Submission to Community Affairs Committee

Social Services Legislation Amendment (Cashless Debit Card) Bill 2017

6 October 2017

About ACOSS

The Australian Council of Social Service (ACOSS) is a national advocate for action to reduce poverty and inequality and the peak body for the community services sector in Australia. Our vision is for a fair, inclusive and sustainable Australia where all individuals and communities can participate in and benefit from social and economic life.

Summary

ACOSS opposes this Bill. There is insufficient evidence to justify the expansion of the Cashless Debit Card (CDC).

If the government is serious about improving the health and wellbeing of Aboriginal and Torres Strait Islander people and communities, it must look to local, community driven solutions.

ACOSS recognises the deeply seated social and economic problems resulting from over two centuries of systemic discrimination. To adequately address these issues, it is critical that communities are given autonomy to develop and drive positive change.

ACOSS also rejects the conflation of receipt of income support and anti-social behaviour. Such statements fundamentally fail to acknowledge the impact of a lack of a viable labour market, long-term unemployment, poor education, and severe health problems, which all contribute to complex social issues. This complexity cannot be properly understood with simplistic phrases like 'intergenerational welfare dependency'.

ACOSS would rather work with government to generate jobs where they are most needed, improve employment services for people who are long-term unemployed, raise inadequate income support payments, and strengthen local communities and services such as domestic violence, drug and alcohol programs, and mental health services for all communities experiencing disadvantage.

This submission is structured in two parts. Part A addresses the importance of local, community-led solutions and sets out a number of alternatives to the mandatory CDC, including local job creation, resourcing of community-driven services and programs and voluntary cashless debit.

Part B considers the proposal to expand the CDC and ACOSS's concerns regarding the lack of robust evidence around the CDC's impact and the process of implementing cashless debit. We outline a number of reform options that should be implemented if the scheme continues.

A. Local, community-led solutions are essential

Communities are best placed to provide the solutions to the problems they face. As Senator Patrick Dodson said in response to the government's expansion of the CDC:

> [T]here are many people living in communities with great ideas about how to address the issues. But they are not listened to. Indigenous communities need and want to be part of the solution. We need support services that are community generated, implemented and properly resourced.[1]

Local communities have the solutions for reform. The government and parliament must hear them and support them.

For example, we note the Kimberley Regional Alcohol Management Roundtable met in July this year and agreed on key principles that should underpin a strategy to address alcohol dependency in the region. Some of these principles include:

- A comprehensive multifaceted regional Kimberley strategy which would empower communities to implement local solutions.
- Measures adopted should be developed and implemented based on consent from affected communities.
- An agreed framework for evaluation and measurement of outcomes must be incorporated in the regional strategy.
- Whilst recognising that urgent short to medium term measures are needed to address the social crisis, sustainable solutions must be based on the recognition of Kimberley Aboriginal people's rights to traditional country, security of culture and participation and equity in the regional economy.[2]

These principles are not reflected in the development or expansion of CDC.

CDC is a top-down policy developed by mining businessman Andrew Forrest as part of his Creating Parity review.[3] It currently applies in blanket fashion to people who receive a working age payment in two trial sites. Seventy-eight per cent of people currently subjected to CDC identify as being Aboriginal and Torres Strait Islander people.[4] CDC restricts 80% of an income support recipient's payment to an EFTPOS-style card that cannot be used to purchase alcohol, gambling or to withdraw cash.

Community leaders have been clear about the importance of community-led approaches. This is supported by the evidence on what does and does not work. The evidence from

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[1] Dodson, P. (2017) 'Indigenous communities need to be part of the solution. Top-down measures don't work' 22 September, https://www.theguardian.com/commentisfree/2017/sep/22/indigenous-communities-need-to-be-part-of-the-solution-top-down-measures-dont-work

[2] Kimberley Regional Roundtable on Alcohol Management (2017) 'Statement on the "Community Driven Strategy for Alcohol Management' http://www.yawuru.com/statement-kimberley-regional-roundtable-alcohol-management/

[3] Department of the Prime Minister and Cabinet (2014) 'Creating Parity - the Forrest review' https://www.pmc.gov.au/resource-centre/indigenous-affairs/forrest-review

[4] Department of Social Services (2017) 'Cashless Debit Card Trial Evaluation' https://www.dss.gov.au/sites/default/files/documents/08_2017/cashless_debit_card_trial_evaluation_-_final_evaluation_report.pdf p.31

several years of income management in the Northern Territory suggests that restricting income support recipients' autonomy in how they spend their money does not make a sustained difference in the lives of individuals or their communities.[5] Further, as recognised in the 2015 *Social Justice and Native Title Report*, alcoholism, drug addiction and problem gambling are not caused by people having unrestricted access to cash, and restricting access to cash "does not address the reasons for harmful behaviour, including poverty, trauma, and lack of education".[6]

Rather, evidence shows that it is access to quality services that are developed and accepted by communities that makes a difference.[7] Policies, services and programs that are tailored to meet individual and community needs are far more effective than blanket application of a policy that pays no attention to individual circumstances and finds limited acceptance in the community.

ACOSS calls for an alternative approach to mandatory CDC in addressing problems caused by alcohol and other complex social issues. Below are some options for reform. It is essential that alternative approaches are driven and led by local communities, and tailored to their specific circumstances. We must hear the solutions communities are proposing and support them.

Recommendations for alternatives to mandatory CDC:

1. Government listening to and working with communities to determine how best support them to progress their solutions to the issues they face. There must be genuine partnership between government and communities to advance local programs, services and ideas for reform.

2. Voluntary CDC, with transition arrangements in place for individuals and communities wishing to remain under CDC. Opt-in schemes should be co-designed with communities and include wraparound and coordinated supports such as drug and alcohol, mental health, financial counselling and social support services. This would be in line with alternatives put forward by the Parliamentary Joint Committee on Human Rights and the Australian Human Rights Commission.[8]

3. As called for by existing trial-site communities, development and support of local, community-led services and programs, including diversionary programs for young people, men and women's support services, follow-up supports for people leaving drug and alcohol rehabilitation, housing and homelessness services. Communities should

[5] J Rob Bray, Matthew Gray, Kelly Hand and Ilan Katz (2014) 'Evaluating New Income Management in the Northern Territory: Final Evaluation Report' http://caepr.anu.edu.au/sites/default/files/cck_misc_documents/2014/12/Evaluation%20of%20New%20Income%20Management%20in%20the%20Northern%20Territory_full%20report.pdf p.xxii

[6] Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda (2015) 'Social Justice and Native Title Report 2015' Australian Human Rights Commission https://www.humanrights.gov.au/sites/default/files/document/publication/SJRNTR2015.pdf

[7] Kenia Parsons, Ilan Katz, Michelle Macvean, Sophia Spada-Rinaldis, Fiona Shackleton (2016) 'Alternatives to Income Management' Social Policy Research Centre www.aboriginalaffairs.nsw.gov.au/pdfs/research-and-evaluation/TAB-A-Alternatives-to-IM-Report_FINAL.pdf p.34

[8] Parliamentary Joint Committee on Human Rights (2017) Report 9 , p. 39
Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda (2016) 'Social Justice and Native Title Report 2016', Australian Human Rights Commission https://www.humanrights.gov.au/sites/default/files/document/publication/AHRC_SJNTR_2016.pdf

have control over the services and programs provided.

4. Community-led approaches to job creation. We refer the Committee to the APO NT model for reform of remote employment services, which offers a viable solution to job creation in remote areas, using a community-led approach.

5. Parenting programs supported and led by local communities. For example, a range of parenting programs were identified by the Social Policy Research Centre and Parenting Research Centre as alternatives to income management.[9] These programs are supported by evidence as being effective in improving outcomes for children and families, providing they 'fit the needs of families'.[10]

Part B: Proposal to expand the CDC

The Bill should be opposed

This Bill would remove the time limit for the CDC trials, which are currently legislated to end 30 June 2018, and abolish the cap on the number of people who can be subjected to the trials, which is 10,000.

Removal of the time limit and cap would allow the government to implement CDC anywhere in Australia via legislative instrument. It would also allow the extension of CDC in the existing trial sites of Ceduna, South Australia and Kununurra and Wyndham, Western Australia.

We call on the Committee to oppose the Bill because it will continue and expand a policy that significantly restricts people's freedoms without a sufficient evidence base to show that it works or is justified. Quarantining people's incomes in an effort to address complex social and health issues fails to address the underlying causes of those problems.

CDC imposes significant restrictions on people's freedom, regardless of whether or not they have an addiction to alcohol, drugs or gambling. It encroaches on their right to privacy, limits where they can shop and causes stigma and shame.[11]

This Bill would permit the expansion of CDC without an Act of Parliament, limiting transparency and scrutiny of a policy that has a substantial effect on people and communities.

There are alternatives to restricting how people spend their income support payments, as outlined above. However, if this Bill proceeds, it should be amended so as to make CDC voluntary, with transition arrangements in place for existing trial sites. An Act of Parliament should be required to expand CDC and communities should be given control over the program, including which services and programs are resourced.

[9] Parsons et al.
[10] Ibid., p. 79
[11] Davey, M. (2017) ''Ration days again': cashless welfare card ignites shame' The Guardian https://www.theguardian.com/australia-news/2017/jan/09/ration-days-again-cashless-welfare-card-ignites-shame

Lack of evidence to support the expansion

There is insufficient evidence to demonstrate that the CDC is meeting its objectives, that is, to reduce spending on alcohol, gambling and illegal drugs. There is also insufficient evidence to determine if reducing spending on these items results in a reduction of harm and violence in the community and encourages 'socially responsible behaviour'.

CDC is currently being trialled in Ceduna, South Australia and the East Kimberley, Western Australia. The Minister for Human Services Alan Tudge stated prior to the trials commencing that expansion of CDC would take place *if* an evaluation found that it works.[12]

The government commissioned private research firm Orima Research to conduct the evaluation of the trial. In two reports, Orima found that CDC had a "considerable positive impact" in the trial communities and "has been effective in reducing alcohol consumption and gambling".[13]

The evaluation found that some people surveyed had lowered their consumption of alcohol and gambling, with 41% of people stating they drank less and 48% of people saying they gambled less than before CDC commenced.[14] It should be noted there are no poker machines in the East Kimberley site, making it difficult to objectively measure any change in gambling behaviour there as a result of CDC.[15]

If if we can rely on the evaluation results showing a reduction in consumption of alcohol and gambling, this is a welcome outcome. However, there are a range of flaws with the research, some of which are outlined below. In addition, despite reports of reduced alcohol consumption and gambling, other outcomes have not improved, such as financial wellbeing, violence and employment. Furthermore, the vast majority of people do not feel like their lives have improved, with 74% of survey respondents stating that the trial had either made no difference to their lives, or had made their lives worse.[16]

For these reasons, we believe it is premature to expand CDC beyond current trial sites. ACOSS has always held the view that if there is solid evidence that CDC improves the health and wellbeing of communities and results in sustained improvements, then we would not oppose the policy, providing the policy had community consent and support. However, we do not believe that there is reliable evidence that such improvements have been made in Ceduna and the East Kimberley.

Key issues with the evaluation

The evaluation has been criticised for lacking rigour by a number of experts. Deputy Director and Senior Fellow at the Centre for Aboriginal Economic Policy Research Janet Hunt stated

[12] Minister for Human Services Alan Tudge (2015) Doorstop, Ceduna SA, Wednesday, 5 August http://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/3996105/upload_binary/3996105.pdf;fileType=application%2Fpdf#search=%22media/pressrel/3996105%22
[13] Department of Social Services, Ibid. pp. 7-9
[14] Ibid., p.4
[15] Department of Social Services, Ibid.pp.53-54
[16] Ibid. p. 82

that the CDC evaluation has "serious flaws". Academic Eva Cox shares this view, arguing that the evaluation offered no justification for extending the trials.[17]

A key reason to doubt the findings of the evaluation reports is the lack of baseline data collected. ACOSS wrote to Minister Tudge in October 2015 (attached) urging the government to collect qualitative and quantitative baseline data to ensure a valid comparison of pre and post-trial outcomes could take place. This did not occur.

Because no baseline data were collected, the evaluators relied on people remembering how much of the prohibited goods they consumed prior to the trial, which commenced around one year before the final interviews took place. Hunt points out that the responses from people recalling their consumption behaviours from over one year ago would likely be unreliable.[18]

In the final evaluation, survey participants had to present identification before providing responses. Hunt argues that this may have resulted in people giving answers they thought interviewers would want to hear and also not incriminate themselves about any behaviours (such as illicit drug taking).[19]

However, Hunt makes clear that even if there had been a decline in the consumption of alcohol, drugs and gambling, there continues to be violence and other socially unacceptable behaviours (whatever their cause) suggesting that "the program is not working and the theory of change needs revisiting".[20]

ACOSS has stressed from the outset that a policy that curtails the freedom of individuals receiving an income support payment must be thoroughly evaluated to determine its success or otherwise. These trials were established to explore whether CDC could improve the wellbeing of communities and be implemented elsewhere. It was therefore critical to have a reliable evaluation of the trials.

However, no respected researcher or social policy expert has supported the Orima evaluation as a robust piece of research. The lack of rigour of the Orima evaluation is deeply disappointing, not least because the people subjected to CDC deserve a reliable evaluation to determine whether or not the card has improved health and wellbeing outcomes. It also means that it is difficult for policy makers to judge the effectiveness of CDC and whether it should be expanded or disbanded.

It is important that the Committee recognise the considerable limitations of the evaluation when assessing the impact of CDC in Ceduna and the East Kimberley.

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[17] Cox, E. (2017) 'Much of the data used to justify the welfare card is flawed' *The Guardian* 7 September https://www.theguardian.com/commentisfree/2017/sep/07/much-of-the-data-used-to-justify-the-welfare-card-is-flawed

[18] Hunt, J (2017) 'The Cashless Debit Card Evaluation: Does it really prove success?' Centre for Aboriginal Economic Policy Research ANU College of Arts & Social Sciences http://caepr.anu.edu.au/sites/default/files/Publications/topical/CAEPR_Topical_Issue_2_2017.pdf p.1

[19] Ibid.

[20] Ibid. pp.1-2

Concerns about the design and implementation of CDC

1. Lack of consultation

While there were consultations in the communities where CDC is being trialled, there are legitimate concerns that many people who stood to be affected by CDC were not consulted. Director of the Kimberley Land Council Marianne Skeen stated that CDC was "forced on communities with little or no consultation with the people who are most affected" and CDC is "another example of governments making decisions for us, not with us".[21]

In addition, this legislation would extend CDC in existing trial sites beyond the end date that was in place when the initial consultations took place. We are unaware of consultations taking place with trial-site communities about removing the end date for the trials.

It is therefore unclear whether trial-site communities have given their consent to extending the trials. We are aware of extensive opposition to the trials in Ceduna and the East Kimberley, but it does not seem like these views are being considered by government. It appears, instead, that extension of the trials is being driven by government and not the communities affected, which is contrary to key principles of working with Aboriginal and Torres Strait Islander communities that should guide reform.

2. Blanket application of CDC

CDC applies to anyone in the trial sites who receives an income support payment and is aged 15 to Age Pension age, including carers, parents, people with disability and people locked out of paid work. Although CDC is designed to reduce spending on drugs, alcohol and gambling, CDC applies to people even if they do not engage in any of these behaviours. Furthermore, it is not possible to be removed from CDC if you demonstrate that you do not use illicit drugs, drink alcohol or gamble.

In the evaluation of CDC, around 75% of survey respondents stated that they did not drink, take drugs or gamble, or had not changed their behaviour since the commencement of trial. In other words, three-quarters of people affected by CDC either do not engage in the behaviours the government is seeking to change or their consumption of these goods are unchanged by CDC.

Just as compulsory income management in the Northern Territory was criticised for being poorly targeted,[22] the Parliamentary Joint Committee on Human Rights questioned the blanket application of CDC. The Committee stated that applying the policy to all working-age payment recipients raises "serious doubts as to whether the measures are the least rights restrictive way to achieve the stated objectives".[23]

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[21] Kimberley Land Council (2017) 'Senators seek feedback on Cashless Debit Card' 18 July. http://klc.org.au/news-media/newsroom/news-detail/2017/07/18/senators-seek-feedback-on-cashless-debit-card

[22] Bray et al. Ibid.

[23] Parliamentary Joint Committee on Human Rights (2017) 'Human rights scrutiny report' Report 9 http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/Scrutiny_reports/2017/Report_9_of_2017 p. 38

Income management has had some limited success where it has been voluntary.[24] We believe a model whereby people may opt-in most appropriate, providing it has community support.

3. *Inability to purchase various permitted goods and services*

A major problem with CDC is the inability to purchase items at places that only accept cash such as schools, markets, and fetes. It also prevents the purchase of second-hand goods where cash or PayPal purchase is required, such as eBay and Gumtree.

People on low incomes depend on being able to find cheaper goods and services to make ends meet, but CDC prevents them from doing so because of a lack of access to cash. Under CDC, people may be able to transfer up to $200 per month to another non-cashless debit account if they have reasonable proof that there is a legitimate reason for doing so. However, this effectively requires seeking permission to purchase permissible goods and services or transfer money, limiting people's agency and right to privacy.

There are also issues when people travel, or move away from the trial sites because they are still subjected to CDC. Many merchants are cash only, require a minimum spend for EFTPOS or charge a fee to pay by card. CDC prevents people from purchasing items at these merchants or requires them to spend more than what they intended, which is a clear problem for people living on very low incomes.

People who move away from trial sites should not be subjected to CDC. We do not live in a cashless society and people on low incomes should not be disadvantaged because they previously lived in a trial site.

4. *Encroachments on the right to privacy*

CDC requires sharing of personal information between the Department of Human Services (DHS) Indue, the company that provides the CDC accounts and cards, as well as with Department of Social Services (DSS). This limits people's right to privacy. The government justifies limitation of trial participants' privacy on the basis of the 'social harm' that CDC is trying to address. However, it appears that the vast majority of people subjected to CDC do not have issues with addiction that has been linked to social harm. There are, therefore, serious questions about the proportionality of the restriction of the right to privacy under CDC.

Concerns have been raised about the community panel process, whereby the personal information of people applying for a reduction in the amount of income restricted to the card is divulged to fellow community members. These community members then decide whether someone is entitled to a reduction in the restricted amount and by how much.

[24]Katz, I. & Bates, S. (2014) 'Evaluation of Voluntary Income Management in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands' Social Policy Research Centre, https://www.dss.gov.au/sites/default/files/documents/09_2014/voluntary_income_management_in_the_apy_lands_final_report_2014.pdf

ACOSS has met with community members in the trial sites who have described this process as demeaning and a gross invasion of privacy. ACOSS has heard that people must hand over hospital records, which, if true, is completely inappropriate and unjustified.

The Community Panel process appears to be operating significantly differently in the two trial sites. A far greater number of people have had the proportion of quarantined income reduced in Ceduna than in the East Kimberley, despite there being fewer people under CDC in Ceduna. In the East Kimberley, just seven of the 38 people who have applied for a reduction in the amount of income quarantined have had the amount reduced. In Ceduna, 121 of 158 people who have applied have had the amount quarantined reduced.[25]

The low number of applications and low success rate in East Kimberley needs further investigation.

We note that the Community Panel in the East Kimberley became operational five months after CDC commenced.[26] It is unacceptable that people in Kununurra and Wyndham did not have access to a key part of CDC until almost halfway through the initial trial period.

We believe that if CDC continues in its current form, the process to reduce the amount of income restricted to the card must be reviewed by the communities in Ceduna and the East Kimberley.

5. Does not address the underlying causes of addiction

The objective of the trials is to 'reduce levels of community harm related to alcohol consumption, drug use and gambling'.[27] This suggests that CDC aims to reduce the incidence and severity of addiction.

Addiction is a complex health issue that requires a multifaceted response. There is no evidence that compulsory income management or CDC help someone with a serious addiction. The evaluation of income management in the Northern Territory found that serious addictions were not helped by income management.[28]

Addiction medicine expert Associate Professor Nadine Ezard argues that people with an addiction will use whatever means necessary to access the substance or good they are dependent on. Furthermore, 'there is no evidence that providing a card that prevents purchase of that substance will change the behaviour around the use of that substance.'[29]

[25] Department of Social Services, Ibid. pp. 107-108
[26] Ibid. , p.107
[27] Department of Social Services (2016) 'Evaluation of the Cashless Debit Card Trial – Initial Conditions Report' Department of Social Services, p.i
[28] Bray et al. (2014) pp.185-186
[29]Associate Professor Nadine Ezard (2017) Evidence at public hearing on the Social Services Legislation Amendment (Welfare Reform) Bill 2017, Sydney, 30 August http://parlinfo.aph.gov.au/parlInfo/download/committees/commsen/e351ebde-3ef4-472d-96bf-e9b9b8dc1291/toc_pdf/Community%20Affairs%20Legislation%20Committee_2017_08_30_5448.pdf;fileType=application%2Fpdf#search=%22committees/commsen/e351ebde-3ef4-472d-96bf-e9b9b8dc1291/0000%22 pp.21-22

CDC fails to treat the underlying causes of addiction and will therefore have limited impact on helping people overcome addiction. Unless underlying causes of addiction are addressed, it is unlikely that long-term behaviour change will be achieved.

6. Cost effectiveness

CDC costs approximately $10,000 per person covered by the trial over a 12-month period.[30] The actual cost of the program over the forward estimates is unknown as this information is commercial-in-confidence.

To put this expenditure into perspective, the individual cost of CDC is almost as much as the single rate of Newstart Allowance, which is $14,000 per annum.

Legitimate questions have been raised about the opportunity cost of CDC, particularly when the trial sites have serious problems such as poverty, lack of employment opportunities, poor/unaffordable housing and poor access to health services.[31] The expenditure on CDC may have far greater impact if it was directed to services and programs developed and led by communities.

7. Does not increase employment

The evaluation of CDC did not find that it had boosted employment. The evaluation claims that there has been an increased motivation to look for work and activity during the trial, but notes that this could be because of the Community Development Program (CDP).[32] CDP started in July 2015 and requires people receiving unemployment payments to undertake 25 hours of job-related activity each week or lose their payments. CDP is present in both trial sites and has had a substantial impact on communities because of its harsh rules.[33] It is far more likely that the threat of loss of payment under CDP has led to an increase in motivation to look for work than CDC.

ACOSS is unaware of any evidence to show that income management, which has been operating since 2007, has led to improved employment outcomes for people looking for work. While governments frame quarantining income as a way to boost employment, this is not reflected in the evidence on income management or CDC.

An Act of Parliament and end dates should be required for all CDC sites

If CDC is to be expanded, this should be done by an Act of Parliament. Allowing extension of CDC via legislative instrument reduces accountability and transparency in the extension of the policy to other sites.

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[30] Department of Social Services (2017) 'Costs of the cashless debit card trials in Ceduna and Kununurra' Documents released under Freedom of Information
https://www.dss.gov.au/sites/default/files/documents/04_2017/attachment_a_cashless_debit_card_trials_costs.pdf
[31] Hunt, J (2017) 'The Cashless Debit Card trial evaluation: A short review'
http://caepr.anu.edu.au/sites/default/files/Publications/topical/CAEPR%20Topical%20Issues%201_2017.pdf p.7
[32] Department of Social Services, Ibid., pp. 73-74
[33] Lucy Hughes Jones (2017) 'NT families go hungry under the Community Development Program' SBS 27 June
http://www.sbs.com.au/nitv/nitv-news/article/2017/06/27/nt-families-go-hungry-under-community-development-program

There should also be sunset clauses if CDC is extended. As currently drafted, the Bill includes no end date for CDC in the current trial sites or for other sites. The Bill is also silent on any consultation process for the current trial sites for CDC to operate indefinitely.

At a minimum, there should be an end date for the current trials.

Recommendations if CDC continues:

6. CDC should be reformed so that participation is voluntary, with transition arrangements in place for people who wish to remain under CDC. The substantial resources expended on CDC should be redirected to community-led services and programs. There should also be sunset clauses. Voluntary CDC is in line with recommendations by the Australian Human Rights Commission and the Parliamentary Joint Committee on Human Rights.[34]

7. The communities in Ceduna and the East Kimberley must consent to the continuation of the CDC trials. If they are to continue, CDC should be co-designed with these communities (including, for example, the types of services that are provided alongside). In this process, discussion and consultation should be held with people affected by the card and not just people in positions of leadership, organisations or businesses in the community.

8. Any expansion of CDC should require an Act of Parliament.

9. The Community Panel process should be reviewed by trial site communities. These reviews could include whether the panel process is fair and equitable, whether it breaches privacy rights, how conflicts of interest are resolved and whether it should continue in its current form.

10. People who move away from trial sites should not be subjected to CDC. We do not live in a cashless society and people on low incomes should not be disadvantaged because they previously lived in a trial site.

11. Communities should be given control over what services are provided under the funding attached to CDC.

12. Communities should be able to identify gaps in service provision (for example, mental health and post-release services), and funding should be provided to address those gaps.

13. Barriers to accessing services must be addressed, including cultural, language and transport issues.

14. Improve connections between services and consider adopting case-management for people who would benefit from such an approach.

[34] Australian Human Rights Commission (2016) Social Justice and Native Title Report 2016, https://www.humanrights.gov.au/sites/default/files/document/publication/AHRC_SJNTR_2016.pdf