

Department of Social Services

Cashless Debit Card Trial Evaluation

Wave 1 Interim Evaluation Report

February 2017

About this Report

This is the **Wave 1 Interim Evaluation Report** of the Cashless Debit Card Trial (CDCT) being conducted in Ceduna and Surrounds (South Australia; SA) and in the East Kimberley (EK) region (Western Australia, WA).

Initial Conditions Report	Wave 1 Interim Evaluation Report	Wave 2 Final Evaluation Report
<p data-bbox="347 573 456 600">July 2016</p> <p data-bbox="220 692 587 768"><i>Qualitative research with 37 stakeholders and community leaders in the Trial communities</i></p>	<p data-bbox="719 573 868 600">January 2017</p> <p data-bbox="614 622 979 835"><i>Qualitative research with 73 stakeholders and community leaders in the Trial communities + quantitative surveys with 552 participants, 78 family members of participants and 110 general community members (non-Trial participants) + administrative data</i></p>	<p data-bbox="1066 573 1310 600">Anticipated June 2017</p> <p data-bbox="1082 672 1295 790"><i>Qualitative research + quantitative research + administrative data Details To Be Confirmed</i></p>

This report consists of several layers of information and data, suited to different readers and purposes. As these layers build on top of each other, some content is repeated across multiple layers as relevant. Readers are suggested to utilise the layer(s) most suited to their needs, and to seek more detailed data from deeper layers as and when required.

The layers are:

1. **Executive Summary.** A brief narrative summary of the CDCT and its objectives, and the key findings from the Wave 1 Interim Evaluation Report (Part I).
2. **Overview of Performance against the KPIs.** A summary of key survey results, qualitative observations and administrative data which specifically relate to the Evaluation Key Performance Indicators (KPIs) of the CDCT, including an overview table of KPIs (Part III).
3. **Response to Evaluation Questions.** A discussion of the broader Evaluation Questions, drawing together and considering evidence from all data sources as they relate to these questions (Part IV).
4. **Conclusions.** A succinct statement of the conclusions as at the Wave 1 Interim Evaluation (Part V).
5. **Quantitative Survey Results.** The detailed survey results in chart and table form, with minimal commentary. These results are presented in two sections – those relating to KPIs (Appendix A) and those relating to other facets of the CDCT (Appendix B).
6. **Qualitative Research Summary Reports.** Detailed descriptive results from the qualitative research with stakeholders and community leaders in each of the Trial sites (Appendix C).

Information on the evaluation **methodology** can be seen in Part II, and in Appendix D: Organisations Interviewed and Contacted in Qualitative Research.

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I. Executive Summary

Background

With support from the Department of the Prime Minister and Cabinet (PM&C), and developed in close consultation with local community leaders, local and state government agencies and other Australian Government agencies, the Department of Social Services (DSS) is conducting a 12-month trial of a Cashless Debit Card for income support payments (ISPs) in two regional communities.

The **Cashless Debit Card Trial (CDCT)** aims to reduce the levels of harm associated with alcohol consumption, illicit drug use and gambling by limiting Trial participants' access to cash and by preventing the purchase of alcohol or gambling products (other than lottery tickets). Between 50% and 80% of CDCT participants' ISPs are directed to a restricted bank account, accessed by the debit card, with the remainder of these payments accessible through a normal (unrestricted) bank account. Participation in the Trial is mandatory for all working age ISP recipients in the selected Trial sites. Wage earners, Age Pensioners and Veterans' Affairs Pensioners who live in the Trial sites can opt in to the CDCT¹. To support the implementation of the Trial, DSS worked with the South Australian and Western Australian state governments, community agencies and local Indigenous leadership to supplement the support services being provided in the Trial areas with significant further investment.

The Trial commenced in Ceduna and Surrounds (South Australia, SA) on 15 March 2016; and in the East Kimberley (EK) region (Western Australia, WA) on 26 April 2016.

Three evaluation reports are planned across the period of the Trial, with this being the second of these. It is based on data collected during the first six months of the Trial (up to 4 October 2016).

<p>Initial Conditions Report</p> <p>July 2016</p> <p><i>Qualitative research with 37 stakeholders and community leaders in the trial communities</i></p>	<p>Wave 1 Interim Evaluation Report</p> <p>January 2017</p> <p><i>Qualitative research with 73 stakeholders and community leaders in the Trial communities + quantitative surveys with 552 participants, 78 family members of participants and 110 general community members (non-Trial participants) + administrative data</i></p>	<p>Wave 2 Final Evaluation Report</p> <p>Anticipated June 2017</p> <p><i>Qualitative research + quantitative research + administrative data Details To Be Confirmed</i></p>
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Prior to the evaluation commencing a Program Logic for the CDCT was developed. From this a series of **Key Performance Indicators (KPIs)**,² and where relevant targets, were agreed against which its performance would be primarily evaluated. These were the basis of the Final Evaluation Framework, which also received an ethics approval.

¹ N=5 Trial participants opted into the CDCT overall. As at 7 October 2016, only N=2 (both in East Kimberley) were recorded as being 'ON' the CDCT.

² The KPIs can be seen in the CDCT Evaluation Framework which was included as an appendix to the Initial Conditions Report, Appendix A of this report and in CDCT Evaluation Framework Summary available on the DSS website.

A number of **broader Evaluation Questions** were also identified as themes to provide greater context and understanding of how and why the CDCT may have an impact, and to assist in fine-tuning or improving its implementation depending on what was learned.

Overview of Findings against KPIs

The findings indicate that, **overall, the CDCT has been effective to date** in terms of its performance against the KPIs established in the evaluation framework. At this early stage of the CDCT, the KPIs underpinning this overall effectiveness assessment were those relating to CDCT program outputs and short term outcomes (ie: those expected to have occurred by 3 months of full implementation). Performance against these KPIs ranged from partially to fully effective. Key findings in relation to these KPIs are set out below.

Output KPIs – performance rated fully effective/ KPI target achieved

- All community leaders (members of regional leadership groups) who participated in the Wave 1 qualitative research were supportive of the CDCT. See Appendix D of full report for list of participating leaders
- Cashless debit cards (CDCs) were provided to participants and activated in a timely manner, with nearly all CDCT participants making their first CDC purchase within one month of the first income support payment (ISP) into their CDC account.
- DHS data indicates that quarantining of ISPs via CDC accounts has been effective, with a large majority of ISP payments to CDC accounts in the early stages of the Trial (98% of total value up to end June 2016) being a result of quarantining at the rate of 80%. The data indicates that 2% of the total value of ISP payments to CDC accounts during this period was made to CDCT participants with an approved lower rate of quarantining.

Output KPIs - performance rated partially effective/ KPI target not achieved

- Participant understanding of CDC conditions and functionality has improved over time. In the Wave 1 survey, nearly all participants understood that people cannot buy alcohol with the CDC. However, the Wave 1 evaluation research found that significant awareness/ understanding gaps remained.
- A large majority of Trial participants surveyed (78% average across the two Trial sites) reported that they had not changed where and how they shopped since the Trial commenced, indicating that they had reasonable access to merchants and products via the CDC. A minority (18% average across the two Trial sites) expressed concerns about constraints on their ability to access allowable goods and services via the CDC. These proportions were close to KPI target levels (90% and no more than 10%, respectively). Problems reported by participants and stakeholders primarily related to participants' constrained ability to make allowable purchases in settings where cash was the normal payment medium.
- Most community leaders in both Trial sites considered that community panels had not been established in a timely manner (in Ceduna the panel was established shortly after trial commencement but not *at* commencement; and in EK the panel had not been established by the time of the Wave 1 fieldwork). These panels were developed at the local community level.

Outcome KPIs - performance rated fully effective/ KPI target achieved

- Indicators relating to alcohol consumption showed positive interim results. The Wave 1 survey found that (on average across the two Trial sites) 25% of CDCT participants and 13% of their family members reported drinking alcohol less frequently since the Trial commenced (with around 1-2% in each case reporting that they were drinking more frequently). Moreover, 25% of CDCT participants reported engaging in binge drinking less frequently since having a CDC, while only 3% reported binge drinking more frequently. Many EK stakeholders

and some Ceduna stakeholders who participated in the Wave 1 qualitative research had noticed positive changes since the commencement of the Trial that were indicative of lower levels of alcohol consumption in their communities (particularly levels of problematic consumption). In addition, in the Wave 1 survey, substantial proportions of non-participant community members (41% average across the two Trial sites), CDCT participants (24%) and CDCT participants' family members (28%) reported that they had noticed a reduction in the drinking of alcohol in their community since the Trial started. However, it should be noted that seasonal factors (particularly the cold and wet winter conditions in Ceduna) may have resulted in less drinking of alcohol in public spaces and hence influenced these perceptions.

- Indicators relating to illegal drug use showed some improvement at the Interim Evaluation stage. The Wave 1 survey found that (on average across the two Trial sites), around a quarter of CDCT participants who reported using illegal drugs before the Trial commenced indicated that they had been using illegal drugs less often since becoming CDCT participants.
- Indicators relating to gambling also recorded positive short-term outcome results. The Wave 1 survey found that (on average across the two Trial sites) 28% of non-participant community members, 27% of CDCT participants and 28% of CDCT participants' family members had noticed a reduction in gambling in their community since the Trial started.

Outcome KPIs - performance rated partially effective/ KPI target not achieved

- Awareness was limited among CDCT participants in relation to local drug and alcohol support services, as well as financial and family support services.

Interim Responses to Evaluation Questions

What have been the effects of the CDCT on program participants, their families and the broader community?

Both quantitative and qualitative evidence indicates that the first few months of the CDCT has seen a reduction in all three targeted behaviours – alcohol consumption, gambling and use of drugs. Among the 66% of participants who reported drinking alcohol, gambling or taking illegal drugs before or during the Trial, one third (33%) reported a reduction in *at least* one of these behaviours.

At the time of the Wave 1 data collection, there was some preliminary evidence to suggest that there has been a reduction in crime, violence and harm related to alcohol consumption, illegal drug use and gambling since the Trial commenced. These are expected to be impacted more in the medium and longer term, but police crime statistics together with the reported perceptions of non-participant community members, community leaders and other stakeholders did provide some preliminary evidence of a reduction in crime and violence in Ceduna and Surrounds. It was anticipated before the Trial that there was some risk of an *increase* in crime when the CDCT started as a way of people seeking to obtain cash, but in the main, at Wave 1 this was not considered to have eventuated. Administrative data relating to sobering up services in the Trial communities showed some positive preliminary signs in relation to problematic alcohol consumption. In particular, sobering up services in East Kimberley recorded lower numbers of cases post Trial than at pre-Trial baseline. In addition, alcohol and drug related referrals to the Kimberley Mental Health and Drug Service declined after the commencement of the Trial.

There was little evidence of change in perceptions of safety. In Kununurra (in EK) it was felt that there may be fewer intoxicated people in the parks, making them safer, but that night time was still problematic.

There have been some **other positive impacts observed in the community**. Overall, stakeholders and community leaders felt the Trial has had some positive impacts on participants' financial capacity (eg: better able to save, money available to spend on children, fewer requests for emergency funds), as well as nutrition and health within their communities (eg: purchasing of more food, school lunches, sobriety, and engagement with programs). In particular, there was a notable increase in East Kimberley community leaders'/stakeholders' average ratings (on a scale of 0 to 10) in relation to the ability of people in their community to afford basic household goods (3.7 to 5.6) and pay bills (3.5 to 5.5) as well as nutrition in the community (3.2 to 4.6). A significant proportion of participants in the survey indicated they had been able to save more money (31%), care for children better (31%) and improve at using technology (21%).

Overall, **perceptions of the impact of the Trial varied between those involved in it and those in the general community**. More participants said the CDCT had made their lives *worse* than made it *better* (49% compared to 22%). Family members of trial participants gave a similar pattern of answers (37% and 27%). However, non-participants had the reverse perception, with 46% saying the Trial had made life in their community better, and only 18% that it had made life worse. Non-participants in East Kimberley were somewhat more positive than those in Ceduna.

Segmenting participants by self-reported behaviour change across the three target behaviours – alcohol consumption, gambling or illegal drug use – showed that participants who reported **positive** behaviour change on *at least* one of the three target behaviours were *more likely* to say that the Trial has made their lives better (30%), compared to those who reported **no change** (22%). No participants who reported **negative** behaviour change (more) said that the Trial had made their lives better, though this was a very small group (n=8).

Have there been any circumvention behaviours that have undermined the effectiveness of the CDCT?

Community leaders and other stakeholders interviewed at Wave 1 indicated that they had heard of various CDCT circumventions having occurred. However, they were unable to comment on how widespread such practices were, and it was not possible to quantify the extent of these reported circumventions. It is likely that neither successful circumventions nor the existence of some sources of income outside of the Trial (such as royalties or emergency assistance payments) could have replaced more than a small proportion of the total value of ISPs quarantined by the CDCT.

Have there been any other unintended adverse consequences?

Perceptions of the impact of the CDCT on humbugging³ has been varied. Stakeholders and community leaders generally felt humbugging had reduced. For example, people who were known to be on the Trial now were either not asked or had an easy answer to decline providing money by stating that they had limited cash because of the Trial. However, stakeholders noted that people known to have access to cash (eg: age pensioners) may be more likely to now be targeted. In contrast, the survey showed that participants and family members both felt that the overall level of humbugging had gone up since the Trial started. This was higher in EK than in Ceduna, but in both sites more people in these groups thought humbugging had increased than thought it had decreased.

³ Making unreasonable financial demands on family members or other local community members.

A few stakeholders in the qualitative research felt that some CDCT participants felt a sense of shame or stigma associated with having a CDC (especially those who felt they were already managing their money appropriately). However, in the quantitative survey only 6% of all participants explicitly raised stigma or shame associated with the card as an issue.

Beyond that, there have been some issues related to the experience of participants using the cards. Typically these related to specific transactions that were difficult without cash, and to effective use of the card itself and its available features.

What lessons can be learnt to improve delivery and to inform future policy?

Given the early stage of the Trial, it is promising that there are signs of the CDCT working in both sites. It was not possible at this stage of the evaluation to reliably assess where the Trial has worked most and least successfully. In the survey data, demographically there were only fairly minor variations seen in the responses of participants. Overall, the pattern of responses varied little by gender, although men were significantly more likely than women to believe that the CDCT has made their lives worse. There was a somewhat more variation seen across age groups. In particular, the 18-24 age group showed generally the most positive profile of changes, and it was the 55+ age group who were the least positive about the effect of the Trial on their lives.

Given the absence of material changes in other influential factors and conditions, the positive short term impacts reported since the commencement of the CDCT appear likely to be largely attributable to the Trial. Moreover, **as the majority of participants had not used any of the existing and additional support services provided in Trial sites, the Wave 1 survey results indicate that the debit card itself had a separate and significant impact** on participants' behaviours. The survey results were suggestive of an additive effect of services on the small proportion of the population using them, but that this was only a relatively small effect for a relatively small proportion of the total participant population.

The Interim Evaluation findings show there are opportunities for improvement in the implementation of the CDCT during the remainder of the Trial period. Initiatives that could be considered include ongoing communications, and continuing to identify and communicate solutions to functionality issues.

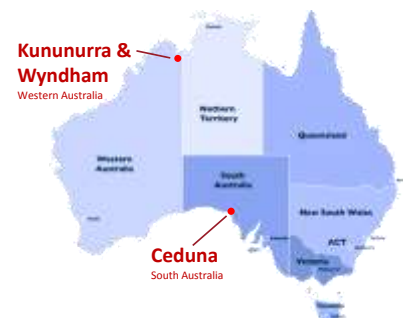
Conclusions

1. Overall, the CDCT has been effective to date in terms of its performance against the key performance indicators (KPIs) established in the evaluation framework.
2. In particular, the Trial has been effective in reducing alcohol consumption, illegal drug use and gambling – establishing a clear 'proof-of-concept' and meeting the necessary preconditions for the planned medium-term outcomes in relation to reduced levels of harm related to these behaviours.
3. The Interim Evaluation findings indicate that the reductions in these behaviours have been largely driven by the impact of the debit card quarantining mechanism and not by the additional services provided via the CDCT package or factors external to the CDCT.
4. At this interim stage there is only limited evidence of early impacts on crime, violence, injuries and perceptions of safety – though as medium-term outcomes these were not expected to be seen in this timeframe and will be a focus of Wave 2 of the evaluation.

II. Background

1. Overview of the Cashless Debit Card Trial

The Cashless Debit Card Trial (CDCT) is a co-designed program developed through collaboration between government and two local communities. The aim of the CDCT is to reduce the levels of harm associated with alcohol consumption, illicit drug use and gambling within the communities of Ceduna and Surrounds in South Australia and East Kimberley in Western Australia (Kununurra and Wyndham). Both communities are relatively small (with populations of around 3,000 and 6,000 respectively) and geographically remote. Such remote sites in Australia typically have significant economic and social challenges, but their relative isolation does allow them to be more effective test sites.



The Trial has been led by the Department of Social Services (DSS), with support from the Department of the Prime Minister and Cabinet (PM&C), and developed in close consultation with local community leaders, local and state government agencies and other Australian Government agencies. Trial participants have been issued with a debit card which cannot be used to buy alcohol, gambling products (with the exception of lottery tickets) or to withdraw cash. Eighty percent of a Trial participant's income support payments (ISPs) are placed into a restricted account linked to the cashless card (100% of lump sum payments and arrears payments), with the remainder of these payments accessible through a normal (unrestricted) bank account. The percentage of funds accessible in an unrestricted manner (e.g. as cash) may be varied by local community panels, up to 50%.

Participation in the Trial is mandatory for all working age ISP recipients in the selected Trial sites. In addition, wage earners, Age Pensioners and Veterans' Affairs Pensioners who live in the Trial sites can opt in to the CDCT.

To support the implementation of the Trial, DSS worked with the South Australian and Western Australian State Governments, community agencies and local Indigenous leadership to supplement the support services being provided in the Trial areas with significant further investment.

The Trial commenced in Ceduna and Surrounds on 15 March 2016; and in East Kimberley on 26 April 2016.



Left: Kununurra
Above: Wyndham
Right: Ceduna



2. Role of the Evaluation

Framework

ORIMA Research has been commissioned by (DSS) to independently evaluate the Trial in both locations using qualitative and quantitative research methods.

ORIMA Research has developed a formal evaluation framework which specifies the scope of the evaluation and the key performance indicators (KPIs) that will lead its assessment of the effectiveness of the CDCT.

The overall evaluation design and process has been informed by feedback from:

- respected academics and commentators with expertise in conducting research and evaluations involving Aboriginal and Torres Strait Islander people, as expert advisors to the Steering Committee;
- leaders and representatives of Aboriginal corporations and community organisations in the Ceduna and Surrounds and East Kimberley regions; and
- officers of Australian and state government agencies with on-the-ground experience in the Trial sites.

Objective

The overall objective of the evaluation is to assess the effectiveness of the CDCT against agreed KPIs.

Broader evaluation questions also include:

1. What have been the effects of the CDCT on program participants, their families and the broader community?
 - Have there been reductions in the consumption of alcohol, illegal drug use, or gambling?
 - Has there been a reduction in crime, violence and harm related to these behaviours?
 - Has there been an increase in perceptions of safety in the Trial locations?
 - Have there been any other positive impacts (e.g. increase in self-reported well-being, reduction in financial stress)?
2. Have there been any circumvention behaviours (e.g. participants selling goods purchased with cashless debit cards to obtain more cash, increase in humbugging or theft) that have undermined the effectiveness of the CDCT?
3. Have there been any other unintended adverse consequences (e.g. feelings of shame, social exclusion)?
4. What lessons can be learnt throughout the Trial to improve delivery and to inform future policy?

- How do effects differ among different groups of participants (e.g. men compared to women, people from different age groups)?
- Where has the Trial worked most and least successfully?
- To what extent can any changes be attributed to the Trial as opposed to external factors such as alcohol restrictions?
- Can the contribution of the debit card be distinguished from that of the additional services in the Trial locations provided via the CDCT support package?

3. Sources of Data

The evaluation is based on data from three principal sources:

- Administrative data;
- Interviews and focus groups with community leaders and stakeholders (qualitative research); and
- Face-to-face interviews with Trial participants, family members of Trial participants and other non-participant community members residing in the Trial sites (quantitative survey).

This Interim Evaluation Report presents findings from all of these sources. It is based on data collected during the first six months of the Trial (up to 4 October 2016).

Administrative data

The administrative data presented in this Interim Evaluation Report includes income support payment data from the Department of Human Services and Indue, as well as other available data from service providers and state government agencies.

Interviews and focus groups with community leaders and other stakeholders

To date, interviews⁴ and focus groups with community leaders and other on-the ground stakeholders in the Trial sites have been conducted in the Trial communities at two points in time:

- Pre-Trial launch – conducted between 21 April and 26 May 2016 across Ceduna and Surrounds and East Kimberley; and
- At Wave 1 – conducted between 15 August and 15 September 2016 in Ceduna, and between 12 September and 4 October in East Kimberley.

⁴ Interviews were conducted either face-to-face or via telephone.

Stakeholders were selected for participation in the research based on their capacity to provide relevant and informed feedback. Selection was informed by desk research, the outcomes of the pre-fieldwork consultations and discussions with the Evaluation Steering Committee.

Table 1: Number of community leaders and stakeholders⁵ participating in the research	Ceduna and Surrounds⁶	East Kimberley⁷	Total
Pre-Trial launch	15	22	37
Wave 1	33	40	73

In Wave 1 there were 28 community leaders and stakeholders who were contacted but not interviewed. Of these, only 16 declined to participate, with the others being cases where an interview at a mutually suitable time was not able to be organised.

All qualitative research was conducted by ORIMA's specialist qualitative research team. This team has extensive experience conducting research with Indigenous people and in regional Australia, and has participated in cultural awareness training sessions.

The research was qualitative in nature, and hence the results and findings are presented in a qualitative manner. This research approach does not allow for the exact number of participants holding a particular view on individual issues to be measured. This Interim Evaluation Report, therefore, provides an indication of themes and reactions among research participants rather than exact proportions of participants who felt a certain way. The following terms used in this Interim Evaluation Report provide a qualitative indication and approximation of size in relation to the proportion of research participants who held particular views:

- Most—refers to findings that relate to more than three quarters of the research participants;
- Many—refers to findings that relate to more than half of the research participants;
- Some—refers to findings that relate to around a third of the research participants; and
- A few—refers to findings that relate to less than a quarter of research participants.

Face-to-face interviews with the Trial communities

Two waves of face-to-face survey interviews were planned to be undertaken with Trial participants, their families and other community members.

The first wave of survey fieldwork was conducted in Ceduna and Surrounds from 17-28 August 2016. This included day visits to Thevenard, Yalata and Oak Valley. A second visit to Yalata was unable to be completed due to a death in the community.

Wave 1 survey fieldwork was conducted in East Kimberley from 12-23 September 2016. Interviews were conducted in Kununurra, Wyndham, Glen Hill, Cockatoo Springs, Mirima and Nulleywah.

⁵ Please refer to Appendix D: Organisations Interviewed and Contacted in Qualitative Research for further detail

⁶ Includes participants in Ceduna, Koonibba, Scotdesco and Yalata

⁷ Includes participants in Kununurra and Wyndham

This Interim Evaluation Report presents the findings of the first survey wave.

The surveys were conducted by ORIMA's Indigenous Fieldforce, consisting of trained Indigenous interviewers supported by other experienced researcher interviewers and some local Indigenous people in support roles. A local cultural awareness session was conducted with the initial interviewing team and the field manager before interviewing commenced.

The surveys used a systematic intercept sampling methodology. High traffic sites around the communities were identified. The interviewing teams were then rostered to fixed locations or roving teams for specified times. During scheduled sessions interviewers, and in some cases dedicated 'interceptors', approached every Xth person who passed by a designated point to conduct an interview. The frequency was adapted to suit traffic volumes, but never dropped below every 2nd person. This approach is commonly used in intercept interviewing methodologies to assist in randomising the sample of participants, allowing more confident extrapolation to the wider population of interest. People who agreed to participate in the survey were then screened into the Participant, Family Member or Non-Participant surveys. Quotas for family members and non-participants were expected to be filled quickly, and once full only participants were screened in to an interview.

Table 2: Wave 1 Starting Maximum Sample Size Quotas

	Ceduna	East Kimberley	Total
Trial participants	325	325	650
Family members of Trial participants	30	30	60
Non-participants of the Trial	50	50	100
Total	405	405	810

Despite the much smaller overall population, the same nominal maximum quotas were set in Ceduna as East Kimberley. Once actual achieved numbers were known in Ceduna, then the target numbers were adapted in EK to suit. (Wave 2 targets will be determined prior to that phase commencing.)

In total 286 interviews were achieved in Ceduna during the specified fieldwork period. A larger interviewing team was deployed to EK in response to the observed response rates and other challenges relating to the nature of the CDCT which emerged while interviewing in Ceduna. This enabled interviewers to operate in larger teams, and to increase the number of interviews which could be achieved. A total of 454 interviews were completed in EK.

Table 3: Wave 1 Sample Sizes of survey respondents

	Ceduna	East Kimberley	Total
Trial participants	196	356	552
Family members of Trial participants	32	46	78
Non-participants of the Trial	58	52	110
Total	286	454	740

The family and non-participant quotas were all achieved and in some cases exceeded, and a total of 552 CDCT participants were interviewed across the two sites.

Participation rates in the quantitative surveys were reasonable for an intercept methodology, with refusals somewhat lower in Ceduna than EK. In EK the proportion of refusals and the proportion of people who agreed to be surveyed were approximately equal, whereas in Ceduna intercepted people were around three times more likely to agree to be interviewed than to refuse.

Table 4: Wave 1 Number of Refusals and screen-outs by methodology

	Ceduna		East Kimberley		Total	
Qualitative Refusals	4		12		16	
Quantitative survey	n	%	n	%	n	%
Completes	286	31%	454	15%	740	19%
Refusals	89	10%	444	15%	533	13%
Screen-outs (total)	560	60%	2157	71%	2717	68%
Under 18	17	2%	93	3%	110	3%
Already completed	129	14%	630	21%	759	19%
Tourist / out of area	221	24%	621	20%	842	21%
Language	12	1%	11	0%	23	1%
Can't be interviewed	14	1%	63	2%	77	2%
Other	167	18%	739	24%	906	23%
Total intercepts	935		3055		3990	

Weighting

Survey data is typically weighted to balance obtained samples against known population characteristics. This maximises the confidence with which results can be extrapolated to the wider population.

In this case, two weighting approaches were employed. First, separate weights were created for the participant results in each Trial location, and then an additional weight was created for the calculation of aggregate results across both Trial sites.

For the two individual trial sites:

- For **participants**, the survey results were weighted independently for Ceduna and East Kimberley to enable analysis at each site. This weighting aligned the distribution of respondents with that of their respective population distributions of CDCT participants on three known population characteristics – age, gender and Indigenous / non-Indigenous origin. The benchmark population distribution data was provided by DHS.
 - Results labelled Ceduna Participant or East Kimberley Participant have been weighted in this way.
- The Family and Non-Participant sub-groups across sites were not weighted due to low sample sizes.

In order to provide an overall **aggregate** measure across both sites, an additional step in the weighting was needed to balance the different sample sizes at the two sites. Despite the different population sizes, equal weight was given to both locations – so that they each contributed 50% of the overall result reported. This location weight was applied on top of the individual participant weighting created for the calculation of results at each site.

- Results labelled Participant Average have been weighted in this way.
- The Family and Non-Participant sub-groups were also weighted equally across sites to give the Family Average and Non-Participant Average results.

Statistical precision

Table 5 provides indicative confidence intervals (at the 95% level of statistical confidence) for different response sizes within the survey, allowing for the impact of weighting as outlined above.

For this survey, overall percentage results for questions answered by at least 500 respondents have a degree of sampling error (i.e. confidence interval) at the 95% level of statistical confidence of **+/- 5 percentage points (pp)**. That is, there is a 95% probability (abstracting from non-sampling error) that the percentage results will be within +/- 5pp of the results that would have been obtained if the entire target population had responded.

Table 5: Indicative confidence intervals – 95% confidence level

Response size (n)	Statistical precision (percentage points)
500	+/- 5pp
350	+/- 6pp
200	+/- 8pp
150	+/-9pp
100	+/- 11pp
80	+/- 13pp
40	+/- 18pp

Higher degrees of sampling error apply to questions answered by fewer respondents and to results for sub-groups of respondents. This is important, because it impacts on the statistical significance of observed differences. In general terms, the smaller the sample size, the larger the difference needs to be in order to be statistically significant (ie: to enable us to conclude that the observation is likely to be a real difference and not just due to natural variation in the sample).

In reality, testing statistical significance is a complex calculation, and the table above is just a guide to understanding how it varies based on sample size. A crude way of conceptualising significance testing is that for a result to be statistically significant, the difference between two numbers needs to be several percentage points in excess of the statistical precision figure shown.

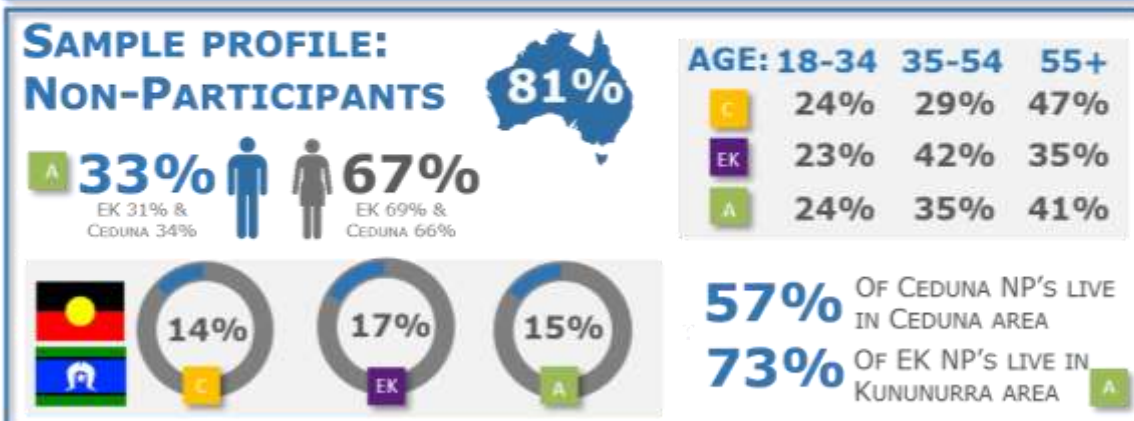
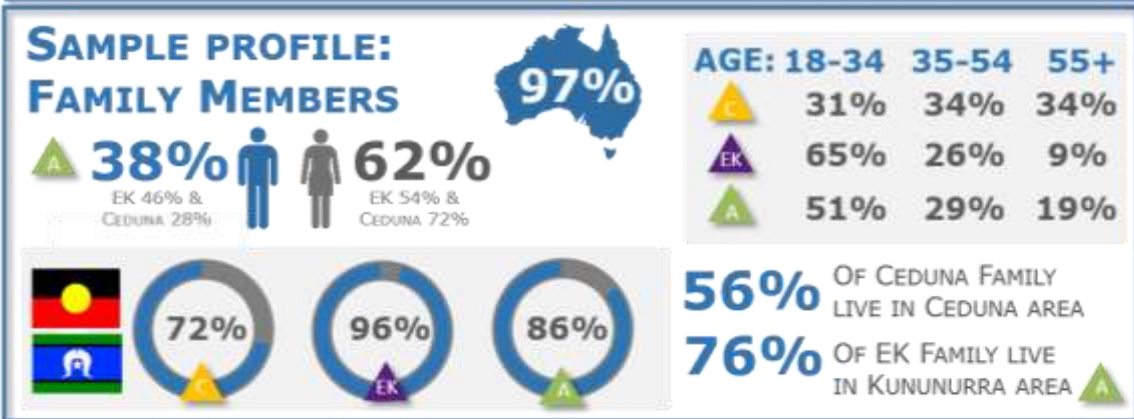
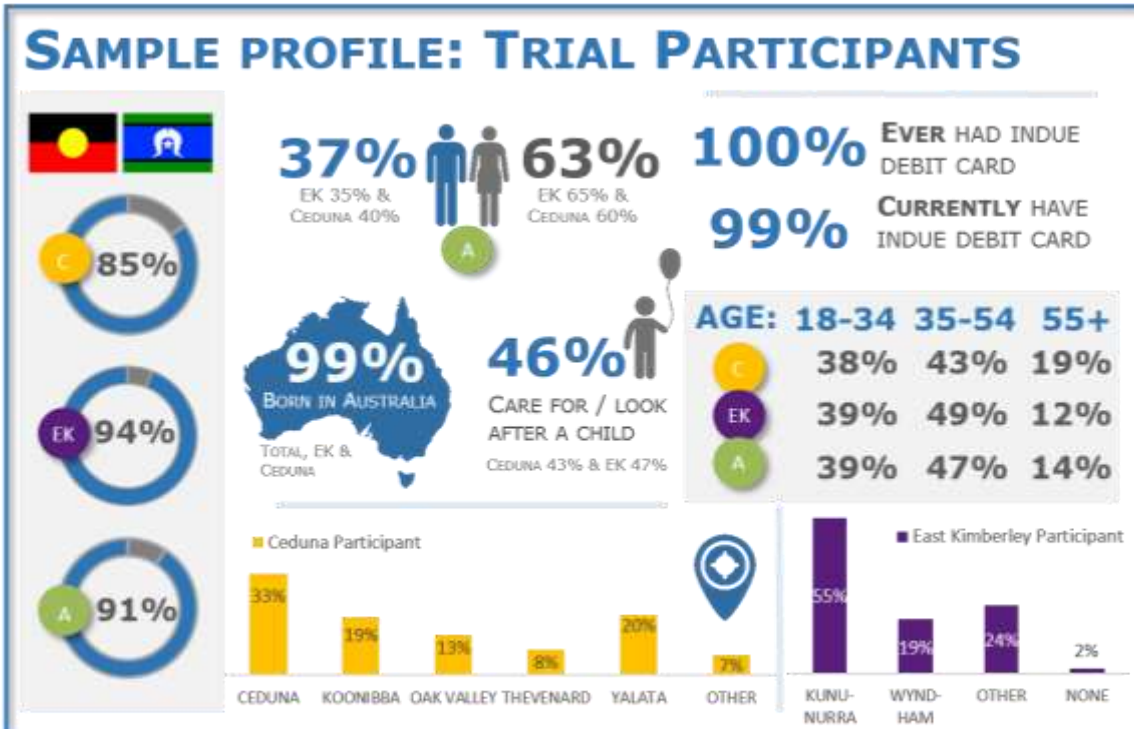
There are several further technical considerations:

- i. We use the 95% confidence level for determining significance. This is a commonly used threshold in social research, and means that 95% of the time a difference which exceeds this threshold should indicate a real difference and not just natural variation.
- ii. The statistical precision shown above is for results of 50%. As the results being examined become higher or lower, the confidence intervals narrow somewhat. In practical terms this means that the absolute difference between two results needed to be statistically significant is smaller the closer the numbers involved get to 0% or to 100% (eg: at 10% or 90%, the difference needed to be statistically significant is just over half what is needed for a significant difference to 50%).
- iii. Weighting data also affects the 'effective sample size'. The more weighting applied, the lower the effective sample size for the calculation of statistical significance. Here, a design effect of 1.30 has been applied to allow for the effect of the weighting required. This scaling means that somewhat larger differences are required before the threshold for statistical significance is reached.

4. Ethics Approval and Quality Assurance

The Bellberry Human Research Ethics Committee (HREC) reviewed this project in accordance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research. The Bellberry HREC is constituted and operates in accordance with the National Statement. The Bellberry HREC approved the project on 8 August 2016.

The project was conducted in accordance with international quality standard ISO 20252.



	CEDUNA	EK	AVERAGE
PARTICIPANTS	(C)	(EK)	(A)
FAMILY	(C)	(EK)	(A)
NON-PARTICIPANTS	(C)	(EK)	(A)

INFORMATION ON THIS PAGE IS UNWEIGHTED. DATA IN THE REST OF THE REPORT HAS BEEN WEIGHTED FOR ANALYSIS PURPOSES.
 Information on this page is unweighted. Data / charts in the remainder of the Interim Evaluation Report have been weighted to population proportions for analysis purposes, unless otherwise stated.

III. Overview of Performance against KPIs

The evaluation framework specifies a range of Key Performance Indicators (KPIs) to be used for the assessment of the effectiveness of the CDCT, and where relevant, targets against which they should be assessed. This chapter presents an overview of the Interim Evaluation findings in relation to the performance of the CDCT against these KPIs. Detailed results for each KPI are presented in Appendix A.

Overall, the Interim Evaluation (Wave 1) findings indicate that the CDCT has been effective to date in terms of its performance against the evaluation KPIs. At Wave 1, with data having been collected less than 6 months after the commencement of the Trial, the KPIs underpinning the overall effectiveness assessment were those relating to CDCT program outputs and short term outcomes (those expected to have occurred by 3 months of full implementation). Performance against these KPIs is summarised below.

Output KPIs

Performance against output KPIs ranged from partially to fully effective. Specifically:

Fully effective/ KPI target achieved

- All community leaders (i.e. members of regional leadership groups)⁸ who participated in the Wave 1 qualitative research were supportive of the CDCT, consistent with the findings of the Initial Conditions qualitative research.
- The interim findings did not find any evidence of compulsory Trial participants not being provided with cashless debit cards (CDCs) in a timely manner.
- Nearly all CDCT participants (97%) made their first CDC purchase within one month of the first income support payment (ISP) into their CDC account. Of the \$10.5 million in ISPs deposited into CDC accounts on or before 30 September 2016, \$10.0 million (95%) was spent on purchases using a CDC.
- DHS data indicates that quarantining of ISPs via CDC accounts has been effective, with a large majority of ISP payments to CDC accounts in the early stages of the Trial (98% of total value up to end June 2016) being a result of quarantining at the rate of 80%.

Partially effective/ KPI target not achieved

- Participant understanding of CDC conditions has improved over time. The Wave 1 survey found that a large majority (80% or more) of CDCT participants understood (in general terms) what goods/ services can be purchased and the merchant types where the card can be used. In particular, nearly all participants (98% average across the two Trial sites) understood that people cannot buy alcohol with the CDC. Additionally, most participants (91% on average) were aware that the card cannot be used to make bets or for other types of gambling. However, awareness gaps remain, particularly in relation to:
 - what to do if the card is lost or stolen;
 - that the card can be used in most places where VISA is accepted;

⁸ Please refer to Appendix D: Organisations Interviewed and Contacted in Qualitative Research for further detail

- that the CDC can be used to make online payment transfers to pay bills;
- how to set up rent payments;
- how to use the card online; and
- how to check balances.
- A large majority of Trial participants (78% average across the two Trial sites) surveyed indicated that they had not changed where and how they shopped since the Trial commenced. A minority (18% average across the two Trial sites) expressed concerns about constraints on their ability to access allowable goods and services via the CDC. These proportions were close to KPI target levels (90% and no more than 10%, respectively). Problems reported by participants and stakeholders primarily related to participants' constrained ability to conduct legitimate purchases in settings where cash was the normal payment medium.
- Most community leaders who participated in the Wave 1 qualitative research considered that the community panel arrangements were an appropriate and reasonable mechanism for adjusting CDCT quarantining restrictions. However, they felt that community panels had not been established in a timely manner. In Ceduna the panel commenced shortly after the commencement of the Trial but was not active *at* commencement, while in East Kimberley, the community panel had not been established at the time of the Wave 1 qualitative research fieldwork.

Outcome KPIs

Performance against short-term outcome KPIs also ranged from partially to fully effective. Specifically:

Fully effective/ KPI target achieved

- Indicators relating to alcohol consumption showed positive interim results.
 - The Wave 1 survey found that (on average across the two Trial sites) 41% of non-participant community members, 24% of CDCT participants and 28% of CDCT participants' family members had noticed a reduction in the drinking of alcohol in their community since the Trial started. In each case, this was significantly higher than the proportion who felt that the drinking of alcohol had increased (7%, 16% and 10% respectively). However, it should be noted that seasonal factors (particularly the cold and wet winter conditions in Ceduna) may have resulted in less drinking of alcohol in public spaces and hence influenced these perceptions.
 - Similarly, the survey found that (on average across the two Trial sites, excluding those who Refused or said Not Applicable) 25% of CDCT participants and 13% of their family members reported drinking alcohol less frequently since the Trial commenced (with around 1-2% in each case reporting that they were drinking more frequently). Moreover, 25% of CDCT participants reported engaging in binge drinking less frequently since having a CDC, while only 3% reported binge drinking more frequently.
 - Many East Kimberley stakeholders and some Ceduna stakeholders who participated in the Wave 1 qualitative research had noticed positive changes since the commencement of the Trial that were indicative of lower levels of alcohol consumption in their communities (particularly levels of problematic consumption).
- Indicators relating to illegal drug use showed some improvement at the Interim Evaluation stage.
 - The Wave 1 survey found that (on average across the two Trial sites, excluding those who Refused or said Not Applicable), 24% of CDCT participants who reported using illegal drugs before the Trial commenced indicated that they had been using illegal

drugs less often since becoming CDCT participants. This was significantly higher than the 3% of these participants who reported using illegal drugs more frequently.

- Indicators relating to gambling also showed positive short-term outcome results.
 - Electronic Gaming Machine (poker machine) revenue in Ceduna and Surrounds in the period after Trial commencement (April-August 2016) was 15% lower than in the same months in 2015.
 - The Wave 1 survey found that (on average across the two Trial sites) 28% of non-participant community members, 27% of CDCT participants and 28% of CDCT participants' family members had noticed a reduction in gambling in their community since the Trial started. In each case, this was significantly higher than the proportion who felt that gambling had increased (4%, 8% and 7% respectively).
 - On average across the two Trial sites, excluding those who Refused or said Not Applicable, 32% of all CDCT participants and 15% of their family members reported gambling less frequently since the Trial commenced (with only 4% of participants and 3% of family reporting that they were gambling more frequently).
 - Survey-based indicators of problem gambling also showed improvement, with (on average across the two Trial sites, excluding those who Refused or said Not Applicable) 27% of all CDCT participants reporting that they less frequently spent more than \$50 a day on gambling and 18% reporting that they less frequently bet more than they could afford to lose.

Partially effective/ KPI target not achieved

- Awareness of local drug and alcohol support services among CDCT participants ranged from 40% in Ceduna and Surrounds to 56% in East Kimberley. Awareness was higher among those who reported using illegal drugs or using prescription drugs for non-medical reasons (68%⁹ and 65%, respectively) and those who reported that they drank alcohol (48% and 57%).
- Awareness of local financial and family support services among CDCT participants was lower, with 33% of those in Ceduna and Surrounds and 37% of those in East Kimberley reporting awareness. Awareness of financial support services among those who reported that they had experienced financial difficulties in the past 3 months was in line with that of the overall CDCT participant population (32% and 33% respectively).
- On average across the two Trial sites, 15% of CDCT participants reported ever having used a drug or alcohol support service, with around half of these having done so within the last 3 months. This is a baseline measure (not an indication of effectiveness) that will be assessed again during Wave 2 survey fieldwork (February-March 2017).
- In each Trial site, 17% of CDCT participants reported ever having used a financial or family support service, with around half of these having done so within the last 3 months. This is a baseline measure (not an indication of effectiveness) that will be assessed again during Wave 2 survey fieldwork (February-March 2017).

⁹ This figure should be interpreted with caution due to the low base of respondents n=8

KEY PERFORMANCE INDICATOR OVERVIEW

RATING			
A	ACHIEVED	P	PARTIAL
L	LIMITED	NA	NOT ASSESSED

OUTPUTS

PI#1 & 4. # COMMUNITY LEADERS WHO ENDORSE PROGRAM % CARDS ACTIVATED		Wave 1 A	Wave 2 TBC	PI#3. % participants in trial locations sent card Wave 1 A	Wave 2 TBC	PI#5. 80% of payments quarantined Wave 1 A	Wave 2 TBC	
PI#2. % Participants who understand card conditions Wave 1 P		Wave 2 TBC	PI#8. # of community leaders who believe appropriate adjustments are made to restrictions Wave 1 P		Wave 2 TBC	PI#7. % with reasonable access to merchants /products Wave 1 P		Wave 2 TBC
PI#6. # support services available in the community Wave 1 NA		Wave 2 TBC						

SHORT-TERM OUTCOMES

STO PI#1. Less drinking of alcohol A		NET LESS - MORE Wave 1 PARTICIPANTS +8PP FAMILY +18PP NON-P'S +33PP	Wave 2 TBC TBC TBC	STO PI#2. Less gambling A		NET LESS - MORE Wave 1 PARTICIPANTS +19PP FAMILY +22PP NON-P'S +24PP	Wave 2 TBC TBC TBC
STO PI#3. % aware of drug & alcohol support services Wave 1 48% P	Wave 2 TBC	STO PI#4. % aware of family support services Wave 1 35% P	Wave 2 TBC	STO PI#5. % ever used drug & alcohol support services Wave 1 15% P	Wave 2 TBC	STO PI#6. % ever used family support services Wave 1 17% P	Wave 2 TBC

MEDIUM-TERM OUTCOMES

To be evaluated in **wave 2.**

MTO PI#3. Less violence MTO PI#4. Drug/alcohol related injuries & hospital admissions		NET LESS - MORE Wave 2 PARTICIPANTS TBC FAMILY TBC NON-P'S TBC	Participants Family Wave 2
MTO PI#5/6. % report feeling safe during...		Day Night At home	Participants Family Non-Participants

IV. Responses to Evaluation Questions

The key evaluation questions are:

1. *What have been the effects of the CDCT on program participants, their families and the broader community?*
 - *Have there been reductions in the consumption of alcohol, illegal drug use, or gambling?*
 - *Has there been a reduction in crime, violence and harm related to these behaviours?*
 - *Has there been an increase in perceptions of safety in the Trial locations?*
 - *Have there been any other positive impacts (e.g. increase in self-reported well-being, reduction in financial stress)?*
2. *Have there been any circumvention behaviours (e.g. participants selling goods purchased with cashless debit cards to obtain more cash, increase in humbugging or theft) that have undermined the effectiveness of the CDCT?*
3. *Have there been any other unintended adverse consequences (e.g. feelings of shame, social exclusion)?*
4. *What lessons can be learnt throughout the Trial to improve delivery and to inform future policy?*
 - *How do effects differ among different groups of participants (e.g. men compared to women, people from different age groups)?*
 - *Where has the Trial worked most and least successfully?*
 - *To what extent can any changes be attributed to the Trial as opposed to external factors such as alcohol restrictions?*
 - *Can the contribution of the debit card be distinguished from that of the additional services in the Trial locations provided via the CDCT support package?*

This chapter directly addresses each of these evaluation questions by drawing on all available data sources. The primary data sources are:

- a. The qualitative research with stakeholders and community leaders
- b. The quantitative data from surveys conducted with participants, family members of participants and non-participant members of the Trial communities

The Interim Evaluation also makes some use of administrative data made available from Australian Government agencies, state government agencies, service providers and other local sources. Only limited reference is made to these sources at this interim stage, as this data has short and varied timeframes, often small base sizes, and is subject to unknown seasonal variations. It is included here to provide additional insight beyond the perceptions of people in the communities, and will play a greater role in the Final Evaluation Report once its reliability and usefulness can be better established.

1. What have been the effects of the CDCT on program participants, their families and the broader community?

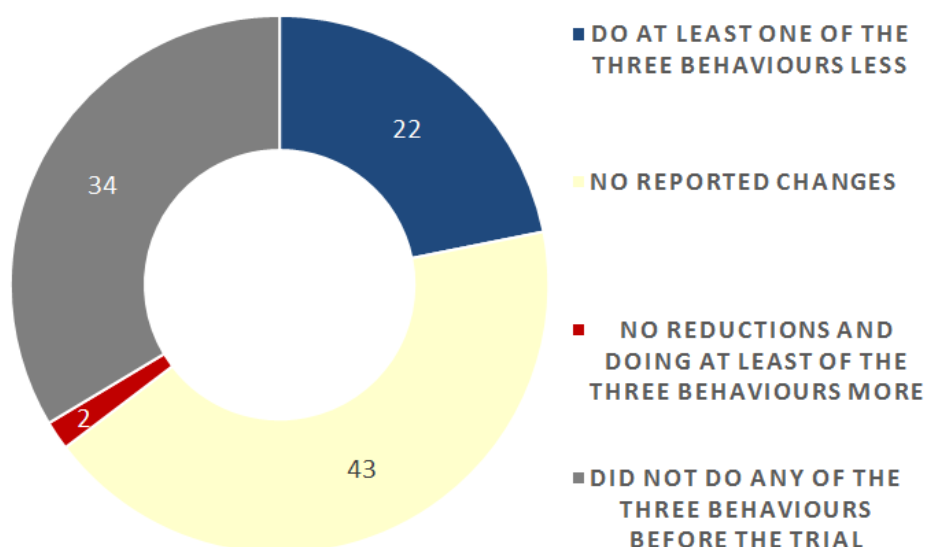
Have there been reductions in the consumption of alcohol, illegal drug use, or gambling?

Both quantitative and qualitative evidence indicates that the first few months of the CDCT has seen a reduction in all three target behaviours.

When asked about changes in their alcohol consumption, gambling or illegal drug use since the commencement of the Trial, almost one quarter of CDCT participants (on average across the two Trial sites) reported a reduction in *at least* one of these behaviours (see Figure 1.) In contrast, just 2% of participants claimed to have experienced solely an increase (ie: doing at least one of the three target behaviours more and none of them any less). 43% reported no change and 34% reported that they did not drink alcohol, gamble or take illegal drugs before or after the Trial. Among the 66% of participants who reported drinking alcohol, gambling or taking illegal drugs before or after the Trial, one third (33%) reported a reduction in *at least* one of these behaviours.

Figure 1: Self-reported changes in alcohol consumption, gambling or illegal drug use

Base: Participants currently on the Trial – average across the two Trial sites.
Excludes those who say 'Refused' or 'Can't Say' across all three measures (n=2).



Q44a (P) / Q44c (P) / q44g (P). Lately, have you done any of these things? Drunk grog or alcohol; Gambled; Used an illegal drug like benzos, ice, marijuana or speed. N=546

Alcohol

Alcohol is a (mostly) legal purchase which can be directly impacted by the CDCT's mechanism of limiting access to cash and preventing use of the debit card to purchase it. Qualitative feedback from

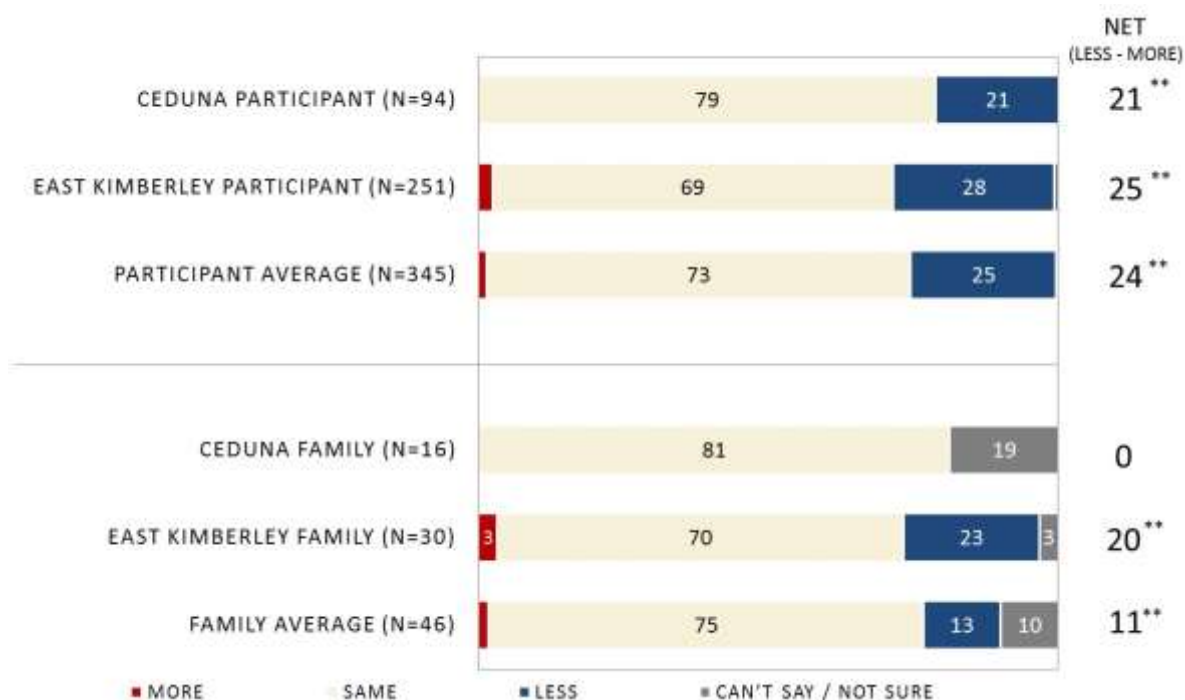
community leaders and other stakeholders is alcohol consumption appears to be lower and less visible. There is a sense that people are drinking less per person per day, and stakeholders in alcohol-related organisations and service providers report patterns of observations consistent with this (e.g. sobering up facilities, ambulance, police).

Community leaders and stakeholders ratings to a short questionnaire in the qualitative research indicated that alcohol abuse had reduced in their local community between pre-Trial and Wave 1 – in Ceduna from 7.4 to 7.0 out of 10 and in East Kimberley (EK) from 8.3 to 6.8 out of 10 (based on average ratings on a scale of 0 (not at all) to 10 (extremely severe)).

The survey data supports these observations and perceptions. Consumption of alcohol still occurs, with 25% of Ceduna participants and 46% of EK participants reporting they consume alcohol at least weekly. However, virtually no participants or family members reported drinking more than before the Trial started, and, on average across the two Trial sites, 25% of participants and 13% of family members of participants interviewed said they now drank less (Figure 2 – note excludes ‘Refused’ and ‘Not Applicable’). Very few said they drank more, with a net positive change of 24 percentage points (pp) seen amongst participants and 11pp amongst family members.

Figure 2: Change in behaviour since Trial started: Drunk grog or alcohol (% of respondents)

Base: Participants currently in Trial and Family. Excludes ‘Refused’ and ‘Not applicable – did not do activity before’.



Q44a (P) / Q26a (F). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Drunk grog or alcohol?

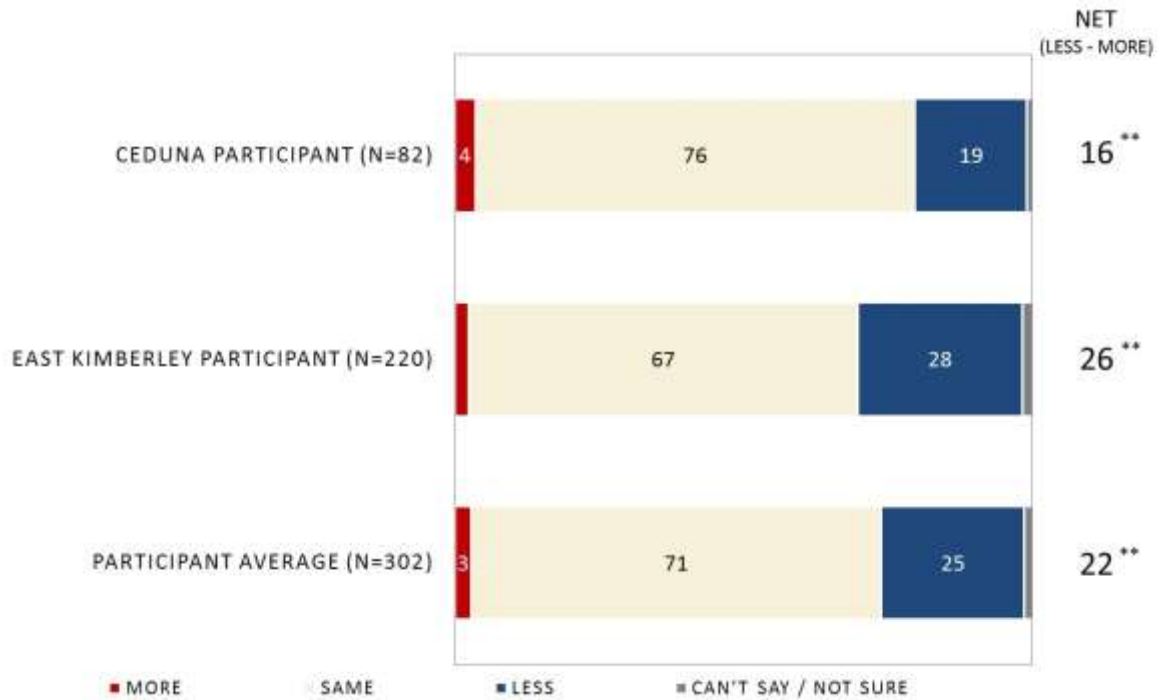
**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level
CAUTION: Note small base sizes for the Family group

Amongst participants, where the question was also asked about having six or more drinks on one occasion, a similar proportion of those who drank alcohol before the Trial said they did this less since

the Trial commenced (25% - Figure 3). Again, with very few who reported doing this more, there was a net positive change of 22pp.

Figure 3: Change in behaviour since Trial started: Had six or more drinks of grog or alcohol at once (% of respondents)

Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.



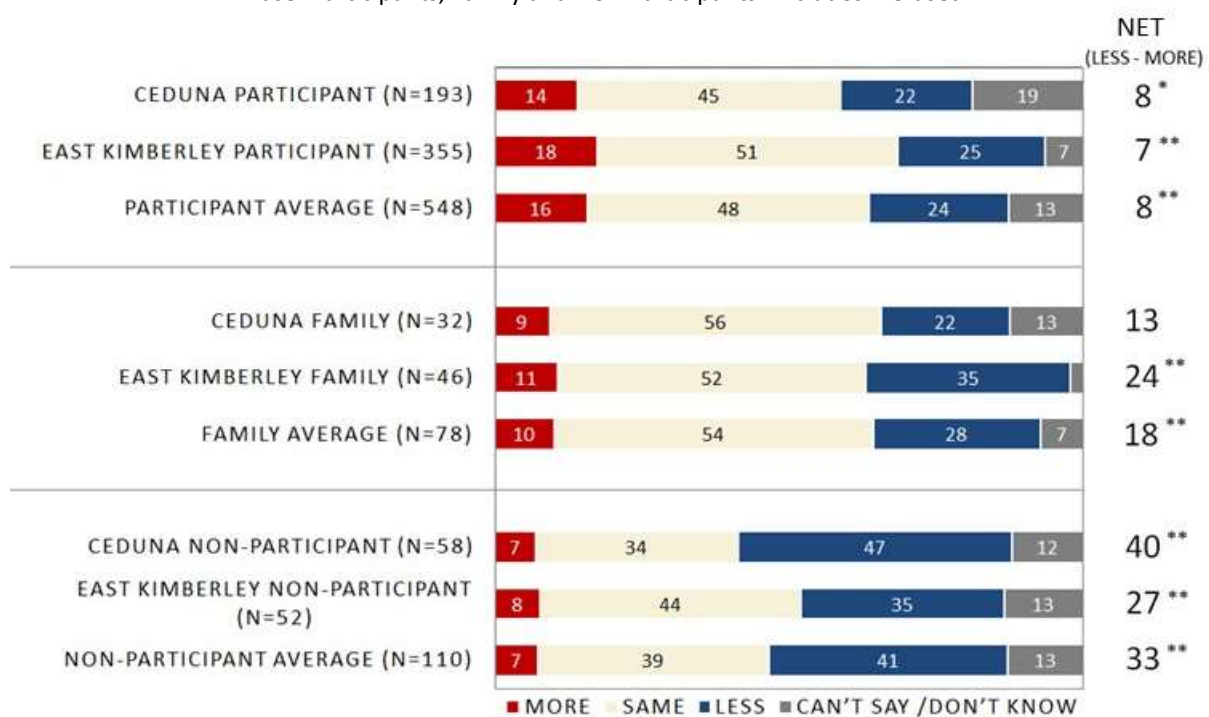
Q44b (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Had six or more drinks of grog or alcohol at one time?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Overall, the survey showed that for all three groups surveyed, there was also a net perception of less drinking in the community since the Trial started. Figure 4 illustrates that there were small proportions who felt they saw *more* drinking, but in all cases this was outweighed by the proportion who noticed *less* drinking. Interestingly, the perception that reductions outweighed increases was least common amongst participants (net 8 percentage point (pp) improvement on average across the two Trial sites), somewhat higher amongst family members (18pp) and higher still amongst non-participants (33pp). However, it should be noted that seasonal factors (particularly the cold and wet winter conditions in Ceduna) may have resulted in less drinking of alcohol in public spaces and hence influenced these perceptions.

Figure 4: Noticed a change in drinking of alcohol or grog in the community since the Trial started (% of respondents)

Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q42a (P) / Q24a (F) / Q16a (NP). Since the Cashless Debit Card / Indue Card Trial started in your community have you noticed more, less or the same amount of: Drinking of alcohol or grog in the community?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Illegal drugs

Use of illegal drugs is difficult to reliably assess due to the illegal and therefore clandestine nature of the behaviour. However, again there is a set of positive indications. Theoretically, being an illegal and therefore predominantly cash-based trade, the reduction in available cash should have the effect of making it generally harder to buy or sell drugs (this is fundamental to the CDCT Program Logic). While most stakeholders and community leaders generally didn't feel they could comment with authority on drug use, there was a general sense, especially in EK, that this behaviour had decreased.

Community leaders and stakeholders’ ratings to a short questionnaire in the qualitative research indicated that drug use problems had remained stable in Ceduna (6.8 out of 10 pre-Trial, 6.7 Wave 1) and reduced in East Kimberley - from 6.9 pre-Trial to 5.6 out of 10 Wave 1 (based on average ratings on a scale of 0 (not at all) to 10 (extremely severe)).

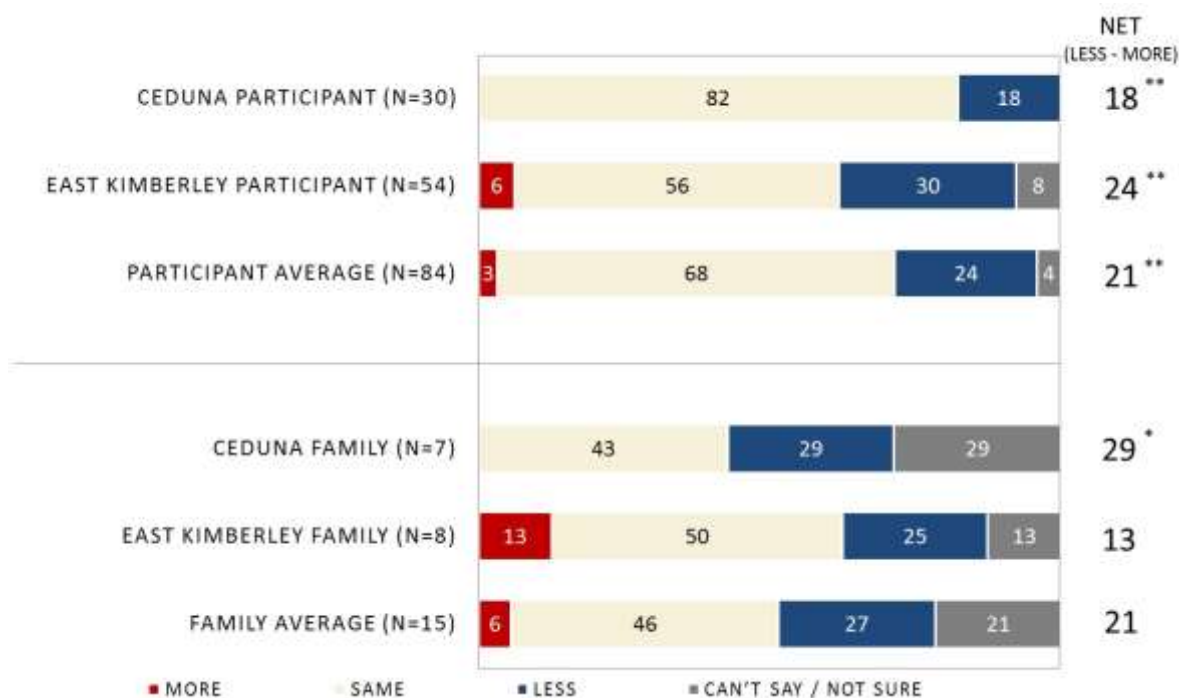
A few stakeholders identified the following anecdotes as evidence:

- Drug dealers finding it harder to sell their products since the Trial started; and
- Known participants who had reduced the amount of drugs they consumed since the Trial.

The quantitative survey data gives us an evidence base to suggest that this is indeed the case. Excluding those respondents who ‘Refused’ or said ‘Not Applicable – did not do activity before’, an average of 24% of participants across the two Trial sites said they used less illegal drugs than before the Trial (a net improvement of 21pp - see Figure 5) as did 27% of family members (also a net improvement of 21pp – although this was not statistically significant due to very small base size for this sample). There was also a net 12pp improvement in the number who reported spending more than \$50 a day on illegal drugs.

Figure 5: Change in behaviour since Trial started: Used an illegal drug (% of respondents)

Base: Participants currently in Trial and Family. Excludes ‘Refused’ and ‘Not applicable – did not do activity before’.



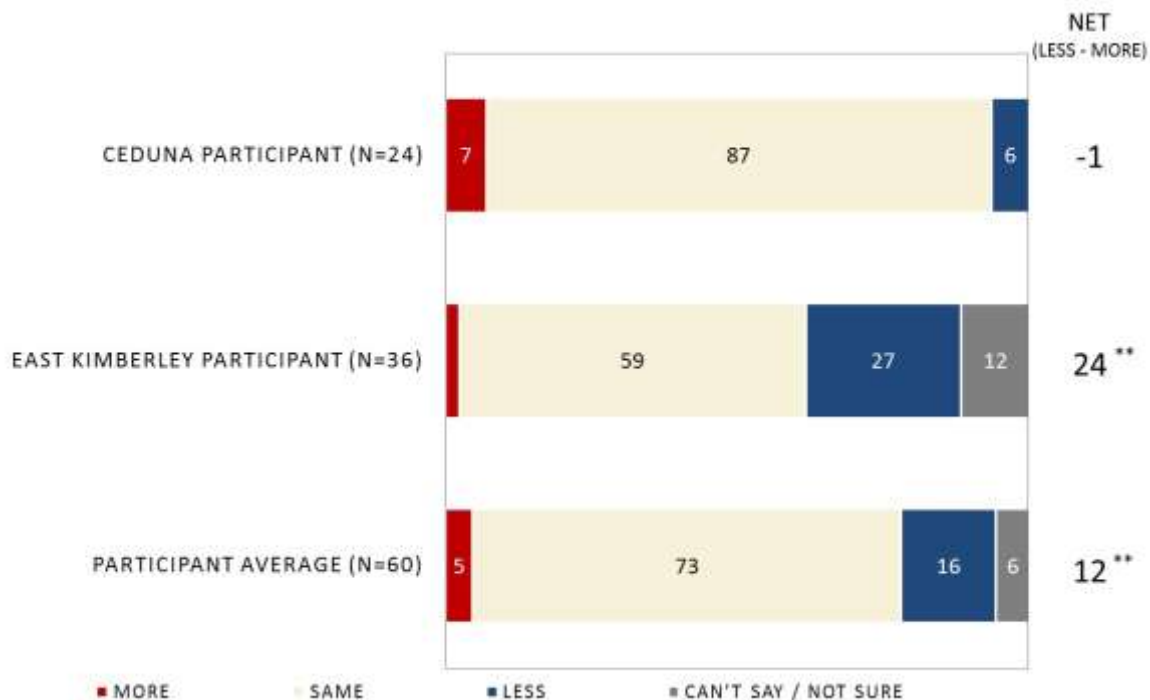
Q44g (P) / Q26c. Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Used an illegal drug like benzos, ice, marijuana or speed?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

CAUTION: Note very small base size for Family group

Figure 6: Change in behaviour since Trial started: Spent more than \$50 a day on illegal drugs (% of respondents)

Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.



Q44h (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Spent more than \$50 a day on illegal drugs like benzos, ice, marijuana or speed?
 **Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Gambling

Similar patterns are also seen with respect to gambling. Qualitatively, stakeholders and community leaders found informal and online gambling difficult to confidently comment on, as it tends to occur in private residences and is not a highly visible activity. Again though, they did have anecdotes to tell about perceived positive impacts.

In Ceduna there is administrative data from the SA Attorney General showing a reduction in Electronic Gaming Machines (EGM) revenue compared to the same time in the previous year (see STO PI#2 in Appendix A). It has also been reported by stakeholders and community leaders that there has been a substantial reduction in money and time spent on legalised gambling in the form of EGMs at the Ceduna Hotel based on their direct observations, feedback from clients / the community and citation of the Attorney General’s report. This was also supported by the observations of the qualitative researchers by comparison to the Initial Conditions visit. However, there is a strong seasonal pattern in the EGM data, and the magnitude of the effect of the CDCT will need to be monitored closely in the Final Evaluation Report.

In EK it was reported that card houses were smaller and running less often, that there may have been fewer card games in public places, and individual stories of people who were now gambling less.

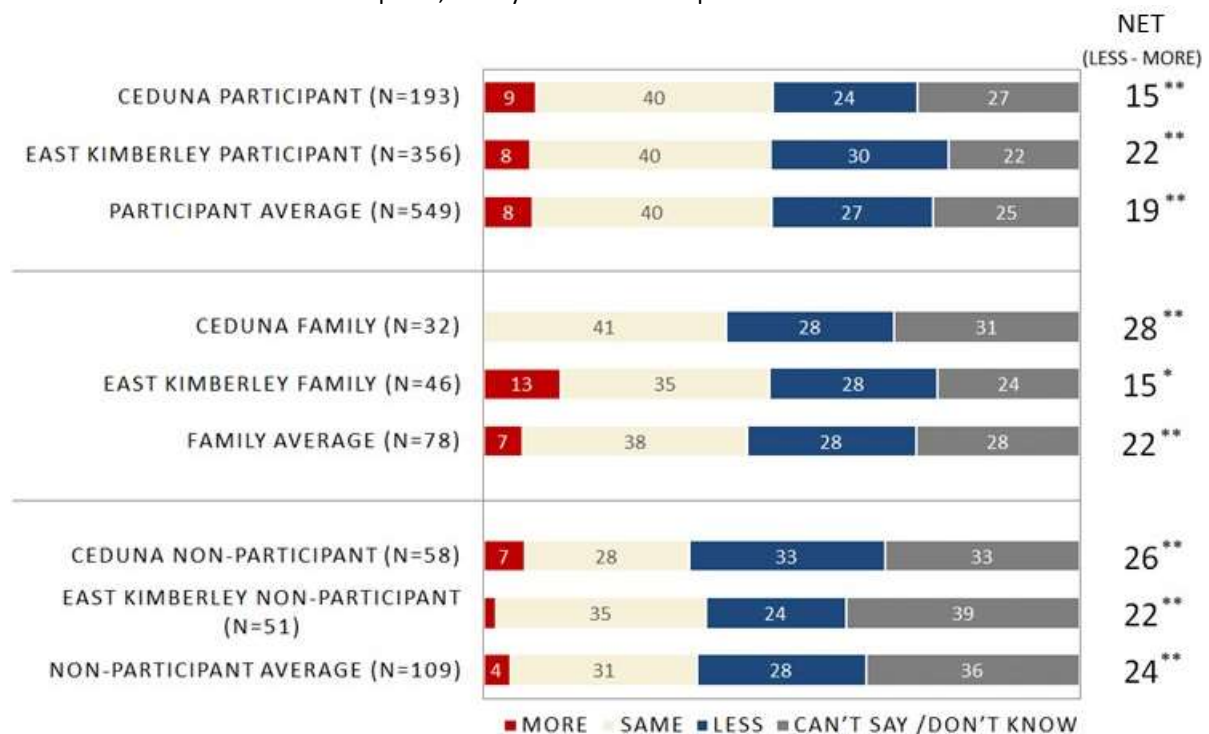


Community leaders and stakeholders’ ratings to a short questionnaire in the qualitative research indicated that problematic gambling had reduced in their local community between pre-Trial and Wave 1 – in Ceduna from 7.7 to 6.5 out of 10 and in East Kimberley from 6.7 to 5.0 out of 10 (based on average ratings on a scale of 0 (not at all) to 10 (extremely severe)).

As with drugs, this perception was backed up by the behaviours and perceptions reported in the quantitative surveys. Asked whether they had seen more or less gambling in the community since the Trial started, an average net improvement of 19-24pp was seen across all three groups surveyed (see Figure 7).

Figure 7: Noticed a change in gambling in the community since the Trial started (% of respondents)

Base: Participants, Family and Non-Participants. Excludes ‘Refused’.



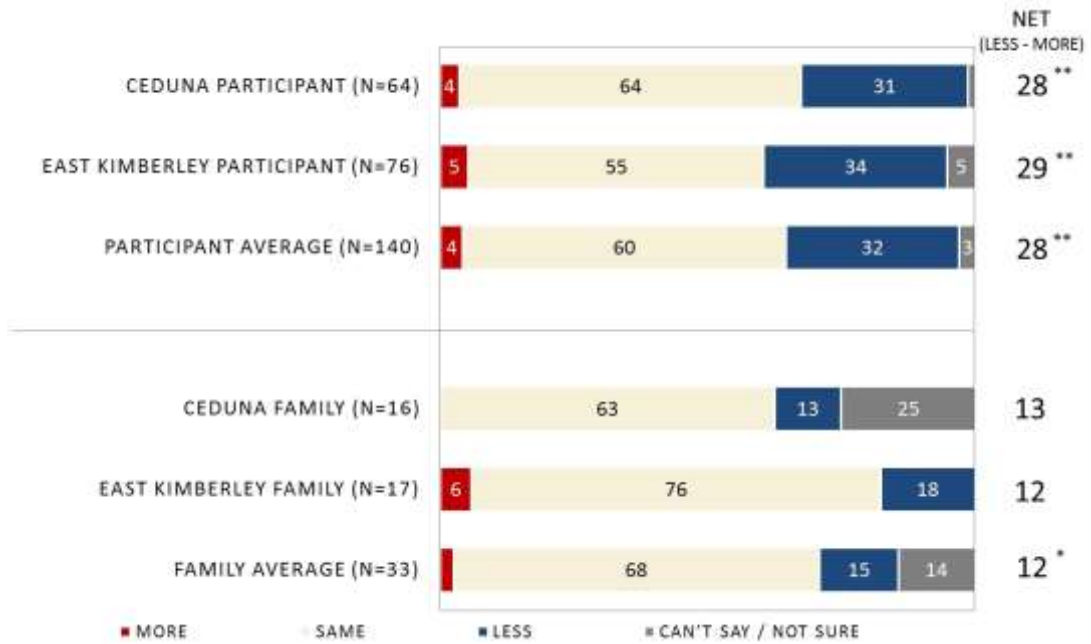
Q42c (P) / Q24c (F) / Q16c. Since the Cashless Debit Card / Indue Card Trial started in your community have you noticed more, less or the same amount of: Gambling in the community?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

On average across the two Trial sites (excluding those who Refused or said Not Applicable)- 32% of participants and 15% of family members interviewed indicated they were gambling less. Of those who didn't refuse or say it was not applicable to them, 27% of participants said they spend more than \$50 a day on gambling less often since the Trial (Figure 8-Figure 9).

Figure 8: Change in behaviour since Trial started: Gambled (% of respondents)

Base: Participants currently in Trial and Family. Excludes 'Refused' and 'Not applicable – did not do activity before'.

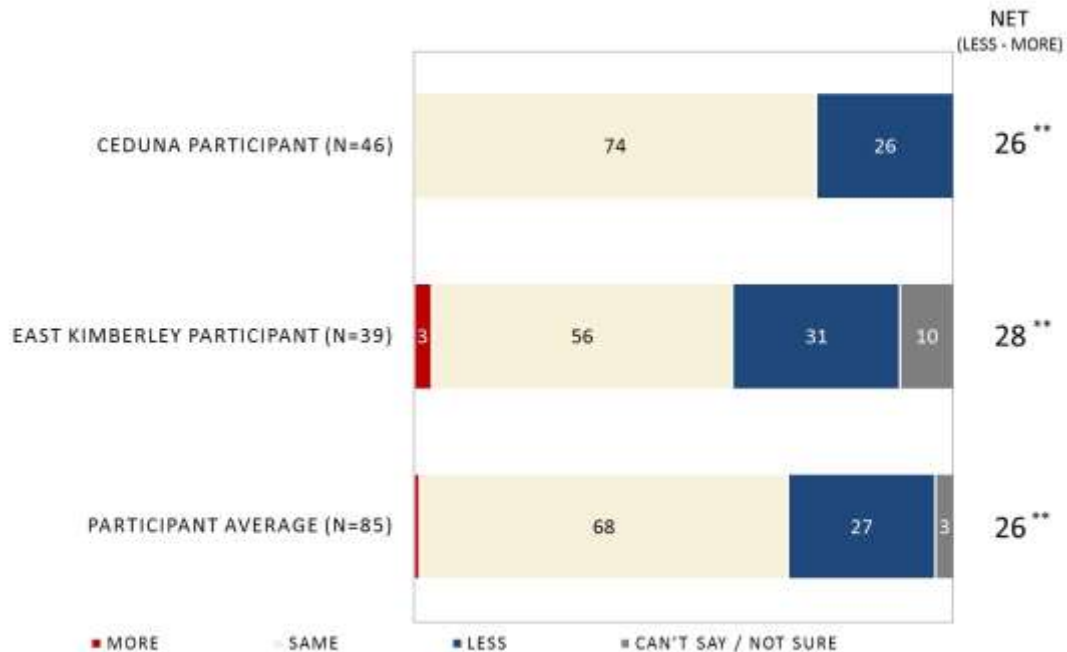


Q44c (P) / Q26b (F). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Gambled?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 9: Change in behaviour since Trial started: Spent more than \$50 a day on gambling (% of respondents)

Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.



Q44d (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Spent more than \$50 a day on gambling?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Has there been a reduction in crime, violence and harm related to these behaviours?

At the time of the Wave 1 data collection, there was only limited evidence to suggest that there has been a reduction in crime, violence and harm related to alcohol consumption, illegal drug use and gambling since the Trial commenced.

Administrative data relating to sobering up services in the Trial communities showed some positive preliminary signs in relation to problematic alcohol consumption. In particular, sobering up services in East Kimberley recorded lower numbers of cases post Trial than at pre-Trial baseline. In addition, alcohol and drug related referrals to the Kimberley Mental Health and Drug Service declined after the commencement of the Trial.

Police administrative data for Ceduna and Surrounds showed some preliminary evidence of a downward trend in the incidence of crime particularly in terms of violent behaviour such as the *acts intended to cause injury* statistics (see Figure 83, Appendix A: Performance Indicators and Wave 1 Results). However, police statistics for EK did not show any evidence of a decline in crime there (see Figure 84 and Figure 85, Appendix A: Performance Indicators and Wave 1 Results) , with the data available for EK covering only a short period of time at the very early stages of the Trial and able to use only a point-in-time baseline. The individual indicators have small base sizes and move in different ways, making it hard to discern any clear overall pattern.

At the Initial Conditions stage it had been anticipated by some stakeholders and community leaders in both Trial sites that there may actually be an *increase* in crime when the CDCT started as a way of people seeking to get cash (this was also raised as a possibility in the Forrest Review). In the main, this has not eventuated – though in Kununurra there was a perception amongst some stakeholders that there had been an increase in crimes committed by young children seeking to get cash that they can no longer get from their parents while on the CDCT.

Community leaders and stakeholders' ratings to a short questionnaire in the qualitative research indicated that violence and other crimes had slightly reduced in their local community between pre-Trial and Wave 1 – in Ceduna from 7.0 to 6.2 out of 10 and in East Kimberley from 8.0 to 6.3 out of 10 (based on average ratings on a scale of 0 (not at all) to 10 (extremely severe)).

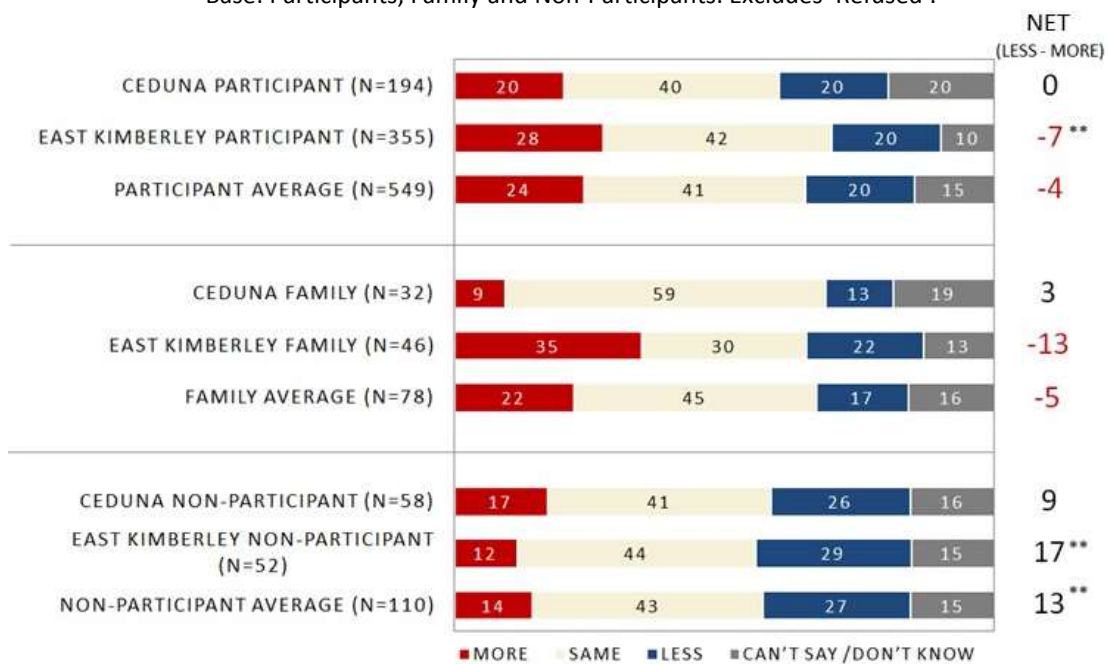
In East Kimberley, a couple of positive changes were cited by some stakeholders including:

- A decrease in vandalism of ATMs; and
- A reduction in the number of injuries indicative of domestic violence presenting at the hospital.

The Wave 1 survey has established a range of benchmarks about individual experiences of violence and crime that will be revisited at Wave 2 (see Figure 86-Figure 88, Appendix A: Performance Indicators and Wave 1 Results). As with alcohol consumption and gambling, the survey also asked respondents about their perceptions of whether violence in the communities has increased, decreased or stayed the same since the commencement of the Trial. The results (see Figure 10) show that perceptions were mixed, with non-participant community members being more likely to report a decrease in violence than CDCT participants and their family members.

Figure 10: Violence noticed in the community since the Trial started (% of respondents)

Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q42b (P) / Q24b (F) / Q16b (NP). Since the Cashless Debit Card / Indue Card Trial started in your community have you noticed more, less or the same amount of: Violence in the community?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Has there been an increase in perceptions of safety in the Trial locations?

As there has been no clear impact (positive or negative) yet on crime and violence, it is not surprising that there is also no strong evidence yet of a change in perceptions of safety.

Qualitatively, there is little sense of change in this area, with both Ceduna and Wyndham stakeholders and community leaders reporting 'no change'. Those in Kununurra suggested that there may have been some gains during the daytime (for example, fewer intoxicated people present in the parks, which made them more available to others to use), but that night time was still problematic.

Community leaders and stakeholders' ratings to a short questionnaire in the qualitative research indicated that community safety had slightly increased in their local community between pre-Trial and Wave 1 – in Ceduna from 4.6 to 5.0 out of 10 and in East Kimberley from 4.2 to 5.2 out of 10 (based on average ratings on a scale of 0 (very poor) to 10 (very well)).

The Wave 1 survey has established benchmarks for feelings of safety in the community, and these will be compared to equivalent figures at Wave 2. The Wave 1 survey figures are consistent with what was drawn from the qualitative interviews – with feelings of safety in the home and on the streets during the day generally very high, but much lower in the streets at night. The survey data also showed that the EK results were considerably lower than Ceduna at night¹⁰, which also supports the views expressed in the qualitative interviews and groups.

¹⁰ Later Trial commencement in East Kimberley may partly explain this difference.

Have there been any other positive impacts?

The Program Logic highlights a number of potential spill-over benefits and adverse consequences. The hypothesised **spill-over benefits** are potential ways in which the program could benefit the community above and beyond the program outcomes. These types of potential benefits are not seen as being central to the Trial's objectives. Their achievement will be important to monitor and record, but whether or not they are achieved is not an indication of the success or failure of the Trial.

At Wave 1 there is considerable data to show that there *are* other positive impacts being seen at an individual level across the Trial sites.

Overall, stakeholders and community leaders felt that the Trial has had some positive impacts on participants' financial capacity, as well as nutrition and health within the community.

Community leaders and stakeholders' ratings to a short questionnaire in the qualitative research indicated that (based on average ratings on a scale of 0 (very poor) to 10 (very well)):

1. **Ability to afford basic household goods** had increased in their local community between pre-Trial and Wave 1 – in Ceduna from 4.4 to 5.6 out of 10 and in East Kimberley from 3.7 to 5.6 out of 10.
2. **Ability to pay bills** had increased in their local community between pre-Trial and Wave 1 – in Ceduna from 4.3 to 5.0 out of 10 and in East Kimberley from 3.5 to 5.5 out of 10.
3. **Nutrition** had increased in their local community between pre-Trial and Wave 1 – in Ceduna from 4.2 to 4.4 out of 10 and in East Kimberley from 3.2 to 4.6 out of 10.
4. **Health and wellbeing** had increased in their local community between pre-Trial and Wave 1 – in Ceduna from 4.4 to 4.7 out of 10 and in East Kimberley from 3.5 to 4.5 out of 10.

Specific, qualitative observations from stakeholders and community leaders include:

- Greater purchasing of food – people are observed with 'trolleys of food rather than bags'.
- More money seems to be being spent on purchases for children – such as food (e.g. for school lunches), clothes, shoes, treats and toys¹¹.
- Some people appear to now be able to save and make larger purchases of appliances and cars.
- Fewer requests for emergency food or money.

¹¹ Indue data on purchases at the level of merchant categories exists (eg: approximately half of expenditure through Indue cards in EK is classified as "Grocery Stores and Supermarkets"). However, this does not have any pre-Trial baseline and does not go to the level of items purchased. Analysis of this data over the longer timeframe of the full Trial period may allow the identification of macro changes in purchasing patterns across merchant types during the duration of the Trial, but direct pre-Trial comparison data is not anticipated and only where merchant categories are very narrow will this provide any information about specific products.

- Possible improvements in IT skills¹².
- Requests for work (especially for cash jobs).
- More engagement with programs (self-referrals, more persistence).
- Stories of individuals who have been sober or off drugs ‘for the first time’ and starting to do more positive and constructive things with the time and functionality they now have.
- Fewer alcohol-related injuries or ambulance call-outs, and fewer people discharging themselves early from hospital against medical advice (EK).

Quantitative survey results include:

- 31% of participants and 23% of family members interviewed said they have been able to save more money than before the Trial.
- Of the participants and family members with children – 31% of participants and 30% of family members said they have been better able to care for their children since the Trial started, and 16% of participants and 7% of family members said they had been more involved in their children’s homework and schooling; and
- 21% of participants said they had got better at things like using a computer, the internet or a smartphone.

All of these results support the observations of the stakeholders and leaders in the qualitative stages.

Perceptions of the impact of the CDCT on **humbugging** has been varied. Overall, stakeholders and community leaders felt that the Trial has had a positive impact on reducing humbugging and street begging. For example, people who were known to be on the Trial now were either not asked or had an easy answer to decline providing money by stating that they had limited cash because of the Trial. Another positive effect described was that it had become easier to say no to being humbugged because it was clearer that the money was being sought for alcohol, drugs or gambling and not for food or looking after children.

Community leaders and stakeholders’ ratings to a short questionnaire in the qualitative research indicated that (based on average ratings on a scale of 0 (not at all) to 10 (extremely severe)):

1. **Humbugging** had reduced in their local community between pre-Trial and Wave 1 – in Ceduna from 6.3 to 4.9 out of 10 and in East Kimberley from 5.9 to 4.7 out of 10.

2. **Street begging** had slightly reduced in their local community between pre-Trial and Wave 1 – in Ceduna from 5.4 to 4.0 out of 10 and in East Kimberley from 5.0 to 3.9 out of 10.

However, people who were known to have access to cash – such as Age Pensioners – were perceived by some stakeholders to now more likely to be targeted.

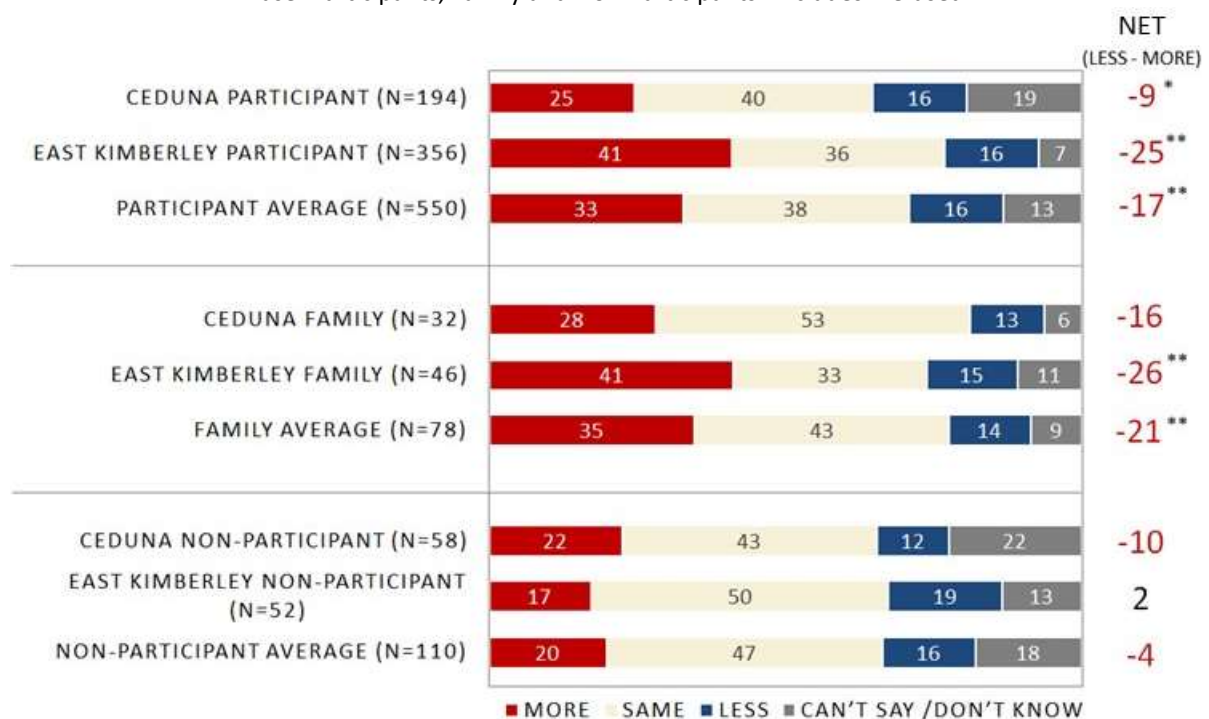
¹² Improvement in IT skills was envisaged in the evaluation framework as a potential spill-over effect. These spill-over benefits are potential ways in which the program could benefit the community above and beyond the program outcomes. These potential benefits, while premised on previous experience with Income Management programs, are not seen as being central to the Trial’s objectives.

In contrast to the qualitative findings, the survey showed that participants and family members both felt that the overall level of humbugging had gone up since the Trial started – though non-participants were more neutral in their views on this. This was higher in EK than in Ceduna, but in both cases more people in these groups thought humbugging had increased than thought it had decreased - with net scores of -17pp and -21pp respectively (Figure 11).

Furthermore, male participants were more likely than females to report a negative change in humbugging (net change -21pp versus -14pp female) and older participants (aged 45-54 years) and those aged 25-34 years were also more likely than others to report this negative change (-19pp to -20pp).

Figure 11: Noticed more humbugging or harassment for money since the Trial started (% of respondents)

Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q42d (P) / Q24d (F) / Q16d. Since the Cashless Debit / Indue Card started in your community, have you noticed more, less or the same amount of: Humbugging or harassment for money?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Amongst family members, 27% said the Trial had made their family's life better and 37% that it had made it worse (net -10pp, see

Figure 12). Across participants interviewed, 22% said it had made their lives better and 49% that it had made their lives worse (net change -26pp). These figures were fairly consistent across the two Trial sites.

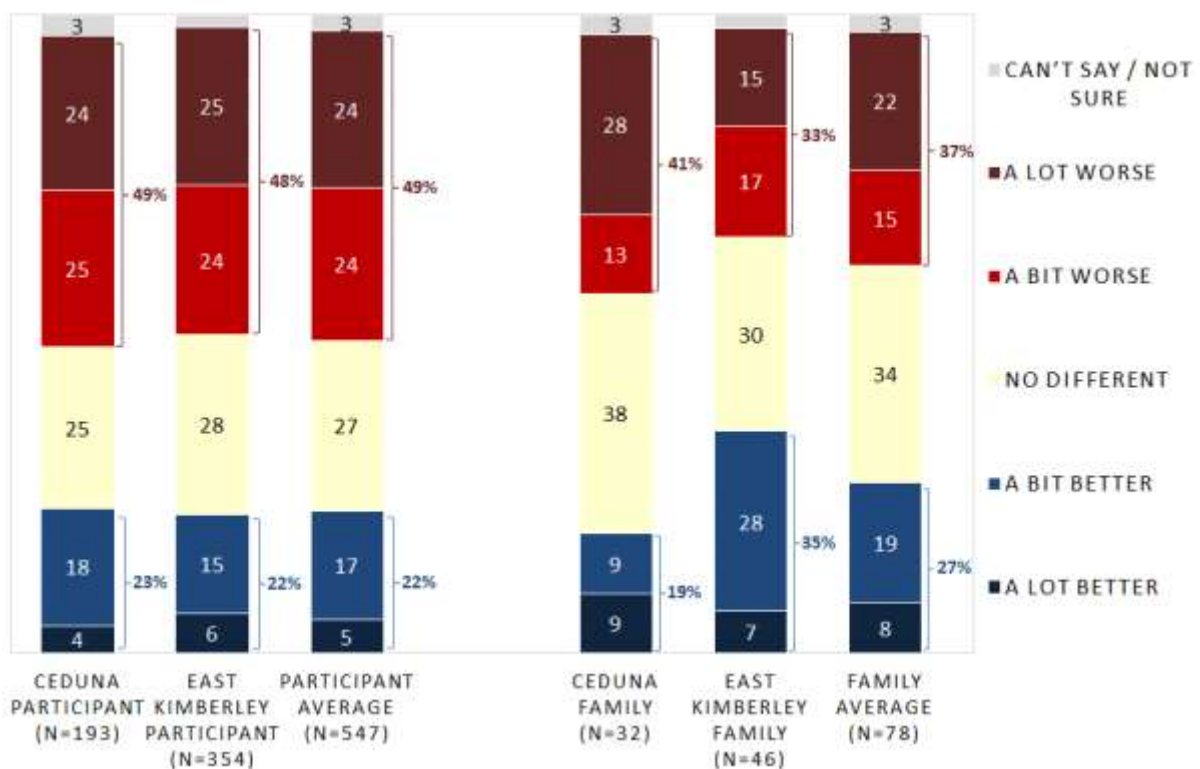
Segmenting participants by self-reported behaviour change across the three target behaviours – alcohol consumption, gambling or illegal drug use – allows for further exploration of the results (please see Figure 1 for further detail on these groups.) As may be expected, participants who reported **positive** behaviour change on *at least* one of the three target behaviours were *more likely* to say that

the Trial has made their lives better (30%, net change -13pp), compared to those who reported **no change** (22%, net change -28pp). No participants who reported **negative** behaviour change (more) said that the Trial had made their lives better, though this was a very small group (n=8).

In contrast, those participants who said that they had done *at least* one of the target behaviours **more** (but none less) or that they had experienced **no change** were *more likely* to report that the Trial had made their lives worse ((67%¹³ and 50% respectively, versus 43% of those who reported positive change).

Figure 12: Impact of the Trial on your life / your family's life

Base: Participants currently in Trial and Family. Excludes 'Refused'.



Q45 (P) / Q27 (F). Would you say the Cashless Debit / Indue Card has made your life / your family's life..?

However, non-participants provided quite different responses. Across both sites 46% of the non-participants said the Trial had made life in their community better, and only 18% that it had made life worse – a net change of +28pp. Non-participants in EK (+35pp) were somewhat more positive than those in Ceduna (+21pp).

Respondents who said that the Trial had made their lives better or worse were asked to provide some information about how. The most common reasons that Trial participants and family members gave for their lives being 'a bit better' or 'a lot better' included:

- More money to spend on other things (e.g. food/rent/clothes) (n=71 participants, n=18 family); and

¹³ This figure should be interpreted with caution due to the low base of respondents n=8

- Saving money (easier)/ Keeping more money (n=43 participants, n=5 family).

The most common reasons that participants and family members provided to explain why their lives were 'a bit worse' or 'a lot worse' related to:

- Not being able to spend money on things you need to (e.g. bills, appointments) or want (e.g. personal items) (n=74 participants, n=8 family).

Trial participants who said that their lives were 'a bit worse or 'a lot worse' also frequently mentioned reasons related to not being able to get cash out / having no cash (n=60), whilst family members also mentioned:

- Not being able to send money to kids/family/friends or buy them presents/ go on excursions (e.g the show) (n=7); and
- Not being able to see how much money you have/ hard to use/ hassle/ don't know where money goes (n=7).

Non-participants who reported that the Trial had made life in their community better (a lot better or a bit better), mentioned the following reasons:

- More money to spend on other things (e.g. food/rent/clothes) (n=22); and
- Less drinking / violence / people on streets / public intoxication (n=15).

Of those who said that the Trial had made life in their community worse, the most common reason was due to the perception of more stealing and more humbugging (n=10).

2. Have there been any circumvention behaviours?

The CDCT Evaluation Program Logic makes explicit reference to a series of potential **program circumventions**. They will be important to monitor because if they occur, they could directly undermine the Theory of Change and help explain why outcomes have not been achieved.

The evidence at Wave 1 relating to these types of circumventions comes mostly from the qualitative interviews with community leaders and other stakeholders. Circumventions are difficult to quantify, but amongst the types which have been reported as being known or seen first-hand are:

- Purchasing goods and returning them for cash¹⁴;
- Merchants overcharging for a product or services and then refunding the difference in cash or using the difference to buy alcohol for Trial participants;
- Buying legitimate products on the Indue card for other people, and being reimbursed with cash (sometimes for less than the full value);

¹⁴ Note that this cannot be done under the epayments code. This code states that refunds must be made to the method that was used to purchase the goods.

- Buying products which are then sold for cash (again, often at reduced value);
- The black market or 'sly grogging' by those who can access alcohol;
- Gambling using non-cash wagers, including giving others the use of CDCs as payment for a lost bet;
- Figuring out secondary purchases that enabled access to cash or prohibited purchases (e.g. the purchase of Paysafe cards was possible with the Indue card at some merchants in Ceduna, which could then be used for online gambling); and
- Transfer systems that enabled secondary access to funds as cash (e.g. by making spurious transfers for 'rent' or to BPAY biller accounts that may have even been set up by themselves, and then withdrawing cash from the end receiving account).

Beyond these attempted circumventions, other strategies to get around the reduced cash available to participants reported by stakeholders included:

- Changing the targets of humbugging to those who can access cash; and
- Illegal and undesirable behaviours in order to obtain cash, including crime and a couple of examples of suspected prostitution were reported.

Taxi drivers in Kununurra were identified by some stakeholders as having long been a player in circumventions for previous systems, and that they continued to be in the CDCT.

Another possible factor which, while not a circumvention per se, could impact the Trial is the influx of cash from other sources. It is hypothesised that this may happen in the form of royalties paid, inheritances and tax or superannuation payments, and even non-quarantined payments such as emergency assistance. It is difficult to assess the impact of these, because their quantum is not knowable. Disclosed royalties were believed to be only in the order of \$12,000 (at EK), but there were unverified stories of six-figure amounts flowing into the communities from time to time depending on individual circumstances (mainly due to inheritances and / or insurance payments).

However, to put that in context, while those lump-sum events do offer access to cash, they are likely to represent only a very small proportion (and as one-off payments only) of the approximately \$10.5 million which has been quarantined via ISPs deposited into CDC accounts on or before 30 September 2016. The apparent magnitude of likely circumventions also appears to be small compared to this total quarantined payments figure.

3. Have there been any other unintended adverse consequences?

A number of potential **adverse consequences** that could occur as secondary effects of the Trial were identified in the Program Logic. These are important to monitor because it is possible for the Trial to create unintended negative consequences while at the same time achieving its stated objectives.

A few stakeholders in the qualitative research reported that some CDCT participants who thought they spent their money appropriately felt as though they were being penalised and/or discriminated against by being forced to participate. These CDCT participants reportedly felt that there was a stigma and sense of shame associated with having a CDC. Through open-ended comments, only 6% of all participants explicitly raised 'stigma' or 'shame' associated with the card as an issue.

Beyond that, there have been some issues related to the experience of participants using the cards. Some of the types of situations which have caused challenges for participants include:

- Being able to transfer money to children that are away at boarding schools¹⁵;
- Being able to participate in the 'second hand' market for used goods;
- Being able to make small transactions at fundamentally cash-based settings¹⁶ (e.g. fairs, swimming pools, canteens);
- Being able to make purchases from merchants or services where EFT facilities were unavailable;
- Being told by a merchant out of the area that they cannot accept this card¹⁷; and
- Effectively setting up automatic payments and other transactions on their cards¹⁸.

Many of these issues are known to DSS, and are either actually achievable with the Indue card or solutions have been developed. However, these were still perceived as issues for some participants.

People who are on the CDCT are heavily reliant on the technology being available to use their cards. Where EFTPOS terminals or other alternatives are not available, they are limited in their ability to make purchases. There was some concern among stakeholders that this leaves them potentially more vulnerable to things like power outages than non-participants might be. This was raised as a concern in the lead-in to the wet season in EK.

¹⁵ The Department can increase other external transfer limits (default \$200) upon reasonable proof and can place children on an Indue Card at boarding school.

¹⁶ The Department advised that the need to have access to cash for such purposes was acknowledged in the co-design process with community leaders and is why 20% of payments are not quarantined.

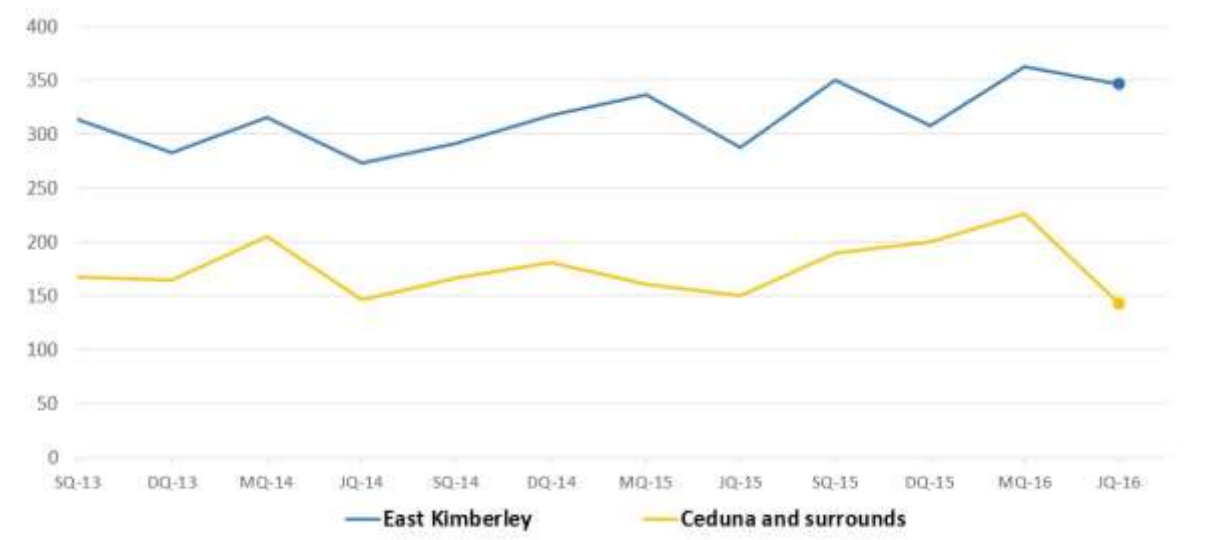
¹⁷ The Department indicated that the CDC has complete coverage of merchants that do not have alcohol or gambling as the main source of business.

¹⁸ The Department acknowledged that there were significant issues with the set-up of automatic payments and other transactions at the start of the trial. It advised that this has since been fixed (as of August 2016).

It was considered a possible risk that people could leave the area before or after the commencement of the Trial, but there is little evidence of this happening to any significant extent.

Figure 13 shows that the number of ISP recipients who moved out of the CDCT sites in the June Quarter of 2016 (i.e. since the introduction of the CDC) was broadly in line with historical experience. It shows that there is historically a steady level of movement out of both sites. There was a larger number who moved out of Ceduna and Surrounds in the March Quarter 2016 compared to the same quarter in 2015, but only by a small proportion compared to the typical quarterly number or compared to the March Quarter 2014. Overall the chart suggests that the CDC has not had a major impact on the number of ISP recipients moving out the CDCT sites. There may have been a small increase immediately prior to the Trial commencing in SA, though given the level of fluctuations observed across quarters this cannot be attributed confidently to the Trial from this data alone.

Figure 13: ISP recipients moving out of the CDCT sites¹⁹



¹⁹ Source: data provided by DHS on all Centrelink customers in receipt of an Income Support Payment whose address has changed from in the defined community, to out of the defined community during a quarter. The data was extracted in September 2016 and so this Figure presents ISP recipient movement statistics up to the June Quarter 2016 (JQ-2016) – the most recent quarter for which complete data was available at the time of data extraction.

4. What lessons can be learnt throughout the Trial to improve delivery and to inform future policy?

How do effects differ among different groups of participants (e.g. men compared to women, people from different age groups)?

In the survey data, demographically there were only fairly minor variations seen in the responses of participants (see Tables in Appendix B). Overall, the pattern of responses varied little by gender, although men were significantly more likely than women to believe that the CDCT has made their lives worse. There was a somewhat more variation seen across age groups. In particular, the 18-24 age group showed generally the most positive profile of changes, and it was the 55+ age group who were the least positive about the effect of the Trial on their lives.

Where has the Trial worked most and least successfully?

Given the early stage of the Trial, it is promising that there are signs of the CDCT working in both sites. It is not possible at this stage of the evaluation to reliably assess where the Trial has worked most and least successfully.

To what extent can any changes be attributed to the Trial as opposed to external factors such as alcohol restrictions?

The Trial sites are complex communities. The CDCT is one facet of a larger suite of interventions and activities operating in each of them. This Trial is not an experimental design which allows the isolation of the different strategies, or where the specific effects of the Cashless Debit Card concept can be unequivocally identified.

However, on the face of it, the positive short-term impacts since the CDCT Trial commenced in relation to alcohol consumption, illegal drug use and gambling appear likely to be largely attributable to the CDCT. This is because available evidence (based on stakeholder interviews – see Appendix C) indicates that there has not been a significant contemporaneous change in potentially influential external factors/ conditions.

This preliminary assessment will be rigorously tested after Wave 2 of evaluation data collection when relatively long data series will be available for both the CDCT sites and comparison sites in both SA and WA where the CDCT is not operating.

Can the contribution of the debit card be distinguished from that of the additional services in the Trial locations provided via the CDCT support package?

The measures at the Trial sites include a combination of the CDC itself and a range of additional services. There is not an experimental design where these two facets are also implemented separately

or in a staggered timing, and so there is no *definitive* way of isolating their individual effects. However, there *is* a way within the evaluation design to investigate the relative contributions of the two facets.

The mechanism by which the CDC part of the Trial should have an effect on alcohol consumption, drug use and gambling is very direct, and is not reliant on the provision of additional services. Rather, the role of those services is more additive to assist individuals adapt to the changes the CDC causes in a positive way. In this sense, the CDC could and should be expected to have a distinct effect in its own right.

The best way to examine this hypothesis in this Trial configuration is to look at those individuals who had used the available services, and compare them to those who had not. This classification of participants cannot be perfect, as concepts such as use of particular types of services are hard to definitively measure in a large-scale survey. However, the survey did ask participants whether they were aware of any services and whether they had used any across two broad categories – drug and alcohol services, and financial services. This gives us some ability to isolate and differentiate between these groups of interest.

The tables below show the proportion of all participants who reported they had used services from either of these categories in two timeframes. The first table is those who have ‘ever’ used a service, and the second is just those who have done so ‘within the past 3 months’ or approximately since the commencement of the Trial – and therefore who are the primary group for examination.

There was little overlap between users of drug and alcohol services and users of financial services, but usage of either category is in a small minority of the interviewed participants. Less than a quarter had ever used a service across either category, and just 12% said they had in the past 3 months (P3M)²⁰. This immediately tells us that the provision of services can be making only a relatively small contribution to the total effect of the CDCT, as the great majority of participants have simply not been exposed to the services.

Table 6: Proportion of participants ever using support services

Status*	Drug and alcohol services		Financial services		Either Drug and alcohol or Financial	
	% all participants (weighted)	Sample size (Unweighted)	% all participants (weighted)	Sample size (Unweighted)	% all participants (weighted)	Sample size (Unweighted)
Ever used	13%	69	15%	78	24%	125
Not used	85%	474	83%	466	76%	424
Refused	1%	8	1%	7	<1%^	2

* Self-reported. Also note that n=1 participant did not respond to these questions. ^Refused in both categories.

²⁰ It was anticipated that DEX administrative data on service usage may provide a way of establishing a baseline of pre-Trial service usage and then examining changes in usage as the CDCT operated. However, examination of the available DEX data reveals that not all service providers fully utilised the DEX facility to report their activity data in the July through December 2015 period. Without this baseline data, it is not possible to reliably ascertain the extent to which service usage has increased or decreased since the introduction of the CDCT.

Table 7: Proportion of participants using support services in the past 3 months

Status*	Drug and alcohol services		Financial services		Either Drug and alcohol or Financial	
	% all participants (weighted)	Sample size (Unweighted)	% all participants (weighted)	Sample size (Unweighted)	% all participants (weighted)	Sample size (Unweighted)
Used past 3 months	7%	32	8%	38	12%	61
Not used past 3 mths	92%	511	91%	506	87%	488
Refused	1%	8	1%	7	<1%^	2

* Self-reported. Also note that n=1 participant did not respond to these questions. ^Refused in both categories.

The distributions provide indicative sample sizes for an exploration, though the samples for the last three months are very small. Because the two categories are quite different, it makes sense to look at them separately as well as to integrate them into a single compound variable.

Using these categories, we can then look at the key survey questions which ask about changes to behaviours since the commencement of the Trial. There are a range of patterns we *could* see in this analysis:

- If we see that it is only participants who have used services showing changes, then we would infer that the CDC may be having little independent effect.
- If there are no differences between those using services and those who are not, then we would infer that the services may be having little independent effect.
- If there are effects seen for those who have used services and different effects seen for those who have not used services, then we would infer that both approaches are likely to be having some separate effect.

It is the third of these possibilities that is evident in the results, though they suggest that the contribution of services seems to be much less than the contribution of the CDC itself.

Table 8: Reported behaviour change across service usage segments

Used in past 3 months	Drug and alcohol services		Financial services		Either Drug/Alcohol OR Financial	
	Used P3M	Not used P3M	Used P3M	Not used P3M	Used P3M	Not used P3M
Since being on the CDCT						
Percent "yes":	n=11-31	n=238-504	n=19-38	n=231-498	n=27-60	n=224-481
You've been able to save more money than before [FIN]	31%	31%	42%	31%	34%	31%
You've been better able to care for your child/ren	54%	29%	35%	31%	29%	31%
You've got more involved in your children's homework and school	43%*	13%	30%	14%	22%	15%
I've got better at things like using a computer, the internet or a smartphone	11%	22%*	40%*	20%	26%	21%

NOTE: * = Statistically significant difference at the 95% confidence level

[FIN]: Financial statement, [D&A]: Drug and Alcohol statement.

Continued from previous page

Used in past 3 months Since being on the CDCT	Drug and alcohol services		Financial services		Either Drug/Alcohol OR Financial	
	Used P3M	Not used P3M	Used P3M	Not used P3M	Used P3M	Not used P3M
Net positive change:	<i>n</i> =31	<i>n</i> =508-509	<i>n</i> =38	<i>n</i> =502-503	<i>n</i> =60	<i>n</i> =485-486
Drunk grog or alcohol [D&A]	23%	14%	24%	14%	20%	14%
Had six or more drinks of grog or alcohol at one time [D&A]	11%	11%	7%	12%	9%	12%
Gambled [FIN]	8%	8%	2%	8%*	5%	8%
Spent more than \$50 a day on gambling [FIN]	3%	5%	10%	4%	6%	4%
Bet more than you can really afford to lose [FIN]	3%	2%	5%	2%	3%	2%
Had to borrow money or sell things to get money to gamble [FIN]	3%	1%	5%	1%	3%	1%
Used an illegal drug like benzos, ice, marijuana, or speed [D&A]	6%	3%	7%	3%	6%	3%
Spent more than \$50 a day on illegal drugs like benzos, ice, marijuana, or speed [D&A]	6%	2%	0%	2%*	2%	1%

NOTE: * = Statistically significant difference at the 95% confidence level

[FIN]: Financial statement, [D&A]: Drug and Alcohol statement.

The small group of participants who had used services in the past 3 months showed a positive trend but few statistically significant differences from those who had not. This is suggestive of an additive effect of services on the small proportion of the population using them, but that this is only a relatively small effect for a relatively small proportion of the total participant population.

In these tables, the 'not used' columns are the closest available proxy for the CDC without services. It shows that without use of services, there have been positive effects of the CDCT on most of these behaviours. From this we can infer that a CDC that does not have additional supporting services would still be expected to impact on the targeted behaviours.

Sample sizes are small, but the general trend in the results was for those participants who reported using a service to be slightly more likely to report positive impacts on behaviours.

This data from the survey is congruent with expectations of the CDC Program Logic, and consistent with the general qualitative feedback from the Trial sites. At this interim stage, the CDC component of the Trial does appear to have an effect independent of the services provided around it.

Those services may have a small complementary role of enhancing the effects of the CDC, but this is a relatively smaller effect and limited to the small proportion of the population who access the services.

Program implementation issues and potential improvements

Many participants in the Trial have reported issues and problems at times – with nearly half of all participants interviewed answering yes to the question “*Have you had any problems using the card?*” (46%, 49% at Ceduna and 43% at EK).

Many of these are likely to be user errors (for example: using a wrong PIN in the case of ‘failed’ transaction attempts) or failures to understand the features and capabilities of the card, while others likely reflect imperfect knowledge and systems amongst some merchants. Some also do reflect limitations of the card and characteristics of its operations.

Regardless of their source, this section seeks to identify where participants have been having issues, drawing on both qualitative observations of participants and feedback from the participants’ themselves. This will enable DSS to target either improvements or communications which can enhance user experiences over the remainder of the Trial. Some of these have been previously brought to the attention of DSS and may already have been addressed.

- **Balances**²¹ – card balances are important for people who are operating sometimes on a cashflow availability basis. The concept of balances is not intuitive or familiar for all Trial participants, in particular the distinction between the ‘account / current balance’ and the ‘available balance’.
 - More education about how to interpret balances would be beneficial.
- **Automatic payments** – automatic payments are causing issues for some participants. In many cases it seems likely to be that they are set up incorrectly (e.g. not correctly synced with incoming payments or due dates). On occasions, this seems to be resulting in participants incurring dishonour or late payment fees, which a) costs them available money, and b) can appear to be unauthorised withdrawals. Some participants lack confidence in the security of their money as a result of hearing about or experiencing these occurrences (and some even reported spending much or all of their money as soon as it comes in just to make sure it is not taken away).

Proactive steps to assist participants set up and check these types of payments may be advantageous, and could be particularly targeted at the point of activation.

- **Acceptance of the card** – the experience of participants is that acceptance is not universal, though technically it should be. There are stories of the cards being declined at stores both within and outside the Trial sites, and though these might be relatively isolated and often due to the user, some cases *do* seem to involve merchants telling cardholders that they cannot use the particular card.

Additional education to assist participants be more confident about using their card may assist them in trying a second time if they make an error, or being more assertive with merchants. Ensuring merchants in the Trial sites know how to use the cards and to assist participants should they make an error would also be potentially useful.

²¹ From February 2017 balance checking will be available at selected ATMs

- **Accessing the legitimate “cash economy”** – while one of the main intentions of the CDCT is to limit access to cash, this does impose some limitations on legitimate places that participants can make purchases when the available cash component of their payments is not available. Examples cited include canteens, schools, swimming pools, carnivals, petrol stations and second hand private sales; as well as some specific merchants who did not accept card payments (e.g. a funeral director). These limitations are a natural consequence of the Trial, but are also a source of frustration for participants, who can feel ‘discriminated’ against by their inability to access these.

- **Rents** – accommodation payments often represent substantial proportions of a welfare recipient’s regular income. Some stories were provided of participants whose private landlords would only accept payment in cash or forms that were not easily able to be met by CDCT participants, resulting in difficulties meeting tenancy requirements²².

²² Please note that informal rent arrangements are possible through the Cashless Debit Card hotline if proof is presented.

V. Conclusions

1. Overall, the CDCT has been effective to date in terms of its performance against the key performance indicators (KPIs) established in the evaluation framework.
2. In particular, the Trial has been effective in reducing alcohol consumption, illegal drug use and gambling – establishing a clear ‘proof-of-concept’ and meeting the necessary preconditions for the planned medium-term outcomes in relation to reduced levels of harm related to these behaviours.
3. The Interim Evaluation findings indicate that the reductions in these behaviours have been largely driven by the impact of the debit card quarantining mechanism and not by the additional services provided via the CDCT package or factors external to the CDCT.
4. At this interim stage there is only limited evidence of early impacts on crime, violence, injuries and perceptions of safety – however, these medium-term outcomes were not expected to be seen in this timeframe and will be the focus of Wave 2 of the evaluation.

Appendix A: Performance Indicators and Wave 1 Results

1. Output Performance Indicators

Output PI#1: Number of community leaders who endorse programme

Figure 14: Output PI #1

Performance Indicator	Interim Rating
Number of community leaders who endorse programme	Achieved
Theme	Details
Specification	Number of community leaders who: <ul style="list-style-type: none"> ◆ feel programme design is appropriate for their community characteristics ◆ believe programme will be / is a good thing for their community ◆ speak positively about programme ◆ believe Trial parameters were developed using a co-design approach
Target	NA
Timeframe	Within one month of programme launch (Initial Conditions), repeated at Wave 1 and Wave 2
Data Sources	Qualitative research with community leaders
Definitions / Notes	Community leaders defined as members of regional leadership groups.

The community leaders initially strongly supported the introduction of the CDCT, and at the Interim Evaluation point this was still the case.

Evidence

Qualitative research with stakeholders

The qualitative research identified that all participating community leaders endorsed the CDCT. Specifically, all community leaders interviewed (see Table 1 for number interviewed):

- ◆ felt the programme design was appropriate for their community characteristics;
- ◆ believed the CDCT will be a good thing for their community – most were expecting to see the evidence of this in the medium to longer term;
- ◆ generally spoke positively about the CDCT; and
- ◆ believed Trial parameters were developed using a co-design approach – most leaders had been involved in the design of the Trial, and felt there were adequate opportunities for input from the community.

Output PI#2: Percent of participants who understand card conditions

Figure 15: Output PI #2

Performance Indicator	Interim Rating
Percent of participants who understand card conditions	Partial
Theme	Details
Specification	<p>Percent of participants who are aware:</p> <ul style="list-style-type: none"> ◆ how much their welfare income is quarantined in terms of cash withdrawals ◆ what they can and cannot purchase on the card ◆ which merchant types they can and cannot use the card at ◆ they can use the card wherever VISA is accepted including online (except where a merchant is blocked) ◆ they can use the card to make online payment transfers for housing and other expenses, and to pay bills ◆ what to do if the card is lost or stolen
Target	NA
Timeframe	Self-reported at Wave 1 and Wave 2
Data Sources	<p>Survey of Trial participants</p> <p><i>Additional Sources:</i></p> <p><i>Survey of families</i></p> <p><i>Survey of community members</i></p> <p><i>Indue data (Declined transactions, by decline reason, Use of online transfers, Number of participants provided with replacement and temporary cards)</i></p>
Survey Questions	<p>Participant questionnaire: q16/17, q20a-c, 21a-d</p> <p>Family questionnaire: q14a-b, q15c-f</p> <p>Non-Participant questionnaire: q12ia-b, q12iic-f</p>
Definitions / Notes	Not applicable

Participant understanding of CDC conditions has improved over time. The Wave 1 survey found that a large majority (80% or more) of CDCT participants understood (in general terms) what goods/services can be purchased and the merchant types where the card can be used. In particular, nearly all participants (98% average across the two Trial sites) understood that people cannot buy alcohol with the CDC. However, awareness gaps remain, particularly in relation to:

- what to do if the card is lost or stolen;
- that the card can be used in most places where VISA is accepted;
- that the CDC can be used to make online payment transfers to pay bills;
- how to set up rent payments;
- how to use the card online; and
- how to check balances.

Evidence

Qualitative research with stakeholders

Stakeholders reported there had been some initial “teething problems” while participants became familiar with the CDC (including using a PIN, the requirement to select the ‘credit’²³ account and setting up rental transfers). However, they noted that participant understanding of card conditions and functionality had improved over time.

In both East Kimberley and Ceduna, some stakeholders considered that there was a need for additional communication around certain aspects of the CDC, as they were causing confusion or were less well understood. These included:

- ◆ how to set up rent payments;
- ◆ how the card worked online; and
- ◆ how to check balances.

Evidence from external data sources

Analysis of CDC purchase²⁴ transactions that have been declined indicates that participant understanding of CDC conditions improved over time. The following chart shows that the proportion of CDC purchases that have been declined has fallen gradually over time. During the CDC roll-out period, the average CDC transaction decline rate was 16.5%. Subsequently, the average CDC transaction decline rate has been 14.3%. It should be noted that the first two weeks (indicated by dashed lines in) had atypically low transaction volumes – with less than 500 transactions, compared to an average of over 12,000 CDC purchase transactions per week subsequently.

²³ Note that card functionality has since been upgraded so that from December 2016 participants can select ‘savings’, ‘cheque’ or ‘credit’.

²⁴ Excludes ISP deposits into CDC accounts.

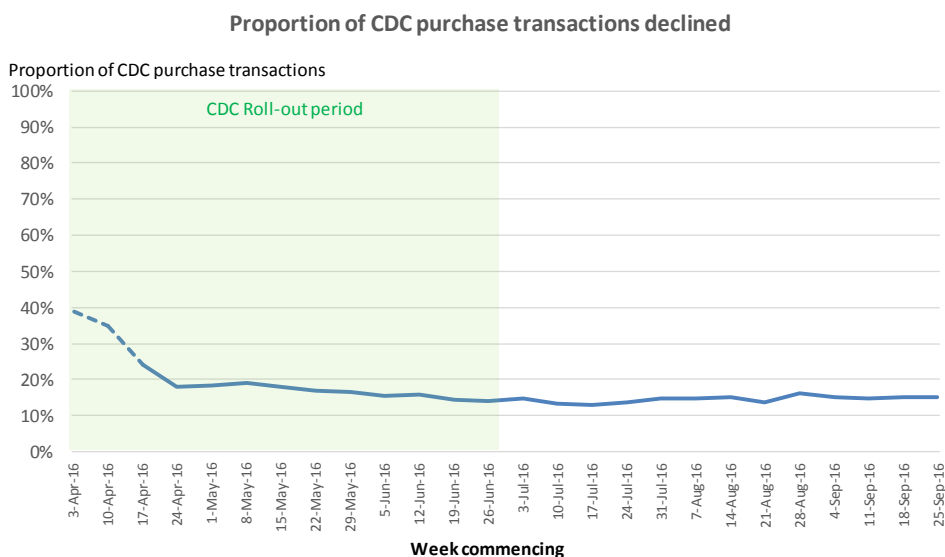


Table 9 shows the reasons for declined CDC transactions over the period April to September 2016.

- ◆ Card user error accounts for 86% of declined CDC transactions.
 - The main reason for transaction declines (accounting for over half of CDC transaction declines) is the CDC cardholder seeking to make a purchase when there are insufficient funds available. Interviews with CDCT participants found that some who did not know how to obtain an account balance simply attempted to make a purchase in order to ascertain whether they had been paid. Interviews also found that there was some confusion about the difference between the “current” and “available” CDC balance and this may have contributed to the number of declined CDC transactions.
 - The second most common reason for transaction declines (accounting for around one quarter of transaction declines) is the CDC cardholder providing an incorrect PIN.
 - The third most common reason for transaction declines (accounting for 6% of transaction declines) is the CDC cardholder seeking to make a transaction that exceeds the CDC transaction value limit.
- ◆ Attempts to use the CDC at prohibited merchants or terminals²⁵ accounted for 8% of declined CDC transactions.
- ◆ Other CDC transaction declines²⁶ accounted for the remaining 6% of declined CDC transactions.

²⁵ The reason for these CDC transaction declines was that they were attempted on blocked terminals associated with a merchant trading under a merchant category code which indicates they sell prohibited goods such as alcohol or gambling products.

²⁶ Reasons for these CDC transaction declines include: advised to reject; card listed as restricted; and card listed as stolen.

Table 9: Reasons for declined CDC transactions (April to September 2016)

Reason for transaction decline	Declined transactions	% of declined transactions	% of CDC purchase transactions*
Card user errors	32,237	86.2%	10.9%
Insufficient funds	20,735	55.5%	7.0%
Incorrect PIN entry	8,416	22.5%	2.8%
Cardholder exceeding withdrawal limit	2,189	5.9%	0.7%
Card listed as lost	897	2.4%	0.3%
Attempts to use card for prohibited purchases	3,022	8.1%	1.0%
Other reasons	2,121	5.7%	0.7%
Total	37,380	100%	12.6%

Source: Indue data.

* CDC transactions excluding deposits of ISPs.

The fact that attempts to use the card for prohibited purchases accounted for only 1% of all CDC purchase transactions (8% of all declined transactions) up to 30 September 2016, indicates a high level of understanding among CDCT participants of what cannot be purchased with the card.

Quantitative research with Participants, Families and Non-Participant stakeholders

The survey found that a large majority of participants were able to specify the proportion of their ISP payment that has been quarantined via a CDC account (see Figure 17). Of those who were unable to specify a proportion, a large majority understood that 'most' or 'almost all' of their ISP has been quarantined (see Figure 18).

Figures 19-22 indicate that a very large majority of CDCT participants understood:

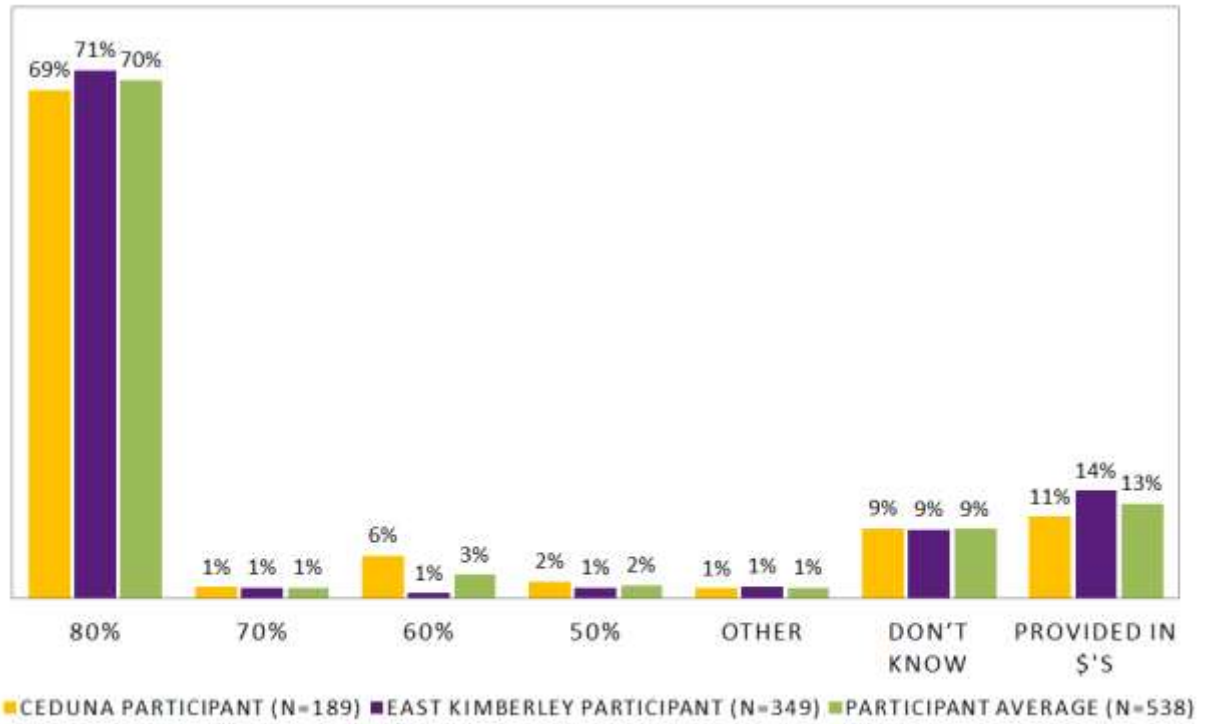
- what people can and can't buy with the CDC (in particular, nearly all participants understood that people can't buy alcohol with the CDC); and
- in general terms, the merchant types they can and cannot use the card at.

However, Figures 23-25 show that significant awareness gaps were found in relation to:

- what to do if the card is lost or stolen (particularly among Ceduna participants);
- that the card can be used in most places where VISA is accepted; and
- that the card can be used to make online payment transfers to pay bills.

Figure 17: Proportion of Centrelink payment that goes onto the card

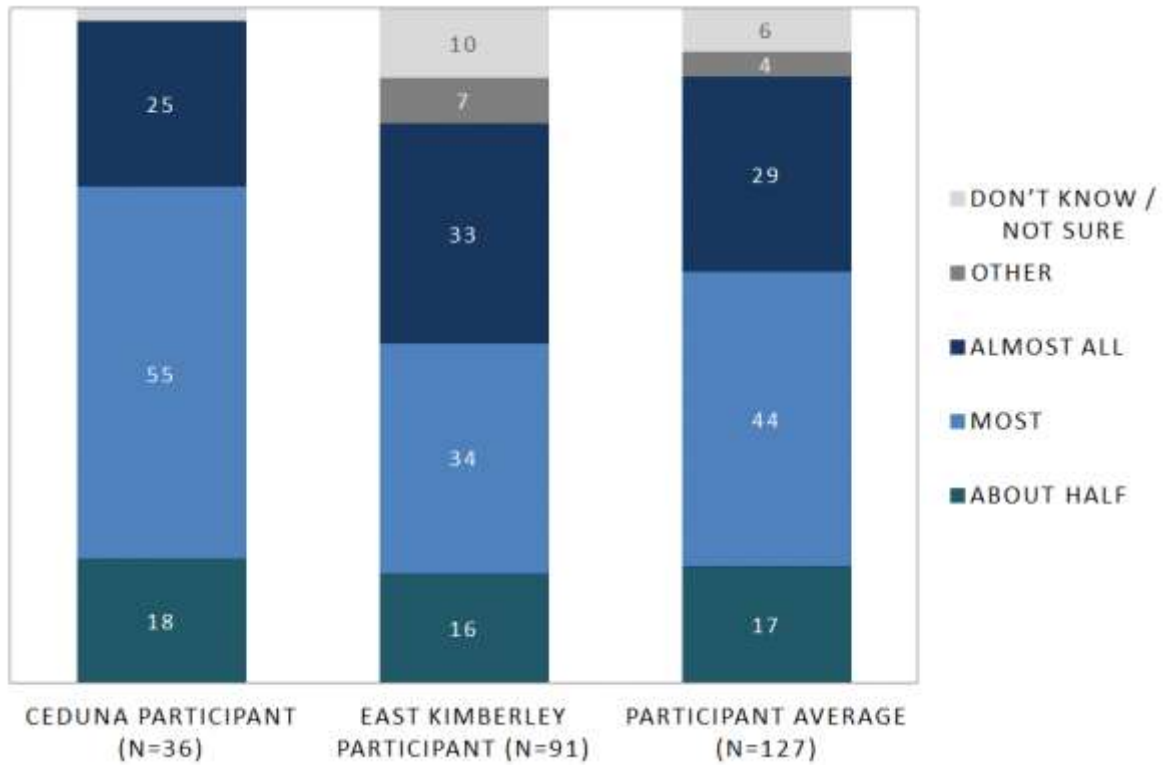
Base: Ceduna, East Kimberley and Total Participants. Excludes 'Refused'.



Q16 (P). How much of your Centrelink payment goes on the Cashless Debit Card / Indue Card?

Figure 18: Proportion of Centrelink payment that goes onto the card if provided in \$'s or don't know

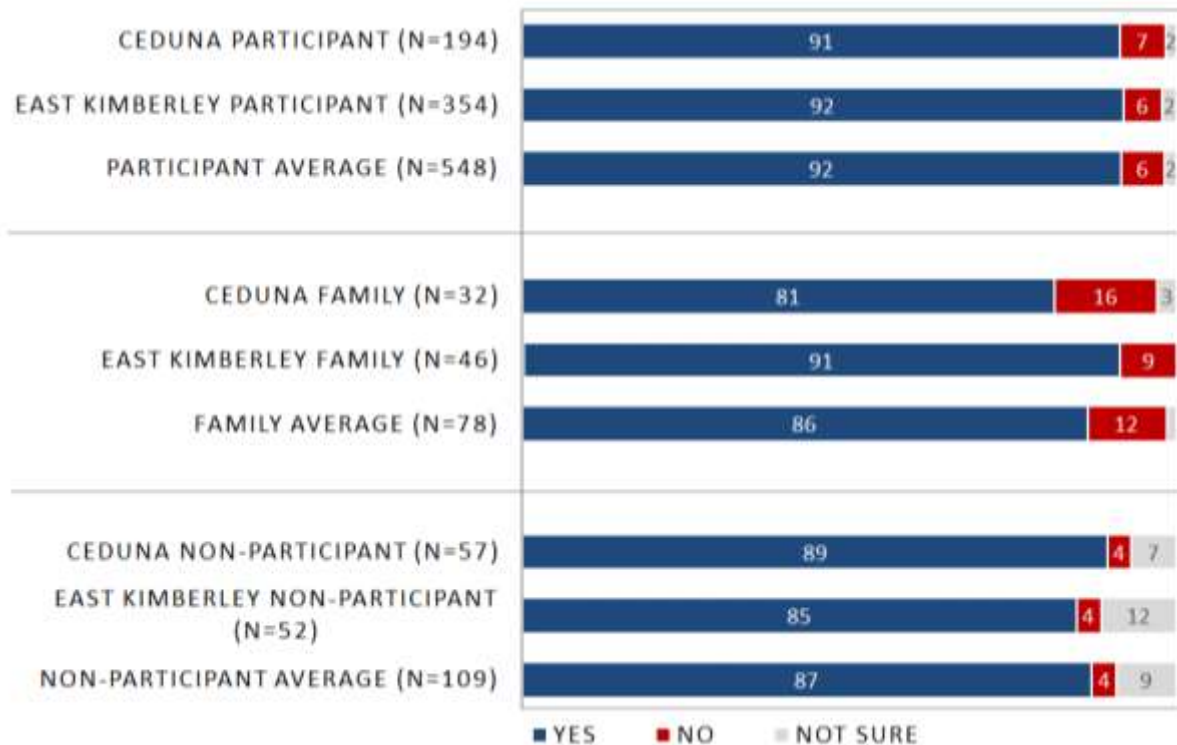
Base: Ceduna, East Kimberley and Total Participants who answered 'provided in \$' or 'don't know' at Q16.



Q17 (P). (IF RESPONSE TO Q16: PROVIDED IN \$ OR DON'T KNOW) Is it..?

Figure 19: Knowledge of what you / people can and can't buy with the card

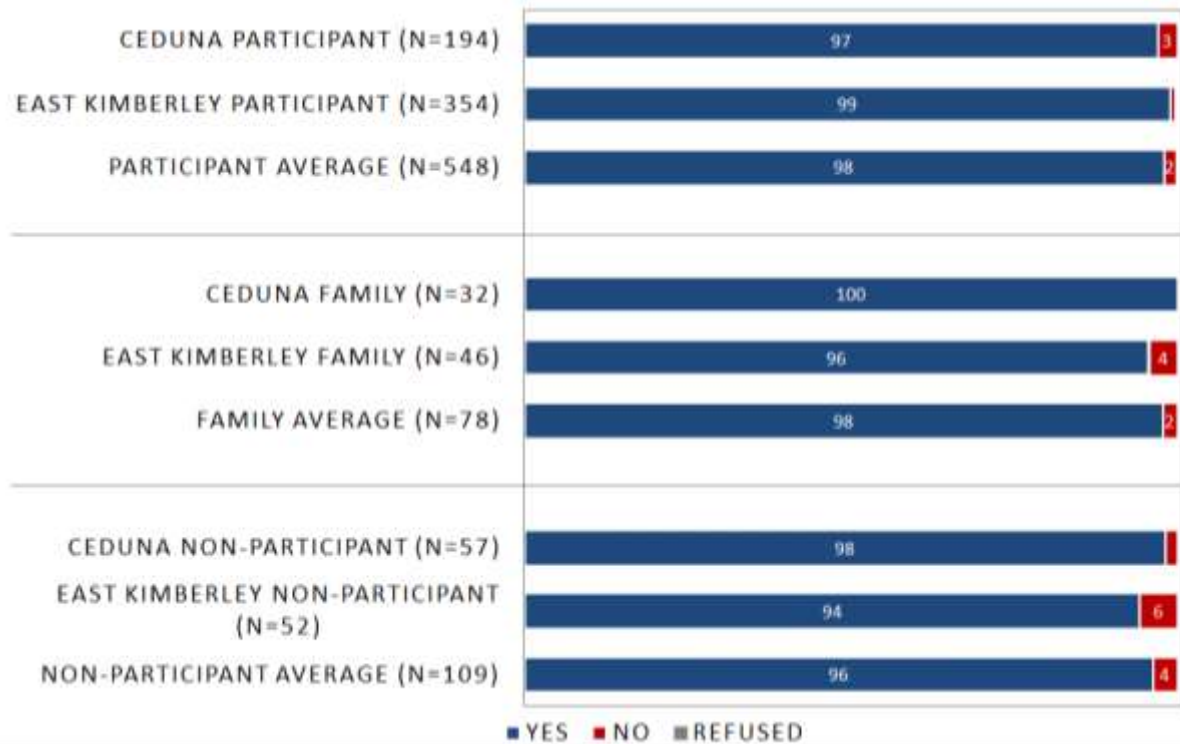
Base: Participants, Family and Non-Participants.



Q20a (P) / Q14a (F) / Q12ia (NP). Do you know what you can and can't buy with the card?

Figure 20: Knowledge that you *can't* buy alcohol or grog with the card

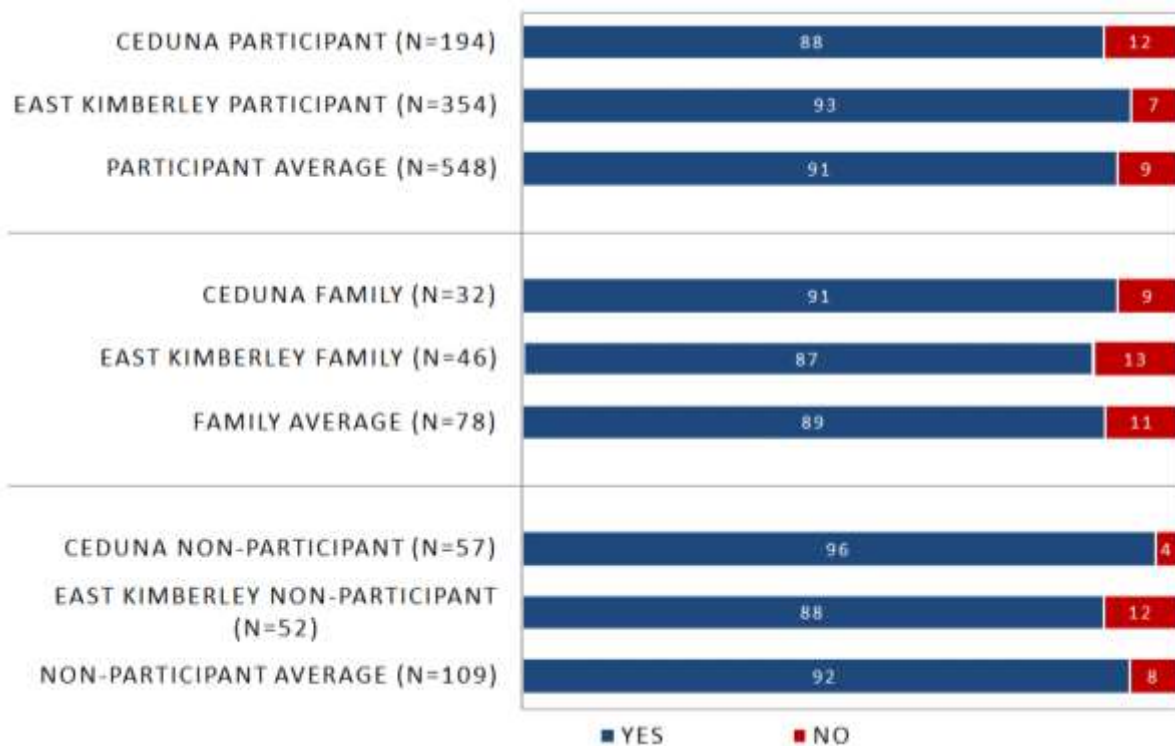
Base: Participants, Family and Non-Participants.



Q21a (P) / Q15c (F) / Q12iic (NP). Before this survey did you know that: You can't buy alcohol or grog with the card?

Figure 21: Knowledge that you *can't* use the card to make bets or for other types of gambling

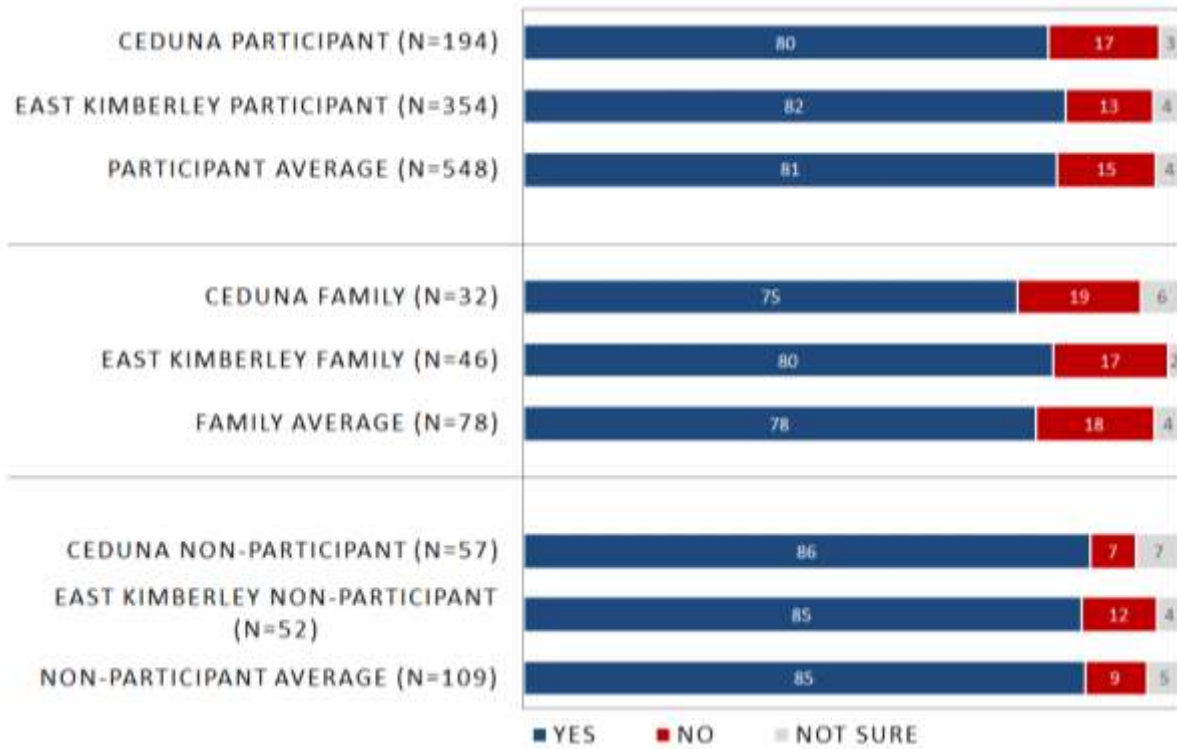
Base: Participants, Family and Non-Participants.



Q21b (P) / Q15d (F) / Q12iicd (NP). Before this survey did you know that: You can't use the card to make bets or for other types of gambling?

Figure 22: Knowledge of the types of places where you / people can and can't use the card

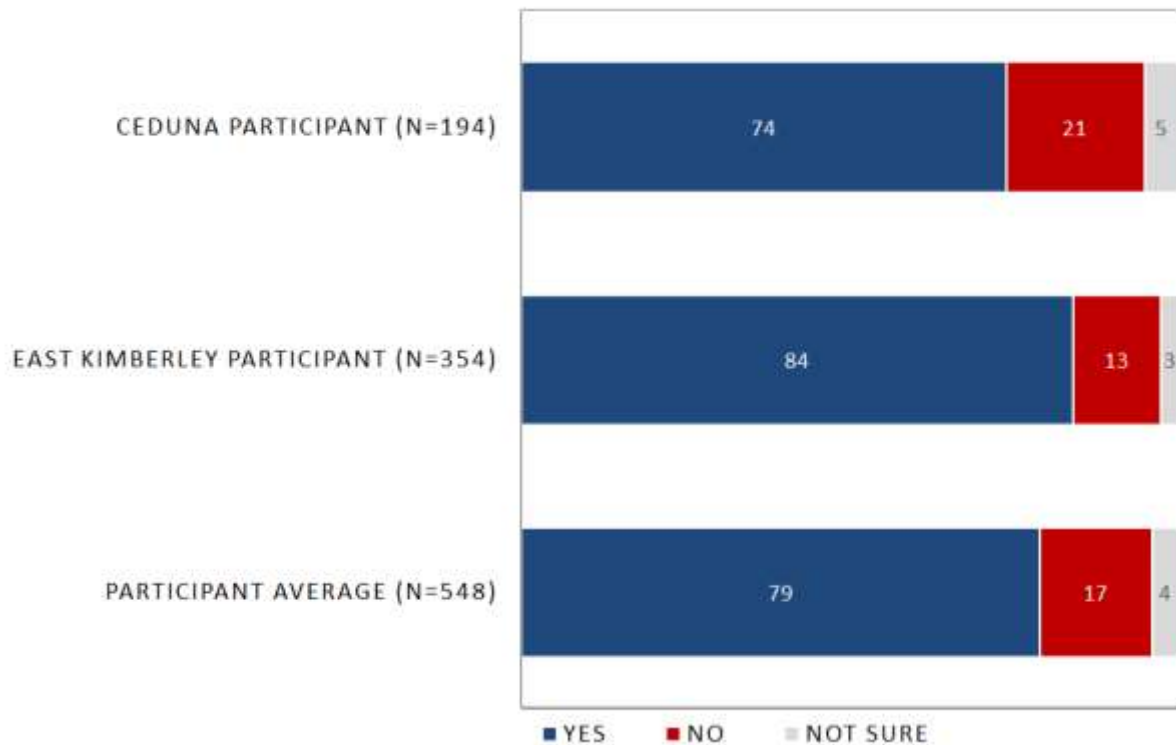
Base: Participants, Family and Non-Participants.



Q20b (P) / Q14b (F) / Q12ib (NP). Do you know the types of places or where you can and can't use the card?

Figure 23: Knowledge of what to do if the card is lost or stolen

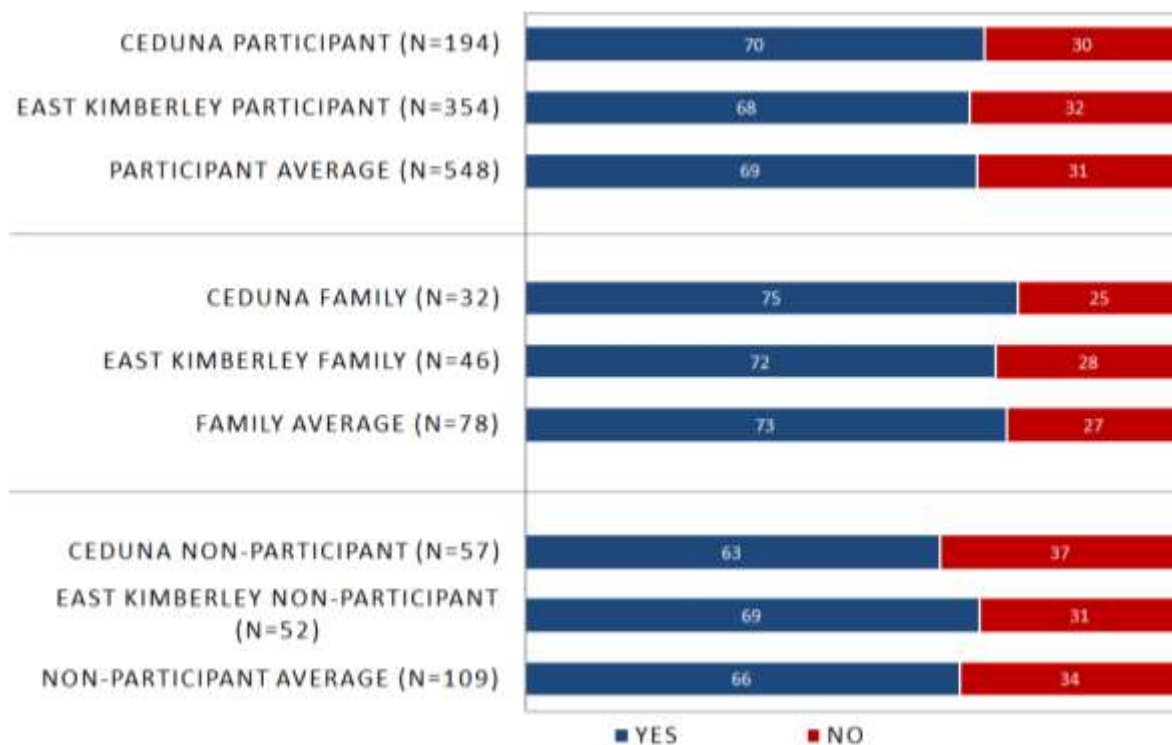
Base: Participants.



Q20c (P). Do you know what to do if the card is lost or stolen?

Figure 24: Knowledge that you can use the card in most places where VISA is accepted

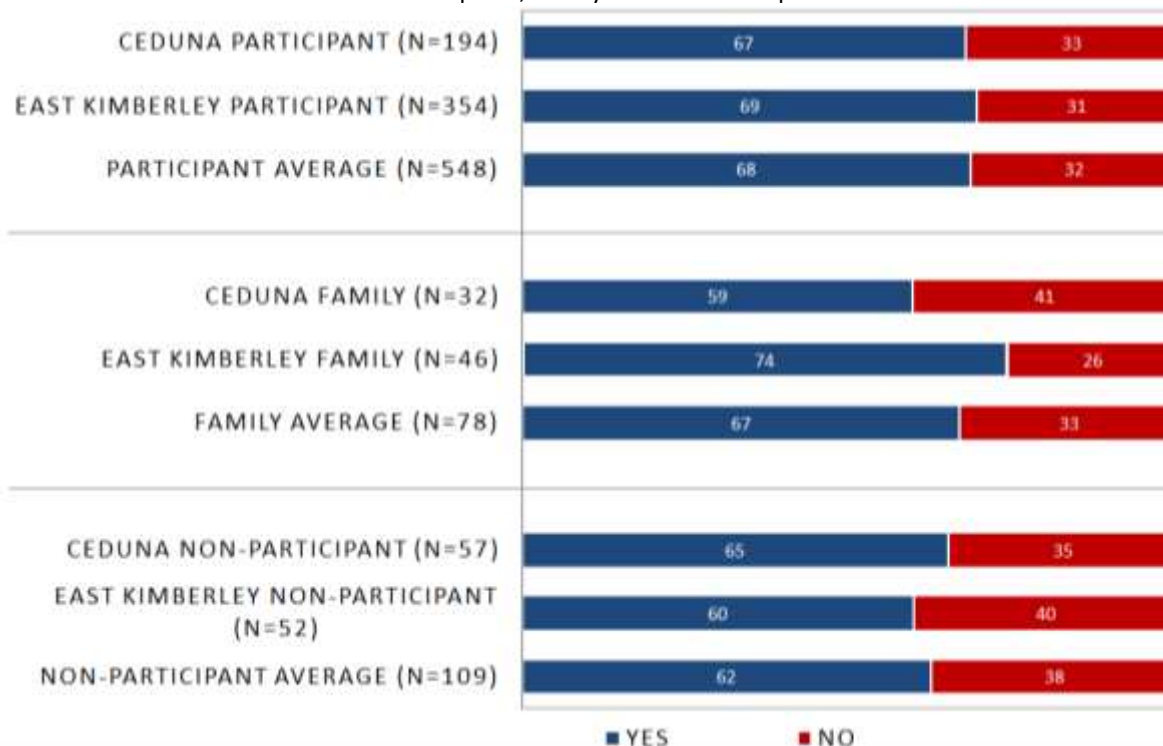
Base: Participants, Family and Non-Participants.



Q21c (P) / Q15e (F) / Q12iie (NP). Before this survey did you know that: You can use the card in most places where VISA cards are accepted, including online or on the internet?

Figure 25: Knowledge that you can use the card to make online payment transfers to pay bills

Base: Participants, Family and Non-Participants.



Q21d (P) / Q15f (F) / Q12iif (NP). Before this survey did you know that: You can use the card to make online payment transfers to pay bills, for housing and other expenses?

Output PI#3: Percent of participants in Trial locations sent card

Figure 26: Output PI #3

Performance Indicator		Interim Rating
Percent of participants in Trial locations sent card		Achieved
Theme	Details	
Specification	Percent of compulsory Trial participants sent a debit card	
Target	100%	
Timeframe	Within two months of program launch	
Data Sources	Indue / DHS Client database	
Definitions / Notes	Not applicable	

There is no evidence that relevant compulsory Trial participants have not been sent cards, but the evaluation cannot confirm 100% was achieved.

Evidence

Evidence from external data sources

Income Support Payment (ISP) data may be used to assist in the assessment of this performance indicator, in the absence of specific data demonstrating the percent of participants in Trial locations who were sent the card.

The official start dates for the CDCT were:

- ◆ 15 March 2016 in Ceduna and surrounds; and
- ◆ 26 April 2016 in the East Kimberley.

Cashless debit cards (CDCs) were progressively distributed to eligible ISP recipients:

- ◆ between mid-April and end-May 2016 in Ceduna and surrounds; and
- ◆ over the month of June 2016 in East Kimberley.

The number of ISP recipients participating in the CDCT changes each week as people move on and off various ISPs. DHS data indicates that, as at end June 2016²⁷ (i.e. around three and a half months after the official start date in Ceduna and surrounds and two months after the official start date in the East Kimberley):

²⁷ The first CDCT participant listing provided to the Evaluation Team.

- ◆ of the 1,972 ISP recipients in the CDCT sites who had been assessed as eligible to be placed on the CDCT, 1,837 (93%) had ISPs paid into their CDC:
 - of the 765 ISP recipients in Ceduna & surrounds who had been assessed as eligible to be placed on the CDCT, 728 (95%) had ISPs paid into their CDC; and
 - of the 1,207 ISP recipients in the East Kimberley who were eligible to be placed on the CDCT, 1,109 (92%) had ISPs paid into their CDC.

The fact that less than 100% of those initially deemed eligible for the CDCT have received ISP payments via a CDC reflects the fact that people may move on and off ISPs and a number of ISP recipients initially assessed to be eligible for the CDCT would have moved off ISP before the official start of the CDCT. In this regard, of the 1,972 persons deemed eligible to be placed on the CDCT as at end-June 2016:

- ◆ 92 (4.7% of those originally deemed eligible for the CDCT) had had their payments cancelled; and
- ◆ 148 (7.5% of those originally deemed eligible for the CDCT) had their ISPs suspended.

Output PI#4: Percent of distributed cards that are activated

Figure 27: Output PI #4

Performance Indicator	Interim Rating
Percent of distributed cards that are activated	Achieved

Theme	Details
Specification	The percentage of CDCT participants who make their first CDC purchase within one month of the first ISP into their CDC account.
Target	95%
Timeframe	Within one month of receiving card
Data Sources	Indue Survey of Trial Participants
Questions	Participant questionnaire: q13
Definitions / Notes	5% margin allowed for people moving in and out of income support payments

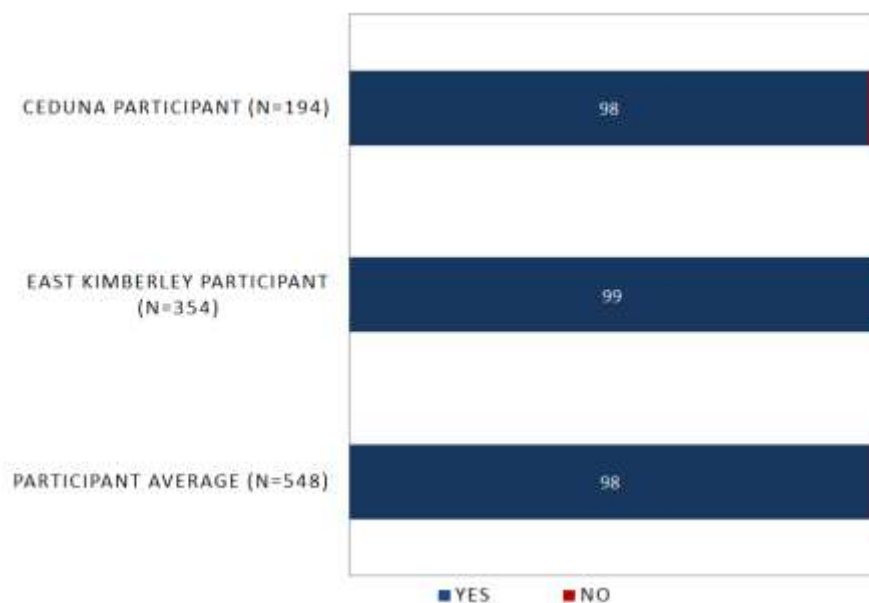
97% of CDCT participants made their first CDC purchase within one month of the first ISP payment into their CDC account.

Evidence

Quantitative research with Participants, Families and Non-Participant stakeholders

Figure 28: Activated and used card

Base: Participants.



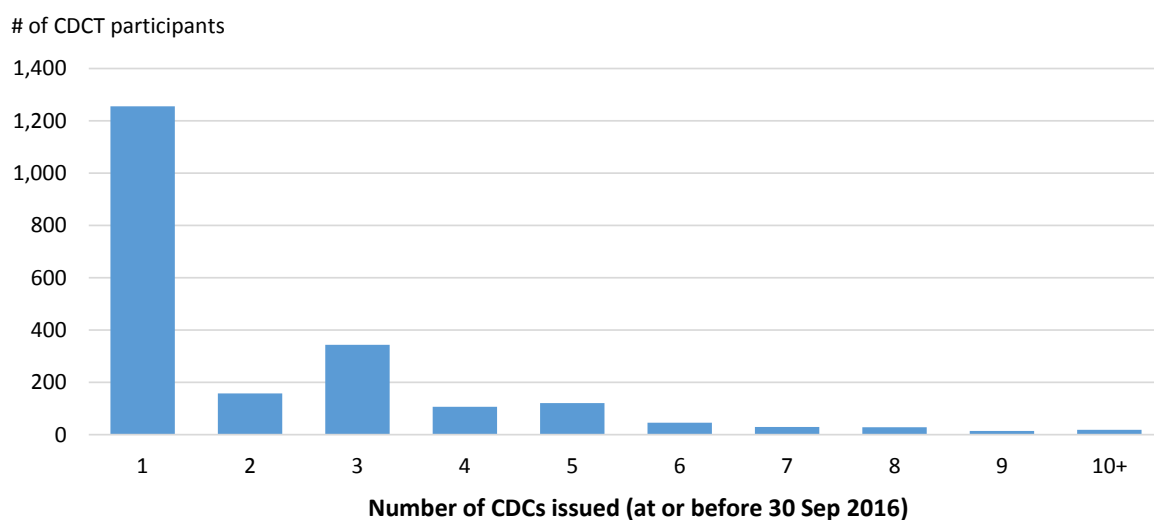
Q13 (P). And have you activated your Cashless Debit / Indue Card and started using it to buy things?

Evidence from external data sources

As at 30 September 2016, 2,125 CDCT participants had ISPs deposited into a CDC account since the introduction of the CDC in April 2016. Over this period, these CDCT participants had been issued a total of 4,716 CDCs, with some being issued more than one card due to, for example, the loss of the originally issued card or the provision of a temporary card. Figure 29 shows the number of cards issued to individual CDCT participants. Of the 2,125 CDCT participants who had ISPs paid into their CDC account at or before 30 September 2016:

- 1,256 (59%) had been issued one CDC;
- 730 (34%) had been issued between two and five CDCs; and
- 139 (7%) had been issued more than five CDCs. The maximum number of cards issued to a single CDCT participant over this period was 16.

Figure 29: Number of CDCs issued to individual CDCT participants



Of the 4,716 CDCs that had been issued to CDCT participants as at 30 September 2016:

- 3,917 (83%) had been activated by CDCT participants, and
- 3,495 (74%) had been activated by CDCT participants within one month.

However, as noted above, a number of CDCT participants have been issued multiple CDCs. While CDCT participants may not have activated all cards issued to them, they may nevertheless be able to access the ISPs deposited into their CDC account via subsequently activated CDCs. Of the 3,917 CDCs activated by CDCT participants for whom ISPs were deposited into their CDC account on or before 30 September 2016:

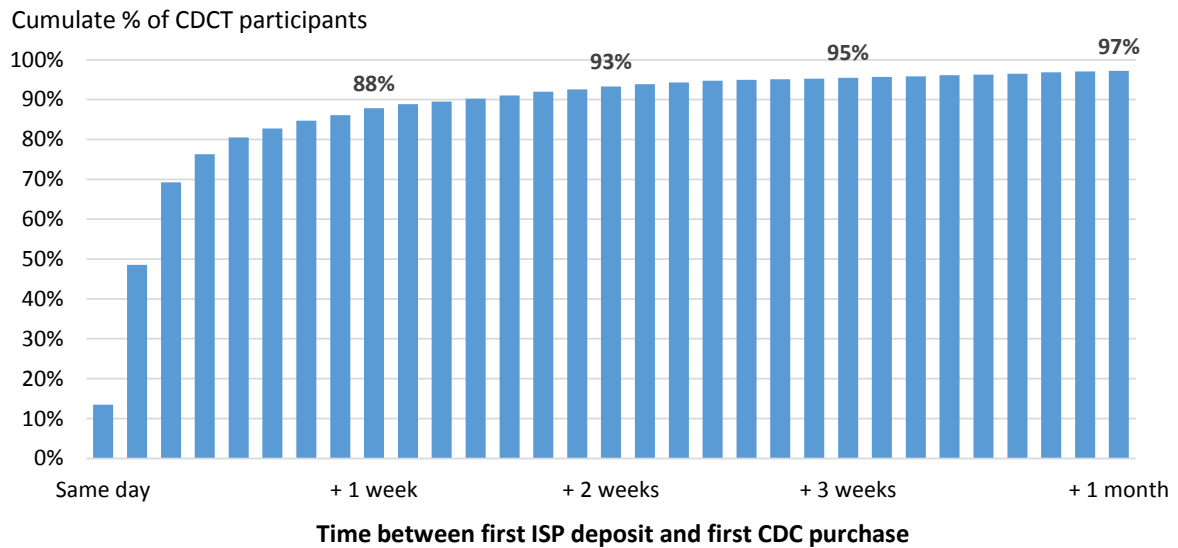
- 3,594 (92%) were activated within a month;
- 3,752 (96%) were activated within two months; and
- 3,792 (97%) were activated within three months.

Of the 2,125 CDCT participants who had ISPs deposited into a CDC account on or before 30 September 2016, 2,089 (98%) had used a CDC to make purchases over this period. This is consistent with the Wave 1 survey results outlined above, which found that 98% of survey participants reported they had activated and used the CDC to buy things.

Figure 30 shows the cumulative proportion of CDCT participants who had made their first CDC purchase within one month of their first ISP being deposited into their CDC account. It shows that:

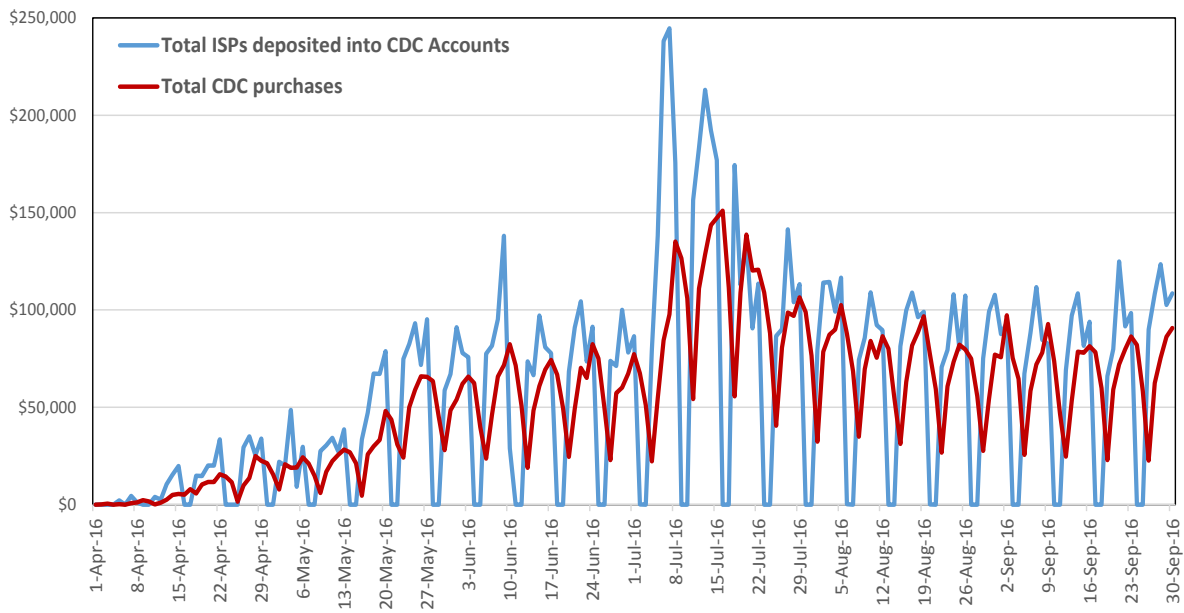
- 88% of CDCT participants made their first CDCT purchase within one week of their first ISP being deposited into their CDC account;
- 93% had made their first CDC purchase within two weeks;
- 95% had made their first CDC purchase within three weeks; and
- 97% had made their first CDC purchase with one month.

Figure 30: Proportion of CDCT participants who made their first CDC purchase within one month of their first ISP payment into their CDC account



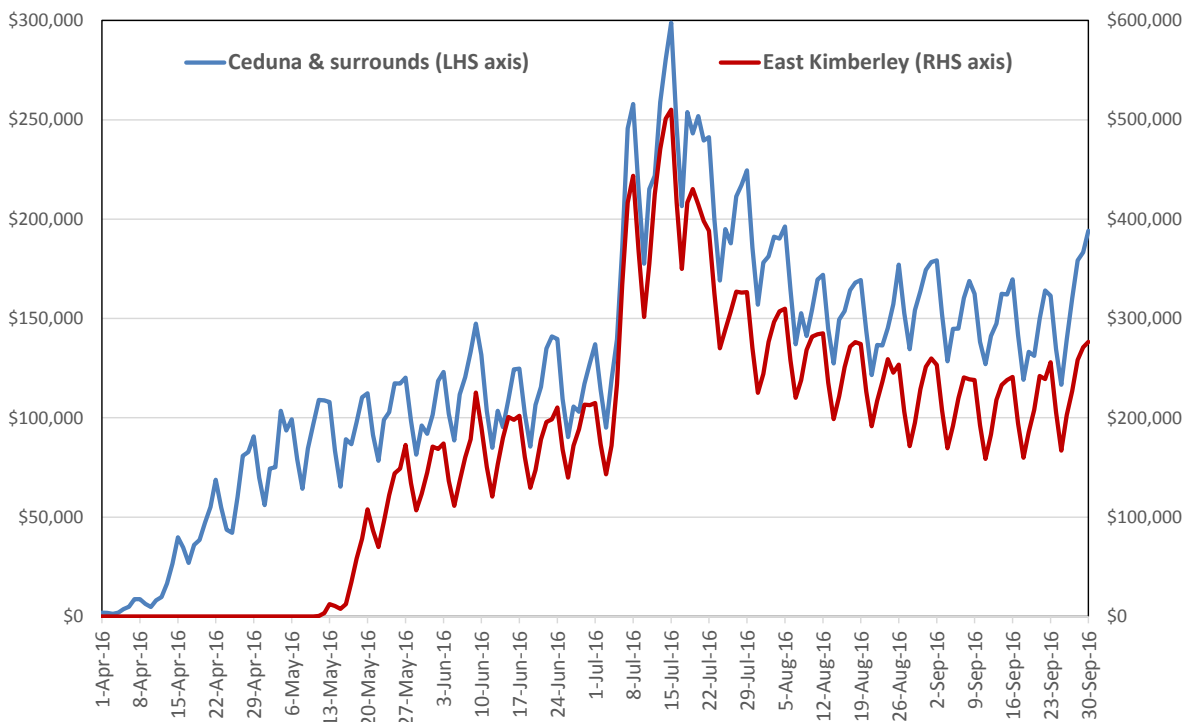
Most CDCT participants spend almost all of the ISPs deposited into their CDC account within a week. As a consequence, there is a close correlation between total ISPs deposited into CDC accounts and total purchases made with CDCs. Figure 31 shows the total ISPs deposited into CDC accounts and total purchases using CDCs on a daily basis.

Figure 31: Total ISPs paid into CDC Accounts vs total purchases using CDCs (daily)



- Most individual CDC account balances peak on “pay day” and then quickly decline to a low level prior to the next pay day. Given that around two-thirds of ISPs are deposited in CDC accounts on Wednesday through Friday, this intra-week pattern is also evident for the total CDC balances in both CDCT sites. Figure 32 shows the total CDC Account balances for CDCT participants in the two CDCT sites.²⁸

Figure 32: Total balance of CDC Accounts (daily)



²⁸ The spike in CDC account balances in July 2016 reflects the end of financial year reconciliation payments for Family Tax Benefit made to CDCT participants.

Of the \$10.5 million in ISPs deposited into the CDC accounts of CDCT participants on or before 30 September 2016, \$10.0 million (95%) has been spent on purchases using a CDC.

The above evidence indicates that:

- CDCT participants have had timely access to the ISPs deposited into their CDC accounts; and
- the vast majority of CDCT participants have activated their CDCs and have started to make purchases with their CDCs.

Output PI#5: 80% of income support payments are quarantined

Figure 33: Output PI #5

Performance Indicator	Interim Rating
80% of income support payments are quarantined	Achieved

Theme	Details
Specification	Income support payments are quarantined and 20% are received in cash (excluding approved adjustments)
Target	100% of recipients
Timeframe	Within two months of program launch
Data Sources	DHS Client database (Regular payment quarantine percentage variable) Survey of Trial participants
Questions	Participant questionnaire: q16/17
Definitions / Notes	Not Applicable

DHS data indicates that 98% of the total value of ISP payments made to CDC accounts up to end June 2016 was paid to CDCT participants for whom (the default) 80% of their ISP had been paid to these accounts. The data indicates that 2% of the total value of ISP payments to CDC accounts during this period was made to CDCT participants with an approved lower rate of quarantining. The majority of participants surveyed could nominate 80% as the quarantined proportion.

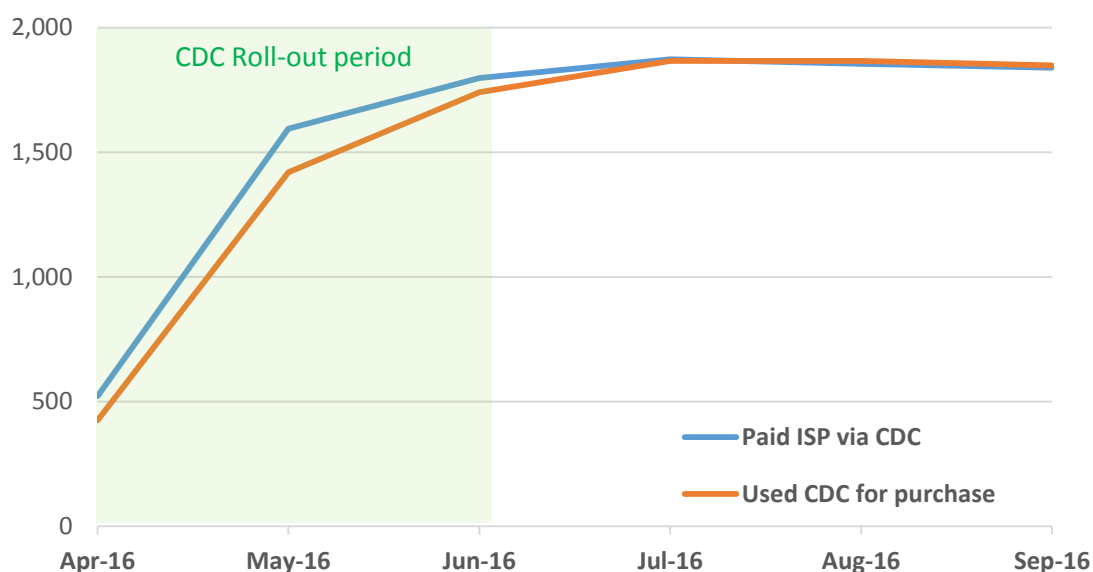
Evidence

Evidence from external data sources

Figure 34 shows the number of people receiving ISPs and making purchases via the CDC over the period April through September 2016. It is evident that after the initial roll-out of the CDC over April through June 2016, the number people receiving ISPs via the CDC has plateaued at around 1,850 each month.

The number of people receiving ISPs via the CDC fluctuates as people move on and off various benefits. In any given month, ISP payments may be made to people currently entitled to ISPs or those who have been entitled to an ISP at some point in that month but who have had their payment cancelled or suspended. Of the approximately 1,850 persons receiving their ISPs each month via the CDC since July 2016, typically around 85% are currently entitled to an ISP and around 15% have had their ISP cancelled or suspended during the month.

Figure 34: Number of people using the CDC



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Paid ISP via CDC	522	1,595	1,798	1,873	1,855	1,840
Used CDC for purchase	424	1,420	1,741	1,867	1,867	1,849

As at end-June 2016²⁹ (i.e. at the end of the CDC roll-out period and almost two months after the first ISPs were made via the CDC) a total of \$3.12 million in ISPs had been delivered via the CDC. Of this, \$3.05 million (98%) was paid to CDC participants for whom (the default) 80% of their ISP was delivered via the CDC. That is, only 2% of the total value of ISPs made via the CDC had been paid to CDCT participants who had successfully applied to a Community Panel for a reduction in their CDC quarantine (to between 50% and 70%). However, it should be noted that, as at end-June 2016, the East Kimberley Community Panel (which will assess individual requests for variations in the CDC quarantine percentage on a case-by-case basis) had not yet been established and so no requests for CDC quarantine reductions had been assessed for the East Kimberley.

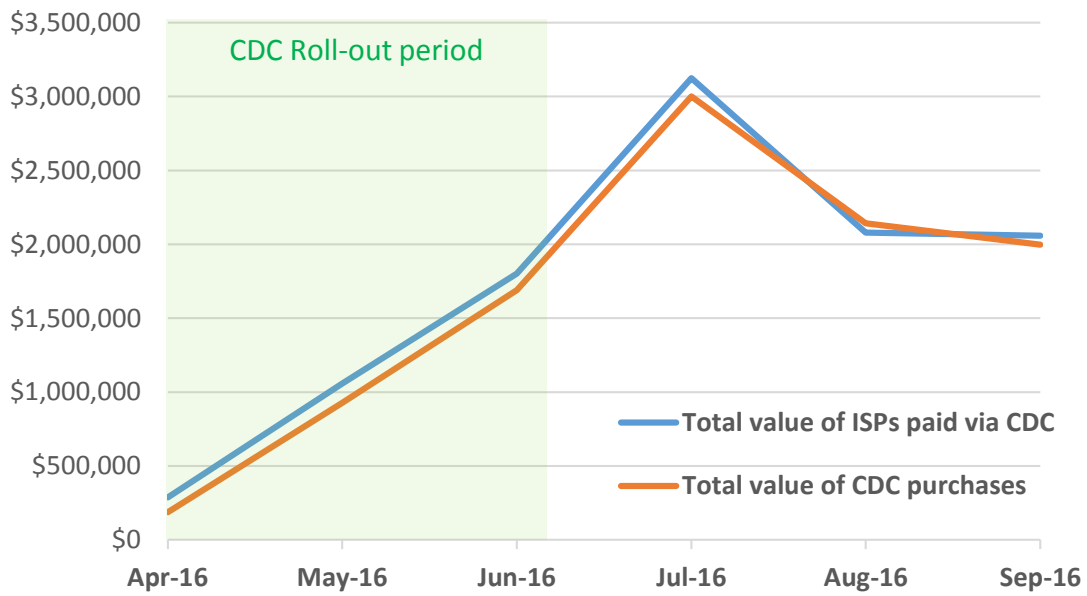
Figure 35 shows the total monthly value of CDC transactions over the six-month period April to September 2016:

- ◆ The value of CDC transactions rose steadily over the CDC roll-out period of April to June 2016.
- ◆ The spike in CDC transactions in July 2016 reflected the payment of End of financial year reconciliation payments for Family Tax Benefit in a number of ISPs³⁰.
- ◆ Most ISPs delivered via the CDC are spent within the same month.

²⁹ Based on DHS data extracted 29 June 2016.

³⁰ End-of-year top-ups (paid in July) have a significant impact on Carer Payments, Family Tax Benefit payments, Parenting Payments

Figure 35: Total value of CDC transactions

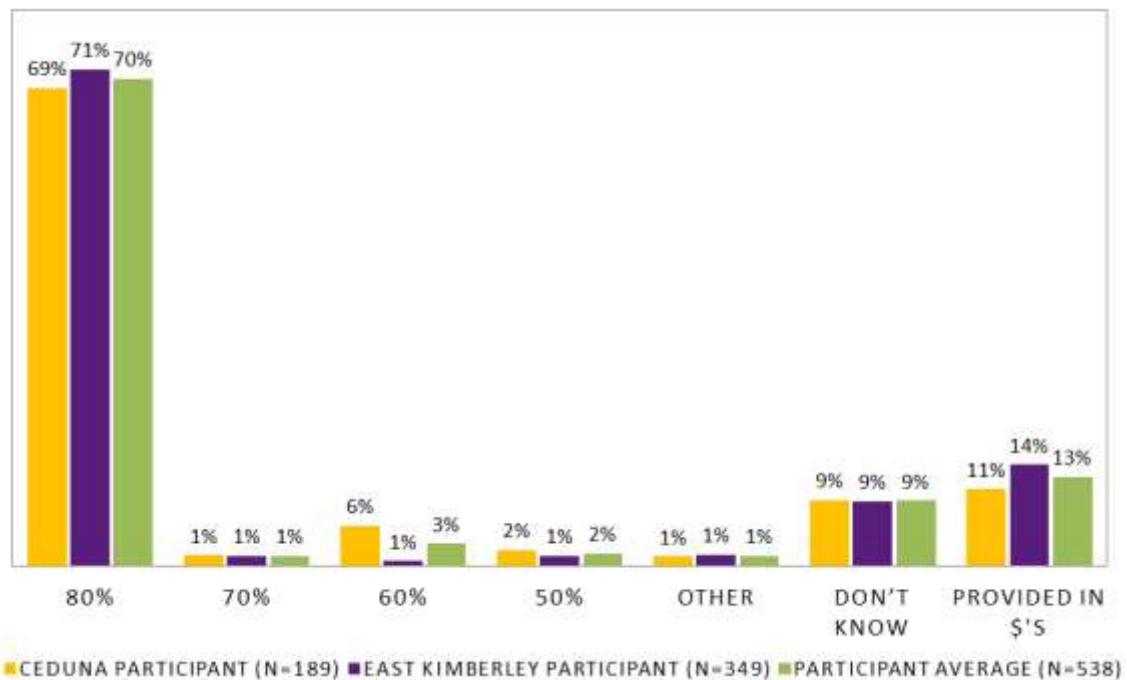


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total value of ISPs paid via CDC	\$286,610	\$1,057,719	\$1,802,274	\$3,125,108	\$2,079,518	\$2,058,492
Total value of CDC purchases	\$187,255	\$927,851	\$1,688,748	\$3,000,069	\$2,141,556	\$1,998,108

Quantitative research with Participants

Figure 36: Proportion of Centrelink payment that goes onto the card³¹

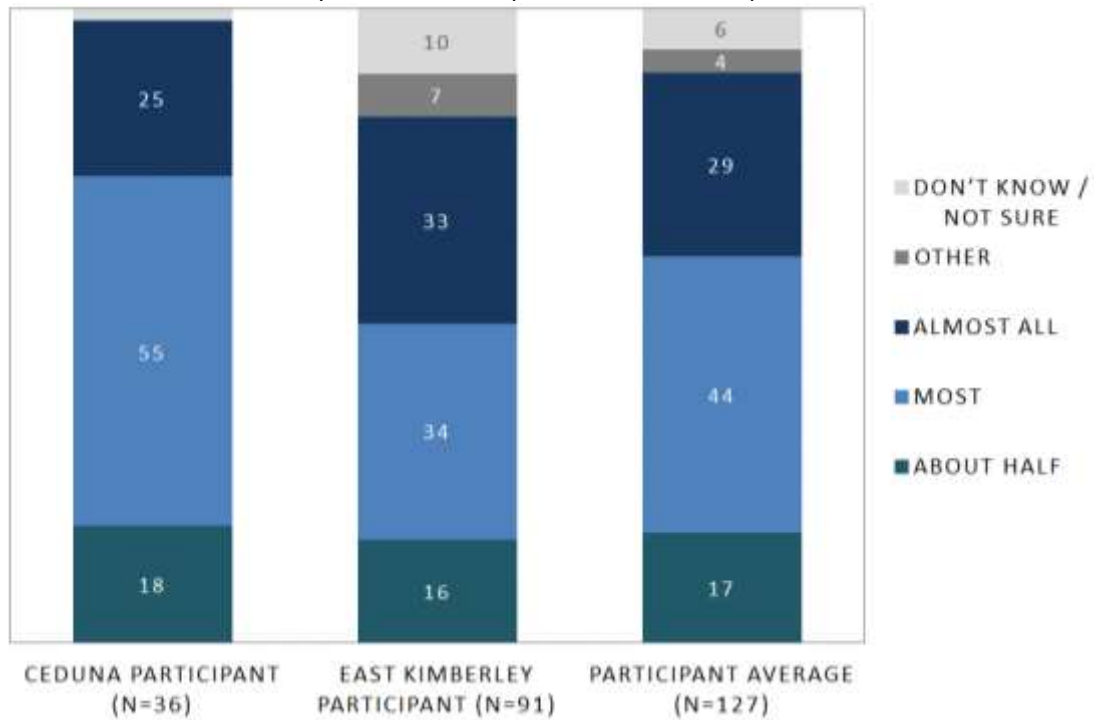
Base: Ceduna, East Kimberley and Total Participants. Excludes 'Refused'.



Q16 (P). How much of your Centrelink payment goes on the Cashless Debit Card / Indue Card?

Figure 37: Proportion of Centrelink payment that goes onto the card- provided in \$'s or don't know³¹

Base: Ceduna, East Kimberley and Total Participants who answered 'provided in \$' or 'don't know' at Q16.



Q17 (P). (IF RESPONSE TO Q16: PROVIDED IN \$ OR DON'T KNOW) Is it..?

³¹ Customers with active Centrepay deductions have a lower net percentage of funds paid to their CDC, as Centrepay is deducted from the default 80% prior to quarantining of funds. This may account for some of those customers who believe that an amount lower than 80% is being paid to their cards.

Output PI#6: Number of support services available in community

Figure 38: Output PI #6

Performance Indicator	Interim Rating
Number of support services available in community	Not assessed

Theme	Details
Specification	Number and type of additional support services in operation as planned
Target	100%
Timeframe	Within three months of program launch
Data Sources	DSS provided
Definitions / Notes	Not Applicable

Data to assess this output performance indicator was not available at the Interim Evaluation point.

Evidence

Evidence from external data sources

Usage of the support services was to be assessed using Data Exchange (DEX) data to be provided by DSS. At face value, the DEX data suggests that usage of specified support services more than doubled over the six months to June 2016 (which encompasses the CDC roll-out period) compared with the six months to December 2015 (which precedes the CDC roll-out):

- ◆ The total of client residents reported as using support services in Ceduna and Surrounds rose from 163 over the six months to December 2015 to 348 over the six months to June 2016.
- ◆ The total of client residents reported as using support services in East Kimberley rose from 49 over the six months to December 2015 to 118 over the six months to June 2016.

However, this sharp increase in reported usage reflects the fact many providers only started using the DEX reporting facility in the six months to June 2016. Consequently, the six months to December 2015 does not provide a reliable benchmark against which to assess service usage rates.

The Department is currently exploring the possibility of identifying those services in DEX that have:

1. Fully reported service provision via DEX in the six months to December 2015; and
2. Received additional funding to support the implementation of the CDCT.

For the above reasons, the Department agreed that it was not advisable to include service usage statistics in the Wave 1 Interim Evaluation Report.

Qualitative research with stakeholders

Many service providers reported that the additional service funding was not provided early enough to allow for services to be ready at the beginning of the Trial, particularly given the significant challenges associated with delivering new programs and support services in a remote location.

Output PI#7: Percent of participants with reasonable access to merchants and products

Figure 39: Output PI #7

Performance Indicator		Interim Rating
Percent of participants with reasonable access to merchants and products		Partial
Theme	Details	
Specification	Excluding the purchase of alcohol and gambling: <ul style="list-style-type: none"> ◆ percent of participants who agree that they can still shop where and how they usually shop ◆ percent reporting concerns over access to allowable products 	
Target	90% agree point 1, and maximum 10% reporting at point 2	
Timeframe	Self-reported at Wave 1	
Data Sources	Survey of Trial participants	
Questions	q22	
Definitions / Notes	Not Applicable	

A large majority of Trial participants (78% average across the two Trial sites) surveyed indicated that they had not changed where and how they shopped since the Trial commenced. A minority (18% average across the two Trial sites) expressed concerns about constraints on their ability to access allowable goods and services via the CDC. These proportions were close to KPI target levels (90% and no more than 10%, respectively). Problems reported by participants and stakeholders primarily related to participants' constrained ability to conduct legitimate purchases in settings where cash was the normal payment medium³².

Evidence

Qualitative research with stakeholders

Overall, most stakeholders reported that CDCT participants had adapted to the conditions of the card, and were generally not concerned about accessing allowable products. However, the following were identified as limiting CDCT participants' ability to access allowable products:

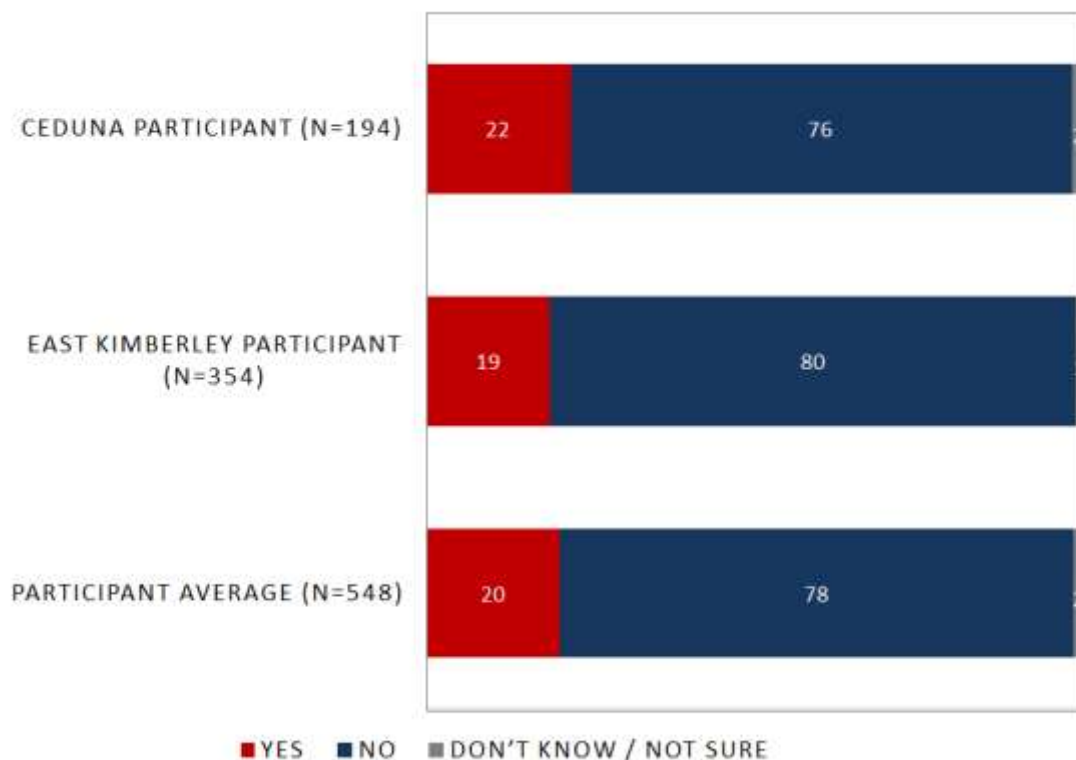
³² The Department advised that 20% of payments are not quarantined due to the need for participants to have access to cash for legitimate purposes. The CDC also allows for \$200 to be transferred externally per 28 days. If a legitimate reason can be provided for requiring this limit to be increased then DSS can assist in this.

- ◆ Some stakeholders in Ceduna felt that CDCT participants were adversely impacted by their inability to make cash-based purchases in some situations, including from second hand websites, sports club canteens, tickets for community events (e.g. Oyster Fest and NAIDOC);
- ◆ A couple of stakeholders in East Kimberley reported that they had heard there were some stores where the card was not accepted / did not work (e.g. petrol stations outside of the Trial site and in Derby); and
- ◆ One stakeholder in East Kimberley was concerned about the potential impact of blackouts during the upcoming wet season, which usually put EFTPOS terminals out of operation. This stakeholder noted that people were usually able to withdraw cash from banks in this situation, but was concerned about what would happen this wet season with people only able to access 20% cash. This stakeholder reported that this issue could be compounded when the DSS office is closed for Christmas for 2 weeks³³.

Quantitative research with Participants

Figure 40: Changed where or how you shop since using the card

Base: Participants.

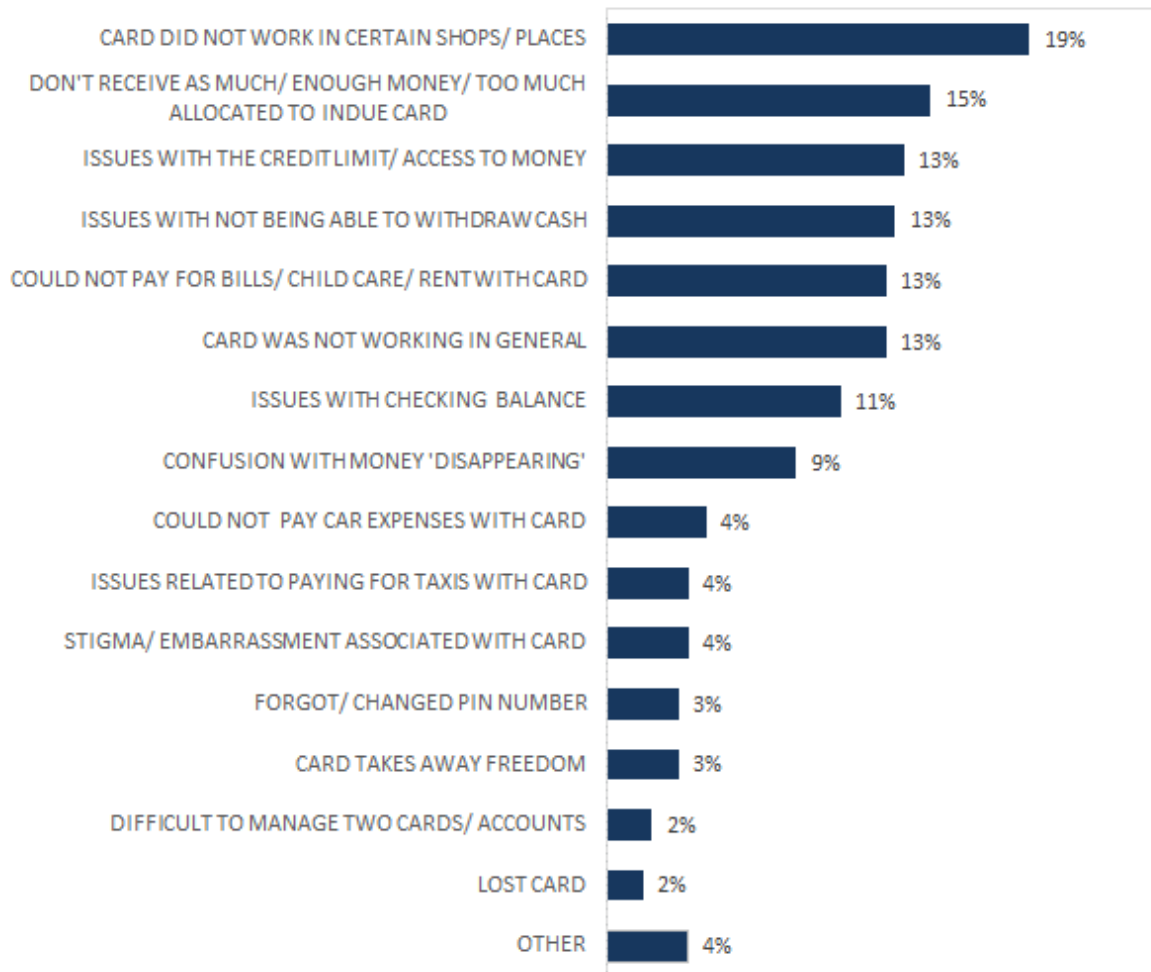


Q22 (P). Since you started using the card, have you had to change where or how you shop?

³³ The Department has contingency arrangements for emergency situations and the Christmas shutdown period. These include assistance through the DSS and Indue hotlines as well as officers on the ground and in Canberra who have the ability to transfer money to external accounts in such situations.

Figure 41: Problems had using the card – open ended

Base: Participants who have had problems using the card.



Q15 (P). Have you had any problems using the Cashless Debit / Indue Card – Yes. Please tell me about these problems.
Unweighted n=245

Output PI#8: Number of community leaders who believe appropriate adjustments are made to income restrictions on a case-by-case basis

Figure 42: Output PI #8

Performance Indicator		Interim Rating
Number of community leaders who believe appropriate adjustments are made to income restrictions on a case-by-case basis		Partial
Theme	Details	
Specification	Number of community leaders who: <ul style="list-style-type: none"> ◆ believe community panels are assessing applications in a timely, consistent and fair manner ◆ believe community panels are making just and reasonable decisions about changing percentage of welfare payments quarantined 	
Target	Most	
Timeframe	Within one month of programme launch (Initial Conditions), repeated at Wave 1 and Wave 2	
Data Sources	Qualitative research with community leaders	
Definitions / Notes	Nil	

The Community Panels have been late to commence in both Trial sites, limiting their effectiveness. Once established the Ceduna Panel has been useful, but the EK Panel only became functional after the Interim Evaluation was completed.

Evidence

Qualitative research with stakeholders

Overall, the qualitative research found that most community leaders felt the community panel arrangements were an appropriate and reasonable method for adjusting income restrictions. However, community leaders identified that community panels had not been established in a timely manner. Specifically:

- ◆ In Ceduna, the panel was not established for the start of the Trial; and
- ◆ In East Kimberley, the panel had still not been established at Wave 1.

Given that the community panels have not been up and running, there is limited evidence to provide feedback / response against this output measure.

2. Short-Term Outcome Performance Indicators

STO PI#1: Frequency of use / volume consumed of drugs & alcohol

Figure 43: STO PI #1

Performance Indicator		Interim Rating
Frequency of use / volume consumed of drugs & alcohol		Achieved
Theme	Details	
Specification	<ul style="list-style-type: none"> ◆ Number of times alcohol consumed by participants per week ◆ Percent of participants who say they have used non-prescription drugs in the last week ◆ Number of times per week spend more than \$50 a day on drugs not prescribed by a doctor ◆ Number of times per week have six or more drinks of alcohol at one time (binge drinking) ◆ Percent of participants, family members and general community members reporting a decrease in drinking of alcohol in the community since commencement of Trial ◆ Number of on-the-ground stakeholders reporting a decrease in drinking of alcohol in the community since commencement of Trial # 	
Target	NA, other than # target = 'many'	
Timeframe	As self-reported at Wave 1	
Data Sources	Survey of Trial participants Survey of families Survey of community members Qualitative research with stakeholders	
Survey Questions	Participant questionnaire: q25a-b/h-j, q42a, q44a-b/g-h Family questionnaire: q17a-b/h-j, q24a, q26a/c Non-Participant questionnaire: q16a	
Definitions / Notes	On-the-ground stakeholders defined as members of the regional leadership groups and observers from government and non-government service providers based in the Trial areas For stakeholders, qualitative indication of number: all, most, many, some, few	

Overall, the KPI measures indicate that the Trial has been effective in reducing alcohol and illegal drug consumption.

Evidence

Ceduna – Qualitative research with stakeholders

Frequency of use / volume consumed of alcohol

Many stakeholders were reluctant to indicate that the CDCT had reduced alcohol consumption in Ceduna and surrounding areas as they felt that there were no direct, visible changes to alcohol consumption since the start of the Trial. However, some had noted broader changes that could suggest an indirect impact on reducing alcohol consumption (e.g. more money directed to other purposes and greater engagement with programs).

The few stakeholders who had noted direct positive impacts of CDCT in relation to alcohol consumption reported that these included:

- ◆ Less visibility / fewer people consuming alcohol in public. This was evidenced by:
 - A few stakeholders seeing and hearing fewer intoxicated people on the streets;
 - Fewer ambulance callouts to public places. While call-out figures were unchanged, there were more to private addresses since the Trial begun;
 - Fewer people drinking in front and back gardens in one remote community (Koonibba);
- ◆ More sobriety – evidenced by:
 - A substantial increase (around 50%) in the number of people attending the lunch service at the ADAC day centre (previously most clients only attended breakfast);
 - More people attending services at CAC while sober;
 - Seeing specific individuals sober – a few stakeholders reported seeing certain individuals in a sober state “for the first time”; and
- ◆ Reduced emergency presentations related to alcohol consumption during the end of the financial year period – there tended to be an influx in hospital presentations associated with excessive alcohol consumption as lump sum payments received at this time of year (e.g. school kids bonus) were spent on alcohol, but this year no spike had been noticed by hospital staff.

Frequency of use / volume consumed of drugs

Overall, consistent with the Initial Conditions Report, stakeholders found it more difficult to comment on levels of drug use in the community as substance usage was less visible. There were minimal positive impacts of the CDCT on drug use identified by stakeholders other than a report by one stakeholder who had spoken with a drug dealer (who was on the CDCT) who had not been able to buy wholesale drugs because he no longer had the supply of cash. Another stakeholder reported hearing reports that it was harder to access marijuana in some of the remote Trial communities outside of Ceduna, however, as there had been some recent arrests of drug suppliers it was unclear if this was as a result of these arrests or the CDCT.

East Kimberley – Qualitative research with stakeholders

Frequency of use / volume consumed of alcohol

While some stakeholders felt that there had been minimal / no change in alcohol consumption, many others had noticed changes at an individual and / or community level since the start of the CDCT.

The stakeholders who had noted positive impacts of CDCT in relation to alcohol consumption reported that these included³⁴:

- ◆ Feedback from Sobering Up Units (SUUs) in Kununurra and Wyndham indicated that there had been:
 - A decrease in the number of people being picked up as well as using the SUU;
 - A change in the types of people being picked up by the SUU – now more likely to be people from outside the Trial area;
- ◆ Less visibility / fewer people consuming alcohol in public – some stakeholders reported seeing and hearing fewer intoxicated people in public places (i.e. on the streets in town, in parks and on the side of the road in the early mornings);
- ◆ One stakeholder had observed that binge drinking patterns had changed amongst some of the CDCT participants that they had dealings with and that these sessions were now of a shorter duration;
- ◆ Hospital related changes:
 - Admissions due to alcohol-related presentations had decreased;
 - A noticeable decrease in rowdy and abusive behaviour towards Accident and Emergency staff since the Trial. A stakeholder from the hospital estimated it to have reduced by around half;
- ◆ Ambulance-related changes:
 - Decrease in primary call-outs (from 107 in August-September 2015 to 73 in August-September 2016);
 - Fewer call-outs for alcohol-related injuries;
- ◆ Substantially decreased sales at a Kununurra bottle shop – this decrease was reported to have occurred since the Trial started, as well as at the comparative point from last year;
 - This had resulted in a need to reduce casual staff (who were mostly backpackers);
- ◆ More sobriety – evidenced by:
 - A local football coach reported that several players who had previously been unable to play / not trained effectively due to frequent intoxication had reduced their alcohol consumption and significantly improved their behaviour and their commitment and performance to the game, resulting in noticeable “transformation” of their lives; and

³⁴ For supporting data see Figure 93 under MTO PI#4: Drug/alcohol-related injuries and hospital admissions.

- A few stakeholders reported seeing individuals they knew to previously be high alcohol users who were now more regularly sober and seen to be spending their money on food, groceries and household items.

Frequency of use / volume consumed of drugs

Overall, consistent with the Initial Conditions Report, stakeholders found it more difficult to comment on levels of drug use in the community – primarily because such behaviours were not as visible and the impacts of using marijuana (the main drug used) were not as overt / aggressive as alcohol.

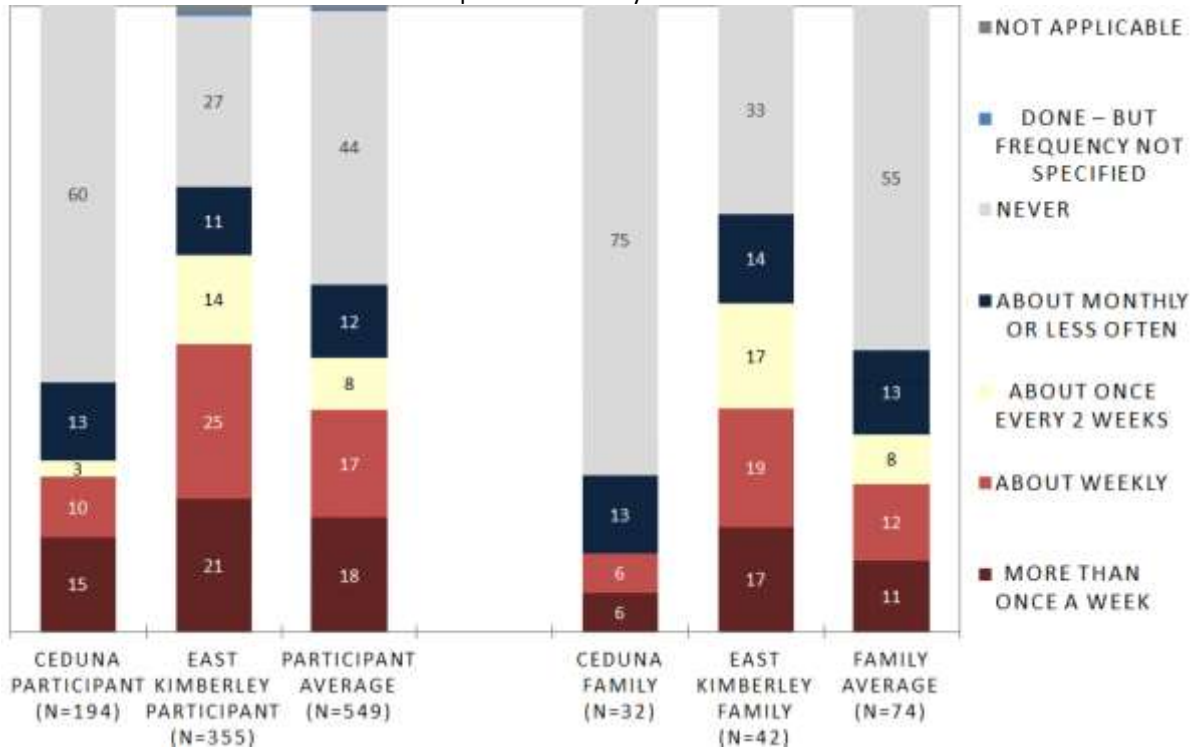
The following positive impacts of the CDCT on drug use were identified by the qualitative research:

- ◆ A couple of stakeholders had directly spoken with CDCT participants who had reduced and / or stopped their drug use as a result of the CDCT, including:
 - A CDCT participant who had previously been addicted to methamphetamines (“ice”) but had stopped using ice due to limited access to cash;
 - A family who was now consuming less marijuana due which had allowed them to spend more money on clothes and food for their child and were supportive / happy about the Trial as a result; and
- ◆ A few stakeholders felt that the frequency of marijuana usage had reduced due to limited access to cash.

Quantitative research with Participants, Families and Non-Participants

Figure 44: Behaviours done lately: Have grog (a drink containing alcohol)

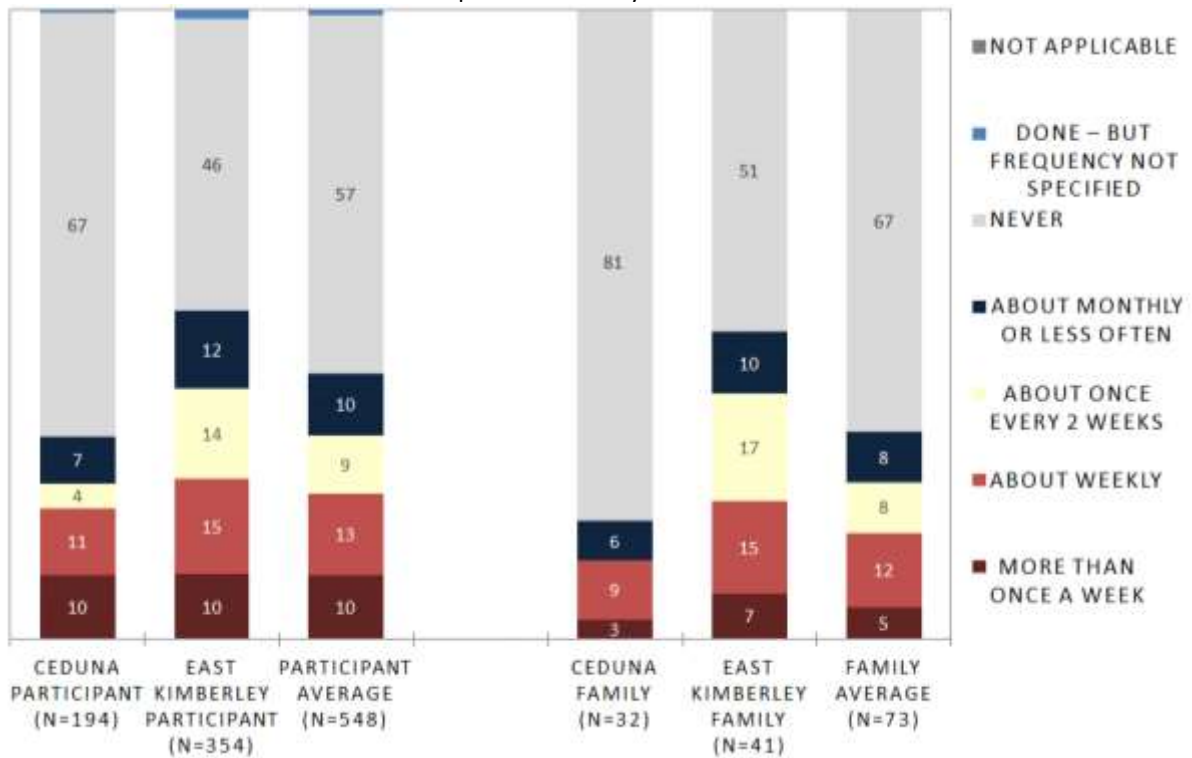
Base: Participants and Family. Excludes 'Refused'.



Q25a (P) / Q17a (F). Lately, have you done any of these things? Have grog (a drink containing alcohol).

Figure 45: Behaviours done lately: Have six or more drinks of grog / alcohol at one time

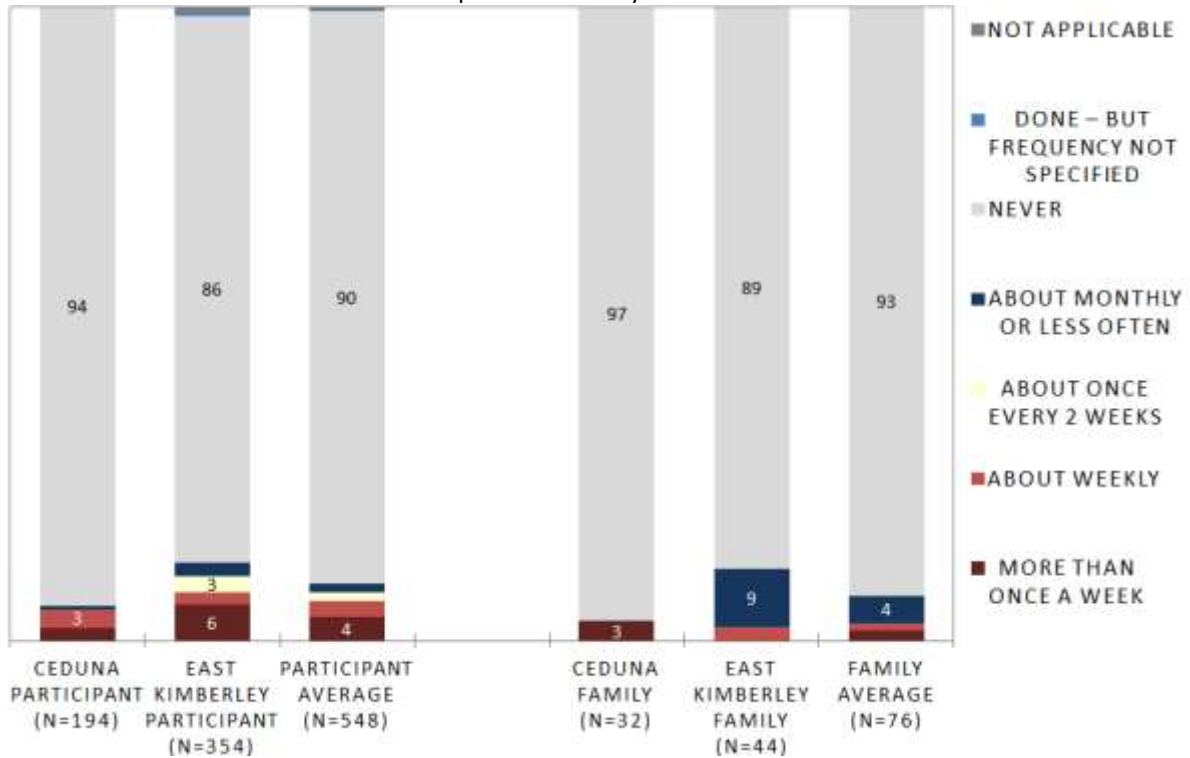
Base: Participants and Family. Excludes 'Refused'.



Q25b (P) / Q17b (F). Lately, have you done any of these things? Have six or more drinks of grog / alcohol at one time.

Figure 46: Behaviours done lately: Use an illegal or prescription drug for non-medical reasons.

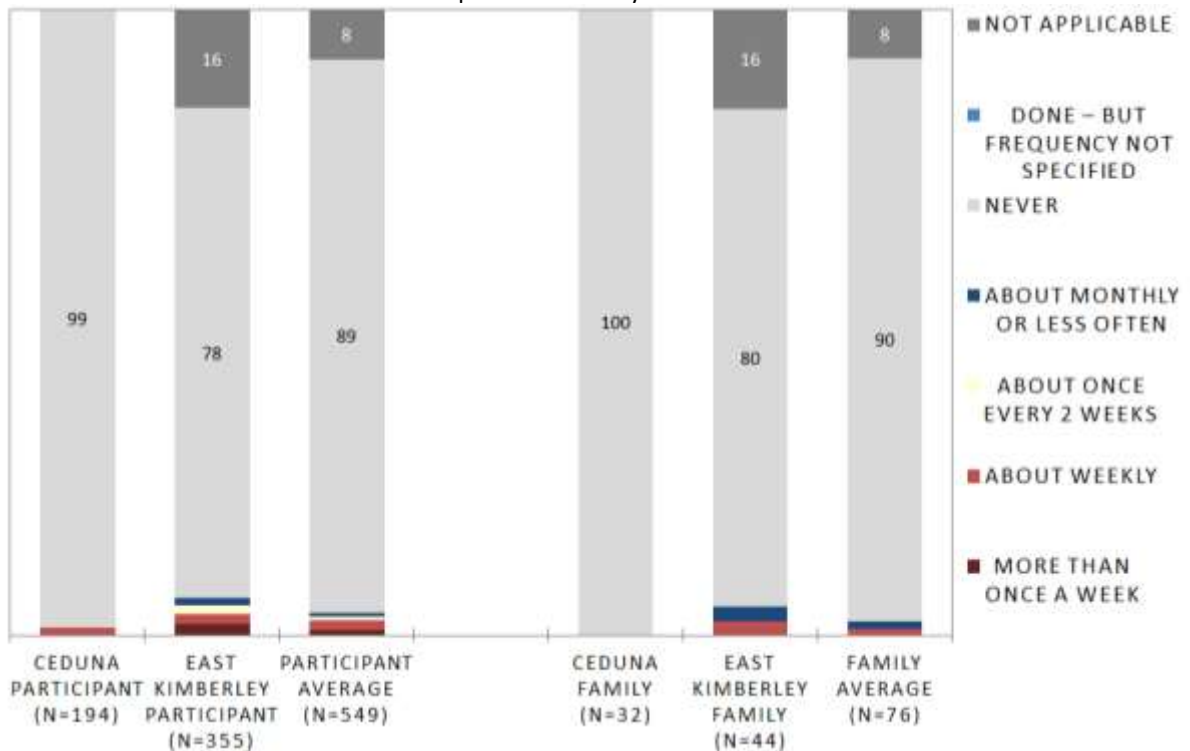
Base: Participants and Family. Excludes 'Refused'.



Q25h (P) / Q17h (F). Lately, have you done any of these things? Use an illegal drug or a prescription medication for nonmedical reasons.

Figure 47: Behaviours done lately: Spend more than \$50 a day on drugs not prescribed by a doctor.

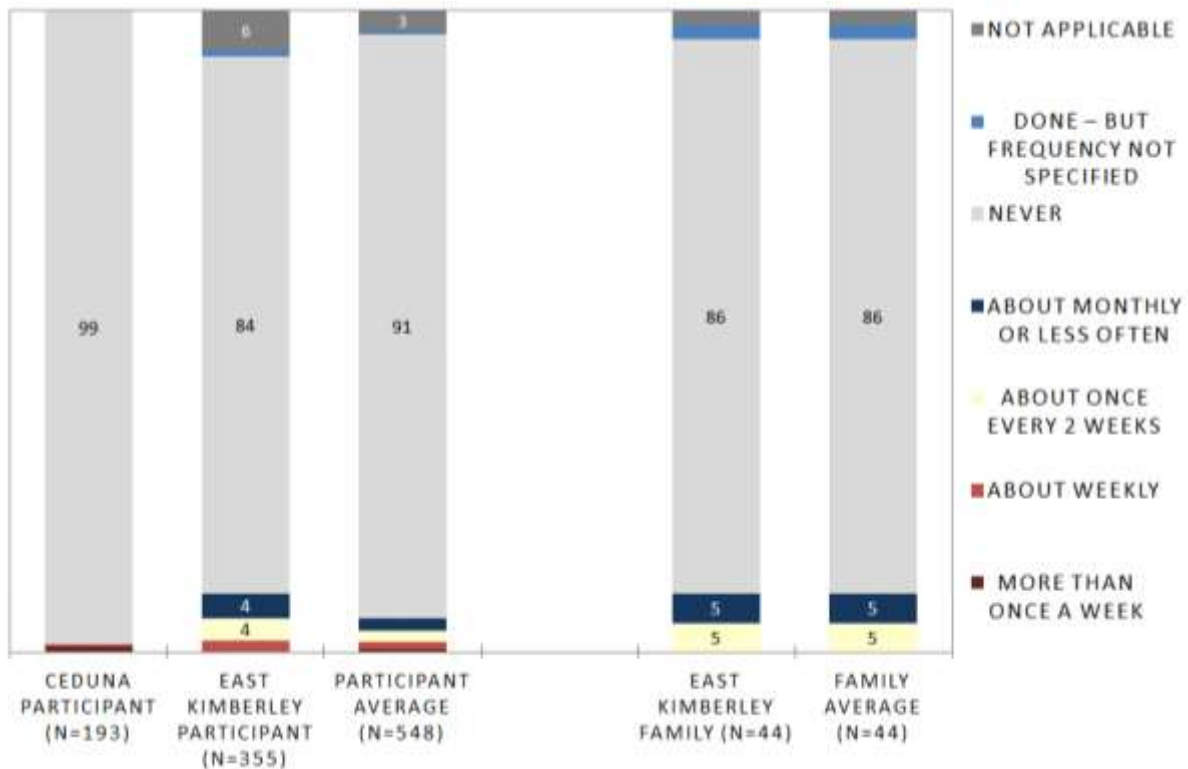
Base: Participants and Family. Excludes 'Refused'.



Q25i (P) / Q17i (F). Lately, have you done any of these things? Spend more than \$50 a day on drugs not prescribed by a doctor.

Figure 48: Behaviours done lately: Borrow money or sell things to buy alcohol/drugs.

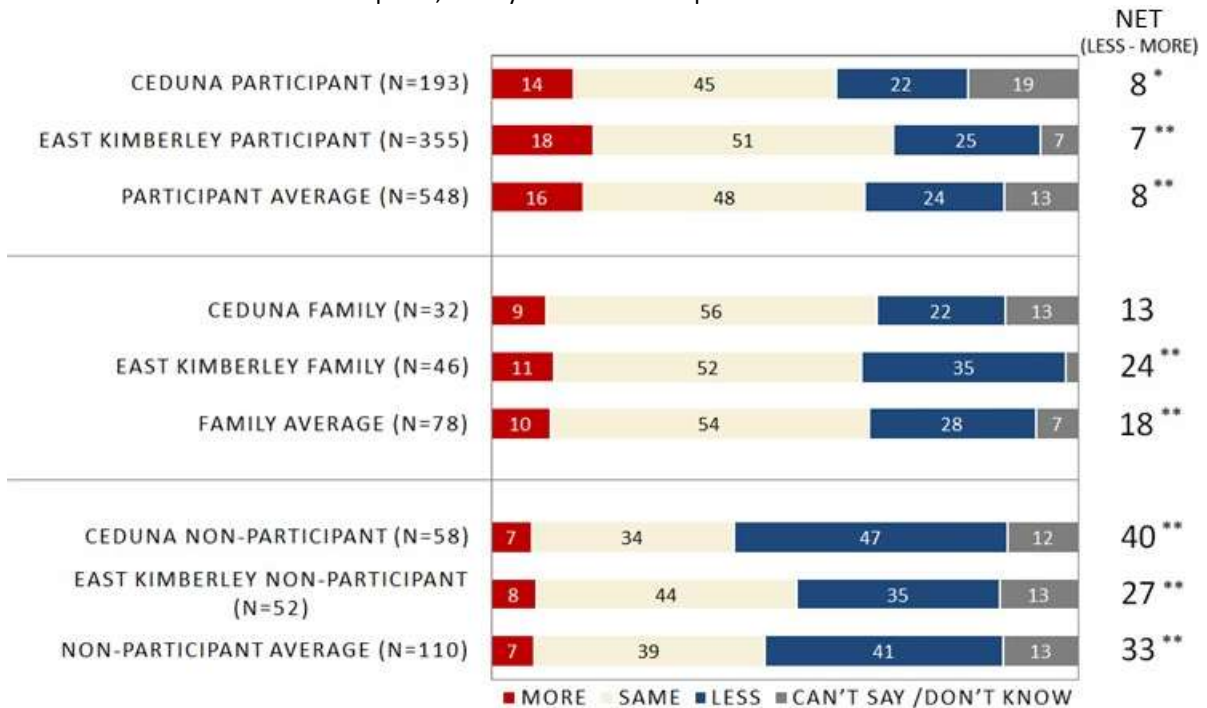
Base: Participants and Family. Excludes 'Refused'.



Q25j (P) / Q17j (F). Lately, have you done any of these things? Borrow money or sell things to get money to buy alcohol / drugs. *Question not asked of Ceduna Family respondents.

Figure 49: Noticed a change in drinking of alcohol or grog in the community since the Trial started

Base: Participants, Family and Non-Participants. Excludes 'Refused'.

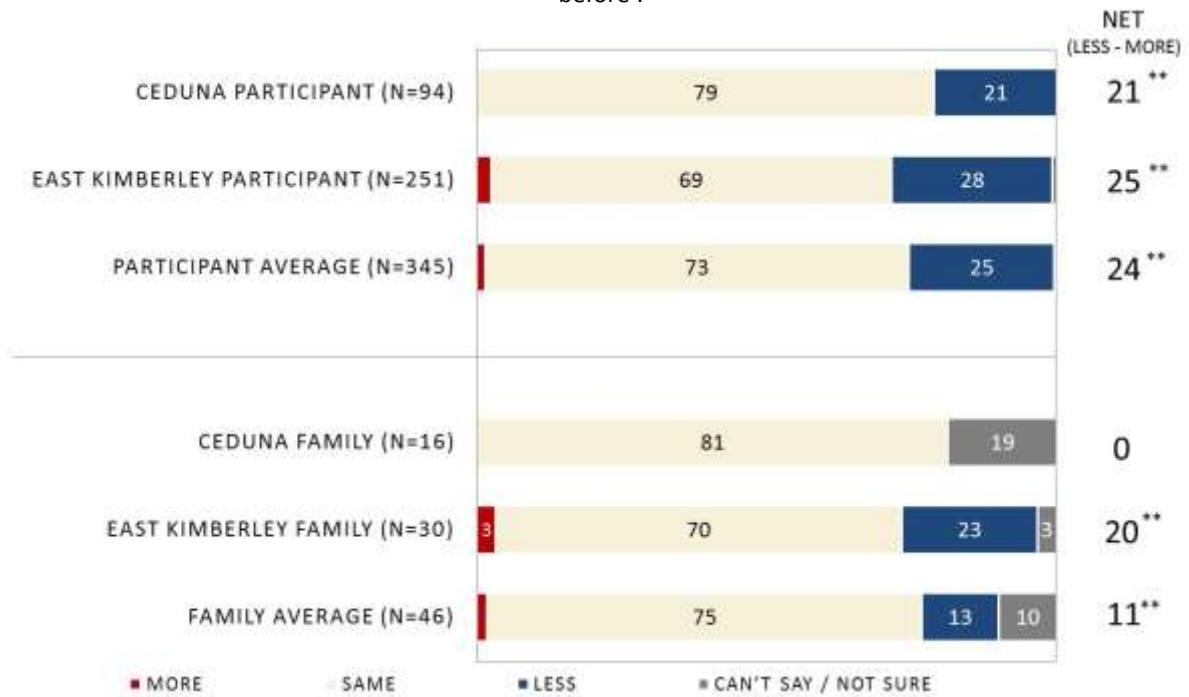


Q42a (P) / Q24a (F) / Q16a (NP). Since the Cashless Debit Card / Indue Card Trial started in your community have you noticed more, less or the same amount of: Drinking of alcohol or grog in the community?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 50: Change in behaviour since Trial started: Drunk grog or alcohol (% of respondents)

Base: Participants currently in Trial and Family. Excludes 'Refused' and 'Not applicable – did not do activity before'.

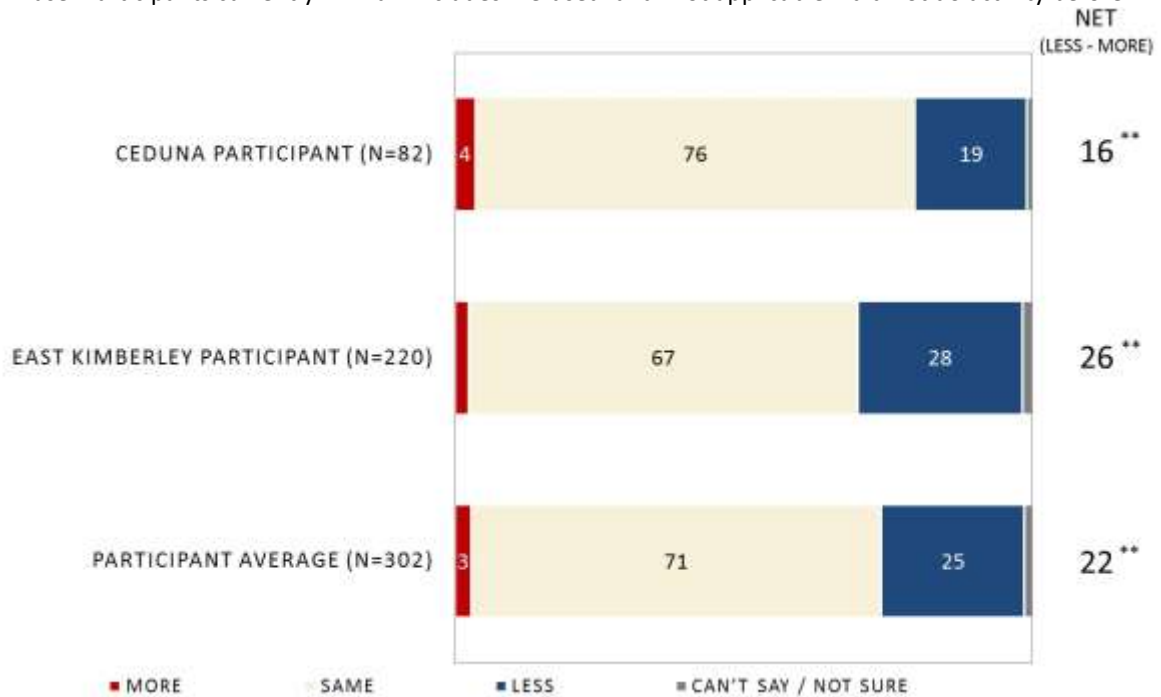


Q44a (P) / Q26a (F). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Drunk grog or alcohol?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 51: Change in behaviour since Trial started: Had six or more drinks of grog or alcohol at one time (% of respondents)

Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.

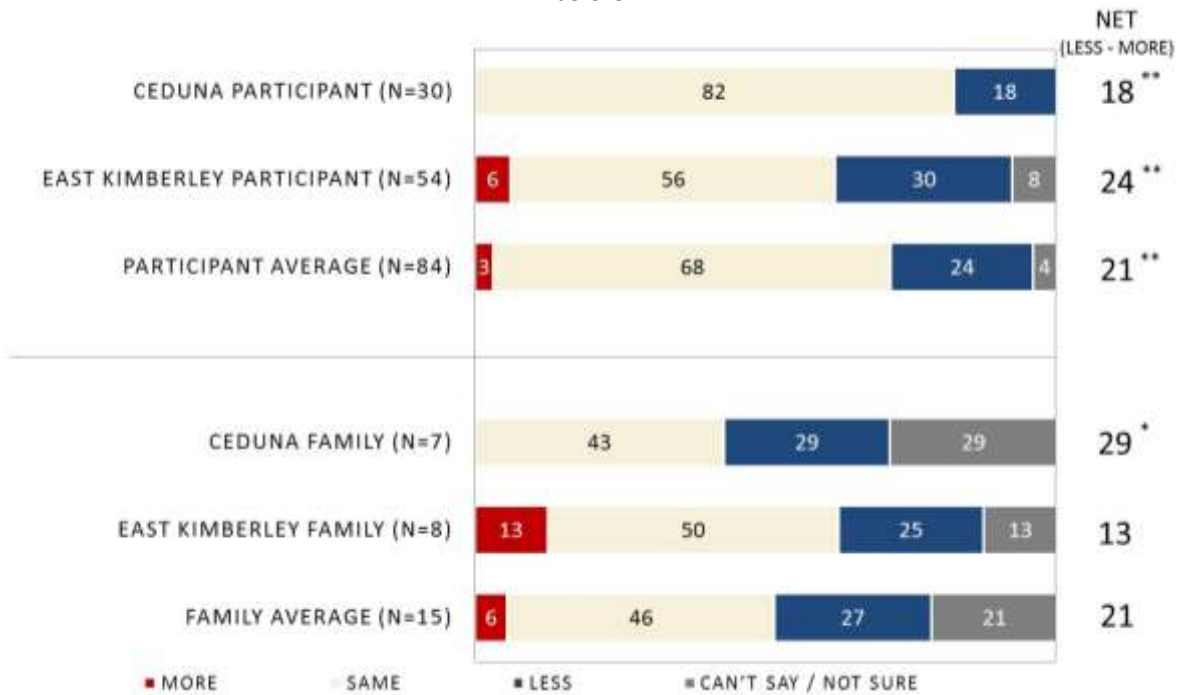


Q44b (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Had six or more drinks of grog or alcohol at one time?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 52: Change in behaviour since Trial started: Used an illegal drug (% of respondents)

Base: Participants currently in Trial and Family. Excludes 'Refused' and 'Not applicable – did not do activity before'.

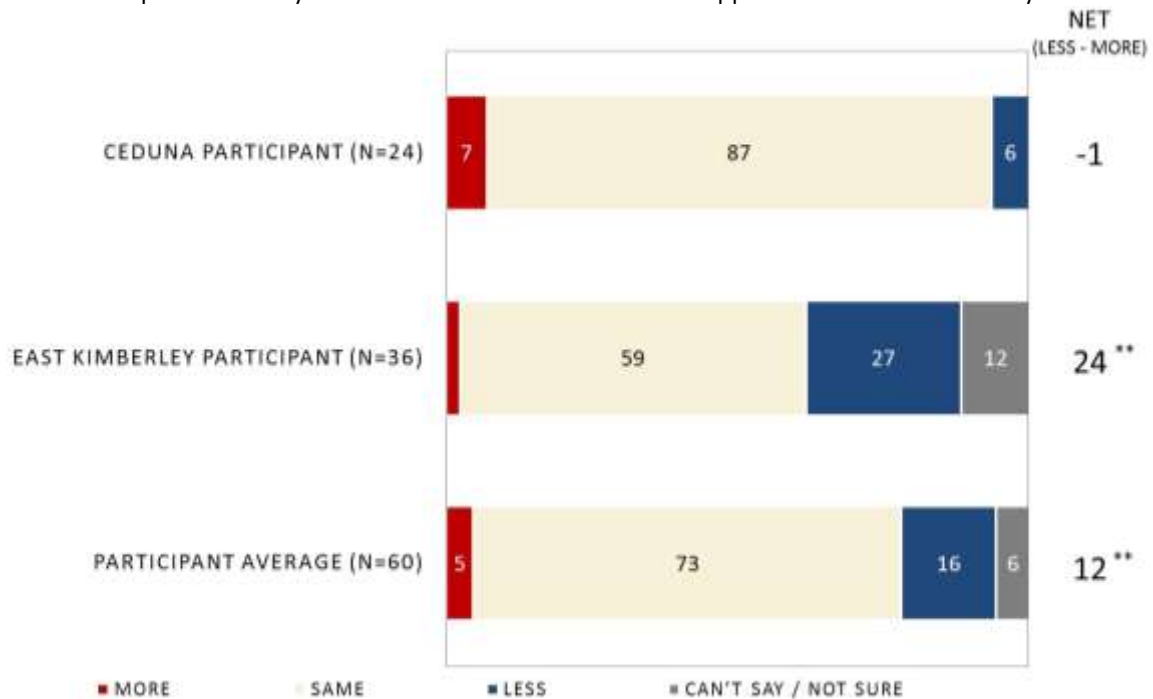


Q44g (P) / Q26c. Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Used an illegal drug like benzos, ice, marijuana or speed?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 53: Change in behaviour since Trial started: Spent more than \$50 a day on illegal drugs (% of respondents)

Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.



Q44h (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Spent more than \$50 a day on illegal drugs like benzos, ice, marijuana or speed?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

STO PI#2: Frequency of use / volume of gambling and associated problems

Figure 54: STO PI #2

Performance Indicator		Interim Rating
Frequency of use / volume of gambling and associated problems		Achieved
Theme	Details	
Specification	<ul style="list-style-type: none"> ◆ Number of times Trial participants engage in gambling activities per week ◆ Number of days a week spend three or more hours gambling ◆ Number of days a week spend more than \$50 gambling ◆ Percent of participants indicating that they gamble more than they can afford to lose or borrow money or sell things to gamble ◆ Percent of participants, family members and general community members reporting a decrease in gambling in the community since commencement of Trial ◆ Number of on-the-ground stakeholders reporting a decrease in gambling and associated problems in the community since commencement of Trial # ◆ EGM ('poker machine') revenue in Ceduna and Surrounds* 	
Target	NA, except # target = 'many' and * target = lower than before Trial	
Timeframe	As self-reported at Wave 1	
Data Sources	Survey of Trial participants Survey of families Survey of community members Qualitative research with stakeholders SA Poker Machine Revenue data	
Survey Questions	Participant questionnaire: q25c-g, q42c, q44c-f Family questionnaire: q17c-g, q24c, q26b Non-Participant questionnaire: q16c	
Definitions / Notes	On-the-ground stakeholders defined as members of the regional leadership groups and observers from government and non-government service providers based in the Trial areas For stakeholders, qualitative indication of number: all, most, many, some, few	

Administrative data on EGMs in SA showed a decline in EGM revenue in Ceduna and Surrounds from the previous year and all survey measures showed positive impacts on behaviours and perceptions. Consistent with these findings, stakeholders in Ceduna and Surrounds considered that

the CDCT has had a significant impact in relation to reducing the amount of time and money spent on EGMs. Stakeholders in East Kimberley generally felt that the CDCT had not had a significant impact on gambling, but were unsure about the impact on informal card playing (the main form of gambling).

Evidence

Ceduna – Qualitative research with stakeholders

Overall, stakeholders reported that CDCT had a significant impact on reducing the amount of money and time spent on formal gambling in Ceduna, particularly on Electronic Gaming Machines (EGMs).

The following positive impacts in relation to gambling were identified by the qualitative research:

- ◆ A significant positive impact on the CDCT in relation to gambling was noted in the reduction in use of EGMs, as evidenced by:
 - Fewer people seen in EGM venues – which was reported by some stakeholders and was observed by ORIMA researchers during the fieldwork period; and
 - A reported 15% reduction in gambling spend in the Eyre Peninsula region – as reported by the Gaming Authority. In addition, a couple of stakeholders reported that in Ceduna specifically, the reduction was 30%.

Many stakeholders reported there had been no change in the amount of informal card-playing and online gambling occurring in Ceduna. However, these stakeholders noted these forms of gambling were more difficult to report on as they usually occurred in private residences and were therefore less visible.

East Kimberley – Qualitative research with stakeholders

Overall, the CDCT was not felt to have had a significant impact on reducing the amount spent on gambling, although stakeholders found it difficult to comment on changes to card playing (the main form of gambling), as it was less visible.

The following positive impacts of the CDCT in relation to gambling were identified by the qualitative research:

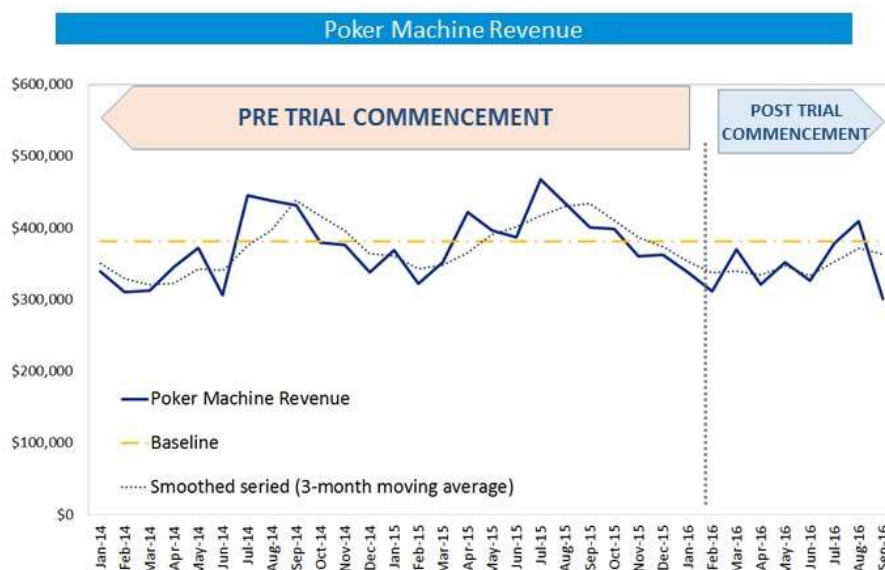
- ◆ A reduction in the number of people playing bingo in Wyndham – one stakeholder reported that the venue had such a reduction that they had almost been unable to obtain their licence for their regular bingo night;
- ◆ A couple of stakeholders reported that people they personally knew found it “too difficult” / “frustrating” to play cards due to limited access to cash;
- ◆ A reduction in card games in public places – identified by a couple of stakeholders; and
- ◆ A reduction in the amount of money being spent in card games – one stakeholder reported that one of his organisation’s staff members was previously spending “all of her money”

gambling and since the CDCT had been spending more money on food as she was unable to afford to continue gambling.

Evidence from External data sources

Figure 55: Gambling – SA Attorney General – EGM (Poker Machine) Revenue (LGAs of Ceduna, Streaky Bay, Le Hunte, Elliston and Lower Eyre Peninsula)

Ceduna



Key observations

- EGM revenue post Trial commencement was below that recorded in the same period in previous years (2015, 2014 and 2013). Revenue in April to August 2016 was 15% lower than that recorded in April to August 2015.
- The upward shift in revenue since June 2016 may be a seasonal increase, with similar increases having occurred in 2015, 2014 and 2013.

Notes and caveats

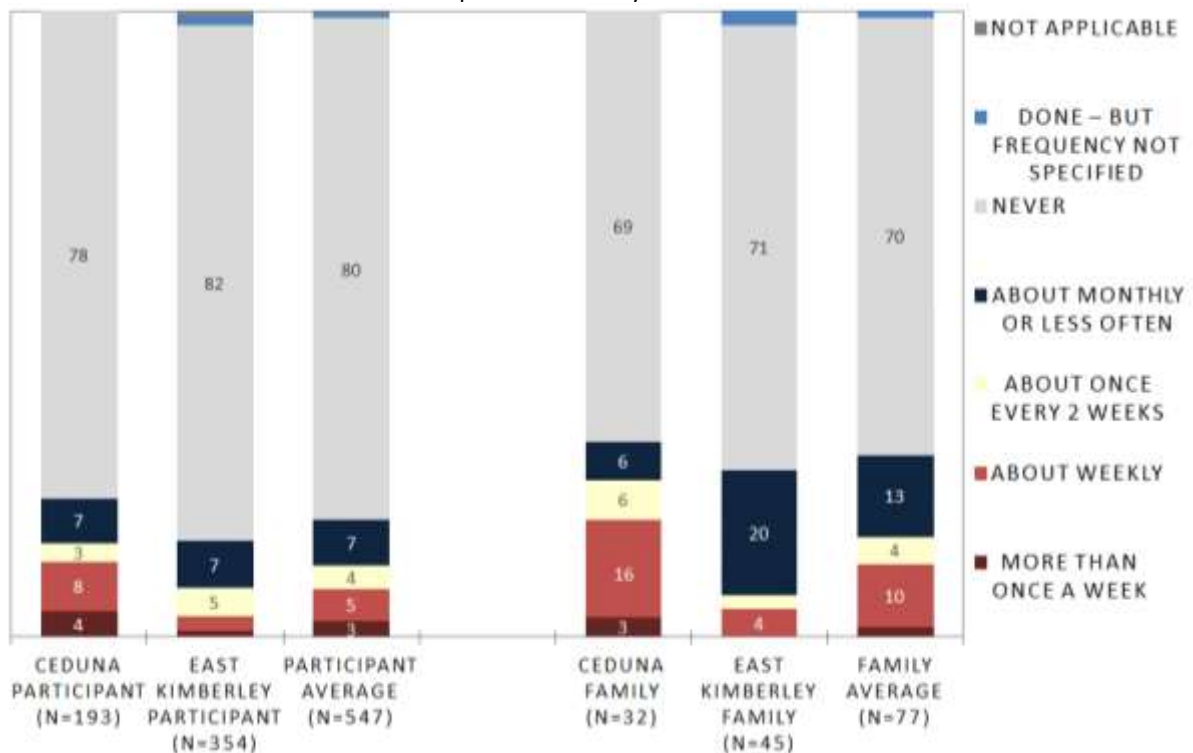
Data source: Department for Communities and Social Inclusion and Drug and Alcohol Services SA (DASSA) In absence of longer time-series data, Simple Moving Average (SMA) was used to smooth the volatility in the monthly data and provide an indication of any short-term trends. The analysis should be treated as indicative only – further data are needed to examine and appropriately account for any seasonal and other time-series effects, as well as potential effects of other factors (e.g. introduction of liquor restrictions in Aug 2015).

Baseline value = average value for the period Jul 13 to Feb 16.

**Data for 2013 not shown in the chart*

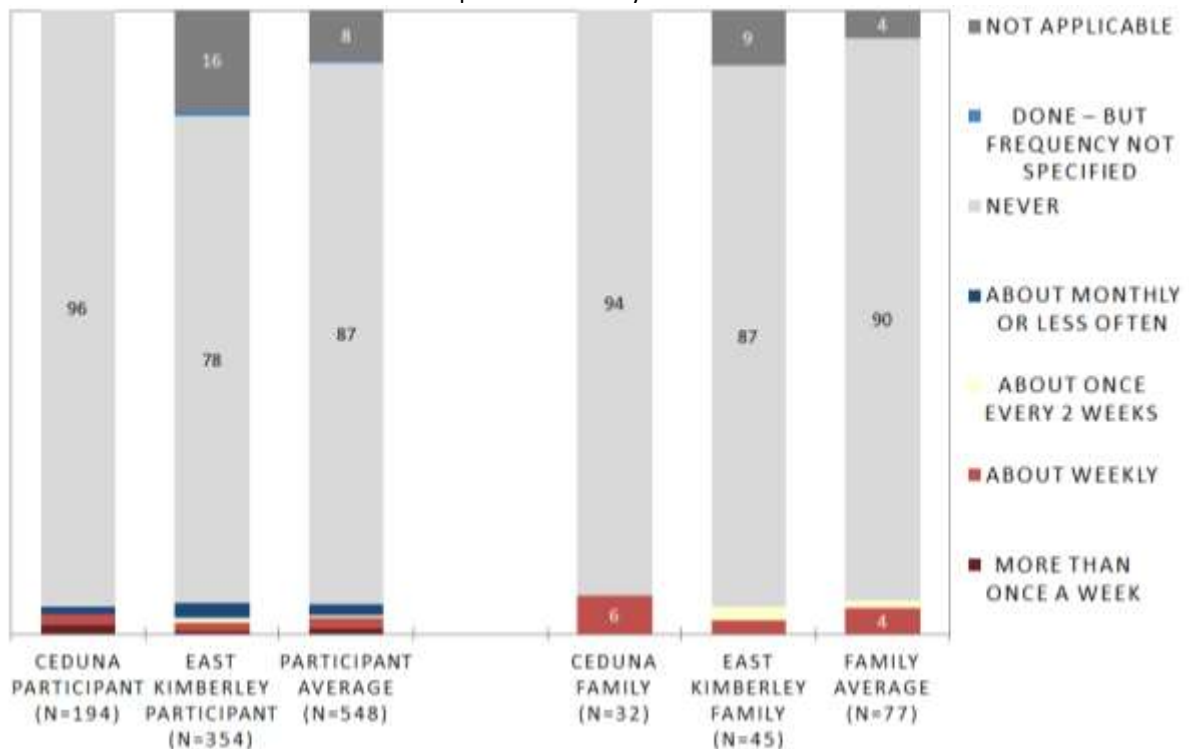
Quantitative research with Participants, Family and Non-Participants

Figure 56: Behaviours done lately: Gamble
 Base: Participants and Family. Excludes 'Refused'.



Q25c (P) / Q17c (F). Lately, have you done any of these things? Gamble.

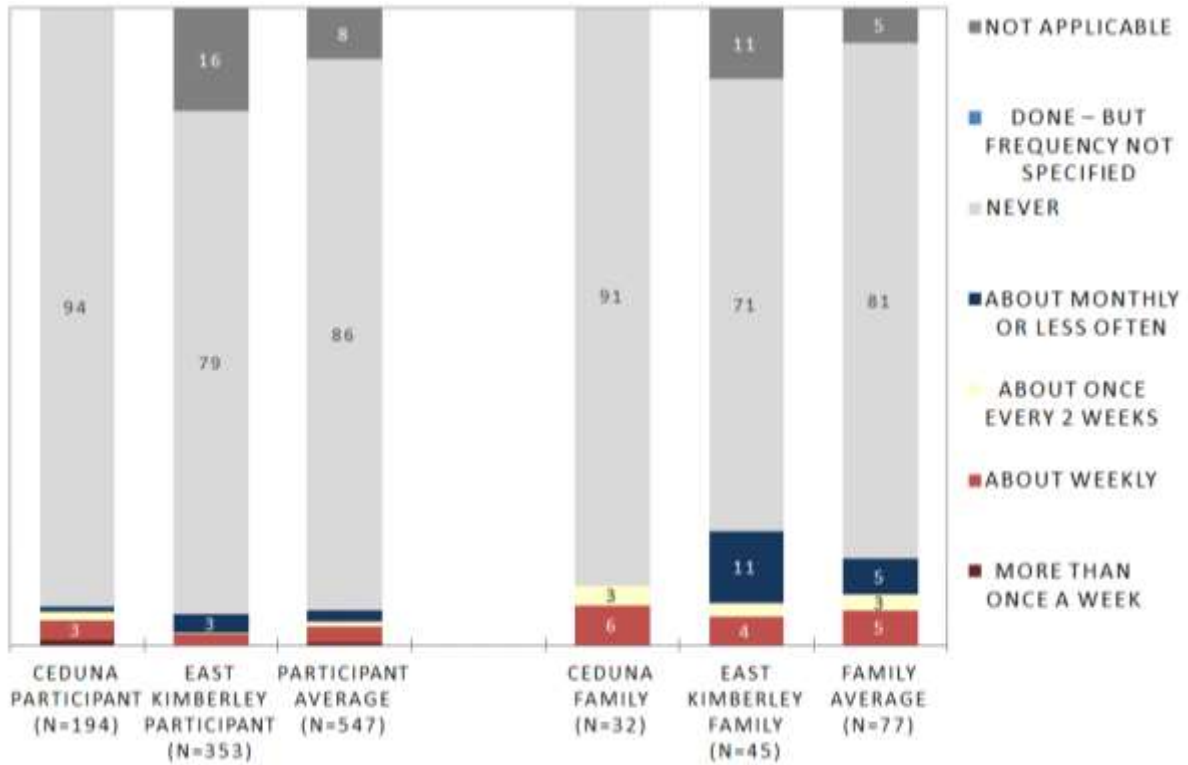
Figure 57: Behaviours done lately: Spend three or more hours a day gambling
 Base: Participants and Family. Excludes 'Refused'.



Q25d (P) / Q17d (F). Lately, have you done any of these things? Spend three or more hours a day gambling.

Figure 58: Behaviours done lately: Spend more than \$50 a day on gambling

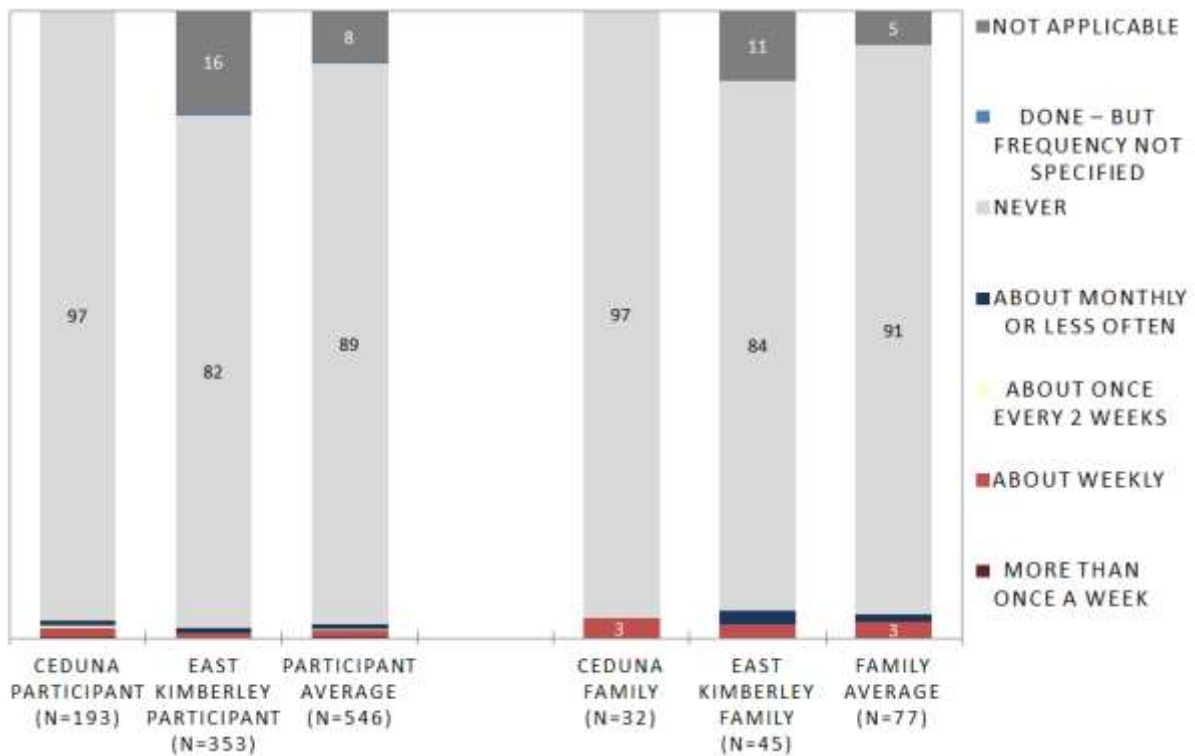
Base: Participants and Family. Excludes 'Refused'.



Q25e (P) / Q17e (F). Lately, have you done any of these things? Spend more than \$50 a day on gambling.

Figure 59: Behaviours done lately: Gamble more than you can afford to lose

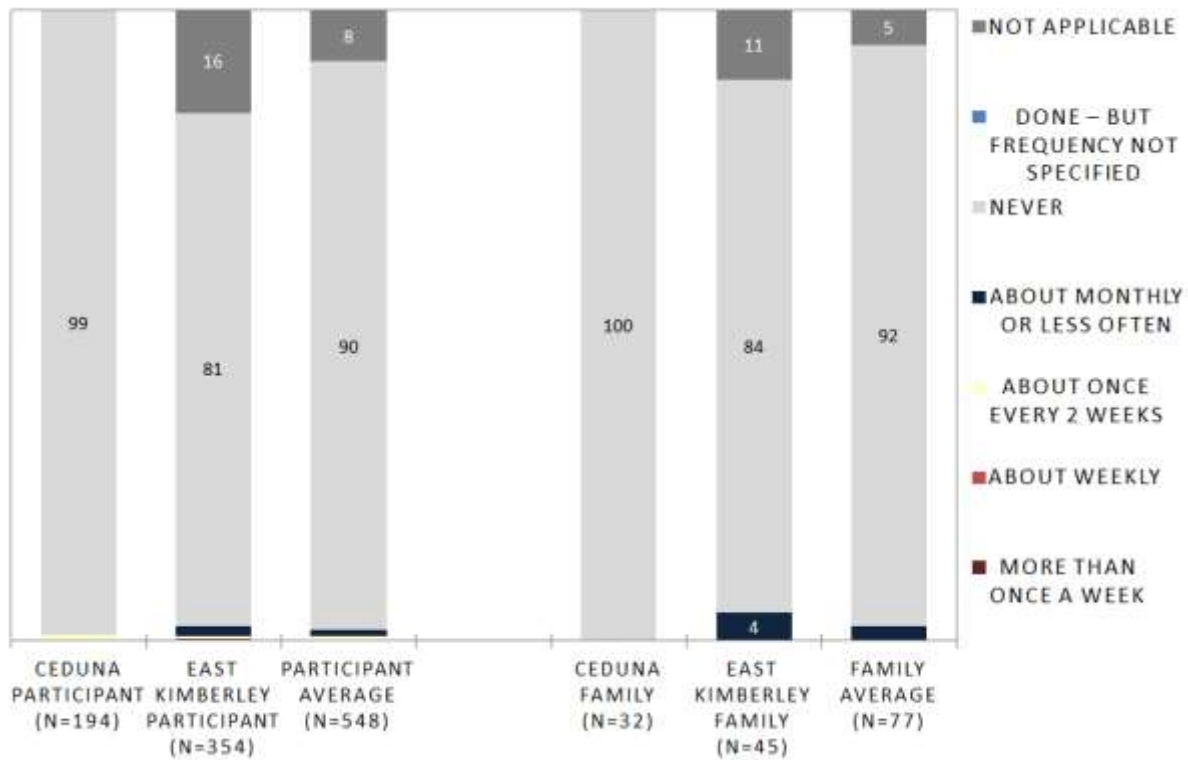
Base: Participants and Family. Excludes 'Refused'.



Q25f (P) / Q17f (F). Lately, have you done any of these things? Gamble more than you can afford to lose.

Figure 60: Behaviours done lately: Borrow money or sell things to get money to gamble

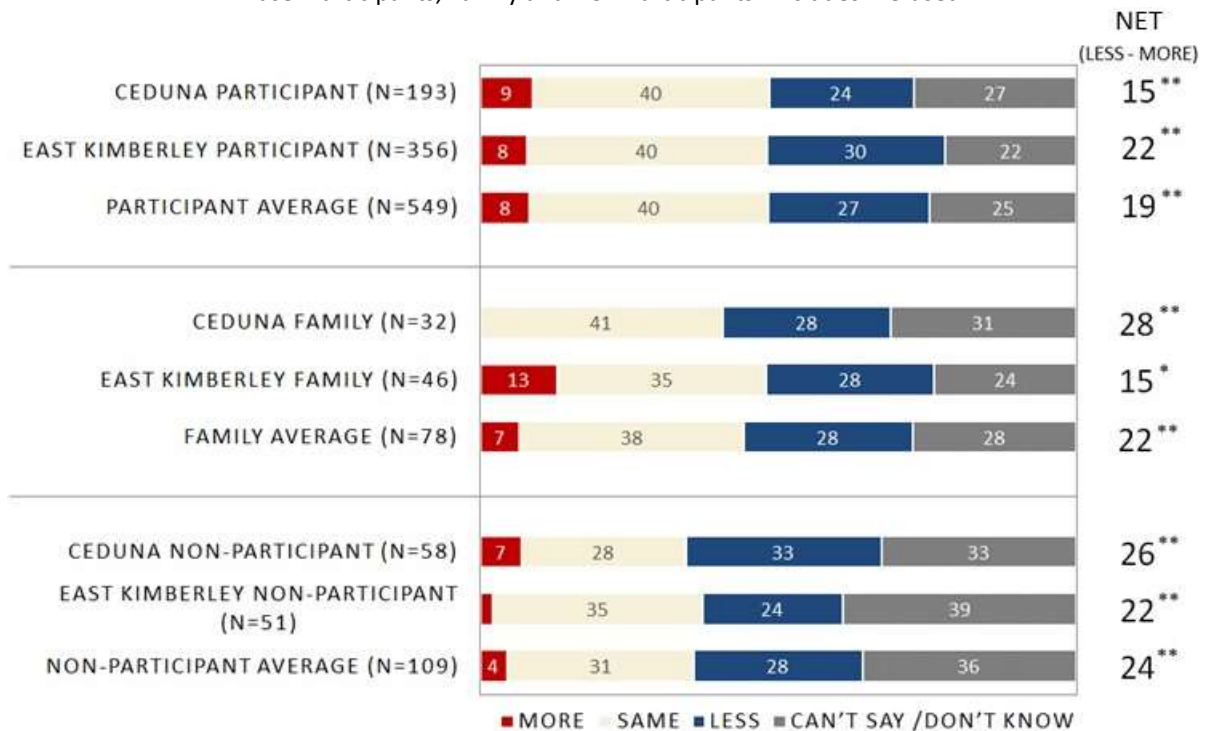
Base: Participants and Family. Excludes 'Refused'.



Q25g (P) / Q17g (F). Lately, have you done any of these things? Borrow money or sell things to get money to gamble.

Figure 61: Noticed a change in gambling in the community since the Trial started

Base: Participants, Family and Non-Participants. Excludes 'Refused'.

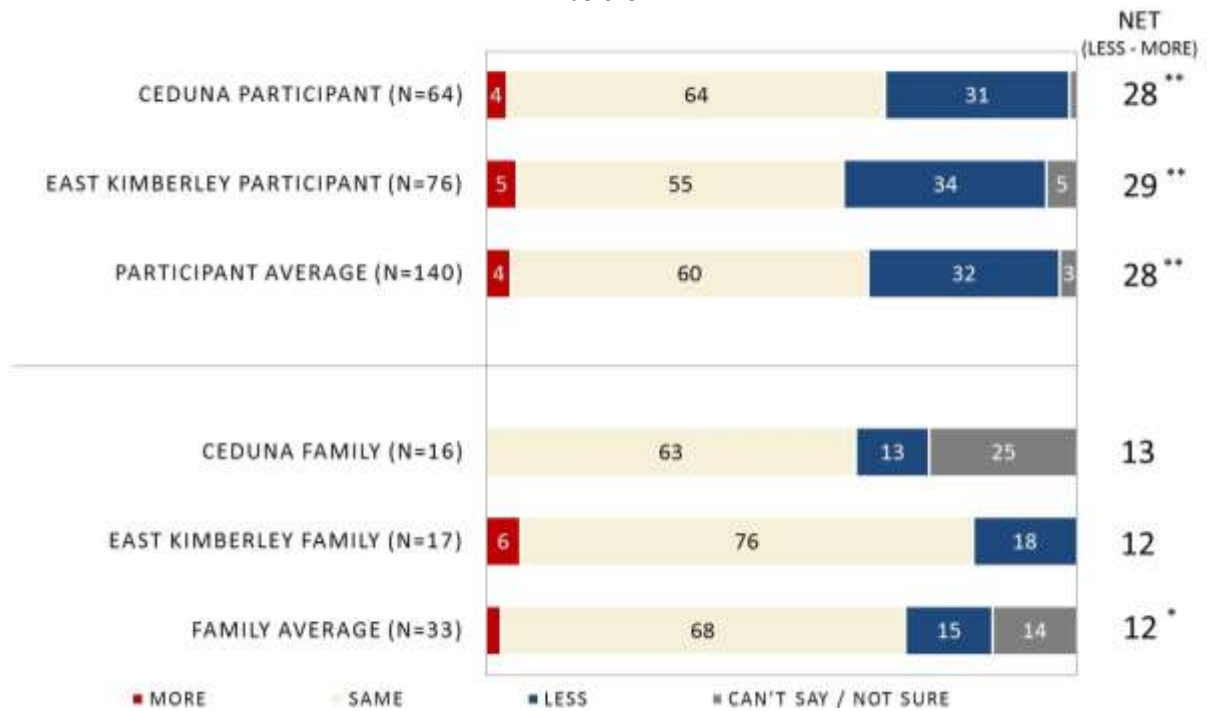


Q42c (P) / Q24c (F) / Q16c. Since the Cashless Debit Card / Indue Card Trial started in your community have you noticed more, less or the same amount of: Gambling in the community?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 62: Change in behaviour since Trial started: Gambled (% of respondents)

Base: Participants currently in Trial and Family. Excludes 'Refused' and 'Not applicable – did not do activity before'.

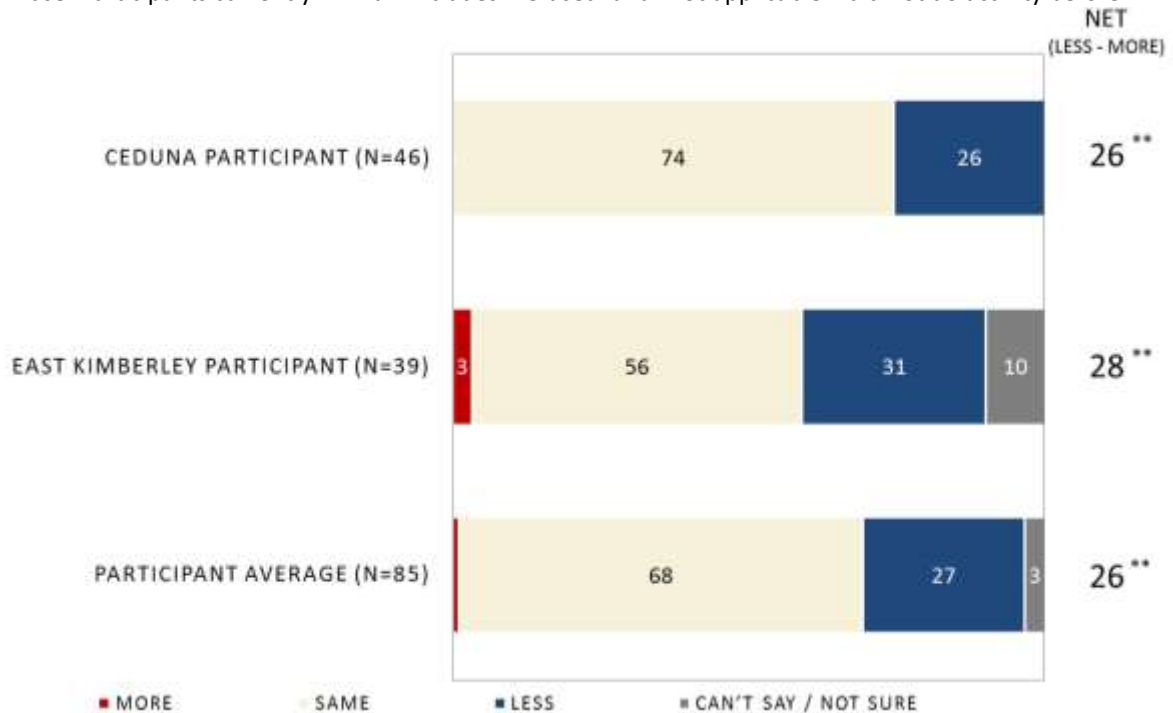


Q44c (P) / Q26b (F). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Gambled?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 63: Change in behaviour since Trial started: Spent more than \$50 a day on gambling (% of respondents)

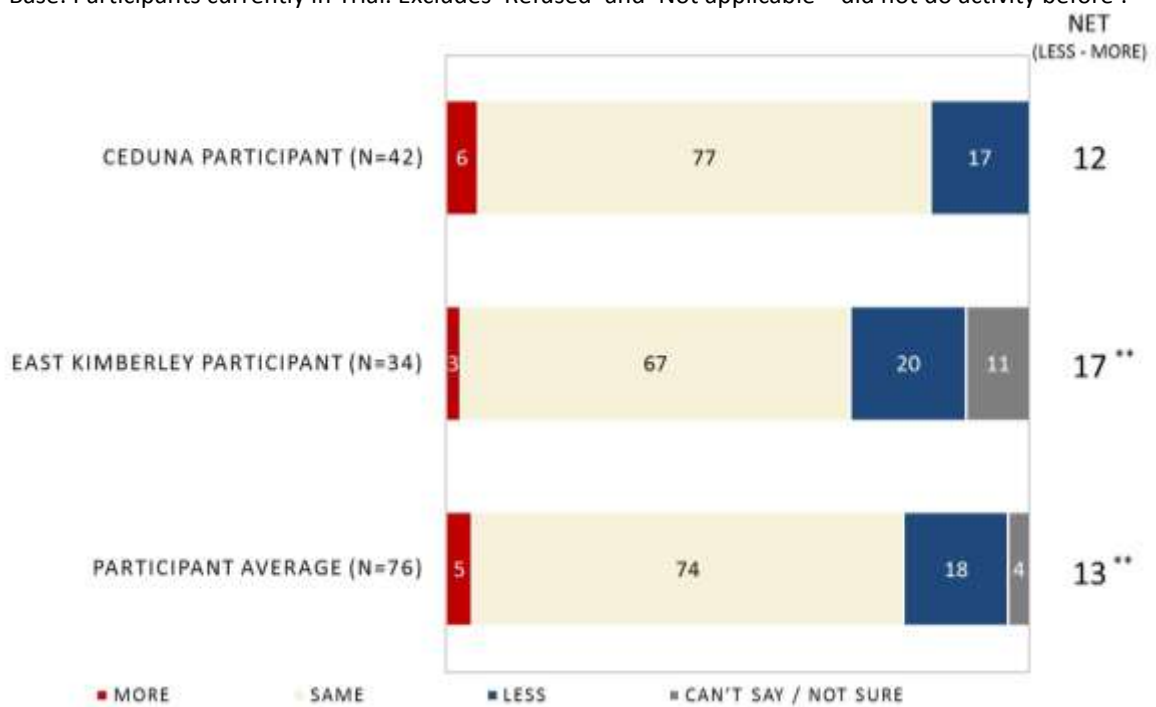
Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.



Q44d (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Spent more than \$50 a day on gambling? **Significantly different to zero at the 95% level

Figure 64: Change in behaviour since Trial started: Bet more than you can really afford to lose (% of respondents)

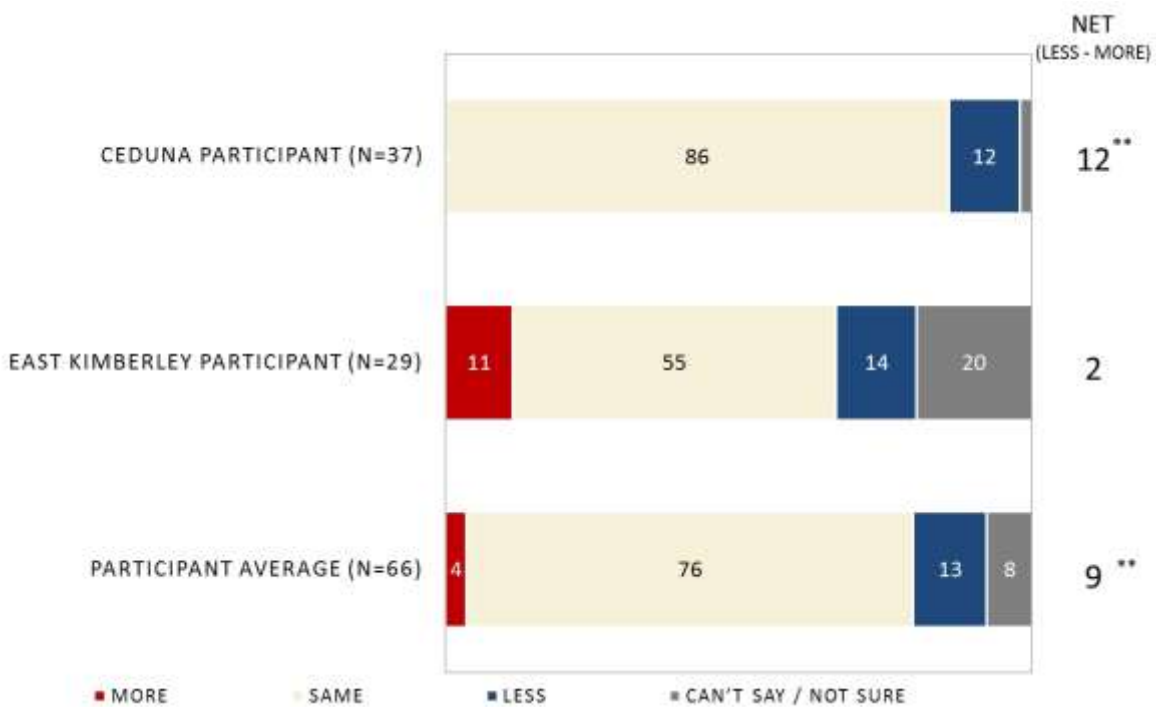
Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.



Q44e (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Bet more than you can really afford to lose? **Significantly different to zero at the 95% level

Figure 65: Change in behaviour since Trial started: Had to borrow money or sell things to gamble (% of respondents)

Base: Participants currently in Trial. Excludes 'Refused' and 'Not applicable – did not do activity before'.



Q44f (P). Since being on the Cashless Debit / Indue Card have you done each of the following more often, less often or the same as before: Had to borrow money or sell things to get money to gamble? **Significantly different to zero at the 95% level

STO PI#3: Percent aware of drug & alcohol support services

Figure 66: STO PI #3

Performance Indicator		Interim Rating
Percent aware of drug & alcohol support services		Partial
Theme	Details	
Specification	Percent participants who are aware of drug and alcohol support services available in their community	
Target	NA	
Timeframe	As self-reported at Wave 1	
Data Sources	Survey of Trial participants	
Survey Questions	q32a	
Definitions / Notes	Services list will be provided by DSS / DHS.	

Awareness of local drug and alcohol support services among CDCT participants ranged from 40% in Ceduna and Surrounds to 56% in East Kimberley. Awareness was higher among those who reported using illegal drugs or using prescription drugs for non-medical reasons (68%³⁵ and 65%, respectively) and those who reported that they drank alcohol (48% and 57%).

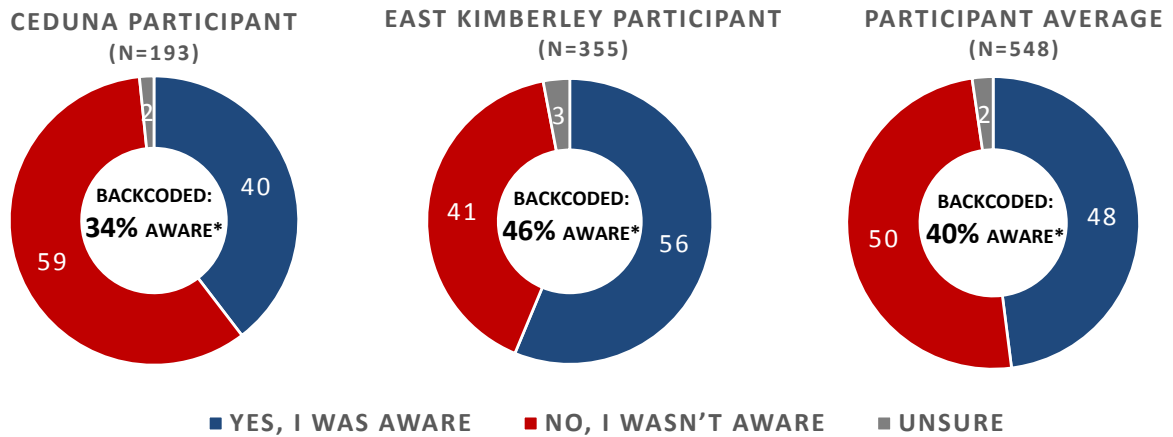
³⁵ This figure should be interpreted with caution due to the low base of respondents n=8

Evidence

Quantitative research with Participants

Figure 67: Self-reported and back-coded awareness of drug and alcohol support services in local area before survey

Base: Participants. Excludes 'Refused'.



Q32a (P). Before this survey were you aware of any drug and alcohol support services in your local area?
 *Post survey, results were back-coded to represent those who said they were aware, and could accurately name a service. Those who could not were recoded as unaware.

STO PI#4: Percent aware of financial & family support services

Figure 68: STO PI #4

Performance Indicator		Interim Rating
Percent aware of financial & family support services		Partial
Theme	Details	
Specification	Percent participants who are aware of financial and family support services available in their community	
Target	NA	
Timeframe	As self-reported at Wave 1	
Data Sources	Survey of Trial participants	
Survey Questions	q37a	
Definitions / Notes	Services list will be provided by DSS / DHS.	

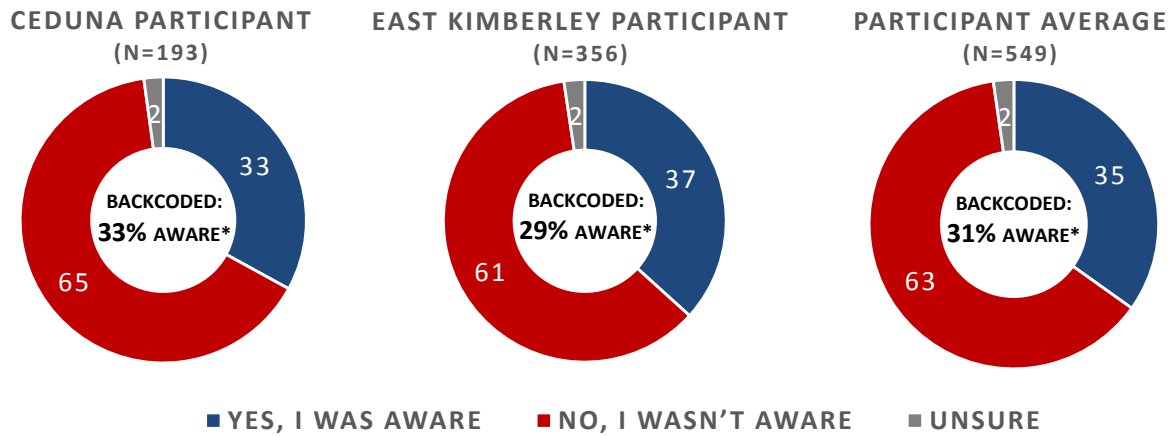
Awareness of local financial and family support services among CDCT participants was lower, with 33% of those in Ceduna and Surrounds and 37% of those in East Kimberley reporting awareness. Awareness of financial support services was similar among those who reported that they had experienced financial difficulties in the past 3 months (32% and 33% respectively).

Evidence

Quantitative research with Participants

Figure 69: Self-reported and back-coded awareness of financial and family support services in local area before survey

Base: Participants. Excludes 'Refused'.



Q37a (P). Before this survey were you aware of any financial and family support services in your local area?
 *Post survey, results were back-coded to represent those who said they were aware, and could accurately name a service. Those who could not were recoded as unaware.

STO PI#5: Usage of drug & alcohol support services

Figure 70: STO PI #5

Performance Indicator		Interim Rating
Usage of drug & alcohol support services		Partial
Theme	Details	
Specification	<ul style="list-style-type: none"> ◆ Percent of participants who have ever used drug and alcohol support services ◆ Number of times services used per participant ◆ Intention to / likelihood of using service in future 	
	<ul style="list-style-type: none"> ◆ Number of people in community using services 	
Target	Above points 1-3: Higher at Wave 2 than at Wave 1 (statistically significant) Above point 4: Higher than before Trial	
Timeframe	Above points 1-3: As self-reported at Wave 1 Above point 4: Trial period compared with 12 months prior to Trial launch	
Data Sources	Above points 1-3: Survey of Trial participants Above point 4: Department of Social Services (based on data from service providers and State Government agencies)	
Survey Questions	q33-34, q36	
Definitions / Notes	NA	

On average across the two Trial sites, 15% of CDCT participants reported having ever used a drug or alcohol support service. Nearly half of these had done so within the last three months. Seven percent of Ceduna and Surrounds participants and 17% of East Kimberley participants indicated an intention to use these services in future.

Evidence

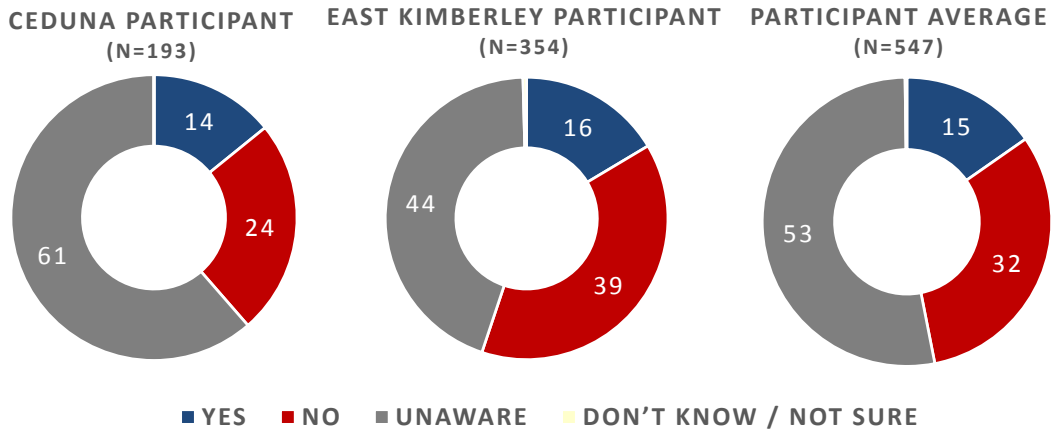
Evidence from external data sources

The Department agreed that due to unverified data, it was not advisable to include service usage statistics in this Wave 1 Interim Evaluation Report. Supporting evidence is outlined in STO PI#1.

Quantitative research with Participants

Figure 71: Self-reported usage of local or other alcohol or drug support services

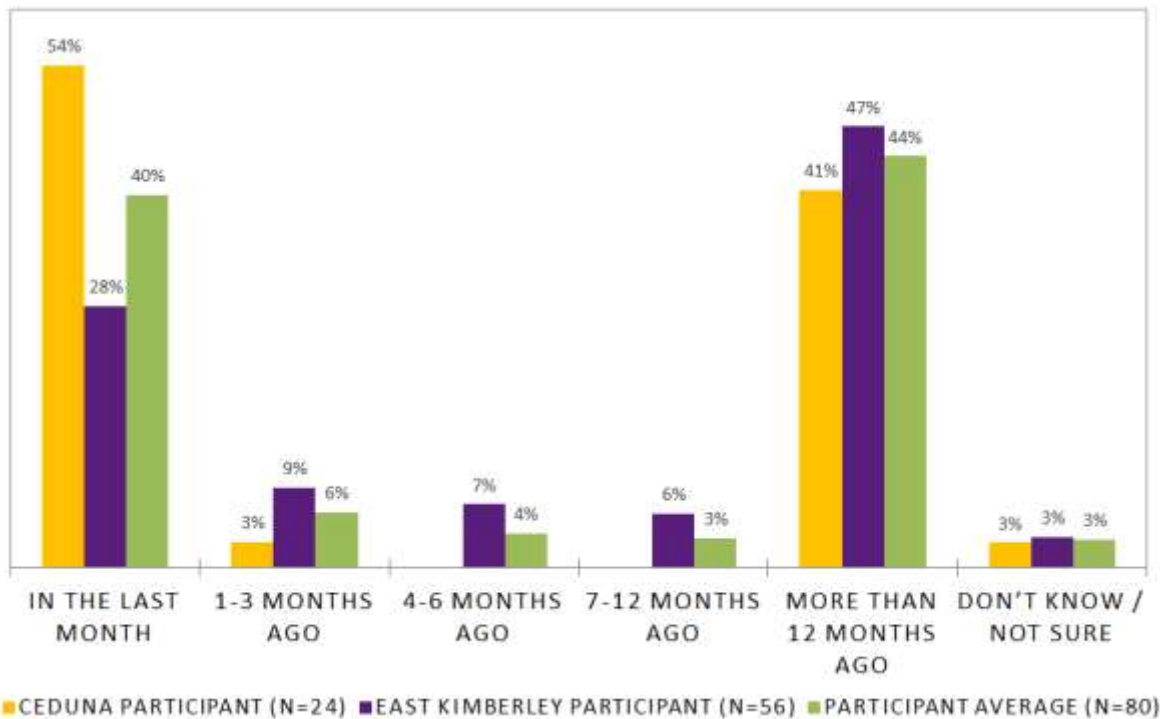
Base: Participants. Excludes 'Refused'.



Q33 (P). Have you ever used these local services or other services that help people to deal with problems related to alcohol or drug use?

Figure 72: Last time got help from an alcohol or drug support service

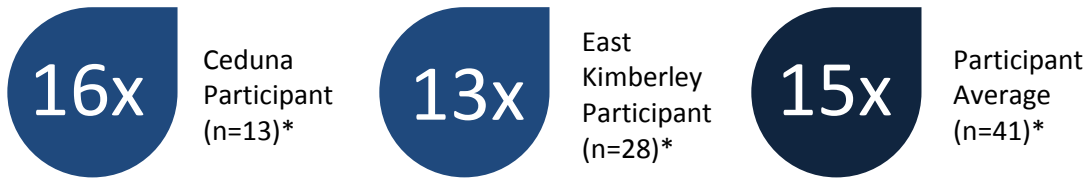
Base: Participants who have ever used alcohol or drug services at q33 (self-reported).



Q34 (P). When was the last time that you got help from an alcohol or drug support service?

Figure 73: Average number of times got help from an alcohol or drug support service

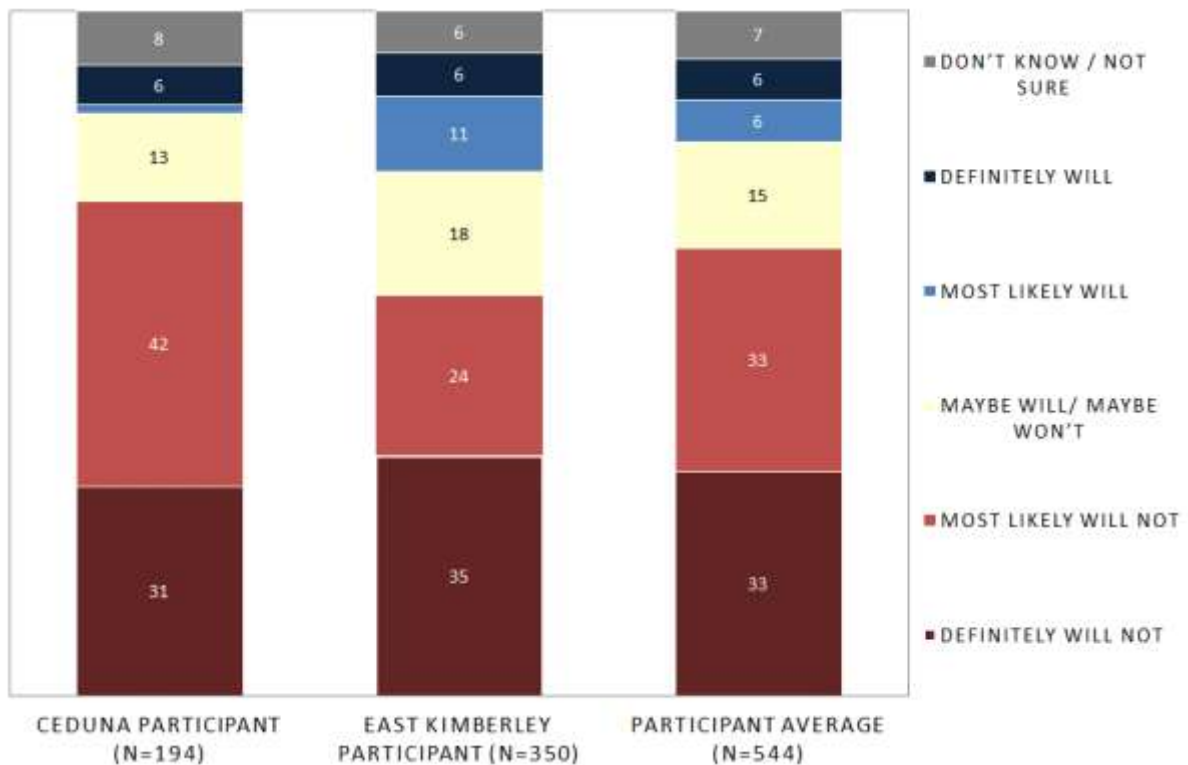
Base: Participants who have used an alcohol or drug support service in the past 12 months. Excludes 'Refused'.



Q35 (P). How many times did you get help from an alcohol or drug support service in the past year? *Note low n

Figure 74: Likelihood of trying to get help from an alcohol or drug support service in future

Base: Participants. Excludes 'Refused'.



Q36 (P). How likely is it that you will try and get help from an alcohol or drug support service in the future?

STO PI#6: Usage of financial & family support services

Figure 75: STO PI #6

Performance Indicator		Interim Rating
Usage of financial & family support services		Partial
Theme	Details	
Specification	◆ Percent of participants who have ever used financial or family support services	
	◆ Number of times services used per participant	
	◆ Intention to / likelihood of using service in future	
	◆ Number of people in community using services	
Target	Above points 1-3: Higher at Wave 2 than at Wave 1 (statistically significant)	
	Above point 4: Higher than before Trial	
Timeframe	Above points 1-3: As self-reported at Wave 1	
	Above point 4: Trial period compared with 12 months prior to Trial launch	
Data Sources	Above points 1-3: Survey of Trial participants	
	Above point 4: Department of Social Services (based on data from service providers and State Government agencies)	
Survey Questions	q38-39, q41	
Definitions / Notes	NA	

In each Trial site, 17% of interviewed CDCT participants reported having ever used a financial or family support service. A greater proportion of these had done so in the last 12 months compared to for drug and alcohol services, but a similar proportion (about half) had done so in the last three months. Stated intention to use these services in future was slightly higher.

Evidence

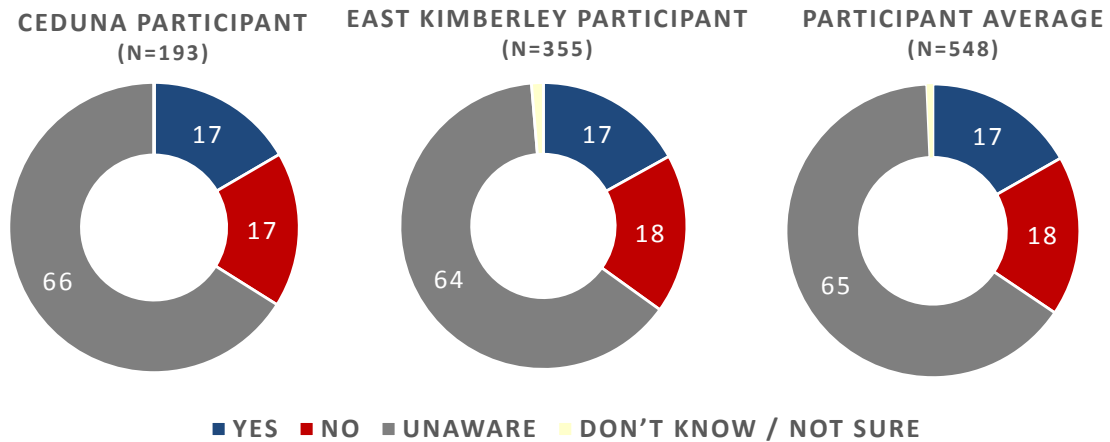
Evidence from external data sources

The Department agreed that due to incomplete and unverified data, it was not advisable to include service usage statistics in this Wave 1 Interim Evaluation Report. Supporting evidence is outlined in STO PI#1.

Quantitative research with Participants

Figure 76: Self-reported and back-coded usage of financial and family support services in local area

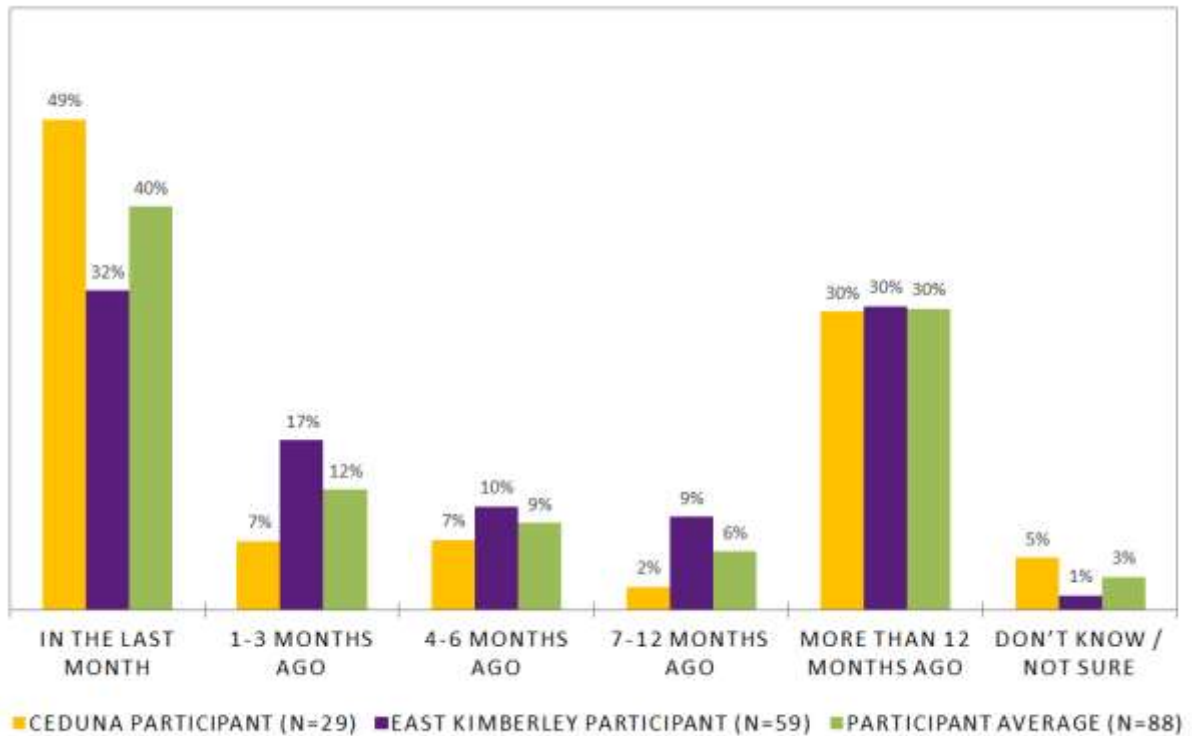
Base: Participants. Excludes 'Refused'.



Q38 (P). Have you ever used these local services or other services that help people deal with financial or family problems?

Figure 77: Last time got help from a financial or family support service

Base: Participants who have ever used financial or family services at q38 (self-reported).



Q39 (P). When was the last time that you got help from a financial or family support service?

Figure 78: Average number of times got help from financial or family support service

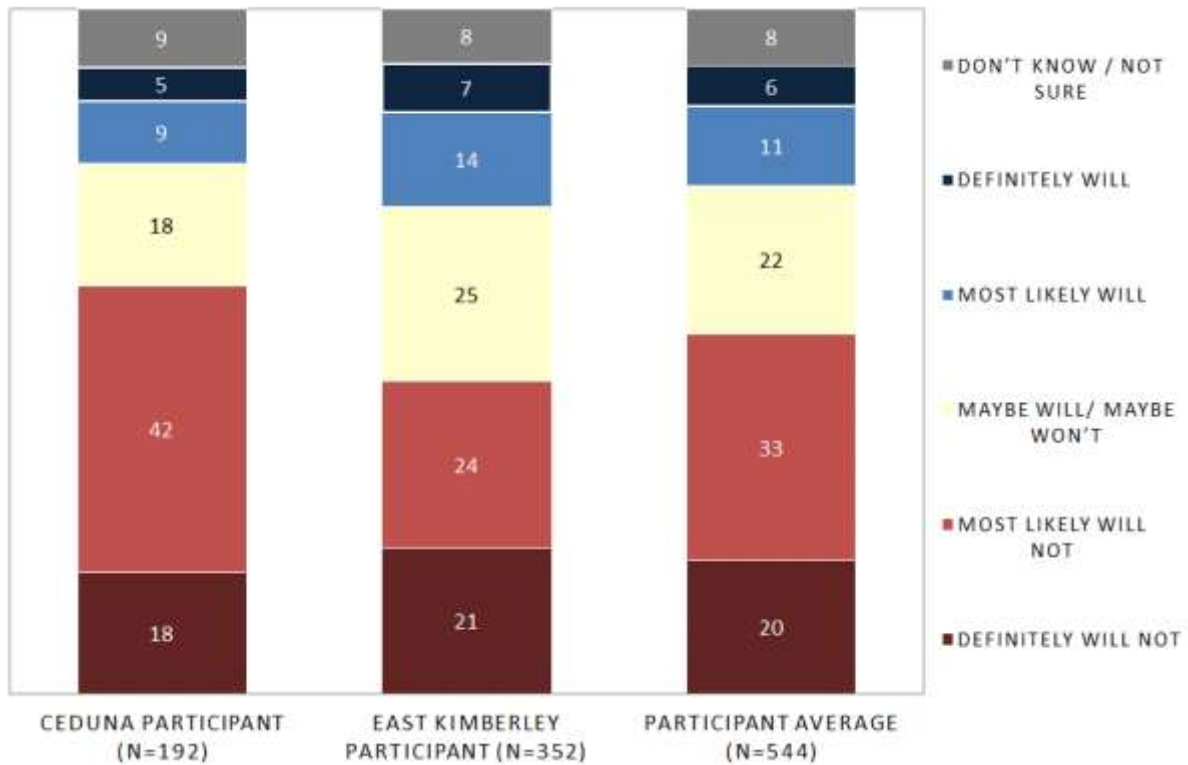
Base: Participants who have used an alcohol or drug support service in the past 12 months. Excludes 'Refused'.



Q40 (P). How many times did you get help from financial or family support service in the past year? *Note low n

Figure 79: Likelihood of trying to get help from a financial or family support service in future

Base: Participants aware of when they last used financial or family services at q39. Excludes 'Refused'.



Q41 (P). How likely is it that you will try and get help from a financial or family support service in the future?

3. Medium-Term Outcome Performance Indicators

MTO PI#1: Frequency of use / volume consumed of drugs and alcohol

Figure 80: MTO PI #1

Performance Indicator	Interim Rating
Frequency of use / volume consumed of drugs and alcohol	Not relevant at interim point
Theme	Details
Specification	<ul style="list-style-type: none"> ◆ Number of times alcohol consumed by participants per week ◆ Percent of participants who say they have used non-prescription drugs in the last week ◆ Number of times per week spend more than \$50 a day on drugs not prescribed by a doctor ◆ Number of times per week have six or more drinks of alcohol at one time (binge drinking) ◆ Percent of participants, family members and general community members reporting a decrease in drinking of alcohol in the community since commencement of Trial ◆ Number of on-the-ground stakeholders reporting a decrease in drinking of alcohol in the community since commencement of Trial
Target	Frequency / volume not higher at Wave 2 than at Wave 1
Timeframe	As self-reported at Wave 2
Data Sources	Survey of Trial participants Survey of families Survey of community members Qualitative research with stakeholders
Survey Questions	Participant questionnaire: q25a-b/h-j, q42a Family questionnaire: q17a-b/h-j, q24a Non-Participant questionnaire: q16a
Definitions / Notes	NA

Evidence

The quantitative measures from STO#1: Frequency of use / volume consumed of drugs and alcohol will be reported here at Wave 2.

MTO PI#2: Frequency of use / volume of gambling and associated problems

Figure 81: MTO PI #2

Performance Indicator	Interim Rating
Frequency of use / volume of gambling and associated problems	Not relevant at interim point
Theme	Details
Specification	<ul style="list-style-type: none"> ◆ Number of times Trial participants engage in gambling activities per week ◆ Number of days a week spend three or more hours gambling ◆ Number of days a week spend more than \$50 gambling ◆ Percent of participants indicating that they gamble more than they can afford to lose or borrow money or sell things to gamble ◆ Percent of participants, family members and general community members reporting a decrease in gambling in the community since commencement of Trial ◆ Number of on-the-ground stakeholders reporting a decrease in gambling and associated problems in the community since commencement of Trial ◆ EGM ('poker machine') revenue in Ceduna and Surrounds
Target	Frequency / volume not higher at Wave 2 than at Wave 1
Timeframe	As self-reported at Wave 2
Data Sources	Survey of Trial participants Survey of families Survey of community members Qualitative research with stakeholders SA Poker Machine Revenue data
Survey Questions	Participant questionnaire: q25c-g, q42c, q44c-f Family questionnaire: q17c-g, q24c, q26b Non-Participant questionnaire: q16c
Definitions / Notes	NA

Evidence

The quantitative measures from STO#2: Frequency of use / volume of gambling and associated problems will be reported here at Wave 2.

SA Poker Machine Revenue data supporting this performance indicator is outlined earlier, in STO PI#2.

MTO PI#3: Incidence of violent & other types of crime and violent behaviour

Figure 82: MTO PI #3

Performance Indicator	Interim Rating
Incidence of violent & other types of crime and violent behaviour	Not relevant at interim point
Theme	Details
Specification	<ul style="list-style-type: none"> ◆ Police reports of assault and burglary offences; drink driving/drug driving; domestic violence incidence reports; drunk and disorderly conduct; outstanding driving and vehicle fines. ◆ Percent of participants, family members and the general community who report being the victim of crime in the past month ◆ Percent of participants, family members and the general community who report a decrease in violence in the community since commencement of Trial ◆ Number of on-the-ground stakeholders reporting a decrease in violence in the community since commencement of Trial
Target	Lower than before Trial
Timeframe	Above point 1: Trial period compared with 12 months prior to Trial launch Above points 2-4: As self-reported at Wave 1 and Wave 2
Data Sources	Above point 1: SA and WA Police Above points 2-4: Surveys of Trial participants, families and community members; and Qualitative research with stakeholders
Survey Questions	Participant questionnaire: q29b,d-e, q42b Family questionnaire: q21b,d-e, q24b Non-Participant questionnaire: q13a, q13c-d, q16b
Definitions / Notes	On-the-ground stakeholders defined as members of the regional leadership groups and observers from government and non-government service providers based in the Trial areas For stakeholders, qualitative indication of number: all, most, many, some, few

As a medium-term outcome this performance indicator is not evaluated at this interim stage. Evidence related to this topic suggests there are few early signs of movement.

Evidence

Ceduna – Qualitative research with stakeholders

At the Initial Conditions reporting stage, many stakeholder participants had expected that there would be a significant increase in petty crime and domestic violence at the start of the Trial. In Wave 1, these participants reported that this had not eventuated, and as such were “relieved”.

Overall, there was no significant positive change noted in relation to crime, violence and harm. However, a few stakeholders identified some increase in domestic violence / intervention orders – although it was not clear whether this was due to changes in reporting requirements or increased community awareness, understanding and willingness to take action, or to the CDCT.

A couple of store owners reported that there had been an increase in thefts from their stores, including:

- ◆ Shoplifting, including by intoxicated adults; and / or
- ◆ Children stealing items (e.g. lollies, hair dye, etc.).

In addition, a few stakeholders reported an increase in the following illegal / harmful behaviours, however it was not clear whether such behaviours were related / attributable to the CDCT:

- ◆ A few stakeholders reported they had heard about an increase in break-ins in Ceduna where laptops, jewellery and cash had been stolen;
 - However, Police reported that they had not seen an increase in crime committed by CDCT participants on the ground and that the recent incidents that they had dealt with had been committed by juveniles and people from outside the Trial area.
- ◆ A few stakeholders from remote communities reported hearing about break-ins in their community (i.e. outside Ceduna) but thought that these crimes were committed by people from out of town (i.e. not local) visiting for funerals and other events;
- ◆ A couple of stakeholders reported that arguments were increasing between community members. Specifically, community members who received less money through payments such as Newstart were reported to be asking others who received larger payments (e.g. Disability Support Pension or Parenting Payments) for cash; and
- ◆ One service provider stakeholder reported that there had been five cases of prostitution among their clients from remote communities outside of Ceduna. However, this occurrence was not mentioned by other stakeholders.

East Kimberley – Qualitative research with stakeholders

At the Initial Conditions reporting stage, many stakeholder participants had expected that there would be a significant increase in petty crime amongst CDCT participants at the start of the Trial. While an increase of such crime was not evident among CDCT participants, it was commonly reported by stakeholders to be occurring among children as a result of reduced access to cash.

Overall, there was no significant positive change noted in relation to crime, violence and harm among CDCT participants. However, a couple of positive changes were noticed / reported by stakeholders, including:

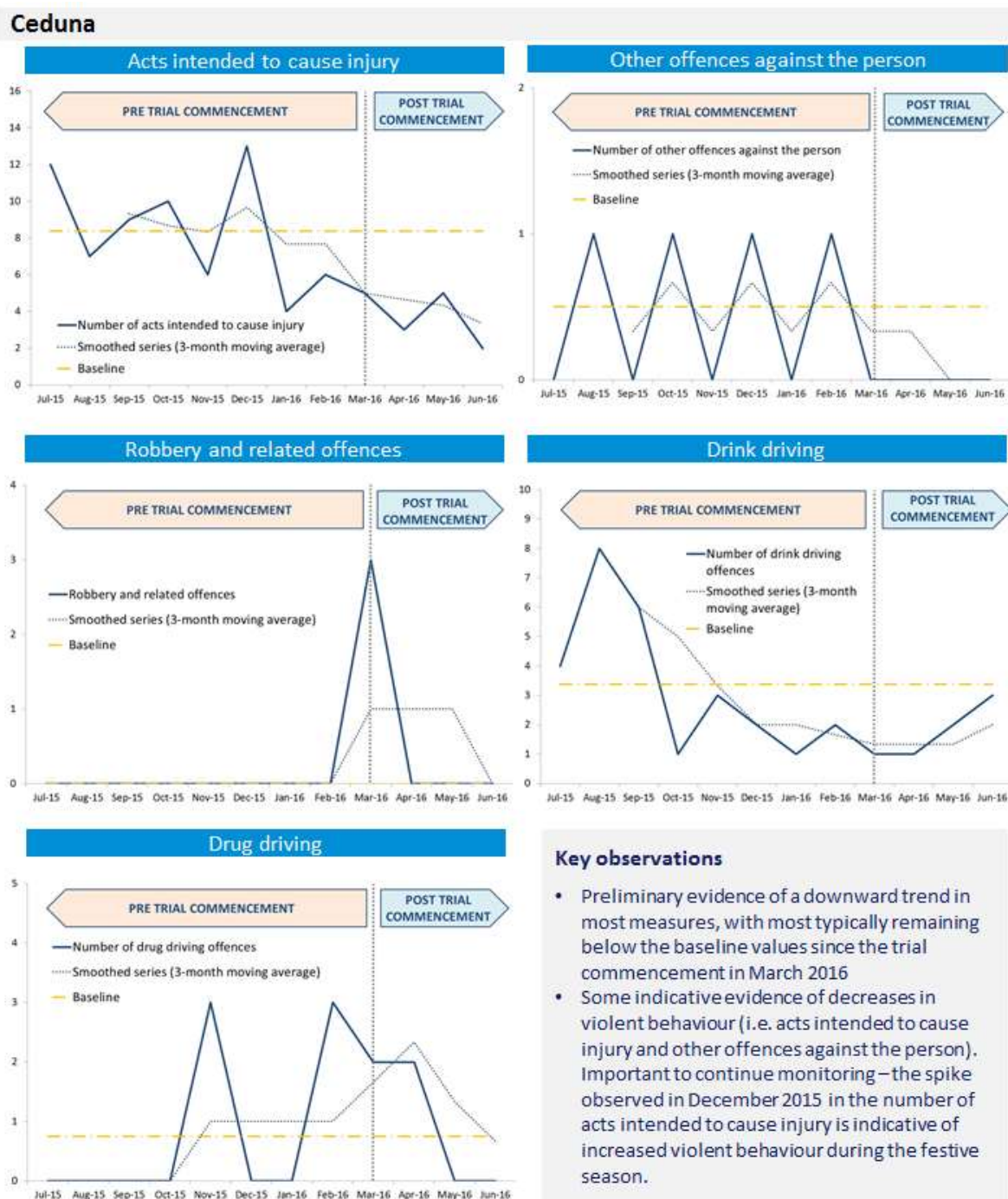
- ◆ A decrease in vandalism of ATMs – noticed by a few stakeholders;
- ◆ A decrease in crime (including alcohol related incidents) in Wyndham – although it was reported that there were many other contributing factors (e.g. TAMS) and it was felt that this could not be directly attributed to CDCT; and
- ◆ A reduction in the number of injuries indicative of domestic violence presenting at the hospital reported by the Accident and Emergency department.
- However, a few stakeholders identified some increase in domestic violence / intervention orders – although it was not clear whether the increase was due to changes in reporting requirements, the policing approach or increased community awareness, understanding and willingness to take action.

In addition, many stakeholders reported an increase in the following illegal / harmful behaviours among young people / children:

- ◆ Robberies / thefts from cars / vehicles and dwellings; and
- ◆ Petty crime (e.g. pickpocketing and “snatch and grab”).

Evidence from external data sources

Figure 83: Crime statistics – South Australian Police – Ceduna LGA

**Notes and caveats**

Data source: South Australian Police – Ceduna LGA (NOTE: data may not be approved for public use)
 In absence of longer time-series data, Simple Moving Average (SMA) was used to smooth the volatility in the monthly data and provide an indication of any short-term trends. The analysis should be treated as indicative only – further data are needed to examine and appropriately account for any seasonal and other time-series effects, as well as potential effects of other factors (e.g. introduction of liquor restrictions in Aug 2015).
 Baseline value = average value for the period Jul 15 to Feb 16.

Figure 84: Criminal behaviour data – Western Australian Police - Kununurra

Kununurra



Key observations

- Overall, based on limited data*, no short-term evidence of a decline in criminal behaviour in Kununurra since the trial commencement in April 2016
- Most statistics were above their respective baseline values** for the three months after the trial commencement (May-July 2016)

Notes and caveats

Data source: Western Australia Police (WAPOL)

The analysis should be treated as indicative only – further data are needed to examine and appropriately account for any seasonal and other time-series effects, as well as effects of other potential factors.

*As a result, the 3-month moving average was not computed

**Baseline values for the above measures are based on values at a single point in time (i.e. July 2015 values).

Figure 85: Criminal behaviour data – Western Australian Police - Wyndham

Wyndham



Notes and caveats

Data source: Western Australia Police (WAPOL)

The analysis should be treated as indicative only – further data are needed to examine and appropriately account for any seasonal and other time-series effects, as well as effects of other potential factors.

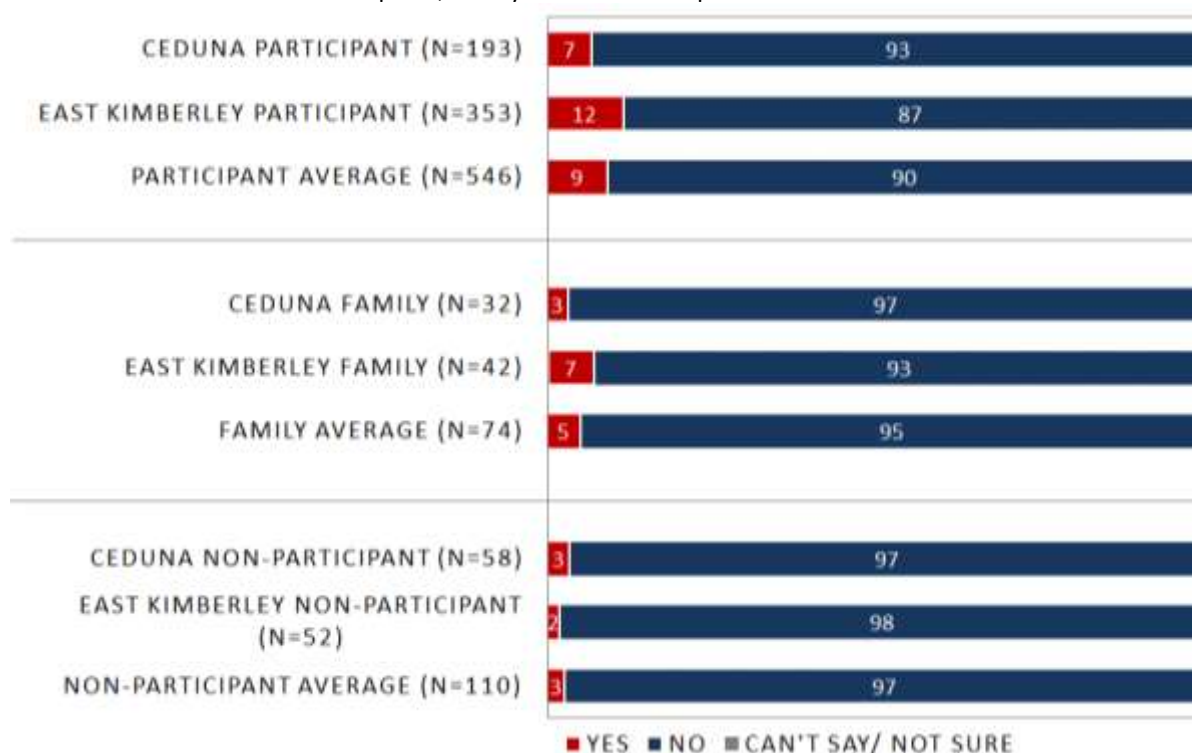
*As a result, the 3-month moving average was not computed

**Baseline values for the above measures are based on values at a single point in time (i.e. July 2015 values).

Quantitative research with Participants, Families and Non-Participant stakeholders

Figure 86: Beaten up, injured or assaulted in the past month

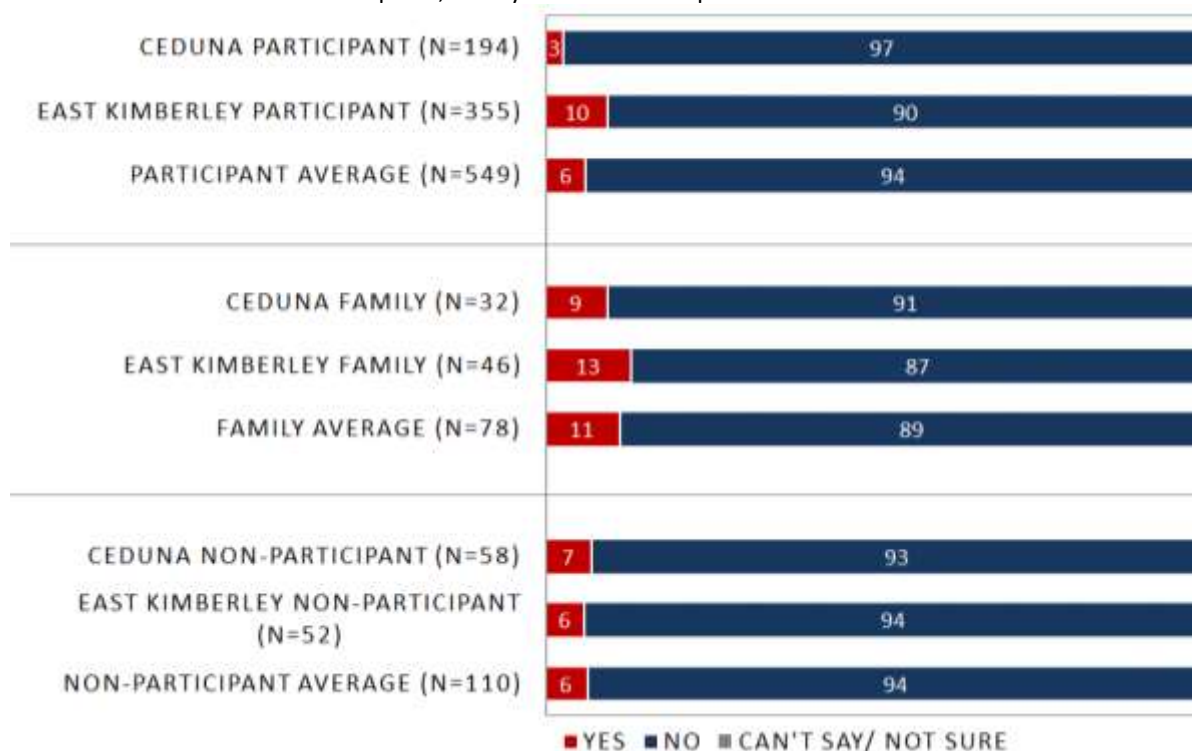
Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q29b (P) / Q21b (F) / Q13a (NP). In the past month have you been: Beaten up, injured, or assaulted?

Figure 87: Robbed in the past month

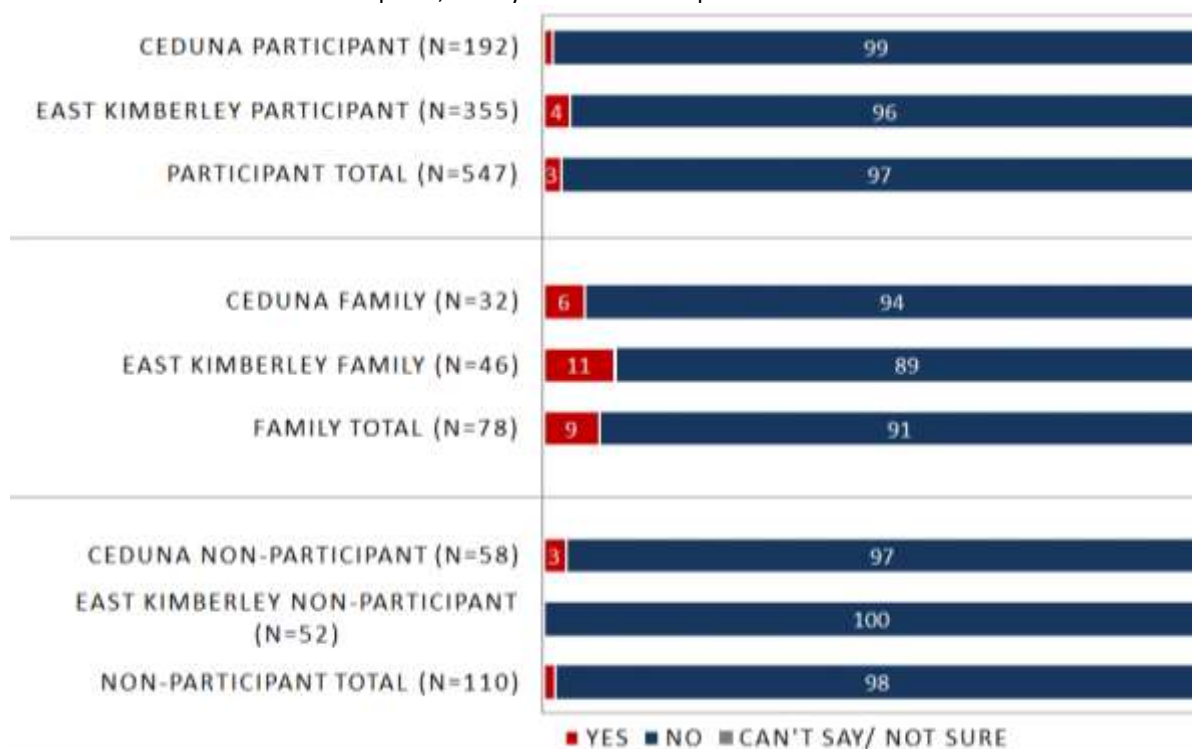
Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q29d (P) / Q21d (F) / Q13c (NP). In the past month have you been: Robbed?

Figure 88: Threatened or attacked with a gun, knife or other weapon in the past month

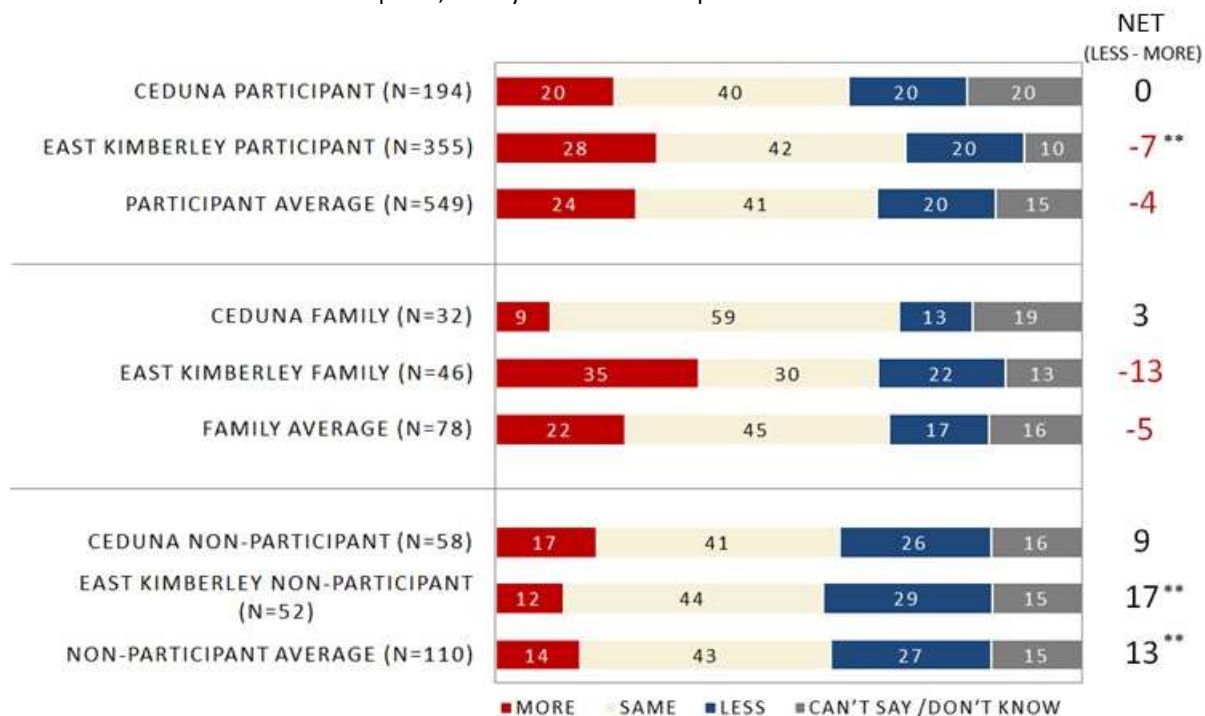
Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q29e (P) / Q21e (F) / Q13d (NP). In the past month have you been: Threatened or attacked with a gun, knife or other weapon?

Figure 89: Violence noticed in the community since the Trial started

Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q42b (P) / Q24b (F) / Q16b (NP). Since the Cashless Debit Card / Indue Card Trial started in your community have you noticed more, less or the same amount of: Violence in the community?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

MTO PI#4: Drug/alcohol-related injuries and hospital admissions

Figure 90: MTO PI #4

Performance Indicator	Interim Rating
Drug/alcohol-related injuries and hospital admissions	Not relevant at interim point
Theme	Details
Specification	<ul style="list-style-type: none"> ◆ Drug / alcohol-related hospital admissions / emergency presentations / sobering up service admissions ◆ Percent of participants / family members who say they have been injured after drinking alcohol / taking drugs in the last month
Target	Lower than before Trial
Timeframe	<p>Above point 1: Trial period compared with 12 months prior to Trial launch</p> <p>Above point 2: As self-reported at Wave 1 and Wave 2</p>
Data Sources	<p>Above point 1: Department of Premier and Cabinet SA, WA Health, Department of Social Services (based on data provided by local sobering up services)</p> <p>Above point 2: Surveys of Trial participants and families</p>
Survey Questions	<p>Participant questionnaire: q29h</p> <p>Family questionnaire: q21h</p>
Definitions / Notes	NA

As a medium-term outcome this performance indicator is not evaluated at this interim stage. Early administrative data relating to sobering up services in the Trial communities are suggestive of positive early signs, but this will be more meaningfully examined at Wave 2.

Evidence

Evidence from external data sources

Figure 91: Problematic Alcohol consumption / intoxication data – Ceduna – Department for Communities and Social Inclusion and Drug and Alcohol Services

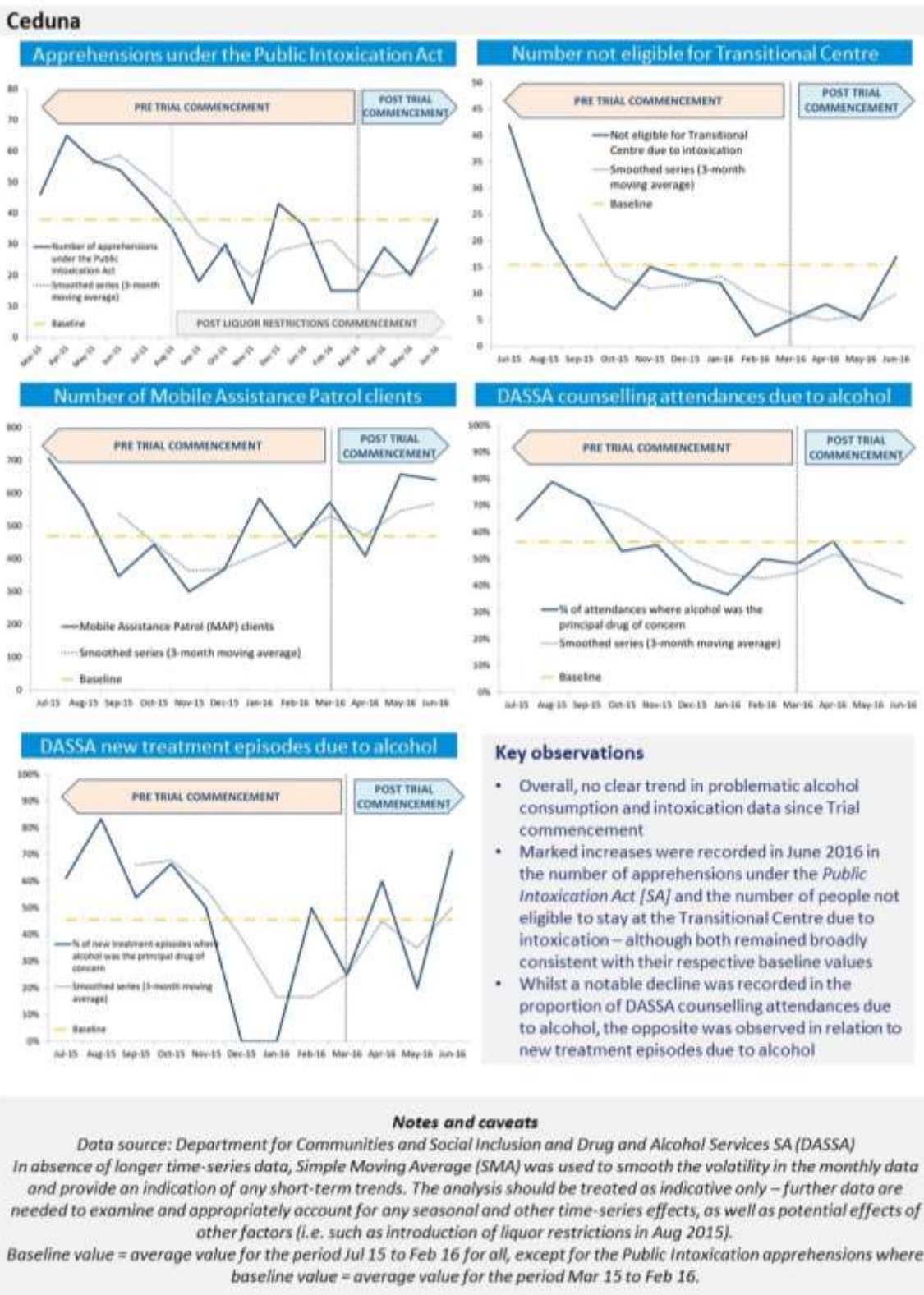


Figure 92: Sobering Up Unit (SUU) – Ceduna – Department for Communities and Social Inclusion

Ceduna



Key observations

- Limited evidence of a short-term impact from the Trial – Most Sobering Up Unit (SUU) measures/indicators remained broadly stable since the trial commencement, with the exception of the number of discharges at risk which continued to decline
- Limited data* available in relation to Blood Alcohol Content on admission to, and on discharge from, the SUU; however, both measures remained below their respective baseline values since the trial commencement

Notes and caveats

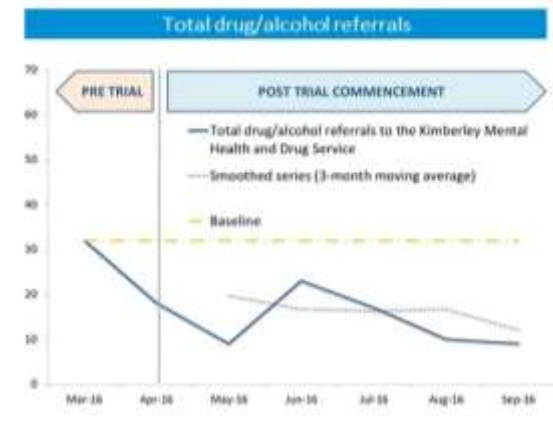
Data source: Department for Communities and Social Inclusion – Ceduna Service Reform

In absence of longer time-series data, Simple Moving Average (SMA) was used to smooth the volatility in the monthly data and provide an indication of any short-term trends. The analysis should be treated as indicative only – further data are needed to examine and appropriately account for any seasonal and other time-series effects, as well as potential effects of other factors (i.e. such as introduction of liquor restrictions in Aug 2015).

Baseline value = average value for the period Jul 15 to Feb 16 for total admissions and discharges at risk, and average of Jan and Feb 16 for Blood Alcohol Content series.

*As a result, the 3-month moving average was not computed

Figure 93: Problematic alcohol consumption / intoxication data Kununurra Waringarri Aboriginal



Key observations

- Some preliminary evidence of a downward trend in problematic alcohol consumption and intoxication rates in both Kununurra and Wyndham
- In both Kununurra and Wyndham, the measures/indicators generally remained below their respective baseline values since the trial commencement
- Important to continue monitoring – evidence of seasonality in the Night Patrol pick ups data (consistent pattern during April to September across 2015 and 2016)

Notes and caveats

Data source: Western Australian Department of Aboriginal Affairs - Kununurra Waringarri Aboriginal Corporation Patrol Service (Kununurra), Western Australian Mental Health Commission - Ngnowar-Aerwah Aboriginal Corporation (Wyndham) and The Drug and Alcohol Office of Western Australia (also Commonwealth Funded) - Ngnowar-Aerwah Aboriginal Corporation (Wyndham)

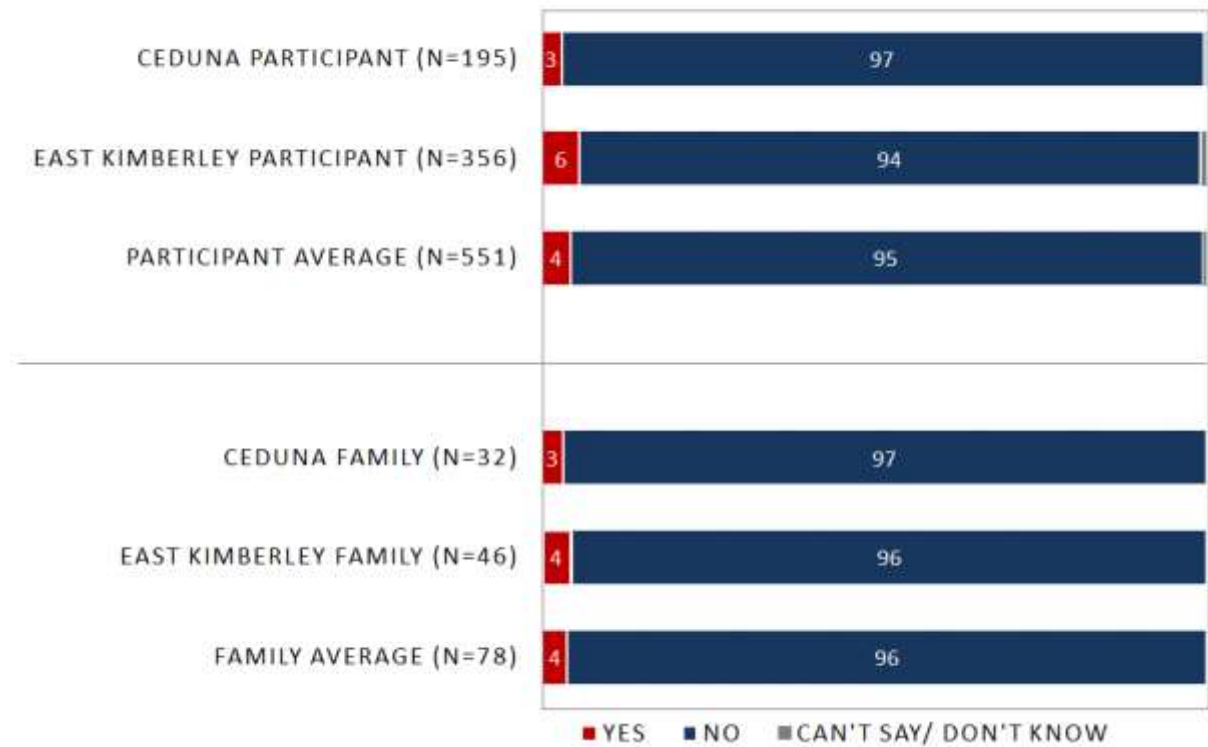
In absence of longer time-series data, Simple Moving Average (SMA) was used to smooth the volatility in the monthly data and provide an indication of any short-term trends. The analysis should be treated as indicative only – further data are needed to examine and appropriately account for any seasonal and other time-series effects, as well as effects of any other potential factors.

Baseline value = average value for the period Apr 15 to Jun 15 for Wyndham Sobering Up Shelter and Night Patrol statistics, Mar 16 value for total alcohol/drug referrals to Kimberley Mental Health and Drug Service, and average of mean values for Jan 15 to Jun 15 and Jan 16 to Feb 16 for Kununurra Sobering Up Shelter referrals and Community Patrol pick ups.

Quantitative research with Participants, Families and Non-Participant stakeholders

Figure 94: Injured or had an accident after drinking alcohol/ grog or taking drugs in the past month

Base: Participants and Family. Excludes 'Refused'.



Q29h (P) / Q21h (F). In the last month have you been: Injured or had an accident after drinking alcohol or taking drugs?

MTO PI#5: Percent reporting feeling safe in the community

Figure 95: MTO PI #5

Performance Indicator	Interim Rating
Percent reporting feeling safe in the community	Not relevant at interim point
Theme	Details
Specification	◆ Percent of participants, family members and other community members who report feeling safe in their community
Target	NA
Timeframe	As self-reported at Wave 1 and Wave 2
Data Sources	Surveys of Trial participants, families and community members SA and WA Police crime data
Survey Questions	Participant questionnaire: q31a-b Family questionnaire: q23a-b Non-Participant questionnaire: q15a-b
Definitions / Notes	NA

As a medium-term outcome this performance indicator is not evaluated at this interim stage. At Wave 1 perceptions of safety on the streets of the Trial communities were high during the day, but considerably lower at night time – especially in East Kimberley.

Evidence

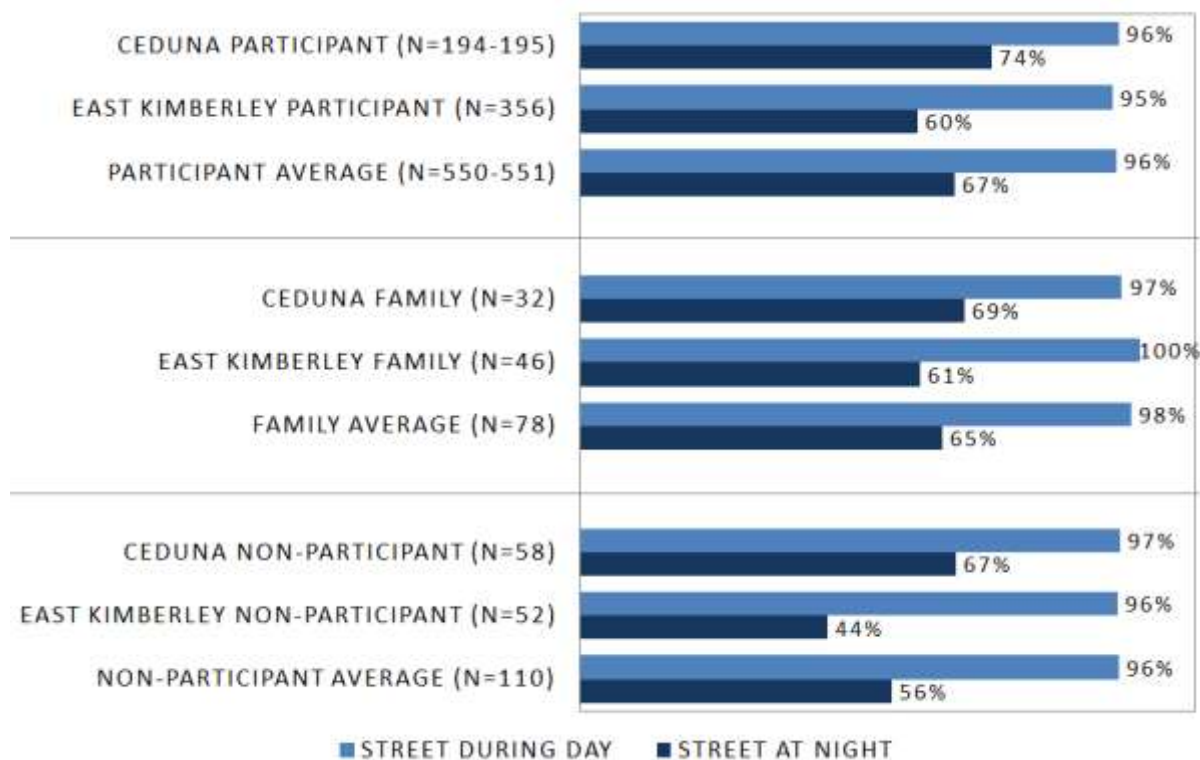
Evidence from external data sources

SA and WA Police crime data supporting this performance indicator is outlined earlier, in MTO PI#3.

Quantitative research with Participants, Families and Non-Participant stakeholders

Figure 96: Reports of feeling either very safe or safe on the streets during the day or at night

Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q31a-b (P) / Q23a-b (F) / q15a-b (NP). Do you feel safe or unsafe on the streets of your community during the day / at night?

MTO PI#6: Percent reporting feeling safe at home

Figure 97: MTO PI #6

Performance Indicator		Interim Rating
Percent reporting feeling safe at home		Not relevant at interim point
Theme	Details	
Specification	◆ Percent of participants, family members and other community members who report feeling safe at home	
Target	NA	
Timeframe	As self-reported at Wave 1 and Wave 2	
Data Sources	Surveys of Trial participants, families and community members SA and WA Police crime data	
Survey Questions	Participant questionnaire: q31c Family questionnaire: q23c Non-Participant questionnaire: q15c	
Definitions / Notes	NA	

As a medium-term outcome this performance indicator is not evaluated at this interim stage. At Wave 1 the sense of safety in the home was high.

Evidence

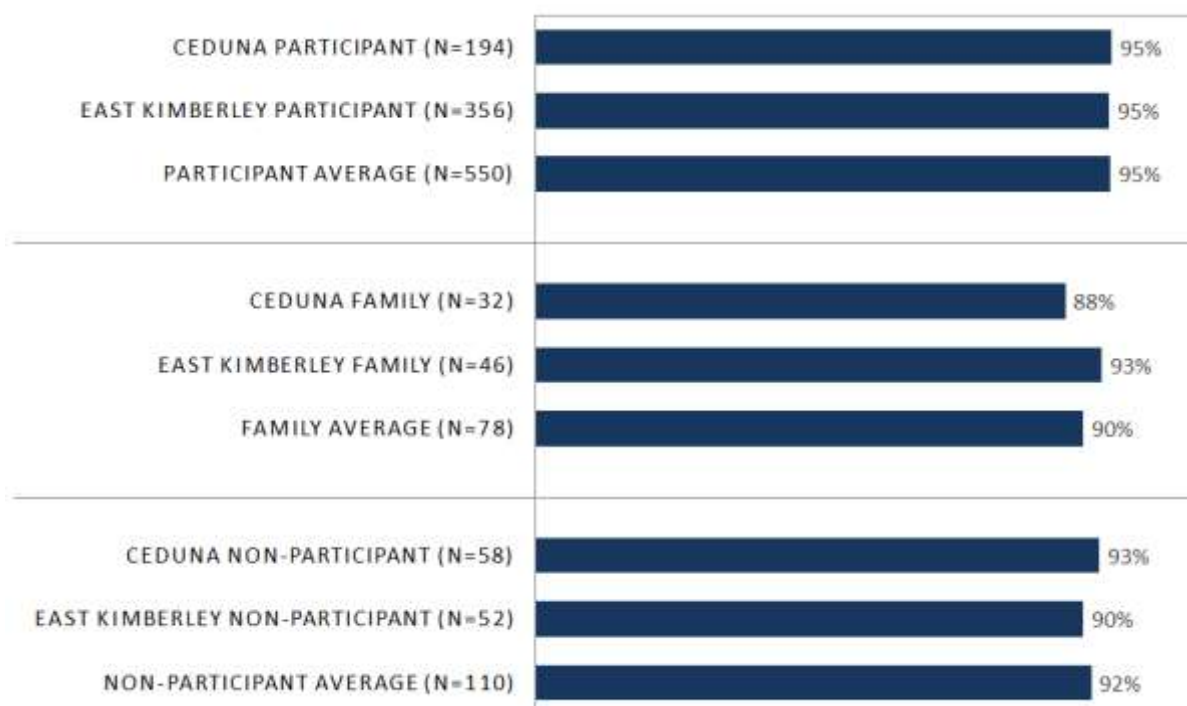
Evidence from external data sources

SA and WA Police crime data supporting this performance indicator is outlined earlier, in MTO PI#3.

Quantitative research with Participants, Families and Non-Participant stakeholders

Figure 98: Reports of feeling either very safe or safe at home

Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q31c (P) / Q23c (F) / q15c (NP). Do you feel safe or unsafe at home?

Appendix B: Non-Performance Indicator Results

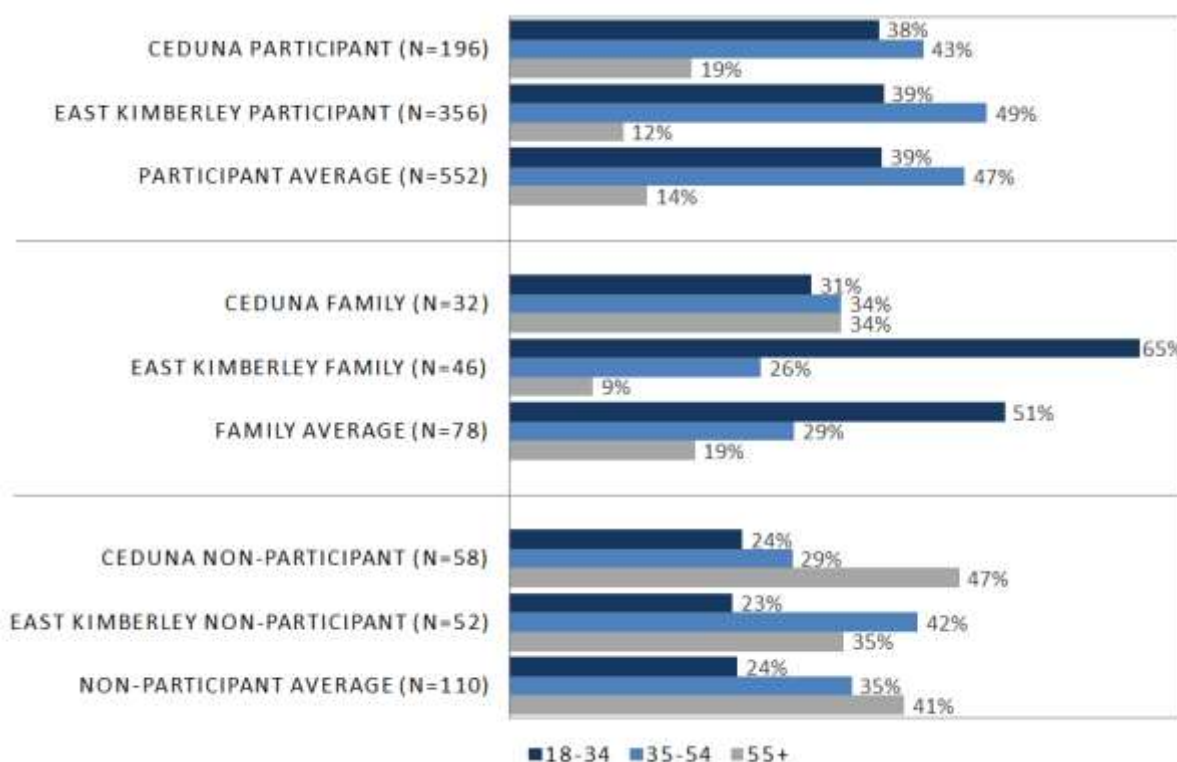
Questionnaire Section A: Demographics (Unweighted)

Ninety-nine percent of all participants said that they currently have an Indue / Cashless Debit card in their name, whilst the remaining 1% had used one in the past. No family or non-participant respondents reported that they had ever had this card in their name.

All of the respondents in the family group reported that someone in their immediate family (that they live with) has the card. No respondents from the non-participant group claimed to live with anyone who has the card.

Figure 99: Age

Base: Participants, Family and Non-Participants.

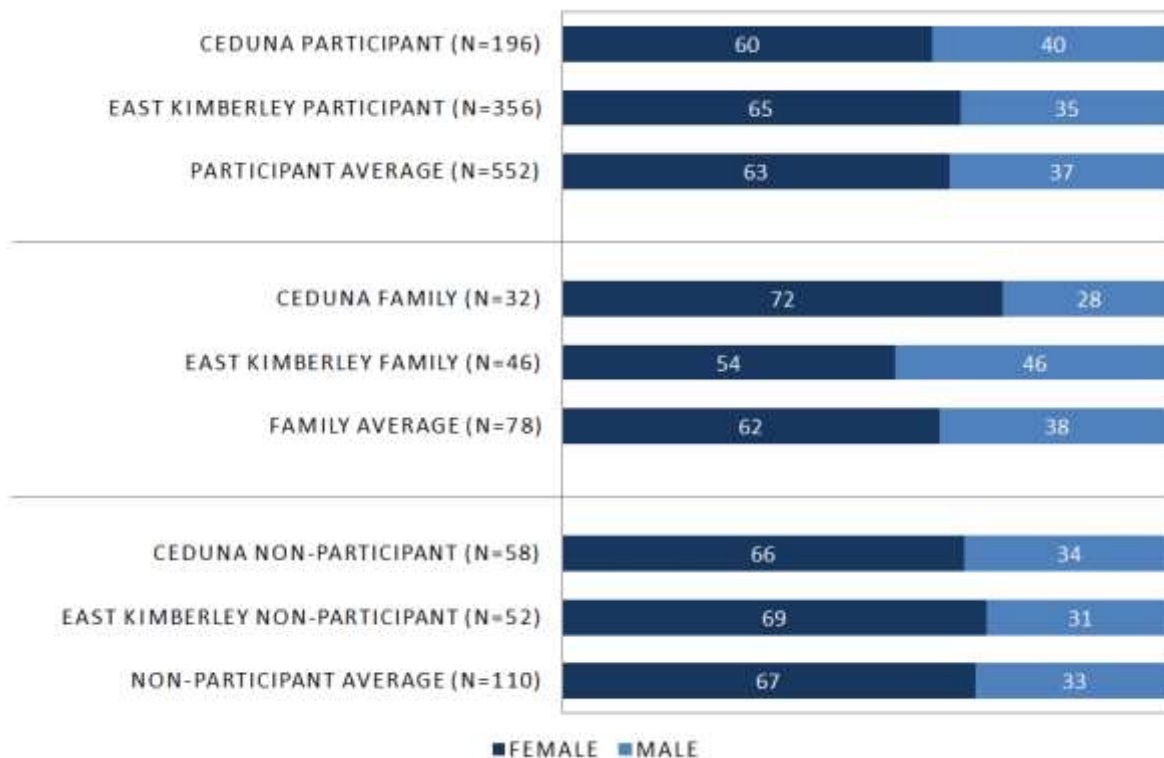


Q1/1a (P) / Q1/1a (F) / Q1/1a (NP). How old are you? Unweighted

NOTE: The systematic intercept methodology used for the surveys produced a sample that was broadly in line with CDCT participant ages in both locations. In both locations the 18-34 age group was slightly under-represented in the raw sample (by -5% in Ceduna and -7% in EK), which is a typical characteristic of most survey samples in any context due to younger people generally being less willing to participate. The 55+ age groups were within +3% (Ceduna) and -2% (EK) of the participant population. The raw participant samples were weighted to CDCT participant population benchmarks on age, gender and Indigenous / non-Indigenous proportions for analysis, correcting these slight age variations for the statistical analysis.

Figure 100: Gender

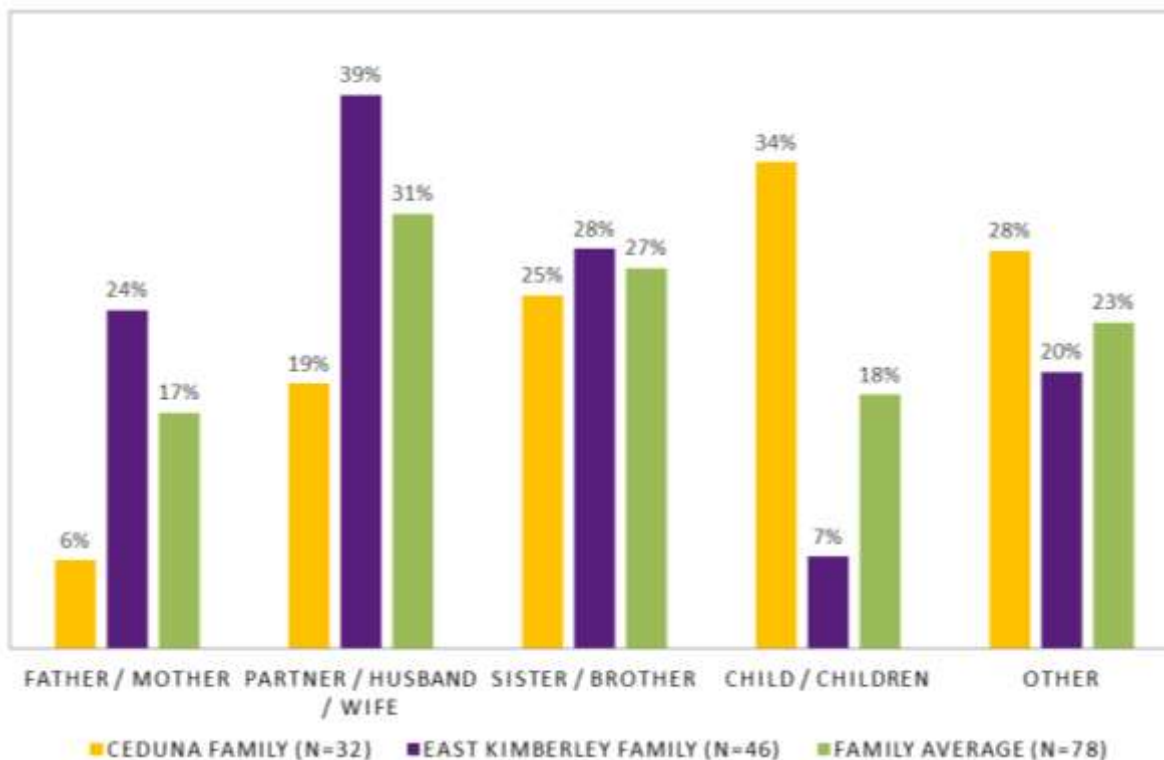
Base: Participants, Family and Non-Participants.



Q4 (P) / Q4 (F) / Q4 (NP). Gender. Unweighted

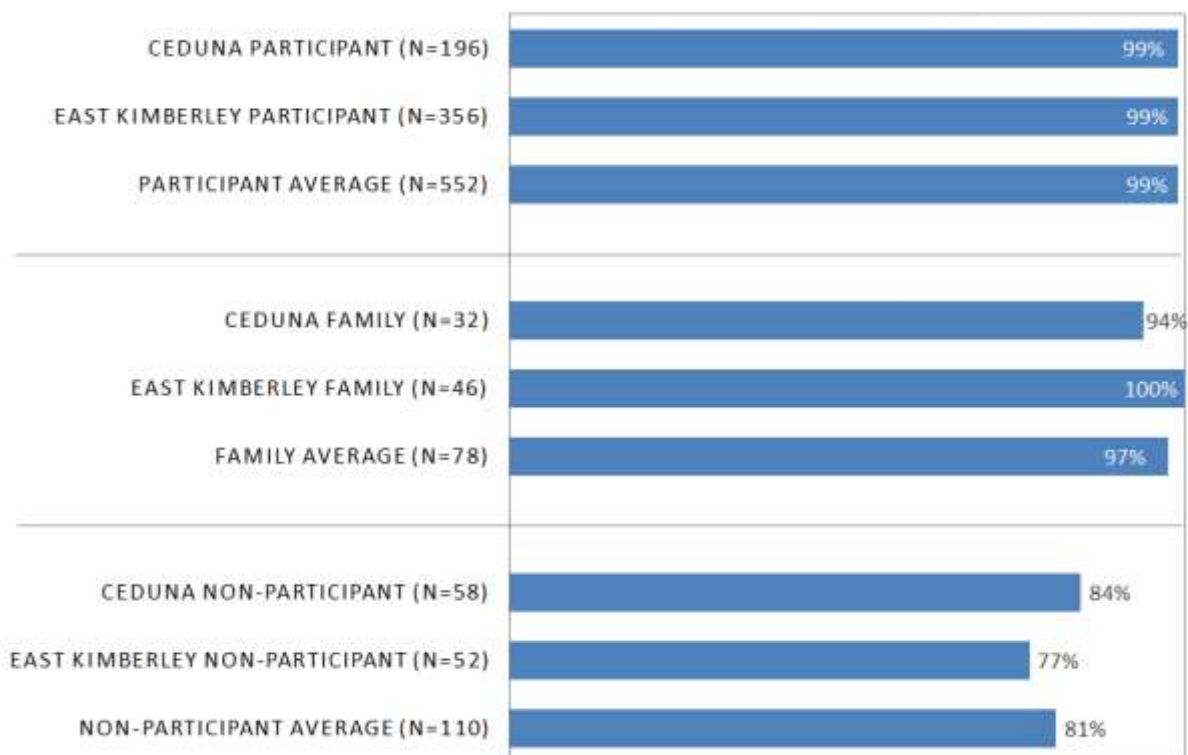
Figure 101: Relationship to family member on card

Base: Family.



Q6 (F). What is your relationship to them? Unweighted

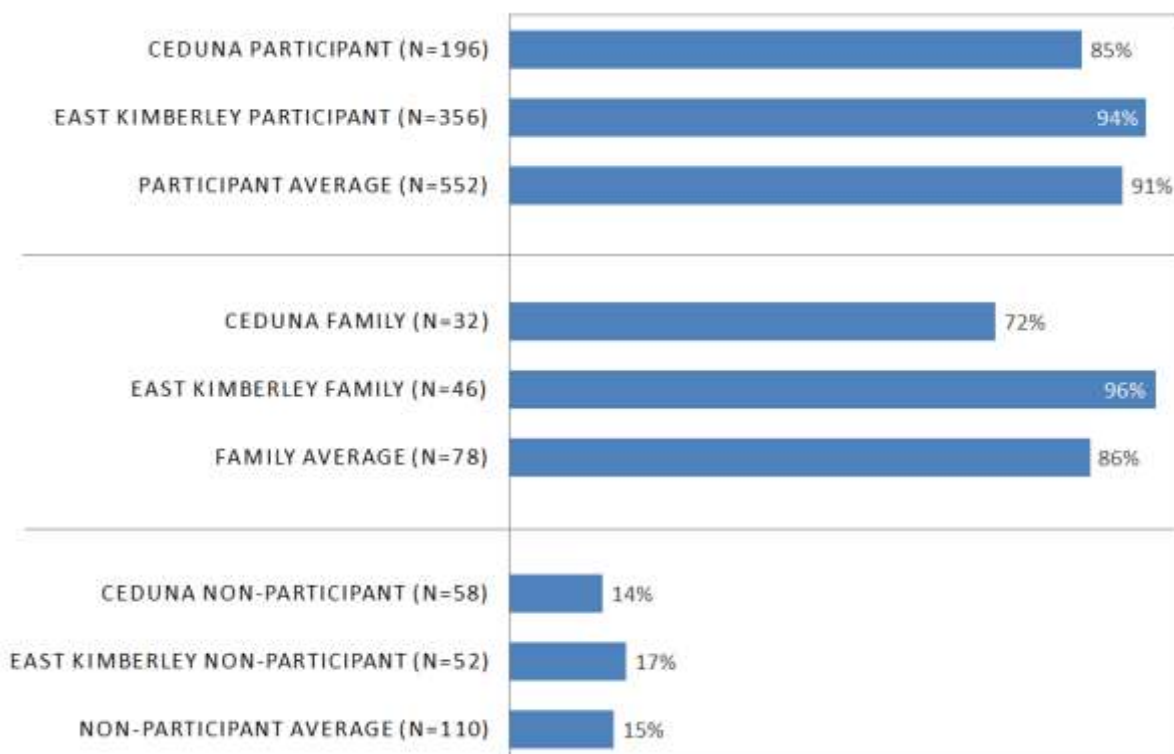
Figure 102: Born in Australia (% yes)
Base: Participants, Family and Non-Participant.



Q5 (P) / Q7 (F) / Q6 (NP). Were you..? Unweighted

Figure 103: Aboriginal or Torres Strait Islander origin (% yes)

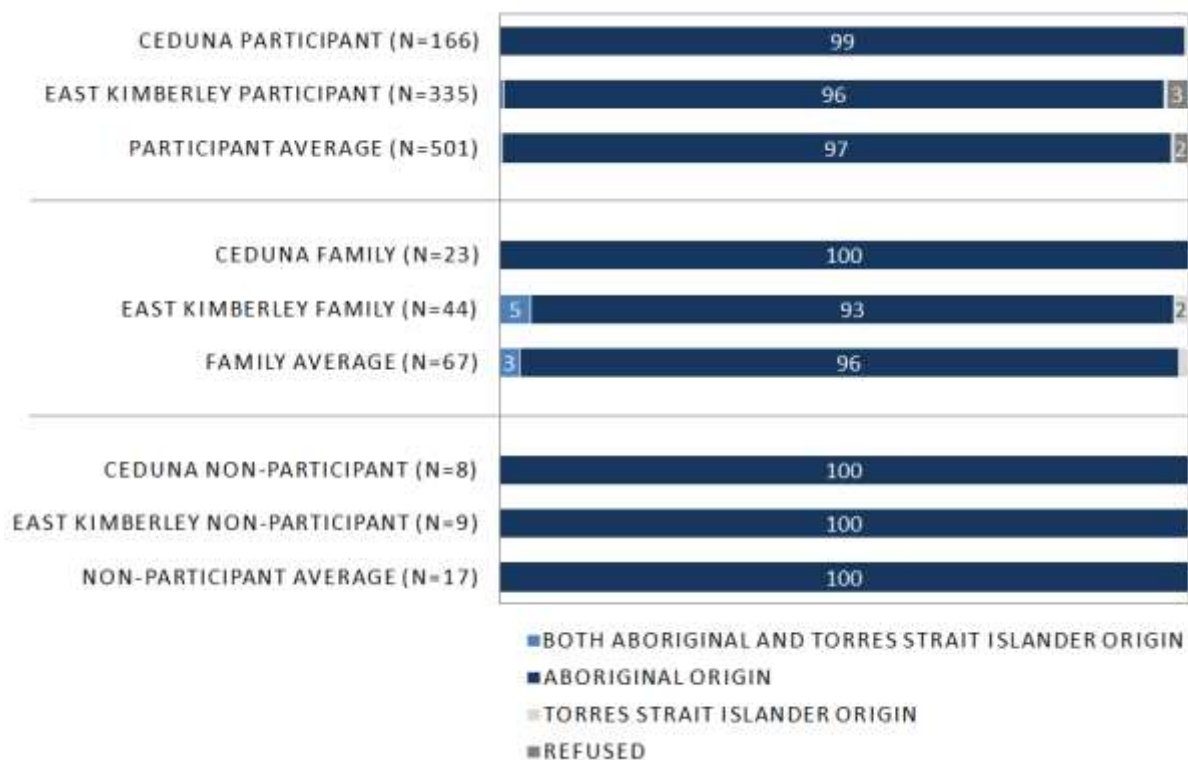
Base: Participants, Family and Non-Participants.



Q6 (P) / Q8 (F) / Q7 (NP). Are you of Aboriginal or Torres Strait Islander origin? Unweighted

Figure 104: Which of the following best describes your origin?

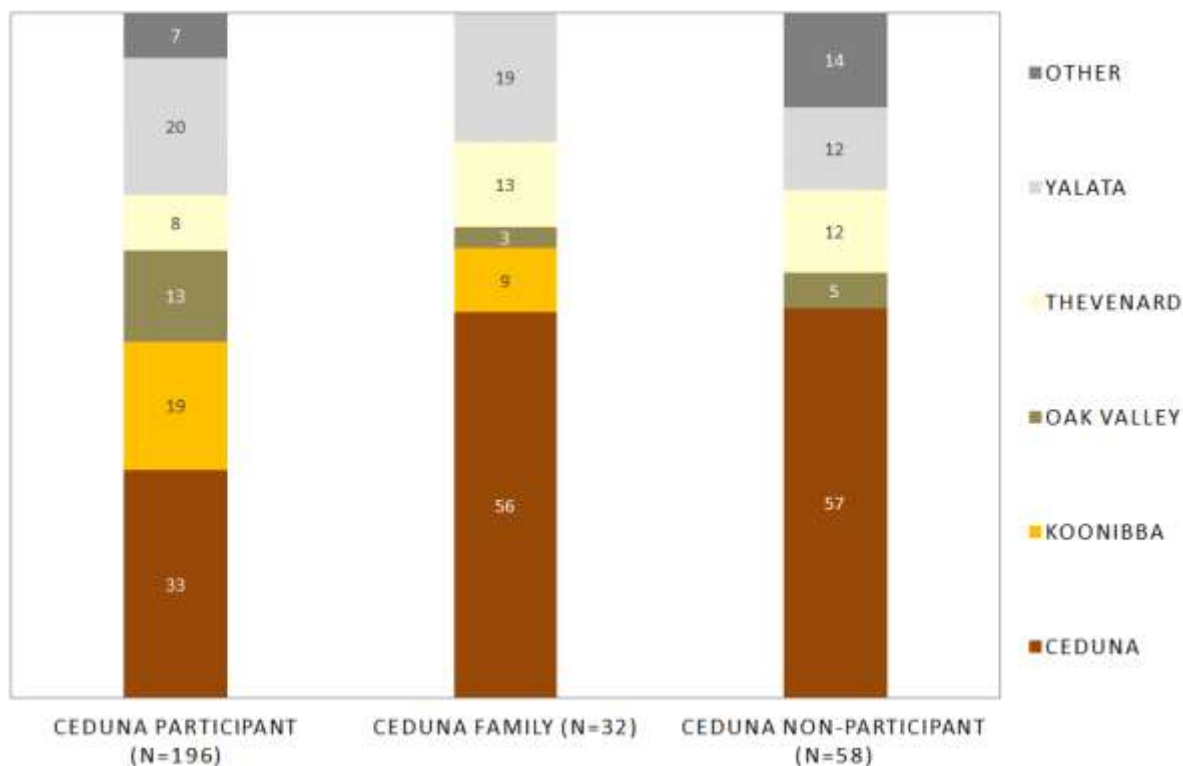
Base: Participants, Family and Non-Participants of Aboriginal and/or Torres Strait Islander origin.



Q6a (P) / Q9 (F) / Q8 (NP). Which of the following best describes your origin? Unweighted

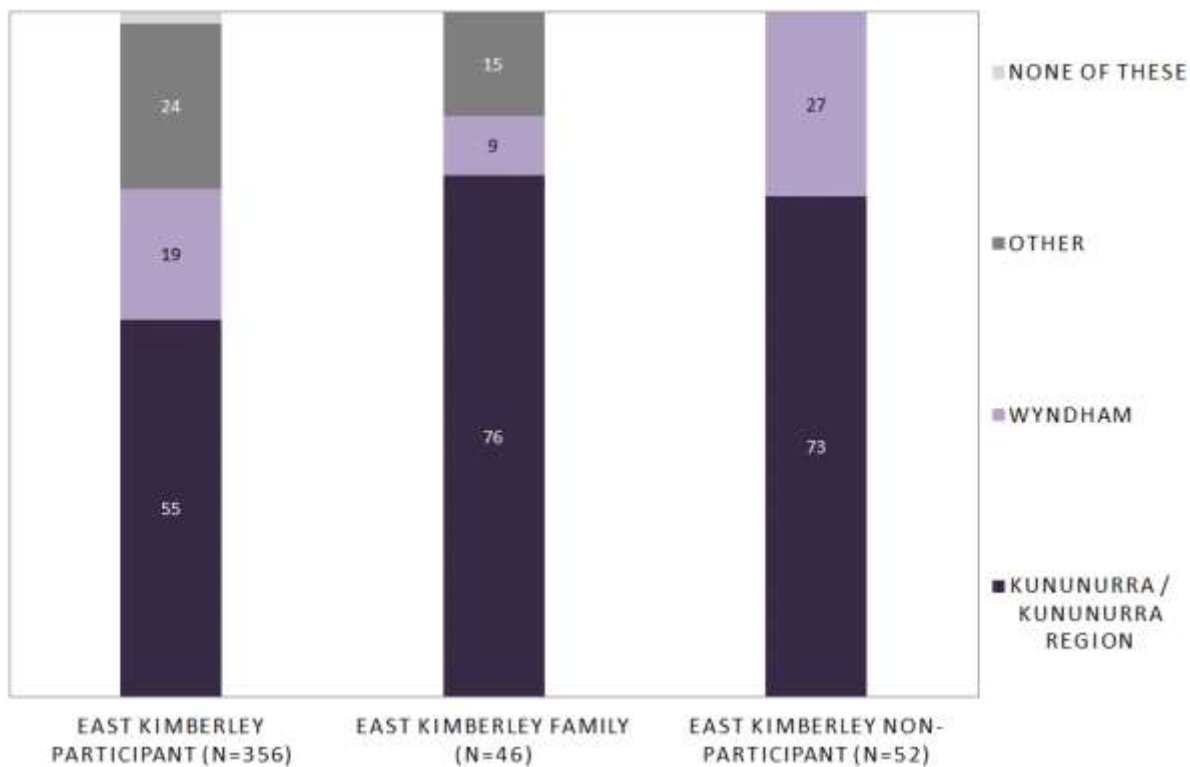
Figure 105: Location of Ceduna respondents

Base: Ceduna Participants, Family and Non-Participants.



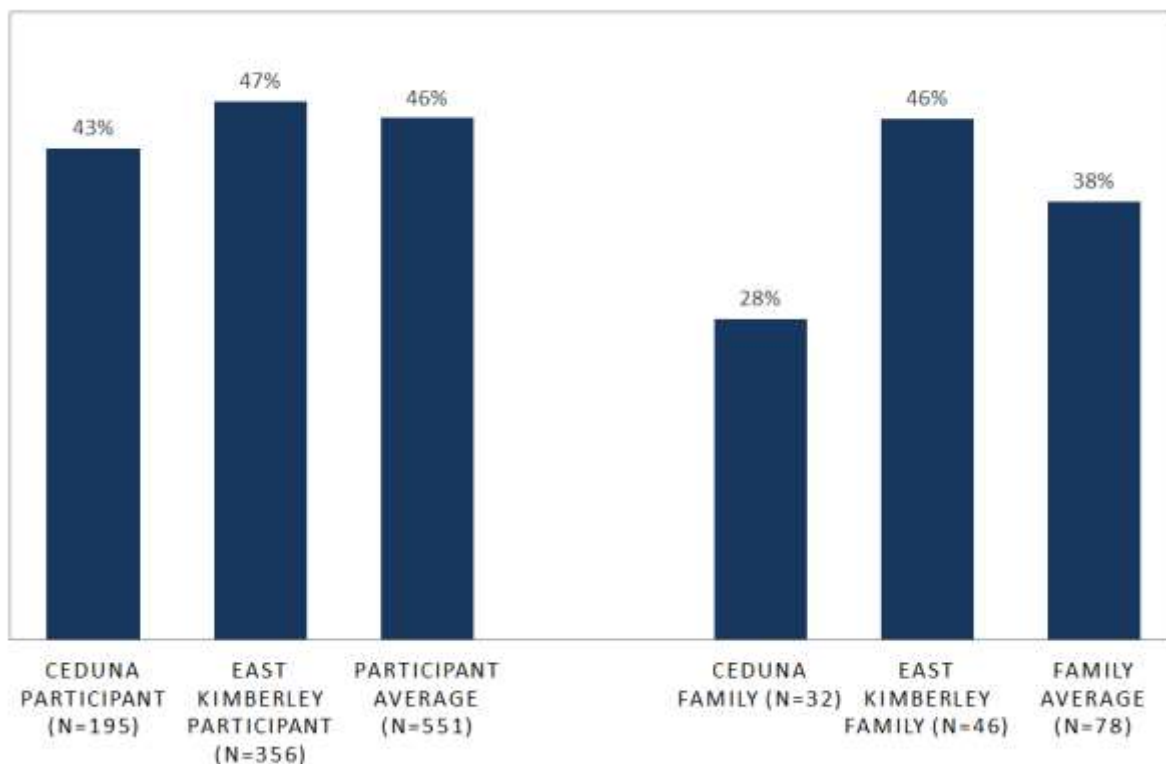
Q7 (P) / Q10 (F) / Q9 (NP). What town, suburb or community do you usually live in? Unweighted

Figure 106: Location of East Kimberley respondents
 Base: East Kimberley Participants, Family and Non-Participants.



Q7 (P) / Q10 (F) / Q9 (NP). What town, suburb or community do you usually live in? Unweighted

Figure 107: Do you care for a child who is less than 18 years old (% yes)
 Base: Participants and Family.

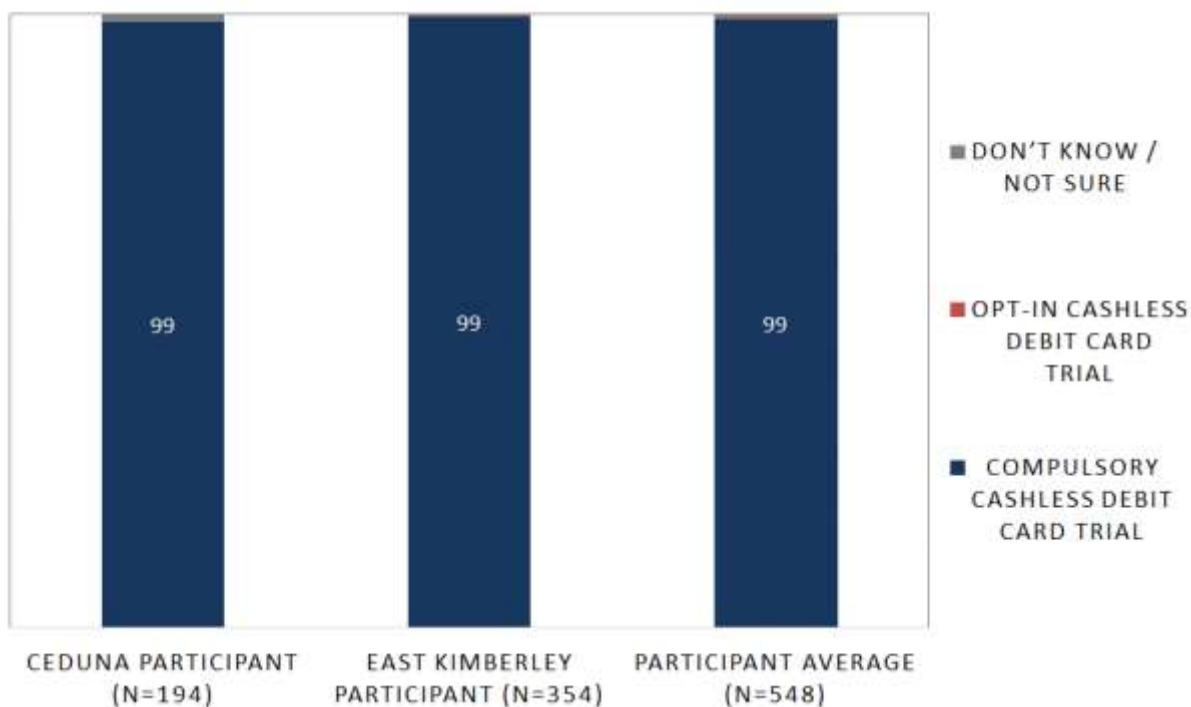


Q9 (P) / Q12 (F). Do you care for, or look after, a child who is less than 18 years old? Unweighted

Questionnaire Section B: Profile of Debit Card Trial Participation

Figure 108: Type of card

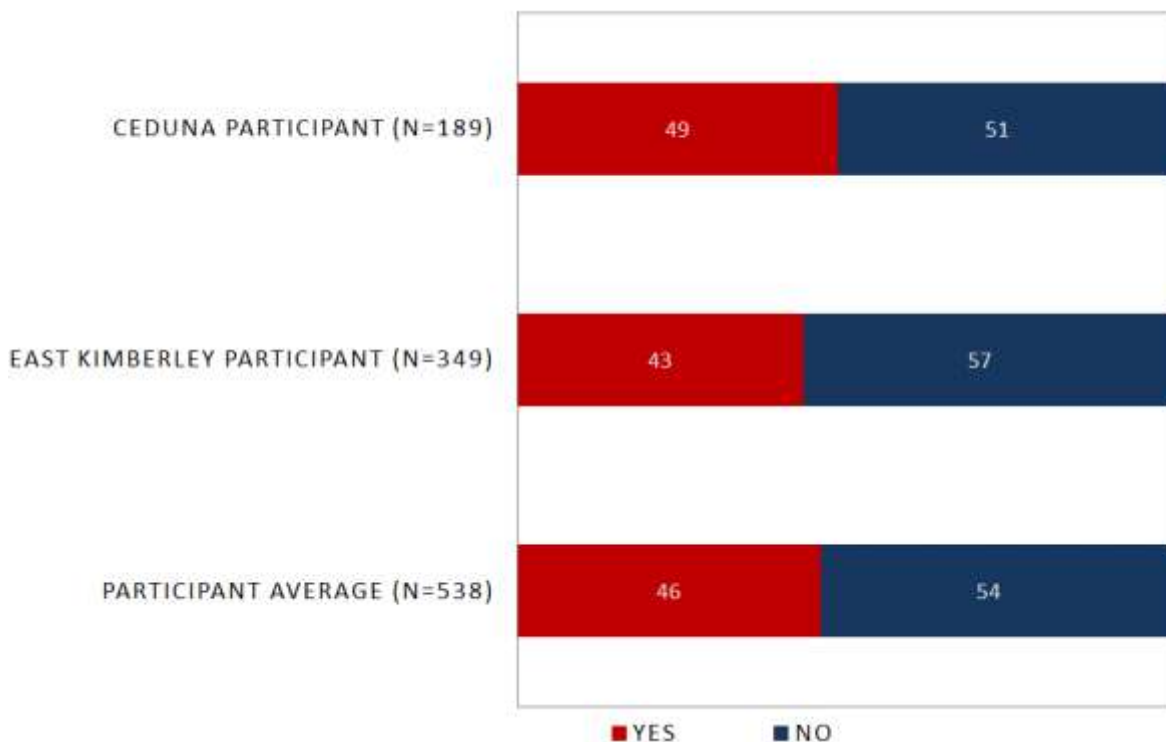
Base: Participants.



Q11 (P). What type of Cashless Debit Card Trial are you currently on?

Figure 109: Experienced problems with the card

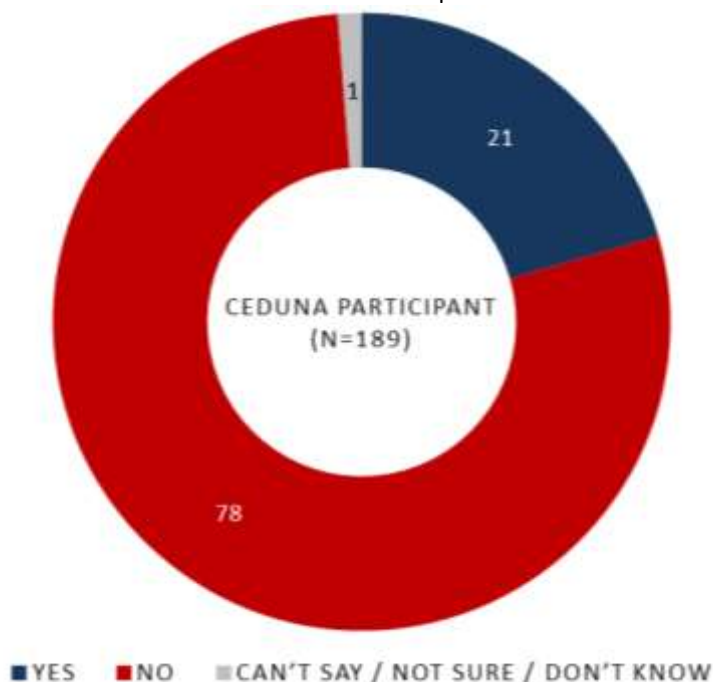
Base: Participants.



Q14 (P). Have you had any problems using the Cashless Debit / Indue Card?

Figure 110: Asked Community Panel for a review

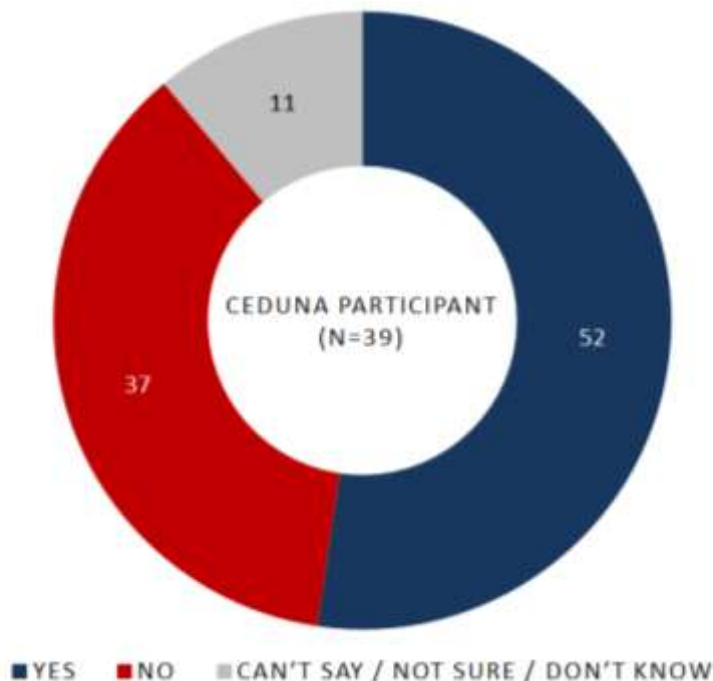
Base: Ceduna Participants.



Q17a (P). Have you asked the Community Panel to review how much of your Centrelink money goes onto the Cashless Debit / Indue Card?

Figure 111: Community Review resulted in a change

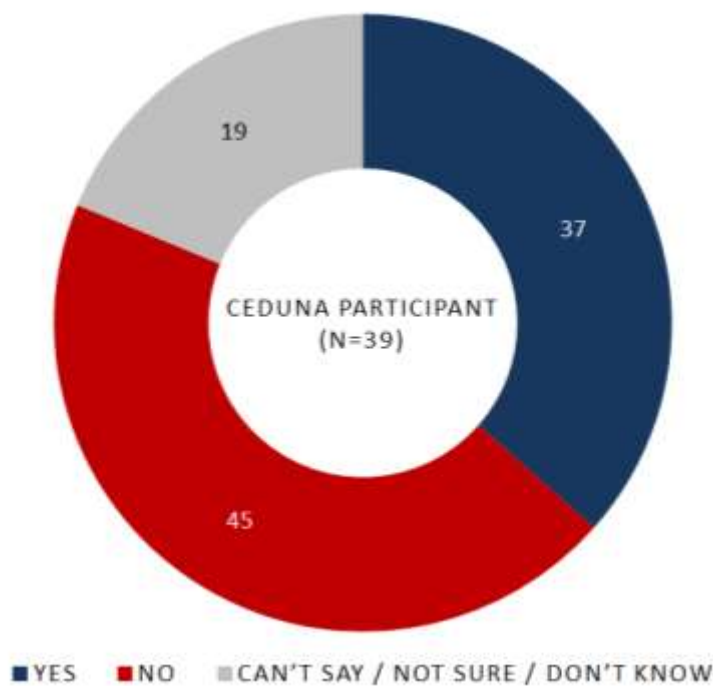
Base: Ceduna Participants.



Q17b (P). Did the amount or per cent of your Centrelink money that goes onto the Cashless Debit / Indue Card change after the Community Panel reviewed you?

Figure 112: Problems with the Community Review panel or process

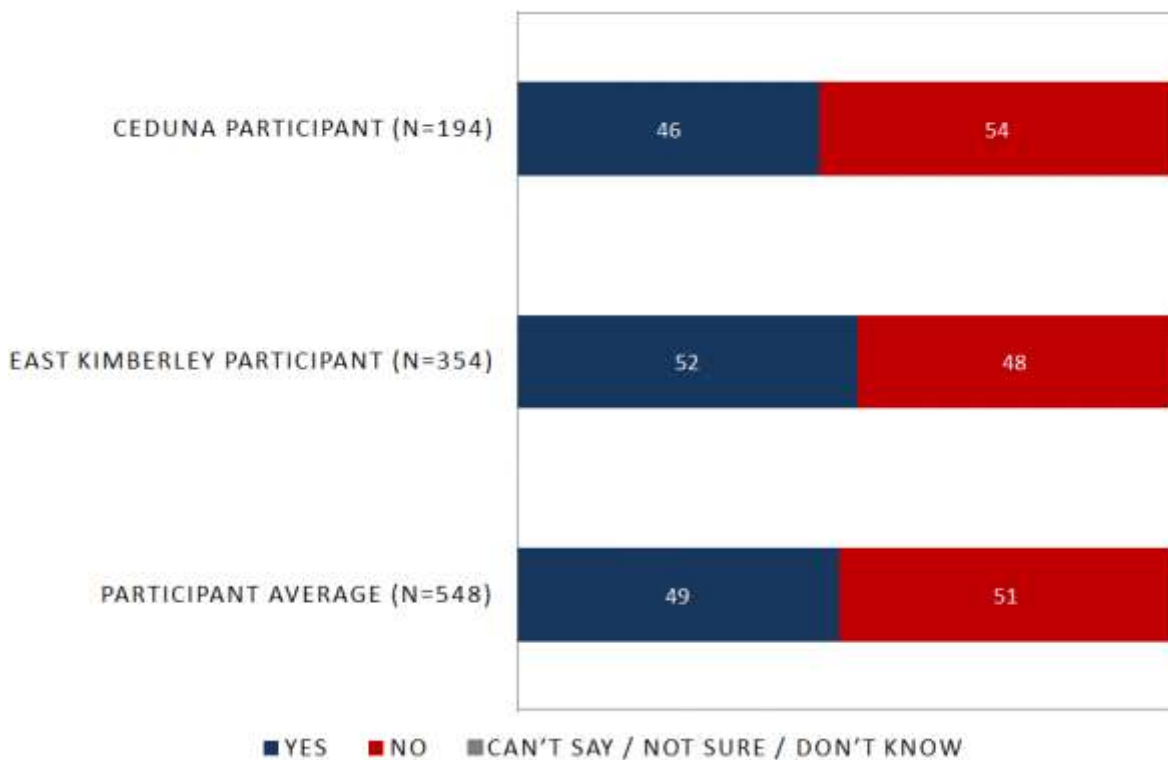
Base: Ceduna Participants.



Q17c (P). Did you have any problems with the Community Panel or the process?

Figure 113: Live with anyone else who is in the Trial

Base: Participants.



Q18 (P). Do you live with anyone else who is in the Cashless Debit Card / Indue Card Trial or who has a Cashless Debit Card / Indue Card?

Figure 114: Other people you live with who are on the card
Base: Participants.

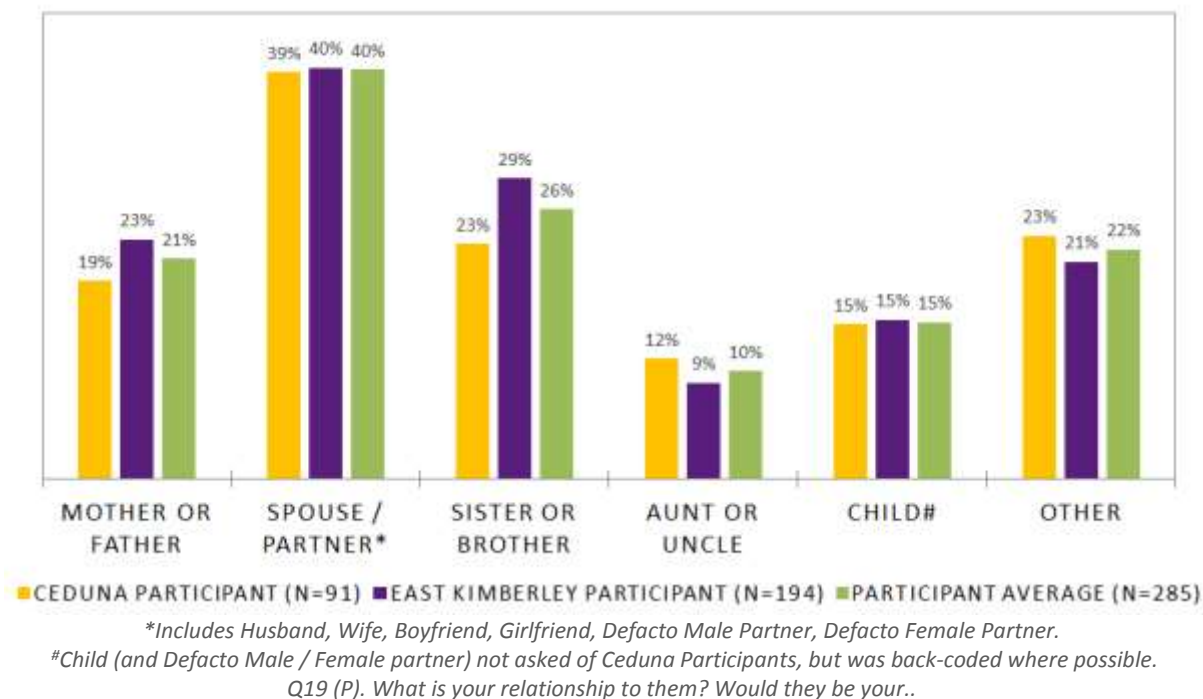
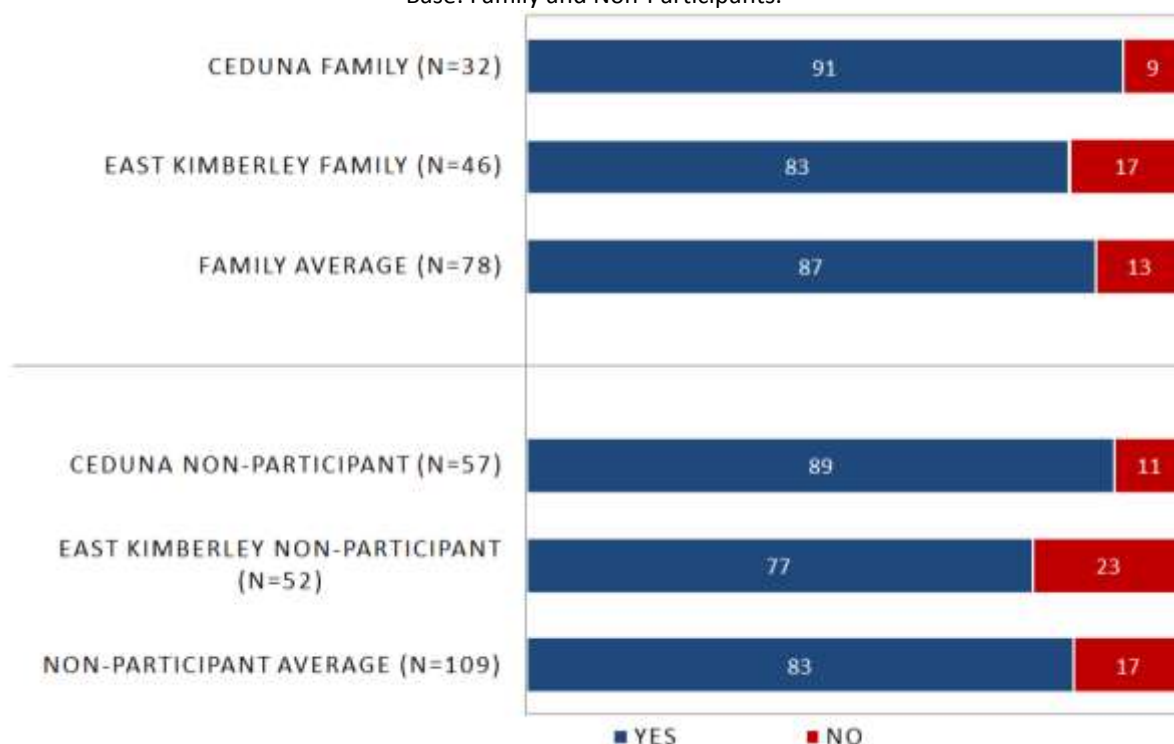


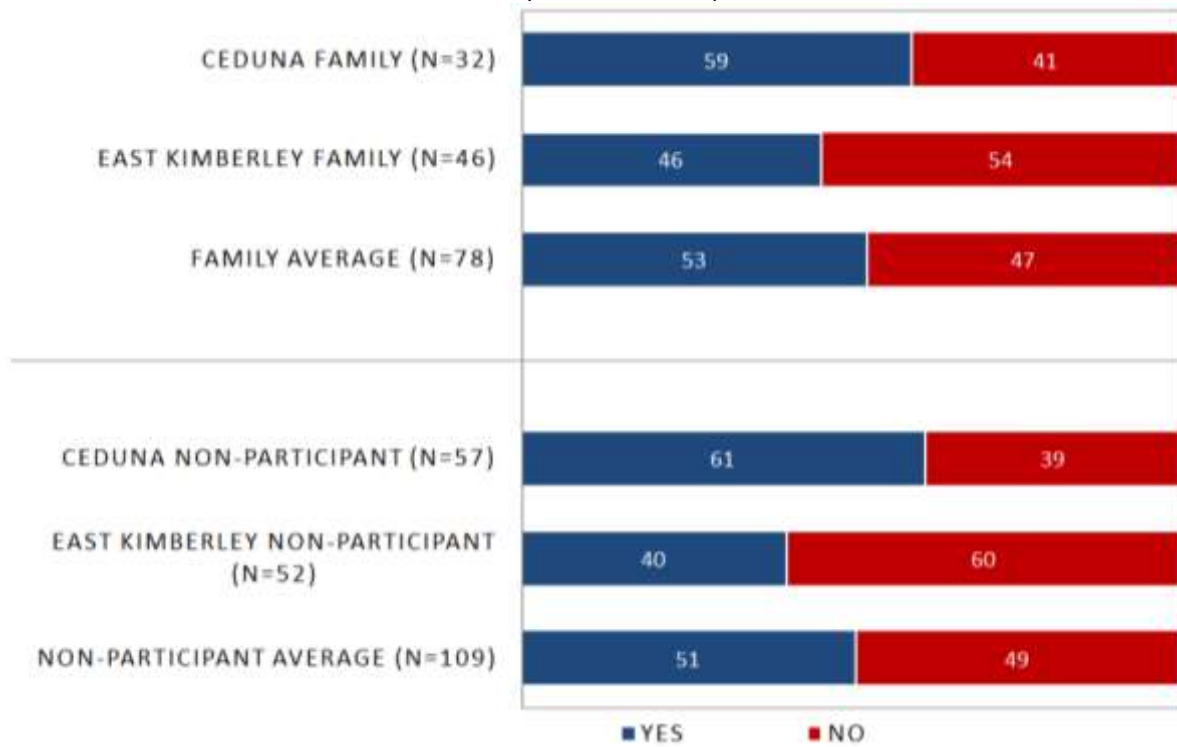
Figure 115: Knowledge that all people receiving Centrelink payments in the area have a big part of their payments put on the card
Base: Family and Non-Participants.



Q15a (F) / q12iia (NP). Before this survey did you know that: All people receiving Centrelink payments who live in this area apart from aged pensioners have a big part of their payments put onto this card?

Figure 116: Knowledge that wage earners and other pensioners can choose to get a card

Base: Family and Non-Participants.

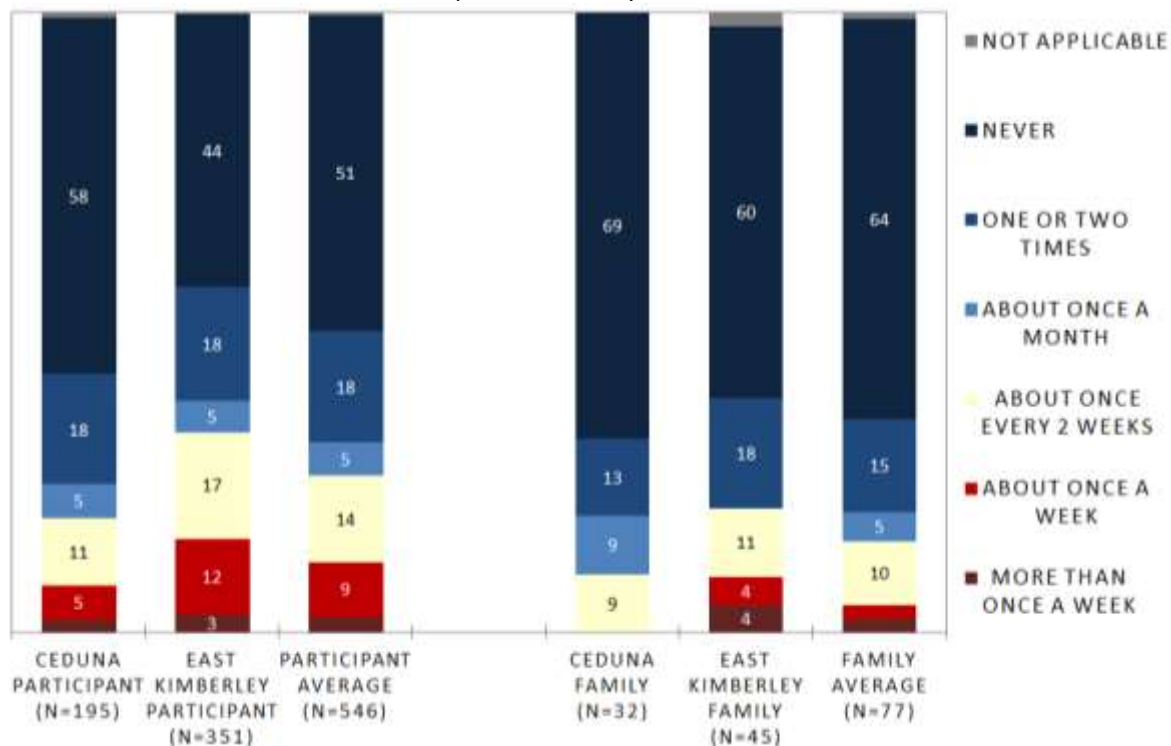


Q15b (F) / q12iib (NP). Before this survey did you know that: Wage earners, aged pensioners and veterans pensioners who live in this area can choose to get one of these cards?

Questionnaire Section C: Profile of Current Behaviour and Attitudes

Financial

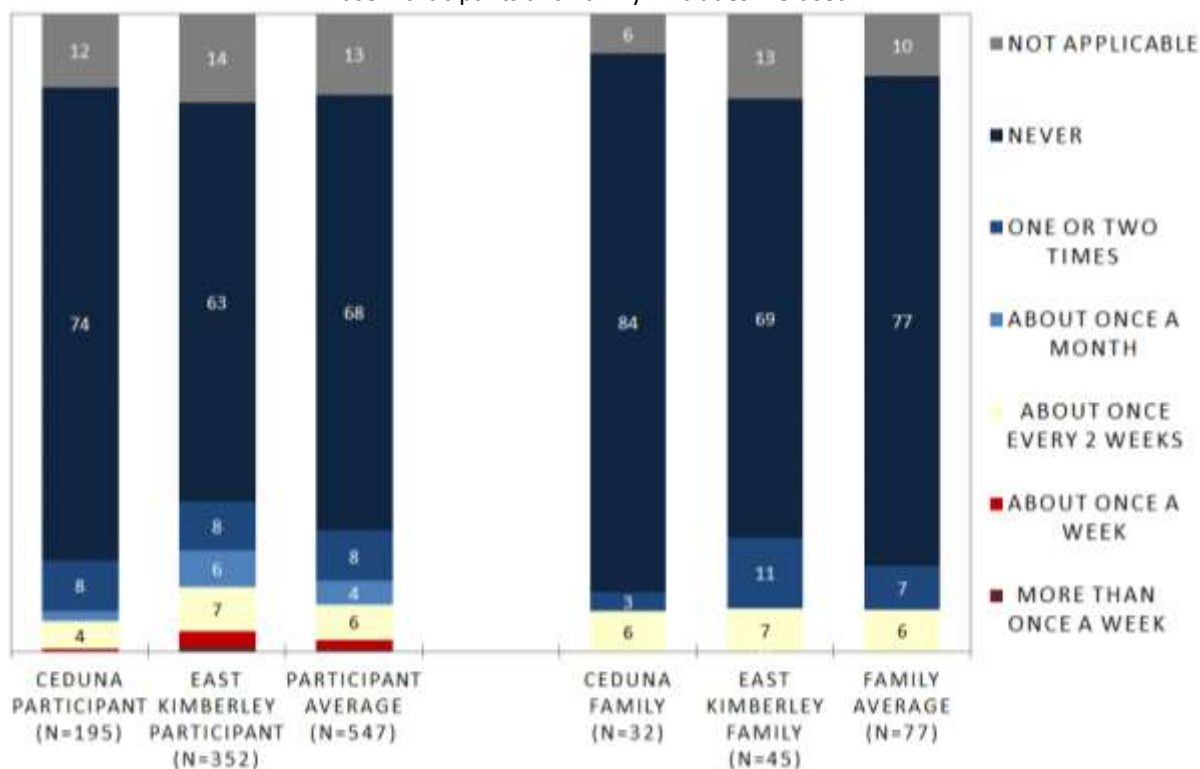
Figure 117: Run out of money to buy food in the last 3 months
 Base: Participants and Family. Excludes 'Refused'.



Q24i (P) / Q16i (F). In the last 3 months, how often, if at all, did you: Run out of money to buy food?

Figure 118: Not have money to pay rent / mortgage in the last 3 months

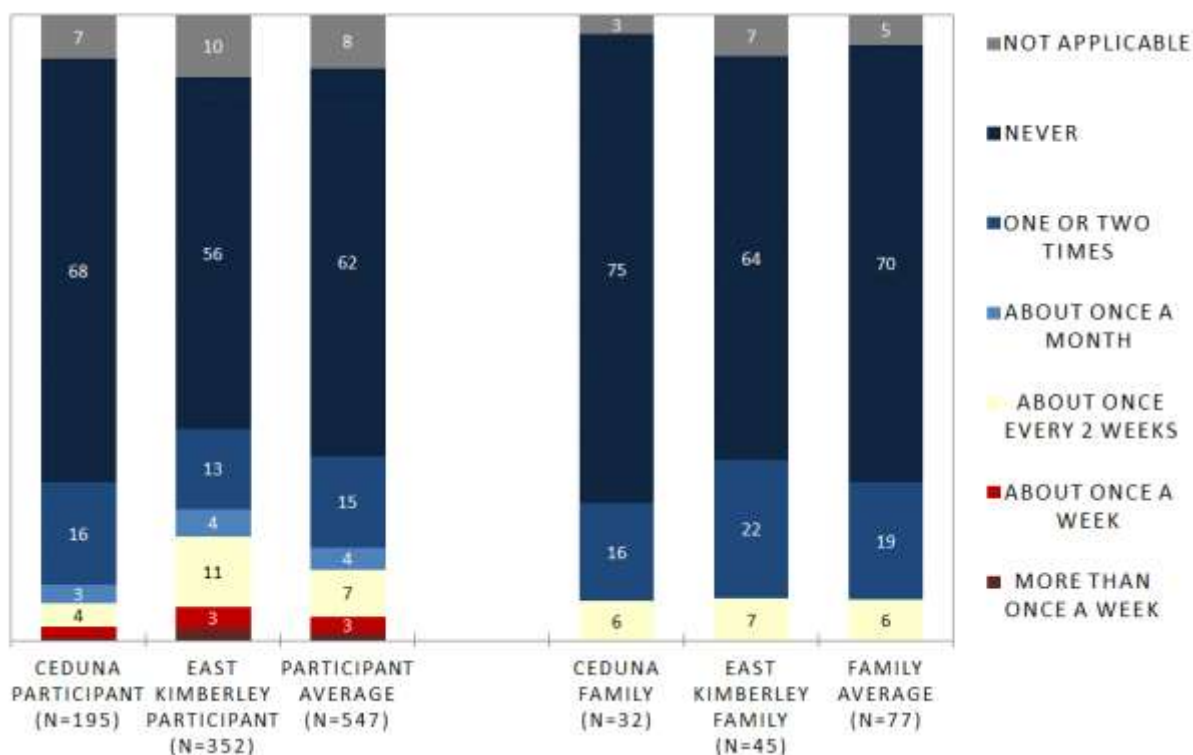
Base: Participants and Family. Excludes 'Refused'.



Q24ii (P) / Q16ii (F). In the last 3 months, how often, if at all, did you: Not have money to pay rent or your mortgage on time?

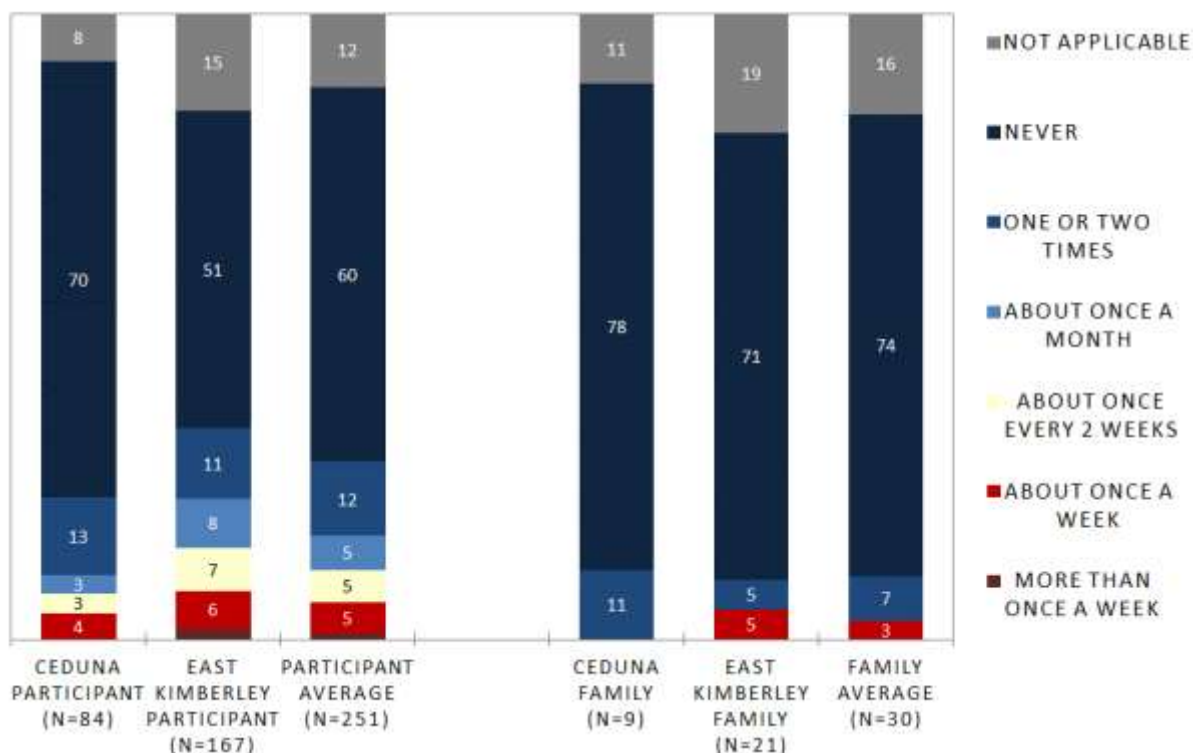
Figure 119: Not have money to pay another type of bill in the last 3 months

Base: Participants and Family. Excludes 'Refused'.



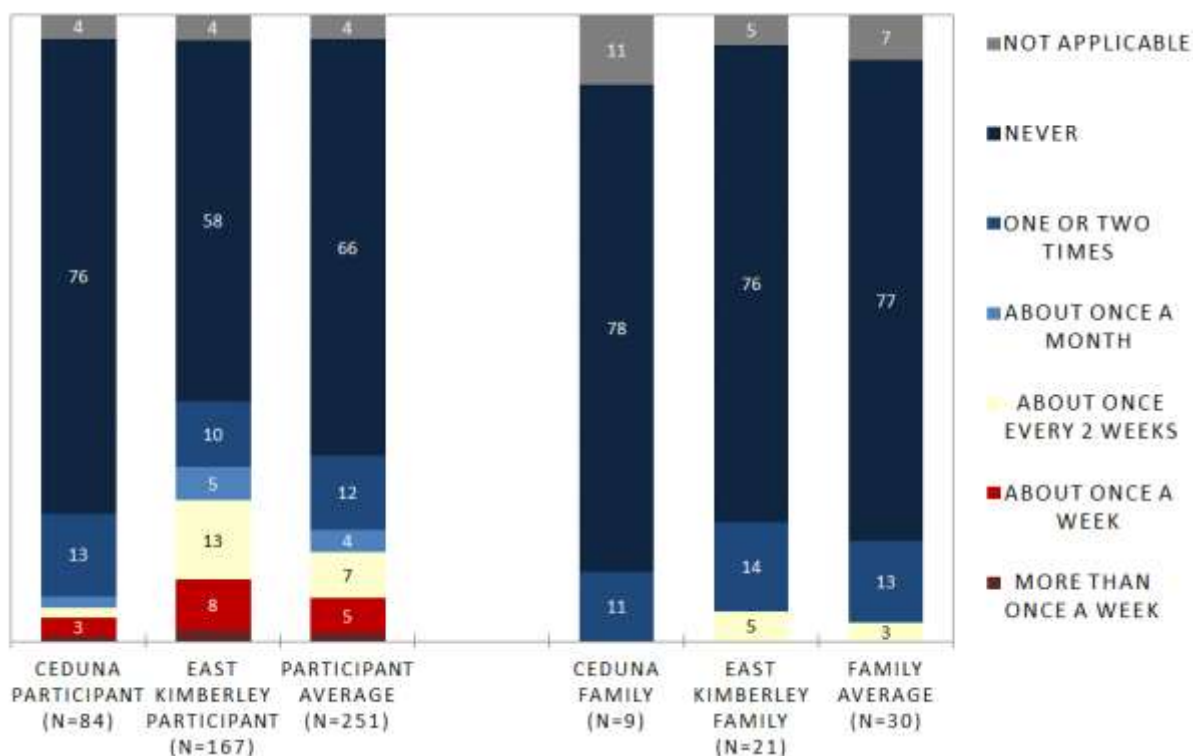
Q24iii (P) / Q16iii (F). In the last 3 months, how often, if at all, did you: Not have money to pay some other type of bill when it was due?

Figure 120: Run out of money to pay for things for your children’s schooling in the last 3 months
 Base: Participants and Family. Excludes ‘Refused’.



Q24iv (P) / Q16iv (F). In the last 3 months, how often, if at all, did you: Run out of money to pay for things that your child / children needed for school, like books?

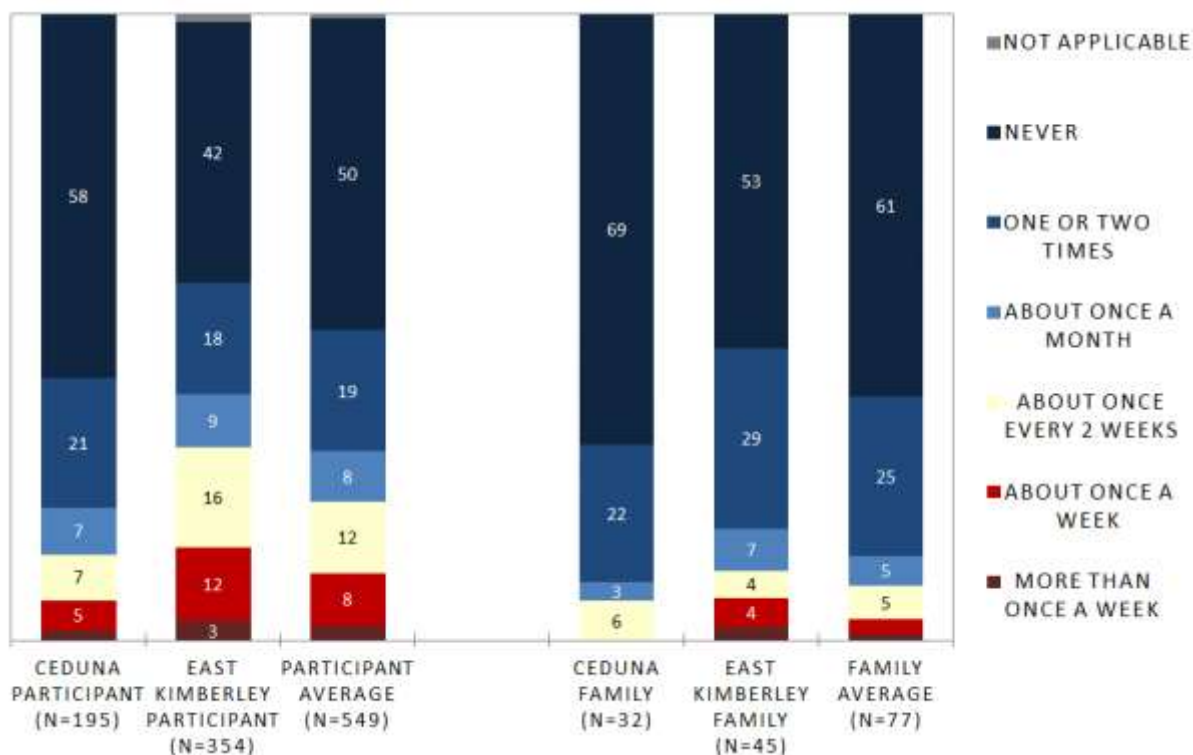
Figure 121: Run out of money to pay for essential non-food items for your children
 Base: Participants and Family. Excludes ‘Refused’.



Q24v (P) / Q16v (F). In the last 3 months, how often, if at all, did you: Run out of money to pay for essential (non-food) items for your children, such as nappies, clothes and medicine?

Figure 122: Borrow money from family or friends in the last 3 months

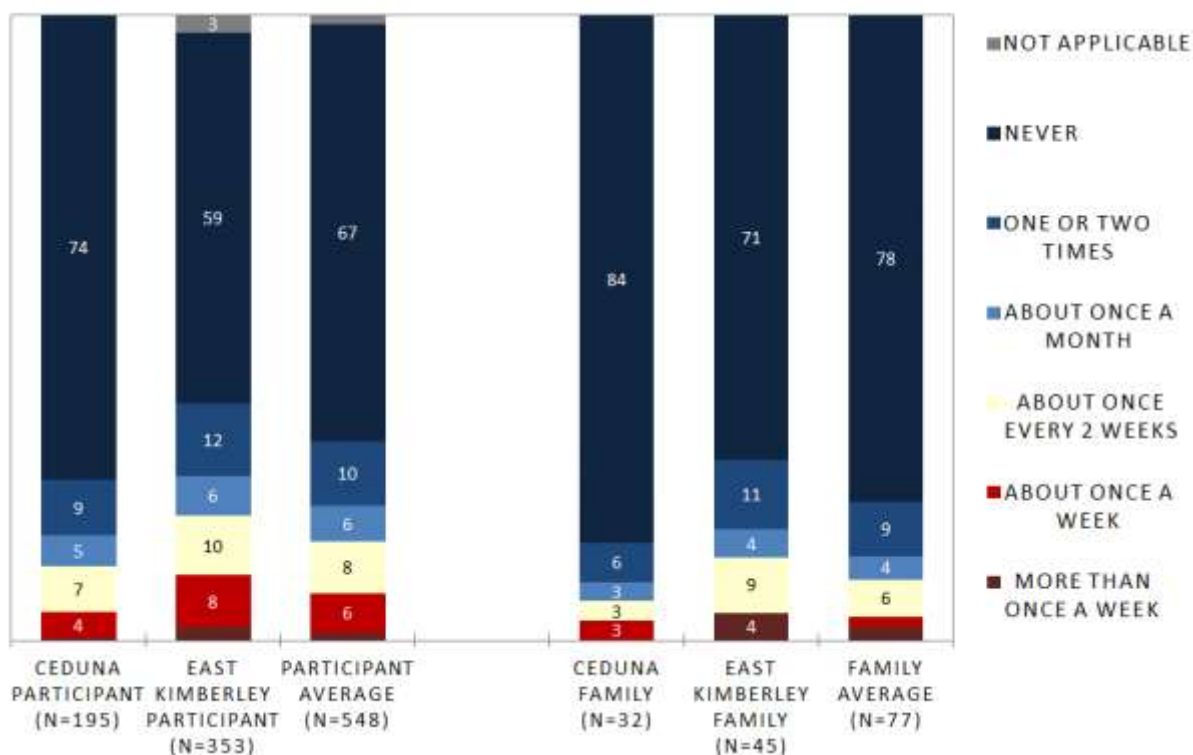
Base: Participants and Family. Excludes 'Refused'.



Q24vi (P) / Q16vi (F). In the last 3 months, how often, if at all, did you: Borrow money from family or friends?

Figure 123: Run out of money because you had given money to friends or family in the last 3 months

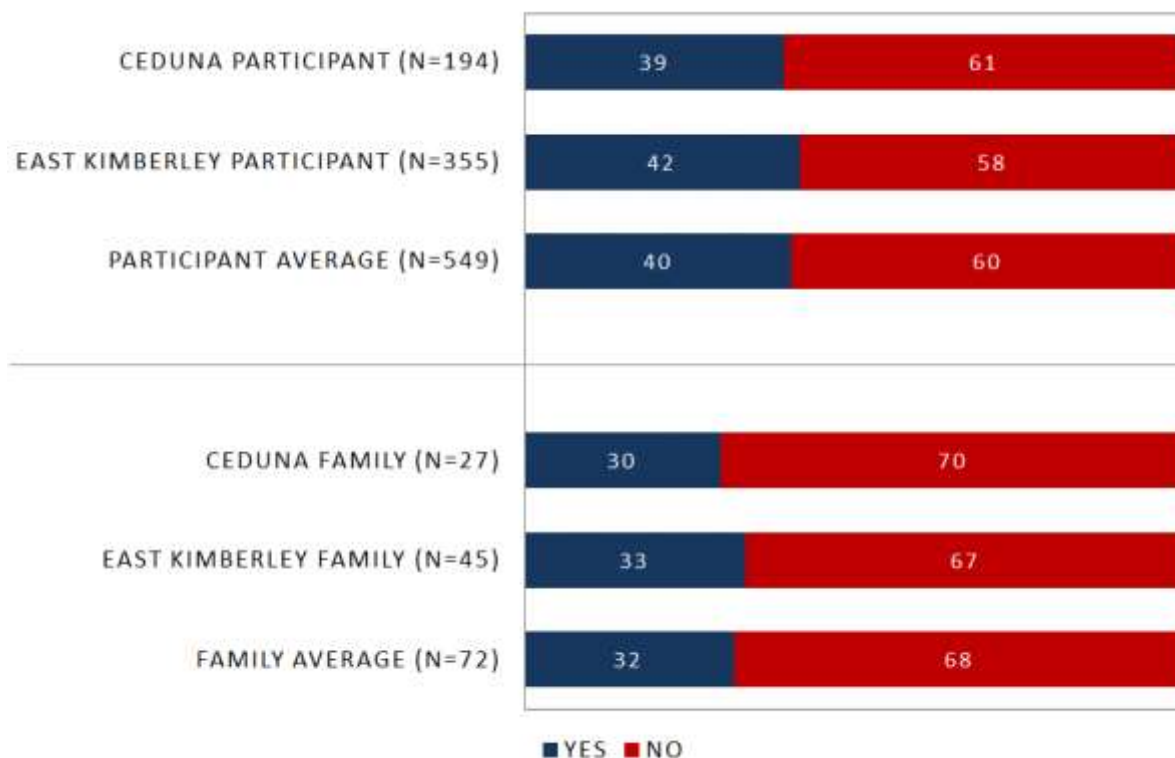
Base: Participants and Family. Excludes 'Refused'.



Q24vii (P) / Q16vii (F). In the last 3 months, how often, if at all, did you: Run out of money because you had given money to friends or family?

Figure 124: Currently looking for a job

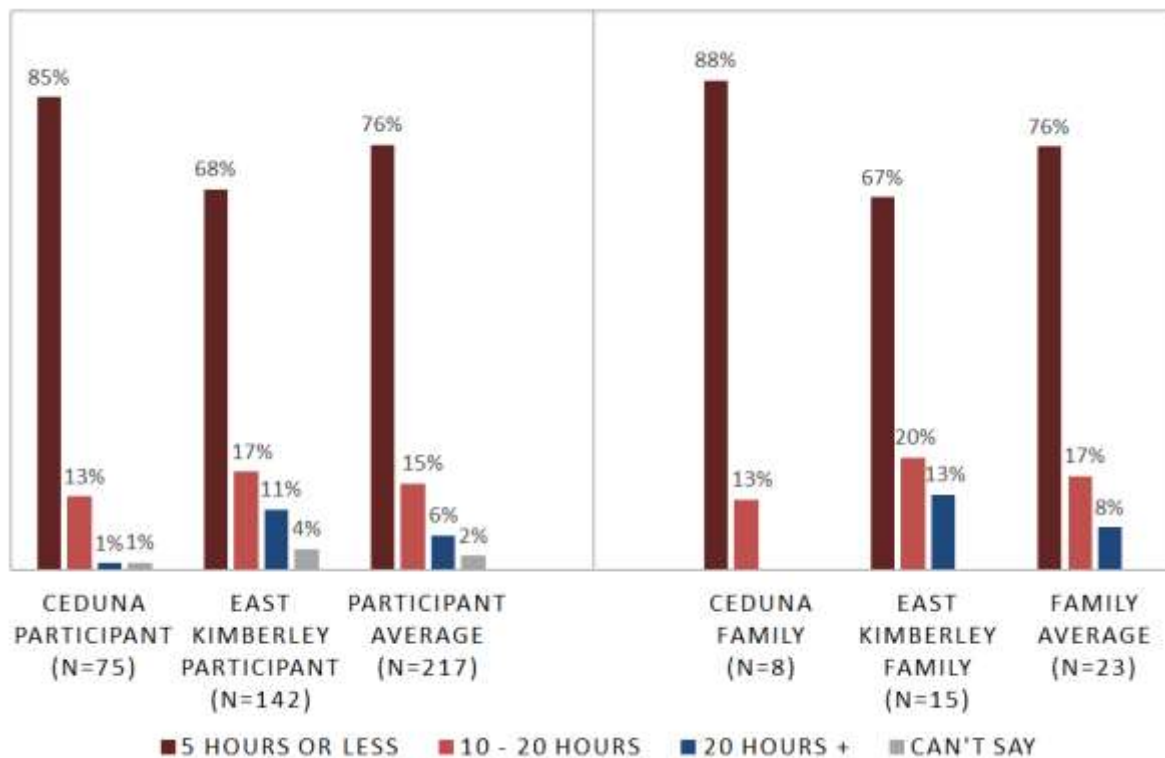
Base: Participants and Family.



Q26 (P) / Q18 (F). Are you currently looking for a job or paid work?

Figure 125: Number of hours usually spend on trying to get a job

Base: Participants and Family. Excludes 'Refused'.



Q27 (P) / Q19 (F). Usually, how many hours a week would you spend on trying to get a job or paid work?

Family

Figure 126: Children go to school

Base: Participants and Family who care for a child / children. Excludes 'Refused'.

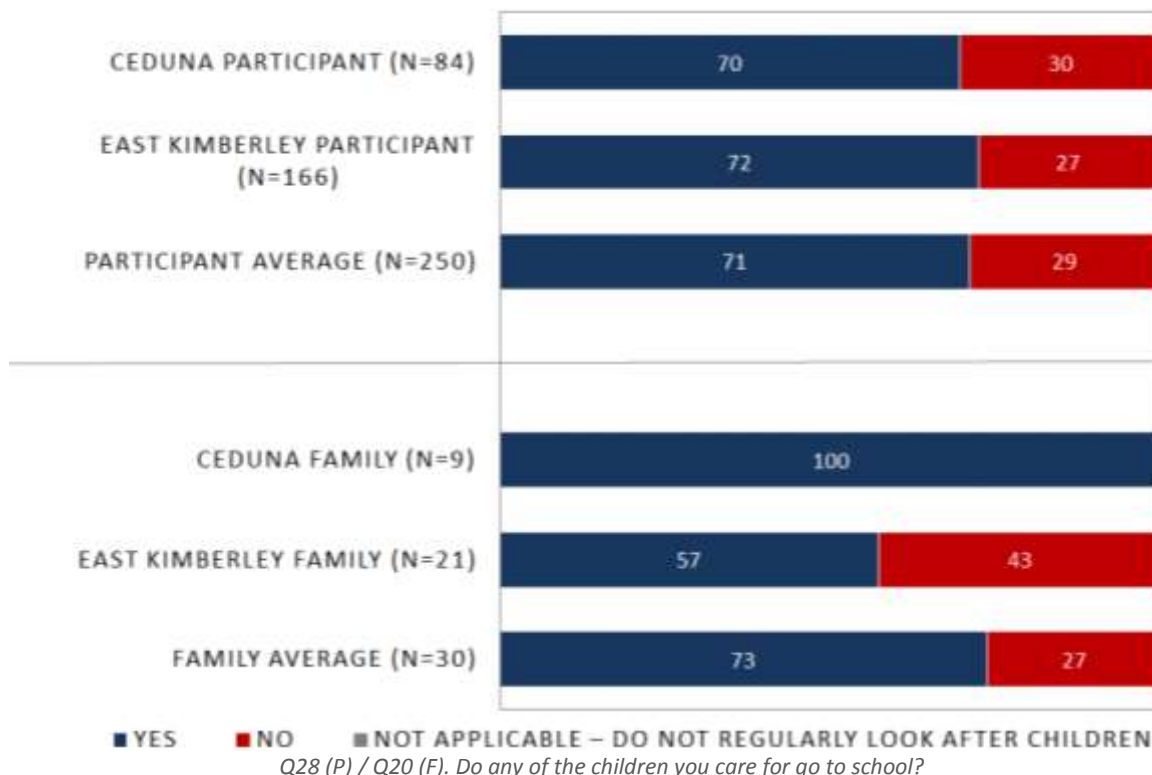
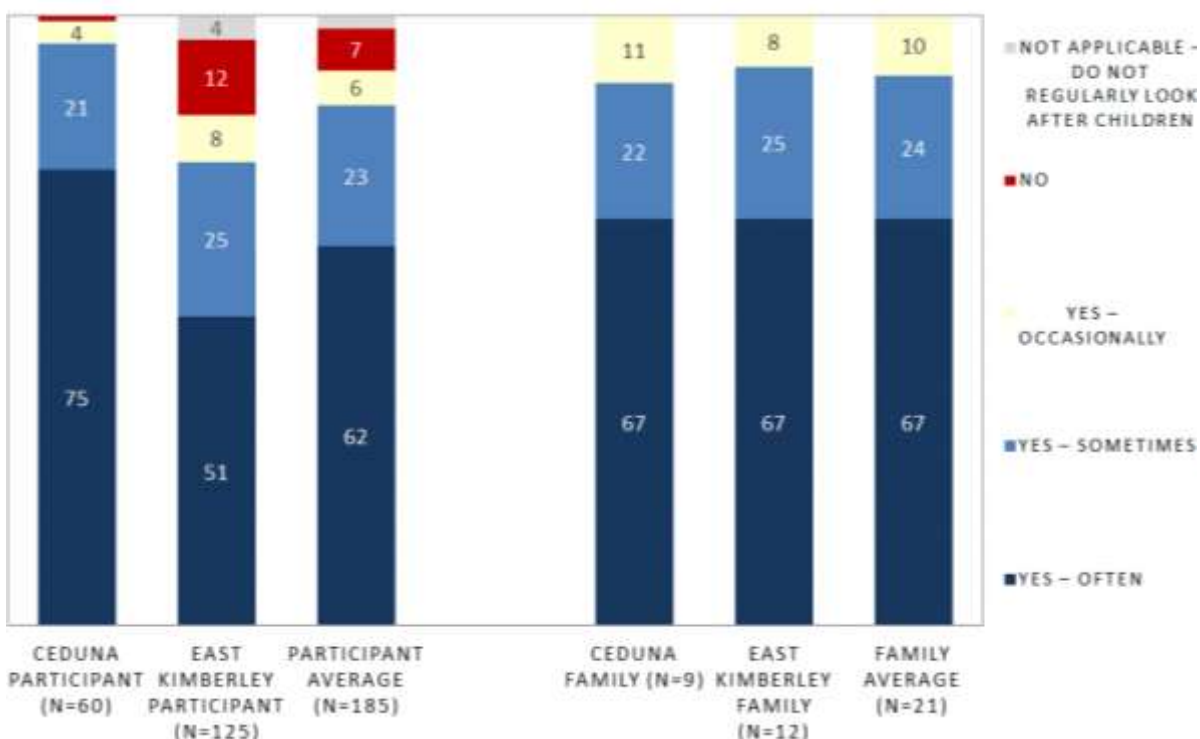


Figure 127: Check on homework or help out with other things to do with school

Base: Participants and Family. Excludes 'Refused'.

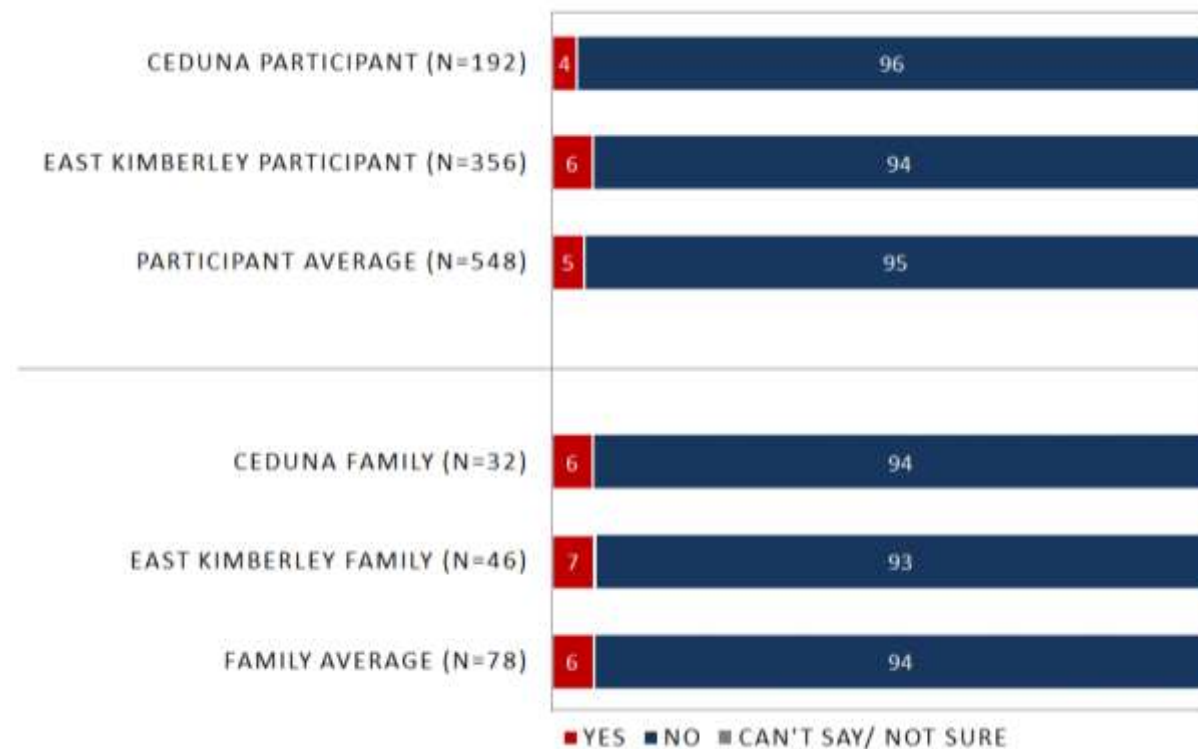


Q28a (P) / Q20a (F). Usually, do you check to make sure that the children are doing their homework or help out with other things to do with school?

Recent experiences

Figure 128: Arrested by the Police in the past month

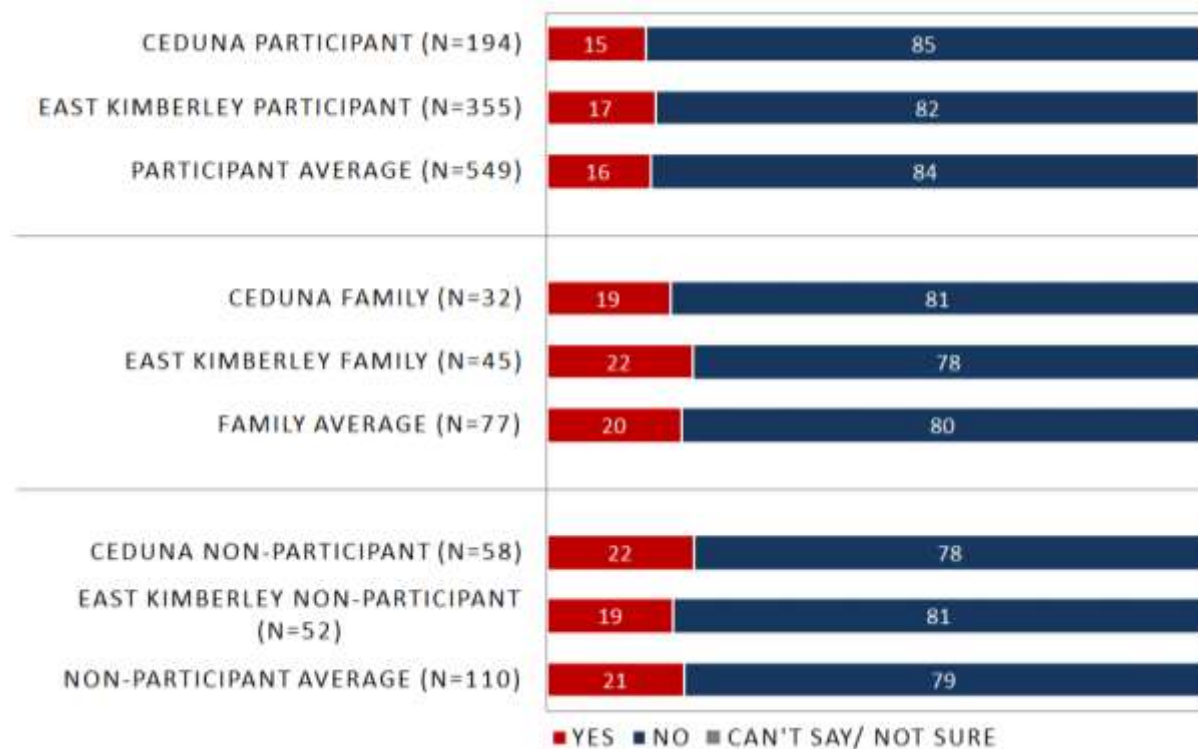
Base: Participants and Family. Excludes 'Refused'.



Q29a (P) / Q21a (F). In the past month have you been: Arrested by Police?

Figure 129: Harassed in the past month

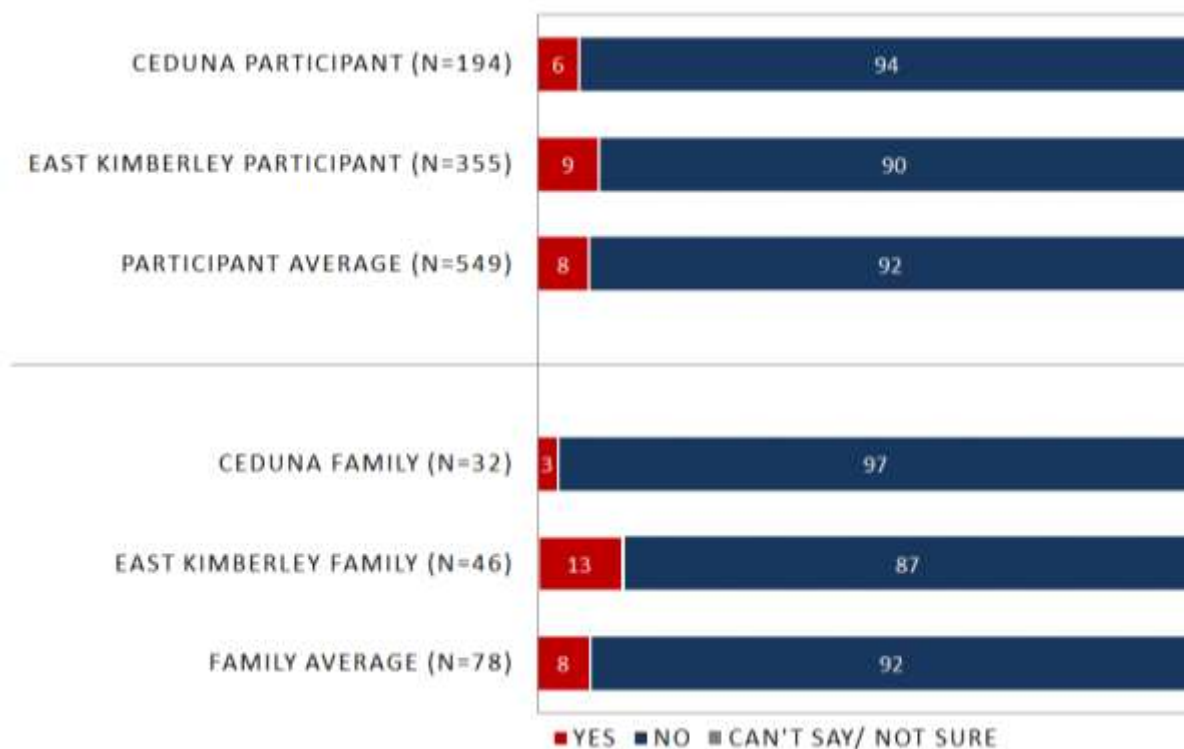
Base: Participants, Family and Non-Participants. Excludes 'Refused'.



Q29c (P) / Q21c (F) / Q13b (NP). In the past month have you been: Harassed?

Figure 130: Been homeless or had to sleep rough in the past month

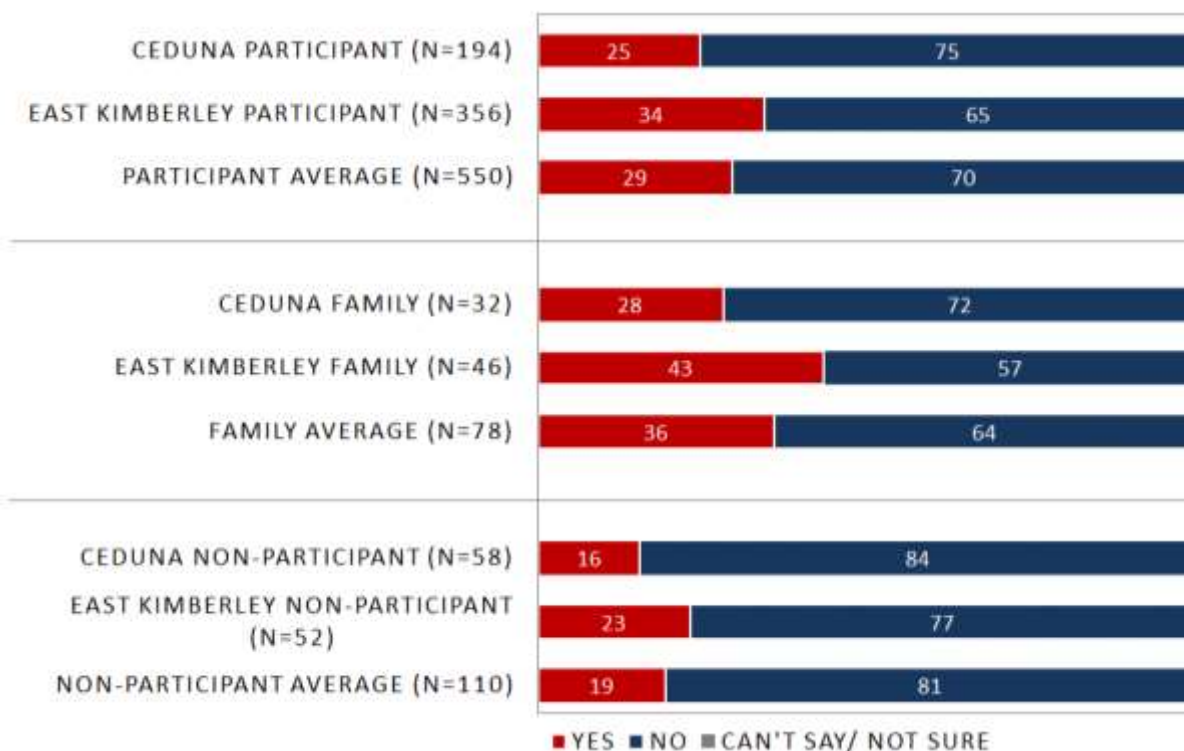
Base: Participants and Family. Excludes 'Refused'.



Q29f (P) / Q21f (F). In the past month have you been: Homeless or had to sleep rough?

Figure 131: Humbugged or pressured by family or friends to give them money in the past month

Base: Participants, Family and Non-Participants. Excludes 'Refused'.

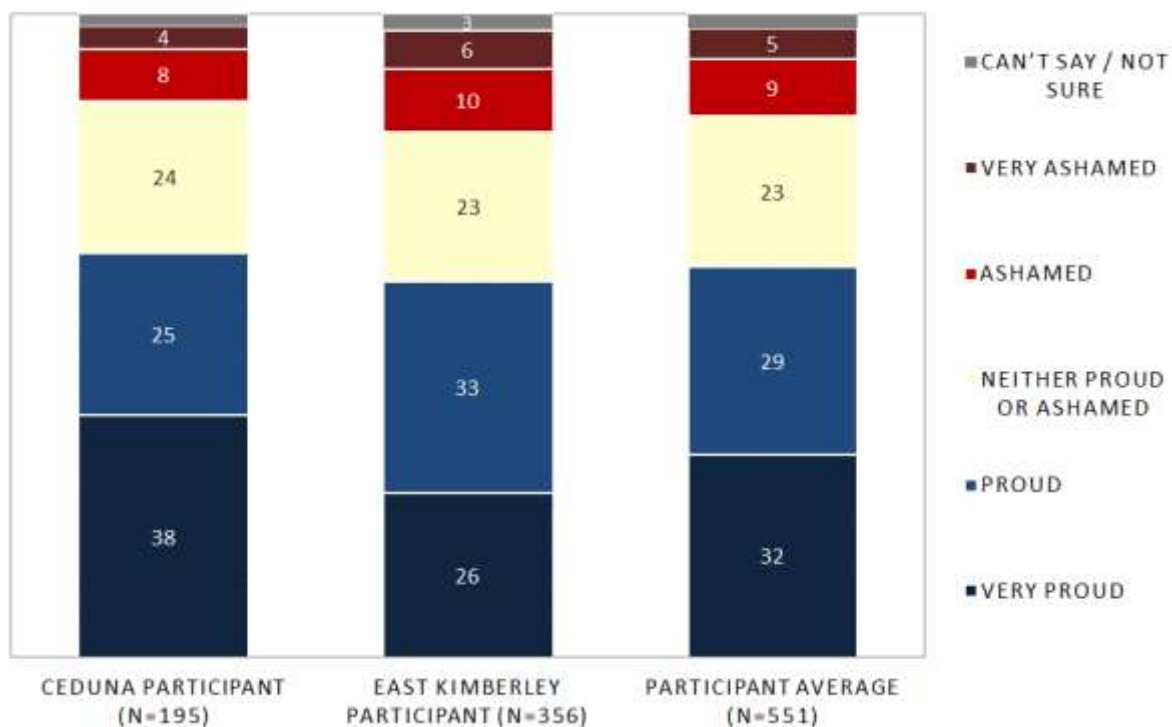


Q29g (P) / Q21g (F) / Q13e (NP). In the past month have you been: Humbugged or pressured by family or friends to give them money?

Community Pride

Figure 132: Participants' feelings toward the community in which you live

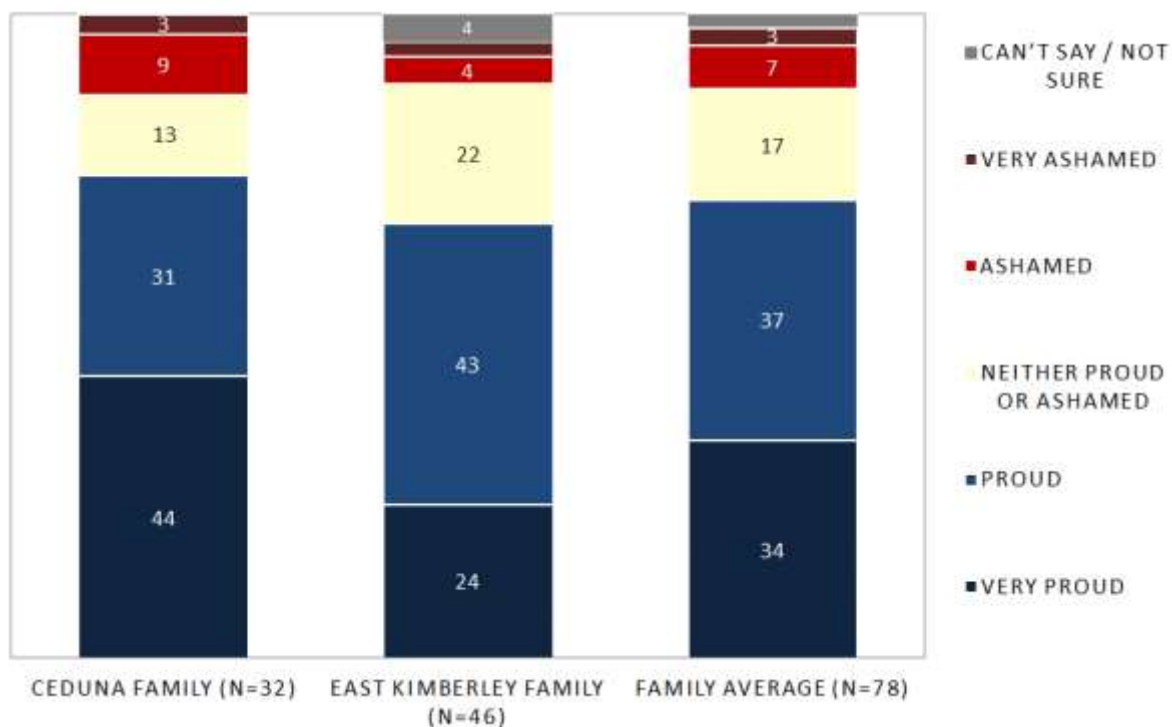
Base: Participants.



Q30 (P). Do you feel proud or ashamed of the community in which you live?

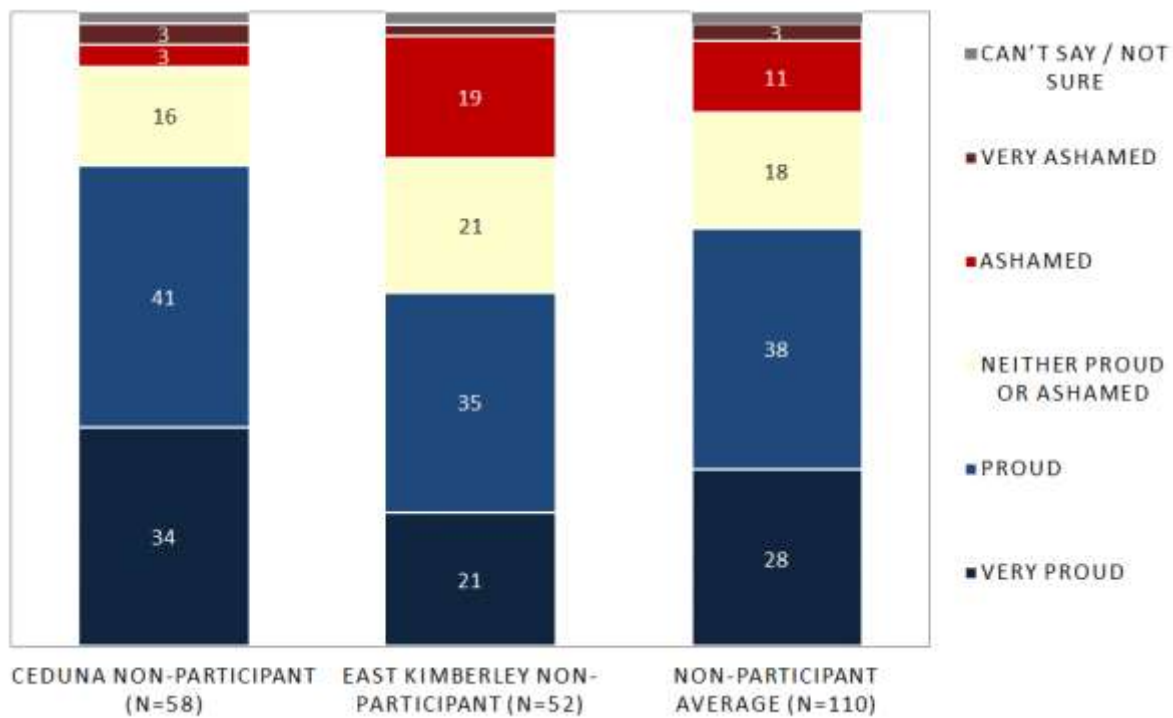
Figure 133: Families' feelings toward the community in which you live

Base: Family.



Q22 (F). Do you feel proud or ashamed of the community in which you live?

Figure 134: Non-Participants feelings toward the community in which you live
 Base: Non-Participants.

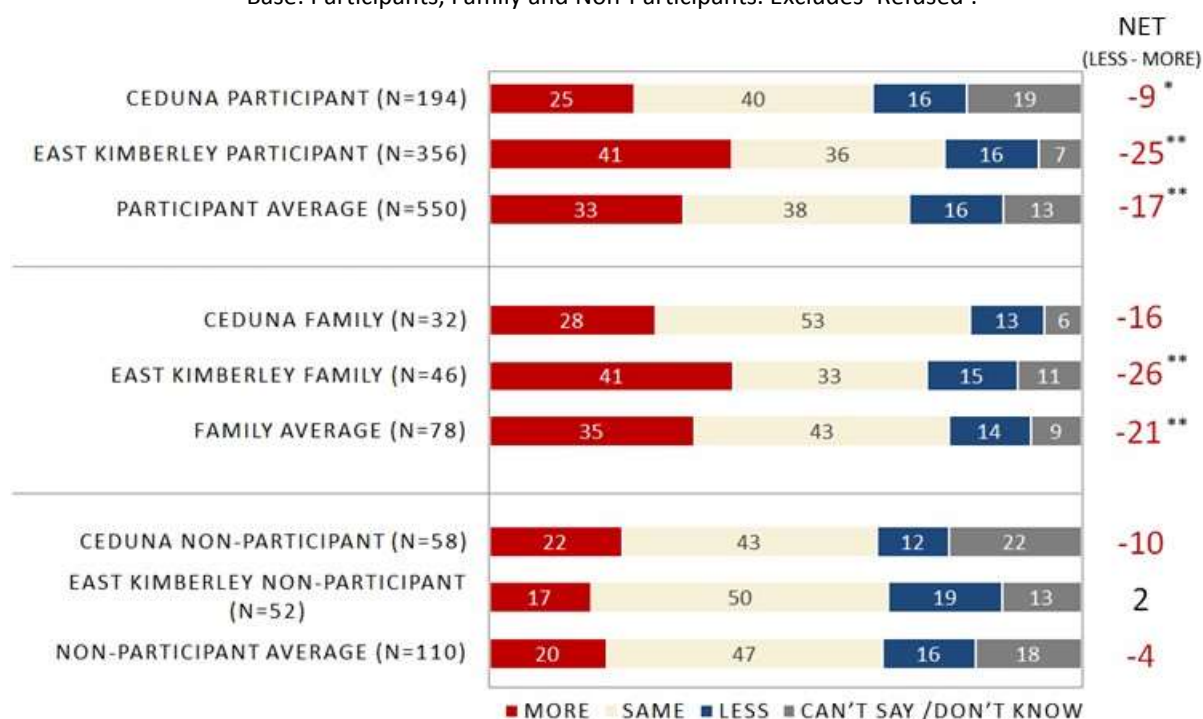


Q14 (NP). Do you feel proud or ashamed of the community in which you live?

Questionnaire Section D: Opinions of the impact of the Debit Card Trial

Figure 135: Noticed more humbugging or harassment for money since the Trial started

Base: Participants, Family and Non-Participants. Excludes 'Refused'.

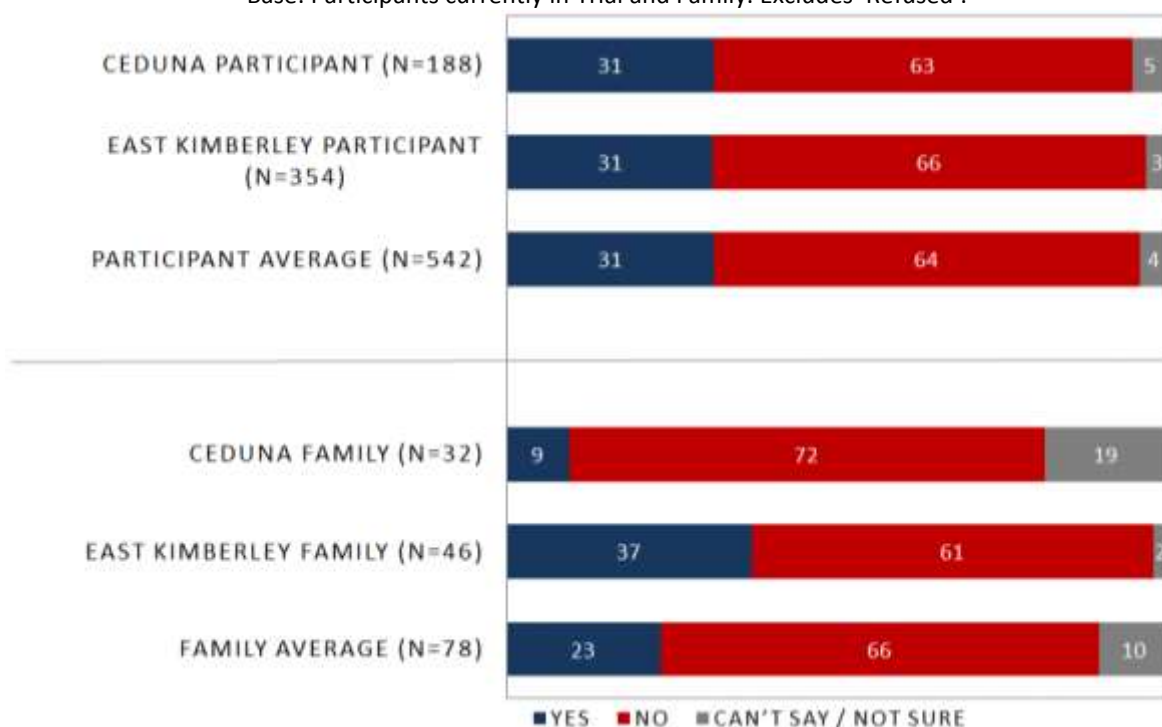


Q42d (P) / Q24d (F) / Q16d. Since the Cashless Debit / Indue Card started in your community, have you noticed more, less or the same amount of: Humbugging or harassment for money?

**Significantly different to zero at the 95% level *Significantly different to zero at the 90% level

Figure 136: Been able to save more money than before since Trial started

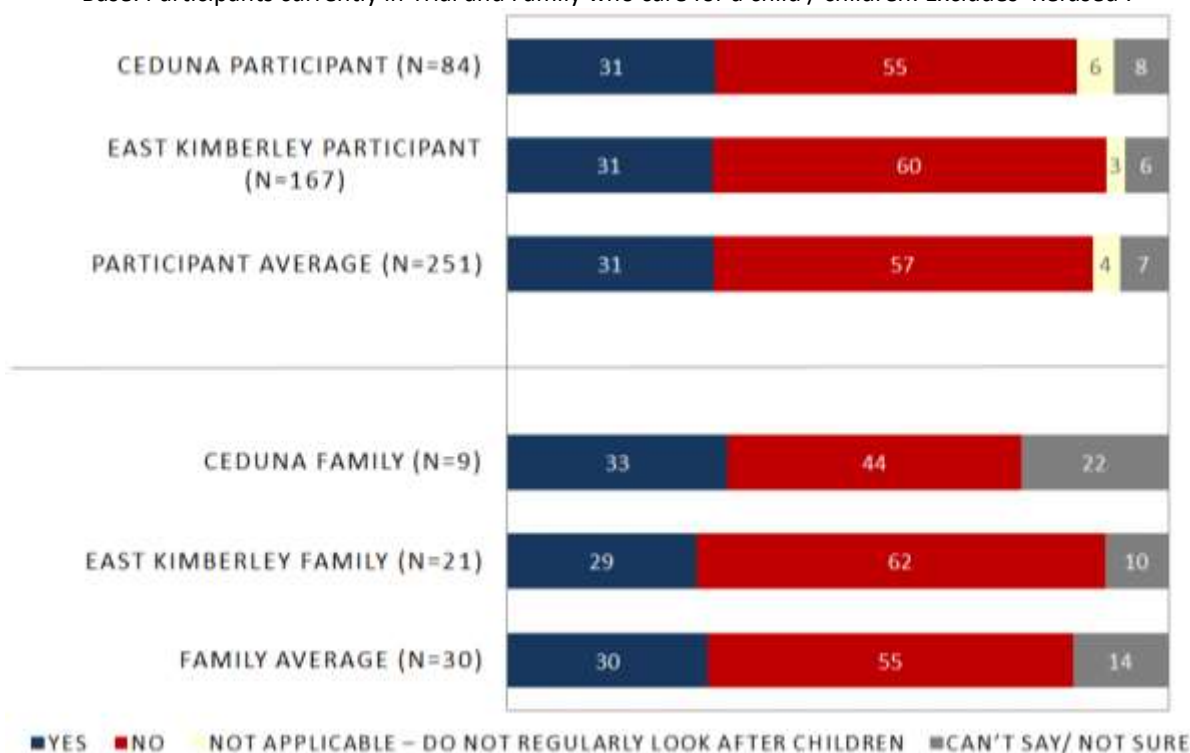
Base: Participants currently in Trial and Family. Excludes 'Refused'.



Q43a (P) / Q25a (F). Since being on the Cashless Debit / Indue Card have these happened to you: You've / the family has been able to save more money than before?

Figure 137: Been better able to care for your child/ren since Trial started

Base: Participants currently in Trial and Family who care for a child / children. Excludes 'Refused'.



Q43b (P) / Q25b (F). Since being on the Cashless Debit / Indue Card have these happened to you: You've / the family has been better able to care for your child/ren?

Figure 138: Got more involved in your children’s homework and school since Trial started

Base: Participants currently in Trial and Family who care for a child / children. Excludes ‘Refused’.

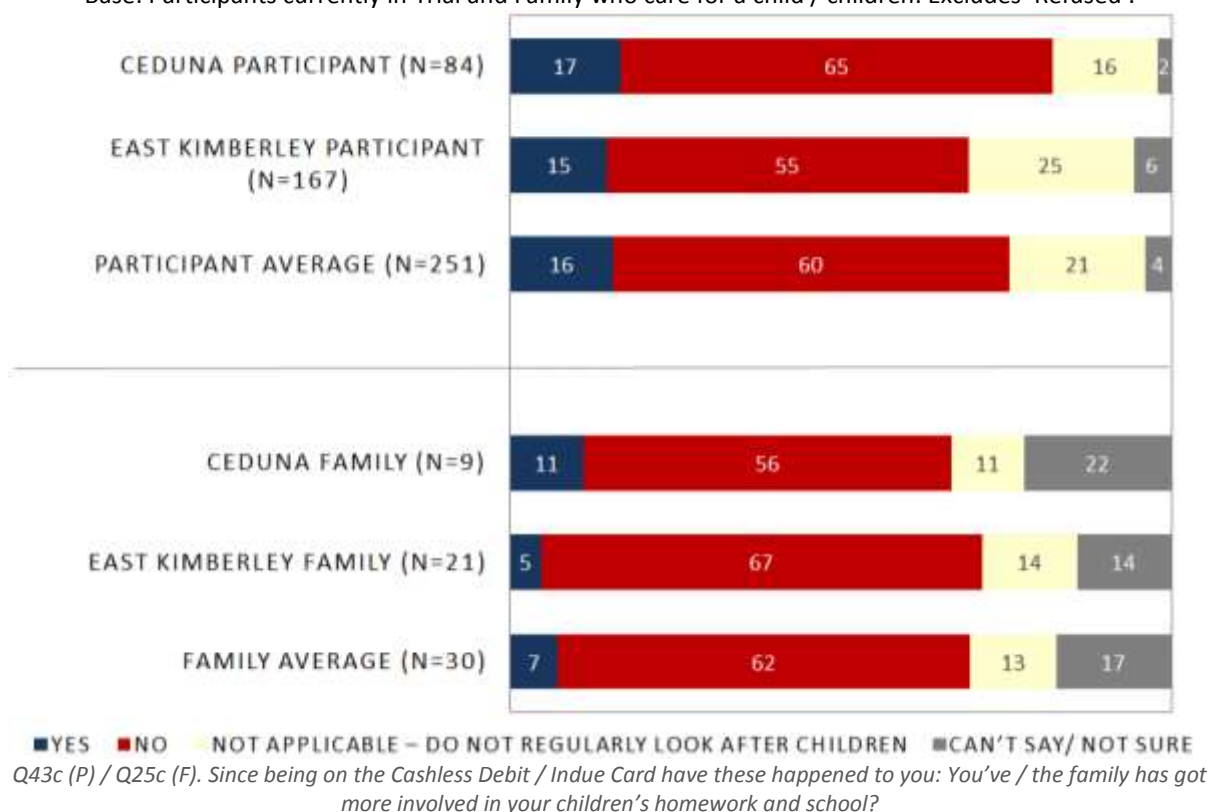


Figure 139: Got better at things like using a computer, the internet or a smartphone since Trial started

Base: Participants currently in Trial. Excludes ‘Refused’.

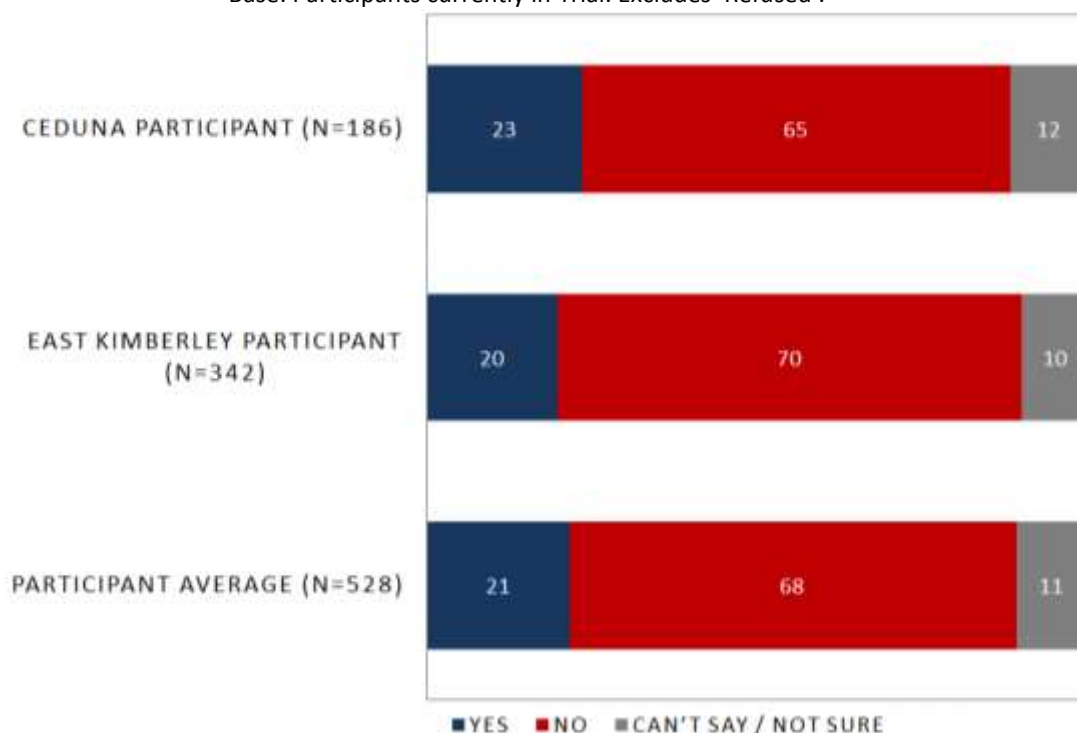
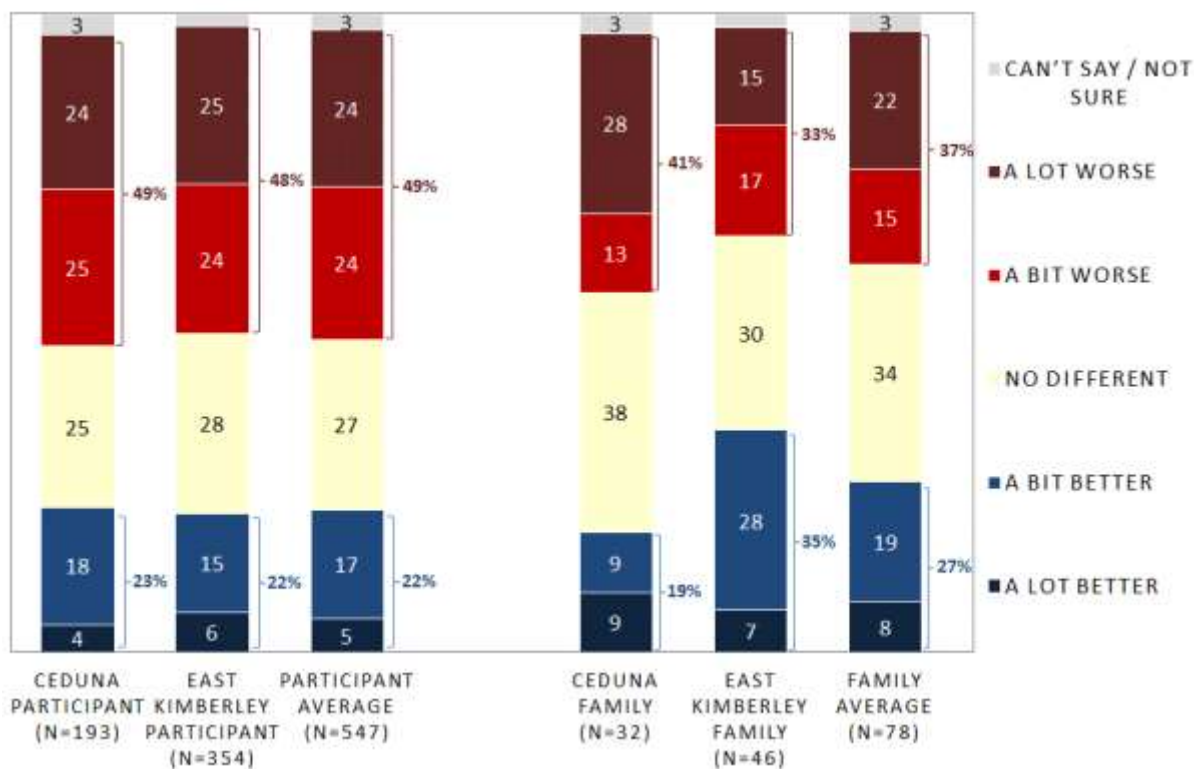


Figure 140: Impact of the Trial on your life / your family's life

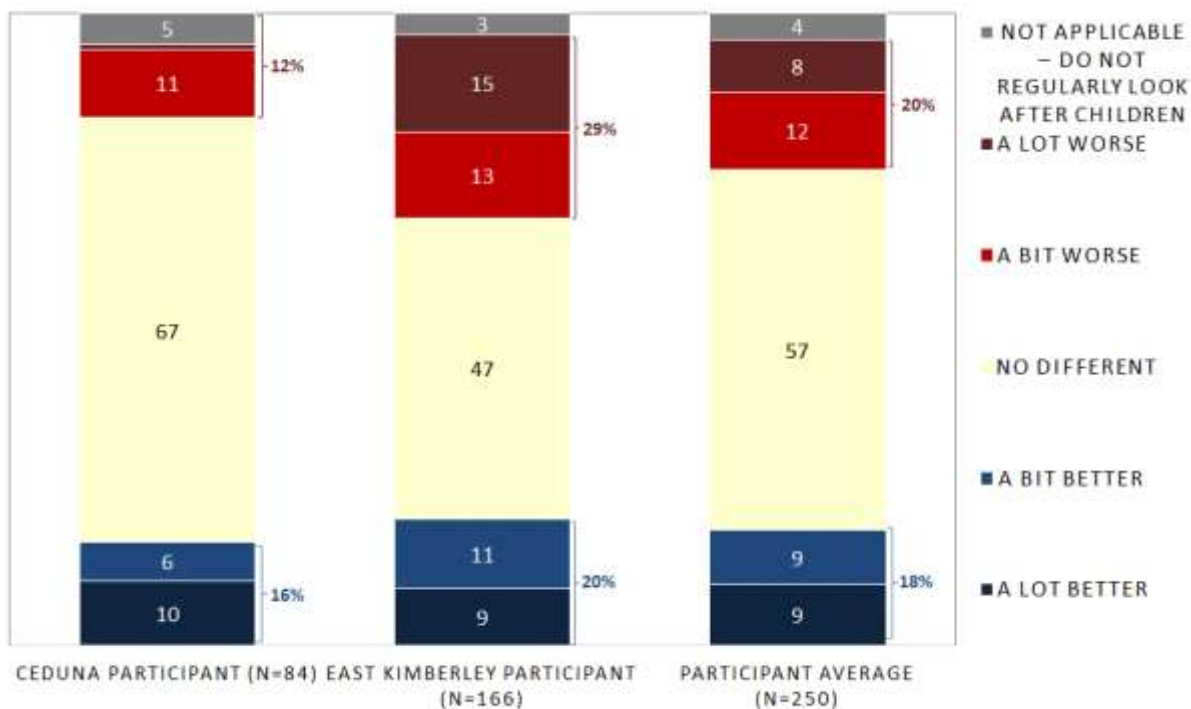
Base: Participants currently in Trial and Family. Excludes 'Refused'.



Q45 (P) / Q27 (F). Would you say the Cashless Debit / Indue Card has made your life / your family's life..?.

Figure 141: Impact of the Trial on your child's life / children's lives

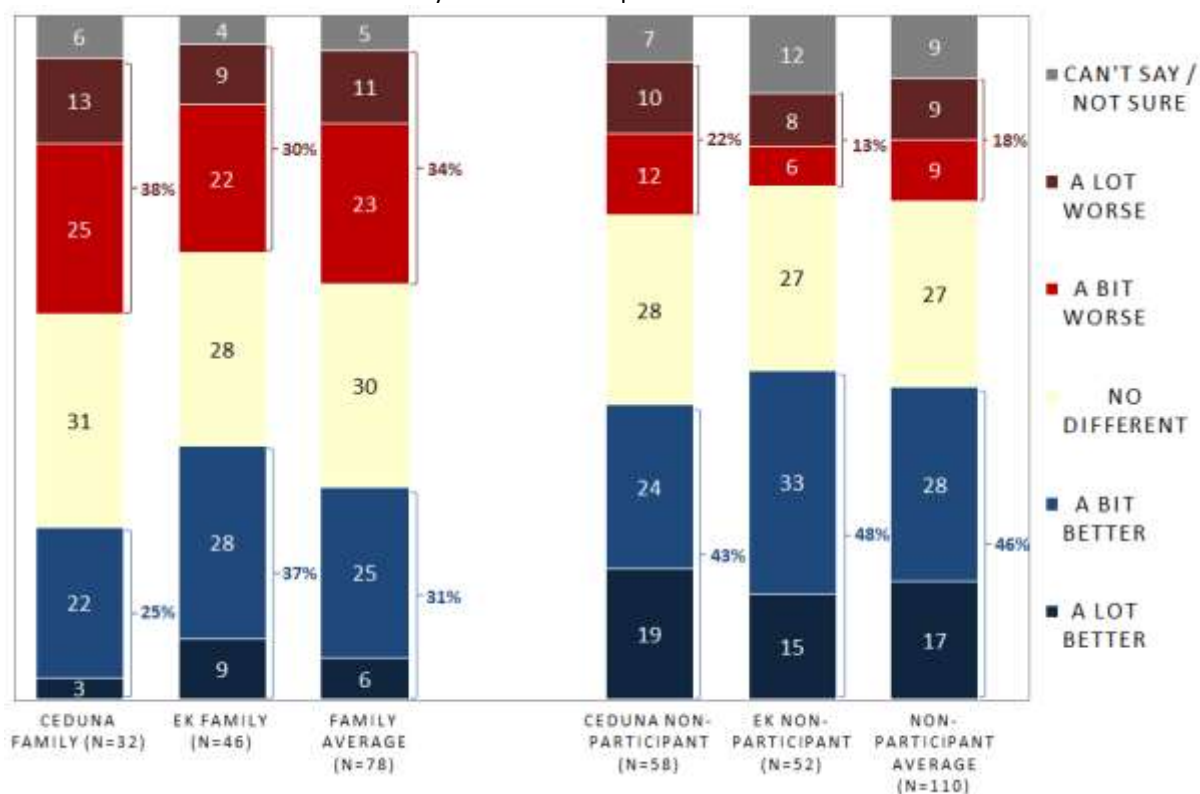
Base: Participants currently in Trial. Excludes 'Refused'.



Q47 (P). Would you say, the Cashless Debit / Indue Card has made your child's life / children's lives..?.

Figure 142: Impact of the Trial on your community

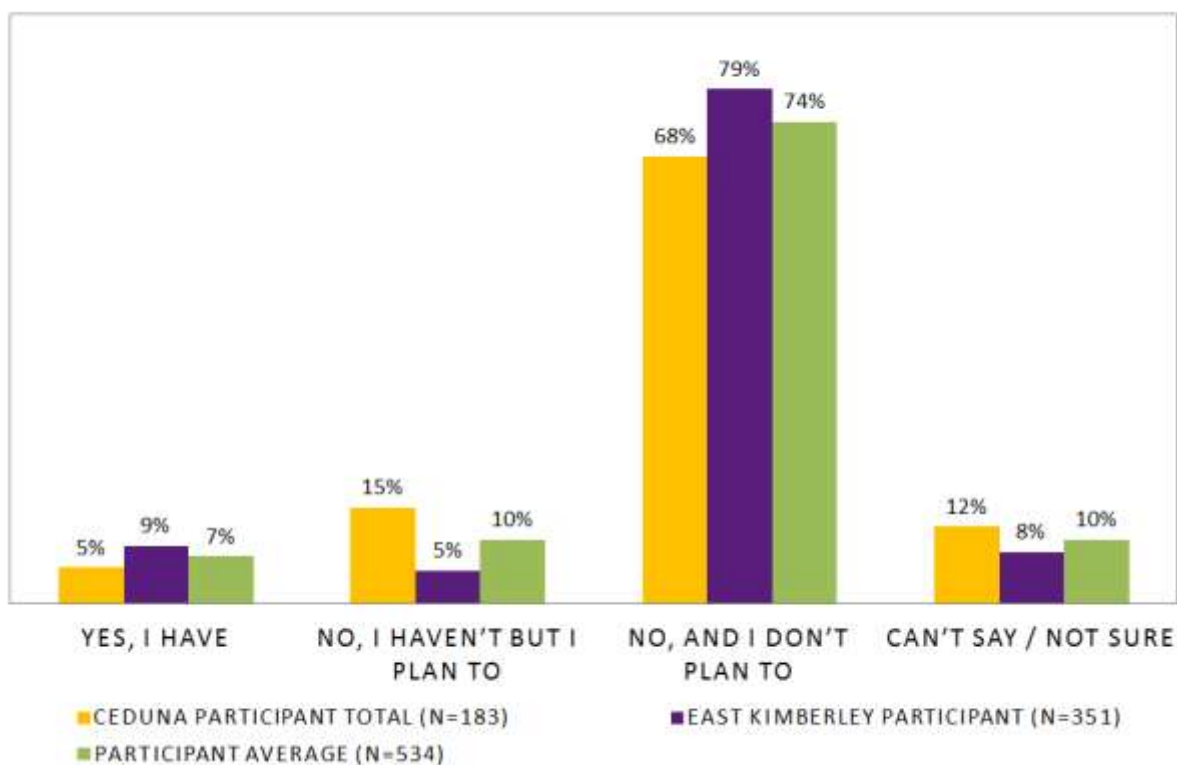
Base: Family and Non-Participants. Excludes 'Refused'.



Q29 (F) / Q17 (NP). Would you say, the Cashless Debit / Indue Card has made life in your community..?

Figure 143: Recommend card to others

Base: Participants currently in Trial. Excludes 'Refused'.



Q48 (P). Have you told anyone who doesn't have a Cashless Debit / Indue Card to get one, or do you plan to?

Further Analysis: Key questions by key demographics

Table 10: Key questions split by age

Since being on the CDCT	Age group				
	18-24	25-34	35-44	45-54	55-64
Percent "yes":	<i>n=37-80</i>	<i>n=79-127</i>	<i>n=72-121</i>	<i>n=44-135</i>	<i>n=19-79</i>
You've been able to save more money than before [FIN]	41%	32%	28%	33%	23%
You've been better able to care for your child/ren	29%	29%	37%	30%	28%
You've got more involved in your children's homework and school	3%	11%	26%	23%	16%
I've got better at things like using a computer, the internet or a smartphone	24%	30%	23%	15%	12%
Net positive change:	<i>n=80</i>	<i>n=130</i>	<i>n=121-122</i>	<i>n=136</i>	<i>n=79</i>
Drunk grog or alcohol [D&A]	18%	13%	19%	14%	10%
Had six or more drinks of grog or alcohol at one time [D&A]	15%	7%	12%	15%	11%
Gambled [FIN]	10%	8%	8%	8%	5%
Spent more than \$50 a day on gambling [FIN]	8%	3%	6%	3%	4%
Bet more than you can really afford to lose [FIN]	5%	-1%	2%	3%	4%
Had to borrow money or sell things to get money to gamble [FIN]	2%	1%	2%	0%	1%
Used an illegal drug like benzos, ice, marijuana, or speed [D&A]	7%	1%	6%	2%	4%
Spent more than \$50 a day on illegal drugs like benzos, ice, marijuana, or speed [D&A]	6%	1%	0%	1%	0%
Net positive change:	<i>n=80</i>	<i>n=130</i>	<i>n=122</i>	<i>n=136</i>	<i>n=79</i>
Would you say the Cashless Debit Card / Indue Card has made your life better	-27%	-33%	-12%	-16%	-45%

[FIN]: Financial statement, [D&A]: Drug and Alcohol statement.

Table 11: Key questions split by gender

Since being on the CDCT	Gender	
	Female	Male
Percent “yes”:	<i>n=200-341</i>	<i>n=51-201</i>
You’ve been able to save more money than before [FIN]	33%	29%
You’ve been better able to care for your child/ren	30%	36%
You’ve got more involved in your children’s homework and school	13%	23%
I’ve got better at things like using a computer, the internet or a smartphone	23%	20%
Net positive change:	<i>n=345-346</i>	<i>n=201</i>
Drunk grog or alcohol [D&A]	13%	17%
Had six or more drinks of grog or alcohol at one time [D&A]	10%	14%
Gambled [FIN]	10%	5%
Spent more than \$50 a day on gambling [FIN]	4%	5%
Bet more than you can really afford to lose [FIN]	2%	2%
Had to borrow money or sell things to get money to gamble [FIN]	1%	1%
Used an illegal drug like benzos, ice, marijuana, or speed [D&A]	3%	5%
Spent more than \$50 a day on illegal drugs like benzos, ice, marijuana, or speed [D&A]	1%	1%
Net positive change:	<i>n=346</i>	<i>n=201</i>
Would you say the Cashless Debit Card / Indue Card has made your life better	-25%	-28%

[FIN]: Financial statement, [D&A]: Drug and Alcohol statement.

Table 12: Key questions split by those who care for a child/children and those that don't

Since being on the CDCT	Care for child	
	Yes	No
Percent "yes":	<i>n=233-251</i>	<i>n=295</i>
You've been able to save more money than before [FIN]	27%	35%
You've been better able to care for your child/ren	31%	-
You've got more involved in your children's homework and school	16%	-
I've got better at things like using a computer, the internet or a smartphone	22%	21%
Net positive change:	<i>n=250-251</i>	<i>n=296</i>
Drunk grog or alcohol [D&A]	14%	16%
Had six or more drinks of grog or alcohol at one time [D&A]	11%	13%
Gambled [FIN]	8%	7%
Spent more than \$50 a day on gambling [FIN]	2%	6%
Bet more than you can really afford to lose [FIN]	2%	3%
Had to borrow money or sell things to get money to gamble [FIN]	0%	3%
Used an illegal drug like benzos, ice, marijuana, or speed [D&A]	5%	2%
Spent more than \$50 a day on illegal drugs like benzos, ice, marijuana, or speed [D&A]	1%	2%
Net positive change:	<i>n=251</i>	<i>n=296</i>
Would you say the Cashless Debit Card / Indue Card has made your life better	-27%	-26%

[FIN]: Financial statement, [D&A]: Drug and Alcohol statement.

Appendix C: Qualitative Summary Reports

Ceduna and Surrounds

Methodology

- In-depth interviews and focus groups – n=33
- Dates: Monday 15 August – Thursday 15 September
- Locations: Ceduna, Koonibba, Scotdesco and Yalata

Overall impact of Trial

Overall, most participants did not believe that there had been significant change / impact of the CDCT, however upon further probing there was evidence of some change starting to emerge. Most of these participants felt it was “too early” in the Trial to determine any considerable change, and were expecting to only see changes in the longer term (i.e. another 6 months or so).

Some participants indicated that there were other external factors which may have impacted on data / behaviour over the Trial period, beyond the impact of CDCT itself, such as:

- Weather – it was noted that the seasonal effect of a cold and wet winter could be contributing to less visible public activities (e.g. public drinking and gambling);
- Lump sum payments – it was reported that there had been an “influx of cash” into the community via tax payments, superannuation payments (a \$200,000+ payment was reported) and inheritances, and this has potentially contributed to abnormal expenditure patterns (e.g. alcohol and large purchases); and
- Alcohol restrictions – some stakeholders felt that the introduction of alcohol restrictions in 2015 had already caused a noticeable change in the community and that this was the cause for the visible reduction in alcohol consumption rather than the CDCT itself (e.g. a health worker participant reported a substantial drop of intoxicated presentations since the changes to liquor laws, but felt that it was not as considerable since the CDCT).

Alcohol consumption

Many stakeholders were reluctant to indicate that the CDCT had reduced alcohol consumption in Ceduna and surrounding areas as they felt that there were no direct, visible changes to alcohol consumption since the start of the Trial. However, some had noted broader changes that could suggest an indirect impact on reducing alcohol consumption (e.g. more money directed to other purposes and greater engagement with programs).

The few stakeholders who had noted direct positive impacts of CDCT in relation to alcohol consumption reported that these included:

- Less visibility / fewer people consuming alcohol in public. This was evidenced by:
 - A few stakeholders seeing and hearing fewer intoxicated people on the streets;
 - Fewer ambulance callouts to public places. While call-out figures were unchanged, there were more call-outs to private addresses since the Trial had begun;
 - Fewer people drinking in front and back gardens in one remote community (Koonibba);
- More sobriety – evidenced by:
 - A substantial increase (around 50%) in the number of people attending the lunch service at the ADAC day centre (previously most clients only attended breakfast);
 - More people attending services at CAC while sober;
 - Seeing specific individuals sober – a few stakeholders reported seeing certain individuals in a sober state “for the first time”; and
- Reduced emergency presentations related to alcohol consumption during the end of the financial year period – there tended to be an influx in hospital presentations associated with excessive alcohol consumption as lump sum payments received at this time of year (e.g. school kids bonus) were spent on alcohol, but this year no spike had been noticed by hospital staff.

The negative impacts of alcohol consumption on health and wellbeing was still a concern and the recent spate of deaths in the community were cited as examples of this. Two out of three deaths in Koonibba in the weeks leading up to the evaluation fieldwork were reported as being related to alcohol. However, these were believed to be long-term health impacts (e.g. heart disease) that the CDCT was unlikely to influence and impact in the short period.

Drug use

Overall, consistent with the Initial Conditions Report, stakeholders found it more difficult to comment on levels of drug use in the community as substance usage was less visible. However, concern about methamphetamines (“ice”) had significantly heightened among the stakeholders compared to when they were interviewed at the Initial Conditions stage of the research (i.e. in April 2016). Most stakeholders consistently reported ice as being more prominent and easily available at Wave 1 compared to the Initial Conditions stage.

There were minimal positive impacts of the CDCT on drug use identified by stakeholders other than a report by one stakeholder who had spoken with a drug dealer (who was on the CDCT) who had not been able to buy wholesale drugs because he no longer had the supply of cash. Another stakeholder reported hearing reports that it was harder to access marijuana in some of the remote Trial communities outside of Ceduna, however, as there had been some recent arrests of drug suppliers it was unclear if this was as a result of these arrests or the CDCT.

Many stakeholders were concerned about ice becoming increasingly available and used (including a few incidents in remote communities, e.g. Yalata). Stakeholders were particularly concerned that it may proliferate very rapidly in the community as it was reported to be very low cost (e.g. \$10) so access to cash was not a barrier to use. One stakeholder noted that they had received increased requests from health services in the Ceduna Trial area to deliver staff training sessions in relation to methamphetamines. However, most stakeholders felt that the growth in this problem was consistent with other areas (i.e. it wasn't confined to Ceduna or related to the CDCT). From a policing perspective it was not reported to be an issue of major concern, and most incidents dealt with related to ice usage did not occur amongst CDCT participants.

Some stakeholders reported that marijuana was being laced with ice to get people "hooked". This was evidenced by a stakeholder from a health service who had new presentations of people behaving in a way that indicated ice use, but who reported only taking marijuana.

In terms of the CDCT, ambulance presentations demonstrated that there hasn't been a significant change in marijuana and other drug use. A few stakeholders reported that abuse of prescription drugs was still an issue.

Gambling

Overall, stakeholders reported that CDCT had a significant impact on reducing the amount of money and time spent on legalised gambling in Ceduna, particularly on Electronic Gaming Machines (EGMs).

The following positive impacts in relation to gambling were identified by the qualitative research:

- A significant positive impact on the CDCT in relation to gambling was noted in the reduction in use of EGMs, as evidenced by:
 - Fewer people seen in EGM venues – which was reported by some stakeholders and was observed by ORIMA researchers during the fieldwork period; and
 - A reported 15% reduction in gambling spend in the Eyre Peninsula region – as reported by the Gaming Authority. In addition, a couple of stakeholders reported that in Ceduna specifically, the reduction was 30%.

Many stakeholders reported there had been no change in the amount of illegal card-playing and online gambling occurring in Ceduna. However, these stakeholders noted these forms of gambling were more difficult to report on as they usually occurred in private residences and were therefore less visible.

Crime, violence and harm

At the Initial Conditions reporting stage, many stakeholder participants had expected that there would be a significant increase in petty crime and domestic violence at the start of the Trial. In Wave 1, these participants reported that this had not eventuated, and as such were “relieved”.

Overall, there was no significant positive change noted in relation to crime, violence and harm. However, a few stakeholders identified some increase in domestic violence / intervention orders – although it was not clear whether this was due to changes in reporting requirements or increased community awareness, understanding and willingness to take action, or to the CDCT. One stakeholder reported that recent deaths related to domestic violence had increased the community’s willingness to report instances of domestic violence and had led to an increase in the number of calls the police received relating to domestic violence. Likewise, the Police and ambulance also had more rigorous domestic violence reporting requirements in recent times.

A couple of store owners reported that there had been an increase in thefts from their stores, including:

- Shoplifting, including by intoxicated adults; and / or
- Children stealing items (e.g. lollies, hair dye, etc.) from the local store in Yalata since the Trial commenced as they no longer had access to cash from their parents. However, the store had taken successful steps to reduce this (e.g. reporting incidents to the school) and such measures had addressed the issue.

In addition, a few stakeholders reported an increase in the following illegal / harmful behaviours, however it was not clear whether such behaviours were related / attributable to the CDCT:

- A few stakeholders reported they had heard about an increase in break-ins in Ceduna where laptops, jewellery and cash had been stolen;
 - However, Police reported that they had not seen an increase in crime committed by CDCT participants on the ground and that the recent incidents that they had dealt with had been committed by juveniles and people from outside the Trial area.
- A few stakeholders from remote communities reported hearing about break-ins in their community (i.e. outside Ceduna) but thought that these crimes were committed by people from out of town (i.e. not local) visiting for funerals and other events;
- A couple of stakeholders reported that arguments were increasing between community members. Specifically, community members who received less money through payments such as ISP Newstart Allowance were reported to be asking others who received larger payments (e.g. Disability Support Pension or Parenting Payments) for cash; and
- One service provider stakeholder reported that there had been five cases of prostitution among their clients from remote communities outside of Ceduna. However, this occurrence was not mentioned by other stakeholders.

Safety

Overall, no change was reported by stakeholders in relation to personal and community safety since the Trial began.

Other impacts

Overall, the qualitative research identified that to date, CDCT has had a more visible / noticeable impact on financial, wellbeing and parenting outcomes than on alcohol and drug consumption. While stakeholders were able to identify a range of impacts relating to finances, wellbeing and parenting, they were less able to identify specific direct changes to alcohol and drug consumption.

Financial

Overall, many stakeholders had noticed changes that indicated that the Trial was having a positive impact on CDCT participants' financial circumstances. These included:

- Many stakeholder participants reported noticing changes in household consumption, believed to be due to people having more disposable income. Changes were particularly noted in relation to increased expenditure on the following items:
 - Clothing – evidenced by:
 - A reported increase in sales at the Ceduna “op shop”;
 - Children attending school and day care with new clothes and shoes – particularly amongst families who previously rarely had new items;
 - Cars – evidenced by several community members purchasing cars. In one instance, this included having funds available to travel to Adelaide to make the purchase;
 - Furniture and large household appliances (e.g. baby equipment, lounge suites, tables and whitegoods) – evidenced by:
 - Increased usage of community trailers / trucks for transporting these items from Ceduna to communities;
 - Increased deliveries of such items to communities through online shopping;
 - Groceries – evidenced by:
 - Stakeholders reported sighting CDCT participants purchasing and consuming more food items, general household items (e.g. cleaning products) and personal hygiene items;
 - An increase in the number of deliveries per week to a remote community from the food truck (increased from one to two deliveries a week);
 - Increased revenue at a sports club's canteen—as reported by one stakeholder;
 - “Big ticket” items (e.g. iPhones, Yamaha keyboard and car spotlights) – reported by an Outback store owner who reported an increase in demand and inquiries about such items. In addition, the store's data showed a substantial increase in sales in the relevant category;

- A few community leaders and financial service providers indicated that they knew of community members who had been able to save money for the first time, or save more money than usual;
- A few stakeholders (including financial counsellors, and services providing homelessness programs) reported a decrease in requests for emergency food hampers, and a decrease in clients financially defaulting (e.g. loan repayments); and
- A few stakeholders indicated that requests for emergency / crisis financial counselling intervention had reduced since the introduction of CDCT.

Some stakeholders felt that there had been an increase in the humbugging of Age Pensioners. This was perceived to be evidenced by an increase in elderly people attending an aged care health service in Yalata to avoid being humbugged. However, some other stakeholders noted that humbugging was always a significant issue and did not think that this behaviour / occurrence had changed but rather was more noticeable as CDCT participants were less likely to be humbugged now.

Social impacts

The qualitative research identified the following positive **social impacts** as a result of the CDCT:

- Improved IT literacy – one stakeholder reported that the requirement of CDCT for participants to use the internet and computers (e.g. to access card balances) had resulted in improved IT skills, including amongst older community members who previously had very low IT literacy³⁶;
- Increased requests for employment opportunities – one stakeholder from a remote community outside of Ceduna reported that more people had been requesting employment in order to earn cash; and
- Increased sense of community pride – reported by some stakeholders.

The qualitative research identified the only negative **social impact** of CDCT as being stigma. A few stakeholders reported that community members who thought they spent their money appropriately felt as though they were being “penalised” and / or “discriminated against”.

Housing impacts

Most participants reported there had been no considerable impact on housing since the commencement of CDCT, with overcrowding and rough sleeping still apparent. Most participants noted that this was still a key issue for the region, particularly given the wide-ranging flow-on effects (including health, hygiene, financial, employment).

Parenting and family impacts

³⁶ The Department advised that the Australian Government had invested over \$100,000 in internet infrastructure in Ceduna and surrounding communities to support the CDCT.

Overall, stakeholders had observed that the Trial had some positive impacts in relation to parenting / family wellbeing, including:

- Increased purchasing of “treats” (e.g. lollies) by and for children – reported by a few stakeholders;
- Some stakeholders working at schools and childcare services noted that some children:
 - Were attending school with packed lunches and appeared to be less hungry; and
 - Had new clothes / shoes that they were “proud” of;
 - The above was noted to be occurring among families who wouldn’t normally have new items; and
- A few stakeholders who ran parenting programs / classes had noticed greater participation and engagement among mothers. For example, one stakeholder reported mothers attending multiple, follow-on classes in a week.

While some stakeholders working in schools / child care centres noticed some improvement in attendance, they were reluctant to attribute this solely to the CDCT. These stakeholders felt that there were other contributing factors, including specific school initiatives and the weather / seasonal effects.

Wellbeing impacts

The qualitative research identified the following positive **wellbeing impacts**:

- Improved nutrition – due to more money being spent on food, as reported by many stakeholders. This was evidenced by stakeholders seeing more people with “full” shopping trolleys; and
- A few stakeholders reported that there were several individuals in the community who were known for severe alcohol abuse who had reduced their alcohol consumption and had actively sought health services since the commencement of the CDCT.

The qualitative research identified the only negative **wellbeing impact** of the CDCT as being increased purchases of cigarettes – one stakeholder reported that CDCT participants who had previously been on the Basics card (which restricted tobacco purchasing) were now purchasing more cigarettes.

Support services

Overall, the research identified good awareness amongst stakeholders of welfare services, Centacare, ABLE, financial counselling services and MAP / street beat. However, beyond these services there was limited understanding of the range of new / revamped services being implemented as part of CDCT.

Many stakeholders reported that the Ceduna service reform was beginning to have a positive impact, with improvements to:

- The communication and linkages between services providers; and

- The assistance provided to clients, including referral to other services as required.

Stakeholders identified the following as **needs / gaps in service provision** or where additional services were needed to meet demand or need:

- Diversionary programs to provide more opportunity and activities
- Financial counselling
- Domestic violence services including safe houses and community education
- Mental health
- Homeless / transitional accommodation – including for those entering and leaving rehabilitation clinics
- Programs for men
- Programs for 8-12 year olds
- Support services that are located / based in remote communities and not just in Ceduna

Circumvention behaviours

Some stakeholders reported that they had heard reports of the following circumvention behaviours, from their clients and / or other community members (however, stakeholders were unable to assess how widespread such practices were):

- Some stakeholders reported Trial participants were selling goods for cash below their value. Examples given included the sale of fishing rods, phone credit and groceries;
- One Ceduna store owner identified the purchase of 'Paysafe' cards for online gambling as a potential circumvention practice, as Paysafe cards were not restricted by the Indue card and these PaySafe cards could be used for online gambling. While this stakeholder had decided not to sell Paysafe cards to Trial participants, cards were reportedly available for purchase at other stores;
- One stakeholder reported that CDCT participants had been initially accessing prohibited items online (e.g. online gambling, obtaining alcohol through Chrisco hampers), however the stakeholder reported that this had been addressed by the Department;
- A few stakeholders reported that some CDCT participants had created BPAY biller accounts and transferred money from their Indue cards to these accounts to later withdraw as cash;
- A couple of stakeholders had heard that clients were transferring money to other family members for rent, and these family members were subsequently providing them with the cash;
- One stakeholder reported that CDCT participants had set up an account at a local store and attempted to seek a refund in cash from the store at another outlet / location – however, it was noted that the particular store had been recording the payment method on the store accounts to prevent this; and

- A few stakeholders had heard of local businesses overcharging / processing fake service transactions on Indue cards in return for cash (e.g. hotel room charged at \$150 and CDCT participant given \$100 cash back).

In addition, stakeholders identified a range of practices that allowed CDCT participants to access additional cash / goods, however these were not specific to the Indue card, and had been occurring prior to CDCT. These included:

- Humbugging;
- Taxi drivers accepting cards with no balance as payment, with the intention of withdrawing cash when the next Centrelink payment was received. The cardholder would then cancel the card and replace it with a new card; and
- Card sharing – using other people’s cards to purchase items.

Perceptions of card implementation

Overall, many stakeholders felt that the level of community concern about the Trial had decreased and some people were now accepting of, and adjusting to, the card. However, some CDCT participants were reportedly “just putting up with it for a year”, and a few stakeholders felt that there may be a backlash if it became permanent or the Trial period was extended. These stakeholders felt that the Department should start educating the community if there was a possibility of the card continuing to minimise potential future hostility.

Overall, most service providers felt that they had been well informed about the Trial and received enough information to be able to assist with client queries. These stakeholders reported there had been some initial “teething problems” while participants became familiar with the card (including using a PIN, the requirement to select the ‘credit’ account and setting up rental transfers), however understanding of the card had improved over time. Specific **positive feedback** about the Trial implementation included:

- Effective rollout and communication in remote communities prior to Trial – most stakeholders felt that remote communities had been very well informed due to the Department’s frequent visits to communities prior to and during implementation. A couple of stakeholders reported that the “door-knocking” approach of houses both with Trial participants and non-Trial participants was effective;
- Store owners reported that they were well-informed of the Trial and card functionality and as a result had been able to assist in educating CDCT participants on how to use the card when making purchases;
- Distributing the card in conjunction with money management / budgeting advice in communities outside of Ceduna was perceived to be very effective;
 - However, stakeholders felt this was not as effective in Ceduna where not everyone was given access to such advice / service;
- Having a direct contact phone line to Indue for card support was considered effective as it minimised waiting times;

- Gradual rollout of the card – a couple of stakeholders felt it was effective to have different Trial start dates for different CDCT participants, to minimise the impact on any one day; and
- Having “one-stop-shops” (e.g. CAC) to assist with checking balances, replacing cards and accessing PINs was felt to be effective.

Stakeholders identified the following **negative feedback** / difficulties with the Trial implementation:

- While the community had been well informed about the Trial and consultation had occurred, there was a perception amongst some stakeholders and amongst some in the community that “the decision had already been made” about adopting the Trial when the consultation occurred;
- Some stakeholders felt that the Trial could have been better communicated to participants and the broader community in Ceduna area (e.g. via TV or radio advertising³⁷);
 - A few stakeholders felt that the usage of written communication materials (e.g. flyers and posters) was not an effective strategy due to low literacy levels amongst the population of cardholders;
- While the Department of Social Services and the Department of the Prime Minister and Cabinet reportedly worked well together in implementing the Trial and were perceived to have a strong on-the-ground presence in the remote communities, a few stakeholders felt that Centrelink / the Department of Human Services appeared to be “missing” and less willing to directly engage with communities about the Trial³⁸;
 - Stakeholders felt it was particularly important for Centrelink to be seen as supportive and willing to assist with the Trial and have an on-the-ground presence in communities, as CDCT participants were more familiar with Centrelink and many had specific questions about their payment arrangements;
- Community panels not up and running – some stakeholders noted that the panel was not set up and fully operational at the start of the Trial;
- High turnover of staff in service provision and government agencies – this was felt to impact on efficiency of processes due to lack of consistency, learning and relationship development;
- One stakeholder reported that having a large number of email addresses created on shared computers in the Oak Valley Corporation office had created a Google security alert and the computers had been locked, although this has since been resolved;
- Many service providers reported that the additional service funding was not provided early enough to allow for services to be ready at the beginning of the Trial, particularly given the significant challenges associated with delivering new programs and support services in a remote location. Specific challenges included:
 - Staff recruitment – there was a lack of staff with appropriate level of skills / qualification in the local area and it was difficult to attract staff to the location;

³⁷ The Department advised the evaluators that it had engaged in radio advertising in each location.

³⁸ Note that the trial was designed to minimise the involvement of the Department of Human Services in quarantining arrangements.

- It was also reported that two staff from the ABLE program did not want to continue working on the program due to their personal views about the CDCT; and
- Staff accommodation (for staff relocating); and
- Some service providers also reported that the duration of the funding for additional services / programs in general is too short (only 1 -2 years) and doesn't allow for effective set-up and relationship building and therefore potentially constrained sustainable and long-term outcomes from being achieved.

Issues with the Indue card / support processes:

The research identified that stakeholders perceived a number of issues with the Indue card and / or its support processes. While stakeholders acknowledged that some of these were initial “teething problems”, it was unclear the extent to which these had been resolved.

- A few stakeholders reported that there was a lag time between when payments appeared on online balances and when they were able to be accessed. Stakeholders reported that participants had tried to purchase goods with the card when their online account showed they had available funds but had been unable to do so. One store manager reported sighting a participant's online balance when this has occurred, and confirmed it appeared to have funds available³⁹;
- In remote communities, the reliance on online accounts to check card balances caused some problems due to limited internet access, digital literacy and familiarity (including the need to remember passwords and login details). As a result some CDCT participants had difficulty accessing and keeping track of their card balances⁴⁰;
 - DSS is currently implementing more technological support to allow people to check their balances (e.g. iPads in shops), however a few stakeholders felt that this may not fully resolve the issue as participants would still need to remember login details;
 - ATM balance checking is also being implemented, available from mid-December 2016.
- The reliance of mobile phones to receive PINs was an issue, particularly in remote communities as:
 - Oak Valley has no phone reception – as a result, departmental and service provider staff had been driving out of the community to areas with phone reception to receive text messages for CDCT participants. This had caused significant delays for CDCT participants in being able to access card funds;
 - Some community members didn't own mobile phones / had lost phones and / or often had no phone credit;

³⁹ The Department advised the evaluators that this issue was the result of banks ignoring requests from DHS to delay payments for Centrelink (of either 2 or 4 working days) and that Indue is not at fault. Ignoring this request results in participants receiving money earlier than they should have.

⁴⁰ The Department advised that other balance checking is available, including phone and SMS alerts.

- CDCT participants in communities with more limited English levels had difficulty accessing support via the Indue phone line due to the language barrier. Some of these CDCT participants had tried to use other community members as translators, however these third parties were unable to deal with Indue on their behalf due to privacy rules / ID checks required. As a result, one Age Pensioner who was voluntarily on the card had removed herself from the Trial; and
- One stakeholder reported that they had recently heard that there was a 30 minute period of time immediately after welfare payments were received when the full amount of welfare payments were accessible in cash (i.e. before 80% was transferred to Indue card accounts) and some Trial participants had become aware of this and had been queuing up to withdraw cash from ATMs at 3am⁴¹. This stakeholder had not had this confirmed and was currently investigating the issue.

Other areas for improvement

The research identified the following additional areas for improvement:

- Ongoing communication – some stakeholders reported that communication and education about the card reduced / stopped once the Trial had begun and felt that there was a need for ongoing communication to:
 - Educate some Trial participants who had not engaged with pre-Trial communications;
 - Consolidate understanding of the card, particularly as there were some functionality aspects that were causing confusion / were less well-understood (e.g. how to set up rent payments, online functionality and how to check balances);
 - Clarify misconceptions – some Trial participants who had payments suspended due to not meeting CDP participation requirements mistakenly thought it was as a result of the CDCT. There is potential for this issue to also arise with forthcoming welfare payment changes;
- Forms for applying to the community panels to have payment arrangements altered – a few stakeholders reported that some of their clients had found these lengthy and difficult to understand, particularly given limited levels of literacy in remote communities;
- One stakeholder suggested placing computer terminals and staff in frontline services in Ceduna (e.g. Day Centre) to provide Trial participants with better access to card support and online card services, particularly as some clients are not comfortable / willing to go into a Centrelink office for support; and
- Some stakeholders felt that CDCT participants were adversely impacted by their inability to make cash-based purchases in some situations, including from second hand websites, sports club canteens, tickets for community events (e.g. Oyster Fest and NAIDOC).

⁴¹ The Department advised the evaluators that this was not technically feasible.

East Kimberley

Methodology

- In-depth interviews and focus groups – n= 40
- Dates: Monday 12 September – Tuesday 4 October
- Locations: Kununurra and Wyndham

Overall impact of Trial

Overall, stakeholders' perceptions of the impact of the CDCT were mixed based on the client base that stakeholders were dealing with. Overall, those stakeholders dealing with the most high needs / disadvantaged cases felt the CDCT had made less of an impact than those stakeholders who dealt with a broader range of clients.

Many stakeholders had noticed some early positive changes / impact of the CDCT, however most felt that it was "too early" in the Trial to determine how widespread such impacts would be. In addition, most felt that it was too early to determine whether there would be any considerable change in relation to longer term issues (e.g. employment, health and housing) and were expecting to only see changes in relation to these issues in the longer term (i.e. in another 6-12 months).

Some stakeholders indicated that there were other external factors which may have impacted on data / behaviour over the Trial period, beyond the impact of CDCT itself, such as:

- Takeaway Alcohol Management System (TAMS) and other alcohol restrictions (including restricted liquor store operating hours, and homeowner nominated alcohol restricted premises);
- Fewer people in town as a result of people leaving / being away during the dry season;
- Lump sum payments – some visitors to the community had received royalty payments and this had encouraged some "party houses" to continue. Stakeholders reported that three royalty payments from neighbouring communities outside the Trial site had been received since the Trial began;
- Weather – while not as big an issue as Ceduna, a few stakeholders indicated that the change in seasons from dry to wet had the potential to have some impact on Trial outcomes;
- As identified in the Initial Conditions Report, Western Australia has restricted Electronic Gaming Machine (EGM) licensing, and there were no EGMs in the Trial sites in WA;
- Changes to health servicing via hospitals – since the Trial began, the Accident and Emergency department in Kununurra Hospital had ceased its GP service;
- Changes in police policing approach / requirements, including:
 - Stricter domestic violence reporting requirements, and an increased focus on domestic violence by the new Police Superintendent;

- A new Police Officer in Charge in Wyndham with a more active focus on reducing public intoxication; and
- Police efforts to increase communication and education about crime rates and statistics;
- Distribution of a large sum of money (\$300,000-\$400,000) by an Indigenous Corporation – one stakeholder reported that community members had placed purchase orders to buy items (e.g. furniture, clothing and shoes) during the Trial; and
- Closure of a mine site near Wyndham – which stakeholders reported had resulted in higher unemployment and less money in town.

Alcohol consumption

While some stakeholders felt that there had been minimal / no change in alcohol consumption, many others had noticed changes at an individual and / or community level since the start of the CDCT.

The stakeholders who had noted positive impacts of CDCT in relation to alcohol consumption reported that these included:

- Feedback from Sobering Up Units (SUUs) in Kununurra and Wyndham indicated that there had been⁴²:
 - A decrease in the number of people being picked up as well as using the SUU;
 - A change in the types of people being picked up by the SUU – now more likely to be people from outside the Trial area;
- Less visibility / fewer people consuming alcohol in public – some stakeholders reported seeing and hearing fewer intoxicated people in public places (i.e. on the streets in town, in parks and on the side of the road in the early mornings);
- One stakeholder had observed that binge drinking patterns had changed amongst some of the CDCT participants that they had dealings with and that these sessions were now of a shorter duration;
- Hospital related changes:
 - Admissions due to alcohol-related presentations had decreased;
 - A noticeable decrease in rowdy and abusive behaviour towards Accident and Emergency staff since the Trial. A stakeholder from the hospital estimated it to have reduced by around half;
- Ambulance-related changes:
 - Decrease in primary call-outs (from 107 in August-September 2015 to 73 in August-September 2016);
 - Fewer call-outs for alcohol-related injuries;

⁴² For supporting data see Figure 93 under MTO PI#4: Drug/alcohol-related injuries and hospital admissions

- Substantially decreased sales at a Kununurra bottle shop – this decrease was reported to have occurred since the Trial started, as well as at the comparative point from last year;
 - This had resulted in a need to reduce casual staff (who were mostly backpackers);
- More sobriety – evidenced by:
 - A local football coach reported that several players who had previously been unable to play / not trained effectively due to frequent intoxication had reduced their alcohol consumption and significantly improved their behaviour and their commitment and performance to the game, resulting in noticeable “transformation” of their lives; and
 - A few stakeholders reported seeing individuals they knew to previously be high alcohol users who were now more regularly sober and seen to be spending their money on food, groceries and household items.

Drug use

Overall, consistent with the Initial Conditions Report, stakeholders found it more difficult to comment on levels of drug use in the community – primarily because such behaviours were not as visible and the impacts of using marijuana (the main drug used) were not as overt / aggressive as alcohol.

The following positive impacts of the CDCT on drug use were identified by the qualitative research:

- A couple of stakeholders had directly spoken with CDCT participants who had reduced and / or stopped their drug use as a result of the CDCT, including:
 - A CDCT participant who had previously been addicted to methamphetamines (“ice”) but had stopped using ice due to limited access to cash;
 - A family who was now consuming less marijuana which had allowed them to spend more money on clothes and food for their child and were supportive / happy about the Trial as a result they; and
- A few stakeholders felt that the frequency of marijuana usage had reduced due to limited access to cash.

The following negative feedback in relation to drug use were identified by the qualitative research, although these reports were not observed amongst CDCT participants:

- One stakeholder in Wyndham reported more young people had told her they were using marijuana, however he / she did not think this increase was a result of the CDCT but rather due to an increase in self-reporting from improved efforts to build more open relationships with young people by her organisation; and
- A couple of stakeholders reported that there had been an incident involving young people using sprays (i.e. aerosols). These stakeholders noted that they had counselled these children and had not heard of any other cases since.

Unlike Ceduna, and consistent with the Initial Conditions Report, ice usage was felt to be contained to the non-CDCT / working population, and not a key area of concern. However, one hospital

stakeholder in Kununurra noted that they had begun to see a small number of cases over the last 6-12 months when previously they had no incidents.

Gambling

Overall, the CDCT was not felt to have had a significant impact on reducing the amount spent on gambling, although many participants noted that gambling was not a key concern for the region. The main form of gambling was in relation to card playing among elderly women and was not believed to have as adverse impacts as alcohol consumption. In addition, stakeholders found it difficult to comment on changes to card playing (the main form of gambling), as it was less visible.

The following positive impacts of the CDCT in relation to gambling were identified by the qualitative research:

- A reduction in the number of people playing bingo in Wyndham – one stakeholder reported that the venue had such a reduction that they had almost been unable to obtain their license for their regular bingo night;
- A couple of stakeholders reported that people they personally knew found it “too difficult” / “frustrating” to play cards due to limited access to cash;
- A reduction in card games in public places – identified by a couple of stakeholders; and
- A reduction in the amount of money being spent in card games – one stakeholder reported that one of his organisation’s staff members was previously spending “all of her money” gambling and since the CDCT had been spending more money on food as she was unable to afford to continue gambling.

The only negative impact identified by the qualitative research in relation to gambling was a few stakeholders who reported that they had seen or heard CDCT participants now “buying-in” to card games with their Indue card, and giving others their PIN to access funds.

Crime, violence and harm

At the Initial Conditions reporting stage, many stakeholder participants had expected that there would be a significant increase in petty crime amongst CDCT participants at the start of the Trial. While an increase of such crime was not evident among CDCT participants, it was commonly reported by stakeholders to be occurring among children as a result of reduced access to cash.

Overall, there was no significant positive change noted in relation to crime, violence and harm among CDCT participants. However, a couple of positive changes were noticed / reported by stakeholders, including:

- A decrease in vandalism of ATMs – noticed by a few stakeholders;

- A decrease in crime (including alcohol related incidents) in Wyndham – although it was reported that there were many other contributing factors (e.g. TAMS) and it was felt that this could not be directly attributed to CDCT; and
- A reduction in the number of injuries indicative of domestic violence presenting at the hospital reported by The Accident and Emergency department.
 - However, a few stakeholders identified some increase in domestic violence / intervention orders – although it was not clear whether the increase was due to changes in reporting requirements, the policing approach or increased community awareness, understanding and willingness to take action.

In addition, many stakeholders reported an increase in the following illegal / harmful behaviours among young people / children:

- Robberies / thefts from cars / vehicles and dwellings – stakeholders reported that in these cases young people were in search of cash; and
- Petty crime (e.g. pickpocketing and “snatch and grab”) – stakeholders reported that children on bikes were often the perpetrators in these cases.

Safety

Overall, some stakeholders reported improvements in the safety of public places, particularly during the day in Kununurra. A few stakeholders thought White Gum Park was safer as a result of decreased alcohol-fuelled behaviours – a couple noted that usage of the park had changed since CDCT began as a result, with more families using it for picnics / BBQs, and riding bikes through the skate park. Other stakeholders indicated that safety was still an issue, especially at night, due to “roaming groups of children” and crime among young people (see above).

Most stakeholders did not feel safety was an issue in Wyndham during the day, although a few felt it was unsafe at night (particularly for non-locals). However, these participants did not report any change in safety in Wyndham.

Other impacts

In addition to direct impacts of CDCT on alcohol and drug consumption, stakeholders identified a range of impacts on financial, wellbeing and parenting outcomes.

Financial

Overall, many stakeholders had noticed changes that indicated that the Trial was having a positive impact on CDCT participants’ financial circumstances. These included:

- Many stakeholder participants reported noticing changes in household consumption, believed to be due to more disposable income. Changes were particularly noted in relation to increased expenditure on the following:

- Clothing – evidenced by:
 - Children attending school and day care with new clothes, uniforms and shoes – particularly amongst families who previously rarely had new items;
 - Increased sales of school sports team jerseys;
 - Community members observed in new clothes;
- Cars – a couple of stakeholders reported knowing of people who had been able to buy a car, and noted that this was due in part to the Indue card;
- Furniture and large household appliances – evidenced by a stakeholder seeing “many purchases” from Retravision on clients’ Indue card statements;
- Groceries – some stakeholders, including store owners, reported sighting Trial participants purchasing and consuming more food items, “luxury items” (e.g. prawns) and more expensive brands of groceries;
- Food – one local takeaway food store in Kununurra that was frequented by Trial participants reported that:
 - Store traffic had increased since the Trial;
 - Families who previously only purchased lunch a couple of times per week were buying lunch more frequently;
 - Some families who previously had not been able to buy children “treats” were now buying these items from the store;
- “Big ticket” items (e.g. iPhones and bicycles) – reported by one stakeholder who had seen children in town with these items;
- School expenses – one school-based stakeholder reported that the school usually had to financially support families to allow children to attend Year 6 camp. This year, all families were able to pay for it themselves without financial support, and children had been given pocket money for spending;
- A change in spending / consumption patterns during the end of financial year period – a few stakeholders reported that when family bonus payments had been received they had been spent on larger purchases and items for children (e.g. scooters – which had sold out of the local shop) when in previous years such lump sum payments were spent on alcohol;
- A few stakeholders indicated that they knew of members of the community who had been able to save money for the first time, or save more money than usual; and
- A few stakeholders reported increased access to, and demand for financial counselling services.

However, the qualitative research identified the following negative **financial impacts**:

- Stakeholders reported that some people were circumventing the card by bartering items for cash at a reduced rate. As a result of this reduced bartering rate, these people had decreased disposable income;
- Some stakeholders reported that there had been an increase in humbugging, particularly of Age Pensioners;

- However, some stakeholders reported that this had decreased since the beginning of the Trial as some Age Pensioners had voluntarily gone onto the CDCT and / or now told family members that they were on the card to avoid being humbugged; and
- Stakeholders reported that taxi drivers had been significantly inflating flat fees for some longer trips for Trial participants.

Social impacts

The qualitative research identified the following positive **social impacts** as a result of the CDCT:

- A few stakeholders reported that more people were seeking employment and cash-in-hand work (both ad hoc and regular);
- One stakeholder reported an improvement in some CDCT participants' willingness to engage in training programs and had been able to engage participants in security training certificates as a result of Trial funding;
- A few stakeholders reported cases of people who had begun to contribute / participate in community activities, including:
 - A member of local sports team who had previously been unable to play due to frequent intoxication, who was now one of the team's best players; and
 - A couple who previously consumed significant volumes of alcohol, who were now sober and had cleaned a public reserve and built children's play equipment.

The qualitative research identified the following negative **social impacts** related to the CDCT:

- Stigma – a few stakeholders reported that community members who thought they spent their money appropriately felt as though they were being “penalised” and / or “discriminated against”. Stakeholders cited the colour of the card as a key issue enabling cardholders to be easily identified and “discriminated against”;
- One stakeholder reported that some families on the CDCT had taken elderly family members out of aged care facilities in order to gain access to their cash; and
- One stakeholder had heard reports that a few Age Pensioners had volunteered for the Trial and their family members had pressured them to withdraw and / or had taken them to Centrelink to force them to withdraw.

In relation to the impact of the CDCT on the level of humbugging in the community, stakeholder views were mixed. While some stakeholders reported that humbugging had increased since the Trial, others thought it had decreased and / or felt that there had been no change. A couple of stakeholders also noted that humbugging behaviours had changed as a result of the Trial, with people now being humbugged for cash and to place bets at the TAB instead of for food.

Housing impacts

Most participants reported there had been no considerable impact on housing as a result of the CDCT.

Parenting and family impacts

Overall, some stakeholders had observed that the Trial had some positive impacts in relation to parenting / family wellbeing, generally in relation to the increased expenditure on children. Positive **parenting / family impacts** included:

- Some stakeholders working at schools and childcare services and / or involved in the delivery of family programs noted that:
 - Some children were now attending school with packed lunches;
 - Some children had new clothes / shoes that they were “proud” of;
 - The above were noted to be occurring among families who wouldn’t normally bring food to school or have new items;
 - When they were conducting client visits, some families appeared to have more food in their homes;
 - One school-based stakeholder reported that children had been given pocket money for spending on school camp which had not occurred in previous years;
- Increased purchasing of “treats” (e.g. lollies) by and for children – reported by a few stakeholders. A couple of stakeholders reported that some toys (including scooters), had sold out at the local store; and
- One stakeholder reported that the recent school athletics carnival had its highest ever attendance (approximately 1,000), and behaviour was considerably better than previous years with no fights or issues relating to alcohol.

Wellbeing impacts

The qualitative research identified the following positive **wellbeing impacts** as a result of the CDCT:

- Hospital related changes:
 - Fewer presentations of injuries and illnesses;
 - A 50% reduction in people discharging themselves against medical advice when admitted to the hospital ward from Accident and Emergency;
- Ambulance-related changes:
 - A decrease in primary call-outs (from 107 in August-September 2015 to 73 in August-September 2016);
 - Fewer call-outs for alcohol-related injuries;
- Improved nutrition (for both adults and children) due to more money being spent on food, and higher quality food being purchased. This was evidenced by:
 - Many stakeholders seeing community members with “full” shopping trolleys, or shopping bags – particularly amongst those who would normally be seen intoxicated and without food;
 - Increased sales at a takeaway food shop;
 - A store owner reporting more money being spent on premium brands and “luxury” items;
- Increased usage of health services, including:

- Self-referrals to a mental health service in Kununurra had increased considerably. In particular, the demand for psychology services at OVAHS had increased so significantly that in order to meet the increase in demand they had reduced consultation times (from 2 hours – 30mins) and frequency (e.g. from three times per week to twice per week per patient); and
- New types of people / clients accessing general health services – a couple of stakeholders felt that this was as a result of people having more sober time, and realising that they required these services; and
- More time being spent on healthy activities, including sports (football), fishing trips, hunting trips and training programs.

The only negative **wellbeing impact** of the CDCT in relation to wellbeing identified by the qualitative research was fewer people from outside the Trial site were reported to be attending a rehabilitation clinic located in the Trial site, as they were concerned they would be put onto the CDCT.

Support services

Overall, most stakeholders (other than those directly delivering additional services) had limited awareness and understanding of support services that were being provided through the Trial in Kununurra and Wyndham. Specifically:

- In Kununurra, there was some awareness that OVAHS and BOAB Health had received additional funding for services as a part of the Trial. However, there was limited awareness of what specific services / programs were being implemented (other than amongst service providers delivering the specific service);
- Ngnowar Aerwah Aboriginal Corporation was reported to have a “flexible” amount of funding to deliver services in Wyndham. This flexibility was felt to be effective as it allowed the Corporation to respond and tailor services to meet specific needs and requests;
 - However, it was reported that only some of the available funding had been accessed and that it had not been fully utilised to date. In addition, community leaders in Wyndham were unaware of how this funding was being used; and
- Some stakeholders reported that an intensive family program ‘One family at a time’ delivered through Waringari had been expanded to Wyndham as a part of the Trial funding.

Stakeholders identified the following as **needs / gaps in service provision** or where additional services were needed to meet demand or need:

- Mental health
- Youth programs (including diversion and support), especially for ages 9 – 16
- Diagnosis of Foetal Alcohol Spectrum Disorders (FASD)
- Staffing of Wyndham services

- Transitional accommodation and holistic support to assist people leaving rehabilitation to re-enter the community and maintain changes in their behaviour;
- Rehabilitation – stakeholders reported that this service was only available in Wyndham, not Kununurra.
- Diversionary programs
- Employment programs

Circumvention behaviours

Some stakeholders reported that they had heard reports of the following circumvention behaviours, from their clients and / or other community members (however, stakeholders were unable to assess how widespread such practices were):

- Some stakeholders reported Trial participants were selling goods for cash below their value. Examples given included groceries, toys, petrol and cigarettes;
- A couple of stakeholders had heard that clients were transferring money to other family members for rent, and these family members were subsequently providing them with the cash;
- Many stakeholders reported that merchants (i.e. taxis) were offering cash back at a reduced rate (e.g. charging the cardholder \$100 and giving them \$70 cash) and / or were buying alcohol on behalf of cardholders;
- “Sly grogging” – i.e. people buying large amounts of alcohol and on-selling this (at a marked-up rate) to CDCT participants via their Indue card by putting through their alcohol purchases as fake transactions (e.g. taxi fares). In some instances taxis were reported to be paying others to buy alcohol on their behalf to overcome TAMS restrictions and because some local bottle shops refused to sell alcohol to taxis due to such practices; and
- A couple of stakeholders reported that they had heard of some incidents of taxi drivers taking advantage of young female CDCT participants (i.e. providing rides in exchange for sexual favours). However, it was reported that such incidents had also occurred before the Trial began.

Perceptions of card implementation

Overall, many stakeholders felt that the level of community concern about the Trial had decreased and some people were now accepting and adjusting to the card. These stakeholders noted that some of their clients / community members reported that they had experienced some positive outcomes as a result of CDCT.

Overall, most service providers felt that they had been well informed that the Trial was commencing. However, many stakeholders felt that the level of community education about the Trial could have been improved, especially in relation to:

- The mechanics of the card;
- What action needed to be taken to transition existing payment arrangements; and

- Where to get assistance / help (i.e. local Indue office).

Stakeholders reported there had been some initial “teething problems” while participants became familiar with the card (including using a PIN, the requirement to select the ‘credit’ account and setting up rental transfers). While understanding of the card had improved, there were still issues being experienced.

Specific **positive feedback** about the Trial implementation included:

- Stakeholders involved with the implementation group reported that the State and Commonwealth Governments worked effectively together and actively engaged with local Indigenous leaders;
- The involvement of local Indigenous corporations in educating and engaging the local community as well as using these corporations to support the card implementation (e.g. for card distribution) was felt to be effective and important;
 - Stakeholders reported that many community members had their mail sent to these corporations, so it was a logical and familiar place to distribute many cards;
- Many stakeholders reported that community leaders had been willing to show their support / back the Trial and engage in direct forums with community members who held negative views / concerns about the CDCT. These stakeholders felt that this was important to show that the local community was supportive of the Trial;
 - However, a few stakeholders felt that these forums / sessions had been “defensive” and community leaders had not actively listened and / or sought answers to people’s concerns and questions;
- A couple of stakeholders reported that information sessions had been held with older children in schools (i.e. aged 16+), and felt this was a good opportunity for students to ask questions; and
- The on-the-ground presence of DSS – stakeholders reported that this enabled easy communication and resolution of issues.

Stakeholders identified the following **negative feedback** / difficulties with the Trial implementation:

- Overall, stakeholders felt the communication about the card had been “rushed”, with limited lead-up time given before the start of the Trial. Understanding of the card was felt to be better in Wyndham, as it was a smaller town and was easier to communicate to a smaller population. However, communication in Kununurra appeared to have been less effective;
 - Most communication was reported to have been passive (i.e. requiring Trial participants to actively approach / engage) – some stakeholders felt there should have been more active communication including door-knocking and local advertising – particularly as many people impacted by the Trial did not attend such sessions and / or despite attending did not understand the mechanics of the card;
 - Specific aspects of the Trial that stakeholders felt CDCT participants had not been aware of and / or were not well-understood included:
 - That arrangements needed to be made to move automatic Centrelink deductions (e.g. rent and payments for schools) – it was reported that some

- CDCT participants had assumed that these direct payments would automatically transfer across to their Indue accounts. As a result some experienced fines, late fees / interest charges and / or “children went without food at school”;
- Understanding what could be bought on the card – a few Trial participants had initially spent all their cash component straight away as they did not understand what they could buy on the card;
 - Understanding of card balances – some CDCT participants thought they were being charged fees and / or “missing money”, which appeared to be due to confusion between their ‘current balance’ and ‘available balance’. Stakeholders indicated that this was still an ongoing issue requiring education;
 - Where to access help / support for their Indue card / account – some stakeholders reported that there was limited awareness of the availability of the local Indue office providing card support;
 - The availability of financial counselling that was implemented as part of the Trial.
- Engagement with Trial participants who spoke English as a second language could have been improved – some of the information / printed materials initially produced were “too complicated” and had to be revised for those who spoke English as a second language.
 - The requirement for cardholders to link the card to an email address caused difficulties / was not simple as many did not previously have an email address and were unfamiliar with technology.
 - The panel was not established at the start of Trial and was still not established at Wave 1 of this Evaluation⁴³;
 - One stakeholder also felt that the change in the payment split variation from the arrangements that were initially communicated to participants (i.e. change from 50-50% to 70-30%) was likely to cause annoyance and anger amongst some Trial participant.
 - Additional ‘wrap around’ support services were not in place for the commencement of the Trial as services providers had only received certainty in their funding arrangements very close to the commencement of the Trial;
 - Service providers indicated that they required a lead up period of approximately three months to ensure that they had adequate time to have additional programs / services established, especially given the staffing challenges in remote locations; and
 - A few service providers also noted that it was important that they be given adequate notice if their funding was to continue and / or cease after the Trial period for planning

⁴³ Note that the community panel commenced in October 2016.

Issues with the Indue card / support processes:

The research identified that stakeholders perceived the following issues with the Indue card and / or its support processes (while it was acknowledged that some of these issues had been initial “teething” / educational problems, it was unclear the extent that they had been addressed):

- A couple of stakeholders reported that there was a group of CDCT participants who were unfamiliar with the concept of using a debit card and were losing their cards very frequently (e.g. once every one-two weeks). These participants were previously able to have a 3rd party hold their card and PIN and withdraw cash once a week (e.g. banks or Aboriginal corporations);
- A couple of stakeholders reported that they had heard there were some stores where the card was not accepted / did not work (e.g. petrol stations outside of the Trial site and in Derby);
- The reliance on online accounts to check card balances caused some problems due to limited internet access, digital literacy and familiarity (including the need to remember passwords and login details). As a result some CDCT participants had difficulty accessing and keeping track of their card balances; and
- The 20% cash component was available in Trial participants’ accounts before the 80% card component – one stakeholder reported that as a result of this some Trial participants ran out of their cash component as they needed to go shopping immediately after receiving their welfare payment, and had to spend their cash component as the card funds were not yet available.

In addition, one stakeholder was concerned about the potential impact of blackouts during the upcoming wet season, which usually put EFTPOS terminals out of operation. This stakeholder noted that people were usually able to withdraw cash from banks in this situation, but was concerned about what would happen this wet season with people only able to access 20% cash. This stakeholder reported that this issue could be compounded when the DSS office is closed for Christmas for 2 weeks.

Other areas for improvement

Stakeholders identified the following additional changes / suggestions to improve the CDCT:

- Ongoing communication – some stakeholders reported that communication and education about the card reduced / stopped once the Trial had begun and felt that there was a need for ongoing communication to:
 - Educate some Trial participants who had not engaged with pre-Trial communications;
 - Consolidate understanding of the card, particularly as there were some functionality aspects that were causing confusion / were less well-understood (e.g. how to set up rent payments, online functionality, understanding of card balances);
 - To inform Trial participants of new arrangements (e.g. when the Community Panel begins operating);

- Clarify misconceptions – a few elders sitting on boards had confused changes in the payment arrangements for sitting fees (which had recently begun to be counted as income by Centrelink) and “blamed” the CDCT for reducing their income support payments;
- Adopting a range of different coloured cards – some stakeholders felt that the stigma of the card would be reduced considerably if Trial participants had different coloured cards, and were able to choose their own colour as they would be less identifiable;
- Increased flexibility in discretionary cash – a few stakeholders felt that they needed to be greater flexibility to access larger amounts of discretionary cash as \$200 per month was not enough in some circumstances (e.g. to pay back personal cash loans and to send money to children at boarding schools); and
- More regularity in the discretionary cash component – a few stakeholders reported that having more regular access but smaller amounts of discretionary cash (i.e. \$50 per week rather than \$200 per month) would be easier for Trial participants to budget / manage their cash component.

Appendix D: Organisations Interviewed and Contacted in Qualitative Research

Ceduna and Surrounds

Participating organisations ⁴⁴		
Ceduna Aboriginal Corporation	Aboriginal Family Support Services	Ceduna District Health Service
Scotdesco	Save the Children	SA Police
Koonibba Aboriginal Community Council Inc.	Ngura Yadurirn Children and Family Centre	Department of Prime Minister and Cabinet
Yalata Community Inc.	Centacare Catholic Family Services	Yalata Outback Store
District Council of Ceduna	Able Program (through Centacare)	SA Ambulance Service
Families SA	Housing SA	IGA Thevenard
Ceduna Area School	Ceduna Youth Hub	Tullawon Health Service
Aboriginal Drug and Alcohol Council	Ceduna Foodland	
Declined invitation to participate		
Life Without Barriers	Uniting Care Wesley	Joanne's Anglican Op Shop
Eyre Futures	Red Cross	
Contacted ⁴⁵ but not reached		
Oak Valley Inc.		

⁴⁴ The number of organisations that participated in the evaluation does not equal the number of participants interviewed because in some cases multiple people from the same organisation were interviewed and n=6 organisations from Ceduna did not consent to being identified.

⁴⁵ Organisations were contacted to participate at least three times.

East Kimberley

Kununurra		
Participating organisations ⁴⁶		
Gelganyem Trust	Save the Children	Wunan Foundation
Ord Valley Aboriginal Health Service	WA Reform Unit	Waringari Aboriginal Corporation
MG Corporation	Kununurra District High School	St John's Ambulance
Kununurra Crisis Accommodation Centre	East Kimberley Chamber of Commerce and Industry	Kimberley Mental Health and Drug Service
WA Attorney General's Department	WA Country Health Service	Gulliver's Tavern
Legal Aid WA	Department of Child Protection and Family Services	
WA Police – Kununurra	WA Housing Authority	
Contacted ⁴⁷ but not reached		
St Joseph's Primary School Kununurra		
Wyndham		
Participating organisations ⁴		
Ngnowar Aerwah Aboriginal Corporation	Kimberley Land Council Board of Directors	Ngnowar Aerwah Sobering Up Shelter
Wyndham District High School	Joongari House	Wyndham Early Learning Activity Centre (WELA)
East Kimberley Job Pathways	WA Police – Wyndham	Wyndham Supermarket
Declined invitation to participate		
Wyndham District Hospital	Wyndham Community Club	
Contacted ⁵ but not reached		
Shire of Wyndham East Kimberley		

⁴⁶ The number of organisations that participated in the evaluation does not equal the number of participants interviewed because in some cases multiple people from the same organisation were interviewed and n=4 organisations from Kununurra / Wyndham did not consent to being identified.

⁴⁷ Organisations were contacted to participate at least three times.

Appendix E: Interview Questionnaire Results

Average ratings across stakeholders who completed the interview questionnaire

Location		East Kimberley		Ceduna	
Question	Indicator	Initial conditions ⁴⁸ n=23	Wave 1 n=36	Initial conditions ¹³ n=19	Wave 1 n=31
How much of an issue are each of the following in the local community? (Average ratings on a scale of 0 – Not at all to 10 – Extremely severe)	Alcohol abuse	8.3	6.8	7.4	7.0
	Drug use	6.9	5.6	6.8	6.7
	Gambling	6.7	5.0	7.7	6.5
	Violence and other crimes	8.0	6.3	7.0	6.2
	Street begging	5.0	3.9	5.4	4.0
	Humbugging	5.9	4.7	6.3	4.9
	Harassment, abuse, intimidation	5.8	4.4	5.9	4.3
How well is the local community performing on each of the following aspects? (Average ratings on a scale of 0 – very poorly to 10 – very well)	Ability to afford basic household goods	3.7	5.6	4.4	5.6
	Paying bills	3.5	5.5	4.3	5.0
	Employment	3.4	3.6	3.6	3.5
	Education / training	3.6	4.5	3.9	4.3
	Nutrition	3.2	4.6	4.2	4.4
	Health and wellbeing	3.5	4.5	4.4	4.7
	Community pride	4.3	5.0	4.9	5.1
	Community safety	4.2	5.2	4.6	5.0

⁴⁸ Some participants in the evaluation who were not interviewed for the Initial Conditions Report completed a questionnaire retrospectively. These average ratings include retrospective responses.