AASW
Australian Association of Social Workers

SUBMISSION TO THE SENATE COMMUNITY AFFAIRS LEGISLATION COMMITTEE: Social Services Legislation Amendment (Cashless Debit Card) Bill 2017

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INTRODUCTION

Who we are

The Australian Association of Social Workers (AASW) is the professional body representing more than 10,000 social workers throughout Australia. We set the benchmark for professional education and practice in social work, and advocate on matters of human rights, social inclusion, and discrimination.

The social work profession

The social work profession is committed to pursuing social justice and human rights. Social workers aim to enhance the quality of life of every member of society and empower them to develop their full potential. Principles of social justice, human rights, collective responsibility and respect for diversity are central to the profession, and are underpinned by theories of social work, social sciences, humanities and Indigenous knowledges. Professional social workers consider the relationship between biological, psychological, social, and cultural factors and how they influence a person's health, wellbeing and development. Social workers work with individuals, families, groups and communities. They maintain a dual focus on improving human wellbeing; and identifying and addressing any external issues (known as systemic or structural issues) that detract from wellbeing, such as inequality, injustice and discrimination.

Our submission

The AASW welcomes the opportunity to contribute to the inquiry into the *Social Services Legislation Amendment (Cashless Debit Card) Bill 2017*. Social workers practice with a range of people across all life stages and within a range of social contexts. Our members have extensive experience with people whose complex needs are related to their lack of employment and their use of alcohol and other drugs.

We acknowledge that there exists a diversity of views around the solutions to these issues among health professionals, academics and respected Aboriginal and Torres Strait Islander elders and community leaders. We share their desire for better outcomes for the most vulnerable members of our society and their frustrations with the current lack of progress against many indicators of wellbeing.

Our commitment to promoting the human rights of people who are experiencing disadvantage informs our response to this Bill. We believe that entrenched problems require a response informed by the dignity and autonomy of all members of the community, which promote human rights and address underlying systemic problems.

Our submission falls into three areas: the approach of the Cashless Debit Card (CDC), the conceptual flaws in the CDC trial and the inconclusive evidence in the evaluation report.

RESPONSE

1. The approach of the Cashless Debit Card

1.1 The Cashless Debit Card (CDC) undermines the dignity and autonomy of people who are forced to use it and contravenes the principles on which our welfare system was founded: to provide people who are unable to work an acceptable standard of living and to encourage economic and social participation. The right to receive income support derives from our recognition of the dignity and autonomy of every person.[1]

1.2 By contrast, the Bill proposes that the CDC will be mandatory, permanent and imposed on all residents of a geographic area regardless of their personal history. Inevitably this will lead to the inclusion of some people who have never abused alcohol, illicit drugs nor gambled. To this extent it contravenes the expectation of fairness and assumption of autonomy that underpins welfare support payments. People who have remained sober, who have supported their families on limited income, are receiving the same treatment as people who have not achieved these personal goals.

1.3 The CDC may humiliate some community members in situations requiring cash, for example, when children need to take money to school for excursions, or when wishing to participate in community events, such as fetes, where items can only be bought in cash.

1.4 The only mechanism by which any changes can be made is for a person to appeal to a community-based panel, which has the power only to increase the proportion of payment that can be received in cash. In a small community, this creates the potential for breaches of privacy for a person facing an emergency or crisis. There is no ability for a person to graduate out of the CDC and, therefore, no encouragement to change.

2. Conceptual flaws in the program logic and theory of change

2.1 There is no therapeutic or transformational element at either individual or community level in the trial of the CDC. The theory of change in the evaluation report specifies only that the amount of money spent on alcohol, drugs and gambling will decrease and that the amount of harm will also decrease. It speculates that there will be changes in attitudes and behaviours but is silent on the mechanism by which these changes will occur for an individual or across a community.[2]

2.2 Although the geographic locations for the expansion were selected because of a high rate of welfare dependence, the government is not undertaking any steps to encourage economic development, to create meaningful work or to expand opportunities for education in these communities.

2.3 We acknowledge that there is clear evidence of high rates of abuse of alcohol and drugs and high levels of problematic gambling in many communities. Nevertheless, there is a variety of mechanisms by which these can be reduced of which limiting access to cash is only one. Other

[1] A Herscovitch & D Stanton, 'History of social security in Australia', *Family Matters*, September: 51, 2008.

[2] ORIMA Research, *Cashless Debit Card trial evaluation final evaluation report*, ORIMA Research, Canberra, 2017.

methods are available that target the providers of alcohol, illicit drugs and gambling opportunities.

2.4 Furthermore, it has not been conclusively established that limiting cash it is the most effective long-term response to gambling or to the abuse of alcohol and other drugs. In fact, the Explanatory Memorandum to the Bill cites the mayor of Ceduna's statement that the most effective previous attempt was the restriction of sale of alcohol.[3] We note that the government is not proposing to address underlying systemic factors that might be contributing to alcohol use, such as the lack of appropriate employment, substandard residential and community infrastructure or individuals self-medicating untreated mental ill health.

2.5 We acknowledge that there is also clear evidence of harm caused by the abuse of alcohol, drugs and gambling in many communities. Again, this proposal is only one of a number of measures that could address the multiple harms that persist in the lives of many people in areas of limited opportunities for economic, cultural and social participation. The program logic for the trial specifies that the introduction of the CDC is to be accompanied by an expansion in the services available in those communities, raising doubts as to which of these two elements will indeed be responsible for the change.

2.6 We share the desire of many people for reduction in violence and an improvement in the safety of vulnerable people. Nevertheless, the tangible, thoroughgoing improvements in wellbeing that some supporters hope for (the 'Spillover benefits'), were in fact described by the evaluation as being beyond its scope, both in terms of the time for them to be realised, and the lack of adequate methods to measure their impacts.[4] Therefore, any claims that this trial has already demonstrated or will demonstrate these benefits need to be treated with caution.

2.7 Income management programs have been trialled and evaluated in various locations since 2007. An overview of the evaluations that has attempted to distil the necessary elements for long-term success has concluded that voluntary participation is common to any successful approach. Our members have extensive experience in working with people who are living with multiple, complex psychosocial issues and in disadvantaged communities. They have observed that entrenched unhelpful behaviours can be due to a combination of complex factors. A measure such as the CDC can provide a useful 'circuit breaker' if it used as an opportunity to work on the underlying contributing factors. In the absence of a double-barrelled approach, limiting access to alcohol and drugs creates the appearance of change but achieves little genuine progress.

3. Methodological flaws and evidence gaps

3.1 The first goal described in the Explanatory Memorandum is to limit the amount of money spent on alcohol, drugs and gambling, and the second is to *determine whether* this leads to a reduction in violence and harm.[5] Despite this, the Evaluation Report specifies that the long-term benefits and the 'Spillover' benefits are beyond its scope.[6] Therefore it is still too early to establish whether long-term changes have been achieved, and impossible to tell whether they will be maintained.

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[3] Parliament of the Commonwealth of Australia, 'Social Services Legislation Amendment (Cashless Debit Card) Bill 2017 Explanatory Memorandum, 2017.

[4] ORIMA Research, *Cashless Debit Card trial evaluation final evaluation report*, ORIMA Research, Canberra, 2017

[5] ibid

[6] Parliament of the Commonwealth of Australia. 2017. "Social Services Legislation Amendment (Cashless Debit Card) Bill 2017 Explanatory Memorandum

3.2 The current Bill is based on an evaluation of the trial's initial stage. The report of this evaluation acknowledges several methodological limitations in the collection of the data.[7] Without repeating them all here, we note that some findings draw on reports of participants, but that many draw on impressions from people who are not participants but who can potentially benefit from the CDC, such as merchants who sell goods other than alcohol.

3.3 Despite these limitations, the evaluation report concludes that the trial was successful in reducing the amount of alcohol and drug consumption and the amount of gambling. To the extent that this result is rigorous and reliable, it is to be welcomed. On the other hand, the evidence about the reduction in violence and harm that has resulted is less conclusive. It is based only on the perceptions of other people (described only as 'stakeholders'), who reported limited improvement in their perceptions of safety.

3.4 In the final evaluation, a third of respondents reported that the trial had made their lives worse. These people were still reporting difficulties in situations where cash remained the only option for payment, despite the trial having been in place for more than a year.

3.5 There is no comparison of these results against other methods of reducing alcohol and drug consumption or gambling, and no cost-benefit analysis. Therefore, there is no evidence that it is the most effective or efficient way to reduce these behaviours.

3.6 Although the evaluation report claims that there is evidence for the trial having achieved the 'Spillover' benefits, this claim is drawn from unsubstantiated perceptions. Inspection of the data shows minimal improvements in actual indicators of economic and social wellbeing. For example, despite perceptions that the trial had positive impacts on employment, the quantitative survey found that there was little change in the number of people looking for work; that improvements in the local Community Development program could also have been due to a stricter compliance regime and that the lack of employment opportunities remained a key issue.[8]

3.7 A similar discrepancy can be found in relation to the key impacts on children's wellbeing. Although people reported that participants were more interested in their children's schooling, there was little change in school attendance rates.[9]

3.8 If the results of reducing access to cash were indeed so obviously beneficial for family and community wellbeing, a mandatory, community-wide trial would only be required as a temporary measure to illustrate the benefits. If this scheme is indeed the answer to these entrenched problems, the results will speak for themselves and an extension of the mandatory scheme will be redundant. We would expect to see it should be possible to adopt a revised model using a staged approach. It would start by encouraging an initial group in any location to participate in order to demonstrate its benefits. After that, other people would be able to opt in for the length of time needed for the benefits to establish themselves.

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[7] ORIMA Researh. 2017. *Cashless Debit Card Trial Evaluation final Evaluation report.* Canberra: ORIMA Research
[8] ibid
[9] ibid

CONCLUSION

Taken together, these concerns add up to a proposal that imposes an unusual penalty on a group of vulnerable people united only by their location; which undermines their autonomy and creates inconvenience, which is not necessarily accompanied by any other intervention, which does nothing to achieve long-term structural change nor individual recovery from addiction and the benefits of which are not conclusive.

A lasting, human rights-based, and theoretically sound approach to income management would be voluntary, adjustable and responsive to changes in a person's behaviour or circumstances. It would be evidence-based and would draw on current best practice. It would be implemented through a partnership with community organisations, and integrated into economic opportunities, job creation and training initiative. It would include accessible community health and family support services. It would be evaluated over the long term. The Australian Association of Social Workers would welcome the opportunity to work with the government to design and implement such a program.

Submitted by and on behalf of the Australian Association of Social Workers Pty Ltd

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