

## Investing in Advocacy Interventions for Parents with Learning Disabilities: What is the Economic Argument?

Annette Bauer, Josephine Dixon, Gerald  
Wistow and Martin Knapp

---

### University of Kent

University of Kent  
Cornwallis Building  
Canterbury  
Kent  
CT2 7NF  
Tel: 01227 823963  
[pssru@kent.ac.uk](mailto:pssru@kent.ac.uk)

---

### London School of Economics

London School of Economics  
LSE Health & Social Care  
Houghton Street  
London  
WC2A 2AE  
Tel: 020 7955 6238  
[pssru@lse.ac.uk](mailto:pssru@lse.ac.uk)

Personal Social Services Research Unit

PSSRU Discussion Paper 2860

April 2013

[www.pssru.ac.uk](http://www.pssru.ac.uk)

This paper has been produced from research that forms part of a NIHR School of Social care Research funded project on the economic consequences for social care interventions. This paper presents independent research and the views expressed in this publication are those of the authors and not necessarily those of the NIHR School for Social Care Research or the Department of Health, NIHR or NHS.

## Acknowledgements

The authors thank the following people for their contributions:

- Phillippa Ashcroft, VoiceAbility
- Reiz Evans, VoiceAbility
- Mary-Ann Foxwell, Family Rights Group
- Rick Henderson, Action for Advocacy
- Phil Jew, Action for Advocacy
- Kath Parson, Older People Advocacy Alliance
- Jennifer Pearl, Advocacy in Barnet
- Mike Pochin, Dorset Advocacy
- Anita Rickard, Advocacy in Greenwich
- Vicky Tantony, Advocacy in Greenwich
- Beth Tarleton, Norah Fry Research Centre, Bristol University
- Alice Twaite, Family Rights Group

## Summary

In the social care area, advocacy refers to an intervention that informs service users of their rights and choices and supports them in resolving issues that have a great impact on their lives. Research at PSSRU funded by the School for Social Care Research investigated some of the costs and outcomes of advocacy provided to parents with learning disabilities who were at risk of losing their children into care. Parents with learning disabilities are a group affected by multiple disadvantages and experience a higher risk of not receiving the support they need.

In our research we explored some of the economic consequences of advocacy interventions for parents with learning disabilities. Our research is part of a larger study being carried out by the Personal Social Services Research Unit at LSE and funded by the School for Social Care Research. This wider study examines the economic case for a selected but diverse range of social care interventions that have previously been identified as, or accepted/argued to be effective in achieving well-being or other social care-related outcomes for adults. Partners who were actively involved in this research included Norah Fry Research Centre at Bristol University, Voiceability, Family Rights Group, Advocacy in Greenwich, Action for Advocacy and Dorset Advocacy.

We employed a range of methods: first, we ran workshops with representatives of advocacy projects to assess the scope for gathering existing data; we then conducted a survey which asked project representatives to provide a range of outcome- and cost-relevant information from their case records and some additional information about characteristics of projects and resources that went into running them; third, we searched the literature for the unit costs of child safeguarding activities, care proceedings and provision as well as for economic evidence on outcomes for parents and their children; finally, we used simple decision modelling techniques to combine the different data sets. The analysis identified the costs of the advocacy intervention and the value of the potential cost savings and benefits associated with outcomes linked to advocacy. We present findings with some threshold values which reflect the number of good practice cases (similar to the ones we looked at) required on the caseload of an advocacy project in order to offset costs.

## Introduction and background

### Advocacy services in the UK

The Independent Advocacy Campaign defines advocacy as ‘taking action to help people say what they want, secure their rights, represent their interests and obtain services they need’ (Lewington & Clipson 2004, p4). It is based on principles of empowerment; individuals or groups of those who are affected by some kind of disadvantage are ‘informed of their rights and choices and, if required, supported and assisted in moving toward a resolution of current and future issues’ (Drage 2010). Advocacy can take many shapes or forms. Distinctions between different kinds of advocacy are based on a range of criteria such as whether advocacy takes place at an individual case or more systemic group level, whether persons are advocating for themselves or are represented by someone (and if the latter whether this done by a professional or a peer). In some areas, advocacy is

mandated by law. In practice, the different types overlap and organisations or projects may provide a combination of different advocacy types. For example, projects which provide representational (professional, citizen or peer) advocacy often also provide opportunities for people to learn the knowledge and skills to advocate for themselves and others (i.e. self-advocacy). In this research we were concerned with third sector-owned projects which are primarily focused on representational, professional advocacy.

Professional advocacy in the social care is a relatively new intervention which has received a growing interest in policy and research. Advocacy has been declared a potentially important supporter of the personalisation of health and social services but it is also recognised that data to support this claim are scarce and better evidence on effectiveness and cost-effectiveness is required (HMSO 2012). A literature review on adult safeguarding carried out by the Social Care Institute for Excellence emphasized the role of advocacy as a preventative and early intervention in the provision of personal social services (Faulkner & Sweeney 2011).

Professional advocacy is, in some instances, a legal entitlement of people who lack the capacity to make specific important decisions that affect their lives substantially (for example, decisions about places to live and medical treatment options as defined in Section 35 of the Mental Capacity Act 2005). Often, however, advocacy is regarded more as a matter of good practice than a necessity and its provision strongly varies between local authorities (Brady 2011). Some national sources, drawing on the views of representatives from local authorities, have reported a recent shortfall in advocacy services but it is difficult to determine the scale of shortfall due to the lack of national data (Faulkner & Sweeney 2011). Advocacy organisations, often reliant on small, short-term funding streams, report struggling to meet increasing demand, or sometimes to maintain existing provision (Action for Advocacy 2011).

Advocacy as a social care intervention varies substantially in its specific purposes and aims, approaches to achieving them and the size and structure of individual projects. The latter's ways of working are likely to strongly depend on the client group targeted such as: people with learning disabilities, mental health problems, physical disabilities and older people at risk of admission to residential care. In this study, we focus on advocacy interventions that aim to support parents with learning disabilities where a concern has been raised about their ability to parent and who are at risk of their children being removed from home. For the purpose of this study the definition of parents who experience learning difficulties includes those that do not meet the formal threshold of a learning disability that would qualify them to access support from adult social care (Mencap 2007). In this area, advocacy is expected to work around the parents' needs and wishes whilst considering their children's wellbeing and safety (Tarleton 2006, Mencap 2007). It is well understood that this can be a particularly challenging process when multiple safeguarding concerns arise for example if parents live in violent relationships (Hester & Westmarland 2005, Kalaga & Kingston 2007).

## **Parents with learning disabilities**

It is difficult to establish an exact prevalence of parents with learning disabilities, particularly due to classification inconsistencies. Latest statistics suggest that the number of adults with learning disabilities in England is 905,000 and findings from an earlier survey showed that 6.7 per cent of

adults with learning disabilities have children, so that our estimated number of parents with learning disabilities is 60,635 (Emerson *et al.* 2005, 2011). Parents with learning disabilities are at a higher risk of becoming subject to child safeguarding procedures and are an overrepresented group in child protection conferences and court proceedings; it is estimated that between 15 to 22 per cent of parents involved in child protection conferences and care proceedings have a learning disability (Hunt *et al.* 1999; Brandon *et al.* 2009). International studies suggest that in some jurisdictions as many as 40 to 60 per cent of parents with learning disabilities had their children taken into care (McConnell & Llewellyn 2002; Emerson *et al.* 2005). The high level of care proceedings involving parents with learning disabilities has been linked to the greater experience of multiple problems and disadvantage faced by this group (Cleaver *et al.* 2011). The complex relationship between learning disabilities and socio-economic disadvantage is widely recognised, and is reflected in, on average, poorer health outcomes and a shorter life expectancy (Emerson & Baines 2010). There is some evidence that suggests that social intervention could help parents to take adequate care of their children (Elvish *et al.* 2006). Problematically, however, parents with learning disabilities are much less likely to seek help independently compared with other parents in similar situations (Cleaver & Nicholson 2008).

## **Evidence of (cost-) effectiveness of advocacy for parents with learning disabilities**

There is rich qualitative evidence of parents with learning disabilities placing very high value of having an advocate when a concern is expressed about their child's safety and wellbeing and during safeguarding procedures (Booth & Booth 2001, Tarleton 2007, Mencap 2007, Greenwich Citizen Advocacy Project 2008, Featherstone *et al.* 2010). But whilst at times of a healthy economy it may be considered acceptable to fund projects on the grounds that they are reported by users to make them 'feel better', at times of financial hardship there is pressures on the government to spend resources on services and support which are known to be good value for money and likely to bring a financial return in the short-term. Evidence on the costs and outcomes of these highly process-orientated and person-centred interventions are scarce for example because it is difficult to define desirable, quantitative outcomes (Rappaport *et al.* 2005; Hussein *et al.* 2007; HMSO 2012). In addition, the data collection capacity of small scale projects is limited. However, there appears to be some consensus in findings from small-scale studies that advocacy can be an important means to increase parents' ability to understand their situation, to communicate with professionals, seek out help more pro-actively and make better use of services (Booth & Booth 1996; Tarleton *et al.* 2006). More recently, a small amount of economically oriented evidence has become available which draws on the perspective of clients, commissioners in local authorities, children's social services and advocacy projects (Hussein *et al.* 2006, Townsley *et al.* 2009, Corry & Maitra 2011). Tentative findings from these studies have focussed on the potential economic implications of a range of possible outcomes such as:

- reduced mental distress;
- reduced child safeguarding activities;
- increased access to early intervention (and reduced use of more intensive services later on);
- reduced likelihood of children going into care.

On the basis of such findings, there is a strong a priori case for the effectiveness and cost-effectiveness of high quality and well-targeted advocacy for parents with learning disabilities. Our research aimed to further explore the economic case for advocacy.

## Methodology

We carried out an economic analysis using simple decision modelling which allowed us to combine information from different data sets and sources. Due to time and budget restrictions we were not able to collect primary data from clients. Instead, information was elicited from workshops with people working in the advocacy field, from an anonymous survey to a selected number of advocacy projects and from reviews of published evidence. The focus of the analysis is the intervention experienced by parents and the support they received in relation to needs and outcomes. This could include outcomes experienced by parents as well as their children.

## Workshops

We held two workshops in February and June 2012 at the London School of Economics and Political Science (LSE). We invited representatives of advocacy projects and umbrella organisations. The choice of organisations was facilitated by the Norah Fry Research Centre in Bristol, which has specialised knowledge of this area, and Voiceability, a leading national advocacy organisation. Those invited had an interest in economic analysis and some of them had been involved in economic research before. Workshops were facilitated by two LSE researchers. The aim was to agree the scope of the research, generate information relevant for assessing outcomes and costs, and to discuss how projects could extract further relevant data and information from their data systems. Information we gathered at the workshops also informed the design of the survey questionnaire.

## Survey

We carried out a survey of individuals from advocacy projects who were (at least as part of their role) involved in frontline delivery. In addition, umbrella organisations which attended the workshops were asked to recruit some of their local projects to participate in the survey. Respondents were able to return the questionnaires anonymously to us via email. The purpose of the survey was to gather quantifiable information from projects that would allow us:

- to roughly estimate the costs of running an advocacy project for parents with learning disability including the costs per parent and intervention;
- to assess the outcomes that parents and their children achieved during the course of the advocacy intervention and
- To evaluate the resources used by parents and their children during the course of the advocacy intervention.

The questionnaire consisted of two parts: first, we asked for information about the inputs that went into running the projects such as number of staff employed, salary ranges, extent of training and supervision, average travelling time and size of case loads. In the second part, we asked the project

representatives to select up to three cases from their existing or past caseload which they thought demonstrated the application of good practice and the delivery of good value<sup>1</sup>. For each case, projects were asked to extract supporting information from their case records about the inputs of advocacy and other support received during the advocacy intervention, the outputs and outcomes in regards to the child safeguarding process and wider health and social outcomes. Specifically, we asked for:

- reasons for the referral and issues identified at assessment;
- the point at which advocacy got involved in the child safeguarding process including the kind of meetings that had already taken place;
- the number and mean duration<sup>2</sup> of meetings attended by an advocate, including one-to-one support for the client and meetings that the advocate attended on their behalf (for example, safeguarding meetings);
- the mean time<sup>3</sup> the advocate spent in preparation for such meetings;
- the number and type of referrals or signposting to other interventions;
- outcomes achieved during the advocacy intervention focusing on those that projects believed were linked to advocacy (either directly or through signposting and referring to other interventions);
- activities or procedures that projects believed had been prevented as a result of the advocacy intervention;
- Aspects of the case that projects believed made it a good practice example.

## Review of the economic literature

We reviewed the literature for evidence about the costs associated with safeguarding activities, care proceedings and children in care. We also searched for evidence on the economic consequences linked to outcomes of advocacy as reported in the survey responses. We additionally looked in the literature for evidence about the cost-effectiveness of the interventions to which advocates had referred parents. We focused our search on recently published studies from the UK- and its findings helped us to cost a range of inputs, outputs and outcomes as shown below.

## Calculations

Using data collected from these different sources we calculated:

- 1) Cost of a mean hour of advocacy work based on a) the information from advocacy projects and b) national data from the PSSRU Unit costs for health and social care 2011 (Curtis 2011) for salary on-costs, overheads and hours worked per year.

---

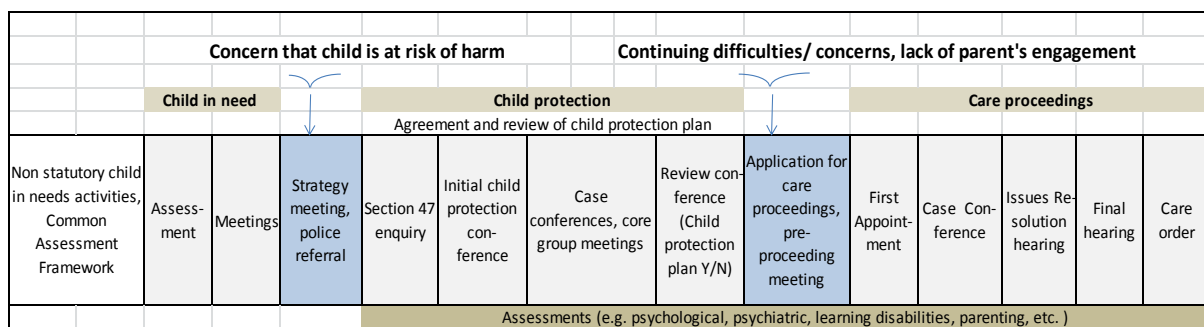
<sup>1</sup> We did not provide a definition of good practice or good value. Instead we asked projects later on in the questionnaire about the interpretation they applied when selecting cases.

<sup>2</sup> Where we asked projects about mean estimates we used the term 'average' which is generally better understood in practice. So, where we asked projects to provide us with average estimates we use this as an approximation of the mean.

<sup>3</sup> Ibid.

- 2) Costs for each case from the costs per hour of advocacy multiplied by the number and length of sessions (measured in hours). To this we added a) the costs for travelling (i.e. mean travelling time from survey responses multiplied by the costs per hour) where we knew that meetings had taken place externally, and b) the costs for preparing meetings (i.e. mean preparation time from survey responses multiplied by the costs per hour).
- 3) Financial benefits or cost savings of prevented child safeguarding activities for each case. We used information from the case descriptions about child safeguarding activities that happened in the presence of advocacy and compared those against those that could be expected in the absence of advocacy based on the regular child safeguarding process. Weightings were applied to reflect the uncertainty of whether an event (or its prevention) was attributable to advocacy. A model of the regular child safeguarding process is pictured in Figure 1. It starts with a statutory assessment of the child’s needs and leads to a formal child protection process if there are concerns that the child may experience harm or neglect. If during this process parents do not engage and the issues remain (or get worse), an application is made for care proceedings which end with a care order if no resolution is found. A more detailed description of the process is presented in the Appendix.

Figure 1 Child Safeguarding Process



For the purpose of our analysis, stages of safeguarding activities were valued with unit costs provided by Holmes et al. (2010), which stemmed from ‘bottom-up’ cost calculations. In cases instances where the information provided in case studies could not be directly linked to the unit costs calculated by this source, we made conservative assumptions about the duration and intensity of activities.

- 4) Mean net benefit across the cases; this refers to the mean cost savings from reduced child safeguarding activities, care proceedings and care provision minus the mean costs of providing advocacy. For each case, this was calculated by deducting 2) above from 3) and then taking the mean across the seventeen cases.
- 5) Costs savings (if any) related to the early intervention that parents were referred or signposted to by the advocate; these were taken from already published cost-effectiveness evidence on early intervention from the literature.
- 6) Mean net benefit of advocacy across the cases; this refers to the mean cost savings from safeguarding activities, care proceedings, care provision and those of early interventions (if any). For each case, this was calculated by deducting 2) from the sum of 3) and 5).



- 7) Economic value of reduced quality of life impairments experienced by parents. Quality of life gains were difficult to estimate; we only considered them if two conditions applied: a) the person was referred to counselling, and b) there was some information provided in the survey response which evidenced substantial changes in persons wellbeing, such as a parent being able to go out of the house again, to build new social relationships, find employment etc. We valued quality of life improvements based on evidence on cost-effectiveness of counselling from the literature.
- 8) Economic value of productivity gains due to employment changes. Productivity gains were difficult to estimate; we only considered them if there was information provided of how the advocacy intervention led to a change in the person's job situation. Earnings were valued with a minimum wage rate.

Costs were inflated with the relevant price and pay index to reflect 2010/11 prices. In addition, we examined some of the potential long-term economic consequences for the children of parents who received advocacy. This was based on longitudinal data from the literature which showed some of the links between short-term child outcomes (focusing on those achieved during advocacy) and long-term benefits. We also looked at the economic evidence of studies concerned with interventions to which parents and their children had been referred to by their advocate.

## Findings

Workshops were attended by representatives of three national umbrella organisation and representatives of two London-based advocacy projects for parents with learning disabilities. Because projects were asked to send information to us anonymously, to preserve confidentiality and to avoid creating any incentive to exaggerate benefits, we cannot specify the exact number of projects which provided information. In addition, some projects responded on the request of their umbrella organisations rather than at our direct request and consequently remained unknown to us. Only four projects supplied organisational information and, of those one described project characteristics but did not provide any further information about resources used to run the organisation. In terms of project characteristics, all four projects responded that they targeted parents at risk of having their children taken into care. Three stated that they had some form of specialist provision for parents with learning disabilities whilst one offered advocacy to all parents at risk of being made subject to child protection cases. Two projects specifically stated that their focus was on deprived areas. One project reported that it covered an urban area, another reported to covered both rural and urban areas.

## Costs of providing advocacy

We received information from three projects about the resources used by their services advocacy. All three projects employed two members of staff; one project employed two advocates on a part-time basis, another employed one advocate (with managerial responsibilities) on a full-time basis and one on a part-time basis, and the third project employed two full-time advocates. Salaries of advocates ranged from £22,310 to £30,700. The projects reported that their staff accessed a wide

range of training and professional development opportunities including the completion of a national advocacy training qualification. Advocates received supervision through the management structure of their organisation which included attendance at a management committee in one instance. Information about training and supervision was not provided at a level of detail that allowed us to estimate their costs. Instead we used national overhead cost estimates from the PSSRU Annual compendium of unit costs in health and social care (Curtis 2011). We took salary-on costs for national insurance from the same source. The total costs (including overheads) of running the three advocacy projects were estimated at £42,860, £62,250 and £83,350 respectively. We estimated the unit costs per hour based on a client-related work time of 1,344 hours per year at £28, £28.40 and £39. For the further analysis of the costs per advocacy intervention we used the mean estimate of £32 per hour. Average travelling times per meeting for each of the projects were estimated by projects at 15, 60 and 70 minutes respectively and we consequently took a mean estimate of 48 minutes for our calculations. The time period for individual advocacy interventions varied considerably from 3 months to (in one case) 6 years and ranged from 3 hours to 68 hours. On average, an advocacy intervention consisted of 95 hours of client-related work (i.e. one-to-one sessions, external meetings including travelling to those and preparation time) provided over a 10 months period. The costs per advocacy intervention ranged widely from as low as £217 (two sessions) to as high as £12,557 for around 340 sessions (provided over a period of 3.5 years). Some cases were still on-going. Averaging across all cases, the mean cost of an advocacy intervention was £3,036. Advocacy was typically provided over several years but because we were unable to trace back costs specific to the time when they actually occurred we assumed that all the costs incurred fell within 2011/12 and costed them accordingly.

## **Factors influencing the success of advocacy**

Project leads of advocacy schemes identified a range of factors that they thought were good practice and influenced the outcomes of the advocacy process. The most commonly cited aspects included the point in time at which advocacy became involved in the safeguarding process, the reasons why parents became subject to the child safeguarding process, the awareness professionals had of parents' learning disabilities, the way in which support services were provided by the council more generally and, in particular, how well agencies worked in partnership with each other around families' needs. Each of these factors is considered below.

### ***The point in time when advocacy got involved***

The time when advocacy became involved with the child in need or safeguarding process was thought to be an important contributor to the final outcome of the process (see Graph/Figure 1 above for an outline of this process). It was considered good practice for the referral to be made at the point of the Section 47 enquiry at the latest. In instances where advocacy got involved at the care proceedings stage, some survey responses suggested that they saw the focus of the advocacy work as one of helping parents to accept the process' outcome and to reduce their level of mental distress (including suicidal thoughts) rather than one of influencing the outcomes of the care proceedings.

### ***The reasons why parents had not engaged with the child safeguarding process***

Advocacy was considered particularly effective in situations where the main reason for the parents' disengagement in the child safeguarding process was related to a learning disability which prevented them from fully understanding the process or what was required of them. For example, parents with learning disabilities could easily feel overwhelmed by the number of written documents and amount of paper work. Advocacy was considered well-placed to offer assistance with these sorts of difficulties. In addition, advocacy was thought to be effective in alleviating fears and defensive behaviours among parents which would make it more likely that they engaged in relationships with professionals.

### ***The way in which services were delivered by the council and how well they worked in partnership***

Many of the parents did not meet the threshold for a severe learning disability and thus were not eligible to receive local statutory support. In a few instances, no one had referred parents for an assessment of their learning disability and they had thus not been able to access the statutory support they were entitled to. Advocacy was considered to have the ability to change professionals' attitudes and lead to a better way of working together. For example, an increase in the awareness that social workers had about the barriers faced by parents with learning disabilities was thought to lead to changes in the way children's social services approached parents. It was felt that with the advocate's involvement sometimes more time was given to considering different options and evaluating the pros and cons of different decisions. It could also lead to greater joint working between agencies around the parents' needs.

## **Case characteristics and groups**

We received information concerning eighteen 'cases'. From the eighteen case studies we excluded one new case. Out of the seventeen remaining cases, all but one involved the mother of the child (the final one involved a father who had taken on the care responsibility for his children). Six cases concerned women who accessed advocacy during pregnancy. Most of these women were already known to social services and had children who had been removed previously from their care. A third of the women were exposed to domestic violence at the time when they accessed advocacy services. In the cases involving older children, concerns had been expressed about their school attendance and performance. Common co-existing problems faced by mothers (or mothers-to-be) at the beginning of the advocacy intervention were housing and debt problems; one woman was homeless when she accessed the advocacy project. In twelve cases, the referral had been made by the local council. Other referrals had come from various agencies including victim support, police, a community nurse and a family charity.

In order to take account of different degrees of uncertainty as to how far the advocacy intervention had been instrumental in removing the need for particular safeguarding activities (and thus in cost savings), we applied the following principles:

- A weight of 1 was applied where information in case studies clearly demonstrated how advocacy had prevented the safeguarding activity. These included cases, for example, where children's social services had involved advocacy at a stage where the parents were about to

become subject to child protection conferences and these were then deemed not necessary after the advocacy intervention.

- A weight of 0.5 was applied when it was not clear from the description whether or not further safeguarding measures would have been taken without the advocacy intervention but where there was some indication that this was likely. This referred primarily to cases where the child protection status was removed during the course of the advocacy intervention and care proceedings did not take place. We conservatively assumed that where parents had been involved in care proceedings previously and their children had been, as a result, removed that the probability that this would have happened for this child as well (in the absence of the intervention) was 50 per cent.
- A weight of 0 was applied where there was either no quantifiable outcome reported or where there was not enough information to determine whether advocacy had had an influence on the outcome: the first scenario referred primarily to cases in which advocacy had got involved towards the end of care proceedings and the primary aim in regards to the child safeguarding process had been to support the parent in understanding and accepting the decision; an example for the second scenario was when advocacy had avoided the need for child protection procedures and, thus, possibly further activities down the line (such as care proceedings) but the information available did not allow us to draw any such conclusions.

Each case was located within one of the following categories, based on our analysis of how advocacy related to the statutory safeguarding process:

**Case group 1a:** Advocacy became involved at a point where there was an identified risk that a child would be put on the child protection register but formal steps had not yet been taken to initiate this process; the risk was identified either by the council's learning disabilities team or by an external agency. In these cases the work of the advocate was focused on preventing the need for the child to be put on the register. Five of the cases submitted fell into this category and in three of those, a Section 47 enquiry was prevented (we attached a probability weight of 1). In one case, a Section 47 enquiry could not be prevented but the child protection status was removed later and it seemed likely that care proceedings would have been initiated in absence of advocacy (we applied a weight of 0.5). In another case the child was put on the child protection register and care proceedings were initiated but advocacy appeared to have prevented the child being removed from home as it had happened to previous children (a weight of 0.5 was applied).

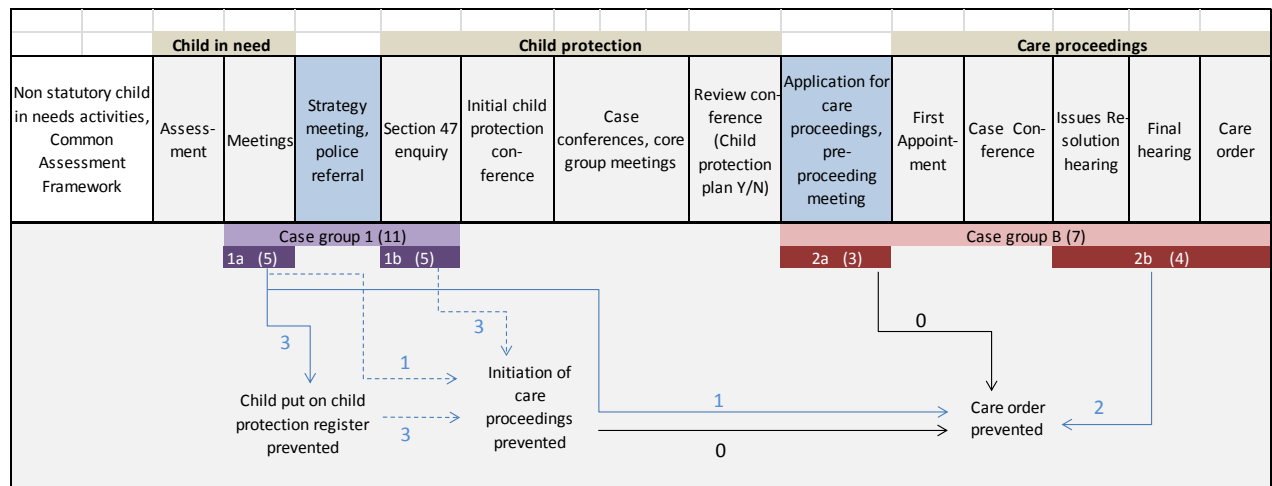
**Case group 1b:** Advocacy became involved at a point where child protection processes had already started or were just about to start. In this situation, advocacy was focused on working with parents to prevent the initiation of care proceedings. Out of the five cases that fell into this category, care proceedings were initiated in two cases. In the other three cases, there was uncertainty whether care proceedings would have been initiated in the absence of advocacy and we applied a 0.5 probability weight. We did not make any assumption about whether those would have resulted into a care home stay (0 weight).

**Case group 2a:** Advocacy became involved at the end of the pre-proceeding stage or when care proceedings had been initiated but not started. Advocacy worked towards preventing a care order and for the child to be taken into care (where this was appropriate). Three cases submitted to the study fell into this category but in none of them did advocacy change the outcome of the care proceedings; instead, the care order was made and children taken away.

**Case group 2b:** Advocacy became involved when care proceedings were already on-going and commonly the final hearing had a fixed date. In these cases the advocate worked with parents either to a care order being made (where this was appropriate) or to achieve their acceptance of the outcome and facilitate a smoother process. Out of the four cases falling into this category, a care order was prevented in two cases (for which we attached a probability of 1).

Graph 2 shows the outcomes for the different cases based on the above categories (1a, 1b, 2a, 2b). These are shown against the relevant activities of the child safeguarding process. Full blue lines indicate where full cost (-savings) were applied (weight of 1) and dotted lines indicate that half the cost (-savings) were attached (weight of 0.5). Black lines indicate that no cost (-savings) were applied (weight of 0). The number of cases that fell into each category is shown through the figures in brackets and figures presented on lines indicate for how many of those an outcome was achieved.

**Graph 2 Child Safeguarding process and outcomes achieved by case groups**



### Net benefits and economic value

The unit costs we used in the analysis are presented in Table 1 alongside the detail of some assumptions we made concerning the duration and intensity of activities.

**Table 1 Unit costs of child safeguarding process and placements**

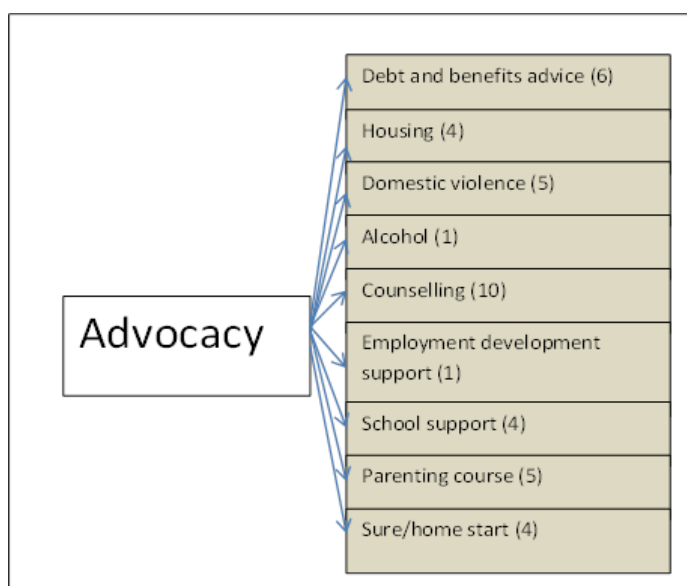
Outcome	Unit cost (Out of London; London), in £	Source and description	Assumption
<b>Section 47 enquiry prevented</b>	728 (661;795)	From Holmes et al., 2010, Table 1 p.7	Process included strategy meeting
<b>Public Law Outline (care proceedings)</b>	2,463 (2,238;2,687)	From Holmes et al., 2010, Table 1 p.7	Standard care proceedings
<b>Looked after care (one year)</b>	16,618	PSSRU Unit costs for health and social care pp74-77:  Care homes p.a. £136,214 (£128,544-£143,884); foster care p.a. £20,800; Children looked after placement statistics: 0.09*£136,214+0.74*£20,800	Other forms of care provision (e.g. after adoption) assumed to be cost free; for care home costs: only establishment costs considered
<b>Child under 6 removed early from child protection plan (but still regular planning and support)</b>	900 (810;988)	From Holmes et al., 2010, Table 1 p.7; Process 3+6 with Process 3: 'on-going support per month' and Process 6 'planning and review'	Process 3 assumed to have lasted 3 months
<b>Support and planning for child under 6 with child protection status prevented</b>	1777 (1,608; 1,946)	From Holmes et al., 2010, Table 1 (p7); Process 3+6 with Process 3= 'on-going support per month' and Process 6= 'planning and review'	Process 3 assumed to have lasted 3 months
<b>Statutory involvement prevented for a new child</b>	516 (466;566)	From Holmes et al., 2010, Table 1 (p7); Process 1+4 with Process 1= 'assessment' and Process 4= 'case closure'	Statutory involvement refers to assessment and closure, no additional activities included
<b>Further statutory involvement in support and planning prevented (child under 6)</b>	878 (844;958)	From Holmes at el., 2010, table 1 (p7); Process 3+6, with Process 3= 'on-going support per month' and Process 6= 'planning and review'	Standard costs, Process 3 assumed to have lasted 3 months

As with other costs where we were unable to identify the time when they incurred, we assumed that they fell within 2011/12 and valued them accordingly. The mean reduction in expenditure to children's social services from a reduction in safeguarding activities, care proceedings and care

provision was estimated at £3,760 per case. Values ranged widely, from £0 to £16,620. After considering the costs of advocacy, the mean net benefit of advocacy was estimated to be £720, with a lowest value of *minus* £3,900 (i.e. net costs) and an upper value of £12,230. The return on investment<sup>4</sup> was estimated to be 1.2 for child safeguarding activities alone (Table 3) so that for every pound invested in advocacy for parents with a learning disability, local councils would realise a financial gain of 20 pence.

The survey responses included information on a wide range of early interventions referred to by the advocate; much information was provided about the health and social care outcomes that parents and sometimes their children achieved as a result of the involvement and intensive support of a range of agencies with which the parent engaged during the advocacy intervention. Graph 3 presents the referrals made across the seventeen case studies.

**Graph 3 Referrals made across seventeen cases**



The most common outcomes that were mentioned included: reduced stress, anxiety and depression; reduced exposure to domestic violence; an increase in benefit entitlements; safer and healthier housing conditions; improved school attendance and performance (where older children were subject to safeguarding). In one case, a mother who had been socially isolated started to build relationships with school teachers and other professionals; the increase in confidence to communicate with professionals led her to seek employment at a local charity shop. In another case, a woman, who had spent most of her time drinking at the local pub, sought help from the alcohol agency to which the advocate had signposted her and maintained an abstinence from alcohol with on-going support provided by the advocacy project. Of the outcomes achieved, we were able to only show the economic value of those that are listed in Table 2.

<sup>4</sup> Return on investment defined as expected economic pay-off per pound invested i.e. expected (=mean) economic gains divided by the expected (=mean) cost of the intervention

**Table 2 Costs and benefits of wider advocacy outcomes**

Referral/ outcome	Costs and benefits (in 2010/11 prices)	Source
<b>Domestic violence</b>	Net benefit (per annum value to public sector) £1,021	Coordinated Action Against Domestic Abuse 2012 reports a cost saving of £3.2 for every pound spent on specialist service provision (public service expenditure only); spending for domestic violence per year was £1.3 million for 2,800 victims so that spending per person per year was £464 per person
<b>Parenting programmes</b>	Net benefit (net present value to public sector) £3,760	Costs of the programmes vary substantially; an average estimate by Bonin <i>et al</i> 2010 is £1,570; the present value of long-term cost savings to society are estimated to be substantially higher (up to £18,000)
<b>Counselling (including postnatal depression and adoption)</b>	Net benefit (HRQOL) £860	<u>Estimate1:</u> Petrou <i>et al</i> 2006; mean net benefit of a preventative primary care intervention; at a willingness to pay threshold of £1,670 per month of postnatal depression avoided  <u>Estimate 2:</u> Cost of a course of psychological therapy estimated at £750 from PSSRU Unit cost for health and social care 2011 ; HRQOL improvement £1,820 (Layard <i>et al</i> 2007)
<b>(Benefits-) and debt advice</b>	Net benefit (per annum costs to public sector/social landlords): £240	Evans <i>et al</i> (2011); financial gains from specialist debt advice due to reduction in evictions and court proceedings
<b>Housing intervention (homelessness prevented)</b>	Net benefit (per annum costs to public sector/housing) £5,850	Housing prevention intervention costs (at 2010/11 prices £1,800); savings based on reduced expenditure for temporary accommodation and cost for re-housing; if costs related to potential crime, health needs and substance misuse are included then savings can exceed £20,000
<b>Alcohol treatment intervention</b>	Net benefit (per annum cost to public sector) £1,950	Godfrey (2005); Net reduction in cost (after considering trial treatment costs) were between £590 and £800 at (2000/1) and over 6 months period; treatment was motivational or social network therapy.

A number of support services could not be included in our analysis because there was not enough information about either costs or outcomes. For example, for employment development support economic evidence in the UK is scarce (Wilkins et al. 2010) and it was not possible to attach values without further information. In addition, although the costs of the national Sure Start programme



have been evaluated, there is much less clarity about the economic gains of the programme, most of which are expected to be realised in the long-term (Department for Education, 2011). Similarly, although better home conditions have been linked in the literature to a range of benefits (such as health improvements) it was not possible to quantify those. Other interventions which were not considered in our analysis because of a lack of evidence included:

- Generic advocacy
- Advice
- Literacy classes
- Peer support
- Support for pre-school children
- Hearing specialist
- Housing support for better home conditions.

Parents who had not yet been assessed for their learning disability were referred to the learning disability team at local councils where they received additional support if they met the eligibility threshold. We assumed that parents would have received a statutory assessment at some point during the child safeguarding process and did not include this element in the analysis although we thought it may be important for future research to gain a better insight into this.

The net benefit from a public sector perspective after considering not only the reduction in expenditure for reduced child safeguarding activities, care proceedings and provision but also the costs and benefits of the early interventions referred to by advocacy and for which there was sufficient economic evidence, was estimated to be £3,130. The potential return on investment for this group of cases was then estimated at 2 i.e. for every pound spent there would be one pound return (Table 3).

Information about improvements in mental wellbeing was available for eleven parents; all of the women had been referred to counselling services including specialist adoption counselling and treatment for postnatal depression. Based on estimates from studies which assigned a monetary value on quality of life gains from counselling we applied a mean net value of £860 per person per annum (Table 2). After those values were included in the analysis, the expected net benefit increased to £3,690 with an estimated return on investment for the group of cases of 2.2 (Table 3).

In one case, as described earlier, a mother started to get involved in school and social activities and found a job at the local charity shop. After considering the increase in earnings for this individual, the mean net benefit increased to £4,340 and the potential return on investment to 2.4.

In Table 3 we summarized the findings from our analysis. All estimates are mean values, presented in pounds and rounded to the next decimal figure.

**Table 3 Findings from economic analysis (presented in averages per advocacy intervention)**

	Benefit (gross)	Costs of the advocacy intervention	Net benefit	Return on investment (Benefit/cost)
Children’s social services	£3,760	£3,040	£720	1.2
Public services (all)	£6,170		£1,900	2.0
Societal perspective (government costs, quality-of-life and productivity gains)	£7,380		£3,680	2.4

The results showed that costs and benefits varied greatly from case to case which made it very difficult to draw any generalizable conclusions based on a small number of cases. In addition, since projects had been asked to select cases which they considered good value those were by definition not representative of the overall caseload. It was possible that the projects we selected were more likely to be good value for money because of their willingness to engage in the research and share cost- and outcome relevant information. Nonetheless, our findings suggest there is scope for securing better value for money in this field, though larger scale, evaluative research is necessary to address the above limitations fully. We were able, however, to conduct some threshold analyses to provide an indication of the caseload size from which advocacy projects might generate benefits in excess of costs assuming the good practice criteria stated above were met. We explored thresholds for the number of cases that were required for advocacy projects running at different costs in order to offset them (Table 4). For example, a project that was expected to run at £62,250 per year would require seventeen cases to offset the costs from financial savings to Children’s social services alone (assuming they could be realised in cash terms); if cost savings to the public sector more generally were considered then eleven cases were required and only eight cases if a wider societal perspective was taken. Again, this would refer to cases that could be characterised as good value and where cashable savings could be achieved

**Table 4 Threshold analysis: number of cases required on caseload in order to offset costs**

Costs of running advocacy project (per year)	Perspective		
	Children’s social services (£3,760 net benefit per case)	Public sector (£6,710 net benefit per case)	Societal (£7,380 net benefit per case)
£42,860	11.4	6.9	5.8
£62,250	16.6	10.9	8.4
£83,550	22.2	22.2	11.3

## **Long-term economic consequences (child)**

Advocacy and the additional access to support for parents and their children were associated with outcomes that were likely to have an important impact on children's or adolescents' later life. In five cases, school attendance and performance strongly improved during the advocate's involvement. Absenteeism, performance problems and misbehaviour are significant predictors of early school leaving (Eivers et al. 2000, p8-9) and the life time costs of a child leaving school without any qualifications has been valued at just below £58,000. In one case, a child who had not attended school for 6 months prior to involvement by the advocate was, at the end of the intervention, attending school regularly and had improved performance. In another case, the child received additional school support as a result of the advocate's involvement. As described earlier, one mother became actively engaged in school activities as a result of an increase in confidence experienced through the advocacy, which has shown to be an important contributor to educational achievement of children (Hill & Tyson 2009). In three cases, parents established regular contact with their children who had been previously removed and who now lived in foster care. Parents started to actively encourage their children to stay in existing care arrangements. Placement stability has been identified and repeatedly confirmed as a lead contributor to improved outcomes for looked-after-children (Pecora 2010). Research shows that children who have had an unstable placement history over 18 months are twice as likely to develop behaviour problems as those children who achieved early stability in their foster placements (Rubin et al 2007). Friedli and Parsonage (2007, 2009) estimated the life-time costs of behaviour problems as £75,000 per case for moderate problems (90 per cent) and £150,000 per case for severe problems (10 per cent). Placement stability is also an independent predictor of school performance. Other costs that may be avoided when a placement is stable are short-term costs to the child welfare system for arranging new placement (Price 2008) and possibly having to arrange (at least temporarily) for care home provision.

## **Discussion and conclusion**

In our research we explored the economic argument for investing in advocacy interventions for parents with learning disabilities at risk of losing their children into care. We focused on a public sector perspective and upon cost savings which could potentially be realised in that sector; first we analysed potential savings to children's social services associated with a likely reduction in child safeguarding activities, care proceedings and provision; we then estimated the potential savings to all public services which included those expected from increased access to early interventions. In addition, short-term quality of life and productivity gains were calculated and presented separately. Finally, we examined some of the potential longer term economic consequences for the children of parents with learning disabilities who received advocacy.

Our findings indicate that investing in advocacy for parents with learning disabilities is likely to offset costs in the short term and bring a positive return on investment from a wider public sector perspective. Furthermore, our research findings suggest that there could be additional quality of life improvements to the parent due to reduced anxiety, stress and depression. In addition, there may be some productivity gains from a few parents who seek and find employment as a result of the

advocacy intervention, possibly due to an increase in confidence and skills in communicating with professionals. Our findings suggest that both, children subject to safeguarding procedures and those previously removed may benefit from the advocacy intervention provided to their parents. In our research, older removed children seemed to achieve some immediate outcomes, such as an increased placement stability, improved school performance and attendance. These outcomes are important predictors for quality of life and economic prospects in later life. Where advocacy was provided to the parent before, during and after the time of birth, it showed that this improved the child's chance to grow up in appropriately safe and healthy conditions with their biological parent. Improved outcomes for parents and children appeared to be linked to the wide range of additional support parents with learning disabilities were able to access and effectively engage with as a result of the involvement of advocacy services.

This research aims to contribute to the economic evidence of social care interventions and adds to a still explorative but growing evidence base of the short- and long-term benefits (including economic ones) that can be achieved through investing in person-centred services, often provided by third sector/ community organizations (Windle et al. 2009; Knapp et al 2011, 2012).

A major limitation of this kind of analysis is that it cannot establish causalities between advocacy and the outcomes that occurred because we did not have a comparison group and our information was drawn from a small number of case studies. Furthermore, we relied on outcomes as they were reported by advocacy projects and even of those we could only include a subset for which there was appropriate economic evidence available from the literature. The study was also dependent on data from organizations or projects that were concerned about providing a cost-effective service. Thus, its findings cannot be generalised to advocacy schemes for parents with learning disabilities and they cannot be generalised to other forms of advocacy targeted at other groups. In practice, it will be important to understand the contextual or organisational factors that influence the cost-effectiveness of projects. Furthermore, it needs to be acknowledged that only certain, quantifiable and 'monetisable' outcomes can be captured with economic evaluation methods; economic findings should therefore be interpreted in the context of qualitative evidence which takes into account personal experiences and satisfaction with services.

On the grounds of these limitations our findings have to be seen tentative in nature but we hope that this report will inform the need for future research and comparative costing exercises in this field. Methodologically, our research wants to contribute to the development of appropriate methods for evaluating highly personalised interventions including those provided by small projects with small numbers of staff and users. Such approaches might, for example, need to ensure that appropriate weight is given in a systematic manner to individuals views about their achievements and the attribution of those to an intervention (in the absence of appropriate comparison groups). In the practice field, this report aims to provide commissioners with additional knowledge about the potential impact of advocacy for parents with learning disabilities which can inform their own costings work and outcome frameworks

## References

- Action for Advocacy (2011), *Advocacy in a cold climate*, Study of the state of services that ensure people are listened to, safeguarded, respected and have choice in health and social care, London.
- Bauer A and Fernandez JL (2012), *Economic Analysis of the Health Champions Scheme in Hammersmith and Fulham*, Personal Social Services Research Unit, London.
- Bonin EM, Stevens M, Beecham J, Byford S, Parsonage M (2011) Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: a modelling study, *BMC Public Health*; 11:803
- Booth T and Booth W (1994), Parental adequacy parenting failure and parents with learning difficulties, *Health Social Care in the Community*, 2:161-172.
- Booth T and Booth W (1999), Parents Together: Action Research and Advocacy Support for Parents with Learning Difficulties, *Health and Social Care in the Community*, 7:464-74.
- CAADA (2012), *Evaluation of 'best value' in specialist service provision for domestic violence and abuse in Devon: October 2010 to September 2011*, Coordinated Action Against Domestic Abuse, Bristol.
- Coles B, Godfrey C, Keung A, Parrott S, Bradshaw J (2010), *Estimating the life-time cost of NEET: 16-18 year olds not in Education, Employment or Training*, Research undertaken for the Audit Commission, University of York.
- Corry D and Maitra S (2011), *Cost-benefit analysis of telephone advice services provided by the Family Rights Group*, A report by FTI Consulting for Family Rights Group, London.
- CSCI (2008), *Raising voices: Views on safeguarding adults*, Commission for Social Care Inspection Report, London.
- DCLG(2012), *Evidence review of the costs of homelessness*, Department for Communities and Local Government, London.
- DfE (2011), *National evaluation of Sure Start local programmes: an economic perspective*, Department for Education, London.
- DH (2006), *Our Health, Our Care, Our Say: A New Direction for Community Services*, Department of Health, London.
- DH (2007), *The Mental Capacity Act 2005*, Gateway number: 7890, Department of Health London.
- Drage J (2012), *New Zealand's National Health and Disability Advocacy Service: A successful model of advocacy*. *Health and Human Rights: An International Journal*, 14:1.
- DWP (2005), *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century*, Department of Work and Pensions, London.

- Eivers E, Ryan E, Brinkley A (2000), Characteristics of early school leavers: results of the research strand of the 8- to 15-year old early school leavers initiative, Educational Research Centre, St Patrick's College, Dublin.
- Elvish J, Hames A, English S, Wills C (2006) Parents with Learning Disabilities: An Audit of Referrals made to a Learning Disability Team, Tizard Learning Disability Review, 11:26-33.
- Emerson E and Baines S (2010), Health Inequalities and People with Learning Disabilities in the UK: 2010; Improving Health and Lives, Learning Disabilities Observatory, Durham.
- Evans G and McAteer M (2011), Does debt advice pay? A business case for social landlords, Final report, The Financial Inclusion Centre, The Money Advice Trust, London.
- Faulkner A and Sweeney A (2011), Prevention in adult safeguarding: A review of the literature. Social Care Institute for Excellence, London.
- Featherstone B, Fraser C, Ashley C, Ledwards P (2010), Advocacy for parents and carers involved with children's services: making a difference to working in partnership?, Child & Family Social Work, 16:266-275.
- Friedli L and Parsonage M (2007), Mental Health Promotion: Building an Economic Case, Northern Ireland Association for Mental Health, Belfast.
- Friedli L and Parsonage M (2009), Promoting mental health and preventing mental illness: the economic case for investment in Wales. Mental Health Promotion Network, Wales.
- Godfrey C (2005), Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). British Medical Journal, 331:544-548.
- Greenwich Citizen Advocacy Project (2008), Advocacy in Greenwich. Parents with a Learning Disability, Greenwich Citizen Advocacy Project, London.
- Hester M and Westmarland N (2005) Tackling domestic violence: Effective interventions and approaches, Home Office Research Study 290, Home Office, London.
- Hill NE and Tyson DF (2009), Parental involvement in middle school: a meta-analytical assessment of the strategies that promote achievement, Journal of Development Psychology, 45:740-63.
- HM Government (2012), Caring for our future: reforming care and support, Social care White Paper, London.
- Holmes L, Munro ER, Soper J (2010), Calculating the cost and capacity implications for local authorities implementing the Laming (2009) recommendations, Report to the Local Government Association, Centre for Child and Family Research, Loughborough University, Loughborough.
- Hussein S, Rapaport J, Manthorpe J, Moriarty J, Collins J (2006), Paying the piper and calling the tune? Commissioners' evaluation of advocacy services for people with learning disabilities, Journal of Intellectual Disabilities, 10:75-91.

Kalaga H and Kingston P (2007), A review of literature on effective interventions that prevent and respond to harm against adults, Scottish Government Social Research, Edinburgh.

Knapp M, McDaid D, Parsonage M (2011), Mental health promotion and mental illness prevention: the economic case. Department of Health, London.

Knapp M, Bauer A, Perkins M, Snell T (2012), Building community capital in social care: is there an economic case?, *Community Development Journal*, first published online September 26.

McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S (2008), Paying the price: The cost of mental health care in England to 2026, Kings Fund, London.

Mencap (2007), Providing the right support for parents with a learning disability, London.

Layard RM, Clarg D, Knapp M, Mayraz G (2007), Cost-benefit analysis of psychological therapy, CEP Discussion Paper No 829, Centre for Economic Performance, London.

Pecora PJ (2010), Why current and former recipients of foster care need high quality mental health services, *Administration and Policy in Mental Health*; 37:185-190.

Perkins R, Farmer P, Litchfield P (2009) Realising Ambitions: Better Employment Support for People with a Mental Health Condition, A review to Government, Department for Work and Pensions, London.

Petrou S, Cooper P, Murray L, Davidson LL (2006), Cost-effectiveness of a preventive counselling and support package for postnatal depression, *International Journal of Technological Assessment in Health Care*, 22:443-453.

Price JM, Chamberlain P, Landsverk J, Reid J, Lave L, Laurent H (2008), Effects of a foster parent training intervention on placement changes of children in foster care, *National Institute of Health, Child Maltreatment*, 13:64-75.

PSSRU (2011), Unit Costs for Health and Social care, compiled by Lesley Curtis, Personal Social Services Research Unit, Kent.

Rapaport J, Manthorpe J, Moriarty J, Hussein S and Collins J (2005), Advocacy and people with learning disabilities in the UK: How can local funders find value for money?, *Journal of Intellectual Disabilities*, 9:219-319.

Rapaport J, Manthorpe J, Hussein S, Moriarty J, Collins J (2006), Old issues and new directions: Perceptions of advocacy, its extent and effectiveness from a qualitative study of stakeholder views, *Journal of Intellectual Disabilities*;10:191-210

Rubin DM, Alessandrini EA, Feudtner C, Mandell DS, Localio AR, Hadley T (2004), Placement Stability and Mental Health Costs for Children in Foster Care, *Pediatrics* 113:1336-1341.

Secretary of State Jeremy Hunt's speech to King's Fund (28th November 2012)  
<http://mediacentre.dh.gov.uk/2012/11/28/28-november-2012-jeremy-hunt-kings-fund-quality-of-care/>

Tarleton B (2007), Specialist advocacy services for parents with learning disabilities. *British Journal of Learning Disabilities*, 36:134–139.

Tarleton B, Ward, L and Howarth, J (2006), Finding the right support. A review of issues and positive practice in supporting parents with learning difficulties and their children, Baring Foundation.

Townsley R, Marriott A and Ward L (2009), Access to Independent Advocacy: An Evidence Review, Office for Disability Issues.

Wilkins A, Love B, Greig R (2012), Economic Evidence Around Employment Support, School for Social Care Research, London School of economics and Political Science.

Windle K, Netten A, Caiels J, Masrani R, Welch E and Forder J (2009), Measuring the outcomes of information and advice services: Final report, PSSRU Discussion Paper 2713, Personal Social Services Research Unit, Kent.

Working together with parents network. Facts and figures about parents with learning disabilities in England, Accessed 30th January 2013 at [www.bristol.ac.uk/wtwpn/resources/facts-pwld.pdf](http://www.bristol.ac.uk/wtwpn/resources/facts-pwld.pdf)



## Appendix

### The process of child safeguarding

The formal child safeguarding process starts with an initial assessment to determine whether a child is 'in Need', as defined under Section 17 (10) of the Children Act 1989. Multi-agency support for the child, involving school teachers, youth workers or health services, may or may not have taken place before this under the Common Assessment Framework (CAF). The CAF refers to an approach of identifying additional needs of children at an early stage based on the principles of information sharing and collaboration between professionals. If it is decided that there are concerns about a child's safety or welfare, a referral to the local authority children's social care is required. An initial assessment is carried out and - if no actual or likely harm to the child is suspected - a 'Child in Need' (CIN) plan is drawn which formalizes a support package. A care team consisting of the key agencies which are involved with child is formed that should meet about every six weeks to review the plan. Meetings should usually be attended by the parents and the child. In more complex cases, a core assessment may be initiated and a core group of professionals may be convened (Butler & Hickman, 2011). If children are identified as being at risk of harm or neglect at any point during this process, a strategy meeting will be convened and a Section 47 enquiry takes place if the risk remains. At this point parents become the subject of child protection conferences (also referred to as case conferences). At these conferences a core group monitors and reports on the family situation. Membership should include the key (social) worker, professionals and foster carers who will have direct contact with the family, the parents and the child (if appropriate). The core group of professionals meets every four weeks to monitor the family situation. Child protection or case conferences generally take place every six months. They are sometimes brought forward if there are concerns or if an assessment is due. If parents do not engage in the process and action plans are not followed, then formal care proceedings will be initiated usually preceded by a pre-proceeding phase. This can either be done with the parents' consent or through an enforced court-led process (carried out by dedicated family courts); either way both involve a complex legal process. The courts and ultimately the judge will then decide on what is in the best interests of the child. Both processes (the series of case conferences and the legal process of implementing care proceedings) can be protracted and the whole process may take up to 12 months. This process is visually presented in Graph 1. The length of the process varies for each child, and parents with several children may be involved in several, sometimes overlapping child protection procedures.