Submission to Senate Community Affairs Legislation Committee on the Social Security (Administration) Amendment (Continuation of Cashless Welfare) Bill 2020

1. Introduction & Recommendation

I welcome the opportunity to make a submission to the Senate Community Affairs Legislation Committee on the Continuation of Cashless Welfare Bill 2020. This is the fifth CDC senate inquiry I have written a submission for, having previously developed submissions from QCOSS, as Senior Policy Officer, in 2017, 2018 and twice in 2019.

Recommendation: That all forms of compulsory income management, including the Cashless Debit Card (CDC), must end immediately as they are *punitive, ineffective, expensive, harmful, unsupported, discriminatory and paternalistic*.

2. Process (How)

Let me tell you what's going to happen in this inquiry and its report on the CDC legislation. We know this because it has always happened this way, with the five previous CDC senate inquiries. And tragically it will follow the same script once more, with the same pre-ordained outcome, regardless of the **overwhelming expert evidence against the CDC.**

1. Numerous stakeholders will provide ***overwhelming expert evidence against the CDC*** in dozens of submissions.
    - These experts will include individuals with lived experience of CDC, independent academic experts, peak bodies, service providers, Aboriginal and Torres Strait Islander organisations, volunteer activists and government commissions.
    - The majority of these submissions will be opposed to the CDC, (76% average in previous inquiries), with a minority of submissions in favour that have a government, partisan or financial interest in the CDC.
2. The committee may also hold public hearings that follow the same pattern.
3. The government-dominated committee will compile a report that puts forward the government's case, despite the ***overwhelming expert evidence against the CDC***.
    - The report will then attempt a fake balance by acknowledging samples of the ***overwhelming expert evidence against the CDC***, ('we note that xx from yy says…', 'we also note that…', etc).
    - The report will then dismiss the ***overwhelming expert evidence against the CDC***, and recommend (along party lines) that the senate vote in the opposite direction to the ***overwhelming expert evidence against the CDC***.
4. The report will also include two Dissenting Reports, from the ALP and The Greens. These will quote the ***overwhelming expert evidence against the CDC***, and recommend opposing Bill, in line with the ***overwhelming expert evidence against the CDC***.
5. The final result of all this effort by dozens of organisations and individuals going to the trouble to develop and lodge submissions, is simply a recommendation in favour of the CDC, along party lines. This outcome is predetermined the moment the make-up of the committee is known, before any of the ***overwhelming expert evidence against the CDC*** is lodged in submissions or heard in public hearings.

This is a mockery of democratic processes and a travesty of natural justice. It is a relentless, farcical perversion of evidence-based policymaking.

3. Legislation & Inquiries (What)

This is the sixth senate inquiry into the CDC since 2015.

Social Security Act Amendment Inquiry	Dates	# CDC Sites	Expand to New Sites	Extend End Date	# Program Participants	# Sub-missions	Opposed to CDCT
1. *Debit Card Trial Act **2015***	Aug-Oct **2015**	3	Ceduna, SA & East Kimberley, WA	**Jun 2018** (12 months max)	10,000 limit (Actual 800 Ced + 1,350 EK = **2,150**)	34	21 (62%)
2. *Cashless Debit Card Act **2017***	Aug-Sep **2017**	3	Goldfields, WA	East Kimberley, WA - **Jun 2019**	10,000 limit (Actual 2,150 + 2,400 GF = **5,550**)	172	137 (80%)
3. *Cashless Debit Card Trial Expansion Act **2018***	Jun-Aug **2018**	4	Hinkler (Bundaberg and Hervey Bay), Qld	Hinkler **Jun 2020.**	15,000 limit (Actual 5,550 + 6,700 Hinkler= **12,250**)	108	69 (64%)
*4. Income Management and Cashless Welfare Act **2019***	Feb-Apr **2019**	4	Changes to EXIT pathway.	Ceduna, EK & Goldfields CDC **Jun 2020.** Cape York IM **Jun 2020.**	15,000 limit (**12,250**)	38	28 (74%)
5. Income Management to Cashless Debit Card Transition Bill **2019** *[not yet passed]*	Sep-Nov **2019**	6	Northern Territory (NT) & Cape York (CY).	All CDC sites **Jun 2021.** Cape York **Dec 2021.**	Unlimited (Actual 12,250 + 25,000 NT + 150 CY = **37,400**)	110	94 (85%)
					Total:	**462**	**349 (76%)**
6. Continuation of Cashless Welfare Bill **2020** *[not yet passed]*	Oct-Nov **2020**	6	Transition NT & CY participants to CDC in 2021.	4 CDCT sites **Unlimited**. NT & CY **Dec 2021**.	Unlimited (Actual **37,400**)	?	?

Regulatory Impact Statement (RIS) included in the Explanatory Memorandum (EM)

This is the first time the government has included a RIS in the EM, covering three options:

Option One: Allow the Cashless Debit Card to expire in current sites.

The RIS explores this option by saying it would be expensive for the government because people have to go back from CDC to IM in the CDC sites. It says that IM is complex and expensive to administer, and that it would be disruptive for people who might not have enough time change their payment arrangements back. ***You know what is not complex, expensive or disruptive? Not being forced onto compulsory income management!*** It also says this option would mean that participants 'would not have the financial management support of CDC / IM'. What exactly is that? ***How do you learn budgeting skills from a piece of plastic that restricts your decision-making agency?***

Option Two: Continue the Cashless Debit Card program as an ongoing measure.

This is the recommended option of the RIS. It claims '*consistent and publicly expressed support',* (despite the Orima report and numerous other studies demonstrating strong community opposition). The RIS claims that the CDC '*gives the public confidence in delivery*

of public funds being used in an appropriate manner'. ***You know what really gives the public confidence that public funds are used in an appropriate manner? Not wasting millions on expensive a social program that has no proven benefit and actually causes harm!***

Option Three: Expand the Cashless Debit Card to new locations and extend the duration of the program.

This option would have continued the relentless expand and extend, expand and extend, until all social security is being compulsorily quarantined by a third party throughout Australia. It says that continual 'trials' create uncertainty, and making them ongoing reduces uncertainty. ***You know what really reduces uncertainty? Being able to access your own income without the barrier of compulsory quarantining by a third party!***

4. Previous Submissions (Who)

The individuals and groups listed below have all expressed opposition to the CDC through inquiry submissions, speaking at public hearings, and in public advocacy campaigns.

Individuals with lived experience

The people directly impacted by the CDC are the most important stakeholders. Despite already having their agency reduced by the CDC, and having no professional resources, individuals have self-advocated by writing about their own experiences of the CDC. Their *hundreds of submissions* are personal stories, not prefabricated templates.

All ignored and dismissed.

Independent academic experts

Academics have not just expressed their expert opinions, but carried out new research studies in the impacted communities. Unlike the government-funded evaluation, which was criticised by the Auditor-General, these studies and submissions are by genuinely independent experts, including the following:

- Adj Prof Eva Cox (UTS)
- Assoc Prof Nadine Ezard (UNSW)
- Assoc Prof Philip Mendes (Monash)
- Dr Elise Klein (ANU)
- Dr Eve Vincent (Macquarie)
- Dr Francis Markham (ANU)
- Dr Hannah McGlade (Curtin)
- Dr Janet Hunt (ANU)
- Dr Jonathon Louth (UniSA)
- Dr Lorraine Kerr (Flinders)
- Dr Rob Bray (ANU)
- Dr Shelley Bielefeld (Griffith)
- Emeritus Professor Jon Altman (ANU)
- Prof Ed Carson (UniSA)
- Prof Greg Marston (UQ)
- Prof Ian Goodwin-Smith (UniSA)
- Prof Matthew Gray (ANU)
- Prof Sven Silburn (USyd)

All ignored and dismissed.

Volunteer advocates

Individual concerned community members, many of whom also have lived experience of the CDC, have been organising against the CDC for five years. This volunteer campaign has been completely independent of any funding by a political party or other vested interest. This effort includes collecting petitions, fundraising, holding stalls, organising rallies and protests, research, writing articles, reports and inquiry submissions, appearing at senate committee public hearings, speaking at events and conferences, and extensive social media activity. This mammoth self-advocacy effort is all the more impressive because it lacks professional resources, and advocates must sustain themselves to survive politicians and the media's relentless dismissal of their efforts as isolated minorities. These groups include:

- Anti-Poverty Network, Queensland
- Anti-Poverty Network, South Australia
- Australian Unemployed Workers Union

- Australian Unemployed Workers Union – Inner West Sydney Branch
- Bundaberg Awareness Group
- No Cashless Card Kalgoorlie and Surrounds
- No Cashless Debit Card Hinkler Region
- Say No to The Cashless Welfare Card Australia
- Sydney Coalition Against the Card
- The Say No Seven Community

All ignored and dismissed.

Peak bodies

Health, legal, social service, child protection, women's, carers, single parents, employment, domestic and family violence, financial counselling, trade union, and disability peak bodies have all been providing evidence and actively speaking out against the CDC. These bodies are important because they represent, and are accountable to, diverse memberships and cannot pursue personal or partisan crusades. They include:

- Accountable Income Management Network (AIMN)
- Australian Association of Social Workers (AASW)
- Australian Council of Social Service (ACOSS)
- Australian Council of Trade Unions (ACTU)
- Australian Women Against Violence Alliance (AWAVA)
- Carers Australia
- Centre for Excellence in Child and Family Welfare (CFECFW)
- Consumer Action Law Centre (CALC)
- Council of Single Mothers and their Children (CSMC)
- Economic Justice Australia (EJA)
- Equality Rights Alliance (ERA)
- Financial Counselling Australia (FCA)
- Jobs Australia
- Law Council of Australia
- Law Society Northern Territory
- Law Society of NSW
- National Council of Single Mothers and their Children Incorporated (NCSMC)
- Northern Territory Council of Social Service (NTCOSS)
- PeakCare Queensland
- People with Disabilities Australia (PWD)
- Public Health Association of Australia (PHAA)
- Respect Inc.
- Queensland Council of Social Service (QCOSS)
- Queensland Teachers Union (QTU)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Victorian Alcohol and Drug Association (VAADA)
- Western Australian Council of Social Service (WACOSS)

All ignored and dismissed.

Social and legal service providers

Service providers have a key perspective on the CDC as they work on the frontline in communities to support individuals impacted by the CDC. They also often receive government funding for their services, so risk '*biting the hand that feeds'* by providing evidence and speaking out against the CDC. They include:

- Anglicare Australia
- Caritas Australia
- Catholic Social Services
- CatholicCare NT
- Darwin Community Legal Service (DCLS)
- Good Shepherd Australia New Zealand
- Goulburn Valley FamilyCare
- Jesuit Social Services
- Queensland Advocacy Incorporated (QAI)
- St Vincent's de Paul
- The Salvation Army
- Uniting Communities
- UnitingCare Australia

All ignored and dismissed.

Aboriginal and Torres Strait Islander Organisations

The CDC was set up in Hinkler partly in response to criticism by the Human Rights Commission and Parliamentary Joint Committee for being racially discriminatory. However,

with the move to include NT and Cape York, the CDC remains targeted overwhelmingly at First Nations individuals and communities. The following Aboriginal and Torres Strait Islander organisations have all provided evidence and expressed opposition to the CDC:

- Aboriginal Health Council of Western Australia (AHCWA)
- Aboriginal Peak Organisation NT (APONT)
- Arnhem Land Progress Aboriginal Corporation
- Baabayn Aboriginal Corporation
- Belyuen Community Government Council
- Central Australian Aboriginal Congress (CAAC)
- Danila Dilba Health Service
- Goldfields Land and Sea Council Aboriginal Corporation
- Indigenous Peoples Organisation (IPO)
- Kinchela Boys Home Aboriginal Corporation
- MG Corporation
- Milingimbi / Yurrwi Island Communities
- National Aboriginal and Torres Strait Islander Catholic Council
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Congress of Australia's First Peoples (NCAFP)
- North Australian Aboriginal Justice Agency (NAAJA)
- Reconciliation Australia (RA)
- Red Dust Healing
- Tangentyere Council Aboriginal Corporation
- Yamatji Marlpa Aboriginal Corporation

All ignored and dismissed.

Government and Government Commissions

Even if all of the above non-government individuals and organisations are dismissed by the inquiry, it might be hoped that evidence from governments and the government's own commissions might be taken seriously. The following have provided evidence and expressed their concerns and opposition to the CDC:

- Australian Human Rights Commission (AHRC)
- Australian National Audit Office (ANAO)
- Bundaberg Regional Council Mayor
- Commonwealth Ombudsman
- Fraser Coast Regional Council Mayor
- Northern Territory Anti-Discrimination Commission (NT ADC)
- Northern Territory Chief Minister
- Parliamentary Joint Committee on Human Rights (PJCHR)

All ignored and dismissed.

5. Evidence vs. Ideology (Why)

The CDC is about ideology, not evidence. It punishes those accessing social security, stigmatising them by framing them as untrustworthy. We know the government's ideology is stigmatising because politicians keep confirming it:

- *"Job snobs", "Lifters, not leaners", "The age of entitlement is over"*
- *"Significant welfare fuelled alcohol or drug abuse"*
- *"The taxed, and the taxed-not", "The best form of welfare is a job"*
- *"Raising Newstart would 'give drug dealers more money'"*

The underlying fallacy is that the *Policy Problem* ('welfare dependency' causing social harm) *does not exist*, and the *Policy Solution* (CDC reducing social harm) *does not work*. The government repeatedly ignores the fact that *correlation is not causality*. Evidence does not demonstrate that accessing welfare causes social harm, nor does it demonstrate that restricting people's access to welfare reduces social harms. ***The CDC is an ideological solution looking for a problem, and it cannot be fixed by tinkering with its technology.***

Non-existent Policy Problem: Welfare Dependence.

There is no such clinical condition as '*Welfare Dependency*': "*receipt of income support does not cause receipt of income support*" (ACOSS, 2018).

The RIS also quotes from the Parliamentary Inquiry into so-called 'Intergenerational Welfare Dependence'. Multiple generations accessing income support is as common as family members accessing youth allowance and parenting payment, or accessing DSP and carers allowance.) That inquiry's terms of reference used the stigmatising language of '*welfare dependence'*. (However, the Select Committee responded to criticism of the title of the inquiry by replacing the term '*welfare dependency'* (which falsely implies personal fault) with '*entrenched disadvantage'* throughout the report. This was a helpful correction acknowledging the complex causes of entrenched disadvantage.
The Household, Income and Labour Dynamics in Australia (HILDA) longitudinal survey has also been researching what it calls '*Welfare Reliance'.* This is defined as "*a situation in which welfare payments represent the primary or main source of income*" and so it has nothing to do with a person's motivation or behaviour. The HILDA report notes that such 'welfare reliance' is very common, (***64% of the working-age population had direct or indirect contact with the income support payments system*** *at some stage over 10 years)* and that it *"provides an important social 'safety net"* (HILDA, 2019).

Failed Policy Solution: The CDC

The CDC is not a mechanism to achieve any of the outcomes it targets. "*Preventing people from purchasing alcohol or gambling products does not address the underlying causes of addiction"* (RANZCP, 2017). The government cannot explain:

- ***How can the CDC create jobs for the unemployed in areas where jobs don't exist? (It is not an employment support program.)***
- ***How can the CDC treat drug, gambling or alcohol addiction? (It is not an addiction treatment program.)***
- ***How can the CDC teach financial budgeting skills when it removes their decision-making agency? (It is not a financial counselling program.)***

If a government social program lacks independent evidence of its success (as the CDC does), then the government could choose to continue with it anyway, (making improvements), provided that it's not too expensive and had no evidence of causing harm. However, the CDC *is* expensive, and it *does* have evidence of causing harm. The only published, completed CDC evaluation, (ORIMA, 2017) contained multiple negative results, ongoing circumvention behaviours, ongoing adverse consequences and evidence of a lack of community support. Such a social program **must be stopped immediately.**

Overwhelming expert evidence against the CDC

I don't keep repeating the phrase '***overwhelming expert evidence against the CDC'*** to try and make a false statement true. (That's what the government does when it keeps repeating "*It works just like a regular bank card*".) There is ***overwhelming expert evidence against the CDC***, (or as *Economic Justice Australia* says: *"a comprehensive body of empirical evidence against the continuation of the CDC and any other form of compulsory income management").* This is not just in the hundreds of submissions lodged at senate inquiries, but in government reports well. According to the government's own reports, (ANAO, 2018; ORIMA, 2017 & PJCHR, 2018) the CDC Trial is 1. Ineffective, 2. Expensive, 3. Harmful, 4. Unsupported, 5. Discriminatory & 6. Paternalistic:

1. Ineffective

The Australian National Audit Office report (ANAO, 2018) on the CDC, indicated that *"the approach to monitoring and evaluation was inadequate, so it was* ***difficult to conclude whether there had been a reduction in social harm".*** Other results included:

- There was no cost-benefit analysis, no post-implementation review, no review of KPIs, no measure of the available drug and alcohol, or financial and family support services in the community or their effectiveness.
- DSS did not build evaluation into the CDC Trial design, nor did they coordinate data collection to ensure an adequate baseline or specific targets to measure the impact of the trial, including any change in social harm, such as frequency of problematic drug, alcohol or gambling usage or violent crime.
- The evidence base supporting DSS advice to the Minister was lacking, including alcohol-related hospital admissions, Ambulance call-outs and school attendance, **each of which had been inaccurately reported and did not support CDC Trial outcomes.**

DSS having agreed to implement the ANAO recommendations changes nothing about the ANAO's statement about a lack of evidence of reduction in social harm.

2. Expensive

The Australian National Audit Office report (ANAO, 2018) indicated that the total cost of the CDC Trial for the two initial sites was $18.3 million, (**more than $10,000 per trial participant**). It also indicated that there were deficiencies in the procurement processes (eg. Indue was awarded the contract from a desktop review with no competitive tender and Orima's evaluation ended up costing $1.6 million, more than double the agreed amount). The current government claim that the cost of the expanded CDC has now reduced to less than $1,000 per person, is based on figures they refuse to publish. If welfare did not have to be "*a good deal for private investors*", then it could be subjected to more appropriate scrutiny, instead of remaining '*not for publication'* because of '*commercial in confidence'*.

3. Harmful

There are numerous results in the Orima Evaluation (Orima, 2017) that show either no improvement or an increase in social harms. The most alarming is that **32% of participants reported that the Trial had made their lives worse**, (while the proportion reporting that the Trial has made their lives better was 23%). Other results include:

- Alcohol abuse increased
- Drug use unchanged / unreliable
- Gambling unchanged
- Crime increased
- Violence mixed / increased
- Injuries / accidents unchanged
- Children worse off

4. Unsupported

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

5. Discriminatory

The Parliamentary Joint Committee on Human Rights (PJCHR, 2018) reported numerous times in its human rights assessments of the CDC, raising concerns about the compulsory quarantining of welfare payments. The committee's concerns related to engaging and **limiting the rights to social security, privacy and family and the right to equality and non-discrimination**. The committee expressed repeated concerns whether measures in the bill are '*rationally connected, effective and proportionate to the stated objective of the bill'*. Each EM follows the same circular process:

1. PJCHR expresses concern that the CDC engages and limits human rights
2. The EM acknowledges PJCHR evidence that CDC engages and limits human rights
3. The EM claims that the limit of these rights is '*rationally connected, effective and proportionate'* to CDC objectives
4. The EM ignores the ***overwhelming expert evidence against the CDC*** that demonstrates that the CDC is ineffective and does not meet its objectives
5. The EM self-declares that the CDC is compatible with human rights
6. PJCHR once again expresses concern that the CDC still engages and limits human rights

6. Paternalistic

The Parliamentary Joint Committee on Human Rights (PJCHR, 2018) has *"raised concerns as to the compulsory quarantining of a person's welfare payments and the **restriction of a person's agency and ability to spend their welfare payments at businesses including supermarkets***." Critics of the welfare system perversely label the safety net 'paternalistic', (just as libertarians often call regulations a 'nanny state'). Yet these critics fail to recognise the actual paternalism in trying to control people's behaviour directly by limiting access to their own money. Apparently '*not telling people how they should spend their money'* only applies to tax cuts, not income support, (which is by law, the recipients own money).

Lived Experience Evidence

I ran the two QCOSS CDC community surveys in the Hinkler trial area in 2019, (one before the trial started, and one 9 months after). Of the 180 people participated in the follow-up survey, over half (55%) were either on the card themselves or had a family member on it. **A significant majority, 81% of respondents oppose the CDC outright**. A significant majority (89%) have concerns about the CDC and a significant majority (82%) say they experience no benefits from the CDC. The most common problems people said they experienced from being on the CDC were health or mental health needing support or treatment. This sample from over 100 personal stories, describes how it affected their **mental health**:

- *"Severe increase in depression and anxiety - had to double one antidepressant dose, start a new antidepressant on top and take something to control anxiety and panic attacks, only since being put on the card."*
- *"I suffer from anxiety, depression, severe stress disorder and PTSD. My health has deteriorated. I suffer from chronic migraines, they have gotten more frequent and worse because I stress about money if Indue will pay my bills on time. I also sleep very little of a night due to stress. Overall my health and well-being has gone downhill."*
- *"It has contributed to the increase in personal anxiety and depression."*
- *"My mental health has suffered, I now have a diagnosis of depression and anxiety, I am socially isolated because of the stigma of the card"*

- *"Since being on the card I've had to start taking medication for depression for the first time in my life. This card has reduced the opportunity for me to seek work as I'm now depressed and can't afford to attend interviews."*
- *"This card has made my depression and anxiety much worse than it was I can't even stand to leave my house because of it"*
- *"You have no idea what it feels like to be someone who doesn't do drugs or have an alcohol addiction yet be classed as a druggo the moment I get seen using the card. It's made my anxiety 100 times worse"*
- *"I suffer from depression and anxiety, both of which have gotten much worse since being forced on the card. I am in counselling because of it"*

False Evidence: Misuse of National Drug Survey Data

The government has repeatedly cherry-picked from both the 2013 and 2016 AIHW National Drug Strategy Household Survey to support both the CDC and the Drug-testing Trials. They have done this in Fact Sheets, in Parliamentary and Public Speeches and in EMs. The government has only ever quoted amphetamine use (which is more common among those unemployed) and never quoted cocaine use (which is more common among those employed). The 2019 AIHW Survey has a more comprehensive list of drugs more commonly used by those who unemployed (smoking, cannabis and meth/amphetamine) and by those who are employed (ongoing and single occasion alcohol, and cocaine).
There are multiple problems with quoting this drug use data to support government interventions. The most obvious one is '***correlation does not imply causation'***. The second is that the Queensland Network of Alcohol and Other Drug Agencies (QNADA, 2019) has urged caution in using these figures as they reinforce confusion between use and problematic use, and reinforce stigmatisation of drug use in general.

6. Conclusion

The CDC is a triumph of ideology over evidence. The problem does not exist, and the solution does not work. It is simply an implementation of the government's agenda of shaming and stigmatising people accessing social security payments.

Come on, committee, surprise us! Just for a change, follow the *overwhelming expert evidence against the CDC*, and reject the Bill. You will be relieving the suffering of many!

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