Review of the Cashless Debit Card Trial in Ceduna and East Kimberley

June 2017

Preface

On 14 May 2017, the Commonwealth government decided to extend the current cashless debit card trials that have been taking place in Ceduna (South Australia) and the East Kimberley (Western Australia) until 30 June 2018. As part of the 2017-18 budget, the government also announced an expansion of the trial to a further two locations from 1 September 2017.

Given the potential for the card to be rolled out in other communities, or even nationally in the future, all child and family service providers need to be well informed about these changes and able to advocate on behalf of clients experiencing vulnerability.

For many of the low income families, the Commonwealth government's approach to welfare reform will be an additional cause of stress. It will be especially challenging for single parents with young children who face additional participation requirements accompanied by the threat of financial penalties for non-compliance.

Self-determination is about families having control over the choices they make. We need to make sure that families are not left worse off under the Commonwealth government's approach to welfare reform. The final evaluation report of the cashless debit card trials is due in July 2017. This paper examines the Wave 1 evaluation report.

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Executive Summary

Following the release of the Wave 1 Interim Evaluation Report for the Cashless Debit Card (CDC) Trial (the Trial) in Ceduna and East Kimberley, the Federal Government has recently extended the scheme for a further two years citing positive results from the report. The intervention sought to improve individual, family and community wellbeing by reducing the harm associated with alcohol, drugs and gambling. The final evaluation measuring the effectiveness of the scheme after 12 months of the Trial is due in mid-2017. The interim report demonstrates positive outcomes for a proportion of the Trial participants as they were able to save more money and spend less on alcohol, but the majority of participants said the scheme had no impact or made their lives worse. There was limited evidence to attribute the card with a reduction in harm associated with drugs and gambling. This paper provides analysis of the report, including how it presents the findings, and highlights some of the important considerations it overlooks.

Background

Alcohol is responsible for a significant level of harm across Australia. Around 3.8 million Australians drink on average 4 standard serves of alcohol each day (twice the recommended limit) amounting to 1 in 5 Australians aged over 14 (Foundation for Alcohol Research and Education 2016). Alcohol contributes to 5,500 Australian deaths each year and 157,000 hospital admissions (Gao et al., 2014). In addition to the health issues, there are the other devastating impacts on families and communities (Jiang, Livingston, & Room 2015: 2).

Harm associated with alcohol affects people and families across all socioeconomic groups in Australia. However, areas with significant income inequality (Dietze et al. 2009) and rural communities are associated with above-average levels of alcohol-related harm (Miller et al 2010). Aboriginal communities are overrepresented in alcohol-related harm, although National Aboriginal and Torres Strait Islander Social Survey (NATSISS) data shows that nearly twice as many Indigenous Australians as non-Indigenous Australians did not drink in the last 12 months (29% compared with 15%) (AIHW 2011: 19).

Rural communities such as Ceduna (South Australia) and Kununurra and Wyndham (East Kimberley) are familiar with the harms caused by excessive alcohol consumption. Between 2005 and 2009, alcohol-related hospital admissions in the Shire of Wyndham-East Kimberley were 4.7 times the Western Australian average and Kununurra's rate of reported alcohol-related assaults was 68 times

higher than the national average in 2015 (Codeswitch 2016: 8,10). Similar concerns have been raised regarding Ceduna following media attention over a number of years (ABC 2013).

The data suggests there are good reasons for government policy responses to reduce the harms associated with alcohol. What is less clear is the evidence to demonstrate a specific relationship between people on welfare payments and experiences of harm associated with alcohol. However 'welfare-fuelled' alcohol and drug use and gambling are the specific target of the Federal Government's current CDC Trial. Interestingly, research conducted by the Foundation for Alcohol Research and Education found that in 2009-2010 it was Australians in the third and fourth income quintiles that spend the highest proportion of their income on alcohol (Jiang Livingston & Room, 2015) rather than those on the lowest incomes.

The following section summarises the development and implementation of the government's current pilot intervention, which seeks to reduce spending on alcohol, drugs and gambling of people receiving government allowances.

The Cashless Debit Card Trial

In 2015, the *Social Security Legislation Amendment (Debit Card Trial) Bill 2015* (legislation for a 12 month cashless welfare card trial) passed the Senate. At the time many organisations raised concerns about the intervention, as identified in the Senate Community Affairs Legislation Committee report (2015).

The concept is attributed to Andrew Forrest's review of Indigenous jobs and training programs requested by the Australian Government (Forrest 2014). It called for a 'cashless welfare system' and a 'Healthy Welfare Card'. The planned card would differ from the Northern Territory's New Income Management 'Basics Card' as purchases would not be restricted to a selected range of shops and purchase of tobacco and would be allowed. The New Income Management (NIM) scheme in the Northern Territory was scrutinised through an extensive evaluation project between 2010 and 2013. It found that the scheme had generally not been successful in meeting its aims across a wide range of measures and that community attitudes towards the scheme remained mixed (Gray, Hand & Katz 2014).

A recent evaluation by Australian National University's Centre for Aboriginal Economic Policy Research on various Australian income management schemes (including NIM) identified several trends (Bray 2016). It found that the most effective schemes generally were voluntary and specifically target people with high-needs as part of a holistic set of services. Many schemes did not demonstrate any

improvements in the income management skills of participants, but showed signs that people may become more dependent on welfare as a result.

According to the Department of Social Services website, the CDC Trial is part of the government's efforts to determine the best ways to provide support to people, their families and communities in areas of high welfare dependence and high levels of harm associated with alcohol and drugs (Department of Social Services 2017a). More specifically, this CDC Trial is aimed at reducing the consumption of alcohol, drugs and gambling affecting the 'health and wellbeing of communities, families and children'.

The year-long Trial which began in 2016 restricts 80% of welfare recipients' payments to a CDC. The CDC delivered by Indue Ltd operates as a regular debit card, but cannot be used to withdraw cash. Customer support is offered through a customer contact centre, a mobile phone app and text alerts. The card can be used to spend on anything except alcohol and gambling (with the exception of lotto).The remaining 20% is paid into a recipient's bank account which can be withdrawn as cash. The Trial does not change the amount of money the person receives from Centrelink. The theory behind the Trial is that by restricting 80% of the payment to the card, less money will be spent on alcohol, drugs and gambling, and more spent on other important items resulting in a positive impact on health and wellbeing. A local leadership board may vary the proportion of the payment that is quarantined.

Unlike the NIM in the Northern Territory, this scheme claims not to target Indigenous people as it applies to whoever receives working-age Income Support Payments (ISP) in the selected areas. Two sites were chosen for the Trial – Ceduna in South Australia and Wyndham/Kununurra (East Kimberley) in Western Australia. Seventy-three per cent of the (ISP) recipients in Ceduna were Aboriginal or Torres Strait Islander and 86% in East Kimberley. Community Panels were established in both regions to inform the implementation of the Trial. In Ceduna the scheme was co-designed with local leaders to 'reduce welfare fuelled alcohol, drug and gambling abuse in communities', and was launched on 15 March 2016. The Trial was later implemented in Wyndham/Kununurra on 26 April 2016.

As of October 4 2016, 757 people in Ceduna and 1247 in East Kimberley had received their ISP payments through CDCs. Almost all participants were compulsorily signed up to the scheme. The most common types of ISP of people in the Trial were Parent Payments, Newstart Allowance, Disability Support Pension, Carer Payments and Youth Allowance. People receiving allowances who were beyond 'working age' were not mandatorily subscribed to the scheme.

The Wave 1 Interim Evaluation Report

Orima Research was commissioned by the Federal Government to evaluate the CDC Trial. The evaluation consists of an *Initial Conditions Report* which was conducted at the start of the Trial, the *Wave 1 Interim Evaluation Report* (released February 2017) which captured data from the Trial after six months, and the *Final Report* which is due to be released mid-2017 after 12 months of the Trial.

The Wave 1 Interim Evaluation Report (Wave 1 Evaluation) draws its content from interviews and focus groups with community leaders and stakeholders, interviews with Trial participants and their family members, and administrative data.

There were 552 people receiving payments through CDCs who participated in the Wave 1 Evaluation (196 from Ceduna and 356 from East Kimberley). Thirty-two family members of participants from Ceduna were surveyed and 46 from East Kimberley. A further 58 community members not receiving CDC payments from Ceduna and 52 from East Kimberley completed the survey.

Key Findings from the Report

Key Performance Indicator (KPI) Ratings

The report delivered findings in relation to a series of short-term output and outcome Key Performance Indicators (KPIs). The KPIs and measurable targets are not in the main report, but can be found after sifting through the Appendix A. Results from surveys with participants, family members and other community members, qualitative data from the stakeholders, and administrative data were used to measure the KPIs. The following tables show the rating given to the short-term KPIs for the Wave 1 Evaluation.

Short-term Output KPIs	Interim Rating
Number of community leaders who endorse programme	Achieved
Percent of participants who understand card conditions	Partial
Percent of participants in Trial locations sent card	Achieved
Percent of distributed cards that are activated	Achieved
80% of income support payments are quarantined	Achieved
Number of support services available in community	Not assessed

Percent of participants with reasonable access to merchants and products	Partial
Number of community leaders who believe appropriate adjustments are made to income restrictions on a case-by-case basis	Partial

Short-term Outcome KPIs	Interim Rating
Frequency of use / volume consumed of drugs & alcohol	Achieved
Frequency of use / volume of gambling and associated problems	Achieved
Percent aware of drug & alcohol support services	Partial
Percent aware of financial & family support services	Partial
Usage of drug & alcohol support services	Partial
Usage of financial & family support services	Partial

Responses to Evaluation Questions

In addition to the KPIs, the evaluation sought to answer several broader research questions.

- *What have been the effects of the CDC Trial on program participants, their families and the broader community?*

The evaluation report indicates that the qualitative and quantitative research shows a reduction in alcohol, drugs and gambling. It supports this with the survey data which shows among the 66% of respondents who had previously had alcohol, consumed drugs or gambled, a third made a reduction in at least one of these areas. The report shows limited evidence to suggest the Trial led to a reduction in crime. Appendices A62 and A63 reveal police crime statistics presented in graphs up until 3 months into the trial. Across the measures the Ceduna data shows somewhat of a downward trend whilst Kunnanura and Wyndam showed a slight upward trend overall. There was some evidence to suggest a proportion of participants had more money to spend on new items as a result of the CDC Trial. The report acknowledged the mixed feelings about the scheme among those who participated in it and from other community members. Around 49% of participants said that the intervention made their lives worse and 29% reported no change, while 46% of non-participants thought the Trial had made life better in the community, and only 18% thought it was worse as a result. Trial participants who said their lives were worse as a result often cited ‘not being able to get cash out / having no cash’ and to a

lesser extent not being able to send money to family members or give children pocket money as reasons for being worse off.

- Have there been any circumvention behaviours that have undermined the effectiveness of the CDC Trial?

The evaluation claimed to find some evidence of circumvention behaviours, but reported that it was difficult to quantify the extent of this. Circumvention behaviours relate to actions participants could use to avoid having to experience the full effects of the CDC by out-smarting the system. The behaviours mentioned included humbugging (asking relatives for cash or other items such as those quarantined by the card) and swapping purchased items for cash. Some claimed there were some criminal incidents as a result of people having less access to cash.

- *Have there been any other unintended adverse consequences?*

The report mentions a small number of the unintended adverse consequences identified in the qualitative research. These included not being able to make second hand purchases in cash-only environments such as markets, technical issues with the card, and sending money to children living in boarding schools. It indicates that only 6% of participants in the Trial reported stigma or shame using the card, although this issue was raised strongly by community leaders in the qualitative part of the study.

- *What lessons can be learnt to improve delivery and to inform future policy?*

Orima Research claim that six months into the 12 month trial is too early to assess in what circumstances the Trial has worked best, and where it has been less successful. Orima state that the evaluation is not an experiment design and therefore the impacts of the intervention cannot be 'unequivocally identified'. However they argue that due to the content of the stakeholder interviews it does appear that external variables (such as other programs seeking to reduce alcohol-related harm) had not changed over the Trial period measured to date and conclude that changes should therefore be able to be attributed to the Trial. Orima asserts that more rigorous techniques will be used in the full evaluation after long data sets become available.

Conclusions

From the assessment of KPIs and answers to the Evaluation Questions, the report drew four conclusions:

- The CDC Trial has been successful to date when compared to the KPIs

- The CDC Trial has been successful in reducing consumption of alcohol, illegal drug use and gambling 'establishing a clear 'proof-of-concept'
- The findings indicate that the CDC Trial is largely the driver behind these positive behavioural changes, not the associated increase in services or other external factors
- The current evidence to suggest a link between the CDC and a reduction in crime, violence, injuries and increased perceptions of community is limited at this point in the trial.

Issues with the Interim Evaluation Report

This section discusses several issues with regards to the report's conclusions, how the statistics are presented, the data in the appendices which is not highlighted in the main report, and methodological issues with the study.

The report's conclusions

The conclusions did not seem to reflect the mixed findings throughout the report (particularly upon reading the appendices). Even though the Wave 1 Evaluation is only the halfway mark of the Trial and the majority of stakeholders said it was too early to assess the scheme's effectiveness, Orima Research was particularly strong in its conclusions, which were used by the Federal Government to justify extending the intervention by two years. Orima claim that 'overall, the [Trial] has been effective to date … in particular, the Trial has been effective in reducing alcohol consumption, illegal drug use and gambling – establishing a clear "proof-of-concept"'. This is despite the Wave 1 Evaluation (Orima 2016: A28) acknowledging difficulty in identifying causes of any changes over the evaluation period regarding alcohol, drugs or gambling. Due to the complexity, Orima write that they will need to 'use more indirect ways to tease out the distinction' through collecting qualitative data, administrative data about service use, and survey results.

The report rightly points out that the other services that were part of the scheme had only just been implemented by the time the Wave 1 Evaluation was completed; therefore the reported drop in alcohol consumption was not linked to these services. However the report does not adequately discuss other external factors, such as the changes in alcohol management schemes in both locations, which a significant proportion of stakeholders raised (as noted in Appendix C of the report).

The year-long Takeaway Alcohol Management System (TAMS)[1] in East Kimberley, which began on 14 December 2015, ran at the same time as the CDC Trial, making it difficult for community members to attribute the impacts of either program. Orima's Wave 1 Evaluation only makes reference to it on page C12 of *Appendix C: Qualitative Summary Reports*, explaining that some East Kimberley stakeholders made note of other external factors that may have contributed to the reduction in alcohol related incidents such as TAMS. This is also reflected in the Final TAMS Review where focus groups of community members and consultations with licensees suggested attribution was difficult given the concurrent changes (Codeswitch 201613). Like the CDC Trial, the TAMS evaluation showed mixed results: some community leaders attributed it to a reduction in public drunkenness and others noted that the approach penalises the law-abiding majority and raised concerns about privacy issues.

Presentation of the statistics

The evaluation often presented the data in ways that emphasised the positive impact of the scheme. A different perspective on the same data presents a less positive picture of its effectiveness. For example, the report highlights that, of the 66% participants who reported drinking alcohol, taking drugs or gambling during or before the Trial, 33% reported a reduction in at least one of these things. Another way of reporting this is that 78% of the overall number of participants made to participate in the scheme did not report a reduction in alcohol, drugs or gambling (which was the very reason the program was developed).

One of the indicators used to demonstrate how the Trial met its KPI regarding impact on gambling would be less convincing if a longer time scale was used. Regarding expenditure on Electronic Gambling Machines (EGM) in Ceduna, the Orima report highlights that spending between April and August was down 15% compared with the previous year. Figure 45-Poker Machine Revenue in the appendices (A40) shows significant variation across the last few years. It also shows revenue fall from its height in the winter of 2015 at the same time as the additional liquor restrictions were introduced. A simple comparison with the EGM revenue with the same time the previous year simply does not reflect its long-term variability and the potential impact of a whole range of other external factors.

Selective use of data in the appendices

The main report lacks some of the nuance provided by data found in the appendices. In particular, much of the rich qualitative data obtained through the focus groups and in-depth interviews with stakeholders (who were selectively chosen for their insight) is largely absent in the main report, and

[1] See Codeswitch (2016) for overview and evaluation of TAMS.

exists only as an appendix. Interspersing this qualitative data throughout the corresponding survey data would have made for greater insight into the numbers reported.

The report states that community leaders and other stakeholders were asked for their in-depth input for the qualitative aspect of the evaluation because of their 'capacity to provide relevant and informed feedback' (p7). Across the focus groups and in-depth interviews with stakeholders in Ceduna and East Kimberley, over 75% felt it was 'too early' in the Trial (halfway) to be able to gauge the impacts of the intervention (Orima Research 2017a: C1, C12). According to the report the interviews were either conducted over the phone or face-to-face.

The majority of the 33 stakeholders in Ceduna 'did not believe that there had been significant change' as a result of the Trial but various stakeholders were able to see some early signs of improvements (C1). Around a third felt external factors, such as the cold wet weather at the time of the data collection and the alcohol restrictions implemented in 2015, were more likely the reasons for lower levels of public drinking. The majority of participants were not prepared to link the CDC Trial with a reduction in alcohol consumption, but around a third noticed some broader positive changes in the community that could be indirectly linked with the Trial. A small proportion of participants felt it was having a positive impact due to the perceived lower level of drinking in public. Another key theme was the perception of less gambling on EGMs in the town since the Trial began.

The qualitative interviews and focus groups with the 40 East Kimberley stakeholders were more positive with around half claiming that they could see early signs of the Trial working. Around a third of participants felt there were external factors that could be influencing the survey findings. These included population decreases as the weather changed from the dry season to the wet season,[2] changes in policing strategies and the closure of a major employer. Around half of the East Kimberley stakeholders reported observable changes at a personal and community level pointing to a reduction in alcohol consumption.

There were two more key findings in the qualitative data from the two sites. First, the majority of stakeholders had seen evidence that CDC Trial participants were better-off financially. This was demonstrated by a perceived increase in purchases of various goods. Secondly, there was a fear at the start of the Trial that there might be an increase in petty crime, however six months in there was little evidence of changing crime rates across the two regions.

[2] The shire's population can decrease by around 20% over the wet season. Codeswitch (2016, 9)

In addition to the qualitative data consigned to the appendices, some interesting administrative data is made available which fails to make headlines in the report. It shows that 21,000 (51%) card transactions failed due to lack of funds on the accounts. Further exploration of this figure would provide important information about whether this is largely explained by people having trouble monitoring their balance or whether people routinely lack the level of income required for basic needs.

Bringing more of this data in the appendices into the main section of the report, and triangulating it with the survey data, would strengthen the evaluation and perhaps result in a different set of conclusions.

Methodological issues

A recently published review of the Wave 1 Evaluation for the Centre for Aboriginal Economic Policy Research at the Australian National University argues that the evaluation relies too heavily upon subjective perceptions and opinions about the effectiveness of the scheme rather than more conclusive forms of data. Additionally this data is not triangulated systematically to verify the findings throughout the report (Hunt 2017). Furthermore, the report (p2) highlights a methodological flaw in the interviewing of some of the Trial's participants. Orima's footnote in Appendix E notes that not all stakeholders interviewed in the Phase 1 Trial were interviewed for their baseline data in the initial Conditions Report. Rather, they were asked to retrospectively complete this at the same time as rating their perception of the scheme six months into the Trial. The number of participants this refers to is not stated, and their ratings were simply included in the average ratings which were used by the Federal Government to justify the decision to continue the scheme beyond the 12 month Trial. Hunt (2017) suggests that as a result these responses were likely affected by recall bias.

Whilst 91% of the CDC Trial participants who were surveyed were Indigenous, only 15% of the stakeholder organisations involved in the focus groups were Aboriginal organisations (D1-2). If there were a higher proportion of Aboriginal voices heard through the qualitative aspect of the evaluation, there would have been greater opportunities for cultural insight into some of the issues facing recipients.

Additionally, the overall information provided by the report and the appendices on the methodology is quite limited. This is highlighted by the lack of survey instruments provided in the appendices. Without this information it is difficult to know how exactly the surveys, interviews and focus groups were conducted and how this affects the findings.

Although a large sample of participants in the scheme was used for the evaluation, the 'systematic intercept method' (mentioned on page 12) that was used is potentially problematic. This method involved standing on 'high traffic sites' as well as roving particular areas and asking at least every second person if they are involved in CDC and if they would like to participate in the evaluation. Although the report claims participation rates were reasonable for the methodology, it led to about the same level of people declining to participate in the evaluation as people accepted in East Kimberley. This raises questions as to whether this methodology led to the most robust evaluation of the program.

There is no cost-benefit analysis of the scheme or comparison with other policy responses, such as increased support services, in the evaluation report. Therefore there is little evidence provided as to whether this policy 'stacks up' economically. The evaluation does not disclose the costs of the program, but details were recently obtained through the Department of Social Services under freedom of information. The estimated maximum cost of the trial is stated to be $18.9 million to administer, which equates to around $11,000 per participant for the year (Department of Social Services 2017b). The report is silent on the existing evidence base on policy interventions to reduce the harms associated with alcohol, drugs and gambling (even though they have been involved in other income management evaluations previously). This leaves the reader without a useful comparison upon which to base the effectiveness of the CDC Trial.

Political responses to the Wave 1 Evaluation

Following the release of the Wave 1 Interim Evaluation Report, the Federal Government hailed the scheme a 'success' with much publicity, citing the report's conclusions and the few highlighted statistics in the executive summary (*The West Australian* 2017;SBS 2017). Based on the results at the halfway mark of the trial, the government has decided to continue the intervention for a further two years with reviews every six months. The 'clear proof of concept' reported in the evaluation (a somewhat ambiguous term that could be misused) has led to calls for further expansion, with the government announcing the introduction of CDC to two new sites by July 2017 (Department of Social Services 2017c). The Federal MP for Ceduna, Rowan Ramsey, told the media 'I find it difficult to envisage a community that it wouldn't work in … It doesn't matter where you go, whether you go to Port Augusta or Adelaide or into the middle of Sydney' (ABC 2017a). Andrew Forrest's organisation, *the Minderoo Foundation*, recently launched a television advertising campaign to expand the CDC, particularly for people under the age of 18. The campaign contends that gambling, alcohol and drug use are down 33%, with reference to the Wave 1 Evaluation (ABC 2017b). Even before the release of the evaluation on 4 October 2016, the Hon Alan Tudge MP, Minister for Human Services, also discussed on ABC radio the government's proposed exploration of cashless welfare cards for youth (Department of Social Services, 2016).

Conclusion

The Wave 1 Interim Evaluation Report for the Cashless Debit Card Trial in Ceduna and East Kimberley shows some signs of improved outcomes for some in the trial. This included reported reductions in alcohol consumption and claims that some participants have more disposable income. However the overall data shows the CDC was ineffective in achieving its goals for the majority of participants who had their income quarantined without their permission. Forty-nine percent of the participants felt the CDC made their lives worse. The interim evaluation does not distinguish for which people the CDC assists and in what circumstances. The evaluation does acknowledge that the final report after the full 12 months of the evaluation will be able to present a fuller picture of the Trial's effectiveness and hopefully provide additional nuances. At the same time however, the Wave 1 Evaluation made some very strong conclusions that were used to justify the extension and expansion of the program. The conclusions reported in the evaluation do not appear to reflect the mixed results of the quantitative and qualitative data. They instead present a more positive picture than the full report and the appendices demonstrate.

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