THE UNIVERSITY of ADELAIDE

Review of the Impact of the Cessation of the Cashless Debit Card:

Final Report

Assoc. Prof. Megan Moskos, Dr Linda Isherwood, Assoc. Prof. Stéphane Mahuteau, Dr Laurence Lester and Dr Zhang Wei

May 2024

make history.

Acknowledgements

This review of the impacts of the ending of the Cashless Debit Card (CDC) program has been conducted by researchers at the University of Adelaide. The research was funded by the Australian Government Department of Social Services (DSS) and we thank them for their background support throughout the project.

The review team would like to acknowledge the many stakeholder representatives and past CDC participants in each of the four trial sites who contributed to this research. We are very thankful to them for giving us their time and for sharing their personal experiences of the ending of the CDC program. The review team would also like to thank the Western Australian government for their provision of policing and health data that was analysed for the review. We further thank the DSS for the administrative data outputs provided to inform the review.

The following people contributed to this research. Associate Professor Megan Moskos was Chief investigator of the review and had overall responsibility for the project. She also led the stakeholder engagement strategy and qualitative research components of the review. Dr Linda Isherwood contributed to the literature review, qualitative data analysis and reporting. Support with conducting the qualitative interviews and analysing transcripts was provided by Dr Kirsten Macaitis, Ms Deb Payne and Dr Helen Walton. Dr Macaitis also assisted with the literature review, and Ms Payne with administrative support for the project. Associate Professor Stéphane Mahuteau led the quantitative components of this review, also undertaking the administrative data analysis and reporting. Dr Laurence Lester and Dr Zhang Wei undertook the analysis and reporting of the community-level quantitative data.

Glossary

BHB	Bundaberg and Hervey Bay
Card	Cashless Debit Card
CDC	Cashless Debit Card
CDP	Community Development Program
CED	Ceduna and surrounding areas
CPIM	Child Protection Income Management
CYWR	Cape York Welfare Reform
DOMINO	Data Over Multiple Individual Occurrences
DSS	Department of Social Services
EDA	Emergency department attendance
eIM	Enhanced Income Management
EK	East Kimberley region
FRC	Family Responsibilities Commission
GF	Goldfields region
NIM	New Income Management
NTER	Northern Territory Emergency Response
PBIM	Place-Based Income Management
VIM	Voluntary Income Management
WA Health	Government of Western Australia Department of Health
WA Police	Western Australia Police Force

A note on the reporting of the qualitative findings

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

In the reporting, respondents are not identified either by their name and/or by their organisation. Instead, a prefix was used for the trial site of the interview ('BHB' for Bundaberg-Hervey Bay, 'CED' for Ceduna, 'EK' for East Kimberley, and 'GF' for Goldfields). A suffix follows which consists of the respondent type, i.e. 'SH' for a stakeholder interview and the prefix 'P' for a participant interview, and the number of the interview. This way the anonymity of all respondents is preserved, whilst allowing the reader to follow an individual's views throughout the whole report. For example, quotes attributed to BHBSH01 would refer to the first stakeholder interview conducted in Bundaberg-Hervey Bay. Similarly, quotes by CEDP02 would refer to the second CDC participant interview conducted in Ceduna.

Table of Contents

1. Executive Summary 1

1.1. Method 1

1.2. Findings 2

2. Background 6

2.1. Overview of the CDC program 6

2.2. Review of the impact of the cessation of the CDC program 7

3. Review Methodology 8

3.1. Stakeholder engagement 8

3.2. Literature review 9

3.3. Qualitative interviews 10

3.4. Analysis of secondary quantitative data 14

3.5. Integration and reporting 18

3.6. Limitations and challenges 18

4. Review Findings – CDC Transition Processes 21

4.1. Perceptions of CDC program cessation 22

4.2. Experiences of the CDC transition 25

4.3. Enhanced Income Management 34

5. Review Findings – Impacts of CDC Transition 39

5.1. Overall impacts of the ending of the CDC 41

5.2. Experiences of agency, autonomy and social inclusion 43

5.3. Financial management 44

5.4. Misuse of alcohol, illegal drugs and gambling 52

5.5. Health and wellbeing 56

5.6. Safety and violence 67

5.7. Support service usage 78

5.8. Transitional visitors 81

5.9. Tourism 82

5.10. Compounding factors 82

6. Review Findings – Beyond the CDC Program 86
6.1. Targeted income management 87
6.2. Broader measures 88
6.3. Support services 90
7. Summary 95
7.1. Impacts of the ending of the CDC program 95
7.2. Impacts for particular cohorts and regions 95
7.3. Outcomes for people exiting the CDC program 96
7.4. Outcomes for people transitioning to enhanced Income Management 97
7.5. Outcomes at the community level 97
7.6. Support services 97
7.7. Limitations and challenges 98
8. References 99
9. Appendices 100
A.1. Appendix 1: Key findings from the literature review 100
A.2. Appendix 2: Further detail on the qualitative methodology 108
A.3. Appendix 3: Further detail on the quantitative analysis methodology 112
A.4. Appendix 4: Additional findings from the Western Australian health data 122
A.5. Appendix 5: Additional findings from the Western Australian police data 137

Tables

Table 3.1: Profile of past CDC participants (N=155) 13
Table 3.2: Cohort sample size 15
Table 3.3: Community-level public data sources 16
Table 4.1: Characteristics of eIM participants 37
Table 5.1: Number of urgent payments per cohort1 50
Table 5.2: Total value of each type of urgent payment per cohort 50
Table 5.3: Average monthly EDAs by site since January 2022 60
Table 5.4: Mean monthly Mental Health EDAs by site and transition periods 63
Table 5.5: Mean monthly Drug and/or Alcohol EDAs by site and transition periods 64
Table 5.6: Mean monthly Alcohol Only EDAs by site and transition periods 65
Table 5.7: Mean monthly Drugs Only EDAs by site and transition periods 66
Table 5.8: Mean monthly Family Violence Offences by site and transition periods 70
Table 5.9: Mean monthly Breach of Violence Restraint Order Offences by site and transition periods 71
Table 5.10: Mean monthly Family Violence Tasks Attended by site and transition periods 72
Table 5.11 : Mean monthly Drug Offences by site and transition periods 73
Table 5.12: Mean monthly Drink Driving Charges by site and transition periods 73
Table 5.13: Mean monthly Assault Offences by site and transition periods 74
Table 5.14: Mean monthly Threatening Behaviour Offences by site and transition periods 75
Table 5.15: Mean monthly Property Damage/Graffiti Offences by site and transition periods 75
Table 5.16: Mean monthly Stealing Offences by site and transition periods 76
Table 5.17: Mean monthly Other Offences by site and transition periods 77
Table A.1: Previous commissioned research income management studies 103
Table A.2: Per cent of EDAs for trial and comparison sites since January 2014 115
Table A.3: EDAs by EDA category (sub-group) and site (2022) 116
Table A.4: Total number of offences recorded in WA Police data by category, trial vs. comparison 119

Figures

Figure 3.1	Stakeholder organisations by location	11
Figure 3.2	Stakeholder organisations by type	11
Figure 3.3:	Data integration and triangulation process.	18
Figure 4.1:	Participant transitions from the CDC program by location	26
Figure 5.1:	Number of crisis payments	48
Figure 5.2:	Number of people granted crisis payments	49
Figure 5.3:	Total amount of urgent payments by trial area and cohort	51
Figure A.1:	Mapping of the trial and control localities in the Kimberley	120
Figure A.2:	Mapping of the trial and control localities in the Goldfields	121
Figure A.3:	EDAs East Kimberley trial vs. comparison site by gender and Indigenous status from 2014	123
Figure A.4:	EDAs Goldfields trial vs. comparison site by gender and Indigenous status from 2014	123
Figure A.5:	EDAs East Kimberley trial vs. comparison site by gender and Indigenous status from 2022	124
Figure A.6:	EDAs Goldfields trial vs. comparison site by gender and Indigenous status from 2022	125
Figure A.7:	EDAs for Mental Health trial vs. comparison site from 2014	127
Figure A.8:	EDAs for Mental Health East Kimberley trial vs. comparison site from 2022	127
Figure A.9:	EDAs for Mental Health Goldfields trial vs. comparison site from 2022	129
Figure A.10:	EDAs for Alcohol and/or Drugs trial vs. comparison site from 2014	129
Figure A.11:	EDAs for Alcohol and/or Drugs East Kimberley trial vs. comparison site from 2022	130
Figure A.12:	EDAs for Alcohol and/or Drugs Goldfields trial vs. comparison site from 2022	131
Figure A.13:	EDAs for Alcohol only trial vs. comparison site from 2014	132
Figure A.14:	EDAs for Alcohol only East Kimberley trial vs. comparison site from 2022	132
Figure A.15:	EDAs for Alcohol only Goldfields trial vs. comparison site from 2022	133
Figure A.16:	EDAs for Drugs trial vs. comparison site from 2014	134
Figure A.17:	EDAs for Drugs only East Kimberley trial vs. comparison site from 2022	135
Figure A.18:	EDAs for Drugs only Goldfields trial vs. comparison site from 2022	136
Figure A.19:	Family violence offences since 2014 - East Kimberley trial vs. comparison	137
Figure A.20:	Family violence offences since 2014 - Goldfields trial vs. comparison	137
Figure A.21:	Family violence offences since 2022 - East Kimberley trial vs. comparison	138
Figure A.22:	Family violence offences since 2022 - Goldfields trial vs. comparison	138
Figure A.23:	Breach of violence restraint order offences since 2014 - East Kimberley trial vs. comparison	139
Figure A.25:	Breach of violence restraint order offences since 2022 - East Kimberley trial vs. comparison	140
Figure A.26:	Breach of violence restraint order offences since 2022 - Goldfields trial vs. comparison	140
Figure A.27:	Family violence tasks attended since 2014 - East Kimberley trial vs. comparison	141
Figure A.28:	Family violence tasks attended since 2014 - Goldfields trial vs. comparison	141
Figure A.29:	Family violence tasks attended since 2022 - East Kimberley trial vs. comparison	142
Figure A.30:	Family violence tasks attended since 2022 - Goldfields trial vs. comparison	142
Figure A.31:	Drug offences since 2014 - East Kimberley trial vs. comparison	143
Figure A.32:	Drug offences since 2014 - Goldfields trial vs. comparison	143
Figure A.33:	Drug offences since 2022 - East Kimberley trial vs. comparison	144

Figure A.34: Drug offences since 2022 - Goldfields trial vs. comparison 144
Figure A.35: Drink driving charges since 2014 - East Kimberley trial vs. comparison 145
Figure A.36: Drink driving charges since 2014 - Goldfields trial vs. comparison 145
Figure A.37: Drink driving charges since 2022 - East Kimberley trial vs. comparison 146
Figure A.38: Drink driving charges since 2022 - Goldfields trial vs. comparison 146
Figure A.39: Assault offences since 2014 - East Kimberley trial vs. comparison 147
Figure A.40: Assault offence rate since 2014 - Goldfields trial vs. comparison 147
Figure A.41: Assault offences since 2022 - East Kimberley trial vs. comparison 148
Figure A.42: Assault offences since 2022 - Goldfields trial vs. comparison 148
Figure A.43: Threatening behaviour offences since 2014 - East Kimberley trial vs. comparison 149
Figure A.44: Threatening behaviour offences since 2014 - Goldfields trial vs. comparison 149
Figure A.45: Threatening behaviour offences since 2022 - East Kimberley trial vs. comparison 150
Figure A.46: Threatening behaviour offences since 2022 - Goldfields trial vs. comparison 150
Figure A.47: Property damage/graffiti offences since 2014 - East Kimberley trial vs. comparison 151
Figure A.48: Property damage/graffiti offences since 2014 - Goldfields trial vs. comparison 151
Figure A.49: Property damage/graffiti offences since 2022 - East Kimberley trial vs. comparison 152
Figure A.50: Property damage/graffiti offences since 2022 - Goldfields trial vs. comparison 152
Figure A.51: Stealing offences since 2014 - East Kimberley trial vs. comparison 153
Figure A.52: Stealing offences since 2014 - Goldfields trial vs. comparison 153
Figure A.53: Stealing offences since 2022 - East Kimberley trial vs. comparison 154
Figure A.54: Stealing offences since 2022 - Goldfields trial vs. comparison 154
Figure A.55: Other offences since 2014 - East Kimberley trial vs. comparison 155
Figure A.56: Other offences since 2014 - Goldfields trial vs. comparison 155
Figure A.57: Other offences since 2022 - East Kimberley trial vs. comparison 156
Figure A.58: Other offences since 2022 - Goldfields trial vs. comparison 156

1. Executive Summary

This review provides evidence about the impacts and outcomes of the cessation of the Cashless Debit Card (CDC) in the first four trial areas in which it was rolled out: Ceduna and surrounds in South Australia, East Kimberley and the Goldfields in Western Australia and Bundaberg and Hervey Bay in Queensland. The review was conducted by a University of Adelaide multidisciplinary team, primarily from the disciplines of Sociology and Economics, who specialise in mixed-methods and multi-disciplinary policy review. The review was funded by the Australian Government Department of Social Services (DSS).

This report presents the consolidated key findings from the review and is divided into seven main chapters. Chapter 1 is the Executive Summary. Chapters 2 to 3 provide the policy introduction and discussion of the methodology used to conduct the review. Chapters 4 to 6 explore the findings of the transition and outcomes of the cessation of the CDC program, as reported by past CDC participants and stakeholders in qualitative in-depth interviews. This qualitative data is supplemented where possible with an analysis of administrative and community-level data. Chapter 7 provides brings together the findings of the whole review.

1.1. Method

The purpose of this review was to create a rigorous evidence base that would be used to assess the impact and outcomes of the cessation of the CDC program and also inform future policy and program development. The review team was tasked with generating this evidence base and providing the necessary analysis and interpretation. The policy implications arising from the review, and any subsequent recommendations, are left for the consideration of the reader.

The review was designed to answer six key questions set by the DSS to assess the overall impact of the cessation of the CDC program. To do this, the review generated new qualitative data and undertook an analysis of existing administrative and community-level data to examine several aspects of the cessation of the CDC, including transition process and impacts. The majority of the evidence from which the review draws is qualitative data generated from 290 in-depth interviews undertaken with key stakeholders and past CDC participants in 2023 across the four trial areas[1]. Where possible this has been integrated and triangulated with the findings arising from the analysis of existing administrative and community-level data. In itself, the quantitative data available to the review has little power to demonstrate the impact of the cessation of the CDC. Its main use was to provide context and corroborative elements to the qualitative analysis which relied on first-hand accounts of a large array of people living in the trial areas. Further components of the review included a stakeholder engagement strategy and a literature review.

[1] In the reporting of the qualitative interview findings, please note that 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 small minority of respondents expressed an opinion.

The review of the ending of the CDC program is not an evaluation in the stricter meaning of the word. The data requirements to conduct a formal evaluation are much stronger and the cost significantly higher than set for the current review. Consequently, while the review assessed the impacts and outcomes of the cessation of the CDC, no causal statements can be issued from the analyses.

Several further factors limited the review's ability to directly attribute observed impacts to the cessation of the CDC program alone. These included: concurrent policies that were in place within the research locations; socio-economic conditions present at the time of the review; the review timeframe which meant that only shorter-term outcomes could be observed; the scope of the review which prevented a quantitative survey from being undertaken or comparison sites to be included; the ability to accurately capture activities that may be subject to strong reporting biases; and limitations inherent in the community-level data. Finally, the generalisability of the review findings faces limitations due to methodological reasons, locational differences and the broader policy environment. Consequently, the review findings presented in this report must be read with these limitations in mind.

1.2. Findings

1.2.1. CDC Transition

The cessation of a policy, and the transition process implemented to enact this change, has the potential to influence outcomes (at a personal and/or community-level) either directly or indirectly. The review explored elements of the CDC program transition which were perceived to have worked well and also the challenges experienced.

Views about the cessation of the CDC:

A majority of past CDC participants and a minority of stakeholders (particularly those located in Bundaberg-Hervey Bay) felt that the ending of the program was a positive step that reduced perceived discrimination and stigmatisation and provided an opportunity to implement more effective policies and programs. In contrast, a majority of stakeholders and a small number of past CDC participants informing the review were disappointed that the program had ended as they considered that it had generated positive impacts and were concerned about increasing social issues being experienced since program cessation.

Dissatisfaction was widely expressed about the level of consultation that had occurred regarding the cessation of the CDC program. Many respondents were also critical of the speed of the transition and felt that insufficient time had been allowed to prepare for the ending of the program.

Experience of the transition:

Both the qualitative and quantitative data indicated that participant exits from the CDC program had occurred quickly. The qualitative interviews provided additional evidence regarding the transition process, with mixed perspectives as to how well this process had been achieved. While some respondents (mostly past CDC participants) felt that the transition had been fairly smooth, challenges

were noted including the speed of the transition, a lack of accessible information and insufficient supports to assist people transitioning from income management. Particular challenges were reported for people without access to technology, with limited literacy skills and who did not have English as a first language.

Brokerage support and Local Service Plans:

Stakeholders were mostly dissatisfied with the level of wraparound services that were in place to support the transition from the CDC program. Stakeholder perspectives were mixed regarding processes for the development and content of Local Services Plans, with concerns expressed regarding the level of consultation, and actionability of the resulting Plan.

Enhanced Income Management (eIM):

Both the qualitative and quantitative evidence indicated that only a small number of past CDC participants had opted onto eIM, and that these tended to be females and older participants. The uptake of eIM was considered to have been constrained due to several factors including a lack of information, complicated transition processes, and family pressure to exit income management.

The qualitative interviews suggested that some past CDC participants were considering transitioning onto eIM in the future in order to assist with financial management. Given the small numbers who had opted onto the program, the review found only limited qualitative evidence of the experiences of eIM.

1.2.2. Impacts of CDC program cessation

The review sought to identify whether the ending of the CDC program had resulted in any impacts – either positive or negative – within the four trial sites. Respondents in the qualitative interviews also suggested potential measures that could be implemented in their regions now that the CDC program had ended.

Trial site differences and compounding factors:

Qualitative interview respondents within the Ceduna, East Kimberley and Goldfields regions were far more likely than those in Bundaberg-Hervey Bay to report that impacts had occurred with the ending of the CDC program. However, several other relevant social and economic conditions and policy changes were identified as being present in each of the regions such as housing and cost-of-living pressures, traditional population movement, the ending of Community Development Program (CDP) mutual obligations, alcohol restrictions and mining royalty payments. These factors were seen to be combining with the cessation of the CDC to compound observed impacts and make it more challenging to clearly identify the specific impacts of the ending of the program.

Positive vs negative impacts:

Perceived impacts of CDC cessation were mostly negative and centred around financial management, alcohol and gambling misuse, child wellbeing and welfare, and safety and violence. However, the review found some evidence that the ending of the CDC program had brought positive change at an individual-level for past CDC participants. In particular, the cessation of compulsory income management was widely felt to have reduced feelings of discrimination and increased personal agency.

Agency, autonomy and social inclusion:

The ending of the CDC program was widely observed in the qualitative data to have decreased feelings of discrimination, stigma and shame and given people more control and freedom over their finances. However, respondents often cautioned that at times this greater freedom over money had resulted in poor decision-making.

Financial management:

Many respondents reported that the ending of compulsory income management had negatively impacted financial management, especially around spending behaviour and budgeting. Some respondents also felt that instances of humbug and financial coercion had increased since the cessation of the CDC program. In contrast, some past CDC participants welcomed now having just one bank account and greater access to cash which was considered to make budgeting and the payment of bills easier. An analysis of DOMINO data indicated that requests for Centrelink urgent payments, alongside the total value of these payments, had increased following CDC cessation. However, this latter trend was not consistent across all locations (increasing only in Bundaberg-Hervey Bay, East Kimberley and the Goldfields) and it is unclear whether the observed changes in urgent payments can be specifically attributed to the ending of the CDC program.

Alcohol, illicit drug and gambling misuse:

The qualitative evidence suggested that alcohol consumption and misuse increased considerably in Ceduna, East Kimberley and the Goldfields following CDC program cessation. The incidence of public drinking and intoxication was also perceived to have risen, along with the consumption of higher alcohol products and rates of alcohol-related violence. Gambling activity was reported to have increased in Ceduna and the East Kimberley. In contrast, the review found little evidence of a change in levels of illegal drug use in any of the four locations.

Health and wellbeing:

Concerns were raised in Ceduna, East Kimberley and the Goldfields of declining levels of child wellbeing and welfare following CDC program cessation, e.g. some children not being fed or clothed properly, not attending school and being out on the streets unsupervised at night. In Ceduna and the East Kimberley the wellbeing of some past CDC participants was also felt to have declined. An analysis of emergency department admissions (EDAs) in the East Kimberley and Goldfields found some evidence of increased EDA rates since CDC program cessation. However it is difficult to know how much (or if any) was specifically due to the change in the CDC policy.

Safety and violence:

Stakeholders in Ceduna, East Kimberley and the Goldfields were more likely than past participants to report increased criminal activity and worsening perceptions of community safety since the ending of the CDC program. While some change was observed in individual measures, overall, an analysis of WA Police data suggested that little substantial change had occurred in policing outcomes for either the East Kimberley or Goldfields trial sites.

Support service usage:

Increased support service need and use was reported by interview respondents in the period since the ending of the CDC program in all four regions. In particular, demand for emergency relief services had risen significantly, while greater demand was also observed across a broad range of support services in Ceduna and the East Kimberley. Respondents were divided, however, as to whether this increased demand was directly related to the cessation of the CDC program or if other factors (such as cost of living and housing pressures) were also contributing.

Perceptions about the future:

Some respondents recommended that targeted income management should be put in place following the ending of the CDC program. However, additional measures were considered to be needed in order to properly address the complex social issues facing past-CDC regions. This included the need for multi-faceted long-term policies and services that adopted an educational and empowerment approach. Respondents also suggested that future policy efforts needed to focus on the adequate funding and provision of support and other essential services.

2. Background

2.1. Overview of the CDC program

The Cashless Debit Card (CDC) was introduced in multiple locations across Australia from 2016. By limiting access to cash and restricting the use of income support payments to purchase alcohol or gambling products, the CDC program aimed to reduce levels of social harm. The development and implementation of the CDC program was undertaken in close collaboration with local community and Indigenous leaders, and local and state government agencies. The roll-out of the CDC was supported by additional funding for wraparound support services[2].

The CDC program operated in six locations across Australia. Commencing in two initial locations – Ceduna and surrounding areas in South Australia (March 2016) and the East Kimberley region in Western Australia (April 2016) – the CDC program later expanded into the Goldfields region of Western Australia (March 2018) and the Bundaberg and Hervey Bay region in Queensland (January 2019). Eligible welfare recipients in the Cape York and Doomadgee regions of Queensland and across the Northern Territory joined the CDC program in March 2021.

Two impact evaluations of the CDC program have been conducted: the first by Orima Research (covering Ceduna and East Kimberley) and the second by the University of Adelaide (encompassing Ceduna, East Kimberley and the Goldfields). These evaluations found mixed evidence of the effectiveness of the CDC program on participant and community-level outcomes. Likewise, the 2022 Australian National Audit Office report on the implementation and performance of the CDC program highlighted that there was inconclusive evidence as to the impacts of compulsory income management.

In July 2022, the Social Security (Administration) Amendment (Repeal of Cashless Debit Card and Other Measures) Bill 2022 was introduced to abolish the CDC. The Senate referred this Bill to the Community Affairs Legislation Committee for inquiry and report. Legislation to end the CDC program was passed by the House of Representatives and the Senate in September 2022.

From 1 October 2022, CDC participants in Bundaberg and Hervey Bay, Ceduna, East Kimberley and the Goldfields have been able to choose to exit the CDC program or volunteer to move onto enhanced Income Management (eIM).

[2] The wraparound services that were funded as part of the CDC program differed between trial sites but included services such as financial counselling, drug and alcohol support, and employment services.

2.2. Review of the impact of the cessation of the CDC program

2.2.1. Purpose of review

The DSS commissioned the University of Adelaide to review the impact of the cessation of the CDC program. The purpose of the review was to develop sound, rigorous evidence-based information and knowledge to support departmental work by:

- Developing evidence to identify the impacts of the CDC program cessation; and
- Developing an evidence base that may be used to inform future policy and program development.

2.2.2. Key review questions

The review of the ending of the CDC program was designed to provide evidence to answer six key questions (and additional sub-questions) set by DSS:

1. What impacts has the CDC program ending had?
    - *Have there been any impacts on financial management?*
    - *Have there been any impacts on experiences of agency, autonomy or social inclusion?*
    - *Have there been any impacts on misuse of alcohol, illegal drugs or gambling?*
    - *Have there been any impacts on wellbeing?*
    - *Have there been any impacts on safety or violence?*
2. Have impacts been experienced by particular cohorts or regions?
3. What kinds of outcomes have there been for people who have exited the CDC program (before, during and after the program ending)?
4. What kinds of outcomes have there been for people who have volunteered to continue on the CDC and transition to income management (before, during and after the program ending)?
5. What kinds of outcomes have there been at the community level in CDC regions (before, during and after the program ending)?
6. How were support services used during and after the CDC program ending?
    - *What kinds of circumstances or needs did people using support services have?*
    - *Did service use or service needs change during or after the CDC program ending?*
    - *Were there any barriers experienced to accessing support services?*

2.2.3. Scope of review

The focus of the review was on the four trial sites where the transition from the CDC program began in October 2022, i.e. Bundaberg and Hervey Bay, Ceduna, East Kimberley and the Goldfields region. Due to different arrangements regarding the cessation of the CDC, the remaining two CDC program locations – the Cape York and Doomadgee region, and the Northern Territory – were outside the scope of this review.

3. Review Methodology

The review methodology allowed for a focused analysis of the impacts of the CDC transition. Specifically, it provided an in-depth analysis of trends and outcomes at the individual and community level and elicited perceptions of CDC program transition processes and potential policies and programs that could be implemented in its place.

The review utilised a mixed methods approach comprised of five key components:

1. Stakeholder engagement strategy;
2. Literature review;
3. Qualitative interviews;
4. Quantitative data analysis; and
5. Data integration and reporting.

3.1. Stakeholder engagement

Acknowledging the need for a culturally appropriate, respectful, inclusive and participatory approach, the review methodology was centred on an intensive stakeholder engagement strategy.

Given the high proportion of Indigenous people who were subject to the CDC program, this stakeholder engagement strategy was founded on best-practice principles for engaging with and embedding Indigenous perspectives in research, policy and practice (see Moskos and Isherwood, 2022). The stakeholder engagement strategy supported the design of a robust and integrated evidence framework, i.e. from qualitative and quantitative sources.

The stakeholder engagement strategy had multiple purposes and sought to:

- Elicit the views of relevant stakeholders and ensure that those views informed the research process;
- Inform the development of key measures to ascertain the impacts of the CDC transition;
- Ensure that the review methodology was of local relevance; and
- Enlist the support of stakeholders to assist the research by sourcing respondents and/or relevant data.

Extensive engagement with key stakeholders within each of the four research locations occurred from the onset of the project. Liaison with these stakeholders ensured that all research activities were culturally appropriate and responsive to the particular needs of the communities that the research team sought to engage. This engagement included processes to identify, and obtain, any permissions that were required in order to enable access to Indigenous communities where the research was to be conducted. The engagement work also sought input to ensure that the review had meaningful involvement from key stakeholders in each region. Hence, through the stakeholder engagement strategy understanding was gained of how the research should be locally placed and include measurement of impacts that were locally important.

Initial stakeholder engagement involved a visit to each of the four primary research locations (Bundaberg-Hervey Bay, Ceduna, East Kimberley and Goldfields) to meet with a broad range of stakeholders. During these engagement meetings, the project was introduced, stakeholders were consulted about key measures and data requirements, interview recruitment processes were initiated, and local and cultural research approval processes were identified and met.

Stakeholder engagement was not confined to the commencement of the review process; indeed active stakeholder engagement occurred throughout the project. This strategy allowed for regular and measured feedback between stakeholders and researchers to ensure that (a) the views of stakeholders were continually sought to inform the research process and content, and (b) stakeholders were informed about research implementation. Therefore, the stakeholder engagement strategy included an information feedback loop that engaged and added voice to key stakeholders throughout the course of the project. At the conclusion of the project, the findings from the review will be presented to local stakeholders in each site.

3.2. Literature review

Providing a comprehensive overview of income management in Australia, the literature review aimed to embed and contextualise the findings arising from the overall review of the cessation of the CDC program. The literature review focused on four key areas:

1. An overview of income management in Australia;
2. The impacts of income management (including the challenges of measuring these impacts);
3. The differential impacts for voluntary and compulsory income management; and
4. Gaps in knowledge and areas for future research.

Databases including Informit, Scopus, ProQuest and Google Scholar were reviewed to identify relevant scholarly and grey literature. Studies were included if they met the following criteria:

1. Reported on primary research with a specific focus on income management;
2. Were formal evaluations or reviews of income management schemes;
3. Were published in the year 2007 or later (i.e. the start of income management in Australia); and
4. Reported on findings from an Australian research context.

A total of 13 studies were found to meet the inclusion criteria for the literature review with their findings presented in a report format. The methods used in these studies included: surveys; qualitative interviews, focus groups and workshops; participant observation; quantitative data analysis (using national, community and administrative data); and case file and report analysis.

A separate report outlining the full findings of the Literature Review was presented to the DSS in October 2023. The key findings from this review are outlined in Appendix 1.

3.3. Qualitative interviews

The review principally utilised qualitative interviews (with stakeholders and past CDC participants) to generate new primary data.

The CDC program was implemented in areas with relatively high populations of Indigenous people and, therefore, this cohort was a focus of the review. Qualitative and face-to-face interview methodologies relate to oral traditions of storytelling in Indigenous culture allowing research to connect with Indigenous knowledge within an Indigenous paradigm. These research methodologies also enable greater control over disclosure for respondents and restructure traditional research power dynamics by shifting control to the respondent. Qualitative research methods are therefore important in ensuring the cultural safety of respondents and formed the basis of the primary data collection that was carried out for this research. These interviews provided new and rich data about individual and community perspectives on the impacts and outcomes of CDC cessation.

All respondents in this research (including Indigenous respondents) were viewed as being the expert on their personal experiences of the ending of the CDC program. The review team were respectful of diverse perspectives and careful that, to the best of our ability, the voice of the respondent was captured without interpreting that through our own biases. In doing so, Aboriginal and Torres Strait Islander people's knowledge and wisdom are recognised and valued.

Ethical approval for the interviews (and the broader review) was obtained from the University of Adelaide’s Human Research Ethics Committee (Ethics Approval Number: H-2023-037).

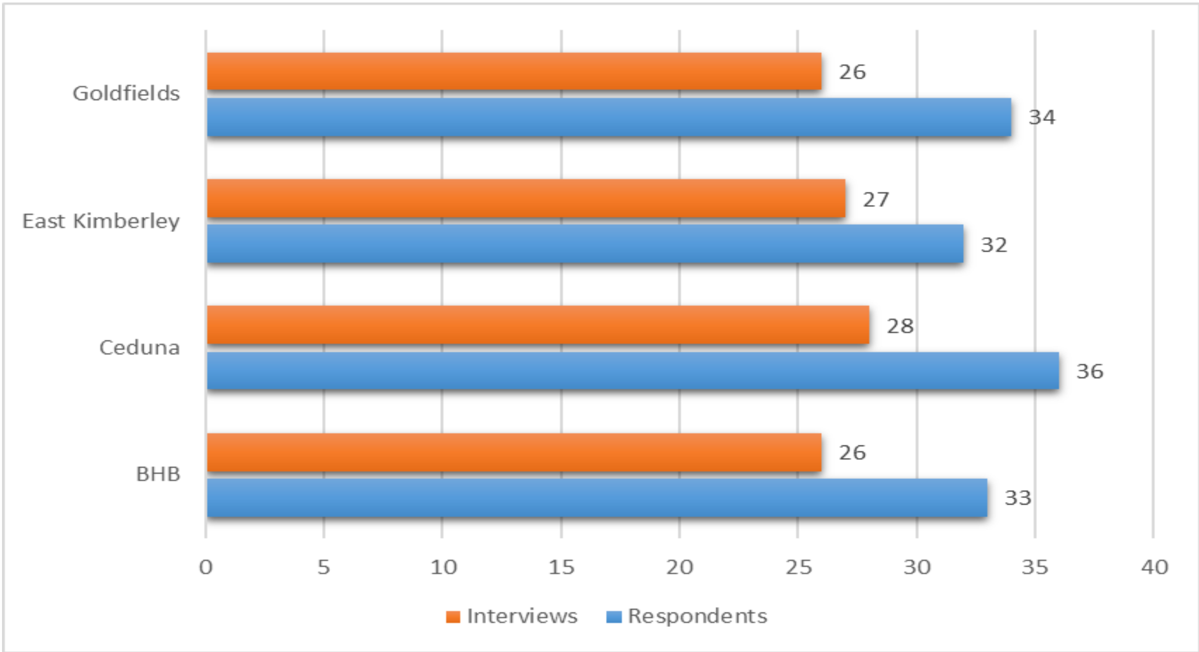
Across the four CDC trial sites, qualitative interviews were conducted with 290 stakeholders and past CDC participants. Further detail on these interviews is provided below and in Appendix 2.

3.3.1. Interviews with stakeholders

In total, 107 semi-structured interviews were undertaken with 135 representatives from various stakeholder organisations operating in the four CDC trial locations. Stakeholders included: representatives from service providers and agencies that work with or represent people previously subject to the CDC program; Indigenous leaders; merchants; and representatives from police, child protection, education, health and Indigenous organisations.

Figure 3.1 shows the spread of the stakeholder organisations who informed the review, by location. Twenty-eight semi-structured interviews were conducted with 36 representatives from various stakeholder organisations operating in the Ceduna and surrounding region. Twenty-seven interviews were conducted with 32 stakeholder representatives in the East Kimberley region, 26 interviews with 34 representatives in the Goldfields region and 26 interviews with 33 representatives in the Bundaberg and Hervey Bay region.

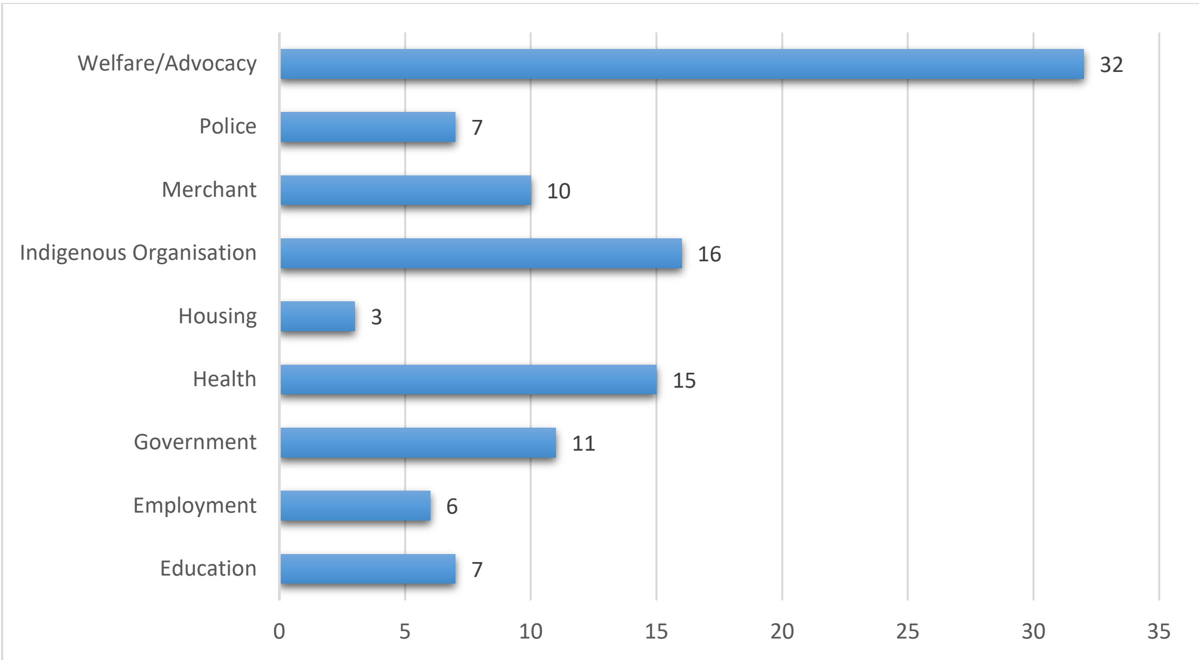
Figure 3.1 Stakeholder organisations by location



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

Figure 3.2 shows the spread of stakeholder organisations who participated in the interviews by service type, across the four trial sites. The stakeholder organisations included welfare and advocacy organisations (N=32); federal, state and local government organisations (N=11); Indigenous-run organisations (N=16); merchants (N=10); police (N=7); employment services (N=6); and the education, housing and health sectors (N=25).

Figure 3.2 Stakeholder organisations by type



3.3.2. Interviews with CDC participants

In-depth semi-structured interviews were also conducted with 155 past CDC participants across the four CDC sites. An overview of the profile of the CDC participants who participated in the qualitative interviews is provided in Table 3.1 below.

Interviews were conducted with 36 past CDC participants in Bundaberg and Hervey Bay, 38 in the East Kimberley, 39 in Ceduna and surrounding region, and 42 in the Goldfields region. An overwhelming majority (76 per cent) of participant interviewees identified as being Indigenous, with 29 per cent being male and 71 per cent female. Respondents were mostly aged 25-39 years (39.3 per cent) and 40-59 years (28.5 per cent). Forty three percent of respondents reported that they received Jobseeker Payment, while around 14 per cent received the Disability Support Pension. Approximately 23 per cent of respondents received Parenting Payment (Partnered or Single).

In the main, recruitment of past CDC participant respondents occurred via stakeholder organisations. A flyer advertising the opportunity to inform the review 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 was therefore somewhat skewed towards those past CDC participants who were engaged with services. However, the opportunity to participate in the review 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 review if they wished.

Table 3.1: Profile of past CDC participants (N=155)

Attribute	Number	Per cent
Location		
Bundaberg and Hervey Bay	36	23.2
Ceduna and Surrounds	39	25.2
East Kimberley	38	24.5
Goldfields	42	27.1
Gender		
Male	45	29.0
Female	110	71.0
Identified as Indigenous		
Yes	118	76.1
No	37	23.9
Age (in categories)		
<24	12	7.7
25-39	61	39.3
40-59	44	28.5
60-69	9	5.8
Not asked	26	16.8
Prefer not to say	3	1.9
Income Support Payment type		
Disability Support Pension	21	13.5
Job Seeker Payment	67	43.2
Parenting Payment	36	23.2
Youth Allowance	8	5.2
Not asked	20	12.9
Other	3	1.9

Note: Not all category percentages total 100 due to rounding.

3.3.3. Reporting of the qualitative findings

In the reporting, respondents are not identified either by their name and/or by their organisation. Instead, a prefix was used for the trial site of the interview ('BHB' for Bundaberg and Hervey Bay, 'CED' for Ceduna, 'EK' for East Kimberley, and 'GF' for Goldfields). A suffix follows which consists of the respondent type, i.e. 'SH' for a stakeholder interview and the prefix 'P' for a past CDC participant interview, and the number of the interview. This way the anonymity of all respondents was preserved, whilst allowing the reader to follow an individual's views throughout the whole report. For example, quotes attributed to BHBSH01 would refer to the first stakeholder interview conducted in Bundaberg-Hervey Bay. Similarly, quotes by CEDP02 would refer to the second CDC participant interview conducted in Ceduna.

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

In the following reporting of the qualitative interview findings, please note that 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 small minority of respondents expressed an opinion.

3.4. Analysis of secondary quantitative data

The quantitative methodology investigated both individual and community outcomes through the:

1. Analysis of aggregated DOMINO administrative data provided by DSS; and
2. Analysis of community data collected at state level.

A brief overview of the quantitative methodology is presented below, with further detail provided in Appendix 3.

3.4.1. DOMINO data

Data Over Multiple Individual Occurrences (DOMINO) is an integrated database of the DSS’s administrative analytical datasets. Prior to the review, the DSS had already undertaken a large amount of internal analysis on the DOMINO data. As part of the review process, the DSS provided the research team with relevant aggregated outputs that were used to inform the review. The review team was unable to directly access unit record data that was previously made available to the University of Adelaide (UoA) for the second impact evaluation of the CDC program. As the DOMINO outputs utilised for the review were provided by the DSS, the accuracy of this data was unable to be independently verified by the UoA. Also, the aggregated nature of the data prevented the use of a multivariate analysis approach as variables were lacking to use as controls. As a result, a descriptive analysis of the administrative data was undertaken with all the caveats this implies in terms of being unable to make causal statements.

The DOMINO data was used to examine the following outcomes:

- Exits from the CDC program;
- Uptake of eIM;
- Applications for crisis payments; and
- Applications for urgent payments.

These outcomes were compared over time across three cohorts of individuals (each across a 22 week window of observation to be as comparable as possible)[3]. The first cohort included all active CDC participants taken 22 weeks prior to 1 October 2022 (the date when the CDC was no longer compulsory)[4]. The second cohort included all government payment recipients within the four CDC trial areas taken on 1 October 2022 and followed for 22 weeks. The third cohort included all government payment recipients taken on 6 March 2023 (the date when the CDC program formally ended) and followed for another 22 weeks.[5] Table 3.2 provides detail of the number of individuals included in each cohort.

Table 3.2: Cohort sample size

Cohort	Number
Cohort 1	9,764
Cohort 2	10,693
Cohort 3	10,774

For each cohort, the above listed outcomes were examined by subgroups defined by demographic characteristics (i.e. location, Indigenous status, gender, age category and combinations of these characteristics). The analyses determined whether those outcomes were significantly different across cohort, suggesting either aggregate improvement or worsening of the outcome. While the comparison across cohorts was informative and provided context to the broader analysis, notably the qualitative investigation, observed differences of outcomes across cohorts cannot be directly attributed to the cessation of the CDC because the local and macro conditions may have changed over time and impacted on individuals' outcomes independently from the effect of the policy change. Such analysis would have required not only access to individual data but also the ability to access information from 'comparison' cohorts (i.e. from outside the trial sites) followed over 22 weeks concurrently to the cohorts described above. Unfortunately this was out of the scope of the review.

3.4.2. Community-level data collected at state and local level

Community-level data can provide important context when considering the effects of a policy, including its implementation and cessation. However, state and local-level data can be limited in its capacity to be utilised to produce formal impact estimations. The second impact evaluation of the CDC program (Mahuteau and Wei, 2021) identified five criteria that should be met to enable community-level data to be used to review the impact of a policy change:

a) Data granularity – the data must offer sufficient granularity to be able to identify change, e.g. be available at a 'suburb' rather than 'postcode' level;

b) Data availability outside the CDC program areas – data should be available for comparable non-CDC program locations to allow specific impacts to be identified;

c) Data availability across a sufficient timespan – available data should be of a sufficient duration to enable consideration of short-, mid- and long-term outcomes;

---

[3] Appendix 3 provides further details on the cohort methodology.

[4] Cohort 1 excludes those in the Northern Territory and the Cape York and Doomadgee region and also those recorded as out of area (as Cohorts 2 and 3 do not include this latter group).

[5] By definition, there are some individuals who are present in all three cohorts if they have remained on government payments at the crucial date of the start of each cohort. Some are present only in one cohort and others are present in two. Since the data was compiled by the DSS and provided to the review team in aggregated form the specific cases of those who are present in several cohorts could not be looked at.

d) Data collection frequency – the data should be available on at least a quarterly basis to ensure that there are sufficient observations over time;

e) Broad data coverage – given the existence of additional policies that seek to address social harm (beyond the CDC program), it is important that the coverage of the community-level data is as broad as possible.

As a first step relevant data was sourced that was publicly available at a state-level (i.e. for Queensland, South Australia and Western Australia) and could potentially be used for the review. This community-level data related to emergency department attendances, crime, domestic and family violence, school attendance, alcohol sales and gaming machines in hotels (see Table 3.3 below). This data was then assessed to ascertain its suitability to inform the review, finding that that the public data failed to meet the criteria outlined above that would be necessary to review the impact of the cessation of the CDC program and make actual causal statements. In particular, the data was often not recent enough, nor collected at an appropriate level of frequency or granularity.

Table 3.3: Community-level public data sources

	Queensland	South Australia	Western Australia
Hospital department attendances	Emergency department – monthly data for individual hospitals on ED attendances and patient triage categories (to August 2023)	No current data – latest record was 2015-16 and contained only a few hospitals (not Ceduna)	Emergency department daily report – information from all hospitals for the last 7 days
Crime	Monthly offences rate by type of crime – available at a division level (to July 2023)	Daily crime statistics by type of crime – available at a suburb level (to July 2023)	Monthly crime statistics by type of crime – available at a police district level
Domestic and family violence	Queensland Courts' domestic and family violence statistics – available for each financial year	Quarterly family and domestic abuse related –offences available at a postcode level	Monthly crime statistics include offence types of (family) assault and threatening behaviour – available at a police district level
School attendance	Website link for school attendance rates did not contain any data	Annual attendance rate for each public school by suburb and postcode (available for 2014 – 2022)	Annual attendance rate for each public school by school name (available for 2020 – 2022)
Alcohol sales	Office of Regulatory Policy collects data, but this was not publicly available	Not available	Not available
Gaming machines in hotels	Monthly data at LGA level (to June 2023)	Financial year data at the grouped LGA level (available only up to 2011-2012)	Not available

Additional community-level police and health data from Western Australia were made directly available to the team for analysis[6]. From this data, a number of community-level outcomes for the East Kimberley and Goldfields sites were analysed and monitored including:

- Police offence rates;
- Police family violence offence rates; and
- Emergency department attendances (EDAs).

This data was found to be more suitable to inform the review than the public data, e.g. as the information was available across the timeframe being considered by the review, at an appropriate level of granularity and was also available for comparison locations.
In order to elicit whether any changes in outcomes may be related to CDC program cessation, outcomes were compared for the East Kimberley and Goldfields CDC trial site locations with 'comparison sites'; the methodology for the construction of the comparison sites is described further in Appendix 3. Given the relatively recent timing of the ending of the CDC program (i.e. from 1 October 2022), a formal impact estimation could not be carried out, and thus, the analyses conducted were descriptive in nature.

Caveats are required in relation to the descriptive analysis of the community data used in this report. For example, in the EDA data, the only individual characteristics available in the data were gender and Indigenous status. Any analysis aimed at establishing – or at least implying – causality requires a much larger suite of individual characteristics (e.g. age group, prior and current mental and physical health status, income, labour market status, marital status, and, even better, indication of whether individuals are or were CDC participants). In a similar vein, specific cultural, social, micro- and macro-economic factors impacting on the populations in the trial and comparison sites influence outcomes associated with the cessation of the CDC program. This information was largely missing from the EDA data. For the police data these issues are equally important, but information on individual characteristics (other than site) was also missing from this data.

The data for both EDAs and the police was found to be very volatile on a monthly basis (e.g. in the police data, in more than one case there was a four-fold increase in offences one month, followed by an equal fall the next). One outcome is that mean values across several months may be subject to unusual and arbitrary variations. Consequently, it is possible that any observed association present from the community-level data, relating to both EDAs and the police, was not causal but subject to missing variable bias and, hence, much of the apparent association is spurious.

When examining individual hospital and policing outcomes two measures were taken into account: (1) the absolute rate – and change over time – of the various EDA types or police related offences, and, (2) the relative rate comparing trial and comparison sites.[7]

The discussion relating to the descriptive analysis of those occurrences across trial and comparison sites over time attempts to balance the interpretation of these two measures. Yet, the time dimension can be considered as being more indicative.

[6] Similar data was not available for Queensland or South Australia.
[7] For example, a possible worsening in rates of offences in a trial site could be because there was no change in the trial site but a small fall in the comparison site (there were 8 combinations of movements that could change the relative outcomes for a trial and comparison site).

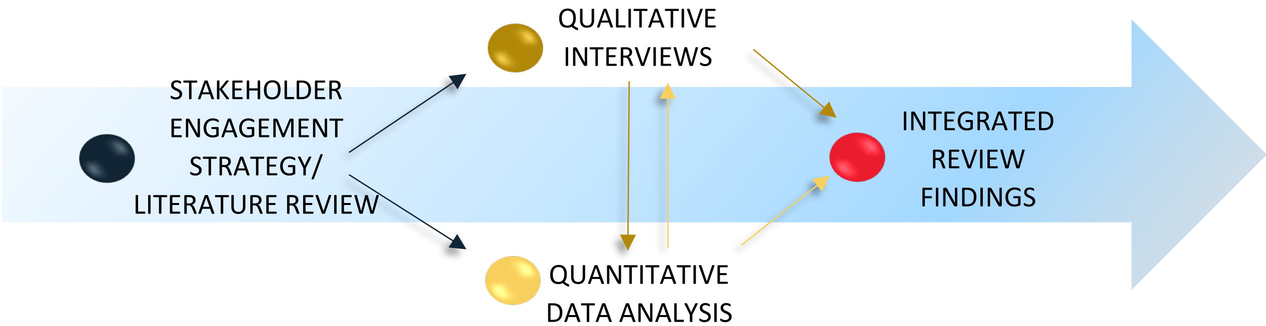
The quantitative findings presented in Chapters 4 and 5 should be considered in light of the many caveats associated with the data. In itself, the quantitative data available to the review has little power to demonstrate the impact of the cessation of the CDC. Its main use was to provide context and corroborative elements to the qualitative analysis which relied on first-hand accounts of a large array of people living in the trial areas.

3.5. Integration and reporting

Where possible, the findings from the qualitative interviews were integrated and triangulated with those arising from the analysis of quantitative data to allow the review to provide a more comprehensive assessment of the impacts of the transition of the CDC – aware, nonetheless, of the caveat regarding caution when using the community data.

An integration and triangulation approach was undertaken continuously throughout all research stages. The quantitative and qualitative research components were, in many cases, mutually reinforcing, with results from each approach informing the other. Results from the stakeholder engagement strategy and literature review also helped to inform the qualitative interviews and guide the quantitative data analysis. In addition, results from the interviews motivated quantitative analyses of different outcome measures or causal channels subject to the availability of data supporting these lines of investigation. Figure 3.3 below illustrates this data integration and triangulation process.

Figure 3.3: Data integration and triangulation process



This report consolidates the findings arising from the qualitative interviews and quantitative analyses. By bringing together this evidence, the report provides a focused analysis of the impacts and outcomes of the cessation of the CDC at the individual and community level. The report also describes the findings related to perceptions of the CDC program transition process, and future measures that could potentially replace the CDC.

3.6. Limitations and challenges

The review methodology relates to an assessment of the impacts and outcomes of the cessation of the CDC program. The aim was to provide rigorous analyses of the community and individual level impacts and outcomes of program cessation.

The review of the ending of the CDC program was not an evaluation in the stricter meaning of the word. An evaluation would require one to estimate ‘counterfactuals’, that is, what impacts and outcomes would have been experienced by the people, had they remained on the CDC program. This information cannot be obtained from those who exited the program since one cannot be both a participant and a non-participant. The data requirements to conduct a formal evaluation are much stronger and the cost of undertaking a robust evaluation would be significantly higher than set in the DSS’s Request for Quotation for the current project. As such, the review methodology focused on the past participants of the CDC program, as well as stakeholder representatives that had in-depth understanding of the program or who worked with/represent people previously subject to the CDC. The review assessed the impacts and outcomes of the cessation of the CDC, but no causal statements could be issued from the analyses.

In addition, it is important to note that there are several challenges which further limits the review’s ability to directly attribute impacts observed to the cessation of the CDC program alone. The review design took into consideration these challenges and proposed a methodology that generated the most robust evidence and meaningful insights given the constraints imposed by the available data and the review’s scope that limited the ability to generate further primary data beyond the qualitative interviews and the four original CDC trial site areas.

3.6.1. Concurrent policies

The CDC program was one policy measure amongst others that had been adopted within the research locations over the time period being considered by this review. As such, a challenge faced by the review was to isolate, as far as possible, the independent contribution of the cessation of the CDC policy on relevant individual- and community-level outcomes.

3.6.2. Community data limitations

A second challenge - which was highlighted in the second evaluation of the CDC and remains relevant for the current review - relates to the analysis of community-level data. Amongst other data issues discussed in Section 3.4.2 above, the CDC participant population represented a relatively small proportion of the overall population in each of the research sites. In this context there is a ‘dilution effect’ whereby behavioural and outcomes changes (even large ones) observed for the CDC population may not be detectable when one looks at community-level data. Furthermore, the analyses undertaken for this review identified much volatility within the community data (particularly at a monthly level) and potential missing variable bias which may indicate that any associations found could be a consequence of unobserved individual or location-specific characteristics.

3.6.3. Longer-term outcomes

A third challenge encountered by the review related to review timeframes and the outcomes that could be observed. The length of time that the review was able to observe was relatively short and, as a consequence, only shorter-term impacts of the cessation of the CDC program were able to be ascertained. There may be additional longer-term impacts that the review was unable to elicit.

3.6.4. Activities subject to strong reporting biases

As some of the behaviours that the CDC program aimed to reduce are socially unacceptable (and in the case of illegal drugs, a criminal offence), reporting of these may suffer from strong biases. As a result, it is difficult to measure the full impact of the ending of the CDC program on such behaviours.

3.6.5. Lack of a quantitative survey

The scope and budget of the review did not allow for quantitative surveys to be undertaken with stakeholders or past CDC participants. While the qualitative interviews provide a rich source of evidence, they cannot be used to make statistically generalisable statements. As noted above, the available administrative and community level data for this review did not overcome this limitation.

3.6.6. Generalisability of the findings

The generalisability of the review findings faces limitations due to (i) methodological reasons (e.g. extensive use of qualitative methods and the lack of a quantitative survey), (ii) locational differences (e.g. the specific socio-demographic characteristics and social issues faced in each trial site), and (iii) the broader policy environment (e.g. the concurrent policies and services in operation in each location).

3.3.7 Lack of comparison areas

The scope and budget of the review did not allow for the research to be undertaken in areas where compulsory income management continues to operate or where it has never operated. Therefore the review is less able to attribute observed trends in past CDC areas to the cessation of the CDC.

4. Review Findings – CDC Transition Processes

Key Findings

- **A majority of past CDC participants and a minority of stakeholders felt that the ending of the program was a positive step that reduced levels of perceived discrimination and stigmatisation and provided an opportunity to implement more effective policies and programs.**
- **In contrast, a majority of stakeholders and a small number of participants were disappointed that the CDC program had ended as they considered that it had generated positive impacts and were concerned about increasing social issues being experienced since program cessation.**
- **Dissatisfaction was widely expressed about the level of consultation that had occurred regarding the cessation of the program. Many respondents were also critical of the speed of the transition and felt that insufficient time had been allowed to prepare for the ending of the program.**
- **While participant exits from the CDC program had occurred quickly, perspectives were mixed as to how well the process had been achieved. While some felt that the transition had been fairly smooth, challenges were noted including the speed of the transition, a lack of accessible information and insufficient supports to assist people transitioning from income management.**
- **Stakeholders were mostly dissatisfied with the level of wraparound services that were in place to support the transition from the CDC program. Perspectives were mixed regarding processes for the development of Local Service Plans, with concerns expressed about the level of consultation, content and actionability of the resulting Plan.**
- **Only a small number of past CDC participants had opted onto eIM, and these tended to be females and older participants. The uptake of eIM was considered to have been constrained due to several factors including a lack of information, complicated transition processes, and family pressure to exit income management.**

An important component of the review was a consideration of the views of past CDC participants and stakeholders on how the transition from the CDC program had been experienced in the trial site regions. The cessation of a policy, and the transition process implemented to enact this change, has the potential to influence outcomes (at a personal and/or community-level) either directly or indirectly. The review explored elements of the transition which were perceived to have worked well and also the challenges experienced. The majority of the evidence pertaining to CDC transition processes is drawn from the qualitative data[8], with additional findings from the analysis of existing administrative data included where this was available.

4.1. Perceptions of CDC program cessation

Legislation to end the CDC program was passed by the House of Representatives and the Senate in September 2022. The review collected evidence about the perceptions held by stakeholders and past participants within the trials sites about the decision taken to end the CDC.

4.1.1. Evidence from in-depth qualitative interviews

Views on the ending of the CDC program

Respondent perceptions about the ending of the CDC program were somewhat mixed. A majority of past CDC participants and a minority of stakeholders (particularly those located in Bundaberg-Hervey Bay) supported the ending of the program.

> *When Labor won the Federal Election and basically Albanese came out and said that they [the federal government] were going to stop the program, and I thought good, can't come quick enough…I had sought help and gotten off the drugs and alcohol since, before the program ended. But I was still happy. I was happy that it was gone…I just felt of it as a discriminatory program, and so I was happy to see it go. Even though I wasn't in the same position that I was. BHBP09*

Many past CDC participants welcomed the end of compulsory income management as they could again have full access to their income support payments, and not have to worry about managing two bank accounts. Others felt less stigmatised as a result of the cessation of the card and were relieved to now have autonomy over their finances. For many participants who supported the ending of the CDC program, however, it was simply a preference for using cash over banks cards.

> *I don't want to mess around with cards anymore. I just can't be bothered. Get your money out of the bank and have the cash. CEDP09*

[8] In the following reporting of the qualitative interview findings, please note that 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 small minority of respondents expressed an opinion.

> *I was happy it was going to end because I was on there for a couple of years, and it was a bit hard on the Indue. Like when I went to the desert because everyone was all cash, and I'd mostly just go and buy in big stores with my money. GFP05*

Some respondents also considered the program to have been a "band aid" that had been ineffective at addressing complex social issues in their communities. The ending of the CDC was considered a positive step which provided an opportunity to implement more effective policies and programs in the regions. Concerns were also expressed that large amounts of taxpayer funds had been directed into the program rather than to on-the-ground services. It was, therefore, hoped that greater resourcing of these services would now occur with the transition from the CDC program.

> *It was just common sense, really, that it was removed. And…that there's more targeted support provided for particular individuals and families…The Cashless Debit Card, that's not it, people find ways to get access to anti-social influences…We need to change the way we're doing things. It's a far more complex issue than one legislation change. EKSH13*

> *Certainly don't need to pay someone $15,000 a year to budget my few bucks. CEDP01*

Others spoke of initial community protests against the CDC program, negative media stories and fear about the introduction of income management. These concerns had largely subsided as the program had continued and a degree of acceptance of being on income management was said to have reached by some participants. Subsequently, some past CDC participants were quite ambivalent towards the operation of the CDC program and also with regards to its ending.

> *There wasn't that much concern being put on the card from what we thought there was going to be. There was a lot of hype in the media about how horrible it was going to be… So for a lot of things, it wasn't a big deal to them [CDC participants]…We didn't feel strongly about it either way when it was introduced. BHBSH25*

> *I stayed on it until they transitioned us. I didn't opt out or anything. I do know a lot of family that did and they just couldn't wait to get off it. But didn't really matter. It didn't really affect me. GFP18*

A further group of respondents reported that they had not been in favour of the CDC program whilst it was in operation and supported its removal. However, their views of the effectiveness of the card subsequently changed once the program ended and perceived negative impacts for their community were experienced.

> *The Cashless Debit Card, I was not for it. But then now that it's gone, I have to say, holy moly, it really did make a difference. GFSH05*

In contrast, a majority of stakeholders and a small number of past CDC participants informing the review were strongly in favour of the CDC and were disappointed that the program had ended. Many of these respondents felt that the program had been generating positive impacts and were concerned about increasing social issues being experienced since program cessation.

> *From my end, it was quite frightening for the town as a person living in town, it was quite frightening, because just from the difference that I've seen it make over the time. Yeah, was a bit daunting as to why they would even take it away. It was something that was working from my view, obviously. So I was concerned. GFSH24*

Some past participants who had supported the continuation of the CDC program described the personal benefits that they or their family members had derived from income management, including being able to save and prioritise spending on essential items.

> *So people may say it was a burden to them but for me it was a Godsend because I was able to pay my debts instead of just wasting money like us young people do. It helps me save money so it taught me a life lesson being on it. The government, not going to lie, the government, it's probably the best thing that they've brought out. BHBP21*

> *I miss the key card, the grey key card. Yeah, like all the feed, enough for us you know. Yeah, money be there, that's bought all the food in the house. I liked the card. I miss the use for the card. Everybody in town all miss the card. GFP06*

Some stakeholders also spoke of the huge toll that the ending of the CDC program had had for the Aboriginal leaders who were instrumental in bringing the CDC program to the regions. Many described the CDC program as garnering fairly unilateral community support over time, including from Aboriginal leaders and community members, and felt that the transition was a backwards step.

> *There was pretty much unilateral support locally for the Card, including from Aboriginal communities, which took them a relatively long period of time to convince people in their communities that it was going to be a good thing…With a national policy position as Aboriginal leaders, they [the leaders] would have the most to lose both reputation, and just flying so close to the political wind...There's a resignation, that it's not going to come back or it's gone now…we've just got to get on with whatever the community needs now. CEDSH04*

Community consultation

Stakeholders uniformly expressed dissatisfaction with the level of community consultation that had occurred between the federal government and local organisations regarding the ending of the CDC program in the four regions. The CDC program was perceived by some as being a "political football" both during its implementation and cessation. The ending of the program was considered to have been delivered as a fact by the federal government and many stakeholders were highly concerned that major political decisions were being made in Canberra for their region without consultation.

Government decided to pull the pin on it without any consultation with the [Aboriginal] leaders' group, or any care in the world about the impact, and so we've been dealing with the fallout from that decision. CEDSH07

I think the majority of town, when you speak to people will be disgruntled with how it was done. That there was no consultation it was just done. Because if someone had bothered to step their foot out of Canberra, they'd [the federal government] come and seen what they were doing to people. What's now changed again. EKSH12

Stakeholders were in agreement that decision-making about policies, such as the CDC program, that could potentially have significant impacts for their regions should consider local community perspectives. Indeed, several stakeholders felt that the ending of the CDC program had been a missed opportunity for the government and those working on the ground to come together to create an alternative place-based solution.

It kills you to see your people like that…You [the federal government] affected people and communities lives through making these decisions without consulting the people it actually affects…If you're going to make big changes like anywhere, whether it's with their card or without the card, you need to empower these communities with the right tools to combat that. CEDSH17-21

Following on from the decision to end the program, some stakeholders noted that they had subsequently participated in engagement meetings with the Minister and the DSS. While several respondents described their meetings with the DSS as being open and engaging, criticisms were levelled that this engagement had also been too limited in scope. For example, some stakeholders expressed concerns that those involved in the subsequent engagement meetings were not necessarily representative of community members. These respondents felt strongly that broader grassroots consultation and engagement should have occurred regarding the ending of the CDC program.

I don't feel there was enough consultation. And when I speak about consultation, I really believe that they [the federal government] needed to be on the ground…It was pretty piss poor, talking to a bunch of service providers… the services are not the one that's struggling and is impacted, it is the people…the community that's going to be impacted, that's who you got talk to…go out there! GFSH02

4.2. Experiences of the CDC transition

From 1 October 2022, CDC participants in Bundaberg and Hervey Bay, Ceduna, East Kimberley and the Goldfields were able to choose to exit the CDC program or volunteer to move onto eIM. The transition period lasted until 6 March 2023 when the CDC formally ended. The review considered the processes and experiences of that transition.

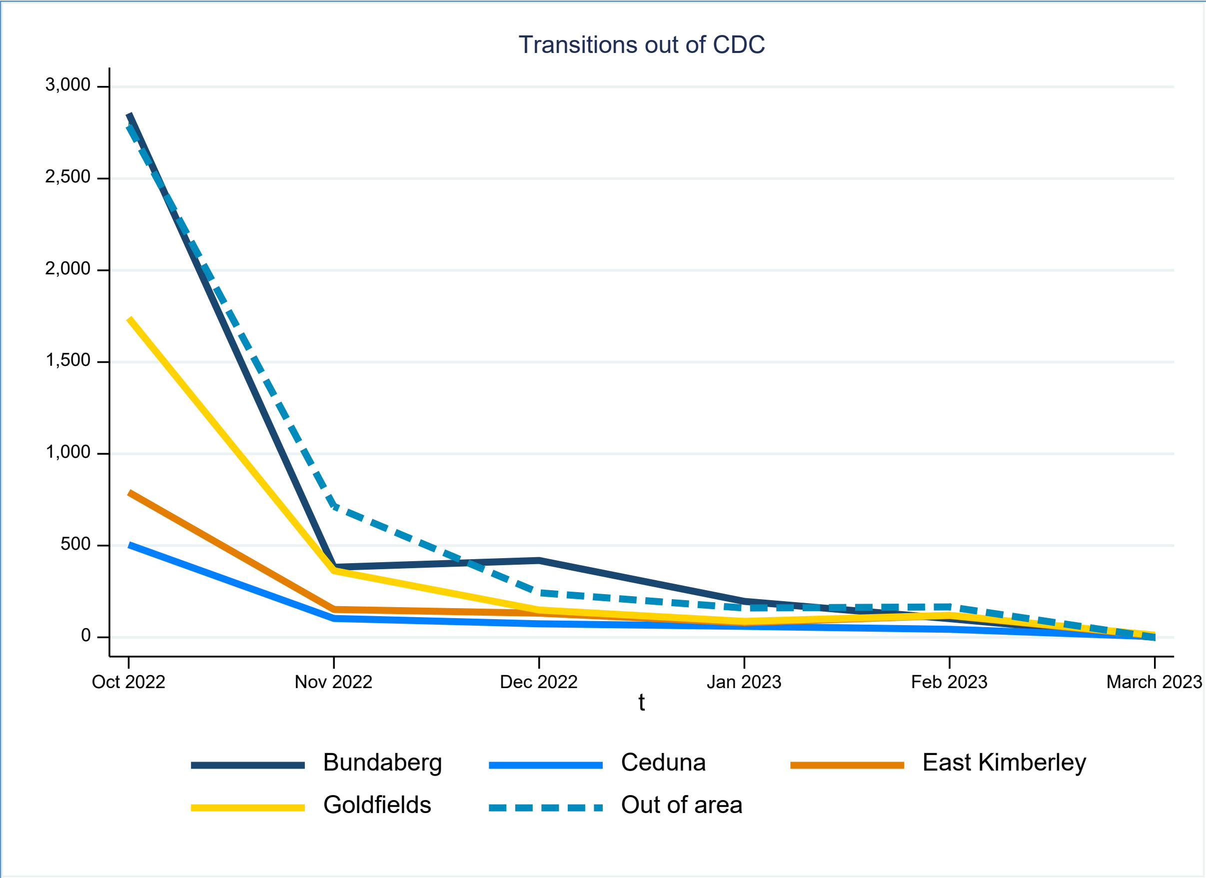
4.2.1. Evidence from administrative data

Administrative data provided by the DSS indicated that 12,567 people transitioned off the CDC in Bundaberg-Hervey Bay, Ceduna, East Kimberley and the Goldfields between 1 October 2022 and 6 March 2023. The transition from the CDC program proceeded very quickly, with 69 per cent of all exits occurring by the end of October 2022.

Figure 4.1 below shows the number of participant transitions out of the CDC program by trial site area. In the first month, proportionally more individuals opted out from Bundaberg-Hervey Bay (and also those identified as currently living out of a trial site area). A faster transition was also apparent in the Goldfields compared to East Kimberley and Ceduna. By January 2023, only 11 per cent of CDC participants remained on the program in Bundaberg-Hervey Bay, 9 per cent in Ceduna, 10 per cent in East Kimberley, and 6 per cent in the Goldfields.

The administrative data showed very little difference in the rate of transition by Indigenous status, gender or age.

Figure 4.1: Participant transitions from the CDC program by location



4.2.2. Evidence from in-depth qualitative interviews

While the qualitative data confirmed that participant exits from the CDC program had occurred relatively quickly in each location, perspectives were mixed as to how well the transition had proceeded.

What worked well

The majority of respondents reported that the transition from the CDC program had proceeded very quickly, with most exits occurring by the end of October 2022. Most past CDC participants themselves indicated that they had actively opted off the card as soon as was officially possible.

> *I was surprised at the speed which people withdrew. So it must have been a really easy process…It was all done very, very quickly…Within less than a month, it was like pretty much everybody had transitioned off in the region. So that really surprised me, the sheer numbers of people that had transitioned off. GFSH03-04*

> *When it came to the time, they [the federal government] sort of gave people time to get off it, and I pretty much rang up straightaway, I would have seen the…I think it was these fellows here [at Centrelink], and I got off it straightaway. EKP32*

In the main, past CDC participants indicated that they had become aware that they could opt off the card via word-of-mouth and social media.

> *It was pretty much through like word-of-mouth and people were sort of talking about it, and we knew it was sort of getting to that point where a lot of people were talking about it, and it was just on the news and stuff there too, like social media. EKP32*

> *People were talking and they [other CDC participants] said to go and see this person and you'll get off it…That's what I did. EKP33*

A few past CDC participants indicated that they had not actively opted off the program and only realised they were no longer on income management when they started receiving their full income support payment back into their everyday banking account.

> *I went right to the end because they [the federal government] said that everybody was getting off, but I just stayed on right until the end, until they took me off. CEDP16*

> *Towards the end. I wasn't in a rush to get off it and then took notice all the money was going from the Indue to the card now, so I was like, "Okay". EKP29*

The process for exiting the CDC program was described by the majority of past CDC participants as being quick, easy and efficient with many indicating that they knew what was required of them to exit income management.

I felt relief because it was just a phone call. Someone rang me saying that it was ending. I've got a few dollars left in there, we'll transfer it back to your normal account. Bob's your uncle, all done. Simple as that. CEDP37

I was in Kalumburu when they [the federal government] came out there and just asked, they told us that Indue card was stopping, and they gave us a number to ring them up. Yeah got off it in Kalumburu. EKP09

Stakeholders reported receiving little negative feedback from their clients with most managing the transition process themselves and not needing assistance. Stakeholders, particularly in Ceduna, noted the work done by Services Australia and the DSS to support participants during the ending of the CDC program. These respondents felt that, in general, CDC participants had been well-informed as to processes for exiting the program and, as a result, had needed little help from local support services.

It all happened quite quickly. So and it wasn't much support we needed to give…People in Kalgoorlie were very proactive…I met two that needed help. And that was just a matter of allowing them to use my phone. And they [the CDC participants] did the rest. GFSH06-08

To be honest It was a lot of work from Centrelink, Services SA…and DSS. They did a lot - the workers. They were brilliant. Fabulous. Absolutely. They came in and they did their best…They really went above and beyond to talk to everyone. The workers were magnificent. CEDSH10-11

Challenges in transition

In contrast, some stakeholders and a small number of participants described challenges that had been experienced by those exiting the CDC program.

Many stakeholders were critical of the speed of the transition and felt that insufficient time had been allowed to ensure that communities were ready for its ending. As the social issues the CDC program had aimed to address were complex and long-standing within the regions, a more considered and longer-term transition plan was felt to have been needed.

The card was in place, and it was quite quickly rolled back. And so that I think made it quite challenging…This sudden impact hit local communities without the ability then to have enough time to develop strategies and or engage with the federal government around mitigation…The uptake [to exit] was just extraordinary. And that meant you saw the real impacts on the ground really quickly. GFSH03-04

There was a really good transition plan that was co-designed with the Department…It's just a real shame they [the federal government] didn't follow up…We very strongly advocated for the need to spend the whole six-month period understanding and planning for it giving us time to change what we needed to on the ground to absorb what the new reality was. And then after the sunset clause ended on the 31st of December, to then transition people off the Card. And that was the

initial impression we were left with…We were quite surprised when the legislation was then tabled in Parliament, ceasing the Card as of December 31, which no-one gave advice that that was a good idea. In fact, everyone gave advice that was a bad idea. That was not enough time to do it appropriately. CEDSH12

Some respondents also reported that in lieu of more formal planning, local networks had had to take on this role and prepare service responses. The speed of the transition was said by these respondents to have placed a considerable subsequent burden on local services and, in some instances, to have jeopardised the safety of people exiting the program.

People from that legislation changing could opt out if they chose immediately. So there was no planned effect, which left communities in a vulnerable position of people exiting the Card model, people were having access to full funds without the support they needed to deal with that. So the people that really got addiction issues or safety concerns were put at a heightened level of risk during that period…Ultimately, it was not done in the safe way to keep people safe. So it was like…chaos in a frenzy, and ultimately, people were coming off the Card, the supports weren't yet put into place. CEDSH02

The information that had been provided to people about the ending of the CDC program was not considered to have been sufficient, with many people said to have heard via word-of-mouth. Some respondents also expressed concerns about the accessibility of the information that had been provided and felt that more simplified information and face-to-face engagement would have been beneficial. As a result, some people were described as having been unsure about how to exit the program.

We had a lot of people coming in all the time because they was coming off the Indue and they didn't know how to check, like how to take themselves off and things like that there. So they was coming for a lot of help and support….and, especially our mob when they come in from the remote communities. CEDP09

I think it could have been done a bit better. And like I stated earlier about that lack of education, lack of information at the right level…It's got to be that one-on-one…They didn't really know what the process was. EKSH11

Respondents also stated that as the CDC program had been in operation in the regions for a significant period of time, some past participants had limited skills in managing their finances without the restrictions of income management. Thus, it was suggested that the availability of additional financial counselling and management services would have been helpful in supporting the transition.

It got a bit hard trying to stand back and think back now I need this money, I need to save this money for this next fortnight for a couple of days in the slack week and all that. EKP17

People just woke up off the card one day and went straight on to being off. And then nothing there. And also no financial management…to help people work out how they would manage their money. There's no financial counsellors on board to talk about that stuff. Yes. So there was nothing put in place…To me, that's not preparing anybody. GFSH05

Further challenges centred around arrangements for the automatic payment of bills which lapsed when participants exited the program. Some past CDC participants were said to have not known that they needed to set up new payment arrangements and this had resulted in them not making payments and accruing debt.

One of the other impacts for the guys downstairs has been all the Centrepay payments that were setup. That's caused absolute chaos…So many people are on Centrepay arrangements and that's all fallen over. EKSH20-21

Concerns were expressed for people exiting the CDC program who may not have the capacity and skills to make positive life choices. As discussed in Section 6.1., many stakeholders (and some past participants) suggested that there was a need for ongoing compulsory income management for vulnerable Centrelink recipients.

So there are those people who are always going to struggle because they haven't had the life skills that other people have had to be able to help them make those good choices. BHBSH01

It's still all right for me now because I control my money. Yep, it's only the young people you've got to worry about, they're still drinking around. They are spending their money all on drink, people aren't buying food, I reckon they should be back on Indue. CEDP34

Brokerage support and the Local Services Plan

As a part of the transition from the CDC program, the federal government extended funding to Local Partner services which delivered a range of supports to CDC participants in Ceduna, Goldfields, Bundaberg-Hervey Bay and East Kimberley. Additional brokerage funding was also provided for community-led and designed initiatives to support economic and employment opportunities. Local Service Plans were developed within each of the four regions which outlined service gaps, social issues, and priority needs.

Brokerage support

Stakeholders in each site were mostly dissatisfied with the level of wraparound services that had been available at the start of the transition from the CDC program. The funded service response was described as being too short-term in nature and as being insufficient to meet the enhanced service demand that had emerged when participants exited the program.

We originally raised prior to the sixth of October, where we said, okay, one of the things we need is a brokerage fund so that when we need to immediately address something, we've got a little bucket of money that's not coming out of our existing grant funding… Come sixth of October, it was still not available. We went back and forth and argued with the Department [the DSS] about this. Come December we finally got the money. CEDSH12

Some stakeholders were critical that brokerage funds had automatically been directed to services that had previously been funded to provide wraparound supports under the CDC program. These respondents questioned the effectiveness of some of these services and suggested that a more considered approach to funding decisions was needed.

The response has been piecemeal, at best…Starting in by working through the existing funded services and making sure that they [the DSS] could extend the timeframes for delivery under those contracts. And so it's evident that they've done that, it's very hard to make an assessment about how effective that's been. Because as we keep saying to them, we actually need to do a place-based review of DSS investment, so that we can actually get a good line of sight over what was previously being funded under the CDC program…and therefore, what needs to continue to be funded long term. EKSH24

Many stakeholders were also critical of the way in which brokerage funding arrangements had been actioned. These respondents felt that there had been a lack of sufficient transparency over the provision of this funding and expressed concerns that there had not been broader consultation over how the funding should be used. Hence, some stakeholders reported that they were unaware how much brokerage funding was available, who it had been allocated to, and what type of services had been funded. In addition, several stakeholders stated that their organisation had only become aware of the brokerage funding once it had already been allocated and had not had the opportunity to apply.

We were aware that there was going to be funds, and they [the federal government] said they would put funds in so we took that at its face value. We never understood the quantum of funds and who they [the funds] were going to and what they were going to be used for. So that was the issue to a large degree is we had no idea…We've been excluded from that entire process. So all we can do sit and watch and see what's happened. EKSH02

That's been some of the questions of the stakeholders, or current CDC providers in the region saying, Hey, you're [the federal government] going to continue to fund us. And…I have a bit of an issue with it…Where's the evidence for the demand for this?...That's a lot of money. Where's the evidence for the demand for this?…Where's the rationale for keeping it going without the evidence that they're [the funded services] actually making a difference…You get five organisations that just get a freebie. BHBSH14

Concerns were also expressed about the short timeframe provided to spend the brokerage funds. This had meant that decisions had had to be made quickly about what services were needed with a lack of time for consultation with community members. As a consequence, some stakeholders did not feel that the right type of services had been funded for their region. In particular, these respondents felt that the funded services, by virtue of the speed at which they needed to spend the brokerage funds, took a reactive rather than a longer-term approach and were not innovative enough, merely repeating what had been provided with limited outcomes for many years.

> *Implementing an innovative program is actually what we [the region] should be doing now. The Cashless Debit Card was a trial, but I think that there should be lots of lessons learned from that trial…But if we just continue to do the same as we've always done, we're gonna get the same results. And our welfare has sort of been the same forever. It's just a way to actually test and trial, different ways of delivering welfare…If I make a cake, and the recipe doesn't work, I don't use that recipe again. I throw that away, and I get a different recipe. BHBSH05-07*

> *We, as a group collectively, representing the community organisations, we are writing saying no, we have other ideas around how that brokerage could work…We want someone independent [to administer funds] which came through loud and clear…[NAME] was there and…he just said, "Who in the room would be happy if local government picked up that role?" and everybody put up their hand because we see that as an independent body. No bias. No agenda…We just want it to be transparent. EKSH20-21*

In contrast, a few stakeholders expressed satisfaction about the funding decisions that had been made. This included respondents from organisations whose funding to provide wraparound supports under the CDC program was automatically rolled over during the transition period.

> *I support that 100 per cent...A lot of the Aboriginal corporations have benefited quite well from that [the brokerage funding]. Places like Wyndham where they're seen as the poor cousin to Kununurra. The youth program there has been funded a bit of the brokerage there as well. Other positive ones like with the community garden and that so... look, a lot of good can come out of that brokerage funding. EKSH11*

> *So I think they [the federal government] have done some really good things with the funding that they are rolling out to support clients to come out of that [the CDC]. So we have funding over with [PROGRAM], and there's funding with the Council around a short-term, intermediate kind of employment program. BHBSH25*

Local Services Plan

Finally, stakeholders discussed the development of the Local Services Plan that had been established in their respective regions to support the transition from the CDC program. Some stakeholders reported that consultation processes for the Plan had worked well and that their organisation had been able to provide feedback. These respondents highlighted that existing service networks within their region were able to be effectively utilised and supported this process. However, it was also noted that timeframes for the development of the Plan were very short and this had led to challenges for the organisations involved, particularly as this work had had to be done in addition to their usual work roles.

> *There is a Goldfields Local Services Plan. So we based it off them 10 priorities. And then we matched it against those key areas and priorities of the Local Services Plan. So that assisted us in providing that conversation about what was really required to secure the understanding from DSS. And I think that the beauty about that now is I think DSS have the trust of us in what we're trying to achieve, and what we're saying. GFSH31*

> *I think it was done very well. They [the DSS] were really consultative. It was a bit short on the timeframe on how much they wanted. BHBSH25*

In contrast, a majority of stakeholders stated that they had not been invited to participate in discussions relating to the Plan. These respondents expressed concerns that several key organisations had not had an opportunity to feed into the Plan and suggested that consultation processes should have been broader, e.g. through the involvement of additional organisations and the hosting of community forums.

> *I've had three meetings with DSS at committee meetings and all they've [the DSS] said last year was that everyone was going to be taken off the card and I have not been part of any other discussions on what services are going to be implemented now that the card has been abolished. EKSH27*

> *I think you can see in the document, who was consulted…and [ORGANISATION], well, they're the ones that are dealing with the homeless and the DV and I can't see in that document where they were actually referenced either…[And] I thought the community input was missing…We'd like to have seen some community forums here and in community, you know, Yalata, Koonibba as well, because, I think that was missing definitely. CEDSH10-11*

Concerns were also expressed by some stakeholders regarding the content of the Plan for their region. These respondents suggested that the Plan was incomplete, missed out on some important content about service gaps and provision, and lacked real action.

I saw it [the Plan] at one of our meetings. There's a lot of fluff in there and I don't know if there's much traction or action. EKSH12

This Local Services Plan, it was talking about organisations that we don't need that don't even exist in this region. So I gave that feedback directly to them [the DSS] which they said they would air but I was like, how is it that Menzies is the only location in the Goldfields with medical issues? Like, what is that? Have you been to Menzies? It's got 20 people in it. This is a regional issue. GFSH03-04

Challenges were noted in trying to formulate a long-term service strategy for the region when the full impacts of the cessation of the CDC program had yet to be understood. Additional work was still considered to be required in order to decide who would provide the services outlined in the Plan, how these supports would be rolled out, and what service provision would look like on the ground.

I think…every service contributes and community members are able to contribute to them [the Plan] and what they look like. The hardest thing is no one knows what normal looks like and what needs to be committed. So there's like an interim response. And then what's the longer-term response? CEDSH02

But I still think that there needs to be more of a plan…What are the priority areas? And what's the timeline to response? What's the solution here? What's the outcome?...More action, but a timely, planned response…Because let's face it, we are very reactive at the moment. GFSH06-08

In addition, a few respondents had not heard of the Local Services Plan at all and were unaware of its contents.

I know nothing about it…I think it's going to be essential. But what's in it and who have they spoken to? GFSH05

4.2.3. Integrated evidence

Both the quantitative and qualitative evidence indicated that participant exits from the CDC program had occurred very quickly, with many exiting the program during the first month of transition (i.e. October 2022).

4.3. Enhanced Income Management

With the cessation of the CDC program, previous CDC participants could choose to either exit the program altogether or volunteer to transition to eIM. People who volunteer for eIM have 50 per cent of their income support payments directed towards meeting their basic needs such as food, clothing, housing and utilities. Income managed funds cannot be spent on alcohol, tobacco, pornography or gambling. Below the findings relating to the uptake and experience of eIM are presented.

4.3.1. Evidence from in-depth qualitative interviews

Uptake of enhanced Income Management

The uptake of eIM was said to have been low in all regions (particularly within the Goldfields and Bundaberg-Hervey Bay). Stakeholders indicated that those choosing this option were predominantly an older cohort and women with children who had benefited from being on the CDC program, e.g. assisting with budgeting, ensuring that money was available for essential items and reducing opportunities for financial coercion. Several stakeholders suggested, however, that those choosing voluntary income management were not necessarily the group most in need of support with their finances.

> *There was some men but a lot of women wanting to voluntarily go onto income management because they were worried about their partners. So there was men too but it was mainly women who had children. EKSH05*
>
> *Out of 6,000 recipients of the card in the hinterland, 20 have taken up the voluntary Income Management. Wow. So the people who need it the most…they're not going to volunteer because the booze is too important…And of course, can buy drugs now. BHBSH04*

The interviews indicated that additional people were currently seeking to opt onto voluntary income management. Several past participants acknowledged that they were considering accessing eIM as they were experiencing financial challenges since exiting the CDC program.

> *I have heard some of the ladies talking and saying that…they might like to stay on the card…They [some of the ladies] just said they didn't want to go through the process of coming off and some of them I think it was around, it was just the management for them…And that could be sometimes, they don't want to say a reason why because they're shame, too. You know, they don't want to admit some things. CEDSH05*
>
> *Indue card was really good before. You can buy fuel, smokes. It makes me save. Yeah. So I might get that one [SmartCard]. CEDP19*

Stakeholders, however, expressed concerns that some people were being pressured not to go back onto income management so that cash was available for family members.

> *Remember, there's a lot of families out there who had no choice but to go on [the] Cashless Debit Card. Right? This is voluntary, this new one…There's a lot of families out there who get pressure from their partner. They might want to go on it, but they can't. CEDSH10-11*
>
> *And I know they [past CDC participants] could voluntary go onto the program, but then I know their family probably swayed them not to. That's probably male dominance again, which is hard. And I've been told that if you spoke to the women, they would be pro-Card, but the men would be an anti…It's a tough one. CEDSH33*

Stakeholders reported that some participants had found the CDC program to be beneficial and would have likely chosen to remain on voluntary income management if more information about this option had been provided prior to the ending of the program. These respondents expressed concerns about a lack of proactive engagement by the DSS with CDC participants about this option and that voluntary income management was not properly explained to people (including what it is and how it works).

> *I don't think that the income management and that they [the federal government] haven't really explained that to people what it is, and how it works, because nobody I know has gone on to it. And if they [past CDC participants] don't understand it they're not going to choose to take it out because it's not been enforced…I'm confused that they [the federal government] didn't introduce that card as a good thing. GFSH05*

> *And there was just no communication. And I think no one really knows about the new program. There has not been no information to look at the new program, the flexibility, that it's more flexible obviously than it was previously. And understanding that would've been a really good position for vulnerable people to be remaining on it. And so there definitely hasn't been that promotion of what it is now as a choice. And the fact that out here typically they [past CDC participants] wouldn't even understand what was going on. They would just now know that it's changed back and they don't have to use that card anymore. CEDSH24-26*

Several stakeholders also noted that their own organisation had been unaware of eIM and, therefore, had been unable to share information on this option with their clients.

> *I have heard a little bit out there in the street that there are some that actually would, because you can do it voluntary. That wasn't told by any organisation. I was actually informed by people out on the streets…And that's a choice that they [past CDC participants] get to make, but to hear it coming from someone in the community and not hear the process as an organisation, especially like [from] Centrelink, or you know the card place [Indue] themselves? BHBSH11-12*

Indeed, many past CDC participants who informed the review were unaware themselves that there was an option for people to continue voluntarily on income management. In line with the stakeholder perceptions above, some indicated that they would have chosen this option if it has been presented to them. Others considered that people would still opt onto the eIM if an education campaign was undertaken and the opportunity was presented to them.

> *No, I didn't know they [the federal government] had one. Do they have a voluntary scheme? BHBP21*

> *I think that someone does need to come out and explain this new card, the SmartCard, and let them [past CDC participants] know what it's about and if they want to do it, get them on it straightaway because a lot of people don't have phones or anything…And let them know you don't have to, but this could help you to have food and things, and you can still pay your bills. EKP11*

Several stakeholders felt that processes for participating in eIM were too complicated, especially for people living in remote areas where English was not their first language. Rather than having to exit the CDC program and then actively opt onto voluntary income management, these respondents suggested that participants could simply have just been transferred over to allow for easier continuation.

> *It's the three-hour phone calls that you're waiting on around and the 4,000 pieces of paperwork you have to do and all the identification you need and something other else. And that's never a simple process. CEDSH17-21*

> *[With the] SmartCard…you just immediately think, well can't you just transfer that information over instead of shutting one system down and then having to recreate and update another one. EKSH16-17*

4.3.2 Evidence from administrative data

The quantitative administrative data confirmed a low uptake of eIM in the past CDC trial site regions, with only 126 people in total transitioning onto eIM following the cessation of the CDC program.

Table 4.1 below provides further details about the characteristics of those transitioning onto eIM. The data indicated that a higher proportion of those opting onto eIM were located in the Goldfields and East Kimberley regions. A slightly higher proportion were women, and around half were aged 51 years and older.

Table 4.1: Characteristics of eIM participants

Attribute	Per cent
CDC Trial Location	
Bundaberg & Hervey Bay	16
Ceduna & Surrounds	15
East-Kimberley	33
Goldfields	36
Gender	
Male	46
Female	54
Age	
< 30 years	17
31-40 years	20
41-50 years	13
51-60 years	33
>61 years	17

4.3.2. Evidence from in-depth qualitative interviews

Experiences of enhanced Income Management

Due to the small number of people who had volunteered to remain on income management in each site, the review was unable to elicit detailed information about how eIM was being experienced.

However, the review did find limited evidence of some of the aspects that past CDC participants liked about the new eIM. These were related to the financial security it afforded and the voluntary nature of being able to opt on to it, rather than being forced on to it.

> *Because like one of my good friends she's still on the Indue. She loves it because, I'll be honest with you, her partner, he does heavy drugs and that so she needs to stay on it because she needs to make sure that her children have got food and things like that there. CEDP09*

> *Now that it's a voluntary reason it makes it a lot better now…Because now people don't feel they're being controlled. They [past CDC participants] can pick and choose whether they want to. CEDP05*

Limited evidence was also obtained from past CDC participants about the potential negatives of participating in eIM. These included the financial risk posed by its payWave functionality and the lower proportion of money that was quarantined on the SmartCard, which was said to reduce the ability to save money.

> *Because it's payWave and if I lose that and if I haven't got a phone to turn it off or block it that's a risk. CEDP11*

> *It's not the same as the Indue Card because you get more in your bank account than you do in the SmartCard…I like to save some money for the weekend for the children, but I can't because every pay day that's only $100 going into the SmartCard? Whereas that Indue we had more going in. GFP42*

4.3.3. Integrated evidence

The qualitative and quantitative evidence on the uptake of eIM was consistent in showing that only a very small proportion of CDC participants chose to remain on income management. Likewise, both sources of data found that females and older participants were more likely to choose this option.

5. Review Findings – Impacts of CDC Transition

Key Findings

- **Interview respondents within the Ceduna, East Kimberley and Goldfields regions were far more likely than those in Bundaberg-Hervey Bay to report that impacts had occurred with the ending of the CDC program.**
- **While perceived impacts were mostly negative, the review found some evidence that program cessation had brought positive change at an individual-level for past CDC participants.**
- **The CDC program cessation was widely observed in the qualitative data to have decreased feelings of discrimination, stigma and shame and given people more control and freedom over their finances. However, respondents often cautioned that at times this greater freedom over money had resulted in poor decision-making.**
- **CDC program cessation was perceived to have had mostly negative impacts for financial management, especially around spending behaviour and budgeting. An increase in urgent payments requests was also found but it is unclear whether this can be attributed specifically to the ending of the CDC. In contrast, some past CDC participants felt that now having just one bank account and greater access to cash made financial management easier.**
- **Alcohol consumption, public intoxication and alcohol-related violence was suggested to have risen considerably in Ceduna, East Kimberley and the Goldfields since the cessation of the CDC. Increased gambling activity was also reported in Ceduna and the East Kimberley. Little evidence was found of a change in illegal drug use in any of the four locations.**
- **Concerns were raised in Ceduna, East Kimberley and the Goldfields of declining levels of child wellbeing and welfare since the cessation of the CDC, e.g. some children not being fed or clothed properly, not attending school and being out on the streets unsupervised at night.**

- **In Ceduna and the East Kimberley, the wellbeing of some past CDC participants was felt to have declined since the cessation of the CDC. An analysis of WA Health data found some evidence of increased EDA rates in the East Kimberley and Goldfields since CDC program cessation. However it is difficult to know how much (or if any) was specifically due to the change in the CDC policy.**
- **Stakeholders in Ceduna, East Kimberley and the Goldfields were more likely than past participants to report increased criminal activity and worsening perceptions of community safety since the cessation of the CDC. Overall, an analysis of WA Police data showed little substantial change in policing outcomes in either the East Kimberley or Goldfields trial sites.**
- **Increased support service need and use was reported by interview respondents in all four regions, and especially demand for emergency relief services. It was unclear whether this increased demand was directly related to the cessation of the CDC program or if other factors (such as cost of living and housing pressures) were also contributing.**
- **Additional perceived impacts of CDC cessation related to transitional visitors and tourism.**
- **Several factors were identified which compounded the observed impacts of the cessation of the CDC and made it more challenging to clearly identify the specific impacts of the ending of the program. These factors included housing and cost-of-living pressures, traditional population movement, the ending of CDP mutual obligations, alcohol restrictions and mining royalty payments.**

The review sought to understand whether the cessation of the CDC had led to any impacts (both positive and negative) at either a personal or community level. The majority of the evidence pertaining to these impacts is drawn from the qualitative data, with additional findings from the analysis of existing administrative and community-level quantitative data included where this was available. The review of the ending of the CDC program is not an evaluation in the stricter meaning of the word. Consequently, while the review assessed the impacts and outcomes of the cessation of the CDC, no causal statements can be issued from the analyses. As discussed below, it is also important to consider that the cessation of the CDC program occurred at a time when several other relevant social and economic conditions were impacting each region. This further limits the review's ability to ascertain the direct impacts which may have resulted purely from the cessation of the CDC policy alone. The findings presented in this chapter must be read with these caveats in mind.

5.1. Overall impacts of the ending of the CDC

Experiences of the ending of the CDC differed across the four sites with perceived impacts reported primarily by interview respondents in Ceduna, East Kimberley and the Goldfields. In contrast, many respondents in Bundaberg-Hervey Bay, and a minority of those in the other three sites, indicated that CDC cessation had not brought significant change for their respective regions. For most of these respondents, the CDC was not felt to have been particularly effective at addressing issues of social harm whilst in operation, and consequently, its ending was also considered to have caused little impact.

> *I haven't seen any major change in behaviours, major change in the way people deal with their money…On the card anyway, we saw no significance whatsoever within the demographic we serve. BHBSH11-12*

> *It was the same before it [the CDC] came in to when it was on, and to now when it's finished. It's all still the same, nothing's changed. GFP10*

Contrary to this viewpoint, a few respondents thought that the CDC had been beneficial for their community and, while not observing any short-term impacts, anticipated that these may yet eventuate in the longer-term.

> *I was quite disappointed [about the ending of the CDC], really, because I thought it did have some really good research behind it and the reasons for doing things…I think it's probably early days to really see but I think there definitely will be [impacts]…So it will be interesting to track it, and look a bit more closely at those families that are now no longer with the Card, what impact it will have on them? GFSH15*

The review found some evidence that the ending of the CDC had brought positive change at an individual-level for past CDC participants. In particular, the cessation of compulsory income management was widely felt to have reduced feelings of discrimination, stigma and shame, and increased perceptions of control over finances.

If anything life is easier for people that I know being off the card. There's been no negatives that the card has left, it's been positive. BHBP14

I think that it's a good thing that it's [the CDC] been removed…I think it has removed the bias of people being on Centrelink benefits, and it's given everybody equal access to their money…It's putting the onus back on the individual…putting that human element back into it. BHBSH10

Overall, however, the perceived impacts of CDC program cessation were considered to be mostly negative and largely centred around financial management, alcohol and gambling misuse, child wellbeing and welfare, and safety and violence. Some respondents suggested that the social issues currently occurring in their region were directly related to the ending of the CDC program. For these respondents, the CDC program was thought to have contributed to the reduction of socially harmful behaviours in their communities, and thereby, the cessation of the program was perceived to have led to an escalation of such behaviours.

I think the impact is the gambling, the alcohol, violence on the street. It's all back. It happened immediately here, as soon as that [the CDC] ceased…The impact was immediate. It's affected not only adults but the kids as well. EKSH08-09

Oh it felt good [when the CDC finished]. But then that's when we realised that it wasn't really good. It stopped help[ing]. Then we ended up with no money…They used to have food and stuff but now it's back to square one where they got to ask the people for food and stuff. GFP37

Others, however, were much more cognisant of other social and economic conditions and policy changes that were concurrently occurring that (additionally) contributed to ongoing issues of social harm. These factors (which are discussed in detail in Section 5.10.) were observed to compound the impacts of the CDC cessation and make it more challenging to identify the specific impacts of the ending of the CDC program alone.

Other factors [need] to be considered, not just coming off the CDC card…It's too many other factors to bring into account to say that any given one was a driving force in an escalation of problems. BHBSH23

Everyone think it's the cards, the abolition of it [the CDC]…[but] it depends on things like the weather, payday, the season, that all has an impact…There was big [cultural] business last year, so we had a spike in people coming through the community…I think it's very easy just to look at the card and saying it's causing all our problems. It's not…it's long-term issues that you need to start resolving them in some way. CEDSH03

5.2. Experiences of agency, autonomy and social inclusion

As the CDC program by design restricted how and where people spent their money, this impacted upon the autonomy and control that CDC participants felt they had over their lives and their sense of inclusion. The review considered how the cessation of the CDC program may have changed these perceptions.

5.2.1. Evidence from in-depth qualitative interviews

The positive impact of the ending of the CDC program on experiences of agency, autonomy and social inclusion was discussed by many past participants as well as some stakeholders (especially those in Bundaberg-Hervey Bay and the East Kimberley). Many of these respondents spoke of the perceived shame, stigma and lack of autonomy that had been experienced by CDC participants whilst subject to compulsory income management. This was thought to be especially pertinent for participants who did not have any issues with alcohol, drugs or gambling and, therefore, felt that they had been unfairly targeted by the program. These feelings were considered to have been compounded by the narrative around the CDC program and community perceptions that those subject to income management were participating in socially harmful behaviour, e.g. drinking excessively and neglecting their children.

> *I think it's been good overall. A lot of that stigma's taken away…It's not paint everyone with the same brush, not 100 per cent of Aboriginal mob in East Kimberley are drunks and do the wrong thing, type of thing. Geez! The vast majority look after their kids. It's that freedom now…It's that, just like anyone's entitled to, is that right to spend the money that you have the way that you want to spend instead of being dictated to. EKSH11*

Consequently, many participants had welcomed the news that the CDC program was ending and that they could exit income management. Past participants at times spoke of the CDC program as having taken away their human rights, and that these had been returned with the ending of the program.

> *The Card was not good. It didn't suit me well. Just felt…robbed of my rights. I felt very uncomfortable…It's really good. I feel much better now with cash. GFP40*

Since exiting the CDC program, past participants often described feeling as if they had more control over their finances including being able to spend their money how, and where, they liked. For some participants, the ending of the CDC program was described as bringing a greater sense of responsibility for themselves and their families.

> *No one is watching every cent I spend. Yeah, that control, like it's up to me what I do, which it always was but it's, yes. Like I'm not going to go somewhere and they [retailers] say, "No, you can't do that because it's on an Indue Card." EKP24*

> *I've got money back now. I feel more independent. Yeah, my responsibility. I'm not putting it all onto something or anything, I've got money and it's my money. CEDP11-13*

Past participants also reported having greater freedom over their lives including opportunities to attend more social and family events in their community, or to travel outside their region.

> *It meant we could actually go to more family types of events once I gained control of my own money back because a lot of places were cash only. You couldn't get cash out so we missed out on quite a few things like that because of it…Festivals and markets, fruit and veg stalls and stuff like that. BHBP05*

> *A lot easier, a lot more freedom. I can go anywhere in Queensland, spend my money anywhere I like…I couldn't use it in Brisbane or anywhere other than Bundaberg or the areas that actually have the card…[And] there was a lot of times I was too embarrassed to pull the card out here in Bundaberg too…just people knowing that I wasn't responsible enough to manage my own money. I didn't have any rights to that it was just taken off my hands. That was pretty hard as well. BHBP16*

However, respondents (mostly in Ceduna, East Kimberley and the Goldfields) cautioned that at times this greater autonomy and control had resulted in poor decision-making in relation to financial management and the increased misuse of alcohol and gambling. This is discussed further in Sections 5.2. and 5.3.

> *I think people should have the right to spend their money as they see fit…but there have been negative results. It's not the freedom that I would love them [past CDC participants] all to have…They're now able to spend more of their disposable income on alcohol and illicit substances, gambling, all of that sort of stuff. CEDSH36*

> *When they [Centrelink] took me off of it I, not going to lie, went pretty crazy with my money because I had it all in front of me. And I was like, "Oh, now I can spend it on stuff that I wasn't allowed to spend it on." I'd honestly prefer to still be on it. I'm telling the honest truth. Because it saved me heaps of money. BHBP21*

Several stakeholders also reported that, after some initial discontent, most participants had become accustomed to being on income management. Thus, according to these respondents, the ending of the CDC program had not contributed greatly to a change in experiences of agency and autonomy.

5.3. Financial management

The CDC aimed to reduce socially harmful behaviours by limiting access to cash and restricting the use of income support payments to purchase alcohol or gambling products. As a result, the introduction of the CDC had widespread implications for financial planning and money management for all CDC participants. Both the qualitative and quantitative data provides evidence about the impacts of the cessation of the CDC on financial management.

5.3.1. Evidence from in-depth qualitative interviews

The majority of respondents in Ceduna, East Kimberley and the Goldfields reported that the cessation of the CDC program had resulted in negative impacts for financial management. During the operation of the program, income management was considered to have assisted some participants to better manage their finances and prioritise spending on essential items (including food, rent and utility bills). Now that compulsory income management had ended, some past participants were said to be spending more of their money on alcohol and gambling products rather than purchasing groceries or paying bills.

> *Other people wanted to get off it because they like alcohol and…Now, they got more alcohol and cigarettes than they got food on the table for some people…They just blow it all on grog. The next day they scratching their head for food. EKP16*

> *They [past CDC participants] know that that they can get the access to cash now, they'll just go and spend it straight at the pub instead of having those priorities set in place where money [is] set aside for the kids food. GFSH28*

Likewise, respondents reported that more people were struggling to budget their finances since the ending of the CDC program. Participation in the CDC program was viewed as not necessarily having built the capacity of participants to budget or manage their finances; without the restrictions of income management, some people were reported to be “blowing their money” and not having sufficient funds to last for the entire payment period. Some respondents spoke of people pooling their Centrelink payments together to enable them to drink every day.

> *The aspect of the Cashless Debit Card which was the key focus, was to allow the families to give them breathing space. They could feed the kids and the families and have money left over. At the moment, there's not one cent. GFSH22-23*

> *As soon as that Indue card went away, all the money, boom, party for a year…Every day is someone’s payday. You shout me, I’ll shout you tomorrow…So they’ve always got drink money…You can’t stop them from spending their money. CEDP25-32*

Some past CDC participants acknowledged that they were struggling financially now that they had exited income management. Whereas previously the income managed proportion of their funds was primarily spent on food and bills, these respondents described spending more of their money on alcohol, gambling and/or non-essential purchases; this made budgeting and saving more difficult.

> *I do miss it a bit. With the groceries thing, I tend to waste my money. And some things don't get addressed. The priority is a bit off again. GFP18*
> *It’s pretty hard for us now. When we was on the cashless card we were saving money, had food in the fridge. But now we’re getting cash and it’s going in straight away on pokies and drink. Yeah, come out with nothing. CEDP33*

Some respondents in Ceduna, East Kimberley and the Goldfields suggested that the restricted availability of cash under the CDC program had discouraged financial coercion within families. Now that compulsory income management had ended, people were considered to be more vulnerable to humbug and financial abuse. In addition, begging on the streets was said to have increased with community members and tourists more frequently approached for cash, cigarettes and food.

> *Humbugging has gotten worse, because we don't have the restricted amount in the bank accounts…Vulnerability is increased…And yes, older people were humbugged because of those cards. But what we're seeing now is they don't even have the fall back of their quarantined amount. CEDSH08*

> *You can't walk our streets as all the drunk people are harassing the general public all the time. I cannot go out and walk the street without being approached asking for money, food. GFSH05*

In contrast, most respondents in Bundaberg-Hervey Bay – along with a minority in the other three locations – considered that the removal of the CDC program had not had a major impact on financial management. Many CDC participants were recognised as managing their money well regardless of whether or not they were subject to income management, and as prioritising spending on essential goods.

> *It was kind of a relief for some families that just do perfectly fine without that structure [the CDC]. They adapted to the new structure, and they…can actually manage their own life, their own finances, and they're all good. And don't need someone controlling their finances. CEDSH06*

> *I've always actually been okay with managing my money. I always found that I knew how to, I always put that money away for certain things and I wouldn't touch it because I was always good with that. And I'm a stingy person with my money anyway. I found that it was not different at all. BHBP15*

In Bundaberg-Hervey Bay, stakeholders also reported that some participants had developed better budgeting skills whilst being on the CDC program and were maintaining good financial management even with the ending of the program. In contrast, several stakeholders in Ceduna and past participants in the Goldfields suggested that the ending of the program had had little impact for CDC participants who struggled to manage their finances whether they were on income management or not, due to a lack of basic money management skills.

> *On the positive side, some families that really care for their kids probably got them into a pattern of budgeting better. So I think there's probably some residual positives, with some people that have seen the benefit of getting some budgeting help or being more disciplined with their funding and getting used to buying the food and doing those other things early. So time will tell on that. But I think some people were on it long enough to probably reap some social benefits for themselves. BHBSH26*

I am seeing the same people that I saw before the Card was phased out. I'm seeing the same people. So the ones that didn't have the money then, still don't have the money. CEDSH30

In addition, some past participants in all four locations and stakeholders in Bundaberg-Hervey Bay, felt that the transition from the CDC program had engendered several positive impacts for financial management. For example, some past participants spoke of the benefits of having easier access to cash. This included being able to purchase goods outside of traditional retail stores (e.g. second-hand goods or food from local markets) which was seen as being beneficial particularly at a time of increased cost-of-living pressures. Past participants also valued being able to share their money with family members if they wished, especially in providing their children with pocket money. The ability to attend more community cash-based activities with their families was also welcomed.

So I can buy second-hand goods and go back to having a normal life [than] having just to buy everything brand new that I can't afford. So financially I've gained from it because now I can buy second-hand things which I've always done because being on the pension, you don't have money just to go out and buy brand new beds. CEDP01

Buying stuff is a lot more easier now because you've got access to more cash to do things. And there's still some places here that prefer cash over card, so it makes it a lot more easier doing that. EKP32

Further positive outcomes relating to financial management that were highlighted by past participants included now having just one account (rather than two) which made budgeting and the payment of bills easier. Some past participants also felt that they had been able to save more money since exiting income management. As described in further detail above in Section 5.2., many participants also enjoyed having greater autonomy and freedom over their spending decisions.

Things are a lot more streamlined. I don't have to worry about the two accounts and not being able to transfer enough money into one account to pay for an item or having to try and split payments on items. It's just been good having all my money in one account. And that's just the one account that I worry about or not worry about. BHBP09

5.3.2. Evidence from administrative data

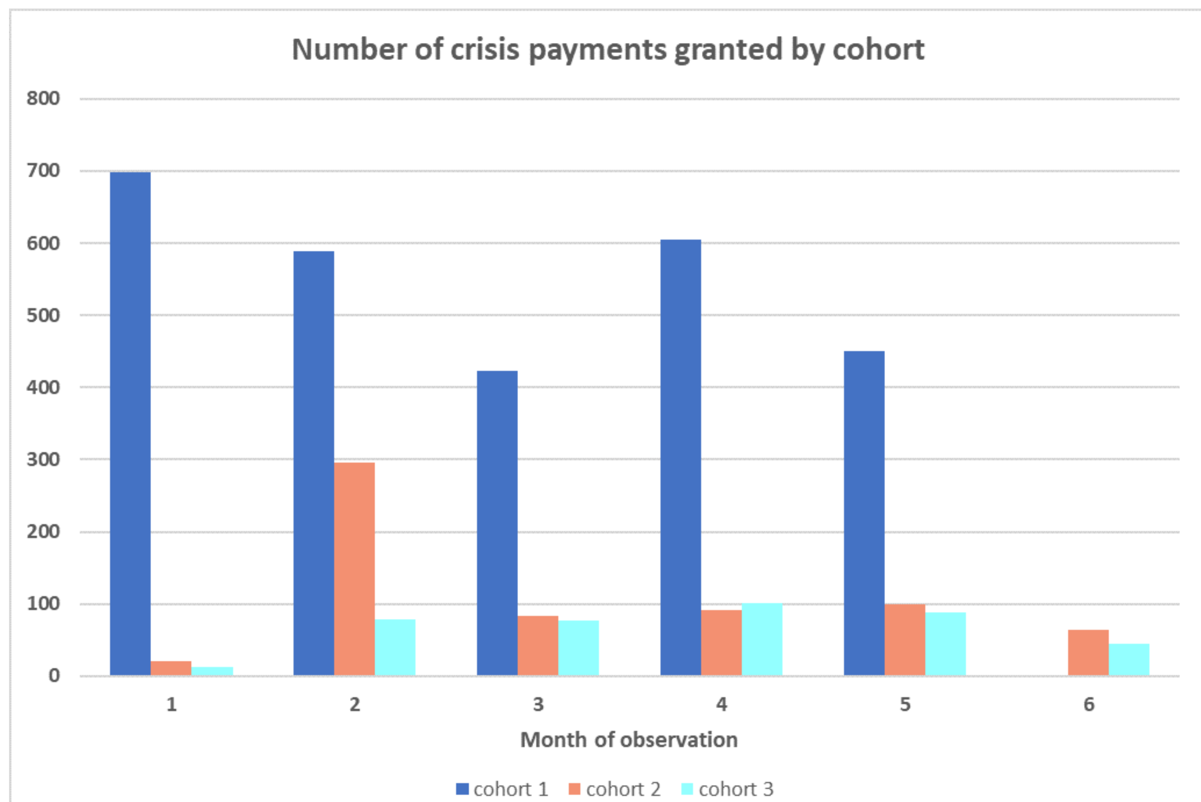
Additional evidence relating to financial management was available from quantitative analyses of administrative data on the provision of crisis and urgent payments in the four trial sites. These payments were investigated as they are provided in certain circumstances when a Centrelink recipient is experiencing severe financial hardship. As such, the trends observed in these payments may be a potential indicator of the effects of CDC program cessation (either positive or negative) on financial management.

Crisis payments

A crisis payment is a one-off payment administered through Services Australia that can be provided under 'extreme circumstances' including for natural disasters, family violence, humanitarian entrants, and release from prison or psychiatric confinement. During the recent pandemic, a specific crisis payment was available for eligible individuals affected by Covid-19[9]; this payment ceased on 1 October 2022.

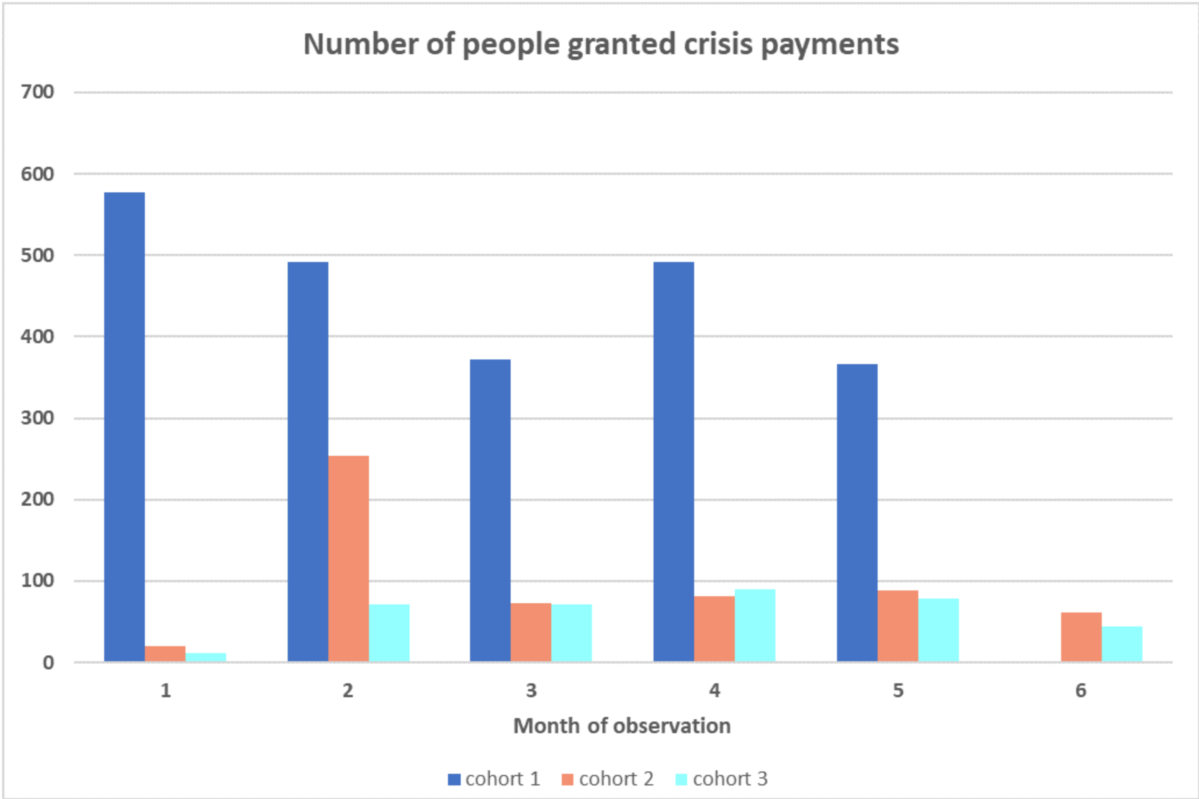
The following figures (5.1 and 5.2) show (i) the number of crisis payments granted throughout the observation window for each cohort, and (ii) the number of people granted crisis payments. As indicated below, the number of people from Cohort 1 who received a crisis payment was considerably higher than for Cohorts 2 and 3. This was likely to be due to the Covid-19 crisis payment being available for those in Cohort 1. Due to the administrative changes in the scope of the crisis payments, this data could not be used to accurately identify any impacts that may potentially have arisen from the ending of the CDC program.

Figure 5.1: Number of crisis payments



[9] The Crisis Payment for National Health Emergency (Covid-19) was available for Centrelink customers in severe financial hardship who were (i) required to be in quarantine or self-isolation, or (ii) caring for an immediate family or household member who was required to be in quarantine or self-isolation.

Figure 5.2: Number of people granted crisis payments



Urgent payments

Under certain circumstances, Services Australia can provide an urgent payment, i.e. the early delivery of a Centrelink payment. Urgent payments can be paid if a recipient is in severe financial hardship as a result of:

- Departmental delay in the provision of an income support payment;
- Exceptional unforeseen circumstances;
- Extraordinary circumstances;
- Funeral expenses; and
- Urgent miscellaneous circumstances.

Table 5.1 below shows the number of such payments granted by cohort. The total number of urgent payments awarded to Cohort 1 was smaller than for the other two cohorts. In contrast, the number of urgent payments were similar for Cohorts 2 and 3. The quantitative evidence therefore suggests that requests for urgent payments increased following the cessation of the CDC program. Comparing the number of payments granted and those denied, a larger percentage of applications were denied in Cohorts 2 (61 per cent) and 3 (66 per cent) compared to Cohort 1 (73 per cent). Across each of the three cohorts, the vast majority of urgent payments were provided due to 'Exceptional Unforeseen Circumstances' or for 'Funeral Expenses'.

Table 5.1: Number of urgent payments per cohort1

	Cohort 1	Cohort 2	Cohort 3
Urgent payment type:			
Departmental delay	58	95	96
Exceptional unforeseen circumstances	2,232	2,613	2,790
Extraordinary circumstances	66	102	82
Funeral expenses	2,209	2,336	2,163
Urgent miscellaneous	0	0	0
Total payments awarded	**4,656**	**5,146**	**5,131**
Total payments denied	1,711	3,298	2,702
Per cent granted	73%	61%	66%

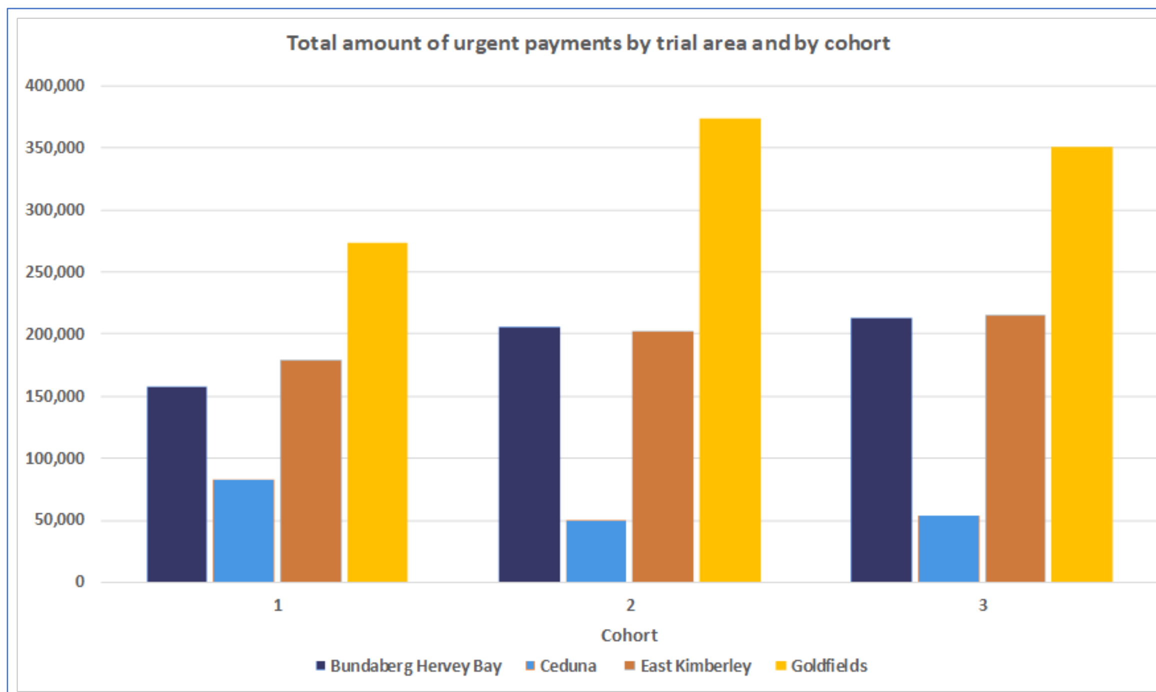
The following Table 5.2 shows the total value of each type of urgent payment per cohort along with the proportion this represents of the total awarded amount. As may be expected given the larger number of urgent payments awarded to Cohorts 2 and 3, the amount of funding provided was also greater in total. In addition, across all cohorts the urgent payments relating to 'Exceptional Unforeseen Circumstances' and 'Funeral Expenses' represented the largest proportion of the total amount of payments granted.

Table 5.2: Total value of each type of urgent payment per cohort

	Cohort 1	Cohort 2	Cohort 3
Departmental delay	$ 22,665 3%	$ 54,391 7%	$ 57,155 7%
Exceptional unforeseen events	$ 361,352 52%	$ 417,932 50%	$ 453,480 54%
Extraordinary circumstances	$ 11,088 2%	$ 21,507 3%	$ 14,502 2%
Funeral expenses	$ 297,518 43%	$ 338,407 41%	$ 308,244 37%
Total	**$ 692,623** 100%	**$ 832,237** 100%	**$ 833,380** 100%

Figure 5.3 below shows how the total amount of urgent payments changed across cohorts for each trial area. Ceduna exhibited a different pattern compared to the other locations. In Ceduna, the total amount of urgent payments decreased between Cohorts 1 and 2, and then increased slightly for Cohort 3. In contrast, the amount paid in urgent payments was lowest for Cohort 1 (the cohort subject to the CDC program) in each of the other three locations. For instance, in Bundaberg-Hervey Bay and East Kimberley, the smallest amounts were received by Cohort 1, followed by increases for both Cohorts 2 and 3. The Goldfields region differed slightly; although Cohort 1 still had the lowest amount of urgent payment paid, a relatively large increase was observed between Cohorts 1 and 2, but with a subsequent decrease between Cohorts 2 and 3.

Figure 5.3: Total amount of urgent payments by trial area and cohort



In further analyses that examined the amount of urgent payments paid by gender and by location, it could be observed in all four locations that around 60 per cent of the total amount of urgent payments were paid to females, compared to 40 per cent for males.

5.3.3. Integrated evidence

The qualitative interviews with stakeholders and past CDC participants indicated that the ending of the CDC program had largely led to negative impacts for financial management in three of the trial sites (Ceduna, East Kimberley and the Goldfields). These impacts included greater spending on alcohol and gambling products rather than essential items, difficulties with budgeting, and more humbug and financial abuse. In contrast, some past CDC participants reported positive changes to financial management due to now having one bank account and greater access to cash.

The qualitative findings pertaining to negative impacts on financial management were somewhat supported by the analysis of the urgent payment data which showed that the number of individuals receiving these payments, and the total value of payments, had increased since the ending of the CDC program. However, this trend was not consistent across all the research locations and some inconsistences were found with the qualitative evidence. For example, while the qualitative interviews suggested that issues with financial management had been experienced post-CDC in Ceduna (alongside East Kimberley and Goldfields), the value of urgent payments granted in that particular location was lower for Cohorts 2 and 3 (i.e. since CDC program cessation). Also, while the qualitative interviews suggested that the ending of the CDC program did not have a major impact on financial management in Bundaberg-Hervey Bay, the total amount of urgent payments increased there over time.

It is important to note that the research for this review occurred at a time where cost-of-living pressures were a major issue across Australia (see Section 5.10. for further discussion). Hence, it cannot be fully ascertained whether the financial challenges found by the review are a direct consequence of the ending of the CDC program or may be due to other factors.

5.4. Misuse of alcohol, illegal drugs and gambling

The CDC program aimed to reduce alcohol and illicit drug consumption and gambling by limiting access to cash and restricting the use of income support payments to purchase alcohol or gambling products. Hence, the review examined any changes that had occurred in this domain with the ending of the program.

5.4.1. Evidence from in-depth qualitative interviews

Alcohol misuse

Many respondents in Ceduna, East Kimberley and the Goldfields suggested that alcohol consumption had increased considerably since the cessation of the CDC. Alcohol misuse was acknowledged to be a long-term issue in each of these locations, and was perceived to have now returned to similar or higher levels to that which were present prior to the implementation of the CDC program. Most of these respondents considered the rise in alcohol consumption to be directly related to the cessation of compulsory income management and greater access to cash.

> *People were still drinking. Yes. But when we had the card, they [past CDC participants] were drinking with 20 per cent of their income versus 100 per cent of their income. CEDSH12*

> *The cash that they [past CDC participants] had…it's jammed back into alcohol…So everything we've gained over the last four years of trying to do something and get them to see…there's an alternative to life rather than drinking yourself to death. And…what we've done over four years, just…thrown out the door. GFSH22-23*

Some of the past CDC participants who informed the CDC review acknowledged that they themselves, or their family members, were drinking more since exiting from income management arrangements.

> *I don't like the drinking you know, just wanted to stop but just can't do it. Spend more money on drink. CEDP33*

The incidence of public drinking and intoxication was also perceived to have increased by many respondents in Ceduna, East Kimberley and the Goldfields. Moreover, some stakeholders noted that the type of alcohol being consumed had changed from the consumption of lower-level alcohol content drinks to higher alcohol products, e.g. pre-mixed drinks and spirits.

> *It's the quality of alcohol, the strength of alcohol that has [changed]. So instead of buying a carton of Export, now they're [past CDC participants] buying cartons of Jack*

Daniels cans, pre-mixes…[Or] they're buying their limit, which is a box of beer and three bottles of wine. So now that they can afford more alcohol. EKSH12

Within the Ceduna region, respondents also perceived that the number of community members from Yalata and Oak Valley residing in the Ceduna township had increased considerably. These communities are “dry” locations where alcohol is not permitted and, hence, mobility was suggested to be occurring due to community members seeking access to alcohol in Ceduna. Several respondents felt that the current provision of support services to these people whilst they were in Ceduna was inadvertently facilitating them to remain in the township and continue to misuse alcohol.

Now everyone's transient and in Ceduna they're [past CDC participants] all standing around waiting for the next person to get paid to support one another's habits…They couldn't spend their money before on so much booze…But now with the cash, it's going straight down the drain. CEDSH17-21

And a lot of Aboriginal people in this town are from other areas, like out-of-towners, and because where they come from, their community, alcohol was not allowed…And then now that they were in town, they’ve got these places where they can be fed, they can be showered, they can go to a place where they can go and have a sleep, and they’ve got all their money left for alcohol. Not a good thing for our people, not a good thing for our town, and it’s not a good thing for the next generation to see that as well. CEDP10

Perceived increased levels of alcohol misuse were also described as having flow-on effects for the incidence of assaults and family violence. Also as discussed below, respondents expressed concerns about the negative impact that problematic drinking was having on child welfare and the health of some past CDC participants. Within the East Kimberley region, services such as the police, ambulance and local emergency department were said to be responding to more alcohol-related issues since the ending of the CDC program. In Ceduna and the East Kimberley, an escalation of alcohol-driven antisocial behaviour in public places, e.g. shouting and fighting, was noted.

There was more severity of things, you know, people fighting...a lot of fighting on the streets, and then it's like war. This wasn't happening before. Alcohol…itself is one thing [that] leads to a lot of things. EKSH32

You see people have [drinks] every day, they’ve [past CDC participants] got no money for food and the kids start going hungry here. EKP02

In contrast, most respondents in Bundaberg-Hervey Bay – alongside a minority of respondents in the other three regions – did not feel that the cessation of the CDC program had impacted upon rates of alcohol consumption. These respondents stated that people who misused alcohol had still been able to purchase alcoholic products whilst participating on the CDC program through the use of workarounds; compulsory income management and its subsequent removal was, therefore, not considered to have affected this behaviour significantly.

Now we don't have the Card, nothing's changed...[On the CDC] you could still do the exact same stuff except you couldn't tap and go at a pub. You could do the exact same stuff, buy alcohol, buy drugs, transfer over...because there's too many loopholes. BHBP30

It's that same cohort doing the same damage to themselves over and over and over again. So that's what they would be able to do whether they're on a Card or not, because if you've got an addiction, there's a way around...they'll go to extraordinary lengths. CEDSH10-11

In addition, the lack of observed impacts on alcohol misuse within Bundaberg-Hervey Bay was partially considered to be due to the focus of the CDC program there being limited to those aged 35 years and under. Hence, some of those affected by alcohol dependency in that region were older than the target cohort for the CDC and had never been subject to income management.

One of the things that we see a lot in our region is significant issues with drug dependency, alcohol dependency...In my view, targeted only at people in that 35 under bracket was probably an under sight. And it [the CDC] should have been reviewed on a larger scale. Because it's not just that cohort of people who suffer in particularly in areas like this from those conditions. BHBSH15

Illegal drugs

In contrast to the widely held perceptions of worsening alcohol misuse, only a small minority of respondents in each location reported that the cessation of the CDC program had contributed to increased levels of illegal drug consumption in each of the four regions. These respondents felt that the removal of income management restrictions had made it easier for individuals to obtain illegal drugs. As a result, the incidence of illegal drug use was stated to be at similar levels as prior to the implementation of the CDC program.

But there has been a significant impact that is directly related to the card, and that is the amount of illicit drugs coming into community has increased. CEDSH24-26

They're [past CDC participants] having more access to their money and they're choosing what they want...and it's the meth. The meth isn't a good thing but that's what all their money has gone on. Because I know a lot of loved ones that I'm close to that's too far gone on it and they were never like that. When the cashless card stopped, they just started having access to their cash and it was just going to all the dealers. GFP03

Other respondents stated that the incidence of illegal drug use was unchanged since the program had ended as people had found workarounds to support their addiction while on income management.

Pretty much the same alcohol, drugs. I would say it's not any different or not any less. It's about the same from before the card came, to when the card was on and when the card is finished. GFP10

We didn't see any changes around alcohol and other drug use as people have predicted [on the CDC]. What we did see was people finding ways to work around the card, and they unfortunately were quite negative and harmful…We haven't seen a change in use either…it hasn't increased because they don't have the card. CEDSH05

Gambling

Whilst not considered to be as prominent an issue as alcohol misuse, some respondents in the Ceduna and East Kimberley regions suggested that gambling had increased considerably and was now at pre-CDC program levels. Excessive gambling was reported by respondents to be directing money away from the purchase of food and other essential items, as well as leading to arguments and fighting.

We speak to the communities about the biggest impact and they tell us the uptake of gambling was actually a bigger impact from the CDC than anything else…Now we're seeing a lot of people…spending their entire weeks wage on the pokies. CEDSH12

Then I felt sad because my grandchildren and my nieces and nephews were going to miss out on a lot of stuff because people, most of the family members, they would gamble, they'll go and play cards or go to the pokies…and it's not a good thing. And then because they're missing out on food, and, "Nanna, I haven't got this," or, "Auntie, I haven't got this here." CEDP10

Locational differences were observed as to the types of gambling that were perceived to be occurring since the transition from the CDC program[10]. Within the Ceduna region, gambling on the poker machines at the local hotel in the Ceduna township was said to have risen substantially. Some respondents observed that the pokies had become a "social hub" with groups of past CDC participants spending all their day – and at times, their whole income support payment – gambling there. In addition, respondents expressed concerns about rising online gambling within that region; this issue was said to be particularly prevalent within remote communities such as Oak Valley and Yalata.

Now the online gambling is big. It's really big here…What they [past CDC participants] call payday was Tuesday…then they're broke straight up. It's gone. It doesn't take long to gamble money away online. It really is bad. And the numbers here, it affects our shop, it affects the livelihood of the community. It really does. CEDSH16

Meanwhile, in the East Kimberley – and especially Kununurra – respondents observed that card games were again being played for money in local parks with large groups said to be congregating. The incidence of these card games was also reported to have increased within private homes.

[10] In part, differences in the type of gambling activity that occurred was due to the gambling regulations of state jurisdictions, i.e. poker machines are permitted in South Australia but not in Western Australia.

> *Gambling also increased…[the] park in town here is a favourite spot for people to gamble. And we had our rangers busy…breaking up three to four gambling games going on a day…It [CDC cessation] certainly has made a huge increase. EKSH02*

In contrast, the ending of the CDC program was considered to have had less of an impact on levels of gambling in the Goldfields; within that region, past participants were more likely than stakeholders to highlight gambling as being an issue.

> *Big changes. They've [past CDC participants] all gone back to how they used to be before the Indue came into it…I know quite a lot gamblers and I've seen changes in them. They're hammering it every time they get paid to the point where some of them don't get left with any money because they've got full access to all cash now so they've got big gambling problems. GFP35*

Little change in the incidence of gambling was reported in Bundaberg-Hervey Bay. It should also be noted that no respondents in any of the four locations stated that there had been a decrease in the misuse of alcohol, illegal drugs and gambling since the cessation of the CDC program.

5.5. Health and wellbeing

The CDC program aimed to improve the health and wellbeing of its participants and, indirectly, their family members. An important measure for the assessment of the impact of the cessation of the policy was the degree to which it impacted the health and wellbeing of past CDC participant families and their children.

5.5.1. Evidence from in-depth qualitative interviews

Child wellbeing

Many respondents – in Ceduna, the East Kimberley and the Goldfields – reported perceptions of declining levels of child wellbeing and welfare since the CDC program had ended. Concerns primarily centred on some children not being fed or clothed properly amid perceptions that household finances were increasingly being directed towards alcohol and gambling products. Therefore, it was noted that these children were going hungry and, were at times, having to be provided meals by schools and welfare services. Some past participants also described being directly approached by children for food.

> *We've always had an emergency lunch program and a breakfast club that runs every day for all kids. And we've just found that we've had more kids asking for food outside of some of those times or spaces…So we've just purchased more, [and] as a school we work with Foodbank to get fruit and things available for kids in the school. EKSH12*

> *That little boy's father got a pay yesterday, and he spent it all on drink and little boy come over to my place and asked me for orange. I said, I got no orange baby because I got no money to buy orange. That's made me sad, you know, little boy crying, he was hungry, didn't have anything to eat. The father got drunk and spent all his money on drink. Even the mother too…They don't think about saving money for the baby. CEDP03*

Further perceived issues relating to child wellbeing included declining school attendance. Since the cessation of the CDC program, some children were said to be attending school less frequently or only coming later in the day once their parents were up and able to bring them in. This issue was considered to be particularly problematic for children living in communities in the Ceduna region. Enhanced transitional mobility into Ceduna was suggested to have occurred following the ending of the CDC program; children present in town with their families were often not engaging with local schools, while those remaining behind in community sometimes had no-one to ensure that they attended school. Absences from school were recognised as having implications for learning outcomes.

> *More of them [children of past CDC participants] go without because of their parents and their needs. You see quite a lot of kids on the street in our community all the time…Their school attendance is down especially in our school because they come and go whenever they want really. GFP35*

> *There's a lot of kids coming and staying at the transitional accommodation [in Ceduna] with their families, but during school time...Those kids are missing out on their learning. And they are absolutely not attending school. And that is a major concern. CEDSH01*

In addition, respondents in the three regions noted that more children had been observed out in public with groups of intoxicated adults or wandering the streets unsupervised at night. Limited adult supervision was perceived to have flow-on effects for antisocial and criminal behaviour (see below).

> *Kids starving. And they on the streets and it's really sad because they're just roaming round and doing what they want to do. Because now that it's gone back to cash again, parents are spending more money, some parents are doing that. And half of the kids are just…they always hang round that 24 hours…And they're hungry. EKP26-28*

> *Children and kids on the streets remain a big issue for us in town. We do understand that there are reasons why these kids [are] on the street, you know, overcrowding in housing, drinking…multiple levels of abuse and things like that. So I can understand why these kids are out on the street, and you can't really blame them for that. But then once they're on the street…they're getting involved with that and do these bad things…The impact on kids…it drives them to do things that they wouldn't normally do. We know that kids go into cars and steal things, mainly to eat…So taking away Cashless Debit Card…there's consequences that that go down the line. EKSH02*

Some respondents also expressed concerns that children were increasingly experiencing situations of family violence and trauma by family members who were intoxicated. Concerns were raised of the potential effect of this on longer-term outcomes for the younger generation including modelling of their parent's behaviour.

The violence, the fighting. Like neglecting children…too many…I'm not saying I'm perfect, but it's not a good way to have kids around those things because they grow up thinking it's all okay. When it's really not you know. Being introduced to that kind of society. EKP29

Whilst still recognising that child wellbeing was problematic in their region, a minority of respondents in Ceduna, East Kimberley and the Goldfields suggested that this issue had not worsened with the ending of the CDC program. This was due to perceptions that issues relating to child wellbeing and neglect occurred only within a small proportion of the families who had been subject to income management. Several past participants also spoke of still prioritising the purchase of food for their children before spending any remaining money on their own needs.

Walking around early morning, visibly drunk…there's probably a handful of our mob here that do that…It's out there…so everyone notices that. No one notices the family that are getting their kids ready for school every day, the parents are going to work. CDCEK11

It's still the same…Nothing's really changed…As long as my children have something still and that's how I was on the Indue. I made sure my babies first. If I did want a drink and stuff, I'd wait and see it out if I needed that percentage that was left in cash for myself or not. But I still make sure some of it is on the children first and then me last. GFP35

A few past CDC participants in Bundaberg-Hervey Bay, Ceduna and the Goldfields, reported that improved child wellbeing had been experienced since program cessation. This was primarily related to parents having greater access to cash that enabled them to go out more as a family and provide their children with money for school activities or pocket money.

My son, because, he did struggle a lot [on the CDC] and it was affecting him because other kids got these things that he didn't…Just little things like book clubs and things and their little mother's day stalls and…they love the fact that I can give them pocket money now, so…it's a lot easier to please my children. BHBP22

Similarly to the previous domains, a large majority of respondents in Bundaberg-Hervey Bay reported that there had been no change in child wellbeing since the ending of the program. Many of the parents who had been subject to compulsory income management were considered to have always cared well for their children. Hence, only a few respondents identified negative changes in wellbeing, e.g. a decline in the care of children. However, it was unclear whether this was connected with the ending of the CDC program or if other factors (such as homelessness and increased cost-of-living pressures) were responsible.

The school breakfast programs, anecdotally, the numbers have increased again back to where they were, but we've got so much homelessness and all those other things going on…It's a negative effect, but to what degree is very hard to quantify. BHBSH26

Past CDC participant wellbeing

Perceived impacts relating to the wellbeing of past CDC participants were also reported in the Ceduna and East Kimberley regions. While there were mixed perceptions in Ceduna as to whether ambulance and hospital presentations had been affected by the ending of the CDC program, some respondents suggested that health issues (both acute and chronic) were increasing across the region. This was particularly so for people affected by alcohol misuse and transient people who were sleeping rough and unable to properly care for their own wellbeing, e.g. eating, showering and taking medication.

> *And then you've got [NAME], just using him as an example, where he only ever got $220 a fortnight [in cash], well now you're giving him $900 so he's drinking $900 a fortnight…so you're killing him. His eyes are yellow. He's not taking his medication, he's walking around, he's just drinking until he passes out. CEDP01*

> *No-one back here, back here [Yalata]…not even looking after themselves. They live in a rough way [in Ceduna], rough in camps and whatever out there now. CEDP25-32*

Several stakeholders also noted that some people were experiencing serious health issues on their return to community following a period of heavy drinking in Ceduna. At times this was said to result in medical evacuations and hospitalisations. In the East Kimberley (as discussed above), an increase in ambulance call-outs and emergency department presentations due to greater alcohol misuse were reported.

> *That's a fairly significant increase since October of medical evacuations where we've had to call RFDS in to actually fly people out…It's due to ill health, but triggered by increased alcohol, increased drugs and increased violence and lack of food. CEDSH24-26*

5.5.2. Evidence from community data

The review used hospital data[11] to assess the community impact on EDAs for the populations living in the CDC sites in East Kimberley and Goldfields. The trends, changes or averages in EDAs were examined and outcomes compared both within the two trial sites and between trial and comparison sites with an emphasis on three periods relevant to exits from the CDC, i.e. the five-month period pre-transition (May 2022 – September 2022), the transition period (October 2022 – March 2023) and the post-transition period (March 2023 – August 2023)[12].

[11] The EDA data was provided by the Government of Western Australia Department of Health (WA Health).

[12] For context when examining these three periods the descriptive analysis generally starts at January 2022 (about 5 months prior to the pre-transition period). Further detail on the quantitative methodology used for these analyses is provided in Appendix 3. Figures for the analyses of the EDA data (both short- and longer-term trends from 2014) are presented in Appendix 4.

Table 5.3 below provides the population adjusted average monthly EDAs (per site per 1,000 population of group defined over gender and Indigenous status[13]) from January 2022. As well as showing total EDAs, the specific rates of EDAs pertaining to Mental Health, Alcohol and/or Drugs, Alcohol Only, and Drugs Only[14] were examined. As shown, total EDAs significantly outnumber the subgroups. Nonetheless the data are informative.

Table 5.3: Average monthly EDAs by site since January 2022

Average monthly EDAs per 1,000 of population				
	East Kimberley		Goldfields	
	Trial	Comparison	Trial	Comparison
Total EDAs				
Male Indigenous	228	195	139	103
Female Indigenous	204	171	111	89
Male non-Indigenous	119	102	59	68
Female non-Indigenous	79	58	39	43
Mental Health				
Male Indigenous	11.6	11.0	12.6	11.0
Female Indigenous	14.0	9.0	9.5	8.6
Male non-Indigenous	2.7	3.3	2.2	2.0
Female non-Indigenous	2.5	2.0	1.9	2.0
Alcohol and/or Drugs				
Male Indigenous	4.2	4.6	6.0	5.5
Female Indigenous	3.5	2.9	5.1	3.0
Male non-Indigenous	1.5	1.0	0.7	0.7
Female non-Indigenous	0.6	0.4	0.4	0.3
Alcohol Only				
Male Indigenous	3.1	2.6	3.0	3.0
Female Indigenous	2.3	1.9	2.9	1.2
Male non-Indigenous	1.0	0.5	0.4	0.4
Female non-Indigenous	0.3	0.3	0.2	0.1
Drugs Only				
Male Indigenous	1.2	1.1	2.6	2.7
Female Indigenous	0.7	0.6	1.7	2.1
Male non-Indigenous	0.4	0.5	0.4	0.3
Female non-Indigenous	0.2	0.2	0.3	0.3

Notes (1) Data are population-adjusted for gender & indigenous status and are monthly averages per 1,000 of site-specific population. (3) Monthly average over 20 months from 2022 (1).

[13] As discussed further in Appendix 3, the analyses of EDAs focused on four population groups: Male Indigenous, Female Indigenous, Male Non-Indigenous and Female Non-Indigenous populations.

[14] It should be noted that the sub-types of EDAs may not be mutually exclusive - see Section 9.3.2.1 for details.

Generalisations for differences between the various sub-groups and sites include:

- In an overwhelming majority of cases average monthly population adjusted EDA rates were higher in the trial sites than the comparison sites (i.e. in only 5 of 32 cases was the rate for the comparison site higher than the trial site).
- Average trial site EDA rates were higher for the Indigenous populations than the non-Indigenous populations.
- Male EDA rates were higher than females (an interesting exception was for mental health EDAs for Indigenous females in the East Kimberley trial site).
- Mental health EDA rates were significantly higher than for the other sub-groups and female Indigenous (EDA rate of 14) was the highest group.
- There were more EDAs for alcohol than drugs and so the rate of EDAs was generally higher for alcohol.
- Non-Indigenous females had the lowest rates of EDAs (and could be as small as 0.1 monthly rate of EDAs).
- The Indigenous male group had the highest rates of EDAs (with the one exception noted above).
- Mental health EDAs were of much greater significance than alcohol or drug related EDAs (noting however mental health was not mutually exclusive of alcohol or drug related issues).

The following analyses took a closer look at the four sub-types of EDAs, i.e. Mental Health, Alcohol and/or Drugs, Alcohol only and Drugs only. In Tables 5.4 to 5.7 the mean monthly rate of EDAs are provided for the three time periods of interest, i.e. the five-month period pre-transition, the transition period itself, and the five-month period post-transition. The EDA rates are provided by site, gender, and Indigenous status (per 1,000 site-group specific population).

In the following discussions, two measures were used to assess impacts of the ending of the CDC program: (1) difference between trial and comparisons sites, and (2) across-time difference for trial and comparison sites. More extensive discussion of across-time differences are found in Appendix 4 where time-series figures for EDA rates are discussed.

As noted previously, monthly averages for sub-groups of EDAs could be quite small even when taken over each five-month period: mental health EDAs were the most frequent (e.g. for the female Indigenous population in the East Kimberley trial site post-transition there were 20 EDAs per 1,000 population – while the least frequent was female non-Indigenous post-transition in the Goldfields trial site at 1.5 per 1,000 population). Moreover, monthly data were volatile and so counts, rates and means could be subject to apparently large change – that could be reversed at the next observation which may occur in the next five-month period and so lead to distortions that effect conclusions about changes.

As indicated when considering average monthly EDAs previously, it was clear that during these three periods the non-Indigenous populations had fewer monthly (population adjusted) rates of EDAs for the four categories of Mental Health, Alcohol only, Drugs only, and Drugs and/or Alcohol (remembering these categories are not mutually exclusive). In addition, for the Indigenous population, rates of EDAs were almost always higher in the trial then the comparison sites.

The tables also include a measure of the difference in frequency between trial and comparison sites. As the tables demonstrate, some differences could be trivially small and, given the tendency for volatility, these differences probably are of no practical importance. Nonetheless, in some cases the analysis of this difference could be quite instructive. For example, for mental health EDAs (Table 5.4) the difference between the East Kimberley trial and comparison sites for Indigenous females showed the comparison rate ranged between about four and eight (which was about 27 per cent to 50 per cent less than the trial site), but in the Goldfields the difference was only between 0.2 and 1.3 (about 3 per cent to 11 per cent).

Overall, the four tables tend to show group consistencies when comparing trial and comparison sites for any one period. Once again using mental health EDAs (Table 5.4) as an example: for the Indigenous population there were only two (of the 12) cases where the comparison site rate of EDAs was higher than the trial site. On the other hand, for the non-Indigenous population seven (of the 12) cases showed the rate of EDAs as higher in the comparison than trial site, but non-Indigenous rates were always significantly smaller than rates for the Indigenous populations. Generally, this table confirms the importance of disaggregating the EDAs between gender and Indigenous status – as do other tables and figures.

Table 5.4: Mean monthly Mental Health EDAs by site and transition periods

Mean monthly Mental Health EDAs (per 1,000 of population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
Male Indigenous						
5 month period pre-transition	9.7	10.2	-0.5	10.3	11.4	-1.1
Transition period	12.8	12.2	0.6	14.2	10.8	3.4
5 month period post-transition	17.5	14.7	2.8	15.4	13.5	1.9
Female Indigenous						
5 month period pre-transition	15.1	7.6	7.5	7.8	7.6	0.2
Transition period	13.7	10.0	3.7	11.3	10.5	0.8
5 month period post-transition	20.0	11.8	8.2	11.4	10.1	1.3
Male Non-Indigenous						
5 month period pre-transition	2.6	2.3	0.3	1.9	2.3	-0.4
Transition period	3.1	3.3	-0.2	2.5	2.4	0.1
5 month period post-transition	2.9	5.0	-2.1	2.8	2.9	-0.1
Female Non-Indigenous						
5 month period pre-transition	2.7	1.6	1.1	1.8	2.0	-0.2
Transition period	2.5	2.1	0.4	2.0	2.1	-0.1
5 month period post-transition	2.8	2.2	0.6	1.5	2.6	-1.1

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate of EDAs per 1,000 of population (for site, gender, and indigenous status specific populations).

Across-time differences in mental health EDAs showed some consistency, but changes could be very small (especially for the non-Indigenous population). For both trial and comparison sites, but more so for East Kimberley than Goldfields region, the average rate of mental health EDAs was higher at the conclusion of the post-transition period than the pre-transition (except for one case - non-Indigenous females). Also, in most cases the transition period rate was higher than the pre-transition period. An increase was seen in both trial and comparison sites – albeit for the Indigenous population generally the increase was greater in the trial sites. On balance there appeared to be an association between the period when the CDC was abolished and mental health EDAs but because of increases in the comparison groups it was difficult to conclude that this was due to the abolition of the CDC. This was consistent with the mixed findings for the qualitative analysis (see Section 5.5.1).

For EDAs for Drugs and/or Alcohol in Table 5.5 below, the patterns continued to differ between gender and Indigenous status – and in many cases between this category and mental health. For example, for non-Indigenous females in the East Kimberley trial site EDAs were significantly higher than the comparison site, but in the Goldfield sites there were virtually no differences. As indicated above, the mental health category differences and size of differences had different patterns: (1) across-time differences also showed some consistence, but as with mental health, changes could be very small; (2) the average rate of EDAs was higher at the conclusion of the post-transition period than the pre-transition (but in this case much more so for the Indigenous groups); (3) in most cases

the transition period rate was higher than the pre-transition period; and (4) there were increases in both trial and comparison sites – somewhat more so for the Indigenous groups. Again, there did appear to be an association between the period when the CDC was abolished and drug and/or alcohol EDAs but it is difficult to know how much (or if any) was due to the abolition of the CDC as an increase was also seen in the relevant comparison groups.

Table 5.5: Mean monthly Drug and/or Alcohol EDAs by site and transition periods

Drug and/or Alcohol EDAs (per 1,000 of population)	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
Male Indigenous						
5 month period pre-transition	4.2	4.1	0.1	5.4	5.4	0
Transition period	4.6	5.2	-0.6	7.5	7.1	0.4
5 month period post-transition	6.8	6.0	0.8	6.9	4.1	2.8
Female Indigenous						
5 month period pre-transition	3.3	2.1	1.2	4.4	2.8	1.6
Transition period	2.3	3.9	-1.6	6.4	3.4	3
5 month period post-transition	6.8	3.9	2.9	5.9	3.7	2.2
Male Non-Indigenous						
5 month period pre-transition	1.9	0.8	1.1	0.7	0.8	-0.1
Transition period	1.6	0.9	0.7	0.8	0.8	0
5 month period post-transition	1.5	1.9	-0.4	0.9	0.8	0.1
Female Non-Indigenous						
5 month period pre-transition	0.7	0.1	0.6	0.3	0.3	0
Transition period	0.8	0.4	0.4	0.4	0.4	0
5 month period post-transition	0.8	0.4	0.4	0.4	0.4	0

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate of EDAs per 1,000 of population (for site, gender, and indigenous status specific populations).

In Table 5.6 below, data for the category alcohol only EDAs are shown. Rates of EDAs were smaller than for drug and/or alcohol and were significantly smaller than mental health rates of EDAs (recalling the issue of non-mutually exclusive categories of EDAs). Nonetheless, the analyses generally confirmed that: (1) the rates of EDAs for the trial sites were higher than the comparison sites; (2) the sites in the East Kimberley had higher rates of EDAs than the Goldfields; (3) rates were higher for the Indigenous populations compared to the non-Indigenous populations; (4) male rates were generally higher than female rates; and (5) the responses between the pre-transition, transition and post-transition periods in some cases had some similarity and in other cases did not.

Table 5.6: Mean monthly Alcohol Only EDAs by site and transition periods

Alcohol only EDAs (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
Male Indigenous						
5 month period pre-transition	2.7	2.2	0.5	2.6	2.0	0.6
Transition period	3.1	2.9	0.2	3.8	3.8	0
5 month period post-transition	4.9	3.6	1.3	3.4	3.4	0
Female Indigenous						
5 month period pre-transition	2.4	1.5	0.9	2.4	0.8	1.6
Transition period	1.7	2.6	-0.9	3.0	1.5	1.5
5 month period post-transition	3.9	2.4	1.5	4.0	1.1	2.9
Male Non-Indigenous						
5 month period pre-transition	1.5	0.5	1	0.2	0.4	-0.2
Transition period	0.6	0.6	0	0.5	0.5	0
5 month period post-transition	1.1	0.8	0.3	0.5	0.5	0
Female Non-Indigenous						
5 month period pre-transition	0.5	0.2	0.3	0.3	0.2	0.1
Transition period	0.2	0.3	-0.1	0.1	0.2	-0.1
5 month period post-transition	0.4	0.3	0.1	0.3	0.1	0.2

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate of EDAs per 1,000 of population (for site, gender, and indigenous status specific populations).

Similar patterns were seen here as with the previous types of EDAs. Once again, a trend of increases in average alcohol only EDAs were found, and few and less changes in the non-Indigenous groups. As changes were also observed in the comparison groups an association between abolishing the CDC and alcohol EDAs could be suggested, but again it is difficult to know how much (or if any) was specifically due to the change in the CDC policy. In addition, as noted in Section 5.10, in various regions at various times alcohol restrictions were in operation (including bans on public drinking, limits on the quantity and types of alcohol purchased, and having to show photo ID to purchasing takeaway alcohol). These events cannot be controlled for when considering the data, and as such, the relative importance of these changes in rates of EDAs.

In Table 5.7 below the rates and changes in EDAs are considered for the category Drugs Only. This category had the lowest rates of EDAs, which necessarily means differences must be smaller and, as noted previously given data issues and caveats, not too much should be read into very small differences in rates of EDAs. Clearly, while drug-related EDAs occur, they were less of a driver of total EDAs than Alcohol Only.

Table 5.7: Mean monthly Drugs Only EDAs by site and transition periods

Drugs only EDAs (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
Male Indigenous						
5 month period pre-transition	1.7	0.9	0.8	1.8	3.0	-1.2
Transition period	1.3	1.4	-0.1	3.2	3.9	-0.7
5 month period post-transition	1.1	1.5	-0.4	3.4	2.2	1.2
Female Indigenous						
5 month period pre-transition	0.8	0.3	0.5	0.9	2.0	-1.1
Transition period	0.6	0.8	-0.2	2.7	2.4	0.3
5 month period post-transition	0.9	0.8	0.1	2.1	2.5	-0.4
Male Non-Indigenous						
5 month period pre-transition	0.0	0.2	-0.2	0.6	0.3	0.3
Transition period	0.6	0.2	0.4	0.4	0.3	0.1
5 month period post-transition	0.5	1.0	-0.5	0.4	0.3	0.1
Female Non-Indigenous						
5 month period pre-transition	0.4	0.1	0.3	0.2	0.3	-0.1
Transition period	0.2	0.2	0	0.3	0.3	0
5 month period post-transition	0.1	0.2	-0.1	0.3	0.3	0

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate of EDAs per 1,000 of population (for site, gender, and indigenous status specific populations).

Moreover, for this category the difference in rates of EDAs between trial and comparison sites was more balanced. That is, of the 24 possible cases 11 had higher rates in the trial site, 10 had higher rates in the comparison site (and 3 had no meaningful difference). For drug only EDAs it can be concluded, on balance, that the patterns and size of changes in trial and comparison sites in EDAs did not indicate any association between these EDAs and the cessation of the CDC; this suggests that there was no evidence of a meaningful influence.

In conclusion, these analyses considered associations between population adjusted rates (i.e. per 1,000 population) of EDA for total EDAs and for four sub-groups of EDAs (i.e. due to Mental Health issues; Alcohol and/or Drugs issues; Alcohol Only; and Drugs Only). Cognisance should be paid, however, to the caveat related to data issues and potential missing variable bias which could suggest that any association with CDC program cessation was spurious and could instead be a consequence of unobserved individual characteristics or site-wide occurrences that are cultural, social, or micro-/macro-economic events. Nonetheless, the analyses suggest that there was some evidence that monthly EDA rates in various sites and for various groups were associated with the cessation of the CDC. Specifically, it can be suggested that, on average, in the East Kimberley and Goldfields trial sites and for Indigenous groups there was a tendency for EDA rates to be higher in the post-transition period than the pre-transition period. However it is difficult to know how much (or if any) was specifically due to the change in the CDC policy.

5.5.3. Integrated findings

The qualitative evidence found perceptions in Ceduna, East Kimberley and the Goldfields of declining levels of child wellbeing and welfare since the CDC program had ended. These concerns primarily centred on some children not being fed or clothed properly as a result of household finances now being spent on alcohol and gambling products. Respondents also commonly noted that more children were out on the streets unsupervised at night. Further issues were raised (and especially in Ceduna) of decreased school attendance. The qualitative evidence suggested that similar concerns were not being experienced in Bundaberg-Hervey Bay.

Our review found more limited evidence regarding the impact of the ending of the CDC program for the wellbeing of past CDC participants. Some stakeholders in Ceduna and the East Kimberley reported that the health of some past participants had been negatively affected by the ending of income management, particularly in relation to alcohol misuse. An analysis of EDAs in the East Kimberley and Goldfields found some evidence of increased emergency department admission rates since CDC program cessation. However, it is difficult to know how much (or if any) was specifically associated with the ending of the CDC program.

5.6. Safety and violence

An expectation of the CDC was that a reduction in harmful behaviours would trickle down into the community and families in the form of increased safety, lower crime and less family violence. However, there was a possibility that the added restrictions introduced by the CDC to limit the availability of cash for harmful behaviours, would result in more criminal activity for the purposes of obtaining necessary cash. The cessation of the CDC, therefore, could be expected to have either increased criminal activity due to more engagement in harmful behaviours or decreased it, due to a reduced need to engage in criminal activity to access cash. The evidence presented in this section includes the findings from qualitative interviews in each of the four CDC trial sites and an analysis of quantitative policing data from Western Australia.

5.6.1. Evidence from in-depth qualitative interviews

Many stakeholders reported that issues around safety and violence had increased in the Ceduna, East Kimberley and Goldfields regions since the transition from the CDC program. Although past CDC participants were less likely to consider the cessation of the card as having impacted on crime, a sizeable minority in the East Kimberley and Goldfields also expressed concerns relating to this domain. While most respondents perceived there to be a direct correlation between the ending of the program and these issues, additional contributing factors were also acknowledged, e.g. broader policy changes, cultural events and seasonal mobility patterns.

> *Across the board, we're seeing an increase in antisocial behaviour, an increase in violence and…the actions of people quite different and dangerous in comparison to what they were. And it is somewhat making people feel unsafe…It's clear that crime has increased…break-ins and things like that…The card ended - it was literally a light switch. CEDSH02*

I know what's going on from just observing…and unfortunately, in the last 12 to 18 months…I've noticed the crime rate has doubled, I reckon. GFP11

Alcohol-related crime was suggested to have increased in particular, including a rise in antisocial behaviour, assaults and family violence (the latter especially in East Kimberley and the Goldfields). A greater incidence of home break-ins and store theft were also described with people attempting to access cash, alcohol and food. As a result of these issues, some stakeholders in East Kimberley and the Goldfields noted associated increased demands on the police; and in the Goldfields demand for refuge services was also said to have risen alongside court-directed orders for drug and alcohol counselling.

Kalgoorlie was not how it is today now, it's a very rowdy town and…a lot of violent stuff is happening like mothers and fathers fighting on the side of a road…a lot of domestic violence. GFP03

Theft has gone back up. Certainly, again, we've got people who are normally very respectful towards the shop and to our staff and that there's been more aggression. They've been trying to steal more stuff. GFSH34

In Ceduna and the East Kimberley, the severity of criminal activity (including the level of violence) was felt to have heightened since the CDC transition. Also in these locations, some respondents noted that a spike in crime had been experienced immediately after the card was stopped.

For months after the ending of the Cashless Debit Card, we saw a dramatic increase. So physical context before that, we'd see maybe one stabbing a month that was related to alcohol. And then we saw, basically a stabbing a day, for about a month after that. Just a lot of people getting very drunk and either stabbing themselves or stabbing someone else. EKSH22

A perceived escalation in youth crime and antisocial behaviour since the ending of the CDC program was reported including shoplifting, stealing cars, breaking into homes, vandalism and intimidation. Perpetrated by a small cohort of young people in each location, this issue was felt to be due to a lack of adequate supervision, and young people being hungry and stealing to eat, or having no safe place to go to and getting into trouble.

The youth is going crazy. They're out of control. I'm not sure if it's because of the card stopping, but they're just out of this world…The youth crime is terrible here. I don't feel safe. EKP21

Kids breaking-in stealing for food…Parents got no food at home…That's why they go do silly stuff, breaking-in. GFP36

In addition, respondents (mostly stakeholders) suggested that perceptions of community safety had worsened. Residents of the East Kimberley and Goldfields were said to feel more unsafe in their local community due to antisocial behaviour in public areas (i.e. shouting and fighting) and home break-

ins. In the East Kimberley this was resulting in community members taking measures to protect their homes and personal items. Meanwhile in Ceduna, although those living in the town were described as being somewhat accustomed to occurrences of antisocial behaviour in public places, these incidents were considered to be especially confronting for visiting tourists.

> *In your own house you shouldn't have to sit there and worry about locking everything up but we all do. Everybody has got security cameras and whatever else if you've got a house…we've got a dog. It's terrible. EKSH18*

> *Everybody's personally affected by it. I mean, just this year, I've had five attempted break-ins of my own house. EKSH02*

Local businesses – such as retail shops, cafes and takeaway food stores – in the East Kimberley and, to a lesser degree, the Goldfields were also said by stakeholders to have been adversely affected by increased criminal activity. As a result, staff felt more unsafe at work, and businesses were hiring additional staff to combat stealing, reducing their opening hours or even considering closing down their business. Current issues relating to safety and violence in the East Kimberley were also said to act as a deterrent in attracting and retaining workers to the region.

> *We've had to put an extra staff on Sundays now, so Sundays penalty rates…because we had a group of 15 kids just come into the shop, just grab everything in sight and just run out laughing and throwing stuff everywhere. This one junior manager, well, she just didn't come back from holidays. Just couldn't do it anymore…Businesses have had to close because there's been kids down there threatening them. EKSH18*

> *We're experiencing a bit of a staffing crisis throughout the whole of Kununurra…Everything kind of has a following on effect, the increased violence, and theft, some break-ins is definitely making a lot of families move. And it's not as attractive for people moving here. So it's hard to recruit staff. EKSH19*

Very little change in community safety and rates of violence following the ending of the CDC program was reported by respondents in Bundaberg-Hervey Bay. Some respondents described long-standing issues with youth crime, antisocial behaviour and family violence that had continued both during, and after, the operation of the program.

> *Our crime went exponentially through the roof in that period that had nothing to do with…the [CDC] trial. And that was a state-wide thing…we've had a juvenile crime wave…Whether it's Covid or whatever, a lot of agencies probably took their finger off the pulse a little bit, and…there's a lot of underlying social welfare issues, underlying issues with families. BHBSH24*

Respondents in the four trial sites (with the exception of one past participant in Ceduna) did not report any improvements in perceptions of safety or reduced levels of violence that had occurred since the cessation of the CDC program.

5.6.2. Evidence from community data

In this section, police data from Western Australia was used to review a number of community policing outcomes in the East Kimberley and Goldfields relating to the cessation of the CDC program. In order to elicit whether any changes in outcomes may be related to program cessation, outcomes were compared for these two CDC trial site locations with 'comparison sites'. As with the hospital emergency admissions data, the analyses considered outcomes at three time periods (the five-month period pre-transition from the CDC program, the transition period itself, and the five-month period post-transition). Longer-term trends (from 2014 to 2023) were also considered to provide context for the review analysis.[15]

The following discussion is based on Tables 5.8 to 5.17 which report mean rates of offences per 1,000 of population for the three periods of interest, i.e. since May 2022, for trial and comparison sites. While these tables are most informative, more refined details in figures covering the longer term (since January 2014) and the shorter CDC related period (starting in May 2022) for all categories of offences are provided in Appendix 5. Although these figures are not commented on individually, they are included to provide context to the discussion of the tables.

Family violence offences

Firstly, the mean monthly rates of family violence offences per 1,000 of the population in the East Kimberley and Goldfields were examined (see Table 5.8 below). Overall, the incidence of family violence was far higher in the East Kimberley compared to the Goldfields region, irrespective of the time period considered.

Table 5.8: Mean monthly Family Violence Offences by site and transition periods

Family Violence Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	24.0	15.5	8.5	4.4	2.4	2.0
Transition period	25.6	18.9	6.7	6.1	2.7	3.4
5 month period post-transition	23.0	16.7	6.3	5.7	3.7	2.0

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

For the East Kimberley, the number of offences in both the trial site and the comparison site grew marginally from the pre-transition to the transition period and then declined in the post-transition period. Consequently, by the post-transition period the difference between the trial and comparison sites increased somewhat. Moreover, there was a small fall in the trial site (about 4 per cent) and a small increase in the comparison site (about 8 per cent). Given the caveats regarding these data (and in particular the inability to disaggregate by gender and Indigenous status) these small changes are probably immaterial.

[15] Further detail on the quantitative methodology used for these analyses is provided in Appendix 3.

A different pattern was observed for the Goldfields region, but the changes were much smaller (as the average rates were much smaller). Family violence offences averages rose in both the trial and comparison sites between pre- and post-transition but by only 1.3 in both cases (in percentage terms the increase was smaller in the trial site than the comparison site (54 per cent vs 30 per cent). The gap in terms of offences between the trial site and comparison regions increased in the transition period before returning to its previous level post-transition.

In summary, in the East Kimberley trial site post-transition rates were lower than pre-transition, and higher in the three other groups, but these changes were quite small numerically. In addition, for both trial sites rates increased between pre-transition and transition, but fell post-transition. While there was an increase in the difference between the East Kimberley trial and comparison sites, this may not necessarily be due to the influence of the cessation of the CDC. Therefore, evidence for the influence of the cessation of the CDC was, at best, mixed – and if any change were brought about by the cessation it appeared to be disappearing.

Breach of violence restraint orders

Breach of violence restraint order is a type of offence that is highly relevant to family violence. The WA Police data indicated that over 90 per cent of the breach of violence restraint order offences in the East Kimberley and Goldfields were flagged as 'family violence'. The mean monthly rates of breach of violence restraint orders are summarised in Table 5.9. Overall rates of violence restraint orders breaches were somewhat higher in the East Kimberley region when compared with the Goldfields.

Table 5.9: Mean monthly Breach of Violence Restraint Order Offences by site and transition periods

Violence Restraint Order Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	8.0	3.3	4.7	1.2	0.6	0.6
Transition period	5.6	4.4	1.2	1.3	0.7	0.6
5 month period post-transition	4.9	3.4	1.5	1.6	1.5	0.1

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

In the East Kimberley trial site, the rate of breaches declined following the ending of the CDC program. In contrast, the monthly rate in the comparison site increased at the time of the transition period, subsequently returning close to the pre-transition level. Furthermore, the gap in the offence rate between the trial and comparison sites declined significantly from the pre-transition period.

The rate of breaches of violence restraint orders in both the Goldfields trial and comparison sites grew during the periods of observation. Importantly, however, the increase in the comparison site was 150 per cent but only about 33 per cent in the trial site. The small gap in offences between these locations remained constant from the pre-transition to the transition period and dropped to almost zero during the post-transition period.

The change in breach of violence restraint orders in the East Kimberley trial site appeared to be negatively associated with the cessation of the CDC. On the other hand, the Goldfields trial site contradicted this negative association due to the small increases in the two later periods.

Family violence tasks attended

A final measure relating to family violence in the policing data are the number of family violence tasks that are attended by the police. The mean monthly rate of family violence tasks for the East Kimberley and Goldfields trial sites and the respective comparison locations are presented in Table 5.10. As with the previous measures, overall the incidence of family violence tasks was considerably higher in the East Kimberley than the Goldfields region.

Table 5.10: Mean monthly Family Violence Tasks Attended by site and transition periods

Family Violence Tasks Attended (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	13.3	15.6	-2.3	4.0	2.7	1.3
Transition period	17.3	17.1	0.2	4.3	3.1	1.2
5 month period post-transition	15.3	16.9	-1.6	3.8	3.0	0.8

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

Of particular note is that in all cases rates were higher in the comparison sites than the trial sites. In addition comparing the pre- and post-transition rates they declined in both trial sites but increased in both comparison sites – and so the difference between trial and comparison sites diminished. Noting the usual caveats that suggest small changes should be treated with caution, there was some evidence here to suggest that the cessation of the CDC was associated with a decrease in the monthly rate of family violence tasks attended to by police after the cessation of the CDC.

Drug offences

Since one of the major objectives of the CDC policy was to reduce social harm associated with the misuse of drugs and alcohol, the analyses examined relevant offences and charges. Table 5.11 below shows the mean monthly number of drug offences (per 1,000 of population) in the East Kimberley and Goldfields. The incidence of drug offences were very similar across the two regions.

Table 5.11 : Mean monthly Drug Offences by site and transition periods

Drugs Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	1.4	1.6	-0.2	1.3	0.7	0.6
Transition period	1.0	3.1	-2.1	1.2	1.0	0.2
5 month period post-transition	1.5	2.6	-1.1	1.4	1.9	-0.5

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

In both the East Kimberley and Goldfields trial sites, the mean number of drug offences did not vary significantly across the three time periods. In contrast, the number of offences in the comparison sites increased slightly during the transition period, and dropped marginally thereafter. The gap in offences between the trial and comparison sites fell significantly at the time of the ending of the CDC program, suggesting a relative decline in the number of these offences in the East Kimberley trial site.

For this type of offence, rates were higher in the East Kimberley comparison site than the trial site, but in the Goldfields this was the case only post-transition. Noting the caveats regarding caution with small changes, there appears to be no evidence that the cessation of the CDC was materially associated with the monthly rate of drug offences.

Drink driving charges

Next the review examined trends in the number of drink driving charges in the East Kimberley and Goldfields regions (Table 5.12 below). The incidence of these offences were slightly higher in the East Kimberley region than in the Goldfields.

Table 5.12: Mean monthly Drink Driving Charges by site and transition periods

Drink Driving Charges (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	2.1	2.3	-0.2	0.6	0.7	-0.1
Transition period	3.0	1.8	1.2	0.6	0.5	0.1
5 month period post-transition	1.5	2.0	-0.5	0.9	0.3	0.6

Notes: (1) Pre-transition May 2022-Sept 2022, Transition Oct 2022–March 2023, Post-transition March 2023-August 2023. (2) Data rate per 1,000 of population.

In both the East Kimberley trial and comparison sites the mean number of drink driving charges was lower by the post-transition period compared to pre-transition. A similar trend was observed in the Goldfields comparison site but in the Goldfields trial site the rate had increased – but a change from 0.6 to 0.9 must be treated as marginal at best. Generally, changes in drink driving charges were very small and suggest a lack of evidence of an association with the cessation of the CDC.

Assault offences

In the next two sections, two types of offences against people, namely 'assault' and 'threatening behaviour'[16] are examined. The mean monthly number of assault offences (per 1,000 of the population) are shown in Table 5.13. The number of assault offences was found to be considerably higher in the East Kimberley than for the Goldfields regions.

Table 5.13: Mean monthly Assault Offences by site and transition periods

Assault Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	14.9	11.3	3.6	3.7	2.0	1.7
Transition period	18.7	12.5	6.2	5.3	2.3	3.0
5 month period post-transition	17.5	12.0	5.5	4.3	2.4	1.9

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

In the East Kimberley trial site, the number of assaults increased moderately at the time of CDC program cessation and then declined slightly in the post-transition period. While following a similar pattern, these changes were less pronounced in the comparison sites. The difference in offences between the two locations increased following the pre-transition period, indicating relatively worsened outcomes in the trial site since the end of the CDC program, but the changes in the Goldfields site were very small. In all sites post-transition rates were higher than pre-transition but these were marginal increases except in the East Kimberley trial site. In addition, in all cases (but the Goldfields comparison site) the rates rose but then fell. On balance, the data provided some indication of an association between increased assaults and the cessation of the CDC in the East Kimberley trial site alone.

Threatening behaviour offences

Next, incidences of 'threatening behaviour'[17] were examined, with the findings presented in Table 5.14. The incidence of threatening behaviour offences was higher for the East Kimberley compared to the Goldfields region.

[16] In the WA Police data, assault was split into family assault and non-family assault. In both the East Kimberley and Goldfields, the former accounted for about three-quarters of all the assault offences. The analysis included both categories of assault.

[17] In the WA Police data, 'threatening behaviour' was also been split into family related and non-family related categories, with the former accounting for about two thirds in the regions of interest. Both of these categories were included in the analysis.

Table 5.14: Mean monthly Threatening Behaviour Offences by site and transition periods

Threatening Behaviour Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	3.2	2.0	1.2	0.8	0.4	0.4
Transition period	3.6	3.5	0.1	1.1	0.6	0.5
5 month period post-transition	2.9	3.4	-0.5	1.0	0.5	0.4

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

The rate of threatening behaviour offences rose in all sites between the pre-transition and transition periods and then fell (marginally in all but the East Kimberley trial site); by post-transition, the East Kimberley trial site was lower than pre-transition but the other sites were higher. The difference between the Goldfields trial and comparison sites did not change but was reversed between the East Kimberley trial and comparison sites. As the changes were small to very small and mixed it was not clear that there was a meaningful association between the cessation of the CDC and threatening behaviour offences.

Property damage/graffiti offences

In the next two sections, findings are presented relating to two types of offences against property, namely 'property damage/graffiti' and 'stealing'[18]. Firstly, the mean monthly offences pertaining to property damage or graffiti are presented in Table 5.15. As often observed for the previous types of offences, the incidence of property damage and graffiti was somewhat higher in the East Kimberley than the Goldfields region and changes were relatively small and mixed.

Table 5.15: Mean monthly Property Damage/Graffiti Offences by site and transition periods

Property Damage/Graffiti Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	5.4	3.8	1.6	2.4	1.2	1.2
Transition period	6.8	4.2	2.6	3.2	1.7	1.5
5 month period post-transition	6.8	3.9	2.9	2.3	2.0	0.3

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

[18] In the WA Police data, these were the two most frequent types of offences against property in the East Kimberley and Goldfields.

In the East Kimberley trial site, the number of offences increased at the time of the transition from the CDC program, and remained stable in the post-transition period. In contrast, the number of such offences committed in the comparison area varied very little during the three time periods. Consequently, the difference in the number of offences between both locations widened somewhat over time, indicating small relatively worsened outcomes in the trial site since CDC program cessation.

In the Goldfields trial site, the number of offences increased slightly during the transition period; subsequently dropping to the levels experienced during the pre-transition period. In contrast, the number of offences committed in the comparison area continued to grow marginally over time. While the difference in offences between the Goldfields trial and comparison sites widened a little initially, this gap almost disappeared during the post-transition period, indicating a relatively positive outcome in the trial site in the months after the ending of the CDC program.

Once again, the changes observed were generally small and somewhat mixed, but the increase from pre- to post-transition in the East Kimberley trial site suggested an association between the cessation of the CDC and increased property damage/graffiti offences at this site, but not elsewhere.

Stealing offences

Next, the occurrence of 'stealing' offences in the East Kimberley and Goldfields was examined (see Table 5.16). Rates of stealing were similar in both regions.

Table 5.16: Mean monthly Stealing Offences by site and transition periods

Stealing Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	3.9	3.5	0.4	2.8	1.5	1.3
Transition period	3.9	3.0	0.9	4.3	1.9	2.4
5 month period post-transition	4.3	3.6	0.7	2.6	1.8	0.8

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

While there was no change in the rate of stealing offences in the East Kimberley trial site between the pre-transition and transition periods it then rose, but only by about 10 per cent, taking it higher post-transition than pre-transition. In contrast, in the Goldfields trial site the rate rose but then fell to be lower post-transition than pre-transition. Both comparison sites showed a very small increase by post-transition but followed different paths. The difference between sites in East Kimberley grew marginally but fell in the Goldfields sites. It can be concluded once again that small changes and mixed results do not indicate a consistent association between the cessation of the CDC and stealing offences.

Other offences

In order to ensure the analyses captured all types of offences recorded in the WA Police data, an 'other offences' category was created by combining the remaining types of offences[19]. The trends relating to the mean monthly number of 'other offences' are displayed in Table 5.17. In the East Kimberley, the number of other offences in both the trial and comparison sites were considerably higher than those found for the Goldfields.

Table 5.17: Mean monthly Other Offences by site and transition periods

Other Offences (per 1,000 population)						
	East Kimberley			Goldfields		
	Trial	Comparison	Difference	Trial	Comparison	Difference
5 month period pre-transition	9.1	8.8	0.3	3.7	2.9	0.8
Transition period	10.7	8.7	2.0	4.5	2.8	1.7
5 month period post-transition	7.5	7.8	-0.3	3.2	2.7	0.5

Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023. (2) Data rate per 1,000 of population.

The rate of such offences in both trial sites increased moderately at the time of the CDC program transition and declined subsequently to below the pre-transition rates. In contrast, the rate of other offences in the comparison sites declined in the transition and post-transition periods. As a result, the gap between the trial and comparison sites was greater during the transition period only, but smaller in the post-transition period and reversing between the East Kimberley sites. The changes to lower rates post-transition were small and generally the differences between trial and comparisons site rates were also small; consequently, there was no strong evidence of an association between the changes and the cessation of the CDC.

5.6.3. Integrated findings

Within the qualitative evidence, differences were found in the perceptions of stakeholders and past CDC participants as to the impact the ending of the CDC program had had on community safety and rates of violence. In particular, many stakeholders in Ceduna, East Kimberley and the Goldfields reported negative perceived impacts including a rise in alcohol-related and youth crime, increased severity of criminal activity, and worsening perceptions of community safety. In contrast, fewer past CDC participants raised similar concerns (and mostly those living in the East Kimberley and Goldfields). Little change in levels of community safety and violence was reported by respondents in Bundaberg-Hervey Bay.

[19] 'Other offences' included 'arson', 'burglary', 'deprivation of liberty', 'fraud and related offences', 'historical sexual offences', 'homicide', 'receiving and possession of stolen property', 'recent sexual offences', 'regulated weapons offences', 'robbery' and 'stealing of motor vehicle'. In the East Kimberley and Goldfields regions, burglary accounted for the vast majority of these 'other offences'.

The analysis of police data for Western Australia indicated that for the vast majority of policing outcomes, both the change in the number of offences occurring in the trial sites and the change in the difference observed between the trial and comparison sites appeared moderate or marginal over the three periods of interest. This indicates that overall the crime-related outcomes in the East Kimberley and Goldfields trial sites have not altered substantially since the ending of the CDC program.

However, when individual policing measures were examined, the findings suggested some small relative and absolute worsened outcomes in relation to rates of assault offences and property damage/graffiti in the East Kimberley trial site since the ending of the CDC program; this was consistent with the stakeholder observations in that region. In contrast, the quantitative findings suggested relative improvement in the domains of family violence, violence restraint orders, and drug and threatening behaviour offences in the East Kimberley, and for drug and property damage/graffiti offences in the Goldfields. This was generally due to relative changes in trial and comparison sites that were observed but, particularly for the comparison sites, there was no information on why a monthly change may have occurred. As with the health data, however, the caveat of potential missing variable bias must be borne in mind and may indicate that any associations found could be a consequence of unobserved individual characteristics or location-specific occurrences.

5.7. Support service usage

The ending of the CDC program was also found to have an impact on organisations that operated in the trial areas, particularly those that provided support services to past CDC participants. The review collected evidence on support service usage since the ending of the CDC program. These findings arise from the in-depth interviews with stakeholders and past CDC participants undertaken in the four trial sites.

5.7.1. Evidence from in-depth qualitative interviews

A majority of respondents (mostly stakeholders) in each of the four regions reported that increased support service need and use had occurred in the period since the ending of the CDC program. Local services were described as often being over-stretched and that current demand was exceeding service capacity and available resources. Some stakeholders also noted that their client group had expanded, with new individuals now seeking support.

> *We were not ready for it. The impact was immediate. And the demand was high for our service, in terms of good supply and the program increasing as well…We were not ready financially for it…People we never had here before are coming constantly as well. EKSH08-09*

> *We obviously have the church…they do breakfasts, and stuff like that, but you see a lot of people down there now…The church is reaching out for food, because they can't keep up with the amount of volume that's coming in. GFSH19-20*

In all four regions, a large increase in the numbers of people seeking emergency relief services was noted. This included access to food vouchers and boxes, clothes, and the payment of items such as school fees, fuel and car registration. In Bundaberg-Hervey Bay and Ceduna, greater numbers of local residents were said to be seeking access to housing support including transitional and short-term accommodation. Respondents in Ceduna and East Kimberley also reported greater demand for breakfast clubs and emergency meal programs at schools and youth services.

> *There was a line up out the door this morning when I went down there at 9 o'clock. So that's for your food vouchers, your food boxes from Foodbank that we give. Just a massive line up there…I know one day down there, it was soon after the card went, there was 36 people lined up down there. So that tells a story. EKSH20-21*

> *So our homeless team across the road they have had like an increase of people coming in for Foodbank over the last since this card's finished. So I don't know if that's to do with this [the CDC program ending] but it's around the same time and…they usually get like about 30 or something whereas now they're getting like 60, 70 coming in. GFP01*

Meanwhile, increased usage of alcohol services was reportedly occurring in Ceduna and the Goldfields, including more directed orders by the police and courts in the latter location. Other support services that were considered to have experienced enhanced demand since the ending of the CDC program included financial counselling services (in Bundaberg-Hervey Bay), school attendance services (in Ceduna), police, ambulance and emergency department services (in East Kimberley and the Goldfields) and family violence services (in the Goldfields).

> *The line showed about a 25 per cent increase in activity and presentations to the hospital compared to the same time last year. And it was similar with the assaults as well, that the police were recording. There was just a lot of a lot of numbers to show that the amount of activity that we had to deal with was increased. And looking at it from sort of the ground level point of view, it looks like it was mostly to do with alcohol. EKSH22*

> *The reliance on assisting people regularly now, is a daily occurrence…[with] a whole range of combination of issues in people's lives that need to be dealt with daily. Not only our organisation there's been pressure put on other organisations too like the police and DCP and the hospital and other organisations. GFSH31*

Respondents were divided, however, as to whether this increased demand was directly related to the cessation of the CDC program or if other factors could also be contributing. In Ceduna and East Kimberley, respondents were most likely to consider that rising support service usage was a direct result of the program ending.

> *It has had a rather negative fallout, [an] increase in people accessing emergency relief…Ultimately, people were coming up off the Card, the supports weren't yet put into place. There were multiple people displaced and stuck here. And we had to be reactive for the first time to a problem and deal with that reaction. CEDSH02*

Respondents also considered that the ending of the CDC program had led to increased numbers of people from Aboriginal communities coming into towns in the Ceduna, East Kimberley and Goldfields regions (see below for further discussion). At times, this placed additional pressure on local organisations who had to provide support to these visitors. In addition, respondents in Ceduna and East Kimberley noted that some people who had exited income management were now accessing free welfare services (e.g. meal provision and short-term accommodation) and spending their Centrelink payments on alcohol. For out-of-town visitors this support was considered to be inadvertently encouraging people to stay away from community.

> *It's just a lot of them [past CDC participants] will spend their money on that first day, have no money for the kids for the next two weeks, but then running around the different services asking for handouts…I see it with my own family…and you get sick of it because they're all grown-ups. EKP19*

> *They're [welfare services] giving them [transitional visitors] freebies. Why would you come back [to community]? They've got all the stuff there [in Ceduna]. 7 o'clock, it's a routine: they get up, walk to the day centre, nice bacon 'n' egg here, a cup of tea. From there they make their way to Red Cross for a cup of tea and watch the pub open straight across the road. Yep, the pub's open, I'm gone, see you. It's a cycle they've gotten into. Then afternoon time they've got a free bed they go to the sobering up unit…It's all a cycle. We've got to get them out of the cycle. CEDP25-32*

Meanwhile, in the Goldfields, stakeholder opinion was more mixed, and most respondents in Bundaberg-Hervey Bay did not consider that the ending of the CDC program was responsible for rising service demand. Other factors that were considered to be influencing support service usage included cost-of-living and housing pressures, and mobility related to cultural business and school holidays which naturally brought more people into the regions. These factors – along with other confounding issues – are discussed in further detail below in Section 5.9.

> *We've seen an increase in the demand for services. But that's purely the environment with homelessness and cost-of-living. I don't think we could contribute any of that to the card. BHBSH27-28*

Many of the past CDC participants who informed this review were connected in with local social services, e.g. neighbourhood centres, employment services, financial counselling, alcohol services and parenting groups. While this involvement mostly pre-dated the cessation of the CDC program, some people stated that they had accessed support either to exit income management or to address issues (e.g. alcohol misuse and financial difficulties) that had arisen following program cessation.

> *My job agency referred me over here to help to get me off the grey card [the CDC] and that's how I got here, and I've been here ever since. BHBP06*

> *Never been drinking for three weeks now…[I go to the] Day Centre…[for] counselling there. CEDP05*

5.8. Transitional visitors

The cessation of the CDC program has the potential to not only impact on those who reside in the trial areas, but also on people who transit through those regions. The evidence described in this section is drawn from the qualitative interviews.

5.8.1. Evidence from in-depth qualitative interviews

Some respondents in Ceduna, East Kimberley and the Goldfields suggested that the ending of the CDC program had led to a considerable increase in the number of transient visitors to towns in their regions. In order to avoid being placed on income management, the CDC program was considered to have deterred people (in receipt of income support payments) who lived outside the trial sites from visiting for lengthy periods. Now that the program had ended, some respondents noted that there had been an influx of visitors and that their length of stay had increased. Respondents also felt that an increase in visitor numbers was exacerbating social issues and (as discussed above) placing a strain on local support services.

> *They [transitional visitors] come in from the Lands…they're coming out from community. I'm talking out further than Laverton…They're coming into town, knowing that there's no accommodation here. So they're all sleeping out on the streets, and then trying to go to the church for assistance…They're sticking around for ages…You've got all these out of towners that are coming in to the communities and causing a ruckus because they have access to the alcohol. GFSH19-20*

In Ceduna, it was additionally observed that the cessation of the CDC had increased the mobility of people from surrounding communities (that had been subject to the CDC program) to come into the township. Indeed, some respondents described an “exodus” and that these communities had “emptied out” since the cessation of the program. As a consequence, concerns were expressed regarding the long-term future of the communities.

> *The impacts have definitely been far more people in Ceduna from communities. I think Oak Valley and Yalata have been pretty emptied out since people realise that they can come and spend…And I'm not saying that that wasn't happening when we did have the Cashless Debit Card…but I think the change has been the numbers of people that are visibly on our streets in Ceduna looking for accommodation. [The] town camp, where transitional accommodation is, is often booked out. And communities [are] telling us that there isn't anyone there. CEDSH01*

> *We've got to get the people back here…there’s no one there [in Yalata]. We’re losing everything. The community won’t be there anymore…For our region it’s really sad. It’s sad what’s happening with that. CEDP25-32*

As discussed in greater detail below, the removal of mutual obligation requirements for the Community Development Program (CDP) was also thought to have contributed to this increased mobility. Prior to ending of the CDC program, however, population movement (even with the changes to the CDP) was considered to be relatively short-term with residents returning after a few days. With the cessation of income management, the length of time spent away from community was considered to have increased dramatically.

> *Over the past six months, I could tell you, we've had up to the highest additional number of people [in Ceduna]...The reason they're staying so long, is because well, actually even that goes back to CDP in terms of mutual obligations...People no longer had to go back to their home community to report and to attend to mutual obligations, they could stay wherever they were. CEDSH12*

5.9. Tourism

5.9.1. Evidence from in-depth qualitative interviews

A further perceived impact of the ending of the CDC program for the Ceduna and East Kimberley regions related to tourism. Some respondents (mostly stakeholders) expressed concerns that the cessation of the program was having an adverse indirect effect on tourism. In particular, an increased incidence of public drinking and intoxication, humbug and crime - in conjunction with negative media reporting about these issues - was said to be affecting tourist numbers. These respondents noted that tourism was a vital part of the local economy in each region and that detrimental impacts would be experienced if tourism continued to be affected.

> *If they [Ceduna] can't get the behaviour under control in town that it is concerning for everybody...the kids, the families themselves, the business owners in there. Because Ceduna is getting quite a bad rep for not being a place that's pleasant to stop and...people aren't stopping. They just...bypass, go straight to Streaky Bay or so on. CEDSH15*

> *Once upon a time, places like Kununurra and Broome would be the jewel in the Kimberley...Word of mouth gets around, "Don't go to Kununurra." It's a knock-on effect. EKSH14-15*

5.10. Compounding factors

The cessation of the CDC occurred at a time when several other relevant social and economic conditions and policy changes were concurrently impacting individual and community level outcomes in the region. These factors were considered by respondents to make it more challenging to ascertain the direct impacts which may have resulted purely from the cessation of the CDC policy alone. This final section draws from themes identified in the qualitative interviews with key stakeholders and past CDC participants about factors considered to compound the impact of the cessation of the CDC.

5.10.1. Evidence from in-depth qualitative interviews

Respondents (mostly stakeholders) described several factors that were combining with the cessation of the CDC to compound observed impacts present in the region and also make it more challenging to identify the specific stand-alone impacts of the ending of the CDC program. These factors included housing and cost-of-living pressures, transitional population movement, the ending of CDP mutual obligation requirements, alcohol restrictions and mining royalty payments.

Housing and cost-of-living pressures

In all four regions, respondents highlighted considerable socio-economic issues that were currently being experienced that affected social functioning and support service demand. These issues included housing pressures such as low vacancy rates and increased rents in the private rental market and an inadequate supply of social housing options (both short-term and permanent) which all contributed to greater incidences of overcrowding and homelessness.

> *That world's changed. So many people with nowhere to live now. We have so many people that can't afford everyday items, we have people that have to choose between either paying rent, eating or having medication. We have 85-year-old women now sleeping in their cars, because the landlord sold the house. BHBSH05-07*

> *It's always been a struggle here…I just recently moved back from [LOCATION]…No housing… You've got houses that are vacant that are not even being renovated etc. So that's why a lot of people are going homeless…on the streets sleeping, not only here, everywhere. EKP29*

Cost-of-living pressures associated with the higher prices of goods and services were also said to be contributing to financial stress for many individuals and families. This was considered to be especially problematic for Centrelink recipients living in remote towns and communities where prices were particularly high.

> *I think since Indue [the CDC] has stopped and we've had the inflation and…the increase of prices, so I think perhaps people are pulling back on their budgeting with the higher cost-of-living and all that…Home ownership and the scarcity of accommodation, which we certainly experience here in Kalgoorlie, so these universals that are hitting us. I just wonder whether it's a bit hard to tease out any positive effects of the Indue because we've now had so many increases in costs and inflation, and they could be compounding variables if you're trying to get a fuller picture. GFP32*

> *Being on the Centrelink up here, you can't really survive because it's bloody expensive. You go to the supermarket, a packet of meat is like $20 for four pieces of chops. So you could try to save but then it's so expensive. The living expenses you know. It's just arm and a leg up here. EKP29*

Traditional population movement

As discussed above, transitional population movement was considered to have increased with the ending of the CDC program in Ceduna, East Kimberley and the Goldfields. However, respondents also noted that transitional visitor numbers were affected by additional factors such as seasonal trends (e.g. greater movement during the summer months and school holidays), cultural business and funerals. Social issues within the regions were said to become more prevalent when visitor numbers were higher, and especially with regard to public drinking and alcohol-related violence; demand for support services also rose at these times.

> *Mobs coming from the Lands…They're starting to come across from Laverton through to here [Leonora]…It's just an influx of people coming…it puts the town on edge…On the card [CDC], you got to go through and move on. But now that it's finished they're coming back to stop here…and they get drunk or whatever, spend all their money in that one day. GFSH02*

During the Coronavirus (COVID) pandemic, there was a significant decrease in traditional population movement due to community lock-downs. It was noted, however, that communities were coming out of lock-down at the point in time that the CDC program was ending and CDP mutual obligation requirements were being lifted. Thus the cessation of the card, the removal of the mutual obligations, and a frustration with having their movements previously restricted due to COVID, were considered to have all combined to create an "exodus" out of communities.

Community Development Program

Changes to the operation of the CDP were considered to be a further factor influencing social and economic conditions in the regions. Previous mutual obligation requirements had been withdrawn, meaning that participation in the CDP became voluntary. Respondents noted that previously the CDP had provided a positive structure for participants with weekdays spent at work activities, and the weekends used for family and leisure time (which sometimes involved travel away from their homes). However, changes to the CDP were said to have removed the incentive to participate in activities and, for those living in remote communities, to remain in community during the week.

> *Ceduna now is a place where you go [to]…In the morning, you'll see them [transitional visitors] all standing around the street. There's nothing back in their communities for something for them to do or work like CDP. Before when CDP was compulsory, everyone's back in their community working and getting paid and they'd come to town and do shopping and they're gone back home again. There was something for them to do and looking forward to back in their community. Now everyone's transient and in Ceduna they're all standing around waiting for the next person to get paid to support one another's habits. CEDSH16*

These issues were considered by some respondents to have been compounded by the ending of the CDC program and access to full income support payments, which together were felt to be contributing to more population movement and alcohol misuse.

We used to have quite a vibrant core group of men that would work. Every day they would show up and there would be a reason to come to work because if they didn't come to work there was no pay…Now the community has gone downhill because of it. We haven't got people doing odd jobs and making the place look like a community. That service has collapsed, and that was good work for our guys. They were proud to do it. But humans are incentive driven and the incentive was not to work all of a sudden. So, that [the CDP] combined with the CDC has put us back a long way. CEDSH36

Alcohol restrictions

Respondents in the Ceduna region, along with stakeholders in East Kimberley and the Goldfields, also noted the presence of alcohol restrictions that were currently in operation. These restrictions – in tangent with the CDC program – were considered to play a role in curbing problematic drinking. Varying across the three locations, the measures included bans on public drinking, limits on the quantity and types of alcohol that could be purchased, and customers having to show photo ID when purchasing takeaway alcohol. Additional restrictions could be temporarily imposed at times of perceived need, e.g. as a preventative measure when funerals were taking place. Stakeholders in Ceduna also noted that additional restrictions relating to opening hours had been temporarily imposed in a direct response to the cessation of the CDC program.

Sometimes they do drinking bans if there's a funeral on. So they might have a 48-hour, bottle shops closed, and the number of ED [emergency department] presentations drops dramatically. And the number of ambulances being called just reduces instantly. EKSH19

Mining royalty payments

Finally, stakeholders in the East Kimberley and Goldfields discussed the impacts of mining royalty payments which were intermittently received in their regions. This influx of additional cash was said to negatively affect community functioning for a period of time afterwards, with heightened levels of alcohol misuse and violence.

People forget that there is royalties that are getting thrown at it as well which hurts. Because when that comes in, then we see a massive drama…We see issues with grog…It's the ease of access to the money has made it ridiculously hard to try and keep a lid on. EKSH12

6. Review Findings – Beyond the CDC Program

Key Findings

- **Some respondents recommended that targeted income management should be put in place for people who were experiencing issues with addiction and child welfare, or who were vulnerable to financial abuse.**
- **Income management approaches such as the Cape York Welfare Reform (CYWR) model or the Western Australian Government's Child Protection Income Management (CPIM) scheme were referenced as potential options.**
- **To properly address long-standing social issues, other measures were considered to be additionally needed including multi-faceted long-term policies and services that adopted an educational and empowerment approach.**
- **Many respondents (mostly stakeholders) also suggested that jobseeker obligations under the CDP should be reintroduced.**
- **A further key focus of future policy efforts was considered to be the funding and provision of support and other essential services.**
- **Considerable service gaps were reported including alcohol and drug services, youth programs, services for transient populations, accommodation and housing, and family violence services. Workforce issues were also recognised as adversely impacting upon service delivery. Further challenges were described in relation to funding arrangements and service provision.**
- **The need for greater inter-service collaboration, new service responses, and less competitive funding models was suggested by stakeholders in order to improve service outcomes.**

A final focus of the qualitative interviews was on the potential measures that could be implemented in the four regions now that the CDC program had ended. Respondents spoke about the social issues that were still present in the CDC regions. The review considered past CDC participants and stakeholders perceptions about what needed to occur within their region to address the social issues being experienced.

> *I've actually rung [Minister] Rishworth's office to tell them all the concerns that's happening in this town, you know, because I see it and I'm worried about it. You know I can't see [NAME] living too much longer if he keeps getting the same amount of money he's getting. CEDP01*

6.1. Targeted income management

6.1.1. Evidence from in-depth qualitative interviews

In light of the perceived negative impacts of the ending of the CDC program some respondents recommended that targeted income management should be put in place. Acknowledging that the blanket adoption of income management was no longer an option, these respondents suggested that people who were experiencing issues with addiction and child welfare, or who were vulnerable to financial abuse, may benefit from compulsory income management.

> *I do think it needs to come back. Yeah, I really do. I think the people that really needed it need a hand with what they're doing with their money and everything else. And we've all been a little bit that way at some point. And to have something that controls, stops them buying the grog, buying coke, putting it through the pokies. BHBSH21-22*

> *I think we need to get tougher…in the various cross-agency meetings about who the people are, that are at risk that we think are vulnerable. So as an example if…[NAME] gets five notifications on this same family for the same stuff, then I should be able to refer that family for income management. Because they need it. And sobering up five presentations, you're on income management. Your kids don't go to school, you're on income management. We have to start treating our clients like adults, because they are adults…We need to start saying there's a consequence for that…you're going to feel it in the money. That's the bit that works. CEDSH01*

Some stakeholders suggested that the adoption of income management approaches such as the CYWR model or the Western Australian Government's CPIM scheme may also be beneficial.

> *Well, I think we're all looking and watching the Family Responsibility Commission's work up in the Cape. And seeing that the government are willing to keep that model in play, it might be a model that could be adaptive across regions. We just don't know if we would have the same level of leadership and be willing to make these decisions for community members. CEDSH02*

Anywhere else they had voluntary income management and then DCP [Department of Child Protection] had the option like a targeted thing, like compulsory income management… Then that's the last resort for these authorities [if] their dysfunction is extreme and it's extreme to the point it's risking the child's life in their care. EKSH16-17

These models also captured the elements of income management that past CDC participants thought should be continued, i.e. targeted at particular groups who were not meeting social norms (e.g. parents whose children were missing school or not being fed), targeted for those whom had dependency issues, and had a voluntary nature or the capacity to exit income management.

It just was hard with the Indue [the CDC] card for some, and it was good for some, but I personally think to myself…whether you want to be on it, or if you don't want to be, it should be a choice, and not the government saying, "You need to be on this here," or, "You need to buy…". And then if the government can see the problem with how people have been spending money and things like that, well, they [the government] need to take account of, and look at the bigger picture on the people that are doing that there; they're the ones that need to have set rules and all that as well. CEDP10

I think there should be some sort of system like that where they [the government] help people that can't feed their children and stuff. They're out spending it, drinking alcohol and all that stuff, the families are affected. I think it something needs to happen to them. BHBP02

Respondents also considered that if targeted income management was to be effective, the loopholes and workarounds that had existed under the CDC program would need to be fixed.

I don't know what the statistics are if less people are gambling and drinking alcohol, I'm not quite sure but, I personally think it was a reasonable idea. But I think they should have access to a bit more money and maybe not do the cashless thing, maybe do food vouchers or something instead of, I don't know. People find a way. BHBP26

6.2. Broader measures

However, respondents also highlighted that alongside targeted income management, other measures should be adopted in order to properly address the complex social issues facing past CDC regions. This included the need for multi-faceted long-term policies and services that adopted an educational and empowerment approach.

If they're [past CDC participants] in trouble with DCP [Department of Child Protection] and they're not feeding their kids and looking after them, absolutely. And if they've got anti-social behaviour with drugs and alcohol that is just out of control, absolutely. And maybe even put in there programs where they have to get help. I know they're not going to like that, but sometimes it is helpful if you can have some kind of drug or alcohol rehabilitation kind of thing joined in with it a little bit. Something to tackle the actual problems as well, not just punish them and something to help them. CEDP14

I think those struggling with gambling issues, alcoholism, but I think the card would only be one step. So it would be, let's help you with your money, and let's also give you other services to steer you in the right direction in a sense. BHBP25

Many respondents (mostly stakeholders) also suggested that jobseeker obligations under the CDP should be reintroduced in order to provide people with more structure and purpose to their day. It was also hoped that this latter recommendation would assist in reducing the high levels of population mobility that was occurring between Aboriginal communities and regional centres. Many went further and called for the reintroduction of the Community Development Employment Projects (CDEP) initiative where a higher payment was paid to those undertaking community development work.

Bring CDEP back in here. The whole version. Because…I believe it's a stepping stone for all community members, and to move on to a better thing…Employment, housing…and they'll [CDEP participants] have roofs over their heads, belly full, warm bed at night and kids are safe. CEDSH17-21

The other thing I reckon that they [the federal government] need to bring back is the CDEP program where they used to work…because that was community work that they used to pay to go to work and since they've taken that away well, what I do now? There is no work here. They [CDEP participants] used to look forward to go to work. There used to be good attendance for people on those programs to go to work. But yeah, that's the main thing I reckon, since that CDEP's gone away, that's the main struggle….As soon as they took that away, lacking education, anything to do, and just turned to drugs and alcohol. GFP10

Finally, some stakeholders (in Ceduna, East Kimberley and the Goldfields) highlighted that there was a need for alcohol management measures to be properly enforced or made stronger to assist the curbing of problematic levels of alcohol misuse.

I think for me what's proven to work is the restrictions. Whether you restrict what they [past CDC participants] can buy or restrict how much they can buy. And you do that either by putting physical restrictions on the bottle shops or putting a cashless card that says you can't use this to buy alcohol. EKSH14-15

To minimise harm in this community, there has to be a reduction of alcohol consumption. Which would ultimately have to come through the liquor license of the hotel, that being altered. GFSH27

6.3. Support services

6.3.1. Evidence from in-depth qualitative interviews

The other key area that respondents suggested should be the focus of future policy efforts was the funding and provision of support and other essential services.

The majority of respondents informing the review spoke of considerable barriers that were present within their region and impacted upon access to support services. Respondents strongly felt that current service provision was inadequate within their respective regions and that many gaps remained. Current support services were typically described as operating beyond capacity and as having long wait lists.

> *The issue is the same in our social services as well. The demand far exceeds the ability for them [social services] to service customers at the moment…and seems to be increasing. BHBSH17-19*
>
> *Right across the board all of the service providers are all struggling, struggling to get staff, struggling to meet the need, waiting lists…We can only deal with so many young people for the staff that we've got. BHBSH13*

The most commonly reported gap related to alcohol and drug services, and in particular, local rehabilitation facilities. Having to travel away to access rehabilitation services was considered to create a disincentive to address dependency issues. Stakeholders also felt that there was a need for harm minimisation measures such as providing a safe place to go to whilst drinking.

> *There's nothing for rehabilitation. So we work focusing on this constant narrative of alcoholism, and there's nothing, there are no options for people to support them through rehabilitation…There's one at Port Augusta, but it's a long wait to get in there…Aboriginal people if they say to you on that day, they want to rehab, you want to be able to act on it. Exactly. Because if you don't, something else will come up. Generally, it's a six week wait if you're lucky…[And] it's a long way for especially our cultural mob to go. CEDSH10-11*
>
> *If we did have a proper drug rehabilitation I think a lot of peoples' lives would've been changed for the better. That is one thing here. I think you've got to go away more for drug rehabilitation and things like that and a lot of people don't want to. CEDP14*

Other key service gaps included the need for greater service offerings for young people such as evening activities, school engagement programs and family support. Respondents hoped that additional services such as these would assist in addressing current issues relating to young people being unsupervised on the streets at night and participating in anti-social behaviour.

You know they [young people] need more support because kids break in a lot because they're bored. There's hardly nothing to do for them. So they turn to breaking in, stealing, they think it's all okay. But then they just end up, they do it ongoing with their age, so then they end up behind bars and stuff. It's sad. EKP29

Just be more for the young uns in Ceduna. They [organisation] have a great youth program in town for sure. But after five o'clock or whatever, there's nothing for the kids that need to go somewhere or need things like that. There's nothing there, that shuts and then you just roam around getting into trouble. CEDSH15

Accommodation and housing was a further service area that was commonly perceived as being deficient in each region. Respondents suggested that there was a need for greater emergency and crisis accommodation and also more transitional accommodation to cater for the increased transient population perceived to be resulting from the cessation of the CDC and the removal of CDP mutual obligation requirements. Also it was noted that a number of social housing properties were standing empty, and in order to reduce long waiting lists for such housing, that repairs needed to be prioritised.

It's also not just not just a lack of housing, it's suitable housing…We've got no crisis accommodation here…We can get emergency accommodation for women and children, but we put them in a hotel room. And there's no cooking facilities. So yes, 'suitable' housing. CEDSH10-11

We've had houses in town here that contractors still haven't attended to. And because they take their time about it, people are just coming around and trashing it even more and making it more work. So then people are out on our streets missing out on a home that's on the wait list. GFP35

Additional service gaps were noted in the provision of domestic and family violence support with more services considered to be needed to address perpetrator behaviour and provide support to affected families. Likewise, mental health services were described as being lacking with additional counselling and psychology services particularly needed.

The gaps in the East Kimberley is significant. Family violence is huge… And yet, we've had a reduction of services around family violence, [ORGANISATION] ran a men's behaviour change program, and then that funding was ceased. And now no one's doing anything…For years, we haven't had anything for perpetrators and we had no support services for families who are impacted…There's no services to refer anyone to…So there's a huge gap around support. EKSH10

They [organisation] didn't have a psychologist, they just had counsellors. Nothing wrong with counsellors, but 90 per cent of the issues we have up here are not just basic issues, they are really deep, deep trauma-based issues that are ongoing and they need psychologists…But they also need people that understand culture. EKP24

A further commonly reported service gap centred on training and employment supports; respondents suggested that there was a need for more meaningful programs to be implemented that could lead to genuine local employment opportunities. Further identified service gaps included financial counselling, vocational and life skills training, grassroots community activities, and out-of-hours primary care services.

> *I would love best case scenarios to actually have appropriately staffed and funded case management support. So we're actually dealing with people one on one, identifying what their barriers are, and putting plans in place for them to overcome them…At the moment we pay Job Services agencies, how much money to try to get people into employment. And we know that that fails. It's just a flick and tick exercise. Have you applied for five jobs this week? Yes, no, move on, rather than going okay. What jobs you're applying for? What is the skills gap? What's the reason why you're not getting the jobs? How do we actually work to get you outcomes? BHBSH17-19*

> *So it's just the budgeting, I don't know if there's like courses that can be offered around that just to help people learn because…I see a lot of my clients they're getting compensation or they get royalties from the Lands and their money goes within that whole week. And we're talking like tens of thousands and that's because they don't understand the value of a dollar. Whereas I think that there needs to be taught really, of how to make your money last longer and what to actually spend it on…because they don't understand. GFP01*

Support service provision within the remoter parts of the CDC trial site regions was described as being particularly problematic. Remote CDC sites had very few local services; and instead, were reliant on visiting service providers from regional centres. Respondents noted that a very limited level of service was received, with providers often only visiting for a few hours on a fortnightly or monthly basis. Moreover, respondents reported uncertainty as to when some services visited and felt that a lack of worker continuity impeded quality service delivery. Thus respondents identified that there was a need for greater on-the-ground service provision within these communities including a focus on programs that would encourage people to remain on country.

> *We get most of that from Kununurra which is 100 kilometres away. So it's 200 kilometres round-trip. So more so than anything else, let's say … mental health drug service, we haven't got one in town so they come over. Okay, we haven't got Department of Health so they come over. Those as an example. EKP01*

> *And the visiting services have not been effective…Visiting services that come once a month or once every six weeks. It's not enough to have those services based in town. So we've got a person [who] does want to talk about their alcohol addiction. Yeah, they've got somebody they can see right now. Yeah, absolutely. Not in six weeks…You have to put in support services. GFSH16*

Respondents also noted several further factors impacting upon support service delivery and access. Considerable workforce issues were described with many organisations having staff vacancies or having to rely on fly-in-fly-out workers or interim staffing. Difficulties were commonly experienced in attracting and retaining skilled workers to the regions due to a lack of affordable housing options and competition with other sectors (particularly mining). The social issues being experienced in each of the regions were also considered to act as a deterrent to potential workers. Many organisations were said to have job vacancies which they were struggling to fill due to the challenges of attracting workers to their region.

> *We've got a real problem attracting professionals to the region. We cannot get OTs, we can't get speech pathologists, we can't get mental health therapists. We can't get psychologists…For them, it's like, Nah, there's no connectedness, there's just not enough facilities. It's not close enough to Brisbane, because it's four hours north. And that's an example of quite a few that have come here with good intent, but then moved away. BHBSH02*

> *The increased violence and theft, some break-ins is definitely making a lot of families move. And it's not as attractive for people moving here. So it's hard to recruit staff. So it definitely feels like we've struggled for staff quite a lot…I guess there's lots of factors, but I definitely think that the things happening in town have affected that. EKSH19*

In addition, limited vocational training options offered by local TAFEs was said to be a barrier for local people to upskill and be able to apply for these roles. Respondents also suggested the need to employ and train greater numbers of local Indigenous workers and liaison officers within the support service sector.

> *TAFE used to offer much, much more…It's not even worth having it here anymore…You know, we used to have trainees from community and well, they [TAFE] don't even offer anything now…Through TAFE if I have any girls out here that want to study they have to drive to Port Lincoln to do theory stuff, that's just ridiculous when they have a TAFE building here…So I can't get anyone here to work and study because they have to travel. CEDSH15*

> *I'm talking about these jobs. Train people up in it so they can help their own mob. That's why there's a high rate of suicide, no one helping. They [workers] sit up on their thrones over there, even the Aboriginal workers, you got them from Queensland, you've got them from Northern Territory, they don't know who's who…You know what I mean, they're not even related to these mob. EKP22*

Stakeholders described the barriers that individuals and families faced in accessing support services. Some Indigenous clients were said to be reluctant to come into regional centres to access services and that an outreach approach may be beneficial for this cohort. In addition, limited bus services in many remote parts of the CDC trial site areas made it extremely challenging for people living in surrounding communities to attend appointments in regional centres.

We've got…all these other communities that are quite small, that we don't really have services out there. Nobody goes out there unless they're required…Why aren't we going out there more often? But our program allows us to only work in Ceduna and not go out very often. So is there better outreach processes? CEDSH14

There's a bus once a week to Kalgoorlie - you come in on the bus on Thursday. And then it goes on Friday. That's once a week. So you can't get to a town to go to appointments or anything like that. That's a huge issue. GFSH16

Finally, several stakeholders reported that in order to address the specific needs of local communities, an evidence-based funding approach should be implemented (both with regard to Local Service Plans and service funding more broadly). In particular, these stakeholders stressed the need for co-designed approaches which could generate place-based solutions that were funded appropriately.

There's no coordinated response to our community and social issues. And I think some of the easy things that can be done is looking at developing place-based solutions, funding them appropriately with an appropriate framework sitting behind them. BHBSH17-19

We as a community, we know our clients, we know our people, we know what the community looks like, and if people can't work with us, then I don't think we're delivering a real positive service to the community. And that's why there's no change…It's complex. We're going to want a starting point to really capture the right method of dealing with issues in our community. If you don't understand the community, I seriously think that there's no positive outcomes for the community, so we've got to try and change the model. GFSH31

The need for services to work collaboratively to support the needs of their local community was also suggested. However, stakeholders acknowledged that current funding models (outside the Local Service Plan) were competitive in nature and hindered joint working. Thus the imposition of funding models that could support a more cohesive and joined-up approach to support service delivery were encouraged as well as more long-term program funding.

The services need to work together. They're [services] all so worried about their own individual funding and grant money that they don't want to actually refer to each other either…For me, like with fresh eyes, I came…and I was just blown away…how everyone is, each of the agencies are so protective of their little bits because they can't lose funding. CEDSH30

Competitive funding for community services, I think doesn't do as much justice. Everybody salivates over funding when it comes out…They're [community services] competitors to each other so sometimes there's a there's a risk to them sharing information…the competitive funding model also means that we're not actually delivering a collective action approach. So we're not we're not facing it as a united community and social services sector. And I think the only way that that can be dealt with is through those funding bodies. BHBSH17-19

7. Summary

The review of the ending of the CDC program adopted a mixed methods approach, utilising qualitative interviews and, integrating and triangulating this where possible, with an analysis of administrative and community-level data. The review sought to address six key questions and a discussion of the key findings pertaining to each of the review questions is presented below.

7.1. Impacts of the ending of the CDC program

The review identified a range of perceived impacts (both positive and negative) that had occurred since the cessation of the CDC program; with these impacts mostly identified in the Ceduna, East Kimberley and Goldfields trial sites. In contrast, many respondents in Bundaberg-Hervey Bay, and a minority of those in the other three sites, indicated that CDC cessation had not brought significant change for their respective regions.

The review found some evidence that the ending of the CDC program had brought positive change at an individual-level for past participants. In particular, the cessation of compulsory income management was widely felt to have provided people with more control over their finances and lives in general. Some respondents (mostly past CDC participants) also spoke of the practical benefits of having easier access to cash now that they were no longer subject to income management arrangements. However, no positive impacts at a community-level were found in any of the four regions.

The perceived impacts of CDC program cessation were mostly negative and centred around financial management (e.g. spending behaviour and budgeting), alcohol misuse and related issues, child wellbeing and welfare, and the number of transitional visitors. Evidence was more mixed with regard to further impacts of the ending of the CDC program. While negative impacts on gambling activity, the wellbeing of past CDC participants, and tourism were also suggested, this was primarily in the Ceduna and East Kimberley regions. An analysis of WA Health data in the East Kimberley and Goldfields also found some evidence of increased emergency department admission rates since CDC program cessation. However, it is difficult to know how much (or if any) was specifically due to the change in the CDC. Stakeholders in Ceduna, East Kimberley and the Goldfields were also more likely than past participants to report increased criminal activity and worsening perceptions of community safety. Overall, however, an analysis of WA Police data found little substantial change in policing outcomes in either the East Kimberley and Goldfields.

7.2. Impacts for particular cohorts and regions

The review also generated evidence relating to the impacts of CDC program cessation for particular groups and regions.

7.2.1. Impacts for particular groups

The qualitative research (most notably in Ceduna, East Kimberley and the Goldfields) suggested that four groups of people had been particularly affected by the ending of the CDC program. Firstly, many respondents felt that the ending of compulsory income management had adversely affected people with a history of alcohol dependence and (to a lesser degree) gambling issues. Children and young people were a second group considered to have been especially impacted by CDC program cessation, with adverse effects reported for their wellbeing and welfare. Other groups of people who were perceived to have been particularly impacted by the ending of the CDC program were people vulnerable to financial coercion and those who did not possess the skills to manage their finances independently.

7.2.2. Impacts for particular regions

The review found similarities and differences across the four research locations with regard to experiences of the ending of the CDC program. The greatest perceived impacts were experienced in the Ceduna, East Kimberley and Goldfields regions, with far fewer impacts observed in Bundaberg-Hervey Bay. While some negative impacts (i.e. financial management, alcohol misuse, child wellbeing, crime and safety, and transitional visitor numbers) were experienced in all of the three former sites, other impacts (on gambling misuse, participant health and tourism) were primarily reported in Ceduna and the East Kimberley. In contrast, many respondents across all four sites suggested that the cessation of compulsory income management had resulted in enhanced autonomy and financial control for past participants. Some differences in outcomes were also observed for particular locations within the trial sites, i.e. between remote communities and urban centres.

Several factors were identified as being present in each region that compounded the effects of the cessation of the CDC and made it more challenging to specifically attribute perceived impacts to the ending of the CDC program alone. These factors included housing and cost-of-living pressures, traditional population movement, the ending of mutual obligations under the CDP, alcohol restrictions and mining royalty payments. However, respondents in Ceduna, East Kimberley and the Goldfields were more likely to report that their respective regions had experienced more complex and inter-generational issues before, during and after the operation of the CDC program.

7.3. Outcomes for people exiting the CDC program

The review evidence indicated that participant exits from the CDC program had occurred quickly. The qualitative interviews, however, revealed mixed perspectives as to how well this exit process had been achieved. While some respondents considered the transition to have been fairly smooth, others described challenges for those exiting the CDC program. These challenges included the speed of the transition, a lack of accessible information and insufficient supports. Particular challenges were noted for people with limited literacy skills, who were without access to technology, and/or did not have English as a first language.

7.4. Outcomes for people transitioning to enhanced Income Management

The qualitative and quantitative evidence found that only a small number of CDC participants had opted onto eIM; mostly females and older participants. The qualitative interviews suggested that others were considering transitioning onto eIM in the future to assist with managing their finances. The uptake of eIM was considered to have been constrained due to several factors including a lack of information, complicated transition processes, and family pressure to exit income management. Given the small numbers of past CDC participants who had opted onto eIM, the review found only limited qualitative evidence pertaining to this experience.

7.5. Outcomes at the community level

The qualitative data indicated that community views about the ending of the CDC program in each of the trial sites were mixed. Some respondents (mostly past CDC participants) had supported the ending of the CDC program in order to remove the perceived discrimination and stigma associated with compulsory income management; program cessation was also considered to provide an opportunity to implement more effective policies and programs at a community level. In contrast, other respondents (especially stakeholders) expressed disappointment that the CDC program had ended as they felt that it had generated positive impacts and were concerned about increasing social issues being experienced in their community since program cessation.

Dissatisfaction was widely expressed about the level of community consultation that had occurred regarding the ending of the CDC program. The speed of the transition process and the short time given to communities to prepare for program cessation was also criticised. Furthermore, stakeholders were mostly dissatisfied with the level of wraparound services that supported the transition from the CDC program. Stakeholder perspectives were more mixed regarding the development and content of the Local Services Plans. However, concerns were expressed about the level of community consultation and the actionability of the resulting Plans.

7.6. Support services

The review found that support service usage had increased in all four trial sites during the period following the ending of the CDC program. In particular, demand for emergency relief services was considered to have risen significantly, while greater demand was also observed across a broad range of support services in Ceduna and the East Kimberley. Perspectives differed, however, as to whether this increased demand was directly related to the cessation of the CDC program or if other factors (such as cost of living and housing pressures) were also contributing.

Considerable service gaps were noted in all four regions and respondents suggested that future policy efforts should focus on the funding and provision of support and other essential services. In addition, workforce issues that adversely impacted upon service delivery was identified as being a further area of focus that needed to be addressed. Further challenges were also described in relation to the current funding of support services; this funding was considered to be too short-term, often spent on the wrong type of programs, and as being competitive and siloed in nature which discouraged collaborative working.

The review also identified further measures which were perceived as being needed to address the complex socio-economic issues still present within the four regions. Some respondents recommended that targeted income management should be implemented for people who were experiencing issues with addiction and child welfare, or were vulnerable to financial abuse. However, it was recognised that additional measures could also be beneficial including the need for multi-faceted long-term policies and services that adopted an educational and empowerment approach, and the reinstatement of jobseeker obligations under the CDP.

7.7. Limitations and challenges

The review methodology aimed to provide a rigorous assessment of the community and individual level impacts of the cessation of the CDC program. The scope of the review did not allow for a formal evaluation and, therefore, no causal statements could be issued from the analyses.

In addition, several factors further limited the review's ability to directly attribute impacts observed to the cessation of the CDC program alone. These included concurrent policies that were in place within the research locations; socio-economic conditions present at the time of the review; the review timeframe which meant that only shorter-term outcomes could be observed; the scope of the review which prevented a quantitative survey from being undertaken and no comparison sites; the ability to accurately capture activities that may be subject to strong reporting biases; and limitations inherent in the community-level data. Finally, the generalisability of the review findings faced limitations due to methodological reasons, locational differences and the broader policy environment.

8. References

ABS. (2021). *Estimates of Aboriginal and Torres Strait Islander Australians*. Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/30-june-2021

Bray, J. R., Gray, M., Hand, K., & Katz, I. (2014). *Evaluating New Income Management in the Northern Territory: Final Evaluation Report*.

Cape York Institute. (2007). *From Handout to Handup: Cape York Welfare Reform Project*.

Deloitte Access. (2015). *Consolidated Place-Based Income Management Evaluation Report 2012 - 2015*.

Department of Families Housing Community Services and Indigenous Affairs. (2011). *Northern Territory Emergency Response: Evaluation Report 2011*.

Department of Families Housing Community Services and Indigenous Affairs. (2012). *Cape York Welfare Reform Evaluation*.

Department of Social Services. (2014). *A Review of Child Protection Income Management in Western Australia*.

Katz, I., & Bates, S. (2014). *Voluntary Income Management in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands*.

KPMG Australia. (2010). *Implementation Review of the Family Responsibilities Commission*.

Mahuteau, S. & Wei, Z. (2021). *Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Region: Quantitative Supplementary Report*.

Mavromaras, K., Moskos, M., Isherwood, L. M., & Mahuteau, S. (2019). *Cashless Debit Card Baseline Data Collection in the Goldfields Region: Qualitative Findings*.

Mavromaras, K., Moskos, M., Mahuteau, S., & Isherwood, L. (2021). *Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Region: Consolidated Report*.

Moskos, M., & Isherwood, L. (2022). *Embedding Indigenous Perspectives in Policy and Practice: Cashless Debit Card Case Study.*

Moskos, M., & Isherwood, L. (2021). *Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Region: Qualitative Supplementary Report*.

Moskos, M., Isherwood, L., Mavromaras, K., & Mahuteau, S. (2019). *Cashless Debit Card Baseline Data Collection in the Bundaberg and Hervey Bay Region: Qualitative Findings*.

Orima Research. (2010). *Evaluation of the Child Protection Scheme of Income Management and Voluntary Income Management Measures in Western Australia*.

Orima Research. (2017). *Cashless Debit Card Trial Evaluation: Final Evaluation Report*.

Ritchie, J., & 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.

Scott, J., Higginson, A., Staines, Z., Zhen, L., Ryan, V., & Lauchs, M. (2018). *Strategic Review of Cape York Income Management - Final report.*

9. Appendices

A.1. Appendix 1: Key findings from the literature review

Key Findings

- **Various income management programs have been instituted across Australia since 2007. A central element has been to quarantine a set proportion of income support payments for spending on essential items and encourage socially responsible behaviour.**
- **Previous studies examining the impacts of income management in Australia have differed considerably in scale, scope and methodological robustness.**
- **Challenges faced in ascertaining the impacts of income management include disaggregating the specific effects within complex policy environments, a lack of experimental design frameworks or baseline data, and 'dilution effects' of community data.**
- **Studies have found mixed evidence on whether income management programs can reduce alcohol, drug and gambling misuse, with the most positive impacts shown for the Northern Territory Emergency Response (NTER) and CDC program. Income management alone may be insufficient to address long-standing dependency issues and program workarounds can limit impacts.**
- **Research findings on impacts of income management for crime and safety are very mixed with some evidence of reduced family violence and enhanced community safety.**
- **Several studies have found that income management may lead to improved child health, emotional wellbeing and school attendance.**
- **More consistent evidence has shown that income management is associated with increased spending on priority items and improved budgeting. However, challenges have also been identified associated to the reduced availability of cash.**
- **Unintended consequences of income management include practical issues, experiences of stigma and shame, and program workarounds.**
- **Overall, more positive outcomes are experienced by individuals who voluntarily choose income management compared to those on mandatory schemes.**
- **More research is needed on the impacts of transitions from income management including which cohorts are most at risk of poorer outcomes and the supports required. Research is also required on transitions from compulsory to voluntary income management.**

A.1.1. Overview of income management in Australia

Income management was first introduced in Australia in 2007. Since then various income management programs have been instituted across Australia by a succession of federal governments. While the particular parameters and operation of these programs have differed, some commonalities exist. For example, a central element of the approaches is to quarantine a proportion of the welfare payments received by participants to ensure that this money is spent only on essential goods and services. In addition, the various income management programs have sought to encourage socially responsible behaviour and reduce the incidence of social harm. Below is a brief outline of the key income management policies which have operated in various locations across Australia from 2007 to 2023.

Northern Territory Emergency Response (2007-2012)

The first instance of income management in Australia occurred from 2007 in a select group of Indigenous communities and town camps within the Northern Territory. Seeking to address and ensure the protection of Aboriginal children from harm, the NTER introduced nine measures including an income management program.

Cape York Welfare Reform (2008-present)

Income management began to be extended into other areas in Australia from 2008. In response to the recommendations of the Cape York Institute’s From Hand Out to Hand Up report, the ‘Cape York Welfare Reform’ (CYWR) commenced in Queensland in early 2008. Income management was one of the measures incorporated under the reform. Income management participants were referred by the Family Responsibilities Commission (FRC) who determined the duration of income management and the proportion of welfare payments to be managed. Community members may also volunteer for income management under the CYWR.

Income Management in Western Australia (2008-present)

Trials of two different approaches to income management were introduced in Western Australia in 2008. The first approach is the Child Protection Income Management scheme (CPIM), a compulsory scheme that aims to reduce the incidence of child abuse and neglect. The second scheme – Voluntary Income Management (VIM) – is available to eligible Centrelink recipients who request help with budgeting and money management.

New Income Management (2010-present)

In 2010 income management was extended across the whole of the Northern Territory with significant changes made to the original NTER model. As part of a broader package of welfare reforms to support vulnerable Australians, New Income Management (NIM) was intended to protect children and families, increase parental responsibility and reduce welfare dependence.

Place-Based Income Management (2012-present)

From 2012, the Place-Based Income Management (PBIM) model brought further extensions of income management to areas of high disadvantage across Australia. Part of a suite of programs to help vulnerable families, PBIM adopts a mix of mandatory and voluntary measures. Participants are referred for income management if they are assessed as being 'vulnerable to financial crisis' ('VULN' measure) or have a child at risk of neglect ('CPIM' measure). In addition, people can also volunteer for income management ('VIM' measure).

Cashless Debit Card (2016-2023)

The Cashless Debit Card (CDC) program was introduced in 2016 in multiple locations across Australia where high levels of welfare dependence co-existed with high levels of social harm. A description of the CDC program is provided in Chapter 2.

Enhanced Income Management (2023-present)

Enhanced Income Management (eIM) commenced in March 2023 and is currently in operation in the Northern Territory as well as some parts of Queensland, South Australia and Western Australia. The operation of eIM differs across these regions including whether participation is compulsory or voluntary. While past CDC participants in the Northern Territory and the Cape York and Doomadgee region were automatically transitioned onto eIM, participation is voluntary in the other four former CDC program trial sites.

A.1.2. Overview of income management research studies

Numerous research studies have been undertaken over the past 15 years examining the impacts of income management in Australia. This has included formal evaluations and/or reviews of each income management scheme (with the exception of the recent eIM). Further detail on these studies is provided in Table A.1.

Scale and scope of studies

The scale and scope of the research studies have differed considerably. While the focus of much of the research has been on evaluating the specific impacts of the various income management programs, other studies have had a broader scope, e.g. evaluations of the NTER and the CYWR, as well as the review of the FRC. The scale of the income management studies have also differed, e.g. as to whether they covered all trial sites or specific locations.

Table A.1: Previous commissioned research income management studies

IM scheme	Study description	Final report date	Author(s) of final report(s)
NTER	Evaluation of whole reform by a consortium of researchers	2011	Department of Families Housing Community Services and Indigenous Affairs
CYWR	Evaluation of whole reform by a team of independent consultants	2012	Department of Families Housing Community Services and Indigenous Affairs
CYWR	Implementation review of the FRC	2010	KPMG Australia
CYWR	Strategic review of CYWR income management by Queensland University of Technology	2018	Scott, Higginson, Staines, Zhen, Ryan and Lauchs
NIM	Evaluation led by the University of New South Wales	2014	Bray, Gray, Hand and Katz
IM in WA	Evaluation of CPIM and VIM	2010	Orima Research
IM in WA	Review of CPIM conducted by the Evaluation Hub of the DSS	2014	Department of Social Services
PBIM	Evaluation of PBIM (VIM, VULN and CPIM)	2015	Deloitte Access
PBIM	Review of VIM in the APY Lands by the University of New South Wales	2015	Katz and Bray
CDC program	First impact evaluation	2017	Orima Research
CDC program	Second impact evaluation by the University of Adelaide[20]	2021	Mavromaras, Moskos, Mahuteau and Isherwood (Consolidated report) Moskos and Isherwood (Qualitative Supplementary report) Mahuteau and Wei (Quantitative Supplementary report)

[20] The second impact evaluation of the CDC program was preceded by baseline data collections by the University of Adelaide in the Goldfields (Mavromaras et al., 2019) and Bundaberg-Hervey Bay regions (Moskos et al., 2019).

Methodological robustness and challenges

Methodological robustness varies across the formal research studies. The research design of each study has included the collection of new primary data via surveys and/or qualitative interviews, focus groups and workshops. However, the extensiveness of these data collections has been mixed. For instance, some studies have only included a relatively small qualitative component or have not included the voice of those subject to income management, focusing instead on stakeholder perspectives. In addition to primary data collection activities, formal income management studies have also typically undertaken analyses of administrative and community-level data; with some also conducting a desktop review of case files and reports.

Several methodological challenges in ascertaining the impacts of income management have been acknowledged in the literature. This includes disaggregating the specific effects of income management within complex policy environments, the lack of an experimental design framework or baseline data, issues regarding the use of community-level data due to 'dilution effects', and methodological limitations inherent within the commissioned design of the evaluation research.

A.1.3. Impacts of income management

The research has sought to understand the impacts of income management policies. This includes impacts on alcohol, drug and gambling misuse; crime and safety; child and family wellbeing; financial management; and also the unintended consequences of income management.

Impacts on alcohol, drug and gambling misuse

The reduction of alcohol, drug and gambling misuse has been a key focus of many income management programs in Australia. However, previous studies have found mixed evidence regarding whether income management is effective in addressing these issues. The most positive impacts were shown for the NTER and CDC programs. With regard to the NTER, more than half of all income management participants reported a decrease in alcohol consumption, marijuana use and gambling (Department of Families Housing Community Services and Indigenous Affairs, 2011). Likewise, the first evaluation of the CDC program reported sustained and increased reductions in these target behaviours over time (Orima Research, 2017). The second evaluation of the CDC program found decreased alcohol consumption alongside a slight reduction in the incidence of gambling, but no conclusive evidence was found for drug use (Mavromaras et al., 2021).

In contrast, the evaluations of the CYWR and NIM were unable to identify significant changes in socially harmful behaviour (Bray et al., 2014; Department of Families Housing Community Services and Indigenous Affairs, 2012). Furthermore, previous research has suggested that income management alone is unable to significantly impact deep-seated dependency issues (Katz & Bates, 2014). Workarounds to income management restrictions have also been shown to limit the impact of income management on alcohol, drug and gambling misuse (Katz & Bates, 2014; Mavromaras et al., 2021; Moskos & Isherwood, 2021).

Impacts on crime and safety

Research findings relating to the impacts of income management on crime and safety have been very mixed. Formal research examining the NTER and the CYWR has suggested that income management is associated with reduced domestic and community violence, and enhanced perceptions of safety (Department of Families Housing Community Services and Indigenous Affairs, 2011; KPMG Australia, 2010; Scott et al. 2018). Positive, but limited, improvements in community wellbeing were also noted as a result of VIM in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands (Katz & Bates, 2014).

Meanwhile, although some evidence of a reduction in alcohol-related violence and improvements in perceptions of community safety were identified in the two evaluations of the CDC program, these outcomes were not consistent across all trial sites (Mavromaras et al., 2021; Moskos & Isherwood, 2021; Orima Research, 2017). Finally, evaluations of the CYWR (Department of Families Housing Community Services and Indigenous Affairs, 2012) and NIM (Bray et al., 2014) were unable to identify any changes in levels of criminal activity or community wellbeing.

Impacts on child and family wellbeing

Improved child and family wellbeing has been a primary goal of several previous income management policies. Several studies have suggested that income management may indeed be associated with improved child health, i.e. children having better access to food (including more nutritious food), being a healthier weight and more physically active (Department of Families Housing Community Services and Indigenous Affairs, 2011, 2012; Katz & Bates, 2014). Positive impacts have also been shown for the emotional wellbeing of children and their families (Orima Research, 2010, 2017) and in improved school attendance (Department of Social Services, 2014). In addition, income management may support the capacity of parents to care for their children and provide household essentials (Department of Families Housing Community Services and Indigenous Affairs, 2012; Katz & Bates, 2014; Orima Research, 2010, 2017).

In contrast, other income management studies have reported more limited outcomes relating to child wellbeing. For example, the second evaluation of the CDC program found mixed evidence as to impacts on child welfare and family wellbeing (Mavromaras et al., 2021; Moskos & Isherwood, 2021). Finally, research on the PBIM concluded that – in part due to the complexity of these issues – income management does not impact significantly upon child outcomes (Deloitte Access, 2015).

Impacts on financial management

A further key aim of Australian income management schemes has been for income support payments to be directed towards meeting essential needs, e.g. food, rent and bills. The literature suggests that income management is associated with increased spending on priority items (Deloitte Access, 2015; Department of Families Housing Community Services and Indigenous Affairs, 2011, 2012; Department of Social Services, 2014; Katz & Bates, 2014; Mavromaras et al., 2021; Moskos & Isherwood, 2021; Orima Research, 2010). Previous research has also shown that some individuals find it easier to budget (Mavromaras et al., 2021; Moskos & Isherwood, 2021; Orima Research, 2010) and save money on income management (Department of Families Housing Community Services and Indigenous Affairs, 2011; Katz and Bates, 2014; KPMG Australia, 2010;

Mavromaras et al., 2021; Moskos & Isherwood, 2021; Orima Research, 2010, 2017). Only the evaluation of NIM found no evidence of impacts upon financial management or spending patterns (Bray et al., 2014).

However, previous studies have also identified several negative impacts relating to financial management. In particular, the reduced availability of cash has been shown to hamper the purchase of cheaper second-hand household goods (KPMG, 2010; Moskos & Isherwood, 2021); the payment of some bills (such as informal board or rental payments) (Bray et al., 2014; Moskos & Isherwood, 2021); and the provision of pocket money to children (Moskos & Isherwood, 2021).

Unintended consequences of income management

The literature also highlights several unintended consequences of income management.

Practical issues

The first unintended consequence of income management identified in previous studies related to practical issues experienced by scheme participants. Some participants have experienced difficulties using their income-managed funds or accessing program exemptions (Department of Families Housing Community Services and Indigenous Affairs, 2011; Katz & Bates, 2014; KPMG Australia, 2010; Orima Research, 2017). Particular challenges were noted for people for whom English was not their first language and those unfamiliar with digital technology (Mavromaras et al., 2021; Moskos & Isherwood, 2021). Many studies have also reported issues with retailers and venues not accepting income management cards (Department of Families Housing Community Services and Indigenous Affairs, 2011; Katz & Bates, 2014; KPMG Australia, 2010; Mavromaras et al., 2021; Moskos & Isherwood, 2021). As a result, consumer choice over where to shop was constrained and, at times, meant that participants were forced to use more expensive outlets (Bray et al., 2014; Deloitte Access, 2015; Department of Families Housing Community Services and Indigenous Affairs, 2011).

Experiences of stigma and shame

A second unintended consequence of income management highlighted in the literature is the stigma and shame experienced by participants. Income managed participants commonly reported feeling embarrassed using their card in public as it signalled to others that they were in receipt of welfare payments (Department of Families Housing Community Services and Indigenous Affairs, 2011; KPMG Australia, 2010; Mavromaras et al., 2021; Moskos & Isherwood, 2021; Orima Research, 2017). Perceptions relating to stigma and a loss of autonomy and control over spending decisions were also frequently noted by participants (Department of Families Housing Community Services and Indigenous Affairs, 2011; Mavromaras et al., 2021; Moskos & Isherwood, 2021).

Program workarounds

Finally, some studies have indicated the presence of 'workarounds' that are used to circumvent income management restrictions (Bray et al., 2014; Deloitte Access, 2015; Katz & Bates, 2014; Mavromaras et al, 2021; Moskos & Isherwood, 2021). While recognising that some initial loopholes were identified and closed, several workarounds were found to persist, lessening the potential positive impacts of income management (Mavromaras et al, 2021; Moskos & Isherwood, 2021).

A.1.4. Differences in outcomes for compulsory and voluntary income management

Studies have clearly shown that positive outcomes of income management are not universally experienced by all participants. Indeed, considerable variation has been found according to the type of income management, i.e. compulsory or voluntary income management. Overall, more positive outcomes have been found to be experienced by individuals who voluntarily choose income management.

A.1.5. Gaps in knowledge and areas for future research

The literature review highlighted two key gaps in knowledge relating to the impacts of income management programs which would benefit from future research. First, there has been very limited research on the impacts of transitions from income management; indeed, the current review of the impacts of the cessation of the CDC program appears to be the first time that formal research has been conducted examining this issue. Concerns have been expressed that income management can cause dependency and it is important that more research is undertaken to understand the impacts of transitions from income management including which cohorts may be at risk of poorer outcomes and the supports that are required to assist this transition.

Second, whilst previous research has sought to understand the respective experiences of people subject to compulsory and voluntary income management, there have been no studies to date that have examined the outcomes for individuals who transition between these two types of income management. People choosing to enter voluntary forms of income management tend to experience better outcomes compared to those subject to mandatory income management schemes. Additional research is required to examine whether this finding holds for people transitioning to voluntary arrangements from compulsory income management. Research is also needed to better understand which individuals are more likely to choose to continue on income management and their motivations for doing so. The current policy environment – with the ending of the CDC program and the commencement of eIM – provides a pertinent opportunity for further in-depth research on this topic to be undertaken.

A.2. Appendix 2: Further detail on the qualitative methodology

Appendix 2 provides further details about the qualitative methodology utilised in the review of the cessation of the CDC.

A.2.1. Aims of the interviews

The interviews contributed strongly to understandings of the individual and community level impacts and outcomes of the CDC transition (Review Questions 1 to 5). This was achieved by exploring personal experiences of exiting the CDC and understanding perceptions of broader community-level impacts. Addressing Review Question 6, the qualitative interviews also explored the impact of the CDC cessation on service use and provided insights into service needs both during and after the transition.

A.2.2. Interview data collection

The qualitative interviews with past CDC participants and key stakeholders were undertaken in each of the four trial locations where the CDC transition commenced in October 2022, i.e. Bundaberg and Hervey Bay, Ceduna, East Kimberley and the Goldfields.

For the interviews with past CDC participants, variation in participant sampling was sought according to key attributes such as gender, age and whether they had exited the program or chosen to transition to eIM. Likewise, for the stakeholder interviews, variation was sought according to location, organisation type and client group. For the latter group, variation was also sought with regard to the level of current organisational contact with the DSS. This ensured that the voices of local stakeholder representatives who did not have a pre-existing active relationship with the DSS could also inform the review.

The exact nature and format of the interviews varied according to the needs and requirements of each respondent. These requirements were discussed with the respondent once they had agreed to participate in the review. The interviews with stakeholders largely occurred via virtual modes (i.e. phone or video conferencing), although the option for a face-to-face interview during the initial engagement trips and subsequent fieldwork trips was also provided. In contrast, most of the interviews with past CDC participants were conducted face-to-face. Furthermore, some Indigenous traditional owners or community members preferred to participate in a group-based interview (yarning circle), and this was accommodated wherever requested. The stakeholder interviews lasted an average for 47 minutes; the length of interview with past participants lasted an average of 28 minutes.

Separate topic maps for the stakeholder and past CDC participant interviews were developed by the research team. The final topic maps were informed via stakeholder engagement (with the DSS and other key stakeholders) and incorporated – where appropriate – areas of inquiry used in previous evaluations of the CDC. The latter allowed for the comparison of data collected for the transition review with the previous CDC data collection activities. This ensured that a baseline was provided from which the impacts of the transition from the CDC could be assessed. The interview topic maps incorporated culturally appropriate content and interview protocols developed

collaboratively between senior researchers and local stakeholders. Copies of the interview topic maps are provided below in Sections A.2.4 and A.2.5.

The implementation of the fieldwork was adapted to the circumstances of each interview and accommodated needs relating to culture, language, and location. Hence, fieldwork was carried out in a flexible manner to enable these circumstances to be taken into account.

Recruitment for the interviews was supported by the stakeholder engagement strategy and existing partnerships with organisations – both Indigenous and non-Indigenous – within the CDC program locations.

All interview participants were offered a $50 store voucher to compensate them for their time. With the consent of respondents, the interviews were audio-recorded and transcribed verbatim by a professional transcription service.

A.2.3. Interview data analysis

The qualitative analysis software NVivo was used to assist in the management and analysis of the transcribed data. Interview transcripts were entered into NVivo and analysed using the Framework approach, a form of thematic analysis that is particularly suited to applied social research (Ritchie and Spencer, 1994). Following familiarisation with the data through the reading of the transcripts, a thematic framework was developed and agreed upon by the qualitative research team. This thematic framework was based around the core topics covered in the interviews and the main sub-themes which emerged during the interviews in relation to these topics. The transcripts were then coded in NVivo according to this thematic framework. Key themes were developed and refined throughout the data analysis to enable further emergent categories to be identified. The thematic analysis identified overarching themes from the interviews and enabled comparison between different cohorts (e.g. by location, respondent type and CDC exit status).

A.2.4. Stakeholder interview topic map

Stakeholder information	Can you start by telling me briefly about the organisation you work for?	Information about organisation, involvement in CDC
	Role	Scope, length of time in role
Views on the CDC program	What did you think of the CDC?	
	What impacts did the CDC have?	Positive/negative impacts (financial management, experiences of agency/autonomy/ social inclusion, alcohol/drugs/gambling, wellbeing, safety/violence, other); groups of CDC participants particularly affected by ending of CDC program
Ending of the CDC program	What did you think when you heard that the CDC was going to be abolished?	Support/not support ending of CDC - reasons
	Were you consulted about the CDC ending?	
	How has the transition out of/from the CDC gone?	
	What do you think the impact of the cessation of the CDC has had?	
	Impacts for CDC participants	Positive/negative impacts (financial management, experiences of agency/ autonomy/ social inclusion, alcohol/drugs/gambling, wellbeing, safety/violence, other); groups of CDC participants particularly affected by ending of CDC program
	Impacts for families	Positive/negative impacts (financial management, experiences of agency/autonomy/ social inclusion, alcohol/drugs/gambling, wellbeing, safety/violence, other)
	Impacts for local community	Positive/negative impacts (financial management, experiences of agency/autonomy/ social inclusion, alcohol/drugs/gambling, wellbeing, safety/violence, other)
	Impacts for own organisation	Positive/negative impacts (referrals, service use, staffing, workloads, other)
Support services since ending of the CDC program	Has the demand for your services changed since the ending of the CDC? Use of support services since end of CDC	Services used, reasons for use
	Availability of services	Waiting times, barriers to access
	Service needs	Services gaps, service needs, types of services, reasons
After the CDC	Involvement with the development of Local Service Plan	Involvement in developing plan, experience of process, satisfaction with plan, understanding of importance of plan
	Suggestions of future policies/programs	Income management, alcohol management, support services, other

A.2.5. CDC participant interview topic map

Participant information	Socio-demographic information	Age, where live/who live with, Indigenous/non-Indigenous
	Centrelink payments	Type, length of time in receipt
	How spend time	Currently working, studying, caring for children/others, other
Experiences of the CDC program	Length of time on the CDC program	
	Views on the ending of the CDC program	Support/not support ending of CDC - reasons
Exiting the CDC program	How exited from the CDC program	Choose to exit CDC or remain on income management
	Reason for choice	Financial, autonomy, wellbeing, self/family, other
Impacts of end of CDC program	Self	Positive/negative impacts (financial management, experiences of agency/autonomy/ social inclusion, alcohol/drugs/gambling, wellbeing, safety/violence, other)
	Family	Positive/negative impacts (financial management, experiences of agency/autonomy/ social inclusion, alcohol/drugs/gambling, wellbeing, safety/violence, other)
	Local community	Positive/negative impacts (financial management, experiences of agency/ autonomy/ social inclusion, alcohol/drugs/gambling, wellbeing, safety/violence, other)
	CDC participants	Any groups of CDC participants particularly affected by ending of CDC program - positive/negative impacts

A.3. Appendix 3: Further detail on the quantitative analysis methodology

Appendix 3 provides further methodological detail about the analysis of the quantitative administrative and community level data.

A.3.1. Analysis of the DOMINO data

The quantitative approach used the ability of the DOMINO administrative data to go back in time through weekly snapshots. At the outset, however, it should be noted that there were several challenges present in using the DOMINO data to review the cessation of the CDC program. One such challenge was that CDC participants did not all exit the program at the same time, i.e. they were able to do so from 1 October 2022 up until 6 March 2023. While a large proportion of CDC participants opted to exit early (with the data indicating around 70 per cent had opted out by the end of the first month), there were still some people who remained on the program for some time after this date.

Also, while people were able to volunteer for eIM, the uptake has been very modest. This meant that the review was unable to use the population on eIM as the reference population from which to compare outcomes with those who have exited the CDC or 'new entrants' (i.e. people accessing relevant Centrelink payments post 1 October).

Another challenge came with the fact that the implementation of the policy change was recent, which meant that there was only a fairly small window of observation post-exit, limiting the ability to look at long-term outcomes. A final challenge came with the fact that DOMINO is not designed to record a wide range of individual outcomes. As a result most outcomes were inferred from the presence or absence of an individual in the records of payment recipients.

Below, the analytical approach used by the review is outlined.

Data requirements

DOMINO data was obtained for individuals on government payments prior to the cessation of the CDC in the trial areas (i.e. CDC participants) and 'new entrants', i.e. those people who received (or have been receiving) relevant government payments since 1 October 2022.

The underlying idea was to construct three cohorts of payment recipients and examine their outcomes (and transitions) over a period of 22 weeks. The first cohort started 22 weeks prior to 1 October 2022 (i.e. those who were CDC participants throughout this period). The second cohort started on the first snapshot available after 1 October 2022 and were followed for a period of 22 weeks (i.e. a 'transitional' cohort which included some CDC participants who had exited the CDC, others who remained on the CDC, as well as 'new entrants' who started receiving income support payments during the transition period and were, therefore, not subject to the CDC).

The third cohort started on the first available snapshot after the second period of 22 weeks (i.e. from around early March 2023). This last cohort included several groups of people including:

- Those who had exited the CDC;
- New entrants who may have been on the CDC prior to cohort 1 (but were not part of cohort 1) or who had never been on the CDC; and
- A small proportion of people on voluntary income management (whether previously on the CDC or not).

In the descriptive analysis the three cohorts were considered as being independent.

To implement the strategy outlined below, the data was organised as a panel for each 22-week data observation period for each cohort. The descriptive analysis relied on the first week vs. last week data snapshot of each cohort from which average outcomes and transitions were computed for simple cohort comparisons. Each panel dataset recorded demographics, location, housing characteristics, payment types, and outcomes (as described below). The cohort set-up allowed the review to look at transitions over a same length of time for all three cohorts, allowing people to transit over the same period of time and thus, making comparisons across groups of relevant individuals.

Analysis approach

The first step of the descriptive analysis consisted of providing comparisons between the three cohorts on outcomes of interest, as well as including demographics and other characteristics of interest (e.g. geographical location, housing, payments, etc.).

First, a comparison of the three cohorts of government payment recipients – observed in the last week of the snapshot for each cohort – was undertaken. This analysis allowed the review to see the extent to which the demographics and other characteristics of each cohort differed and how the population receiving government payments evolved over time. For each cohort, the outcomes of interest and the transitions (for binary outcomes) between the first week and last week of snapshot were analysed. For continuous outcomes (e.g. income), summary statistics were looked at over the 22-week period for each cohort. These transitions were then contrasted across cohort to understand whether any changes were observed following the ending of compulsory income management under the CDC program.

Altogether, the descriptive analysis compared the dynamic trajectories of each cohort of individuals throughout the 22 weeks they were followed.

A.3.2. Analysis of Western Australia community-level data

A further element of the quantitative research component for the review was the analysis of community-level health and police data from Western Australia.

As the ending of the CDC program was fairly recent, the research team was unable to undertake any formal impact estimations and, as a result, the analyses of this community-level data were largely descriptive. Trends, changes or averages in health and police outcomes were examined with an emphasis on three periods relating to the ending of the CDC program, i.e. the 5-month period pre-transition (May 2022 – September 2022), the transition period itself (October 2022 – March 2023), and a 5-month period post-transition (March 2023 – August 2023). In order to provide context for the analyses, the longer-term trends (i.e. from January 2014) were also examined where this data was available. This latter data preceded the start of the CDC program in both the East Kimberley (April 2016) and the Goldfields (March 2018) and, therefore, provided a longer-term background to the analyses.

To enable a better understanding of the possible effects of the ending of the CDC program, the approach used in the second formal Evaluation of the CDC was followed, i.e. to construct a 'comparison site' for each trial site, and examine the trends in a range of outcomes in the comparison site. An overview of the construction of the trial and comparison sites for analysis is provided below.

Importantly, two measures were considered: (1) the absolute rate, and change in rate, in the community level data and (2) the relative rate comparing trial and comparison sites. Taking into account the various caveats that have been referred to previously, differences in outcomes between the trial and comparison sites prior to, during and post the ending of the CDC program can be informative. For example, a decline in the gap in a particular outcome in the trial and comparison sites may indicate relatively improved outcomes in the trial site since CDC program cessation. In contrast, an increasing gap may suggest poorer outcomes have occurred in the CDC program trial sites following the ending of the program. Nonetheless, awareness needs to be paid to the fact that, by design, any changes observed in a comparison site are not due to the CDC program and can be for a multitude of reasons; this factor can potentially obscure the reaction to the ending of the CDC program when comparing relative rates across trial and comparison sites. The discussion presented in this report attempts to balance the interpretation of these two measures.

Western Australia health data

For the health data, the area in the scope of our analysis consisted of 24 Statistical Area Level 2 (SA2s), including one in the East Kimberley trial site, with four in the comparison site, and six in the Goldfields trial site with 12 in the comparison site. It is important to note that the underlying population in the four sites varies – particularly regarding Indigenous status.

The health data allowed the review to examine trends in EDAs in the East Kimberley and Goldfields regions. Table A.2 below provides the proportion of EDAs in the four sites disaggregated by gender and Indigenous status. As can be seen there are substantial differences,

e.g. for the East Kimberley trial site 36 per cent of EDAs pertained to Indigenous females and 17 per cent for the Goldfields trial site; whereas Indigenous males in the Goldfields comparison site accounted for only 4 per cent of EDAs. Moreover, the whole of the East Kimberley region is classified as 'very remote'; while 82 per cent of the Goldfields is 'outer regional' and 18 per cent 'very remote' areas. Hence, overall, there was greater heterogeneity within the Goldfields than the East Kimberley sites (see Mavromaras et al., 2021) and so a priori differences in EDAs between the Goldfields and East Kimberley were expected and this proves to be the case. Consequently, the data was adjusted for site population disaggregated to Indigenous and non-Indigenous (ABS Estimates of Aboriginal and Torres Strait Islander Australians, 2021), and weighted for proportion of gender per site based on DOMINO estimations.

Table A.2: Per cent of EDAs for trial and comparison sites since January 2014

EDAs for trial and comparison sites since January 2014 (Per cent)				
	Female Indigenous	Male Indigenous	Female non-Indigenous	Male non-Indigenous
East Kimberley trial	36	26	18	21
East Kimberley comparison	39	31	13	16
Goldfields trial	17	15	32	36
Goldfields comparison	5	4	44	46

The analysis was conducted using a dataset provided by WA Health. The dataset contained records of EDAs occurring in 24 localities between 1 January 2014 and 31 August 2023.[21] After accounting for duplications of counts (due to the way the data were recorded missing or uninformative data), and zero-count records there were 1,374,567 total EDAs from 2014(1) to 2023(8).[22] For the period from 2022(1) the total was reduced to 241,887 total EDAs.

Data were available for total EDAs and also for the following four sub-groups or categories:

- Alcohol only related EDAs;
- Drug only related EDAs;
- Either drug and/or alcohol related EDAs; and
- Mental health related EDAs.

The categories are not, however, mutually exclusive, but as advised by WA Health:

- Alcohol Only and Drug Only are mutually exclusive of each other.
- Either Drug and/or Alcohol is derived from a drug related code or alcohol related code (as well as other generalised intoxication codes where it is not possible to distinguish

[21] Note that the initial DSS data contained 127,420 rows of data with various counts of EDA in each row. These are not unit records as rows contained data that are sub-totals based on 5 items of interest, e.g. for the SA2 of Kojonup in Jan 2018 there were 15 rows of data but that is because 4 rows were for mode of arrival at the hospital (count=373), 2 rows for human intent (count=373), 4 rows for triage (count=373) and 4 rows for gender and Aboriginal status (count=373) and so in total, including missing and other non-informative content (e.g. Indeterminate), there were potentially 33 rows that represent EDAs in a single month and SA2.

[22] There were multiple entries in the data reported as "<5" EDAs. To make them useful – and not reduce the raw rows by about 32,000 – integers 1 to 4 were randomly assign to these cases.

between drug or alcohol). This means that any records from the Alcohol Only or Drug Only items are also counted in this item, but some records included in this item are not necessarily included in 'Alcohol Only' or 'Drug Only.'

- 'Mental Health' is not mutually exclusive from the drug/alcohol items (e.g. a patient presenting as Alcohol Only, may also be included in the Mental Health category).
- Emergency department presentation is the total of EDAs (the four other categories are sub-sets of this count, but the four categories do not, of course, constitute all EDAs).

The analyses were primarily interested in the four sub-groups of the total EDAs for the period from 2022(1). As shown in Table A.3 below, counts of EDAs were significantly less for these sub-groups. Combined, the four EDA categories, for example in 2022, account for only 11,064 of a total of 140,021 presentations. Moreover, for the Mental Health category, which has the largest EDA category count, there were 6,768 EDAs in 2022.

Table A.3: EDAs by EDA category (sub-group) and site (2022)

EDAs by category and site					
	East Kimberley		**Goldfields**		
EDA sub-group	**Trial**	**Comparison**	**Trial**	**Comparison**	**Total**
Alcohol Only	123	429	*313*	*353*	1,218
	0.9%	0.9%	*1.2%*	*0.7%*	0.9%
Drug Only	52	183	*285*	*394*	914
	0.4%	0.4%	*1.1%*	*0.7%*	0.7%
Alcohol and/or Drug	179	716	*593*	*676*	2,164
	1.4%	1.5%	*2.3%*	*1.3%*	1.5%
Mental Health	630	2,199	*1,537*	*2,402*	6,768
	4.8%	4.7%	*5.9%*	*4.5%*	4.8%
Total four sub-groups	**984**	**3,527**	***2,728***	***3,825***	**11,064**
Percent of total EDAs	7.5%	7.5%	*10.4%*	*7.1%*	7.9%
Percent of total EDAs	7.5%	7.5%	10.4%	7.1%	7.9%
Total EDAs	***13,205***	***46,801***	***26,150***	***53,865***	***140,021***

Notes (1) Data are not population adjusted. (2) As noted above sub-categories are not mutually exclusive so column per cent are an approximation only.

When distributed over 12 months and between gender, Indigenous status, and trial or comparison sites (analytical groups) there were about 35 EDAs per month per group. When adjusted for the site's underlying population (for EDAs per 1,000 persons disaggregated over gender and Indigenous status), and distributed across analytical groups this reduced to less than seven (per 1,000 population per month). On the other hand, the smallest EDA category of 'Drugs Only' had a total of 914 EDAs in 2022 and on an adjusted for population basis this resulted in a monthly average of 0.9 EDAs per analytical groups (per 1,000 population). For the smaller (e.g. less than one) monthly average counts of EDAs (per 1,000 population) this indicates that an expectation that for some months for the analytical groups the EDA count would be zero and this was observed. Nonetheless, although monthly counts could be very small (or zero) in multiple cases, the disaggregated to EDA sub-

categories by gender and Indigenous status was considered too important to ignore.[23]
An important consideration was whether there was any value in an analysis of total EDAs. Consider the counts for the year 2022 of EDA categories in Table A.3 above. As this table clearly shows, the four EDA sub-categories of interest were very small proportions of the total EDA in general and in each site. In addition, the main interest was in three five-month periods, so it was very clear that numbers for each item, for each site by gender and Indigenous status were completely overwhelmed when compared to the total EDAs. Further there seemed to be no strong argument that the CDC policy would have had a significant impact on total EDAs. For example, total EDAs includes multiple other reasons for hospital attendance (e.g. accidents, pregnancy, childbirth, and general health such as pneumonia, heart conditions, etc.). Consequently, except by way of an introduction to contextualise the sub-categories of EDAs from 2022(1), total EDAs were not considered in detail. In addition, the EDA data were very volatile. For example, over the period 2022(1) to 2023(8) the range for monthly total EDAs ranged from about 7 to 120 which is, population adjusted, a range of about 2 to 15 EDAs. In comparison the smallest sub-category, Drugs Only, had a population adjusted range of zero to just 0.32.

After considering the several points above, it was concluded that the best approach to the data was to: (i) disaggregate into four sub-populations (defined by gender and Indigenous status), (ii) adjust observed EDA counts to represents per 1,000 population in each site for the four sub-populations, (iii) concentrate predominantly on four sub-categories of EDAs; and (iv) when analysing EDAs over the longer-term from 2014 apply a three-month moving average to monthly data.

Although, as is shown in several of the figures in Appendix 4, for some categories for analysis data were very volatile and average monthly counts per 1,000 population became very low – and in some cases were zero. Consequently, this defeated the purpose of presenting figures for 2022 onwards as moving averages as it was the values related to the exact month of the transition periods that were of interest. It should also be noted that due to the volatility, monthly data can be distorted if there are peaks or troughs on the cusp of change in the periods of interest.

There were three other measures included with the EDA data: mode of arrival at the hospital, human intent and triage. These data were recorded for the total EDAs only and did not coincide with each other, or with gender or Indigenous status. Consequently, the only potential analysis was the per cent of each at any period. The analyses looked for any meaningful difference across the three transitional periods for these additional measures and found nothing of interest, thus, were not considered further.

Western Australia police data

For the police data, the area in the scope of our analysis consisted of 126 localities: three localities in the East Kimberley trial site, with 33 localities in the comparison site; and 49 localities in the Goldfields trial site with 41 localities in the comparison site.

[23] Because the analysis is based on groups defined by gender and Indigenous status, the data for analysis excludes instances where gender is reported as “Not stated…” and where Indigenous status is “Unknown”, and where either in missing.

The analysis was primarily conducted using three datasets provided by the Western Australian Police Force. The main dataset contained 216,283 unit records of offences committed in 166 localities between 1 January 2014 and 31 July 2023. It was observed that one locality in the Goldfields trial site, one in the comparison site for the broader Goldfields region and one in the East Kimberley comparison site did not have any records in the data, which may indicate that no offences were observed in these localities during the time period.

The offences in the dataset were classified at the second level of reporting of offences, and the number in each category of offences is shown in Table A.4 below across the four relevant sites (i.e. two trial sites and two comparison sites). This classification was used to analyse various categories of offences, with a particular focus on offences in relation to family violence and drug/alcohol misuse, as well as the prevalent types of offences against people (namely 'assault' and 'threatening behaviour') and property ('property damage/graffiti' and 'stealing'). In addition, the dataset included a flag to indicate whether family violence was involved for a given offence and, thus, this flag was used in the analyses to identify family violence related offences.

Given that a number of localities in scope have a very small population, it was frequent to see a very small number of offences in the dataset at a locality level. Thus, the analysis was carried out at the site level using the monthly number of offences. Further, given the difference in terms of population across the East Kimberley and Goldfields regions, the focus was on the rates of offences (per thousand population in each site) rather than on the actual number of offences recorded, where the population statistics are derived from the Census 2021.

The second dataset used in the analysis contained 73,105 family violence tasks attended by the WA Police in 133 localities from 1 January 2014 to 31 July 2023. In this dataset, it was found that 14 localities in the Goldfields trial site, ten in the Goldfields comparison site and six in the East Kimberley comparison site did not have any records in the data. In the remaining 96 trial and comparison localities, 67,851 tasks were attended during the recorded period. Family violence tasks attendance was another indicator in relation to the incidence of family violence. Thus, in addition to the analysis on the family violence related offences (using the first dataset), long-term and recent trends of the number of family violence tasks attended (converted per thousand population) were also examined in the CDC program trial sites, and compared with the corresponding comparison localities.

Table A.4: Total number of offences recorded in WA Police data by category, trial vs. comparison

WAPOL Level 2 reporting	Total number of offences			
	East Kimberley		Goldfields	
	Trial	Comparison	Trial	Comparison
Arson	162	477	362	125
Assault (Family)	6,201	20,798	7,763	2,206
Assault (Non-Family)	1,373	5,325	4,526	1,338
Breach of Violence Restraint Order	2,317	7,138	3,270	1,058
Burglary	3,097	12,385	7,710	2,842
Deprivation of Liberty	23	101	71	15
Drug Offences	1,336	6,909	6,014	3,585
Fraud & Related Offences	619	2,559	3,985	791
Graffiti	161	256	277	82
Historical Sexual Offences	53	351	144	88
Homicide	22	45	34	12
Property Damage	3,491	11,264	11,868	3,403
Receiving and Possession of Stolen Property	165	615	819	260
Recent Sexual Offences	435	1,323	893	356
Regulated Weapons Offences	143	691	986	316
Robbery	55	259	284	27
Stealing	2,483	10,484	12,561	3,369
Stealing of Motor Vehicle	923	3,266	1,868	475
Threatening Behaviour (Family)	844	3,073	911	248
Threatening Behaviour (Non-Family)	301	1,184	996	450
Total	**24,204**	**88,503**	**65,342**	**21,046**

The last dataset provided by the WA Police Force contained 22,333 records of drink driving charges issued in 264 localities from 1 January 2014 to 31 July 2023. It was found that 49 localities in the scope of the analysis did not show any driving charges, and 11,953 records were observed in the remaining 77 locations. Similar to the approach used with other two datasets, the monthly number of drink driving charges (converted per thousand population) were also derived for each site of interest. A statistical comparison was provided of how this number changed over time both before and after the ending of the CDC program in the trial sites. Finally, trends in drink driving charges were examined and compared in the comparison sites.

CDC and comparison localities in the Western Australian sites

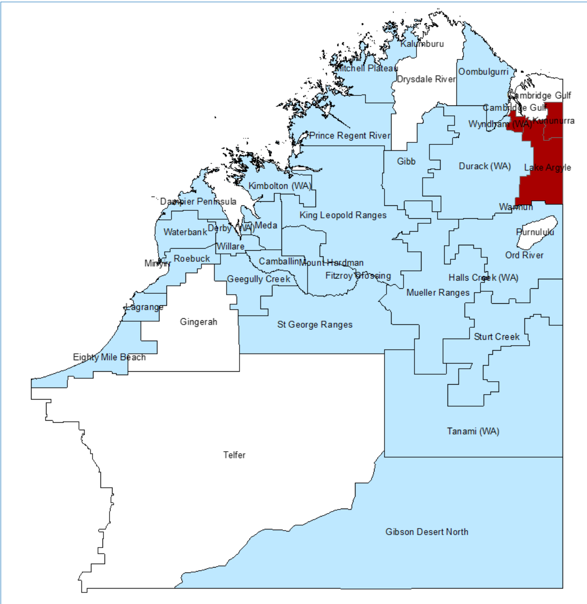
The following section, using the WA Police data as an example, outlines how the CDC trial and comparison sites were constructed in the analyses of the Western Australian community data.

Choice of localities for analysis

The following maps give an illustration of the localities[24] included in the analysis of the impact of CDC program cessation on police outcomes. They highlight, in red, the localities that are included in the CDC trial sites, and, in blue, those that were used to construct the comparison sites in the analysis.

The following map (Figure A.1) presents the geographical distribution of the trial and comparison localities used in the analyses in the East Kimberley region. There are only three localities included in the East Kimberley trial site and a group of 33 localities were able to be used as a comparison group. Among the comparison group localities, Derby and Broome were used as two places that can be compared, to some extent, with Kununurra. While Broome is larger in population size than Kununurra, both are characterised by large variations in population numbers due to the seasonality of tourism and the presence of a large proportion of seasonal jobs. Derby and Kununurra are very similar with regard to the proportion of Indigenous people living there, even though Derby's population is about half that of Kununurra. Overall, the comparison and trial groups of localities were assessed as being satisfactorily comparable.

Figure A.1: Mapping of the trial and control localities in the Kimberley

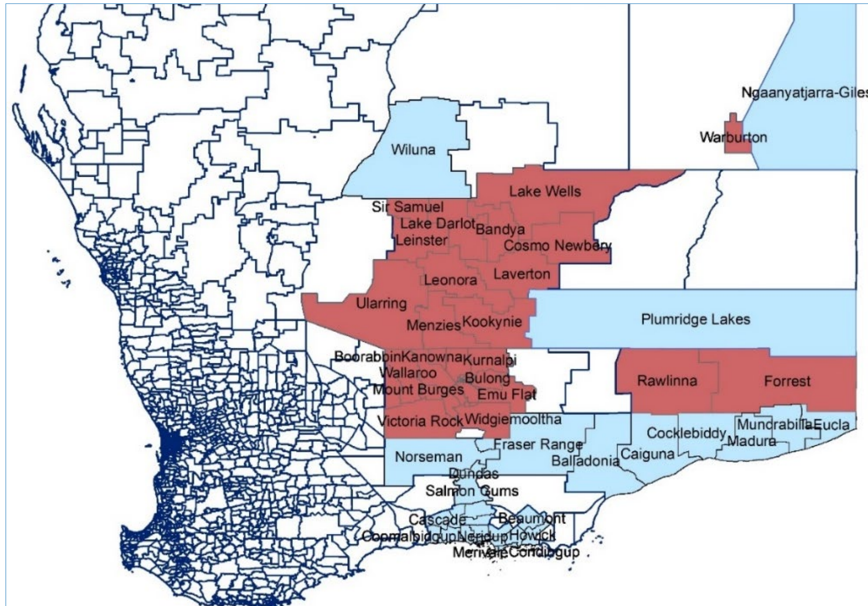


The following map (Figure A.2) presents the Goldfields area with the trial and control areas highlighted. The WA Police data did not include any localities that were comparable to Kalgoorlie in size so other, less populated places, like Esperance and neighbouring Castletown were used.

[24] According to the ABS Statistical Areas level 2 (SA2) "…consist of whole gazetted suburbs or rural localities." Hence reference here is to locality in preference to suburb.

Altogether, the comparison group for the Goldfields area was considered satisfactory for the purpose of the analysis.

Figure A.2: Mapping of the trial and control localities in the Goldfields



Aggregation of localities for analysis

As noted above the WA police data was supplied at a Suburb/Locality level and the WA Health data was supplied at Statistical Areas Level 2 (SA2).

These levels of reporting were not considered to be suitable for analysis for this report. For example, as outlined above for the WA Police data, CDC trial and comparison site level data was used because a number of in-scope localities had very small populations and it was common for there to be very small numbers of offences in the dataset at a locality level. Consider the total number of offences of 216,283 (in 48 categories of offences) in the Police data provided. This covered January 2014 to December 2022 or 96 monthly periods. If analysis of the data was undertaken at a locality level, there were approximately 2,252 offences per month. For the 166 unique localities in the data that implies approximately 14 offences per month per locality. There are 48 types of offences in the data which we aggregate to 20 offence categories thus there are approximately 0.7 offences/month/per suburb. Clearly this is not suitable for analysis.

For the WA Health data, although reported at the SA2 level, there is a similar problem to the WA Police data. For example, there are 24 unique SA2s in the data; 5 categories of EDAs (that are not mutually exclusive); 120 months; males and females; Indigenous and non-Indigenous status. That is there are over 50,000 ‘cells’ that require data. For the total count of EDAs of 50,495 the average EDA per cell is <1. This is clearly not satisfactory.

For these reasons tables and figures in the report are presented at a Site level.

A.4. Appendix 4: Additional findings from the Western Australian health data

To provide some context for the analysis of EDAs in relation to the cessation of the CDC program, the longer-term trend of the population-adjusted monthly number of EDAs were examined. The population adjustments were based on 2021 Census and ABS data disaggregated by gender and Indigenous status. Thus, generally, the analysis and figures are of the rate of EDAs per 1,000 of site-gender-Indigenous status population. As noted previously, because of high data volatility, a three-month moving average of population adjusted rates of EDAs was applied when examining longer-term data (i.e. from 2014).

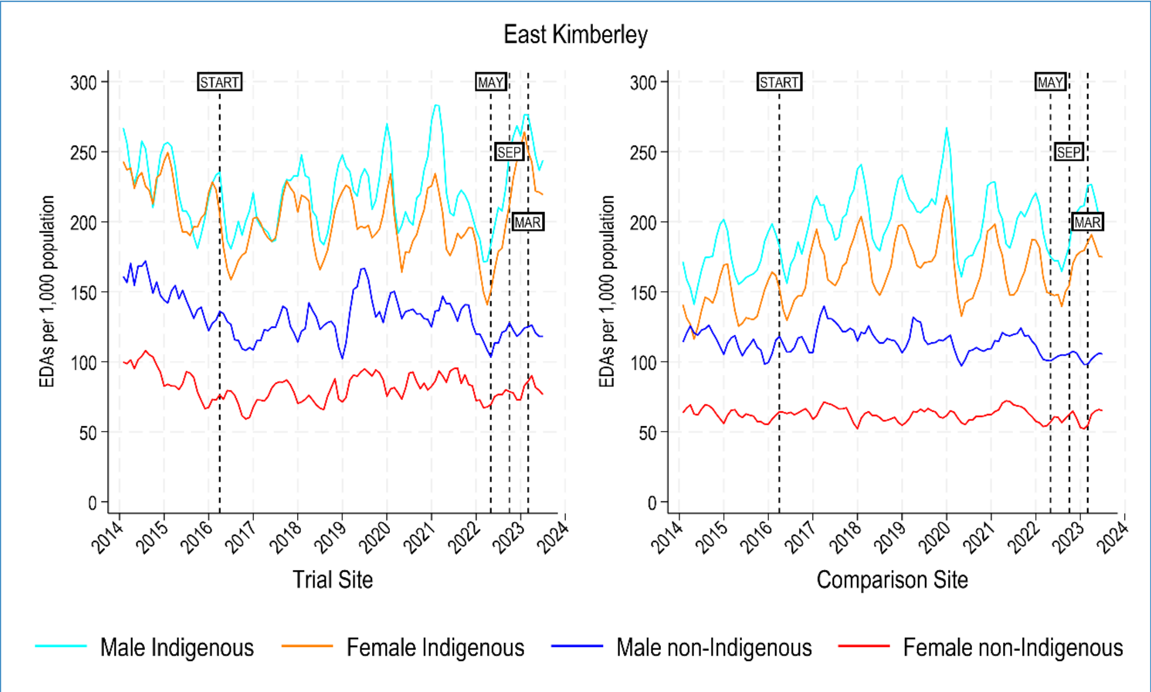
Note that to allow more informative comparisons between trial and comparison sites, where practical a common scale was applied to the vertical axis.

A.4.1. Total EDAs (population adjusted)

Figures A.3 and A.4 below clearly demonstrate the results summarised in Table 5.3 (in Section 5.3.2):

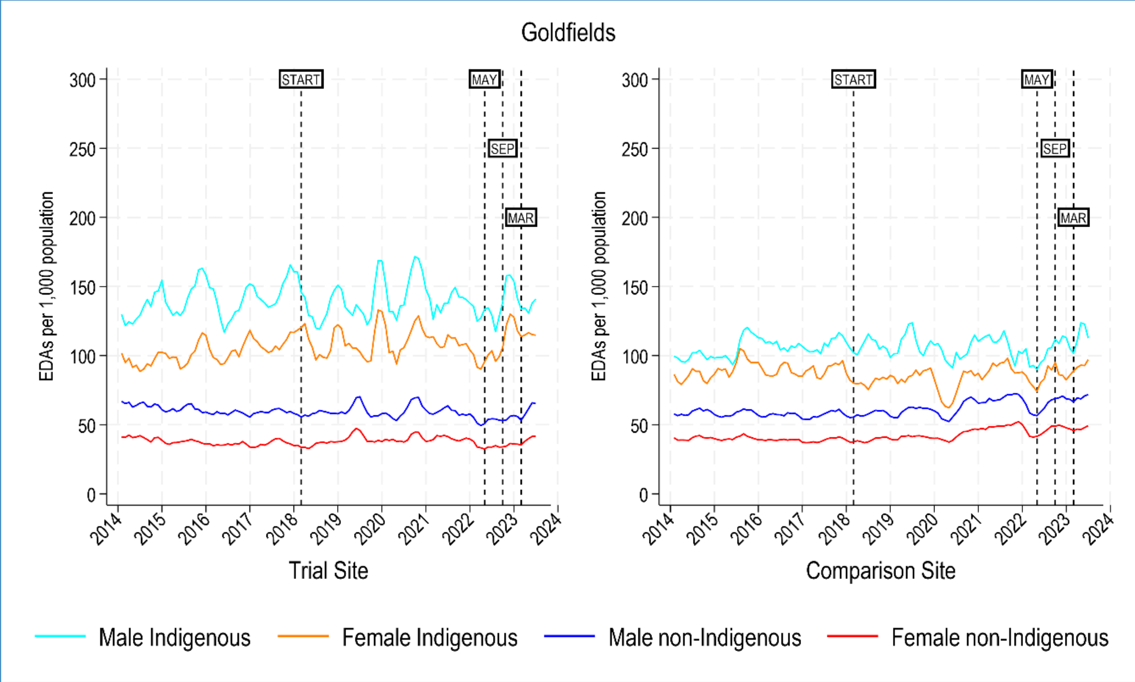
- The monthly data were volatile – even when provided as a three-month moving average.
- Overall the data for the comparison sites were less volatile than for the trial sites.
- Overall non-Indigenous populations were less volitive in EDA rates, and generally non-Indigenous females had the least volatility in EDA rates.
- Population adjusted monthly EDA rates for males were always higher that females.
- EDAs for Indigenous populations were always higher than for non-Indigenous populations.
- In the trial sites there was a small decrease in EDAs at the start of the CDC, but it appears to have lasted for six months or less. There was a smaller decrease in the comparison sites and it lasted less time.
- Between the start of the CDC and May 2022 (the start of the pre-transition period), there was a small decrease in rates of EDAs in the trial sites but not the comparison sites.
- Differences in trends between the trial and comparison sites varied considerably, but appeared to be relatively small.

Figure A.3: EDAs East Kimberley trial vs. comparison site by gender and Indigenous status from 2014



Notes: (1) MAY, SEP, MAR represents three period: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) START represents the start of the CDC in the East Kimberley site. (3) Data are a three-month moving average. (4) In this and all following figures EDAs are the rate of EDAs per 1,000 of population (for site, gender, and indigenous status specific populations).

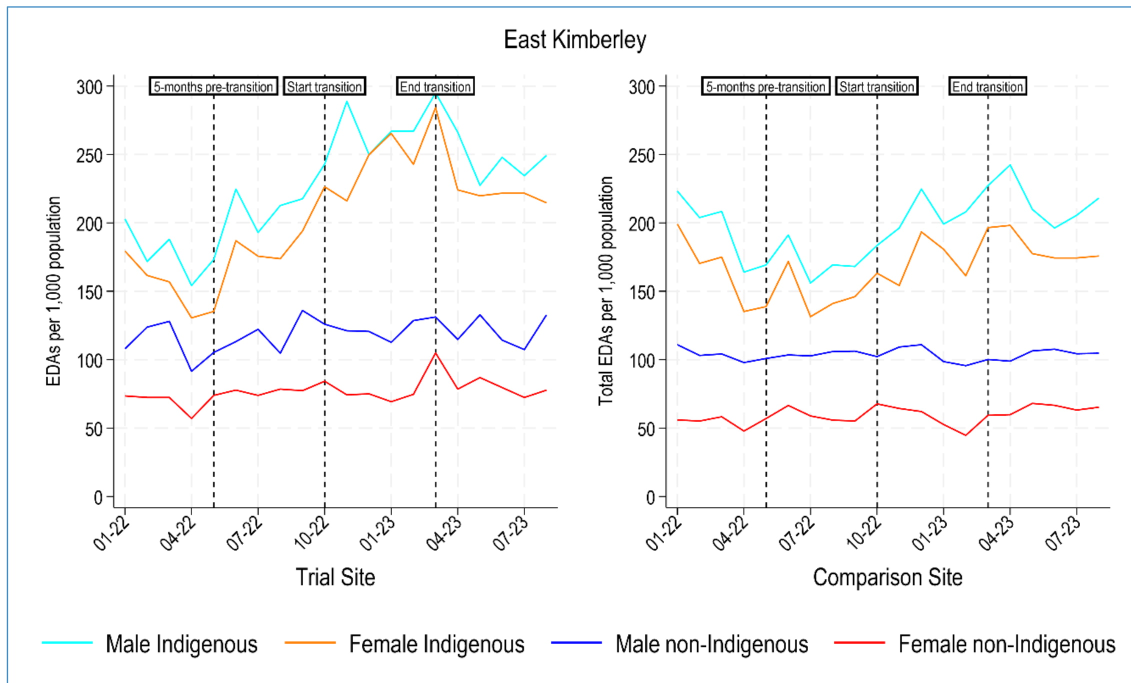
Figure A.4: EDAs Goldfields trial vs. comparison site by gender and Indigenous status from 2014



Notes: (1) MAY, SEP, MAR represents period: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) START represents the start of the CDC in the Goldfields. (3) Data are a three-month moving average.

In Figure A.5 below the data range was restricted to start in 2022 so that potential impacts of the changes to the CDC policy are clearer. The data were population adjusted, but a moving average was not used.

Figure A.5: EDAs East Kimberley trial vs. comparison site by gender and Indigenous status from 2022



Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023). (2) Data are not a moving average.

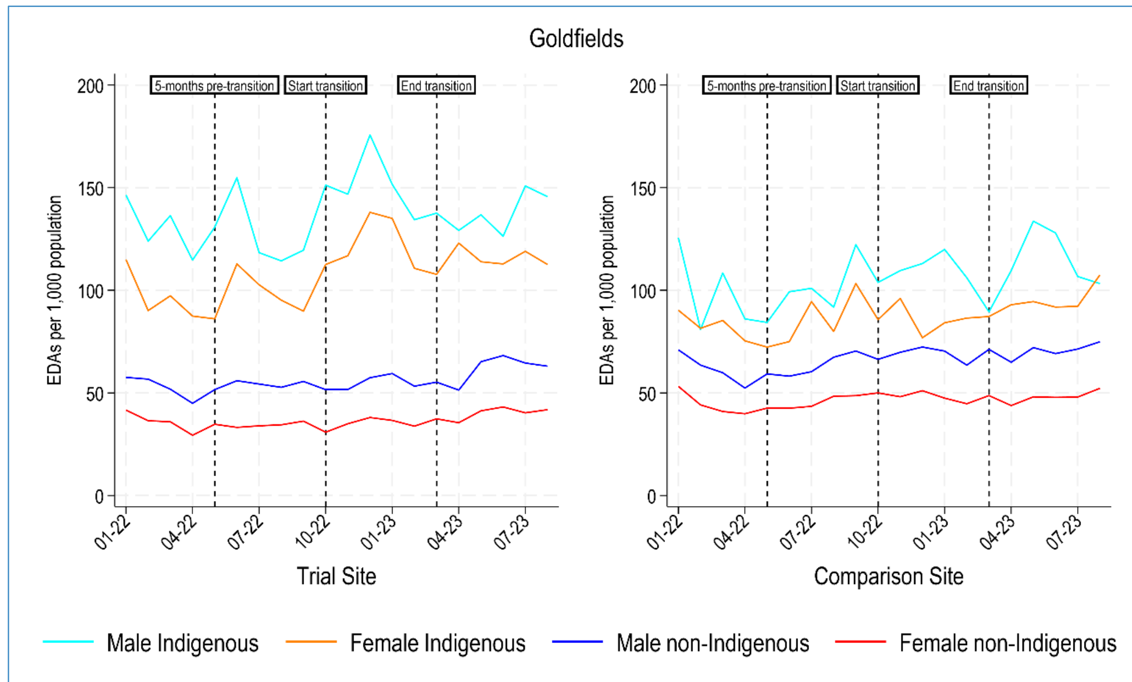
As Figure A.5 above shows:

- The pre-transition period was associated with a reversion of the previous downward trend in total rate of EDAs in the trial sites.
- During the pre-transition and transition period a strong upward trend was observed for the Indigenous population in the East Kimberley trial site with a smaller upward trend in the comparison site.
- Post-transition there was a strong fall in EDAs in the trial site and a smaller one in the comparison site; this then tended to level out.
- At the end of the data following post-transition, EDAs were higher in the trial site (except for non-Indigenous females) and more so for the Indigenous populations.
- There was no apparent difference in EDAs in the comparison site for the non-Indigenous population; in the trial site there was more movement but a tendency to revert to a long-term average.
- The volatility in the data, and differences in peaks and troughs between trial and comparison sites, complicate consideration of trends in differences between the two sites.

- Possible association between total rate of EDAs: (i) rates for the Indigenous populations in the trial site suggested trend increases in the pre-transition and transition periods, with a fall and then levelling out post-transition, and (ii) similarly for the comparison site, but to a smaller extent.

The corresponding figures for the Goldfields are shown in Figure A.6 below.

Figure A.6: EDAs Goldfields trial vs. comparison site by gender and Indigenous status from 2022



Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August2023). (2) Data are not a moving average.

As Figure A.6 above shows:

- The pre-transition period was associated with a rise and then a fall in EDAs. By the start of the transition period EDAs were higher than the start of the pre-transition period for the Indigenous population.
- By the end of the transition period EDAs for the Indigenous population were higher than the start.
- Post-transition there was little movement in EDAs for several months for the Indigenous population in the trial site, but comparing trial and comparison sites there was little common pattern between the four Indigenous populations.
- At the end of the data following post-transition, EDAs were about the same as in 2022(1) for the trial site Indigenous and comparison female Indigenous populations but marginally lower for the male Indigenous population.
- There was very little difference in EDAs for the non-Indigenous population.
- There were very noticeable differences between the East Kimberley and Goldfields trends and patterns.
- As noted previously, differences in peaks and troughs between trial and comparison sites, complicated consideration of trends in differences between the two sites.

Attention was then turned to viewing the four categories of EDAs graphically. This has the advantage that monthly rates of EDAs could be observed in more detail and so allowed a visual comparison of the across-time changes within sites, between trial and comparison sites, and between the East Kimberley and Goldfields sites. First, the rate of EDAs from 2014(1) was briefly considered - and this allowed a comparison between rates of EDAs pre and post the implementation of the CDC in the East Kimberley and Goldfield sites. Second, a more detailed consideration of the EDA rates, from 2022(1), of the changes associated with the abolishing the CDC and the three related periods (pre-transition, transition, and post-transition).

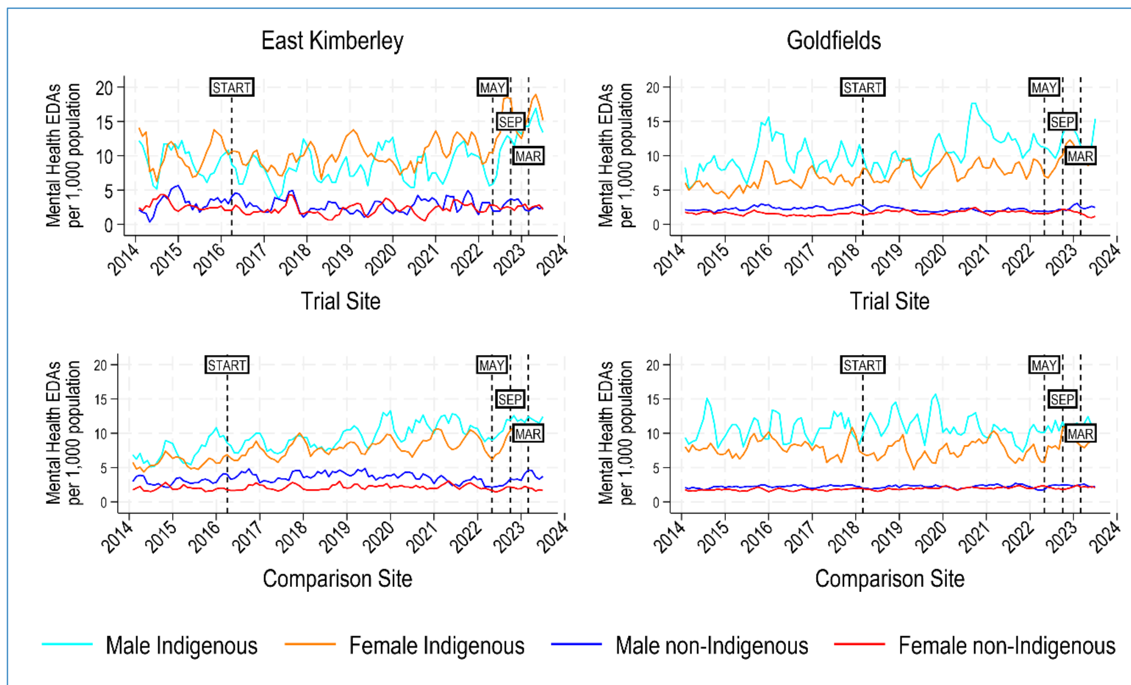
A.4.2. Mental Health EDAs

Figure A.7 below summarises the Mental Health associated EDA rates from 2014(1) as a three-month moving average of EDAs per 1,000 of specific site-gender-Indigenous status population.

The following was observed:

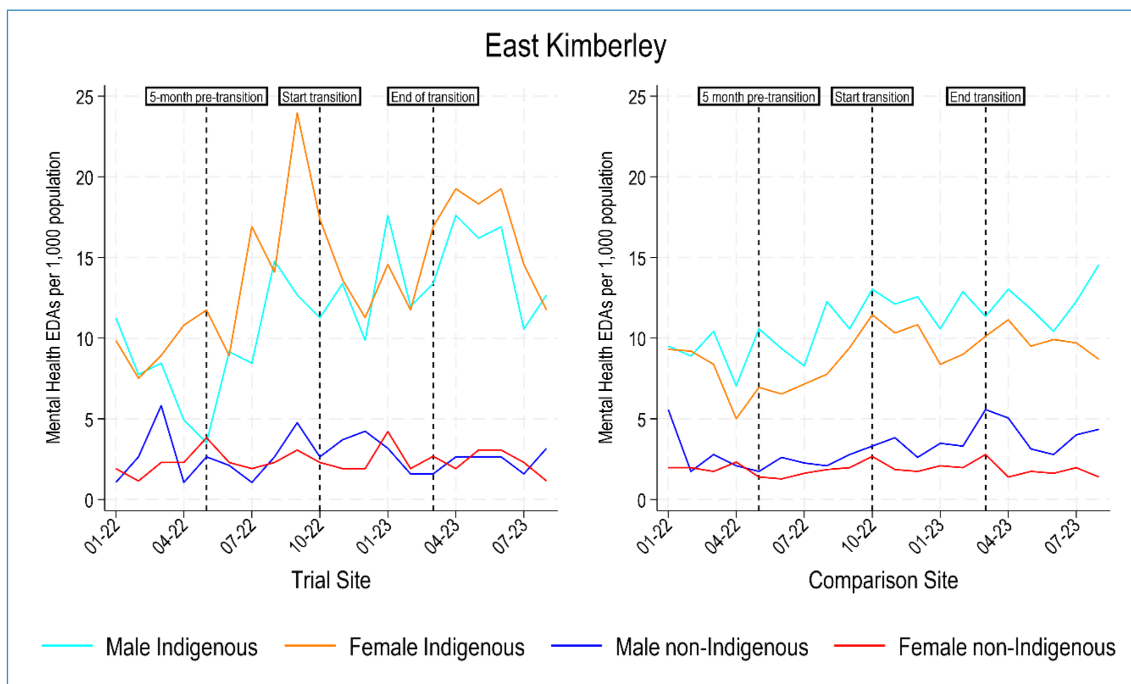
- The volatility for this sub-group of EDAs did not appear to be very different to that for the total rate of EDAs (keeping in mind that presentation in this form tends to make peaks and troughs look steep as the length of the time axis was compressed).
- There was less difference between non-Indigenous populations than for total EDA rates.
- For the Indigenous population, the rates of Mental Health EDAs was no different to that of the total EDAs.
- Volatility continued following the implementation of the CDC program [‘START’ in the figure], and importantly - taking a smoothed-view - the start of the CDC did not appear to be associated with any significant longer-term changes to the rates of EDAs.
- The longer-term figures showed that on a three-month moving average basis over the 116 months since 2014(1), rates of Mental Health EDAs for the Indigenous and non-Indigenous population were relatively steady in both the East Kimberley and the Goldfields. This picture had previously emerged for the rate of total EDAs.

Figure A.7: EDAs for Mental Health trial vs. comparison site from 2014



Notes: (1) MAY, SEP, MAR represents period: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) START represents the start of the CDC in the East Kimberley site. (3) Data are a three-month moving average.

Figure A.8: EDAs for Mental Health East Kimberley trial vs. comparison site from 2022



Notes: (1) Pre-transition May2022-Sept2022, Transition Oct2022–March2023, Post-transition March2023-August 2023. (2) Data are not a moving average.

As Figure A.8 above shows for the East Kimberley sites for Mental Health related EDA rates:

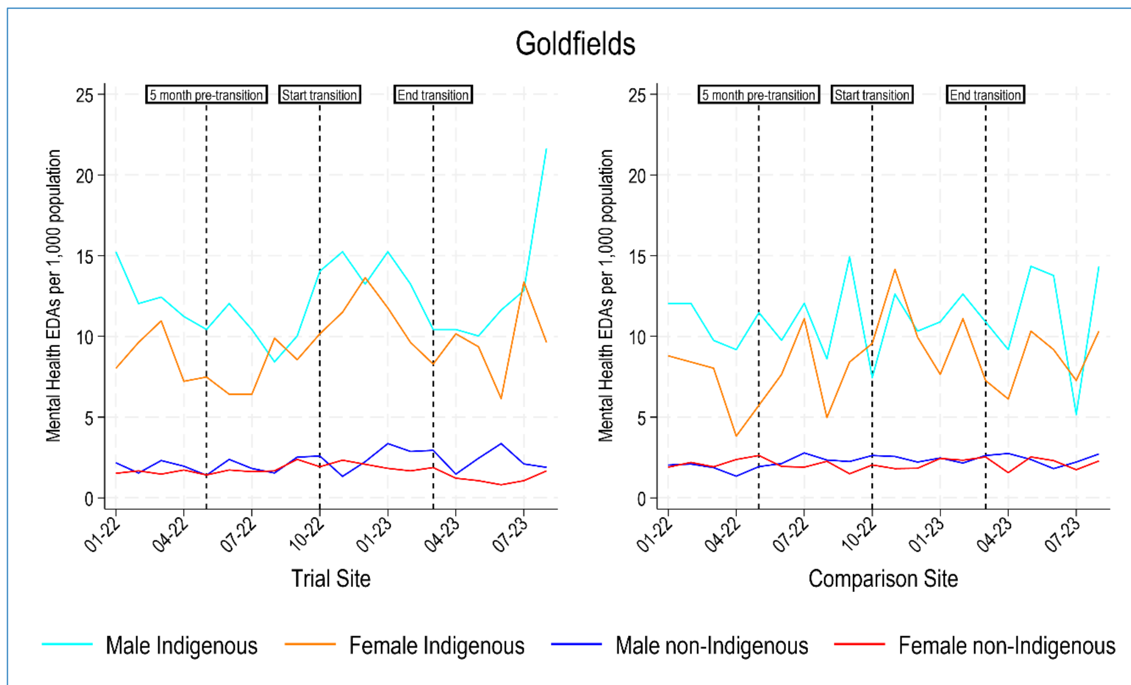
- For the East Kimberley trial site the Indigenous population showed a very sharp increase for much of the pre-transition period – with a revision towards its end, but changes were much smaller in the comparison site.
- During the transition period monthly volatility was apparent and the EDA rate observed at the end was very similar to the start of the transition.
- Post-transition for the trial site showed a rise and then a fall, so that at the end there was little difference; there was a mixed outcome in the comparison site.
- At the end of the data following post-transition, EDAs rates were little different to the rate in 2022(1) – except for Indigenous males in the trial and comparison site.
- There was very little difference in EDAs for the non-Indigenous population, and although there was some volatility this was much less than for the Indigenous population.
- There was evidence that trends and changes in the trial site across time were different to those in the comparison site, but by the end of the period these changes appeared to be smoothing out.
- Nonetheless, some likelihood of an association between the cessation of the CDC and mental health EDAs was observed.

In Figure A.9 below for the Goldfield sites for Mental Health related EDA rates:

- For both Goldfield sites the Indigenous population data showed monthly volatility, but by the end of the post-transition period there was little change from 2022(1) – except for the male Indigenous population showing a very sharp increase at the end of the data. At this point a sensible option was to treat this as an outlier and wait for further data.[25] Nonetheless, some evidence of an association between the cessation of the CDC and mental health EDAs was seen for the Indigenous populations.
- There was very little difference in EDAs rates for the non-Indigenous population from 2022(1) onwards and so little evidence that the trends and changes for this population in the trial site were of material difference to those in the comparison site.

[25] A check of the original data showed three or four unusually high monthly counts of EDAs specifically for this site and sub-group.

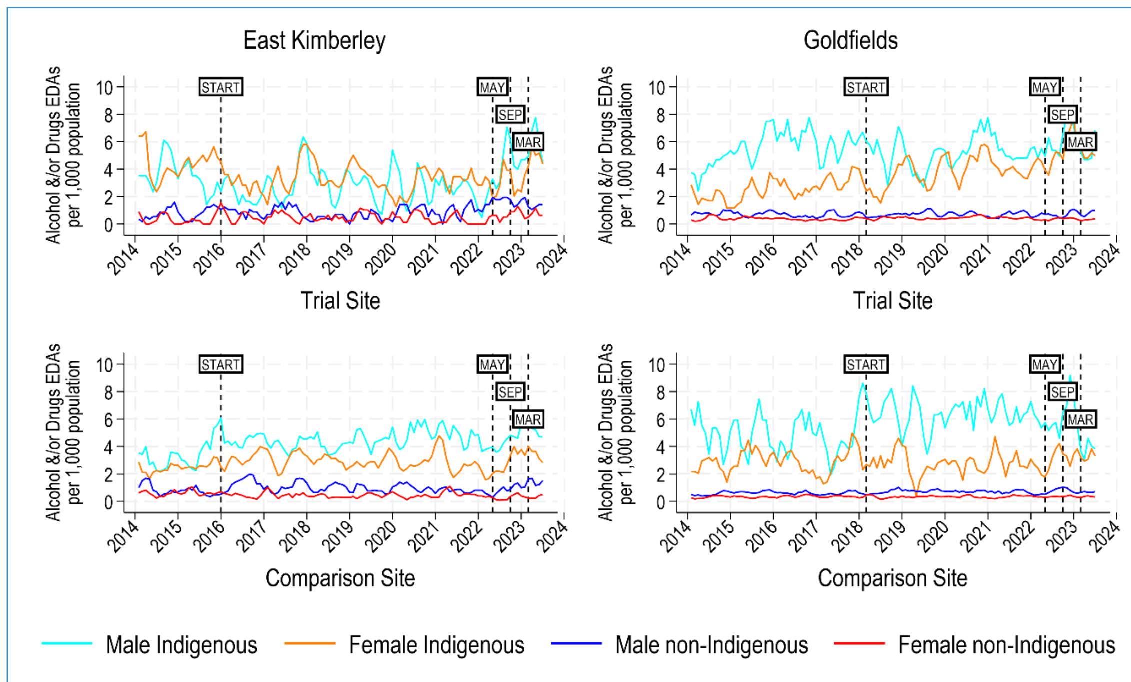
Figure A.9: EDAs for Mental Health Goldfields trial vs. comparison site from 2022



Notes: (1) Three period of interest: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) Data are not a moving average.

A.4.3. Alcohol and/or Drugs

Figure A.10: EDAs for Alcohol and/or Drugs trial vs. comparison site from 2014

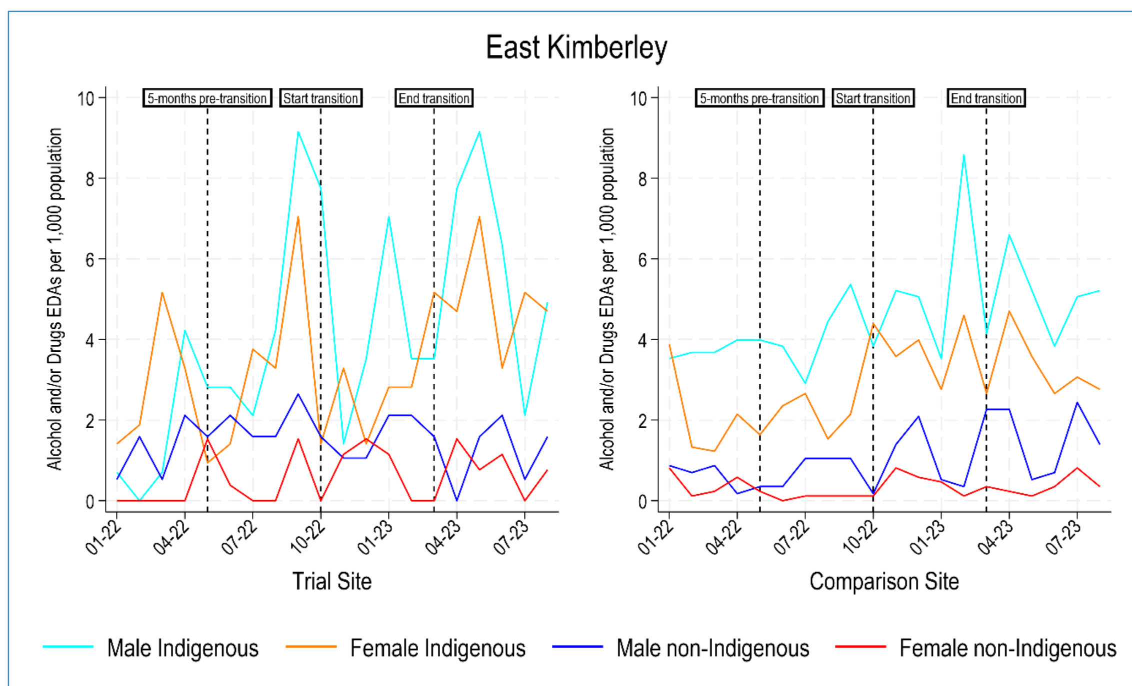


Notes: (1) MAY, SEP, MAR represents period: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) START represents the start of the CDC in the East Kimberley site. (3) Data are a three-month moving average.

Figure A.10 above shows longer-term EDA rates on a three-month moving average basis for the Alcohol and/or Drugs category:

- Data had become more volatile for the Indigenous populations, but more so for the East Kimberley trial site.
- Over the period since 2014(1) rates of EDAs for the non-Indigenous population were relatively steady in both the East Kimberley and Goldfields sites, more so for the Goldfields sites.
- There appeared to be more volatility around the three transition periods (MAY, SEP, MAR).
- Rates of EDAs by the end of the data in 2023(8) did not look materially different than the start in Goldfield sites but looked somewhat higher in the trial sites.

Figure A.11: EDAs for Alcohol and/or Drugs East Kimberley trial vs. comparison site from 2022



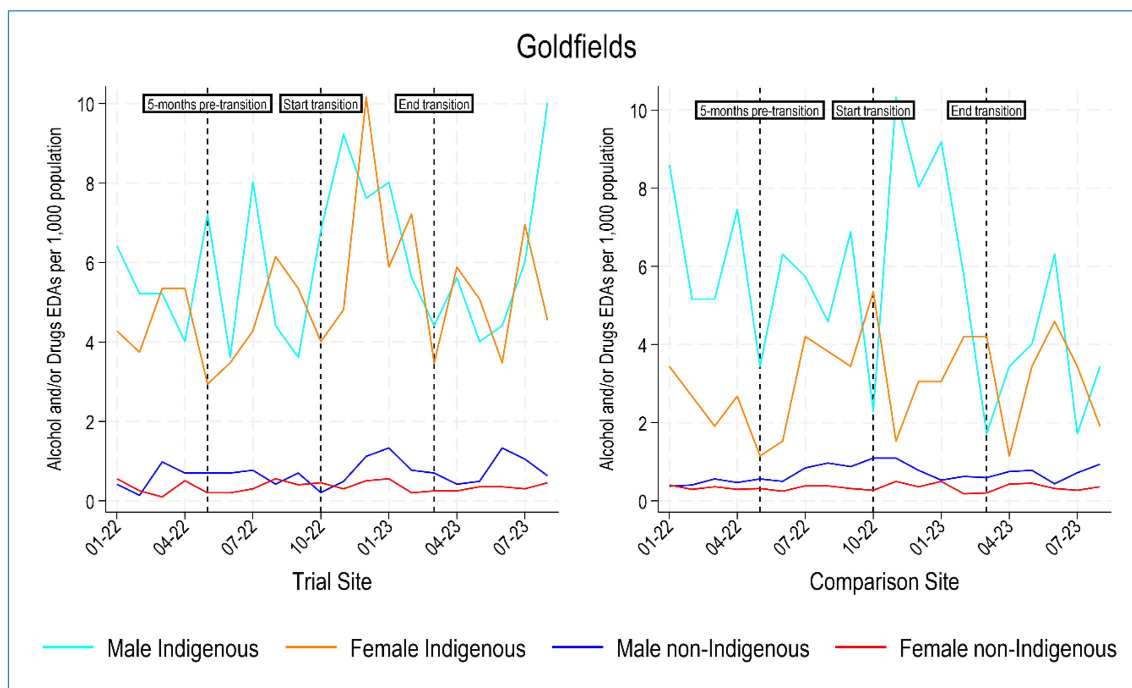
Notes: (1) Three period of interest: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) Data are not a moving average.

Figures A.11 (above) and A.12 (below) shows EDA rates from 2022(1) for the Alcohol and/or Drugs category:

- Both the East Kimberley and Goldfield sites for the Indigenous population showed high monthly volatility. Trial site data were most volatile in the East Kimberley trial site.
- There was greater volatility for non-Indigenous populations than for the previous EDA categories.
- By the end of the post-transition period there was little change from 2022(1) for the non-Indigenous populations.

- Similarly, putting aside the volatility, the Indigenous populations rate of EDAs at the end of the period did not appear to be very different from the start – except for the male Indigenous population in the East Kimberley who showed a very sharp increase at the end of the data. At this point a sensible option was to treat this as an outlier and wait for further data.[26]
- Rates of EDAs for males were slightly higher than female rates, and more so the Indigenous populations.

Figure A.12: EDAs for Alcohol and/or Drugs Goldfields trial vs. comparison site from 2022



Notes: (1) Three period of interest: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) Data are not a moving average.

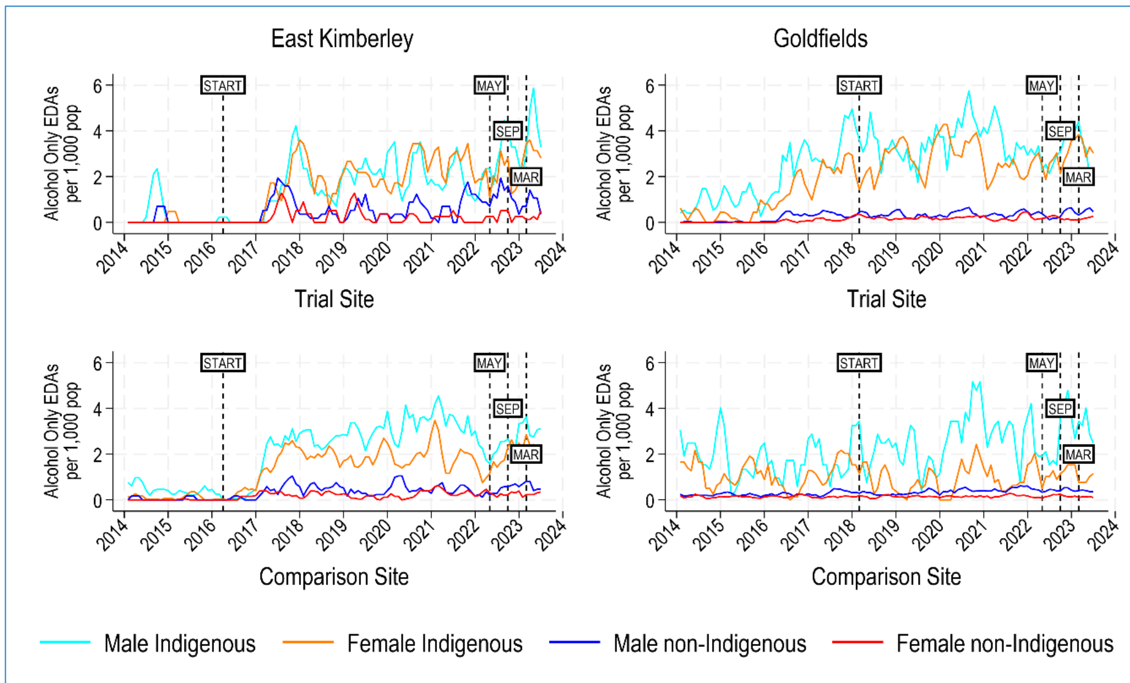
A.4.4. Alcohol Only

Figure A.13 below shows EDA rates from 2014(1) for the Alcohol Only category:

- As discussed previously, for the EDA categories with smaller monthly EDA counts the population adjusted rates were quite small – and in some cases were on average zero. This was more so for the non-Indigenous populations but also appeared to occur for the Indigenous populations in the early years of the data.
- Both the East Kimberley and Goldfields sites for the Indigenous population showed high monthly volatility. Trial site data were most volatile and the East Kimberley trial site had the most volatile data.
- There was greater volatility for non-Indigenous populations than for previous EDA categories, but high volatility for the Indigenous population was consistent with other EDA categories.

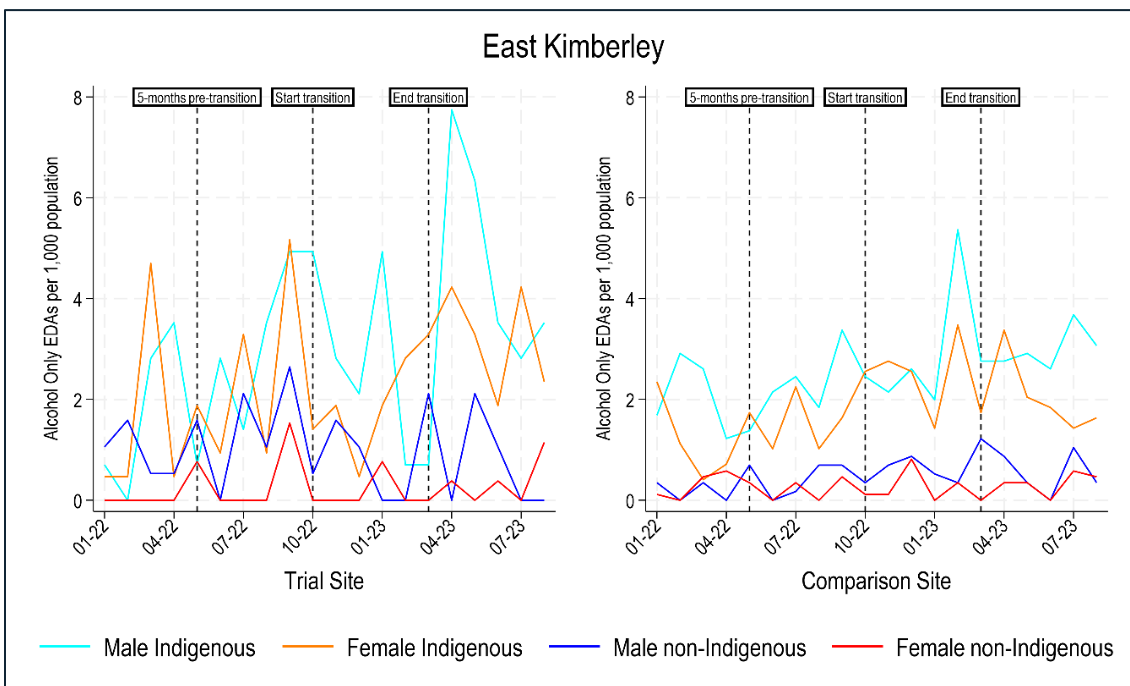
[26] A check of the original data showed three or four unusually high monthly counts of EDAs.

Figure A.13: EDAs for Alcohol only trial vs. comparison site from 2014



Notes: (1) MAY, SEP, MAR represents period: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) START represents the start of the CDC in the East Kimberley site. (3) Data are a three-month moving average.

Figure A.14: EDAs for Alcohol only East Kimberley trial vs. comparison site from 2022

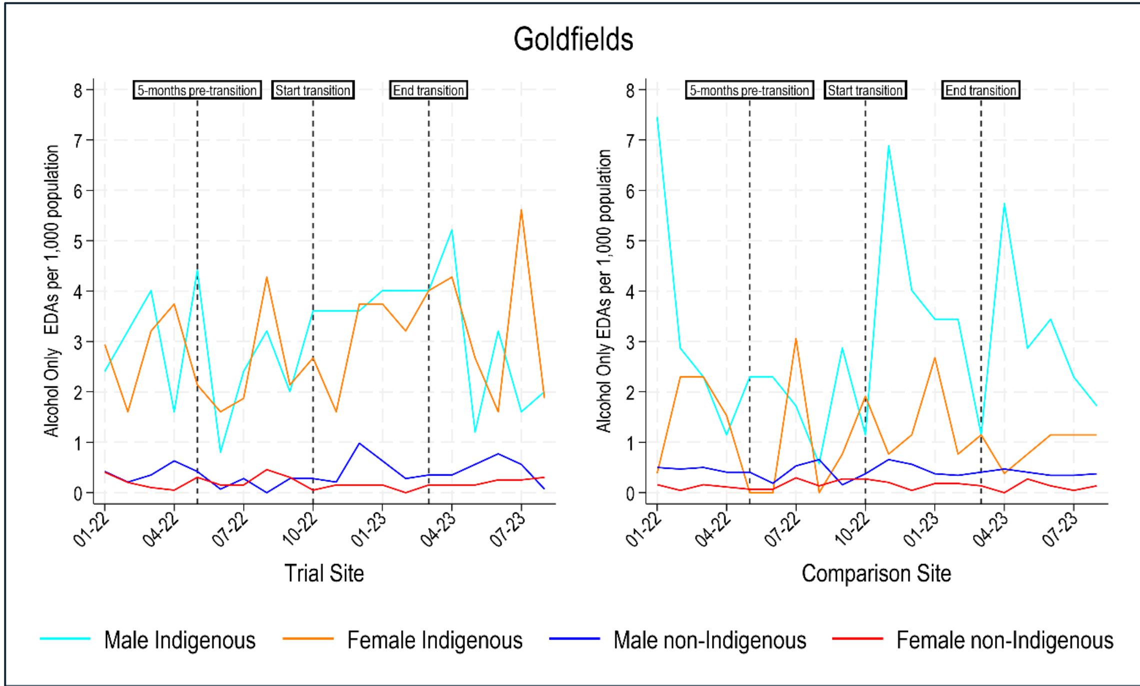


Notes: (1) Three period of interest: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) Data are not a moving average.

As Figures A.14 (above) and A.15 (below) for EDAs for Alcohol Only show:

- The East Kimberley trial site data are very volatile – predominantly due to small EDA monthly counts – and therefore the monthly EDA data should be treated with some caution.
- If the data showed anything it was the consistent view that the male Indigenous population generally had the higher rates of EDAs – in this case, due to Alcohol Only reasons, followed by females who often did not differ very much from males, and in some months had a higher rate of EDAs.
- There was some difference in EDAs for the non-Indigenous population between males and females, more so in the East Kimberley sites.
- In all but the East Kimberley trial site, non-Indigenous EDA rates were higher for the Indigenous population, and males compared to females.
- In almost all months in the East Kimberley trial site, EDAs were materially higher for the Indigenous population than the non-Indigenous population, but elsewhere there was no ambiguity.
- By the end of the post-transition period rates of EDAs were mixed. In the Goldfields rates were either unchanged or lower. In the East Kimberley sites Indigenous EDA rates were higher, but female rates were approximately unchanged.

Figure A.15: EDAs for Alcohol only Goldfields trial vs. comparison site from 2022



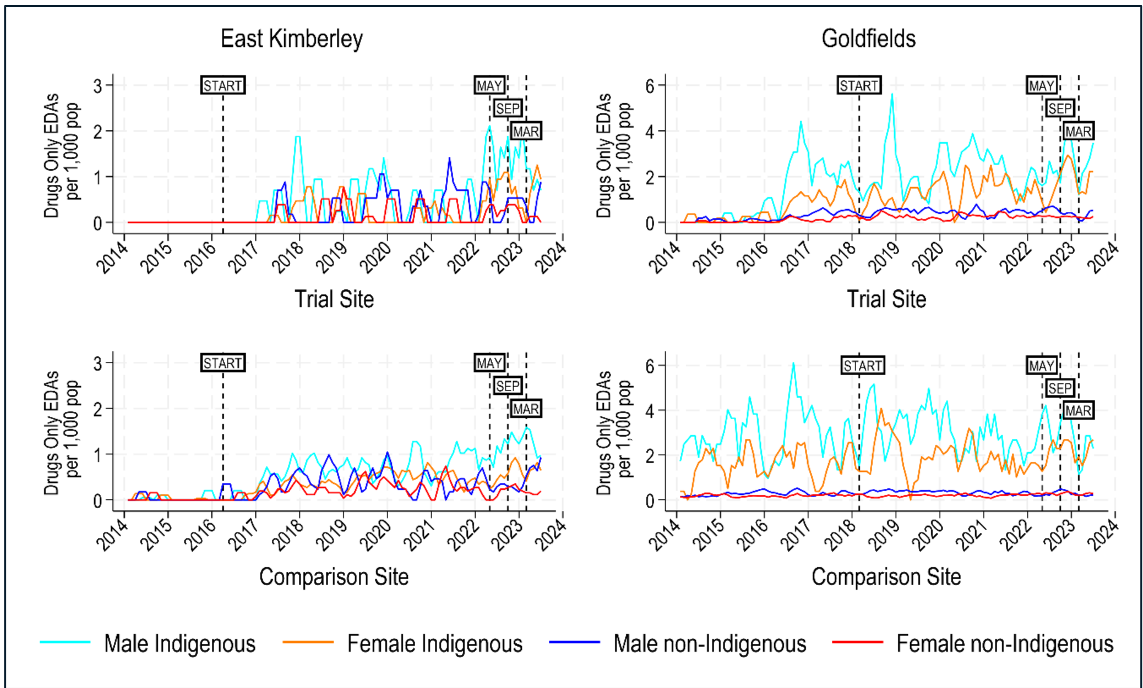
Notes: (1) Three period of interest: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) Data are not a moving average.

A.4.5. Drugs Only

Finally, the Drugs Only EDAs were considered. This category had the lowest rates of EDAs and appeared to be the most volatile and to have the highest occurrence of zero counts, i.e. for several periods the data were scarce. Notice in Figure A.16 below that the monthly EDA rate for the East Kimberley was very low (maximum about 2 per 1,000 of population) for the Indigenous population and not materially above zero for the non-Indigenous population. The following additional points are noted:

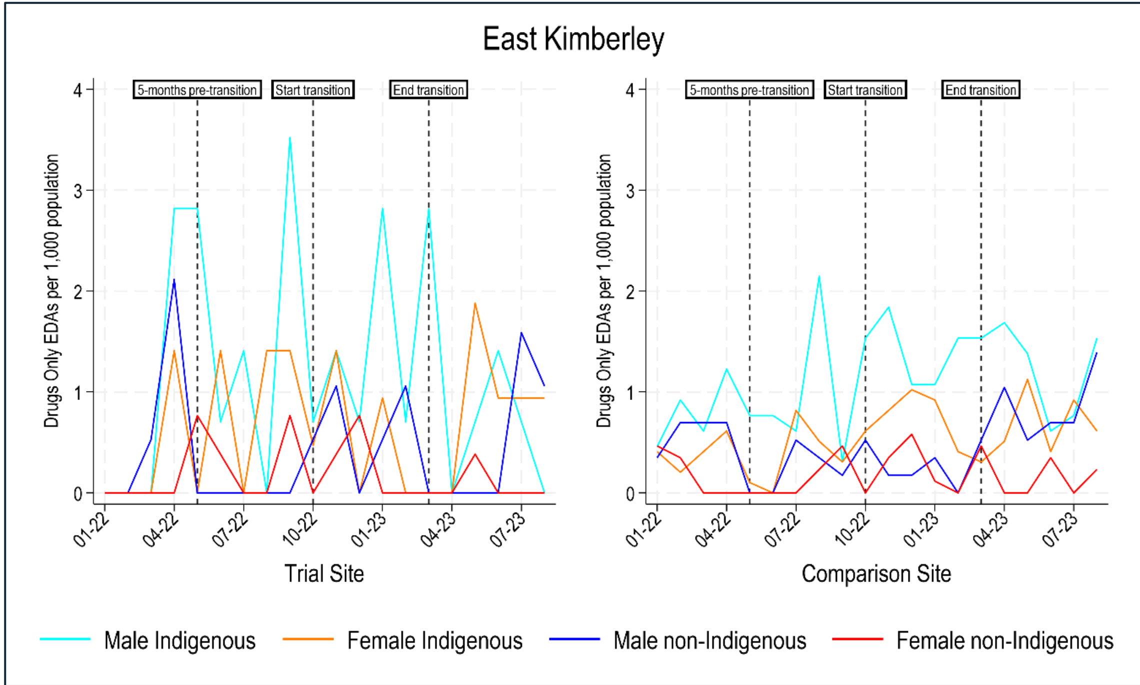
- Prior to the start of the CDC program, rates of EDAs in the East Kimberley appeared to be dominated by monthly averages that were so small they appeared as zero. For the Goldfields, rates were marginally higher in the trial site, but not the comparison site.
- Following the implementation of the CDC program, the rate of EDAs increased, but the volatility (even on a three-month average basis) was very high and it was difficult to be precise. Nonetheless:
    - EDA rates grew in the East Kimberley comparison site but did not become larger than the trial site.
    - The Goldfields trial site seemed to be less volatile than its comparison site, but by the end of the data there was little difference in EDA rates.
    - Contrary to other EDA categories, EDA Drugs Only rates in the Goldfields sites were noticeably higher than the East Kimberley sites (note the scale for East Kimberley was 0 to 3, but 0 to 6 for the Goldfields).

Figure A.16: EDAs for Drugs trial vs. comparison site from 2014



Notes: (1) MAY, SEP, MAR represents period: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) START represents the start of the CDC in the East Kimberley site. (3) Data are a three-month moving average.

Figure A.17: EDAs for Drugs only East Kimberley trial vs. comparison site from 2022

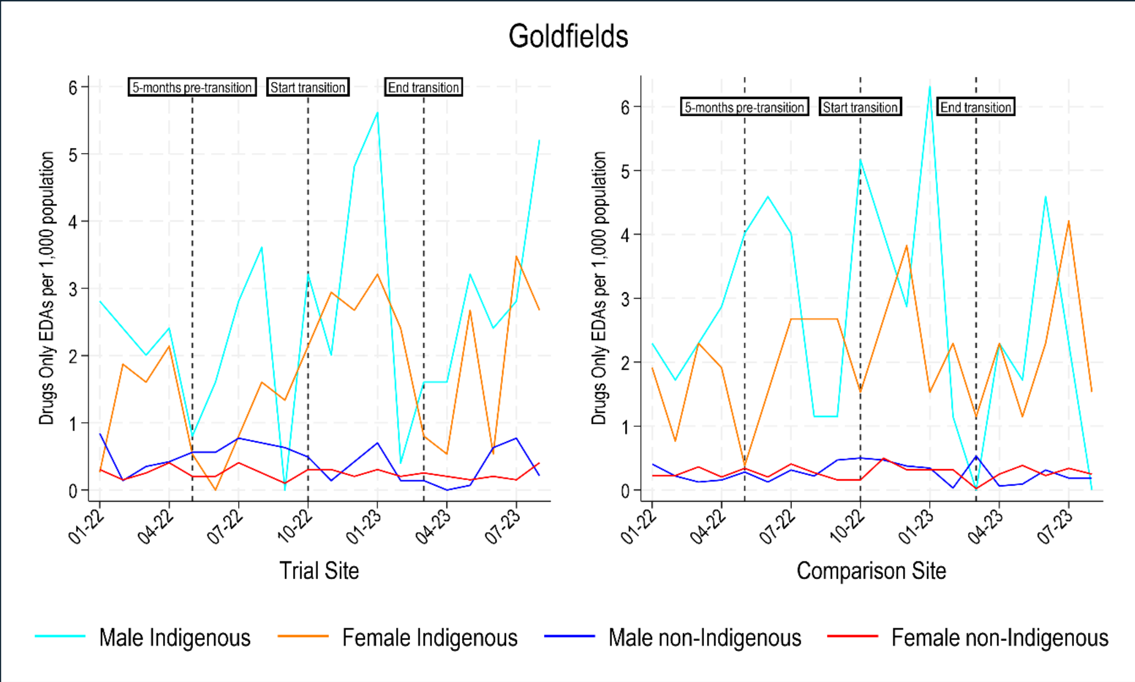


Notes: (1) Three period of interest: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) Data are not a moving average.

In Figures A.17 (above) and A.18 (below) for EDA rates for Drugs Only the following was noted:

- East Kimberley trial site data were very volatile – predominantly due to small EDA monthly counts – and therefore the monthly EDA data should be treated with some caution.
- In the Goldfields, the data for the non-Indigenous population were not particularly volatile and were low compared to the Indigenous population. At the end of the data period, rates of EDAs were not materially different from the start, i.e. 2022(1).
- For the non-Indigenous population in the Goldfields sites, rates of EDAs were the same at the beginning and end of the data, and generally unchanged. The implication (i.e. all other things ignored) was that the ending of the CDC program, as expected, had no impact in the comparison sites.
- In the East Kimberley sites it appeared that rates of EDAs were higher at the end of the time period than the beginning. Nonetheless, this should be viewed as a possible result but not definitive. If the end of the data was considered as a few months earlier the result would be 'little change'.
- One consistent outcome was that the male Indigenous population generally had higher rates of Drug Only EDAs followed by the Indigenous population. But note that the data for the male Indigenous population was very volatile and varied between zero and the maximum. Consequently, perhaps a monthly rate of EDAs was too fine to observe longer-term trends.

Figure A.18: EDAs for Drugs only Goldfields trial vs. comparison site from 2022



Notes: (1) Three period of interest: 5 months pre-transition (May2022-Sept2022), the transition (Oct2022 – March2023) and post-transition (March2023-August2023). (2) Data are not a moving average.

A.5. Appendix 5: Additional findings from the Western Australian police data

A.5.1. Family violence offences

Figure A.19: Family violence offences since 2014 - East Kimberley trial vs. comparison

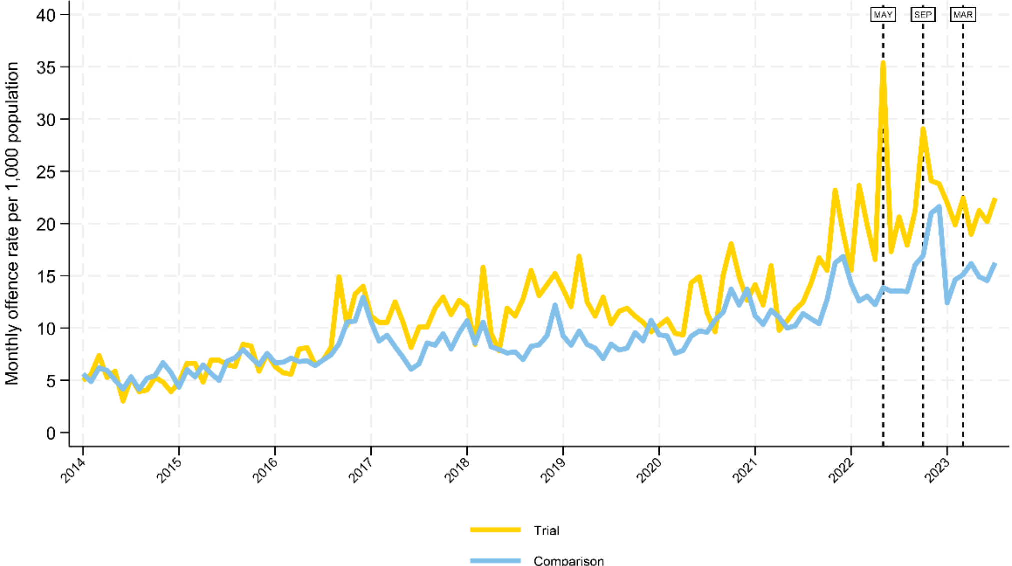


Figure A.20: Family violence offences since 2014 - Goldfields trial vs. comparison

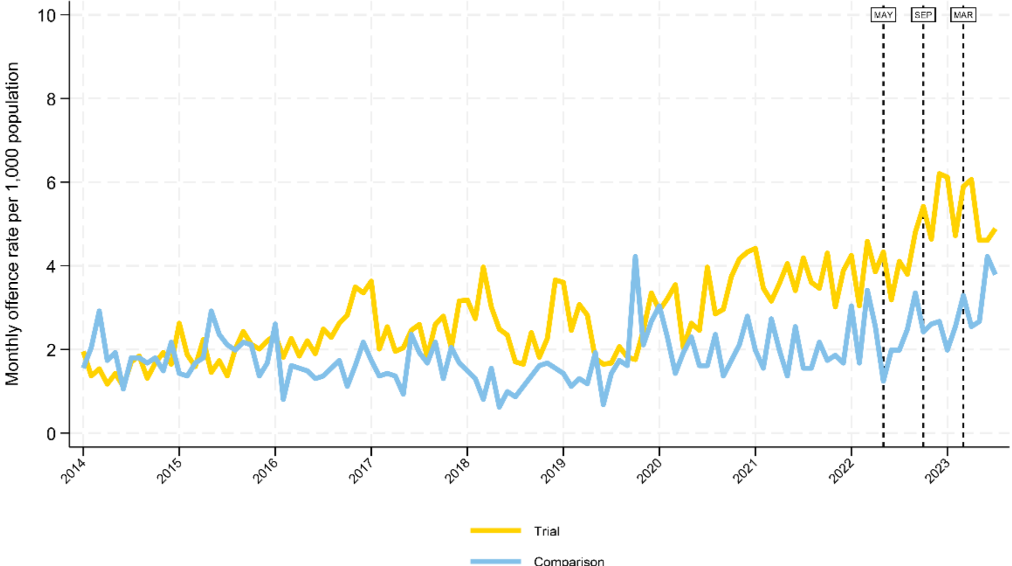


Figure A.21: Family violence offences since 2022 - East Kimberley trial vs. comparison

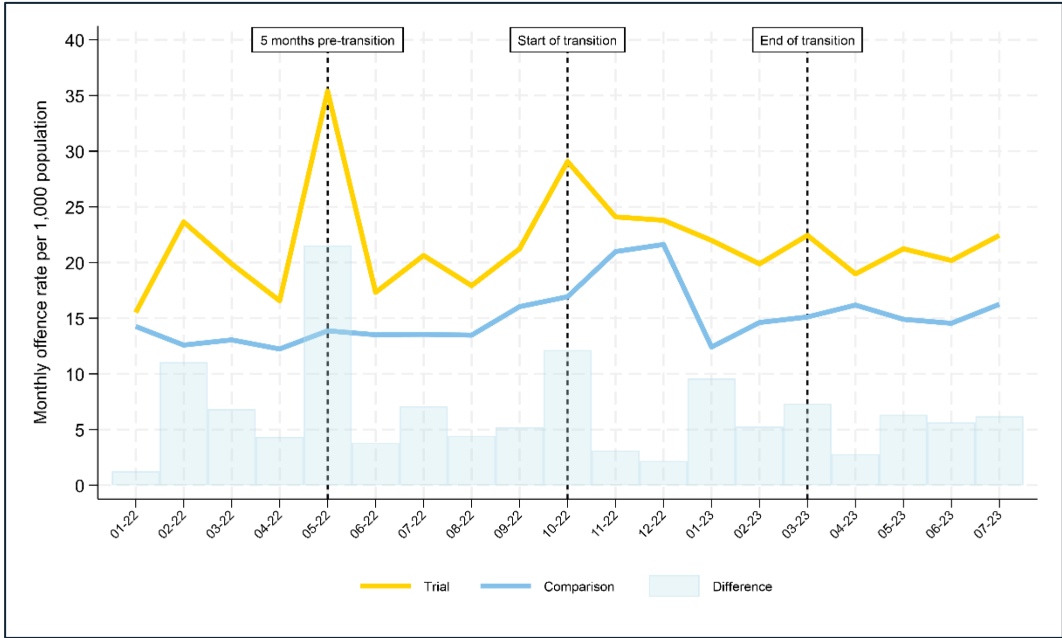
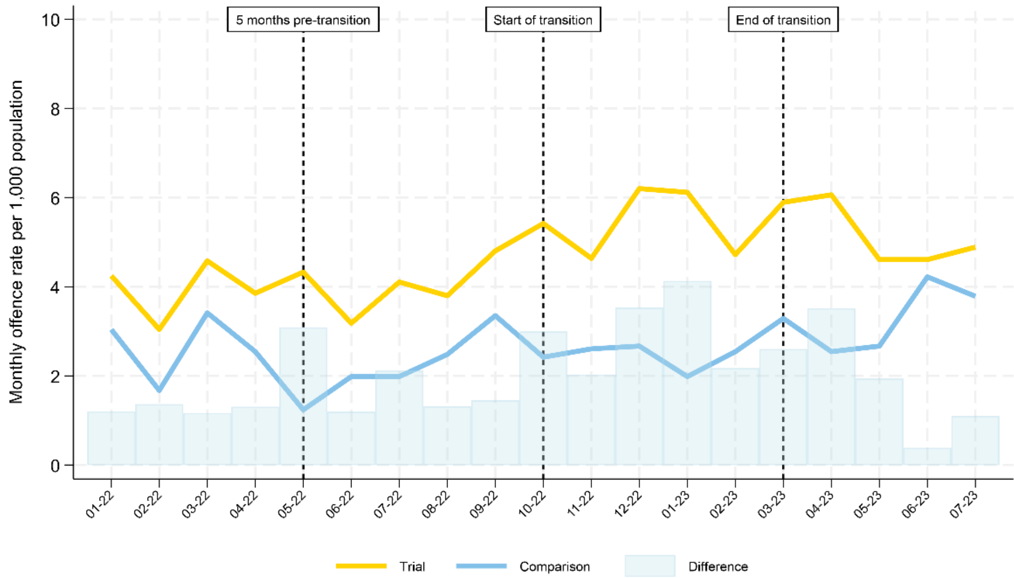


Figure A.22: Family violence offences since 2022 - Goldfields trial vs. comparison



A.5.2. Breach of violence restraint orders

Figure A.23: Breach of violence restraint order offences since 2014 - East Kimberley trial vs. comparison

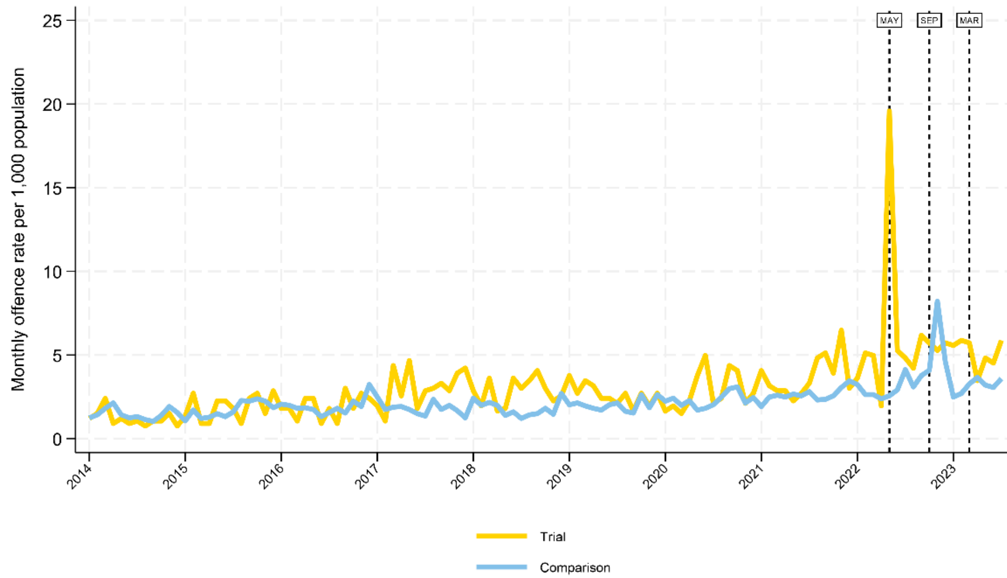


Figure A.24: Breach of violence restraint order offences since 2014 - Goldfields trial vs. comparison

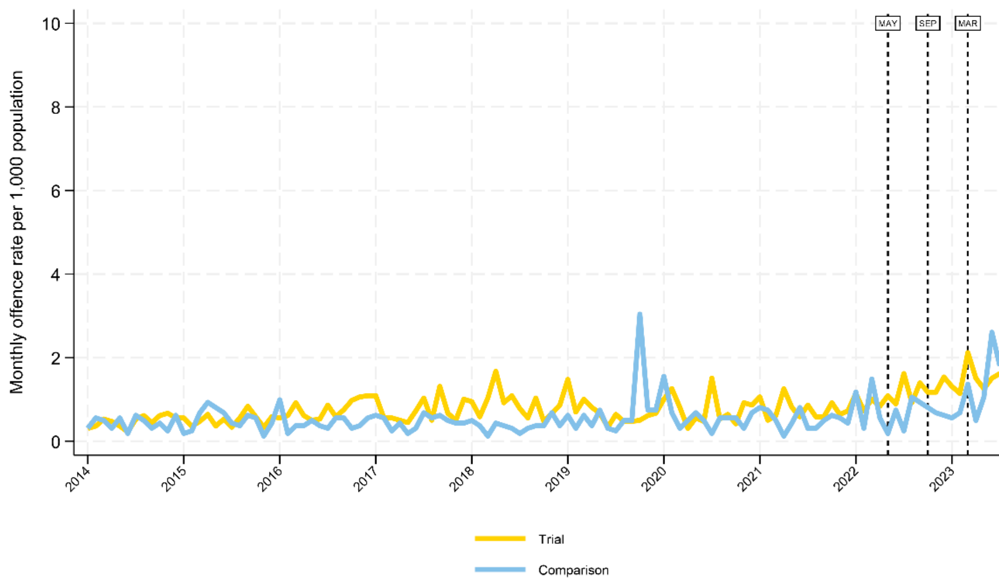


Figure A.25: Breach of violence restraint order offences since 2022 - East Kimberley trial vs. comparison

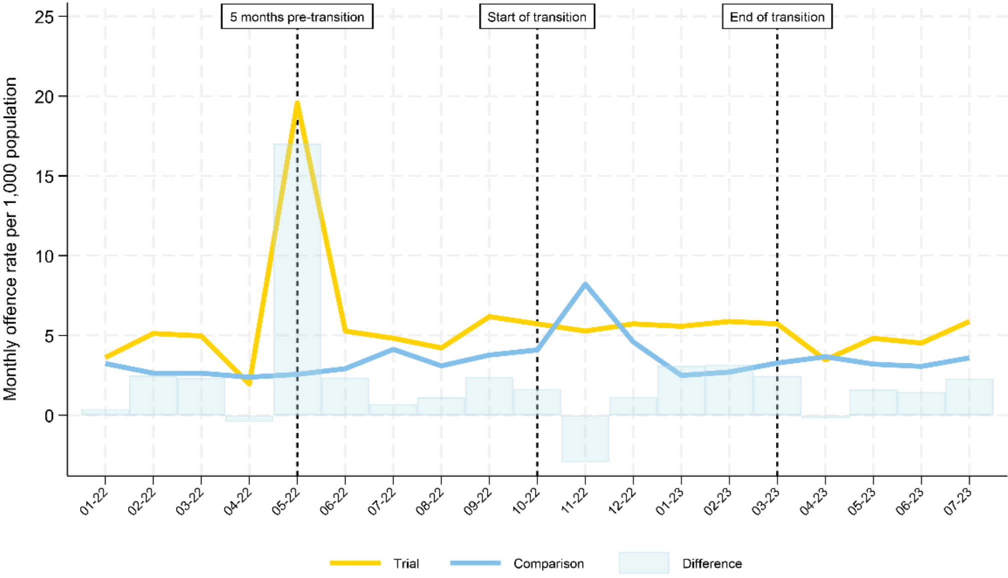
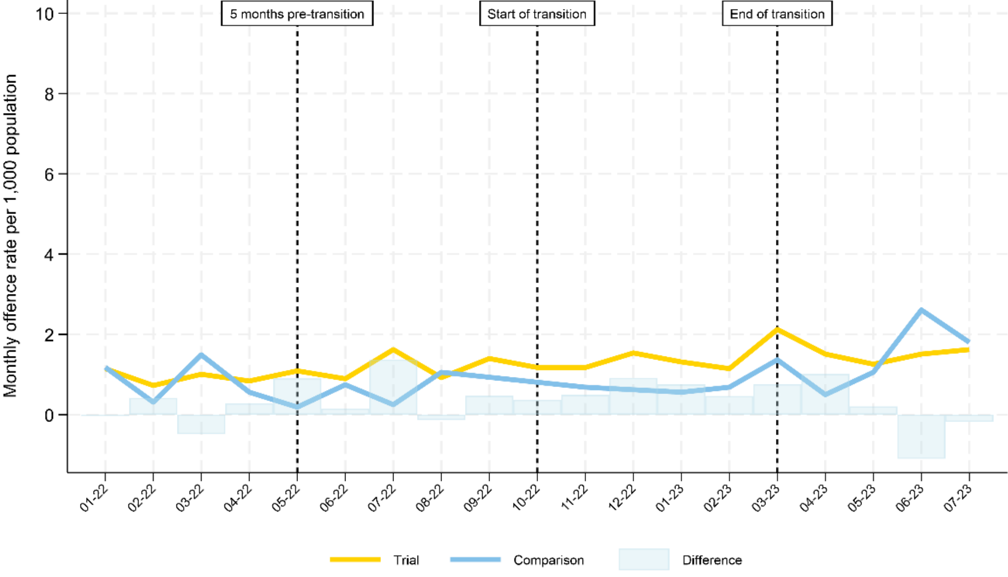


Figure A.26: Breach of violence restraint order offences since 2022 - Goldfields trial vs. comparison



A.5.3. Family violence tasks attended

Figure A.27: Family violence tasks attended since 2014 - East Kimberley trial vs. comparison

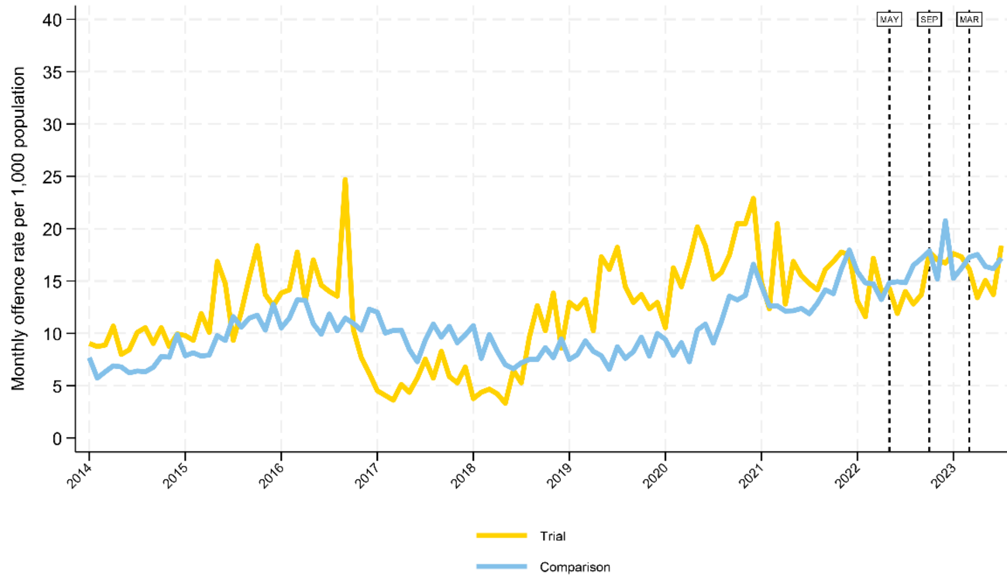


Figure A.28: Family violence tasks attended since 2014 - Goldfields trial vs. comparison

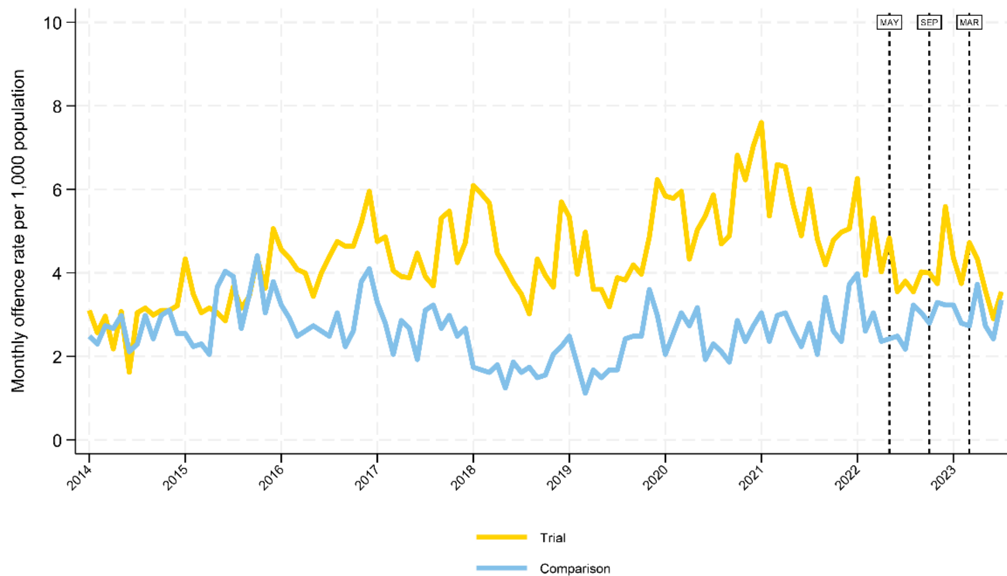


Figure A.29: Family violence tasks attended since 2022 - East Kimberley trial vs. comparison

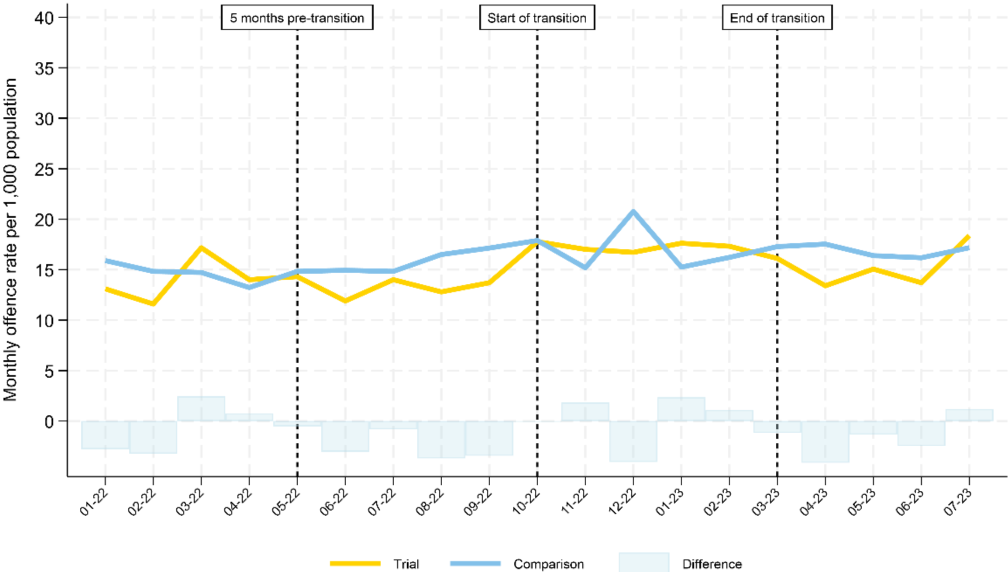
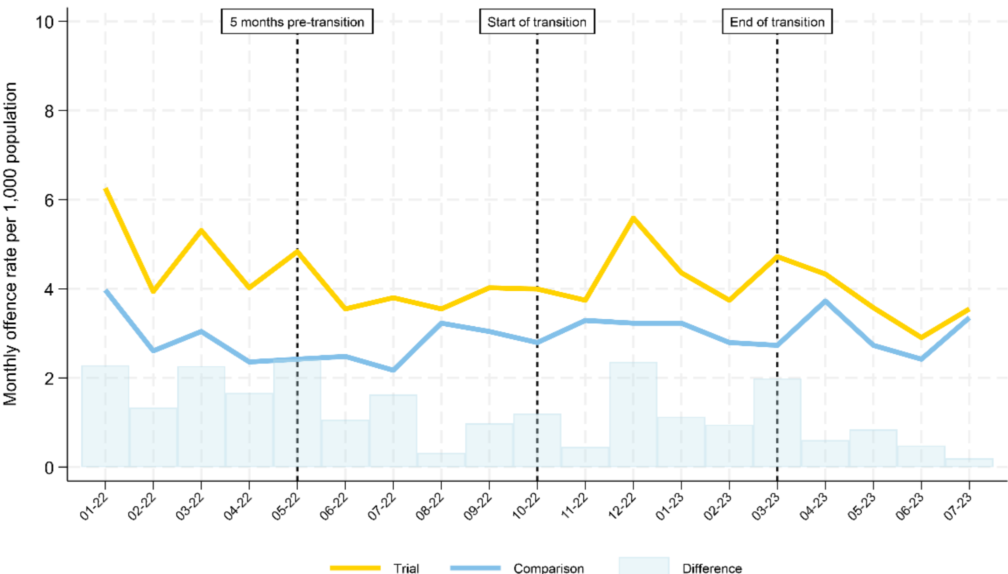


Figure A.30: Family violence tasks attended since 2022 - Goldfields trial vs. comparison



A.5.4. Drug offences

Figure A.31: Drug offences since 2014 - East Kimberley trial vs. comparison

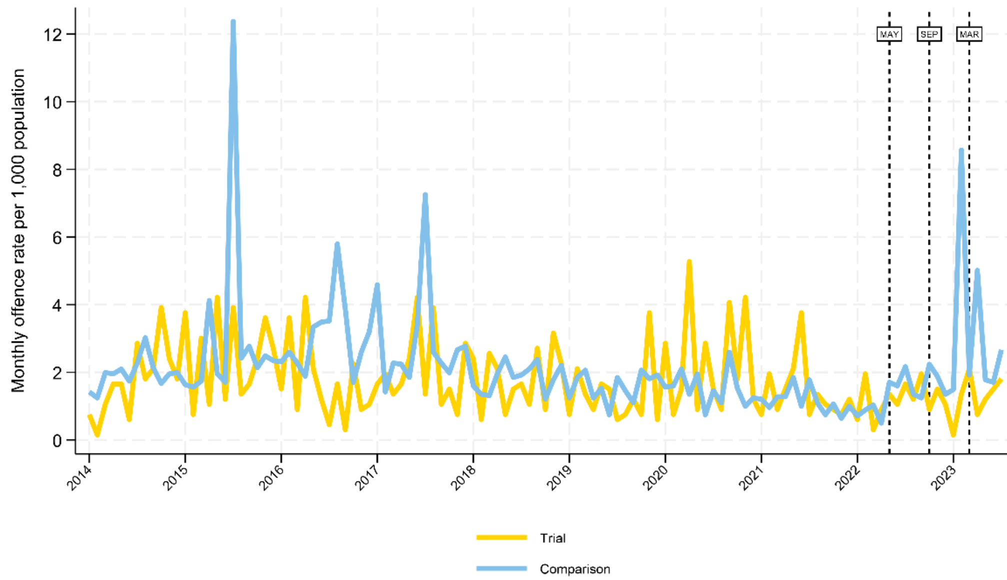


Figure A.32: Drug offences since 2014 - Goldfields trial vs. comparison

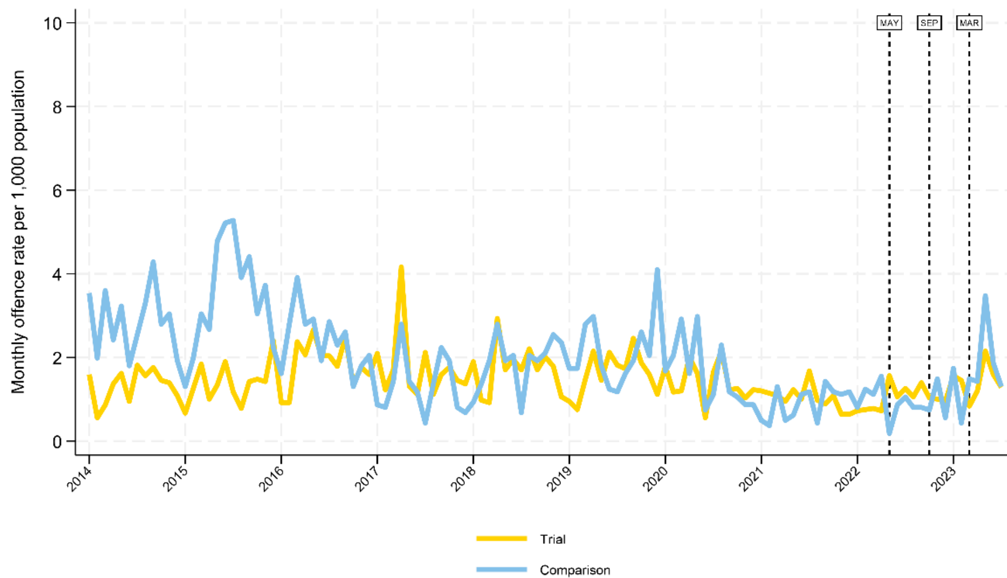


Figure A.33: Drug offences since 2022 - East Kimberley trial vs. comparison

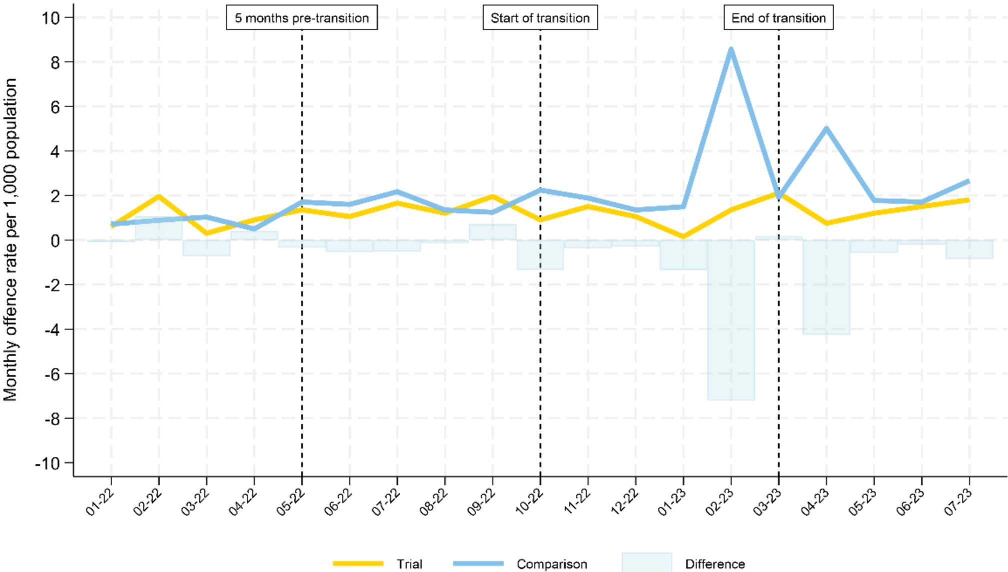
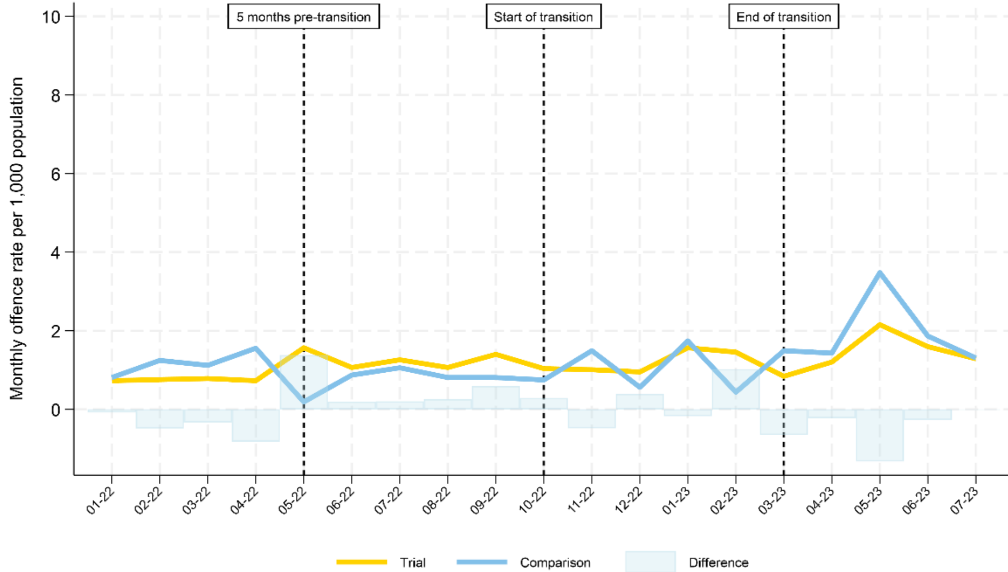


Figure A.34: Drug offences since 2022 - Goldfields trial vs. comparison



A.5.5. Drink driving charges

Figure A.35: Drink driving charges since 2014 - East Kimberley trial vs. comparison

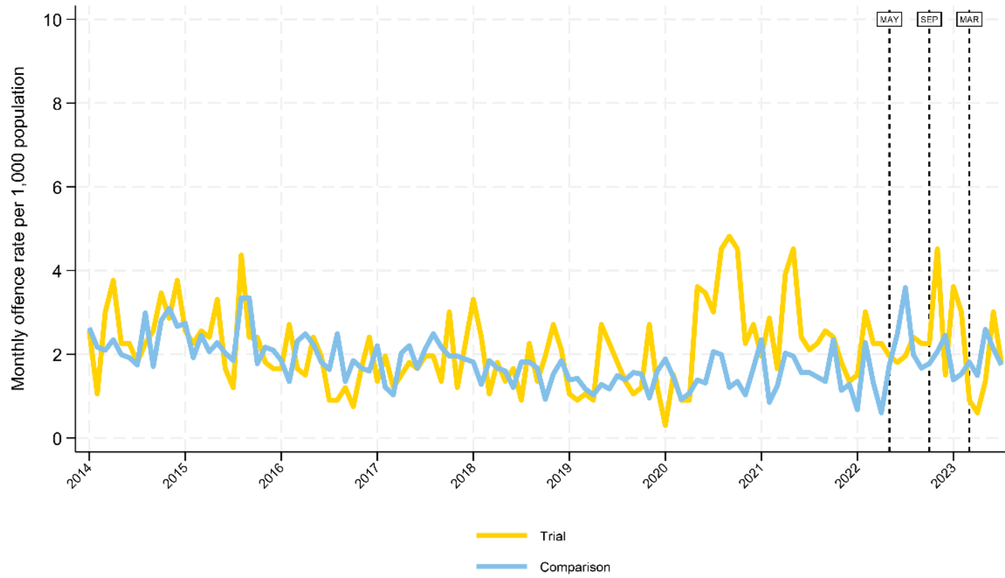


Figure A.36: Drink driving charges since 2014 - Goldfields trial vs. comparison

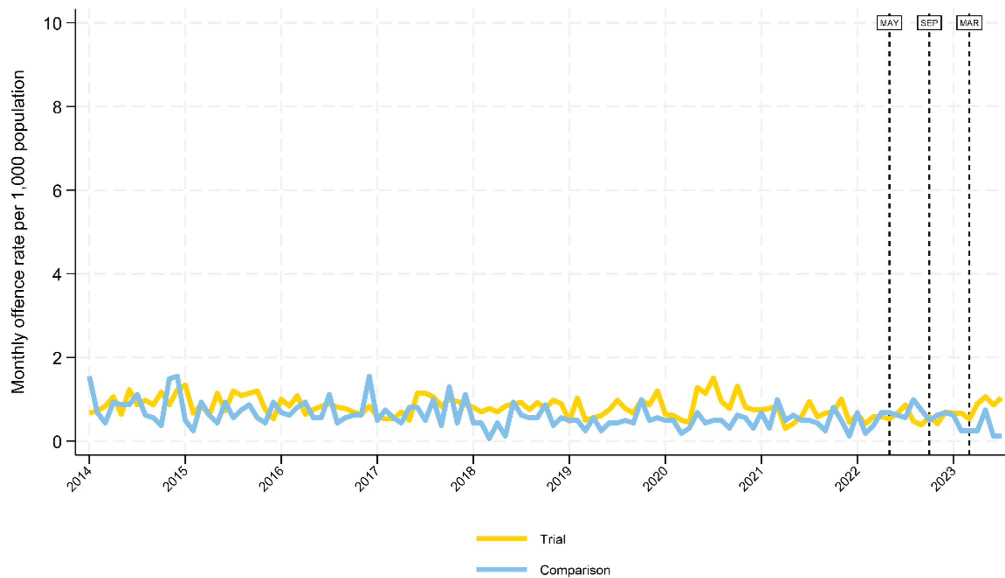


Figure A.37: Drink driving charges since 2022 - East Kimberley trial vs. comparison

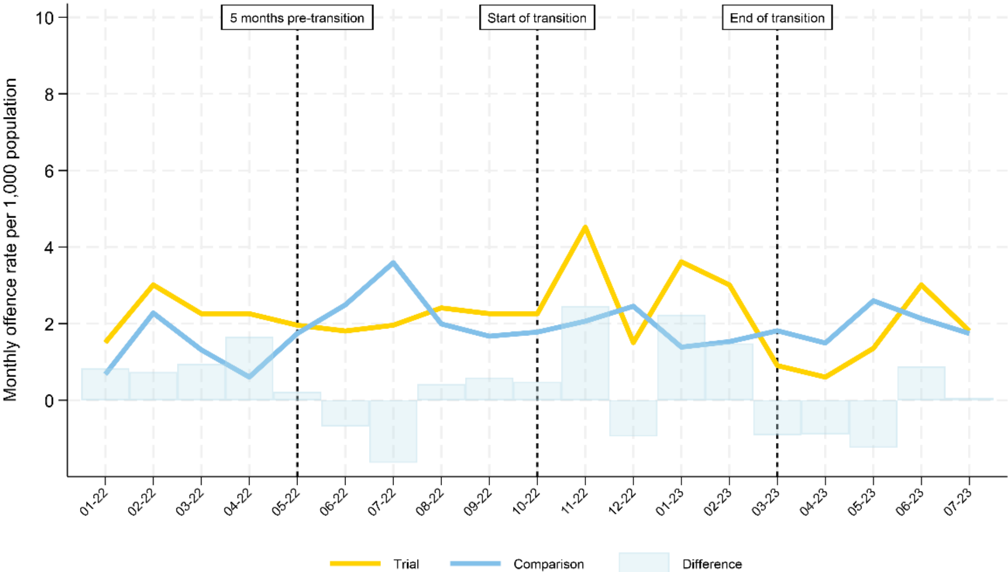
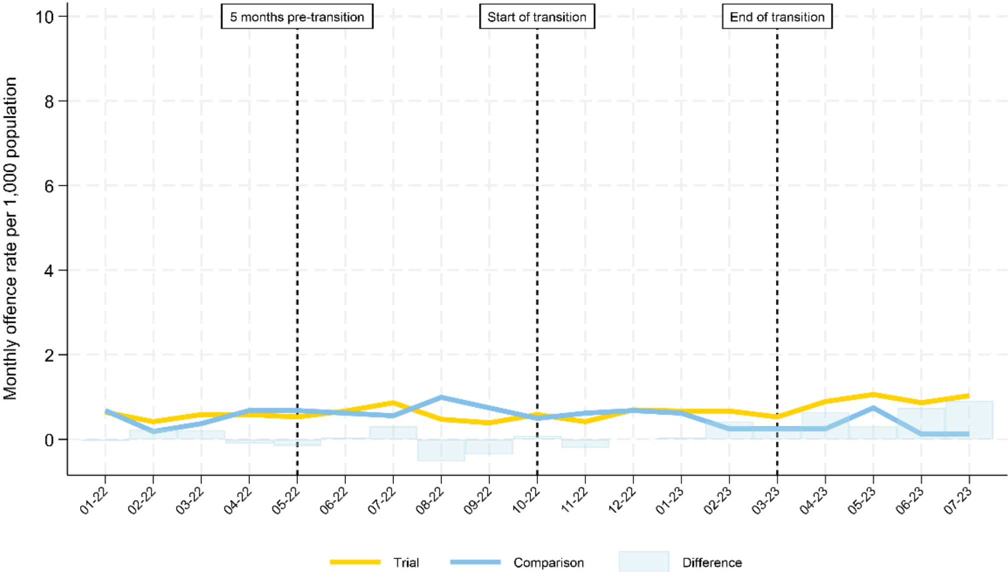


Figure A.38: Drink driving charges since 2022 - Goldfields trial vs. comparison



A.5.6. Assault offences

Figure A.39: Assault offences since 2014 - East Kimberley trial vs. comparison

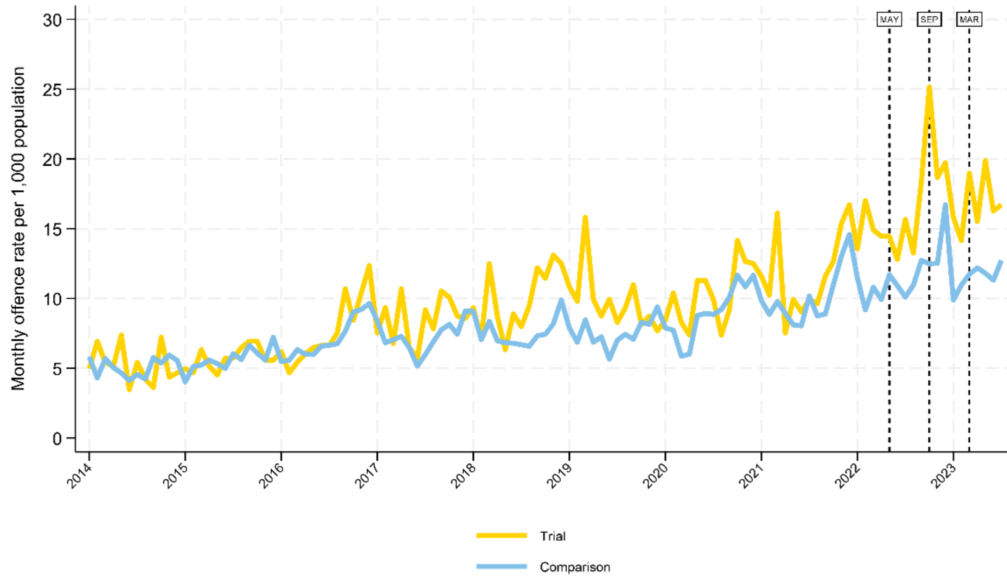


Figure A.40: Assault offence rate since 2014 - Goldfields trial vs. comparison

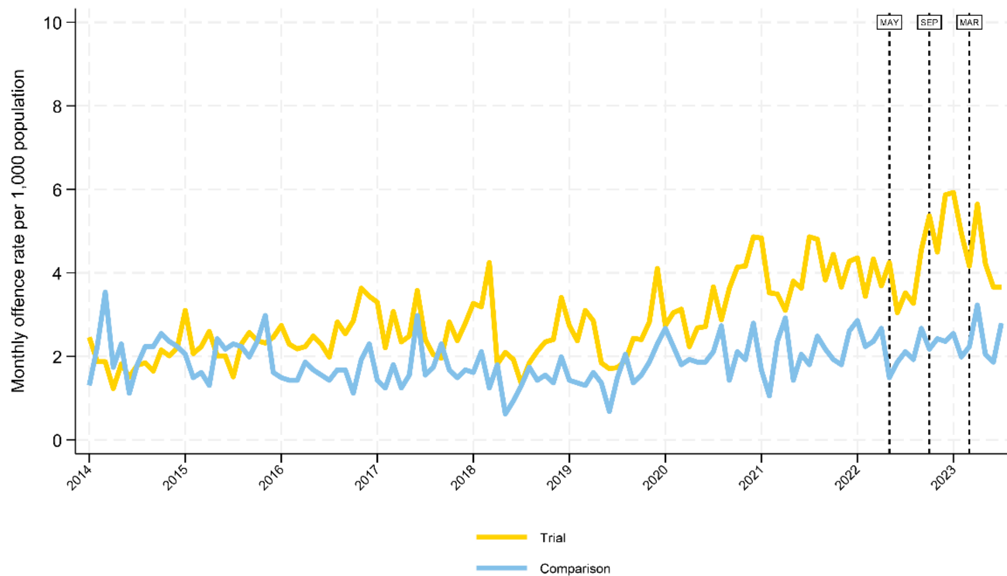


Figure A.41: Assault offences since 2022 - East Kimberley trial vs. comparison

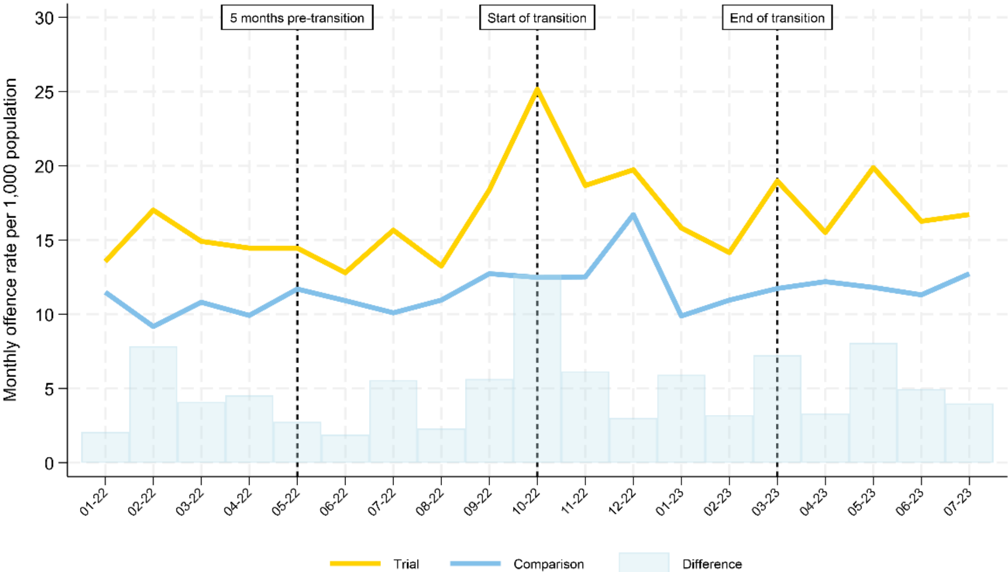
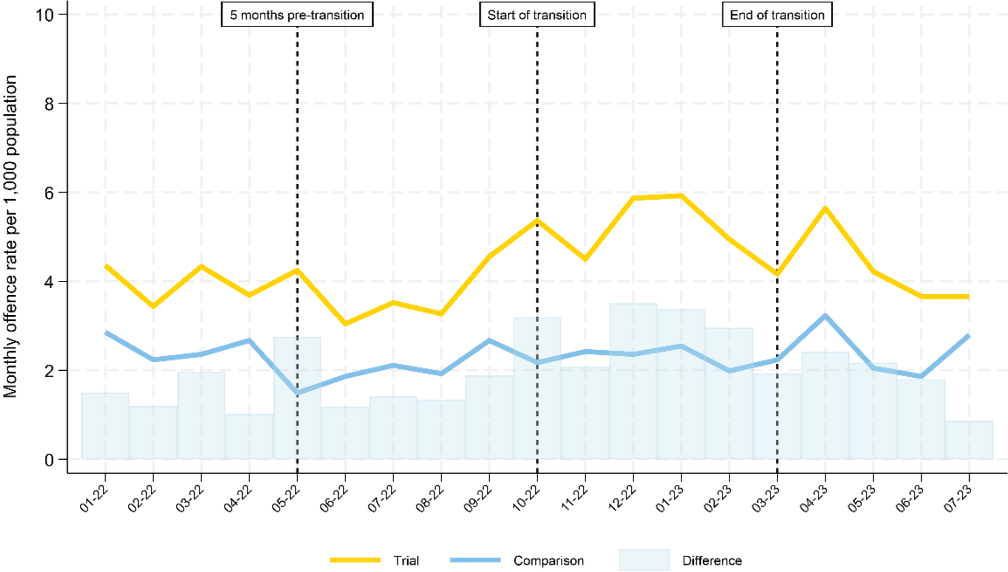


Figure A.42: Assault offences since 2022 - Goldfields trial vs. comparison



A.5.7. Threatening behaviour offences

Figure A.43: Threatening behaviour offences since 2014 - East Kimberley trial vs. comparison

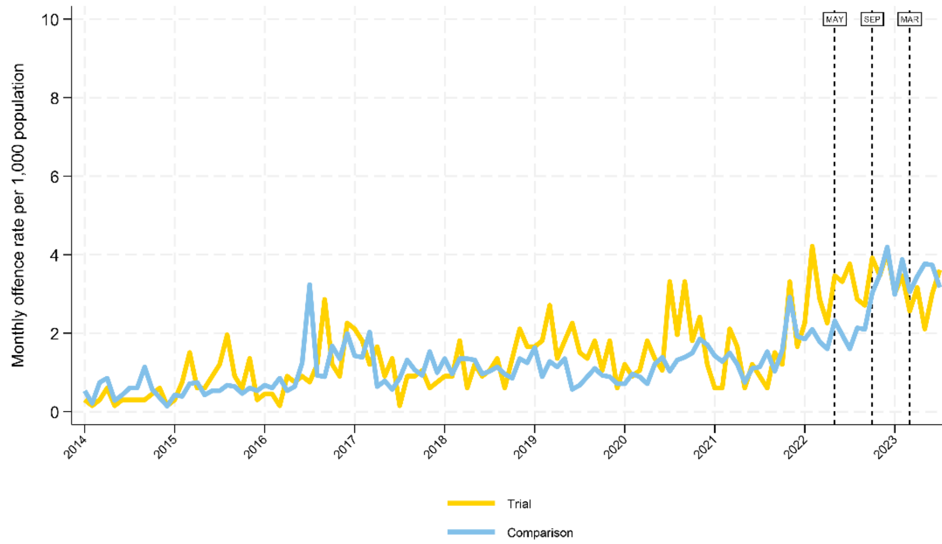


Figure A.44: Threatening behaviour offences since 2014 - Goldfields trial vs. comparison

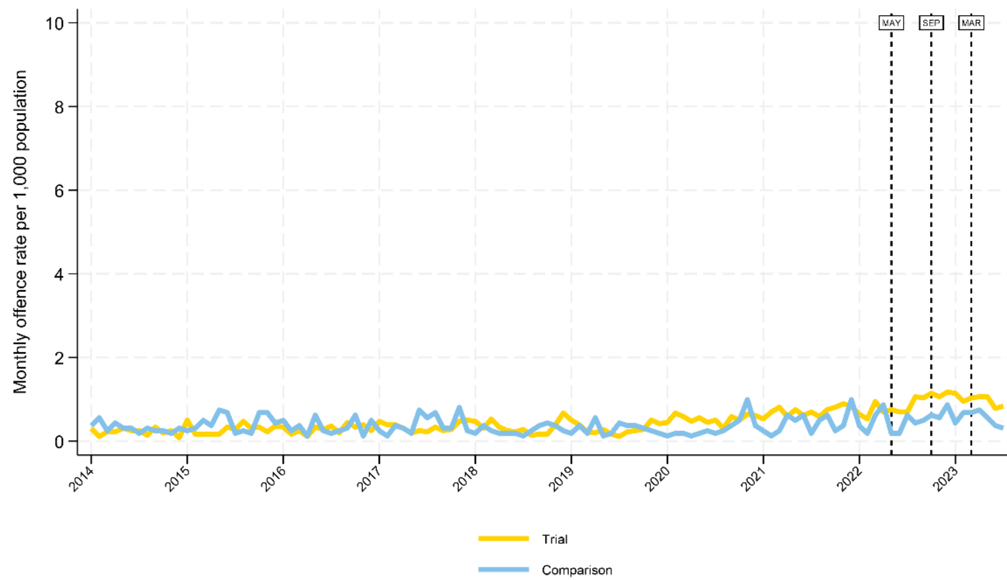


Figure A.45: Threatening behaviour offences since 2022 - East Kimberley trial vs. comparison

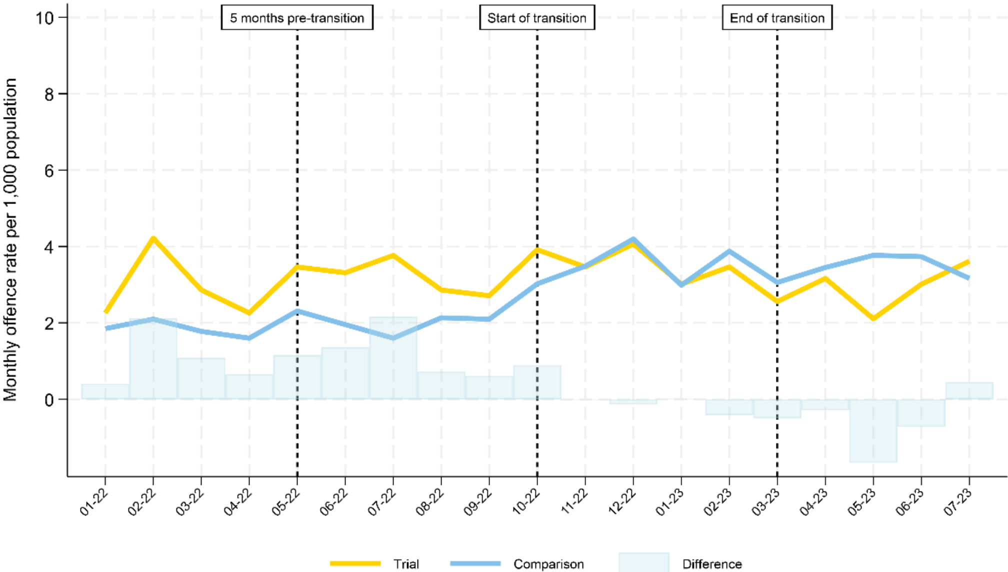
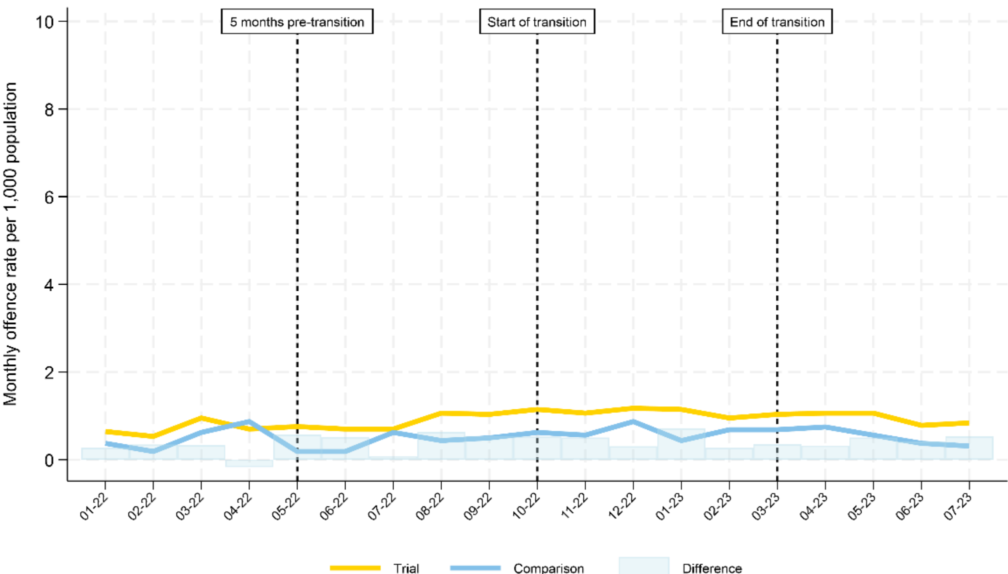


Figure A.46: Threatening behaviour offences since 2022 - Goldfields trial vs. comparison



A.5.8. Property damage/graffiti offences

Figure A.47: Property damage/graffiti offences since 2014 - East Kimberley trial vs. comparison

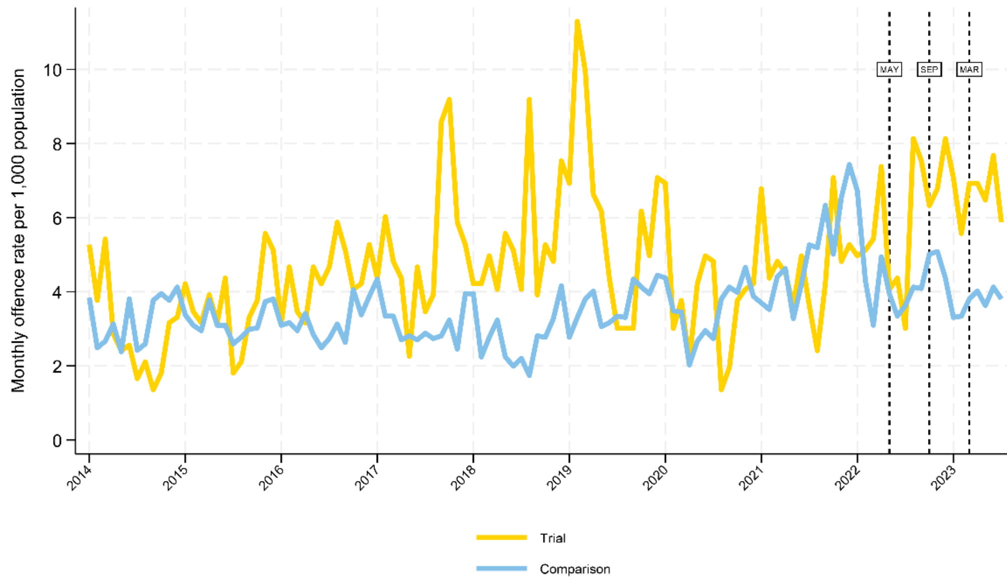


Figure A.48: Property damage/graffiti offences since 2014 - Goldfields trial vs. comparison

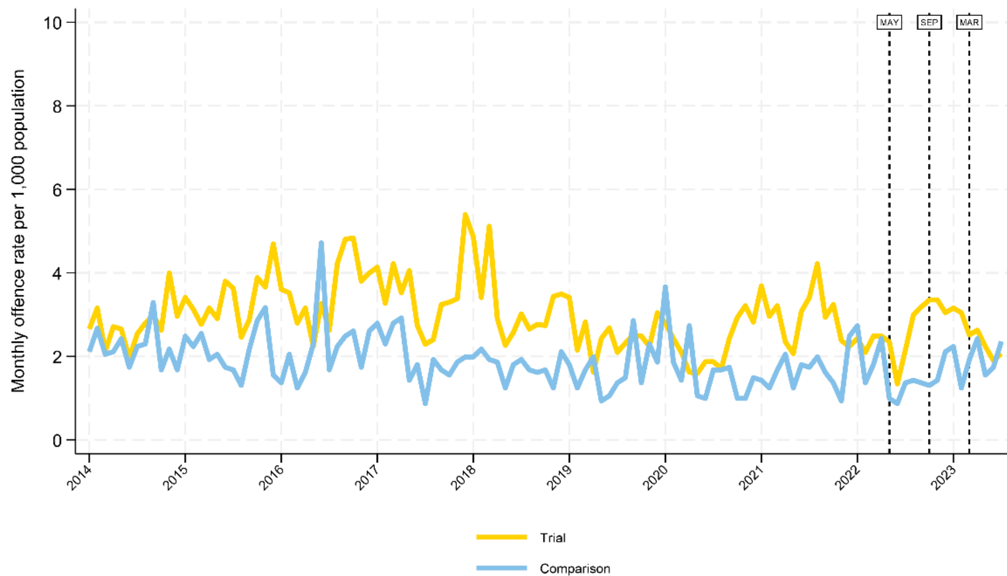


Figure A.49: Property damage/graffiti offences since 2022 - East Kimberley trial vs. comparison

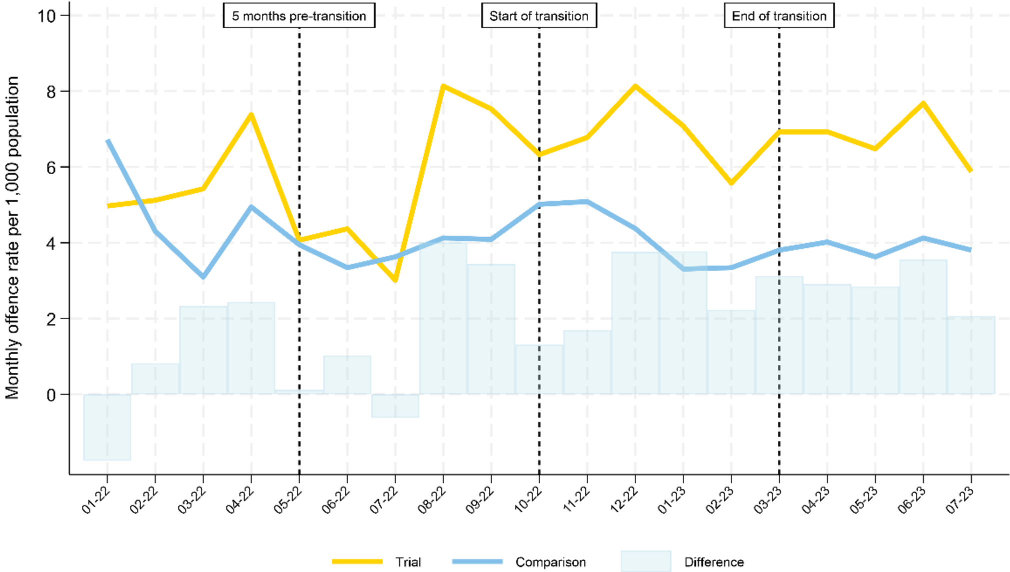
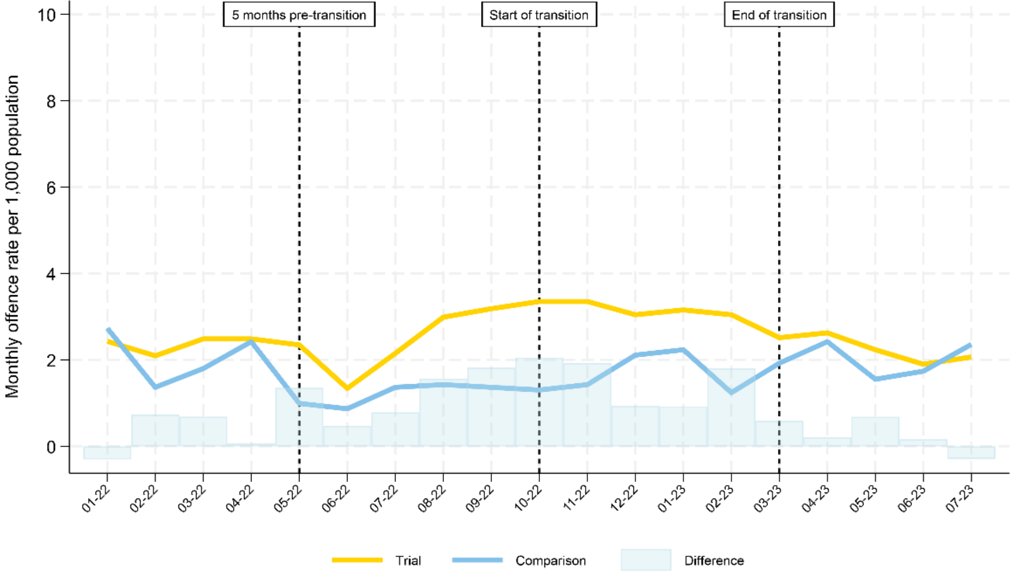


Figure A.50: Property damage/graffiti offences since 2022 - Goldfields trial vs. comparison



A.5.9. Stealing offences

Figure A.51: Stealing offences since 2014 - East Kimberley trial vs. comparison

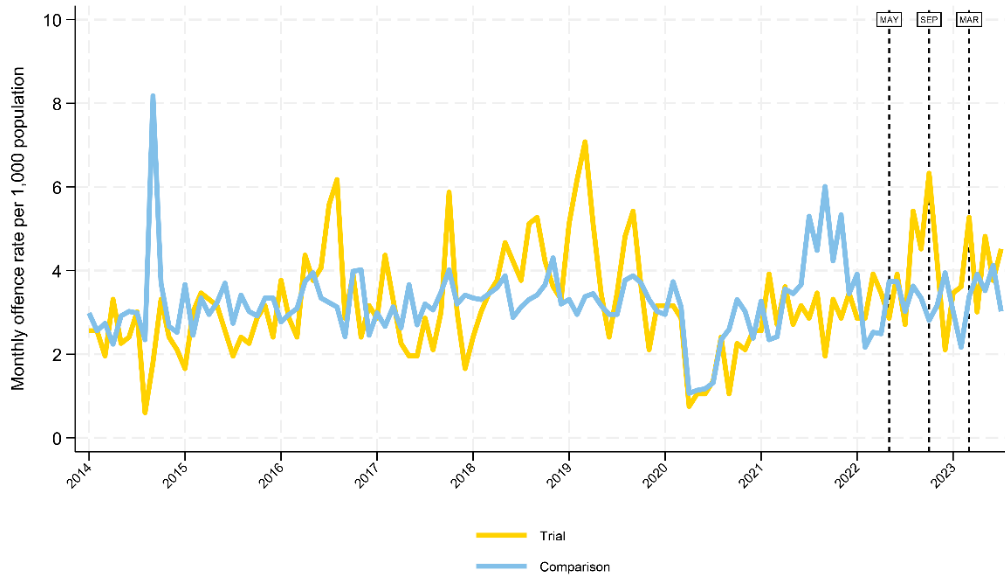


Figure A.52: Stealing offences since 2014 - Goldfields trial vs. comparison

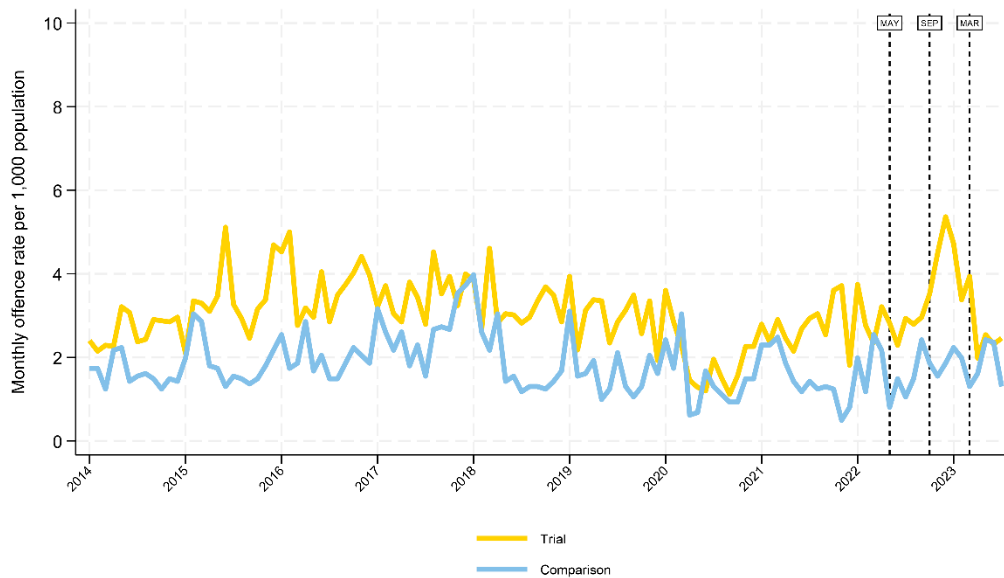


Figure A.53: Stealing offences since 2022 - East Kimberley trial vs. comparison

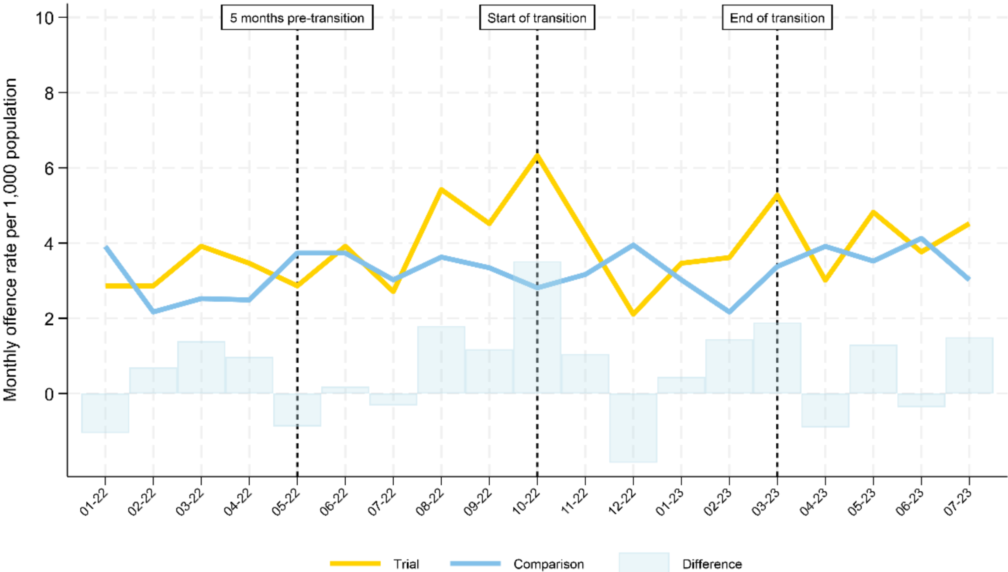
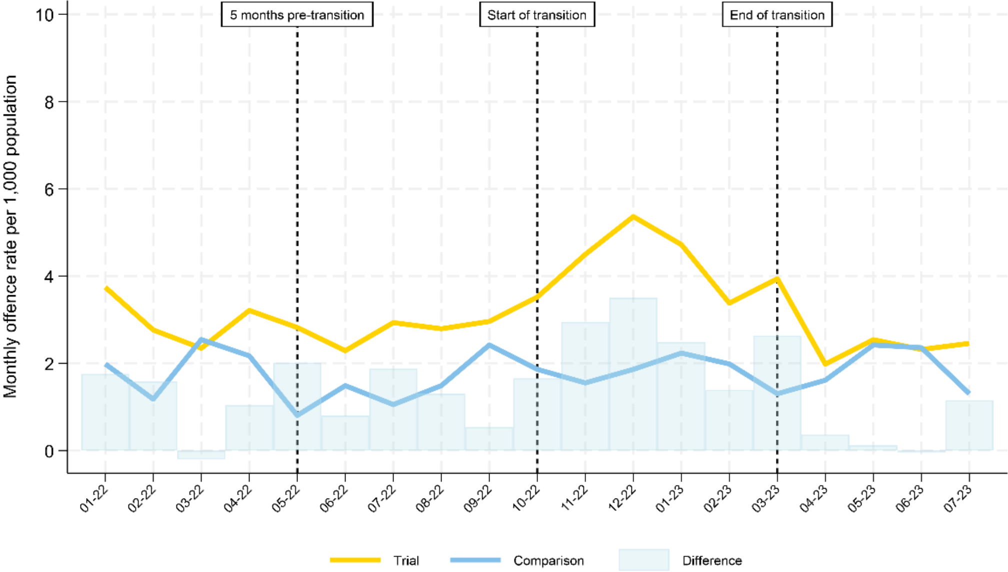


Figure A.54: Stealing offences since 2022 - Goldfields trial vs. comparison



A.5.10. Other offences

Figure A.55: Other offences since 2014 - East Kimberley trial vs. comparison

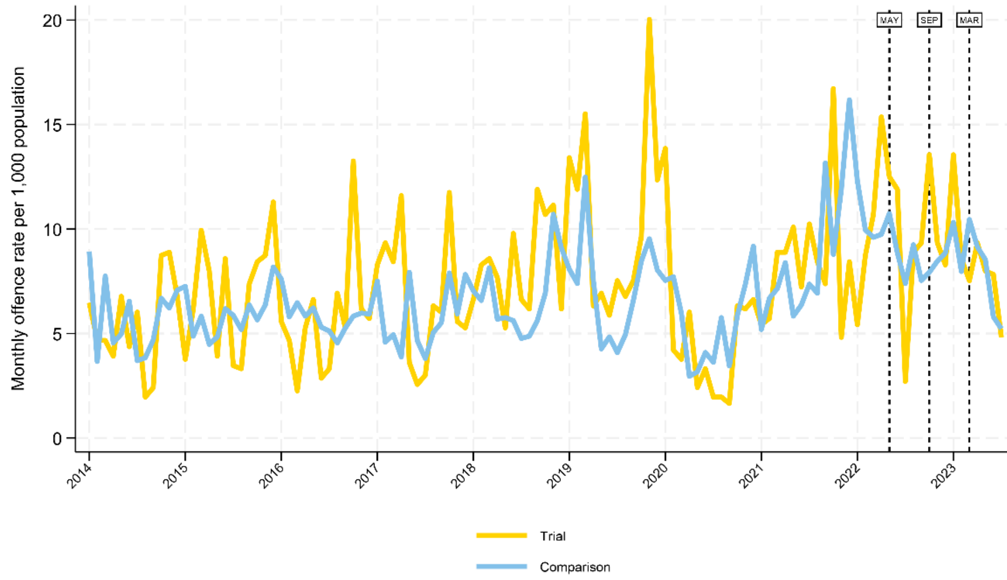


Figure A.56: Other offences since 2014 - Goldfields trial vs. comparison

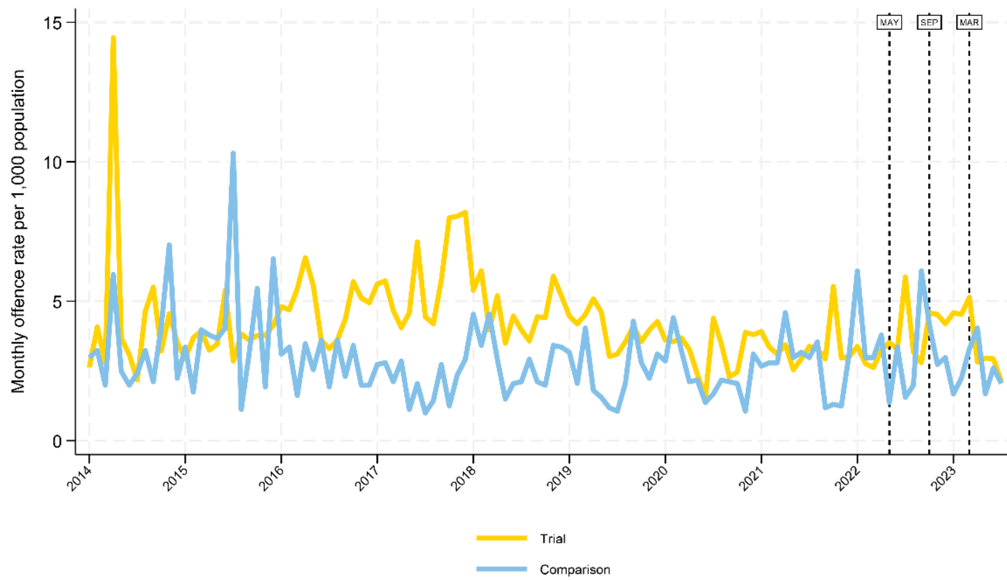


Figure A.57: Other offences since 2022 - East Kimberley trial vs. comparison

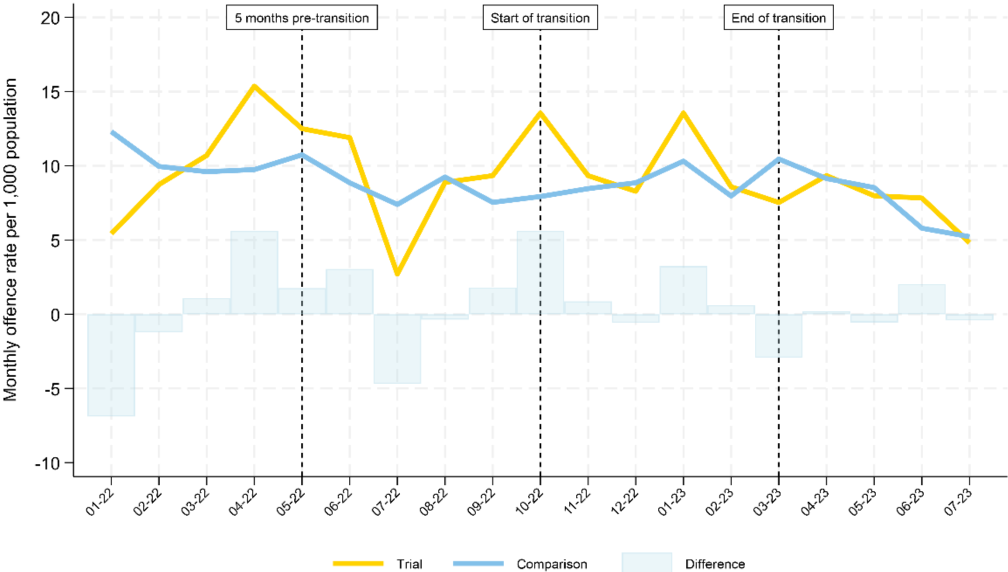


Figure A.58: Other offences since 2022 - Goldfields trial vs. comparison