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Cashless Debit Card Trial Evaluation

Final Evaluation Report

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I. Executive Summary

Background

With support from the Department of the Prime Minister and Cabinet (PM&C) and the Department of Human Services (DHS), 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 Trial of a Cashless Debit Card (CDC) for income support payments (ISPs) in two remote communities.

The **Cashless Debit Card Trial (CDCT) aims to reduce the levels of harm underpinned by 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). Eighty per cent of CDCT participants' ISPs, as well as other supplementary payments, 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. The percentage of funds accessible in an unrestricted manner (e.g. as cash) may be varied by local community panels, up to a maximum of 50%. 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, and people outside of the Trial sites (subject to approval by DSS) can volunteer for the CDCT [1].

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. As at 2 June 2017, there was a total of 2,141 CDCT participants (794 in Ceduna and Surrounds and 1,347 in EK). A large majority of CDCT participants in each Trial site identified as being Indigenous Australians.

ORIMA Research was commissioned by DSS to independently evaluate the Trial in both locations. This report presents the final findings of the evaluation.

Responses to Key Evaluation Questions

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?

Wave 1 quantitative survey data and qualitative research findings indicated that the first 6 months of the CDCT was associated with a reduction in all three target behaviours among CDCT participants – alcohol consumption, illegal drug use and gambling. Wave 2 data from these sources (collected around 9 months after Wave 1) indicated that these reductions had been sustained and broadened, with a larger proportion of CDCT participants reporting reduced levels of each behaviour (compared to before being on the Trial). In addition, CDCT participant survey results indicated that the reductions in alcohol consumption and gambling were deepened among CDCT participants, with the average reported frequency of alcohol consumption and gambling declining significantly between Wave 1 and Wave 2. On average across the two Trial sites:

1 As at 26 May 2017, n=6 Trial participants were recorded as having been voluntary CDCT participants

- Among CDCT participants who had been consuming alcohol before being in the Trial, the proportion who reported drinking alcohol less frequently than they did before participating increased significantly from 25% (n=345) at Wave 1 to 41% (n=231) at Wave 2.
- At Wave 2, when asked about having six or more drinks on one occasion, 37% (n=237) of participants who engaged in such drinking before being in the Trial said they were doing this less often than they did before participating, also demonstrating a significant positive change from the Wave 1 result (25%, n=302).
- At Wave 2, 38% of participants who reported drinking alcohol stated that they drank alcohol about weekly or more often (n=229) - a substantial reduction from 63% at Wave 1 (n=327).
- Among CDCT participants who had used illegal drugs before being in the Trial, the proportion reporting that they were doing so less frequently than they did before participating increased significantly from 24% (n=84) at Wave 1 to 48% (n=62) at Wave 2.[2]
- When asked about whether their gambling behaviour had changed since becoming Trial participants, at Wave 2, 48% of those who gambled before the Trial reported doing this less often (n=109), up from 32% at Wave 1 (n=140).[3]
- In addition, there was a significant increase between Wave 1 (27%, n=85) and Wave 2 (54%, n=86) in the proportion of participants who reported less frequently spending more than $50 a day gambling than they did before becoming CDCT participants.

The limited available administrative data was consistent with these findings. In particular, in the 12 months following the introduction of the CDCT (April 2016 to March 2017), electronic gaming (poker) machine revenue in the Ceduna and surrounding Local Government Areas (Streaky Bay, Le Hunte, Elliston, and Lower Eyre Peninsula) was 12% lower than in the previous 12 months (April 2015 to March 2016).

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 was a reduction in crime, violence and harm related to alcohol consumption, illegal drug use and gambling since the Trial commenced. Overall, in Wave 2 there was some additional evidence of positive impacts in these domains. However, it is important to note that, with the exception of drug driving offences and apprehensions under the Public Intoxication Act (PIA) in Ceduna, crime statistics showed no improvement since the commencement of the Trial.

Administrative data other than crime statistics provided some evidence of a reduction in harm in the Trial sites.

- In Ceduna, lower levels of harm related to alcohol consumption were indicated by decreases in alcohol-related hospital presentations, alcohol-related outpatient counselling by Drug and Alcohol Services South Australia (DASSA) and the number of apprehensions under the Public Intoxication Act.

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2 It should be noted that self-reports of illegal drug use in a survey context are subject to a high risk of social desirability bias and should be interpreted with caution.

3 The change between Wave 1 and 2 was not statistically significant at the 95% level of confidence (but it was at the 94% level).

- In Kununurra, lower levels of alcohol-related harm were indicated by decreases in alcohol-related pick-ups by the Miriwoong Community Patrol Service and referrals from this service to the Moongoong Sober Up Shelter.
- In Wyndham, lower levels of alcohol-related harm were indicated by decreases in pick-ups by the community patrol service.

The qualitative research found considerable observable evidence being cited by many community leaders and stakeholders of a reduction in crime, violence and harmful behaviours over the duration of the CDCT across both Trial sites. Indirect evidence of this impact of the CDCT was also reported by the police and some service providers who noted that the police had a greater capacity to conduct positive community engagement/preventative programs since the CDCT, due to the decreased need to perform reactive policing.

- Community leaders', stakeholders' and merchants' ratings to a short questionnaire in the qualitative research indicated that, overall, they perceived the problem of violence and crime to have diminished in Ceduna between Wave 1 and Wave 2, from 6.2 to 5.0 out of 10 (7.0 pre-Trial), and to have remained relatively stable in EK, from 6.3 to 6.4 out of 10 (8.0 pre-Trial), based on average ratings on a scale of 0 (not at all) to 10 (extremely severe).

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

There was no statistically significant change between Wave 1 data collection (a few months post CDCT implementation) and Wave 2 (9 months later) in CDCT participant and non-participant perceptions of safety (as measured in the quantitative survey).

In the qualitative research, community leaders', stakeholders' and merchants' feedback indicated that, overall, they perceived that community safety had increased in their local community during the CDCT period and between Wave 1 and Wave 2.

- Community leaders', stakeholders' and merchants' ratings of their community's performance in terms of community safety increased between Wave 1 and Wave 2 – in Ceduna from 5.0 to 6.3 out of 10 (4.6 pre-Trial) and in EK from 5.2 to 5.7 out of 10 (4.2 pre-Trial), based on average ratings on a scale of 0 (very poor) to 10 (very well).
- At Wave 2, many stakeholders reported that there had been greater use of public facilities (e.g. families having picnics, playing ball, etc.) than pre-CDCT. They also cited noticeable increases in the numbers of families and tourists accessing and using public areas (e.g. parks). Furthermore, merchants and stakeholders reported that returning tourists/visitors had commented on feeling safe and had provided positive feedback on the changes in the community.

Have there been any other positive impacts?

There was considerable evidence from the quantitative surveys and qualitative research to suggest that there were benefits from the CDCT other than those discussed above at an individual and community level in both Trial sites. Many of these benefits can be grouped under a long-term (by 2 years or more after implementation) planned outcome of the Trial that was included in the Program Logic: **increased community, personal and children's wellbeing**.

For example, the quantitative survey results provided indicative evidence of positive **financial impacts** for participants at an overall level, as a result of the Trial. Since being on the CDCT, just under half (45%) of participants on average across the two sites at Wave 2 reported that they had

been able to save more money than before (n=461). This represents a significant improvement on the Wave 1 result of 31% (n=542). This positive trend was reported in both Ceduna and EK.

The quantitative survey also found some indicative evidence of positive impacts on **parenting** as a result of the Trial. At Wave 2, on average across the Trial sites:

- 40% of participants who had caring responsibilities (n=198) reported that they had been better able to care for their children since being in the CDCT Trial; and
- 39% of such participants (n=197) stated that that they had become more involved with their children's homework and school since before being in the CDCT Trial.

Despite these positive improvements, when asked about the impact of the Trial on their child/children's lives overall, participants on average across the two sites reported mixed perceptions. At Wave 2, 17% of participants who had children reported that they felt their lives were better as a result of the Trial (n=198, consistent with 18% at Wave 1 (n=250)), whilst 24% felt their child/children's lives were worse (consistent with 20% at Wave 1). There was no material difference in results across Trial sites.

- Among participants who said that the Trial had made their child/children's lives worse, the most prevalent reasons were related to not being able to give children cash (n=20) and not being able to buy goods for their children with cash (n=16).
- Reasons provided for why the Trial had improved the lives of children were mostly related to being able to meet basic needs better (such as food, clothes, etc. n=26).

Subjective wellbeing was also assessed in the quantitative survey by asking participants about the impact of the Trial on their lives. On average across the two sites, at Wave 2 participants were more likely to indicate that it had made their lives worse than better. However, negative perceptions were less prevalent than at Wave 1. At Wave 2, 32% of participants on average reported that the Trial had made their lives worse (n=462), significantly down from 49% at Wave 1 (n=547). The proportion reporting that the Trial had made their lives better, however, remained consistent - 23% at Wave 2 (n=462) and 22% at Wave 1 (n=547).

- Ceduna participants (28%, n=228) were significantly more likely than those in EK (18%, n=234) to report a positive impact on their wellbeing.
- Indigenous CDCT participants were significantly more likely than non-Indigenous participants to indicate that their lives were better under the CDCT: 26% (n=405), compared with 15% among non-Indigenous participants (n=56).

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

Community leaders, stakeholders and merchants 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 was expected 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.

Overall, the evaluation found that the range of circumventions reported to be occurring at Wave 1 had somewhat reduced at Wave 2, as measures had been put in place to address some of the

circumventions. In addition, further exploration of some of the perceived circumventions conducted at Wave 2 found little evidence to support that they were occurring to a material extent.

Have there been any other unintended adverse consequences?

Consistent with Wave 1, a few stakeholders in the Wave 2 qualitative research reported that some Trial participants who 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. However, in the quantitative survey, only 4% of all participants on average across the two sites explicitly raised 'stigma' or 'shame' associated with the card as an issue at Wave 2 (6% did so at Wave 1). At Wave 2, 6% of participants also mentioned lack of freedom and/or concerns about their rights.

Beyond that, adverse consequences for Trial participants predominantly related to complications/limitations experienced by some when using CDCs, such as being unable to transfer money to children that are away at boarding schools and being unable to make small transactions at fundamentally cash-based settings (e.g. fairs, swimming pools and canteens). At Wave 2, the quantitative survey found that 33% of CDCT participants (on average across the Trial sites, n=458) had experienced such issues. This was a significant decrease from the 46% who reported difficulties at Wave 1 (n=538). It should be noted that, by Wave 2, many of the issues had been rectified for most Trial participants through education and assistance with setting up card processes. In addition, measures had been and/or were in the process of being put in place to enable CDCs to be used in traditionally cash-based settings (e.g. EFTPOS facilities introduced at cash-based fairs).

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

Where has the Trial worked most and least successfully?

The evaluation findings indicate that the Trial has had a considerable positive impact in both Trial sites. The evidence suggests that the Trial was a little more successful in Ceduna than in East Kimberley, largely due to more effective implementation. That said, at both sites, there was a large degree of support from stakeholders and community leaders for the CDC to be extended across the country because of the positive changes that had been observed as a result of the Trial, which were considered to be applicable on a broader scale.

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

Apart from alcohol restrictions, the CDCT (including the CDC, the additional funding for services provided under the Trial) and State service reform initiatives, qualitative research with community leaders, local merchants and stakeholders did not identify any other potentially substantial influences on alcohol consumption, illicit drug use or gambling in the Trial sites during the CDCT. An analysis of the relative impact on these behaviours of the CDC compared with that of local drug and alcohol support services, as well as financial and family support services (summarised in the next section) indicated that the impact of State service reforms on these behaviours is likely to have been small. The potential impact of alcohol restrictions is discussed below.

The primary evidence for a reduction in alcohol consumption being a direct result of the CDCT presented in this report flows from quantitative survey self-reports by CDCT participants. There is a strong case that these self-reports were not materially influenced/biased by any behavioural

changes associated with alcohol restrictions. The alcohol restrictions in each site had been in place for a considerable period of time before survey respondents commenced in the CDCT[4] and hence the recalled (pre-participation) level of consumption would have reflected a level of consumption that had been fully adapted to the alcohol restrictions (with the exception of CDCT participants who had moved into the Trial area during or shortly before its commencement).

In this context, it is also important to note that the takeaway alcohol restrictions in each Trial site were not highly restrictive (with the exception of bans on sale to residents of certain Aboriginal communities near Ceduna). For example, throughout the Trial, an individual in the EK has been able to purchase (each day apart from Sunday) 22.5 litres of full-strength beer, 4.5 litres of wine and 1 litre of spirits/fortified wine. Therefore, such restrictions are unlikely to have been a binding constraint on consumption for most CDCT participants.

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 CDCT support package included investment in additional drug and alcohol support services, as well as financial and family support services. The quantitative survey of CDCT participants indicated that 19% had used a service from either category during the period of the CDCT. Comparative analysis of the self-reported behavioural changes of surveyed CDCT participants who had used these services, and those who had not, indicated that the CDC had a significant positive effect on targeted behaviour (and associated benefits) that was independent of the effect of the services. It should be noted that the analysis tested the effect of all such services (whether part of the additional funding package or not – including services subject to State service reform initiatives). The analysis was suggestive of an additive positive effect (above that of the CDC) of the services on the small proportion of the CDCT population who had used them. However, this was only a relatively small effect for a small proportion of the total participant population.

Methodology

Based on information about Trial inputs, outputs and intended outcomes provided by DSS, ORIMA Research developed a formal evaluation framework which specified the scope of the evaluation and the key performance indicators (KPIs) that would lead its assessment of the effectiveness of the CDCT.

Five sources of data were used in the evaluation of the CDCT:

1. Two quantitative, face-to-face surveys of CDCT participants (Wave 1: August-September 2016, with 552 participants) (Wave 2: May-June 2017 with 479 participants).
2. A quantitative, face-to-face survey of family members of CDCT participants (August-September 2016, with 78 family members).
3. Two quantitative, face-to-face surveys of other community members - i.e. not CDCT participants and not family members of participants (Wave 1: August-September 2016, with 110 people) (Wave 2: May-June 2017 with 141 people).
4. Qualitative research interviews and focus groups with community leaders, stakeholders and merchants (April-May 2016, with 37 people) (August-October 2016, with 73 people) (May-June 2017, with 86 people).

4 In EK, the alcohol restrictions applying during the course of the CDCT had been put into place in 2011 (with strengthened compliance via the Takeaway Alcohol Management System introduced in December 2015). In Ceduna, the alcohol restrictions applying during the course of the CDCT had been put into place in 2012.

5. Administrative data sourced from the CDC provider (Indue Limited), DHS, state government agencies and local service providers.

The quantitative surveys were the primary data sources, with one or more of these surveys specified as a data source/s for all of the outcome KPIs in the evaluation framework. This is reflected in the relative prominence of these data sources in the findings presented in this report.

The surveys at both Wave 1 and 2 were based on a systematic intercept sampling methodology. There was also a longitudinal survey component - 134 CDCT participants who were interviewed in the Wave 1 survey were also interviewed in the Wave 2 survey. All 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. This helped ensure that data collection was conducted in a culturally appropriate and sensitive manner.

Each of the data sources used has its limitations. In particular, the following limitations should be considered in interpreting the findings of the surveys and the qualitative research:

- As most of the research fieldwork was conducted 6-12 months after the commencement of the CDCT, recall error is likely to be present in the reports of conditions prior to the commencement of the CDCT.
- When reporting on their own behaviours, survey respondents may be prone to social desirability effects and hence respond in a socially acceptable way. In order to minimise this source of error, interviewers were trained to remain impartial and free from judgement when conducting interviews and respondents were also provided with full confidentiality of responses.

The analysis of administrative data was subject to the following limitations:

- imperfect alignment between the CDCT evaluation KPIs and the available administrative data
- unavailability of adequate time series data to perform robust pre-Trial and post-Trial comparisons
- low numbers of cases (as a result of small population numbers in the Trial sites) which led to considerable volatility over time in the measures and made it difficult to detect trends
- comparison site data were only available for a limited number of measures
- recording and collection issues with administrative data sets which reduced their reliability.

Conclusions

1. The evaluation findings indicate that the CDCT has been effective in reducing alcohol consumption and gambling in both Trial sites and are also suggestive of a reduction in the use of illegal drugs.
2. The evaluation findings show some evidence that there has been a consequential reduction in violence and harm related to alcohol consumption, illegal drug use and gambling.
3. The evaluation findings provide limited evidence of an improvement in perceptions of safety in the Trial locations.
4. The evaluation findings indicate that the Trial has had widespread positive spill-over benefits.
5. The evaluation findings indicate that many Trial participants initially had negative perceptions of the Trial, but that acceptance has increased over time.

6. The evaluation findings indicate that many Trial participants have experienced complications and limitations when using CDCs, but that these issues have been ameliorated over time as a result of greater familiarity, as well as education and assistance provided by DSS, Indue Limited and its Local Partners.

II. Introduction

A. Overview of the Cashless Debit Card Trial

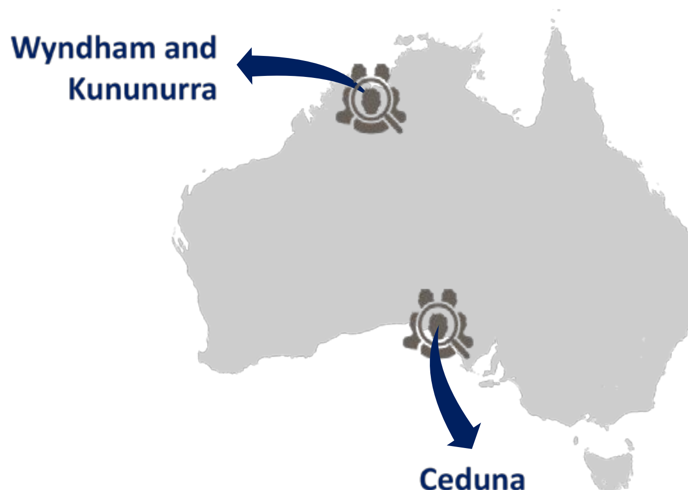
The Cashless Debit Card Trial (CDCT) is a co-designed program developed through collaboration between government and two communities. The aim of the CDCT is to reduce the levels of harm underpinned by alcohol consumption, illicit drug use and gambling within the communities of Ceduna and Surrounds in South Australia and East Kimberley in Western Australia (Kununurra and Wyndham). Both communities are relatively small (with populations of around 4,000 and 5,000 respectively) and geographically remote. Such remote sites in Australia typically have considerable economic and social challenges. Their relative isolation allows them to be more effective test sites than locations with adjacent populations who travel to and from trial locations.

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 the Department of Human Services (DHS), 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, to a maximum of 50%. CDCT participants in the Trial sites can apply to the community panels to reduce the percentage of their ISP paid via the CDC, so they can have greater access to cash.

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, and people outside of the Trial sites (subject to approval by DSS) can volunteer for the CDCT.[5]

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 further investment.

Locations of CDCT trial sites – Ceduna (SA) and East Kimberley (Wyndham and Kununurra – WA)



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

As at 2 June 2017, n=794 residents of Ceduna and Surrounds and n=1,347

5 As at 26 May 2017, n=6 Trial participants were recorded as having been voluntary CDC participants.

residents of East Kimberley were receiving an ISP via a CDC[6].

The Cashless Debit Card commercial provider, Indue Limited, has engaged 'Local Partners' in Ceduna and the East Kimberley to provide participants with on-the-ground face-to-face support. Local Partners in each site can assist with things such as account balance queries and using the Indue online portal. Participants can report a lost card and access a replacement card at a Local Partner. In addition, participants can raise queries related to paying utility bills, rent, mortgage and large purchases from their CDC with the Local Partners.

B. Role of the Evaluation

B.1 Framework

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

Based on information about Trial inputs, outputs and intended outcomes provided by DSS, ORIMA Research developed a formal evaluation framework[7] which specified the scope of the evaluation and the key performance indicators (KPIs) that would lead its assessment of the effectiveness of the CDCT.

The overall evaluation design and process was 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
- officers of Australian and state government agencies with on-the-ground experience in the Trial sites.

B.2 Objective

The overall objective of the evaluation was 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)?

6 Source: Department of Human Services .

7 See Appendix A.

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?

C. Evaluation Methodology and Sources of Data

To triangulate the evidence and guide conclusions, five sources of data were used in the evaluation:

1. Two quantitative, face-to-face surveys of CDCT participants (Wave 1: August-September 2016, with 552 participants) (Wave 2: May-June 2017 with 479 participants).
2. A quantitative, face-to-face survey of family members of CDCT participants (August-September 2016, with 78 family members).
3. Two quantitative, face-to-face surveys of other community members - i.e. not CDCT participants and not family members of participants (Wave 1: August-September 2016, with 110 people) (Wave 2: May-June 2017 with 141 people).
4. Qualitative research interviews and focus groups with community leaders, stakeholders and merchants (April-May 2016, with 37 people) (August-October 2016, with 73 people) (May-June 2017, with 86 people).
5. Administrative data sourced from the CDC provider (Indue Limited), DHS, state government agencies and local service providers.

Table 1 below presents a mapping of evaluation data sources against the outcome KPIs in the evaluation framework. It shows that the quantitative surveys are the primary data sources, with one or more of these surveys specified as a data source/s for all of the outcome KPIs in the framework. This is reflected in the relative prominence of these data sources in the chapters that follow.

Table 1: Correspondence of evaluation framework outcome KPIs and evaluation data sources

Key Performance Indicator	Data Sources
Frequency of use/volume consumed of drugs and alcohol	Quantitative survey of Trial participants Quantitative survey of family members of Trial participants Quantitative survey of non-participants Qualitative research
Frequency/volume of gambling and associated problems	Quantitative survey of Trial participants Quantitative survey of family members of Trial participants Quantitative survey of non-participants Qualitative research Administrative data from SA Attorney-General's Department - Electronic Gaming Machine revenue in Ceduna and Surrounds
Percentage of participants aware of drug and alcohol support services	Quantitative survey of Trial participants
Percentage of participants aware of financial and family support services	Quantitative survey of Trial participants
Usage of drug and alcohol support services	Quantitative survey of Trial participants Administrative data from service providers
Usage of financial and family support services	Quantitative survey of Trial participants Administrative data from service providers
Incidence of violent and other types of crime and violent behaviour	Quantitative survey of Trial participants Quantitative survey of family members of Trial participants Quantitative survey of non-participants Qualitative research Administrative data - SA and WA police crime data
Drug/alcohol-related injuries and hospital admissions	Quantitative survey of Trial participants Quantitative survey of family members of Trial participants Administrative data from SA and WA Government agencies
Percentage feeling safe in the community	Quantitative survey of Trial participants Quantitative survey of family members of Trial participants Quantitative survey of non-participants
Percentage feeling safe at home	Quantitative survey of Trial participants Quantitative survey of family members of Trial participants Quantitative survey of non-participants

C.1 Quantitative surveys

Two waves of quantitative, face-to-face surveys were undertaken with Trial participants and other community members, and one wave was undertaken with family members of participants (Wave 1).

The first wave of survey fieldwork was conducted in Ceduna and Surrounds from 17-28 August 2016 and the second wave of survey fieldwork was conducted in Ceduna and Surrounds from 22-31 May 2017. Specific locations included: Ceduna, Thevenard, Oak Valley and Yalata.

The first wave of East Kimberley survey fieldwork was conducted from 12-23 September 2016 and Wave 2 East Kimberley survey fieldwork was conducted from 12-20 June 2017. Interviews were conducted in Kununurra, Wyndham and Mirima.

The surveys in both waves 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.

C.1.1 Quantitative survey methodology

The surveys at both Wave 1 and 2 made use of 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 X^{th} 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 or non-participant surveys (or family survey in Wave 1). Quotas for non-participants were expected to be filled quickly, and once full only participants were selected for an interview.

Further to this, at Wave 2, a number of participants from Wave 1 (who provided contact details) was re-contacted and invited to participate again. These respondents were telephoned prior to the commencement of fieldwork and invited to meet with an interviewer during the fieldwork period. These re-contacted participants were offered a slightly higher incentive with the view to interviewing as many Wave 1 participants as possible, for longitudinal analysis purposes. Data checks and cleaning was undertaken to ensure participant respondents were correctly matched across Waves. The final sample included n=67 longitudinal Ceduna participants and n=67 longitudinal EK participants.

Despite their different populations and number of CDCT participants, the original evaluation plan identified balanced target sample sizes across the two Trial sites, reflecting their equal importance in terms of assessing Trial effectiveness. While it was recognised that this would provide more precise overall statistical estimates for the smaller Trial site (Ceduna and Surrounds), this balanced approach was adopted to maximise the ability for robust drill-down analysis to CDCT participant sub-groups at each site. Small family samples were included to provide a 'red flag' for any major impacts on family members. Planned participant sample sizes were lower in Wave 2 to allow for attrition between the two waves (i.e. people interviewed at Wave 1 who were not able to be interviewed at Wave 2). This reflected an initial wholly longitudinal design for the participant and family surveys. In contrast, the non-participant survey sample sizes were set at the same level in Wave 1 and Wave 2, reflecting the fact that this survey was not longitudinal (i.e. fresh samples were taken in each wave).

Table 2: Wave 1 and 2 starting maximum sample size quotas – quantitative surveys

	Ceduna Wave 1	Ceduna Wave 2	EK Wave 1	EK Wave 2	Total Wave 1	Total Wave 2
Trial participants	325	235	325	235	**650**	**470**
Family members of Trial participants	30	20	30	20	**60**	**-**
Non-participants of the Trial	50	50	50	50	**100**	**140**
Total	**405**	**305**	**405**	**305**	**810**	**610**

The small family member sample was dropped in Wave 2, with those interviews re-directed to boosting the number of non-participants who were interviewed. This was done because it was assessed that greater analytical value from the limited resources available for the survey would be obtained from enabling more statistically precise comparisons of Wave 1 and Wave 2 non-participant surveys than from a family member survey with a very small sample size (which would not have provided statistically reliable estimates).

Table 3 shows the number of interviews achieved across the two Waves of fieldwork. In Ceduna, n=286 interviews were achieved in the Wave 1 fieldwork period and n=310 at Wave 2. In EK, n=454 interviews were completed at Wave 1 and n=310 at Wave 2. The Wave 1 quotas were not all achieved in Ceduna but were achieved in EK. The Wave 2 quotas were all achieved and in some cases exceeded. Overall, a total of n=552 CDCT Participants were interviewed across the two sites at Wave 1 and n=479 at Wave 2.

Table 3: Wave 1 and 2 sample sizes of quantitative survey respondents

	Ceduna Wave 1	Ceduna Wave 2	EK Wave 1	EK Wave 2	Total Wave 1	Total Wave 2
Trial participants	196	239	356	240	**552**	**479**
Family members of Trial participants	32	-	46	-	**78**	**-**
Non-participants of the Trial	58	71	52	70	**110**	**141**
Total	**286**	**310**	**454**	**310**	**740**	**620**

Participation rates in both Waves of the quantitative surveys were reasonable for an intercept methodology (see Table 4 and Table 5). Wave 2 intercept refusals were slightly higher than Wave 1 in both locations. However, the proportion refusing across sites was more consistent in Wave 2, with 22% of intercepts refusing in Ceduna and 21% in EK. The overall recorded co-operation rate (the ratio of obtained intercept interviews to intercept refusals) of 1.3 was significantly higher than what is typically recorded in general community telephone surveys in Australia (below 0.2 - i.e. below one interview to five refusals).[8]

8 Bednall et. al. (2013) Response Rates in Australian Market Research, Deakin University, Melbourne.

Table 4: Wave 1 – Fieldwork statistics for the quantitative surveys

Quantitative survey W1	Ceduna (n)	Ceduna (%)	East Kimberley (n)	East Kimberley (%)	Total (n)	Total (%)
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**	100%	**3055**	**100%**	**3990**	**100%**

Table 5: Wave 2 - Fieldwork statistics for the quantitative surveys

Quantitative survey W2	Ceduna (n)	Ceduna (%)	East Kimberley (n)	East Kimberley (%)	Total (n)	Total (%)
Total Intercept + Recontact Sample	**1094**		**919**		**2013**	
Total Completes	**310**	**28%^**	**310**	**34%^**	**620**	**31%^**
Recontacts						
W1 Recontact Sample (provided details)	**87**		**171**		**258**	
Completes (recontact)	**67**	**77%**	**67**	**39%**	**134**	**52%**
W1 Sample Recontacted & Confirmed	28	32%	40	23%	68	26%
W1 Sample no interview confirmed	59	68%	131	77%	190	74%
Refused Invite	*1*	*<1%*	*0*	*0%*	*1*	*<1%*
Agreed but did not attend	*0*	*0%*	*0*	*0%*	*0*	*0%*
No Answer	*7*	*8%*	*20*	*12%*	*27*	*10%*
Disconnected	*21*	*24%*	*43*	*25%*	*64*	*25%*
Not Available for Survey Period/Moved away	*3*	*3%*	*15*	*9%*	*18*	*7%*
Left Message/SMS	*27*	*31%*	*53*	*31%*	*80*	*31%*
Other	*0*	*0%*	*0*	*0%*	*0*	*0%*
W1 Sample interviewed by intercept/approach^^	**39**	**45%**	**27**	**16%**	**66**	**26%**
Intercepts						
Total intercepts	**1007**		**748**		**1755**	
Completes (intercept)	**243**	**24%**	**243**	**32%**	**486**	**28%**
Refusals	**222**	**22%**	**158**	**21%**	**380**	**22%**
Screen-outs (total)	514	51%	307	41%	821	47%
Under 18	*4*	*<1%*	*5*	*1%*	*9*	*<1%*
Already completed	*155*	*15%*	*73*	*10%*	*228*	*13%*
Tourist/out of area	*202*	*20%*	*174*	*23%*	*376*	*21%*
Language	*1*	*<1%*	*7*	*1%*	*8*	*<1%*
Can't be interviewed	*5*	*<1%*	*12*	*2%*	*17*	*1%*
Family member	*13*	*1%*	*2*	*<1%*	*15*	*1%*
Other	*134*	*13%*	*34*	*4%*	*168*	*10%*

^ Overall response rate based on the total number of intercepts plus total number of available recontacts ^^ Some recontacts were found through intercept methods or approaching the interview teams and providing information to match the W1 recontact sample

Variations in refusals and the total number of intercepts between Waves 1 and 2 largely reflect the combinations of several characteristics of sample sizes and processes in each case (though it is also possible that, in Wave 2, there could have been a reduced motivation to participate in a survey wave conducted longer after the introduction of the Trial). The total number of participants interviewed in Ceduna increased from Wave 1 (196) to Wave 2 (239), while in EK more participants were interviewed in Wave 1 (356) than in Wave 2 (240). In both cases, more than a quarter of all participants interviewed in Wave 2 were 'recontacts' interviewed after being directly contacted in advance rather than through fresh intercepts. The extended interviewing period and larger participant sample size in EK in Wave 1 meant that we also reached a higher level of saturation of the population there, which resulted in a higher proportion of people who screened out for having already done the survey in Wave 1. These factors very substantially reduced the total number of intercepts required in EK, where the total number of respondents in Wave 2 recruited by fresh intercept was around half of that at Wave 1; while in Ceduna the increase in efficiency mostly balanced the larger sample size. The increase in non-participant sample sizes in both sites from 50 in Wave 1 to 70 in Wave 2 meant that there were fewer screen-outs on the basis of being a non-trial participant after those quotas were filled (classified as 'other'). Instead, a higher proportion of intercepted non-trial participants were classified as a refusal rather than as a screen-out in Wave 2, impacting the balance of refusals and the total number of intercepts.

Comparison of the demographic characteristics of the Wave 1 and Wave 2 CDCT participant response samples against population benchmarks (age, gender and Aboriginal and/or Torres Strait Islander origin from DHS administrative data) indicated that the raw/unweighted sample distributions were broadly in line with population benchmarks. In order to further improve the accuracy/representativeness of the findings, the survey results were weighted (see C.1.3 below). This weighting aligned the distribution of the CDCT participant response sample with that of the CDCT population in respect of the abovementioned characteristics. Therefore, the reported results of each survey wave were based on balanced population estimates. This provides assurance that changes in survey results between survey waves were due to underlying changes in the population and not due to response sample compositional change.

Non-participants were also surveyed at both Wave 1 and Wave 2. Results for non-participant surveys have not been weighted by demographic characteristics due to low response sample sizes. Comparison of the demographic characteristics of the Wave 1 and Wave 2 response samples (age and gender) indicates that the sample profiles were broadly consistent, with the exception of the gender split in EK (49% female at Wave 2 and 69% female at Wave 1). However, there were only very few statistically significant differences between the results of men and women non-participants in EK (at either Wave 1 or Wave 2) and these differences did not have a material impact on the comparative analysis.

C.1.2 Interpretation of quantitative survey results

This report has endeavoured to include certain information in the body of the text to maximise the ease of interpretation for the reader. The following section is designed to assist readers to understand the quantitative survey results and how they have been presented. It is recommended that this section is understood prior to reading the remainder of the report.

Discussion of quantitative survey results

This report covers survey results from both Waves of the quantitative surveys. In the majority of cases throughout the report, survey results have been referred to explicitly as Wave 1 or Wave 2 results. However, in any case where Wave is not specifically mentioned, percentages from the

quantitative research presented in the report are from Wave 2 of the evaluation. It is important to note that Wave 1 and Wave 2 results are never combined throughout this report.

In the body of the text, sample size has been included to accompany all percentages that are based on sub-groups of the total sample. This sample size represents the base that the percentage was derived from. Where sample sizes are low, the reader will be warned to interpret with caution.

Percentages from the quantitative research presented in the report are based on the total number of valid responses made to the question being reported on. In most cases, results reflect those respondents who had a view/for whom the questions were applicable. 'Don't know/not sure' or 'Not applicable' responses have only been presented where this aids in the interpretation of the results. When such responses have been removed/results have been rebased, this will be mentioned in either the body of text or associated figure.

Presentation of quantitative survey results in figures

It should also be noted that results in figures are all weighted results, whilst sample sizes are all unweighted. Results in tables are also weighted unless otherwise stated, and sample sizes are all unweighted. Percentage results throughout the report may not always sum to 100% due to rounding.

Throughout this report, quantitative survey results are presented in figures which may be split by respondent type (participant/non-participant) and/or location (Ceduna/EK), depending on which groups were asked the question.

In the case that a figure or the text refers to 'participant average'/'non-participant average' or similar (e.g. 'on average across the two sites, participants reported..'), this includes respondents of that type from both Ceduna and EK combined. This combined result was created by taking an average across the two locations.

It is important to note that although respondents of each type have been combined across sites, participants and non-participants are never combined. The views and results from these respondent types have been kept separate in order to gain a clear understanding of how the Trial has impacted both those who are on the Trial and those who are not.

In some cases a green arrow, red arrow or a dash will be present alongside charted results in figures. A green arrow indicates a statistically significant change (in the desired direction) between Waves in the survey result denoted in the heading above it, whilst a red arrow indicates a significant change in the undesired direction. A dash indicates that no significant change has occurred across Waves. Statistical significance throughout the report is tested at the 95% confidence level.

C.1.3 Weighting of quantitative survey results

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/average 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 separately for Wave 1 and Wave 2.
  - Results labelled Ceduna participant or East Kimberley participant have been weighted in this way.
- The Family (for Wave 1 only) and non-participant sub-groups across sites were not weighted by demographic characteristics due to low sample sizes.

In order to provide an overall **aggregate/average** 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. The rationale for this locational weighting method was that, from an evaluation perspective, each Trial site was treated as being of equal importance in assessing the effectiveness of the Trial. In standard survey research, it is usual for overall population estimates to be calculated such that locational weights align with relative population proportions. This standard approach was deemed inappropriate for the evaluation as it would have given greater weight in the overall evaluation performance measures to the EK than the Ceduna experience.

  - Results labelled 'participant average' have been weighted in this way.
- The family (Wave 1 only) and non-participants were also weighted equally across sites to give the family average (Wave 1 only) and non-participant average results.

C.1.4 Statistical precision

Table 6 provides indicative confidence intervals (at the 95% level of statistical confidence) for different response sizes within the surveys, allowing for the impact of weighting as outlined above.

Table 6: Indicative confidence intervals – 95% confidence level

Response size (n)	Statistical precision (percentage points)
500	+/- 5pp
350	+/- 6pp
200	+/- 8pp
150	+/-9pp
100	+/- 12pp
80	+/- 13pp
40	+/- 19pp

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 (i.e.: 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 statistical 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. All survey result differences in this report (e.g. Wave 1 compared with Wave 2) that have been described as 'significant' are statistically significant at the 95% confidence level.

ii. The statistical precision shown above is for percentage results from a survey of 50% (e.g. 50% of participants who were aware of an aspect of the CDCT). As the percentage 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% (e.g.: 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 is applied, the lower is the effective sample size for the calculation of statistical significance. Here, a design effect of 1.40 has been applied to allow for the effect of the weighting required at Wave 2 for the CDCT participant survey. This scaling means that somewhat larger differences are required before the threshold for statistical significance is reached.

iv. In addition to allowing for the effects of weighting, the calculations conducted in order to test for statistically significant differences have taken into account the fact that part of the CDCT participant response sample at Wave 1 and Wave 2 (longitudinal sample) overlapped (i.e. the same respondents were interviewed in both waves). This necessitated the use of repeated measures statistical tests when testing differences between Wave 1 and Wave 2 results within the longitudinal sample. It also involved the use of a complex, blended (longitudinal and non-longitudinal) sample statistical significance testing procedure for comparing aggregate CDCT participant survey results (i.e. those based on all respondents in each wave). This procedure is detailed in the technical report at Appendix C.

C.2 Interviews and focus groups with community leaders, stakeholders and merchants

C.2.1 Interview and focus group methodology

Interviews[9] and focus groups with community leaders, other on-the-ground stakeholders and local merchants in the Trial sites were conducted in the Trial communities at three points in time:

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

- Initial conditions – conducted between 21 April and 26 May 2016 across Ceduna and Surrounds and East Kimberley.
- At Wave 1 – conducted between 15 August and 15 September 2016 in Ceduna, and between 12 September and 4 October in East Kimberley.
- At Wave 2 – conducted between 22 May and 31 May 2017 in Ceduna, and between 12 June and 20 June in East Kimberley.

At all stages, stakeholders and merchants 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.[10]

Interviews and focus groups with community leaders and stakeholders were arranged based on participants' availability to attend the scheduled focus groups and preferences to provide feedback in a group or interview format. Separate focus groups were conducted with community leaders and stakeholders and included no more than 8 participants in each group. Merchants participated in interviews as part of the evaluation.

Table 7: Number of community leaders participating in the research

Phase	Ceduna and Surrounds[11]	East Kimberley[12]	Total
Pre-Trial launch	4	8	**12**
Wave 1	6	14	**20**
Wave 2[13]	7	5	**12**

Table 8: Number of stakeholders[14] participating in the research

Phase	Ceduna and Surrounds[15]	East Kimberley[16]	Total
Pre-Trial launch	10	14	**24**
Wave 1	25	25	**50**
Wave 2	23	35	**58**

10 Questioning was tailored to the operating context, environment and client-base of each type of organisation involved in the research.

11 Includes participants in Ceduna, Koonibba, Scotdesco and Yalata

12 Includes participants in Kununurra and Wyndham

13 Please note that at Wave 2 a number of community leaders previously interviewed were no longer on the leadership panel, however, as they were still based at the Trial location, they were still interviewed as part of the qualitative research process

14 See Appendix B for further detail regarding organisations that were interviewed

15 Includes participants in Ceduna, Koonibba, Scotdesco and Yalata

16 Includes participants in Kununurra and Wyndham

Table 9: Number of merchants[17] participating in the research

Phase	Ceduna and Surrounds[18]	East Kimberley[19]	Total
Pre-Trial launch	1	0	**1**
Wave 1	2	1	**3**
Wave 2	10	6	**16**

In Wave 2 there were 61 community leaders and stakeholders who were contacted but not interviewed. Of these, only 4 declined to participate, with the others being cases where an interview at a mutually suitable time was not able to be organised or the contact was no longer at the organisation/Trial site.

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

C.2.2 Interpretation and presentation of qualitative findings

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 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 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
- a few – refers to findings that relate to less than a quarter of research participants.

Please note that some findings have not been represented against these indicative thresholds because the information was specific to only a particular sub-group or type organisation/service provider. Therefore, these have been identified as the 'relevant stakeholder/s'.

In the qualitative research, community leaders, stakeholders and merchants were encouraged to provide evidence for their responses based on their own direct experiences where possible. Where anecdotal/"hearsay" sources were cited, the qualitative research sought to validate this directly from the source. However, when this was not possible or viable, only anecdotes that were heard

17 See Appendix B for further detail regarding organisations that were interviewed

18 Includes participants in Ceduna, Koonibba, Scotdesco and Yalata

19 Includes participants in Kununurra and Wyndham

three times or more from different community leaders, stakeholders and/or merchants have been used as evidence in the evaluation report.

C.2.3 Definitions

The following terms have been adopted throughout this final Evaluation Report to refer to the different types of qualitative research participants:

- community leaders – refers to members of the Leadership Group in the Trial sites
- stakeholders – refers to all qualitative participants other than community leaders and local merchants; e.g. service providers, police etc. (see Appendix B for the full list of organisations)
- merchants – refers to managers/owners of local retail businesses and Visitor Information Centres.

C.3 Administrative data

An extensive set of administrative data was examined as part of the evaluation. A detailed tabulation of all administrative data examined (apart from Indue and DHS data) and its sources is appended (see Appendix H: Administrative data examined in the Evaluation). This administrative data was subject to a number of important limitations (discussed below). It has only been presented in the report in cases where, despite the limitations, such presentation substantively assists in understanding the effectiveness of the CDCT. The administrative data related to the two CDCT Trial sites and three comparison sites. The comparison sites were initially suggested by the South Australian and Western Australian State Governments and accepted by the evaluators as being appropriate. These comparison sites do not represent perfect "control sites" but are similar in character to the CDCT sites in terms of underlying demographic and socio-economic characteristics:

- Coober Pedy and Port Augusta were used as comparison sites for the Ceduna and Surrounds CDCT site.
- Derby was used as the comparison site for the East Kimberley CDCT site.

Movements in administrative data series (e.g. changes in drug/alcohol-related hospital admissions) used in assessing the impact of the CDCT could occur due to either the impact of the CDCT or other (external) factors (e.g. decrease in the general availability of certain kinds of illicit drugs in Australia). In order to assess the possible impact of these external factors (so as to better estimate the impact of the CDCT), wherever possible, movements in Trial site data were compared with those in the comparison sites where the CDCT has not been implemented. The latter provide an indication of what would have happened in the Trial sites in the absence of the CDCT.

D. Limitations

The following section outlines these various limitations of the methodology for the consideration of the reader and to aid in the interpretation of results and conclusions.

D.1 Administrative data limitations

The first limitation of the administrative data was that it was collected for purposes other than the CDCT evaluation. This meant that there was imperfect alignment between the CDCT key performance indicators and the available administrative data. Therefore, the data available generally

serve as imperfect proxy measures for problematic alcohol consumption, illegal drug use, gambling and anti-social and disruptive behaviours. For example, measures such as sobering up unit admissions and alcohol-related pick-ups by community patrol services are used as proxy measures for problematic alcohol consumption, whilst the only proxy measure for illegal drug use that was available was drug driving in Ceduna. The other implication of the abovementioned limitation was that data was not always available at the required locality. For example, poker machine revenue data covers an area larger than the trial site of Ceduna, extending to Streaky Bay, Le Hunte, Elliston, and Lower Eyre Peninsula.

The second limitation relates to the unavailability of adequate time series data to perform robust pre-Trial and post-Trial comparisons. Whilst such data was available for some measures (e.g. crime statistics for EK), data for most measures was not available for the planned period of 12 months before and 12 months after Trial commencement. Since the same pre and post time range had to be used to control for seasonal effects, the impact of this was that a reduced time period (i.e. less than 12 months) had to be used for many pre and post comparisons. For example, Ceduna crime statistics data were only available from July 2015 to March 2017 – i.e. 12 months after the Trial and 9 months before the Trial. The comparability requirement meant that although 12 months of data was available post-Trial, only 9 months could be used for comparison purposes (as that was all that was available for the pre-Trial period).

Another problem relating to lack of availability of adequate time series data involved the low frequency of data collected/recorded limiting the number of observations available for robust pre- and post-Trial comparisons. Whilst for most measures monthly data were available, some were only recorded/available quarterly or less frequently. For example, disruptive tenancies data for Ceduna, Coober Pedy and Port Augusta (the latter two being comparison sites) were only available at quarterly intervals from Q1 2014/15 to Q3 2016/17, whilst school attendance data were available at term/semester level.

The third limitation was a difficulty in detecting trends due to low numbers of cases (as a result of small population numbers in the Trial sites) which led to considerable volatility over time in the measures.

The fourth limitation relates to the comparison site data which were only available for a limited number of measures. For example, no comparison site data were available for problematic alcohol consumption or gambling measures.

The last limitation relates to the quality of the administrative data in terms of its accuracy and representativeness. Most administrative data is subject to recording and collection issues which affect its reliability. Crime statistics, for example, only reflect incidents reported to, and subsequently recorded by, state police departments. As such, they are subject to two levels of error, as not all criminal activity is reported to police, and police subsequently use their discretion on whether and how they record an incident. Similar issues are likely to apply to other administrative data, especially in cases where subjective judgement is exercised during data collection. These issues are further exacerbated if there are changes to administrative practices that govern what is recorded and how. The extent to which the administrative data used for the CDCT evaluation is affected by these recording and collection issues is largely unknown – unless reliability concerns were specifically noted in the data provided, it was assumed that the data was not subject to issues beyond those that could be expected in general for such administrative data.

D.2 Recall error

In order to triangulate evidence, it was decided that both quantitative and qualitative research would be undertaken. Each of the respective methodologies were carefully designed by ORIMA Research in collaboration with the Department to ensure the most reliable and robust data was collected. For this evaluation, like many others, such quantitative and qualitative methods relied heavily on respondent recall as a way to measure change over time. Due to the long-term nature of the Trial, respondent recall error is likely to be present.

At both waves, respondents were asked to report on their behaviours at that time and before the Trial. Therefore, recall bias at Wave 2 may be greater due to the extended duration of time since before the Trial began.

- In an attempt to combat this error, respondents were able to answer one or more of the following: 'can't say', 'don't know', 'unsure' or 'refused', when asked to reflect on their past behaviour.

This source of error is acknowledged by the evaluation team and should be considered by the reader when interpreting results and conclusions.

D.3 Response bias

As participants and stakeholders knew the intent of the Trial, there was a potential for response bias. This bias could manifest in a positive or negative way for different respondents, depending on their level of support for the Trial. Due to the mixed opinions toward the Trial, this bias would arguably not have impacted results in an overall positive or negative direction. Furthermore, if present, this bias is likely to have been present in both Waves of the Trial. Therefore, measures of change between Waves are likely to be relatively unaffected by this issue.

D.4 Self-report measures

Self-report measures were used in the evaluation of the CDCT as a practical way of measuring changes in respondent behaviour over time. It would not have been possible to accurately measure actual behaviours, such as alcohol consumption, consistently for the duration of the Trial for each participant.

Although a common methodology, self-report measurement does have its limitations. When reporting on their own behaviours, respondents may be prone to social desirability effects and hence respond in a socially acceptable way. In order to combat this bias, interviewers were trained to remain impartial and free from judgement when conducting interviews and respondents were also provided with full confidentiality of responses.

D.5 Observation bias

The 'Hawthorne effect', or observation bias, is common in social science research methodologies. It results from study participants modifying their behaviour or responses due to an awareness of being observed.

This effect may have been present amongst the longitudinal sample as not only were they aware that they would be interviewed again, but they were also aware of the questions that would be asked in the survey. In order to investigate this, statistical significance tests were run to compare the results across key questions for the longitudinal and non-longitudinal samples at Wave 2. The results

showed that there were very few significant differences between the two groups. This suggests that this effect was not a material issue.

D.6 General methodological limitations

Systematic intercept sampling, qualitative interviews and focus groups each come with their relative strengths and limitations.

Some limitations of systematic intercept sampling that should be acknowledged include:

- Non-response bias: while substantial effort was made to include a random selection of Trial participants and non-participant members of the community through the random intercept methodology, participation in the survey was voluntary. Hence there may be certain types of participants or non-participants who were less likely or did not participate as they did not consent to be interviewed.
- Not necessarily gaining a statistically representative random sample of the underlying population due to unequal selection probabilities.

Both of the above issues were partially addressed through weighting of survey data at the analysis stage in order to calibrate the obtained sample against known population characteristics.

Specific limitations/considerations in relation to the qualitative interviews and focus groups that should be acknowledged include:

- The qualitative feedback from stakeholders was found to be influenced by the type of audiences/Trial participants that stakeholders had direct exposure to/dealings with. Some stakeholders who dealt with a very ‘high-risk’ client-base tended to base their feedback and observations on a very small group of Trial participants and found it difficult to consider the impacts of the Trial from a broader perspective (i.e. the impact of the Trial on other Trial participants and the broader community).
- Due to staff turnover, leave and timing of the research some organisations were not able to participate in both Waves of the research and/or were represented by a different staff member. This reduced the ability to make direct comparisons between Wave 1 and Wave 2 findings in some instances.
- While considerable effort was made to include all current members of the community leadership groups as identified by the Department in both Waves of the evaluation research[20], there were some leaders who did not participate and/or only participated in the Wave 1 evaluation as they were unable to be contacted[21].

20 All community leaders identified by the Department were contacted a minimum of 5 times to seek their participation.

21 At Wave 1 two community leaders in Wyndham and one community leader in Ceduna did not participate. At Wave 2, two community leaders in Kununurra, three community leaders in Wyndham and one community leader in Ceduna did not participate.

E. Ethics Approval and Quality Assurance

An ethical risk assessment was conducted during the planning of the evaluation. It was assessed that, for all research/data collection components with the exception of the quantitative surveys, there was no more than a low ethical risk (i.e. the only foreseeable risk was one of discomfort or inconvenience to research participants). Accordingly, formal, independent ethical review was sought only for the survey research involving CDCT participants, their family members and non-participants in the relevant communities. The Bellberry Human Research Ethics Committee (HREC) reviewed these surveys 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 surveys on 8 August 2016.

The project was conducted in accordance with international quality standard ISO 20252 and the Australian Privacy Principles contained in the *Privacy Act 1988 (Cth)*.

F. About this report

F.1 Reporting framework

This is the final evaluation report of the Cashless Debit Card Trial. Two earlier reports have been prepared, as set out below.

Initial Conditions Report **July 2016** *Qualitative research with 37 stakeholders and community leaders in the Trial communities*	**Wave 1 Interim Evaluation Report** **January 2017** *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*	**Wave 2 Final Evaluation Report** **July 2017** Qualitative research with 86 stakeholders and community leaders in the Trial communities + quantitative surveys with 479 participants and 141 general community members (non-Trial participants) + administrative data

F.2 Acknowledgements

This evaluation would not have been possible without the hard work, support, insights and knowledge of the team at the Department of Social Services. The authors would also like to thank the Department of the Prime Minister and Cabinet and the Department of Human Services for their valuable inputs and support. A number of other individuals, organisations and groups contributed to this work directly and indirectly including the Evaluation Steering Committee, the Evaluation Expert Panel, leaders and representatives of Aboriginal corporations and community organisations in the Ceduna and Surrounds and East Kimberley regions, officers of WA and SA Government agencies and the local councils in the Ceduna and East Kimberley regions. ORIMA Research would like to extend our gratitude to all who were involved. Particular thanks must be extended to the research participants themselves, across both Ceduna and Surrounds and East Kimberley, who took the time to talk honestly and openly about their lives and experiences.

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F.5 Glossary of acronyms

Term	Definition	Term	Definition
CAPI	Computer Assisted Personal Interviewing	ISP	Income Support Payment
CDC	Cashless Debit Card	MAP	Mobile Assistance Patrol
CDP	Community Development Programme	PI	Performance Indicator
CDCT	Cashless Debit Card Trial	PIA	Public Intoxication Act
DASSA	Drug and Alcohol Services South Australia	Pp	Percentage points
DHS	Department of Human Services	PM&C	Prime Minister and Cabinet
DSP	Disability Support Pension	SA	South Australia
DSS	Department of Social Services	SUU	Sobering Up Unit
EK	East Kimberley	WA	Western Australia
KPI	Key Performance Indicator		

III. Contextual background

A. About this chapter

This chapter presents background and contextual information for the evaluation findings described in the later chapters of the report.

Firstly, the chapter presents the population demographic data for the Trial sites based on the 2016 ABS Census and data on the demographic profile of CDCT participants, sourced from the Department of Human Services. Secondly, the chapter addresses other contextual information, based on the qualitative research component of the evaluation, to enhance understanding of the environmental and personal factors influencing the people in the CDCT communities. Finally, the chapter presents key findings from the initial conditions report relating to the circumstances in the communities prior to the commencement of the CDCT.

B. Population demographic background

The 2016 Census found that the total population of Ceduna and Surrounds[22] was 4,110 and the total population of the East Kimberley[23] was 5,139.

Figure 1 overleaf shows that similar proportions of the population in the CDCT Trial sites identified as being of Aboriginal and/or Torres Strait Islander origin in the 2016 Census. These proportions were much higher than that among the Australian population as a whole (3%).

22 Ceduna and Surrounds is comprised of the Local Government Area of Ceduna and the following geographical areas from Statistical Area Level 1 (SA1s): 40601113409, 40601113410, 40601113501 and 40601113502.

23 East Kimberley is comprised of the following SA1s: 5126516, 5126512, 5126511, 5126508, 5126518, 5126510, 5126513, 5126507, 5126506, 5126509, 5126503, 5126515, 5126505, 5126520. Note that for 2016 Census data, area codes for East Kimberley are different to those in the 2011 Census (data from which was used in the Initial Conditions Report). MA1 plots from the Census of 2011 and 2016 were compared on maps and the areas with the most overlap were picked as their replacements. The previous codes were: 5120801, 5120802, 5120804, 5120805, 5120807, 5120808, 5120810, 5120811, 5120812, 5120814, 5120815, 5120816, 5120817, and 5120818.

Figure 1: Aboriginal and/or Torres Strait Islander Origin — Percentage of the population residing in CDCT sites[24]

Source: ABS Census 2016.

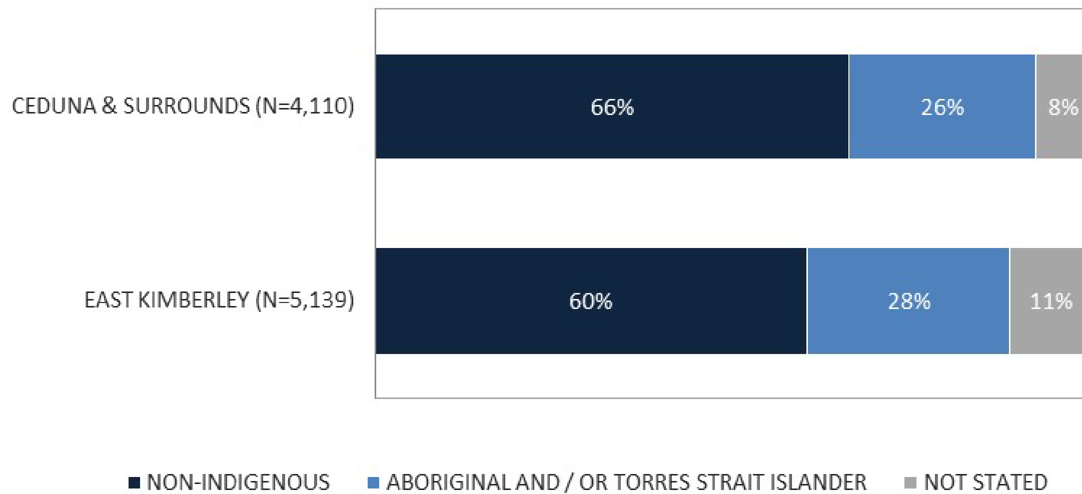
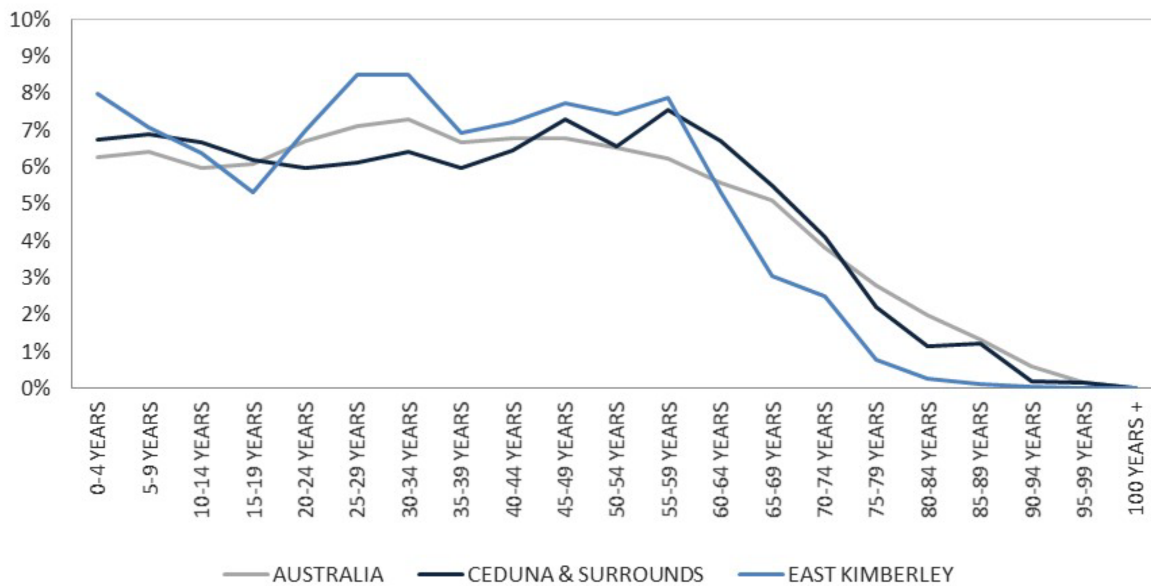


Figure 2 below shows that the population of Ceduna and Surrounds in 2016 had a similar age distribution to that of Australia as a whole, while that of East Kimberley had a relatively high proportion of people of working age (15-64 years of age).

Figure 2: Age Distribution — Population residing in CDCT trial sites

Source: ABS Census 2016.

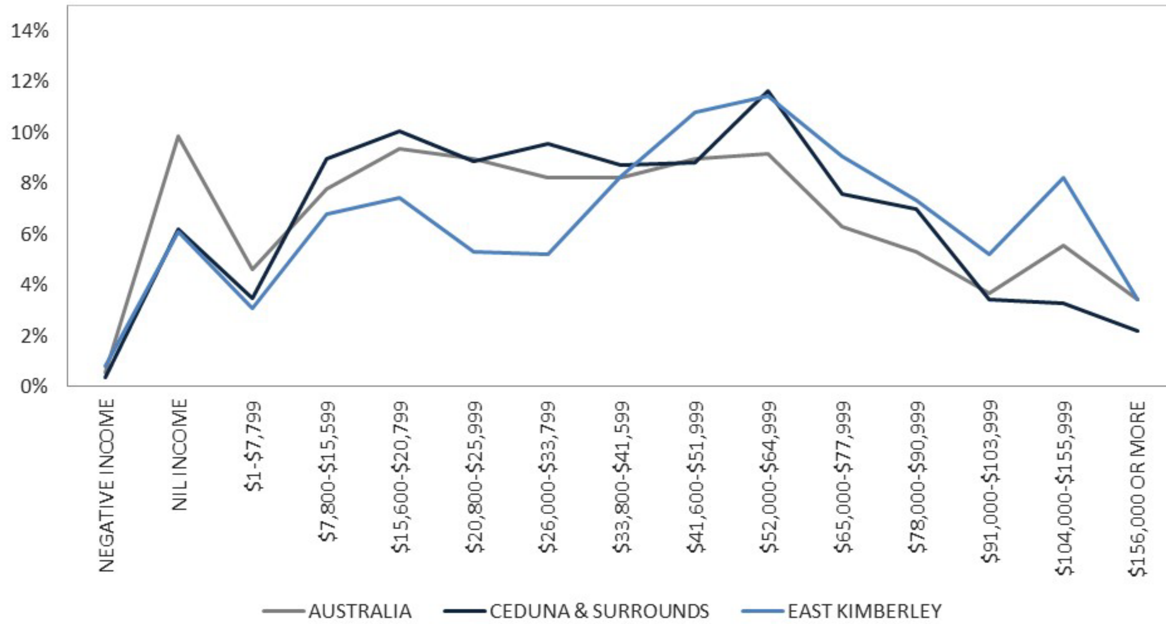


24 Percentages in this Figure and throughout this report are subject to rounding and hence may not sum to 100%.

Figure 3 shows that the population of Ceduna and Surrounds in 2016 had a total annual personal income distribution that was similar to that of Australia as a whole. In contrast, the income distribution of East Kimberley was skewed towards higher income brackets.

Figure 3: Total Annual Personal Income Distribution — Population residing in CDCT trial sites[25]

Source: ABS Census 2016.



25 Negative income refers to cases where losses accrued to a person as an owner or partner in unincorporated businesses or rental properties exceed income from other sources. Losses occur when operating expenses and depreciation are greater than total receipts.

C. Trial participants' demographic profile

As at 2 June 2017, there was a total of 2,141 CDCT participants. This reflected an increase of 200 people from 1,941 participants at 24 June 2016 (when the Trial had been fully implemented)[26].

Figure 4 shows that, of the 2,141 participants:

- 794 people were residents of Ceduna and Surrounds in June 2017, up from 737 in June 2016
- 1,347 people were residents of East Kimberley, up from 1,204 in June 2016.

Figure 4: CDCT participant population by year

Source: Department of Human Services

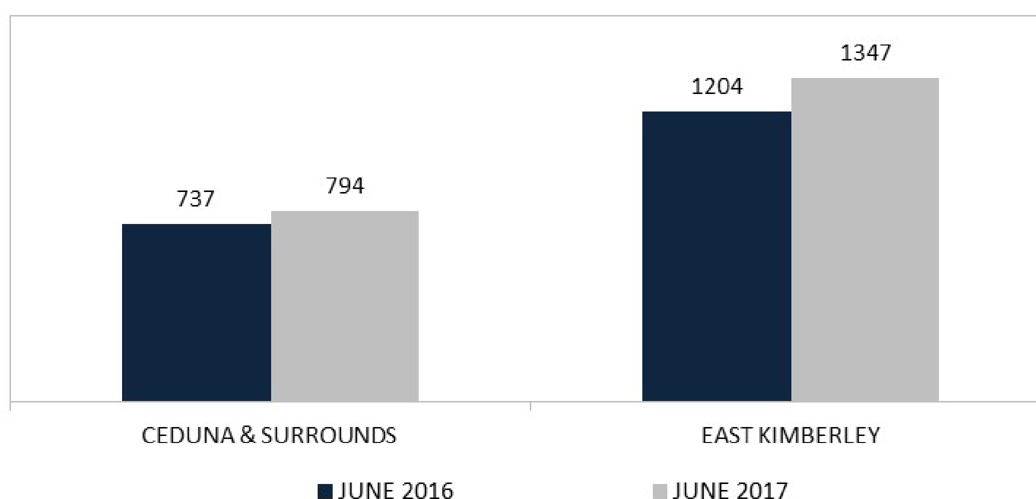
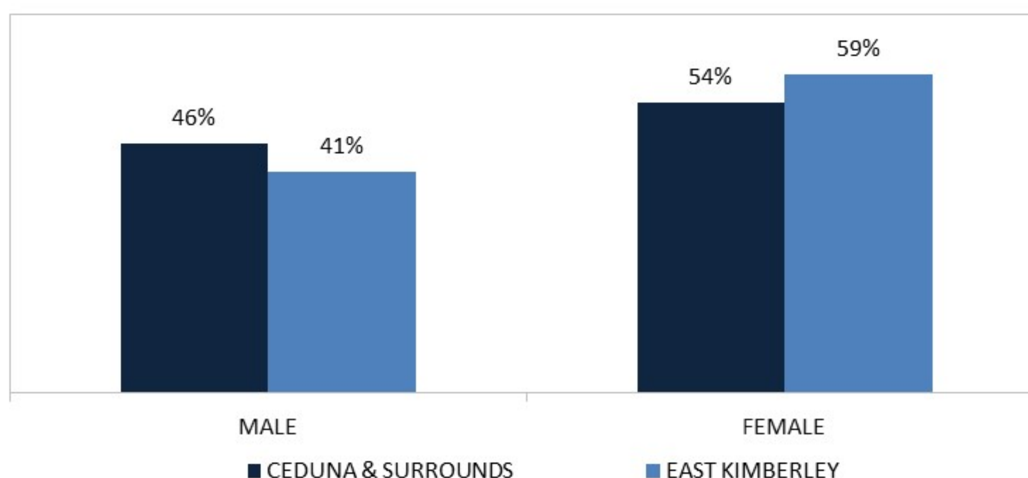


Figure 5 below shows that there were more female than male CDCT participants in both Trial sites, with the gender breakdown skewed more heavily towards females in East Kimberley.

Figure 5: CDCT participant population by gender – 2 June 2017

Source: Department of Human Services



26 Cashless debit cards 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.

Figure 6 below shows that the age distribution of the CDCT participant population was similar in the two Trial sites, with a majority of participants being under 45 years of age.

Figure 6: CDCT participant population by age group – 2 June 2017

Source: Department of Human Services

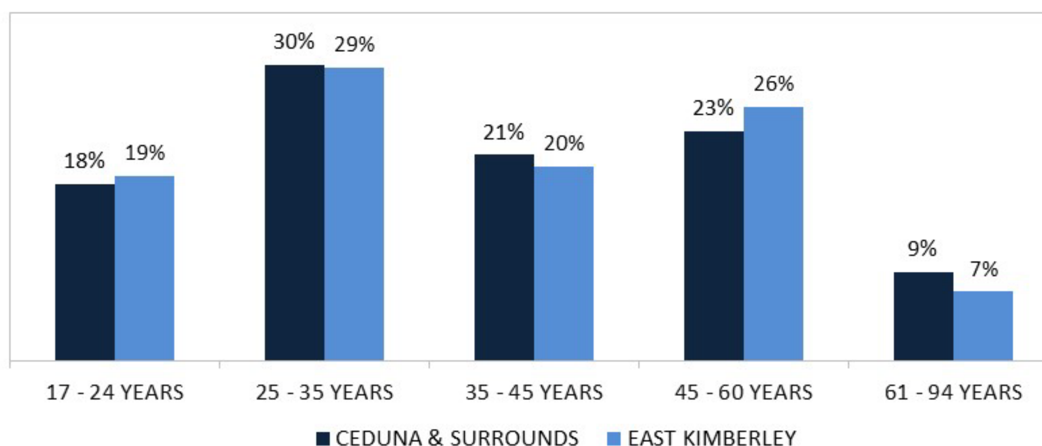
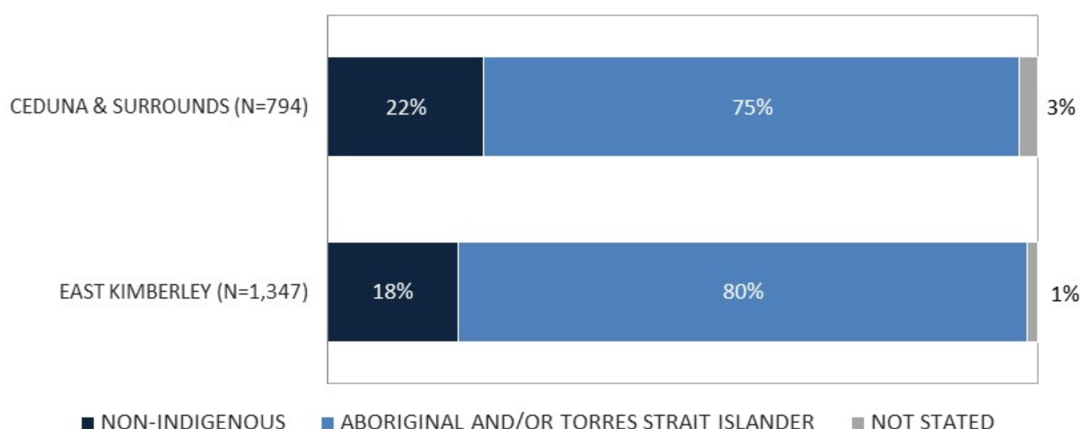


Figure 7 below shows that a large majority of CDCT participants in each Trial site identified as being Indigenous Australians.

Figure 7: Percentage of CDCT participant population identifying as being of Aboriginal and/or Torres Strait Islander Origin – 2 June 2017

Source: Department of Human Services



D. Key factors influencing the Trial communities

Overall, the qualitative evaluation component found that there were a number of background, environmental and historical factors in the Trial communities that influenced the implementation process as well as how the Trial was perceived and accepted by the community. These factors included:

- transient nature of the Trial populations
- IT and financial literacy levels

- remoteness
- cultural and traditional considerations
- history with governments
- community dynamics.

Community leaders and stakeholders commonly reported on the highly mobile or transient nature of many of the Indigenous people in the Trial communities. There were two common forms of residency patterns: those who resided in permanent addresses and those who were transient and commonly spent periods of time (ranging from a couple of weeks to several months) living outside their community when visiting family and friends, attending cultural ceremonies/events or receiving medical treatment. The level of transiency meant that it was particularly challenging to reach the breadth of Trial participants in the lead up to and during the implementation of the CDCT in terms of consultation and communication activities as well as delivering support services for the Card.

Community leaders and stakeholders commonly felt that the level of IT and financial literacy among some Trial participants was particularly low and problematic (e.g. awareness, understanding, skills and/or confidence). These groups of Trial participants were perceived to require substantially more effort, time and support to adjust and accommodate to the new CDC requirements. Furthermore, access to reliable and operational technology was also a concern in some Trial areas (e.g. limited or "patchy" signal coverage for mobile phones and the internet).

Location was commonly identified as a major barrier to accessing timely support and Card-related services and assistance. Trial participants living in town (i.e. Ceduna or Kununurra) were perceived to be better catered for than those living in remote (e.g. Wyndham or Scotdesco) or very remote (e.g. Oak Valley) locations. Therefore, many community leaders and stakeholders felt that out-reach and the use of local providers/people were particularly important for reaching and engaging with Trial participants in remote and very remote locations. Proactively 'going to the people' was perceived as being a necessary mechanism for engagement, rather than expecting people to go to a centralised service model.[27]

Cultural and traditional factors among people living in Ceduna and Surrounds were reported as being very different to those among people in the East Kimberley. Some community leaders and stakeholders felt that government processes tended to adopt a generalised and potentially disrespectful approach in dealing with Indigenous people, and didn't necessarily account for customs, culture and traditions – which were particularly important for remote communities. Given this view, it is not surprising that some community leaders and stakeholders identified a need for better accommodation of local customs, culture and traditions in CDCT processes.

Some community leaders and stakeholders felt that past experiences with governments negatively influenced some Trial participants' perceptions of, and engagement with, the CDCT. Some community leaders and stakeholders indicated that Indigenous Trial participants, or members of their families, had negative past experiences with governments, which made them fearful and suspicious of the intentions and rationale behind the CDCT. For these reasons, it was found to be particularly important that the target audience and local drivers of the CDC initiative be continuously communicated and explained in a positive, supportive and helpful tone.

27 DSS advised that Local Partners were funded in Wyndham, Scotdesco and Oak Valley.

Finally, some community leaders and stakeholders in each trial site felt that local community dynamics had influenced how the CDCT was perceived and accepted (e.g. racial biases, perceptions of local service providers and community leaders, turnover of service staff and programs, closure of industries, limited employment options, etc.).

E. Conditions in the Trial communities before the Trial

The Initial Conditions qualitative research with community leaders and stakeholders in Ceduna, Wyndham and Kununurra found widespread local concern about high levels of alcohol consumption and, to a lesser extent, illicit drug use and gambling activity. Most community leaders and stakeholders indicated that these issues had been becoming progressively worse over the past 5 to 10 years and that the local communities were experiencing considerable adverse impacts. In particular, most community leaders and stakeholders felt that excessive alcohol consumption was at a "crisis point", and was having wide-ranging negative impacts on individuals, their families and the community.

These were commonly identified in relation to:

- The health of adults and children in the communities (e.g. a range of injuries and longer-term health issues such as anxiety, depression, cancer, high blood pressure and Foetal Alcohol Syndrome).
- Safety and security (e.g. domestic and family violence, sexual violence, assaults and harassment/intimidation).
- Financial problems (e.g. inability to pay fines, inability to fund basic living expenses for items such as food, clothing, rent and utilities).
- Social problems such as family arguments/disputes, unemployment/underemployment and humbugging.
- Inability to secure stable housing.
- Living in overcrowded housing conditions.
- Adverse impacts on the wellbeing of children as a result of poor parenting/neglect of family responsibilities and lack of engagement (e.g. lower school attendance and engagement, poor educational outcomes and poor nutrition).

At the Initial Conditions stage, a few stakeholders and community leaders believed that the levels of alcohol consumption had reduced since the introduction of alcohol restrictions in these communities. These restrictions are discussed in Section F below.

The Initial Conditions research also found that, overall, there was generally good awareness and general understanding of the CDCT amongst stakeholders in both Trial sites. Community leaders tended to have a better and more detailed understanding of the CDCT processes than other stakeholders.

Across all Trial locations, most stakeholders and community leaders felt strongly that there was a need for something to be done to address the high levels of alcohol consumption and, to a lesser extent, illicit drug usage and gambling in the community and their associated harms. Many also felt that a new approach was required to address these issues as current and previous programs and services had not reduced these behaviours.

As such, most community leaders and stakeholders were broadly supportive of the CDCT. However, at the time of the Initial Conditions Report, perceptions in relation to the likely effectiveness of the Trial were mixed.

F. Alcohol restrictions in the Trial communities

Ceduna and Surrounds

The townships of Ceduna and Thevenard have been Dry Areas since 1988. This means that it has been illegal since 1988 to drink alcohol in a public place within the Ceduna and Thevenard town boundaries. In recent years, the SA Liquor and Gambling Commissioner, SA Police, Ceduna District Council and local alcohol licensees have introduced a range of measures in relation to responsible service, sale and consumption of alcohol in Ceduna and Surrounds. In 2012, ID-Tect machines were introduced at all takeaway alcohol outlets in Ceduna, Thevenard and Smoky Bay (these machines are used to record and validate photographic identification at point of sale) along with alcohol sales restrictions.

Since 17 September 2015[28] the following alcohol sales restrictions have been in force[29]:

- Everyone must show identification to purchase takeaway alcohol.
- Licensees may only sell one 750ml bottle (or less) of spirits per person per day. Should two or more bottles of spirit be purchased, licensees must record the person's details including name, address and identification number in a maintained register.
- Licensees may only sell one 2 litre cask to a person in one day.
- Licensees may not sell port or fortified wine for takeaway purposes.
- Licensees may not sell alcohol for takeaway purposes to a person whose address is recorded as 'prescribed lands' identified as: Oak Valley Community, Maralinga Tjarutja Lands, Yalata Reserve, Tjuntjunjara, Umoona Community, Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, Ngaanyatjarra Lands and Tjuntjuntjura Lands.

East Kimberley

The WA Department of Racing, Gaming and Liquor introduced alcohol restrictions in Wyndham and Kununurra in 2011. The following restrictions have been in place since then:

- The sale and supply of liquor for consumption at hotel/tavern premises is prohibited before 12 noon except where it is sold ancillary to a meal (or to a lodger at hotel premises).
- Takeaway alcohol restrictions include (trading hours Monday to Saturday 12pm – 8pm)[30:]
  - No limits per person per day on Low strength alcohol (i.e. 2.7% alcohol by volume (ABV) or less).
  - Limit of 22.5 litres (e.g. two cartons of beer) on Mid to Full strength alcohol (i.e. 2.7% to 7% ABV) per person per day.

28 Source: http://www.ceduna.sa.gov.au/webdata/resources/news/New%20Rules%20for%20Alcohol%20Sales%2017%20Sept%202015.pdf

29 Source: http://www.ceduna.sa.gov.au/dryzoneandalcoholrestrictions.

30 Special exemptions apply in some cases. See http://www.swek.wa.gov.au/tams.aspx.

- Limit of 4.5 litres (e.g. six bottles of wine) on Full strength alcohol (i.e. 7% to 15% ABV) per person per day.
- Limit of 1 litre of alcohol (e.g. some spirits or wines) greater than 15% ABV per person per day.

- Additionally, takeaway liquor may not be sold in the entire Kimberley region in individual containers greater than 1 litre of liquor (6% ABV or more) or in glass bottles of 400ml or more of beer.

To support takeaway alcohol outlets (and licensees) to effectively manage compliance with these restrictions, the Kununurra/Wyndham Alcohol Accord implemented a trial of the Takeaway Alcohol Management System (TAMS) which began on 14 December 2015. This system tracks individuals' daily alcohol purchases by using scanning technology of their personal identification.[31]

31 More detailed information about TAMS in Kununurra / Wyndham and surrounding areas can be found at http://www.rgl.wa.gov.au/maps/Restrictions/KununurraWyndham.pdf and http://www.swek.wa.gov.au/tams.aspx.

IV. Effects of the CDCT on consumption of alcohol, illegal drug use and gambling

A. About this chapter

This chapter presents the evaluation findings in relation to the following outcomes expected among CDCT participants: lower alcohol consumption, lower illicit drug use and decreased gambling.

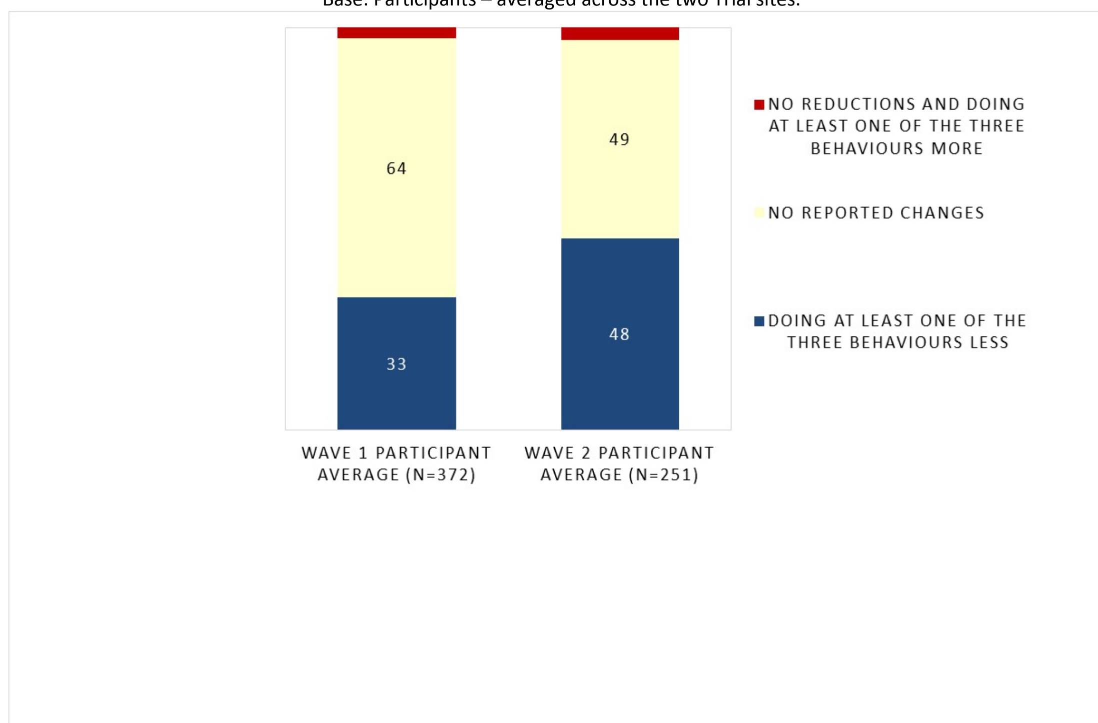
B. Overall findings

Wave 1 quantitative survey data and qualitative research findings indicated that the first few months of the CDCT were associated with a reduction in all three target behaviours among CDCT participants – alcohol consumption, illegal drug use and gambling. Wave 2 data from these sources (collected around 9 months after Wave 1) indicated that these reductions had been sustained and broadened, with a larger proportion of CDCT participants reporting reduced levels of each behaviour (compared to before being on the Trial). In addition, CDCT participant survey results indicated that the reductions in alcohol consumption and gambling were deepened among CDCT participants, with the average reported frequency of alcohol consumption and gambling declining significantly between Wave 1 and Wave 2.

In Wave 2, of those participants who reported doing one of the three aforementioned target behaviours before the Trial, almost half reported a reduction in at least one of these three behaviours since participating in the Trial (48% on average across the two sites, n=251 – see Figure 8). This was a significant improvement on the 33% reporting a reduction at Wave 1 (n=372). This positive result was consistently reported across sites - 45% in Ceduna (n=115) and 50% in EK (n=136).

Figure 8: Self-reported changes in alcohol consumption, gambling or illegal drug use since becoming a participant in the CDCT

Base: Participants – averaged across the two Trial sites.



Q44a (P) / Q44c (P) / q44g (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?

Excludes those who say 'Refused' or 'Can't Say' or 'NA – did not do any of the three behaviours before the trial' across all three measures. Wave 1 participant average: Refused (n=1), Not Applicable (n=174), Can't say (n=1). Wave 2 participant average: Refused (n=15), Not Applicable (n=200), Can't say (n=1).

Available secondary administrative data was consistent with the abovementioned primary research findings. For example, in the 12 months following the introduction of the CDCT (April 2016 to March 2017), electronic gaming (poker) machine revenue in the Ceduna and surrounding Local Government Areas (Streaky Bay, Le Hunte, Elliston, and Lower Eyre Peninsula) was 12% lower than in the previous 12 months (April 2015 to March 2016).

C. Consumption of alcohol

Overall, the qualitative research findings, the quantitative survey data and the available administrative data indicate that the CDCT has had a positive impact in lowering alcohol consumption across the two Trial sites. Amongst participants who reported drinking alcohol before commencing in the Trial, self-reported reductions in alcohol consumption were similar across the Trial sites, whilst amongst non-participants, perceptions of reduced alcohol consumption in the community were more positive in Ceduna than EK.

C.1 Amount of consumption

Prior to the implementation of the CDCT, the Initial Conditions research revealed that, across both sites, alcohol consumption was the most concerning issue for community leaders and stakeholders. Most community leaders and stakeholders felt that excessive alcohol consumption was at a "crisis

point", and was having wide-ranging negative impacts on individuals, their families and the community.

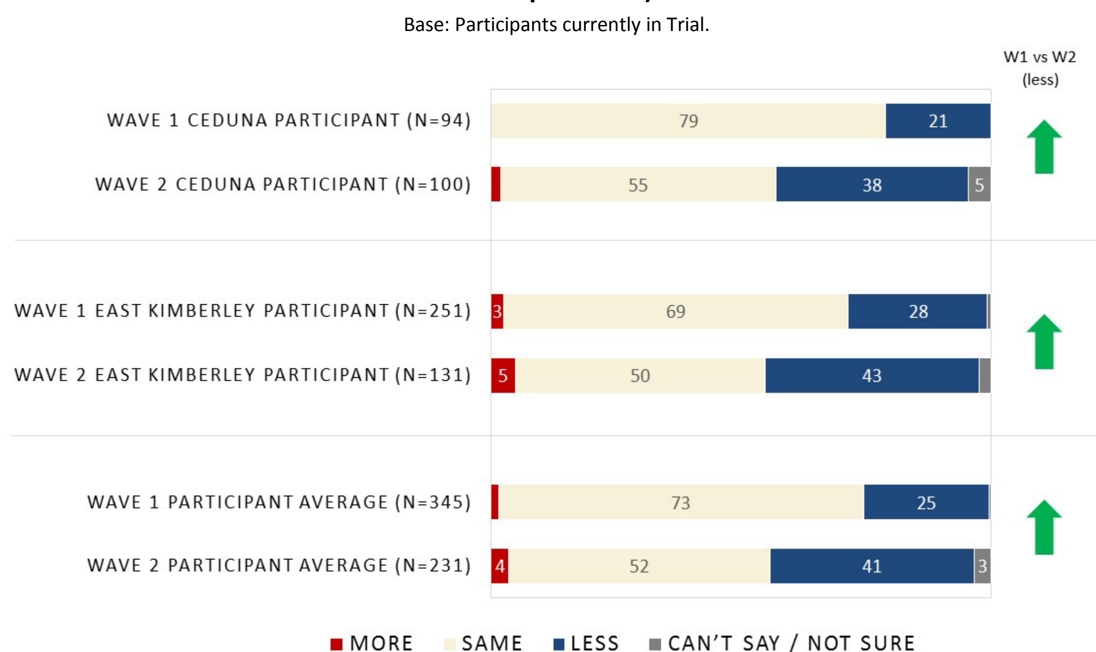
At Wave 1 of the evaluation, feedback from some community leaders, stakeholders and merchants in Ceduna and many in EK was that alcohol consumption appeared to be lower and less visible. Positively, qualitative feedback from many community leaders, stakeholders and merchants indicated that these positive impacts had continued at Wave 2. There was a continued sense that people were drinking less per person per day, and stakeholders in alcohol-related organisations and service providers (e.g. sobering up facilities, ambulance and police) reported observations consistent with this.

Community leaders', stakeholders' and merchants' ratings to a short questionnaire in the qualitative research indicated that they perceived that alcohol abuse in Ceduna had decreased between Wave 1 and Wave 2, from 7.0 to 5.7 out of 10 (7.4 pre-Trial), and increased marginally in East Kimberley (EK), from 6.8 to 7.4 out of 10 (8.3 pre-Trial), based on average ratings on a scale of 0 (not at all) to 10 (extremely severe).

The Wave 1 and 2 survey data support these qualitative findings. Figure 9 shows that, at Wave 2, on average across the two sites, 41% of participants who reported drinking alcohol before commencing in the Trial said they did so *less* frequently than they did before being in the Trial (n=231, a significant improvement on 25% at Wave 1 – n=345), whilst only 4% claimed to drink *more* frequently (n=231, consistent with 1% at Wave 1 – n=345. Note this excludes 'Refused' and 'Not Applicable'). These positive trends were consistent across the two Trial sites.

Figure 9: Change in behaviour since becoming a participant in the CDCT: Drunk grog or alcohol (% of respondents)

Base: Participants currently in Trial.

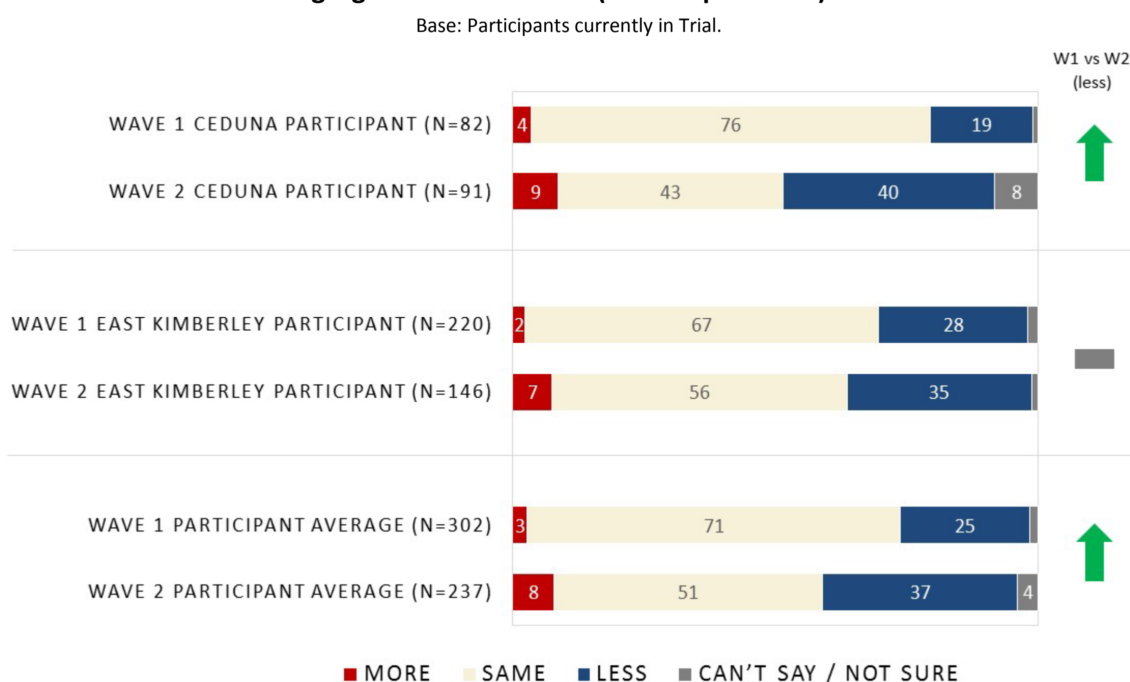


Q44a (P). Since being on the Cashless Debit/Indue Card have you done each of the following more often, less often or the same as before: Drunk grog or alcohol? Excludes 'Refused' and 'Not applicable – did not do activity before'. Wave 1 Ceduna participants: Refused: (n=1), Not Applicable (n=99). Wave 1 East Kimberley participants: Refused (n=0), Not Applicable (n=103). Wave 2 Ceduna participants: Refused (n=16), Not Applicable (n=117). Wave 2 East Kimberley participants: Refused (n=3), Not Applicable (n=100).

When asked about having six or more drinks on one occasion, 37% of participants on average across the two sites (n=237) at Wave 2 (of those who had done this activity before being participants) said they did this *less* frequently than they did before participating in the Trial, also demonstrating a significant positive change from the Wave 1 result (25%, n=302 – see Figure 10). Although a similar proportion of Ceduna and EK participants reported doing this behaviour *less* often in Wave 2, those in Ceduna showed a greater improvement in the proportion saying *less* often since Wave 1: +21 percentage points (pp) compared to +7pp in EK.

Figure 10: Change in behaviour since becoming a participant in the CDCT: Had six or more drinks of grog or alcohol at once (% of respondents)

Base: Participants currently in Trial.



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?

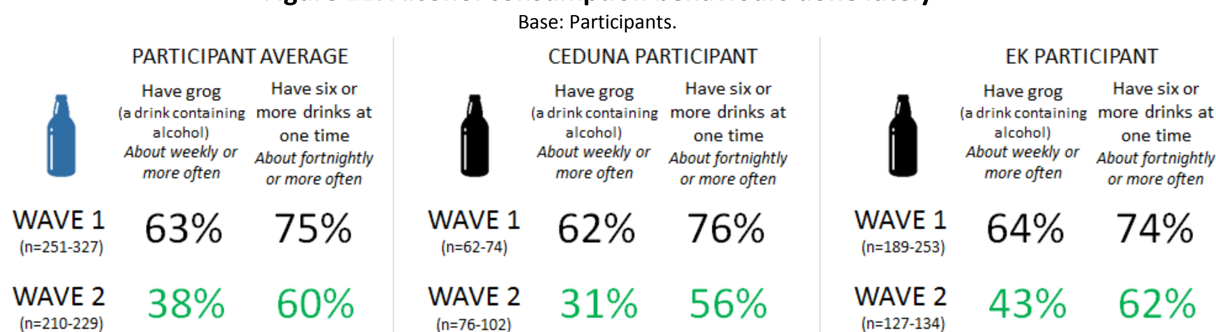
Excludes 'Refused' and 'Not applicable – did not do activity before'. Wave 1 Ceduna participants: Refused: (n=1), Not Applicable (n=111). Wave 1 East Kimberley participants: Refused (n=1), Not Applicable (n=133). Wave 2 Ceduna participants: Refused (n=19), Not Applicable (n=123). Wave 2 East Kimberley participants: Refused (n=3), Not Applicable (n=85).

Figure 11 illustrates that the self-reported *frequency* of alcohol consumption also reduced significantly from Wave 1 to Wave 2. On average across the two sites at Wave 2, 38% of participants who reported doing this behaviour 'lately' stated that they drank alcohol *about weekly or more often* (n=229). This is a substantial reduction from the 63% reported at Wave 1 (n=327). This reduction was apparent across both sites, but was more prominent in Ceduna than in EK (31pp reduction in Ceduna versus 21pp in EK).

The self-reported *frequency* of excessive drinking behaviour also reduced significantly from Wave 1 to Wave 2. On average across the two sites, among participants who reported having six or more drinks at one time lately, the proportion doing so *about fortnightly (every 2 weeks) or more often* reduced from 75% at Wave 1 (n=251), down to 60% at Wave 2 (n=210). Again, this reduction was apparent across both sites, but was also more prominent in Ceduna than in EK (20pp reduction in Ceduna versus 12pp in EK).

Figure 11: Alcohol consumption behaviours done lately

Base: Participants.



Q25a (P). Lately, have you done any of these things? Have grog (a drink containing alcohol). Q25b (P). Lately, have you done any of these things? Have six or more drinks of grog/alcohol at one time.

Excludes 'Refused', 'Not applicable' and 'Never'. Q25a. Wave 1 Ceduna participants: Refused (n=1), Not Applicable (n=0), Never (n=120). Wave 1 East Kimberley participants: Refused (n=1), Not Applicable (n=5), Never (n=97). Wave 2 Ceduna participants: Refused (n=21), Not Applicable (n=27), Never (n=89). Wave 2 East Kimberley participants: Refused (n=7), Not Applicable (n=3), Never (n=103). Q25b. Wave 1 Ceduna participants: Refused (n=1), Not Applicable (n=0), Never (n=132). Wave 1 East Kimberley participants: Refused (n=2), Not Applicable (n=1), Never (n=164). Wave 2 Ceduna participants: Refused (n=22), Not Applicable (n=25), Never (n=116). Wave 2 East Kimberley participants: Refused (n=9), Not Applicable (n=5), Never (n=92).

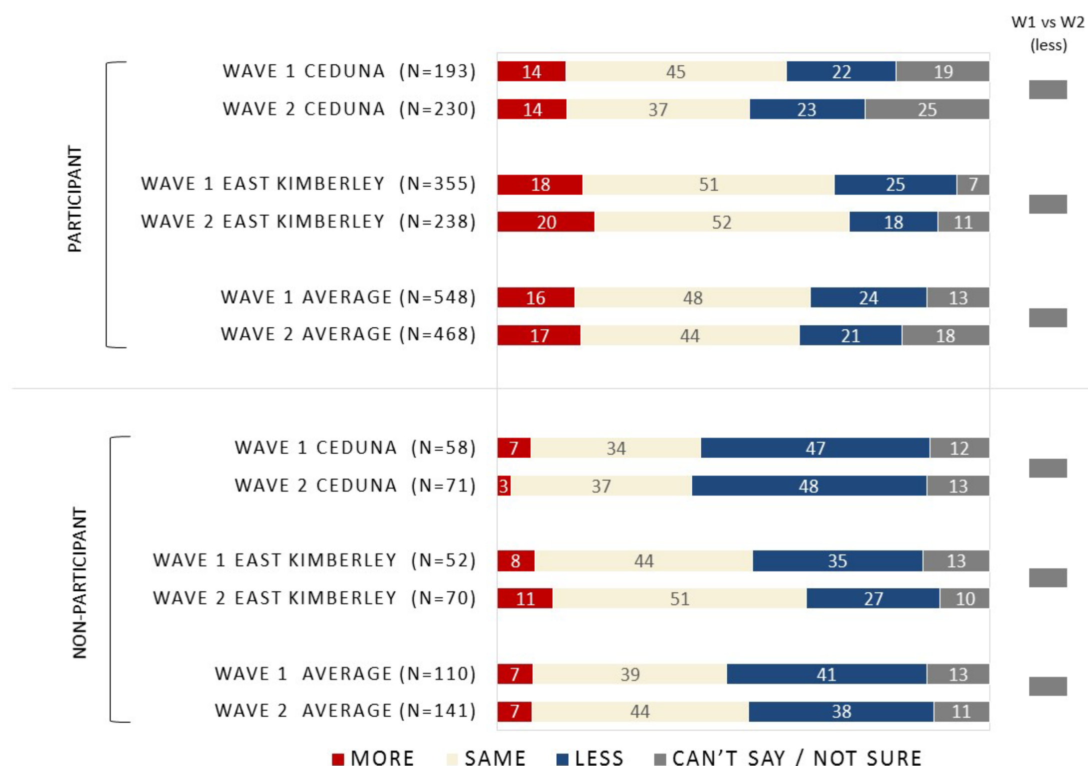
The average *number of times* participants reported drinking and having six or more drinks at one time per week also decreased at Wave 2.

- Participants who claimed to drink alcohol at least once every 2-3 months reported doing so an average of 1.2 times per week (n=200), down from 1.8 times per week at Wave 1 (n=305) – on average across the two sites).
- Participants who claimed to drink six or more drinks at one time at least once every 2-3 months reported doing so an average of 0.9 times per week (n=190), down from 1.5 times per week at Wave 1 (n=219) – on average across the two sites.

At Wave 2, as was the case in Wave 1, around four-in-ten non-participants (on average across the two Trial sites) perceived that there had been a reduction in drinking in their community since the CDCT commenced and less than one-in-ten perceived that there had been an increase (see Figure 12). Non-participants in Ceduna were significantly more likely than those in EK to report noticing a reduction in drinking. Such perceptions were more evenly balanced among CDCT participants.

Figure 12: Noticed a change in drinking of alcohol or grog in the community since the Trial started (% of respondents)

Base: Participants and non-participants.



Q42a (P) / 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?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 2 Ceduna participants: Refused (n=9). Wave 1 East Kimberley participants: Refused (n=1). Wave 2 East Kimberley participants: Refused (n=2). All non-participants: Refused (n=0).

C.2 Demographic differences in quantitative survey data

The reduction in the proportion of CDCT participants who reported drinking alcohol weekly or more often between Wave 1 and Wave 2 was significantly higher (34pp reduction from 68% (n=176) to 34% (n=141)) among younger CDCT participants (aged 18-44 years) than among older participants (8pp reduction from 55% (n=131) to 47% (n=88)).

While there was no statistically significant difference between female and male CDCT participants in the extent of the reduction in reported alcohol consumption from Wave 1 to Wave 2, female participants were significantly less likely than male participants to consume alcohol weekly or more often at both Waves (at Wave 2, 29% among women (n=128) and 45% among men (n=101)).

At Wave 2, male CDCT participants were also more likely than female participants to report seeing *less* drinking of alcohol in the community (28% on average (n=170) compared to 15% (n=298) respectively).

The reduction in the proportion of CDCT participants who reported drinking alcohol weekly or more often between Wave 1 and Wave 2 was significantly higher among Indigenous participants (31pp reduction from 64% (n=300) to 33% (n=194)) than among non-Indigenous participants (7pp reduction from 59% (n=35) to 52% (n=33)).

Consequently, Indigenous CDCT participants were significantly less likely than non-Indigenous participants to report drinking alcohol *about weekly or more often* at Wave 2 (33% (n=194) compared with 52% for non-Indigenous participants (n=33)).

C.3 Observable impacts

Consistent with the qualitative and quantitative primary research findings reported above, available secondary administrative data also indicates that the CDCT has been associated with lower levels of alcohol consumption.

In Ceduna, lower levels of problematic alcohol consumption were indicated by decreases in alcohol-related hospital presentations, alcohol-related outpatient counselling by Drug and Alcohol Services South Australia (DASSA) and the number of apprehensions under the Public Intoxication (PIA) Act (i.e. apprehensions of individuals in public places who were under the influence of alcohol or other substances to the point that they were 'unable to take proper care' of themselves).

- From October 2016 to March 2017, there were 122 alcohol-related hospital emergency department presentations, down 5% from 128 presentations in the corresponding period before the commencement of the CDCT (October 2015 to March 2016).[32] Moreover, such presentations in the first quarter of 2017 (January to March 2017) were 37% lower than in the first quarter of 2016 (immediately prior to the commencement of the CDCT).
- From July 2016 to March 2017, there were 100 DASSA alcohol-related outpatient attendances, a reduction of 49 (33%) on the 149 attendances recorded from July 2015 to March 2016.[33]
- From April 2016 to March 2017 (the twelve months following the commencement of the CDCT), a total of 366 PIA apprehensions were made, a reduction of 58 (14%) on the 424 recorded in the previous 12 months (April 2015 to March 2016). Moreover, PIA apprehensions in the first quarter of 2017 (January to March 2017) were 26% lower than in the first quarter of 2016.

It should be noted that the abovementioned reductions occurred against the backdrop of an increase in the number of pick-ups by the Mobile Assistance Patrol (MAP) and sobering up service admissions in Ceduna. This suggests that at least part of the reduction in each of the three data series discussed above may have been due to greater service intervention by these services rather than reduced levels of problematic alcohol consumption.

- The Ceduna MAP had an average of 735 clients per month from July 2016 to March 2017[34], compared to an average of 480 clients per month from July 2015 to March 2016.
- The Ceduna Sobering Up Unit (SUU) had an average of 269 clients per month from July 2016 to March 2017, compared to an average of 212 clients per month from July 2015 to March 2016.

Feedback from a few relevant stakeholders interviewed in the qualitative research indicated that these increases may have been driven by additional funding provided to these services and/or improvements in services providers connecting with each other as part of the CDCT service package

32 October 2016 to March 2017 has been used as the CDCT reference period for Ceduna hospital presentations data because pre-CDCT Trial data was only available from October 2015 to March 2016. The same monthly range was used to control for seasonal effects.

33 July 2016 to March 2017 has been used as the CDCT reference period for Ceduna DASSA alcohol-related outpatient attendance data because pre-CDCT Trial data was only available from July 2015 to March 2016. The same monthly range was used to control for seasonal effects.

34 July 2016 to March 2017 has been used as the CDCT reference period for Ceduna MAP and SUU data because pre-CDCT Trial data was only available from July 2005 to March 2016. The same monthly range was used to control for seasonal effects.

as well as other service reform initiatives (i.e. Regional Services Reform[35] and the Ceduna Services Reform[36]). In addition, some stakeholders considered that increased usage of the SUU partly reflected a greater willingness to use this service by intoxicated people as a result of them having consumed less alcohol than the previous norm (due to the impact of the cash restrictions imposed under the CDCT). A few stakeholders considered that another factor driving increased usage was a lower general level of drunkenness in the community, which meant that there were more relatively sober people who were able to notice those who were drunk and support them to obtain assistance from services.

In Kununurra, lower levels of problematic alcohol consumption were indicated by decreases in alcohol-related pick-ups by the Miriwoong Community Patrol Service and referrals from this service to the Moongoong Sober Up Shelter.

- From June 2016 (when CDCs were progressively rolled out in EK) to March 2017, 3,979 alcohol-related pick-ups were recorded, down 723 (15%) from the 4,702 recorded from June 2015 to March 2016.
- From June 2016 to March 2017, a total of 1,669 referrals were recorded to the Sober Up Shelter, down 147 (8%) from the 1,816 recorded from June 2015 to March 2016.

In Wyndham, lower levels of problematic alcohol consumption were also suggested by decreases in pick-ups by the community patrol service.

- From June 2016 to September 2016, a total of 842 pick-ups were recorded by the patrol service, down 118 (12%) on the 960 recorded during the comparable period of June 2015 to September 2015.

In addition, the qualitative research with community leaders, stakeholders and merchants identified the following as evidence of lower alcohol consumption:

- Observations by many stakeholders, community leaders and merchants of fewer people intoxicated in public.
- Observations by a few community leaders and stakeholders and many merchants of fewer empty alcohol containers left in public spaces.
- Examples cited by relevant stakeholders of people now presenting and seeking medical treatment for health conditions that were previously “masked by alcohol effects”.
- Examples cited of a few “heavy drinkers” consuming alcohol in lower quantities and/or less frequently and attending rehabilitation and/or other drug and alcohol treatment programs.
- Fewer alcohol-related security incidents in hospital emergency departments.
- A decrease in alcohol-related family violence notifications (in Ceduna).
- Examples cited of residents of surrounding Trial communities spending less time on “drinking trips” (in Ceduna).
- A decrease in the number of women in hospital maternity wards drinking through pregnancy (in East Kimberley).

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35 The Regional Services Reform was established by the Western Australian Government in May 2015 and the Regional Services Reform Unit became part of the new Department of Communities in July 2017

36 A South Australian Government initiative

- A decrease in hospital presentations of intoxicated people and people presenting with alcohol-related injuries.

D. Use of illegal drugs

Overall, the qualitative research findings, quantitative survey data and available secondary administrative data suggest that the CDCT has had a positive impact in lowering illegal drug use across the two Trial sites.

D.1 Amount of consumption

Prior to the implementation of the Trial, community leaders and stakeholders across both Trial locations reported that usage of illicit drugs was less widespread than alcohol consumption. Although most community leaders and stakeholders considered the excessive consumption of alcohol to be a greater issue, they still reported that drug use was of concern as they saw it as a problem that was likely to increase into the future.

The use of illegal drugs is difficult to reliably assess due to the clandestine nature of the behaviour. It should also be noted that self-reports of illegal drug use in a survey context are subject to a high risk of social desirability bias and should be interpreted with caution. In addition, in interpreting the survey results presented in this section, caution should be exercised due to the relatively small sample sizes of those reporting drug use (particularly at the individual Trial site level).

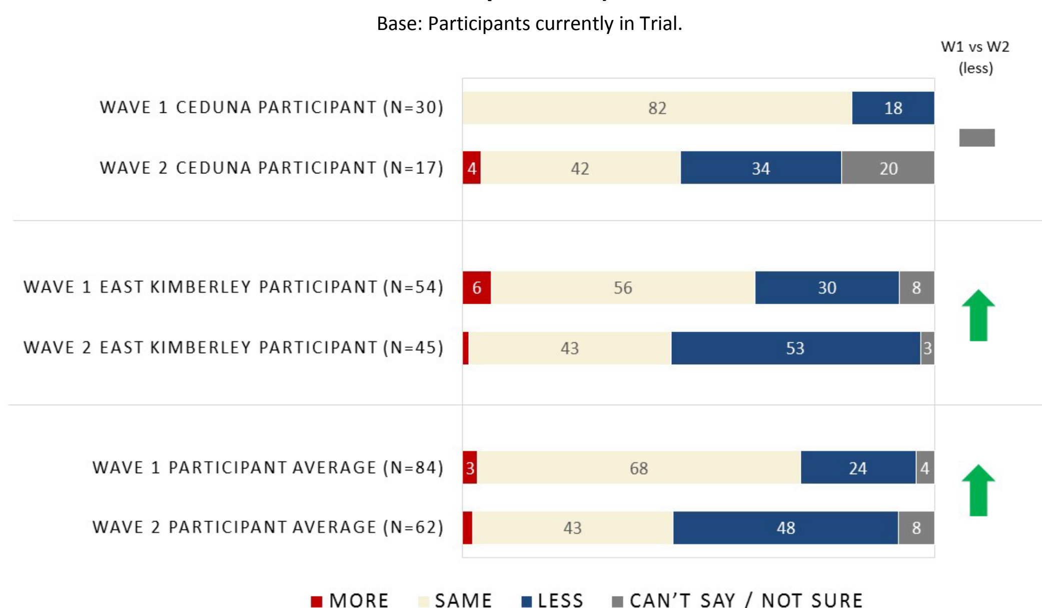
Wave 1 of the primary research (qualitative and quantitative results) provided positive early signs of a reduction in illegal drug use across both Trial sites. At Wave 2, the results were more positive.

Community leaders', stakeholders' and merchants' ratings to a short questionnaire in the qualitative research indicated that they perceived that drug use problems had decreased in Ceduna between Wave 1 and Wave 2, from 6.7 to 5.3 out of 10 (6.8 pre-Trial), and remained stable in EK, from 5.6 to 5.7 out of 10 (6.9 pre-Trial), based on average ratings on a scale of 0 (not at all) to 10 (extremely severe).

Of CDCT participants who had used illegal drugs before the Trial, the proportion reporting that they had done so *less* often than they did before participating in the Trial increased significantly from 24% (n=84) at Wave 1 to 48% (n=62) at Wave 2 on average across the two Trial sites (see Figure 13). Furthermore, the proportion reporting that they did this behaviour *more* often remained very low.

Figure 13: Change in behaviour since becoming a participant in the CDCT: Used an illegal drug (% of respondents)

Base: Participants currently in Trial.



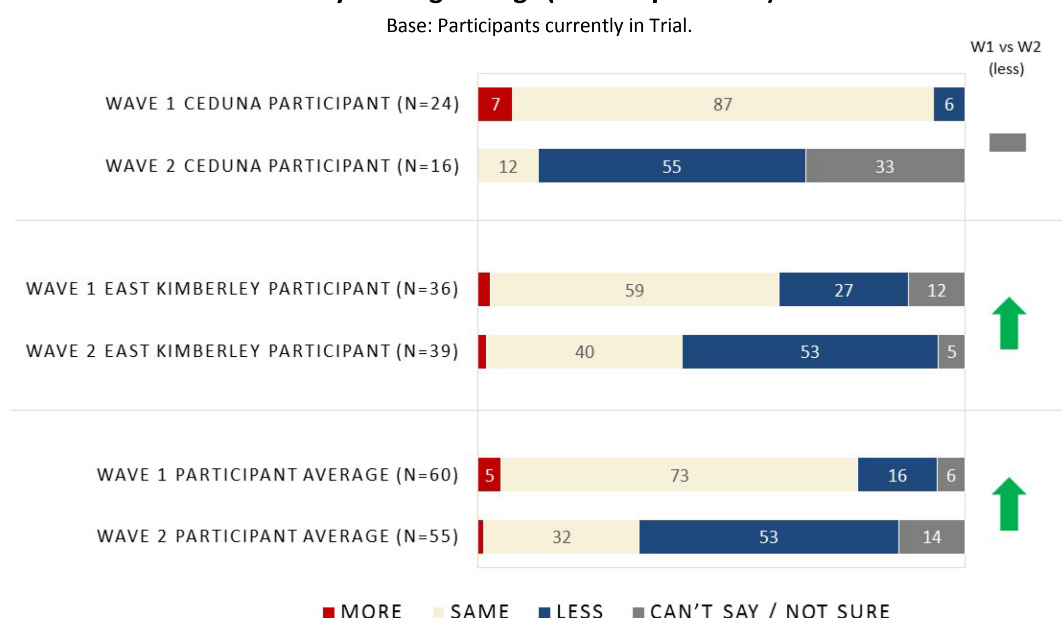
Q44g (P). Since being on the Cashless Debit/Indue Card have you done each of the following more often, less often or the same as before: Used an illegal drug like benzos, ice, marijuana or speed?

Excludes 'Refused' and 'Not applicable – did not do activity before'. Wave 1 Ceduna participants: Refused (n=1), Not Applicable (n=163). Wave 2 Ceduna participants: Refused (n=17), Not Applicable (n=199). Wave 1 East Kimberley: Refused (n=0), Not Applicable (n=300). Wave 2 East Kimberley: Refused (n=2), Not Applicable (n=187).

The proportion of CDCT participants who reported spending more than $50 a day on illegal drugs *less* often than they did before becoming CDCT participants also improved substantially – from 16% at Wave 1 up to 53% at Wave 2 on average (n=60 and n=55, respectively). Figure 14 illustrates that the proportion reporting a positive change was broadly consistent across sites.

Figure 14: Change in behaviour since becoming a participant in the CDCT: Spent more than $50 a day on illegal drugs (% of respondents)

Base: Participants currently in Trial.



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? CAUTION: Low base (response size) for Ceduna participant results means that the Ceduna estimate is not statistically reliable.

Excludes 'Refused' and 'Not applicable – did not do activity before'. Wave 1 Ceduna participants: Refused (n=1), Not Applicable (n=169). Wave 2 Ceduna participants: Refused (n=16), Not Applicable (n=201). Wave 1 East Kimberley participants: Refused (n=0), Not Applicable (n=318). Wave 2 East Kimberley participants: Refused (n=2), Not Applicable (n= 193).

Although the results should be interpreted with caution due to low sample size, the Wave 2 results also suggest that the *frequency* of illicit drug use has reduced since Wave 1 overall. At Wave 2, the proportion of participants (on average across the two sites) who reported that they used an illegal drug or prescription medication for non-medical reasons *about weekly or more often* was 39% (n=30), significantly down from 68% at Wave 1 (n=47 – note this excludes those who said NA or Refused). Results at the site level are not statistically reliable due to low response sample sizes (n<20).

The average number of times CDCT participants reported using illegal drugs per week also decreased significantly at Wave 2. Participants who claimed that they used illegal drugs *at least once every 2-3 months* reported doing so an average of 1.4 times per week (n=24), down from 3.0 times per week at Wave 1 (n=38) on average across the two sites.

D.2 Demographic differences in quantitative survey data

Due to low response sample sizes in relation to illegal drug use, demographic differences were not statistically significant.

However, the data was suggestive of a greater impact of CDCT participation among female users of illegal drugs than among male users. Although the results were not statistically significant and should therefore be interpreted with caution, on average across the two sites (amongst those who reported illegal drug use before the Trial) at Wave 2:

- 58% of female participants reported that they had used illegal drugs less often than they did before becoming CDCT participants (n=38), compared to 38% of males (n=24).

- 63% of female participants reported that they had spent more than $50 a day on illegal drugs less often than they did before becoming CDCT participants (n=36), compared to 42% of males (n=19).

D.3 Observable impacts

In terms of observable impacts, most of the feedback received in the qualitative research appeared to be very much anecdotal and based on hearsay rather than based on hard or direct evidence – this is not surprising as drug taking behaviour was reported as being "hidden" given its illegal nature.

Bearing this in mind, the qualitative research identified the following as possible indications of reduced illicit drug use:

- Stories from some stakeholders' clients reporting that there was less access to drugs due to the reduced availability of cash.
- Those affected by drugs were perceived by a few community leaders and stakeholders to be more noticeable in the community due to the increased sobriety of others – so there was a belief that people were more likely to intervene or report the matter to authorities.

There was only very limited secondary administrative data available (for Ceduna) that related specifically to illegal drug use, but this data was indicative of a reduction in illegal drug use following the implementation of the CDCT. [37]

- From July 2016 to March 2017, there were 113 DASSA outpatient counselling attendances in Ceduna that did not relate to alcohol, a reduction of 9 (7%) on the 122 attendances recorded from July 2015 to March 2016.
- From July 2016 to March 2017, there was only one drug driving offence recorded in Ceduna. This compared to 8 such offences recorded from July 2015 to March 2016. It should be noted, however, that there was also a 52% decrease between these periods in drug driving offences recorded in Port Augusta (the comparison site for Ceduna) – from 50 such offences to 24. Therefore, part of the reduction in drug driving offences in Ceduna is likely to have reflected factors other than the CDCT.

E. Gambling behaviour

Overall, the qualitative research findings, quantitative survey data and available secondary administrative data indicate that the CDCT has had a positive impact in reducing gambling across the two Trial sites.

E.1 Amount of gambling

The Initial Conditions research demonstrated that although gambling behaviours differed between the two sites, most community leaders and stakeholders in Ceduna and a few in EK reported that excessive gambling was prevalent in their community. Ceduna community leaders and stakeholders considered gambling as a serious concern, almost on par with alcohol consumption, whilst those in EK felt that gambling was not as much of an issue in comparison. It was found that electronic gaming

37 July 2016 to March 2017 has been used as the CDCT reference period for these data because pre-CDCT Trial data was only available from July 2015 to March 2016. The same monthly range was used to control for seasonal effects.

machines (EGMs) were prevalent in Ceduna (but not available in EK), whilst gambling in EK was reported to be more of an informal/private activity – suggesting that the less visible nature of this informal gambling may have been the reason for the lower level of concern in EK.

Qualitatively, stakeholders, community leaders and merchants 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.

Community leaders', stakeholders' and merchants' to a short questionnaire in the qualitative research indicated that they perceived that problematic gambling had decreased in Ceduna between Wave 1 and Wave 2, from 6.5 to 4.5 out of 10 (7.7 pre-Trial), and remained relatively stable in EK, from 5.0 to 4.8 out of 10 (6.7 pre-Trial), based on average ratings on a scale of 0 (not at all) to 10 (extremely severe).

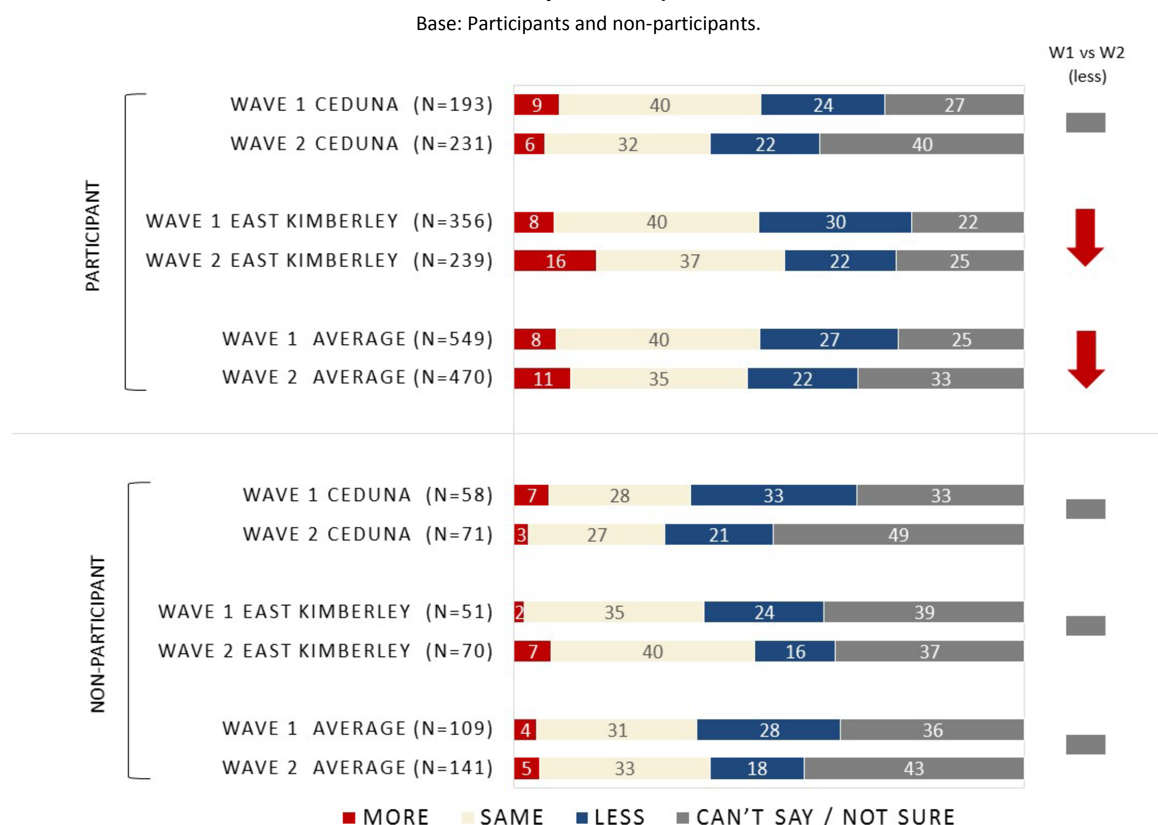
The Wave 1 survey results showed that, on average across the Trial sites, around one-quarter of both participants and non-participants perceived that there had been a reduction in gambling in the community since the commencement of the CDCT.

Figure 15 illustrates that this proportion fell to around one-fifth at Wave 2, although the reduction in the proportion of non-participants who perceived a reduction in gambling was not statistically significant.

EK participants were more likely to report that they had noticed *more* gambling at Wave 2 than Wave 1 (16%, n=239 versus 8%, n=356) and less likely to report that they had noticed *less* gambling (a reduction from 30% down to 22%). A similar trend was apparent amongst EK non-participants (although the change was not statistically significant for this group).

Figure 15: Noticed a change in gambling in the community since the Trial started (% of respondents)

Base: Participants and non-participants.



Q42c (P) / Q16c (NP). 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?

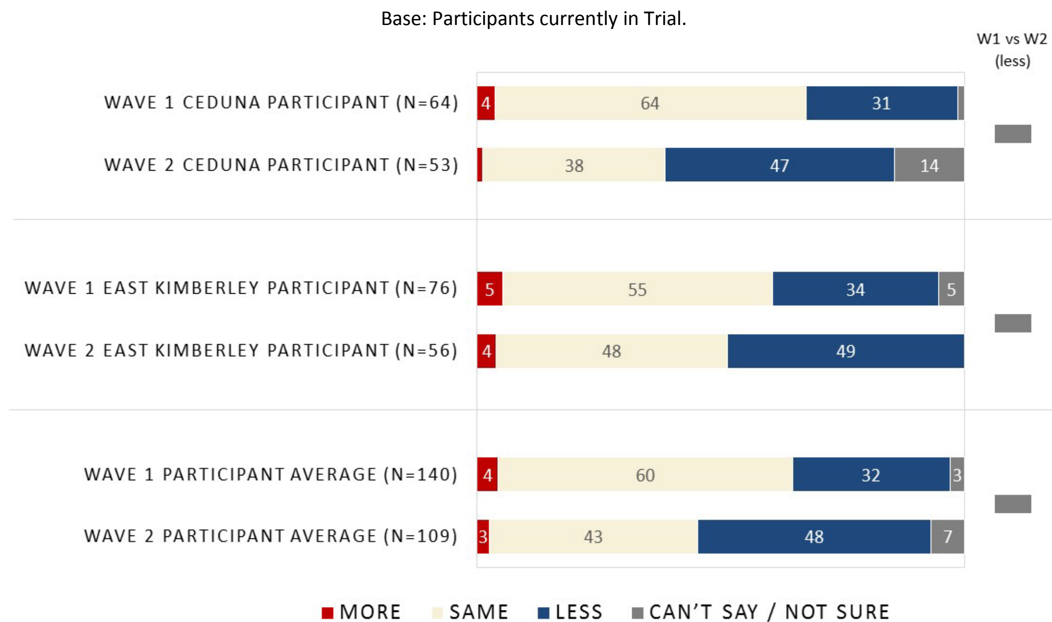
Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 2 Ceduna participants: Refused (n=8). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 East Kimberley participants: Refused (n=1). All non-participants: Refused (n=0).

When asked about whether their own gambling behaviour had changed since becoming Trial participants, at Wave 2 (on average across the two Trial sites), 48% of those who gambled before the Trial reported doing this *less* often (n=109), up from 32% at Wave 1[38] (n=140).

38 The increase was not statistically significant at the 95% level of confidence (but was at the 94% level).

Figure 16: Change in behaviour since becoming a participant in the CDCT: Gambled (% of respondents)

Base: Participants currently in Trial.

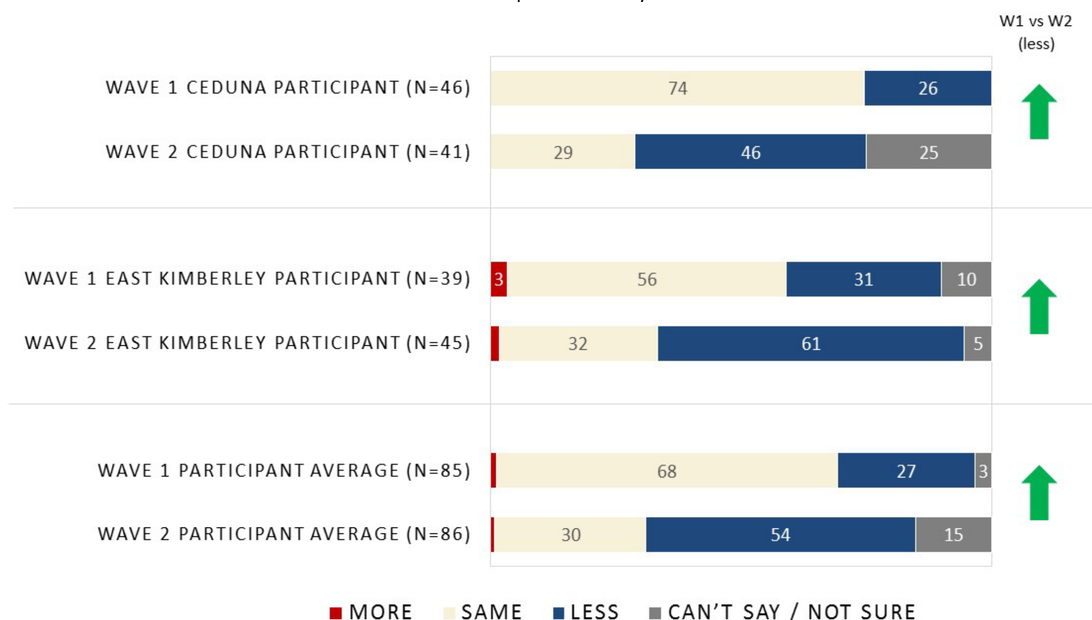


Q44c (P). Since being on the Cashless Debit/Indue Card have you done each of the following more often, less often or the same as before: Gambled? Excludes 'Refused' and 'Not applicable – did not do activity before'. Wave 1 Ceduna participants: Refused (n=1), Not Applicable (n=129). Wave 2 Ceduna participants: Refused (n=17), Not Applicable (n=163). Wave 1 East Kimberley participants: Refused (n=0), Not Applicable (n=278). Wave 2 East Kimberley participants: Refused (n=2), Not Applicable (n=176).

Figure 17 overleaf shows that at Wave 2, more than half of participants (on average across the Trial sites) who had spent more than $50 a day gambling before the Trial reported that they did so *less* often since being in the CDCT (54%, n=86). This is a substantial improvement on the result reported in Wave 1 of 27%. A significant positive change in the proportion stating they did this behaviour *less* often was recorded in both EK and Ceduna.

Figure 17: Change in behaviour since becoming a participant in the CDCT: Spent more than $50 a day on gambling (% of respondents)

Base: Participants currently in Trial.

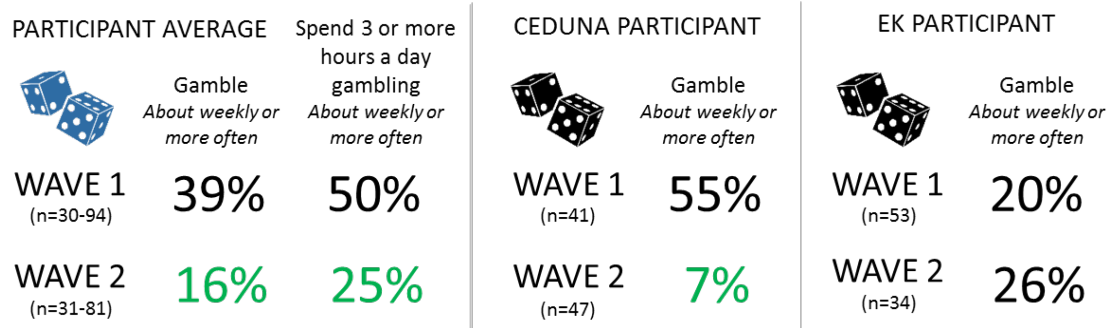


Q44d (P). Since being on the Cashless Debit/Indue Card have you done each of the following more often, less often or the same as before: Spent more than $50 a day on gambling?

Excludes 'Refused' and 'Not applicable – did not do activity before'. Wave 1 Ceduna participants: Refused (n=1), Not Applicable (n=147). Wave 2 Ceduna participants: Refused (n=17), Not Applicable (n=175). Wave 1 East Kimberley participants: Refused (n=0), Not Applicable (n=315). Wave 2 East Kimberley participants: Refused (n=2), Not Applicable (n=187).

Figure 18: Gambling behaviours done 'lately'

Base: Participants.



Q25c (P). Lately, have you done any of these things? Gambled. Q25d (P). Lately, have you done any of these things? Spent three or more hours a day gambling (Note: results at the site level for spending 3 or more hours a day gambling have not been reported due to low sample sizes (n=9-21)).

Excludes 'Refused', 'Not applicable' and 'Never'.Q25c. Wave 1 Ceduna participants: Refused (n=2), Not Applicable (n=0), Never (n=152). Wave 1 East Kimberley participants: Refused (n=2), Not Applicable (n=4), Never (n=297). Wave 2 Ceduna participants: Refused (n=16), Not Applicable (n=38), Never (n=138). Wave 2 East Kimberley participants: Refused (n=4), Not Applicable (n=7), Never (n=195). Q25d. Wave 1 Ceduna participants: Refused (n=1), Not Applicable (n=0), Never (n=185). Wave 1 East Kimberley participants: Refused (n=2), Not Applicable (n=56), Never (n=277). Wave 2 Ceduna participants: Refused (n=15), Not Applicable (n=43), Never (n=166). Wave 2 East Kimberley participants: Refused (n=3), Not Applicable (n=6), Never (n=215).

The reported *frequency* of gambling behaviours also reduced from Wave 1 to Wave 2. Figure 18 shows that, at Wave 2, on average across the two sites, only 16% of participants who reported doing this behaviour lately claimed to gamble *about weekly or more often* (n=81). This represents a

significant reduction on the Wave 1 result of 39% (n=94). The proportion of participants spending three or more hours a day gambling and more than $50 a day on gambling also reduced by around half (25% (n=31) and 18% (n=33), respectively). The recorded increase in the proportion of EK participants who gambled about weekly or more often shown in Figure 18 was not statistically significant.

Furthermore, the average number of times participants reported gambling per week significantly decreased across Waves. At Wave 2, participants who gambled *at least once every 2-3 months* reported doing so an average of 0.4 times per week (n=51), down from 0.8 times per week at Wave 1 (n=78, on average across the two sites).

E.2 Demographic differences in quantitative survey data

When considering self-reported behaviours around gambling, female Trial participants showed significantly greater improvements than male participants. On average across the two sites (amongst those who reported gambling before the Trial):

- 63% of female participants reported that they had gambled less often since being in the CDCT (n=74), compared to just 30% of Males (n=35).
- 67% of female participants reported that they less frequently spent more than $50 a day on gambling (n=56), compared to just 39% of Males (n=30).
- 61% of female participants reported that they less frequently borrowed money or sold things to get money to gamble (n=37), compared to just 26% of Males (n=25).

E.3 Observable impacts

The qualitative research with community leaders, stakeholders and merchants identified the following as evidence of reduced gambling behaviour:

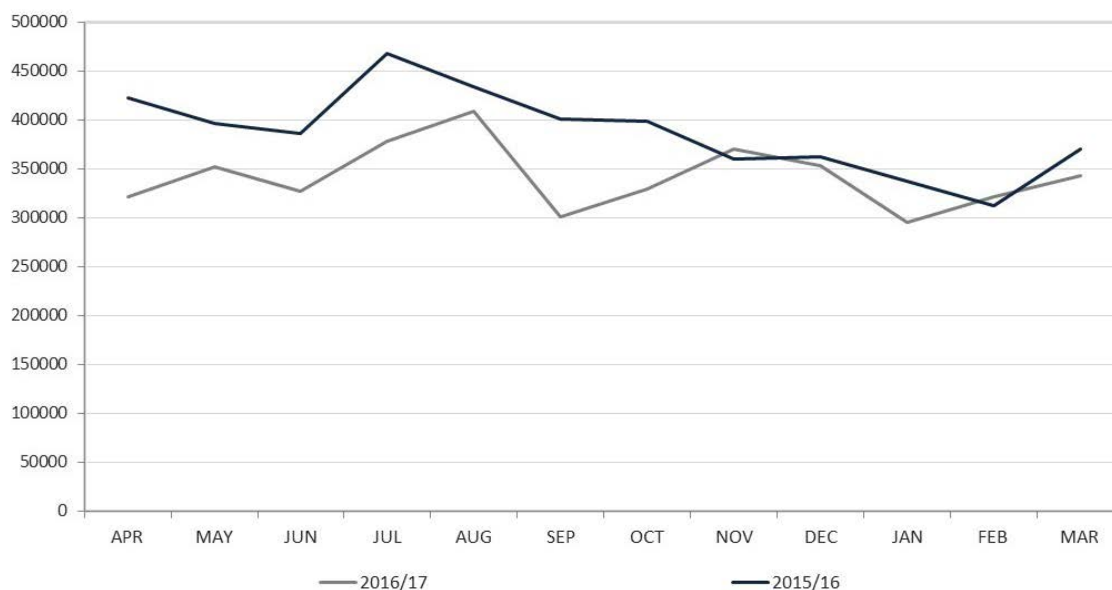
- Observations by many community leaders and stakeholders of a reduction in the numbers of people seen playing EGMs in Ceduna.
- Observations by some stakeholders and community leaders of a reduction in the frequency of EGM gambling among some known “regulars”, who were not seen at the EGM venue as often in Ceduna.
- A notable reduction in the amount of money spent on EGM gambling, demonstrated by:
  - financial counsellors (with explicit knowledge of clients’ finances/spending patterns) reporting a reduction in the amount clients spent on EGMs
  - anecdotal reports that the gambling-based revenue at the Ceduna Foreshore had decreased materially – heard by many community leaders, stakeholders and merchants.
- A reduction in the purchases of cash cards for accessing online gambling being sold by merchants.
- A reduction in the amount of money used (i.e. “coins rather than notes”) for unregulated gambling (e.g. cards) as told to and witnessed by a few service providers and community leaders.

The only administrative data related to gambling that was available concerned electronic gaming (poker) machine revenue in SA. This data was not available for the Ceduna Trial site, but only for a broader area covering the Ceduna Local Government Area (LGA) and the surrounding LGAs of Streaky Bay, Le Hunte, Elliston, and Lower Eyre Peninsula. The monthly revenue data showed a

substantial reduction (of over half a million dollars) in the overall amount spent playing poker machines in Ceduna and surrounding LGAs following the commencement of the CDCT. In the 12 months following commencement of the CDCT (April 2016 to March 2017), total revenue was $4,100,667 (an average of $341,722 per month), compared with $4,649,935 (a monthly average of $387,495) in the previous 12 months (a reduction of 12%).

Figure 19: Poker machine revenue – Ceduna and Surrounding Local Government Areas

Source: SA Department of Premier and Cabinet



It should be noted that only 40 of the 143 poker machines in the reference area were in the Ceduna Trial site. This means that, to the extent that the CDCT caused a reduction in poker machine revenue in the Trial site, the aggregated LGA figures will understate this impact. It should also be noted that, since 2011-12, there has been a downward trend in poker machine revenue in this area, with a geometric average decline in revenue of 3.8% per annum from 2011-12 to 2014-15. Therefore, part of the 12% decline since the introduction of the CDCT is likely to reflect other factors that have been driving this trend.

V. Effects of the CDCT on crime, violence and harm related to these behaviours

A. About this chapter

This chapter presents the Evaluation findings in relation to the anticipated outcome of lower incidence of crime and violent behaviours in the communities, related to a reduction in alcohol consumption, illegal drug use and gambling from the CDCT.

B. Overall findings

At the time of the Wave 1 primary data collection, there was only limited evidence to suggest that there was a reduction in crime, violence and harm related to alcohol consumption, illegal drug use and gambling, since the Trial commenced. Overall, in Wave 2 there was some additional evidence of positive impacts in these domains. It is important to note that with the exception of drug driving offences and apprehensions under the Public Intoxication Act (PIA) in Ceduna, crime statistics showed no improvement since the commencement of the Trial.

The qualitative research found observable evidence being cited by many community leaders, stakeholders and merchants for a reduction in crime, violence and harmful behaviours over the duration of the CDCT. Local merchants and police reported at Wave 2 that there had been fewer incidents of theft involving food-related items and clothing. Indirect evidence of this impact of the CDCT was also reported by the police and a few service providers who noted that the police had a greater capacity to conduct positive community engagement/preventative programs since the CDCT, due to the decreased need to perform reactive policing.

Community leaders', stakeholders' and merchants' ratings to a short questionnaire in the qualitative research indicated that violence and other crimes had reduced in Ceduna between Wave 1 and Wave 2, from 6.2 to 5.0 out of 10 (7.0 pre-Trial), and remained relatively stable in EK, from 6.3 to 6.4 out of 10 (8.0 pre-Trial), based on average ratings on a scale of 0 (not at all) to 10 (extremely severe).

C. Crime

The administrative data available in relation to the levels of criminal activity across the two Trial sites generally did not show evidence of a reduction in crime since Trial commencement.

Comparisons of crime statistics in Kununurra, Wyndham and Ceduna before and after the Trial[39] did not show a decrease in the number of assaults (domestic and otherwise) and other offences against the person, and robbery and related offences (including theft and burglary). In East Kimberley, an overall increase in criminal incidents was recorded – this was however mirrored in the comparison site of Derby, indicating that factors other than the CDCT could have underpinned this increase. The only notable reductions were recorded in relation to drug driving offences and PIA apprehensions in Ceduna.

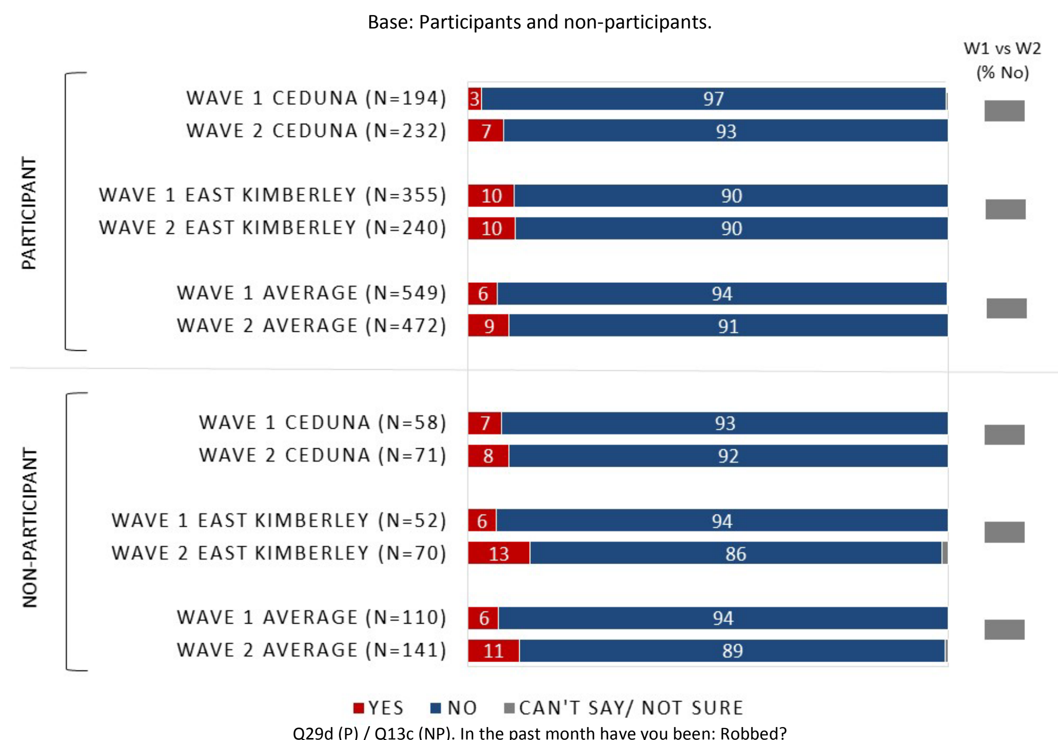
39 Wherever sufficient data was available, comparisons included data for 12 months before and 12 months after the trial – across comparable time periods.

- From July 2016 to March 2017[40], there was only one drug driving offence recorded in Ceduna. This compared to 8 such offences recorded from July 2015 to March 2016. It should be noted, however, that there was also a 52% decrease between these periods in drug driving offences recorded in Port Augusta (the comparison site for Ceduna) – from 50 such offences to 24. Therefore, part of the reduction in drug driving offences in Ceduna is likely to have reflected factors other than the CDCT.
- From April 2016 to March 2017 (the twelve months following the commencement of the CDCT), a total of 366 PIA apprehensions were made, a reduction of 58 (14%) on the 424 recorded in the previous 12 months (April 2015 to March 2016). Moreover, PIA apprehensions in the first quarter of 2017 (January to March 2017) were 26% lower than in the first quarter of 2016.

At both Wave 1 and Wave 2, a large majority of respondents to the quantitative survey reported that they had not had recent personal experience with crime (in the form of robbery, assault or threatened assault). Figure 20 illustrates that, at Wave 2, 91% of participants (n=472) and 89% non-participants on average across the two Trial sites (n=141) indicated that they *had not* been robbed in the past month (consistent with Wave 1 results – the change was not statistically significant).

Figure 20: Robbed in the past month

Base: Participants and non-participants.



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

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=1). Wave 1 East Kimberley participants: Refused (n=1). Wave 2 Ceduna participants: (n=7). Wave 2 East Kimberley participants (n=0). All non-participants: Refused (n=0).

Figure 21 and Figure 22 show that, at Wave 1:

- 90% of participants (n=546) and 97% of non-participants (n=110) on average across the two sites reported that they *had not* been beaten up, injured or assaulted in the last month.

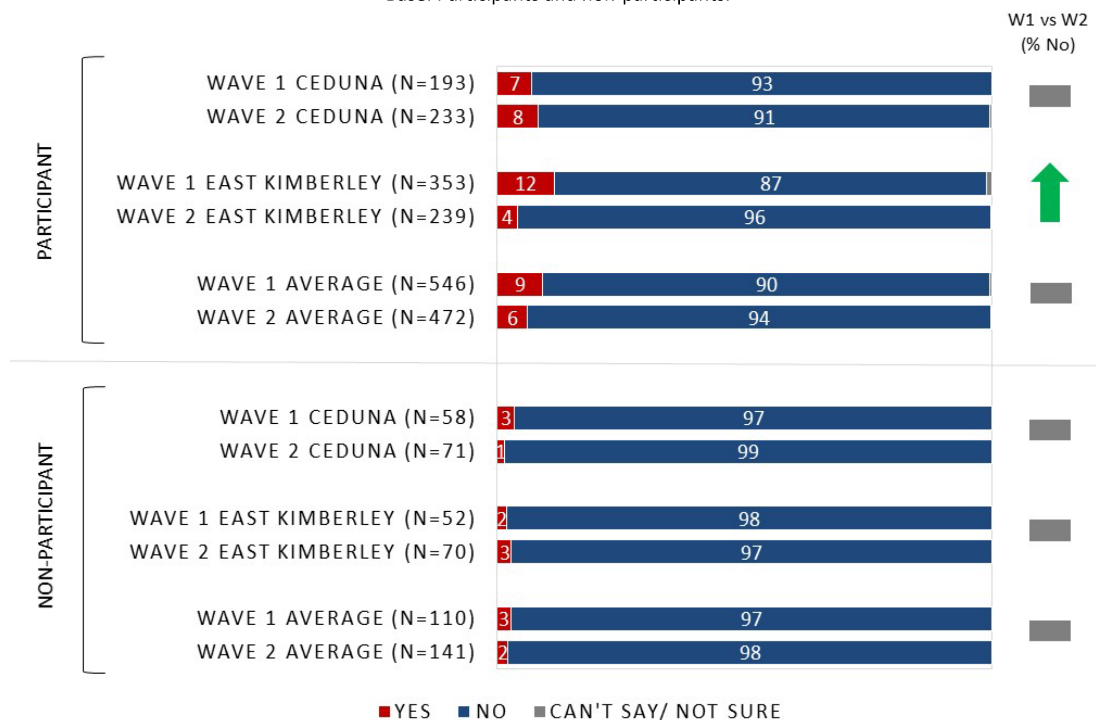
40 July 2016 to March 2017 has been used as the CDCT reference period for these data because pre-CDCT Trial data was only available from July 2015 to March 2016. The same monthly range was used to control for seasonal effects.

- 97% of participants (n=547) and 98% of non-participants (n=110) on average across the two sites reported that they *had not* been threatened or attacked with a gun, knife or other weapon.

The results at Wave 2 were broadly consistent, with 94% of participants (n=472) and 98% of non-participants (n=141) on average reporting that they *had not* been beaten up, injured or assaulted and 94% of each group reporting that they *had not* been threatened or attacked with a gun, knife or other weapon (n=470 participants, n=141 non-participants). In EK, there was a significant reduction in the proportion of participants from Wave 1 (12%, n=353) to Wave 2 (4%, n=239) who indicated that they had been beaten up, injured or assaulted in the past month.

Figure 21: Beaten up, injured or assaulted in the past month

Base: Participants and non-participants.

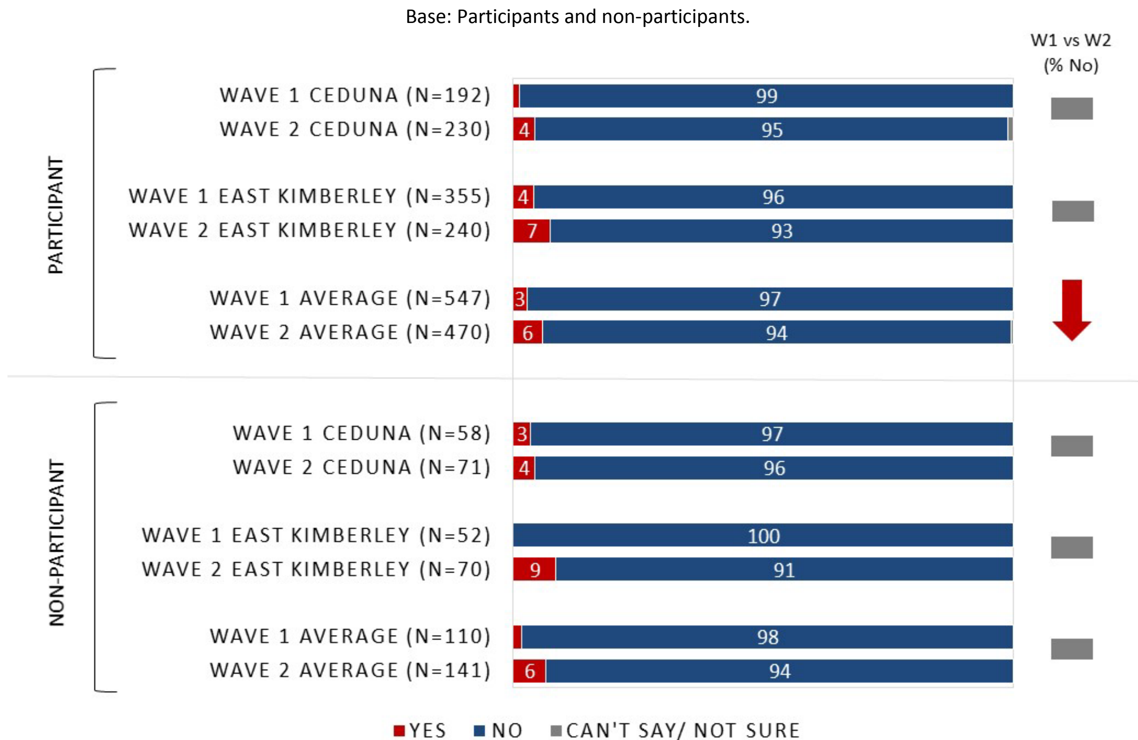


Q29b (P) / Q13a (NP). In the past month have you been: Beaten up, injured, or assaulted?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 1 East Kimberley participants: Refused (n=3). Wave 2 Ceduna participants: Refused (n=6). Wave 2 East Kimberley participants: Refused (n=1). All non-participants: Refused (n=0).

Figure 22: Threatened or attacked with a gun, knife or other weapon in the past month

Base: Participants and non-participants.



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

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=3). Wave 1 East Kimberley participants: Refused (n=1). Wave 2 Ceduna participants: Refused (n=9). Wave 2 East Kimberley participants: Refused (n=0). All non-participants: Refused (n=0).

The general lack of improvement in crime statistics and survey-based reports of being a victim of crime during the course of the CDCT is, on the face of it, inconsistent with the qualitative research findings in relation to community leader, stakeholder and merchant perceptions and observations. However, there are two reasons as to why these findings are not necessarily inconsistent.

Firstly, crime statistics are a narrow indicator of police activity – police actions that do not result in an offence/incident report being filed are not recorded in these statistics. Therefore, the reduced need to perform reactive policing reported by police and service provider stakeholders since the commencement of the CDCT may not necessarily result in a reduction in incidents recorded in crime statistics. In addition, movements in crime statistics are influenced by changes in police administrative practice. Some relevant stakeholders interviewed in the qualitative research in EK indicated that police in the Kimberley region and WA as a whole had adopted (due to management direction) a more stringent approach to recording incidents in 2016. These stakeholders noted that types of incidents which had not been officially recorded previously were now being recorded. In addition, police and a few relevant stakeholders and community leaders stated that there had been a trend towards greater reporting of domestic violence in the community in recent years due to government initiatives and changing community sentiment. These factors may partly explain the recorded increase in criminal incidents in both EK and the comparison site of Derby (in West Kimberley).

Secondly, the impact of criminal activity is narrowly focused in the community over a short period (e.g. the past month as measured in the quantitative survey). Therefore, it is difficult to identify change in sample surveys of the community that are subject to a normal degree of sampling

error/variability. Much larger samples would have been required in the evaluation for a precise measure of change in the incidence of crime.

D. Violence

Community leaders and stakeholders across both Trial sites at the Initial Conditions stage felt that alcohol was the primary contributor to violent behaviours. Drug use and gambling were also identified as contributing factors. Stakeholders and community leaders noted that intoxication tended to lead to anger and negative behaviours. Alcohol consumption, illegal drug use and gambling also led to increased financial pressures, resulting in arguments and disputes.

Qualitatively, stakeholders and community leaders indicated that violence had slightly reduced in their communities at Wave 1. This trend continued in Wave 2, with most stakeholders and community leaders reporting that violent and aggressive behaviours had reduced as evidenced by:

- A noticeable reduction in the number of visible or public demonstrations of aggressive and violent behaviours compared to before the Trial – many stakeholders and community leaders reported that such behaviours now tended to be a rare occurrence.
- A reduction in the number of police callouts to incidents involving drunk/aggressive behaviours, as reported by the local police.
- Feedback received by local tourist information centres, merchants and some other stakeholders from returning tourists/visitors, who commented on the reduced levels of negative behaviours observed in the community.
- A reduction in alcohol-related security issues and “rowdy” behaviours in hospital emergency departments, reported by relevant stakeholders.

In addition, a few service provider case-workers reported that there was a noticeable decrease since the CDCT started in high risk domestic violence call-outs/reports and the number of families that were put on the ‘watch-list’.

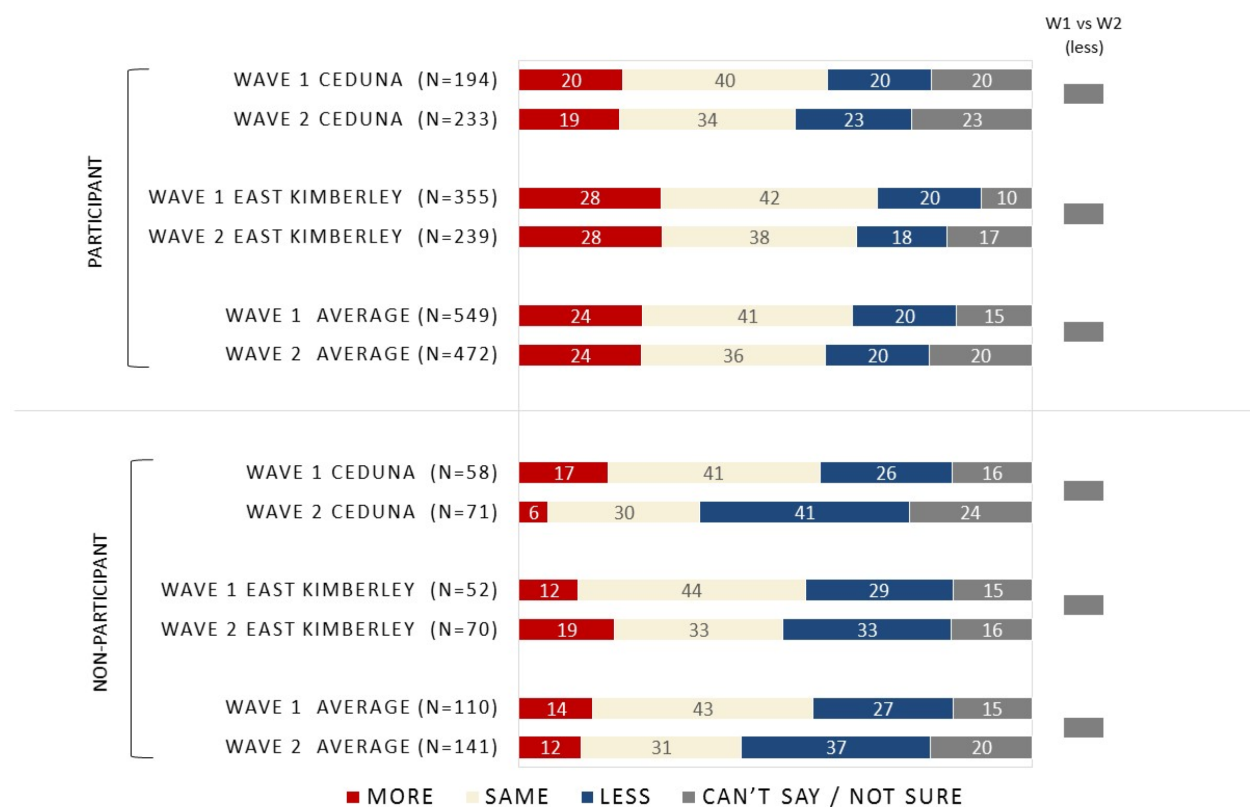
Wave 2 survey results with non-participants supported these findings. On average across the two Trial sites, nearly four-in-ten non-participants perceived that violence in their community had reduced since the commencement of the CDCT (see Figure 23). Consistent with Wave 1, non-participants were significantly more likely to perceive that violence in the community had reduced than increased.

In contrast, perceptions among CDCT participants were more mixed, with there being no statistically significant difference on average across the two sites between those who perceived that violence had decreased (20%) and those who perceived that it had increased (24%) (n=472). In EK, at both Wave 1 and Wave 2, a greater proportion of participants felt that violence had increased than had decreased.

Changes between Wave 1 and Wave 2 in the proportion of each group noticing less or more violence were not statistically significant.

Figure 23: Violence noticed in the community since the Trial started (% of respondents)

Base: Participants and non-participants.



Q42b (P) / 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?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=1). Wave 1 East Kimberley participants: Refused (n=1). Wave 2 Ceduna participants: Refused (n=6). Wave 2 East Kimberley participants: Refused (n=1). All non-participants: Refused (n=0).

E. Other related harms

In Ceduna, lower levels of harm related to alcohol consumption were indicated by decreases in alcohol-related hospital presentations, alcohol-related outpatient counselling by Drug and Alcohol Services South Australia (DASSA) and the number of apprehensions under the Public Intoxication Act (i.e. apprehensions of individuals in public places who were under the influence of alcohol or other substances to the point that they were 'unable to take proper care' of themselves) (discussed at Chapter IV, Section C.3, p.48).

In Kununurra, lower levels of alcohol-related harm were indicated by decreases in alcohol-related pick-ups by the Miriwoong Community Patrol Service and referrals from this service to the Moongoong Sober Up Shelter (discussed at Chapter IV, Section C.3).

In addition, the qualitative research with community leaders and stakeholders identified the following as evidence of lower alcohol-related harms:

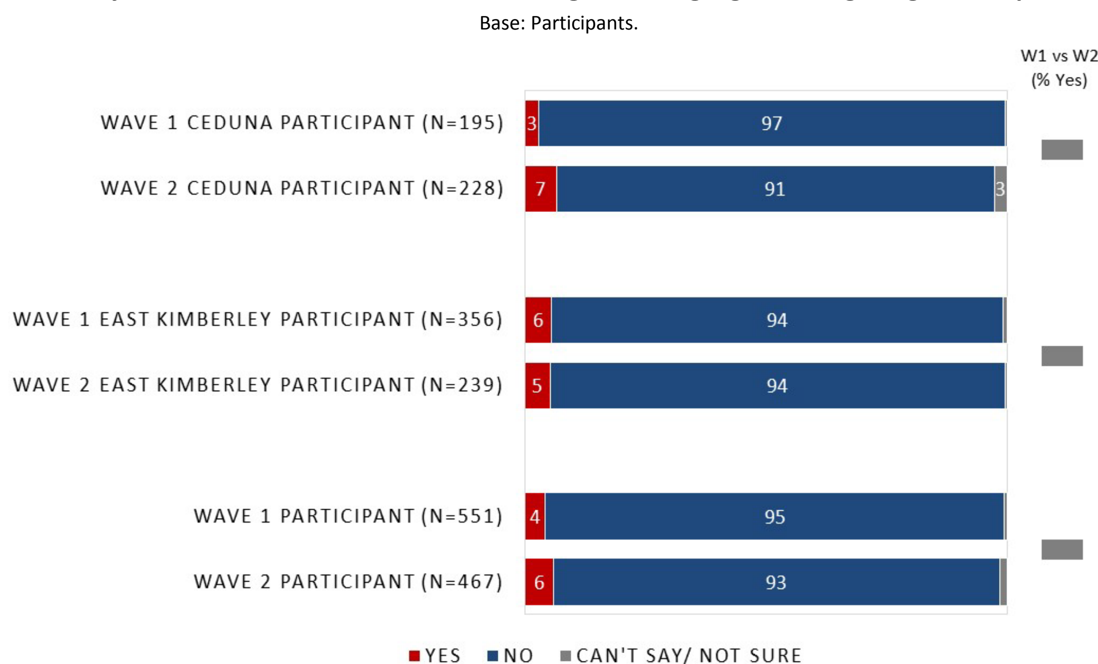
- Observations of fewer people intoxicated in public – reported by many stakeholders and community leaders.

- Examples cited of people presenting and seeking medical treatment for health conditions that were previously "masked by alcohol effects" – reported by a few community leaders and relevant stakeholders.
- Examples cited of a few "heavy drinkers" consuming alcohol in lower quantities and/or less frequently and attending rehabilitation and/or other drug and alcohol treatment programs.
- Fewer alcohol-related security incidents in hospital emergency departments.
- A decrease in alcohol-related family violence notifications (in Ceduna).
- A decrease in the number of women in hospital maternity wards drinking through pregnancy (in East Kimberley).
- A decrease in hospital presentations of intoxicated people and people presenting with alcohol-related injuries.

The quantitative survey results showed that, on average across the two Trial sites and within each Trial site, there was no statistically significant change between Wave 1 and Wave 2 in the proportion of CDCT participants who reported having been injured or having an accident after drinking alcohol or taking drugs in the past month (see Figure 24).

Figure 24: Injured or had an accident after drinking alcohol/grog or taking drugs in the past month

Base: Participants.



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

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=0). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=11). Wave 2 East Kimberley participants: (n=1).

VI. Effects of the CDCT on perceptions of safety in the Trial locations

A. About this chapter

This chapter presents the evaluation findings in relation to the expected outcome of community members feeling safer on the streets in the day and night and at home.

B. Overall findings

While there was no statistically significant change between Wave 1 data collection (a few months post CDCT implementation) and Wave 2 (9 months later) in CDCT participant and non-participant perceptions of safety (as measured in the quantitative survey), the qualitative research findings suggested that there was a generally greater sense of safety in the Trial communities at Wave 2 than before the Trial commenced.

C. Safety

Most community leaders and stakeholders at the Initial Conditions stage reported that they felt the excessive consumption of alcohol contributed to a low sense of community safety in the Trial sites. It was reported that many community members felt particularly unsafe due to large numbers of 'rowdy' intoxicated people, high incidence of violence and crime, verbal abuse, humbugging and groups of children roaming the streets at night (in EK).

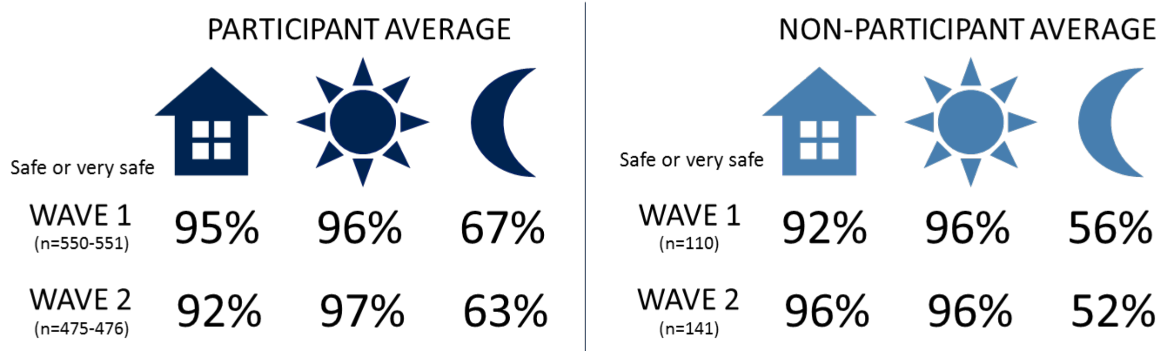
Community leaders', stakeholders' and merchants' ratings to a short questionnaire in the qualitative research indicated that they perceived that community safety had increased in their local community between Wave 1 and Wave 2 – in Ceduna from 5.0 to 6.3 out of 10 (4.6 pre-Trial) and in EK from 5.2 to 5.7 out of 10 (4.2 pre-Trial), based on average ratings on a scale of 0 (very poor) to 10 (very well).

At Wave 2, many community leaders, stakeholders and merchants in the qualitative research reported that there had been greater use of public facilities (e.g. families having picnics, playing ball, etc.) now than pre-CDCT. They cited noticeable increases in the numbers of families and tourists accessing and using public areas (e.g. parks). Furthermore, the local tourist centre, merchants, community leaders and stakeholders also reported that returning tourists/visitors had commented on feeling safe and had provided positive feedback on the changes in the community. Some community leaders and stakeholders in Ceduna also indicated that there was greater willingness among families to walk in the evenings since the Trial.

At the time of the Wave 1 quantitative survey data collection with CDCT participants and non-participant community members, it was found that feelings of safety in the home and on the streets during the day were nearly universal (see Figure 25). Perceptions of safety on the streets at night, however, were far less positive.

Figure 25: Reports of feeling either very safe or safe at home and on the streets in the day/night

Base: Participants and non-participants.



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

Excludes 'Refused'. Wave 1 participants: Refused (n=1). Wave 2 participants: Refused (n=3-4) All non-participants: Refused (n=0).

Wave 2 results were consistent with those at Wave 1. There was no substantive change in perceptions of safety amongst participants nor non-participants. The vast majority of respondents continued to report feeling safe at home and on the streets during the day. As was the case at Wave 1, perceptions of safety on the streets at night amongst non-participants were much less widespread in EK than in Ceduna: 39% percent of EK non-participants reported feeling safe or very safe on the streets of their community at night (n=70), compared with 66% of Ceduna non-participants (n=71).

VII.Spill-over benefits of the Trial

A. About this chapter

The Program Logic highlights a number of potential spill-over benefits (covered in this chapter) and adverse consequences (discussed in Chapter IX). The hypothesised spill-over benefits are potential ways in which the program could benefit the community above and beyond the medium-term program outcomes that are the primary focus of the evaluation (and have been covered in previous chapters). Many of these benefits can be grouped under a long-term (by 2 years or more after implementation) planned outcome of the Trial that was included in the Program Logic[41]: increased community, personal and children's wellbeing.

This chapter reports on the occurrence of hypothesised spill-over benefits, as well as additional positive impacts of the Trial.

B. Overall findings

Overall, there was considerable data to show that there *were* spill-over benefits at an individual and community level across the Trial sites. At Wave 1, qualitative feedback from community leaders, stakeholders and merchants identified a number of positive impacts of the CDCT on participants' financial capacity, as well as nutrition and health within the community. These continued to be observed at Wave 2, and in some cases were further strengthened. Specifically:

- Qualitative feedback and quantitative evidence suggested that there were both indicative positive and negative **financial impacts** as a result of the Trial. Overall, just under half of participants reported that they had been able to save more money than before being a CDCT participant.
- Indicative low impacts on **employment** were primarily in the form of increased motivation, with an increase between Wave 1 and Wave 2 in the proportion of CDCT participants spending 11 hours or more per week trying to get a job or paid work.
- Indicative positive **parenting impacts** were also evidenced by qualitative and quantitative findings of an overall improvement in parental responsibility (including improved care and nurture of and expenditure on children) and parent engagement.
- There was some feedback to suggest there had been positive impacts on **wellbeing/health**, though most stakeholders and community leaders felt it was too early for longer term outcomes to be evident.
- Some qualitative feedback indicated that there had been positive **social impacts**, demonstrated by observations of increased optimism, positivity, family interaction and the ownership of more food/goods. A few other stakeholders and community leaders, however, felt that there had been no observable change.

Other positive impacts were also observed in relation to improvements in IT skills and unexpected benefits to businesses (such as improved sales). One area where limited impacts were observed was

41 Presented in the evaluation framework at Appendix A.

in relation to housing, where only some minor positive impacts were reported such as Trial participants taking greater care of and pride in their properties.

C. Financial impacts

Overall, most community leaders, stakeholders and merchants felt that the Trial had considerable positive financial impacts on Trial participants and the community. These included:

- Spending a higher proportion of income on meeting basic living needs (e.g. food, clothing, household goods, transportation and bills).
- Increased expenditure on children.
- Greater investment in assets (e.g. household furniture, beds, vehicles, white goods).
- Increased savings.

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

- Ability to afford basic household goods had slightly increased in their local community between Wave 1 and Wave 2 – in Ceduna from 5.6 to 5.9 out of 10 (4.4 pre-Trial) and in EK from 5.6 to 6.3 out of 10 (3.7 pre-Trial).
- Ability to pay bills had increased in their local community between Wave 1 and Wave 2 – in Ceduna from 5.0 to 5.7 out of 10 (4.3 pre-Trial) and in EK from 5.5 to 6.0 out of 10 (3.5 pre-Trial).

Specific evidence cited by community leaders, merchants and stakeholders to support this included:

- Local merchant reports of an increase in the amount and frequency of the following purchases – food, groceries, clothing (new and second hand), hygiene products, household goods, toys/ entertainment and "treats" for children.
- A few stakeholders reported that families had a greater capacity to bring contributions (e.g. plates of food) to events/activities.
- Observations by a few stakeholders and community leaders of improved transportation options and greater capacity to travel, including:
  - more money spent on transportation expenses (e.g. petrol, vehicle maintenance and registration and new vehicles)
  - some Trial participants being able to afford to travel more frequently to cities and other areas outside Trial sites to visit relatives, take holidays and purchase goods etc.
- An improvement in the payment of a range of financial commitments reported by relevant stakeholders and merchants, including:
  - bills (e.g. utilities, fines), fees (e.g. child care, school excursions, lunch orders and uniforms) and tickets (e.g. football)
  - payment plans/laybys being paid directly through CDC, which had previously had high default rates.
- A decrease in requests for emergency food relief and financial assistance from service providers in Ceduna.

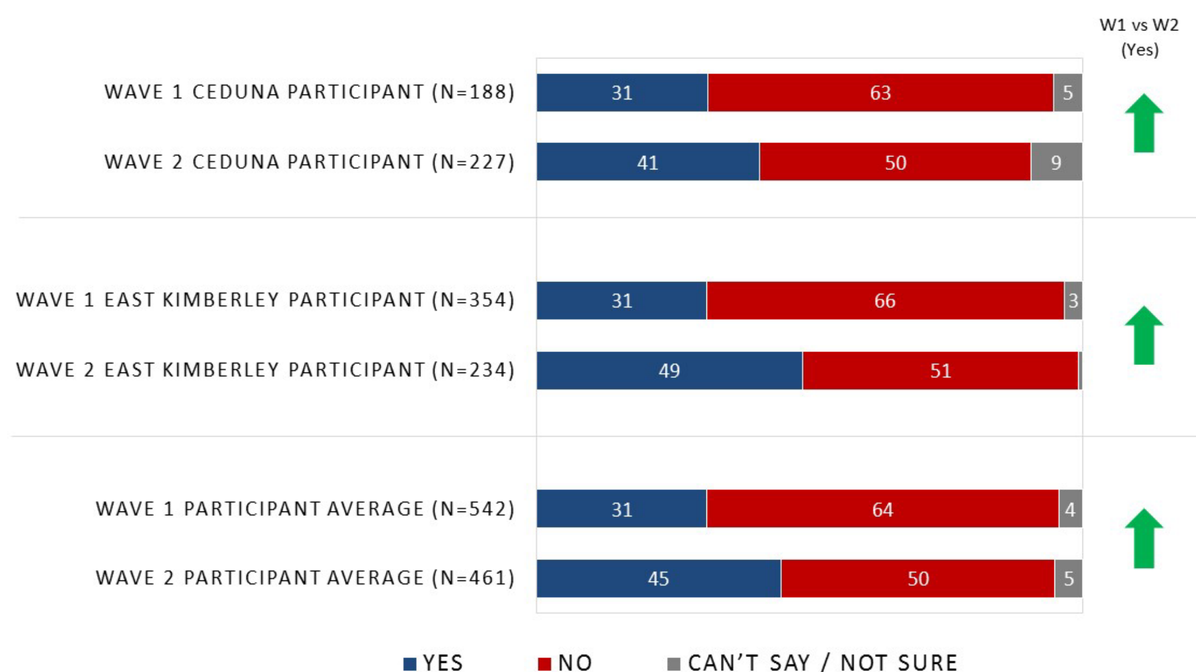
- Direct feedback received by some stakeholders and community leaders from Trial participants who had been able to save money for the first time.

However, some stakeholders, community leaders and merchants in the qualitative research reported that there had also been some negative financial impacts on some Trial participants, particularly earlier on in the Trial period (e.g. reduced ability to access cash and/or difficulties adjusting to accessing money via the Indue card) as well as negative financial impacts on businesses (e.g. increased merchant fees).

The quantitative survey results also provided evidence of positive financial impacts for participants at an overall level, as a result of the Trial. Since being on the CDCT, just under half (45%) of participants on average across the two sites reported that they had been able to save more money than before (n=461). This represents a significant improvement on the Wave 1 result of 31% (n=542 – see Figure 26). This positive trend was reported in both Ceduna and EK.

Figure 26: Reported ability to save more money than before being a CDCT participant

Base: Participants currently in Trial.



Q43a (P) Since being on the Cashless Debit Card…you've been able to save more money than before?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=6). Wave 2 East Kimberley participants: Refused (n=0).

The quantitative survey also asked Trial participants more specific questions about their financial situation in the last three months. Although there was little change between Wave 1 and Wave 2 in the majority of indicators, some negative changes were recorded. It should be noted that the Wave 1 measurement was not a pre-CDCT baseline – the survey fieldwork occurred from 15 August to 4 October 2016 (around 6 months after the commencement of the Trial).

In relation to the proportion who reported 'frequent financial hardship' (every 2 weeks or more in the last 3 months) there were no substantial changes from Wave 1 to Wave 2 (see Table 10). However, in terms of financial hardship more broadly (at all in the last 3 months), there were

significant differences across Waves in metrics related to children, and giving money to family and friends (see table below).

Table 10: Participant average self-reported financial indicators across Waves

	Wave 1 (n=223-546)	Wave 1 (n=223-546)	Wave 2 (n=186-469)	Wave 2 (n=186-469)
Participant Average Excludes 'refused' and 'NA'	**At all in the past 3 months**	**About once every 2 weeks or more**	**At all in the past 3 months**	**About once every 2 weeks or more**
Run out of money to buy food	49%	25%	52%	26%
Not have money to pay rent or your mortgage on time	22%	8%	19%	6%
Not have money to pay some other type of bill when it was due	32%	12%	35%	11%
Run out of money to pay for things that your child/children needed for school, like books	32%	13%	45%*	19%
Run out of money to pay for essential (non-food) items for your children, such as nappies, clothes and medicine	31%	15%	44%*	19%
Borrow money from family or friends	50%	22%	55%	21%
Run out of money because you had given money to friends or family	32%	16%	43%*	17%

*significantly higher at 95% level

This perceived deterioration in relation to provision of items for children is at odds with the quantitative survey results regarding participants being able to better provide care for children (see section F below) and being able to save more money (see above). One potential reason for this increase in negative reports at Wave 2 may be the timing of the Wave 2 survey. As the reference period for the Wave 2 survey (3 months up to June 2017) coincided with the early part of the school year, participants are likely to have needed to purchase more school items than at Wave 1, which was conducted later in the school year. In addition, the qualitative research and quantitative survey with participants indicated that one of the challenges participants faced under the CDCT was providing financial assistance to children who are at boarding school.

Across Trial sites, there was little change in the majority of financial hardship indicators from Wave 1 to Wave 2. Specifically, EK participants reported no substantial changes since Wave 1 in relation to 'frequent financial hardship', aside from a reduction in the proportion who reported that they had borrowed money from family or friends (20% at Wave 2, n=238 – down from 31% at Wave 1, n=351). In relation to difficulties reported by this group more broadly (at all in the last 3 months), these were consistent with that of participants overall, as follows:

- Run out of money to pay for things that your child/children needed for school (55% at Wave 2, n=98 – up from 40% at Wave 1, n=145).

- Run out of money to pay for essential (non-food) items for your children (54% at Wave 2, n=101 – up from 40% at Wave 1, n=160).

In contrast, Ceduna participants did not report significant changes across Waves in relation to providing for their children. Instead, this group reported greater 'frequent financial hardship' at Wave 2 than at Wave 1 in relation to:

- Borrowing money from friends and family (22%, n=228 – up from 14% at Wave 1, n=195).
- Running out of money because they had given it to family and friends (20%, n=226 – up from 12% at Wave 1, n=195).

At Wave 2, Ceduna participants were also more likely than at Wave 1 to report running out of money to buy food at least once in the past 3 months (52%, n=229 – up from 42% at Wave 1, n=193).

D. Employment impacts

Overall, some community leaders, stakeholders and merchants felt that the Trial had had some positive impacts on employment, including increased motivation and activity amongst Trial participants.

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

- The local community's performance in relation to employment had improved in Ceduna between Wave 1 and Wave 2, from 3.5 to 5.3 out of 10 (3.6 pre-Trial), and had improved slightly in EK, from 3.6 to 4.0 out of 10 (3.4 pre-Trial).

The quantitative survey findings indicated that there was little change in the proportion of CDCT participants looking for work from Wave 1 to Wave 2. However, motivation to find work appeared to have improved across Waves. At Wave 2, on average across the two sites:

- 42% of survey respondents (n=473) indicated that they were currently looking for a job or paid work (consistent with 40% at Wave 1 (of n=549)).
- 23% of survey respondents (n=178) indicated that they spent 11 hours or more per week trying to get a job or paid work (up from 11% at Wave 1 (of n=217)).

Specific qualitative feedback that supported this included:

- Increased job search activity and interest (e.g. requests for work opportunities and assistance to find employment) among some Trial participants who wanted to "get off the card" or "get access to more cash", observed by some stakeholders and merchants.
- Feedback from a few stakeholders and community leaders of increased take-up of employment opportunities by some Trial participants, especially for cash jobs and/or taking on additional, part-time or casual work.
- Increased attendance rates and improved performance in Community Development Programme (CDP) work – as a result of this, one CDP provider reported that their CDP program had improved its reputation and was receiving more community requests to complete work.

- However, relevant stakeholders felt that stricter CDP requirements had also contributed to the improved attendance rates, and felt that while the Trial was an important complementary measure, it was not solely responsible for the improvement.

Some stakeholders and community leaders noted that a lack of employment opportunities in the Trial locations remained a key issue, which made it difficult for Trial participants to seek a pathway off the CDC.

E. Social impacts

Some stakeholders, community leaders and merchants perceived that community pride had increased, especially amongst the Indigenous community, since the commencement of the Trial. They felt this was demonstrated by their observations of increased optimism, positivity, family interaction and ownership of more food/goods. However, others found this hard to assess or reported that there had been no observable change.

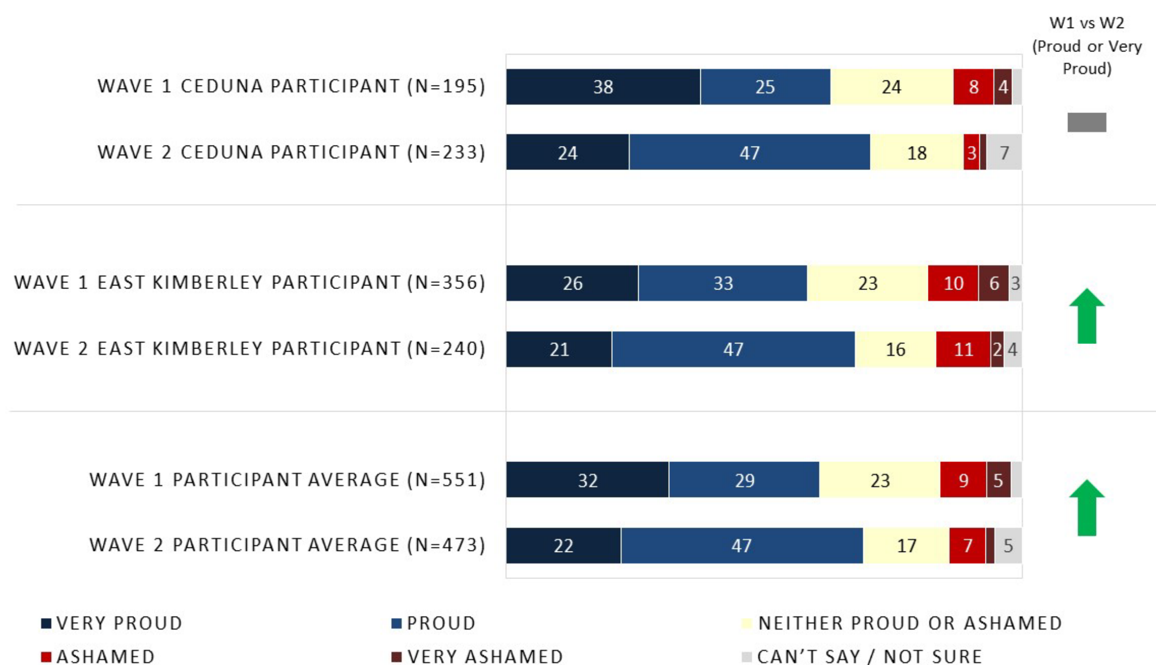
Community leaders', stakeholders' and merchants' ratings to a short questionnaire in the qualitative research indicated that (based on average ratings on a scale of 0 (very poorly) to 10 (very well)) they perceived that:

- The local community's performance in relation to community pride had improved slightly in Ceduna between Wave 1 and Wave 2, from 5.1 to 6.0 out of 10 (4.9 pre-Trial), and also in EK, from 5.0 to 5.8 out of 10 (4.3 pre-Trial).

The quantitative survey results endeavoured to measure feelings of community pride and how these may have changed over time. Figure 27 illustrates that amongst Trial participants, community pride increased across Waves. At Wave 2, on average across the two sites, 69% of participants reported that they were either proud or very proud of the community in which they live (n=473), an increase on 61% at Wave 1 (n=551). Community pride was equally as strong across the two Trial sites, although a greater increase was seen across Waves amongst EK participants.

Figure 27: Community pride

Base: Participants currently in Trial.



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

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=0). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=6). Wave 2 East Kimberley participants: Refused (n=0).

Overall, stakeholders, community leaders and merchants held mixed perceptions of the Trial's impact on humbugging in the community which depended on their personal experiences, observations and feedback from the particular client groups that they worked with.

Some community leaders, stakeholders and merchants felt that there had been a reduction in humbugging since the beginning of the Trial, particularly of Trial participants as they had limited access to cash. Some also perceived that humbugging of tourists and locals had reduced, although some others felt that it had remained the same.

Some stakeholders also reported that humbugging of particular groups in the community had increased (e.g. the elderly). This is discussed further in Chapter XII.D

Community leaders', stakeholders' and merchants' 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)) they perceived that:

- Humbugging had slightly reduced in Ceduna between Wave 1 and Wave 2, from 4.9 to 4.4 out of 10 (6.3 pre-Trial), and remained relatively stable in EK, from 4.7 to 4.9 out of 10 (5.9 pre-Trial).
- Street begging had remained relatively stable in their local community between Wave 1 and Wave 2 – in Ceduna from 4.0 to 3.8 out of 10 (5.4 pre-Trial) and in EK from 3.9 to 4.2 out of 10 (5.0 pre-Trial).

Stakeholders, community leaders and merchants identified a range of other positive social impacts since the commencement of the Trial. These included:

- Greater capacity for police to run community engagement/preventative programs, due to the decreased requirement to respond to reports/callouts.

- A reduction in visible/public occurrences of arguments, disputes, fights and "rowdy" behaviour – this was evidenced by personal observations of many stakeholders, community leaders and merchants, as well as through feedback they had received from tourists/visitors to the larger Trial sites (i.e. Ceduna and Kununurra).
- More time spent on constructive community activities – a few stakeholders and community leaders reported occurrences of Trial participants voluntarily engaging in efforts to improve the local environment (e.g. clearing/removing rubbish from public areas).

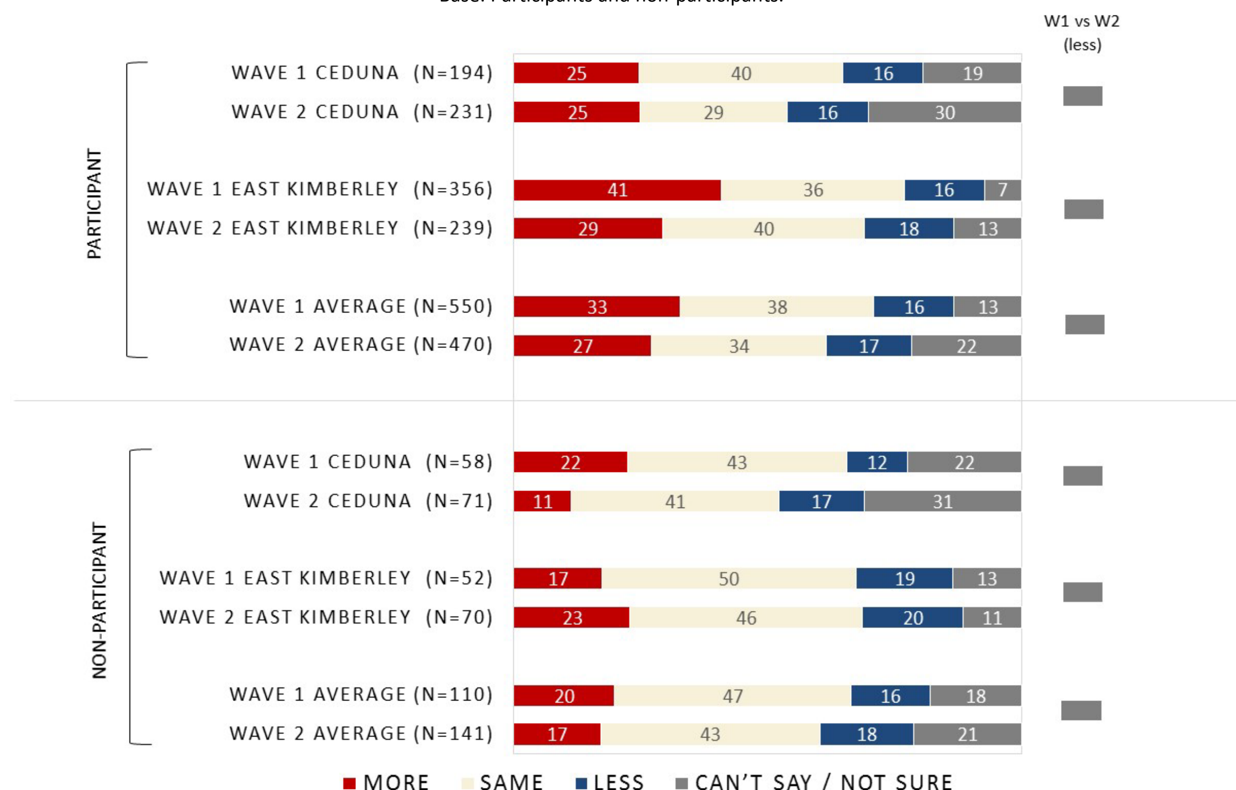
Consistent with the qualitative findings, the quantitative reports of humbugging were mixed. At Wave 2, 27% of participants on average across the two sites reported that they had noticed *more* humbugging (n=470), down from 33% at Wave 1 (n=550). The proportion amongst this group reporting that they had noticed *less* humbugging remained stable (17% at Wave 2, consistent with 16% at Wave 1).

- Results from Ceduna participants were consistent across Waves, with no change in the proportion indicating less or more from Wave 1 to Wave 2.
- In contrast, there was a 12 percentage point decrease from Wave 1 to Wave 2 in the proportion of EK participants who felt that humbugging had increased.

Non-participants were more evenly divided in their views than participants. When asked about their personal experiences with humbugging, participants on average reported consistent results at Wave 1 and Wave 2, with 29% reporting that they had been humbugged or pressured by family or friends to give them money in the last month at both Waves (n=471 Wave 2, n=550 Wave 1). This consistency across Waves was apparent at both Trial sites.

Figure 28: Noticed more humbugging or harassment for money since the Trial started (% of respondents)

Base: Participants and non-participants.



Q42d (P) / Q16d (NP). 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?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=1). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=8). Wave 2 East Kimberley participants: Refused (n=1). All non-participants: Refused (n=0)

F. Parenting impacts

Overall, many community leaders, stakeholders and merchants felt that the Trial had a positive impact on parenting and family wellbeing among some families in relation to:

- Parental responsibility, including improved care and nurture of, and expenditure on children.
- School attendance.
- Parent engagement with school and child care, particularly in Ceduna.

Specific qualitative feedback that supported this improvement included:

- Merchant reports and stakeholder and community leader observations of increased purchases of baby items, food, clothing, shoes, toys and other goods for children amongst families that they were familiar with and in stores generally.
- Observations by relevant stakeholders of more children attending school and child care centres with packed lunches.
- An increase in the number of families paying for school excursions and other school-related costs.

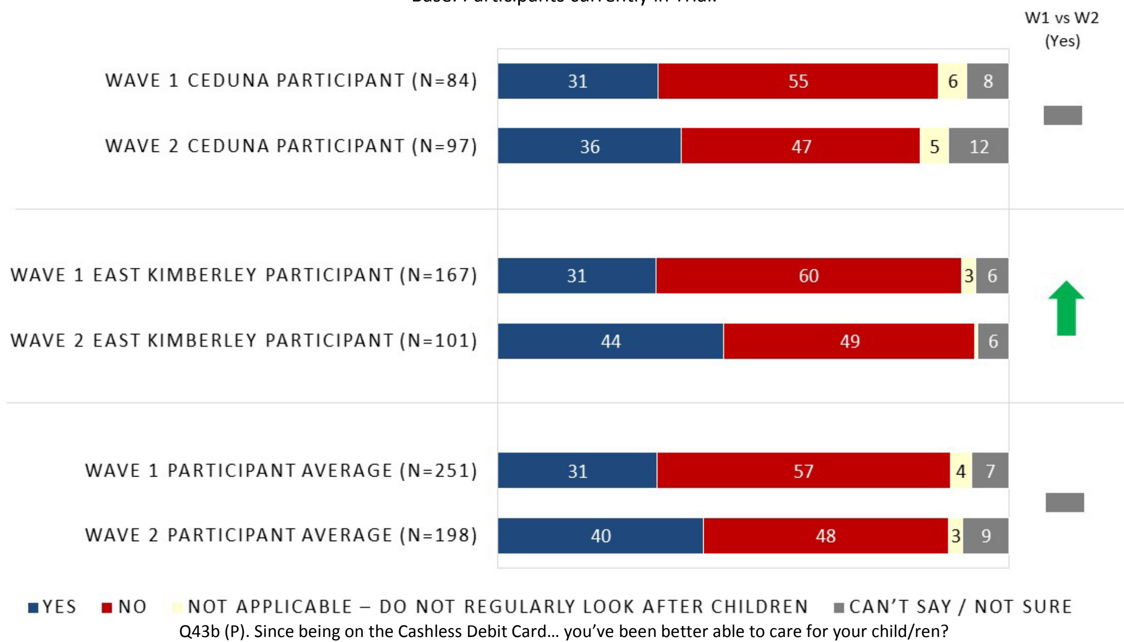
- Improvements in school attendance rates in Ceduna communities, as families were staying in their local communities.
  - However, some stakeholders noted that this improvement was not seen amongst all families on a consistent basis and some families from Indigenous communities still brought children into town for shopping and administration trips when they should be in school.
- Feedback from some stakeholders who worked with families in Ceduna that parents were more committed to encouraging school attendance amongst children (e.g. dropping children off at school).
- Greater attendance at school events, gatherings and information sessions for parents as well as increased attendance at parenting classes in Ceduna.
- Improvements in school attendance amongst specific families who were participating in the Trial funded 'One Families at A Time Program' in Wyndham and Kununurra.
- In Kununurra, community leaders and stakeholders hearing direct feedback from a few community members who had previously been asked to financially provide and care for grandchildren that parents were now taking on this responsibility.
- Better parental/adult supervision observed by a few stakeholders in homes known to have multiple drinkers.

At an aggregate level, available administrative data on school attendance rates showed little change during the CDCT period in Ceduna and Surrounds (72% average attendance rate in Term 3 2016, compared with 71% in Term 3 2015). In Kununurra, available administrative data on school attendance also showed little change in average attendance rates for Indigenous children during the CDCT period (52.4% in Terms 3 and 4 of 2016, compared with 52.9% in Terms 3 and 4 of 2015).

Quantitative survey results generally supported the qualitative findings. At Wave 2, on average across the Trial sites, 40% of participants who had caring responsibilities (n=198) reported that they had been better able to care for their children since being in the CDCT Trial. Figure 29 overleaf indicates that there was a statistically significant increase between Wave 1 and Wave 2 in this proportion among EK participants.

Figure 29: Been better able to care for your child/ren since being a CDCT participant

Base: Participants currently in Trial.



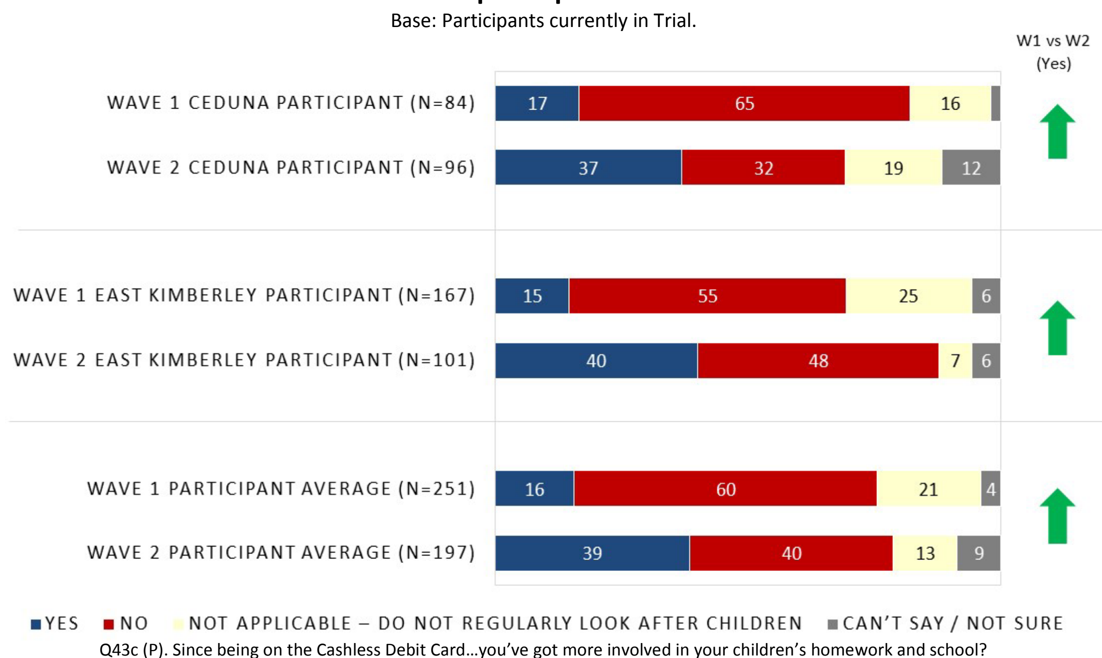
Q43b (P). Since being on the Cashless Debit Card… you've been better able to care for your child/ren?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=0). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=3). Wave 2 East Kimberley participants: Refused (n=0).

Figure 30 illustrates substantial improvements across the Trial sites between Wave 1 and Wave 2 in the proportions of CDCT participants with caring responsibilities who reported that they had become more involved with their children's homework and school since before being in the CDCT Trial. At Wave 2, on average across the Trial sites, 39% of such participants (n=197) stated that this had occurred, up from 16% at Wave 1 (n=251). One potential reason for this increase at Wave 2 may be the timing of the Wave 2 survey. As the reference period for the Wave 2 survey (3 months up to June 2017) coincided with the early part of the school year, participants are likely to have needed to become more involved than at Wave 1, which was conducted later in the school year.

Figure 30: Got more involved in your children's homework and school since being a CDCT participant

Base: Participants currently in Trial.



Q43c (P). Since being on the Cashless Debit Card…you've got more involved in your children's homework and school?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=0). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=4). Wave 2 East Kimberley participants: Refused (n=0).

Despite these positive improvements, when asked about the impact of the Trial on their child/children's lives overall, participants on average across the two sites reported mixed perceptions. At Wave 2, 17% of participants who had children reported that they felt their lives were *better* as a result of the Trial (n=198, consistent with 18% at Wave 1 (n=250)), whilst 24% felt their child/children's lives were *worse* (consistent with 20% at Wave 1). There was no material difference in results across Trial sites.

- Participants who said that the Trial had made their child/children's lives better or worse were asked to provide some information about why this was the case (n=74 across the two sites. Those who did not feel the Trial had an impact were not asked to elaborate). Of those who said *worse*, the most prevalent reasons were related to not being able to give children cash (n=20) and not being able to buy goods for their children with cash (n=16).
- Reasons provided for why the Trial had improved the lives of children were mostly related to being able to meet basic needs better (such as food, clothes, etc. n=26, out of n=34 who said *better*).

G. Housing impacts

Overall, most stakeholders and community leaders reported that the Trial had not had a material impact on housing in the Trial sites. Lack of housing, overcrowding and rough sleeping were still noted as key issues in the Trial communities. In one remote community in Ceduna surrounds, overcrowding was reported to be worsening, and was felt to have contributed to arguments and disputes in the community.

However, a few stakeholders and community leaders reported some minor positive impacts in relation to housing, including Trial participants taking greater care of properties and buying more household goods to improve their appearance (e.g. pot plants). Specific evidence in support of these observations included:

- Merchant feedback of increased purchases of household items.
- A stakeholder organisation receiving an increase in requests to borrow gardening/property maintenance tools.

Administrative data on the number of disruptive tenancy complaints in public housing in Ceduna provided some further evidence of an improvement in this domain during the CDCT period. From 1 July 2016 to 30 March 2017, there were 6 such complaints recorded, which represented a 40% reduction on the 10 complaints recorded in the corresponding period a year earlier (1 July 2015 to 30 March 2016). Comparison site data for Port Augusta showed a 16% increase in such complaints over the same timeframe.

In contrast, administrative data on the number of disruptive tenancy complaints in the East Kimberley showed a deterioration during the CDCT period. From 1 January to 30 April 2017, there were 62 such complaints recorded, an increase of 51% on the 41 complaints recorded from 1 January to 30 April 2016.

H. Wellbeing impacts

Overall, some stakeholders and community leaders identified some positive impacts of the Trial in relation to health and wellbeing. These were generally shorter term improvements in nutrition, hygiene and increased access of health services. Most stakeholders and community leaders felt that it was too early for any longer term health outcomes to be achieved from the CDCT.

Community leaders', stakeholders' and merchants' ratings to a short questionnaire in the qualitative research indicated that they perceived that performance in relation to health and wellbeing had increased in their local community between Wave 1 and Wave 2 – in Ceduna from 4.7 to 5.7 out of 10 (4.4 pre-Trial) and in EK from 4.5 to 5.3 out of 10 (3.5 pre-Trial), based on average ratings on a scale of 0 (very poor) to 10 (very well).

Specific qualitative feedback from some stakeholders, community leaders and merchants that demonstrated positive wellbeing impacts included:

- Improved nutrition, associated with the increased quantity and quality of food consumed.
- An increase in people presenting for wider health assessments and treatments due to the "unmasking of health conditions" due to reduced alcohol levels in Kununurra. Ambulance transfers in and out of treatment facilities were also reported to have increased.
- An improvement in responsiveness to treatments due to more patients following health plans and taking medications as directed.
- A reduction in people self-discharging from hospital.
  - However, in Kununurra it was noted that this could also be attributed to the appointment of an Indigenous Liaison Officer.

- Improved hygiene – evidenced by fewer instances of health issues associated with poor hygiene (e.g. boils and sores) and merchant feedback in Ceduna of increased purchases of hygiene products.

Subjective wellbeing was assessed in the quantitative survey by asking participants about the impact of the Trial on their lives.

Figure 31 shows that, on average across the two sites, at Wave 2 participants were more likely to indicate that it had made their lives *worse* than *better.* However, negative perceptions were less prevalent than at Wave 1. At Wave 2, 32% of participants on average reported that the Trial had made their lives *worse* (n=462), significantly down from 49% at Wave 1 (n=547). The proportion reporting that the Trial had made their lives *better,* however, remained consistent - 23% at Wave 2 (n=462) and 22% at Wave 1 (n=547).

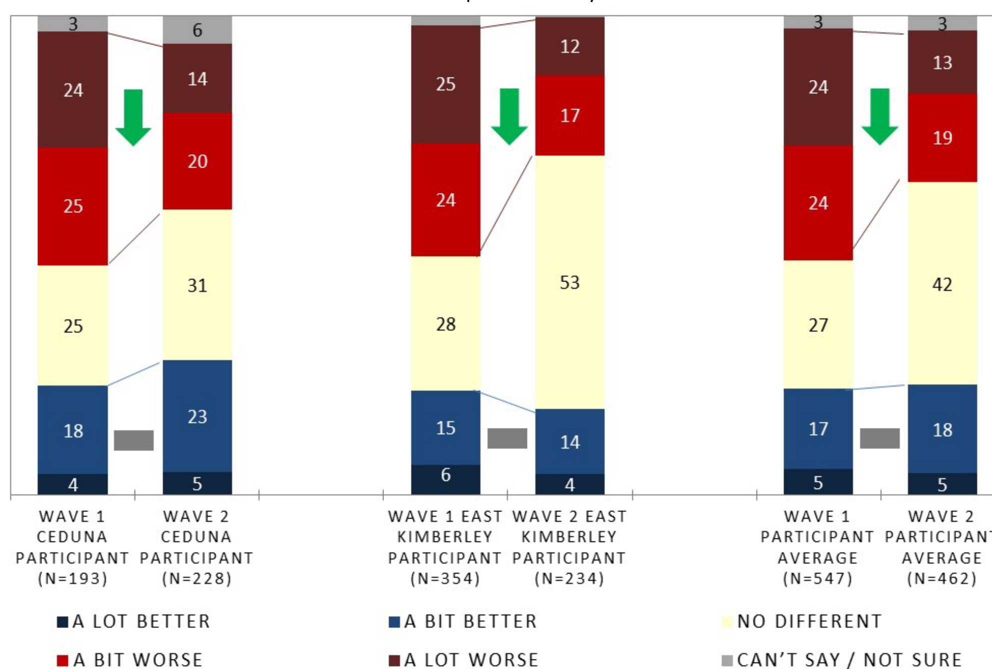
Ceduna participants were more likely than those in EK to report a positive impact on their wellbeing. At Wave 2:

- 28% of Ceduna participants (n=228) stated that the Trial had made their lives better (consistent with 23% at Wave 1, n=193).
- At Wave 2, 18% of EK participants (n=234) stated that the Trial had made their lives better (consistent with 22% at Wave 1, n=354).

At Wave 2, Indigenous CDCT participants were significantly more likely than non-Indigenous participants to indicate that their lives were *better* under the CDCT*:* 26% (n=405), compared with 15% among non-Indigenous (n=56).

Figure 31: Impact of the Trial on your life

Base: Participants currently in Trial.



Q45 (P). Would you say the Cashless Debit/Indue Card has made your life…

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=1). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=5). Wave 2 East Kimberley participants: Refused (n=0).

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 8 for further detail on these groups). As was the case at Wave 1, 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 (27%, consistent with 30% at Wave 1), compared to those who reported **no change** (23%, consistent with 22% at Wave 1).

Trial participants who said that the Trial had made their lives better (n=115) were asked to provide some information about why this was the case. Consistent with Wave 1, the most common reasons that participants gave for their lives being 'a bit better' or 'a lot better' included:

- Being better able to meet basic needs (bills, food etc.) (n=70 participants).
- It has made it easier to save money (n=28 participants).

A small proportion also mentioned improvements in community/personal safety/well-being or less humbugging (n=17).

The most common reasons that participants provided to explain why their lives were 'a bit worse' or 'a lot worse' (n=146) related to:

- Not being able to buy the things they want/need or give cash to family/friends (n=65 participants).
- Not having enough cash (n=25 participants).
- That using the card is a hassle/time consuming/frustrating (n=22 participants).

At Wave 2, 41% of non-participants (on average across the sites) felt the Trial had made lives in their community better (n=140, consistent with 46% at Wave 1, n=110). This was a significantly more widespread view than that the Trial had made life in their community worse (reported by 19% at Wave 2, consistent with 18% at Wave 1).

Among non-participants who indicated at Wave 2 that the Trial had made life in their community worse overall (n=27 across the two sites), the most common reason was due to the perception of more crime/more humbugging (n=12). In contrast, non-participants who reported that the Trial had made life in their community better (n=58), most commonly mentioned the following reasons:

- Families' basic needs are being better met (n=32).
- Less violence/drunkenness/humbugging/drug use (n=28).

I. Other positive impacts

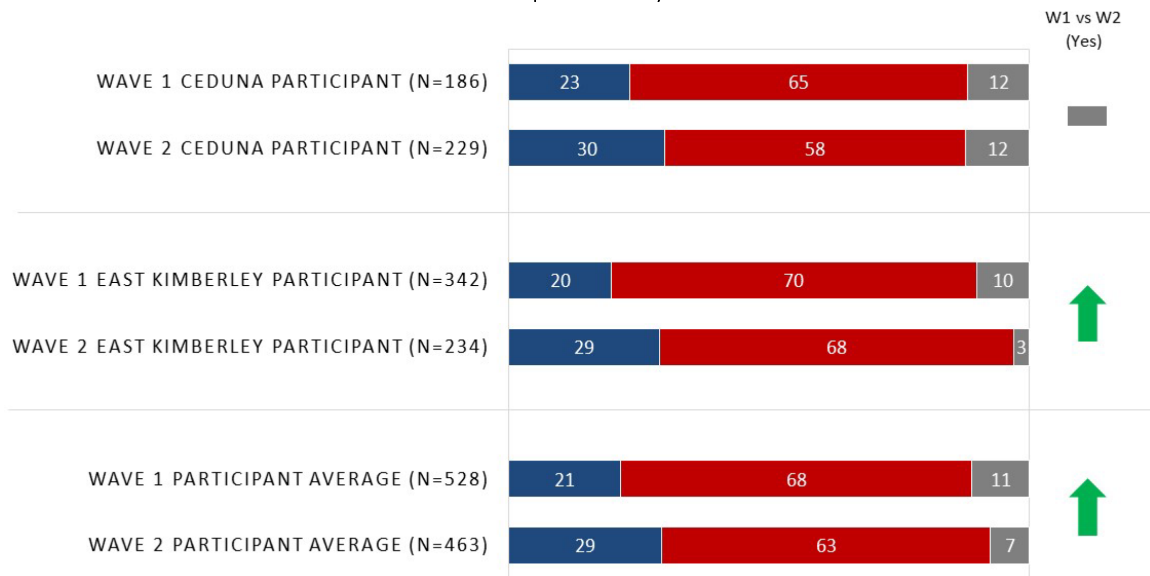
A few community leaders and stakeholders felt that IT literacy/skills had improved amongst some Trial participants since the introduction of the CDC. They had observed that some Trial participants, who previously had very low IT literacy, had become more comfortable using computers and/or EFTPOS terminals due to the requirement to use these technologies with the Trial.

Quantitative results indicated that, on average, around one third of participants reported that they had got better at using technology since the Trial started (29%, (n=463) – see Figure 32). This represents a significant increase from 21% at Wave 1 (n=528). Reports of such improvements were consistent across sites.

In addition, a few merchants who had purchased EFTPOS facilities for the Trial reported that their businesses had unexpectedly benefited as a result, as the EFTPOS facility had increased their sales and customer base.

Figure 32: Got better at things like using a computer, the internet or a smartphone since being a CDCT participant

Base: Participants currently in Trial.



Q43d (P). Since being on the Cashless Debit Card have….I've got better at things like using a computer, the internet or a smartphone?

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=4). Wave 2 East Kimberley participants: Refused (n=0).

VIII. Extent of circumvention behaviours

A. About this chapter

The CDCT Evaluation Program Logic makes explicit reference to a series of potential program circumventions that could undermine the achievement of intended outcomes.

This chapter reports on the Evaluation findings in relation to such circumventions behaviours. These findings are drawn from the qualitative interviews with community leaders, stakeholders and merchants.

B. Overall findings

Stakeholders and community leaders identified a range of circumvention behaviours amongst Trial participants that were perceived to be occurring and/or that they had heard reports of across the Trial period. As many of these reports were based on 'hearsay'/"community talk", it is difficult to assess how extensive the circumvention practices were in the community. However, most stakeholders, community leaders and merchants did not perceive these practices to be pervasive or widespread. DSS indicated that it was aware of potential workaround behaviours and had worked with the relevant stakeholders to minimise their impact on policy integrity.

Overall, the Evaluation found that concerns in the qualitative research around the range of circumventions reported to be occurring at Wave 1 had somewhat reduced at Wave 2, as measures had been put in place to address some of the circumventions. In addition, further exploration of some of the perceived circumventions conducted at Wave 2 found limited evidence to support that they were occurring to any large extent.

C. Circumvention behaviours

The following circumvention behaviours identified by community leaders, stakeholders and merchants at Wave 1 were reported to have been somewhat reduced at Wave 2 of the evaluation:

- The purchase of cash substitute cards (which were not restricted by the Indue card) for online gambling – relevant stakeholders indicated that merchants had been educated about the practice and most had stopped stocking the cards and/or monitored the method of purchase and avoided selling cash substitute cards to customers who wished to use an Indue card for their purchase[42].
- Access of prohibited items online (e.g. online gambling and alcohol in Chrisco hampers) – this was reported to have been addressed by the Department of Social Services.
- Seeking cash refunds via store accounts – one merchant reported instances early in that CDCT of Trial participants setting up local store accounts and attempting to seek cash refunds from other store locations. This had been addressed by the merchant, and the particular store had been recording the payment method on store accounts to prevent this.

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42 DSS reported that it had undertaken extensive work with multiple merchants to ensure cash substitute products were not sold to CDC participants.

The following circumvention behaviours were reported by some community leaders and stakeholders (based on reports from their clients and/or other community members). However, when further explored with relevant merchants/stakeholders, the qualitative research found that there was little evidence to support the view that they were occurring:

- Trial participants selling goods for cash below their value (specific examples that stakeholders had heard of included the sale of meat, whitegoods and groceries) – when explored with local relevant merchants, there was limited evidence to support this.
- A local drug dealer in Ceduna having acquired an EFTPOS terminal – this was reported by a couple of stakeholders, however was based on "hearsay" and not able to be verified by the Evaluation.

The following circumvention behaviours identified at Wave 1 were reported to still be occurring at Wave 2 and/or whether or not they had been addressed was unclear:

- "Grog running[43]" – in both Trial locations some stakeholders and community leaders had heard reports that this was still occurring.
- Merchants/businesses supporting circumvention behaviours:
  - In Kununurra, some stakeholders, community leaders and merchants reported that taxis were offering cash back at a reduced rate (e.g. charging the cardholder $100 and giving them $70 cash) and/or buying alcohol on behalf of Trial participants. Some also indicated that taxis were known to engage in similar undesirable behaviours to assist the circumvention of other systems[44].
  - A few stakeholders in Wave 1 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 Trial participant given $100 cash back).
- The transfer of money from Indue accounts to other accounts to withdraw as cash – reported by a few stakeholders at Wave 1.
- Rent transfers from Indue accounts to family members which were subsequently provided to Trial participants as cash – a couple of stakeholders reported that this was occurring amongst their clients at Wave 1.
- Card sharing – friends/family using participants' cards to purchase items in exchange for cash.

In addition, community leaders and stakeholders identified a range of practices that allowed CDCT participants to access additional cash which were circumvention behaviours unrelated to the use of CDCs. These included:

- Humbugging.
- Gambling with Indue cards (however, previously this had been done with other forms of cash/debit cards).

43 i.e. the illegal transportation of alcohol into prescribed 'alcohol free' areas from outside towns. The CDC was not intended to prevent "grog running" occurring.

44 DSS reported that it was aware of the taxi circumventions and had worked extensively with taxi merchants to highlight the behaviour of taxi drivers who were enabling circumvention behaviour.

- Prostitution – this was identified in the Program Logic as having the potential to increase as a result of the Trial. While a couple of stakeholders in Ceduna had heard stories of a few incidents during the Trial period, there was limited evidenced to suggest that this had increased.

IX. Unintended adverse consequences

A. About this chapter

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.

This chapter discusses the Evaluation findings in relation to adverse consequences of the CDCT on Trial participants, community members, community leaders and merchants across Wave 1 and Wave 2 of the evaluation. Evaluation findings are primarily drawn on feedback from stakeholders obtained via the qualitative research. Relevant survey data is also presented.

B. Overall findings

Overall, the qualitative feedback from stakeholders, community leaders and merchants indicated that some of the unintended adverse consequences of the CDCT hypothesised by the Program Logic had occurred to some extent during the Trial, namely:

- Perceived stigma as well as financial implications/complications for some Trial participants.
- Increased/targeted humbugging of vulnerable community members.

However, some of these consequences (financial complications and targeted humbugging) had become less problematic at Wave 2 of the evaluation as measures had been put in place to address these (i.e. community education and assistance to improve awareness and understanding of how to perform card transactions and check account balances and measures to facilitate access to goods and services in traditionally cash-based settings) and the community had adapted to the Trial.

The evaluation also identified a couple of additional unintended negative impacts of the CDCT on merchants that were not hypothesised in the Program Logic. These included increased fees associated with more credit transactions and financial costs to install new EFTPOS facilities.

C. Adverse consequences experienced by Trial participants

Consistent with Wave 1, a few stakeholders in the Wave 2 qualitative research reported that some Trial participants who 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. However, in the quantitative survey, only 4% of all participants on average across the two sites explicitly raised ‘stigma’ or ‘shame’ associated with the card as an issue at Wave 2 (6% did so at Wave 1). At Wave 2, 6% of participants also mentioned lack of freedom and/or concerns about their rights.

Some stakeholders and community leaders who perceived that there was a stigma associated with being on the CDC, felt that a lack of communication and understanding of the reasons, as well as the broad target audience of the Trial had contributed to this. Some of these stakeholders felt that greater communication efforts may have helped to reduce such perceptions.

Beyond that, adverse consequences for Trial participants predominantly related to complications/limitations experienced by some when using CDCs. The range of issues reported to have caused challenges for Trial participants across the Trial period included:

- Being unable to transfer money to children that are away at boarding schools[45].
- Being unable to participate in the 'second hand' market for used goods.
- Being unable to pool funds for larger purchases (e.g. cars)[46].
- Being unable to make small transactions at fundamentally cash-based settings[47] (e.g. fairs, swimming pools and canteens).
- Being unable 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 card[48].
- Having difficulties using the card online (including some online merchants not accepting the card).
- Being unable to set up automatic payments and other transactions on their cards at the beginning of the Trial[49].
- Difficulties keeping track of automatic payments/understanding deductions from account balance.
- Being embarrassed when the card does not work/cannot be used/have insufficient funds.
- Payment system problems - e.g. chip not recognised, EFTPOS machine not working, and card damaged.
- Losing the card[50].
- Difficulties with checking the card account balance.
- Difficulties remembering their PIN/online login details.

At Wave 2, the quantitative survey found that 33% of CDCT participants (on average across the Trial sites) had experienced at least one of the issues discussed above (see pages 100 - 101 below for more details).

It should be noted that many of the abovementioned transactions are actually achievable with the Indue card and by Wave 2 had been rectified for most Trial participants through education and

45 The Department can increase external transfer limits (default $200) upon reasonable proof. This facility can be used to transfer money to children at boarding school.

46 The Department advised that participants can have external transfers approved by DSS to enable the purchase of large items such as cars. Reasonable proof is required.

47 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. DSS also advised that it worked with local cash based fairs, such as the Kununurra Agricultural show, to ensure Trial participants had the option to make purchases via EFTPOS.

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

49 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 had since been fixed (as of August 2016).

50 The Department indicated that Local Partners in Trial communities are available to provide temporary cards to those who have lost them. These are able to be activated and associated with an account instantly.

assistance with setting up card processes. In addition, measures had been and/or were in the process of being put in place to enable CDCs to be used in traditionally cash-based settings (e.g. EFTPOS facilities introduced at cash-based fairs) at Wave 2.

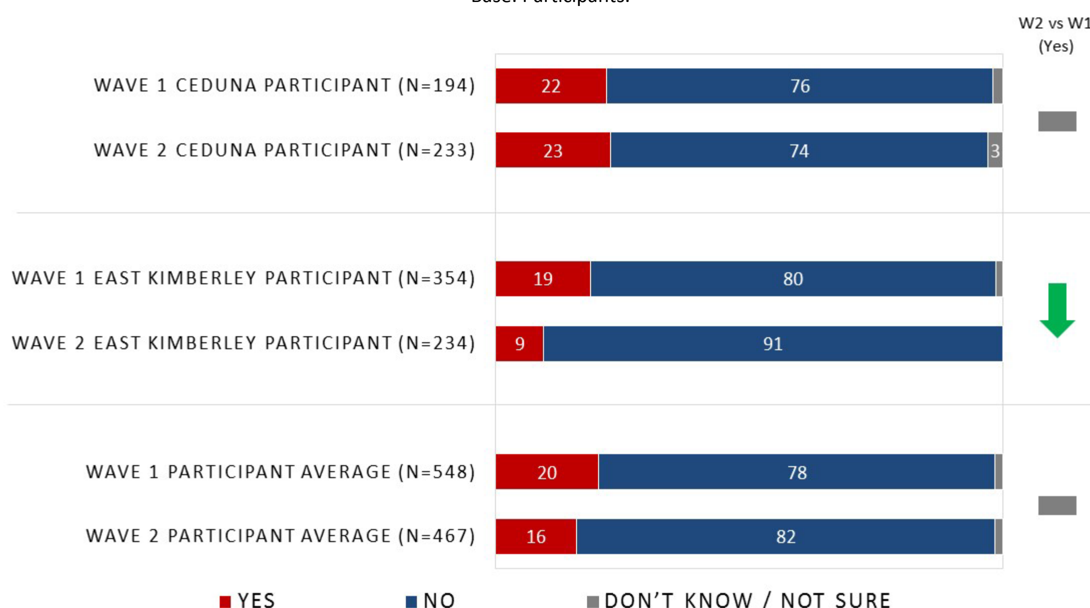
In the quantitative survey, at Wave 2, on average across the two sites, only 16% of participants reported that they had changed where or how they shopped (for non-prohibited items) since being on the CDCT. There was a significant reduction from Wave 1 to Wave 2 in this proportion in EK (see Figure 33). This change in EK was potentially the result of the implemented changes mentioned above, as well as the additional education and assistance offered since Wave 1.

Although most participants felt having to change how or where they shop was a negative thing, around 1 in 5 who said that they had changed where or how they shop explained that this was a positive thing (n=58):

- *"It has changed, am able to have more food in the fridge and petrol to travel to visit family."*
- *"My shopping has changed with buying food and paying my bills. Also, I can buy fuel, taxi fare and smokes and it pays for our travels."*
- *"I buy more food and clothing."*

Figure 33: Changed where or how you shop since using the card

Base: Participants.



Q22 (P). Please think about the things you buy at shops but not any alcohol or gambling products. Since you started using the card, have you had to change where or how you shop?

A few stakeholders also reported that there had been a few instances in which Trial participants with limited IT and financial literacy had been "taken advantage of" when seeking technical assistance from family/friends and lost money in the process (i.e. funds had been transferred into another person's account without consent).

In addition, a few stakeholders and community leaders perceived/had observed a few other negative changes in the communities since the Trial began. However, the evaluation found that there was limited evidence that these were directly related to the Trial. Specifically:

- Some Trial participants in Ceduna were reported to be experiencing higher Centrepay commitments, and as a result had less funds since available for other needs since the start of the Trial[51].
- Trial participants having ISP payments suspended and becoming financially dependent on family/friends as increased CDP obligations in combination with the lower appeal of receiving quarantined payments, had discouraged CDP compliance.
  - However, this was only reported to have occurred amongst a couple of Trial participants and data from DSS relating to reasons for payment cancellations was inconclusive in relation to these reports.

D. Adverse consequences experienced by merchants

The evaluation found that some merchants in the Trial sites had experienced increased business costs as a result of the Trial. These included:

- Increased fees associated with credit transactions – many merchants reported that they had a considerable increase in the fees they paid for EFT transactions where 'credit' was selected. While they acknowledged that it was now possible for 'savings' to be selected for purchases on the Indue card, they felt that further education and communication of this option was required, particularly as upgrades to card functionality allowed Trial participants to select 'savings', 'cheque' or 'credit', where previously they had only been able to select 'credit' with the CDC.
- Financial and resource costs associated with installing EFT facilities for merchants who had not had these available previously – this was reported to be a considerable expense for smaller/community-based organisations.

51 DSS advised that no CDC policy or program directive obligates customers to use the Centrepay system. Centrepay is an optional tool that is used for basic needs such as rent and utilities. It can be freely adjusted by the participant.

X. Awareness, usage and impact of support services

A. About this chapter

This chapter discusses evaluation findings in relation to support services that were funded as part of the Trial. It discusses the awareness and usage of the services as well as key factors that influenced the overall impact of services – selection and funding, implementation and service design and delivery approaches.

B. Overall findings

Overall, the evaluation found that there was limited uptake and usage of the services funded through the Trial.

Qualitative feedback from stakeholders and community leaders identified a number of perceived issues and areas for improvement in service selection and funding, implementation and communication and delivery approaches that were perceived to have reduced the overall impact of Trial funded services. These issues are discussed in detail below.

C. Awareness

The qualitative research found that most community leaders had good awareness of the range of support services and programs that were available as part of the Trial. In contrast, most stakeholders had limited awareness of the full breadth of programs and were only aware of some of the support services that were funded as part of the Trial. Stakeholders were more likely to be aware of Trial services that were:

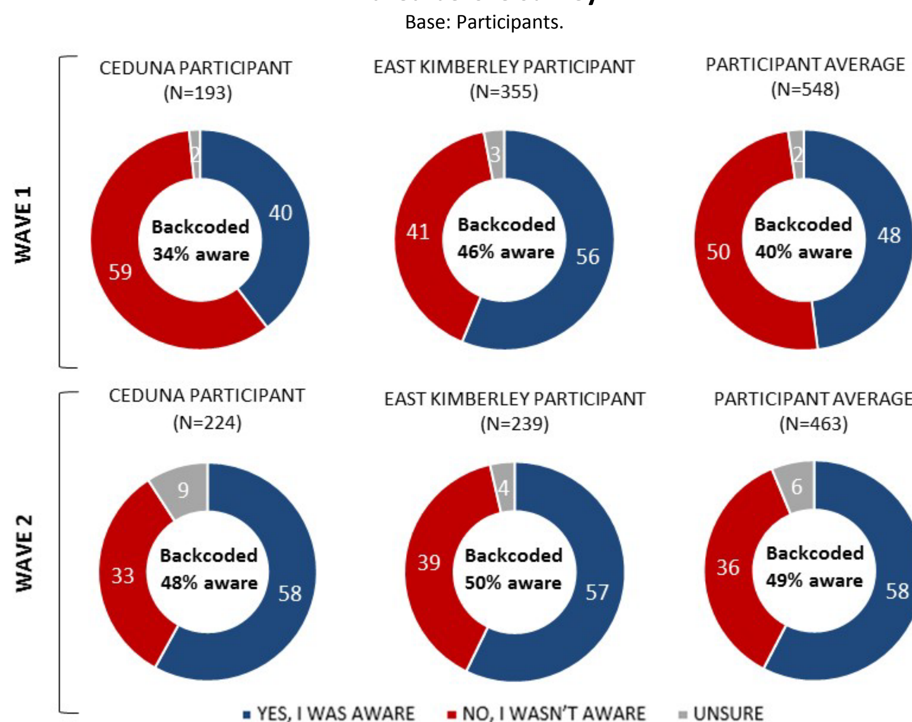
- In their own sector.
- Related to financial counselling as well as drug and alcohol counselling (that were well communicated as being a part of the Trial).
- Delivered by organisations that already had a presence in the community prior to the Trial.

Overall, stakeholders had limited awareness of new service providers that were funded as part of the Trial.

The quantitative survey results amongst Trial participants themselves demonstrated an overall improvement in awareness of local drug and alcohol support services, on average, from Wave 1 to Wave 2. Figure 34 illustrates a more substantial improvement in Ceduna than EK, increasing from 40% to 58% at Wave 2 (n=193 and n=224, respectively). EK participants' awareness remained more stable (57% (n=239) versus 56% at Wave 1 (n=355)).

Figure 34: Self-reported and back-coded[52] awareness of drug and alcohol support services in local area before survey

Base: Participants.



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.

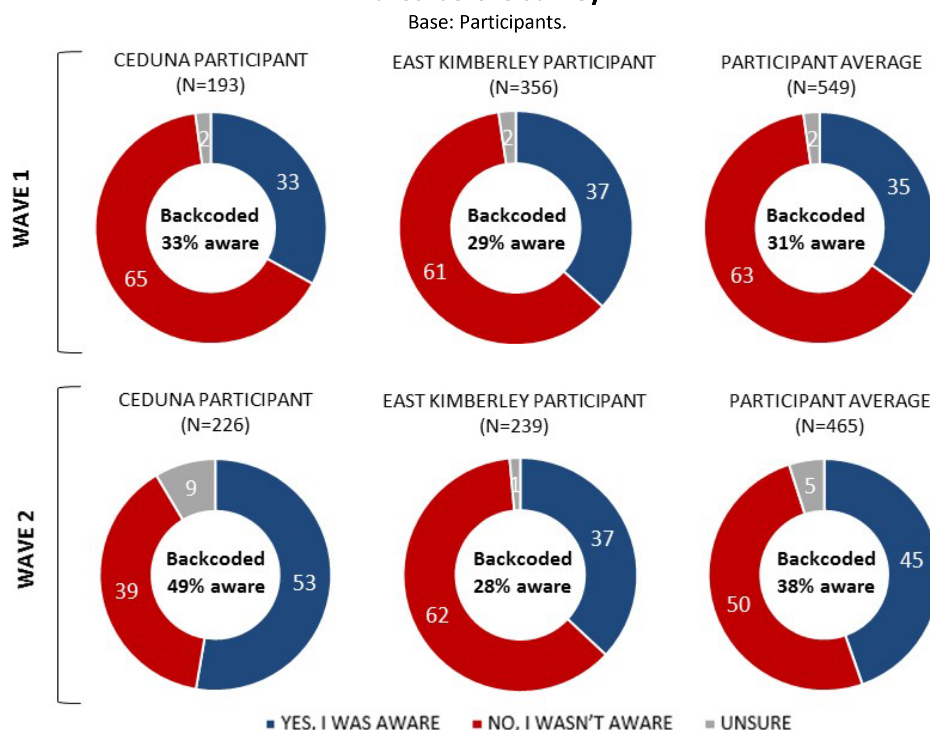
Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 1 East Kimberley participants: Refused (n=1). Wave 2 Ceduna participants: Refused (n=15). Wave 2 East Kimberley participants: Refused (n=1).

Amongst participants on average, awareness of local financial and family support services was lower than that of local drug and alcohol services. Awareness of these services, however, improved substantially from Wave 1 to Wave 2 (see Figure 35). As was the case with drug and alcohol support services, improvements in awareness were greater in Ceduna than in EK. In Ceduna, 53% of participants reported that they were aware of financial or family support services (n=226), up from 33% at Wave 1 (n=193). Awareness in EK again remained stable, with 37% aware at both Waves (n=356 at Wave 1, n=239 at Wave 2).

52 Back-coded awareness refers to the proportion who were aware based on their ability to accurately name a service, rather than simply state that yes, they were aware. Specifically, those who said they were aware and could accurately name a service were counted as 'aware', whilst those who said they were aware, but could not accurately name a service were then back-coded as unaware.

Figure 35: Self-reported and back-coded awareness of financial and family support services in local area before survey

Base: Participants.



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.

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 1 East Kimberley participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=13). Wave 2 East Kimberley participants: Refused (n=1).

D. Usage

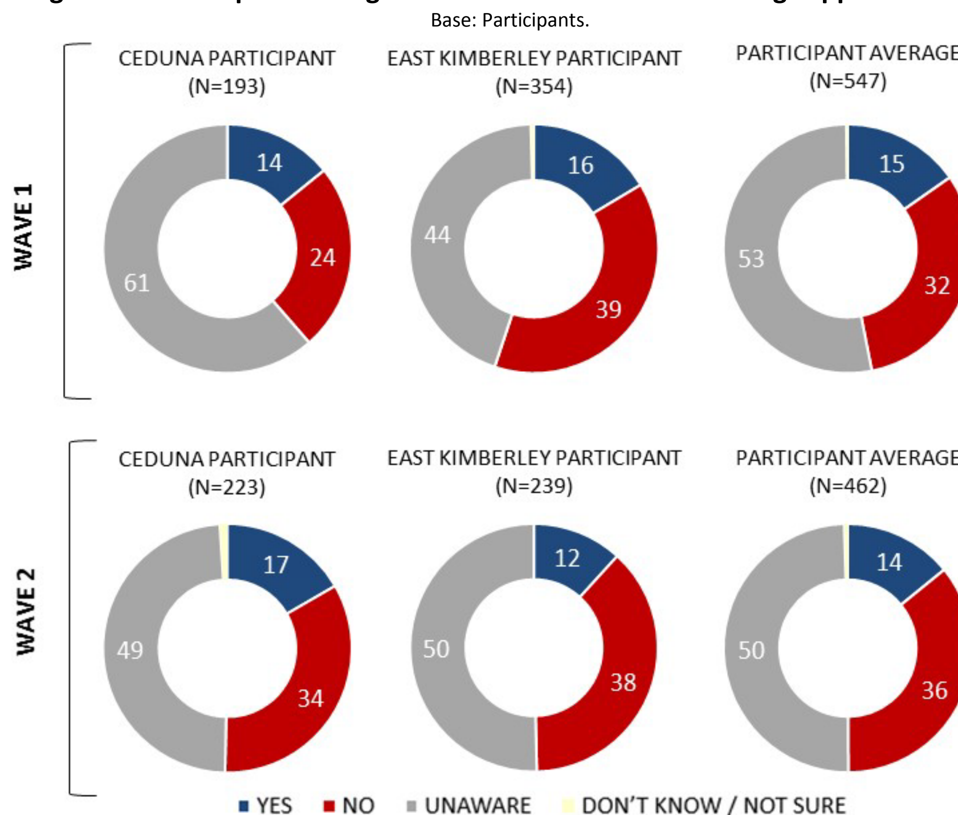
At the time of the Initial Conditions Report, some stakeholders and community leaders were anticipating a high level of usage of some services by CDCT participants (e.g. rehabilitation, and drug and alcohol counselling). However, most service provider stakeholders reported that this had not eventuated and their case load had remained relatively stable since the introduction of the CDC.

A couple of stakeholders in the medical sector felt that the limited uptake of alcohol and drug services was unsurprising, as they perceived a large number of Trial participants to be binge drinkers and therefore less likely to experience withdrawal symptoms.

The quantitative survey results generally supported the perceptions of most service provider participants, with the proportion who reported using alcohol or drug support services remaining stable (i.e. no statistically significant change) across Waves at both sites – see Figure 36.

Figure 36: Self-reported usage of local or other alcohol or drug support services

Base: Participants.



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? Question not asked of Participants who said they were aware at Q32a, but could not name a service provider.

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 1 East Kimberley participants: Refused (n=2). Wave 2 Ceduna participants: Refused (n=16). Wave 2 East Kimberley participants: Refused (n=1).

Participants were also asked about their intention to use an alcohol or drug support service in future, which increased significantly at both sites across Waves.

- At Wave 2, 34% of EK participants (n=239) reported that they most likely or definitely would try and get help from an alcohol or drug support service in the future, up from 17% in Wave 1 (n=350).
- At Wave 2, 20% of Ceduna participants (n=219) reported that they most likely or definitely would try and get help from an alcohol or drug support service in the future, up from 7% (n=194).

This reported intention at Wave 1, however, did not correlate with increases in usage at Wave 2.

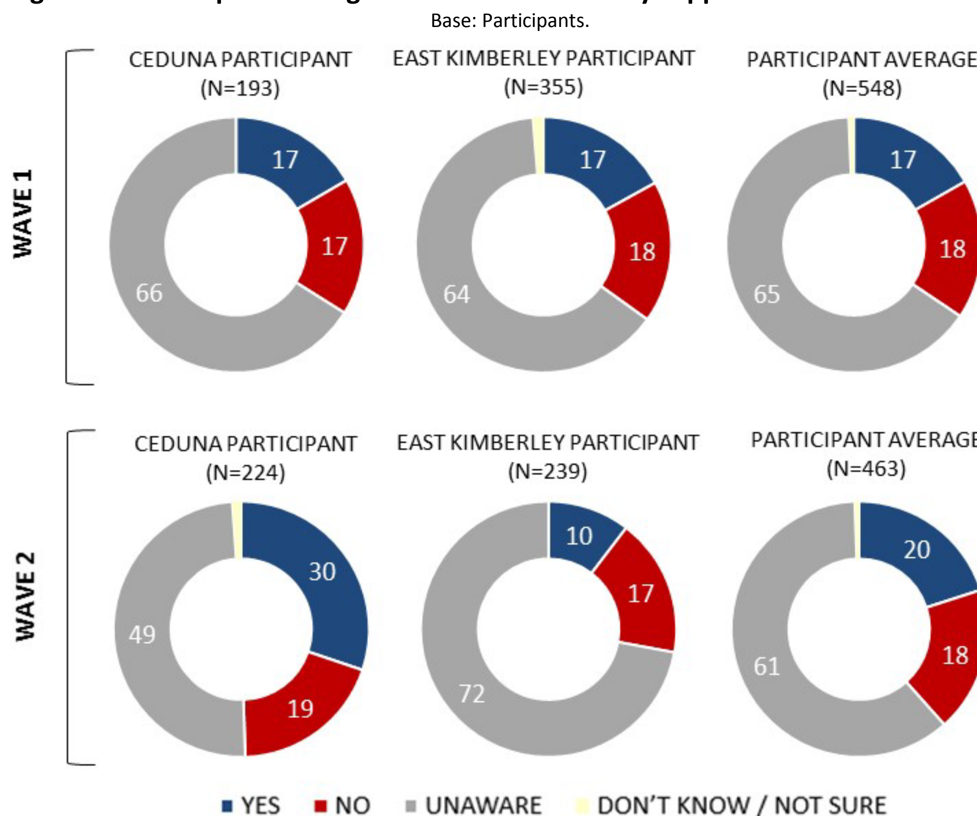
Community leaders and relevant stakeholders in Ceduna reported that there had been increased usage of financial counselling, as services had proactively sought clients in conjunction with the implementation phase of the CDCT.

This perception was supported by the quantitative survey data. Figure 37 illustrates that self-reported usage of such services in Ceduna increased from 17% (n=193) at Wave 1 to 30% (n=224) at Wave 2. However, this same trend was not seen in EK. Amongst this group, the proportion who reported using a financial or family support service decreased by 7% (n=239). As a result, the

proportion using financial and family support services on average across the two sites remained relatively stable across Waves.

Figure 37: Self-reported usage of financial and family support services in local area

Base: Participants.



Q38 (P). Have you ever used these local services or other services that help people deal with financial or family problems? Question not asked of Participants who said they were aware at Q37a, but could not name a service provider.

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=2). Wave 1 East Kimberley participants: Refused (n=1). Wave 2 Ceduna participants: Refused (n=15). Wave 2 East Kimberley participants: Refused (n=1).

Intention to use financial or family support services in the future significantly increased among participants from Wave 1 to Wave 2. Thirty-two percent of participants on average reported that they most likely or definitely would try and get help from such services in future (n=464), up from 17% at Wave 1 (n=544 – excludes 'refused'). This trend was also apparent across sites.

- At Wave 2, 37% of EK participants (n=239) reported that they most likely or definitely would try and get help from an alcohol or drug support service in the future, up from 21% (n=352).
- At Wave 2, 26% of Ceduna participants (n=225) reported that they most likely or definitely would try and get help from an alcohol or drug support service in the future, up from 14% (n=192).

Such reported intentions at Wave 1 were broadly in line with reported increases in usage at Wave 2 for Ceduna participants. Intentions amongst EK participants at Wave 1, however, again did not correlate with reported increases in usage at Wave 2.

E. Selection and funding of services

Overall, most stakeholders and community leaders across the Trial sites felt that the selection of services that had received Trial funding had been overly focused on services that were specifically aimed at the target behaviours and 'high-needs' services (e.g. rehabilitation and drug and alcohol counselling), which were only required by a small proportion of CDCT participants. These stakeholders and community leaders felt that Trial funded services would have had a larger impact if more funding had been allocated to a broader range of services for CDCT participants with less intensive support needs and to address current service gaps in the community. In particular, diversionary and longer term programs to support pathways off the Trial (e.g. employment and training initiatives) were felt to be important gaps in the programs/services that were funded.

Some stakeholders felt that the decision making process in relation to the funding of Trial services (including both the types of services funded and specific providers chosen) was not as robust or effective as it could have been. These stakeholders perceived the process to lack a clear evidence-base and overall framework to support decision making. A few stakeholders suggested that the process be underpinned by expert advice and established addiction/behaviour change theories to support evidence-based decision making and maximise the return on program investment.

Overall, many stakeholders and community leaders felt that longer term and more flexible funding arrangements were required to maximise the effectiveness of Trial services. Specifically:

- Trial funding was reported to be allocated for very specific/narrowly defined criteria and resources (e.g. a drug and alcohol counsellor). Many service providers noted that many of these resources had been underutilised, funding had been inflexible and was not able to be reallocated to adapt services to the local context and community needs.
- Some stakeholders reported that funding rules were too restrictive and did not allow for partnering arrangements between local service providers which they felt had led to the duplication of services.
- Short-term funding arrangements (i.e. 12 month contracts) were reported to limit the ability of services to achieve positive and sustainable outcomes. This was due to the considerable lead time required to set-up and resource services, particularly in remote locations, and to build community awareness and client relationships.

F. Implementation

Overall, the evaluation found that the support services funded through the Trial had not been implemented in a timely manner. Many of the funded services were not fully operational and accessible at the commencement of the Trial. Some community leaders felt that this reflected negatively on them, as they had "promised" their communities that such services would be available when the Trial commenced.

In the qualitative research many stakeholders and community leaders were critical of the lack of notification provided for Trial funding decisions. Many stakeholders reported that service provision contracts were only finalised between two weeks and two months prior to Trial commencement. This was reported as the key reason that services had not been in place at the start of the Trial. Most stakeholders indicated that at least 3-6 months' notice was required (depending on the type of service) to ensure that there was adequate time to establish, resource and market/communicate the

availability of services with the community. This notification period was reported to be particularly important to overcome challenges associated with the delivery of services in remote locations.

In addition, some stakeholders reported that the extension of contracts/funding arrangements with the continuation of the Trial had also been rushed and untimely and made it difficult for service providers to plan accordingly.

Some stakeholders also felt that communication of the availability and range of additional support services funded through the Trial, amongst Trial participants as well as service providers, had not been effective or sufficient which had contributed to a lack of service uptake and referrals.

G. Design and approach of service delivery

Through the qualitative research with stakeholders and community leaders, a range of key learnings in relation to the design and delivery of services across the Trial sites were identified.

Where services were found to be more effective in achieving their intended outcomes and had the greatest impact, the following factors had contributed to this:

- A coordinated service approach – stakeholders reported that the service reform group in Ceduna was having a positive impact due to its coordinated approach with regular meetings, and opportunity for collaboration between services and encouraging referrals.
  - However, some stakeholders felt that there was still scope for further coordination and collaboration to better meet individuals' broader needs.
- Use of localised services and staff, as this had provided greater understanding of the local context and community, and more established relationships with clients/community members.
- Providing outreach services (i.e. proactively seeking out and visiting clients) was reported to have been effective in increasing awareness and usage of services.
- Consideration of cultural needs in Trial sites – including the use of local Indigenous staff and organisations for services targeted at Indigenous Trial participants, and understanding local cultural dynamics in remote and very remote communities (including the differences between communities).
  - Services that had utilised non-local/non-Indigenous services and staff were reported to have had more limited success in the delivery of Indigenous-targeted services. This was attributed to a lack of knowledge and understanding of local community dynamics and culture, as well as a lack of pre-existing relationships which limited trust and credibility of the services.
  - In addition, a few stakeholders and community leaders in very remote communities reported that outreach services visited very infrequently (e.g. every two months), which reduced the number of clients they could serve and their ability to build relationships with clients/potential clients.

XI. Implementation of the CDCT

A. About this chapter

This chapter discusses the evaluation findings in relation to the implementation of the CDCT. It primarily draws on community leader and stakeholder qualitative feedback, but also covers relevant participant survey and administrative data. It should be noted that this evaluation is primarily an outcomes evaluation and not an implementation review and, as such, its coverage of the implementation process is limited.

The findings are presented in relation to implementation processes spanning from the initial set-up, roll-out and ongoing operation of the CDCT – covering the topics of awareness and understanding, consultations, communications, representativeness of decision makers and the community panel.

B. Overall findings

Overall, the evaluation found that there were aspects of the implementation process of the CDCT – from initial set-up, roll-out, ongoing operation to the extension of the Trial – that were perceived by community leaders and stakeholders as being appropriate and effective whereas other aspects were felt to be less effective.

In general, aspects of the implementation process that were perceived to have **worked well** included:

- ♦ Adopting an inclusive, co-design approach for the development, set-up and implementation of the CDCT between the community leaders and the Australian Federal, State and Local Government authorities.
- ♦ Tapping into local knowledge and trusted sources for information dissemination and CDCT assistance (e.g. Indigenous community organisations and local service providers).
- ♦ Using appropriate, targeted channels for specific harder to reach/vulnerable audiences – e.g. outreach for remote communities via the Department, Local Partners and/or leadership groups visiting some communities and "door-knocking" some local houses, and having information sessions with older children in schools (i.e. aged 16 years or more).
- ♦ Distributing the CDC in conjunction with money management/budgeting advice in communities outside of Ceduna – this was perceived to be very effective in educating, skilling and supporting the transition to the CDC.
- ♦ Having a direct contact to assist with card-related issues – e.g. DSS staff being on the ground, direct phone line to Indue for card support and "one-stop-shops" (e.g. Ceduna Aboriginal Corporation and Complete Personnel).
- ♦ Gradually rolling out the card, which allowed for different start dates for different CDCT participants, and hence minimised the risk of adverse impacts and disruption.

In contrast, aspects of the implementation that were perceived to have not worked well included:

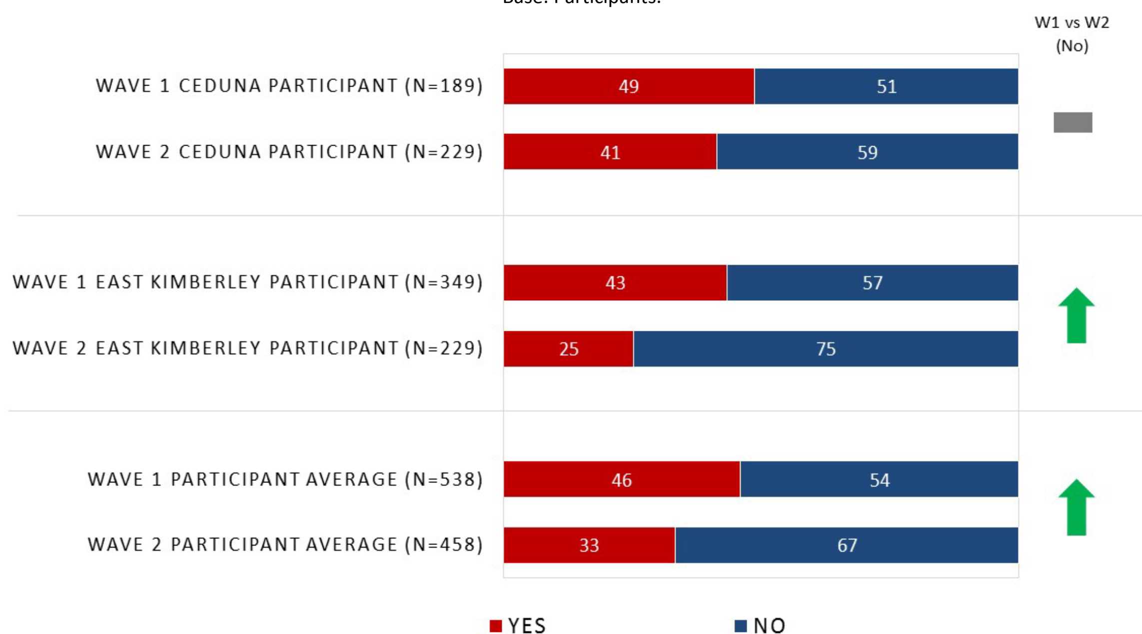
- ♦ Perceived poor initial community consultation process and general communications/education about the CDCT (including adopting a passive approach rather than active communication approach) – i.e. in terms of reach, channels, timing and level of language.

- Perceived limited role, involvement and integration of Centrelink/the Department of Human Services in the implementation process (e.g. displayed by a lack of presence and being less willing to directly engage with communities about the Trial[53]).
- Lack of timeliness in key processes commencing at the same time as the CDCT (e.g. community panels and Trial funded support services).
- High turnover of staff in service provision and government agencies – this was felt to impact on efficiency and effectiveness of processes due to lack of consistency, learning and relationship development.
- Technology issues (e.g. infrastructure for technology not being in place in time for commencement, overestimation of technology skills in remote communities and the requirement for email accounts).
- Limited recognition of local cultural needs/sensitivities due to not using local people/service providers in some communities and lack of cultural training for outsiders coming into communities.
- Comprehensively educating service providers and merchants – while educating store owners on the CDC's functionality (so that they knew how to assist trial participants with their card usage) was conducted in remote communities, this was not uniformly done across all merchants nor in neighbouring locations outside the Trial sites. Similarly, service providers in locations neighbouring the Trial sites were felt to have been missed in CDCT communications.

The quantitative survey results indicated that although around one third of participants on average at Wave 2 reported that they had experienced problems using their card (n=458), this proportion had significantly reduced since Wave 1 (46%, n=538 – see Figure 38).

Figure 38: Experienced problems with the card

Base: Participants.



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

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

When asked about the problems they had encountered with the card, participants reported the following (top 5 reasons, on average across the two sites):

- Lack of access to cash (not related to actual problems using the Card) (n=21).
- Wanted to use in circumstances where credit card payment not an option (n=18).
- Difficulties with checking card balance (n=17)[54].
- Finding it difficult to use online/some online merchants not accepting Card (n=15)[55].
- Payment system problems - e.g. chip not recognised, EFTPOS machine not working, card damaged (n=13).

These, and other issues found in the qualitative research, are discussed in detail below.

C. Endorsement of the CDCT

Overall, the evaluation found that almost all community leaders, stakeholders and merchants wanted the CDC to continue operating after the Trial, with some minor changes to strengthen it. This widespread support for the CDCT reflected the positive changes perceived to have been achieved by the CDC as well as the general acceptance of it across both Trial sites.

Removal of the CDC was not seen as a "good idea" by almost all of these qualitative research participants as they held concerns about the:

- Return to the levels of negative behaviours and practices witnessed prior to the CDCT.
- Interruption to newly established financial and wellbeing practices.
- Level of community and service disruption that would be caused to Trial participants and their families as well as subsequently the broader community, if people were required to adapt to "another set of changes".

The community leaders strongly felt that the CDCT was appropriate for their community's characteristics and need at the time of the Trial set-up. At Wave 2, they continued to believe that the CDC was a "good thing" for their community, as they did at the initial set-up stages of the CDCT. While some were disappointed that the early implementation processes did not go as smoothly (see sections below for more detail) as they would have liked, they nonetheless spoke positively about the initiative and continued to endorse it as being positive and necessary for their community.

D. Awareness and understanding of the CDCT

Both the qualitative and quantitative research components at Wave 2 found that awareness and understanding of the CDCT had improved since Wave 1.

In the qualitative research, most stakeholders, community leaders and merchants felt that there was now better awareness and understanding of the relevant Centrelink payment groups that are

54 DSS advised that participants can check balances through SMS, the Online Account Portal, selected ATMs and by calling the Indue Customer Centre.

55 DSS advised that participants can buy products online from approved online merchants. The Department can activate relevant online merchants instantly on request.

affected by the CDCT, payment arrangements (80% card and 20% cash), card restrictions and sources for further information and help (i.e. relevant service providers) than was the case at Wave 1.

The quantitative survey results supported these findings.

At Wave 2, 97% of participants (n=467) and 96% of non-participants (n=135) reported that they generally understood what can and can't be purchased with the card (on average across the two sites, up from 92% (n=548) and 87% at Wave 1 (n=109), respectively).

- When asked specifically if they knew whether the card could be used for alcohol purchases, almost all participants and non-participants reported that they understood that this could not be done at both Waves (96-98% on average).
- When asked specifically if they knew whether they could use the card for gambling, a large proportion of participants and non-participants reported that they understood that this could not be done at both Waves (91-94% on average).

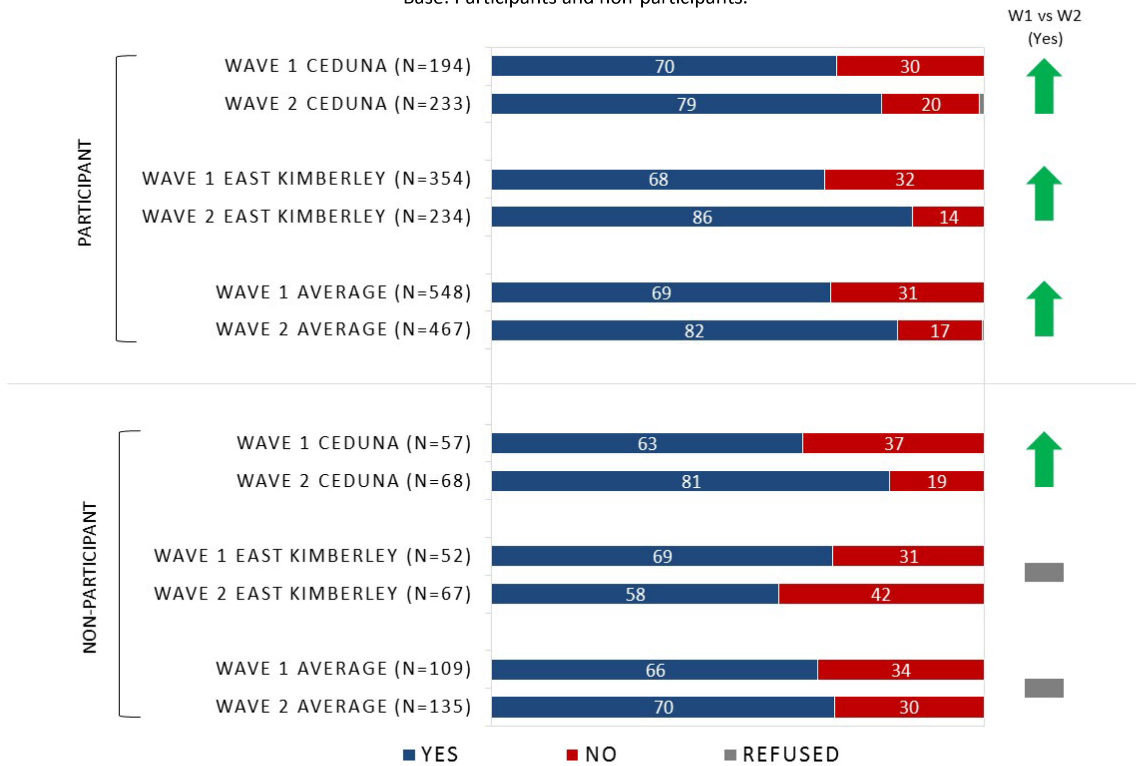
The majority of participants on average across the two sites (93%, n=467) also understood what to do if the card was lost or stolen at Wave 2 (up from 79% (n=548) at Wave 1). Results in relation to the above metrics were generally consistent across Trial sites.

Certain aspects of the card that were less understood at Wave 1 appeared to have improved at Wave 2, particularly amongst participants. At Wave 2, 92% of participants (n=467) and 91% of non-participants (n=135) understood the types of places where the card can and can't be used (up from 81% (n=548) and 85% at Wave 1 (n=109), respectively).

- When asked specifically if they knew that they could use the card in most places VISA is accepted, 82% of participants (n=467) and 70% of non-participants (n=135) reported that they understood that this could be done at Wave 2. This represented a significant improvement on understanding at Wave 1 amongst participants overall – see Figure 39.
- Figure 40 illustrates that participants also reported an improved understanding of the fact that they can use the card to make online payment transfers to pay for housing, bills and other expenses.

Figure 39: Knowledge that you can use the card in most places where VISA is accepted

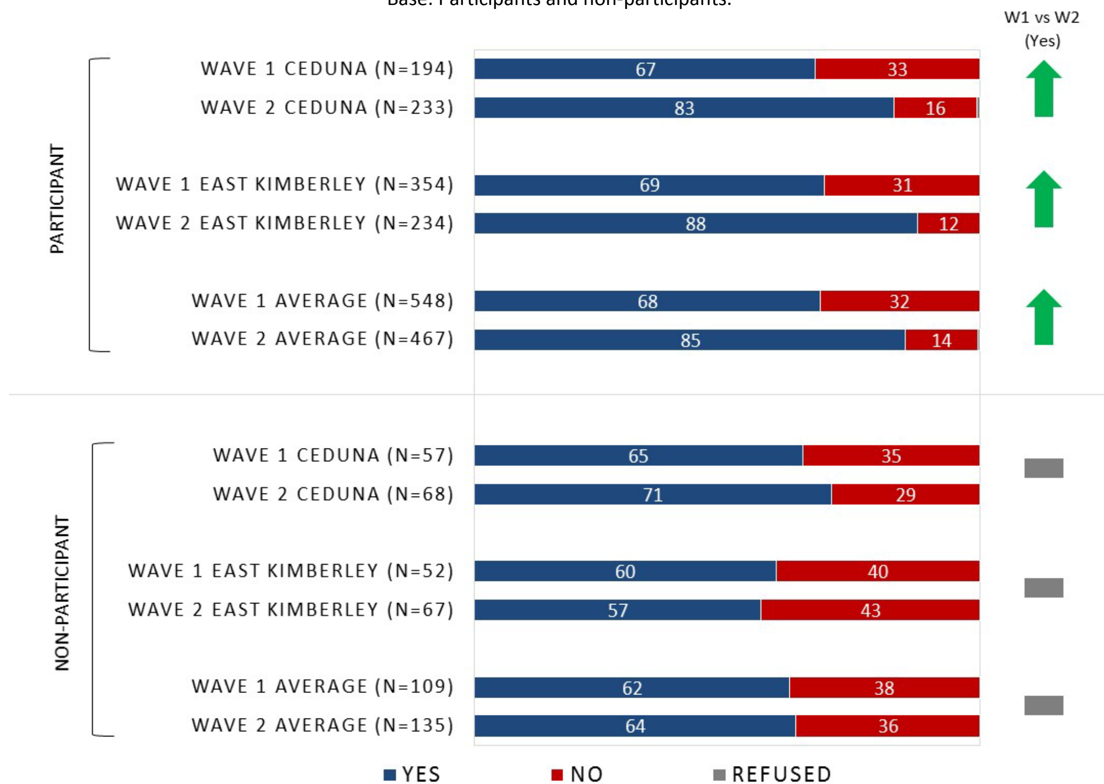
Base: Participants and non-participants.



Q21c (P) / 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 40: Knowledge that you can use the card to make online payment transfers to pay bills

Base: Participants and non-participants.



Q21d (P) / 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?

Demographically there were some variations in understanding around certain aspects of the card depending on the age of the Trial participants. Participants aged over 45 years (on average across the two sites) were significantly *less likely* than younger participants (18-44) to understand card conditions related to online use.

- 76% of participants aged over 45 years understood that they can use the card in most places VISA is accepted, including online or on the internet (n=204), compared to 86% of younger participants (n=263).
- 79% of participants aged over 45 years understood that they can use the card to make online payment transfers to pay bills, for housing and other expenses (n=204), compared to 88% of younger participants (n=263).

There were minimal differences across gender in terms of understanding, however, female participants were significantly more likely than males to report understanding the types of places where you can use the card (95% (n=300) compared to 87% of males (n=167)).

Participants who were in receipt of the Disability Support Pension (DSP) (n=115) were significantly less likely than participants in receipt of other payments (n=352) to report (on average across the two sites) awareness:

- Of what to do if the card is lost or stolen (87% of those on DSP, compared with 94% of other participants).
- That the card cannot be used to purchase alcohol (89% of those on DSP, compared with 99% of others).
- That the card cannot be used for gambling purchases (88% of those on DSP, compared with 96% of others).
- That the card can be used in most places VISA is accepted (75% of those on DSP, compared with 84% of others).
- That the card can be used to make online payment transfers to pay bills, for housing and for other expenses (77% of those on DSP, compared with 87% of others).

Consistent with the abovementioned findings, a few stakeholders and community leaders felt that awareness and understanding of the CDCT was lower among some people with disability as they required more in-depth and tailored communications to fully comprehend the mechanics and processes of the CDC.

Feedback from some merchants, leaders and other stakeholders indicated that understanding was still less widespread and unclear in relation to:

- The option for using direct debit as a means of managing the cash component of payments received.
- The option to select ‘savings’ rather than ‘credit’ at EFTPOS terminals to minimise merchants incurring additional charges.
- The available mechanisms/processes to facilitate legitimate cash purchases (e.g. screen shots of Ebay purchases or receipts for second hand goods to arrange direct debit payments through Indue);

- The rationale and target audience for the CDCT (i.e. that it is not directed at certain groups of people in the community but applicable to all relevant income support recipients in that location and why Trial locations were selected).
  - While the perception that the Trial was targeted at specific groups in the community (namely Indigenous people) existed in both locations, it appeared to be stronger in EK.
- The difference between CDP, other welfare reform changes and CDCT – specifically, that CDP non-compliance payment reduction and mutual obligation requirements that affected payment rates were separate to the CDCT.

E. Communication processes

Overall, the communications and marketing processes across all stages of the CDCT implementation process was reported by many stakeholders, some merchants and a few community leaders as being “poorly co-ordinated”. Perceptions of communications issues in relation to the implementation processes appeared to be more negative in the East Kimberley than in Ceduna, but there clearly appeared to be scope for improvement across both Trial sites.

Common gaps were identified in relation to the communication of the implementation processes from initial set-up, roll-out through to on-going implementation and the announcement of the Trial extension, including:

- Information needs not being fully met.
- The limited channels used to inform, reach and engage with the wide range of audiences directly and indirectly impacted by the CDCT (e.g. the utilisation of written communication materials was not considered to have been an effective strategy due to low literacy levels amongst the population of cardholders).
- The lack of appropriate and consistent tone of information provided about the CDCT (i.e. a tone that was helpful, supportive, positive, collaborative and optimistic).
- The limited notice provided of the Trial extension.

Feedback from these stakeholders and merchants suggested that there appeared to be a lack of a comprehensive communications strategy across the implementation stages to facilitate a coordinated, consistent and integrated communications approach across each stage of the implementation process.

In addition, the evaluation consistently found that there was a gap in communication of the CDCT beyond the Trial sites. Many stakeholders felt that it was important for the neighbouring merchants and service providers to be aware of and educated about the CDCT requirements and how best to support Trial participants when they were visiting or moving to these locations. It was evident that Trial participants who were fairly mobile tended to have higher support needs and hence required such supports beyond just the Trial locations (e.g. who to contact when card was not working).

F. Community consultation processes

Overall, the evaluation found that the community leaders held a different view about the effectiveness of the consultation process than stakeholders. Community leaders generally felt that there had been sufficient opportunity and communication about the consultation processes to allow

those who were interested in the process to participate. It was felt that some members of the community chose not to engage in the early discussions but only became involved later in the process, after the decision to proceed with the CDCT had been made. Consultations were reported to have occurred via community meetings and discussions.

While the community consultation processes were perceived by stakeholders and merchants to be better in Ceduna than in EK, this aspect of the implementation process was generally felt to be less than fully effective across both Trial sites.

There was some acknowledgement among community leaders and stakeholders that the decision to embark on the Trial was necessitated by frustrations in community conditions and concerns that were "worsening" and adversely impacting on the wellbeing of individuals and their families, which required "strong leadership decisions" to be made. There was also some agreement among stakeholders and community leaders that while such decisions were not palatable across all community members, they were necessary for the "greater good". Some stakeholders and community leaders felt that this case could have been made more consistently and strongly across some sectors of the community to promote better understanding of the rationale for the CDCT.

Many stakeholders regarded the consultation process as insufficient in reaching the wide target audience in the community. These stakeholders felt that there had been too much reliance on formal channels (i.e. town hall meetings), rather than small group discussions – which were considered to be more accessible and appropriate for the wide target audience and to facilitate more constructive in-depth discussions of the Trial rationale and scope, to build the case for the CDCT. Some stakeholders also felt that the consultation process had lacked a strategy to engage with those target audience members who did not participate in the formal meetings.

A few stakeholders indicated that their clients had not engaged with the consultation process because they felt that the decision to proceed with the CDCT had already been made.

G. Representativeness of key decision makers

The evaluation identified concerns among some stakeholders about the representativeness of key decision makers of the CDCT, especially at the operational stages of the implementation process. It was felt that while key Indigenous community organisations and the local council had been represented, other key entities such as the State government, local businesses/employers and key service provider organisations were missing in the operational stages of the CDCT. While these concerns were evident across both sites, they were more prominent in Kununurra. It was felt that having a wider involvement at the operational stage of the implementation would have resulted in better:

- Integration of Trial participants' needs into existing and new support services.
- Reach, support and engagement of Trial and non-Trial participants in the Trial communities.
- Information dissemination and timely correction of myths and misconceptions about the CDCT as they arose.

Similarly, feedback from community leaders indicated that getting a representative group of community panel members was also somewhat challenging (see section below) as some of the original leadership group had changed over the Trial period.

H. Community Panels

Community leaders asked for community panels to be established in the Trial sites to allow Trial participants to have the percentage of their welfare payments that were quarantined reviewed. Panels were formed and operated by the community and comprised community leaders and in some instances, representatives from relevant organisations (e.g. police force). Criteria for reviewing applications were generally decided by the community leaders in each Trial site, based on the particular community and social norms that they wanted to encourage.

Overall, the community panel process was found to be more effective in Ceduna than in East Kimberley. However, feedback from stakeholders and community leaders across both Trial sites indicated that the community panels had not been operational in time for the commencement of the CDCT and at Wave 2, were still perceived to be not well understood or communicated to the wider community.

The availability of the community panels for reviewing the percentage of welfare payments quarantined was reported by community leaders and stakeholders to be a good and necessary safeguard process in the Trial to ensure that personal/family circumstances and needs were taken into consideration. However, the delay in establishing and commencing the community panels from the start of the Trial was perceived as a failing in the CDCT. Furthermore, many stakeholders felt that the community panel process was not adequately known and communicated to the Trial participants and the communities.

The community panel process was reported to have commenced in Ceduna in April 2016, shortly after the commencement of the CDCT. In the East Kimberley, it commenced in September 2016, five months after the commencement of the Trial.

The numbers of applications to the community panels over the period of its operation are presented in Table 11 below. The data indicates that, across both Trial sites, the number of applicants have gradually declined since the commencement of the panels.

Table 11: Number of Community Panel applications as at 31 March 2017

Time period	Ceduna	Kununurra	Wyndham	Total
March – July 2016	134	-	-	134
August – December 2016	12	20	6	38
January – March 2017	12	6	6	24
Total	**158**	**26**	**12**	**196**

The data also indicates that the number of changes approved as at 31 March 2017 was 128, with a total of 33 applications rejected and 26 yet to be assessed.

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Table 12: Community Panel sittings and outcomes as at 31 March 2017

	Ceduna	Kununurra	Wyndham	Total
Total number of panel meetings/sittings	10	4*	3*	17
Applicants who have had their restricted portion reduced	121	6	1	128
Applicants who have had their application rejected	21	10	2	33
Applications pending additional information	1	4	2	7
Applications withdrawn	2	0	0	2
Applications yet to be assessed	13	6	7	26

*As at 13 July 2017

Overall, once the community panel process was in operation, the process was generally reported by community leaders to have run smoothly – with applications being assessed in a timely, consistent and fair manner. While the community leaders/panel members were clearly aware of the criteria used for reviewing the percentage of welfare payments quarantined, most stakeholders indicated that they were unaware of such information. It was generally reported by community leaders/panel members that changes were approved based on the criteria of whether:

- The individual was meeting their "responsibilities" (e.g. police incidents reports, hospitalisation reports and school attendance of those who had children).
- Decreasing the percentage of welfare payments quarantined would cause "harm to the individual/family".

A few community panel members identified frustration with:

- Meetings not being conducted when planned due to a lack of attendance by all the required panel members.
- Not having the necessary information (e.g. paperwork/documentation) available and complete to allow for decisions to be made.
- Not having sufficient local knowledge of the individuals applying for percentage adjustments so that the criteria for those adjustments could be properly determined.
- Anonymity of panel members not being maintained.
- Inconsistency in panel membership – particularly in Kununurra, where the panel membership was operating on a rotation basis, which was felt to limit consistency of decision making, especially when applications were being reconsidered at subsequent meetings.

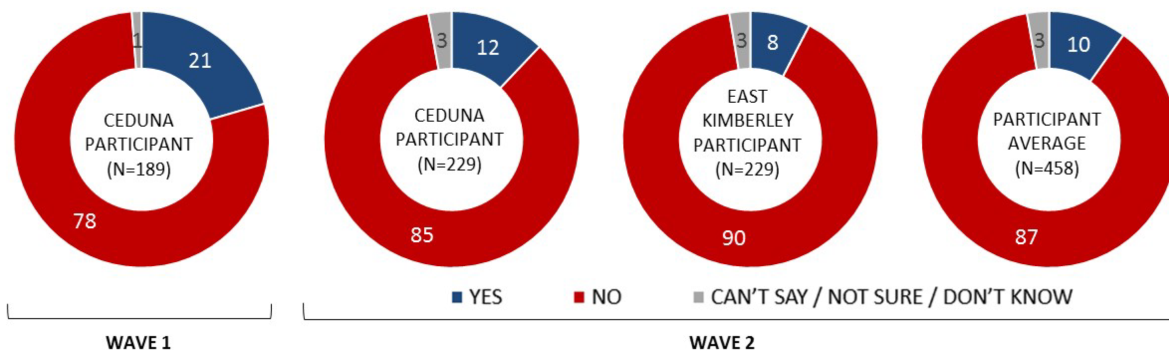
Due to the delay in setting up the community panels in EK, relevant quantitative survey questions were only asked of Ceduna participants at Wave 1. At Wave 1, 21% of Ceduna participants reported that they had asked the community panel for a review (n=189) and of this group, 52% reported that their review resulted in a change in the proportion of money that goes onto their card (n=39). At Wave 2, the proportion who had asked for review decreased to just 12% in Ceduna (n=229), with reports of a change also decreasing to 36% (n=30 – see Figure 41 and Figure 42).

Of those Ceduna participants that undertook a review, 37% indicated that they had problems with the panel or the process itself at Wave 1 (n=39). This proportion at Wave 2 had risen slightly to 42% (caution low base - n=30).

In EK, reports at Wave 2 suggested that the community Panels had been used less than in Ceduna – with just 8% reporting that they had asked the Panel for a review (n=229). This proportion was too small to confidently report on in term of the result of their review or if they had any problems with the Panel or process (n=16 respondents).

Figure 41: Asked Community Panel for a review

Base: Participants.

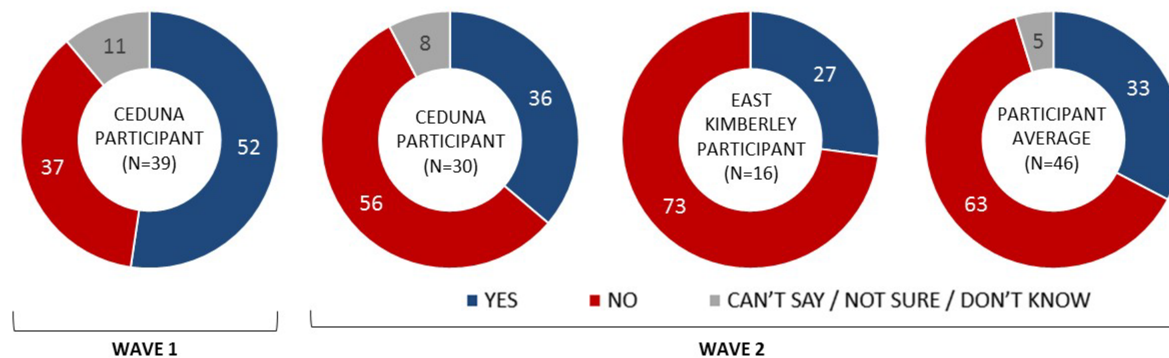


Q17a (P). Have you asked the Community Panel to review how much of your Centrelink money goes onto the Cashless Debit/Indue Card? NOTE: Q17a not asked of EK participants at Wave 1 due to the Panel not being established at the time of survey.

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=0). Wave 2 East Kimberley participants: Refused (n=0).

Figure 42: Community Panel review resulted in a change

Base: 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? CAUTION low sample size for EK result.

Excludes 'Refused'. Wave 1 Ceduna participants: Refused (n=0). Wave 2 Ceduna participants: Refused (n=0). Wave 2 East Kimberley participants: Refused (n=0).

XII. Lessons to improve delivery and to inform future policy

A. How do effects differ among different groups of participants?

The qualitative research found that stakeholders and community leaders had observed greater positive behavioural change amongst females and families than among single males in relation to the target behaviours and broader spill-over benefits.

Differences in results in the quantitative survey findings among demographic groups have been reported in detail throughout this report under each reporting theme. Key differences are summarised below.

Indigenous Background

The reduction in the proportion of CDCT participants who reported drinking alcohol weekly or more often between Wave 1 and Wave 2 was significantly higher (31pp reduction from 64% (n=300) to 33% (n=194) among Indigenous CDCT participants than among non-Indigenous participants (7pp reduction from 59% (n=35) to 52% (n=33)).

Consequently, Indigenous CDCT participants were significantly less likely than non-Indigenous participants to report drinking alcohol *about weekly or more often* at Wave 2 (33% (n=194) compared with 52% for non-Indigenous participants (n=33)).

At Wave 2, Indigenous CDCT participants were significantly more likely than non-Indigenous participants to indicate that their lives were *better* under the CDCT*:* 26% (n=405), compared with 15% among non-Indigenous (n=56).

Gender

In relation to self-reported behaviours around gambling, female Trial participants were significantly more likely to report reductions than male participants. At Wave 2, on average across the two sites (amongst those who reported gambling before the Trial):

- 63% of female participants reported that they had gambled *less* than before becoming CDCT participants (n=74), compared to just 30% of males (n=35).
- 67% of female participants reported that they had spent more than $50 a day on gambling *less* than before becoming CDCT participants (n=56), compared to just 39% of males (n=30).
- 61% of female participants reported that they had borrowed money or sold things to get money to gamble *less* (n=37), compared to just 26% of males (n=25).

Due to low response sample sizes in relation to illegal drug use, demographic differences were not statistically significant. However, the data was suggestive of a greater impact of CDCT participation among female users of illegal drugs than among male users. On average across the two sites (amongst those who reported illegal drug use before the Trial) at Wave 2:

- 58% of female participants reported that they had used illegal drugs *less* than they did before becoming CDCT participants (n=38), compared to 38% of males (n=24).
- 63% of female participants reported that they had spent more than $50 a day illegal drugs *less* than they did before becoming CDCT participants (n=36), compared to 42% of Males (n=19).

<u>Age</u>

The reduction in the proportion of CDCT participants who reported drinking alcohol weekly or more often between Wave 1 and Wave 2 was significantly higher (34pp reduction from 68% (n=176) to 34% (n=141)) among younger CDCT participants (aged 18-44 years) than among older participants (those aged 45 years or more) (8pp reduction from 55% (n=131) to 47% (n=88)).

Younger participants (18-44 years) were also significantly more likely than older participants to report certain spill-over benefits, as follows:

- 48% of participants aged 18-44 reported that they had been able to save more money than before being in the CDCT (n=260), compared to 38% of participants aged 45 and older (n=201).
- 35% of participants aged 18-44 reported that they had got better at things like using a computer, the internet or a smart phone (n=261), compared to 18% of participants aged 45 and older (n=202).

B. Where and why has the Trial worked most and least successfully?

The evaluation findings indicate that the Trial has had a substantial positive impact in both Trial sites. The evidence suggests that the Trial was a little more successful in Ceduna than in East Kimberley, largely due to more effective implementation. That said, at both sites, there was support from most stakeholders and community leaders for the CDC to be extended across the country because of the positive changes that had been observed as a result of the Trial, which were considered to be applicable on a broader scale.

In terms of Trial participants' self-reported outcomes in relation to alcohol, drugs and gambling, these were generally positive and consistent across the two sites. Similarly, this was also the case with stakeholder and community feedback in the two locations.

There were some differences in the effectiveness of the implementation processes between the two sites. While there were areas for improvement identified in both sites (as would be expected for a Trial), it was assessed that the implementation was executed more effectively in Ceduna than in the East Kimberley. In particular, this was in relation to the communications and marketing of the CDCT, community panel implementation and community consultation processes (see Chapter XI for further discussion). As a result, there appeared to be somewhat broader community support and acceptance of the Trial in Ceduna, compared to in EK.

The quantitative survey of non-participant community members in each Trial site found that non-participants in EK were less likely than those in Ceduna to report that they had noticed reductions in drinking and violence in the community since the Trial. Perceptions of safety overall were also less positive in EK.

CDCT participants in Ceduna were more likely than those in EK to report that the Trial had made their lives better. Similarly, Ceduna non-participants were also more likely to report that the Trial had made life in their community better, compared to EK non-participants.

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

The evidence presented in this report indicates that substantial positive change has occurred in Ceduna and EK following the introduction of the CDCT, underpinned by a sustained reduction in **alcohol consumption** among CDCT participants. A key factor external to the CDCT that has impacted on alcohol consumption in both Trial sites has been the existence of takeaway alcohol restrictions (these are detailed in Section F of Chapter III).

Self-reported reductions in alcohol consumption by CDCT participants in the quantitative survey are unlikely to have been materially influenced by the impact of alcohol restrictions. One line of enquiry in the survey questionnaire was to ask respondents about the extent to which their consumption had changed since they became CDCT participants. That is, participants were asked to make a comparative assessment between their consumption at the time of the survey (August-September 2016 at Wave 1 and May-June 2017 at Wave 2) and before they became CDCT participants (which would have ranged from a few days prior to the survey to April 2016).[56] The alcohol restrictions in each site had been in place for a considerable period of time before survey respondents commenced in the CDCT[57] and hence the recalled (pre-participation) level of consumption would have reflected a level of consumption that had been fully adapted to the alcohol restrictions (with the exception of CDCT participants who had moved into the Trial area during or shortly before its commencement).

Another line of enquiry in the quantitative survey was to ask CDCT participants for their recent consumption patterns. Again, given the length of time since the implementation (or change) of alcohol restrictions in each location, changes in these patterns from Wave 1 to Wave 2 of the survey would have largely reflected factors other than the alcohol restrictions.

In this context, it also important to note that the takeaway alcohol restrictions in each Trial site were not highly restrictive (with the exception of bans on sale to residents of certain Aboriginal communities near Ceduna). For example, throughout the Trial, an individual in the EK has been able to purchase (*each day* apart from Sunday) 22.5 litres of full-strength beer, 4.5 litres of wine and 1 litre of spirits/fortified wine. Therefore, such restrictions are unlikely to have been a binding constraint on consumption for most CDCT participants.

The above reasoning also implies that observed reductions in alcohol consumption since the commencement of the CDCT reported by non-participant community members in the quantitative survey were unlikely to have been influenced materially by the impact of alcohol restrictions.

In relation to indicators of **reduced illicit drug use**, analysis of comparison site (Port Augusta) data for the Ceduna Trial site indicated that part of the reduction in drug driving offences measured in Ceduna post CDCT implementation is likely to have reflected factors other than the CDCT (see Chapter IV.D).

56 Cashless debit cards (CDCs) were progressively distributed to eligible ISP recipients in Ceduna and the East Kimberley. CDCs were distributed to eligible ISP recipients mainly between mid-April and end-May 2016 in Ceduna and over the month of June 2016 in East Kimberley.

57 In EK, the alcohol restrictions applying during the course of the CDCT had been put into place in 2011 (with strengthened compliance via TAMS introduced in December 2015). In Ceduna, the alcohol restrictions applying during the course of the CDCT had been put into place in 2012.

In relation to indicators of **reduced gambling**, part of the measured decline in poker machine revenue in Ceduna and Surrounds since the introduction of the CDCT is likely to reflect a general downward trend in poker machine revenue driven by factors other than the CDCT (see Chapter IV.E).

With the exception of alcohol restrictions, the CDCT (including the CDC, the additional funding for services provided under the Trial) and State service reform initiatives, qualitative research with community leaders, local merchants and stakeholders did not identify any other potentially large influences on alcohol consumption, illicit drug use or gambling in the Trial sites during the CDCT. An analysis of the relative impact on these behaviours of the CDC compared with that of local drug and alcohol support services, as well as financial and family support services (summarised in Section E below) indicated that the impact of State service reforms on these behaviours is likely to have been minimal.

D. Adverse consequences experienced by specific community members

Some stakeholders and community leaders reported that some groups in the community with greater access to cash were now experiencing more humbugging and/or harassment since the Trial. This included:

- Humbugging of working families and people living in the community from outside the Trial sit.
- Humbugging and harassment of vulnerable community members (including the elderly people and people with disability).
  - However, it was unclear whether or not such instances had increased, with many stakeholders noting that this had already been occurring prior to the Trial. In addition, a few stakeholders felt that such instances had reduced since the early stages of the Trial, as older community members were now avoiding humbugging by telling others that they were also on the Trial.
    - The quantitative survey found no significant difference between *perceptions* or *experiences* of humbugging in the community amongst younger (<45 years) versus older (45 years and older) participant or non-participant community members.
    - However, participants with children were more likely than those without children to report *experiencing* this behaviour (37% (n=201) versus (23% (n=270)). This group were also more likely to report noticing this behaviour *more* since before the Trial (37% (n=201) versus 20% (n=269), respectively).

The quantitative survey results for non-participant community members showed mixed results in terms of these people noticing humbugging in their community. At Wave 2, on average across the Trial sites, 18% of non-participants felt that humbugging had decreased since Trial commencement, 17% felt that it had increased and 43% felt that it had remained the same (n=141).

Participants themselves were more likely to report that they had noticed *more* humbugging since before the Trial (see Chapter VII.E for further discussion on this topic).

The evaluation also found that some community leaders had faced challenges in their communities due to their association with the Trial. Specifically, these leaders reported experiencing difficulties in their relationships with some of the community and/or hostility from community members who opposed the CDCT, felt that they had been "misled" about the details of the Trial and/or not appropriately consulted.

E. 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?

Through the restriction of funds that are accessible for cash, the Cashless Debit Card itself should have a very direct impact on the target behaviours of alcohol consumption, drug use and gambling. The evaluation hypothesis, therefore, was that it should not be 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.

This hypothesis was examined by looking at the differences in responses to key quantitative survey questions amongst CDCT participants who *had used the available services,* and those who *had not* (based on self-reported usage). Although this classification method is not perfect due to recall and social desirability biases in the survey context, it does provide a robust platform for analysis of this issue. The survey asked participants whether they were aware of any services and whether they had used any across two broad categories – drug and alcohol services, and financial and family support services. It should be noted that the analysis tested the effect of all such services (whether part of the additional funding package or not – including services subject to State service reform initiatives).

At Wave 2, this analysis was conducted amongst those who reported having used a service ‘within the past 15 months’, which was the approximate time since the commencement of the Trial. The tables below show the proportion of all participants who reported they had used services from two broad categories – drug and alcohol services, and financial and family support services, in two timeframes. The proportions that had ‘ever used’ support services remained relatively stable, however there was a small increase in the proportion using financial and family support services (19%, up from 15% at Wave 1). Overall, less than one third of participants had ever used a support service across either category (27%, consistent with 24% at Wave 1) and 19% had used a service from either category in the last 15 months.

As was the case at Wave 1, these small proportions again suggest 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. The distributions provide indicative sample sizes for an exploration, though the drug and alcohol service usage group is quite 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.

Table 13: Proportion of participants ever using support services

	Drug and alcohol services		Financial and family support services		Either drug and alcohol or financial/family services	
Status*	% all participants (weighted)	*Sample size (Unweighted)*	% all participants (weighted)	*Sample size (Unweighted)*	% all participants (weighted)	*Sample size (Unweighted)*
Ever used	13%	*60*	19%	*87*	27%	*127*
Not used	83%	*399*	78%	*376*	70%	*339*
Refused	4%	*20*	3%	*16*	2%^	*13*

*Self-reported. Note: participants coded as refused for the purpose of this analysis if they refused to name a service at q32a or q37a. ^Refused in both categories.

Table 14: Proportion of participants using support services in the past 15 months

Status*	Drug and alcohol services		Financial and family support services		Either drug and alcohol or financial/family services	
	% all participants (weighted)	*Sample size (Unweighted)*	% all participants (weighted)	*Sample size (Unweighted)*	% all participants (weighted)	*Sample size (Unweighted)*
Used past 15 months	7%	*33*	14%	*61*	19%	*88*
Not used past 15 months	89%	*425*	84%	*402*	78%	*378*
Refused	5%	*21*	3%	*16*	2%^	*13*

*Self-reported. Note: participants coded as refused for the purpose of this analysis if they refused to name a service at q32a or q37a. ^Refused in both categories.

At both Waves, these categories were then used to look at the key survey questions which ask about changes to behaviours since the commencement of the Trial. There are a range of patterns that *could* be seen 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 again at Wave 2. These results, in conjunction with the other findings related to support service usage (see Chapter X, X.D: Usage), suggest that the contribution of services seems to be much less than the contribution of the CDC itself.

Table 15: Reported behaviour change across service usage segments

Used in past 15 months	Drug and alcohol services		Financial and family support services		Either drug/alcohol OR financial/family services	
Since being on the CDCT	Used P15M	Not used P15M	Used P15M	Not used P15M	Used P15M	Not used P15M
Percent "yes" (excludes 'refused'):	*n=12-33*	*n=179-414*	*n=27-54*	*n=165-396*	*n=38-81*	*n=155-372*
You've been able to save more money than before [FIN]	39%	46%	40%	45%	42%	45%
You've been better able to care for your child/ren	56%	39%	49%	39%	51%	37%
You've got more involved in your children's homework and school	58%	37%	26%	41%	35%	40%
I've got better at things like using a	33%	29%	42%*	27%	38%*	27%

Used in past 15 months Since being on the CDCT	Drug and alcohol services Used P15M	Drug and alcohol services Not used P15M	Financial and family support services Used P15M	Financial and family support services Not used P15M	Either drug/alcohol OR financial/family services Used P15M	Either drug/alcohol OR financial/family services Not used P15M
computer, the internet or a smartphone						
Percent "less" (base excludes 'refused', includes NA – did not do activity before Trial):	*n=33*	*n=404-407*	*n=52-53*	*n=387-390*	*n=79-80*	*n=362-365*
Drunk grog or alcohol [D&A]	26%	21%	27%	22%	27%	21%
Had six or more drinks of grog or alcohol at one time [D&A]	25%	20%	25%	19%	25%	19%
Gambled [FIN]	6%	12%	16%	11%	13%	11%
Spent more than $50 a day on gambling [FIN]	6%	10%	18%*	8%	15%*	8%
Bet more than you can really afford to lose [FIN]	10%	8%	14%*	8%	14%*	7%
Had to borrow money or sell things to get money to gamble [FIN]	8%	5%	9%	5%	9%*	4%
Used an illegal drug like benzos, ice, marijuana, or speed [D&A]	25%*	6%	3%	8%	11%	6%
Spent more than $50 a day on illegal drugs like benzos, ice, marijuana, or speed [D&A]	24%*	6%	3%	7%	11%	6%

* Statistically significant difference.

As in Wave 1, overall there is a positive trend amongst the small group of participants who had used the services since the commencement of the Trial, however there were few statistically significant differences from those who had not. This suggests that the services are having a positive impact on the small proportion of the population using them, however it 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 for those who did not use the services *positive effects of the CDCT can still be seen on most of these behaviours*. Therefore, from this was can infer that CDC without additional supporting services would still be expected to impact on the targeted behaviours

In general, even though some sample sizes were small, participants who reported having used a service in the last 15 months were 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 final evaluation 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.

XIII. Conclusions

1. **The evaluation findings indicate that the CDCT has been effective in reducing alcohol consumption and gambling in both Trial sites and are also suggestive of a reduction in the use of illegal drugs.**

The primary evidence for this conclusion is self-reported behavioural change by CDCT participants collected via a quantitative survey. Such self-reported data is subject to recall error and social desirability bias and hence should be interpreted with caution. The latter effect is particularly problematic in relation to illegal drug use. That said, the CDCT participant survey was designed to minimise the impact of these limitations. For example, participants were not asked to recall specific quantities of alcohol consumed before and after the Trial commenced – they were simply asked to state whether or not they consumed alcohol (and more than six drinks at one time) more often, less often or with the same frequency. While this approach does not enable estimates to be made of the change in the volume of alcohol consumed, it does provide robust indicative evidence of the direction of behavioural change.

Confidence in the validity of the conclusion is strengthened by the fact that the self-reports of CDCT participants were triangulated (verified) by three other data sources: surveys of family members of CDCT participants at Wave 1; surveys of general community members (not participants or their family members) at Wave 1 and Wave 2; and qualitative research with community leaders, stakeholders and merchants. In relation to gambling in Ceduna, a fourth data source (electronic gaming (poker) machine revenue) further reinforced the evidentiary base.

2. **The evaluation findings show some evidence that there has been a consequential reduction in violence and harm related to alcohol consumption, illegal drug use and gambling.**

Administrative data available in relation to criminal activity across the two Trial sites generally did not show evidence of a reduction in crime since Trial commencement. However, administrative data (hospital presentations, community patrol pick-ups, outpatient counselling, apprehensions of intoxicated people) did provide some evidence of lower levels of alcohol-related harm.

Qualitative research with community leaders, stakeholders and merchants in both Trial sites indicated that most perceived the problem of violence and crime to have diminished in their communities since the commencement of the CDCT. Most could point to observable evidence that underpinned their perception (e.g. a noticeable reduction in the number of visible public demonstrations of aggressive and violent behaviours).

Wave 2 survey results with general community members supported these findings. On average across the two Trial sites, nearly four-in-ten community members perceived that violence in their community had reduced since the commencement of the CDCT.

3. **The evaluation findings provide limited evidence of an improvement in perceptions of safety in the Trial locations.**

In the qualitative research, community leaders', stakeholders' and merchants' feedback indicated that, overall, they perceived that community safety had increased in their local community during the CDCT period and between Wave 1 and Wave 2.

4. The evaluation findings indicate that the Trial has had widespread positive spill-over benefits

There was considerable evidence from the quantitative surveys and qualitative research to suggest that there were benefits from the CDCT other than those discussed above at an individual and community level in both Trial sites. Many of these benefits can be grouped under a long-term (by 2 years or more after implementation) planned outcome of the Trial that was included in the Program Logic: **increased community, personal and children's wellbeing**. The benefits identified included more money being spent on meeting basic living needs, increased savings, increased motivation to find employment, and positive impacts on parenting and family wellbeing.

5. The evaluation findings indicate that many Trial participants initially had negative perceptions of the Trial, but that acceptance has increased over time

Wave 2 of the CDCT participant survey found that around a third of participants (average across the two sites) felt that the Trial had made their lives worse, primarily due to them not being able to buy the things they want/need or give cash to family/friends. This was significantly lower than in the Wave 1 survey, when around half of participants had this view.

6. The evaluation findings indicate that many Trial participants have experienced complications and limitations when using CDCs, but that these issues have been ameliorated over time as a result of greater familiarity, as well as education and assistance provided by DSS, Indue Limited and its Local Partners.

Wave 2 of the CDCT participant survey found that around a third of participants (average across the Trial sites) had experienced a range of issues with using CDCs that had caused challenges/difficulties for them. These included being unable to transfer money to children away at boarding schools, being unable to make small transactions at cash-based settings (e.g. fairs, swimming pools and canteens) and being unable to make purchases from merchants or services where EFT facilities were not available. Education, assistance and other measures designed to ameliorate these issues were implemented by DSS, Indue Limited and its Local Partners progressively during the CDCT and the evaluation data indicate that these were effective.

Appendix A: Evaluation Framework

Australian Government Department of Social Services

Cashless Debit Card Trial: Evaluation Framework

September 2016

ORIMA RESEARCH

1. Executive Summary

ORIMA Research has been commissioned by the Department of Social Services (DSS) to evaluate the Cashless Debit Card Trial (CDCT) in South Australia (SA) and Western Australia (WA).

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 SA and East Kimberley in WA (Kununurra and Wyndham). These sites were proposed by local community leaders and the CDCT has been developed via a collaborative process involving local community leaders, local and state government agencies and Australian Government agencies (led by DSS). The two CDCT sites have experienced high levels of community harm related to alcohol consumption, drug use and gambling.

The overall objective of this evaluation is to assess the effectiveness of the CDCT. This document specifies the design framework for the evaluation.

The evaluation design is based on a **multi-staged and multi-method** approach including desk research, qualitative research, quantitative research and analysis of administrative and program data. The evaluation will consist of six key (and sometimes overlapping) phases:

1. **Project Inception meetings** and set up (including initial desktop program scoping, consultation with community representatives and leadership, development of the Program Logic (PL), Key Performance Indicators (KPIs) and Theory of Change (TOC), ethics approval);

2. **Three waves of qualitative research** with observers/on-the-ground stakeholders (named initial conditions, wave 1 and wave 2);

3. **Two waves of quantitative research** (termed waves 1 and 2) amongst CDCT participants and their families, as well as non-participant community members;

4. **Collation and analysis of administrative data** from the Department of Human Services (DHS), Indue Ltd, State Government agencies and local service providers (with comparison between CDCT Trial sites and non-CDCT comparison sites where applicable);

5. Ongoing **monitoring of the DSS CDCT 'inbox' and hotline**; and

6. Interim and final **reporting**.

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2. Introduction

2.1 Objective of the framework

The evaluation of the Department of Social Services' (DSS) Cashless Debit Card Trial (CDCT) is being conducted by ORIMA Research, an independent specialist social and government research and evaluation service provider. The overall objective of the evaluation is to assess the effectiveness of the CDCT.

This document presents the design framework for the evaluation.

This evaluation framework will:

- Describe the Cashless Debit Card Trial program and what will be evaluated;
- Help to develop sound evaluation plans and implementation of evaluation activities;
- Articulate the program goals and measurable short, medium and long-term objectives;
- Define relationships among inputs, activities, outputs, outcomes and impacts; and
- Clarify the relationship between program activities and external factors.

2.2 The Cashless Debit Card Trial

The Australian Government is undertaking the CDCT to deliver and manage income support payments (ISPs) in order to reduce levels of community harm related to alcohol consumption, drug use and gambling. This initiative has been informed by a recommendation in Andrew Forrest's Creating Parity report.[58] It has also been informed by lessons learned from previous income management (IM) trials.

In the CDCT, a proportion (from 50 to 80 per cent) of an individual's ISP is directed to a restricted bank account, accessed by a debit card (not allowing cash withdrawals). This debit card cannot be used at merchants who sell alcohol and gambling related products.[59]

Participation in the CDCT is mandatory for all working age ISP recipients who live 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.

58 Forrest, A. (2014). The Forrest Review: Creating Parity. Commonwealth of Australia, Canberra.

59 Merchants within Trial locations who sell both excluded and allowable goods are involved in individual mixed merchant agreements. Lottery purchases are permissible.

To date, the CDCT is being implemented in Ceduna and Surrounds[60] in South Australia (SA) and Kununurra / Wyndham (East Kimberley)[61] in Western Australia (WA). These sites were proposed by local community leaders and the CDCT has been developed via a collaborative process involving local community leaders, local and state government agencies and Australian Government agencies (led by DSS). The two CDCT sites have experienced high levels of community harm related to alcohol consumption, drug use and gambling.

To support the CDCT implementation, DSS has worked with the SA and WA State Governments, community agencies and Indigenous leadership to supplement the social services being provided to the Trial areas. Additional services that have been provided at the Trial sites are listed below:

- **Kununurra/Wyndham**
  - AOD Brokerage Fund
  - Substance abuse rehabilitation support for adolescents
  - 'One family at a time' program
  - 'A Better Life' program
  - Children and Parenting Services (CaPS)
  - Improved financial counselling
- **Ceduna and Surrounds**
  - Alcohol and Other Drug Outreach Workers
  - Ceduna 24/7 Mobile Outreach 'Street Beat'
  - Brokerage Fund
  - Domestic Violence: Family Violence Prevention Legal Services
  - Mental Health support services
  - A Better Life (ABLe)
  - Financial counselling and support services
  - Additional aftercare support service
  - Outreach and transport support services (Mobile Assistance Patrol)

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60 The Ceduna and Surrounds Trial site is defined by the town of Ceduna (meaning the area of the District Council of Ceduna as defined in accordance with the Local Government Act 1999 (SA); and the surrounding region of Ceduna, which is composed of and limited to the ABS 2011 Australian Statistical Geography Standard (ASGS) Statistical Area Level 1s (SA1) of 40601113409, 40601113410, 40601113501 and 40601113502.

61 The Wyndham/Kununurra Trial site is situated in the East Kimberley region of Western Australia. The Trial site, incorporating communities within the postcode regions 6740 and 6643, comprises a number of SA1s.

The main elements of the Trial include:

- Co-design with local community reference groups in the Trial sites;
- A cashless debit card, delivered by a commercial provider (Indue Ltd);
- 80 per cent of welfare payments to be placed into a restricted account linked to the cashless card (100% of lump sum payments and arrears payments);
- The quarantined percentage may be varied by local leadership boards to a base level of 50 per cent;
- Alcohol and gambling (excluding lotteries) will not be able to be purchased with the card, and no cash will be able to be withdrawn from the card;
- The debit card and associated services will be provided by the commercial partner who will provide support to participants via a customer contact centre, a mobile phone app and text alerts to keep people informed;
- The optional operation of a community panel in each Trial site;
- All working age income support recipients in selected Trial locations will be included in the Trial. Those who move from the Trial location elsewhere will remain participants in the Trial;
- Aged and Veterans pensioners and wage earners may opt-in to participate;
- Up to three sites will operate for 12 months, with a staggered rollout from March 2016; and
- The individuals impacted have been informed about the Trial by DSS through direct consultation, a community reference group and community members who were involved in the consultation phase. In addition, public information sessions have been held in Ceduna and the East Kimberley, and local Indigenous organisations have been highly involved in informing participants about the Trial.

2.3 Contextual factors

This document has been informed by feedback from:

- respected academics and commentators with expertise in conducting research and evaluations involving Aboriginal and Torres Strait Islander Peoples (via an expert panel convened by the Department of Social Services);
- 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 CDCT sites.

The evaluation design is largely based on measuring the views and reported experiences of several stakeholder segments:

- Local observers and on-the-ground stakeholders in the CDCT sites - community leaders, as well as government and non-government service providers;
- CDCT participants;
- CDCT participants' families; and
- Other members of the general community living in the CDCT sites.

The evaluation design takes into account two important contextual issues:

1. A need for the evaluation to assess the impact of CDCT on individual and community functioning taking into account the impact of factors other than the CDCT which may also affect its planned outcomes; and

2. DSS needs ‘real-time’ early warning of any issues and problems uncovered by ORIMA Research. These need to be communicated in a timely manner to the Department as the evaluation progresses. In practice, this will take place over the three two-week periods during which the ORIMA Research qualitative team is on the ground at each location, as well as the two two-week periods during which ORIMA specialist Indigenous interviewers are on the ground at each location, and as any issues are identified through data provided to ORIMA Research via the DSS CDCT email ‘inbox’.

2.4 Ethics clearance and approval

ORIMA Research will develop ethical protocols in accordance with Human Research Ethics Committee (HREC) requirements and obtain ethics clearance for the research involving CDCT participants, their family members and non-participants in the relevant communities. It will not be necessary to obtain ethics approval for collecting data amongst observer groups, including community leaders. ORIMA Research will use the services of the Bellberry Human Research Ethics Committee to ethically review and provide approval for the methodology, interview questions, reimbursement of research participants, consent forms, and information sheets.

3. Evaluation scope and key measures

3.1 Introduction

In this evaluation, the Program Logic methodology has been used to establish the scope of the evaluation and the key performance indicators that will inform an assessment of the effectiveness of the CDCT. If the outputs, short-term outcomes and medium-term outcomes specified in the CDCT Evaluation Program Logic are achieved, this will indicate that the CDCT has been effective. In order to measure the extent of effectiveness, each individual output and outcome has been translated into one or more Key Performance Indicators (KPIs), which have been operationalised very specifically and are measurable via existing or new data sources.

The CDCT Program Logic also identifies a range of potential longer-term outcomes and impacts of the CDCT that are outside of the scope of the evaluation because the expected timeline for their realisation extends beyond that of the evaluation.

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 school attendance, 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?

3.2 CDCT Evaluation Program Logic

In consultation with DSS, a CDCT Program Logic was developed for the purposes of the evaluation. The CDCT Evaluation Program Logic uses a Theory of Change approach to articulate the objectives of

the Trial, and to trace the links between program activities and these objectives. The Program Logic clearly specifies hypothesised or desired (as opposed to actual) outcomes.

There are five major components to the Program Logic (see Figure 43). Starting from the left and moving right, we begin with the program inputs. These are the resources and infrastructure that are essential for program activities to occur. The inputs support the program activities – the specific actions that make up the program. These activities will produce or create a series of immediate outputs. The outcomes are the intended changes in the communities as a result of the program. For the purpose of the CDCT, these are divided into short-term outcomes (changes in behaviour, attitudes and perceptions achieved by 3 months of Trial launch), medium-term outcomes (changes in behaviour, attitudes and perceptions achieved by 12 months) and long-term outcomes (changes in state achieved in two or more years). Finally, the Program Logic articulates the intended impact of the CDCT, 'safer families and communities' - as the intended societal change but, like the long-term outcomes, is not included in the scope of the evaluation as it lies beyond the timeframe of the evaluation.

The core causal relationship is presented in the centre of the Theory of Change diagram (see Figure 44). As access to cash is restricted to 20% of Trial participants' income support payments, participants are expected to have less money to purchase alcohol and drugs, as well as to gamble. This restriction is therefore expected to lead to less alcohol consumption, less drug use and less gambling, in both the short- and medium-term. The reduction in alcohol consumption and drug use is expected to lead to less alcohol- and drug-fuelled violence, fewer accidents and fewer injuries. Over time, this process is expected to lead people at the Trial locations feeling safer in their homes and communities and feeling prouder of their communities.

Figure 43: Program Logic – Cashless Debit Card Trial

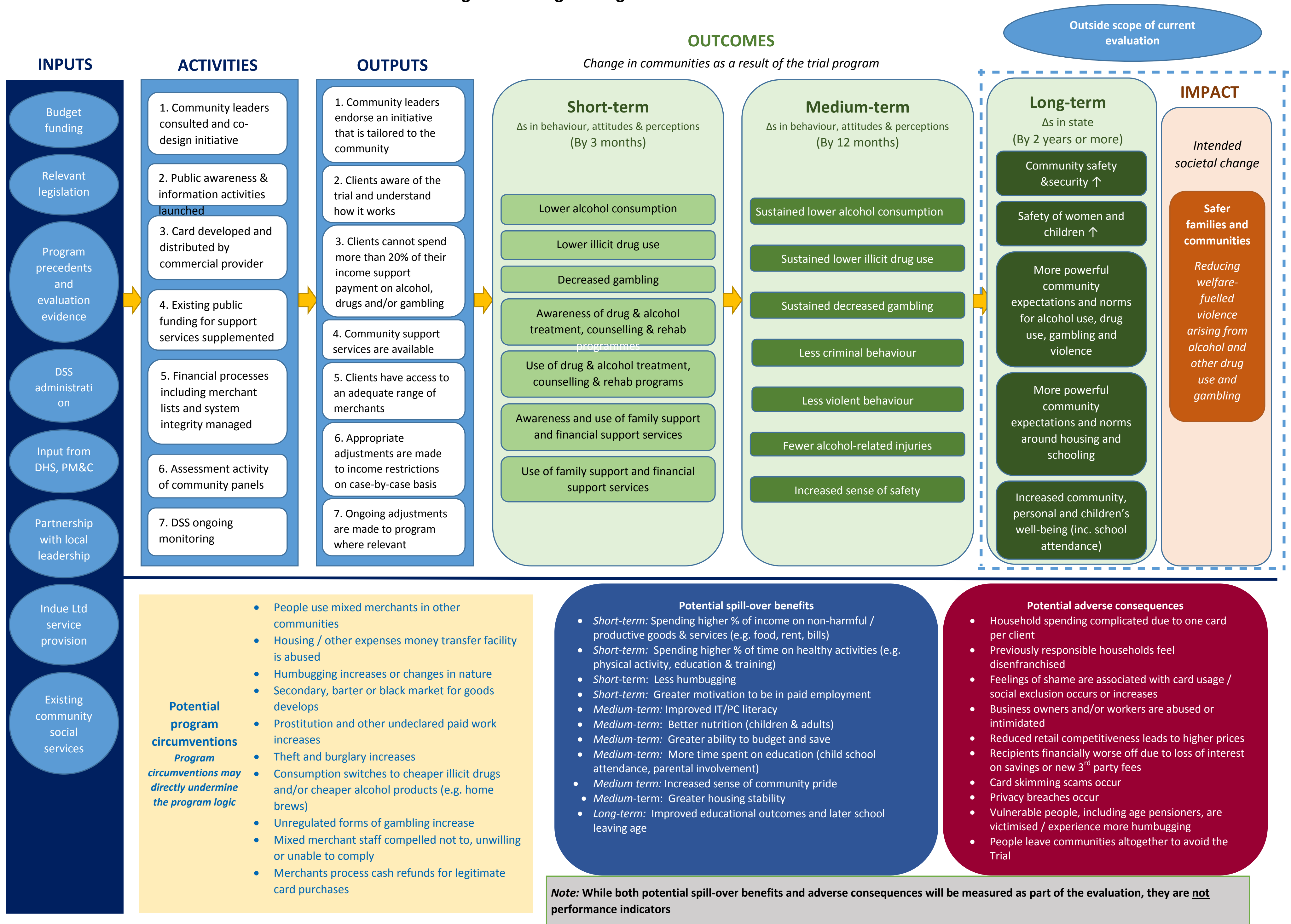
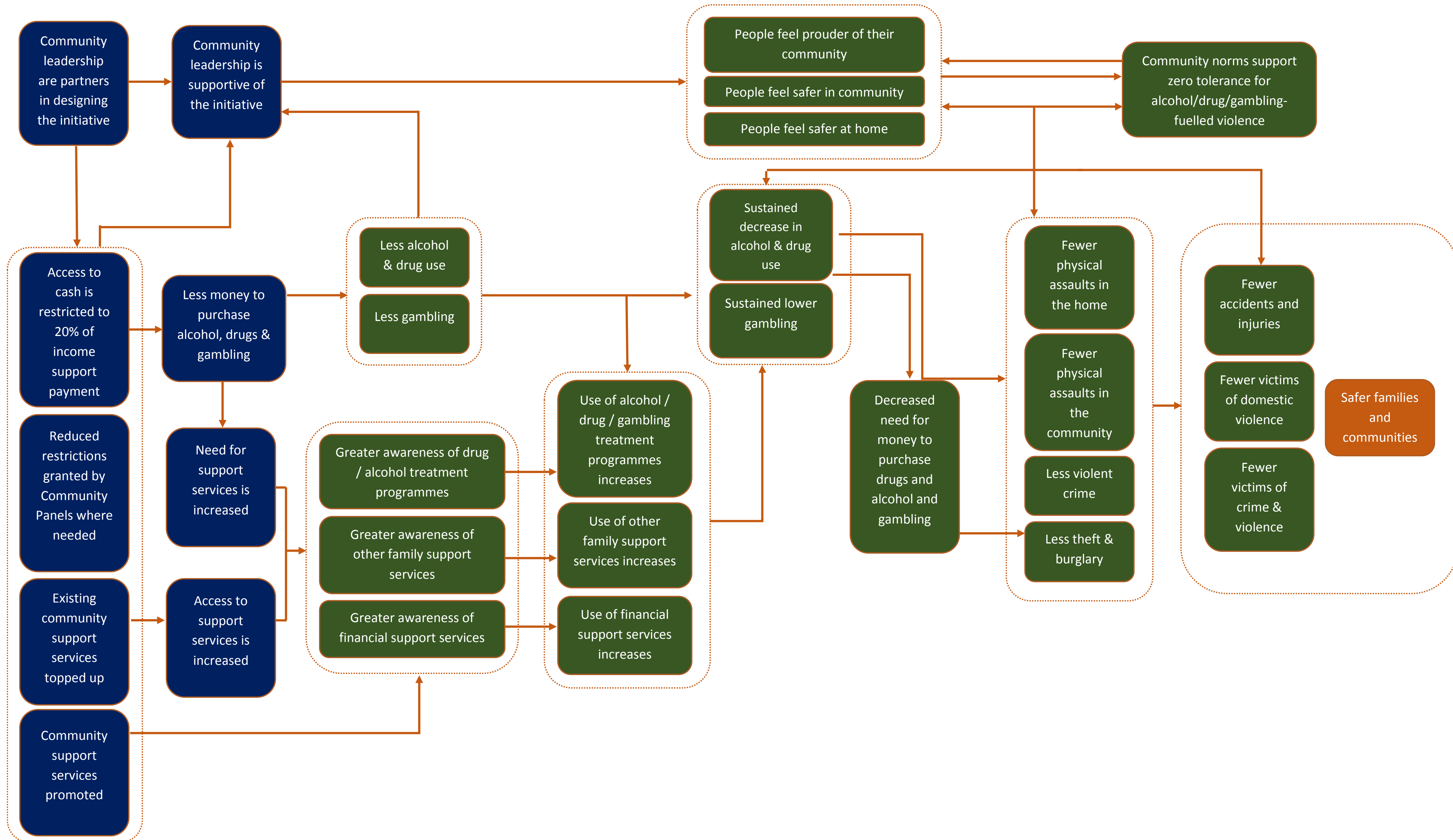


Figure 44: Theory of Change



As highlighted in the Program Logic diagram (Figure 43), ultimately this process is expected to lead to positive long-term outcomes in the areas of improved community safety and general well-being, as well as more powerful community expectations and norms in relation to alcohol use, drug use, gambling, violence, housing and schooling. A key long-term outcome is expected to be greater safety for women and children. Women and children could also benefit in the short-medium term (see potential spill-over benefits in the Program Logic – Cashless Debit Card Trial diagram) from having more money for food, greater housing stability and more parental involvement in children's education.

The Theory of Change diagram also highlights important elements that are expected to support the core process outlined above. These include greater access to community support services (drug and alcohol treatment, family support, financial support), and the partnership / co-design role of community leadership. An important component of the latter role is the ability of local leadership boards to vary an applicant's restricted amount of payment so that it is lower than 80 per cent of their total ISP (but no lower than 50 per cent). This flexibility is expected to build community acceptance of the Trial and to help reduce any unintended adverse effects of the Trial.

In relation to support services, it should be noted that not all Trial participants are expected to access these services and that the Trial is expected to have positive impacts irrespective of the take-up of these services. Further, fewer people using some services in the longer term could indicate Trial success. For example, fewer people may use sobering up services, because they no longer need to.

The CDCT Evaluation Program Logic also makes explicit reference to a series of potential **program circumventions**. These potential circumventions are based on experience with previous IM programs.[62] 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.

Finally, the Program Logic also 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 potential benefits, while premised on previous experience with IM programs, 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. Conversely there are a number of potential **adverse consequences** that could occur as secondary effects. These too will be important to monitor because it is possible for the Trial to create unintended negative consequences while at the same time achieving its stated objectives.

62 See: Deloitte Access Economics (2015) Consolidated Place Based Income Management Evaluation Report 2012-2015, for DSS; DSS Evaluation Hub (2014) A Review of Child Protection Income Management in Western Australia: Final report; ORIMA Research (2010) Evaluation of the Child Protection Scheme of Income Management and Voluntary Income Management Measures in Western Australia, for Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA); Social Policy Research Centre (2010) Evaluation Framework for New Income Management, for FaHCSIA; Social Policy Research Centre (2014) Voluntary Income Management in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, for DSS; Social Policy Research Centre (2014) Evaluating New Income Management in the Northern Territory: Final Evaluation Report, for DSS

3.3 Key Performance Indicators

The Program Logic and the underlying Theory of Change led to the development of a series of Key Performance Indicators (KPIs) that will drive evaluation of the effectiveness of the Cashless Debit Card Trial. The specific KPIs developed for this evaluation are detailed in the following pages.

Figure 45: Performance Indicators

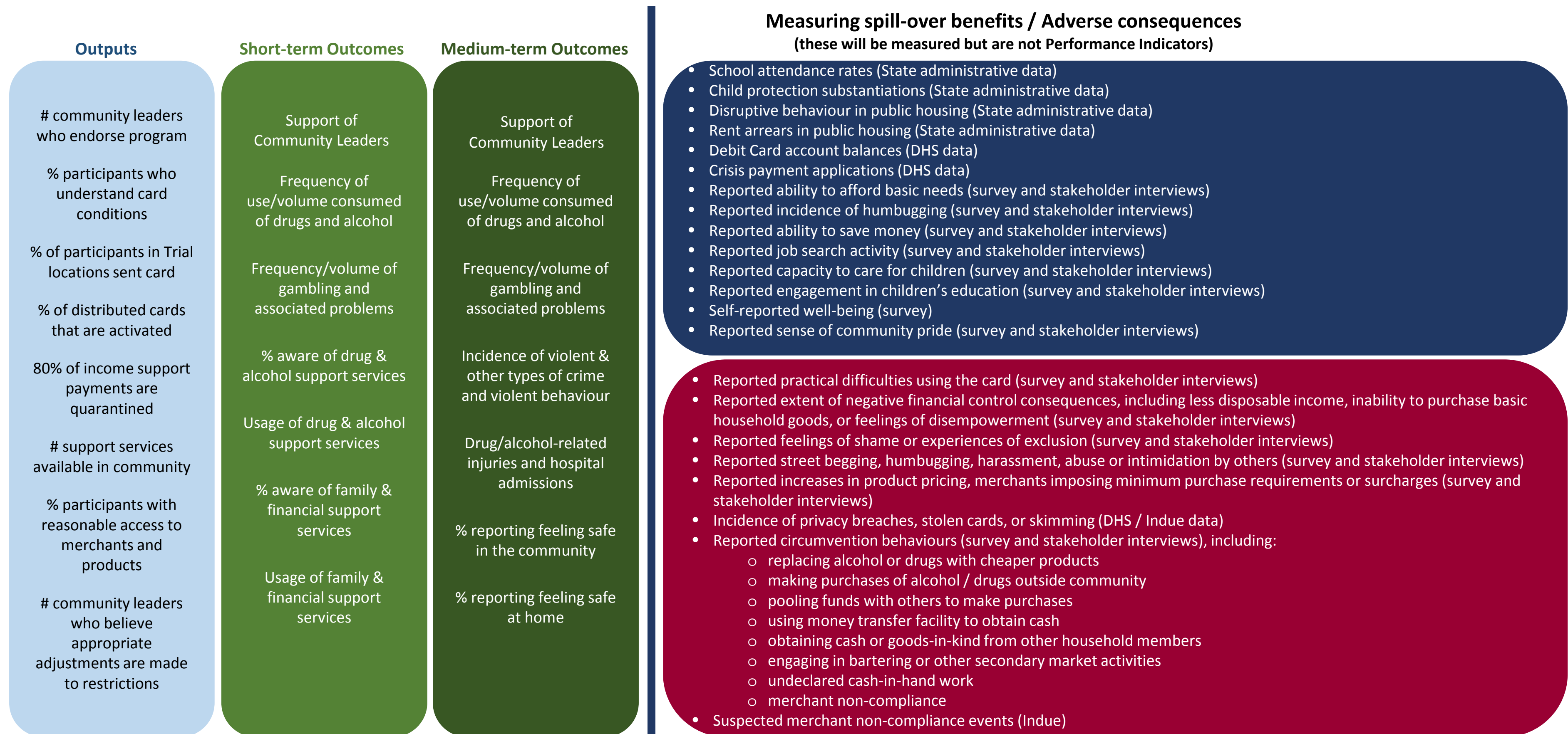


Table 16: Output Performance Indicators

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
Number of community leaders who endorse program	Number of community leaders who: • feel program design is *appropriate* for their community characteristics • believe program will be / is a *good thing* for their community • *speak positively* about program • believe Trial parameters were developed using a co-design approach	Not applicable	Within one month of program launch (initial conditions), repeated at Wave 1 and Wave 2	Qualitative research with community leaders	Community leaders defined as members of regional leadership groups Qualitative indication of number: all, most, many, some, few
% participants who understand card conditions	% of participants who are aware: • How much of 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	Not applicable	Self-reported at Wave 1 and Wave 2	Survey of Trial participants	Not applicable
% of participants in Trial locations sent card	% of compulsory Trial participants sent a debit card	100%	Within two months of program launch	Indue / DHS Client database	Not applicable

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
% of distributed cards that are activated	Of all cards distributed to participants, % of these that are activated	95%	Within one month of receiving card	Indue	5% margin allowed for people moving in and out of income support payments
80% of income support payments are quarantined	Income support payments are quarantined and 20% are received in cash (excluding approved adjustments)	100% of recipients	Within two months of program launch	DHS Client database	Not applicable
# support services available in community	# and type of additional support services in operation as planned	100%	Within three months of program launch	DSS provided	Need for services is expected to develop over the first 3 months of the program
% participants with reasonable access to merchants and products	Excluding the purchase of alcohol and gambling % of participants who agree that they can still shop where and how they usually shop % reporting concerns over access to allowable products	90% 10% maximum	Self-reported at Wave 1	Survey of Trial participants	Not applicable
# community leaders who believe appropriate adjustments are made to income restrictions on a case-by-case basis	Number of community leaders who believe community panels are assessing applications in a timely, consistent and fair manner Number of community leaders who believe community panels are making just and reasonable decisions about changing percentage of welfare payments quarantined	Most	Within one month of program launch (initial conditions), repeated at Wave 1 and Wave 2	Qualitative research with community leaders	Community leaders defined as members of regional leadership groups Qualitative indication of number: all, most, many, some, few

Table 17: Short-term Outcome Performance Indicators[63]

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
Frequency of use /volume consumed of drugs and alcohol	• Number of times alcohol consumed by participants per week • % 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) • % 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	Many	As self-reported at Wave 1	Survey of Trial participants Survey of families Survey of community members Qualitative research with stakeholders	No targets specified for survey data due to absence of baseline (pre Trial) survey 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

63 Following the finalisation of the Evaluation Framework it was agreed that the Support of Community Leaders should also be considered as a short-and-medium-term outcome as well as an output measure. In practice these will be addressed in the Output Performance Indicators section, but their importance as an outcome is noted here.

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
Frequency/volume of gambling and associated problems	• 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 • % of participants indicating that they gamble more than they can afford to lose or borrow money or sell things to gamble • % 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	Many Lower than before Trial	As self-reported at Wave 1	Survey of Trial participants Survey of families Survey of community members Qualitative research with stakeholders	No targets specified for survey data due to absence of baseline (pre Trial) survey For stakeholders, qualitative indication of number: all, most, many, some, few Gambling revenue data only available in SA (not WA)
% aware of drug and alcohol support services	% participants who are aware of drug and alcohol support services available in their community	Not applicable	As self-reported at Wave 1	Survey of Trial participants	No sound evidentiary basis for setting a target
% aware of financial and family support services	% participants who are aware of financial and family support services (including domestic violence support services) available in their community	Not applicable	As self-reported at Wave 1	Survey of Trial participants	No sound evidentiary basis for setting a target
Usage of drug and alcohol support services	• % 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	Higher at Wave 2 than at Wave 1	As self-reported at Wave 1	Survey of Trial participants Department of Social Services	Not applicable

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
	• Number of people in community using services	(statistically significant) Higher than before Trial	Trial period compared with 12 months prior to Trial launch	(based on data from service providers and State Government agencies)	
Usage of financial and family support services	• % of participants who have ever used financial or family support services (including domestic violence support services). • Number of times services used per participant • Intention to / likelihood of using service in future • Number of people in community using services	Higher at Wave 2 than at Wave 1 (statistically significant) Higher than before Trial	As self-reported at Wave 1 Trial period compared with 12 months prior to Trial launch	Survey of Trial participants Department of Social Services (based on data from service providers and State Government agencies)	Not applicable

Table 18: Medium-term Outcome Performance Indicators[64]

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
Frequency of use/volume consumed of drugs and alcohol	See short-term indicators of frequency of use / volume consumed of drugs and alcohol	Frequency/volume not higher at Wave 2 than at Wave 1	Wave 2	Not applicable	Not applicable
Frequency/volume of gambling and associated problems	See short-term indicators of frequency/volume of gambling and associated problems	Frequency/volume not higher at Wave 2 than at Wave 1	Wave 2	Not applicable	Not applicable
Incidence of violent and other types of crime and violent behaviour	• Police reports of assault and burglary offences; drink driving / drug driving; domestic violence incidence reports; drunk and disorderly conduct; outstanding driving and vehicle fines. • % of participants, family members and the general community who report being the victim of crime in the past month • % 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	Lower than before Trial	Trial period compared with 12 months prior to Trial launch As self-reported at Wave 1 and Wave 2	SA and WA Police Surveys of Trial participants, families and community members Qualitative research with stakeholders	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

64 Following the finalisation of the Evaluation Framework it was agreed that the Support of Community Leaders should also be considered as a short-and-medium-term outcome as well as an output measure. In practice these will be addressed in the Output Performance Indicators section, but their importance as an outcome is noted here.

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
	reporting a decrease in violence in the community since commencement of Trial				number: all, most, many, some, few
Drug/alcohol-related injuries and hospital admissions	• Drug / alcohol-related hospital admissions / emergency presentations / sobering up service admissions • % of participants / family members who say they have been injured after drinking alcohol / taking drugs in the last month	Lower than before Trial Not higher at Wave 2 than at Wave 1	Trial period compared with 12 months prior to Trial launch As self-reported at Wave 1 and Wave 2	Department of Premier and Cabinet SA, WA Health, Department of Social Services (based on data provided by local sobering up services) Surveys of Trial participants and families	Not applicable
% reporting feeling safe in the community	% of participants, family members and other community members who report feeling safe in their community	Higher at Wave 2 than at Wave 1 (statistically significant)	As self-reported at Wave 1 and Wave 2	Surveys of Trial participants, families and community members	Not applicable
% reporting feeling safe at home	% of participants, family members and other community members who report feeling safe at	Higher at Wave 2 than at Wave 1 (statistically	As self-reported at Wave 1 and	Surveys of Trial participants, families and	Not applicable

Performance Indicator	Specification	Target	Timeframe	Data Sources	Definitions/comments
	home	significant)	Wave 2	community members	

4. Data Collection Approach

4.1 Introduction

Data collection for the evaluation is based on a multi-staged and multi-method approach including:

1. Three waves of qualitative research with observers / on-the-ground stakeholders (named initial conditions, wave 1 and wave 2);
2. Two waves of quantitative research (termed waves 1 and 2) amongst CDCT participants and their families, as well as non-participant community members; and
3. Collation of administrative data from the Department of Human Services (DHS), Indue Ltd, State Government agencies and local service providers.
4. Ongoing monitoring of the DSS CDCT 'inbox' and hotline.

Prior to commencing data collection, ORIMA Research will visit Ceduna, Kununurra and Wyndham. During the visits we will consult with local community representatives and other relevant stakeholders:

- Regarding the proposed evaluation / research plan and its implementation;
- To gain any feedback and answer questions representatives and other stakeholders have about the evaluation;
- To seek advice about issues such as the nature of the reimbursements to be provided to survey respondents, focus group attendees and individual interview participants; and
- To gain views on the profile of appropriate interviewers to be used by ORIMA Research.

4.2 Qualitative research with on the ground observers/ stakeholders

Interviews and focus groups will be conducted in Kununurra/Wyndham and Ceduna and Surrounds around the time of the Trial launch (as well as at two-post launch points) with relevant observer groups and on-the-ground stakeholders (members of regional leadership groups as well as government and non-government service providers). The initial round of research will be used to gain a detailed understanding of on-the-ground conditions prior to the Trial, as well as gather insights the community and stakeholders might have about the Trial itself. The second and third rounds of research will focus on how the Trial has impacted individuals and the broader community, relating to the area of expertise on which the observers are able and qualified to answer. Stakeholders will be selected for participation in the research based on their capacity to provide informed feedback relevant to the CDCT. Selection will be informed by desk research, the outcomes of the pre-fieldwork consultations and consultations with the Evaluation Steering Committee.

Table 19: Interviews and focus groups with observers / on-the-ground stakeholders

Who will we talk to?	Researched how? How many?	When? (Ceduna / Kununurra / Wyndham)
Observers / on the ground stakeholders: • Regional Leadership Groups; and • Government and non-government service providers	• 4 group discussions • 10 individual interviews	At three points: • Initial conditions (April/May 2016), • Wave 1 (August/September 2016), and • Wave 2 (February/March 2017). (Total 75 people per site, 25 per visit)

4.3 Quantitative research

Two waves of quantitative, face-to-face survey interviews will be undertaken with CDCT participants, family members of CDCT participants and other community members in both CDCT locations. The first wave will occur between August and September 2016, while the second wave will occur between February and March 2017. These interviews will provide information (stated behaviours, perceptions and observations) on the impact of the CDCT on participants, their families and the communities. The survey findings will be analysed in the context of the findings of other evaluation data collection mechanisms and with appropriate regard for the limitations inherent in self-reported, survey-based feedback.

Over the two survey waves, ORIMA Research will conduct a total of 1,350 face-to-face interviews across the two CDCT locations covering a longitudinal sample of CDCT participants and family members (same people interviewed across the two waves) and a non-longitudinal sample of other community members, as shown in the table below.

Table 20: Face-to-face interviews with CDCT participants, families and community members

Who/what	Wave 1 N (August/September)	Wave 2 N (February/March)
CDCT participants	325	200^
CDCT participants' families: • Partners, siblings, significant others	30	20^
Non-participant community members	50	50#
Total/site	N = 405	N = 270
Total across 2 CDCT sites (Ceduna and Kununurra/Wyndham)	N = 810	N = 540

^ Lower N at Wave 2, due to expected attrition
# Independent sample, i.e. not longitudinal

Wave 1 data collection will be conducted as an intercept survey in the vicinity of a range of locations (e.g. outside venues and central meeting points such as the Kununurra Community Resource Centre,

local shopping centres, Centrelink, Ceduna Aboriginal Arts and Cultural/Language Centre, etc.), using a systematic and unbiased selection process: approaching every third or fourth person encountered in each location.

The second wave of research (Wave 2) will be conducted face-to-face, but primarily by appointment as Wave 1 interviewers will collect the contact details of most Wave 1 respondents (CDCT participants and family members) and these will then be followed up at Wave 2. Non-participant community members will be interviewed via an intercept survey in Wave 2 (same approach as in Wave 1).

Initial selection of survey respondents via systematic intercept sampling at neutral public places is the most statistically robust sampling approach that is available for the study. Cultural sensitivities preclude the adoption of a door-to-door household survey. Legal privacy constraints preclude the selection of a probability sample from Department of Human Services (DHS) administrative data on CDCT participants. Lack of access to landline and mobile telephones as well as cultural barriers to participating in a telephone interview mean that probability based sampling from local telephone number listings would lead to considerable statistical coverage bias.

A number of research design features will minimise the extent of coverage bias (i.e. the extent to which members of the target underlying population have a zero probability of selection):

- Overcoming cultural engagement barriers by conducting fieldwork using an interviewing team of local Indigenous interviewers, experienced Indigenous interviewers from outside of the local area (this will address barriers that are likely to arise for some respondents in relation to sharing personal information with local people who may be connected socially with them), and an experienced ORIMA non-Indigenous field manager;
- Selection of appropriate intercept locations based on advice from local stakeholders and pre-fieldwork observation / site inspection by senior ORIMA personnel;
- In each fieldwork location a marquee will be set-up for interviews to be conducted in an environment that maximises interviewer and interviewee privacy, safety and confidentiality (this will minimise barriers that may arise due to fear of lack of privacy or harassment as a result of participating in the survey);
- Promotion of the value and bona fides of the survey via pre-fieldwork communications (via local community organisations and service providers); and
- Conducting the survey fieldwork over a two-week period in each location, which will minimise the risk of failing to provide an opportunity for members of the target population to come across the interviewing team.

Identity and contact information will be obtained from survey respondents in the first wave of the survey (primarily to enable follow-up interviews in the second wave for CDCT participants and family members of CDCT participants). This information will be verified via inspection of a form of proof of identification (e.g. debit card or driver's licence). This measure will minimise the risk of people attempting to participate in the survey on more than one occasion in each wave of the survey. In addition, at the data processing stage, survey responses will be checked for duplicate identification details and any duplicates identified will be removed from analysis.

Notwithstanding the abovementioned measures it is likely that the sample selection process will produce a degree of sample selection bias (in the sense that the probability of selection will differ across the target population). In addition, it is expected that there may be differential non-response rates among different groups within the target population. We will control for these issues at the data analysis stage via weighting the raw survey results using population parameters obtained from

DHS administrative data and ABS population data. This form of weighting (known as calibration) will effectively deal with these issues and associated measurement biases (at the cost of a reduction in effective sample size – i.e. higher degree of sampling error / lower level of statistical precision).

The sample sizes for the study have been selected based on the following considerations:

- Available resources and constraints;
- Requirement to obtain statistically precise findings in relation to CDCT participants:
  - at the aggregate level (i.e. estimates relating to the total CDCT participant population);
  - at the level of each of the CDCT sites (Ceduna and Kununurra/Wyndham) – with each site of separate and equal analytical importance;
  - separately for men and women; and
  - separately for Indigenous and non-Indigenous participants;
- Requirement to obtain indicative (unbiased but not statistically precise) findings in relation to CDCT participants' families and other community members; and
- Desirability of minimising the overall study burden placed on CDCT participants, their families and their local communities.

Recruitment and training of interviewers

ORIMA Research will deploy an interview team at each location that will comprise:

- ORIMA's fieldwork manager (a highly experienced non-Indigenous person);
- Two experienced interviewers from ORIMA's specialised Indigenous interviewers who are not based in the CDCT communities (both are Indigenous people); and
- Two Indigenous people recruited from the local community and trained for the purposes of this project.

By having a mixed team of existing and new interviewers, we will provide a supportive environment for our interviewers to share learnings, experiences and strategies to facilitate skill development and minimise any challenges and potential harm from the interview process. Our existing interviewers are older, well respected community members and have considerable interview experience.

To recruit local Indigenous interviewers, ORIMA Research will actively network with community-based groups within the region(s) where the interviewing is required.

ORIMA Research will conduct initial training with all new fieldworkers following their selection from the recruitment process. As a minimum, training will include:

- the general principles of market, opinion and social research;
- ethical requirements, including respondent safeguards and data protection issues;
- the treatment of children or any vulnerable respondents they may encounter;
- interviewing skills and/or other relevant techniques; and
- interview role playing.

The ORIMA Research fieldwork manager will accompany interviewers on each day of fieldwork with feedback provided to the interviewers as required.

Initial training will last for at least six hours and will cover:

- a structured training session that covers the points described above;
- tablet operations and software training;
- practice interviews with other interviewers or ORIMA Research staff; and
- coaching (including conducting interviews that are observed by the ORIMA data collection manager).

Fieldwork management

In each fieldwork location a marquee will be set-up for interviews to be conducted in an environment that maximises interviewer and interviewee privacy, safety and confidentiality. Such a process ensures that both interviewers and interviewees are not easily visible or identifiable to the wider community. Interviews will be conducted via Computer Assisted Personal Interviewing (CAPI), whereby answers to interview questions will be entered into a tablet computer by the interviewers.

Our procedures will include:

- Conducting a full-day training workshop at each survey site for the interviewing team;
- Having our highly experienced national fieldwork manager for initial and on-going interviewer training as well as support throughout the fieldwork;
- Interviewers will be observed in field and receive feedback from validation of their work (a minimum of 10% of interviews will be observed by our fieldwork manager);
- Conducting daily briefings to ensure that any potential issues or concerns are proactively addressed and allowing opportunities for feedback on skill enhancement/development;
- Conducting an end of fieldwork debriefing process which incorporates strategies for addressing any current and anticipated sensitivities and concerns (e.g. how to deal with interviewees who may raise the subject matter with interviewers after the fieldwork period); and
- Having an established network of supportive relationships with key community leaders and stakeholders on-the-ground for our interviewers to access on a needs basis.

Interviewers will be supplied with:

- an ORIMA ID, which includes a validity period and the contact details for ORIMA Research;
- a tablet computer on which to conduct interviews; and
- brief notes, a hard copy questionnaire, information sheets on support services available at each site and reimbursements.

For each wave of research, respondents will receive a voucher to compensate them for their time ($30 value in Wave 1 and $50 value in Wave 2). The vouchers will be sourced from local services. For example, in Oak Valley we have arranged for the vouchers to be provided through the Oak Valley Outback store to enable purchase of items from this local store. Similarly, in other locations we plan to use local food stores and services for the provision of these vouchers.

4.4 Collation and analysis of administrative data

ORIMA Research will collate and conduct analysis of relevant administrative / secondary data. Wherever possible, the data will be compared at two time points – at Baseline (12 months prior to Trial launch) and at Wave 2 (10-12 months into the Trial), i.e. a pre-post Trial comparison. A listing of

data sources and key areas of interest is shown in the table below and reflects the earlier outlined KPIs and indicators of potential spill-over benefits and adverse consequences.

Table 21: Analysis of Administrative / secondary data

How/What	When / Evaluation phase
Analysis of administrative / secondary data:	
• DHS data on proportion of income support payments to Trial participants that are quarantined and number of crisis payment applications	Collated throughout Trial period
• Indue (card provider) data on activation and usage of the card, including account balances	Collated throughout Trial period
• Data collated by DSS from State and NGO service providers on number of people using drug and alcohol support services and family/financial support services	
• Available State Government data. For example: – Police reports of assault and burglary offences; drink driving / drug driving; domestic violence incidence reports; drunk and disorderly conduct; outstanding driving and vehicle fines. – School attendance rates – Child protection substantiations – Disruptive behaviour in public housing – Rent arrears in public housing – Drug / alcohol-related hospital admissions / emergency presentations / sobering up service admissions	Collated and compared at two points: • Baseline (12 months preceding the Trial) • Wave 2 (10-12 months post-launch)

CDCT Comparison Sites

Movements in statistics (e.g. changes in drug / alcohol-related hospital admissions) that will be used in assessing the impact of the CDCT could occur due to either the impact of the CDCT or other (external) factors (e.g. decrease in the general availability of certain kinds of illicit drugs in Australia). In order to assess the possible impact of these external factors (so as to better estimate the impact of the CDCT), wherever possible, movements in Trial site statistics will be compared with those in comparable locations where the CDCT has not been implemented. The latter will provide an indication of what would have happened in the Trial sites in the absence of the CDCT.

These comparison sites do not represent perfect "control sites" and differences in movement of community statistics over the CDCT period cannot be solely attributed to the impact of the CDCT. Nevertheless, it is the intention that these comparison sites be similar in character to the CDCT sites (in terms of underlying demographic and socio-economic characteristics) and that comparing the movement in community statistics of the CDCT and comparison sites would usefully supplement the other information gathered over the course of the evaluation.

The South Australian and Western Australian State Governments have suggested comparison areas for Ceduna and Surrounds and the East Kimberley (or Kununurra/Wyndham), respectively, and have agreed to provide relevant data for these comparison areas. In particular:

- the South Australian State Government has suggested that Coober Pedy and Port Augusta be used as comparison sites for the Ceduna and Surrounds CDCT site; and
- the Western Australian State Government has suggested that Derby be used as the comparison site for the East Kimberley CDCT site.

We consider that the proposed comparison sites are appropriate given that they are similar in character to the CDCT sites in terms of underlying demographic and socio-economic characteristics.

In terms of the South Australian CDCT and comparison sites, in 2011:

- Ceduna had a usual resident population of approximately 4,200, of which approximately 30% were Indigenous;
- Coober Pedy had a usual resident population of approximately 1,500, of which approximately 20% were Indigenous; and
- Port Augusta had a usual resident population of approximately 13,000, of which approximately 20% were Indigenous.

The Socio-Economic Indexes for Areas (SEIFA, based on 2011 Census data) for Ceduna, Coober Pedy and Port Augusta indicate that all are relatively disadvantaged. All three have similar proportions of the population who are Indigenous. However, compared to Ceduna, Coober Pedy has less than half the population, while Port Augusta has almost four times the population. Although local issues facing these three communities differ, Coober Pedy has similar liquor restrictions in place as Ceduna. We consider that Coober Pedy would serve as an appropriate primary comparison site for Ceduna and Port Augusta could serve as a useful secondary comparison site. Having a secondary site may assist where data for the primary site (Coober Pedy) is unavailable, unreliable and/or not suitable for comparison purposes. Moreover, Port Augusta has a range of similar services (e.g. Sobering Up unit) as Ceduna, potentially making extra comparison data available.

In terms of the Western Australian CDCT and comparison sites, in 2011:

- Kununurra had a usual resident population of approximately 7,800, of which approximately 40% were Indigenous; and
- Derby had a usual resident population of approximately 3,300, of which approximately 45% were Indigenous.

Geographically, Derby and Kununurra are both located in the Kimberley region of WA. Kununurra and Derby are both relatively disadvantaged with similar SEIFA values. Taken in conjunction with their geographic proximity and Indigenous population ratios, this indicates that Derby represents a reasonable comparison site for the Kununurra CDCT site.

One of the important considerations for the evaluation will be the question of 'attribution' of any changes observed to the CDCT. The research design is intended to yield a range of data which, collectively, will reveal if there has been a change in the trial communities. The comparison sites will assist in interpreting any such changes and understanding whether they are broader effects that just happen to affect the trial communities, or localised to the area where the trial is occurring.

The Trial sites involve both the introduction of the cashless debit card itself, but also the increased provision of support services. This makes it more difficult to identify what is the impact (if any) of the debit card, what is the impact of the additional services, and what is the impact of the combination. As there are no comparison sites where only one or the other of the interventions has been trialled, we need to use more indirect ways to tease out the distinction. Qualitative information will assist this, and this will be supported by administrative data about service use which is made available to the evaluation. However, the main way of examining the effect of the debit card itself may ultimately come from examining any differences between CDCT participants in the survey who have used or not used the services available.

5. Timing of evaluation reporting

Key reporting milestones are as follows:

- An Initial Conditions report by July 2016;
- A Wave 1 Interim Report by December 2016;
- A Wave 2 Interim Report by May 2017; and
- A Final Report by June 2017.

6. Challenges in evaluating the Cashless Debit Card Trial

All evaluations face a number of conceptual and practical challenges that need to be addressed in order to observe processes and measure impacts accurately. This evaluation presents a number of significant challenges, some of which are generic to Indigenous research, while others are particular to the income payment quarantining context. Below we have outlined some of the main challenges we foresee, taking into account the contextual environment and objectives of the evaluation.[65]

Table 22: Key challenges and considerations specific to the project

Challenge/ consideration	How we will address this challenge / consideration
Maintaining sensitivity with at-risk families	This project will need to be highly sensitive to issues of perceived coercion and government and research intrusion into families' time and personal environment. For both Indigenous and non-Indigenous families, the evaluation will need to be responsive to factors such as socio-demographic characteristics, previous experience with government agencies, and potentially low engagement with social research.
Ensuring independence between the evaluator and the Trial design and implementation teams	At all times, the ORIMA Research analysis and reporting team will remain at arm's length from the design and program implementation teams. All liaison and necessary communication will be conducted via the Department's Evaluation Unit which is responsible for managing the evaluation within DSS and / or the Department's on the ground contact officers. Issues identified by ORIMA Research around Trial implementation and the Debit Card program will be raised directly with the Department and any response / further communication with the program implementation and design teams will be left strictly to the Department.
Logistical challenges of the research fieldwork	The need for the evaluation to stand up to robust scrutiny and to ascertain differences between audience segments will demand a substantial evaluation program in terms of sample size across both locations. The fact that much of the research fieldwork will need to be undertaken in the East Kimberley (which is largely inaccessible during the wet season) adds a further element of logistical difficulty to the evaluation. The resource demands of the project will be compounded by the geographic remoteness of the research locations, and consequent time-consuming nature of travel to, from and within these areas. Furthermore, based on prior experience, we expect that in these

65 This chapter has been informed by the following income management program evaluation reports: Deloitte Access Economics (2015) Consolidated Place Based Income Management Evaluation Report 2012-2015, for DSS; DSS Evaluation Hub (2014) A Review of Child Protection Income Management in Western Australia: Final report; ORIMA Research (2010) Evaluation of the Child Protection Scheme of Income Management and Voluntary Income Management Measures in Western Australia, for Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA); Social Policy Research Centre (2010) Evaluation Framework for New Income Management, for FaHCSIA; Social Policy Research Centre (2014) Voluntary Income Management in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, for DSS; Social Policy Research Centre (2014) Evaluating New Income Management in the Northern Territory: Final Evaluation Report, for DSS.

Challenge/ consideration	How we will address this challenge / consideration
	areas significant time will be spent building rapport in communities prior to conducting fieldwork, as well as in unplanned for 'downtime'. Considerable time, effort and logistical resources will therefore need to be brought to bear to successfully arrange and conduct the evaluation program in the time available. These factors have, in part, informed our decision to recruit local field workers and interviewers.
The sensitivity of the subject matter	From our experience with similar evaluations, as well as with other studies targeting income support recipients, it is clear that collecting representative information from all of the target audiences in this evaluation will present a challenge. Financial matters can be sensitive for some people to discuss – overlaying these issues with cultural factors in relation to gender roles, child neglect issues and the historically often difficult relationship between Indigenous communities and government, creates a potentially difficult mix. These issues should not be avoided, but rather recognised and dealt with appropriately to ensure the research design and data collection approaches are developed so as to ensure these issues do not obstruct the collection of high quality, reliable data or create any additional discomfort for the community and individuals involved. In addition to evaluation design issues, a sound understanding of the multiple factors 'external' to the CDC Trial itself, but nevertheless capable of impacting on the evaluation outcomes, will be vital. For instance, it will be critical for the researchers involved in conducting the qualitative research to establish credibility in the areas of questioning in order to have a robust dialogue that will elicit rich and detailed information from participants. This in turn will depend on the evaluation team having an understanding of the broader issues in relation to Indigenous welfare and disadvantage in general and welfare quarantining in particular, so that the collection, synthesis and interpretation of data and the subsequent development of recommendations is appropriate and comprehensive.
Difficulty of 'attribution' and isolating Trial impact on participants from impact of other concurrent factors	One of ORIMA Research's responses to this challenge is to deploy a number of independent data sources on trial impact and participant experiences. If all or most data sources are pointing to a specific set of conclusions, it provides stronger evidence of impact than one data source. Thus, survey feedback from Trial participants, feedback from local leaders and stakeholders, and administrative data will all be deployed to assess both total and disaggregated impact of all the Trial and non-Trial changes taking place in local communities. Administrative data will also be compared against corresponding data in appropriate non-trial or comparison areas in SA and WA to help assess the impact of non-CDCT factors on movements in Trial site statistics. The evaluation will therefore use several sources of complementary qualitative and quantitative information and will 'triangulate' the data sources to both verify the consistency of data collected, and to understand the potential impact and contribution of other factors on

Challenge/ consideration	How we will address this challenge / consideration
	the Trial sites and the participants. Using a longitudinal data collection approach means we can isolate the impact of the CDCT on Trial participants on a 'case-by-case' basis. Self-reports from individuals on the Trial will tell us what they are doing and experiencing in response to the Trial itself and what, if any, changes in their lives are taking place in response to provision of new support services for example. These self-reports will of course be checked on an aggregate level when we look at service usage data. All these 'case studies' will then be 'aggregated up' to give us a clear picture of precisely what (in the mix of changes taking place in each Trial community) is and is not impacting on Trial participants (as well those not on the Trial). This approach is important for the evaluation in order to assess and isolate the individual contribution of the Debit Card to individual and community functioning, while simultaneously acknowledging and isolating other factors.
Developing practical strategies and recommendations to inform any future rollout of income quarantining programs	Notwithstanding the complexity of the contextual environment within which the evaluation is being conducted, the success of the evaluation program will hinge on the evaluation team's effectiveness in being able to clearly and succinctly synthesise, interpret and analyse the feedback elicited from respondents. The ability to subsequently develop practical, clear guidance to inform the evaluation and potential subsequent rollout of CDCT on a broader basis will be a critical success factor. The lessons learned from previous complex evaluations have informed the design of and our overall approach to this evaluation.

Table 23: Generic challenges and considerations

Challenge/ consideration	How we will address this challenge / consideration
Maintaining engagement and involvement of all stakeholder agencies	Due to the range of stakeholders involved in this project, maintaining communication, awareness and engagement will be critical to the project's success. Clear lines of reporting between the Departmental project team, consultancy team and other stakeholders will be essential and all stakeholders will need to have a shared understanding of the roles of the different agencies and their staff.
Questionnaire and discussion guide techniques do not answer objectives	The very high level of questionnaire and discussion guide design experience within ORIMA Research makes it unlikely that there will be any serious problems with wording or design of the evaluation materials. The survey and discussion guides will be drafted by senior members of the project team and overseen by the project manager, to ensure they meet need and facilitate participation across a spectrum of the interview and group participants.
Outputs do not meet the Department and Steering Committee's expectations	Ongoing communication with the Department and an effective inception / start-up workshop will be critical to ensuring that the deliverables meet expectations. We feel that the amount of contact we will have with the Department throughout this project will ensure that our outputs meet expectations. All outputs will be submitted in draft

Challenge/ consideration	How we will address this challenge / consideration
	form to be agreed with the Department and the frequent contact up to this point means the Department will already have a good understanding of the emerging findings. In addition, each deliverable is subject to Quality Assurance and oversight from at least one Director of ORIMA Research. In this case, Szymon Duniec will provide both strategic project oversight and approve all deliverables prior to these being forwarded to the Department. This is another significant step in our approach to minimising risks of any project.
Timetable slippage	A strong evaluation team has been assembled with individual roles defined, led by a highly experienced and senior Associate Partner. The scale of ORIMA Research resources also means that this is not a serious risk. Adequate moderating and interviewing resources will be allocated to ensure that fieldwork is finished to schedule. In addition, ensuring high quality recruitment at the outset will assist in delivering the quantitative fieldwork within the required timeframe. The timetable we have proposed is achievable but is contingent on all parties adhering to milestone dates. In meeting our commitment to the timetable we will provide regular updates to the Department on progress vs milestones achieved and monitor fieldwork closely. We aim for transparency with our stakeholders so that if problems with the timetable emerged, these will be shared. There would be three main recovery options depending on the reason for the slippage: • Increasing the size of the project team; • Drawing additional resources on tasks such as discussion guide and data analysis or report writing; and • Assigning more senior resources to the team if the timetable slippage is due to unforeseen circumstances.

Appendix B: Organisations interviewed and contacted in qualitative research

Ceduna and Surrounds

Participating organisations[66]:

Aboriginal Drug and Alcohol Corporation

Aboriginal Family Support Services

Betta Electrical

Bill's Pizza & Pasta Shop

Ceduna Aboriginal Corporation

Ceduna Area School

Ceduna Hospital

Ceduna Koonibba Aboriginal Health Service

Ceduna Youth Club

Centacare

Complete Personnel

Department of Prime Minister and Cabinet

District Council of Ceduna

Families South Australia

Foodland

Homescene

IGA Thevenard

Joanna's Op Shop

Life Without Barriers

Ngura Yadurirn Child and Family Centre

Oak Valley Incorporated (Maralinga)

Save the children

Scotdesco

South Australia Police

Visitor Info Centre

Yalata Community

Yalata Outback Store

Declined invitation to participate:

66 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=3 organisations from Ceduna did not consent to being identified.

Ceduna Foreshore Motel

Eyre Futures

Contacted[67] but not reached / unavailable during fieldwork period:

Aboriginal Legal Rights Movement

Ceduna District Health Services

Department of Communities and Social Inclusion

Family Violence Legal Service

Far West Coast Aboriginal Corporation

Housing South Australia

Koonibba Community

Mobile Assistance Patrol

Oak Valley Aboriginal School

Oak Valley Health Clinic

South Australia Ambulance Service

South Australian National Football League

Step Down Unit, Ceduna Hospital

Tullawon Health Service

East Kimberley

Kununurra

Participating organisations[68]:

Department of Child Protection and Family Services

Department of Corrective Services Youth Justice

Department of Prime Minister and Cabinet

East Kimberley Chamber of Commerce and Industry

Grab-A-Bargain Variety Store

Gulliver's Tavern

Kimberley Mental Health Drug Service

Kununurra District Hospital

Nirrumbuk Environmental Health

Ord Valley Aboriginal Health Service

67 Organisations were contacted to participate at least three times.

68. 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=2 organisations from Kununurra did not consent to being identified.

Regional Services Reform Unit

Save the Children

Shire of Wyndham East Kimberley

Target Kununurra

Tuckerbox Stores

V A Fashions Kununurra

Visitor Information Centre

Waringarri Aboriginal Corporation

Western Australia Housing

Western Australian Department of Regional Development

Western Australia Police

Department of Aboriginal Affairs

St John's Ambulance

MG Corporation

Declined invitation to participate:

Department of the Attorney General Western Australia

Contacted[69] but not reached / unavailable during fieldwork period:

Aboriginal Legal Service

Kununurra District High School

Kununurra Women's Crisis Centre

Wyndham

Participating organisations[70]:

East Kimberley Job Pathways

Joongarri House

Ngowner Aerwah Aboriginal Corporation

Seven Mile Residential Rehabilitation Facility

Shire of Wyndham East Kimberley

Wyndham District High School

Wyndham Early Learning Activity Centre

Wyndham Supermarket

69 Organisations were contacted to participate at least three times.

70. 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=3 organisations from Wyndham did not consent to being identified.

Contacted[71] but not reached / unavailable during fieldwork period:

Wyndham Community Club

Wunan Foundation Support Services

Wyndham District Hospital

71 Organisations were contacted to participate at least three times.

Appendix C: Technical report

Overview

The Cashless Debit Card Trial (CDCT) evaluation methodology was developed collaboratively by the evaluators (ORIMA Research) and the Department of Social Services (DSS), and in consultation with an Expert Panel and Steering Committee convened by the Department. The final methodology reflected a combination of best-practice research and evaluation principles, and the practical constraints of the CDCT context. These included the timing of the evaluation being limited to only commencing after the CDCT itself, and the characteristics and locations of the trial sites (Ceduna and surrounds in South Australia, and the East Kimberley region of Western Australia).

The final methodology was reviewed and approved by Bellberry, an accredited Human Rights Ethics Committee (HREC). The project was conducted in accordance with international quality standard ISO 20252 and the Australian Privacy Principles contained in the *Privacy Act 1988 (Cth)*.

The evaluation period covered approximately the first year of the CDCT. Three sources of data were integrated into the design – two being primary data generated directly by the evaluation, and one being secondary data available to supplement them.

1. Quantitative data generated from a systematic intercept survey of participants and other community members (family members of participants, and general community members);
2. Qualitative research interviews and focus groups with community leaders and stakeholders; and
3. Administrative data provided to ORIMA Research by the Department of Social Services (DSS).

These three sources each have relative strengths and limitations, and are used in combination to triangulate evidence and guide conclusions.

Primary data collection took place in the trial sites on three occasions:

	Approximate Timing	Research conducted	Role
1	First month of the CDCT *April - May 2016*	**Qualitative only**	Provide insight into the "Initial Conditions" of the trial
2	~ 6 months into the trial *August – October 2016*	**Qualitative plus quantitative surveying**	Interim evaluation of the immediate impact of the CDCT
3	~ 14 months into the trial *May – June 2017*	**Qualitative plus quantitative surveying**	Final evaluation of the impact of the initial CDCT implementation

Quantitative Survey Methodology

The quantitative survey data was collected by ORIMA Research's Indigenous Field Force. While neither the CDCT nor the two trial locations are specifically Indigenous, both sites have large Indigenous populations, and in both cases a majority of the trial participants are Indigenous. Interviewing Indigenous Australians requires a cultural sensitivity, as well as interviewing skills, and the Indigenous Field Force offered an appropriately skilled and culturally-appropriate capability for effectively collecting survey data from both Indigenous and non-Indigenous members of the trial communities.

Data Collection

All survey data was collected in face-to-face CAPI[72] interviews. Trained interviewers administered the relevant questionnaire using a tablet computer. CAPI interviews allow surveys to be automatically tailored to each respondent, with the program managing the routing through the survey to ensure only relevant questions are asked, and in places customising the survey wordings based on previous answers.

Sampling

While theoretically a sample frame of CDCT participants could be produced for the evaluation, the nature of the populations and the trial communities meant that a phone or online survey would not be expected to yield a suitably representative sample. Instead, a systematic intercept methodology was selected as being the most practical solution to obtain a large and robust sample of CDCT participants.

Interviewers worked in teams of two or three, and were stationed at the highest and most central foot-traffic locations in the trial sites (typically outside the main supermarkets, plus other central locations where community members congregated or moved through). Interview teams also visited Indigenous communities in the wider trial site regions where there were participants, though residents of these and other communities were also frequently encountered in the main townships. Specific locations used in included:

> Ceduna: Ceduna Memorial Hall, Poynton St; Foodland Supermarket, Poynton St; IGA Thevenard; Oak Valley Community; and Yalata Community
>
> East Kimberley: Kununurra shopping centre; White Gum Park, IGA and surrounding streets; Nullywah; Mirima; Glen Hill; Cockatoo Springs and Wyndham

In whatever location they were operating except the out-of-town communities, interviewers identified a particular landmark, and then approached every Xth person who passed that spot and requested an interview. During periods of moderate to high traffic volume, every 5th person was approached, but during periods of lower traffic this was reduced to every 4th or 3rd person in order to maintain a sufficient flow of interviewing to achieve overall target numbers. This systematic process allows a level of random selection into the sampling which enhances the capacity of the final sample to be projected to the wider population. People who approached the interviewers asking to participate were turned away unless they were also the targeted Xth person and therefore eligible to participate.

People who agreed to participate were then asked to provide a form of identification. This information was used to prevent individuals from being interviewed more than once (and also to confirm participation in Wave 1 during the Wave 2 survey). Selected respondents who did not have ID were invited to return to complete the survey with ID during the field process. Once the ID was recorded, respondents were given an information sheet about the survey and completed an informed consent form.

Three cohorts of respondents were interviewed in Wave 1 – CDCT participants, family members of a CDCT participant, and non-CDCT participants who were also unrelated to a participant. Family members were not interviewed in Wave 2. Screening into the correct cohort took place in the initial

72 Computer Assisted Personal Interviewing

questions of the survey, and the survey path to be completed was customised to the respondent. Once the smaller sample size quotas were filled, potential respondents screened out of the survey. No quotas were applied to the demographics of the survey respondents, but weighting was applied to the raw data from CDCT participants to correct any imbalances between the raw sample and the known population.

In Wave 2, CDCT participants who had been surveyed in Wave 1 were attempted to be resurveyed, to provide a longitudinal sample. All respondents who had provided contact details in Wave 1 (44% of respondents in Ceduna and 48% in EK) were contacted by phone in the days immediately before and during the field period, and respondents invited to come and be resurveyed. Respondents needed to produce matching ID to be re-interviewed.

All respondents were given a voucher to a local business to thank them for their time and to encourage participation in the survey. Vouchers were primarily to supermarkets, as suitable businesses needed to provide a range of products under the voucher value, and not allow access to purchasing alcohol or gambling products. All vouchers were for $30, except for the CDCT participants re-interviewed in Wave 2, who received a $50 voucher (to encourage participation to boost the longitudinal sample).

Questionnaires

The primary questionnaire was the CDCT participant questionnaire. Once finalised (approved by both the Department and the HREC), derivatives were developed for family members (Wave 1) and non-participant members of the community (Wave 1 and 2). Only very minor edits to ensure appropriate wordings and relevance were made to the questionnaires used in Wave 2, to maximise comparability between the results from the two waves. Wave 1 and 2 questionnaires are provided in Appendix D.

Average survey duration (Mins)	**Ceduna**	**East Kimberley**	**Total**
Wave 1			
Participants	16:25	19:48	**18:06**
Family	12:57	14:30	**13:43**
Non-participants	12:31	10:47	**11:39**
Wave 2			
Participants	21:32	16:24	**18:58**
Non-participants	12:03	11:02	**11:32**

For participants the average duration of the interviews was around 18 minutes in Wave 1, and around 19 minutes in Wave 2. The family members' survey was shorter at nearly 14 minutes (Wave 1 only), while non-participant community members had the shortest surveys at just under 12 minutes in both Wave 1 and Wave 2.

Timing

Interviewing was conducted over an extended period at each site, in each Wave. This meant that a wider range of community members were likely to be picked up the survey sampling, including surveying at least once on every day of the week, and by extending into a second week, some people who only visit the survey location areas less frequently.

Survey Dates	Ceduna	East Kimberley
Wave 1	17-28 August 2016	12-23 September 2016
Wave 2	22-31 May 2017	12-20 June 2017

Sample sizes

Despite their different populations and number of CDCT participants, the original evaluation plan identified balanced target sample sizes across the two Trial sites, reflecting their equal importance in terms of assessing Trial effectiveness. While it was recognised that this would provide more precise overall statistical estimates for the smaller Trial site (Ceduna and Surrounds), this balanced approach was adopted to maximise the ability for robust drill-down analysis to CDCT participant sub-groups at each site. The small family samples were included to provide a 'red flag' for any major impacts on family members, especially at Wave 1. Planned participant and family sample sizes were lower in Wave 2 to allow for attrition between the two waves (i.e.: people interviewed at Wave 1 who were not able to be interviewed at Wave 2). This reflected an initial wholly longitudinal design for the participant and family surveys. In contrast, the non-participant survey sample sizes were set at the same level in Wave 1 and Wave 2, reflecting the fact that this survey was not longitudinal (i.e. fresh samples were taken in each wave).

Target Survey Sample Sizes	Wave 1				Wave 2			
	Participants	Family members	Non-participants	**Total**	Participants	Family members	Non-participants	**Total**
Ceduna	325	30	50	**405**	200	20	50	**270**
EK	325	30	50	**405**	200	20	50	**270**
Total	**650**	**60**	**100**	**810**	**400**	**40**	**100**	**640**

Ultimately, a total of 1,360 interviews were conducted across the two CDCT sites and the two waves of surveying (compared to a total of 1,350 in the original targets).

In Wave 1, only 44% of CDCT participants interviewed in Ceduna and 48% in EK were able to give valid contact details to be re-contacted for Wave 2. This was insufficient to fully meet the overall evaluation targets, and so these needed to be supplemented with additional 'new' participant interviews obtained using the systematic-intercept method originally used in Wave 1. Ultimately 28% of CDCT participants interviewed in Wave 2 in both sites were re-interviews (additional analysis is conducted using this sub-sample).

The small family member sample was dropped in Wave 2, with those interviews re-directed to boosting the number of non-participants who were interviewed. This was done because it was assessed that greater analytical value from the limited resources available for the survey would be obtained from enabling more statistically precise comparisons of Wave 1 and Wave 2 non-participant surveys than from a family member survey with a very small sample size (which would not have provided statistically reliable estimates).

Quantitative survey Sample Sizes	Wave 1				Wave 2			
	Participants	Family members	Non-participants	**Total**	Participants	Family members	Non-participants	**Total**
Ceduna	196	32	58	**286**	239*	-	71	**310**
EK	356	46	52	**454**	240#	-	70	**310**
Total	**552**	**78**	**110**	**740**	**479**	**-**	**141**	**620**

* 67 respondents from Wave 1 were re-interviewed in Ceduna in Wave 2 (from 87 who provided valid contact details)

67 respondents from Wave 1 were re-interviewed in EK in Wave 2 (from 171 who provided valid contact details)

The very first survey site was Ceduna Wave 1, and this proved to be something of a learning experience for the evaluation methodology. A number of factors here resulted in a smaller than anticipated sample of participants, including slower completion rates, availability of expected local resources to supplement the interviewing team, closure of a community, and a number of incidents relating to strong opinions about the recent introduction of the CDCT. Based on these experiences, larger interviewing teams with more senior managers on the ground at all times were deployed for all subsequent interviewing fieldwork, and larger sample sizes were achieved at all field periods after this.

The imbalance of participant numbers in Wave 1 was corrected by statistical weighting of the data for the purposes of producing overall Wave 1 average results across both sites.

In Wave 1, a total of 19% of all people approached by the interviewers were interviewed (31% in Ceduna and 15% in EK). Thirteen per cent refused, while 68% screened out (e.g. had already been interviewed, was a visitor to the areas, was under 18, or a variety of other reasons). For the intercept sample, both participation rates (28%) and refusal rates (22%) were higher in Wave 2, with 47% screening out. Participation rates were more consistent across the two sites in Wave 2 overall (recontacts plus intercepts), with 28% participating in Ceduna and 34% in EK.

Data processing

Raw data from the surveys was quality checked and cleaned prior to analysis. This involved deleting a small number of interviews where the same person was interviewed more than once (though respondents were asked to confirm they had not been previously interviewed, a small number did the interview twice – but were identified by the ID provided and their second response removed).

The final cleaned data was then weighted to known benchmarks. Weighting survey samples is part of best practice research and evaluation, as it matches a raw sample to the proportions of a known population, enabling more confident projection from the sample to the population. Two weighting schemes were used for different analyses.

1. CDCT participant samples within each of the trial sites were weighted to the known proportions of the CDCT population based on age, gender and Indigenous / non-Indigenous origin. Benchmark data on the CDCT population in both trial sites provided by the Department of Human Services (DHS) was used for this weighting.

2. A second 'location' weight was applied on top of the individual weights which balanced the contribution of responses from Ceduna and EK for the purposes of calculation overall average CDCT participant results using the full sample of all participants.

Due to the small sample sizes involved, no weights were applied to the family member or non-participant samples.

Weighting survey data does impact on the *effective sample size*. When projecting sample survey results to a population, there is a 'margin of error' which can be calculated. Broadly, for a population of any given size, the larger the sample the smaller the margin of error. Calculations of statistical significance take into account the estimated margin of error when determining how likely an observed difference or a change is to reveal a real difference or change in the population, or whether it just reflects natural variation in the sample. Weighting a sample reduces the effective sample size, meaning that the margin of error is larger and therefore larger differences or changes need to be observed before they can be considered reflective of real variations in the population. To allow for this, a design effect of 1.3 was applied to Wave 1, and 1.4 was applied to Wave 2.

Statistical significance testing

The 95% confidence level has been used for determining statistical 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. All survey result differences in this report (e.g. Wave 1 compared with Wave 2) that have been described as 'significant' are statistically significant at the 95% confidence level.

In addition to allowing for the effects of weighting, the calculations conducted in order to test for statistically significant differences have taken into account the fact that part of the CDCT participant response sample at Wave 1 and Wave 2 (longitudinal sample) overlapped (i.e. the same respondents were interviewed in both waves). This necessitated the use of repeated measures statistical tests when testing differences between Wave 1 and Wave 2 results within the longitudinal sample. It also involved the use of a complex blended (longitudinal and non-longitudinal) sample statistical significance testing procedure for comparing aggregate CDCT participant survey results (i.e. those based on all respondents in each wave). The test statistic employed[73] (referenced against the standard normal distribution) was as follows:

$$z_8 = \frac{\bar{p}_1 - \bar{p}_2}{\sqrt{\frac{\bar{p}(1-\bar{p})}{n_{12}+n_1} + \frac{\bar{p}(1-\bar{p})}{n_{12}+n_2} - 2r_1\left(\frac{\sqrt{\bar{p}(1-\bar{p})}\sqrt{\bar{p}(1-\bar{p})}n_{12}}{(n_{12}+n_1)(n_{12}+n_2)}\right)}}$$

Where:

- p_1 and p_2 are the proportions being compared (Wave 1 and Wave 2 respectively);
- p = weighted average of p_1 and p_2 (weighted by total sample size at each Wave);
- r_1 = Pearson's phi correlation coefficient within the overlapping (longitudinal) sample;
- n_1 = independent sample size at Wave 1;
- n_2 = independent sample size at Wave 2; and
- n_{12} = overlapping (longitudinal) sample size.

73 As recommended in Derrick, B., Dobson-Mckittrick, A., Toher, D. and White, P. (2015) Test statistics for comparing two proportions with partially overlapping samples. Journal of Applied Quantitative Methods, 10 (3). ISSN 1842-4562

Analysis and Reporting

Analysis of the quantitative data was conducted using the SPSS statistical package. Mainly descriptive analysis methods are used (e.g.: frequencies, mean scores, and cross-tabulations).

An integrated Wave 1 data file was created which includes data from all three respondent groups. As all questions in the family and non-participant surveys have direct analogues in the participant survey, data for all questions is aligned across groups using the participant survey structure. A similar integrated Wave 2 data file was also created. These data files are used for the majority of the descriptive analysis, and are the source of most results.

Two secondary data files are also used. One includes a number of selected variables across both waves in order to simplify the process of conducting significance testing on differences between waves. The other includes all data from the 134 participants who were interviewed in both waves. This is used for the 'longitudinal' analysis to explore any evident changes over time which might be apparent in this subgroup.

Throughout the reporting and analysis the three groups of respondents are never combined, but data from the two trial sites *is* combined within these groups. That is – participants and non-participants are never combined, but participants from Ceduna and participants from EK are combined to produce an overall average. Data from Wave 1 and from Wave 2 are never combined.

Qualitative Methodology

The qualitative data was generated and analysed by ORIMA Research's specialist qualitative research team. This team is experienced in working with stakeholders and members of the community across Australia, including with Indigenous Australians. The team periodically completes cultural awareness training sessions to ensure the researchers are familiar with and confident working in a wide range of cultural settings.

Data Collection

Data collection for the qualitative research was conducted through individual interviews, or small focus group sessions of similar types of respondents. This combination maximised the opportunity for respondents to participate, while also providing a confidential forum if required by respondents.

Most sessions were attended by more than one researcher, with one acting in a note-taking role where practical.

Interviews and groups were held in a combination of convenient central locations (e.g.: hotels, council facilities etc.) and, particularly for the individual interviews, in locations of convenience to respondents. While there was a preference for face-to-face participation for its additional richness, telephone interviews were conducted where necessary to facilitate participation.

Sampling & Recruiting

Qualitative research was conducted with community leaders and stakeholders.

The Leadership Groups in each CDCT site were provided by the Department at each time period. Every leader included on the lists was attempted to be included on each occasion. Recruitment was primarily by phone from the contact information provided, but where necessary and possible, other avenues were explored to make contact and organise participation. At Wave 2, only 1 of the 4 leaders from EK participated in an interview / focus group. A minimum of eight contact attempts was made with each of the other 3 leaders, however a mutually suitable time was unable to be arranged. As a proxy, the views of people who were leaders in EK at Wave 1 (but no longer at Wave 2) have been included in the evaluation.

Lists of identified stakeholders were also provided at each time period by the Department, and these lists formed the primary mechanism for recruitment. Again, phone contacts were the main mechanism for organising participation, but other channels were used as practical and necessary. All identified stakeholders were attempted to be contacted at each period. Some additional stakeholders were identified during the course of the qualitative fieldwork, particularly to validate 'second-hand' information or evidence provided by other participants (e.g.: businesses which may be able to comment on possible circumventions, or additional or less formal service providers who were identified as a source of a particular comment or observation).

A full list of the leaders and stakeholders who participated and agreed to be identified can be seen in Appendix B of the Final Evaluation report.

Discussion Guides

All interviews and focus groups used a semi-structured format directed by an approved discussion guide. The guide sets out the anticipated agenda and scope of the session, but the nature of qualitative research is that not every session covers every part of the guide (or not in the same level of detail) or in the same order. However, the guide does ensure consistency in the way questions and probes are asked, that all sessions follow a reasonably stable sequence, and that across the aggregated sessions that all key topic areas are addressed. Discussion guides used in the research are located at Appendix E: Qualitative issues guides.

The discussion guides were prepared by ORIMA Research's qualitative moderators, and approved by the Department prior to commencement.

Timing

The qualitative fieldwork periods included 3-5 day on-the-ground visits in each of the trial sites, but timing of telephone interviews extended either side of those visits in order to maximise the opportunity for leaders and stakeholders to participate. The timing of the qualitative research either overlapped or was immediately adjacent to the survey data collection fieldwork periods in Wave 1 and Wave 2.

Qualitative Fieldwork Dates	Ceduna	East Kimberley
Initial Conditions	21 April to 26 May 2016	21 April to 26 May 2016
Wave 1	15 August to 15 September 2016	12 September to 4 October 2016
Wave 2	22 May to 13 July 2017	12 June to 13 July 2017

Sample sizes

In total 196 people participated in interviews or focus groups across the three qualitative stages of the evaluation (noting that some of these are the same person participating up to three times). There were slightly more participants in EK (108) than in Ceduna (88), reflecting the larger population of EK and the greater number of stakeholders available.

Qualitative sample sizes	Initial conditions	Wave 1	Wave 2	*Qual Total*
Ceduna	15	33	40	*88*
EK	22	40	46	*108*
Total	**37**	**73**	**86**	***196***

Participation rates amongst invited leaders and stakeholders was high, with very few who actively declined to participate.

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. In Wave 2 there were 61 who were unable to be interviewed, but only 4 who actively declined (with the passage of time, there were more stakeholders who were no longer at the organisation they had originally been at in Wave 2).

Analysis and Reporting

The data from the qualitative stage is quite different to the statistical survey data, and is analysed and reported differently.

Summary notes were written following each interview and focus group, and were collated following completion of fieldwork in each site. All moderators then participated in an exploration and analysis workshop, comprising:

- A debrief and brainstorm of key findings;
- Examination of key findings for consistency and differences between specific target audience segments;
- Testing of findings for 'group think', social desirability and other effects associated with being in a research environment; and
- Cross-checking of qualitative findings for consistency with administrative data and quantitative survey findings.

For the most part, the report leads with the quantitative survey data, and uses the qualitative data to provide context, explanation or verification. Priority is given in the reporting of qualitative data where the respondent was able to provide first-hand evidence (i.e.: direct observations or experiences), and where only second-hand evidence was available this is noted.

Administrative Data

An extensive set of administrative data was examined as part of the evaluation. A detailed tabulation of all administrative data examined (apart from Indue and DHS data) and its sources is

appended (see Appendix H: Administrative data examined in the Evaluation). This administrative data was subject to a number of important limitations (discussed below). It has only been presented in the report in cases where, despite the limitations, such presentation substantively assists in understanding the effectiveness of the CDCT. The administrative data related to the two CDCT Trial sites and three comparison sites. The comparison sites were initially suggested by the South Australian and Western Australian State Governments and accepted by the evaluators as being appropriate. These comparison sites do not represent perfect "control sites" but are similar in character to the CDCT sites in terms of underlying demographic and socio-economic characteristics:

- Coober Pedy and Port Augusta were used as comparison sites for the Ceduna and Surrounds CDCT site; and
- Derby was used as the comparison site for the East Kimberley CDCT site.

Movements in administrative data series (e.g. changes in drug / alcohol-related hospital admissions) used in assessing the impact of the CDCT could occur due to either the impact of the CDCT or other (external) factors (e.g. decrease in the general availability of certain kinds of illicit drugs in Australia). In order to assess the possible impact of these external factors (so as to better estimate the impact of the CDCT), wherever possible, movements in Trial site data were compared with those in the comparison sites where the CDCT has not been implemented. The latter provide an indication of what would have happened in the Trial sites in the absence of the CDCT.

The evaluators have not conducted any cleaning or validation of this administrative data, but rather report it 'as is' through the report. As with the qualitative data, for the most part the administrative data is used to triangulate and complement the results from the primary quantitative survey data generated by the evaluation.

Administrative Data Limitations

The first limitation of the administrative data was that it was collected for purposes other than the CDCT evaluation. This meant that there was imperfect alignment between the CDCT key performance indicators and the available administrative data. Therefore, the data available generally serve as imperfect proxy measures for problematic alcohol consumption, illegal drug use, gambling and anti-social and disruptive behaviours. For example, measures such as sobering up unit admissions and alcohol-related pick-ups by community patrol services are used as proxy measures for problematic alcohol consumption, whilst the only proxy measure for illegal drug use that was available was drug driving in Ceduna. The other implication of the abovementioned limitation was that data was not always available at the required locality. For example, poker machine revenue data covers an area larger than the trial site of Ceduna, extending to Streaky Bay, Le Hunte, Elliston, and Lower Eyre Peninsula.

The second limitation relates to the unavailability of adequate time series data to perform robust pre-Trial and post-Trial comparisons. Whilst such data was available for some measures (e.g. crime statistics for EK), data for most measures was not available for the planned period of 12 months before and 12 months after Trial commencement. Since the same pre and post time range had to be used to control for seasonal effects, the impact of this was that a reduced time period (i.e. less than 12 months) had to be used for many pre and post comparisons. For example, Ceduna crime statistics data were only available from July 2015 to March 2017 – i.e. 12 months after the Trial and 9 months before the Trial. The comparability requirement meant that although 12 months of data was available post-Trial, only 9 months could be used for comparison purposes (as that was all that was available for the pre-Trial period).

Another problem relating to lack of availability of adequate time series data involved the low frequency of data collected / recorded limiting the number of observations available for robust pre- and post-Trial comparisons. Whilst for most measures monthly data were available, some were only recorded / available quarterly or less frequently. For example, disruptive tenancies data for Ceduna, Coober Pedy and Port Augusta (the latter two being comparison sites) were only available at quarterly intervals from Q1 2014/15 to Q3 2016/17, whilst school attendance data were available at term / semester level.

The third limitation was a difficulty in detecting trends due to low numbers of cases (as a result of small population numbers in the Trial sites) which led to considerable volatility over time in the measures.

The fourth limitation relates to the comparison site data which were only available for a limited number of measures. For example, no comparison site data were available for problematic alcohol consumption or gambling measures.

The last limitation relates to the quality of the administrative data in terms of its accuracy and representativeness. Most administrative data is subject to recording and collection issues which affect its reliability. Crime statistics, for example, only reflect incidents reported to, and subsequently recorded by, state police departments. As such, they are subject to two levels of error, as not all criminal activity is reported to police, and police subsequently use their discretion on whether and how they record an incident. Similar issues are likely to apply to other administrative data, especially in cases where subjective judgement is exercised during data collection. These issues are further exacerbated if there are changes to administrative practices that govern what is recorded and how. The extent to which the administrative data used for the CDCT evaluation is affected by these recording and collection issues is largely unknown – unless reliability concerns were specifically noted in the data provided, it was assumed that the data was not subject to issues beyond those that could be expected in general for such administrative data.

Appendix D: Quantitative survey questionnaires

Australian Government
Department of Social Services

Evaluation of the Cashless Debit Card Trial

Trial Participant Questionnaire – Wave 1

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ID Check

1. Medicare Card [specify last four digits]
2. Drivers Licence [specify last four digits]
3. Indue Card[specify last four digits]
4. Continue without ID
5. Continue with other ID [Specify]
6. Terminate interview

Introduction

Good morning/afternoon. My name is [SAY NAME] from ORIMA Research.

We have been asked by the Australian Government Department of Social Services to talk to people in the community and find out how the new Cashless Debit Card is working here in [Ceduna] [Kununurra] [Wyndham].

What will the survey interview involve?

The survey interview should last around 20 minutes. I want to ask you some questions about the new Debit Card system and what you and your family and community think about it.

If you qualify and complete the survey you will get a voucher worth $30, which you can use at a local store, as a small 'thank you' for your time.

If you want to talk to us again, we'll be back again in about six months. We want to find out what you think about this card and find out what everyone thinks about it. The second time will also be about 20 minutes long. We will give you a voucher worth $50 the second time we talk to you.

What will be done with the information?

Unless you want us to tell other people, or we are required to do so by an Australian law, no one other than ORIMA Research staff working on this survey will find out what you tell me during the survey. The Department of Social Services will get a report later on, but they will not see your name or what you have told us.

What you tell me in the survey will tell the Australian Government how well the new Debit Card system is working.

You can get a copy of the results of the survey. If you would like to be sent a copy of the results, please let me know later on.

Participation is voluntary

By doing this survey you'll get to have a say about what works and what doesn't work in the Debit Card system. While we would really like to hear your views, you do not have to do the interview. It is up to you if you want to talk to us or not. We will not tell Centrelink whether or not you have spoken to us, and your Centrelink payments will not be affected by your decision to take part in this survey, or if you decide to withdraw later on. You don't have to answer all the questions. You can stop talking if you want to any time.

If you want to talk about the survey and what you told us, please feel free to contact Ingrid Curtis at ORIMA Research on our toll-free number 1800 654 585.

SECTION A:
Demographics

Let's start by asking you to tell me a little about yourself.

1.	**How old are you?**	
	Age ____________________________	
	Refused	99

IF PERSON IS LESS THAN 18 YEARS OLD, THANK AND END

IF 1=99 (REFUSED) ASK 1A

1A.	**Which age group do you belong to?** **SINGLE RESPONSE. READ OUT**	
	Less than 18 years old	1
	18-19	2
	20-24	3
	25-34	4
	35-44	5
	45-54	6
	55-64	7
	65 years old and over	8
	[Refused]	99

IF 1A=99 OR 1A=1, THANK AND END

2.	**Do you have one of these Indue Debit Cards in your name?** [Show the picture of an Indue card] **SINGLE RESPONSE**	
	Yes	1
	No	2
	Refused	**99 Terminate interview**

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IF Q2= 1 (Yes), SKIP TO 4

3.	**Have you <u>ever</u> had one of these cards? SINGLE RESPONSE**	
	Yes	1
	No SWAP TO NON-PARTICIPANT COMMUNITY MEMBER SURVEY SCRIPT	2

4.	[Interviewer to indicate gender of participant]	
	Female	1
	Male	2
	Indeterminate	3

5.	**Were you... SINGLE RESPONSE**	
	Born in Australia	1
	Born overseas (specify country_________________________)	2
	Refused	99

6.	**Are you of Aboriginal or Torres Strait Islander origin? SINGLE RESPONSE**	
	No – SKIP TO Q7	1
	Yes	2
	Refused	99

6A.	**Which of the following best describes your origin?** **READ OUT. SINGLE RESPONSE**	
	Both Aboriginal and Torres Strait Islander origin	1
	Aboriginal origin	2

6A.	**Which of the following best describes your origin?** **READ OUT.** SINGLE RESPONSE	
	Torres Strait Islander origin	3
	Refused	99

7.	**What town, suburb or community do you usually live in?** (If more than one, **“the one in which you spend most time”**.) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK “**What’s that nearest to?”** REPEAT UNTIL FOUND IN LIST OR SELECT **“None of the above”** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	BALD HILL	1.	ALLIGATOR HOLE	61.
	BETTS CORNER	2.	BELL SPRINGS	62.
	BOOKABIE	3.	BETHAL	63.
	BORDER VILLAGE	4.	CARLTON HILL	64.
	BULINDA	5.	COCKATOO SPRINGS	65.
	CACTUS BEACH	6.	DILLON SPRINGS	66.
	CEDUNA	7.	DINGO SPRINGS	67.
			DOON DOON	68.
	CEDUNA TOWN CAMP	8.	EMU CREEK	69.
	CHINBINGINA	9.	FLYING FOX	70.
	CHINTA	10.	FOUR MILE	71.
	CHARRA	11.	GEBOOWAMA	72.
	CHUNDARIA	12.	GLEN HILL	73.
	CUNGENA	13.	GOOSE HILL	74.
	COORABIE	14.	GUDA GUDA	75.
	CARAWA	15.	GULBERANG	76.
	DENIAL BAY	16.	HOLLOW SPRINGS	77.
	DINAH LINE	17.	JIMBILUM	78.
	DUCKPOND	101.		
	DUNDEE	102.		
	KOONGAWA DUNDEE	18.	KUMBRARUMBA	79.
	EMU FARM	19.	**KUNUNURRA**	80.
	FOWLERS BAY	20.	KUNUNURRA REGION	81.
	GLEN BOREE	21.	MINIATA	82.
	HEAD OF GREAT AUSTRALIAN BIGHT	22.	MIRIMA	83.
	KALANBI	23.	MOLLY SPRINGS	84.

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7.	**What town, suburb or community do you usually live in? (If more than one, "the one in which you spend most time".) SINGLE RESPONSE** **[IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "What's that nearest to?"** **REPEAT UNTIL FOUND IN LIST OR SELECT "None of the above" [999]**			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	KOONIBBA	24.	MUD SPRINGS	85.
	LAURA BAY	25.	MUNTHANMAR	86.
	COLONA	26.	NGULWIRRIWIRRI	87.
	LOOKOUT HILL	27.	NIMBING	88.
			NINE MILE	89.
	MALTEE	28.	NULLYWAH	90.
	MERGHINY	29.	RED CREEK	91.
	MUNDA MUNDA WATA TJINA	30.	WARINGARRI	92.
	MUDAMUCKLA	31.	WARRAYU	93.
	MUNDA WANNA-MAR	32.	WOOLAH (or Doon Doon)	94.
	MURAT BAY	33.	WUGGABUN	95.
	NADIA	34.	**WYNDHAM**	96.
	NANBONA	35.	YIRRALALLEM	97.
	NANWOORA	36.		
	NULLARBOR	37.		
	NUNJIKOMPITA	38.		
	NUNDROO	39.		
	OAK VALLEY	40.		
	OVER ROAD	41.		
	PENONG	42.		
	PIMBAACLA	43.		
	PUNTABIE	44.		
	PINTUMBA	45.		
	PUREBA	46.		
	SCOTDESCO	47.		
	SMOKY BAY	48.		
	TALLOWON	49.		
	THEVENARD	50.		
	TIA TUCKIA	51.		

7.	**What town, suburb or community do you usually live in? (If more than one, "the one in which you spend most time".) SINGLE RESPONSE** **[IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "What's that nearest to?"** **REPEAT UNTIL FOUND IN LIST OR SELECT "None of the above" [999]**			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	UWORRA	52.		
	WATRABA	53.		
	WAREVILLA	54.		
	WANDANA	55.		
	WHITE WELL CORNER	56.		
	YALATA	57.		
	YARILENA	58.		
	YELLABINNA	59.		
	YUMBARRA	60.		
	None of the above – but has Indue card (sighted)	998		
	None of the above	999		

8.	**Do you get any of the following benefits or payments?** **MULTIPLE RESPONSE. READ OUT**	
	Austudy	1
	ABSTUDY	2
	Youth Allowance	3
	Parenting Payment (Partnered)	4
	Parenting Payment (Single)	5
	Newstart Allowance	6
	Disability Support Pension	7
	Age Pension	8
	Carer's Payment or Allowance	9
	Family Tax Benefit (FTB)	10
	Child Care Benefit (CCB)	11
	Veterans Payment	12
	Other *[Please specify]*______________________	13
	None of these	14
	Don't know	98
	Refused	99

9.	**Do you care for, or look after, a child who is less than 18 years old? SINGLE RESPONSE**	
	Yes	1
	No – **SKIP TO 11**	2
	Refused – **SKIP TO 11**	99

10.	**How many children do you care for, or look after, who live with you for at least one day per week, or for at least one whole month in a year?**	________
	Refused	99

SECTION B:
Profile of Debit Card Trial Participation

IF Q2=1 – NO LONGER ON DEBIT CARD TRIAL, GO TO SECTION C.

The next few questions are about the card I showed you earlier.

Would you like us to call this a “Cashless Debit Card” or an “Indue Card”?

A. Cashless Debit Card

B. Indue Card

[Survey programme will automatically fill remainder of questions referring to the card itself with either A or B depending on respondent’s answer.]

11.	**What type of Cashless Debit Card Trial are you currently on?** **READ OUT IF NECESSARY. SINGLE RESPONSE**	
	Compulsory Cashless Debit Card Trial	1
	Opt-in Cashless Debit Card Trial	2
	Don’t know / not sure	98
	Refused	99

IF CODE 2 AT 11 (OPT-IN), ASK, OTHERWISE SKIP TO 13

12.	**Why did you opt-in to go on the Cashless Debit Card?** **Open-ended / free text. PROBE FULLY** ____

13.	**And have you activated your [Cashless Debit Card] [Indue Card] and started using it to buy things? SINGLE RESPONSE**	
	Yes	1
	No	2
	Don’t know / not sure	98

	Refused	99

IF CODE 2 (NO), 98 (DON'T KNOW / NOT SURE) or 99 (REFUSED) AT 13, SKIP TO 18

14.	**Have you had any problems using the [Cashless Debit Card] [Indue Card]?** SINGLE RESPONSE	
	Yes	1
	No	2

ASK ONLY IF 14=1 OTHERWISE SKIP TO 16

15.	**Please tell me about these problems.** Open-ended / free text PROBE FULLY ____

16.	**How much of your Centrelink payment goes on the [Cashless Debit Card] [Indue Card]?** SINGLE RESPONSE. DO NOT READ OUT	
	80%	1
	70%	2
	60%	3
	50%	4
	Other ______________________________	5
	Don't know/ Not sure	98
	If provided in $ amount write in ____________________	97
	Refused	99

IF 98 or 97/'DON'T KNOW'/'NOT SURE' / $ AMOUNT PROVIDED AT 16 ASK:

17.	**Is it ...? READ OUT [SINGLE RESPONSE]**	
	About half	1
	Most	2
	Almost all	3
	Other (Specify)_____________ DO NOT READ OUT	4
	Don't know / Not sure DO NOT READ OUT	98

ASK ALL

17A	**Have you asked the Community Panel to review how much of your Centrelink money goes onto the [Cashless Debit Card] [Indue card]? SINGLE RESPONSE**	
	Yes – ASK Q17B, OTHERWISE SKIP TO Q18	1
	No	2
	Can't say / Not sure / Don't know	98

	Refused	99

17B	**Did the amount or per cent of your Centrelink money that goes onto the [Cashless Debit Card] [Indue card] change after the Community Panel reviewed you? SINGLE RESPONSE**	
	Yes	1
	No	2
	Can't say / Not sure / Don't know	98
	Refused	99

17C	**Did you have any problems with the Community Panel or the process? SINGLE RESPONSE**	
	Yes – ASK Q17D, OTHERWISE SKIP TO Q18	1
	No	2
	Can't say / Not sure / Don't know	98
	Refused	99

17D	**Please tell me about these problems.**	
	Open-ended / free text PROBE FULLY ____	

18.	**Do you live with anyone else who is in the Cashless Debit Card Trial or has a [Cashless Debit Card] [Indue Card]? SINGLE RESPONSE**	
	Yes	1
	No	2
	Can't say / Not sure / Don't know	98
	Refused	99

ASK ONLY IF 18=1 OTHERWISE SKIP TO 20

19.	**What is your relationship to them? Would they be your… MULTIPLE RESPONSE**	
	Father	1
	Mother	2
	Husband	3
	Wife	4
	Defacto Male Partner	12
	Defacto Female Partner	13
	Boyfriend	5
	Girlfriend	6
	Sister	7

19.	**What is your relationship to them? Would they be your…** MULTIPLE RESPONSE	
	Brother	8
	Aunt	9
	Uncle	10
	Child	11
	Other (specify)____	97

The next few questions are about how the [Cashless Debit Card] [Indue Card] works and what you know about it.

20.	**Do you KNOW …** ROTATE	Yes	No	Not sure
A.	**What** you can and can't buy with the card	1	2	98
B.	The **types of places or where** you can and can't use the card	1	2	98
C.	What to do if the card is **lost or stolen**	1	2	98

21.	**Before this survey, did you know that ….** ROTATE	Yes	No	Refused
A.	You **can't buy alcohol or grog** with the card	1	2	99
B.	You **can't use the card to make bets** or for other types of gambling	1	2	99
C.	You can use the card **in most places where Visa cards are accepted**, including online or on the internet	1	2	99
D.	You can use the card to make **online payment transfers** to pay bills, for housing and other expenses	1	2	99

22.	**Since you started using the card, have you had to change where or how you shop?** SINGLE RESPONSE	
	Yes	1
	No	2
	Don't know / not sure	98

ASK ONLY IF 22=1 OTHERWISE SKIP TO 24

23.	**Please tell me about these changes.** **Open-ended / free text PROBE FULLY** ____

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SECTION C:

Profile of Current Behaviour and Attitudes

Thanks for all that. The next few questions are about the last three months, so May, June and July. They include questions about personal things, including your money situation, how much you gamble, how much alcohol you drink, whether you take drugs, whether you have been arrested, beaten up or robbed and how safe you feel in your community. I'd just like to remind you that you don't have to answer any of these questions. You can skip any question that you are not comfortable answering. You can stop talking if you want to any time.

24.	**First, about some things that may or may not have happened to you. In the last 3 months how often, if at all, did you…?** DO NOT ROTATE
i.	Run out of money to buy food
ii.	Not have money to pay rent or your mortgage on time
iii.	Not have money to pay some other type of bill when it was due
iv.	Run out of money to pay for things that your child/children needed for school, like books [ONLY ASK IF CARING FOR CHILDREN AT 9]
v.	Run out of money to pay for essential (non-food) items for your children, such as nappies, clothes and medicine [ONLY ASK IF CARING FOR CHILDREN AT 9]
vi.	Borrow money from family or friends
vii.	Run out of money because you had given money to friends or family

RESPONSE FRAME: Would you say…

1. More than once a week
2. About once a week
3. About once every 2 weeks
4. About once a month
5. One or two times
6. Never

97. Not Applicable
99. Refused

INTERVIEWER NOTE: at C below clarify that gamble/gambling refers to any of the following: poker or gaming machines, betting on horse, harness or greyhound races, lottery products in person or online, keno, blackjack, roulette, bingo, betting on a sporting event like football, card games like poker privately for money, and any other games such as dice games privately for money

25.	**Lately, have you done any of these things? ROTATE. ENCOURAGE BEST ESTIMATE, IF DONE AT ALL, PROBE FOR HOW OFTEN**
A.	Have grog (a drink containing alcohol)
B.	Have six or more drinks of grog / alcohol at one time
C.	Gamble
D.	Spend three or more hours a day gambling
E.	Spend more than $50 a day on gambling
F.	Gamble more than you can afford to lose

25.	**Lately, have you done any of these things? ROTATE. ENCOURAGE BEST ESTIMATE, IF DONE AT ALL, PROBE FOR HOW OFTEN**
G.	Borrow money or sell things to get money to gamble
H.	Use an illegal drug or a prescription medication for nonmedical reasons
I.	Spend more than $50 a day on drugs not prescribed by a doctor
J.	Borrow money or sell things to get money to buy alcohol / drugs

RESPONSE FRAME:

1. More than once a week – Specify: ______
2. About weekly
3. About once every 2 weeks
4. About monthly
5. Every 2-3 months
6. Less often
7. Never
8. Done – but frequency not specified

97. Not Applicable
99. Refused

IF 8=8 (AGE PENSION) SKIP TO 28

26.	**Are you currently looking for a job or paid work? READ OUT SINGLE RESPONSE**	
	Yes	1
	No	2
	Refused	99

IF 26=2 OR 99 (NOT LOOKING FOR A JOB) SKIP TO 28

27.	**Usually, how many hours a week would you spend on trying to get a job or paid work? SINGLE RESPONSE. READ OUT**	
	Less than 2 hours per week	1
	3-5 hours	2
	6-10 hours	3
	11-20 hours	4
	21-30 hours	5
	More than 30 hours	6
	Can't say/ Not sure	98
	Refused	99

IF NOT CARING FOR CHILDREN AT 9 (9>1), SKIP TO 29

28.	**Do any of the children you care for go to school? SINGLE RESPONSE. READ OUT**	

28.	**Do any of the children you care for go to school?** **SINGLE RESPONSE. READ OUT**	
	Yes – ASK Q28A, OTHERWISE SKIP TO Q29	1
	No	2
	Not Applicable – do not regularly look after children	97
	Can't say/ Not sure	98
	Refused	99

28A	**Usually, do you check to make sure that the children are doing their homework or help with any other things to do with school? SINGLE RESPONSE. READ OUT**	
	Yes – often	1
	Yes – sometimes	2
	Yes – occasionally	3
	No	4
	Not Applicable – do not regularly look after children	97
	Can't say/ Not sure	98
	Refused	99

Now, just think about the **past month** when you are answering these next few questions.

29.	**In the last month have you been ….** **ROTATE**	Yes	No		Can/t say/ Not sure	Refused
A.	arrested by the police	1	2		98	99
B.	beaten up, injured, or assaulted	1	2		98	99
C.	harassed	1	2		98	99
D.	robbed	1	2		98	99
E.	threatened or attacked with a gun, knife or other weapon	1	2		98	99
F.	homeless or had to sleep rough	1	2		98	99
G.	humbugged or pressured by family or friends to give them money	1	2		98	99
H.	injured or had an accident after drinking alcohol or grog or taking drugs	1	2		98	99

Now some questions about your local community.

30.	**Do you feel proud or ashamed of the community in which you live? Is that very proud /ashamed? SINGLE RESPONSE.**	

30.	**Do you feel proud or ashamed of the community in which you live? Is that very proud /ashamed? SINGLE RESPONSE.**	
	Very proud	1
	Proud	2
	Neither proud or ashamed	3
	Ashamed	4
	Very ashamed	5
	Can't say / Not sure	98
	Refused	99

31.	**Do you feel safe or unsafe … ROTATE. Is that very safe/unsafe?**	Very safe	Safe	Neither	Unsafe	Very unsafe	Can't say / Not sure	Refused
1.	On the streets of your community during the day	1	2	3	4	5	98	99
2.	On the streets of your community during the night	1	2	3	4	5	98	99
3.	At home	1	2	3	4	5	98	99

Now I'd like to ask you some questions about support services in your community.

32A	**Before this survey, were you aware of any drug and alcohol support services in your local area?**	
	Yes, I was aware	1
	No, I wasn't aware SKIP TO Q36	2
	Unsure	98
	Refused SKIP TO Q36	99

32B	**Can you give me up to three examples of drug and alcohol services in your local area that you know of?** **MULTIPLE RESPONSE. MAXIMUM OF THREE RESPONSES. [PROBE FOR MOST SPECIFIC DESCRIPTION]**	
	[Please specify]	
	[Please specify]	
	[Please specify]	
	None SKIP TO Q36	98
	REFUSED	99

33.	**Have you ever used these local services or other services that help people to deal with problems related to alcohol or drug use?** SINGLE RESPONSE	
	Yes	1
	No	2
	Don't know / not sure	98
	Refused	99

IF 33>1, SKIP TO 36

34.	**When was the last time that you got help from an alcohol or drug support service?** SINGLE RESPONSE	
	In the last month	1
	1-3 months ago	2
	4-6 months ago	3
	7-12 months ago	4
	More than 12 months ago	5
	Don't know / not sure	98
	Refused	99

ASK ONLY IF 34<5

35.	**How many times did you get help from an alcohol or drug support service in the past year?**	________
	Refused	99

36.	**How likely is it that you will try and get help from an alcohol or drug support service in the future?** SINGLE RESPONSE	
	Definitely will not	1
	Most likely will not	2
	Maybe will/ maybe won't	3
	Most likely will	4
	Definitely will	5
	Don't know / not sure	98
	Refused	99

INTERVIEWER NOTE: Financial support services give advice, information and help with debt, bills, and budgeting to people that may be facing financial problems or finding it hard to get by. **Family** support services give advice and information to people on income support payments for families.

37A	**Before this survey, were you aware of any financial and family support services in your local area?**	
	Yes, I was aware	1
	No, I wasn't aware [SKIP TO 41]	2
	Unsure	98
	Refused [SKIP TO 41]	99

37B	**Can you give me up to three examples of financial and family support services in your local area that you know of? MULTIPLE RESPONSE. MAXIMUM OF THREE RESPONSES. [PROBE FOR MOST SPECIFIC DESCRIPTION]**	
	[Please specify]	
	[Please specify]	
	[Please specify]	
	None SKIP TO 41	98
	Refused	99

38.	**Have you ever used these local services or other services that help people to deal with financial or family problems? SINGLE RESPONSE**	
	Yes	1
	No	2
	Don't know / not sure	98
	Refused	99

IF 38>1, SKIP TO 41

39.	**When was the last time that you got help from a financial or family support service? SINGLE RESPONSE**	
	In the last month	1
	1-3 months ago	2
	4-6 months ago	3
	7-12 months ago	4
	More than 12 months ago	5
	Don't know / not sure	98
	Refused	99

ASK ONLY IF 39<5

40.	**How many times did you get help from a financial or family support service in the past year?**	________
	Refused	99

41.	**How likely is it that you will try and get help from a financial or family support service in the future?** SINGLE RESPONSE	
	Definitely will not	1
	Most likely will not	2
	Maybe will/ maybe won't	3
	Most likely will	4
	Definitely will	5
	Don't know / not sure	98
	Refused	99

SECTION D:
Opinions of the impact of the Debit Card Trial

These final questions are about how life is going here now in [Ceduna] [Kununurra] [Wyndham] since the Cashless Debit Card came in.

42.	**Since the [Cashless Debit Card] [Indue Card]started in your community have you noticed more, less or the same amount of:** ROTATE	Less	Same	More	Can't say /Don't know	Refused
A.	Drinking of alcohol or grog in the community	1	2	3	98	99
B.	Violence in the community	1	2	3	98	99
C.	Gambling in the community	1	2	3	98	99
D.	Humbugging or harassment for money	1	2	3	98	99

IF NO LONGER ON THE DEBIT CARD, BUT HAD ONE (Q2=1) GO TO SECTION E

The next few questions are about how <u>your life</u> is going now that you have the [Cashless Debit Card] [Indue Card].

INTERVIEWER NOTE: At **43A** below 'save money' includes money saved in a person's Debit Card account as well as money saved in other accounts or in cash for a specific purpose (beyond day-to-day living expenses).

43.	**Since being on the [Cashless Debit Card] [Indue Card] have these happened to you?** ROTATE	Yes	No	Not applicable – do not	Can't say / Not sure	Refused

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				regularly look after children		
A.	You've been able to save more money than before	1	2		98	99
B.	You've been better able to care for your child/ren [ONLY ASK IF CARING FOR CHILDREN AT 9]	1	2	97	98	99
C.	You've got more involved in your children's homework and school [ONLY ASK IF CARING FOR CHILDREN AT 9]	1	2	97	98	99
D.	I've got better at things like using a computer, the internet or a smartphone	1	2		98	99

44.	**Since being on the [Cashless Debit Card] [Indue Card], have you done each of the following more often, less often or the same as before?** ROTATE	Less	Same	More	Not applicable – did not do activity before	Can't say / Not sure	Refused
A.	Drunk grog or alcohol	1	2	3	97	98	99
B.	Had six or more drinks of grog or alcohol at one time	1	2	3	97	98	99
C.	Gambled	1	2	3	97	98	99
D.	Spent more than $50 a day on gambling	1	2	3	97	98	99
E.	Bet more than you can really afford to lose	1	2	3	97	98	99
F.	Had to borrow money or sell things to get money to gamble	1	2	3	97	98	99
G.	Used an illegal drug like benzos, ice, marijuana, or speed	1	2	3	97	98	99
H.	Spent more than $50 a day on illegal drugs like benzos, ice, marijuana, or speed	1	2	3	97	98	99

45.	**Would you say, the [Cashless Debit Card] [Indue Card] has made your life...** **SINGLE RESPONSE. READ OUT**	
	a lot better	1
	a bit better	2

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45.	**Would you say, the [Cashless Debit Card] [Indue Card] has made your life...** **SINGLE RESPONSE. READ OUT**	
	no different	3
	a bit worse	4
	a lot worse	5
	Can't say / not sure	98
	Refused	99

IF 45=1, 2, 4 or 5 ASK46, ELSE SKIP TO 47

46.	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

47.	ONLY ASK IF CARING FOR CHILDREN AT 9] **Would you say the [Cashless Debit Card] [Indue Card] has made your [child's life]/[children's lives] ...** **SINGLE RESPONSE. READ OUT**	
	a lot better	1
	a bit better	2
	no different	3
	a bit worse	4
	a lot worse	5
	Not applicable – do not regularly look after children	97
	Can't say / not sure	98
	Refused	99

IF 47=1, 2, 4 or 5 ASK 47 A, ELSE SKIP TO 48

47A	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

48.	**Have you told anyone who doesn't have a [Cashless Debit Card] [Indue Card] to get one, or do you plan to?** **SINGLE RESPONSE. READ OUT**	
	Yes, I have	1

	No, I haven't but I plan to	2
	No, and I don't plan to	3
	Can't say / not sure	98
	Refused	99

49.	**Why do you say / did you do that?**
	Open-ended / free text. PROBE FULLY ____

SECTION E:

This section is for those individuals who are no longer on the CDCT

IF 3=1 ASK 50, ELSE SKIP TO 51

I understand you don't have a [Cashless Debit Card] [Indue Card] anymore but you used to.

50.	**Can you please tell me why this is? (Probe further if there is any mention of 'Community Panel' or 'Panel' in the response.)** **Open-ended / free text. PROBE FULLY** ____

SECTION F:

CONCLUSION

51.	**Are there any other changes, either good or bad, that have happened in your life or in the community since the [Cashless Debit Card] [Indue Card] came in?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2
52.	**What other changes have happened? Open-ended / free text.** ____	

53.	**We have come to the end of the questionnaire. Would you like to say anything else about the [Cashless Debit Card] [Indue Card], the Trial, or your experiences that we haven't asked you about?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2

54.	**What would you like to add? Open-ended / free text.** ____

We will contact you again to take part in the next survey in your community in a few months. For this purpose only, can I please record your name, address and phone number/s?

Respondent's Name: ....

Respondent's Phone1: (.......) ....

Respondent's Phone2: (.......) ....

Respondent's Address: ....

Email:__________________@_______________________________

Also, just in case we have problems contacting you in a few months, are you able to provide me with a name and phone number of someone else who would know how to contact you?

Alternate contact's name: ....

Alternate contact's Phone1: (.......) ....

Alternate contact's Phone2: (.......) ....

Respondent's Signature: (confirming they have received their incentive):

……………………………………………………………………….

DO NOT READ OUT C1A

C1A.	**DID RESPONDENT INDICATE THEY WOULD LIKE TO GET A SUMMARY OF THE SURVEY RESULTS?**	SINGLE RESPONSE DO NOT READ OUT
	Yes	1
	No	2

ASK ONLY IF RESPONDENT REQUESTED A SUMMARY OF THE SURVEY RESULTS (C1A=1)

C1.	**You mentioned that you would like to get a summary of the survey results. How would you like us to send that to you?**	SINGLE RESPONSE READ OUT OPTIONS 1 AND 2
	By email	1
	By post	2
	[Changed mind – does not want summary to be provided]	3

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Our Privacy Policy is available at www.orima.com and contains further details regarding how you can access or correct information we hold about you, how you can make a privacy related complaint and how that complaint will be dealt with. Should you have any questions about our privacy policy or how we will treat your information, you may contact our Privacy Officer, Liesel van Straaten on (03) 9526 9000.

Until we de-identify our research records, you have the right to access the information that we hold about you as a result of this interview. You may request at any time to have this information de-identified or destroyed.

Thank you for taking the time to participate in the study.

Interviewer to complete before signing.

- *I have informed the respondent of the purpose of the research and their rights.* ☐
- *I have informed the respondent that their identity will be kept confidential and that any information they supply will only be used for the purposes of the research.* ☐
- *I have informed the respondent of their right to stop the interview at any time and / or ask that the information they've given not be used by contacting ORIMA Research.* ☐
- *The respondent has consented to participating in the survey for evaluation of the Cashless Debit Card Trial measures in Ceduna/ Kununurra/ Wyndham* [strikeout whichever not applicable]. ☐

Signature: ______________________________________

Interviewer Name: _______________________________

Date: _______ /________ / 2016

Australian Government
Department of Social Services

Evaluation of the Cashless Debit Card Trial

Non-Participant Questionnaire – Wave 1

ORIMA RESEARCH

ID Check

1. Medicare Card [specify last four digits]
2. Drivers Licence [specify last four digits]
3. Indue Card[specify last four digits]
4. Continue without ID
5. Continue with other ID [Specify]
6. Terminate interview

Introduction

Good morning/afternoon. My name is [SAY NAME] from ORIMA Research.

We have been asked by the Australian Government Department of Social Services to talk to people in the community and find out how the new Cashless Debit Card is working here in [Ceduna] [Kununurra] [Wyndham].

What will the survey interview involve?

The survey interview should last around 10 minutes. I want to ask you some questions about the new Cashless Debit Card trial and what you and the community think about it.

You will get a voucher worth $30, which you can use at a local store, as a small 'thank you' for your time.

What will be done with the information?

Unless you want us to tell other people, or we are required to do so by an Australian law, no one other than ORIMA Research staff working on this survey will find out what you tell me during the survey. The Department of Social Services will get a report later on, but they will not see your name or what you have told us.

What you tell me in the survey will tell the Australian Government how well the new Debit Card system is working.

You can get a copy of the results of the survey. If you would like to be sent a copy of the results, please let me know later on.

Participation is voluntary

By doing this survey you'll get to have a say about what works and what doesn't work in the Debit Card system. While we would really like to hear your views, you do not have to do the interview. It is up to you if you want to talk to us or not. We will not tell Centrelink whether or not you have spoken to us, and your Centrelink payments will not be affected by your decision to take part in this survey, or if you decide to withdraw later on. You don't have to answer all the questions. You can stop talking if you want to any time.

If you want to talk about the survey and what you told us, please feel free to contact Ingrid Curtis at ORIMA Research on our toll-free number 1800 654 585.

SECTION A:
Demographics

Let's start by asking you to tell me a little about yourself.

1.	**How old are you?**	
	Age ______________________________________	
	Refused	99

IF PERSON IS LESS THAN 18 YEARS OLD, THANK AND END

IF 1=99 (REFUSED) ASK 1A

1A.	**Which age group do you belong to?** **SINGLE RESPONSE. READ OUT**	
	Less than 18 years old	1
	18-19	2
	20-24	3
	25-34	4
	35-44	5
	45-54	6
	55-64	7
	65 years old and over	8
	[Refused]	99

IF 1A=99 OR 1A=1, THANK AND END

2.	**Do you have one of these Indue Debit Cards in your name? [**Show the picture of an Indue card] **SINGLE RESPONSE**	
	Yes - **SWAP TO TRIAL PARTICIPANT SURVEY SCRIPT**	1
	No – **CONTINUE**	2
	Refused – **TERMINATE INTERVIEW**	99

3.	**Have you <u>ever</u> had one of these cards?** SINGLE RESPONSE	
	Yes - SWAP TO TRIAL PARTICIPANT SURVEY SCRIPT	1
	No – CONTINUE	2

4.	[Interviewer to indicate gender of participant]	
	Female	1
	Male	2
	Indeterminate	3

5.	**Does <u>anyone</u> in your immediate family who lives with you have one of these cards?** (show again as necessary)? **So this could be your partner, husband, wife, child, parent, brother or sister.** SINGLE RESPONSE	
	Yes – SWAP TO FAMILY MEMBER OF TRIAL PARTICIPANT SURVEY SCRIPT	1
	No – CONTINUE	2
	Can't say / Not sure / Don't know - TERMINATE INTERVIEW	98
	Refused - TERMINATE INTERVIEW	99

6.	**Were you...** SINGLE RESPONSE	
	Born in Australia	1
	Born overseas (specify country________________________)	2
	Refused	99

7.	**Are you of Aboriginal or Torres Strait Islander origin?** SINGLE RESPONSE	
	No – SKIP TO Q9	1
	Yes	2
	Refused – SKIP TO Q9	99

8.	**Which of the following best describes your origin?** **READ OUT.** SINGLE RESPONSE	
	Both Aboriginal and Torres Strait Islander origin	1
	Aboriginal origin	2
	Torres Strait Islander origin	3
	Refused	99

9.	**What town, suburb or community do you usually live in?** (If more than one, **"the one in which you spend most time".**) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "**What's that nearest to?"** REPEAT UNTIL FOUND IN LIST OR SELECT **"None of the above"** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	BALD HILL	1.	ALLIGATOR HOLE	61.
	BETTS CORNER	2.	BELL SPRINGS	62.
	BOOKABIE	3.	BETHAL	63.
	BORDER VILLAGE	4.	CARLTON HILL	64.
	BULINDA	5.	COCKATOO SPRINGS	65.
	CACTUS BEACH	6.	DILLON SPRINGS	66.
	CEDUNA	7.	DINGO SPRINGS	67.
			DOON DOON	68.
	CEDUNA TOWN CAMP	8.	EMU CREEK	69.
	CHINBINGINA	9.	FLYING FOX	70.
	CHINTA	10.	FOUR MILE	71.
	CHARRA	11.	GEBOOWAMA	72.
	CHUNDARIA	12.	GLEN HILL	73.
	CUNGENA	13.	GOOSE HILL	74.
	COORABIE	14.	GUDA GUDA	75.
	CARAWA	15.	GULBERANG	76.
	DENIAL BAY	16.	HOLLOW SPRINGS	77.
	DINAH LINE	17.	JIMBILUM	78.
	DUCKPOND	101.		
	DUNDEE	102.		
	KOONGAWA DUNDEE	18.	KUMBRARUMBA	79.
	EMU FARM	19.	**KUNUNURRA**	80.
	FOWLERS BAY	20.	KUNUNURRA REGION	81.
	GLEN BOREE	21.	MINIATA	82.
	HEAD OF GREAT AUSTRALIAN BIGHT	22.	MIRIMA	83.
	KALANBI	23.	MOLLY SPRINGS	84.
	KOONIBBA	24.	MUD SPRINGS	85.
	LAURA BAY	25.	MUNTHANMAR	86.
	COLONA	26.	NGULWIRRIWIRRI	87.
	LOOKOUT HILL	27.	NIMBING	88.

9.	**What town, suburb or community do you usually live in? (If more than one, "the one in which you spend most time".) SINGLE RESPONSE** **[IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "What's that nearest to?"** **REPEAT UNTIL FOUND IN LIST OR SELECT "None of the above" [999]**			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
			NINE MILE	89.
	MALTEE	28.	NULLYWAH	90.
	MERGHINY	29.	RED CREEK	91.
	MUNDA MUNDA WATA TJINA	30.	WARINGARRI	92.
	MUDAMUCKLA	31.	WARRAYU	93.
	MUNDA WANNA-MAR	32.	WOOLAH (or Doon Doon)	94.
	MURAT BAY	33.	WUGGABUN	95.
	NADIA	34.	**WYNDHAM**	96.
	NANBONA	35.	YIRRALALLEM	97.
	NANWOORA	36.		
	NULLARBOR	37.		
	NUNJIKOMPITA	38.		
	NUNDROO	39.		
	OAK VALLEY	40.		
	OVER ROAD	41.		
	PENONG	42.		
	PIMBAACLA	43.		
	PUNTABIE	44.		
	PINTUMBA	45.		
	PUREBA	46.		
	SCOTDESCO	47.		
	SMOKY BAY	48.		
	TALLOWON	49.		
	THEVENARD	50.		
	TIA TUCKIA	51.		
	UWORRA	52.		
	WATRABA	53.		
	WAREVILLA	54.		
	WANDANA	55.		

9.	**What town, suburb or community do you usually live in? (If more than one, "the one in which you spend most time".) SINGLE RESPONSE** **[IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "What's that nearest to?"** **REPEAT UNTIL FOUND IN LIST OR SELECT "None of the above" [999]**			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	WHITE WELL CORNER	56.		
	YALATA	57.		
	YARILENA	58.		
	YELLABINNA	59.		
	YUMBARRA	60.		
	None of the above	**999**		

10.	**Do you get any of the following benefits or payments?** **MULTIPLE RESPONSE. READ OUT**	
	Austudy	1
	ABSTUDY	2
	Youth Allowance	3
	Parenting Payment (Partnered)	4
	Parenting Payment (Single)	5
	Newstart Allowance	6
	Disability Support Pension	7
	Age Pension	8
	Carer's Payment or Allowance	9
	Family Tax Benefit (FTB)	10
	Child Care Benefit (CCB)	11
	Veterans Payment	12
	Other *[Please specify]*_____________________	13
	None of these	14
	Don't know	98
	Refused	99

SECTION B:
Profile of Cashless Debit Card Knowledge

The next few questions are about the card I showed you earlier.

Would you like us to call this a "Cashless Debit Card" or an "Indue Card"?

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C. Cashless Debit Card

D. Indue Card

E. Other: [Specify] ________

[Survey programme will automatically fill remainder of questions referring to the card itself with either A, B or C depending on respondent's answer.]

The next few questions are about how the [Cashless Debit Card] [Indue Card] works and what you know about it.

11.	**Before this survey, had you heard of the [Cashless Debit Card] [Indue Card]?** SINGLE RESPONSE	
	Yes	1
	No – SKIP TO SECTION C	2

12. (i)	**Do you KNOW ...** ROTATE	Yes	No	Not sure
A.	**What** people can and can't buy with the card	1	2	98
B.	The **types of places or where** people can and can't use the card	1	2	98

12. (ii)	**Before this survey, did you know that ....** ROTATE ALL EXCEPT FOR A AND B	Yes	No	Refuse d
A.	**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	1	2	99
B.	Wage earners, aged pensioners and veterans pensioners who live in this area **can choose to get one of these cards**	1	2	99
C.	You **can't buy alcohol or grog** with the card	1	2	99
D.	You **can't use the card to make bets** or for other types of gambling	1	2	99
E.	You can use the card **in most places where Visa cards are accepted**, including online or on the internet	1	2	99
F.	You can use the card to make **online payment transfers** to pay bills, for housing and other expenses	1	2	99

SECTION C:
Profile of Current Behaviour and Attitudes

Thanks for all that. Now, please just think about the **past month** when you are answering these next few questions. They include questions about personal things, including whether you have been beaten up or robbed and how safe you feel in your community. I'd just like to remind you that you don't have to answer any of these questions. You can skip any question that you are not comfortable answering. You can stop talking if you want to any time.

13.	**In the last month have you been ….** ROTATE	Yes	No		Can't say/ Not sure	Refused
A.	Beaten up, injured, or assaulted	1	2		98	99
B.	Harassed	1	2		98	99
C.	Robbed	1	2		98	99
D.	Threatened or attacked with a gun, knife or other weapon	1	2		98	99
E.	Humbugged or pressured by family or friends to give them money	1	2		98	99

Now some questions about your local community.

14.	**Do you feel proud or ashamed of the community in which you live? Is that very proud /ashamed?** SINGLE RESPONSE.	
	Very proud	1
	Proud	2
	Neither proud or ashamed	3
	Ashamed	4
	Very ashamed	5
	Can't say / Not sure	98
	Refused	99

15.	**Do you feel safe or unsafe … ROTATE. Is that very safe/unsafe?**	Very safe	Safe	Neither	Unsafe	Very unsafe	Can't say / Not sure	Refused
1.	On the streets of your community during the day	1	2	3	4	5	98	99
2.	On the streets of your community during the night	1	2	3	4	5	98	99
3.	At home	1	2	3	4	5	98	99

SECTION D:
Opinions of the impact of the Debit Card Trial

These final questions are about how life is going here now in [Ceduna] [Kununurra] [Wyndham] since the [Cashless Debit Card] [Indue card] came in.

16.	**Since the [Cashless Debit Card] [Indue Card] started in your community have you noticed more, less or the same amount of:** ROTATE	Less	Same	More		Can't say /Don't know	Refused
A.	Drinking of alcohol or grog in the community	1	2	3		98	99
B.	Violence in the community	1	2	3		98	99
C.	Gambling in the community	1	2	3		98	99
D.	Humbugging or harassment for money	1	2	3		98	99

17.	**Would you say the [Cashless Debit Card] [Indue Card] has made life in <u>your community</u> ...** **SINGLE RESPONSE. READ OUT**	
	a lot better	1
	a bit better	2
	no different	3
	a bit worse	4
	a lot worse	5
	Can't say / not sure	98
	Refused	99

IF Q17=1, 2, 4, 5 ASK Q18, ELSE SKIP TO SECTION E

18.	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

SECTION E:
Conclusion

19.	**Are there any other changes, either good or bad, that have happened in the community since the [Cashless Debit Card] [Indue Card] came in?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2

20.	What other changes have happened? Open-ended / free text. ____

21.	We have come to the end of the questionnaire. Would you like to say anything else about the [Cashless Debit Card] [Indue Card], the Trial, or your experiences that we haven't asked you about?	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2
22.	What would you like to add? Open-ended / free text. ____	

Respondent's Signature: (confirming they have received their reimbursement):

____

DO NOT READ OUT C1A

C1A.	DID RESPONDENT INDICATE THEY WOULD LIKE TO GET A SUMMARY OF THE SURVEY RESULTS?	SINGLE RESPONSE DO NOT READ OUT
	Yes	1
	No	2

ASK ONLY IF RESPONDENT REQUESTED A SUMMARY OF THE SURVEY RESULTS (C1A=1)

C1.	You mentioned that you would like to get a summary of the survey results. How would you like us to send that to you?	SINGLE RESPONSE READ OUT OPTIONS 1 AND 2
	By email	1
	By post	2
	[Changed mind – does not want summary to be provided]	3

Our Privacy Policy is available at www.orima.com and contains further details regarding how you can access or correct information we hold about you, how you can make a privacy related complaint and how that complaint will be dealt with. Should you have any

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questions about our privacy policy or how we will treat your information, you may contact our Privacy Officer, Liesel van Straaten on (03) 9526 9000.

Until we de-identify our research records, you have the right to access the information that we hold about you as a result of this interview. You may request at any time to have this information de-identified or destroyed.
Thank you for taking the time to participate in the study.

Interviewer to complete before signing.

- *I have informed the respondent of the purpose of the research and their rights.* ☐
- *I have informed the respondent that their identity will be kept confidential and that any information they supply will only be used for the purposes of the research.* ☐
- *I have informed the respondent of their right to stop the interview at any time and / or ask that the information they've given not be used by contacting ORIMA Research.* ☐
- *The respondent has consented to participating in the survey for evaluation of the Cashless Debit Card Trial measures in Ceduna/ Kununurra/ Wyndham* [strikeout whichever not applicable]. ☐
- *I have provided the respondent with an information brochure on support services.* ☐

Signature: ______________________________________

Interviewer Name: ______________________________

Date: _______ /________ / 2016

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Australian Government
Department of Social Services

Evaluation of the Cashless Debit Card Trial

Family Member Questionnaire – Wave 1

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ID Check

1. Medicare Card [specify last four digits]
2. Drivers Licence [specify last four digits]
3. Indue Card[specify last four digits]
4. Continue without ID
5. Continue with other ID [Specify]
6. Terminate interview

Introduction

Good morning/afternoon. My name is [SAY NAME] from ORIMA Research.

We have been asked by the Australian Government Department of Social Services to talk to people in the community and find out how the new Cashless Debit Card is working here in [Ceduna] [Kununurra] [Wyndham].

What will the survey interview involve?

The survey interview should last around 15 minutes. I want to ask you some questions about the new Cashless Debit Card trial and what you and your family and community think about it.

You will get a voucher worth $30, which you can use at a local store, as a small 'thank you' for your time.

If you want to talk to us again, we'll be back again in about six months. We want to find out what you think about this card and find out what everyone thinks about it. The second time will also be about 15 minutes long. We will give you a voucher worth $50 the second time we talk to you.

What will be done with the information?

Unless you want us to tell other people, or we are required to do so by an Australian law, no one other than ORIMA Research staff working on this survey will find out what you tell me during the survey. The Department of Social Services will get a report later on, but they will not see your name or what you have told us.

What you tell me in the survey will tell the Australian Government how well the new Debit Card trial is working.

You can get a copy of the results of the survey. If you would like to be sent a copy of the results, please let me know later on.

Participation is voluntary

By doing this survey you'll get to have a say about what works and what doesn't work in the Debit Card system. While we would really like to hear your views, you do not have to do the interview. It is up to you if you want to talk to us or not. We will not tell Centrelink whether or not you have spoken to us, and your Centrelink payments will not be affected by your

decision to take part in this survey, or if you decide to withdraw later on. You don't have to answer all the questions. You can stop talking if you want to any time.

If you want to talk about the survey and what you told us, please feel free to contact Ingrid Curtis at ORIMA Research on our toll-free number 1800 654 585.

SECTION A: Demographics

Let's start by asking you to tell me a little about yourself.

1.	**How old are you?**	
	Age ____	
	Refused	99

IF PERSON IS LESS THAN 18 YEARS OLD, THANK AND END

IF 1=99 (REFUSED) ASK 1A

1A.	**Which age group do you belong to?** **SINGLE RESPONSE. READ OUT**	
	Less than 18 years old	1
	18-19	2
	20-24	3
	25-34	4
	35-44	5
	45-54	6
	55-64	7
	65 years old and over	8
	[Refused]	99

IF 1A=99 OR 1A=1, THANK AND END

2.	**Do you have one of these Indue Debit Cards in your name?** [Show the picture of an Indue card] **SINGLE RESPONSE**	
	Yes - **SWAP TO TRIAL PARTICIPANT SURVEY SCRIPT**	1
	No – **CONTINUE**	2
	Refused – **TERMINATE INTERVIEW**	99

3.	**Have you <u>ever</u> had one of these cards?** SINGLE RESPONSE	
	Yes - **SWAP TO TRIAL PARTICIPANT SURVEY SCRIPT**	1
	No – **CONTINUE**	2

4.	[Interviewer to indicate gender of participant]	
	Female	1
	Male	2
	Indeterminate	3

5.	**Does <u>anyone</u> in your immediate family who lives with you have one of these cards?** (show again as necessary)? **So this could be your partner, husband, wife, child, parents, brother or sister** SINGLE RESPONSE	
	Yes – **CONTINUE**	1
	No - **SWAP TO TRIAL NON- PARTICIPANT SURVEY SCRIPT**	2
	Can't say / Not sure / Don't know - **TERMINATE INTERVIEW**	3
	Refused - **TERMINATE INTERVIEW**	99

6.	**What is your relationship to them? Would they be your... MULTIPLE RESPONSE**	
	Father / Mother	1
	Partner / Defacto / Husband / Wife	2
	Sister/ Brother	3
	Child / children	4
	Other (specify)_______________________________________ **ENSURE THIS IS A FAMILY MEMBER, IF NOT -- TERMINATE**	5

7.	**Were you... SINGLE RESPONSE**	
	Born in Australia	1

	Born overseas (specify country________________________)	2
	Refused	99

8.	**Are you of Aboriginal or Torres Strait Islander origin?** SINGLE RESPONSE	
	No – SKIP TO Q10	1
	Yes	2
	Refused	99

9.	**Which of the following best describes your origin?** **READ OUT.** SINGLE RESPONSE	
	Both Aboriginal and Torres Strait Islander origin	1
	Aboriginal origin	2
	Torres Strait Islander origin	3
	Refused	99

10.	**What town, suburb or community do you usually live in?** (If more than one, **"the one in which you spend most time".)** SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK **"What's that nearest to?"** REPEAT UNTIL FOUND IN LIST OR SELECT **"None of the above"** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	BALD HILL	1.	ALLIGATOR HOLE	61.
	BETTS CORNER	2.	BELL SPRINGS	62.
	BOOKABIE	3.	BETHAL	63.
	BORDER VILLAGE	4.	CARLTON HILL	64.
	BULINDA	5.	COCKATOO SPRINGS	65.
	CACTUS BEACH	6.	DILLON SPRINGS	66.
	CEDUNA	7.	DINGO SPRINGS	67.
			DOON DOON	68.
	CEDUNA TOWN CAMP	8.	EMU CREEK	69.
	CHINBINGINA	9.	FLYING FOX	70.
	CHINTA	10.	FOUR MILE	71.
	CHARRA	11.	GEBOOWAMA	72.
	CHUNDARIA	12.	GLEN HILL	73.
	CUNGENA	13.	GOOSE HILL	74.
	COORABIE	14.	GUDA GUDA	75.

10.	What town, suburb or community do you usually live in? (If more than one, "the one in which you spend most time".) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "What's that nearest to?" REPEAT UNTIL FOUND IN LIST OR SELECT "None of the above" [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	CARAWA	15.	GULBERANG	76.
	DENIAL BAY	16.	HOLLOW SPRINGS	77.
	DINAH LINE	17.	JIMBILUM	78.
	DUCKPOND	101.		
	DUNDEE	102.		
	KOONGAWA DUNDEE	18.	KUMBRARUMBA	79.
	EMU FARM	19.	**KUNUNURRA**	80.
	FOWLERS BAY	20.	KUNUNURRA REGION	81.
	GLEN BOREE	21.	MINIATA	82.
	HEAD OF GREAT AUSTRALIAN BIGHT	22.	MIRIMA	83.
	KALANBI	23.	MOLLY SPRINGS	84.
	KOONIBBA	24.	MUD SPRINGS	85.
	LAURA BAY	25.	MUNTHANMAR	86.
	COLONA	26.	NGULWIRRIWIRRI	87.
	LOOKOUT HILL	27.	NIMBING	88.
			NINE MILE	89.
	MALTEE	28.	NULLYWAH	90.
	MERGHINY	29.	RED CREEK	91.
	MUNDA MUNDA WATA TJINA	30.	WARINGARRI	92.
	MUDAMUCKLA	31.	WARRAYU	93.
	MUNDA WANNA-MAR	32.	WOOLAH (or Doon Doon)	94.
	MURAT BAY	33.	WUGGABUN	95.
	NADIA	34.	**WYNDHAM**	96.
	NANBONA	35.	YIRRALALLEM	97.
	NANWOORA	36.		
	NULLARBOR	37.		
	NUNJIKOMPITA	38.		
	NUNDROO	39.		
	OAK VALLEY	40.		

10.	What town, suburb or community do you usually live in? (If more than one, "the one in which you spend most time".) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "What's that nearest to?" REPEAT UNTIL FOUND IN LIST OR SELECT "None of the above" [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	OVER ROAD	41.		
	PENONG	42.		
	PIMBAACLA	43.		
	PUNTABIE	44.		
	PINTUMBA	45.		
	PUREBA	46.		
	SCOTDESCO	47.		
	SMOKY BAY	48.		
	TALLOWON	49.		
	THEVENARD	50.		
	TIA TUCKIA	51.		
	UWORRA	52.		
	WATRABA	53.		
	WAREVILLA	54.		
	WANDANA	55.		
	WHITE WELL CORNER	56.		
	YALATA	57.		
	YARILENA	58.		
	YELLABINNA	59.		
	YUMBARRA	60.		
	None of the above	**999**		

11.	**Do you get any of the following benefits or payments?** MULTIPLE RESPONSE. READ OUT	
	Austudy	1
	ABSTUDY	2
	Youth Allowance	3
	Parenting Payment (Partnered)	4
	Parenting Payment (Single)	5
	Newstart Allowance	6

11.	**Do you get any of the following benefits or payments?** **MULTIPLE RESPONSE. READ OUT**	
	Disability Support Pension	7
	Age Pension	8
	Carer's Payment or Allowance	9
	Family Tax Benefit (FTB)	10
	Child Care Benefit (CCB)	11
	Veterans Payment	12
	Other *[Please specify]*____________________	13
	None of these	14
	Don't know	15
	Refused	99

12.	**Do you care for, or look after, a child who is less than 18 years old?** **SINGLE RESPONSE**	
	Yes	1
	No – **SKIP TO SECTION B**	2
	Refused – **SKIP TO SECTION B**	99

13.	**How many children do you care for, or look after, who live with you for at least one day per week, or for at least one whole month in a year?**	________
	Refused	99

SECTION B:
Profile of Cashless Debit Card Knowledge

The next few questions are about the card I showed you earlier.

Would you like us to call this a "Cashless Debit Card" or an "Indue Card"?

A. Cashless Debit Card

B. Indue Card

C. Other (specify)____________

[Survey programme will automatically fill remainder of questions referring to the card itself with either A, B or C depending on respondent's answer.]

The next few questions are about how the [Cashless Debit Card] [Indue Card] works and what you know about it.

14.	**Do you KNOW … ROTATE**	Yes	No	Not sure
A.	**What** people can and can't buy with the card	1	2	98

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B.	The **types of places or where** people can and can't use the card	1	2	98

15.	**Before this survey, did you know that ….** ROTATE ALL EXCEPT FOR A AND B	Yes	No	Refused
A.	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	1	2	99
B.	Wage earners, aged pensioners and veterans pensioners who live in this area can **choose to get one of these cards**	1	2	99
C.	You **can't buy alcohol or grog** with the card	1	2	99
D.	You **can't use the card to make bets** or for other types of gambling	1	2	99
E.	You can use the card **in most places where Visa cards are accepted**, including online or on the internet	1	2	99
F.	You can use the card to make **online payment transfers** to pay bills, for housing and other expenses	1	2	99

SECTION C:
Profile of Current Behaviour and Attitudes

Thanks for all that. The next few questions are about the last three months, so May, June and July. They include questions about personal things, including your money situation, how much you gamble, how much alcohol you drink, whether you take drugs, whether you have been arrested, beaten up or robbed and how safe you feel in your community. I'd just like to remind you that you don't have to answer any of these questions. You can skip any question that you are not comfortable answering. You can stop talking if you want to any time.

16.	**First, about some things that may or may not have happened to you. In the last 3 months how often, if at all, did you…?** DO NOT ROTATE
i.	Run out of money to buy food
ii.	Not have money to pay rent or your mortgage on time
iii.	Not have money to pay some other type of bill when it was due
iv.	Run out of money to pay for things that your child/children needed for school, like books [ONLY ASK IF CARING FOR CHILDREN AT Q12]
v.	Run out of money to pay for essential (non-food) items for your children, such as nappies, clothes and medicine [ONLY ASK IF CARING FOR CHILDREN ATQ12]
vi.	Borrow money from family or friends
vii.	Run out of money because you had given money to friends or family

RESPONSE FRAME: Would you say…

1. More than once a week

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2. About once a week
3. About once every 2 weeks
4. About once a month
5. One or two times
6. Never
97. Not applicable
99. Refused

INTERVIEWER NOTE: at C below clarify that gamble/gambling refers to any of the following: poker or gaming machines, betting on horse, harness or greyhound races, lottery products in person or online, 'scratchies', keno, blackjack, roulette, bingo, betting on a sporting event like football, card games like poker privately for money, and any other games such as dice games privately for money

17.	**Lately, have you done any of these things? ROTATE. ENCOURAGE BEST ESTIMATE, IF DONE AT ALL, PROBE FOR HOW OFTEN**
A.	Have grog (a drink containing alcohol)
B.	Have six or more drinks of grog / alcohol at one time
C.	Gamble
D.	Spend three or more hours a day gambling
E.	Spend more than $50 a day on gambling
F.	Gamble more than you can afford to lose
G.	Borrow money or sell things to get money to gamble
H.	Use an illegal drug or a prescription medication for nonmedical reasons
I.	Spend more than $50 a day on drugs not prescribed by a doctor
J.	Borrow money or sell things to get money to buy alcohol / drugs

RESPONSE FRAME:

1. More than once a week – Specify: ______
2. About weekly
3. About once every 2 weeks
4. About monthly
5. Every 2-3 months
6. Less often
7. Never
8. Done – but frequency not specified
97. Not Applicable
99. Refused

IF Q11=8 (AGE PENSION) SKIP TO Q20

18.	**Are you currently looking for a job or paid work? READ OUT SINGLE RESPONSE**	
	Yes	1
	No	2

	Refused	99

IF 18=2 OR 99 (NOT LOOKING FOR A JOB) SKIP TO 280

19.	**Usually, how many hours a week would you spend on trying to get a job or paid work?** **SINGLE RESPONSE. READ OUT**	
	Less than 2 hours per week	1
	3-5 hours	2
	6-10 hours	3
	11-20 hours	4
	21-30 hours	5
	More than 30 hours	6
	Can't say/ Not sure	98
	Refused	99

IF NOT CARING FOR CHILDREN AT Q12 (Q12>1), SKIP TO Q21

20.	**Do any of the children you care for go to school?** **SINGLE RESPONSE. READ OUT**	
	Yes – **ASK Q20A, OTHERWISE SKIP TO Q21**	1
	No	2
	Can't say/ Not sure	98
	Refused	99

20A	**Usually, do you check to make sure that the children are doing their homework or help with any other things to do with school? SINGLE RESPONSE. READ OUT**	
	Yes – often	1
	Yes – sometimes	2
	Yes – occasionally	3
	No	4
	Not Applicable – do not regularly look after children	97
	Can't say/ Not sure	98
	Refused	99

Now, just think about the **past month** when you are answering these next few questions.

21.	**In the last month have you been ....** **ROTATE**	Yes	No		Can/t say/ Not sure	Refus ed
A.	arrested by the police	1	2		98	99

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21.	**In the last month have you been ....** ROTATE	Yes	No		Can/t say/ Not sure	Refused
B.	beaten up, injured, or assaulted	1	2		98	99
C.	harassed	1	2		98	99
D.	robbed	1	2		98	99
E.	threatened or attacked with a gun, knife or other weapon	1	2		98	99
F.	homeless or had to sleep rough	1	2		98	99
G.	humbugged or pressured by family or friends to give them money	1	2		98	99
H.	injured or had an accident after drinking alcohol or grog or taking drugs	1	2		98	99

Now some questions about your local community.

22.	**Do you feel proud or ashamed of the community in which you live? Is that very proud /ashamed?** SINGLE RESPONSE.	
	Very proud	1
	Proud	2
	Neither proud or ashamed	3
	Ashamed	4
	Very ashamed	5
	Can't say / Not sure	98
	Refused	99

23.	**Do you feel safe or unsafe ...** ROTATE. Is that very safe/unsafe?	Very safe	Safe	Neither	Unsafe	Very unsafe	Can't say / Not sure	Refused
1.	On the streets of your community during the day	1	2	3	4	5	98	99
2.	On the streets of your community during the night	1	2	3	4	5	98	99
3.	At home	1	2	3	4	5	98	99

SECTION D:
Opinions of the impact of the Debit Card Trial

These final questions are about how life is going here now in [Ceduna] [Kununurra] [Wyndham] since the [Cashless Debit Card] [Indue card] came in.

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24.	**Since the [Cashless Debit Card] [Indue Card] started in your community have you noticed more, less or the same amount of:** **ROTATE**	Less	Same	More	Can't say /Don't know	Refused
A.	Drinking of alcohol or grog in the community	1	2	3	98	99
B.	Violence in the community	1	2	3	98	99
C.	Gambling in the community	1	2	3	98	99
D.	Humbugging or harassment for money	1	2	3	98	99

The next few questions are about how your life is going now that others in your family have the [Cashless Debit Card] [Indue Card].

25.	**Since** [ANSWERS/ FROM Q5] **has / have been on the [Cashless Debit Card] [Indue Card] have these happened to your family?** **ROTATE**	Yes	No	Not applicable – do not regularly look after children	Can't say / Not sure	Refused
A.	The family has been able to save more money than before	1	2		98	99
B.	The family has been better able to care for the children [ONLY ASK IF CARING FOR CHILDREN AT 12]	1	2	97	98	99
C.	The family has become more involved in the children's homework and school[ONLY ASK IF CARING FOR CHILDREN AT 12]	1	2	97	98	99

26.	**Since** [ANSWERS/ FROM Q5] **has / have been on the [Cashless Debit Card] [Indue Card], have YOU done each of the following more often, less often or the same as before?** **ROTATE**	Less	Same	More	Not applicable – did not do activity before	Can't say / Not sure	Refused

26.	**Since** [ANSWERS/ FROM Q5] **has / have been on the [Cashless Debit Card] [Indue Card], have YOU done each of the following more often, less often or the same as before?** ROTATE	Less	Same	More	Not applica ble – did not do activity before	Can't say / Not sure	Refuse d
A.	Drunk grog or alcohol	1	2	3	4	98	99
B.	Gambled	1	2	3	4	98	99
C.	Used an illegal drug like benzos, ice, marijuana, or speed	1	2	3	4	98	99

27.	**Would you say the [Cashless Debit Card] [Indue Card] has made your family's life...** SINGLE RESPONSE. READ OUT	
	a lot better	1
	a bit better	2
	no different	3
	a bit worse	4
	a lot worse	5
	Can't say / not sure	98
	Refused	99

IF 27=1, 2, 4, 5 ASK 28, ELSE SKIP TO Q.29

28.	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

29.	**Would you say the [Cashless Debit Card] [Indue Card] has made life in your community ...** SINGLE RESPONSE. READ OUT	
	a lot better	1

29.	**Would you say the [Cashless Debit Card] [Indue Card] has made life in <u>your community</u> ...** **SINGLE RESPONSE. READ OUT**	
	a bit better	2
	no different	3
	a bit worse	4
	a lot worse	5
	Can't say / not sure	98
	Refused	99

IF Q29=1, 2, 4, 5 ASK Q30, ELSE SKIP TO SECTION E

30.	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

SECTION E: CONCLUSION

31.	**Are there any other changes, either good or bad, that have happened in your family or in the community since the [Cashless Debit Card] [Indue Card] came in?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2
32.	**What other changes have happened? Open-ended / free text.** ____	

33.	**We have come to the end of the questionnaire. Would you like to say anything else about the [Cashless Debit Card] [Indue Card], the Trial, your experiences, or your family's experiences that we haven't asked you about?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2

34.	**What would you like to add? Open-ended / free text.** ____

We will contact you again to take part in the next survey in your community in a few months. For this purpose only, can I please record your name, address and phone number/s?

Respondent's Name: ....

Respondent's Phone1: (.......) ....

Respondent's Phone2: (.......) ....

Respondent's Address: ....

Email:_________________@______________________________

Also, just in case we have problems contacting you in a few months, are you able to provide me with a name and phone number of someone else who would know how to contact you?

Alternate contact's name: ....

Alternate contact's Phone1: (.......) ....

Alternate contact's Phone2: (.......) ....

Respondent's Signature: (confirming they have received their reimbursement):

....

DO NOT READ OUT C1A

C1A.	**DID RESPONDENT INDICATE THEY WOULD LIKE TO GET A SUMMARY OF THE SURVEY RESULTS?**	SINGLE RESPONSE DO NOT READ OUT
	Yes	1
	No	2

ASK ONLY IF RESPONDENT REQUESTED A SUMMARY OF THE SURVEY RESULTS (C1A=1)

C1.	**You mentioned that you would like to get a summary of the survey results. How would you like us to send that to you?**	SINGLE RESPONSE READ OUT OPTIONS 1 AND 2
	By email	1

	By post	2
	[Changed mind – does not want summary to be provided]	3

Our Privacy Policy is available at www.orima.com and contains further details regarding how you can access or correct information we hold about you, how you can make a privacy related complaint and how that complaint will be dealt with. Should you have any questions about our privacy policy or how we will treat your information, you may contact our Privacy Officer, Liesel van Straaten on (03) 9526 9000.

Until we de-identify our research records, you have the right to access the information that we hold about you as a result of this interview. You may request at any time to have this information de-identified or destroyed.

Thank you for taking the time to participate in the study.

Interviewer to complete before signing.

- *I have informed the respondent of the purpose of the research and their rights.* ☐
- *I have informed the respondent that their identity will be kept confidential and that any information they supply will only be used for the purposes of the research.* ☐
- *I have informed the respondent of their right to stop the interview at any time and / or ask that the information they've given not be used by contacting ORIMA Research.* ☐
- *The respondent has consented to participating in the survey for evaluation of the Cashless Debit Card Trial measures in Ceduna/ Kununurra/ Wyndham* [strikeout whichever not applicable]. ☐
- *I have provided the respondent with an information brochure on support services.* ☐

Signature: ____

Interviewer Name: ________________________________

Date: _______ /________ / 2016

Australian Government
Department of Social Services

Evaluation of the Cashless Debit Card Trial

Trial Participant Questionnaire – Wave 2

ORIMA RESEARCH

Preliminary Screening

Ask respondent if they were interviewed as part of our Wave 1 fieldwork (between 15 August and 15 September 2016 in Ceduna, and between 12 September and 4 October 2016 in East Kimberley).

If respondent says that they were interviewed, check their identity against the master list of Wave 1 respondents using the proof of identity (Medicare Card, Drivers' Licence, Indue Card etc.) recorded on the list.

If identity is verified (i.e. person is recorded on the master list), enter the person's SPSS ID (as recorded on the master list):

SPSS ID: ______________________________

For all respondents (those interviewed in Wave 1 and those who were not), conduct ID check (say to respondent that this is to ensure that people can only do the interview once – to prevent double counting/ dipping).

ID Check

1. Medicare Card [specify last four digits]
2. Drivers Licence [specify last four digits]
3. Indue Card[specify last four digits]
4. Continue without ID
5. Continue with other ID [Specify]
6. Terminate interview

Introduction

Good morning/afternoon. My name is [SAY NAME] from ORIMA Research.

We have been asked by the Australian Government Department of Social Services to talk to people in the community and find out how the new Cashless Debit Card is working here in [Ceduna] [Kununurra] [Wyndham].

What will the survey interview involve?

The survey interview should last around 20 minutes. I want to ask you some questions about the new Debit Card system and what you and your family and community think about it.

IF RESPONDENT WAS INTERVIEWED IN WAVE 1: Thank you for talking to us last year – we really appreciate it. We want to find out what you now think about this card. If you complete the survey you will get a voucher worth $50, which you can use at a local store, as a small 'thank you' for your time.

IF RESPONDENT WAS NOT INTERVIEWED IN WAVE 1: If you qualify and complete the survey you will get a voucher worth $30, which you can use at a local store, as a small 'thank you' for your time.

What will be done with the information?

Unless you want us to tell other people, or we are required to do so by an Australian law, no one other than ORIMA Research staff working on this survey will find out what you tell me during the survey. The Department of Social Services will get a report later on, but they will not see your name or what you have told us.

What you tell me in the survey will tell the Australian Government how well the new Debit Card system is working.

You can get a copy of the results of the survey. If you would like to be sent a copy of the results, please let me know later on.

Participation is voluntary

By doing this survey you'll get to have a say about what works and what doesn't work in the Debit Card system. While we would really like to hear your views, you do not have to do the interview. It is up to you if you want to talk to us or not. We will not tell Centrelink whether or not you have spoken to us, and your Centrelink payments will not be affected by your decision to take part in this survey, or if you decide to withdraw later on. You don't have to answer all the questions. You can stop talking if you want to any time.

If you want to talk about the survey and what you told us, please feel free to contact Robbie Corrie at ORIMA Research on our toll-free number 1800 654 585.

SECTION A:

Demographics

Let's start by asking you to tell me a little about yourself.

11.	**How old are you?**	
	Age ____	
	Refused	99

IF PERSON IS LESS THAN 18 YEARS OLD, THANK AND END

IF 1=99 (REFUSED) ASK 1A

1A.	**Which age group do you belong to?** **SINGLE RESPONSE. READ OUT**	
	Less than 18 years old	1
	18-19	2
	20-24	3
	25-34	4
	35-44	5
	45-54	6
	55-64	7
	65 years old and over	8
	[Refused]	99

IF 1A=99 OR 1A=1, THANK AND END

2.	**Do you have one of these Indue Debit Cards in your name?** [Show the picture of an Indue card] **SINGLE RESPONSE**	
	Yes	1
	No	2
	Refused	**99 Terminate interview**

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IF Q2= 1 (Yes), SKIP TO 4

3.	**Have you ever had one of these cards? SINGLE RESPONSE**	
	Yes	1
	No SWAP TO NON-PARTICIPANT COMMUNITY MEMBER SURVEY SCRIPT	2

4.	[Interviewer to indicate gender of participant]	
	Female	1
	Male	2
	Indeterminate	3

5.	**Were you... SINGLE RESPONSE**	
	Born in Australia	1
	Born overseas (specify country_________________________)	2
	Refused	99

6.	**Are you of Aboriginal or Torres Strait Islander origin? SINGLE RESPONSE**	
	No – SKIP TO Q7	1
	Yes	2
	Refused – SKIP TO Q7	99

6A.	**Which of the following best describes your origin?** **READ OUT. SINGLE RESPONSE**	
	Both Aboriginal and Torres Strait Islander origin	1
	Aboriginal origin	2

6A.	**Which of the following best describes your origin?** **READ OUT.** SINGLE RESPONSE	
	Torres Strait Islander origin	3
	Refused	99

7.	**What town, suburb or community do you usually live in?** (If more than one, **"the one in which you spend most time".**) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK **"What's that nearest to?"** REPEAT UNTIL FOUND IN LIST OR SELECT **"None of the above"** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	BALD HILL	1.	ALLIGATOR HOLE	61.
	BETTS CORNER	2.	BELL SPRINGS	62.
	BOOKABIE	3.	BETHAL	63.
	BORDER VILLAGE	4.	CARLTON HILL	64.
	BULINDA	5.	COCKATOO SPRINGS	65.
	CACTUS BEACH	6.	DILLON SPRINGS	66.
	CEDUNA	7.	DINGO SPRINGS	67.
			DOON DOON	68.
	CEDUNA TOWN CAMP	8.	EMU CREEK	69.
	CHINBINGINA	9.	FLYING FOX	70.
	CHINTA	10.	FOUR MILE	71.
	CHARRA	11.	GEBOOWAMA	72.
	CHUNDARIA	12.	GLEN HILL	73.
	CUNGENA	13.	GOOSE HILL	74.
	COORABIE	14.	GUDA GUDA	75.
	CARAWA	15.	GULBERANG	76.
	DENIAL BAY	16.	HOLLOW SPRINGS	77.
	DINAH LINE	17.	JIMBILUM	78.
	DUCKPOND	101.		
	DUNDEE	102.		
	KOONGAWA DUNDEE	18.	KUMBRARUMBA	79.
	EMU FARM	19.	**KUNUNURRA**	80.
	FOWLERS BAY	20.	KUNUNURRA REGION	81.
	GLEN BOREE	21.	MINIATA	82.
	HEAD OF GREAT AUSTRALIAN BIGHT	22.	MIRIMA	83.
	KALANBI	23.	MOLLY SPRINGS	84.

7.	**What town, suburb or community do you usually live in? (If more than one, "the one in which you spend most time".) SINGLE RESPONSE** **[IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "What's that nearest to?"** **REPEAT UNTIL FOUND IN LIST OR SELECT "None of the above" [999]**			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	KOONIBBA	24.	MUD SPRINGS	85.
	LAURA BAY	25.	MUNTHANMAR	86.
	COLONA	26.	NGULWIRRIWIRRI	87.
	LOOKOUT HILL	27.	NIMBING	88.
			NINE MILE	89.
	MALTEE	28.	NULLYWAH	90.
	MERGHINY	29.	RED CREEK	91.
	MUNDA MUNDA WATA TJINA	30.	WARINGARRI	92.
	MUDAMUCKLA	31.	WARRAYU	93.
	MUNDA WANNA-MAR	32.	WOOLAH (or Doon Doon)	94.
	MURAT BAY	33.	WUGGABUN	95.
	NADIA	34.	**WYNDHAM**	96.
	NANBONA	35.	YIRRALALLEM	97.
	NANWOORA	36.		
	NULLARBOR	37.		
	NUNJIKOMPITA	38.		
	NUNDROO	39.		
	OAK VALLEY	40.		
	OVER ROAD	41.		
	PENONG	42.		
	PIMBAACLA	43.		
	PUNTABIE	44.		
	PINTUMBA	45.		
	PUREBA	46.		
	SCOTDESCO	47.		
	SMOKY BAY	48.		
	TALLOWON	49.		
	THEVENARD	50.		
	TIA TUCKIA	51.		

7.	**What town, suburb or community do you usually live in?** (If more than one, **"the one in which you spend most time".**) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK **"What's that nearest to?"** REPEAT UNTIL FOUND IN LIST OR SELECT **"None of the above"** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	UWORRA	52.		
	WATRABA	53.		
	WAREVILLA	54.		
	WANDANA	55.		
	WHITE WELL CORNER	56.		
	YALATA	57.		
	YARILENA	58.		
	YELLABINNA	59.		
	YUMBARRA	60.		
	None of the above – but has Indue card (sighted)	998		
	None of the above – TERMINATE INTERVIEW	999		

8.	**Do you get any of the following benefits or payments?** MULTIPLE RESPONSE. READ OUT	
	Austudy	1
	ABSTUDY	2
	Youth Allowance	3
	Parenting Payment (Partnered)	4
	Parenting Payment (Single)	5
	Newstart Allowance	6
	Disability Support Pension	7
	Age Pension	8
	Carer's Payment or Allowance	9
	Family Tax Benefit (FTB)	10
	Child Care Benefit (CCB)	11
	Veterans Payment	12
	Other *[Please specify]*_____________________	13
	None of these	14
	Don't know	98

8.	**Do you get any of the following benefits or payments?** MULTIPLE RESPONSE. READ OUT	
	Refused	99

9.	**Do you care for, or look after, a child who is less than 18 years old?** SINGLE RESPONSE	
	Yes	1
	No – SKIP TO 11	2
	Refused – SKIP TO 11	99

10.	**How many children do you care for, or look after, who live with you for at least one day per week, or for at least one whole month in a year?**	________
	Refused	99

SECTION B:
Profile of Debit Card Trial Participation

IF Q2=2 – NO LONGER ON DEBIT CARD TRIAL, GO TO SECTION C.

The next few questions are about the card I showed you earlier.

Would you like us to call this a "Cashless Debit Card" or an "Indue Card"?

A. Cashless Debit Card

B. Indue Card

[Survey programme will automatically fill remainder of questions referring to the card itself with either A or B depending on respondent's answer.]

11.	**What type of Cashless Debit Card Trial are you currently on?** READ OUT IF NECESSARY. SINGLE RESPONSE	
	Compulsory Cashless Debit Card Trial	1
	Opt-in Cashless Debit Card Trial	2
	Don't know / not sure	98
	Refused	99

IF CODE 2 AT 11 (OPT-IN), ASK, OTHERWISE SKIP TO 13

12.	**Why did you opt-in to go on the Cashless Debit Card?** Open-ended / free text. PROBE FULLY ____

13.	**And have you activated your [Cashless Debit Card] [Indue Card] and started using it to buy things?** SINGLE RESPONSE	

	Yes	1
	No	2
	Don't know / not sure	98
	Refused	99

IF CODE 2 (NO), 98 (DON'T KNOW / NOT SURE) or 99 (REFUSED) AT 13, SKIP TO 18

14.	**Have you had any problems using the [Cashless Debit Card] [Indue Card]? SINGLE RESPONSE**	
	Yes	1
	No	2

ASK ONLY IF 14=1 OTHERWISE SKIP TO 16

15.	**Please tell me about these problems.** **Open-ended / free text PROBE FULLY** ____

16.	**How much of your Centrelink payment goes on the [Cashless Debit Card] [Indue Card]? SINGLE RESPONSE. DO NOT READ OUT**	
	80%	1
	70%	2
	60%	3
	50%	4
	Other ______________________________	5
	Don't know/ Not sure	98
	If provided in $ amount write in ____________________	97
	Refused	99

IF 98 or 97/'DON'T KNOW'/'NOT SURE' / $ AMOUNT PROVIDED AT 16 ASK:

17.	**Is it ...? READ OUT [SINGLE RESPONSE]**	
	About half	1
	Most	2
	Almost all	3
	Other (Specify)_____________ DO NOT READ OUT	4
	Don't know / Not sure DO NOT READ OUT	98

ASK ALL

17A	**Have you asked the Community Panel to review how much of your Centrelink money goes onto the [Cashless Debit Card] [Indue card]? SINGLE RESPONSE**	

	Yes – ASK Q17B, OTHERWISE SKIP TO Q18	1
	No	2
	Can't say / Not sure / Don't know	98
	Refused	99

17B	**Did the amount or per cent of your Centrelink money that goes onto the [Cashless Debit Card] [Indue card] change after the Community Panel reviewed you? SINGLE RESPONSE**	
	Yes	1
	No	2
	Can't say / Not sure / Don't know	98
	Refused	99

17C	**Did you have any problems with the Community Panel or the process? SINGLE RESPONSE**	
	Yes – ASK Q17D, OTHERWISE SKIP TO Q18	1
	No	2
	Can't say / Not sure / Don't know	98
	Refused	99

17D	**Please tell me about these problems.**	
	Open-ended / free text PROBE FULLY ____	

18.	**Do you live with anyone else who is in the Cashless Debit Card Trial or has a [Cashless Debit Card] [Indue Card]? SINGLE RESPONSE**	
	Yes	1
	No	2
	Can't say / Not sure / Don't know	98
	Refused	99

ASK ONLY IF 18=1 OTHERWISE SKIP TO 20

19.	**What is your relationship to them? Would they be your… MULTIPLE RESPONSE**	
	Father	1
	Mother	2
	Husband	3
	Wife	4
	Defacto Male Partner	12

19.	**What is your relationship to them? Would they be your… MULTIPLE RESPONSE**	
	Defacto Female Partner	13
	Boyfriend	5
	Girlfriend	6
	Sister	7
	Brother	8
	Aunt	9
	Uncle	10
	Child	11
	Other (specify)____	97

The next few questions are about how the [Cashless Debit Card] [Indue Card] works and what you know about it.

20.	**Do you KNOW … ROTATE**	Yes	No	Not sure
A.	**What** you can and can't buy with the card	1	2	98
B.	The **types of places or where** you can and can't use the card	1	2	98
C.	What to do if the card is **lost or stolen**	1	2	98

21.	**Before this survey, did you know that …. ROTATE**	Yes	No	Refused
A.	You **can't buy alcohol or grog** with the card	1	2	99
B.	You **can't use the card to make bets** or for other types of gambling	1	2	99
C.	You can use the card **in most places where Visa cards are accepted**, including online or on the internet	1	2	99
D.	You can use the card to make **online payment transfers** to pay bills, for housing and other expenses	1	2	99

22.	**Please think about the things you buy at shops but not any alcohol or gambling products. Since you started using the card, have you had to change where or how you shop for these things? SINGLE RESPONSE**	
	Yes	1
	No	2
	Don't know / not sure	98

ASK ONLY IF 22=1 OTHERWISE SKIP TO 24

23.	**Please tell me about these changes.** Open-ended / free text PROBE FULLY ____

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SECTION C:
Profile of Current Behaviour and Attitudes

Thanks for all that. The next few questions are about the last three months, so March, April and May. They include questions about personal things, including your money situation, how much you gamble, how much alcohol you drink, whether you take drugs, whether you have been arrested, beaten up or robbed and how safe you feel in your community. I'd just like to remind you that you don't have to answer any of these questions. You can skip any question that you are not comfortable answering. You can stop talking if you want to any time.

24.	**First, about some things that may or may not have happened to you. In the last 3 months how often, if at all, did you…?** **DO NOT ROTATE**
i.	Run out of money to buy food
ii.	Not have money to pay rent or your mortgage on time
iii.	Not have money to pay some other type of bill when it was due
iv.	Run out of money to pay for things that your child/children needed for school, like books [ONLY ASK IF CARING FOR CHILDREN AT 9]
v.	Run out of money to pay for essential (non-food) items for your children, such as nappies, clothes and medicine [ONLY ASK IF CARING FOR CHILDREN AT 9]
vi.	Borrow money from family or friends
vii.	Run out of money because you had given money to friends or family

RESPONSE FRAME: Would you say…

1. More than once a week
2. About once a week
3. About once every 2 weeks
4. About once a month
5. One or two times
6. Never

97. Not Applicable
99. Refused

INTERVIEWER NOTE: at C below clarify that gamble/gambling refers to any of the following: poker or gaming machines, betting on horse, harness or greyhound races, lottery products in person or online, keno, blackjack, roulette, bingo, betting on a sporting event like football, card games like poker privately for money, and any other games such as dice games privately for money

25.	**Lately, have you done any of these things? ROTATE. ENCOURAGE BEST ESTIMATE, IF DONE AT ALL, PROBE FOR HOW OFTEN**
A.	Have grog (a drink containing alcohol)
B.	Have six or more drinks of grog / alcohol at one time
C.	Gamble
D.	Spend three or more hours a day gambling

25.	**Lately, have you done any of these things? ROTATE. ENCOURAGE BEST ESTIMATE, IF DONE AT ALL, PROBE FOR HOW OFTEN**
E.	Spend more than $50 a day on gambling
F.	Gamble more than you can afford to lose
G.	Borrow money or sell things to get money to gamble
H.	Use an illegal drug or a prescription medication for nonmedical reasons
I.	Spend more than $50 a day on drugs not prescribed by a doctor
J.	Borrow money or sell things to get money to buy alcohol / drugs

RESPONSE FRAME:

1. More than once a week – Specify: _____
2. About weekly
3. About once every 2 weeks
4. About monthly
5. Every 2-3 months
6. Less often
7. Never
8. Done – but frequency not specified

97. Not Applicable
99. Refused

IF 8=8 (AGE PENSION) SKIP TO 28

26.	**Are you currently looking for a job or paid work? READ OUT SINGLE RESPONSE**	
	Yes	1
	No	2
	Refused	99

IF 26=2 OR 99 (NOT LOOKING FOR A JOB) SKIP TO 28

27.	**Usually, how many hours a week would you spend on trying to get a job or paid work? SINGLE RESPONSE. READ OUT**	
	Less than 2 hours per week	1
	3-5 hours	2
	6-10 hours	3
	11-20 hours	4
	21-30 hours	5
	More than 30 hours	6
	Can't say/ Not sure	98

	Refused	99

IF NOT CARING FOR CHILDREN AT 9 (9>1), SKIP TO 29

28.	**Do any of the children you care for go to school?** **SINGLE RESPONSE. READ OUT**	
	Yes – ASK Q28A, OTHERWISE SKIP TO Q29	1
	No	2
	Not Applicable – do not regularly look after children	97
	Can't say/ Not sure	98
	Refused	99

28A	**Usually, do you check to make sure that the children are doing their homework or help with any other things to do with school?** **SINGLE RESPONSE. READ OUT**	
	Yes – often	1
	Yes – sometimes	2
	Yes – occasionally	3
	No	4
	Not Applicable – do not regularly look after children	97
	Can't say/ Not sure	98
	Refused	99

Now, just think about the **past month** when you are answering these next few questions.

29.	**In the last month have you been ....** **ROTATE**	Yes	No		Can/t say/ Not sure	Refused
A.	arrested by the police	1	2		98	99
B.	beaten up, injured, or assaulted	1	2		98	99
C.	harassed	1	2		98	99
D.	robbed	1	2		98	99
E.	threatened or attacked with a gun, knife or other weapon	1	2		98	99
F.	homeless or had to sleep rough	1	2		98	99
G.	humbugged or pressured by family or friends to give them money	1	2		98	99
H.	injured or had an accident after drinking alcohol or grog or taking drugs	1	2		98	99

Now some questions about your local community.

30.	**Do you feel proud or ashamed of the community in which you live? Is that very proud /ashamed?** SINGLE RESPONSE.	
	Very proud	1
	Proud	2
	Neither proud or ashamed	3
	Ashamed	4
	Very ashamed	5
	Can't say / Not sure	98
	Refused	99

31.	**Do you feel safe or unsafe …** ROTATE. Is that very safe/unsafe?	Very safe	Safe	Neither	Unsafe	Very unsafe	Can't say / Not sure	Refused
1.	On the streets of your community during the day	1	2	3	4	5	98	99
2.	On the streets of your community during the night	1	2	3	4	5	98	99
3.	At home	1	2	3	4	5	98	99

Now I'd like to ask you some questions about support services in your community.

32A	**Before this survey, were you aware of any drug and alcohol support services in your local area?**	
	Yes, I was aware	1
	No, I wasn't aware SKIP TO Q36	2
	Unsure	98
	Refused SKIP TO Q36	99

32B	**Can you give me up to three examples of drug and alcohol services in your local area that you know of?** MULTIPLE RESPONSE. MAXIMUM OF THREE RESPONSES. [PROBE FOR MOST SPECIFIC DESCRIPTION]	
	[Please specify]	
	[Please specify]	
	[Please specify]	

32B	**Can you give me up to three examples of drug and alcohol services in your local area that you know of?** MULTIPLE RESPONSE. MAXIMUM OF THREE RESPONSES. [PROBE FOR MOST SPECIFIC DESCRIPTION]	
	None SKIP TO Q36	98
	REFUSED	99

33.	**Have you ever used these local services or other services that help people to deal with problems related to alcohol or drug use?** SINGLE RESPONSE	
	Yes	1
	No	2
	Don’t know / not sure	98
	Refused	99

IF 33>1, SKIP TO 36

34.	**When was the last time that you got help from an alcohol or drug support service?** SINGLE RESPONSE	
	In the last month	1
	1-3 months ago	2
	4-6 months ago	3
	7-12 months ago	4
	13-15 months ago	5
	More than 15 months ago	6
	Don’t know / not sure	98
	Refused	99

ASK ONLY IF 34<5

35.	**How many times did you get help from an alcohol or drug support service in the past year?**	________
	Refused	99

36.	**How likely is it that you will try and get help from an alcohol or drug support service in the future?** SINGLE RESPONSE	
	Definitely will not	1
	Most likely will not	2
	Maybe will/ maybe won’t	3

	Most likely will	4
	Definitely will	5
	Don't know / not sure	98
	Refused	99

INTERVIEWER NOTE: Financial support services give advice, information and help with debt, bills, and budgeting to people that may be facing financial problems or finding it hard to get by. **Family** support services give advice and information to people on income support payments for families.

37A	**Before this survey, were you aware of any financial and family support services in your local area?**	
	Yes, I was aware	1
	No, I wasn't aware [SKIP TO 41]	2
	Unsure	98
	Refused [SKIP TO 41]	99

37B	**Can you give me up to three examples of financial and family support services in your local area that you know of?** MULTIPLE RESPONSE. MAXIMUM OF THREE RESPONSES. [PROBE FOR MOST SPECIFIC DESCRIPTION]	
	[Please specify]	
	[Please specify]	
	[Please specify]	
	None SKIP TO 41	98
	Refused	99

38.	**Have you ever used these local services or other services that help people to deal with financial or family problems?** SINGLE RESPONSE	
	Yes	1
	No	2
	Don't know / not sure	98
	Refused	99

IF 38>1, SKIP TO 41

39.	**When was the last time that you got help from a financial or family support service?** SINGLE RESPONSE	
	In the last month	1

39.	**When was the last time that you got help from a financial or family support service?** SINGLE RESPONSE	
	1-3 months ago	2
	4-6 months ago	3
	7-12 months ago	4
	13-15 months ago	5
	More than 15 months ago	6
	Don't know / not sure	98
	Refused	99

ASK ONLY IF 39<5

40.	**How many times did you get help from a financial or family support service in the past year?**	________
	Refused	99

41.	**How likely is it that you will try and get help from a financial or family support service in the future?** SINGLE RESPONSE	
	Definitely will not	1
	Most likely will not	2
	Maybe will/ maybe won't	3
	Most likely will	4
	Definitely will	5
	Don't know / not sure	98
	Refused	99

SECTION D:
Opinions of the impact of the Debit Card Trial

These final questions are about how life is going here now in [Ceduna] [Kununurra] [Wyndham] since the Cashless Debit Card came in.

42.	**Since the [Cashless Debit Card] [Indue Card]started in your community have you noticed more, less or the same amount of:** ROTATE	Less	Same	More	Can't say /Don't know	Refus ed
A.	Drinking of alcohol or grog in the community	1	2	3	98	99
B.	Violence in the community	1	2	3	98	99
C.	Gambling in the community	1	2	3	98	99

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42.	**Since the [Cashless Debit Card] [Indue Card]started in your community have you noticed more, less or the same amount of:** ROTATE	Less	Same	More	Can't say /Don't know	Refused
D.	Humbugging or harassment for money	1	2	3	98	99

IF NO LONGER ON THE DEBIT CARD, BUT HAD ONE (Q2=2) GO TO SECTION E

The next few questions are about how <u>your life</u> is going now that you have the [Cashless Debit Card] [Indue Card].

INTERVIEWER NOTE: At **43A** below 'save money' includes money saved in a person's Debit Card account as well as money saved in other accounts or in cash for a specific purpose (beyond day-to-day living expenses).

43.	**Since being on the [Cashless Debit Card] [Indue Card] have these happened to you?** ROTATE	Yes	No	Not applicable – do not regularly look after children	Can't say / Not sure	Refused
A.	You've been able to save more money than before	1	2		98	99
B.	You've been better able to care for your child/ren [ONLY ASK IF CARING FOR CHILDREN AT 9]	1	2	97	98	99
C.	You've got more involved in your children's homework and school [ONLY ASK IF CARING FOR CHILDREN AT 9]	1	2	97	98	99
D.	I've got better at things like using a computer, the internet or a smartphone	1	2		98	99

44.	Since being on the [Cashless Debit Card] [Indue Card], have you done each of the following more often, less often or the same as before? ROTATE	Less	Same	More	Not applicable – did not do activity before	Can't say / Not sure	Refused
A.	Drunk grog or alcohol	1	2	3	97	98	99
B.	Had six or more drinks of grog or alcohol at one time	1	2	3	97	98	99
C.	Gambled	1	2	3	97	98	99
D.	Spent more than $50 a day on gambling	1	2	3	97	98	99
E.	Bet more than you can really afford to lose	1	2	3	97	98	99
F.	Had to borrow money or sell things to get money to gamble	1	2	3	97	98	99
G.	Used an illegal drug like benzos, ice, marijuana, or speed	1	2	3	97	98	99
H.	Spent more than $50 a day on illegal drugs like benzos, ice, marijuana, or speed	1	2	3	97	98	99

45.	**Would you say, the [Cashless Debit Card] [Indue Card] has made your life...** SINGLE RESPONSE. READ OUT	
	a lot better	1
	a bit better	2
	no different	3
	a bit worse	4
	a lot worse	5
	Can't say / not sure	98
	Refused	99

IF 45=1, 2, 4 or 5 ASK46, ELSE SKIP TO 47

46.	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

47.	ONLY ASK IF CARING FOR CHILDREN AT 9] **Would you say the [Cashless Debit Card] [Indue Card] has made your [child's life]/[children's lives] ...** **SINGLE RESPONSE. READ OUT**	
	a lot better	1
	a bit better	2
	no different	3
	a bit worse	4
	a lot worse	5
	Not applicable – do not regularly look after children	97
	Can't say / not sure	98
	Refused	99

IF 47=1, 2, 4 or 5 ASK 47 A, ELSE SKIP TO SECTION E

47A	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

SKIP TO SECTION E

55.	**RESERVED – DO NOT ASK**	
	Yes, I have	1
	No, I haven't but I plan to	2
	No, and I don't plan to	3
	Can't say / not sure	98
	Refused	99

56.	**RESERVED – DO NOT ASK**
	Open-ended / free text. PROBE FULLY ____

SECTION E:
THIS SECTION IS FOR INDIVIDUALS WHO ARE NO LONGER ON THE CDCT

IF 3=1 ASK 50, ELSE SKIP TO 51

I understand you don't have a [Cashless Debit Card] [Indue Card] anymore but you used to.

57.	**Can you please tell me why this is? (Probe further if there is any mention of 'Community Panel' or 'Panel' in the response.)** **Open-ended / free text. PROBE FULLY** ____

SECTION F:
CONCLUSION

58.	**Are there any other changes, either good or bad, that have happened in your life or in the community since the [Cashless Debit Card] [Indue Card] came in?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2
59.	**What other changes have happened? Open-ended / free text.** ____	

60.	**We have come to the end of the questionnaire. Would you like to say anything else about the [Cashless Debit Card] [Indue Card], the Trial, or your experiences that we haven't asked you about?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2
61.	**What would you like to add? Open-ended / free text.** ____	

Respondent's Signature: (confirming they have received their incentive):

…………………………………………………………………………….

DO NOT READ OUT C1A

C1A.	**DID RESPONDENT INDICATE THEY WOULD LIKE TO GET A SUMMARY OF THE SURVEY RESULTS?**	SINGLE RESPONSE DO NOT READ OUT
	Yes	1
	No	2

ASK ONLY IF RESPONDENT REQUESTED A SUMMARY OF THE SURVEY RESULTS (C1A=1)

C1.	**You mentioned that you would like to get a summary of the survey**	SINGLE

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	results. How would you like us to send that to you?	RESPONSE READ OUT OPTIONS 1 AND 2
	By email	1
	By post	2
	[Changed mind – does not want summary to be provided]	3

IF REQUESTED SUMMARY: For this purpose only, can I please record your name, and email/ postal address?

Respondent's Name: ....

Respondent's Address: ....

Email:_________________@_____________________________

Our Privacy Policy is available at www.orima.com and contains further details regarding how you can access or correct information we hold about you, how you can make a privacy related complaint and how that complaint will be dealt with. Should you have any questions about our privacy policy or how we will treat your information, you may contact our Privacy Officer, Liesel van Straaten on (03) 9526 9000.

Until we de-identify our research records, you have the right to access the information that we hold about you as a result of this interview. You may request at any time to have this information de-identified or destroyed.

Thank you for taking the time to participate in the study.

Interviewer to complete before signing.

- *I have informed the respondent of the purpose of the research and their rights.* ☐
- *I have informed the respondent that their identity will be kept confidential and that any information they supply will only be used for the purposes of the research.* ☐
- *I have informed the respondent of their right to stop the interview at any time and / or ask that the information they've given not be used by contacting ORIMA Research.* ☐
- *The respondent has consented to participating in the survey for evaluation of the Cashless Debit Card Trial measures in Ceduna/ Kununurra/ Wyndham* [strikeout whichever not applicable]. ☐

Signature: ____________________________________

Interviewer Name: ______________________________

Date: _______ /________ / 2017

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Australian Government
Department of Social Services

Evaluation of the Cashless Debit Card Trial

Non-Participant Questionnaire – Wave 2

ORIMA RESEARCH

Preliminary Screening

For all respondents, conduct ID check (say to respondent that this is to ensure that people can only do the interview once – to prevent double counting/ dipping).

ID Check

1. Medicare Card [specify last four digits]
2. Drivers Licence [specify last four digits]
3. RESERVED – DO NOT USE
4. Continue without ID
5. Continue with other ID [Specify]
6. Terminate interview

Introduction

Good morning/afternoon. My name is [SAY NAME] from ORIMA Research.

We have been asked by the Australian Government Department of Social Services to talk to people in the community and find out how the new Cashless Debit Card is working here in [Ceduna] [Kununurra] [Wyndham].

What will the survey interview involve?

The survey interview should last around 10 minutes. I want to ask you some questions about the new Cashless Debit Card trial and what you and the community think about it.

If you qualify and complete the survey you will get a voucher worth $30, which you can use at a local store, as a small 'thank you' for your time.

What will be done with the information?

Unless you want us to tell other people, or we are required to do so by an Australian law, no one other than ORIMA Research staff working on this survey will find out what you tell me during the survey. The Department of Social Services will get a report later on, but they will not see your name or what you have told us.

What you tell me in the survey will tell the Australian Government how well the new Debit Card system is working.

You can get a copy of the results of the survey. If you would like to be sent a copy of the results, please let me know later on.

Participation is voluntary

By doing this survey you'll get to have a say about what works and what doesn't work in the Debit Card system. While we would really like to hear your views, you do not have to do the interview. It is up to you if you want to talk to us or not. We will not tell Centrelink whether or not you have spoken to us, and your Centrelink payments will not be affected by your decision to take part in this survey, or if you decide to withdraw later on. You don't have to answer all the questions. You can stop talking if you want to any time.

If you want to talk about the survey and what you told us, please feel free to contact Robbie Corrie at ORIMA Research on our toll-free number 1800 654 585.

SECTION A:
Demographics

Let's start by asking you to tell me a little about yourself.

12.	**How old are you?**	
	Age ______________________________	
	Refused	99

IF PERSON IS LESS THAN 18 YEARS OLD, THANK AND END

IF 1=99 (REFUSED) ASK 1A

1A.	**Which age group do you belong to?** **SINGLE RESPONSE. READ OUT**	
	Less than 18 years old	1
	18-19	2
	20-24	3
	25-34	4
	35-44	5
	45-54	6
	55-64	7
	65 years old and over	8
	[Refused]	99

IF 1A=99 OR 1A=1, THANK AND END

13.	**Do you have one of these Indue Debit Cards in your name?** [Show the picture of an Indue card] **SINGLE RESPONSE**	
	Yes - **SWAP TO TRIAL PARTICIPANT SURVEY SCRIPT**	1
	No – **CONTINUE**	2
	Refused – **TERMINATE INTERVIEW**	99

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14.	**Have you ever had one of these cards? SINGLE RESPONSE**	
	Yes - **SWAP TO TRIAL PARTICIPANT SURVEY SCRIPT**	1
	No – **CONTINUE**	2

15.	[Interviewer to indicate gender of participant]	
	Female	1
	Male	2
	Indeterminate	3

16.	**Does anyone in your immediate family who lives with you have one of these cards?** (show again as necessary)? **So this could be your partner, husband, wife, child, parent, brother or sister. SINGLE RESPONSE**	
	Yes – **TERMINATE INTERVIEW**	1
	No – **CONTINUE**	2
	Can’t say / Not sure / Don’t know - **TERMINATE INTERVIEW**	98
	Refused - **TERMINATE INTERVIEW**	99

17.	**Were you... SINGLE RESPONSE**	
	Born in Australia	1
	Born overseas (specify country_________________________)	2
	Refused	99

18.	**Are you of Aboriginal or Torres Strait Islander origin? SINGLE RESPONSE**	
	No – SKIP TO Q9	1
	Yes	2
	Refused – SKIP TO Q9	99

19.	**Which of the following best describes your origin?** **READ OUT.** SINGLE RESPONSE	
	Both Aboriginal and Torres Strait Islander origin	1
	Aboriginal origin	2
	Torres Strait Islander origin	3
	Refused	99

20.	**What town, suburb or community do you usually live in?** (If more than one, **"the one in which you spend most time".**) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK **"What's that nearest to?"** REPEAT UNTIL FOUND IN LIST OR SELECT **"None of the above"** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	BALD HILL	1.	ALLIGATOR HOLE	61.
	BETTS CORNER	2.	BELL SPRINGS	62.
	BOOKABIE	3.	BETHAL	63.
	BORDER VILLAGE	4.	CARLTON HILL	64.
	BULINDA	5.	COCKATOO SPRINGS	65.
	CACTUS BEACH	6.	DILLON SPRINGS	66.
	CEDUNA	7.	DINGO SPRINGS	67.
			DOON DOON	68.
	CEDUNA TOWN CAMP	8.	EMU CREEK	69.
	CHINBINGINA	9.	FLYING FOX	70.
	CHINTA	10.	FOUR MILE	71.
	CHARRA	11.	GEBOOWAMA	72.
	CHUNDARIA	12.	GLEN HILL	73.
	CUNGENA	13.	GOOSE HILL	74.
	COORABIE	14.	GUDA GUDA	75.
	CARAWA	15.	GULBERANG	76.
	DENIAL BAY	16.	HOLLOW SPRINGS	77.
	DINAH LINE	17.	JIMBILUM	78.
	DUCKPOND	101.		
	DUNDEE	102.		
	KOONGAWA DUNDEE	18.	KUMBRARUMBA	79.
	EMU FARM	19.	**KUNUNURRA**	80.
	FOWLERS BAY	20.	KUNUNURRA REGION	81.

20.	**What town, suburb or community do you usually live in?** (If more than one, **"the one in which you spend most time".**) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK "**What's that nearest to?**" REPEAT UNTIL FOUND IN LIST OR SELECT **"None of the above"** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	GLEN BOREE	21.	MINIATA	82.
	HEAD OF GREAT AUSTRALIAN BIGHT	22.	MIRIMA	83.
	KALANBI	23.	MOLLY SPRINGS	84.
	KOONIBBA	24.	MUD SPRINGS	85.
	LAURA BAY	25.	MUNTHANMAR	86.
	COLONA	26.	NGULWIRRIWIRRI	87.
	LOOKOUT HILL	27.	NIMBING	88.
			NINE MILE	89.
	MALTEE	28.	NULLYWAH	90.
	MERGHINY	29.	RED CREEK	91.
	MUNDA MUNDA WATA TJINA	30.	WARINGARRI	92.
	MUDAMUCKLA	31.	WARRAYU	93.
	MUNDA WANNA-MAR	32.	WOOLAH (or Doon Doon)	94.
	MURAT BAY	33.	WUGGABUN	95.
	NADIA	34.	**WYNDHAM**	96.
	NANBONA	35.	YIRRALALLEM	97.
	NANWOORA	36.		
	NULLARBOR	37.		
	NUNJIKOMPITA	38.		
	NUNDROO	39.		
	OAK VALLEY	40.		
	OVER ROAD	41.		
	PENONG	42.		
	PIMBAACLA	43.		
	PUNTABIE	44.		
	PINTUMBA	45.		
	PUREBA	46.		
	SCOTDESCO	47.		
	SMOKY BAY	48.		

20.	**What town, suburb or community do you usually live in?** (If more than one, **"the one in which you spend most time".**) SINGLE RESPONSE [IF YOU CANNOT FIND THE TOWN IN THE LIST, ASK **"What's that nearest to?"** REPEAT UNTIL FOUND IN LIST OR SELECT **"None of the above"** [999]			
	CEDUNA LIST		**KUNUNURRA/WYNDHAM LIST**	
	TALLOWON	49.		
	THEVENARD	50.		
	TIA TUCKIA	51.		
	UWORRA	52.		
	WATRABA	53.		
	WAREVILLA	54.		
	WANDANA	55.		
	WHITE WELL CORNER	56.		
	YALATA	57.		
	YARILENA	58.		
	YELLABINNA	59.		
	YUMBARRA	60.		
	None of the above – TERMINATE INTERVIEW	**999**		

11.	**Do you get any of the following benefits or payments?** MULTIPLE RESPONSE. READ OUT	
	Austudy	1
	ABSTUDY	2
	Youth Allowance	3
	Parenting Payment (Partnered)	4
	Parenting Payment (Single)	5
	Newstart Allowance	6
	Disability Support Pension	7
	Age Pension	8
	Carer's Payment or Allowance	9
	Family Tax Benefit (FTB)	10
	Child Care Benefit (CCB)	11
	Veterans Payment	12
	Other *[Please specify]*______________________	13
	None of these	14

11.	**Do you get any of the following benefits or payments?** MULTIPLE RESPONSE. READ OUT	
	Don't know	98
	Refused	99

SECTION B:
Profile of Cashless Debit Card Knowledge

The next few questions are about the card I showed you earlier.

Would you like us to call this a "Cashless Debit Card" or an "Indue Card"?

A. Cashless Debit Card

B. Indue Card

C. Other: [Specify] ________

[Survey programme will automatically fill remainder of questions referring to the card itself with either A, B or C depending on respondent's answer.]

The next few questions are about how the [Cashless Debit Card] [Indue Card] works and what you know about it.

13.	**Before this survey, had you heard of the [Cashless Debit Card] [Indue Card]?** SINGLE RESPONSE	
	Yes	1
	No – SKIP TO SECTION C	2

14. (i)	**Do you KNOW …** ROTATE	Yes	No	Not sure
A.	**What** people can and can't buy with the card	1	2	98
B.	The **types of places or where** people can and can't use the card	1	2	98

12. (ii)	**Before this survey, did you know that ….** ROTATE ALL EXCEPT FOR A AND B	Yes	No	Refused
A.	**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	1	2	99
B.	Wage earners, aged pensioners and veterans pensioners who live in this area **can choose to get one of these cards**	1	2	99
C.	You **can't buy alcohol or grog** with the card	1	2	99
D.	You **can't use the card to make bets** or for other types of gambling	1	2	99
E.	You can use the card **in most places where Visa cards are accepted**, including online or on the internet	1	2	99
F.	You can use the card to make **online payment transfers** to pay bills, for housing and other expenses	1	2	99

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SECTION C:
Profile of Current Behaviour and Attitudes

Thanks for all that. Now, please just think about the **past month** when you are answering these next few questions. They include questions about personal things, including whether you have been beaten up or robbed and how safe you feel in your community. I'd just like to remind you that you don't have to answer any of these questions. You can skip any question that you are not comfortable answering. You can stop talking if you want to any time.

16.	**In the last month have you been ….** ROTATE	Yes	No		Can't say/ Not sure	Refused
A.	Beaten up, injured, or assaulted	1	2		98	99
B.	Harassed	1	2		98	99
C.	Robbed	1	2		98	99
D.	Threatened or attacked with a gun, knife or other weapon	1	2		98	99
E.	Humbugged or pressured by family or friends to give them money	1	2		98	99

Now some questions about your local community.

17.	**Do you feel proud or ashamed of the community in which you live? Is that very proud /ashamed?** SINGLE RESPONSE.	
	Very proud	1
	Proud	2
	Neither proud or ashamed	3
	Ashamed	4
	Very ashamed	5
	Can't say / Not sure	98
	Refused	99

18.	**Do you feel safe or unsafe … ROTATE. Is that very safe/unsafe?**	Very safe	Safe	Neither	Unsafe	Very unsafe	Can't say / Not sure	Refused
1.	On the streets of your community during the day	1	2	3	4	5	98	99
2.	On the streets of your community during the night	1	2	3	4	5	98	99

18.	**Do you feel safe or unsafe … ROTATE. Is that very safe/unsafe?**	Very safe	Safe	Neither	Unsafe	Very unsafe	Can't say / Not sure	Refused
3.	At home	1	2	3	4	5	98	99

SECTION D:
Opinions of the impact of the Debit Card Trial

These final questions are about how life is going here now in [Ceduna] [Kununurra] [Wyndham] since the [Cashless Debit Card] [Indue card] came in.

17.	**Since the [Cashless Debit Card] [Indue Card] started in your community have you noticed more, less or the same amount of: ROTATE**	Less	Same	More		Can't say /Don't know	Refused
A.	Drinking of alcohol or grog in the community	1	2	3		98	99
B.	Violence in the community	1	2	3		98	99
C.	Gambling in the community	1	2	3		98	99
D.	Humbugging or harassment for money	1	2	3		98	99

23.	**Would you say the [Cashless Debit Card] [Indue Card] has made life in <u>your community</u> ...** **SINGLE RESPONSE. READ OUT**	
	a lot better	1
	a bit better	2
	no different	3
	a bit worse	4
	a lot worse	5
	Can't say / not sure	98
	Refused	99

IF Q17=1, 2, 4, 5 ASK Q18, ELSE SKIP TO SECTION E

24.	**Why do you say that?**
	Open-ended / free text. PROBE FULLY ____

ORIMA RESEARCH

SECTION E:
Opinions of the impact of the Debit Card Trial

25.	**Are there any other changes, either good or bad, that have happened in the community since the [Cashless Debit Card] [Indue Card] came in?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2
26.	**What other changes have happened? Open-ended / free text.** ____	

27.	**We have come to the end of the questionnaire. Would you like to say anything else about the [Cashless Debit Card] [Indue Card], the Trial, or your experiences that we haven't asked you about?**	
	No / nothing else	1
	Yes [ENTER TEXT BELOW]	2
28.	**What would you like to add? Open-ended / free text.** ____	

Respondent's Signature: (confirming they have received their reimbursement):

____

DO NOT READ OUT C1A

C1A.	**DID RESPONDENT INDICATE THEY WOULD LIKE TO GET A SUMMARY OF THE SURVEY RESULTS?**	SINGLE RESPONSE DO NOT READ OUT
	Yes	1
	No	2

ASK ONLY IF RESPONDENT REQUESTED A SUMMARY OF THE SURVEY RESULTS (C1A=1)

C1.	**You mentioned that you would like to get a summary of the survey results. How would you like us to send that to you?**	SINGLE RESPONSE READ OUT OPTIONS 1 AND 2

	By email	1
	By post	2
	[Changed mind – does not want summary to be provided]	3

IF REQUESTED SUMMARY: For this purpose only, can I please record your name, and email/ postal address?

Respondent's Name: ....

Respondent's Address: ....

Email:_________________@______________________________

Our Privacy Policy is available at www.orima.com and contains further details regarding how you can access or correct information we hold about you, how you can make a privacy related complaint and how that complaint will be dealt with. Should you have any questions about our privacy policy or how we will treat your information, you may contact our Privacy Officer, Liesel van Straaten on (03) 9526 9000.

Until we de-identify our research records, you have the right to access the information that we hold about you as a result of this interview. You may request at any time to have this information de-identified or destroyed.

Thank you for taking the time to participate in the study.

Interviewer to complete before signing.

- *I have informed the respondent of the purpose of the research and their rights.* ☐
- *I have informed the respondent that their identity will be kept confidential and that any information they supply will only be used for the purposes of the research.* ☐
- *I have informed the respondent of their right to stop the interview at any time and / or ask that the information they've given not be used by contacting ORIMA Research.* ☐
- *The respondent has consented to participating in the survey for evaluation of the Cashless Debit Card Trial measures in Ceduna/ Kununurra/ Wyndham* [strikeout whichever not applicable]. ☐

Signature: ____

Interviewer Name: ________________________________

Date: _______ /________ / 2017

Appendix E: Qualitative issues guides

Initial Conditions Issues Guide

Department of Social Services

Evaluation of the cashless debit card trial

Issues guide

Explanatory notes

- This issues guide provides an idea of the range and coverage of issues that will come out of the research project.
- It is a guide for discussion, and will not be used as a script—phrasing, wording and order will be adapted as appropriate for the target audience.
- This guide does not represent a complete list of the questions that will be asked or covered in each focus group / interview. The coverage will be guided by the researchers and informed by participants. All questions are fully open-ended.
- Some questions are necessary for context-setting and testing for 'group think' effects.
- Some questions are similar because they are trying to get at an issue from a number of angles and to validate responses / views.
- The order and flow of the questions will be guided by the researchers and informed by the group / interview.
- Reported issues / data will be probed for evidence / examples wherever relevant.
- Please note questions will be adapted for each target audience type.
- Throughout the guide, 'CDCT' refers to the cashless debit card trial.

Introduction

- Introduction of self (and observers)
- Purpose
  - We are conducting research for the Australian Government Department of Social Services.
  - This research is part of the evaluation of the cashless debit card trial – focusing mainly on how things were in the community before the trial (e.g. in relation to alcohol, drug and gambling abuse). We are also interested to know about any issues relating to program implementation and ideas you might have for improvements.
- Use of data
  - The information from the discussion today will be analysed and form part of our evaluation, in particular to help provide a baseline for the trial.
- Participant role
  - Today we would ask that you discuss your views as a representative of the organisation from which you come.

- As part of our report we will list the organisations / communities of people who took part in the discussions. While individuals will not be identified in the report, the research is not anonymous.
- If you have personal views about elements of the debit card trial that are not necessarily shared by your agency we would be interested in these but please do identify them as such to us as you share these.

- Please turn off or put on silent mode mobile phones
- Observations and recording
- Housekeeping—discussion will take around 90 minutes, catering, amenities
- Group rules—different points of view encouraged, no right or wrong answers, moderator and participant roles

ASK PARTICIPANTS TO COMPLETE CONTACT CARD AND CONSENT FORM

Introduction

1. About participants
   a. Name
   b. Organisation representing
   c. What role have you or the organisation you represent had in initiating the trial or deciding how it works?
   d. What types of dealings do you have with people who may be using the debit card?

2. Expectations of trial
   a. Do you expect the trial will have any impact? Why?
   b. What positive outcomes are you expecting to come from the trial? Why?
   c. What negative outcomes are you expecting to come from the trial? Why?

Awareness and understanding of the CDCT

3. Awareness and understanding of the CDCT among clients:
   a. What do clients know about the CDCT? [Probe: what, who for, who excluded, when start, how long trial for and how it will work]
   b. How do people refer to the CDCT? [Probe type words / terms used]
   c. What's the purpose of the CDCT? How well was the CDCT communicated to clients?
   d. How do clients find out what you need to know about the CDCT?
   e. Is there anything about the trial that is unclear to clients or needs explaining more?
   f. How could this best be achieved for clients/people you represent?

Performance indicators – output measures

4. Community leader's perceptions of the CDCT
   a. How do the community leaders feel about the CDCT? [Probe for level of endorsement]
   b. How do the Indigenous leaders feel about the CDCT? [Probe for level of endorsement]

5. Stakeholders' perceptions of the CDCT
    a. How does your organisation feel about the CDCT?
    b. How does your organisation feel about the community panel (i.e. process for exceptions to the 80-20 condition)?

6. Community's perceptions of the CDCT
    a. What does the community think about the CDCT? How do you know this?
    b. What do they see as the purpose of CDCT?
    c. Do they understand how it works?

Performance indicators – outcome measures

THE FOLLOWING QUESTIONS RELATE TO BEFORE THE TRIAL STARTED

7. Alcohol / drug use behaviours
    a. Before the trial, what problems existed in the community in relation to alcohol and drug abuse? How severe was the problem? [Probe: examples]
    b. What were the consequences of this? Who was impacted? [Probe for drug and alcohol related injuries, hospital admissions, etc.]
    c. Do you expect the CDCT to have any impact on these problems? What? Why / why not? What impacts if any have you seen so far? What makes you think / say that?

8. Gambling behaviours
    a. Before the trial, what problems existed in the community in relation to gambling? How severe was the problem? [Probe: examples, types of gambling – regulated vs unregulated]
    b. What were the consequences of this? Who was impacted?
    c. Do you expect the CDCT to have any impact on these problems? What? Why / why not? What impacts if any have you seen so far? What makes you think / say that?

9. Clients' awareness and usage of support services (family, financial, drug, alcohol, gambling etc.)
    a. Before the trial, what family and financial support services were available in the community? [Probe: other services like drug and alcohol, gambling, etc.]
    b. Were clients / people aware of these services?
    c. Has this changed for better or worse (number, type, availability of services) since the launch of the CDCT?
    d. Before the trial, what level of awareness existed in the community of family and financial support services, alcohol and drug services and gambling services?
    e. What levels of usage were there in the community of these services? Who used them? Why?
    f. What were the consequences of such usage? Who was impacted?
    g. Do you expect the CDCT to have any impact on awareness and usage of these services? What? Why / why not? What impacts if any have there been seen so far? What makes you think / say that?

10. Violence / other crimes
    a. Before the trial, what problems existed in the community in relation to violence and criminal behaviour? How severe was the problem? [Probe: examples]
    b. What were the consequences of this? Who was impacted?

c. Do you expect the CDCT to have any impact on these problems? What? Why / why not? What impacts if any have there been seen so far? What makes you think / say that?

11. Safety
    a. Before the trial, how safe / unsafe do you believe people felt at home? And in the community? Why? [Probe: examples]
    b. What were the consequences of this? Who was impacted?
    c. Do you expect the CDCT to have any impact on clients' perceptions of safety? What? Why / why not? What impacts if any has there been seen so far? What makes you think / say that?

12. Community pride
    a. Before the trial, how did people in this town / area feel about their community? How proud were they of their community? Why? What contributed to this? [Probe: examples]
    b. What were the consequences of this? Who was impacted?
    Do you expect the CDCT to have any impact on clients' pride in the community? What? Why / why not? What impacts if any has there been seen so far? What makes you think / say that?

Spill-over benefits

13. Meeting basic needs
    a. Before the trial, what problems existed in the community in relation to people's ability to afford basic household goods / paying bills? How severe was the problem? [Probe: examples]
    b. What were the consequences of this? Who was impacted?
    c. Do you expect the CDCT to have any impact on these problems? What? Why / why not? What impacts if any has there been seen so far? What makes you think / say that?

14. Employment / education / training
    a. Before the trial, what problems existed in the community in relation to employment, education and training? How severe was the problem? [Probe for motivation to be in paid employment, school attendance, engagement with children's education]
    b. What were the consequences of this? Who was impacted?
    c. Do you expect the CDCT to have any impact on these problems? What? Why / why not? What impacts if any has there been seen so far? What makes you think / say that?

15. Nutrition
    a. Before the trial, what problems existed in the community in relation to nutrition? How severe was the problem? [Probe: examples]
    b. What were the consequences of this? Who was impacted?
    c. Do you expect the CDCT to have any impact on these problems? What? Why / why not? What impacts if any has there been seen so far? What makes you think / say that?

16. Health and wellbeing
    a. Before the trial, what problems existed in the community in relation to health and wellbeing? How severe was the problem? [Probe: examples]
    b. What were the consequences of this? Who was impacted?
    c. Do you expect the CDCT to have any impact on these problems? What? Why / why not? What impacts if any has there been seen so far? What makes you think / say that?

Adverse consequences

17. Humbugging, stigma, harassment, begging, intimidation
    a. Before the trial, how much of the following occurred in the community? [Probe: how much (a little, some, a lot) and how often (never, sometimes, always)]
        - Humbugging
        - Harassment
        - Begging
        - Abuse or intimidation
    b. In Ceduna: Since the introduction of the trial, have you noticed any changes in these behaviours? What? How?

18. Privacy breaches, skimming, stolen cards
    a. In Ceduna: Since the introduction of the trial, have you noticed any changes in these behaviours? What? How?

19. Circumvention behaviours
    a. In Ceduna: Since the introduction of the trial, have you noticed any ways that people have got around the 80-20% cash arrangements / CDCT? What? How?

Conclusion

20. What are the 3 key positive impacts you expect to see (or have already seen) as a result of the trial?

21. What are the 3 key negative impacts you expect to see (or have already seen) as a result of the trial?

22. How can any negative impacts of which you're aware be addressed in the remainder of the trial?

Finish

Summarise outcomes

- Conducting the research as part of the baseline for the evaluation of the CDCT for the Australian Government Department of Social Services.

Thank participants.

Wave 1 Issues Guide

Department of Social Services

Evaluation of the cashless debit card trial

Issues guide – Wave 1

Introduction

- Introduction of self (and observers)
- Purpose
    - Conducting evaluation for the Australian Government Department of Social Services.
    - Evaluation of the cashless debit card trial – focusing mainly on how things are in the community since the trial began (Ceduna: 15 March 2016; East Kimberly: 26 April 2016). Also interested to know about how the card has been implemented, how to better support the community with the trial and ideas you might have for improvements.
- Use of data
    - Spoke with some of you at the baseline stage of the evaluation, before the trial fully started.
    - The information from discussion today will form part of our evaluation, in particular to help provide data / feedback on the initial stages of the trial (Wave 1).
    - We'll be back again towards the end of the trial (Wave 2) to talk with you.
- Participant role
    - Today we would ask that you discuss your views as a representative of the organisation from which you come.
    - As part of our report we will list the organisations / communities of people who took part in the discussions. While individuals will not be identified in the report, the evaluation is not anonymous.
    - If you have personal views about elements of the debit card trial that are not necessarily shared by your agency we would be interested in these but please do identify them as such to us as you share these.
- Please turn off or put on silent mode mobile phones
- Observations and recording
- Housekeeping—discussion will take around 90 minutes, catering, amenities
- Group rules—different points of view encouraged, no right or wrong answers, moderator and participant roles

Name: ___________________________ Organisation: _________________________

Role in organisation: ____

Agreement to organisation name being identified in list of participants for the evaluation? Yes / No (remain anonymous)

Introduction

About participants

b. Name
c. Organisation representing
d. Role in organisation
e. Types of dealings organisation has with people using the debit card

Impact of trial

Overall impact of trial

a. Identify 5 key impacts that the trial has had so far
b. Positive things seen from trial so far
    - Whether thought this would happen before trial?
c. Negative things seen so far
    - Whether thought this would happen before trial?

Specific impact of trial

a. Key impacts noticed / seen in individuals
b. Key impacts noticed / seen in families
c. Key impacts noticed / seen in community

Alcohol consumption

Alcohol consumption

a. Overall impact of trial so far on alcohol consumption
b. Frequency / amount of alcohol consumed
c. Frequency of binging

Patterns of most noticeable changes

a. Who – gender, ages, types of circumstances
b. When – times of day / week
c. What – change in types of alcohol consumed

Consequences / outcomes

a. Injuries / harm observed – individual + others
b. Personal health and wellbeing observed
c. Usage of alcohol support services

Drug use

Drug use

a. Impact of trial so far on drug use (e.g. marijuana, heroin, amphetamines)
b. Frequency / amount of drug use
c. Frequency of binging

Patterns of most noticeable changes

a. Who – gender, ages, types of circumstances
b. When – times of day / week
c. What – change in types of drugs used

Consequences / outcomes

a. Injuries / harm observed – individual + others
b. Personal health and wellbeing observed
c. Usage of drug support services

Gambling activity

Gambling activity

a. Impact of trial so far on gambling activity [e.g. regulated (pokies, TAB, online), unregulated (cards)]
b. Frequency / amount of gambling

Patterns of most noticeable changes

a. Who – gender, ages, types of circumstances
b. When – times of day / week
c. What – change in types of gambling activity

Consequences / outcomes

a. Harm observed – individual + others
b. Wellbeing observed
c. Usage of financial and family support services

Awareness and usage of support services

Awareness

a. Awareness of range of support services (e.g. drug, alcohol, family, financial)
b. Any new services started since trial began – awareness of these

Usage

a. Usage of support services – volume / frequency
b. Who using – gender, ages, types of circumstances
c. When using – crisis point, referral

d. What other supports accessed – whether referred / connected with other services (e.g. treatment, rehabilitation, counselling, employment, education, family, DV)
e. Gaps in support needs

Consequences / outcomes

a. Changes observed – individual + others
b. Other unexpected outcomes

Crime, safety and security

Violent and criminal behaviours

a. Overall impact of trial so far on violence and/or crime
b. Types / range – (e.g. assaults, burglaries / robberies / theft, vandalism, DUI, prostitution, public intoxication)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Safety and security

a. Overall impact of trial so far on community safety and/or security
b. Types / range – (e.g. violence / crime, rowdy behaviour, humbugging, verbal abuse, children roaming streets)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Other community experiences and concerns

Social impacts

a. Overall social impact of trial so far
b. Types / range – (e.g. arguments/disputes/fights, under-/un-employment, humbugging, abuse/intimidation of the vulnerable)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Financial impacts

a. Overall financial impact of trial so far
b. Types / range – (e.g. money for food, clothing, rent, bills, utilities, transportation, fines, ability to budget and save, motivation to be in paid employment)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Housing impacts

a. Overall housing impact of trial so far
b. Outcomes / changes observed – individual + others

Parenting impacts

a. Overall parenting impact of trial so far

b. Types / range – (e.g. school attendance + engagement, role-modelling, care + nurturing)
c. Frequency amount occurring
d. Outcomes / changes observed

Wellbeing impacts

a. Overall impact of trial so far on individual and children's wellbeing
b. Types / range – (e.g. time spent on healthy activities, nutrition, health)
c. Outcomes / changes observed

Awareness, understanding and initial implementation of the CDCT

Awareness and understanding of the CDCT

a. Awareness and understanding of trial – (e.g. target audience for mandatory vs voluntary, payment conditions (80% card-20% cash); community panel, card restrictions)
b. Gaps – anything about trial still unclear / needs explaining more

Implementation

a. Overall perceptions of initial implementation / roll-out of trial
b. Aspects that <u>worked</u> well
c. Aspects <u>not worked</u> well
d. Areas for improvement in implementation process

Community panels

a. Overall perceptions of community panel process/ set-up
b. Aspects that working well
c. Aspects not working well
d. Areas for improvement for community panel process/ set-up

Adverse consequences

Adverse consequences

a. Any adverse behaviours emerging so far in trial (e.g. humbugging, stigma, harassment, begging, intimidation, privacy breaches, skimming, stolen cards)
b. Any ways that people working around the 80-20% cash arrangements

Conclusion

Summing-up

a. 3 key positive impacts you have observed / seen as a result of the trial
b. 3 key negative impacts you have observed / seen as a result of the trial
c. What could be done to address negative impacts in the remainder of the trial?

Finish

Summarise outcomes

- ♦ Conducting the evaluation as part of the initial stage of the evaluation of the CDCT for the Australian Government Department of Social Services.

Thank participants.

Wave 2 Issues Guide

Department of Social Services

Evaluation of the cashless debit card trial

Issues guide – Wave 2

Explanatory notes

- This issues guide provides an idea of the range and coverage of issues that will come out of the research project.
- It is a guide for discussion, and will not be used as a script—phrasing, wording and order will be adapted as appropriate for the target audience.
- This guide does not represent a complete list of the questions that will be asked or covered in each focus group. The coverage will be guided by the researchers and informed by participants. All questions are fully open-ended.
- Some questions are necessary for context-setting and testing for 'group think' effects.
- Some questions are similar because they are trying to get at an issue from a number of angles and will validate responses / views.

Introduction

- Introduction of self (and observers)
- Purpose
  - Conducting evaluation for the Australian Government Department of Social Services.
  - Evaluation of the cashless debit card trial – focusing mainly on how things are in the community since the trial began. Also interested to know about how the card has been implemented, how to better support the community with the trial and ideas you might have for improvements.

Location	Trial began	Baseline FW	Wave 1 FW
Ceduna	15 March 2016	April 2016	August 2016
East Kimberley	26 April 2016	May 2016	September 2016

- Use of data
  - Spoke with some of you at the baseline stage of the evaluation and / or during Wave 1
  - The information from discussion today will form part of our evaluation, in particular to help provide data / feedback on the final stages of the trial (Wave 2).
- Participant role
  - Today we would ask that you discuss your views as a representative of the organisation from which you come.

- As part of our report we will list the organisations / communities of people who took part in the discussions. While individuals will not be identified in the report, the evaluation is not anonymous.
- If you have personal views about elements of the debit card trial that are not necessarily shared by your agency we would be interested in these but please do identify them as such to us as you share these. *ORIMA to record these views as personal and report as such.*

♦ Please turn off or put on silent mode mobile phones

♦ Observations and recording

♦ Housekeeping—discussion will take around 90 minutes, catering, amenities

♦ Group rules—different points of view encouraged, no right or wrong answers, moderator and participant roles

Name: ____________________________ **Organisation: __________________________**

Role in organisation: ____

Agreement to organisation name being identified in list of participants for the evaluation? Yes / No (remain anonymous)

Was participant involved in:	(Circle)
Setting up / designing the trial?	Y / N
Implementing the trial?	Y / N
Leadership group?	Current / past / never
Community panel that reviews applications for adjustments to card restrictions?	Current / past / never

To complete for past / current community leaders only:

Output performance indicator	Result
PI #1: Endorses programme	
Feels programme design is appropriate for their community characteristics	
Believes programme will be / is a good thing for their community	
Speaks positively about programme	
Believes Trial parameters were developed using a co-design approach	
PI #8: Believes appropriate adjustments are made to income restrictions on a case-by-case basis	
Believes community panels are assessing applications in a timely, consistent and fair manner	
Believes community panels are making just and reasonable decisions about changing percentage of welfare payments quarantined	

Introduction

About participants

a. Name
b. Organisation representing
c. Role in organisation
d. Types of dealings organisation has with people using the debit card

Impact of trial

Overall impact of trial

a. Identify 5 key impacts that the trial has had

b. Positive things seen from trial
   - Whether thought this would happen before trial?

c. Negative things seen
   - Whether thought this would happen before trial?

Specific impact of trial

a. Key impacts noticed / seen in individuals
b. Key impacts noticed / seen in families
c. Key impacts noticed / seen in vulnerable groups [Probe for differences for key vulnerable groups e.g. women, children, Indigenous, disability, older people]
d. Key impacts noticed / seen in community

Any other external factors that may have contributed to these impacts? (E.g. state government interventions).

Alcohol consumption

Alcohol consumption

a. Overall impact of trial on alcohol consumption since Wave 1 / trial commencement
b. Frequency / amount of alcohol consumed
c. Frequency of binging

Patterns of most noticeable changes

a. Who – gender, ages, types of circumstances [Probe for differences for key vulnerable groups e.g. women, children, Indigenous, disability, older people]
b. When – times of day / week
c. What – change in types of alcohol consumed

Consequences / outcomes

a. Injuries / harm observed – individual + others
b. Personal health and wellbeing observed
c. Usage of alcohol support services

Drug use

Drug use

a. Impact of trial since Wave 1 / trial commencement on drug use (e.g. marijuana, heroin, amphetamines)
b. Frequency / amount of drug use
c. Frequency of binging

Patterns of most noticeable changes

a. Who – gender, ages, types of circumstances [Probe for differences for key vulnerable groups e.g. women, children, Indigenous, disability, older people]
b. When – times of day / week
c. What – change in types of drugs used

Consequences / outcomes

a. Injuries / harm observed – individual + others
b. Personal health and wellbeing observed
c. Usage of drug support services

Gambling activity

Gambling activity

a. Impact of trial on gambling activity [e.g. regulated (pokies, TAB, online), unregulated (cards)]
b. Frequency / amount of gambling

Patterns of most noticeable changes

a. Who – gender, ages, types of circumstances [Probe for differences for key vulnerable groups e.g. women, children, Indigenous, disability, older people]
b. When – times of day / week
c. What – change in types of gambling activity

Consequences / outcomes

a. Harm observed – individual + others
b. Wellbeing observed
c. Usage of financial and family support services

Awareness and usage of support services

Awareness

a. Awareness of range of support services (e.g. drug, alcohol, family, financial)
b. Any new services started since Wave 1 / trial commencement – awareness of these

Usage

a. Usage of support services – volume / frequency [Probe for differences for key vulnerable groups e.g. women, children, Indigenous, disability, older people]
b. Who using – gender, ages, types of circumstances
c. When using – crisis point, referral
d. What other supports accessed – whether referred / connected with other services (e.g. treatment, rehabilitation, counselling, employment, education, family, DV)
e. Gaps in support needs

Consequences / outcomes

a. Changes observed – individual + others
b. Other unexpected outcomes

Crime, safety and security

Violent and criminal behaviours [moderator to probe on differences between violence and criminal behaviour]

a. Overall impact of trial on violence and/or crime since Wave 1 / trial commencement
b. Types / range – (e.g. assaults, burglaries / robberies / theft, vandalism, DUI, prostitution, public intoxication)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Safety and security

a. Overall impact of trial on community safety and/or security since Wave 1 / trial commencement
b. Types / range – (e.g. violence / crime, rowdy behaviour, humbugging, verbal abuse, children roaming streets)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Other community experiences and concerns

Social impacts

a. Overall social impact of trial since Wave 1 / trial commencement
b. Types / range – (e.g. arguments/disputes/fights, employment levels, humbugging, abuse/intimidation of the vulnerable, community pride)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Financial impacts

a. Overall financial impact of trial since Wave 1 / trial commencement
b. Types / range – (e.g. money for food, clothing, rent, bills, utilities, transportation, fines, ability to budget and save, motivation to be in paid employment)
c. Frequency / amount occurring
d. Outcomes / changes observed – individual + others

Housing impacts

a. Overall housing impact of trial since Wave 1 / trial commencement (if not mentioned, probe: homelessness)
b. Outcomes / changes observed – individual + others

Parenting impacts

a. Overall parenting impact of trial since Wave 1 / trial commencement
b. Types / range – (e.g. school attendance + engagement, role-modelling, care + nurturing)
c. Frequency amount occurring
d. Outcomes / changes observed

Wellbeing impacts

a. Overall impact of trial since Wave 1 / trial commencement on individual and children's wellbeing
b. Types / range – (e.g. time spent on healthy activities, nutrition, health)
c. Outcomes / changes observed

Awareness, understanding and initial implementation of the CDCT

Awareness and understanding of the CDCT

a. Awareness and understanding of trial – (e.g. target audience for mandatory vs voluntary, payment conditions (80% card-20% cash); community panel, card restrictions)
b. Gaps – anything about trial still unclear / needs explaining more

Implementation

a. Overall perceptions of initial implementation / roll-out of trial
b. Aspects that worked well
c. Aspects not worked well
d. Areas for improvement in implementation process

Community panels

a. Overall perceptions of community panel process/ set-up
b. Aspects that worked well
c. Aspects not worked well
d. Applications were assessed in a timely / consistent / fair manner?
e. Making just and reasonable decisions (about changing percentage of welfare payments quarantined)?
f. Areas for improvement for community panel process/ set-up

Adverse consequences

Adverse consequences

a. Any adverse behaviours emerging so far in trial (e.g. humbugging, stigma, harassment, begging, intimidation, privacy breaches, skimming, stolen cards)
b. Any ways that people working around the 80-20% cash arrangements

Conclusion

Summing-up

a. 3 key positive impacts you have observed / seen as a result of the trial
b. 3 key negative impacts you have observed / seen as a result of the trial
c. What could be done to address negative impacts?
d. Now that the trial is almost over what should the next steps be / what should happen next?

Finish

Summarise outcomes

- Conducting the interview / focus group as part of the final stage of the evaluation of the CDCT for the Australian Government Department of Social Services.

Thank participants.

Appendix F: Qualitative interview questionnaire results

Average ratings of issues in the local community (stakeholders who completed the interview questionnaire)

Indicator	East Kimberley: Initial conditions [74] n=23	East Kimberley: Wave 1 n=36	East Kimberley: Wave 2 n=36	Ceduna: Initial conditions n=19	Ceduna: Wave 1 n=31	Ceduna: Wave 2 n=28
Alcohol abuse	8.3	6.8	7.4	7.4	7.0	5.7
Drug use	6.9	5.6	5.7	6.8	6.7	5.3
Gambling	6.7	5.0	4.8	7.7	6.5	4.5
Violence and other crimes	8.0	6.3	6.4	7.0	6.2	5.0
Street begging	5.0	3.9	4.2	5.4	4.0	3.8
Humbugging	5.9	4.7	4.9	6.3	4.9	4.4
Harassment, abuse, intimidation	5.8	4.4	4.5	5.9	4.3	3.8

Stakeholders were asked: 'How much of an issue are each of the following in the local community?' Table shows average ratings on a scale of 0 – Not at all to 10 – Extremely severe.

Average ratings of how well the community is performing (stakeholders who completed the interview questionnaire)

Indicator	East Kimberley: Initial conditions n=23	East Kimberley: Wave 1 n=36	East Kimberley: Wave 2 n=36	Ceduna: Initial conditions n=19	Ceduna: Wave 1 n=31	Ceduna: Wave 2 n=28
Ability to afford basic household goods	3.7	5.6	6.3	4.4	5.6	5.9
Paying bills	3.5	5.5	6.0	4.3	5.0	5.7
Employment	3.4	3.6	4.0	3.6	3.5	5.3
Education / training	3.6	4.5	4.8	3.9	4.3	5.3
Nutrition	3.2	4.6	5.3	4.2	4.4	5.1
Health and wellbeing	3.5	4.5	5.3	4.4	4.7	5.7
Community pride	4.3	5.0	5.8	4.9	5.1	6.0
Community safety	4.2	5.2	5.7	4.6	5.0	6.3

Stakeholders were asked: 'How well is the local community performing on each of the following aspects?' Table shows average ratings on a scale of 0 – very poorly to 10 – very well.

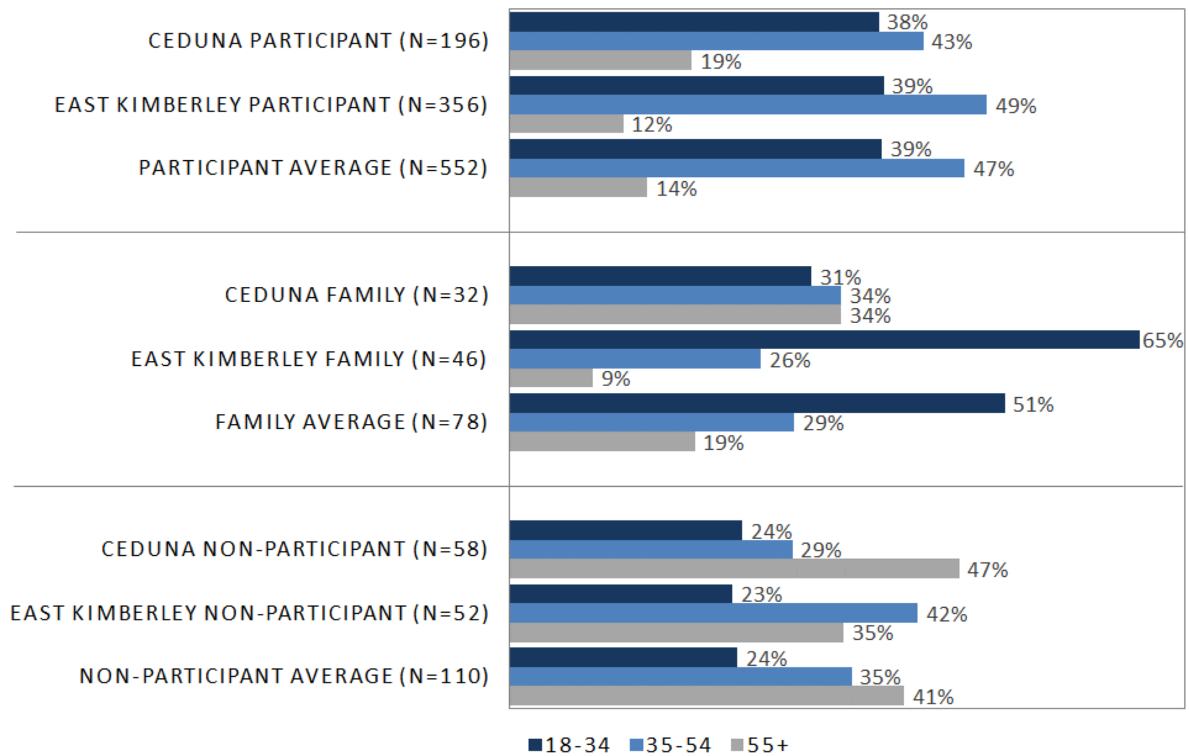
74 Some participants in the evaluation who were not interviewed for the Initial Conditions Report completed a questionnaire retrospectively. These average ratings include retrospective responses.

Appendix G: Demographic profile of quantitative survey respondents

Wave 1 Demographic Profile: Unweighted

Figure 46: Age

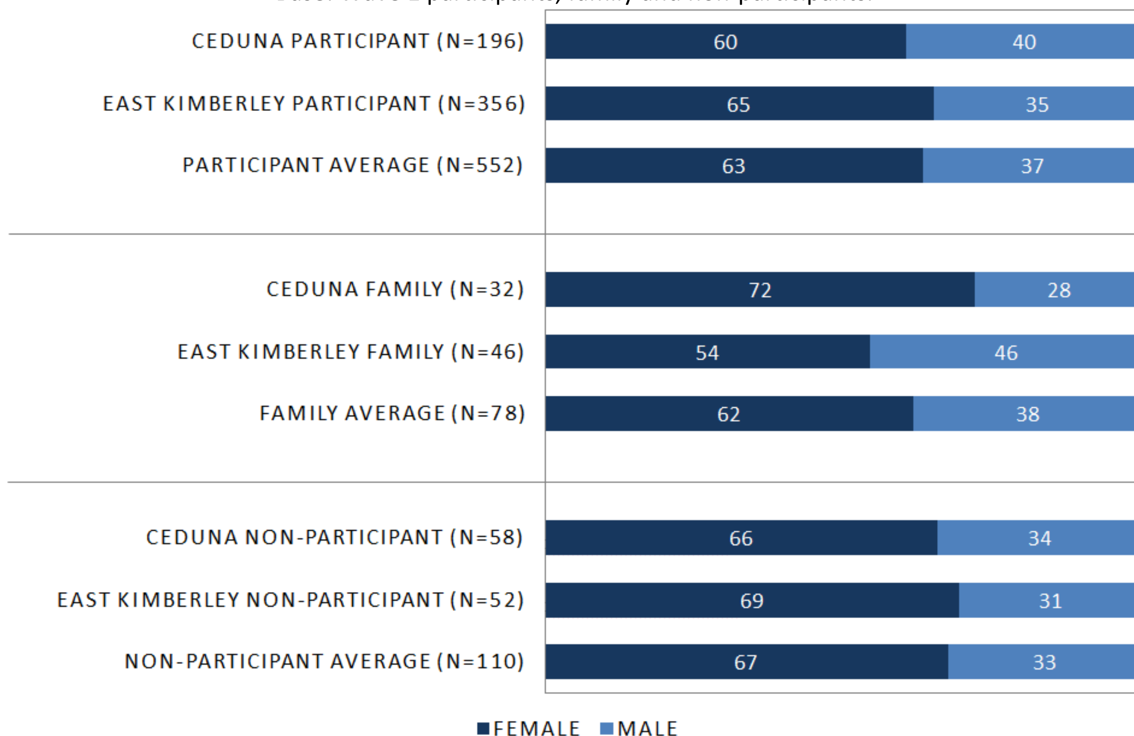
Base: Wave 1 participants, family and non-participants.



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

Figure 47: Gender

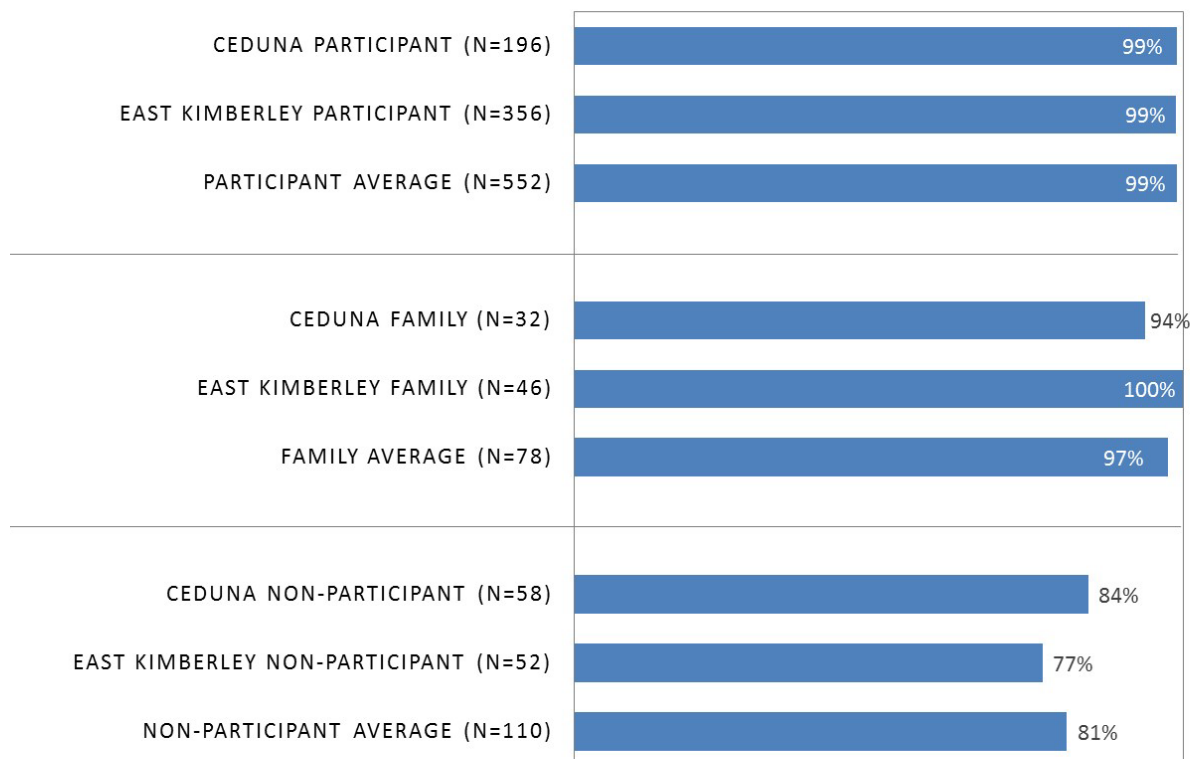
Base: Wave 1 participants, family and non-participants.



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

Figure 48: Born in Australia (% yes)

Base: Wave 1 participants, family and non-participant.



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

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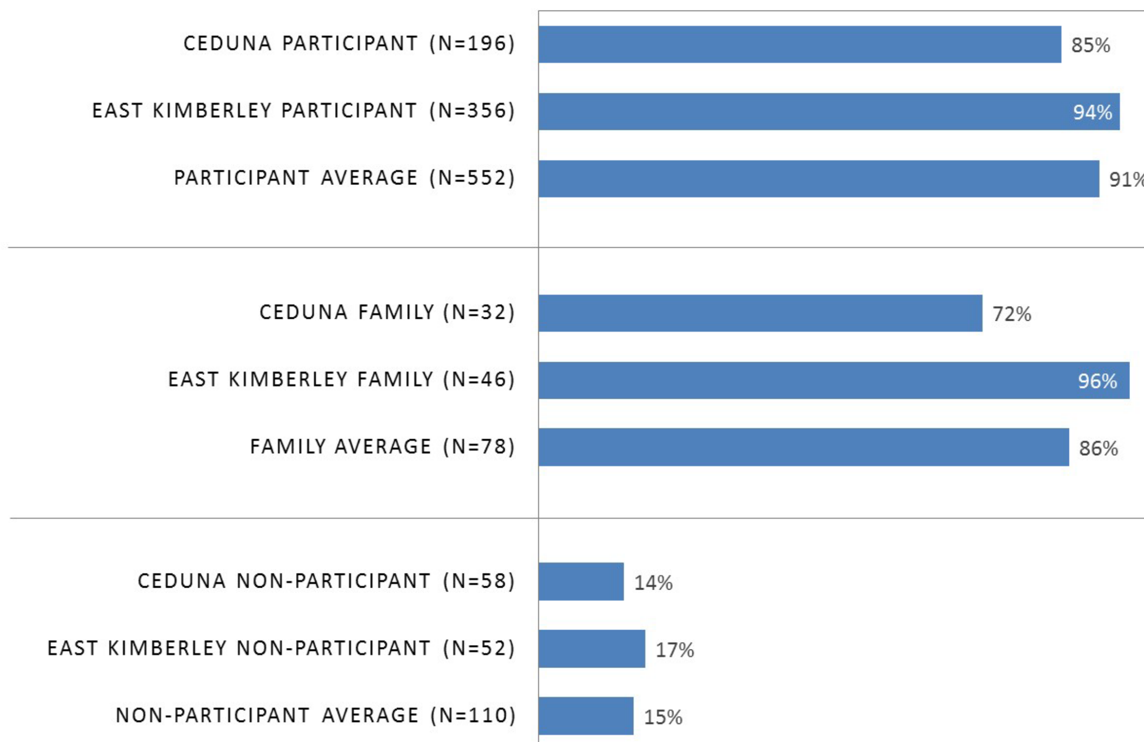
Figure 49: Aboriginal or Torres Strait Islander origin (% yes)

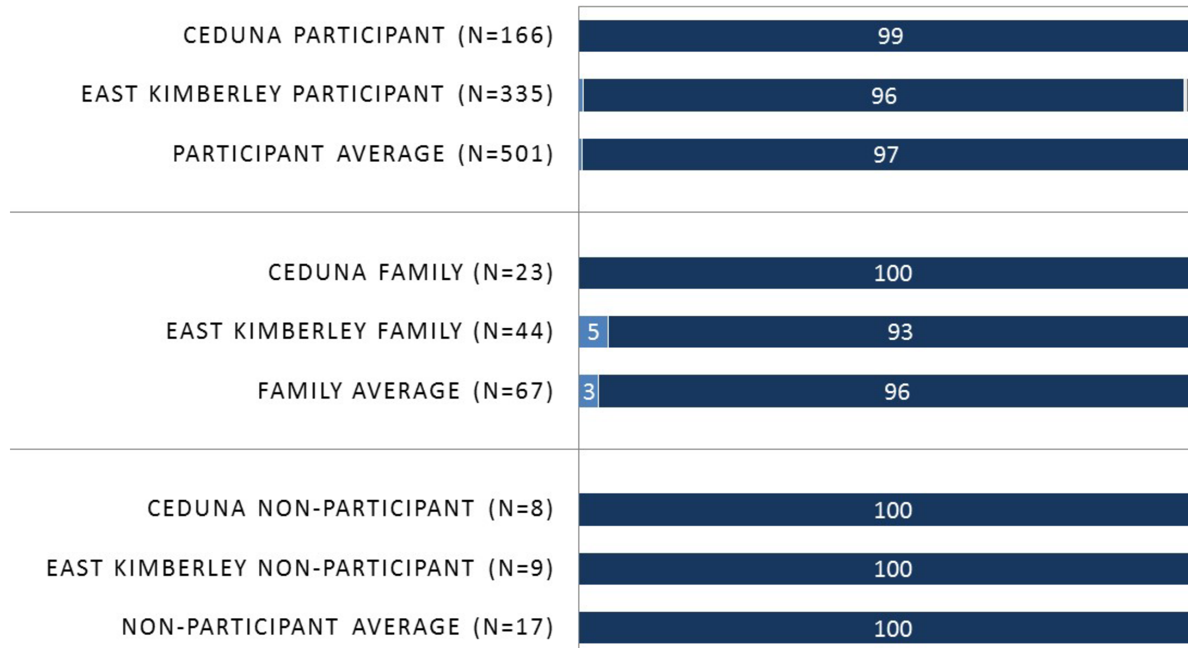
Base: Wave 1 participants, family and non-participants.



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

Figure 50: Which of the following best describes your origin?

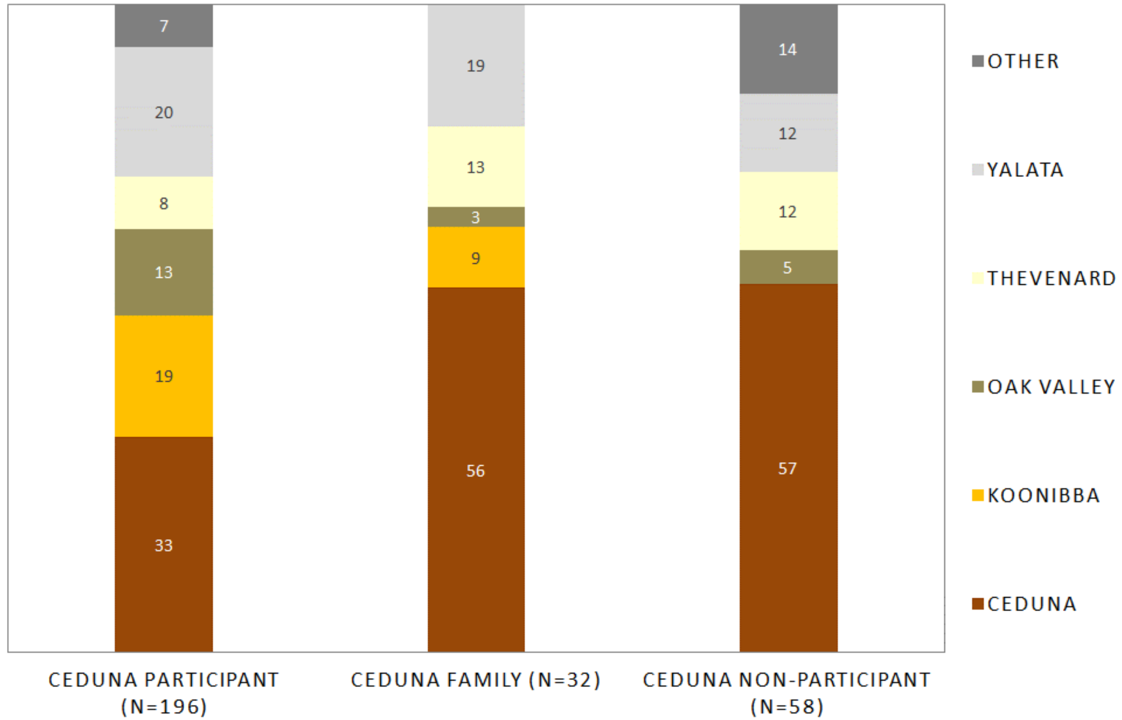
Base: Wave 1 participants, family and non-participants of Aboriginal and/or Torres Strait Islander origin.



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

Figure 51: Location of Ceduna respondents

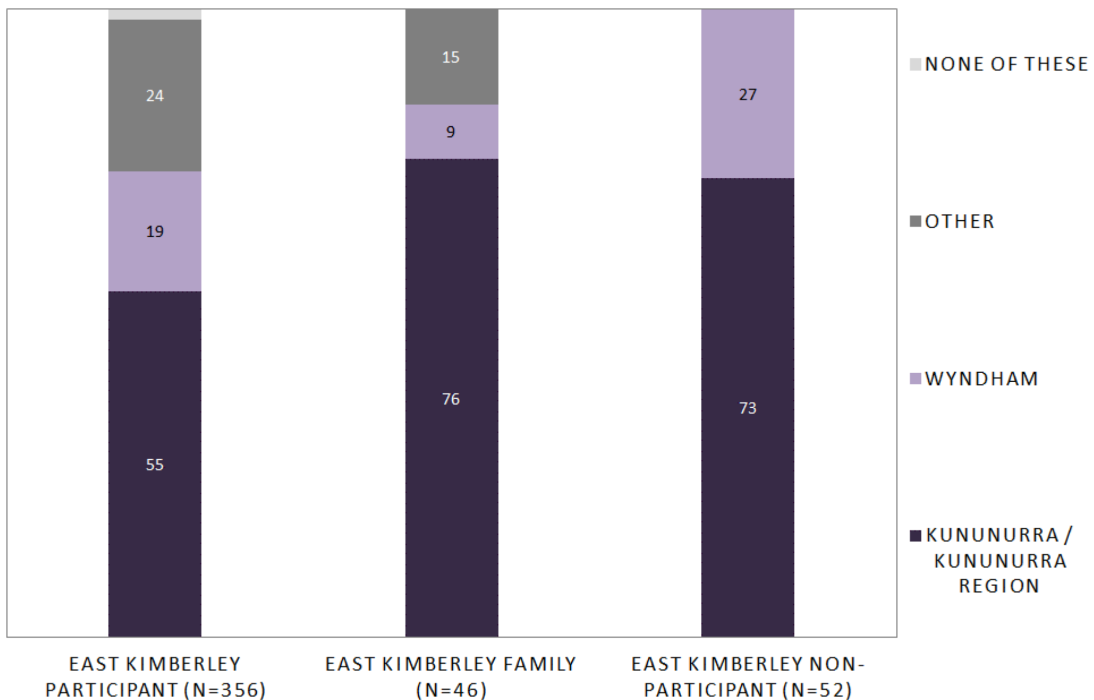
Base: Wave 1 Ceduna participants, family and non-participants.



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

Figure 52: Location of East Kimberley respondents

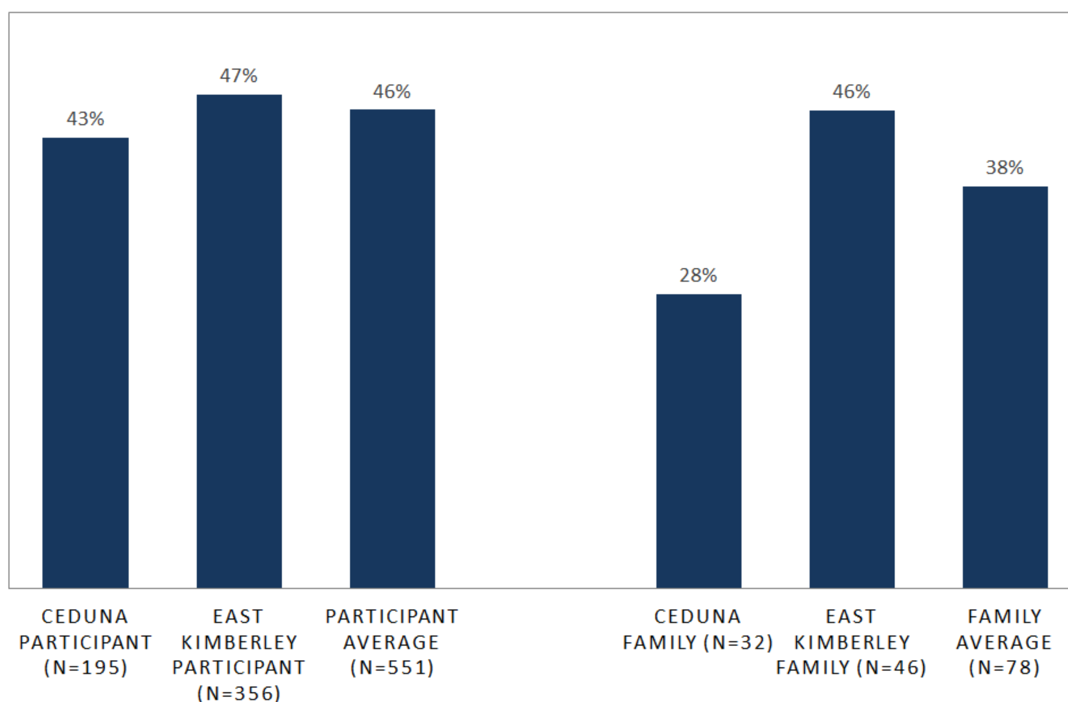
Base: Wave 1 East Kimberley participants, family and non-participants.



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

Figure 53: Do you care for a child who is less than 18 years old (% yes)

Base: Wave 1 participants and family.



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

Table 24: Self-reported payment type: Wave 1 Participants

Wave 1 Participant	Ceduna Participant (n=196)	East Kimberley Participant (n=356)	Participant Average (n=552)
Austudy	0%	0%	0%
ABSTUDY	0%	1%	0%
Youth Allowance	6%	3%	4%
Parenting Payment (Partnered)	8%	4%	6%
Parenting Payment (Single)	15%	21%	19%
Newstart Allowance	52%	41%	45%
Disability Support Pension	17%	26%	23%
Age Pension	1%	0%	0%
Carer’s Payment or Allowance	5%	4%	4%
Family Tax Benefit (FTB)	15%	22%	19%
Child Care Benefit (CCB)	1%	1%	1%
Veterans Payment	0%	0%	0%
Other	0%	0%	0%
None of these	1%	0%	1%
Don’t know	1%	0%	0%
Refused	0%	0%	0%

Table 25: Self-reported payment type: Wave 1 Family

Wave 1 Family	Ceduna Family (n=32)	East Kimberley Family (n=46)	Family Average (n=78)
Austudy	0%	0%	0%
ABSTUDY	3%	4%	4%
Youth Allowance	0%	7%	4%
Parenting Payment (Partnered)	3%	0%	1%
Parenting Payment (Single)	0%	11%	6%
Newstart Allowance	16%	4%	9%
Disability Support Pension	0%	9%	5%
Age Pension	16%	2%	8%
Carer's Payment or Allowance	9%	0%	4%
Family Tax Benefit (FTB)	16%	9%	12%
Child Care Benefit (CCB)	0%	0%	0%
Veterans Payment	0%	0%	0%
Other	0%	4%	3%
None of these	44%	52%	49%
Don't know	0%	2%	1%
Refused	0%	0%	0%

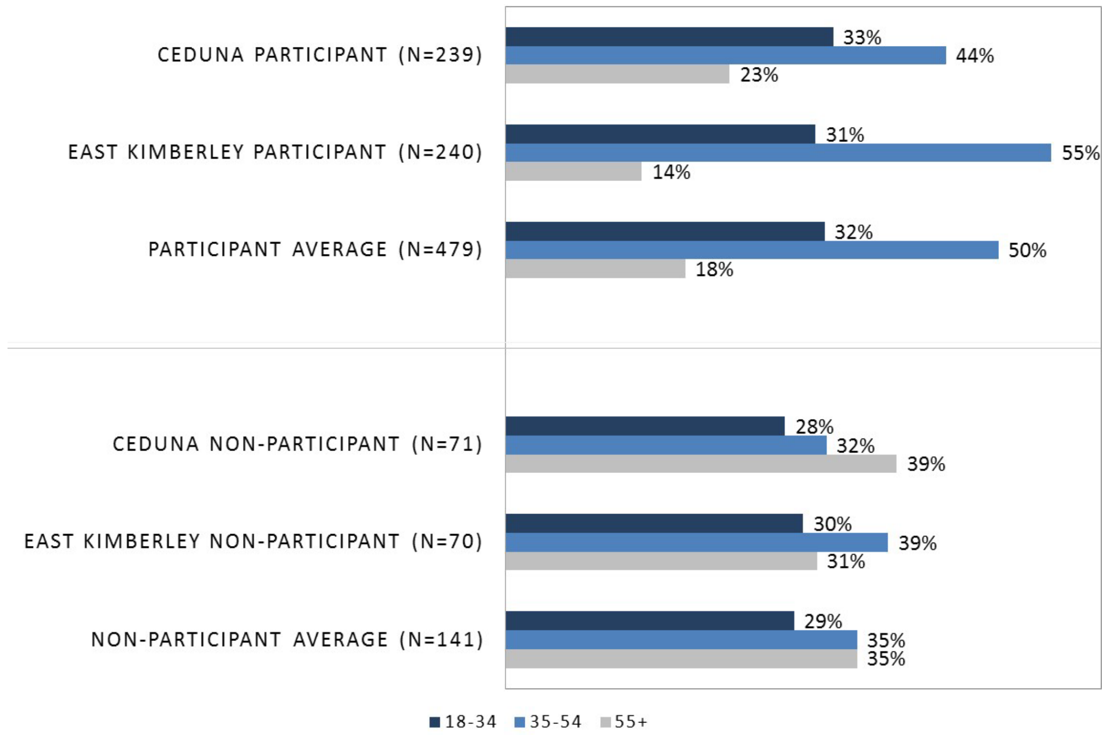
Table 26: Self-reported payment type: Wave 1 Non-participants

Wave 1 Non-participant	Ceduna Non-participant (n=58)	East Kimberley Non-participant (n=52)	Non-participant Average (n=110)
Austudy	0%	0%	0%
ABSTUDY	0%	0%	0%
Youth Allowance	2%	0%	1%
Parenting Payment (Partnered)	2%	2%	2%
Parenting Payment (Single)	2%	0%	1%
Newstart Allowance	0%	0%	0%
Disability Support Pension	2%	2%	2%
Age Pension	16%	13%	15%
Carer's Payment or Allowance	0%	4%	2%
Family Tax Benefit (FTB)	10%	10%	10%
Child Care Benefit (CCB)	0%	10%	5%
Veterans Payment	0%	0%	0%
Other	0%	0%	0%
None of these	67%	65%	66%
Don't know	0%	0%	0%
Refused	0%	0%	0%

Wave 2 Demographic Profile: Unweighted

Figure 54: Age

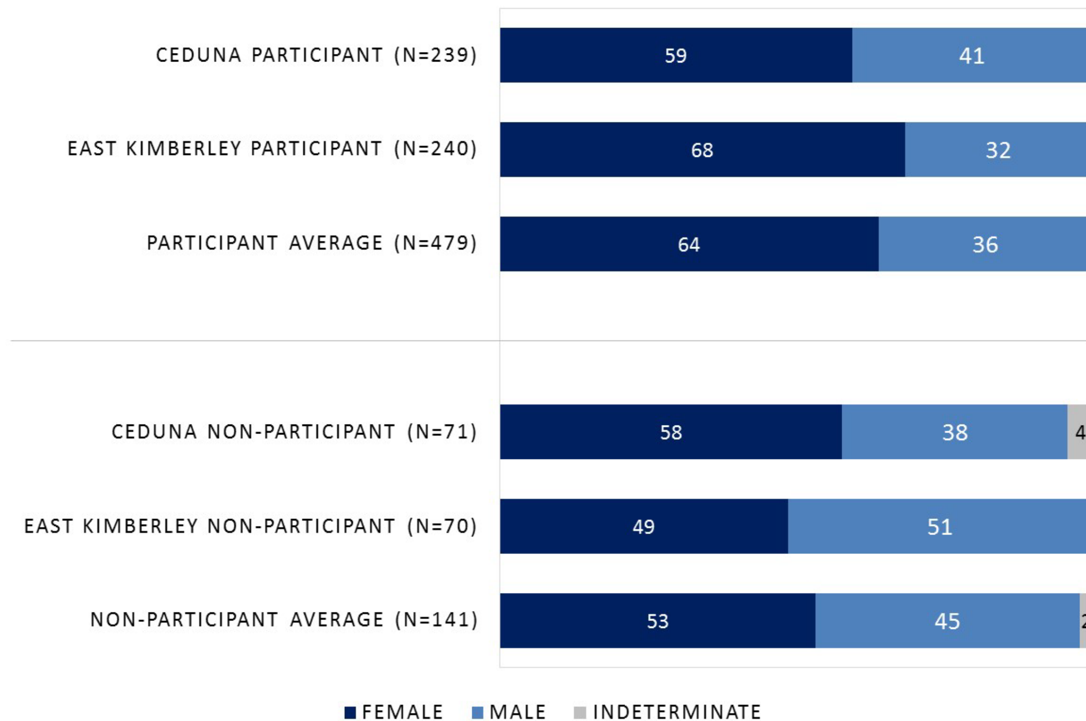
Base: Wave 2 participants and non-participants.



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

Figure 55: Gender

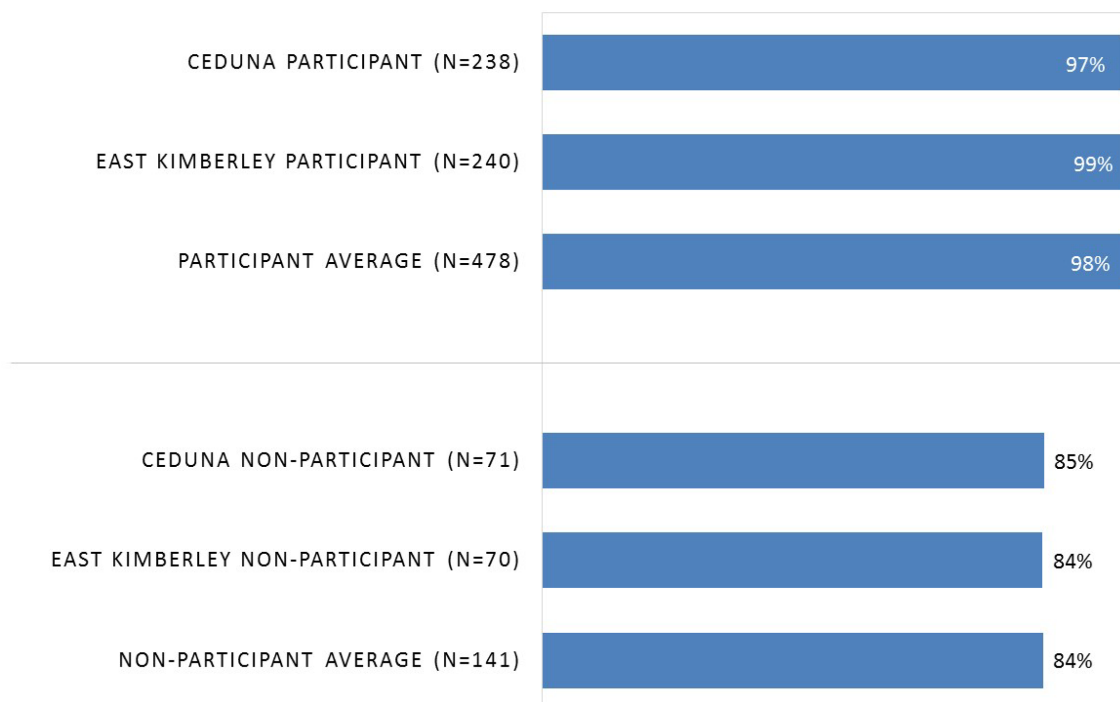
Base: Wave 2 participants and non-participants.



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

Figure 56: Born in Australia (% yes)

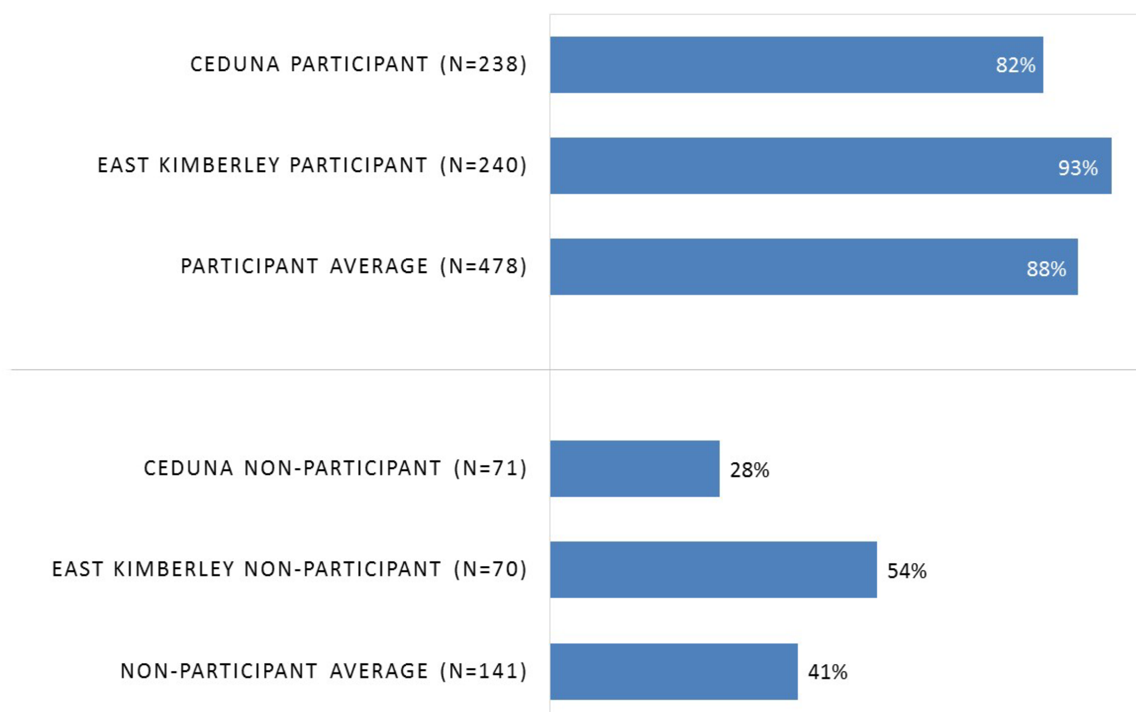
Base: Participants and non-participants.



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

Figure 57: Aboriginal or Torres Strait Islander origin (% yes)

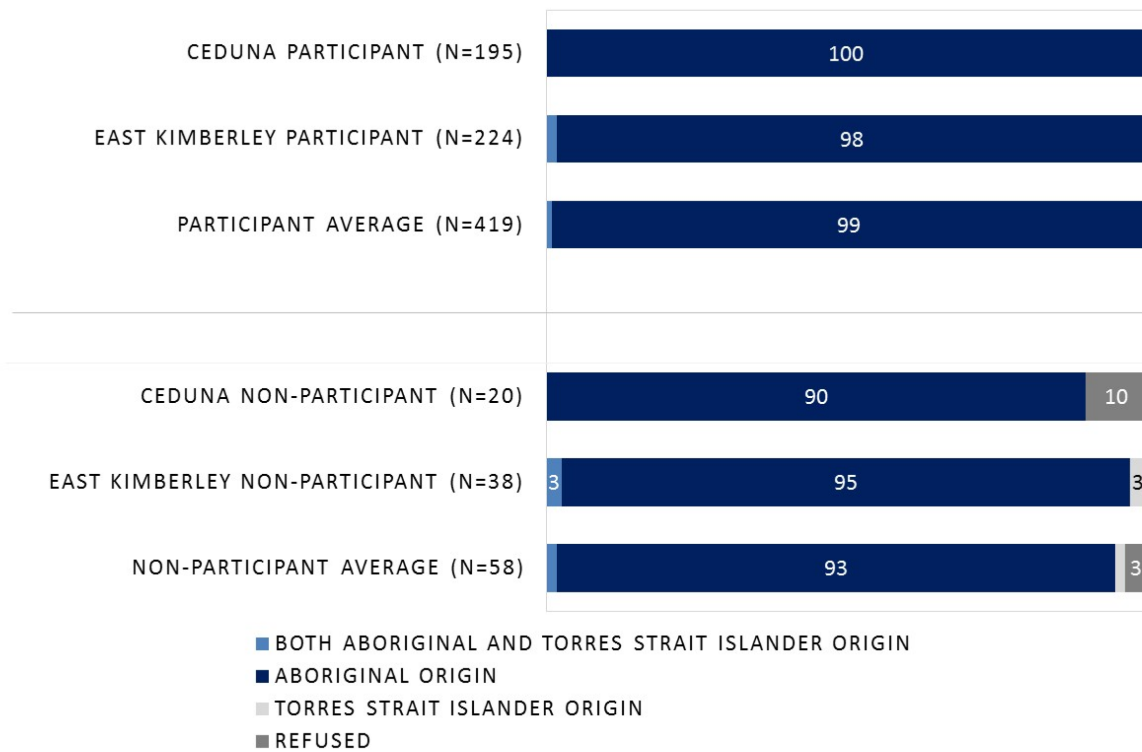
Base: Wave 2 participants and non-participants.



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

Figure 58: Which of the following best describes your origin?

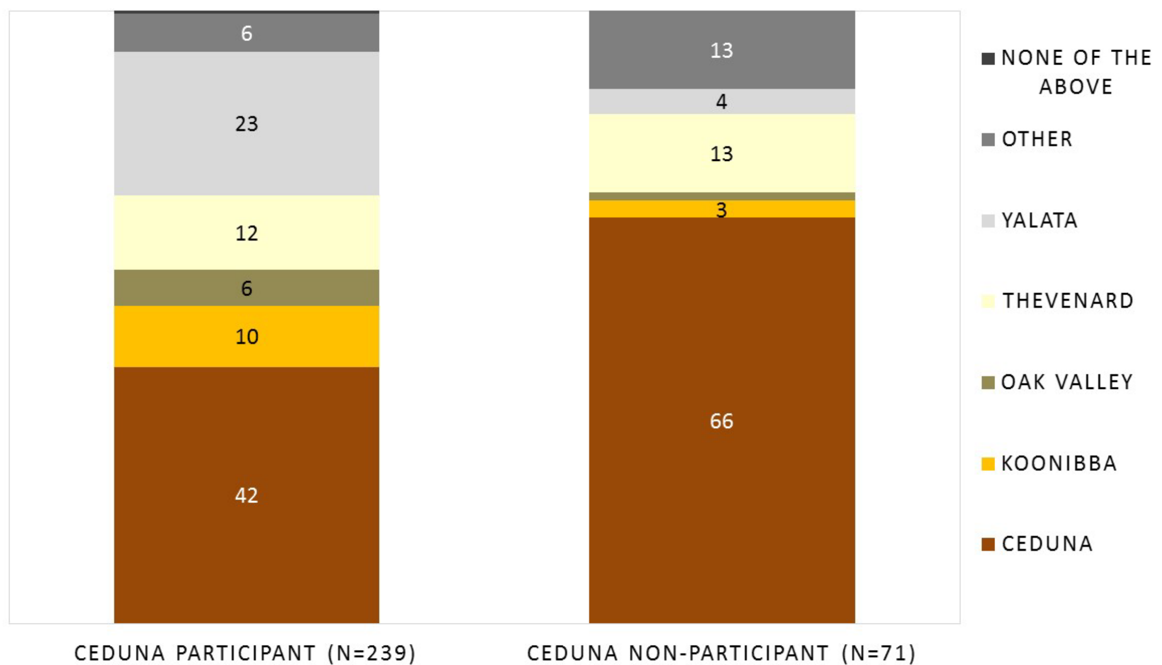
Base: Wave 2 participants and non-participants of Aboriginal and/or Torres Strait Islander origin.



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

Figure 59: Location of Ceduna respondents Wave 2

Base: Wave 2 Ceduna participants and non-participants.



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

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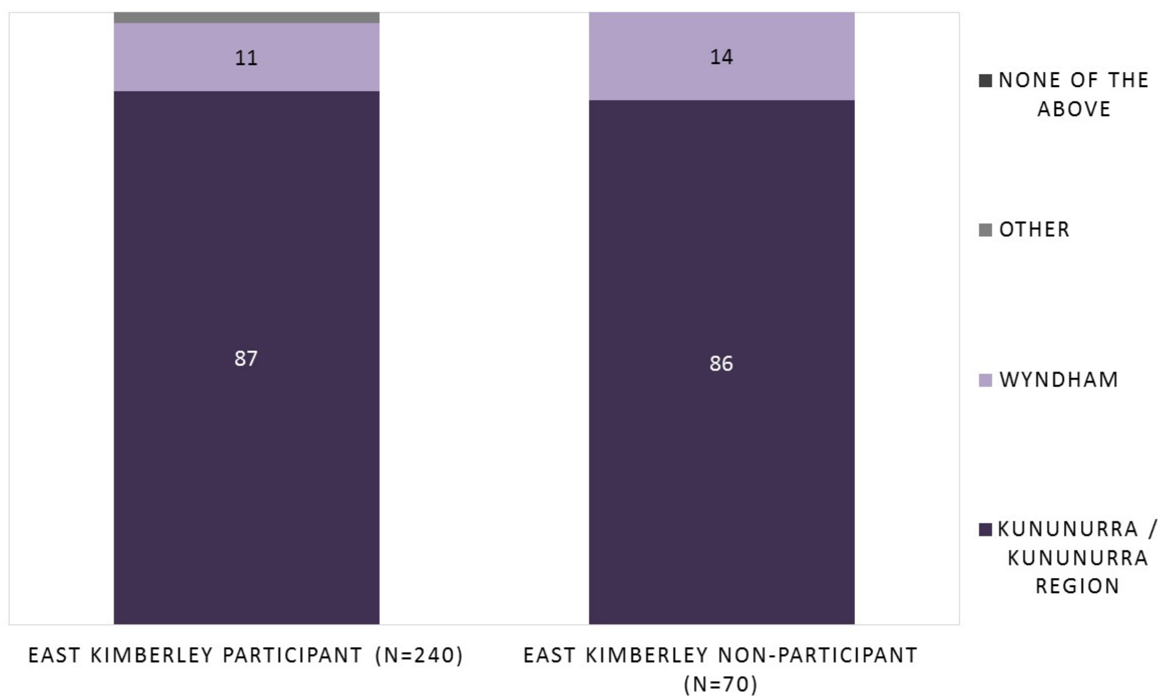
Figure 60: Location of East Kimberley respondents

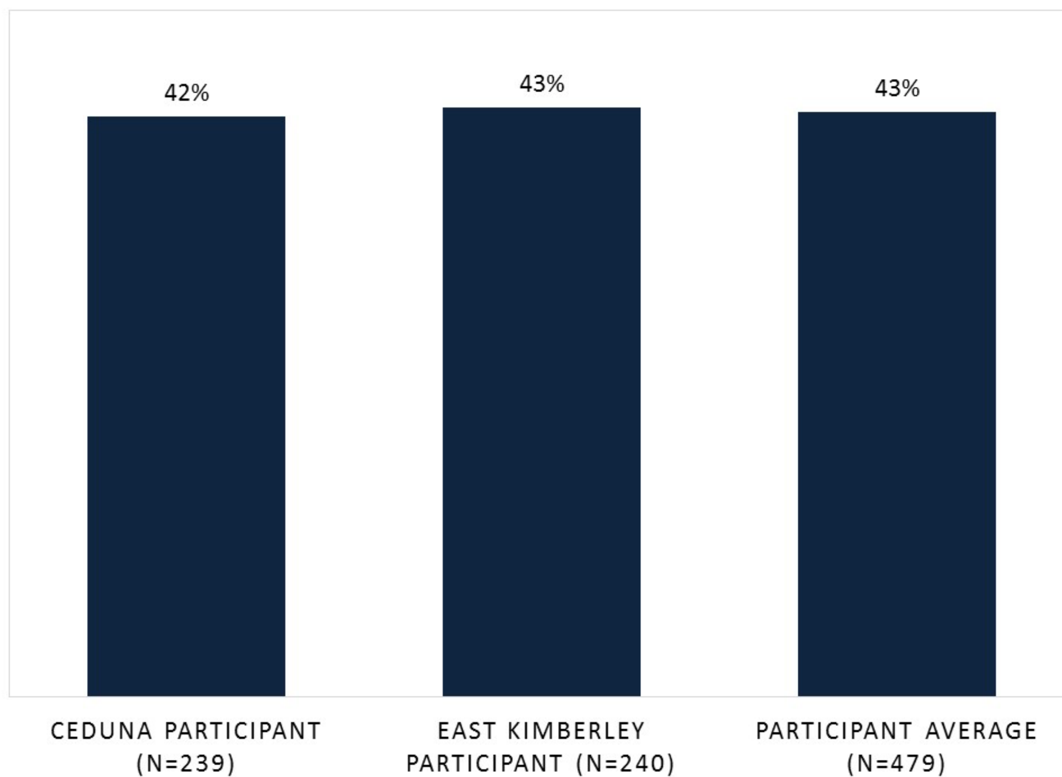
Base: Wave 2 East Kimberley participants and non-participants.



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

Figure 61: Do you care for a child who is less than 18 years old (% yes)

Base: Wave 2 participants.



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

Table 27: Self-reported payment type: Wave 2 Participants

Wave 2 Participant	Ceduna Participant (n=239)	East Kimberley Participant (n=240)	Participant Average (n=479)
Austudy	0%	0%	0%
ABSTUDY	0%	0%	0%
Youth Allowance	5%	5%	5%
Parenting Payment (Partnered)	5%	6%	5%
Parenting Payment (Single)	13%	15%	14%
Newstart Allowance	48%	40%	44%
Disability Support Pension	20%	28%	24%
Age Pension	1%	1%	1%
Carer's Payment or Allowance	7%	5%	6%
Family Tax Benefit (FTB)	19%	15%	17%
Child Care Benefit (CCB)	0%	0%	0%
Veterans Payment	0%	0%	0%
Other	1%	0%	1%
None of these	1%	1%	1%
Don't know	0%	0%	0%
Refused	0%	0%	0%

Table 28: Self-reported payment type: Wave 2 Non-participants

Wave 2 Non-participant	Ceduna Non-participant (n=71)	East Kimberley Non-participant (n=70)	Non-participant Average (n=141)
Austudy	0%	0%	0%
ABSTUDY	0%	0%	0%
Youth Allowance	1%	0%	1%
Parenting Payment (Partnered)	3%	0%	1%
Parenting Payment (Single)	3%	1%	2%
Newstart Allowance	3%	14%	9%
Disability Support Pension	3%	4%	4%
Age Pension	24%	14%	19%
Carer's Payment or Allowance	6%	1%	4%
Family Tax Benefit (FTB)	8%	4%	6%
Child Care Benefit (CCB)	3%	3%	3%
Veterans Payment	0%	0%	0%
Other	0%	0%	0%
None of these	49%	60%	55%
Don't know	0%	0%	0%
Refused	0%	0%	0%

Appendix H: Administrative data examined in the evaluation

CEDUNA

Service, source and notes	Data	Period	Frequency
SA Police, SA Attorney-General's Department 1. Ceduna data for sexual assault, domestic violence, and homicide are not included as the small population may lead to identification. 2. Data for Eyre local service area (LSA) encompasses an area larger than Ceduna.	Ceduna acts intended to cause injury	July 2015 – March 2017	Monthly
	Ceduna other offences against the person		
	Ceduna robbery & related offences		
	Ceduna drink driving		
	Ceduna drug driving		
	Eyre homicide & related offences		
	Eyre acts intended to cause injury		
	Eyre sexual assault & related offences		
	Eyre robbery & related offences		
	Eyre other offences against the person		
	Eyre serious criminal trespass		
	Eyre theft & related offences		
	Eyre fraud, deception & related offences		
	Eyre property damage & environmental		
Poker Machines in Ceduna and Surrounds, SA Attorney-General's Department 1. Data is for the local government areas of Ceduna, Streaky Bay, Le Hunte, Elliston, and Lower Eyre Peninsula. 2. Figures should be interpreted cautiously as there	Monthly poker machine revenue	July 2013 – March 2017	Monthly

Service, source and notes	Data	Period	Frequency
are often large fluctuations in spending month to month. There are 143 poker machines in Ceduna and the surrounding LGAs. Of these, an estimated 40 are located in Ceduna.			
Ceduna Hospital, Drug and Alcohol Services SA, SA Health Number of emergency department admissions related to alcohol at Ceduna Hospital. An inpatient separation means that the person was hospitalised, in this case for alcohol-related reasons. The separation itself denotes the date of discharge.	Alcohol related separations	October 2015 – March 2017 (uninterrupted) Additional data points available for October – December 2015	Monthly
Yalata Community Referrals, Yalata Community Inc.	Referrals made to health services by Yalata Community Inc.	Q2 2015/16 – Q1 2016/17 (uninterrupted) Additional data point available for Q2 2014/15	Quarterly
Child Protection, Families SA Substantiations of child abuse notifications occur when an investigation has concluded and there is reasonable cause to believe that the child had been, was being, or will likely be; abused, neglected, or otherwise harmed. Does not necessarily require sufficient evidence for a	Child abuse substantiations	16 March – 11 July 2016 2012/13 – 2015/16	Daily Yearly

Service, source and notes	Data	Period	Frequency
successful prosecution and does not imply treatment of case management was provided. 1. Substantiation data is for postcode areas of Ceduna (5690), Streaky Bay (5680), Tarcoola (5710), Port Augusta (5700), and Coober Pedy (5723).			
Drug & Alcohol Services SA (DASSA)	Total counselling attendance	July 2015 – March 2017	Monthly
Individual counselling support services for clients	Alcohol related attendance		
and/or close family and friends of clients who have	Total episodes		
substance abuse issues.	Alcohol related episodes		
MySchool, SA Department for Education and Child Development	School attendance rate	Semester 1 2014 – Semester 1 2016	Term and semester level data
School attendance data at eight selected SA schools and some other schools in the Port Augusta region.	School attendance level	Term 3 2015 – Term 3 2016	
Housing SA, SA Department for Communities and Social Inclusion	Total customer debt	Q1 2014/15 – Q3 2016/17	Quarterly
	Tenants with debt		Quarterly
1. Debt is point in time and not cumulative. 2. Customers may have a debt for a short period between rent charges and payments, which will be captured in this data.	Proportion of tenants with debt		Quarterly
3. Some tenants routinely go into debt after water charges are applied.	Average debt per tenant		Quarterly

Service, source and notes	Data	Period	Frequency
Housing SA, SA Department for Communities and Social Inclusion Substantiated disruptive tenancy complaints (i.e. proven to have occurred) for abusive behaviour, domestic/family disputes, frightening behaviour, noise and nuisance, physical assault, property damage, threatening behaviour, or violent acts. 1. Ceduna includes the suburbs of Ceduna and Thevenard	Disruptive tenancy complaints	Q1 2014/15 – Q3 2016/17	Quarterly
Housing SA, SA Department for Communities and Social Inclusion Data on clients supported by Specialist Homeless Services agencies. 1. Data does not consider what the main reporting issue was, only if DV and/or drug/alcohol issues were identified. 2. Data may include transient clients not bound to agency locations.	Total clients supported by specialist homeless services	Q1 2014/15 – Q3 2016/17	Quarterly

Service, source and notes	Data	Period	Frequency
Other considerations: - There are ten specialist homelessness services (SHS) agencies in the suburbs of Ceduna, Coober Pedy, and Port Augusta. - Issues are attached to a client's support period regardless of how many quarters the clients support period spans. All support periods counts represent a client's intake and all client counts are unique, although a client can have more than one support period with differing circumstances.	Number of clients supported – DV identified		
- Client counts are a unique representation of total support periods identified with the corresponding issues raised. Therefore, client and support period counts across quarters can be aggregate counts (e.g. a client's support period that spans 3 quarters is given both a unique client and support period count in each of the respective quarters)	Number of clients supported – drug / alcohol identified		
Public Intoxication Act, SA Department for Communities and Social Inclusion Data for the number of apprehensions under the Public Intoxication Act 1984 [SA].	Number of apprehensions	March 2015 – March 2017	Monthly

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Service, source and notes	Data	Period	Frequency
Ceduna District Health Services, SA Department for Communities and Social Inclusion Data on the number of people admitted to the emergency department at Ceduna Hospital. Also includes the number of presentations where alcohol is a primary or secondary diagnosis. 1. Only manually collected data on alcohol-related presentations is provided as the alternative, centrally collected data, and includes presentations where alcohol is the primary diagnosis only.	Total admissions		Quarterly
	Alcohol related admissions	July 2015 – March 2017	Monthly
Sobering-up shelter, Ceduna/Koonibba Aboriginal Health Service The sobering-up shelter provides a safe place for intoxicated people to sober-up and minimise potential associated harm. It is located next to a liquor store.	Total admissions	July 2015 – March 2017	Monthly
	At-risk discharges		
Wangka Wilurrara Transitional Accommodation Centre, SA Department for Communities and Social Inclusion Provide short-term accommodation, meals, and support to homeless or transient Indigenous people.	Not eligible for transitional centre	July 2015 – March 2017	Monthly

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Service, source and notes	Data	Period	Frequency
Aboriginal Sobriety Group, SA Department for Communities and Social Inclusion MAP provides transport for individuals affected by alcohol and other drugs and at risk of harm to themselves or others.	Mobile Assistance Patrol clients	July 2015 – March 2017	Monthly

PORT AUGUSTA AND COOBER PEDY

Service, source and notes	Data	Period	Frequency
SA Police, SA Attorney-General's Department	Port Augusta acts intended to cause injury	July 2015 – March 2017	Monthly
	Port Augusta other offences against the person		
	Port Augusta robbery & related offences		
	Port Augusta drink driving		
	Port Augusta drug driving		
Child Protection, Families SA Substantiations data provided for postcodes 5700 and 5723 – including Port Augusta, Port Augusta West, Coober Pedy	Child abuse substantiations	2012/13 – 2015/16	Yearly
Housing SA, SA Department for Communities and Social Inclusion	Total tenants	Q1 2014/15 – Q3 2016/17	Quarterly
Data provided for Port Augusta and Coober Pedy	Tenants with debt		
	Debt		

Service, source and notes	Data	Period	Frequency
Housing SA, SA Department for Communities and Social Inclusion Substantiated disruptive tenancy complaints (i.e. proven to have occurred) for abusive behaviour, domestic/family disputes, frightening behaviour, noise and nuisance, physical assault, property damage, threatening behaviour, or violent acts. Data provided for Port Augusta and Coober Pedy	Disruptive tenancy complaints	Q1 2014/15 – Q3 2016/17	Quarterly
Housing SA, SA Department for Communities and Social Inclusion Data provided for Port Augusta and Coober Pedy Data on clients supported by Specialist Homeless Services agencies. 1. Data does not consider what the main reporting issue was, only if DV and/or drug/alcohol issues were identified.	Total clients supported by specialist homeless services	Q1 2014/15 – Q3 2016/17	Quarterly
2. Data may include transient clients not bound to agency locations. Other considerations: - There are ten specialist homelessness services (SHS) agencies in the suburbs of Ceduna, Coober Pedy, and Port Augusta. - Issues are attached to a client's support period	Number of clients supported – DV identified		

Service, source and notes	Data	Period	Frequency
regardless of how many quarters the clients support period spans. - All support periods counts represent a client's intake and all client counts are unique, although a client can have more than one support period with differing circumstances.			
Client counts are a unique representation of total support periods identified with the corresponding issues raised. Therefore, client and support period counts across quarters can be aggregate counts (e.g. a client's support period that spans 3 quarters is given both a unique client and support period count in each of the respective quarters)	Number of clients supported – drug / alcohol identified		
MySchool, SA Department for Education and Child Development Data provided for Port Augusta	School attendance rate	Semester 1 2014 – Semester 1 2016 Term 3 2015 – Term 3 2016	Term and semester level data
	School attendance level		

EAST KIMBERLEY

Service, source and notes	Data	Period	Frequency

Service, source and notes	Data	Period	Frequency
WA Police, WA Department of Regional Development Crime data from Kununurra and Wyndham 1. WA Government data is provided by WA Department of Regional Development and is specially coded for trial monitoring.	Kununurra assault	February 2015 – April 2017	Monthly
	Kununurra burglary (dwelling)		
	Kununurra burglary (non-dwelling)		
	Kununurra verified domestic assault		
	Kununurra attended domestic violence		
	Kununurra theft		
	Kununurra motor vehicle theft		
	Kununurra disorderly conduct		
	Wyndham assault		
	Wyndham burglary (dwelling)		
	Wyndham burglary (non-dwelling)		
	Wyndham verified domestic assault		
	Wyndham attended domestic violence		
	Wyndham theft		
	Wyndham motor vehicle theft		
	Wyndham disorderly conduct		
Child Protection, WA Department for Child Protection and Family Support	Safety & wellbeing assessments	May 2016 – May 2017	Monthly

Service, source and notes	Data	Period	Frequency
The number of substantiated safety and wellbeing assessments and mandatory reports received by WA Child Protection. 1. Number of children in care data is for the last day of each month.	Mandatory reports		
	Children in care		
Child Protection, WA Department for Child Protection and Family Support	Domestic violence incidence reports received	December 2013 – July 2016	Monthly
Domestic violence data from WA Child Protection. WA Police forward all domestic violence incidence reports (DVIRs) to Child Protection regardless of whether or not a child is involved. Where a child is involved, it is recorded as an 'assist'.	Domestic violence incidence reports assisted		
Kununurra District High School, WA Department of Education	Indigenous school attendance	May 2015 – October 2015 (uninterrupted)	Monthly
Data on Indigenous and non-Indigenous school attendance	Non-Indigenous school attendance	July 2016 – Jan 2017 (uninterrupted	
Public Housing, WA Housing Authority Number of disruptive behaviour complaints received in the East Kimberley. Complaints are made to housing over disruptive behaviour such as loud parties and alcohol related behaviour.	Number of complaints	January 2016 – April 2017	Monthly

Service, source and notes	Data	Period	Frequency
St John Ambulance	Total callouts	January 2014 – February 2017	Monthly
St John Ambulance is a charitable organisation serving Kununurra through first aid.	Trauma (domestic)		
1. Total callouts does not include transfers between hospitals.	Trauma (assault)		
2. Medical-related callouts are included in total callout figures.	Alcohol intoxication		
3. Alcohol-related callouts refers to cases where alcohol intoxication is the primary problem. If a client has a medical problem but is also intoxicated (e.g. fighting while drunk), the system codes them for the medical problem.	Transfers		
Kununurra Miriwoong Community Patrol Service for Alcohol, Kununurra-Waringarri Aboriginal Corporation The Night Patrol picks up intoxicated people, and those at risk of being harmed, from around the Kununurra area. These clients are taken home or to another safe location or shelter for the night.	Total pick-ups	July 2012 – April 2017	Monthly
	Alcohol abuse related pick-ups		
	Non-alcohol related pick-ups		
	Referred to SUU		

Service, source and notes	Data	Period	Frequency
Moongoong Sober Up Shelter, Kununurra-Waringarri Aboriginal Corporation The Moongoong Sober Up Shelter provides overnight accommodation for Aboriginal peoples 18 years and older who are found intoxicated in public areas.	Total admissions	February 1997 – April 2017	Monthly
Kununurra Crisis Accommodation Centre, Gawooleng Yawoodeng Aboriginal Corporation	Total distinct stays	April 2015 – September 2015 April 2016 – September 2016	Monthly
Provides crisis accommodation for women, with or without children, escaping family or domestic violence.	Total bed nights		
Wyndham Night Patrol, Ngnowar Aerwah Aboriginal Corporation	Total pick-ups	July 2012 – September 2016	Monthly
	Alcohol abuse	July 2012 – June 2016	Monthly
	Non-alcohol		
	Referrals to SUU		
Wyndham Sobering-Up Shelter, Ngnowar Aerwah Aboriginal Corporation A safe and secure place for those affected by alcohol and other drugs. Clients are provided with a meal, shower, and a bed.	Total admissions	January 2003 – September 2016	Monthly

Service, source and notes	Data	Period	Frequency
Kimberley Mental Health & Drug Service The Kimberley Mental Health and Drug Service provides community based mental health, community alcohol, and other drug services to the Kimberley region.	Drug/alcohol referrals	March 2016 – September 2016	Monthly
	Total referrals		

DERBY

Service, source and notes	Data	Period	Frequency
WA Police, WA Department of Regional Development Crime data from Kununurra and Wyndham	Derby assault	February 2015 – April 2017	Monthly
	Derby burglary (dwelling)		
	Derby burglary (non-dwelling)		
	Derby verified domestic assault		
	Derby attended domestic violence		
	Derby theft		
	Derby motor vehicle theft		
	Derby disorderly conduct		
Child Protection, WA Department for Child Protection and Family Support The number of substantiated safety and wellbeing assessments and mandatory reports received by WA Child Protection.	Safety & wellbeing assessments	Qtr. ending July 2015 – Qtr. ending October 2016	Quarterly
	Mandatory reports		
	Children in care		
Public Housing, WA Housing Authority Public Housing DB & IUP complaints received	Number of complaints received	01/10/2016 - 30/04/2017	NA – only one, single point in time number available
Derby District High School Data, WA Department of Education Data on Indigenous and non-Indigenous school attendance	Indigenous school attendance	Term 1 2015 – Term 1 2017	Term level
	Non-Indigenous school attendance		

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