Submission to the Senate Community Affairs Legislation Committee inquiry into the

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

7 March 2019

The Western Australian Council of Social Service Inc. (WACOSS) welcomes the opportunity to make a submission to the Senate Community Affairs Legislation Committee inquiry into the Social Security (Administration) Amendment (Income Management and Cashless Welfare) Bill 2019.

WACOSS is the peak body of community service organisations and individuals in Western Australia. WACOSS stands for an inclusive, just and equitable society. We advocate for social and economic change to improve the wellbeing of Western Australians and to strengthen the community services sector that supports them. WACOSS is part of a national network consisting of ACOSS and the State and Territory Councils of Social Service, who assist people on low incomes and experiencing disadvantage Australia wide.

We acknowledge the contributors to this submission, including Beverley Walley, whose response to the Senate Community Affairs Legislation Committee's inquiry into the Social Services Legislation Amendment (Cashless Debit Card) Bill 2017 is appended to this submission.

WACOSS strongly opposes the extension of the cashless debit card trials to June 2020.

Evaluation Data

The extension of the trials relies on the findings of the ORIMA Research. Along with many other organisations and individuals, WACOSS identified serious shortcomings with this evaluation in our submission to the 2017 inquiry.

As we noted, the analysis relied in large part on secondary survey data of reported purchasing patterns (many of them given some time after the fact), rather than on primary data of income support recipients' consumption of goods that cannot be purchased with the card. This results in several confounding factors that directly impact the reliability and validity of the research results, and the ability to draw conclusions from it that allow the attribution of causality of changes in behaviour and wider social outcomes. These include research design and sampling strategy, questionnaire design, recall bias and social desirability bias, rising refusal rates and the combination of longitudinal and intercept data among others.

'Recall bias' is where reliability is impaired because people's memories of past patterns of behaviour are unreliable and shown to be easily influenced by the context in which questions about historic behaviour are asked. Recall data needs to be tested against primary sources of data such as actual spending behaviour. Self-reports are also at a high risk of 'social desirability bias', where participants respond in what they consider to be a socially acceptable way. Interviewees were asked to provide personal ID before being interviewed about a government program with a high public profile that

includes coercive powers, then questioned about alcohol consumption, gambling and illicit drug use. Researchers working with Aboriginal people (and a significant proportion of those interviewed were Aboriginal) are particularly conscious of cultural conventions where it is considered polite to agree with others and there is a risk they will only tell a stranger or a person in authority what they think they want to hear. It is, in fact, specifically stated in the final evaluation report that this is a particular concern around self-reports of illegal drug use and as a result these reports should be "interpreted with caution."

Though these trials are taking place in areas with a high proportion of Aboriginal people, such as the East Kimberley, there was no indication given as to how the survey evaluation engaged with people whose primary language was not English. This is of particular importance considering the difficulties reported in the trial for Aboriginal subjects accessing support for problems with the Cashless Debit Card from Indue due to language barriers. There are robust and well-established ethical principles for conducting research with Aboriginal people – both the AIATSIS (2012) Guidelines and the NHMRC (2003) Guidelines – but neither is mentioned or appear to have been adhered to in the evaluation.

We also noted that the data from the East Kimberley and Ceduna sites were weighted equally, despite the East Kimberley having a much higher rate of trial participants (1247 compared to 757). The description of the first and second survey sampling periods as 'waves' is somewhat misleading, as this language is properly associated with a longitudinal study model. The second stage of the study is in fact a combination of a second round of systematic intercept sampling and follow-up sampling of 134 subjects. This data is not analysed separately and it is unclear whether this model introduced a systematic bias into the findings.

The high level of non-responders and refusers to the survey undermines the representativeness of the results. It is important to acknowledge that the experiences of non-responders are often different to those who respond to surveys, and sometimes dramatically so. We noted that there was a dramatic increase in the refusal rate to the second round of the survey (89 refusals in 'Wave 1' vs '222 in 'Wave 2' in Ceduna). This is partially masked by the way the data is reported, as follow up surveys with those who agreed to be re-interviewed in the first round and were directly contacted are included, producing an apparent refusal rate of 24% rather than the actual refusal rate of new interviewees of 48%.

Furthermore, a significant proportion of the respondents in the interviews reported none of the behaviours the trial was intended to target – 180 of the 552 respondents (31.5%) in wave 1 and 228 of the 479 respondents (42%) in wave 2 reporting not drinking, gambling or taking drugs before or during the trial period. The proportion of those not doing so significantly increasing in the second wave at the same time the refusal rate has also risen dramatically.

Taken together, these factors cast significant doubt on the representativeness of the survey findings. As a result, the ability to meaningfully generalising from the survey findings as to the impact the trials have had on behaviour and consumption is very limited.

We recommend that the Committee takes note of the Queensland Council of Social Service Review of the Cashless Debit Card Trial and Evaluation and the Australian National University Centre for Aboriginal Economic Policy Research Cashless Debit Card Evaluation, both of which clearly elucidate the fundamental limitations of the ORIMA Research evaluation report.

Kalgoorlie 'Baseline' Report

We note that the report from the Future of Employment and Skills Research Centre at the University of Adelaide entitled *Cashless Debit Card Baseline Data Collection in the Goldfields Region: Qualitative Findings* faces many of the same problems and limitations as the ORIMA Research. The report relies upon interviews conducted with 66 stakeholder representatives and 64 CDC participants within the Goldfields CDC sites and is limited in its generalisability to broader population groups.

The interviews highlight shared community concerns about social harm and dysfunction within the Goldfields and emphasise considerable gaps in service coverage and functionality within the region. Critical ongoing issues in the region include alcohol and drug misuse, child safety and welfare, family violence, poverty, lack of opportunity and crime. While some respondents expressed hope that the CDC trial may provide a stimulus or avenue to prompt action on these problems and bring in additional services, resources and support, it is clear from their responses that the CDC alone is not considered to be an effective solution to these underlying issues.

During a WACOSS consultation visit to Kalgoorlie in June 2018, we heard from both community service providers and those with lived experience of the cashless debit card system. We were particularly concerned by a number of personal stories shared with us that highlighted the personal and financial problems created by the manner in which the CDC was implemented, particularly in relation to the cancellation of existing direct debit arrangements, the time taken to navigate and get approval to meet ongoing financial commitments, the need to constantly renegotiate ongoing payments through the shop-front, and the financial costs of payment cancellations and delays.

Many people who are reliant on income support, including single parents and carers for people with a disability, are in fact exceptionally good at budgeting to balance their financial needs and obligations against their meagre income on a day-by-day and week-by-week basis, and arbitrary decisions to interfere in and over-ride their household budgets can result in unnecessary financial hardship and distress. Efforts at financial management assistance should start from the position of understanding current household budgetary arrangements and the reasons behind ongoing expenditure arrangements. Assistance should be directed to where it is needed to improve financial management skills and build ongoing budgeting capacity. It is notable that many of those surveyed supported a more targeted approach to the provision of support and intervention based on need.

We also note that the perceptions of some stakeholders of improvements in spending patterns and crime rates need to be grounded in real data, and more detailed analysis is required to separate out seasonal factors or the impacts of wider economic cycles, as well as changes in policing or service provision, from changes attributable to the trial.

Impacts of the Trials

As we noted in our previous submission, while the ORIMA research has been used as a justification for extending and expanding the trials, no credence seems to have been placed on the finding in both the Wave 1 and 2 reports that the *majority* of participants indicated that the card had made their lives *worse*, rather than better. As an outcome from the trials, this seems to be an extraordinary failure and something should at the very least be taken as an indication that the trials should be put on hold until an appropriate fix or service response can be determined, if not permanently ending the trials.

Individuals that we have spoken to in the East Kimberley have reported a serious sense of disempowerment amongst participants in the trial. They have observed a continued deteriorating in

the quality of life for families and children, who have experienced significant suffering while on the Cashless Debit Cards as a result of mental ill-health, chronic illness and violence.

One East Kimberley resident stated that participants "are not LIVING being on the welfare card and trying to put bread and food on the table, they are just SURVIVING."

A social worker whose clients have been using cashless cards informed WACOSS that they have observed clients buying 'allowed' products using the card, which they have then exchanged for products and services they are not able to purchase using the card. Typically, however, the clients were needing to spend more on the allowed products they intended to trade than the value of the item for which they were trading. As a result, the card was not preventing them obtaining the items they were not able to purchase with it, but was simply seeing them spending more of their income on those items, contributing to higher levels of financial hardship and increased negative social outcomes.

It is the position of WACOSS that mandatory income management will inevitably disempower participants. Income management approaches can be effective, but in order to be so they must be genuinely voluntary and supported by appropriate wrap-around, holistic services that enable those effected to address their particular needs and take control of their own finances. It is crucial that people are the decision-makers in their own lives and that is in no way diminished by a person requiring social security payments for any period of time.

Attempting to address complex social issues in highly impoverished regions with a blunt instrument like the Cashless Debit Card is simply inappropriate. Instead, the investment and focus should be on job creation and providing appropriate, culturally-accessible services that support people to address alcohol and other drug misuse and problem gambling.

An approach that empowers and respects people as the decision-makers in their lives is needed to design a system that supports communities, rather than the punitive and paternalistic approach of the cashless debit card.

If you would like to discuss this submission further, please contact the WACOSS Research and Policy Development Leader Chris Twomey at chris@wacoss.org.au or 9420 7222.

Yours sincerely,

Louise Giolitto
Chief Executive Officer
WACOSS

APPENDIX 1

Submission to the Senate Community Affairs Legislation Committee on the:

Social Services Legislation Amendment (Cashless Debit Card) Bill 2017

29 September 2017

Public and Joint submission from:

Beverley Walley
Gailene Chulung

We live in Kununurra and lead a group of people who are opposing the extension of the cashless welfare card trial. We and much of our community, oppose this trial as it is a paternalistic measure that aims to allow the government to tell Indigenous people how to spend their money. This cashless card will cause more problems and issues for already struggling families. We will outline issues concerning this trial.

1. The government claims the trial was community based and was driven by the community, in reality is was not. The trial was and is contested. Rather a limited and privileged group of people have had more opportunity for input than the majority of the impacted community.

2. Community was not informed or aware of who the leaders were who were being consulted in regards to signing on to the trial. We understand now that many of those leaders were leaders of organisations and not representative of leaders from our communities.

3. The introduction of the trial was rushed and this has cause much hardship to the people impacted by the trial. It was announced in February 2016 and the roll out was April 2016. This resulted in less than two months' public lead time. It meant people being on the card prior to even understanding what is was and how it would impact them, let alone how it even worked.

4. After the trial started there was a town meeting held at White Gum Park in Kununurra to hear community concern. Approximately 80 people attended to express their frustrations as to why the card had to be compulsory and why a broader representative of community people were not consulted.

5. We found similar oversite in the coordination of the 2016 Kununurra Community panel
    a. Many people did not understand how the panel was to work
    b. Many did not understand that there were opportunities to change quarantined amounts
    c. Majority of people did not know who to a make a request for changed quarantined amount
    d. Many people neither had access to technology nor the technology literacy to take part

6. This Cashless Debit Card certainly targets Indigenous people regardless of official government communication as this trial disproportionately impacts Indigenous people.

7. Our experience tells us that government communication has not improved since the roll out and vulnerable people continued to be caught off guard by it. For example, one mother told me she could not put her child on the school bus because the bus only takes cash and her income support entitlements were on her card.

8. While the government talked about providing wrap around services for people impacted by the card through a 1.6-million-dollar budget to community organisation. It was not and is not clear if the funds are for services who provide support to people impacted by the card or a substitution for existing programs which are already running on tight budgets.

9. The ORIMA Evaluation The ORIMA Evaluation commissioned by the government to evaluate the trial is methodically 'flawed' for the following reasons;

    1. The data presented claims causality and 'proof of concept', however causality cannot be shown because the impact of the card cannot be isolated from other programs operating in the East Kimberly including 'Taking Away Alcohol Management'(TAMS) that record and restrict alcohol purchases by individuals in Kununurra and Wyndham.
    2. TAMS was a yearlong trial introduced five months (12 December 2015) before the CDC. An evaluation of the TAMS trial presented inconclusive evidence on the effectiveness of the trial, as those effects could not be separated from the CDC trial.
    3. While undertaking the evaluation, the ORIMA team offered $30 food vouchers to people if they took part in the survey; this brings some suspicion regarding the supposed volunteer nature of taking part.
    4. If the CDC trial was successful as claimed by Government, then we ask the question, why are there further restrictions being placed on alcohol purchasing?

This card is causing shame for the people, it is disempowering already vulnerable people rather than addressing drug, alcohol and addiction abuse in this region. Programs such as this should be designed with our community in a consultative manner. Furthermore, those people and families affected by these programs should be provided with the appropriate support to take control of their own finances and deal with any addiction, mental health problems or impacts of trauma.

We would like to see government collaborate with community to set up local action groups to tackle these issues, not punish a large proportion and block them out of an opportunity to participate in the change.

We would like to acknowledge the Western Australian Council of Social Service's support in writing and submitting this submission.