - for instance the SF-36 and HADS health outcome measures were administered in each wave of the study, whilst remaining questions within the question schedules were developed according to the data required. At wave 2 and 3 the question schedules were almost identical, with the exception of a small number of additional open questions incorporated into the question schedule.

The question schedule at baseline collected data to determine respondents' demographic characteristics; their advice issues; financial circumstances; health; adequacy of social support and signs of social isolation.

At wave 2 and 3, question schedules focused on practical outcomes such as the total value of welfare benefits gains acquired for clients, the sum of debts managed or written off, and other practical outcomes. Data was gathered to examine if improvements in clients' financial circumstances impacted on aspects of personal spending, and spending on their dependent children (where applicable). It was also important to gather data to examine how CAB advice impacted on the quality of life of clients and their dependent children (where applicable).

Access to the CAB service was examined at baseline and again at wave 2 and 3. At baseline, the research set out to learn how clients heard about and accessed the CAB service and their satisfaction with access and information about the service. At wave 2 and 3 this aspect of the study looked at factors that influenced clients' decision to

pursue the advice provided by CAB; and their personal experiences of working with CAB to resolve their problem(s).

In order to arrive at this point, variables pertinent to the concept being studied were identified, methods of measuring the variables devised and an instrument to record data was developed. What follows is an account of this process.

### **Linking Survey Data to Administrative Data**

As a starting point, key demographic data and information about the problems for which clients sought advice was to be acquired in the study. CABx collect this data routinely. From the outset of the project it was expected that administrative data would be linked to survey data.

The linkage of survey data to administrative data provides many opportunities for the researcher to supplement or validate survey data, adjust for non response or alternatively integrate within the design of the survey (Calderwood and Lessof, 2009). One further advantage of utilising administrative data to support survey data is that it reduces the burden on the survey interviewer and the respondent.

Key demographic data and information about the problems for which CAB clients seek advice is collected routinely by CAB advisors during advice sessions. Once client issues are resolved the outcomes of cases are recorded. Examples of the kind of data recorded is the amount of ongoing welfare benefit payments, one off payments, and the value of debts written off or managed for clients.

On the other hand, historically CAB data collection methods were inconsistent and incompatible with data linking techniques, although a new computerised system was about to transform this – or so it was believed.

As discussed earlier, implementation of the new Management Information System for client case records, called ‘CASE’, was underway as the project started. It was reported, throughout the preparatory stages of the project, that all bureaux would be

using CASE to record client issues and demographic data by the time the study began. In addition to recording client data for bureau use, the system shares limited key variables with a partner system operated by Citizens Advice, which in theory would enable the creation of management reports. An example of this is reports on individual bureaux activity, reports on issues such as discrimination across Wales or the demographic profile of those using particular services. It was logical that CASE data should supplement survey data, that is, until it transpired that many bureaux were resisting implementation of the system, whilst bureaux that were using the system complained it was cumbersome. It is perhaps for these reasons that errors were common and test reports taken from the system proved data was highly unreliable.

In addition to the CASE system, Citizens Advice Cymru was in the process of launching an 'Outcomes' system, which is essentially a programmed spreadsheet with pre-coded variables. Once data is entered it automatically populates pre-set charts and reports for the easy production of advice outcomes data. At methodology meetings it was reported that this system was used widely and all staff had received training in the use of the Outcomes system. It transpired much later in the project, during data collection phases, that none of the bureau staff involved in the project had heard of the Outcomes system and for these reasons they did not use it. Nevertheless, they did their best to embrace the system although more support had to be provided by the researcher due to this oversight by Citizens Advice.

Wide scale data linking would therefore involve collating information from multiple systems (spread sheets, CASE, older MIS systems and manual records) with different variable response sets. Chesher and Nesheim (2006) caution that inconsistent design properties of each data source can create difficulties standardising data into any structure, although non-statistical manipulation can offer a solution at analysis stage.

The procedures involved in linking administrative data such as client issues and demographics to survey data presented too many challenges. As a compromise, all demographic questions and some questions regarding client issues contained in the survey mirrored those in the CASE system, it was hoped this would speed up questioning for some bureaux as those using CASE would be familiar with the



questions and response options. It also allowed advisors to cross reference responses and compensate for non response in some cases. Citizens Advice Cymru was keen to support this approach in the hope that bureaux would see the benefits of collecting comparable data. Questions about outcomes acquired for clients were incorporated into the second and third waves of the study. A record sheet was developed containing questions contained in the Outcomes System. Thus attempts were made to standardise data collection approaches in bureaux with the study. Although bureaux were not particularly concerned themselves with standardisation this approach did allow the researcher to circumvent confusion.

### **Conceptualising Health**

Health is commonly referred to negatively as the absence of disease, illness and sickness (Bowling, 1997). Taking this approach, departures from health are measured, rather than indices of health itself (ibid). Stimulating a trend in positive perceptions of health, the World Health Organisation (WHO) constitution of 1946 claimed “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity (WHO, 1958). Despite being criticized as utopian and conceptually weak (Bowling, 1997), this was to become highly influential (Seedhouse, 1986). In recent years, in a statement of Health for all by the Year 2000 and the Ottawa Charter for Health Promotion (1986), the WHO focused on helping individuals increase control over, and improve their health.

In a useful explanation, Lamb et al (1988) propose that positive health could be described as the ability to cope with stressful situations, maintain strong social support systems, integrate in the community, enjoy high morale and life satisfaction, psychological well-being, physical fitness and physical health. However, upon review it is evident that there is no accepted definition of health but the general consensus is that health is more than the absence of disease or disability. It is palpable that health has many dimensions and in addition to key domains of physical and mental health, the term incorporates the concept of social health and quality of life.

In light of the literature, a range of questions were incorporated into questionnaires to tap into the different dimensions of health and broader concepts of health such as social health. Due to a very tight timescale and limited time for questionnaire development, many of questions were adopted from the ESRC Survey 'Question Bank', which contains a searchable data base of national survey questions.

In addition to saving time, this approach brought other benefits. Questions taken from the question bank are validated, although the ordering of questions within the questionnaire should still be tested. Another advantage is that it is possible to compare data with results published elsewhere.

### **Social Health**

In the context of the research it was desirable to gain insights into levels of social support experience by respondents, as those with severe problems are at greater risk of social exclusion in circumstances where they have inadequate social support. Evidence of this can be found in the work of Caplan (1974) and Cassel (1976), whilst Donald et al (1978) propose social health is a constituent of health status. Social support systems may intervene and modify the effects of the environment and life stress events on physical and mental health. Measurement of social health focuses on the individual and can be defined in terms of interpersonal interactions such as visits with friends and social participation. Both objective and subjective constructs are included in this definition.

It is acknowledged in the literature that the concept of social health builds in a broader way on symptoms, illness and functional ability, seen as distinct from physical and mental health (Donald et al, 1978). This view is supported by Greenblatt et al (1982); Renne (1974) and Lerner (1973) who proposed health status can be a role of non health factors external to the individual such as the environment, the community and in terms of a persons' ability to function as a member of the community. Taking such a perspective the research focus is on role related coping, family health and social participation. Previous research has shown that those with serious, persistent problems such as personal debt, and those living on very low incomes are more prone

to mental health problems. The literature illustrates that mental illness often occurs as a consequence of a complex interplay with other variables such as the resources a person has and their environment, the occurrence of stressful life events and individual coping ability. Environmental resources refer to social support offered by friends, family and other people within a person's social network (Billing and Moos, 1982, 1985).

Elaborating on this Bowling (1997) explains that 'social support' and 'social networks' are two distinct concepts, although the concept of social support derives from the theory of social networks, which is concerned with the network of transactions between people. It is through these social networks that social support is provided. Thus social networks sustain our identity; they provide the mechanism for emotional support, when required they can help provide for our material needs, supply information and even services whilst networks also open up the possibility of new social contacts (Walker et al, 1977). Social support is concerned with the individual's belief that they are cared for, loved and esteemed as a member of the network through mutual obligations - the process of social support is interactive. (Cobb, 1976). Therefore, as House (1981) explains, social support involves emotional concern such as loving or liking a person, as well as instrumental aid, information and appraisal, the process by which self evaluation occurs.

Despite a superfluity of interest in these concepts, measuring social support and social networks is, as Bowling (1997) puts it, "fraught with difficulty", not least because most measures have not been fully tested for validity and reliability. To add to the problem, although a number of attempts have been made to conceptualise social support, agreement has not been reached, and most frequently what has been achieved is seen as inadequate (ibid). One of the main challenges is that social support is a complex, situational, interpersonal and intrapersonal process that shapes perceptions (Sarason et al, 1994).

Under the circumstances, it was logical in the context of this research to omit social support and social network questionnaires, particularly as few have been validated. What's more they would make the questionnaire lengthily and cumbersome. An

alternative option, to include a small number of validated questions from national surveys was taken instead. These were sourced from the ESRC Survey Question Bank, which is openly available to researchers.

One question set, previously used in the Poverty and Social Exclusion in Britain Survey of 1999, presents seven situations, each with four response options to indicate how much support an individual would receive in each situation. The situations included practical help or support as well as emotional support. Practical help, for example, includes needing help around the home, needing help with household or garden jobs, needing help with looking after children/elderly or disabled adults and needing somebody to look after possessions. The remaining items relate to emotional support.

The overall aim of asking these questions was to see whether respondents showed signs of social exclusion due to poor support systems. Clients were not asked for specific instances of support although it is likely that they would draw on experience to answer how supported they would likely to be in each situation.

Another question adopted from the ESRC Question Bank focused on social isolation. The question asked if there had been times during the past year when respondents had felt cut off or isolated from society. Twelve possible response options were available and multiple options could be selected. An additional in-house question was developed in this style, in which respondents were asked if they felt cut off or isolated from society because of the problems for which they sought CAB advice.

### **Conceptualising and Measuring Quality of Life**

Fallowfield (1990) positions the concept 'quality of life' as a vague term that is difficult to define explicitly in a manner that permits objective measurement, with professional opinion being split, for instance, between the likes of the philosopher, psychologist, doctor, poet, and the priest. However, regardless of professional context, 'quality of life' is generally understood as a grade of 'goodness' (Bowling, 1977: 6).

In the world of medicine, new technology and modern medical treatments can sustain life longer than ever before for conditions that would in the past be fatal. It is often in this context that the term quality of life is used. However, it is becoming increasingly widespread to see quality of life equated with all non-medical data and this can cause confusion with conceptual perceptions (Bowling, 1997). For instance, experts concede that medical interventions aim not only to increase a person's length of life but also their quality of survival (Carr et al, 2003).

Historically, the concept 'quality of life' has been understood in different ways. Arising at the end of World War two in the United States it implied a higher than average material lifestyle. In a report by the Commission on National Goals, which was created by Eisenhower (1960), the concept was extended to include education, health and welfare, economic and industrial growth and the defence of the 'free' world (ibid).

In line with advances in technology and medicine quality of life became synonymous with health. Ebbs et al (1989) assert that major political and social change in the late sixties illustrates a shift from materialistic interpretation of quality of life towards personal freedom, leisure, emotion, enjoyment, simplicity and personal caring.

One observation that illuminates the concept 'quality of life' is provided by Pirsig (1974: 220):

“The world can function without it (quality), but life would be so dull as to be hardly worth living. In fact, it would not be worth living. The term worth is a Quality term. Life would just be living without any values or purpose at all.

Offering a more detailed explanation, Fallowfield (1990) identifies four core domains that amalgamate in a complex fashion to determine quality of life: Psychological, social, occupational, and physical.

Psychological items typically include depression, anxiety, and adjustment to illness.

Social aspects of quality of life include personal and sexual relationships and engagement in social and leisure activities. Taking this focus, Mendola and Pelligrini (1979) define quality of life as a person's achievement of an agreeable social situation within the limits of their perceived physical capacity. This has been criticised as a limited definition that offers nothing more complex to attempts to operationalise the concept (Bowling, 1997). The literature highlights occurrences of 'abandonment' during illness (Foster and Anderson, 1978); similarly it is well known that those experiencing personal problems can also experience forms of abandonment that can make them feel cut off or isolated from society.

Another core domain that is important to quality of life is occupational. This relates to one's ability and desire to carry out paid employment and ability to cope with household duties. Finally, the core domain of physical health typically taps into pain, mobility, sleep, appetite and nausea, and sexual functioning. Fallowfield (1990) observes that good health is often noticed more by its absence than presence, and makes the bold suggestion that perception of health is only possible if we have experienced the loss of it. The emotional perception of wellbeing is enhanced following recovery from illness.

However, other explanations go much further. For instance Shin and Johnson (1978) propose that the resources a person possesses that are necessary to satisfactorily meet needs, wants and desires is an important component, as is the individual's ability to participate in activities so as to achieve satisfactory levels of personal development and self actualisation in comparison to other people, and in the context of their experiences and knowledge. Taking a somewhat different approach, Patterson (1975) suggests characteristics such as general health status, comfort, emotional and economic status is important in evaluations of quality of life.

Although universal agreement as to what constitutes quality of life is yet to be reached, there is agreement that such a concept exists. In selecting appropriate quality of life measures, the literature review and assessments of two health outcome measures were influential – the Short Form 36 and the Hospital Anxiety and Depression Scale.

Tracking the effects of CAB advice on the health and quality of life of individuals was at the heart of the research and underpinned the need for longitudinal analysis. Robinson et al (2003) provide guidance to those choosing a quality of life instrument. They argue there are three key factors that determine the choice of instrument: the reasons why the researcher wants to use one; whose quality of life they want to measure; and, the questions the research wants to answer. To elaborate, the choice of quality of life measure is determined, in part, by the underlying reasons for using a quality of life measure.

Early exploration of Quality of Life questionnaires revealed that some, for instance the WHOQOL and other lesser known questionnaires, include questions about respondents' work achievements and position in hierarchy; family support; social activity and friendships; financial adequacy; personal life; personal achievements; philosophy and sexual satisfaction. Due to the nature of questions that tap into these concepts, the steering committee raised some concerns. Some members of the committee strongly objected to questioning respondents on matters concerning sexual satisfaction, philosophy, personal achievements, and so on. For these reasons, the WHOQOL and questionnaires containing highly personal questions were considered unacceptable.

This was supported by the view that the rationale for incorporating quality of life measures in the research was to identify factors that influence health, to use as an outcome to assess the impact of advice intervention, and should the results prove favourable, to provide robust evidence that would enable the sponsoring organisation to seek resources and influence policy makers. Questions regarding sexual satisfaction would not meet this requirement.

Other determinants of choice included consideration of the research participants, as generic measures are designed to assess general health related quality of life whereas condition or disease specific instruments are not.

It was also important that the instrument suits the needs of respondents in terms of ease of completion, questionnaire length, the mode of administration and so on. On

this point Addington-Hall and Kalara (2003) highlight the complexities of using quality of life measures with respondents with cognitive impairments, communication difficulties and those in severe distress or who find the measure a burden. They argue that it is these individuals for whom quality of life is most needed, to inform policy and practice. Within the target population there are those that meet this criterion.

Finally, consideration was given to the type of questions being asked and expected methods of analysis. The multidimensional nature of quality of life imposes restrictions in the range of analytical techniques possible in some measures; some tools collect data on several domains whilst others limit analysis to a few summary statistics. Other aspects within this criterion include consideration of reliability and validity of the instrument in target groups and optimal follow up times (ibid).

A full assessment of the quality of life measures selected for use in the study follows.

### **Short Form 36**

The Short Form 36 (SF-36) is a short form measure of general health status in the general population. It is one of the most well known instruments of its kind measuring domains from physical functioning to social participation (Sulch and Kalra, 2003). In total the SF-36 consists of 36 questions that are related to eight health scales and comprise of Physical and Mental Health domains:

#### **Physical Health**

- **Physical Functioning:** is concerned with how health may limit physical activity, for example: vigorous to moderate activities and everyday functions.
- **Role Functioning:** focuses on how physical health affects every day activity such as cutting down time, accomplishing less, being limited or having difficulty.



- **Bodily Pain:** considers the existence and level of pain and how this interferes with activities.
- **General Health:** is a subjective view of personal health

### Mental Health

- **Vitality:** is concerned with levels of energy and tiredness
- **Social Functioning:** considers the impact of physical and emotional problems have on the normal social activity of a person
- **Role Functioning:** measures how usual roles may be limited due to emotional problems
- **Mental Health:** is related to psychological well being and measures the level of nervousness, if a person feels down, peaceful, sad or happy.

Item scores for each of the eight dimensions are summed and transformed using a scoring algorithm, into a scale from zero, which indicates poor health to 100, which indicates no difficulty of good health. It is convention to report the results as mean scores for each sub-scale (Bowling, 1997).

One advantage of using the SF-36 is that it has been found to have high internal consistency (Garratt et al, 1993; Jenkinson et al, 1993) with considerable evidence of reliability and construct validity it can distinguish between groups. (Brazier et al, 1992; Lyons et al, 1994). Additionally, it is responsive to changes in health status in common clinical conditions (Garratt et al, 1994). In a postal survey in the UK Brazier et al (1992) found the SF-36 to be more sensitive to grades in poor health than the EuroQol and the Nottingham Health Profile (NHP). It is interesting that as long ago as 1985 in a study undertaken by Veitch, who pioneered the use of health outcome measures in advice settings, the NHP instrument was reported to be insensitive to change.

Sensitivity to change in the health of general populations has been explored using the SF-36 in cross sectional studies where it has proved reliable (1994). It has been found to sense differences between groups classified by age, gender, socioeconomic status, geographic region and clinical conditions.

The SF-36 is an inexpensive way of measuring health outcomes in the general population (Hemmingway et al, 1997: 2). It is suitable for elderly populations in interview settings; (Lyons et al, 1994) is an acceptable tool in general (Garratt et al, 1993) and is easy to use with high response and completion rates (Brazier et al, 1992). It can be self administered or administered by an interviewer although the response rates and response bias vary between telephone, postal and face to face methods. Despite this, in the weeks leading up to the pilot study, some committee members expressed concern about the inclusion of validated health instruments (although they had previously been approved), and suggested that certain questions, most of which related to physical health, should be removed. The explanation given was that questions relating to physical health were not relevant and removing these questions would reduce the length of the questionnaire.

An alternative explanation is that some individuals were concerned that the validated instruments would fail to reveal positive outcomes. Thus, to some extent there were attempts to engineer the outcomes of the study. The British Sociological Association (2002, item 44) stresses that “Research should be undertaken with a view to providing information or explanation rather than being constrained to reach particular conclusions or prescribe particular courses of action.” It goes on to advise “Members should not accept contractual conditions that are contingent upon a particular outcome or set of findings from a proposed inquiry. A conflict of obligations may also occur if the funder requires particular methods to be used” (2002, item 49).

Consequently, attempts to retract on the inclusion of these instruments were resisted on a number of grounds. It is recognised that physical health and emotional health are inextricably linked. Emotional aspects of physical health have been recognised by clinicians, and states of anxiety and depression can increase suffering of physical

illness and sometimes even result in misdiagnosis. The recovery time for Somatic symptoms can take longer when states of anxiety and depression are present. In some cases individuals may not comply with treatment or develop harmful coping strategies such as dependence on alcohol (Zigmond and Snaith, 1983). Therefore, although the primary reason for including validated instruments was to measure aspects of mental health, elements of the validated instruments concerned with physical health were not completely redundant.

Removing some questions would invalidate the instruments and breach license agreements, as combinations of SF-36 question responses, once transformed, are used in algorithms to produce scores for each of the 8 domains of health.

Reassurances appeared to resolve the issue, however, just a few weeks later, during the pre-testing period, and 3 weeks before the pilot study, a meeting was held to discuss requests to incorporate additional questions within the questionnaire and the removal of elements of the SF-36. Minutes from the meeting tentatively record events: “person x stated that some survey questions have been incorporated by KJ for her research but are not needed by Citizens Advice Cymru.” In response, an advisor to the methodology working group stated “questions must be research focused” (Methodology Working Group, 9<sup>th</sup> February 2007). Some minor concessions were agreed whereby some additional questions were incorporated into the questionnaire upon the condition that remaining questions were unchanged. These included, for example, an open question on ‘any housing problems’ clients’ wished to report.

### **Hospital Anxiety and Depression Scale**

The core psychological domain that contributes to quality of life includes Anxiety and Depression. Individuals who suffer from severe Anxiety and Depression cannot enjoy or function adequately in other areas thought to contribute to quality of life. For these reasons, Anxiety and Depression measures were vital to the study.

The Hospital Anxiety and Depression Scale (HADS), developed by Zigmond and Snaith (1983) consist of two subscales – Anxiety and Depression. The HADS includes 14 items, seven for each subscale, and respondents rate each item on a four point scale. The test, which does not include items of a somatic nature, measures states of Anxiety and Depression:

- **Anxiety:** relates to the state of anxious mood, restlessness and anxious thoughts. The anxiety scale was based upon estimates of ‘feelings of tension’, tendency to unnecessary worry’ and ‘apprehensive anticipation’. It is not focused upon any situation; instead it is the state of generalised anxiety that is measured. Therefore, manifold somatic symptoms of anxiety are not reflected in this scale (Sigmond and Snaith, 1983).
- **Depression:** is used in several senses that include states of grief, demoralisation, low self esteem and pessimism (Snaith, 1987). The depressive state is characterised by ‘enjoyment of usual activities’, retention of sense of humour’, ‘depressed mood’ and optimistic attitude’ (Zigmond and Snaith, 1983). The depression scale is concerned mostly, although not completely, with loss of interest and diminished pleasure response, which is known to be a reliable guide to mood disorders of a biological origin that are most likely to respond to antidepressant medication (Klein, 1974). Persistently high depression scores will indicate, therefore, that antidepressant prescription would be advantageous.

The HADS was designed to be brief, easy to understand and therefore acceptable to respondents (Snaith,1993). It takes just minutes to complete (rarely more than two minutes), and can be administered in a variety of situations including waiting rooms or more formal settings. It is also extremely easy to score. One advantage is that it can distinguish between adverse emotional states and does not need to include questions about physical illness. Furthermore, scoring and interpretation is straightforward and provides interpretation at four levels of mood disorder – normal, mild, moderate and severe – in domains of anxiety and depression. Both subscales are sensitive to change and can be repeated when required. Validation against the

Clinical Interview Schedule proved that the HADS has satisfactory sensitivity and specificity (Fallowfield, 1990).

In a sample of 50 respondents' reliability, as a measure of internal consistency, and item subscale correlations, conducted by Zigmond and Snaith (1983) produced significant associations of between 0.76 and 0.41 on the Anxiety scale and between 0.60 and 0.30 on the Depression scale. Upon removal of a weaker correlated item on each subscale, the number of question sets was reduced from 16 to 14 items.

Mooray et al (1991) went onto establish the internal consistency of both subscales in a sample of 568 research participants. Chronbach's alpha was 0.93 for the Anxiety scale and 0.90 for the Depression scale. Clark and Fallowfield (1986) have also reported satisfactory validity and reliability, whilst psychometric properties for the HADS were also established by Jack et al (1987). Snaith and Zigmond (1994) report good face validity for the HADS, it is easy to complete and acceptable to respondents. During the aforementioned study Moorey et al (1991) confirmed the construct validity for the two subscales. Independent assessments conducted by Snaith and Taylor (1985) and Aylard et al (1987) provide further confirmation of the relation of Anxiety and Depressions subscales to assessments of mood disorders. Concurrent validation was originally assessed by Snaith and Zigmond with a 5 point psychiatric rating scale for Anxiety and Depression with a sample of 100 individuals. Correlations were 0.54 for the Anxiety scale and 0.79 for the Depression scale. In a later studies Aylard et al (1987); Bramely et al (1988); Barczak, 1988; Ibbotson et al, 1989; reported concurrent validity.

### **Open Questions**

At baseline the question schedule contained closed questions with the exception of a small number of open questions. One advantage of using closed questions is that they can be answered quickly either through self completion methods or interview. Closed questions may clarify the meaning of the question to the respondent. Compatible data is collected and this can be quickly processed in preparation for data analysis (Bryman, 2004: 148). This was important in the baseline study because demographic

data was acquired in addition to data about the problems for which respondents sought advice and other research questions.

The incorporation of open questions as a more viable option arose in wave 2 and 3 with the need to tap the complexities of concepts surrounding respondents' experiences with CAB. It was desirable in follow up waves to understand the impact of advice on aspects of quality of life and to better understand the meaning and values that respondents attached to their experiences.

Budget and time restrictions eliminated the option of more traditional qualitative study but open questions provide some opportunity to allow the respondent to answer in their own terms, and to give responses that the researcher may not have thought to derive in fixed choice response sets. The experiences of respondents can be tapped, as can their knowledge and understanding of issues. Open questions allow the salience of issues for respondents to be explored (Bryman, 2004: 145). They can also give way to useful information, particularly when the researcher wishes to understand complex issues that do not have a finite outcome (Carey and Morgan, 1996).

However, O'Cathain and Thomas, (2004) encourage researchers to develop a strategic use of including open questions, as this can optimise the quality of the data and the analysis; ethically, one upshot of this is that respondent data is more likely to be used:

“A closed question is followed by an open question in which respondents are asked to elaborate on the answer given within the closed question. These open questions may be used to address ‘why’ and ‘how’ questions associated with the strengths of qualitative research...These questions have clear roles in that responses to them will help to explain, illuminate or expand upon a specific quantitative question” ( O'Cathain and Thomas, 2004: 3).

A number of open questions were incorporated into the questionnaire at wave 2 and wave 3 to gain respondents' views in their words and explore any views that may not have been elicited from closed question response sets. It is also fair to say that quotes from open responses were used extensively in written reports to enliven the

comparably dry statistical content in the hope that this would appeal to a wider audience. Another advantage is that open responses can be used to corroborate answers to closed questions, offering reassurance that the questions are valid (O’Cathain and Thomas, 2004: 1).

Questionnaires for each wave of the study can be found in Appendix Three.

## **Ethics**

Codes of professional conduct for researchers require that ethical considerations should be taken into account in all social science studies. The Economic and Social Research Council (ESRC) (n.d.) in its Research Ethics Framework states that “Research Ethics refers to the moral principles guiding research, from its inception through to completion and publication of results and beyond – for example, the duration of data and physical samples after the research has been published”.

In research involving sponsors it is imperative that all parties understand the obligations that they have to research participants, as well as to professional colleagues, and at a broader level to the sociological community. Ethical guidance and statements should be circulated to all involved to facilitate the discussion and development of ethical practice (British Sociological Association, 2002). The Citizens Advice service and the CABx work to professional standards and a code of practice, which was conducive to collaborative development of research ethics.

Research relationships are often characterised by disparities of power and status (British Sociological Association, 2002). Psychological studies draw attention to the influence and power that researchers possess in relation to their respondents, the interviewee is delegated to a vulnerable position (Field and Hole, 2003: 98).

Therefore, researchers have an obligation to research subjects to ensure studies are conducted within an ethical framework. Diener and Crandall (1978) identify four key ethical issues: whether there is harm to participants; a lack of information; invasion of privacy; and, deception.

The first point is concerned with harm that could occur to participants. Principles set out by the British Sociological Association (2002) require “the physical, social and psychological well-being of research participants is not adversely affected by the research.” In their Statement of Statement of Ethical Practice (2002, item 27) the British Sociological Association advises:

“While some participants in sociological research may find the experience a positive and welcome one, for others, the experience may be disturbing. Even if not harmed, those studied may feel wronged by aspects of the research process.”

Lessof (2009) suggests harm can be avoided if relationships with respondents are positive. To achieve this she recommends communicating effectively and providing clear explanations of the study’s objectives.

Ethical principles were discussed at training events and project presentations. Advisors responsible for conducting interviews with respondents were fully instructed on all matters. Due to their expertise in questioning clients and discussing difficult issues (such as personal debt) advisors have experience in managing potentially stressful situations and dealing with confidential matters in an ethical manner. This is important as Beauchamp et al (1982) argue the values of the researcher are of equal importance to legal requirements.

The second and third issues identified by Diener and Crandall’s (1978) are concerned with consent and privacy. Research participants should freely give informed consent (British Sociological Association, 2002). A statement of purpose should set out the central intent for the study and indicate who is responsible for it and who is sponsoring the study (Creswell, 2003: 62). The research participant has the right of privacy, and this means that although they provide informed consent they have the right, and are completely justified, to refuse to answer questions should they wish. Participants should be informed of what the study involves and be made fully aware of their rights while taking part; this should include the right to withdraw from the study or stop the interview at any time (Field and Hole, 2003). In addition, the ESRC (n.d.) recommends that complaints procedures should also be in place and information



made available so that research participants may express concern, should the need arise.

The four issue identified by Deiner and Cradall (1978) is concerned with deception. This occurs when the researcher presents the research as being for another purpose than that intended.

### **Ethical Procedures**

In accordance with ethical principles, prospective participants to the study were provided with information about the research in a letter of purpose, which was also explained verbally prior to consent being obtained. The statement explained who was conducting the research and the sponsors. It provided information about the aims of the research and how information provided by respondents would be used. In addition to explaining procedures to ensure their anonymity, research participants were told “if you feel distressed answering any of the questions please tell your advisor and ask to stop.” They were advised that they could withdraw from the study at any time. In addition, during the debriefing with the interviewer they were given time to ask questions about the study.

Rigorous procedures were developed to protect respondents’ data and ensure confidentiality and anonymity. Research participants were identified by a code, this was recorded on the questionnaire that they completed and stored on a record sheet with their contact details. Questionnaires and record sheets were stored separately. Questionnaires were returned to the researcher, whilst the identity of the respondent, as stored on a record sheet, was retained by the Bureau so that respondents could be contacted for follow up interviews.

In summary, if the research poses no harm to the interests or confidentiality of research participants, Lessof (2009) states that ethics committees and researchers should conclude that the research is ethical. Ethical approval for the project was provided in February 2007.

## **Piloting the Study**

During the process of developing a questionnaire considerable attention is given to the final product to ensure it is comprehensive and relevant to those who will complete it. Pre-testing questions on colleagues and friends is a logical first step, questionnaires were also reviewed by CAB advisors and managers; however, a pilot study is accepted and expected as a rule in research.

## **Why Conduct a Pilot Study?**

Moser and Kalton (1971: 48) explain “The pilot study is the dress rehearsal and, like a theatrical dress rehearsal, it will have been preceded by a series of preliminary tests and trials.” They proceed to elucidate several aspects of the questionnaire that are tested: the layout, clarity of wording and questions, acceptability and relevance of questions, clarity of instructions and codes chosen for pre-coded questions. In addition to testing the adequacy of the questionnaire on the target audience, the pilot study addresses the adequacy of the sampling frame and suitability of the method of collecting data. It is a valuable exercise to gauge non-response rates occurring as a result of estimated refusals, and the efficiency of events in the field, and in communication between the researcher, interviewer and, in this instance, the manager of the bureau who volunteered to conduct the pilot study.

Pre-testing and piloting the study reassured the sponsoring organisation and their representatives on the steering committee and methodology working group that the questionnaire was acceptable to clients and CAB staff.

## **Pre-testing**

Pre-tests can focus on isolated problems of the design (Moser and Kalton, 1971: 48). The pre-test focused on the acceptability of the health questionnaire and time required to complete it. The health questionnaire was designed to be self-administered unless respondents requested to complete an alternative version via structured interview, for instance, due to literacy problems or dislike of forms.

Respondents to the pre-test were sampled using a snowball techniques beginning with family, friends and professional contacts of the researcher, who had previously worked as a further education lecturer. As a result a large proportion of respondents were sampled from the further education sector in the UK and Europe, so the importance of piloting the questionnaire with people from a broader range of backgrounds and age groups was emphasised amongst contacts, which resulted in responses from a broader demographic.

A total of 25 people aged between 12 years and 65+ completed the questionnaire. Of these, 17 were female and 6 male whilst the sex of two is unknown. Fifteen respondents stated their first language as English, five Welsh, three Dutch, one Native American and one Polish. The results of pre-testing illustrated that the time needed to complete the questionnaire was reasonable, and much quicker than some comparable survey material. Respondents took between four minutes to twenty minutes to complete it. Those taking longer admitted that they pondered over questions and could complete it in less time. One respondent with severe dyslexia said “Sat down with a cup of tea, took 10 minutes.” Please see Appendix One for further details.

Interestingly, the majority of comments from respondents to the pre-test referred to the similarity of questions contained within the SF-36, which cannot be modified. For example one respondent said “Mostly straight forward to answer except questions 4 & 5, had to read them a few times so I can imagine people with poor education struggling with those.” Another person commented “I did notice that questions 6 & 10 are very similar”, whilst one offered suggestions to improve the wording “Should chose a different word than "accomplished" in 4 & 5 - some people are really thick.”

Respondents’ feedback proved that the questionnaire was well accepted and easy to complete: “It was very easy to follow and no difficult areas to understand.” A colleague in Holland provided general feedback from respondents he had referred “No one did have problems with your questions.”

It was not possible to test the second part of the questionnaire with this group as questions asking how they accessed the CAB service; the problems for which they were seeking advice, and so on, were not relevant. Instead a draft of the questionnaire was taken to forum meetings and to training sessions provided for CAB staff involved in the study. Feedback from staff at these events proved to be most useful in ironing out problems with instructions and questions within the questionnaire. Many small changes were made as a result of their feedback.

### **The Dress Rehearsal**

It is important that a pilot study is conducted on people who characterise the sample to be employed in the full study (Bryman, 2004: 160). Ynys Mon CAB volunteered to conduct the pilot study, and subsequently delegated the task to one advisor who was only able to commit limited time to the project. For these reasons only five clients participated. As discussed already, prolonged discussions and deliberations about questionnaire content meant the timeframe for piloting the study was extremely tight, consequently the advisor had just one month to collect data. Due to other commitments he was able to spend approximately two weeks on the pilot study. During this time ongoing communication was maintained via telephone and email with the advisor and manager of the bureau. This ensured feedback and progress reports were received at the earliest opportunity.

Summative feedback proved that the content of the questionnaire was comprehensive to respondents, all of whom understood the questions. With regard to the structure and order of questions, the advisor reported “no problems reported within schedule one – all clients completed by themselves. Schedule two structure was OK too.”

Respondents included an elderly lady who felt lots of questions were irrelevant for her as she had just had an operation. She was interviewed when her health was poor, and felt that if interviewed in four weeks time her responses would present a completely different picture of health. Another respondent was pregnant and did not feel her responses provided a true reflection of her physical abilities and her answers would be completely different had she not been pregnant.

One respondent, a lone parent, was very offended by some questions which asked about her ability to afford items for her child. As a result of this feedback, training and guidance was developed further so that emphasis was placed on the research subject's right to refuse answers. Another respondent – an elderly gentleman found the schedule acceptable and had no problems or concerns completing it.

Respondents were asked to rate the structure, content, and clarity of the questionnaire, plus the time required to complete it and ease of use. Response options included Excellent; Good; Neither good nor poor; poor; and, very poor. Findings from four out of five respondents were received, in which they rated these aspects of the questionnaire as 'Good'.

None of the respondents provided suggestions for further improvements to the questionnaire.

### **Reflecting on the Pilot Study**

Although the sample was small the findings from the pilot study indicated that the questionnaire was comprehensive. The advisor found clients willing to participate, few had refused. Overall the results were encouraging considering the time and staffing available for the pilot study.

### **Drawing the Sample**

As with other aspects of research methodology, sampling techniques were discussed within the framework of a methodology working group. It was agreed that probability sampling techniques should be adopted, to ensure statistical techniques that permit inferences to be made about the population from which the sample is drawn (Bryman, 2004: 90). Gaining agreement on a suitable sampling technique was challenging and essentially involved making decisions about sampling at two levels, first at the level of the bureau and second, the client.

## **Bureau Considerations**

Initially multi stage clustering techniques were explored; the key advantage being that the researcher restricts activity to a more geographically concentrated area (ibid).

Maps of Wales were examined to consider bureaux locations within local authorities, within the objective one area, across electoral regions, and across north, south, and mid Wales regions. This latter geographic arrangement conflicted with the preferred organisational regions of CAB, which instead cluster in south east Wales, south west Wales and north Wales.

Despite the obvious advantages of clustering techniques, concerns were raised by Citizens Advice Cymru that some bureaux sampled for participation in the project would co-operate minimally or refuse completely. At earlier stages of the project Citizens Advice explained that bureaux were legally required to participate in research under the terms of their membership agreement with Citizens Advice. However, at later preparatory stages it became clear from discussions with CAB advisors and managers that many were apprehensive about the research, others were suspicious and a few refused to discuss the matter at all.

Noting signs of bureau resistance, Citizens Advice voiced the view that they would like to select bureaux for participation in each of the clusters. Informal conversations centred on which bureaux were the keenest and therefore the best for inclusion in the project. Expressing a preference for non-probability sampling of bureau, minutes from a meeting of the Methodology Working Group dated 4th December 2006 show one committee member on behalf of Citizens Advice “expressed concerns about bureau take up.” In response it was “explained that bureau must be able to decline rather than be excluded if the sample is random.”

Multi stage cluster sampling could, therefore, have incorporated large numbers of unwilling bureaux which would lead to poor representation in some important geographic areas, and ultimately a small sample with which to conduct the study.

It was also vitally important that bureaux could utilise findings with sponsors of their services at Local Authority and Town Council level. Bureaux who were very keen to participate expressed concerns that they would be excluded by the sampling method, claiming their sponsors would almost certainly dismiss the research because they had not participated in it.

Reaching a final agreement the Methodology Working Group agreed all thirty two member bureaux in Wales would be given the opportunity to participate in the research.

### **Sample Size**

Defining the target population is a prerequisite in any survey but in longitudinal studies the dynamics of the population creates additional complications. Attrition is an inevitable outcome in longitudinal surveys, for this reason the eventual sample size required should be taken into account together with estimated rates of attrition (Smith et al, 2009). Previous research in the field provided valuable indicators on which to estimate sample recruitment at baseline and subsequent attrition in later waves of the study.

Pioneering research in the field, Veitch (1995) recruited 52 individuals but later concluded this sample was too small. A similarly small sample of 48 was studied by Abbott and Hobby (1999), although in their later research of 2002 they recruited 345 people into the baseline sample; 245 were interviewed again at 6 months and 201 at 12 months. Greasley and Small (2002: 17) designed a study to replicate the work of Abbott and Hobby (1999) but on a larger scale. Estimating 40% attrition at 12 months and allowing for 25% of those asked to participate to do so he aimed to recruit a sample of 500 individuals (ibid). Later reports show that during an eight month period when advisors saw 717 clients only 132 (18%) completed the initial questionnaire, 64 (48%) completed the six month follow up and 36 people at twelve months. Of those 22 were included in the final statistics (Greasley, 2003).

A minimum sample size of 50 is recommended for use with the SF-36 but this varies across the different dimensions of health and depends upon the type of statistical technique used in analysis.

Based on these findings, and practical considerations such as the time scale and resources available, a sample size of approximately 320 clients was anticipated at baseline to allow for panel attrition in later waves of the study. It was estimated that attrition would be less likely if bureaux took the lead following clients with whom they had an ongoing working relationship but this could be in the region of 50% or more. With 32 member bureaux in Wales, a sample of 320 clients equates to 10 clients being sampled by each CAB. However, bureaux size, staffing capacity and the type of services provided varies considerably, therefore a criterion for sampling was established.

### **Criterion for Sampling**

Within the bureau setting a method of sampling clients was formulated. Methods of stratifying the population by a criterion were assessed; including the type and level of CAB service required, the category of problem for which clients sought advice, and the size and capacity of the bureau. These criteria will be discussed in turn.

Citizens Advice Bureaux offer a number of advice services which provide different levels of assistance to clients, depending upon client needs. At a minimal level, a client may simply require basic information about other service providers; for example, their local housing department. This is referred to as 'signposting'.

Although some clients proceed to use this information independently, others prefer to be 'referred' to appropriate service providers. In addition to this service, some clients receive advice that enables them to 'self help', for example, using the Citizens Advice online advice guide. Others are offered 'assisted information' where they are guided through the information they need by an advisor. 'generalist advice' involves helping clients decide between options and providing assistance where required with the likes of form filling. Finally, the most significant level of input from bureaux occurs in Casework or Specialist advice. These cases tend to be complex and lengthily to



resolve and require ongoing assistance from a dedicated caseworker or specialist advisor.

In order to maximise the opportunities to isolate and understand the impact of advice intervention the project focused on clients receiving casework or specialist advice, as a reminder this is defined as follows:

“In casework the bureau take on responsibility for the conduct of a case and the adviser takes action on behalf of the client. This may include negotiation and representation on the client’s behalf to third parties including at appeal proceedings where necessary. The bureau drives and manages the case, generally devolving responsibility to a caseworker(s) who will have a continuing relationship with the client” (Citizens Advice, 2004: 4).

Casework clients are predominantly those presenting cases under the problem categories of ‘welfare benefits’ and ‘personal debt’. However, discrimination is a key policy priority of Citizens Advice Cymru and as such it was included in the range of presenting problems that would be included in the study alongside welfare benefits and debt advice, in the hope that some cases would be ‘picked up’.

Due to the nature of the study it was essential to capture data at the earliest point of referral; therefore, sampling from existing lists of clients would have introduced timely delays into the project. As a result, all clients requiring assistance from a caseworker or specialist advisor within the timescale for data collection were invited to participate in the study.

Methods of weighting the sample on the criterion of bureaux capacity were initially agreed but later proved to be flawed.

Citizens Advice reported that discussions with bureaux showed that they were willing to interview approximately ten clients per legal entity, this figure being weighted according to the number of case workers/specialist advisors working at each bureau. However, data on staffing of the CAB service in Wales, supplied to calculate the weightings, revealed problems with this approach.

Caseworkers/specialist advisors hours of work fluctuated considerably from one bureau to another. Some bureau relied entirely upon voluntary advisors, others had a full team of paid staff, and some had a mixture of volunteers and paid staff. A small number of bureaux (n=4) also employed casework supervisors, although these tended to be full time advisors employed for a small number of hours per week in a supervisory role.

According to the database, 104 casework/specialist advisors in Wales were paid, whilst 15 volunteered. This totalled 119 casework/specialist advisors in 29 out of 32 bureaux in Wales. Three bureaux not included in the database used generalist advisors to provide specialist advice. These bureaux were included in the study although no accurate data on their staffing capacity was provided.

The number of casework/specialist advisors per bureau ranged from one to 12 staff. Their hours of work fluctuated considerably. For example, according to the database, Maesteg CAB<sup>4</sup> relied on one volunteer who worked 9 hours per week. Torfaen CAB employed 11 casework/specialist advisors for a total of 302.6 hours per week, plus a casework supervisor employed for 5 hours per week, and they had a volunteer caseworker for 9 hours per week.

According to the database, in total 2,752 hours of casework advice was provided by paid staff in Wales each week, plus 155 hours by volunteers. This totalled 2,907 hours per week across the 29 bureaux included in the database for Wales. This figure excludes supervisory hours.

Weighting the sample according to the hours of casework/specialist advice as opposed to the number of staff was a more accurate option but this still resulted in substantial variation in sampling across the CAB service. Based on this weighting 15 bureaux would sample the agreed number of up to ten clients. This left larger bureaux to sample over the agree number of ten clients, some in excess of 20 clients. This was

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<sup>4</sup> Incidentally, Maesteg CAB sampled two clients for the Baseline study whereas Torfaen CAB declined to participate due to 'time pressures'. This illustrates the point that motivation and interest in the research outweighed the issue of bureau staffing capacity, although naturally this was important.

deemed unacceptable to Citizens Advice Cymru who requested that bureaux should not be restricted or conversely put off by weightings.

Discussing the matter further with bureaux, the situation was further complicated when it appeared that the database was out of date and therefore inaccurate. Bureaux managers explained that some voluntary staff work irregular hours and take long holidays from the service; consequently the average hours of work logged into the database did not provide an accurate picture of staffing capacity. The hours worked by paid caseworkers vary with funding streams for these services, changes such as newly imposed legal service contracts had impacted on the hours caseworkers could commit to their clients, although many were known to provide their time freely beyond their contracted hours. Some bureaux appeared to experience a high turnover of staff, which seemed to be linked to ongoing worries about funding streams and job security. Therefore, data on staffing in Wales was unreliable and, equally importantly, an unpopular method of weighting the sample.

As a result of direct requests from the Director of Citizens Advice Cymru it was agreed that bureaux would not be restricted by a weighting and could recruit as many clients as possible who met the agreed criteria for inclusion in the study within the agreed time frame for data collection. This ensured a simple random sample of clients was recruited into the study. A full account of the results of sampling follows in a later chapter.

Citizens Advice staff and advisors to the committees later confirmed that sample was deemed representative of casework clients in terms of demographic characteristics and the range of problems for which they sought advice.

## **Data Analysis**

The social scientist conducts research in order to answer questions about a particular population. Once data is collected it is analysed so that the researcher can then begin to convey answers to their research questions to a wide audience. This may involve displaying the data, summarising the data and drawing conclusions from the data

(Kent, 2001). Nevertheless, it is a mistake to see data analysis as a discrete phase in research that occurs after the data is collected, it is important that techniques for analysis of the data are considered at the earliest stages in the research as techniques have to relate to the type of variables constructed for the research and how this data is classified. What's more sample size can also pose limitations (Bryman, 2004). In quantitative longitudinal data analysis a number of challenges face the researcher. These are now discussed together with techniques adopted in the analysis of the data.

### **Dealing with missing data**

Problems with respondent recollection can result in missing responses although there may be other reasons for this, such as administrative error, respondent refusal or oversight. It is important that missing data is coded accordingly. Failure to comply with this convention can result in the computer software interpreting the code entered incorrectly (Bryman, 2004).

It is important that techniques adopted for quality of life measures comply with recommended guidance. The SF-36 and HADS manuals supplied with the instruments provide clear instructions for dealing with missing responses. Missing SF-36 and HADS data was dealt with using the recommended conventions.

Guidance for the SF-36 states that in instances where fifty percent of multi scale items are answered or in odd numbered multiple scales, half plus one question, a mean score is calculated using the final item values for that scale. In instances where respondents marked two responses next to each other one is selected randomly. Where two responses not adjacent are marked this is recorded as a missing response. All markings such as ticks, circled responses, underlined responses and Yes/No hand written responses are recorded as if marked as instructed in the questionnaire.

Guidance provided with the HADS states that the score for a single missing item from a subscale is inferred by using the mean of the remaining 6 items. The subscale becomes invalid if more than one item is missing.

A greater number of SF-36 questionnaires had missing responses than the HADS. The HADS appears to have optimal completion rates compared to the SF-36, although the reason why fifteen SF-36 questionnaires were invalid is primarily due to a batch of questionnaires being invalidated when an administrative assistant at Citizens Advice omitted to correctly photocopy a batch.

Two respondents failed to complete the HADS questionnaire at baseline. Consequently these respondents were not included in the analysis. In total, five instances of missing responses were found in HADS items, of these none contained more than one missing item per scale and so the conventional method of inferring a score was adopted by calculating the mean score of the remaining six items in the scale.

Extremely thorough procedures were put in place to check the data for consistency, possible irregularities or anomalies. As a result a number of respondents were excluded from the study at wave 2. Seventy six respondents participated in the study at wave 2; however 68 are included in the analysis. Those excluded from the sample include one respondent, aged 88, who became forgetful during the survey interview, which was subsequently terminated. This respondent was not followed up at wave 3.

A further seven respondents, sampled from one bureau, were excluded from the study at wave 2 and were not followed up at wave 3. The decision to exclude these respondents was particularly difficult but was the data was deemed unreliable. Evidence was found of response shift, for example, two males who at baseline had no dependent children mentioned being better able to afford items for their dependent children at wave 2. It is possible that their circumstances changed during the intervening period but the anomaly could not be explained by other evidence or by the Bureau. Unfortunately this was not an isolated query.

Most incriminating evidence was found in the scores from the SF-36 questionnaire. A noteworthy number of respondents from this bureau experienced unexplained improvements in their health during the intervening six months since the baseline study. Further exploration of the data highlighted irregularities with domains of

health that improved and the health conditions respondents reported. Conversely, comparable data from other bureaux illustrated, quite remarkably, how health conditions and deteriorating health reported by respondents correlated with changes to their scores in related domains of health.

It was for these reasons that the difficult decision was taken to omit this bureau from the study from wave 2 onwards. Multiple iterations of manual data checks, cross tabulations, and other statistical techniques were undertaken over several weeks to scour all data for any sign of unexplainable response switching and for anomalies in individual and bureau response sets. As a result all remaining data was judged to be trustworthy.

### **Analysing Quantitative Data**

Quantitative research involves statistical techniques that enable the researcher to answer their research questions. By doing so the researcher can produce empirical evidence and some measure of what is being studied, in order that methods can be replicated by other researchers, and to answer research questions in an objective way (Field and Hole, 2003).

The type of data required for the study and the techniques used to analyse it was considered long before data collection began. Two distinct approaches were used to analyse and interpret the data: descriptive statistics and inferential statistics; these are discussed in turn.

What is commonly referred to as descriptive statistics, fulfils the task of displaying and summarising data (Kent, 2001: 77). Frequency tables were used to provide summaries of the number and percentage of respondents belonging to a particular category of a variable. It is also possible to group individuals into categories, for example, some categories were low in frequency and were collapsed into a smaller number of categories. Another advantage is that where continuous data exists it can be re-coded into categories (Bryman, 2004). Re-coding respondents' ages into age groups is one example of when this approach was used.

Bivariate cross tabulations, which are sometimes referred to as contingency or two way tables, display the relationship between two categorical variables. They can consist of any number of rows and columns but care was taken with larger tables as they become difficult to interpret (Kent, 2001). It is also important to check bivariate relationships against other variables that might affect the relationship.

Diagrams or graphic displays such as bar charts are commonly used in quantitative data analysis to display data. Bar charts were used extensively in the research to display data vertically, horizontally, in stacked and clustered charts. They provide useful summaries for groups of cases and separate variables; they also illustrate overall response to the whole question set. One advantage is that they are fairly easy to interpret and are therefore suitable for a wide audience. This was important as the audience consisted of a wide range of financial stakeholders with an interest in the CAB study, plus CAB staff and the wider advocacy and third sector community.

Measures of central tendency – mean, median and mode - provide a value that is emblematic for a distribution. The mean takes account of all values in the distribution and although this can be advantageous, it is for this reason that the mean can be affected by extreme values and so it was used with care during data analysis. Mode illustrates scores that occur most in the sample, because of this, in instances where bi modal or multimodal outcomes occur using the mode can be confusing. What's more, additional single cases of data can result in unrepresentative measures (Field and Hole, 2003: 114). One advantage of using the median is that it is relatively unaffected by outliers and does not bias the outcome too much with the odd case of anomalous data and it is less affected by the mean and skewed distributions. However, because the median does not take account of all scores in the data it is less useful as a measure. It is also unstable to sample fluctuations (Robinson and Donaldson, 2003).

Drawing conclusions involves one or more techniques that can include statistical inference, evaluating hypothesis against the data or explaining discovered relationships between variables (Kent, 2001: 77). Inference statistics, statistical inference, significance testing or testing statistical significance, are all terms used to

refer to these procedures. The overriding concern when evaluating hypothesis is to gauge the extent to which the data 'fits' in with or supports the researcher's ideas (ibid). It is conventional in the social sciences that tests of statistical significance utilise a  $p < 0.05$ , which indicates that fewer than five chances in every 100 in a sample show a relationship where one does not exist (Bryman, 2004).

When testing hypothesis for statistical significance it is vital that the researcher considers the kind of data they will use. The test may include one, two or more than two variables, referred to as univariate, bivariate and multivariate analysis. Variables can be categorical or interval (ibid). Categorical data is also referred to as discrete or dichotomous data, and interval data is sometimes referred to as continuous data (Tabachnick and Fidell, 2007). For example, scores from the SF-36 and HADS questionnaires provide interval data.

Before deciding upon a technique it is vital to establish if the data is parametric or non parametric. Parametric tests work on the arithmetic mean; consequently the data must be measured at interval (or ratio) level and certain assumptions about the data must be met. Data should be normally distributed and assumptions of homogeneity of variance and sphericity should be met. (Field and Hole, 2003: 160). Parametric tests conducted on non-parametric data produce degraded results, particularly if the data is positively or negatively skewed. Therefore, data was screened for normality using a series of statistical and graphical techniques available in SPSS.

Two components of normality are skewness and kurtosis. Skewness is concerned with the symmetry of the distribution; if the mean of the data is not in the centre of the distribution then the data is skewed. Data can be positively or negatively skewed; in such instances, the data can be observed in a histogram concentrated mostly to the left or right. Kurtosis is concerned with the peakedness of a distribution. Observed in a histogram, a positive kurtosis is too peaked and will have short thick tails, whilst a negative kurtosis is too flat and will have long thin tails. The data was screened for skewness and kurtosis graphically through histograms, normal probability plots and detrended normal probability plots. Statistical techniques available in SPSS, produce values for skewness and kurtosis, when a distribution is normal the value will be zero



(Tabachnick and Fidell, 2007: 79). Miles and Shevlin, 2001: 74) provide supplementary parameters, they suggest Kurtosis values of less than one are likely to cause few problems, and values between one and two may possibly pose a problem. In addition they recommend that if skew or kurtosis is greater than twice the standard error then the distribution differs significantly from normal.

According to Tabachnick and Fidell (2007: 80) it is conventional to evaluate the significance of skewness and kurtosis in small to moderate samples with .01 or .001 alpha levels. However, they caution that in larger samples the impact of departure from zero diminishes; for example, in a sample of 100 or more underestimates of variance related to positive kurtosis disappears and in samples of 200 or more negative kurtosis disappears.

Levene's test and Mauchley's test were conducted to test homogeneity of variance and sphericity, to check the variability in the dependent variable was approximately the same at all levels of the grouping variable (Tabachnick and Fidell, 2007).

In addition to graphical techniques, the distribution of the data was assessed for normality using two statistical techniques available in SPSS, the Kolmogorov-Smirnov test and Shapiro Wilk test. Non-significant values (of more than .05) can be considered normal (Miles and Shevlin, 2001). These techniques compare the set of scores in the sample to a normally distributed set of scores with the same mean and standard deviation. Consequently, the results indicate whether the sample varies significantly from a normal distribution. Caution should be exercised however as the power of these tests is dependent upon sample size (Field and Hole, 2003: 160).

Using a combination of these graphical and statistical techniques, data was assessed for normality and parametric tests were undertaken where all the assumptions were met. In cases where the data was deemed non-parametric, appropriate techniques were used to analyse the data.

At wave 2 the HADS data was found to be normally distributed, whilst the SF-36 formed a non-normal distribution. A paired samples t-test was conducted on the

HADS data. The test statistic produced by the t-test, the  $t$ , is the ratio of the difference between means for two groups divided by the estimate of the standard error of the difference between those two sample means (Field and Hole, 2003, 162). At wave 2 the SF-36 data was found to be non-parametric and consequently the Wilcoxon Signed Rank test was used. In this technique, data is ranked and differences in the ranked positions of scores in the two conditions are examined. One advantage of the Wilcoxon Signed Rank test is that outliers do not bias the results because the ranks are analysed as opposed to the actual data (ibid).

Friedman's ANOVA is the non-parametric equivalent of the one way repeated measures ANOVA. It is used to test for differences in experimental conditions, where the same participants take part in more than two conditions (ibid). Friedman's ANOVA was conducted on three conditions of HADS and SF-36 data, collected at baseline, wave 2 and wave 3. As with the all non-parametric tests, Friedman's ANOVA is based on ranks rather than scores. Wilcoxon tests were subsequently used to further support the analysis. Further details are contained where specific results are reported.

In addition to the aforementioned statistics, chi square tests were undertaken. Chi square indicates whether a relationship exists between two variables, it does not explain the relationship nor does it explain the causal relationship between variables tested, for these reasons Field and Hole (2003: 260) recommend that chi square tests should be avoided if possible. Achieving statistical significance also depends also upon the number of categories of the variables being analysed and the associated degrees of freedom (Bryman, 2004). Nevertheless, the sponsoring organisation requested a series of tests for statistical significance, for which the chi square technique was best suited. Consequently chi square tests were undertaken with caution to examine the characteristics of those who left the study and those who remained to establish if particular groups were more likely to withdraw than others. Making these comparisons, it was possible to gauge (with caution) how representative the sample was at wave 2 and wave 3 of the initial sample who participated in the project at baseline.

## **Analysing Qualitative Data**

There is some debate as to whether responses to open questions constitute qualitative data; and some researchers have described them as ‘quasi-qualitative’ (Murphy et al, 1998). There has been further debate about which methods provide the greatest reliability and validity in representing open responses in context (Gerbner et al, 1969). Jackson and Trochim (2002) note that open responses are challenging because they tend to be brief compared to interview transcripts and it is not possible for the researcher to follow responses with further questions where clarification is required. What’s more, some respondents will be more willing to provide answers than others; consequently topics will be noted more or less frequently by some respondents compared to others (Geer, 1991; Rea and Parker, 1997; Sproull, 1988). This means that attempts to standardise responses or re-code them will be complicated (Jackson and Trochim, 2002).

Treating open responses as qualitative data can be problematic, as “no bank of explicit methods and techniques that the qualitative research can use has been developed” (Kent, 2001: 228).

Ryan and Bernard (2000) recommend two distinct methodological approaches for the analysis of textual survey responses. The first is ‘words as units of analysis’, this refers to key words in context, semantic networks and cognitive maps. The second approach is ‘codes as units of analyses’, as used in grounded theory, traditional content analysis, and schema analysis. Highlighting that discovering themes is at the heart of qualitative data analysis, they define these as “abstract, often fuzzy, constructs which investigators identify before, during and after data collection” (Ryan and Bernard, 2003: 85).

Helpfully, outlining a dozen techniques for discovering themes in texts, Ryan and Bernard (2003) provided a valuable resource at data analysis stage. They caution that scrutiny based techniques and linguistic based approaches can be overkill for analysing short responses to open questions. They recommend that a more powerful strategy should combine multiple techniques in a sequential manner. Consequently,

combinations of techniques were used beginning with a 'pawing' exercise where texts were marked with coloured pens and key words and phrases underlined. Bogdan and Biklen (1982: 165), suggest pawing the text at least twice in order to get a feel for the data. Bernard (2000) refers to this as the 'ocular scan method'.

The next stage utilised compare and contrast techniques. Texts were compared for similarities or differences between respondents' answers and within respondent's answers to different questions. This method is also known as the 'constant comparison method' (Glazer and Strauss, 1967: 116).

Word based techniques were used to analyse responses to open questions to gain respondents' views in their words and explore any views that may not have been elicited from closed question response sets. Key words in context are based on simple observation of instances of the word or phrase in the text. This was followed by a more thorough 'cutting and sorting' activity in which responses were cut out and organised manually using a pile sorting technique. Themes were identified and responses allocated accordingly into piles. These were sometimes re-sorted further by sub-themes and cross-cutting themes were often identified.

Using these techniques it was possible to identify key themes in open response texts for discussion and analysis. In some instances though, as Kent (2001: 228) argues some data appeals intuitively and does not need further interpretation whilst other data can be paraphrased into broad categories.

Writing techniques studied at workshop held by Kathy Charmaz (2008) proved to be influential. At the writing stage, Charmaz (2008) recommends clustering ideas around central themes in order to create sub-categories to show relationships. Configurations of clusters help construct an image of how main categories fit together and relate to other categories. Once writing begins, it is vital to entice the reader to the story, provide context and reproduce the power of the experience, recreating the experiential mood brings the scene to life. Providing further guidance she advocates the writer should show how unforeseen events accumulate, convey the tension,

recount the predicament and reveal meanings, assumptions, subtle world views and hidden social pressures.

Here the challenge is to produce a thesis that incorporates rounder styles of writing normally associated with ethnographic research with hard statistical data.

In addition to these techniques a small number of open questions were used in the questionnaires in instances where the number of possible responses was too long and where there was uncertainty over responses. For example, the baseline questionnaire asked clients' their age; one open question was incorporated to gather data about any problems they experienced with their home, and another open question asked respondents where they heard about the CAB service that they used. Age data was re-coded into categories of age groups. The remaining questions were coded numerically and transformed into quantitative data. The process involved creating a list of answers from responses in the questionnaires, these were examined in depth and a coding frame was developed in accordance with the key themes which emerged. Responses were then coded accordingly into quantitative data.

## **Conclusions**

This chapter sets the scene by introducing critical underlying organisational behaviours that were to shape the research throughout its life. The rationale for the approach adopted was set out. To act as a reminder of the key points, a brief summary follows:

All Citizens Advice member bureaux in Wales were invited to participate in the study and they were responsible for sampling clients seeking welfare benefits, debt and/or discrimination problems. The study was longitudinal in design; data was gathered at baseline and again at 6 months and 12 months during the existence of the project. This explicitly follows a model developed by Abbott and Hobby (1999) and subsequently Abbott and Hobby (2002) and Greasley (2003).

Questionnaires incorporated two validated health outcome measures - the Short Form 36 (SF-36) and Hospital Anxiety and Depression Scale (HADS), plus a range of questions sourced from the ESRC Survey Bank, in house questions, and a small number of open questions.

Utilising CAB staff in the research, it was possible to benefit from their expertise in dealing with clients. It was hoped that through their involvement, they would gain ownership of project and an opportunity to develop new skills and knowledge in research. Full ethical approval was gained; a pilot study was undertaken and a training programme was delivered for CAB staff involved in the project. Ongoing support was provided throughout the existence of the project via telephone, email and through presentations at Regional and Social Policy Forums, plus the Better Advice: Better Health (BABH) Forum.

What follows is an account of the process of sampling, which involved getting into bureaux, getting on with the research, getting out and getting back (Buchanan et al, 1988) to conduct further waves of data collection.

## CHAPTER FOUR

### **Getting in, Getting on, Getting out and Getting Back in**

Gaining access to research participants through formal organisational structures is one way of encouraging their participation. However, 'getting in' is just one aspects of access. According to Buchanan et al (1988) gaining access is an ongoing process with four dimensions: getting in, getting on, getting out and getting back. This aspect of the study proved to be particularly challenging and unpredictably it was also very interesting.

Diary notes were maintained throughout the research process to monitor the progress of individual bureaux with data collection. Initially these notes provided practical records, later they provided valuable and illuminating insights into the organisation and issues that emerged gaining continued access to bureaux. Illustrative examples of diary notes have been lightly edited to protect the identity of the individuals and bureaux concerned; however, no further editing has occurred and the diary excerpts are incorporated in their original form so as to convey events 'in the moment'.

#### **Getting In**

At the earliest planning stage, according to Citizens Advice Cymru 'getting in' would be unproblematic. On occasions bureau participation was conveyed as an obligatory requirement of the terms and conditions of the membership agreement between member bureaux and Citizens Advice. At other times the commitment to participation as binding was somewhat ambiguous, although the support and enthusiasm of bureau staff was reiterated regularly at committee meetings. Still, the emerging tensions between the organisations, which one can only learn with time and exposure to organisational culture, forced the realisation that Bureau conviction to the project was not altogether universal. Yet, questions about Bureau interest and motivation for compliance and cooperation with the project were dismissed until much later when such issues could no longer be ignored.

As Aldridge and Levine (2001) point out, authorisation of research by senior people does not necessarily mean that the rank and file will be enthusiastic. People have to be won over; their co-operation has to be gained so that respondents can be accessed. This was vital as Citizens Advice Bureau staff were required to mediate the relationship between the researcher and respondent.

The strategy for ‘getting in’ to bureaux involved presenting information about the research at regional forums and social policy forums in north Wales, south west Wales and south east Wales. Research benefits were expressed in terms of the influencing power of independent research on financial stakeholders of the service, both at national and local level. During presentations it was vital to generate a sense of curiosity about the outcomes of the research that could illuminate how advice impacts upon the lives of individuals, to appeal to those with altruistic tendencies. To counter the sceptics and suspicious, it was important to convey some of the positive outcomes emerging from research in the field and demonstrate a sensitivity to the ethos and values of the CAB service. Reassuring bureau staff, listening to their concerns and answering questions honestly helped overcome some barriers. Confidentiality had to be carefully negotiated, ethical issues discussed and sensitivity demonstrated.

The pressures of time and all personal worries about the success of the research had to be concealed behind a confident, positive and enthusiastic exterior.

‘Getting in’ to some bureaux was unproblematic and in such cases it was a pleasure to speak with bureau staff about progress with the baseline study. A summary of progress at one bureau, logged in the research diary simply notes: “Returned April & May surveys, received additional materials. Spoke with [advisor] at BABH forum and she was very happy with everything.”

However, winning hearts and minds is a challenge when gatekeepers purposefully hinder entry. After all, early departure from meetings allowed some to ‘miss’ research presentations, email is easy to ignore, and some individuals creatively avoided telephone communication.



However, some did at least discuss their concerns directly. For example, a diary note of a conversation with one manager says:

“Spoke with [X bureau] manager at the X forum. She reported that her staff are reluctant to ask clients to participate or feel embarrassed asking them. She asked if the approach taken to asking clients makes a difference in responses to the survey and I confirmed that I believe it does. She will speak to her staff this week to motivate them and instil positive approach.”

Others were less willing to discuss concerns. After repeated attempts to gain access to a bureau that covered a large geographic district a last ditch attempt was made, with the assistance of a member of the steering committee, which resulted in victory. The process is logged in the following diary excerpts:

“Telephoned X CAB repeatedly but couldn’t get through. [A member of the Steering Committee] spoke with the manager, which resulted in a response to my messages. Visited the CAB to talk with staff on 29 May, they will begin on 4 June.”

“Emailed for progress report on 11/6/07 - response: ‘All caseworkers are back in this week so commencing today, sorry, all have either been on annual leave or off sick.’”

Shortly afterwards it was noted in the diary that “Some staff members were present at 2 talks I gave (X regional forum & X social policy forum).” As no progress was reported by the staff attending these forums the matter was followed up again; the response logged in the diary states: “Further email from bureau: delays starting due to staff holidays and illness, now starting 17/6/07.”

At this point the bureau accepted an extension for the baseline study to the 14 August 2007. Although efforts to ‘get into’ the bureau were successful they sampled just two clients in the baseline study.

An impromptu visit to another bureau was not as successful – although by chance two bureau managers were present to be ‘tackled’. One of these managers was responsible for the bureau visited, whilst the other manager was in attendance for a meeting. Diary excerpts logging attempts to ‘get in’ to these bureaux first describe

problems experienced by the visiting manager. The first excerpt, taken from notes from a telephone conversation state “[He claimed he had] not received any survey packs.<sup>5</sup> [More] survey materials sent out 14/5/07.” After seeing the manager in person at the bureau he was visiting, the follow entry was made:

“Spoke with manager when visiting x CAB and the regional forum. After talking about the project he became interested but has difficulty persuading some volunteers to take on tasks they don’t want to do. Seemed undecided.”

A later entry states “[Steering Committee member] has spoken with [the manager] (19/07) and it looks promising.” However, this was followed by a final note on the matter that explains the manager:

“opted out due to in-house problems. Offered to support study in future if he can, really sorry but can’t persuade his volunteers, has serious problems with them and working on this.”

The manager of the bureau visited was also undecided. Diary notes from early May 2007 state: “Experiencing severe staff shortages and unable so far to complete surveys but will try if their situation changes.” Upon visiting the bureau, the following note was entered into the diary:

“Visited x CAB, Manager won’t participate due to capacity. She was later at the forum meeting (14/6/07) and looked as if she may have regretted her decision. I asked [Steering Committee member] to speak to her.”

The outcome of this was “he has spoken with [the manager] (19/6/07), after the AGM she may be more receptive.” The last entry for this bureau states “No change, isn’t interested.”

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<sup>5</sup> The distribution of survey materials was supervised personally and all survey materials were distributed to all bureaux. Several bureaux stated that they did not receive these materials, although it later transpired that the survey packages were mistaken for a standard monthly mailing pack from Citizens Advice Cymru, which some bureaux automatically binned.

Despite making a slow start some bureaux were keen, and once they were adequately prepared 'getting in' was straight forward. A diary entry for one bureau illustrates this well:

“This CAB contacted me at the start of the project to say they wanted to participate. They haven't been able to complete any surveys in April due to operational difficulties and the Easter holidays. However, they will be conducting surveys in May and are perfectly happy with materials.”

Others appeared uncommitted but produced some surprising results, as noted here:

“Has only just opened the survey yesterday to read it. Trying to think about how to manage the project and persuade debt & welfare benefits advisors to join in but not optimistic that they will assist. Commented that due to new contracts all time has to be accounted for and conducting surveys does not fall within the contract hours. Outcome: Sensed apathy in the project but persuaded her to have a go although she still sounded un-committed.”

A later entry reads “Called 15/6/07, they've completed 4 and hope to do more, advisor going on holiday for 2 weeks though.”

### **Getting On**

The process of 'getting on' involves patience and persistence, having the will and ability to seize the opportunity, win people over and negotiate a wide range of gatekeepers who can facilitate or hinder research (Buchanan et al, 1988). In relation to getting on there were many successes but also failures. In some instances after exhaustive efforts to 'get in', some bureaux did not 'get on' and this resulted in some disappointing unexpected losses.

A classic example can be seen in a series of diary entries relating to one bureau. This bureau manager acted as a gatekeeper between her staff and the researcher. She refused to take telephone calls, did not respond to messages, did not answer email messages and did not disseminate information about the research to her staff. However, after seeing a presentation about the research at a regional forum she appeared to warm to the idea of participating. Not all attempts to contact this bureau

were recorded in the diary, although the excerpts provided give a good summary of the experience:

“Called [district headquarters] 3 times early May, said they will call me back twice – didn’t.”

“Spoke to X CAB, bureaux in district are working individually on the project as opposed to as a district. [This individual] CAB has just started but haven’t recruited any clients yet.”

“Met BABH advisor (one) at May Shrewsbury forum, she didn’t know anything about the project but said she would locate the survey pack and participate in the project.”

“Met a large number of X staff and [the bureau manager] at X regional forum. [Advisor two] asked for a survey pack, very keen. I met him at the York Conference, he hasn’t heard any more about the project since then. After giving a short talk on the project [the manager] also put her name down for a survey pack. (They have had one already but can’t locate it).”

“Met [senior advisor from this bureau] at SP Forum in X, she will check on bureau progress.”

“Email from [the senior advisor] 9/6/07 to say they will take extension; [advisor one] is administering surveys and is off on holiday.”

“Message from [advisor two] 12/6/07 ‘Nothing has come through yet but I will monitor the post and let you know.’”

“Spoke to [advisor one] at BABH forum 14/8/07 (last day of wave one) and she had put the project on the backburner then realised the deadline was up, hasn’t done anything.”

Losing this particular bureau was extremely disappointing. The bureau covers a large district and had a reputation for excellent work. Perhaps unsurprisingly they were also known for being fiercely independent and resisted close allegiance to Citizens Advice.

Some Bureaux joined the project late. In these instances appointments were made for telephone support to be provided and lengthily discussions took place to cover important aspects of the study.

An example of this can be seen in a series of diary excerpts relating to one bureau:

“Spoke to manager, X, early May. She hasn’t yet started and felt unsure what to do as her staff had been at an event I was talking at but hadn’t really got organised at the bureau. I explained everything to her and she is much happier now about starting and identified suitable staff and systems for administering surveys as a result of our conversation.”

“Further communication with one advisor on 29 May who wanted more information about the project. They haven’t started but plan to soon.”

“Emailed [manager] for a progress report on 11/6/07. Spoke to [manager] at X regional forum 14/6/07 – starting shortly, hope to contribute 10 surveys, would appreciate additional time if she hasn’t met her target by end June.”

“Email from [manager] 12 July, they have 5 completed surveys and want an extension to do more.”

In a small number of cases, the bureaux declined to participate in the research from the onset. A note relating to one bureau states “Not participating in project, manager passed on message to receptionist who could provide no reason why.” Similarly another bureau declined to participate and did not respond to any further correspondence on the matter. The British Sociological Association (2002, item 56) Statement of Ethical Practice states that “Members should be wary of inadvertently disturbing the relationship between participants and gatekeepers since that will continue long after the researcher has left.” In such instances, it was not practical or ethical to insist on participation.

Outright refusal was rare; consequently establishing who was ‘getting on’ with the research took tremendous time and effort. Most bureaux that did not participate remained undecided throughout the baseline study, whilst others took time to ‘get organised’. As noted earlier, at the first meeting of the Methodology Working Group an advisor cautioned that data collection could dominate PhD activity. This proved to be the case and involved liaising with and monitoring the progress of around 30 bureaux in the baseline study, although bureau attrition reduced this number in subsequent waves of data collection.

Ongoing support was provided via telephone and email. In addition to supporting on the ground staff, it was possible to monitor the number of surveys administered across Wales and track the level of participation at each bureau. In addition to providing support, supervision was designed to detect problems in order to deal with these quickly.

As seen in these excerpts, presentations continued at the regional forums and at the Better Advice: Better Health forums throughout the whole of the research project. Due to re-structuring across Citizens Advice the schedule of Social Policy forums temporarily ceased whilst re-organisation occurred. The role of Social Policy manager ceased to exist, consequently this person left the organisation and therein one 'gate opener' was lost.

Bureaux were asked to return batches of completed questionnaires monthly so that they could be checked for quality - completeness of the questionnaire and compliance with consent procedures. In some instances this worked effectively and it was possible to track bureau progress over the whole of the project. Notes from baseline study for one bureau state:

“Returned surveys for April & May. At the BABH forum [an advisor] said they hope to complete 50 surveys as they want to use the project to fulfil the requirements of their funding to produce research on the impact of their work.”

“Emailed for a progress update 11/6/07. Response – they've completed 3 more surveys, have one advisor on holiday which will impact on their target number.”

Further updates were received from this bureau on a regular basis and all data was returned monthly throughout each wave of data collection. This suggests that the methods adopted could work, if all parties co-operated.

However, in the majority of cases the process of obtaining completed questionnaires was extremely time consuming and involved repeated telephone calls, emails, and in some instances, formal written requests from the steering committee.

The most damaging effect of this was seen when a large batch of questionnaires was returned from one bureau after the first wave of data collection. Seven of these questionnaires were missing sections of the SF-36 questionnaire<sup>6</sup>, which invalidated them. Diary notes taken of correspondence with the bureau before they returned their questionnaires state:

“Completed about 4 surveys so far but only really started this week (early May) after distributing to advisors. They are aiming to collect 24 from their district. Will continue with data collection. Emailed [manager] for progress report 11/6/07 – Response, all advisors have been provided with surveys they just need to collect them in, number completed unknown. Email from [manager] 18/6/07, she has spoken with [advisor] who confirms all 24 surveys will be returned by end June. I have asked her for bureau stats etc ready for analysis.”

‘Getting in’ and ‘getting on’ with the baseline study was exceptionally challenging. It required support from the highest level of the organisation and from key members of the Steering Committee. At the end of the baseline study the committee resolved to obtain a statement of endorsement for the research from the Welsh Assembly Government. Edwina Hart, the Minister for Health and Social Services and the previous Minister for Social Justice at the Welsh Assembly Government provided a statement that was incorporated into a letter to all bureaux in Wales:

"I'm very much welcome this CAB research in Wales. As an Assembly Government Cabinet Minister for more than eight years I have been very aware, in a range of key policy areas, of the work which Bureaux undertake on behalf of some of our least well-off communities and families.

This research will provide us with real information about real lives and help us to improve services for the future. I will need the active participation of workers, volunteers and users of CAB services across Wales. This is an investment for the future on which all of us will be able to draw. I thank all those who will give up their time, in advance, for the contribution you will make and urge anyone who has the chance to take part in this research to do so" (Edwina Hart, 4 July 2007).

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<sup>6</sup> The bureau requested additional questionnaires from a member of staff at Citizens Advice headquarters who they regularly communicated with but this person was not involved in the project and incorrectly photocopied the batch.

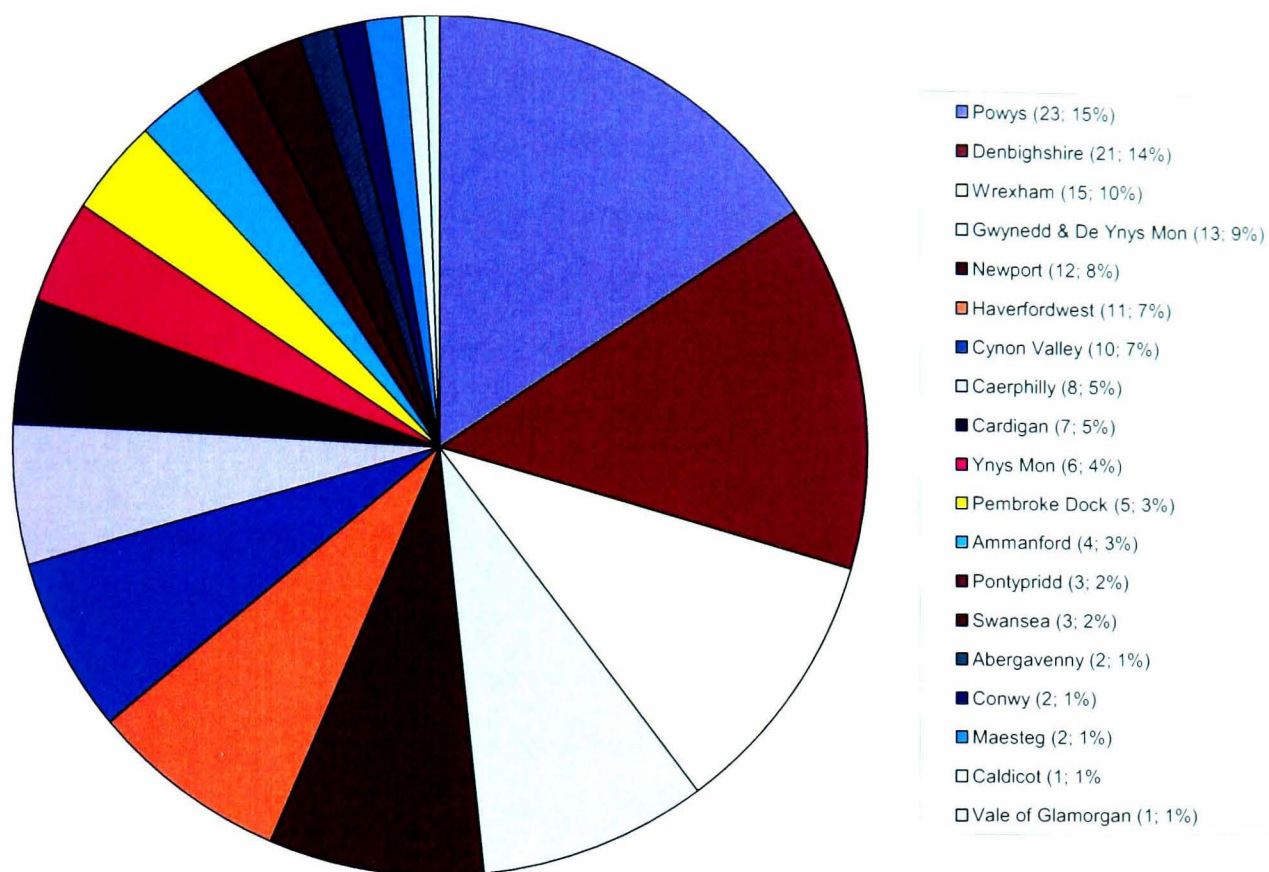
## **Results of Sampling**

Invitations to participate in the research were extended to all 32 member Citizens Advice Bureaux services operating in Wales at baseline. The rationale for including the entire CAB service in Wales was that bureaux would be able to utilise research findings with a wider range of local financial stakeholders, such as Unitary Authorities, if they participated in the study. Despite considerable efforts to include the entire service, 19 member bureaux chose to participate at baseline. They successfully sampled a total of 149 respondents, approximately half the sample originally planned.

It can be seen from the data set out in Figure 2 that disparities in the number of respondents sampled by bureaux occurred. This is partly because of a variation in the size and capacity of each bureau, in terms of staffing and funding. In the north, several bureaux have amalgamated into larger districts, whereas in the south there is a tendency towards smaller clusters of bureaux serving populations that are more concentrated. However, this does not fully explain the differences in sampling between bureaux.



Figure 2: Results of Sampling by Bureaux at Baseline



Issues faced in the sampling process were often compounded by the restrictions of funding streams that support many advice services. These often dictate the time an advisor can spend with a respondent; during such advice interviews it is only natural that advice giving takes priority over research. It was also found at baseline that some advisors were frequently reluctant to trouble respondents who were already anxious and overwhelmed with problems.

It is evident that the day-to-day operational problems experienced by some bureaux impinged upon their capacity and significantly influenced their resilience and enthusiasm for the research project. A considerable proportion of the bureaux that did not participate in the study gave as reasons their severe funding difficulties. Further complications occurred at some bureaux that experienced staffing shortages due to extended periods of staff leave or staff sickness. These problems restricted their capacity and hindered their ability to play a part in the project. However, they were not unique in this situation and the more motivated bureaux managed to overcome these limitations, some more effectively than others.

In some instances, bureaux put the material to one side, which delayed progress with the project so that, eventually, the deadline for sampling had elapsed. Some bureaux believed strongly that they should be independent of Citizens Advice; tensions between the two organisations were at the root of their rejection of the research. Other bureaux, particularly the smaller south Wales services, historically have a poor track record of engagement with Citizens Advice activity. Overall, bureaux exhibited varying levels of motivation, which partly explains the disparity in the sampling and the lack of engagement in the project by some bureaux.

A short review of the geographic spread of participating bureaux illustrates that Flintshire CAB, in north Wales, was the only bureau which did not participate in the north; the remainder of the bureaux contributed significantly to the sample. Powys CAB in mid Wales provided the largest sample of 23 clients. Responses in south Wales were less positive and resulted in patchy coverage of the area. Overall, it was the response from the bureaux in the industrialised areas that proved most disappointing, particularly in the south.

Bureaux in Bridgend, Blaenau Gwent, Bridgend, Carmarthen, Chepstow, Merthyr Tydfil, Neath Port Talbot, Llanelli, Monmouth and Torfaen are not represented, nor are Cardiff. These include some of the most deprived communities in Wales. Nevertheless, a number of bureaux located in other areas of deprivation and industrialisation in the south did participate. These include Caerphilly, Cynon Valley, Pontypridd / Rhondda Cynon Taf, Maesteg and Swansea bureaux.

This variation in the sample across the service and the lack of engagement by a proportion of the bureaux affected the sample size, which originally was aimed at a double of what was achieved. Nevertheless, 19 out of 32 member bureaux throughout Wales participated in the study and the cohort of 149 respondents who participated at baseline made the project viable. They represented both rural and industrial areas, as well as north, mid and south Wales.

## **Getting Out**

‘Getting out’ is not simply a case of escape – rushing out with a sigh of relief. It is vital that relationships are formed with key stakeholders so that links can be maintained, and access re-gained should this be needed (Buchanan et al, 1988).

Dissemination of results and feedback is an important component in this process. Strategies to feedback research progress and findings included the aforementioned endorsement from the Welsh Assembly Government and ongoing updates at the CAB forums. A research newsletter was launched but after two editions, which were incorporated in monthly mailings from Citizens Advice Cymru, it transpired the newsletter was not reaching bureau staff. An unintended outcome of the research was the discovery that monthly mailings from Citizens Advice Cymru to CAB head offices across Wales were regularly filed in the bin unopened; after high level re-evaluation the monthly bureau mailings were discontinued.

As key contacts within bureaux were established it became easier to communicate by email and to locate someone at each bureau that was familiar with the research. In some instances correspondence was mailed for the attention of individual contacts within bureaux to ensure that important documents and research information was received. Working relationships developed and it became easier to provide feedback through these key contacts to bureau staff. In addition the research updates featured regularly on the agenda of regional forums.

## **Getting Back**

Essentially, at wave 2 and wave 3 ‘Getting back’ (Buchanan et al, 1988) occurred at two levels, first between the researcher and the bureaux, and second the bureaux and the research participants. In order to conduct three waves of data collection ‘getting back’ into bureaux was vital.

However, some bureaux, accepting an extension for data collection at baseline, took so long collecting their baseline data that ‘getting out’ was not an option and the

process of 'getting back' hardly occurred. Due to extensions, a two week gap was created between each wave of data collection, although it took much longer to acquire the data from some bureaux. The Chair of the Steering Committee intervened in such cases by writing formally to the bureaux concerned.

'Getting back' naturally correlated with attrition, of which there were two categories: first, bureau attrition, and second, respondent attrition.

Some bureaux made heroic efforts to 'get back'. An example of this can be seen in an entry taken from the research diary, in which a short update on a volunteer's progress with data collection in the early stages of wave 2 was logged:

“[The volunteer] had some early problems with an aggressive client and another one who was in Jail and could not be contacted. She is persisting with the former and thinking of ways to contact the latter.”

An email message, from another advisor, illustrates his pragmatic approach to data collection at wave 2:

“Unless I have any emergency appointments I have allocated time next Monday to look at these. I know I will have problems with two of the clients as they have not responded to bureau correspondence and do not answer phone calls. I may see one of the clients at an outreach at a MIND day centre on Monday. Another is an existing client so I am still in contact with him. The other two, no longer clients, should be not a problem both are on the phone and live not far from me so I should be able to complete.”

Some bureaux experienced difficulties contacting respondents and securing appointments in order to conduct follow up surveys, as seen in this email correspondence from a bureau manager dated 12/2/08:

“Although only having [number] candidates for this project I've had difficulty getting responses from them. Having no response from letters I am now hurriedly trying to contact them. One of the subjects has the questionnaire and has promised to return it this week, I will go round to collect this if necessary, I have arranged to go out on Friday 15th to see another. Of the other two I have left a phone message asking her to call, but the last one I have not been able to call as the number I have for him is now unobtainable.”

On occasions internal problems surfaced, for example, one bureau advisor explained that she didn't know if she should continue with project as she hadn't heard from the researcher. It later came to light that the advisor and her district manager were experiencing communication problems and one had not informed the other about the second wave of the study. The problem was quickly resolved and good progress was made with wave 2.

However, other bureaux were less willing to continue in the research. Obtaining information about their progress with the second and third wave of the study proved to be difficult. As noted earlier, telephone calls are easy to avoid and email messages can be ignored. Some bureaux experienced changes in management, and in a small number of cases changes in staffing resulted in the loss of key contacts, previously responsible for data collection.

### **Sample and Bureau Attrition**

Attrition rates in quarterly and annual panel surveys indicate that the most significant loss occurs between the first and second waves of data collection (Smith et al, 2009: 25). This proved to be an accurate predictor of attrition in the study.

At wave 2, a total of 76 respondents, 51% of the baseline sample, participated in the study; however 68 of these were included in the analysis of findings at wave 2. Those respondents excluded from the sample include one who became forgetful during the survey interview, which was subsequently terminated, and others whose responses were also deemed unreliable; these respondents were not followed up at wave 3.

At wave 3, 42 respondents, 62% of those included in the study at wave 2, remained; four of these participated in the baseline study but not at wave 2.

Table 1: Sample Attrition across Bureaux

<i>CAB (count)</i>	<i>Wave 1</i>	<i>Wave 2</i>	<i>Wave 3</i>
Powys	23	14	14
Denbighshire	21	12	5
Wrexham	15	8	3
Gwynedd	13	7	5
Newport	12	7	0
Haverfordwest	11	7	4
Cynon Valley	10	3	2
Caerphilly	8	4	3
Cardigan	7	0	0
Ynys Mon	6	2	0
Pembroke Dock	5	2	0
Ammanford	4	2	0
Pontypridd	3	3	3
Swansea	3	3	0
Abergavenny	2	2	2
Maesteg	2	0	1
Conwy	2	0	0
Caldicot	1	0	0
Vale Of Glamorgan	1	0	0
Total Sample	149	76 *	42

\* 76 respondents participated in the study at wave 2; however 68 of these are included in the analysis of the findings at wave 2.

Staffing shortages, long term absence and funding difficulties that delayed baseline sampling also disrupted some follow up interviews. Motivation for the research was also a key variable. Therefore, the same problems that affected sampling also impacted on attrition later in the study.

The second wave of data collection was scheduled to take place at six months. Some variation was to be expected in the 6 month timeframe between wave one and two of the study, as it may not always be possible to contact a respondent or arrange a convenient time to administer the questionnaire precisely 6 months after the respondent first sought the advice of a CAB.

The timeframe between baseline and wave 2 interviews ranged from approximately just less than five months to around nine months. Between wave 2 and wave 3 interviews ranged from approximately five to seven months. Bureaux explained that

some respondents were unavailable precisely at six or twelve months and some were difficult to trace, for example one respondent was found to be in prison and others had moved. Due to an extension provided in the baseline study (to boost the sample size), the second wave of data collection coincided with the Christmas and New Year holidays, which naturally interrupted the flow of some follow up interviews.

It has been recognised by others in the field that these groups often lead a fragile existence, moving home regularly and consequently being difficult track and contact. For example, in a longitudinal study of the impact of debt advice on people's lives, which was conducted over a comparable time frame to this study, Pleasance et al (2007) reported difficulties following up respondents, and found that 29% of those successfully followed up reported changes in their housing situation. Similarly, it can be seen from excerpts of correspondence with CAB staff that in some instances contacting respondents was problematic in this research.

## **Conclusions**

Utilising the four dimensions of access to the research field developed by Buchanan et al, (1988), this chapter has discussed issues of access, sampling and panel attrition in the context of this CAB study. By drawing on diary entries recorded 'in the moment', a much broader account is provided that epitomize the considerable and persistent efforts that were required to get this research off the ground. But the hard work did not end there, in order to maintain momentum over three waves of data collection ongoing management of the project was crucial. Building relationships with bureaux was essential to the continuance of the study, whilst diligent record keeping ensured progress was monitored and the project was completed.

Although the remaining sample at wave 3 was small, it is not unusual in the context of this field of study to work with small samples, and attrition is to be expected in research of this design.

This is a particularly relevant issue as it will be seen that it was clearly established in the baseline findings that this sample of respondents, who were seeking advice at

casework level for complex problems consisted of vulnerable and sometimes hard to reach groups.

Despite the difficulties experience during sampling, a significant number of bureaux, located throughout Wales participated in the research and a total of 149 clients participated in the baseline Study. It is hoped that the findings will contribute to a growing corpus of literature by providing useful longitudinal evidence on the impact of advice on the lives of individuals. Beginning at baseline, the findings are discussed in the following chapter.



## CHAPTER FIVE

### Outcomes of the Baseline study

In order to learn about the impact of advice on the lives of individuals it is imperative to begin with an assessment of their circumstances at baseline, prior to advice intervention. This chapter begins with a profile of respondents and the problems for which they sought advice. It gives insights into prevalent financial difficulties reported by respondents and material disadvantage. The chapter ends with an assessment of their health and social wellbeing. Appendix Two contains detailed statistics gathered during the baseline study.

#### Profile of Research Subjects

Respondents to the baseline study encompassed a broad age range, from 16 to 88 years. The mean and median age was 46 years. Sixty three percent were female and 37% male. Just over half the sample was of Welsh nationality; this figure can be compared with the 67.8% who considered themselves Welsh in the Welsh Labour Force Survey/Annual Population Survey of 2006. The sample consisted predominantly of those of white British ethnicity. Just five respondents (3.5%) were from non-white ethnic backgrounds compared with 2.9% in the aforementioned survey. As with the rest of the UK, geographic differences exist in the proportion of ethnic minority groups across Wales, with the majority concentrated in urban areas such as Cardiff and Newport in the south. Consequently, the proportion of ethnic minority respondents to the survey was dependent upon participation by bureaux in key areas.

The majority of the sample spoke English, three who spoke 'other' first languages were from Bangladesh, Pakistan, and Europe; all of them, however, also spoke English. Overall, 18.6% spoke Welsh, a figure lower than statistics for Wales which indicate that of 26.7% speak Welsh (Local Welsh Labour Force Survey/Annual Population Survey, 2006). However, these statistics represents members of the population aged three and upwards, and for this reason do not enable direct comparisons with the sample. Possibly related to this outcome, no Welsh language

questionnaires were returned. Given the nature of the research project, it is not possible to determine whether nor to what extent was this a reflection of respondent choice or the Welsh language capacity within the bureaux.

Approximately a third of the sample was single, 27% a couple, 24% a couple with dependent children, whilst 11% were single with dependent children. All of the single respondents with dependent children were female. Overall, 47 respondents had responsibility for 88 children; a further 3 had child responsibilities but did not disclose the number of their dependent children. As a result, the number of dependent children cared for by respondents will be somewhat higher.

### **Housing Status of the Sample**

Drawing on baseline findings, a striking disparity was found in proportion of the sample that were homeowners compared to national statistics for Wales. Thirty percent owned their home, a figure that diverges significantly from the 71% who were home owners in Wales in the Census of 2001. Sixty four percent rented their home, including one respondent who was renting temporary accommodation. Of the remainder, one was homeless, whilst a small number lived rent free, for example with family or friends.

These figures diverge from housing statistics for Wales as for instance, in the Census of 2001, 27% of the whole of the population of Wales were recorded as renting (Local Government Data Unit Wales and Wales Centre for Health, 2004). Still, the housing status of the baseline sample is comparable to other studies of CAB respondents, for example, in a study of CAB debt respondents in the UK 65% were tenants (Phipps and Hopwood Road, 2006: 5).

In relation to those living in rented accommodation, further disparities were found with official statistics for Wales. A report on households in Wales based on the Census of 2001 shows that 18% of the population rented from a social landlord, this compares with 37% of respondents in this study, whilst Welsh statistics show 9% of

the population rented from private landlords compared to 27% in this study (Local Government Data Unit Wales and Wales Centre for Health, 2004).

Further exploration of the housing arrangements of respondents with dependent children established that 60% lived in rented accommodation, of which 38% rented from a social landlord and 22% from private landlords. One respondent lived with family/friends and the remaining 38% were homeowners.

Although significant differences can be observed in the housing tenure of the sample compared to the population in Wales, due to the nature of the study it is likely that this respondent group represents poorer members of the Welsh population. Data for the UK highlights striking disparities between the homeowner and tenant's situation. A recent UK Housing Review (Chartered Institute of Housing, 2009) found Local Authority tenants had less than a third of the gross income of home owners with mortgaged properties and significantly less disposable income. The main source of income for 92% of homeowners with mortgaged properties was wages and salary, or they were self-employed. Only 4% of this group relied on social security benefits compared to 45% of those in Local Authority homes.

Perhaps not surprisingly, given the housing arrangements of the sample, just over a third reported problems with their home. Tenants were more than twice as likely as homeowners to report such a problem.

Problems concerning accommodation broadly fell within four themes: dissatisfaction with its material condition; unsuitable; anti-social behaviour in the neighbourhood; and finally, because of money worries some respondents were concerned about the upkeep of their home. Responses that fall broadly within these themes are now explored.

Those voicing concerns about the condition of their accommodation reported, for example, that the: "walls run with water, woodworm in bathroom", another respondent complained about "the condition, as a lot of maintenance is needed. The ceiling needs re-plastering from leaks upstairs etc."

Others felt their home was no longer suitable as it did not meet their needs or the needs of a household member. Some respondents struggled with steep stairs or needed adaptations to the home. Those with children described a lack of space for children to play or reported that the property had steep stairs. For example, one person explained their home was “unsuitable for needs due to chronic illness, waiting to be re-housed”, whilst another said “top flat, nowhere safe for children to play”, and a respondent living with her adult son explained that her accommodation was “not suitable - bathroom is upstairs and no bedroom of my own, there is a toilet downstairs.”

Antisocial behaviour and neighbourhood problems were reported by some. This respondent disliked “the area, neighbours, everything really. Neighbours are violent and threaten us, we want out”, and another explained problems with the “family over the road, the police have been many times, the children all drink - beer cans, the neighbours complained to Council also.”

Because of money worries some respondents were concerned that they could lose their home whilst others worried about the cost of maintenance, for example one was “threatened with eviction”, and another explained how she feared “losing it because of rent arrears, especially because children have lost so much since marriage breakdown”.

Concerns about accommodation affected approximately one third of the sample, and it can be seen that responses point to deprivation, although this is difficult to determine for a number of reasons.

The Welsh Index of Multiple Deprivation 2008 (WIMD) (Welsh Assembly Government, 2008) housing deprivation domain includes households lacking central heating and household overcrowding, excluding student households. While the reported problems were significant for the respondents concerned, no one explicitly reported a lack of central heating although one respondent said their heating boiler had broken and another complained that their home needed updating and heating.

Although no one overtly reported household overcrowding there are signs that some may have experienced this; for example, a woman living with her adult son complained that she did not have her own bedroom.

In relation to the condition of respondents' homes, there were indications of conditions that might constitute accommodation that was 'unfit for human habitation'. The technical and legal term 'unfitness' relates to the physical fabric of a property and its condition. The condition of a property is judged against eleven criteria. If the property does not meet the required standard on any one of these 11 items it is classified as unfit for human habitation. The two most common reasons (items) for 'unfitness' are usually disrepair and dampness (National Assembly for Wales, 2005).

Respondents in this survey who reported damp conditions made comments such as "dark, damp and dreary", while another complained the home was "damp around the windows." With regard to 'disrepair', comments included: "house needs urgent repairs", "bad electrics"; and, "flat has rotten windows, can't be opened". However, it is not possible to assess the severity of the housing conditions and it is not known whether a professional surveyor would classify them as unfit. Nevertheless, from respondents' descriptions it is clear that many were distressed and unhappy with their accommodation, and this should not be dismissed.

### **Personal Status of the Sample**

Respondents were able to select multiple responses to describe their personal status. Nearly a third said they were incapable of work, nearly a fifth was unemployed and 17.6% were off sick. Overall, a small proportion of the sample was employed, 15.5% was in full-time employment and 7.7% worked part-time.

In terms of employment status and economic activity, significant differences were found between the sample and labour market statistics for Wales, available for a comparable time point in November 2007. For example, seasonally adjusted employment figures for Wales then stood at 71.2%, whilst 75.5% of those aged 16-59/64 was economically active. This can be compared with the status of the sample,

which reveals 33 out of 124 respondents aged 16-59/64 undertook paid employment, equating to 26.6%.

Wales has a high level of working age individuals suffering ill health who are economically inactivate and consequently living in poverty (JRF, 2005). Based on the number of respondents who were in employment, we can deduce that a considerable proportion of the sample were at risk of poverty because of economic inactivity.

### **Main Source of Income**

It is not surprising, due to levels of economic inactivity already discussed that 60% of working age respondents (aged 16-59/64) said their main source of income was Social Security benefits or tax credits. A wage or salary was the main source of income for just 31% of the sample.

Interestingly, a much greater percentage of women relied on a wage or salary as their main source of income compared to men - 41% compared to 15%. As equal proportions of men and women worked full time, this disparity could perhaps be indicative of more women benefiting financially from a partner's income. Related to this finding 68% of males relied on social security benefits and /or tax credits, a much higher percentage than the 55% of females.

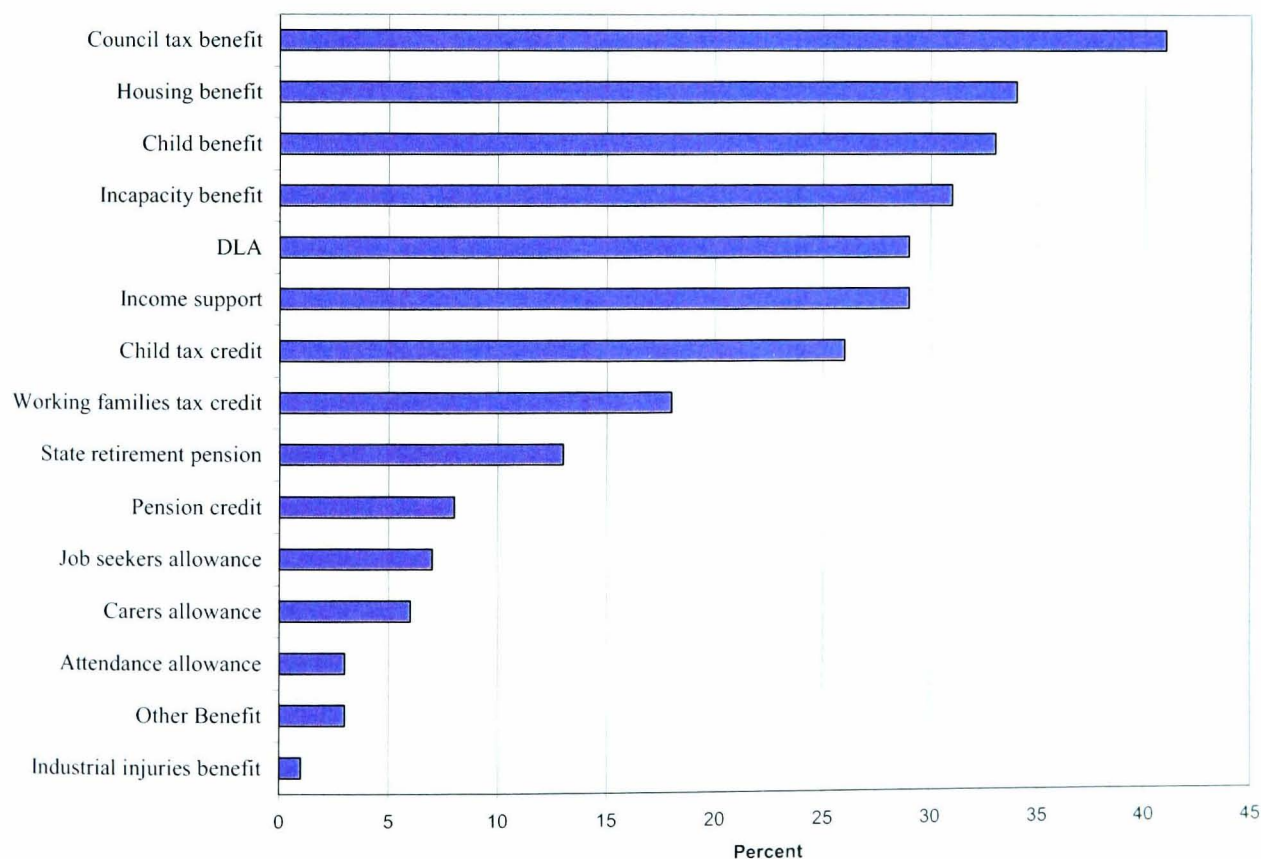
Further exploration of the main source of income reported by respondents with dependent children revealed a little over a third depended on a wage or salary as their main source of income. Just one single parent with dependent children said a wage or salary was their main source of income. One couple and one single parent, both with children, reported having no income. Citizens Advice explained that although rare, in circumstances such as family breakdown or homelessness an individual may have no income for a number of reasons. For example, at the onset of relationship breakdown a partner may withhold money and /or seize financial records, whilst those with no home can find it difficult to obtain and maintain employment and / or welfare benefits due to the transient nature of their life and because they do not have a permanent address.

The circumstances of respondents caring for dependent children reflect a common situation in Wales, where one in four children lives in a low-income family, around half of these being lone parent families (Kenway et al, 2005). In Wales, 60% of low-income working age households do not have anyone in them who is working, resulting in the commonest root cause of poverty - an economically dormant household where no one is working (ibid). Baseline statistics suggest that many children in the sample lived in low-income families, and as a result were in danger of living in poverty.

### Welfare Benefits Received by Respondents

At baseline the sample was in receipt of 337 welfare benefits in total, as illustrated in Figure 3 below.

Figure 3: Welfare Benefits Received by Respondents at Baseline



A noteworthy number of respondents were in receipt of welfare benefits, which are agreed indicators in the income deprivation domain of the WIMD08. These include

adults and children in households in receipt of income support, working families' tax credits, working tax credit, income based job seekers allowance and / or Pension Credit.

Here we can see further evidence of deprivation in one or more of the WIMD08 domains due to the number of respondents in receipt of these benefits and tax credits. For example, 29% of those in receipt of benefits were in receipt of income support, 26% were in receipt of child tax credit, 18% working tax credit, 8% pension credit and 31% were in receipt of incapacity benefit, which forms part of the employment deprivation domain of the WIMD08.

In accordance with the WIMD08 individuals can be classed as deprived in one or more domains; depending on how many types of deprivation they experience. Deprivation is a different concept to poverty. It relates to unmet need caused by inadequate resources and not just financial or material resources (Local Government Data Unit Wales, 2007).

The characteristics of the sample were deemed representative by CAB staff involved in the research, many of whom commented that the baseline findings accurately described their client group. The literature points to parallel characteristics in samples from comparative studies. For example, Abbott and Hobby (1999: 18) reported their sample consisted of a higher percentage of females (58%) and only 8% of the whole of the sample was employed. In their later study just over half of the sample was female, only 12% was in work, and half lived in rented accommodation (Abbott and Hobby, 2002: 15). Similarly Greasley and Small (2005a: 252) reported 61% of the sample was female, despite a relatively broad range of age groups being in the sample, just 6% worked full time.

The characteristics of the baseline sample provide a much needed profile of casework or specialist CAB clients in Wales. Data for users of the service is not available or routinely published. There are a number of reasons for this omission, first inconsistent methods and systems of data collection limit comparisons across the service; second, a significant proportion of bureaux fail to disseminate data to Citizens



Advice Cymru for publication. Third, data specifically relating to ‘casework’ advice is not delineated from general statistics. Finally, these particular statistics are not published for or by individual bureaux, unless they choose to do so through other means. Similarly, research with CABx in England has revealed a “paucity of adequate data to describe the activity” leading to recommendations “that CABx consider the importance of gathering robust data on a routine basis” (Abbott and Hobby, 1999: 14). Based upon experiences during the 3 years of the research it can be concluded that little has changed since Abbott and Hobby’s (1999) recommendation and lessons regarding data collection are yet to be learnt.

### **Advice Issues**

Data concerning the problems for which respondents sought advice was gathered at baseline. Advice issues were categorised according to the system in operation by bureaux. It was also deemed practical to utilise data collection measures already in operation by bureaux to avoid confusion, and so that results could be easily interpreted by an audience already familiar with this approach. Each issue is counted separately, the rationale being that each respondent issue requires individual attention.

Welfare Benefits issues may be categorised in a number of ways. First, advice about new benefit claims; second, advice to those considering an appeal against the loss of existing benefits; and third, advice about an existing benefit. In the latter case, for example, a respondent may believe they are entitled to more income, or they may have a query about an existing benefit.

In the case of Debt advice, respondents seeking advice with debt re-scheduling issues typically required help negotiating with creditors in order to manage their debts, whilst respondents’ seeking help with a debt challenge include those challenging all or part of the debt.

Quite often those seeking Welfare Benefits and/or debt advice are routinely offered income advice. This may involve a screening process to ascertain if a person is

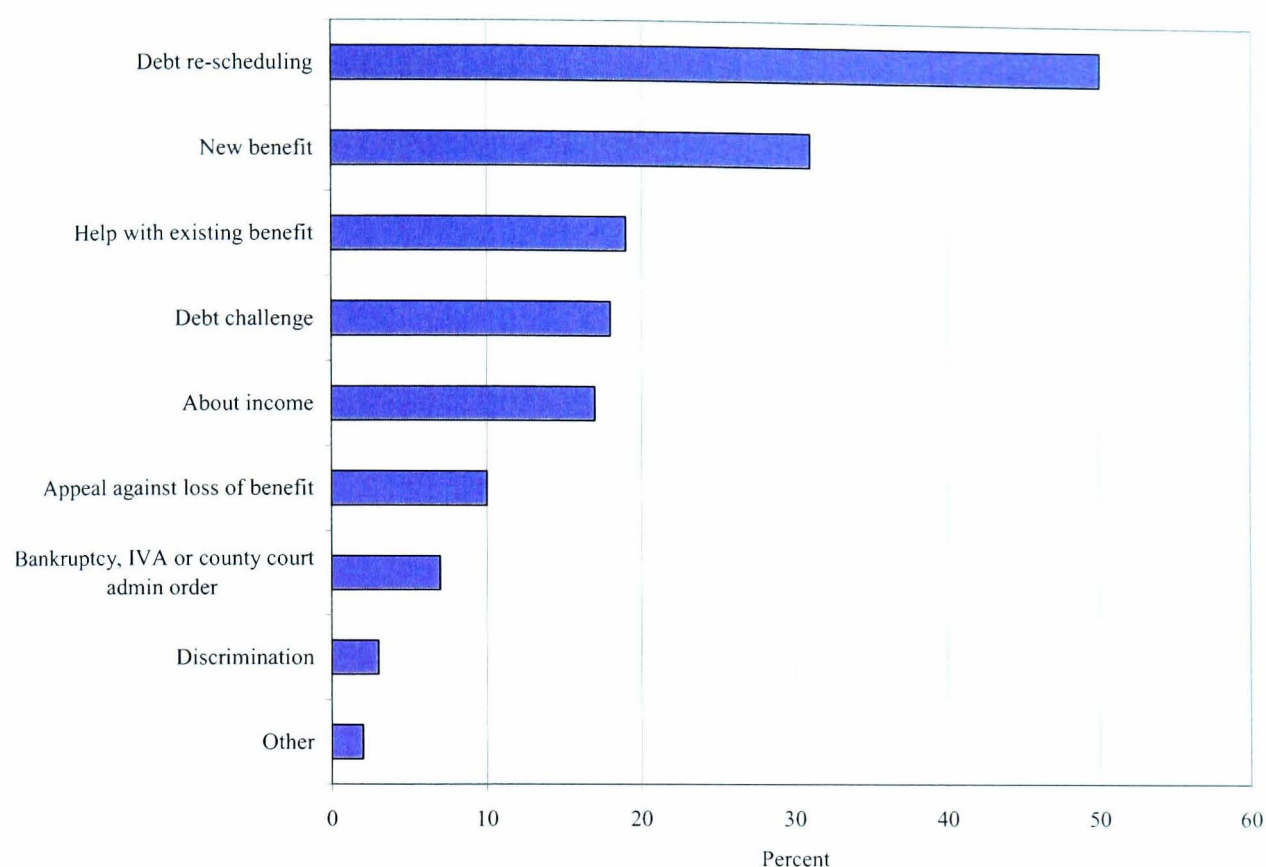
entitled to certain benefits or tax credits, and to offer advice about managing income in general.

As discussed earlier, there is no universally agreed definition to describe problem debt, nor is there an established definition of what constitutes debt advice. Some debate surrounds the level of input and the degree to which a debt problem is investigated and analysed (Pleasance et al, 2007). However, for the purposes of this study respondents receiving ‘casework’ advice were included in the sample. To recap, in such cases a bureau generally takes on responsibility for the conduct of a case and the adviser takes action on behalf of the respondent. This may include negotiation and representation on the respondent’s behalf to third parties. Citizens Advice defines problem debt as when an individual is “unable to pay their current credit repayments and other commitments without reducing other expenditure below normal minimal levels” (Edwards, 2003). For simplicity the definition of problem debt provided by Edwards in research for Citizens Advice is adopted here.

A small number of respondents sought advice for discrimination issues, which included employment and disability discrimination.

Figure 4 below, illustrates the proportion of the sample that sought advice for each issue.

Figure 4: Issues for which Respondents sought advice at Baseline



Overall, respondents sought the advice of a CAB for a total of 221 issues ranging from one to 6 per respondent. At baseline 83 respondents sought help with a total of 105 debt issues and 70 people sought help with a total of 85 welfare benefits issues. Discrimination accounted for four issues and income advice 24 issues. Three ‘other problems’ included housing problems, an employment grievance and a mortgage re-possession, which respondents presented alongside debt, welfare benefits or discrimination problems.

The proportion of respondents seeking debt advice may be due, in part, to 3.15 million pounds Financial Inclusion Funding acquired by Citizens Advice in 2006/07 to increase face-to-face debt advice, doubtless reflected in the debt advice statistics in this study. However, in the same year £923,000 was acquired in joint funding from the DTI and Disability Rights Commission for discrimination advice but only four discrimination issues were included in the study.

With regard to discrimination advice, advisors specialising in this area were principally located in Newport. Although Newport CAB offered outreach support to

bureaux in Wales dealing with discrimination cases, it was generally acknowledged that this was a small but increasing area of advice. Due to the subtle nature of discrimination, less experienced advisors may overlook signs presented in, for example, an employment grievance. It is known from the literature that individuals tend not to define their experiences as discrimination within the context of the law (Williams et al, 2003).

Further funding to increase discrimination advice was being sought by Citizens Advice and partnerships with discrimination agencies were being developed, which perhaps created the imperative for it to be included in the focus issues in the study. Consequently, there were a number of reasons for the inclusion of discrimination advice in the study, and an obvious lack of respondents seeking such advice.

Interestingly, in 2003 a study of discrimination advice in Wales highlighted weak infrastructure, support and representation. Poor systems of referral and coordination existed between agencies, including transfer of cases between expert agencies (Williams et al, 2003). Although additional funding was available for discrimination advice at the time of the baseline study, it appears that little progress has been made since the aforementioned research concluded that there is considerable unmet need and ‘vast advice deserts’ exist in terms of discrimination advice in Wales (ibid).

It may be for these reasons that few respondents with discrimination issues were included in the sample. This outcome was not altogether unexpected. Had it not been for Citizens Advice interests, more specifically requests to incorporate those seeking in discrimination advice this issue may not have been included in categories of advice to be examined in the study.

### **Characteristics of those seeking debt and welfare benefits advice**

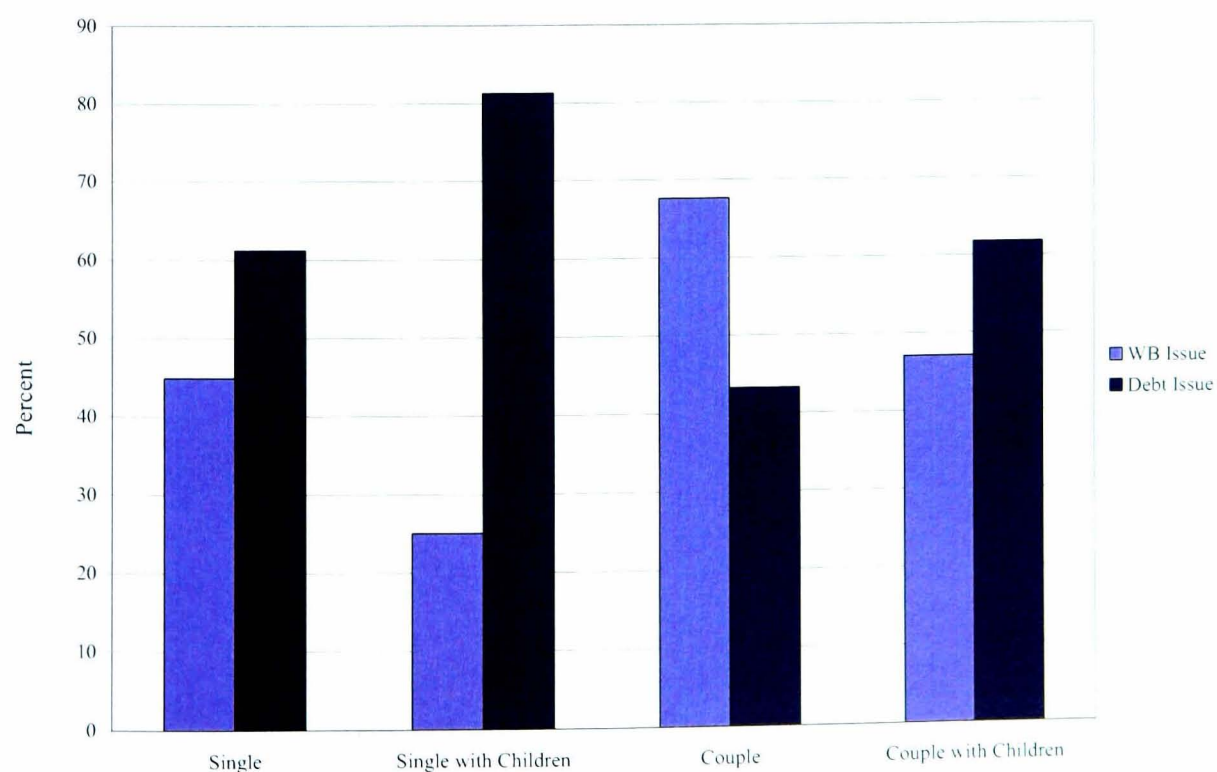
Further exploration was undertaken of the two key advice issues included in the study – debt advice and welfare benefits advice, to see if differences exist between groups of respondents who sought advice for these issues.

It can be seen from Figure 5 below that a much higher percentage of single Respondents with child care responsibilities sought debt advice than any other group. They were all female. Other research has found that debt affects lone parents disproportionately, for the reasons that lone parents are more likely to live on a low income (Bridges and Disney, 2004: 22). However, alternative explanations have been provided by others. Relationship breakdown is known to be a factor in debt cases. Due to loss of income or the failure of a partner to make support payments a situation can occur where bills accumulate and it even becomes difficult buy food. As a consequence people become susceptible to debt (Phipps and Hopwood Road, 2006: 4).

It can be noted from Figure 5 that similar proportions of couples with children sought debt advice as single people without children. The link between households with children and debt is well known; however, in recent years a new category of individuals experiencing debt has emerged – the single person without children (ibid).

With regard to welfare benefits advice, a much higher percentage of couples (without children) sought advice for welfare benefits issues.

Figure 5: Household Composition and Advice Issue



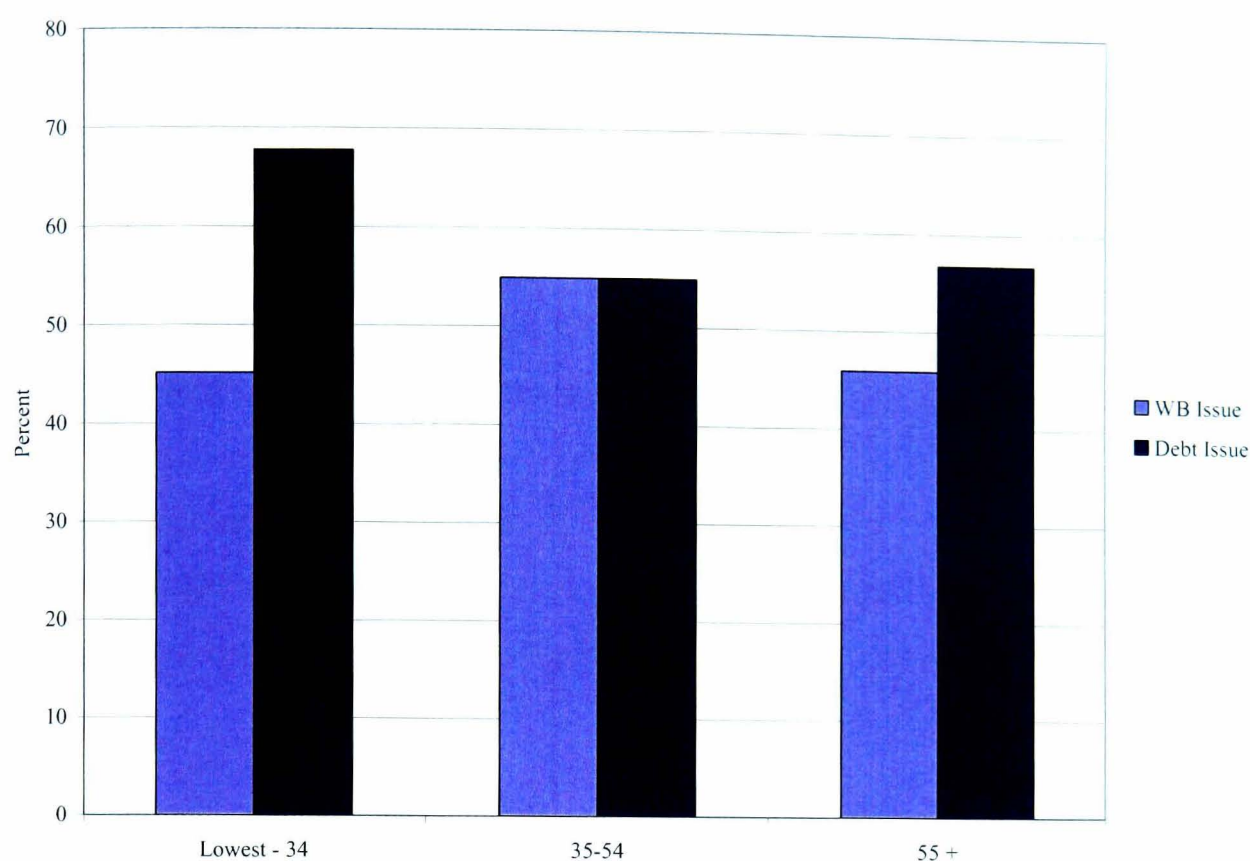
Differences were also found in the advice sought by males and females. A much higher percentage of females sought debt advice than males, 65% compared to 48%.

Overall, 66% of respondents with dependent children sought advice for debt. There are clearly implications for children living in these households. The incidence of debt reported by women is no doubt related to the proportion of the sample with dependent children who were seeking debt advice.

Gendered differences were also found in the proportion of men and women seeking advice for welfare benefits issues - 62% of males sought welfare benefits advice compared to 43% of females. In this instance chi square tests with one degree of freedom were statistically significant ( $\chi^2 = 3.938, P < .05$ ). In keeping with this outcome, 40% of respondents with dependent children sought welfare benefits advice, a much smaller proportion than had sought debt advice.

It can be seen in Figure 6 that a greater proportion of respondents were aged up to 34 years of age. Research has shown that those under 35 years are susceptible to debt, perhaps because of their lower incomes (Phipps and Hopwood Road, 2007: 4). It is particularly striking that such a large proportion of those aged 55 plus sought debt advice.

Figure 6: Age group of Respondents, Debt and Welfare Benefit Issues



In summary, the majority of the sample sought debt and / or welfare benefits advice, with just four discrimination issues reported. Respondents also sought income advice and advice for a small number of other problems. Key differences were found between the characteristics of individuals seeking debt and welfare benefits advice, although not all were statistically significant.

These advice issues will now be explored further. A detailed account follows of the type of debts for which respondents sought advice, plus a summary of individual welfare benefit claims and appeals against the loss of benefits. Further information concerning the four discrimination issues in the study will be provided.

### **Breakdown of Debt Advice Issues**

Respondents reported £907,113 of personal debt problems. The mean was £9,754 per person although debts ranged from £80.00 to £40,000. Seventy two percent reporting personal debt problems had been in arrears with commitments for 12 months or less.

and the mode was 12 months. It was apparent that some respondents lacked knowledge of the duration and true extent of their arrears.

Figure 7 below, provides a breakdown of 214 debt problems reported by 79 respondents at baseline, 71% (n=56) of whom had multiple debts. The number of debts reported by respondents ranged from one to eight per person. These figures do not include multiple debts within each debt category. For example, a respondent could be in debt with multiple credit cards but this is not illustrated.

Equal proportions of the sample sought advice for credit card debts and utility debts, which were also the most frequently reported debt problems. In third place, Council Tax debt advice was sought by approximately a third of those seeking advice for debt problems.

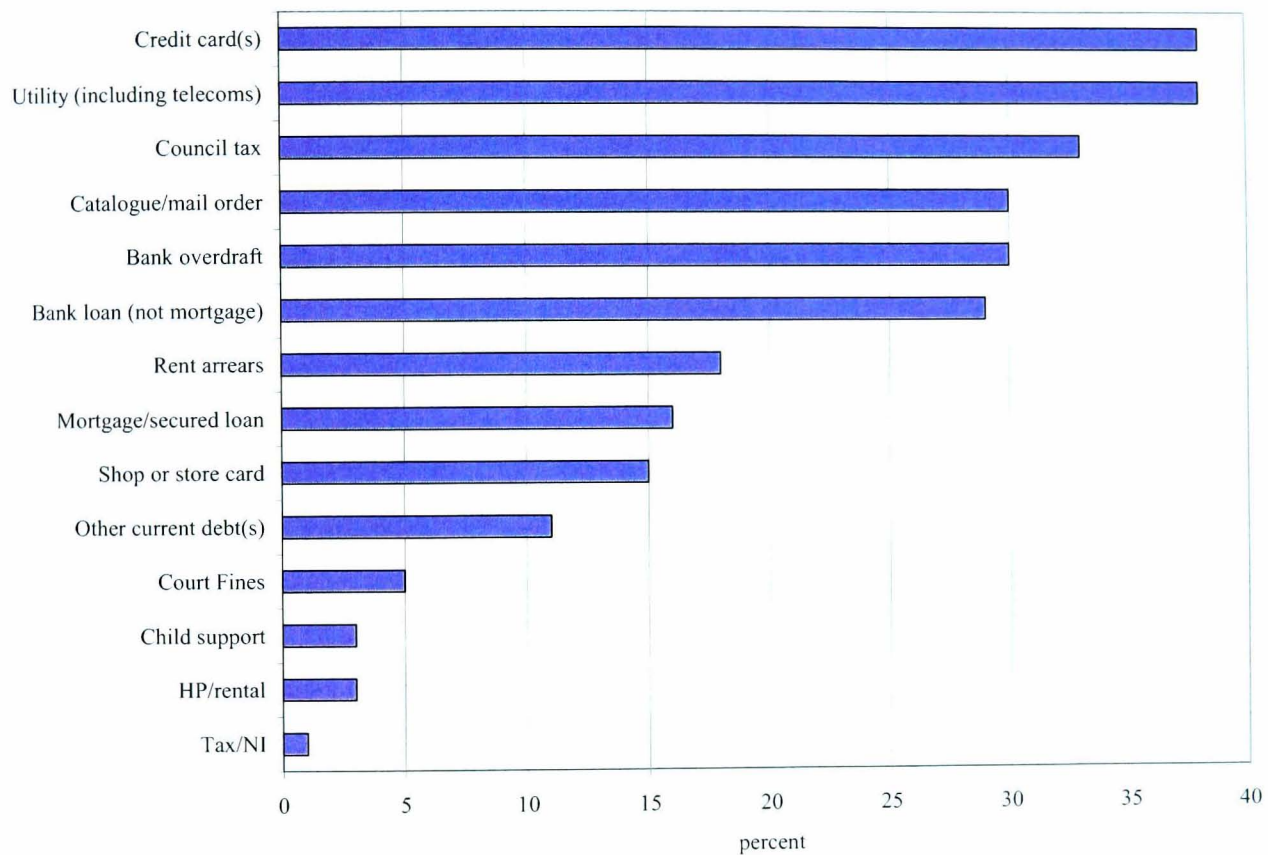
Some interesting comparisons can be seen with the literature. Trends across the UK over a five year period to 2002, show new consumer debt enquiries, such as credit cards and loans to CAB rose by 47%, whilst utility debt shrank by 3% (Edwards, 2003: 7). Analysis of national survey data gathered between the years 1979 and 2005 has also revealed a significant shift in the type of credit used over time. Credit tied to specific purchases, which is most commonly associated with mail order and hire purchase has declined in favour of credit cards and personal loans (Finney et al, 2007).

It is not possible to determine the causes of the shift observable in the baseline findings towards higher utility debt, although measures by utility companies to address non-payment have arguably become more demanding, whilst CAB debt advice is more widely available and publicised as a source of help for those struggling with utility payments. It is also possible that utility companies have followed recommendations provided by the Griffiths Commission on Personal Debt (and local councils) to “develop more sophisticated debt management systems which prioritise debt management and prevention and result in less customers falling into arrears and higher debt collection” (2005: 109). This may account for the rise in utility debt advice.



With reference to the third most frequent debt advice issues, Council tax debt is known to be widespread in the UK. Approximately one in seven households receive a summons for non-payment of Council tax each year but the problem is most prevalent in low income households (Orton, 2006). As such Orton (2004) argues it is a particularly illuminating form of debt to study.

Figure 7: Debt Issues at Baseline



It is of particular concern that a significant proportion of the sample had priority debts. Citizens Advice defines a debt as a priority debt if:

“non-payment would give the creditor the right to deprive the respondent of her/his home, liberty, or essential goods and services. Examples of priority debts include mortgages/secured loans, rent, council tax and community charge, gas, electric (but not water, although current payments are invariably treated as essential expenditure), child support and maintenance, fines, and hire purchase goods or telephones but only where these are essential” (Correspondence to the Steering Committee, n.d.).

This definition requires expert interpretation as no definition is provided regarding what constitutes ‘essential expenditure’.

Edwards (2003: 1) offers another explanation, explaining priority debt as being those commitments “where the ultimate sanction for non-payment is imprisonment, loss of home, disconnection of fuel supply or repossession of essential goods on hire purchase.” Non-priority debts usual include non-secured consumer credit debts, although money owed to family, friends and also the social fund is included in this category. Creditors in these cases will usually sue for non-payment through the court system.

Respondents to the baseline study reported a range of debts considered to be priority debts, the most frequent was utilities (38%) followed by council tax (33%). Other priority debts included mortgages/secured loans, fines and child support debts. The consequences of failing to deal with such debts are serious.

Some respondents seeking advice for debt problems did not disclose the full details of their debts at baseline, whilst others disclosed debt problems, such as arrears with payments, but did not indicate that they were seeking debt advice, although it emerged later that some of these respondents did receive debt advice. One hypothesis for this situation is that they approached CAB on the pretext of a less stigmatised problem. Advisors are particularly skilled at identifying the signs of debt and this could be one other reason why advice was provided on payment arrears, although the respondent did not initially seek advice on such matters.

One can conclude from the findings that many respondents had serious debt problems, and a considerable number had multiple debts. However, due to the level of response to debt questions, these findings provide an insight into respondents’ debt problems rather than an accurate depiction. The true number of debt problems, had all data been available, would be considerably higher. Interestingly though, the challenges of gathering data bring to light the challenges facing debt advisors, and the time and skills required for the job. The findings also highlight some of the difficulties facing researchers in this field.

## **Breakdown of Welfare Benefits Advice Issues**

Advice for welfare benefits was sought by 44 respondents to the study in relation to a total of 14 different welfare benefits. In total 73 applications/appeals against the loss of welfare benefits were reported by the 44 respondents. However, full details were not forthcoming from all respondents seeking advice for welfare benefits issues at baseline. At this early stage in the advice process respondents may not understand the benefits that they are entitled to claim.

Disability Living Allowance (DLA) accounted for the largest number of welfare benefits cases (48%). The workload involved in dealing with such cases is considerable, particularly if the matter is taken to appeal. This was followed in frequency by council tax, incapacity benefit, housing benefit, pension credit, with a small number of respondents seeking advice for a range of other benefits.

Over a third of the group of 44 respondents who provided details of their welfare benefit issues sought advice or assistance with multiple welfare benefits, as illustrated in Table 2 below. Naturally each welfare benefits case requires individual attention and involves varying levels of input from advisors in terms of work hours.

Table 2: Number of Welfare Benefits Issues per Respondent

<i>No. WB Issues</i>	<i>No. Respondents</i>	<i>%</i>
1.00	29	66
2.00	6	14
3.00	5	11
4.00	3	7
5.00	1	2

## **Discrimination Advice Issues**

Three respondents sought advice for a total of 4 discrimination issues. All three sought advice for employment discrimination, whilst one also sought advice for disability discrimination. As discussed earlier in this chapter, discrimination is a small area of CAB advice.

All 3 respondents seeking discrimination advice were female; they also sought advice for other problems. One required income advice; another sought help with a new benefit claim, plus employment discrimination advice and income advice. The third respondent came to CAB for advice with five issues, which included: employment discrimination, help with new welfare benefit claim/appeal against the loss of welfare benefit, bankruptcy/IVA and county court issues, debt re-scheduling and debt challenge issues. Further checks revealed this respondent sought welfare benefits advice for four benefits, namely: council tax, incapacity benefit, housing benefit and industrial injuries benefit. Details of the individual debts for which the respondent sought advice were not disclosed, however, she had been in arrears for four months with debts amounting to £25,000.

In conclusion, these findings illustrate the complexity of cases, it can be seen that a considerable proportion of the sample sought help with multiple and complex problems. Other studies have shown that certain types of problems are likely to occur in combination (Pleasence et al, 2004). In cases of this kind considerable time and resources are required to gather together details of a respondent's personal situation in order to unravel their problems. The administrative workload following some advice sessions is likely to be considerable and it is to be expected that a respondent with multiple and complex problems will require more than one interview and ongoing assistance from their caseworker for some time after their initial interview. It was beyond the scope of the research to gather data on the workload generated by cases; however, research suggests that a typical welfare benefits issue can take approximately 6 hours and 40 minutes of case worker time, whilst a typical multiple debt case can take 16 hours and 20 minutes (Caiels and Thurston, 2005: 29).

Aspects of advice concerned with building customer relationships are often overlooked in the literature. It takes time and commitment to reassure respondents and draw out the details of their problems in a trusting environment. This is particularly challenging for advisors as the experience of seeking advice can be stressful for respondents. Edwards (2003: 48) described how many people seeking debt advice feel ashamed and embarrassed. They worry that they will be judged and blame themselves for not being able to manage their finances effectively. Perhaps

such anxieties were a contributory factor to why it was not possible to collect more complete data on respondent issues in the baseline study.

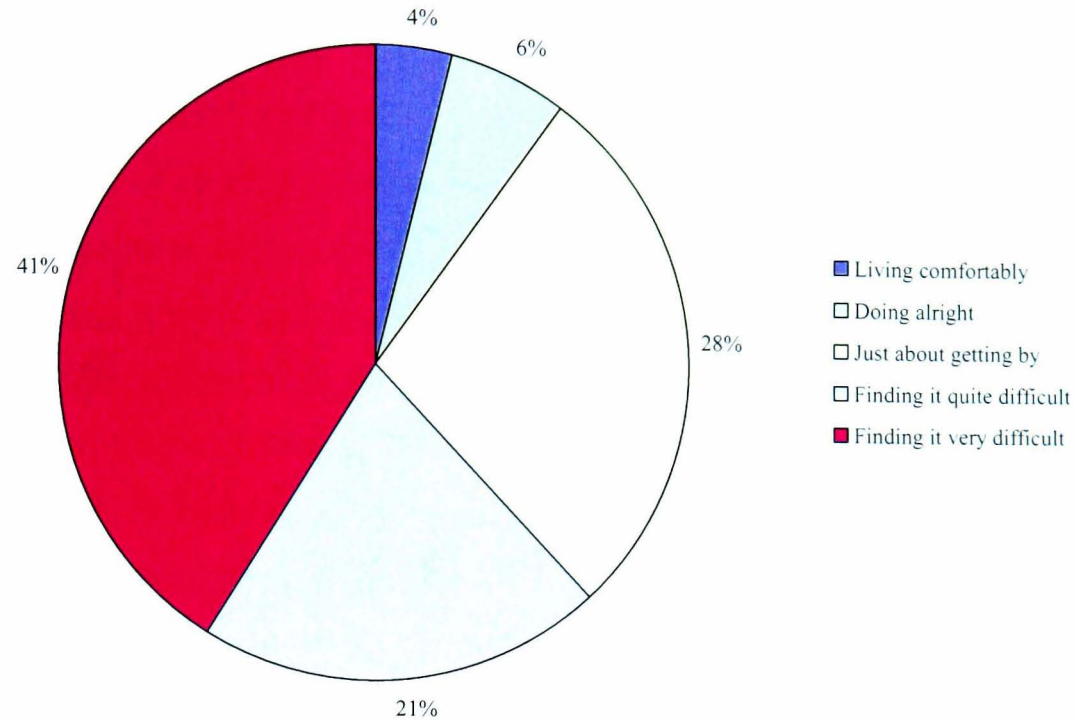
Although it was not possible to gather precise baseline data that would accurately quantify respondent issues, the outcomes of the baseline study provided insights into respondents' circumstances and the environment in which advisors work. This aspect of the study highlights the importance of funding which accurately takes account of the time advisors need to help respondents.

### **Signs of Financial Difficulty and Child Poverty**

One aim of the baseline study was to learn about the financial circumstances of the sample and to gain an insight into the prevalence and extent of financial difficulties and early signs of difficulty respondents may have experienced.

At baseline, respondents were asked 'How well would you say you are managing financially these days?' Response options included: living comfortably; doing alright; just about getting by; finding it quite difficult; or, finding it very difficult. It can be seen from Figure 8 that just 10% of the sample said they were 'living comfortably' or 'doing all right'. The remaining 90% were struggling to some degree. Focusing on those with dependent children, it was found that only three couples were 'doing alright', the remainder were 'just about getting by', 'finding it quite difficult', or 'finding it very difficult.' The group of single parents in the sample consisted entirely of women; they all reported struggling financially.

Figure 8: Respondents' view of their Financial Situation



### **Borrowing from un-regulated Sources**

It is well known that those on low incomes often do not have access to mainstream borrowing from sources such as banks or building societies. These groups are often excluded in a number of other ways, and are particularly at risk from social exclusion which is reinforced by financial exclusion (Kempson et al, 2000).

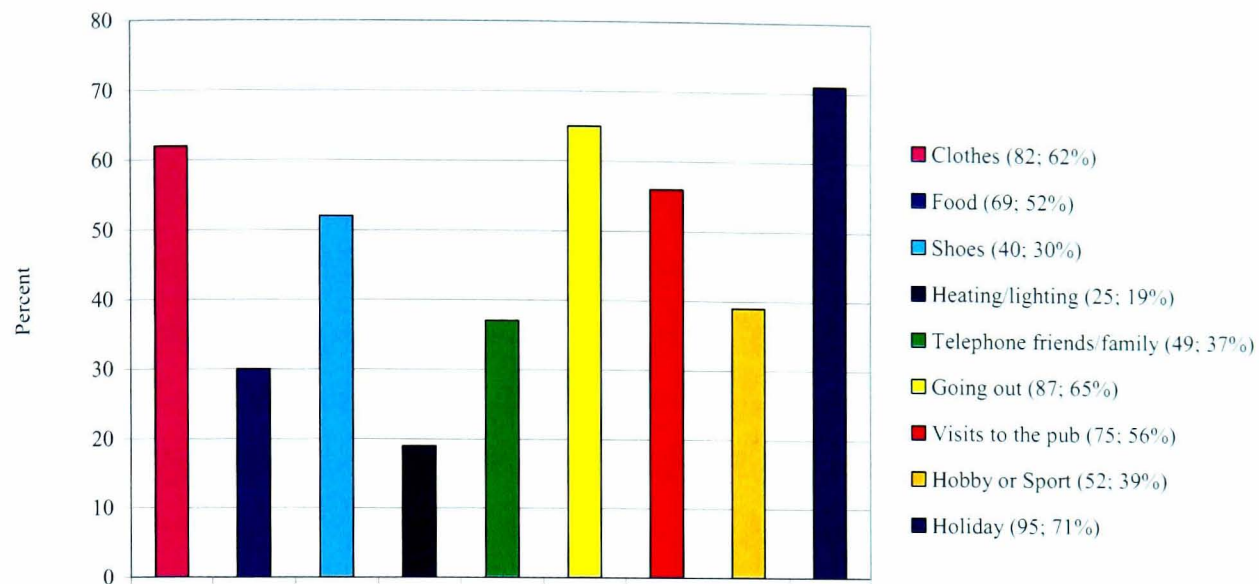
Findings from the baseline study show that in order to pay for day-to-day needs 60% of the sample had borrowed money in the previous year from family, followed in frequency by 26% who borrowed money from friends, and 15 % who borrowed from doorstep money lenders, whilst three had borrowed from a pawnbroker. Overall, a much greater proportion of tenants borrowed from these sources than home owners - 80% compared to 49% of home owners. Research concerned with the use of credit among low income families in the UK has highlighted discrepancies in the types of credit utilised by home owners and tenants. Low income homeowners generally use credit arrangements comparable with the rest of the population, for example, credit cards, bank overdrafts and loans. On the other hand tenants turn to family and friends and finance companies for loans (Bridges and Disney, 2004: 22).

Those on low incomes denied access to mainstream banking products may turn to alternative sources of borrowing, with high interest rates and tough repayment conditions (Jones, 2001). Many simply do not understand the cost of borrowing or become so desperate that they choose to overlook the cost (Jones and Barnes, 2005). Further compounding these financial difficulties, they are not able to make payments for bills via direct debit, nor are they able to put money aside in a savings account for emergency purchases or access low cost loans when needed. (Financial Inclusion Task Force BMRB, 2006). Research suggests that those excluded from mainstream financial services have to borrow at APRs at between 100 and 400 percent (Collard and Kempson, 2005) Consequently, their exclusion from mainstream financial services reinforces other forms of exclusion.

### **Signs of Individual Material and Social Deprivation at Baseline**

Respondents to the baseline study were asked if they had personally gone without a range of items and /or activities in the previous year because of a shortage of money, as set out in Figure 9. Overall, 121 individuals went without a total of 574 items and /or activities ranging from one to nine per person, whilst over half of the group went without five or more items and / or activities. Findings suggest a considerable proportion of the sample experienced material and social deprivation because of financial hardship.

Figure 9: Items Respondents' went without in the past year because of a shortage of money



Further exploration was undertaken of groups of individuals who went without items listed above. Couples (without children or with non-dependent children) were generally the least deprived group. Whilst single respondents with dependent children (referred to as lone parents) generally went without items or activities more than any other group, with a few exceptions. Life cycle needs and wants of particular groups were reflected in perceptions of un-met need. For example, a greater proportion of single respondents said they cut back on 'going out', whilst approximately equal proportions of single respondents and couples with children cut back on 'visits to the pub'.

A greater proportion of women compared to men curtailed spending on items or activities, with the exception of 'visiting the pub' and pursuing a 'hobby or sport'. It is possible that these women had less desire to visit the pub and pursue a hobby or sport than men; which could explain why they did not feel they had curtailed spending on such activities.

Research by Pahl (2000) shows spending patterns are highly gendered. Related to this it has been found that economic resources are not allocated equally within families; gendered patterns of economic resource allocation are known to exist (Goode et al. 1998). Even benefit claims have been found to reflect traditional gender roles in some



households. A good example of this is where the named claimant for key subsistence benefits is the male (Snape et al, 1998).

Patterns of money management have been found to reflect norms and values (Pahl, 1989). Research shows that money is pooled and managed jointly in just one fifth of households; in this group men and women experience the greatest equality in the sharing of economic resources, for the remaining four fifths of households the situation remains disparate (1995). Conversely, individualised approaches to money can be seen most frequently among and affluent younger couples (Pahl, 2005). Related to this feature is spending and saving patterns, and patterns in the use of credit cards which highlight further disparities between men and women (Pahl, 1999; Pahl and Opit 2000). Those without access to such sources are at risk of financial exclusion (Pahl, 1999). Women have been found to be particularly disadvantaged because of limited control and access to resources (Vogler and Pahl, 1994). It is known that these inequalities can impact on financial management as well as creating inequalities within households (Millar and Ridge, 2001: 80). Gendered inequalities in economic resource allocation may also partly explain why a greater proportion of women sought advice for debt problems compared to men.

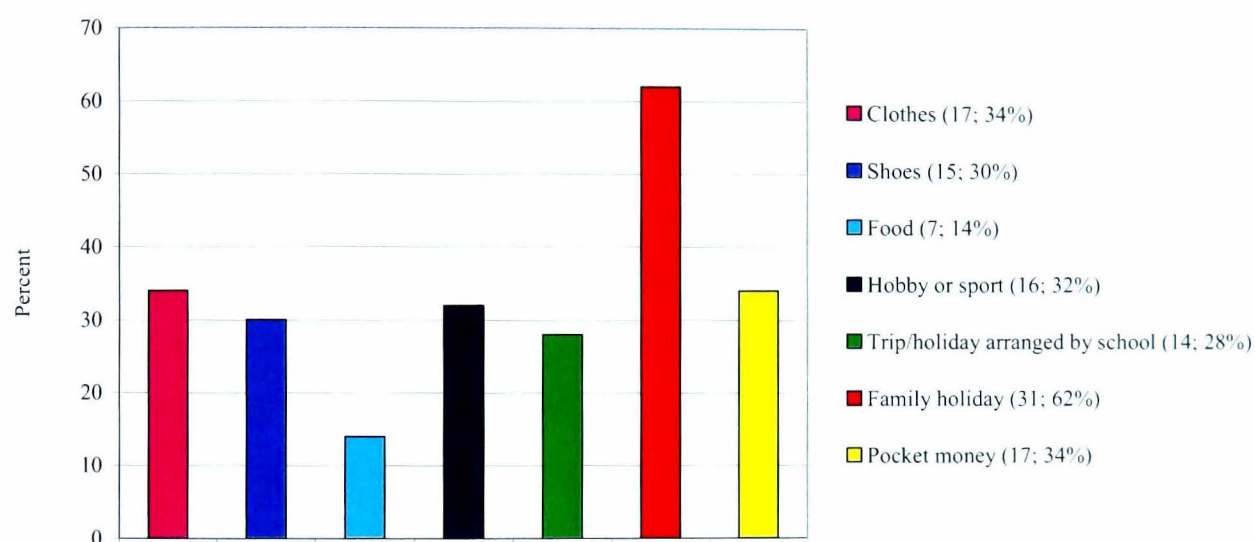
Perhaps also unsurprisingly, a much higher percentage of lone parents went without items such as clothes, shoes, food, telephoning friends or family, a hobby or sport and a holiday. This conflicts with one study noted in the literature, where a quarter of lone mothers were reported to feel better off because they had greater control over their finances (Bradshaw and Millar, 1991). Based upon the baseline findings from this study it can be seen that lone parents failed to intercede material or social deprivation.

### **Signs of Child Poverty**

Respondents with dependent children were asked a related question about constraints to spending on their child or children. They were asked if, due to a shortage of money in the previous year, their child or children had gone without items or activities such as: clothes; shoes; food; a hobby or sport; a trip or holiday arranged by the school; a

family holiday; and, pocket money. Forty-one parents out of 50 with dependent children (82%) had, on occasions, curtailed spending on these items during the previous year because they could not afford them for their child, as illustrated in Figure 10. This group of 41 parents had curtailed spending on 117 items/activities in total; 80% said their child had gone without more than one item, over half had gone without 3 or more items, whilst the worst scenario is that of two parents who reported that their child had gone without seven items on occasions in the previous year due to a shortage of money.

Figure 10: Items Child went without on occasions in the last year due to a shortage of money



Some variation was found in some responses from lone parents and couples with dependent children. Children of lone parents were approximately twice as likely as those of couples to have gone without a hobby or sport. For example, 50% of lone parents said their child had gone without a hobby or sport in the past year compared to 24% of couples. On the other hand a much greater proportion of couples said their child went without a school trip or holiday – 32% compared to 19% of lone parents. Interestingly though, a greater proportion of children from lone families went without a family holiday – 68% compared to 58% living with couples. So it is possible that some lone parents compensated for missing family holidays by sending their child on school trips or holidays, whilst some couples prioritised spending on a family holiday as opposed to trips or holidays arranged by the school. Children from lone parent

households were also much more likely to go without pocket money. Overall they fared worse than children living with couples.

### **Comparing Parent and Child Deprivation**

The deprivation experienced by children in the sample does not fully convey the deprivation experienced at household level. In the group of parents with dependent children there was evidence that parents went without more often than their children. It is already known from other research that resources are not always distributed equally between family members (Gordon et al, 2000: 32). In low income families women endeavoured to protect their partner and children from the deprivation they experienced themselves. Studies have also shown that some parents make personal sacrifices to protect their children from necessities deprivation by making their child's needs a priority (Magadi and Middleton, 2007: 11; Gordon et al, 2000: 35). Baseline evidence supports the findings of researchers in this field. Respondents were separately asked if they had personally gone without a list of comparable items to their children, as outlined earlier. Noteworthy differences were found in the items parents went without compared with the items that their dependent children went without, for example:

- 78% of parents reported there were times in the past year when they went without purchases of clothing for themselves compared with only 34% who, on occasion, had curtailed purchases of clothing for their child because of shortages of money.
- With regard to purchases of shoes, 60% of parents went without compared with 30% of children.
- It was reported that 30% of parents cut back on food purchases compared with 14% of children.
- Parents had been deprived of opportunities to participate in sports or a hobby in 48% of cases compared with 32% of children.

- It was found that 78% of parents had gone without a family holiday in the previous year compared with 62% of children.
- It was reported that 18% of children ‘never go without’ compared with 4% of parents.

The social consequences for children of living in poverty are immense. Failing to keep up with fashion trends can lead to verbal abuse and bullying (Crowley and Vulliamy, 2007: 11-17). Consequently, parents and children are often under great pressure to keep up appearances. Despite this, children worry about family finances and often hide their needs so as not to distress their parents; as a result this impacts on their emotional wellbeing (Hooper et al, 2007: 61).

It is important to note that the circumstances of those reporting their child ‘never goes without’ did not differ greatly to those whose child ‘did go without’. In other words, there were no great differences between these groups. Of the nine respondents who reported that their child ‘never goes without’, four had borrowed money from family in the past year; one had also borrowed from a doorstep moneylender. Seven out of nine of these respondents had personally gone without an item or activity listed, ranging from one to seven items each, because of shortages of money on occasions in the previous year. It should also be noted that five out of nine of these respondents came to CAB for advice with debt problems. Out of the nine respondents who said their child or children ‘never go without’ only one showed no obvious signs of financial difficulty; the remaining eight clearly had financial problems, most of which were serious. There are signs that they had borrowed from one source to pay another and juggled financial commitments, thereby falling in and out of debt with different financial commitments.

It is possible that the stigma of poverty is so great that this group of respondents chose to conceal their difficulties, perhaps to ‘keep up appearances’; they appear to have provided necessities for their children which were beyond their means. A situation of this kind provides insight into hidden poverty; parents appear to have made personal

sacrifices and prioritised their child's needs, whilst for some families this would undoubtedly contribute to their debt. This situation is a familiar one: in a report aptly named 'Robbing Peter to Pay Paul' (Save the Children, 2007) the ongoing cycle of debt experienced by low-income families, and the problem of inadequate access to affordable credit, is highlighted.

Research from elsewhere has also shown that families experience poverty in different ways. Findings from the Family Resources Survey (Jenkins and Rigg, 2001) illustrate, for example, that for the nine years from 1991-99 13% of children were poor once, although these measures were taken at one sampling point. However, this suggests that these children experience what is referred to as temporary poverty where families may be going through a 'bit of a rough patch'. Much higher proportions - nearly a third, experienced recurrent poverty and another 10% were in persistent poverty associated with entrenched material deprivation. Of course, there are many families that fall just beneath the poverty line and the measures used can give a misleading view of poverty (Smith and Middleton, 2007).

Interrelated gaps in policy responses have been identified that are of particular relevance here. Smith (2008) argues that at times when families move on and off benefits, serious time lags occur in the benefit or tax system that put families under considerable strain. Similarly, responses to financial volatility associated with other aspects of family change create what Smith refers to as "flash points" for entering poverty. The US emphasis on personal agency has led to what Alcock (2004) refers to as a focus on policies to get people into work both in the US and the UK. In areas of Wales where work opportunities, especially for women, often lead to low paid, temporary and part time positions, the situation regarding their welfare benefit entitlements can be complex and may well have contributed to some of the difficulties experienced by these households.

## **Health, Social Support and Social Isolation at Baseline**

A key aim of the research was to learn about the impact of advice on the health of individuals. In order to measure changes in health in subsequent waves of the study it was necessary to begin at baseline with an assessment of individual health.

### **Self-reported Ill Health**

Respondents were asked if they had any long-term illness, health problem, or disability which limited their daily activities or the work they could do, including problems resulting from old age. Limiting long-term health is a commonly used measure of health status. When compared with results from the Wales Health Survey of 2005 it was found that respondents suffered from a particularly high level of limiting long-term ill health, that is, in, 41% cases compared to 27% in the Wales Health Survey (2005) and 27% in the Census Report (2001). A little over a third reported a mental illness or nervous problem and 43% reported a physical disability.

In total 187 health conditions were reported by 148 individuals in the sample, as set out in Table 3 below. The most frequent health condition, reported by approximately one third of the sample, was arthritis and / or rheumatism. This was followed in frequency by high blood pressure and asthma.

A further 31 health problems or conditions were reported under the category of 'other health condition'. These included: anaemia, auto immune hepatitis, back problems, bladder problem, episodic ataxia, bronchitis, cellulitis, crohn's disease, circulation problems, COPD, digestive problems, deep vein thrombosis in legs, epilepsy, frozen shoulder, kidney problems, lymphoma, myelofibrosis, polymyositis, placenta accreta, ulcerative colitis, eczema, poor balance, problems due to pregnancy, vertigo, osteoporosis, knee replacement.

In addition several respondents complained of stress, notably this is the only other health condition to be related to mental health.

Table 3: Health Conditions

Health Condition	<i>n</i>	%
Arthritis/rheumatism	50	34
Asthma	29	20
Diabetes	10	7
Heart trouble/angina	12	8
High blood pressure	32	22
Sensory impairment	18	12
Stroke	5	3
Other health condition	31	21

### Short Form 36 (SF-36) Scores at Baseline

The rationale for administering the Short Form 36 (SF-36) and the Hospital Anxiety and Depression Scale (HADS) was to measure changes in health between the administration points of the survey. The baseline scores also verify high levels of morbidity reported by respondents.

Valid SF-36 questionnaires were received from 134 respondents at baseline.<sup>7</sup>

Responses were scored according to the guidelines. Scores for each domain range from 0 to 100; higher scores indicate better health. The mean scores of the sample, set out in Table 4 below, range from 36 to 51; this can be interpreted as indicating poor health.

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<sup>7</sup> A small batch of SF-36 questionnaires was invalidated when a member of the administrative support team omitted to photocopy a page of questions for a bureau that requested more questionnaires.

Table 4: SF-36 Mean scores at Baseline

<i>Health Domain</i>	<i>SF-36 Score</i>
Physical Functioning	50.8
Role Functioning –Physical	36.0
Body Pain	43.6
General Health	40.7
Vitality	33.7
Social Functioning	39.2
Role Functioning – Emotional	37.1
Mental Health	47.2

*Scores 0-100, higher scores indicate better health (n=134)*

### **Hospital Anxiety and Depression Scale at Baseline (HADS)**

The HADS measures domains of *Anxiety* and *Depression*. Valid responses from 147 individuals at baseline were scored according to the guidelines. Scores can range from 0 to 21. Unlike the SF-36, in the HADS lower scores indicate better health. HADS scores at baseline produced a mean anxiety score of 12.18 and a mean depression score of 9.30. Interpretation of scores indicates that on average respondents were moderately anxious and mildly depressed. However, it can be seen from the interpretation set out in Table 5 that 35.4% of Respondents were severely anxious and 13.6% were severely depressed. This is not all together unsurprising as research has shown that a person is more likely to suffer with clinical depression if they have been living for an extended period in economic hardship (Lynch et al, 1997).



Table 5: HADS Interpretation

	<i>HADS Anxiety</i>		<i>HADS Depression</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Normal	27	18.4	53	36.1
Mild	25	17.0	31	21.1
Moderate	43	29.3	43	29.3
Severe	52	35.4	20	13.6

*Scores 0-21 Lower scores indicate better health (n=147)*

### **Social Support at Baseline**

In order to assess levels of social support respondents were presented with seven situations where one might normally expect practical help or emotional support. The situations were taken from the Poverty and Social Exclusion in Britain Survey of 1999 (a large-scale national survey conducted throughout the UK). Situations where practical help might be required include: needing help around the home; needing help with household or garden jobs; needing help with looking after children/elderly or disabled adults; and, needing somebody to look after possessions. The remaining situations relate to emotional support, and include: help if in bed with flu/illness; needing advice; support with relationship problems; and, needing someone to talk to when feeling depressed (Table 6).

The overall aim of asking these questions was to see if respondents showed signs of social exclusion due to poor support systems. As with the national survey, Respondents were not asked for specific instances of support although it is likely that they would draw on experience to answer how supported they would likely to be in each situation.

A range of results for each situation illustrates that many respondents felt they would receive support, while others did not. The worst scenario was for those needing someone to look after their children/elderly or a disabled adult. Here only 35% of respondents would receive 'some' or 'a lot' of support.

Table 6: Situations in which Individuals may need Support

	<i>Some/A lot</i>	<i>None /Not much</i>
1. Help around the home if you are in bed with flu/illness	59%	41%
2. Help with a household or garden job that you cannot manage alone, for example, moving furniture	66%	34%
3. Needing advice about an important change in your life, for example changing jobs, moving to another area	56%	44%
4. Being upset because of problems with your spouse/partner	50%	50%
5. Feeling a bit depressed and wanting someone to talk to	70%	30%
6. Needing someone to look after children/elderly or a disabled adult	35%	65%
7. Needing someone to look after your home/possessions when away	53%	47%

*(Percentages based on valid responses to each question, ranging from 128 to 143 respondents)*

The findings can be interpreted to some extent by drawing on the outcomes of the Poverty and Social Exclusion Survey of 1999 (Gordon et al, 2000: 64). Respondents to the baseline study reported noticeably lower levels of social support than those in the national study. For instance, in the Poverty and Social Exclusion Survey (1999):

- 91% said they would receive 'some' or 'a lot' of help if in bed with flu/illness compared with 59% in the baseline study.
- 87% would receive 'some' or 'a lot' help with heavy household jobs compared with 66% in this study.
- When needing advice, 87% would receive 'a lot' or 'some' support compared with 56% in this study.
- With regard to relationship problems, 77% would receive 'some' or 'a lot' support compared with 50% in this study.

- If needing someone to talk to when feeling depressed, 89% would receive 'some' or 'a lot' support compared with 70% in this study.
- The most significant finding is that 71% would receive 'some' or 'a lot' help with informal caring responsibilities compared with 35% in this study.
- Finally, 89% would receive 'some' or 'a lot' of support when needing someone to look after their positions when away compared with 53% in this study (Gordon et al, 2000: 64).

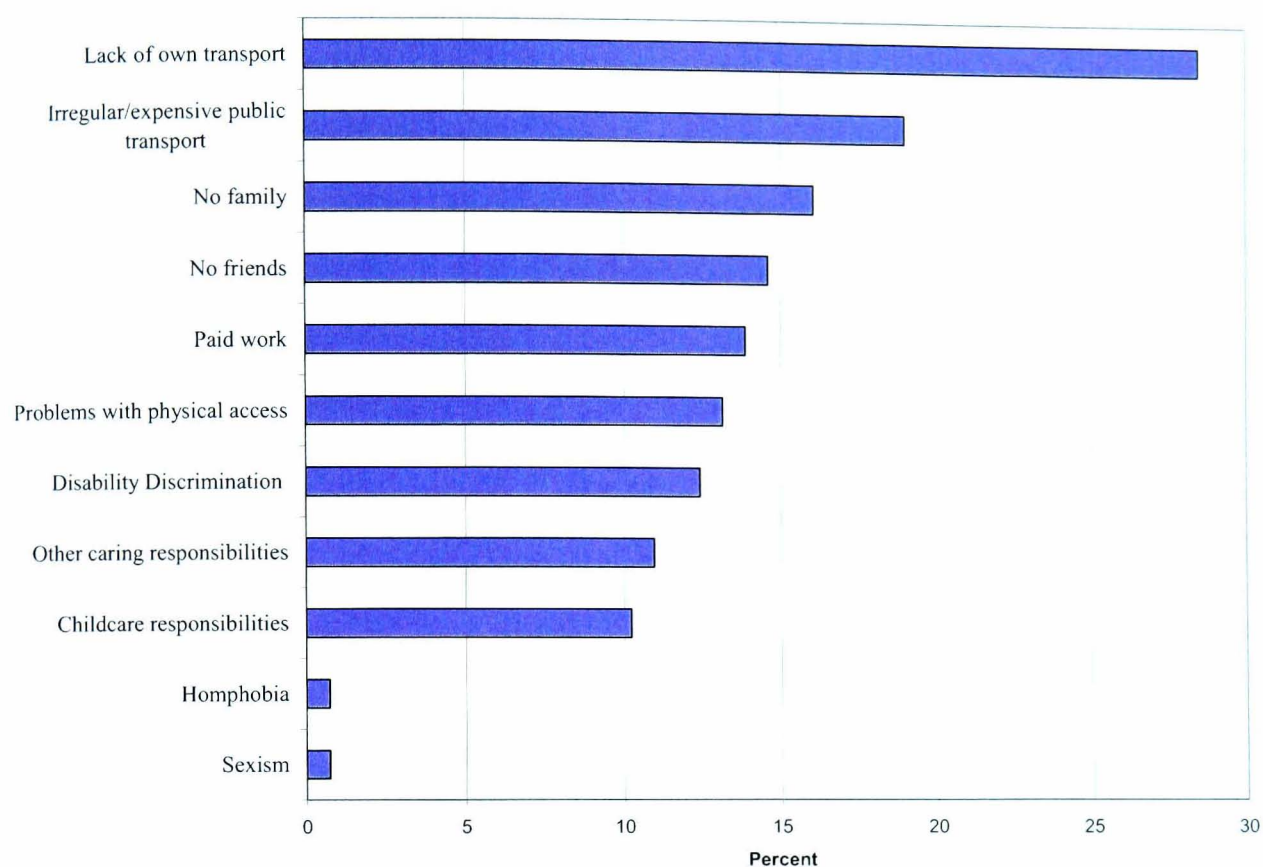
Discrepancies between social support experienced by those in the national survey and CAB respondents in the baseline study may lie in the evidence provided throughout this chapter. Where the national survey captures responses from the general population, it is apparent that the baseline sample represents some of the poorest and potentially excluded sectors of Welsh society.

### **Social Isolation at Baseline**

Gaining further insight into aspects of social deprivation respondents were asked if there had been times during the past year when they had felt cut off or isolated from society for any of the reasons set out in Figure 11. Eighty-five respondents reported feeling isolated or cut off from society in relation to 206 situations in total.

The greatest problems experienced by respondents occurred because of a 'lack of own transport' followed by 'irregular or expensive public transport'. Transport plays a critical role in promoting social inclusion; it increases access to a wider range of jobs and improves access to health care, education, training, and shopping and leisure facilities. Poor public transport along with low car ownership further isolates those who are already disadvantaged (Kenway et al, 2005: 116).

Figure 11: Feeling isolated or Cut off from Society



(n=137)

It is also worth highlighting the number of respondents who felt isolated or cut off from society due to discrimination, including 12% who felt isolated because of disability discrimination. A further 10% of responses related to 'other' causes, such as: "trouble leaving the house - get nervous", "lack of money, depression", "disruptive neighbours", "partnership problems", "living on own in an isolated area", "drug addiction problems", "depression", "paranoia" and "loss of job." Several respondents listed money worries. One respondent described how within 12 months she had lost her home, split up with her husband, and was left to care alone for her three children. This had affected her health and she was able to cope only with the help of a support worker.

Overall 62% of the baseline sample felt isolated or cut off from society in one or more situations, 42% in multiple instances. It was also found that 57% of the respondents felt some sense of social isolation due to the problems for which they were seeking advice, and nearly a quarter of the sample answered 'Yes, a lot' to this question.

The circumstances of those in the baseline sample put them at high risk of social exclusion, observable in the findings. A large proportion of the sample was economically inactive; they also suffered from high levels of poor health and disability and struggled financially. Labour market exclusion, which can occur for a range of reasons, is a known risk factor related to exclusion from social relations. Being confined to the home is also a known risk factor (Gordon et al, 2000: 65), which can occur as a result of poor health, disability, caring responsibilities, and from not being able to afford to go out, as well as for other reasons.

## **Conclusions**

Findings from the baseline study indicate that the sample represents some of the poorest and most vulnerable sections of Welsh society. There were high levels of economic inactivity, high levels of self-reported financial difficulty and clear evidence of poor health, thin social support, and indicators of social isolation at baseline. Many clients sought advice with multiple and complex issues. A noteworthy proportion of the sample sought help with debt problems lacked full knowledge of their financial circumstances and were unable or unwilling to provide full details of their financial commitments.

## CHAPTER SIX

### **Precipitating and Intervening Events, the Sample at Wave 2 and 3,**

It is natural to experience attrition in a longitudinal survey. The characteristics of those who left the study and those who remained were compared to establish if particular respondent groups were more likely to withdraw from the study than others. Making these comparisons, it was also possible to ascertain how representative this second group of respondents was of the whole of the sample who participated in the project at baseline.

The chapter begins with a retrospective discussion on precipitating experiences, as described by respondents at wave 3 of the study. This looks at events that respondents attributed to triggering or causing the problems for which they sought advice. The rationale for beginning with a retrospective account is that this provides context to emerging findings, and bridges a gap in the baseline study.

#### **Characteristics of Sample at Wave 2 and 3**

Based on data collected at baseline, it was established that respondents remaining in the study at wave 2 represented a slightly older age group than at baseline; this trend continued in wave 3. For example 43% of the sample at wave 3 was aged 55+ compared with 27% at baseline. In line with this outcome, it was found that 24% were pensioners compared with 13% at baseline. Naturally this affected the percentages of those in receipt of state pension in the study at these time points.

A higher proportion of the sample suffered with a long term health problem, physical disability or diabetes at wave 2 than at baseline. It is also possible that those with health problems or a disability may have more complex cases, which take longer to resolve, although no correlation was found with the issues for which respondents were seeking advice. At wave 3 a noteworthy increase was found in the percentage of respondents who had reported health problems such as arthritis/rheumatism, sensory impairment and/or high blood pressure at baseline, although smaller percentages at wave 3 suffered with asthma. It is possible that due to the older age group of

participants in subsequent waves of the study, who were more likely to be pensioners, the probability of this group experiencing health problems and disability increased, as sometimes occurs as one becomes older. Nevertheless, no significant difference existed in baseline SF-36 or HADS scores between the groups participating at baseline, wave 2 or wave 3.

Those who had borrowed money from friends were less likely to be represented in wave 2 and wave 3. It is not known why this outcome occurred but it is reasonable to propose that those borrowing from friends are more likely to be 'let off' repaying the loan, and this may relieve some of their troubles. Or it may be that the respondent is less willing to allow a CAB to intervene on a pro-rata and priority debt basis.

Respondents reporting utility debts at baseline were less likely to remain in the sample at wave 3, just two respondents participating at wave 3 had reported utility debts (at baseline) compared with 30 respondents participating at baseline. A higher percentage of respondents who withdrew from the study had curtailed purchases of food and had gone without a holiday at times in the previous year (at baseline) than those remaining in the sample at wave 3.

### **Respondent Issues at wave 2 and 3**

The second wave of the study took place approximately six months after respondents first approached a CAB for help and advice. The third wave occurred 12 months after referral. A brief synopsis of the status of client issues, together with confirmation of CAB involvement in cases, at each of the follow up surveys follows.

At wave 2, 41% of the sample said their problem was fully resolved, 51% said it was partly resolved, and 5% said it was not resolved. It was confirmed that CAB was active in helping the entire group of clients whose problem was completely or partly resolved. Many cases were ongoing (45%); consequently, the findings capture responses at a variety of stages in the advice process.

At wave 3, 83% confirmed they had completely followed CAB advice and 4 (10%) had partly followed CAB advice. One respondent did not follow CAB advice and two did not respond.

Half of the sample at wave 3 confirmed their problem was completely resolved at wave 3 whilst a little over a third said their problem was partly resolved. Three respondents had not resolved their problems and another three did not respond. The 36 respondents whose problem was completely or partly resolved at wave 3 said this was because of the help and advice they had received from CAB. At wave 3, CAB was still dealing with the cases of 13 respondents out of 42 remaining in the sample.

This cohort sought the advice of a CAB for problems relating to welfare benefits, debt or discrimination problems, which often involves ongoing, prolonged assistance from CAB. Although the final wave of the study was conducted 12 months after each respondent first approached a CAB for advice with their problem, it should be noted that findings capture responses at a variety of stages in the advice process.

### **Precipitating Events, Deteriorating Health and Other Problems**

Based on data emerging from the first two waves of the study, the third and final wave sought to develop a deeper understanding of events that may have caused or triggered the problems for which respondents sought advice from CAB, and to learn how these problems affected individuals prior to CAB intervention. This part of the chapter draws on a number of responses which are illustrative of key themes emerging in the data. It transports the reader to an earlier time, and through the narrative of the respondents themselves it provides insights into the impact serious problems have on individual lives. This journey is dramatic, and somewhat out of character with earlier statistical evidence. It captures in respondents' own words their account of life changing, significant and disturbing events.

For some individuals, deteriorating health and other problems occurred in their lives as the study progressed. It is not possible to disentangle other mediating factors from



the effects of the advice intervention; nevertheless, gaining a rounder understanding of individual circumstances helps put the findings into context.

### **Events that Caused or Triggered Problems**

Three broad key themes emerged in accounts of events that respondents cited as triggering or causing their problems. A number of respondents traced their problems back to health problems, some of these occurred as a result of serious accidents. Others noted sudden changes to their welfare benefit entitlements, which caused them to seek advice. And the final theme captures those who described living with persistent, accumulative and damaging financial or personal problems.

Beginning with health impediments, there were a number of reasons for deteriorating health and the events this triggered. At this juncture, a simple explanation is given by one respondent of deteriorating health in old age: “I was less able to keep my home and do things because of my health and age.” Thus the transition to a new phase in the life cycle is determined, bringing permanent changes in this person’s circumstances. For others though, the expected path to retirement was cut short: “ill health and having to retire from work with an outstanding mortgage and loans to pay off.” In this instant, disordered unresolved financial matters are compounded by no longer possessing the capacity to earn money and take control over financial aspects of life. Already stretched with financial commitments, unexpected deteriorating health can compound the crisis, as seen in this explanation: “I was going out and getting loans when I couldn’t really afford them and then after some ill-health I got into difficulty and got behind with payments.”

Sudden life changing events reverberate in further testimonials:

“My business had to be closed down when I lost my eye and I wasn’t able to work. My financial problems started then.”

“I had a serious motorbike accident, smashed my arm and had to give up work.”

“Ruptured appendix, near loss of life, loss of income.”

Such accounts illustrate how the physical pain of the condition experienced is surpassed with time by new forms of loss, the workless state changing identity and sense of self. Beyond which the practicalities of changing circumstances must be dealt with as it becomes increasingly difficult to pay household bills, purchase day to day items, and meet repayments on loans, a mortgage or rent. As time passes, debts accumulate.

The following theme centres on events that respondents traced to problems with their welfare benefits, which caused them to seek advice from CAB. For some natural life cycle events prompted them to seek help with benefits, for example, upon approaching retirement age. Another person was refused benefits and one thought he was entitled to more. For others though, sudden changes in benefits occurred, as simply stated here: “benefits stopped for no reason.” Another person received “letters from DWP” as did this individual: “a letter from DWP debt management asking me to repay over £8,000 of benefit.” Embarking upon an uphill battle with officialdom is an overwhelming experience for some, and this can intensify other difficulties in their lives, as illustrated in this excerpt:

“The social security stopped my money as I did not attend a board. I did explain to them that a day or two before that, because of all the rain we had in November/December my kitchen was soaking. I tried to fix it by sitting in the kitchen ‘till 4:00 in the morning with the window down and door open but because I didn’t phone them on the morning they stopped my money, housing benefit, everything. My son was giving me £20.00 a week, my daughter was putting electricity/gas and cooking me dinners. There was an accident in my street where a car hit a motor cyclist, which tossed him up in the air. I phoned 999; when I got home I had lost my electric token and didn’t want to borrow any more money. My close friend, they have told me if I have any forms to take them there [to CAB].” I felt suicidal before CAB, but now I feel that I have someone to turn to for help.

Within the narrative one senses feelings of injustice and accompanying anguish. Life’s events can be chaotic and rapidly situations can spiral out of control. For this individual a life-line was extended and there was light at the end of the tunnel when a friend recommended the CAB.

Not understanding an event creates the foundation for fear and helplessness: One respondent's words illustrate this well: "felt alone, that big company did not listen but as soon as CAB was mentioned ... what a difference!"

The final theme emerging illustrates the damaging effects of persistent, prolonged financial difficulties which result from living on a low income illustrated in this respondent's explanation:

"Just couldn't afford to pay the bills or debts or buy food sometimes. I was desperate and my counsellor referred me to BABH Kelly [the Better Advice Better Health Service] at CAB."

The account brings to light the reality of living on a low income, the anguish of struggling to make ends meet. Some individuals who relied previously on family faced up to the realisation that longer term solutions had to be sought, as seen here: "I realized I needed to seek advice and could not rely on my mother to bail me out again." For others, personal long term difficulties accumulated; one had fallen out with family, another admitted to overspending, and one described "a long term fight with alcohol and mental stress which caused me to lose my job".

Compounding difficulties emerged in other responses: "I was made redundant from an organisation where work place bullying had gone on so I was feeling low and deflated, and financial impact was horrendous!" One individual blamed drug addiction for their problems - this respondent was caught stealing, an event that forced her to confront her problems and seek help.

Referring to the literature it can be seen that precipitating events have been reported in a small number of related studies, some undertaken in primary care advice settings; whilst others relate specifically to debt advice. Nevertheless, the most common triggering events reported are in keeping with these findings.

For instance, in an evaluation of Warrington District CAB Primary Care service Caiels and Thurston (2005: 32) found 64% of respondents experienced at least one adverse life event in the six months prior to seeing an advisor. The most frequent

events included loss of a benefit, a new illness, bereavement and relationship breakdown, although a number of additional reasons were given.

Research with people with mental health problems who are also experiencing debt problems has revealed that most of the causes of debt are associated with poverty and illness. Related factors include changes in income due to illness or disability, redundancy, or changes to Welfare Benefits. Previous findings show some people have difficulty accessing Welfare Benefits and others are less able to manage money due to mental health problems (Sharpe and Bostock, 2002: 5). Similarly, in a study of debt advice Edwards (2003: 48) established a number of precipitating events. Most commonly though debt could be attributed to changes in personal circumstances such as job loss, ill health, relationship breakdown, over commitment and poor money management. In keeping with this Pleasence et al (2007: 5b) found that debt problems were triggered by a combination of events. Job loss, ill health or relationship breakdown were often among them. Debt was broadly attributed to three key causes – changing circumstances, poor money management and creditor behaviour. Changing circumstances exacerbated existing debt or caused debt.

Having established some of the underlying events that triggered respondents' problems, the impact these problems had on their lives is discussed next.

### **The Impact of Problems on the Lives of Individuals**

Reflecting upon events prior to receiving advice from CAB, respondents described how their problems impacted on their lives. Their stories tell of sleepless nights, stress, fear and worry; accounts symptomatic of chronic stress, anxiety and in some cases depression. These excerpts, reminiscent of explanations taken from the pages of a medical almanac, provide insights into the appalling impact that serious and persistent problems have on a person's mental health. At the brink of despair, some experienced suicidal thoughts. Illustrative examples of their accounts follow:

“It was awful – I wasn't sleeping and was so worried and sensitive, it was affecting all areas of my life, and I feared being homeless and losing my job as a consequence.

“I was a nervous wreck. I didn’t know which way to turn. If I hadn’t done anything then I would have gone under. I don’t usually talk to others about problems so coming to CAB and being able to talk in confidence made all the difference.”

Overwhelming demands and persistent worries stimulate an instinctive ‘fight or flight’ reaction, every system in the human body is disrupted. But the body can’t distinguish between physical and psychological threats so it reacts as if coping with a life or death situation – it never switches off. Prolonged periods of stress result in it becoming increasingly difficult for a person to switch off. Complications occurring from stress include anxiety and depression - the most common mental health problems in the UK. Tolerance to stress is suppressed further by poor social support networks; those socially isolated are even more vulnerable. The symptoms of chronic stress include sleep problems, relationship problems, reduced productivity and quality of life (NHS Direct, 2008). These symptoms are clearly depicted in respondents’ accounts.

Summarising the impact on their life, this person said: “loss of sleep, stress and depression.” Another noted the impact of debt problems: “it affected everything – I was being hounded by creditors.” Alluding to a heightened nervous state this person described how they were affected: “terribly, I was constantly in a panic mode, and frightened of everything.” Another described how: “the stress had become very bad. My health was affected mentally and physically.” Thus relationships become strained, as seen here: “very worried and stressed, caused relationship problems and constant arguments.” And productivity reduced: “it affected me a lot with my work, I was having sleepless nights.” With no solution in sight problems intensify: “I did not have a clue what I was doing; I was worried about losing my house, couldn’t work and didn’t know where to turn.”

As respondents’ accounts unfold, so too do the classic symptoms of chronic stress. Inescapable and un-relenting these problems affected all aspects of their lives, most conspicuously their mental health. By appreciating respondents’ earlier circumstances, experiences and feelings, it is possible to provide a wider context for

findings that exemplify the impact of advice on the health and quality of life of individuals.

Parallel findings demonstrate the impact serious problems have on mental health. In their aforementioned research Caiels and Thurston (2005: 32) reported 69% of respondents felt anxious or stressed because of life events that occurred in the 6 months prior to seeking advice. Pleasence (2007: b) found 89 % of respondents worried about their debt problems most or all of the time, and the majority described these problems as impacting on their health. Likewise, Greasley (2003: 5) established that 75% of respondents said the problems for which they were seeking advice affected their health or the way they were feeling, although he did not comment directly upon events that triggered these problems.

Other studies have shown the relationship between debt and ill health, for example, Reading and Reynolds (2001: 443) found evidence of an association between debt and maternal depression in lone parents. Drentea (2000: 445) reported levels of anxiety increased with the ratio of income to credit card debt. Not only have factors associated with disability been found to create debt problems but the onset of mental health problems have been ascribed to the process of dealing with debt, and experiences with unsympathetic creditors (JFK, 1995). Whilst Brown et al (2005: 659b) found evidence of increased levels of psychological distress in those with debt.

In summary, debt problems can occur due to a change in an individual's personal circumstances, such as job loss, ill health, the birth of a child, death of a family member, divorce, an unexpected cost or bill or through simply struggling to live on a low income. Pleasance et al (2007b) summarises this as changing circumstances, poor money management and creditor behaviour. For some, debt problems occur or are compounded by poor financial and money management skills, and on occasion, mental health problems can also weaken financial management capability (Sharpe and Bostock, 2002).

## **Health and Events in intervening period between each Wave of the Study**

One of the key aims of the research was to measure changes in the health of respondents between each wave of the study. The hypothesis was that an individual who received ongoing help and advice with a serious problem was likely, as a result of that intervention, to enjoy improvements in aspects of their health, particularly their mental health. For that reason it was also important to learn about any experiences that may have affected respondents' health during the intervening period between each wave of the study. For example, a respondent with a life-limiting illness or newly diagnosed health condition is unlikely to describe improvements in health, no matter how effective the advice they receive may be.

At wave 2, 68 respondents remained in the sample. One third described deteriorating health or experiences that affected their health or the way they were feeling, which occurred after the baseline study. Two respondents said their arthritis had worsened; causing constant pain, especially when walking. The health of one person with a life limiting illness had deteriorated. Another reported continuing sight problems, for which there is no treatment. One person was diagnosed with angina, and several respondents described experiences that affected them emotionally.

At wave 3, 42 respondents remained in the sample. A little under a quarter reported deteriorating health and a further six described incidents that affected their health or the way they were feeling since wave 2. One worried about ongoing pain in the shoulder joints. Another had undergone several Computerised Axial Tomography (CAT) scans and a Magnetic Resonance Imaging (MRI) scan for benign tumours. This person also had arthritis in the knees, neck, left arm and shoulder and her husband had Deep Vein Thrombosis in both legs, which left him weak and made walking difficult. One respondent was awaiting the results of an MRI scan to learn if cancer, diagnosed since wave 2, had affected tissues around the prostate gland. Others reported a series of health problems including walking difficulties, a triple by-pass operation, and high blood pressure. One person experienced ongoing health problems that occurred as the result of an earlier physical assault that caused brain damage.

During the period between the wave 2 and wave 3 interviews, several respondents described worries they had experienced with caring responsibilities which affected their health or the way in which they were feeling. For example, one person was caring for her sick father and she had also recently experienced the death of a friend from cancer. Another experienced setbacks looking after her 18 year old grandson who suffered from epilepsy, and another was caring for her mother and considering the option of moving her permanently into a residential care home.

Respondents described other problems that had significantly affected them. One respondent's job had been threatened; another had a serious leak to the roof that had not been repaired; this person had to reapply for disability benefits, which was causing some anguish.

## **Conclusions**

This chapter began by comparing the characteristics of those remaining in the sample at wave 2 and 3 of the study to those sampled at baseline. As a consequence of precipitating and intervening events, it is evident that ongoing health problems, particularly problems with physical health, and day to day problems impacted on a noteworthy proportion of the sample. The circumstances of the sample must be considered alongside findings that set out to quantify improvements in domains of health between each wave of the study, as this information affords crucial context to such findings. In light of the persistent and serious nature of clients' problems and the impact they had on their lives it understandable that a number of positive psychosocial outcomes may emerge from the advice process.



## CHAPTER SEVEN

### The Impact of Advice

#### Health – The Impact of Advice

Changes in health were measured using two well known validated instruments - the Short Form 36 (SF-36) and the Hospital and Anxiety and Depression Scale (HADS). The SF-36 measures eight domains of health, across dimensions of physical health and mental health. The HADS measures two scales - Anxiety and Depression. Statistical tests were conducted to ascertain whether the health of the sample improved significantly over time.

Prior to undertaking statistical tests the data was screened for normality. Parametric statistical techniques assume that scores for each variable are normally distributed in a bell shaped curve, otherwise referred to as a Gaussian distribution (Miles and Shevlin, 2001: 62). If the assumptions required for a particular statistical test are not met then the results may be inaccurate or degraded (Tabachnick and Fidell, 2007: 79). For these reasons SF -36 and HADS variables were screened for normality, predominately through statistical methods, although graphical methods were also utilised for confidence.

Statistical methods assess skewness and kurtosis. Skewness is concerned with the symmetry of the distribution of the variable. If a variable is skewed its mean will not be in the centre of the distribution. Variables that are symmetrical but do not have the characteristic bell shaped curve exhibit kurtosis. For normality, Miles and Shevlin (2001: 67) recommend skewness and kurtosis values close to zero, although they cautiously suggest that skewness statistics below one should not cause problems. Skewness that is greater than 1.0 but less than 2.0 may have an effect on parametric estimates; therefore, the conservative aforementioned value was imposed to determine normality. In order to determine if skewness and kurtosis differs significantly from what might reasonably be expected in a normal population, the values should be not greater than twice their standard error (ibid).

Kolmogorov-Smirnov statistics were also inspected to assess normality. A non-significant result ( $P > .05$ ) indicates normality (Pallant, 2001: 58).

Using graphical methods, the distribution of the data for each variable was also inspected in a histogram, stem and leaf plot, normal Q-Q Plot, detrended normal Q-Q plots and stem and box plot.

### **Findings from SF-36 Scores**

#### *SF-36 Results at Wave 2*

SF-36 scores obtained from 56 respondents who participated in both waves of the study were analysed. The distribution of the scores for the Role Physical variable at wave 2 was significantly skewed. Kurtosis values for a number of variables, along with their associated standard errors were both high and significant. It was concluded that the SF-36 scores formed a non-normal distribution, and consequently a non-parametric test was appropriate.

The Wilcoxon matched pairs, signed rank test confirmed statistically significant improvements in SF-36 scores beyond .05 level in three out of eight domains, namely the domains of Social Functioning, Role Emotional, and Mental Health. Furthermore, improvements in the means scores of the sample were found in all eight domains of the SF-36, from baseline to the second wave of the study.

It should be noted that scores in the SF-36 range from 0-100. In this instance, higher scores indicate better health.

Table 7: Wilcoxon Signed Rank Test –SF-36 Scores from Baseline to Wave 2

	<i>Baseline</i> <i>Mean (SD)</i>	<i>Wave Two</i> <i>Mean (SD)</i>	<i>P-value Difference</i> <i>between groups</i>
Physical Functioning	45.8 (34.4)	47.5 (31.6)	P = .870
Role Physical	29.0 (39.8)	34.8 (39.2)	P = .147
Bodily Pain	40.2 (31.5)	46.3 (31.0)	P = .211
General Health	35.8 (23.6)	38.2 (23.1)	P = .391
Vitality	31.5 (22.0)	35.4 (23.3)	P = .077
Social Functioning	40.6 (29.2)	51.1 (29.3)	P = .003 *
Role Emotional	37.5 (43.6)	50.6 (46.7)	P = .018 *
Mental Health	48.1 (25.3)	55.8 (23.5)	P = .004 *

*(n=56) SF-36: Higher scores indicate better health, \* Difference in change in score is statistically significant, indicating improvements in health from baseline to wave 2 of the study.*

### ***SF-36 Results at Wave 3***

At wave 3, test statistics compared eight domains of health in the SF-36 at baseline, wave 2 and wave 3. Kurtosis values for a number of variables were significant and high enough to warrant concern about normality. Kolmogorov-Smirnov statistics were significant for a number of variables, consequently non-parametric tests were adopted.

The results of the analysis, set out in Table 8, illustrate that statistically significant improvements in scores were found in the SF-36 domains of Vitality, Social Functioning and Mental Health.

Table 8: SF-36 Outcomes at Wave 3

	<i>Baseline</i>	<i>Wave Two</i>	<i>Wave Three</i>	<i>Test Results: Friedman's</i>
	<i>Mean (SD)</i>	<i>Mean (SD)</i>	<i>Mean (SD)</i>	<i>ANOVA</i>
Physical Functioning	42.65 (34.3)	44.26 (31.8)	45.88 (30.9)	$\chi^2 (2) = 1.487, P = .476$
Role Physical	28.68 (40.9)	34.56 (39.4)	36.03 (40.9)	$\chi^2 (2) = 2.375, P = .305$
Bodily Pain	42.65 (32.9)	47.74 (30.3)	49.74 (31.2)	$\chi^2 (2) = .933, P = .627$
General Health	35.82 (24.8)	40.79 (22.8)	41.28 (19.8)	$\chi^2 (2) = 2.778, P = .249$
Vitality	33.68 (21.9)	39.26 (22.5)	40.74 (21.5)	$\chi^2 (2) = 6.145, P = .046^*$
Social Functioning	44.49 (31.1)	55.88 (29.6)	56.62 (30.0)	$\chi^2 (2) = 7.794, P = .020^*$
Role Emotional	45.10 (46.3)	56.86 (47.5)	51.96 (48.0)	$\chi^2 (2) = 2.000 P = .368$
Mental Health	50.47 (25.0)	59.88 (22.2)	63.18 (24.3)	$\chi^2 (2) = 13.312, P = .001^*$

(n=34) SF-36: Higher scores indicate better health \* Difference is statistically significant beyond the 0.05 alpha levels.

A series of further tests were conducted to verify the results. A Wilcoxon Signed Rank Test revealed statistically significant improvements in this sample of 34 respondents between *baseline* and *wave 2* of the study in the SF-36 domains of Social Functioning (P = .025), Role Emotional (P = .031) and Mental Health (P = .009). Statistically significant improvements in scores were also found between *baseline* and *wave 3* of the study in the domains of Social functioning (P = .022) and Mental Health (P = .001).

Comparisons also revealed improvements of borderline significance between baseline and wave 3 in the domains of Vitality (P = .051), and General health (P = .056). It is also worth noting a close to significant improvement in Vitality between baseline and wave 2 (P = .084).

Four respondents were unavailable to complete wave 2 of the study; consequently further analysis was undertaken of SF-36 data available for the slightly larger sample of 38 respondents who completed the study at baseline and wave 3, as set out in Table 9. Statistically significant improvements occurred between *baseline* and *wave 3* in the

domains of *General Health, Vitality, Social Functioning* and *Mental Health* in this slightly larger sample.

Table 9: SF-36 Outcomes for 38 Respondents at Baseline and Wave 3

	<i>Baseline</i> <i>Mean (SD)</i>	<i>Wave Three</i> <i>Mean (SD)</i>	<i>Test Results:</i> <i>Wilcoxon Signed</i> <i>Rank Test</i>
Physical Functioning	42.37 (33.7)	48.68 (31.3)	P = .098
Role Physical	30.26 (41.6)	40.79 (42.5)	P = .102
Bodily Pain	42.53 (31.7)	51.16 (30.4)	P = .124
General Health	34.95 (23.7)	42.70 (19.8)	P = .015 *
Vitality	31.32 (22.2)	41.58 (21.1)	P = .009 *
Social Functioning	42.76 (32.8)	57.89 (28.7)	P = .007 *
Role Emotional	43.86 (45.9)	53.51 (47.5)	P = .185
Mental Health	47.89 (25.4)	62.21 (24.1)	P = <.001 *

(n=38) SF-36: Higher scores indicate better health \* Difference is statistically significant beyond the 0.05 alpha levels.

As large sample sizes are required for certain calculations, with a small sample there is a risk of a type B error occurring. With an alpha of 0.05, and power of 80%, a simple two tailed repeated measures test would need a sample of 21 to detect 10 points of difference in the Mental Health domain of the SF-36. However, this rises to a sample of 69 to detect 10 points difference in the Role Emotional domain, and rises again to a sample of 74 to detect difference of 10 points in the Role Physical domain (Ware et al, 2000: 7:11). Consequently, with a larger sample, significant findings may have occurred in more of the domains of the SF-36.

Scales related most directly to physical health are *Physical Functioning, Role Physical and Bodily Pain*. These address different aspects of physical health, such as behavioural performance in everyday activities, the extent to which one is limited in everyday activities due to physical problems, and the severity of bodily pain and associated ability to perform in activities. Although the mean scores for domains concerned with physical health improved at wave 2 and wave 3, statistically significant improvements were not expected due to the occurrence of poor and

deteriorating health in the sample. However, the findings illustrate how physical health can be influenced by a person's state of mind, for example, coping with bodily pain. This could be as a result of the Hawthorne effect, which is something that has been noted by Abbott and Davidson (2000) and Abbott et al (2005).

The three scales that provide the best measure of mental health are *Social Functioning, Role Emotional, and Mental Health*. Statistically significant improvements were found in each of these domains at wave 2 and in Social Functioning and Mental Health at wave 3.

Social functioning influences an individual's behaviour in normal social activities and it can be affected by emotional problems that they experience.

The Role-emotional domain can be affected by emotional problems also. It is this domain that will influence the scope a person has to carry out work or other daily activities. Consequently, being limited in these roles because of emotional problems can interfere with a person's ability to perform work or daily tasks (Ware et al, 2000).

Mental health domains are influenced mostly by how peaceful, happy or calm one may be (Ware et al, 2000). Improvements in mental states were also verified with statistically significant improvements in HADS Anxiety and Depression scales, which are reported below.

## **Findings from the HADS**

### *HADS Results at Wave 2*

At wave 2 scores for the HADS Anxiety and Depression scales were compared with the test statistics at baseline (prior to advice intervention) and wave 2 (following advice intervention). Kolmogorov-Smirnov statistics for both Anxiety and Depression scales for each wave of the study were significant ( $P > .05$ ) indicating normality in the distribution of the scores. Skewness and Kurtosis statistics were

reasonably normal as were graphical tests. It was concluded that the HADS data was normally distributed, and therefore suitable for parametric tests.

Scores obtained from 67 respondents who participated in both waves of the study, set out in Table 10, show mean Anxiety and Depression scale scores improved between baseline and wave 2. Scores on each scale can range from 0-21. Lower HADS scores indicate better mental health. A paired samples t-test with an alpha level of .05 was conducted to evaluate whether the improvement in HADS Anxiety and Depression scores from baseline to wave 2 of the study was statistically significant.

Improvements were found to be statistically significant, confirming the hypothesis that states of Anxiety and Depression improved from baseline to wave two.

Table 10: Improvements in HADS scores from Baseline to Wave 2

	<i>Baseline</i>	<i>Wave Two</i>	<i>Test</i>	<i>P-value</i>
	<i>Mean (SD)</i>	<i>Mean (SD)</i>		<i>Difference between groups</i>
HADS Anxiety	12.00 (4.7)	10.31 (5.0)	t = 3.754 d.f = 66	P < .001 *
HADS Depression	9.22 (4.4)	8.19 (4.3)	t = 2.231 d.f = 66	P = .029 *

(n=67) HADS: Lower scores indicate better health, \* Difference in change in score is statistically significant beyond the 0.05 alpha level, indicating improvements from baseline to wave 2 of the study.

### *HADS Results at Wave 3*

At wave 3 scores on the HADS Anxiety and Depression scales were compared with the test statistics at baseline, wave 2 and wave 3. There were some moderate signs of skew, and the kurtosis value for the HADS Anxiety scale at wave 3 was high, although associated standard errors for skew and kurtosis were acceptable.

Kolmogorov-Smirnov tests indicate that the HADS Depression scale at wave 3 deviated from normal. Sensing caution from a member of the Steering Committee for the research, on this occasion a particularly conservative approach was adopted and non-parametric tests were conducted.

Valid HADS scores from all three waves of the study were available for 37 respondents, as set out in Table 11. Test results revealed a statistically significant improvement in the HADS Anxiety scale whilst the Depression scale did not reach significance.

Table 11: HADS findings at Wave 3

	<i>Baseline</i> <i>Mean (SD)</i>	<i>Wave Two</i> <i>Mean (SD)</i>	<i>Wave Three</i> <i>Mean (SD)</i>	<i>Test Results: Friedman's</i> <i>ANOVA</i>
Anxiety	11.22 (4.5)	9.57 (4.7)	9.11 (5.3)	$\chi^2(2) = 8.756, P = .013 *$
Depression	8.76 (4.3)	7.95 (4.2)	7.38 (4.9)	$\chi^2(2) = 3.619, P = .164$

(N=37) HADS: Lower scores indicate better health \* Difference is statistically significant beyond the 0.05 alpha levels.

Further tests were conducted to measure changes in health between paired sets of data at *baseline* and *wave 2* of the study, and between *baseline* and *wave 3*, for the wave 3 sample. Wilcoxon Signed-Rank tests revealed a statistically significant improvement in HADS Anxiety mean scores between baseline and wave 2, (P = .013), and also between baseline and wave 3, (P = .003).

In order to conduct the aforementioned statistical tests valid HADS scores were required for each respondent from all three waves of the study. A small number of Respondents who participated in the study at baseline and at wave 3 were unable to participate in the second wave of interviews (as was the case with the SF-36). Consequently valid HADS data was available for a sample of 41 respondents who participated in the study at *baseline* and *wave 3* (but not wave 2). It is evident from test statistics set out in Table 12 that with this slightly larger sample the HADS Depression scale is close to significant.



Table 12: HADS findings for 41 Respondents at Baseline and Wave 3

	<i>Baseline</i> <i>Mean (SD)</i>	<i>Wave Three</i> <i>Mean (SD)</i>	<i>Test Results: Wilcoxon</i> <i>Signed Rank Test</i>
Anxiety	11.63 (4.6)	9.17 (5.3)	P = .002 *
Depression	9.07 (4.3)	7.17 (4.9)	P = .052

(n=41) HADS: Lower scores indicate better health \* Difference is statistically significant beyond the 0.05 alpha levels.

Drawing on previous evidence, a summary of reported improvements in domains of the SF-36 and HADS is provided next. These findings relate to three studies; Abbott and Hobby conducted in 1999 and 2002 and Greasley and Small (2002), the key findings of which are reported by Greasley (2003).

In a 6 month follow up study of CAB respondents Abbott and Hobby (1999) reported statistically significant improvements, in a sample of 48 respondents whose income had increased, in 3 domains of the SF-36: *Vitality*, *Role Emotional* and *Mental Health*. No significant health gain was found in the group not receiving increased income from welfare benefits. However, at 12 months the results were not maintained at a statistically significant level although they did generally remain higher than at baseline, this may have been due to chronic illness in sample (Abbott and Hobby 1999).

In a later study concerned with the impact of income maximisation schemes on the physical and mental health of primary care health service users, Abbott and Hobby (2002) reported the findings for two groups constructed for the research – a group whose income increased and a quasi control group consisting of those unsuccessful obtaining increased income. A detailed outline of their findings is provided in Chapter One; however, to act as a reminder here the authors suggest that *Vitality* and *Mental Health* appear to be most closely associated with increased income. Findings from their 6 month follow up study show SF-36 *Vitality* scores increased in the income increase group, and decreased in the control group – thus creating a statistically significant difference, however, this was not maintained at 12 months. Nevertheless, the difference between groups since baseline was statistically significant in the *Mental Health* domain at 12 months.

Other noteworthy findings were reported by Greasley (2003), in research concerned with welfare advice in primary care. Comparing results at baseline, 6 and 12 months, a repeated measures ANOVA revealed statistically significant improvements in the SF-36 domains of General Health and Mental Health. Improvements of borderline significance were reported for the HADS anxiety scale and SF-36 Vitality and Social Functioning scales, which were close to significant. Overall a trend was seen across all SF-36 domains except for Bodily Pain. However, the results should be treated with caution due to the sample size, which included 22 respondents at wave 3.

Greasley (2003) in contrast to Abbott et al (2005) concludes that advice cannot be expected to impact on bodily pain. Interestingly, Abbott et al (2005) suggest that increases in income appear to reduce bodily pain; this may be because anxiety reduces tolerance to pain. This is an important finding as it demonstrates the benefits to individuals of prompt welfare benefits processing, the impact of anxiety possibly related to the claiming process and the impact anxiety may have on bodily pain.

Consequently, it is important not to disregard the importance of welfare benefits advice services in primary care; however, due to the nature of this research, which was concerned with welfare benefits, debt and discrimination advice, the sample represent a particularly at risk group with serious and persistent problems. Perhaps it is for these reasons that the benefits to health were so profound, and the impact on psychosocial health most noticeable. It is logical that a person with serious financial problems, suffering with chronic stress or depression will enjoy considerable peace of mind having their financial problems resolved.

Findings from the results of the SF-36 and HADS contribute to a relatively small evidence base that has assessed the impact of advice with validated instruments. In order to gain a rounder measure of health outcomes, open questions were incorporated into the second and third wave of the study; these are discussed in the following text.

## Respondents' Views on Improvements to Health

Respondents described improvements in their health, which they attributed to the help and advice that they received from CAB. Their accounts verify and provide further explanation for the improvements found in domains of the SF-36 and HADS associated with dimensions of mental health. Articulating the relief that accompanies release from money or debt worries adds some colour to the findings of the statistical analysis, and it is hoped that this will provide meaningful explanations of respondents' experiences. Common themes emerged, which were expressed in terms of – less anxiety, less stress, fewer worries, not so many panic and anxiety attacks, feeling more settled, more relaxed, gaining control, and peace of mind.

Illustrative of these themes, one respondent noted feeling “less anxious, feel more in control of my affairs.” As did this person: “mentally improved, less stressful.” Released from psychologically damaging spiralling financial obligations, nervous tensions appear to shrink away, as noted here: “I feel more settled and not as anxious about my debt.” Recurring repeatedly in accounts respondents said “I feel less worried about money.” As did this person: “I feel less worried about debt.” And, here a respondent explains how the help and advice they received helped: “yes, they helped by dealing with bills, that helped to take away my panic and anxiety attacks.” Another person also explained that: “they helped me to sort out my benefits and finances, which gave me peace of mind. Very happy with advisor and can't say how much I appreciate it.”

In these accounts respondents talk of better health; of sleeping better; their appearance being better; eating better; things at work being better; financially better; thinking better of oneself; and, the health of others can now ‘get better’:

“Most definitely, I'm warmer; in my appearance is better and eating better. My family are **better**, which makes me happier and you haven't got to prove yourself to any of them.”

“I am sleeping **better** and don’t feel so pressurised and have been very happy with the help and advice.”

“More at ease now - has taken the burden from me. Don’t worry so much, can concentrate on getting my health and my mother’s health **better**.”

“Yes, I don’t worry about my job as much as I used to. Things at work are a lot **better**.”

“Circumstances financially are a lot **better** since CAB dealt with my debts; I can afford a piece of meat now.”

“My skin, no cracks, no infection – 40 years! Kate [CAB advisor] showed me how to continue when my Eczema was drawing me to a horrible place, I let her down – she did not let me down. I think **better** of myself; I was only in pain – that’s easy.” (emphasis added)

Reminiscent of recover from illness, recovery from a problem appears to revitalise. Improved circumstances recur in the sentiments shared by respondents; feeling happier, having less to worry about and a ‘good outcome’ is positively echoed. The final excerpt, in which a respondent remarks on improvements to a skin condition, reveals a poignant story of a person who lived with skin cracks and infections for 40 years before his CAB advisor negotiated a medical outcome. Thus the physical pain of a condition is transcended by the emotional states that this condition shaped; self worth, and release from this state are emotively revealed to the reader. Such recollections shed further light on the impact of advice, which cannot be captured so eloquently in closed questionnaire response sets. At this juncture the reader should be left in no doubt that advice-giving makes a considerable difference to the lives of individuals.

## **Financial Wellbeing – the Impact of Advice**

The study focused on respondents receiving casework or specialist advice for problems relating to welfare benefits, debt or discrimination, although some additional issues were dealt with also. Improvements in financial circumstances can occur as a consequence of receiving income advice, debt advice, securing welfare benefits entitlements or settling employment disputes associated with some discrimination cases. It is hoped that this aspect of the study will lead to a better understanding of how the improved or stabilised financial circumstances of an individual can impact on their material wellbeing and that of their dependent child or children, where applicable.

Findings reported here relate to a total of 47 respondents who participated in wave 2 and/or 3 of the study. It was feasible, although undoubtedly challenging, to gather data from bureaux on outcomes acquired for respondents who withdrew from the research. A request was made for this data but it was not provided, consequently the findings only concern those participating in subsequent waves of the study.

A total of 21 respondents received additional ongoing welfare benefit payments, ranging from £55.57 to £8,710.00 throughout the whole of the period of the study. Seven received one-off welfare benefits, which ranged from £27.73 to £2,183.96.

A total of 152 debts were managed for 25 respondents, ranging from one to 19 debts per person. The mean number of debts per person was six. The total amount of debt managed ranged from £1,320.00 to £53,312.84 per person; the mean was a little under £15,000. One respondent won a case in which a £6,956 pension credit overpayment was written off.

Table 13: Total Financial Outcomes: Welfare Benefits and Debt Issues

	<i>Number of Respondents</i>	<i>Total £</i>
Ongoing Welfare Benefits Payments Per Annum	21	£73,169.38
One off Welfare Benefits Payments	7	£6,499.63
Benefits in Kind	1	£6,000.00
Debt Written off (Pension Credit overpayment)	1	£6,956.00
<b>Total Gains</b>		<b>£92,625.01</b>
Debt Managed	25	£374,502.84

Table 14: Total Reported Additional Outcomes

	<i>Number of Respondents</i>
Debt Court Action Avoided	8
Bailiff's Action Prevented	7
House Repossession Avoided	1
Employment Terms and Conditions Improved or Reinforced	2
Other Employment Issue Outcome	1
Disability Discrimination Success	1
Health Complaint Resolved	1

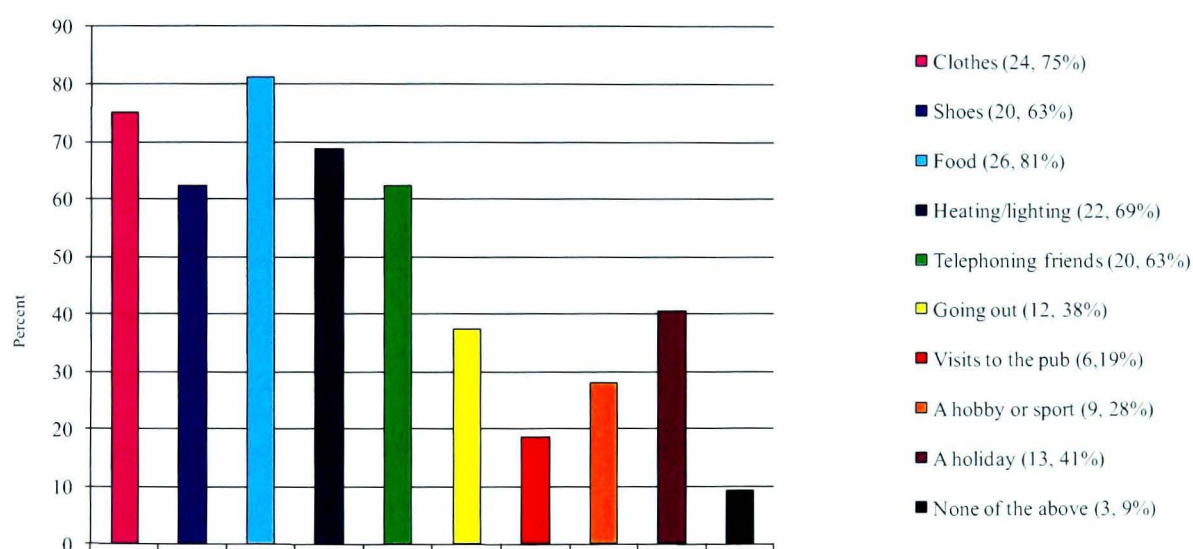
Due to the relatively small sample, the financial gains reported by bureaux for clients were quite small. However, it has long been established that considerable financial gains result from money related advice, such welfare benefits and debt advice. Considerable financial gains and improved take up of welfare benefits entitlements have been reported for many years as noted earlier in the literature. Because of the complexity of the welfare benefits system, current levels of take up and the differing needs of individual claimants', strong demand still exists for these services (Wigan and Talbot, 2006: 6).

## Impact of Financial Outcomes on Material Wellbeing

In the baseline study a high proportion of the sample had gone without essential items at times in the previous year due to a shortage of money. At wave 2 and wave 3 respondents were asked if they were better able to afford an identical list of items or activities as a consequence of CAB advice.

A total of 32 respondents (76%) were better off or more secure financially at wave 3. Twenty nine (91%) were better able to afford a total of 152 essential items or social activities as a consequence of improvements in their financial situation, as seen in Figure 12.

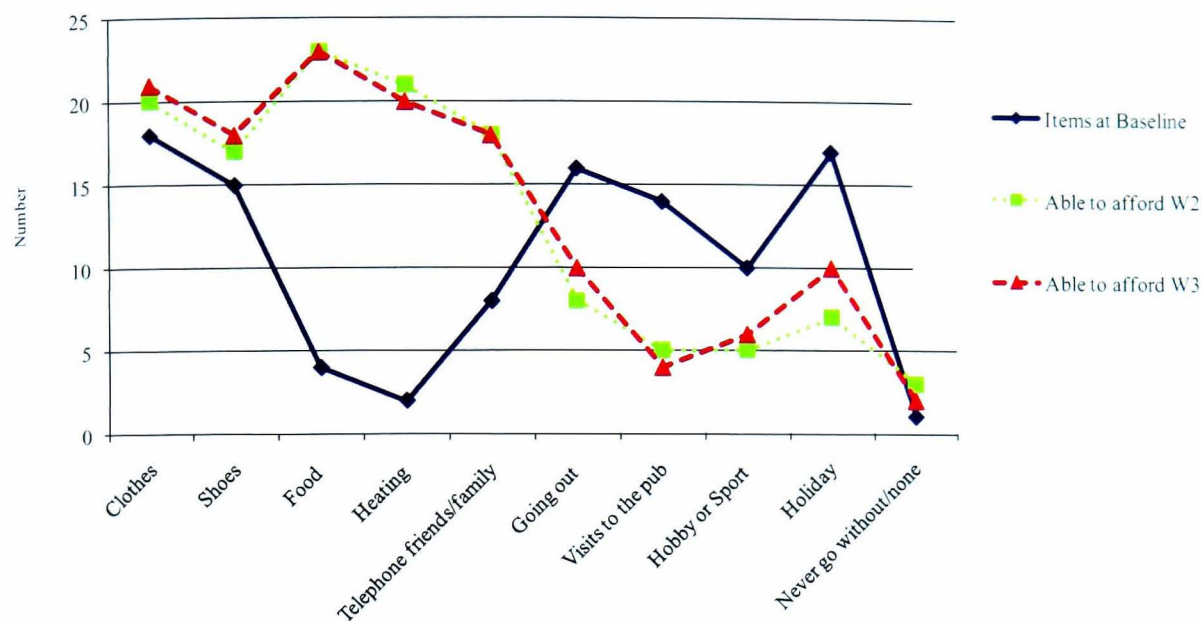
Figure 12: Items Respondents were better able to afford in wave 3



(n=32)

Figure 13 compares those items respondents went without on occasion at baseline (due to shortages of money in the previous year) with an identical list of items that the same group of respondents was better able to afford in wave 2 and wave 3 of the study. Data from 27 respondents, who participated at each wave of the study, is compared.

Figure 13: Comparison of items which respondents went without at baseline and could subsequently afford as a consequence of CAB advice



(n=27)

Figure 13 illustrates that spending was prioritised less on social and leisure activities than on purchases of clothes, shoes, food, heating and telephone calls. Slightly more Respondents were able to afford purchases of clothes and shoes at wave 2 and wave 3 than had gone without at baseline. A much larger number were better able to afford purchases of food and heating than had gone without in the previous year at baseline, although during the period of the study there was an unprecedented increase in the cost of food and fuel, which may have influenced respondents' perceptions of the affordability of some of these items.

Data was collected for wave 2 of the study between October 2007 and March 2008, and wave 3 of the study occurred between April and early September 2008. During the preceding 12 month period to September 2008, the Consumer Price Index (CPI), reported a 12.7% increase in food costs and 39.5% in gas, electric and other fuels (Office for National Statistics, 2008). This may explain why some respondents felt they were better able to afford food and heating, even if they had not cut back on these items at earlier stages of the research.



## **Financial Wellbeing – Respondents’ Views of the Impact of Advice**

In their own words respondents expressed the difference CAB advice made to them financially; their explanations refer not only to financial wellbeing in monetary terms but also to psychological, emotional and practical perspectives. Themes emerging in the data at wave 2 and wave 3 of the study are explored further with illustrative excerpts of respondents’ accounts. This begins first with - being better able to afford day to day items, second - having greater control over finances and budgets, and third - peace of mind. Unconsciously, at the end, some of these accounts depict liberation from debt, and in so doing provide a powerful reminder of earlier indications of creditor harassment, and the intensity of distress caused by debt collection agencies.

Earlier it was established that because of improvements to their financial wellbeing, the majority of respondents were better able to afford a range of everyday items and activities. Some elaborated on this further when explaining the difference CAB advice made to them financially, for instance, this person said: “It has helped with the heating. I’m not very well at the moment and it has helped me buy more nourishing food.” In another account the respondent revealed being able to afford a number of previously unaffordable items: “... we can afford the licence for the TV now; we didn’t have one for years. We can afford things like food and heating.”

Others had a little extra money available: “I have extra money left over at the end of the month for myself and children.” And this person explained how they had: “More money to spend on little luxuries.” For some, social outings were possible: “I can get a taxi now and the extra money helps with my husband’s petrol – helps me to go out.”

Many more referred also to being able to repay debts. For instance, in this account the respondent describes the difference CAB advice made financially: “A lot of difference, money I paid out before is now fixed - how much I pay out for clothing, food, dog, insurances, for car and creditors paid off, etc.”

Some improvements to financial wellbeing were small but nevertheless made a difference, as noted here: “We are better off - not much - we can afford one night out

a month.” It was a step in the direction for others: “Disability allowance, mobility, mortgage and some peace of mind. I am still not making ends meet but we are getting there.”

For others though, improvements to their financial wellbeing not only enabled them to pay for everyday items or extras, but also enhanced their lives in a number of additional ways:

“Well you can stay warmer, eat healthier, pay your way if you go places, not worry about how much a phone call is going to cost you, and put a little aside for emergencies.”

“It’s given me a little bit more to spend on my food and other things and occasional treat like ‘fish and chips’ because I haven’t been paying so much to creditors. It’s taken a lot of worry off my back.”

Having a little money left over for treats or emergencies fostered a sense of wellbeing, and relief from some worries, particularly debt, as it became easier to manage and make repayments to creditors.

It was established that prior to receiving CAB advice, money worries preoccupied the lives of many individuals in the study. It is not surprising; therefore, that they subsequently described how they were able to put their finances in order: “It caused me to look more carefully where my money was going. I spring cleaned my bank account and financial situation.”

Understanding budgeting and where money goes, and securing payment plans that were affordable helped some gain control over their finances, ensuring they were able to live within their means. For instance: “I know exactly how much is going [out] and I can plan.” This also prevented debts from spiralling further: “The advice has helped me gain control of my finances so they are not getting any worse.” For those already living on a low income or with debts to repay this was particularly important:

“It has helped me regain some order about my life. On a low income it has allowed me to live more within my means – paying regular payments to those I owe money to.”

“Debts all amalgamated and I make one payment once a month. This is much easier to monitor and manage. I can budget much better.”

Some respondents noted earlier that they had lived beyond their means. Sometimes they simply juggled debts and day to day living expenses whilst some irresponsible spending and borrowing had undoubtedly occurred. Having learnt from these experiences this respondent said: “It has enabled me to pay off my debts gradually meaning I don’t have to live outside my means.” And another explained: “The advice I was given has made me think about looking after my finances in the future, I don’t spend money unwisely now.”

Financial stability appeals to the need for order in our lives; feeling in control and knowing how to remain in control of finances is important. At this point in time illuminating accounts reveal again the horror of being pursued, hounded and harassed by creditors. Unable to escape requests for money that these individuals simply did not have, they felt powerless and weighted down by their financial worries.

Explaining the relief, this person said: “I have been relieved of harassment by creditors and free debt advice has provided me with some reassurance.” Whilst another replied “I’m able to sleep of a night without worrying now that the financial problems aren’t there and I’m better off.”

Release from fear and peace of mind were common themes that emerged in the transcripts:

“It’s more the case that they took away the huge amount of fear I was experiencing due to written threats and feeling completely powerless [in relation to debts]. The CAB helped in this hugely, gave me plenty of information in a calm and measured way.”

“I now know I do not have to be frightened of debt collectors threatening me or taking my car or TV away, and I do not have to be threatened over the telephone. I still feel worried as one of my problems is not solved yet, as the firm in question has completely ignored my correspondence but I know I can go back to the CAB for advice and help.”

“Again, I was shoveling everything under the carpet not seeing my debts. I plucked up the courage to come to CAB and they helped me with my debts; I’ve got peace of mind about my debts.”

“Improved it [the financial situation] as no longer worrying about post and phone – can answer phone. Feel better that the threat of bailiffs and creditor harassment has been overcome.”

These aspects of experiences of debt emerged throughout the study, and are worthy of further research. Advisors often articulated their concerns about respondents who were frightened and driven to states of despair because of debt problems. In the early stages of the study one bureau alone reported the suicide of six young men over a period of a few weeks. Each young man had sought advice for serious debt problems, and reported being pursued relentlessly by debt collectors in the area in which they lived. The value of peace of mind to those individuals overcoming such problems should not be underestimated. The implications for their families are also immense. In this instance, some of these young men had debts underwritten by family members, who were consequently pursued by debt collectors once the debts became their responsibility.

### **Impact of Financial Outcomes on Respondents’ Children**

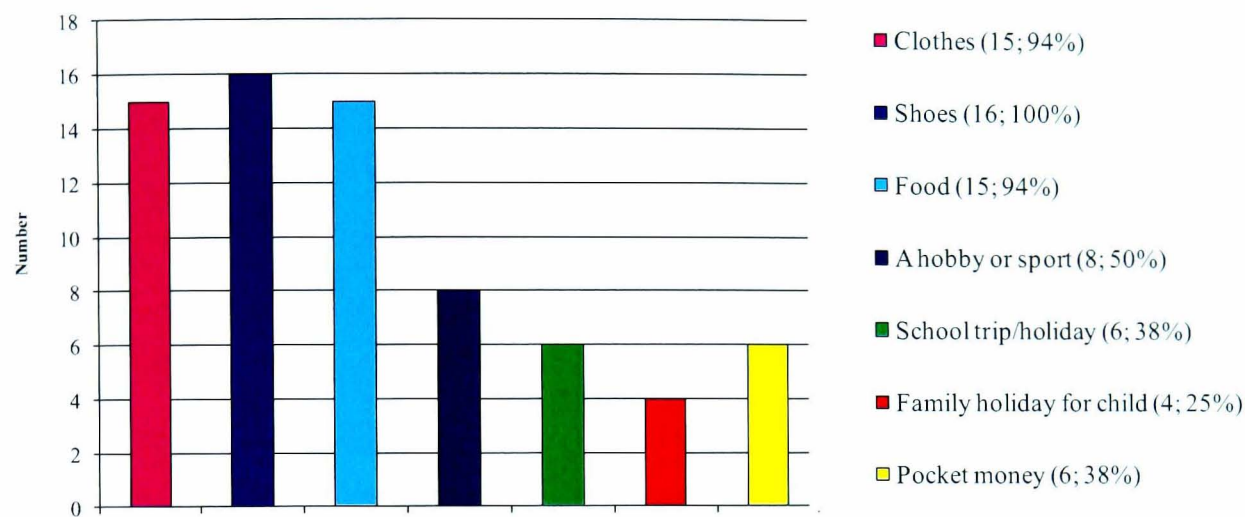
It was hoped that the second and third waves of the study would show how financial outcomes acquired for respondents impacted on their material wellbeing and the material wellbeing of their dependent children.

At baseline, 41 parents out of 50 with dependent children (82%) reported that on occasions in the previous year their child or children went without essential items or activities due to shortages of money. At wave 2 and 3, those remaining in this group were presented with an identical list of items, as set out in Figure 14, and asked if they were better able to afford any of the items for their dependent child or children as result of CAB advice.

Those parents who were better off or more secure financially were included in the statistics as it would be unreasonable to expect their material situation to improve otherwise. At wave 2, 16 respondents with child care responsibilities were better off or more secure financially, whilst due to the reduced size of the sample just nine respondents were included at wave 3. This is a very small sample to draw

conclusions from but, nevertheless, some insights are gained. Data from wave 2 and wave 3 is presented to compensate in some way for the small samples and allow comparisons to be made between each wave of the study.

Figure 14: Items parents, who were better off or more secure financially, were better able to afford for their children at Wave 2

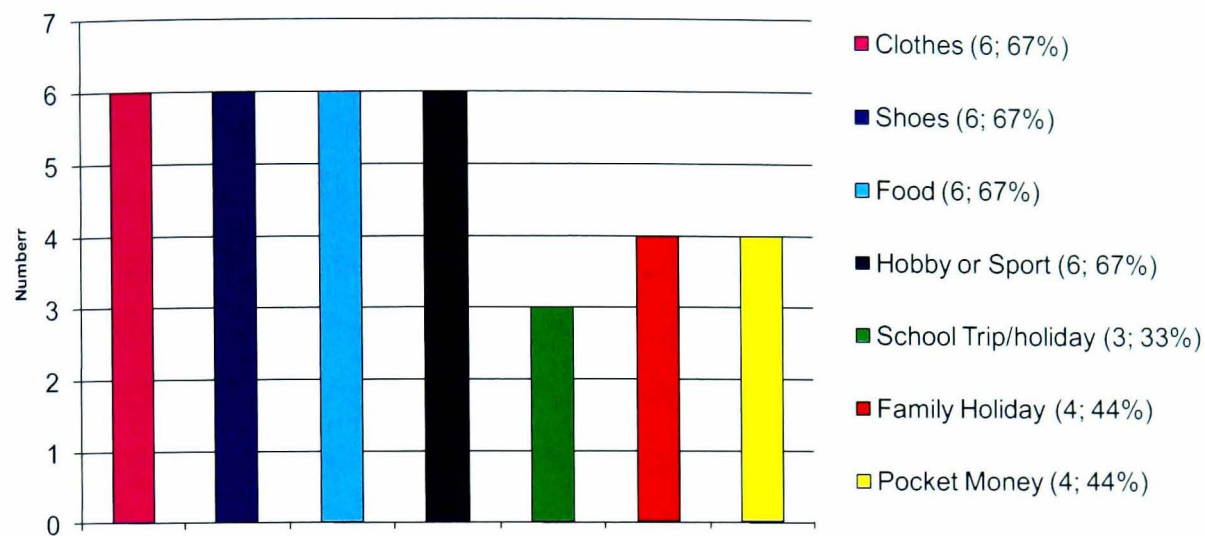


(n=16)

At wave 2, all of the dependent children cared for by the 16 respondents benefited from improvements in their parent's financial circumstances, as seen in Figure 14. A greater percentage of parents were better able to afford purchases of clothing, shoes and food, whereas spending on a hobby or sport was prioritised less, as was a trip or holiday arranged by school, a family holiday and pocket money. Nevertheless some children still benefited from increased affordability of these items.

At wave 3, seven out of the nine parents who were better off or more secure financially said they were better able to afford some of the items or activities for their children, as set out below in Figure 15. Clearly a greater percentage of the children of respondents participating at wave 2 benefitted than those at wave 3. Due to the small size of the samples it is not possible to draw any conclusions from this discrepancy.

Figure 15: Items parents, who were better off or more secure financially, were better able to afford for their children at wave 3



(n=7 out of 9)

Findings consistently illustrate how spending on clothing, shoes and food was prioritised. It was also found that whilst parents were better able to afford comparable items and social activities for their personal use, children gained more from the improved financial status of the parent, as indicated in data to follow.

Earlier evidence from the baseline study showed parents prioritised spending on their children, a greater proportion had reported going without items such as clothes, shoes, food and social activities on occasions, due to a shortage of money, compared to their children.

At wave 2 and wave 3, adults were asked if they were better able to afford a similar list of everyday items and a range of activities themselves, as a consequence of the outcomes of CAB advice. A comparison is presented here of items that parents were better able to afford for themselves compared to their children at wave 2. Due to the size of the sample at wave 3, this comparison focuses on data from wave 2 only.

The data relates to 15 respondents with children, who responded to the survey questions at baseline and wave 2, and reported that they were better off or more secure financially as a consequence of CAB advice. Three respondents who were not better off or more secure financially were excluded from this comparison as their

financial circumstances had not been affected by CAB advice at the time of data collection.

Whilst parents were better able to afford a range of items and social activities, their children clearly still gained more from the improved financial status of the parent. Parents and their children were equally as likely to be better able to afford purchases of food; this is logical as food purchases are more likely to be made for the family as a whole, whilst in all other instances children gained more from the improved or stabilised financial circumstances of their parent. Just one parent was not better able to afford any of the items listed, although none of the children were categorised here, therefore all of the children in this group benefited from the improved financial situation of their parent at wave 2. Due to the small sample with dependent children remaining in the study at wave 3, full statistical data is not provided although the outcomes found here were comparable.

### **Parents' views of the Impact of Advice on their Child**

Respondents with dependent children were asked to describe the difference (if any) CAB advice made to the quality of life of their dependent child or children.

Responses to this question fell into two themes, first - the benefits of living with “a less stressed mum!” second - having more money meant that parents were better able to provide for their child or children, as seen here:

“Less worry for me has meant less worry in the house for everyone. The financial advice has helped me to manage money better so I can afford to spend on his clothes and food.”

“Tom doesn't do without anymore now; I have more money to play about with. I've got a bit more money in my pocket. He goes swimming once a week now and does other after school activities.”

Because of improvements in their financial circumstances parents were happier and more relaxed and this shaped the emotional wellbeing of their children: “I'm not stressed as much, I am much happier so they are much happier.” An almost identical response was provided by this parent: “I am not as worried, so I am more relaxed around my children. The next response illustrates how family relationships improved:

“They have more attention, less stress. My 8 year old said to me the other day, ‘It’s nice spending quality time with you!’”

Outcomes assessed quantitatively were further verified by respondents who described in their own words how they were better able to afford to spend money on their child. As seen here: “I can now afford things for my children, money for school, clothes and food shopping.” And this parent also explained that she was: “able to spend more money on him and buy some luxuries.” Importantly though, the possibility of saving up for the child became feasible, as this parent explains: “a great deal, instead of me saying ‘no we can’t afford it’, it’s now ‘maybe’ or ‘let’s save up for it’.”

Clearly, due to the size of the sample, it is not possible to draw firm conclusions from these findings. It does appear though, that children benefit when their parent’s financial circumstances improve in a number of ways. This aspect of the study provides further insights into how money is spent in families and how resources are allocated between parents and children, particularly when their financial circumstances improve. The findings provide a glimpse of how advice can improve relationships between parents and children, which must have positive implications for the mental health of parents and the emotional wellbeing of their children. This phase of the research provides insights into the contribution advice services make to child poverty agendas and certainly also offers scope for further research.

### **Quality of Life - The Impact of Advice**

The impact of advice on the quality of life of individuals shines through in all aspects of the study. Earlier improvements in psychosocial aspects of health were verified in respondents own words. As a consequence of CAB help and advice, respondents noted a number of positive changes in the way they were feeling. It can be seen from Table 15 that respondents were most likely to cite improved peace of mind, less stress or anxiety, followed by increased happiness.



Table 15: Improvements reported by Respondents

	<i>Some or A Lot of Difference</i>
	<i>n (%)</i>
Peace of mind	35 (88)
Stress or anxiety	32 (80)
Happiness	29 (74)
Ability to enjoy day to day activities	28 (72)
Quality of life	28 (70)
Feelings of being isolated or cut off from society	22 (56)
Ability to get on with people	20 (51)

(n=39-40)

They were asked to explain these outcomes in their own words. Some people talked about feeling less isolated with their problems, and feeling part of society again, for example:

“Well instead of feeling you don’t belong to a society because you’ve got nothing, it’s made me feel we are all the same and do belong with the rest of the people, whether you have money or not”

“When you are walking around with such worries it is difficult to put them to the back of your mind. Now with the support of the CAB I don’t feel so isolated with my problem.”

Some simply appreciated “having someone to share problems with and talk to.”

Others noted “less stress from money worries.” And this person explained that “because of peace of mind and freedom of outstanding debt, we are enjoying our life much more.” Another noted: “I feel much happier and more myself and more secure. I’m not afraid to open the door or post.” This person simply noted: “peace of mind is worth a lot.”

The study showed that respondents enjoyed improved emotional states of mind and feelings of self belief as illustrated by Table 16. A noteworthy percentage noticed some or a lot of difference in the control they felt over their worries.

Table 16: Difference CAB Help and Advice made to Respondents

	<i>Some or A Lot of Difference</i>
	<i>n (%)</i>
Greater control over worries	36 (90)
More positive about oneself	32 (80)
Feeling more confident	28 (70)
Improved self esteem	26 (65)
More effective and useful	24 (60)
Feeling more assertive	24 (60)

(n=40)

These sentiments were expressed again in responses to open questions. Themes identified earlier emerge again – knowing how the system works, being aware of one’s rights, not feeling alone with problems, and being in control of one’s circumstances. Some noted that this made them feel better in themselves and not so alone with their problems; they were not so easily bullied by their bank or by creditors. One person said “I feel different” whilst another explained that “since coming to CAB my confidence has increased.”

### **Respondents’ Views of improvements to Quality of Life**

Respondents described in more detail the impact CAB help and advice had on their quality of life. Nearly all of the accounts contained some reference to money problems that were managed with the help of CAB. The relief they felt upon being free from money worries was expressed by respondents in terms of: less worry about money and financial problems or pressures, being more secure, having the situation under control, being better off financially. Many appreciated knowing someone was

there to talk to and to help with problems. For some this enabled them to move on and begin to rebuild their lives. Illustrative examples follow:

“As I said, it has taken an enormous financial pressure off me at present. I still owe the same amount of money. It has given me time to sort my health issues out, hopefully return to work, so I can start to rebuild myself a decent life and eventually repay the money I owe.”

“Taking CAB help and advice has made a big difference to our quality of life, although we both have health problems mainly brought on by stress and worry of our financial situation due to having to retire, due to health reasons. CAB gave us the advice and help to move forward and deal with our situation in a sensible and positive way.”

“Most of my money worries are being dealt with. I have a car so I can be taken out (when we can afford petrol), but I am still not able to afford extras, but we enjoy the free things in life.”

“I have more energy; feel less anxious and fearful about our future. I realise how much of my life and energy was taken up with worry about a situation I seemed not to be able to do anything about. Now I feel I can do something about it and I have been able to start dealing with my deafness and make adjustments which has helped both myself and my family cope with the situation. I feel relief and gratitude - my quality of life since I lost my hearing and earning ability and was drifted into debt.”

### **Learning from CAB**

It is reasonable to hope that as a consequence of receiving help and advice with their problems, individuals will gain some skills to enable them to deal with problems in the future. It is also hoped that they will have a better understanding of help that is available. This hypothesis was tested at wave 2 and 3 of the study.

Findings, illustrate that with the exception of one person at wave 2 all respondents felt they learnt to some degree from working with CAB. The entire sample agreed that they had had a better understanding of help that is available. Nevertheless, a small number said they did not feel better able to deal with problems in the future (five respondents at wave 2 and one person at wave 3). Overall, 62% agreed fully that they had a better understanding of how to deal with future problems. Although it appears that some will still need assistance with problems that may arise in the future, when put into context this is not altogether surprising. Based upon the severity of many

cases, it would be interesting to assess just how many people would be able to deal alone with such problems.

In response to open questions further insights were gained, some respondents resolved to be more self-assured and firm, for instance: “Have learnt to be more assertive.” Likewise this person said “To stand for my rights.” Whilst the others had a better understanding of help that is available: “Learnt that I am not on my own that there is someone there to talk to and help me.” Sometimes this could involve knowing where to go for practical help: “There is help out there if you know how to fill out forms and find your way through the system. As I am dyslexic it is very difficult for me to deal with all this.”

On a practical level, earlier findings were reaffirmed as some respondents explained that they had gained financial skills, as this person notes: “I’ve learnt how to deal with my money and how to solve my problems.” The same theme is covered in this response also: “Budgeting skills and finances, I am in greater control of my finances.”

## **Conclusions**

Statistically significant improvements found in the SF-36 domains of *Social Functioning*, *Role Emotional* and *Mental Health*, and in the *Anxiety* and *Depression* scales of the HADS at wave 2 were further verified when comparing scores across baseline, wave 2 and wave 3. Statistically significant improvements were found in the domains of *Vitality*, *Social Functioning* and *Mental Health* in the SF-36, and in the *Anxiety* scale of the HADS. Providing further evidence, respondents described a number of health related improvements. They felt better; they were less anxious, less stressed and less worried about money. Understanding and recognising individual experiences is important in order to fully value the contribution that advice-giving can make to health, as the context of the intervention is unique to each individual, their existing health status and circumstances. What is more, individual circumstances, problems and contexts are fluid; any outcome on health should be understood in this context, for it cannot surpass all experiences in the daily life of an individual.

Over the period of the study welfare benefits gains acquired for clients totalled £92,625.01, and £374,502.84 of personal debt was managed. Improvements to financial wellbeing meant clients were better able to afford a range of essential items such as clothes, shoes and food, and social activities for themselves, and for their dependent children, where applicable. Improvements to aspects of quality of life were discussed. Those with dependent children reported improved relationships with their children; they were more relaxed with their children. Some respondents noted a positive difference to their peace of mind, levels of stress or anxiety, happiness, ability to enjoy day to day activities, their quality of life, feelings of being isolated or cut off from society and their ability to get on with people. A number reported improved emotional states of mind and feelings of self belief. The entire sample at wave 3 said they had learnt from their experiences with CAB. Some learnt to be more assertive, they noted a greater understanding of their rights and entitlements, and some gained practical skills such as learning how to budget and solve problems. The findings illustrate the interconnecting web of interactions between financial resources, material disadvantage and social factors such as social isolation, social support and health. Consequently, improvements to the financial circumstances of the sample improved their lives in a number of ways.

## CHAPTER EIGHT

### Personal Experiences and Satisfaction with the CAB Service

#### The Importance of Access to Services

The research set out to learn about the personal experiences of individuals receiving CAB advice. It was hoped that this would lead to a better understanding of the issues that individuals may face in accessing the CAB service over prolonged periods of time, which are often associated with casework or specialist advice work. Such cases tend to be complex and lengthily.

Citizens Advice Cymru places Access to services as a key policy priority. In line with this improved access to public services was particularly topical at the onset of the study due to the publication of a series of documents by the Welsh Assembly Government, aimed at improving public service provision in Wales. First with its document: *Making the Connections* (2004) and with the action plan *Delivering the Connections* (2005). *Delivering Beyond Boundaries* (2006) set out a response to a review of local service delivery conducted by Jeremy Beecham published in his report: *Beyond Boundaries* (2006). Importantly, the key policy framework '*Making the Connections – Building Better Customer Service*' (2007) is aimed at all public service organisations in Wales. It is structured around five customer service outcomes or 'core principles' that aim to provide a 'Citizen Centred Approach'. The first 3 of these 'core principles' were addressed, in part, in this study.

Core principle one, access to services, was addressed in the baseline Study. Individuals should be able to find and access information and advice about services, which they can understand, in a timely manner. Core principles two, personal experience, and three, responsiveness, were addressed in wave 2 and wave 3 of the study.

It should be noted that this research did not set out to fully evaluate compliance with the Welsh Assembly Government framework. Nevertheless, it was deemed appropriate to investigate those aspects of respondents' experiences that relate to

specific elements of the Welsh Assembly Government Customer Service delivery plans, thereby supplementing various additional research activities being conducted by CAB and Citizens Advice Cymru.

### **Sources of Referrals at Baseline**

Evidence from the literature suggests that disadvantaged groups are likely to experience inequalities accessing services. A recent evaluation by the Legal Services Research Centre on debt advice outreach services found over half of respondents with a CAB within two miles of their home were unaware of this (Buck et al, 2009). A report from the Legal Services Research Centre highlighted the importance of telephone contact as an initial route to advice services and notes difficulties expressed by those attempting to contact the CAB by telephone. It concludes that barriers to advice services include poor opening hours and un-answered telephones in CABs (Pleasence, 2006). A situation of this kind can further aggravate economic marginalisation (Riddell et al, 2005). Although aware of advice services, research has found that the majority of people do not know how to access advice (Galvin et al, 2000: 278). Consequently referral to the CAB service was of interest in this study.

Baseline findings show that research participants accessed the CAB service predominantly because the service was recommended to them. Family or friends referred nearly a third of the sample to the CAB service. A combination of General Practitioners, health and social care professionals, health schemes, and other organisations referred a quarter of the respondents. Relationships with past customers were evident as 15% of the baseline sample was returning customers.

By developing partnerships and a good reputation, bureaux appear to have successfully raised awareness of their services more successfully than through traditional advertising. Only 6% had heard about the service as a result of publicity materials, which in these instances included television, yellow pages, a library and local advertising. This could also reflect diminishing revenue for such forms of advertising. The findings show that informal partnerships exist between bureaux and local organisations, particularly in the health sector.

Comparable findings emerge in the literature, for instance, Greasley (2003) noted referrals from family, friends, and a range of professionals, of whom 28% were GPs, although this is not altogether surprising as this study took place in a primary care environment. What is particularly relevant though is the very small proportion of the sample that cited publicity material as a source of information. Likewise, Stone (2006) found referrals were made by friends or family, the police, personal counsellors, council officers, GP's, wardens and a letting agent. Age Concern, the local Neighbourhood Policing Team, County Council and local prison all made referrals to the service. Similarly, though Caiels and Thurston (2005) found 37% self referred, the remainder heard about the service through what is by now a fairly recognisable list of sources.

Despite its national reputation as an advice service provider the majority of service users appear to have made contact after recommendation or referral rather than of their own initiative. Services that are designed to meet local need, perhaps inadvertently confuse potential customers with inconsistent opening hours, different drop in service opening hours, and systems of operation. For example, some bureaux only deal with priority debt whilst the majority deal with any debt problem.

Alternatively, as noted earlier in the literature, endorsement by professionals can dispel the worries a person may have regarding the advice process. Those taking a 'rights' approach can add to the legitimacy of welfare rights advice (Toeg et al, 2003), and no doubt other forms of advice such as debt. Similarly endorsement or referral from friends and family must also add to the legitimacy of a case and remove much of the stigma. This may explain why the majority of respondents were referred or had the service recommended, or were returning customers.

### **Access to and Satisfaction with CAB Services**

At baseline it was established that respondents received advice in a range of settings, including their home and secondary outlets, but the majority received advice in primary care locations or high street bureaux. Most made an appointment to see an



advisor although 25 people out of the baseline sample of 149 used drop-in services. Over half the respondents making an appointment saw an advisor within a week or less and 87.6% had seen an advisor within the previous two weeks.

Respondents rated access to the service highly, 94% (n=120) rated contacting CAB for an appointment as good or very good. This question was not applicable to those using drop-in services. It also materialised that 94% (n=129) rated the convenience of the location where they received advice as good or very good, and again 94% (n=128) rated information about the service as good or very good.

At wave 2 and 3 respondents were asked if they had found it difficult to access the CAB service for reasons which could make access problematic over a prolonged period of time. These included transport costs; public transport services; travelling distances; caring responsibilities; health or a disability; getting through on the telephone; and, the cost of telephoning. Responses from those remaining in the study at wave 3 were compared with their responses at wave 2, in order to track potential barriers to the service over the whole period of the study.

Health problems or a disability made access to the service very difficult or a little difficult for some respondents, as did caring responsibilities. Transport costs and travelling distances created difficulties for a small number of respondents at wave 2 but not at wave 3. A small number noted difficulties due to transport services, and also getting through on the telephone and the cost of telephoning. Whilst these difficulties are acknowledged, the majority did not find it difficult to access the CAB service during the 12 months since they first approached CAB for advice with their problem.

### **Experiences with CAB**

In order to further assess the quality of the service, at wave 2 and 3 research participants were asked about their experiences with CAB since referral at baseline. They were asked if they were well informed and consulted, if they were involved in sorting out their problem, and if they understood the advice provided.

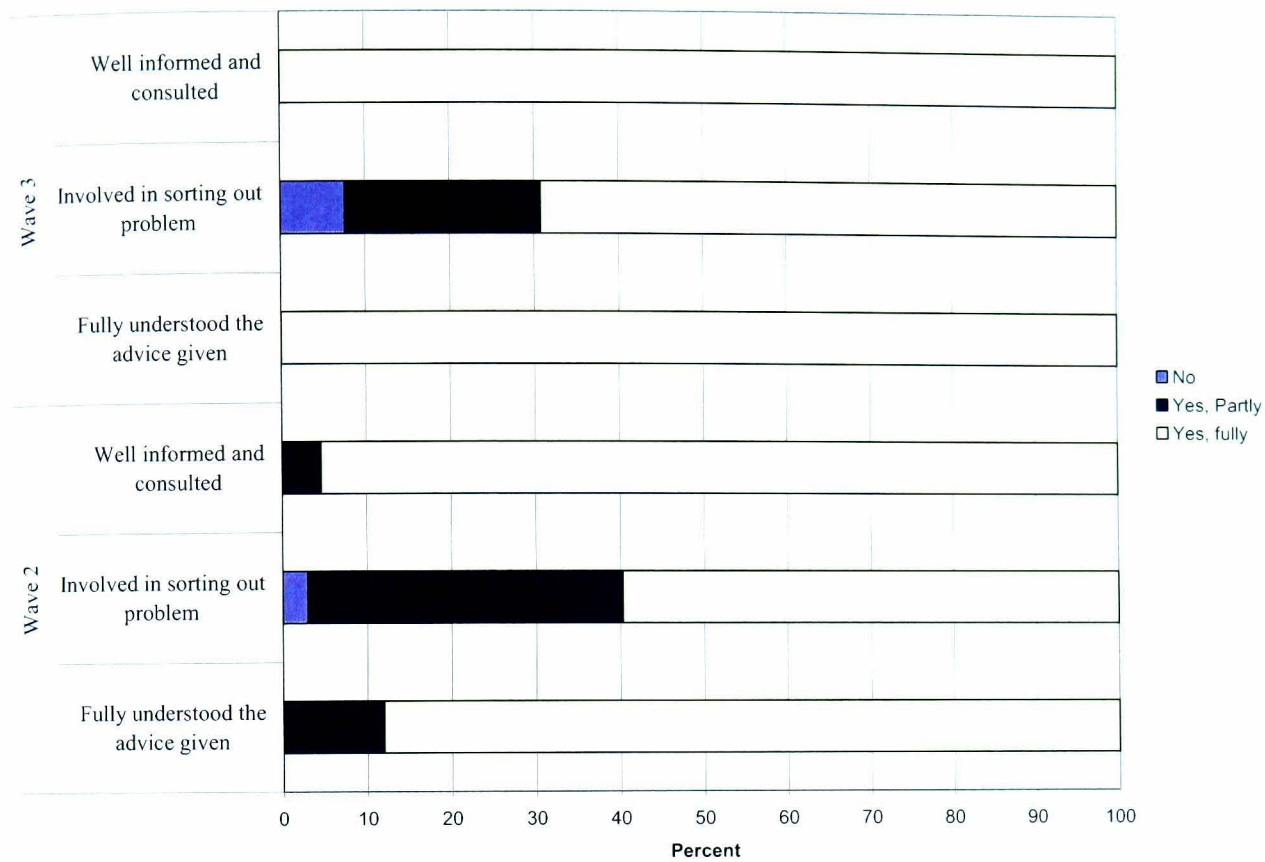
The results, displayed in Figure 16, show the entire cohort at wave 2 was kept fully or partly informed and consulted by their advising bureau. At wave 3 they all said they were fully involved and consulted.

Less favourable responses emerged when asked if they were involved in sorting out their problem. Three percent responded with 'no' to this question at wave 2, this equates to just 2 people, and 7% or 3 individuals at wave 3.

At wave 2 it can also be seen that a small percentage said they partly understood the advice given, whereas at wave 3 the entire sample said they fully understood the advice.

Overall, respondents appear to have had positive experiences with CAB. It is understandable that due to the complexity of client issues, advisors chose to involve some clients less, perhaps not wanting to worry or add to their stress, particularly in instances where clients already suffered with mental health problems or other illness.

Figure 16: Client Experiences of CAB during the Study



Although the data suggests generally high levels of satisfaction, there are a number of limitations to these findings. As data was collected by bureaux that respondents attended for advice the incidence of desirable responding is high. It is also likely that respondents felt grateful for the help they received, particularly as most were urgently in need of advice for serious problems. In such circumstances, social norms often make it difficult for individuals to criticise or complain (Borham and Gibson, 1978). It is difficult to ascertain to what extent responses were modified to meet the approval of CAB staff.

Literature concerned with customer satisfaction emerges first from marketing theory and is predominately based upon the business sector, although some contributions stem from public sector fields such as medicine and education. Nevertheless, interpretation of findings concerned with customer satisfaction and service quality are aided by aspects of marketing theory. Recently, organisational researchers' interests have also shifted towards customer perceptions of service quality, to predict customer satisfaction (Zabava Ford, 1998: 99).

For instance, communication practices which factor upon perceptions of service quality were proposed by Parasuraman et al (1985: 47) in exploratory research that led to a model of ten dimensions of service quality. Later the model was condensed to five dimensions and subsequently refined over the years (Parasuraman et al, 1988, 1991). Although administered in a wide range of private and public sector settings, the instrument received a number of criticisms. Acknowledged by Parasuraman et al (1994), there is a noticeable absence of expectation measures, and reports of problems with reliability, and validity. Nevertheless, dimensions used in the construction of the instrument have relevance to this research, and discussions about customer service satisfaction in general.

Of particular relevance are measures concerned with courteous or personalised communication practices. Also notably relevant to this aspect of the baseline findings, two key dimensions include 'access' to services and service 'responsiveness'. With regards to access to services, Parasuraman et al (1985) proposes services should be easy to access by telephone, waiting times for should not be extensive; services should be conveniently located and operate at convenient times. Responsiveness relates to the willingness of staff to provide the service; this means appointments should be set up quickly and telephone calls returned quickly. The literature has shown less favourable satisfaction is exhibited amongst those waiting longer for appointments, whereas once in consultation, quality of time spent is more important than length of time (Buller and Buller, 1987: 386).

Satisfaction, however, is also mediated by customer expectation and the gap between expectation and satisfaction determines whether a customer is satisfied or disappointed with a service.

“The quality that a consumer perceives in a service is a function of the magnitude and direction of the gap between expected service and perceived service” (Parasuraman et al, 1985: 46).

Therefore, the level of satisfaction a person expresses with a service is likely to be influenced also by their expectations of that service in the first instance, which may be affected also by the gap between actual standards of delivery and external

communications about the service (ibid). Where a person has few expectations, there is scope for favourable perceptions of service quality expressed in their level of satisfaction, as the distance between expectation and outcome is great. Conversely a service that is consistently outstanding has to continually find new ways of ‘delighting’ the customer as expectations will be high. Still, various interrelated factors contribute to perceptions, such as whether the provider exhibits affiliated behaviours or controlling behaviours, their communication style, and even their age (Buller and Buller, 1987). This is explained next.

### **Why Respondents’ followed CAB Advice**

In follow up surveys respondents described why they followed CAB advice, their responses were analysed thematically. For many, practical assistance such as form filling and liaising with creditors was critical. As noted by a respondent with dyslexia: “the advisor helped me to fill out the forms correctly.” On-going support and practical assistance was important for others. For example, one person explained how CAB “took me through start–finish re: bankruptcy,” whilst another commented on how they were “able to get feedback on progress.”

What emerged most clearly was the central role advisors play explaining problems and possible solutions to respondents; a theme identified in the second wave of the study also. Respondents were able to understand their problem and a range of solutions to the problem because of the clarity of explanations provided by the advisor. This was the most universal reason why respondents followed CAB advice. Illustrative of this theme, this person said: “advice was well explained and easy for me to follow.” Whilst another commented: “because it was put down in black and white, and I understood it – I needed a good kick!” This person said: “advisor easy to follow.”

The communication style of providers has been the focus of evaluations of service quality for some time. As long ago as 1976, Ben Sira argued that patient evaluations of doctors are largely affected by their evaluations of affective communication behaviour. Paying attention to interaction theory, in later research he stressed quality

interactions involving emotional support will influence service users' perceptions (Ben Sira, 1980: 177). Likewise, Parasuraman et al (1985) also argued 'empathy' with customers will influence their perception and subsequent evaluation of quality. Empathy is determined by the caring behaviour of the provider and individualised attention given to customers. The 'assurance' with which a service is provided will be dictated by the knowledge, courtesy and ability to inspire trust and confidence in customers.

Contributing to the literature in the field of health care, Buller and Buller (1987) found favourable satisfaction levels were associated with highly 'affiliated' doctors, whilst 'dominant' behaviour produced less positive evaluations. Reflecting, in part, personalised communication behaviours advocated by Parasuraman et al (1985), Buller and Buller drew on literature to conclude that affiliation can include

“behaviour that communicates interest, friendliness, empathy, warmth, genuineness, candour, honesty, compassion, a desire to help, devotion, sympathy, authenticity, a non-judgemental attitude, humour, and a social orientation relationships” (1985: 376) .

In light of this it is particularly relevant that when asked if they would recommend CAB to family or friends, respondents answers echo concepts from the literature:

“Yes, very much because you feel as if you have got someone there who can help. I feel as if I have become friends with my CAB caseworker as well. I feel as if I can just pick up the phone and she will be there to help and give me peace of mind.”

“Yes, because I find CAB people helpful, approachable, reliable, and friendly. I can depend on CAB to do what they say they will.”

Importantly, all respondents remaining in the final wave of the study said they would recommend CAB to family or friends, some had already made recommendations. Their responses bring to life relationships with advisors, and point to the important role advisors play supporting respondents emotionally and practically. Evidence from the literature shows service users appreciate the way staff deliver the CAB service and the respect with which they are treated, this elicits feelings of self esteem and a positive outlook (Waterhouse, 1997: 30). Comparable research has shown users note

the ease with which they can speak to their advisor and their helpfulness, interest and understanding of problems (Galvin et al, 2000: 280). These findings herein are supported further by research from the Legal Services Research Centre which reports on the 2006 English and Welsh Civil and Social Justice Survey. Eighty six percent of those who obtained help from a Citizens Advice Bureau said they would definitely or probably recommend them, this compares favourably to 73% of those using local council general enquiries services and 62% of users who would definitely or probably recommend law centre services (Pleasence et al, 2008).

Nevertheless, the positive qualities highlighted are not unique to the CAB service. Bell (2005: 7) also found users of a home and hospital visiting service in North Bristol appreciated the degree of support they received from advisors. Clients noted that nothing was too much trouble for their advisor and advisors were friendly and accommodating.

Possibly related to the nature of the work, individuals pursuing a career as an advisor appear to possess particular qualities, which many other service sectors spend considerable time and effort attempting to replicate. Customer service effectiveness has been the focus of many programs developed to improve empathy and social support in settings such as banking, hairdressing, fast food, and airline industries, to name just a few (Zabava Ford, 1998: 95-98). For CAB and other advice agency advisors though, a genuine interest in people and desire to help appears to come naturally.

### **Final Comments from Respondents**

Those participating in the final wave of the study were invited to provide their final comments regarding the CAB service. The question was deliberately kept fairly open, so as to prompt respondents to comment freely. They were simply asked ‘Is there anything else you would like to tell us about your experiences with CAB?’

Their responses reaffirm findings that emerge throughout the study, drawing on earlier precipitating events this person noted: “Very helpful, took away a lot of the

stress of being ill.” Whilst others talked again of their personal experience with CAB: “I always felt at ease when going to see them, [I was] treated like a human being, they were very helpful to me – always patient.” For some the help they received was life changing: “Changed my life, much more in control of my life.” Some felt unable to express this adequately: “I would advise CAB to anyone – I can’t explain fully enough what the help has done for me.”

Principally their accounts illustrate overwhelming gratitude towards advisors and the CAB service in general:

“Although we were very distressed at the time of our first visit, CAB made us feel the situation we were in was not entirely all our fault, as nobody can predict ill health affecting your entire life as it did with both my husband and myself. We will be eternally grateful and appreciative of their help to us.”

“A very friendly and helpful service - appreciate everything that has been done, very informative. I am so grateful that the outreach comes to St David’s as because of my health I would not have been able to travel to Haverfordwest.”

“I can only say thank you. Without them I know I would not be here to fill this survey for you.”

There is evidence here of what Titmuss called ‘social growth’,

“These are indicators that cannot be measured, cannot be quantified, but relate to the texture of relationships between human beings. These indicators cannot be calculated. They are not, as my friends the economists tell me, counted in all the Blue Books and in all the publications of the Central Statistical Office” (Titmuss, 1974: 150)

To what extent clients’ gratitude eclipsed perspectives of the service they received is unknown; it is likely that a somewhat more balanced, critical review of the CAB service would be elicited from those less grateful or less happy with the CAB service or the outcome of their case. It is also possible that those remaining in the study did so because they were happy and grateful for the help that they received, and obliged with the research as an act of thanks. Nevertheless, accounts capture examples of high-quality practice experienced by those with serious persistent problems, who had very positive experiences with CAB.



## **Conclusion**

Respondents explained that they followed CAB advice because advisors helped them to understand their problem and a range of solutions to their problem. Advisors were able to provide explanations in a clear language that was easy to follow. This was the most universal reason why they followed CAB advice. Advisors play an important role supporting clients both emotionally and practically, often over prolonged periods of time. Indicative of the high levels satisfaction expressed with the service, at wave 3 the entire sample said they would recommend the CAB service to family or friends. Although no major issues were raised regarding access to the service and satisfaction with the service, some respondents may have felt obliged to answer to provide socially acceptable answers to these questions.

## CHAPTER NINE

### Conclusions, Policy Recommendations and Future Research Directions

This chapter begins with a summary of empirical findings and emerging themes. Beginning at the baseline, the study set out to determine the demographic profile and social characteristics of the client group; their advice issues; financial circumstances; health; and adequacy of social support. It also sought to detect signs of social isolation. Findings from subsequent waves of the study are discussed thematically, first with a reminder of precipitating events, followed by a summary of the impact of advice on health, financial wellbeing, quality of life, and clients' personal experience with the CAB service. Reflecting upon the process and outcomes of taking a quantitative perspective some thoughts are provided on the strengths and limitations of the study. Importantly, underpinning this research was the aspiration that it would constructively inform policy and practice. In light of this a number of recommendations are made that it is hoped will be of interest to policy makers, advice practitioners and those responsible for planning and delivering advice services. The chapter closes with a discussion on possible directions for future research, and provides some final reflections upon the journey undertaken.

The findings illustrate that overall, the sample, with its particular emphasis on welfare benefits, debt and discrimination issues, involves clients from some of the poorest sections of Welsh society. This is evidenced by the disproportionately high number of respondents who live in rented accommodation compared with the national statistics for Wales and the significantly high proportion who were economically inactive. It is further underlined by the numbers who were dependent on social security benefits, state pension or tax credits as their main source of income.

One aim of the baseline study was to establish the problem issues for which this cohort sought advice. One unexpected key outcome of the baseline study was that at this early stage in the advice process many of those seeking help with debt problems lacked full knowledge of their financial circumstances and were unable or unwilling

to provide full details. Due to the level of response to debt questions, the findings provide an insight into clients' debt problems rather than an accurate depiction. In relation to welfare benefits issues, it is understandable that a person visiting a bureau for their first interview may only know that they want to apply for welfare benefits and they may not have full knowledge of the specific benefits which they are entitled to claim. Although the precise statistical results do not reflect the full extent of advice issues at baseline, this is not to say that the study did not meet its aim. Overall it does give a picture of the problems for which respondents sought advice.

One alternative interpretation could be that the baseline findings highlight the time, resources, knowledge, and skills necessary to resolve complex problems and difficult circumstances. This outcome provides revealing insights into the complexity of the casework problems and captures the situation as individuals enter the advice process for the first interview with a caseworker. Many respondents appeared to lack basic but essential knowledge of their financial circumstances and commitments.

Furthermore, significant numbers required help with multiple problems. From a CAB perspective this highlights the situation advisors confront in unravelling client problems on a daily basis and the particular challenges in terms of staff time and resources. A situation of this kind also creates challenges for researchers.

Signs of financial difficulty were clearly evident. In total, 90% of the baseline sample reported some level of difficulty when asked how they were doing financially. Ninety one percent reported going without essential items such as clothes, shoes, food, heating, and a range of social activities because there were times in the previous year when they could not afford these items or activities. Over a quarter had borrowed from friends, 60% had borrowed from family, and 15% had borrowed from doorstep moneylenders in the past year. In addition, 113 reported being behind in paying within the time allowed for a total of 233 items in the past year. These do not include multiple commitments in each category such as multiple credit card arrears or current debt problems. There was considerable evidence that a substantial proportion of the sample was poor and struggling financially to buy essential items and pay within the time allowed for others.

From the baseline findings, we gain illuminating insights into the daily struggle of being poor. The document: 'Wales: A Better Country' (2003) aims to:

“take action on social justice that tackles poverty and poor health, and provide people and their communities with the means to help themselves and break out of the poverty trap” (Welsh Assembly Government, 2003: 4).

Based upon the findings from the baseline study there is clear evidence that bureaux deal with vulnerable groups with multiple and complex problems. The findings suggest that many of these individuals experience regular difficulties.

Of relevance to the Welsh Assembly Government child poverty strategy 'A Fair Future for our Children' (2005) are findings that relate to the key areas of concern regarding income poverty, participation poverty and service poverty amongst children. The baseline study found 82% of those with dependent children reported their children had gone without essential items such as clothing, food, heating, and social activities on occasions in the past year due to a shortage of money. With the exception of one respondent, those who claimed their children 'never go without' clearly experienced severe financial difficulties. Furthermore, 62% relied on social security benefits or tax credits as their main source of income and two families reported that they had no income at all. Sixty percent lived in rented accommodation including one couple in temporary accommodation. This is more than double the average for households in Wales. Therefore, the findings indicate that these children were either living in poverty or at high risk of doing so.

Health data from the baseline study indicated high levels of morbidity in the sample. This is evident in the disproportionate number reporting long-term health problems (compared with Welsh statistics) and the number of clients reporting a range of health problems and conditions. In terms of social support, the findings indicate that significant numbers of clients received thin social support and over half reported feeling isolated or cut off from society in one or more situations, the most common situation being a lack of transport followed by irregular or expensive public transport. In addition, 57% reported feeling cut off or isolated from society due to the problems for which they sought advice from CAB.

The baseline findings provide insights into how CAB services in Wales support Welsh Assembly Government social policy agendas. This can be seen, for example, in the contribution bureaux make to dealing with over-indebtedness in Wales. By responding to the most vulnerable and hard to reach sectors of society it is argued that the CAB service supports the Welsh Assembly Government's public service plans, and contributes to the Welsh Assembly Government's strategic agenda to deal with poverty and poor health, as set out in the document 'Wales: A Better Country' (2003), and in its health action plans. However, operating within the restraints of funding and staffing capacity it is not possible to claim that bureaux reach out to all those that are vulnerable in Wales and it is likely that there is considerable unmet need.

The baseline study highlighted the complexities of conducting research across a large geographic area with a large number of independent bodies. Increased participation by some bureaux, leading to a larger sample of clients, would have significantly strengthened the study. Nevertheless, the project was deemed viable to contribute useful data in the academic field and to provide Citizens Advice service with further evidence of the benefit of their service. Certainly from a methodological perspective it should provide useful insights for researchers.

In subsequent waves of the study the key objectives were: to measure changes in dimensions of health using the SF-36 and HADS to determine if the health of clients improved over time between baseline, wave 2 and wave 3 of the study; to report findings, such as gains from welfare benefits, management of debts and other outcomes; to analyse how changes in respondents' financial circumstances impacted on aspects of personal spending, and spending on their dependent children (where applicable); to learn how CAB advice impacted on the quality of life of respondents and their dependent children (where applicable); and, to identify how they heard about and accessed the CAB service at baseline; to identify levels of satisfaction with access and information about the service; to specify the factors that influenced the decision to pursue the advice provided by CAB; and to explore their personal experiences of working with CAB to resolve their problem(s).

Findings from wave 2 and 3 of the study illustrate that the CAB service provided vital advice and support to this cohort at a critical time in their life. The findings support those published by Pleasence et al (2007b), which highlight how serious and persistent problems impact on an individual's health and quality of life. This is particularly evident in the case of those with serious financial worries and/or personal debt problems.

By incorporating health outcome measures it was possible to provide a quantifiable measure of the impact of advice on the health of individuals. Consequently the results build on a body of existing research. Statistically significant improvements were found in the SF-36 domains of *Social Functioning*, *Role Emotional* and *Mental Health*, and in the *Anxiety* and *Depression* scales of the HADS at wave 2. At wave 3 statistically significant improvements were found in the domains of *Vitality*, *Social Functioning* and *Mental Health* in the SF-36, and in the *Anxiety* scale of the HADS. These findings build on statistically significant findings reported in previous research by Abbott (1999, 2002) and Greasley (2003).

In light of the serious and persistent nature of the problems for which respondents sought advice, there is good evidence from replies to the open questions that these problems had a serious the impact on their lives. In a discussion of the afflictions of inequality and the psychological causes of illness, Wilkinson argues:

A sense of desperation, bitterness, learned helplessness or aggression are all wholly understandable responses to various social, economic and material difficulties. Prolonged stress from any of these sources is often all it takes to damage health" (1996: 184).

Consequently, it is not to be expected that improvements to a person's financial wellbeing will reverse the cumulative effect of their difficulties over a relatively short term of six or twelve months. However, improvements to material wellbeing may in the long term enable a person's physical health to improve because of the effects of a healthier diet, better heating, and being able to afford trips out from time to time.

Relief from the stressful circumstances in which individuals lived can be seen in improvements to their psychosocial health. Statistically significant improvements seen in test results clearly point to an association between health and advice and improvements found in the SF-36 and HADS results. These were further confirmed by respondents' explanations about 'feeling better', and being 'less stressed and anxious'. Improvements to the SF-36 domain of *Social Functioning, Role Emotional and Mental Health*, and in the *Anxiety and Depression* scales of the HADS at wave 2 and *Vitality, Social Functioning and Mental Health* in the SF-36, and in the *Anxiety* scale of the HADS at wave 3 show that the association is found in psychosocial domains of health as opposed to physical health. It is interesting to note here that the effect on the Role Emotional domain was not maintained at wave 3, but it was seen in Vitality instead.

There is evidence here is consistent with previous research that illustrates health gains associated with welfare rights advice. The present research shows that such an association exists also in the context of debt advice. Most importantly, the persistent and complex nature of debt and the impact it has is expressed in the words of respondents and their explanations regarding the impact of CAB advice on their lives.

These findings could be taken as one further illustration of how CAB services support the Welsh Assembly Government's strategies for tackling the underlying socioeconomic causes of health inequalities. However, continuing research is needed in this area, especially as the Welsh Assembly Government is currently renewing its commitment to improve health and tackle health inequalities in Wales. The technical working paper 'Our Healthy Future' recognises the challenge. It states:

“Inequalities in health and wellbeing between different areas and social groups are proving extremely resistant to policies and actions which seek to narrow the gaps” (2009, 13).

Consequently, it has adopted a dual strategy for action in its document 'Targeting Poor Health' that includes measures to tackle socio-economic determinants of health inequalities as well as action to reduce inequalities in access to services within the NHS. Whether advice can reduce inequalities in the long term remains to be seen.

Much longer term evaluations would be needed and then, of course, the effects of the advice intervention would be difficult to isolate. However, there appear to be grounds to suppose that alongside numerous other approaches, advice services can make some contribution to this cause.

With regard to aspects of the study concerned with the financial benefits of advice, results were recorded for 47 respondents, some of whom were still awaiting further outcomes at the twelve month data collection point. It should be noted that some bureaux were not particularly organised in providing this data, so it is likely to be indicative rather than complete. Over the period of the study welfare benefits gains totalled £92,625.01, and £374,502.84 of personal debt was managed. Consequently it can only be claimed that the data provides a selection of outcomes. However, in light of substantial existing evidence regarding the financial outcomes of welfare rights advice (Adams et al 2006: 13) and evidence from the literature concerned with the outcomes of debt advice, the study contributes to the strong body of evidence to show that advice leads to significant financial benefits.

This research builds in another way on previous studies. As seen in the literature, many previous evaluations have focused on advice services in primary care; they illustrate that older populations and those with poor health or disabilities benefit most from these advice services. With its focus on families with young children, research by Reading et al (2002) contributed further insights into evaluations in primary care settings, by showing the range of outcomes for a somewhat younger group. It found a wider range of outcomes. For instance, in addition to recurring welfare benefits, respondents received one off payments, debt management and rescheduling, legal actions and outcomes relating to housing changes. It is hoped that by drawing a sample from a broad range of age groups, this study illustrates also that the financial outcomes of advice are not specific to certain age groups, although they may benefit in a number of different ways from advice for problems that present more frequently at certain points in the life cycle. Consequently, future evaluations could consider the life cycle needs of particular groups, and a more detailed analysis of associated outcomes which may in future facilitate new targeted advice services.



It was anticipated that the research would lead to further insights into how financial gains may improve material and social wellbeing. In keeping with Moffatt (2004, 2006a, 2006b), the findings show that as a result of improvements to their financial wellbeing, a number of improvements to material wellbeing occurred. By providing a 'before and after' perspective the research illustrates how respondents were better able to afford essential items such as clothes, shoes and food, and social activities for themselves, and for their dependent children, where applicable. However, so as not to overburden respondents the number of question response sets was limited to key items such as clothing, food, shoes etc. Continuing research in this area could adopt a wider range of items and draw further on items that form deprivation indicators. This would provide a more complete picture to build on what has been achieved here.

On this theme but opening a new avenue, the findings begin to explain how advice contributes to the material wellbeing and quality of life of dependent children of clients, who appeared to be at risk of living in poverty. Aspects of material and social deprivation eased as financial circumstances improved. As a consequence of advice, families were better able to afford a range of day to day items for their children and they were in a better position to pay for some social activities such as school trips, sports and holidays.

Providing further insights into improvements in family relationships discussed by Pleasence et al (2007b), interrelated outcomes, not measurable in quantifiable terms, showed that family relationships improved, parents were happier and more relaxed with their children. These outcomes build explicitly on research by Reading et al (2001, 2002) who explored advice targeted at families with young children. They found that the birth of a baby brought about considerable financial and social stress that had consequences for mothers' mental health and the wellbeing of their children. In addition to acknowledging the value of CAB on material wellbeing, their findings also pointed to positive effects on maternal and child health. Due to the small size of the samples in the aforementioned study and in this research, the findings to date are not yet conclusive, although there appear to be good grounds for directing more interventions with material and social benefits to families. Much more research is needed in this priority area.

It is evident that interventions of this kind make an important contribution to policy for children and families. More targeted services of this nature would potentially contribute to a range of policies, for example, the new Welsh Assembly Government Integrated Family Support Service (IFSS, 2009); the child poverty strategy (2005) and child poverty implementation plan (2006); plus proposals in the One Wales programme of government (2007) and most recently the agenda for action for children in severe poverty in Wales (2008); the National Service Framework for Children, Young People and Maternity Services (2005); and, policies for children and young people that address key determinants of health and wellbeing, such as educational attainment, child poverty and parenting skills. In light of these findings it is feasible that advice services can support the realisation of some of the core aims of the Welsh Assembly Government's Proposed Rights of Children and Young Persons (Wales) Measure (2010) adapted from the UN Convention on the Rights of the Child and linked to which are its Local Authority Children and Young People's Plans for the years 2008-2011.

Naturally there is scope for much more research and policy development in this area. It is hoped that this aspect of the study may revitalise interest in the potential benefits of advice for families with children, initially formulated by Reading et al (2001, 2002), and open new avenues of future research.

Findings from wave 2 and 3 suggest that as a consequence of advice and the outcomes of advice, respondents' quality of life improved in a number of ways. Some noted a positive difference to their peace of mind, levels of stress or anxiety, happiness, ability to enjoy day to day activities, their quality of life, feelings of being isolated or cut off from society and their ability to get on with people. Others enjoyed improved emotional states of mind and feelings of self belief. Though it was not possible to quantify all of the outcomes of advice, it emerged that some gained a better understanding of financial matters; they learnt how to budget and gained problem solving skills. This supports the evaluation of debt advice by Orton (2008, 2009b, 2010) and uncovers potential areas for further research, namely the educational and capacity building impact of advice.

In light of the WAG actions plan 'Making the Connections - Delivering Beyond Boundaries: Transforming Public Services in Wales' (2006), it is argued that the findings show that CAB services respond to the most vulnerable and hard to reach sectors of society. There is evidence of some flexibility in their provision based upon the range of settings in which clients received advice, including primary care settings, high street services, secondary outlets and the client's home. The WAG plan advocates partnership approaches to service delivery in Wales, which the findings suggest already exist between CABx and a variety of partner organisations, particularly those in the health sector. Developing advice services in a range of other settings would build on what they have achieved so far, particularly their achievements within primary care services, and enable the service to reach out to many more sections of Welsh society that are in need. As discussed already, families with young children may be one group that could benefit from such targeted services.

Respondents expressed high levels of satisfaction with information about the service and access to the service. It is argued that the findings showcase many of the unique strengths of the CAB service but this is not to say that it does not have its flaws. Buck et al (2008) drew attention to the difficulties people generally face in obtaining advice for legal problems. Whilst some deal with their problems independently, others do nothing themselves and rely entirely upon advice, and there are those who try but fail to obtain advice. The considerable difficulties people experience accessing debt advice was also highlighted by Orton (2008).

Whilst this research found that CAB clients generally found access to the service easy there is clearly considerable unmet need. As a key policy priority, Citizens Advice acknowledges the need for improved access to its service and as part of its Access Strategy it will launch a new 'Gateway' system, which was piloted in 2009. Through a central telephone line callers will be assessed and directed to the most suitable source of help, whether this is the online 'advice guide' or an appointment with a local CAB advisor, for example. During the three years of this study, research presentations at regional forums coincidentally coincided with talks on the Access Strategy. It has to be said that these presentations were not met with universal

enthusiasm. Consequently, to be successful in achieving its targets for access to the service Citizens Advice must gain buy in and co-operation from Bureaux.

Due to the complexity of cases and prevalence of multiple problems, one positive aspect from the findings was that bureaux were able to provide a holistic service; advisors were able to provide advice on a range of issues. Crucially, the findings bring to light the important role of specialist casework advisors, who were highly skilled at explaining problems to respondents and setting out a range of solutions using straightforward language that they could understand. These particular advisors had the ability to reassure clients that solutions to their problems were achievable. Casework advisors deal with complex problems that take time to unravel and resolve. It is evident from clients' textual responses that many advisors went beyond the requirements of the job; they provided considerable emotional and practical support to clients over prolonged periods of time. Once more, there are parallels with Orton's findings here (2008).

Reflecting upon the value of taking a quantitative approach, there have clearly been a number of benefits, although that is not to say some areas of the study could not be improved. A critical reflection of the approach adopted follows, starting with aspects of intrinsic worth.

By adopting a quantitative approach it has been possible to build on a corpus of previous research and more specifically to build on the findings of improvements in health found by Abbott and Hobby (1999, 2002) and Greasley (2003). Results from validated health outcome measures provide comprehensive data that shows significant improvements occurred in the health of those receiving advice for their problems. This aspect of the research contributes additional findings that build on and extend the work of others in this field and allow for further replication of this model.

Adopting a longitudinal approach it has been possible to track respondent outcomes in a number of additional key areas, most notably changes to financial and material wellbeing and quality of life.

Researchers adopting mixed method approaches have argued for the benefits. Through face to face interviews they have gathered qualitative data to allow them to interrogate data sets acquired through quantitative measures (Moffatt et al, 2006b). It was not possible due to financial and time limitations to undertake qualitative research as part of a mixed methods approach, which would have been the preferred option. However, by incorporating open questions into the questionnaires administered at wave 2 and wave 3 new avenues of interest could be investigated and this facilitated a deeper understanding of some quantitative responses. While it is said that the positivist paradigm underpins quantitative methods and the constructionist paradigm lies beneath qualitative methods (Howe, 1988), it would be erroneous to suggest that particular research designs can only be equated with quantitative or qualitative methods and that adopting a quantitative approach will result only in statistics with no credence attached to subjective meanings or the context within which individual experiences play out (de Vaus, 2001: 10). It is hoped that this thesis illustrates that quantitative research can tap into some of the feelings, thoughts and experiences of research participants, albeit through the inclusion of open survey questions.

The findings from these open questions provide illuminating insights into the circumstances of respondents at a critical time in their life, facilitating our understanding of how serious and persistent problems impact on an individual's health and quality of life. This is particularly evident in the case of those with serious financial worries or personal debt problems. Through open questions it was possible to gain insights into precipitating events that respondents cited as causing or triggering their problems. Capturing their experiences and tapping into previously undisclosed fears, the reader is transported to the world of the poor and the life of the debtor. Emerging from the advice process, the study provides a longitudinal account of the impact CAB had on respondents' lives. Empirical findings are supported by the insights gained from explanations provided in respondents own words.

Despite the clear evidence for many positive outcomes, this project was bounded by a number of practical limitations and some methodological problems that will be discussed next.

Some interesting insights were gained into the circumstances of children living in low income households that clearly struggled to make ends meet. As a consequence of advice, the lives of these children were enriched in a number of ways. Greater financial security led to improvements in their material and emotional wellbeing and parent's reported improved relationships with their children. However, due to the small number of parents with dependent children participating in the whole of the study, these findings do not provide a definitive account. It was always expected that this would form a small aspect of the study and it is now hoped that this will set the scene for potential new areas of future research.

Access to the CAB was not particularly problematic for this sample but previous research has demonstrated that many people face difficulties accessing advice services. Admittedly the study does not account for those who may have withdrawn from the research (and advice process) because they couldn't get through to an advisor or found it costly to visit the bureau. Those participating in later waves of data collection may have developed strategies that made access easier. Additionally, awareness of CAB in local areas was not considered or any measures of unmet need assessed. Consequently, a full and thorough evaluation on issues of access could reveal much more on this topic. In the mean time bureaux should continue with their efforts to improve access to their services.

Aspects of the study concerned with discrimination appealed to the interests of some steering committee members involved in the early formulation of the research. The aim to 'pick up' bureaux with employment caseworkers and others that had discrimination caseworkers by incorporating 'discrimination' as an advice category for inclusion in the study was somewhat limited in scope. Whilst this provided some support to a funding application that was imminent at the time, much more research could be done in this area.

The sampling process proved to be the greatest challenge and at times resistance from bureaux formed the greatest threat to the project. It was hoped that all 32 bureaux in

Wales would participate in this study.<sup>8</sup> The rationale for this approach was underpinned by the need to fulfil the requirements of the project brief to incorporate all bureaux and also to ensure a random sample of bureaux was included in the project.

Previous experience has shown that bureaux are extremely busy and under enormous pressure to deliver their services to their clients. At the end of the project it transpired that previous larger studies undertaken by Citizens Advice Cymru have offered assistance, support and incentives to help bureaux with the collection of research data. They included, for example, an evaluation of the BABH service in Wales. Conducted by Borland (2004), this project rewarded participating bureaux with extra funding. Unfortunately this information was not divulged in the preparatory stages of the present research. By comparison, this smaller-scale PhD study operated with very limited resources and therefore the option of offering rewards was not possible.

Despite the hard efforts of the researcher and Steering Committee, ultimately the sample consisted of clients from 19 member bureaux in Wales, some of whom joined the project at a rather late stage and provided smaller samples of clients than had been anticipated. Many lessons have been learnt from this experience. Researchers should be aware that voluntary participation by a large number of independent bodies requires considerable efforts on the part of the researcher and can be problematic. Despite these limitations, a good number of bureaux, located throughout Wales participated in the research.

Having reflected upon the results of the study and the contribution it may make to the literature, a number of implications for policy and practice are discussed in more detail. The findings have implications for the current provision of advice and for ensuring future needs are met. There are also implications for public policy bodies in Wales and across the UK in terms of the contribution that the work of advice services makes to policy priorities, for example, the Welsh Assembly Government's policies

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<sup>8</sup> 32 member bureaux existed at the onset of the research, one of these closed during the study.

that aim to tackle social justice, poverty and poor health, and social and financial exclusion.

It is evident that the Citizens Advice service and its Bureaux operate in an uncertain environment. During the three years of this study CAB services experienced considerable changes and ongoing threats to their funding streams. Recent changes have included transforming civil legal aid. In 2010 new contracts will be introduced which will determine the way services are bought and paid for by the Legal Services Commission. The introduction of 'best value' tendering is advocated as a way of providing viable quality services (Legal Services Commission, 2008).

Recently, there have been demands for greater accountability and evidence of the impact and effectiveness of debt advice. Consequently, the future for advice services is likely to be increasingly competitive and demanding.

A recent report by the Public Accounts Committee (2010) on the Department for Business, Innovation and Skills strategy for those with debt problems claimed:

“There has been a complete failure to manage delivery of the strategy. No one is in charge of the strategy, groups intended to oversee it have not met, and there has been no reporting on its progress since 2007. The strategy has not been evaluated to assess whether the policy goals have been achieved and the Department does not know how effective the interventions making it up have been” (House of Commons Public Accounts Committee, Standing Order No 148, 2010: summary).

While the Committee acknowledged that the department was successful with its debt advice project, delivered by Citizens Advice and other third sector organisations, it concluded that the “Department does not even know which are the most and least cost effective of its own interventions.” Raising concerns regarding disparity in the cost of providers, it called for a better understanding of cost, appropriateness, and effectiveness of each delivery channel; greater consideration of the quality of the advice provided and the contribution that private sector advice could make in the future; and it raised concerns as to whether debt advice services are targeting those most in need.



It is hoped that this research may go some way to providing such evidence and stimulate some shifts in thinking that will shape future policy directions. Nutley et al (2007) argue that agencies involved in research advocacy, such as charities, can actively shape public opinion, lobby policy makers and consequently re-shape the policy context. They note that beyond the narrow confines of government is an array of policy networks that seek to shape policy. However, taking this approach involves a shift away from ‘modernising’ approaches based on central control and rationality, criticised as reductionist by some (Hudson, 2006: 14), to approaches that are more democratising and enable a greater diversity of voices and views to be heard (Parsons, 2002; Sanderson, 2006). Expanding on this Nutley et al explain:

“ Broader models of policy making open up more radical opportunities for research to have an influence, moving beyond expectations that it will simply support or refine current policy preoccupations to a hope that it will challenge those preoccupations or even stimulate paradigmatic shifts in thinking” ( 2007: 262).

If the Welsh Assembly Government is to be successful in achieving its long term strategic objective to tackle poverty, poor health, and inequalities that exist between socio-economic groups, it may have to consider innovative new ideas and ways of thinking about policy and its future implications. It will need to give adequate recognition to activities that involve “...looking beyond a single future to the implications for today’s decisions” (Horizon Scanning Centre in Bochel and Duncan, 2007: 35). While this alone will not result in a forward looking policy it can improve resilience and strengthen the adaptability of strategic plans and priorities.

The findings from this research highlight the need for financial capability provision for adults to help them to identify and address their problems at an earlier stage. The formulation of the Public Legal Education and Support Task Force (PLEAS) may go some way to improving the legal education of the public by raising awareness, providing the means for self-help and improving legal capability, community development and law reform.

The PLEAS Task Force makes a strong case for future directions, in its report of 2007, for the development of a new and independent non departmental public body to

act as a high level strategic body to focus on the implementation of the Public Legal Education (PLE) strategy. It argues that “no existing organisation has the breadth of remit to take on the strategy” (PLEAS Task Force, 2007: 25) and Citizens Advice, in keeping with other advice agencies, it claims, is too narrow to take on and drive it.

Consequently it advocates the creation of a new independent body to secure government funding and implement long term strategy. Facilitating awareness, knowledge and understanding of rights and legal issues, the Public Legal Education Centre would help people gain confidence and skills to deal with disputes, gain access to justice by recognising when support may be needed, and the sort of advice available and how it might be accessed. In doing so, it hopes to dispel myths surrounding the ‘legal’ and help people recognise how the law can be used, for example, in dealing with debt problems. It is argued that approaches that heighten understanding between access to justice and social inclusion agendas, and greater alignment with broader government objectives, will help those currently experiencing social exclusion and prevent others from slipping into social exclusion (Genn, 1999).

Naturally, any policy that aims to facilitate equitable access to civil justice is to be commended. Whether the creation of the new independent body will assuage social exclusion in the longer term remains to be seen.

Importantly, in planning future directions those responsible for funding service provision should note further recommendations in the PLEAS Task Force report (2007). It identified a number of strategic tasks that include the need to develop good practice, secure sustainable funding and find ways to overcome the existing fragmented nature of advice provision. Arguably, short term funding does little to cajole advice providers to aim in the ‘same direction’ or at the very least not to undermine each other’s work (Mulgan, 2005: 1). Thus directions for ‘joined-up policy making’ (Cabinet Office Strategic Policy Making Team, 1999) need to support advice services to work alongside each other complementarily, as opposed to operating in competition with each other for scarce resources.

While UK policy reviews of 2006/07 appeared to mark a move away from joined up approaches to personalised services driven by user choice - and the option of market exit (Parry and Kerr, 2007: 135), there is still undoubtedly a requirement for cross cutting programmes. This can be seen in Wales in Beecham's 'citizen' model of services that centres on partnership approaches in which "citizens receive high quality, personalised, joined-up services, planned across organisational boundaries" (Beecham, 2006: 6). Consequently, sustainable funding that enables such endeavours must be made available. However, this should take account of problems advice services face in gaining 'new' funding. In order to illustrate the difficulties created by current funding approaches, the organisation AdviceUK described a typical situation that arises when funding is allocated to Local Authorities or Local Authority organisations, the response from these Local Authorities is often "Ah, there is £100,000 coming in, so we will cut money correspondingly", or alternatively, "No, we will not cut your organisation's funding, but we will cut another organisation's funding" (Pearson, 2005, 5). Facilitating a more joined up approach that genuinely directs 'new' funding to advice provision is needed. High quality advice services can only plan future provision and joined up approaches with sustainable funding.

Unity within the service will be of the essence in the coming years for the continuance of the CAB service as new competitive tendering for the provision of advice services gains momentum. In a climate where demand for debt advice currently outstrips the Department for Business, Innovation and Skills capacity, the environment in which Citizens Advice services operate will require full co-operation from bureaux to provide evidence of the effectiveness and quality of their service. This will be crucial in meeting the requirements of the Public Accounts Committee and other funders of their services.

In the mean time, maintaining a high quality service and sustaining the effort to improve the number of clients able to access the CAB service remains vital.

On the wider topic of financial inclusion much more can be done. While it is beyond the scope of this thesis to offer a comprehensive discussion on the issue, it has been recognised in the literature that exclusion from mainstream banking services

contributes to financial exclusion. It has also been argued by those concerned with financial inclusion that “basic bank accounts are one way, but a more refined approach is also needed, where Citizens Advice Bureaux, local authorities and banks work together and follow individuals through the process” (McFall, 2005: 7). Contributing to the debate, Jones (2005: 5) supports the argument herein that there is “no one easy solution to tackling financial and social exclusion. One issue that needs to be stressed is support. Advice without support is meaningless.”

Importantly, in planning future advice service provision, the research carried out here should act as reminder that services should always bear in mind those aspects of service delivery which were most valued by clients – time, personal care and a willingness to address the person and not the ‘problem’. These findings augment recommendations made by a leading authority on civil justice, Professor Hazel Genn (1999) who has argued for the need for a refocus on the development of ‘customer’ orientation and services designed to meet the needs of citizens.

Underlining the practical nature of advice, a vital aspect to be considered is the way in which advice interventions can build relations to the most vulnerable that make a lasting difference to their ability to deal with the realities of their circumstances. For those with debt problems there is evidence from this research that supports the view that “advice is not just about debt resolution; it is also about giving people the support to enable them to control their future and not get into debt” (Perchard, 2005: 7). The findings from this research underline the relevance to the client’s life of the current service including their confidence and trust in the service and their identified appreciation of the ongoing nature of the support offered when appropriate. Trust is vital if clients’ are to feel at ease and articulate their problems (Buck et al, 2009). These findings indicate the need for the service to continue to deliver face to face advice, which can devote adequate time to individuals from outreach and other venues if the service is to continue to deliver the outcomes for clients identified in this study. Advice in trusted locations is important (ibid).

In addition the findings are a reminder that clients using the service are often unable to describe their problems fully or, for example, necessarily identify the extent of their

indebtedness, prior to the intervention of an adviser to help them. This has a number of implications for service delivery due to the complexities of the lives of many clients. The need continues for Citizens Advice to maintain its approach to clients as individuals with a range of potential problems. The compartmentalisation of subject areas of work needs to be avoided so as to ensure the best service possible for clients. Policy must recognise the specific needs of clients and the complexity of their cases. Approaches should be sensitive to dealing with 'the person' not just the problem. The current pressure from some funders to restrict the time spent with individual clients in order to achieve 'value for money' needs to be assessed against the cost to the client whose health may not improve and for whom the increased self-confidence to deal with their future situation may not be as positive.

In particular the improvements in health and wellbeing which flow from good advice provision should be an important consideration in the design of future services. Research on well-being has revealed the importance of socially valuable personal relationships, the importance of trust and the importance of participation for the maintenance of quality of life (Jordan, 2008). The findings herein illustrate that while free and impartial advice is absolutely imperative, fundamentally it is the context in which this is provided that fosters wellbeing. On the topic of 'wellbeing', growing political interest is evident, as seen in the UK government's National Wellbeing Project, and at an international level in the work of the 'Commission on the Measurement of Economic Performance and Social Progress' (Stiglitz et al, 2006). As a measure of social progress 'wellbeing' is gaining political momentum. However, the research set out here should act as a reminder of the challenges facing those who hope to capture the less tangible aspects of individual experiences that enhance wellbeing. Despite the fact that the Short Form 36 and HADS instruments utilised in this study provided a quantifiable picture of the impact of advice on the health of individuals, what emerged most clearly was the central role advisors play in this process. The care and respect with which individuals were treated was critical to the subsequent health improvements that they enjoyed. The findings herein add support to calls for a paradigm shift in social policy from economic models of welfare as individual utility towards those that introduce social value in public policy (Jordan, 2008).

Contemporary approaches to welfarism, the growth in cost-effectiveness analysis and focus on ‘happiness’ that emerge from hedonic conceptions of wellbeing (Dean, 2010), risk directing attention away from the underlying causes poor health that arise from social inequalities. Drawing on eudaimonic psychology Deci and Ryan (2000) emphasise the importance to wellbeing of autonomy, competence and positive relationships. Eudaimonic conceptions of wellbeing create a bridge between the more private realm of personal happiness seen in hedonic psychology, to the more public issues of competencies, freedoms and opportunities expressed in eudaimonic explanations (Huppert et al, 2006).

This research illustrates the importance to individual wellbeing of knowing that someone cares and knowing that there is someone to turn to for help when needed.

Consequently, funders should recognise the value to the client of time spent with them to ensure that they achieve positive practical and health outcomes. It is argued elsewhere that inequalities in health can only be effectively tackled by policies that reduce poverty and income inequality (Shaw et al, 1999). Reducing health inequalities requires the underlying causes of those inequalities to be addressed.

It has been recognised that “most debt problems are caused by unexpected life events (job loss, divorce etc) which cannot be foreseen” (House of Lords, 2006 b). The findings from this research illustrate the ‘clustering’ effect of problems whereby certain legal problems cluster, such as money problems, employment problems and housing problems. These cascade and create difficulties and problems in other areas of people’s lives (Pleasence et al, 2004). Changing family circumstances often lead to periods of financial volatility and can create a ‘flash points’ for poverty, consequently policy responses that speed up the transition to and from benefits fill a serious gap in child poverty strategies (Smith, 2008). Advice agencies can assist families in accessing the benefits and tax credits to which they are entitled in times of change, and manage debts that in such circumstances can spiral out of control.

Benefit take-up and debt advice remains vital in improving the financial circumstances of individual lives. The findings from this research illustrate that this

benefits individuals and children in these families. Approaches must take account of the multidimensional experience of social exclusion and the consequences for children's lives (Morris et al, 2009). This is particularly relevant in Wales where research has shown that approximately 13% of children live in severe poverty (Crowley and Winckler, 2008) and one in four lives in a low income household (Kenway et al, 2005). Although child poverty was seen to be stalling in 2007 at around 28% (Kenway and Palmer, 2007), a recent second update of Monitoring Poverty and Social Exclusion in Wales shows as many low income children in Wales come from working families as non-working ones (Kenway et al, 2009).

Consequently, maximising family income and providing money advice to all family groups that require help remains vital – not just those who are deemed at risk due to economic inactivity. There is strong evidence that social safety nets are needed in order to reduce and eventually eradicate child poverty (Lloyd, 2006), although this should not be the only solution. What is more, the distribution of resources within the family has been a critical issue for social policy analysts and calls to re-gender policies must not be forgotten (Lister, 1992, 2000).

Historically, it was noted that popular explanations of poverty are considered to be an important aspect of a country's welfare culture. Welfare benefits advice and debt advice are often seen as issues that raise questions about agency, as well as structure. It is argued here that long held attitudes can be traced historically to early philosophers, economists and anthropologists. Orton (2009a) notes that agency has received growing interest since the 1980s. Deacon and Mann (1999) provide a helpful summary of the revival. They note that the role of individual behaviour has received increasing attention in debates concerning social policy and welfare.

Whilst there is an extensive literature on the topic, those embroiled in the debate emerging from the moralist camp, include such contributors as Etzioni, Mead, Murray and Field. Whilst they have put forth their own set of ideas regarding the direction of welfare policy, they share the logic that such policies should encourage and reward responsible behaviour. Whilst Etzioni (1993) has argued for a four point agenda on rights and responsibilities, Mead (2004), with his welfare to work response, stands for

policy solutions that demand agency. Whereas Murray (1990) has focused on the behaviour of the 'underclass', he is pessimistic about the capacity of governments to provide solutions to the 'problem' and this has caused him to propose that authentic self-government by local communities is the only solution. Field (2001), on the other hand, has emphasised the structural causes of the underclass and argues that a comprehensive approach is needed to make welfare work.

A full account of the debate is beyond the scope of this discussion. However, a body of evidence contradicts the culture of poverty/dependency thesis. It is of particular note that a review of 31 studies for the Joseph Rowntree Foundation by Kempson (1996) concluded that people who live on low incomes are not an underclass. Like other members of society, they have aspirations to have a home, a job and income to pay their bills and hopefully have a little spare money for other things, as was seen in the findings reported herein. Kempson cites social and economic changes, from which the majority of the population have benefited, as making life more difficult for this growing minority. In keeping with the findings reported here, she found those on low income frequently fall into debt but most feel ashamed of their debt. What is more, their situation is exacerbated by the unsympathetic practices of some creditors, which creates even greater anxiety, as was the case for many CAB respondents in this study.

Within an extensive literature on the topic, the work of Lister is particularly pertinent to the findings herein. Whilst Lister (2004) argues that the ability to exercise agency cannot be separated from the structural position of those that are disadvantaged (*ibid*: 178), recognising the capabilities that individuals possess to be creative and reflexive, she positions their agency within forms of stratification and power relations (Williams et al, 1999). Consequently, Lister recognises the structural constraints which limit the opportunities of disadvantaged groups, but states a balance is needed that provides recognition that members of these groups are also agents or actors in their own lives (1996: 12).

Lister (2004) identifies four ways in which people in poverty exercise forms of agency that were seen to a degree in this research.



First, 'getting out' is concerned with routes individuals may take to escape poverty. It could be argued that by seeking advice for their financial problems respondents to this research were attempting such a transformation.

Second, 'Getting by' refers to approaches people in poverty take to manage to live on a low income. It includes strategies to prioritise the needs of children (Lister, 2006), seen in this research, and particularly noticeable in respondents' accounts of the difference CAB advice had made to their lives, illustrated here in terms of: "... money I paid out before is now fixed - how much I pay out for clothing, food, dog, insurances, for car and creditors paid off, etc." Many other respondents articulated financial gains in terms of being better able to manage their financial situation. As a consequence of greater financial stability they were better able to 'get by'.

Third, 'Getting (back) at' is concerned with the way people may engage in forms of resistance such as benefit fraud and the informal economy. Although there was no evidence of such activity in this study, one respondent did acknowledge that upon resolving their issues "... we can afford the licence for the TV now; we didn't have one for years..." However, it is not known if this omission was a rationalized attempt at 'getting back' or simply a consequence of very limited financial resources that did not stretch to the purchase of a television license.

Fourth, 'Getting organised' refers to forms of collective action individuals may engage in. To enable this process, Lister asserts that there is a need for a dual politics of redistribution, and recognition and respect. The importance of recognition and respect emerged most clearly throughout this research as a key feature of CAB advice. To act as a reminder that illustrates this point, an excerpt from an earlier chapter is included here where the respondent describes the difference CAB advice made to her:

"Well instead of feeling you don't belong to a society because you've got nothing, it's made me feel we are all the same and do belong with the rest of the people, whether you have money or not."

In this response we see the broader outcomes of advice that cannot be so easily measured in quantitative terms. This also brings to life the concept of ‘otherings’ discussed by Lister (2004), which she uses to explain the way in which the rest of society treat people in poverty as different. By exploring the symbolic cultural non-material aspects of poverty and representations of poverty, Lister has shown what poverty means to people who are in poverty. ‘Othering’ is transmitted through the media, politicians, service professionals, officials and others who treat people in poverty as ‘other’ to us. Thus difference and distance is created between people who are poor and the rest of society. The excerpts from open questions in earlier chapters support Lister’s argument that people who are poor feel that the worst thing about being poor is being treated with contempt by other people and being treated as if they do not matter. As Taylor has argued, “Due recognition is not just a courtesy we owe people. It is a vital human need” (1994: 26).

The findings herein support the view that demands for greater agency through calls for increased personal responsibility are of limited analytical value and instead adds support to the notion of agency and structure as ‘both and’ rather than ‘either or’ (Orton, 2009a: 496). Explanations of poverty that blame the victim and focus on the behaviour and values of the ‘underclass’, divert attention from wider social, economic and political causes of poverty; policy should combat poverty and increasing social polarisation (Walker, 1996).

However, as Giddens (1999) and Beck (1992) have pointed out, modern cultures have created a more abstract, socially disembedded World where there is a strong focus on individual responsibility and reflexive individualised ways of thinking and behaving. Market reforms, responsible for reversing growing collectivism of the previous century, have revised ways of viewing citizenship by de-emphasising social rights and emphasising individual responsibility (Hudson and Lowe, 2004). As outlined earlier, this has fuelled debates regarding rights and responsibilities. In response to such transformations the key role of welfare states and social policy will no longer be to distribute resources or provide directly for people’s needs but to enable people to manage risks (Dean, 2007:6). The research conducted here provides a good example. Whilst there is primarily a concern that the CAB service will achieve individual

practical gains for its clients, there is clearly an expectation that in the process of acquiring these outcomes, advisors will ‘empower’ individuals, no doubt so that as a ‘responsible’ citizen they can manage the risks themselves in the future. This expectation is also reflected in aspects of the research that emerged from the political imperative to gauge whether respondents felt better able to deal with their problems in the future as a consequence of the advice they received.

According to Dean (2007) ideological discourse built on an individual ethic of responsibility is corroding people’s ability to construe and support welfare provision as an expression of their interdependency. While individual identity was celebrated in the era of new social movements, discussed earlier, this was on occasions at the cost of solidaristic interpretations of rights (ibid: 8). On the other hand, early forms of welfare activism encapsulated in the activities of the rights movement and campaigning organisations have exposed the limitations of a false universalism and highlighted the divergent needs of particular groups (Clarke and Newman, 1997: 9), whilst also revealing the exclusive rather than inclusive citizenship intrinsic in policy responses (Williams, 2000: 339).

Explicitly instrumental, those calling for a new politics of welfare have highlighted a critical political question concerning the feasibility of combining a commitment to universalism in policies, whilst respecting a diversity of identities, practices and beliefs (Williams, 2000).

Offering a way of understanding the struggle for self realization and collective struggles of different groups against disrespect, Taylor (1994) discusses ‘due recognition of identity’. He refers to two aspects of identity - the ontological (sense of self) and categorical (sense of belonging), as a means for understanding the social relations of welfare. Taylor argues that it is possible to explore how individuals build a sense of coherence through their multiple identifications and through this we can understand the way in which individuals form attachments to social movements and enter into political agency (ibid: 341). On this point, Dean (2007) highlights the tension inherent in maintaining ontological identity whilst sustaining categorical

identities that may involve contractarian claims to equal treatment by members of a variety of social groups (p. 8).

A framework built out of a commitment to recognition and respect and a reordering of social relations of welfare, tentatively conceptualises such possibilities (Williams, 2000). The notion of an active welfare subject, found in the new politics of welfare, centres on the diverse as well as the particularistic, by noting specific needs and a politics of redistribution it goes further, making claims for the realization of personhood and wellbeing, cultural respect, autonomy and dignity (ibid). Drawing on the work of Honneth (1996), Taylor (1994) and Fraser (1995), Williams (2000) sets out seven principles of recognition and respect – recognition for interdependence and care, respect for intimacy, bodily integrity and identity, recognition of transnational boundaries and of voice. Within this framework, the key principles of recognition and respect have raised awareness of norms governing behaviour and social relations, whilst also bringing about the realisation that there are many common aspirations and concerns (ibid: 341).

As Williams argues, the intersection of the seven principles of recognition and respect with dimensions of redistribution, go beyond conventional thinking of redistribution of wealth, to encompass work and time, and care and space. In so doing, this framework provides a way forward where we “can begin to provide a shared vocabulary with which to write our individual and collective welfare scripts” (ibid).

At this juncture, the importance of learning lessons from the past cannot be overlooked, this now involves “asking policy makers to move out of their comfort zone” in order to “engage with alien perspectives that might run counter to their own world view...” (Hudson, 2007: 210).

In considering the way forward policy makers must consider the complexity and multifaceted nature of social and financial exclusion, and direct their policies and funding appropriately.

While it is hoped that the findings from this research have contributed in a number of useful ways discussed here, further research is of course still needed. Many areas of potential interest emerged as a result of this study but for the purposes of this chapter a summary of the most viable areas in which future research could be directed is provided.

Whilst it is assumed that certain groups are most 'in need', in the current economic climate it is likely that more people will require help for problems such as debt (and other issues), consequently recommendations by the Public Accounts Committee (House of Commons Standing Order No 148, 2010) to "...compare in more detail the profile of those accessing debt advice services with that of the wider population of over-indebted people" offer opportunities for future research directions. Similarly in the area of Welfare Rights advice, Adams et al (2006: 2) recommended that future research should explore the characteristics of those most likely to benefit financially from advice. This would ensure that future provision is targeted more effectively, and perhaps provide advice services with evidence for their funders that they are, in fact, reaching out to those in need.

Advice services will need to respond to changes in the economic climate that will affect demand for various forms of advice, including Welfare Rights, Debt and other issues such as employment and housing that cluster with money problems.

At the time of writing, up to date figures on the extent of personal debt in households in Wales were not available. Clearly, in order to create forward looking policies this data is needed, particularly in the current economic climate. This, together with other macro-economic datum would produce essential predictors of future need for advice services as well as other related sectors such as the financial industry. One way of predicting future need is to assess unmet need in the general population through analysis of secondary survey data. This would establish a base from which predictions on the extent of debt problems in Wales could be established. The values of longitudinal research discussed herein provide support for new longitudinal research to measure changes in advice seeking behaviour over the coming years in Citizens Advice Bureaux and other advice services. Combined with secondary survey

data analysis, macro-economic predictors and social and economic statistics at local area level, this would build a rich picture of what is known about the extent of debt across Wales and inform policy and practice responses. Extrapolation indicators can plot trends and while it is acknowledged that these can be difficult to predict, other approaches such as modelling economic data can also illustrate the potential response to any changes. Modelling can allow a variety of options to be tested and allow the investigation of what sort of change may result in particular effects. Nevertheless, the accuracy and cost effectiveness of modelling is open to debate and it is recognised that these approaches would require much more considered investigation (Bochel and Shazson, 2007, 26). Whatever the approach, it will be particularly important in recognising the needs of those with debt problems in the years following the present economic downturn, one outcome of which may be a shift in the demographics of those seeking advice.

Whilst there have been some important contributions to the literature from longitudinal qualitative studies, much more research of this design is needed in order to develop a deeper understanding of the social context in which the trajectories of those experiencing financial difficulties play out, and the subjective meaning they attach to their experiences. Longitudinal qualitative research would lead to a better understanding of how those with serious financial difficulties can be supported to cope with their problems in the longer term so that their problems are not aggravated.

The literature drew attention to a paucity of research into the impact of debt advice on the health and lives of individuals. Despite clear evidence of health gains, this study does not provide a definitive account and more could be done to build a solid evidence base with further assessments of health outcomes. The SF-36 and HADS instruments are highly recommended for this.

There is certainly scope for further research of the kind undertaken for this study in the field of debt advice and more research is needed in advice settings that provide services for families and younger age groups. Evaluation of different types of services and the impact on different groups will be particularly important in understanding the intensity and type of service response that is best suited to different groups and

problem categories. However, models to prevent social exclusion, particularly in the context of children's welfare, have in the past failed to make reference to their intended inclusionary outcomes for children, families and communities (Morris et al, 2009). Future research could explicitly address this. There is, for example, potential to learn more about the impact of advice on the material, financial and emotional wellbeing of families, particularly mothers and their children. Research most closely associated to this aspect of the thesis emerged originally from a study conducted by Reading and Reynolds on advice targeted at mothers with a child less than one year of age, in their concluding comments the authors note:

“Our results provide some theoretical support for such studies, as we can postulate a pathway between an aspect of social and financial hardship (i.e. debt) and an objective measurable health outcome (i.e. maternal depression). There may also be scope for comparing the effects on maternal mood of psychological interventions against depression with social interventions directed against debt and financial hardship” (2001: 251).

As yet no research of this nature has emerged, so the prospect remains open. The authors did note that the criteria for inclusion in the study were too restrictive, and they recommended research with mothers of a wider age range of children, not just those under one year.

Previous research has shown the extent to which children go without day to day necessities and this has provided a useful measure of child poverty (Lloyd, 2006). The findings from the present study illustrate that the material and social situation for children improved with the financial circumstances of the parent. It is hoped that this study may lead to new avenues of future research that will look at the impact advice has on ‘necessities deprivation’ and the potential that advice may have for preventing ‘flash points’ into poverty. Future research should assist policy makers and advice services in targeting the underlying causes of different types of poverty and filling the gaps in current policy (Smith, 2008).

The research journey has been enriched by insights gained into a remarkable service that has been helping people to resolve their problems since it was formed in 1939 to deal with welfare issues in the War years. Over 70 years later the Citizen Advice

service finds itself in a fast changing highly competitive environment in which it faces many challenges. Only time will tell whether in the later stages of the life-cycle it will be able to renew itself and survive. Considering the strengths of the service it is hoped that the CAB will continue to provide help and advice to individuals in Wales that reflects the level of care demonstrated by advisors in this study, illustrated in the gratitude of their clients. From the words of CAB clients participating in this research it is possible see examples of what Titmuss (1974: 150) believed

“...a compassionate society can achieve when a philosophy of social justice and public accountability is translated into a hundred and one detailed acts of imagination and tolerance.”

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## APPENDIX ONE: PRE-TEST STUDY

Table 17: Results of Pre-test Study Conducted February-March 2007

<i>Sex</i>	<i>Age/ Age Group</i>	<i>Learning difficulties</i>	<i>First Language</i>	<i>Minutes taken to complete</i>
Female	46-55		English	10
Male	46-55	Severe Dyslexia	English	10
Female	36-45		English	4
Female	12		English	12
Male	16		English	5
Female	36-45		English	8
Male	36-45		English	8
Female	36-45		English	4
Female	36-45		English	7
Female	36-45		English	5
Female	63		English	10
Female	36-45		Polish	12
Male	36-45		English	10
Female	26-35		Welsh	10
Female	46-55		Welsh	20
Female	46-55		Welsh	5
Female	48 years		Dutch	8
Unknown	50 years		Native American	10
Unknown	55 years		Dutch	17
Male	54		Dutch	8
Female	14		English	20
Female	46-55		English	9
Female	56-65		Welsh	10
Female	36-45		English	8
Male	65+		Welsh	19

## APPENDIX TWO: BASELINE DATA COLLECTION TABLES

Table 18: Sample Characteristics

<i>Assessed at Baseline</i>		<i>Baseline</i> <i>(n=142) *</i>		<i>Wave Two</i> <i>(n=68) *</i>		<i>Wave Three</i> <i>(n=42) *</i>	
		N	%	N	%	N	%
<b>Sex</b>	Female	89	(63)	41	(61)	24	(59)
	Male	53	(37)	26	(39)	17	(42)
<b>Age Group</b>	Lowest - 34	31	(22)	9	(14)	2	(5)
	35-54	71	(51)	33	(50)	21	(53)
	55 +	38	(27)	24	(36)	17	(43)
<b>1<sup>st</sup> Language</b>	Welsh	10	(7.2)	3	(4.6)	4	(10)
	English	126	(91)	61	(94)	37	(90)
	Other	3	(2)	1	(2)	0	(0)
<b>2<sup>nd</sup> Language</b>	Welsh	16	(11)	5	(8)	0	(0)
	English	11	(8)	4	(6)	3	(7)
<b>Ethnicity</b>	White British	132	(94)	64	(97)	41	(100)
	White Other	4	(3)	1	(2)	0	(0)
	Pakistani	1	(1)	0	(0)	0	(0)
	Bangladeshi	1	(1)	0	(0)	0	(0)
	Black British or Black Caribbean	1	(1)	1	(2)	0	(0)
	Other Group	2	(1)	0	(0)	0	(0)
<b>Nationality</b>	Welsh	73	(51)	32	(48)	24	(59)
	English	37	(26)	20	(20)	9	(22)
	Irish	1	(1)	0	(0)	0	(0)
	British	29	(20)	14	(21)	8	(20)
	Other	2	(1)	1	(2)	0	(0)

\* Or appropriate valid responses

Table 19: Household Composition and Housing

<i>Assessed at Baseline</i>		<i>Baseline</i> <i>(n=142) *</i>		<i>Wave Two</i> <i>(n=68) *</i>		<i>Wave Three</i> <i>(n=42) *</i>	
		N	%	N	%	N	%
<b>Household Composition</b>	Single	49	(35)	27	(40)	16	(39)
	Single & children	16	(11)	6	(9)	4	(10)
	Couple	38	(27)	19	(28)	13	(32)
	Couple & children	34	(24)	12	(18)	6	(15)
	Other	5	(4)	3	(5)	2	(5)
<b>Housing</b>	Home owner	43	(30)	21	(31)	14	(34)
	Rented	91	(64)	42	(63)	23	(56)
	Other	8	(5.6)	4	(6)	4	(9.8)

\* Or appropriate valid responses

Table 20: Status of Sample

<i>Assessed at Baseline</i>	<i>Baseline</i> ( <i>n=142</i> )		<i>Wave Two</i> ( <i>n=67</i> )		<i>Wave Three</i> ( <i>n=40</i> )	
	n	%	n	%	n	%
Incapable of work	46	(32)	22	(33)	16	(39)
Unemployed	27	(19)	8	(12)	4	(10)
Off sick	25	(18)	12	(18)	6	(15)
Disabled	23	(16)	14	(21)	7	(17)
Employed F/T	22	(16)	10	(15)	5	(12)
Carer for children	21	(15)	9	(13)	3	(7)
Pensioner	19	(13)	14	(21)	10	(24)
Employed P/T	11	(8)	6	(9)	4	(10)
Lone parent	8	(6)	3	(4)	1	(2)
Carer full-time	6	(4)	4	(6)	3	(7)
Volunteer	2	(1)	2	(3)	2	(5)
Unemployed on programme	1	(1)	1	(1)	1	(2)
Student	1	(1)	0	(0)	0	(0)

NB: Respondents could select multiple categories

Table 21: Main source of income

<i>Assessed at Baseline</i>	<i>Baseline</i> ( <i>n=142</i> )		<i>Wave Two</i> ( <i>n=67</i> )		<i>Wave Three</i> ( <i>n=41</i> )	
	n	%	n	%	n	%
Wages or salary	39	(28)	21	(31)	11	(27)
Self employed	3	(2)	1	(1)	1	(2)
Occupational or private pension	6	(4)	3	(4)	2	(5)
Social Security benefits, state pension, tax credits	88	(62)	42	(63)	27	(66)
Other	4	(3)	0	(0)	0	(0)
No income	2	(1)	0	(0)	0	(0)

Table 22: Welfare Benefits and Tax Credits Received by Respondents

<i>Assessed at Baseline</i>	<i>Baseline</i> <i>(n=119)</i>		<i>Wave Two</i> <i>(n=61)</i>		<i>Wave Three</i> <i>(n=39)</i>	
	n	%	n	%	n	%
Council tax benefit	49	(41)	23	(38)	18	(46)
Housing benefit	41	(34)	18	(30)	14	(36)
Child benefit	39	(33)	17	(28)	9	(23)
Incapacity benefit	37	(31)	18	(30)	12	(31)
Income support	35	(29)	13	(21)	7	(18)
DLA	35	(29)	19	(31)	13	(33)
Child tax credit	31	(26)	14	(23)	8	(21)
Working families tax credit	21	(18)	14	(23)	8	(21)
State retirement pension	16	(13)	13	(21)	9	(23)
Pension credit	9	(8)	6	(10)	4	(10)
Job seekers allowance	8	(7)	1	(2)	1	(3)
Carers allowance	7	(6)	4	(7)	4	(10)
Attendance allowance	4	(3)	3	(5)	3	(8)
Other Benefit	4	(3)	3	(5)	1	(3)
Industrial injuries benefit	1	(1)	0	(0)	0	(0)

Table 23: Respondent Issues

<i>Assessed at Baseline</i>	<i>Baseline</i> <i>(n=141)</i>		<i>Wave Two</i> <i>(n=67)</i>		<i>Wave Three</i> <i>(n=41)</i>	
	n	%	n	%	n	%
New benefit	44	(31)	25	(37)	17	(41)
Appeal against loss of benefit	14	(10)	10	(15)	5	(12)
Help with existing benefit	27	(19)	14	(21)	10	(24)
About income	24	(17)	13	(19)	7	(17)
Bankruptcy, IVA or county court admin order	10	(7)	5	(7)	5	(12)
Debt re-scheduling	70	(50)	31	(46)	15	(37)
Debt challenge	25	(18)	12	(18)	4	(10)
Employment discrimination	3	(2)	3	(4)	1	(2)
Disability discrimination	1	(1)	1	(1)	0	(0)

Table 24: Debt Problems

<i>Assessed at Baseline</i>	<i>Baseline</i> <i>(n=79)</i>		<i>Wave Two</i> <i>(n=37)</i>		<i>Wave Three</i> <i>(n=24)</i>	
	n	%	n	%	n	%
Utility (including telecoms)	30	(38)	11	(30)	2	(8)
Credit card(s)	30	(38)	18	(49)	14	(58)
Council tax	26	(33)	11	(30)	5	(21)
Bank overdraft	24	(30)	12	(32)	8	(33)
Catalogue/mail order	24	(30)	10	(27)	4	(17)
Bank loan (not mortgage)	23	(29)	14	(38)	10	(42)
Rent arrears	14	(18)	6	(16)	2	(8)
Mortgage/secured loan	13	(16)	4	(11)	3	(13)
Shop or store card	12	(15)	8	(22)	5	(21)
Other current debt(s)	9	(11)	5	(14)	5	(21)
Court Fines	4	(5)	1	(3)	0	(0)
HP/rental	2	(3)	2	(5)	1	(4)
Child support	2	(3)	2	(5)	0	(0)
Tax/NI	1	(1)	1	(3)	0	(0)

The number of debt problems reported by respondents ranged from one to 8 problems per respondent, as outlined in Table 24. These figures do not include multiple debts within each debt category. For example, respondents may have had multiple credit card debts but this is not illustrated. Some respondents seeking advice for debt problems did not disclose the full details of their debts at baseline, whilst others disclosed debt problems that they were not originally seeking advice for, although debt advice was subsequently provided.

Table 25: Welfare Benefits Applications/Appeals against the Loss of Benefits

<i>Assessed at Baseline</i>	<i>Baseline</i>		<i>Wave Two</i>		<i>Wave Three</i>	
	<i>(n=44)</i>		<i>(n=26)</i>		<i>(n=16)</i>	
	n	%	n	%	n	%
DLA	21	(48)	13	(50)	6	(38)
Council tax benefit	13	(30)	7	(27)	3	(19)
Incapacity benefit	10	(23)	6	(23)	3	(19)
Housing benefit	10	(23)	7	(27)	3	(19)
Pension credit	5	(11)	5	(19)	4	(25)
Income support	4	(9)	1	(4)	0	(0)
Child benefit	2	(5)	0	(0)	0	(0)
Child tax credit	2	(5)	1	(4)	0	(0)
Industrial injuries benefit	1	(2)	1	(4)	0	(0)
Attendance allowance	1	(2)	0	(0)	0	(0)
Working tax credit	1	(2)	0	(0)	0	(0)
Disabled facilities grant	1	(2)	0	(0)	0	(0)
Job seek allowance	1	(2)	0	(0)	0	(0)
State retirement pension	1	(2)	1	(4)	1	(6)

Forty four respondents sought assistance with 14 different Welfare Benefits. Table 25 provides a breakdown of 73 applications or appeals against the loss of welfare benefits by these 44 respondents at baseline. However, full details of Welfare Benefits Applications/Appeals against the loss of benefits were not forthcoming from all respondents seeking advice for Welfare Benefits issues at baseline. At this early stage in the advice process respondents may not understand the benefits that they are entitled to claim.

Table 26: Subjective opinion of Financial Situation

<i>Assessed at Baseline</i>	<i>Baseline</i> ( <i>n=139</i> )		<i>Wave Two</i> ( <i>n=64</i> )		<i>Wave Three</i> ( <i>n=41</i> )	
	n	%	n	%	n	%
Living comfortably	6	(4)	5	(8)	4	(10)
Doing alright	8	(6)	2	(3)	2	(5)
Just about getting by	39	(28)	22	(34)	14	(34)
Finding it quite difficult	29	(21)	12	(19)	8	(20)
Finding it very difficult	57	(41)	23	(36)	13	(32)

Table 27: Sources of Borrowing

<i>Assessed at Baseline</i>	<i>Baseline</i> ( <i>n=126</i> )		<i>Wave Two</i> ( <i>n=61</i> )		<i>Wave Three</i> ( <i>n=38</i> )	
	n	%	n	%	n	%
Family	75	(60)	35	(57)	22	(58)
<i>None of these</i>	<b>37</b>	<b>(29)</b>	<b>22</b>	<b>(36)</b>	<b>15</b>	<b>(39)</b>
Friends	33	(26)	10	(16)	4	(11)
Door-step money lender	19	(15)	8	(13)	5	(13)
Pawnbroker	3	(2)	1	(2)	0	(0)
Other (social fund)	3	(2)	0	(0)	0	(0)

*(n=126)*

Table 28: Items respondents personally went without due to shortages of money

<i>Assessed at Baseline</i>	<i>Baseline</i> ( <i>n=133</i> )		<i>Wave Two</i> ( <i>n=64</i> )		<i>Wave Three</i> ( <i>n=41</i> )	
	n	%	n	%	n	%
Clothes	82	(62)	38	(59)	22	(54)
Shoes	69	(52)	33	(52)	18	(44)
Food	40	(30)	15	(23)	5	(12)
Heating	25	(19)	9	(14)	4	(10)
Telephoning friends or family	49	(37)	22	(34)	12	(29)
Going out	87	(65)	39	(61)	24	(59)
Visits to the pub	75	(56)	35	(55)	18	(44)
Hobby or Sport	52	(39)	23	(36)	13	(32)
Holiday	95	(71)	43	(67)	24	(59)
Never go without	12	(9)	6	(9)	5	(12)

At baseline respondents were asked if there were times in the past year when they had personally gone without any of the items or activities listed in Table 28 because of a shortage of money. One hundred and twenty one respondents had personally gone without a total of 574 of the items or activities listed in total. Table 29 contains responses that relate to the dependent children of CAB clients.

Table 29: Items Child went without due to shortages of money

<i>Assessed at Baseline</i>	<i>Baseline</i> ( <i>n=50</i> )		<i>Wave Two</i> ( <i>n=18</i> )		<i>Wave Three</i> ( <i>n=10</i> )	
	n	%	n	%	n	%
Clothes	17	(34)	5	(28)	3	(30)
Shoes	15	(30)	7	(39)	3	(30)
Food	7	(14)	2	(11)	1	(10)
Hobby or sport	16	(32)	6	(33)	3	(30)
Trip or holiday arranged by school	14	(28)	4	(22)	1	(10)
Family holiday	31	(62)	10	(56)	5	(50)
Pocket money	17	(34)	7	(39)	2	(20)
Child never goes without	9	(18)	3	(17)	3	(30)



Table 30: Health Problems

<i>Assessed at Baseline</i>	<i>Baseline Group (n=148)</i>	<i>Wave Two Group (n=67)</i>	<i>Wave Three Group (n=42)</i>
	<i>n (%)</i>	<i>n (%)</i>	<i>n (%)</i>
Long term illness	61 (41)	33 (48.5)	19 (45.2)
Health Problem	67 (45)	38 (55.9)	22 (52.4)
Mental health or nervous illness	51 (34)	23 (33.8)	14 (33.3)
Physical disability	64 (43)	36 (52.9)	22 (52.4)
Learning disability	6 (4)	3 (4.4)	1 (2.4)
Arthritis/rheumatism	50 (34)	27 (39.7)	19 (45.2)
Asthma	29 (20)	12 (17.6)	4 (9.5)
Heart trouble/angina	12 (8)	4 (5.9)	3 (7.1)
High blood pressure	32 (22)	16 (23.5)	14 (33.3)
Sensory impairment	18 (12)	12 (17.6)	10 (23.8)
Other health condition	31 (21)	17 (28.3)	9 (21.4)
Diabetes	10 (7)	8 (11.8)	5 (11.9)
Stroke	5 (3)	2 (2.9)	2 (4.8)

Table 31: Baseline Scores SF-36 and HADS

<i>Assessed at Baseline</i>	<i>Baseline Scores Mean (SD)</i>
SF-36 Physical Functioning	50.8 (35.9)
SF-36 Role Physical	36.0 (42.8)
SF-36 Bodily Pain	43.6 (34.0)
SF-36 General Health	40.7 (26.6)
SF-36 Vitality	33.7 (22.3)
SF-36 Social Functioning	39.2 (30.0)
SF-36 Role Emotional	37.1 (43.4)
SF-36 Mental Health	47.2 (23.7)
HADS Anxiety	12.18 (4.9)
HADS Depression	9.30 (4.8)

*(n=134 SF-36, n=147 HADS)*

SF-36: Scores 0-100. Higher scores indicate better health

HADS: Scores 0-21. Lower scores indicate better health.

Table 32: Source of Referral to CAB Service

<i>Assessed at Baseline</i>	<i>Baseline</i> (n=126)		<i>Wave Two</i> (n=59)		<i>Wave Three</i> (n=39)	
	n	%	n	%	n	%
Family/Friend(s)	40	(32)	19	(32)	11	(28)
Previous customer	19	(15)	11	(19)	6	(15)
Reputation	16	(13)	6	(10)	5	(13)
Health and social care professionals/scheme GP	12	(10)	7	(12)	5	(13)
Word of Mouth	8	(6)	2	(3)	1	(3)
Other Organisation	8	(6)	5	(8)	4	(10)
Publicity material	7	(6)	2	(3)	1	(3)
Other	5	(4)	2	(3)	1	(3)

(n=126)

Table 32: Wait for Appointment

<i>Assessed at Baseline</i>	<i>Baseline</i> (n=112)		<i>Wave Two</i> (n=52)		<i>Wave Three</i> (n=36)	
	n	%	n	%	n	%
Less than a week	20	(18)	8	(15)	6	(17)
1 week	45	(40)	19	(37)	12	(33)
2 weeks	33	(29)	17	(33)	13	(36)
3 weeks	7	(6)	4	(8)	3	(8)
4 weeks	5	(4)	3	(6)	2	(6)
5 weeks	2	(2)	1	(2)	0	(0)

Table 33: Respondent Rating Contacting CAB for an Appointment

<i>Assessed at Baseline</i>	<i>Baseline</i> (n=128)*		<i>Wave Two</i> (n=59)*		<i>Wave Three</i> (n=40)*	
	n	%	n	%	n	%
Good or Very Good	120	(94)	58	(98)	39	(98)
Neither Poor nor Good	5	(4)	1	(2)	1	(2)
Poor or Very Poor	3	(2)	0	(0)	0	(0)

\* Question not applicable to some respondents

Table 34: Respondent Rating Convenience of Location of CAB

<i>Assessed at Baseline</i>	<i>Baseline</i> (n=137)		<i>Wave Two</i> (n=64)		<i>Wave Three</i> (n=41)	
	n	%	n	%	n	%
Good or Very Good	129	(94)	60	(94)	39	(95)
Neither Poor nor Good	7	(5)	3	(5)	2	(5)
Poor or Very Poor	1	(1)	1	(2)	0	(0)

Table 35: Respondent Rating Information about the CAB Service

<i>Assessed at Baseline</i>	<i>Baseline</i> (n=136)		<i>Wave Two</i> (n=64)		<i>Wave Three</i> (n=41)	
	n	%	n	%	n	%
Good or Very Good	128	(94)	60	(94)	39	(95)
Neither Poor nor Good	6	(4)	3	(5)	1	(2)
Poor or Very Poor	2	(2)	1	(2)	1	(2)

Table 36: Access issues issues at Wave 2 and 3

	<i>Wave 2</i>			<i>Wave 3</i>		
	<i>Very difficult</i> n (%)	<i>A little difficult</i> n (%)	<i>Not difficult or n/A</i> n (%)	<i>Very difficult</i> n (%)	<i>A little difficult</i> n (%)	<i>Not difficult or N/A</i> n (%)
Transport costs	-	1 (3)	37 (97)	-	-	38 (100)
Public transport services	1 (3)	-	37 (97)	2 (5)	-	36 (95)
Travelling distances	-	4 (11)	34 (89)	-	-	38 (100)
Caring responsibilities	-	4 (11)	32 (89)	2 (5)	4 (11)	32 (84)
Your health or a disability	3 (8)	11 (29)	24 (63)	4 (11)	5 (13)	29 (76)
Getting though on the telephone	1 (3)	2 (5)	35 (92)	-	2 (5)	35 (95)
Cost of telephoning	-	2(5)	36 (95)	-	3 (8)	34 (92)

(n= 38) Where valid responses were provided.

Respondents were asked if they had found it difficult to access the CAB service for reasons which could make access problematic over a prolonged period of time. Valid responses from 38 respondents who participated at wave 2 and 3 of the study are set out for comparison.

## **APPENDIX THREE: QUESTIONNAIRE SCHEDULES**

Including:

- Baseline Questionnaire Part One & Part Two
- Wave 2 Questionnaire
- Wave 3 Questionnaire



# University of Wales, Bangor & Citizens Advice Cymru

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RESEARCH PROJECT

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## Survey One (Part 1)

Client Ref Code.....

Date:...../...../2007

**INSTRUCTIONS:** This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

- Excellent ..... 1
- Very good..... 2
- Good ..... 3
- Fair ..... 4
- Poor ..... 5

2. Compared to one year ago, how would you rate your health in general now?

(circle one)

- Much better now than one year ago ..... 1
- Somewhat better now than one year ago..... 2
- About the same as one year ago..... 3
- Somewhat worse now than one year ago ..... 4
- Much worse now than one year ago ..... 5

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

<u>ACTIVITIES</u>	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing <b>several</b> flights of stairs	1	2	3
e. Climbing <b>one</b> flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking <b>more than a mile</b>	1	2	3
h. Walking <b>half a mile</b>	1	2	3
i. Walking <b>one hundred yards</b>	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	YES	NO
a. Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
b. <b>Accomplished less</b> than you would like	1	2
c. Were limited in the <b>kind</b> of work or other activities	1	2
d. Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a. Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
b. <b>Accomplished less</b> than you would like	1	2
c. Didn't do work or other activities as <b>carefully</b> as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(circle one)

- Not at all .....1  
 Slightly.....2  
 Moderately .....3  
 Quite a bit.....4  
 Extremely .....5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

- None.....1  
 Very mild .....2  
 Mild.....3  
 Moderate .....4  
 Severe .....5  
 Very severe .....6



8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

- Not at all .....1  
 A little bit.....2  
 Moderately .....3  
 Quite a bit.....4  
 Extremely .....5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks –

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of life?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and low?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

- All of the time .....1
- Most of the time.....2
- Some of the time .....3
- A little of the time.....4
- None of the time.....5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

	<b>Definitely True</b>	<b>Mostly True</b>	<b>Don't Know</b>	<b>Mostly False</b>	<b>Definitely False</b>
a. I seem to get ill more easily than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

12. Read each item below and **underline the reply** which comes closest to how you have been feeling in the past week.

Don't take too long over your replies, your immediate reaction to each item will probably be more accurate than a long, thought-out response.

I feel tense or 'wound up'  
Most of the time  
A lot of the time  
From time to time, occasionally  
Not at all

I feel as if I am slowed down  
Nearly all the time  
Very often  
Sometimes  
Not at all

I still enjoy the things I used to enjoy

Definitely as much  
Not quite so much  
Only a little  
Hardly at all

I get a sort of frightened feeling like 'butterflies'  
in the stomach  
Not at all  
Occasionally  
Quite often  
Very often

I get a sort of frightened feeling as if something  
awful is about to happen  
Very definitely and quite badly  
Yes, but not too badly  
A little, but it doesn't worry me  
Not at all

I have lost interest in my appearance  
Definitely  
I don't take as much care as I should  
I may not take quite as much care  
I take just as much care as ever

I can laugh and see the funny side of things  
As much as I always could  
Not quite so much now  
Definitely not so much now  
Not at all

**I feel restless as if I have to be on the move**  
Very much indeed  
Quite a lot  
Not very much  
Not at all

Worrying thoughts go through my mind  
A great deal of the time  
A lot of the time  
Not too often  
Very little

**I look forward with enjoyment to things**  
As much as I ever did  
Rather less than I used to  
Definitely less than I used to  
Hardly at all

I feel cheerful  
Never  
Not often  
Sometimes  
Most of the time

**I get sudden feelings of panic**  
Very often indeed  
Quite often  
Not very often  
Not at all

I can sit at ease and feel relaxed

Definitely  
Usually  
Not often  
Not at all

**I can enjoy a good book or radio or  
television programme**  
Often  
Sometimes  
Not often  
Very seldom

13. Do you have any long-term illness, health problem, or disability which limits your daily activities or the work you can do? Please include any problems that are due to old age.

(circle ALL that apply)

- Long-term illness.....1
- Health Problem .....2
- Mental health or nervous illness .....3
- Physical disability.....4
- Learning disability .....5
- None of the above .....6

14. Do you suffer with any of the health conditions on this list?

(circle ALL that apply)

- Arthritis/rheumatism .....1
- Asthma.....2
- Diabetes.....3
- Heart trouble/angina.....4
- High blood pressure .....5
- Sensory impairment .....6
- Stroke .....7
- Other (Please write in) .....8

15. Have you been prescribed medication because of the problem you are seeking advice for?

(circle one number only)

- Yes.....1
- No.....2

16. How much support would you get in the following situations?

*(circle one number on each line)*

	<b>A lot</b>	<b>Some</b>	<b>Not much</b>	<b>None at all</b>
Help around the home if you are in bed with flu/illness	1	2	3	4
Help with a household or garden job that you cannot manage alone, for example, moving furniture	1	2	3	4
Needing advice about an important change in your life, for example changing jobs, moving to another area	1	2	3	4
Being upset because of problems with your spouse/partner	1	2	3	4
Feeling a bit depressed and wanting someone to talk to	1	2	3	4
Needing someone to look after children/elderly or a disabled adult	1	2	3	4
Needing someone to look after your home/possessions when away	1	2	3	4

17. Have there been times in the past year when you have felt isolated and cut off from society for any of the following reasons?

(circle ALL that apply)

- Paid work ..... 1
- Childcare responsibilities .....2
- Other caring responsibilities.....3
- Lack of own transport.....4
- Irregular or expensive public transport .....5
- No friends .....6
- No family .....7
- Problems with physical access .....8
- Sexism .....9
- Racism.....10
- Homophobia .....11
- Discrimination relating to disability .....12
- Other .....13

18. Have you felt cut off or isolated from society because of the problem you are seeking advice for?

(circle *one number only*)

- Yes, a lot..... 1
- Yes, a little .....2
- No, not at all.....3

Cyngor Ar Bopeth Cymru  
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RESEARCH PROJECT

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## Survey One (Part 2)

To be administered by Interview

Client Ref Code.....

Date:...../...../2007

1. I would like to ask you some questions about yourself and your household

Question	Answer
a. Your gender is? – tick one	Female <input type="checkbox"/> Male <input type="checkbox"/>
b. How old are you?	Write in:
c. What is your 1st language?	Write in:
d. Do you have a 2nd language, if yes, what is it?	Write in if applicable:
e. What do you consider your national identity to be? Are you...?	<p>Please circle one number only</p> <p>Welsh..... 1</p> <p>English..... 2</p> <p>Scottish..... 3</p> <p>Irish..... 4</p> <p>British..... 5</p> <p>Other..... 6</p> <p>If other, Please write in.....</p>
f. Which of these best describes your ethnic origin...?  <b>Please use SHOWCARD 1</b>	<p>Please circle one number only</p> <p>White British..... 1</p> <p>White Other..... 2</p> <p>Mixed White and Black Caribbean..... 3</p> <p>Mixed White and Black African..... 4</p> <p>Mixed White and Asian..... 5</p> <p>Indian..... 6</p> <p>Pakistani..... 7</p> <p>Bangladeshi..... 8</p> <p>Black British or Black Caribbean..... 9</p> <p>Black British or Black African..... 10</p> <p>Chinese..... 11</p> <p>Other group..... 12</p> <p>If other, please write in.....</p>
g. Which of these best describes your household composition ...?  <b>Please use SHOWCARD 2</b>	<p>Please circle one number only</p> <p>Single..... 1</p> <p>Single with dependant children..... 2</p> <p>Single with non-dependant children..... 3</p> <p>Couple..... 4</p> <p>Couple with dependant children..... 5</p> <p>Couple with non-dependant children..... 6</p> <p>Other adult..... 7</p> <p>Other with dependant children..... 8</p> <p>If other, please write in.....</p>
h. How many dependant children, (under 19 years of age) live in your home?	Number of dependant children in home.....



**2. I'd like to ask you some questions about the place where you live.**

<p>a. Which of these options best describes your home?</p> <p><b>Please use SHOWCARD 3</b></p>	<p><i>Please circle one number only</i></p> <p>Own – outright..... 1          Own - with help of mortgage/loan..... 2          Pay part rent and part mortgage..... 3          Rent it..... 4          Live rent-free..... 5          Mobile home ..... 6          Squatting..... 7          Homeless..... 8          Other..... 9</p> <p>If other, please write in.....</p>
<p>b. In whose name is the accommodation owned or rented?</p>	<p><i>Please circle one number only</i></p> <p>Your name only..... 1          You and another person jointly..... 2          Not owner/renter..... 3</p>
<p>c. If renting, who is the landlord?</p> <p><b>Please use SHOWCARD 4</b></p>	<p><i>Please circle one number only</i></p> <p>Council/local authority ..... 1          Housing association/Co-operative,          Charitable trust or registered social          landlord..... 2          Private landlord ..... 3          Employer of a household member..... 4          Relative or friend..... 5          Other..... 6</p> <p>If other, Please write in.....</p>
<p>d. In your own words can you tell me if there is anything that worries you about your home? For example:          The condition, the area, is it suitable for your needs etc - Please write in:</p>	

**3. Next I'd like to ask you about your situation and how you've been financially.**

<p>a. Which of the items on this card describe your current situation?</p> <p><b>Please use SHOWCARD 5</b></p>	<p><i>Please circle ALL that apply</i></p> <ul style="list-style-type: none"> <li>Unemployed..... 1</li> <li>Unemployed on a programme..... 2</li> <li>Employed full-time (over 30 hours p/w) 3</li> <li>Employed part-time (30 hours or less p/w) 4</li> <li>Student..... 5</li> <li>Volunteer..... 6</li> <li>Off sick..... 7</li> <li>Incapable of work..... 8</li> <li>Carer for children..... 9</li> <li>Carer full-time (for elderly, disabled)..... 10</li> <li>Lone parent..... 11</li> <li>Pensioner..... 12</li> <li>Disabled..... 13</li> </ul>																																																																								
<p>b. What is the <u>main</u> source of your income; is it...?</p>	<p><i>Please circle one number only</i></p> <ul style="list-style-type: none"> <li>Wages or salary..... 1</li> <li>Self employed..... 2</li> <li>Occupational or private pension..... 3</li> <li>Social security benefits, state pension, tax credits..... 4</li> <li>Child maintenance (eg child support)..... 5</li> <li>Other..... 6</li> </ul> <p>If other, please write in.....</p>																																																																								
<p>c. Do you <u>currently</u> receive any of the following benefits?</p> <p><b>Please use SHOWCARD 6</b></p> <p>d. Are you <u>applying</u> for or <u>appealing</u> against refusal of an application or loss of any of the following...?</p> <p><b>Please use SHOWCARD 6 again</b></p>	<p><i>Circle ALL that apply</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 10%; text-align: center;">Receive Now</th> <th style="width: 10%; text-align: center;">Applying/ appealing</th> <th style="width: 10%;"></th> </tr> </thead> <tbody> <tr><td>Income Support.....</td><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Council Tax Benefit.....</td><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Incapacity Benefit.....</td><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Housing Benefit.....</td><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Disability Living Allowance</td><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Industrial Injuries Benefit..</td><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Attendance Allowance.....</td><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Carer allowance.....</td><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Working tax credit.....</td><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Child benefit.....</td><td style="text-align: center;">10</td><td style="text-align: center;">10</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Child tax credit.....</td><td style="text-align: center;">11</td><td style="text-align: center;">11</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Disabled facilities grant....</td><td style="text-align: center;">12</td><td style="text-align: center;">12</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Job Seekers Allowance....</td><td style="text-align: center;">13</td><td style="text-align: center;">13</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>State retirement pension..</td><td style="text-align: center;">14</td><td style="text-align: center;">14</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Pension Credit.....</td><td style="text-align: center;">15</td><td style="text-align: center;">15</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>No benefit.....</td><td style="text-align: center;">16</td><td style="text-align: center;">16</td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Other.....</td><td style="text-align: center;">17</td><td style="text-align: center;">17</td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>If other, please write in.....</p>		Receive Now	Applying/ appealing		Income Support.....	1	1	<input type="checkbox"/>	Council Tax Benefit.....	2	2	<input type="checkbox"/>	Incapacity Benefit.....	3	3	<input type="checkbox"/>	Housing Benefit.....	4	4	<input type="checkbox"/>	Disability Living Allowance	5	5	<input type="checkbox"/>	Industrial Injuries Benefit..	6	6	<input type="checkbox"/>	Attendance Allowance.....	7	7	<input type="checkbox"/>	Carer allowance.....	8	8	<input type="checkbox"/>	Working tax credit.....	9	9	<input type="checkbox"/>	Child benefit.....	10	10	<input type="checkbox"/>	Child tax credit.....	11	11	<input type="checkbox"/>	Disabled facilities grant....	12	12	<input type="checkbox"/>	Job Seekers Allowance....	13	13	<input type="checkbox"/>	State retirement pension..	14	14	<input type="checkbox"/>	Pension Credit.....	15	15	<input type="checkbox"/>	No benefit.....	16	16	<input type="checkbox"/>	Other.....	17	17	<input type="checkbox"/>
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<p>e. What is your usual total gross household income each month, (before deductions), is it...?</p> <p><b>Please use SHOWCARD 7</b></p>	<p><i>Please circle one number only</i></p> <p>Under £400..... 1  £400-£599..... 2  £600-£999..... 3  £1,000-£1,499..... 4  £1,500-£1,999..... 5  £2,000-£2,499..... 6  £2,500-£2,999..... 7  Over £3,000..... 8</p> <p>If other, please write in.....</p>
<p>f. How well would you say you are managing financially these days? Would you say you are:</p>	<p><i>Please circle one number only</i></p> <p>Living comfortably..... 1  Doing alright..... 2  Just about getting by..... 3  Finding it quite difficult..... 4  or finding it very difficult..... 5</p>
<p>g. <b>IF RESPONDENT HAS DEPENDANT CHILDREN</b></p> <p>Has your child or children gone without each of these things in the last year because of a shortage of money?</p> <p><b>Please use SHOWCARD 8</b></p>	<p><i>Please circle ALL that apply</i></p> <p>Clothes..... 1  Shoes..... 2  Food..... 3  A hobby or sport..... 4  A trip or holiday arranged by the school.. 5  A family holiday..... 6  Pocket money..... 7  Never go without..... 8  Money never tight..... 9</p>
<p>h. Which of these items have you <u>PERSONALLY</u> gone without in the last year because of a shortage of money?</p> <p><b>Please use SHOWCARD 9</b></p>	<p><i>Please circle ALL that apply</i></p> <p>Clothes..... 1  Shoes..... 2  Food..... 3  Heating/lighting..... 4  Telephoning friends or family..... 5  Going out..... 6  Visits to the pub..... 7  A hobby or sport..... 8  A holiday..... 9  Never go without..... 10  Money never tight..... 11</p>
<p>i. Have you been disconnected from a utility service (eg water, fuel, telecoms)? If yes, which service?</p>	<p>Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/></p> <p>Disconnected from: .....</p>

<p>j. Have there been times during the past year when you have had to borrow money from any of the following, excluding banks and building societies, or credit unions to pay for your day-to-day needs?</p>	<p>Please circle <u>ALL</u> that apply</p> <p>Pawnbroker..... 1  Door step money lender..... 2  Friend(s)..... 3  Family..... 4  None of these..... 5  Other..... 6</p> <p>If other, please write in.....</p>																																																			
<p>k. Have there been times during the <u>past year</u> when you were seriously behind in paying within the time allowed for any of these items?</p> <p><b>Please use SHOWCARD 10</b></p> <p>l. Are you <u>currently</u> seeking advice for debt problems or arrears relating to any of these items?</p> <p><b>Use SHOWCARD 10 again</b></p>	<p>Please circle <u>ALL</u> that apply</p> <table border="1" data-bbox="942 605 1589 1275"> <thead> <tr> <th></th> <th>Behind in Past Year</th> <th>Current problem</th> </tr> </thead> <tbody> <tr><td>Mortgage/secured loan..</td><td>1</td><td>1</td></tr> <tr><td>Rent arrears.....</td><td>2</td><td>2</td></tr> <tr><td>Council tax.....</td><td>3</td><td>3</td></tr> <tr><td>Court fines.....</td><td>4</td><td>4</td></tr> <tr><td>Tax/NI.....</td><td>5</td><td>5</td></tr> <tr><td>HP/rental.....</td><td>6</td><td>6</td></tr> <tr><td>Bank loan (not mortgage)</td><td>7</td><td>7</td></tr> <tr><td>Shop or store card.....</td><td>8</td><td>8</td></tr> <tr><td>Bank overdraft.....</td><td>9</td><td>9</td></tr> <tr><td>Magistrate court fines.....</td><td>10</td><td>10</td></tr> <tr><td>Utility (telecoms, fuel, water)</td><td>11</td><td>11</td></tr> <tr><td>Credit card(s).....</td><td>12</td><td>12</td></tr> <tr><td>Catalogue/mail order.....</td><td>13</td><td>13</td></tr> <tr><td>Child support.....</td><td>14</td><td>14</td></tr> <tr><td>None.....</td><td>15</td><td>15</td></tr> <tr><td>Other.....</td><td>16</td><td>16</td></tr> </tbody> </table> <p>If other, please write in.....</p> <p><b>If client has a <u>current</u> debt problem or arrears continue, if not go to question 4</b></p>		Behind in Past Year	Current problem	Mortgage/secured loan..	1	1	Rent arrears.....	2	2	Council tax.....	3	3	Court fines.....	4	4	Tax/NI.....	5	5	HP/rental.....	6	6	Bank loan (not mortgage)	7	7	Shop or store card.....	8	8	Bank overdraft.....	9	9	Magistrate court fines.....	10	10	Utility (telecoms, fuel, water)	11	11	Credit card(s).....	12	12	Catalogue/mail order.....	13	13	Child support.....	14	14	None.....	15	15	Other.....	16	16
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<p>m. What is the <u>total</u> amount of your <u>current</u> personal debt(s)?</p> <p>If unknown, please ask client to estimate</p>	<p>Please write in £.....</p>																																																			
<p>n. How long have you been in arrears with these commitments?</p> <p>If unknown, please ask client to estimate</p>	<p>Please write in <b>months</b>.....</p>																																																			

**4. I like to talk to you more now about the problem you are seeking advice for.**

<p>a. What is the problem(s) you would like the CAB to help you with?</p> <p><b>Please use SHOWCARD 11</b></p>	<p>like</p>	<p><i>Please circle <u>ALL</u> that apply</i></p> <p>A New benefit claim..... 1</p> <p>Appeal against loss of benefit..... 2</p> <p>Help with an existing benefit..... 3</p> <p>About income..... 4</p> <p>Bankruptcy, IVA or county court administrative order..... 5</p> <p>Debt re-scheduling..... 6</p> <p>Debt challenge..... 7</p> <p>Employment discrimination..... 8</p> <p>Sex discrimination..... 9</p> <p>Race discrimination..... 10</p> <p>Disability discrimination..... 11</p> <p>Age discrimination..... 12</p> <p>Discrimination because of belief/religion..... 13</p> <p>Discrimination due to sexual orientation..... 14</p> <p>Other..... 15</p> <p>If other, please write in.....</p> <p>.....</p>
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**5. I'd like to ask you some last questions about your experiences of our service so far.**

a. How did you hear about the CAB? Please write in:	
b. How long did you wait for an appointment?	<p><i>Please write in week(s).....</i></p> <p><i>Tick if drop in service <input type="checkbox"/></i></p>

**Can you rate how you found the following?**

<i>Please circle <u>one</u> number only on <u>each</u> line</i>	<b>Very Poor</b>	<b>Poor</b>	<b>Neither Poor nor good</b>	<b>Good</b>	<b>Very good</b>	<b>N/A</b>
c. Getting in touch with the bureau to make an appointment	1	2	3	4	5	6
d. The convenience of the location where you have received advice	1	2	3	4	5	
e. Information about the service	1	2	3	4	5	

**Thank You!**

*Office Use Only*

**Location of Advice:** High Street  Secondary Outlet  Primary Care Location

Clients Home  Other, please write in \_\_\_\_\_

Cyngor Ar Bopeth Cymru  
Citizens Advice Cymru



# University of Wales, Bangor & Citizens Advice Cymru

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RESEARCH PROJECT

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## 6 Month Follow up Survey

Self Administered Version – to be completed by client

Client Ref Code.....

Date:...../...../.....

**INSTRUCTIONS:** This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

- Excellent ..... 1
- Very good..... 2
- Good ..... 3
- Fair ..... 4
- Poor ..... 5

2. Compared to one year ago, how would you rate your health in general now?

(circle one)

- Much better now than one year ago ..... 1
- Somewhat better now than one year ago..... 2
- About the same as one year ago..... 3
- Somewhat worse now than one year ago ..... 4
- Much worse now than one year ago ..... 5

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

<u>ACTIVITIES</u>	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing <b>several</b> flights of stairs	1	2	3
e. Climbing <b>one</b> flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking <b>more than a mile</b>	1	2	3
h. Walking <b>half a mile</b>	1	2	3
i. Walking <b>one hundred yards</b>	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	YES	NO
a. Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
b. <b>Accomplished less</b> than you would like	1	2
c. Were limited in the <b>kind</b> of work or other activities	1	2
d. Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort)	1	2



5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a. Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
b. <b>Accomplished less</b> than you would like	1	2
c. Didn't do work or other activities as <b>carefully</b> as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(circle one)

- Not at all .....1  
 Slightly .....2  
 Moderately .....3  
 Quite a bit .....4  
 Extremely .....5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

- None .....1  
 Very mild .....2  
 Mild .....3  
 Moderate .....4  
 Severe .....5  
 Very severe .....6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

- Not at all .....1  
 A little bit.....2  
 Moderately .....3  
 Quite a bit.....4  
 Extremely .....5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks –

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of life?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and low?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

- All of the time .....1
- Most of the time.....2
- Some of the time .....3
- A little of the time.....4
- None of the time.....5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

	<b>Definitely True</b>	<b>Mostly True</b>	<b>Don't Know</b>	<b>Mostly False</b>	<b>Definitely False</b>
a. I seem to get ill more easily than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

12. Read each item below and **underline the reply** which comes closest to how you have been feeling in the past week.

Don't take too long over your replies, your immediate reaction to each item will probably be more accurate than a long, thought-out response.

I feel tense or 'wound up'  
Most of the time  
A lot of the time  
From time to time, occasionally  
Not at all

I feel as if I am slowed down  
Nearly all the time  
Very often  
Sometimes  
Not at all

I still enjoy the things I used to enjoy

Definitely as much  
Not quite so much  
Only a little  
Hardly at all

I get a sort of frightened feeling like 'butterflies' in the stomach

Not at all  
Occasionally  
Quite often  
Very often

I get a sort of frightened feeling as if something awful is about to happen

Very definitely and quite badly  
Yes, but not too badly  
A little, but it doesn't worry me  
Not at all

I have lost interest in my appearance

Definitely  
I don't take as much care as I should  
I may not take quite as much care  
I take just as much care as ever

I can laugh and see the funny side of things

As much as I always could  
Not quite so much now  
Definitely not so much now  
Not at all

**I feel restless as if I have to be on the move**

Very much indeed  
Quite a lot  
Not very much  
Not at all

Worrying thoughts go through my mind

A great deal of the time  
A lot of the time  
Not too often  
Very little

**I look forward with enjoyment to things**

As much as I ever did  
Rather less than I used to  
Definitely less than I used to  
Hardly at all

I feel cheerful

Never  
Not often  
Sometimes  
Most of the time

**I get sudden feelings of panic**

Very often indeed  
Quite often  
Not very often  
Not at all

I can sit at ease and feel relaxed

Definitely  
Usually  
Not often  
Not at all

**I can enjoy a good book or radio or television programme**

Often  
Sometimes  
Not often  
Very seldom

The following questions relate to how things have been in the last 6 months.

13. Have you noticed any change during the last 6 months in the following:

Please circle one number only on each line

	No Change	Less than usual	More than usual
The number of visits you have made to your GP?	1	2	3
The number of prescription items from your GP?	1	2	3

14. Have you noticed any difference in your health as a result of CAB help and advice?

Please write in:

15. Have you experienced anything in the last six months that has significantly affected your health, your circumstances or the way you feel?

Please write in:

16. Was it difficult for you to access the CAB service during the last 6 months because of any of the following?

Please circle one number on each line

	Yes, very difficult	Yes, a little difficult	No, not difficult	Not applicable
a. Transport costs?	1	2	3	4
b. Public transport services?	1	2	3	4
c. Travelling distances?	1	2	3	4
d. Caring responsibilities?	1	2	3	4
e. Your health or a disability?	1	2	3	4
f. Getting through on the telephone?	1	2	3	4
g. The cost of telephoning?	1	2	3	4

17. These questions ask about your experience with CAB in the last 6 months

*Please circle one number on each line*

	No	Yes, partly	Yes, fully
a. Did you fully understand the advice you were given?	1	2	3
b. Were you involved in sorting out your problem?	1	2	3
c. Were you well informed and consulted?	1	2	3
d. Have you learnt from working with CAB?	1	2	3
e. Do you have a better understanding of help that is available?	1	2	3
f. Do you feel better able to deal with problems in the future?	1	2	3
g. Has your situation improved as a result of CAB advice?	1	2	3

18. Were you able to follow up the advice provided by CAB?

*Please circle one number only*

Yes, completely .....1  
 Yes, partly .....2  
 No, not at all .....3

Please explain why:
---------------------

19. Has your problem been sorted out now?

*Please circle one number only*

Yes, completely .....1  
 Yes, partly .....2  
 No, not at all .....3

20. If YES, is this because of the help and advice provided by CAB?

*Please circle one number only*

Yes, completely .....1  
 Yes, partly .....2  
 No .....3

21. If applicable, how long did it take to sort out your case? *Please write in months:.....*

**These questions are about the difference (if any) CAB advice has made to your quality of life and financial situation in the last 6 months.**

20. Are you better off or more secure financially as a consequence of CAB advice?

*Please circle one number only*

Yes .....1  
No.....2

23 What difference (if any) has CAB advice made to you financially?

*Please write in:*

24. Do you have dependant children?

*Please circle one number only*

Yes .....1  
No.....2

**If YES continue, if NO go to question 27**

25. As a result of CAB advice are you better able to afford any of the following items for your child or children?

*Circle ALL that apply*

Clothes .....1  
Shoes .....2  
Food .....3  
A hobby or sport.....4  
A trip or holiday arranged by the school .....5  
A family holiday .....6  
pocket money.....7  
None of the above.....8

26. What difference (if any) has CAB help and advice made to the quality of life of your child or children?

*Please write in:*

27. Are you now better able to afford any of the following items for yourself?

*Circle ALL that apply*

- Clothes ..... 1
- Shoes ..... 2
- Food ..... 3
- Heating/lighting ..... 3
- Telephoning friends or family ..... 4
- Going out..... 5
- Visits to the pub..... 6
- A hobby or sport..... 7
- A holiday ..... 8
- None of the above..... 9

28. In your own words what difference has CAB help and advice made to your quality of life?

*Please write in:*



29. As a consequence of CAB help and advice have you experienced a positive difference in any of the following?

*Please circle one number only on each line*

	No difference	Some difference	A lot of difference
a. Your ability to enjoy day to day activities?	1	2	3
b. Your ability to get on with people?	1	2	3
d. Your quality of life?	1	2	3
e. Your levels of stress or anxiety?	1	2	3
f. Your peace of mind?	1	2	3
g. Your happiness?	1	2	3
h. Feelings of being isolated or cut off from society?	1	2	3

30. These questions are about the difference (if any) CAB help and advice has made to the way you feel about yourself

*Please circle one number only on each line*

	No difference	Some difference	A lot of difference
a. Do you feel more positive about yourself?	1	2	3
b. Do you feel more effective and useful?	1	2	3
c. Has your self esteem improved?	1	2	3
d. Do you feel more confident?	1	2	3
e. Do you feel more assertive?	1	2	3
f. Do you feel more in control now over your worries?	1	2	3

31. What is the current situation with your case with CAB?

*Please circle one number on each line*

	Yes	No
Is CAB still dealing with your case?	1	2
Are you expecting an outcome in the next 6 months?	1	2

**Please check all questions have been answered, thank you!**

Cyngor Ar Bopeth Cymru  
Citizens Advice Cymru



# Bangor University & Citizens Advice Cymru

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RESEARCH PROJECT

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## 12 Month Follow up Survey

Self Administered Version – to be completed by client

Client Ref Code.....

Date:...../...../.....

**INSTRUCTIONS:** This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

- Excellent ..... 1
- Very good..... 2
- Good ..... 3
- Fair ..... 4
- Poor ..... 5

2. Compared to one year ago, how would you rate your health in general now?

(circle one)

- Much better now than one year ago ..... 1
- Somewhat better now than one year ago..... 2
- About the same as one year ago..... 3
- Somewhat worse now than one year ago ..... 4
- Much worse now than one year ago ..... 5

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

<b><u>ACTIVITIES</u></b>	<b>Yes, Limited A Lot</b>	<b>Yes, Limited A Little</b>	<b>No, Not Limited At All</b>
a. <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing <b>several</b> flights of stairs	1	2	3
e. Climbing <b>one</b> flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking <b>more than a mile</b>	1	2	3
h. Walking <b>half a mile</b>	1	2	3
i. Walking <b>one hundred yards</b>	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	<b>YES</b>	<b>NO</b>
a. Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
b. <b>Accomplished less</b> than you would like	1	2
c. Were limited in the <b>kind</b> of work or other activities	1	2
d. Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

	YES	NO
a. Cut down on the <b>amount of time</b> you spent on work or other activities	1	2
b. <b>Accomplished less</b> than you would like	1	2
c. Didn't do work or other activities as <b>carefully</b> as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(circle one)

- Not at all .....1  
 Slightly .....2  
 Moderately .....3  
 Quite a bit .....4  
 Extremely .....5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

- None .....1  
 Very mild .....2  
 Mild .....3  
 Moderate .....4  
 Severe .....5  
 Very severe .....6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

- Not at all .....1  
 A little bit.....2  
 Moderately .....3  
 Quite a bit.....4  
 Extremely .....5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks –

(circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of life?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and low?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

- All of the time .....1
- Most of the time.....2
- Some of the time .....3
- A little of the time.....4
- None of the time.....5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

	<b>Definitely True</b>	<b>Mostly True</b>	<b>Don't Know</b>	<b>Mostly False</b>	<b>Definitely False</b>
a. I seem to get ill more easily than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

12. Read each item below and underline the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies, your immediate reaction to each item will probably be more accurate than a long, thought-out response.

I feel tense or 'wound up'  
 Most of the time  
 A lot of the time  
 From time to time, occasionally  
 Not at all

I feel as if I am slowed down  
 Nearly all the time  
 Very often  
 Sometimes  
 Not at all

I still enjoy the things I used to enjoy

Definitely as much  
 Not quite so much  
 Only a little  
 Hardly at all

I get a sort of frightened feeling like 'butterflies' in the stomach

Not at all  
 Occasionally  
 Quite often  
 Very often

I get a sort of frightened feeling as if something awful is about to happen

Very definitely and quite badly  
 Yes, but not too badly  
 A little, but it doesn't worry me  
 Not at all

I have lost interest in my appearance

Definitely  
 I don't take as much care as I should  
 I may not take quite as much care  
 I take just as much care as ever

I can laugh and see the funny side of things

As much as I always could  
 Not quite so much now  
 Definitely not so much now  
 Not at all

**I feel restless as if I have to be on the move**

Very much indeed  
 Quite a lot  
 Not very much  
 Not at all

Worrying thoughts go through my mind

A great deal of the time  
 A lot of the time  
 Not too often  
 Very little

**I look forward with enjoyment to things**

As much as I ever did  
 Rather less than I used to  
 Definitely less than I used to  
 Hardly at all

I feel cheerful

Never  
 Not often  
 Sometimes  
 Most of the time

**I get sudden feelings of panic**

Very often indeed  
 Quite often  
 Not very often  
 Not at all

I can sit at ease and feel relaxed

Definitely  
 Usually  
 Not often  
 Not at all

**I can enjoy a good book or radio or television programme**

Often  
 Sometimes  
 Not often  
 Very seldom



The following questions relate to how things have been in the last 6 months.

13. Have you noticed any change during the last 6 months in the following:

*Please circle one number only on each line*

	No Change	Less than usual	More than usual
The number of visits you have made to your GP?	1	2	3
The number of prescription items from your GP?	1	2	3

14. Have you noticed any difference in your health as a result of CAB help and advice?

*Please write in:*

15. Have you experienced anything in the last 6 months that has significantly affected your health, your circumstances or the way you feel?

*Please write in:*

16. Was it difficult for you to access the CAB service during the last 6 months because of any of the following?

*Please circle one number on each line*

	Yes, very difficult	Yes, a little difficult	No, not difficult	Not applicable
a. Transport costs?	1	2	3	4
b. Public transport services?	1	2	3	4
c. Travelling distances?	1	2	3	4
d. Caring responsibilities?	1	2	3	4
e. Your health or a disability?	1	2	3	4
f. Getting through on the telephone?	1	2	3	4
g. The cost of telephoning?	1	2	3	4

17. These questions ask about your experience with CAB in the last **12 months**

*Please circle one number on each line*

	No	Yes, partly	Yes, fully
a. Did you fully understand the advice you were given?	1	2	3
b. Were you involved in sorting out your problem?	1	2	3
c. Were you well informed and consulted?	1	2	3
d. Have you learnt from working with CAB?	1	2	3
e. Do you have a better understanding of help that is available?	1	2	3
f. Do you feel better able to deal with problems in the future?	1	2	3
g. Has your situation improved as a result of CAB advice?	1	2	3

18. Were you able to follow up the advice provided by CAB?

*Please circle one number only*

- Yes, completely .....1  
 Yes, partly .....2  
 No, not at all .....3

Please explain why:
---------------------

19. Has your problem been sorted out now?

*Please circle one number only*

- Yes, completely .....1  
 Yes, partly .....2  
 No, not at all .....3

20. If YES, is this because of the help and advice provided by CAB?

*Please circle one number only*

- Yes, completely .....1  
 Yes, partly .....2  
 No .....3

21. If applicable, how long did it take to sort out your case? *Please write in months:.....*

These questions are about the difference (if any) CAB advice has made to your quality of life and financial situation in the last 12 months (since you first came to CAB for help with your problem).

22. Are you better off or more secure financially as a consequence of CAB advice?

*Please circle one number only*

Yes ..... 1  
 No.....2

23 What difference (if any) has CAB advice made to you financially?

*Please write in:*

24. Do you have dependant children?

*Please circle one number only*

Yes ..... 1  
 No.....2

**If YES continue, if NO go to question 27**

25. As a result of CAB advice are you better able to afford any of the following items for your child or children?

*Circle ALL that apply*

Clothes ..... 1  
 Shoes ..... 2  
 Food ..... 3  
 A hobby or sport..... 4  
 A trip or holiday arranged by the school ..... 5  
 A family holiday ..... 6  
 pocket money ..... 7  
 None of the above..... 8

26. What difference (if any) has CAB help and advice made to the quality of life of your child or children?

*Please write in:*

27. Are you now better able to afford any of the following items for yourself?

Circle ALL that apply

- Clothes .....1
- Shoes .....2
- Food .....3
- Heating/lighting .....4
- Telephoning friends or family .....5
- Going out.....6
- Visits to the pub.....7
- A hobby or sport.....8
- A holiday .....9
- None of the above.....10

28. In your own words what difference has CAB help and advice made to your quality of life?

*Please write in:*

29. As a consequence of CAB help and advice have you experienced a positive difference in any of the following?

*Please circle one number only on each line*

	No difference	Some difference	A lot of difference
a. Your ability to enjoy day to day activities?	1	2	3
b. Your ability to get on with people?	1	2	3
c. Your quality of life?	1	2	3
d. Your levels of stress or anxiety?	1	2	3
e. Your peace of mind?	1	2	3
f. Your happiness?	1	2	3
g. Feelings of being isolated or cut off from society?	1	2	3

Please explain:

30. These questions are about the difference (if any) CAB help and advice has made to the way you feel about yourself

*Please circle one number only on each line*

	No difference	Some difference	A lot of difference
a. Do you feel more positive about yourself?	1	2	3
b. Do you feel more effective and useful?	1	2	3
c. Has your self esteem improved?	1	2	3
d. Do you feel more confident?	1	2	3
e. Do you feel more assertive?	1	2	3
f. Do you feel more in control now over your worries?	1	2	3

Please explain:

31. Thinking back to just over 12 months ago, to the time just before you approached CAB for help with your problem, how was your problem affecting you then?

Please explain:

32. Was there anything that caused or triggered the problem for which you sought advice from CAB?

Please explain:

33. Overall, what do you think you have learnt (if anything) from working with CAB to sort out your problem?

Please explain:

34. Would you recommend CAB to family, friends or people in your community?

Please explain:

35. Have you been dealing with CAB in the last 6 months in order to sort out your problem?

*Please circle one number only*

Yes .....1  
No.....2

36. What is the current situation with your case with CAB?

*Please circle one number on each line*

	Yes	No
Is CAB still dealing with your case?	1	2
Are you expecting an outcome in the future?	1	2

37. Is there anything else you would like to tell us about your experiences with CAB?

*Please write in:*

**Please check all questions have been answered, thank you!**

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