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With rights in mind

Is there a role for social welfare law advice in improving young people's mental health?

A review of evidence

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1 Introduction

Aims and scope

This paper reviews research evidence of relevance to a number of linked topics high on policy agendas, in both Government and non-government circles:

- the mental and emotional health, and general well-being, of young people;
- social exclusion experienced by young people with complex needs, as they negotiate the transition from childhood to adulthood;
- the extent and nature of social welfare law problems, their effects on people's lives, and approaches to resolving them.

The primary aim is to review evidence on whether advice about social welfare law problems may have a positive impact on mental health, among young people aged 13 to 25. To provide context, key evidence on the prevalence of mental health problems and social welfare law problems, and links between the two, is reviewed.

A reasonably broad interpretation of mental health is adopted – evidence regarding stress, worry, and loss of confidence is included, but the term 'mental health' is used throughout for convenience. The analysis assumes six main categories of social welfare law problems. They are: employment, housing (divided into problems to do with rented and owned housing), homelessness or the threat of being homeless, money/debt, and welfare benefits. Wider civil law problems (see Box 1) are also referred to, particularly where social welfare law problems could not be separated out. Discussion of social welfare issues is confined to those which most clearly may involve a need for legal advice, and wider economic, social and other factors linked with mental health are not reviewed. However, in light of their importance to policy agendas, some detail regarding young people who are NEET (not in education, employment, or training), is included.

Mental health problems are often associated with long term illness, disability, and poorer general health, both in adults (Singleton et al, 2001) and children (Green et al, 2005). So are civil and social welfare law problems (Pleasence, 2006). Due to lack of space, such associations are not discussed in this paper, save for where mental health problems have been reported together with long-standing illness or disability.

Data sources and selection of evidence

The paper draws on a number of sources – primarily large scale, nationally representative surveys, but small scale studies are also reviewed. Much of the evidence is from the English and Welsh Civil and Social Justice Survey (the CSJS). This is outlined in Box 1. Of particular relevance is analysis commissioned by Youth Access relating to the period January 2006 to September 2008, during which 841 young people aged 18-24 took part (LSRC, 2009). The author and Youth Access are grateful to Nigel Balmer of the Legal Services Research Centre for that analysis.

Box 1: The English and Welsh Civil and Social Justice Survey (CSJS)

The CSJS is a private household survey of adults aged 18 and over, now conducted on a continuous basis. It estimates the incidence of problems which raise civil law issues, experienced during the preceding three years, and which were difficult to solve. The impact of such problems on people's lives, and strategies for and experiences of going about resolving them, are also examined. Civil law problems covered include the six categories of social welfare law problems already noted. Other categories included are: consumer, neighbours, personal injury, clinical negligence, discrimination, divorce, relationship breakdown, domestic violence, children, unfair police treatment, immigration, and mental health. References in this paper to 'civil law problems' are to all 18 categories taken together .

Reports of some studies among adults do not allow for age-specific information to be extracted. Where this is so, it cannot be assumed that findings regarding adults generally, apply equally to young people. However, evidence from such studies is included as contributing to the overall picture regarding links between these areas.

Much of the evidence deals in bare percentages. Where statistically significant differences or associations have been reported – i.e. those unlikely to have arisen by chance, this is noted. Where an independent association is noted, this means that a statistically significant relationship remained when other factors were controlled for. An independent association, however, does not necessarily establish causation.

2 Executive Summary

- Mental health problems are common among young people. At any one time, around one in six 16-24 year olds meet thresholds for clinical diagnoses of problems such as anxiety and depression. When problems such as post traumatic stress, attempted suicide, eating disorders, and alcohol and drug dependence are added in, the proportion affected rises to almost a third. Mental health problems are also common among the 11-16 age group, with around one in eight meeting thresholds for clinical diagnoses at any one time.

- Mental health problems are much more common among certain groups of young people, such as those looked after by local authorities, and in custody.

- Social welfare law problems are also known to be common among 18-24 year olds. Around one in five report one or more such problems during a three year period. More than one in three report wider civil law problems (including social welfare law problems). Some will almost certainly have been experienced at 16 or 17, and perhaps also 15. But there is a gap in the evidence base regarding the full extent and nature of problems experienced by under 18s.

- Evidence from the CSJS also suggests that both mental health problems, and social welfare and wider civil law problems, are more common among 18-24 year olds who are NEET than those in education, employment or training. Also, that stress related illness, loss of confidence and worry, as a result of civil law problems generally, are more common among those who are NEET.

- The full extent to which mental health problems may cause social welfare law problems and vice versa is hard to determine. But there is evidence that people with mental health problems are more likely than those without, to experience a range of social welfare law and civil law problems. Also, that social welfare law and civil law problems can lead to and/or exacerbate stress and depression in particular, and can also have wider impacts on mental health, such as causing worry and loss of confidence.

- The evidence base linking mental health problems and social welfare law problems tends to relate to adults generally. But there is also evidence indicating similar links among young people, both generally, and particularly with regard to homelessness and mental health.

- In the CSJS, 15% of 18-24 year olds who reported mental health problems (whether or not together with long-standing illness/disability) reported homelessness problems, compared to 1% of those reporting neither type of health problem. Approximately 35% who reported mental

health problems, reported housing problems more generally. This rose to approximately 50% among those who also reported long-standing illness or disability.

- Looked at from the other direction, although the numbers involved were small, 62% of 18-24 year olds in the CSJS who reported homelessness problems, also reported mental health problems. In another survey, a third of 16-17 year olds accepted as statutorily homeless reported current anxiety, depression, or other mental health problems.

- Notwithstanding the difficulties in establishing cause and effect, it seems clear that social welfare law advice should have a role to play in improving mental health, and in thus reducing the social and economic costs associated with mental ill-health. Although as noted below, the evidence base for the impact of social welfare law advice is currently fairly limited, what evidence there is points to it potentially being instrumental to improvements in this area. And as Pleasence and Balmer (2009) put it:

  To the extent that problems involving rights play a role in bringing about or exacerbating mental illness, there is a role for legal and advice services in its reduction. ..... To the extent that mental illness plays a role in bringing about or exacerbating rights problems, advice services should be integrated with mental health services, to accommodate this and reflect the particular needs of people facing mental illness. To the extent that rights and mental health problems simply co-occur, advice and mental health services should anyway be integrated where possible, to enable clients/patients to receive "seamless services".

- With regard to young people specifically, two other dimensions to mental health problems indicate the importance of advice that may help to ameliorate them. The first is that mental health problems experienced by children and young people are often enduring – and have been found to often persist three years after initial assessments. The second is that such problems are also frequently precursors to mental health problems later on in life. Both dimensions point up the importance of early intervention.

- Several studies have sought to demonstrate impacts of advice quantitatively, using recognised measures of health. Some of these have compared mental health scores before and after advice. Some have also compared changes in mental health scores between clients who received advice and gained as a result, and those who did not. A small number of statistically significant improvements in mental health scores following advice have been noted, as have a small number of significantly greater improvements among those who gained as a result of advice, compared to those who did not.

- Other quantitative studies, including two randomised controlled trials (RCTs), have not generated statistically significant findings of a similar nature. That however appears due to methodological limitations as much as anything else.

- A number of studies have relied on self-reporting by clients (and sometimes their GPs). Whether quantitative or qualitative, these all point towards social welfare law advice being instrumental to improvements in mental health. In particular, reduced levels of stress and depression tend to be reported.

- The evidence base here relates mainly to adults generally, but there is also some evidence regarding positive impacts of advice for young people aged 16-25, provided by YIACS (Youth Information, Advice, Counselling and Support Services).

- There is scope for further research here. The evidence base is still fairly limited, and largely relates to impacts of welfare benefits advice accessed via healthcare settings, and debt advice, for adults generally. A need for further research into the impacts on mental health of advice for

young people, and regarding homelessness and housing problems specifically, is indicated. Addressing the gap in the evidence base on the prevalence of social welfare and civil law problems among 16-17 year olds would appear to be a useful preliminary step towards this.

- Identifying and measuring impacts of social welfare law advice can however require considerable resources in terms of time and skills. Rigorous studies will be beyond most advice providers without substantial additional inputs.

- Specific challenges relevant to researching the impact of advice on young people's mental health include establishing that tools used are age-appropriate, i.e. are capable of measuring aspects of mental health that are most relevant to them.

- An additional consideration is that quite substantial proportions of people who report social welfare and civil law problems, also report obtaining medical treatment, including counselling, for stress etc. resulting from those problems. Isolating the effects of social welfare law advice from the effects of such treatment can be a complex exercise. Improvements in emotional outlook may be attributed to practical help received from advice providers. But help from formal, non-legal sources that deal specifically with emotional or mental health difficulties, may be equally important.

- There is also evidence suggesting that people want help with debt problems to include counselling, 'someone to talk to and share feelings with', and 'help with stress and depression'. Research into the impact of social welfare law advice delivered in conjunction with counselling services, and which investigates what it is about each type of intervention that may be most beneficial for young people's mental health, would therefore seem of value.

- Also with regard to young people specifically, advice outcomes may be linked to the contexts in which it is received. Young people may prefer to get legal advice in youth settings, and favour either youth workers with good legal knowledge, or advisers/lawyers specialising in young people. This indicates a need for research on impacts to take account of young people's preferred methods of accessing advice.

3 How common are mental health problems among young people?

Summary

- At any one time, around one in six 16-24 year olds meet thresholds for clinical diagnoses of problems such as anxiety and depression.
- When problems such as post traumatic stress, attempted suicide, eating disorders, and alcohol and drug dependence are added in, the proportion affected rises to almost a third.
- Mental health problems are also common among 11-16 year olds, with around one in eight meeting thresholds for clinical diagnoses at any one time.
- Evidence from the CSJS suggests that young people who are NEET are more likely to experience mental health problems than those who are in education, employment or training.

Evidence from psychiatric morbidity surveys

A series of national surveys have used clinically recognised measures to estimate psychiatric morbidity – i.e. prevalence of mental health problems. These surveys have covered people living in private households in Britain, and selected other populations. The most recent covered England (McManus et al, 2009). It estimated that almost a third of 16-24 year olds (32%) were affected by one or more psychiatric disorder. This was higher than for all adults (23%). Twelve percent of 16-24 year olds were affected by two or more disorders, compared to 7% of all adults. Eighteen percent in this age group met the threshold for clinical diagnosis of common mental disorders (principally anxiety and depression). This appears broadly in line with findings from an earlier, similar survey across Britain (Singleton et al, 2001).

Table 1 gives breakdowns for problems included in the headline figures, that affected 16-24 year olds most frequently. It also illustrates some of the differences between the sexes here.

Table 1: Psychiatric disorders most frequently affecting 16-24 year olds living in private households in England, 2007 (source: McManus et al, 2009).

Disorder, symptoms, or behaviour included in headline figures	Reference period	16-24 year olds			All adults
		Male	Female	All	
		%	%	%	%
Common mental disorders*	Past week	13.0	22.2	17.5	16.2
Post traumatic stress disorder (PTSD)	Past week	5.1	4.2	4.7	3.0
Attempted suicide	Past year	1.0	2.4	1.7	0.7
Eating disorder + 'significant impact'*	Past year	1.7	5.4	3.5	1.6
Alcohol dependence (mainly 'mild')	Past 6 months	12.6	9.8	11.2	5.9
Drug dependence (mainly cannabis)	Past year	13.3	7.0	10.2	3.4
Problem gambling	Past year	2.3	-	1.2	0.7

*Common mental disorders comprised: mixed anxiety and depressive disorder, generalised anxiety disorder, depressive episode, phobia, obsessive-compulsive disorder, panic disorder. Eating disorder + 'significant impact' indicates that respondents also said feelings about food interfered with their ability to work, meet personal responsibilities, and/or enjoy a social life.

Other surveys in the same series have focused on the mental health of children and young people. Green et al (2005) found that among 11-16 year olds in Britain, around 1 in 8 (12%) had one or more mental disorder. As noted in Box 2, constructs of disorders here differed from those for adults. The most common were conduct and emotional disorders, which affected 7% and 5% of 11-16 year olds overall.

Box 2: Definitions and prevalence of mental disorders affecting 11-16 year olds living in private households in Britain, 2004 (source: Green et al, 2005).

Emotional disorders were similar to common mental disorders in adults, in that they involved anxiety and depression. But they also included a specific separation anxiety, and post traumatic stress. Conduct disorders, a category not applied in the adult population, comprised oppositional defiant disorder, and socialised and unsocialised conduct orders. Overall, mental disorders were more common among boys (13%) than girls (10%), as were conduct disorders (8% vs 5%). Emotional disorders were slightly more common among girls (6% vs 4%).

Away from private households, mental health problems have been found to be far more common. For example in England, 49% of 11-15 year olds and 39% of 16-17 year olds looked after by local authorities, have been found to have mental disorders (Meltzer et al, 2003b). Much of the increase here was attributable to conduct disorders being far more prevalent, but the incidence of emotional disorders was also much greater than comparable general population estimates.[1]

Incidence of mental health problems has been found to be higher still among young people in custody. Lader et al (2000) reported that of 16-20 year olds in custody in England and Wales, the percentages with common mental disorders ranged from 42% among sentenced males, to 68% among sentenced females. Among males, personality disorders and psychotic disorders (a category that includes schizophrenia and bi-polar disorder) were far, far more common than in the general population.[2]

Mental health problems have also been found to be much more common among homeless young people. Homelessness and mental health is discussed later on.

Evidence from the English and Welsh Civil and Social Justice Survey (CSJS)

Box 3: Measures of health in the CSJS

The CSJS includes two self-reported measures of health: whether respondents have had a long-standing illness, disability or infirmity that troubled or was likely to affect them over a period of time, and whether they have suffered from 'stress, depression or some other kind of mental health problem' (referred to in this paper simply as 'mental health problems'). The reference period is the previous three years. Although not based on clinical measures, 72% of self-reported mental health problems have been reported to involve medical treatment. Of those, diagnoses of depression have been reported for 60% (Pleasence and Balmer, 2009).

During 2007, the CSJS also incorporated a shortened version of the General Health Questionnaire (the GHQ-12). This is used principally to identify symptoms of common mental disorders such as anxiety and depression. Analysis of results was by GHQ scoring, with a score of 4 or more taken to indicate possible disorder. In 2007, Diener's Satisfaction With Life Scale, a measure of subjective well-being, was also added. This produces scores according to which people may be assessed as being satisfied, neutral or dissatisfied with life overall.

Based on data from 2006-2008 (LSRC, 2009), 14% of 18-24 year olds reported mental health problems. This included 4% who also reported long-standing illness or disability. During 2007, 266 18-24 year olds took part whilst the GHQ-12 was in use; 12% (31) met the threshold for possible psychiatric disorder. During the period over which satisfaction with life was measured, 15% (76/503) assessed as dissatisfied.

Among 18-24 year olds who were NEET, 32% reported mental health problems. This included 12% who also reported long-standing illness or disability. The figures for those in education, employment or training were 10% and 2% respectively. Over the period during which the GHQ-12 was employed, 16% of those NEET met the threshold for possible psychiatric disorder, compared to 11% of those not NEET.

[1] Other studies by Meltzer and colleagues have found similar patterns in Scotland and Wales.
[2] There were too few female prisoners to analyse prevalence of these disorders among them.

4 How common are social welfare law problems among young people?

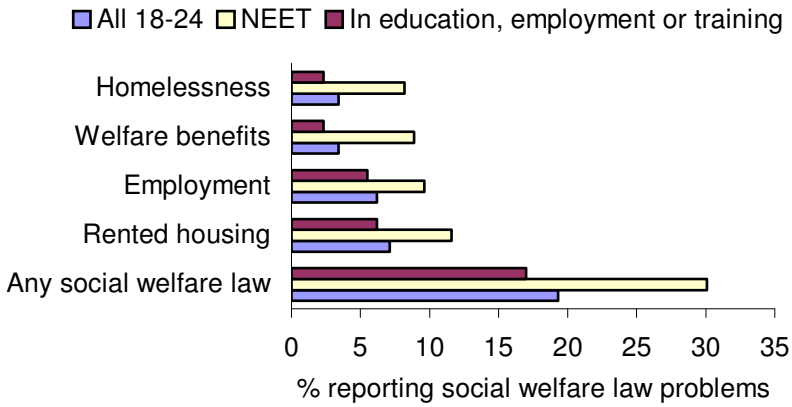
Summary

- Around one in five 18-24 year olds report one or more social welfare law problems over a three year period.
- Young people who are NEET appear more likely to report social welfare law problems than those in education, employment or training.
- Some problems will almost certainly have been experienced at 16 or 17, and perhaps also 15. But there is a gap in the evidence base regarding the full extent and nature of problems experienced by under 18s.

Analysis of 2006-2008 data from the CSJS (LSRC, 2009) indicated that 19% of 18-24 year olds reported experiencing one or more social welfare law problems.[3] The most common were to do with: rented housing (reported by 7%), employment (6%), money/debt (6%), welfare benefits (3%) and homelessness/the threat of homelessness (3%).[4] As the reference period for the CSJS is the preceding three years, some of these problems will almost certainly have been experienced at 16 or 17, and perhaps also 15. However, how many problems and what types is not known. There is also a general gap in the evidence base regarding under 18s here.

Among those NEET, problem rates were higher: 30% reported one or more social welfare law problems, compared to 17% of those in education, employment or training. When broken down by problem type numbers are small, and so should be viewed with caution. But higher percentages of those NEET reported certain types of problems compared to those in education, employment or training. This was so for problems to do with rented housing (12% vs 6%), employment (10% vs 6%), welfare benefits (9% vs 2%) and homelessness/the threat of homelessness (8% vs 2%).

Figure 1: Incidence of social welfare law problems (source: LSRC, 2009)



The CSJS, being a private household survey, excludes certain populations. In 2001, a parallel survey was conducted among approximately 200 people living in temporary accommodation (hostels, bed and breakfast, etc.), of whom 43% were 18-24 year olds. Among respondents generally to this parallel survey, 84% reported one or more *civil* law problems.[5] Problems to do with rented housing were the most common, reported by 52%. Employment, debt/money, welfare benefits and homelessness problems were also reported more often than in the main survey (Pleasence, 2006).

[3] Figures here for incidence of social welfare law problems are lower than those usually reported in respect of legal problems. This is because reporting usually focuses on civil law problems, which – as they comprise three times as many categories, are much more common (see Box 1). By way of comparison, in 2006-2008, 36% of 18-24 year olds reported one or more civil law problems. This figure rose to 46% among those NEET, compared to 34% among 18-24 year olds who were in education, employment or training.

[4] Less than 1% reported problems to do with owned housing, reflecting relatively low levels of home ownership among this age group.

[5] An equivalent figure for the proportion reporting *social welfare* law problems is not available.

The CSJS highlights that people may experience multiple problems, and that certain types of problem tend to cluster, i.e. be reported along with others. Balmer et al (2007) have reported that there is some evidence that for 18-24 year olds, this includes a tendency for employment, homelessness, rented housing and money/debt problems to cluster together (although the numbers of problems involved in the analysis leading to identification of this tendency have been small).

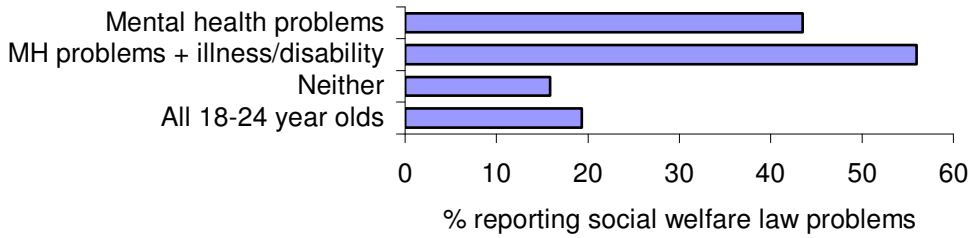
5 Are young people with mental health problems more likely to report social welfare law problems?

Summary

- Among 18-24 year olds, social welfare law problems (and civil law problems generally) are reported much more often by those who experience mental health problems, than those who do not.
- Those who report both mental health problems and long-standing illness or disability appear most likely to report social welfare law (and civil law) problems.
- Notable differences have been found in relation to homelessness, and housing problems in particular. Fifteen percent of 18-24 year olds who reported mental health problems (whether or not together with long-standing illness/disability) reported homelessness problems, compared to one percent of those reporting neither type of health problem. Approximately 35% who reported mental health problems, reported housing problems more generally. This rose to approximately 50% among those who reported long-standing illness/disability in addition to mental health problems.

Analysis from the CSJS (LSRC, 2009) indicated that among 18-24 year olds, social welfare law problems, and wider civil law problems, were reported much more often by those who experienced mental health problems. Fifty six percent of those who reported both mental health problems and long-standing illness/disability reported social welfare law problems, compared to sixteen percent of those with neither type of health problem.

Figure 2: Social welfare law problems by mental health status (source: LSRC, 2009)



Social welfare and civil law problems were also more common among those who assessed as dissatisfied with life, rather than satisfied with or neutral about it. Civil law problems were also more common among those with possible psychiatric disorders (Table 2 below).

Table 2: Prevalence of social welfare law and civil law problems among 18-24 year olds, according to mental health status (source: LSRC, 2009).		
	% reporting one or more	
	social welfare law problems	civil law problems
Self reported health status:		
Mental health problem only	44	66
Mental health problem + long-standing illness/disability	56	76
Neither	16	31
GHQ-12 scores:		
4 or more (possible psychiatric disorder)	Not available	58
Less than 4		34
Satisfaction with life:		
Dissatisfied	38	59
Neutral or satisfied	17	33

When categories of social welfare law problems are looked at according to whether mental health problems were reported, the numbers become small. Therefore, some caution is warranted. However, the 87 young people with mental health problems (including those also with long-standing illness/disability) reported five types of social welfare law problems more often than those who reported neither type of health problem: 9% vs 6% for employment, 15% vs 1% for homelessness, 15% vs 6% for money/debt, 16% vs 6% for rented housing, and 12% vs 3% for welfare benefits.

The evidence above is consistent with findings from the CSJS regarding adults generally. Based on data from 2006-07, Pleasence and Balmer (2009) reported an independent association between mental health problems and *civil* law problems. Those who reported mental health problems were significantly more likely to report one or more civil law problems than other respondents (65% vs 32%). The analysis also indicated a significant association between reporting of mental health problems alone, with eight individual categories of problems, including employment, homelessness, and money/debt. Mental health problems and long-standing illness/disability together, were significantly associated with 13 out of 14 categories analysed (the exception being problems to do with owned housing).

Also based on the CSJS, Pleasence and Balmer (2007a) have reported an independent association between self-reported mental health problems, and housing problems (defined as involving neighbours, owned and rented housing – including mortgage/rent arrears, and homelessness/threat of homelessness). Adults who reported mental health problems were more than twice as likely to report housing problems, compared to those who reported neither mental health problems nor long-standing illness or disability. Adults who reported both mental health problems and long-standing illness/disability, were three times as likely to report housing problems.

Homelessness problems in particular were notable here: they were around ten times more likely to be reported by those who reported mental health problems. Overall, 26% of adults who reported mental health problems, reported housing problems, as did 30% of those who reported both mental health problems and long-standing illness/disability. Comparable rates among 18-24 year olds were higher than this: approximately 35% and 50% respectively.

Also with regard to housing problems generally, Meltzer et al (2002) compared the circumstances of adults with four types of mental health disorder (common mental disorders, probable psychotic disorder, alcohol or drug dependence) with those who had none of these disorders. Between 9% and 19% of those with such disorders described their home as being in a poor state of repair, and between 11% and 20% reported damp, compared to 4% and 6% respectively of adults with none of the four disorders. Between 11% and 15% of those with such disorders reported a lack of security in their accommodation, in that they thought they might have to leave before they wanted to, compared to 5% of people with none of the four disorders. These findings need to be read in the context of adults with any of the four disorders being far more likely to live in rented accommodation, than those with no such disorders.

Links between debt and mental health of adults generally, are well-established. Meltzer et al (2002) found that the same four categories of mental disorder discussed above, were independently associated with being in debt.[6] Based on re-analysis of Meltzer et al's data, Jenkins et al (2008) have reported that overall, adults with any of the four disorders were three times as likely to have been in debt, compared to those with none of the disorders (23% vs 8%). They also found that the likelihood of mental disorder increased with the number of debts. Interestingly, they also found that when other factors were controlled for, the relationship between debt and mental disorder appeared stronger than that between low income and mental disorder.

Mind (2008) conducted an online survey with the Royal College of Psychiatrists, among adults who had 'experienced mental distress' or used a mental health service during the previous two years. Half (51%) reported recent experience of 'problem debt'.[7] Of these respondents, 66% cited mental health problems as a reason for their problem debts. Over 85% said that their mental health problems had made their debt problems worse. (The direct applicability of these findings to young people is not clear: 'most' of the 1,800 responses were reported to be from 30-39 year olds.)

6 Are young people with social welfare law problems more likely to report mental health problems?

Summary

- Mental health problems are reported more frequently by 18-24 year olds who report social welfare law problems, than by those who do not.
- 18-24 year olds who report civil law problems also report mental health problems more frequently. But overall, poorer mental health may be more common where social welfare law problems are reported.
- Though based on small numbers, substantial proportions of 18-24 year olds in the CSJS who report social welfare law problems, also report mental health problems. Homelessness problems stand out here: 62% of those who reported such problems also reported mental health problems.
- These findings are consistent with those from other sources. In one survey, a third of 16-17 year olds accepted as statutorily homeless reported current anxiety, depression or other mental health problems.

Among 18-24 year olds in the CSJS who reported social welfare or civil law problems, between two and three in ten reported mental health problems, had possible psychiatric disorders, or assessed as dissatisfied with life. These features were less common among those who did not report social welfare or civil law problems. For example, 31% of young people who experienced one or more social welfare law problems also reported mental health problems, compared to 9% of those who did not report social welfare law problems. Similarly, those reporting social welfare law problems were more than twice as likely to be dissatisfied with life.

Table 3 provides breakdowns. The figures suggest that overall, poorer mental health may be more common when social welfare law problems are reported.

[6] Defined as having been behind with one or more payments during the previous 12 months – most often council tax, phone bills, rent, utilities, and credit card payments.
[7] Defined as having been two or more consecutive payments behind with a bill during the previous 12 months.

Table 3: Mental health problems, possible psychiatric disorder, dissatisfaction with life, among 18-24 year olds reporting social welfare/civil law problems (source: LSRC, 2009).			
	Mental health problems, whether or not also long-standing illness/disability	Possible psychiatric disorder (GHQ-12 score of 4 or more)	Dissatisfied with life
	%	%	%
Social welfare law:			
One or more problems	31	29	28
No such problems	9	Not available	12
Civil law:			
One or more problems	26	18	24
No such problems	7	8	10

Possible psychiatric disorder also appeared more common among those NEET who reported social welfare and civil law problems, although the numbers involved were small. When social welfare law problems were reported, 36% (5/14) scored 4 or more on the GHQ-12, as did 26% of those who reported civil law problems (6/23). Comparable figures for those in education, employment or training were 27% (10/37) and 16% (12/75).

When the prevalence of mental health problems is analysed in relation to categories of social welfare law problems, the numbers become small. However, as shown in Figure 3 and Table 4, quite substantial proportions of all 18-24 year olds who reported social welfare law problems, also reported mental health problems. Notwithstanding the small numbers, homelessness problems stand out here: 62% of those who reported such problems also reported mental health problems.

Figure 3: Percentage of 18-24 year olds reporting social welfare law problems who also reported mental health problems (source: LSRC, 2009)

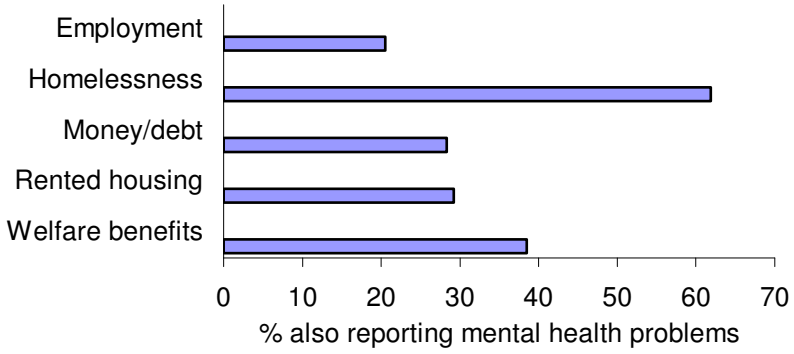


Table 4: Numbers of 18-24 year olds who reported social welfare law problems, and numbers/percent of those who also reported mental health problems (source: LSRC, 2009).			
	Reported by all 18-24 year olds	Also reporting mental health problems, whether or not long-standing illness/disability	
Problem type	**N**	**N**	**%**
Employment	39	8	21
Homelessness	21	13	62
Money/debt	46	13	28
Rented housing	48	14	29
Welfare benefits	26	10	39

A good number of other studies have highlighted links between youth homelessness and mental health problems. Although estimates vary depending on the populations studied and definitions employed, they routinely suggest that mental health problems are much more common among homeless young

people than in the general population (Stephens, 2002). For example, Lader et al (2000) cite a survey in the psychiatric morbidity series referred to earlier.[8] This found that 39% of homeless 16-24 year olds staying in hostels or in leased accommodation had common mental disorders. Three percent in hostels had a psychotic disorder.

Pleace et al (2008) and Quilgars et al (2008) reported on surveys of 350 16-17 year olds, and a little over 2,000 families, accepted as statutorily homeless in England. Of the families, almost 40% were headed by 16-24 year olds. Among the 16-17 year olds, 33% self-reported current anxiety, depression, or other mental health problems (40% of females, 24% of males). So did 23% of the 16-24 year old heads of families.

Fifty two percent of the 16-17 year olds, and approximately forty five percent of the 16-24 year old heads of families, reported *ever* having experienced anxiety, depression, or other mental health problems. Both heads of families generally, and the 16-17 year olds, who reported current mental health problems were more likely to say they had got worse than better since leaving their last settled accommodation.[9]

There is also evidence linking debt problems and poorer mental health. Reading and Reynolds (2001) reported that among approximately 270 mothers of children under a year old, worries about debt were independently associated with increased likelihood of depression.[10] A quarter of the mothers were aged 25 or under. Melhuish et al (2008) analysed data from around 8,000 mothers of three year olds, living in deprived areas with Sure Start programmes. They found significant relationships between financial difficulties (which included bills not being paid on time) and five aspects of psychological well-being: lower satisfaction with life, depression, malaise (e.g. feeling tired, miserable, worried), lower self-esteem, and feeling less in control of one's life.[11]

7 Do social welfare law problems impact on young people's mental health?

Summary

- 18-24 year olds frequently report that their civil law problems (including social welfare law problems) lead to stress related illness. Also, that they worry about such problems all or most of the time.
- Those who report mental health problems, particularly when together with long-standing illness or disability, appear more likely to report such adverse impacts.
- Young people who are NEET also appear more likely to report such adverse impacts.
- Of social welfare law problems, homelessness problems are most frequently reported as leading to stress related illness, and as the subject of worry all or most of the time.
- There is also a wider evidence base indicating that debt problems often have adverse effects on mental health.

The CSJS asks about time spent worrying about problems. It also asks about adverse consequences, including stress related illness, and loss of confidence. Table 5 below provides breakdowns for *civil* law problems reported by 18-24 year olds.[12] It suggests that as well as adverse consequences flowing generally from such problems, existing mental health problems are often exacerbated. For example, 22% of civil law problems reported by 18-24 year olds generally, were reported to have led to stress related illness. This almost doubled to 41% where mental health problems alone were reported, and further increased to 59% where mental health problems featured together with long-standing

[8] Gill, B., Meltzer, H., Hinds, K. and Petticrew, M. (1996) *OPC Surveys of Psychiatric Morbidity in Great Britain, Report 7: Psychiatric morbidity among homeless people* (HMSO).
[9] Although whether other respondents had mental health problems in their last settled accommodation but no longer had them at the time of the surveys is not known.
[10] Measured using the Edinburgh Postnatal Depression Scale.
[11] Data on these mothers' ages is not reported, but a report of the main survey on which the analysis was based, suggests that in the region of 10% may have been under 20 when their child was born:
NESS (2008) *The Impact of Sure Start Local Programmes on Three Year Olds and Their Families* (DCSF).
[12] Comparable figures for social welfare law problems were not available at the time of writing.

illness/disability. The figures also suggest that such adverse consequences resulted more frequently for those NEET than those in education, employment or training.[13]

Although the numbers involved were quite small due to the structure of the survey (which only asks each respondent about treatment for one problem), 35% of 18-24 year olds who reported stress related illness as a consequence of civil law problems (17/49) said they visited a GP, hospital or other health care worker as a result.

Table 5: Adverse health consequences reported as resulting from civil law problems, by 18-24 year olds generally and by sub-groups (source: LSRC, 2009)

	Stress related	Loss confidence	Worry all/most of time
Problems reported by	% of problems	% of problems	% of problems
18-24 year olds generally	22	9	36
With mental health problem only	41	13	46
With mental health problem + long-standing illness/disability	59	17	63
Neither	11	7	28
NEET	34	13	45
In education/training/employment	18	7	32

Table 6 provides breakdowns for adverse consequences reported for main categories of social welfare law problems, based on an earlier analysis relating to adults generally (Pleasence et al, 2007). Homelessness problems were most likely to lead to stress-related illness (53%), and to be the subject of worry all or most of the time.[14] Employment problems were most likely to result in loss of confidence (33%).

Table 6: Adverse consequences for mental health reported by adults generally, as resulting from social welfare law problems (source: Pleasence et al, 2007)

	Stress related	Loss confidence	Worry all/most of time
Problem type	% of problems	% of problems	% of problems
Employment	40	33	over 50%
Homelessness	53	19	over 70%
Housing – owned	17	9	approximately 40%
Housing – rented	27	12	approximately 40%
Money/debt[15]	21	10	approximately 25%
Welfare benefits	31	6	over 40%

Moorhead et al (2006) reported on qualitative interviews with 58 advice agency clients seeking help with welfare benefits, rented housing, and debt problems, Consistent with findings from the CSJS, they reported that *'many clients spoke of feeling under pressure, or of the stress and anxiety of dealing with their problems'*.

The wider evidence base for the impact of social welfare law problems on mental health includes surveys of advice agency clients with debt problems. Edwards (2003) reported that among 374 clients seeking help with debt from Citizens Advice Bureaux (CABx), 62% cited the impacts as including stress, anxiety or depression. Of these, 43% had sought treatment or counselling through their GP – although over half of those who had sought treatment had done so before the onset of their debt problems. Williams and Sansom (2007) reported that of 176 clients of advice agencies (predominantly CABx) seeking help with debt problems: 83% said they spent all or most of their time worrying about money/their debts, 96% said that worrying about money had made them feel stressed, 88% that it had made them feel depressed, and 89% said it was difficult to carry on living normally while experiencing

[13] Figures in Table 5 are lower than figures from the 2004 CSJS (Balmer et al, 2007, plus further unpublished analysis conducted for Youth Access). Reasons for this are not clear.

[14] Pleasence and Balmer (2009) reported that 43% of homelessness problems led to stress related illness. Although this is lower than the earlier figure, homelessness was again cited as the category of social welfare law problem most likely to lead to stress related illness.

[15] The relatively low levels of adverse consequences for money/debt problems may reflect the fact that in the CSJS, this category is both wider and narrower than one simply covering debt problems that involve difficulties in making payments, and arrears.

debt problems. Sixty two percent were currently receiving treatment, medication or counselling for debt-related ill health/stress, of whom most had seen GPs. In the Mind survey referred to earlier, 91% of respondents with debt problems, said that they had made their mental health problems worse (Mind, 2008).

Several studies have examined links between student debt and mental health. Cooke et al (2004) surveyed 4,900 university undergraduates (of whom 80% were under 21 on entry to university). They found significant relationships between how the students felt about debt – i.e. the extent to which they worried about it, and the extent to which financial concerns were currently an issue for them – and mental health.[16] Those who were more worried about debt, and those for whom financial concerns were more of a current issue, had significantly worse mental health scores than those who worried less about debt, and for whom finances were less of a current concern.

More generally, YouthNet and Citizens Advice (2008) conducted an online survey among 16-25 year olds in the UK, to which 651 responded. Of these, 34% said they had debt related problems at the time. A further 13% said they had done in the past. Of the total 47% who reported experience of such problems, 53% said that their mental health had been negatively affected. The report of this survey does not define 'debt related problems' or 'mental health'. But it is included here due to its focus on young people, including 16 – 17 year olds, which appears unusual.

8 The potential impact of social welfare law advice on mental health

Summary

- There is some evidence indicating that social welfare law advice may have a positive impact on the mental health of young people – and that when it does, the impact can be substantial. But the evidence base is currently limited.
- Statistically robust evidence of social welfare law advice leading to improvements in mental health also appears fairly limited at a more general level. However, that appears due to methodological limitations as much as anything else.
- What evidence there is, including evidence from qualitative studies, points to advice potentially being instrumental to improvements in this area.
- Research efforts to date appear to have focused on the impact of welfare benefits and debt advice. However, small scale pilots suggest potential for measurable gains in other areas, such as employment and housing advice.

Evidence generally

There is increasing interest in outcomes and wider impacts of social welfare law advice. Literature reviews have been conducted in respect of debt (Williams, 2004), welfare benefits (Wiggan and Talbot, 2006; Adams et al, 2006) and advice more generally – though with an emphasis on welfare benefits (Greasley and Small, 2002). These and other studies indicate that statistically robust evidence linking advice to improvements in mental health is fairly limited. That however appears due to methodological limitations as much as anything else. What evidence there is, both quantitative and qualitative, points towards social welfare law advice potentially being instrumental to improvements in this area.

Much of the evidence comes from studies of welfare benefits advice accessed via healthcare settings. In addition to quantifying monetary gains for clients, such studies have attempted to capture improvements in both mental and physical health – largely, it seems, on the premise that improved financial circumstances ought to produce such benefits. Adams et al conducted a systematic review of evidence in this area, which identified over 50 relevant studies. Many clearly demonstrated the financial gains to be had, but most were reported to lack scientific rigour in their assessments of impacts on health. Half a dozen UK projects were however identified which involved before and after studies and/or

[16] Scored using GP-CORE (General Population version of Clinical Outcomes in Routine Evaluation).

included (non-ramdomised) comparison groups. In some, the intervention tested was the provision of advice, and in others it was an increase in income following advice. These studies employed a variety of validated tools, noted in Box 4, to measure changes in physical and mental health scores between baseline and follow up (most often at 6 or 12 months), and differences between intervention and comparison groups.

A number of improvements in physical and mental health were reported, but relatively few involved statistically significant changes. Those that did, tended to be in respect of mental and emotional health, rather than physical health. Several factors, including small sample sizes, appeared likely to have contributed to the relative lack of significant findings. This led Adams et al to conclude that their review primarily identified an *'absence of good quality evidence, rather than evidence of absence of an effect'*.

Box 4: Validated health measures used in studies reviewed by Adams et al (2006)
SF-36 (Short Form 36) – a general measure of physical and mental health;
HADS (Hospital Anxiety and Depression Scale);
MYMOP (Measure Yourself Medical Outcome Profile scale) – which measures well-being based on aspects of physical and mental health which patients themselves identify as most important to them;
NHP (Nottingham Health Profile) – which measures physical and emotional health;
Edinburgh Postnatal Depression Scale.

One larger scale study was that by Abbott et al (2006). This was conducted in 2000-2001, and involved recipients of welfare benefits advice provided by outreach services in GP surgeries. Physical and mental health were measured using the SF-36 shortly after initial receipt of advice, and 6 and 12 months later. Scores were compared for clients who had and had not gained (unquantified) increases in income (of whom 160 and 84 respectively remained in the study at 6 months, and 134 and 50 remained at 12 months).

At six months, one significant difference was found: average improvements in scores regarding bodily pain were significantly greater among those who had gained increased income, than those who had not. At 12 months, there were two significant differences, in respect of mental health scores, and scores for emotional role (i.e. the extent to which emotional problems interfered with work or other regular activities). Average improvements in scores on both these measures were significantly greater among those who had gained increased income, than those who had not.

Most studies regarding the impact of welfare benefits advice appear to have involved localised projects. One exception is Borland and Owens (2004). They reported on the 'Better Advice, Better Health' initiative, which involved Citizens Advice Bureaux (CABx) across Wales giving welfare benefits advice, via referrals from GPs and other primary healthcare providers. Almost 1,100 clients completed a postal questionnaire. This included one question of interest here: 88% said that they 'felt better after seeing the advice worker'.[17] Borland and Owens relied on a postal survey of GPs, to which 35 (73%) responded, for more information. Substantial majorities agreed that benefits of the project for their patients included those noted in Box 5 below.

Box 5: Selected benefits for patients of the 'Better Advice, Better Health' initiative in Wales, identified by GPs (source: Borland and Owens, 2004)
Statements and percentages who agreed/strongly agreed with them: makes patients feel that someone cares, reduces feelings of hopelessness (both 84%), gives them a lift, increases feelings of effectiveness (both 69%), increases self esteem (63%), increases quality of life (77%), improves general health (63%), helps patients to deal with chronic illness (61%).

There appears to have been one randomised controlled trial (RCT) designed to test the impact of welfare benefits advice on health: a pilot conducted by Mackintosh et al (2006). This involved a randomly generated sample of 126 older people (aged 60 and over) recruited via GP practices, of whom 109 remained in the study at the end. Participants were randomly allocated to intervention and control groups. Both were offered a full 'benefits check' via a home visit, and where appropriate received help with making claims, but for the control group, this was delayed by six months.

[17] What led to their feeling better is not clear: the proportions of respondents for whom advice did and did not lead to financial or other gains are not reported.

A battery of tools, including the SF-36 and the HADS (see Box 4), were used to measure various aspects of physical and mental health at baseline and after 6, 12, and 24 months. The trial detected very little evidence of changes in health between groups, or over time. Likely reasons suggested for this included small sample size, and that the intervention tested was receipt of a benefits check. Just over 40% in both groups were found not eligible for any unclaimed benefits, thus reducing the scope for gains which might have led to quantitatively measurable changes in health.

Mackintosh et al also suggested that some of the measures they used may not have been age-appropriate, or powerful enough to detect subtle changes in aspects of well-being of importance to their participants. In an accompanying paper, Moffat et al (2006) reported on qualitative interviews with 25 participants from the RCT, which suggested a rather more positive picture. Among those who did obtain unclaimed benefits as a result of the advice they received, the impacts of both financial and non-financial gains (e.g. disabled parking permits, household aids and adaptations) were perceived as considerable. They meant that people were better able to maintain their independence and to take part in social activities, and these improvements, together with a general *'easing of financial worries'*, led to greater overall *'peace of mind'*.

The Legal Services Research Centre (Pleasence and Balmer, 2007) has also conducted a RCT, as part of a multi-strand Impact of Debt Advice Research Project. The RCT involved 402 participants with debt problems,[18] recruited from Job Centres, who were randomly allocated to intervention and control groups. Due to ethical and other considerations, the intervention tested was the offer of, rather than the receipt of, advice (it being considered impractical, as well as unethical, to attempt to ensure that the control group did not obtain advice). It was intended that the trial should run for approximately a year, with assessments at baseline, and follow ups at 20 and 50 weeks. Hypotheses included that those offered advice would, among other things, be in better general health, and less anxious.[19]

The trial was stopped at 20 weeks due to higher than anticipated attrition – only 234 participants remained in the study, too few to continue. At that point, a very small positive change in general health, and a small reduction in anxiety, were observed among the group offered advice, but neither difference approached statistical significance. Implications of the lack of statistically significant changes appear limited – again it seems, largely due to methodological issues. It was noted that 20 weeks is not very long for debt problems to be resolved, and therefore not very long for impacts of advice to be experienced. Furthermore, as already noted, the intervention tested was the offer of, rather than the provision of advice – and although the expectation seems to have been that the intervention group would in fact obtain advice, only around a third had done so at 20 weeks. In addition, almost 10% of the control group had obtained advice, further limiting the scope for contrast.

Also as part of the Impact of Debt Advice Research Project, Williams and Sansom (2007) surveyed clients who received advice from 14 agencies. This identified substantial positive changes in self-reported mental and general health, including those noted in Box 6 below, among 61 clients who took part in follow ups. It is worth noting some of the main outcomes, which appear relevant to self-assessed improvements in health. For example, at 12 months, almost all said that their problem had been completely or partially sorted out. Most said they felt more in control of their finances. Two thirds said they owed less, and just over half that making payments was less difficult. Most said the advice had stopped them getting further into debt.

[18] Defined as being behind with one or more of a range of payments *and* having a problem paying the money owed, *or* experiencing real difficulty managing debt.

[19] Measures used were the EuroQol EQ-5D (general health), and the State Trait Anxiety Index (STAI-6). Both are short instruments.

Box 6: Changes in self-reported general and mental health states among 61 clients following receipt of debt advice (source: Williams and Sansom, 2007)

- 87% initially said it was fairly or very difficult to carry on living normally while experiencing their debt problems. This reduced to 48% after 6 months, and 40% after 12 months.
- 89% initially said they spent all or most of their time worrying about money/their debts. This reduced to 59% after 6 months, and 31% after 12 months.
- At 6 months, 74% of those who initially said that worrying about money made them feel stressed, said they felt a bit less stressed (45%) or not stressed (29%).
- At 6 months, 73% of those who initially said that worrying about money made them feel depressed, said they felt a bit less depressed (43%) or not depressed (30%).
- 56% initially said they were receiving treatment, medication or counselling for ill health or stress related to money worries. This reduced to 43% at 6 months, and 31% at 12 months.

The Advice Services Alliance has reported on pilot efforts to measure outcomes of specialist casework in two Law Centres: one for employment cases (Bhavnani, 2008a) and the other for housing cases (Bhavnani, 2008b). In the employment pilot, clients were surveyed when their cases were taken on, with follow ups at the conclusion of cases, and three and 6 months thereafter. By the time an interim report was produced, 20 clients had taken part, of whom one had reached the final stage. In the housing pilot, a one off survey was conducted among clients whose cases had been concluded during a set period, with 16 taking part.

The nature of the employment and housing problems involved is not clear from the reports of these pilots. Nor are the interventions being tested explicit (i.e. whether they were the casework, or gains arising from problems being resolved in clients' favour). However, the results suggest that there are likely to be health gains in these areas of advice work which could potentially be measured. For example, in the employment pilot, of eight clients who had been surveyed a second time at the conclusion of their case: six said it was now easier to live normally, seven said they were less stressed, and four reported higher self-confidence. In the housing pilot, of 16 clients: eight said that following the conclusion of their case, they were more able to take part in social activities compared to the time during which their problems were ongoing, 14 said they were less stressed, and 13 said that various aspects of physical and mental health that had been troubling them had improved.

Evidence specifically relevant to young people

A before and after study by Caiels and Thurston (2004) involving 74 clients referred by primary care staff to advice services is of interest here, because – unusually, two fifths were aged 24 or under. Also, whilst a majority received welfare benefits advice, almost half also received help with housing issues. The intervention tested is not explicitly reported. But it seems to have been advice leading to resolution of problems, as eligibility for follow up depended on cases being closed, and most clients (85%) said they would not, or probably would not, have been able to sort their problems out without the help they received. Mental and physical health were measured using the SF-12 (a short version of the SF-36). Mean scores for both were reported to be below average, at both baseline and follow up. However, whilst there was hardly any change in physical health scores at follow up, there was a statistically significant improvement in mean scores for mental health (up 14 points on a 100 point scale).

Youth Access, which is also piloting work on outcomes, commissioned external consultants to assess the impact of advice (Michael Bell Associates (MBA), 2007). This involved qualitative interviews with 27 young people aged 16-25 (11 of whom were 16-18), who had received 'in depth, rights-based advice' from YIACS (Youth Information, Advice, Counselling and Support Services). As with other reports, detail is lacking regarding the problems dealt with, but most of these young people were reported to have presented with more than one problem. As well as reporting on outcomes generally (which appeared to revolve around stabilising, safeguarding and improving housing and money situations), the report notes that nearly all these young people reported that their confidence and self esteem had improved. 'Many'

attributed physical health benefits, and some reductions in drug use, to the advice received. Also, 'some' reported feeling less stressed and depressed as a result.

Interestingly, the report also notes what the young people thought would have happened to them if they had not obtained advice when they did. In addition to 'many' saying that they would have been homeless: five felt that they 'would probably be dead now', a number 'admitted they would still be self-harming and feeling suicidal', one 'felt they would probably have been sectioned', and 'many admitted they would be feeling very depressed and possibly might have suffered breakdowns'.

The MBA report includes some limited additional data from 16-25 year old clients of a young people's Law Centre, collected for a pilot exercise. Of relevance here, at the outset 12 out of 13 clients reported that they often felt stressed. Although 7 reported still often feeling stressed at the end of the advice process, all 12 said that the support the adviser had given, had helped them feel less stressed.

9 Discussion

The full extent to which mental health problems may cause social welfare law problems, and vice versa, is hard to determine. It is clear that social welfare and civil law problems can lead to and/or exacerbate mental health problems. But other links between the reporting of both types of problems within a three year reference period, as found in the CSJS, do not in themselves establish causation one way or the other (or even that they necessarily co-incide in time). An added complication, noted by Pleasence and Balmer (2009) in relation to a range of problems, is that causation is frequently bi-directional. For example, in the Mind survey previously noted, over 85% of respondents who reported recent experience of problem debt said that their mental health problems had made their debt problems worse. Ninety one percent said that their debt problems had made their mental health problems worse. On a similar note, Quilgars et al point to difficulties in establishing the extent to which mental health problems among young people who are homeless, pre-date or are a consequence of their homelessness. They attribute this to a lack of longitudinal research.

Notwithstanding all this, it seems clear that social welfare law advice should have a role to play in improving mental health, and thus in reducing the social and economic costs associated with mental ill-health.[20] As noted in the previous section, although the evidence base for the impact of social welfare law advice is currently fairly limited, what evidence there is points to it potentially being instrumental to improvements in this area. And as Pleasence and Balmer (2009) put it:

To the extent that problems involving rights play a role in bringing about or exacerbating mental illness, there is a role for legal and advice services in its reduction. ..... To the extent that mental illness plays a role in bringing about or exacerbating rights problems, advice services should be integrated with mental health services, to accommodate this and reflect the particular needs of people facing mental illness. To the extent that rights and mental health problems simply co-occur, advice and mental health services should anyway be integrated where possible, to enable clients/patients to receive "seamless services".

With regard to young people specifically, two other dimensions to mental health problems indicate the importance of advice that may help to ameliorate them. One is that longitudinal studies involving private household surveys, have found that mental health problems often persist (or perhaps recur) over time. For example, 46% of 16-24 year olds assessed as having a common mental disorder in 2000, also had such a disorder 18 months later (Singleton and Lewis, 2003). Other studies of children and young people have found that emotional and conduct disorders often persist *three years* after initial assessments (Parry-Langdon, 2008; Meltzer et al, 2003a).[21]

[20] The costs of mental illness in England in 2002/03, including monetary values ascribed to human costs, have been estimated at £77 billion (Sainsbury Centre for Mental Health, 2003).

[21] These studies reported on slightly different age groups within 11-16 year olds, producing several figures. Of those initially assessed as having emotional disorders, between 17% and 40% also had such disorders three

The importance of early intervention is pointed up by Maughan et al (2004), who refer to a body of evidence from longer term longitudinal studies, which suggests that *'for many young people, mental health problems in childhood mark the early stages of difficulties that continue well into adult life'*. One such study from New Zealand (Kim-Cohen et al, 2003) involved a cohort of just over 1,000 people, who were assessed at several intervals using clinically recognised measures. Of those who were assessed at age 26 as having a psychiatric disorder, three quarters (74%) had been identified as having a disorder by the time they were 18 (often but by no means always of the same type). Half had been identified as having a disorder between ages 11-15.

Some implications for research

The evidence base for the impact of social welfare law advice on the mental health of young people, is even more limited than that in respect of advice generally. Further research appears warranted, particularly regarding the potential impact of advice on homelessness problems, and housing problems generally. Addressing the gap in the evidence base on the prevalence of social welfare and civil law problems among 16-17 year olds would appear to be a useful preliminary step towards this.

Identifying and measuring impacts of social welfare law advice can however require considerable resources in terms of time and skills, and rigorous studies will be beyond most advice providers without substantial additional inputs (Adams et al). Specific challenges relevant to researching the impact of advice on young people's mental health also include establishing that tools used are age-appropriate, i.e. are capable of measuring aspects of mental health that are most relevant to them.

An additional consideration is that quite substantial proportions of people who report social welfare and civil law problems, also report obtaining medical treatment. This includes counselling for stress etc. resulting from those problems, as well as for mental health problems which may pre-date them. Isolating the effects of social welfare law advice from the effects of such treatment can be a complex exercise, as indicated by a qualitative study conducted by Turley and White (2007) for the Impact of Debt Advice Research Project. They reported that interviewees attributed improvements in emotional outlook, and increased confidence, to practical help received from advice providers. But help from non-legal sources such as GPs, psychiatric consultants or the Samaritans, that dealt specifically with emotional or mental health difficulties, was also identified as at least equally important for some.

Turley and White also noted that interviewees generally wanted help with debt problems to include counselling, 'someone to talk to and share feelings with', and 'help with stress and depression'. Research into the impact of social welfare law advice delivered in conjunction with counselling and related services, and which investigates what it is about each type of intervention that may be most beneficial for young people's mental health, would therefore seem to be of value.

Lastly with regard to young people specifically, the outcomes noted in the MBA report appeared linked to the contexts in which advice had been received, including the development of 'solid and trusting relationships' between advisers and clients. Most of the young people interviewed said they would prefer to get legal advice in a youth setting, such as a YIACS, a Connexions centre or a youth centre. Almost all favoured either a youth worker with good legal knowledge, or an adviser/lawyer specialising in young people. Given the settings in which those interviewed had received advice, such findings are not surprising. But they indicate a need for research on impacts to take account of young people's preferred methods of accessing advice.

years later. Comparable figures for conduct disorders ranged from 28% to 58%. Incidence of other disorders was too low to compare across time.

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Feedback

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Youth Access

Youth Access is the national membership organisation for a network of 200 youth information, advice and counselling services.

Through its members, Youth Access is one of the largest providers of youth advice and counselling services in the UK, dealing with over 1 million enquiries a year on issues as diverse as sexual health, mental health, relationships, homelessness, benefits and debt.

Youth Access provides the training, resources, research, campaigning and other infrastructure support to ensure high quality services exist to meet young people's diverse needs.

For more information about Youth Access, including a national directory of youth information, advice and counselling services, go to www.youthaccess.org.uk.

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