



THE UNIVERSITY  
of ADELAIDE

FUTURE OF EMPLOYMENT AND SKILLS  
Research Centre



# EVALUATION OF THE CASHLESS DEBIT CARD IN CEDUNA, EAST KIMBERLEY AND THE GOLDFIELDS REGION

## CONSOLIDATED REPORT

KOSTAS MAVROMARAS, MEGAN MOSKOS, STÉPHANE MAHUTEAU & LINDA ISHERWOOD

JANUARY 2021

# Acknowledgements

---

This evaluation of the Cashless Debit Card (CDC) has been conducted by the Future of Employment and Skills Research Centre at the Faculty of the University of Adelaide and was funded by the Australian Government Department of Social Services.

We would like to acknowledge the Department of Social Services, whose background support has been invaluable. We are deeply grateful to the stakeholder representatives and the CDC participants in each of the three trial sites for giving us their time with abundant generosity and for sharing their personal experiences with such deep trust. Without them, this work would not have been possible.

The following people contributed to this research. Kostas Mavromaras was Chief Investigator of this evaluation of the CDC and had overall responsibility for the project. Reporting has been shared as per authorship of each report. Megan Moskos led the qualitative components of this evaluation of the CDC, and was responsible for the design, conduct, analysis and reporting of the qualitative components. Linda Isherwood contributed to the conduct, analysis and reporting of the qualitative components of this evaluation of the CDC. Stéphane Mahuteau led the quantitative components of this evaluation of the CDC and was responsible for the design, conduct and reporting of the quantitative component. He was supported by Alison Goode, Nadezhda Baryshnikova and Zhang Wei. Alison Goode was responsible for survey data production, data integrity and quality assurance. Nadezhda Baryshnikova and Zhang Wei provided assistance with the analysis of community data. Support with conducting qualitative interviews and analysing transcripts was also provided by Helen Walton, Llainey Smith and Zoei Sutton. Karen De Cruz provided administrative, project management and research support.

We would also like to state that the cover photos are purchased images and not images of CDC participants or people who participated in the evaluation.

Contact for follow-up:

Professor Kostas Mavromaras

Phone: +61 (8) 8313 6532

Email: [kostas.mavromaras@adelaide.edu.au](mailto:kostas.mavromaras@adelaide.edu.au)

# Foreword

---

It is with a deep sense of responsibility that in November 2018 we assumed the task to inform the debate about the impact of the Cashless Debit Card (CDC) in the first three trial areas. The policy aims to tackle alcohol, drugs and gambling misuse, among a part of the Australian population where social harm and vulnerability from the outcomes of such misuse is heightened. Our job was to be creative and committed to get the authentic and truthful voices of CDC participants and relevant stakeholders about what they thought was working well with the CDC and what was not. Our assessment needed to be impartial and informed by both the evidence base and our expertise. Our findings needed to be accessible and useful to policy makers, professionals and the public.

We recognised from the outset that this would be a challenging evaluation that had to develop a bespoke approach. The complexity of the policy and the diversity of the trial sites and the participants needed to be accounted for. In creating the evaluation's evidence base, we had to find better ways than before to reach and include as many CDC participants and stakeholders as we could. We had to find ways to make our findings more relevant, insightful, representative and reliable. To do this we created new evidence and incorporated existing evidence from as many sources as possible. We were moved by the enthusiasm and trust we were met with during our data collection fieldwork in all trial sites. We remain indebted and deeply thankful to all those who added their voices to the rich mosaic of our evidence base.

With our evidence base at hand, we had to assess what claims could be made about the CDC and what claims could not be made by each of the different forms and sources of evidence we collected. We worked painstakingly to be methodologically rigorous and uncompromising, but also worked hard to deliver our findings as fast as could be done, always retaining the quality of our analysis and the integrity of our findings. We present our findings in a way that makes it more likely the new knowledge is useful and will get used. In many cases we found the reality to be more complex and nuanced than can be expressed as clear cut answers, and we said so. Our objective has been to produce an independent policy assessment that is well informed, relevant, impartial and socially useful. We have given it our very best and sincerely hope that we have met this objective.

Kostas Mavromaras

(On behalf of the whole research team of the Future of Employment and Skills Research Centre at the University of Adelaide)

# Table of Contents

<b>ACKNOWLEDGEMENTS .....</b>	<b>I</b>
<b>FOREWORD .....</b>	<b>II</b>
<b>GLOSSARY .....</b>	<b>XI</b>
<b>1. EXECUTIVE SUMMARY .....</b>	<b>1</b>
1.1 OUTLINE .....	1
1.2 METHOD.....	1
1.3 FINDINGS .....	2
<b>2. INTRODUCTION .....</b>	<b>5</b>
2.1 THE CASHLESS DEBIT CARD.....	5
2.2 IMPACT EVALUATION PURPOSE, SCOPE AND OBJECTIVE .....	6
2.3 KEY EVALUATION QUESTIONS TO BE ADDRESSED .....	7
2.4 METHODOLOGY .....	8
2.5 REPORTING .....	8
<b>3. METHODOLOGY.....</b>	<b>9</b>
3.1 POLICY LOGIC OF THE CDC AND EVALUATION FRAMEWORK .....	9
3.1.1 Policy logic of the CDC .....	10
3.1.2 Transmission mechanism of the CDC.....	11
3.2 STAKEHOLDER ENGAGEMENT .....	13
3.3 COLLECTION AND ANALYSIS OF QUALITATIVE DATA (CDC PARTICIPANTS AND STAKEHOLDERS) .....	14
3.3.1 Interviews with stakeholders.....	14
3.3.2 Interviews with CDC participants.....	16
3.3.3 Further detail on qualitative interviews .....	19
3.4 COLLECTION AND ANALYSIS OF QUANTITATIVE DATA .....	20
3.4.1 Australian Government administrative data .....	20
3.4.2 State-level community data.....	21
3.4.2.1 <i>Practical considerations regarding the use of data collected at the community level by state governments</i> .....	21
3.4.2.2 <i>The importance of aggregation and dilution when using community-level data</i> .....	22
3.4.2.3 <i>The timeframe covered by community-level data and the sequential nature of outcomes matter</i> .....	24
3.4.2.4 <i>Changes in definitions of outcomes and concurrent policies hinder impact identification and detection</i> .....	24
3.4.2.5 <i>Fitness criteria for community-level data</i> .....	25
3.4.2.6 <i>Assessment of the practical use of community data for this evaluation</i> .....	25
3.4.3 Quantitative survey of CDC participants.....	26
3.4.3.1 <i>Fieldwork dates and survey yield</i> .....	26
3.4.3.2 <i>The design of the quantitative survey instrument</i> .....	28
3.4.3.3 <i>Survey fielding strategy</i> .....	30
3.5 METHODOLOGICAL STRENGTHS, WEAKNESSES, CHALLENGES, AND CAVEATS OF THE EVALUATION .....	32
3.5.1 The importance of this evaluation’s contribution to the evidence base .....	32
3.5.2 Challenges and caveats.....	33
3.5.2.1 <i>Activities subject to strong reporting biases</i> .....	33
3.5.2.2 <i>Lack of experimental design in the trials</i> .....	33
3.5.2.3 <i>There was no quantitative survey of stakeholders and the broader non-CDC population</i> .....	34
3.5.2.4 <i>Longer-term outcomes and a short study timeframe</i> .....	34
3.5.2.5 <i>Community data limitations</i> .....	34
3.5.2.6 <i>Concurrent policies</i> .....	34



3.5.2.7	History of the rollout.....	34
3.5.2.8	Generalisability of the findings .....	35
<b>4.</b>	<b>THE FIRST THREE CDC TRIAL SITES .....</b>	<b>36</b>
4.1	THE FIRST THREE CDC TRIAL SITES: AN OVERVIEW .....	36
4.1.1	Ceduna and the surrounding region .....	36
4.1.2	East Kimberley .....	38
4.1.3	The Goldfields region .....	40
4.1.4	Kalgoorlie-Boulder .....	42
4.1.4.1	Coolgardie and Kambalda.....	42
4.1.4.2	Laverton and Leonora .....	42
4.1.4.3	Menzies.....	43
4.2	THE CDC PARTICIPANT POPULATION: CORE DEMOGRAPHICS AND CHARACTERISTICS USING AUSTRALIAN GOVERNMENT ADMINISTRATIVE DATA.....	43
4.2.1	Demographic differences across sites .....	45
4.2.2	Home ownership and type of accommodation .....	46
4.2.3	Type of government payments.....	47
4.2.4	Changes of the CDC population over time, since the rollout of the CDC.....	47
4.3	INITIATION OF THE CDC TRIAL.....	48
4.3.1	Reasons for the CDC trial .....	48
4.3.2	Community leaders' involvement in the CDC trial.....	49
4.3.3	Community consultation .....	50
4.3.4	Broader social policy environment .....	50
<b>5.</b>	<b>PERCEIVED IMPACTS OF THE CASHLESS DEBIT CARD .....</b>	<b>52</b>
5.1	ALCOHOL USE AND MISUSE .....	53
5.1.1	Key findings.....	53
5.1.2	Evidence from large scale survey.....	54
5.1.2.1	Change following the introduction of the CDC.....	55
5.1.2.2	Characteristics of CDC participants who report a reduction in alcohol consumption since the introduction of the CDC.....	60
5.1.3	Evidence from in-depth interviews with Stakeholders and Participants.....	62
5.1.4	Integration of evidence.....	63
5.1.5	The evidence base .....	64
5.1.6	Observations, limitations and caveats .....	64
5.1.7	Summary .....	65
5.2	DRUG USE AND MISUSE.....	66
5.2.1	Key findings.....	66
5.2.2	Evidence from large scale survey.....	67
5.2.2.1	Illicit drugs that cause the most problems .....	67
5.2.2.2	Has the CDC helped decrease the use of illicit drugs?.....	70
5.2.2.3	Personal use of illicit drugs .....	70
5.2.2.4	How was the CDC reported to help reduce drug use in the trial areas?.....	71
5.2.2.5	Individual characteristics that are associated with a higher probability that CDC participants report improvements on illicit drug use because of the CDC.....	73
5.2.3	Evidence from in-depth interviews with Stakeholders and Participants.....	74
5.2.4	Integration of evidence.....	75
5.2.5	The evidence base .....	76
5.2.6	Observations, limitations and caveats .....	77
5.2.7	Summary .....	77
5.3	GAMBLING .....	78
5.3.1	Key findings.....	78
5.3.2	Evidence from large scale survey.....	78
5.3.2.1	Personal incidence of gambling .....	78
5.3.2.2	How was the CDC reported to help reduce gambling problems in the trial areas?.....	79

5.3.3	Evidence from in-depth interviews with Stakeholders and Participants .....	81
5.3.4	Integration of evidence .....	82
5.3.5	The evidence base .....	82
5.3.6	Observations, limitations and caveats .....	82
5.3.7	Summary .....	83
5.4	FINANCIAL PLANNING AND MONEY MANAGEMENT .....	84
5.4.1	Key findings .....	84
5.4.2	Evidence from large scale survey .....	85
5.4.2.1	<i>Direct measures of change since the CDC was introduced .....</i>	<i>85</i>
5.4.2.2	<i>Aspects of financial management .....</i>	<i>92</i>
5.4.2.3	<i>How was the CDC reported to help money management in the trial areas? .....</i>	<i>95</i>
5.4.3	Evidence from in-depth interviews with Stakeholders and Participants .....	97
5.4.3.1	<i>Financial planning and money management .....</i>	<i>97</i>
5.4.3.2	<i>Spending patterns .....</i>	<i>99</i>
5.4.3.3	<i>Financial abuse and humbugging .....</i>	<i>100</i>
5.4.4	Integration of evidence .....	101
5.4.5	The evidence base .....	102
5.4.6	Observations, limitations and caveats .....	102
5.4.7	Summary .....	103
5.5	SAFETY, CRIME AND FAMILY VIOLENCE .....	103
5.5.1	Key findings .....	103
5.5.2	Evidence from large scale survey .....	104
5.5.2.1	<i>Feeling safer after the introduction of the CDC? .....</i>	<i>104</i>
5.5.2.2	<i>Current levels of safety comparing day/night and streets/home by site .....</i>	<i>105</i>
5.5.2.3	<i>Changes in safety since the introduction of the CDC .....</i>	<i>108</i>
5.5.2.4	<i>Type of change in safety since the introduction of the CDC .....</i>	<i>111</i>
5.5.2.5	<i>Group who reported that their safety was reduced since the introduction of the CDC .....</i>	<i>112</i>
5.5.2.6	<i>Group who reported that their safety remained unchanged since the introduction of the CDC .....</i>	<i>114</i>
5.5.2.7	<i>Group who reported that their safety improved since the introduction of the CDC .....</i>	<i>116</i>
5.5.2.8	<i>Characteristics of those who experienced change since the introduction of the CDC .....</i>	<i>116</i>
5.5.3	Evidence from community-level data .....	119
5.5.3.1	<i>Was the available community-level data fit for the job? .....</i>	<i>119</i>
5.5.3.2	<i>Estimation methodology and practical considerations .....</i>	<i>119</i>
5.5.3.3	<i>Estimation results .....</i>	<i>120</i>
5.5.4	Evidence from in-depth interviews with Stakeholders and Participants .....	123
5.5.5	Integration of evidence .....	125
5.5.6	The evidence base .....	126
5.5.7	Observations, limitations and caveats .....	126
5.5.8	Summary .....	126
5.6	CHILD WELFARE AND FAMILY WELL-BEING .....	127
5.6.1	Key findings .....	127
5.6.2	Evidence from large scale survey .....	128
5.6.3	Evidence from in-depth interviews with Stakeholders and Participants .....	133
5.6.4	Integration of evidence .....	134
5.6.5	The evidence base .....	134
5.6.6	Observations, limitations and caveats .....	135
5.6.7	Summary .....	135
5.7	HEALTH AND WELL-BEING .....	136
5.7.1	Key findings .....	136
5.7.2	Evidence from large scale survey .....	137
5.7.2.1	<i>Snapshot of health and well-being of CDC participants .....</i>	<i>137</i>
5.7.2.2	<i>Does the CDC improve the quality of life of its participants? .....</i>	<i>140</i>
5.7.2.3	<i>Has the CDC improved life quality? .....</i>	<i>140</i>
5.7.2.4	<i>How was the CDC reported to help improve life quality in the trial areas? .....</i>	<i>141</i>

5.7.2.5	Evidence from multivariate regression analysis.....	143
5.7.3	Evidence from in-depth interviews with Stakeholders and Participants.....	145
5.7.4	Integration of evidence.....	146
5.7.5	The evidence base .....	147
5.7.6	Observations, limitations and caveats .....	147
5.7.7	Summary .....	147
5.8	AUTONOMY AND CONTROL.....	148
5.8.1	Key findings.....	148
5.8.2	Evidence from large scale survey.....	149
5.8.2.1	Control over life.....	149
5.8.2.2	Control over money.....	150
5.8.2.3	Who reported they feel more in control since the introduction of the CDC?.....	151
5.8.3	Evidence from in-depth interviews with Stakeholders and Participants.....	153
5.8.4	Integration of evidence.....	154
5.8.5	The evidence base .....	155
5.8.6	Observations, limitations and caveats .....	155
5.8.7	Summary .....	155
5.9	DISCRIMINATION, STIGMA, SHAME, EMBARRASSMENT AND FAIRNESS .....	156
5.9.1	Key findings.....	156
5.9.2	Evidence from large scale survey.....	157
5.9.3	Evidence from in-depth interviews with Stakeholders and Participants.....	160
5.9.4	Integration of evidence.....	161
5.9.5	The evidence base .....	162
5.9.6	Observations, limitations and caveats .....	162
5.9.7	Summary .....	162
5.10	EMPLOYMENT .....	163
5.10.1	Key findings.....	163
5.10.2	Evidence from large scale survey.....	163
5.10.2.1	Had a job in the last four weeks - Hours worked and length of time in job .....	164
5.10.2.2	Perceived barriers to employment by trial site .....	164
5.10.2.3	Looking for work .....	165
5.10.3	Evidence from in-depth interviews with Stakeholders and Participants.....	166
5.10.4	Integration of evidence.....	167
5.10.5	The evidence base .....	167
5.10.6	Observations, limitations and caveats .....	167
5.10.7	Summary .....	167
5.11	LOCAL ORGANISATIONS.....	168
5.11.1	Key findings.....	168
5.11.2	Evidence from in-depth interviews with Stakeholders and Participants.....	168
5.11.3	The evidence base .....	169
5.11.4	Observations, limitations and caveats .....	169
5.11.5	Summary .....	169
5.12	TRANSIENT POPULATIONS.....	170
5.12.1	Key findings.....	170
5.12.2	Evidence from in-depth interviews with Stakeholders and Participants.....	170
5.12.3	The evidence base .....	171
5.12.4	Observations, limitations and caveats .....	171
5.12.5	Summary .....	171
<b>6.</b>	<b>VIEWS ABOUT THE IMPLEMENTATION OF THE CASHLESS DEBIT CARD .....</b>	<b>172</b>
6.1	KEY FINDINGS.....	172
6.2	WHAT WAS PERCEIVED TO BE WORKING WELL? .....	173
6.2.1	CDC local partners/shopfronts.....	173
6.2.1.1	Evidence from in-depth qualitative interviews.....	173

6.2.2	Perceived positive practical aspects of the Card .....	174
6.2.2.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>174</i>
6.2.3	Groups for whom the CDC was reported to be working well .....	175
6.2.3.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>175</i>
6.3	WHAT WAS PERCEIVED TO NOT BE WORKING WELL? .....	176
6.3.1	Financial management and the availability of cash .....	176
6.3.1.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>176</i>
6.3.2	Perceived negative practical aspects of the Card .....	177
6.3.2.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>177</i>
6.3.2.2	<i>Evidence from large scale survey .....</i>	<i>179</i>
6.3.3	Policy targeting .....	182
6.3.3.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>182</i>
6.3.4	Card workarounds.....	183
6.3.4.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>183</i>
6.3.5	Perceptions of insufficient community consultation and information .....	185
6.3.5.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>185</i>
6.3.6	Wraparound services .....	186
6.3.6.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>186</i>
6.3.7	Groups for whom the CDC is considered not to be working well .....	188
6.3.7.1	<i>Evidence from in-depth qualitative interviews.....</i>	<i>188</i>
6.4	INTEGRATION OF EVIDENCE .....	189
6.5	THE EVIDENCE BASE.....	189
6.6	OBSERVATIONS, LIMITATIONS AND CAVEATS.....	189
6.7	SUMMARY.....	190
<b>7.</b>	<b>PERCEPTIONS ABOUT THE FUTURE OF THE CDC.....</b>	<b>191</b>
7.1	KEY FINDINGS.....	191
7.2	EVIDENCE FROM LARGE SCALE SURVEY .....	192
7.2.1	Which CDC participants were more likely to prefer to stay on the Card?.....	193
7.3	EVIDENCE FROM THE QUALITATIVE INTERVIEWS .....	195
7.3.1	Views on ending the CDC Trial .....	195
7.3.2	Views on continuing the CDC Trial.....	196
7.4	INTEGRATION OF EVIDENCE .....	197
7.5	THE EVIDENCE BASE.....	198
7.6	OBSERVATIONS, LIMITATIONS AND CAVEATS.....	198
7.7	SUMMARY.....	198
<b>8.</b>	<b>CONCLUDING REMARKS .....</b>	<b>200</b>
8.1	FINDINGS ON ALCOHOL, DRUGS AND GAMBLING.....	201
8.1.1	Alcohol .....	202
8.1.2	Illicit drugs.....	202
8.1.3	Gambling.....	203
8.2	FINDINGS ON FURTHER OUTCOMES OF THE CDC .....	203
8.2.1	Financial planning and money management .....	203
8.2.2	Safety, crime and family violence .....	204
8.2.3	Health and well-being.....	205
8.2.4	Child welfare and family well-being.....	205
8.2.5	Autonomy and control .....	206
8.2.6	Discrimination, stigma, shame, embarrassment and fairness .....	206
8.3	FURTHER FINDINGS ABOUT THE CDC .....	207
8.3.1	Miscellaneous outcomes .....	207
8.3.2	Views about the Implementation and the future of the Cashless Debit Card .....	208
8.3.3	Differences between trial sites .....	208
8.3.4	Differences between respondent groups .....	209

8.3.5	Individual profiles of CDC participants and CDC impacts.....	209
8.3.6	Feasibility of establishing a longitudinal dataset to allow the analysis of medium-to-long term effects of the CDC .....	210
<b>9.</b>	<b>REFERENCES .....</b>	<b>211</b>
<b>10.</b>	<b>APPENDICES .....</b>	<b>213</b>
	APPENDIX 1: TOPIC GUIDES.....	213
	Stakeholder Topic Guide.....	213
	CDC Participant Topic Guide.....	216
	APPENDIX 2: CDC PARTICIPANTS INDIVIDUAL SURVEY QUESTIONNAIRE .....	218

# List of Tables

TABLE 3-1: PROFILE OF CDC PARTICIPANTS WHO WERE INTERVIEWED .....	18
TABLE 3-2: QUANTITATIVE SURVEY RESPONSE RATES, BY TRIAL SITE .....	28
TABLE 4-1: DISTRIBUTION OF ACTIVE CDC PARTICIPANTS IN THE TRIAL SITES .....	44
TABLE 4-2: DISTRIBUTION OF INDIGENOUS STATUS IN THE TRIAL SITES (CURRENT) .....	45
TABLE 4-3: DISTRIBUTION OF GENDER IN THE TRIAL SITES (CURRENT).....	46
TABLE 5-1: AMOUNT OF ALCOHOL CONSUMED ON A USUAL DRINKING DAY, BY TRIAL SITE.....	55
TABLE 5-2: SINCE BEING ON THE CDC, CHANGE IN ALCOHOL CONSUMPTION OF THOSE WHO REPORTED THEY DRINK ALCOHOL, ALL TRIAL SITES .....	56
TABLE 5-3: SINCE BEING ON THE CDC, CHANGE IN FREQUENCY AND AMOUNT OF ALCOHOL CONSUMPTION (JOINT DISTRIBUTION), ALL TRIAL SITES .....	57
TABLE 5-4: CHANGES IN ALCOHOL CONSUMPTION OF THOSE WHO REPORTED THEY DRINK ALCOHOL, BY TRIAL SITE .....	57
TABLE 5-5: HAS THE CDC HELPED DECREASE ALCOHOL CONSUMPTION, BY TRIAL SITE .....	59
TABLE 5-6: MOST PROBLEMATIC DRUG IN THE AREA YOU LIVE, BY INDIGENOUS STATUS AND GENDER.....	68
TABLE 5-7: MOST PROBLEMATIC DRUG IN THE AREA YOU LIVE, THOSE WITH AN OPINION, BY TRIAL SITE.....	69
TABLE 5-8: HAS THE CDC HELPED DECREASE USE OF ILLICIT DRUGS, BY TRIAL SITE .....	72
TABLE 5-9: HAS THE CDC HELPED REDUCE GAMBLING PROBLEMS, BY TRIAL SITE.....	80
TABLE 5-10: CHANGE IN FINANCIAL CIRCUMSTANCES AFTER THE INTRODUCTION OF THE CDC, ALL TRIAL SITES .....	86
TABLE 5-11: CHANGE IN FINANCIAL CIRCUMSTANCES AFTER THE INTRODUCTION OF THE CDC, ALL TRIAL SITES BY FINANCIAL DOMAIN .....	87
TABLE 5-12: CHANGE IN FINANCIAL CIRCUMSTANCES AFTER THE INTRODUCTION OF THE CDC, BY TRIAL SITE AND FINANCIAL DOMAIN .....	89
TABLE 5-13: MONEY-RELATED CHANGE SINCE BEING ON THE CDC, ALL TRIAL SITES.....	93
TABLE 5-14: HAS THE CDC HELPED IMPROVE MONEY MANAGEMENT, BY TRIAL SITE.....	96
TABLE 5-15: FEELING SAFER ON THE CDC, BY TRIAL SITE .....	105
TABLE 5-16: ESTIMATED IMPACT OF THE CDC ON POLICE OUTCOMES, EAST KIMBERLEY AND GOLDFIELDS TRIAL SITES (COMMUNITY-LEVEL DATA).....	121
TABLE 5-17: PERCEIVED CDC IMPACT ON CHILDREN IN YOUR AREA (ALL DOMAINS), BY TRIAL SITE .....	128
TABLE 5-18: PERCEIVED CDC IMPACT ON CHILDREN IN YOUR AREA (HEALTH, FOOD, SAFETY, SCHOOL ATTENDANCE), BY TRIAL SITE.....	130
TABLE 5-19: PERCEIVED CDC IMPACT ON CHILDREN IN YOUR AREA (HAPPINESS, CULTURAL ACTIVITIES, SOCIAL ACTIVITIES), BY TRIAL SITE .....	131
TABLE 5-20: MEAN PCS AND MCS SCORES AND MEAN DIFFERENCES FROM REFERENCE CATEGORY BY INDIVIDUAL CHARACTERISTICS .....	139
TABLE 5-21: HAS THE CDC MADE LIFE BETTER OR WORSE, BY INDIGENOUS STATUS AND GENDER.....	140
TABLE 5-22: HAS THE CDC IMPROVED QUALITY OF LIFE, BY TRIAL SITE.....	142
TABLE 5-23: BEING ON THE CARD, HOW OFTEN DO YOU FEEL MORE IN CONTROL OF YOUR LIFE, BY INDIGENOUS STATUS AND GENDER .....	149
TABLE 5-24: BEING ON THE CARD, HOW OFTEN DO YOU FEEL MORE IN CONTROL OF YOUR MONEY, BY INDIGENOUS STATUS AND GENDER .....	150
TABLE 5-25: BEING ON THE CARD, FEELINGS OF DISCRIMINATION, EMBARRASSMENT AND UNFAIRNESS, BY INDIGENOUS STATUS AND GENDER .....	157
TABLE 5-26: BEING ON THE CARD, FEELINGS OF DISCRIMINATION, EMBARRASSMENT AND UNFAIRNESS, BY HOUSEHOLD TYPE.....	159
TABLE 5-27: EMPLOYMENT STATUS OF CDC PARTICIPANTS, BY TRIAL SITE .....	164
TABLE 5-28: REASONS FOR NOT WORKING AT THE MOMENT, BY TRIAL SITE.....	165
TABLE 6-1: PROBLEMS USING THE CARD, BY TRIAL SITE .....	179
TABLE 6-2: SPECIFICALLY MENTIONED PROBLEMS ABOUT THE USE OF THE CARD AND WITH THE CDC OVERALL (SURVEY FREE TEXT BOXES), BY TRIAL SITE.....	181



# List of Figures

FIGURE 3-1: CDC POLICY LOGIC, GENERAL PRINCIPLE .....	11
FIGURE 3-2: EXPECTED TRANSMISSION MECHANISM OF THE CDC POLICY .....	12
FIGURE 3-3: NUMBER OF STAKEHOLDER ORGANISATIONS WHO PARTICIPATED IN INTERVIEWS, BY LOCATION .....	15
FIGURE 3-4: NUMBER OF STAKEHOLDER ORGANISATIONS WHO PARTICIPATED IN INTERVIEWS, BY SERVICE TYPE .....	16
FIGURE 3-5: CDC POPULATION WITHIN THE TRIAL AREAS, THE ISSUE OF DATA AGGREGATION .....	23
FIGURE 4-1: MAP OF THE CEDUNA REGION .....	37
FIGURE 4-2: MAP OF THE EAST KIMBERLEY REGION .....	39
FIGURE 4-3: MAP INCLUDING THE CDC SITES WITHIN THE GOLDFIELDS REGION .....	41
FIGURE 4-4: DISTRIBUTION OF CDC PARTICIPANTS' GOVERNMENT BENEFIT TYPE IN THE TRIAL SITES (CURRENT).....	47
FIGURE 5-1: FREQUENCY OF ALCOHOL CONSUMPTION, BY TRIAL SITE.....	54
FIGURE 5-2: CDC PARTICIPANTS WHOSE FINANCIAL SITUATION IMPROVED/WORSENE SINCE THE CDC, ALL TRIAL SITES BY FINANCIAL DOMAIN.....	88
FIGURE 5-3: CDC PARTICIPANTS WHOSE FINANCIAL SITUATION IMPROVED/WORSENE SINCE THE CDC, BY FINANCIAL DOMAIN, EAST KIMBERLEY .....	90
FIGURE 5-4: CDC PARTICIPANTS WHOSE FINANCIAL SITUATION IMPROVED/WORSENE SINCE THE CDC, BY FINANCIAL DOMAIN, GOLDFIELDS.....	91
FIGURE 5-5: CDC PARTICIPANTS WHOSE FINANCIAL SITUATION IMPROVED/WORSENE SINCE THE CDC, BY FINANCIAL DOMAIN, CEDUNA & SURROUNDS .....	91
FIGURE 5-6: HOW SAFE DO YOU CURRENTLY FEEL (STREETS-DAYS), BY TRIAL SITE .....	106
FIGURE 5-7: HOW SAFE DO YOU CURRENTLY FEEL (STREETS-NIGHTS), BY TRIAL SITE .....	106
FIGURE 5-8: HOW SAFE DO YOU CURRENTLY FEEL (HOME-DAYS), BY TRIAL SITE.....	107
FIGURE 5-9: HOW SAFE DO YOU CURRENTLY FEEL (HOME-NIGHTS), BY TRIAL SITE.....	108
FIGURE 5-10: DO YOU FEEL MORE OR LESS SAFE SINCE THE INTRODUCTION OF THE CDC (STREETS-DAYS), BY TRIAL SITE .....	109
FIGURE 5-11: DO YOU FEEL MORE OR LESS SAFE SINCE THE INTRODUCTION OF THE CDC (STREETS-NIGHTS), BY TRIAL SITE .....	110
FIGURE 5-12: DO YOU FEEL MORE OR LESS SAFE SINCE THE INTRODUCTION OF THE CDC (HOME-DAYS), BY TRIAL SITE.....	110
FIGURE 5-13: DO YOU FEEL MORE OR LESS SAFE SINCE THE INTRODUCTION OF THE CDC (HOME-NIGHTS), BY TRIAL SITE.....	111
FIGURE 5-14: CURRENT LEVEL OF SAFETY FOR THOSE WHO REPORTED THAT THEIR SAFETY WAS REDUCED SINCE THE CDC WAS INTRODUCED (STREETS-DAYS; -NIGHTS), BY TRIAL SITE.....	113
FIGURE 5-15: CURRENT LEVEL OF SAFETY FOR THOSE WHO REPORTED THAT THEIR SAFETY WAS REDUCED SINCE THE CDC WAS INTRODUCED (HOME-DAYS; -NIGHTS), BY TRIAL SITE.....	114
FIGURE 5-16: CURRENT LEVEL OF SAFETY FOR THOSE WHO REPORTED THAT THEIR SAFETY WAS NOT CHANGED SINCE THE CDC WAS INTRODUCED (STREETS-DAYS; -NIGHTS), BY TRIAL SITE.....	115
FIGURE 5-17: CURRENT LEVEL OF SAFETY FOR THOSE WHO REPORTED THAT THEIR SAFETY WAS NOT CHANGED SINCE THE CDC WAS INTRODUCED (HOME-DAYS; -NIGHTS), BY TRIAL SITE .....	115
FIGURE 5-18: RATE OF REPORTED DOMESTIC VIOLENCE OFFENCES PRE- AND POST-CDC ROLLOUT, EAST KIMBERLEY VERSUS CONTROL (COMMUNITY-LEVEL DATA) .....	122
FIGURE 5-19: RATE OF REPORTED DOMESTIC VIOLENCE OFFENCES PRE- AND POST-CDC ROLLOUT, GOLDFIELDS VERSUS CONTROL (COMMUNITY-LEVEL DATA) .....	122
FIGURE 5-20: HAS THE CDC MADE LIFE BETTER OR WORSE, BY TRIAL SITE .....	141
FIGURE 5-21: HAS THE CDC IMPROVED QUALITY OF LIFE, BY TRIAL SITE (CDC PARTICIPANTS WHO REPORTED A POSITIVE IMPACT) .....	143
FIGURE 5-22: BEING ON THE CARD, HOW OFTEN DO YOU FEEL MORE IN CONTROL OF YOUR LIFE, BY TRIAL SITE .....	150
FIGURE 5-23: BEING ON THE CARD, HOW OFTEN DO YOU FEEL MORE IN CONTROL OF YOUR MONEY, BY TRIAL SITE .....	151
FIGURE 5-24: BEING ON THE CARD, FEELINGS OF DISCRIMINATION, EMBARRASSMENT AND UNFAIRNESS, BY TRIAL SITE .....	158
FIGURE 5-25: FEELINGS OF FAIRNESS/UNFAIRNESS ABOUT BEING ON THE CDC BY CDC PARTICIPANTS' PERSONAL VIEWS ABOUT THE CDC POLICY (SURVEY FREE TEXT BOXES) .....	160
FIGURE 6-1: PROBLEMS USING THE CARD, BY INDIGENOUS STATUS AND HOUSEHOLD TYPE .....	180
FIGURE 7-1: STATED PREFERENCE ABOUT GETTING OFF THE CARD VS. STAYING ON THE CARD, BY TRIAL SITE.....	192
FIGURE 7-2: STATED PREFERENCES ABOUT GETTING OFF THE CARD VS. STAYING ON THE CARD, BY INDIGENOUS STATUS AND TRIAL SITE .....	193

# Glossary

---

<b>ABS</b>	Australian Bureau of Statistics
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>AUDIT</b>	Alcohol Use Disorders Identification Test
<b>Card</b>	The cashless debit card
<b>CDC</b>	Cashless Debit Card
<b>D.A.G</b>	Drugs, alcohol and gambling
<b>DHS</b>	Department of Human Services
<b>DiD</b>	Difference in Difference (estimation technique)
<b>DSP</b>	Disability Support Pension
<b>DOMINO</b>	Data Over Multiple Individual Occurrences
<b>DSS</b>	Department of Social Services
<b>DUI</b>	Driving under the influence
<b>DV</b>	Domestic violence
<b>FES</b>	Future of Employment and Skills research centre, University of Adelaide
<b>FIFO</b>	Fly in/fly out workforce
<b>HILDA</b>	Household Income and Labour Dynamics in Australia
<b>IM</b>	Income management
<b>Indue</b>	Financial institution that is currently contracted as the CDC provider
<b>ISP</b>	Income support payments
<b>KEQs</b>	Key evaluation questions
<b>MCS</b>	Mental component summary
<b>N</b>	Number of observations
<b>NDSHS</b>	National Drug Strategy Household Survey
<b>PCS</b>	Physical component summary

# 1. Executive Summary

---

## 1.1 Outline

This evaluation provides evidence about the outcomes of the Cashless Debit Card (CDC) in the first three trial areas in which it was rolled out: Ceduna and surrounds in South Australia and East Kimberley and the Goldfields in Western Australia. The majority of the evidence was collected in 2019. The evaluation was conducted by a University of Adelaide multidisciplinary team of independent experts, primarily from the disciplines of Economics and Sociology, who specialise in mixed-methods and multidisciplinary policy evaluation. The evaluation was funded by the Australian Government Department of Social Services (DSS) and the evaluation team were contracted to conduct the evaluation independently of DSS.

The evaluation reports in three parts. The first part is the present Consolidated Report, the second part is the Qualitative Supplementary Report and the third part is the Quantitative Supplementary Report. The Consolidated Report focuses on the presentation of the impacts of the CDC, while the two supplementary reports include the full qualitative and quantitative analyses that underpin the evaluation.

The Consolidated Report is divided into eight chapters. It begins with an Executive Summary as its first chapter. It continues with Chapters 2 to 4 which introduce the policy, discuss the methodology of the evaluation and provide context about the three trial sites. In doing so, these three chapters explore the anticipated outcomes of the CDC and current understandings regarding key pathways, mechanisms and assumptions that underpin the policy. They also provide an outline of the evidence bases that were generated and put together for the purposes of the evaluation, both qualitative and quantitative. Chapters 5 to 7 explore the outcomes of the CDC, both intended and unintended, as reported by stakeholders and CDC participants through a mix of qualitative in-depth interviews and a large scale quantitative survey conducted by the evaluation team, and as traced by government administrative data that was made available to the evaluation team. Chapter 8 provides concluding remarks, which bring together the findings of the whole evaluation.

## 1.2 Method

The purpose of this evaluation was to create a new, integrated evidence base and use it to assess the impact of the CDC, as these were presented to the evaluation team by the many stakeholders and CDC participants who informed the research. The evaluation team was tasked with generating the evidence base and providing the necessary analysis and its interpretation. Policy implications, and any subsequent recommendations, are left for the consideration of the reader.

The Key Evaluation Questions (KEQs) were designed to assess the overall impact of the CDC as this was reported by all of the trial site CDC participants and relevant stakeholders who responded to the evaluation's evidence collection. To do this the evaluation combined qualitative and quantitative methodologies to build an evidence base examining several aspects of the CDC, including anticipated outcomes and actual outcomes. The overall evidence base was extensive in its scope, inclusive in its reach, diverse in its composition and complementary in its content. The quantitative survey contacted 4,424 CDC participants with a target of 1,300 responses. The target was enthusiastically exceeded by

CDC participants, reaching 2,041 responses, of which 1,963 were valid responses. The qualitative evidence target was also reached, with over 340 in-depth interviews of stakeholders and CDC participants.

A core set of the evaluation questions related to whether the CDC policy works well or not, in what circumstances, when, where and for whom. Another aspect of the evaluation was to assess whether the changes the CDC brought were intended or unintended and how these changes were perceived. The answers to these questions regarding the CDC are not straightforward. If one were to try to summarise how the CDC policy outcomes were perceived and reported by the evaluation's respondents, a fair assessment would be that some aspects of the CDC were perceived to have worked well for some people, but not for others; that many of the CDC outcomes were intended, but some were not; that some of the CDC outcomes were the same or very similar in all locations and for most CDC participants, while other outcomes were different in different locations and for different CDC participants.

## 1.3 Findings

The findings of the evaluation are presented under the following headings which relate to a number of core outcomes following the evaluation's research design. For the correct interpretation of the evaluation's findings on the misuse of alcohol, drugs and gambling, we note that of all CDC participants survey respondents and depending on the precise definition, around 10 to 20 per cent reported levels of alcohol consumption that the evaluation could categorise as problematic, around six per cent reported using illicit drugs and around 15 per cent reported to have been gambling prior to the introduction of the CDC.

**Alcohol:** We found consistent and clear evidence that alcohol consumption has reduced since the introduction of the CDC in the trial sites. However, with the current evidence, it is not possible to attribute these changes to the CDC alone. They can be attributed, however, to the full complement of relevant policies in the trial areas.

**Illicit Drugs:** We present evidence on the use of different types of illicit drugs and on the degree to which the CDC is perceived to decrease the use of illicit drugs from the evaluation's new and useful qualitative in-depth interviews and quantitative survey of CDC participants. The integrated evidence was mixed and cannot offer any definitive conclusion about whether the CDC influences the personal or social harm caused by the use of illicit drugs.

**Gambling:** Short-term evidence suggested that the CDC has been helping to reduce gambling, with positive impacts especially in the context of family and broader social life. No longer-term evidence was available.

**Financial planning and money management:** There was no single evaluation finding on the financial outcomes of the CDC. Instead, there were multiple, complex findings. A core finding of the evaluation in relation to financial planning and money management was that the CDC was reported to make things better for those who were probably the most vulnerable and who needed it most. It also found that the CDC was reported to introduce widely felt and costly hurdles to many participants in relation to financial planning and money management, including those who felt that they needed the CDC the least.

**Safety, crime and family violence:** The evaluation found that safety had been improving since the introduction of the CDC, with the exception of the Goldfields, where a sizeable minority of CDC

participants reported negatively on safety changes. We cannot attribute the observed changes in relation to safety improvements to the CDC alone. We are, however, able to provide guidance as to where these safety improvements were reported to have taken place and who had reported to benefit most from them among the CDC participants in all trial sites.

**Child welfare and family well-being:** There is little consensus about whether and how children's welfare had changed since the introduction of the CDC in the trial areas. Within the quantitative survey data, most CDC participants reported no major change regarding most aspects of children's welfare. A sizeable minority of CDC participants in the quantitative survey reported an overall positive view in relation to changes, while another larger minority reported an overall negative view in relation to changes. CDC participants and stakeholders in the qualitative in-depth interviews (particularly in Ceduna and the Goldfields) were more positive about the perceived impacts of the CDC on family functioning and outcomes for children.

**Health and well-being:** The evaluation produced mixed findings about the impact of the CDC on the health and well-being of participants. A large proportion of CDC participant survey respondents reported that their quality of life had been affected in a negative way, especially in the Goldfields trial site and more so for non-Indigenous CDC participants. However, a sizeable minority reported an overall positive impact of the CDC on their quality of life, especially in the East Kimberley site. Longer-term evidence will be required to fully understand the impact of the CDC on health and well-being.

**Autonomy and control:** The qualitative and quantitative evidence collected by the evaluation gave rise to mixed findings. The qualitative evidence (which reported feelings about oneself and perceptions about others for participants and perceptions about others for stakeholders) reported that a large decline in the level of autonomy and control was experienced by CDC participants as a result of the CDC. The quantitative survey evidence in comparison, found diversity in almost equal portions: about half the CDC participants reported that their control had improved and half that their control had been reduced since the introduction of the CDC. Improvements were largely reported by Indigenous CDC participants. In contrast a large majority of non-Indigenous CDC participants in the Goldfields reported reduced control over their lives and their money.

**Discrimination, stigma, shame, embarrassment and fairness:** The qualitative and quantitative data both highlighted that feelings of discrimination, embarrassment, shame and unfairness as a result of being on the Card were reported across all trial sites by a majority of CDC participants. In contrast, it was only a small minority of CDC participants who did not report any of these negative feelings about the CDC, either when asked directly or when reporting in the survey's free text boxes.

**Employment and training:** No discernible change in employment outcomes since the introduction of the CDC was reported to the evaluation within all three trial sites. The quantitative survey of CDC participants found that most CDC participants reported they were not working. The main reasons provided by the majority of survey respondents were their own disability or ill health or care responsibilities. For the remaining minority who would contemplate working, either they perceived there to be no available jobs or considered their skills, training and experience to be inadequate for the jobs that may be available.

**Local organisations:** Stakeholder in-depth interview respondents considered that the trial of the CDC had brought changes to their own and other local organisations. These included the additional provision of services (including hard to reach people), increased workload and concerns over staff safety when dealing with client's frustrations with the CDC.

**Transient populations:** Both Ceduna and the Goldfields region are common congregation points for Indigenous people living in neighbouring communities (some of these communities are outside the

trial sites). CDC participants and stakeholders reported that the movement of people from neighbouring Indigenous communities had not been influenced by the introduction of the CDC. They also reported that a heightening of social issues occurred during these visits and compromised the potential positive outcomes of the CDC trial.

**Views about the implementation of the Card:** The importance attached by CDC participants and stakeholders to the implementation of the CDC policy was examined. A large number of negative aspects of the implementation of the CDC and a small number of positive aspects were reported by both survey and in-depth interviews respondents. Positive aspects of the implementation included the CDC local partners and shopfronts, as well as some practical aspects of the Card. Negative implementation issues reported by respondents included financial management and the availability of cash, some practical aspects of the Card, policy targeting, card workarounds, community consultation and information provision, and wraparound services. Limited but important quantitative evidence relating to problems experienced with the Card was also presented, suggesting areas where the CDC implementation was perceived to be problematic and thus could be improved.

**Perceptions about the future of the Card:** The qualitative (CDC participants and stakeholders) and quantitative (CDC participants) methodologies provided complementary evidence when considering the views reported to the evaluation on the future of the CDC. The quantitative evidence suggested that under the current circumstances the majority of CDC participants would prefer to opt out of the CDC trial. The qualitative evidence, which included the views of stakeholder interviewees as well as CDC participants, found the majority of stakeholders reported they wanted the CDC to continue in some form and that the views of CDC participants were mixed.

**Differences between trial sites:** Substantial differences were evident between the three trial sites. All trial sites reported considerable problems with alcohol, drugs and gambling prior to the CDC and they reported to be responding to the CDC in different ways. Some of the differences could be traced in part to the socio-demographic composition of each trial site and in part to the concurrent relevant public policies relating to alcohol, drugs and gambling. These differences helped the evaluation understand some of the strengths and the weaknesses of the CDC policy design and also helped us understand why the CDC may impact each trial site differently.

**Differences between respondent groups:** Stakeholders and CDC participants often expressed different views about the CDC. Stakeholders, whose views were only captured by the qualitative in-depth interviews, expressed positive views and opinions about the CDC, although there was also a considerable degree of scepticism among them regarding the implementation and the future of the CDC and several suggestions were made about potential improvements to the CDC. Largely, CDC participants were negative about the CDC, however, an identifiable minority recognised or saw improvements and benefits from it.

**Profiles of CDC participants and CDC outcomes:** The evaluation identified various profiles of CDC participants who were more likely to report experiencing improved life outcomes through the CDC. These are examined in the report using both qualitative and quantitative methodologies as well as multivariate regression techniques.

**Feasibility of a longitudinal dataset:** The evaluation explored the feasibility of establishing a longitudinal dataset to allow the analysis of medium-to-long term effects of the CDC. The evaluation established that a longitudinal data collection is feasible, and that it would be valuable, for the CDC that a longitudinal dataset be constructed, including a control group element. It has been anticipated in the present research design that the one-wave current survey collection could be used as the first wave if such a longitudinal continuation were to take place.



## 2. Introduction

---

### 2.1 The Cashless Debit Card

Developed in close consultation with local community and Indigenous leaders and local and state government agencies, the Australian Government has implemented a Cashless Debit Card (CDC) for income support payments (ISPs) in multiple locations where high levels of welfare dependence co-exist with high levels of social harm.

Originally envisaged in *Creating Parity – The Forrest Review* (Forrest 2014) as a ‘Healthy Welfare Card’, the CDC aims to reduce the levels of harm associated with alcohol consumption, illicit drug use and gambling by limiting CDC participants’ access to cash and by restricting the use of ISPs to purchase alcohol or gambling products. Those on the CDC receive:

- 20 per cent of their welfare payment in their usual bank account.
- 80 per cent of their welfare payment onto the CDC.
- 100 per cent of any lump sum payments from Centrelink onto the CDC.

The Card cannot be used at merchants that primarily sell restricted goods, even if that merchant has eftpos facilities. The Card cannot be used for the purchase of alcohol or gambling products, cash-like gift cards or to withdraw cash, but can be used to purchase other goods, including groceries and household goods, and to pay rent and bills.

The rollout of the CDC was supported by additional funding for support services to assist those with drug and alcohol issues. The support services included access to drug and alcohol rehabilitation services, financial management services and family violence services. Organisations located in the trial sites were also contracted by the Card provider, to assist participants with activating and using the Card and with other Card-related issues. These services were referred to as local partners or CDC shopfronts.

In early 2016, the CDC commenced in two regions across Australia. It began in the Ceduna region in South Australia on 15 March 2016 and in the East Kimberley region in Western Australia on 26 April 2016.<sup>1</sup> In the 2017-18 Budget, the Australian Government announced its intention to expand the CDC to two new locations. The Goldfields region in Western Australia was one of the new expansion sites, following support for the Card in the region.<sup>2</sup> The CDC was progressively rolled out in the Goldfields region from March 2018 over a period of about one and a half months.

In September 2018, the Social Services Legislation Amendment (Cashless Debit Card Trial Expansion) Bill 2018 was passed by Parliament. The Bill expanded the CDC to the Bundaberg and Hervey Bay (BHB) region in Queensland. The rollout in the BHB region commenced on 29 January 2019.

In November 2018, DSS commissioned the Future of Employment and Skills research centre (FES) to undertake an independent evaluation of the three initial CDC trial sites of the Goldfields and East

---

<sup>1</sup> Including the Indigenous Communities of Yalata, Koonibba, Scotdesco and Oak Valley.

<sup>2</sup> The Goldfields region covers the local government areas of Kalgoorlie-Boulder, Laverton, Leonora, Coolgardie and the suburbs of Menzies, Kookynie and Ularring in the Shire of Menzies in Western Australia.

Kimberley regions in Western Australia and Ceduna and surrounding areas in South Australia. CDC participants who were triggered in the BHB region were not part of this evaluation.

As at 27 September 2019, the survey's 'census date', the CDC involved approximately 11,547 participants. They were distributed between 'in scope' and 'not in scope' of this evaluation as follows.<sup>3</sup>

- 671 participants present in Ceduna and surrounds on the census date (included in this evaluation).
- 1,049 participants present in East Kimberley on the census date (included in this evaluation).
- 2,713 participants present in the Goldfields on the census date (included in this evaluation).
- 5,031 participants in the Bundaberg and Hervey Bay region (not included in this evaluation).
- 2,083 out of area participants who previously lived and were triggered in one of the CDC trial sites, but lived outside of the CDC trial site areas on 27 September 2019 (1,355 of whom were triggered in Ceduna and surrounds, East Kimberley and the Goldfields and are therefore included in the CDC evaluation).<sup>4</sup>

The evaluation was thus based on the active participants in Ceduna and surrounds, East Kimberley and the Goldfields and those CDC participants who had been triggered into the CDC in these three sites by 27 September 2019, including those who were by then living outside of these areas.<sup>5</sup>

## 2.2 Impact evaluation purpose, scope and objective

Overall, the impact evaluation aimed to produce new robust evidence, which would allow the systematic assessment of the impact of the CDC as it evolved in the Goldfields, East Kimberley and Ceduna trial sites. The purpose of the CDC impact evaluation was to further develop an evidence base for the CDC to better understand 'what works, for whom, and in what contexts'.

The impact evaluation was designed to extend and enhance the evidence base previously generated through evaluation of the Ceduna and East Kimberley sites. It utilised the advancements made by the baseline data collection previously undertaken by FES in the Goldfields site. The impact evaluation also established a framework for possible longer-term longitudinal studies of the CDC in the Ceduna, East Kimberley and Goldfields sites.

---

<sup>3</sup> These figures are based on the number of "active CDC participants". The number of "active participants" is lower than the number of participants originally triggered onto the Card.

<sup>4</sup> As explained below and in the Quantitative Supplementary Report, the total number of 5,788 'in scope' participants (671+1,049+2,713+1,355) was further reduced by removing the records of deceased people and those of participants with cards that had not been activated or that had no transactions (credit or debit) at all recorded on them.

<sup>5</sup> Section 4.2 describes the location of active participants in some detail. Out of the total 2,083 "out of area" participants, 1,355 had originally been triggered in one of the evaluation's first three trial sites and are included in the analysis. Furthermore, we note that for practical and unavoidable reasons that are explained below, the evaluation's "census" date of 27 September 2019, was not adhered to exactly. Between 27 September 2019 and the date when fieldwork was completed, a small number of new CDC participants (that is participants who had been triggered after 27 September 2019) presented themselves to the CDC survey completion research team in the trial areas and (as legitimate CDC participants) completed the survey. Given the strict confidentiality rules governing the data collection, they could not have been identified at the time of completion and for ethical reasons their contributions were included in the analysis. Their presence has been reflected in the calculation of the population weights and a statistical examination of their responses suggested that they are not systematically different than those participants who had already been triggered by 27 September 2019 and were already in the sample. The adjustment brings the total of active CDC participants to 6,039, which corresponds to the active CDC participants population at the end of fieldwork.

## 2.3 Key evaluation questions to be addressed

The impact evaluation was designed to provide evidence that would enable six KEQs to be answered:

1. What were the anticipated outcomes from the CDC and what were the current understandings and evidence regarding key pathways, mechanisms and assumptions that underpinned these, for each location?
2. What outcomes, both intended and unintended, had been observed from the CDC to date in each of the three sites, including:
  - a. Assessing whether ‘first round’ effects from the CDC (for example, reduced spending and consumption on alcohol, illegal drugs and gambling) occurred, and if so, how these had interacted?
  - b. Assessing how these contribute to ‘second round’ effects (for example, increased spending on groceries, basic household goods and paying bills)
  - c. Assessing tertiary impacts (for example, reduced violence and crime in CDC sites, increased economic participation from CDC participants and reduced social security spending).
3. What was the current community sentiment regarding the CDC and had this changed over time?
4. How did perceptions of the CDC’s impacts (both positive and negative) align with the available data?
5. What other dynamics and factors might have been influencing (both positively and negatively) the outcomes observed to date?
6. What was the feasibility of establishing a longitudinal dataset to allow analysis of medium-to-long-term effects of the CDC?

The impact evaluation was designed to build on the evidence base for the CDC, to allow a better understanding of what worked and did not work in relation to the CDC, for whom and in what contexts. It was also designed to include any unintended consequences that had occurred that were associated with the CDC.

It was not in the remit of this evaluation to consider the cost effectiveness of any aspects of the CDC policy.

The CDC impact evaluation recognised diversity at the individual and at the community level including:

- Different socio-demographic profiles.
- Specific site/community circumstances.
- Different social harm issues, at the individual and community level.

## 2.4 Methodology

The impact evaluation was underpinned by three inter-connected core methodologies:

1. Stakeholder Engagement Strategy.
2. Collection and analysis of qualitative data
  - In-depth interviews with stakeholders (N= 178).
  - In-depth interviews with CDC participants (N=231).
3. Collection and/or analysis of quantitative data
  - Large-scale survey of CDC participants in the three trial sites (N=1,963).
  - Australian Government and state government administrative data.

These methodologies were used in an inter-connected manner throughout the evaluation.

## 2.5 Reporting

The evaluation reported its full results in three parts to reflect the KEQs and the methodologies used to address them. The first part was the Consolidated Report. It presented and brought together key findings arising from the qualitative fieldwork conducted in each of the three trial sites and the collection and analysis of quantitative data, including data generated by the survey of CDC participants and the available administrative data. The Consolidated Report presented the core evidence. First, the Consolidated Report focused on the integration of the results and their policy-relevant interpretation. Second, the Qualitative Supplementary Report presented the full qualitative analysis of the three sites. The reader will note that only a few sample quotes and their surrounding discussion were selected for inclusion in the Consolidated Report, leaving the full analysis for the longer supplementary report. Third, the Quantitative Supplementary Report presented a more extensive version of the quantitative analysis in scope and in scale. The inclusion of these two supplementary reports aimed not only to provide more extensive and detailed evidence, but also to explain and guarantee the methodological integrity of the evaluation. The reader is encouraged to delve into these two supporting reports as they contain valuable multifaceted information in scope and scale, at different levels, and from different and complementary angles to the Consolidated Report.

## 3. Methodology

---

This chapter outlines the methodology used for the evaluation. First, we describe the policy logic of the CDC and the evaluation framework we developed. Next, we outline the three main methodological components used. We conclude with the discussion of the evaluation's methodological strengths, weaknesses, challenges and caveats.

### 3.1 Policy logic of the CDC and evaluation framework

The evaluation investigated what works well and does not work well in relation to the CDC, by building a better understanding of the experiences of CDC participants and relevant stakeholders in the first three trial sites of the CDC.

The policy logic and related KEQs were used to guide the design of the evaluation, within the context of the available time, available resources, and previous evaluation activities that had already taken place in the trial sites.<sup>6</sup> First, we needed to decide on the most relevant outcomes to consider. Second, we needed to determine the level at which these outcomes could be best observed (individual/family/household/community). Third, we needed to assess the appropriate timeframe for each outcome distinguishing between short-term, mid-term and long-term. Finally, we had to put these considerations together to determine the appropriate combination of methodologies for assessing the impact of the CDC in its first three trial sites.

As shown throughout this Consolidated Report, we had to adapt to the circumstances and constraints as these emerged during the research. Throughout the Consolidated Report, we saw that factors such as data availability, quality of the information recorded, level of aggregation of the data (individual vs community data), were all considered jointly in our effort to choose the most appropriate methodology for detecting the impacts of the CDC. One of our core objectives was to determine the best methodology through which robust causal statements could be made about the impacts of the CDC, where possible, as opposed to making mere associations that describe but do not explain the workings of the policy.

Some potential impacts may be detected through qualitative methodologies only (i.e. stakeholder perceptions of changes that may not be as yet discernible through quantitative analysis, but may be unambiguously manifested through the qualitative evidence). Other potential impacts may be detected only through quantitative methodologies at the individual level, through the quantitative survey responses from CDC participants. Other impacts may be detected at the community level. We would expect that very strong impacts that are also of a short-term nature might be detected at several levels and through several methodologies. The objective of the evaluation was to apply triangulation of all results, where possible, to achieve as refined a picture of the impacts of the CDC, by allowing each of the methodologies to feed into the other at various levels of aggregation.

---

<sup>6</sup> Prior to this evaluation, an independent impact evaluation of the CDC had been conducted between 2016 and 2017 in Ceduna and East Kimberley by ORIMA Research and a baseline data collection had been conducted in the Goldfields by the University of Adelaide.

### 3.1.1 Policy logic of the CDC

We considered the policy logic of the CDC in order to place the use of each of our evaluation methodologies into a broader context. We highlighted the expected transmission mechanisms of the policy, that is, how we expect causes and effects to be taking place, and, subsequently, (i) the level at which positive or negative changes, or intended or unintended consequences, could be observed; (ii) the timeframe of such changes (short-term *versus* long-term); and, more generally, (iii) whether it is at all possible to attribute observed changes to the CDC. We highlighted a range of outcomes and their metrics which may be impacted by the CDC and for which it would be desirable to try to obtain data.

The general principles of the CDC policy are summarised in the following Figure 3-1. The thinking that underpins the CDC relies on the premise that excessive consumption of illegal drugs, alcohol and/or gambling products (D.A.G) is associated with negative outcomes, not only for individuals who engage in these behaviours, but also at the level of their families/households. It also relies on the premise that excessive consumption engenders a social cost that can be observed at the level of the community, for example, through increased crime and disturbances, accidents, use of health services and/or child protection services. We refer to these costs as social costs (or social harm) because the costs associated with excessive consumption of D.A.G products spread beyond the sphere of the individuals involved and potentially affect the outcomes of many people around them.<sup>7</sup>

Excessive consumption of D.A.G products is thought to be generating a vicious circle of individual harm, whereby life-outcomes that are more general can deteriorate because of the harmful behaviour and these deteriorations may encourage further harmful behaviours. For example, excessive alcohol consumption may reduce the ability to participate actively in the labour force, or cause health or financial problems. Being out of work may then encourage further alcohol consumption, creating a cycle of behaviour which will have further negative impacts. At the family/household level, financial stress may influence all members of the household, especially if a significant part of the household's resources is diverted to consumption of D.A.G. products. With fewer resources (including time) remaining available for other household activities, new concerns will emerge (e.g. school attendance, nutrition, the consumption of cultural goods).

The academic literature suggests that there is a strong relationship between excessive D.A.G consumption, social status and domestic violence and crime (see notably Weatherburn 1992, 2001; Loxton et al. 2018, Rennison & Welchans 2000). The academic literature also suggests that, where we encounter excessive D.A.G consumption, we are also more likely to encounter an intergenerational transmission of welfare dependence and marginal attachment to the labour force. It also suggests that there is an increased likelihood that the children in these families will reproduce the environment they were raised in when they become adults (see Weatherburn 1992, 2001; Loxton et al. 2018, Rennison & Welchans 2000). Such vicious circles can lead to negative community outcomes as social harm puts stress on community services.<sup>8</sup> Social harm at the community level may be further compounded

---

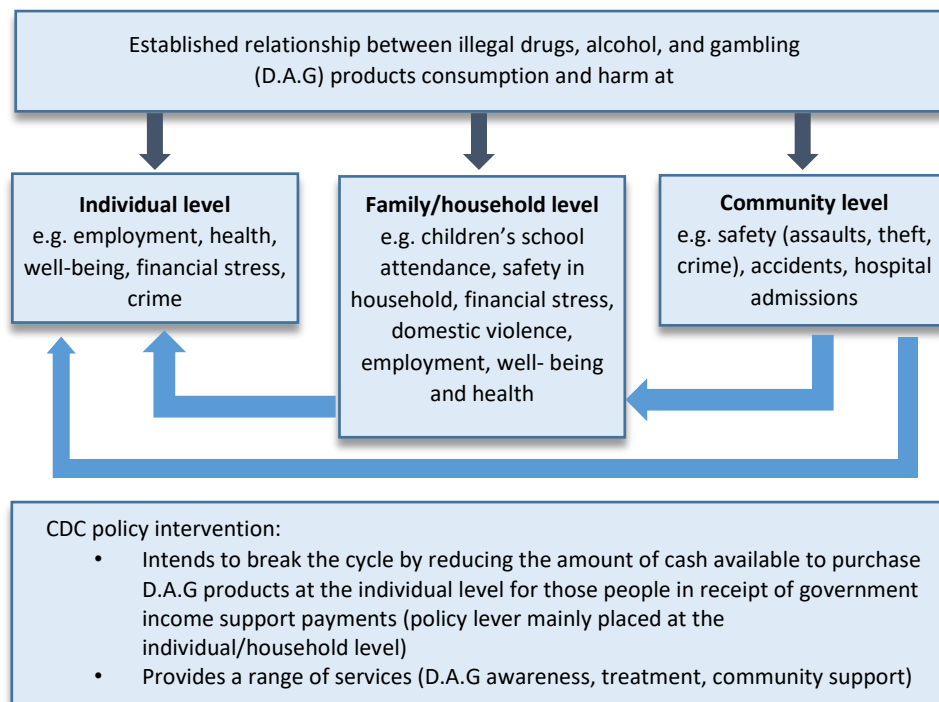
<sup>7</sup> In the discipline of Economics, such outcomes are called externalities. They are formally defined as consumption or production activities that are generating costs or benefits to other economic agents but are not controlled by those other agents. A good example of a negative externality is passive smoking where the activity makes others worse off, but costs nothing to the smokers themselves.

<sup>8</sup> Community services will be impacted through decreased levels of safety (e.g. increased crime and violence, accidents resulting from driving under the influence (DUI), domestic violence, etc.), increased hospital presentations, increased incidence of chronic diseases and longer-term negative health outcomes due to regular consumption of illegal drugs and alcohol, increased use of child protection services and other similar factors.



through people's geographical mobility thus generating suburbs/communities where social harm is more concentrated.

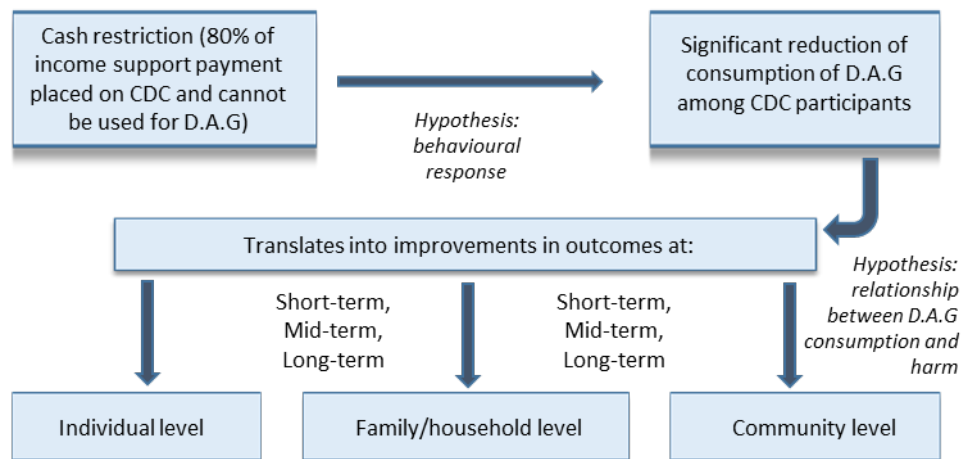
Figure 3-1: CDC policy logic, general principle



### 3.1.2 Transmission mechanism of the CDC

The objective of the CDC is to disturb the vicious circle of social harm generated by excessive use of D.A.G products, mainly through restricting the availability of cash for people receiving certain government income support payments. The transmission mechanism of the policy assumes that such cash restrictions will induce a behavioural response from those individuals who engage in excessive consumption of D.A.G products in the form of lower consumption. The CDC hypothesises that a decrease in the consumption of D.A.G products, as a result of the CDC, would eventually translate into significant improvements in outcomes, which would spread at all levels, from individuals to their families/households and to their community in general. The following Figure 3-2 summarises the expected transmission mechanism of the CDC policy.

Figure 3-2: Expected transmission mechanism of the CDC policy



In order to capture the diverse behaviours and outcomes, the evaluation method was designed to be flexible, adaptable and, where possible, generalisable. The evaluation was underpinned by the three inter-connected core methodologies outlined in the Introduction, namely stakeholder engagement and qualitative and quantitative evidence collections. The framework presented in Figures 3-1 and 3-2 is utilised throughout the report for each of the direct and indirect domains of change within the broader implementation of the CDC. Chapters 5 to 7 present individual investigations and the findings from the use of the different methodologies that we apply. A synthesis is provided where the findings make it relevant and appropriate within each investigation and at the end of the report in Chapter 8.

The evaluation design recognised that particular methodologies are better, or faster, at detecting change in relation to some outcomes, compared to others:

- Some impacts will be detected more readily through qualitative methodologies (e.g. the perception of changes not yet discernible through quantitative methodologies).
- Some impacts will be detected only through qualitative methodologies (e.g. when we need personal and precise answers to general and broad questions).
- Some impacts will be detected only through quantitative methodologies (e.g. where we need answers to be statistically generalisable to the broader population of CDC participants or the local population).
- Some will be detected by both methodologies, but at different speed and possibly be more suited for exploring different aspects of change.

The evaluation aimed to provide sufficient information to allow for the triangulation of results through a *feedback loop* between quantitative and qualitative methodologies. This feedback loop helps the

reader build a picture of the impact of the CDC that is both detailed and refined, as well as representative of the broader population that was examined.<sup>9</sup>

Next, we review the three core methodologies that were implemented in this evaluation in order to address the KEQs in all three trial sites. These comprise a stakeholder engagement strategy, the collection and analysis of qualitative evidence and the collection and analysis of quantitative evidence.

## 3.2 Stakeholder engagement

A stakeholder engagement strategy was essential for the adequate and timely collection of data for this evaluation. The strategy involved extensive pre-interview engagement with key stakeholders to introduce the research to them, to enlist their support for the research, and to obtain appropriate consents. This intense engagement design also allowed for the collection of information from key stakeholder representatives as well as obtaining follow-up assistance with sourcing potential CDC participant interviewees and securing space for the research team to conduct interviews with CDC participants. Stakeholders promoted the impact evaluation broadly in their communities, but also individually to CDC participants, often providing practical help in the form of safe and trusted locations where interviews with CDC participants could be conducted.

Stakeholder engagement commenced with a visit to locations within the CDC trial sites to meet stakeholders, to introduce the project and to initiate interview recruitment processes.<sup>10</sup> This included ensuring all local research and cultural approval processes were met.

Subsequently, stakeholder engagement involved several steps: an initial approach via email or phone by the researchers; booking and undertaking a face-to-face engagement visit in the region; following up and arranging an interview time; and then conducting an actual interview (either face-to-face or by telephone).

---

<sup>9</sup> A *feedback loop* is a critical aspect of our methodology (see Evaluation of the NDIS for an example of using a feedback loop in the context of an evaluation data collection: Final Report <https://www.dss.gov.au/disability-and-carers/programs-services/for-people-with-disability/national-disability-insurance-scheme/ndis-evaluation-consolidated-report>). Simply put, a *feedback loop* is the situation where, as research progresses, the first research results (such as new questions or new answers) are utilised to inform the design and direction of the subsequent research. The principle is simple: all new answers inform the re-thinking of the original questions to create new questions. Subsequently newer answers emerge, which give rise to even newer questions, and so it continues. A feedback loop can be supported by new evidence that emerges as time goes by or as evidence from a different methodology is taken on board. Both are the case in this evaluation design. This evaluation commenced with a policy logic and a comprehensive stakeholder engagement strategy. These jointly informed the initial design of the qualitative research and the initial quantitative strategy (which combined administrative, community and new quantitative survey data). The next step was extensive fieldwork, which took place at speed and which was determined partly by our research design and partly by what was practically feasible. A critical reality was that different methodologies require different resources and time. Typically, it took the longest to run the quantitative survey and build the quantitative evidence base, so that qualitative results were the first to arrive. The result was that qualitative fieldwork outputs were the first to be analysed, compared and triangulated as the research progressed and they were the first to be used to inform further stakeholder engagement and the development of the quantitative data methodologies. The collection and analysis of the quantitative data was thus informed by the preceding research. At this stage, the continual piecemeal triangulation was converted into an integration exercise: (i) to assess the impact of the policy and (ii) to inform the design of a potential continuing evaluation exercise. This methodological design recognised the need for flexibility in the implementation of a policy across different areas and over time and the major benefits that are conferred by the ability of policy to learn and to be further developed as it is implemented.

<sup>10</sup> Including the Indigenous Communities of Yalata, Koonibba and Scotdesco in Ceduna; the local government areas of Kalgoorlie-Boulder, Laverton, Leonora, Coolgardie-Kambalda and the Shire of Menzies in the Goldfields region; and Wyndham and Kununurra in the East Kimberley region.

Follow-up engagement occurred with stakeholders who had agreed to be interviewed themselves and/or offered to facilitate the recruitment of CDC participants for the qualitative interviews.

In addition, extensive engagement work was undertaken with CDC participants to ensure they felt comfortable in informing the research. This included emphasising the confidentiality of information they shared, the independence of the University of Adelaide research team from both DSS and the Card provider, and ensuring that the research approach used was culturally appropriate and widely accepted.

The stakeholder engagement strategy, therefore, encouraged and facilitated the participation of CDC participants and stakeholders in the research and supported the integrity of the evaluation's evidence base. Stakeholder engagement was a respectful two-way process. It helped the evaluation team to build contacts and trust, to learn about CDC participants and stakeholders in each area, and to inform CDC participants and stakeholders about the evaluation's purpose and expected outcomes.

The stakeholder engagement process also made an important contribution to the development of the quantitative survey of CDC participants in the different trial areas. This contribution included exploring the possible ways a survey could be fielded and the supports that would be required to do so under different circumstances, including the differences between urban, rural and remote areas. The stakeholder engagement strategy was central to the successful implementation of the quantitative survey. To undertake the quantitative survey, and obtain a good response rate, it became clear that local support staff were needed to assist in fielding the survey. The stakeholder engagement strategy provided invaluable insights into relevant organisations that could be approached to obtain assistance in finding those staff.

Without significant stakeholder engagement in the field, both the qualitative and quantitative (survey) data collection methodologies would have been inadequate in number and biased in their content. Although the outputs of stakeholder engagement are difficult to single out and quantify, we note that they are an essential part of the research process that brings all thinking together and acts as an information and ideas conduit throughout the research process, especially where different methodologies and disciplines need to navigate and work together towards a common research aim.

### **3.3 Collection and analysis of qualitative data (CDC participants and stakeholders)**

The FES qualitative research team conducted an extensive number of in-depth interviews with CDC participants and stakeholders in each of the first three CDC trial sites.<sup>11</sup>

#### **3.3.1 Interviews with stakeholders**

In total, 140 semi-structured, in-depth interviews were conducted with 178 representatives from various stakeholder organisations operating in the CDC trial locations.<sup>12</sup> These interviews sought to explore both the functioning of aspects of the CDC and the perceived impacts of the CDC. They also collected evidence about perceptions regarding the future of the CDC.

---

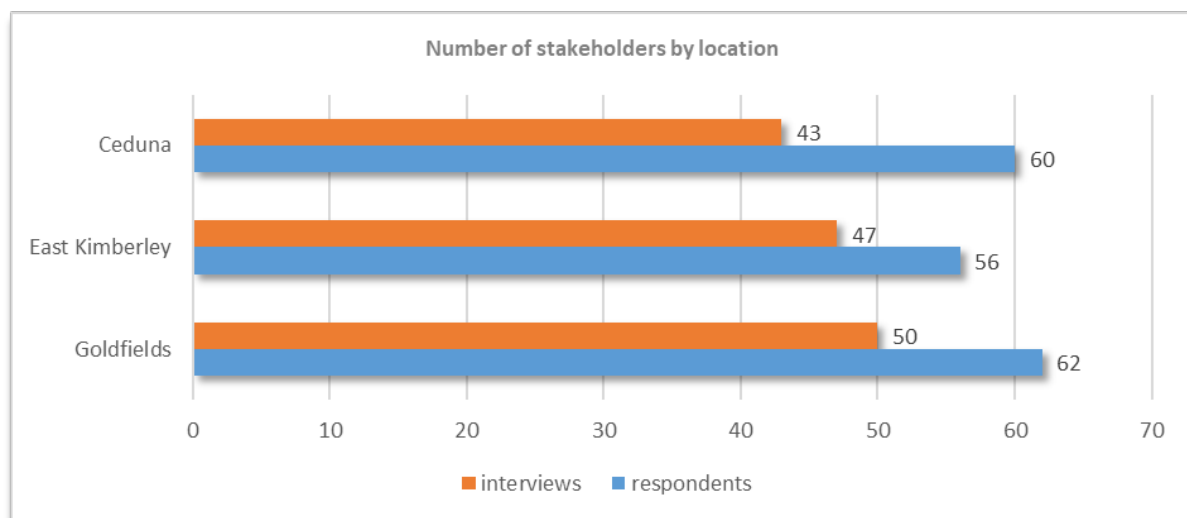
<sup>11</sup> Extensive information about the qualitative interviews conducted in each of the CDC trial sites is in the Qualitative Supplementary Report.

<sup>12</sup> Some interviews included more than one stakeholder representative, but always from the same stakeholder organisation. Some stakeholders were also themselves currently on the CDC or had previously had experiences of being on the card.

The selection of stakeholders to approach about interviews was informed by pre-fieldwork site visits and informal consultations undertaken at that time as a part of our stakeholder engagement activities. DSS also provided information and contact details for relevant stakeholder groups. However, the decisions about who to approach/interview were made independently by FES and DSS were not informed about who had been approached and/or interviewed.

Figure 3-3 shows the spread of the stakeholder organisations who informed the evaluation, by location. Forty-three semi-structured interviews were conducted with 60 representatives from various stakeholder organisations operating in the Ceduna and surrounding region. Forty-seven interviews were conducted with 56 stakeholder representatives in the East Kimberley region and 50 interviews with 62 representatives in the Goldfields region.

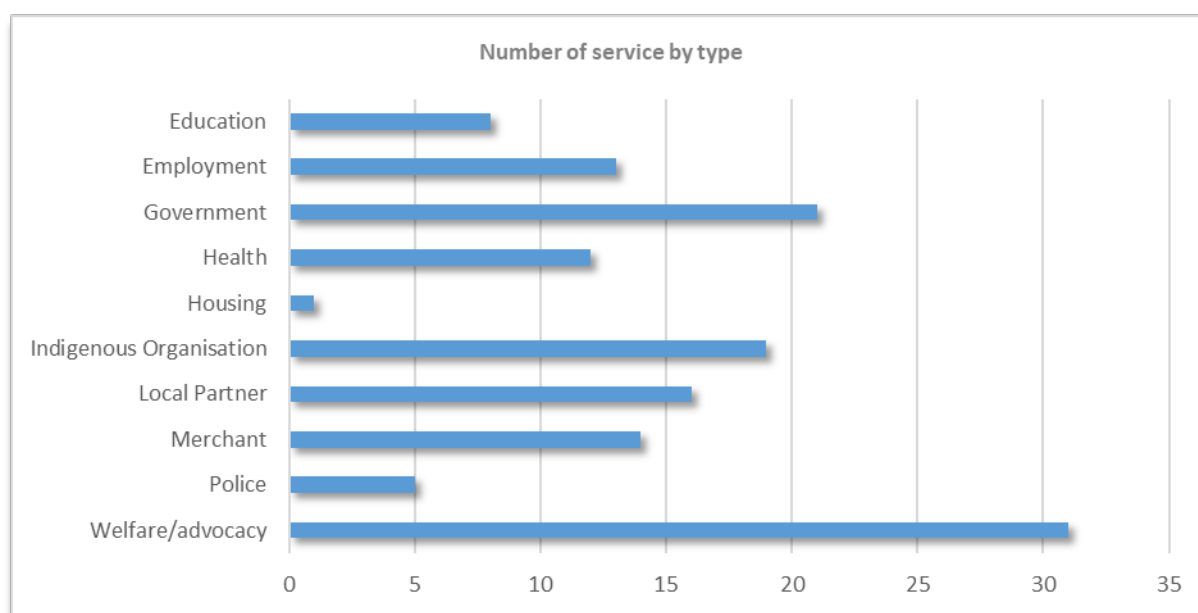
Figure 3-3: Number of stakeholder organisations who participated in interviews, by location



*Note: Some interviews included more than one stakeholder representative, but always from the same stakeholder organisation.*

Figure 3-4 shows the spread of stakeholder organisations who participated in the interviews by service type, across the three trial sites. These stakeholder organisations included representatives from federal, state and local government organisations (N=21); CDC local partners or shopfronts (N=16); welfare and advocacy organisations (N=31); Indigenous-run organisations (N=19); employment services (N=13), merchants (N=14); police (N=5) and the education, housing and health sectors (N=21).

Figure 3-4: Number of stakeholder organisations who participated in interviews, by service type



### 3.3.2 Interviews with CDC participants

In-depth semi-structured interviews were also conducted with 231 CDC participants across the first three trial sites. The interviews sought to obtain information relating to people's views about the CDC and perceptions of its impact on their lives and the communities in which they live. Similar to the stakeholder interviews, the CDC participant interviews also sought to collect evidence on the views of participants about the future of the CDC. An overview of the profile of the CDC participants who participated in the qualitative interviews is provided in Table 3-1.

Interviews were conducted with 78 CDC participants in both Ceduna and the Goldfields and 75 participants in the East Kimberley. An overwhelming majority (78 per cent) of CDC participant interviewees identified as being Indigenous, while around a third of interviewees were male (34 per cent) and two-thirds were female (66 per cent).

Over half of respondents reported that they received Newstart Allowance<sup>13</sup> (58 per cent), while around 14 per cent received the Disability Support Pension. Approximately 15 per cent of respondents received Parenting Payment (Partnered or Single).

In the main, recruitment of CDC participant respondents occurred via stakeholder organisations. A flyer advertising the opportunity to inform the research was developed and provided to stakeholders to distribute and/or display. People interested in participating in an interview either contacted the research team directly or consented to have their contact information provided to the research team by the stakeholder organisation. The interview sample is therefore somewhat skewed towards those CDC participants who were engaged with services. However, the opportunity to participate in the research was also advertised more broadly via flyers and social media to ensure that people not engaged with services were aware of the research and that they too had the opportunity to inform the research if they wished.

<sup>13</sup> In March 2020, Newstart Allowance was replaced by the new JobSeeker Payment.



Two groups of CDC participants were specifically targeted for interviews in order to have them proportionately represented in the overall qualitative research. These groups were “older CDC participants” and “family members”. This was done in response to feedback from consultation with stakeholders and also because we know these to be hard to reach groups. It was therefore necessary to make an explicit effort to engage and recruit them to ensure their representation. Overall, 20 per cent of all CDC participant interviewees were family members of another CDC participant who was interviewed as part of the evaluation. These interviews allowed us to understand how the CDC influenced families, where two or more members were on the CDC. Sixteen per cent of CDC participants interviewed were older being aged over 55 years.

Table 3-1: Profile of CDC participants who were interviewed

Attribute	Number (N) = 231	%
<b>LOCATION:</b>		
Ceduna & surrounds	78	<b>33.8</b>
East Kimberley	75	<b>32.5</b>
Goldfields	78	<b>33.8</b>
<b>GENDER:</b>		
Male	79	<b>34.2</b>
Female	152	<b>65.8</b>
<b>IDENTIFIED AS INDIGENOUS:</b>		
Yes	180	<b>77.9</b>
No	51	<b>22.1</b>
<b>AGE (IN CATEGORIES)</b>		
Below 24 years	15	<b>6.5</b>
25-29	25	<b>10.8</b>
30-34	25	<b>10.8</b>
35-39	21	<b>9.1</b>
40-44	26	<b>11.3</b>
45-49	33	<b>14.3</b>
50-54	29	<b>12.6</b>
55-59	17	<b>7.4</b>
60-64	15	<b>6.5</b>
65-69	4	<b>1.7</b>
Not asked	19	<b>8.2</b>
Not known	2	<b>0.9</b>
<b>INTERVIEWED FAMILY MEMBER:</b>		
Yes	44	<b>19.0</b>
No	187	<b>81.0</b>
<b>INCOME SUPPORT PAYMENT TYPE:</b>		
Disability Support Pension	33	<b>14.3</b>
Newstart Allowance	134	<b>58.0</b>
Single parenting payment	27	<b>11.7</b>
Partnered parenting payment	7	<b>3.0</b>
Joined voluntarily	1	<b>0.4</b>
Other	24	<b>10.4</b>
Not stated	5	<b>2.2</b>

Note: Due to rounding, the total percentages in this table may not sum exactly to 100. Given that many participants identified as Indigenous, "Interviewed family member" status was determined by kin relations as well as blood relations, and therefore may include non-blood relations if they were recognised as important by the participant.

### 3.3.3 Further detail on qualitative interviews

Recruitment was conducted in accordance with an ethics approval granted by the University of Adelaide Human Research Ethics Committee (approval number H-2018-117) and the interviews were conducted between April and December 2019.

The qualitative interview guides were modelled on those developed by FES for the previous baseline data collection in the Goldfields region. They also incorporated (where appropriate) questions used in the previous evaluation of the CDC in Ceduna and the East Kimberley. This allowed for the possible comparison of data collected in the Goldfields CDC baseline data collection with data collections from other CDC areas. The interview guides also judiciously introduced additional questions in order to answer the KEQs, including perceptions about whether the CDC had been successful in achieving its aims. The interview guides incorporated culturally appropriate content and protocols for the conduct of the research and were developed collaboratively between senior researchers from FES and local stakeholders.

CDC participant interviews ranged in duration from 11 to 73 minutes, while stakeholder interviews ranged from 17 to 75 minutes. Interviews were primarily conducted face-to-face, although some interviews, mostly with stakeholders, were conducted by phone if it better suited the respondent. For stakeholders, face-to-face interviews were typically conducted in a quiet location at their place of work, although several respondents opted to be interviewed in a quiet public space instead. CDC participant interviews were principally conducted on the premises of key service provider organisations, although several respondents chose for their interview to be conducted in a quiet public space or in their home. All respondents, both stakeholders and CDC participants, were offered a \$50 supermarket voucher (which could not be used to purchase alcohol) to compensate for their time.

With the consent of respondents, interviews were recorded using a digital recorder and transcribed verbatim by a professional transcription service. The transcribed data was entered into NVivo (qualitative data analysis software) in order to assist with the management and analysis of the data.

The analysis of all interview data was conducted according to the Framework approach (Ritchie and Spencer 1994), which is particularly suited to applied social research. Following familiarisation with the data through reading the transcripts, a thematic framework was developed and agreed upon by the qualitative research team. This thematic framework was based around the core topics outlined in the interview schedule and also included the main sub-themes, which emerged during the interviews in relation to these topics. The interview transcripts were then coded according to this thematic framework. Key themes were developed and refined throughout the data analysis to enable further emergent categories to be identified.

Given that these findings arise from in-depth qualitative research, they are subject to limited generalisability to broader population groups or other geographic locations. The strength of this research methodology is that findings are derived from deep and wide coverage of the views, circumstances, expectations and opinions present in areas where the CDC is being implemented. However, the qualitative findings presented in this report are not intended to be interpreted as statements of how frequently perceptions and issues were raised. Readers should note that, like other findings from in-depth qualitative interviews, the views of respondents that are included in this report are respondents' perceptions. The accuracy of statements made by respondents has not been independently verified because the in-depth interviews sought to gain an understanding of respondents' perceptions.

## Findings from the qualitative fieldwork

The full findings of the qualitative fieldwork conducted in the first three CDC trial sites for this evaluation have been reported on separately (see Qualitative Supplementary Report). We encourage readers to review this supplementary material to access this rich data and the deep and wide coverage of the views, circumstances, expectations and opinions present in these three areas.

## The use of terminology and quotes

In some instances in our reporting, we distinguish between the views of “stakeholders” who were interviewed and the views of “CDC participants” who were interviewed. In other instances, we do not. Where the report mentions “respondents” and does not differentiate between stakeholders and CDC participants further, the reader should assume that both stakeholders and CDC participants raised the issues as frequently as each other. Where the report mentions either “stakeholders” or “CDC participants” the reader should assume that what is written applies only to this named group.

In our reporting, we do not identify respondents (either by their name and/or by their organisation). Instead, we use the prefix SH for a stakeholder interview and the prefix P for a participant interview. A suffix follows which consists of the number of the interview and the trial site of the interview (‘C’ for Ceduna, ‘EK’ for East Kimberley, and ‘GF’ for Goldfields). This way we preserve the anonymity of all respondents, whilst allowing the reader to follow an individual’s views using the category prefix, the number of the interview and the location suffix. For example, throughout the whole report, quotes by SH03C refer to the third stakeholder interview conducted in Ceduna. Similarly, throughout the whole report, quotes by P05C refer to the fifth participant interview conducted in Ceduna.

Please note that when describing the views of respondents, terms such as “perceived”, “considered” and “reported” have been used interchangeably. In addition, the terms “most” and “many” have been used when a majority of respondents expressed a viewpoint. Likewise, the term “some” was used when a sizeable minority of respondents shared an opinion. Finally, the terms “a few” and “several” were used interchangeably when only a minority of respondents expressed an opinion.

## 3.4 Collection and analysis of quantitative data

### 3.4.1 Australian Government administrative data

The evaluation was informed by Australian Government administrative data. The data comprised (i) Services Australia (former Department of Human Services–DHS) administrative data on CDC participants in all trial areas; and (ii) administrative data from the Card provider, including information

on card activation, transactions information at the merchant category code level; and attempts at purchases from restricted merchants.<sup>14,15</sup>

The Australian Government administrative data was rich and of high quality and was used at several stages/levels of the evaluation, including:

- To examine the demographic composition of CDC participants in each trial site, outline demographic differences and explore issues related to the practical uses of the Card. A detailed overview of the CDC population in the first three trial sites is provided in the Quantitative Supplementary report and a summarised version is provided in Chapter 4 of the present Consolidated Report.
- As the base for drawing the sample for the quantitative survey of CDC participants and to determine which CDC participants were in scope at the time of the fielding of the survey. Among those in scope, the administrative data also allowed us to determine who had consented to be approached for research purposes.
- Where consent from survey respondents was obtained, their administrative data was linked with their survey answers to improve the level of analysis that could be undertaken. We sought active consent for this linkage from survey respondents through the addition of a consent question within the survey document (accompanied with a thorough explanation of what the linking aimed to do). A large majority of CDC participants surveyed (84 per cent) consented to have their survey answers linked with their administrative data.

### 3.4.2 State-level community data

Part of the remit of the current evaluation was to analyse relevant state government administrative data, in order to assess whether we could make impact statements about the CDC using this community-level data. This section explores the use of community data, first in general terms and then specifically for the CDC evaluation.

#### 3.4.2.1 *Practical considerations regarding the use of data collected at the community level by state governments*

An important consideration regarding the use of community-level data sets is that this type of community data is collected by state and territory governments, and their various organisations, for their own diverse reporting purposes. As a result, such data collections follow business driven definitions, which often need to change over time in order to remain relevant. Such data collections may also be conducted at a geographical level that may not be fully compatible with the boundaries of the CDC trial areas, leading to geographical overlapping or a high level of geographical aggregation when different data collections are compared. Community-level data collections often follow the

---

<sup>14</sup> Transaction data is only available at merchant category code level. It does not provide any information on individual items that have been purchased or on the identity of the purchasers.

<sup>15</sup> The evaluation was undertaken with ethics approval from the University of Adelaide Human Research Ethics Committee and the Australian Government administrative data was made available consistent with the relevant legislative and privacy provisions under the *Social Security Act 1999*, the *A New Tax System (Family Assistance) (Administration) Act 1999* and the *Student Assistance Act 1973*.

relevant business time frequency (real time, monthly, quarterly and annually) and changes are made as required by business needs. This may limit the number of observations available for analysis. The necessary standardisation of the way we generate data (over time and across different parts of the population and different locations) is often not achievable, thus limiting the broader statistical use of such community-level data collections.<sup>16</sup>

In the context of the CDC, which aims to contribute to improving several outcomes at the broader community level (that is, over and above the impact on individual CDC participants), such community-level impacts are more likely to manifest themselves clearly and in numbers that would allow for their precise measurement over a long time period. It is reasonable to argue that, in the context of evaluations, short periods of observation are less likely to capture longer-term policy impacts. We think such an argument applies to this evaluation, namely that the timeframe of the present CDC trials and their evaluation are too short for longer-term impacts to be manifested and accurately measured. Further, we note that the impacts we seek to identify and measure within an area may be harder to measure accurately, as they will pertain only to the sub-population of CDC participants. We now discuss some of the core limitations that relate to the use of community-level data for the present evaluation of the CDC.

### 3.4.2.2 *The importance of aggregation and dilution when using community-level data*

The smaller the proportion of CDC participants in the overall community, the more diluted the impact of the CDC will be in any community-level data, making it harder to measure impact.

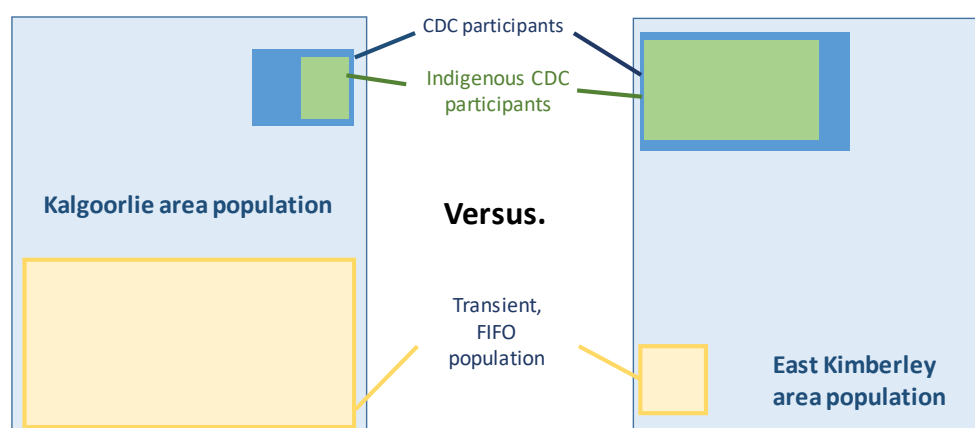
The overall proportion of CDC participants in a given community may be relatively small. As a result, even if there is a large change in a given outcome for a large proportion of the CDC participants, it may still be difficult to detect these changes by looking at aggregated community data. Any change experienced by the CDC participants will be diluted within the broader community data and will become less visible to the researchers. The impact of this dilution may be further compounded if the geographical aggregation of the community data does not coincide with the boundaries of the CDC trial areas. The following figure, Figure 3-5, illustrates the principle underpinning this issue by contrasting the demographic make-up of areas within two CDC trial sites (the main population centre of Kalgoorlie, in the Goldfields trial site, versus the East Kimberley trial site as a whole).<sup>17</sup>

---

<sup>16</sup> Administrative data, including community level data, is not directly useable for analysis in the context of an evaluation. The nature of the research questions and the general conditions that must be fulfilled in order to generate meaningful statistics imply that the original data must be standardised and harmonised before being analysed.

<sup>17</sup> The underlying data for this Figure can be found in the Australian Government administrative data analysis in the next chapter. At this stage, we use this data only as a realistic illustration that does not require reference to exact actual numbers.

Figure 3-5: CDC population within the trial areas, the issue of data aggregation



In Kalgoorlie, the CDC participant population represents barely 10 per cent of the total population of Kalgoorlie and about 50 per cent of the CDC participants there identify as Indigenous. By contrast, the CDC participant population represents nearly 20 per cent of the total population in the East Kimberley CDC trial site, with over 80 per cent of the CDC participant population identifying as Indigenous. Given these proportions, it would be difficult to observe changes driven by the CDC participant population through community-level data, even if those changes were important. By way of a concrete example, assume that a given outcome improves by 10 per cent for the CDC participants in Kalgoorlie, but does not change for the rest of the Kalgoorlie population. The outcome observed at the community level would show an improvement of 1 per cent. Likewise, if the outcome for the CDC participant population of Kalgoorlie decreased by 1 per cent on average, the total change observed at the community level in Kalgoorlie would be 0.1 per cent. Given the relatively small proportions of CDC participants within the broader community populations, it becomes clear that it is challenging for the research to detect any impact of the CDC by relying on data on community-level outcomes.<sup>18</sup>

Notwithstanding that it is difficult to know how different an offence rate may be between different people and within and between different localities, the last numerical example suggests that the dilution problem is a hurdle that needs to be considered seriously when developing a data strategy that uses community-level data.

<sup>18</sup> We have shown that, for each specific locality, the lower the proportion of CDC participants in the overall population (i.e. the higher the dilution) the less able we will be to trace and estimate the impact of the CDC on an outcome using community-level data. Using a fictitious locality and offence, but with realistic numbers, we build an example where 10 per cent of the population are on the Card, with a 20 per thousand population-wide offence rate. Let us assume that we know that the CDC impact is to halve the offence rate of CDC participants from 20 per thousand to 10 per thousand. The dilution effect will result in us observing the rate dropping from 20 per thousand down to 19 per thousand post-CDC offence rate for the whole of the locality. Although statistically tracing a 1 per thousand reduction is much harder than tracing a 10 per thousand reduction, given a sufficiently large and precisely constructed data set, it would be possible to try to extrapolate in order to find the true impact of the CDC. However, it is only if we made the assumption that the pre-CDC offence rate in the locality is the same for CDC participants and non-participants that the extrapolation would be right. Supposing this assumption did not hold and that CDC participants were more (or less) likely to offend. The impact of dilution on our ability to derive the right impact estimate would then reduce (or increase), but by how much? Extending the example, assume that the pre-CDC rate was 20 per thousand for non-CDC participants and, say, double at 40 per thousand for CDC participants. The whole-population offence rate would then be 22 per thousand (comprising 90 per cent non-CDC participants at 20 per thousand and 10 per cent CDC participants at 40 per thousand). Assuming the same impact of the CDC (halving the rate), we would end up with a post-CDC population rate of 20 per thousand, so the observed population drop would be 2 per thousand from 22 per thousand to 20 per thousand. Still a small proportion for statistical purposes.



### 3.4.2.3 *The timeframe covered by community-level data and the sequential nature of outcomes matter*

The short timeframe covered by currently available community-level data sets, combined with the longer-term nature of many important potential outcomes is a shortcoming for use of this data in the evaluation.

Impacts of the CDC policy would be expected to start at the individual level (for example, lower alcohol/drug consumption, better nutrition, better budgeting, less financial stress), then flow through to the household/family level and then reach the broader community level. The implication for deciding on the appropriate use of data is that coverage of a longer timeframe is more likely to capture the sequence of impacts at these three levels. Similarly, the impacts on elements of this sequence may not become apparent at the same speed. For instance, potential improvements in personal health, due to lower alcohol consumption, could emerge and become visible quickly at the individual level, but could take longer to manifest themselves in a collection of aggregated community-level data.

### 3.4.2.4 *Changes in definitions of outcomes and concurrent policies hinder impact identification and detection*

The advantages that could be gained by community-level data that covers a longer timeframe may be curtailed or even completely lost if there is a lack of continuity of measurement.

As many community-level data sets are almost exclusively designed to serve the current business purposes of the organisations that collect them, they will be diverse across organisations and often change over time within organisations. They will also differ between states and territories, as they will be guided by their own specific needs. In Section 5.5 we show how a change in the definition of domestic violence may have interfered with the assessment of the impact of the CDC. Such changes in definitions may make detection and comparisons harder and possibly uncertain.

Another limitation emerges from the presence of concurrent policies with influences that cannot be distinguished from one another. In several instances, the available evidence makes the identification and detection of impacts of the CDC difficult, as we may not be able to isolate the impact of the CDC from the potential influences of other concurrent policies. In such circumstances, it is advisable that we note the problematic empirical surrounds and that we do not attempt to make causal statements about the impact of the CDC. We note that this is not a problem that pertains only to community-level data. However, we mention it here, as it is a much harder problem to address in the case of community-level data.

### 3.4.2.5 *Fitness criteria for community-level data*

For the purposes of this evaluation, we used five pertinent criteria as our guiding principles to help us judge if a data collection was more or less likely to be useful as part of the overall evidence base needed for a formal impact evaluation:<sup>19</sup>

- Criterion 1: Data granularity. The data must offer sufficient granularity to identify change at several critical levels of analysis.
- Criterion 2: Data availability outside the CDC areas covered by the impact evaluation. The data must be available for comparable non-CDC areas.
- Criterion 3: Data availability before the CDC rollout in the relevant sites. The data must include observations before and after the rollout of the CDC in the relevant sites and the timespan of the data must be long enough to allow time variation to be identified.
- Criterion 4: Data collection frequency. More frequently collected data is better.
- Criterion 5: National coverage. The data must inform about other policies aiming to address the same problem of harmful behaviours as the CDC and how these may differ across the nation and over time.

Finding that these criteria may be fulfilled for any specific set of data can be taken to be a good guide, but not a guarantee, about the feasibility of implementing methodologies compatible with what is known as Difference-in-Difference (DiD), in order to estimate the impact of the CDC in the trial areas. A case-by-case further assessment will always be necessary.<sup>20</sup>

### 3.4.2.6 *Assessment of the practical use of community data for this evaluation*

Using the guiding principles encompassed in the five criteria outlined above and conducting further investigations specific to the questions pertaining to the CDC evaluation, we found that the community data collected at state level and made available to the evaluation research team was mostly unsuitable for formulating impact statements about the CDC. With the exception of Police data provided by Western Australia and South Australia, there was little that could be used to assess the impact of the CDC in the first three trial sites. In most cases, the community-level data provided was not fit for the purpose of an evaluation. The limitations of the data were prohibitive, so that statistically very little could be done to correct or overcome them. Nevertheless, these data sets were used in the Quantitative Supplementary report in an illustrative way to display changes over time (pre- and post-CDC rollout), albeit without allowing us to determine whether the changes we observe are due to the CDC or due to other factors.

---

<sup>19</sup> More information and detail about community data requirements can be found in the Quantitative Supplementary report. The criteria we mention here are guiding principles for defining the necessary conditions to help us assess the fitness for purpose of community-level data sets. They should not be viewed either as definitive statements or as sufficient conditions. Notwithstanding the criteria that we mention here, all data collections will need to have the right and relevant information content in order to be fit for purpose and the final judgement will always need to be made on a case-by-case basis, depending on the empirical question that needs to be addressed.

<sup>20</sup> More specifically, the DiD methodology entails the statistical comparison of how outcomes change over time before and after the rollout of the CDC in CDC trial areas, with how outcomes change over time in the same period in statistically 'comparable' suburbs where the CDC has not been implemented. The more the 'comparison suburbs' can be made statistically comparable, the more the research will be able to attribute the estimated differences in outcomes to the rollout of the CDC. A range of methodologies can be implemented to suit the extent and the type of information available, to account for the degree to which the five criteria are fulfilled and to test and correct for a number of potential statistical biases that may be present in the data.

### 3.4.3 Quantitative survey of CDC participants

#### 3.4.3.1 *Fieldwork dates and survey yield*

A large-scale quantitative survey of CDC participants was conducted in the first three trial sites. The survey was the main quantitative source of information on outcomes gathered by the evaluation. Before we introduce the survey, it is worth reminding the reader of the value and the nature of the information the survey generates, and how this is used, in the broader context of the evaluation and among the other methodologies we use. Our large-scale survey is a unique and valuable study that captures important information about the circumstances and attitudes of CDC participants in the trial sites. Its design principles follow the well-trodden paths of major large-scale survey collections like the Household Income and Labour Dynamics in Australia (HILDA) survey and the UK Understanding Society survey. Such data collections are currently considered to be the Gold Standard for social and economic research. The innovation of the CDC participants' survey lies in its close relationship in both design, implementation and analysis, with the other two main methodologies described earlier in this chapter.

The high value of our qualitative evidence collections is clear and undisputed. Without hearing the detailed voices of key stakeholders and CDC participants, any research effort would struggle to understand the deep personal stories of all those influenced by the policy and take their views on board. Equally clear and undisputed is the value of administrative data. Without administrative data we would not be able to know the precise composition of the population of CDC participants, which is necessary for making any generalisable statement about our research findings. But the depth of the qualitative data and the generalisability of the administrative data cannot be combined without a survey of individual CDC participants. The first major contribution of the quantitative survey of CDC participants was to provide this bridge of evidence. The second major contribution was that the survey allowed a large number of individuals to express their views about what is happening to them in the context of the policy, thus forming the most reliable source of large-scale information on what individuals think about the CDC outcomes.

All social science empirical methodologies have their strengths and weaknesses. Qualitative data is typically small-scale and not generalisable. Administrative data is by design frugal in its collection of personal information, especially of personal views on the policy. Survey data collections are based largely on what individuals report to be the case, which may be biased or not. The advantage of utilising simultaneously the different methodologies within this evaluation's framework is that we can triangulate and check all our findings as they emerge from each different methodology.

The evaluation framework outlined earlier in this chapter was built on this concept of triangulation and has determined the nature of the survey instrument developed for the evaluation. An important role in this development was played by the qualitative evidence collected by the evaluation team in all three sites, starting with the baseline data collection in the Goldfields, during which the survey design was cognitively tested and then piloted.

The fielding strategy was adapted to fit with the overall timing and development of the evaluation. It is important to note from the outset that the quantitative survey was designed to survey actual CDC participants in the three trial sites and did not survey any stakeholders or any CDC participants who were outside the trial sites, even if they had been triggered into the Card in one of the trial sites. The original survey design was planned and budgeted for a hardcopy delivery with a mix of postal and face-to-face completions.

Early consultations with stakeholders and information gained from the qualitative fieldwork led the research team to decide to switch to face-to-face survey completion as the main delivery method, with a universal postal approach as a secondary method.<sup>21</sup> The earlier consultations and the cognitive testing and piloting of a first version of the survey in the Goldfields area in 2018 led to the following considerations:

- CDC participants would need various levels of assistance to complete the survey, ranging from no assistance at all and a postal completion, to face-to-face survey completion using language and, possibly, Easy English pictorial supports.
- A large proportion (mostly composed of Indigenous CDC participants) would need a face-to-face survey completion.
- Survey response rates and quality of the survey responses could be greatly improved through the explicit engagement of local organisations, training and utilising some of their staff as survey assistants.

In response to these findings and the need to compress the time needed to achieve the required response target of 1,300 CDC participants, the fielding strategy was redesigned. In each trial site, the head of the quantitative research team, along with a minimum of three fellow researchers from the University of Adelaide (supported, when possible, by the lead of the qualitative team) remained in the trial sites for the whole duration of the fieldwork in order to train and supervise local staff and conduct the surveys. All local people who were either hired directly by the University of Adelaide or seconded by their organisations in order to provide support for the survey completions, were trained by the leads of both the quantitative and qualitative research teams. The training sessions lasted for half a day. After completion of training, survey assistants were buddied with a University of Adelaide researcher to undertake survey completions. We note that all local individuals supporting the survey completions were trained to deliver surveys in a culturally and ethically appropriate manner, respecting the answers given by the CDC participants without trying to influence answers one way or the other.<sup>22</sup> Moreover, the local individuals were accompanied by researchers from the University of Adelaide who were conducting survey activities alongside them. The fielding strategy is described in detail in the Quantitative Supplementary Report.

The fielding of the survey was staggered. Survey fieldwork took place in the East Kimberley from 11 to 25 October 2019 and continued in the Goldfields trial site from 18 November to 2 December 2019. Fieldwork in Ceduna and surrounds was split into two periods, in order to accommodate cultural business and the Christmas break, and took place from 9 to 18 December 2019 and later from 9 to 14 February 2020.

The survey fieldwork yielded 1,963 useable survey responses. The following Table 3-2 displays the number of CDC participants contacted by post for the survey in each trial site and the total number of those CDC participants who provided survey responses by post. We relied on the administrative data in order to determine the sample of CDC participants to be contacted for the survey. Through this process, we observed that a number of CDC participants' contact details were through a nominee

---

<sup>21</sup> The survey was set out to commence in mid-February 2019. The necessary authorisations for the commencement of fieldwork were obtained in October 2019.

<sup>22</sup> In order to further safeguard against the possibility of interviewer bias, these hired researchers were given an ID code that was to be written on each survey document they assisted with the completion of. They were instructed that the codes would be used to statistically check for interviewer bias.

(about 227 CDC participants). This was notably the case for some CDC participants who were in receipt of (Disability Support Pension (DSP). In such cases, the survey package was sent to both the CDC participants and their nominee, expecting a postal survey completion.<sup>23</sup> As it turned out, around 40 CDC participants who were flagged as being contactable via their nominees presented themselves for a face-to face completion during fieldwork and were accepted to do so.

**Table 3-2: Quantitative survey response rates, by trial site**

Trial site	CDC participants contacted	Total responses	(Postal responses) <sup>1</sup>	Valid responses
<b>East Kimberley</b>	956	456	(24)	444
<b>Goldfields</b>	2,760 (193 via nominees)	1,213	(177)	1,158
<b>Ceduna &amp; surrounds</b>	708 (34 via nominees)	372	(36)	361
<b>Total</b>	<b>4,424</b>	<b>2,041</b>	<b>(237)</b>	<b>1,963</b>

*Note: Total responses include postal and on site. Postal ones are indicated in a separate column, but they are included in the Total responses column.*

### 3.4.3.2 The design of the quantitative survey instrument

The questions included in the quantitative survey and the fielding methodology, were determined by a range of factors and principles, including the particular context of the trial sites, the evaluation methodology, and our contractual obligations.<sup>24</sup> The key survey design features are as follows<sup>25</sup>:

- The evaluation's framework and KEQs determined the relevant outcomes.
- The baseline data collection in the Goldfields (2018) provided early cognitive testing and informed the fielding methodology.
- The complementarities between the qualitative and quantitative methodologies were utilised to inform the overall design and, in particular to provide information about the "hard to reach" sub-groups of the intended population.
- The use of Australian Government administrative data reduced the interview burden and was also used to construct population weights.
- The survey included selected questions used in the previous evaluation of the CDC for potential continuity purposes.

<sup>23</sup> The survey package included a cover letter with instructions on how to complete the survey, including addresses of local places where CDC participants could receive assistance to fill out the survey (including face-to-face completion), the survey document and a reply paid envelope to return the survey if the CDC participant opted for a full postal survey completion. The nominees received a personalised cover letter, asking them to help the CDC participant complete the survey.

<sup>24</sup> It was pertinent to the design of the survey that the remit of the evaluation included a single wave of survey data collection in the trial sites without a 'control' group of 'eligible CDC participants', that is, individuals in receipt of Government payments living outside of the trial areas who would be CDC participants if they were in the trial sites. The need for longitudinal information was acknowledged by requiring that the survey design and fieldwork could be extended to include further waves later.

<sup>25</sup> The full survey design features are explored in detail in the Quantitative Supplementary Report.

- The survey included longitudinal instruments to enable potential future continuation through the collection of further waves of data.
- The data collection was restricted to CDC participants only and did not include a control group. It was also restricted to only one wave of data collection.
- For the purposes of the evaluation, the survey included several retrospective questions, which are intended to be used from the first wave of data collection.<sup>26</sup>

The quantitative survey of CDC participants included seven fixed-structure modules and one free-text module, which was added in order to allow respondents to provide additional unstructured feedback about what they find good and what they find bad about the CDC, and give feedback not covered by the survey questions. Free-text boxes were also intended to provide a useful cross-fertilisation ground between the quantitative and qualitative methodologies, able to yield knowledge that neither of the two methodologies manages exclusively by itself. The survey included the following sections:

#### Section A: Basic demographic information and information on children and school attendance

We restricted the demographic information to a minimum, as the survey answers were later linked with administrative data, if the individual survey respondents gave their consent. As a precaution against the possibility of a poor consent rate, basic demographics were elicited in the survey. It turned out that 84 per cent of the survey respondents consented to have their survey answers linked to their administrative data. The part dedicated to school attendance mostly used existing survey instruments (from the previous CDC evaluation in Ceduna and East Kimberley and/or from the evaluation of Income Management in Northern Territory) for comparability.

#### Section B: Work and employment

This part elicited information about people's employment. For those who are not in employment, information was elicited about the difficulties they report in looking for/finding a job. In a first wave of data collection, this provided baseline information from which changes could be observed in a potential second wave of data collection.

#### Section C: Financial position and financial stress

This section elicited information on the financial situation of the survey participant, including the date when their CDC participation commenced. It asked for retrospective information on financial stress, referring to 12 months before becoming a CDC participant, and then repeated the same questions, asking people to refer to a more recent time (within the last four weeks), with no reference to the CDC. These survey questions (referred to as 'instruments') were used in previous evaluations (the first

---

<sup>26</sup> These questions required the CDC participants to think back to before the commencement of the CDC and report on their situation then. In some cases, we also ask the same question about their current situation (under the CDC) and make a comparison. In other cases, we asked them directly to make a comparison about change they experienced since the CDC, or even due to the CDC. All such questions were trying to introduce an element of 'comparison over time' as a measure of change. We note that all these questions may suffer from inaccurate memories or even biased memories about what happened in the past (often called 'recall bias'). In this instance it was not only bias (i.e. the estimate is pointing to the wrong number) we needed to deal with, but also imprecision (i.e. the estimate is pointing with little precision). There is no escape from the fact that all such estimates we generated may be either imprecise but not biased, or precise but biased, or both. This does not render the information useless, it just means that we should be scrutinising it further whenever and however this may be possible. The additional and complementary information provided by the qualitative data is a critical aspect of our design regarding its capacity to scrutinise results and should be used as often as possible to this purpose. The present research has done this as an essential part of its analysis. This is a caveat to bear in mind, but in the absence of a true longitudinal collection (which takes years to achieve) this type of question supported by all other evidence the project generates from participants and stakeholders is the best direct evidence that could be had under the circumstances.

evaluation of the CDC undertaken by ORIMA and the evaluation of Income Management in the Northern Territory).

#### Section D: Behaviour and attitudes towards alcohol and drugs

We included the AUDIT (Alcohol Use Disorder Identification Test) questions to elicit information on alcohol consumption and to enable the computation of an individual score for each survey respondent. We also included a retrospective question that referred directly to the CDC (question D13) which allowed the researchers to look at self-assessed changes in alcohol consumption since becoming a CDC participant. Results from retrospective questions can be taken as early indications of outcomes, before information from a potential second wave has been collected. We also adapted and included some of the previous evaluations' (CDC and IM) survey instruments (questions D15 and D16).

This section also elicited information on perceptions about drugs using validated survey questions from the National Drug Strategy Household Survey (NDSHS) conducted by the Australian Institute of Health and Welfare (AIHW). The answers to these questions allowed the researchers to place our observations in the broader context of the states and Australia as a whole.

#### Section E: Health and well-being

We used a set of validated questions about health and well-being so comparisons could be drawn between CDC survey participants and nationally representative surveys. We used the SF12-Version2 health questions (adapted for Australia) and the PWI well-being index questions. These instruments are, by nature, longitudinal as the same question is asked in different points in time. They would achieve their complete usefulness after a second wave of data collection is undertaken.

#### Section F: Feelings about being on the Card

These questions referred directly to being on the CDC, asked how people felt about being on the CDC and to what extent they felt a number of life outcomes had changed for them because of the CDC, e.g. about money issues and saving money. We also asked whether they would like to stay on the CDC as it is now, whether they would like to stay on the CDC but with a lower proportion of their income support payment being placed on the Card or whether they would rather get off the CDC altogether if they could.

#### Section G: Feelings about the community they live in

This set of questions asked participants about the community they live in as a whole, notably how safe they think they are at home or in the streets and whether they think the CDC has had an impact on these feelings of safety. Questions G3 and G4 elicited the same type of information on further community indicators.

#### Section H: Free text entries

At the end of the survey, all respondents were given the opportunity to let us know what they thought was good or bad about the CDC in an unscripted free text manner, so they could give feedback on topics that they felt were not adequately covered by the survey.

A full copy of the relevant questionnaire is included in the appendices of this report.

#### 3.4.3.3 *Survey fielding strategy*

The fielding strategy of the survey had to be sensitive to the broad range and complexity of the questions that we needed to ask CDC participants, in addition to needing to be as inclusive as possible with a very heterogeneous population to be surveyed.



An initial draft of the survey was widely circulated to stakeholders in the Goldfields area as part of the Goldfields baseline data collection. The full survey was cognitively tested with a number of CDC participants in the Goldfields who were selected to provide a representative sample. We ensured the survey instruments were culturally sensitive and tested this aspect with local stakeholders in the Goldfields and also Indigenous language centres in order to obtain opinions from elders and specialists. Following this initial feedback, appropriate adjustments were made to the survey instruments. The survey was shortened, and, where appropriate, had some of its questions redesigned with 'plain English' replacing the validated original survey questions.

The cognitive testing phase of the survey made it clear that some CDC participants would be able to manage the completion of the survey by themselves and would prefer to complete a hardcopy version that they could return in the mail. Other CDC participants, however, were likely to require support, as their level of literacy (and English) would not have allowed them to answer the questions independently. Therefore, there was a need for supported completion through trusted third party individuals and organisations and there was a potential need for an easy English pictorial version of the survey instruments to be used by these support staff. In addition, there was a need for the research team to actively involve local stakeholders to facilitate participation in the survey and to provide support.

Thus, the fielding methodology was updated in order to increase the inclusiveness of the survey and produce a good yield, while maintaining the breadth of the questions asked. All CDC participants who were in scope as of the first week of September 2019, were sent a survey pack containing a cover letter, with instructions on how to complete the survey, the survey document itself, and a reply-paid envelope.<sup>27</sup> In the cover letter, CDC participants were given a number of addresses where they could seek assistance with completing the survey and were encouraged to seek this assistance if needed.

With the assistance of the lead of the qualitative research, intensive engagement was undertaken with local stakeholder groups in the weeks leading to the fielding of the quantitative survey to identify organisations and individuals who could help support the fielding of the survey. Some organisations and individuals actively promoted the survey by distributing posters and flyers (all translated in language), while others were directly engaged by the research team to help support a face-to-face delivery for those who required it. These people were known and trusted by the CDC participants and were able, as the need arose, to translate some of the questions into language. The involvement of staff of local organisations was discussed above in Section 3.4.3.

Most of the survey activity was conducted at a few locations hired by the research team, so that everyone who wished to be assisted by the University of Adelaide researchers could do this in a trusted and safe environment. Finally, at the end of each day throughout the survey fieldwork's duration, the head of the University of Adelaide quantitative research team reviewed all completed survey documents and a daily briefing was conducted the next morning, so that all rules for the collection of survey data could be reinforced. The local employees made an invaluable contribution to the success of the survey fieldwork and allowed us to get completions from hard to reach and hard to survey CDC participants. The University of Adelaide researchers are very thankful for their assistance. Further details about the fielding methodology are available in the Quantitative Supplementary report, including the discussion about deriving population weights in order to provide statistics from the survey that are representative of the whole CDC population.

---

<sup>27</sup> In scope CDC participants were defined as those who were identified as active as of the first week of September 2019, who had activated their card and undertaken at least one transaction (debit or credit) and who were identified in the administrative data as living within the trial areas.

## 3.5 Methodological strengths, weaknesses, challenges, and caveats of the evaluation

The final section of this chapter outlines the strengths and weaknesses of this evaluation of the CDC and the important contribution this evaluation makes to the evidence base on the CDC. It also highlights some of the challenges that were experienced (and mostly overcome) during the evaluation, and outlines some of the most important caveats that must be borne in mind when reading its findings.

### 3.5.1 The importance of this evaluation's contribution to the evidence base

This report comprises a robust, transparent and objective evaluation conducted by independent evaluators, essential for the credibility of the trial of the CDC. By advising on the strengths and weaknesses of the CDC trial implementation, the evaluation increases the scope for its effective rollout and management. This evaluation was conducted using a multidisciplinary approach that produced a wealth of well-evidenced and informed conclusions to contribute to the evidence base of the CDC.

In addition to its direct findings about perceptions of what works well and what does not work well in relation to the CDC in the trial areas, the evaluation provides a template for the potential further collection of independent data. The evaluation team were engaged to design evaluation tools that could continue to assess the CDC into the future, if required. The CDC quantitative survey could also be linked with other data sources, such as the Australian Government administrative data. As a result, the evaluation produced the first wave of a very cost-effective longitudinal data set, which could be used as the springboard for further evaluation of the CDC in the future.<sup>28</sup>

The integration of quantitative and qualitative evidence has enabled a well-informed data design and subsequent evidence interpretation. In addition, the use of an inclusive, culturally sensitive, and accessible multi-method and multi-mode approach, rather than a conventional quantitative survey design, enabled the participation in the evaluation of a wide range of CDC participants. This included participants who may generally be harder to reach for research purposes. Consequently, the evidence base developed for the evaluation is highly informative and representative of the very diverse population of CDC participants.

The use and integration of multi-method and multi-mode data collections was necessary given the diversity within and between the groups of people who took part in the evaluation. The qualitative evidence has allowed more in-depth and detailed understanding of the quantitative research. The quantitative evidence has allowed us to judge the overall prevalence of opinions and situations discussed in the in-depth interviews, especially for those who were either very negative or very positive about the CDC. The synergies that have been realised through the integration of our findings

---

<sup>28</sup> The cost-effectiveness of running a quantitative survey alongside with the qualitative research is an important aspect that needs specific mention. The design and piloting of the survey questionnaire needs knowledgeable qualitative researchers and the right contacts for its fieldwork. The fieldwork benefited enormously by the existing experience and trusting relationships that had already been generated by the qualitative team of the project. It would not be an exaggeration to argue that without the support of the qualitative team, the survey would have been far weaker in both its design and implementation.

have been many and useful and have created a higher level of understanding of the overall evaluation evidence.

The ambitious design of the evaluation produced an evidence base that spans across many different areas of individual behaviour and outcomes that the CDC is designed to influence. The wide and far-reaching findings of this report show a large variety of intended and unintended outcomes. These findings, however, have not come without many challenges and caveats.

### 3.5.2 Challenges and caveats

The complexity of this evaluation has given rise to several reporting caveats, some of which remain unresolved. Several of the methodological challenges were the direct result of the necessary multi-disciplinary design of the research and its reliance on a multi-faceted evidence base. The way they were dealt with is detailed in the two Supplementary Reports and, within this report, in the areas where they were shown to emerge and to be more relevant. Here we outline a few specific and important caveats that pertain to this evaluation. They are not listed in order of their importance.

As we put forward and discuss briefly these caveats and limitations, we would like to stress that they are not offered because we believe that this research is flawed or that, by extension, the evidence in this evaluation is flawed. Our intention is to stress the inherent and unavoidable limitations that empirical research of this nature has. Our ultimate objective is that the reader does not reach misleading conclusions that are either too strong, or too weak, or in any particular direction. To this purpose, we encourage the reader to use the findings and their associated caveats and limitations to develop a judicious and measured evidence-based understanding of the CDC outcomes.

Further, we note that the innovative nature of the evaluation has produced insights from accessing and analysing Australian Government and state government administrative data, including the linking of survey with administrative data. Some of the limitations and resulting caveats that have been noted by the research should not be considered as a failure of the methodology, but rather as valuable lessons and findings arising from this project that can guide future research. Above all, it is hoped that by considering the challenges and the caveats listed below, the reader will be able to make a more nuanced and useful assessment of this evaluation's results.

#### 3.5.2.1 *Activities subject to strong reporting biases*

The social acceptability of some of the behaviours the CDC is attempting to reduce range from being partially socially unacceptable to being clearly illegal. As such, their reporting may suffer from severe biases and is difficult to measure in an accurate way. The generation of the CDC evaluation evidence base had to use information that was known to be imperfect but was also known to be the best that could be achieved within these constraints.

#### 3.5.2.2 *Lack of experimental design in the trials*

The trials were not implemented with an evaluation design built into them. This evaluation was put in place after the CDC trial started and, as such, it could not create methodological tools for measuring impact through a robust experimental framework. To this purpose we would have needed a design that would have allowed direct before-after comparisons for CDC participants as well as comparisons between potential and actual CDC participants who live in different areas. Similarly, a lack of

quantitative survey information available from prior to the CDC's commencement limits the impact questions that can be examined through quantitative survey analysis in a statistically robust manner.

### *3.5.2.3 There was no quantitative survey of stakeholders and the broader non-CDC population*

We do not have clearly quantifiable information on the opinions of stakeholders about the CDC. The qualitative interviews with stakeholders are a rich source of evidence, but they cannot be used for making statistically generalisable statements. Similarly, the views of the broader non-CDC population are not part of the evaluation design. Some of the intended outcomes of the CDC are thus beyond the scope of this evaluation.

### *3.5.2.4 Longer-term outcomes and a short study timeframe*

Several of the intended outcomes of the CDC are longer-term outcomes. As such, they are beyond the reach of an evaluation with a short timeframe and the capacity to survey CDC participants only once. Although the need for longitudinal evidence is recognised in the design of the evaluation's evidence base, the present report draws on a single point in time evidence collection.

### *3.5.2.5 Community data limitations*

Overall community-level data is not always fit for the evaluation of policies. The research team was tasked to explore the capabilities of community-level data in the specific context of this CDC evaluation. It concluded that, with a few exceptions which are described in this Report, most of the community-level data that was made available for this evaluation was unsuitable for the examination of impacts.

The evaluation has shown a polarised field of opinions and perceptions about the CDC. Most of what we have collected evidence about (starting from the concept, design, implementation, and current outcomes of the CDC) exhibits a complexity of impacts that make straightforward conclusions and opinions difficult to find. The CDC means many different things to many different people, which makes it hard to make clear-cut statements about how well it works and for whom.

### *3.5.2.6 Concurrent policies*

There are many concurrent policies and initiatives that, like the CDC, aim to reduce harmful behaviours and mitigate the harm that they cause to individuals, their families, their friends, and their broader communities. In such circumstances, while it may be possible to measure and trace relevant outcomes, it may be much harder to identify whether it was the CDC that drove the observed change, or another policy or initiative, or both. In many instances, the evidence base for making such distinctions simply does not exist.

### *3.5.2.7 History of the rollout*

Many respondents (particularly stakeholders) reported that there had already been a negative history of the rollout of the trial in East Kimberley and Ceduna and considered that the previous evaluation of the policy had not managed to yield reliable results. The challenge of the second evaluation was to gain the trust of the CDC participants and core stakeholders within this context.

### 3.5.2.8 *Generalisability of the findings*

The generalisability of the findings has limitations due to methodological reasons (e.g. extensive use of qualitative methodologies, lack of an underpinning experimental design), practical reasons (e.g. the specific socio-demographics of the trial sites and the history that comes with them) and the pre-CDC policy environment (e.g. existing other services and initiatives).

These caveats and others of lesser importance are mentioned, where appropriate, throughout the Consolidated Report and are discussed in more detail in the two Supplementary Reports. It is important that the reader interprets the findings of the evaluation in light of these caveats and the ways in, and extent to, which these caveats were addressed where this was possible.

As mentioned in the start of this section, the limitations and resulting caveats we have encountered do not invalidate the findings of the evaluation. On the contrary, they are presented in order to enhance each finding with an understanding about the associated strength and precision of the underpinning evidence and analysis. We particularly warn the reader to not interpret the evaluation's findings as "either", "or" statements (that is, statements that some aspect of the CDC either "works well" or "does not work at all") or as "all encompassing" statements (that is, an outcome applies either to all CDC participants, or to none). The findings from this evaluation are mostly nuanced and specific, that is, they are findings that may apply up to a point and for some people, but not for others. We encourage the reader to bear this distinction in mind throughout their use of this report.

## 4. The First Three CDC Trial Sites

---

In this chapter, we provide context for the findings of the CDC evaluation. We start with an overview of the first three trial sites (Ceduna and surrounds, in South Australia, and East Kimberley and the Goldfields, in Western Australia). Using Australian Government administrative data, we then provide an overview of the characteristics of the CDC participants in each of these three trial sites.

### 4.1 The first three CDC trial sites: an overview

#### 4.1.1 Ceduna and the surrounding region

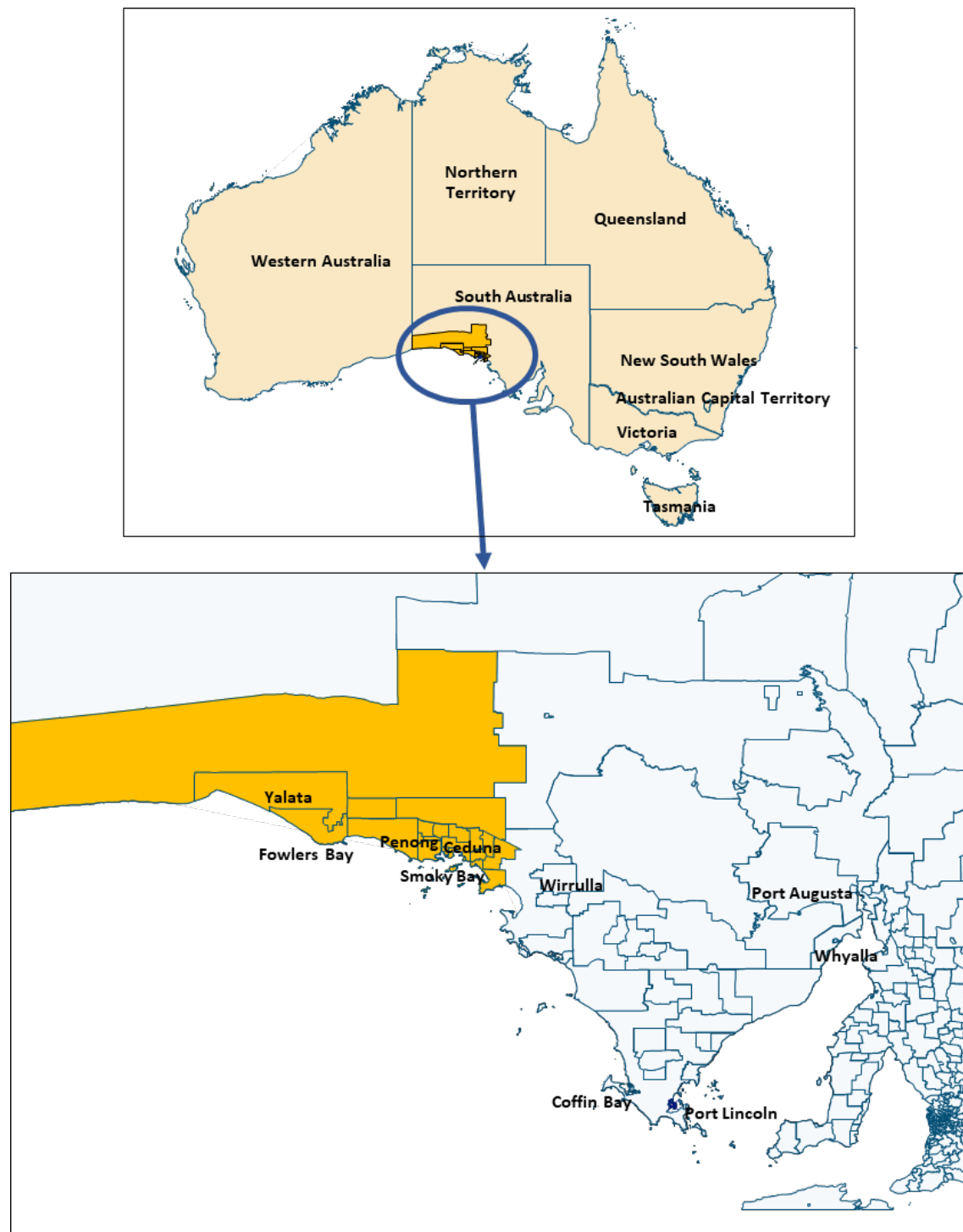
The Ceduna region was the first region to commence the trial of the CDC. The CDC commenced in the region on 15 March 2016. The township of Ceduna lies on the west coast of South Australia. It is situated in a relatively remote location, almost 800 kilometres north-west of Adelaide. Ceduna is located approximately 400 kilometres from Port Lincoln and 500 kilometres from the town of Whyalla. The town is the last major settlement before crossing the Nullarbor Plain. Figure 4-1 provides a map of the Ceduna region.

In the 2016 Census (ABS 2016a), the Ceduna and Thevenard conjoined township had a population of 3,408 people, making it the smallest of the three initial trial sites. Various figures are available in relation to the proportion of Indigenous people residing in the Ceduna community, but it is widely accepted that, at any given time, somewhere between 20 per cent and 30 per cent of the region's population is Indigenous. The 2016 Census (ABS 2016a) indicated that Indigenous people made up 21.7 per cent of the Ceduna population.

Ceduna has a number of Indigenous homelands situated within close proximity of the township. There are also several Aboriginal communities to the west of Ceduna. The Koonibba Aboriginal community is located approximately 40 kilometres northwest of Ceduna. The Yalata Anangu Aboriginal community is situated approximately 200 kilometres to the west of Ceduna and the Maralinga Tjarutja (Oak Valley) community is approximately a further 300 kilometres north from Yalata.

Compared to the other trial sites, Ceduna had the smallest overall population, with only 3,408 people. This compares to the overall East Kimberley population of 7,148 and the overall Goldfields population of 39,097.

Figure 4-1: Map of the Ceduna region



### 4.1.2 East Kimberley

The East Kimberley region was the second region to commence the trial of the CDC. The CDC commenced in the East Kimberley region on 26 April 2016. This remote region spans some 263,908 square kilometres, with communities spread from the northern coastal community of Kalumburu to the most southern community of Yarramural in the Great Sandy Desert (Western Australia Government 2017). Figure 4-2 provides a map of the East Kimberley region.

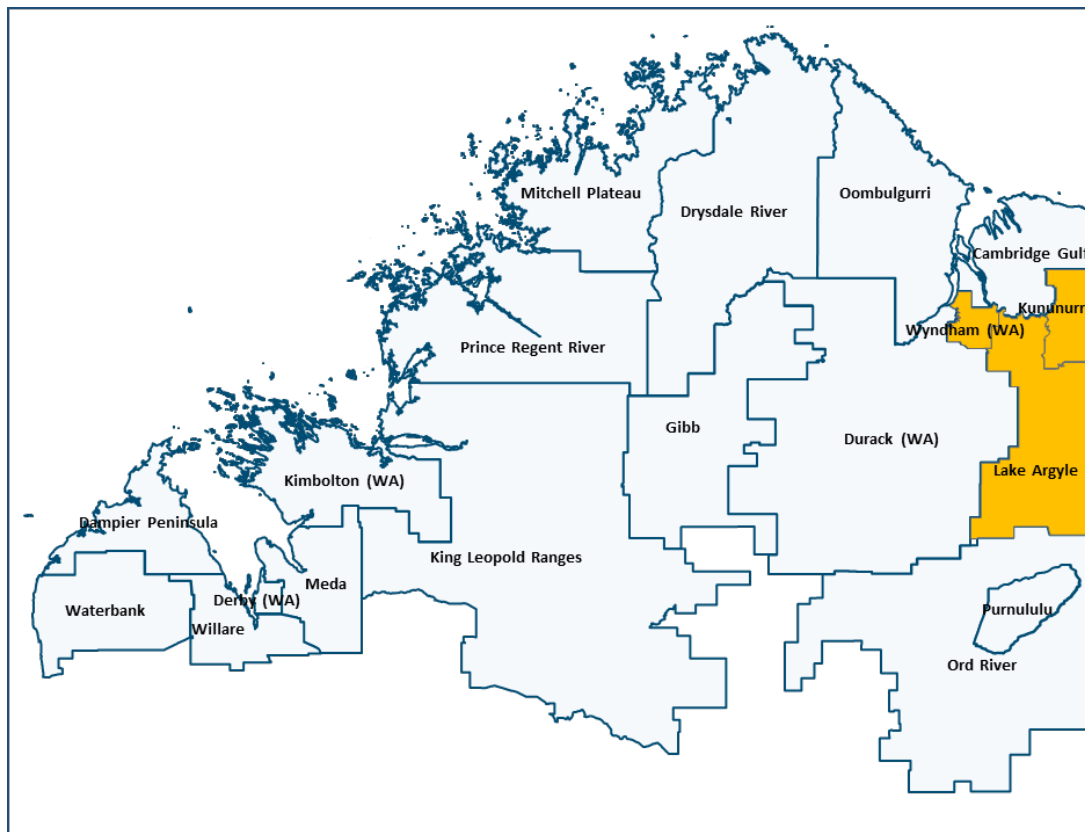
The East Kimberley CDC trial operates in two main centres—Kununurra and Wyndham. Kununurra was developed largely to service the Ord River Irrigation Scheme. It is located at the eastern extremity of the East Kimberley and approximately 37 kilometres from the border with the Northern Territory (Kununurra 2020). Wyndham is located around 100 kilometres North West of Kununurra and is 2,210 kilometres from the state capital of Perth (Wyndham 2020).

The East Kimberley region has a population of 7,148 people. Of these, 5,308 live in Kununurra and 780 in Wyndham. The largest town in the region, Kununurra has a sizeable transient population. If itinerant residents in the outlying farm areas and communities were included in its population count, the Kununurra total population would be much larger (Kununurra 2020).

Of the three CDC trial areas included in this evaluation, the East Kimberley region has the highest proportion of the overall population identifying as being Aboriginal and Torres Strait Islander: at 32.7 per cent, compared to 21.7 per cent in Ceduna and 12.3 per cent in the Goldfields region (ABS 2016b).



Figure 4-2: Map of the East Kimberley region



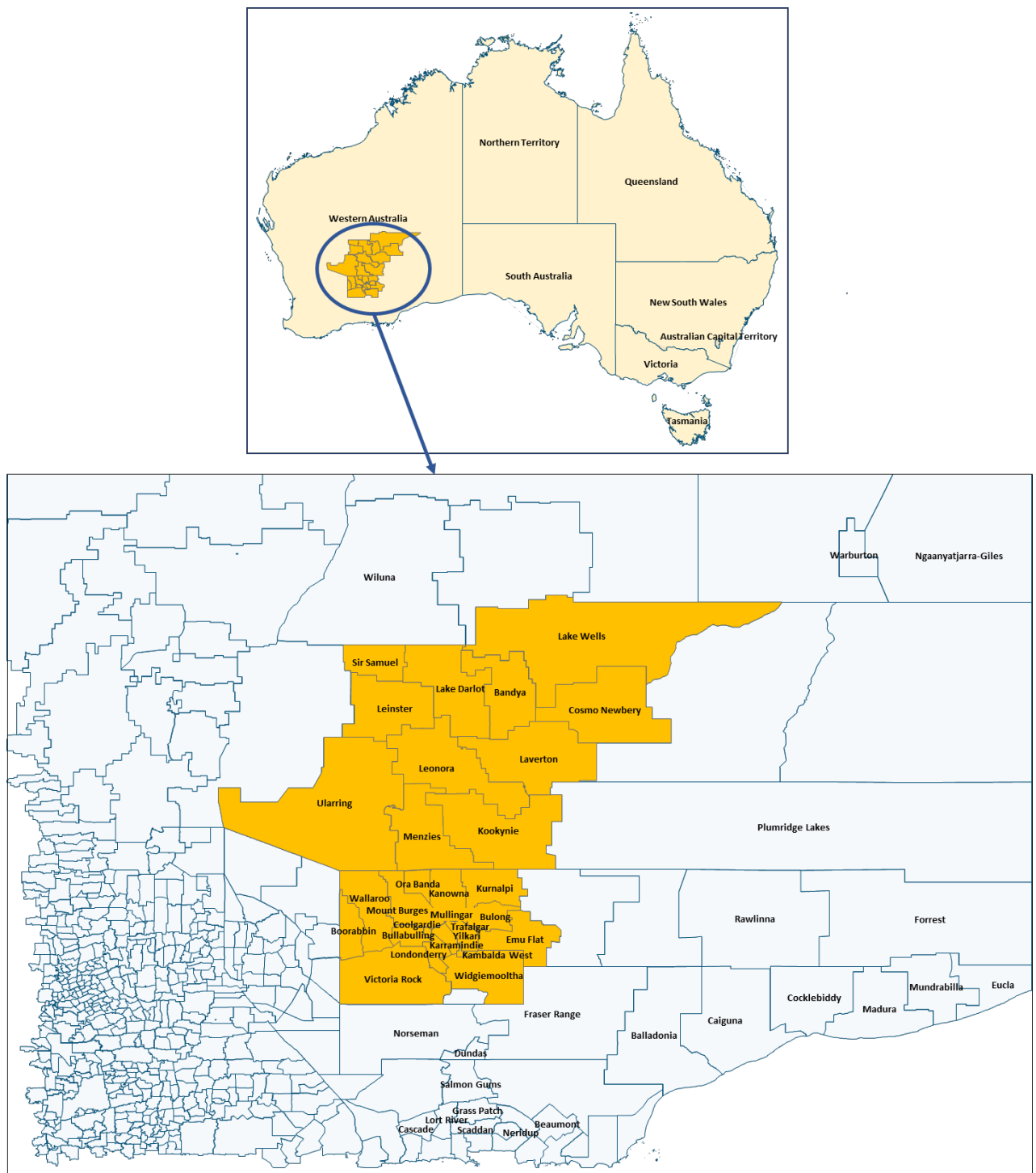
### 4.1.3 The Goldfields region

The Goldfields region was the third location to commence the trial of the CDC. The CDC commenced in the Goldfields region on 26 March 2018. The Goldfields region is located in the South Eastern corner of Western Australia and is the largest region in the state, with a land area of 771,276 square kilometres.

The Goldfields has a very different demographic make-up compared to Ceduna and East Kimberley. The Goldfields region has the largest overall population of 39,097 residents. Of the three CDC trial sites included in this evaluation, the Goldfields region has the lowest proportion of the overall population identifying as being Aboriginal and Torres Strait Islander (12.3 per cent) (ABS 2016c).

There is great heterogeneity within the Goldfields region, with places such as Leonora and Laverton being very different from Kalgoorlie-Boulder and Kambalda (for example, in relation to population composition and size, socio-economic conditions and remoteness). Figure 4-3 below provides a map which includes the location of the CDC sites in the Goldfields region. These different areas are described below.

Figure 4-3: Map including the CDC Sites within the Goldfields region



#### 4.1.4 Kalgoorlie-Boulder

The City of Kalgoorlie-Boulder is one of 159 local government areas in Western Australia. It is the largest outback city in the state and the hub of the Goldfields region. From wild beginnings as a gold rush town, it has grown into a bustling cosmopolitan city with a distinctive character. It has a population of around 40,000 people and a large fly-in/fly-out (FIFO) workforce. While not especially large in population terms, Kalgoorlie-Boulder is noted to be very powerful in economic terms with a globally significant mining industry driving the economy.<sup>29</sup>

##### 4.1.4.1 *Coolgardie and Kambalda*

The Shire of Coolgardie is one of the smallest shires in the Goldfields. The Shire has two main towns, Coolgardie and Kambalda, and smaller satellite towns such as Widgiemooltha, and the Kurrawang Indigenous community, which is located about halfway between Coolgardie and Kalgoorlie. The local industries within the Shire of Coolgardie consist of gold and nickel mining, pastoral, tourism, commercial/retail and light industrial (Shire of Coolgardie 2020).

The Shire's two main towns are quite different. Coolgardie is located around 40 kilometres from Kalgoorlie-Boulder and was the birthplace of the great gold rush of 1892. Known now as a tourist town and a mining ghost town, Coolgardie was once the third largest town in Western Australia. In the 2016 Census there were 878 people residing in Coolgardie, with Indigenous people comprising 21 per cent of the population. The median age of the population was 42 years (Coolgardie 2020).

Kambalda is located around 60 kilometres from Kalgoorlie-Boulder. Built by Western Mining in the 1960s, it was Australia's first nickel town. It is split into two town sites approximately 4 kilometres apart: Kambalda East and Kambalda West. In the 2016 Census there were 2,539 people residing in Kambalda and Indigenous people made up 5 per cent of the population. The median age of the population was 32 years (Kambalda 2020).

The ownership of the town by Western Mining was considered to have been important in securing the town's services and infrastructure. The later withdrawal of Western Mining from the town was reported in our interviews to have been detrimental to the community of Kambalda, resulting in decreased employment opportunities, closure of essential services, and a continued shrinking of the population.

##### 4.1.4.2 *Laverton and Leonora*

Laverton is located around five hours from Kalgoorlie-Boulder at the western edge of the Great Victoria Desert. The township marks the start of the Outback Way—a highway which goes through the Northern Territory to Winton in outback Queensland. Although Laverton is primarily a mining area, it also has a long history of pastoralism with sheep and cattle, and a substantial area of land is still used in this way (Laverton 2020). One and a half hours drive west of Laverton is the Shire of Leonora. Leonora is primarily a mining town, but the area also supports a significant pastoral industry and tourism (Leonora 2020).

In the 2016 Census, there were 871 people residing in Laverton and Indigenous people made up 20 per cent of the population. Within Leonora, the total population in 2016 was 781 and Indigenous

---

<sup>29</sup> For relevant information see for example <https://www.australiasgoldenoutback.com/destination/kalgoorlie-boulder> ; <https://en.wikipedia.org/wiki/Goldfields%E2%80%93Esperance>.

people comprised 23 per cent of the population. The median age of people in Laverton and Leonora was 38 and 36 years respectively. It was frequently noted in our interviews, however, that both towns' populations were volatile and could expand or shrink depending on cultural activities occurring in the region.

#### **4.1.4.3**      *Menzies*

Menzies is located around 133 kilometres North West of Kalgoorlie. There was a total population of 490 people residing in Menzies Shire as at June 2016. The township of Menzies itself had around 108 residents, with a further 240 people living in the Tjuntjuntjara Community near the South Australian border.<sup>30</sup> The population of Tjuntjuntjara is predominantly Indigenous, whereas in the township of Menzies there is about a 50/50 split between Indigenous and non-Indigenous residents (Menzies 2020).

The Quantitative Supplementary Report includes further information on the trial areas through a statistical description of several pertinent aspects of the socioeconomic make up of these areas.

## **4.2      The CDC participant population: core demographics and characteristics using Australian Government administrative data**

The Australian Government administrative data made available for the evaluation included demographic information about the CDC participants in the first three trial sites, the type of government benefits they received and relevant information on card and transaction activity.<sup>31</sup> In this section, we present an overview of the characteristics of the CDC participants in the first three trial sites. The Quantitative Supplementary report includes a more comprehensive analysis of the characteristics of CDC participants and of their transaction activities since being rolled into the CDC.<sup>32</sup>

The statistics presented in this section correspond to the CDC participant population of 5,788 as it was on 27 September 2019, shortly before the quantitative survey was fielded.

As mentioned earlier, after excluding deceased people from the list, people who had not activated their Cards and people who had no transactions (credit or debit) recorded in their Cards, we were left with 5,716 CDC participants, including 1,355 individuals currently recorded as living 'out of area'. These 'out of area' CDC participants included people who had moved away from the trial site since they were triggered on the Card but also people from neighbouring suburbs that are not in the CDC area, who were triggered on the Card after temporarily living in a trial area. For instance, in East Kimberley, we encountered a number of CDC participants who lived in Halls Creek, which is not in the trial area but is comparatively close to Kununurra. Likewise, in the Goldfields, we observed CDC participants whose place of residence was Warburton, which is out of area. Presumably, these people either moved after being triggered onto the Card or visited trial locations such as Laverton and were triggered while visiting there. We also observed some people whose current residence was much farther away from the trial sites, such as Sydney or Perth. In the following analysis, we report statistics

---

<sup>30</sup> The Tjuntjuntjara community is not part of the CDC trial in the Goldfields.

<sup>31</sup> Work on this evaluation adhered to the requirements of the Privacy Act 1988, in particular the Australian Privacy Principles regarding the management, use and security of information.

<sup>32</sup> This data does not provide information on individual items that have been purchased.

for the overall population of CDC participants currently active as at September 2019, whether they live within the trial sites or not. If CDC participants do not currently live in the trial sites, we identify them in the statistics as ‘out of area’.

#### Box 4.1: Overall observations about the population of CDC participants

The composition of the CDC participant population living in the Goldfields trial site was different to that in the other two sites. Overall, the CDC participant population in the Goldfields differed from Ceduna and surrounds and East Kimberley in many ways, including Indigenous status, household composition and type of benefit received. The data on the CDC participant population also highlighted a strong heterogeneity within the Goldfields site. CDC participants living in places such as Laverton, Leonora and Menzies had different demographics from CDC participants living in places like Kalgoorlie and Kambalda. In contrast, we observed much more homogeneity within the two other sites of Ceduna and surrounds and East Kimberley.

We provide an overview of our analysis of the demographics of the CDC participant population in the trial areas using Table 4-1 below, which displays the distribution of the CDC participant population across the three original trial sites. The first set of columns (‘Original site’) provide information according to the site in which CDC participants were triggered onto the Card. The second set of columns (‘Current site’) provides the same information according to CDC participants’ current location. Based on the latter, the Goldfields included the largest number of currently active CDC participants with 2,663 people (47 per cent). East Kimberley followed with 1,032 active participants (18 per cent). Ceduna included 666 active participants (12 per cent). The remaining 1,355 people (24 per cent) were recorded as living outside of the trial areas as at end-September 2019.

Table 4-1: Distribution of active CDC participants in the trial sites

Trial area	Original site		Current site	
	N	%	N	%
<b>East Kimberley</b>	1,488	<b>26</b>	1,032	<b>18</b>
<b>Goldfields</b>	3,299	<b>58</b>	2,663	<b>47</b>
<b>Ceduna &amp; surrounds</b>	929	<b>16</b>	666	<b>12</b>
<b>Out of area</b>	–	–	1,355	<b>24</b>
<b>Total</b>	<b>5,716</b>	<b>100</b>	<b>5,716</b>	<b>100</b>

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.*

Almost a quarter of the currently active CDC participants, who were triggered on the Card in the first three trial sites, were not living in these trial sites as at 27 September 2019. As stated above, some had moved away from the trial site after they were triggered on the Card. Others resided outside the trial area originally, but they were triggered on the Card because they spent some time living in a trial area. They later returned to their usual place of residence but remained on the Card. The majority of the ‘out of area’ CDC participants lived in suburbs that were near the trial area, which explains their

large number.<sup>33</sup> As a group, ‘out of area’ CDC participants differed significantly from those who still lived in a trial site. Members of this group tended to be much younger, were more likely to be single and receiving Newstart Allowance and were less likely to receive Disability Support Pension or Parenting payments (for more detail see Quantitative Supplementary report).

#### 4.2.1 Demographic differences across sites

There were demographic differences by trial sites. Ceduna and surrounds and East Kimberley were demographically mostly homogenous, but the Goldfields was internally diverse. A main demographic difference between trial sites was the proportion of Indigenous CDC participants. In the Goldfields, the proportion was below 50 per cent, while in Ceduna and surrounds and East Kimberley it was above 74 per cent as depicted in the following Table 4-2.

Table 4-2: Distribution of Indigenous status in the trial sites (current)

Current site	Indigenous status							
	Non-Indigenous		Indigenous		Prefer not to say		Total	
	N	%	N	%	N	%	N	%
<b>Ceduna &amp; surrounds</b>	156	<b>23</b>	496	<b>74</b>	14	<b>2</b>	666	<b>100</b>
<b>East Kimberley</b>	162	<b>16</b>	849	<b>82</b>	21	<b>2</b>	1,032	<b>100</b>
<b>Goldfields</b>	1,322	<b>50</b>	1,221	<b>46</b>	120	<b>5</b>	2,663	<b>100</b>
<b>Out of area</b>	432	<b>32</b>	895	<b>66</b>	28	<b>2</b>	1,355	<b>100</b>
<b>Total</b>	<b>2,072</b>	<b>36</b>	<b>3,461</b>	<b>61</b>	<b>183</b>	<b>3</b>	<b>5,716</b>	<b>100</b>

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.*

The distribution of Indigenous CDC participants was not homogenous within the Goldfields site itself. CDC participants in places such as Laverton and Leonora were over 80 per cent Indigenous.

Ceduna and surrounds and East Kimberley are classified as ‘very remote’. Of all Goldfields CDC participants, 82 per cent live in an ‘outer regional’ area and 18 per cent in a ‘very remote’ area.

There were more women than men on the CDC in all trial sites (overall 58 per cent women) as shown in the following Table 4-3.

---

<sup>33</sup> The term ‘neighbouring’ must be understood in the context of remote areas. A neighbouring ‘suburb’ will probably share its physical boundaries with a trial site but may be quite far in terms of kilometres. Yet the trial sites exert some attraction for these ‘out of area’ people (for example, availability of shops, visiting family members, getting out of dry communities, etc.). For instance, Halls Creek can be considered as a neighbouring community of Kununurra, even though it is 380 kilometres away. We can also mention Warburton (out of area) which is 550 kilometres away from Laverton, but has many connections between the people living in each of these ‘suburbs’.

Table 4-3: Distribution of gender in the trial sites (current)

	Male		Female		Total	
Current site	N	%	N	%	N	%
Ceduna & surrounds	313	47	353	53	666	100
East Kimberley	408	40	624	60	1,032	100
Goldfields	1,114	42	1,549	58	2,663	100
Out of area	590	44	765	56	1,355	100
Total	2,425	42	3,291	58	5,716	100

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Marital status varied across trial sites, with the Goldfields CDC participant population having the smallest proportion of de facto/married CDC participants (17 per cent) and a comparatively larger proportion of single people (36 per cent). The proportion of divorced/separated CDC participants in the Goldfields area was similar to that of East Kimberley (around 47 per cent). By comparison, the proportion of CDC participants who were in a de facto or married relationship was 30 per cent in Ceduna and surrounds. Among CDC participants, a smaller proportion of Indigenous people were de facto/married (16 per cent compared to 22 per cent) and a slightly larger proportion of Indigenous people were divorced (48 per cent compared to 44 per cent).

There were very few variations between trial sites in relation to the age distribution of CDC participants. Younger CDC participants were more mobile, as shown by the lower average age of the 'out of area' group.

## 4.2.2 Home ownership and type of accommodation

Around 6 per cent of CDC participants were homeowners (or were currently purchasing a home). The large majority of those homeowners were located in the Goldfields (77 per cent).

The most common type of accommodation for CDC participants who were not homeowners, was public housing (52 per cent in East Kimberley, 38 per cent in Ceduna, 31 per cent in the Goldfields and 21 per cent of those living 'out of area'). Renting was the second most common type of accommodation (7 per cent in East Kimberley, 18 per cent in Ceduna and 30 per cent in the Goldfields). CDC participants were more reliant on the private market for their accommodation in the Goldfields than the other two trial sites.

A striking feature regarding the type of accommodation of CDC participants was the high proportion of CDC participants who were boarding (either free or not). They amounted to 35 per cent in East Kimberley and 38 per cent in Ceduna and surrounds. Those recorded as living 'out of area' were also different from all three trial areas. The proportion of boarding and free boarding was higher and the proportion of public housing was the lowest for the 'out of area' group of CDC participants in the analysis.

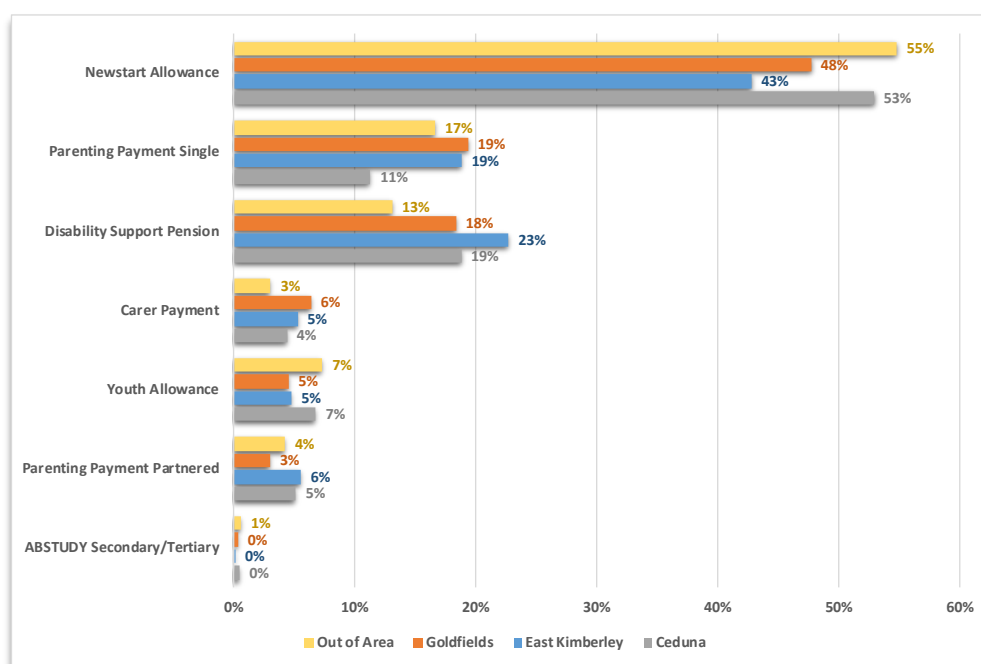


### 4.2.3 Type of government payments

Overall, the most prevalent payment was Newstart Allowance. The second most prevalent payment was either Parenting Payment Single or Disability Support Pension, with little difference between them. All other payments were a lot less prevalent.

The following Figure 4-4 shows that in the Goldfields and Ceduna around 50 per cent of CDC participants were on Newstart Allowance and around 20 per cent on Disability Support Pension (DSP). In comparison, there were fewer active CDC participants in East Kimberley on Newstart Allowance (43 per cent) and more on DSP (23 per cent). Altogether, the proportion of active CDC participants on Newstart Allowance was 55 per cent for participants living out of area, 48 per cent in the Goldfields, 43 per cent in the Goldfields, 43 per cent in East Kimberley and 53 per cent in Ceduna and surrounds.

Figure 4-4: Distribution of CDC participants' government benefit type in the trial sites (current)



### 4.2.4 Changes of the CDC population over time, since the rollout of the CDC

In July/August 2018 we were provided with data on CDC participants in the trial areas for the Baseline Data Collection project in the Goldfields. We combined this early data from 2018 with later data from September 2019, in order to compare the demographic differences between the earlier (July/August 2018) and the later (September 2019) CDC participant population. Our purpose was to check if the demographics had changed between the earlier CDC participants and the later CDC participants.<sup>34</sup> Out of the 5,716 currently active participants in September 2019, 3,912 were already CDC participants in mid-2018 and 1,804 were 'new' CDC participants. We observed some noticeable differences between these two groups. Notably, the proportion of people on DSP was much smaller among the 'new' CDC participants (8 per cent, compared to 22 per cent in the other group). The proportion of people on

<sup>34</sup> We did not obtain any earlier information on those earlier participants in the other two trial sites of Ceduna and East Kimberley, where the CDC was rolled out before 2018.

Newstart Allowance was also larger (and driven mostly by the increase in the Goldfields area) and the proportion of people on parenting payment (single) was significantly smaller.

The Quantitative Supplementary Report provides more detailed information on the demographics and the composition of the CDC populations in each site. It also reports CDC transaction patterns, such as declined transactions, the reasons why these attempted transactions were declined and the extent to which the patterns of declined transactions change over time, as people gain experience on the CDC.

## **4.3 Initiation of the CDC Trial**

While not a central aim of the evaluation, the qualitative fieldwork collected historical information about the initiation of the CDC trial in each of the first three trial sites. Respondents (mainly stakeholders) discussed the entrenched social issues that were considered the impetus behind the CDC trial. They also described the involvement of key community leaders in both supporting the trial and contributing to its design. In addition, the interviews examined the broader social policy environment in which the CDC trial was introduced. The qualitative fieldwork also collected evidence about community and CDC participant reactions to the introduction of the CDC and how this had changed in each site over the trial period.

### **4.3.1 Reasons for the CDC trial**

In each of the trial sites, in-depth interview respondents (mainly stakeholders) discussed the entrenched social issues that were the impetus behind the CDC trial. In particular, each region was considered to have had a long history of social dysfunction and harm generated by widespread substance use and misuse. This was considered by interview respondents to be detrimental to the physical and mental well-being of individuals and the community more broadly. Substance misuse was associated with other problematic issues including anti-social behaviour, child well-being, family violence and crime. The issues with substance use and misuse were considered by interview respondents to stem from a long history of cultural dislocation, dispossession and poverty.

In the East Kimberley region, respondents linked substance abuse and associated problematic behaviours to the suicides of around 13 young people that occurred in that region over a very short period of time. These suicides, and the broader social issues that were considered by interview respondents to have contributed to the young people taking their own lives, were said to be the impetus behind the CDC trial in the East Kimberley region.

In Ceduna, the social and individual harm being caused by substance abuse issues was evidenced most clearly in the 2011 Coronial Inquest into the alcohol-related deaths of six Aboriginal people in the Ceduna region. Combined with other factors such as the timing, release and recommendations included in Andrew Forrest's 'Creating Parity' report (Forrest 2014), this was seen by interview respondents to be the catalyst behind the trial of the CDC.

In the Goldfields region, stakeholder interview respondents considered that each township had different reasons as to why the CDC may be a good idea. For example, Menzies and Kambalda were reported by interview respondents not to experience many social issues but were captured in the CDC trial because they had other areas within their Shires where alcohol use and misuse was an issue or that they saw the CDC as a preventative measure to ensure that social issues did not come to their town. Many stakeholders in Leonora, Laverton and Coolgardie, meanwhile, wanted to see an improvement in children's well-being and to break the cycle of intergenerational disadvantage and

welfare dependence. In Laverton and Leonora, the CDC was also seen by interview respondents as a potential way to curb the social harm considered to be caused by some from neighbouring Aboriginal communities.

### 4.3.2 Community leaders' involvement in the CDC trial

Interview respondents also described the involvement of key community leaders in both supporting the trial and contributing to its design within each of the CDC trial site regions.

In the Ceduna region, the key drivers of the CDC being trialled were considered to be the Far West Aboriginal Leaders Group. This group comprised CEOs of the five Aboriginal communities in the Far West region of South Australia as well as representatives from the Ceduna regional council. Respondents reported that these leaders had identified a need to do more than what was currently being undertaken to curb the social harm evident within the region. After the release of Andrew Forrest's 'Creating Parity' report (Forrest 2014), the Australian Government presented the idea of a cashless debit card to the group. Insisting on community ownership and support, the leadership group had input over the design of the trial in the region. The group met fortnightly, and sometimes even weekly, with the Australian Government to discuss and design all aspects of the trial, even down to the appearance of the Card. This process was spoken about positively and was considered a true co-design exercise.

The key drivers of the CDC being trialled in the East Kimberley region were considered to be a select number of Aboriginal Leaders. These leaders had identified a need for an alternative approach to curb the evident social harm. Some of the leaders actively lobbied government to try to stimulate a reform agenda within the region and were presented with the proposition of the CDC trial. Some stakeholders considered that a lengthy period of consultation and negotiation then ensued. The leaders were reported by interview respondents to have requested that certain conditions sit around the CDC if it was to be trialled in the region. The first of these conditions was that the trial be accompanied by wraparound services, as they were all cognisant that, in and of itself, the Card was not enough to reduce the social harm that was being generated by substance misuse. The second of these conditions was that the community would determine which wraparound services needed to be funded. Finally, the leaders were said to have advocated for a community panel, which would allow people to apply to adjust the proportion of their income support payments which were placed onto the Card and, more significantly, apply to be able to exit the Card if they were meeting their responsibilities in regards to the five social norms<sup>35</sup>.

In the Goldfields region, it was less clear who the primary driver of the CDC being implemented was perceived to be. The City of Kalgoorlie-Boulder was reported to be one of the key players, lobbying for the CDC to be implemented in the Goldfields region and, having watched the Ceduna and East Kimberley trial closely, pushed for the Goldfields to join the trial. Regional councils were also central in the decision to implement the CDC. Likewise, it was noted that Rick Wilson, Federal Member for O'Connor, was also instrumental in supporting the Kalgoorlie-Boulder City and regional councils in the drive for the CDC. In some other communities within the Goldfields, it was the local residents group and Indigenous Elders who were the key supporters of the CDC in a hope to drive social change.

---

<sup>35</sup> The five social norms were centred upon children participating in education and learning, caring for children and vulnerable people, adults participating in work or training, having stable housing, and living in safe communities.

### 4.3.3 Community consultation

Stakeholder interview respondents indicated that there had been community engagement work undertaken by DSS in each of the trial sites, prior to the trial occurring. This consultation work, which included door knocking, community meetings and disseminating information material, was said by interview respondents to have occurred both within urban centres and in the surrounding Aboriginal communities.

In Ceduna, most respondents (particularly stakeholders) considered the stakeholder engagement work that had been undertaken to have been comprehensive and far-reaching. Similarly, the stakeholder engagement work undertaken by DSS in the Goldfields was said by interview respondents to have been extensive and inclusive, engaging not only easy-to-reach groups but also engaging appropriately and sensitively with Indigenous community groups. However, in the East Kimberley, only a few interview respondents considered that the community consultation work undertaken was adequate.

A number of interview respondents (particularly CDC participants) in each of the trial sites, particularly in the East Kimberley, reported that they were dissatisfied with the level of consultation. They indicated that this had been skewed and focused largely on a select group of community members and that the engagement was not undertaken in a culturally appropriate way. It was said that they operated on a one-on-one basis rather than in a group or community forum setting. The latter was reported to be a preferred meeting format for Aboriginal communities. In addition, in each trial site many respondents reported dissatisfaction with the consultation that had occurred following the implementation of the trial. These respondents spoke about feeling abandoned by government after the trial commenced, particularly by senior members of government.

### 4.3.4 Broader social policy environment

The CDC trial was implemented at a time when there were other significant reforms being pursued or implemented within each of the CDC trial site locations.

In the East Kimberley region, this included the Empowered Communities reform and the Remote Services Reform agenda. In Ceduna, the Ceduna Service Reform Strategy was occurring alongside the CDC. Along with Centrelink's shared responsibilities model, these were said to have fundamentally changed the delivery of many human and community services in the regions around the same time the CDC was implemented.<sup>36</sup>

In addition to this, other policies were also being implemented at the time of the introduction of the CDC, the main being related to local Alcohol Accords. In both Ceduna and East Kimberley, a local accord had been introduced prior to the CDC, which placed a number of restrictions on the supply of alcohol, including the amount and types of alcohol that could be purchased in those regions. In the Goldfields, an intervention that was occurring concurrently to the rollout of the CDC was "Operation Fortitude". This was described as an ongoing intervention, which sought to increase the number of police in the city of Kalgoorlie-Boulder and also to change the style of policing to enable more of a public presence. In addition to "Operation Fortitude", the "Safer Streets Patrol" was introduced. It

---

<sup>36</sup> The Qualitative Supplementary Report provides more context and detail on reform and related matters raised in this paragraph.

funded the presence of four workers to patrol and combat antisocial behaviour in key precincts in the city of Kalgoorlie-Boulder.

It was noted by many stakeholders in each trial site that changes in the broader social service sector and policy environment, as well as the other interventions operating to curb issues with alcohol abuse, would make any assessment and attribution of whether the CDC had caused behaviour change within the trial sites difficult.

## 5. Perceived Impacts of the Cashless Debit Card

---

This chapter focusses on specific outcomes of the CDC as these are identified and measured by the evaluation. The CDC was developed as a means to help “stabilise the finances and lives of vulnerable families, ensure welfare payments are used as intended, and reduce money available for alcohol and gambling in an effort to reduce social dysfunction where it exists in some communities”.<sup>37</sup>

Some outcomes can be measured in the short term but some need a longer time to happen and to be measured. Several of the desired behavioural changes the CDC is intended to achieve are of a longer-term nature (particularly changes in behaviour related to addiction or changes in life-long habits). As such, these longer-term outcomes will be harder to observe in the short term available to this evaluation. This impacts on how the evidence we present should be interpreted.

In reading about findings, it is important to consider that the CDC was introduced at a time when several other interventions or programs were occurring in each of the three trial sites. This makes it challenging to ascertain the direct impacts which may have resulted purely from the CDC policy alone, as these other interventions may also be impacting upon social and other relevant conditions within the trial regions. This chapter’s findings pertaining to the relevant changes that have been reported by CDC participants and stakeholders to have happened since the introduction of the CDC, must be read with this thought in mind.

In accordance with the KEQs presented in Section 2.3, this evaluation was tasked to gather, analyse and assess evidence as to whether the CDC is meeting its intended aims. The findings presented in this chapter refer to the time of data collection (described in Chapter 3). They are the most prominent findings emerging from this evaluation and cover all outcomes defined in the KEQs, in so far as the data and the research timelines have allowed.

Reading some parts of this chapter will unavoidably require a level of technical expertise. We have purposely kept this to a necessary minimum. For those readers who wish to see the full technical explanations, we present the full findings and analyses in two supplementary reports, one for the quantitative and one for the qualitative methodologies that underpin this research.<sup>38</sup>

Both qualitative and quantitative data provide evidence used to assess the findings. This chapter begins by reporting the findings on the core issues which are the main objective of the CDC: a reduction in alcohol, illegal drugs and gambling. In doing so, we find that just under four in every ten CDC participants reported that they neither drink, nor use illicit drugs, nor gamble. It then reports on secondary and tertiary issues, namely: financial planning and money management; safety crime and family violence; child welfare; health and well-being; autonomy and control; discrimination, stigma, embarrassment and fairness; and employment and training. We conclude with reporting on local organisations and transient populations.

---

<sup>37</sup> Guide to Social Security Law 8.7.1 <https://guides.dss.gov.au/guide-social-security-law/8/7/1>.

<sup>38</sup> For example, all tabulations present population-weighted data which serves to project the numbers of CDC participants to the actual numbers in the trial areas. This allows the reader to form a more realistic view of the CDC policy and its potential impact.

## 5.1 Alcohol use and misuse

The CDC aims to reduce alcohol consumption by prohibiting the purchase of any alcohol on the non-cash component of the Card.

### 5.1.1 Key findings

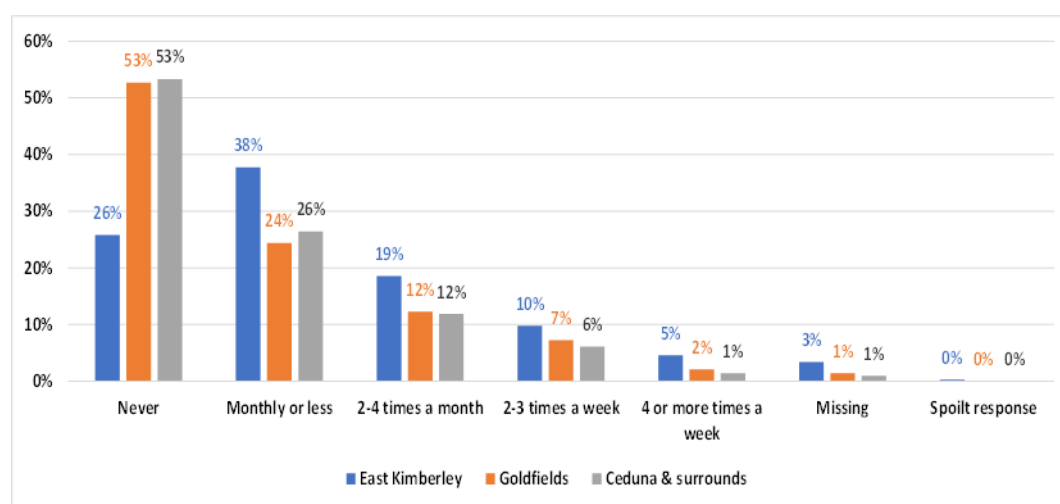
- Forty-six per cent of all CDC participants reported never consuming alcohol. Only 26 per cent reporting never drinking in East Kimberley but over 50 per cent did so in both Ceduna and the Goldfields.
- Alcohol consumption was reported to have been reduced since the introduction of the CDC by between one third and a half for the CDC participants who drink.
- Reported frequency of drinking was down by 11 per cent, the amount of drinking was down by 14 per cent and both frequency and amount were down by 11 per cent.
- Where there was more reduction in the frequency of drinking, there was also more reduction in the amount consumed at any one time. Relevant policies can influence both aspects.
- The CDC has come in the midst of several long-standing policy efforts to reduce alcohol consumption and it was very hard to separate the impact of individual policies.
- East Kimberley was in a much worse position regarding alcohol use and misuse at the start of the CDC and has seen the strongest reduction.
- Ceduna and the Goldfields were in a much better position at the start of the CDC and have seen a weaker reduction.
- Indigenous CDC participants were more likely than non-Indigenous participants to report a reduction in alcohol consumption. This was most prominent in the Goldfields.
- Alcohol-related aggression, violence and trauma (both self-inflicted and towards others) was also reported to have lessened since the implementation of the CDC.
- Depending on the definition and the method of risk assessment used, there were between one in 10 and two in 10 CDC participants who reported the problematic drinking behaviours the CDC aims to influence.
- Multivariate analysis provided a wide range of profiling about the demographics and the circumstances surrounding alcohol consumption and the potential impact of the CDC.
- Reductions in alcohol consumption have been notably more successful among women, families with or without children and Indigenous people, as well as in remote areas.
- CDC participants were reported to still be able to access alcoholic drinks through the use of the cash component of the CDC and through card workarounds, but at a higher cost to them.

## 5.1.2 Evidence from large scale survey

The quantitative survey of CDC participants included a range of questions about alcohol. The first major objective of the survey was to establish how many people drink alcohol at all and when they drink, how risky and harmful their behaviour is. For those who drink alcohol, the survey established the amount they usually drink at any one time and how frequently they drink. It also collected data using the AUDIT index as an estimate for the riskiness of individual alcohol consumption.<sup>39</sup> Finally, the survey collected very rich information on demographic and socioeconomic conditions that may be associated with many aspects of drinking.

Forty-six per cent of all CDC participants in all three trial sites indicated that they never drink alcohol, 52 per cent of whom were women and 37 per cent were men. There are notable differences between East Kimberley and the other two trial sites in the reported frequency of alcohol consumption (26 per cent in East Kimberley compared to just below 53 per cent in the Goldfields and just above 53 per cent in Ceduna and surrounds). Figure 5-1 below shows the frequency of drinking by trial site.

Figure 5-1: Frequency of alcohol consumption, by trial site



*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Responses are considered as 'spoilt' where respondents tick more than one choice to a question that requires only one answer and as 'missing' when an answer is required but not provided.*

Of the 54 per cent who reported drinking, there are notable differences between East Kimberley and the other trial sites in the amount of alcohol consumed “on a usual drinking day”, shown in Table 5-1, with East Kimberley reporting greater frequency of high levels of drinking.<sup>40</sup>

<sup>39</sup> For further information on this index see Quantitative Supplementary Report.

<sup>40</sup> We note the reported high frequency of having 10 drinks or more in East Kimberley and discuss possible explanations and caveats below. This finding is worth further investigation.



Table 5-1: Amount of alcohol consumed on a usual drinking day, by trial site

Amount of alcohol consumed on a usual drinking day								
	All sites		East Kimberley		Goldfields		Ceduna & surrounds	
	N	%	N	%	N	%	N	%
<b>1-2 Drinks</b>	610	<b>19</b>	80	<b>7</b>	438	<b>26</b>	91	<b>21</b>
<b>3-4 Drinks</b>	654	<b>20</b>	160	<b>13</b>	396	<b>24</b>	98	<b>22</b>
<b>5-6 Drinks</b>	643	<b>20</b>	179	<b>15</b>	367	<b>22</b>	96	<b>22</b>
<b>7-9 Drinks</b>	302	<b>9</b>	121	<b>10</b>	130	<b>8</b>	51	<b>12</b>
<b>10 or more</b>	889	<b>27</b>	588	<b>50</b>	228	<b>14</b>	74	<b>17</b>
<b>Missing information</b>	135	<b>4</b>	56	<b>5</b>	58	<b>4</b>	21	<b>5</b>
<b>Spoilt response</b>	48	<b>1</b>	0	<b>0</b>	40	<b>2</b>	8	<b>2</b>
<b>Total</b>	<b>3,280</b>	<b>100</b>	<b>1,185</b>	<b>100</b>	<b>1,658</b>	<b>100</b>	<b>438</b>	<b>100</b>

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Responses are considered as 'spoilt' where respondents tick more than one choice to a question that requires only one answer and as 'missing' when an answer is required but not provided.*

Amongst those who consumed alcohol, 36 per cent reported consuming seven drinks or more at any one time. Around a fifth of the CDC population in the three trial sites considered by this evaluation have reported high level problem drinking behaviours that the CDC aims to reduce.<sup>41</sup>

The Quantitative Supplementary Report examines how these aspects of alcohol consumption may differ by several pertinent factors such as household type, gender, age, Indigenous status, employment status, where alcohol is consumed, and where alcohol is obtained.

### 5.1.2.1 Change following the introduction of the CDC

The quantitative survey collected information about how the consumption of alcohol may have changed since the time that the CDC was implemented, by comparing reported consumption of the "before" and "after" type.<sup>42</sup> However, for the purposes of the present exercise, the quantitative survey also asked direct questions about the impact of the CDC on levels of alcohol consumption for the individual, their family, their friends and the area they live in.

Overall, reduction in alcohol consumption (Table 5-2) is considerable. Twenty-five per cent of all those who drink reported that they have reduced the amount they drink at any one time since the introduction of the CDC. Twenty-two per cent reduced the number of times they drink, 8 per cent consumed more low-alcohol drinks and 6 per cent stopped drinking altogether since the introduction of the CDC. This means that, notwithstanding the important interpretation caveat about the potential impacts of concurrent policies, at the time of the survey between a third and a half of the total CDC participant population surveyed and who consumed alcohol, have changed the way they do this.

<sup>41</sup> Problematic drinking is defined using the AUDIT score, as explained in the Quantitative Supplementary Report.

<sup>42</sup> It is widely recognised that any observed change over time that is measured this way will contain the individual impact of the CDC policy, but it will also contain the individual (and possibly independent of the CDC) impacts of other concurrent policies, as well as their possible interactions with the CDC policy. Further longitudinal data collections will be required to overcome this identification problem and the quantitative survey has been commissioned to offer a design that can continue with a second wave of data collection.

Table 5-2: Since being on the CDC, change in alcohol consumption of those who reported they drink alcohol, all trial sites

Since being on the CDC, changes in alcohol consumption			
	No	Yes	%
Reduced amount of alcohol	2,458	822	25
Reduced frequency of drinking	2,552	728	22
Consumed more low-alcohol drinks	3,029	251	8
Stopped drinking all together	3,093	187	6
None of the above	1,488	1,792	55

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. It is critical to read this table noting that the percentages refer to those who reported that they drink alcohol and not to the whole population. Percentages add to 116, which is more than 100 because survey respondents were allowed to select all categories that applied to them and 16 per cent of them did so.*

The quantitative survey provided rich information about the specific ways and circumstances that this change in alcohol consumption is occurring. A critical aspect of the change is the degree to which the reduction in the amount and the reduction in the frequency of alcohol consumption may work with or against each other in practice. This is important to consider as, in order to address the social harm caused by alcohol misuse, the CDC aims to reduce both the amount and frequency of alcohol consumption.

Looking at the total instances where CDC participants reported that they drink alcohol, Table 5-3 shows three combinations of reduction:

- 14 per cent of cases indicate a reduction in the amount but not the frequency;
- 11 per cent of cases indicate a reduction in the frequency but not the amount; and
- 11 per cent of cases indicate a reduction in both the amount and the frequency.

These estimates suggest that there is substantial interaction between the two potential responses to the CDC. Of the 22 per cent who drink less frequently, half (11 per cent) also drink a lesser amount each time they drink. Of the 25 per cent who reduced the amount they drink, just less than half (11 per cent) also drink less frequently. Thus, there appears to be a synergy in whatever it is that makes for these reductions, as we observed a sizeable proportion of CDC participants who experienced a reduction in both the frequency and the amount of alcohol consumption. This is a noteworthy finding, as it shows that a reduction is reported in both the amount and the frequency of alcohol consumption since the introduction of the CDC, but that the two outcomes are not one and the same.

Table 5-3: Since being on the CDC, change in frequency and amount of alcohol consumption (joint distribution), all trial sites

Since being on the CDC, change in frequency and amount of alcohol consumption						
Reduced amount of alcohol consumed	Reduced frequency of drinking					
	No		Yes		Total	
	N	%	N	%	N	%
No	2,084	64	375	11	2,458	75
Yes	468	14	353	11	822	25
Total	2,552	78	728	22	3,280	100

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Having established the overall level of reduction in alcohol consumption since the introduction of the CDC trial, we present these reductions by trial site in Table 5-4. Given the different starting points explained in the previous section (where East Kimberley presented a much worse picture regarding alcohol consumption, both in terms of frequency and amount), the proportion of CDC participants reporting changes in their alcohol consumption are considerably higher in East Kimberley than in Ceduna and the Goldfields trial sites.<sup>43</sup>

Table 5-4: Changes in alcohol consumption of those who reported they drink alcohol, by trial site

Changes in alcohol consumption, since being on the CDC				
	East Kimberley	Goldfields	Ceduna & surrounds	Total
	%	%	%	%
Reduced amount of alcohol at any one time	29	23	22	25
Reduced frequency of drinking	24	21	22	22
Consumed more low-alcohol drinks	9	7	6	8
Stopped drinking all together	3	7	9	6
None of the above	52	57	52	55

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Percentages refer to those who stated that they drink. These are 72 per cent in East Kimberley, 45 per cent in the Goldfields and 45 per cent in Ceduna and surrounds.

<sup>43</sup> It is critical to read Table 5-4 with care, noting that the percentages refer to those who stated that they drink shown in Figure 5-1. These are 72 per cent in East Kimberley, 45 per cent in Goldfields and 45 per cent in Ceduna and surrounds, noting the small percentage of missing and spoilt responses and the unavoidable rounding of percentages. The number of cases as a proportion of the total population of CDC participants will be much larger in East Kimberley where 74 per cent reported they drink than in the other two trial areas where 45 per cent reported they drink. For example, 21 per cent of all CDC participants in East Kimberley have reported that they reduced the amount of alcohol they consume at any one time (this is 29 per cent of the 74 per cent who drink), compared with 10 per cent of all CDC participants in the Goldfields (23 per cent of the 45 per cent who drink) and 10 per cent in Ceduna and surrounds (22 per cent of the 45 per cent who reported they drink). Using Ceduna and surrounds data as our example we see the two separate messages that are offered. The 22 per cent speaks for the extent of the change that happens among those who belong to the relevant behavioural group (those 45 per cent who drink). The 10 per cent speaks for the extent of the change in the overall population.

Further analysis by site reveals that in East Kimberley 13 per cent of the CDC participants who indicated they consume alcohol have reduced both the amount and the frequency of consumption, 12 per cent have reduced the frequency of alcohol consumption only and 16 per cent have reduced the amount they drink at any one time only. Altogether, 41 per cent of the CDC participants who consume alcohol have reduced their intake of alcohol in some form. In addition, 3 per cent have stopped drinking altogether.

In the Goldfields site, 10 per cent of the CDC participants who indicated they consume alcohol have reduced both the amount and the frequency of consumption, 10 per cent have reduced the frequency of alcohol consumption only, and 13 per cent have reduced the amount they drink at any one time only. Altogether, 33 per cent of the CDC participants who consume alcohol have reduced their intake of alcohol with a further 7 per cent having stopped drinking altogether.

In the Ceduna and surrounds site, 7 per cent of the CDC participants who reported they consume alcohol have reduced both the amount and the frequency of consumption, 15 per cent have reduced the frequency of alcohol consumption only, and 15 per cent have reduced the amount they drink at any one time only. Altogether, 37 per cent of the CDC participants who consume alcohol have reduced their intake of alcohol. In addition, 9 per cent have stopped drinking altogether.

The quantitative survey also put forward to all CDC participants a direct question irrespective of their own drinking status, starting with “Is the Cashless Debit Card making a difference for You, Your family, Your friends, and Where you live?” and asked whether “The Cashless Debit Card helps decrease alcohol consumption”.<sup>44</sup>

Responses to this direct question are presented in two panels in Table 5-5. The first Panel A shows how all CDC participants responded to this question, drawing on the main distinction being those who reported that they saw a positive difference (27.5 per cent for all trial sites), those who reported that they saw no difference (47.3 per cent for all trial sites) and those who either reported they did not know or did not answer at all (25.2 per cent for all trial sites). The second Panel B focuses only on those participants who saw a positive difference and shows the type of difference (You, Your family, Your friends, and Where you live), noting that the question allowed multiple responses. Using the whole of the trial sites in the leftmost column of Table 5-5, Panel B as an example, we see that 44.6 per cent saw a positive difference for themselves, 44.2 per cent saw a positive difference for their families, 33.6 per cent for their friends and 55.3 per cent where they live. We note that the percentages in brackets are the proportion of those who reported the specific positive difference among those who reported at least one positive difference (that is, 1,658 CDC participants) and not the proportion of the whole population. To clarify this important distinction, Panel B reports the total number of respondents who saw a positive difference (which is 1,658), the total number of responses (which is 2,946) and the average number of instances of positive difference reported per CDC participant (1.78).

As we will be using the same table format as Table 5-5 several times below in this section on other outcomes, it is worth explaining its contents in some detail. Panel A is reporting strictly the number of people and their responses to this question (with a total weighted sample of 6,039 people). Of those, 27.5 per cent (that is, 1,658 people) ticked at least one of the four boxes of the four outcomes that are presented in Panel B. But as these people were allowed to tick as many of the four boxes as they saw relevant, Panel B reported the instances that each box was ticked. Thus, we see that 739 persons

---

<sup>44</sup> The same direct question has been asked about decreasing the use of illicit drugs, reducing gambling problems, improving money management and improving the quality of life. These questions are asking directly whether these positive outcomes have been identified by the survey respondent.

ticked “You”, 733 ticked “Your family” and so on. We note that there were 2,946 ticks in total, with an average of 1.78 ticks per person. We must stress that the percentages in Panel B refer to the proportion of those who reported a specific category among all those who reported at least one positive change (for example 739 is 44.6 per cent of the 1,658), and not to the whole population of CDC participants.

Table 5-5: Has the CDC helped decrease alcohol consumption, by trial site

The CDC helps decrease alcohol consumption										
Panel A (full sample who were asked the question)										
	All sites		East Kimberley		Goldfields Indigenous		Goldfields Non-Indigenous		Ceduna & surrounds	
The CDC has made a:	%		%		%		%		%	
Positive difference	27.5		29.4		33.8		19.3		29.2	
No difference	47.3		56.7		33.4		52.9		44.6	
Don't know/missing	25.2		13.9		32.9		27.9		26.2	
Total sample (N)	6,039		1,597		1,655		1,848		939	
Panel B (sub-sample of 27.5% who saw at least one positive difference)										
For:	N	%	N	%	N	%	N	%	N	%
You	739	44.6	313	66.9	212	37.9	105	29.4	109	39.6
Your family	733	44.2	291	62.2	259	46.3	35	9.9	148	53.8
Your friends	557	33.6	252	53.8	178	31.9	36	10.2	91	33.0
Where you live	917	55.3	251	53.6	281	50.3	248	69.8	136	49.5
Total respondents	1,658	100	469	100	559	100	356	100	274	100
Total responses	2,946		1,108		932		425		483	
Responses per person	1.78		2.36		1.66		1.19		1.76	

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Table 5-5 also shows that the reported difference the CDC made regarding alcohol consumption varied by trial site. In the Goldfields, a larger positive difference was reported by Indigenous than by non-Indigenous CDC participants. Further examination of the data showed interesting differences, such as, for example, that in East Kimberley and Ceduna the answers were more positive for females. Further analysis of this question was therefore conducted using multivariate regression and is reported in the next section.

### 5.1.2.2 *Characteristics of CDC participants who report a reduction in alcohol consumption since the introduction of the CDC*

Using multivariate regression analysis, we estimated the characteristics of CDC participants who reported a reduction in alcohol consumption since the introduction of the CDC.<sup>45</sup> The quantitative survey includes the AUDIT questions developed by the World Health Organisation (WHO). We used the AUDIT questions in order to categorise CDC participants according to their level of potentially harmful drinking behaviour (low risk, moderate, high, very high). In particular, we wanted to see if the CDC improves alcohol consumption for those that are most at risk. The key findings from the multivariate regression analysis are presented in Box 5.1 below:

#### Box 5.1: Who is more likely to report a decrease in alcohol consumption due to the CDC

- A higher proportion of CDC participants in the Ceduna region (49 per cent) reported that the CDC had a positive impact on reducing alcohol consumption for either themselves, their family, their friends or in the area in which they lived. East Kimberley had the lowest proportion with only 28 per cent of CDC participants reporting a positive impact on alcohol consumption. Goldfields had 34 per cent of CDC participants reporting a positive impact on alcohol consumption for either themselves, their family, their friends or in the area in which they lived.
- After controlling for demographic characteristics, reported reductions in CDC participants' own alcohol consumption appeared similar in all three sites.
- The CDC was reported to have had a much higher impact in terms of reducing alcohol consumption for those targeted by the policy. Participants in the high risk AUDIT category were 44 per cent likely to report a reduction (for either themselves, their family, their friends or in the area in which they lived) against a probability of 23 per cent by everyone else.
- Those living alone were the least likely to experience a reduction in alcohol consumption (21 per cent) and families with or without children were the most likely to see a reduction (34 per cent).
- The estimated probability of Indigenous CDC participants reporting a reduction in alcohol consumption was 31 per cent, compared to 21 per cent for non-Indigenous CDC participants.
- The estimated probability of female CDC participants reporting a reduction in alcohol consumption was 30 per cent, compared to 25 per cent for their male counterparts. There was no gender difference in the reported reduction in own consumption (11 per cent).
- The estimated probability of CDC participants who were employed in the last four weeks (including work for the dole) reporting a reduction in alcohol consumption was 33 per cent, compared to 26 per cent for non-employed CDC participants.
- Having experienced problems using the Card was associated with a lower probability of reporting reduced alcohol consumption (23 per cent) than those not reporting problems (32 per cent).

---

<sup>45</sup> Using multivariate analysis, we looked at the characteristics of CDC participants who reported that the CDC had a positive impact on alcohol consumption. We used two models. The first model estimated the probability that CDC participants may report a positive impact of the CDC on alcohol consumption for any of the four possible categories: themselves, their family, friends, or in the community they live in. The second model conducted the same estimation, but only for the potential help to reduce own alcohol consumption.

- Where there was financial stress prior to the CDC, the introduction of the CDC was more likely to have reduced alcohol consumption.
- There is weak evidence that the longer a participant has been on the CDC the more likely they were to report reductions in alcohol consumption.
- There were no statistically discernible age differences in reporting a reduction in alcohol consumption.

### 5.1.3 Evidence from in-depth interviews with Stakeholders and Participants

The qualitative research uncovered little consensus as to whether the CDC is fulfilling its intended aim of reducing the social harm caused by alcohol misuse. Respondents were evenly divided as to whether or not the implementation of the CDC had contributed to any beneficial impacts on levels of alcohol misuse in each of the trial sites (further details are provided in the Qualitative Supplementary Report).

While it was acknowledged that alcohol misuse continued to be a problematic issue in each of the three trial sites, around half of all respondents reported that the CDC had led to positive change including decreased spending on alcoholic beverages. Within the Goldfields, improvements were particularly centred on the smaller communities outside of Kalgoorlie-Boulder. As a result of the restrictions placed on the purchase of alcohol under the CDC alongside the placing of funds onto the Card, it was considered by interview respondents to be more challenging to spend money on alcohol. Consequently, some CDC participants were described as now prioritising their spending on essential items such as food and purchases for their children rather than on alcohol.

*In that 15 years we would have tried 50 or 60 different initiatives to try and address these problems. To me, this one [CDC] is the key. The key is if you haven't got money that you can spend on drugs and alcohol, then you spend it far more sensibly. I stand by that. SH18C*

Levels of alcohol consumption were therefore reported by some respondents as having reduced since the commencement of the CDC trial. This was illustrated by some of the CDC participants interviewed who provided personal stories of themselves or close family members having slowed down or stopped their drinking as a result of the CDC. Examples were also given by stakeholders of clients who had experienced improvements in their drinking behaviour.

*'Cause I was a bad drinker, sometimes I couldn't control how I spent my money and stuff. So, I would waste it and then sober up and think, "Where's all my money gone?" I think now, on the Indue, I find it good for me 'cause I still have that money there if I spend all my cash...I probably drink once a week. P59EK*

Aligned with a perceived decrease in alcohol consumption, some respondents described that there had been a considerable reduction in the incidence of public drunkenness in all three trial sites. Alcohol-related aggression, violence and trauma (both self-inflicted and towards others) was also reported to have lessened since the implementation of the CDC. It was recognised (most commonly by stakeholder representatives), however, that other interventions to address problematic drinking behaviour had also been occurring alongside the CDC within all three regions. Perceived reductions in alcohol misuse were considered by many of these respondents to have been the result of the CDC and other local interventions working in tandem.

*I think it's successful beyond our wildest dreams...I could go for a month and not hear anything about fighting, brawling, domestic violence, alcohol abuse...Look out the window, walk down the street...They're not drunk. SH01C*

*We've got very strict rules around that [public drinking] anyway in Kalgoorlie and they're really well enforced. I think going back to the police presence in the community, you know and also we have a Safe Streets patrol...It's actually quite rare to see disruption in the community than when I was here maybe 18 months to two years ago. The same things would erupt and there*



*would be shouting and fights and all the rest of it. But again, is that part of the card or is that really the fact that the police are there? SH15GF*

In contrast, a further half of all respondents felt that access to alcohol and levels of alcohol misuse in the CDC trial site regions were unaffected by the CDC. Public drunkenness was still said by interview respondents to be occurring, and the resulting social harm associated with this continuing. Despite the CDC restricting the amount of money one could use to purchase alcohol, CDC participants were reported to still be able to access alcoholic drinks, e.g. through the use of the cash component of the CDC and card workarounds (further details are provided in the Qualitative Supplementary Report). It was also acknowledged by some respondents (mostly stakeholder representatives) that influxes of people into the trial site from neighbouring Aboriginal communities not participating in the CDC was contributing to continuing issues with alcohol misuse in the region.

*Right now we've got two re-burials and we've got a lot of people from out of town, there's been a lot more increase in, I don't know about violence, but certainly around alcohol. Alcohol has spiked and we've got a lot more problems happening. SH31GF*

For these respondents, the CDC was not seen as effectively addressing problematic alcohol consumption and associated social harm in the region. In order to overcome their addictions, it was noted that people had to first want to change their own behaviour. The CDC by itself was therefore perceived to be unable to impose lasting change for those with entrenched alcohol problems. Furthermore, the need for wraparound services which could address the underlying reasons for alcohol addiction was recommended by some stakeholder representatives.

*They never stop anyone from their drinking, no. And they're still the same problem there. This is like the government using it as a Band-Aid to say they're doing something about our so-called problem. P64EK*

*What things like the cashless card doesn't do, is that it doesn't recognise addiction. So, it just makes the assumption that if you limit the amount of cash available for alcohol or drugs or whatever, then you're going to stop a person from being addicted. Well that doesn't work. Because people who are addicted or are used to a certain pattern of behaviour around drinking or taking drugs are going to find other ways of doing it regardless of what's in place...When people are ready to change, they'll want to make a change. SH03C*

#### **5.1.4 Integration of evidence**

Both the qualitative interviews and the quantitative survey suggest that since the introduction of the CDC there has been a reduction in alcohol consumption in all trial sites. Largely, the two sources of evidence are telling us a consistent story. As we say elsewhere, whilst we do not have reservations in reporting that alcohol consumption has been decreasing since the implementation of the CDC in the trial sites (more so for some participants than for others), we cannot be sure whether and how much this reduction can be attributed to the CDC. This is where the qualitative evidence provides valuable additional information with specific examples provided by CDC participants on how the CDC has caused alcohol consumption to decrease.

The qualitative evidence also supports the quantitative findings that suggest that reduced alcohol consumption also results in a reduction in other harmful behaviours and social outcomes that follow. As we see, the question of whether the CDC helps reduce alcohol consumption “where you live” is answered in the affirmative by many and in all trial sites. Whilst the quantitative evidence reports

widespread improvements on the alcohol reduction front, the qualitative evidence uncovers dissenting voices and that not all is fine. These dissenting voices are a reminder of the relative inability of the quantitative survey to trace with accuracy smaller groups of strong opinions.

There is a large majority of people in this evaluation who report that they do not drink at all, or who drink only moderately. It is important to note that when it comes to the behavioural responses that the CDC aims at regarding alcohol, this large majority of the CDC participants has nothing to do with the behavioural change (of reducing alcohol consumption, especially the misuse of alcohol) the CDC seeks to achieve. The qualitative research highlights the frustration these people feel in being subjected to the same constraints which aim to reduce problematic drinking (see section 5.9 and section 6.3.3).

### **5.1.5 The evidence base**

The quantitative survey data provided a strong base for comparisons between the three sites and for analysing changes in terms of alcohol consumption after the introduction of the CDC. The lack of a control group is problematic. The quantitative evidence on alcohol was not hindered too much by the issue of potential lack of trust between the interviewer and interviewee, largely because of the strong and cooperative situation created during the fielding of the survey. This was achieved by the extensive, culturally sensitive and inclusive stakeholder engagement strategy that was implemented throughout the project. The one disappointing element of the data collection has been the scarcity of community-level data. Despite some valiant efforts from both DSS and the two states of South Australia and Western Australia, useable community-level data on alcohol consumption and harmful behaviours was not available. We note the use of the DOMINO data for preparing accurate population weights for the report.

### **5.1.6 Observations, limitations and caveats**

Whilst we observed a clear reduction in alcohol consumption in all three trial sites since the introduction of the CDC, we cannot unambiguously attribute this change to the CDC. Where there are other policies that are concurrently aiming for the same outcome, sometimes in the same area and sometimes for the same people, it is difficult to distinguish between them and their outcomes, for example, the various Alcohol Accords operating in each trial site. In principle, we would need data to be developed in two main directions. First, we would want to have longitudinal data, which observes accurately how one policy develops for a given group of people over time. This data describes how each individual responds to the policy over time. Ideally, one wants to have observed these individuals some time before the policy commenced and sometime after. This data is made to measure the “before-after” change for those who are in the policy. As we do not have true longitudinal data at our disposal, we asked several retrospective questions and have a design of survey that could be rolled into a second wave at a later date.

Second, we would want to have data on parts of the population that have not been subjected to the policy we are evaluating. This is typically called control group data and it also needs to contain time variation, preferably spanning over the same calendar period as the before-after data for the trial site. The problems introduced by the lack of a control group can be ameliorated by introducing very rich information in the trial group and possibly utilising external data sets, the latter being the poorer substitute of the two.

The combination of longitudinal data and control group data would allow us to construct the basic difference-in-difference structure and estimate impacts.

One additional problem we have in the case of assessing harmful behaviours, is that in most instances a new policy is introduced in the same space where policies may have operated in the past or even be operating presently. The implication is that it becomes very difficult to identify which of the many policies in operation is causing any change we observe. This problem of “identification” is ever-present in policy evaluation data, including the data used in this evaluation. Another problem that we face in the case of assessing harmful and illegal behaviours is that reporting can be severely biased towards not reporting or under-reporting, in ways that can be difficult to model. These problems are mentioned in this section as a reminder to the reader of the fundamental difficulties in deriving precise impact estimates. In this work they are in part ameliorated through the use of a mix of qualitative and quantitative evidence. The qualitative evidence triangulation can be of great help to overcome some of the interpretational uncertainties and we certainly use the qualitative information to understand the quantitative data as extensively as possible.

Finally, we note the higher proportion of excessive drinking in East Kimberley when compared with both Ceduna and the Goldfields. Looked at in isolation, excessive drinking in East Kimberley was a lot more prevalent than in the Goldfields and Ceduna for reasons that need further explanation than what is provided by our data. First, we note that the Alcohol Accord is stricter in Ceduna and this may offer part of an explanation. Second, we note the reported consumption of and concern about some illegal drugs in the Goldfields is higher than in East Kimberley. These two considerations suggest that the easier outlet for substance abuse in East Kimberley may be alcohol, while in the Goldfields illegal drugs may be easier to come by. Combined, this thinking may provide a partial explanation of the differences between East Kimberley (with a higher alcohol problem and concern and lower drugs problem and concern) and the other two trial sites. We note the need for further investigation and evidence on this matter, especially through the use of a longitudinal methodology.

### 5.1.7 Summary

We found consistent and clear evidence that alcohol consumption had reduced for some participants since the introduction of the CDC in the trial sites. With the current evidence it is not possible to attribute these changes to the CDC alone. They can be attributed, however, to the full complement of the policies in operation in the trial areas at the time of this evaluation.

## 5.2 Drug use and misuse

The CDC aims to reduce personal and social harm caused by illicit drug use and misuse directly by reducing the amount of cash available to participants thus making it harder for them to purchase illicit drugs.

### 5.2.1 Key findings

- There was strong agreement among CDC participants and stakeholders that the two substances that cause the most problems within the trial sites are alcohol and meth/amphetamines, with marijuana/cannabis a long way behind the top two.
- Among Indigenous CDC participants in all trial sites, alcohol was the substance reported to be most problematic.
- Among non-Indigenous CDC participants, meth/amphetamines come at the top, but was closely followed by alcohol.
- East Kimberley reported the biggest alcohol problem and the smallest meth/amphetamine problem.
- The Goldfields site was divided with Indigenous CDC participants naming alcohol as the biggest problem and non-Indigenous naming meth/amphetamines, but just.
- Ceduna reported a strong alcohol problem and a sizable meth/amphetamine problem.
- Around 20 per cent of all CDC participants report that the CDC has helped decrease illicit drug use for themselves, family, friends and community in all trial sites.
- The inter-connectedness between alcohol and meth/amphetamine misuse was evident throughout all trial sites.
- The reported decrease in illicit drug use was highest among the Goldfields/Indigenous CDC participants, followed closely by participants in East Kimberley and Ceduna.
- The reported decrease in illicit drug use was lowest among the Goldfields/non-Indigenous CDC participants.
- Among CDC participants, females, Indigenous, members of a family (with or without dependents), young, or on Newstart Allowance were *more* likely to report a decrease in illicit drug use.
- Among CDC participants, males, older, singles, were *less* likely to report a decrease in illicit drug use.
- Qualitative and quantitative evidence delivered the same mixed and inconclusive message about the impact of the CDC on illicit drug use, namely that, although we see some reporting a decrease, there is no definitive conclusion to be made on the harm reduction front.

## 5.2.2 Evidence from large scale survey

The quantitative survey asked questions that aimed to elicit distinct types of information about illicit drugs. First, about the use, second, about the harm, third, about the CDC impact and finally a number of general questions about personal attitudes towards drug use.

Information about individual consumption of prohibited substances such as drugs through a survey is difficult and inaccurate to collect. The dedicated literature highlights that survey respondents systematically under-report the level of their involvement with, and consumption of illegal drugs. Being aware of these issues and expecting that trying to measure drug consumption from the CDC participants may antagonise respondents and prevent us from getting responses on the many other domains covered by the survey, we opted for a softer and less direct strategy as described below.

The survey therefore asked few direct use questions and instead focused on a range of questions about how CDC participants feel about drugs, if they cause harm and where the CDC may be changing things related to drugs. These included questions which tried to tease out some information about which drugs CDC participants consider as being the most widespread in their community and the drugs that cause the most problems in the area where they live. They also included questions designed to elicit their general views about drugs, whether they consider it acceptable for adults to consume a range of drugs, whether some drugs should be legalised, and whether they think the existing penalties around dealing with drugs in Australia are adequate. On the whole, this strategy has proven effective and good response rates were achieved for the indirect questions.

Specifically, CDC participants were asked:

- about their use of illegal drugs, their related spending, and if they borrow money or sell things to get money to buy drugs. As expected, these questions were probably under-reported;
- to identify the drugs that cause the most problems in the area where they live. Good response rates were achieved for these questions;
- if the CDC helped decrease the use of illicit drugs, bringing change to them personally, to their families, to their friends and in the area where they live; and
- a host of questions about the attitudes of CDC participants towards drugs. These attitudinal questions aimed to help benchmarking with the national picture and follow closely the relevant questions asked by the NDSHS.

This section focusses on the identification of the drugs that are considered most problematic and on the capacity of the CDC to decrease the use of illicit drugs. All remaining questions are examined in the Quantitative Supplementary Report.

### 5.2.2.1 *Illicit drugs that cause the most problems*

The quantitative survey presented the following list of drugs to CDC participants and asked them to choose the one category that causes the most problems in the area where they live: Alcohol; Tobacco; Marijuana/Cannabis; Meth/amphetamine; Cocaine; Ecstasy; Heroin; Pain-relievers and Opioids; Methadone/Buprenorphine; Steroids, or none of these.<sup>46</sup> Table 5-6 below shows the drugs that were

---

<sup>46</sup> The inclusion of alcohol and tobacco was considered appropriate after broad consultation with stakeholders and in recognition of their interdependence. It was also the appropriate choice for retaining comparability with the NDSHS.

reported to cause the most problems, first for the whole of CDC participants, then by Indigenous status and gender.

Table 5-6: Most problematic drug in the area you live, by Indigenous status and gender

Most problematic drug in the area					
	All	Indigenous	Non-Indigenous	Male	Female
	%	%	%	%	%
<b>Excessive drinking of alcohol</b>	28.4	29.3	26.8	30.4	26.9
<b>Tobacco smoking</b>	4.1	5.3	1.9	3.7	4.4
<b>Marijuana/Cannabis</b>	7.8	9.5	4.7	7.1	8.2
<b>Meth/Amphetamine</b>	17.7	11.8	28.2	18.7	16.9
<b>Other drugs</b>	2.3	1.6	3.6	2.4	2.2
<b>None stated</b>	39.8	42.6	34.9	37.6	41.5
<b>Total (N)</b>	<b>6,039</b>	<b>3,898</b>	<b>2,141</b>	<b>2,589</b>	<b>3,450</b>

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Only one answer was allowed per respondent.*

Throughout the trial areas, alcohol was considered by most people as the drug that causes the most problems with 28.4 per cent of all CDC participants naming it as their top choice. Meth/amphetamines were second (17.7 per cent), followed by Cannabis (7.8 per cent), Tobacco (4.1 per cent) and all other drugs together last (2.3 per cent).<sup>47</sup> The category “None stated” was chosen by a large proportion of the CDC participants.

Thus, the broad picture that emerged is that about three in ten CDC participants reported that alcohol was the worst problem, about two in ten that meth/amphetamines were the worst problem, just over one in ten that smoking (tobacco or cannabis) was the worst, a very small number of CDC participants thought that some other drug was the worst and about four in ten either had no view or expressed too many views.<sup>48</sup> We note that the views on alcohol were relatively evenly spread across Indigenous and non-Indigenous, as well as across male and female CDC participants. We note the substantially higher concentration of negative meth/amphetamine views among the non-Indigenous CDC participants.

A more informative way to look at these statistics is by including (temporarily) in the sample only those who expressed a view and reported what they thought was the most problematic drug. Table 5-7 below presents these numbers and percentages (however, the bottom row shows the total number of observations in brackets, for complete transparency of the calculations).

Of those who expressed a view, just under half (47.2 per cent) considered alcohol as the worst problem and just under one third (29.3 per cent) meth/amphetamines. Clearly, cannabis can be a

<sup>47</sup> Having used the NDSHS listing, we think that some specific practices, such as petrol sniffing and similar, are not covered by this question. We cannot know if these were included in “None stated/Not answered” responses.

<sup>48</sup> Over 90 per cent of those with missing answers to this survey instrument ticked several drugs causing the most problems in the area where they live while they were required to tick only one. Their answer was recoded as ‘none stated’ following the usual rule that applies when survey respondents do not follow the instructions.

major problem according to a sizable minority of 12.9 per cent of CDC participants. It is not clear why and how tobacco is the top choice of problematic drug for almost seven per cent of the respondents.<sup>49</sup>

Differences by trial site are pronounced in Table 5-7, reflecting and in line with differences observed in other aspects of the CDC. East Kimberley has by far the highest problem with alcohol and the Goldfields, especially the non-Indigenous CDC population, has the lowest problem with alcohol. The exact opposite holds with meth/amphetamines, which were considered highly problematic by the non-Indigenous Goldfields CDC population and far less so in East Kimberley. The fact that the Indigenous CDC participants reported meth/amphetamines to be seriously problematic (33 per cent respondents rank them the highest) suggests that meth/amphetamine use was considered to be a bigger problem in the Goldfields than elsewhere. It is of concern to see that Ceduna CDC participants reported such a high problem of meth/amphetamines (19 per cent respondents rank it the highest) whilst still having a strong problem with alcohol.

Table 5-7: Most problematic drug in the area you live, those with an opinion, by trial site

Most problematic drug in the area you live, those with an opinion					
	All sites	East Kimberley	Goldfields Indigenous	Goldfields Non-Indigenous	Ceduna & surrounds
Most problematic:	%	%	%	%	%
Excessive drinking of alcohol	47	67	43	37	48
Tobacco smoking	7	7	7	3	14
Marijuana/Cannabis	13	19	14	7	14
Meth/Amphetamine	29	7	33	47	19
Other drugs	4	1	3	6	6
With an opinion (N)	3,634	854	978	1,212	589
Total population (N)	6,039	1,597	1,655	1,848	939

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Goldfields is presented by Indigenous status. Percentages refer to only those who stated an opinion for the drug that causes the most problems (the difference between 6,039 and 3,634, which can be seen in Table 5-7 are the 39.8 per cent who did not state a drug). Similarly, we can calculate the number of those without an opinion in each area.*

While alcohol was highlighted as the drug causing the most problems in all trial sites, a large proportion of CDC participants agree (or strongly agree) with the statement that it is permissible for alcohol to be regularly used by adults, notably by 67 per cent of respondents in East Kimberley and 43 per cent in the other two trial sites.<sup>50</sup>

The two main drugs of concern were alcohol and meth/amphetamines, with cannabis being ranked by a small minority as the top problematic drug. There were large differences between the trial sites and by Indigenous status. The ubiquitous supply of alcohol is well known, but the obvious widespread concern about the use of meth/amphetamines in some trial areas is noteworthy.<sup>51</sup>

<sup>49</sup> It is possible that the health implications of tobacco are better understood and more personally relevant to these respondents or someone close to them.

<sup>50</sup> For more detail and analysis see the Quantitative Supplementary Report.

<sup>51</sup> As the question refers specifically to the area where people live, the reported problematic drugs will depend on all people and not only on CDC participants, including in some of the Goldfields areas fly-in, fly-out workers.



### 5.2.2.2 *Has the CDC helped decrease the use of illicit drugs?*

This subsection focusses on two aspects. First, reported personal use of illicit drugs and frequency of use, and second, how the CDC was reported to have influenced drug use of those living in the trial areas. We did this in two steps below. First, we asked CDC participants to answer two direct questions about the frequency of their own illicit drug use in two specific periods of time: (i) in the 12 months before being on the CDC and (ii) since being on the CDC. Second, and much later in the survey, CDC participants were asked whether the CDC is making a difference by helping to decrease illicit drug use. The question asked if the CDC has helped four categories of people: “You”, “Your family”, “Your friends”, and “Where you live”. The same question was asked about alcohol, as we reported in the previous section, allowing the survey respondents to tick as many categories as they thought relevant.

### 5.2.2.3 *Personal use of illicit drugs*

The reported incidence of personal drug use (as measured by CDC participants who reported that they used an illegal drug or prescription medicine for non-medical reasons in the 12 months before being on the CDC and since being on the CDC) was very low, both overall and across trial sites.<sup>52</sup> Overall, about 6 per cent of CDC participants reported using illicit drugs in the 12 months before being on the CDC and about 11 per cent reported using illicit drugs since being on the CDC. Of the 6 per cent who reported using illicit drugs in the 12 months before being on the CDC, about 60 per cent *were not* and 40 per cent *were* using since being on the CDC. Of the 11 per cent who were using since being on the CDC, about 80 per cent *were not* using and about 20 per cent *were* using before the CDC. Although the absolute numbers may be small, these percentages indicate a strong fluidity in behaviours when we contrast the 12 months prior to the CDC and the months after being on the CDC.<sup>53</sup>

The survey also asked all CDC participants to report their use of illicit drug, including the frequency of their use. A majority of those CDC respondents using illicit drugs reported using monthly or less than once a month (56 per cent in the 12 months before being on the CDC and 59 per cent since). Of those reporting using drugs, weekly, users accounted for 22 per cent of drug users in the 12 months before being on the CDC and 20 per cent since being on the CDC. Twenty-two per cent reported being daily or almost daily users in the 12 months before being on the CDC and since being on the CDC.

---

<sup>52</sup> The reader must keep in mind the small numbers in the case of drug use, which limit the precision of descriptive analysis and any figures reported should be interpreted with appropriate caution. We note that the percentages presented are an approximation of the broader picture. The reason is that some respondents who did (did not) answer the pre-CDC question did not (did) answer the post-CDC question, which allows for different statistics depending on how these cases of non-response to the specific question are treated. We can present numbers with, or without, these cases included. Here we have chosen to include them. Given the very small number of these cases the difference between the two ways to present the data are of no practical importance.

<sup>53</sup> A relatively consistent picture emerged from what was reported by those who answered the questions, however we note the possibility of under-reporting, as the reported drug use prevalence is well below any potentially comparable estimates for a 12-month period (e.g. both NDSHS and the HILDA survey data sets which report that 12.6 and 12 per cent of respondents respectively reported having used drugs at least once in the last 12 months). If one assumes that if CDC respondents reported that the CDC helps with decreasing their own illicit drug use, they had used illicit drugs at some time, this information, combined with the information reported by CDC participants as to personal drug use in the 12 months before the CDC and since the CDC, allowed us to approximate that around 13 per cent of the total population had used illicit drugs at some time. This approximation is more consistent with findings from both NDSHS and the HILDA survey data (see [https://melbourneinstitute.unimelb.edu.au/data/assets/pdf\\_file/0009/2944080/hdps118.pdf](https://melbourneinstitute.unimelb.edu.au/data/assets/pdf_file/0009/2944080/hdps118.pdf)). However, the reader should note that all figures presented in this report refer to only the evidence as reported by CDC participants in the survey.



In the 12 months before being on the CDC, incidence of illicit drug use was reported to be just under 5 per cent in East Kimberley, just under 6 per cent in Goldfields and just under 7 per cent in Ceduna. Similarly, since being on the CDC, Goldfields and Ceduna appear to have the highest incidence of illicit drug use (at just under 6 per cent) and East Kimberley the lowest at just under 4 per cent.

Of the small percentage of CDC participants who reported using illicit drugs throughout (that is, in the 12 months before being on the CDC *and* subsequently during their time on the CDC), the proportion of those who reported daily/almost daily use is indicative of the differences between the trial sites. In East Kimberley nobody reported daily/almost daily use.<sup>54</sup> In Ceduna and surrounds 19 per cent reported daily/almost daily use and in the Goldfields 30 per cent reported daily/almost daily use (the split being 19 per cent among Indigenous and 39 per cent among non-Indigenous CDC participants).<sup>55</sup>

#### 5.2.2.4 *How was the CDC reported to help reduce drug use in the trial areas?*

The second focus of our analyses is on whether CDC participants reported that the CDC had helped reduce the use of illicit drugs. This is presented in Table 5-8 below in the same format as Table 5-5 in the previous section on alcohol. Again we draw on the main distinction (Panel A) being those who reported that they saw a positive difference (20.8 per cent for all trial sites), those who reported that they saw no difference (47.6 per cent for all trial sites) and those who either reported they did not know or did not answer at all (31.6 per cent for all trial sites).

The second part of the table (Panel B) focuses only on those participants who saw a positive difference and shows the type of difference (You, Your family, Your friends, and Where you live), noting that the question allowed multiple responses. Using the whole of the trial sites in the leftmost column of Table 5-8, Panel B, we see that 35.8 per cent saw a positive difference for themselves, 39.1 per cent for their families, 35.8 per cent for their friends and 56.1 per cent for where they live.

---

<sup>54</sup> This finding cannot be interpreted to imply that there is no such use in East Kimberley. It means that the use is uncommon enough to not have been captured by the data.

<sup>55</sup> This evidence suggests that where meth/amphetamines are reported to be the worst problem we also find the highest percentage of CDC participants who are using 'daily/almost daily' and are more likely to be subject to addiction.

Table 5-8: Has the CDC helped decrease use of illicit drugs, by trial site

The CDC helps decrease use of illicit drugs										
Panel A (full sample who were asked the question)										
	All sites		East Kimberley		Goldfields Indigenous		Goldfields Non-Indigenous		Ceduna & surrounds	
The CDC has made a:	%		%		%		%		%	
Positive difference	20.8		21.4		27.5		13.1		23.2	
No difference	47.6		56.1		34.4		52.7		46.0	
Don't know/missing	31.6		22.5		38.1		34.2		30.8	
Total sample (N)	6,039		1,597		1,655		1,848		939	
Panel B (sub-sample of 20.8% who saw at least one positive difference)										
For:	N	%	N	%	N	%	N	%	N	%
You	450	35.8	184	53.8	131	28.9	65	26.9	70	31.9
Your family	492	39.1	194	56.7	179	42.7	194	80.0	99	42.2
Your friends	450	35.8	184	53.9	161	40.5	184	76.0	75	34.2
Where you live	705	56.1	198	58.0	246	43.6	198	81.8	109	49.8
Total respondents	1,257	100	342	100	455	100	242	100	218	100
Total responses	2,097		760		708		641		351	
Responses per person	1.67		2.22		1.56		2.65		1.61	

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Table 5-8 also shows that the reported difference the CDC made regarding illicit drug use varied by trial site. In the Goldfields, a larger positive difference was reported by Indigenous (27.5 per cent) than by non-Indigenous CDC participants who reported the lowest incidence of 13.1 per cent. Similar proportions of CDC participants in East Kimberley (21.4 per cent) and Ceduna (23.2 per cent) reported a positive difference. Further examination of the data (presented in Panel B) shows interesting patterns in reporting. The proportions reported for each of the four options are relatively evenly distributed in East Kimberley, suggesting that the decrease in illicit drug use was perceived to be a general finding. In contrast, there was more variation in the reporting by Indigenous CDC participants living in the Goldfields and Ceduna. However, non-Indigenous CDC participants in the Goldfields reported a considerably higher positive difference for their family, friends and where they live relative to a positive but lower difference for themselves than do CDC participants in East Kimberley, Ceduna and their Indigenous Goldfields counterparts. Further analysis of this question was therefore conducted using multivariate regression and is reported in the next subsection.

#### 5.2.2.5 *Individual characteristics that are associated with a higher probability that CDC participants report improvements on illicit drug use because of the CDC*

We estimated a multivariate model in order to examine the individual characteristics that are associated with a higher probability that a CDC participant would report a decrease in the use of illicit drugs because of the CDC. This is an alternative way to examine the information in Table 5-8 which allows us to see how the differences we observe are associated with the different socio-demographics present in the trial areas. These estimates do not report raw data differences but relative differences (measured in percentage points) between different subgroups in the trial sites after we have controlled for individual characteristics.<sup>56</sup>

We find that, compared with CDC participants living in East Kimberley, CDC participants living in Ceduna and surrounds were more likely to report a decrease in the use of illicit drugs due to the CDC by 11 percentage points and those living in the Goldfields were more likely by 4 percentage points.

Indigenous CDC participants were more likely to report that the CDC has helped decrease the use of illicit drugs compared with non-Indigenous CDC participants (by 13 percentage points on average).

Household type also matters with regard to perceptions of illicit drug use. The least likely household to report a decrease in drug use was one with single people living alone. Couples with children (dependent or not) were 12 percentage points more likely to report a positive impact compared to a single person; couples living alone (or unrelated adults) were 9.4 percentage points more likely to report improvement. The difference is somewhat smaller for single parents (with dependents or not) who were only 1.8 percentage points more likely to report a positive impact of the CDC on drug consumption compared with single people.

CDC participants who were on Newstart Allowance were more likely to report a positive impact compared to people on other types of payments (notably parenting payments).<sup>57</sup> The magnitude of the difference was 4.4 percentage points.

We find that CDC participants who reported negatively on their experiences on the CDC were also less likely to report that, in their view, the CDC resulted in reduced illicit drugs use or in reduced alcohol consumption.

At odds with the estimations on alcohol consumption, where older people were more likely to report a reduction in alcohol consumption due to the CDC, we found that the probability to report a decrease in illicit drug use due to the CDC was lower for the older CDC participants. We presume that this is because illicit drugs were less prevalent among and less visible to older people. Box 5.2 sums up these findings, which we remind the reader refer to individual CDC participants having reported an improvement in any one of the four categories (you, your family, your friends, where you live) captured by the survey data.

---

<sup>56</sup> The description of the methodology and full estimation results are in the Quantitative Supplementary Report. Briefly, using question G4, we estimate the propensity of a CDC participant to report an improvement in illicit drug use in *at least one* of all four areas question G4 asks about, namely you, your family, your friends, where you live.

<sup>57</sup> In March 2020, Newstart Allowance was replaced by the new Jobseeker Payment.

### Box 5.2: Who is more likely to report a decrease in the use of illicit drugs due to the CDC?<sup>58</sup>

- Those living in Ceduna were the most likely to report a decrease in drug use due to the CDC, followed by the Goldfields, with East Kimberley the least likely.
- Indigenous participants were more likely to report a decrease in drug use due to the CDC in all trial sites.
- Participants living alone or single parents (with dependents or not) were least likely to report a decrease in drug use due to the CDC than those living in all other types of households.
- Older CDC participants were less likely to report a decrease in drug use due to the CDC.
- CDC participants who were on Newstart Allowance were more likely to report a decrease in drug use due to the CDC compared to people on all other payments.
- Those who had been longer on the CDC were less likely to report a decrease in drug use due to the CDC.

### 5.2.3 Evidence from in-depth interviews with Stakeholders and Participants

Impacts of the CDC on illicit drug use and misuse in the region were also discussed by in-depth interview respondents (further details are provided in the Qualitative Supplementary Report). Perceptions were very mixed as to the impact that the CDC had on drug use and misuse within each of the trial sites, with little agreement found as to whether the CDC was effectively reducing the social harm caused by this issue.

Some respondents reported that the use of illicit drugs in the trial sites had decreased since the implementation of the CDC, as the restricted availability of cash had encouraged some CDC participants to reduce their drug use and address their addictions. Within the Goldfields, benefits had been observed especially in communities outside Kalgoorlie-Boulder.

*People are being forced to buy food rather than drugs, which I think is fantastic...I was at Woollies doing my fortnightly shopping and there was this six-foot eight goliath of a man walking through the fruit and veg section and...I know in the community that he was a regular heroin user...Here he is with his shopping trolley full of fresh produce and fruit and I thought, "Well, it looks like the Indue card finally made you spend your money on food and not heroin"...That that man would have died in six months had he not been put on that card. P61GF*

Other respondents (and particularly CDC participants themselves) felt that levels of drug use were unchanged and continued to be problematic. A further smaller group of respondents considered that illicit drug use had worsened since the CDC was implemented. However, there was a lack of consensus about whether or not this perceived increase in drug use was directly linked with the CDC.

*I do know that it has not impacted on the drugs at all. You've still got the drug addicts here. P06GF*

---

<sup>58</sup> For a basic explanation about reading the regression results please see previous Box 5.1 in the alcohol section. For full details see the Quantitative Supplementary Report.

*Well the drugs are still around now, like, there's hard stuff kicking around town...like ice, crack and shit like that there...People still get what they want it just makes it a lot more difficult for them, that's all it is. Doesn't really make a difference I've found. P21C*

Despite the restrictions imposed by the Card, many CDC participants with an addiction were described as still managing to find the funds to support their habit. The continued purchase of illicit drugs was said to be occurring primarily by these CDC participants through the use (and at times pooling together) of the cash component of the CDC, alongside the monthly transferring of additional funds from their CDC for this purpose. In addition, the trading of goods purchased with the CDC or the giving of the Card to others to use was noted as workarounds to the policy which facilitated the purchasing of drugs. Workarounds also included buying items directly for drug dealers or the transfer of monies into a dealer's CDC account.

*There's ice here. My nephew's on it, and he gets it, like, it's here. And they pay for the thing, so the dealers sell it to them for the Indue. They transfer the money to their account or swap their card. Because that's what my nephew was telling me. So they've got a way to get their drugs here. P74EK*

## 5.2.4 Integration of evidence

All sources of evidence present a similarly mixed message about the use of illicit drugs and how the CDC may have impacted on it. As other sections indicate, notably the one on impacts to finances, the constraints imposed by the CDC are working for some CDC participants. This section suggests that any CDC impact on illicit drugs will be intimately related with the CDC impact on alcohol consumption. Further, it suggests that the CDC is having an impact on the use of illicit drugs. However, it does not offer any direct evidence on any actual reduction in the harm that the use of illicit drugs may cause to CDC participants, their families and friends and their communities. Attempts to find direct evidence from other community-level data sources were not successful.<sup>59</sup> Notwithstanding, the quantitative data collection has allowed us to quantify with new levels of granularity where the problem lies, what the perceptions are at the local and personal level and perhaps where some of the policy pressure points may be. This new knowledge is based on the combination of the qualitative depth and the quantitative representativeness that derives from the large data evidence.

We note that in some areas when alcohol is compared with other drugs, it is considered to be the substance that causes the most problems, but also the substance with the most tolerated use by adults in the trial sites. For example, in East Kimberley about two thirds of CDC participants consider alcohol to be highly problematic and the same proportion agree/strongly agree that it is acceptable for adults to drink alcohol.<sup>60</sup> Combined with the qualitative sources of evidence, this affords us several interpretations. First, this stated high level of social harm coexisting with the high level of social tolerance suggests that all communities make a clear distinction between responsible drinking that should be allowed and harmful drinking that is highly undesirable. Our evidence also highlights the presence of divisions between locations, communities and people on this topic. On the one hand, we find those for whom alcohol is not a major problem and who consider the restrictions imposed by the CDC because of alcohol misuse less justifiable for themselves, their communities and where they live. On the other hand, we find those for whom alcohol is the most problematic drug and who are thus

---

<sup>59</sup> See Chapter 3 of this report and the relevant sections in the Quantitative Supplementary Report about community-level data analysis.

<sup>60</sup> We note that similar social acceptability of illicit drug use may exist.

prepared to accept the restrictions imposed by the CDC for themselves, their communities and where they live. Of course, the more homogenous and/or isolated a group of people is, the more likely it is that these differences can be handled by variations in the rules. However, the Goldfields is an example where such divisions have become apparent by the research, as there are overlapping areas and populations with different attitudes and problems and tolerances for both alcohol and for illicit drugs. In this context we note that meth/amphetamine use within the Goldfields is considered highly problematic by Indigenous CDC participants and even more so by the non-Indigenous participants. In contrast, concerns relating to meth/amphetamine use were lower in the other trial sites (and particularly in East Kimberley).

### 5.2.5 The evidence base

The qualitative and quantitative evidence bases have worked well together in the context of understanding the impact of the CDC on illicit drug use by CDC participants. However, community-level data has been of limited use for several reasons (see also the section on Safety, Crime and Family Violence). First, any impact on drugs within community-level data collections (which focus on the broader population rather than specifically on CDC participants) is bound to get diluted giving rise to biased and imprecise estimates. This is more of a case with illicit drugs as their use is an illegal activity that is habitually underreported or misreported. Second, in the case of the CDC, the inter-dependence between different harmful behaviours and their outcomes has to be modelled, making data requirements particularly onerous. The case of alcohol and illicit drugs consumption and impacts is a manifestation of the limitations of community-level data collections, the reality being that, unless there is a clear experimental research design in such a collection, the chances that such data will be useful are limited. The positive side of this argument is that, if one could design such a community-level data collection to match related quantitative and qualitative collections along the lines of the present study, one could end up with a particularly powerful evidence base that would be much more likely to generate both unbiased and precise estimates to guide policy.

### 5.2.6 Observations, limitations and caveats

As is the case with alcohol, there are concurrent policy efforts at various levels within the three trial sites aimed at reducing illicit drug use. The CDC is one more such policy and it is difficult to isolate its impact on any specific desired outcome regarding illicit drugs. The potential of drugs to be addictive is a concern that has been expressed in different instances in this research, as the new financial constraints introduced by the CDC may drive further illegal activities to overcome them. The evidence on this possibility is mixed and lacks in the necessary detail for being conclusive. We have already discussed in this report the limitations of attempting to estimate longer-term impacts using short-term evidence and analyses; these reservations should also be applied to the evaluation of the impacts of the CDC on illicit drug use. We have also discussed the inadequacy of community-level data to support this research elsewhere, despite some of the valiant efforts by relevant organisations, notably the Western Australia Police.

The time allowed by the project design for econometric work has proven to be inadequate for reaching the full potential of the new data set of the CDC participants' quantitative survey. Further, the desired benchmarking with broader national data bases is proving to be less feasible than we expected mainly due to the fact that larger national data collections typically under-report Indigenous respondents, which is not the case in the present study.

As already mentioned, additional longitudinal data would be very useful, as would the inclusion of "control areas" to support the estimation of impacts. We have already outlined in this report the limitations of relying on recall information for comparisons between today and the past in order to establish change. These limitations apply more strongly and with added caution due to the under-reporting that is associated with self-reported drug use activities. For the same reason, we find the qualitative evidence triangulation has been of greater help to overcome some of the interpretational uncertainties, as has the free text box data collection included in the quantitative survey.

Finally, we note the large differences between Indigenous and non-Indigenous participants in the Goldfields trial site. They appear to be fundamental and further and extensive study of these differences may be informative. At the heart of these differences lies the question of how much a single-design policy can be applied to diverse parts of the Australian population. The quantitative survey reveals that the Goldfields example could be very informative regarding this question, a message that was not anticipated in any quantifiable manner by the largely qualitative Baseline Goldfields study in 2018-2019.

### 5.2.7 Summary

We presented limited direct evidence on the use of illicit drugs along with new and useful survey evidence on whether the CDC is perceived to decrease the use of illicit drugs. While the integrated evidence was mixed and cannot offer any definite causative conclusions about whether the CDC can influence the personal or social harm caused by the use of illicit drugs, it appears that the CDC is supporting a decline in alcohol consumption and illicit drug use. We highlighted the important relationship between alcohol and drug use to aid holistic policy design and assessment.

## 5.3 Gambling

The CDC aims to reduce gambling directly by prohibiting the non-cash component of the Card from being used for any gambling activity.

### 5.3.1 Key findings

- Gambling was found to be most prevalent in Ceduna, where between one in four and one in three persons reported to have been gambling prior to the CDC. In comparison this was just over one in ten for the Goldfields and East Kimberley.
- A modest reduction in the prevalence of gambling was reported in each of the CDC trial site areas since the introduction of the CDC.
- In the context of the modest reduction reported, there were differences between trial sites, with Ceduna experiencing the largest reduction, East Kimberley next and Goldfields the lowest.
- The proportion of CDC participants who gamble has declined since the CDC. Those who continue to gamble do so less frequently.
- One in five CDC participants reported that the CDC has helped reduce gambling problems in at least one of the following dimensions: for themselves, their family, their friends, and where they live.
- Where improvements are reported, they were more likely to be among CDC participants who live as couples (with or without children), residents of Ceduna and East Kimberley, and Indigenous people.
- Cash previously used for gambling was directed towards spending on essentials such as food.
- Continuation of some gambling activity was attributed to card workarounds and humbugging for cash.

### 5.3.2 Evidence from large scale survey

The quantitative survey collected self-reported information on gambling behaviours. First, it asked direct questions of CDC participants on personal gambling incidence and intensity, differentiating between gambling in the last 12 months before the CDC and gambling since the CDC was introduced. Second, it focussed on the question of whether the CDC helped reduce gambling since its introduction.

#### 5.3.2.1 *Personal incidence of gambling*

Overall, 14.4 per cent of all CDC participants reported gambling in the 12 months before the CDC and 11 per cent were gambling since being on the CDC, a net reduction of about 3.5 percentage points. Reporting is suggestive of several findings.

First, incidence, as measured by CDC participants who reported that they gamble, was low and differed by trial site. Ceduna appeared to be the site with the highest incidence (22 per cent), followed by the Goldfields and East Kimberley with a much lower incidence (11 and 6 per cent respectively).

Second, the data suggested the lower incidence rate of gambling in all sites since the introduction of the CDC by a net of about 3.5 percentage points was largely attributable to a reduction in the number



of those who reported gambling in the 12 months before the CDC (by about 5 percentage points) countered by a smaller increase in the number of those who did not gamble in the 12 months before the CDC (by about 1.5 percentage points).<sup>61</sup>

Third, the overwhelming majority of those who reported gambling did so once a month or less than monthly (more than 80 per cent), with only a small proportion of CDC participants (less than 20 per cent) reporting to be gambling more regularly (e.g. weekly or daily/almost daily).

### 5.3.2.2 *How was the CDC reported to help reduce gambling problems in the trial areas?*

The second focus is on whether CDC participants reported that the CDC has helped reduce gambling problems. This is presented in Table 5-9 below in the same format as Tables 5-5 and 5-8 in the previous sections on alcohol and drugs. Again we draw on the main distinction (Panel A) being those who reported that they saw a positive difference (21 per cent for all trial sites), those who reported that they saw no difference (44.2 per cent for all trial sites) and those who either reported they did not know or did not answer at all (34.9 per cent for all trial sites).

The second part of the table (Panel B) focuses only on those participants who saw a positive difference and shows the type of difference (You, Your family, Your friends, and Where you live), noting that the question allowed multiple responses. Using the whole of the trial sites in the leftmost column of Table 5-9, Panel B, we see that 34.8 per cent saw a positive difference for themselves, 43 per cent for their families, 38.4 per cent for their friends and 59.7 per cent for where they live.

---

<sup>61</sup> As mentioned in the last section on the use of illicit drugs, these are approximate percentages. Overall, 35 per cent of those who gambled before the CDC had given up (65 per cent continued) and 2 per cent who did not gamble before had started. This amounts to approx. 3.4 per cent of the total CDC participant population. Unlike the similar calculation for illicit drug use, where there was a net increase in the behaviour, here we observe a reported decrease in gambling. Most of the reported change since the introduction of the CDC came from the “once a month or less” very low frequency gambling category, who reported that they typically shifted from ‘gambling very infrequently’ to ‘not gambling at all’. We believe the numbers on reported gambling activity lack in statistical significance, probably due to under-reporting by those who gamble more regularly.

Table 5-9: Has the CDC helped reduce gambling problems, by trial site

The CDC helps reduce gambling problems										
Panel A (full sample who were asked the question)										
	All sites		East Kimberley		Goldfields Indigenous		Goldfields Non-Indigenous		Ceduna & surrounds	
The CDC has made a:	%		%		%		%		%	
Positive difference	21.0		22.9		27.3		12.2		23.8	
No difference	44.2		54.1		32.2		46.0		44.7	
Don't know/missing	34.9		23.0		40.5		41.8		31.5	
Total sample (N)	6,039		1,597		1,655		1,848		939	
Panel B (sub-sample of 21.0% who saw at least one positive difference)										
For:	N	%	N	%	N	%	N	%	N	%
You	441	34.8	195	53.3	127	28.0	47	20.7	73	32.4
Your family	544	43.0	207	56.5	201	44.4	23	10.3	114	50.8
Your friends	487	38.4	211	57.5	175	38.7	24	10.5	78	34.8
Where you live	757	59.7	232	63.4	238	52.6	171	75.8	116	52.0
Total respondents	1,267	100	366	100	452	100	225	100	224	100
Total responses	2,229		844		740		264		381	
Responses per person	1.76		2.31		1.64		1.17		1.70	

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Table 5-9 also shows that the reported difference the CDC made regarding gambling varied by trial site. In the Goldfields, a larger 'positive difference' was reported by Indigenous (27.3 per cent) than by non-Indigenous CDC participants who reported the lowest incidence of 12.2 per cent. Similar proportions of CDC participants in East Kimberley (22.9 per cent) and Ceduna (23.8 per cent) reported a positive difference. Two further numbers are noteworthy from Panel A in Table 5-9. First, a much smaller proportion of 'no difference' was reported by Indigenous CDC participants in the Goldfields (32.2 per cent), with Goldfields non-Indigenous participants, and those in Ceduna and East Kimberley reporting higher proportions (46, 44.7 and 54.1 per cent, respectively). Second, a much lower proportion of 'don't know or missing' was reported by CDC participants in East Kimberley (23 per cent), with Goldfields (Indigenous and non-Indigenous) and Ceduna reporting higher proportions of this view (40.5, 41.8 and 31.5 per cent, respectively).

Further examination of the data (presented in Table 5-9, Panel B) shows interesting patterns in reporting, with several prominent patterns emerging. First, in East Kimberley, we observe the strongest reported impact and the most evenly spread impact across the reporting categories. The impact is clearly widely and evenly spread between the respondent, their family, their friends and where they live. Second, the most prominently perceived improvement is about community-level gambling reductions ('where you live' responses range from 52 to 76 per cent). Third, the difference between gambling within one's own circle (taking this to include 'you', 'your family' and 'your friends') and the rest of the community (represented by 'where you live') is most prominent among the non-Indigenous CDC participants in the Goldfields (ranging from 20.7 to 10.3 per cent for the 'own circle' and 75.8 per cent for all others, 'where you live'). It is clear that whilst a large majority of non-

Indigenous CDC participants report an improvement in gambling behaviour since the CDC where they live, far fewer of them report that this helped them personally (20.7 per cent), their family (10.3 per cent), or their friends (10.5 per cent).

### 5.3.3 Evidence from in-depth interviews with Stakeholders and Participants

Interview respondents were fairly positive (particularly in Ceduna and the Goldfields) about the impact of the CDC on levels of gambling (further details are provided in the Qualitative Supplementary Report). A reduced incidence of public card games in all three trial sites, spending on poker machines (in the Ceduna region) and the use of the TAB (in the Goldfields) was reported since the start of the CDC. In the Goldfields, positive impacts of the CDC on gambling behaviour were especially noted for the communities of Laverton and Leonora.

*Gambling, you used to see gambling everyday across here, that's non-existent. SH39GF*

Respondents commented that reduced access to cash under the CDC as well as restrictions placed on the purchase of gambling products meant that the funds previously used by some CDC participants to support their gambling habits were now being directed towards spending on essentials such as food. Personal examples to support these observations were provided by CDC participants and stakeholders alike.

*When I was in NT, I still had some cash, you just go crazy about gambling...I've been a worse gambler all my life but ever since Indue came, I thank God for Indue because, you know, it settled down, I don't even think about gambling anymore. P68EK*

*There's significant numbers of non-Aboriginal people who have been helped as well. One of them is a brother to a very good friend of mine. I know him well...He was always poverty stricken because of his problems with the poker machines. Now he can't do that anymore because he can't access the cash and the money is going to his family. Really his family was suffering because of his addiction. He knew that but he couldn't stop. Now he has to stop. To me that's the key. SH18C*

However, not all respondents agreed that gambling use had been curbed with the implementation of the CDC, with some arguing that the levels of gambling remained the same as before the CDC. Through the use of their cash component, the utilisation of card workarounds (including the use of royalty monies) and humbugging for cash, some CDC participants were said to be continuing to participate in gambling activities.

*The gambling hasn't slowed down, you go out to the park whatever, they're gambling \$100 a round there. I don't know where that money is coming out from but this card isn't stopping the gambling. P07EK*

Furthermore, it was noted by some respondents that the local police had become more active in breaking up card games which were held in parklands and moving these people on. Occurring concurrently with the CDC, this intervention was strongly felt to be impacting upon the occurrence of public gambling. As a result of this, some respondents questioned whether gambling behaviour had actually decreased with the CDC or if it was instead now hidden and being conducted away from public areas.

*It's slowed down gambling, nobody gambles here. Nobody gambles here. Even if they go sit with a park and get a packet of playing cards, the Shire is all over them...You look now there's nobody there because the police and the Shire instantly just close them down. P52EK*

*It hasn't impacted much on the gambling. As we're local people we know where they gamble but they don't do where people can see them basically. They still play cards...and they just like mould into their money situation. SH23EK*

### 5.3.4 Integration of evidence

Overall, the integration of the evidence available to this study suggests that the CDC is reducing gambling, but it does so in a qualified way. The quantitative evidence makes the distinction between CDC participants who have no view on gambling and those who have a view, applying its focus on those who answer the gambling impact questions. The quantitative survey's evidence on prevalence and intensity of gambling is not sufficiently strong for a definitive answer, possibly due to under-reporting or reporting bias. The survey's broader question on whether the CDC has helped reduce gambling in several individual and social dimensions provides stronger evidence, clearly suggesting that the CDC is reducing gambling in all trial sites. On the whole, the quantitative evidence suggests that any such impact is not universal and can be best understood within the confines of parts of the CDC participants' population, like families, Indigenous participants, female participants and other subgroups.

The short-run evidence from the qualitative in-depth interviews also supports the finding that gambling outcomes are fairly positive. However, the in-depth interviews also cast some doubt on whether such improvements will be maintained, pointing to ways that the CDC objectives are being circumvented and neutralised through negative behavioural responses by those who wish to continue to gamble. It was also noted that concurrent policies were occurring within the trial sites which could also be contributing to reduced levels of gambling.

### 5.3.5 The evidence base

Changing gambling prevalence and intensity could happen immediately upon the introduction of the CDC and, if this had occurred, we expect it would be visible in both the qualitative interviews and quantitative survey data. The two main sources of evidence are the in-depth qualitative interviews and the survey. The strength of the quantitative evidence is variable, with direct questions on personal gambling use offering less useable evidence than the less direct questions about the broader impact of the CDC on gambling, which suggest some improvement since the introduction of the CDC, especially at the wider community level. The qualitative evidence is supportive of the quantitative impact evidence. There is no longer-term evidence base on gambling that could be used in the present study and there was no accessible administrative data to capture this information. The longitudinal capacity of the survey would allow the observation of a longer-term impact of the CDC on gambling, should a second wave of data collection be undertaken.

### 5.3.6 Observations, limitations and caveats

While we can see the short-term change that is reported in both the interviews and survey responses, we cannot judge the degree to which longer-term behaviours and habits directly or indirectly related to gambling may be changing due to the CDC. The questions that refer to actual personal behaviours

do not offer sufficient evidence for strong statistical inference. The questions on the broader impact of the CDC are much stronger. However, all evidence is particularly short-run. As with many public policies, any longer term effects will take time to emerge, if they are to emerge at all. We note that the strongest impacts are observed for all trial sites for families and for the area where the respondent lives, which can be taken as the closest we can get to an indication of the birth of potential longer-term impacts.

### **5.3.7 Summary**

Short-term evidence suggests the CDC has been helping reduce gambling, with positive impacts especially in the context of family and broader social life. Yet, these impacts appear to be small, applying to a small part of the CDC population. No longer-term evidence was available for this evaluation.

## 5.4 Financial planning and money management

The CDC aims to reduce socially harmful behaviours by introducing a new approach to the management of individual finances through the Card. By placing 80 per cent of the person's income support payment onto the Card which cannot be used to purchase alcohol, gambling products, cash-like gift cards or to withdraw cash, the CDC aims to ensure that people receiving welfare payments will have money available to meet essential needs. This introduction has widespread implications about financial planning and money management for all CDC participants.

The CDC touches on the financial position of a very diverse group of people in ways that can be highly complex. The outcomes depend a lot on the starting (pre-CDC) individual family and community circumstances of participants and their families. As will become apparent upon reading this section of the report, the complexity and diversity of circumstances and outcomes that give rise to our findings will require especially careful reading. We apologise to the reader for this, but it is necessary in order to preserve the narrative that emerges.

### 5.4.1 Key findings

- The quantitative survey of CDC participants collected information on a broad variety of financial outcomes. Reported change since the introduction of the CDC was both positive and negative, but only experienced by a minority of CDC participants. Three quarters of CDC participants reported no change in their financial situation and money management. One quarter reported a change since the CDC introduction.
- We examined 13 financial position measures in a before-and-after context (12 months prior to the CDC and in the last four weeks) at the individual CDC participant level.
- The starting position prior to the CDC was important: Two in four responses reported no change, with no problems (neither "before" nor "after"). One in four responses reported no change, however, with a persistent problem both "before" and "after".
- The remaining one in four CDC participants reported change in both directions. Things got worse for some (about two out of three answers report a new problem) and better for others (about one out of three answers report the resolution of an old problem).
- The CDC improved individual financial domains in higher proportions for those who started with a problem. It also made individual domains worse for those who started without a problem in lower proportions.
- As many more people started without a financial problem than with a problem, despite these proportions, we found more cases where things got worse than where they improved.
- Multivariate regression was used to profile those who found the CDC made their financial lives easier or harder.
- Finances were made easier for those who were most affected by harmful behaviours of others, those who were in the severest forms of financial hardship and those with good supports.
- Finances were made harder for those who could handle complexity of the CDC the least, those with fewer/weaker supports, those who felt that they should not be on the Card, and those whose personal behaviours were most likely to be effectively curtailed by the Card.

- The quantitative survey also showed that about 40 per cent of CDC participants recognised personal and wider social benefits regarding money management.
- East Kimberley started with the lowest proportion of CDC participants experiencing financial problems prior to the CDC and showed the strongest increase in financial problems since the start of the CDC. Ceduna started with the worst financial issues and has showed strong improvement. The Goldfields fell in the middle with strong diversity in outcomes within the trial site.
- The qualitative data supported the mixed findings arising from the quantitative evidence.
- The qualitative findings suggested that the CDC provides a mechanism to re-direct money away from the purchase of alcohol, drugs and gambling products.
- While financial management and spending patterns were reported to have improved for many CDC participants, it also created a number of challenges. These included the ability to provide cash money to their children and grandchildren (e.g. for pocket money, school lunches and excursions); difficulties with the ability to purchase second-hand (and therefore cheaper) goods; and challenges regarding the payment of bills such as board, rent and car payments.
- Moreover, respondents expressed perceptions and concerns that the CDC was associated with the occurrence of financial abuse, fraud and exploitation; older people (both CDC participants and Age Pension recipients) were reported to be particularly affected by these issues.
- There was no single or simple definitive message on the financial outcomes of the CDC in the trial sites.
- The CDC made financial management better for those who are more vulnerable and need the CDC the most, but also made this worse for others who believe they do not need to be on the CDC.

## 5.4.2 Evidence from large scale survey

The quantitative survey collected information on several aspects of the financial impact of the CDC on its participants. This information falls into three main categories.

First, we derived direct measures of the impact of the CDC on measures of financial hardship.

Second, we examined whether the change experienced by CDC participants since the rollout has made life easier or harder regarding matters to do with money management.

Finally, we examined how broadly potential improvements have been felt, by the individual CDC participant, by their family, by their friends, and within the area they live.<sup>62</sup>

### 5.4.2.1 *Direct measures of change since the CDC was introduced*

Information on specific outcomes of the CDC was collected with reference to two specific points in time. The survey asked all respondents first about specific experiences “In the 12 months before being on the Cashless Debit Card” and subsequently in a separate question about the same experiences “In the last four weeks”. Respondents were asked to answer the following questions on outcomes with a

---

<sup>62</sup> Quantitative survey questions C7 and C8, F2 and G4 are the direct focus of this section.

yes/no/not applicable/do not know. Our analysis focuses on the yes/no answers at these two points in time on the following dimensions:

“Did any of these things happen to you?”

- Ran out of money to buy food
- Ran out of money to buy clothes
- Ran out of money to buy medicines
- Unable to pay rent on time
- Unable to save up bond money
- Unable to pay water and electricity bills on time
- Able to save money
- Gave money to others causing financial problems for you
- Asked for money from others because you could not buy essential things (e.g. food, clothes, medicine, bills)
- Asked for emergency relief
- Unable to afford to travel to visit family/friends
- Unable to pay for things that your child/children needed for school, like books
- Unable to pay for school activities/trips or sports for children.

Adjusting for the content of the question, the answers relating to 12 months prior to the CDC were contrasted with those about the last four weeks for each financial domain, with pairs of data constructed. The impact analysis is based on the following before-after template and the comparisons that can be made using it.

Table 5-10 presents the overall picture that emerged when we put together all pairs of before-after comparisons, provided by respondents, to all domains of financial information in the survey. This provides the highest possible aggregation of the data about financial domains and how they changed during the investigation period. The survey recorded a total of 59,580 before-after comparisons provided by 6,039 individual CDC participants, using population weighted data.

**Table 5-10: Change in financial circumstances after the introduction of the CDC, all trial sites**

Reported change in financial circumstances, all domains				
No change reported		Change reported		Total
No-No (No change)	Yes-Yes (No change)	Yes-No (Better)	No-Yes (Worse)	N
No problem before and no problem after	A problem was present before and still is after	A problem was present but has now been resolved	A new problem has emerged since the CDC introduction	(100%)
<b>53.6%</b>	<b>22.3%</b>	<b>8.5%</b>	<b>15.6%</b>	<b>59,580</b>

*Note: Based on the comparison of questions C7 (“before” which refers to the last 12 months before the CDC was introduced) and C8 (“after”, which refers to the last four weeks prior to completion of the survey) in the survey of CDC participants. Total number of respondents 6,039 over a total of thirteen financial domains. The four categories of answers are used extensively below. Table reports population weighted data.*

Two main messages emerge from Table 5-10. First, a large majority of CDC participants (three out of four) reported that they are in a similar financial position to the one they were in the 12 months prior to the CDC introduction. Second, of the remaining one quarter of CDC participants who reported a change, two thirds reported a change to the worse and one third a change to the better.



Table 5-11 below disaggregates the data to show each of the different financial domains for all trial sites put together.

**Table 5-11: Change in financial circumstances after the introduction of the CDC, all trial sites by financial domain**

Reported change in financial circumstances, by domain				
Domains and Change	No change %		Change %	
	No-No (No problems)	Yes-Yes (Problems)	Yes-No (Better)	No-Yes (Worse)
Buying food	48	25	8	18
Clothing	49	26	8	18
Medicines	62	17	6	15
Paying rent	59	17	9	16
Saving for bond	57	18	9	16
Paying bills	56	19	8	16
Saving money	27	40	12	21
Giving money	62	18	9	10
Asking for money	49	25	10	16
Emergency relief	63	16	9	12
Travel and visit	47	28	8	17
Kids' school needs	64	17	5	14
Kids' school activities	62	17	5	15

*Note: The four categories of answers are the same as in Table 5-10. Percentages add up horizontally. Rounding makes some percentages to not add up to exactly 100 per cent.*

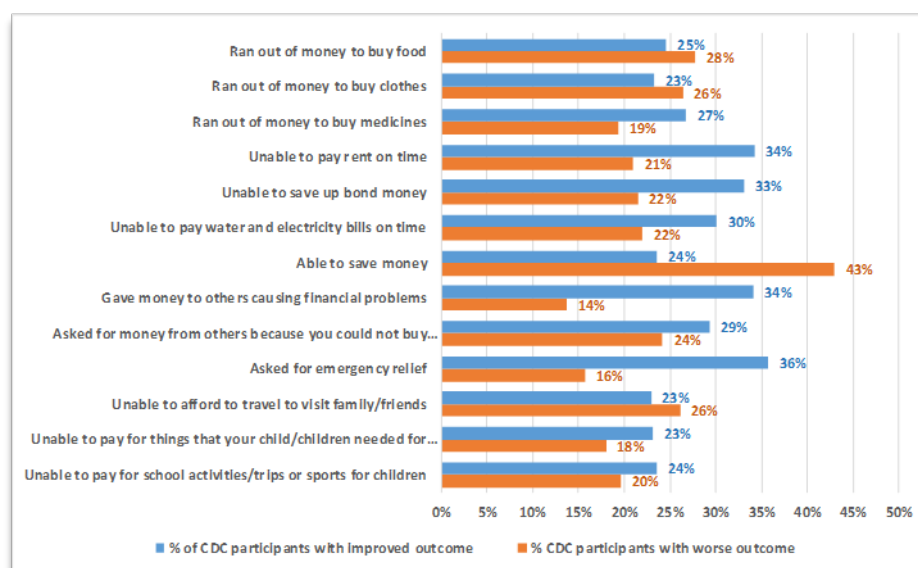
The proportions reported for individual domains in Table 5-11 are not very different to the highly aggregated averages reported in Table 5-10. With the exception of “Saving money”, which was a clear outlier, Table 5-11 shows that reporting the continuing absence of a problem ranged from 47 to 64 per cent between the different financial domains and from 17 to 28 per cent for those reporting a continuing problem. Of those who reported change, 5 to 12 per cent reported the removal of an old problem and 10 to 18 per cent reported the emergence of a new problem. Largely we would say the majority of no change consisted of those who reported no problems both before and after, and the majority of change consisted of those who reported things getting worse.

In order to examine further both wanted and unwanted financial change since the introduction of the CDC, Figure 5-2 below focusses on where change happened, distinguishing between changes resulting in improved or worse outcomes. This is achieved by showing, for each domain, the percentages of CDC participants whose financial situation has:

- Improved (blue histograms): That is the percentage of CDC participants who reported that they do not currently experience a problem while they used to prior to the CDC.
- Worsened (orange histograms): That is the percentage of CDC participants who reported that they currently experience a problem while they did not prior to the CDC.

Note that the bases from which those percentages are computed are different. In the first instance the reference is the number of CDC participants who used to experience a problem prior to the CDC. In the second instance, the reference (the denominator) is the number of CDC participants who did not experience a problem prior to the CDC. Those two numbers are different. Technically speaking, Figure 5-2 displays conditional proportions. By way of an example, Figure 5-2 shows that 34 per cent of the CDC participants who were “Unable to pay rent on time” prior to the CDC, were now able to do so. At the same time it shows that 21 per cent of those CDC participants who were able to pay their rent on time prior to the CDC, were no longer able to do so in the last four weeks before the survey.<sup>63</sup>

Figure 5-2: CDC participants whose financial situation improved/worsened since the CDC, all trial sites by financial domain



The diversity of results emerging from Figure 5-2 are examined in more detail in the Quantitative Supplementary Report.<sup>64</sup>

Our next focus is to examine each of the three trial sites presented in Table 5-12 below.

<sup>63</sup> Table 5-11 and Figure 5-2 are showing the same data from a different angle. We explain using Paying Rent as an example. Table 5-11 shows that *prior to the CDC* (59+16=) 75 per cent of our sample could pay their rent and (17+9=) 26 per cent could not. Figure 5-2 translates the 16 out of 75 (21 per cent) and the 9 out of 26 (34 per cent) into percentage points. In technical terms Figure 5-2 makes a *conditional* statement, while Table 5-11 presents the full before and after data *jointly*. Both angles are useful for understanding the stocks and the flows involved in the description of the data. Why do we bother about stocks and flows separately? The non-technical reader should envisage the whole volume of water in a water tank as a *stock* at the point in time it is measured (the unit will be cubic meters) and water that is flowing into the tank while it is being filled up as the *flow* over a period of time that we define (the unit will be litres per minute, or some other unit that makes sense). Clearly, the two concepts convey different information and the distinction is used extensively in social science to reflect where things are (the stock) and how things change (the flow).

<sup>64</sup> Note that the two percentages presented in Figure 5-2 for each domain are not comparable with one another, as they are percentages of a different part of the sample as explained in the previous footnote. The blue line is about those who had a problem prior to the CDC and uses them as the denominator for calculating the percentage. The orange line is about those who did not have a problem prior to the CDC. From Table 5-11 we know that for all domains the number of those *with* a specific problem is smaller than the number of those *without* that specific problem. This difference must be borne in mind when we interpret findings.

Table 5-12: Change in financial circumstances after the introduction of the CDC, by trial site and financial domain

Reported change in financial circumstances, by domain and trial site												
Domains and Change	East Kimberley				Goldfields				Ceduna & surrounds			
	No Change		Change		No Change		Change		No Change		Change	
	N-N %	Y-Y %	B %	W %	N-N %	Y-Y %	B %	W %	N-N %	Y-Y %	B %	W %
Buying food	43	22	10	26	52	25	7	16	43	31	11	15
Clothing	45	23	8	25	53	25	7	15	41	34	10	15
Medicines	62	10	6	22	62	19	6	13	60	20	8	12
Paying rent	55	12	10	23	61	18	7	13	57	19	12	13
Saving for bond	56	15	6	24	58	19	10	13	60	18	11	11
Paying bills	55	12	10	23	58	22	7	14	54	23	11	12
Saving money	27	35	10	28	26	43	14	17	31	36	12	21
Giving money	61	15	7	16	64	18	10	7	57	25	10	8
Asking for money	49	19	10	22	50	26	10	14	47	30	11	11
Emergency relief	64	7	9	20	64	18	9	9	61	21	9	8
Travel and visit	51	19	8	22	44	31	8	16	48	34	8	10
Kids' school needs	63	11	4	22	65	18	4	12	63	20	9	7
Kids' school activities	63	9	5	24	62	19	5	14	62	24	9	5

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. The categories of answers are the same as in Tables 5-10 and 5-11.

The overall proportion of CDC participants reporting “No change without a problem” was similar in all trial sites (lowest in East Kimberley and highest in Ceduna). The overall proportion experiencing “No change with a problem remaining unresolved” was clearly the lowest in East Kimberley, a bit above average in the Goldfields and above average in Ceduna. “Change towards getting better” also appeared to be happening at a similar overall pace in all sites (probably highest in Ceduna). The most pronounced regularity in Table 5-12 was the clearly negative net change in East Kimberley, where the proportion of reported negative change was much higher than that proportion of reported positive change. In contrast, Ceduna appeared to have several domains where a small positive net change was reported.<sup>65</sup>

As previously, we also looked at where both negative and positive changes happen. Figures 5-3, 5-4 and 5-5 below show East Kimberley, Goldfields and Ceduna respectively.

The domains where we observed the largest percentage of CDC participants experiencing an improvement are similar to those highlighted above in Figure 5-2. In East Kimberley (Figure 5-3) 44 per cent of the CDC participants who could not pay their rent on time, could now do so; 46 per cent were now able to pay bills on time, while they stated they could not before the CDC; 55 per cent of the CDC participants no longer asked for emergency relief where they used to.

<sup>65</sup> Further examination of individual domains is presented in the Quantitative Supplementary Report.

However, we see the CDC participants' ability to save money deteriorated with about 50 per cent of those who used to be able to save money, reporting that they could not do so anymore.

Figure 5-3: CDC participants whose financial situation improved/worsened since the CDC, by financial domain, East Kimberley

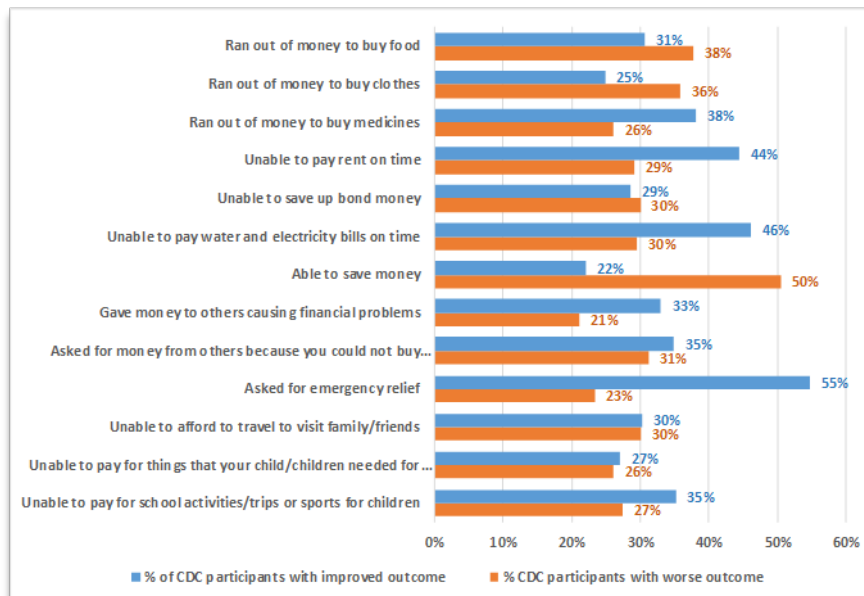
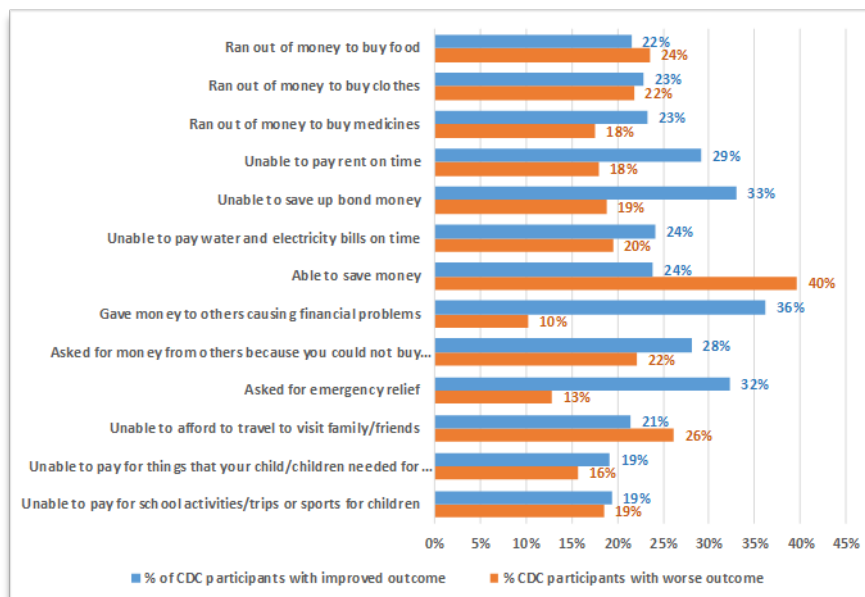


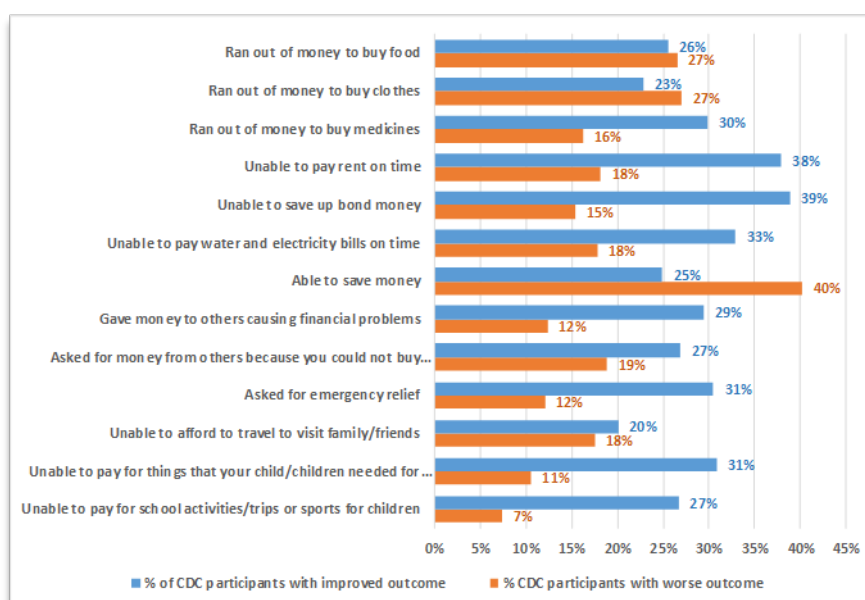
Figure 5-4 below shows the same information for the Goldfields. We observed similar improvements in the ability to pay the rent on time, being able to save up for bond money, and being able to pay bills on time. We also note the same issue with CDC participants who did not have these problems prior to the CDC, especially relating to running out of money to buy food post-CDC and showing a decreased capacity to save money. Corroborating qualitative evidence suggests the possibility that these observations are partly due to CDC participants needing to use direct debit arrangements more than they did prior to the CDC. Setting up direct debit payments means rent and bills are more likely to get paid on time, but it also means less flexibility for making money available for discretionary expenses like clothes and food.

Figure 5-4: CDC participants whose financial situation improved/worsened since the CDC, by financial domain, Goldfields



The following Figure 5-5 displays the information on the percentage of CDC participants improving/worsening their financial situation for Ceduna and surrounds. In essence, the results are similar to those highlighted in the previous two sites. A notable exception is with the last two items concerning expenses related to the needs of children, which showed a larger proportion of CDC participants reporting improvement in these domains than in the other sites.

Figure 5-5: CDC participants whose financial situation improved/worsened since the CDC, by financial domain, Ceduna & surrounds



In conclusion, we see that the examination of different domains of the financial position of CDC participants (before the CDC was introduced and in the last months of 2019, when the survey was completed) reveals a complicated and diverse picture. First, looking at the overall picture emerging

from Tables 5-10 and 5-11, which reported the present position of CDC participants, we see very clearly about three in four reported having experienced no change (two in four without a problem and one in four with a problem) and the remaining one in four have experienced change (two thirds being change to the worse and one third to the better). Table 5-12 looked at that evidence by trial site and found East Kimberley experienced the most change overall and the most change to the worse. Ceduna was the opposite, experiencing the least overall change and the most change to the better. The Goldfields were somewhere in the middle, but we noted a very diverse picture that requires further analysis for systematic differences within the Goldfields trial site. The overall picture is thus one of net change to the worse in the financial situation of CDC participants.

However, the findings in Figures 5-2 to 5-5 look at the evidence from a different angle, namely, how the CDC may have changed the reporting of those who started prior to the CDC with a (financial) problem and how the CDC may have changed the reporting of those who started prior to the CDC without a (financial) problem. Ideally, for all relevant financial domains, one would want a policy that helps out those with a problem and at the same time does not impact negatively those without a problem. However, as the policy was applied universally to all CDC participants, the financial position of every participant can potentially be impacted upon (either positively or negatively). The important finding is that the degree of impact is different depending on the financial starting (pre-CDC) position of CDC participants. The finding suggests that the CDC appeared to improve most of the financial domains in question in higher proportions for those with an existing problem (the intended beneficiaries of the policy) than worsening the situation for those previously without a problem (these are people who did not need the policy intervention to improve the specific domains). Figures 5-2 to 5-5 reveal that in most domains the proportion of those who experienced improvement (as a proportion of all who could improve, not as a proportion of the total population of CDC participants) is higher than the proportion of those who experienced negative change (as a proportion of all those whose situation could potentially worsen). However, given the number of those whose financial situation could improve is much lower than the number of those whose situation could worsen, we end up with the finding in Tables 5-10 to 5-12, namely that for every *one* CDC participant with an improved financial domain response there were *two* with a worse financial domain response.

#### 5.4.2.2 *Aspects of financial management*

Moving on from the individual before and after financial domain questions, we turn to a more general question asked by the CDC participants survey. The survey directly asked CDC participants whether certain aspects of their financial situation had become easier or harder since the CDC rollout. The survey asked each respondent the following questions “Since being on the Cashless Debit Card, how have the following things changed for you?”:

- Managing your money
- Saving money
- Having enough money for food
- Having enough money to pay rent
- Knowing how much money you have
- Looking after family obligations

Respondents were asked to choose between three options: Easier, About the same, and Harder.<sup>66</sup>

We note that, although this is a much broader question than the financial domains we dealt with previously, the question still asked a direct impact about the change the CDC has brought. Unlike the previously examined domain questions, however, here we have a more general set of questions. They were designed to convey a broad opinion about the change the CDC has caused and some of the answers need to be interpreted more widely, so we should not expect a precise correspondence between this question and the previously examined questions on specific financial domains of the CDC. For example, answering about “Knowing how much money you have” required a reflection jointly upon a group of financial domains and the answer probably also included some consideration of aspects of implementation.

Table 5-13 corroborates what was suggested in the section above dealing with the specific financial domains, namely that change brought by the CDC has been more often negative than positive. A smaller overall proportion of answers stated that things remained the same.

**Table 5-13: Money-related change since being on the CDC, all trial sites**

Money-related change since the CDC				
Change in:	Easier %	The same %	Harder %	Total N
<b>Managing your money</b>	16	34	50	5,477
<b>Saving money</b>	14	34	52	5,475
<b>Having enough money for food</b>	19	52	29	5,408
<b>Having enough money to pay rent</b>	15	51	34	5,092
<b>Knowing how much money you have</b>	16	43	41	5,421
<b>Looking after family obligations</b>	14	44	41	5,174

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Total number of respondents who were asked is 6,039. Total respondents who answered is reported for each domain. Population weighted data. A detailed table by trial site is included in the Quantitative Supplementary Report.*

We used multivariate regression in order to present the individual characteristics of those who were most likely to find things easier (the ones for whom the policy works) and those who were most likely to find things harder (the ones for whom the policy is not working). The following Boxes 5.3 and 5.4 summarise these findings, with the details presented in the Quantitative Supplementary Report. The two boxes have to be read jointly. The results offer precise estimates, but the broader interpretation of the two boxes is highly relevant.

Box 5.3 shows the most likely characteristics of CDC participants who found financial matters easier after the CDC. The emerging profiles suggest those who are most affected by harmful behaviours of others, such as Indigenous participants and female participants, found the CDC improved their financial situation. Also, those in the most severe financial hardship, such as single mothers and those unable to work, were more likely to find the CDC made things easier for them. We note that the

---

<sup>66</sup> At this point we remind the reader that the CDC does not reduce the welfare payment amount participants receive. It changes the way in which participants receive their fortnightly payments and presents them with limitations as to how they may spend these payments. The information presented here is derived from Question F2 in the CDC participants survey. Respondents were also allowed to answer “Don’t know”, which was chosen with a frequency of 5 per cent and these answers (not the respondents) were excluded from the analysis.

categories above include some of the most vulnerable CDC participants. Finally, those who had support in managing the practical aspects of the Card, typically from other family members, also tended to report improvements to their finances.

#### Box 5.3: Who is most likely to state that their financial situation has become easier since the CDC

**Financial situation is now easier for the following groups of CDC participants:**

- Ceduna CDC participants (followed by East Kimberley) on most dimensions (i.e. managing money, enough money for rent, knowing how much money they have, looking after family obligations).
- Females.
- Indigenous CDC participants.
- CDC participants who stated they have not experienced issues using the Card.
- CDC participants who live with someone else who is also on the Card.
- CDC participants who were in receipt of Parenting payments (single and partnered) and FTB.
- CDC participants who were in receipt of DSP (except for the dimension related to 'looking after family obligations').
- Older CDC participants: the older the CDC participants the more likely they are to state that things are now easier.
- CDC participants who experienced more financial hardship prior to the CDC.

In contrast, Box 5.4 suggests that those who can least handle the complexity of the Card felt that the CDC has made things harder financially for them. These are people with fewer informal supports (e.g. singles) and people who state they find the Card difficult to use. Those reporting their financial situation has worsened also includes people who believe they are least likely to need the Card or believe they should not be on the Card. Typically, these are more likely to be people who suffered the least (relative) financial hardship prior to the CDC, including younger people and those with the strongest labour market attachment. It can also be people whose behaviours are more likely to be targeted by the CDC, such as younger males and males in general. CDC participants within the Goldfields trial site were also more likely to report that their financial situation had become harder since the introduction of the Card. These estimations provide useful insights about how and why opinions about the Card are developed.



#### Box 5.4: Who is most likely to state that their financial situation has become harder since the CDC

**Financial situation is now harder for the following groups of CDC participants:**

- Goldfields CDC participants (on most dimensions).
- Males.
- Non-Indigenous CDC participants.
- CDC participants who stated they experienced issues using the Card (on all dimensions except for looking after family obligations).
- CDC participants who do not live with someone else who is on the Card.
- CDC participants who were in receipt of Newstart Allowance.
- CDC participants who were in receipt of DSP payment (only with regards to 'looking after family obligations').
- Younger CDC participants.
- CDC participants who experienced the least amount of financial hardship prior to the CDC were more likely to state that things have become harder.

To sum up the multivariate results, we found that those who need the Card the most and/or can handle its complexity best (and are thus more likely to feel some benefits from the CDC) report that it makes things easier for them financially. In contrast, those who need it least and/or can least handle its complexity (and are thus least likely to feel any benefits from the CDC) report that it makes their financial situation harder for them. As in the previous section, the emphasis is on both impact and targeting of the CDC policy. We note that the proportion of those who made the more general statement of financial matters being harder for them because of the CDC, was larger than the proportion reporting a detrimental impact due to any individual financial domain examined in the previous section.

#### 5.4.2.3 *How was the CDC reported to help money management in the trial areas?*

We now turn to the question of whether CDC participants reported that the CDC has helped improve money management since its introduction. This is presented in Table 5-14 below in the same format as Tables 5-5, 5-8 and 5-9 in the previous sections on alcohol, drugs and gambling. Again, we draw on the main distinction (Panel A) being those who reported that they saw a positive difference in money management (24.5 per cent for all trial sites), those who reported that they saw no difference (44.7 per cent for all trial sites) and those who either reported they did not know or did not answer at all (30.9 per cent for all trial sites).

The second Panel B focuses only on those participants who saw a positive difference in money management and shows the type of difference (You, Your family, Your friends, and Where you live), noting that the question allowed multiple responses. Using the whole of the trial sites in the leftmost column of Table 5-14, Panel B, 55.9 per cent saw a positive difference for themselves, 43.1 per cent for their families, 34.3 per cent for their friends and 47.9 per cent for where they live.

Table 5-14: Has the CDC helped improve money management, by trial site

The CDC helps improve money management										
Panel A (full sample who were asked the question)										
	All sites		East Kimberley		Goldfields Indigenous		Goldfields Non-Indigenous		Ceduna & surrounds	
The CDC has made a:	%		%		%		%		%	
Positive difference	24.5		30.2		30.1		14.2		24.9	
No difference	44.7		52.3		32.8		49.5		43.2	
Don't know/missing	30.9		17.5		37.1		36.3		32.0	
Total sample (N)	6,039		1,597		1,655		1,848		939	
Panel B (sub-sample of 24.5% who saw at least one positive difference)										
For:	N	%	N	%	N	%	N	%	N	%
You	826	55.9	249	72.3	228	45.8	125	47.6	124	53.0
Your family	636	43.1	282	58.5	207	41.5	35	13.3	113	48.2
Your friends	507	34.3	239	49.6	164	33.0	25	9.3	79	33.8
Where you live	708	47.9	236	49.0	227	45.5	139	52.7	106	45.5
Total respondents	1477	100	482	100	498	100	263	100	234	100
Total responses	2,677		1,106		826		323		422	
Responses per person	1.76		2.31		1.64		1.17		1.70	

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Table 5-14 also shows that the reported difference the CDC made regarding money management use varied by trial site. In the Goldfields, a larger 'positive difference' was reported by Indigenous (30.1 per cent) than by non-Indigenous CDC participants who reported the lowest incidence of 14.2 per cent. Similar proportions of CDC participants in East Kimberley (30.2 per cent) and Ceduna (24.9 per cent) reported a positive difference in money management. Two further numbers are noteworthy from Panel A in Table 5-14. First, a much smaller proportion of 'no difference' was reported by Indigenous CDC participants in the Goldfields (32.8 per cent), with Goldfields non-Indigenous, Ceduna and East Kimberley CDC participants reporting higher proportions (49.5, 43.2 and 52.3 per cent, respectively). Second, a much lower proportion of 'don't know or missing' was reported by CDC participants in East Kimberley (17.5 per cent), with those in the Goldfields (Indigenous and non-Indigenous) and Ceduna reporting higher proportions of this view (37.1, 36.3 and 32 per cent, respectively).

Further examination of the data presented in Table 5-14, Panel B, shows interesting patterns in reporting, with several prominent patterns emerging. First, in East Kimberley, we observed the strongest reported impacts especially regarding an improvement in the respondent's own (72.3 per cent) and their family's money management (58.5 per cent). A large proportion of non-Indigenous CDC participants in the Goldfields reported an improvement in their own money management (47.6 per cent) and 'where they live' (52.7 per cent) with much lower proportion of improvement for their family (13.3 per cent) and their friends (9.3 per cent). Most of these findings on the perceptions of CDC respondents about how money management may have been helped by the introduction of the

CDC follow the pattern we have discovered for the other important CDC outcomes where this question was asked.

### 5.4.3 Evidence from in-depth interviews with Stakeholders and Participants

The qualitative research uncovered a number of impacts the CDC was having on the finances of participants. These included impacts on the financial management of participants, spending patterns and instances of financial abuse and humbugging. The Qualitative Supplementary Report describes these impacts in detail for each of the trial sites. We provide a summary below of the main findings.

#### 5.4.3.1 Financial planning and money management

While within the East Kimberley region, mostly positive outcomes were described with regard to the impacts of the CDC on financial planning and management, outcomes were more mixed in the Ceduna and Goldfields trial sites.

Some respondents, particularly in the East Kimberley region, reported positive impacts on financial management since the introduction of the CDC; the placing of Centrelink funds to the Card was felt to enhance the ability of CDC participants to budget, keep track of their spending, and have control over their finances.

*It helps me budget. I can save a little bit, because the Indue card's for food and the other money is for miscellaneous...I used to withdraw my money, cash out of the ATM and I used to go pay all my bills, buy all my food, get a \$10 lotto ticket, my medication and then I'd look into my wallet and think, "Well, where's all my money gone?". But now with the Indue card, I find it easier. I find it easier to know where my money is. P61GF*

The Card was seen as providing an important back-up for unexpected expenses or ensuring that adequate funds for essential items (such as food) were available until the next pay period. Moreover, while acknowledging the challenges of living on welfare payments, the ability to save money was considered by these respondents to have improved with the CDC.

*Some people have been saving their money in their CDC card and purchasing bigger items. It's working. It's like that kitty, that savings. If they look at it like that and they're obviously, some of them, if they're not drinkers or they're not spending all their money in one go, it can be that kind of savings holder. SH41EK*

*Many of the women have been able to save small amounts of money and we heard, you know, people buying Christmas presents and enjoying Christmas trees for the first time. SH12C*

CDC participants themselves provided examples of using the CDC as a tool to save money in order to pay off debts, buy big-ticket items such as cars and televisions, or to attend family events and activities.

*We save it, you know, for buy some feed, clothes, shopping...saved up too. I saved for, I don't spend it. If I see good things, I'll buy it. 'Cause I buy one TV in the Indue card...'Cause I like it that Indue, it's saving that money. P12C*

Indeed, improved financial management was the most common aspect of the CDC that was considered to be working well. More than half of all respondents reported that financial management had been strengthened with the Card. Respondents frequently reported that the placing of monies onto the CDC and the reduced availability of cash, encouraged participants to take more responsibility and control over their financial situation. As a consequence, the subsequent developing and improving of budgeting skills—and the use of the CDC as an avenue for saving money—were seen as positive elements of the introduction of the Card.

However, not all respondents agreed that the CDC had had a beneficial impact on financial planning and management. Insufficient access to cash under the CDC was considered by many (and especially CDC participants) to be problematic, hindering the provision of money to children (e.g. for pocket money, school lunches and excursions), and attendance at community activities. A decreased ability to purchase second-hand goods (online and at garage sales) was also reported to be occurring with the CDC. This was said to adversely affect the financial position of CDC participants as they were now forced to purchase new— and more expensive—items.

*There's also not a good side to it as well. Because parents don't have cash for their kids, and they want to go to the shops and buy stuff...When the sideshow comes as well, you have to have cash on you. And also at the leisure centre, the swimming pool, that as well. You need cash for that. SH04EK*

*I can't afford to go into a furniture shop and buy a brand new dining table or brand new mattress and bed for the kids or anything like that, but you can look on pages like your internet and everything and find second hand things for a tenth of the price...I needed to replace my fridge...a fridge was on Facebook for \$600...Money talks you know and I missed out on that fridge because I said I would have to get the money transferred and the lady said oh no, I am not going to wait because I have got other people interested. P33GF*

Some respondents described the processes of the CDC as being complex for CDC participants who had previously had a preference for, and had been used to, dealing with their money in cash. For example, the management of two different accounts (the CDC and regular bank account) was said to be difficult for some CDC participants. Issues had been encountered with managing two separate cards, PINs and funds.

*There's been huge implications. Again, pretty much a traditional people who had no understanding, and quite a lot still had passbooks for bank accounts, and then, you know, trying to, in the space of a few months, educate them on the 21st Century world; that was a huge stress. SH12C*

*But sometimes I forget you know, all my details and stuff...Sometimes even for PIN numbers I just go blank and forget PIN numbers. P01EK*

Other difficulties around financial management that were noted to have occurred with the CDC, were centred on the payment of bills. For example, challenges in paying for informal board arrangements were noted. Also described were issues with paying large bills (such as rental or mortgage payments and car registration) and the inconvenience of having to split these payments across two separate accounts (the CDC and regular bank account).

*If I've got an adult living with me and I'll say, \$200 board a fortnight, that means they have to give me their card to go and do a grocery. They can't actually pay the \$200 out. So, it's sort of taken away...that independence...and made people more reliant. SH05C*

*So every time I have to pay my rent I have to make one transaction out of this card and one transaction out of my bank card. Because the amount that's on the Indue card is not enough to pay the rent. So I might as well be all in one card...so I wouldn't have to do two transactions, just one. P01C*

Some CDC participants reported that these difficulties had led them to fall behind in their payments and, when these payments related to accommodation expenses, concerns were expressed that this could potentially lead to homelessness.

*My daughter though, got evicted from her house because of the white card. Because the payments, you can only do a certain amount every 28 days. She set it up for the 28 days, but...it started getting mucked up, and then she'd call and ask, "Look, I need to either boost it, you know, make it a higher amount or whatever," and sometimes they just didn't get back to her and everything and she ended up with a \$2,000 debt, and she just had to give the house up and she moved back in with me. P44EK*

#### 5.4.3.2 *Spending patterns*

The qualitative research found that across all of the three trial sites, one of the most commonly perceived positive impacts of the CDC related to the spending patterns of CDC participants. Both stakeholders and CDC participants reported that the CDC was prioritising and therefore encouraging greater spending on essential items such as food, bills, clothes, household goods and fuel.

*First time I got it, I spent \$200 on food and that's the first time I did that, so my kids were happy with that. P48C*

*It helps me more with my food and I always know that that's the backup. I get all my food and everything so I'm always bills paid and everything, food...so when I'm poor I'm actually okay because I've got everything I need. P38GF*

The CDC was therefore considered by many respondents to be successfully acting as a barrier to the unwise spending of funds on non-essential purchases. Respondents recognised that the CDC acted as a mechanism to re-direct money away from purchase of alcohol, drugs and gambling products. Some CDC participants provided examples of how the CDC assisted them in reducing their spending on drugs and alcohol and had led to a beneficial change in their own spending patterns.

*I remember seeing, about a year after the card had been in, the sales figures. I think, from memory, the grog shop had dropped about 30 per cent and food sales had gone up 40 per cent in the supermarket...We saw the figures that showed one dropped, one rose. It's exactly what we wanted. SH31EK*

*Before I would spend my money paying my rent upfront, get my cigarettes, my alcohol, my drugs and then food... I'm eating properly now, helped me out in fuelling my car. P59GF*

Indeed, a key positive of the policy which was reported by many respondents, was that it encouraged CDC participants to spend more of their Centrelink payments on essential items for themselves and their families and diverted money away from alcohol, drugs and gambling. Hence, greater spending was noted on food, bills, clothes and household goods. The children of some CDC participants were felt to be particularly benefiting from this change in spending patterns; some of whom were reported to be better fed, dressed and cared for since the introduction of the CDC.

*Simple things like maybe the increases in Coles shopping trolleys, increases in kids with a scooter, increases in kids with new clothes, maybe that...I know I was thinking about it the other day and remembering when I was first up here and you never saw evidence of kids being bought things like that. SH03EK*

Despite these positive perceptions about patterns of spending, concerns were also expressed that CDC participants no longer had control over how their money was used. This was particularly seen as being unfair for people who had previously managed their finances appropriately and were budgeting well prior to the CDC rollout. Concerns were also noted about the ability of CDC participants to use their Card away from the trial site areas with some reporting stores not accepting the CDC.

*I know a lot of people in this community before this Indue card come out, they already had their own little systems in place where they getting their bills paid through Centrepay deductions and things like that there. And then whoever made the Indue card thing come in and just like took that all away from them. People was already being responsible. SH05C*

#### **5.4.3.3 Financial abuse and humbugging**

Respondents commonly reported an increased risk of financial abuse, fraud and exploitation with the CDC. Many respondents felt that older people (both CDC participants and Age Pension recipients) had become more vulnerable to financial abuse since the start of the CDC. Some of the older cohort participating in the CDC trial were reported to have lower literacy levels and be less familiar with the use of bank cards and modern technology. As a consequence, these individuals required more support with managing and using their Card and were therefore considered more vulnerable to being targeted for their cash or being forced to hand their Card to others.

*I've actually heard that people are getting threatened, like the elders by the younger kids that are actually on these drugs. Give me your Indue card we're going to use it on whatever, it might be food and then they'll be trading it for something else. SH02GF*

Aged pensioners who were not part of the CDC—and therefore did not have their Centrelink payments placed on the Card—were now said to be more frequently targeted for cash. To allay this issue, some stakeholders reported that older people on the Age Pension were being encouraged to voluntarily opt onto the CDC.

*Some of our elders...didn't go on the cashless debit card...so they were being targeted even more so. So there was a lot more elder abuse that we recognised and we could see that they were being really targeted I suppose for their cash and targeted more so than they used to be and so that cohort...they really found it very difficult. SH30C*

In addition to the reported occurrence of elder abuse under the CDC, broader instances of financial fraud were reported by some respondents. Two primary methods of fraud were described: firstly, the stealing (and subsequent use) of Cards; and secondly, the online transfer of CDC funds without the permission of the account holder. Those individuals who relied on assistance from family members to manage their Card were said to be particularly vulnerable to this latter form of financial abuse. While these methods of fraud were also described as occurring with a person's normal bank card, respondents indicated it was less likely to happen as greater value was placed on these cards and people were more likely to keep them safe and less likely to provide them to family and friends to use.

*My family was actually robbing me, getting my details, my email address and password for the Indue, they go and use another phone and they put my email and password in their phone so*



*they can steal money from my account. I actually put a stop on that, on my family from stealing money from me. I told them I am really struggling you know, I have three kids, I don't have a mother or father to see in this world to help me, I am struggling, I am a dependent woman and I really needed this money in the Indue card for my kids. P49EK*

*We get a lot of elderly clients that come in, that when you look into their account they've got 20, 30, 40, you know, their money's all gone. And it's just all these little small transfers that people have, they've given their password out to grandkids or nieces or nephews and just been totally ripped off. SH09C*

Furthermore, the exploitation of CDC participants was described by some respondents as taking place. In order to continue to support their alcohol or drug habits, some CDC participants were described as taking part in card workarounds or sly grogging, which left them financially disadvantaged and without money to pay for essential items such as food (further details are provided in the Qualitative Supplementary Report).

*So people they go and trade and...they'll say well if you buy me a carton or you buy me a bottle of wine or whatever you can get it out of my Indue but you can spend an extra \$20 or \$50 and people are doing it...and they're spending all that for something that doesn't cost as much as they're spending out of that person's card, so they're ripping them off at the same time. I know somebody who bought somebody a couple of bottles of wine and then they said oh my pay go in there, this old person and he had over \$900 in there, she's spent the lot. P07EK*

Perceptions were mixed as to whether the incidence of humbugging—i.e. requests for money from others—had increased or not with the CDC. Although some respondents felt humbugging had increased since the CDC, participants frequently provided personal stories of how, because of being on the Card, they could decline demands for money from family members and as a consequence manage their own finances better.

*Sad to say there's been more humbugging because they want cash. Alcohol and drugs. Because they know us and we're family. So, "Hello, sis. Have you got \$10, \$20 for me?" It's all the time. SH04C*

*Best thing is you don't have to give out money...Some people was asking me, "Oh, any money?" and I said, "You know we're on that card now? We can't get out money," which is good. You know, that's a good thing. You don't have to support their bad habit. P22EK.*

#### **5.4.4 Integration of evidence**

Both qualitative and quantitative evidence on the impact of the CDC on financial planning and money management produce a mixed picture where the CDC is found to make some things better and some things worse, for some people but not for others. The evidence is not easy to interpret and this is reflected in the narrative that emerges. As it always does, the qualitative evidence approached the issue from many different angles and has offered a consistent message which says the policy works for some people but not for others and in different ways through different behavioural routes. It alerts the reader by mentioning that there are cases where the CDC leads participants to problematic financial outcomes. Through the design of the relevant part of the questionnaire, the quantitative survey evidence approached questions of financial impacts from several different angles, from the very specific, using a large number of financial situation/stress domains, to the less specific, using a

broader set of questions on money management, with a final question of how widely any possible benefits from the CDC may be spread, starting from the participants themselves all the way to the area they live. With the support of the precise population weighting that the Australian Government administrative data supported and the large sample size obtained at survey collection, the quantitative data allowed us to examine the impact questions with some confidence.

We do not find a simple answer about the impact of the CDC, but as the quantitative results reveal, we find a consistent narrative, which suggests there are issues with both the implementation and the targeting of the CDC. This consistent narrative emerges from both the qualitative and quantitative evidence regarding financial planning and money management and shows the CDC has strong beneficial effects to the fewer people who need them, but it also has negative effects to the rest of the CDC participants who may not need the financial discipline the CDC has introduced for them. The quantitative results show very clearly that each trial site has its own narrative, with the impacts experienced differently in each. Even within a particular trial site (the Goldfields) we can see two different narratives emerge. The quantitative survey evidence confirms and quantifies, something the qualitative research has been suggesting throughout this research, namely, that one size may not fit all when we deal with a policy that touches, in the most personal manner, several groups of people with a variety of social, community and individual characteristics. The combined evidence offered by this study can assist in informing the future development of the CDC policy.

#### **5.4.5 The evidence base**

The qualitative evidence base allowed us to build a wide range of hypotheses and guided the relevant parts of the questionnaire design. There has been a very strong complementarity between qualitative and quantitative methodologies (including the stakeholder engagement strategy) in the design, collection and analysis phases on the topic of financial planning and management. In particular, the informed wide-lens views of stakeholders have been very useful. Community data has not been able to support this part of the evaluation. The much larger than targeted and expected sample size of the quantitative survey has allowed the granular examination of some of the more detailed financial questions (for example, of the individual 13 financial domains individually and by site), enabling the ongoing multivariate analyses of the overall impact of the CDC.

#### **5.4.6 Observations, limitations and caveats**

Asking a question that does not have a single or simple answer is where multi-method and multi-disciplinary evidence bases and their analyses are at their best. The examination of the financial aspects of the CDC impact is a point in case. A powerful narrative is emerging regarding financial impacts, namely that the CDC is working well for the smaller part of the CDC participants who need the CDC, but is not working well for the much larger part of the CDC participants who do not need the CDC for their financial planning and money management.

A limitation is the short-term nature of the evidence we are studying. The longitudinal nature of the survey would address this limitation, albeit gradually, as panel data sets do.<sup>67</sup> The inter-dependence of all factors that influence the impacts of the CDC recommends caution when we try to interpret any sections of the Consolidated Report individually.

---

<sup>67</sup> Panel datasets means that one observes each individual several times in the survey data. Looking at how survey respondents' answers change over time allows one to use more robust statistical techniques to make impact statements.



### 5.4.7 Summary

There is no single or simple message on the financial outcomes of the CDC. A core finding of this Report is that the CDC makes things better financially for those who are probably the most vulnerable and who need it most. It was also reported that the CDC introduces widely felt hurdles to all participants, including those who feel they need it the least.

## 5.5 Safety, crime and family violence

An expectation from the CDC is that a reduction in harmful behaviours will trickle down into the community and families in the form of increased safety, lower crime and less family violence. However, there is a possibility that the added restrictions introduced by the CDC to limit the availability of cash for harmful behaviours, may result in more criminal activity. This may occur at least in the short term and especially where addictive behaviours may be involved for the purposes of obtaining the necessary cash, or due to the frustration of not having access to sufficient cash.

### 5.5.1 Key findings

- Most CDC participants reported that they do not feel safer since the introduction of the CDC and a large minority reported that they do: the split is about 60/40, but with major site differences.
- The East Kimberley produced the most polarised picture where also females were less likely to report feeling safe on the CDC than males.
- Ceduna produced the most positive picture about improvements in safety and this was felt more by females than males.
- The Goldfields picture was overwhelmingly divided with Indigenous participants feeling more safe and non-Indigenous participants feeling a lot less safe.
- Perceptions of safety were highest in the East Kimberley, followed closely by Ceduna with the Goldfields some distance behind. The lowest reporting about feeling safe came from the non-Indigenous CDC participants in the Goldfields.
- In all trial sites perceptions of safety were at their highest during the day in the street and at the lowest during the night at home.
- Multivariate analysis allowed us to highlight those individual characteristics of the CDC participants that were more likely to report that their safety was worse/better since the CDC.
- The most prominent characteristics of the CDC participants who reported that their safety had become worse were: males, non-Indigenous, single parents, living in the Goldfields site (or in Ceduna), with less experience on the CDC.
- The most prominent characteristics of the CDC participants who reported that their safety had improved were: females, couples, living in East Kimberley, Indigenous, with longer experience on the CDC, in receipt of DSP.
- Community-level data allowed only a limited estimation effort of the impact of the CDC using data on Police outcomes. Estimations suggested there was an increase in domestic violence in the East

Kimberley site. There were some statistically weak results in the Goldfields for increased domestic violence and drug offences as well as increased stealing in the East Kimberley. These statistically weak results are subject to serious caveats and limitations of the data, which could not be fully addressed by our use of a comprehensive econometric modelling strategy.

- o The qualitative findings caution against assuming changes in safety, crime and family violence be attributed to the CDC. The CDC was introduced at a time when several other policy reforms and interventions were occurring in the trial sites making it difficult to determine the direct impacts from the CDC policy alone, as these other reforms and interventions also affected social conditions within the region.

## 5.5.2 Evidence from large scale survey

The quantitative survey of CDC participants included a number of measures which aimed to assess the impact the CDC has had on safety. Respondents were asked three questions.

First, we asked whether individuals felt safer on the CDC. This is a direct question about the impact of the CDC on safety, asking about a general feeling of safety without going into any specifics.

Second, we asked how safe CDC participants feel about their current safety levels in the area the respondents live, making the distinction between home and street safety and day and night safety and not asking specifically about the CDC. This question gives us four combinations: *Home in the day*, *Street in the day*, *Home in the night* and *Street in the night*. Although not directly asked, it is easy to see how each of these combinations would place more emphasis on the different outcomes of safety, crime and family violence.

Third, we asked how these four combinations of safety are perceived to have changed since the CDC was introduced, again in the area where respondents live.<sup>68</sup> A similar question was asked regarding changes in the safety of children since the CDC introduction, which is reported in the section on Child Welfare and Family Well-being and is also briefly mentioned here in the general safety context.

### 5.5.2.1 Feeling safer after the introduction of the CDC?

Table 5-15 below shows that about 63 per cent of respondents said they “never” or “hardly ever” felt safer on the CDC, about 18 per cent said they felt safer “sometimes” and about 20 per cent that they felt safer “most” or “all” of the time. Overall, the picture is one where most people reported no improvement in safety and a large minority (in the case of Ceduna almost half) reported an improvement in safety. The most polarised picture emerged in East Kimberley, the most positive in Ceduna and by far the most negative picture in the non-Indigenous CDC participants in the Goldfields.

---

<sup>68</sup> This is the clearest direct question about a CDC impact on safety. We note that the question does not ask about changes that were caused by the CDC, it simply asks for change that happened “since the CDC was introduced”.

Table 5-15: Feeling safer on the CDC, by trial site

Feeling safer on the CDC					
	All sites %	East Kimberley %	Goldfields Indigenous %	Goldfields Non- Indigenous %	Ceduna & surrounds %
<b>Never</b>	50.9	48.4	45.1	64.1	38.7
<b>Hardly ever</b>	11.7	7.1	12.1	14.2	13.7
<b>Sometimes</b>	17.9	16.0	21.3	12.7	25.8
<b>Most of the time</b>	5.9	6.5	6.8	3.5	7.9
<b>All of the time</b>	13.6	22.0	14.7	5.5	13.9
<b>Total (N)</b>	<b>5,713</b>	<b>1,509</b>	<b>1,549</b>	<b>1,770</b>	<b>885</b>

*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. The total of all sites will be below 6,039 when we do not report the missing observations explicitly.*

Alongside the strong differences between Indigenous and non-Indigenous CDC participants showcased within the Goldfields trial site (43 per cent of Indigenous CDC participants in the Goldfields reported improved safety, compared with 22 per cent among their non-Indigenous counterparts), differences in perceptions of safety were also found for male and female participants in some trial sites. Fewer females (42 per cent) than males (48 per cent) reported improved safety in East Kimberley, while more females (53 per cent) than males (42 per cent) reported improved safety in Ceduna.

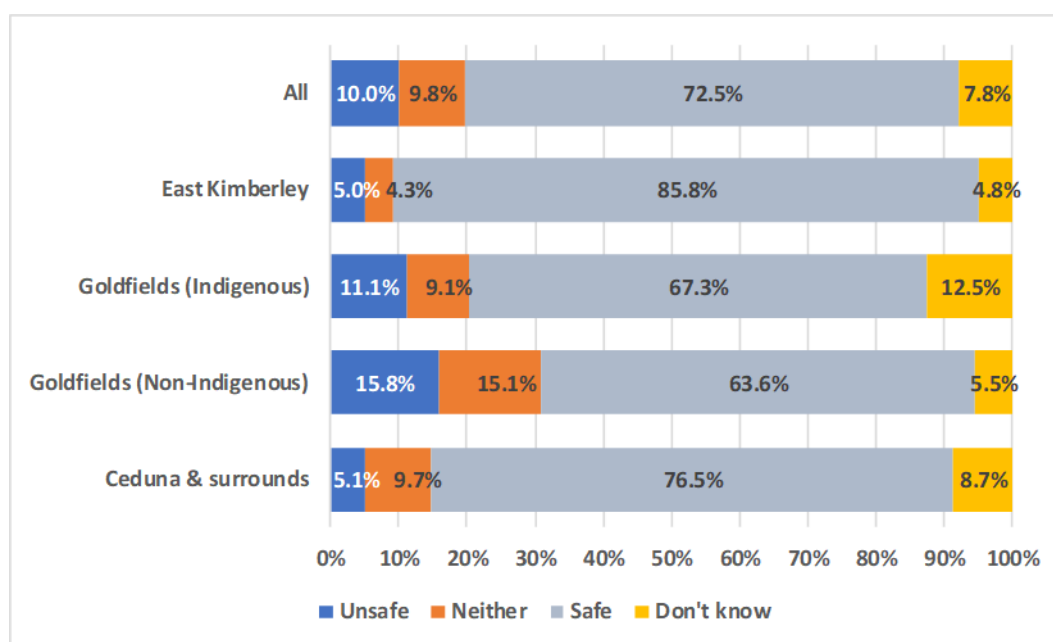
### 5.5.2.2 *Current levels of safety comparing day/night and streets/home by site*

We now move to the second question about *current levels of safety*, where respondents are asked to make a clear distinction between feeling unsafe and feeling safe.<sup>69</sup> Figures 5-7 to 5-10 show safety “in the streets in the day”, “in the streets at night”, “in the home in the day”, and “in the home at night” respectively.

Figure 5-6 shows *safety in the streets during day time*. East Kimberley is considered to be the safest trial site with 85.8 per cent of respondents reporting they currently feel safe and only 5 per cent feeling unsafe. A similar picture emerges from Ceduna where 5.1 per cent reported that they feel unsafe. In the Goldfields this proportion is reported to be more than three times the East Kimberley and Ceduna size (15.8 per cent) by non-Indigenous CDC participants and more than twice the size (11.1 per cent) by the Indigenous CDC participants in the Goldfields. It is clear the more positive picture presented in East Kimberley and Ceduna is far less prevalent in the Goldfields.

<sup>69</sup> We present these percentages in a group of four Figures, noting that the relevant sample sizes are very similar to the ones reported in Table 5-15 above. We combine the categories “very unsafe” and “unsafe” into one, labelled as “unsafe”, and the categories “safe” and “very safe”, into one, labelled as “safe”. Category “neither safe, nor unsafe” is labelled as “same”.

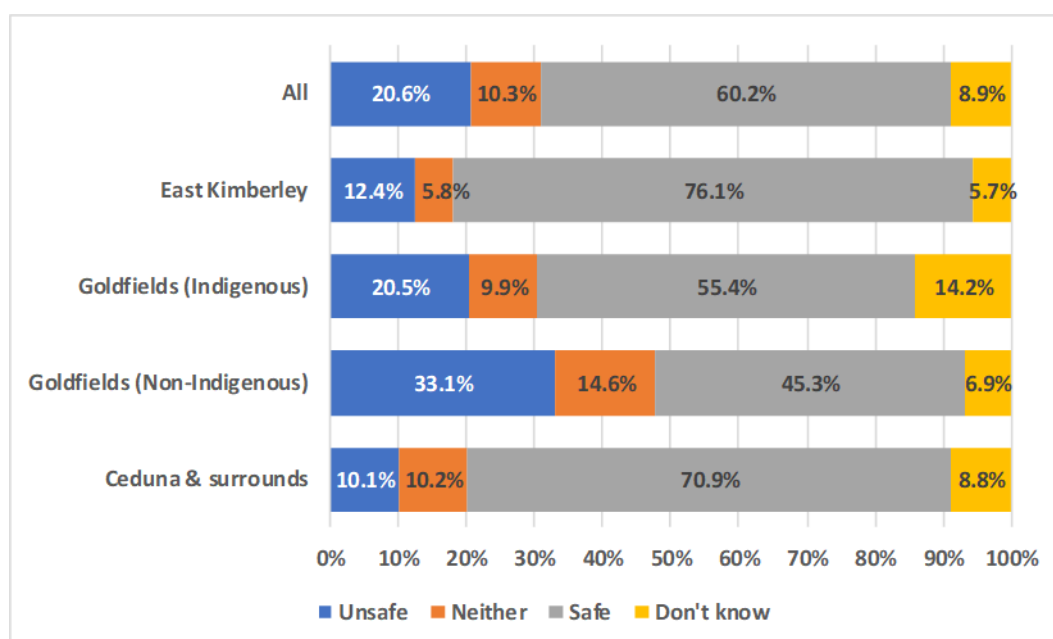
Figure 5-6: How safe do you currently feel (Streets-Days), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Category "same" refers to people who report they feel neither safe nor unsafe.

Figure 5-7 shows *safety in the streets at night* and also allows us to see the differences between day and night safety in the streets. East Kimberley retained the largest proportion of respondents who felt safe at night in the streets of the area they live (76.1 per cent) which is similar to the Ceduna proportion (70.9 per cent), but much larger than the Indigenous Goldfields proportion (55.4 per cent), and especially the non-Indigenous Goldfields proportion (45.3 per cent).

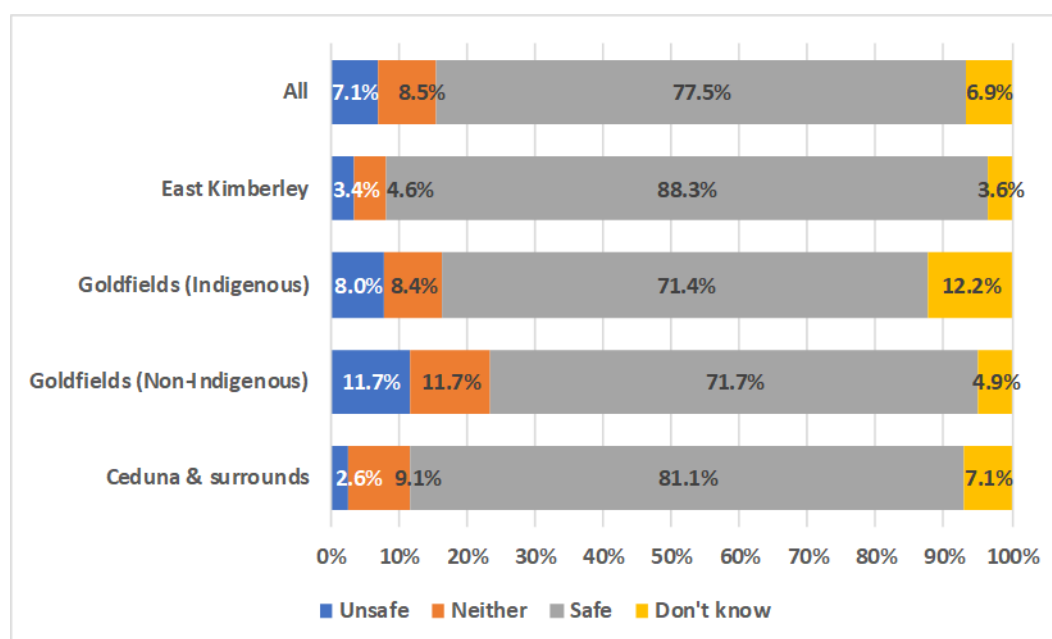
Figure 5-7: How safe do you currently feel (Streets-Nights), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Figure 5-8 below shows *safety in the home during day time*. Similar to street safety, East Kimberley and Ceduna reported the highest proportions of CDC participants feeling safe in their homes during the day time (88.3 and 81.1 per cent respectively) and a much lower proportion of people feeling unsafe (3.4 and 2.6 per cent respectively). Interestingly, the Goldfields respondents reported a high proportion of participants feeling safe (almost identical for Indigenous and non-Indigenous at 71.4 and 71.7 per cent). However, compared to the other two trial sites, the Goldfields again had a higher proportion of CDC participants who reported feeling unsafe (at 11.7 per cent for non-Indigenous and 8.0 per cent for Indigenous CDC participants).

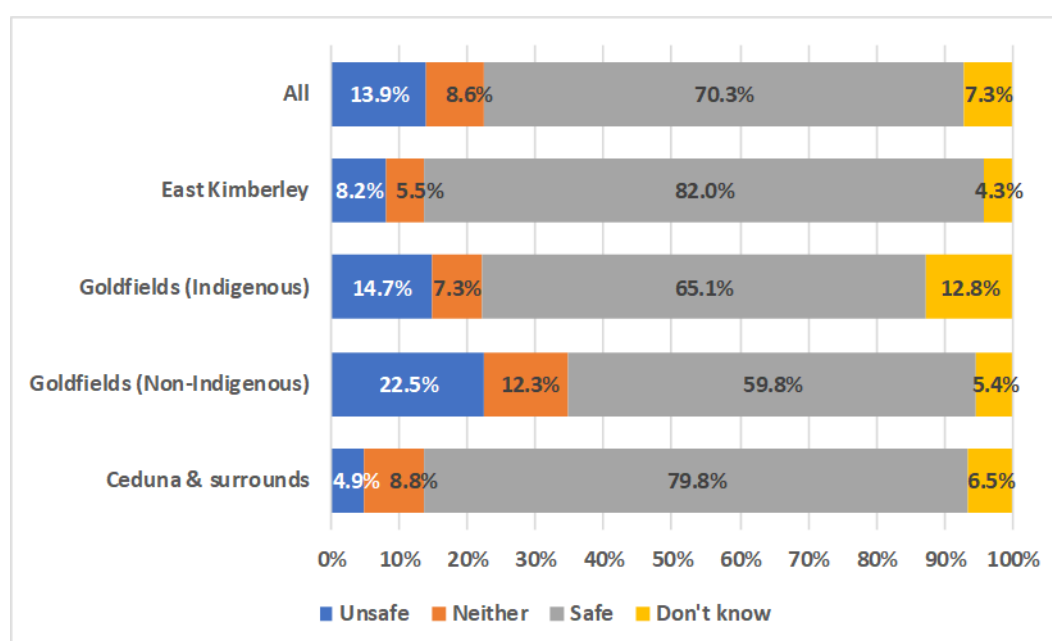
Figure 5-8: How safe do you currently feel (Home-Days), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Figure 5-9 below shows *safety in the home during night time* and allows us to examine the difference between Day and Night. This difference was not very prominent for East Kimberley and for Ceduna as shown by the modestly smaller proportion of participants who reported they felt safe at night than during day time (from 88.3 down to 82 per cent for East Kimberley and 81.1 to 79.8 per cent for Ceduna). The proportions of respondents who felt unsafe at night was much larger, but it still remained small in size (it rose from 3.4 to 8.2 per cent in East Kimberley and from 2.6 to 4.9 per cent in Ceduna).

Figure 5-9: How safe do you currently feel (Home-Nights), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

The largest difference that emerged in the night versus day safety comparison was in the Goldfields, especially among the non-Indigenous CDC participants of whom 22.5 per cent reported feeling unsafe in the night in their homes. The suggestion is that safety is a multifaceted concept in both its causes and outcomes and cannot be easily explained by any single narrative. To sum up the evidence on current safety levels and their specifics, while the first and more general question we asked provided a picture of low levels of safety, the more specific safety questions in Figures 5-6 to 5-9 suggested generally high levels of safety, that were also present in the night.<sup>70</sup>

### 5.5.2.3 Changes in safety since the introduction of the CDC

We now move to the examination of how CDC participants perceived safety to have changed since the introduction of the CDC.<sup>71</sup>

<sup>70</sup> We asked CDC participants how safe they are now and whether they feel safer or not since the CDC. From the answer about what safety is like now and the answer to the second question we get an idea about what safety was like before. This is evidence from a one wave data collection and is subject to the usual reservations about recall bias. The longitudinal aspect of the outcomes elicited in the survey is thus limited by definition. However, a second wave that asked how safe these same people currently feel would allow a much finer analysis by looking at the differences overtime and correct for observed and unobserved heterogeneity. This is the case for most of the outcomes elicited in the survey because of the single wave of data collection. In the meantime, these are the best information that one can get given the circumstances.

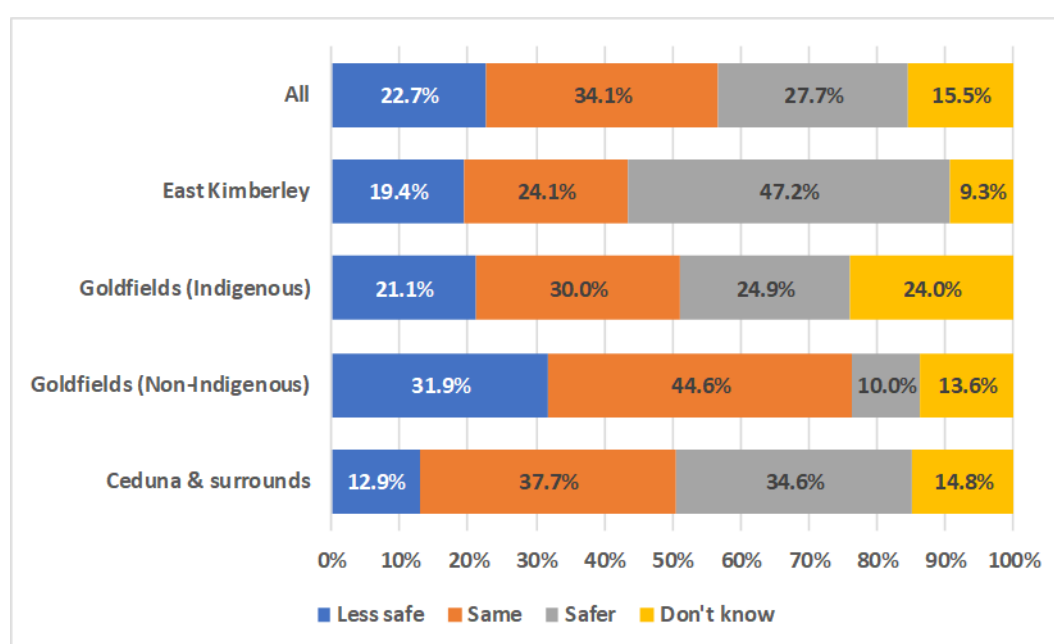
<sup>71</sup> We use a very similar tool for exposition, namely Figures 5-11 to 5-14 below. They are identical to Figures 5-7 to 5-10 with the only difference that they present how safety changed since the CDC introduction. The answers now are all about change and are colour coded as follows:

- "A lot less safe" and "Less safe" (blue);
- "Neither" (orange);
- "Safer" or "A lot safer" (grey); and
- With the remainder "Do not know" in yellow.

Otherwise the presentation is the same as in the previous section. The change questions are always cognitively more demanding and burdensome, which is manifested by the larger proportion of respondents picking the "Don't know" option.

Figure 5-10 below shows the change in safety in the streets during day time. The aggregation in the first row (all sites) concealed strong site differences. If we calculate the simplest of all indicators of improvement by subtracting the proportion of those who felt less safe from the proportion of those who felt safer, the “net” impact of the CDC for all trial sites (top row in Figure 5-10) would be a modest 5 per cent improvement in safety.<sup>72</sup> The highest such improvement appeared in East Kimberley (a net of +27.8 per cent) with Ceduna following close (a net of +21.7 per cent).

Figure 5-10: Do you feel more or less safe since the introduction of the CDC (Streets-Days), by trial site



*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.*

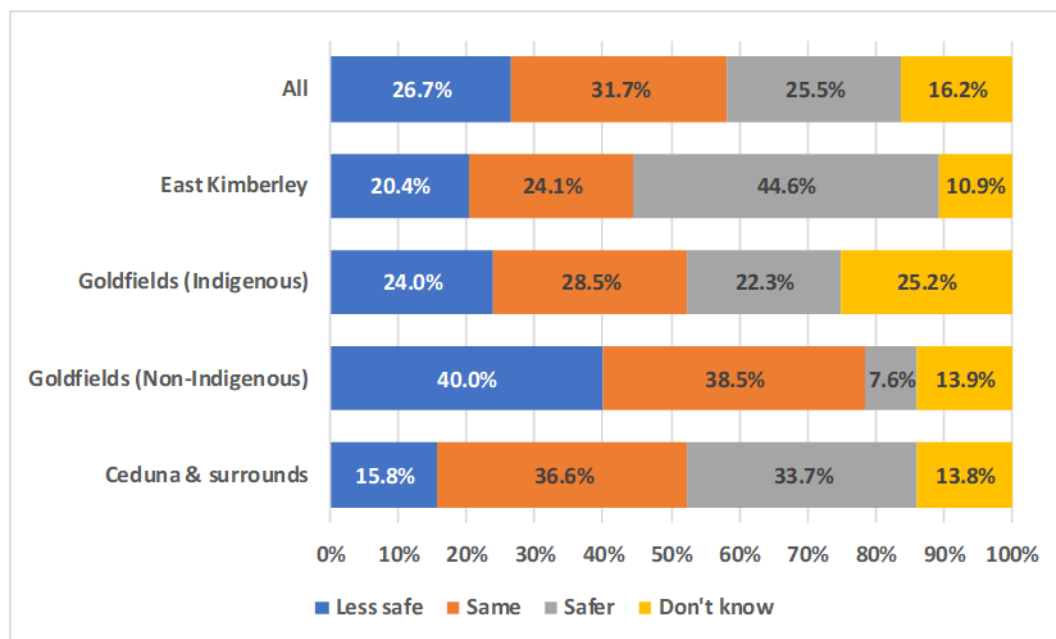
Indigenous CDC participants in the Goldfields emerged with a net improvement of +3.8 per cent followed by non-Indigenous CDC participants in the Goldfields with a perceived reduction in safety (net of -21.9 per cent) since the CDC introduction. Figure 5-10 therefore suggested large differences in the perceptions of safety in the different CDC sites.<sup>73</sup>

A very similar picture emerges in Figure 5-11 below about safety in the street during night time: it is just considered less safe all round at night. The reduction in safety reported by the 40 per cent of non-Indigenous CDC participants in the Goldfields is particularly large with a net deterioration of -32.4 per cent.

<sup>72</sup> 27.7 per cent reported “safer” and 22.7 per cent “less safe”, providing a net of 5 per cent improvement. This calculation is an oversimplification for pure illustrative purposes. All indices of this type need to make interpersonal comparisons that may be anything from the best given the evidence to totally unsuitable for the job. We do not claim that the simple indicator used here can have any more value than to provide a qualitative illustration about improvement.

<sup>73</sup> We note that this large “net” number of -21.9 per cent is the result of the largest proportion of CDC participants feeling less safe since the CDC (31.9 per cent) accompanied by the largest proportion who felt no change (44.6 per cent) and the smallest proportion feeling safer (only 10 per cent).

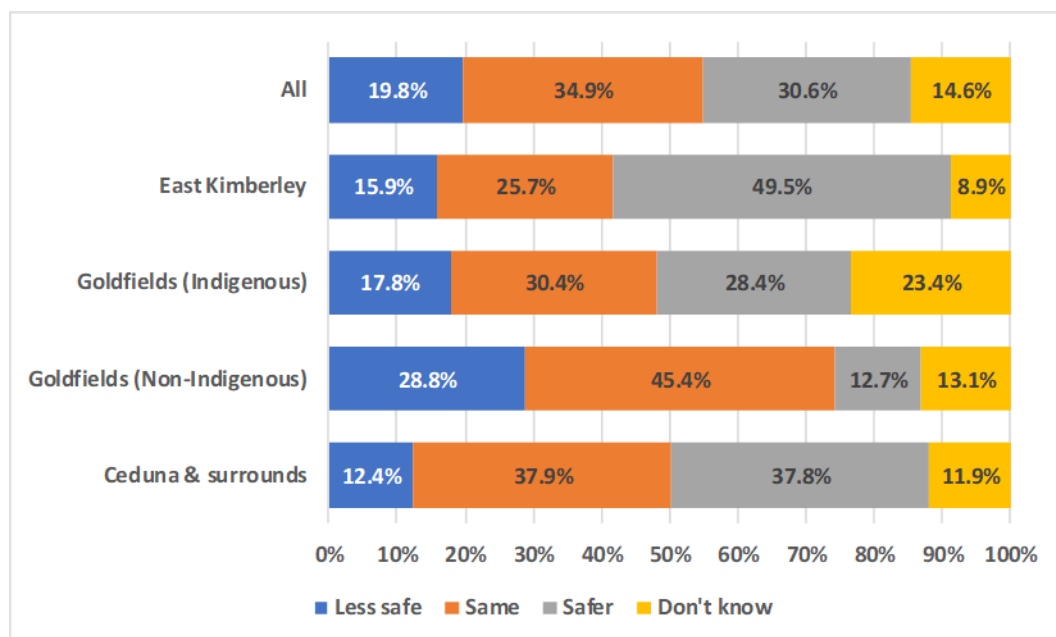
Figure 5-11: Do you feel more or less safe since the introduction of the CDC (Streets-Nights), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Figure 5-12 shows reported safety changes in the home during day time since the introduction of the CDC. A similar pattern to that found for street safety emerged, with East Kimberley reporting the largest improvement in safety in the home during the day (49.5 per cent), with Ceduna following close with sizeable improvements. A modest improvement was reported in the Goldfields by Indigenous CDC participants and a sizeable deterioration by their non-Indigenous counterparts.

Figure 5-12: Do you feel more or less safe since the introduction of the CDC (Home-Days), by trial site

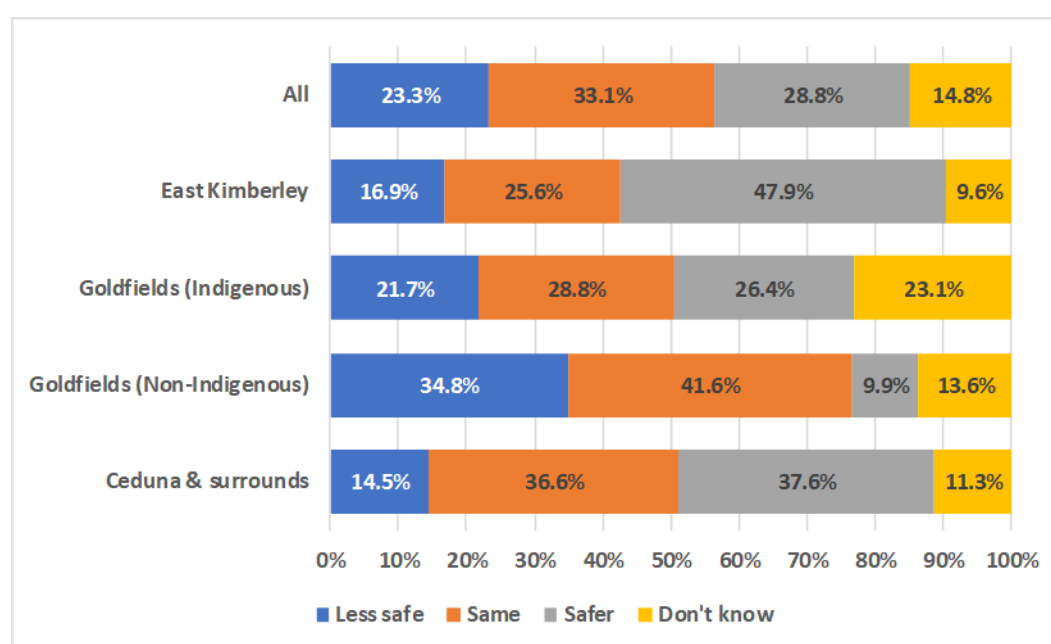


Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.



Figure 5-13 reports safety in the home during the night since the introduction of the CDC. Both East Kimberley and Ceduna CDC participants reported very similar safety changes in the night at home as they did for daytime home safety, with East Kimberley reporting more cases of improvement than Ceduna. Following the established general pattern, the Goldfields non-Indigenous participants reported a net reduction in safety that was worse at night with more than one in three non-Indigenous CDC participants reporting worse safety and only one in ten reporting improved safety.

Figure 5-13: Do you feel more or less safe since the introduction of the CDC (Home-Nights), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

In the remainder of this section we try to identify the type of change that is reported and the type of person who reports change.

#### 5.5.2.4 Type of change in safety since the introduction of the CDC

The quantitative survey provided information for a more detailed assessment of the impact of the CDC on the safety of its participants in the areas they live. This section reports on two such investigations, both based on the capacity of the data to examine *change at the individual level*, first by combining the information on the *type of change* and second, by conducting multivariate analysis on the *type of person* who experienced different types of change.

The first investigation focused on the nature of the reported change in safety since the CDC introduction and combined it with the current safety status of individual CDC participants. Intuitively put, we asked those who reported having experienced a change for the better or for the worse, about their reported current safety status. The distinction that can be made in this context is that, from a personal point of view, change in safety does not only matter in and by itself, it also matters in regard to the person's current perceptions of safety. Specifically, this first investigation cross-analysed participants reports of current perceptions of safety with their perceptions of how their safety had changed post the CDC (did safety improve or not) with the level of current safety (is the respondent feeling safe or unsafe) *at the individual level*. This combination allowed us to examine the current

safety status of individual CDC respondents alongside the change in safety they experienced since the introduction of the CDC.

Simply put, this section makes the distinction between being made safer to the degree that you feel safe and being made safer to the degree of still feeling unsafe. Similarly, one can feel less safe, but still in absolute terms report that they feel safe, which is very different from someone who reports that they were made less safe to the degree of feeling unsafe. As the data does not provide pure longitudinal information as yet, this type of investigation can provide a second best until such data is generated. Further detail relating to these analyses is provided in Box 5.5 below.

### Box 5.5: Types of change

We begin by distinguishing between those CDC participants who reported that, since the CDC introduction:

- their safety had got worse or a lot worse;
- their safety had stayed the same; and
- their safety had got better or a lot better.

For each one of these three categories we then examine the individual reported current safety status, in the following three categories:

- those who currently feel safe or very safe;
- those who currently feel neither safe nor unsafe; and
- those who currently feel unsafe or very unsafe.

We then combine the data at the individual level and examine the four safety outcomes (Street/Home and Day/Night) for the whole CDC population and by each trial site, with Goldfields split between Indigenous and non-Indigenous CDC participants.

These possibilities are described in Figures 5-14 to 5-17.

#### 5.5.2.5 *Group who reported that their safety was reduced since the introduction of the CDC*

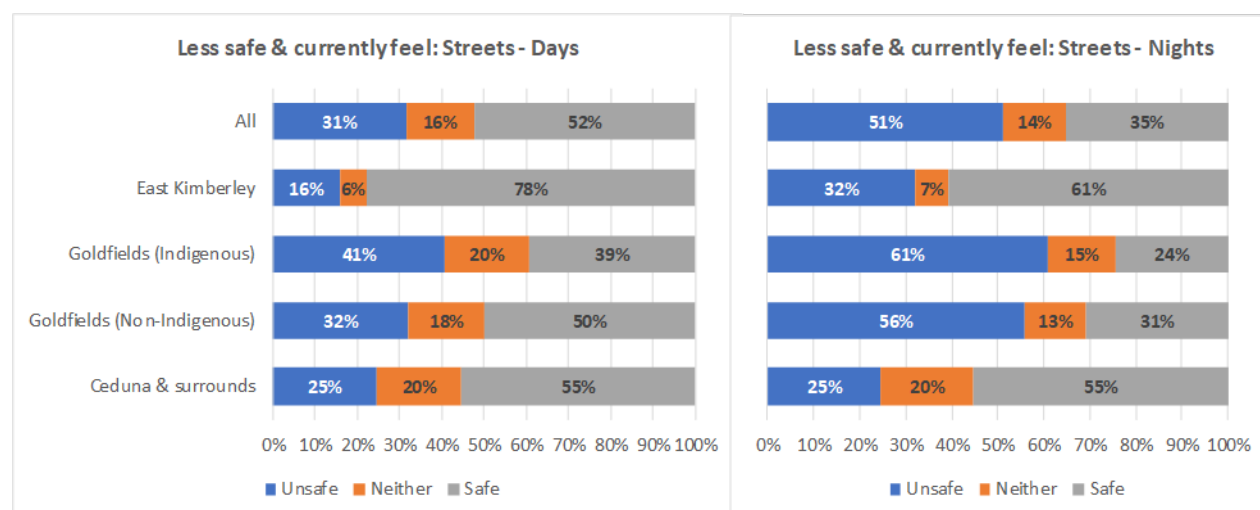
This subsection explores the evidence collected for the subset of CDC participants who reported that their safety was reduced since the introduction of the CDC. Figures 5-14 and 5-15 show the current safety status of the 28 per cent of CDC participants who reported that their safety had reduced (less safe or a lot less safe) since the introduction of the CDC in any one of the four domains (street - day, streets - nights, home - day and/or home - nights).<sup>74</sup> Three current safety outcomes are presented, colour-coded in: blue for 'unsafe or very unsafe'; orange for 'neither safe or unsafe'; grey for 'safe or very safe'. In Figure 5-14 street safety reduction is associated with about one third of all CDC

---

<sup>74</sup> Of the 28 per cent reporting a reduction in their safety since the CDC was introduced, those who did not report valid information for both how safe they currently feel and since the CDC was introduced were excluded from the analysis presented in the figures below. This excluded less than one per cent of the whole sample.

respondents feeling unsafe during day time (31.5 per cent) and more than half feeling unsafe during the night (51.1 per cent).

Figure 5-14: Current level of safety for those who reported that their safety was reduced since the CDC was introduced (Streets-Days; -Nights), by trial site

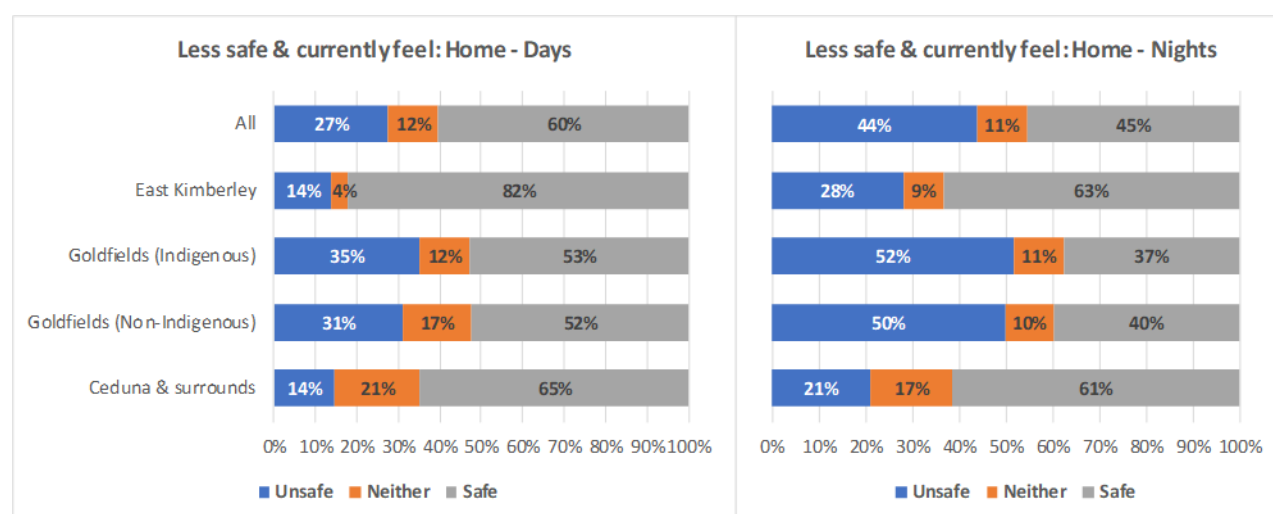


*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Sample size for Street Days Safety reduced is 1,323 and for Street Nights Safety reduced is 1,547. The sample used for this table excludes those who stated 'Do not Know' in either of the two questions and those who did not answer both questions.*

The reverse proportions are reported for those who, notwithstanding their safety having become worse, still reported that they currently felt safe (52.3 per cent for day and 35.2 per cent for night safety). Only a small proportion of those who experienced a reduction in safety reported that they currently felt neither safe nor unsafe (16.2 and 13.6 per cent for day and night safety respectively). There were large differences between the three sites, the most notable one being that the reported reduction in safety in the Goldfields was associated with high levels of CDC participants feeling unsafe, more so among the non-Indigenous participants and a lot more in the night than in the day. This finding identified safety as a major concern of CDC participants in the Goldfields trial site.

Figure 5-15 presents current safety in the home for those who experienced a reduction in safety since the CDC introduction. Qualitatively, the picture of safety in the home was very similar to that in the streets, it just appeared to be that the home was overall a safer place to be than the streets. The differences by trial site followed the same pattern with the Goldfields reporting low levels of current safety and more so at night, but with differences found between Indigenous and non-Indigenous reporting.

Figure 5-15: Current level of safety for those who reported that their safety was reduced since the CDC was introduced (Home-Days; -Nights), by trial site



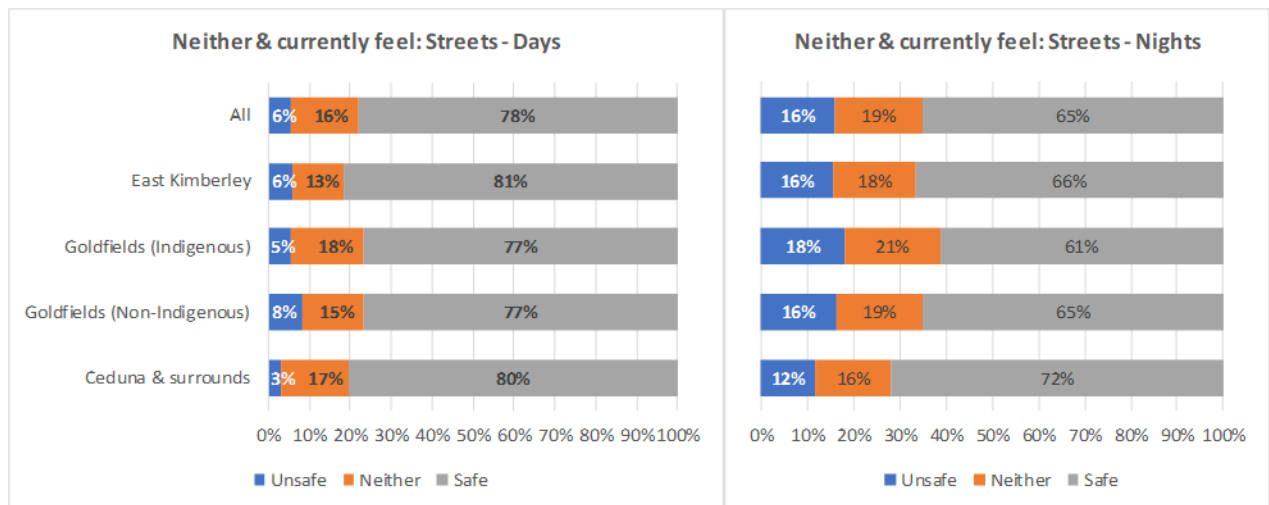
Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Sample size for Home Days Safety reduced is 1,173 and for Home Nights Safety reduced is 1,387.

The conclusion from Figures 5-14 and 5-15 is that there is an identifiable sub-group among the CDC participants who have reported their safety became worse since the introduction of the CDC *and* they currently felt either unsafe or very unsafe (shown by the blue marked parts in these figures). These participants were mostly located in the Goldfields trial site, but not exclusively. Our analyses indicated that a sizeable minority of CDC participants were in a worse safety position, especially with regard to perceptions of street safety.

#### 5.5.2.6 Group who reported that their safety remained unchanged since the introduction of the CDC

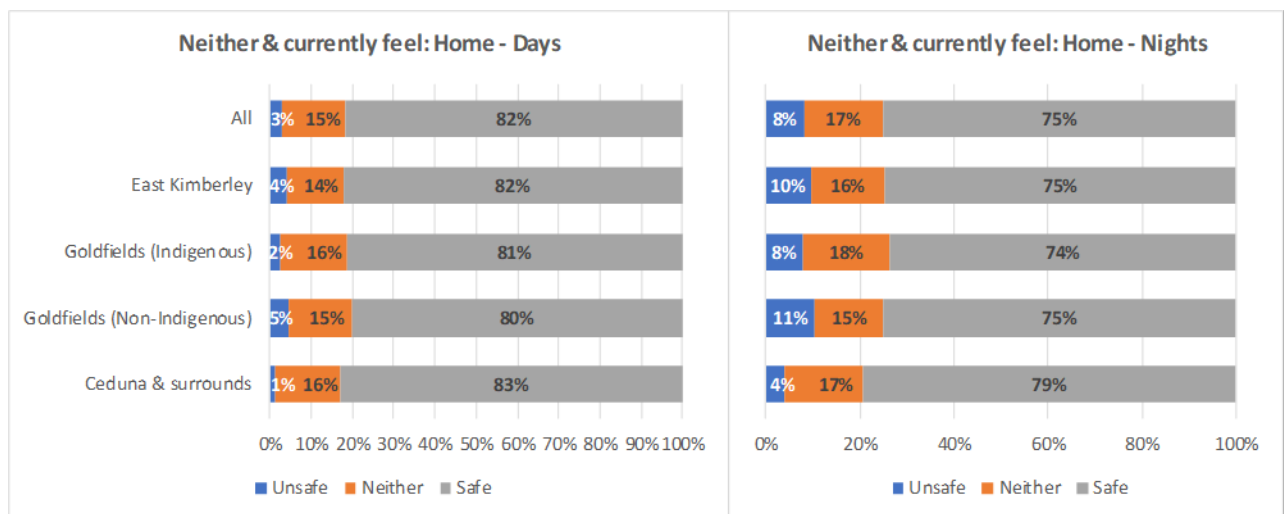
This subsection explores the evidence collected for the subset of CDC participants who reported that their safety remained unchanged since the introduction of the CDC. For those who have reported their safety on the streets and at home remained the same since the introduction of the CDC (as presented in Figures 5-16 and 5-17), only very small proportions reported they currently felt unsafe (between 5 and 16 per cent for all trial sites combined). Unlike in the previous subsection (Figures 5-14 and 5-15), there were no major differences between the three trial sites. Night safety remained considerably lower both in the streets and the home, but in a background of high levels of overall safety, this difference was not as pronounced in the absolute numbers.

Figure 5-16: Current level of safety for those who reported that their safety was not changed since the CDC was introduced (Streets-Days; -Nights), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Sample size for Street Days Safety remaining the same is 2,043 and for Street Nights Safety remaining the same is 1,882.

Figure 5-17: Current level of safety for those who reported that their safety was not changed since the CDC was introduced (Home-Days; -Nights), by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Sample size for Home Days Safety remaining the same is 2,092 and for Home Nights Safety remaining the same is 1,968.

#### *5.5.2.7 Group who reported that their safety improved since the introduction of the CDC*

This subsection explores the evidence collected for the subset of CDC participants who reported that their safety was improved since the introduction of the CDC. The group of CDC participants who reported their safety had improved since the introduction of the CDC reported overwhelmingly that they currently felt safe in proportions that are close to 100 per cent, so we do not present the relevant figures.<sup>75</sup>

#### *5.5.2.8 Characteristics of those who experienced change since the introduction of the CDC*

We conducted multivariate analysis, looking at the characteristics of those CDC participants who were more likely to report respectively that it is now less safe or safer since the introduction of the CDC. We estimated a series of models looking at each dimension of safety: In the street (day and night) and at home (day and night). In all models we controlled for CDC participants' views about their current safety.

The following box (Box 5.6) identifies and quantifies the characteristics of the participants who were more likely to report that it is less safe since the CDC.

---

<sup>75</sup> We note that the group who reported improved safety are a sizeable part of the CDC participants population. For comparability the sample sizes for deriving these statistics were: for Street Days Safety 1,617; for Street Nights Safety 1,507; for Home Days Safety 1,824; and for Home Nights Safety 1,709. The full results are available in the Quantitative Supplementary Report, but for reasons of space are not presented here.

### Box 5.6: Characteristics of the CDC participants who report that it is less safe since the introduction of the CDC

These characteristics were very similar for street and home safety:

- **Males:** males were more likely to report that it was less safe in the streets (about 4 percentage points more likely than females, both for safety during the day and at night).
- **CDC participants living in the Goldfields:** CDC participants in the Goldfields were 7.2 percentage points more likely to report that it was less safe in the streets during the day than CDC participants in East Kimberley. They were 9.3 percentage points more likely to state that it was less safe during the night.
- **CDC participants living in Ceduna:** CDC participants living in Ceduna were 4.2 percentage points more likely to say that it was less safe at night but no difference was found for daytime street safety (reference category is East Kimberley).
- **Non-Indigenous CDC participants:** were 14 percentage points more likely to report it was less safe (both during the day and at night) in the streets than Indigenous CDC participants.
- **CDC participants with less experience on the CDC:** while the effect is relatively small, those who had been rolled onto the CDC more recently were more likely to state it was less safe in the streets. The probability that CDC participants reported it was less safe in the street during the day since the CDC decreased by 1.2 per cent per 10 months after being on the CDC (2 per cent in the streets at night). For instance, comparing someone who had just been triggered onto the CDC with someone who had been rolled out two years ago, the former was 2.8 per cent more likely to report it was less safe in the streets during the day (and 4.8 per cent at night) after the CDC.
- **Experienced issues with using the Card:** were 10 percentage points more likely to say it was less safe in the streets.
- **Single parents (and other types of households):** were more likely than persons living alone to find safety had worsened in the street (5 and 4.7 percentage points for day and night respectively). Couples (with or without children) did not significantly differ from people living alone in their appraisal of how safety has changed over time.
- **Those currently experiencing higher financial stress.**
- **Those who did not hold a paying job within the four weeks of the survey:** were 5.6 percentage points more likely to report safety had worsened (both during the day and night).
- **Those identified as being high/very high risk in terms of their alcohol consumption:** compared to those who were low risk, they were 7 percentage points more likely to say the streets were less safe during the day (8.2 percentage points more likely to say that streets were less safe at night).
- **Those who stated they do not drink:** compared with the low risk individuals, they were slightly more likely to report streets were less safe (2.3 and 5.1 percentage points respectively for 'during the day' and 'at night').

We conducted a similar set of estimations about those CDC participants who reported they feel safer since the introduction of the CDC. The following box (Box 5.7) identifies and quantifies the characteristics of the participants who are more likely to report it is safer now since the introduction of the CDC.

**Box 5.7: Characteristics of the CDC participants who report it is safer since the introduction of the CDC (day and night)**

- **Females:** Females were more likely than males to report that safety had improved both in the streets and at home (both day and night). The magnitude of the gender differences ranged from 3.3 percentage points (safety at home at night) to 4.5 percentage points (safety in the streets during the day). No evidence of interaction effects were found between trial site and gender.
- **CDC participants in East Kimberley:** compared with CDC participants in the Goldfields, CDC participants in East Kimberley were between 8.3 percentage points ('in the streets during the day') and 10 percentage points ('at home at night') more likely to report that safety had improved.
- **East Kimberley CDC participants:** were also more likely to report that safety had improved in the streets at night and at home (both day and night). The magnitude of the difference ranged from 3.9 percentage points ('in the streets at night') to 6.7 percentage points ('home at night').
- **Indigenous CDC participants:** differed greatly from non-Indigenous participants. They were about 14 percentage points more likely to report that safety had improved across all dimensions of safety.
- **Longer experience on the CDC:** the longer CDC participants had been on the CDC, the more likely they were to report improvements in safety across all dimensions.
- **CDC participants living alone or as couples (with or without children):** were more likely to report safety improvements than single parents.
- **CDC participants in receipt of DSP:** they were between 3.9 ('in the streets during the day') and 4.7 ('at home at night') percentage points more likely to report safety improvements than other benefit recipients.
- **CDC participants who experienced more financial stress in the year leading to the CDC rollout.**
- **CDC participants who had a paying job within the four weeks of the survey:** they were between 3.4 ('at home at night') and 6.6 ('in the streets during the day') percentage points more likely to report that safety had improved since the CDC compared to those who did not hold a job.



## 5.5.3 Evidence from community-level data

### 5.5.3.1 *Was the available community-level data fit for the job?*

Community-level data was used for the purposes of the evaluation in only a few cases, the main reason being the limitations of this data source and the associated caveats, as discussed in the earlier Chapters in this report. One of the cases where community-level data could be used for estimation purposes was the Police data that was made available by the States of Western Australia and South Australia. The police data on crime allowed the evaluation to examine if adequately robust impact statements about the CDC (and related measures accompanying the CDC) could be obtained.<sup>76</sup> The results are presented here in a summary format. We note that Police data was available on a per quarter basis, which resulted in a small number of data points pre- and post-CDC rollout, especially in the Goldfields where the CDC was rolled out progressively between the very end of March and the middle of May 2018.

In reporting this analysis, we ask the reader to be mindful of the caveats that must accompany the reading of these estimation results. First, the estimates we present pertain to the broader population and not only the CDC participants. Thus, the findings we present are diluted, meaning that there may be impacts specifically relating to the CDC that the data does not manage to detect because of this dilution. Second, crime reduction is the permanent and continuing objective of a large number of concurrent policies. Thus, even if we detect an impact through the use of broad community-level data, we cannot know for sure whether it is a CDC impact or an impact of other related policies, or a mix of both. Practically, direct identification and attribution to a single policy is very hard to achieve. Third, the specific behaviours and outcomes we are measuring can be subject to many distortions and biases. For example, it would not be unreasonable to expect that the implementation of the CDC in the trial areas may have also led to increased awareness of the public, increased police activity and stronger targeting of those offenses that the CDC may be aiming to reduce.<sup>77</sup> With these caveats in mind, we invite the reader to interpret the findings of this section with appropriate caution.

### 5.5.3.2 *Estimation methodology and practical considerations*

There are additional caveats with the Police data, which are of a practical nature for the analysis of the impact of the CDC (and related measures) on crime in the trial areas. These practical issues are discussed at length in the Quantitative Supplementary Report. They pertain to the fact that most of the localities included in the data are sparsely populated. When analysing Police outcomes, this meant that we encountered a large number of sparsely populated localities with few or no recorded offences in several quarters within the window of observation of the data. The issue is compounded by the fact that the analysis needed to distinguish between different types of recorded offences in order to provide as rich a picture of the Police outcomes as possible in the trial areas. Methodologically, this data shortcoming further complicated the analysis of the impact of the CDC and related measures on

---

<sup>76</sup> Bespoke confidential data was made available by South Australia Police (SAPOL) on Domestic Violence. However, the information on comparison sites was not sufficient to enable conduct robust difference-in-difference impact estimations. Altogether, the evaluation relied on publicly available data from the SAPOL website for the analysis of Police outcomes in South Australia.

<sup>77</sup> The list of caveats is extensive. They are discussed in the methodology section of this report and are examined in more detail in the Quantitative Supplementary Report. Notwithstanding these caveats we report these results, as they need to be considered for the purposes of conducting further research on the issue of family violence.

the Police outcomes and led to some variability of the results depending on the modelling strategy adopted to address these practical issues.<sup>78</sup> Depending on the type of offences analysed, these strategies led to different estimation results and conclusions, thus rendering the totality of our findings based on community-level data analysis largely inconclusive.

### 5.5.3.3 *Estimation results*

Overall, the impact evaluation using the Police data has not enabled us to make any definitive impact statements about changes in crime following the introduction of the CDC, with one possible exception where all estimation strategies point in the same direction. In the case of domestic violence, we found an increase in recorded offences in East Kimberley. In the Goldfields, the estimated impact of the CDC on domestic violence was weaker, with results varying depending on the methodology implemented.

Beside this result, we found weak evidence of an impact in East-Kimberley for offences related to property damage and stealing. For those types of offences, two out of four estimation strategies implemented suggested that the number of offences had significantly increased after the roll out of the CDC in the trial area. Results on all types of offences, along with details on the methodological strategies implemented to estimate impact are available in the Quantitative Supplementary Report. We note that no significant impact could be detected in South Australia for the Ceduna and surrounds CDC trial site.

Table 5-16 displays the estimated impact of the CDC in the Goldfields and East Kimberley trial areas separately and for all offence types for which data was available (some of which have been grouped together for sample size reasons). While four different strategies were implemented in order to estimate these impacts, we report the results obtained from the strategy that provided the most stable estimates. The Quantitative Supplementary Report provides all estimates obtained from each estimation strategy undertaken for the Evaluation. The numbers with asterisks indicate offences for which we find a statistically significant impact of the CDC on recorded offence numbers. The detailed analysis is available in the Quantitative Supplementary Report.<sup>79</sup> Notably, the present report does not include figures for Police outcomes in Ceduna and surrounds because no significant impacts were detected for any of the offence types. Further, it was not possible to examine domestic violence using the South Australian data. The table provides estimates of impact in terms of total number of offences per reported quarter. In order to put these estimates in the context of the trial areas and their population, we convert those that appear statistically significant into a number of offences per thousand in the columns adjacent to the estimates.

---

<sup>78</sup> We conducted the analysis of the Police data using four strategies, namely:

- (i) taking the Police data as it is (ignoring instances where no offences are recorded for some localities in some quarters) and taking the number of offences as the unit of analysis;
- (ii) transforming the original data into a balanced panel, accounting for instances where localities recorded no offences for some quarters and taking the number of offences as the unit of analysis;
- (iii) implementing the first strategy taking the rate of offences per thousand as the unit of analysis; and
- (iv) implementing the second strategy using the rate of offences per thousand as the unit of analysis.

For each strategy, we implemented a number of model specifications designed to estimate the impact of the CDC on Police outcomes in the most statistically robust way as possible given the constraints imposed by the data.

<sup>79</sup> A similar, but not as extensive due to data limitations, investigation was conducted using the South Australian data (Ceduna and surrounds), but did not produce any estimation results of statistical significance. Nevertheless, for the purpose of completeness, these results are presented in the Quantitative Supplementary Report.

Table 5-16: Estimated impact of the CDC on Police outcomes, East Kimberley and Goldfields trial sites (community-level data)

Estimated impact of the CDC on police outcomes				
Type of offence	Goldfields		East Kimberley	
	Estimate	(per 1,000)	Estimate	(per 1,000)
<b>Domestic violence</b>	3.14*	<b>0.09</b>	42.46***	<b>6.73</b>
<b>Assault</b>	-0.54		0.53	
<b>Burglary, robbery</b>	0.34		6.18	
<b>Disorderly conduct/threatening behaviour</b>	-1.05		0.32	
<b>Drug offences</b>	1.67		-6.75	
<b>Property damage</b>	-1.39		9.30*	<b>1.47</b>
<b>Stealing</b>	0.09		10.27*	<b>1.63</b>
<b>All stealing</b> (incl. burglary, robbery, motor vehicles)	-0.60		19.93*	<b>3.16</b>
<b>All offences</b>	-2.75		60.17***	<b>9.54</b>

Note: The significance level of the impact estimates is denoted by \*\*\* for  $p < 0.01$ , \*\* for  $p < 0.05$  and \* for  $p < 0.10$ .

Table 5-16 suggests an increase in the rate of domestic violence offences (per thousand) in the East Kimberley site. Everything else held constant, the rate of domestic violence offences recorded by the Police was estimated to have increased by around 6.7 per thousand post-CDC, compared to a set of statistically similar suburbs (used as a control group).<sup>80</sup> We note that this finding has to be placed in the context where we observe some relatively large variations in the recorded cases occurring from the second quarter of 2016, where recorded domestic violence rates seem to have increased throughout Western Australia.

The following two figures illustrate how the rate of reported domestic violence offences changed over time in each trial area (colour coded in orange) and contrasts them with the rate in their corresponding control localities (colour coded in blue). We note that a new definition for the reporting of domestic violence offences was introduced in July 2017 in Western Australia. In line with this change of definition, which defines family members in a broader way, the rates of family violence appear to have increased and they also showed wider variations over time from the second quarter of 2016. It is noted that the rates increased more in the Kimberley area, both East and West, than they did in the middle/southern part of non-metropolitan Western Australia used for the investigation of the Goldfields trial site.

Figure 5-18 shows the domestic violence offences from the 3<sup>rd</sup> quarter of 2014 to the 2<sup>nd</sup> quarter of 2019 in East Kimberley (trial site) and the control sites. We marked in this figure the start of the CDC in the 2<sup>nd</sup> quarter of 2016 and the change in the reporting of domestic violence in the 3<sup>rd</sup> quarter of 2017. We observed a spike in the data after the CDC rollout in East Kimberley for both the trial (starting with two quarters showing a sharp rise, followed by two quarters showing a sharp fall) and control (starting with one quarter showing a sharp rise, two quarters of no change and one quarter showing a sharp fall) areas. We also note that change was less pronounced in the control area. The presence of a time trend and/or seasonality cannot be tested formally using such a short time series data.

<sup>80</sup> The design of the control data and the overall econometric estimation are discussed in the Quantitative Supplementary Report.

Figure 5-18: Rate of reported domestic violence offences pre- and post-CDC rollout, East Kimberley versus control (community-level data)

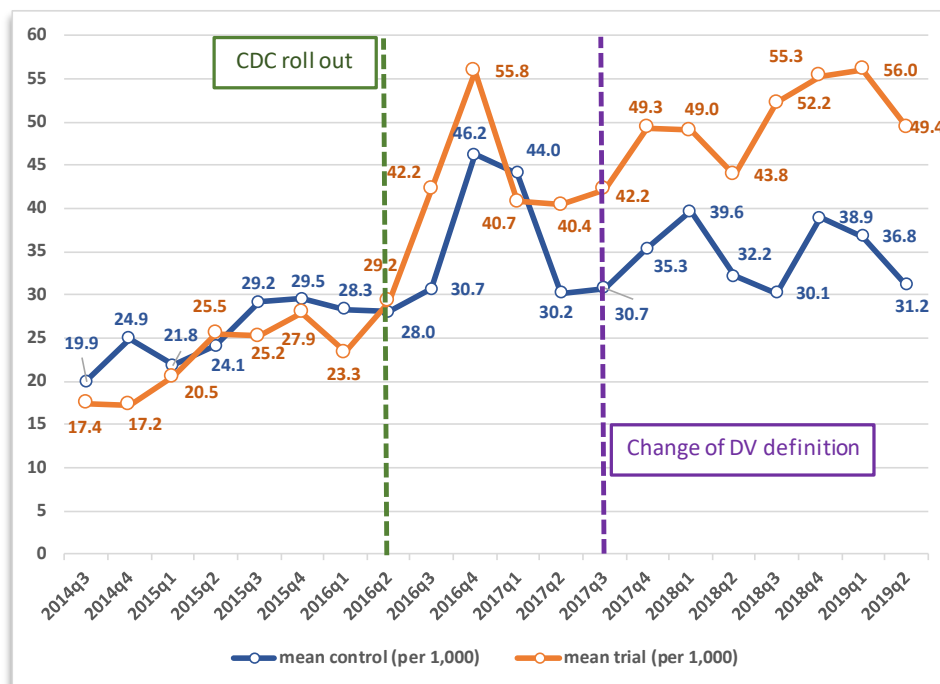
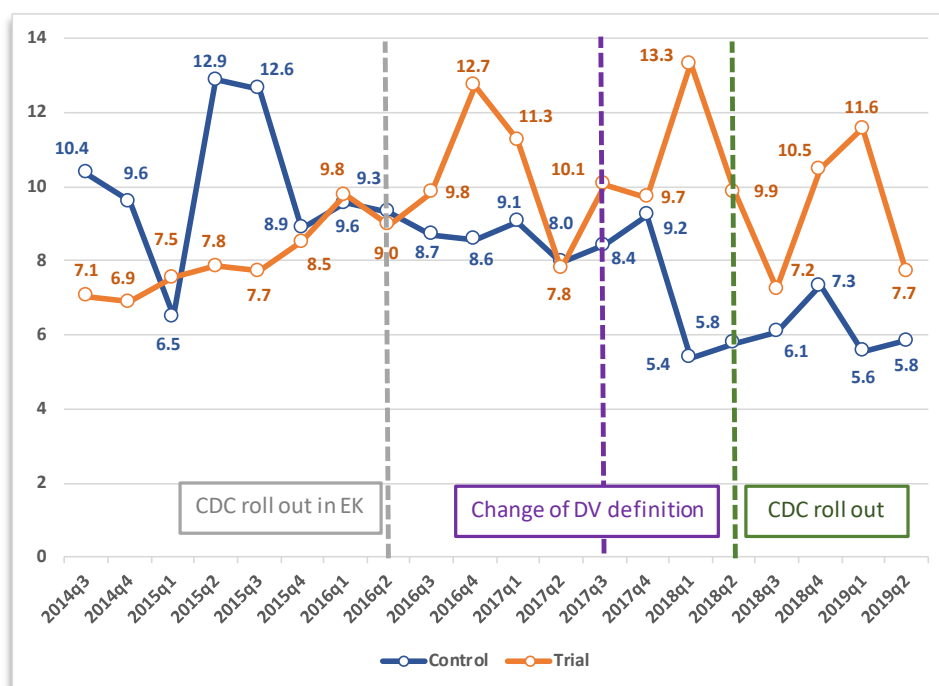


Figure 5-19 shows the same information on reported domestic violence offences for the Goldfields, marking the change in the domestic violence definition in the 3<sup>rd</sup> quarter of 2017 and adding the subsequent CDC rollout in the Goldfields trial site which took place between the end of March and the middle of May 2018.

Figure 5-19: Rate of reported domestic violence offences pre- and post-CDC rollout, Goldfields versus control (community-level data)



Several observations emerge from Figure 5-19. First, that the general profile of domestic violence offences in the Goldfields area and corresponding control localities were quite different from those observed for the northern part of the State in the Kimberleys. Second, the number of domestic violence offences (per thousand) seemed to exhibit greater variation from around the second quarter of 2016 in the trial area. Third, the variations following the change of definition of domestic violence were less obvious in the Goldfields area than what can be observed in the previous figure for East Kimberley. While we noted discernible increases in both control and trial areas in the latter case, the profiles seemed to take opposite directions in the former, with a spike in the trial area and a trough in the control localities. Abstracting from the potential impact of the definition change, there does not seem to be much evidence that reported domestic violence changed in any way recorded in the data at hand after the introduction of the CDC. The estimations showed a weak increase of the number of domestic violence offences post-CDC in the trial area by 0.09 per thousand only. In conclusion, we note the different pictures that emerged in the analyses of domestic violence in the East Kimberley and the Goldfields trial sites.

The other instances where we estimated a statistically significant impact of the CDC was regarding property damage and offences related to stealing in East Kimberley. Expressed in terms of rates per thousand, we found that the CDC (and other concomitant measures) had led to an increase of recorded property damage offences by about 1.47 per thousand. Likewise, looking at a broad definition of stealing offences (see Table 5-16 above), we estimated an impact of the CDC of about 3.16 additional offences per thousand in the East Kimberley trial site. Yet, as stated at the start of this subsection, the results on these offences are less conclusive than what we observed for domestic violence. Indeed, the results are supported only by some of the methodologies we implemented to estimate impact, in contrast to domestic violence, where the result of a post-CDC increase was supported by all methodologies, albeit at different statistical significance levels. The full results are available in the Quantitative Supplementary Report.

We bring the section on community-level data on crime and the impact of the CDC to a close by noting that the analysis of the impacts of the CDC through the use of community-level data was fraught with caveats and limitations and cannot as yet produce reliable econometric results. With time, with a more bespoke data collection design, and with longer data series, several of the caveats will weaken and even be systematically removed to allow for a reliable investigation on this important aspect of the CDC rollout. As the community-level data stands now, the main reason for the inclusion of its analysis in this report is to retain completeness and transparency and to alert the reader of the possibilities suggested by the data.

#### **5.5.4 Evidence from in-depth interviews with Stakeholders and Participants**

Variance in the perceived impacts of the CDC on crime and family violence was found across the trial sites<sup>81</sup>. While a lack of clear outcomes of the CDC on crime was described in the Ceduna trial site, within the East Kimberley and Goldfields, a majority of interview respondents relayed concerns that criminal activity had increased since the implementation of the Card (further details are provided in the Qualitative Supplementary Report). A rise in the incidence of break-ins, car thefts, assaults and

---

<sup>81</sup> It should be noted that other concurrent interventions including police operations and alcohol management protocols were also occurring within each of the trial sites alongside the CDC and were also impacting upon criminal activity and violence.

robberies were noted especially by CDC participants in these regions, and those living in the city of Kalgoorlie-Boulder (in the Goldfields) and in Kununurra (in East Kimberley).

*It's actually increased. There's more antisocial behaviour. At the moment there's a massive crime spree going through the town, house invasions, robberies and suchlike, burglaries, I think there's been over this weekend, I believe there was five home invasion/burglary...Vehicle damage, as in going through your car to see if you've got coin or anything that they can sell. That's increased in the town. SH08GF*

Within the East Kimberley region this issue centred upon an escalation in youth crime. However, disagreement was expressed by respondents in this site as to whether it was directly related to the implementation of the CDC and, in particular, a consequence of young people having less access to cash from their parents who were participating in the scheme. Other respondents felt the incidence of youth crime was a broader issue affecting the Kimberley region and was impacted upon by poverty, family dysfunction and a lack of parental role-modelling and discipline.

*Theft has massively increased. Break-ins massively increased. Vandalism, hugely increased. We've had sexual assaults going on. I'm not saying that this is all due to the Indue card, but it's certainly been a bit of a catalyst to this, I think. I think it's played its part...Before kids would be given money for whatever; to go buy food, to go buy toys, whatever they wanted to do. Now, because there's reduced cash, they're not getting the cash, so they're going and breaking in to get cash. SH43EK*

In the Goldfields region, observations of reduced criminal activity were reported for the smaller communities in the trial site outside of Kalgoorlie-Boulder. Some respondents described towns such as Coolgardie, Laverton and Leonora as generally being less volatile and safer than prior to the CDC. However, criminal activity was observed by interview respondents to increase again in these communities when visitors (who were not on the CDC) came in from the surrounding lands. Improvements to crime and safety were not noted within the regional centre of Kalgoorlie-Boulder, however, where many respondents felt that levels of criminal activity had increased since the commencement of the CDC.

*I think the crime thing in Laverton has slowed down as well. Because I did go to the last stakeholders meeting and they mentioned that since the card has been out, domestic violence, alcohol-fuelled crime has decreased...So the numbers have dropped since the card's been out. It only rises when we've got visitors in town. So like when funerals are happening, at Christmas time. SH47GF*

Opinions were also mixed as to the impact of the CDC on domestic and family violence in the three trial sites. Some respondents (and especially stakeholders based in Ceduna) reported that rates of family violence had decreased with the CDC; this was thought to be associated with declines in alcohol misuse within families. In contrast, other respondents considered the incidence of family violence to be either unchanged or to have increased (the latter in response to heightened tensions in some families due to a decrease in the availability of cash funds).

*Certainly seeing the statistics on presentation to emergency for domestic violence injuries and things like that, or self-inflicted sort of injuries through drug and alcohol, I mean the decrease in that would suggest to me that there's some positives there. SH25C*

*Sometime it make some people angry, some families. They get angry with their family...and someone will get hurt, increased that family violence...They say, "This card here, spend it on food." And they'll say, "No, I don't want food." P65EK*

The placing of funds with the CDC was also thought by several stakeholder representatives to assist in the protection of women who were now considered less likely to be pressured into handing over cash to their male partners to use to purchase alcohol.

*There are some benefits that also happened as a result. Like, particularly for the women, because culturally, if you've got money, you're sort of obliged really to share it. And if there is something that stops you from sharing that, like if you said no, then you'd either be outcast or bashed. Or, you know, you would suffer the consequences for saying no, type thing. Whereas, if there is something that's saying no for them, then that absolves that responsibility type of thing, and it's not my fault, I'm not the one saying...So some mothers who have a genuine concern for their kids and stuff like that appreciate the fact that they have that. SH03C*

*I think it's gone down. For the ones that did have domestic violence, there was alcohol involved but now the alcohol consumption's gone down and so has the DV. SH32C*

The discussions about crime and family violence with stakeholder representatives noted that the CDC was only one policy which was making inroads into this area. Other concurrent interventions including police operations and alcohol management protocols were also noted to be impacting upon criminal activity and violence in the area.

*We've got paramedics in place that go out to where they're drinking and we've got Street Beat, we've got so many agencies here now since the card. It's going to be really tricky to weigh up what's changed. But we didn't just bring the card in, we brought in all these other agencies and stuff as well that work 24-7. SH08C*

*I think going back to the police presence in the community, you know and also we have a Safe Streets patrol. And they are around the community and to be honest, it's actually quite rare to see disruption in the community than when I was here maybe 18 months to two years ago. The same things would erupt and there would be shouting and fights and all the rest of it. But again, is that part of the card or is that really the fact that the police are there. SH15GF*

### 5.5.5 Integration of evidence

The qualitative evidence provides a very mixed picture, which is confirmed by the quantitative data. Qualitative responses and outcomes from the CDC rollout regarding crime have been many and diverse, and open to several different interpretations about an overall picture and cause. The quantitative investigations focused on safety (both its level and its change since the CDC), confirmed the presence of this diversity and helped us to quantify it. Thus, we have concluded that there was a sizeable minority of CDC participants that reported much worse safety and a large majority that either have not experienced change or report safety improvements. The investigations into the types of change and into the types of persons who experienced the good and the bad change have added valuable percentages to the qualitative narrative. The complementarity of the evidence bases has produced a valuable integrated evidence, where the CDC appears to be improving safety, but not without a cost.



For all the caveats and limitations that they come with, the results from the analysis of community-level data resonate well with some of the qualitative analyses about the potential emergence of domestic violence within communities, a topic that warrants further investigation and data investment. Similar narratives emerge in other sections of this report, including notably substance abuse and financial stress.

### **5.5.6 The evidence base**

The survey strategy to ask extensively about the various aspects of safety has proved a success, providing rich information for analysis. The power of the quantitative survey analysis has been showcased, as has the potential for more longitudinal information that can only be derived from longer term repeated sampling on both the qualitative and quantitative evidence bases.

The qualitative analysis has provided a rich tapestry of evidence to work on for the quantitative design and interpretation, making the narratives that emerged from quantitative data easier to understand and develop.

The quantitative and qualitative supplementary reports are able to provide the needed detail about each of these data bases and argue strongly about the useful contribution of both evidence bases to the research.

Community-level data has proven to be more limited than anticipated with only few instances where evidence of change has been established, notably on domestic violence in East Kimberley and to a much lesser extent in the Goldfields, and, not conclusively, on stealing in East Kimberley. Although the limitations of community-level data have been clearly exposed in this section, it is still the case that they point towards a similar direction of potential impact as is suggested by some of the qualitative evidence, suggesting that further research and data investment could prove useful.

### **5.5.7 Observations, limitations and caveats**

This section focussed on one of the most important aspect of the lives of CDC participants, namely, safety. We have already noted the limitations of using community data to observe changes in specific subsets of a population and will not repeat them here. Therefore, our present analysis placed most of its weight in using the quantitative survey of CDC participants as our most trusted quantitative evidence base and the qualitative in-depth interviews of CDC participants and stakeholders for judging what was reported about the change in safety experienced after the introduction of the Card.

### **5.5.8 Summary**

A majority of the CDC participants indicated that they felt safe where they live. Yet, a sizeable minority reported that they felt unsafe (especially at night). Since the introduction of the CDC, improvements in safety were reported in greater proportion by those who indicated they felt safe. Improvements were not uniformly distributed among CDC participants. For a sizeable minority of CDC participants in the Goldfields, safety concerns were reported to be getting worse. This analysis cannot attribute the observed change (to the better or to the worse) to the introduction of the CDC alone, but it can provide guidance about the type of improvement or deterioration in safety that has been taking place and who it has been affecting most.



## 5.6 Child welfare and family well-being

The CDC aims to improve the welfare of its participants. An important measure for the assessment of the policy is the degree to which it manages to improve the welfare of the children of CDC participant families and carers.<sup>82</sup>

### 5.6.1 Key findings

- There was no clear-cut consensus view about a positive or negative impact of the CDC on the life and welfare of children in the CDC trial areas.
- We sought and elicited views on the impact of the CDC in the area survey respondents live on several domains: health, school attendance, food, safety, happiness, and participation in cultural and social activities.
- Well over half of CDC participants reported no change for children, just over a fifth reported that the CDC made things worse and just under a fifth reported that the CDC made things better.
- There were considerable differences by domain, between the three trial areas, and by several other factors.
- On the whole, there were more positive than negative responses for health and food and more negative than positive responses for safety, school attendance and happiness.
- Participation in cultural and social activities was reported to have reduced considerably since the CDC introduction.
- Both the quantitative and qualitative evidence indicated that East Kimberley projected the most negative picture, where more people reported that the CDC made things worse for children than better, in all domains with the sole exception of food.
- Both the quantitative and qualitative evidence indicated that Ceduna projected the most positive picture, with many more people reporting that the CDC had led to improvements for children than people reporting that it made things worse (in all aspects with the exception of participation in social activities).
- The Goldfields is somewhere in the middle, where Indigenous CDC participants were largely more positive than negative and non-Indigenous CDC participants were considerably more negative than positive.
- We found no discernible gender difference in the data. Non-carers reported more positive impacts than main carers in East Kimberley and Ceduna but not in the Goldfields.
- The more we disaggregate the data, the more granular the narratives became and the more pronounced the differences we found, confirming that the impact of the CDC on children was highly diverse.

---

<sup>82</sup> The aim of the CDC is to “help stabilise the finances and lives of vulnerable families” and “to reduce social dysfunction where it exists in some communities” (<https://guides.dss.gov.au/guide-social-security-law/8/7/1>). Children being among the most vulnerable members of society and often the victims of social dysfunction, identifies the significance of this secondary aim of the CDC policy. Further detail and explanations on all findings are in the two supplementary reports.

## 5.6.2 Evidence from large scale survey

The quantitative survey of CDC participants included a number of measures which aimed to assess the perceived impact the CDC has had on children's welfare and well-being within the area in which they live. The survey asked CDC participants if change had been experienced since the start of the CDC across several domains—children's health, the amount of food children had access to, children's safety, school attendance, children's happiness, and children's participation in cultural and social activities. Table 5-17 shows that CDC participants were most likely to report that change had not occurred in these domains as a result of the CDC.

Table 5-17: Perceived CDC impact on children in your area (all domains), by trial site

Perceived CDC impact on children in your area: all domains								
	All trial sites		East Kimberley		Goldfields		Ceduna & surrounds	
	N	%	N	%	N	%	N	%
<b>Worse</b>	6,370	<b>22.5</b>	2,333	<b>29.5</b>	3,395	<b>21.5</b>	642	<b>13.9</b>
<b>Same</b>	16,913	<b>59.7</b>	3,803	<b>48.1</b>	9,990	<b>63.1</b>	3,120	<b>67.6</b>
<b>Better</b>	5,053	<b>17.8</b>	1,767	<b>22.4</b>	2,434	<b>15.4</b>	852	<b>18.5</b>
<b>Total</b>	<b>28,336</b>	<b>100</b>	<b>7,904</b>	<b>100</b>	<b>15,819</b>	<b>100</b>	<b>4,613</b>	<b>100</b>

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

The highly aggregated numbers in the leftmost column in Table 5-17 show that 59.7 per cent of all answers reported that things were the same since the introduction of the CDC, with 22.5 per cent reporting that things got worse and 17.8 per cent reporting that things got better. There is much granularity and diversity when the three trial sites are presented separately in the rest of Table 5-17. East Kimberley showed the most polarised picture with the highest proportion of answers in the "worse" category (with an average count of 29.5 per cent) alongside the highest proportion of answers in the "better" category (with an average count of 22.4 per cent). In contrast, Ceduna showed the lowest "worse" proportion of answers in all domains (13.9 per cent), the highest "same" category (67.6 per cent) and was the only trial site with a positive net change (4.6 per cent with 18.5 per cent better against 13.9 per cent worse). The Goldfields site was somewhere in the middle in making these comparisons, but we note that the diversity of responses in that trial site was very high, making these highly aggregated averages less informative.

The following two tables (5-18 and 5-19) show each of the child domains by trial site and briefly discuss their main findings. Table 5-18 shows Health, Food, Safety and School Attendance and Table 5-19 shows Happiness, Cultural Activities and Social Activities. We discuss these two tables together, beginning with the leftmost columns, which refer to the seven domains as these appear for all three trial sites together.

By a substantial margin, children's health is the domain where the least change was reported (65.2 per cent of all answers reported no change). Given the long-term nature of health changes, this difference from the other domains was not unexpected. Table 5-18 presents the four domains where opinions as to the direction of change (positive or negative) appeared to be the least polarised, namely, Health, Food, Safety and School Attendance. Health and Food were the two domains where we saw a modestly sized net positive in the responses with more respondents in the "better" category than in the "worse" one (the difference being 1.7 and 2.6 percentage points respectively). Safety and

School Attendance were the two domains where we saw a modestly sized net negative in the responses with fewer respondents in the “better” category than in the “worse” one (the difference being -5.2 and -3.3 percentage points respectively).

We continue with the leftmost columns in Table 5-19, which present the remaining three domains of Happiness, participation in Social Activities and participation in Cultural Activities. The responses to these domains were strongly more negative than positive, with a net negative of 7.1, -10.7 and -10.6 respectively. These net positive or negative estimates represented a percentage that refers to the overall population of CDC participants.

Given that, in the case of children, the views of those who experience change or those who are carers of children may be of particular interest, there can be different statistics that we may wish to use in order to assess the policy under examination.<sup>83</sup>

The next step was to examine the variation between the three trial sites for each individual domain of potential impact of the CDC. These are presented in the right-hand side columns of Tables 5-18 and 5-19.

---

<sup>83</sup> One can view these percentages and their differences as a proportion of the total of CDC participants, in which case there will be instances where the differences in percentages may appear to be small. For example, the net positive response in Food amounted to only 2.6 per cent of the relevant population, which in our sample would amount to a net difference of 106 people. The net negative response for School Attendance would be similar, at -3.3 per cent amounting to 131 people. The net negative response to Cultural Activities would, at -10.7 per cent, amount to 429 people. If we wish to know the headcount of people of one or the other opinion on the CDC, this would be the most appropriate count. Such a count would include all those who responded that they see no change. If, however, we want to examine where change is happening and its direction, we may wish to focus only on those who report change and leave the rest out of our calculations. In the case of changes to children’s welfare there may be an added reason for such an exercise, namely that many people who do not have any caring responsibilities for children and are not impacted on this front by the policy may not have as strong, informed or relevant views for informing policy. In practical terms, using this alternative way to calculate the net difference reported since the CDC was introduced, would make a fair difference. Following this logic, the percentages for Food, School and Cultural Activities would increase (from 2.6 to 6.2; -3.3 to -8.3; and -10.7 to -27, respectively). These would be the percentage of net change within the group that experienced any change. In concrete number terms this type of estimate would suggest that the people who experienced change in Food, School Attendance, and Cultural Activities were split between Worse/Better by 46.9/53.1, 54.2/45.9 and 63.5/36.5, respectively. Similarly, we may wish to focus on the subgroup of main carers when we examine the data. Such examinations are explored in the Quantitative Supplementary Report.

Table 5-18: Perceived CDC impact on children in your area (health, food, safety, school attendance), by trial site

Perceived changes for children in your area since the introduction of the CDC								
	All trial sites		East Kimberley		Goldfields		Ceduna & surrounds	
Perceived impact on	N	%	N	%	N	%	N	%
<b>HEALTH:</b>								
Less healthy	666	16.5	279	24.8	311	13.9	76	11.6
About the same	2,626	65.2	573	51.0	1,591	70.8	462	70.2
Healthier	735	18.2	271	24.2	344	15.3	120	18.2
<b>Total responses</b>	<b>4,026</b>	<b>100</b>	<b>1,123</b>	<b>100</b>	<b>2,245</b>	<b>100</b>	<b>658</b>	<b>100</b>
<b>FOOD:</b>								
Less food	801	19.7	296	25.9	426	18.8	79	12.0
About the same	2,365	58.1	515	45.1	1,409	62.1	441	66.5
More food	907	22.3	330	29.0	434	19.1	143	21.5
<b>Total responses</b>	<b>4,073</b>	<b>100</b>	<b>1,141</b>	<b>100</b>	<b>2,268</b>	<b>100</b>	<b>664</b>	<b>100</b>
<b>SAFETY:</b>								
Less safe	955	23.3	316	27.8	545	23.7	94	14.3
About the same	2,396	58.6	529	46.5	1,429	62.1	438	66.9
Safer	741	18.1	292	25.7	326	14.2	123	18.8
<b>Total responses</b>	<b>4,092</b>	<b>100</b>	<b>1,137</b>	<b>100</b>	<b>2,300</b>	<b>100</b>	<b>655</b>	<b>100</b>
<b>SCHOOL ATTENDANCE:</b>								
Going to school less	858	21.4	352	31.0	423	18.8	84	13.3
About the same	2,430	60.5	542	47.7	1,476	65.7	412	65.1
Going to school more	727	18.1	243	21.4	348	15.5	137	21.6
<b>Total responses</b>	<b>4,015</b>	<b>100</b>	<b>1,136</b>	<b>100</b>	<b>2,247</b>	<b>100</b>	<b>633</b>	<b>100</b>
<b>Total respondents</b>	<b>6,039</b>		<b>1,597</b>		<b>3,503</b>		<b>939</b>	

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Table 5-19: Perceived CDC impact on children in your area (happiness, cultural activities, social activities), by trial site

Perceived changes for children in your area since the introduction of the CDC								
	All trial sites		East Kimberley		Goldfields		Ceduna & surrounds	
Perceived impact on	N	%	N	%	N	%	N	%
<b>HAPPINESS:</b>								
Less happy	998	24.6	358	31.7	552	24.5	88	13.0
About the same	2,353	57.9	523	46.3	1,384	61.3	446	66.3
Happier	710	17.5	249	22.0	322	14.3	139	20.7
<b>Total responses</b>	<b>4,061</b>	<b>100</b>	<b>1,131</b>	<b>100</b>	<b>2,258</b>	<b>100</b>	<b>673</b>	<b>100</b>
<b>CULTURAL ACTIVITIES:</b>								
Fewer activities	1,009	25.1	361	32.3	549	24.5	98	14.9
About the same	2,435	60.5	594	53.0	1,380	61.4	462	69.9
More activities	580	14.4	164	14.6	316	14.1	100	15.2
<b>Total responses</b>	<b>4,024</b>	<b>100</b>	<b>1,119</b>	<b>100</b>	<b>2,245</b>	<b>100</b>	<b>660</b>	<b>100</b>
<b>SOCIAL ACTIVITIES:</b>								
Fewer activities	1,083	26.8	371	33.2	589	26.1	122	18.2
About the same	2,308	57.1	528	47.3	1,321	58.6	459	68.3
More activities	653	16.2	217	19.5	346	15.3	90	13.4
<b>Total responses</b>	<b>4,044</b>	<b>100</b>	<b>1,117</b>	<b>100</b>	<b>2,256</b>	<b>100</b>	<b>671</b>	<b>100</b>
<b>Total respondents</b>	<b>6,039</b>		<b>1,597</b>		<b>3,503</b>		<b>939</b>	

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

The first major observation was that change in children's welfare was reported to be the strongest in East Kimberley than in the Goldfields or Ceduna. This holds for all domains. In all domains the proportion of those who reported no change is approximately 20 per cent higher in the Goldfields and Ceduna than in East Kimberley. The direction of the change is very diverse and needs further detailed examination. For reasons of space, only core highlights are presented here and additional tables are included in the Quantitative Supplementary Report.

East Kimberley presented a particularly polarised picture with no consensus on how children's welfare has been changing since the introduction of the CDC.<sup>84</sup> For example, 29 per cent of all respondents reported that children have access to more food after the introduction of the CDC, but also 26 per cent reported the opposite, with only 45 per cent reporting no change. Similarly, 28 per cent reported that children are less safe and 25 per cent that they are less healthy, while 26 per cent reported that that they are safer and 24 per cent that they are healthier. In the remaining domains of School Attendance, Happiness, Cultural Activities and Social Activities, the CDC is reported to have made things worse by 31 per cent, 32 per cent, 32 per cent and 33 per cent of all CDC participants

<sup>84</sup> Further analysis is presented about this diversity in the Quantitative Supplementary Report. There are also valuable insights on these findings in the qualitative evidence in the Qualitative Supplementary Report.

respectively. A sizeable minority of 21 per cent, 22 per cent, 15 per cent and 20 per cent respectively, reported an improvement.

A different picture emerged from the Ceduna data, with two main findings. First, a lot less change was reported, and it was mostly for the better. Second, with the exception of participation in Social and Cultural Activities, Ceduna CDC participants were considerably more likely to report a positive than a negative change in children's welfare after the introduction of the CDC. Reporting on Cultural Activities was evenly balanced (15 per cent reported that things got better and 15 per cent that things got worse) while participation in Social Activities was reported to have got worse by 18 per cent and better by 13 per cent of CDC participants.

Finally, the Goldfields picture in Table 5-19 concealed very different reporting within the trial site. Health, Food, Safety and Schooling of children was reported by Indigenous CDC participants to have improved considerably since the introduction of the CDC. In contrast, non-Indigenous CDC participants in the Goldfields painted a very negative overall picture. They reported, in relatively large numbers, a deterioration and, in very small numbers, an improvement. The differences between Indigenous and non-Indigenous CDC participants within the Goldfields trial site was large and not clearly regular. In total for all domains, Indigenous CDC participants reported 22 per cent positively and 20 per cent negatively, compared with 8 per cent and 23 per cent respectively by non-Indigenous CDC participants. These differences are further explored in the Quantitative Supplementary Report.

The quantitative survey also included further and broader information that could be indirectly related to the welfare of children and the family. This included the question "Since being on the CDC, how have the following things changed for you?" which referred to the capacity of the CDC participant to manage financially and asked explicitly about "Looking after family obligations". Responses were 35.5 per cent "Harder", 38 per cent "About the same" and 12.1 per cent "Easier". The main variation by trial site was in the Goldfields where there were above average negative responses (40 per cent "Harder") and below average positive responses (9 per cent "Easier"). This question provided an indirect indication that the CDC may be introducing new financial hurdles to its participants in a way that impacted on the welfare of children.

Finally, CDC participants responding to the survey were asked whether the CDC had led to any improvements for themselves and their family. Overall, 45 per cent of CDC participants indicated that the CDC had improved things for themselves and their family (either sometimes, most of the time or all of the time). The most prevalent reporting of improvements was among CDC participants in Ceduna at 57 per cent, followed by East Kimberley at 50 per cent. The lowest reported improvements were in the Goldfields at 40 per cent.

Further, unstructured information was provided through the survey's free text boxes which provide insights on several possible impacts of the CDC relating directly or indirectly to the welfare of children. Although evidence on these impacts cannot be usefully quantified in percentage terms, it is useful for setting the right context. The most commonly suggested positive impact of the CDC was that it increased the amount of money left over for putting food on the table and the availability of money to do family activities at weekends. At the same time, the most commonly suggested negative impact of the CDC was that, in its effort to take cash away from harmful activities, it also took cash away from participants performing their parental roles. In circumstances of an overall low income, restrictions on cash flow were reported by some survey respondents who wrote in the survey's free text boxes. Such cash flow restrictions were reported to be acting as a hurdle regarding the need to always find the lowest cost avenue for family spending. This finding provides a powerful context for the interpretation of the negative impact of the CDC on both social and cultural activities of children, which was similarly reported across all trial sites.

In conclusion, the quantitative survey has provided extensive evidence regarding changes in the welfare of children since the introduction of the CDC in all three trial sites. The emerging narrative from all reporting points consistently towards the presence of both positive and negative change, in the midst of diversity in the circumstances of CDC participants, of the diversity in the behavioural responses to the CDC and of diversity in the outcomes.

### 5.6.3 Evidence from in-depth interviews with Stakeholders and Participants

Interview respondents (particularly in Ceduna and the Goldfields regions) were generally positive about the impacts the CDC was having on family functioning and outcomes for children (further details are provided in the Qualitative Supplementary Report). Improvements were centred upon four key factors: spending on children, child welfare, school attendance and participation in activities. However, it was acknowledged by some stakeholders that other interventions—school attendance programs, family support services and recreational programs—were occurring alongside the CDC that could also be positively influencing child welfare and well-being. Hence, the direct impacts that the CDC itself was having on these issues were felt to be unclear.

It was widely reported that families on the CDC were now spending more of their Centrelink payments on their children, e.g. on food, clothes and toys. Some respondents also considered that the overall welfare of children had improved since the introduction of the CDC. The incidence of child neglect was said to have lessened and reports were given of parents spending more time with their children and providing better supervision and care. As a consequence of these factors, the children of CDC participants were thought to be better fed and dressed, were physically healthier and happier, were safer in their own homes and less likely to be out on the streets at night.

*I see families that I would have been used to seeing in that shopping centre with bottles of coke and white bread under their arm, now with full shopping trolleys. That to me is one of the biggest demonstrations that kids are probably eating a bit better and families are probably eating a bit better and there's perhaps not quite as much going on alcohol. SH34EK*

*We know that it has been successful. We are not seeing the kids being dragged around by drunks at all hours of the night through the freezing winter months. With barely little clothes on their bodies. We're not seeing the kids starving. The way that they have been in the past. SH44GF*

Improvements were also considered by these respondents to have occurred with regard to school attendance and participation in school activities and excursions. Furthermore, it was suggested that, due to improved family circumstances, children were more alert when attending school and better able to learn. It was also noted that some students were now more likely to come to school having had their breakfast, wearing clean uniforms and were being provided with a school lunch. Other respondents reported that, because of the CDC, children were participating to a greater extent in activities such as community and sporting events, attendance at child development programs and informal family activities.

*Children weren't going to school because their home environment was dangerous. The parents were drunk. They had lots of visiting drinkers and they felt unsafe. They got bashed. They were going to school hungry, tired; they were roaming the streets in gangs of up to 50, and that's verified by the police. Now that has stopped. Their family lives and children who rarely got a meal at home are getting meals. Children who wore dirty substandard clothing are now*



*wearing clean good clothing. To me, that is the biggest achievement of the card. The lives that some of these children were leading was miserable. SH18C*

However, a minority of respondents disagreed and thought that little had changed with regard to child welfare and well-being. Some respondents (mainly stakeholders) reported that children were still living in risky environments and due to a lack of parental supervision, were walking around on the streets at night. Several stakeholders also noted that child protection notifications and removals remained at similar levels as before the CDC.

*Like they keep saying in the papers or whatever, "The card is working because there's been a decrease in violence, a decrease in children being removed, a decrease in crime." Bullshit. It's all bullshit...Within the last three, four years, there's been a very high increase of children being removed. There's so many children being removed a week it's not funny....Card hasn't stopped it, hasn't helped the situation. SH04C*

*Even now kids don't attend school, you know. They out on the streets, they're hanging out at the 24-hour all hours of the night. Still there. They can bring another card, that issue will be still there. Doesn't work. P01EK*

#### **5.6.4 Integration of evidence**

The picture that emerged from the quantitative survey is very diverse. It included narratives of improving children welfare that appear to be happening at the same time and right next to narratives of a worsening of children welfare. The qualitative evidence pointed clearly and optimistically towards some of the domains of this overall improvement, such as better food and clothing, but also advised caution towards attributing these improvements to the CDC alone. It is clear that these are socially important targets of improvement and that where they happen, these are welcome changes. The polarised picture that emerged from the survey, however, suggests that there are areas and demographics where the quantitative evidence is mixed. Presently, the combined evidence from this study suggests that while the CDC clearly improves the welfare of some children in CDC families, for the majority of children there has been either no change or a change to the worse.

#### **5.6.5 The evidence base**

The core sources of evidence were the qualitative interviews evidence and the large scale quantitative survey evidence. In the background, Government administrative data supported the statistical robustness of the work. Data from States and Community organisations were examined, but were found to contain little useable information, mainly due to collections being made for non-research purposes and without the necessary granularity. The qualitative interviews were extensive in number in order to capture the whole picture in all three trial sites. They have revealed, as planned, much of the depth of the views of CDC participants across the three trial sites. In addition, the quantitative survey has provided extensive statistical information about the way children's welfare is faring within the implementation of the CDC, indicating areas, which are currently working and those which are not.

We noted that, in the particular case of children's welfare where there is no clear consensus, the use of an integrated methodology and resulting multi-disciplinary evidence base and analysis yields unique additional benefits to our attempt to assess the workings and outcomes of the CDC. The benefits that emerge by integrating these methodologies can become critical when the data



requirements grow. This will be the case, especially when the subject matter is divided into smaller cells with high diversity and differences in circumstances, opinions and outcomes, as in such cases having adequate data becomes increasingly harder.

### **5.6.6 Observations, limitations and caveats**

As already mentioned, the evidence on the impact of the CDC on children's welfare is very divided. Within the survey data, cases of people for whom and of circumstances where things got better since the introduction of the CDC, are often equally matched with cases of the exact opposite where things got worse since the introduction of the CDC. This is the type of problem integrated methodologies are best at dealing with, as they can handle the necessary depth and detail alongside the statistical necessities policy assessment requires. The subject of children's welfare is even more complicated in the study of the CDC, as children are only impacted by the CDC indirectly through the circumstances and behaviours of their families and carers. Similarly, the reporting on any such impacts is conducted by their families and carers rather than by the children themselves. Thus, one can expect that the range of such indirect impacts will be large and possibly difficult to identify or separate from other impacts and that the reporting may be subject to the biases parents may bring with them when they refer to their children's welfare. The use of direct questions in both the qualitative interview topic guides and the quantitative survey questionnaire helped to ameliorate this problem.

A general caveat that applies to all studies that attempt to estimate the impact of a policy on children, is that such impacts are typically longer-term than the study's observation period. Children have a longer life span ahead of them and policies rightly aim to improve this long-term, rather than focus on the short term only. These caveats are well-known and they all point towards the understanding that the more a policy assessment seeks to find concrete benefits for children, the more likely it is that the assessment will under-estimate and under-report some important longer-term benefits that may emerge from the policy over time. The way this study aimed to ameliorate this problem is by asking questions about aspects that measure immediate benefits alongside questions that are good indicators of future benefits and well-being. Thus, we have asked questions about safety, clothing, participation in activities and similar, that focus more on the present, alongside questions on health, food and schooling that typically combine short-term with longer-term outcomes. For example, attending school will (immediately) reduce the chances of taking part in criminal activities for the older children. It will also increase the chances of completing school education in the medium run. It will also improve future education achievement and productive employment and social participation in the longer-term. Although such considerations are notoriously hard to quantify, it is important that they are explicitly included in the narrative of the overall assessment of the CDC.

We note the presence of concurrent policies that aimed directly or indirectly to improve children's welfare in all trial sites and we acknowledge that the attribution to either improvements or deteriorations in children's welfare directly and/or solely to the CDC cannot be conducted with any accuracy. Whilst our multiple-base evidence may provide us with some confidence in certain instances, we still need to be cautious about making such interpretations.

### **5.6.7 Summary**

There were mixed views about whether and how children's welfare had changed since the introduction of the CDC in the trial areas. Within the survey data, most people reported no major change regarding most aspects of child well-being. A sizeable minority reported an overall more positive view on change, while another larger minority reported an overall more negative view on

change. In contrast, respondents in the qualitative interviews (particularly in Ceduna and the Goldfields) were more positive about the perceived impacts of the CDC on family functioning and outcomes for children.

## 5.7 Health and well-being

While improving health is not a primary aim of the CDC program, it is important to assess the degree to which the policy has an impact on the health and wellbeing of participants though restricting the purchase of harmful substances. It is recognised that improvements in these domains would be largely a long-term policy outcome of the CDC.

### 5.7.1 Key findings

- Health and well-being are long-term outcomes that may be influenced by the introduction of the CDC, directly and indirectly. However, the time span of the policy is too short to expect that such impacts may be fully and accurately traced in a robust statistical manner.
- We found a mixed impact of the CDC on health and well-being.
- The qualitative evidence showed opinions were greatly divided in East Kimberley and Ceduna while they were overwhelmingly negative in the Goldfields.
- The quantitative survey suggested that the self-assessed health scores of CDC participants were lower than those of the average Australian. The scores on the separate physical component summary (PCS) scale and the mental component summary (MCS) scale were also both lower than the Australian average.
- The highest self-assessed health (both PCS and MCS) and personal well-being scores (PWI) were reported in East Kimberley closely followed by Ceduna. Much lower scores were reported in the Goldfields.
- Indigenous CDC participants reported consistently the highest scores in self-assessed health (in both PCS and MCS scales) and personal well-being (PWI) compared to non-Indigenous CDC participants. Yet, Indigenous CDC participants living in the Goldfields scored significantly lower on all scales than Indigenous participants in the other trial sites.
- Qualitative evidence suggested that, while some CDC participants highlighted improvements in nutrition and better compliance with medical treatments made possible by lower levels of alcohol consumption, many also pointed out the negative impact of the CDC on their psychological well-being.
- The quantitative evidence corroborated the qualitative evidence of a mixed impact of the CDC on health and well-being.
- Asked a general question about whether the CDC had improved their lives, most CDC participants answered in the negative (particularly in the Goldfields) and a small minority reported an improvement.
- Between 9 and 17 per cent of CDC participants reported that the CDC had improved their life. Over a quarter (26 per cent) of Indigenous and 13 per cent of non-Indigenous CDC participants reported

improved quality of life in at least one level (their own life, that of their family, their friends, or their community).

- The quantitative survey identified some groups of CDC participants who were particularly vulnerable, including those who live alone, especially if they had not had a paying job around the time of the survey.
- The quantitative survey estimated those participants who were more likely to report an improvement in their quality of life due to the CDC. They were more likely to be in East Kimberley, Indigenous, couples (with children or not), females, older, or living with someone else who is on the Card as well.

## 5.7.2 Evidence from large scale survey

The quantitative survey of CDC participants included a number of questions which aimed to assess the impact the CDC has had on health, well-being and the quality of life of CDC participants and those around them. Some survey questions were longitudinal in nature, designed to help estimating impacts of the CDC if a second wave of data collection takes place. They were used in this report in order to provide a snapshot of the self-assessed health and well-being of CDC participants. Other survey questions provided further information about potential direct and indirect impacts of the CDC on health well-being and life quality.

### 5.7.2.1 *Snapshot of health and well-being of CDC participants*

The survey drew evidence from the SF-12 self-assessed health index and from the Australian Unity Wellbeing Index. The former set of instruments is a short-form health survey with 12 questions that provide data on physical and mental health and well-being, which is widely used in clinical research and increasingly so in medical and public health practice (Andrews 2002). It allows one to compute a Physical Component Summary (PCS) score and a Mental Component Summary (MCS) score, where the higher the score, the better the physical or mental health. In Australia, these scores have a mean of around 50 and a standard deviation of around 10.<sup>85</sup> One can define a number of thresholds indicating whether one has some degree of disability (and how severe). We used these scores to categorise the CDC participants between those with (i) severe disability (score below 30), (ii) moderate disability (score between 30 and 39), (iii) mild disability (40 to 49), and (iv) no disability (score 50 or above).<sup>86</sup>

Overall, we observed that the self-assessed health scores for the CDC participants surveyed were, on average, lower than the scores of Australians as a whole.<sup>87</sup> There were important differences in self-assessed health according to individual characteristics and by trial site. The following Table 5-20 shows the average scores using the PCS and MCS scales (in Columns Mean PCS score and Mean MCS score)

---

<sup>85</sup> A useful description of the SF-12 and SF-36 can be found in Andrews (2002). This report uses the SF-12 questions and follows the thresholds found in Andrews (2002) and references therein.

<sup>86</sup> The Quantitative Supplementary Report explains the provenance of the thresholds used in this Report and provides more information on the SF-12 and Australian Unity Wellbeing Index, along with relevant references and statistics computed from the CDC Participants survey data. We acknowledge that the use of any thresholds to define disability categories using these measures will involve an element of arbitrariness in its definition of labels and cut off points and we recognise that this is an area of open debate. Our choice has been pragmatic, to use what we consider to be widely used such measures and labels.

<sup>87</sup> The average score for the physical component summary (PCS) of CDC participants was 47 (with a standard deviation of 10.8). Their average score for the mental component summary (MCS) was 48 (with a larger standard deviation of 12.3).

for groups of CDC participants defined by their location and some core individual characteristics. Table 5-20 also presents (in the two columns Difference) the level of the difference in the mean scores between the specific sub-group and the reference category and if this difference was statistically significant.

CDC participants in the East Kimberley scored significantly higher for both PCS and MCS scales. The corresponding average scores in the Goldfields were 4.3 points lower on the PCS and 6.2 points lower on the MCS.

Indigenous CDC participants reported higher average self-assessed health than their non-Indigenous counterparts. We also note that the lower self-assessed health scores observed in the Goldfields also applied to the Indigenous CDC participants who live there and we provide more detail on this finding in the Quantitative Supplementary Report.

Males reported a lower PCS than females. The difference was small but statistically significant.

Couples with children (dependent or not) scored higher on both PCS and MCS scales, followed by single parents, couples living alone or with unrelated adults and people living alone. For both PCS and MCS, we also observed that those who reported that they were in employment in the four weeks prior to the survey (including work for the dole) also reported higher levels of health on average. Further statistics on self-assessed health and well-being are discussed in the Quantitative Supplementary Report.

Table 5-20: Mean PCS and MCS scores and mean differences from reference category by individual characteristics

Comparison of PCS and MCS scores across groups of CDC participants					
	Group (Reference)	Mean PCS score	Difference	Mean MCS score	Difference
Site	<b>East Kimberley</b>	49.6		52.1	
	Goldfields	45.3	4.3***	45.9	6.2***
	Ceduna & surrounds	47.4	2.2***	48.7	3.4***
Indigenous status	Non-Indigenous	43.3	4.7***	43.7	5.9***
	<b>Indigenous</b>	48.1		49.6	
Gender	Male	45.8	1.4***	47.8	0.1 (ns)
	<i>Female</i>	47.2		47.8	
Household type	Living alone	44.9	1.9***	46.6	2.9***
	<b>Couple with children</b>	46.7		49.5	
	Couple living alone	45.0	1.7**	47.7	1.8**
	Single parent	48.9	-2.2***	48.0	-1.5**
	Other	47.0	-0.3 (ns)	47.0	2.5***
Worked 4 weeks prior to survey	No	45.8	-3.2***	46.9	-3.4***
	<b>Yes</b>	48.9		50.3	

Note: Significance levels are indicated as follows \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ , (ns) stands for 'not statistically significant'

The survey utilised the Australian Unity Wellbeing Index in order to compute personal well-being scores (PWI scores) for CDC participants and provide comparisons across relevant groups.<sup>88</sup> As a benchmark, the average PWI score for Australia has remained very stable for the past decade, within the range of 73.9 to 76.8 points. The literature on subjective well-being also highlights the fact that Indigenous people tend to report higher levels of well-being.<sup>89</sup>

Overall, CDC participants reported an average well-being of 72.2, slightly lower than the Australian population average. This average score, however, hid important differences across sites. PWI scores produced from the quantitative survey were higher than the national average in East Kimberley (84.3) and Ceduna (78.9) and considerably lower in the Goldfields (64.9). We found that the difference between the Goldfields and the other sites was not just due to the larger proportion of non-Indigenous CDC participants in the Goldfields. It was also due to the fact that Indigenous CDC participants in the

<sup>88</sup> For a description of the PWI methodology, see <http://www.acqol.com.au/uploads/pwi-a/pwi-a-english.pdf> and Cummins et al. (2003). Further detail can be found in the Quantitative Supplementary Report.

<sup>89</sup> We note that in the case of the PWI, as we have done with measurements of the SF-12 data and the similar drugs data, we are not using a broader methodology in order to make direct comparisons between the national averages and the CDC participants. Given the systematic differences between our population and the broader national population, such comparisons would probably not be particularly useful. However, we strive to use tested methodologies, so that we utilise existing designs that have already proven their value for research purposes. Doing this allowed us to make comparisons within the overall population of the CDC participants in the trial areas. Thus, whilst one could argue that we were benchmarking at the national and international methodological level, we were not benchmarking with any national data sets for the reasons mentioned in this note.

Goldfields scored significantly lower (74.4) than their counterparts in the other two sites (85.9 in East Kimberley and 80.9 in Ceduna).

We found that the PWI scores were not significantly different between male and female CDC participants, except in the Goldfields where females reported higher scores. We observed significant differences across household types where couples with children (dependent or not) reported significantly higher levels of PWI scores than any other type of household, scoring 71.8.<sup>90</sup> The quantitative survey revealed a much lower score for those CDC participants who live alone. Their score (57.5) placed them near the bottom of the range that is considered as “normal” (50 to 100) in the relevant literature.<sup>91</sup>

### 5.7.2.2 *Does the CDC improve the quality of life of its participants?*

The survey included two questions that asked each CDC participant about the perceived impact of the CDC on their lives. The first was a broad question that asked whether the CDC had made life better or worse for the CDC participant. The second question narrowed the impact type by asking only for potential improvements, but broadened the scope of the impact by asking whether the CDC had improved the quality of life for one’s self, for their family, for their friends, and finally in the area where they live. This question allowed for the response that no change has occurred. Respondents were invited to answer all categories that apply to them.

### 5.7.2.3 *Has the CDC improved life quality?*

The following Table 5-21 shows whether CDC participants experience improvements in the quality of their life or not. The majority of CDC participants indicated that the CDC has made their life worse (56 per cent) and 31 per cent reported that the CDC had improved their life or did not make it different. Indigenous CDC participants reported that the CDC had improved their lives at nearly twice the rate of non-Indigenous participants (17 per cent and 9 per cent respectively). Responses did not differ by gender.

Table 5-21: Has the CDC made life better or worse, by Indigenous status and gender

The CDC has made life...										
	All		Indigenous		Non-Indigenous		Male		Female	
	N	%	N	%	N	%	N	%	N	%
<b>Worse</b>	3,254	<b>55.8</b>	1,821	<b>48.5</b>	1,433	<b>69.2</b>	1,443	<b>57.6</b>	1,811	<b>54.5</b>
<b>No different</b>	994	<b>17.1</b>	655	<b>17.4</b>	339	<b>16.3</b>	392	<b>15.6</b>	602	<b>18.1</b>
<b>Better</b>	844	<b>14.5</b>	655	<b>17.4</b>	189	<b>9.1</b>	359	<b>14.3</b>	485	<b>14.6</b>
<b>Don’t know</b>	736	<b>12.6</b>	625	<b>16.6</b>	111	<b>5.4</b>	311	<b>12.4</b>	425	<b>12.8</b>
<b>Total (N)</b>	<b>5,827</b>	<b>100</b>	<b>3,756</b>	<b>100</b>	<b>2,072</b>	<b>100</b>	<b>2,504</b>	<b>100</b>	<b>3,323</b>	<b>100</b>

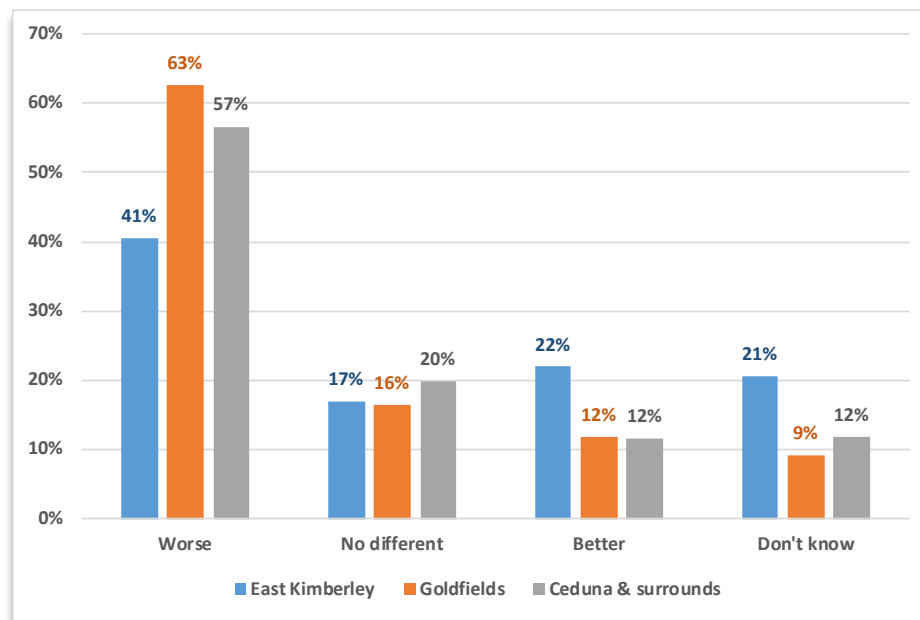
Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies. Respondents who did not answer the question (3.5 per cent) are excluded.

<sup>90</sup> This result is typically observed in all studies of well-being and is described in the Quantitative Supplementary Report.

<sup>91</sup> See Quantitative Supplementary Report and relevant references therein.

The following Figure 5-20 illustrates that there were large variations across trial sites. While the proportion of CDC participants who reported that the CDC was having no impact on their life was similar across sites (between 16 and 20 per cent), opinions differed substantially among the other categories.

Figure 5-20: Has the CDC made life better or worse, by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Figure 5-20 shows that almost two thirds (63 per cent) of CDC participants in the Goldfields and 57 per cent in Ceduna stated that the CDC had made their life worse. By contrast, only 41 per cent of CDC participants in East Kimberley reported a negative outcome and 22 per cent indicated that the CDC has improved their life. We also note that there was a larger proportion of CDC participants in East Kimberley who had not made up their mind, one way or the other (21 per cent), which was substantially more than in the other sites.

#### 5.7.2.4 How was the CDC reported to help improve life quality in the trial areas?

The second focus is on whether CDC participants reported that the CDC had helped improve the quality of life since its introduction. This is presented in Table 5-22 below in the same format as Tables 5-5, 5-8 and 5-9 in the previous sections on alcohol, drugs and gambling. Again we draw on the main distinction (Panel A) being those who reported that they saw a positive difference (21.3 per cent for all trial sites), those who reported that they saw no difference (47.8 per cent for all trial sites) and those who either reported they did not know or did not answer at all (30.9 per cent for all trial sites).

The second part of the table (Panel B) focuses only on those participants who saw a positive difference and shows the type of difference (You, Your family, Your friends, and Where you live), noting that the question allowed multiple responses. Using the whole of the trial sites in the leftmost column of Table 5-22, Panel B, we see that 53.1 per cent saw a positive difference for themselves, 47 per cent for their families, 36.5 per cent for their friends and 56.1 per cent for where they live.

Table 5-22: Has the CDC improved quality of life, by trial site

The CDC helps improve quality of life, by trial site										
Panel A (full sample who were asked the question)										
	All sites		East Kimberley		Goldfields Indigenous		Goldfields Non-Indigenous		Ceduna & surrounds	
The CDC has made a:	%		%		%		%		%	
Positive difference	21.3		25.1		26.6		12.4		23.1	
No difference	47.8		56.4		34.4		53.7		45.1	
Don't know/missing	30.9		18.5		39.0		33.8		31.8	
Total sample (N)	6,039		1,597		1,655		1,848		939	
Panel B (sub-sample of 21.3% who saw at least one positive difference)										
For:	N	%	N	%	N	%	N	%	N	%
You	683	53.1	305	76.1	192	43.6	86	37.4	101	46.4
Your family	606	47.0	262	65.3	207	47.0	25	10.7	112	51.8
Your friends	470	36.5	227	56.5	157	35.6	27	12.0	59	27.3
Where you live	723	56.1	254	63.5	223	50.6	147	63.9	99	45.6
Total respondents	1287	100	401	100	440	100	230	100	217	100
Total responses	2481		1048		778		285		371	
Responses per person	1.93		2.61		1.77		1.24		1.71	

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

Table 5-22 also shows that the reported difference the CDC made regarding quality of life varied by trial site. In the Goldfields, a larger 'positive difference' was reported by Indigenous (26.6 per cent) than by non-Indigenous CDC participants who reported the lowest incidence of 12.4 per cent. Similar proportions of CDC participants in East Kimberley (25.1 per cent) and Ceduna (23.1 per cent) reported a positive difference. Two further numbers are noteworthy from Panel A in Table 5-22. First, a much smaller proportion of 'no difference' was reported by Indigenous CDC participants in the Goldfields (34.4 per cent), with Goldfields non-Indigenous, Ceduna and East Kimberley reporting higher proportions (53.7, 45.1 and 56.4 per cent, respectively). Second, a much lower proportion of 'don't know or missing' was reported by CDC participants in East Kimberley (18.5 per cent), with Goldfields (Indigenous and non-Indigenous) and Ceduna reporting higher proportions of this view (39, 33.8 and 31.8 per cent, respectively).

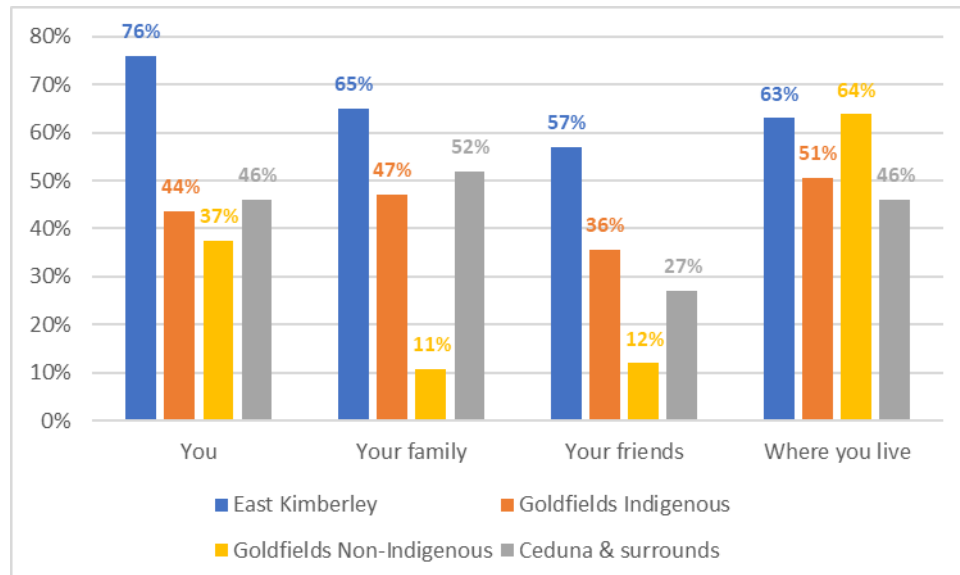
Further examination of the data presented in Table 5-22, Panel B, shows interesting patterns in reporting, with several prominent patterns emerging. First, in East Kimberley, we observe the strongest reported impacts especially regarding own (76.1 per cent) and family (65.3 per cent) life quality improvements. Non-Indigenous CDC participants in the Goldfields reported the highest difference between the life quality within one's own circle (taking this to include 'you', 'your family' and 'your friends') and the rest of the community (represented by 'where you live'). This finding followed the pattern we have discovered for other important CDC outcomes.

The following Figure 5-21 highlights the differences between trial sites with respect to the impact of the CDC on quality of life. Following a pattern that we have already observed, the proportion of CDC participants who reported a positive impact was highest in the East Kimberley site for all levels and



lowest in the Goldfields, with the exception of the area in which the CDC participant lives where there was a higher impact in the Goldfields than in Ceduna and surrounds.

Figure 5-21: Has the CDC improved quality of life, by trial site (CDC participants who reported a positive impact)



#### 5.7.2.5 Evidence from multivariate regression analysis

We estimated multivariate models in order to investigate the characteristics of those who are most likely to report an improvement in quality of life associated with or attributed to the introduction of the CDC. The following box (Box 5.8) highlights and quantifies the individual characteristics that are associated with reporting that the CDC has made life better or worse.

**Box 5.8: characteristics of CDC participants who were most likely to report their life was better/worse since the CDC**

**Characteristics of CDC participants who were most likely to report their life was better since the CDC:**

- CDC participants in East Kimberley (in the Goldfields and Ceduna the probabilities were respectively 4.6 and 3.8 percentage points lower reporting life was now better)
- Indigenous CDC participants (4 percentage points higher than non-Indigenous)
- Couples with children (4.8 percentage points higher than people living alone) or couples living alone (4.5 percentage points higher)
- Living with someone else on the Card (1.5 percentage points higher than those who do not)
- Female (2.8 percentage point higher than males)
- Older CDC participants
- Had a paying job (including work for the dole) in the 4 weeks preceding the survey (3.3 percentage points higher than those who did not work)
- Experienced higher financial stress in the year leading to the CDC
- CDC participants identified as having moderate to high risk alcohol consumption behaviour (4 percentage points higher probability compared to someone identified as low risk)

**Characteristics of CDC participants who were most likely to report their life was worse since the CDC:**

- CDC participants living in the Goldfields (8.7 percentage points higher probability to report worse outcome than CDC participants in East Kimberley)
- CDC participants living in Ceduna and surrounds (7.7 percentage points higher than East Kimberley)
- Non-Indigenous CDC participants (7.8 percentage points higher than Indigenous)
- CDC participants living alone (8.8 percentage points higher probability than couples with children)
- Younger CDC participants
- CDC participants who indicated they experienced issues using the Card (29 percentage points higher probability than those who did not)
- Male (5.5 percentage points higher probability than females)
- CDC participants who stated they do not drink alcohol (4.8 percentage points more likely than those identified as having a low risk alcohol consumption)

We also estimated a second set of multivariate models, broadening the focus to improvements at own, family, friends and community level. We found the characteristics of those reporting improvements are very similar to those highlighted above. These results are presented and discussed in detail in the Quantitative Supplementary Report.

### 5.7.3 Evidence from in-depth interviews with Stakeholders and Participants

Mixed views about the impact of the CDC on the health and well-being of participants were described by interview respondents in Ceduna and the East Kimberley, with opinions divided as to whether these impacts had been positive or negative. In contrast, within the Goldfields region, a majority of respondents thought the introduction of the CDC had led to negative impacts, particularly on the psychological well-being of CDC participants (further details are provided in the Qualitative Supplementary Report).

Positive impacts of the CDC on health and well-being were seen as being primarily related to lower levels of alcohol consumption, which had led to the intake of more food, better compliance with medical treatments and improved attendance at health care services. While cautious of making direct linkages with the CDC due to other interventions and programs which were simultaneously occurring to address health and well-being issues, fewer incidences of alcohol-related assaults and injuries, hospital presentations and ambulance call-outs were reported by stakeholders (particularly in the Ceduna and East Kimberley trial sites).

*Inevitably, the violent deaths that I attend are alcohol related and I haven't attended an Aboriginal person suiciding for as long as I can remember either, post the cashless debit card. So, prior to the cashless debit card, I'd be attending a violent death, either by someone's own hand or another's probably once every two months, I would imagine. Thereabouts. Sometimes more frequent, sometimes less and for me not to have attended an event such as that in two-ish years is worthy of note. SH40EK*

However, other respondents (particularly in the Goldfields region) were concerned about the negative impact of the CDC on the psychological well-being of participants. The Card was thought to be stressful and burdensome for some CDC participants, and was perceived to be contributing to the re-experiencing of trauma, and heightened symptoms of depression and anxiety for those with pre-existing mental health issues.

*Looks it has set off a lot of anxieties, it brought me right back down to a place I didn't really want to go...I was in a really good place, I had a job, the kids were all doing well, we got a new house, we were doing well in that...I felt like I was being punished for being a single parent, that's how I felt and I stopped working and everything because of it, started going a bit crazy and losing the plot a lot. P33GF*

Of most concern, it was suggested by some respondents in the East Kimberley and Goldfields that the implementation of the CDC had contributed to suicidal ideation and several incidences of attempted suicide and self-harm.<sup>92</sup>

*I've heard stories of people attempting suicide because of it. Like it's all just becoming too much...We went out to do a bit of community consultation and just get ideas from the community on how things were going and how we could maybe improve them and things. Overwhelmingly the cashless debit card came up and I sat in a lady's driveway and she was*

---

<sup>92</sup> It is important to note that these are subjective views, verification with substantive evidence was outside the scope of this research. The reason why a person may want to take their own life is a complex issue with multiple contributors, which may include social determinants and clinical factors (The University of Western Australia, 2017).

*crying to me telling me that she tried to commit suicide three times because of the hassle from her kids from the cashless debit card. SH14EK*

#### 5.7.4 Integration of evidence

Evidence on health and well-being is hard to integrate in the context of this analysis. We cannot expect these domains to change in a substantial and sufficiently visible manner in the short period of time covered by this analysis and due to the impacts of a policy that has also been at work for a short duration. Therefore, the health and well-being data is more likely to be useful in identifying where vulnerabilities may exist in the CDC population than to reveal health impacts of the CDC policy itself. Further waves of data collection would allow one to investigate the longer-run impact of the CDC on these indicators using the longitudinal aspect of the survey questions.

There are several indicators in the study that point towards outcomes that could reasonably be expected to impact the longer term health and well-being of CDC respondents, such as potential changes in nutrition, capacity to promote financial security and other factors, many of them discussed in other sections of this report. Such associations are indicated in the qualitative analysis and should be used as a guide for future work linking such factors with the longer-term health outcomes of people on the CDC.

Quality of life is a good indicator of future health and well-being outcomes as well as being an outcome in its own right about the present. The distinction between the PCS and MCS dimensions of well-being is also an important predictor of health and again an outcome in its own right. As the quantitative survey evidence stands in the present analysis, it can be used for monitoring the development of the CDC rollout in general, with the added value that it can help profile the more vulnerable CDC participants by identifying their vulnerabilities and monitoring their life journey within the context of the CDC policy.

More specifically, both the quantitative and qualitative evidence produced a mixed picture as to the impact of the CDC on health and well-being. The qualitative evidence pointed to some improvements in health through decreased alcohol consumption and better nutrition for some, particularly in the East Kimberley and Ceduna sites. It also highlighted the distress felt by many CDC participants for being, in their expressed view, unjustly put on the Card. These feelings of unfairness and issues related to the practical implementation of the Card are claimed to have adversely affected well-being and may be associated with adverse mental health impacts.

The large quantitative survey evidence of an impact of the CDC on objective health outcomes is not yet available as it necessitates a second wave of data collection, the SF-12 and Australian Unity Wellbeing Index being longitudinal in nature. This was part of the design of the survey. It was also part of the design of the survey to produce an indirect measure of the impact of the CDC on health and well-being that could be derived through a single wave of data collection and used in the present report, where a second wave of data is not available. Thus, CDC participants were asked whether the CDC has made their life better or worse and whether they could see any improvement in their quality of life, that of their family, friends or community. The survey evidence corroborated, in a quantitative manner, the mixed picture highlighted by the in-depth qualitative interviews, namely that a large proportion of CDC participants felt their life has been affected in a negative way, especially in the Goldfields trial site and more so for non-Indigenous CDC participants. It also identified and characterised those CDC participants who felt that the CDC has helped improve their quality of life, which is potentially beneficial for a more targeted implementation of the CDC.

### 5.7.5 The evidence base

The evidence bases worked well in tandem for the investigation of the potential impacts of the CDC on health and well-being. The survey design recognised from the outset that health improvements are a longer-term aim of the policy and provided alternative measures as empirical proxies for health status, as well as alternative indicators of change that could be reasonably expected to improve future health. It also provided ample opportunity for the indirect measurement of life quality. The quantitative evidence base has also laid the foundations for future longitudinal development to inform deeper and broader questions as the policy matures.

The qualitative evidence has been instrumental in pointing towards the correct interpretation of several of the measures that have to do with health and especially well-being and its many qualitative facets. The contribution of community data was minimal in this aspect of the research, primarily due to the absence of suitable datasets.

### 5.7.6 Observations, limitations and caveats

There are two main caveats in the analysis of health and well-being outcomes in this research. First, health impacts are typically of a longer term nature and they are hard to make causal statements about, in that health status can be both a cause of well-being and an outcome of well-being (in the empirical literature this is called “endogeneity”). It is, therefore, often hard to tell whether worse health is caused by an adverse life factor or an adverse life factor is caused by bad health. For example, poor finances can be caused by poor health and poor health can be caused by poor finances. It is often impossible to distinguish the behavioural drivers of observed change without longer term individual data. Second, well-being can be a deeply subjective outcome. Two persons that are observationally identical may express very different views about a life circumstance and a policy. To this purpose, both the qualitative and quantitative evidence has strived to provide objective benchmarking in its evidence in the form of questions that relate to specific factors that may influence well-being in a quantifiable and identifiable manner, such as for example by asking for changes to one’s self, their families, friends and their communities.

### 5.7.7 Summary

There are mixed views about the impact of the CDC on the health and well-being of participants to date. In newer sites, such as the Goldfields, a greater proportion of CDC participants felt that their quality of life had been affected in a negative way and more so for non-Indigenous CDC participants. However, a significant minority reported an overall more positive impact of the CDC on their quality of life, in particular the East Kimberley site.

## 5.8 Autonomy and control

The CDC is highly likely to impact upon the autonomy and control that CDC participants feel they have over their lives as the CDC, by design, restricts how and where they spend their money and possibly how they live their lives.

### 5.8.1 Key findings

- The quantitative evidence suggested the impact of the CDC on participant's sense of control over their lives and their money was mixed.
- The quantitative survey showed that slightly more CDC participants reported that they felt less in control of their lives since the introduction of the CDC than that it had increased their feelings of control.
- The survey also showed that there is a big difference between Indigenous CDC participants in all three sites and non-Indigenous CDC participants in the Goldfields.
- Indigenous CDC participants, in all three trial sites, were slightly more likely to have experienced increased control over both their lives and their money after the introduction of the CDC rather than a decrease in control.
- In contrast, two thirds of the non-Indigenous CDC participants in the Goldfields reported that they had less control over their lives and money after the CDC.
- Regression analysis highlighted the CDC participants' individual characteristics that were associated with an increased sense of control over their lives, namely they were more likely to: be living in Ceduna, be Indigenous, have been worse off financially before the CDC, be better off financially now, be on DSP.
- Individual characteristics associated with increased sense of control over one's money were estimated to: be Indigenous, be living in a couple relationship with children, have been worse off financially before the CDC, be better off financially now.
- The CDC appeared to be levelling up those who started in the least favourable financial position prior to the CDC, by enabling them to increase control over their lives and money.
- The CDC did not appear to be levelling down those who found themselves in a good current financial position. They too were more likely to be experiencing more control than what they had prior to the CDC.
- The qualitative evidence suggested an overall decline in the level of autonomy and control experienced by CDC participants as a result of the CDC.
- Interview respondents perceived similarities with previous government policies which impacted the lives of Indigenous Australians.

## 5.8.2 Evidence from large scale survey

The quantitative survey asked CDC participants whether they felt more in control of their lives and their money since the rollout of the CDC.

### 5.8.2.1 Control over life

Overall, Table 5-23 shows that a small majority of CDC participants (51 per cent) reported that they 'never' or 'hardly ever' felt more in control of their lives since the introduction of the CDC. In contrast a large minority (42 per cent) reported that they 'sometimes', 'most of the time' and 'all of the time' felt more in control of their lives since the CDC. Table 5-23 shows a considerable difference between Indigenous and non-Indigenous CDC participants, with Indigenous participants reporting substantially higher gains in the control they felt over their lives than non-Indigenous CDC participants. We did not detect a difference between men and women.

Table 5-23: Being on the Card, how often do you feel more in control of your life, by Indigenous status and gender

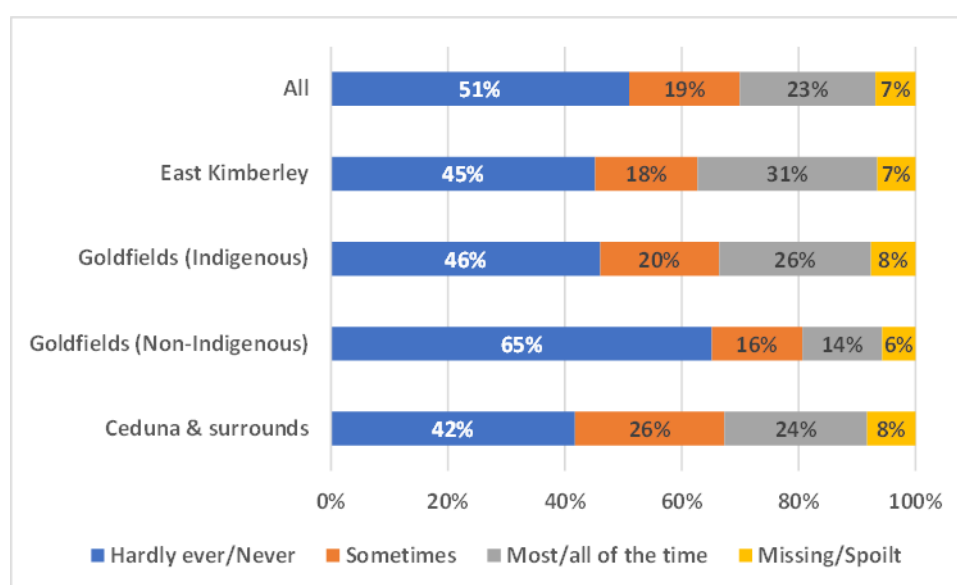
Being on the Card, how often feel more in control of life...										
	All		Indigenous		Non-Indigenous		Male		Female	
	N	%	N	%	N	%	N	%	N	%
Never	2,277	38	1,269	33	1,008	47	944	36	1,333	39
Hardly ever	803	13	444	11	359	17	370	14	429	12
Sometimes	1,143	19	829	21	314	15	484	19	660	19
Most of the time	488	8	337	9	151	7	205	8	283	8
All the time	914	15	732	19	181	8	457	18	457	13
Missing	380	6	261	7	120	6	116	4	265	8
Spoilt	34	1	26	1	7	0	13	1	20	1
<b>Total (N)</b>	<b>6,039</b>	<b>100</b>	<b>3,898</b>	<b>100</b>	<b>2,141</b>	<b>100</b>	<b>2,589</b>	<b>100</b>	<b>3,450</b>	<b>100</b>

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

As we show below, there were large differences in opinion about changes of control over life due to the CDC, clearly visible by location and by other personal characteristics and circumstances. For ease of illustration and discussion, Figure 5-22 and all similar figures in this section combine the categories 'never' and 'hardly ever' and the categories 'most of the time' and 'all of the time'. Figure 5-22 below shows that negative feelings about reduced control due to the CDC were more prevalent among the non-Indigenous CDC participants in the Goldfields (65 per cent) than any other CDC participants. In comparison, Indigenous Goldfields participants and those in East Kimberley and Ceduna were less likely to report having reduced control (46 per cent, 45 per cent and 42 per cent respectively).

Among the Indigenous CDC participants in all three trial sites we saw an approximate half/half split in reporting more or less control of one's life if we count the response 'sometimes' as indicating that CDC participants feel more in control (49 against 45 per cent in East Kimberley, 46 against 46 per cent in the Goldfields and 50 against 42 per cent in Ceduna). A very different split of one third/two thirds between more (30 per cent) or less (65 per cent) control was found among the non-Indigenous CDC participants in the Goldfields.

Figure 5-22: Being on the Card, how often do you feel more in control of your life, by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

### 5.8.2.2 Control over money

A similar picture emerged when we looked at the question of whether CDC participants felt more in control of money since the introduction of the CDC. For the whole of the population, Table 5-24 shows that overall, 55 per cent of CDC participants reported less control ('never' or 'hardly ever') and 41 per cent reported more control over their money since the introduction of the CDC (sometimes, 'most of the times' and 'all of the times'). As with life control, the non-Indigenous CDC participants reported far less control (68 per cent reported 'never' or 'hardly ever') than more control (27 per cent reported 'sometimes', 'most of the times' and 'all of the times'), with an almost equal split among the Indigenous CDC participants (48 per cent less and 47 per cent more control). There was no discernible difference between what men and women reported.

Table 5-24: Being on the Card, how often do you feel more in control of your money, by Indigenous status and gender

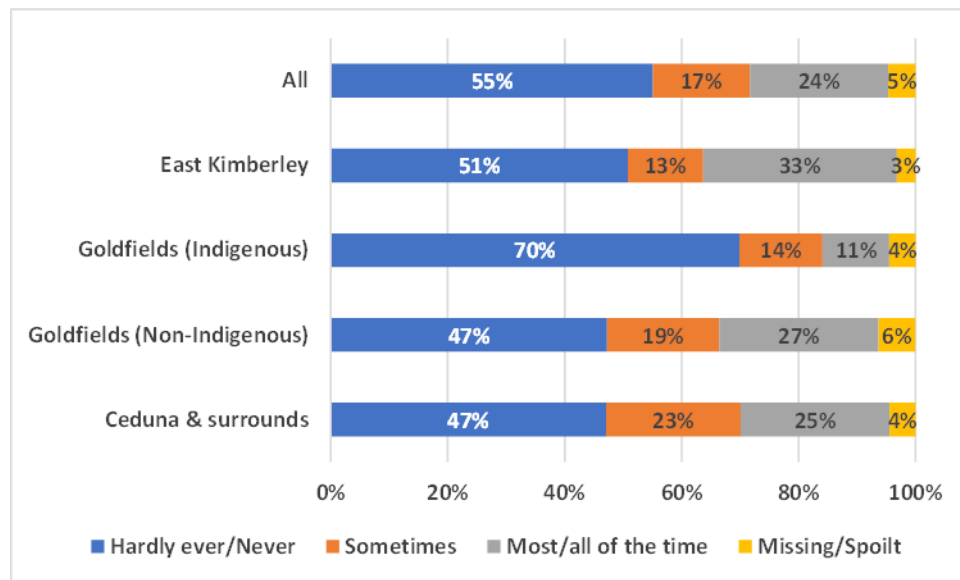
Being on the Card, how often feel more in control of money...										
	All		Indigenous		Non-Indigenous		Male		Female	
	N	%	N	%	N	%	N	%	N	%
Never	2,583	43	1,431	37	1,152	54	1,082	42	1,501	44
Hardly ever	744	12	434	11	310	14	334	13	410	12
Sometimes	1,002	17	713	18	289	13	415	16	587	17
Most of the time	419	7	305	8	114	5	192	7	227	7
All the time	1,012	17	828	21	183	9	463	18	549	16
Missing	262	4	169	4	93	4	100	4	161	5
Spoilt	17	0	17	0	0	0	3	0	14	0
Total (N)	6,039	100	3,898	100	2,141	100	2,589	100	3,450	100

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.



Figure 5-23 below confirms the differences between trial sites. The difference between the non-Indigenous CDC participants who reported more or less control over their money was clearly apparent in the Goldfields compared to anywhere else. Among the Indigenous CDC participants in the Goldfields and the whole of the East Kimberley and Ceduna populations, the split was around half/half, as it was in the case for life control.

Figure 5-23: Being on the Card, how often do you feel more in control of your money, by trial site



*Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.*

While the interpretation of controlling one's life is more general than controlling one's money, the two indicators did not differ greatly from one another.

### 5.8.2.3 Who reported they feel more in control since the introduction of the CDC?

We used multivariate regression to estimate the most likely individual characteristics of CDC participants who reported their control over their life and their control over their money improved with the introduction of the CDC. We estimated one model for control over life (Box 5.9) and one for control over money (Box 5.10). Each model examined a large number of individual characteristics and circumstances, including age, gender, location, type of income support payment, household type.

### Box 5.9: Who is more likely to report feeling more in control of their life since being on the CDC?

A CDC participant who reported they felt more in control of their life since the introduction of the CDC was:

- more likely to be in Ceduna and surrounds (5.5 percentage points larger probability of feeling more in control over their lives than CDC participants from the East Kimberley, which was the reference category)<sup>93</sup>;
- more likely to be an Indigenous CDC participant (11 percentage points more likely to report feeling more control over their lives compared to non-Indigenous CDC participants);
- more likely to be in receipt of DSP payments (5.3 percentage points more likely to report feeling more control over their lives than CDC participants on other benefits);
- more likely to have been worse off financially before the CDC: a one percentage point higher level of financial stress prior to the CDC (based on the index of financial stress) was associated with a 2.1 per cent higher probability of reporting feeling more control over their lives;
- more likely to be better off financially now: a higher level of current financial stress was associated with a 2.2 per cent lower probability that the CDC participants were more in control of their lives.
- Age and length of time on the CDC did not seem to be associated with reported feelings of having more control over their lives.

Once we controlled for location, Indigenous status, pre-CDC and current financial status and support status, some of the common indicators like age and time on the CDC appeared to not be associated with reported feelings of control.

We conducted the same type of multivariate analysis as in Box 5.9 above on CDC participants who felt more in control over their money since being on the CDC. Box 5.10 sums up our findings on control over one's money, which were qualitatively similar to the findings on control over one's life, with two possible differences. First, the negative attitudes reporting loss of control appear to be stronger over money control than they are over life control. Second, the finding that DSP recipients were more likely to report increased control over their life, does not apply to control over one's money: DSP recipients were not more likely to report improved control over their money.

---

<sup>93</sup> However, once we control for CDC participants' financial situation pre- and post-CDC, no significant differences across sites were detected any longer. This suggests that the effect associated with Ceduna was due to variation in the composition of the CDC participants with regards to financial situation.

### Box 5.10: Who is more likely to report feeling more in control over their money since being on the CDC?

A CDC participant who reported they felt more in control of their money since the introduction of the CDC was:

- more likely to be an Indigenous CDC participant (13 percentage points more likely to report gaining more control over money since being on the CDC compared to non-Indigenous CDC participants);
- more likely to be in a couple with children relationship (5.6 percentage points more likely to state they had improved control over money compared to people living alone);
- more likely to be living with others (6.7 percentage points more likely to state improved control over money compared to people living alone);
- more likely to have been worse off financially before the CDC (a one percentage point higher level of financial stress before the CDC was associated with a 2.2 per cent higher probability of improved control over money);
- more likely to be better off financially now: a higher level of current financial stress was associated with a 2.5 per cent lower probability that the CDC participants have more control over their money.
- Age and length of time on the CDC did not seem to affect CDC participants' feelings of having control over their money.

*Note: After controlling for the demographic makeup of the trial sites, we do not find significant differences across sites with respect to the probability that CDC participants reporting that they have now more control over their money. DSP recipients are not more likely to report improved control over their money in spite of being more likely to report increased control over their life.*

Finally, we note a commonality in one finding for both types of control. Namely, those who started from a less favourable financial position before the CDC, appeared to have an improved sense of control over both money and life.<sup>94</sup> The implication of this finding is that this beneficial outcome of the policy (i.e. experiencing increased control) impacted more on those who were more in need of it when they were introduced to the CDC. At the same time, we found those who were currently in a favourable financial position, appeared to also have reported higher levels of improvement in the way they control their money and their life. Put together, these two findings suggest that the policy is having a “levelling up” impact as manifested by those who were in a bad place prior to the CDC, but is not having a “levelling down” impact as manifested by those who are currently in a good place.

### 5.8.3 Evidence from in-depth interviews with Stakeholders and Participants

Interview respondents in all three trial sites reported concerns that the CDC took away the autonomy and control of participants to make decisions about their own lives and how they spent their Centrelink payments (further details are provided in the Qualitative Supplementary Report). This was felt by some to be a violation of their human rights and also to disempower and reduce the independence and dignity of CDC participants. Respondents who were currently in paid part-time employment, were participating in work-for-the-dole programs, had previously been in the workforce

---

<sup>94</sup> As this is another continuous indicator variable, the strength of this improvement can best be understood by examining the Quantitative Supplementary Report's multivariate regression results.

and paid taxes, had a disability, along with those who were already managing their money well were particularly concerned about having restrictions placed upon their money.

*I think it's taken away people's ability to choose what they do. And yes they do make wrong decisions, but don't we all? And I don't think that we have a right...I really don't personally see anything too good in it at all, because I just think it takes away people's rights to be responsible and to own their own money, however they choose to use it. SH08C*

*Why are they doing this to us? You know, it's our money, we work for this, work for the dole. P19EK*

Perceived similarities with previous government policies which had impacted the lives of Indigenous Australians was also noted by some respondents. In particular, references were made of the parallels between the historical distribution of rations to Aboriginal people and the placing of monies under the CDC. Furthermore, the CDC was considered by these respondents to be a paternalistic policy, which was being imposed disproportionately on Aboriginal people who had not been given an opportunity to voice their opposition.

*I also was really angry because I go back to colonisation days, and thinking about my ancestors, how they used to live on the ration stations and that. And I thought, "Why the hell do I have to?" Me, being an Aboriginal woman, why do I have to put in a piece of paper and write to someone and say, "Excuse me, sir or ma'am, can I please pay my rent?" That's so degrading for me in society today...The government's still trying to control and protect, monitor people. P22GF*

Respondents reported that some individuals had chosen to either move away from the area or to come off Centrelink payments as a way of avoiding going onto the CDC and having their finances managed.

*There's been a lot of people moving out of town just to avoid being on the Indue card...They might not be big drinkers, they just don't like being told that they have to be on Indue. P46C*

#### 5.8.4 Integration of evidence

The qualitative and quantitative evidence collected around the impacts of the CDC on the autonomy and control of CDC participants contradicted each other somewhat. On the one hand, the qualitative evidence suggested a decrease in the level of autonomy and control experienced by CDC participants. This finding was not borne out in the quantitative data, where we saw almost equal proportions of CDC participants reporting a decline in control over their lives and money and those reporting an increase in these two types of control (over life and money) since the rollout of the CDC. The polar views on control over money were consistent with the earlier section on Financial Planning and Money Management, where CDC participants reported some aspects of their finances getting better and some worse. The quantitative data does not address issues of autonomy directly, so this aspect is only covered by the qualitative evidence.<sup>95</sup>

---

<sup>95</sup> Table 6-2 relates to what some CDC participants have recorded in their free text answers and does not come from a specific survey question that were answered by everyone. The quantitative survey did not include a direct question on autonomy.

### 5.8.5 The evidence base

The quantitative evidence base, while examining perceptions of control, did not provide any direct data on the topic of autonomy. The qualitative data examined both aspects of autonomy and control. Community and other government datasets could not provide any information on this topic. Some of the quantitative findings will benefit from future longitudinal evidence, especially in order to build a better picture of the pathways to change, such as the finding of a broad improvement in control for those who started from the lowest financial position before the CDC.

### 5.8.6 Observations, limitations and caveats

Autonomy and control are two general concepts of well-being. Whilst it is a by-product of the CDC that it reduces autonomy and control over money, reporting suggests it is also improving control for a large proportion of CDC participants, in some cases as many as half of them. The pathways are not clear and more work will be required for definitive answers. The noteworthy current differences between perceptions of the non-Indigenous and Indigenous CDC participants in the Goldfields will also require further work to understand their exact meaning and the pathways that led to them. In the multivariate analysis results reported in this section, it is important to stress the regressions cannot be interpreted as estimations of a causal relationship, they are estimates of statistical associations.<sup>96</sup> The information about control elicited in the survey is longitudinal in nature. Impact statements would be made possible with a second wave of survey collection.

### 5.8.7 Summary

The qualitative and quantitative evidence collected by the evaluation gave rise to mixed findings. The qualitative evidence suggested a large decline in the level of autonomy and control experienced by CDC participants as a result of the CDC. The quantitative evidence, in comparison, found diversity in almost equal portions: about half the CDC participants reported their control had improved and half, that their control had been reduced since the introduction of the CDC.

---

<sup>96</sup> The estimation describes the *joint* association between the “explained variable” control and the set of “explanatory variables”. It does not suggest that a causal relationship is in place. The point to note is that a causal relationship *may be present*, but this estimation design is unable to support such statements.

## 5.9 Discrimination, Stigma, Shame, Embarrassment and Fairness

One of the unintended consequences of the CDC is that being on the Card may result in feelings of discrimination, stigma, shame, embarrassment and unfairness.

This section begins with the presentation of the feelings of CDC participants on discrimination, embarrassment and unfairness about being on the Card as these were reported in the large scale survey. It continues with the presentation of additional evidence provided by the qualitative research offering further depth and nuance to how CDC participants feel about being on the Card.

### 5.9.1 Key findings

- The survey included a number of instruments eliciting CDC participants' feelings of shame and embarrassment from being on the Card.
- Responses of CDC participants to these questions were very stable across sites and between individual characteristics. Overall, 75, 73 and 75 per cent of CDC participants reported that they felt discriminated against, embarrassed about being on the Card or that being on the Card was not fair, respectively.
- In contrast 21, 22 and 20 per cent respectively reported that they never or hardly ever had these feelings about the Card. These reported proportions were also relatively similar across sites and between individual characteristics. A slightly larger proportion of CDC participants in East Kimberley indicated they do not feel embarrassed, discriminated against or unfairly targeted (about 25 per cent of the CDC participants) compared to CDC participants in Ceduna (about 17 per cent).
- Additional commenting in the survey through free text boxes suggested a minority of CDC participants reported that they found the CDC to be overall acceptable, but only for others and not for themselves.
- The qualitative evidence corroborated the quantitative findings. They both highlighted the large proportion of CDC participants who felt embarrassed, stigmatised and unfairly targeted by the policy. Both methodologies also pointed towards such feelings being widespread among all demographic groups making up the CDC population.
- Qualitative evidence showed that CDC participants felt this way partly because being on the Card painted them with the brush of alcoholism, addiction, social harm and neglect of their children, the issues of which the policy has been promoted to tackle directly.
- Holding the Card was seen as signalling to others in the community that one receives welfare payments, thus potentially exposing oneself to disparaging comments about being an addict, too lazy to find a job, and to being treated differently in the shops they frequent.
- Practically, these feelings of stigmatisation had led some CDC participants to try and hide that they were on the Card, avoiding their usual local shops.

## 5.9.2 Evidence from large scale survey

The quantitative survey asked CDC participants a number of questions regarding their feelings about being on the Card. Specifically, they are asked how often they feel (i) discriminated against, (ii) embarrassed to be on the Card, and (iii) that it is not fair for them to be on the Card.

Table 5-25 displays the answers provided by CDC participants about these feelings. A large majority of CDC participants (75 per cent) reported that they felt discriminated against (either ‘sometimes’ 18 per cent, or ‘most/all of the time’ 57 per cent) as a result of being on the CDC. Similar large majorities reported that they felt embarrassed (73 per cent) and that it was not fair that they were on the CDC (75 per cent). Far fewer CDC participants reported that they ‘never’ or ‘hardly ever’ had these feelings about the CDC (21, 22 and 20 per cent for each of these three questions, respectively). These findings were very similar between Indigenous and non-Indigenous CDC participants and between men and women.

Table 5-25: Being on the Card, feelings of discrimination, embarrassment and unfairness, by Indigenous status and gender

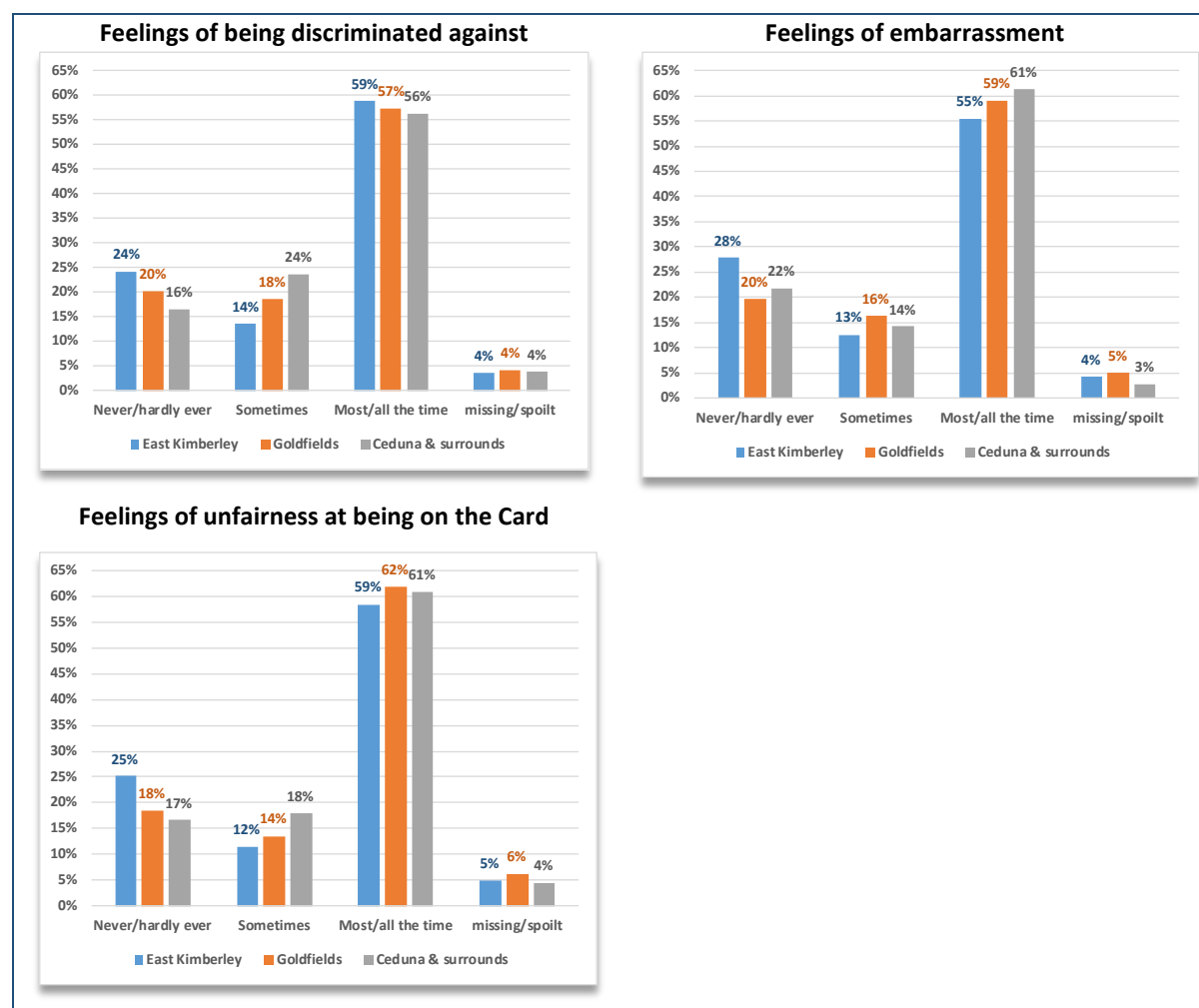
Feelings of discrimination, embarrassment and unfairness										
	All		Indigenous		Non-Indigenous		Male		Female	
	N	%	N	%	N	%	N	%	N	%
FEEL DISCRIMINATED AGAINST										
Never/hardly ever	1,245	21	805	21	440	21	527	20	718	21
Sometimes	1,085	18	701	18	384	18	516	20	569	17
Most /all the time	3,471	57	2,222	57	1,248	58	1,478	57	1,993	58
Missing/spoilt	238	4	170	4	68	3	67	3	171	5
BEING ON THE CARD IS EMBARRASSING										
Never/hardly ever	1,340	22	926	24	414	19	564	22	776	23
Sometimes	905	15	564	14	341	16	400	15	505	15
Most/all the time	3,529	58	2,223	57	1,306	61	1,520	59	2009	58
Missing/spoilt	265	4	185	5	80	4	105	4	159	5
IT IS NOT FAIR BEING ON THE CDC										
Never/hardly ever	1,204	20	816	21	388	18	486	19	718	21
Sometimes	826	14	536	14	290	14	384	15	442	13
Most/all the time	3,673	61	2,315	59	1,358	63	1,597	62	2,076	60
Missing/spoilt	336	6	231	6	105	5	122	5	214	6
TOTAL	6,039	100	3,898	100	2,141	100	2,589	100	3,450	100

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

These feelings about discrimination, embarrassment and unfairness associated with the CDC were also shown to vary little between the three sites, as pictured in Figure 5-24 below. These findings were in stark contrast to the pattern we have observed with many other impacts of the CDC, where it is either that Indigenous CDC participants typically report more positive outcomes and perceptions and/or the

non-Indigenous CDC participants in the Goldfields trial site typically report more negative outcomes and perceptions. In the case of these general feelings of embarrassment and discrimination, there appeared to be a consensus among four out of every five CDC participants.

Figure 5-24: Being on the Card, feelings of discrimination, embarrassment and unfairness, by trial site



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

We examined several individual characteristics using more complex tabulations (see example in Table 5-26 below) and multivariate regression analysis (see Quantitative Supplementary Report), but without managing to discover any major patterns. There was some weak evidence that CDC participants without any adult support in their household (that is, either living alone or as a single parent) may be more likely to report negative feelings about the CDC, but the differences we observed were not statistically significant.



Table 5-26: Being on the Card, feelings of discrimination, embarrassment and unfairness, by household type

Feelings of discrimination, embarrassment and unfairness										
	Living alone		Couple living alone		Couple with children		Single parent		Other household	
	N	%	N	%	N	%	N	%	N	%
FEEL DISCRIMINATED AGAINST										
Never/hardly ever	301	19	170	27	226	23	266	17	243	23
Sometimes	301	19	105	17	164	17	268	17	203	19
Most /all the time	956	59	331	52	549	56	931	61	578	55
Missing/spoilt	54	3	27	4	40	4	71	5	33	3
BEING ON THE CARD IS EMBARRASSING										
Never/hardly ever	370	23	188	30	231	24	277	18	234	22
Sometimes	226	14	97	15	144	15	215	14	189	18
Most/all the time	948	59	318	50	557	57	975	63	603	57
Missing/spoilt	68	4	31	5	47	5	69	4	31	3
IT IS NOT FAIR BEING ON THE CDC										
Never/hardly ever	342	21	143	23	191	20	255	17	237	22
Sometimes	209	13	77	12	159	16	192	13	150	14
Most/all the time	976	61	383	61	556	57	992	65	632	60
Missing/spoilt	85	5	30	5	73	7	96	6	39	4
TOTAL	1,612	100	633	100	979	100	1,535	100	1,057	100

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

\*Total sums to 5,816 as 223 (3.7 per cent of 6,039) survey respondents did not report their household type.

A conclusion of the quantitative evidence is that feelings of discrimination, embarrassment and unfairness surrounding the CDC were widespread with approximately four out of five CDC participants expressing them in all three dimensions we have explored, without distinction of location or individual characteristics and circumstances.

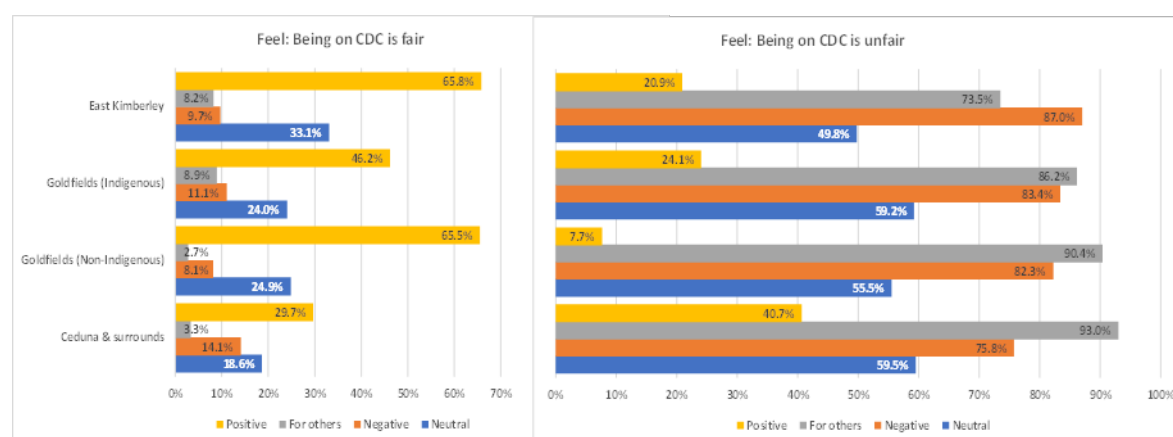
The quantitative survey also collected information in a set of five free text boxes where all respondents were invited to express their opinions over and above what they had said through their structured survey answers. Although these answers are provided in a form that may be harder to analyse in a formal statistical way, they have provided a number of useful insights. Following these free-text answers we categorised only those comments that expressed explicitly the personal views of CDC participants about the CDC as a policy, into the following categories:

- “Neutral” (54 per cent), those who did not express explicitly any personal view about the policy;
- “Negative” (28 per cent), those who expressed a negative personal view on the policy;
- “For Others” (11 per cent), those who expressed a personal view that they should not be on the CDC, as they did not have the problems the CDC was trying to address, but that the CDC was a good policy idea for those who needed it; and

- “Positive” (7 per cent), those who expressed a positive personal view about the policy.<sup>97</sup>

Figure 5-25 below combines the four categories of personal views with the reported view of whether the CDC participant considers that being on the CDC is fair or unfair. The left panel of Figure 5-25 reports the views of those who felt that being on the CDC is fair and the right panel reports the views of those who felt that being on the CDC is unfair. The left panel on Figure 5-25 suggests that those who reported feeling that being on the CDC was fair, had a predominantly positive view about the policy. The right panel on Figure 5-25 suggests that those who reported feeling that being on the CDC was unfair have a negative personal view about the policy.<sup>98</sup>

Figure 5-25: Feelings of fairness/unfairness about being on the CDC by CDC participants' personal views about the CDC policy (survey free text boxes)



Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

The findings in Figure 5-25 about fairness were repeated in the context of discrimination and embarrassment. They are indicative of the multi-layered factors that are at play when opinions, views and perceptions are formed about the CDC and they offer an additional lens for viewing the oft encountered mixed findings in this report.

### 5.9.3 Evidence from in-depth interviews with Stakeholders and Participants

In each trial site interview respondents raised concerns about the perceived stigma, shame and embarrassment of participating in the CDC (further details are provided in the Qualitative Supplementary Report). This issue was particularly identified by respondents in the Goldfields trial site. The policy was seen by these respondents as stigmatising and breaching confidentiality, as being on the Card enabled CDC participants to be identified within their community as being in receipt of

<sup>97</sup> As this part of the evidence is collected in a non-random way—respondents with the strongest views are more likely to provide additional information—the response rates need to be interpreted accordingly. The way this evidence can be collected and analysed, and the interpretation of the evidence are further examined in the Quantitative Supplementary Report.

<sup>98</sup> We read Figure 5-25 as follows. Using East Kimberley as an example, of those who expressed a negative personal view on the CDC (28 per cent in total), 9.7 per cent thought that it is fair to be on the CDC (in the left panel) and 87 per cent felt that it is unfair (in the right panel). Each personal view category presents a separate message. In the example used in this footnote a complex picture emerges which suggests that feelings for unfairness for oneself and for others may differ when the CDC policy is considered. Similar patterns emerge for the questions on Discrimination and Embarrassment.

Centrelink payments. As a result, some CDC participants felt as if they were being judged by others in the community as “dole bludgers” and too lazy to work.

*I honestly believe that it's actually, it's providing a divide in the community. Definitely providing a divide. So, it's like 'us' and 'them' and they might as well go around with a beacon on their head, like, "I'm on the cashless card"...They're also getting, set in a bad light, because they're on benefits. They're being tarred with the same brush, you know, you're on benefits, you're a low-life, you're a good-for-nothing and there's a lot of shame, there's a lot of embarrassment. SH08GF*

Moreover, as the primary aim of the CDC was to address the social harm caused by alcohol, drugs and gambling, there was said to be widespread community misperceptions that the Card was only for those with an addiction or who neglected their children. As a consequence, some CDC participants expressed concerns that they were being wrongly labelled as alcoholics, drug users or as not caring adequately for their children.

*Other people they see the Indue card as "Oh you're a druggie", "You're a gambler", "You're an alcoholic", just because we're on the Indue card. Well me, I'm not an alcoholic. I don't gamble. I don't take drugs. But to other people when they see me...walk into the shop with the Indue and they look at the card "Oh Indue card, that's a druggie, that's an alcoholic". It's branding us, the card itself. P31C*

This perceived stigma was associated with feelings of embarrassment and shame of having to participate in the CDC. As a result, some CDC participants were reluctant to use the CDC in their local shops. Respondents also commonly reported perceptions that CDC participants were treated differently in shops and businesses and examples were provided of negative responses received from sales assistants or members of the community when using the Card.

*It's discriminative, it's humiliating, it's depressing, it's very segregating, it has segregated people a lot...Every time you pull that thing out it's like everyone knows who you are and what the government has perceived you as being and that's the saddest part about it is that you have been judged generally and every time you use that card that's how you feel...I have heard people laughing at you behind your back. I went to Esperance with my kids over Christmas last year and when I used the card in Woolworths the young fella behind the counter started laughing and saying "ha ha ha ha that's a cashless card isn't it?" P33GF*

Feelings of shame were even said to be experienced by children when they had to borrow the Card belonging to their parent or grandparent or did not have access to cash for school and social activities.

*My granddaughter, she goes to netball, football, every Saturday, and well there's no cash, and when I tell her to grab the Indue card "No nanna, it's shame carrying the Indue card down to football". Because even the little ones are feeling that shame, for taking the Indue card. Not only us, it's the little ones too that's coming up. P31C*

#### 5.9.4 Integration of evidence

The qualitative and quantitative data both highlight that feelings of discrimination, embarrassment, shame, and unfairness, as a result of being on the Card, are experienced widely by CDC participants. The CDC survey allowed us to quantify the extent of these feelings among CDC participants and identify whether some subgroups of CDC participants were more likely to experience feelings of discrimination, embarrassment, and unfairness. The evidence showed that these feelings were mostly

negative and were evenly spread among the CDC participant population, even among those CDC participants who also were either neutral or thought positively about the CDC as a policy.

It is recognised that the quantitative methodology is less suited for conducting deeper investigations into the reasons for such feelings, at least not without generating survey questions that may direct CDC participants' answers, or without generating biases through self-selected response rates. It is also recognised that the survey has quantified the prevalence of perceptions and feelings of discrimination, embarrassment and unfairness reported by CDC participants. The qualitative research has elicited a deeper understanding of the policy. It highlighted that being on the Card resulted in CDC participants being easily identified as welfare recipients in their community and creates misperceptions of the CDC participants as being either 'addicts' or 'dole bludgers'. The mixed method approach has been useful in the examination of such aspects of the policy where perceptions and views have been shown to take their own dynamics by influencing change in the way the policy is understood by the public.

The findings in this section highlight a major unintended consequence of the Card and corroborate the view expressed in other parts of the report where CDC participants suggested the need for a more targeted implementation of the CDC.

### **5.9.5 The evidence base**

The qualitative and quantitative evidence bases on how CDC participants felt about being on the Card have shown their high complementarity. The need for further longitudinal evidence (both qualitative and quantitative) on discrimination, embarrassment and fairness feelings about being on the Card will be critical component to follow up as the policy matures.

### **5.9.6 Observations, limitations and caveats**

The concepts that are dealt with in this section are complex and sensitive. The specific outcomes of the Card that have been explored by this research, suggests that responses to the Card can be very diverse depending on both the outcome and the participant and the circumstances surrounding them. The examination of the general feelings about being on the Card by CDC participants (which are at least in part the outcome of the specific outcomes of the Card) looks at the policy from a wider lens asking for the participants "feelings about being on the Card". The need for "translation from the specific to the holistic", that is, from the many specific outcomes to the one general feeling about the Card as a whole, is manifested in this section. The potential of the present research to provide clear policy guidance through its evidence base will remain limited without additional evidence going deeper (through further qualitative evidence) and without additional evidence to become broader and more generalisable (through further longitudinal quantitative evidence).

### **5.9.7 Summary**

The qualitative and quantitative data both highlighted that, as a result of being on the Card, feelings of discrimination, embarrassment, shame and unfairness were reported widely and largely evenly by CDC participants.

## 5.10 Employment

Improving employment and training is not an explicit direct aim of the CDC. It is expected that through its direct objective of reducing harmful behaviours, the CDC will indirectly encourage and facilitate engagement in social and economic participation, such as training and employment.

### 5.10.1 Key findings

- Most CDC participants were not in employment.
- The main reported reasons for not working were having a disability and/or having caring responsibilities.
- Further important barriers to employment were lack of jobs, followed by a lack of skills, training and experience.
- Most CDC participants with a disability and or/caring role and not working were not actively looking for work and did not want a job.
- Most CDC participants not working but looking for work did not report a disability or caring role.
- Most CDC participants not working and not looking for work but would like to have a job were those in caring roles or those with no disability or caring role. A fifth were CDC participants with a disability.
- Most jobs held were reported to be part-time (less than 37 hours). The proportions differed by trial site.
- A high proportion of working CDC participants had been in that job for a year or less. The proportions differed by trial site.
- While some opportunities for employment-related outcomes appeared to be present particularly in the Goldfields, these were more limited in East Kimberley and Ceduna.
- Qualitative evidence recognised the potential of employment to improve CDC participants' lives but found little evidence of increased job seeker activity.

### 5.10.2 Evidence from large scale survey

Although the quantitative survey was not designed with the study of employment as one of its primary objectives, it examined whether CDC participants work and what type of work they do. It also examined the barriers to employment that CDC participants encounter in their lives, especially for those who do not work.

Most CDC participants were not in any form of employment (Table 5-27). Ceduna and East Kimberley had the highest employment rate, primarily because reported employment included Work for the Dole.

Table 5-27: Employment status of CDC participants, by trial site

Not working - Working								
Status	All trial sites		East Kimberley		Goldfields		Ceduna & surrounds	
	N	%	N	%	N	%	N	%
<b>Not working</b>	4,317	<b>71</b>	1,048	<b>66</b>	2,663	<b>76</b>	606	<b>65</b>
<b>Working</b>	1,722	<b>29</b>	549	<b>34</b>	840	<b>24</b>	333	<b>35</b>
<b>Total</b>	<b>6,039</b>	<b>100</b>	<b>1,597</b>	<b>100</b>	<b>3,503</b>	<b>100</b>	<b>939</b>	<b>100</b>

Note: Cells may not add up to row/column totals due to rounding of both percentages and population weighted frequencies.

#### 5.10.2.1 Had a job in the last four weeks - Hours worked and length of time in job<sup>99</sup>

The majority (63 per cent) of those CDC participants who reported having had a job in the last four weeks, also reported working part-time (less than 37 hours per week); the highest proportion being Indigenous CDC participants in the Goldfields (74 per cent), followed by non-Indigenous CDC participants in the Goldfields (66 per cent), East Kimberley (59 per cent) and Ceduna (53 per cent).<sup>100</sup> Of those CDC participants who reported having had a job in the last four weeks, forty-nine per cent reported having been in that job for 12 months or less. More non-Indigenous CDC participants in the Goldfields reported having been in that job for 12 months or less (60 per cent) than either Indigenous CDC participants in the Goldfields (49 per cent), East Kimberley (44 per cent) or Ceduna (38 per cent).

#### 5.10.2.2 Perceived barriers to employment by trial site

The survey asked the group who were not working to identify the reasons why they were not in employment, by selecting from a large list of options all reasons that applied to them. The reasons fell into three main categories: (i) own disability or short term illness or because they were carers of someone else; (ii) employment related reasons; and (iii) all other reasons (including study, holidays, travel and other).

The most cited reason for not working (see Table 5-28)<sup>101</sup> was own disability, own illness or care of another person.<sup>102</sup> Around 80 per cent of the CDC participants stated this as one of their reasons for not being in employment. Work related limitations were not as prevalent in East Kimberley (18 per cent) but acted as a considerable barrier to employment for CDC participants in the Goldfields (45 per cent) and Ceduna (35 per cent).

<sup>99</sup> As the majority of employment is Work for the Dole, there are few meaningful differences to explore. For full information see Quantitative Supplementary Report.

<sup>100</sup> A small proportion of those working reported that they work 37 hours or more. They are distributed as follows: a much higher proportion of non-Indigenous CDC participants in the Goldfields reported working in jobs for 37 hours or more per week (17 per cent) compared to their Indigenous counterparts in the Goldfields (7 per cent), East Kimberley (6 per cent and Ceduna (5 per cent). Percentages do not add up to 100 in this calculation as there were several respondents (28 per cent on average) who reported that they work but did not answer the hours worked question. We note that the numbers are very small for meaningful further investigation on the topic of type of employment.

<sup>101</sup> Although the question about employment barriers was only addressed to those who had stated they were out of work in the last four weeks, it was also answered by some people who were in work in the last four weeks but who were out of work on the day they filled in the survey. The analysis focused on the 4,317 who reported they were not working in Table 5-27.

<sup>102</sup> Around 16 per cent of the CDC participants are on DSP and a further 4 per cent receive Carer Payment (CA) or Carer Pension (CP).

Table 5-28: Reasons for not working at the moment, by trial site

Reasons for not working at the moment						
Reason:	East Kimberley		Goldfields		Ceduna & surrounds	
	N	%	N	%	N	%
<b>Own health</b>	80	<b>8</b>	377	<b>14</b>	62	<b>10</b>
<b>Own disability</b>	287	<b>27</b>	665	<b>25</b>	152	<b>25</b>
<b>Caring (children; ill; disabled; elderly)</b>	491	<b>47</b>	1150	<b>43</b>	258	<b>43</b>
<b>Skills and jobs related</b>	186	<b>18</b>	1192	<b>45</b>	212	<b>35</b>
<b>Miscellaneous</b>	85	<b>8</b>	260	<b>10</b>	96	<b>16</b>
<b>Total responses (N)</b>	1,129		3,644		780	
<b>Total respondents (N)</b>	1,048		2,663		606	

*Note: As people were allowed to pick more than one reason, the total of the percentages add up to more than 100 measuring the extent to which more than one reason was provided.*

Skills- and jobs-related reasons were distinguished between those CDC participants who stated their own lack of skills, training and work experience as the prime impediment (deficient supply of labour: lack of skills) and those who stated their skills were adequate but for various reasons the jobs were not there (deficient demand for labour: lack of jobs). The split between 'lack of skills'/'lack of jobs' for not working was 30/70 for both Ceduna and East Kimberley and 41/59 for the Goldfields. Clearly, employment opportunities were poor for CDC participants and especially so in East Kimberley and Ceduna.

Health/Disability/Care reasons were distinguished between those CDC participants who stated their own disability or ill health as the reason and those who stated care responsibilities as the reason. These were almost evenly split in all three trial sites. The split between own disability or ill health and care reasons for not working was 43/57 for East Kimberley, 45/55 for Ceduna and 48/52 for the Goldfields.

This suggests that there is a relatively small pool of CDC participants not working for a reason other than a disability/health reason or a caring role of 30 per cent: East Kimberley 21 per cent; the Goldfields 32 per cent and Ceduna 27 per cent.

### 5.10.2.3 Looking for work

All CDC participants were asked if they were looking for work and, if they were not looking for work, if they would like a job. Overall, 66 per cent of those not working reported they were not looking for work, 76 per cent of whom were those who reported own disability or a caring role as the reason for not working. Of the 30 per cent who said they were looking for work, 72 per cent were those who did not report either their own disability or a caring role as the reasons for not working.<sup>103</sup>

<sup>103</sup> For clarity, Table 5-27 shows that there were 4,317 CDC participants not working and 96 per cent of them answered a question about the reason why they were not looking for work. Of them, 2,849 (66 per cent of the 4,317) reported they were not looking for work. Of those 2,849, 2,165 (76 per cent) reported that the main reasons they were not looking for work were their own disability, ill health or care role. Of the remaining 1,295 (30 per cent of the 4,317) who reported looking for work, a majority of 932 (72 per cent) reported that they had no own disability, ill health or caring role as an impediment for looking for work.



Of the 66 per cent not looking for work, 56 per cent also reported not wanting to a job, 82 per cent of whom were those who reported their own disability or a caring role as the reason for not working. Of those reporting wanting a job, 33 per cent were those reporting no disability or caring role, 21 per cent with own disability and 46 per cent having a caring role (with or without an own disability).

These figures combined suggest the scope for improving labour market opportunities for CDC participants would be at its lowest in East Kimberley, would have some more scope in Ceduna and more so again in the Goldfields.

### 5.10.3 Evidence from in-depth interviews with Stakeholders and Participants

The introduction of the CDC was reported not to have had many impacts on participation in employment and training in any of the three trial sites by interview respondents (further details are provided in the Qualitative Supplementary Report). In principle, the CDC was seen by some respondents as potentially providing motivation to CDC participants to seek work. Employment was considered by interview respondents as a way of addressing the restrictions placed on spending by the CDC, providing either an opportunity to earn some additional cash alongside Centrelink payments or to fully exit the Card.

*It's just the inconvenience, the extra steps that they have to go through to be able to do what they want with the money...The people have a choice and to get out of the inconvenience and the positive choice of getting a job so that they are in control of their lives is really the way forward for them. SH27EK*

It was noted, however, that alongside the CDC, Centrelink had introduced more strenuous mutual obligations and activity requirements for Newstart Allowance recipients. This was also reported by interview respondents to have affected employment outcomes in the region.

*The Cashless Debit Card came in and the Centrelink Shared Responsibilities came in at the same time...They work hand in hand and I think that's actually critical...I'm surprised by the number of people who are like really committed to the job seeker activity and that's really fantastic...And we've been able to employ people who demonstrated their commitment to that. SH03EK*

However, only a few examples were provided by interview respondents of increased job seeker activity or the successful gaining of employment since the implementation of the CDC. In addition, the challenges of finding work (particularly within some of the more remote areas in the CDC trial sites) was observed by some CDC participants due to a lack of appropriate skills or experience and also the limited availability of jobs. Hence, the CDC was not considered by these respondents to be an appropriate way of addressing joblessness caused by a lack of employment opportunities.

*It's a good idea but the reality is that it's not addressing anything other than what you're spending your money on...So for me personally, in that regard, it's not helping the problems that I'm on Centrelink for. It doesn't help me find a job. P47GF*

However, as discussed elsewhere one frequently mentioned positive unintended consequence of the CDC was the increased number of people participating in traditional cultural activities (carving boab nuts or painting canvases or seashells) to subsequently sell for cash.



#### **5.10.4 Integration of evidence**

The survey data showed clearly the numbers involved in each of the important categories relating to employment status and draws the critical distinctions between being able to work, wanting to work and jobs being available for those who can and want to work. The survey data also pointed towards the diversity within each of the trial sites and between them in terms of the human capital that may be available for potential employees. This thinking was clearly reflected in the low expectations expressed by CDC participants and stakeholders alike in the qualitative interviews regarding the impact that the CDC can have on employment. Interestingly, the life-changing potential of employment was stated as one of the attractive attributes of the CDC, albeit in the negative context of not having employment.

#### **5.10.5 The evidence base**

The survey questions on employment were answered adequately and meaningfully. However, the definition of “working” may not be as clear as we would have liked it to be, a limitation stemming from the way Work for the Dole is perceived and implemented in practice in the trial sites. For some areas within the Goldfields this would be different, but then, the numbers would probably be too low for statistical work and the information collected by the survey would need further support by the Government administrative data base. The qualitative evidence confirmed these findings and adds confidence to our interpretations.

#### **5.10.6 Observations, limitations and caveats**

The type of labour market policy that would be effective for each of these three sites is different. Hence the interpretation of any results pertaining to employment (and, by extension, to training for employment) must account for the diversity of both demand for and supply of work within, for example, the various parts of the Goldfields.

#### **5.10.7 Summary**

Most CDC participants reported that they were not working. The main reason was their own disability or ill health or care responsibilities. For the minority who would contemplate working, either there were no available jobs or their skills were not adequate for the jobs that may be available. To date the CDC has had little impact on employment outcomes within all three trial sites.

## 5.11 Local organisations

The CDC not only impacts on participants but also on organisations that operate in the trial areas. The evidence described in this section is drawn from the qualitative interviews with stakeholders conducted in the three trial sites.

### 5.11.1 Key findings

- Stakeholder respondents considered that the trial of the CDC had brought changes to their own and other local organisations.
- A positive impact of the trial had been additional funding of services to support the implementation of the trial and CDC participants.
- An increased workload for organisation staff was a frequently mentioned impact, as organisations provided additional support to clients on the CDC to assist them with practical aspects of the Card.
- Some stakeholders were concerned for the safety of staff as clients took their frustrations with the policy out on local support staff.

### 5.11.2 Evidence from in-depth interviews with Stakeholders and Participants

The stakeholder interviews examined the impacts that the CDC had on both the representative's own organisation as well as on other services within the trial sites (further details are provided in the Qualitative Supplementary Report). While a minority of respondents reported that the CDC had had no discernible impact (to client numbers, the types of referrals received or the issues clients were experiencing), others noted that the trial had brought changes to their own and other local organisations.

Some stakeholder representatives reported that the CDC had had positive impacts with the direct funding of services based in their local area. This included the establishment (or further development) of services to support the implementation of the CDC such as local partner or shopfront services, financial counselling programs, youth services, and men's and women's groups.

*We're very fortunate because, through the Department of Social Services, who funds the cashless debit card, we have been nominated to obtain funding that's supported very much with the participation around men and women's programs, youth...The cashless card funding has been very supportive of this. SH36EK*

A further common impact reported by local organisations was additional work directly related to the implementation of the policy. Respondents commonly spoke of the need to assist clients with issues they were experiencing with their Card. This included providing information about the CDC, emotional and financial support and assisting with CDC processes (e.g. obtaining replacement cards, applying to exit the CDC trial, and accompanying CDC participants to the local partner or shopfront offices). While this additional work was felt to add considerably to the workload of these organisations, it was considered by some stakeholders as a way of potentially improving engagement and rapport with clients.

*It also gave us an opportunity to find out a little bit more about our clients and to deliver a better service. To be honest, when they come through the door for Indue, it was a real way to catch people that would normally fall through the cracks. So, that's from a delivery perspective as well. So, we had so many success stories because we caught them when we normally wouldn't have. SH09C*

It was also noted by a few stakeholders (primarily in the Goldfields region) that as a result of some clients becoming so angry and distressed as a result of their experiences with the CDC, this had led to concerns for the safety of their staff. Mixed impacts of the CDC were noted across each of the trial sites with regard to numbers of referrals and participation in client support programs.

*It has also increased in terms of mental health issues, which is now causing issues for the community and for resources such as ours, because at the end of the day, we're having to deal with a hell of a lot more high-volatile situations and behaviours. At the end of the day, it becomes a safety risk for everybody. SH08GF*

### **5.11.3 The evidence base**

The evidence about the impact of the CDC on local organisations was drawn solely from the in-depth interviews undertaken with stakeholder representatives.

### **5.11.4 Observations, limitations and caveats**

Given that these findings arise from qualitative research, they are subject to limited generalisability to broader population groups or other geographic locations. Readers should note that, like other findings from in-depth qualitative interviews, the views of respondents that are included in this report are respondents' perceptions. The accuracy of statements made by respondents has therefore not been independently verified because the in-depth interviews sought to gain an understanding of respondents' perceptions.

### **5.11.5 Summary**

Stakeholder respondents considered that the trial of the CDC had brought changes to their own and other local organisations. These included the additional provision of services, increased workload and concerns over staff safety when dealing with client's frustrations with the CDC.

## 5.12 Transient populations

The CDC not only impacts on participants who reside in the trial areas, but also on people who transit through those regions for lengthy periods of time. The evidence described in this section is drawn from the qualitative interviews.

### 5.12.1 Key findings

- Both Ceduna and the Goldfields region were common congregation points for Indigenous people living in neighbouring communities (some of which were outside of those trial sites).
- A heightening of social issues was reported when individuals who were not on the CDC visited the region and were thought to have compromised the potential outcomes of the CDC trial.
- The movement of people from neighbouring Aboriginal communities was reported by interview respondents not to have been influenced by the introduction of the CDC.
- Challenges were reported for transient people who had been triggered onto the CDC during their stay in a trial site region.
- Issues had been experienced once they returned to their communities due to the lack of infrastructure in those communities to support people with the CDC.

### 5.12.2 Evidence from in-depth interviews with Stakeholders and Participants

Impacts of the CDC on transient populations were discussed by respondents in Ceduna and the Goldfields, as both areas were common congregation points for Indigenous people living in neighbouring communities (further details are provided in the Qualitative Supplementary Report). Within Ceduna, views were mixed as to whether the CDC had led to a change in the number of people coming into the town from surrounding (dry) communities and the impact this had on levels of alcohol misuse and associated social harm within the trial site. Difficulties were also noted when CDC participants had entered Ceduna from these communities without their Card or had subsequently lost their Card, leaving them with limited access to funds to purchase basic necessities.

*So for a lot of the community to access services, to access things like licenses and all these things, they need ID and stuff. And unfortunately a lot of them lose them, because they are transient, a lot of—and Indue cards are the same...It's a small card and living that lifestyle, it seems to me problematic in terms of always having it on your body. And if you don't, well, you can't get access to cash and you literally, you are going to be hungry, you just can have to go without until you can get to somewhere where they can give you a temp card. SH19C*

In comparison, within the Goldfields, it was recognised by respondents that the movement of people from neighbouring Aboriginal communities had not been influenced by the introduction of the CDC. The communities these individuals usually lived in were not part of the CDC trial site and therefore did not have restrictions placed on the use of their Centrelink payments and had greater access to cash. As a consequence, a heightening of social issues—alcohol and drug misuse, gambling, child neglect,

crime and violence—were noted during times where a high number of people were visiting the region and this was thought to compromise the potential positive outcomes of the CDC trial.

*Every night prior to the cashless card coming in, you'd be hearing disputes whereas now you only get them when people from the lands come in. And they do, they create absolute havoc here for the police and emergency services and everything...When the family members from out on the lands come in, and because they're not on the card and they're cashed up, well they can go and stay with a local family and of course the local family can go, right, well we'll buy the food, you can buy the alcohol. SH39GF*

Challenges were also noted for transient people from neighbouring Aboriginal communities in the Goldfields who had been triggered onto the CDC during their stay. Issues had been experienced once they returned to their communities due to the lack of infrastructure in those communities to support people with the CDC. Other issues included having difficulty understanding the processes of the CDC, using the Card in their communities, struggling to access funds if the Card was lost, and difficulties with checking account balances or paying bills.

*People come in from the lands and...if they're reporting and they're in Laverton, they automatically get on the card...They lose their card, they've got no way access of getting their money. Which makes it really, really hard. SH47GF*

### 5.12.3 The evidence base

The evidence about the impact of the CDC on transient populations was drawn solely from the in-depth qualitative interviews undertaken with CDC participants and stakeholder representatives.

### 5.12.4 Observations, limitations and caveats

Given that these findings arise from qualitative research, they are subject to limited generalisability to broader population groups or other geographic locations. Readers should note that, like other findings from in-depth qualitative interviews, the views of respondents that are included in this report are respondents' perceptions. The accuracy of statements made by respondents has therefore not been independently verified because the in-depth interviews sought to gain an understanding of respondents' perceptions.

### 5.12.5 Summary

Both Ceduna and the Goldfields region were common congregation points for Indigenous people living in neighbouring communities (some of which were outside of those trial sites). The movement of people from neighbouring Aboriginal communities had not been influenced by the introduction of the CDC. It was reported that a heightening of social issues occurred during these visits and compromised the potential positive outcomes of the CDC trial.

## 6. Views about the implementation of the Cashless Debit Card

---

An important component of the evaluation was a consideration of the views of CDC participants and stakeholders on how the policy had been implemented in the trial site regions. The implementation of a policy has the potential to influence outcomes either directly or indirectly. The evaluation explored elements of the implementation of the CDC which were perceived to be working well and elements which were perceived to not be working well.

### 6.1 Key findings

- The evaluation findings about the implementation of the CDC are largely based on evidence from the in-depth interviews undertaken with CDC participants and stakeholder representatives.
- Two key aspects of the implementation of the CDC were considered to be working well by interview respondents: The CDC local partners or shopfronts and some practical aspects of the Card.
- The CDC local partners/shopfronts—which were established to provide assistance to CDC participants with managing processes connected with the Card—were reported to have played an important role in the implementation of the CDC.
- Several practical aspects of the CDC were reported to be working well, including the functionality of the CDC as a bank card and the ability to make monthly transfers into a keycard.
- Interview respondents reported the CDC was working best for three groups of participants: partnered and single parent families; people who had previously struggled with managing their money; and participants experiencing social issues including substance abuse, homelessness and child neglect.
- Interview respondents were more vocal about aspects of the implementation of the CDC that they perceived to not be working well. Six key aspects were identified.
- The first aspect perceived to not be working well centred on financial management. Some participants expressed the view that they found the limited availability of cash under the CDC, limitations in the ability to manage money and pay bills to be problematic.
- The second aspect that was considered not to be working well was related to the practical use of the Card. It included the capacity to make certain purchases using the Card. The processes associated with managing the CDC (e.g. activating the Card, setting up an email account, remembering PINs and passwords, checking balances and arranging transfers and direct debits) were also considered to be challenging for some CDC participants.
- Third, reservations were expressed by interview respondents about the cohort chosen to participate in the CDC trial, with some respondents seeing the blanket approach of the CDC as inappropriate.
- Fourth, in-depth interview respondents reported the use of card workarounds which they perceived as lessening the potential positive effects of the CDC. The workaround reported most frequently by respondents was the selling of goods purchased with the CDC for cash. Other commonly reported workarounds included participants selling their Card or allowing others to borrow and use their Card

in exchange for cash, obtaining cash via monthly transfers from the Card and the purchase of alcohol via the black market.

- Fifth, some respondents expressed the view that insufficient information about the Card had been provided to CDC participants and stakeholders. Many respondents suggested there was a need for community consultation to inform future decisions about the CDC trial.
- Finally, many respondents were either unaware that funding for wraparound services to support the CDC had been implemented, or expressed dissatisfaction with the focus of these services. In particular, some respondents perceived a need for broader wraparound services to address substance misuse and mental health issues and to better service remote areas.
- In-depth interview respondents reported the CDC was not working particularly well for five groups, namely, older people, people with physical and psychosocial disability, individuals experiencing entrenched addiction, Indigenous participants living in remote communities and those with limited literacy and IT skills.

## 6.2 What was perceived to be working well?

The key aspects of the implementation of the CDC which were considered to be working well by interview respondents included the CDC local partners and practical aspects of the Card. These are discussed in more detail below.

### 6.2.1 CDC local partners/shopfronts

#### 6.2.1.1 Evidence from in-depth qualitative interviews

The CDC local partners and shopfronts were established to provide assistance to CDC participants with managing processes connected with the Card and were reported by interview respondents to have played an important role in the implementation of the Card. Many of the CDC participants interviewed had sought assistance and benefitted from the services offered by these offices. In particular, vital support was noted to have been given to CDC participants with managing processes such as card activation, balance checks, fund transfers, direct debits, replacement cards, and exit applications. Respondents reported that the services provided by the CDC local partners and shopfronts were very valuable and had assisted considerably in increasing understanding of, and reducing concerns about, the CDC.

*They're fantastic, yeah. They've got good communication skills about it and I appreciate it and I find it welcoming...It works out good too, like good people. P23C*

While respondents acknowledged that the need for support with the Card had reduced somewhat over time, as participants became accustomed to the processes of the CDC, there was still a significant core of CDC participants for whom ongoing on-the-ground assistance was considered to be vital. This included people with lower levels of financial and English literacy, those who had no access to, or found the use of technology difficult (including older participants and people from very remote Aboriginal Communities) and people with disability or mental health issues. In addition, respondents expressed the view that there was an ongoing role for the local partner offices and shopfronts to

support new CDC participants who required assistance (at least initially) to activate their Card, set up direct debit payments and aid their understanding of the CDC and its processes.

*Twenty per cent of our participants really struggle and they need a lot of help. So we tend to work the majority with those 20 per cent...That 20 per cent are people who are really needing that support so the people where literacy is pretty low, where people may have mental health problems, disabilities, English is not their first language...But also people that are self-sufficient, sometimes when there's changes need that help and advice and support. SH31GF*

The success of the CDC local partners and shopfronts was seen by interview respondents as hinging on several key factors including, most importantly, the employment of the right type of staff. The hiring of local people—and particularly Indigenous staff—with knowledge of their community and the people living in it was considered to be essential to the effective support of CDC participants. Furthermore, respondents considered it was important to have a local, on-the-ground presence and the ability to create a safe space for CDC participants (particularly Indigenous community members) so that they felt comfortable in coming and asking for assistance.

*A lot of times I lost the card...[NAME OF SHOPFRONT WORKER] alright, she's deadly. We like [NAME], all know her and we feel more comfortable talking to her, speaking with her...We all kids you know, family here in a small community. [It's important] someone that you know. P25EK*

Within Ceduna and the Goldfields, the co-location of some local partner offices and shopfronts with other services was also seen by interview respondents as enhancing the ability of CDC participants to obtain information about and access other community supports. Finally, it was observed in the Goldfields that the capacity of shopfront staff to provide a holistic approach and assist with underlying needs beyond the CDC (e.g. support with banking, housing and Centrelink) was important in aiding client engagement and positive longer-term outcomes.

*I think it's helped having us being the shopfront. It's building relationships with people and I've found since they come in for other stuff that they needed in their life. I think it's really good. SH42GF*

## **6.2.2 Perceived positive practical aspects of the Card**

### **6.2.2.1 Evidence from in-depth qualitative interviews**

When discussing the implementation of the CDC, around a quarter of interview respondents reported practical aspects of the Card that they considered to be working well. In particular, the functionality of the CDC was praised. The CDC was considered by respondents to operate as a normal bank card, which was relatively easy to use. The ability to purchase a wide variety of items with the Card, both in stores and online, was also seen by respondents as being advantageous.

*What I like best about the card? It's just like a normal bank card...I still use it to pay my bills, do my shopping, as I would with my normal bank card. P22C*

The ability to make monthly transfers from the CDC to make purchases or assist other family members with money was welcomed by some respondents, as was the provision to organise direct debit payments for bills. Finally, the capacity to monitor CDC accounts online or via a phone app was seen in a positive light and was thought to be encouraging CDC participants to learn how to use technology.



These skills were perceived by some stakeholders as being important in an increasingly cashless society.

*You can transfer. Yeah, they give, friends and family, and when you've got no money they can transfer money to you. Yeah, that's good if that's what happens. P14EK*

*We've both got the app, downloaded it on her iPad and my phone. It's easy to use...It's pretty much like all your banks when you're paying someone. As long as you know what you're doing and how to do it and rah, rah, rah, you just whack it all down, done. P29GF*

## 6.2.3 Groups for whom the CDC was reported to be working well

### 6.2.3.1 Evidence from in-depth qualitative interviews

Across the three trial sites, interview respondents reported that the CDC was working well for three groups of participants: families, people who had previously struggled with managing their money and participants experiencing social issues including substance abuse, gambling, homelessness and child neglect.

Overall, respondents considered that the Card was working best for CDC participants with children and especially within family groups where the consumption of alcohol and drugs had previously been problematic. Respondents also thought the CDC had enabled some women—who may have been experiencing domestic violence, whose partners had substance misuse issues or were the subject of excessive humbugging from other family members—to now have greater control over the household finances.

*It's good for people who's got young children and not looking after 'em...It probably does work good for people with kids who's on drugs and alcohol all the time. They're wasting their money on that instead of looking after their own kids...It's good for people who need it for the kids' safety and feeding them and that. You need that. P26GF*

*I like it as a tool and as a strategy because I think that, if used properly, it really can empower people and particularly, from what we've seen, young women, young mums, to have greater ownership over their own finances, particularly with the cultural obligations up here and some of the pressure that they experience around FDV in their relationships. SH06EK*

A second group for whom the CDC was considered to be working well across all three trial sites by respondents (especially CDC participants) were those experiencing issues with alcohol, drugs and gambling. The Card was perceived as assisting in reducing access to funds to feed these habits.

*[The] card's built specifically for people with gambling issues, drug and alcohol related...In some cases, it could help some people that do have those issues. P77C*

A further group identified as benefiting from the CDC, by interview respondents in Ceduna and the East Kimberley, were people who had previously struggled with managing their money. This included those who were considered more vulnerable to financial abuse, e.g. older members of the community.

*Some of the elders in Aboriginal communities felt the card was really useful because they can't be humbugged basically. Previously they would have lost all their money as soon as they were paid to family. That clearly isn't quite like that under the cashless card. So I think they are probably benefiting. SH27C*

## 6.3 What was perceived to not be working well?

Qualitative interview respondents also reported aspects of the implementation of the CDC that they considered to not be working well. Six issues were identified by respondents: financial management and the availability of cash; practical aspects of the Card; policy targeting; card workarounds; insufficient consultation and information sharing; and inadequate wraparound services. A minority of respondents considered there to be no unfavourable aspects of the implementation of the CDC. Further evidence regarding issues that relate to practical aspects of the Card was collected through the quantitative survey and is discussed in the relevant section below.

### 6.3.1 Financial management and the availability of cash

#### 6.3.1.1 Evidence from in-depth qualitative interviews

The aspect of the implementation of the CDC that was most commonly reported by respondents (especially CDC participants) as not working well was related to financial management. In particular, the limited availability of cash under the CDC was considered problematic and CDC participants commonly expressed discontent with the proportion of funds available to them as cash. Limited access to cash was said by interview respondents to make it difficult for CDC participants to give money to children, attend some sporting and community activities and make purchases of second-hand goods.

*It's hard enough being on the dole and living off the amount that you have to live off without being able to stretch that a little bit further by buying stuff say, on Facebook, like you can buy say, a lounge suite, for an eighth, a tenth of the price that you would in a retail store. SH09GF*

Additional concerns were also raised by some respondents regarding the ability to manage money under the CDC. Having two different accounts was thought by interview respondents to have been confusing for some CDC participants and to have made it more difficult for them to keep track of account balances and budget their finances. In addition, while the ability to arrange direct debits was available under the CDC and seen in a positive light, some respondents reported that issues had been encountered with making payments (e.g. for accommodation or car expenses). Interview respondents said that at times, some organisations did not accept the Card, or that CDC participants were having to split large payments across their two accounts, which was considered cumbersome.

*We've got a lot of clients that can visualise their cash in their hand...using like the old envelope system when you go, you know, this pocket's for this much and this is for something and here's for your bills and here's for your food, when all of a sudden it's on a one big bulky card and then you kind of go spend, spend, spend, spend, and then they end up in trouble. SH17GF*

Finally, the ability to access savings accumulated in the CDC account was also flagged as a further implementation issue by some respondents. While some CDC participants were unaware that they could apply to have a large purchase made from their CDC account, other interview respondents were concerned that the processes involved for doing this were lengthy and/or intrusive.

*Say if you wanted to try and save up for a second hand car you know, accessing the cash for that, but again you have to get the permission and there's quite a bit of a process for it, you can't just say oh yes, by the time you do that the car could be gone. P25GF*

A suggested area for improvement proposed by some respondents (particularly CDC participants) was a change in the proportion of cash available under the CDC. Limited access to cash was reported to

have led to issues for some CDC participants. These respondents considered that having greater discretionary cash funds would help alleviate these concerns, provide CDC participants with more autonomy over their spending, and make it easier to make purchases and share money with family members.

*I just thought that 20 per cent was too low, been just a lot better at 50-50...an extra 30 per cent would just give people that little bit extra breathing room so they actually could save up a few dollars and buy themselves something outside the box, besides everything being on the card and recognised and no bartering power. P50GF*

A large majority of those respondents who advocated in the interviews for a change in the proportion of cash placed onto the CDC suggested that a 50:50 split of funds (i.e. 50 per cent onto the CDC and 50 per cent into a keycard account) would be most preferable. However, it was also argued by interview respondents that this change should only be applied to those managing their money well and that the current arrangements for placing money on the CDC remain in place for those experiencing issues with addictions or difficulties in the management of finances.

*I was on it [the BasicsCard<sup>104</sup>] for like four years. I pretty much enjoyed it. Half of my money going into cash and half of the money going on the card, that's really budgeting your money there. You can easily save up on that. If they would have split this Indue card 50/50 on your amount of money that you get that would be much better for the people here. You wouldn't hear any whining about it. So they could just do whatever they want with their cash, and the Indue goes to the kids. P47EK*

## 6.3.2 Perceived negative practical aspects of the Card

### 6.3.2.1 Evidence from in-depth qualitative interviews

While acknowledging that improvements had been made over the CDC trial period, CDC participants and stakeholders respondents reported that several practical aspects of the CDC continued to challenge implementation. This included the capacity to make certain purchases using the Card and an inability to use the CDC in some stores (particularly those outside the CDC trial sites, e.g. mixed merchants) and on certain online sites.

*Getting accommodation, fuel, meals. I've had heaps of trouble, especially when you go to areas that don't know anything about the Indue card, are not set up for the Indue card. Being rural and remote, just about everywhere around...the service station/accommodation/where you get your meals, is always a licensed premises. So you go in to get some fuel and a feed and maybe even sleep the night, get a motel or a room. But you can't because it's a licensed premises. SH27GF*

Secondly, the processes associated with managing the CDC (e.g. activating the Card, setting up an email account, remembering PINS and passwords, checking balances, arranging transfers and direct debits) were reported by respondents to be challenging for some CDC participants. This was thought to be particularly the case for individuals who did not have English as their first language, or were unfamiliar with modern technology and did not have access to the internet or mobile phones. Finally,

---

<sup>104</sup> Delivery mechanism for Income Management that gives a participant access to funds in their Income Management account through eftpos facilities at approved stores and businesses.

concerns related to security and associated fraudulent use of the Card were reported by some respondents.

*For people to access their online systems, they need to have some level of basic computer use. So establishing an email, which becomes a username, and passwords. Some of our clients struggle to retain their pin numbers, which is a four digit code, let alone an email address and a username and password. So I think that's a challenge that we have seen constantly throughout the use of the card. SH13EK*

Some respondents advocated for changes to potentially improve various practical aspects of the CDC. Improvements proposed by these respondents included greater flexibility over what the Card could be used for and expanding where purchases could be made. Moreover, some respondents suggested that the potential for product-level (rather than the current outlet-level) blocking of excluded items be explored to improve the functionality of the Card for CDC participants.

*I guess the flexibility of it [could be improved]. Making sure that you can actually use it anywhere and everywhere. SH35C*

The appearance of the Card itself was a further factor that many respondents felt could be improved as the CDC trial continued. The ability to personalise the look of the Card was suggested by these respondents as a way of potentially reducing the stigma associated with using the Card. Some respondents also expressed their view that there was a need for a more simplified and faster exit processes to come off the CDC.

*I've helped them since day one, as soon as you have the application we've had ten, and none of them have come off. They are still waiting. And it's pretty sad, because the amount of information they ask to exit the program, you know some of them didn't even have a birth certificate and we helped them get birth certificates to identify them. And none of them are off. You know if they were willing to go all that way just to get off it, because they felt intimidated, they felt embarrassed, and controlling, and they're still on it today...Someone has been waiting six months and they haven't heard back to exit the program...So we do hit lot of negatives about that form, where the DSS needs to try and up their game. SH48GF*

Further possible improvements were suggested by some respondents. These suggested changes included increasing the maximum monthly transfer amount and simplifying the processes for additional transfers for special purchases. Improvements to the security of the CDC (e.g. removing the PayWave function for small purchases and incorporating additional steps when making online transfers of funds) to reduce the potential risk of fraudulent use were also recommended by some respondents.

*Get it to where you need a PIN for whatever how much amount that you do even if it's down to \$3...People can use up to \$34 on your card and then press credit and then it's paid for if they steal your card...And maybe put a more security thing on your online one. So like where they don't need just your email and password to just log straight in. Maybe some security questions. P38C*

Some interview respondents from Ceduna and the East Kimberley also suggested improvements could be made to the operation of the community panels. When asked, many respondents in these areas reported that they were unaware of the existence of the panel and its role in relation to the CDC. Some respondents suggested there was a need for greater transparency over membership of the panels and how decisions to access a higher proportion of unrestricted funds or to gain an exemption

or exit from the Card were made. Although some respondents thought it was appropriate that decisions regarding exemptions and exits be made locally, others felt this responsibility should lie with DSS<sup>105</sup>.

*I do think there needs to be a community panel. I think who's on it should be more public, and they need to be meeting more often...There needs to be more consistency of the people staying on the panel...But certainly, there needs to be Aboriginal people on the panel. SH30EK*

### 6.3.2.2 Evidence from large scale survey

The quantitative survey of CDC participants allowed us to quantify the proportion of survey respondents who reported experiencing problems using their Card. The question “Have you had any problems using your Cashless Debit Card?” was asked in the survey section that was “About Money” and the answers are presented in Table 6-1. Overall, 57 per cent of all survey respondents said that they had had no problems using the Card and 37 per cent that they had experienced problems. The incidence differed by trial site, with a yes/no split of 75/21 per cent in East Kimberley, 51/43 per cent in the Goldfields and 50/42 per cent in Ceduna and surrounds.

Table 6-1: Problems using the Card, by trial site

Problems with using the Card								
	All trial sites		East Kimberley		Goldfields		Ceduna & surrounds	
	N	%	N	%	N	%	N	%
<b>No</b>	3,446	<b>57</b>	1,204	<b>75</b>	1,776	<b>51</b>	466	<b>50</b>
<b>Yes</b>	2,230	<b>37</b>	342	<b>21</b>	1,492	<b>43</b>	395	<b>42</b>
<b>Missing</b>	349	<b>6</b>	38	<b>2</b>	235	<b>7</b>	76	<b>8</b>
<b>Spoilt</b>	14	<b>0</b>	13	<b>1</b>	0	<b>0</b>	2	<b>0</b>
<b>Total</b>	<b>6,039</b>	<b>100</b>	<b>1,597</b>	<b>100</b>	<b>3,503</b>	<b>100</b>	<b>939</b>	<b>100</b>

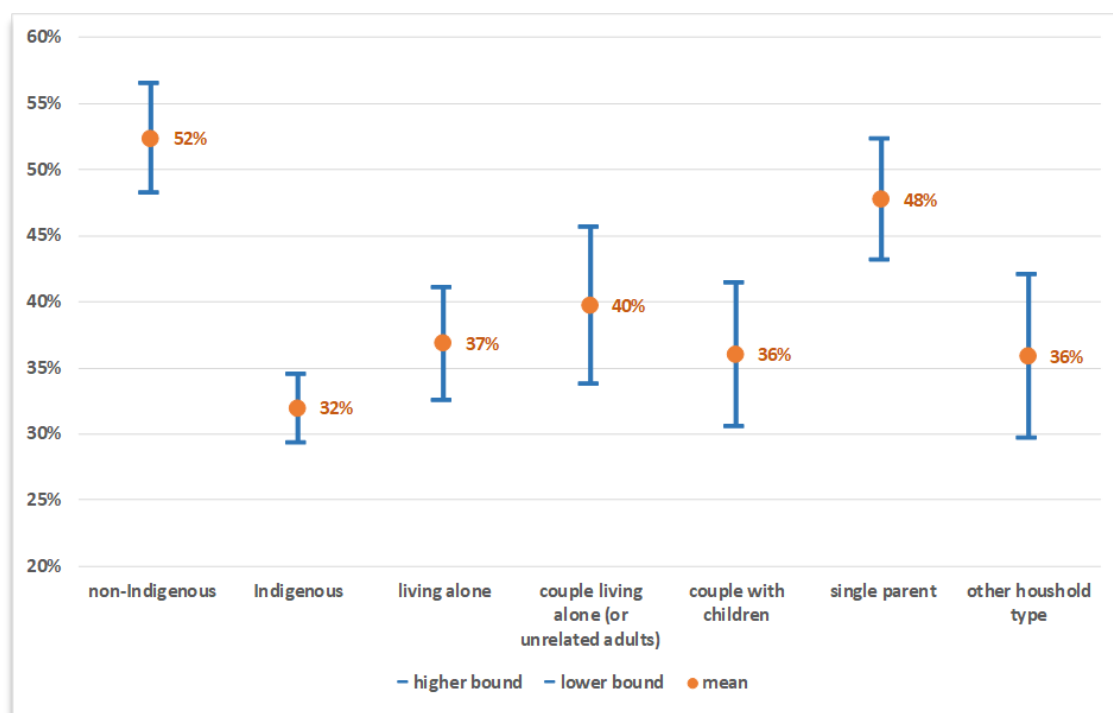
Note: Due to the use of population weighted data and rounding, the sum of frequencies and percentages may not always coincide with the figures displayed in the 'Total' row.

Figure 6-1 shows the mean proportion of people reporting that they had experienced problems with the use of their Card, first by Indigenous status and second by family and household type, for all trial sites.<sup>106</sup> The proportion of non-Indigenous CDC participants who reported having had problems using their Card was significantly larger than for Indigenous CDC participants (52 compared to 32 per cent). With the exception of single parents (48 per cent of whom reported having had problems with the use of their Card), all other types of family/household reported a proportion very near the national average of 37 per cent.

<sup>105</sup> Community panels do not consider exit applications.

<sup>106</sup> For each sub-group of CDC participants, Figure 6-1 also displays the 95 per cent confidence intervals around each mean.

Figure 6-1: Problems using the Card, by Indigenous status and household type



Through the use of free text entries, the quantitative survey allowed CDC participants to elaborate further than what is reported in Table 6-1 on specific problems they had experienced with both the use of their Card and the CDC overall. Table 6-2 below lists the problems mentioned by CDC participants in any of the five free-text boxes by broad categories from the most to the least common problem.<sup>107</sup> The most common problem (identified by 41 per cent of those who mentioned a problem) related to the proportion of income support payments placed in the participant's normal bank account. The second most commonly reported problem (30 per cent) was that the Card was too limited in where and how participants could use it. Other problems included budgeting (28 per cent), money transfers (26 per cent), being excluded from the cash economy (23 per cent), the inability to purchase items online (15 per cent of respondents), and problems with using the Card to pay bills/utilities (15 per cent). It is noted that all of these problems were similarly reported and discussed at length in the qualitative interviews.

<sup>107</sup> Table 6-2 was constructed using the answers in all of the free text boxes in the survey of CDC participants. Using the field 'Not enough cash component' as an example, every time a survey respondent mentioned in a free text box that they thought there was not enough of a cash component or that they did not have enough cash, the field 'Not enough cash component' was coded as a Yes. Where there was more than one mention of cash, or cash was mentioned in more than one box the field was still coded as a Yes. Where there was no mention of cash in any of the free text boxes, the field 'Not enough cash component' was coded as a No. Thus, for the field of 'Not enough cash component' there were 1,522 people who mentioned cash at least once out of the total 3,684 respondents who mentioned at least one of the problems included in Table 6-2. In total, Table 6-2 reports the composition of 8,627 instances where a problem was mentioned (the sum of the leftmost column of numbers (starting from 1,522 and finishing with 187), suggesting that on average each person who has written in a free text box mentioned 2.34 problems. The problems have been ordered in the order of their frequency starting from the most common and finishing with the least common.

Table 6-2: Specifically mentioned problems about the use of the Card and with the CDC overall (survey free text boxes), by trial site

Free text boxes: problems mentioned about the Card and the CDC overall								
	All		East Kimberley		Goldfields		Ceduna & surrounds	
	N	%	N	%	N	%	N	%
Not enough cash component	1,522	41	358	44	1,008	43	157	31
Limited where/how the Card can be used	1,095	30	200	25	745	32	150	29
Budgeting; saving; couples having to cope with 2 Cards; used to using cash; families used to pool income but no longer possible	1,019	28	225	28	666	28	127	25
Issue with transfer limits; time taken to do transfers; transfer system faults	969	26	155	19	677	29	138	27
Being excluded from the cash economy (impacting ability to pay for school events; kids' activities; emergencies; choices of where to buy	845	23	177	22	581	25	86	17
Being excluded from buying on-line (second hand or cheap goods via Facebook, Gumtree)	544	15	92	11	357	15	94	18
Paying bills; utilities; insurance	558	15	41	5	458	19	59	11
Paying rent or mortgage	442	12	36	5	358	15	48	9
Money inexplicably taken out; unable to obtain explanations; transaction errors	285	8	80	10	120	5	85	17
Card being declined; no means to pay when eftpos not available	300	8	56	7	183	8	60	12
Getting or paying back loans, debts, fines	267	7	62	8	184	8	21	4
Paying for travel	200	5	50	6	130	5	21	4
Worsened/same crime problems	175	5	38	5	123	5	15	3
Worsened or same humbugging & 'gaming the system' issues	118	3	24	3	84	4	10	2
Losing the Card or forgetting pin numbers	96	3	26	3	42	2	28	5
Worsened or same alcohol problems	95	3	19	2	64	3	12	2
Worsened or same drug problems	79	2	4	1	62	3	14	3
Worsened or same gambling problems	18	0	9	1	3	0	7	1
<b>Number who mentioned at least one problem in the free text boxes (N)</b>	<b>3,684</b>		<b>810</b>		<b>2,361</b>		<b>512</b>	

Note: Percentages add to more than 100 as respondents were allowed to report multiple problems. For the same reason, total observations for all CDC participants are fewer than the total number of responses, for example, 3,684 respondents reported a total of 8,627 problems.



### 6.3.3 Policy targeting

#### 6.3.3.1 Evidence from in-depth qualitative interviews

Qualitative interview respondents frequently expressed reservations about which cohort had been chosen to participate in the CDC trial. A blanket approach, whereby all income support payment recipients of working age were placed on the Card, was perceived to be inappropriate by many respondents. These respondents expressed the view that it was unfair that people who were “doing the right thing”, such as managing their money well, caring for their children, working (either in part-time employment or Work for the Dole programs), as well as people who did not have an addiction, had to participate in the CDC.

*They say, “Put them on the Indue to get them off of drugs, alcohol and gambling”, well myself, I’m a 55 year old widow. I don’t do drugs. I don’t drink alcohol. I don’t gamble. What am I doing sitting on the Indue card? I don’t know what I’m doing on it. P31C*

Concerns were also expressed by respondents that the areas chosen as the first three trial sites for the CDC had large Indigenous populations. Hence, some respondents perceived that the CDC policy had racial undertones and was unfairly targeting and stereotyping Indigenous Australians.

*It almost feels like a racial thing the card...It’s really only the black fellow besides maybe a few white fellows. There’s not many white fellows on the card, it’s really all black fellows. It’s basically targeted for us coloured mob. P21C*

Further concerns were expressed by some respondents about the areas chosen as trial sites for the CDC. These respondents felt that other communities within South Australia and Western Australia were experiencing more challenging social conditions and should have been placed on the Card first. Some respondents also considered the exclusion of surrounding Indigenous communities from the CDC trial in the Goldfields region to be an oversight, which had limited the emergence of potential outcomes.

*I don’t understand the reason why we got the card, not Halls Creek or anything like that and them people, they are compulsive drinkers. They go to Broome and everything and they get alcohol, and that’s the thing that’s killing them...If you ever went to Halls Creek and pass, every second house, the gambling. People are walking around drunk. P29EK*

Adopting a more selective targeting of the groups chosen to participate in the CDC, was considered by respondents as appropriately enabling CDC participants who were responsible and managing their money well with the opportunity to come off the Card. Groups whose participation in the CDC was considered by respondents to be particularly inappropriate included people receiving disability or carer’s pensions, older participants (aged in their 50s and 60s) and those who were currently working (either part-time or in Work for the Dole programs) or had previous extensive employment histories.

*I think that anything that has ‘pension’ attached to it...Disability, Carer’s, should not have even been thrown onto it...There are a demographic that do need the assistance, people that are in the drug rehabs or are known to the police or are known to Centrelink, that need assistance. This can be a great tool but it’s just not implemented properly. It’s just ‘dump everybody in the same bucket’ and it doesn’t really help everybody because you can’t identify who really needs the help. P16GF*



## 6.3.4 Card workarounds

### 6.3.4.1 Evidence from in-depth qualitative interviews

The use of card workarounds, which were perceived to lessen the potential positive effects of the CDC, were reported by many respondents in the qualitative interviews. These workarounds were said by interview respondents to have been identified and adopted by some CDC participants soon after the initial implementation of the CDC.

*The aim of the card was to control the alcohol consumption, the gambling and...drug use. But after three months, when the card first came after three months everyone found a loophole that there's a loophole that it does not stop the alcohol abuse, gambling and also the drug abuse. P13C*

The workaround reported most frequently by interview respondents in all the trial sites was trading, i.e. the selling of goods purchased with the CDC (such as food, cigarettes, fuel and electrical items) for cash or alcohol. Other common workarounds included participants selling their Card or allowing others to use their Card in exchange for cash or alcohol. It was suggested by interview respondents that many people were trading goods or their Card for a much lower price than they were actually worth. This was considered by many respondents to be financially disadvantaging an already disadvantaged group.

*If I really need the cash, I just sit at the shops and just ask anybody, "I got money on the white card, I just need extra cash." It works. P72EK*

Additional workarounds were also reported by respondents in the different trial sites. For example, in Ceduna and the East Kimberley, the purchase of alcohol was reported to be occurring via pre-existing sly grogging networks. Some respondents (in the East Kimberley and the Goldfields) also reported that alcohol could still be purchased with the CDC from retailers both inside and/or outside their trial site. Although DSS was acknowledged to have been proactive in blocking merchants who were actively circumventing the restrictions of the CDC, many respondents reported that some local businesses were still profiting from card workarounds.

*They take their card and give it to someone's who's selling sly grog. So they give them that card and instead of being 50 bucks like you do in a bottle shop, they're paying 100 bucks plus, off their debit card. So, alcoholics are not going to change, no matter what you do, they'll still find a way to use that card to get alcohol...Then there's always people preying on them. And they will take advantage of them...Instead of giving the going rate, what everybody else in the community pays, they're paying twice as much. P64EK*

Several further (but less frequently reported) workarounds to circumvent the CDC were described by respondents as a way of supplementing the cash component available under the Card. This included one frequently mentioned positive unintended consequence of the CDC—the increased number of people participating in traditional cultural activities (carving boab nuts or painting canvases or seashells) to subsequently sell for cash in Ceduna and the East Kimberley. Respondents also reported the use of royalty money to purchase additional supplies of alcohol was occurring in the East Kimberley and Goldfields. In addition, the use of refunds and the purchasing of gift cards which were then exchanged for cash or alcohol was reported by respondents in the Goldfields region.

*A lot of money that comes into this town is through royalties to mining companies, that seems to be paid out as cash and it overwhelms anything we might have achieved with the cashless*

*debit card. When it hits it's lots of money...People just get drunk for days and everybody's drunk. SH18EK*

Some respondents in each of the three trial sites suggested that some female CDC participants were prostituting themselves for cash in order to buy drugs and alcohol. However, this was reported to have been occurring before the introduction of the CDC as alternative ways to obtain money.

*We're also aware of some instances of trading sex for alcohol...for example some of the young ones will hang around outside the pub and participate in those behaviours to be given alcohol...They might have more limited access to cash that's definitely a negative of the card because the people that do want to use drugs and alcohol will find a way to use it and to get access to it if they don't have cash and unfortunately that often if you're a female comes at the expense of your body. SH05GF*

## 6.3.5 Perceptions of insufficient community consultation and information

### 6.3.5.1 Evidence from in-depth qualitative interviews

Dissatisfaction was expressed (particularly by respondents within the East Kimberley and Goldfields trial sites) that insufficient information about the CDC had been provided directly by DSS to stakeholders and CDC participants. Some respondents—and especially CDC participants—still expressed confusion about the CDC, including the aims of the policy, practical processes, the role of the community panels, the ability to exit from the Card and the future of the trial.

*I read the paper and the news and watch policy reforms and releases and things, so we see a lot of stuff that comes out which clients will then come to us and question us on, and we have had no direct email advice from DSS or Indue to say legislation has just passed, here is what is passed. SH13EK*

Gaps in knowledge about the CDC were said by many interview respondents to have been filled by stories in the media or via social media channels such as Facebook. Sometimes this information was considered by respondents to have been inaccurate and was thought to have contributed to negative community reactions to the introduction and continuation of the CDC. Concerns were raised by some respondents regarding the format and accessibility (particularly for those with low literacy or English-language ability) of formal information provided to those participating in the trial.

*It's probably the ignorance of people just believing what's in the media and going with that little information and saying, "I can't do anything on that card". The worst thing about it personally also I would say is the media, just bringing forward wrong information. I can recall a few articles in the paper where participants were saying they can't make certain payments and me, as the shopfront staff, knowing what people can do. It's just wrong information that's been promoted. SH10GF*

*We didn't get much information on it...It was a bit hard to understand; they used big words. P36GF*

Some respondents felt there was a need for more information about the CDC to be shared with both stakeholders and CDC participants. This perception included information on processes, and any changes which were made to these, the cost of the CDC program and the future of the trial. However, many respondents considered it important that this information be provided in a form that was accessible to all CDC participants, including those with low literacy skills or a first language other than English.

*I'd really like to see more education about the cashless debit card...If it's not going away, in order for it to really work and for everyone to see its benefit then everyone needs to be on board with it you know and that can only be done through better education. If that means coming and having conversations and getting a translator so the people who don't have English as a first language can better understand what their options are, what it means directly for them. SH30C*

In addition, some respondents perceived a need for further community consultation to inform future decisions about the CDC trial. This included obtaining feedback relating to perceived improvements that could be made to the Card, opinions on the types of wraparound services that should support the CDC, and whether the trial should continue and, if so, in what format.

*I actually think the conversation that we need to be having as a community now is, what does this now mean? The card is a concept that can be tweaked and changed, how do we make this work for this community now?...Let's use this as an opportunity to make some changes to say, "Well, these areas of the card work really well, these are areas we need to change". I think that's really important because nothing's fixed, everything can be changed. SH22C*

## 6.3.6 Wraparound services

### 6.3.6.1 Evidence from in-depth qualitative interviews

A widely held view by respondents was that the CDC trial was intended to be accompanied by wraparound services to support the effectiveness of the Card and that funds were allocated for this purpose within each of the trial sites. However, many respondents (and especially CDC participants) expressed a lack of awareness of any additional support services that had been funded under the umbrella of the CDC in their locations. These respondents reported insufficient transparency (mostly in the East Kimberley trial site) as to where these funds had been spent and what outcomes had been achieved from these services.

*We got told that there was increased funding, and there was supposed to be a couple of new programs happening, but I don't know if they've actually occurred or not, because there doesn't seem to be a lot of knowledge about that...From my point of view, those services still aren't happening. Where's the accountability? You've given some significant funding to these organisations, but the services certainly don't seem to be happening. I'm not sure of the accountability of that. What's going on with that? SH43EK*

Among some respondents who were aware of the allocation of CDC funding to support services in their areas, concerns were expressed that these funds had not been targeted well. In particular, the funding of broader wraparound services—such as drug and alcohol rehabilitation, mental health and counselling services—to work alongside the CDC and effectively address the issues causing social harm in each region, was not thought by many respondents to have been realised.

*That's one big issue I think with the CDC. At the start they said there were going to be all these wraparound services for like drug and alcohol counselling, financial counselling, like child support, all things like that, and...they just didn't deliver...I believe there could be a lot more support out there for people. SH07GF*

*I see lots of things in terms of that's tagged as support through the leftover fund through the cashless debit card, often through prime minister and cabinet, but I would go back, very cautiously, I'd go back to has that been used as wisely as it could to really take some of these, and address some of that core dysfunction. I doubt, no it hasn't. SH10EK*

Some stakeholders reported a lack of co-ordination in the way funding for wraparound services was arranged. In Ceduna, a lack of notice in relation to the awarding of funds was reported to have led to challenges in the filling of staff positions for these services. Finally, some stakeholders (mostly within Ceduna) expressed uncertainty as to whether the funding of wraparound services to support the CDC had continued beyond the initial first year of the trial.

*So some of the funding just sort of turned up and said, "Here is some funding for this, go and now recruit someone, you've got a week to do it," type thing. And of course finding someone with those skills was really difficult. So one position we had we couldn't fill. SH23C*

*The cashless debit card brought some different services into Ceduna...Now I think there isn't anything that's being funded under the cashless debit card, I think it's all, the ones that were working have kind of gone to, my understanding is other funding streams so they're not tied to card...The services that I'm involved in have now been funded under other streams not under the card. SH20C*

Disappointment was expressed by some respondents (especially in the Goldfields region) who perceived that the agreed funding of wraparound services to run alongside the CDC had not occurred to a sufficient extent. A perceived need for improvement to wraparound services and policy measures within the three CDC trial sites was reported by respondents. Future improvements to services were perceived by these respondents either as being an important part of an overall strategy to complement the provisions of the CDC, or as being a replacement to the Card.

*I'm not under misapprehension that this is a silver bullet and will solve the social ills of Kununurra or the East Kimberley. It is but one tool in an arsenal. It needs to be matched with strong support services that needs to be matched with employment, education and training services. It needs to be matched with positive policy interventions, not just negative policy interventions. There needs to be both incentive and removal of disincentives. It's a really complex environment. SH34EK*

Some respondents perceived there to be current gaps in service provision which they considered required enhanced funding (such as alcohol and drugs services, mental health and suicide prevention services, financial counselling, job readiness programs, housing services and programs for young people). Many interview respondents also considered that it was imperative that funding for the CDC local partners and shopfronts continue, in order to assist CDC participants when transitioning onto the Card and with any day-to-day issues experienced with the functionality of the Card.

*Don't try to put a band aid fix on this because it's not, it's only a band aid fix. You know, if you want to do sustainable change and sustainable things, make it sustainable...It's just ridiculous. No referral services, no support services. What happened for those people that have been alcoholics and drug addicts all their life, where's their rehabilitation services here in Ceduna? P10C*

*The only advice I could give you, if anyone were to roll it out, was that the local partner involvement is invaluable...I think there's less issues because of local partners. The work that these guys do in community is very valuable...that's able to convey messaging and ensure that people have a fuller understanding. That's just really valuable. SH41C*

A perceived need for job creation schemes to provide enhanced opportunities for CDC participants to obtain employment and thereby exit the Card was also reported by some respondents. Several respondents in the East Kimberley also suggested a strengthening of the Alcohol Accord restrictions currently operating in Kununurra and Wyndham.

*Like Ceduna, everyone wants to get off of the card. This place needs more support and jobs, there's no jobs. People would love to work and earn money and it would help them get off this card. There's just nothing here in Ceduna. P13C*

*Here we are in Kununurra with the worst drinking laws in the world. We've got the Indue card. There's only two people on the banned drinking list. So, you try and tell me how, if the government is really serious about it, why is it that every single person that gets done for domestic violence, and they go and say, "What did you do that for?" "I was drunk." Why aren't they stopped from buying alcohol?...We're asking for people that have an issue with alcohol to be put on a banned drinkers' list. SH08EK*

## **6.3.7 Groups for whom the CDC is considered not to be working well**

### *6.3.7.1 Evidence from in-depth qualitative interviews*

Across all three trial sites, interview respondents considered that there were two groups of CDC participants for whom the CDC was not working particularly well. The first group of CDC participants who these respondents felt the CDC was especially challenging for people with physical and psychosocial disability. Some of these individuals were reported by respondents to find the processes of the CDC overwhelming and to experience a feeling of heightened stigma from being on the Card. For those with pre-existing mental health issues, the transition to the CDC was said by many respondents to have brought additional stress and anxiety.

*We saw a good number of people with quite significant mental health issues and things, that were just never going to cope with it...They were, just not being able to cope with managing the card then on top of that they have their own mental health issues, it just adds up all together. SH15GF*

A second group, identified in all three trial sites to be struggling with the requirements of the CDC, were participants with limited literacy and IT skills. These CDC participants were reported to need ongoing support with many CDC processes, including the setting up and managing of email accounts, card activation, balance checking, transfers and the replacement of lost cards.

*The majority of the clients will come in that don't have the IT skills...The ones that we have that are repeat customers are the customers that don't have access to computers. They don't understand the login, they don't understand the transferring. So, probably low literacy or comprehension. I would say that the clients that we have, 90 per cent of them that would come through the door would be of low literacy and, a low comprehension and not very high IT skills. SH09C*

Interview participants identified further sub-groups which found the CDC particularly challenging in some (but not all) of the trial sites. In Ceduna and the Goldfields, older CDC participants were reported to frequently experience difficulties with the CDC due to being more used to having cash finances and less familiarity with technology.

*We get a couple of old gentlemen from time to time who are on the Indue card and...they'll say I don't know where my card is. And then you find out that someone has taken their card and used it, but clearly they've given their PIN number as well. So I see a lot of that in play...I find the older people with access to money that aren't drinkers or don't use the card, it just accumulates, are often the ones that we see where the card's gone and someone's using it. SH10C*

Indigenous CDC participants who came from remote communities in the Ceduna and Goldfields trial sites were a further group reported by many interview respondents to be experiencing difficulties with

the CDC. These individuals were often said to be experiencing very complex issues and with English as a second language and a lack of understanding or access to technology, which made the processes of the CDC to be particularly challenging.

*It's sad seeing my older people from the bush, traditional people, on the card. And I'm like, this is not right, you know, because they're traditional, more honour, they live in the bush more, connected to land. They should have coins, money, it's more old-fashioned. P34GF*

Finally, some respondents in Ceduna and the East Kimberley reported that the CDC was not effective in assisting individuals with entrenched substance misuse issues to address their addictions. Workarounds to the Card were said to be common amongst this group and, therefore, the effectiveness of the policy was questioned by these interview respondents.

*You can't for a minute think that by putting in restrictions, that that's going to stop an alcoholic or a person who's addicted from abstaining altogether. It sort of doesn't work like that. So there does need to be other things in place. SH03C*

## 6.4 Integration of evidence

Most evidence on the implementation of the CDC was collected from the qualitative interviews. There was therefore limited scope for integration with the quantitative survey data to quantify the prevalence/frequency of perceived problems with, or perceived benefits of, the Card. It is also possible that with longitudinal evidence one would be able to explore the development of the implementation of the CDC over a longer period of time. This would require further qualitative (longitudinal) interviews asking specific questions about how implementation has been progressing over time, alongside additional questions in a quantitative survey of CDC participants that focussed on implementation aspects of the CDC.

## 6.5 The evidence base

The evaluation findings about the implementation of the CDC are largely based on evidence from the in-depth interviews undertaken with CDC participants and stakeholder representatives. While the quantitative survey of CDC participants did not explicitly aim to collect information about the implementation of the CDC, it did collect some information which allowed us to quantify the proportion of CDC participants who reported experiencing problems using their Card.

## 6.6 Observations, limitations and caveats

Given that these findings primarily arise from qualitative research, they are subject to limited generalisability to broader population groups or other geographic locations. Readers should note that, like other findings from in-depth qualitative interviews, the views of respondents that are included in this report are the respondents' perceptions. The accuracy of statements made by respondents has therefore not been independently verified because the in-depth interviews sought to gain an understanding of what respondents thought and not whether their thoughts were factually or otherwise correct or not. However, we note that quantitative information on the frequency of

reporting experiencing problems with the use of the Card provides useful and quantifiable support to those qualitative findings.

## 6.7 Summary

CDC participants' and stakeholders' views on the importance of the implementation of the CDC is showcased in this section. A large number of aspects (both negative and positive) surrounding the implementation and ease of use of the CDC were reported by respondents. The emerging evidence suggests a very mixed picture of implementation and ease of use of the Card. Limited but important quantitative evidence relating to reports of problems experienced with the use of the Card was presented, suggesting that improvements could be made.



## 7. Perceptions about the future of the CDC

---

The evaluation also explored the views of CDC participants and stakeholders as to whether the trial of the CDC should continue. We remind the reader that the views of CDC participants were explored by both qualitative and quantitative methodologies, whilst the views of stakeholders were only explored by the qualitative methodology.

### 7.1 Key findings

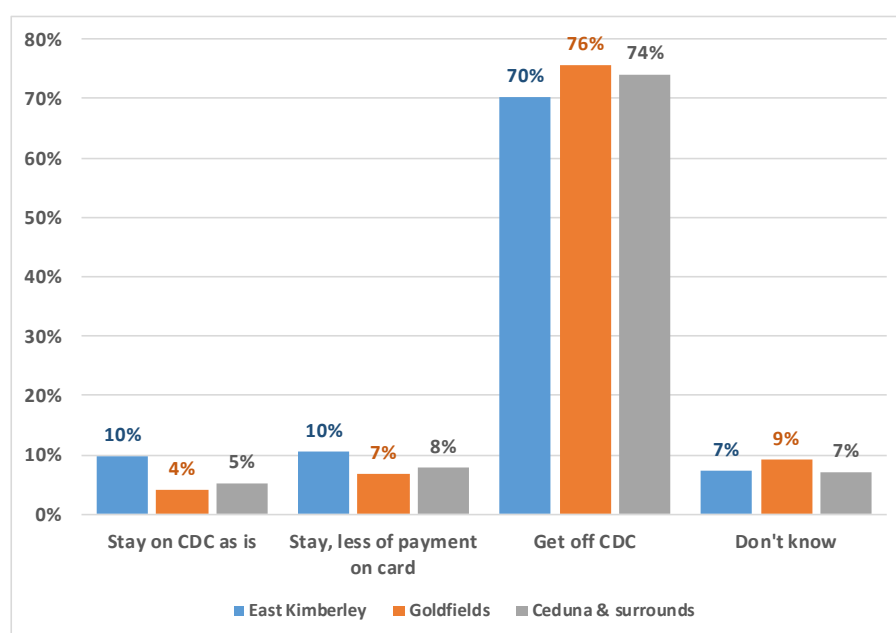
- The quantitative survey evidence suggested that a large majority of participants wanted to come off the CDC (74 per cent).
- Depending on the site, between 11 per cent and 20 per cent of all CDC participants would prefer to stay on the Card. Of these participants, a small majority would prefer staying on the CDC with a lower proportion of their income support payment being placed on the Card.
- CDC participant survey respondents who reported a positive impact of the CDC were more likely to want to remain on the Card.
- The preference to remain on the Card depended on the length of time the participant had been on the Card. It was U shaped, that is, it was at its highest for those who had been on the Card for the shortest (less than one year) and for the longest (more than two years) time and at its lowest for the ones in the middle (between one and two years).
- CDC participants who were on parenting payment (single or partnered), in East Kimberley, were older, or who had not experienced issues using the Card, were the most likely participants to want to remain on the Card.
- Household type, gender and Indigenous status did not seem to be associated with the preferences of CDC participants about staying on the Card or not.
- The qualitative evidence, which included the views of stakeholder interviewees, found that the majority of respondents reported they wanted the CDC to continue in some form. This qualitative evidence was largely reflective of the views of stakeholder groups and may not be a clear indication of CDC participants' preferences, especially as they emerged from the quantitative survey responses.
- The qualitative evidence highlighted the view of many respondents that, if the CDC were to continue, they would prefer it to be more targeted and aimed solely at those individuals experiencing problems with alcohol, drugs and gambling, with money management, or with caring for their children.

## 7.2 Evidence from large scale survey

The quantitative survey of CDC participants sought the views of respondents about whether they would prefer to stay on the CDC (either in its current form or with less of their payment going on the Card) or to come off the Card. The evidence from the survey of CDC participants indicated that a large majority of participants would prefer to come off the Card. Figure 7-1 shows that about 74 per cent of all CDC participants surveyed indicated that they would prefer to come off the Card, with a slightly higher proportion in the Goldfields (76 per cent) and Ceduna (74 per cent), compared to East Kimberley (70 per cent).

Between 11 and 20 per cent of all CDC participants surveyed, across the three sites, reported that they would prefer to stay on the Card. This proportion was largest in East Kimberley (20 per cent) and smallest in the Goldfields (11 per cent). In East Kimberley, about half of those who reported that they would prefer to stay on the Card, would prefer less of their payment going on their Card, with the other half reporting they would prefer to stay on the Card in its current form. In the other two sites, larger proportions among those who wanted to stay on the Card reported that they would prefer less of their payment going on the Card.

Figure 7-1: Stated preference about getting off the Card vs. staying on the Card, by trial site

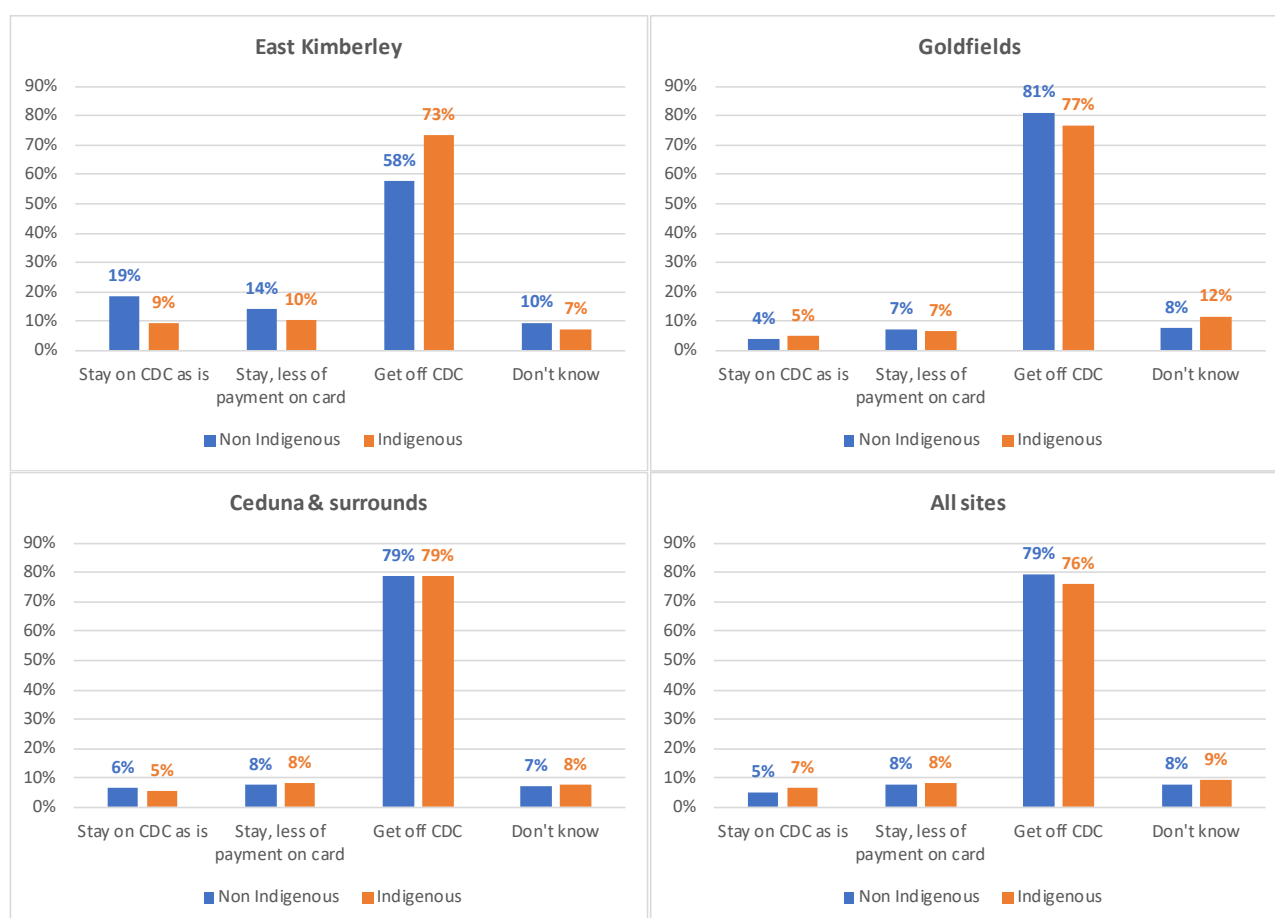


*Note: The proportions do not sum to 100 per cent because we have removed the very small percentages of spoilt answers and missing responses*

The following Figure 7-2 displays the preferences of CDC participants with regards to remaining on/coming off the Card by trial site and by Indigenous status. For both groups, a majority of CDC participants would rather come off the Card.

Within the East Kimberley trial site, the quantitative survey found that the proportions of those who wanted to stay on the Card as it is currently set up was higher for non-Indigenous CDC participants (19 per cent against 9 per cent). In the other two sites, the proportion of those who would rather stay on the Card was similar by Indigenous status and varied little across the two options (stay on the Card as it is currently set up, or stay on with less of their payment going on the Card).

Figure 7-2: Stated preferences about getting off the Card vs. staying on the Card, by Indigenous status and trial site



Note: The proportions do not sum to 100 per cent because we have removed the very small percentages of spoiled answers and missing responses.

### 7.2.1 Which CDC participants were more likely to prefer to stay on the Card?

We conducted multivariate regression analysis on the quantitative survey responses in order to estimate the most likely individual characteristics of those CDC participants who would prefer to stay on the Card. Given the relatively low proportion of CDC participants who reported they would prefer to stay on the Card, the analysis cannot be conducted with much granularity. Thus, we were not able to distinguish between those who would prefer to stay on the Card as it is currently set up, or with less of their payment going on the Card. The following Box 7.1 highlights the main multivariate findings.

### Box 7.1: Which CDC participants were more likely to report wanting to remain on the CDC? <sup>108</sup>

Individual characteristics of CDC participants estimated to be more likely to prefer staying on the Card (based on quantitative survey responses):

- **Living in East Kimberley:** CDC participants who lived in the East Kimberley were more likely to report that they preferred to stay on the Card than CDC participants living either in the Goldfields (more likely by 4.3 percentage points) or in Ceduna and surrounds (more likely by 4.1 percentage points).
- **Experience on the CDC: The relationship between experience on the CDC and the probability of wanting to stay on the Card was 'U-shaped':** it was highest for those who had been on the Card the shortest time (about one year) and for those who had been on the Card the longest (about three years). The probability of wanting to stay on the Card was lowest for those who had been on the Card for about 24 months. This result remained after we control for the later Goldfields rollout.
- **Older CDC participants:** Older CDC participants were more likely to want to stay on the Card. The estimated probability of preferring to stay on the Card was extremely low (close to zero) for CDC participants below the age of 30 (especially in the Goldfields).
- **CDC participants who reported a positive impact of the CDC on alcohol consumption (for themselves, or their family, or their friends, or their community):** These participants were 5 percentage points more likely to prefer to stay on the Card than those who did not identify such an improvement after the introduction of the CDC.
- **CDC participants in receipt of parenting payments (both single and partnered):** These participants were 8.2 percentage points more likely (than participants receiving other types of payment) to prefer to stay on the Card.
- **Experienced higher financial hardship prior to the CDC:** CDC participants who reported experiencing higher financial hardship in the year leading to the introduction of the CDC were more likely to prefer to stay on the Card.
- **Experienced less financial hardship at the time of the survey:** Those who reported experiencing less financial hardship at the time of the survey (compared to other survey respondents) were more likely to prefer to stay on the Card.
- **Those who did not report they had problems using their Card:** CDC participants who reported no implementation issues with the Card were 6.8 percentage points more likely to prefer to stay on the Card than those who did.

---

<sup>108</sup> Two clarifications about the interpretation of our findings are needed at this stage. First, the statistics in tables and figures convey a different message than the multivariate regression statistics, so that comparisons must be made with care. Tabulations and figures show univariate statistics, e.g. Figure 7-1 compares the willingness to stay on the card by trial site. It does not tell us if any difference is associated with the observed demographics of the three sites. Using multivariate regression in Box 7.1 takes us one important step further: it estimates whether and how much the demographic composition of CDC participants in the three sites is associated with the outcome of interest.

Second, we estimate a two-outcomes model (a binary probabilistic model). For this type of model, whatever is said in Box 7.1 about the chosen outcome (that is, having stated a preference to stay on the card), can automatically be reversed for the alternative outcome. For example, the finding that "CDC participants in East Kimberley are more likely to prefer to stay on the card (compared to, say, their Goldfields counterparts)", could be stated as "CDC participants in East Kimberley are least likely to prefer to not stay on the card (again compared to their Goldfields counterparts)". It is only in models with more than two possible outcomes (e.g. harder, same, easier) that we may need to distinguish between the (more than two) outcomes as the probabilities may not be uniformly (that is, evenly) distributed across each outcome. The Quantitative Supplementary Report includes more detail about the multivariate analysis, results and interpretation.

- Household type, gender and Indigenous status did not seem to affect CDC participants' preferences about staying on the Card.

## 7.3 Evidence from the qualitative interviews

The qualitative interviews identified that in each of the trial sites views were mixed as to whether the CDC should continue (either in its current form or in an adapted form) or whether it should be halted altogether. The strongest differences were between the views of CDC participants and the views of stakeholder representatives. CDC participants were more likely to express a view that the trial ought to be stopped altogether and stakeholders were more likely to express a view that the CDC ought to be continued. This qualitative section focuses on deep and detailed evidence, which allows us to better understand the views of CDC participants and stakeholders in relation to why they want the trial to end and about what would need to change to the Card and the surrounding policy environment, if the policy were to be continued at the end of the trial periods.

### 7.3.1 Views on ending the CDC Trial

Around a third of interview respondents (overwhelmingly CDC participants) reported that they wanted the CDC trial to end in their region. The reasons provided by these respondents for wanting the trial to end included perceptions of a lack of impacts from the CDC in addressing the social issues present in the region. Perceptions about the cost of implementing the CDC and the potential for these funds to be diverted into other local efforts and support services was a further reason provided by these respondents for wanting the CDC trial to end.

*I don't think the card is ever going to work properly because it's got too many pitfalls...And from what I understand it costs more to operate the card than the money it supposedly saves anyway. SH07C*

*I'd like to see the cashless debit card dumped completely because it's flawed legislation...It destroys our rights as Australian citizens. To say they're not being racist. That is flawed. There's no exit. That is flawed. Sure they're putting an exit thing in place now. An exit policy that is almost impossible for Aboriginal people to apply for. I've applied for it. I said to them, I said do you know how many Aboriginal people could fill this form out, print it out, sign it, scan it as a PDF and send it back let alone answer all the questions. P67EK*

The interviews also asked respondents for their views on the potential consequences for the regions if the trial was to end and participants reverted to receiving their full income support payment into their regular bank account. Opinions were mixed as to the likely consequences of ending the CDC trial. In general, stakeholder representatives expressed concerns about the potential negative impact of ending the trial, anticipating an increase in the incidence of substance misuse, alcohol-fuelled violence and child neglect.

*I do think we would fall into a level of higher alcohol abuse. High gambling, you know, that fridge full of food probably wouldn't be stocked as often, you know, the uniforms for kids, turning up late to school, all those things probably would decrease. SH10EK*

*That's a tough one whether the card should continue. Philosophically I'd probably say no but practically I'd probably say yes. I'd hate to be the person that just removes the card and then all of a sudden the family houses are awash with alcohol and kids going hungry...I would be scared it would happen, but it may not. SH29C*

In contrast, CDC participants were evenly divided as to whether ending the CDC would lead to a negative change or no change or whether the well-being and happiness of CDC participants and their families would increase if the trial stopped.

*Well, everybody would be happy. No, negative, but it will all be positive because they can all be able to hold cash and they can feed their kids, get their kids money for whatever, stuff they want. Like walk into the shop a civilised human being, instead of walking in with a card and it's like, "Oh, shame". P29EK*

*Families will be happier...because then the kids'd be happy because they'll be able to get money for sports or when they go on excursions or holidays or out of town. They can just walk into any shop and buy whatever they need or would like to buy without being refused because they might not have that card. P73C*

### 7.3.2 Views on continuing the CDC Trial

Slightly more than half of interview respondents (and especially stakeholders) reported that they were in favour of the CDC continuing. However, only a few wished for it to be maintained in its current form.

*I dread the possibility that it might stop operating in the future...I think it's the best thing that's ever happened in our community and I'll stand by that. SH18C*

*At the end of the day it's about the children getting fed and a woman getting looked after, so for me, I would say that it should continue, because it's improving, and everyone has to remember it's only new, and if it helps three families out of 3,000, good, because those three families obviously needed it. P44EK*

The majority of respondents wanted the CDC to continue but perceived certain changes were needed. Even if CDC participants did not think the Card was appropriate for themselves, some considered it should carry on for others, albeit with certain changes. These changes included a preference for a more targeted approach to participation, so the CDC would be aimed solely at those individuals experiencing issues with alcohol, drugs and gambling; money management problems; or were inadequately caring for their children.

*I think it should be more targeted for people that are problematic. Not just a whole lot of us. I find it's, kind of, a violation to just put it on all of us. P21C*

*I reckon it should be only based at people who's abusing alcohol and drugs. That's what it was supposed to be in the first place. Just the people who's abusing, you know, drug abuse and alcohol abuse, that's what it's supposed to be but it all aimed at the innocent people who don't do it. P31GF*

Many respondents suggested that CDC participants who were managing their finances well, did not have an addiction and cared well for their children should be able to apply for an exemption from the CDC.<sup>109</sup>

*Yes, I do think clients should have an option. If they want to stay on it, they can. If they want to apply to, if they can prove that they are responsible or whatever, if they can prove that they don't have any social financial, whatever reasons they brought out the CDC card for, if they can prove all that sort of stuff, they should be able to just...get off it, if they want to. SH24EK*

*People that are doing the right thing should be given a reward to say, "Well, you know what? You've proven over the last four, five months you have not spent your money crazily on alcohol, excessive drugs and all that stuff, so you have the option to either, one, stay on it or you can transfer off. It's your choice." SH04C*

## 7.4 Integration of evidence

The qualitative and quantitative evaluation evidence bases were complementary. We should be mindful when considering views on the future of the CDC, that the two methodologies answered somewhat different questions: the focus of the quantitative methodology was on participants and on large-scale representative evidence. The focus of the qualitative methodology was on both stakeholders and participants and focused on why each of the two groups held their views, rather than how many of them did. The complementarity is obvious in principle, but the quantitative survey evidence suggested that 11 to 20 per cent of CDC participants wanted the Card to continue in some form and that about 70 per cent would like to opt out of the CDC trial. The qualitative evidence found the majority of respondents reported they wanted the CDC to continue in some form. It is important to note that the qualitative evidence in this instance also reflects the views of stakeholder groups, who are largely in favour of retaining the CDC, while the qualitative views of CDC participants are mixed, hence the finding that the majority of qualitative respondents are in favour of retaining the CDC. Drawing from the qualitative interviews, we found evidence on the potential reasons for these views, which include experiencing problems with the Card, the lack of perceived impacts of the CDC, as well as the perceived cost and opportunity cost of implementing the policy.

The quantitative survey evidence provided complementary evidence, in that it reflected the views of CDC participants only and presented statistically reliable evidence that the majority of CDC participants would like to opt-out of the CDC for a number of reasons. The quantitative evidence also pointed out that a sizeable minority of CDC participants wanted to stay on the Card, a majority among them preferring that the policy should continue with less payment going on the Card. More detail on these views of CDC participants is included in the Quantitative Supplementary Report.

The qualitative evidence highlighted views about what an adapted form of the CDC could or should look like. Respondents suggestions for a modified version of the CDC included a more targeted approach to participation or a version aimed solely at those individuals experiencing issues with alcohol, drugs and gambling; money management; or with caring for their children. More detail on these views of CDC participants and stakeholders is included in the Qualitative Supplementary Report.

---

<sup>109</sup> From July 2019 participants could apply to exit the CDC.

## 7.5 The evidence base

Unlike other aspects of the CDC evaluation, where our methodologies provided evidence on similar questions and aspects in a way that allowed the triangulation and further confirmation of the findings, when we examined the views of respondents on the future of the CDC the qualitative and the quantitative evidence bases performed different and highly complementary roles. The survey evidence provided a quantitative basis for understanding what CDC participants think about the CDC as it currently is. Simply put, the quantitative methodology asked the question: given what has happened and where you are now, would you prefer to stay on the Card or not? There are no obvious nuances in this question. The free-text analysis from the quantitative survey, suggested that there may be additional information to be explored.<sup>110</sup> However, the quantitative methodology did not allow for sufficient nuance and exploration for doing so.

In a complementary fashion, the qualitative evidence allowed the research to explore the views of CDC participants and relevant stakeholders, not only about their views on the continuation of the Card, but also on whether and how they believed the CDC could be improved. Simply put, the qualitative methodology also explored the question: given your experiences and current position, if the CDC were to be continued, in what form would you prefer to see it continue and develop? This is a far more nuanced exploratory question, which was highly suitable when respondents were asked to talk about the future. The two evidence bases therefore, acted in a highly complementary manner, each of them performing a role that falls naturally to them but would be difficult for the other methodology to perform.

## 7.6 Observations, limitations and caveats

It is clear from the analysis that the views of CDC participants and stakeholders on the question of whether the Card should continue and in what form this may be done most successfully, are highly complex and have not been fully answered in this research. More evidence would be required for that, with two possible directions mentioned below.

First, more longitudinal evidence would allow the portrayal of the acceptance or rejection of the policy to be put in the relevant timeframe, which could not be done in this evaluation as we have only one time point to draw from.

Second, there has been evidence in the research that the views on whether the Card should continue for oneself *and* for others can be different from whether the Card should continue for others *but not* for oneself. This evidence needs further investigation. It makes the distinction between personal and social costs and benefits, which has not been sufficiently researched in this analysis.

## 7.7 Summary

The qualitative and quantitative methodologies provided complementary evidence when considering the views of CDC participants and stakeholders on the future of the CDC. The quantitative evidence suggested that, under the current circumstances, the majority of CDC participants would prefer to opt out of the CDC trial. The qualitative evidence, which included the views of stakeholder interviewees,

---

<sup>110</sup> The Quantitative Supplementary Report provides further explanation on the methodology.



found the majority of stakeholders reported they wanted the CDC to continue in some form and that the views of CDC participants were mixed. Both methodologies explored the views of their respondents as to what changes would be desirable, if the trial were to be continued.

## 8. Concluding Remarks

---

The core objective of this evaluation has been to provide evidence about the outcomes of the CDC in the first three trial areas in which it was rolled out: Ceduna and surrounds, East Kimberley and the Goldfields. Chapters 2 to 4 introduced the policy, discussed the methodology of the evaluation and presented the context for the three trial sites. In doing so, these chapters explored the anticipated outcomes from the CDC and current understandings regarding key pathways, mechanisms and assumptions that underpin the policy. They also provided an outline of the evidence bases that were generated for the purposes of the evaluation, both qualitative and quantitative. With the first three chapters having laid the conceptual foundations for an evaluation, Chapters 5 to 7 set out to explore the outcomes, both intended and unintended, observed in relation to the CDC in each of the trial sites. This final chapter summarises all outcomes, interprets them and provides an overall context for their interpretation. The purpose of this evaluation is to present evidence about the impact of the CDC, as presented to the evaluation team by the many stakeholders and CDC participants who informed the research. This report focuses on the evidence and its impartial interpretation. Policy implications and any subsequent recommendations are left to the consideration of the reader.

A core question regarding every public policy is whether the policy works well or not and whether the changes it brings were the intended changes or not. The answer to this question regarding the CDC is not straightforward. We remind the reader that the evidence we present has been derived primarily, but not exclusively, from what we heard from CDC participants. If one were to try to summarise how the CDC policy outcomes are perceived, a fair assessment would be that some aspects of the CDC are perceived to have worked well for some people, but not for others. It would also be a fair assessment to say that: (i) many of the CDC outcomes were intended, but some were not; (ii) some of the CDC outcomes were the same or very similar in all locations and for most CDC participants; and (iii) other outcomes were different in different locations and for different participants.

There are instances where the evidence we present is clear, either because it is supported by different sources of data, or because it is supported very strongly by a specific source of data. For example, in identifying specific sub-groups of CDC participants in specific locations for whom the CDC may be clearly working well or clearly not working well at all. There are other instances where the evidence has to be treated with caution. For example, when it relates to an indirect transmission mechanism or to a longer-term potential impact. It is important that the reader considers the evidence base that underpins each of our statements, as the strength of evidence varies.

We have provided a large number of caveats and have been upfront about the limitations of this research and we will not repeat them here. However, we would like to stress that these caveats and limitations have not been offered because we believe that the research is flawed, or that the evidence generated by this evaluation is flawed. Our intention has been to stress the inherent and unavoidable limitations that empirical research of this nature has, so that the reader does not reach misleading conclusions, either too strong or too weak. We stress that the diversity of the people who are CDC participants and the diversity of the behaviours that the CDC is designed to influence, is very broad and requires a more nuanced understanding of the evidence we provide. The diversity of the circumstances of those who are influenced by the CDC, be that stakeholders, participants themselves, or communities and society as a whole, is also very large and must be similarly understood in a nuanced manner. Given that the timespan of this research is short, but some of the potential impacts of the CDC policy are designed to bring long-term change, it is important to recognise that many of the findings may be temporary, or short lived and that presently we cannot know whether this is the

case or not. Many of our conclusions unavoidably depend on our statistical inference, which again calls for a nuanced understanding of uncertainty and forecasting.

This research is therefore not offered as a perfect and definitive answer to all the questions that emerge about such an important policy. It is offered as the best possible attempt to illuminate as many aspects of the policy as can be illuminated by the evidence base that has been generated, whilst bearing in mind that, as time rolls on and as new evidence emerges, our statements will need to be updated according to that new evidence. Associated with the judicious reading that we ask the reader to apply, we also ask readers to keep in mind that, by reading this research, they are hearing the voices of literally hundreds of core stakeholders and thousands of CDC participants. These voices were collected systematically over a period longer than a year. They were then put together and analysed using an innovative combination of sound methodologies, by a group of dedicated, impartial, and independent experts.

The KEQs were designed to assess the overall impact of the CDC as this was felt by all of the trial site participants and key stakeholders who informed the research. To do this, the evaluation combined qualitative and quantitative methodologies to build an evidence base on several aspects of the CDC trials, including anticipated outcomes and actual outcomes. Outcomes and their (desired) effects on participants and stakeholders, were put in three broad categories. First round effects, primarily direct effects on the targeted behaviours (for example, a reduction in spending and consumption in relation to alcohol, illegal drugs and gambling). Second round effects, primarily indirect effects that are felt at the personal level as a result of the CDC (for example, better budgeting and paying bills, increased spending on food, increased safety in the home). Third round effects, primarily indirect effects, felt at the broader social level (for example, increases in safety in the community day and night, improved health and well-being, reduction in crime and violence).

Recognising that there may be other useful ways for the evaluation to categorise the effects of the CDC, the KEQs also asked for distinctions to be made between the different trial sites, between short-term and longer-term impacts, between intended and unintended consequences, as well as how each effect of the CDC policy may be changing over time. Finally, the project design required that the evaluation examine the feasibility of establishing a longitudinal dataset to allow analysis of medium-to-long term effects of the CDC.

The fact that all these effects (and the KEQs associated with them) are inter-dependent and often overlapping, is reflected in the way the evaluation collected, analysed and presented its evidence. The evaluation implemented two broadly complementary methodologies and allowed each of them to generate evidence for each one of 12 broad categories of perceived impacts of the CDC policy in Chapter 5. It then examined the broader views of participants and stakeholders in Chapter 6 on the implementation of the CDC. The next Chapter 7 examined briefly the views of participants and stakeholders on the future of the CDC. Each of these individual impact categories is attempting to answer all of the KEQs, from the different angles allowed by the evidence base.

This concluding section does not attempt to provide any new evidence. Its main purpose is to bring all impact categories together and to provide the reader with a common narrative for the whole of the current evaluation.

## **8.1 Findings on alcohol, drugs and gambling**

Reducing alcohol and illicit drug use and misuse as well as gambling activity are the aims of the CDC. The CDC is designed to do so directly by disallowing the non-cash component of the Card to be used

for alcohol purchases and for gambling activity. It is also designed to reduce illicit drug use, alcohol and gambling by reducing the amount of cash available to participants, thus making it harder for them to purchase or engage in these activities. The broader aim is to reduce the personal and social harm caused by these behaviours and provide the basis for significant improvements in life outcomes. There are inherent difficulties in measuring directly the prevalence and intensity of these activities and indirectly their broader outcomes in society.

We found consistent and clear evidence that alcohol consumption has reduced since the introduction of the CDC in the trial sites. With the current evidence, it is not possible to attribute these changes to the CDC alone. Reductions can be attributed, however, to the full complement of all policies in force at the time of the CDC introduction in the trial areas, not just to the CDC. We found limited direct evidence of any impact of the CDC on the use of illicit drugs. Measuring illicit drug use directly is notoriously difficult to achieve through direct survey methods. We found survey evidence that the CDC is perceived by CDC participants to decrease the use of illicit drugs. The integrated evidence is mixed and cannot offer any definitive conclusion about whether the CDC influences the personal or social harm caused by the use of illicit drugs. We highlighted an important relationship between alcohol and drug use, in that they appear to be substitute activities, depending on the location of the CDC participants. There is short-term evidence suggesting that the CDC has been helping reduce gambling, with positive impacts, especially in the context of family and broader social life. No longer-term evidence is available for any of these three activities.

### **8.1.1 Alcohol**

In its objective to reduce alcohol consumption the CDC appeared to be reducing the number of days that drinking takes place and the amount consumed in each one of these days. East Kimberley was the site affected most by alcohol problems, but was also the site that experienced the greatest reduction since the introduction of the CDC. The fact that the CDC is working in tandem with several other policies aiming to reduce problematic alcohol consumption, makes any definitive statement about the CDC's impact on alcohol consumption impossible. However, the reported perceptions in the survey of CDC participants suggested that a clear reduction in alcohol consumption has taken place since the CDC was introduced. Stakeholders made similar suggestions in their in-depth interviews. Statistical analyses of the survey responses of CDC participants suggested that improvements were more likely to be felt by women, by families with or without children, by Indigenous participants (in all sites) and by all participants in the more remote sites. The qualitative evidence highlighted, however, that workarounds were present, but this also makes alcohol more expensive to obtain.

### **8.1.2 Illicit drugs**

The most problematic illicit drugs within the CDC trial sites were reported to be meth-/amphetamines and marijuana/cannabis. Perceptions differed about what the most problematic type of substance misuse was. Indigenous CDC participants reported that alcohol was the most problematic, while non-Indigenous CDC participants reported that it was meth-/amphetamines. This divide was reflected in the overall differences, where CDC participants in East Kimberley reported alcohol as the core problem (with cannabis a close second), CDC participants in the Goldfields reported meth-/amphetamines as the core problem and CDC participants in Ceduna and surrounds were somewhere in the middle. The inter-connectedness between alcohol and meth-/amphetamine consumption was clear in all trial sites.

While there was no direct evidence about illicit drug use, it was reported by CDC participants that there had been a decrease in illicit drug use since the introduction of the CDC. This reported decrease was highest among Indigenous CDC participants in the Goldfields, followed closely by CDC participants in East Kimberley and Ceduna and was lowest among non-Indigenous CDC participants in the Goldfields. Statistical analyses of survey responses from CDC participants suggested that improvements due to reductions in illicit drug use were more likely to be felt by women, by Indigenous participants (in all trial sites), by families with or without children, by participants on Newstart Allowance and by younger CDC participants.

The qualitative evidence was more mixed as to the impact that the CDC has had on drug use within each of the trial sites. There was little agreement as to whether the CDC was effectively reducing the social harm caused by substance misuse.

### **8.1.3 Gambling**

The evaluation found some evidence of reductions in gambling as a direct outcome of the CDC. A small minority of the CDC participants surveyed reported that the CDC had helped reduce gambling at either the personal, family, friends or community level. The proportion of CDC participants who gamble has declined since the CDC and those who continue to gamble reported they do so less frequently. Gambling was reported to be more prevalent in Ceduna and surrounds, where the largest reduction was also reported to have taken place. Statistical analyses of survey responses from CDC participants suggested that improvements due to reduced gambling were more likely to be felt by couples, with or without children, by Indigenous participants (in all sites) and by all participants who live in Ceduna and surrounds and East Kimberley. The qualitative evidence found that cash previously used for gambling was being redirected to essentials such as food. The qualitative evidence highlighted, however, that workarounds and humbugging were still present and were used to enable the continuation of some gambling activities among CDC participants.

## **8.2 Findings on further outcomes of the CDC**

### **8.2.1 Financial planning and money management**

The introduction of the CDC had widespread implications for the financial planning and money management of all CDC participants. There was no single evaluation finding on the financial outcomes of the CDC. Instead, there were multiple, complex findings. A wide variety of financial measures were examined in a before-and-after context to identify the presence of financial problems, through the quantitative survey of CDC participants. A majority of CDC participants reported they started without a financial problem prior to the CDC and most reported no change since the introduction of the CDC. CDC participants who reported a change, since the introduction of the CDC, were split in two categories: those who reported they had a problem before the CDC was introduced (a small pool) and those who reported they did not (a much larger pool). CDC participants in the former category (who reported they had a prior problem) were highly likely to report benefitting from the CDC. This means the CDC had its intended effect of helping a high proportion of those who had financial problems. The latter category of CDC participants (who reported they had no prior problem) were likely to report becoming worse off, since the introduction of the CDC. This means the CDC had an unintended effect of creating new financial problems for this group. Thus, CDC participants reported the CDC has helped

in high proportions the smaller pool of people who identified prior problems and made things worse for a low proportion of the larger pool of people who identified no prior problems.

This evidence becomes even more complicated when the role of individual characteristics and location was taken into account. The evaluation used multivariate statistical methodologies to describe the core characteristics of these two groups in order to identify where and by whom the intended and the unintended consequences were more likely to have been reported. A core multivariate regression finding was that the CDC is more likely to have been reported to make things better for those who could be described as the more vulnerable among the CDC participants and who would therefore need it most. At the same time, another core multivariate regression finding was that the CDC is more likely to be reported to make things worse for other CDC participants who believe they do not need it.

The qualitative evidence supported these quantitative survey findings and provided additional understanding and detail about the nature of both intended and unintended consequences of the CDC on financial planning and money management. These findings included impacts on the financial management of participants, spending patterns and instances of financial abuse and humbugging. The qualitative research found that the most commonly perceived positive impact of the CDC was on improving the financial management and spending patterns of CDC participants. CDC participants felt that the Card enhanced their ability to budget, to keep track of their spending and to have control over their finances, thus encouraging greater spending on essential items such as food, bills, clothes, household goods and fuel. However, the qualitative evidence also uncovered perceptions of respondents of an increased risk of financial abuse, fraud and exploitation as a result of the CDC, particularly for older people and for people with lower literacy levels and for people who were less familiar with the use of bank cards and modern technology. Difficulties were also commonly reported around the limited availability of cash under the CDC.

### **8.2.2 Safety, crime and family violence**

The evaluation found that safety has been improving since the introduction of the CDC, but not for all. For the majority, both the streets and the home are perceived to be safer, compared with prior to the CDC, both during the daytime and in the night. Female respondents to the CDC survey were more likely to report these improvements. However, a sizeable minority of CDC participants (particularly non-Indigenous CDC participants living in the Goldfields), reported that things have become considerably worse since the CDC was introduced. Thus, the expectation the CDC would result in a reduction in harmful behaviours that would trickle down into families and the community in the form of increased safety, lower crime and less family violence, is only partly supported. Using community data from Western Australia and multivariate regression we found evidence of the possibility of a short-term increase in family violence in East Kimberley, since the introduction of the CDC, but not in the Goldfields. This finding comes with a strong caveat, however, as neither the short-run data nor the short-run analysis are ideal for this type of estimation.

The qualitative evidence provided a mixed picture of the impacts of the CDC on crime and family violence. A rise in crime was reported by CDC participants living in the city of Kalgoorlie-Boulder (in the Goldfields) and in Kununurra (in the East Kimberley). However, observations of reduced criminal activity were reported for smaller communities in the trial sites outside of regional centres such as Ceduna and Kalgoorlie-Boulder. Opinions were also mixed as to the impact of the CDC on domestic and family violence. Some respondents (especially stakeholders based in Ceduna) reported that rates of family violence had decreased after the introduction of the CDC, which was thought to be

associated with declines in alcohol misuse within families. In contrast, other respondents considered the incidence of family violence to be either unchanged or to have increased.

The conclusion of the evaluation is that, while the overall finding that safety has been perceived to be improving in the trial sites since the introduction of the CDC can be trusted, we are not able to attribute this improvement to the CDC alone. We are, however, able to provide guidance as to where these safety improvements are reported to have taken place and who has reported to benefit most from them among the CDC participants in all trial sites.

### **8.2.3 Health and well-being**

While improving health is not a primary aim of the CDC program, it is important to assess the degree to which the policy has an impact on the health and well-being of participants. This can happen directly, through restricting the purchase of harmful substances, or indirectly, through the improvement of other life outcomes that can make people healthier and improve their well-being. For example, by improving safety, finances, employment status and other such life circumstances, longer-term health prospects may also improve. It is recognised that such improvements are hard to measure as they take a long time to establish and manifest themselves.

The evaluation produced mixed findings about the impact of the CDC on the health and well-being of participants to date. A large proportion of CDC participant survey respondents reported that their quality of life had been affected in a negative way, especially in the Goldfields trial site and more so for non-Indigenous CDC participants in the Goldfields. However, a sizeable minority in all trial sites reported an overall positive impact of the CDC on their quality of life. Longer-term and/or indirect evidence, such as school attendance for children, employment and training outcomes for CDC participants, housing and nutrition for families, would be required to fully understand the impact of the CDC on health and well-being, but such evidence will only emerge as the years go by if appropriate data is collected.

The evaluation provides indirect evidence, which could be indicative of possible future health and well-being improvements. For example, evidence of improving finances, nutrition, employment status, safety and other such outcomes measured by the evaluation, could be used as indicators of the possibility of future health improvements. Some of them could be very strong indicators of better future health (for example, strong evidence of improved nutrition or reduction of alcohol and drug misuse by young females, where the causal link is clearly that better nutrition improves health and avoiding alcohol improves the chances of healthy babies). Other indicators may prove to be less appropriate for predicting future health (for example, improved employment status, where the causal direction may have been that better health helped improve employment status). Evidence on outcomes that may have indirect effects on future health can be valuable, but the evidence will need to be assessed carefully and individually for each such outcome. Several possibilities of indirect health and well-being outcomes are discussed below, including child welfare and family well-being, feelings of control over one's own life, feelings of discrimination and other. All of them have the potential of an indirect impact on health and well-being, but in a varying timeline and with a varying strength and duration of impact.

### **8.2.4 Child welfare and family well-being**

An important measure for the assessment of the CDC is the degree to which it manages to improve the welfare of the children of CDC participants. There are mixed views and evidence about whether



and how children's welfare has changed since the introduction of the CDC in the trial areas. Within the quantitative survey data, most CDC participants reported no major change regarding questions they were asked to report on that were related to the welfare of children. A sizeable minority reported an overall more positive view on change (focussing on health and food), while another, larger, minority reported an overall more negative view on change (focussing on safety, school attendance and happiness). There were large differences between East Kimberley (where the most negative picture emerged) and Ceduna (which had the most positive picture). A finding common across all trial sites was that the CDC was perceived to have made children's participation in social activities much harder. In contrast, the views of respondents in the qualitative interviews which included the views of stakeholders were more positive about the perceived impacts of the CDC on family functioning and outcomes for children (particularly so in Ceduna and in the Goldfields).

### **8.2.5      Autonomy and control**

By reducing the proportion of income support payments provided as cash, the CDC is highly likely to reduce the autonomy and control of participants over how they spend their money. The qualitative and quantitative evidence collected by the evaluation give rise to mixed findings. The qualitative evidence, which included the reporting from stakeholders and from CDC participants, suggested a large decline in the level of autonomy and control experienced by CDC participants, as a result of the CDC.

The quantitative evidence in comparison, found diversity in almost equal portions: slightly more than half of the CDC participants reported that their control had reduced and slightly fewer than half reported that their control had improved since the introduction of the CDC.

Improvements were largely reported by Indigenous CDC participants, with a large majority of non-Indigenous CDC participants in the Goldfields reporting reduced control over life and over money after the CDC. A similarity emerges with the findings on financial planning. The CDC appears to be levelling up those who started in the least favourable financial position prior to the CDC, enabling them to increase control over their lives and their money. At the same time, the CDC does not appear to be levelling down those who find themselves in a good current financial position: they too are more likely to be experiencing more control than what they experienced prior to the CDC.

### **8.2.6      Discrimination, stigma, shame, embarrassment and fairness**

One of the feared unintended consequences of the CDC is that it is potentially detrimental to CDC participants and that being on the Card may result in feelings of discrimination, stigma, shame and embarrassment. Both qualitative and quantitative evidence highlighted a large majority of CDC participants who expressed strong feelings of discrimination, stigma, embarrassment and shame because they are on the Card. Further, a feeling of unfairness was also expressed by the same majority as a result of being on the Card.

The qualitative evidence described some of the circumstances that give rise to such feelings in detail. It explained how the policy is widely understood to have been promoted and put in place as a means of tackling problematic excessive behaviours by a subgroup of welfare recipients related to alcohol, drugs and gambling. It also explained how CDC participants feel that being on the Card paints them with the brush of addiction, social harm and neglect of their children and other such behaviours. The majority of the CDC participants who informed the evaluation reported that they did not abuse



alcohol, were not using drugs illegally and that since the policy has been put in place because of these issues they find the stigma unfair.

Quantitative evidence confirmed that these negative feelings about being on the Card are reported widely and evenly by a large majority of CDC survey participants who responded to the survey, amongst all demographic groups making up the CDC population in all three trial sites. Survey evidence found that a small minority of CDC participants did not report any of the above mentioned negative feelings about the CDC.

## **8.3 Further findings about the CDC**

### **8.3.1 Miscellaneous outcomes**

The evaluation also sought to collect evidence on employment and training. The quantitative survey of CDC participants found that most CDC participants reported they were not working. The main reasons provided by survey respondents were their own disability or ill health or care responsibilities. For the minority who were not working but had been looking for work, the main obstacles for not getting a job were perceived to be that, either there were no available jobs at all, or that they would not be considered for the jobs that were available because their skills, training and experience were not adequate. A main overall finding of the evaluation on the employment front has been that to date and across the first three trial sites, the CDC has had little impact on employment outcomes. There can be two potential explanations for this finding. First, that the socio-demographics of these three trial sites suggest a mismatch or a gap between the skills and training available by welfare recipients and the skills and training required by job vacancies. Second, in such circumstances, in order to eliminate the mismatch and close the gap to achieve an increase in employment rates, we would need to see first an increase in new training activity. Such a change in training and related activity has not been traced by the data.

The evaluation found that the CDC does not only impact on CDC participants, but also on the organisations that operate in the trial sites. Stakeholder respondents considered that the trial of the CDC had brought changes to their own and other local organisations. These included the additional provision of services, including bringing services into contact with normally hard to reach people, but also increased workload and concerns over staff safety when dealing with clients' frustrations with the CDC.

The evaluation found that the CDC also impacts on people who transit through CDC trial sites for lengthy periods of time. Both Ceduna and the Goldfields regions are common congregation points for Indigenous people living in neighbouring communities, some of which were not designated as trial sites. The movement of people from neighbouring Indigenous communities had not been influenced by the introduction of the CDC. A heightening of social issues was noted during these visits and compromised the potential positive outcomes of the CDC trial. Challenges were noted for visitors who were triggered onto the CDC during a temporary stay in a trial site region, with many experiencing issues once they returned to their communities due to the lack of infrastructure in those communities to support CDC participants.

### **8.3.2 Views about the Implementation and the future of the Cashless Debit Card**

The evaluation provided evidence relating to problems experienced with the Card, where CDC participants reported that implementation issues occurred and discussed how the implementation of the Card could be improved.

The evaluation utilised both qualitative and quantitative methodologies to distinguish between elements of the implementation of the CDC which were perceived to be working well and elements which were perceived to not be working well. A large number of negative implementation issues related to the CDC, and a smaller number of positive aspects, were presented by CDC participants and stakeholders. Positive aspects of the implementation included the CDC local partners and shopfronts, as well as some practical aspects of the Card. Negative implementation issues reported by respondents included financial management and the availability of cash, some practical aspects of the Card, policy targeting, card workarounds, community consultation and information provision, and wraparound services.

The qualitative and quantitative methodologies provided complementary evidence when considering the views of CDC participants and stakeholders on the future of the CDC. The quantitative evidence suggested that, under their current circumstances and in the present policy format, a very large majority of CDC participants would prefer to opt out of the CDC trial. The qualitative evidence explored the views of stakeholders, who broadly supported the continuation of the CDC, as well as the views of CDC participants, who held more mixed opinions about the future of the CDC, as to what reforms would be needed if the trial were to be continued.

### **8.3.3 Differences between trial sites**

The evaluation took place at different points in time in the trial experiences of the three CDC sites. East Kimberley and Ceduna had already experienced several years of the CDC, while the Goldfields region was a relative newcomer to the CDC. This made any direct comparisons difficult. Notwithstanding this caveat, the evaluation identified some pertinent features of the three trial sites.

East Kimberley, as a whole, was the site where most problems were reported to have existed prior to the introduction of the CDC. It was also the site that reported the strongest positive change. Compared with the other two trial sites, Ceduna and surrounds appeared to be the trial site with the least problems prior to the introduction of the CDC and appeared to also be in a favourable position at the time of the evaluation. The Goldfields provided a divided picture, clearly split between the perceptions of the Indigenous and the non-Indigenous CDC participants. Indigenous CDC participants in the Goldfields reported many problems prior to the CDC and modest improvements after its introduction. In contrast, non-Indigenous CDC participants in the Goldfields reported many problems prior to the CDC and even more at the time of the evaluation evidence collection (which was up to one and a half years after the CDC rollout in the Goldfields).

The evidence suggested that, over and above the sociodemographic diversity between the trial sites, there appear to be pure site differences at work. In part, these were identified by stakeholders and CDC participants to be due to differences in previous policies and their history in each of the trial sites. The evaluation found some evidence that aspects of the CDC have been improving, but it found no systematic evidence either that the CDC is improving outcomes as it matures, or that the CDC participants are getting more used to it, or that they dislike it less, after they have been on it for longer.

### 8.3.4 Differences between respondent groups

Stakeholders, whose views were only captured by the qualitative methodology of the evaluation, largely expressed positive views and opinions about the CDC. Many agreed with the overall tenor of the policy and with the potential benefits to the target communities that could be derived by its successful implementation and made suggestions about potential improvements. Notwithstanding, many also expressed reservations about the CDC including that they had become or remained sceptical about the implementation of the policy.

On the whole, CDC participants were negative about the CDC. General views expressed about the CDC in its entirety were negative, in large numbers and proportions of the participants' population. When asked to go into more detail, the views of CDC participants on specific aspects of the CDC remained largely negative, but less frequently so. There are some specific aspects of the CDC which were reported in a negative manner, but less frequently than others and with more instances of positive responses. When asked about instances of positive change, even more CDC participants had something positive to say, either about having experienced an improvement themselves, or about having seen some improvement experienced by others, or more broadly about having observed an improvement within their community or where they live. Thus, while the CDC participants who reported positively about the CDC were almost invariably a minority, the exact size of that minority varied depending on the specificity and the nature of the questions asked.

### 8.3.5 Individual profiles of CDC participants and CDC impacts

Using multivariate regression analysis, we investigated the profiles of CDC participant survey respondents who were most likely to report an improvement following the introduction of the CDC. We found that the individual profiles of those who reported an improved outcome varied widely but had some common elements. Each of the following individual characteristics of CDC participants were more likely to be associated with improved outcomes: being Indigenous (in all trial sites), living in East Kimberley, being female, being older, and living in a family/couple (with or without children). In the context of the change the CDC brought, those who reported suffering from the worst financial difficulties prior to the CDC were more likely to report seeing improvements, as were younger people who used drugs. Without the help of more over time change, it is difficult to argue how any of these characteristics and associated circumstances may be driving change to the better. To that purpose we would need richer and of longer duration longitudinal information and a control group for an appropriate experimental design which would enable the full use of the evidence base.

The qualitative evidence added invaluable depth of understanding to the statistical results obtained from the quantitative survey of CDC participants. It suggested the CDC was working best for three groups of participants: (i) partnered and single parent families; (ii) people who had previously struggled with managing their money; and (iii) participants experiencing social issues including substance abuse, homelessness and child neglect. The qualitative evidence highlighted five key groups for whom the CDC was not working well: (i) older people; (ii) people with physical and psychosocial disability; (iii) individuals experiencing entrenched addiction; (iv) Indigenous participants living in remote communities; and (v) people with limited literacy and IT skills. It provided detailed explanations about the obstacles these groups experienced in their CDC participation.

### **8.3.6 Feasibility of establishing a longitudinal dataset to allow the analysis of medium-to-long term effects of the CDC**

The remit of the present evaluation was to rely on a single wave of qualitative and quantitative data collections, with the exception of the qualitative interviews in the Goldfields, without sampling a control group of income support payment recipients living outside the trial areas. The evaluation therefore lacked the means for making any comparison between those on the CDC and those not on the CDC. As a result, the evaluation used several survey questions to ask about the CDC participants' situation before and after the CDC roll out. The quantitative survey asked CDC participants to contrast their situation 12 months prior to the introduction of the CDC with their current situation. This is not ideal for making robust impact statements, due to likely recall bias from the CDC participants.

The evaluation was also tasked to establish a framework for longer term longitudinal studies of the CDC in each of the three current locations. The evaluation established that it is feasible, and would be valuable, for a longitudinal dataset to be constructed, including a control group element. The longitudinal nature of the data and the inclusion of a control group would allow statistically robust statements about the impact of the CDC in the trial areas. The quantitative survey used in this evaluation was designed with this requirement and the resulting considerations in mind. The existing wave could serve as the first wave of a longitudinal data set and the current questionnaire, fieldwork design and implementation plan could be used, following minimal alterations, for a second wave of data collection. We suggest linking survey responses with Australian Government data be continued as an essential element of the design of any second wave of data collection. We note that, in the current evaluation, consent to linking was obtained from more than 80 per cent of CDC participant survey respondents. We also suggest that a control group be introduced in the longitudinal design.

## 9. References

---

- Andrews, G. (2002), "A brief integer scorer for the SF-12: validity of the brief scorer in Australian community and clinic settings", *Australian and New Zealand Journal of Public Health* 2002, vol. 26 no. 6.
- Australian Bureau of Statistics (2016a), "Ceduna (Local Government Area)". 2016 Census QuickStats. Retrieved July 2020.
- Australian Bureau of Statistics (2016b), "Wyndham-East Kimberley (Local Government Area)". 2016 Census QuickStats. Retrieved July 2020.
- Australian Bureau of Statistics (2016c), "Goldfields (Statistical Area Level 3)". 2016 Census QuickStats. Retrieved July 2020.
- Australian National Audit Office (ANAO)(2018), *The Implementation and Performance of the Cashless Debit Card Trial*.
- Cummins R.A., Eckersley R., Pallant J., Van Vugt J., and Misajon R. (2003), "Developing a national index of subjective wellbeing: The Australian Unity Wellbeing Index", *Social Indicators Research*, 64, pp 159-190.
- Coolgardie (2020), Wikipedia. Available at [https://en.wikipedia.org/wiki/Coolgardie,\\_Western\\_Australia](https://en.wikipedia.org/wiki/Coolgardie,_Western_Australia) (Accessed: 30 July 2020).
- Forrest, A. (2014), *Creating Parity – The Forrest Review*. Canberra: Commonwealth of Australia.
- Kambalda (2020), Wikipedia. Available at [https://en.wikipedia.org/wiki/Kambalda,\\_Western\\_Australia](https://en.wikipedia.org/wiki/Kambalda,_Western_Australia) (Accessed: 30 July 2020).
- Kununurra (2020), Wikipedia. Available at [https://en.wikipedia.org/wiki/Kununurra,\\_Western\\_Australia](https://en.wikipedia.org/wiki/Kununurra,_Western_Australia) (Accessed: 30 July 2020).
- Laverton (2020), Wikipedia. Available at [https://en.wikipedia.org/wiki/Laverton,\\_Western\\_Australia](https://en.wikipedia.org/wiki/Laverton,_Western_Australia) (Accessed: 30 July 2020).
- Leonora (2020), Wikipedia. Available at [https://en.wikipedia.org/wiki/Leonora,\\_Western\\_Australia](https://en.wikipedia.org/wiki/Leonora,_Western_Australia) (Accessed: 30 July 2020).
- Loxton, D., Townsend N., Forber, P., and Coombe, J. (2018) *Domestic Violence, Risk Factors and Health, Australian Longitudinal Study on Women's Health, Women's Health Australia*, Report for the Australian Department of Health.
- Mavromaras, K., Moskos, M., Mahuteau, S., and Isherwood, L. (2018), *Evaluation of the NDIS: Final Report*. Canberra: Australian Government Department of Social Services.
- Mavromaras, K., Moskos, M., Isherwood, L., and Mahuteau, S. (2019), *Cashless Debit Card Baseline Data Collection in the Goldfields Region: Qualitative Findings*. Canberra: Australian Government Department of Social Services.
- Menzies (2020), Wikipedia. Available at [https://en.wikipedia.org/wiki/Menzies,\\_Western\\_Australia](https://en.wikipedia.org/wiki/Menzies,_Western_Australia) (Accessed: 30 July 2020).
- ORIMA (2017), *Cashless Debit Card Trial Evaluation Final Evaluation Report*, August 2017, Australian Government Department of Social Services.

Rennison, C.M., and Welchans, S. (2000), *Intimate Partner Violence, Bureau of Justice Statistics Special Report* (9NCJ 178247). Washington, DC: US Department of Justice.

Ritchie, J. and Spencer, L. (1994), "Qualitative data analysis for applied policy research", in A. Bryman and R. Burgess (eds.) *Analyzing Qualitative Data*, pp.173-194. London: Sage.

Shire of Coolgardie (2020), Shire of Coolgardie: Mother of the Goldfields. Available at <https://www.coolgardie.wa.gov.au/> (Accessed: 30 July 2020).

The University of Western Australia (2017), *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project*. Available at <http://www.atsispep.sis.uwa.edu.au/> (Accessed October 2020).

WA Government (2017), East Kimberley Available at <https://regionalservicesreform.wa.gov.au/pr/east-kimberley> (Accessed: 30 July 2020).

Weatherburn D., Lind, B., and Ku, S., (2001), "The Short-run Effect of Economic Adversity on Property Crime: an Australian Case Study", *The Australian and New Zealand Journal of Criminology*, vol34(2), pp 134-148.

Weatherburn, D. (1992), "Economic Adversity and Crime", *Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice*, no 40, Canberra, Australia.

Wyndham (2020), Wikipedia. Available at [https://en.wikipedia.org/wiki/Wyndham,\\_Western\\_Australia](https://en.wikipedia.org/wiki/Wyndham,_Western_Australia) (Accessed: 30 July 2020).

# 10. Appendices

---

## Appendix 1: Topic guides

### Stakeholder Topic Guide

#### 1. About the person and their organisation

Thank you for agreeing to take part in the research. We are interested in talking with you as a representative of [organisation name]. Let's start by you telling me a little bit about yourself and the organisation you work for.

- 1.1. Could you tell me a little about the organisation you work for?
- 1.2. What is your role in the organisation?
- 1.3. What has been your organisation's involvement with people on the cashless debit card? (Probe here on types of involvement with CDC participants, frequency of contact, numbers etc.)

#### 2. Implementation of the CDC

- 2.1. What have been the reactions of the community to the implementation of the CDC? (Probe for positive/negative/mixed, reasons for these reactions, any differences in views between CDC participants and broader community). Have these reactions changed over time? How? Why?
- 2.2. What is working well so far with the CDC?
- 2.3. Are there any aspects of the CDC that are not working well? Why?
- 2.4. Are there any groups of people for whom it is working better than others? Why?
- 2.5. Are there any groups of people for whom it is working worse than others? Why?
- 2.6. Have you heard of anyone working out ways to get more cash? (Probe for strategies to circumvent card restrictions; who is using strategies—CDC participants, family and friends of participants, non-participants including people living outside the CDC region, people delivering services to participants). Have these workarounds been addressed or are they still occurring?
- 2.7. Have you heard of anyone trying to get an exemption to opt out of the CDC? (Probe: If yes, on what grounds? Were they successful? Did they receive any assistance with the exemption processes?)
- 2.8. Have you heard of people seeking to voluntarily opt into the CDC? (Probe: If yes, who/types of people? Reasons for wanting to be on CDC?)
- 2.9. Are you aware of the recent legislation changes that have occurred that impact on the CDC policy?
- 2.10. What are your expectations about these changes?

#### 3. Community Panel (For Ceduna and East Kimberley only)

- 3.1. Are you aware of the community panel?

- 3.2. What is the role of the panel?
- 3.3. How often do they meet?
- 3.4. What type of representatives are on it?
- 3.5. How do you feel about the panel? Is it working well/what needs improvement?
- 3.6. How do you think the recent legislative changes will impact on the role of the community panel?

#### **4. Impacts of the CDC**

4.1. What impacts has the cashless debit card had so far on:

- Your organisation?
- Other organisations in your community?

(For each of the above probe for positive/negative impacts, demand for services/referrals, funding of services, types of services provided.)

4.2. What impacts has the cashless debit card had so far on:

- CDC participants and their families?
- The broader community?

(For each of the above probe for positive/negative impacts? Why? Impact on alcohol use and misuse, substance use and misuse, gambling, child welfare and well-being, anti-social behaviour and safety, crime and family violence, health, mental health and well-being, spending patterns and management of money, employment/training, transient populations?)

#### **5. Adverse or Unintended changes due to the CDC**

5.1. Do you think there have been any unintended consequences of the cashless debit card? (Probe for more or less of: humbugging, harassment, more stealing, begging, elder abuse or intimidation, stigmatisation/marginalisation/acceptance).

#### **6. Support services (family, financial, drug, alcohol, gambling etc.)**

- 6.1. Since the cashless debit card was implemented, has there been any change in the levels or types of support services that are available in your local community to help CDC participants? (Probe for services for drug and alcohol issues, gambling, family support, financial management, mental health etc.)
- 6.2. Do you think that the cashless debit card has impacted on awareness and use of these services? Why/why not?
- 6.3. Are there any current gaps in support services that you are aware of? What is the reason for these gaps? (Probe for funding, remote location etc.)
- 6.4. Are there any other issues related to support services which need addressing? (Probe for barriers to access/engagement, service duplication, co-ordination of services, staffing)

#### **7. Wrapping up**

- 7.1. Overall what are some of the things that you consider to be best about the cashless debit card?
- 7.2. What aspects of the cashless debit card do you like least? Why?



- 7.3. Is there anything about the cashless debit card that you think could be improved? (Probe for operation of the CDC, information/support for CDC participants, policy targeting, 80/20 split)
- 7.4. Do you think that the CDC should continue to operate in your area? Why/why not?
- 7.5. What would happen if the CDC stops in this region?
- 7.6. Any other comments/things that have been missed?

## CDC Participant Topic Guide

### 1. About you and where you live

You have agreed to take part in this research because you are a participant of the Cashless Debit Card. Can we start by you telling me a little about yourself?

- 1.1. How old are you? Where do you live? (Probe for town, suburb usually live) Who do you live with? (Probe for children under 18 years)
- 1.2. Can you tell me a little about how you spend your time? (Probe for what do you do in a usual day: care provision, education, work, looking for work, community involvement, time with family and friends)
- 1.3. What benefit do you currently receive? (Probe on length of time in receipt of benefits) Before going on the cashless debit card, have you previously been on any form of income management? (Probe for what type, how long and reason why)

### 2. The CDC Experience

- 2.1. How long have you been on the cashless debit card?
- 2.2. What do you feel is good about the Cashless Debit Card? Why?
- 2.3. What do you feel is bad about the Cashless Debit Card? Why?
- 2.4. Have you experienced any problems with the card? (Probe for activation, setting up direct debits, inability to pay for something, whether problems have been overcome/resolved)
- 2.5. How does being on the cashless debit card make you feel? (Probe for discriminated against, embarrassed, more/less in control of money, feel safer)
- 2.6. If you had a choice would you like to come off the CDC? If yes, why? If no, why not?
- 2.7. Have you heard of anyone working out ways to get more cash? (Probe for strategies to circumvent card restrictions; people involved including participants, family and friends of participants, non-participants including people living outside the site, people delivering services to participants) Are these workarounds still happening or have they been stopped?
- 2.8. Are you aware of the recent legislative changes that have occurred that impact on the CDC policy?
- 2.9. What are your expectations about these changes?

### 3. Interactions with CDC local partners

- 3.1. Have you received any assistance from DSS shop fronts/CDC local partners since you got the cashless debit card?
- 3.2. What types of assistance have you received (i.e. card activation, accessing extra cash, arranging direct debits)?
- 3.3. How many times have you sought assistance?
- 3.4. Were you satisfied with the assistance you received from DSS shop fronts/CDC local partners?

### 4. Interactions with community panel (for Ceduna and East Kimberley only)

- 4.1. Are you aware of the community panel? If yes, what do you know about the panel (e.g. role, how to apply for a review)?
- 4.2. Have you applied to the panel for the proportion of money you receive on the Cashless Debit Card to be reviewed?

- 4.3. If yes, what was the process of applying for a review? Did you receive any support with your review? What was the outcome?
- 4.4. How do you feel about the community panel? Is it working well/what needs improvement?
- 4.5. How do you think the recent legislative changes will impact on the role of the community panel?

## **5. Impacts of the CDC**

- 5.1. What impacts has the cashless debit card had so far on:
  - 5.1.1 You?
  - 5.1.2 Your family?
  - 5.1.3 Other cashless debit card participants and their families?
  - 5.1.4 The broader community where you live?

(For each of the above probe for positive/negative impacts? Why? Impact on alcohol use and misuse, substance use and misuse, gambling, child welfare and well-being, anti-social behaviour and safety, crime and family violence, health, mental health and well-being, spending patterns and management of money, employment/training, transient populations?)

- 5.2. Are there any groups of people for whom it is working better than others? Why?
- 5.3. Are there any groups of people for whom it is working worse than others? Why?

## **6. Adverse or Unintended changes due to the CDC**

- 6.1. Do you think there has been any unintended consequences of the cashless debit card? (Probe for more or less of: humbugging, harassment, stealing, begging, abuse or intimidation, violence, drug or alcohol use, stigmatisation/marginalisation/acceptance).

## **7. Support services (family, financial, drug, alcohol, gambling etc.)**

- 7.1. What support services are currently available in your local community to help people who are on the CDC? (Probe for services for drug and alcohol issues, gambling, family support, financial management, mental health etc.)
- 7.2. Do you think that the cashless debit card has changed people's use of these services? Why/why not?
- 7.3. Have you or your family used any of these services since the start of the CDC? (Probe for type of service(s), reason, outcome, levels of satisfaction)
- 7.4. Are there any other services which are needed in your local community to help CDC participants and their families?

## **8. Wrapping up**

- 8.1. Overall what are some of the things that you consider to be best about the cashless debit card?
- 8.2. What aspects of the cashless debit card do you like least?
- 8.3. Is there anything about the cashless debit card that you think could be improved? (Probe for operation of the CDC, information/support, policy targeting, 80/20 split)
- 8.4. Do you think that the CDC should continue to operate in your area? Why/why not?
- 8.5. What would happen if the CDC stops in this region?
- 8.6. Any other comments/things that have been missed?

## **Appendix 2: CDC participants individual survey questionnaire**

The following pages provide the questionnaire that was used for the in-depth interviews with CDC stakeholders and participants.

# *Have your say about the Indue card*

## **Cashless Debit Card Participants Survey**

**Thank you for helping us with the evaluation of the Cashless Debit Card by answering this survey.**

The results from this survey will be used to find out what people think about the Cashless Debit Card and what their experiences are using the card. We also want to examine whether the card is helping people to manage their money better and if it is changing attitudes to alcohol, drug and gambling use. This survey is part of the independent evaluation currently being conducted by the University of Adelaide on behalf of the Department of Social Services.

It is important for this study to understand the views of people who are already using the Cashless Debit Card. We appreciate you finding the time to complete this survey. By answering and returning the survey you are providing your consent to be included in the evaluation.

You will receive a \$50 supermarket voucher to thank you for the time you took to answer this survey. You will find instructions about how to receive your voucher at the end of this survey.

All information collected is confidential. Your answers will be used for research purposes only.

Participation in the survey is voluntary. It will not have any impact on any benefits or payments you currently receive from Centrelink.



The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2018-117).

## How to fill out this survey

### Please use a black or blue ballpoint pen

To answer most of the questions you only need to cross a box

Please mark the box closest to your answer like this: ☒

Don't worry if you make a mistake or want to change your answer; simply colour in the wrong box and mark the correct box like this:

YES ☒ NO ☒

Please write numbers into individual boxes like this:

Sometimes you can write an answer in a box.

You will see this symbol  above or beside the box.

Not all questions will apply to you. If you see a → **GO TO** instruction next to your answer, go to that question. It will look like this: ☒ → **GO TO**

If there is no → **GO TO** instruction, continue to the next question.

Call us on 1800 519 672 or send us an email at [cdc\\_fes@adelaide.edu.au](mailto:cdc_fes@adelaide.edu.au) if you have any questions about the survey or if you need assistance.

**Your answers to this survey are completely confidential. Your responses will be used for research purposes only. You and your household will never be identified.**

### ETHICS APPROVAL:

The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2018-117).

If you have questions or problems about your participation in the project or want to raise a concern or complaint about the project, please contact the Principal Investigator Kostas Mavromaras on 1800 519 672 or email [directorfes@adelaide.edu.au](mailto:directorfes@adelaide.edu.au).

If you want to speak to an independent person about the study, please contact the Human Research Ethics Committee's Secretariat on +61 8 8313 6028 or email [hrec@adelaide.edu.au](mailto:hrec@adelaide.edu.au); or by mail to: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000.

Any complaint or concern will be treated in confidence and will be fully investigated. You will be informed of the outcome.

## Section A: About You

A1. What is your gender?

Male ☐

Female ☐

A2. What is your current age?

years

A3. Which category best describes the household you live in?

Person living alone ☐

Couple living alone ☐

Couple with non-dependent child(ren) ☐

Couple with dependent child(ren) ☐

Couple with dependent and non-dependent child(ren) ☐

Single parent with non-dependent child(ren) ☐

Single parent with dependent child(ren) ☐

Single parent with dependent and non-dependent child(ren) ☐

Adults you are not related to who share your house/apartment ☐

Other household type (specify in the box below) ☐



A4. Are you the main carer of any children aged under 5 years?

Yes, one child aged under 5 ☐

Yes, two children aged under 5 ☐

Yes, three or more children aged under 5 ☐

No ☐

A5. Are you the main carer of any children aged 5 years up to 15 years?

Yes, one child aged between 5 and 15 years ☐

Yes, two children aged between 5 and 15 years ☐

Yes, three or more children aged between 5 and 15 years ☐

No ☐

IF YOU ANSWERED 'NO' to the previous question, please **GO TO SECTION B: Work/Employment**

OFFICE USE ONLY

Date:   /   /

ASSISTANT CODE:

UID\_CODE:

## CHILDREN AT SCHOOL:

A6. For each child you care for (aged 5-15 years), how often did they go to school last term?

	Every Day	Most Days	Sometimes	Never	Don't Know
Child aged 5-15, 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child aged 5-15, 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child aged 5-15, 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child aged 5-15, 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child aged 5-15, 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED 'Sometimes', 'Never' or 'Don't know' for any of your children, please **GO TO THE NEXT QUESTION. → GO TO A7**

IF YOU ANSWERED 'Everyday' or 'Most days' for all your children, please **GO TO SECTION B**

A7. Why did they not attend school more often?

(Mark all that apply)

Have other cultural or family obligations more important than school ☐

Don't need to go to school ☐

Have no way of getting there / no transport ☐

The school is not culturally appropriate for my child ☐

The school in my area is not good quality ☐

Child has special needs / has a disability or very sick ☐

Child is picked on / bullied or scared to go to school ☐

Child doesn't like school / doesn't want to go to school ☐

Child is taken to school – but leaves ☐

Other (specify in the box below) ☐



## Section B : Work/Employment

B1. In the last 4 weeks, did you do any work?

Yes, CDP job / work for the dole

(Job Active) ☐

Yes, other paid work ☐

No ☐ → GO TO B4

B2. How long have you been doing that job?

Number of days

Number of months

Number of years

B3. How many hours do you work in that job each week?

Number of hours   → GO TO B5


Don't know ☐ → GO TO B5

**B4. Why are you not working at the moment?***(Mark all that apply)*

- Lack necessary training / qualifications / experience ☐
- Considered too old by employers ☐
- Difficulties with language or ethnic background ☐
- Unable to work because of disability ☐
- No jobs with suitable conditions/ arrangements ☐
- Problems with access to transport ☐
- Short term sickness or injury ☐
- No jobs or vacancies in locality / line of work / at all ☐
- Studying / returning to studies ☐
- Moving house ☐
- Taking holidays ☐
- Caring for children ☐
- Caring for ill/ disabled/ elderly person ☐
- Pregnancy ☐
- Home duties ☐
- No need / satisfied with current arrangement / retired (for now) ☐
- Visa requirements ☐
- Other (specify in the box below) ☐

  
**B5. At any time in the last 4 weeks, have you been looking for work?**Yes ☐ → **GO TO SECTION C**No ☐ → **GO TO B6****B6. Even though you have not been looking for work in the last 4 weeks, would you like a job / different job?**Yes ☐No ☐**Section C : About Money****C1. Have you activated your Cashless Debit Card and started using it to buy things?**Yes ☐No ☐Don't know ☐**C2. For how long have you been on the Cashless Debit Card?**Date got the card: //

Or

Number of months since you got the card:  months**C3. Have you had any problems using your Cashless Debit Card?**Yes ☐No ☐ → **GO TO C5****C4. Please tell us about these problems**  
**C5. Do you live with anyone else who is on the Cashless Debit Card?**Yes ☐No ☐ → **GO TO C7****C6. What is your relationship to them?**Are they your... *(Mark all that apply)*Father ☐Mother ☐

Husband / Wife / De facto partner / Boyfriend /

Girlfriend ☐Brother / Sister ☐Aunt / Uncle ☐Child ☐Other (specify in the box below) ☐  

Reminder: Your answers are completely confidential. Your responses are used for research purposes only.

You and your household will never be identified.

Your accurate and honest responses to this survey are important and appreciated.




**C7. In the 12 months before being on the Cashless Debit Card, did any of these things happen to you? (Answer all items)**

	Yes	No	Not applicable	Don't know
Ran out of money to buy food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ran out of money to buy clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ran out of money to buy medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay rent on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to save up bond money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay water and electricity bills on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to save money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gave money to others causing financial problems for you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asked for money from others because you could not buy essential things (e.g. food, clothes, medicine, bills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asked for emergency relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to afford to travel to visit family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay for things that your child/children needed for school, like books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay for school activities/trips or sports for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


**C8. In the last 4 weeks, did any of these things happen to you? (Answer all items)**

	Yes	No	Not applicable	Don't know
Ran out of money to buy food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ran out of money to buy clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ran out of money to buy medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay rent on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to save up bond money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay water and electricity bills on time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to save money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gave money to others causing financial problems for you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asked for money from others because you could not buy essential things (e.g. food, clothes, medicine, bills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asked for emergency relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to afford to travel to visit family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay for things that your child/children needed for school, like books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to pay for school activities/trips or sports for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C9. Since being on the Cashless Debit Card, what has helped with any money problems you may have had?**



**C10. Since being on the Cashless Debit Card, what has caused you to experience any money problems?**



## Section D: Behaviour and Attitudes

### D1. How often do you drink alcohol?

- Never ☐ → GO TO D15
- Monthly or less ☐
- 2-4 times a month ☐
- 2-3 times a week ☐
- 4 or more times a week ☐

### D2. Where do you usually drink alcohol?

(Mark all that apply)

- In my own/spouse/partner's home ☐
- At a friend's house ☐
- At a party at someone's house ☐
- At rave/dance parties ☐
- At restaurants/cafes ☐
- At licensed premises (e.g. pubs, clubs) ☐
- At school, TAFE, university, etc. ☐
- At my workplace ☐
- In public places (e.g. parks, beaches) ☐
- In a car or other vehicle ☐
- Somewhere else ☐

### D3. Where do you usually get your alcohol?

(Mark one response only)

- Friend or acquaintance ☐
- Brother or sister ☐
- Parent ☐
- Spouse or partner ☐
- Other relative ☐
- Get stranger/someone not known to me to get it ☐
- Steal it ☐
- Purchase it myself to take home ☐
- Purchase it myself to drink at a venue (e.g. pub, café) ☐
- Other ☐

### D4. How many drinks of alcohol do you have on a usual day when you are drinking?

- 1 or 2 ☐
- 3 or 4 ☐
- 5 or 6 ☐
- 7 to 9 ☐
- 10 or more ☐

### D5. How often do you have six or more drinks at one time?

- Never ☐
- Less than Monthly ☐
- Monthly ☐
- Weekly ☐
- Daily or almost daily ☐

### D6. How often during the last year have you been unable to stop drinking once you had started?

- Never ☐
- Less than Monthly ☐
- Monthly ☐
- Weekly ☐
- Daily or almost daily ☐

### D7. How often during the last year have you not done what was expected of you because of drinking?

- Never ☐
- Less than Monthly ☐
- Monthly ☐
- Weekly ☐
- Daily or almost daily ☐

### D8. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?

- Never ☐
- Less than Monthly ☐
- Monthly ☐
- Weekly ☐
- Daily or almost daily ☐

### D9. How often during the last year have you felt guilty after drinking?

- Never ☐
- Less than Monthly ☐
- Monthly ☐
- Weekly ☐
- Daily or almost daily ☐

### D10. How often during the last year have you been unable to remember what happened because of your drinking?

- Never ☐
- Less than Monthly ☐
- Monthly ☐
- Weekly ☐
- Daily or almost daily ☐

### D11. Have you or someone else been injured because of your drinking?

- No ☐
- Yes, but not in the last year ☐
- Yes, during the last year ☐

**D12. Has a relative, friend, doctor or other health care worker been worried about your drinking or suggested you cut down?**

- No ☐  
 Yes, but not in the last year ☐  
 Yes, during the last year ☐

**D13. Since being on the Cashless Debit Card, have you?**  
*(Mark all that apply)*

- Reduced the amount of alcohol you drink at any one time ☐  
 Reduced the number of times you drink each week ☐  
 Drink more low-alcohol drinks ☐  
 Stopped drinking alcohol ☐  
 None of the above ☐ → **GO TO D15**

**D14. What were the reasons for doing that?**  
*(Mark all that apply)*

- Health reasons (e.g. weight, diabetes, avoid hangover) ☐  
 Life style reasons (e.g. work/study commitments, less opportunity) ☐  
 Social reasons (e.g. believe in moderation, concerned about violence) ☐  
 Pregnant and/or breastfeeding ☐  
 Taste/Enjoyment (e.g. prefer low alcohol beer, don't get drunk) ☐  
 Drink driving rules ☐  
 Financial reasons ☐  
 Adult/parent pressure ☐  
 Peer pressure ☐  
 The price of alcohol has increased ☐  
 Other ☐

**D15. In the 12 months before being on the Cashless Debit Card, did you...** *(Answer all items)*

	Not at all	Less than monthly	Monthly	Weekly	Daily or almost daily
Gamble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spent more than \$50 a day gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gamble more than you could afford to lose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borrow money or sell things to have money to gamble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use an illegal drug or prescription medicine for non-medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spent more than \$50 a day on drugs not prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borrow money or sell things to get money to buy drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D16. Since being on the Cashless Debit Card, have you...** *(Answer all items)*

	Not at all	Less than monthly	Monthly	Weekly	Daily or almost daily
Gambled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spent more than \$50 a day gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambled more than you could afford to lose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borrowed money or sell things to have money to gamble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used an illegal drug or prescription medicine for non-medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spent more than \$50 a day on drugs not prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borrowed money or sell things to get money to buy drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D17. When people talk about “a drug problem”, which is the first drug you think of? (Mark one response only)**

	Alcohol	<input type="checkbox"/>
	Tobacco	<input type="checkbox"/>
	Marijuana/Cannabis	<input type="checkbox"/>
(e.g. Pot, Grass, Weed, Reefer, Joint, MaryJane, Acapulco gold, Rope, Mull, Cone, Spliff, Dope, Hydro, Bhang, Ganja, Hash, Chronic)		
	Meth/amphetamine	<input type="checkbox"/>
(e.g. Speed, Base, Ice, Crystal, Meth, Amphet, Shabu, Tina, Paste, Skates, Ox blood, Leopards blood, Whizz, Zip)		
	Cocaine	<input type="checkbox"/>
(e.g. Coke, Crack, Flake, Snow, White lady/girl, Happy dust, Gold dust, Toot, Scotty, Charlie, Cecil, C, Freebase)		
	Ecstasy	<input type="checkbox"/>
(e.g. Molly, XTC, E, Ex, Ecce, E and C, Adam, MDMA, MDDA, MDEA, Eve, PMA)		
	Heroin	<input type="checkbox"/>
(e.g. Hammer, Smack, Horse, H, Boy, Junk, Gear)		
	Pain-killers/Pain-relievers and Opioids	<input type="checkbox"/>
(e.g. Panadeine Forte, Nurofen Plus, Mersyndol, Disprin Forte, Morphine, Oxycodone)		
	Methadone/Buprenorphine	<input type="checkbox"/>
(e.g. Done, Junk, Jungle juice, Bupe, Sub)		
	Steroids	<input type="checkbox"/>
(e.g. Roids, Juice, Gear, Andriol, Halotestin)		
	Drugs other than listed	<input type="checkbox"/>
	None/Can't think of any	<input type="checkbox"/>

**D18. Which of these drugs causes the most problems in the area where you live? (Mark one response only)**

Excessive drinking of alcohol	<input type="checkbox"/>
Tobacco smoking	<input type="checkbox"/>
Marijuana/Cannabis	<input type="checkbox"/>
Non-medical use of Meth/amphetamine	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Non-medical use of Pain-killers/Pain-relievers and Opioids (e.g. Morphine, Panadeine Forte, Nurofen Plus)	<input type="checkbox"/>
Non-medical use of Methadone/Buprenorphine	<input type="checkbox"/>
Non-medical use of Steroids	<input type="checkbox"/>
None of these	<input type="checkbox"/>

**FOR THIS SURVEY, THE TERM “NON-MEDICAL USE” MEANS DRUGS USED:**

1. By itself to give a drug experience or feeling;
2. With other drugs to enhance a drug experience;
3. For performance enhancement (e.g. athletic); or
4. For cosmetic purposes, (e.g. body shaping).

**Reminder: Your answers are completely confidential. Your responses are used for research purposes only. You and your household will never be identified. Your accurate and honest responses to this survey are important and appreciated.**

**D19. For each of the drugs below, do you agree or disagree to them being regularly used by adults?**

*(Mark one response for each drug type below)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-medical use of Tranquillisers, Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-medical use of Prescription Pain-killers/ Pain-relievers and Opioids (e.g. Oxycodone, Panadeine Forte, Morphine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-medical use of Over-the-counter Pain-killers/ Pain-relievers and Opioids (e.g. a codeine product such as Nurofen Plus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-medical use of Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing Petrol/Glue/Aerosols/Solvents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens/LSD/Magic Mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-medical use of Methadone/Buprenorphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-medical use of Meth/amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kava	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D20. What one thing do you think should happen to people if they are caught with a small amount of the following drugs?** *(Mark one response only for each drug type i.e. one answer in each column)*

	Marijuana/ Cannabis	Ecstasy	Heroin	Meth/amphetamine (Non-medical Use)	Hallucinogens
No action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A caution or warning only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral to drug education program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral to treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Something similar to a parking fine, up to \$200	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A substantial fine, around \$1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A community service order	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekend detention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A prison sentence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some other arrangement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D21. Do you think that using Marijuana/Cannabis should be illegal?**

Yes ☐  
 No ☐  
 Unsure/Don't know ☐

**D22. If Marijuana/Cannabis were legal to use, would you...? (Mark one response only)**

Not use it, even if it were legal and available ☐  
 Try it ☐  
 Use it about as often as you do now ☐  
 Use it more often than you do now ☐  
 Use it less often than you do now ☐  
 Don't know ☐

**D23. For each of these drugs, do you agree or disagree that they should be legal for personal use?**  
*(Mark one response in each row)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Marijuana/Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meth/amphetamine (i.e. Speed, Ice, Crystal, Base)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D24. For each of these drugs, do you agree or disagree that there should be more penalties for their sale or supply?**  
*(Mark one response in each row)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Marijuana/Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meth/amphetamine (i.e. Speed, Ice, Crystal, Base)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

You are getting close to the end of the survey! Thank you for making the effort and sharing your views with us. Please continue to the end!

## Section E: Health

E1. In general, would you say your health is:

- Excellent ☐  
 Very Good ☐  
 Good ☐  
 Fair ☐  
 Poor ☐

E2. The following questions are about activities you might do during a typical day.

Does your health limit you from doing any of these activities? If so, how much? *(Answer all items)*

	Yes, a lot	Yes, a little	No, not at all
Moderate activities such as moving a table, pushing a vacuum cleaner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? *(Answer all items)*

	Yes	No
Done less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Affected the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

E4. During the past 4 weeks, have emotional problems affected your work or daily activities in the following ways? *(Answer all items)*

	Yes	No
Done less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Affected the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

E5. During the past 4 weeks, how much did pain interfere with your normal work (both in and outside the home)?

- Not at all ☐  
 A little bit ☐  
 Moderately ☐  
 Quite a bit ☐  
 Extremely ☐

E6. During the past 4 weeks, how much has your physical health or emotional problems affected your social activities (such as visiting friends and relatives)?

- All of the time ☐  
 Most of the time ☐  
 Some of the time ☐  
 A little of the time ☐  
 None of the time ☐

E7. During the past 4 weeks, how much of the time did you...? *(Answer all items)*

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Feel calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have lots of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E8. The following questions ask how happy you feel about things in your life.**

*Please use the scale from 1 to 10 to say how you have been feeling this week. 1 means you are 'not at all happy' and 10 means you are 'completely happy'*

**a. How happy are you with your life as a whole?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

**b. How happy are you with your standard of living?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

**c. How happy are you with your health?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

**d. How happy are you with what you are currently achieving in life?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

**e. How happy are you with your personal relationships?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

**f. How happy are you with how safe you feel?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

**g. How happy are you with feeling part of your community?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

**h. How happy are you with your future security?**

Not at all happy

Completely happy

☐ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5   ☐ 6   ☐ 7   ☐ 8   ☐ 9   ☐ 10

## Section F: Feelings about being on the Cashless Debit Card

**F1. How often do you feel this way about being on the Cashless Debit Card? (Answer all items)**

	All the time	Most of the time	Sometimes	Hardly ever	Never
I feel discriminated against	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being on the Cashless Debit Card is embarrassing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am more in control of my life since being on the Cashless Debit Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is not fair for me to be on the Cashless Debit Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Things are better for me and my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel I have more control over my money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safer on the Cashless Debit Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**F2. Since being on the Cashless Debit Card, how have the following things changed for you? (Answer all items)**

	Easier	About the same	Harder	Don't know
Managing your money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saving money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having enough money for food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having enough money to pay rent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowing how much money you have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking after family obligations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**F3. Do you want to...**

- Stay on the Cashless Debit Card as it is currently set up ☐
- Stay on the Cashless Debit Card but with less of your Centrelink payments going on the card ☐
- Get off the Cashless Debit Card ☐
- Don't know / Not sure ☐

**F4. Would you say that the Cashless Debit Card has made your life ...**

- A lot better ☐
- A bit better ☐
- No different ☐
- A bit worse ☐
- A lot worse ☐
- Don't know / Not sure ☐

## Section G: Feelings about the community you live in

**G1. How safe do you feel in the area where you live? (Answer all items)**

	Very Safe	Safe	Neither	Unsafe	Very unsafe	Don't know
On the streets where you live during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On the streets where you live during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At home during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At home at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**G2. Since the Cashless Debit Card was introduced, has the safety of the area where you live changed? (Answer all items)**

	A lot safer	Safer	Neither	Less Safe	A lot less safe	Don't know
On the streets where you live during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On the streets where you live during the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At home during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At home at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**G3. Since the Cashless Debit Card was introduced, have you noticed any changes for children in the area where you live? (Answer all items)**

	Healthier	About the same	Less healthy	Don't know
Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food	More food <input type="checkbox"/>	About the same <input type="checkbox"/>	Less food <input type="checkbox"/>	<input type="checkbox"/>
Safety	Safer <input type="checkbox"/>	About the same <input type="checkbox"/>	Less safe <input type="checkbox"/>	<input type="checkbox"/>
School	Going to school more <input type="checkbox"/>	About the same <input type="checkbox"/>	Going to school less <input type="checkbox"/>	<input type="checkbox"/>
Happiness	Happier <input type="checkbox"/>	About the same <input type="checkbox"/>	Less happy <input type="checkbox"/>	<input type="checkbox"/>
Cultural activities	More cultural activities <input type="checkbox"/>	About the same <input type="checkbox"/>	Less cultural activities <input type="checkbox"/>	<input type="checkbox"/>
Social activities	More social activities <input type="checkbox"/>	About the same <input type="checkbox"/>	Less social activities <input type="checkbox"/>	<input type="checkbox"/>


**G4.** For the items below, is the Cashless Debit Card making a difference for you, your family or friends, and the area where you live? *(Answer all items and all that apply)*

The Cashless Debit Card...	You	Your family	Your friends	Where you live	No change at all	Don't know
... helps decrease alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... helps decrease the use of illicit drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... helps with reducing gambling problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... improves money management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... improves the quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Section H: Further comments about the Cashless Debit Card

Please tell us if you have anything more to say about the Cashless Debit Card. You can write as much as you like. If you run out of space, please use page 17 or you can write more on a separate piece of paper and attach it to this questionnaire. Please remember that your views will be treated in total confidence like the whole of the survey. Thank you again.

**H1.** Overall, what do you think is good about the Cashless Debit Card?



H2. Overall, what do you think is bad about the Cashless Debit Card?



A large, empty rectangular box with a blue border, intended for handwritten responses to the question above.

Please turn over...

## Section I: Demographics

We need to ask you a few more questions to finish the survey. *Please answer the following.*

11. Do you identify as being Aboriginal or Torres Strait Islander origin?

- No ☐
- Yes, Aboriginal ☐
- Yes, Torres Strait Islander ☐
- Yes, both ☐
- Prefer not to say ☐

12. What town, suburb or community do you usually live in?  
(Where you have spent most of your time in the past 4 weeks).

Town, suburb or community:

In which state or territory?

- Western Australia ☐
  - South Australia ☐
  - Northern Territory ☐
  - Victoria ☐
  - Queensland ☐
  - Australia Capital Territory ☐
  - New South Wales ☐
  - Tasmania ☐

13. Do you get any of the following benefits or government payments? (Mark all that apply)

- |                                  |                          |
|----------------------------------|--------------------------|
| Austudy                          | <input type="checkbox"/> |
| ABSTUDY                          | <input type="checkbox"/> |
| Youth Allowance                  | <input type="checkbox"/> |
| Parenting Payment (Partnered)    | <input type="checkbox"/> |
| Parenting Payment (Single)       | <input type="checkbox"/> |
| Newstart Allowance               | <input type="checkbox"/> |
| Disability Support Pension       | <input type="checkbox"/> |
| Age Pension                      | <input type="checkbox"/> |
| Carer's Payment or Allowance     | <input type="checkbox"/> |
| Family Tax Benefit (FTB)         | <input type="checkbox"/> |
| Child Care Benefit (CCB)         | <input type="checkbox"/> |
| Veterans Payment                 | <input type="checkbox"/> |
| None of these                    | <input type="checkbox"/> |
| Don't know                       | <input type="checkbox"/> |
| Other (specify in the box below) | <input type="checkbox"/> |

## Data Linkage

We would like to ask your permission to link your survey answers with your Cashless Debit Card administrative records provided to us by the Department of Social Services (DSS).

Linking your survey answers to your administrative records will help the research team get a more accurate picture of how the Cashless Debit Card is going in the trial areas.

Personal details will be kept COMPLETELY confidential at all times.

If you give consent for your survey answers to be linked, only the research team will be able to match the survey answers to your administrative records. The research team must comply with strict ethical and confidentiality criteria:

- Administrative records will be used only for the purpose of this study in order to provide information that is not asked in the survey.
- All identifying information will be removed from participants' survey answers before they are released to the research team for statistical analysis or publication.
- At no time will any participants in this study be identifiable from their survey answers. Everything will be anonymised, that is, any names and identifiable information will be removed from your survey.

You can withdraw your consent to link your survey answers at any time. To do this call: 1800 519 672. Consent to the linking of survey answers ceases from the date of withdrawal.

If you require further information before consenting to linking your survey answers to your administrative records, please call: 1800 519 672.

**Do you consent to your survey answers being linked to your administrative records for the purpose of this study?**

Yes ☐

No ☐

**Thank you for taking part in the survey.**

**Information about claiming your \$50 voucher is on the following page.**

