

KEEP THEM SAFE OUTCOMES EVALUATION

FINAL REPORT – ANNEX H
NSW DEPARTMENT OF PREMIER AND CABINET

JUNE 2014

DATA DEVELOPMENT



Authors

This report was written by the evaluation team led by the Social Policy Research Centre (SPRC) at the University of NSW. The evaluation team includes researchers at the Bankwest Curtin Economics Centre (BCEC), the University of Melbourne (UoM) and the Parenting Research Centre (PRC). Chief investigators for the Outcomes Evaluation are:

kylie valentine (SPRC)
Ilan Katz (SPRC)
Rebecca Cassells (Curtin)
Aron Shlonsky (UoM)

Authors of this report include Rebecca Cassells, Christine Eastman, Ilan Katz, Marcia Keegan, Aron Shlonsky and kylie valentine.

Suggested citation: Cassells R, Eastman C, Katz I, Keegan M, Shlonsky A and valentine k (2014) *'Keep Them Safe Outcomes Evaluation: Data Development Final Report, Annex H*, Sydney: NSW Department of Premier and Cabinet.

Acknowledgements

The evaluation team would like to acknowledge the contribution of Peter Ryan and Tomas Kosik from NSW DPC and Venessa Smoothy and Joanna Hopkins from NSW FACS.

Ethics and police clearance

The outcomes evaluation has received human research ethics clearance from the University of New South Wales Ethics Committee. Researchers involved in this project have obtained appropriate clearances (police checks) which are required to work with sensitive datasets..

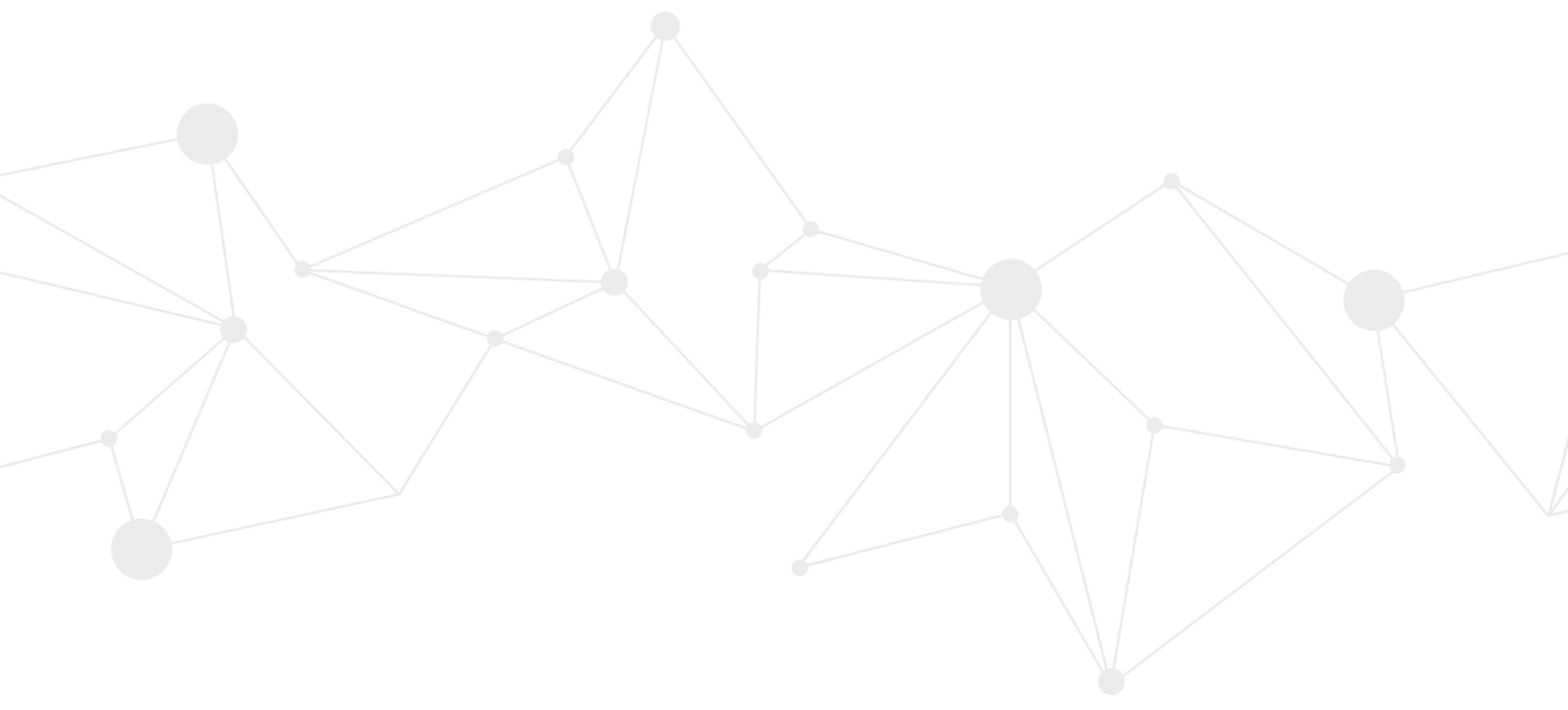


KEEP THEM SAFE OUTCOMES EVALUATION

FINAL REPORT – ANNEX H
NSW DEPARTMENT OF PREMIER AND CABINET

JUNE 2014

DATA DEVELOPMENT



Contents

1	Lessons learnt from the KTS evaluation	3
1.1	Child Protection Intake and Assessment	4
1.1.1	Lack of follow through of referrals	4
1.1.2	Poorly articulated data fields	4
1.1.3	Aboriginal data	4
1.1.4	Out-of-home-Care (OOHC)	5
1.1.5	In OOHC	5
1.1.6	Exiting OOHC to independence	5
1.2	Program monitoring and evaluations	6
2	Recommendations for data development	7
2.1	Administrative data	7
2.1.1	Aboriginal data	8
2.1.2	Out-of-home care	9
2.2	Data linkage	10
2.2.1	Individual level	10
2.2.2	Area level	10
2.3	Geographic disaggregation	12
2.3.1	Geographic Concordances	12
2.4	Program monitoring and evaluation	13
2.4.1	Financial data	15
3	Summary of recommendations	17
3.1	Administrative data: general	17
3.2	Aboriginal data	17
3.3	Out-of-home care data	18
3.4	Data linkage	18
3.5	Program data	19
3.6	Financial data	19

1 Lessons learnt from the KTS evaluation



The NSW Government has made a substantial investment towards protecting children from harm through its \$750 million Keep Them Safe child protection initiative. Keep Them Safe (hereafter KTS) was introduced in 2009 as the NSW government's response to the Special Commission of Inquiry into Child Protection Services in NSW undertaken by Justice Wood (Wood Inquiry). A detailed description of KTS is provided in Section 2.1 of the Outcomes Evaluation Final Report.

This is one of eleven evaluation reports that make up the KTS outcomes evaluation. The evaluation involved nine separate yet complimentary methodologies that were designed to address eight evaluation questions and to analyse the various sources of data available to the evaluation team. A detailed description of the evaluation is provided in the KTS Outcomes Evaluation Final Report.

Keep Them Safe Outcomes Evaluation: Final report

- Annex A. Indicators report
- Annex B. Unit record analysis
- Annex C. Cost effectiveness report
- Annex D. Workforce survey
- Annex E. Spatial analysis report
- Annex F. Appraisal of project evaluations
- Annex G. Report on client interviews
- Annex H. Data Development**
- Annex I. Other NSW strategies and initiatives
- Annex J. Literature review

The data development recommendations provided here have been informed by the experiences of the KTS evaluators to obtain meaningful data to assess the relative progress of child protection reform

efforts in NSW over the course of the KTS period. It is intended to address data gaps in understanding the effectiveness of the NSW child protection system, and to assist with future data collection, linking and data quality.

1.1 Child Protection Intake and Assessment

1.1.1 Lack of follow through of referrals

The KTS outcomes evaluation identified a number of significant gaps in NSW data. These are outlined below.

Most organisations note when they refer a child or family to another agency, however data on whether the referral was accepted and whether the family actually received the service are mainly lacking in accessible datasets. This means that it is impossible to identify children who are failing to receive a service and whose problems may be escalating without appropriate intervention.

1.1.2 Poorly articulated data fields

A number of datasets had key data fields which were misleading or too unspecific to identify what had actually happened to children¹. Data fields should clearly describe the action taken and if possible the outcome of that action. Where possible 'catch all' fields should be avoided.

1.1.3 Aboriginal data

Many of the KTS Indicators were available disaggregated by Aboriginality. However, enumeration of this population, particularly at a geographically disaggregated level, is required to gain a true sense of the prevalence of a particular condition. New estimates of the Aboriginal population were recently released by the ABS (see Estimates and Projections; and Aboriginal and Torres Strait Islander Australians, 2001 to 2026, ABS Cat No. 3238.0). These new estimations reduced the prevalence rates of ROSH etc. considerably. Maintaining this series is essential, and enhancement to gain more regular geographic breakdowns would be worthwhile pursuing with the ABS.

1 The prime example of this was 'no further action' which was used in a number of datasets. This could have very different meanings with very different implications for protection of children. This could apply, for example if it was found that a child was not at ROSH (either by the Helpline or at a CSC) but could equally mean that another agency was already dealing with the child and family. Unless more information was sought from the file this field could provide very misleading findings about the outcomes for children.

1.1.4 Out-of-Home care (OOHC)

There is a substantial lack of readily available information about the wellbeing of children while in OOHC. This includes the safety and protection of children when in care.

Very limited information exists about how well children are prepared to leave OOHC and how successful these transitions are.

1.1.5 In OOHC

Data was available from the Office of the Children’s Guardian about whether children in OOHC had individualised health plans, education plans and leaving plans. However, these data were only available for one year for each type of plan and provided through a file audit rather than complete count. This has made it impossible to determine whether the number of children who had each type of plan was increasing or decreasing or even the status quo at that particular point in time.

An alternative data source was also used to assess the proportion of young people with a leaving plan. CREATE, an organisation dedicated to supporting children in OOHC, conducts regular surveys on children and young people’s experiences in their transition from OOHC to independence. They have conducted a number of such surveys from 2005 to 2013. The data they collect is useful to consider along with the Office of the Children’s Guardian (OCG) data. However, it is not directly comparable – the OCG data is drawn from audits of children and young people’s case files, while CREATE data is drawn from surveys of children and young people. In some cases the children and young people surveyed by CREATE may be unaware of all the information in their files; for example, while a young person’s casefile with the OCG may indicate they have a leaving care plan, the young person may not be aware of it.

The proportion of children who reported they had leaving or education plans in the CREATE survey is much lower than the proportion of children in the OCG sample whose casefiles said they had a plan in place. Combined with the fact that many children and young people who reported they had a plan said they knew little about it, suggests that many children in OOHC may have these plans in place but are unaware of them.

According to the CREATE survey, much lower proportions of young people are likely to know about the existence of a leaving care plan when compared to administrative records.

It should be noted that some organisations such as Barnardos keep comprehensive records of children in their care, including their leaving care plans, educational and health plans etc. However this is not common practice across the whole sector.

1.1.6 Exiting OOHC to independence

No information was available about how young people fared when leaving the OOHC system, including their employment, education and housing outcomes. This presents a huge knowledge gap about the success or otherwise of the OOHC system, including whether or not these young people are able to set

and achieve goals such as education, employment, housing and relationships to maintain independence, or if they struggle with adult life.

Studies from the UK and US tend to use linked administrative data to ascertain service utilisation of Care Leaver across health, mental health, financial assistance, justice, housing, education and other services systems. This should be more vigorously pursued using existing data sets across sectors.

1.2 Program monitoring and evaluations

Significant program investments have been made throughout NSW in prevention and early intervention as well as statutory services and OOHC. The impact of prevention and intervention programs on child outcomes and the cost effectiveness of those programs in delivering benefits efficiently are the two major criteria for evaluation. It is therefore important that these programs, particularly those with the greatest investment, have appropriate evaluation strategies and data collection systems in place in order to monitor and evaluate participation, completions and outcomes. In particular, the use of valid and reliable tools for measuring children's baseline and ongoing progress should be used. In addition, looking only at program completers is substantially biased. An intention to treat approach, whereby all referrals to a service are tracked over time, whether services are completed or not, is highly recommended.

A shortcoming of a number of the KTS evaluations examined by the project team was that the period available for evaluation was not sufficient for a valid or credible attribution of positive outcomes to program treatments. In other cases, data on outcomes of program participants was unavailable as it simply hadn't been collected. As a result many evaluations struggled to estimate the short to medium term outcomes of the program. Other programs which were aimed at system improvements similarly lacked a robust enough evaluation design to provide convincing evidence that the program had resulted in significant changes in the operation of the system.

2 Recommendations for data development



A number of recommendations have been made around future data collection. These measures are likely to secure efficiency gains in a number of ways, serving to minimise future spend and direct future spend more effectively given the added strength of the evidence base available to inform such decisions.

2.1 Administrative data

Choosing a large number of indicators (as was done for KTS) provides a more nuanced and comprehensive picture of developments. However, there are a number of disadvantages to this approach. These include:

- Costs of collating and analysing the data
- Lack of clarity when indicators appear to be contradictory or inconsistent
- Potential for 'cherry picking' amongst indicators.

A small number of easily understood and clear indicators can provide a good overview of the system if they are consistent and are true proxies for a range of outcomes. For example the AIHW have developed 19 headline indicators of child wellbeing in Australia. One of these is dental health. Dental health is relatively important in itself but its real significance lies in the fact that it signals a whole range of health outcomes; research shows that children with poor dental health are also likely to have poor nutrition and generally to have unhealthy lifestyles.

Recommendation

Recommendation: Ultimately the most appropriate way forward would be to identify a relatively small set of key indicators (around 20) which will be reported every year. These should be additional to measures reported routinely in annual statistical reports and should, where appropriate, link datasets to provide insight into the operation of the system.

Recommendation

Agencies should consider developing clearer outcome measures in their datasets. This does not mean following up clients and surveying them. Rather it involves re-examining current data collection and better using data for monitoring practice and management.

2.1.1 Aboriginal data

The Aboriginal population is one of the most over-represented populations in the child protection system. However over-representation is a function of many factors, including structural inequities and a long history of intrusive and often harmful interventions. Great care must be taken to both sensitively respond to increased risk and to avoid assuming that progress is not being made. While major health and child protection disparities continue to exist, these are complex and it is difficult to rigorously ascertain whether things are improving for Aboriginal children and young people. In particular, cross-sectional examination of data that involve longitudinal processes are prone to overestimating poor outcomes. Put another way, poor outcomes associated with prior child protection history influence what we observe, and things may be different for children and young people encountering the system for the first time. Great care must be taken to model these trends well or there may be a tendency toward overcorrection. In addition, strong cultural differences, past history and current marginal living and economic conditions mean that Aboriginal children, young people and communities require specialised services and programs. The provision of these services and, to the greatest extent possible, what they entail will go a long way toward understanding what works for bridging the gap.

Recommendation

Ongoing support for collection and dissemination of data at a geographic level. Ongoing support for the new ABS data collection that gives better estimates of the Aboriginal population. New support to provide more frequent geographic breakdown of the Aboriginal population. Support for longitudinal data analysis that is more sensitive to shorter term trends. Support for data collection on the types of services received by Aboriginal children, young people and families.

2.1.2 Out-of-home care

Safety and Protection

New data processes should be developed to regularly collect and report on information about children being reported at risk of significant harm while in care and the nature (including actuality of event), and frequency of reports.

The reports should specify whether the abuse occurred while the child was in OOHC or was only reported during a spell in OOHC but occurred prior to starting care. The alleged perpetrator should also be identified; in particular whether the perpetrator was a carer, another child in the household or another person. Allegations of abuse by the child should also be reported.

Education and Development

Education can provide these children with the means to be independent and successful in the future, but also serves as a protective factor at the same time.

Information about children's education and developmental performance should also be readily available, including pre-school, child care, primary and secondary school participation. Participation and performance in national testing processes such as NAPLAN and the AEDI, as well as more regular measures that assess their progress will give valuable information as to their wellbeing and potential areas for intervention while in OOHC.

There should be a measure of the 'added value' of OOHC; i.e. a measure of how well the child is doing as he/she progresses through care compared to the baseline at first entry into care. Ideally educational attainment of children in OOHC would also be benchmarked against children with similar characteristics who are in the general population.

Health

Each child coming into OOHC should be assessed. Key measures should be stored and assessed during progress reviews so that the child's health condition can be tracked over time. For indicator use a small number of indicators which could be subject to change could be used (conditions which are not able to be improved such as physical or sensory impairments or chronic health conditions may be important to review for practice purposes, but are not suitable for indicators) Ideally this should also be linked to MBS data so that access to medical services can be tracked.

Recommendation

Data collection measures to ensure greater ease of data extraction that allows information about how protected children are cared for when in OOHC are required. Linking information about the educational, health, and mental health progress of children in OOHC is also highly recommended.

Leaving Care

Overall, reliance on audits or surveys for data on the existence or not of a leaving care plan is expensive and inefficient. Furthermore, information about whether a young person has a leaving care plan, the nature of the plan, the way it has been implemented and whether the plan has sustained is crucial for effective casework as well as case management, and should therefore be available for monitoring purposes as well.

Recommendation

Administrative data should not only record whether a young person has a plan, but whether the plan has been implemented and ideally, the outcomes related to that plan. There are current platforms available such as the Barnardos MyStory package which could be adapted or developed to meet this need.

2.2 Data linkage

A number of opportunities exist to link data across government departments and with external data sources. A dataset that stores information across a variety of aspects that relate to child wellbeing – health, education, interaction with the statutory system, etc – will provide a powerful policy tool where efficiency gains can be secured. Data linkage can be used for indicators, as discussed above, but it is also important for monitoring and evaluation of programs, policies and practices.

2.2.1 Individual level

A number of unique identifiers exist from which children can be successfully linked across agencies. These include Medicare and student IDs, as well as Centrelink customer service numbers for families. Something as simple as attaching the child's Medicare ID to all child level databases will enable data linking across numerous databases.

It will also be important to link individual children to other family members and households. Advances in database technology now allow us to efficiently store relationship-level information for households, and even account for multiple and changing relationships. In many ways our experience on the KTS evaluation revealed that client history is an extremely important predictor of future encounters with the system. Included in this history are relationships: mapping these and including them in statistical models has a great deal of promise in terms of identifying risk and modelling pathways through systems over time.

2.2.2 Area level

It is essential that any future data development strategy includes a commitment to maintain and improve a comprehensive, integrated repository of cross-departmental data that combines program information with local/environmental factors and child protection outcomes.

There are a number of compelling rationales for establishing an integrated local area panel of child protection data of this form:

- to establish a baseline of accurate local area level information against which the effectiveness of specific child protection programs (either singly or in combination) can be evaluated through comparison with appropriate reference localities;
- to capture local area environmental factors and circumstances that potentially impact on child wellbeing and protection outcomes, and against which to measure patterns of change or improvement (over time and across locality) in child health and development indicators;
- to identify LGAs that may usefully be ‘clustered’ or grouped together as comparator local areas when measuring the relative effectiveness of child protection interventions, trials or initiatives targeted at a local area level;
- as an early indication of ‘hotspots’ of relatively good/poor child outcomes, or the relative improvement/deterioration in child outcomes over time within LGAs, when assessed against appropriate local comparator areas;
- As a contribution to an efficient ‘triage’ process in which KTS treatments can be prioritised across local areas to balance resource allocations with the severity of risk indicators and adverse child outcomes.
- Child welfare studies from the US and elsewhere indicate that area differences often account for a substantial portion of observed variability in child outcomes, even when accounting for individual differences.

At an area level there exists a unique opportunity for NSW government to enhance the capacity for evidence-informed program development and resource allocation as well as facilitating monitoring and evaluation. The unique Child Protection Basefile (CPB) developed for the KTS evaluation provides an excellent opportunity to develop just this level of capability, with area level (LGA) information about child safety (ROSH); OOHC, economic activity, demographic and socio-economic indicators as well as information about program expenditure and other government activity within the area.

Recommendation

The maintenance and development of the CPB as a key information source for child outcomes in NSW, and as an input into the monitoring, evaluation and development of KTS child protection programs.

2.3 Geographic disaggregation

Geographically disaggregated data is a powerful tool for effective program planning and targeting. Collection of data at a functional and consistent spatial unit is essential to allow meaningful analysis of particular conditions within areas. Continued support for collecting and disseminating data at a geographic level is highly recommended. In the first instance agencies should explore how location of children, parents, and households are included in FACS and Health databases and enhance data capture and use in services planning (e.g., location of school; location of other families members (siblings, relatives)).

2.3.1 Geographic concordances

Child protection cases, such as ROSH and OOHC, are usually recorded by residential address and geographically grouped and reported by post codes, while economic activity and other socio-economic indicators are more likely to be aggregated at Local Government Area (LGA) level. To allow for consistent analysis it is possible to disaggregate economic indicators to postcode level, but this is a complicated process and requires a large amount of extra information. Alternatively it is possible to aggregate child protection data from postcodes to LGAs. This is also not a simple process because there is no unique concordance between postcodes and LGAs. The solution can be very simple if in each child protection case the corresponding LGA or Local Health Division (LHD) can be detected while the child's residential address is recorded. Although the division of LGAs changes over years for administrative reasons, the contemporary geographical consistency between data on child safety and program data will lead to greater efficiency in geographic analyses.

Recommendation

Allocate each child protection case to corresponding LGA and LHD according to the child's residential address and OOHC locations. This can help trace resource allocations and improve program evaluation.

2.4 Program monitoring and evaluation

Significant program investments have been made throughout NSW in prevention and early intervention as well as statutory services and OOHC. The impact of prevention and intervention programs on child outcomes, and the cost effectiveness of those programs in delivering benefits efficiently, are the two major criteria for evaluation. It is therefore imperative that these programs, particularly those with the greatest investment, have appropriate evaluation strategies and data collection systems in place in order to monitor and evaluate participation, completions and outcomes. In particular, the use of valid and reliable tools for measuring children's baseline and ongoing progress should be used. In addition, looking only at program completers is substantially biased. An intention to treat approach, whereby all referrals to a service are tracked over time, whether services are completed or not, is highly recommended.

A shortcoming of a number of the KTS evaluations examined by the project team was that the period available for evaluation was not sufficient for a valid or credible attribution of positive child protection outcomes to program treatments. In other cases, data on outcomes of program participants was unavailable as it simply hadn't been collected. As a result, many evaluations struggled to estimate the short to medium term outcomes of the program.

The decision on the most appropriate evaluation method for each program should be informed by a number of considerations, ethical as well as practical. For those programs that warrant a full randomised control trial the evaluation and data collection strategies should take place over a time period sufficient to capture any positive effects that may have occurred. Depending on the nature of the intervention, it may be necessary to set up a plan for evaluating the program over a period of between 2 and 5 years to facilitate the selection of a sample of program participants and control group, allowing the treatment group to complete the program and then compare the outcomes of the treatment group to the control group.

For example, an intensive family preservation program that runs for 12 months could identify a group of eligible families at the start of the program and randomly allocate them to treatment and control groups and gather data on relevant targets such as student absenteeism, ROSH reports etc. After the program is completed families should be surveyed on their experiences with the program and data on program targets should be collected again. Finally, after another year or two years data should be collected a third time for treatment and control groups to identify whether the control group shows better outcomes than the treatment group after the completion of the program.

It may be ethically unacceptable from a child welfare perspective to withhold care (potentially for a number of years) from an untreated control group of children at risk of harm. In such circumstances, a more nuanced approach to program evaluation design and data collection could be considered, for example by introducing variants to groups of families within or across local areas with a view to capturing significant relationships between program variants and outcomes. Alternative approaches include using natural experiments such as implementing programs in different locations or over different timescales and then measuring the outcomes for equivalent children in locations where the program exists and where it has not been implemented.

Many programs are not aimed directly at improving outcomes for children and families or are not feasible to evaluate using experimental or quasi experimental designs. However even in these cases there should be robust evaluations which measure the expected impact of the program or practice on the outcomes it is aimed at producing.

In Annex F to the KTS evaluation report a framework for measuring the utility and robustness of evaluations was developed.

Recommendation

All future major program investments should include a sound data collection and analytical plan to facilitate monitoring and better evaluations.

Recommendation

The framework developed to assess the utility of project evaluations should be further developed and should be used by commissioning agencies to design and fund the most robust and useful evaluation possible. Where it is not possible because of resource or time constraints to fund a useful evaluation, then a decision should be made about whether an evaluation is necessary or whether some other form of appraisal or monitoring would be more cost-effective.

2.5 Financial data

Financial data exercises such as the one conducted could benefit from some amendments to existing data practices. These would allow future exercises to be conducted with greater precision and lower cost.

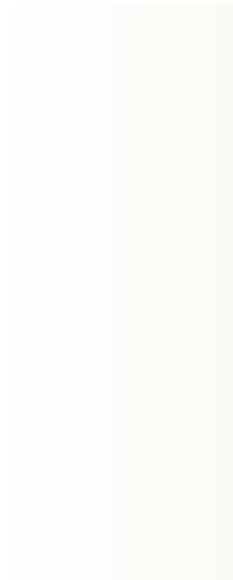
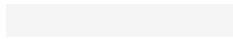
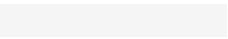
First, departments should use consistent methods of identifying funding by region or small area level; both at an inter-department and intra-department level. Over the KTS period numerous different regional classifications have been used that have differed between departments, including LHD for Health, FACS CSC, CSN and IFP regions, education regions and so forth. A consistent method across departments would be helpful. Furthermore, it would be very useful if these classifications lined up with an external, commonly used geographical classification, such as SLA, LGA or postcode, so regional breakdowns by department can be readily compared to other regional data.

Where it is not feasible to have a single regional classification for every department there should be an attempt to ensure that regional classifications are consistent at within a department. This way, a department's funding by program can be clearly mapped. Some departments are already doing this, for example all Health programs that could be mapped were mapped by LHD. However, other departments seemed to use a mix of classifications even within programs, for example LGA locations or town names in densely populated areas but broader IFP regions in sparsely populated areas. This makes mapping exercises difficult as it is unclear who is supposed to benefit from funding allocated to a specific area.

Secondly, some programs allocate funding to a service provider based in a particular small area but it is not clear whether that service provider will provide services only to those in the immediate area, spread their services evenly over an LGA, LHD or other regional classification, or focus on the local area but provide some services to areas further away. It would be very useful to collect information on the location of clients serviced for early intervention programs such as *Got It!* and Home School Liaison Officers and acute services programs such as Whole Family Teams and Intensive Family Preservation. This way funding can be mapped according to where the benefits are received rather than where the service provider is allocated. This could potentially allow other programs to be mapped by LGA in future evaluations.

Recommendation

Where possible, the location of families or children treated under KTS programs should be aggregated, so it is possible to identify the location of people who receive services under these programs. This way the location of the intended benefits can be readily identified. Ensuring that departments use similar geographic classifications would be helpful.



3 Summary of recommendations



3.1 Administrative data: general

- Identify a relatively small set of key indicators (around 20) which will be reported every year. These should be additional to measures reported routinely in annual statistical reports and should, where appropriate, link datasets to provide insight into the operation of the system.
- Agencies should consider developing clearer outcome measures in their datasets. This does not mean following up clients and surveying them. Rather it involves re-examining current data collection and better use of data for monitoring practice and management.

3.2 Aboriginal data

- Ongoing support for collection and dissemination of data at a geographic level.
- Ongoing support for the new ABS data collection that gives better estimates of the Aboriginal population.
- New support to provide more frequent geographic breakdown of the Aboriginal population.
- Support for longitudinal data analysis that is more sensitive to shorter term trends.
- Support for data collection on the types of services received by Aboriginal children, young people and families.

3.3 Out-of-home care data

- Data collection measures to ensure greater ease of data extraction that allows information about how children are cared for when in OOHC.
- Linking information about the educational, health, and mental health progress of children in OOHC
- Administrative data should not only record whether a young person has a plan, but whether the plan has been implemented, and ideally, the outcomes related to that plan.
- Further data collection on how well young people are prepared to leave OOHC and how well they fare upon independence.

3.4 Data linkage

Individual level:

- Linking of unique identifiers, e.g. Medicare and Centrelink, to all child level databases.
- Linking of individual children to other family members and households.

Area level:

- The maintenance and development of the Child Protection Basefile (CPB) developed for the Keep Them Safe (KTS) Evaluation as a key information source for child outcomes in NSW, and as an input into the monitoring, evaluation and development of KTS child protection programs.

Geographic disaggregation:

- Allocating each ROSH or OOHC case to corresponding LGA and LHD according to the child's residential address and OOHC locations.

3.5 Program data

All future major program investments should include a sound data collection and analytical plan to facilitate monitoring and better evaluations.

The framework developed to assess the utility of project evaluations should be further developed and should be used by commissioning agencies to design and fund the most robust and useful evaluation possible. Where it is not possible because of resource or time constraints to fund a useful evaluation, then a decision should be made about whether an evaluation is necessary or whether some other form of appraisal or monitoring would be more cost-effective.

3.6 Financial data

The location of families or children treated under child protection programs should be aggregated, so it is possible to identify the location of people who are receiving services under these programs.

Ensure that departments use similar geographic classifications where feasible.

