Submission to the Senate Community Affairs Legislation Inquiry into the Social Services Legislation Amendment (Cashless Debit Card) Bill 2017

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Introduction

Thank you for the opportunity to make this submission. I write 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. 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 is both in order to get the best outcomes, but also to ensure the greatest efficiency in public expenditure.

The proposed 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 trial evaluation supports this continuation and expansion, and whether the considerable cost of this program is reaping commensurate benefits. In public policy there are always opportunity costs of any expenditure. In other words, my concern is whether this program is the best way to spend limited public funds to reach a desired outcome or if there are more cost efficient and effective alternatives.

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. It is this Wave 1 evidence which the Statement of Compatibility with Human Rights relating to this Legislation uses to justify the proposed legislation. I argue that this evidence is flawed, and does not provide a sound basis for continuing the Cashless Debit Card Trial (CDCT) program. Whilst superficially appealing, a careful analysis of the evaluation reveals many problems with the purported findings.

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 read the Wave 2 Report. Just before the report was released, the Minister issued a Press Release which hailed the success of the trial without qualification. But once the Report was public it was clear that the Report's authors had in fact qualified their positive findings with many caveats which have been completely ignored by the Minister in his public statements about the evaluation. So while I have serious problems with the evaluation design and the data presented, I am also aware that the Minister has ignored important reservations about some of the findings that the Report's authors did make clear.

This submission outlines many of the shortcomings of the evaluation, both Wave 1 and Wave 2.

The challenges of Social Science Evaluation

The challenges of social science research of this nature is establishing a baseline of the situation prior to the program intervention; assessing change after a period of the program's operation; and assessing the extent to which the program may have contributed to any change that is measured, since communities are complex places with many influences and factors that could affect outcomes. The issue of attribution (or more realistically, contribution) is central. That is, if there is change, did the program cause it or contribute to it – or were other factors at work that may have affected the outcome? Social Science evaluation has to deal with social complexity and an inability to control all other factors that might affect an outcome of a program, which is inevitable in the real world. One approach to dealing with this is known as Contribution Analysis[1]. This approach enables an evaluator to systematically assess the contribution that a particular intervention has made to outcomes, and includes a step in which counter evidence and counter explanations are considered. Orima Research has not used such an approach, and thus some important steps in their evaluation are missing. In particular, they have not explored data well to try to better understand what it might be telling them.

What was the trial supposed to achieve?

According to the Orima Initial Conditions Report (ICR) (2016,p*i*), the 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 communities expressed before the trial began were about alcohol, with some also fearing that drug problems, notably ice, could increase in the future, although it was noted that due to their high cost, amphetamines were largely used by people in work, and more in Ceduna than the East Kimberley (ICR p24); and although gambling was present, there was less concern about its effects, although the concerns in Ceduna were greater than in the East Kimberley. 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[2]. A number of performance indicators and sources of data to assess these indicators were identified.

Establishing a Baseline

In conducting evaluations to assess change, it is normal to establish the baseline against which change will be judged. This baseline needs to relate to the program's proposed objectives. There was in fact no proper baseline study conducted in either Ceduna or Kununurra by Orima Research[3], the organisation contracted to conduct the evaluation. A proper baseline study would have surveyed potential CDCT participants to assess their levels of alcohol & drug use and gambling before the card was introduced, since the stated purpose of the card was to reduce this usage. There would also be good baseline data about criminal and violent behaviour, alcohol-related injuries and people's sense of safety. As the trial progressed, the same data would be collected and compared with the findings from the pre-trial situation.

There was no survey of potential CDCT participants to assess their usage of alcohol, and drugs or the extent of their gambling. This did not occur until some months after they had been on the card, so it

[1] http://www.betterevaluation.org/en/plan/approach/contribution_analysis

[2] Fig13 Program Logic pA8 ICR

[3] This may not be Orima Research's fault as they may not have been commissioned early enough to do that.

cannot be considered as baseline data. Orima collected some baseline administrative data in the Initial Conditions Report, which seemed to indicate that these data sets would be used at the end to assess any change. In fact, in the Wave 2 Report this type of data was almost entirely missing, even though some was publicly available and relevant. The 'baseline' established at the outset relied on interviews with 37 'stakeholders' who were largely regional leaders and service providers in the towns. These interviews were conducted between 21 April – 26 May 2016. While these gave some valuable information about the concerns these people had, what evidence or impressions they based their concerns on, and indicated some slight differences in emphasis between the two sites, it was not a baseline survey of the participants themselves. The Initial Conditions Report also included, as Appendix A, a Program Logic and Theory of Change. Importantly, this Theory of Change showed that as cash was restricted the need for support services (e.g. drug/alcohol treatment programs) was expected to increase and the services made available would be increased. The logic also identified some potential circumventions of the card, which were to be monitored, and outlined a number of Key Performance Indicators to be used for the Program evaluation. Some output indicators relating to the operation of the card, as well as short-term and medium term outcome performance indicators relevant to the program aims were identified.

Who were the participants in the trial?

The ICR reports that the CDC was to be compulsory for all income support recipients other than Age or Veteran's Pensioners, who could opt-in (6 did). By October 2016, 757 Ceduna residents and 1247 East Kimberley residents were receiving their ISP via the Card. (That number increased slightly by Wave 2). The ICR shows a breakdown by age and Indigeneity, as well as type of payment by total amount of ISP paid. It is not clear how many people in each category are on the card (except in relation to age). In Ceduna the largest payments are to those on Newstart, with the next largest to those on Parenting Payment Single, and Disability Support pension. A total of 82% of those on IPSs in Wave 2 were on these three payments (Wave 2 p287). In East Kimberley the same three categories top the list, though the amount paid for Parenting Support Single is greater than Newstart. The gender breakdown shows more ISP funding going to women on the card than men, and the largest amounts to the age range 25-35 years. By far the greatest proportion of the ISP payments goes to Indigenous people. With the exception of gender in some cases, there is never, in the later analysis, any breakdown of these ISP categories among people interviewed, so we cannot tell whether the card is good for some groups of ISP recipient and not for others. This is a major shortcoming of this evaluation. We also cannot tell whether the people interviewed in Wave 1 or Wave 2 were a reasonably representative sample of these categories of people. Rather, the data was weighted after collection to reflect the proportions against age, gender and Indigeneity, thus potentially extrapolating results from small numbers of interviews. There is no transparency in the Wave 1 or 2 evaluations about these issues. A far better approach would have been to have some targeted numbers of interviewees from each category of ISP type, and/or gender, age and Indigeneity. This would not have been difficult to do, and is regular practice for survey companies.

The Wave 1 Evaluation

The Wave 1 Evaluation report was published in February 2017 and released in March 2017.

I attach the critique that I wrote of it, http://caepr.anu.edu.au/Publications/topical/2017TI1.php. and highlight two key points from it, although note that even these need to be read with caution due to the methodological problems with the whole evaluation:

'According to the report, 22% of participants reported reduction in at least one of the three targeted behaviours, but notably 34% said they did not practise any of those behaviours before the trial and 43% reported no change. Thus *for 77% of participants there has been no positive impact of the trial*.'

'The most significant finding is this:

> Amongst family members, 27% said the Trial had made their family's life better and 37% that it had made it worse (net –10pp, see Figure 12). Across participants interviewed, 22% said it had made their lives better and 49% that it had made their lives worse (net change –26pp). These figures were fairly consistent across the two Trial sites (Orima 2017:34).

That almost half the participants felt that the trial had made their lives worse is a worrying result, particularly given the rather limited substantiated positive results to date. Though we can welcome the fact that 22% felt their lives were better, the question is, at what cost? Is it acceptable for public policy to make more than twice as many participants' lives worse in order that 22% can say their lives are better? Calculating a so-called 'net' improvement is hardly valid when we are talking about different participants and their families who are experiencing real outcomes.' There is also the question of the cost of this program if 77% say it had no positive impact on them.

The attached critique presents a great deal more detailed analysis of the Wave 1 report and the conclusions drawn from it.

One important additional point to note is that the Community Panels which were meant to have been established early in the process were late commencing, and had still not commenced in the East Kimberley at the time the Wave 1 report was produced. This issue is one of a number of reasons a senior Kimberley leader who initially supported the trial withdrew his support in August 2017.[4] The Community Panel was intended as a mechanism to vary the proportion of the ISP which had to be quarantined on the card if people requested this and were able to show that they would be responsible in their expenditure.

Secondly, the increased services that were meant to have been ready to meet the increased demand once the card commenced had not yet really begun, and in any case few people reported using services in the Wave 1 interviews.

The Wave 2 Evaluation

For a brief summary of the problems with the Wave 2 Evaluation please see the attached.

http://caepr.anu.edu.au/sites/default/files/Publications/topical/CAEPR_Topical_Issue_2_2017.pdf

Methodological problems with the Wave 2 Evaluation

The Wave 2 Survey report was an improvement on Wave 1, if only because there was a little more transparency, for example, copies of the actual questionnaires used were appended. However, highly regarded social policy analyst Eva Cox[5] 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. In particular, for Aboriginal participants in the trial, there are many

[4] MG Corporation Press Release 22 August 2017 'My people have spoken'.
[5] https://www.theguardian.com/commentisfree/2017/sep/07/much-of-the-data-used-to-justify-the-welfare-card-is-flawed?CMP=share_btn_link

aspects of communication that might affect the outcomes. The offer of a $30 or $50 voucher for each participant at Wave 2 (the higher amount for those also interviewed at Wave 1) would have been a substantial incentive for people to be interviewed but they may well have been worried that if they did not say things were getting better that further sanctions would be applied in their community. Originally Orima had planned a longitudinal survey but this was clearly too difficult to operationalise in practice, and it did not happen.

It is important to emphasise some major problems with the evaluation design and the reporting of results, which create problems in trying to make sense of the data presented, or which may make such data unreliable:

- 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 identification. 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 particularly sensitive.[6] The ethics of this approach is dubious, and the results likely to be of little value. Overall, in relation to any of the behaviours, many trial participants interviewed may have been concerned that if they did not say things were getting better the sanctions imposed may have been increased.

- The issue of 'gratuitous concurrence' is well known when interviewing Indigenous people, particularly those for whom their first language is not English. That is, where direct questioning is used, people will agree with a statement rather than not respond (for example where they have not fully understood) in order to keep the interaction going or hasten its conclusion. This is well recognised in the legal context, for example. This can easily lead to results which do not reflect the actual situation.[7]

- 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. Whilst clearly each site needed enough participants to be able to undertake an analysis by site which would have some validity, the imbalance towards Ceduna is problematic. In fact the data are double weighted – first to match by age and gender the proportions of people on the card overall, and then to reflect the two sites equally (Wave 2 p 161). Such weightings could significantly affect the results.

- 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

[6] 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

[7] Eades, D.. Communicative Strategies in Aboriginal English, in Maybin, J & Mercer,N, 1996 Using English From Conversation to Canon, Routledge, London.pp 28-32.

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. Variations that are not statistically significant may just be the result of chance in relation to who was interviewed.

- 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, thus distorting it. 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. The two samples were not comparable. 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.[8] Evaluation is a form of research, and the participants in these trials are overwhelmingly Aboriginal and Torres Strait Islanders.

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. 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?

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 reported *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.

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

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. Reductions may be sustained but why would they continue to reduce? There is no program logic to explain that expectation.

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. However, Community leaders and stakeholders reported that alcohol abuse in East Kimberley had increased between Wave 1 and Wave 2 p.44). 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 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 that 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[9] were more likely to say that they thought gambling had gone up. There is also no clear explanation of why gambling would reduce between Wave 1 and Wave 2 when people had exactly the same amount of cash available. If gambling has in fact increased in the East Kimberley, then it would seem that the CDC is not a solution to gambling in that location.

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

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

the evaluation report, so it is hard to draw conclusions. This is an example of the attribution problem mentioned earlier.

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 for obvious reasons. 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 number of respondents is 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. These data cannot be relied upon and Orima itself cautions against the reliability of its own findings in this area (Wave 2 p 50). It also refers to a significant reduction in drug-driving in Port Augusta which is a comparator non- CDCT site. These cautions seem to have been ignored by the Minister's public statements. At the very least these qualifications suggest that factors beyond the card may also be at work.

Other performance indicators

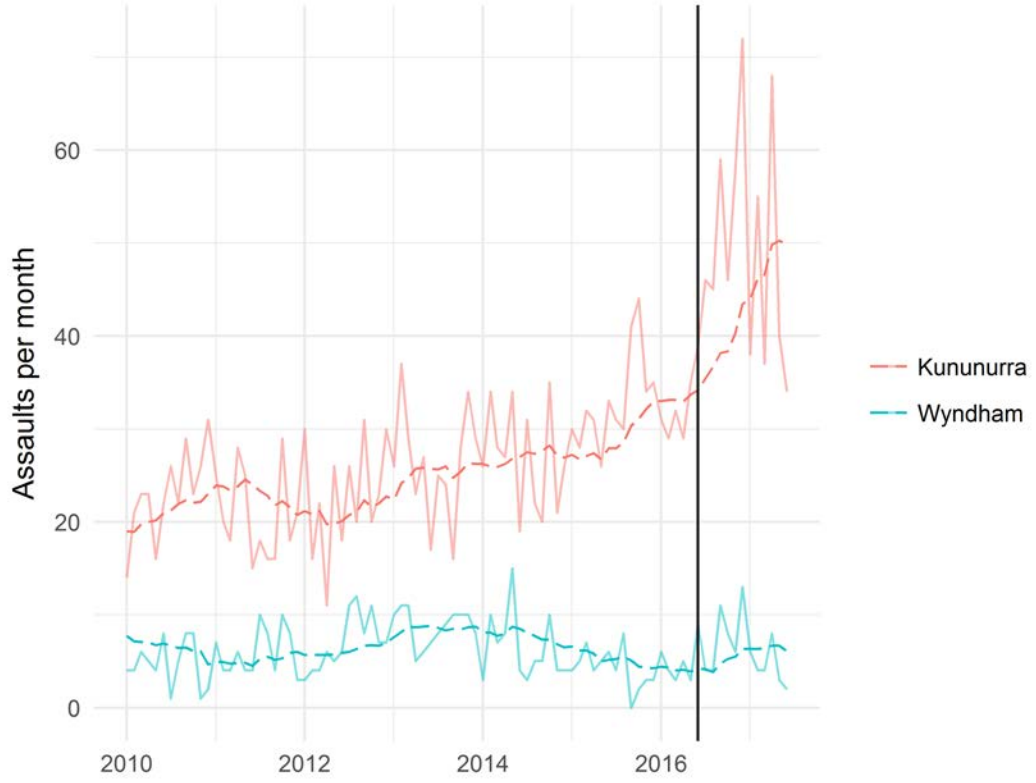
As indicated above, the initial Evaluation plan indicated that a range of administrative data would be used in the evaluation. This would have complemented survey research and helped to 'triangulate' the finding (i.e. find various sources of evidence that all support the same conclusion). However, the administrative data sources eventually used in the Wave 2 report are minimal. 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. However, the Report makes the point that at least some of this may have resulted from more active intervention by the Mobile Assistance Patrol and Sobering up service in Ceduna than from reduced alcohol use (Wave 2 p 48). 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, whether some of the heaviest drinkers had left the town etc. These issues should have been checked and reported.

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. Similarly there was little to no change in crime statistics apparently (Wave 2, p63), although Orima makes the point that police practices may have changed during the reporting period, implying that more crime was now being recorded than previously. This may be true.

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. However, a quick

search of administrative data (e.g. on violence, crime) that are publicly available immediately signals some concerns. Firstly because they are not quoted in the Wave 2 Report and secondly because they run counter to the narrative of the Report.

Interestingly the views of CDCT participants were very mixed on violence, 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.[10] 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 Wave 2 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 caused 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:

[10] 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. However, as will be indicated below, it cannot resolve poverty issues. 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. This is really a very great problem with the evaluation.

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, although numbers were small. 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.

Interpreting the Evaluation reports

The Prime Minister has claimed 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.*[11]

The Wave 2 Report commissioned by his Minister does not say that, and as I have indicated above the evaluation undertaken has serious flaws.

There are two ways to think about how to interpret the CDCT Evaluation. 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, if any, 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 in both locations. 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 and some limited additional services 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

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

imposed in a punitive way. Senator Patrick Dodson has called the trial 'a public whip'[12], and, as indicated above, one of its influential Kimberley advocates is now saying it is not working[13].

All the evidence of what works in Indigenous communities is that programs must engage with people and solve problems with them, not do things to them. It is also interesting to note that whilst these communities have undoubtedly got some serious problems, Orima (ICR) makes clear that both have *higher than the national average levels of people of working age in employment*. So perhaps the problems they have are not related to a higher than average level of ISPs, but have other, perhaps more complex, causes.

As a Social Scientist I would say that the CDCT evaluation does not give the Government a firm basis to claim the success it is claiming for this program; while appearing to bombard one with data, the evaluation is actually unable to genuinely demonstrate the program's success. There is a lot of anecdotal information, and some survey data about people's recall over a year, which is of dubious reliability, and a very select amount of administrative data. There are no data presented from the longitudinal sample in its own right (134 persons), which would have been the most valuable. And the methodology leaves a great deal to be desired, so the results have to be treated with great caution. In summary, the quality of the evaluation raises concerns about the justification for plans to extend the CDCT both in time at current sites and to extend the number of sites. This justification assumes the trials are working. The evaluation evidence cannot be relied on as evidence to support that.

On the basis of my knowledge of successful programs in Indigenous Australia I would go further and argue that the Government should not roll out any more of these trials at the present time. Certainly the evidence presented does not convince me that the trial is working, or even that the program logic is correct. Nor does this trial reflect principles in program design which are known to work in Indigenous communities, among them genuine partnership, strong participation of local people in the design (not just leaders), an empowerment approach, working towards Indigenous aspirations, building on strengths, and Indigenous-led and controlled. A major program re-design appears to be needed.

Further Comments on Human Rights Compatibility

The right to social security and the right to an adequate standard of living

I note that the requirement in relation to social security is 'to provide a minimum level of benefits to all individuals and families that will enable them to acquire at least essential health care, basic shelter and housing, water and sanitation, foodstuffs and the most basic form of education.' The Orima Evaluation makes clear that for at least some families on the CDCT, even with 80% of their income quarantined for expenditure on basics, many went without food and other essentials for their children on a regular basis. As noted above, the Wave 2 Report makes clear that around a quarter of CDCT 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

[12] https://www.theguardian.com/australia-news/2017/aug/22/pat-dodson-says-cashless-welfare-card-a-public-whip-to-control-indigenous-people
[13] https://www.theguardian.com/australia-news/2017/aug/23/aboriginal-leader-withdraws-support-for-cashless-welfare-card-and-says-he-feels-used

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.

It would seem that the right to adequate social security and the right to an adequate standard of living (as defined in the Compatibility Statement) is not being enjoyed by all participants in the trial sites. This may be because the level of social security provided does not meet the requirement above. Adequate housing is also a problem in both locations and the CDCT makes no provision for overcrowding in housing.

The right to privacy

I note that the sharing of participant information to the card provider and to Department of Social Services is justified on the grounds that it is proportionate to the social harm the card is meant to reduce. The problem is that a significant proportion of CDCT participants (34% in Wave 1[14]) have never practiced any of these harmful behaviours, and in Wave 2 only 41% reported drinking alcohol before the trial[15] (i.e. 59 % did not drink alcohol) yet their right to privacy is also reduced.

The right to self-determination

The reference to this right has been totally misinterpreted in the Statement of Compatibility. This right is, as is recorded on p7, a right of *peoples*: ' all peoples have the right of self-determination…". This right is a collective right of a people as a collective, not the individual right of a person. It could be argued that most Australian Government policy towards Aboriginal and Torres Strait Islander peoples breaches this right at the present time. If this right were being upheld in relation to the problem of alcohol-fuelled violence and crime, one option would be that Aboriginal peoples, such as the native title holders in each location where the CDC is now being trialled, would themselves determine the policies to deal with the problems they confront as a people. Their own legitimate governance mechanisms and processes would be used to make decisions about appropriate policies. This is not what has happened in these trial sites. Government has used its own 'consultation' processes, not locally developed Indigenous governance processes to make decisions. The right of self-determination is most definitely not being complied with. I would urge the Committee so seek further legal advice in relation to the right to self-determination for Indigenous people, and to consult the UN Declaration on the Rights of Indigenous Peoples to assess whether the CDC breaches this right.

Final Comments

It is my view that the funds currently being spent on the CDCT and that might be spent on future roll outs could potentially be better spent for more significant outcomes. As the needs in Indigenous Australia are so significant, public funds should not be spent on programs that are not cost effective in achieving outcomes. Programs should be built on the best available evidence of what works.

I would urge the Committee to consider inviting my ANU colleagues Dr Maggie Brady to give evidence on successful strategies to reduce drug and alcohol consumption in Indigenous communities and Dr Marisa Fogarty to give evidence in relation to gambling.

[14] Wave 1 p22,
[15] Wave 2 Report p 45. I have been unable to find a figure in the Wave 2 Report of the total who never practiced any of the three behaviours targeted.

Acknowledgments

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

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