QCOSS
Queensland Council of Social Service

Review of the Cashless Debit Card Trial and Evaluation

September 2017

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About QCOSS

The Queensland Council of Social Service (QCOSS) is the state-wide peak body representing the interests of individuals experiencing or at risk of experiencing poverty and disadvantage, and organisations working in the social and community service sector.

For more than 50 years, QCOSS has been a leading force for social change to build social and economic wellbeing for all. With members across the state, QCOSS supports a strong community service sector.

QCOSS, together with our members continues to play a crucial lobbying and advocacy role in a broad number of areas including:

- place-based approaches
- citizen-led policy development
- cost-of-living advocacy
- sector capacity and capability building.

QCOSS is part of the national network of Councils of Social Service lending support and gaining essential insight to national and other state issues.

QCOSS is supported by the vice-regal patronage of His Excellency the Honourable Paul de Jersey AC**,** Governor of Queensland**.**

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1. Introduction and Summary

QCOSS does not support the expansion of mandatory income management through a Cashless Debit Card (CDC). We believe that addressing complex health and social issues, such as alcohol, drug and gambling problems, through the welfare system is fundamentally flawed. There is a lack of evidence of a causal link between people receiving income support and people with alcohol, drug and gambling problems. Participation in the Cashless Debit Card should only be on a voluntary basis and supported by a suite of relevant support services.

QCOSS cautions that the Cashless Debit Card may further stigmatise welfare recipients in areas where there are limited economic options and has the potential to divide communities.

This report reviews the Cashless Debit Card Trial and evaluation focussing primarily on the *Final Evaluation Report* released by the Australian Government in September 2017. The Evaluation by Orima Research, is intended to evaluate the Trial in the first two trial sites of Ceduna, South Australia and in East Kimberley, Western Australia. As well as analysing the *Final Evaluation Report* itself, this review also examines the extensive expert commentary on the trial and evaluation.

This is undertaken with a view to the Federal Government's desire to expand the trial firstly to the Goldfields, WA and Hinkler electorate Queensland – but also the current intention to remove the limitations within the existing legislation, potentially allowing expansion across the nation.

In our view, expansion of the Trial should not be supported on the basis that:

- there is insufficient evidence of success to warrant any further expansion of the trial at this stage
- there is a lack of clarity on the key goals and outcomes of the trial. While a theory of change and program logic have been developed, this is not consistent with the narrative from government. This narrative has increasingly been including outcomes relating to unemployment and welfare dependency which are outside the current Trial outcomes
- the evaluation methodology is questionable and the outcomes inconclusive. In addition, the two new sites represent a markedly different environment and Trial scope which has yet to be tested and evaluated
- that operating in complexity requires testing of multiple options, preferably options that are supported by evidence and expert opinion. The CDC Trial is currently the only option being considered to address these complex social issues and is not supported by the evidence of what works
- community support has not been clearly evidenced, and indeed appearances indicate divisions in the community. It is critical that solutions for communities should be based on community need, driven by community need
- accountability for public funds would recommend that there is clear articulation of costs and benefits of the trials prior to any further expansion.

2. What is the Cashless Debit Card Trial?

The CDC Trial has been designed to decrease the level of consumption of drugs, alcohol and gambling by quarantining the majority of income support payments for recipients in identified areas.

The CDC was initially trialled in the remote communities of Ceduna, South Australia and East Kimberley, Western Australia. In these areas, the card is mandatory for all recipients of working age Income Support Payment recipients. Recipients of the Age Pension, a veteran's payment or who earn a wage can volunteer for the CDC.

The Federal Government has recently announced further expansion of the Trial to two further sites. In the Goldfields, Western Australia the CDC will be mandatory for all recipients of working age Income Support Payments. Different arrangements exist for the fourth location, Hinkler, Queensland in which it will be mandatory for people who are 35 years and under and who are receiving Newstart, Youth Allowance (Job seeker), Parenting Payment (Single) or Parenting Payment (Partnered).

The CDC doesn't change the amount of money a person receives from Centrelink. It only changes the way in which people receive and spend fortnightly payments:

- 80 per cent is paid onto the CDC
- 20 per cent is paid into a person's regular bank account.

The CDC is operated by a company called Indue. It operates like a normal bank card, except it cannot be used to buy alcohol or gambling products, or to withdraw cash. The card can be used in stores that accept EFTPOS. It will work at approved online stores, to pay bills including recurring payments and for online banking through an app.

Participant numbers in the sites underway and announced are:

Location	Participant Numbers
Ceduna	794
East Kimberley	1,347
Goldfields	3,400
Hinkler	6,700

Changing make-up of Trial sites

As outlined above, the original trial occurred in the sites of Ceduna and East Kimberley. These sites are both remote and include significant Aboriginal and Torres Strait Islander populations.

The currently announced expansion of the trial to Goldfields and Hinkler sees the Trial move into more 'mainstream' sites. While Goldfields remains a relatively remote site, Hinkler is only four hours from Brisbane, is on the East Coast of Queensland and does not have high numbers of Aboriginal and Torres Strait Islander populations. This is a significant change in trial make up.

3. Clarity of Purpose

The stated purpose of the Trial is "*to reduce the levels of harm underpinned by alcohol consumption, illicit drug use and gambling by limiting Trial participants' access to cash and by preventing the purchase of alcohol or gambling products*" (Orima, 2017b, p. 3).

The evaluation framework including the theory of change and program logic clearly outlines the short, medium and long term outcomes of the trial including:

- Decreased alcohol, drug and gambling use
- Increased awareness and use of support services
- Decreased harm including crime, violence and injury
- Increased safety and security
- More powerful community expectations and norms

However much of the narrative of the Trial has also included outcomes related to employment or intergenerational welfare dependency. The Department of Social Services website lists the criteria for selection of trial sites as "*high levels of welfare dependence*" (DSS, 2017a) conflating, 'drug and alcohol dependency' with so-called 'welfare dependency'.

The evaluation did not test this presumed connection between income support and harmful behaviours. The evaluation did not do any quantitative surveys on the level of harmful behaviours among non-participants, nor any exploration of the critical supportive role of income support in helping people recover from alcohol, drug and gambling problems.

Indeed, the recently-released ABS household expenditure survey data does provide evidence comparing alcohol consumption of income support recipients and non-recipients: "*It shows households relying on welfare spend just 1.8% of their total spending on alcohol, which is lower than other households by about 0.4 percentage points"* (Knaus, 2017).

The announcement of the Electoral Division of Hinkler as a CDC site (Tudge, 2017a), reversed the priority of alcohol, drug and gambling problems, to focus firstly on youth unemployment.

The CDC Trial was not designed to target employment outcomes, nor does the evaluation provide any evidence of employment outcomes attributable to the CDC. It noted stakeholder's views that: "*a lack of employment opportunities in the Trial locations remained a key issue, which made it difficult for Trial participants to seek a pathway off the CDC*" (Orima, 2017b, p. 74). With few economic opportunities in Hinkler it is unlikely the CDC will solve the problem and will have the unintended consequence of further stigmatising welfare recipients.

It will be critical to ensure that the purpose and goals for the Trials are clear and are evaluated prior to any further expansion.

4. Need for Robust Evaluation

As stated earlier, Orima Research were contracted to undertake the evaluation of the two preliminary remote sites for the Trial with the Final Evaluation Report released in August 2017. The Federal Government has used the findings of the evaluation as evidence of the success of the trial and to support further roll out. However, the methodology for the evaluation has been criticised and findings themselves are less than conclusive.

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Evaluation Methodology

There has been much commentary on the evaluation methodology including:

- reliance of the evaluation on individual recall of behaviour;
- the impact of social desirability effects on the results;
- payment of evaluation participants; and
- survey design and structure. (Cox, 2017a & 2017b)

The report itself noted the limitations of the data including recall error and desirability effects. (Orima, 2017 p. 9)

Issues also arise with the assignment of attribution. Social science statistical analysis regularly warns that '*correlation does not imply causation'*. The evaluation goes to some lengths to try and exclusively attribute positive results entirely to the Trial. This is despite the complex inter-dependent nature of the social and mental health problems being addressed.

The evaluation seeks to prove the independence from the effects of treatment services and existing alcohol restriction, (both new and established), stating with confidence that "*the CDC could and should be expected to have a distinct effect in its own right."* (Orima, 2017b p. 114). The analysis used is not the standard statistical approach of multi-variate regression analysis, which would have established, with some degree of confidence, the independent or dependence of variables being measured. A simple aggregated comparison is made between self-reported use of services and self-reported improved behaviours resulting in the imprecise conclusion that "*the contribution of services seems to be much less than the contribution of the CDC itself*" (p. 115), "*Those services may have a small complementary role of enhancing the effects of the CDC, but this is a relatively smaller effect and limited to the small proportion of the population who access the services*." (p. 116).

There is no statistical analysis of the potential impact of alcohol restrictions in the communities. The evaluation simply says that restrictions "*been in place a considerable period of time*" (Orima, 2017b, p. 8). This is not entirely true, as the evaluation acknowledges the 'Takeaway Alcohol Management System' (TAMS) has only been in place since December 2015 (p.40-41). In addition, the Codeswitch research identified that "*many people could not separate TAMS from the broader welfare reform agenda*" (Codeswitch, 2016).

Other issues with the methodology include:

- **No baseline data**: The CDC evaluation had no participant baseline data. Even the Initial Conditions evaluation began one month after the Trial started, and interviewed only 37 stakeholders / community leaders, but no participants. The first wave evaluation occurred six months after the trial began and relied on participants' memory
- **Flawed design of survey instrument**: The design of the survey instrument has been criticised for "*its length, the order of questions, the language and shape of some questions, and importantly, the probable contamination of responses*". It has sampling problems and complex questions, with ethical implications where the answers could lead to anxieties, distress and discomfort, or "*have legal implications and risk child abuse interventions"* (Cox, 2017b).
- **No comparison with wider population statistics**: National and state statistics for alcohol consumption, drug use and problem gambling are readily available but are not utilised in the report. Use of this level of data analysis would provide useful comparisons particularly in the absence of base line data.
- **Not consistently significant sample sizes**: Sample sizes vary across questions. The participant surveys eventually reached 30% of participates in Wave 1 and 25% in Wave 2, which is significant engagement overall however the report still includes data for some survey questions where the sample size was as low as 7% (p. 51-52).

- **Identified unreliability dismissed**: In two cases the evaluation falsely dismissed the unreliability of data. Firstly, presuming that opposite views of the Trial would cancel out each other's bias without exploring the strength of either view: "*As participants and stakeholders knew the intent of the Trial, there was a potential for response bias. This bias could manifest in a positive or negative way for different respondents, depending on their level of support for the Trial. Due to the mixed opinions toward the Trial, this bias would arguably not have impacted results in an overall positive or negative direction*." (Orima, 2017b p. 27). Secondly, when the administrative data appears to contradict positive survey results, (in particular, crime reduction), instead of highlighting the potential unreliability of both sets of data, it proposes an (untested) hypothesis as to why there should be an opposite result for the administrative data, and thereby falsely uses it to support the survey data: "*The general lack of improvement in crime statistics and survey-based reports of being a victim of crime during the course of the CDCT is, on the face of it, inconsistent with the qualitative research findings in relation to community leader, stakeholder and merchant perceptions and observations.* " (Orima, 2017b p. 63)
- **Contradictory conclusions drawn**: The increased and decreased use of support services are both used as measures of success. Opposite conclusions are also chosen when the survey result was contradicted by administration data.
- **No control group sites**: The evaluation attempts to make use of some comparative administration data. However, it acknowledges that "*comparison sites do not represent perfect "control sites"*" (Orima, 2017b, p. 25, 146, 166). The evaluation research was not established until after the CDC trial began and no control sites were established, with only a limited amount of comparison administration data: "*comparison site data were only available for a limited number of measures*" (p. 9).
- **Unequal weighting to Ceduna:** Standard statistical practice was disregarded in favour of a weighting approach that gave disproportionate emphasis to the Ceduna site which had more favourable outcomes, but a smaller population. "*Despite the number of evaluation respondents being far greater in the East Kimberley than in Ceduna, the weighting ensured the two sites were treated as if their numbers were equal, thus giving greater weight to the responses from Ceduna over those from East Kimberley."* (Hunt, 2017b, p. 2) "*The evidence suggests that the Trial was a little more successful in Ceduna than in East Kimberley, largely due to more effective implementation*." (Orima, 2017, b p. 7). This departure from standard practice is not justified, it is simply stated that the two sites needed equal weighting for the evaluation: "*To provide an overall aggregate / average measure across both sites, an additional step in the weighting was needed to balance the different sample sizes at the two sites. Despite the different population sizes, equal weight was given to both locations – so that they each contributed 50% of the overall result reported. …. This standard approach was deemed inappropriate for the evaluation as it would have given greater weight in the overall evaluation performance measures to the EK than the Ceduna experience.*" (Orima, 2017b, p. 21) This results in a skewing of the data, so even where there is a negative result in East Kimberley this could be overshadowed by a larger positive result in the smaller population in Ceduna.
- **Skews results by excluding relevant data**: The CDC is mandatory for all community members on ISP regardless of them having identified drug, alcohol or gambling problem. Some evaluation results deliberately excluded those reporting "*did not do activity*", or reported frequency as "*never*". In the case of '*Alcohol Consumption'* on average this excluded 100 participants from each site, or over 200 responses per survey question (Orima, 2017, p. 46). The numbers excluded were even higher for drugs and gambling (identified by stakeholders as being far less of a problem than alcohol), with over 200 per site being excluded (p. 52, 57). This is despite Minister Tudge's response to the Parliamentary Joint Committee on Human Rights' concerns about the CDC trial, stating "*The trial will involve … a larger proportion of individuals within the community, so community level data will be more relevant for analysis*" (PJCHR, 2015). This exclusion of relevant data decreases confidence in the result by significantly reducing the sample size,

inflating the reported percent of use reduction. (To exclude this data from the evaluation, raises the question as to why these participants are even on the trial.)

- **No exploration of diverse perception of whole of community effects:** It is understandable when survey participants self-report a diversity of individual behaviours. However, the evaluation also reported a wide diversity of perceptions of the whole-of-community effects, which it did not did not explore. E.g. "*around four-in-ten non-participants … perceived that there had been a reduction in drinking in their community since the CDC commenced and less than one-in-ten perceived that there had been an increase*" (Orima, 2017b p. 46) The diversity is even more pronounced among participants than non-participants but the report ignores this data, providing no narrative to highlight the fact that 17% of participants perceived an increase in drinking in the community… and 21% perceived a decrease. Dr Janet Hunt says "*a problem … is such a diversity of perceptions. One would think that if there had been a change it would be perceived with a degree of consistency across the community, not just by a minority"* (Hunt, 2017b p. 3).

Evaluation Results

Any genuine and sustained reduction in the harmful effects of substance abuse or problem gambling in Ceduna and East Kimberley is to be welcomed. However, the information in the evaluation report does not indicate that such positive results are accurate, consistent, sustained and attributable to the CDC.

The positive results reported by the Federal Government are not an accurate representation of the evaluation, which is far more cautious. It indicates that the trial is not an unambiguous success, including numerous negative results as well as unintended adverse consequences, ongoing circumvention behaviours, and significant limitations of the evaluation methodology.

There are numerous results that show either no improvement or a decline including:

- **Alcohol abuse increased**: "Community leaders', stakeholders' and merchants' ratings …indicated that they perceived that alcohol abuse … increased marginally in East Kimberley from 6.8 to 7.4 out of 10." (Orima, 2017b p. 44). "17% of Participants perceived an increase in drinking in the community, (up slightly from 16% in Wave 1), and only 21 perceived a decrease (down from 24% in Wave 1)" (p. 47).
- **Drug use unchanged / unreliable**: "Community leaders', stakeholders' and merchants' ratings … indicated that they perceived that drug use problems had … remained stable in EK, … 5.6 to 5.7 out of 10." (Orima, 2017b p. 50). "the results should be interpreted with caution due to low sample size" (p. 52)
- **Gambling unchanged:** "Community leaders', stakeholders' and merchants' … indicated that they perceived that problematic gambling had … remained relatively stable in EK, from 5.0 to 4.8 out of 10." (Orima, 2017b p. 54)
- **Crime increased**: "it is important to note that, …crime statistics showed no improvement since the commencement of the trial." (Orima, 2017b p. 4, 60) "In East Kimberley, an overall increase in criminal incidents was recorded" (p. 60)
- **Violence increased:** "In contrast, perceptions among Trial participants were more mixed, … those who perceived that violence had decreased (20%) and those who perceived that it had increased (24%) (n=472). In EK, at both Wave 1 and Wave 2, a greater proportion of participants felt that violence had increased than had decreased." (Orima, 2017b p. 64)
- **Injuries / accidents unchanged:** "The quantitative survey results showed that, on average across the two Trial sites and within each Trial site, there was no statistically significant change between Wave 1 and Wave 2 in the proportion of Trial participants who reported having been injured or having an accident after drinking alcohol or taking drugs in the past month" (Orima, 2017b p. 66)
- **Safety decreased**: "There was no statistically significant change between Wave 1 … and Wave 2 … participant and non-participant perceptions of safety" (Orima, 2017b p. 5, 67).

"Participants (63% down from 67%) and non-participants (52% down from 56%) felt less safe in Wave 2 than in Wave 1." (p. 68).

- **Children worse off**: "24% felt their child/children's lives were worse (consistent with 20% at Wave 1)." (Orima, 2017b p. 6, 80)
- **Wellbeing worse**: "On average across the two sites, at Wave 2 participants were more likely to indicate that it had made their lives worse than better. At Wave 2, 32% of participants on average reported that the Trial had made their lives worse … the proportion reporting that the Trial has made their lives better … remained consistent – 23% at Wave 2 and 22% at Wave 1." (Orima, 2017b p. 6,82)

A number of 'circumvention behaviours had been identified in the Wave 1 evaluation report. That were reported to still be occurring at Wave 2 and/or whether or not they had been addressed was unclear. This includes:

- "Grog running" – in both Trial locations some stakeholders and community leaders had heard reports that this was still occurring.
- Merchants/businesses supporting circumvention behaviours:
  - In Kununurra, some stakeholders, community leaders and merchants reported that taxis were offering cash back at a reduced rate (e.g. charging the cardholder $100 and giving them $70 cash) and/or buying alcohol on behalf of Trial participants. Some also indicated that taxis were known to engage in similar undesirable behaviours to assist the circumvention of other systems.
  - A few stakeholders in Wave 1 had heard of local businesses overcharging/processing fake service transactions on Indue cards in return for cash (e.g. hotel room charged at $150 and Trial participant given $100 cash back).
- The transfer of money from Indue accounts to other accounts to withdraw as cash – reported by a few stakeholders at Wave 1.
- Rent transfers from Indue accounts to family members which were subsequently provided to Trial participants as cash – a couple of stakeholders reported that this was occurring amongst their clients at Wave 1.
- Card sharing – friends/family using participants' cards to purchase items in exchange for cash." (Orima, 2017b p. 86)

Ongoing adverse consequences

The Evaluation does not explore adverse consequences in detail, however some of the adverse consequences for Trial participants include:

- Being unable to transfer money to children that are away at boarding schools.
- Being unable to participate in the 'second hand' market for used goods.
- Being unable to pool funds for larger purchases (e.g. cars).
- Being unable to make small transactions at fundamentally cash-based settings (e.g. fairs, swimming pools and canteens).
- Being unable to make purchases from merchants or services where EFT facilities were unavailable.
- Being told by a merchant out of the area that they cannot accept this card.
- Having difficulties using the card online (including some online merchants not accepting the card).

At Wave 2, the quantitative survey found that 33% of Trial participants … had experienced at least one of the issues discussed above." (Orima, 2017b p. 89)

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5. An Evidence Based Approach

QCOSS supports innovation and testing new approaches to address complex issues such as alcohol, drug and gambling addiction. However, it is critical that these approaches are evidence based and supported by expert knowledge.

The CDC Trial has been roundly criticised by a range of experts across a range of policy and program areas. The table below provides a summary of this commentary.

Drug and alcohol clinical experts

Assoc. Prof. Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Hospital Sydney.	• Definition of substance dependence is a lack of control over use, procurement, intoxication, recovery and withdrawal from that substance. In severe dependence, the drug procurement and use takes salience over everything else, including paying rent and seeking food. • Will use whatever means are available, will work around a card. Just because card isn't allowing purchase doesn't mean won't have access to substances. People adapt to situation, to make sure those things are met. • No evidence that providing a card that prevents purchase of substance will change the behaviour around the use of that substance (SCALC, 2017, p. 21, 22).
Sam Biondo, Executive Officer Victorian Alcohol and Drug Association (VAADA). Drug and alcohol expert.	• Short-sighted. Not a solution to curb substance abuse, lead to alternate methods of finding money or other drugs. • More effective ways to tackle drug and alcohol dependency than using such one-dimensional, simplistic approaches. • Complexity attached to addiction, put funding into drug and alcohol services, especially in remote areas (Thals, 2015).
Michael Bret Hart, Adjunct Clinical Associate Professor Curtin Medical School Public Health Physician, Curtin University.	• Evidence-based approaches ignored for easily digestible and emotive campaigns. • Little evidence that Income Management improves child wellbeing. Northern Territory intervention showed no statistically significant change. • Tackle social determinants of health, then structural causes, otherwise blaming individuals for sickness from their choices (Bret Hart, 2017).

Indigenous and social policy experts

Dr Hannah McGlade, Senior Indigenous Research Fellow at Curtin University.	• The mandatory nature punishes the community for the actions of a few • Need to address structural and systemic inequalities • Gordon inquiry into Aboriginal family violence and child abuse did not support a top-down approach being imposed • Paternalistic, does not address wider social and economic problems (McGlade, 2017)

Prof Ed Carson, Professor of Social Policy at the University of South Australia, and **Dr Lorraine Kerr,** Lecturer in Social Work and Social Planning in the School of Social and Policy Studies at Flinders University.	• Government not treating all Australians the same regarding eligibility for income support • Ignore the fact that the previous income management policy was a failure • Seen as limiting and disempowering • Limits human rights and citizenship entitlements. (Carson and Kerr, 2017 p. 186)
Dr Janet Hunt, Deputy Director and Senior Fellow at the Centre for Aboriginal Economic Policy Research, and a Research Associate at the Development Policy Centre, at the Australian National University. (Comments refer to Wave 1 Evaluation Report.)	• Relies on subjective perceptions without adequate triangulation with other sources. Lack of adequate baseline data makes real assessment of change difficult. • Results in many cases reflect quite small numbers of people and may not be statistically significant. • Data shows 55 per cent transactions on the cards failed due to insufficient funds (nearly 21,000), only one per cent failed trying to use card for prohibited purchases. • Stakeholders identified a range of needs in Ceduna and EK. Services not provided before CDC was rolled out. • Costs for participants for whom trials are totally unnecessary as they have never participated in targeted anti-social behaviours. • Government quick to highlight conclusions of Evaluation. Yet more thorough reading leads to significantly different framing of conclusions. Public policy not well served by data not carefully interpreted. (Hunt, 2017a & 2017b)
Dr Shelley Bielefeld, Braithwaite Research Fellow at the School of Regulation and Global Governance (RegNet) at the Australian National University. Publications focus on the impact of welfare law, land rights, criminal justice and constitutional issues pertaining to Australia's First Peoples.	• Indigenous welfare recipients are grossly overrepresented • Government relied on views of card advocates, dismissive to contrary feedback by those forced to use it. • Significant problems for those subject to program: numerous users report card has created difficulties in meeting their everyday needs. • Those objecting, not because they want to buy alcohol, illicit drugs or gambling products, but because they do not want to experience financial and social exclusion. • Rationalised by the rhetoric of substance abuse and gambling addiction, linked to alleged deficits in the character and capacity of welfare recipients. • Less funding for services to assist people in need, especially children. • Fair social security system would treat people who need income support with dignity, rather than based on imagined deficiencies. • Selectively interpreted to garner support for preferred government policy pathways to "prove" program success. Occurred with numerous income management evaluations, and government's media release declaring the evaluation positive continues this. (Bielefeld, 2017a & 2017b)

Dr Elise Klein, Lecturer in Development Studies, University of Melbourne, Post-doctoral research fellow at the Centre for Aboriginal Economic Policy Research at the Australian National University, worked in various Indigenous organisations in North West Victoria and in the East Kimberley.	• Led to economic and social harm among people compulsorily included. • Both sites have a high proportion of Indigenous people, so invariably racially targeted. • Methodology questionable, unable to separate findings from other programs in the trial sites e.g. TAMS in EK. • Based on alcohol, drug use and gambling being primary causes of poverty. Yet most people did not gamble and did not report consuming illegal drugs or alcohol in excess. • Exacerbated economic insecurity for poor families. Limits cash for informal renting arrangements, second-hand goods, cash purchases of locally grown produce, and pocket money for children. Many struggled to use it. • Disempowering. Government failed to consult, nor to obtain consent. Instead, engaged select group of like-minded individuals and organisations to roll out card to communities. Many who agreed to host in EK did so for $1.5 million sweetener for badly needed services. • Clear opposition expressed at public meetings, strikes and petitions dismissed and ignored. People subjected to community panel –amount quarantined can be reduced only after being scrutinised by fellow community members. • Poorly conceived, ideologically driven policy. (Klein, 2017)
Dr Michele Lonsdale, Director of Social Policy and Research, Centre for Excellence in Child and Family Welfare (peak body for nearly child and family services in Victoria), and former ACER Principal Research Fellow. (17-page review responding to Wave 1 evaluation report).	• Additional source of stress for low-income families already battling complex needs before having use of their Centrelink payments so tightly prescribed. • Majority of participants report that the scheme had no impact or made their lives worse. • Presents data in ways that emphasise positive impact. Clear majority of participants in the scheme did not report a reduction in alcohol, drugs or gambling. • Strong conclusions do not reflect the mixed findings, particularly data contained in lengthy appendices. • Less clear is the evidence to demonstrate a specific relationship between people on welfare payments and experiences of harm associated with alcohol. • Research shows Australians in the third and fourth income quintiles that spend the highest proportion of their income on alcohol rather than those on the lowest incomes. • 91 per cent of participants surveyed were from Aboriginal and Torres Strait Islander background, only 15 per cent of stakeholder organisations in focus groups were Aboriginal. • No cost-benefit analysis or comparison with other policy responses, such as increased support services. • Made some very strong conclusions used to justify extension and expansion. Conclusions reported do not reflect mixed results of quantitative and qualitative data, instead present a more positive picture than full report and appendices demonstrate. (Lonsdale, 2017a & 2017b)

Eva Cox, Development Professorial Fellow, Jumbunna Indigenous House of Learning, University of Technology Sydney, fellow of the Centre for Policy and Australian Humanist of the Year. (Comments refer to Final Evaluation Report.)	• Judgemental and stigmatising, blames victims. • Data quoted is less valid and reliable than official views claim. Serious flaws in data collection. Some limits are acknowledged, but not by the government. • Media fail to question validity of findings and legitimacy of drastic and expensive changes to welfare policy. Evaluations in 2014 of similar trials in the Northern Territory were negative, reporting failure of similar desired outcomes. • Results do not support claims restricting all welfare recipients' access to cash. Extending trials and seeking to expand locations is not justifiable on basis of "evidence" offered. Much data collected from participants is flawed and some qualitative responses are questionable. • Not a supporter of highly conditional welfare because there is little evidence it works. • Criticism includes user questionnaire design, its length, order of questions, language and shape of questions, and probable contamination of responses. (Cox, 2017a & 2017b)

This lack of a clinical evidence-informed approach is further indicated by the following quotes that show no clinical evaluation was done to determine the nature of appropriate support services needed: "*At the time of the Initial Conditions Report, some stakeholders and community leaders were anticipating a high level of usage of some services by CDC Trial participants (e.g. rehabilitation, and drug and alcohol counselling). However, most service provider stakeholders reported that this had not eventuated and their case load had remained relatively stable since the introduction of the CDC. A couple of stakeholders in the medical sector felt that the limited uptake of alcohol and drug services was unsurprising, as they perceived a large number of Trial participants to be binge drinkers and therefore less likely to experience withdrawal symptoms*." (Orima, 2017b p. 94).

As Dr Janet Hunt says of the Wave 1 report: "*Both Ceduna and the East Kimberley have major social and economic problems which are complex, and have resulted from a range of historical factors as well as contemporary policies. It seems extremely naïve to think that controlling people's income to the degree now happening in these trials will be the solution to these complex problems. It is 'silver bullet' thinking to believe that these simple policy changes, which bring government increasingly into the everyday lives of welfare recipients and reduce their own capacities to control their lives, will solve the challenges they face*" (Hunt, 2017b p. 6).

National Drug Strategy

In addition, the Trial does not appear to have been informed by the National Drug Strategy 2017-2026 (Department of Health, 2017), or by clinical research on the treatment of problems with alcohol, drugs or gambling. The National Drug Strategy identifies '*Evidence-informed responses'* as one of its 'Underpinning Principles' (p. 15). The evaluation indicates that stakeholders protested a lack of an evidence-based approach: "*Some stakeholders felt that the decision-making process in relation to the funding of Trial services (including both the types of services funded and specific providers chosen) was not as robust or effective as it could have been. These stakeholders perceived the process to lack a clear evidence-base and overall framework to support decision making. A few stakeholders suggested that the process be underpinned by expert advice and established addiction/behaviour change theories to support evidence-based decision making and maximise the return on program investment."* (Orima, 2017b p. 97).

One of the relevant sub-strategies of the National Drug Strategy is the 'National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019' (ICOD, 2014). Most relevant to the CDC Trial is its comments about 'Social Determinants', where it states that "*Health and wellbeing are not simply a matter of individual life-style choices…. Research conducted for the World Health Organisation has shown that there is a social gradient in health and wellbeing, with the most socioeconomically disadvantaged experiencing poorer health status than the more affluent. This work identified solid evidence for the negative effects of: … lack of control over one's life circumstances*" (p. 10). Clearly the Trial ignores the evidence that poor health outcomes of often unrelated to individual lifestyle choices, and imposes restrictions that have been demonstrated to cause negative effects by reducing control over people's life circumstances.

Multi-faceted, strengths-based, voluntary approach

The CDC Trial has been pursued as the only option to supporting communities to address issues of alcohol, drug and gambling dependency and harm. With issues of this complexity, it would be appropriate to trial a variety of approaches. Preferably these approaches would be based on evidence and expert advice.

The CDC trial is deficit-based, seeking to control the harmful effects of problem drinking, drug use and gambling by controlling welfare recipients' access to cash. Without providing any establishing evidence, this frames the harmful behaviours as being firmly linked with (a) welfare recipients, and (b) access to cash. This approach fails to acknowledge in any way the complex nature of substance use disorders, and the complex social problems experienced in trial communities, which are entwined with numerous other structural causes of disadvantage.

The mandatory nature of the trial for all welfare recipients, (regardless of the level of harmful behaviours) is arbitrary and punitive. Many people required to participate in the trial do not have issues with alcohol or drug abuse or gambling. Numerous experts and peak bodies have recommended that the CDC be voluntary, not mandatory. These include the Australian Human Rights Commission, the Australian Council of Social Service, Financial Counselling Australia, and the Australian Association of Social Workers, (SSCOCA, 2015).

Human rights concerns

There are ongoing concerns about the human rights impacts of the Trial. Using an evidence based approach would also ensure that best practice standards are adhered to including human rights.

The Australian Human Rights Commission (AHRC) originally expressed concerns about the human rights impact of the CDC Trial, in both its submission to the 2015 Senate Inquiry (AHRC, 2015), and in its 2016 '*Aboriginal and Torres Strait Islander Social Justice Commissioner Report'* (AHRC, 2016). It suggested that the Bill engaged with the following human rights:

- Right to non-discrimination and equality
- Right to social security
- Right to privacy

In 2017 the Parliamentary Joint Committee on Human Rights (PJHRC) reiterated that the new amendment to extend the trials also "*engages and limits these rights*" (PJHRC, 2017, P. 35)

The '*Statement of Compatibility'*, in the '*Explanatory Memorandum'* for the 2017 Bill (Tudge, 2017d), does acknowledge engagement with the three Human Rights originally suggested by the AHRC and the PJCHR. In order to satisfy the original PJHRC request: "*it is incumbent on the legislation proponent to explain how the measures are likely to be effective (that is, rationally connected) to the stated objective*" (PJHRC, 2015, p. 23), the 2017 '*Statement of Compatibility'* shifts from claiming that the CDC Trial is a '*test'* to relying instead on the flawed Orima Evaluation as evidence of the its beneficial outcomes, to be balanced against the

limitations on human rights caused by the Bill (Tudge, 2017d, p. 3). However, this '*rational connection'* would require the Evaluation to be demonstrate an attributable dependency between the CDC restrictions and its outcome objectives. Specifically, the Evaluation would have needed to demonstrate that it was the CDC which caused a reduction in harmful effects of alcohol, drug and gambling problems, which it does not. In 2017, the PJHRC noted these flaws in the Evaluation (PJHRC, 2017, p. 37).

6. Consultation

The consultation process was perceived by stakeholders to be inadequate: "*this aspect of the implementation process was generally felt to be less than fully effective across both Trial sites…. Many stakeholders regarded the consultation process as insufficient in reaching the wide target audience in the community. These stakeholders felt that there had been too much reliance on formal channels (i.e. town hall meetings), rather than small group discussions.*" Orima, 2017b (p. 106). It also acknowledges that the CDC Trial did not have universal support from the local community: "*participants and stakeholders … bias could manifest in a positive or negative way for different respondents, depending on their level of support for the Trial. Due to the mixed opinions toward the Trial."* (p. 27). Several community members and leaders (including CDC participants) have expressed their opposition to it:

Lawford Benning, chair of the MG Corporation, Kununurra, one of the four Aboriginal leaders who supported the government's cashless welfare card trial in Western Australia. Regularly met with Minister Tudge and was critical to drumming up support for the card in his community.	• Feels "used" by the human services minister and no longer supports the card. • The card not addressed issues of alcoholism and violence in his community. Was advocating for it due to the commitment given by Minister Tudge that support services would be provided for people with alcohol, drug and employment issues prior to the card's introduction. • Supports didn't come for seven months after card was introduced, and when they did not appropriate. (Davey, 2017c)
Jody Miller, a Nauo man, member of the Aboriginal community council in Koonibba, 43km from Ceduna, but included in the trial.	• Sense of shame • Majority are being punished for the alcohol and gambling issues of a few • Questions why the trial has been rolled out in communities where most welfare recipients are Aboriginal • Those on card find ways to get extra cash. People approach shoppers at stores and ask them to pay for items with card in exchange for cash. (Davey, 2017a)
Keith Peters, chair of the Maralinga Tjarutja Council, Ceduna.	• Does not support card • At a meeting of more than 100 people from Ceduna and the surrounding towns in November 2015, no one supported universal application of the card to everyone on welfare in the community. (Davey, 2017a)
Ted Carlton senior Miriuwung and Gajerrong man, (East Kimberley)	• Doesn't affect too much, because doesn't drink, (got caught up with booze, but luckily broke out of dependency circle) • But doesn't think process was adopted the proper way with the mob, and that's the concern. • Should have been another approach used, a community development approach, an educational approach. (Parke, 2016)

Greg Peters, member of the Oak Valley Maralinga Tjarutja council.	• Struggles to see any positives to the card. • Aboriginal people feeling disempowered and voiceless, those with alcohol and gambling problems had found ways to get around the card and those without problems were being affected. • Fears that those with drinking problems will be placed at higher risk, going to more extreme measures to obtain alcohol and to hide their use. • Being on the card is like being placed on a ration. This is particularly painful because white pastoralists gave ancestors rations of food, rather than wages, in return for their labour. (Davey, 2017a)
Jocelyn Wighton, Ceduna resident, on disability support pension and on the debit card since March 2016.	• Had negative impact on her life, made her life difficult: still having trouble using the card at local shops, regularly doesn't work, and can't buy second hand goods. • People who need help, need more services, not their money quarantined. Most of us put on the card weren't over-consumers. • Biggest thing is doesn't get choice. • Concerned about long term domestic violence, less money makes people needier, more desperate and leads to more crime (Cetta, 2017; West Coast Sentinel, 2017)
West Coast Sentinel, Ceduna Newspaper	• A West Coast Sentinel poll received 371 votes with **85.7 per cent** saying the card should not be rolled out to other areas in Australia (West Coast Sentinel, 2017)

The Final Evaluation Report does not itself recommend an extension of the Trial. It vaguely reports that despite the initial stated reservations ("*perceptions in relation to the likely effectiveness of the trial were mixed*"), a "*large degree of support from stakeholders and community leaders for the CDC to be extended across the country because of the positive changes that had been observed … which were considered to be applicable on a broader scale"* (Orima, 2017b, p. 7).

7. Costs and Benefits

The true and complete costs of the CDC Trial are difficult to determine due to details being withheld by the government. The evaluation does not reflect at all on the cost of the CDC Trial, (despite the stated aim of addressing impact on "*taxpayer dollar*" (Tudge, 2017c). The 2017-18 Federal Budget also did not report on the cost of the CDC noting simply 'nfp' (Not For Publication) in the relevant line items (Morrison, 2017). However, some details have been released under Freedom of Information which show the pilot program costing $18.9 million, of which Indue the CDC provider, was being paid $7.9 million (Conifer, 2017; DSS, 2017e), working out at over $10,000 per participant across the first two trial sites.

Further investigation of the government's contracts with Indue, indicate that the payments to Indue have escalated from this initial figure of $7.9million, to now over $13 million for the CDC Trial (Mac, 2017). This figure means that the Trial is now costing almost $13,000 per participant. Which compares with a similar figure of just $13,925 income support per person for someone on the Newstart allowance (Conifer, 2017; Mac, 2017). By comparison with the government spending almost the same as Newstart on the Trial, they have promised support services of only around $1 million per site as below:

Site	Number of Participants	Allocated Funding for Support Services	Support Service Funding per Participant
1. Ceduna, S.A.	800	$1.0 million	$1,250
2. East Kimberley, W.A.	1,350	$1.6 million	$1,185
3. Goldfields, W.A.	3,400	$1.0 million	$294
4. Hinkler, Qld.	6,700	$1.0 million	$149

Figures from Department of Social Services Fact Sheets (DSS, 2016a, 2016b, 2017b & 2017c).

Despite the number of participants roughly doubling for each new trial, the promised funding for support services barely changed, reducing to just $149 per participant promised for the fourth site of the federal electorate of Hinkler.

Requirements for accountability for public funds would require greater information provision and transparency prior to further rollout.

8. Conclusion and Recommendations

QCOSS does not support the expansion of mandatory income management through a Cashless Debit Card. QCOSS believes addressing complex health and social issues through the welfare system is fundamentally flawed.

We recommend instead, that the Australian Government:

- Clearly articulate the objectives of the Cashless Debit Card and explore a full range of alternative options to address objectives of the Cashless Debit Card.
- Explore alternative options, to be developed, tested and evaluated to identify the most effective response to these social issues. This includes seeking expert clinical advice regarding the scientific understanding of substance use and addictive disorders, in the context of wider community socio-economic problems.
- Based on this, work with all levels of government and the community to develop an evidence based strategy for addressing alcohol, drug and gambling problems in target communities.
- Adopt a place-based, citizen-led, strengths-based approach to address the effects of alcohol, drug and gambling problems, that ensures people impacted by the Card are involved in decision-making.
- Make any participation in income management voluntary, and supported by a suite of relevant, adequately funded, holistic services.
- In all locations, ensure that the final strategy incorporates an economic development focus to ensure participants have a pathway to employment.

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