THE CASHLESS DEBIT CARD TRIAL: A PUBLIC HEALTH, RIGHTS-BASED APPROACH TO BETTER HEALTH AND SOCIAL OUTCOMES

by Kristen Smith

INTRODUCTION

In early 2016, the Australian Government introduced a trial of the cashless debit card ('CDC') for working age adults receiving specific Income Support Payments ('ISP') in Kununurra and Wyndham, East Kimberley ('WA') and Ceduna and surrounding region ('SA').[1] The CDCs can be used in the same manner as other debit cards, but do not allow cash withdrawals, and cannot be used to purchase alcohol or gambling products.[2] The CDCs are attached to a separate, restricted bank account of which 80 per cent of the recipient's ISP is directed.[3] The remainder of the ISP is paid to the recipient's usual account. [4] For example, a single person with no dependants on Newstart Allowance in private rental accommodation will receive $526 on their CDC and $131 to an unrestricted account each fortnight. A single parent with four children in private rental will receive $1,705 on their CDC and $426 in an unrestricted account each fortnight.[5] The main aim of the CDC trial is to provide a suite of measures that will support 'disadvantaged communities to reduce the consumption and effects of drugs, alcohol and gambling that impact on the health and wellbeing of communities, families and children'.[6]

Both trial sites have Indigenous populations of approximately 30 per cent. About a quarter of the working age population of both areas were deemed eligible for the CDC trial and were receiving their ISPs on this basis at the end of 2016.[7] Indigenous CDC trial participants consisted of 49 and 45 per cent of the total Indigenous populations in the East Kimberley and Ceduna regions, respectively. Non-Indigenous CDC trial participants made up six and five per cent of the total non-Indigenous populations at each site.[8]

The level and extremity of social and health-related harms have increased in both trial areas during the past decade, predominantly associated with the misuse of alcohol, but also in relation to excessive illegal drug misuse and gambling.[9] Unacceptable rates of violence, assault, early death and avoidable illness in both communities have been closely associated with increasing levels of alcohol misuse.[10] These factors have led to the strong support of the trial by community leaders in the East Kimberley and Ceduna and surrounds.[11]

This article outlines the background and rationale of the CDC trial, illustrating its public health, rights-based approach with a focus on alcohol issues. It further addresses outcomes of early evaluations and related evidence. Although initial evaluations of the trial have reported largely positive results, there are also mixed and negative findings.[12] It is accurately pointed out by the evaluators and understood by experts and practitioners, that one year is insufficient time to decisively understand the long-term outcomes of any new and complex social or public health program. However, given all factors, this article argues the recently granted extension of the trial was warranted, allowing the incorporation of potential improvements and better understandings of its long-term outcomes.[13]

BACKGROUND

The CDC trial emerged from the recommendations of Andrew Forrest's Review of Indigenous Jobs and Training.[14] What was entitled the 'Healthy Welfare Card' in the Review was only one aspect of a broader suite of reforms conceptualised, with the overarching objective to 'create opportunities, engage and provide incentives for first Australians, prevent disadvantage by initiating intensive early childhood development and education, and support the most vulnerable to make sound life choices and manage their finances'.[15]

The CDC trial was enabled by the *Social Security Legislation Amendment (Debit Card Trial) Act 2015* (Cth), with aims to:

(a) reduce the amount of certain restrictable payments available to be spent on alcoholic beverages, gambling and illegal drugs;[16] and
(b) determine whether such a reduction decreases violence or harm in trial areas; [17] and
(c) determine whether such arrangements are more effective when community bodies are involved; [18] and
(d) encourage socially responsible behaviour[19]

Although the Healthy Welfare Card was not framed as 'income management' ('IM') by the Forrest Review, the CDC trial can be loosely placed in this category, in that it diverts a percentage of a welfare recipient's funds into an account that places restrictions on cash availability and purchasing.[20] However, unlike other IM programs in Australia, those receiving ISPs on the trial can spend 80 per cent of their payment on anything in the cashless economy, except for alcohol and gambling. The remainder of their payment can be used for anything in the cash economy, which includes alcohol or gambling if the recipient so chooses. Further, the ratio of the ISP that is apportioned to an individual's CDC and regular payments can be varied on the basis of a recipient's application to a site-specific community board, by legislative instrument by the Minister for either a trial area, or class of persons in a trial area.[21]

THE CDC TRIAL AS A PUBLIC HEALTH, RIGHTS-BASED APPROACH

In Australia and internationally, 'public health' approaches are used to respond to many population-based issues. A public health approach can be defined as an:

> … organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole, or population sub-groups.[22]

The body of national and international evidence correlating alcohol access and high levels of consumption with alcohol-related health and social harms is indisputable, and is broadly understood as a public health issue.[23] Australian adults consume approximately 7.9 million standard drinks per year. This is the equivalent of 9.7 litres of pure alcohol per adult, or more than 500 cans of beer annually.[24]

The National Wastewater Drug Monitoring study of 14 million Australians released by the Australian Criminal Intelligence Commission further confirmed that alcohol (alongside tobacco) is the most highly consumed substance in all Australian jurisdictions.[25] However, we also know that around a fifth of the population abstain from alcohol altogether, more so in the Indigenous population (23 per cent Indigenous compared to 17 per cent non-Indigenous),[26] and that about 60 per cent of Australians drink in moderation. Thus, the remaining one fifth of the population drink nearly three quarters of all alcohol consumed in Australia. Half of this group drink more than six standard drinks per day every day,[27] which is over three times that recommended by the National Health and Medical Research Council's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*.[28]

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As such, measures regulating the supply of alcohol, commercial practices of licensed venues, who is allowed access, and so forth, are now the norm globally. Across Australia, problematic use of alcohol, drugs and gambling are addressed prolifically through regulations that attempt to reduce consumption, purchase and consequent related harms.[29]

The acute need for disruptive intervention in the context of the extreme alcohol-related harms and alcohol misuse in both trial areas are also validated by a wide range of datasets, including indicators reporting on alcohol consumption, alcohol-related offences and alcohol-related hospitalisations. In the Kimberley, the estimated per capita consumption of pure alcohol (16.10 litres) is far higher than the national annual average (9.71 litres).[30] Both police and hospital data in Kununurra illustrate the extremity of the problem of alcohol misuse and related harm in the area. Police data in Kununurra during 2013 showed 744 incidents of assault, 323 of which were alcohol related and 207 of which were alcohol-related domestic assaults.[31] In 2014, of the 675 assaults, 328 were alcohol-related, 181 of these being alcohol-related domestic assault. Further, around 60 per cent of sexual assaults in the region are alcohol-related and alcohol-related domestic assaults occur at four times the rate of domestic assaults without any involvement of alcohol.[32] More than 80 per cent of domestic assault offences are alcohol-related, and this rate has steadily increased since 2010.[33] Two thirds of all other assaults are alcohol-related.[34] Hospital data from Kununurra has recorded that the incidence of all alcohol-related conditions occur at a rate that is more than four times that of the rate of the rest of Western Australia, and account for at least 75 per cent of all treatment episodes.[35]

A South Australian Coronial Inquest released in 2011, investigating the deaths of six Indigenous people in Ceduna and surrounds (2004 to 2009), pointed to the severity of alcohol abuse for each individual and how it played a significant factor in their lives and deaths.[36] It reported that 'evidence adduced before the Court establishes that there is without a doubt a severe and intractable culture of excessive alcohol consumption',[37] particularly in the transient Indigenous population of Ceduna and surrounding communities. It further described how attempts to reduce the extreme harms experienced as a result of alcohol misuse in the area had been largely ineffective.

Thus, a core aim of the CDC trial is to reduce alcohol misuse and associated harms such as family violence. Alcohol consumption increases the likelihood of family and intimate partner violence and homicide, with 87 per cent of intimate partner violence among the Indigenous population being alcohol related.[38] In Australia, over a six-year period, nearly half of homicides were classified as alcohol-related.[39] Further, 81 per cent of homicides involving one or more Indigenous victims were categorised as alcohol-related. We also know that Indigenous women are 34 times more likely to be hospitalised for assault than non-Indigenous women.[40] The human right to live a life free from violence in all of its forms is recognised in all of the key international human rights agreements.[41] In contrast, the right to buy or possess alcohol has little to no international or national legal status. This question was addressed by the High Court decision of *Joan Monica Maloney v The Queen*.[42] The plaintiff, a resident of Palm Island, was convicted of possessing alcohol in excess of the restrictions. She asserted that the restrictions in the *Liquor Act 1992* (Qld) were racially discriminatory and affected her right to own property (i.e. alcohol), which was in breach of section 10 of the *Racial Discrimination Act 1975* (Cth) ('RDA').[43] Although a five to one majority of the Court held that the provisions did have a discriminatory effect upon the rights of Indigenous persons to own property, it was further held that the restrictive laws are special measures under section 8 of the RDA (which refers to article 1(4) of the *Convention on the Elimination of all Forms of Racial Discrimination*).[44] Krennan J stated:

> The human right or fundamental freedom sought to be protected … is the right of Aboriginal persons of Palm Island, in particular women and children, to a life free of violence, harm and social disorder brought about by alcohol abuse.[45]

Kiefel J further reiterated that the freedom to possess alcohol for consumption cannot be characterised as a human right.[46]

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The 'Capabilities Approach' (CA) provides an alternative rights-based framework to dominant understandings of justice, liberty and welfare. CA examines both the substantive and procedural requirements for the achievement of social justice. This approach is attributed to Sen and Nussbaum.[47] Sen discusses capabilities as 'substantive freedoms', or the combination of opportunities and abilities individuals might have to live a dignified life.[48] Nussbaum contends there is a need for a moral, philosophical dimension to ensure social justice in society and that there are some freedoms that should supersede others.[49] When addressing alcohol-related problems from a CA perspective, alcohol misuse is understood as an infringement of freedoms so weighty that it is irreconcilable with people's lives being led with human dignity. The excessive levels of violence associated with high levels of alcohol misuse destroy the capabilities of individuals, families and communities, interfering with their right to health, safety and freedom from violence. These detrimental effects, particularly for women and children, have repeatedly been detailed in reports such as the 'Cape York Justice Study'[50] and 'The Little Children are Sacred Report'.[51]

In 1990, Australia ratified the *Convention on the Rights of the Child,* which sets out the child-centric spectrum of human rights.[52] Articles 19 and 26, in particular, outline the role of the state in ensuring children are protected from all forms of violence and their right to benefit from Social Security.[53] Safeguarding these specific rights of the child are key features sought to be addressed by the CDC trial. However, critics have argued that the CDC trial's approach to reducing problematic alcohol consumption is paternalistic, driven by neoliberal ideology and is an affront to human rights.[54] Those claiming it is paternalism contend the CDC trial limits the autonomy of ISP recipients, and that for communities with high Indigenous populations it limits self-determination. Mendes further contends the trial is a 'spray-on' solution, using a minimal community approval approach to disguise the trial as participatory model rather than what he argues is really a top-down, neoliberal intervention.[55] Community leaders have not indicated concern regarding lack of community consensus, nor of paternalism undermining self-determination. In contrast, many Indigenous community leaders in the East Kimberley and the Ceduna area have gone on public record to express their support of the trial. For example, Greg Franks, a representative of the Yalata community of the Ceduna region noted:

> It is not about restricting people's lives; it is about providing an opportunity for people to reshape their lives and to find a healthy life; and it is about putting the support measures in to help them maintain that healthy life.[56]

Ian Trust, Executive Director of the Wunan Foundation and well-respected Indigenous leader in the East Kimberley noted:

> Unlike other reform efforts undertaken by government, it has been the Indigenous leaders of the East Kimberley who have led this reform. This has not been about government imposing its will on us. This has been about Indigenous leaders making the tough decisions, backed by government policy, in order to make change happen.[57]

The Chairpersons and Boards governing the Koonibba Aboriginal Community Corporation, the Yalata Community Council, and the Ceduna Aboriginal Corporation all endorsed the Ceduna CDC trial explaining their position in a submission to the Senate Community Affairs Committee:

> At the heart of this reform, is a change that is being shaped specifically to meet our local needs. It has been a true collaboration to ensure that we can give our people and our Communities every chance to create real and genuine change in their lives.[58]

ADDRESSING THE EVIDENCE: CDC TRIAL EVALUATIONS AND RELATED DATA

There have been two stages of the evaluation of the CDC trial conducted by the independent research organisation ORIMA, with a third scheduled for release in mid-2017. The first was primarily qualitative , undertaken prior to the trial, to establish a baseline for comparison over time.[59] The second evaluation used mixed-methods, including qualitative research with stakeholders and community leaders, alongside quantitative surveys of participants, family members and non-trial community members.[60] Both evaluations have included analysis of administrative data.

A key finding from the first report was that alcohol misuse was the primary area of concern for stakeholders in both regions and that excessive consumption had increased over the past decade.[61] It reported the common alcohol-related harms at the trial sites included fatal and non-fatal injuries to the drinker and to others; chronic and severe acute health conditions in the drinkers and their children, including mental illness and Foetal Alcohol Syndrome Disorders (FASD); and family violence.[62] Alcohol misuse was the main perceived contributing factor to violent and criminal behaviours, which contributed progressively to a decline in resident security and community safety at both sites. Further, although drug use was not thought to be as widespread at the sites, excessive consumption remained a concern, particularly increases in the use of amphetamines.[63] Gambling was viewed as more of a problem in Ceduna compared to the East Kimberley region, where it was considered a significant barrier impacting on individuals and family's abilities to meet basic living needs such as food, housing and supervision of children.[64] In the second evaluation, a quarter of CDC trial participants and 13 per cent of their family members reported drinking alcohol less frequently. A quarter of participants also reported engaging in less frequent binge drinking. More than 40 per cent of people across the trial sites noticed a reduction of alcohol consumption in their communities. More than a quarter of people across the trial sites reported a reduction in gambling in the area. Approximately a quarter of the self-reported illegal drug users reported a reduction in use.[65]

Negative or mixed findings from the second evaluation included that the community panels that assess applications to vary the percentage of ISP payments to the CDC had not been established fast enough at either trial site. Most participants and family members also reported that demands and requests for money from family or community members (known as 'humbugging') had increased, but other stakeholders reported this had decreased. Trial participants were not effectively informed about the additional alcohol, drug, financial and family support services available to them. Nearly half of the participants reported that the trial made their lives worse, but this varied significantly by gender, with men reporting it made their lives worse at a significantly higher rate than women.[66] Langton argues that this data does not prove that lives are actually getting worse, only that people perceive this to be the case. In the absence of greater context, she suggests one reason for this could be participant and family resentment of the CDCs initial technical problems or lack of understanding.[67] These early evaluations have also been questioned by Hunt, contending that the complexity of the trial site contexts require a more in-depth and nuanced approach to evaluation, with greater care taken in the interpretation of the data. She further argues that the short-term duration of the trial means that many of the conclusions drawn are questionable, highlighting the positive outcomes and downplaying the negative.[68]

CONCLUSION

The CDC trial is best understood as a public health, rights-based program. It prioritises the rights and freedoms of women, families and children to live their lives free from the ill-effects of excessive alcohol, drugs and gambling. Initial evaluations of the trial at both sites have reported largely positive results, notably reductions in alcohol consumption, alongside negative and mixed outcomes.[69] Although the evidence presented by the first phases of evaluation of the CDC are not yet sufficient to decree the trial a success or failure, they are arguably enough to warrant its extension to determine its long-term effectiveness. The rotating policy and legislative agenda experienced in many Indigenous Australian contexts too often results in the introduction of measures that are removed by successive governments before there is enough evidence to understand their efficacy. As the CDC is still in its trial phase, instead of reactive calls for its removal, it is surely far better to adjust the evaluation processes to better understand how it can be improved to benefit its recipients and the communities in which it is implemented.

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