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Submission to the Senate Community Affairs Legislation Committee

Inquiry into Social Services Legislation Amendment (Cashless Debit Card) Bill 2018

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Introduction

The St Vincent de Paul Society National Council (the Society) welcomes the opportunity to provide feedback on the *Social Services Legislation Amendment (Cashless Debit Card) Bill 2018* (the Bill).

The cashless debit card (CDC) compulsorily quarantines a portion of a person's social security benefits, placing 80 per cent of their income support onto a card that cannot be used to withdraw cash or purchase alcohol or gambling products. This Bill seeks to extend the CDC trial to the Federal electorate of Hinkler, an area in Queensland that includes Bundaberg and Hervey Bay. The Bill delimits the scope of participants in the new trial location to people who are 35 years of age and under and who receive the Newstart Allowance, Youth Allowance (other) or Parenting Payment. According to the Minister's second reading speech, the proposed new trial will affect around 6,700 people, making it the largest of all the CDC trial sites.[1]

As an organisation committed to social justice and overcoming the causes of poverty and inequality, we strongly recommend that this Bill be rejected. There is a clear and compelling need for more effective policies that tackle entrenched poverty, long-term unemployment and the social problems that stem from profound social and economic disadvantage. We also recognise that alcohol and drug abuse cause significant health and social harms across Australia. This Bill, however, does not provide an effective response to these pressing social problems. We believe the CDC is a paternalistic and counterproductive measure that is not supported by evidence and risks compounding some of the very factors that contribute to ongoing disadvantage and disempowerment among those who rely on income support.

This submission examines the assumptions underlying the CDC, assesses the existing evidence base and official evaluation of the CDC trial, and considers the wider moral and ethical implications of this measure. Based on this analysis, we identify several key objections to the expansion of the CDC trial. Firstly, we reject the implied causes and solutions to the problems that the CDC is meant to solve. Underlying the trial is an assumption that poverty, unemployment and entrenched disadvantage stem from irresponsible behaviours, idleness, and poor lifestyle choices. This deficit model of social disadvantage blames individuals for their poverty and unemployment, deflecting attention away from the wider structural causes of unemployment and poverty, such as a lack of available work.

Second, we challenge claims that the expansion of the CDC is supported by evidence.[1] There is a lack of reliable evidence demonstrating the efficacy of the CDC in existing trial sites, and proponents of the CDC expansion have cherry-picked and misrepresented the official evaluation. A recent audit of the official evaluation confirms its numerous flaws and the lack of a credible evidence base to justify a further expansion of the trial.

While the evidence does not show the CDC is effective in meeting its stated objectives, we are also concerned about its potential to create and exacerbate social problems. There is evidence that compulsory income management has led to a range of adverse consequences, including an increase in social exclusion, stigma, difficulty providing for family needs, and the erosion of individual autonomy. If passed, this Bill risks creating problems that the Government has failed to address and acknowledge in the trials that have been undertaken to date.

Further concerns stem from the inadequacy of consultations with local communities and the ongoing practical and logistical problems that beset the roll-out of the card. The CDC is incompatible with

domestic and international human rights laws, including the right to social security, the right to privacy and the right to self-determination. It is also extremely costly to administer and diverts resources away from other, more productive approaches to tackling inequality and entrenched poverty.

Ultimately, we believe that the CDC is a paternalistic and punitive measure, driven by ideology rather than evidence. While reducing the harmful effects of drug and alcohol addiction is a legitimate policy objective, the social security system is neither an appropriate nor effective policy lever for achieving such outcomes. Using social security as a punitive tool to control and disempower people detracts from the underlying purpose of the social safety net, and it does not address the underlying factors leading to drug and alcohol abuse or long-term unemployment. This approach is not supported by evidence and contributes to the ongoing demonisation of income support recipients.

The most marginalised in our society deserve a socially just social security system based upon need, not prejudice, and the targeting of public funds to productively improve their livelihoods rather than unproductively vilify them. It is imperative, therefore, that the Bill currently under consideration by the Senate is rejected. In a context of persistent poverty and growing inequality, we urge the Government to reinstate poverty alleviation as the central goal of income support policy, rather than extend a punitive income management agenda on the basis of questionable evidence.

About the St Vincent de Paul Society

The St Vincent de Paul Society (the Society) is a respected lay Catholic charitable organisation operating in 149 countries around the world. Our work in Australia covers every state and territory, and is carried out by more than 58,000 members, volunteers, and employees. Our people are deeply committed to social assistance and social justice, and our mission is to provide help for those who are marginalised by structures of exclusion and injustice. Our programs assist millions of people each year, including people living with mental illness, people who are homeless and insecurely housed, migrants and refugees, women and children fleeing domestic violence, and people experiencing poverty.

Our concerns with the Bill

Problems with the underlying assumptions and approach

The CDC has been rationalised as a means of overcoming 'intergenerational welfare dependency', substance abuse and gambling addiction. The expansion of the trial is premised on the notion that withholding cash payments from unemployed young people will curb anti-social behaviours and strengthen employment outcomes, as well as improving parenting practices and the wellbeing of children. According to the Explanatory Memorandum for the Bill:

> Rolling out the debit card in the Bundaberg and Hervey Bay area will stabilise the lives of young people in the area by limiting spending on alcohol, drugs and gambling, thus improving their chances of finding employment or successfully completing education or training. It will also assist young families to meet the needs of their children.[2]

This approach relies on a simplistic understanding of social disadvantage and substance addiction that is reductionist and individualist, focusing on individual responsibility and the alleged shortcomings of people receiving income support. It rests on several questionable assumptions, including:

- ***Poverty, unemployment and entrenched disadvantage stem from irresponsible behaviours, individual attitudes or ineptitude, and/or poor lifestyle choices.*** This deficit model of social disadvantage blames individuals for their poverty and unemployment.
- ***Income support payments foster 'welfare dependency' and encourage irresponsible spending habits and anti-social behaviours.*** This thinking is reflected in the reasons given for selecting Hinkler as the trial site, which conflate "high youth unemployment and intergenerational welfare dependence" with the "neglect of children" and "high use of alcohol, drugs and gambling".[2,3,4]
- ***Quarantining income support and reducing discretionary funds for alcohol, drugs and gambling will decrease the harms associated with these products, encourage socially responsible behaviours, and improve employment outcomes.*** The assumption is that controlling spending choices will 'correct' individual behaviours and attitudes, resulting in better social, health and employment outcomes.

We reject these simplistic assumptions and the underlying deficit-oriented approach that blames individuals for their poverty and unemployed status. We recognise there are high levels of youth unemployment in the proposed trial site and levels of social disadvantage that are unacceptably high. While there are a number of complex reasons for this disadvantage, the key driver for reliance on income support is the lack of local job opportunities.

In addition to the subdued labour market, a range of social and economic factors contribute to social disadvantage in the Wide Bay region, including lower levels of educational attainment, the undersupply of health and mental health services, and limited access to youth services and drug and alcohol services. While most young people who are unemployed do not have issues with drug and alcohol dependency, we recognise that a minority struggle with complex issues of addiction and social disengagement. Such issues, however, are complex and require responses that are informed by an understanding of the causes of drug and alcohol dependency and other social problems.

There is no simple remedy for entrenched disadvantage. It is not just a matter of cutting off access to cash payments and alcohol and drugs. Responses need to be informed by an understanding of the underlying causes and complex realities of people's lives. Lack of local job opportunities, weak social networks, limited access to services and support for parents and at-risk youth, poor mental and physical health, low levels of skills and limited educational opportunities, and chronically low incomes all contribute to the persistence of disadvantage. These problems need a comprehensive approach informed by evidence – not a simplistic and punitive response based on stereotypes.

Problematic notion of 'intergenerational welfare dependency'

Both the Explanatory Memorandum and the Minister's second reading speech refer to 'intergenerational welfare dependency' as part of the justification for introducing the CDC in the Bundaberg and Hervey Bay region.[2,5] However, the notion that parental receipt of income support is itself responsible for chronic youth unemployment is misleading and unhelpful and, contrary to the Minister's assertions, is not supported by the weight of empirical evidence.

While there is evidence that children with an unemployed parent are more likely to experience unemployment during adulthood, research shows that it is inequality of opportunity and the cumulative effects of social and economic disadvantage that are the primary reason for this association.[6,7] This is highlighted in a recent study undertaken by Cobb-Clark et al., which examined the relationship between parents' and their children's receipt of income support over an 18-year period.[8] Although the children of parents receiving income support were more likely to subsequently require income support than children with parents had never received income support, the study found that the length of time parents received income support did not strongly influence children's receipt of income support. Instead, receipt of disability or carer payments by parents was more strongly correlated with children receiving income support, suggesting that circumstantial factors (such as disability and poor health) may reduce parents' ability to invest in their children, thereby shaping subsequent employment outcomes. The report's authors also maintain that the fact that what matters is not how much income support is received by parents, but whether parents received it at all, "argues against the existence of a widespread welfare culture in which values are shaped and disadvantage becomes increasingly entrenched".[8]

Simplistic explanations that attribute unemployment to intergenerational cultures of welfare dependency overlook the range of social and economic factors that contribute to entrenched disadvantage. Disadvantages can cluster in regions due to a range of structural issues and policy failings, including limited access to quality education or services, lack of local labour market opportunities, inadequate income support payments and underinvestment in economic and social infrastructure. The cumulative impact of these economic disadvantages contributes to deep and long-term poverty, which can in turn compromise educational, health and employment outcomes.

Comparative analysis of inequality and rates of poverty across countries shows a clear association between policies that reduce income inequality and lower levels of intergenerational disadvantages:

> Countries with greater inequality of incomes also tend to be countries in which a greater fraction of economic advantage and disadvantage is passed on between parents and their children… Inequality lowers mobility because it shapes opportunity. It heightens the income consequences of innate differences between individuals; it also changes opportunities, incentives, and institutions that form, develop, and transmit characteristics and skills valued in the labor market; and it shifts the balance of power so that some groups are in a position to structure policies or otherwise support their children's achievement independent of talent.[6]

From this perspective, the focus on so-called 'cultures of welfare dependency' or parental attitudes to work is misplaced and distracts from the structural factors affecting equality of opportunity. As the research shows, it is these structural factors which have a more decisive effect on the labour market outcomes of children who grow up in families receiving income support. In other words, the problem of youth unemployment targeted in this Bill requires a comprehensive response that reduces inequalities in opportunities and grapples with the underlying causes of labour market disadvantage – not an approach based on simplistic and misleading notions of intergenerational welfare dependency.

Neglects structural and systemic drivers of disadvantage

The introduction of the CDC will do little to address the social and economic drivers of disadvantage and unemployment in the Bundaberg and Hervey Bay region. While economic solutions alone will not eliminate disadvantage, any policy that fails to engage with the social and economic context is unlikely to result in meaningful and sustained improvements in employment and other social outcomes.

Economic and labour market conditions in the Bundaberg and Hervey Bay region

The primary factor driving high levels of unemployment in Bundaberg and Hervey Bay is the disparity between job opportunities and the number of people seeking work. As the Member for Hinkler, Keith Pitt, has himself acknowledged, "one of the major hurdles that job seekers face locally is a lack of vacancies and, of course, the high number of applicants".[9] Similarly, a 2017 report on workforce development in the Wide Bay and Fraser Coast region reported that:[10]

> Stakeholders were concerned about the high levels of unemployment in the area. They reported that there was a shortage of jobs in the area, with job seekers outnumbering the positions advertised.

It was also reported that many local workers are in relatively unskilled, insecure and low-paid roles, with limited opportunity for professional development and career advancement.

The lack of paid job opportunities has been affected by a range of regional factors and wider macro-economic trends, as well as inadequate government investment in infrastructure and economic development. In recent years, the economy of the Bundaberg and Hervey Bay region has grown at substantially lower levels than the average growth rate of both Queensland and Australia. As the Economic Development Strategy for the Wide Bay Burnett region states, this low level of economic growth is in part attributable to "limited infrastructure for economic activities, limited investment in assets and an unskilled workforce".[11] The labour market in this region has been highly volatile and vulnerable to structural adjustments in the economy, with downturns in traditional industries and a workforce prone to frequent shifts into and out of employment.[10,12]

Economic activity and business confidence in the region remains subdued. Employers have indicated that future recruitment activity is likely to be subdued and, compared with overall levels of employer confidence across Australia, they are more pessimistic about economic conditions in the region and future demand for products and services.[13] Between 2015 and 2016, the number of businesses registered in Bundaberg dropped by 1.5 percent and, since 2016, there has been a downward trend in the number of jobs and people employed.[14]

An employment forum convened by the Queensland Government in 2016 identified a range of challenges to the labour market in Wide Bay Burnett region, including:

- an overreliance on a limited number of industries, many of which are subject to seasonal fluctuations or had experienced a downturn over the past decade;
- difficulties finding workers with higher-level skills or qualifications to match job vacancies;
- insufficient opportunities to upskill youth and low-skilled workers, with training not sufficiently oriented toward tangible job opportunities and local labour market needs;
- poor quality registered training organisations and lack of confidence among employers in the training system and training certificates;
- limited investment in infrastructure supporting economic activities;
- poor quality digital infrastructure;
- lack of alignment between government funding and unique regional needs;
- poor collaboration across tiers of government; and,
- underinvestment in capital works.

There are, in short, a constellation of factors contributing to high unemployment rates in the Bundaberg and Hervey Bay region, highlighting the need to attend to the economic drivers of unemployment and the scope for Federal and state government investment to create more job opportunities, such as in the building and construction sector. Ultimately, it is the lack of paid work opportunities that is the key driver of high rates of unemployment.

While the Government maintain the CDC will lift employment, it fails to explain how it will address the underlying economic factors and regional labour market challenges. In the Ceduna and Kununurra trials, there is no evidence that the CDC has influenced employment outcomes. Instead of funding expensive and ineffectual income management interventions, we believe targeted investment to improve labour market conditions and the underlying structural challenges in the region would be a better use of government funding.

Educational disadvantage

Corresponding with the structural challenges in the regional economy are poor overall educational outcomes. While there have been improvements in recent years, the Australian Early Development Index (AEDI) shows a significant proportion of children in the region start school with developmental vulnerabilities, with 28 per cent of children in the Bundaberg region developmentally vulnerable in one or more domain of early childhood development (compared to 22 percent Australia-wide), and 15.3 per cent developmentally vulnerable in two or more domains (compared to 11 per cent across Australia).[15] These poorer outcomes correlate with socio-economic disadvantage and have been linked to limited access to affordable and high-quality early childhood services for low-income families.[17] Greater efforts need to be directed toward investing in the region's early childhood workforce and improving coordination between local early childhood education and care providers and other family and community support services.[16,17] This could include, for example, scaling up the Intensive Early Childhood Development Program which was recently piloted in Bundaberg.[18*]

Overall levels of secondary school completion and post-school qualifications are also significantly lower than the rest of Queensland and Australia, as shown in the table below. Over a third of residents have not completed Year 12, with schools in the region reporting challenges in reducing attrition rates and improving the outcomes of students from low socio-economic backgrounds.[16]

TABLE: Highest level of educational attainment in Bundaberg, Queensland and Australia.*

Level of highest educational attainment, 2016 *(People aged 15 years and over)*	**Bundaberg** (%)	**Queensland** (%)	**Australia** (%)
Bachelor Degree level and above	9.8	18.3	22.0
Advanced Diploma and Diploma level	6.4	8.7	8.9
Certificate level IV	2.7	3.0	2.9
Certificate level III	17.1	15.2	12.8
Year 12	13.3	16.5	15.7
Year 11	4.8	4.3	4.9
Year 10	18.2	12.9	10.8
Year 9 or below	12.3	7.3	8.0

**Source of data: ABS, 2016 Census.*

* This 12-month pilot program, which was piloted in Bundaberg and several other sites in 2016, provided intensive and holistic support to vulnerable children and their families. The findings of the evaluation showed significant improvements in a range of outcomes.[18]

The regional growth in service-type employment has seen an increase in the demand for school qualifications and other educational credentials. Increased credentialism in occupations means that the lack of a qualification is now more of a handicap in the labour market than it may have been in the past. Since 2009, the region has experienced a significant reduction in relatively unskilled or low-skilled jobs (including labourers, machinery operators and drivers, sales workers, technicians and trades workers), and an increase in semi-skilled and skilled occupations in the services sector (including disability, aged care, health and education).[10] Given the demographic profile of the region, the demand for skilled workers in the aged care, disability and health sectors is projected to grow substantially. Such trends point to the need to strengthen education and training programs that are oriented towards those skillsets experiencing increased demand. Investing in such programs would be far more productive than forcing people to participate in an expensive income management trial.

Health and mental health

Although the population in the Bundaberg-Hervey Bay region experiences a comparatively high burden of disease and higher rates of mental illness, significant gaps exist in terms of accessible and coordinated health services and support.[19,20] The Wide Bay area ranks highest of all 61 former Medicare Local regions for psychological distress.[20] While the population in the region has higher rates of mental and behavioural problems (16.5%, compared to 12.1% across Australia), psychological distress (12.3%, compared to 11.7% across Australia) and suicides, fewer people access mental health services, with comparatively low rates of mental health care plans prepared by GPs and significantly lower use of psychiatrists, psychologists and social worker services.[21,22] In addition to a reported shortfall of GPs, identified service gaps include youth mental health workers (including early intervention), dental services, psychologists, experienced mental health practitioners, maternity and antenatal care services, and health services tailored toward women at risk of disengagement from health systems (including those experiencing domestic violence).[21,23] Stakeholders in the region have indicated that out-of-pocket expenses and transport were significant barriers to accessing health services for low-income people.[19]

Recent assessments of local health needs and services also reveal shortcomings in the provision of drug and alcohol treatment, early intervention and prevention services. This includes high levels of unmet need for treatment and support, a lack of drug and alcohol treatment services for young people (including no support or rehabilitation services for youth under 18), poor service coordination and referral pathways, and a lack of school and community-based education and early intervention.

Poorer health and mental health outcomes, higher levels of disability and chronic disease, and difficulties accessing affordable and integrated health services are all factors which can limit people's capacity to engage in employment. While tackling drug and alcohol misuse in the region is a laudable objective, there is no evidence that this objective will be achieved through the CDC. Analysis of the region's health profile and services shows significant levels of unmet need and service gaps. We believe greater investment in services and improved coordination across relevant service sectors would be a more effective means of improving mental health outcomes and reducing the harms of drug and alcohol addiction.

Rental stress and lack of affordable housing

The 2017 Rental Vulnerability Index (RVI) shows Bundaberg has one of the highest levels of rental vulnerability in Queensland.[24,25] Measures of rental vulnerability take into account the range of regional factors that can render people vulnerable to problems with housing affordability, including

the levels of rental stress, the availability of rental housing that is affordable on local incomes, the distribution of social housing and marginal tenures such as boarding houses, as well as demographic indicators such as levels of unemployment, educational attainment, disability, and the incidence of single-parent households and young and elderly renters.[24] Although median rents are comparatively lower in the Bundaberg–Hervey Bay region, the incidence of rental stress is high, as is the proportion of renters vulnerable to problems in accessing and keeping decent, secure housing.

The lack of secure and appropriate housing for people on low incomes can have wide-ranging implications, affecting people's well-being, employment opportunities and their vulnerability to poverty. Accordingly, improving access to affordable, secure and appropriate housing for people on low incomes is necessary to support better social and economic outcomes across the Bundaberg–Hervey Bay region. Increasing the availability of social and affordable housing would not only generate new employment opportunities in the construction industry, but would help improve the lives of individuals and families living on low incomes.

Stigmatisation of income support recipients

A key concern with the design and delivery of the CDC is that it is demeaning and stigmatising, reducing the autonomy of people on income support and fostering feelings of shame. A blanket, compulsory approach that that pre-emptively designates income support recipients as socially irresponsible, dysfunctional or financial inept is profoundly disempowering and demoralising, denying their capacities to interpret their own needs, experiences and life problems.

Many of those subjected to the card have reported feelings of shame and humiliation.[26] The Government has maintained that the CDC operates like a normal bank account, and they have dismissed concerns regarding the stigma it generates.[27] The card, however, does *not* operate like a normal bank card, and those subject to it are conscripts – not customers. Researchers working in the East Kimberley region, where the CDC trial has taken place, report that the card has generated a sense of disempowerment, shame and humiliation for many of those subjected to it.[28] Such concerns are echoed in the Final Evaluation Report of the CDC trial, which states that:

> some Trial participants who spent their money appropriately felt as though they were being "penalised" and/or "discriminated against" by being forced to participate. These CDCT participants reportedly felt that there was a stigma and sense of shame associated with having a CDC.[29]

The CDC trial singles out people on income support, limiting their access to cash and prohibiting the purchase of goods and services available to other member of the community. As Shelley Bielefeld notes, this "raises significant issues about the wellbeing of welfare recipients, who are treated as though they are not 'the moral equal of others'".[12] By shaming and infantilising income support recipients, compulsory income management has the capacity to undermine "attitudes of self-respect, self-trust, and self-esteem" which are essential to autonomy and social wellbeing.

A core principle underpinning the work of the St Vincent de Paul Society is respect for the inherent dignity of all people. In the context of the social safety net, respect for human dignity relates not only to the adequacy of income support, but also to the way the social security system is framed, structured and delivered.

Social security measures that erode dignity, reduce autonomy and engender shame can have detrimental social and emotional effects. The Australian Psychological Society have observed that "[a]utonomy is a core human need"[30], and there is a significant body of research showing the

importance of a sense of agency to social well-being.[31,32,33] Restricting autonomy and increasing feelings of shame can undermine self-esteem and self-confidence, thereby lessening the chances of people escaping poverty:

> Shame is the most debilitating of the emotions, causing people to retreat socially, to lose faith in themselves and to find their sense of agency eroded. While we may naively wish to encourage people in poverty to help themselves by shaming them, we are, in fact, more likely to have the opposite effect. Shame undermines people's ability to help themselves.[34]

Poverty-induced shame can have several negative consequences. It not only hurts but also undermines individual agency and dignity, adding to the negative experience of poverty and its perpetuation.

Reinforces discrimination and unequal power relations

Compulsory income management also risks reinforcing the social and economic marginalisation of certain groups. The CDC, along with other forms of income management, has disproportionately impacted women, Indigenous peoples, and people with a disability. There is a long history of paternalistic government policies that have sought to alter the behaviours of Indigenous Australians, including restrictions on access to wages and social security and interventions to micromanage the finances of Aboriginal peoples.[35] The CDC echoes a similar dynamic of disempowerment and paternalism, triggering trauma, grief and frustration for many.

Although the Aboriginal and Torres Strait Islander population targeted in the Bundaberg–Hervey Bay region is comparatively lower than in existing trial sites, the expansion of the CDC to this region will still disproportionately affect Indigenous peoples. While the overall proportion of Aboriginal and Torres Strait Islander peoples in the region is around 4.0 per cent (compared to 2.8 per cent Australia-wide), the Government has estimated that 14 per cent of CDC participants in the area will be Aboriginal and Torres Strait Islander peoples.

In other trial sites, women, and particularly Aboriginal women, have been disproportionately subject to the CDC, and this risks reinforcing unequal power relations. In a 2011 Inquiry into Family Violence and Commonwealth Laws, the Australian Law Reform Commission (ALRC) examined evidence showing that compulsory income management undermines efforts to strengthen the self-agency of women subjected to violence. The ALRC concluded that that "a problem arising from coercive and controlling conduct should not be met with a similar response".[36] The ALRC further noted that, rather than alleviating anti-social or violent behaviours, there is evidence that income management can "fuel violence in families".[36] As the Good Shepherd Youth and Family Service suggested in their joint submission to the ALRC Inquiry:

> Family violence, the exercise of power and control of one person over another, is an attack on the individual autonomy, agency, and freedom of the victim. In this context, the risks of further disempowerment and loss of independence from compulsory income management are high. Replacing individual power and control with state power and control is at best stop-gap and at worst a further abuse.[37]

Targeting people aged 35 years and under

In addition to the demeaning and disempowering effects of the CDC, we oppose its blanket application to young people receiving social security. This blunt approach targets all young people receiving income support, even if there is no evidence of substance abuse, poor parenting practices, or any inability to manage their own finances. This indiscriminate approach implies all young people receiving income support payments cannot be trusted with their money and that, left unsupervised, they will squander it on alcohol, gambling or drugs. This may in turn contributes to shame and

embarrassment, with the card serving as a public label of drug or alcohol dependency and an inability to responsibly manage one's own finances.

This blanket approach also presupposes an association between receipt of income support and drug and alcohol dependency – an association that is not supported by evidence. While people on income support are slightly more likely to use certain illicit drugs, the overwhelming majority of people receiving income support do *not* use illicit drugs or suffer alcohol dependency. According to the 2013 Australian Institute of Health and Welfare Household Survey, just under a quarter (24.5 per cent) of unemployed people had used illicit drugs in the previous 12 months. Recent household expenditure data from the Australian Bureau of Statistics also shows that that people whose main source of income is government pensions or allowances typically spend less on alcohol ($12.14 per week, or 1.8 per cent of their income) compared to the average Australian household ($31.95 per week, or 2.2 per cent of their income).[38]

The Society acknowledges that drug and alcohol dependency is a serious and socially damaging problem that requires a comprehensive and considered policy response. We also recognise that, while substance misuse cuts across different socioeconomic groups, it is more concentrated in certain communities and regions.[39] However, there is no evidence that receiving income support causes or maintains substance abuse.[40] In regional and remote communities, it is the lack of job opportunities, and not a desire to fund a life of leisure, that is a primary reason for seeking access to social security payments.

Undermines the core purpose of social security

The Government has maintained that compulsory income management is an effective means of overcoming problems such long-term unemployment, gambling addiction, drug and alcohol abuse, and child neglect. The Society firmly believes, however, that addressing complex social and health issues through the social security system is inappropriate and fundamentally flawed. This approach disingenuously identifies 'appropriate' income expenditure as the solution to difficult problems whose genesis lies elsewhere. It is not only ineffectual, but is also contrary to the underlying needs-based and poverty alleviation focus of income support.

Social security is a first and foremost a redistributive mechanism that provides a safety net for those who are otherwise without. The need to reaffirm and strengthen this underlying goal of social security is crucial in a context of growing inequality and unacceptable levels of poverty in Australia.[41] It is also vital that the social security system is designed and administered in a way that is respectful and supports the inherent dignity of people. An important aspect of human dignity is self-determination and the ability to exercise decisions about one's own life, free from social stigma and government interference.[42]

Compulsory income management represents a fundamental shift away from this understanding of social security, moving the focus from redistribution and poverty alleviation to social control. By quarantining income and restricting access to cash payments, the Government is denying the self-determinisation of income support recipients, counter to the very purpose of social security. Using social security to impose conditions and restrictions on some people, and not on others, violates the autonomy and dignity of income support recipients, and implicitly questions their capacity for rational choice. It also reinforces hierarchies of 'deservingness' among those on low incomes.

The specific design of the CDC scheme, whereby access to cash is limited to income support recipients in designated regions, effectively redefines people's financial autonomy and their right to social security on the basis that they live in a region where poverty and disadvantage is concentrated. Such an approach is not only at odds with the principle of a needs-based and non-discriminatory social security system, but also feeds into stigmatising and divisive rhetoric that denigrates people who receive social security. The notion that people cannot be trusted and require surveillance and control perpetuates a divide between the "deserving" and "undeserving" poor – a divide which the Society strongly repudiates.

Lack of supporting evidence

In a bid to justify the efficacy, expansion and extension of the CDC, the Minister for Human Services has championed the alleged success of the CDC trials, insisting that a sound evidence base has been established by the Government-commissioned ORIMA evaluation reports. Just before the Final Evaluation Report was publicly released, the Minister issued a media release announcing that the trial had been a success and would be continued indefinitely.[43] The Prime Minister similarly lauded the merits of the CDC trial, declaring that:

> It's seen a massive reduction in alcohol abuse, in drug abuse, in domestic violence, in violence generally; a really huge improvement in the quality of life, not just for the families who are using the Cashless Welfare Card, but for the whole community. But above all, above all it's an investment in the future of the children.[44]

Such claims, however, do not withstand scrutiny: both the official evaluation of the CDC, and the wider body of evidence on income management, do not demonstrate that the CDC is effective or an appropriate use of public funds.

A closer analysis of the Final Evaluation Report reveals conflicting findings and inconclusive results, along with significant methodological flaws that call into question the report's findings. In our 2017 submission to this Committee on the CDC trial, we identified numerous methodological flaws in this report, including the lack of baseline data; fundamental weaknesses in the survey design (rendering the outcomes highly liable to recall inaccuracies and social desirability bias); statistically insignificant sample sizes; lack of comparison with administrative data and wider population statistics; flawed data weighting methods; and a failure to incorporate principles and standard practice in relation to conducting research among Aboriginal and Torres Strait Islander communities.[45] Further issues stemmed from interpretive flaws and invalid claims regarding causation, including a failure to adequately take into account confounding variables and the effects of concurrent policies and programs, such as alcohol restrictions and additional funding for local support services.

These concerns were underscored by the recent audit from the Australian National Audit Office (ANAO), which concluded that monitoring and evaluation of the CDC "was inadequate" and "as a consequence, it is difficult to conclude whether there had been a reduction in social harm and whether the card was a lower cost quarantining approach".[46] The report documented a host of problems with the design, implementation and reporting of the evaluation, including the lack of robustness in data collection; the failure to use baseline data and available administrative data; the failure to build evaluation into the program design; the absence of any cost-benefit analysis; poor risk management; inadequate review of key performance indicators; poor procurement practices; and inconsistencies between the stated findings and the actual data collected through the evaluation. In addition, the ANAO question the generalisability of the evaluation findings, noting that

the trial "was not designed to test the scalability of the CDC" and that "[m]any findings from the trial were specific to the cohort (predominantly Indigenous) and remote location".[46]

The ANAO's scathing assessment indicates that the expansion of the CDC trial to the Bundaberg and Hervey Bay region is not justified by the official evaluation. The wider evidence base relating to income management also does not support the card's expansion. Income management has operated in Australia since 2007 and has been implemented in a variety of different locations and forms. Numerous evaluations have been undertaken which show little, if any, evidence of positive change. For example, a 2016 literature review of income management concluded:

> No evaluation has found that compulsory forms of income management [IM] have resulted in medium or long-term behavioural change at the individual or community level. There is some evidence that voluntary forms of IM have some impact on financial harassment and possibly on financial management although they can also result in higher levels of dependency on the welfare system for those who become habituated to IM. In addition, there is evidence of unintended negative consequences of IM, particularly compulsory forms of IM.[47]

Similarly, another review of the multiple evaluations of income management, which was undertaken by the Centre for Aboriginal Economic Policy Research in 2016, found no conclusive evidence of beneficial outcomes. It reported that the most effective schemes were voluntary and specifically target people with high-needs as part of a holistic set of services. Further, it found that "a recurrent thread across many of the evaluations" was that compulsory income management can diminish financial management skills and increase dependency on the welfare system.[48]

The weight of evidence does not, in short, support the continuation and expansion of compulsory income management.

The evidence on tackling drug and alcohol addiction

One of the central justifications the Government has provided for implementing the CDC is the need to tackle drug and alcohol addiction. There is no doubt that alcohol and drug abuse contribute to significant social, health and economic harms across communities. However, while there is a clear need for comprehensive government policy to reduce drug- and alcohol-related harms, there is no conclusive evidence to support the approach taken in the CDC trial.

First, there is no evidence of a causal relationship between the receipt of cash payments and drug and alcohol addiction.[40] As discussed above, the majority of people on income support do *not* use illicit drugs and do not have alcohol addictions. The most recent household expenditure data from the Australian Bureau of statistics shows that that people whose main source of income is government pensions or allowances typically spend less on alcohol compared to the average Australian household.[38] Similarly, while ABS data suggests there is a slightly higher rate of illicit drug use among people reliant on income support, the evaluation of the CDC trial indicated that most income support recipients in the trial locations did not have issues with alcohol, drugs or gambling.

The research evidence from both Australia and overseas provides little evidence for the effectiveness of restricting cash payments to overcome drug and alcohol addiction.[49] A number of empirical studies from the United States have shown that welfare benefits in the form of cash payments do not encourage substance abuse, and there are well-documented social costs and externalities for depriving alcoholics and addicts of benefits.[50,51]

For those with serious drug and alcohol addictions, cutting off access to cash may result in 'circumvention' behaviours, with addicts seeking out other means to access alcohol and drugs, often with detrimental consequences for those around them. In a discussion of money management interventions for people with substance abuse disorders, US researcher Elizabeth Carpenter-Song writes:

> It is… possible that the absence of cash may, somewhat paradoxically, increase other risky behaviors as individuals seek out substances through informal networks of exchange. Individuals may render themselves vulnerable to assaults when drug dealers extend "credit" that goes unpaid. Some people may steal to gain access to resources. Women, in particular, may be at risk for negotiating sexual favors for drugs.[52]

Several Australian studies and inquiries have shown that, when income management has been used to restrict access to alcohol in Aboriginal communities, people with alcohol addiction have engaged in a range of activities to circumvent restrictions on their patterns of spending.[53,54] These activities include humbugging (asking relatives for cash or other items quarantined by the card), card sharing, theft, taxi cashbacks, and swapping purchased items for cash. A number of those surveyed for the evaluation of the CDC trial reported an increase in such activities. A further concern with denying access to cash for people with entrenched drug and alcohol addiction is the enhanced risk of family violence and criminal activities.[36,54]

Ultimately, income management does not address the underlying causes of drug and alcohol addiction, and there are more effective, evidence-based approaches that should be pursued. Achieving meaningful and sustained reductions in alcohol- and drug-related harms requires attention to the systemic factors and social determinants that contribute to substance abuse, such as limited education and employment opportunities, substandard or insufficient community infrastructure, and under-resourced health and mental health services. This approach is emphasised in Australia's *National Drug Strategy 2017-2025,* which refers to research showing "health and wellbeing are not simply a matter of lifestyle choices" and "solid evidence" for the negative effects of "lack of control over one's life circumstances".[55] Thus, if the Government is genuinely committed to meeting the objectives of its own National Strategy to reduce alcohol and drug-related harms, it is imperative it draws upon the existing evidence of what works and abandons compulsory income management.

Evidence of adverse effects and unintended harms

Existing research suggests that compulsory income management can result in a range of unintended consequences and has the potential to create or exacerbate social problems – including some of the very problems the CDC is meant to remedy. As discussed above, there is some evidence that compulsory income management can exacerbate unequal power relations, compound problems with family violence, and contribute to risk-taking and socially detrimental behaviours for those with entrenched drug or alcohol addictions. The most comprehensive evaluation of the New Income Management in the Northern Territory found that, rather than promoting financially responsible behaviours, income management tends to erode financial management skills and indepedence.48

One key concern is the additional financial burden that the CDC places on individuals and families. For example, in the Final Evaluation Report, many of the surveyed participants reported running out of money to buy food, or to pay for items for their children:

- 49% reported that they had "**run out of money to buy food**", and by Wave 2 the figure had increased to **52%**;
- 32% did "**not have money to pay some other type of bill when it was due**" (**35%** by Wave 2);

- 32% had "**run out of money to pay for things that… children needed for school**, like books" (**45%** by Wave 2);
- 31% had "**run out of money to pay for essential (non-food) items for… children**" (**44%** by Wave 2);
- 50% had needed to "**borrow money from family or friends" to survive** (**55%** by Wave 2).[29]

While these negative outcomes cannot be attributed to the card alone, such high levels of financial stress are disturbing and conflict with the Government's narrative of overwhelming success. Moreover, while the card has been touted as a means of improving parenting and family wellbeing, nearly half the participants stated they had run out of money to buy essential non-food items for children, with almost a quarter (23 per cent) saying the card had made their children's lives worse. Such findings are consistent with the conclusions drawn by literature reviews of income management, which have found no evidence of improved parenting practices and child wellbeing, and evidence of "unintended negative consequence for some families and communities".[47]

There is also evidence that forcing people to have the bulk of their meagre income attached to a card, with only a small portion accessible as cash, constrains choices and can make life more difficult for people already experiencing financial disadvantage. Compulsory income management excludes people from the cash economy, cutting them off from more cost-effective means of purchasing items, such as second-hand goods market, garage sales and other more economical cash purchases.[35] Some merchants are cash only, require a minimum spend for EFTPOS purchases, or charge a surcharge for payments made by card – thereby preventing people from making certain purchases, or requiring them to spend more than what they otherwise would have expended. The CDC can also make a range of other cash transactions difficult, such as cash payments for rent, payments for small expenses associated with children's education, and various services or products requiring cash (parking metres, shopping trolleys, bus fares, laundromats).

As indicated above, compulsory income management has had a disproportionate impact on women and can have adverse consequences for women and children fleeing domestic violence. The ALRC Inquiry into Family Violence emphasised that income management should be avoided in the context of family violence as it can lead to more problems.[36] Women experiencing domestic violence typically require easily accessible funds for crisis accommodation and travel to get away from perpetrators of violence. Previous analysis of the compulsory income management in Tennant Creek recorded that "[d]omestic violence is fuelled by peoples' inability to control their money" and that income management "can fuel violence in families".[56]

Inadequate consultation

The Government maintains it has consulted widely with communities in the Bundaberg and Hervey Bay region, insisting that the Department of Social Services has held 188 meetings with "key stakeholders and community members".[1] A number of community members and groups, however, have indicated they have not been consulted about the design, scope or application of the card, and they have criticised the consultation process as opaque, high selective and unreliable as an indicator of community sentiment. We note, for example, that the Gidarjil Development Corporation, which is one of the largest Indigenous organisations in Bundaberg, has not been consulted about the card. During the previous inquiry hearings into the expansion of the CDC trial, various representatives from the region told the Committee that the consultation process had been difficult to access and unrepresentative of the community.[57] Some have claimed that divergent community views were marginalised and those directly affected were not adequately included. Others who attended

meetings with the Department questioned the adequacy of the consultations, noting that they were primarily information sessions about the proposed trial and allowed little scope for community members to raise concerns.[58]

Practical and logistical problems

A range of practical and logistical problems using the CDC have been reported in existing trial sites, and this has at times compounded card holders' financial hardship, stress and feelings of humiliation and shame. As indicated, practical challenges arise from card holders' inability to cover small cash transactions, merchant surcharges and requirements that prevent the use of the card for certain purchases, and the inability to purchase goods or services in the cash economy or from merchants lacking EFPTOS facilities. Additional practical and logistical issues include a high rate of failed transactions and transaction errors[59]; difficulties ascertaining card balances (including for those without phones or sufficient phone credit, internet access, or access to a mobile phone or internet server coverage); disruption of established payment arrangements; and delays replacing lost cards.

A further practical difficulty arises for retailers who sell a mix of excluded and non-excluded goods. While the card is able to prevent cardholders making purchases at particular categories of merchant (for example, bottle shops or casinos), there is currently no way of automatically blocking purchases of particular products.[60] This system presents a fundamental problem for retailers who sell a mix of goods, some restricted and some not. As the Department of Human Services explains:

> For mixed merchants, for example a bar and bistro, Indue engages with these merchants to enter into a contract to refuse the sale of restricted goods to anyone using the [cashless debit card]. In practice, this generally requires the register operator to manually sight the card and refuse the sale of restricted goods. Both of these options present opportunities for non-compliance and workarounds.[62]

Including mixed merchants in this way introduces additional administrative complexities and costs. Indue has to enter into a contract with mixed merchants and manually unblock each point-of-sale terminal. Staff at mixed merchants also need to receive training to ensure they can identify the card, determine when a cardholder is trying to buy excluded goods, and manually refuse the purchase. This process is not only cumbersome, but also adds to the shame and humiliation of card users. According to some sources in existing trial sites, the difficulties of making payments to mixed merchants has created problems for women fleeing domestic violence, preventing them, for example, from using the CDC to stay at the local hotel.[61] If the CDC is continued and expanded, these practical challenges will be exacerbated by variations in alcohol licensing laws and regulations across different state and territory jurisdictions, while also making the CDC vulnerable to changes in liquor licensing regimes. For example, it will be much more difficult to implement the CDC in states and territories where supermarkets can sell alcohol from the same point-of-sale terminal as other goods.

The Society understands that the Government has been seeking an external provider to develop software to "automatically prevent the sale of restricted goods at the Point of Sale (POS)" at mixed merchants.[62] However, this is an ambitious project and is yet to be achieved. The Australian Bankers' Association has previously declared that it is not feasible to create a debit card and accompanying software system that selectively blocks particular goods and services.[63] The development of a similar software system was explored by a Commission of Inquiry in United States, which was set up to develop a "cashless funds system to prevent misuse of income support payments".[64] A report prepared for the Commission examined the feasibility of creating such a system but recommended against it, noting that this option "would require an extreme financial commitment and yet not

achieve total control over cash assistance misuse."[64] Such findings highlight unresolved technological issues and the technical challenges and prohibitive costs of overcoming these logistical difficulties.

Erosion of human rights, privacy and consumer protections

Human rights implications

A person should not lose their basic rights simply because they receive income support. However, if enacted, this Bill will undermine the human rights of individuals subjected to the CDC, including the right to social security[65], privacy[65], equality and non-discrimination (particularly racial discrimination)[66], and self-determination.[65]

Under international law, limitations on human rights are only permissible when States can demonstrate such limitations are a reasonable, necessary and proportionate way of pursuing a legitimate objective.[65] In this regard:

a) any limitation on human rights must fulfil a legitimate and pressing purpose;
b) any limitation on human rights must be targeted, proportionate and interfere with rights to the minimal extent possible; and,
c) limitations on rights must be demonstrably justified and evidence-based.

We believe the Government has failed to provide credible, cogent and compelling evidence that the limitations on human rights imposed by the CDC are reasonable, necessary and proportionate.

The Parliamentary Joint Committee on Human Rights (PJCHR) has previously found that compulsory income management does not satisfy the criteria justifying limitations on human rights, stating that:

> the income management regime involves a significant intrusion into the freedom and autonomy of individuals to organise their private and family lives by making their own decisions about the way in which they use their social security payments. The committee considers that the imposition of conditions restricting the use that may be made of such payments enforced through the BasicsCard system represents both a restriction on the right to social security and the right not to have one's privacy and family life interfered with unlawfully or arbitrarily.[67]

The Committee further states: "the burden lies on the government to justify that such limitations are justifiable, namely that they are a rational and proportionate means of pursuing legitimate objectives".[67]

The current Bill does not resolve the fundamental human rights concerns previously identified by the PJCHR. In order to justify the infringement of human rights, the Statement of Compatibility refers to "positive findings" from the interim Evaluation Report, asserting that "any limitation… is reasonable and proportionate".[2] However, to be permissible, any limitation of a human right requires a "very high degree of probability" and supporting evidence which meets a "stringent standard of justification". The evidence should be "cogent and persuasive and make clear the consequences of imposing or not imposing the limit."[†] The PJCHR conclude that the CDC trial fails to meet these stringent standards, noting the Evaluation contains mixed and inconclusive findings and fails to establish a rational connection between the CDC and the trial's stated objectives.[68]

[†] See, for example, R v Oakes [1986] 1 SCR 103, 105, 136-7; Minister of Transport v Noort [1992] 3 NZLR 260, 283; Moise v Transitional Land Council of Greater Germiston 2001 (4) SA 491 (CC), [19].

In assessing the *proportionality* of the measures, the PJCHR note there must be "adequate and effective safeguards" that can "ensure that limitations on human rights are the least rights restrictive way of achieving the legitimate objective of the measure".[68] The Committee notes that the blanket application of the CDC to young income support recipients in the proposed trial location is inconsistent with these requirements:

> the cashless debit card would be imposed without an assessment of individual participants' suitability for the scheme. In assessing whether a measure is proportionate, relevant factors to consider include whether the measure provides sufficient flexibility to treat different cases differently or whether it imposes a blanket policy without regard to the circumstances of individual cases.[68]

According to the Committee, these concerns are heightened "insofar as the trial applies not only to persons whose usual place of residence 'is or becomes' within the Bundaberg and Hervey Bay area, but also applies to a person whose usual place of residence *was* within the area". The PJCHR raises further concerns about the compulsory nature of the card, noting this approach cannot be justified as proportionate:

> In its 2016 Review, the committee stated that, while income management 'may be of some benefit to those who voluntarily enter the program, it has limited effectiveness for the vast majority of people who are compelled to be part of it'. The application of the cashless debit card scheme on a voluntary basis, or with a clearly defined process for individuals to seek exemption from the trial, would appear to be a less rights restrictive way to achieve the trial's objectives. This was not discussed in the statement of compatibility.[68]

In addition to the mandatory and inflexible nature of the CDC, the Statement of Compatibility does not address whether there are less restrictive alternatives that could have been adopted. There is, for example, no mention about the lack of rehabilitation facilities and properly-funded drug and alcohol services in Bundaberg–Hervey Bay. Clearly, providing essential services for young people struggling with drug and alcohol addiction would have been a less restrictive means of assisting those with entrenched addiction issues.

The Statement of Compatibility also downplays the intrusiveness and coercive nature of the CDC, maintaining that there is no significant infringement of privacy, choice or autonomy for those who are subjected to the card. The Society does not agree with these claims. Restricting how a person can access and spend their social security benefits clearly interferes with their right to personal autonomy and, therefore, their right to a private life. As noted above, we also hold concerns about the lack of adequate consultation, which in turn infringes on the right to self-determination. The Statement of Compatibility asserts that the right to self-determination is not engaged by the CDC. This assertion is inconsistent with the United Nations Economic and Social Council, which emphasises that the "right of individuals and groups to participate in decision-making processes that may affect their exercise of the right to social security should be an integral part of any policy, programme or strategy concerning social security."[69]

Further, under the UN Declaration on the Rights of Indigenous Peoples, countries such as Australia are obligated to "consult and cooperate in good faith" with Indigenous peoples "in order to obtain their free, prior and informed consent before adopting and implementing legislative and administrative measures that may affect them."[70] Although the *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) was not mentioned by the PJCHR in its scrutiny of the Bill, we believe that it retains relevance in relation to the CDC, which will disproportionately affect Aboriginal and Torres Strait Islander people in the Bundaberg–Hervey Bay region.

Consumer protections

It is beyond the scope of this submission to fully examine the consumer protection implications of the Bill, however we note a range of concerns have been previously canvassed by organisations such as the Consumer Action Law Centre and the National Social Security Rights Network. The requirement to hold a prescribed bank account, for instance, directly interferes with the right to private contract, and potentially exposes card holders to increased costs and inconvenience. The card holder has no say about which account 80 per cent of their benefits are directed to, and the terms and conditions stipulated by Indue – the private card provider – states that card holders cannot earn interest from the restricted allowance. This requirement also impedes access to affordable banking measures that banks have established to support people with very low incomes.

The CDC is applied to a particularly financially vulnerable cohort, and it is imperative that they benefit from the consumer protections and accountability mechanisms that other people expect. However, we note with concern that ASIC has exempted Indue from certain financial services laws and consumer protection regulations. Indue also does not subscribe to the Centrelink Code of Operation, nor to any industry code of conduct – codes which include a range of important commitments and independent compliance and monitoring requirements. The absence of such consumer protections and accountability mechanisms is deeply concerning and, as David Tennant has remarked, risks creating a "banking underclass" that are denied the basic rights and protections that other citizens take for granted.[71]

Cost-ineffectiveness and privatisation

The CDC is an extremely costly program to administer, diverting funds away from evidence-based programs and under-resourced support services. The Evaluation Report of the CDC trial provides no cost-benefit analysis of the scheme or comparison with other policy responses, such as increased support services. However, according to documents released under Freedom of Information, the Government spent nearly $18.9 million to trial the cashless welfare card.[72] This equates to over $10,000 per person participating in the trial.

The Explanatory Memorandum does not specify how much funding will be dedicated to expanding the CDC (citing commercial-in-confidence negotiations with private providers), but the expenditure figures to date suggest the amount will be substantial. We believe this represents an unacceptable opportunity cost, depriving other more effective program and services of funds. We believe the expenditure on continuing and expanding the CDC would have far greater impact if it was directed toward measures grounded in evidence of what works, and developed and led by communities.

A further concern is the large portion of funds directed toward the private companies contracted to roll-out the CDC. Indue was awarded a contract of $7.9 million for the CDC trial, with an additional $2.9 million to develop the CDC information technology infrastructure. This illustrates how expanding the CDC will increase the wealth of private entities like Indue and the overall cost of social security provision within Australia – and yet without providing benefits for the people subjected to the CDC, and delivering detrimental outcomes to many.[73] Moreover, the involvement of Indue underscores concerns about the privatisation of social security payment processes.

The expenditure directed toward private providers, such as Indue, is misplaced and inappropriate in a climate where genuine job creation is urgently needed, and alternative program funding is

required to address the social issues the government claims to be targeting with the CDC. When resources are so desperately needed for the programs and approaches that create job opportunities, support struggling families, and break the vice of alcohol or substance abuse, we cannot afford to dedicate precious funding to failed but expensive policy options like the CDC.

Conclusion

There is a clear and compelling need for more effective policies that tackle entrenched poverty and the social problems that stem from profound social and economic disadvantage. This Bill, however, does not provide an effective policy response to poverty or disadvantage, and we urge the Committee to recommend it be abandoned. The CDC is a blunt measure driven by ideology rather than evidence, and it risks compounding some of the very factors that contribute to ongoing disadvantage and disempowerment among those on low incomes.

This submission has outlined the numerous drawbacks and harms associated with the CDC, including its blanket application and punitive effects; its erosion of dignity and incompatibility with international laws, including the right to social security; and its denial of agency, autonomy and citizenship rights. We believe the considerable resources expended on the CDC and other forms of compulsory income management would be better spent on improving the adequacy of income support payments and funding appropriate and effective services for struggling individuals and families.

Increasing the punitive and paternalistic aspects of social security is a misplaced policy lever for improving social outcomes. Such an approach detracts from the underlying purpose of the social security system. With inequality growing and poverty levels remaining unacceptably high, we urgently need to reinstate poverty alleviation as the central goal of income support policy, rather than extending a punitive income support agenda on the basis of questionable evidence.

We urge the Committee to reject this patronising, ideologically driven approach that hurts rather than helps. Instead of punitive and paternalistic interventions, there is a pressing need for flexible, supportive and non-judgemental social security policies that build social resilience and cohesion and provide real income security. And if the Government is genuinely committed to tackling complex social and health issues, such as alcohol and drug addiction, we encourage it to support initiatives that are grounded in evidence and implemented in genuine partnership with communities.

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