Senate: Community Affairs Legislation Committee:

Inquiry: Social Security (Administration) Amendment (Income Management and Cashless Welfare) Bill 2019

Submission by Dr Janet Hunt, Associate Professor and Interim Director at the Australian National University's Centre for Aboriginal Economic Policy Research.

Janet.hunt@anu.edu.au

Thank you for the opportunity to make a submission to the Community Affairs Legislation Committee Inquiry into the Social Security (Administration) Amendment (Income Management and Cashless Welfare) Bill 2019. The Bill seeks to extend the operation of the cashless welfare trial and income management in all locations to 30 June 2020. Below are my recommendations, followed by the justification.

Recommendations

My recommendations, based on evidence drawn from evaluations of the Cashless Debit Card conducted to date and data relating to Indigenous employment and unemployment, are that:

- The CDC not be applied or extended in a blanket way. Any income management scheme be only undertaken with those individuals who are demonstrating socially harmful behaviours and serious child neglect, as part of a wider case management strategy with holistic support to address the complex issues they face, and for a limited time while they do so; and for those who wish to remain on income management voluntarily.
- That funds be directed to boost the necessary services to these localities and individuals, among them drug and alcohol, rehabilitation, healing, family violence prevention and the like (according to the local priorities) and to provide suitable youth activities such as sport and recreation programs, or other programs seen as valuable at a local level.
- That more policy and program effort, including funding, be directed towards community economic development in order to create the necessary jobs to enable people to enter the labour market and appropriate adult education and training to build their skills to take the opportunities created.

As you may be aware, in 2017 I made a submission to a similar Parliamentary Enquiry into the Cashless Debit Card trial that had then begun in Ceduna and the East Kimberley. At that time I made a number of points about the poor quality of the Orima Evaluation and the somewhat cavalier use by the Minister and others of selected sections of the evaluation to claim that the CDC at both sites was an overwhelming success. In fact, the evaluation was poorly carried out, and to the extent that one could draw any substantive conclusions from it, they were far more mixed than had been claimed. One could see that only about 1 in 5 people on the card found it helped them/made their lives better. For 49% it made their lives worse; and 34% never drank, gambled or used drugs in the first place – so for most participants the card had no positive value. Violence may have increased in Kununurra. This is a costly measure. It cost $18m for one year, for a total of around 2,000 participants – almost $10, 000 per participant. My question remains: is this the best investment of this considerable amount of money to tackle the problems it purports to address?

This poor Orima Evaluation of the Cashless Debit Card in Ceduna and the East Kimberley, is still relied on in the Explanatory Memorandum for this Legislation as justification for the extension of this trial in Ceduna and East Kimberley despite the fact that in 2018 the Australian National Audit Office itself vindicated my arguments about the poor quality of the evaluation and concluded 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 particularly perplexing.

The "trial" in Ceduna and the East Kimberley has now been underway for almost three years and it should by now be clear whether or not it is working, whether it needs changing in any way and if it is to continue, how it will be phased out, once problems it was designed to tackle are resolved (if it is now working more effectively than the 2017 evaluation found). This is a very long "trial". One of the issues with these "trials" are the fact that there seems to be no end point[1]. There is apparently a second evaluation underway and it seems evident that this should inform decisions going forward. However, we are told that the extension is necessary to provide sufficient time for the findings of this second study to be finalised. But there is no information on when that evaluation is reporting.

There is reference to the so-called "Baseline Study" in the Goldfields. This is not a bad qualitative study[2] 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 (ie 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, a baseline should be undertaken *prior to* an intervention and subsequent evaluation undertaken after a period which is judged adequate for signs of the effects of the intervention to be evident. In this case, because the nature of the intervention immediately restricts income support recipients' access to 80% of their entitlement onto the card, after a fairly short period (i.e .6 months) one might expect to see some change if the intervention is starting to work.

The other major issue with this evaluation 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 have been useful, it would make it difficult, if not impossible, to disentangle the effects of the CDC from the effects of this boost to policing, particularly in terms of things like public drunkenness,

[1] I note that the income management regime in the Northern Territory has now been going well over a decade and there seems to still be no end point in sight.

[2] It is not clear from the study however, whether or how the researchers consulted with First Nations groups in the region about the design, or used First Nations researchers to conduct the study with First Nations people in it.

children on streets at night etc. The evaluation notes this but is really unable to do anything about it. So the attribution of many changes observed to the CDC is tricky. The impact may be more the result of the policing changes than the introduction of the card, or perhaps the interaction of the two.

The Goldfields study is qualitative only. While this provides some very rich data which gives a good sense of the situation, it relies on perceptions only with no triangulation with other data. In a baseline study one would expect to try to find some more objective data that one might try to track over time – some possibilities are mentioned in various participant comments, e.g. RFD call outs to violent incidents etc., hospital records, records from emergency welfare agencies. However no recommendations are made about collecting some of this data that might bear out the qualitative interview reports of some social improvements attributed to CDC. This means that any follow up evaluation has none of this type of data to compare.

There are almost 3,000 CDC participants in Goldfields and only 64 were interviewed. These people were invited through stakeholder organisations. While this may have been for practical reasons and to ensure voluntary participation, there may have been a bias in the recruitment process towards those more connected to agencies, and fewer who are more marginalised. The numbers were also unduly weighted towards Indigenous people. Of the 64 interviewed 64% identified as Indigenous and 36% did not. But in terms of total numbers on the CDC, 57% are not Indigenous and only 43% are Indigenous. As the report notes that non-Indigenous CDC participants were more critical of the card than Indigenous people on it, this slightly biases the findings to a more positive outcome than if the balance had better reflected the actual representation of people on the CDC. There were 66 stakeholder representatives from 59 organisations interviewed, so in fact more stakeholders than participants interviewed, which is unusual.

The study illustrates well the complexity of the problems in the Goldfields and itself makes clear that a card may not be an adequate solution. The issue of Wrap-Round services remains a major problem. There have clearly been serious service shortfalls in areas such as drug and 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. The card should be a tool to help people while they deal with their addictions/problems, not a permanent fixture as it is very expensive (though there is no data on cost in this particular study, but we know this from information on other sites already in the public domain).

The study reveals that there is real concern about people on disability pension and their carers as well as 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 in the Goldfields according to that respondent) and provide stronger support for them than waste money on rolling it out to everyone who did not need it and some who have been negatively affected by it e.g. due to mental health issues.

According mostly to stakeholders and a few participants the Card may be helping some people - and if they find it helpful that's good – but it is also having negative effects on some groups, so a much finer tuned public policy is needed (see sections 10.1 and 10.2 of the Study) that targets only those

whose behaviours are causing serious social harms or child neglect and is part of a more intensive suite of program supports that address the underlying causes of this behaviour. People on disability pensions, their carers, and people with mental health issues should not generally be on the card. Nor should people who have no need to be on it as their behaviours demonstrate social responsibility.

The CDC is also meant to discourage people from remaining on welfare and move them back into the workforce. If the problem is welfare dependency i.e. unemployment, the solution has to be job creation and economic development, so that people have a path off welfare. This is a structural problem relating to a failure of community and economic development as well as lower levels of Indigenous education relative to others. Overall, in Australia the gap between Indigenous and non-Indigenous employment rates narrowed between 2011-2016, but in remote areas it widened. It is also the case that Indigenous employment rates trend with the wider labour market and there are specific challenges in remote Australia which has a weak labour market post the mining boom and GFC. And since the end of the CDEP program (that allowed wages top up) fewer people are able to participate to some degree in the labour market in that way.

Overall, Indigenous women are doing better than men. Their employment rate is up between 2001 - 2016 from 38% - 45% as they are clustered in industries and occupations where jobs opportunities are expanding. Interestingly**, in the sites for which data is available, it seems more women than men are on the CDC, which is ironic, given their employment outcomes are actually better than men's**. Men tend to be in industries and occupations that are stagnant or in decline, so their employment rate fell to 49%, but non- Indigenous men's employment rate also fell. Furthermore, many unemployed Indigenous people have low levels of education (51% less than Year 12) and the job market for them is declining. Whilst there is a lack of economic opportunities in many of the targeted communities, there are also other factors in Aboriginal communities that are causing what is termed 'social dysfunction'. Many Aboriginal people in these communities are working to try to turn things around through their regional and local Aboriginal organisations but these need far more support (for drug and alcohol rehabilitation, healing and family violence prevention programs etc.). As the Goldfields study pointed out, there also need to be programs for young people, such as sport and recreational activities that can give them opportunities to build skills for positive futures. Better support for these essential services in remote AborigInal communities is required.

References

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