Submission on the Social Services Legislation Amendment (Cashless Debit Card Trial Expansion) Bill 2018

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Thank you for the opportunity to make a submission to your Enquiry. I am only able to provide a short submission so I refer the Committee to previous evidence I gave to your Committee in 2017 on this topic and previous publications I provided to you **(and have provided again as Attachments B,C & D**). In this submission I wish to make three key points:

1) The evidence cited as justification for the success of the Cashless Debit Card is illusory and in any case cannot be relied on in such a different context and different program as is proposed for Hinkler compared to existing sites;
2) Given the problems that Government wishes to tackle in Hinkler there are far better options which may generate more successful outcomes than a Cashless Debit Card; and
3) If any income management support is to be used it should only be as part of a much wider family case management program, where an entire family is supported to recover from complex problems with an intensive mix of social supports over a sustained period, and it should be only in extremely complex cases if some family members would find it useful during period of transition. The decision to use it should be voluntary.

1. The evidence cited as justification for the success of the Cashless Debit Card is illusory and in any case cannot be relied on in such a different context and different program as is proposed for Hinkler compared to existing sites

The appallingly bad 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 this trial in Hinkler, despite the fact that now the Australian National Audit Office itself has vindicated my arguments about the poor quality of the evaluation and has 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), to make grossly misleading and inaccurate claims about the overwhelming "success" of the trials in Ceduna and East Kimberley is particularly perplexing and somewhat dishonest.

Furthermore, I argue that the *extension* of the "trial" proposed in this legislation cannot be justified on the basis of the experience in remote Aboriginal communities, since it is in a large, urban and regional, predominantly non-Aboriginal community and the card is only to be applied to those under 35, and not to older people unemployed or those on a Disability Pension (categories of people included in other sites). On top of the inconclusive outcomes from these earlier sites, the **design** of

the new roll out and the **context** in which it is occurring is **so different** that these outcomes cannot justify the proposed expansion. Almost everything about it is different. It would be more honest to simply admit that it is an entirely new trial and cannot be justified based on previous experience. It therefore would need to have excellent baseline data, a clear program logic, clear KPIs, and a far better evaluation than we have seen to date if it were to proceed. Some transparency about the planned evaluation which should be built into the program design should be provided. Without such information it is impossible to judge whether this represents an adequately designed trial.

As a researcher I would not get University Ethics Committee approval to conduct an experiment with human beings, which is essentially what this trial is doing, on such flimsy design information, inadequate evidence of the benefits likely to flow, and without a clear and well justified plan for evaluating it, let alone without the informed consent of the specific individuals to whom it was being applied.

There is a serious question about whether this trial should proceed. Research advice by myself and a number of other respected academics and social policy experts and a highly critical audit by the ANAO should be sufficient to raise in the Committee some serious doubts about the value of pursuing this approach to the social and economic problems it is intended to solve. If this evidence doesn't cause the Government to reconsider and this Committee to reject this proposal, then I am not sure what will. I am also extremely disturbed by the wasteful public expenditure on very low quality evaluation work, and a costly program with dubious outcomes. In particular I highlight that we are dealing with some extremely poor people whose lives are already very difficult, so unless we can be sure that this program is actually going to improve things for them ***and that it is the best option to assist them,*** we should not proceed. That is, it should have a good likelihood of success in reducing social harms, unemployment etc, and it should use public funds in a cost effective way to achieve those outcomes. It should also reduce social harms *without creating additional negative outcomes,* yet these appear to have occurred in current sites from the evaluation provided.

Furthermore I do not believe that the objectives and logic of this CDC program have been consistent across the trials. In earlier roll-outs of the CDC the argument was given that the card was to reduce violence and increase people's perceptions of safety, by reducing the harm caused by alcohol, drug abuse and gambling in areas with high levels of welfare dependency. It was to reduce the amount of cash available in the communities. Now we are told that "the Cashless Debit Card has the objective of reducing immediate hardship and deprivation, reducing violence and harm, encouraging socially responsible behaviour, and reducing the likelihood that welfare payment recipients will remain on welfare and out of the workforce for extended periods of time." So the purposes have broadened somewhat with **reducing hardship and deprivation and moving people off welfare and into the workforce** added. The Explanatory Memorandum adds "The community has significant issues regarding **youth unemployment, intergenerational welfare dependency and families who require assistance in meeting the needs of their childre**n" so these seem to be the problems the community wants to solve, and it is suggested that the program has been tailored to address these in this context. So we might add, meeting the needs of children as a further objective. This seems to me to reflect muddled thinking about (a) the problems the CDC program is meant to address, and (b) the program design to address them. It also raises for me the deeper question about whether these problems are best solved through a mechanism such as this card.

It was this latter question that has led me to research what evidence there is about solutions to problems of Indigenous alcohol abuse and violence which were the major concerns in the two previous sites, according to the evaluation I critiqued. I recognise that the proposed Hinkler site is not predominantly Aboriginal, but even so there will be a disproportionate number of young

Indigenous people in the target group of participants, so this research remains highly relevant**. I attach my findings as Attachment A**.

The findings were in line with so much of what we know about what works in Indigenous policy and programs, that we need to fully engage the community (not superficially); they need to take control of the approach, informed by the evidence and supported fully; there need to be respectful partnerships between Aboriginal organisations and those trying to help them with these problems, using both knowledges – local expertise and external experts; and that we have to build on local people's aspirations for a meaningful life. And the process has to be incremental, adaptive, flexible and it must take a learning approach, so that feedback from actions shapes future strategies. And of course it must have sustained and adequate funding for the task at hand. I believe that this type of approach is what's required in the trial sites. We need to far better understand the sources of the problem and then tailor a response that is informed by community knowledge, especially young people's experience, with participation in research and drawing on expertise that is available locally or elsewhere. In one valuable study I refer to in **Appendix A** young Aboriginal people acknowledged that they binge-drank due to boredom, but when pressed further, "boredom" really meant no hope in life, no meaning - so it is this lack of meaning and hope that has to be tackled among young unemployed Aboriginal people it seems – and probably among all unemployed young people.

2. **Given the problems that Government wishes to tackle in Hinkler there are far better options which may generate more successful outcomes than a Cashless Debit Card.**

A quick search of data about the Hinkler region shows that there are some persistent characteristics of the area.

The region has higher than Australian average rates of older people, and people with disabilities, high unemployment rates, lower education rates (less than 60% of 25-34 year olds completed year 12 in 2011) and high rates of young people neither working nor studying and lower than average education rates overall. Another interesting feature of the region is the relatively high number of people who are engaged in voluntary work with organisations, or in childcare of their own or others' children or who are providing care to other members of their family or others.

Rates of unfilled vacancies are *lower* than the Australian average, indicating that while strengthened education and training may help some job-seekers into work, the key strategy required is economic development and job-creation. **There appear to be insufficient jobs to overcome persistent unemployment.** Sanctioning individuals and families for this situation in which they are suffering intergenerational unemployment is not the solution. **Economic development and job creation is where priority focus should be.**

There is no doubt that persons with higher level education – ie some post school qualification (whether TAFE Certificates III or IV or a Bachelor's Degree for more professional jobs) - increases the chances of employment. So improved pathways to assist young people into jobs through such technical, vocational and university education will be valuable, the reality is that there are not enough jobs to go round. There is then a vicious cycle as young people do not have work experience in the areas they are seeking employment, and this is a major reason that employers say they are unsuitable for jobs. They may also not have the motivation, communication, confidence and 'soft skills' needed to hold a job. Thus some innovative programs to help them develop such skills, become work ready and have the confidence and resilience to transition from unemployment to a job may be essential as well as further training that is targeted to the growing sectors of the region's economy.

Structurally, employment in manufacturing, agriculture, forestry and fishing and construction industries in Wide Bay region have declined over the last decade or more, but the growth sectors are in health care and social assistance, including aged care, and jobs in lower skilled areas such as retail and hospitality seem to be available. It is also notable in the ABS statistics that there are many young people in the 20-45 age range who are absent from the region, and have obviously left to seek education and work elsewhere. For intergenerationally unemployed families such options are usually impossible because of the costs of such a move.

An interesting article by Professor Jeff Borland (Economics, Melbourne University) following his participation in an important national dialogue organised by Social Ventures Australia about youth unemployment in Australia is worth quoting (Borland 2014). He made the point that where economic opportunities are limited it is *always* the youth that lose out in the labour market and he concluded the following, based on the discussions at that workshop:

- "Assistance to the unemployed should ideally involve a job placement. This is the best pathway to long-term employment and the best context for increasing skills. Many employers are willing to support initiatives to improve outcomes for the unemployed; for example, by providing job placements.
- A prerequisite for employers to offer placements is that they want workers who already have basic capabilities needed for work. They are happy to partner not-for-profits/service providers who can do the work of giving the unemployed those basic capabilities. An example profiled on the day was a partnership between Leighton Contractors and Beacon Foundation and CareerTrackers.
- Not-for-profits can also successfully create job placements that improve the employment prospects of young unemployed. A leading example is the STREAT program which provides young jobless homeless youth with the training and skills for a career in the hospitality sector.
- To support building relationships between business and not-for-profits or service providers it is necessary to have a local or decentralised model of assistance for the unemployed and the young who are making the transition from education to work.
- Part of the local assistance to young people making the transition from education to work should be a greater role for schools and suppliers of tertiary education in providing opportunities to engage with the workplace. For example, having more information on work options allows students to make better study choices and provides greater motivation for study.
- Training and obtaining a formal qualification can be an important part of improving outcomes for the unemployed, but the incentives to undertake training and the value of training are greatest when it is matched to a job placement.
- All this can only happen if we have government funding that supports a decentralised model of assistance to the young unemployed. Any funding model should require that specified outcomes be achieved, but must also allow greater flexibility and less bureaucracy than current government schemes.
- The government funding model should recognise that "you get what you pay for". Some young unemployed have a substantial level of disadvantage, which will require significant spending for them to acquire basic capabilities for employment. Therefore, it is necessary to take a long-run approach to benefit-cost in evaluating this type of spending
- It is important to make more effort to do rigorous evaluation of programs that seek to assist the unemployed, as a basis for refining our knowledge of what is most effective.

- Applying these principles to the design of programs for young unemployed would be a big step forward in Australia. It would give us a good chance of, as one participant put it at the Employment Dialogue, "getting money to where it will be most effective and starting to make a difference".

So it seems that government needs to develop strong partnerships with NFPs and the private sector to develop a long-term community-based and regional strategy and the necessary programs for the young unemployed of this region. A well designed social and economic strategy is essential.

Social Programs

As it seems drug and alcohol issues are significant social problems in the region, best evidence-based practice should be drawn upon to solve these problems. It is hardly surprising that the region has high rates of depression, self-harm and injury if people remain poor, unemployed and face this prospect into the future. ***Drug and alcohol problems and mental health issues need treatment which no Cashless Debit Card can provide.*** There may be such programs in the area, but how well are they all coordinated? How well are they reaching the significant number of people needing them? Do they amount to a real pathway for people out of their problems? What evaluation has been done of all this? ***The best treatment may well be better life opportunities through job creation***.

Many of the non-profit organisations that work daily with people facing these challenges have developed excellent programs of wrap-round support that help people overcome their problems and start on pathways to a better life. This is where the Government and this Committee should look for advice about how to transform the problems facing young people in the Hinkler electorate. A few million dollars spent on well-crafted evidence-based programs could begin to turn these issues around for the long term, (rather than wasting $1.6 million on such a poorly designed evaluation of the CDC). And the Government needs to take a much longer-term view of these issues, with strong programs at school level to prevent perpetuation of this situation.

3. **If any income management support is to be used it should only be as part of a much wider family case management program, where an entire family is supported to recover from complex problems with an intensive mix of social supports over a sustained period, and it should be only in extremely complex cases if some family members would find it useful during a period of transition. The decision to use it should be voluntary.**

Some families or individuals may find having a card to prevent them or other family members accessing illegal drugs, alcohol, or gambling useful. The evaluation in other sites, though extremely badly implemented, does indicate that some people found having a card helpful. Unfortunately nothing in that evaluation indicated which people, under which conditions, this might be. It is therefore not really possible to say who might or might not find a card useful. In my view, and in all the evidence I have seen and heard to date (including that previously given to your Committee), the likelihood of success is greatest where a card is used voluntarily and is part of a much wider set of wrap round services to help families or individuals deal with their problems.

Conclusion

In defending the Cashless Debit Card during its Second Reading Speech, Mr Pitt, the Member for Hinkler, made the following comment:

> "I accept that this is not a panacea. This is not the only way to deal with this, but this is the only policy that is on the table" (Hansard 21 June 2018:23).

This is precisely the problem. **It should not be the only solution offered** to the people of Hinkler, and particularly not to the unemployed young people of Hinkler. They deserve more thoroughly researched, innovative and proven solutions than they are being offered here, because there is no single solution, no magic bullet like a CDC. A mixture of strategies, economic, social, and educational will be required. What is the card going to do to stimulate economic development? How will it encourage young people to enhance their education and boost their training? It may reduce easy access to alcohol and drugs, but people who are addicted will soon find ways to satisfy their addictions, including through crime, so over time it will probably not solve that issue either.

I strongly urge the Government and this Committee to take a step back and consider a wider range of options that would be more effective, and more *cost* effective, particularly over the longer term.

I urge the Government to stop wasting scarce public resources on unproven experiments and take seriously their responsibilities as leaders in this society to address the social and economic development challenges facing people in areas where structural transformation is hitting them hard. If young people had hope in their futures, their likelihood of self-abusive behaviour would reduce substantially, and they would be able to turn their lives around.

Sources used in this submission:

Australian National Audit Office (2018) The Implementation and Performance of the Cashless Debit Card Trial, Department of Social Services, Auditor-General Report No1 2018-19 Performance Audit

Australian Government Department of Employment, n.d. (approx. 2014) Labour Market Conditions in the Southern Wide Bay-Burnett region.

Australian Government Department of Employment, (2014) Labour Market Conditions in the Bundaberg region

Ivan Neville (2013) Bundaberg-Hervey Bay Priority Employment Area, Presentation, Bundaberg 20 March 2013.

Borland J (2014) Unemployment is hitting youth hard: This is what we should do. *The Conversation* 20 June 2014.

Australian Bureau of Statistics: Data by Region: Bundaberg, Hervey Bay

I also attach my previous submission and published articles about the Cashless Debit Card as Attachments B-D.

Attachment A

Research findings in relation to evidence of what works in reducing alcohol abuse and family violence in Australian Aboriginal communities.

What does the evidence say about **reducing alcohol use** through various measures? Firstly it is clear **no single measure provides a solution**. The current National Aboriginal and Torres Strait Islander Peoples' drugs strategy (2014-19) covers alcohol & all other drugs and is based on wide consultation with Alcohol and other Drug (AOD) experts and was developed by the Intergovernmental Committee on Drugs (IGCD). 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 demand ….need 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 (ATSI) ownership of solutions (ie through ATSI controlled organisations)
- Holistic approaches that are culturally safe, competent and respectful
- Whole of Government partnerships
- 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 very recent and scholarly review of the evidence (Review of the harmful use of alcohol amongst Indigenous Australians) conducted by Murdoch 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 [45] [108], decisions about the type of strategies to use may need to continue to come from observed assessments, or evidence from other populations and settings [96]. 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"

The report also states:

> Aboriginal community-controlled organisations offering Indigenous-specific alcohol and other drug interventions are limited by a lack of resources, short-term funding, difficulty attracting qualified and trained staff, and trouble accessing training and workforce development for staff [9]. Community-control alone is not enough if an organisation is under-resourced and inadequately staffed, and these limitations need to be addressed (p?)

In WA Alcohol and other Drug services across the state are severely underfunded to meet the level of demand (Government of WA Mental Health Commission 2014 p20), so it is very unlikely that even if all other conditions were met, that the resourcing would be there.

Fitzroy Crossing gives us an example of how community-led solutions are working at least with one targeted sub group – pregnant women. According to pediatrician James Fitzpatrick the community-based 'Making FASD History campaign', has reduced the rate of drinking by pregnant Fitzroy women from 60 per cent in 2010 to 15 per cent in 2017 (Fitzpatrick personal website). A smaller program in Kununnurra run by the Ord Valley Aboriginal Health Service as far back as 2008 also had rates of alcohol use by pregnant women drop by 50% in just a 12 month period (Bridge 2011).

What does the evidence say on **successful approaches to reduce Family Violence** in Aboriginal communities? ANROWS commissioned a major review of the evidence available in Australia and the researchers found:

- Solutions are likely to focus on healing, restoration of family cohesion and processes that aim to let both the victim and perpetrator deal with their pain & suffering
- Indigenous communities want to play a stronger role in shaping programs and services, and services need to be culturally sensitive
- Rebuilding family and kinship ties is often central to any response
- Ongoing planned and consistent funding for service provision is considered a major issue. (Olsen and Lovett 2016)

I would add that global evidence indicates that Family Violence is associated with gender inequality.

This is what the evidence says. So my question is: Has all this been tried simultaneously and with adequate resourcing in the trial sites and the proposed sites? Is there genuine Aboriginal control of these measures in the trial sites? Has this been evaluated and what has been learned?

The second point to make is this: Just focussing on these behaviours will not provide a lasting solution. I want to use a small study undertaken in a remote Queensland community to illustrate 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.

Beat da Binge was a 2-year 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. 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 is far more widespread among some Aboriginal (and non-Indigenous) young people (and some 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, and 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.

References

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Edith Cowan University & Department of Health and Ageing (n.d). Review of the harmful use of alcohol amongst Indigenous Australians, HealthInfo Net Australian Indigenous Health Plain language

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Dennis Gray, Mandy Wilson, Steve Allsop, Sherry Saggers, Edward Wilkes & Coralie Ober (2014) Barriers and enablers to the provision of alcohol treatment among Aboriginal Australians: A thematic review of five research projects *Drug and Alcohol Review* (September 2014), 33, 482–490.DOI: 10.1111/dar.12137

Dennis Gray, Sherry Saggers, Brooke Sputore & Deidre Bourbon (2000) , What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians*, Addiction,* 95(1), 11- 22.

Janya McCalman, Komla Tsey, Roxanne Bainbridge, Anthony Shakeshaft, Michele Singleton and Christopher Doran (2013) Tailoring a response to youth binge drinking in an Aboriginal Australian community: a grounded theory study, *BMC Public Health* 2013, 13:726.

James P. Fitzpatrick,1,2 June Oscar,3,4 Maureen Carter,5 Elizabeth J. Elliott,2,6 Jane Latimer,7 Edie Wright,8 John Boulton9,10 (2017) The Marulu* Strategy 2008–2012:overcoming Fetal Alcohol Spectrum Disorder (FASD) in the Fitzroy Valley Australian and New Zealand Journal of Public Health, vol. 41 no. 5: 467-473.

Anna Olsen, Ray Lovett (2016) Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: State of knowledge paper, Sydney : ANROWS.

Western Australian Mental Health Commission (2015). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*. Perth, Western Australian Mental Health Commission

Attachment B

Legislation Inquiry Social Services Legislation Amendment (Cashless Debit Card Bill)

I write to you as an experienced social science researcher with over 30 years of experience in the fields of international and Indigenous development. I am as concerned about the situation of Indigenous people in Ceduna and the East Kimberley as anyone, and very much want to see their lives improve. However, I am also very much driven by evidence about what works, and as a social science researcher am concerned that the evidence provided for policy making is the most robust and credible as possible.

This legislation seeks to make possible the extension of the Cashless Debit Card trial in Ceduna and the East Kimberley and facilitate the expansion of this program geographically. My concern is whether the evidence of the evaluation supports this continuation and expansion.

My interest in this was sparked when the Wave 1 Report was released in March this year, and I decided to look at what the evaluation said. I was shocked when I read the report, as the Minister had already announced that the trial was a success and would be continued indefinitely. When I read the report, I discovered that it was extremely flawed and did not provide adequate evidence to draw the conclusions that had clearly been drawn. As I was extremely concerned at the poor quality of the evidence on which the Minister had made his decision, I wrote a critique of the Wave 1 Report, which was peer-reviewed and published by CAEPR as a Topical Issue. I attach that critique. http://caepr.anu.edu.au/Publications/topical/2017TI1.php.

Given my concerns about the quality of the Wave 1 Report and the Minister's interpretation of data from it, I was naturally interested to see whether the Wave 2 Report was a better report. In this case, the Report addressed some of my concerns (e.g. it gives better contextual information at the front), but remains problematic. In addition, where the Report's authors have qualified their positive findings with many caveats, these have been ignored by the Minister in his public statements about the evaluation.

Eva Cox[1] has highlighted many of the problems with the Wave 2 survey design, the way interviews were conducted, and the ethics of the process, all of which would suggest that the results presented should be treated with great caution. Her criticisms of the evaluation process are valid But I have tried to explore what can be drawn from the data that is presented, flawed as it is. Is there any evidence that this trial is achieving its stated objectives?

First, it is important to emphasise some problems with the evaluation design and the reporting of results, which create problems in trying to make sense of the data presented:

- People were approached for an interview, by people they would not have known, in public places, about a government program. If they agreed to be interviewed they were asked for their ID. This may well have affected any of people's answers, as Eva Cox notes. But in particular, having provided ID, their answers to questions about use of illicit drugs or any other activity that might be illegal or reportable, would almost certainly avoid revealing any such activity. The fieldwork was conducted shortly after the 2017 Federal Budget announcement of proposed drug testing of people on welfare, when this would have been

[1] https://www.theguardian.com/commentisfree/2017/sep/07/much-of-the-data-used-to-justify-the-welfare-card-is-flawed?CMP=share_btn_link

particularly sensitive.[2] The ethics of this approach is dubious, and the results likely to be of little value.

- The data from the two sites are weighted equally which favours the findings from the Ceduna sample that are slightly better than from East Kimberley. Yet the East Kimberley has by far the majority of the CDCT participants (1,247 compared with 757 in Ceduna at the outset), and their responses are thereby discounted. The sample should have been in proportion to the participant numbers in each site to give a true picture of the trial outcomes.
- While the report provides initial guidance on the confidence levels required for statistical significance of the reported findings, it rarely cautions in relation to data it provides where the statistical significance of results is very dubious due to small numbers. This can give a misleading impression about change in a number of places throughout the report. Such change may just be due to variation in the sample of respondents, and not reflect a statistically significant difference.
- The sampling approach in Wave 2 is a strange mixture of a longitudinal sample and systematic intercept sampling; whilst much is made of the longitudinal sample in the early part of the report there is absolutely no outcome data provided from that sample of 134 people who were recontacted from the Wave 1 sample. Instead this group was added to the new intercept sample from Wave 2 without explanation of the reasons for doing this. This is to add a non-random sample (people who could be contacted again) to a random sample. Further it is hard to see the Wave 1 and Wave 2 samples as comparable, when in the first Wave, 31.5% said they never drank, gambled or used illicit drugs but in Wave 2, almost 42% said they never did so. Whilst the evaluators say they applied a number of statistical procedures to deal with some of these issues, the logic and rationale for what they have done is very unclear.
- The Wave 2 data is presented differently in some respects from that in Wave 1 so that it is difficult if not impossible to make comparisons. For example, in relation to alcohol, Wave 1 reports data from participants and family members together but Wave 2 only reports data from participants, as family members were not interviewed. So the results are not comparable.
- Overall, the design of the evaluation appears to take little account of the many important principles for conducting research among Aboriginal and Torres Strait Islander communities set out in the AIATSIS Guidelines for Ethical Research, and makes no mention of them.[3] Evaluation is a form of research, and the participants in these trials are overwhelmingly Aboriginal and Torres Strait Islanders.

What was the trial supposed to achieve?

According to the Orima Initial Conditions Report (2016,p*i*), this trial is 'to deliver and manage income support payments (ISPs) with the aim of reducing levels of community harm related to alcohol consumption, drug use and gambling.' Of these, the greatest concerns the community expressed

[2] http://www.abc.net.au/news/story-streams/federal-budget-2017/2017-05-12/federal-budget-2017-pm-says-welfare-drug-test-plan-based-on-love/8520564

[3] https://aiatsis.gov.au/sites/default/files/docs/research-and-guides/ethics/gerais.pdf

before the trial began were about alcohol, with some also fearing that drug problems, notably ice, could increase in the future; and although gambling was present, there was less concern about its effects. Concerns about high levels of crime and violence were associated with alcohol in particular.

The program logic suggested that after 12 months, there should be sustained reductions in alcohol consumption, illicit drug use, and gambling resulting in less criminal and violent behaviour, fewer alcohol-related injuries and an increased sense of safety[4]. A number of performance indicators and sources of data to assess these indicators were identified. Bearing all the caveats above in mind, I have tried to understand the key results against these indicators, with a particular focus on the views and behaviours of the CDCT participants themselves.

Alcohol reduction

The Wave 2 report focusses on what people said about *change in the amount of alcohol* they consumed since joining the trial rather than their reports about *current alcohol useage*. These reports of change were positive, indicating that people thought they drank less than before the trial commenced. However, such recall over a year is not likely to be very reliable, and given the context of the interviews, people may have said what they thought the interviewer wanted to hear. The reporting of 'alcohol behaviours done lately' which might have given more reliable data than reports of change over time, is impossible to compare from Wave 1 to Wave 2. In Wave 1 data presented is for participants and family together, while in Wave 2 data is given for participants only, and only those who drink at all. Thus we cannot tell if reports of *actual behaviours* show any change. It would have been perfectly possible to present the participant only data from Wave 1 with the same for Wave 2 but that was not done.

There is also a question about the program logic behind an expected reduction in alcohol consumption between Wave 1 and wave 2 reports. The report says that people reported *a change in their alcohol consumption* between Wave 1 and Wave 2. At Wave 1, participants were already receiving their income support payments through the CDC, so their ability to purchase alcohol was already restricted. As welfare recipients it seems unlikely that they would have savings to draw on to purchase alcohol, which might reduce as time passed. So what is the program logic that would support the idea that alcohol consumption would continue to reduce many months after the CDC was first operational? That is unclear.

If self-reports of alcohol consumption may be influenced by individual's concerns that other sanctions could be introduced if their alcohol use has not dropped, participant reports of change in the community may be more likely to be accurate than their reports of their own alcohol use. Fig 12 (p.47) presents participant perceptions of change in alcohol use in the community at the two sites since the trial started. The results are very mixed. For example, in East Kimberley 20% of respondents say there has been more drinking and 18% say there has been less. In Ceduna, 14% say more, 23% say less, but 25% can't say. The largest proportion in each site say the level of drinking is the same. Non-participants in the trial have a more positive view. It is very unclear why there is such variation in these views and this is not investigated further, which it should have been.

There is also no sales data from liquor outlets checked against people's reporting, but there are anecdotes which suggest change in the right direction. In contrast to the Wave 1 report, there has been some attempt to separate the impacts of simultaneous alcohol restrictions from those of the CDCT, which suggests most of the change reported (if it is to be believed) is attributable to the CDCT. However, overall, this data raises as many questions as it answers, and if in fact there has been a

[4] Fig13 Program Logic pA8 ICR

significant decline in alcohol use, then there are further questions about the program logic behind the trial, which are explored below, as the community harms thought to be attributable to alcohol appear to persist.

Gambling

The Wave 2 report suggests that there is reduced gambling, however there were a number of qualifications to claim in the Report which were completely ignored by the Minister. These included that this did not seem to be the case in the East Kimberley, where both participants and non-participants[5] were more likely to say that they thought gambling had gone up.

In Ceduna the issue is poker machine use, and so revenue data from poker machines can provide some more objective measure of change (although clearly many people who use the poker machines are not on the CDCT). The available data on revenue from poker machine gambling however, covers an area far larger than Ceduna and reflects a 12% reduction over the twelve months following the introduction of the CDCT. The report makes clear that only 40 out of 143 of the poker machines which the data covers are in the CDCT area. This could suggest that a 12% reduction in gambling revenue over a year was not predominantly due to the CDCT, but due to other factors across the region. Or the drop may be focussed in the CDCT area. There is no further investigation about this in the evaluation report, so it is hard to draw conclusions.

What is noticeable from Fig 19 on poker machine revenue (p59) is that the level of revenue fluctuates through the year, and has increased in the three months since Jan 2017 to a level higher than in April 2016, suggesting no clear downward trend in gambling is apparent, even if expenditure on gambling has reduced. In fact a stronger downward trend was evident in 2015-16 before the trial commenced. In summary, the data presented cannot confidently support claims that gambling has significantly reduced at both sites.

Illegal Drug use

The data about illegal drug use is probably the least reliable. Importantly, the Wave 2 results may be considerably affected by the publicity about drug testing of welfare recipients, particularly just prior to the Ceduna fieldwork in May 2017. Furthermore, although self-reports suggest a drop in illegal drug use, the numbers of respondents are small and the reliability of the data in such small numbers is low. Using Orima's own guidance about the confidence one could have in the statistical significance of the results, the possible reduction may be far smaller than first appears.

Other performance indicators

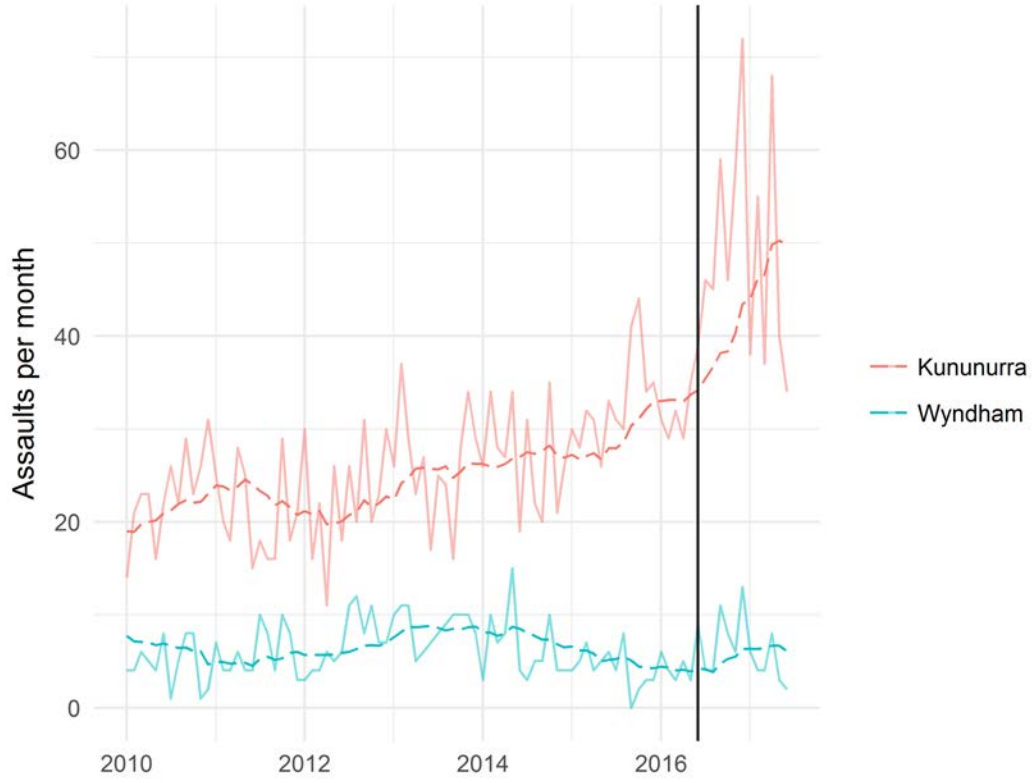
Rates of drug and alcohol related injuries and hospital admissions were listed as performance indicators and some data is presented which suggests that alcohol-related attendances at hospital emergency and outpatients departments in Ceduna have dropped. In East Kimberley the report says that there have been fewer alcohol-related pick-ups by the Community Patrol. However, there may be other explanations for the latter which are not explored and ruled out, for example whether the Community Patrol was functioning every night throughout both periods that were compared.

The percentage of respondents feeling safe was another indicator, and the report acknowledges that that there was 'no statistically significant change' between Wave I and Wave 2 data collection on participant and non-participant feelings of safety. Concerns for safety at night remained, particularly in the East Kimberley.

[5] The non-participant result was not statistically significant however.

Finally the indicators for violence and other types of crime and violent behaviour were to include police reports as well as perceptions of participants and others. No administrative data is provided for any of these, so the only data provided is perceptions of those interviewed.

Interestingly the views of CDCT participants were very mixed on this, and in the East Kimberley more participants thought that violence had increased than thought it had reduced. This is certainly borne out by data on assault offence/incidence reports from the WA Police which rise sharply around the time the CDCT began in the East Kimberley in mid-2016, as the figure below indicates.[6] This data itself needs to be treated with caution as there may have been a major change in policing behaviour that contributed to such a sharp rise in such reports, but it is consistent with the CDCT participant perception data. In relation to crime, the report itself states that administrative data did not show evidence of reduced crime since the trial began, and in fact crime increased in the East Kimberley as it did in Derby, a comparator site. This suggests that the CDC was not able to counter whatever is causing this crime.



Looking at the bigger picture

The CDCT was designed to reduce the levels of harm underpinned by the three behaviours targeted. In the early stage of the trial the community consultations identified the adverse consequences of these behaviours as relating to:

[6] https://www.police.wa.gov.au/Crime/Crime-Statistics-Portal
The vertical black line indicates 1 June, when the roll out of the CDCT in the East Kimberley was almost complete.

- Health effects
- Safety and security
- Financial problems
- Social problems such as humbugging and unemployment
- Inability to secure stable housing and overcrowding
- The impacts on the wellbeing of children.

Whilst one cannot expect major change on all these fronts in 12 months, what is of concern is that there appears to have been limited or no change in relation to many of these adverse effects identified by the communities before the trial began, *even if the reductions in the behaviours targeted are real*. As indicated above, there appears to be no change in perceptions of safety and in fact in East Kimberley perceptions of safety after dark may have worsened. Further, there seems to be no reduction in perceptions of violence or in assaults, whether domestic violence or other, and data from the East Kimberley suggest that things may have got substantially worse.

The one key area where some positive change may be emerging is in financial management – the card does appear to be helping some people manage their money better, and there are various pieces of evidence that indicate this. In all the other areas the data reveals no change or is very mixed. Health gains would be too soon to see, except where underlying health problems are now more evident, and that may be the case in a few instances according to the report.

However, the real problem, which the CDCT does nothing about, is the level of poverty people are experiencing. And as the report itself says , 'on average across the two sites, at Wave 2, participants were more likely to indicate that it *(i.e. the CDCT)* had made their lives worse than better.' (p 82). The data presented says that 23% said the trial made their lives better and 32% said it made their lives worse. It did not explore whose lives were getting better or worse. Given that many participants in each of the samples never undertook any of the three behaviours the card was targeting, I would want to know if their lives were made worse, and I would want to know if those whose lives were better were actually any of the targeted individuals. The report does not explore this, so we really do not know where any benefits are being felt or where serious problems may be occurring.

While some reports suggest parenting and family well-being may be improving, there is data which suggests this is not the full story. The report shows that around a quarter of participants run out of money for food at least every two weeks, and over half have run out of money for food in the last three months, and this may be worsening. And there are mixed findings in relation to children's wellbeing. Around 44-45% said they had run out of money to pay for essential non-food items for children (like nappies, clothes, medicine) in the last three months, and 19% had done so at least every two weeks. Such findings in themselves should raise alarm bells. If participants whose income is so firmly constrained through the CDCT cannot feed themselves or buy essentials for their children then there is a problem far larger than the card can address. In addition, parents gave mixed reports about the impact of the trial on children's lives with 17% saying it had made their child's lives better and 24% saying it had made children's lives worse (p6).

There are mixed reports about humbugging with some saying it has reduced and others experiencing more humbugging. Although there is a slight rise in people looking for work, it is hard to know if that is statistically significant, and whether it relates to the CDCT or to the pressure from the CDP program (in East Kimberley in particular). The fact is that more economic development initiatives are needed to help create suitable jobs in these locations or people will simply not be able to exit from the CDCT. The other concerns expressed at the outset of the CDCT, housing and overcrowding, are not addressed at all by the CDCT.

The use of increased services

Associated with the CDCT was funding for increased services. The report does not make clear exactly what those service increases were in each location, but does conclude that the card, rather than the services, has had the greatest impact on the result. There seem to be several reasons for this: the significant delay in providing additional services; the narrow range of services provided; and the lack of awareness on the part of trial participants of the services available. Some people had obviously found some value in the services that they had used. The contribution services might make in the future could be greater, one assumes, as they become better known, and perhaps if a broader range were provided to address the many issues identified above.

Conclusion

The Prime Minister was in Western Australia on 3 September, claiming the enormous success of the trial.

> *It's seen a massive reduction in alcohol abuse, in drug abuse, in domestic violence, in violence generally; a really huge improvement in the quality of life, not just for the families who are using the Cashless Welfare Card, but for the whole community. But above all, above all it's an investment in the future of the children.*[7]

Someone needs to tell him that the report commissioned by his Minister does not say that, and that the evaluation undertaken has serious flaws. So what to do?

There are two ways to think about what conclusions we can draw from the trial about the CDC program and its intent. First, perhaps, despite all the flaws in the evaluation, there has actually been positive change on the ground in relation to the three behaviours targeted. If that is the case, these behaviour changes do not appear to have had much impact on the harms that the program was supposed to address, particularly in relation to safety and violence which were the community's big concerns. If so, the program logic has been built on some wrong assumptions, such that despite any behaviour changes, the underlying problems remain and the program needs rethinking.

The other way of thinking about this is to suggest that perhaps the program is not reducing the alcohol, drug and gambling behaviours it was meant to target. This could be because people are finding ways around the constraints of the card, or because the problems require far more than a card to solve them. In which case the program also needs rethinking.

What is clear is that the complex and interrelated problems of drug and alcohol abuse, poverty, unemployment, poor or overcrowded housing, and violence need solutions that will work to improve the overall wellbeing of adults and children. These solutions are likely to be multi-faceted and undertaken with strong engagement of the people whose lives they are meant to improve, not imposed in a punitive way. Senator Patrick Dodson has called the trial 'a public whip'[8], and one of its influential Kimberley advocates is now saying it is not working[9].

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[7] https://www.malcolmturnbull.com.au/media/address-to-the-wa-liberal-party-state-conference-3-september-2017

[8] https://www.theguardian.com/australia-news/2017/aug/22/pat-dodson-says-cashless-welfare-card-a-public-whip-to-control-indigenous-people

[9] https://www.theguardian.com/australia-news/2017/aug/23/aboriginal-leader-withdraws-support-for-cashless-welfare-card-and-says-he-feels-used

On the basis of the evaluation the Government cannot legitimately claim the success it is claiming and it should not roll out any more of these trials at the present time. The results are too poor and ambiguous to warrant the public expenditure.

Acknowledgments

I am grateful to Rob Bray and Francis Markham for assistance in making this analysis of the Orima Wave 2 report. However all responsibility for the accuracy of information in it and for the analysis remains mine.

8 September 2017.

Any evaluation of government programs is complex and difficult, and attributing particular outcomes to specific program interventions in particular places is always tricky. In order to deal with this problem, which is inevitable in the real world, evaluators use an approach known as Contribution Analysis. http://www.betterevaluation.org/en/plan/approach/contribution_analysis. It would have been far better if such an approach had been used for this evaluation. This is particularly the case, since from the outset in both locations there were simultaneous alcohol restrictions in place and it would be important to get a sense of the contribution to change that they might be making, as well as the contribution of additional services that were supposed to have been provided as part of the trials. Furthermore, this program had a program logic set out in the Initial Conditions Report, and Contribution Analysis is particularly well suited to a context where a program logic is clear.

Attachments C & D – CAEPR Topical Issues 2017 Nos 1& 2 are provided in separate files.