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THE CASHLESS DEBIT CARD TRIAL IN THE EAST KIMBERLEY

E KLEIN AND S RAZI

Centre for Aboriginal Economic Policy Research

ANU College of Arts & Social Sciences

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The Cashless Debit Card trial in the East Kimberley

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Abstract

This paper focuses on the Cashless Debit Card trial in the East Kimberley, Western Australia. The card aims to restrict cash and purchases to curb alcohol consumption, illegal drug use and gambling. The card targets Indigenous people disproportionately – 82.0% of the people in the East Kimberley trial are Indigenous. The current study is based on 13 months of research into the Australian Government's trial of the card in the East Kimberley. We review the card in the context of current policies to manage Indigenous consumption. We then look at aspects of the trial in the East Kimberley, including its implementation, lack of community engagement, community resistance and effects on money management. We find not only that the trial was chaotic, but that its logic is deeply flawed, and disconnected from the relational poverty experienced by people receiving state benefits. We also find that the card has become a symbol of government control and regulation in the study site.

Keywords: Cashless Debit Card, East Kimberley, conditionality, punitive welfare, Indigenous policy

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Acronyms

ANU	The Australian National University
CAEPR	Centre for Aboriginal Economic Policy Research
CDC	Cashless Debit Card
CDEP	Community Development Employment Projects
CDP	Community Development Programme
FOI	freedom of information
NTER	Northern Territory Emergency Response
PM&C	Australian Government Department of the Prime Minister and Cabinet

Contents

Series Note ii
Abstract iii
Acknowledgments iv
Acronyms iv
Introduction 1
Income management and Indigenous policy in Australia 2
Methods 3
Bringing the card to the East Kimberley 4
A disordered experiment 5
Wrap-around services 6
The community panel 6
Theory of change and inducing hardship 6
Making money management hard 7
Depoliticisation of poverty and unemployment 8
Constructing community and fragmenting social relations 11
Excluding community 12
Resistance and agency 12
Conclusion 13
Notes 14
References 16

Tables and figures

Table 1. Key items for cash use (before the Cashless Debit Card) 7
Table 2. Items that are harder to purchase under the Cashless Debit Card 8
Table 3. Socioeconomic data, Kununurra 9
Table 4. Socioeconomic data, Wyndham 9
Table 5. Breaching rates under the Community Development Programme, Western Australia 10

Introduction

In this paper, we focus on the Cashless Debit Card (CDC) trial in the East Kimberley in Western Australia. The trial began in early 2016 in both Ceduna (South Australia) and the East Kimberley (Western Australia), quarantining 80% of state benefits received by all working-age people (15–64 years) in the trial sites.

The Commonwealth legislation – the *Social Security Legislation Amendment (Debit Card Trial) Act 2015* – passed by the Coalition government with Labor support, aims to restrict cash and purchases to curb alcohol consumption, illegal drug use and gambling. The CDC regulates state benefits at the merchant level on restricted items. It also limits the amount of cash that can be withdrawn to 20% of the total money recipients receive. Put into figures, on a single Newstart fortnightly payment of $538.80, it allows a recipient to withdraw $107.76, while the remaining $431.04 is quarantined.

The CDC trial targets all working-age people (15–64 years) living in the region who receive state benefits. This compulsorily includes people receiving disability, parenting, carers, unemployed and youth allowance payments. People on the aged pension, on a veteran's payment or earning a wage are excluded from the trial but can volunteer to take part.

Although Australian Government communications state that the CDC is for both Indigenous and non-Indigenous welfare recipients, both the trial sites target Indigenous people disproportionately. Specifically, 75% of people in the Ceduna trial and 82% in the East Kimberley trial are Indigenous.[1] The CDC was first proposed as a key recommendation in the review by mining billionaire Andrew Forrest[2] of Indigenous employment and training (Forrest 2014). This recommendation followed various other forms of income management, including a program that was part of the 2007 Northern Territory Emergency Response (NTER). The NTER required the suspension of the *Racial Discrimination Act 1975* to explicitly target all Indigenous people on welfare.[3]

The specific aims of the trial outlined in the *Social Security Legislation Amendment (Debit Card Trial) Act 2015* are to:

- 'reduce the amount of certain restrictable payments available to be spent on alcoholic beverages, gambling and illegal drugs'
- 'determine whether such a reduction decreases violence or harm in trial areas'
- 'determine whether such arrangements are more effective when community bodies are involved'
- 'encourage socially responsible behaviour'.

These aims suggest four assumptions underpinning the CDC:

- that there is an implicit nexus between unemployment and excessive use of alcohol, illegal drugs or gambling
- that behaviours, norms and aspirations of all people receiving welfare are currently problematic and need to change
- that a community panel presiding over trial participants would be effective
- that the punitive approach of the CDC will be able to address addictions to illegal drugs, gambling and alcohol, and create that behaviour change.

Indue, a private company, was contracted to implement the CDC. Indue was granted more than $10.8 million[4] of the $18.9 million spent on the trial (up to April 2017) for operating the CDC during the trial (in both Ceduna and the East Kimberley) and building the technology. It has not been disclosed which specific elements of the intellectual property Indue owns, but some of it is retained for the company's own commercial purposes.

The Australian Government employed ORIMA, another private company, to design the evaluation of the CDC trial. ORIMA conducted the interim evaluation of the trial in August–September 2016 and the final evaluation in May–June 2017. The ORIMA interim evaluation was a key plank in the 'evidence' used by the government to justify the ongoing extension of the trial in March 2017.[5] The final evaluation was used to justify an extension of the trial to three other proposed sites. The interim ORIMA evaluation was criticised for flaws, including poor analysis and claims of causality.[6] Similar issues with analysis and claims of causal success of the trial can be seen in the final evaluation. For example, both evaluations claim that there has been a reduction in the consumption of alcohol, illegal drugs and gambling. This is despite an absence of baseline data to test this claim, and numbers to suggest that for most receiving state payments use or overuse was not an issue. Specifically, the ORIMA interim evaluation showed that 45% of East Kimberley evaluation participants on the CDC reported they *never* had more than six drinks of alcohol at one time (only 10% did), 86% *never* used an illegal or prescription drug for nonmedical reasons, and 82% *never* gambled (ORIMA 2017a).

Both the interim and final ORIMA evaluations overlooked or superficially analysed important data that were not favourable to the trial. Although mentioning reports of a possible increase in crime,[7] domestic violence[8] and hardship on children in the East Kimberley, the interim report dismissed these increases, saying it did not have enough data to draw conclusions, and further examination was missing in the final report. In the ORIMA interim evaluation, only 22% of East Kimberley people surveyed on the CDC said that their lives were better. In contrast, 48% said that the trial had made their lives worse. In the East Kimberley ORIMA final evaluation, only 18% said that their lives were better since being on the card, but 29% said that their lives were worse and 53% of people reported no change. Further, 29% of the East Kimberley interim evaluation participants on the card reported that their children were worse off under the trial (ORIMA 2017a:142). In the final evaluation, 49% of people on the card said that they could not look after their children better on the card. As Hunt states, reflecting on the interim evaluation report results:

> That almost half of the participants felt that the trial had made their lives worse is a worrying result, particularly given the rather limited substantiated positive results to date … the question is, at what cost? Is it acceptable for public policy to make more than twice as many participants' lives worse in order that 22% can say their lives are better? (2017:5)

Despite the methodological flaws and the overlooking of significant hardship stated by survey participants, the government has claimed that the trial in the East Kimberley (and Ceduna) was a success (ORIMA 2017a,b).

In this paper, we present findings from a 13-month study examining the trial in the East Kimberley region. We interviewed people on the CDC, as well as community leaders, community services and policy makers, to understand the design, logic and impact of the card. We triangulated the research with discourse analysis and participant observation made by one author while living in the East Kimberley through the trial lead-up and implementation. We question ORIMA's claim that the CDC has been successful, drawing attention to significant issues in the implementation, design and logic of the trial. We also respond to Hunt's (2017) question about the cost associated with the CDC's introduction, arguing that the card has had undesirable and unnecessary impacts on vulnerable people living in the East Kimberley. We proceed in three sections. First, we give a brief review of the policy logic underpinning past income management programs in Australia, which has been reasserted in the East Kimberley trial. Second, we introduce the methodology used in the study. Third, we present findings on how the CDC experiment was chaotically implemented, and the disorder and hardship it brought to people's lives.

Income management and Indigenous policy in Australia

The CDC is the latest iteration of the Australian Government's income management regime. Income management was first introduced in Australia as legislated policy through the 2007 NTER under the *Social Security and Other Legislation Amendment (Welfare Payment Reform) Act 2007* (Cwlth). Quarantining Indigenous people's welfare payments was one of a raft of racially targeted measures,[9] supported by a suspension of the Racial Discrimination Act. Compulsory income management under the NTER meant that 50% of state payments received by Indigenous people were quarantined through the EFTPOS BasicsCard. This card could be used to buy 'essential items' at accredited stores. The BasicsCard restricted the purchase of alcohol, tobacco, pornography and gambling. The government assumed that such restrictions would reduce social harm and promote responsible economic behaviour[10] – logic that has been extended in the CDC trial. New Income Management (NIM) was introduced across the Northern Territory in 2010, replacing the initial NTER income management program. To reinstate the Racial Discrimination Act, NIM was broadened from the racially targeted regime to include non-Indigenous people. Regardless, 90.2% of people on NIM in the Northern Territory in 2013 were Indigenous (Bray et al. 2014).

The Australian Government commissioned an evaluation of NIM in the Northern Territory. This evaluation showed that, despite the $410.5 million dollars spent on NIM, the program had not achieved the desired outcomes. Specifically, Bray et al. concluded that:

> A wide range of measures related to consumption, financial capability, financial harassment, alcohol and related behaviours, child health, child neglect, developmental outcomes, and school attendance have been considered as part of this evaluation … Despite the magnitude of the program the evaluation does not find any consistent evidence of income management having a significant systematic positive impact. (2014:316)

Although the Northern Territory was the first site of income management in Australia, Noel Pearson had

proposed 'welfare reform' before the NTER. Pearson identified income management as a way to instil responsibility in *From hand out to hand up*, published through The Cape York Institute think tank (CYI 2007). Income management in the Cape York model was introduced in 2008, targeting Indigenous people in four communities: Aurukun, Coen, Hope Vale and Mossman Gorge. The Cape York model was more nuanced than the blanket application across the Northern Territory as part of the NTER. The Cape York Model included the establishment of the Families Responsibilities Commission (FRC) (Altman & Johns 2008). The FRC is a statutory body made up of Indigenous people (except the Chair, who is non-Indigenous), who are advised by authorities when individuals exhibit low school attendance, tenancy breaches, child safety issues or convictions in magistrates courts. These individuals appear in front of the FRC, where options are discussed with individuals on the best course to change their problematic behaviour. In these 'conferences', voluntary and compulsory income management were two options presented, but the majority of people going on income management were put on the compulsory measure (FaHCSIA 2012). In the 2012 Cape York Welfare Reform evaluation carried out by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs, the evaluators argued that 'the evidence suggests that the impact of the local FRC Commissioners is in their listening, guiding and supporting role, rather than in the exercising of their punitive powers to order income management' (FaHCSIA 2012:50).

In 2012, the Australian Government, as part of the Better Futures, Local Solutions policy framework, introduced 'place-based income management' initiatives. This regime was trialled in five sites across Australia: Playford (South Australia), Shepparton (Victoria), Bankstown (New South Wales), Rockhampton (Queensland) and Logan (Queensland). An evaluation of place-based income management by Deloitte (2015) found limited positive outcomes for people on voluntary income management and no positive outcomes for people on compulsory income management. The report concluded that compulsory income management should be removed (Deloitte 2015, Bray 2016).

In 2013, then Prime Minister Tony Abbott commissioned mining billionaire Andrew Forrest to conduct a review into Indigenous employment and training. The 200 recommendations in Forrest's review went far beyond the conventional remit of employment and training, rejecting forms of productive labour outside the market and including paternalistic interventions relating to early childhood development, housing, school attendance and welfare reform (Klein 2014). A pillar of the Forrest review was the Healthy Welfare Debit Card. Forrest recommended that the card should quarantine 100% of state payments of all welfare recipients in a bid to restrict purchases of alcohol, drugs and gambling. In a number of public interviews, Forrest refrained from referring to the card as income management.[11] The Australian Government is now trialling this card as the more benignly named Cashless Debit Card.

Through his Minderoo Foundation, Forrest continues to play a role in promoting the CDC and lobbies for the card's uptake around Australia. Minderoo has established a website dedicated to the CDC, where people can sign a petition to support the program coming to their town. Minderoo has also created and aired advertisements in support of the CDC on commercial television stations. The advertisements are voiced by Ian Trust, who is the executive director and founder of Wunan, an Aboriginal development organisation in the Kimberley. The advertisements specifically call for viewers to consider a trial in their community and sign a petition, on which they are asked to leave their contact details. Minderoo has also produced a video claiming chronic and widespread Indigenous violence and sexual abuse, and has shown the video to politicians to secure more trial sites for the CDC. The CDC was an Australian Government project, but Andrew Forrest's involvement in policy design and implementation exposes a curious alliance between the state, enterprise and philanthropy.

Methods

The current study was based on 13 months of research into the trial of the CDC in the East Kimberley. This research was not meant to be an evaluation framed in terms of government priorities and perspectives, because such an evaluation can obscure key relations of power involved in the very process of framing 'the problem' (Altman & Russell 2012, Bray 2016). Instead, we used discourse analysis of speeches, documents and texts relating to the CDC. We also included structured interviews with people on the card (51 in total: 16 pretrial and 35 during the trial) and semistructured interviews (37) of key informants (all names and affiliations are withheld for anonymity). The key informant interviews were with people from a diverse group affected by the trial; all had knowledge of either the process involved in the card's implementation or dealing with the effects of the trial. This group included representatives from community services, local business owners, government officials and leaders. The key informants were contacted directly

by the primary researcher to take part in semistructured interviews. They were asked about their understanding of the trial (and its implementation), their observations of the trial and any effects they had noticed.

We triangulated discourse analysis and interviews with participant observation of people living in the towns, and witnessing lives and events unfold as the trial was rolled out. Observations were made through six visits to the trial site by the primary researcher, and by the secondary researcher – who lived in the trial site during the 15 months of the trial.

Participants who took part in the research were involved in a variety of ways. Legal services in Kununurra and Wyndham agreed to interview clients receiving state benefits. For example, some clients were asked whether they would take part in a 30-minute questionnaire about the CDC following their legal interview. The legal services interviewed people before the trial began in April 2016, to understand the extent to which they had been consulted on, or knew about, the pending trial.[12] We employed a research assistant from the East Kimberley to interview people on the CDC outside the legal service network, to broaden the range of people interviewed. The legal services and research assistant also interviewed people during the trial between November and December 2016 to document their experiences on the card. Those on state benefits interviewed were not a representative sample – by community, gender or age. However, their insights did give an important picture to supplement other observations of the trial.

Bringing the card to the East Kimberley

The CDC was developed in response to a deficit narrative of an assumed alcohol, gambling and drug crisis in Indigenous communities, fuelling violence and lack of interest in capitalist formal employment.[13] For example, Andrew Forrest, in making a case for the CDC, argued that:

> Communities, especially remote first Australian communities, are desperate to stop the incoming tide of drugs and alcohol [enabled by unconditional state benefits]. They have exhausted every possible option in the search for effective methods for restricting the flow of cash to harmful uses and redirecting it to paying for essentials while in temporary and occasionally difficult circumstances, such as unemployment. (2014:102)

Ian Trust has a similar view:

> We're supporting the trial because we need a catalyst to bring about social change … We've got 80 to 90 per cent of our people on welfare, very few of our kids graduate from year 12, we have heaps of people in prisons, there's big issues in regards to domestic violence and child neglect … It's welfare from basically straight out of school from the grave [sic] and we don't think that's good enough for our people … We want them to have a better life and we think we've got to start with welfare reform. (Edwards 2015:1)

These narratives of deficit make certain assumptions about Indigenous dysfunction. They also claim a causal relationship between people on state benefits and dysfunction. However, no evidence has been presented that these issues apply to everyone receiving state benefits in the East Kimberley, or that they do not apply to people who have employment. These assumptions also suggest that any dysfunction is primarily a behavioural problem of the individual, rather than a lack of formal employment in the East Kimberley (see below for a further exploration of structural unemployment in the East Kimberley).

These assumptions also embody the normative views of responsible behaviour – that is, assimilation into settler norms through capitalist employment, home ownership and English education – and discourage anything else. For example, the playing of card games among Indigenous peoples in the East Kimberley is described very simplistically and pejoratively as gambling. Yet researchers have examined card games in Indigenous communities and have suggested that, although they may have some negative effects, they are important social interactions and means of economic distribution (Altman 1985, McMillen & Donnelly 2008). This cultural activity has been reduced to 'gambling' and is now targeted under the CDC.

To criticise the narrative of deficit is not to overlook issues in the Kimberley relating to alcohol, drugs or violence. However, there is a need to critically engage with the lack of research establishing the actual extent of alcohol, illegal drug and gambling addiction;[14] the appropriateness of a blanket compulsory measure; and the appropriateness of income management to deal with any addiction. For example, in response to the Australian Government's 2017 plan to trial the drug testing of 5000 welfare users, placing those testing positive on the CDC, the Clinical Director of St Vincent's Hospital's Alcohol and Drug Service in Sydney, Nadine Ezard,

said, 'By definition, people with severe substance use disorders are unable to modify their behaviour, even in the face of known negative consequences … In fact, an increase in stigma and anxiety for people with substance use disorders will exacerbate addiction issues rather than address them' (St Vincent's Health Australia 2017:1). It is a critical observation that, for the CDC trial in the East Kimberley (and Ceduna), the government did not see the need to propose the limited initiative of drug testing social benefit recipients, but instead compulsorily applied the CDC to all (predominantly Indigenous) recipients. This reveals the racialised belief held in government policy that Indigenous welfare users are drug and alcohol abusers.

The timing of the declaration of crisis and the intervention of the CDC is of concern because previous attempts by community leaders to gain government support for culturally significant programs have been unsuccessful. For example, women's groups in the East Kimberley that were concerned about community development put forward a series of measures to government that would address issues, but these were not taken up by the government.[15] Finally, declaring a crisis justified radical and racialised measures such as the CDC, which would not be acceptable under ordinary circumstances (Watson 2009). The framing of crisis also bypasses inconvenient truths about the causes of transgenerational trauma relating to economic and colonial dispossession and continued structural violence.

All but one of the 35 people we interviewed on the CDC said that the trial had made their lives worse. This pattern is reflected in the ORIMA evaluation, which showed high levels of difficulty reported by those on the card. Our research suggests that this hardship was because of various aspects of the trial, including its chaotic implementation, and its ill-conceived theory of change and design. This affected people's ability to management their money and fragmented social relations. These aspects are discussed further below.

A disordered experiment

The CDC trial began officially on 26 April 2016, originally for a year. However, in March 2017, the Australian Government announced that the trial would be extended for at least another year. By compulsorily including people in the trial, the government denied people the option to refrain from involvement. The trial was framed as an experiment, and its incomplete and ill-conceived design affected vulnerable lives in various ways.

The introduction of the CDC was rushed and chaotic. It was publicly announced in February 2016 that the card would be trialled in the East Kimberley, and the rollout was from 26 April 2016. Although various aspects of the card would have been planned before this (e.g. leaders signing on to the card had been consulted by the government about the card as early as August 2015), the trial had less than two months lead-in time. As a result, most people who found themselves on the card did not understand what it was or how it worked. In interviews with 16 people in Kununurra and Wyndham before the trial, many said that they had received limited communication about the trial. For example, only 1 out of 16 people was told verbally about the trial; the rest received a letter in the mail telling them that they would be on the card. Mail communication has problems in a remote context – Kununurra has no home postal delivery, and identification is required for pickup at the local post office.[16] Only 4 of the 16 people knew where to go for a replacement card, 8 knew where they could use the card, and 8 knew how much cash they would receive under the trial. Only 3 people of the 16 knew where to go for complaints about the card.

Government communications about the CDC did not improve even after the card had been rolled out and people were living on it. Of the 35 people interviewed on the card during the trial, 3 were told how much money they would receive, 3 were told why they were being included in the trial, none reported being told how the card worked, 3 were told where to go if they had complaints, and 1 was told when the trial would finish.

The rapid introduction of the trial also meant that services and facilities were not established in time for the rollout of the CDC. Although government officials tried to have the card accepted where all debit cards were accepted, in reality, people were still restricted from payments, such as those made online. Many places in the region – for example, the Kununurra cinema – did not have debit card facilities and only accepted cash. The restriction meant that card holders who had used up their cash allowance were turned away, some expressing a sense of shame in our interviews. Events such as the agricultural show publicised that the card could be used, but parents still had their cards rejected. One female interviewee with two children stated, 'I don't like it. Couldn't use card when the side show came to Kununurra'.

The chaotic and ill-conceived nature of the trial meant that some of the technologies designed to support participants actually made their experience harder. The mobile app was advertised as a way for people to view their account balance, but many people did not know how to use the app, own a smart phone or use the internet. (Of the 35 people who we spoke to on the card, only 4 said that they used the internet.) A 50-year-old man on disability support explained in his interview the issues he faced in trying to check his account balance: '[My] money don't last long, I don't have phone, I can't afford credit, I don't have patience or time to check the balance'. The hotline set up for access to the Australian Government Department of Social Services in Canberra to answer questions about the trial sometimes provided contradictory information; this was often because details of the trial were still being worked out at the time of implementation. People were also mistakenly placed on the card who were not in the trial site. For example, people living in Halls Creek and even Kalumburu – both towns with limited internet and card facilitates – were put on the card.

Wrap-around services

Even aspects of the experiment that were meant to support people on the CDC were poorly applied. The government aimed to support people on the card by providing $1.6 million to community organisations for 'wrap-around services' across the two main towns of Wyndham and Kununurra. These funds were for 'drug and alcohol services, additional capacity for existing mental health services, enhancing existing financial management services and extra funding for family violence services' (DSS 2015). Much of this funding was used after, rather than before, the trial commenced – in some cases, towards the end of the first year. The types of services funded were limited in scope, focusing on treating assumed vices such as drug and alcohol addiction, and an inability to manage finances. This narrow focus overlooked funding for community development initiatives already on tight budgets, which may have more relevance to people on social benefits. The ORIMA final evaluation acknowledged the poor implementation of service funding:

> Overall, the evaluation found that the support services funded through the Trial had not been implemented in a timely manner. Many of the funded services were not fully operational and accessible at the commencement of the Trial. Some community leaders felt that this reflected negatively on them, as they had 'promised' their communities that such services would be available when the Trial commenced … Some stakeholders also felt that communication of the availability and range of additional support services funded through the Trial, amongst Trial participants as well as service providers, had not been effective or sufficient which had contributed to a lack of service uptake and referrals. (2017b:98–99)

Most notable, however, is the limited reported use of these services by people on the CDC. The ORIMA (2017b) final evaluation found that only 12% of people they interviewed on the card reported using drug and alcohol services, and 10% used financial and family support services. This suggests that the assumption that people on welfare had vices to be serviced by drug and alcohol programs, and money management programs was not justified. As well, for people wanting to use the services, the services were not available in time.

The community panel

People who were put on the CDC had the option to present a case to a community panel to reduce the amount quarantined from 80% to 50%; they did not have the option to be taken off the card.[17]

The panel was not functioning in Kununurra and Wyndham until late 2016. When it was running, the government agencies selected members of the Kununurra and Wyndham communities to review a paper application prepared by the individual, and then deliberate and decide on a new amount to be quarantined. To submit a case to the panel, the individual on the CDC was asked to sign a statement giving community members on the panel, whose identities and interests were undisclosed, access to personal information such as information on school attendance, health information, police records and housing records. Bilateral agreements were developed for sharing information between the various services. In other words, the process required someone on the card to disclose personal data to an unspecified 'community' panel, without representation. The panel process assumed that people in the region 'knew' each other and could make fair assessments about each others' lives, without any legal recourse for the individual making the claim.

The ORIMA (2017b) evaluation acknowledged that the panel had limited success. Our research also found that it was not clear for many people how the panel worked, who was on the panel, and how people on the CDC could have legal representation. For example, of the 35 people on the card at the time of our survey, 5 knew about the panel, 5 had never heard of it, and 20 were not sure if they had heard of it.

Theory of change and inducing hardship

Beyond what was seen by some government officials as inevitable teething problems of getting the experiment right, the CDC had other impacts on people's lives that could not be straightened out. These impacts related to the deficit assumptions underpinning the trial: that the overuse of alcohol, illegal drug use and gambling are caused by excessive access to cash, and that people have a behavioural deficiency limiting their ability to find a job.

Making money management hard

The perception that the overuse of alcohol, illegal drug use and gambling are caused by excessive access to cash is disconnected from the reality of people living on state benefits. For example, one 46-year-old woman on the CDC stated, 'I am capable of managing my own money. I don't need government to tell me how to spend. Why tag all of us on the CDC?' A 50-year-old female interviewee on a carer's payment also stated, 'I don't like it because it's taking us back to the ration days, telling me how to manage my money as I don't drink and smoke'. Of the 51 people interviewed, most reported that their biggest cause of poverty was not behavioural or the mismanagement of funds, but simply not having enough money. Further, from the 35 interviews of people on the card, 31 people said that the CDC trial had made the management of their money harder (4 people did not answer the question).

People interviewed said that the card made the management of money difficult because they did not know where their money was going, and some even reported that the card took fees they did not know about (25 of the 35 people interviewed on the card thought they had been charged fees, and 9 people were not sure if they had). A 35-year-old female interviewee on a parenting payment and family assistance stated, 'I don't like it [the card] at all, especially when you have six kids and your routine of early hours shopping for school lunches can't happen [because I run out of cash]. It's too stressful'. A 21-year-old female interviewee on a parenting payment and family assistance said, 'I prefer the old system, [I had] more cash on hand. With the card, I am always finding out about different balances when I check. Fees are charged. I am not happy as I cannot save'. A 25-year-old female interviewee stated, '[The card is] not helping, I don't like the white card. I cannot save'. Another female interviewee with four children stated, 'I don't agree with what I have been told; it has mucked my paydays up; it's very hard for me and my children. It's very stressful'. Similarly, Hunt (2017), in her analysis of the ORIMA interim evaluation, raised questions about the CDC causing difficulty for vulnerable people: '55% of transactions on the cards failed due to insufficient funds … that is nearly 21 000 transactions where people were unable to purchase what they wanted' (Hunt 2017:5). Despite the trial's assumptions about the overuse of alcohol, illegal drugs and gambling, less than 1% of failed transactions were because people were trying to use the card for prohibited items (Hunt 2017).

The CDC dramatically limits the amount of cash people have. Yet cash is an important aspect of living in remote areas (Peterson 1991, Altman 2015). Remote economies in Australia do not operate under the free market logic that government policy promotes. Indeed, remote economies in the Kimberley include not just the public (or state) sector and the private sector but also the nonmarket or customary sector. These characteristics in remote Australia are what Altman (2005) has termed the 'hybrid economy'. Cash circulates through the state and market sectors of the hybrid economic frameworks, but also through the nonmarket sector when customary activity is exchanged for cash payments (e.g. painting, hunting, labour) (Taylor 2004, Altman 2005) and when people invest in means of production outside the market sector (e.g. second-hand equipment and tools). The CDC, by restricting cash and tying people to stores with CDC facilities, can restrict people's engagement in the hybrid economy.

TABLE 1. Key items for cash use (before the Cashless Debit Card)

Item	Percentage of respondents	Number of respondents (n = 51)
Present to give someone	29.4	15
Social events (e.g. Kimberley moon)	13.7	7
Eating out	25.5	13
Big item for the home (e.g. fridge)	49.0	25
Medicine from the chemist	21.6	11
Transport costs (e.g. for taxis and buses)	64.7	33
Lunch money for children	21.6	11
Bills	23.5	12
Rent	29.4	15
Fuel	51.0	26
Small grocery shopping	62.7	32
Big grocery shopping	58.8	30

Cash is also important for people engaging in the private and public sectors to purchase goods to meet their basic needs. Table 1 shows the responses given by the 51 people interviewed about what they used cash for (before the trial). Transport and lifts around town, big and small grocery shopping, and fuel were important cash commodities in the East Kimberley. People also reported using cash for informal renting arrangements, lunch and pocket money for their children, buying second-hand goods informally, purchasing fresh food and meat from local farms and stations (which can be cheaper than from stores in town), and for paying for the show and other events coming to town.

Although the rationale for the CDC is to reduce the amount of cash people have to spend on alcohol, illegal drugs and gambling (even though there are no poker machines in the East Kimberley), the card has caused difficulty for people who use cash to support basic needs. Table 2 shows the types of key items that people found it hard to pay for after the card came into circulation. They include transport – which is a key need for people to get to their work-for-the-dole responsibilities (which have harsh penalties for not showing up) – shopping for food, taking children to school and attending social events.

TABLE 2. Items that are harder to purchase under the Cashless Debit Card

Item	Percentage of respondents	Number of respondents (*n* = 51)
Present to give someone	20.0	7
Events (e.g. Kimberley moon)	22.9	8
Eating out	14.3	5
Big item for the home (e.g. fridge)	80.0	28
Medicine from the chemist	68.6	24
Transport costs (e.g. for taxis and buses)	65.7	23
Lunch money for children	11.4	4
Bills	48.6	17
Rent	22.9	8
Fuel	20.0	7
Small grocery shopping	22.9	8
Big grocery shopping	65.7	23

Depoliticisation of poverty and unemployment

The material poverty experienced by people receiving state benefits in the East Kimberley has structural and historical roots. However, the CDC reconfigures and re-articulates socioeconomic and postcolonial issues as a crisis of the individual.

Poverty in the East Kimberley disproportionately affects Indigenous people: 47% of Indigenous people living in Kununurra and 32% in Wyndham live on less than $20 799 per year, whereas only 12% of non-Indigenous people in Kununurra and 13% in Wyndham live on less than $20 799 per year (data sourced from the Australian Bureau of Statistics 2016 Census data). Tables 3 and 4 show the median household and individual incomes for people living in Kununurra and Wyndham;[18] Indigenous income levels are far below non-Indigenous levels. Poverty is also exacerbated by a higher cost of living; the cost of living in the Kimberley is 13% higher than in Perth (KDC 2017). Further, Tables 3 and 4 show that the likelihood of home ownership is lower for Indigenous people in Kununurra and Wyndham. Indigenous people in both towns have a higher need for physical assistance than non-Indigenous people, and contribute more time to unpaid child care.

Material poverty for Indigenous people in the East Kimberley is linked to colonial processes (as elsewhere in Australia), in that wealth generated has been through the exploitation of Indigenous labour and land. The development of the town of Kununurra was contingent on the flooding of Miriuwung country to create the Ord Dam and Lake Argyle, the largest lake in Australia. The damming of the Ord River flooded more than half of Miriuwung country, including songlines; this is one of the most recent acts of dispossession, displacement and occupation in Australia's history (Sullivan 1996). As Grudnoff and Campbell (2017) reported, despite $2 billion spent on the Ord River Scheme, limited benefits have been enjoyed by a few. The scheme has resulted in only 260 (predominantly non-Indigenous) jobs (Grudnoff & Campbell 2017). Indentured and unpaid Indigenous labour built the pastoral industries of the East Kimberley, and many families suffered through Stolen Generation policies, under which their children were taken and used as slave or indentured domestic labour in settler households. The 2006 Senate Inquiry into Indigenous Stolen Wages acknowledged how unpaid Indigenous labour in the Kimberley was used to build the very industries generating private profits in the East Kimberley today. The inquiry also noted that this exploitation of labour has clear links to the material poverty many Indigenous people currently experience.[19]

TABLE 3. Socioeconomic data, Kununurra

Variable	2011		2016	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Population	1335	3018	1158	2897
Population 18 years and over	744	2429	686	2309
Population 18 years and over (%)	55.7	80.5	59.2	79.7
Home owner or purchasing (%)	9.9	52.2	12.4	47.7
Provided child care for own children, and/or other children (%)	48.7	27.2	38.3	28.4
Have a need for assistance (%)	5.3	1.5	7.9	2.0
Median personal income ($/week)	355.7	1039.1	428.1	1124.3
Median household income ($/week)	1273.5	1745.5	1293.3	2096.1

Notes:
1. All calculations are based on population 18 years and over.
2. All calculations exclude 'not stated' responses.
3. Calculation of median household income is based on place of enumeration; all others are based on place of usual residence.
Source: Data from Australian Bureau of Statistics 2011 and 2016 census data.

TABLE 4. Socioeconomic data, Wyndham

Variable	2011		2016	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Population	409	287	359	186
Population 18 years and over	253	219	225	151
Population 18 years and over (%)	61.9	76.3	62.7	81.2
Home owner or purchasing (%)	20.2	43.0	14.4	59.1
Provided child care for own children and/or other children (%)	42.4	36.3	29.8	23.7
Have a need for assistance (%)	6.3	4.0	7.1	3.3
Median individual income ($/week)	357.7	1064.0	530.0	1294.3
Median household income ($/week)	1168.3	1764.1	1024.9	1781.8

Notes:
1. All calculations are based on population 18 years and over.
2. All calculations exclude 'not stated' responses.
3. Calculation of median household income is based on place of enumeration; all others are based on place of usual residence
Source: Data from Australian Bureau of Statistics 2011 and 2016 census data.

Material poverty in the East Kimberley is therefore relational (Mosse 2010); it is a persistent 'consequence of historically developed economic and political relations, as opposed to "residual" approaches which might regard poverty as the result of being marginal to these same relations' (Mosse 2010:1157). In the East Kimberley, relational poverty is a consequence of economic and colonial processes compounded by punitive workfare and welfare policies, such as the CDC and a work-for-the-dole scheme (explained below).

Unemployment

The CDC trial compulsorily included most working-aged people who are unemployed in the East Kimberley. This creates a nexus between unemployment and excessive use of alcohol, illegal drugs or gambling, and also suggests that behaviours, norms and aspirations of all people receiving welfare are currently problematic and need to change (which will lead to employment). However, the key cause of unemployment in the East Kimberley is not a behavioural issue but the absence of formal jobs (KDC 2013). The Kimberley Development Commission

shows that bringing Kimberley Indigenous employment to Australia's average by 2025 would require 120 new full-time and ongoing jobs per year until then (80 jobs for Indigenous people and 40 for non-Indigenous people). The Kimberley Development Commission (KDC 2013) argues that, based on the current labour market trends, Indigenous employment parity will not be met in the Kimberley until around 2040.

The absence of formal jobs for Indigenous people provides employment for non-Indigenous people. Service provision for Indigenous people is one of the key areas of employment creation for non-Indigenous people in the East Kimberley. Health organisations; legal organisations; and government departments and agencies such as child protection, housing and social services employ a workforce of hundreds of staff – disproportionately non-Indigenous (Empowered Communities 2015, Marrie 2015).

Despite the limitations of the East Kimberley labour market, government policy has abolished programs that supported Indigenous labour, such as the Community Development Employment Projects (CDEP) scheme. CDEP was established nationally in 1977 and reached the Kimberley in the early 1980s. It provided support for Indigenous people to undertake productive labour on country, and to engage in community and commercial activities. CDEP was based on a realisation that standard Australian state benefits and employment creation institutions were unsuitable for the economic, geographic, situational and cultural circumstances of Indigenous people living remotely, and that an innovative institution that recognised such difference was needed.[20] CDEP in the East Kimberley supported various productive activities such as hunting, fishing, art and craft manufacture, land management and ceremonial business. As Taylor (2004) observed, such activities did have market potential.[21] CDEP proved popular, and, by 2004, more than 35 000 Indigenous people were participating (70% of these in remote Australia), and 265 community-based Indigenous organisations were administering the scheme (Altman & Klein 2017). CDEP was progressively abolished from 2004; since its abolition, unemployment has increased by 20% in the East Kimberley (KDC 2013).

Despite the lack of formal jobs, the Australian Government launched a punitive remote work-for-the-dole scheme called the Community Development Programme (CDP), which claims to prepare people for work; however, the work is simply not there.[22] This means that people in the East Kimberley are not only subjected to the quarantining of their state benefits with conditions on how they spend their money through the CDC; they also have to endure harsh work-for-the-dole requirements, including punitive conditions on accessing state benefits in the first place.[23] CDP requires working-age participants (18–49 years) to attend manufactured 'work-like' initiatives, up to 25 hours a week, 5 hours a day and 5 days a week, for a payment well below minimum awards (Altman 2017). The requirements for CDP are harsher than the government's nonremote and mainly non-Indigenous jobactive program, leading to CDP participants breaching the requirements at a rate 30–40 times higher than jobactive participants (Fowkes 2016).

Table 5 shows the dramatic increase in penalties for people subjected to CDP in Western Australia[24] after the introduction of the program on 1 July 2015. The no-show, no-pay penalty is applied for people missing their work-for-the-dole activity. Each no-show, no-pay penalty results in the loss of one-tenth of an individual's fortnightly income support payment ($53.88 of a fortnightly $538.80 Newstart allowance). Three days missed can result in an eight-week suspension of income support. The Western Australian numbers mirror the national trend of a significant increase in penalties applied to people on CDP. (Nationally, there were 22 984 no-show penalties before CDP; after CDP was introduced, this rose to 125 670, showing the consequences of the increased punitive approach.)

TABLE 5. Breaching rates under the Community Development Programme, Western Australia

Penalty	2014–15 financial year	2015–16 financial year	Increase in penalties (%)
No-show, no-pay incidents	4 297	22 662	527
Total 8-week non-payment periods	599	2 629	438
Total financial penalties	6 734	25 621	380

Some people in the East Kimberley have tried to resist being subjected to both the CDC and CDP. Workers at the CDP facility in Kununurra went on strike, citing their frustration at being penalised twice. They asked why, if CDP was work (as the government claimed), they had to be on CDC (which targets the unemployed). Despite the overlap between government policies and their impact on people's lives, government analysis is reluctant to examine these links.

Despite the historical and structural links to poverty and unemployment, those targeted for the CDC trial are judged on their apparent failure to be good economic citizens by the very account that they are in need of state

assistance. It is assumed that their poverty or hardship is a matter of behaviour, and, under the right economic incentive/disincentive structure, their behaviour will improve to a level consistent with, and acceptable to, the rest of the population. Andrew Forrest (2014:133) states in the chapter 'Breaking the welfare cycle' in the Forrest review, … for most people a quick, small "hit to the wallet" can be the most effective incentive to change behaviour'. However, poverty and inequality in the East Kimberley are not matters of individual behaviour, but are relational features of Australian settler colonial capitalism.

Constructing community and fragmenting social relations

The Australian Government claims that the CDC trial was community based and driven by the community. For example, Alan Tudge, the Minister for Human Services, who led the introduction of the CDC in the East Kimberley, stated in a media release the day he introduced legislation into the House of Representatives to authorise the trials of the card:

> Government has been working closely with communities on the ground co-designing the parameters of the trial ... When community leaders stand up and call for reform to better their community, governments should listen and that is exactly what we are doing. (2015:1)

The declaration of working with the community gives the perception that the trial was 'invited' and 'co-designed' by those in the East Kimberley, despite its being a government program proposed in the Forrest review. The government recruited a limited number of residents and organisations operating in the East Kimberley to become the 'community' face of the trial.[25] This group's involvement was key for the government to secure the trial's implementation, given the high degree of contestation for the CDC across the East Kimberley.

The leaders signing onto the CDC, whether intending to or not (see below regarding issues with the consultation process), took on work of the Australian Government through the CDC trial. This included espousing government rhetoric about the card, speaking in the name of the diverse population in support of the card, administering aspects of the card by sitting on the community panel, and, importantly, taking the brunt of criticism from people on the card. In August 2017, Lawford Benning, Chair of the Miriuwung Gajerrong Corporation, retracted his support of the CDC (Davey 2017).

Our research finds that the trial is highly contested, and the decision for the card was anything but a community decision that represented the region's diverse population. Tudge and others use the term 'community' to imply homogeneous support, but the community of the East Kimberley comprises diverse peoples in colonial, class and gender dynamics. Some people had more of a say than others, and the claim that the CDC trial was community led is misleading. In its submission to the senate inquiry into the CDC, the Miriuwung Gajerrong Corporation raised concerns about the unrepresentative nature of the trial, noting that, although the 'Department of Social Services (DSS) states that the Cashless Debit Card program was co-designed with local leaders in Kununurra … in reality, only four local leaders were consulted in relation to the introduction of the CDC in Kununurra'.

Of the 51 people we interviewed who were on the CDC (16 before the trial and 35 during the trial), only 2 people felt that the government had spoken to the right people who represented their community, 25 people said that they were not the right people (they were leaders from organisations but not from the community), and 23 people were not sure if they were the right people or not. People in these interviews highlighted that some people signing their community onto the card were leaders but either were not the right leaders or did not include all the leaders. One interviewee called this 'white person's research', implying that the consultation was just with white people or those aligned with white people. The government consultation about the card was tokenistic in the sense that the frame of reference was never open to change. Instead, consultation was about selling the card to those they spoke to, and not participatory, such that other alternatives could be proposed and pursued.[26]

Even the leadership signing up to the card were confused about the intent of the trial and what it would entail.[27] For example, in a town meeting organised for people to express their frustration to the leaders, various key figures acknowledged that they did not have all the details of the trial from the government before the trial started. Some also had the understanding that the panel would have the ability to take people completely off the card, which was not the case.

Furthermore, although some of the leadership signing the region on to the card did support the government's rationale for a CDC, it was not that clear-cut for others. Instead, some agreed to take the card as a way to get much-needed funds for service delivery, since some Indigenous organisations in the East Kimberley were feeling extreme financial pressure in a tight funding

environment after witnessing the defunding of Indigenous organisations through the Australian Government's Indigenous Advancement Strategy.[28] Other leaders felt that the trial was an opportunity for Empowered Communities,[29] a network of Indigenous organisations, to get the government to take them seriously to support their broader objective of being a vehicle for Indigenous governance across the East Kimberley. Both reasons point to a situation in which there was little real choice but to accept the CDC.

The pressure placed, and tactics used, on communities by the Australian Government to accept the trial can be further seen in the example of Halls Creek. Halls Creek was an initial location identified by the government to trial the CDC, but the shire rejected the proposal. The Halls Creek Shire conducted its own extensive consultation with remote communities to garner the views of residents about the proposed trial. These consultations found that residents had considerable informed concerns about the trial.[30] The shire councillors voted against having the trial, even though they were under considerable pressure by government to accept the trial. Minutes from the council meetings refer to a visit by the then Western Australian Minister for Regional Development, Terry Redman, warning the shire that it might miss out on funds in the Western Australian regional reform if it rejected the trial.[31] After Redman's visit, the shire councillors again voted against the trial. This shows the pressure placed on leaders when they disagree with, or refuse, the government's will. The implications of saying no to the trial remain to be seen, given that the regional reform funding is still being worked out.

Excluding community

The Australian Government has used the term 'community' and 'leadership' to give the impression that the CDC was a local initiative with grassroots support. Yet, when they were being selected for the trial, large groups of people in the East Kimberley, especially dissenting voices, were dismissed and excluded. Overlooked were the views of many recipients of state benefits who were to be put on the card. These people were portrayed as not understanding, or having the ability to understand, the logic of the card. Concerns voiced in interviews show that people on the card had very legitimate and informed concerns about the trial and its possible impacts on the community:

> I think it is quite racist, I think it breaches our civil liberties and it's a bunch of crap. They tarred us with the same brush.

> I think its unfair – it's targeting us people living in remote towns. It is going to cause problems. Why do they give old people trouble? It'll mean old people get bashed for money. There will be more violence. We're going backwards in Australia – back to the ration days. I think it will cause even death in this community. Young people on drugs, it will cause violence and suicide.

> It's not gonna help people that been drinking or smoking all their lives. People like that will just start drinking brake fluids and methylated spirits.

> Should not have happened to us in the first place, it's not going to change anything. I was better off before the welfare card been announced.

These views of the community are discarded as 'disgruntled' and not taken seriously. Narratives of deficit, dysfunction and irrationality usurp any ability to question the card's usefulness. Often, proponents of the card have viewed any reported hardship by people on the card as caused by alcohol and drug use. The frustration and hardship experienced by people on the card are delegitimised, as these people are assumed to be alcoholics and gamblers. Hardship is a mechanism used to get participants to accept new norms and behaviours. The extent of the disempowerment felt by those on the card through exclusion was hard to gauge; however, of the 51 people we interviewed, only 6 felt that their concerns about the card would be listened to, 21 said they would not be listened to, and 23 were not sure if people would listen to them.

The card was socially fragmenting not just in the way it divided people through the limited consultation and approval, but also because it physically stratified people by identifying card users in social spaces. Because the card stops purchases of alcohol at the merchant level, shops that serve both alcohol and food, such as pubs and restaurants, were either banned from accepting the CDC or, in the case of key pubs in Kununurra, had two tills in operation. In the latter case, people on the CDC could only use one of the tills, which identified them to other patrons.

Resistance and agency

Many saw the CDC as an extension of the government's ongoing desire to regulate and control Indigenous lives and subjectivities. Although many punitive government interventions were under way in the East Kimberley, such as the defunding of remote communities through regional reform and punitive work-for-the-dole requirements, it

was the CDC that was the symbol of settler colonialism. Although the card aimed to change the behaviours of (mostly Indigenous) people receiving state benefits, it was not successful. Instead, there was resistance.

Within weeks of the card's rollout, the card was given an entirely new name among those on it: the White Card. At no stage has the card been white (it is silver), so this is a curious reflection. When asked, both those on the card and government workers reflected that the card was renamed the White Card because it was imposed by white people. It is unclear how this name emerged, but its impact was instant. Within weeks, few people called it anything else in the East Kimberley. Every time the name White Card was uttered, a space of subtle resistance was created. The response from the government and Indue reflected this: survey participants told us that Indue refused to serve clients who called the card White Card.

Two large meetings were held in the main park of Kununurra at which people subjected to the CDC voiced their concerns. The leaders who had agreed with the government to bring in the card were invited to listen to the frustration of people on the card, and their families. More than 80 people attended this meeting and expressed their concerns about why the card was compulsory and why only a few people had been consulted. There was also a petition for the Australian Government to stop the trial in the East Kimberley, which was signed by more than 100 people.

People found ways around the CDC, such as swapping goods paid for by the card for cash (often for a lower amount). The card also put people in further vulnerable situations; some key informants reported people having sex for cash or moving away from the trial site. Some people just never picked up their card, and thus cut themselves off state payments to avoid being subjected to the trial. For those suffering from addiction, the assumption that the restriction of cash would support their rehabilitation seems over-optimistic at best, and dangerous at worse. In the interviews, people spoke of instances in which people found had ways to support their addictions without cash, or had left town.

In response to European occupation, both physical and behavioural, Indigenous people have always resisted in ways that have delegitimised the narrative of settler colonialism (Watson 2009). Responses to the CDC have included ways for people to reclaim power to counter bureaucratic power. The government discredits and racialises such agency as dysfunctional. It refuses to acknowledge and actively undermines the productive and emancipatory potential of Indigenous agency.

Conclusion

The logic behind the CDC, and income management more broadly, has developed in conjunction with other policy initiatives. It is connected with the rise of paternalism as part of the neoliberal turn of Australian social and economic policy (Altman 2014, Cahill 2014, Strakosch 2015). The discourse underpinning neoliberal logic is of scarce economic resources, such that all citizens must accept state austerity and be self-disciplined in making the right (economic) choices. Although rhetoric calls on all sectors of society to do the 'heavy lifting' (as the former Federal Treasurer Joe Hockey called it), the burden of austerity falls on the most vulnerable in society (Engels 2006, Standing 2011, Stanford & Taylor 2013). This is because the unemployed or those not working are seen as exhibiting a behaviour deficiency. This view overlooks the increasing failure of the labour market to provide full, secure and dignified employment, particularly in remote and regional areas. In Australia, governments, while also targeting non-Indigenous people, have aggressively pursued Indigenous people through income management and harsh work-for-the-dole measures (Fowkes 2016, Jordan 2016), as well as defunding 'unproductive communities' through Western Australia's regional reform.

The trial of the CDC in the East Kimberley is perverse contemporary Indigenous policy. Not only did the trial, by limiting the amount of cash, bring material hardship, it furthered the disempowerment of those marginalised by relational poverty. The terms 'community' and 'consultation' were used by government and advocates of the card as a tactic to give the impression that the diverse populations in Kununurra and Wyndham were unified in approval of the card. They do not reflect the substantive opposition to the card from many people living in the study site; indeed, the White Card has become a symbol for disempowerment and neocolonial government control.

Use by the Australian Government of bespoke 'evidence' to tell only the story that the government wants to be heard is disturbing. It has two purposes: to continue the trial and expand the program in other regions, and to obfuscate the reality that the CDC's logic is deeply flawed and reliant on jobs that do not exist. The card cannot achieve the aims it seeks, as the framing is perverse and disconnected from the lives of those on the card.

Notes

1. 565 of the 752 people in the Ceduna trial and 984 of the 1199 people in the East Kimberley trial are Indigenous (Australian Human Rights Commission 2016:91–92). Nationally, 2.7% of the Australian population identified as being of Aboriginal and/or Torres Strait Islander origin in the 2011 Census.
2. Freedom of information (FOI) documents relating to consultation in Halls Creek communities about the introduction of the CDC (later rejected) show that the Department of the Prime Minister and Cabinet (PM&C), when communities asked where the card comes from, stated 'the Forrest Review'. This was a review carried out by mining magnate Andrew Forrest into Aboriginal training and employment (FOI consultation in Mulan (WA), September 2015).
3. Other elements that show the CDC as primarily an Indigenous program include the key role that PM&C has played in developing and rolling out the CDC trial in both sites, despite social security being the responsibility of the Department of Social Services and the Department of Human Services. PM&C has responsibility for Aboriginal policy. Further, the card was proposed for approval in the East Kimberley to organisations within the Empowered Communities – an Aboriginal organisation network (and not non-Indigenous organisations).
4. Contract (number CN3323493) awarded to Indue for operations: $7 939 809.00. Contract (number CN3290604) awarded to Indue for the information technology build: $2 870 675.50.
5. The evaluation was released the same day as the announcement that the trial would be extended, even though the government had been planning to extend the trial for some time. For example, Indue was issued with written notice to extend its contract implementing the CDC past the original end date of 21 April 2017, six weeks before the government made the extension public (information obtained under FOI request no. 16/17-141).
6. See Hunt (2017) for a good summary of the key methodological flaws in the ORIMA evaluation.
7. The interim ORIMA evaluation also notes the increase in crime, particularly youth crime: 'many stakeholders reported an increase in the following illegal/harmful behaviours among youth people/children: robberies/thefts/vehicles and dwellings – stakeholders reported that in these cases young people were in search of cash; and petty crime (e.g. pickpocketing and "snatch and grab") – stakeholders reported that children on bikes were often the perpetrators in these cases' (ORIMA 2017a:163).
8. The ORIMA interim evaluation does state that 'a few stakeholders identified some increase in domestic violence/intervention orders – although it was not clear whether the increase was due to changes in reporting requirements, the policing approach or increased community awareness, understand and willingness to take action' (ORIMA 2017a:163).
9. The Howard Government's Northern Territory Emergency Response implemented measures including bans on alcohol consumption, bans on pornography, quarantining of state benefits, highly regulated tenancy arrangements that disallowed different residential arrangements, compulsory acquisition of township leases from the legally recognised owners to facilitate governmental controls, and appointment of government business managers with legal rights to monitor the meetings of community organisations and with absolute powers in townships (Altman 2007).
10. See the Second Reading speech for the Social Security and Other Legislation Amendment (Welfare Payment Reform) Bill 2007; the Northern Territory National Emergency Response Bill 2007; and the Families, Community Services and Indigenous Affairs and Other Legislation Amendment (Northern Territory National Emergency Response and Other Measures) Bill 2007.
11. Communications about the CDC in 2014 state that it is not income management. This perhaps is to put distance between the trial in the Kimberley and the government-commissioned multiyear independent evaluation of New Income Management in the Northern Territory (see Bray et al. 2014).
12. No-one was paid to take part in the current study, and no-one on the card refused to take part in the survey. Some key informants did decline an interview, especially those working in government departments.
13. Construction of Aboriginal pathology in the Kimberley has had a long history. In 2014, the Aboriginal settlement of Oombulgurri, just out of Wyndham, was dramatically bulldozed because it was claimed to be so dysfunctional, including with regard to the sexual abuse of children. Instead of dealing with the sexual offenders in the settlement, the whole population was forcibly removed to the town of Wyndham, where the waiting time for housing can be up to eight years. Applications for public housing made in 2008 are only being processed in 2016.
14. The ORIMA evaluation commissioned by the government to test the trial did not register any quantitative consumption data or responses from trial participants before the rollout of the CDC. Instead, the 'Initial conditions report' is primarily based on qualitative research (interviews and focus groups) with key stakeholders (mainly services) in each of the trial sites.
15. See also Watson (2009), who showed how crisis was used in a similar way to bring in the Northern Territory Emergence Response in 2007.
16. Some Indigenous people do not have identification because their births were not registered or they do not have birth certificates. This can cause issues in securing licences and other forms of recognised identity cards, which are needed to pick up postal items (Castan & Gerber 2015).

17. A vague process was developed by the Department of Social Services (DSS), in which an individual can seek a social worker to assess their case. If the assessment shows severe impacts on the individual's wellbeing, the social worker can make recommendations to DSS for the individual to be removed from the trial. It is not clear how many people have been successful through this process, but the number is low, given that the number of people on the trial has not decreased significantly.
18. These data are based on the whole population in the two towns and not just those on the CDC. At the time of writing this paper, data on employment and unemployment had not been released by the Australian Bureau of Statistics.
19. For example, in her submission to the Standing Committee on Legal and Constitutional Affairs, Professor Anna Haebich (2006) argues, 'Aboriginal people played a major role in building the state economy in the pastoral and rural industries in the north and south of the state. It was the state government's discriminatory employment system that prevented Aboriginal workers from benefiting from the Australian labour system, which was hailed around the world as an exemplary model for protecting workers' wages and rights. Instead, Aboriginal people were subject to a disabling system which denied them proper wages, protection from exploitation and abuse, proper living conditions, and adequate education and training. So while other Australians were able to build up financial security and an economic future for their families, Aboriginal workers were hindered by these controls. Aboriginal poverty in Western Australia today is a direct consequence of this discriminatory treatment' (Parliament of Australia 2006:29).
20. Refer to Jordan (2016) for an extensive analysis of CDEP. John Taylor discussed the specific importance of CDEP in the East Kimberley (see Taylor 2004, 2008).
21. Taylor (2004) references the Warmun community arts centre, which in 2004 made an annual turnover of $1 000 000, and 'has 88 artists registered, and employs 18 of these full-time with earnings well above the regional average' (p. 114).
22. Another Australian Government workfare initiative, which links state benefits to work outcomes in the East Kimberley, is transitional housing. Transitional housing puts conditions on people wanting to access housing, under which they must prove that their children have at least 85% school attendance; at least one adult in the house must be in work; and the family agrees to transition into private rental or private home ownership (normally between two and three years, with a maximum of five years). Transitional housing started in Kununurra between the Western Australian Housing Authority and the Wunan Foundation. It was extended to other parts of the Kimberley and is set to further expand under the regional reform.
23. Although CDP has a similar name to CDEP, there is a drastic difference between the two (see Jordan & Fowkes 2016).
24. The Western Australian numbers are shown because FOI requests for Kimberley-specific information on breaching rates were unsuccessful. The reason given was a concern that CDP providers could be identified. However, informants who have seen the breaching rates in the East Kimberley have indicated a dramatic increase in breaching in both Kununurra and Wyndham since CDP was introduced.
25. Organisations originally named as championing the card included the Wunan Foundation, the Miriuwung Gajerrong Corporation, the Waringarri Aboriginal Corporation and East Kimberley Job Pathways (a joint venture between the Australian Government and the Wunan Foundation). Both East Kimberley Job Pathways and the Waringarri Aboriginal Corporation were named in the contract between the Department of Social Services and Indue as supporting the rollout of the CDC in the East Kimberley (FOI request no. 16/17-141).
26. See Cooke and Kothari (2001) for a good analysis of the limits and possibilities to community participation.
27. The tokenism displayed by the CDC process is in direct conflict with the United Nations Declaration on the Rights of Aboriginal Peoples, which calls for free, prior and informed consent. For example, article 19 outlines that 'States shall consult and cooperate in good faith with the Aboriginal peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them'.
28. In 2014, much of the $4.8 billion relied on by Aboriginal sector organisations was put to tender by the government under what was called the Indigenous Advancement Strategy (IAS). The IAS forced organisations, many small and unfamiliar with such processes, to apply in a competitive funding process. As a result, Aboriginal applications constituted only 40% of the total and a smaller 26% of successful grants. Further, the average size of grants was $663 000 – much less than the average sought of $2.8 million (see Altman 2015). The funding cuts were significant, as many organisations were already struggling under financial pressure, and having only partial funding severely affected many organisations' ability to undertake their work.

29. The Empowered Communities network is a group led by various individuals from eight Indigenous groups across Australia. In 2014, it was supported by senior policy officials from both the Australian and state governments, senior business leaders and a $5 000 000 grant to publish the *Empowered communities: empowered peoples – design report*. The report sets out a model for Indigenous development and empowerment for the eight regions (including the East Kimberley), with the long-term goal of a national rollout. The network expressly states its alignment with the recommendations of the Forrest review and promotes controversial welfare reform such as income management. However, what is outlined in the Empowered Communities report is different from how Empowered Communities operates in the East Kimberley. Many organisations are involved in Empowered Communities in the East Kimberley not because there is a clear understand of, and/or affinity with, the theory of change underpinning its model of development, but based on a concern of missing out on funding, exposure and opportunity.
30. Independent of the shire's own consultation, PM&C conducted its own meetings with residents in remote parts of the shire. Documents received via FOI requests show that questions recorded from the residents to the department also show informed concerns about the trial.
31. The shire meeting minutes held on 19 November 2015 state, 'That the council notes that the Minister of Regional Development met with the President and Chief Executive Officer on 11 November 2015; notes that the Minister expressed concern regarding the Shire's public opposition to the trial of the cashless debit card in the Shire and as part of a wider trial in the East Kimberley; notes that the Minister indicated that if the Shire was not to be part of the East Kimberley trial area it would not benefit from investment resulting from the Regional Services Reform for the Kimberley' (p. 9).

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