Department of Social Services

Evaluation of the Cashless Debit Card Trial – Initial Conditions Report

Table of Contents

[Executive Summary i](#_Toc476138347)

[A. Introduction i](#_Toc476138348)

[B. Demographic profile of the trial communities i](#_Toc476138349)

[C. Initial data – debit card roll out ii](#_Toc476138350)

[D. Stakeholder views of pre-CDCT conditions ii](#_Toc476138351)

[E. Awareness, understanding and expectations of the CDCT iv](#_Toc476138352)

[F. Conclusions v](#_Toc476138353)

[I. Introduction 1](#_Toc476138354)

[A. Background 1](#_Toc476138355)

[B. Evaluation framework 2](#_Toc476138356)

[C. Qualitative research methodology 3](#_Toc476138357)

[D. Presentation of findings 5](#_Toc476138358)

[E. Quality assurance 5](#_Toc476138359)

[II. Demographic profile of the trial communities 6](#_Toc476138360)

[A. About this chapter 6](#_Toc476138361)

[B. Total population 6](#_Toc476138362)

[C. Indigenous population 6](#_Toc476138363)

[D. Labour force status 7](#_Toc476138364)

[E. Age distribution 8](#_Toc476138365)

[F. Early Childhood Development 8](#_Toc476138366)

[G. Income distribution 10](#_Toc476138367)

[III. Initial data – cashless debit card roll out 11](#_Toc476138368)

[A. About this chapter 11](#_Toc476138369)

[B. Progressive roll out 11](#_Toc476138370)

[C. Proportion of CDCT trial site populations with a CDC 12](#_Toc476138371)

[D. Income Support Payments (ISPs) paid via the CDC 14](#_Toc476138372)

[IV. Stakeholder views of pre-CDCT conditions 19](#_Toc476138373)

[A. About this chapter 19](#_Toc476138374)

[B. Alcohol consumption and impacts 19](#_Toc476138375)

[C. Illicit drug consumption and impacts 23](#_Toc476138376)

[D. Gambling activity and impact 24](#_Toc476138377)

[E. Awareness and usage of support services 26](#_Toc476138378)

[F. Crime, safety and security 28](#_Toc476138379)

[G. Other significant community experiences and concerns 31](#_Toc476138380)

[H. Summary ratings of initial conditions 33](#_Toc476138381)

[V. Awareness, understanding and expectations of the CDCT 34](#_Toc476138382)

[A. About this chapter 34](#_Toc476138383)

[B. Stakeholders’ awareness and understanding of CDCT 34](#_Toc476138384)

[C. ISP recipients’ awareness and understanding of CDCT 36](#_Toc476138385)

[D. Stakeholders’ expectations of the CDCT 36](#_Toc476138386)

[VI. Baseline Administrative Data 39](#_Toc476138387)

[VII. Conclusion 41](#_Toc476138388)

Appendices

[Appendix A: Evaluation Framework](#_Toc476139145)

# Executive Summary

## Introduction

The Australian Government is undertaking a Cashless Debit Card Trial (CDCT) to deliver and manage income support payments (ISPs), with the aim of reducing levels of community harm related to alcohol consumption, drug use and gambling.

In the CDCT, a proportion of an individual’s ISP is directed to a restricted bank account, accessed by a debit card (not allowing cash withdrawals). 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.

To date, the CDCT is being implemented in Ceduna and Surrounds in South Australia and Kununurra / Wyndham (East Kimberley) in Western Australia.

The Department of Social Services (DSS) commissioned ORIMA Research to conduct an independent evaluation of the CDCT. This report is focused on identifying initial conditions prevailing in the trial sites before the implementation of the CDCT.

The report is primarily based on the findings of qualitative research (interviews and focus groups) with key stakeholders in each of the trial sites. It also includes some coverage of administrative data that was available at the time of report writing.

A total of 37 stakeholders (members of regional leadership groups as well as government and non-government service providers) participated in the qualitative research, which was conducted between 21 April and 26 May 2016.

## Demographic profile of the trial communities

The 2011 Census found that the total population of Ceduna and Surrounds was 4,221, of which 2,289 people lived in the town of Ceduna. The total population of the East Kimberley was 6,950, including:

* 5,525 people living in Kununurra, and
* 1,003 people living in Wyndham.

Around one-third of the population in each trial area identified as being of Aboriginal and / or Torres Strait Islander origin in the 2011 Census, compared with 2.7% of the overall Australian population. Most of the Indigenous people (62%) in Ceduna and Surrounds lived in communities outside of the Ceduna urban area.

## Initial data – debit card roll out

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.

As at 4 October 2016, 785 residents of Ceduna and Surrounds (around 26% of the total working age population) and 1,225 residents of East Kimberley (26% of the working age population) had received an ISP via a CDC[[1]](#footnote-1).

In both locations, 42% of Aboriginal and / or Torres Strait Islander residents had received an ISP via a CDC compared with around 5% of non-Indigenous residents. This reflects the fact that a large majority of ISP recipients (73% in Ceduna and Surrounds and 86% in East Kimberley)[[2]](#footnote-2) were Indigenous people. The disproportionately high share of Indigenous people in the ISP recipient population reflected their relatively high levels of socio-economic disadvantage.

## Stakeholder views of pre-CDCT conditions

### Alcohol consumption and impacts

Overall, the research found that alcohol consumption was the most concerning issue for stakeholders across both trial sites, in comparison to gambling and drug use. Most 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.

A few stakeholders believed that the levels of alcohol consumption had reduced since the introduction of alcohol restrictions in these communities in late 2015. However, a few other stakeholders felt that such reductions were likely to be only temporary based on the perceived impacts of previous alcohol restriction arrangements[[3]](#footnote-3).

### Illicit drug consumption and impacts

Overall, stakeholders across both trial locations reported that, in comparison to alcohol consumption, usage of illicit drugs was less widespread. Although most 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 potential issue that was likely to increase into the future.

Marijuana was reported as being the most commonly used drug (other than alcohol). In comparison to alcohol and other illicit forms of drugs, stakeholders felt that marijuana had less of an impact on the wider community as it tended not to lead to “aggressive” and violent behaviours.

Overall, amphetamine usage was reported by stakeholders as being less common than marijuana. However, many stakeholders (especially in Ceduna) indicated that usage of amphetamines, in particular methamphetamine (i.e. “ice”), had increased over the last 12 months as it had become more readily available. Stakeholders reported that due to their higher cost, amphetamines were mainly used by adults who were working full-time. Whilst not widely used drugs, amphetamines were considered to be particularly harmful (especially when “mixed” with alcohol) as use often resulted in aggressive and violent behaviours, and thus the impacts on others in the community were perceived to be quite severe.

### Gambling activity and impact

Overall, most stakeholders in Ceduna and a few stakeholders in Kununurra and Wyndham reported that excessive gambling was prevalent in their community. Gambling behaviours differed between the two sites, with gambling via electronic gaming machines (“pokies”) prevalent in Ceduna, but not available in Kununurra and Wyndham. Excessive gambling in the East Kimberley was perceived by stakeholders there to be primarily based on informal gambling activities (e.g. card games).

The research found that most stakeholders in Kununurra and Wyndham did not hold serious concerns about the impacts of gambling in their communities, particularly compared to that of alcohol. In contrast, many stakeholders in Ceduna felt that gambling (particularly the “pokies”) was a serious issue in their community, similar to alcohol consumption.

### Awareness and usage of support services

Overall, stakeholders in both trial areas reported that there was a large number of family and support services available in their community. These included:

* Short term / relief services – e.g. accommodation services (e.g. the Sobering Up Unit and the town camps), meal services, food vouchers and food hampers, and shower and laundry services;
* Longer term rehabilitation and counselling services – drug and alcohol counselling and rehabilitation, financial counselling and planning, and family counselling; and
* Indigenous specific and mainstream services.

Most stakeholders also felt that there was good awareness of these services in the community, including amongst trial participants.

The inclusion of additional services (particularly drug and alcohol, mental health and financial counselling services) as part of the CDCT was considered “very important” in ensuring that adequate care and support was provided for CDCT participants – especially, for those who may experience “withdrawals” as a result of reduced alcohol / drug consumption. However, the research found that, at the time of the research, there was limited awareness amongst most stakeholders about what extra services would be provided / funded in the CDCT – particularly in Kununurra and Wyndham, where stakeholders from support services reported they had not been informed regarding any additional funding, and were unsure whether or not they would receive extra funding.

### Crime, safety and security

Overall, across both trial sites stakeholders indicated that the excessive use of alcohol, drugs and / or gambling contributed to high levels of crime and / or violence in their communities. Most stakeholders felt that alcohol was the predominant cause of many of these behaviours, particularly those where violence was involved (e.g. assaults).

Most stakeholders also perceived that the general sense of safety and security in their communities had gradually eroded, predominantly due to the excessive consumption of alcohol and its resulting impacts. Drug use and excessive gambling were also identified as contributing factors.

Many stakeholders felt that criminal and violent behaviours were under-reported and unprosecuted in the trial sites. As such, they believed that the crime statistics for the trial sites would be considerably lower than the actual number of incidents occurring on a daily basis. Additionally, some felt that crime statistics were likely to reflect policing strategies (e.g. periodic focus on specific criminal issue / “blitzes”) and as such may not accurately reflect the true nature of criminal incidents in the communities.

### Other significant community experiences and concerns

The research found significant concern among many stakeholders about the social, financial, housing and schooling impacts on their communities as a result of excessive alcohol consumption (and to a lesser extent illicit drug use and gambling).

## Awareness, understanding and expectations of the CDCT

The research found that there was generally good awareness and understanding of the CDCT amongst stakeholders in the trial sites. Community leaders tended to have a better and more detailed understanding of the CDCT processes than other stakeholders.

Most stakeholders felt that the CDCT had been well communicated, overall, to their organisation by DSS and felt adequately informed. However, a few stakeholders in Ceduna felt that services in adjacent / nearby areas needed to be better informed about the trial. These stakeholders reported knowing of some services in nearby areas that had dealings with trial participants who had left Ceduna, but had not been aware of the trial.

Stakeholders reported that while most ISP recipients had known that the CDCT was occurring, many had shown limited interest in the trial and had not attended information sessions that were held prior to the rollout. As a result, stakeholders indicated that some trial participants had a limited understanding about the details of card usage and logistics.

The research also identified a number of stakeholder concerns around implementation issues / difficulties with the debit card, which was being rolled out during the time of the research fieldwork. These concerns related to card activation, impact on attendance at cash-only events, communicating the CDCT to clients in remote communities and with limited literacy, ability to facilitate private rental arrangements and funds transfer / direct debit limitations.

Across both trial locations, most stakeholders 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 stakeholders were broadly supportive of the CDCT. However, perceptions in relation to the likely effectiveness of the trial were mixed.

## Conclusions

The initial conditions qualitative research with 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.

Stakeholders indicated that these issues had become progressively worse over the past 5-10 years and that the local communities were experiencing significant adverse impacts.

In particular, most 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.

Most stakeholders who participated in the research felt strongly that there was a need for something to be done to address these issues and were broadly supportive of the CDCT.

# Introduction

## Background

The Australian Government is undertaking a Cashless Debit Card Trial (CDCT) to deliver and manage income support payments (ISPs), with the aim of reducing 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[[4]](#footnote-4). It has also been informed by lessons learned from previous income management trials.

In the CDCT, a proportion of an individual’s ISP is directed to a restricted bank account, accessed by a debit card (not allowing cash withdrawals). 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.

To date, the CDCT is being implemented in Ceduna and Surrounds in South Australia and Kununurra / Wyndham (East Kimberley) in Western Australia. The sites were proposed by community leaders in these locations 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 the Department of Social Services – DSS).

The two CDCT sites have experienced high levels of community harm related to alcohol consumption, drug use and gambling. In its submission to a Senate Committee Inquiry into the Social Security Legislation Amendment (Debit Card Trial) Bill 2015, the Ceduna District Council noted that its “*community has a long-standing problem associated with substance abuse, particularly of alcohol. In common with some other communities we also have issues with drug and gambling addiction*.”[[5]](#footnote-5) Similarly, recent WA State Government agency reports have identified relatively high levels of harm related to alcohol consumption and drug use in the East Kimberley (and wider Kimberley) region, including:

* Between 2005 and 2009, per capita alcohol-related hospitalisations for the Shire of Wyndham-East Kimberley were 4.7 times higher than the WA State average[[6]](#footnote-6);
* Between 1999 and 2007, per capita alcohol-caused deaths in the Kimberley region were 2.9 times higher than the State average[[7]](#footnote-7); and
* In 2013, the per capita incidence of drug offences in the Kimberley region was 1.7 times higher than the State average[[8]](#footnote-8).

While only around one-third of the population in each trial area identified as being of Aboriginal and / or Torres Strait Islander origin in the 2011 Census, a large majority of ISP recipients (73% in Ceduna and Surrounds and 86% in East Kimberley)[[9]](#footnote-9) are Indigenous people. The disproportionately high share of Indigenous people in the ISP recipient population reflects their relatively high levels of socio-economic disadvantage. In turn, these reflect a range of general, long-term historical factors in Australia that have driven significant gaps between the education, health, social and economic outcomes for non-Indigenous Australians and those for Indigenous Australians[[10]](#footnote-10).

The main elements of the CDCT include:

* A cashless card, delivered by a commercial provider (Indue Ltd);
* 80% of income support payments to be placed into a restricted account linked to the cashless card (100% of lump sum payments and arrears payments);
* The percentage of funds accessible in an unrestricted manner (e.g. as cash) may be varied by local community panels;
* 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;
* CDCT participants who move away from the trial sites will remain participants in the CDCT; and
* Up to three sites will operate for 12 months, with a staggered rollout from March 2016.

DSS commissioned ORIMA Research to conduct an independent evaluation of the CDCT. This report presents the initial findings of that evaluation process. It is focused on identifying initial conditions prevailing in the trial sites before the implementation of the CDCT.

## Evaluation framework

This report is the first in a series of three evaluation reports. It is primarily based on the findings of qualitative research (interviews and focus groups) with key stakeholders in each of the trial sites. It also includes some coverage of administrative data that was available at the time of report writing.

The evaluation will be based on evidence collected via a range of data sources, including:

* Three waves of qualitative research with on the ground stakeholders (i.e. initial conditions, wave 1 and wave 2);
* Two waves of post-implementation quantitative research amongst CDCT participants and their families, as well as non-participant community members;
* Department of Human Services (DHS) administrative data;
* State government secondary data; and
* Unidentifiable data from the DSS welfare card ‘inbox’ and hotline – provided to ORIMA Research via summary tables and de-identified comments.

It should be noted that pre-implementation baseline primary research with potential CDCT participants and the broader community was not possible due to the timing of evaluation commissioning and the time required to obtain ethical clearance from a Human Research Ethics Committee prior to the conduct of such research.

The Evaluation Framework (presented in Appendix A) for the project outlines in detail the evaluation’s scope, key questions concerning impacts and higher-level process issues, the evaluation design and methodologies, data sources and specific data to be used or generated by this project.

## Qualitative research methodology

A total of 37 stakeholders participated in the qualitative research, which was conducted between 21 April and 26 May 2016 (across Ceduna, Wyndham and Kununurra) via:

* Two focus groups with members of the regional leadership groups;
* Nineteen face-to-face interviews with members of the regional leadership groups and stakeholders from government and non-government service providers; and
* Ten telephone interviews with members of the regional leadership groups and stakeholders from government and non-government service providers.

Table 1 shows the research design and locations adopted for the research. Table 2 and Table 3 overleaf present the full list of organisations that research participants represented.

Table 1: Qualitative research design – initial conditions research

|  |  |  |  |
| --- | --- | --- | --- |
| **Research location:** | **Ceduna** | **Kununurra / Wyndham** | **TOTAL** |
| Regional leadership group representatives | 3 x IDIs  1 x Telephone IDI  n=4 | 2 x FG  n=8  4 x IDIs  n=4 | 2 x FG  n=8  7 x IDIs  1 x Telephone IDI  n=7 |
| Service provider representatives | 5 x IDIs  6 x Telephone IDIs  n=11 | 7 x IDIs  3 x Telephone IDIs  n=9 | 12 x IDIs  9 x Telephone IDIs  n=20 |
| **Total number of groups / interviews** | **8 x IDIs**  **7 x Telephone IDIs**  **n=15** | **2 x FG**  **11 x IDIs**  **3 x Telephone IDIs**  **n=22** | **2 x FG**  **19 x IDIs**  **10 x Telephone IDIs**  **n=37** |

Table 2: Qualitative research - list of organisations that research participants represented – Ceduna and Surrounds

| Interviewed | Contacted[[11]](#footnote-11) – not interviewed |
| --- | --- |
| * Regional leadership group representatives * Ceduna Aboriginal Corporation * Scotdesco * District Council of Ceduna * Families SA * Ceduna Area School * Aboriginal Drug and Alcohol Council * Save the Children * Centacare Catholic Family Care * Housing SA * Ceduna Youth Club * SA Police: Ceduna * Foodland * Not willing to be identified x 2 | * Koonibba Community * Oak Valley (Maralinga) Inc. * Yalata Community * Red Cross * Ceduna Hospital * Family Violence Legal Service * Ceduna Koonibba Aboriginal Health Service * Complete Personnel * Ngura Yadurirn Children and Family Centre * Eyre Futures |

Table 3: Qualitative research - list of organisations that research participants represented – Kununurra / Wyndham

| Interviewed | Contacted – not interviewed |
| --- | --- |
| * Regional leadership group representatives * Kununurra Empowered Communities * Wunan Foundation * MG Corporation * Waringari Aboriginal Corporation * Kununurra Chambers of Commerce and Industry * WA Police: Kununurra * Kimberley Mental Health and Drug Service * Dept of Corrective Service - Youth Justice Services * Save the Children * Kununurra Local Drug Action Group * Department of Social Services * Ngnowar Aerwah Aboriginal Corporation * Wyndham Early Learning Activity Centre * Wyndham District High School * WA Police: Wyndham * Wyndham District Hospital * Shire of Wyndham East Kimberley | * Gelganyem Trust * Kununurra District Hospital * Community Housing Limited * St John’s Ambulance * WA Housing * Kimberley Community Legal Services Inc. * Wyndham Community Club * East Kimberley Job Pathways |

## Presentation of 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 the report provide a qualitative indication and approximation of size of the target audience who held particular views:

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

The most common findings are reported except in certain situations where only a minority has raised particular issues, but these are nevertheless considered to be important and to have potentially wide-ranging implications / applications.

Quotes have been provided throughout the report to support the main results or findings under discussion.

We acknowledge and understand that Aboriginal and / or Torres Strait Islander people is the preferred term when referring to Indigenous Australians. However, in this report we have opted to use the term Indigenous participants when referring to Aboriginal and / or Torres Strait Islander participants for brevity of readership.

## Quality assurance

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

# Demographic profile of the trial communities

## About this chapter

This chapter presents contextual demographic data for the Ceduna and East Kimberley CDCT sites. All data presented in the chapter has been sourced from the last ABS Census (2011).

## Total population

The 2011 Census found that the total population of Ceduna and Surrounds[[12]](#footnote-12) was 4,221, of which 2,289 people lived in the town of Ceduna.

The total population of the East Kimberley[[13]](#footnote-13) was 6,950, including:

* 5,525 people living in Kununurra; and
* 1,003 people living in Wyndham.

In both Ceduna and Surrounds (50.3%) and East Kimberley (52.6%), the proportion of residents who were male was a little higher than the national average (49.4%).

## Indigenous population

Of the people living in Ceduna and Surrounds during the 2011 Census, 4,015 (95%) stated whether or not they were of Aboriginal and / or Torres Strait Islander origin. Of this group, 1,245 (31%) identified as being of Aboriginal and / or Torres Strait Islander origin. Most of these Indigenous people (773) lived in communities outside of the Ceduna urban area. Twenty one per cent of the Indigenous population in the area spoke a language other than English and 1% did not speak English well.

Of the 6,950 people living in the East Kimberley during the 2011 Census, 6,304 (91%) stated whether or not they were of Aboriginal and / or Torres Strait Islander origin. Of this group, 2,068 (33%) identified as being of Aboriginal and / or Torres Strait Islander origin. Sixteen per cent of the Indigenous population in the area spoke a language other than English and 1% did not speak English well.

Nationally, 2.7% of the Australian population identified as being of Aboriginal and/ or Torres Strait Islander origin in the 2011 Census. Thirteen per cent of the Australian Indigenous population spoke a language other than English and 2% did not speak English well.

## Labour force status

The 2011 ABS Census found that of the working age population[[14]](#footnote-14) living in Ceduna and Surrounds:

* 65% were employed;
* 3% were unemployed; and
* 32% were not in the labour force.

Of the working age population living in the East Kimberley:

* 74% were employed;
* 3% were unemployed; and
* 22% were not in the labour force.

Nationally, in the 2011 Census, 61% of the Australian working age population were employed, 4% were unemployed and 35% were not in the labour force.

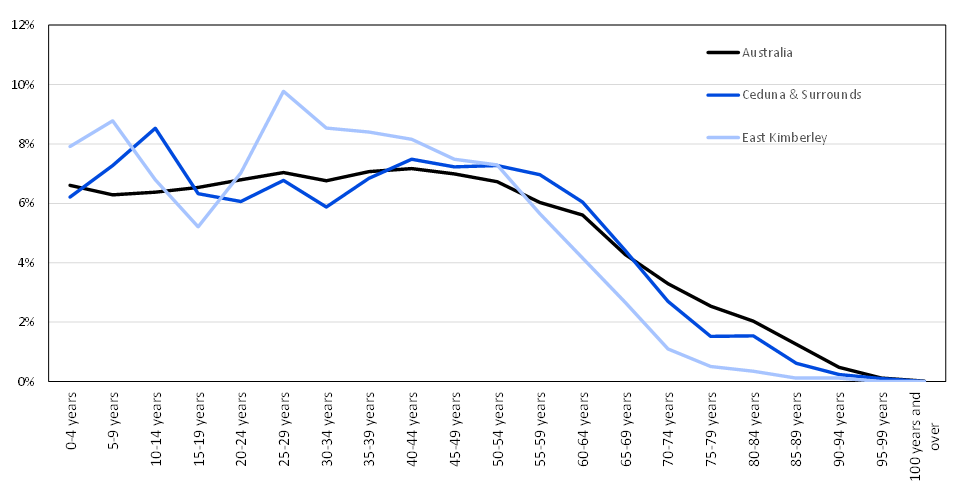
In Ceduna and Surrounds, the agriculture sector was the largest employer of non-Indigenous persons (followed by health care and social assistance), while the health care and social assistance sector was the largest employer of Indigenous persons.

In the East Kimberley, the construction sector was the largest employer of non-Indigenous persons (followed by health care and social assistance), while the health care and social assistance sector was the largest employer of Indigenous persons.

## Age distribution

Figure 1: Age Distribution — Population residing in CDCT trial sites below shows that the population of Ceduna and Surrounds in 2011 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.

Figure 1: Age Distribution — Population residing in CDCT trial sites

 Source: ABS Census 2011.

## Early Childhood Development

The Australian Early Development Census (AEDC) is conducted every three years and has occurred in 2009, 2012 and 2015. The AEDC measures the development of children in Australia in their first year of full-time school. The AEDC is considered to be a measure of how well children and families are supported from conception through to school age.

AEDC data is collected using an Early Development Instrument (completed by each child’s teacher) that consists of approximately 100 questions across five key domains, which are closely linked to:

1. physical health and wellbeing;
2. social competence;
3. emotional maturity;
4. language and cognitive skills (school-based); and
5. communication skills and general knowledge.

AEDC domain scores are calculated for each domain for each child where enough valid responses have been recorded.[[15]](#footnote-15) In 2009, domain cut-off scores were established and children falling below the 10th percentile in a domain are categorised as 'developmentally vulnerable'. The percentage of children assessed as developmentally vulnerable on two or more domains provides a summary indicator of developmental vulnerability of young children in the community or population group being considered.

Table 4 summarises the AECD findings for the CDCT sites and provides corresponding national, Indigenous and non-Indigenous findings. It shows that in 2015:

* Indigenous children accounted for 5.5% of Australian children in their first year of school who were assessed in the AEDC process
* 26.2% of Indigenous children were assessed as developmentally vulnerable in two or more AEDC domains, compared to 10.2% of non-Indigenous children
* the proportion of children assessed as developmentally vulnerable in two or more domains in East Kimberley (27.0%) and Ceduna & surround (19.6%) were higher than hypothetical rates (of 19.6% and 17.3%, respectively) controlling for the higher-than-average proportion of Indigenous children in these communities.[[16]](#footnote-16)

Table 4: 2015 AEDC findings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Population group / Community | Children with valid domain scores (#) | Indigenous children (%) | Developmentally vulnerable in two or more domains (DV2%) | Hypothetical DV2% allowing for indigenous % (%) |
| Australia | 286,616 | 5.5 | 11.1 | - |
| Indigenous Children | 15,875 | 100 | 26.2 | - |
| Non-Indigenous Children | 270,741 | 0 | 10.2 | - |
| East Kimberly (CDCT Site) | 126 | 58.7 | 27 | 19.6 |
| Ceduna & Surrounds (CDCT Site) | 56 | 44.6 | 19.6 | 17.3 |

Source: AEDC Community Profile and National Report, 2015.

## Income distribution

Figure 2 below shows that the population of Ceduna and Surrounds in 2011 had a total annual personal income distribution that was skewed towards lower and middle income brackets compared to that of Australia as a whole. In contrast, the income distribution of East Kimberley was skewed towards higher income brackets.

Figure 2: Total Annual Personal Income Distribution — Population residing in CDCT trial sites

Line chart showing total annual personal income distribution for Australia, Ceduna and Surrounds and East Kimberley for 12 income increments, ranging from negative income, through nil income, up to $104,000 or more.
 Source: ABS Census 2011.

# Initial data – cashless debit card roll out

## About this chapter

This chapter presents initial data concerning the distribution of cashless debit cards to eligible persons in the Ceduna and East Kimberley CDCT sites. All data presented in the chapter has been sourced from the Department of Human Services.

## Progressive roll out

Cashless debit cards (CDCs) were progressively distributed to eligible Income Support Payment (ISP) recipients in Ceduna and the East Kimberley. Figure 3 below shows that 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.

Figure 3: Number of persons paid an ISP via a CDC

Line chart showing number of persons paid an Income Support Payment via a CDC for East Kimberley, Out of Area - East Kimberley, Ceduna and Surrounds and Out of Area - Ceduna for monthly increments, ranging from 1 April 2016 to 4 October 2016.


Source: Department of Human Services.

As at 2 October 2016, a total of 2,115 persons had been paid an ISP via a CDC of which:

* 757 were residents of Ceduna and Surrounds;
* 43 were residents of Ceduna and Surrounds at the time of CDC eligibility assessment (15 March 2016) and had subsequently moved out of area;
* 1,247 were residents of the East Kimberley;
* 63 were residents of the East Kimberley at the time of CDC eligibility assessment (26 April 2016) and had subsequently moved out of area; and
* 1,181 (56%) were female and 934 (44%) were male.

## Proportion of CDCT trial site populations with a CDC

As at 4 October 2016, 757 residents of Ceduna and Surrounds had received an ISP via a CDC – this represents:

* around 18% of the total resident population of Ceduna and Surrounds[[17]](#footnote-17), and
* around 27% of the total working age[[18]](#footnote-18) resident population of Ceduna and Surrounds[[19]](#footnote-19)

As at 4 October 2016, 1,247 residents of the East Kimberley had received ISPs via a CDC – this represents:

* around 18% of the total resident population of East Kimberley[[20]](#footnote-20), and
* around 25% of the total working age resident population of East Kimberley[[21]](#footnote-21).

Figure 4 shows the proportion of CDCT area residents who had received an ISP via a CDC by age group.

Figure 4: Proportion of CDCT Area Residents paid an ISP via a CDC, by Age Group

Column chart showing proportion of CDCT area residents paid an Income Support Payment via a CDC, by Age group. Ceduna and Surrounds: Less than 25 years (10%), 25 - 35 years (37%), 35 - 45 years (28%), 45 - 60 years (21%) and Over 60 years (8%). East Kimberley: Less than 25 years (10%), 25 - 35 years (27%), 35 - 45 years (22%), 45 - 60 years (23%) and Over 60 years (11%).


Figure 5 shows the proportion of CDCT area residents who had received an ISP via a CDC by Indigenous status.

* In Ceduna and Surrounds, 45% of Aboriginal and / or Torres Strait Islander residents had received an ISP via a CDC compared with 6% of non-Indigenous residents.
* In the East Kimberley, 24% of Aboriginal and / or Torres Strait Islander residents had received an ISP via a CDC compared with 10% of non-Indigenous residents.

Figure 5: Proportion of CDCT Area Residents paid an ISP via a CDC, by Indigenous Status

Column chart showing proportion of CDCT area residents paid an Income Support Payment via a CDC, by Indigenous Status. Ceduna and Surrounds: Indigenous (45%), Non-Indigenous (6%), Unknown (11%). East Kimberley: Indigenous (49%), Non-Indigenous (5%), Unknown (4%)


## Income Support Payments (ISPs) paid via the CDC

As at 4 October, a total of $10.4 million of Income Support Payments (ISPs) had been paid via the CDC to CDCT participants, while around $2.6 million[[22]](#footnote-22) of ISPs were accessible as cash[[23]](#footnote-23).

Figure 6 shows that as at 4 October 2016:

* CDCT participants in Ceduna and surrounds were paid at total of $4.1 million of ISPs via their CDCs and around $1.0 million accessible as cash; and
* CDCT participants in East Kimberley were paid a total of $6.2 million of ISPs via their CDCs and $1.6 million accessible as cash.

Figure 6: Income Support Payments (ISPs) via CDC (as at 4 October 2016)

Stacked column chart showing Income Support Payments paid via CDC and Income Support Payment accessible as cash for Ceduna and Surrounds and East Kimberley.


|  |  |  |  |
| --- | --- | --- | --- |
|  | **ISP paid via CDC** | **ISP accessible as cash\*** | **Total ISP** |
| **Ceduna & surrounds** | $4,130,112 | $1,032,528 | $5,162,639 |
| **East Kimberley** | $6,229,961 | $1,557,490 | $7,787,451 |
| **Total** | $10,360,072 | $2,590,018 | $12,950,090 |
| \*based on assumption that all CDC participants have default 80% of ISP paid via CDC. | | | |

Figure 7 and Figure 8 show the total value of ISPs delivered via the CDC (as at 4 October 2016) to CDCT participants in Ceduna and surrounds and East Kimberley, respectively.

Figure 7: ISPs via CDC, Ceduna & surrounds, by ISP type

Bar chart showing Income Support Payments for CDCs in Ceduna and Surrounds, by Income Support Payment type. Newstart allowance (n=408) $1,635,640; Parenting Payment Single (n=82) $846,342; Disability Support Pension (n=129) $711,958; Parenting Payment Partnered (n=42) $374,229; Carer Payment (n=37) $303,999; Youth Allowance (n=58) $133,801; Other* (n=29) $124,143. 


\*Other ISP types paid via CDC include: Family Tax Benefit; Sickness Allowance; ABSTUDY; Partner Allowance; Widow Allowance; and Maternity Immunisation Allowance.

Figure 8: ISPs via CDC, East Kimberley, by ISP type

Bar chart showing Income Support Payments for CDCs in East Kimberley, by Income Support Payment type. Parenting Payment Single (n=198) $1,834,644; Newstart allowance (n=525) $1,801,659; Disability Support Pension (n=249) $1,333,362; Parenting Payment Partnered (n=68) $520,454; Carer Payment (n=44) $333,270; Family Tax Benefit (n=24) $188,869; Youth Allowance (n=98) $168,777; Other* (n=19) $48,925. 


\*Other ISP types paid via CDC include: ABSTUDY; Widow Allowance; Sickness Allowance; Age Pension; and Maternity Immunisation Allowance.

Figure 9 shows the total value of ISPs delivered via the CDC (as at 4 October 2016) to CDCT participants with ATSI and non-ATSI status.

Figure 9: ISPs via CDC, by ATSI status

Stacked column chart showing Income Support Payments paid via CDC in Ceduna and Surrounds and East Kimberley, by ATSI Status.


|  |  |  |  |
| --- | --- | --- | --- |
|  | **Ceduna & surrounds** | **East Kimberley** | **Total** |
| **ATSI CDC holders** | $3,101,160 | $5,185,600 | $8,286,760 |
| **Non-ATSI CDC holder** | $929,453 | $954,275 | $1,883,729 |
| **ATSI status unknown** | $99,499 | $90,085 | $189,584 |
| **Total** | $4,130,112 | $6,229,961 | $10,360,072 |

Figure 10 shows the total value of ISPs (as at 4 October 2016) to male and female CDCT participants. Around two-thirds of ISPs were paid to female CDCT participants:

* 66% of ISPs paid in Ceduna were to female CDCT participants; and
* 66% of ISPs paid in East Kimberley were to female CDCT participants.

Figure 10: ISPs via CDC, by CDC holder gender

Stacked column chart showing Income Support Payments paid via CDC in Ceduna and Surrounds and East Kimberley, by Gender.


|  |  |  |  |
| --- | --- | --- | --- |
|  | **Ceduna & surrounds** | **East Kimberley** | **Total** |
| **Female** | $2,714,504 | $4,324,262 | $7,038,766 |
| **Male** | $1,415,608 | $1,905,699 | $3,321,307 |
| **Total** | $4,130,112 | $6,229,961 | $10,360,072 |

Figure 11 and Figure 12 shows the total value of ISPs (as at 4 October 2016)

* Ceduna and surrounds; and
* East Kimberley

Figure 11: ISPs via CDC, Ceduna and surrounds, by CDC holder age

Bar chart showing Income Support Payments for CDCs in Ceduna and Surrounds, by CDC holder Age. Less than 25 years (n=143) $575,328; 25 to 35 years (n=229) $1,448,965; 36 to 45 years (n=168) $986,840; 46 to 60 years (n=198) $915,055; Over 60 years (n=47) $203,925.


Figure 12: ISPs via CDC, East Kimberley, by CDC holder age

Bar chart showing Income Support Payments for CDCs in East Kimberley, by CDC holder Age. Less than 25 years (n=252) $1,049,442; 25 to 35 years (n=361) $2,116,958; 36 to 45 years (n=254) $1,1311,256; 46 to 60 years (n=304) $1,483,323; Over 60 years (n=54) $286,982.


# Stakeholder views of pre-CDCT conditions

## About this chapter

This chapter presents research findings relating to stakeholders’ views about the on-the-ground conditions before the Cashless Debit Card Trial (CDCT) across the trial locations.

It presents stakeholders’ observations and perceptions about alcohol consumption and its impacts, illicit drug usage and its impact, and gambling and its impacts. The chapter presents their views about the communities’ awareness and usage of on-the-ground support services, as well as observations about crime, safety and security. Finally, the chapter covers stakeholders’ perceptions about other significant community experiences and concerns.

## Alcohol consumption and impacts

Overall, the research found that alcohol consumption was the most concerning issue for stakeholders across both trial sites, in comparison to gambling and drug use. Most 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

“It’s a social catastrophe, nearly everything is linked to alcohol. It’s at the core of nearly every problem”—Kununurra

Overall, most stakeholders reported that excessive consumption of alcohol was prevalent in their town, and that this had increased over time (particularly in the past 5-10 years). Stakeholders stated that this was evidenced by:

* Visible public drunkenness;
* Increasing numbers of people who needed help and assistance as a result of alcohol use;
* Family and community concern and discussions about the adverse effects of high alcohol consumption; and
* Extremely high blood alcohol content (BAC) readings of people presenting to hospitals.

“I’ve been here 40 years and I’ve seen the rise of chronic alcohol abuse”—Ceduna

“0.3, 0.4 alcohol [blood alcohol concentration] doctors say they should technically be dead”—Ceduna

A few stakeholders believed that the levels of alcohol consumption had reduced since the introduction of alcohol restrictions in these communities. However, a few other stakeholders felt that such reductions were likely to be only temporary, based on the perceived impacts of previous alcohol restriction arrangements[[24]](#footnote-24). The restriction arrangements reported by stakeholders included:

* Dry areas and alcohol restrictions in Ceduna[[25]](#footnote-25) – the Ceduna District Council, South Australian Police and local alcohol licensees and the Office of the Liquor and Gambling Commissioner have introduced a range of measures in relation to responsible service, sale and consumption of alcohol. These include the introduction of Dry Areas, restrictions on sales of certain types of alcohol and the introduction of ID Tect machines; and
* The Takeaway Alcohol Management System (TAMS) in Wyndham and Kununurra[[26]](#footnote-26) – the Kununurra / Wyndham Alcohol Accord has implemented a 12 month trial of TAMS which began on 14 December 2015. This system limits individuals’ daily alcohol purchases by using scanning technology of their personal identification.

“TAMS has made a difference – I base that on how people behave around the ‘Big Croc’, that’s mainly where antisocial behaviour occurs”—Wyndham

Stakeholders reported that excessive alcohol consumption was common amongst people from:

* Both genders;
* Both Indigenous and non-Indigenous backgrounds;
* A range of ages – stakeholders reported that while frequent excessive alcohol consumption was more common amongst those over 18, it was common for children to begin drinking at 14-15 years of age with the behaviour increasing as they got older; and
* Local ‘dry’ communities – who typically travelled into town in order to consume alcohol.

“It’s not a racial thing... non-Indigenous have their issues too”—Wyndham

“They’ll be out camping and drinking and then they’ll come into Ceduna pissed”—Ceduna

“Port was the drink of choice – as it’s cheap and very high alcohol content”—Ceduna

“Through circumstance there’s a lot of drinking in public. People who are itinerate don’t have a place to stay and drink”—Ceduna

For people consuming excessive amounts of alcohol, stakeholders reported that the most commonly consumed beverages were low cost and had high alcohol content. However, when lump sum payments were available in the community (e.g. royalties) more expensive beverages were consumed, particularly spirits.

Overall, stakeholders reported that alcohol consumption amongst Indigenous community members was more noticeable than that of non-Indigenous community members. This was attributed to a more communal nature of drinking among Indigenous community members, as well as housing constraints (e.g. overcrowding) and the prevalence of people from outside the trial sites visiting these communities. This meant that there was a greater likelihood for Indigenous community members to consume alcohol in public and / or highly visible places such as parks, on the street and at “party houses” (i.e. houses where large groups of people regularly congregated to consume alcohol). In contrast, stakeholders reported that non-Indigenous community members generally consumed alcohol privately.

“There’d be white fellas that are as big an alcoholic but you don’t see them because they’ve got a home and they’re more private”—Ceduna

As such, while stakeholders reported that the consequences of drinking were similar and evident across both groups, they generally found it more difficult to report on the specific timing and frequency of alcohol consumption of non-Indigenous people.

Stakeholders reported that there were several patterns of excessive alcohol consumption that were observed amongst Indigenous community members, including:

* Regular binge drinking – i.e. consuming very large amounts of alcohol several times a week;
* Irregular binge drinking – stakeholders indicated that there were some people living in Indigenous communities who stayed in town for periods of time to drink before returning to their dry communities and / or ‘going bush’ and / or visiting others; and
* Dependant / continuous drinking – stakeholders reported that there were some community members who were highly dependent on alcohol and “continuously” intoxicated.

“… some people would be intoxicated all the time… they’re seasoned, hardened alcoholics”—Ceduna

In terms of the timing of alcohol consumption, stakeholders reported that:

* Excessive drinking occurred throughout the week;
* However, in Kununurra and Wyndham stakeholders reported a decrease in consumption during periods when bottle shops were closed (e.g. on Sundays and during police-enforced Liquor Act closures); and
* It was common for people to begin drinking as soon as bottle shops opened in the morning (i.e. 10am) – this was also observed by researchers conducting fieldwork at the trial sites.

“Bottle shops are closed on Sundays and this place is a ghost town then”— Wyndham

Stakeholders reported that while the level of alcohol consumption was high throughout the year, it tended to increase further during events (e.g. football games) and communal gatherings (e.g. funerals).

“For funerals people drink to excess”—Wyndham

Stakeholders across the trial sites reported that in their communities, the excessive consumption of alcohol caused:

* a range of injuries, both directly to the individual consuming the alcohol and to others;
* longer-term adverse health impacts to the individual and their unborn / new born and older children; and
* negative social impacts for the community.

“Tourists were scared, on the grey nomad networks they were saying ‘give Ceduna a miss’”—Ceduna

The following alcohol-related injuries to the individual were commonly reported by stakeholders:

* Fatalities and injuries sustained while intoxicated (e.g. from falls and fights);
* Fatalities and injuries as a result of drunk driving or being near moving vehicles while intoxicated;
* Exacerbation of mental illness – leading to self-harm and suicide; and
* Alcohol poisoning.

“There’s been a lot of road accidents with people travelling to get more alcohol”—Wyndham

“There’s a high level of suicide attempts, a couple of people every week”—Kununurra

Alcohol-related injuries to others were frequently reported by stakeholders as being sustained from intoxicated people in the community via widespread:

* Domestic violence;
* Rape and sexual violence, assaults and abuse; and
* Physical “outbursts” / assaults / violent behaviour.

“Family violence is huge… people get pissed and fight in front of the kids”—Ceduna

The research also identified a range of longer-term health impacts of excessive alcohol consumption based on feedback from stakeholders, including:

* Memory loss and “confusion”;
* Physical illness / conditions – e.g. cancers, high blood pressure, kidney damage, liver failure, stomach / digestion problems, diabetes, etc;
* Mental illness / conditions – e.g. anxiety and depression; and
* Foetal Alcohol Syndrome and learning difficulties in children.

“Because of the amount of liver failure there’s quite a number of people in dialysis here in Wyndham and Kununurra”—Wyndham

“We see kids with foetal alcohol syndrome too… it affects their behaviour and their concentration at school”—Kununurra

## Illicit drug consumption and impacts

Overall, stakeholders across both trial locations reported that, in comparison to alcohol consumption, usage of illicit drugs was less widespread. Although most 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 potential issue that was likely to increase into the future.

Marijuana was reported as being the most commonly used drug (other than alcohol). Stakeholders indicated that usage was relatively widespread and that the drug had “always been present” in communities. Marijuana usage was reported as being more prevalent amongst younger community members, including those below 18 years of age. Some stakeholders reported incidents of children using marijuana from as young as 10 years of age. In comparison to alcohol and other illicit forms of drugs, stakeholders felt that marijuana had less of an impact on the wider community as it tended not to lead to “aggressive” and violent behaviours. Rather, a few stakeholders reported that marijuana use was more commonly associated with low levels of motivation to find paid employment, as well as low levels of school engagement and performance amongst children.

“Number one is alcohol and then cannabis”—Kununurra

“Ganja has been around and a lot of people handle it”—Wyndham

“Marijuana is a big thing, the kids are using it”—Wyndham

“Marijuana mellows you out”—Kununurra

Overall, amphetamine usage was reported by stakeholders as being less common than marijuana. However, many stakeholders (especially in Ceduna) indicated that usage of amphetamines, in particular methamphetamine (i.e. “ice”), had increased over the last 12 months as it had become more readily available. Stakeholders reported that due to its higher cost, amphetamines were mainly used by adults who were working full-time. Whilst not a widely used drug, it was considered to be particularly harmful (especially when “mixed” with alcohol) as it often resulted in aggressive and violent behaviours, and thus the impacts on others in the community were perceived to be quite severe.

“Ice has started to creep in”—Kununurra

“It’s tradies [using amphetamines] you know, young guys who earn a lot of money”—Ceduna

“Ice takes everything to a different level with the aggression”—Ceduna

Based on feedback received from stakeholders, amphetamines appeared to be more widely available and used in Ceduna than in the other two trial sites. The research suggested that this was due to Ceduna’s proximity to the highway, which stakeholders reported as providing a “convenient supply route” into the area.

In contrast, in the smaller, more isolated communities (i.e. outside of Kununurra and Ceduna) amphetamine use was reported as being uncommon and generally not perceived to be an issue of concern. Stakeholders noted that availability of amphetamines was limited in smaller, more remote communities. Furthermore, they felt that the small size and isolated nature of these communities made it relatively easy for authorities and community leaders to control and monitor the drug situation. In addition, these communities generally had less money available to purchase higher cost substances.

“Being a small community, everyone knows what’s going on”—Wyndham

A few instances of heroin usage were cited by some stakeholders, however usage of this form of illicit substance was perceived to be less prevalent in comparison to usage of other substances – primarily due to cost reasons.

Stakeholders reported that drug use was evident in both the Indigenous and non-Indigenous populations in the communities.

While stakeholders reported that some children were using marijuana in public areas, overall drug usage generally did not occur in public places as consumption was illegal. As the usage of the other forms of illicit drugs was less visible, stakeholders were less able to comment on consumption patterns.

Stakeholders that worked in drug related support services noted that amongst users of drugs, consumption tended to be regular and ongoing due to dependency. The binge patterns that were evident with alcohol were generally not seen.

## Gambling activity and impact

Overall, most stakeholders in Ceduna and a few stakeholders in Kununurra and Wyndham reported that excessive gambling was prevalent in their community. The South Australian Attorney General reports that poker machine revenue in the Ceduna region for August 2014 was $437,646[[27]](#footnote-27), which was estimated to be 5.5% of Ceduna’s total monthly income[[28]](#footnote-28) .

Gambling behaviours differed between the two sites, with gambling via electronic gaming machines (‘pokies’) prevalent in Ceduna, but not available in Kununurra and Wyndham. Excessive gambling in the East Kimberley was perceived by stakeholders there to be primarily based on informal gambling activities (e.g. card games). The research found that most stakeholders in Kununurra and Wyndham did not hold serious concerns about the impacts of gambling in their communities, particularly compared to that of alcohol. In contrast, many stakeholders in Ceduna felt that gambling (particularly the ‘pokies’) was a serious issue in their community, similar to alcohol consumption.

“Gambling pales in comparison to alcohol”—Kununurra

“A lot of people here wish the town never got pokies”—Ceduna

Stakeholders reported that excessive behaviours were evidenced by:

* Individuals’ reported expenditure on gambling when presenting to financial counselling services;
* Individuals accessing support services to meet basic needs (e.g. meals and food vouchers);
* Individuals in government assisted housing not being able to meet rental repayments;
* Presentation of unsupervised children at support services;
* Observed neglect of children (e.g. children not being adequately fed and cases of children being locked in cars during gambling sessions); and
* Direct observation of extended amounts of time spent gambling (e.g. individuals arriving at pokie venues and remaining all day).

“We’ve had some clients who admit they go to the TAB and we have to work out a budget”—Wyndham

“They will call us for an order from the supermarket to feed their families”—Ceduna

“There have been cases where kids have been locked in cars and the police have been called”—Ceduna

Generally, stakeholders who worked in financial and family support services and / or who dealt with clients’ financial issues (e.g. housing services) were better able to assess the impact that excessive gambling had on individuals. Many other stakeholders found it difficult to comment on the impacts of excessive gambling, as they were not privy to individuals’ financial circumstances.

Overall, stakeholders reported that both unregulated and regulated gambling were common amongst adults in their towns, including:

* Unregulated card games – reported by stakeholders as being more common amongst older Indigenous females;
* Electronic gaming machines – which only occurred in Ceduna due to government restrictions in WA which meant that these were not available in Kununurra and Wyndham. Usage of pokies was reported as being high across all demographic types of people (i.e. males vs females, young vs older, Indigenous vs non-Indigenous);
* ‘Scratchies’ – appeared to be more common amongst females;
* TAB – reported as being more common amongst males;
* Online gambling (e.g. sports betting) – which was commonly reported in Ceduna as an activity that was more prevalent amongst males.

“All the elderly ones do gambling, but it’s just cards”—Wyndham

“Also scratchies, people buying hundreds of dollars of them and scratching them on the footpath”—Kununurra

“There’s gamblers who get up at midnight and gamble online… by the next morning they’ve lost all their money”—Ceduna

The research found that there was not always a linkage between excessive gambling behaviours and excessive alcohol consumption and / or drug use. Stakeholders reported that while some people in the trial sites engaged in excessive gambling in addition to excessive alcohol consumption and / or drug use, others only engaged in excessive gambling behaviours.

Stakeholders reported that most regulated forms of gambling were conducted in venues (e.g. pubs and clubs).

In contrast, unregulated gambling (e.g. card games) was reported to occur in private houses – stakeholders noted that there was often an unofficially designated house for such activities. In Kununurra and Wyndham, card games were also reported to take place in parks, which authorities received complaints about from the public.

Most stakeholders reported that gambling behaviours occurred at all times throughout the day and throughout the year. However, the research found that regulated gambling took place less often in Wyndham, as the TAB (the only venue in town) was only open on limited days / time.

“There’s a card house, mainly elderly ladies and it’s very controlled”—Wyndham

“I think gambling at the park has increased”—Kununurra

## Awareness and usage of support services

Overall, stakeholders in both trial areas reported that there was a large number of family and support services available in their community. These included:

* Short term / relief services – e.g. accommodation services (e.g. the Sobering Up Unit and the town camps), meal services, food vouchers and food hampers, and shower and laundry services;
* Longer term rehabilitation and counselling services – drug and alcohol counselling and rehabilitation, financial counselling and planning, and family counselling; and
* Indigenous specific and mainstream services.

“The obvious ones are the District Health Service, the Aboriginal Health Service – they run the Sobering-up Centre”—Ceduna

Most stakeholders also felt that there was good awareness of these services in the community, including amongst trial participants.

Stakeholders reported that there was high usage of services providing immediate relief. This was believed to be particularly the case among those who consumed excessive amounts of alcohol, drugs or gambled frequently and their families – as many of these community members had limited funds available for basic needs due to these behaviours.

Some stakeholders in Ceduna also noted that the meal and accommodation services were often accessed by people living in the neighbouring Indigenous communities who spent periods in Ceduna on “drinking binges” and facilitated / encouraged this behaviour.

“There’s an argument that says we’ve allowed all the drinkers to come to Ceduna because of all the services… like a holiday camp for drinkers… they’ll take the bits they need, like go to the day centre and get a feed”—Ceduna

In contrast, stakeholders reported that there was generally limited engagement with longer-term assistance / services such as rehabilitation / counselling services. Stakeholders from these services indicated that they received limited self-referrals.

Across both trial sites, many stakeholders felt that the available range of services in their towns lacked coordination with each other, and “operated in silos”. This was felt to negatively impact the strategic approach to case management and the pathways into longer-term support programs. However, a few stakeholders in Ceduna felt the implementation of the Ceduna Services Reform had improved the coordination of service delivery and were expecting that this initiative would improve integration of services.

“A lot of services aren’t communicating with partners and other people in the town, they are working in silos”—Wyndham

“There’s much better value coming up from those services now”—Ceduna

The inclusion of additional services (particularly drug and alcohol, mental health and financial counselling services) as part of the CDCT was considered “very important” in ensuring that adequate care and support was provided for CDCT participants – especially, for those who may experience “withdrawals” as a result of reduced alcohol / drug consumption.

However, the research found that, at the time of the research, there was limited awareness amongst most stakeholders about what extra services would be provided / funded in the CDCT – particularly in Kununurra and Wyndham, where stakeholders from support services reported they had not been informed regarding any additional funding, and were unsure whether or not they would receive extra funding.

### Drug and alcohol counselling, treatment and rehabilitation

The research found that overall there was limited use of drug and alcohol support services across the trial sites.

For example, many stakeholders in Ceduna reported high usage of daily support services offered by the Sobering-up Unit and Day Centre (e.g. accommodation, shower, laundry and meal services), but very limited usage of the treatment, rehabilitation and counselling services offered by these facilities and other drug and alcohol services.

“No one talks to the counsellors at the day centre, they just go there for a feed and a wash”—Ceduna

### Family support

Stakeholders reported some usage of family support services by trial participants. In particular, stakeholders reported high demand and use of:

* Homelessness programs; and
* Domestic violence services.

However, stakeholders reported much of the use of these services occurred as a result of outreach, referrals (e.g. families identified as at-risk of child protection removal) and / or court orders (e.g. to attend counselling services) rather than self-referral.

“If we have a domestic at night, we go in the next morning and separate them for 24 hours and to reinforce that we have counselling”—Wyndham

### Financial counselling and support

Most stakeholders reported high usage of financial support services that provided immediate relief (e.g. food vouchers and hampers).

“We’ve noticed a steady stream of clients asking for food hampers”—Ceduna

## Crime, safety and security

Overall, across both trial sites stakeholders indicated that the excessive use of alcohol, drugs and / or gambling contributed to high levels of crime and / or violence in their communities. Most stakeholders felt that alcohol was the predominant cause of many of these behaviours, particularly those where violence was involved (e.g. assaults).

“The police and St John’s workload decreases dramatically on Sundays when the [alcohol] stores are closed which shows alcohol is the key driver”—Kununurra

Most stakeholders also perceived that the general sense of safety and security in their communities had gradually eroded, predominantly due to the excessive consumption of alcohol and its resulting impacts. Drug use and excessive gambling were also identified as contributing factors.

### Violent and criminal behaviours

Specific violent and / or criminal behaviours reported in trial sites by stakeholders included:

**Assault** – which reportedly occurred due to the increased aggression and lowered inhibitions associated with high alcohol consumption and illicit drug use (particularly amphetamines). Types of assaults included:

* Domestic violence / spousal abuse – stakeholders reported that this was very common, and also occurred due to arguments about family finances due to excessive gambling and alcohol consumption. Law enforcement stakeholders indicated that a large volume of their call-outs were related to domestic violence, however they (and other stakeholders) noted that “a lot of domestic violence went unreported” and thus expected that rates would be “significantly higher” than shown by data;

“Domestic violence is the number one issue we deal with… it’s 22% higher than last year”—Kununurra

* Fights between people in the trial sites – stakeholders reported that it was common for fights to breakout between people when intoxicated and that these would often result in physical injuries. Stakeholders reported that some of these fights were part of long-term inter-family disagreements, particularly amongst the Indigenous community members;

“They’re beating the shit out of each other in the main street”—Ceduna

* Elder abuse – stakeholders reported that there were some instances where older people in the community were assaulted in an attempt to obtain money, goods or liquor from them;
* Physical abuse of children; and
* Sexual assault and rape.

“Throughout a year a whole heap of young girls being sexually abused and raped”—Wyndham

**Burglaries, robberies and thefts** – of money, food, liquor, vehicles and personal property. Stakeholders cited that such items were stolen from private properties and shops;

**Vandalism** – this included property damage, damage to motor vehicles and graffiti;

“We get bursts of graffiti from kids too”—Ceduna

**Driving under the influence of drugs and / or alcohol** – as discussed earlier in the Chapter, injuries and fatalities from drink driving or pedestrians being intoxicated were reported by many stakeholders as being commonplace;

“A lot don’t drive but they’ll get on the highway when they’ve been drinking all day”—Wyndham

**Prostitution** – some stakeholders reported that some people in the community resorted to prostitution for additional income in order to gamble and / or purchase alcohol or drugs; and

**Public intoxication** – this was reported to be widespread across the trial sites. However, some stakeholders in Ceduna felt that the community had “quietened down” since the introduction of alcohol restrictions.

“We noticed a big reduction in alcohol fuelled violence [after] there were some liquor licencing restrictions”—Ceduna

In addition, stakeholders reported that the excessive use of alcohol (and to a lesser extent illicit drug use and gambling) indirectly caused violent and criminal behaviours amongst children / minors in the community. These included:

* Burglaries, robberies and thefts – many stakeholders reported that the children of those who abused alcohol, drugs and / or gambling were involved in stealing money, food or other goods. These stakeholders reported that this occurred as a result of parents spending excessive amounts of money on alcohol, drugs and / or gambling, which left insufficient money for groceries, toys and other necessary household items; and
* Assaults / violent behaviour by children – a few stakeholders reported that children had been violent toward their parents in order to obtain money from them. Stakeholders reported that these children had reduced access to money and goods as a result of their parents’ excessive spending on alcohol, drugs and / or gambling.

“Kids are breaking into homes looking for money”—Wyndham

### Safety and security

Most stakeholders felt that the excessive consumption of alcohol (and to a lesser extent illicit drug use and gambling) contributed to a low sense of community safety in the trial sites.

“For residents, you don’t feel safe, you’ve got to be constantly aware”—Kununurra

It was reported that members of the community, particularly women, children, elderly people, as well as visitors / tourists to the trial sites often “did not feel safe" as a result of:

* High incidence of violence and crime – as discussed above;
* Large numbers of intoxicated people in the trial sites, who were often “rowdy” (i.e. yelling and / or swearing);

“In the streets you see drunken people yelling and carrying on”—Ceduna

* Humbugging of people at ATMs and / or outside stores – it was reported that tourists were often targeted when they were doing their banking transactions;

“It’s intimidating and frightening, black fellas who are drunk asking you for money and cigarettes”—Ceduna

* Verbal abuse – a few stakeholders reported incidents where they had witnessed or experienced verbal abuse as a result of refusing requests for cash from people in the streets and when local businesses conducted bag checks; and
* Groups of children roaming the streets – some stakeholders reported that there were groups of children / minors who roamed the streets at night as they did not feel safe in their homes due to groups of adults, including strangers, drinking (i.e. at the ‘party houses’ previously mentioned). Stakeholders reported that while the children themselves were not safe, they also made others in the community feel unsafe. These children were also reported as sometimes being involved in crimes.

The kids wander the streets and get up to no good”—Wyndham

“Some of the kids, I don’t think they feel safe at home… that’s why they’re roaming the streets”—Wyndham

“Some people are afraid because of the kids that roam… they’re sometimes involved in incidents”—Kununurra

### Crime Statistics

Many stakeholders felt that criminal and violent behaviours were under-reported and unprosecuted in the trial sites. As such, they believed that the crime statistics for the trial sites would be considerably lower than the actual number of incidents occurring on a daily basis. Additionally, some felt that crime statistics were likely to reflect policing strategies (e.g. periodic focus on specific criminal issue / “blitzes”) and as such may not accurately reflect the true nature of criminal incidents in the communities.

“It could be the way we’re receiving information about it [domestic violence], we see more reports from third parties”—Ceduna

## Other significant community experiences and concerns

The research found significant concern among many stakeholders about the social, financial, housing and schooling impacts on their communities as a result of excessive alcohol consumption (and to a lesser extent illicit drug use and gambling).

Many stakeholders commonly noted a range of social impacts associated with excessive alcohol consumption, illicit drug use and / or gambling, including:

* Family arguments, disputes and “fights”;
* Unemployment or under-employment;
* Humbugging; and
* Abuse and / or intimidation of more vulnerable members of the community.

“There’s fighting with the alcohol… assaults”—Wyndham

“My wife came home and said she got harassed out the front of the Foodland”—Ceduna

They also identified financial impacts on the individuals, their families and communities as a result of significant expenditure on alcohol, drugs and / or gambling on an ongoing basis, including:

* Accumulation of and inability to pay fines, which in some cases has led to incarceration of individuals; and
* Inability to fund basic living requirements including food, clothing, hygiene requirements, rent, bills / utilities and transportation.

A lot of money is going on grog which means less money for groceries”—Kununurra

In addition, many stakeholders were concerned about housing challenges facing their communities as a result of overcrowding and inability to meet financial responsibilities associated with securing permanent housing. While some stakeholders felt that poor housing access was due to insufficient affordable housing stock in those communities, others disagreed. They felt that lack of “sobriety”, “clear headed thinking” and “motivation” – as a result of excessive alcohol consumption and / or gambling – had restricted opportunities for employment and financial stability which were perceived to be necessary prerequisites to securing stable housing.

“We need more housing”—Kununurra

Finally, there was widespread concern among most stakeholders about the impact that excessive alcohol consumption (and to a lesser extent illicit drug use and gambling) were having on children.

“It’s dysfunctionality… kids come to school without breakfast and with no lunch packed”—Ceduna

Such concerns were primarily in relation to poor parenting / neglect of family responsibilities and lack of engagement, especially in relation to:

* School attendance, engagement and performance;
* Positive parental / familial role-modelling; and
* Being able to properly nurture, care and protect children from harm and abuse associated with lack of safety and security in their environment (as discussed above).

“Kids don’t go to school”—Kununurra

“A lot of kids don’t want to be at home… if there’s strangers partying there”—Wyndham

## Summary ratings of initial conditions

Stakeholders participating in the research completed a short questionnaire which asked them to rate the prevalence and severity of issues in their local community as well as aspects of community functioning. Average ratings provided by participants are presented in Table 5 below.

Table 5: Stakeholders’ average ratings of severity of issues and community functioning

(n=31)

|  |  |  |
| --- | --- | --- |
|  | **Kununurra / Wyndham** | **Ceduna** |
| **How much of an issue are each of the following in the local community? (Average ratings on a scale of 0 – Not at all to 10 – Extremely severe)** |  |  |
| Alcohol abuse | 8.3 | 7.7 |
| Drug use | 7.2 | 7.0 |
| Gambling | 6.6 | 8.3 |
| Violence and other crimes | 8.1 | 7.4 |
| Street begging | 4.8 | 6.0 |
| Humbugging | 5.7 | 6.1 |
| Harassment, abuse, intimidation | 5.9 | 6.5 |
| **How well is the local community performing on each of the following aspects? (Average ratings on a scale of 0 – Very poorly to 10 – Very well)** |  |  |
| Ability to afford basic household goods | 3.7 | 4.6 |
| Paying bills | 3.4 | 5.5 |
| Employment | 3.4 | 3.8 |
| Education / training | 3.2 | 3.9 |
| Nutrition | 3.1 | 4.4 |
| Health and wellbeing | 3.3 | 4.8 |
| Community pride | 4.4 | 4.9 |
| Community safety | 4.1 | 4.5 |

# Awareness, understanding and expectations of the CDCT

## About this chapter

This chapter presents research findings relating to awareness, understanding and expectations of the CDCT amongst stakeholders across the trial locations. It also reports on feedback stakeholders provided about ISP recipients’ awareness and understanding of the trial.

## Stakeholders’ awareness and understanding of CDCT

Overall, the research found that 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.

Most stakeholders were aware of the following:

* The trial was mandatory for all ISP recipients (other than Age Pensioners and Veterans’ Affairs Pensioners);
* However, one Indigenous leader in Wyndham thought that the trial was an Indigenous specific measure;
* That Age Pensioners and Veterans’ Affairs Pensioners could elect to participate in the trial on a voluntary basis;
* Payment conditions – i.e. that 80% of trial participants’ income support payments would be paid to the cashless debit card and 20% into their regular bank account;

“80% will be reasonable to buy food and clothes and everything they need to become a strong family”—Kununurra

* Arrangements for altering payment conditions – i.e. that trial participants would be able to make an application to a community panel to increase the percentage of their payments received as cash;

“We have this panel that can decide whether we go from 80-20 to 50-50”—Ceduna

* Card restrictions – i.e. the card could not be used to purchase alcohol or gambling products or to withdraw cash; and
* That additional funding was being provided for support services in trial locations.

“Programs are going to be funded as part of the trial is a good thing”—Wyndham

However, some stakeholders had a more limited understanding of the details of this (e.g. how many additional drug and alcohol workers would be funded, etc.)

In contrast, the research found that most stakeholders’ had limited knowledge of specific operational / functional elements of the card and trial (e.g. how the card would operate, how participants could view card balances and assessment criteria used by the community panel). However, most stakeholders were aware of who had responsibility for supporting the rollout / operation of the card in their trial site and indicated that they would refer their client queries about such matters to these organisations.

Overall, most stakeholders felt that the CDCT had been well-communicated to their organisation by DSS and felt adequately informed. However, a few stakeholders in Ceduna felt that services in adjacent / nearby areas needed to be better informed about the trial. These stakeholders reported knowing of some services in nearby areas that had dealings with trial participants who had left Ceduna, but had not been aware of the trial.

“They needed to send out information to Port Lincoln. Port Lincoln Aboriginal Health Services had people come through at the time of the roll-out”—Ceduna

The research also identified a number of stakeholder concerns around implementation issues / difficulties with the debit card, which was being rolled out during the time of fieldwork. These included:

* Card activation – a few stakeholders reported CDCT participants were attempting to use cards that had not yet been activated due to some confusion around the staggered starting date of the trial;
* Concerns that CDCT participants would be unable to access funds to attend and / or spend at specific cash only events;

“[People ask] ‘when they’re selling a ticket and they don’t have EFTPOS, how am I going to get it?’ ”—Wyndham

* Communicating the CDCT to clients in remote communities and with limited literacy – many stakeholders noted that a substantial effort was required to inform and ensure understanding of the CDCT amongst some of their clients living in remote communities who were limited in terms of their English literacy and access to the internet;
* Private rent arrangements – a few stakeholders dealt with clients who rented privately and had difficulties arranging for rental payments to be taken from their cashless debit card account and / or were soon to begin the trial but were unsure about how these payments would be made;
* Concerns regarding funds transfer limitations – one stakeholder reported a client experienced “high anxiety” due to uncertainty about how to repay personal loans to family / friends given the transfer limitations;

“Our last session all she talked about was the card… she had high anxiety about how she was going to pay her mother back with it and how to put money away for her kids”—Ceduna

* Direct debit limitations – the card would only facilitate direct debits via a card number and did not allow direct debits to be set-up using a BSB (i.e. electronic transfer). Some stakeholders noted that this limitation impacted trial participants’ ability to set-up regular payment arrangements (e.g. car repayments) as not all businesses offered this form of direct debit. Furthermore, some organisations charged extra fees when direct debits were made via a card. A few stakeholders also expressed concerns that they had not been made aware of this limitation and had been informing the community that the card would support all direct debit arrangements; and

“Direct debits we thought would be no problem. Someone who’s turned his life around can’t make his car repayments”—Ceduna

“We’ve gone and told people in the community that direct debits won’t be a problem… now we look like idiots”—Ceduna

* Confusion regarding account selection for EFTPOS transactions – a few stakeholders noted that some CDCT participants were unsure about whether to select ‘savings’ or ‘cheque’ when paying for goods using EFTPOS. However, these stakeholders noted that this had not caused any concerns as it was easily remedied by staff at point-of-sale.

## ISP recipients’ awareness and understanding of CDCT

Stakeholders reported that while most ISP recipients had known that the CDCT was occurring, many had shown limited interest in the trial and had not attended information sessions that were held prior to the rollout. Stakeholders indicated that these people had only begun to engage with trial information once the rollout had begun / was about to begin and had become more relevant. As a result, stakeholders indicated that some trial participants had a limited understanding about the details of card usage and logistics. As such, one stakeholder felt additional face-to-face information sessions would be beneficial to allow ISP recipients to ask questions and voice any concerns they had regarding card logistics.

“… they’re resistant to engage with it until it happens”—Ceduna

In addition, a few stakeholders in Ceduna indicated that some ISP recipients had their payment suspended for failing to meet participation requirements of the Community Development Programme. These clients had thought that this was due to problems with the cashless debit card as the timing had coincided with the rollout of the cards.

“There’s a new provider that has come in and they are enforcing the cut-off and they think that the cashless debit card isn’t working”—Ceduna

## Stakeholders’ expectations of the CDCT

Across both trial locations, most stakeholders 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.

“We’re treading water, just surviving”—Kununurra

“Rehab’s not working but we keep spending”—Wyndham

As such, most stakeholders were broadly supportive of the CDCT. However, perceptions in relation to the likely effectiveness of the trial were mixed. The research found that:

* Some stakeholders felt strongly that the CDCT would have a positive impact on reducing alcohol consumption, illicit drug usage and gambling – these tended to be stakeholders who had been involved in initiating the trial in their community (i.e. members of the regional leadership groups); and
* Some others were less confident about the extent to which the CDCT would address these issues. These participants reported that, while they were “hopeful” that the trial would have a positive impact, it was “too early to say” whether or not the CDCT would reduce these issues.

Stakeholders reported that they were expecting and / or hoping that there would be a range of positive outcomes, for individual CDCT participants and their families, as well as the broader community as a result of the trial reducing the consumption of alcohol, illicit drug use and gambling. These included (as discussed in Chapter IV):

* A reduction in the amount of domestic violence, crime, assaults and self-harm;
* A reduction in street drinking and conflict;
* A decrease in the humbugging of women and the elderly in Indigenous communities;
* “Stronger families” and improved outcomes for children, in relation to safety, health / nutrition and school attendance and engagement;

“There’s a culture in the communities of men taking money from women when they don’t have any… there’s a strong hope that this will be addressed”—Ceduna

* One stakeholder felt it was important to assess the type of attendance data that would be used for decisions in altering the 80 / 20 arrangements with the community panel. This stakeholder felt many parents had become “savvy” at explaining their children’s absence from school and therefore felt that to be effective at increasing school attendance the community panel should use “bums on seats” data rather than explained / unexplained absences data;
* In Indigenous communities around Ceduna, more people returning to their community (i.e. not staying in town to drink) and taking an interest in improving their towns / communities; and
* An increase in the uptake of longer-term counselling / rehabilitation services and a decrease in the use of crisis / short-term services (e.g. meal and short-term accommodation services).

Despite most stakeholders being generally supportive of the trial, there were some concerns about specific aspects of the trial, such as:

* The potential for adverse consequences – some stakeholders were also expecting and / or concerned about a range of negative impacts that the trial may have. Most commonly, that some ISP recipients would try to access cash and / or alcohol and drugs in other ways, which would negatively impact the community (e.g. increased humbugging / harassment, prostitution and petty theft);

“I’m worried about the impact on prostitution and petty crime”—Kununurra

* The community panel arrangements – a few stakeholders were concerned about the extent of personal information / data the panel would have access to when assessing applications to alter the cash component paid. These stakeholders were particularly concerned that local community members would have access to this information given the small size of the trial communities; and
* Additional support services were not in place at the beginning of the trial – a few stakeholders were concerned that extra support services were not in place at the commencement of the trial. These stakeholders felt that it was essential that these services were in operation to support participants through initial withdrawal periods and to enable the trial’s impact to be properly evaluated. A few stakeholders also noted that due to the lack of funding certainty for service providers, there would be significant delays in establishing extra services / supports once the contracts were in place.

“In reality if [support services] are not on the ground when the card is running how do you assess it?”—Kununurra

“Nobody signed off on anything… you have to recruit and train staff. It could take you 6-10 weeks”—Kununurra

In addition, a few stakeholders expressed personal views that that the trial did not address the “root causes” of the high rates of alcohol and drug use in the communities and were critical that the CDCT would only be “a short-term fix”.

“These are deep seated problems... you’re dreaming if you think it’ll fix everything”—Ceduna

# Baseline Administrative Data

The South Australian and Western Australian State governments have provided the CDCT evaluation with a range of administrative data relating to social harm for the CDCT sites. Table 6 (below) and Table 7 (over page) presents baseline values[[29]](#footnote-29), where available, for these social harm indicators for Ceduna and surrounds and the East Kimberley CDCT sites, respectively.

Table 6: SA state government baseline social harm data for Ceduna and surrounds

|  |  |  |
| --- | --- | --- |
| **Explanation of Data** | **Frequency** | **Baseline** |
| ***South Australian Police - Number of Police Reports (Eyre local Service Area - wider than trial area)*** |  |  |
| Murder, homicide and related offences | Quarterly | 0.44 per month (Jun-15 to Feb-16) |
| Acts Intended To Cause Injury (i.e. assault) | Quarterly | 84.11 per month (Jun-15 to Feb-16) |
| Sexual Assault And Related Offences | Quarterly | 5.67 per month (Jun-15 to Feb-16) |
| Robbery And Related Offences | Quarterly | 0.89 per month (Jun-15 to Feb-16) |
| Other Offences Against The Person | Quarterly | 7.56 per month (Jun-15 to Feb-16) |
| ***Emergency Department admissions*** |  |  |
| Number of emergency department admissions | Quarterly | 21.17 per month (Sep-15 to Feb-16) |
| ***Department for Communities and Social Inclusion - Ceduna Service Reform*** |  |  |
| Sobering Up Unit (SUU) admissions | Quarterly | 214.75 per month (Jul-15 to Feb-16) |
| Sobering Up Unit (SUU) - discharges at risk | Quarterly | 32.88 per month (Jul-15 to Feb-16) |
| Sobering Up Unit (SUU) - Blood Alcohol Content on admission | Quarterly | average 0.259 (Jan-16 and Feb-16) |
| Sobering Up Unit (SUU) - Blood Alcohol Content on discharge | Quarterly | average 0.106 (Jan-16 to Feb-16) |
| ***Drug and Alcohol Services SA (DASSA) outpatient counselling*** |  |  |
| Total attendances | Quarterly | 30.25 per month (Jul-15 to Feb-16) |
| Proportion of attendances where alcohol was the principal drug of concern | Quarterly | 56.48% average (Jul-15 to Feb-16) |
| Total number of new treatment episodes | Quarterly | 7 per month (Jul-15 to Feb-16) |
| Proportion of new treatment episodes where alcohol was the principal drug of concern | Quarterly | 45.62% monthly average (Jul-15 to Feb-16) |
| ***Department for Communities and Social Inclusion*** |  |  |
| Not eligible for Transitional Centre | Quarterly | 15.5 monthly average (Jul-15 to Feb-16) |
| Number of apprehensions under the Public Intoxication Act | Quarterly | 37.92 per month (Mar-15 to Feb-16) |
| Mobile Assistance Patrol (MAP) clients | Quarterly | 468.5 per month (Jul-15 to Feb-16) |
| ***SA Attorney-General*** |  |  |
| Poker Machine Revenue | Quarterly | $381,257 average monthly expenditure (Jul-13 to Feb-16) |
| ***Department for Communities and Social Inclusion – Housing SA*** |  |  |
| Proportion of Tenants with debt | Quarterly | 48% quarterly average for Q2 & Q3 2015/16 |
| Total Customer (Tenants) Debt ($) | Quarterly | $253,356 quarterly average for Q2 & Q3 2015/16 |
| Acts Intended To Cause Injury (i.e. assault) | Quarterly | 2 quarterly average for Q2 & Q3 2015/16 |
| Number of Support Periods (counts represent a client's Intake) | Quarterly | 424 quarterly average for Q2 & Q3 2015/16 |
| Number of clients (all client counts are unique) | Quarterly | 400.5 quarterly average for Q2 & Q3 2015/16 |
| Proportion of clients where Domestic Violence issue was identified | Quarterly | 15.7% quarterly average for Q2 & Q3 2015/16 |
| Proportion of clients where Drug/Alcohol issue was identified | Quarterly | 3.0% quarterly average for Q2 & Q3 2015/16 |
| ***Department for Education and Child Development*** |  |  |
| Collated attendance figures for the Koonibba, Oak Valley, and Yalata Anangu schools (data for Ceduna will be provided through the MySchool system every six months) | End of each school term. MySchool data by March 2017 | 66.0% term average 2015 |

Table 7: SA state government baseline social harm data for Ceduna and surrounds

|  |  |  |
| --- | --- | --- |
| **Explanation of Data** | **Frequency** | **Baseline** |
| **Western Australia Police (WAPOL)** |  |  |
| Kununurra Verified Assaults | Quarterly | 9 (July 15) |
| Kununurra Verifed Burglary | Quarterly | 4 (July 15) |
| Kununurra Verified Domestic Violence Assault | Quarterly | 25 (July 15) |
| Kununurra Verified Theft | Quarterly | 10 (July 15) |
| Kununurra Police attended Domestic Violence Reports | Quarterly | 46.3 per month (between May 15 and Jul 15) |
| Wyndham Verified Assault | Quarterly | 1 (July 15) |
| Wyndham Verified Domestic Violence Assault | Quarterly | 3 (July 15) |
| Wyndham Verified Burglary | Quarterly | 0 (July 15) |
| Wyndham Verified Theft | Quarterly | 2 (July 15) |
| Wyndham Domestic Violence - Police attended incidents | Quarterly | 7.33 per month (between May-15 to Jul-15) |
| **Western Australian Department for Child Protection and Family Support** |  |  |
| Substantiated safety and wellbeing assessments | Quarterly | Not yet available |
| Mandatory Child Protection Reports Received | Quarterly | Not yet available |
| Number of children in care as at last day of the month | Quarterly | Not yet available |
| **Western Australian Housing Authority** |  |  |
| Disruptive Tennancy Complaints | Quarterly | Not yet available |
| **Western Australian Health (KNX hospital)** |  |  |
| Emergency Presentations | Monthly | Not yet available |
| **St John Ambulance** |  |  |
| Total Call Outs | Monthly | 351 (May-Jul 14); 464 (May-Jul 15); 84 (1-22 Aug 15) |
| Alcohol Only Related Call Outs | Monthly | 7 (May -Jul1 14); 21 (May-Jul 15); 3 (1-22 Aug 15) |
| [Assault Related Call Outs](file:///C:\Users\oliver.tan\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.MSO\3D64FD6A.xlsx#RANGE!A1) | Monthly | 23 (May-Jul 14); 22 (May-Jul 15); 11 (1-22 Aug 15) |
| Stabbing Related Call Outs | Monthly | 4 (May-Jul 14); 3 (May-Jul 15); 0 (1-22 Aug 15) |
| **The Department of Education and Catholic Schools** |  |  |
| Aboriginal Male Attendence | Quarterly | 57% (May to June 15) |
| Aboriginal Female Attendance | Quarterly | 56% (May to June 15) |
| Non-Aborignal Male Attendance | Quarterly | 90% (May to June 15) |
| Non-Aboriginal Female Attendance | Quarterly | 91% (May to June 15) |
| **Western Australian Deptarment of Aboriginal Affairs - Kununurra Waringarri Aboriginal Corporation Patrol Service (Kununurra)** |  |  |
| Total Number of People picked up by Kununurra Miriwoong Community Patrol Service for Alcohol | Monthly | 494 per month (Jan 16 - Feb 16); 541 (Jan 15- Jun 15) |
| Total People Refered to Sobering Up Shelter Moongoong Sober Up Shelter (Kununurra) | Monthly | 190 (Jan 15 - Jun 15; 153 (Jan 16 - March 16) |
| **Western Australia Dept. Child Protection and Family Support (Wyndham)** |  |  |
| Total Assisted by Women’s Crisis Centre | Monthly | Not yet available |
| **Western Australian Mental Health Commission - Ngnowar-Aerwah Aboriginal Corporation (Wyndham)** |  |  |
| Total assisted by the Sobering Up Shelter | Monthly | 97 (April 15); 54 (May 15); 71 (Jun 15) |
| Total Assisted by the Night Patrol | Monthly | Average 250 (Apr 15 - Jun 15) |
| **The Drug and Alcohol Office of Western Australia (also Commonwealth Funded) - Ngnowar-Aerwah Aboriginal Corporation (Wyndham)** |  |  |
| Total assisted by the Kimberley Mental Health and Drug Service | TBD | Not yet available |
| **Women’s Safe House (Kununurra)** |  |  |
| Estimated number of clients | TBD | Not yet available |
| **Western Australian Police** |  |  |
| Drunk related behaviours (driving, drunk and disorderly etc.) | Quarterly | Not yet available |

The baseline value percentages in Table 6 and Table 7 are derived from the average of totals for the stated time periods. Where historical data is not yet available, current figures are included, noting that as further data is provided the baseline data will be updated. At this stage, the evaluation considers that it would be premature to draw conclusions from initial monthly movements in the above indicators, which may too be volatile on a monthly basis and subject to seasonality. Trend movements in the above indicators will be analysed and reported during the course of the evaluation. In addition, the department is sourcing administrative data reports as input to the evaluation, which present the number of clients and level of services provided by Commonwealth organisations delivering services in the CDCT sites.

# Conclusion

The initial conditions qualitative research with 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.

Stakeholders indicated that these issues had been becoming progressively worse over the past 5-10 years and that the local communities were experiencing significant adverse impacts. 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, Foetal Alcohol Syndrome);
* safety and security (e.g. domestic 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; and
* 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).

In particular, most 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.

Overall, the research found that 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 both trial locations, most stakeholders 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 stakeholders were broadly supportive of the CDCT. However, perceptions in relation to the likely effectiveness of the trial were mixed.

###### Appendix : Evaluation Framework

Australian Government Department of Social Services

Cashless Debit Card Trial: Evaluation Framework

Contents

[1 Executive Summary 1](#_Toc461458147)

[2 Introduction 2](#_Toc461458148)

[2.1 Objective of the framework 2](#_Toc461458149)

[2.2 The Cashless Debit Card Trial 2](#_Toc461458150)

[2.3 Contextual factors 4](#_Toc461458151)

[2.4 Ethics clearance and approval 5](#_Toc461458152)

[3 Evaluation scope and key measures 6](#_Toc461458153)

[3.1 Introduction 6](#_Toc461458154)

[3.2 CDCT Evaluation Program Logic 7](#_Toc461458155)

[3.3 Key Performance Indicators 11](#_Toc461458156)

[4 Data Collection Approach 20](#_Toc461458157)

[4.1 Introduction 20](#_Toc461458158)

[4.2 Qualitative research with on the ground observers/stakeholders 20](#_Toc461458159)

[4.3 Quantitative research 21](#_Toc461458160)

[Recruitment and training of interviewers 23](#_Toc461458161)

[Fieldwork management 24](#_Toc461458162)

[4.4 Collation and analysis of administrative data 25](#_Toc461458163)

[CDCT Comparison Sites 25](#_Toc461458164)

[5 Timing of evaluation reporting 27](#_Toc461458165)

[6 Challenges in evaluating the Cashless Debit Card Trial 28](#_Toc461458166)

# 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**.

# Introduction

## 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.

## 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.[[30]](#footnote-30) 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.[[31]](#footnote-31)

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.

To date, the CDCT is being implemented in Ceduna and Surrounds[[32]](#footnote-32) in South Australia (SA) and Kununurra / Wyndham (East Kimberley)[[33]](#footnote-33) 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)

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.

## 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’.

## 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.

# Evaluation scope and key measures

## 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?

## 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 1 on page 9). 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 page 10). 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 1: Program Logic – Cashless Debit Card Trial

This figure details the Program Logic developed for the Cashless Debit Card Trial as discussed in Section 3.2 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. 

Figure 2: Theory of Change

This figure details the theory of change for the Cashless Debit Card Trial as discussed in Section 3.2 Evaluation Program Logic.

The theory of  change can be summarised as follows. 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.

As highlighted in the Program Logic diagram (Figure 1), 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 theProgram 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. [[34]](#footnote-34) 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.

## 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 3: Performance Indicators

Performance Indicators. Outputs: # Community Leaders who endorse program, % participants who understand card conditions, % of participants in Trial locations sent card, % of distributed cards that are activated, 80% of income support payments are quarantined, # support services available in community, % participants with reasonable access to merchants and products, # community leaders who believe appropriate adjustments are made to income restrictions on a case-by-case basis. Short-Term Outcomes: Support of Community Leaders, Frequency of use /volume consumed of drugs and alcohol, Frequency/volume of gambling and associated problems, % aware of drug and alcohol support services, % aware of financial and family support services, Usage of drug and alcohol support services, Usage of financial and family support services. Medium-Term Outcomes: Support of Community Leaders, Frequency of use/volume consumed of drugs and alcohol, Frequency/volume of gambling and associated problems, Incidence of violent and other types of crime and violent behaviour, Drug/alcohol-related injuries and hospital admissions, % reporting feeling safe in the community, % reporting feeling safe at home.


Table 1: 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 |
| **% 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 2: Short-term Outcome Performance Indicators*[[35]](#footnote-35)*

| **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 |
| **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 * 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 |
| **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 3: Medium-term Outcome Performance Indicators*[[36]](#footnote-36)*

| **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 reporting a decrease in violence in the community since commencement of Trial | 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 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 home | 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 |

# Data Collection Approach

## 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.

## 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 4: 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) |

## 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 5: 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.

## 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 6: 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 * Indue (card provider) data on activation and usage of the card, including account balances * 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 throughout Trial period  Collated throughout Trial period  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.

# 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.

# 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.[[37]](#footnote-37)

Table 7: 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 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 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 8: 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 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. |

1. Statistics based on Indue Cashless Debit Card transactions data [↑](#footnote-ref-1)
2. Source: Department of Social Services, March 2015. [↑](#footnote-ref-2)
3. These perceptions were consistent with the findings of two recent reviews of alcohol sale restrictions in Ceduna and Kununurra/ Wyndham, which found evidence of significant levels of circumvention (particularly creation/ growth of a secondary supply market) and displacement (e.g. shift of drinking from public to private spaces) activities: Office of the Liquor and Gambling Commissioner of South Australia (2011), *Report on Liquor Sales within the Ceduna Region;* Western Australian Alcohol and Drug Authority (2012), *The Impact of Liquor Restrictions in Kununurra and Wyndham (Twelve Month Review)*. [↑](#footnote-ref-3)
4. Forrest, A. (2014). The Forrest Review: Creating Parity. Commonwealth of Australia, Canberra. [↑](#footnote-ref-4)
5. District Council of Ceduna (2015), Submission to Senate Standing Committee on Community Affairs, Inquiry into the Social Services Legislation Amendment (Debit Card Trial) Bill 2015, 18 September 2015 [↑](#footnote-ref-5)
6. WA Drug and Alcohol Office and Epidemiology Branch of Department of Health WA (2011), Alcohol-related hospitalisations and deaths: Kimberley [↑](#footnote-ref-6)
7. Epidemiology Branch of Department of Health WA and the Cooperative Research Centre for Spatial Information (2011), Health status report on alcohol deaths – drug-caused for the Kimberley Health Region. [↑](#footnote-ref-7)
8. WA Drug and Alcohol Office (2015), Alcohol and Other Drug Indicators Report – Kimberley Health Region [↑](#footnote-ref-8)
9. Source: Department of Social Services, March 2015. [↑](#footnote-ref-9)
10. See Department of the Prime Minister and Cabinet (2016), *Closing the Gap Prime Minister’s Report*. [↑](#footnote-ref-10)
11. Minimum of 3 contact attempts made via phone and / or email. [↑](#footnote-ref-11)
12. 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. [↑](#footnote-ref-12)
13. East Kimberley is comprised of the following SA1s: 5120801, 5120802, 5120804, 5120805, 5120807, 5120808, 5120810, 5120811, 5120812, 5120814, 5120815, 5120816, 5120817, 5120818. [↑](#footnote-ref-13)
14. Working age population is defined for the purposes of this report as people aged 15-64 years. [↑](#footnote-ref-14)
15. Domain information about children with special needs is not included in the AEDC results. [↑](#footnote-ref-15)
16. These hypothetical DV2% rates were derived by assuming that Indigenous and non-Indigenous DV2% rates in these communities were equal to the national averages (of 26.2% and 10.2%, respectively) and applying the Indigenous children proportions for each of these communities. [↑](#footnote-ref-16)
17. In 2011, the population of Ceduna and Surrounds was 4,221 persons. [↑](#footnote-ref-17)
18. In this report, working age population has been defined as those aged 15 to 64 years. [↑](#footnote-ref-18)
19. In 2011, the working age population of Ceduna and Surrounds was 2,823 persons [↑](#footnote-ref-19)
20. In 2011, the population of East Kimberley was 6,950 persons. [↑](#footnote-ref-20)
21. In 2011, the working age population of the East Kimberley was 4,982 persons. [↑](#footnote-ref-21)
22. Assumes all CDC holders have default 80% of ISP paid via CDC. As at 4 October 2016: 100% of CDCT participants in the East Kimberly had the default 80% of their ISP paid via their CDC; and over 95% of CDCT participants in Ceduna and surrounds had the default 80% of their ISP paid via the CDC (with the remaining 5% being paid between 50% and 70% of their ISP via their CDC – yielding an average proportion of ISP paid via the CDC of 79%). [↑](#footnote-ref-22)
23. Excludes royalty payments and other cash payments (e.g. emergency assistance payments) made to CDCT participants. The Department identified five (5) CDCT participants who reported royalty payments totalling around $10,000 per annum, which represents less than 0.1% of total ISPs to the CDCT communities. [↑](#footnote-ref-23)
24. These perceptions were consistent with the findings of two recent reviews of alcohol sale restrictions in Ceduna and Kununurra/ Wyndham, which found evidence of significant levels of circumvention (particularly creation/ growth of a secondary supply market) and displacement (e.g. shift of drinking from public to private spaces) activities: Office of the Liquor and Gambling Commissioner of South Australia (2011), Report on Liquor Sales within the Ceduna Region; Western Australian Alcohol and Drug Authority (2012), The Impact of Liquor Restrictions in Kununurra and Wyndham (Twelve Month Review). [↑](#footnote-ref-24)
25. More detailed information about dry areas and alcohol restrictions in Ceduna and surrounding areas can be found at http://www.ceduna.sa.gov.au/dryzoneandalcoholrestrictions. [↑](#footnote-ref-25)
26. 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. [↑](#footnote-ref-26)
27. Source: SA Attorney-General [↑](#footnote-ref-27)
28. Source: ABS National Regional Profile: Ceduna (last updated 23/09/2016) – Estimates of Personal Income – Total annual income (excl. Government pensions and allowances): $95m [↑](#footnote-ref-28)
29. The baseline values reported in Table 6 have been calculated by the Department of Social Services based on data provided by the SA and WA governments. [↑](#footnote-ref-29)
30. Forrest, A. (2014). *The Forrest Review: Creating Parity*. Commonwealth of Australia, Canberra. [↑](#footnote-ref-30)
31. Merchants within Trial locations who sell both excluded and allowable goods are involved in individual mixed merchant agreements. Lottery purchases are permissible. [↑](#footnote-ref-31)
32. 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. [↑](#footnote-ref-32)
33. 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. [↑](#footnote-ref-33)
34. 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 [↑](#footnote-ref-34)
35. 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. [↑](#footnote-ref-35)
36. 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. [↑](#footnote-ref-36)
37. 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. [↑](#footnote-ref-37)