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Dear Sir/Madam

Submission on the Social Security (Administration) Amendment (Cashless Debit Card Transition) Bill 2019

Attached find my submission to your Inquiry

Yours sincerely

Dr Janet Hunt

Submission on the Social Security (Administration) Amendment (Cashless Debit Card Transition) Bill 2019

Associate Professor Janet Hunt, CAEPR, ANU

Thank you for the opportunity to make a submission to your Enquiry. I refer the Committee to previous evidence I gave to your Committee in 2017, 2018 and earlier in 2019 on the topic of the evaluation of the Cashless Debit Card and previous publications and submissions I provided to you and other Parliamentary Committees (**a selection of which I have provided again as Attachments**). In this submission I wish to make the following key points:

- 1) The process of this Bill is unacceptably fast, leaving no possibility of adequate consultation, let alone partnership, with the affected remote-living Aboriginal and Torres Strait Islander people.
- 2) The continuing high public cost of this program and plans to expand it with still no adequate independent evidence for its effectiveness, three and a half years from its commencement, is unjustifiable.
- 3) It would be better to spend the allocated funds on approaches to the problems ostensibly being addressed by the Cashless Debit Card on programs and approaches that we know work. Aboriginal people and other welfare recipients deserve this respect.

1. Process is not a partnership

In his 2019 Closing the Gap address to Parliament, Prime Minister Morrison rightly criticised the top-down way in which the Closing the Gap policy had been implemented by previous governments and indicated a change in approach by his Government. He said this:

“Late last year, a Coalition of Aboriginal and Torres Strait Islander Peak Bodies made representations to me about Closing the Gap.

They came to me seeking a partnership.

One where we listen, work together and decide together how future policies are developed – especially at a regional and local level.

This is a message I’ve also heard from the Indigenous Advisory Council.

At COAG in December last year, all governments committed to share ownership of, and responsibility for, jointly agreed frameworks, targets and ongoing monitoring of a refreshed Closing the Gap Agenda, with Aboriginal and Torres Strait Islander peoples at its heart.

COAG asked that this work be finalised by the middle of this year.

This is a major step toward the genuine and mutually respectful formal partnership between governments and Aboriginal and Torres Strait Islander Australians that will empower individuals and allow communities to thrive.

Governments fail when accountabilities are unclear. When investment is poorly targeted, When systems aren't integrated. And when we don't learn from evidence."(Morrison 2019 *my bolding*).

The current rushed approach to the extension of the Cashless Debit Card (notwithstanding some valuable extension of time), which overwhelmingly affects Indigenous people in the Northern Territory and Cape York, reflects everything that the Prime Minister rightly criticised about the previous Closing the Gap policy and fails completely to work in partnership with Aboriginal organisations. This partnership approach, welcomed in the Closing the Gap policy, needs to be applied consistently across all policies that have significant impact on Aboriginal and Torres Strait Islander lives, as this does. Policies that don't work this way will fail, as the Prime Minister correctly stated.

It is worth recalling the findings of the NTER Review, following the introduction of the Basics Card and other measures in the NT in 2007. According to the Productivity Commission Overcoming Indigenous Disadvantage Report 2009:

“ The Review Board found that the positive potential of the NTER had been diminished because of the manner in which it was imposed (that is, top down rapid imposition of the NTER). Genuine community engagement in designing, developing and implementing policies going forward is necessary to provide the basis for long term and sustainable change in the communities. Local Indigenous community members have been employed to provide community input into Government decision-making.” (Productivity Commission 2009 p11.23)

The very fact that the Basics Card is still in place over 12 years on, and is about to be transitioned to the CDC, suggests that it is not demonstrating success in generating sustainable change in communities. Why is it still needed after so long? Why are so few people transitioned off it? The policy appears to be indefinite, rather than contributing to sustainable change. There seems to be no strategy for moving people off the card. And it also seems that it is very difficult for Aboriginal people in particular to gain exemptions from it.

In 2013, for the Closing the Gap Clearing House, I was commissioned to review all the literature on engagement with Indigenous people to identify what works and what doesn't work (Hunt 2013a,b). That research confirms that the process of this Bill is far too rushed, and consequently does not allow time for proper engagement with the majority of Indigenous people it is going to affect.

It is unfortunate that there is still no First Nations Voice to Parliament as this legislation, and its rushed process, demonstrates the urgent need for one. A genuine dialogue with First Nations

representatives about the problems facing their communities in the Northern Territory and Cape York would be very worthwhile, but I doubt that the solution that would emerge from such genuine discussions would be a compulsory Cashless Debit Card. The Northern Territory and Cape York have some excellent Indigenous organisations doing their best to address many of these problems but they do so with far too few resources and insufficient government support. Some (e.g. Tangentyere Council (which I believe used Centrepay¹) & , Arnhem Land Progress Association (ALPA) with their Food card)² have used a voluntary system to help people manage their finances, and this could be a useful part of the mix, but it would be quite insufficient without other programs to complement it, if the deep-seated problems are to be overcome effectively. First Nations deserve the best policies and programs we can develop, and not to be subjected to such an extreme level of individual control (this Bill gives the Minister the possibility of quarantining 100% of their income onto the card).

2. Public Value : Cost & hence need for evidence it works in a cost effective way and is proportionate

The Cashless Debit Card is an expensive policy. From the information that is publicly available, it seems that up till March 2018, expenditure on the card for Ceduna and East Kimberley alone was \$23.7m, plus \$1.6m for the Orima Evaluation. This new extension to the NT and Cape York is to cost \$128.8m, and the Explanatory Memorandum mentions an additional \$17.8m for the transition from the Basics Card to the CDC. This amounts to at least \$170m, plus the cost of the card in Goldfields and Hinkler. There is no information on the public record of the expenditures in the Goldfields and Hinkler, which have more than trebled the number of people on the card. So, conservatively, the total cost to date may well far exceed \$510m (i.e. three times the cost we know about). This is a significant amount of money in Indigenous Affairs. Indeed, income management overall is reported to have cost over \$1 billion to 2012, and presumably far more seven years on.

As Prime Minister Morrison said, “Governments fail ...When investment is poorly targeted.” This investment is an example of poor targeting – apart from anything, it targets many people who do not need it at all because they do not engage in any of the behaviours it is trying to change. They may be out of the workforce but there may be very good reasons for that in many cases (e.g. health or disability related reasons, and/or that they are caring for children or sick or older people). Research we have conducted with the ABS on Aboriginal and Torres Strait Islander people not in the labour force reveals that more than half have a disability, and over a quarter

¹ Centrepay is a free bill paying service. People can use Centrepay to arrange regular deductions from their Centrelink payment to assist them with budgeting.

<https://www.humanservices.gov.au/individuals/services/centrelink/centrelink/what-centrelink>

² For more details of the ALPA Food Card see <http://www.alpa.asn.au/alpa-food-card/>

cared for a person with a disability, a health condition or an elderly person)³. And one certainly cannot use the Orima Evaluation to argue that the Cashless Debit Card is effective, as that evaluation was seriously flawed.

Evidence for IM – CDC or Basics Card?

My question is ‘What **rigorous evidence is there** that the Cashless Debit Card extension is a cost effective policy for reducing harms and enabling people on welfare to move into work?’

The Cashless Debit Card is just a further iteration of income management ‘experiments’ in different parts of Australia, predominantly among Indigenous people. In the Northern Territory, it is proposed to replace the Basics Card, which has been in use since 2007, with the CDC. It is worth therefore exploring what success there has been with the range of approaches to income management in Australia over the last decade or more, and particularly the Basics Card itself.

Referring specifically to a major evaluation of New Income Management in the Northern Territory, Bray’s team’s overall findings were that ‘taken as a whole, **there is no evidence to indicate that income management has any effects at the community level, nor that income management, in itself, facilitates long-term behavioural change**’ (2014: 320). (my bolding). Thus the Basics Card appears to have had little to no impact on the behaviours it was trying to change. In contrast to the main compulsory component the evaluation found some more positive, although still limited, outcomes for voluntary Income management.

Furthermore, as researchers at the Menzies School of Tropical Health were surprised to find, there **was no evidence that school attendance increased after the introduction of income management (Cobb-Clark et al 2017)**, and there was **no improvement in child health**. As the researchers stated:

“The findings of our study suggest that income management did not improve one measure of child health outcomes, and, by extension, that income management does not appear to have produced the desired change in household consumption patterns, at least for households with pregnant women. In fact, income management may have had a negative impact on newborn health – lower average birthweights and a higher probability of low birthweight (defined as less than 2500g), over and above what would be expected if a baby was premature.” (Doyle et al 2017, non-technical summary).

At the time of the public release of the final NIM evaluation, the then Minister suggested its findings were at odds with other research then available. As evaluations of various approaches to income management have been undertaken since IM began in 2007, Bray then undertook a comprehensive review of all of those undertaken up to 2015. As he said,

³ [https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Factors%20associated%20with%20Aboriginal%20and%20Torres%20Strait%20Islander%20people%20being%20out%20of%20the%20labour%20force%20\(Feature%20Article\)~10102](https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Factors%20associated%20with%20Aboriginal%20and%20Torres%20Strait%20Islander%20people%20being%20out%20of%20the%20labour%20force%20(Feature%20Article)~10102)

“These vary in rigour, methodology, and the set of programs considered. This has led to an apparent diversity of findings, which has been exaggerated by selective use in public debate” (Bray 2016: 449).

Bray went on to document how Ministers and the Department had selectively reported the findings of the various evaluations to present some positive aspects, without reporting the qualifications or distinguishing between the results for voluntary IM as against compulsory IM; incomplete quotes taken out of context often highlighted the positive without reporting the negative consequences or failings of the card. Bray also compared the methodologies of the various evaluations undertaken and found that those which focussed on subjective perceptions of change were generally more positive in their results than those which used more objective measures of change such as changes in spending patterns (Bray 2016:449). Furthermore, Bray found a marked difference in outcomes for those on voluntary IM compared to those compulsorily placed on it, unless individuals want to change and are given the necessary wrap-round support to do so (Bray 2016: see p 464).

“To the degree there have been any impacts on outcomes, these are for people who have chosen to go onto VIM. **In contrast there is no evidence of such impacts for those placed on compulsory income management under generalised categorical targeting.**

— The evidence base of the smaller highly targeted compulsory measures is less substantive and more reliant upon qualitative information, but suggests potential benefits where individuals are motivated to make changes and are supported by case workers and other interventions.” (Bray 2016: 464). (my bolding)

Despite Bray’s finding about compulsory IM applied indiscriminately, the CDC is an example of precisely that approach. **The evidence from a range of evaluations is that voluntary income management can have positive outcomes, and there is potential for positive outcomes when the approach is highly targeted (ie to particular individual cases) and is supported by strong casework and wrap-round services.**

If we are to have evidence-based policy, and the Prime Minister states that we should, then the evidence suggests that these two ways to use a Cashless Debit Card could be useful, but compulsory use with blanket categories of persons is not likely to be effective, and hence is poor investment of public funds.

The Explanatory Memorandum ignores all this evidence about income management evaluations and uses as justification for extending the CDC, the results of the initial Orima Evaluation – now over two years old, which has been criticised for its methods by myself and others (see Cox 2017), and which the Australian National Audit Office stated very clearly was not adequate.

In 2018 the Australian National Audit Office vindicated my arguments about the poor quality of the Orima evaluation, concluding that the Department of Social Security’s “...approach to monitoring and evaluation was inadequate. As a consequence, it **is difficult to conclude whether**

there had been a reduction in social harm and whether the card was a lower cost welfare quarantining approach.”(p 8).

Thus the ANAO has made two key points which I raised in my original submission:

- (1) The evaluation could not be relied upon as an indicator that the use of the CDC was reducing social harm – which was its stated purpose; and furthermore,**
- (2) That this may not have been a cost-effective approach to the problems it was intended to solve.**

That the Government continues, against all the evidence (including all the qualifications in the Final Report itself and the ANAO Audit report), to make grossly misleading and inaccurate claims about the overwhelming “success” of the trials in Ceduna and East Kimberley is rather insulting to the citizens of Australia who expect them to be honest and to use public funds in line with evidence for their efficacy.

I note that the Parliamentary Joint Committee on Human Rights in their second human rights scrutiny report of 2019 raised serious doubts about the proportionality and effectiveness of the measure in relation to its objectives, and drew attention to the less positive results from the Orima Evaluation that has been relied on to justify this expansion, saying:

“The statement of compatibility explains that the final evaluation found that the cashless debit card trial has had a 'considerable positive impact' in the communities in which it operated, and that the trial had been effective in reducing alcohol consumption and gambling in both of the trial sites reported on. However, in relation to this research, the committee's previous reports on the measures noted that the ORIMA research also contains some more mixed findings on the operation of the scheme. For instance, while the ORIMA report pointed to evidence of the reduction in alcohol-related harm in the trial sites based on administrative data, the ORIMA report states that 'with the exception of drug driving offense and apprehensions under the Public Intoxication Act (PIA) in Ceduna, crime statistics showed no improvement since the commencement of the trial'. The ORIMA report also notes that 32 per cent of participants on average reported that the trial had made their lives worse; 33 per cent of participants had experienced adverse complications and limitations from the trial, including difficulties transferring money to children that are away at boarding school and being unable to make small transactions at fundamentally cash-based settings (such as canteens); 27 per cent of participants on average noticed more 'humbugging', as did 29 per cent of nonparticipants; and in the East Kimberley, a greater proportion of participants felt that violence had increased rather than had decreased. These statistics are not cited in the statement of compatibility. Such results raise concerns that the measure is not rationally connected to its stated objective.” (Report 2 of 2019 p150). *(all footnotes removed)*

Since the Orima Report, a further so-called 'Baseline Study of the Goldfields' site has been released (Mavromaras et al 2019). This is a qualitative study of the situation in the Goldfields, but it is not what I would consider a genuine baseline study – it was not undertaken to assess social conditions in the Goldfields *before* the intervention (i.e. CDC) was introduced. The fieldwork for this study was undertaken between June – September 2018, i.e. at least 3 months *after* the introduction of the CDC (which began March 2018). This may not have been the fault of the evaluation team, and they clearly tried to get a qualitative assessment of conditions before the card was introduced. However, they have not drawn on any objective data for a baseline – this report is entirely based on subjective assessments.

The other major issue is that apparently simultaneously with the roll out of the CDC in the Goldfields, the police began an operation known as "Operation Fortitude" to increase the police numbers, and change the policing style to ensure more public presence. So, while this may be useful, it would make it difficult to disentangle the effects of the CDC from the effects of this boost to policing, particularly in terms of things like public drunkenness, children on streets at night etc. The evaluation notes this but is really unable to do anything about it. So the attribution of at least some changes observed to the CDC is certainly tricky. They may result much more from a change in policing.

Despite its shortcomings, this report makes some important comments on the CDC program which do not appear to have been taken into account in the proposed extension of the Card to the NT and Cape York, as there is no mention in the Explanatory Memorandum of any supplementary wrap round services that may be provided in the NT or Cape York, should they be needed:

- 1) **The issue of Wrap-Round services remains a major problem.** There have clearly been serious service shortfalls in areas such as drug & alcohol services and mental health services for some time in the Goldfields region. These have not been addressed with the roll-out of the CDC. This is extremely important – as some people seem happy to be helped (by the CDC) to control their drinking or drug behaviours, but the rehabilitation and related supports are not there for everyone; they need to be ongoing, not FIFO supports.
- 2) **There is real concern about people on disability pension & their carers plus people with mental health issues being on the card.** And the continuing concerns of **people who don't drink, or do any other socially harmful behaviours being forced onto the card** – and lots of **concern re stigma/shame**, especially for Aboriginal people. In fact, **there is quite a strong call for much better targeting of the card to those people whose behaviours are really problematic or whose children are neglected.** One respondent suggested better to focus on them (maybe 300 people according to that respondent) and provide stronger support for them than waste money on rolling it out to everyone who didn't need it (and some who have been negatively affected by it eg due to mental health issues).

The card does seem to be helping some people in Goldfields, according mostly to stakeholders (and a few participants), but it is also having negative effects on some groups, so a finer tuned public policy is needed (see sections 10.1 and 10.2 of the Baseline Study).

In short, if it is to be extended, the card should only be used as a voluntary tool or to help specific individuals while they deal with their addictions/problems, not a permanent fixture. And in such cases it must be supported by and integrated with case management and suitable and adequate wrap round services. Clearly some people would like to overcome their addictions but without adequate services to help them it is very difficult for them to do so.

When the 'pilot' sites of Ceduna and East Kimberley were extended to the end of 2019, this was explained in terms of needing to give time for a further evaluation to be undertaken. The Report from this evaluation is due in late 2019, but is not yet publicly available. Why should the Parliament now be asked to extend the Cashless Debit Card to these two sites only two to three months before we know the results of that evaluation? This is an insult to the Parliament and the public and no extension should be countenanced for these two sites until that evaluation is public and has been independently reviewed, including by the ANAO. As I said in my first paper back in 2017 about the Wave 1 Evaluation:

'Perhaps the critical evaluation question that needs to be asked is *'which people is it useful for, and exactly how is it helping them?'* (Hunt 2017a)

This question has not yet been adequately answered, although the Goldfields Baseline does tell us who it is **not** useful/suitable for.

Finally, it is deeply concerning that a requirement for independent evaluation of such a major program is to be removed if it proceeds. The Productivity Commission is currently working on a framework for improving evaluation of all of Government's Indigenous programs, and this proposal seems to be working at complete odds with this Productivity Commission initiative.

In summary, the evidence to support blanket application of income management across the Northern Territory is simply not there and hence I oppose any further rushed roll out of compulsory CDC as poor Indigenous policy and poor investment of public funds. There is perhaps a case for a voluntary scheme, and possible use of the card for highly targeted support to particular individuals as part of a wider case management strategy in partnership with local communities. This would require adequate funding and provision of the relevant support services.

3) What might work?

I am as keen as anyone to see the deep social and economic issues in communities tackled, but this needs to be done in line with what we already know works. And this means genuine partnerships with Aboriginal organisations and people. I therefore will not prescribe precisely

what should be done as there are capable organisations in the NT and Cape York and their views and those of affected community members should prevail, and they may vary with the different contexts.

However, I would point out some research or evaluations that point to what has worked in different locations in solving entrenched problems of violence, conflict, incarceration etc.

If the harms of violence and addiction to legal as well as illegal drugs are the key issues, then strategies that we know work to tackle them should be used.

Violence

- 1) I would refer the Committee to the work of the Tangentgyere Family Violence Program⁴ in Alice Springs, which ironically struggles for funding, yet appears to be leading lasting change in Central Australia in relation to Family Violence. Supporting much more of this type of work might have a more lasting and positive impact on Family Violence in the NT than the CDC.
- 2) Other successful or promising initiatives to reduce family violence are documented in *Communities working to reduce Indigenous family violence*, Brief 12, June 2012, Kylie Cripps and Megan Davis, Written for the Indigenous Justice Clearinghouse⁵.
- 3) Similarly the work of the Yuendumu Mediation and Justice Committee which involved support for developing and operating a local mediation service in Yuendumu was extremely successful in keeping that community peaceful so that children could go to school, people could get to the health centre and the place could operate in a normal way. It had a rate of return of 4.3 dollars for every dollar spent according to a Cost Benefit Analysis by University of Canberra economists.⁶
- 4) ANROWS paper: Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: *State of knowledge paper* (See in particular pages 57-62 on what seems to be working). (Olsen & Lovett 2016).

Drugs and Alcohol

The current National Aboriginal and Torres Strait Islander Peoples' drugs strategy (2014-19)⁷ covers alcohol & all other drugs and is based on wide consultation with AOD experts and was developed by the Intergovernmental Committee on Drugs (IGCD).

⁴ <https://www.tangfamilyviolenceprevention.com.au/>

⁵ <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.393.8975&rep=rep1&type=pdf>

⁶ <https://aiatsis.gov.au/gallery/video/cost-benefit-analysis-yuendumu-mediation-and-justice-committee-economic-case-local-dispute-management-services>

⁷ <https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-peoples-drug-strategy-2014-2019>

Their strategy is based on three key pillars:

Supply reduction: effective strategies include: ‘price controls by banning cheap high alcohol content beverages such as cask wine, restrictions on trading hours, fewer outlets, dry-community declarations and culturally sensitive enforcement of existing laws.’

Demand reduction: ‘preventative strategies such as early intervention, education and health promotion, provision of alternatives to AOD use; **community-led initiatives** leading to alcohol bans, permits and restrictions on hours of supply. For optimal treatment outcomes, a range of treatment options (provided in various settings) aimed at reducing individual demandneed to be available.’

Harm reduction: ‘Effective harm reduction strategies include: bans on the serving of alcohol in glass containers, night patrols, and sobering-up shelters.’

It is based on four principles:

- Aboriginal and Torres Strait Islander ownership of solutions (ie through Aboriginal and Torres Strait Islander-controlled organisations)
- Holistic approaches that are culturally safe, competent and respectful
- Whole of Government partnership
- Resourcing on the basis of need.

Its highest priority action is to build the capacity of local AOD program providers and their workforce to manage these activities.

Just to reinforce this point, a scholarly review of the evidence conducted by Edith Cowan University states the following:

“There is no single solution to the harms associated with alcohol use and given the lack of evaluations of Indigenous-specific alcohol use interventions decisions about the type of strategies to use may need to continue to come from observed assessments, or evidence from other populations and settings . What the available evidence does show is that for interventions to be effective they should:

- have the support of and be controlled by local communities
- be designed specifically for the needs of a particular community and sub-groups within the community
- be culturally sensitive and appropriate
- have adequate funding and support

- provide aftercare
- meet the needs of difficult cases”

(Australian Government Department of Health and Ageing and Edith Cowan University. 2013:7)

I suggest that to reduce alcohol-related harms in the Northern Territory and elsewhere programs consistent with these findings should be supported. The Northern Territory Government has undertaken a major review of alcohol legislation and policy, and the Commonwealth should work to strengthen the NTG’s very thoroughly considered approach (Northern Territory Government 2017). Following this review, Stephens et al (2019) have identified the specific needs for strengthening of alcohol-related services in the Northern Territory. These documents should guide Commonwealth policy in the Northern Territory, as they are based on wide consultation and the experience of experts in the field.

A small study undertaken in a remote Queensland Community also illustrates why I think a very different approach to solving the problems the card is claimed to target, and other problems that these communities are experiencing, like unemployment itself, is required.

Beat da Binge was a 2-yr project (2010-2012) designed to prevent the harm caused by binge drinking among young Aboriginal people in Yarrabah - a discrete Aboriginal community of around 2400 residents, half of whom are under 25 years old (McCalman et al 2013). It supported a raft of one-off activities with key messages about alcohol harms. However, this was not hugely successful so they changed tack and involved young people in developing and administering a survey, which in short revealed that ‘young people reported consuming alcohol because they were bored or disengaged, lacking employment or other life opportunities’ (p7). Digging a little deeper it became clear that ‘boredom’ really referred to ‘a deeper lack of purpose, engagement or meaning in life’ for young people, and not to a lack of activity or entertainment. “Binge drinking provided a way of creating social connectedness with peers and relief from a cycle of disengagement and lack of hope for the future” (p7)

I think this is a very important finding. I would suggest that this sense may be far more widespread among some Aboriginal young people (and older ones) than just this Yarrabah group. Beat da Binge’s focus shifted to helping young people overcome barriers to education, employment or training that might help them achieve meaningful lives. That is, it started to address the underlying issues.

This project engaged the community widely (8 different organisations), young people themselves, experts and researchers. It was a process which they saw as ‘negotiating knowledges and meanings to tailor a community response’. It informed young people about the evidence AND young people informed the response. Sadly, like many such promising projects, its funding ended.

An approach that is achieving significant change in related areas

But most importantly I would like to draw the Committee's attention to the considerable **success** being demonstrated in remote NSW town of Bourke, with **a genuine partnership approach** to many of the same problems. **The Maranguka Justice Reinvestment Project** does not have precisely the same aims as the CDC but is trying to reduce the high levels of incarceration; it is having considerable impact and there are areas of overlap with the goals of the CDC, but the key point is that **the process undertaken slowly and in genuine partnership between the Indigenous community and government agencies is driving the change**. The KPMG report highlights improvements in three key areas:

- Family strength: a 23% reduction in police recorded incidence of domestic violence and comparable drops in rates of reoffending
- Youth development: a 31% increase in year 12 student retention rates and a 38% reduction in charges across the top five juvenile offence categories
- Adult empowerment: a 14% reduction in bail breaches and 42% reduction in days spent in custody. (KPMG 2018).

Maranguka Justice Reinvestment has been largely supported by philanthropists. The economic impact was approximately five times greater than the operational costs in 2017. Maranguka Justice Reinvestment, resulted in a gross economic impact of \$3.1 million in 2017. If just half of the results achieved in 2017 are sustained, Bourke could deliver an additional economic impact of \$7 million over the next five years. Thus the long term changes will drive economic benefits to Bourke and cost savings to governments.

Conclusion

I conclude with a reference to comments from Professor Marcia Langton at the National Press Club on 25 September 2019 in answer to a question about the Cashless Debit Card , in which she made the point that in Kununurra there had been some initial community support for a Cashless Debit Card trial, with a community-agreed design, which would have allowed a local committee to exempt responsible people from the card and focus it on those with known problems (e.g. those with convictions for violence, drunkenness etc) , but that is not what happened during implementation. Instead, as she said, the card is now in disrepute because of its punitive implementation; she said that the government wielded a big stick to punish the poor, and it has been brutal.

I think it is time for the Government to think again about the blanket use of this card in all the trial sites, and to focus its energies on helping communities gain social and economic development in more positive ways, making the card voluntary and with an option for compulsory use in a very small number of highly targeted cases along with much wider wrap-round support. It is also important to ensure that the services are there and well-funded to enable them to work with those who want to reduce violence, alcohol use, drug use etc. and turn

their lives around. The funds would be better spent on them if Government is serious about making sustainable change in people's lives.

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Attachments

Hunt, J. CAEPR Topical Issue 1 /2017

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