



Australian Government

Department of Social Services

Reforming the Cashless Debit Card and Income Management

Copyright notice



This document is licensed under the [Creative Commons Attribution 4.0 International Licence](https://creativecommons.org/licenses/by/4.0/legalcode)

Licence URL: <https://creativecommons.org/licenses/by/4.0/legalcode>

Please attribute: © Commonwealth of Australia ([Department of Social Services](#)) 2022

Notice:

- 1.If you create a derivative of this document, the Department of Social Services requests the following notice be placed on your derivative: Based on Commonwealth of Australia (Department of Social Services) data.
- 2.Inquiries regarding this licence or any other use of this document are welcome. Please contact: Branch Manager, Communication and Media Branch, Department of Social Services. Phone: 1300 653 227. Email: communication@dss.gov.au

Notice identifying other material or rights in this publication:

- 1.Australian Commonwealth Coat of Arms — not Licensed under Creative Commons, see <https://www.itsanhonour.gov.au/coat-arms/index.cfm>
- 2.Certain images and photographs (as marked) — not licensed under Creative Commons

Contents

Introduction	5
Purpose	5
Executive Summary	5
Background.....	7
Income Management	7
Cashless Debit Card	9
The difference between Income Management and Cashless Debit Card	11
1. Problem Statement:	13
The current Cashless Debit Card and Income Management programs are no longer required	13
1.1 Cashless Debit Card and Income Management programs do not target those who need support the most	13
1.2 The changed policy landscape has reduced the need for Cashless Debit Card and Income Management programs	14
1.2.1 Both Programs have similar objectives and functions operating concurrently	17
1.3 Evidence for the success of the programs is unclear	17
1.4 The compulsory nature of the program restricts freedom of choice and carries a stigma.....	19
1.5 Current BasicsCard technology restricts participant choice.....	19
1.6 Voluntary Income Management carries less stigma and can be more effective	20
1.7 There is a higher opportunity cost to continue Cashless Debit Card and Income Management.....	21
1.8 Summary of stakeholder impacts.....	21
2. Why is Government action needed?	22
2.1 Why the government should reform the programs.....	22
2.2 Alternatives to Commonwealth Government action	22
2.3 Objectives of the policy change.....	22
2.4 Constraints or barriers to achieving these objectives	22
2.5 The Governments capacity to reform the programs successfully and overcome these barriers	23
3. What policy options are you considering?	23
3.1 Option 1 – Maintain the status quo	23
3.1.1 The ability of the ‘status quo’ option to address the problem.....	25
3.2 Option 2 – Reform the Cashless Debit Card and Income Management programs	26
3.2.1 Key elements	26
3.2.2 Abolish the Cashless Debit Card	27
3.2.3 Card technology for voluntary IM participants	27
3.2.4 Supporting participants exiting the Cashless Debit Card programs through transitional arrangements	28
3.2.5 Transition from mandatory to voluntary IM	30
3.2.6 Opt-in referral based IM arrangements	31
3.2.7 The Transition Communications Strategy	31
3.2.8 Expanded support services for affected communities	31

3.2.9 Options for later transition.....	33
3.2.10 Required Legislative changes to the programs	33
3.2.11 The ability to reform the Cashless Debit Card and Income Management programs option to address the problem	33
3.3 Comparison of the two options.....	34
4. What is the likely net benefit of each option?	36
4.1 Option 1 – (Status quo) Maintain both programs	36
4.1.1 Overall impacts.....	36
4.1.2 Regulatory impacts – benchmark.....	45
4.2 Option 2 – Reform of the CDC and IM programs	46
4.2.1 Overall impacts.....	46
4.2.2 Reforming CDC and IM programs including technology enhancements.....	46
4.2.3 Accessing Support Services	65
4.2.4 Regulatory impacts – benchmark.....	71
5. Who did you consult and how did you incorporate their feedback?	72
5.1 Feedback from the Senate hearing to repeal the cashless debit card and other measures	72
5.2 Current Ministerial engagement with affected communities.....	72
5.3 Engagement with Merchants	74
6. What is the best option from those you have considered?	76
6.1 Option 2.....	77
7. How will you implement and evaluate your chosen option?.....	77
7.1 Implementation of Option 2 (preferred option)	77
7.1.1 Implementation plan.....	77
7.1.2 Monitoring and evaluation.....	79
Attachment A	81
Income Management	81
Attachment B	84
Cashless Debit Card (CDC)	84
History of CDC	84
Ongoing consultation on the CDC	85
Stakeholders.....	85
Attachment C	86
Summary of legislation related to the CDC and IM.....	86
Six deferral instruments	86
Amend 4 instruments.....	87
Amend two Instruments	87
Attachment D	88

Support services summary managed by the CDC area of the Department	88
Attachment E.....	90
Outline of Merchants	90
Attachment F:.....	91
CDC and IM participant numbers justification and assumptions	91
Table 1: Existing Income Management sites and applicable measures	8
Table 2: Cashless Debit Card sites	9
Table 3: Policy and operational differences between Income Management and the Cashless Debit Card.....	12
Table 4: Examples of community programs that are achieving Cashless Debit Card and Income Management objectives (this list is not comprehensive)	15
Table 5: Income Management evaluations commissioned by the Department	18
Table 6: Key differences between the two options.....	34
Table 7: Annual cost to state and territory-run authorities to refer individuals to CDC and IM.....	44
Table 8: Active CDC participants – current location (as at 27 May 2022)	56
Table 10: Summary of key themes from the Minister’s consultation	73
Table 11: Risk Table.....	79
Figure 1: Income Management	8
Figure 2: Cashless Debit Card	11
Figure 3: Income Management how it operates in practice	24
Figure 4: How CDC operates in practice.....	24
Figure 5: Contemporary card Merchant onboarding	28
Figure 6: Summary of participant transition off CDC and IM programs.....	29
Figure 7: Summary of participants under Community led models	29
Figure 8: Summary of participant expected transition off CDC program NT	30
Figure 9: Summary of merchants requirements	58

Introduction

Purpose

The Australian Government (the Government) has committed to abolish the Cashless Debit Card (CDC) program and reform Income Management (IM). The Government will work with communities on alternatives to the CDC and IM programs (the programs) to address the issues in communities moving forward. Reforming the programs does not change the amount of income support current participants receive rather it will return the ability for people to determine how and where they spend their money.

The Government will deliver a staged approach with the first stage being exiting people off the CDC program shortly after the passage of legislation. Participants will be given an alternative to quarantine their income support payments for essential items if that is what they want to do. Reforms to IM will follow with card technology updates to provide more functions such as tap and go and BPAY which will provide a better service to those who remain on IM.

Support services will assist people transitioning off the programs and into the future.

Executive Summary

Currently, there are two programs in operation that restrict what people can purchase with their welfare payments. These programs are IM which was established in 2007 and the CDC program which was established in 2016. These programs run concurrently across several locations in Australia. Both CDC and IM have an objective to restrict the purchase of items such as alcohol and gambling products so participants prioritise expenditure on essential expenses such as rent, food and utilities.

Since the CDC program inception, the policy landscape has changed considerably in Australia. Frameworks established between the Commonwealth and the States and Territory governments have seen the development of new national and community level initiatives to address the effects of drug and alcohol misuse and reduce domestic, family and sexual violence (DFSV). The Commonwealth and State governments have also entered into a National Partnership agreement with the Coalition of Peaks on Closing the Gap.

Both programs have undergone several evaluations to monitor and evaluate the programs' successes and shortfalls. These evaluations have established that the CDC program has produced mixed results in achieving its intended objectives. The recent audit report of the *Cashless Debit Card by the Australian National Audit Office (ANAO)* (published 2022) highlights a lack of available data to confirm that the CDC program is achieving its outcomes and little evidence to support the continuation of the program.

The Government made an election commitment to abolish the CDC program and consult with communities about alternative options to support individuals and communities including options for voluntary IM.

In supporting the Government's implementation of this commitment, the Department of Social Services (the Department) has considered 2 options regarding the future of welfare quarantining.

The first option, for purpose of comparison, maintains the status quo, and continues a CDC program that has not demonstrated an ability to achieve its policy outcomes and places a regulatory burden on participants, businesses and communities due to geographical location and places barriers in relation to undertaking simple financial transactions. The CDC program assumes all people in a particular geography, in receipt of working age income support payments, need restrictions on the types of goods and services that can be purchased with their money.

The **preferred option is Option 2** where the CDC program is abolished and reforms are made to IM to enable a greater level of community decision-making. Transitional arrangements including support services would assist those who choose to leave the programs. Option 2 complements the Government's strategic priority to give people on these programs more choice on how they spend their income support payments. It will also provide greater value for money given the lack of evidence that the programs are meeting their objectives.

Option 2 will see a reduction in the regulatory burden faced by individuals and businesses in affected locations and provide participants with greater freedom to choose how and where to spend their money and how they manage their finances including decisions on who they bank with. These are freedoms afforded to most Australians and those on the program have limits placed on these choices. The **regulatory save** has been calculated at **\$21.5m over 10 years**.

The Department has undertaken consultation with those in affected locations including targeted Ministerial visits by the Minister for Social Services, the Hon Amanda Rishworth MP (the Minister) and the Assistant Minister for Social Services, the Hon Justine Elliot MP (the Assistant Minister). Senator the Hon Patrick Dodson, Senator the Hon Malarndirri McCarthy, and Ms Marion Scrymgour MP have also participated in consultations. This has included consulting with CDC participants and other local stakeholders about the cessation of the CDC program. Consultations captured a wide range of stakeholders and captured a diversity of perspectives, including CDC participants, senior First Nations leaders, Community Reference Groups, service providers, local police, health services and local councils. Engagement with communities will continue as part of the implementation of the reforms.

Consultations involved understanding what the impacts of the CDC program are and how these are impacting individuals and businesses in the affected regions. It also involves seeking their views on what a suitable process for people to transition off the CDC program needs to include and what supports the community feel are required. In addition, in preparation for stage 2 discussions were held regarding what IM could look like.

At all times, the focus of these consultations is to understand the CDC participants' experiences and possible impacts on them and their communities to inform implementation arrangements and understand individual and community support needs.

These early consultations have included key service agencies and First Nations leadership groups. Consistent with the CDC program's evaluations they have stated that the impact of the program has been variable. The preference is the importance of support services to participants and their communities. Further, they have been clear that if the CDC program is removed, these services must endure to support the community and they must be guided by local priorities and led by local leadership.

Transition will be a staged approach with any future evaluation focused on the experience of participants coming off the programs and effectiveness of support services. The Department will consult with affected communities to ensure that the evaluation methodology is fit for purpose. This may include co-designing an evaluation methodology with communities, and identifying measures the communities see as important. It is important to note this information along with any lessons learnt will help develop Government's future evidence based policy.

Background

Income Management

IM was introduced in the Northern Territory (NT) in 2007 as part of the Northern Territory Emergency Response (NTER) and has been progressively implemented across various locations in Australia. IM directs between 50 and 90 per cent of income support payments to the priority needs of the participant and their family and other dependents. IM provides vulnerable participants with intensive face-to-face support from Services Australia to ensure their income support payment is being directed to essentials, such as food, housing, electricity and education. Income managed funds are unable to be spent on alcohol, gambling, tobacco, pornography and other related products and are unable to be withdrawn as cash.

Under Part 3B of the *Social Security (Administration) Act 1999* (the Administration Act), the key objectives of IM are to:

- reduce immediate hardship and deprivation by directing income support payments to the priority needs of recipients, their partner, children and other dependents
- help participants to budget so that they can meet their priority needs
- reduce the amount of discretionary income available for alcohol, gambling, tobacco and pornography
- reduce the likelihood that income support payment recipients will be subject to harassment and abuse in relation to their payments and
- encourage socially responsible behaviour, particularly in the care and education of children.

IM participants are provided with a BasicsCard to access their income managed funds. The BasicsCard is a stored value PIN-protected card that operates through the existing eftpos infrastructure, and can be used at approved BasicsCard merchants. It aims to provide a secure way for participants to spend their income managed funds while preventing participants from purchasing restricted items or withdrawing cash. Merchants must be approved to accept the BasicsCard. There are approximately 18,000 approved merchants nationally.

A participant can be referred onto IM through multiple measures. IM measures are targeted to specified groups of income support payment recipients, based on their higher risk of social isolation and disengagement, poor financial literacy, and participation in risky behaviours. IM measures include:

- **Voluntary measure (VIM)** – People can volunteer to go onto IM and have 50 per cent of their income support payments income managed.
- **Vulnerable measure (VWPR)** – This measure is aimed at helping vulnerable youth or at-risk individuals and their families to manage their income support and family assistance payments more effectively. People on the vulnerable measures have 50 per cent of their income support payments income managed.
- **Child Protection measure** – IM is an additional tool for child protection authorities to ensure income support payments are spent in the best interest of children and families. Child protection authorities can refer a person for Child Protection IM where 70 per cent of a person's income support payments are income managed.
- **Supporting People at Risk measure (SPaR)** – Currently the Supporting People at Risk measure is being used by the Northern Territory Registrar of the Banned Drinker Register for people needing help with alcohol abuse. People who are referred by the Registrar have 70 per cent of their income support payments income managed.
- **Long Term Welfare Payment Recipients and Disengaged Youth measures (NT only)** – People in the NT who have been out of work or study for some time, go onto these measures and have 50 per cent of their income support payments income managed.

IM sites were selected based on certain criteria, including:

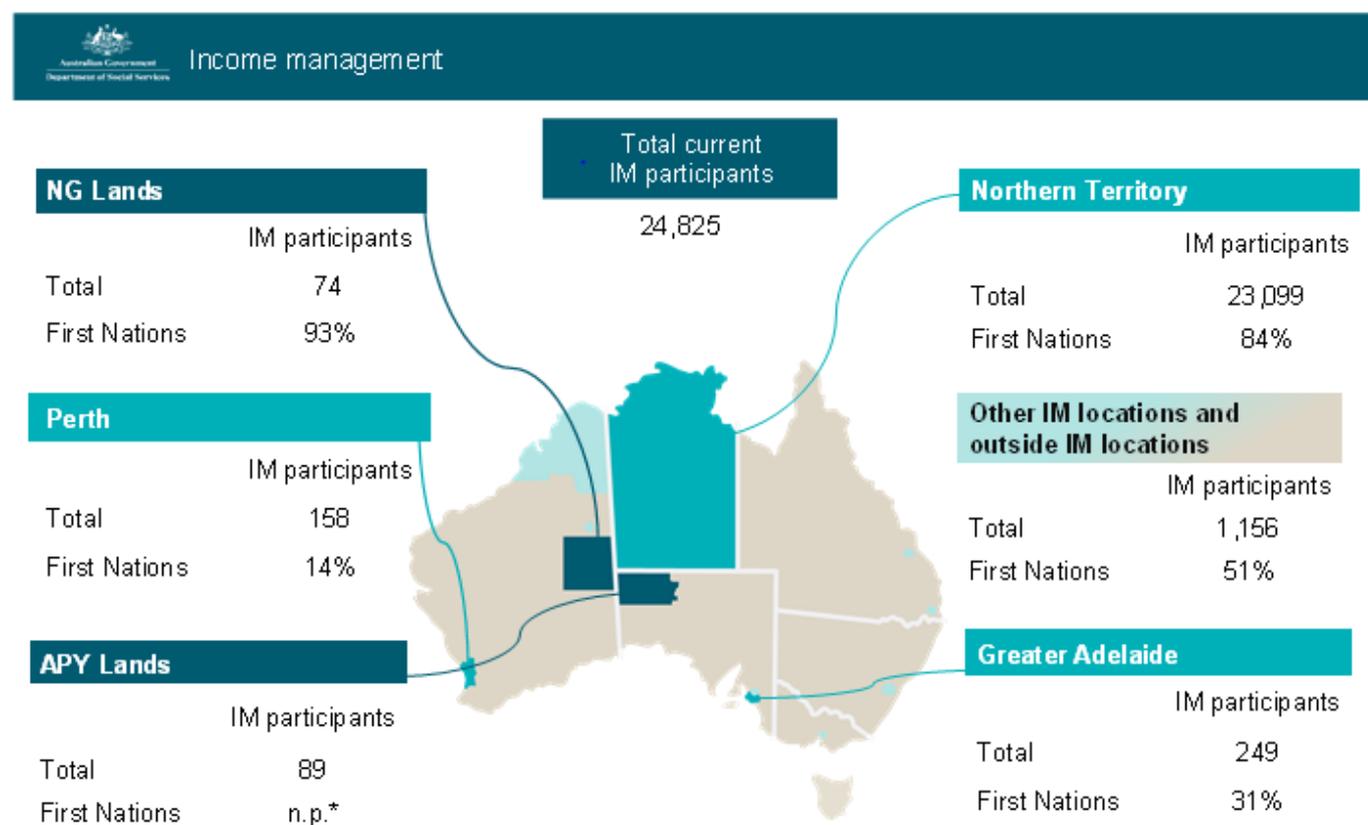
- High levels of antisocial behaviour, including violence and alcohol consumption;
- Following a consultation period at the request of a community; and
- In response to a recommendation of an inquiry or inquest.

The existing sites and applicable measures are summarised in Table 1.

Table 1: Existing Income Management sites and applicable measures

LOCATION	MEASURE
Income Management in the NT	Voluntary Income Management Vulnerable measure
<i>As of 17 March 2021, Northern Territory Income Management participants can opt-in to the CDC program. Participants can remain on Income Management if they choose to do so.</i>	Child Protection measure Disengaged Youth measure Long Term Welfare Payment recipient measure Support people at risk
Place-based Income Management sites:	Voluntary Income Management
<ul style="list-style-type: none"> Rockhampton, Logan and Livingstone in Queensland Metro Perth, the Peel district, the Kimberley and Ngaanyatjarra (NG) Lands in Western Australia Bankstown in New South Wales Greater Shepparton in Victoria Greater Adelaide, APY Lands and Playford in South Australia 	Children Protection Measure Vulnerable Measure (Social Worker Referrals) Vulnerable Measure (Youth Trigger)

Figure 1: Income Management



This infographic shows IM participants by their current location. 'Other IM locations' are Kimberley (WA), Kiwirrkurra community (WA), Playford (SA), Greater Shepparton (VIC), Bankstown (NSW), Logan (QLD) and Rockhampton (QLD). 'Outside IM locations' refers to participants who have moved out of an IM location but remain on the program.

Active IM participant data as at 27 May 2022. Note regional population data for the Northern Territory from the 2026 census (Australian Bureau of Statistics): total Northern Territory population 228,833 (26% First Nations)

In line with departmental data confidentiality requirements, data relating to small numbers of people are not provided (n.p.).

On 26 March 2020 the *Social Security (Administration) Amendment (Continuation of Cashless Welfare) Act 2020* (the Act) was passed and allowed for the transition of IM participants in the Cape York region to the CDC and enabled NT IM participants to transition to the CDC program, if they choose to do so. IM continues to operate in the NT for those that choose not to transition to the CDC program.

Cashless Debit Card

The CDC program was developed based on recommendations from the *Creating Parity – The Forrest Review* (Forrest 2014) in which the then Government committed to supporting communities to reduce the levels of harm associated with alcohol consumption, illicit drug use and gambling. In 2016, after consultation with local communities, First Nation community leaders and local and state government agencies, the then Australian Government implemented the CDC program for income support recipients in multiple locations where high levels of welfare dependence co-exist with high levels of social harm.

The CDC program objectives under Part 3D of the Administration Act are to:

- reduce the amount of certain restrictable payments available to be spent on alcoholic beverages, gambling and illegal drugs;
- support program participants and voluntary participants with their budgeting strategies; and
- encourage socially responsible behaviour.

The CDC program commenced in: March 2016 in the Ceduna region, South Australia; April 2016 in the East Kimberley region, Western Australia; March 2018 in the Goldfields region, Western Australia; and on January 2019 in the Bundaberg and Hervey Bay regions, Queensland. In March 2021, IM participants in the Cape York region, Queensland, were transitioned to the CDC and IM participants in the NT were able to choose to transition to the CDC program. CDC regions and measures are summarised in Table 2.

Table 2: Cashless Debit Card sites

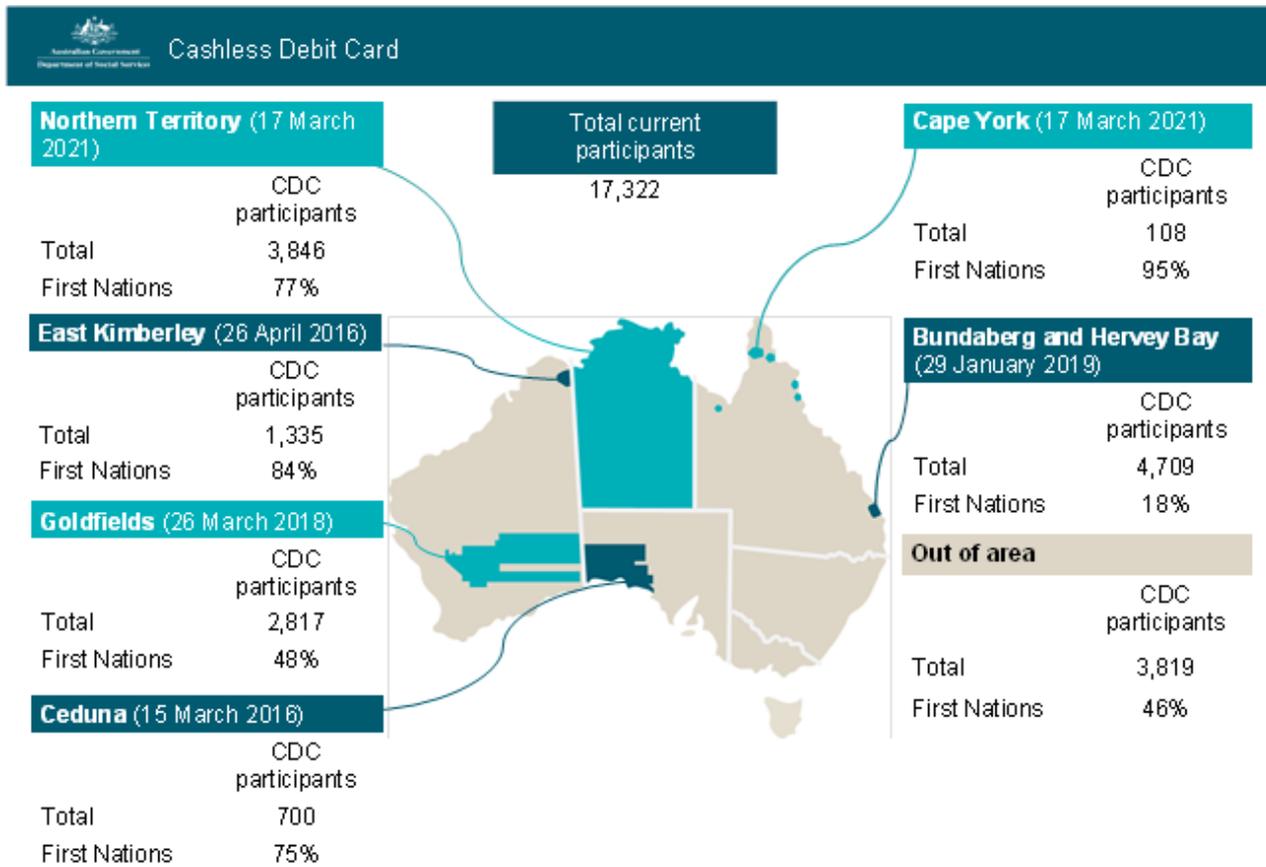
REGION	START DATE	ELIGIBILITY	REASONS FOR SELECTION
Ceduna region	15 March 2016	People who are recipients of working age payments (for example JobSeeker Payment and Youth Allowance).	Ceduna region was selected based on a range of factors, including community interest and support, levels of welfare dependence, and levels of community harm caused by gambling, alcohol and drug abuse.
East Kimberley region	26 April 2016	People who are recipients of working age payments (for example JobSeeker Payment and Youth Allowance).	East Kimberley was selected based on a range of factors, including community interest and support, levels of welfare dependence, and levels of community harm caused by gambling, alcohol and drug abuse.
Goldfields region	26 March 2018	People who are recipients of working age payments (for example JobSeeker Payment and Youth Allowance).	The Goldfields region was selected based on the support of community leaders for its introduction.
Bundaberg and Hervey Bay region	20 December 2017	People aged 35 years and under who receive JobSeeker Payment, Youth Allowance (Job seeker), Parenting Payment (Single) or Parenting Payment (Partnered) receive the card. A person can volunteer to remain on the program once they turn 36 years of age.	Stakeholders requested the CDC to address social issues such as high youth unemployment and intergenerational welfare dependence.
Cape York	17 March 2021	Existing IM participants in the Cape York Region were transitioned to the CDC on 17 March 2021. The CDC does not automatically apply to everyone on a trigger payment in the Cape	These sites were chosen to transition from IM to the CDC program to provide the improved technology of the CDC, retaining other aspects of the Cape York model.

REGION	START DATE	ELIGIBILITY	REASONS FOR SELECTION
		York Region. A person is subject to the CDC under the Cape York Measure, if: <ul style="list-style-type: none"> • the individual, or the individual's partner, is an eligible recipient of a category P welfare payment, and • the Families Responsibility Commission (FRC) has given a valid notice to the delegate requiring that the individual be subject to the income management regime, and • the notice has not ended or been revoked or withdrawn, and • if the individual has a payment nominee under part 3B of the Administration Act, who is a CDC participant or subject to income management 	
Northern Territory	17 March 2021	The program applies to IM participants who have chosen to transition to CDC as well as eligible income support recipients who have volunteered for the program.	These sites were chosen to transition from IM to the CDC to provide the improved technology of the CDC.

Under the CDC, a percentage of a participant’s income support payment is placed on a Visa debit card that cannot be used to purchase alcohol, gambling products and open loop gift cards and cannot be used to withdraw cash. To be a CDC participant, an individual must reside or have previously resided in a CDC region and be the recipient of a trigger payment. Trigger payments include certain social security payments that will automatically activate (also referred to as trigger) participation onto the CDC program.

In most of the CDC sites, the amount of payment that is placed onto the CDC is 80 per cent. CDC participants transitioning from IM in the NT and Cape York retain their original IM payment split which can be either higher or lower than 80 per cent.

Figure 2: Cashless Debit Card



This infographic shows CDC participants by their current location. 'Out of area' refers to participants who have moved out of a CDC region but remain on the program.

CDC participant data as at 27 May 2022; regional data from 2016 census (Australian Bureau of Statistics). The CDC was implemented at different times in different regions. Date of implementation shown for each region.

Passage of the *Social Security Legislation Amendment (Debit Card Trial) Act 2015* established the CDC as a program with a sunset date of 31 December 2022. Legislative authority for the CDC is established under Part 3D of the *Administration Act*.

Social Security (Administration) Amendment (Repeal of Cashless Debit Card and Other Measures) Bill 2022

In July 2022, the *Social Security (Administration) Amendment (Repeal of Cashless Debit Card and Other Measures) Bill 2022* was tabled into the Australian Parliament. This Bill enacts the Government’s 2022 election commitment to abolish the CDC. Amendments, where necessary, will be made to legislative instruments under Part 3B of the *Administration Act* to facilitate arrangements for individuals to enter or re-enter the IM program if they choose to.

The Bill also makes consequential amendments to the *A New Tax System (Family Assistance) (Administration Act) Act 1999*, the *National Emergency Declaration Act 2020* and the *Social Security Act 1991* to reflect the repeal of Part 3D and associated measures.

The difference between Income Management and Cashless Debit Card

The main difference between the policy intentions of the two programs is that IM is focussed on directing participants to the purchase of essential needs, whereas the CDC program is focussed on minimising exposure to goods that cause community-level harm. Key operational and policy differences between IM and the CDC program are summarised in Table 3.

Table 3: Policy and operational differences between Income Management and the Cashless Debit Card

Feature	Income Management	Cashless Debit Card
Policy Objectives	Directing expenditure towards priority needs and helping participants budget.	Providing budgeting support and restricting expenditure on harmful good to reduce the social harm caused by these goods.
Merchant Management	Merchants are excluded from accepting the Basics Card unless they enter into an agreement with Services Australia. All merchants require manual management and ongoing compliance checks.	Merchants are included unless they sell a restricted item. Manual management and compliance agreements are only required for mixed merchants (those selling restricted and non-restricted goods).
Operational	BasicsCard accepted at around 18,000 merchants. Can only be used at approved merchants and not for online shopping or bank transfers. For other transactions, Services Australia facilitates the transfer of funds.	Accepted at over 900,000 merchants and has similar functions as other Visa debit cards.
Restricted Goods	Alcohol, tobacco and tobacco products, pornography, gambling products, or to withdraw cash.	Alcohol, gambling products, cash-like products, or to withdraw cash.
Interest	No interest accrued.	Interest at 1 per cent. Paid by Government
Technology	Merchants cannot accept the BasicsCard unless they have signed an agreement.	PLB technology will block the purchases that contain a restricted item. Merchants such as bottle shops and gambling venues are automatically blocked.
Participant Support	Services Australia initially provides one on one support with each participant in order to identify their basic needs and those of their family, and set up the appropriate payment deductions. Can assess ongoing support from Services Australia through a range of channels.	Can access banking services via an online portal, a mobile app and a telephone hotline. Services Australia provides face-to-face support, online servicing and a hotline, at the participants request.

1. Problem Statement:

The current Cashless Debit Card and Income Management programs are no longer required

The overarching objective of the programs is to reduce the issues in communities caused by alcohol, drugs and gambling. However, the CDC program is targeted at whole communities not individuals, meaning many of the participants on the CDC program do not have drug, gambling and alcohol issues, with 46 per cent of CDC participants¹ reporting they did not drink at all, either before or after they were put on the card.

For participants who face issues with drugs, alcohol and gambling, the policy landscape has changed. There are now a greater number of targeted, community-led programs that offer better support for these participants, reducing the need for the compulsory programs. The programs were meant to reduce consumption of drugs, alcohol and gambling by limiting the ability of participants to spend their money on these goods and services. However, there is limited evidence that compulsory programs actually reduces substance abuse and gambling issues. Rather, there is evidence through the recent Ministerial consultations that participants with substance abuse and gambling issues find ways to circumvent the system enabling them to keep consuming these goods. Further, the additional targeted health and social programs have a stronger preventative focus as they are aimed at addressing the underlying causes of addiction and societal issues and are therefore more likely to achieve sustained results. This raises questions as to whether the current compulsory programs are the most effective way to achieve the overarching objectives, especially when there are more effective ways to achieve them.

Those participants who do not have a history of substance misuse or problem gambling face the stigma of being on the programs as they are associated with people with these issues. They also cannot access certain activities and products that only accept cash, such as school canteens or second hand markets. Stakeholders have also raised concerns that the programs are potentially discriminatory given a considerable overrepresentation of First Nations people in the participant numbers.

The issues with the compulsory programs are not found in the voluntary IM program. Evaluations have found that the voluntary IM program helps support people to manage their money and reduces the risk of social harm. It also does not carry the same stigma and loss of autonomy as people make the choice to join.

In conclusion, the Government is removing compulsory CDC and transitioning away from compulsory IM as a tool to address the social problems they were designed to address and will instead consider other approaches to address these issues. In addition, a voluntary IM model carries less stigma and reduces costs to Government.

1.1 Cashless Debit Card and Income Management programs do not target those who need support the most

While the sites were chosen due to the high proportion of people in receipt of welfare payments, as well as concerns with drugs, alcohol and gambling, many people are automatically placed on the programs due to them living in the site and receiving an income support payment rather than being identified as needing support to address these problems. At an individual level, this means they have restrictions on their payments and autonomy with limited personal benefit.

This tension between the objectives of the legislation and who is placed on the programs has resulted in the programs being criticised for including people without a history of substance misuse or problem gambling. In an evaluation of the CDC

¹ Future of Employment and Skills Research Centre, University of Adelaide, 2021, Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Regions: Consolidated Report, p192 https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021.pdf [PDF 8.1MB] accessed on 17 August 2022

program, 74 per cent of participants indicated they wanted to be off the card². This can lead to the concerns surrounding the stigma of being on the program as it is associated with people with problems with drugs and alcohol. It also raises the question of whether the programs are the best use of Government funds to support individuals or communities.

1.2 The changed policy landscape has reduced the need for Cashless Debit Card and Income Management programs

The Australian policy landscape has changed since the establishment of the programs. Greater collaboration between the Commonwealth and State and Territories has seen the development of frameworks and initiatives to combat social harm within communities. Examples of these are the **National Drug Strategy 2017-2026**³, **National Alcohol Strategy 2019-2028**⁴ and **National Consumer Protection Framework for Online Wagering**⁵. These frameworks seek to provide greater support to community level organisations to assist vulnerable individuals, greater law enforcement cooperation between the Commonwealth and State/Territory authorities and improved funding for rehabilitation initiatives. The NSW state government for example, established the **Centre for Alcohol and Other Drugs**⁶ to coordinate the NSW Health contribution to whole-of-government policy development and implementation in alcohol and other drugs.

Implementation of initiatives such as these provides opportunities for Commonwealth and State and Territory authorities to support vulnerable people in more direct ways than the CDC program can do. Further, evidence is clear that programs that respond to the needs of an individual are more effective than broad brush policy such as the CDC and IM programs that are based on residency.

Further, the Closing the Gap Agreement⁷ and associated implementation plans provides a framework for a new way for Governments to work in authentic partnership with First Nations people. This framework brings all levels of Government together with First Nations people to design culturally appropriate and community driven solutions to problems.

Table 4 outlines some of the community programs that are targeting issues within the CDC communities. These community programs have mixed funding from all levels of government with the program's objectives consistent with the CDC objectives. Whilst unable to obtain the data on the effectiveness of these programs the Department is aware that these have the potential to better target the needs of vulnerable people in the community therefore make the CDC program redundant.

These programs in Table 4 also indicate how services can be developed to better target the needs of vulnerable people. There is evidence both nationally and internationally supporting the success of targeted, community-based services addressing alcohol and drug misuse, particularly for vulnerable groups in society. A review of community-based efforts to reduce alcohol misuse among youth and young adults in the United States, found engaging local community in the design and implementation of prevention programs has the potential to improve individual and collective health and well-being⁸.

Community-led programs also strengthen the ability of the community to identify, prevent and respond to local alcohol and other drug issues. In an Australian review of preventative measures on substance use risk and harm in Australia, it was found that community is an effective way of organising and delivering prevention targeted at legal drugs, especially alcohol, and

² Future of Employment and Skills Research Centre, University of Adelaide, 2021, Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Regions: Consolidated Report, p192 https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021 [PDF 8.1MB] accessed on 17 August 2022

³ Department of Health, 2017, National Drug Strategy 2017-2026, <https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026> accessed on 17 August 2022

⁴ Department of Health, 2019, National Alcohol Strategy 2019-2028, <https://www.health.gov.au/resources/publications/national-alcohol-strategy-2019-2028> accessed on 17 August 2022

⁵ Department of Social Services, 2018 (updated 3 May 2022), National Consumer Protection Framework for Online Wagering in Australia – National Policy Statement, <https://www.dss.gov.au/communities-and-vulnerable-people-programs-services-gambling/national-consumer-protection-framework-for-online-wagering-national-policy-statement> accessed on 17 August 2022

⁶ NSW Health, Centre for Alcohol and other Drugs, <https://www.health.nsw.gov.au/about/ministry/Pages/aod.aspx> accessed on 24 August 2022

⁷ Closing the Gap Agreement (2020) <https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap> accessed on 23 August 2022

⁸ Fagan AA, Hawkins JD, Catalano RF. Engaging Communities to Prevent Underage Drinking. *Alcohol Research & Health*. 2011;34(2):167-74. PMID: 22330215; PMCID: PMC3860564.

that interventions that target structural policy change at the local level are the most effective in terms of outcomes⁹. Engaging local community in the development of interventions is also effective to create supportive community environments for healthy choices and quality of life¹⁰.

Table 4: Examples of community programs that are achieving Cashless Debit Card and Income Management objectives (this list is not comprehensive)

State or territory	Programs
South Australia	<p>South Australian Network of Drug and Alcohol Services (SANDAS) enhances community wellbeing and reduce the harms associated with alcohol and drug use. It is a not-for-profit association funded by membership contributions, the Australian Government Department of Health, Drug and Alcohol Services of South Australia, the South Australian Department of Health and a range of other organisations on a project basis.</p> <p>Drug and Alcohol Services South Australia (DASSA) provides a range of clinical services. Provides clinical advice for medical practitioners, nurses and pharmacists working with people with alcohol and drug problems (the South Australian Department of Health).</p> <p>Aboriginal Drug & Alcohol Council responds to the needs of Indigenous Communities In Metropolitan Adelaide.</p> <p>Ceduna region</p> <p>Ceduna Aboriginal Corporation and SA government: Diversionary Programs - activities aimed to involve Aboriginal men, women and youth building resilience through participating in social and emotional wellbeing activities through connecting participants with a range of specialist service.</p> <p>Street Beat Service - 24/7 mobile outreach team patrol the streets and provide assistance to vulnerable people to access the services that will prevent the escalation of incidents that cause harm.</p> <p>CatholicCare NT - No More Campaign is an educational program for Aboriginal men to raise awareness of family violence, using sporting activities to engage them.</p> <p>CentaCare - A Better Life (ABLE) provides non-clinical support to people suffering from mental illness, including alcohol and drug misuse and problem gambling, to ensure they are connected with appropriate services, also providing after-care services to support people to transition back into family and community life.</p> <p>Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation provides assessments and referrals to support services for people who experience drug and alcohol addictions, including transport and funding for people affected by drugs and alcohol to book into, and travel to and from funded support and counselling services.</p>
Western Australia	<p>Next Step Drug and Alcohol Services (Next Step) provides a range of treatment services for people experiencing problems associated with their alcohol and other drug use, as well as support for families (Government of Western Australia Mental Health Commission).</p> <p>Community Alcohol and Drug Services (CADS) provides individuals and their families with alcohol and other drug treatment and support services in the community. Services are provided for people aged 14 years and over, their carers' and their families. Also provide support for families and services dealing with people younger than 14 years. Individuals do not require a referral and can self-refer by calling or attending their nearest CADS.</p> <p>East Kimberley region</p> <p>Boab Health Services Pty Ltd–Wyndham & Ngnowar Aerwah Aboriginal Corporation–Wyndham & Ord Valley Aboriginal Health Service–OVAHS – Kununurra - ABLe provides services include allied health, mental health, and an Integrated Team Care Program. The mental health team includes mental health nurses, clinical psychologists, social workers and occupational therapists. The</p>

⁹ Loxley W, Toumbourou J, Stockwell T, Haines B, Scott K, Godfrey C, and Waters, E. and Patton, G. and Fordham, R. and Gray, D. and Marshall, J. and Ryder, D. and Siggers, S. and Sand, L. and Williams, J. 2004. The prevention of substance use, risk and harm in Australia: a review of the evidence, ed. A. Kirsner. Commonwealth of Australia. <https://espace.curtin.edu.au/handle/20.500.11937/30403> accessed on 16 August 2022.

¹⁰ Anderson LM, Adeney KL, Shinn C, Safranek S, Buckner-Brown J, Krause LKendall. Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations. Cochrane Database of Systematic Reviews 2015, Issue 6. Art. No.: CD009905. DOI:10.1002/14651858.CD009905.pub2

State or territory	Programs
	<p>organisation has a holistic approach to health and offers programs like singing and drumming groups, art therapy, back to country trips and school holiday programs. They also provide space for drive-in/drive-out service providers. The services offered include an alcohol and other drugs counselling program; a residential rehabilitation facility for individuals, couples and families; a sobering up shelter; a night patrol service; a safe house for women and children affected by family violence and homelessness; the Building Solid Families program; a youth Grow the Music program; and a horsemanship program for young people.</p> <p>Wyndham Early Learning Activity–WELA includes parenting education and support, life skills development and home budgeting skills with the aim of supporting families, strengthening relationships, improving the wellbeing of children and young people, and increasing participation of people in community life.</p> <p>Wyndham Youth Aboriginal Corporation supports adolescents unable to access age-appropriate drug and alcohol rehabilitation services.</p> <p>Goldfields region</p> <p>Wirrpanda Foundation aims to lead the provision of education, employment and business opportunities for Aboriginal and Torres Strait Islander Australians by working together to empower and build capacity amongst individuals, their families and their communities. The priority of the Wirrpanda Foundation remains delivering programs that are designed and developed by Aboriginal and Torres Strait Islander people.</p> <p>Midwest Employment & Economic Development Aboriginal Corporation (MEEDAC) provides a single point of contact for job seekers and employers in the Midwest-West and Kambalda regions which includes the following locations and surrounding areas: Mullewa, Northampton, Dongara, Kalbarri, Yalgoo, Morawa, Narngulu, Kambalda, Norseman, Hopetoun and Coolgardie.</p> <p>Vocational Training and Employment Centre (VTEC) connects Indigenous job seekers with a guaranteed job for 26 weeks. The guarantee of a job before job-specific training starts, is the key feature of VTECs. This ensures: job seekers choose to participate in the program vocational or job-specific training is directly related to available jobs.</p> <p>Kambalda Community Resource Centre & Coolgardie Resource Centre & Laverton Community Services & Menzies Community Centre are volunteer-based Not-for-Profit operating under the Community Development framework and underpinned by the Social Justice principles providing support for the local communities and businesses.</p>
Queensland	<p>Bundaberg/Hervey Bay, and Cape York</p> <p>Alcohol restrictions in Queensland communities (Aurukun, Hope Vale, Doomadgee) - these restrictions ban or limit the amount and type of alcohol you can take into a community. In some communities, alcohol is completely banned.</p> <p>Mental Health, Alcohol and Other Drugs Service - Alcohol & Other Drugs (AODS) teams (Bundaberg and Hervey Bay) - A specialist service within a harm minimisation framework, where individuals directly or indirectly affected by their own or another alcohol or drug use can access an assessment or a range of specialist services.</p> <p>Gambling Help Queensland (Bundaberg)</p> <p>The counselling service provides free, professional face-to-face and telephone counselling 24/7. Counselling may include help with addictions, relationships and financial counselling for people with gambling-related problems and their families. It immediate information and assistance over the phone, crisis support and referral to your closest Gambling Help service. These services are available for anyone affected by problem gambling, a partner, family member or friend.</p>
Northern Territory	<p>Alcohol Management Plans (AMPs) - describe strategies and actions to reduce the harms associated with alcohol in the community. These strategies target alcohol harm reduction, alcohol demand reduction and alcohol supply reduction. There are 35 communities in the NT, which have undertaken AMP processes.</p> <p>Banned Drinker Register (BDR) - the BDR identifies people who are banned from purchasing takeaway alcohol and stops their purchase. It assists in reducing alcohol-related harm to individuals, families and the community.</p> <p>Alcohol Action Initiatives (AAs)</p>

State or territory	Programs
	<p>AAIs are community driven projects that develop local solutions and practical actions to alcohol misuse. The AAI program provides short term funding to support community action to minimise the harm caused by the consumption of alcohol through supply, demand and harm reduction strategies.</p> <p>Ice Action Plan - The Ice Action Plan - Tackling Ice in the NT contains whole-of-community and agency-specific activities to reduce the supply, demand and harms from crystal methamphetamine.</p>

1.2.1 Both Programs have similar objectives and functions operating concurrently

The existence of two programs operating across Australia, creates a challenge in explaining the objectives of each program. Both CDC and IM programs are methods of delivering income support payments, which encourage responsible spending of a recipient’s payments. However, the two programs differ in participant requirements, referral mechanisms, technologies, and service support levels. The complexity of the dual program has created confusion for people seeking the best social outcome in particular in the NT where people have a choice of the two programs. IM participants are reluctant to move from the BasicsCard to the CDC program due to the effort required in moving from a known entity to an unknown entity, regardless of the benefits it may provide. There are also inefficiencies caused by the complexity of merchants having to maintain a dual program. Having a single program for people who volunteer to use it would reduce these concerns.

In addition, there are other community-based programs that support individuals. These other policy levers also aim to support a reduction of social harm while empowering communities. This may include health, economic, psychosocial responses from different levels of government, businesses, community and individuals.

1.3 Evidence for the success of the programs is unclear

Evaluating the impact of the programs has been difficult. Evaluations and analyses have often lacked a baseline against which to measure the programs impact. Where changes for individuals or communities have been observed, evaluations have often been unable to attribute these to the programs due to the number of other policies and programs also implemented.

Cashless Debit Card evidence

Evaluations of the CDC program have reported both positive and negative findings. Reviewing previous evaluation activities, the ANAO audit report found that while the Department’s administrative oversight of the CDC program is largely effective, the Department was not able to demonstrate that the CDC program is meeting its intended objectives.

The second impact evaluation of the CDC in Ceduna, East Kimberley and the Goldfields Region was undertaken by the University of Adelaide. It commenced in November 2018 and was released in February 2021.¹¹ The evaluation found evidence of reductions in alcohol consumption and gambling, and suggestions of a reduction in the use of illicit drugs.

Twenty five per cent of surveyed CDC participants who reported they drink alcohol reported reducing the amount they drink at any one time, and 22 per cent reported reducing the number of times they drink. Twenty one per cent of survey respondents reported a positive change in gambling behaviours for either themselves, family, friends or the community where they live. The report did not find any clear effect on child welfare. Forty six per cent of CDC participants reported they did not drink at all, either before or after they were put on the card. The evaluation also found that CDC participants reported experiences of stigma and discrimination. Of those surveyed 74 per cent of CDC participants wanted to opt out, although the majority of survey respondents (made up of stakeholders and participants) supported the continuation of the CDC in some form.

The evaluators noted that analysis had been constrained by limitations of available data. The evaluators noted that a range of programs and policies impact on outcomes in CDC regions, making it more complicated to attribute impacts to the CDC.

¹¹ Future of Employment and Skills Research Centre, University of Adelaide, 2021, Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Regions: Consolidated Report, https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021.pdf accessed 24 August 2022

These findings of the second impact evaluation, including data limitations, were consistent with those of the first impact evaluation undertaken by ORIMA Research on the CDC in the Ceduna and East Kimberley regions.

Feedback from consultations are that some people are finding ways around the card's restrictions to continue purchasing drugs or alcohol or to gamble. Examples include people finding a merchant who is prepared to overcharge for a product and provide cash back to the CDC participant. There are also anecdotal reports of people bartering with the card, by purchasing unrestricted goods such as groceries for a person who then pays them cash in return. These activities are hard to identify, and reports of people successfully applying workarounds to access cash have continued over the life of the programs.

Income Management evidence

Between 2010 and 2019, seven evaluations of IM have been undertaken or commissioned by the Department. Evaluations for the most part, have been region based and considered compulsory and voluntary income management models. Findings across evaluations have been relatively consistent and included both positive and negative findings, although evaluators noted that analysis had been constrained by situational differences between income management regions and that a range of policies and programs operate in income managed communities - making impacts difficult to attribute to the IM program.

The New Income Management in the Northern Territory: First Evaluation Report, by the University of New South Wales Social Policy and Research Centre, was released in 2012. The evaluation found few indicators of strong or consistent impacts of IM, rather, they found there have been diverse outcomes that affect a wide range of people and inconsistent range of views and experiences. First Nations people subject to IM reported strong perceptions to improvements in the wellbeing of children in their community and ability to afford food. Amongst First Nations people, 59 per cent on voluntary IM felt that IM had made things better, compared to 36 per cent on compulsory IM¹². Consistent with the First Evaluation Report the other evaluations found perceived improvements to access to children's clothing and education, decreased crime rates, reduced opportunities for humbugging and reduced access to alcohol and tobacco.

A consistent theme throughout several evaluations was the negative impacts of the restrictions including; limitations on where they could shop, difficulties using IM for public transport and widespread feelings of unfairness and disempowerment. Evaluators for the First Evaluation Report indicated that many people subject to compulsory income management appeared not to demonstrate the behaviour problems or financial difficulties income management was intended to remedy. Table 5 provides a summary of the IM evaluations commissioned by the Department.

Table 5: Income Management evaluations commissioned by the Department

Evaluation	Publication date
Evaluation of the Child Protection Scheme of Income Management and Voluntary Income Management Measures in Western Australia	2010
Evaluation of Cape York Welfare Reform	2012
Review of Child Protection Income Management in Western Australia	2014
Evaluation of Voluntary Income Management in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands	2014
Evaluation of New Income Management in the Northern Territory (series of reports)	2012 and 2014
Consolidated Place-Based Income Management Evaluation Report	2015
Strategic Review of Cape York Income Management	2018

¹² Social Policy Research Centre, UNSW (2012), "Evaluating New Income Management in the Northern Territory: First Evaluation Report November 2012" <https://www.dss.gov.au/our-responsibilities/families-and-children/programs-services/income-management/evaluating-new-income-management-in-the-northern-territory-first-evaluation-report> accessed on 23 August 2022.

1.4 The compulsory nature of the program restricts freedom of choice and carries a stigma

The main criticism of the programs is that they remove personal choice by compulsorily controlling the spending of participants income support and do not address the root cause of the issues that are trying to be addressed. It is noted that the IM program differs from the CDC program in that in addition to placing restrictions on the purchasing of alcohol and gambling products, and the withdrawal of cash, it also restricts the purchasing of tobacco and pornography. It has been argued that not being able to access cash for emergencies or purchases of second hand goods places a strain on those in the programs and requires them to purchase goods at a higher price. This has been more of a criticism of the CDC program as it has a higher quarantine amount of 80 per cent compared to the typical quarantine amount of 50 per cent in IM.

The CDC program specifically was criticised as being a blunt instrument, which is applied to people who have not demonstrated a need for their income support payments to be quarantined. The arrangements attempt to achieve community wide outcomes but in doing so they impinge upon the individual freedoms of those without identified problems with drugs, alcohol and/or gambling. The current CDC program focuses on geographic sites rather than individual circumstances. By focusing on geographical sites, critics claim the CDC program perpetuates the stigma faced by minority communities.

The issue of stigma has also been raised as a concern. In submissions to the Senate Community Affairs Legislation Committee inquiry into the *Social Security (Administration) Amendment (Income Management to Cashless Debit Card Transition) Bill 2019*, a person on the CDC program stated that they were being judged as a drug user and it was difficult to effectively budget while on the CDC program. It is easier to identify a person on the IM program as the BasicsCard is a PIN only card with a very distinctive design.

Another criticism of the programs is they are discriminatory as there are a high proportion of First Nation people on the programs. Some argue the programs could be in breach of the *Racial Discrimination Act 1975*. Currently, 50 per cent of CDC participants are First Nations people. This is compared with 3.2 per cent of people who identify as First Nations within the Australia community¹³. For example, as at 27 May 2022, in Ceduna, there were 700 CDC participants in the Ceduna region of which around 75 per cent of participants identify as Aboriginal or Torres Strait Islanders.

1.5 Current BasicsCard technology restricts participant choice

The legislative design of the IM means that the BasicsCard can only be used in merchants that have entered into an agreement with the Government under the BasicsCard Merchant Approval Framework. This means that a person on the CDC program is able to directly purchase goods from more merchants than if they are on IM. Services Australia can arrange for goods to be purchased from non-approved merchants which is a further burden on individuals.

The approval process for the BasicsCard also places a higher regulatory burden on merchants. As part of the process, merchants must complete and submit a BasicsCard application form, which will be used by Services Australia to assess whether the business is suitable to participate in the BasicsCard. Merchants must also read the BasicsCard Merchant Approval Framework, in conjunction with the Merchant Application and the Merchant Terms and Conditions that contain the contractual obligations for merchants.

In addition, mixed merchants, defined as businesses selling both restricted and unrestricted items (including supermarkets and petrol stations), wishing to accept the BasicsCard must ensure in-store procedures are in place to recognise which goods and services can be sold to BasicsCard holders. This often entails staff training and maintaining a separate till to serve BasicsCard holders. Due to the strict approval and compliance process for merchants, the BasicsCard can only be accepted at

¹³ Australian Bureau of Statistics, 2022, Aboriginal and Torres Strait Islander people: Census, [ps://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-people-census/2021](https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-people-census/2021) accessed on 24 August 2022

approximately 18,000 approved merchants nationally, limiting IM participants' access to retailers and merchants' access to potential customers.

The BasicsCard also does not have the same functionality of a direct debit card used in the CDC program. The BasicsCard can only be used to purchase goods at the approved merchants. It does not allow a person to use tap and go, make payments through BPAY or internet purchases. Users of direct debit cards now expect these functions.

1.6 Voluntary Income Management carries less stigma and can be more effective

The problems identified above largely relate to the compulsory nature of the program, especially issues with stigma and discrimination. Also, participants who are forced onto the program but have drug and alcohol issues are the ones that are most likely to try to circumvent the system.

Participants on voluntary IM experience positive impacts on their financial management, including having enough money to pay for accommodation costs, and improvements to their money situation, in comparison to compulsory participants¹⁴. A voluntary program would still give participants the benefit of IM if they feel this will support them to better manage their funds, especially in the face of addiction issues. As they have volunteered for IM they do have an incentive to find loop holes to continue consumption of these goods. It also does not carry the same stigma, loss of autonomy and discrimination issues as people make the choice to join.

There is strong evidence to support these claims. A 2012 report found that amongst First Nations people, 59 per cent on voluntary IM felt that IM had made things better, compared to 36 per cent on compulsory IM¹⁵. Further, a 2015 Deloitte report found there is evidence that voluntary IM achieved better outcomes than compulsory IM and the evaluators suggested less use of compulsory IM, except in exceptional circumstances¹⁶. It found that IM was effective for some participants, improving financial stability, financial management and housing. Positive impacts were more often experienced by voluntary participants who chose to take part in IM. The evaluators also recommended that future program design should be more narrowly targeted to those who are likely to benefit, including people who are self-motivated to participate. A CDC evaluation found those most likely to remain on the program were participants who received Parenting Payment (Single or Partnered) and were either older or had not experienced issues using the CDC.¹⁷

Anecdotal evidence from an IM stakeholder during the February 2022 consultation on remaking the legislative instrument for voluntary IM in the region, indicated that an elderly lady benefitted from being a voluntary participant for more than 10 years, which prevented family members from withdrawing cash without her consent, allowing her to pay rent and bills on time.

These findings may provide an indication of which CDC participants may continue to experience benefits through opting for voluntary IM.

¹⁴Deloitte Access Economics, 27 May 2015, *Consolidated Place Based Income Management Evaluation Report 2012-2015*, pp 40-41 <https://www.dss.gov.au/families-and-children/programmes-services/welfare-conditionality/income-management/consolidated-place-based-income-management-evaluation-report-2012-2015> accessed 24 August 2022.

¹⁵Social Policy Research Centre, UNSW (2012), "Evaluating New Income Management in the Northern Territory: First Evaluation Report November 2012" <https://www.dss.gov.au/our-responsibilities/families-and-children/programs-services/income-management/evaluating-new-income-management-in-the-northern-territory-first-evaluation-report> accessed on 23 August 2022.

¹⁶Deloitte Access Economics, 27 May 2015, *Consolidated Place Based Income Management Evaluation Report 2012-2015*, Executive Summary piv.

¹⁷Future of Employment and Skills Research Centre, University of Adelaide, 2021, Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Regions: Consolidated Report, p192 https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021 [PDF 8.1MB] accessed on 17 August 2022.

1.7 There is a higher opportunity cost to continue Cashless Debit Card and Income Management

The Government spent \$180.7 million on the CDC program from 2016 to 2022, and spent \$341.2 million since 2016-17 on IM. There are currently around 42,000 participants in these programs. As noted above, many CDC participants have no reported drug, alcohol and gambling issues which the programs aim to address. As a result, the Government could take the opportunity to repurpose funds to deliver targeted services to individuals with substance abuse and gambling issues, as well as community-based preventative services. This is why ongoing community support services are a key focus of the proposed solution in option 2 articulated below.

1.8 Summary of stakeholder impacts

As at 27 May 2022, there were 17,322 participants on the CDC program. This included 66 voluntary participants (excluding the Cape York region). At 27 May 2022, there were 108 participants on the CDC program in the Cape York region, where participants can volunteer or be referred to the CDC program through the FRC.

The CDC program is compulsory for almost all participants. Many CDC participants have no reported drug, alcohol and gambling issues but are placed on the program because they reside in a CDC region. Many participants reported feeling stigmatised or discriminated against. However, the second impact evaluation of the CDC program found only 25 per cent of survey respondents (who reported they drank alcohol) reported reducing the amount they drink at any one time, and only 22 per cent reported reducing the number of times they drink. Only 21 per cent of survey respondents reported a positive change in gambling behaviours for either themselves, family, friends or the community where they live.

As at 27 May 2022, there were 24,825 participants on IM. This included 2,663 IM participants under the Voluntary Income Management measure. (Note that some participants on voluntary IM may be subject to compulsory IM measures if they exited). Participants on mandatory IM report similar issues around the stigma and use of their funds, for limited clear benefit. In addition, IM participants face significant issues using the BasicsCard due to the basic functionality of the technology platform it uses.

These programs also impact the merchants that need to install technology and train staff to accept the card. As the CDC program has Product Level Blocking (PLB) the card can be used at most vendors and online without any burden on the business. The exception is the 400 mixed merchants (that is who sell a mixture of restricted and unrestricted items) in the CDC sites who currently do not have PLB in their business. There are also over 18,000 merchants that are on the IM program and these businesses incur costs such as staff training and in some cases, maintaining a separate till to serve BasicsCard holders. They also face stricter approval and compliance processes as a result of being an IM merchant.

2. Why is Government action needed?

2.1 Why the government should reform the programs

As the programs are Government operated, their reform can only be actioned by Government.

To continue a program without reliable evidence of its utility is not a suitable use of public funds and Government action is required to consider alternative approaches. The Australian policy landscape in relation to dealing with individual issues with drugs, alcohol and gambling has changed since the introduction of the programs. There has been a clear shift to place based approaches that are co-designed with local communities and respond to local needs or opportunities. This shift is evident in policies and programs addressing a range of policy areas, including alcohol and illicit drug misuse and domestic, family and sexual violence.¹⁸

2.2 Alternatives to Commonwealth Government action

The introduction of other government policies (at both a Commonwealth and State and Territory level) recognises the complexity and multifaceted nature of these social issues and provides more targeted interventions that are aligned with community aspirations. These alternative approaches provide more effective alternatives to the current programs which are not specifically targeted at problems individuals are facing. Alternatives allowing people to choose to quarantine part of their income support payments can complement these community based alternatives. Community groups, businesses and individuals also have a role to play to reduce societal harm. However, they currently spend time and resources on the existing compulsory programs which would be freed up to consider alternative approaches if the Government reforms these programs.

2.3 Objectives of the policy change

The objectives of abolishing CDC and reforming IM programs are to:

1. return control and choice of income support payments back to individuals.
2. offer the option of continuing support for people who want to continue to have part of their payments quarantined through voluntary IM.
3. Ensure those who volunteer for IM do not return to the BasicsCard but will have similar card functionality to what they are currently using.
4. increased levels of funding support for place-based approaches that are co-designed with local communities to better achieve social and wellbeing outcomes, such as reducing drug and alcohol misuse and problem gambling.

2.4 Constraints or barriers to achieving these objectives

The Government has identified several barriers to achieve the objectives of the policy changes. These will be carefully considered and addressed through the design and implementation process. These barriers are:

- **Time constraints** – there could be difficulties in transitioning all participants off the CDC program by 31 December 2022 due to the limited time period for transition and the mobile nature of many participants.
- **Voluntary participation in the program** – participation in the voluntary program is based on a number of assumptions around the current rate of volunteering in the IM program. There is a risk that these assumptions are incorrect and the numbers of people who do volunteer are either higher or lower than what is forecast. Risks on the downside are that people do not volunteer at or above the current rate, as is assumed in the voluntary participant numbers, due to a preference to have full access to all of their income support payment. Participation numbers are

¹⁸ Department of Social Service, 2019, Fourth Action Plan 2019-2022, The National Plan to Reduce Violence against Women and their Children 2010-2022 [Implementation and Performance of the Cashless Debit Card Trial – Follow-on | Australian National Audit Office \(anao.gov.au\)](#) accessed 24 August 2022

also contingent on future government decisions. Low participation in the program could raise concerns with the viability of the program. Conversely, the number of people could also be higher. The reasons for this could be the broad based nature of the CDC and IM programs. This means there are already a high number of people mandatorily on the programs which reduces the number of people who may have volunteered had they not been placed on the program. The government's intent to consult on community and state government referrals and a national program may also increase the estimate of the number of people on the program, noting estimated participation rates for these populations are included below. Higher numbers in the program would increase the fiscal costs of running the program, but reduce the cost per head.

- **Uptake of support services** – there may be a reluctance to engage with supports or a lack of knowledge of the additional services available to participants who either leave cashless welfare or are transitioning to IM.
- **Legislation not passed in a timely manner** – there may be a barrier due to not having the passage of legislation or that Royal Assent is not received in a timely manner. This may lead to reduced time to implement the transition process.
- **Difficulties engaging with stakeholders** – there are challenges in the engagement with community and state/territory governments in the consultation to inform the changes to the policy and many stakeholders are being consulted on other matters at the same time.
- **COVID-19** – there may be challenges with unforeseen outbreaks of COVID-19 which may impact being able to access face-to-face support especially if Services Australia staff are physically needing to move from location to location.

2.5 The Governments capacity to reform the programs successfully and overcome these barriers

To ensure the Government achieves its objectives of abolishing the CDC program and reform IM, arrangements will be developed to allow an open and transparent transition off the programs. Support will be given to individuals so they are aware of the need to change direct debit arrangements so they are moved to their bank account so payments will continue to be made for essential services such as rent and paying bills. Additional support will be provided to those who need it, building on the existing services footprint in order to fill gaps and enable future co-design of services. A communication strategy will commence once the legislation to abolish the CDC program has passed to raise awareness and provide information to affected participants of the changes and inform them opportunity to participate in IM. How Government will successfully overcome the barriers outlined above are explained in further detail in the options description.

The legislation provides for the ability for the Minister to put in place arrangements for people who are unable to transition off the program by 31 December 2022. The expectation is that this will be a small number of people.

3. What policy options are you considering?

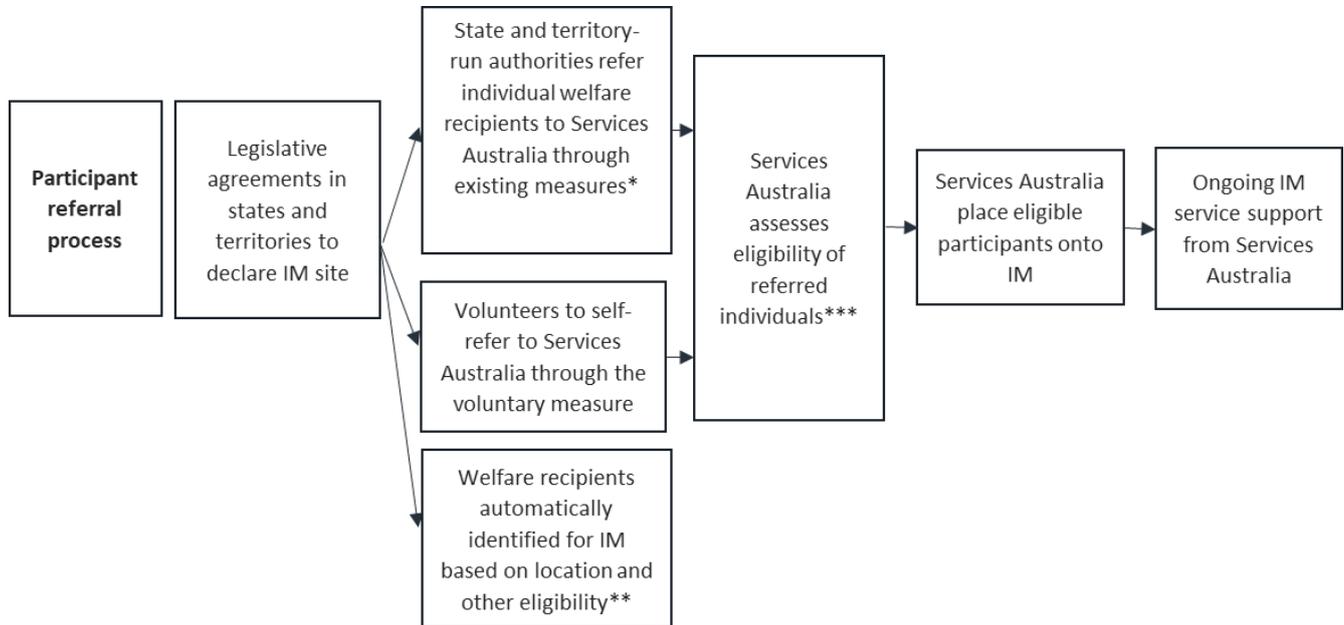
As this policy is addressing an election commitment, only 2 options have been considered.

3.1 Option 1 – Maintain the status quo

The status quo option would see the existing arrangements for both IM and CDC program continue to run in current sites of operation (see Background section for details of sites).

The existing referral mechanisms would continue to apply to place participants onto the programs. Current service delivery and operational arrangements would also continue for all participants on either program. **Figure 3** and **Figure 4** below illustrates how the two programs operate in practice (also refer to **Attachment A and B** for specific practices in each site).

Figure 3: Income Management how it operates in practice



*Existing measures include Vulnerable measure (VWPR), Child Protection measure, Supporting People at Risk measure (SPAR).

** This mechanism identifies under 16 Special Benefit Payment, over 16 and unable to live at home, under 25 prison release, disengaged youth (NT only) and long term welfare recipient (NT only).

*** Assessment of eligibility can occur automatically.

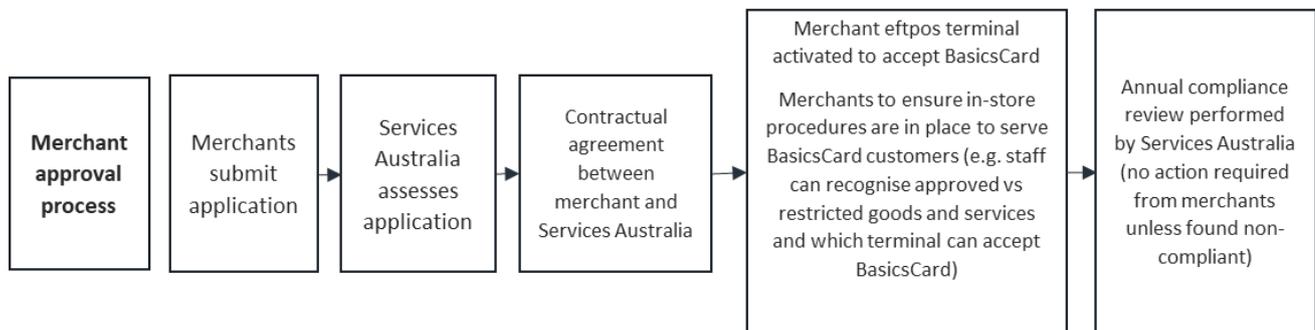
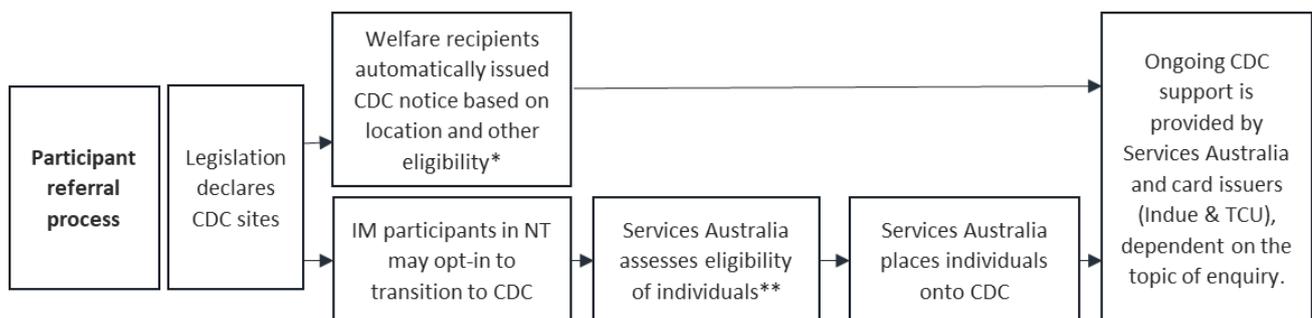


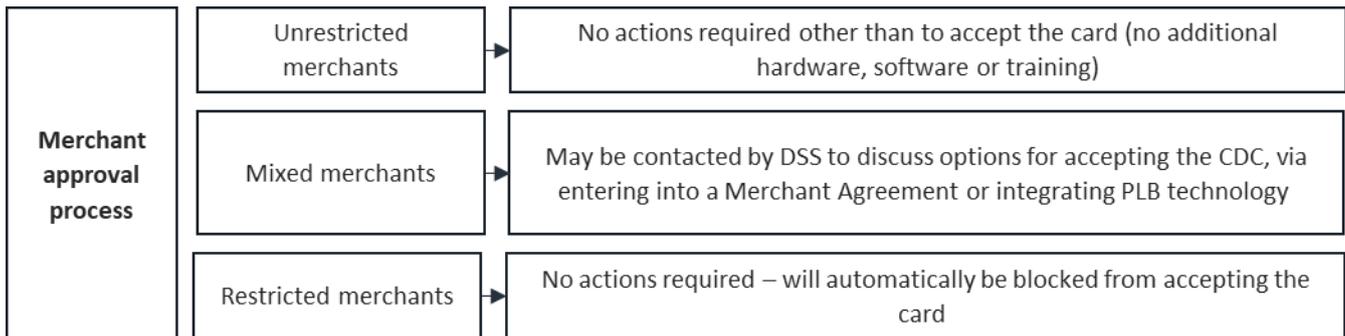
Figure 4: How CDC operates in practice



*Cohorts of welfare recipients in certain locations are automatically enrolled under the CDC program:

- In the Ceduna region, the Goldfields region and the East Kimberley region the program applies to all people who receive a working age welfare payment. People receiving the Age Pension may volunteer to participate.
- In the Bundaberg and Hervey Bay region, the program applies to people aged 35 and under who receive JobSeeker Payment, Youth Allowance (Job seeker), Parenting Payment (Partnered) and Parenting Payment (Single). People over 35 years of age or receiving the Age Pension may volunteer to participate.
- In the Cape York region in Queensland, the program applies to those who the FRC have referred. People on Age Pension may choose to volunteer to participate.

** Assessment of eligibility can occur automatically.



Under the status quo, there will continue to be two programs running concurrently. As the two programs differ in eligibility criteria, referral mechanisms, technologies and service levels, this can create unnecessary confusion for potential participants. This option does not consider any changes to the current geographical eligibility criteria for either programs, meaning both will continue to only run in their respective current locations.

Merchants wishing to sell goods and services to participants under IM will continue to be subject to existing requirements.

No discrete implementation activity would be required by the Government, but the Government would continue to serve its existing role in leading program delivery (continued oversight, make incremental adjustments to governance framework as needed, manage entry of new welfare recipients). The CDC program has a legislative sunset date of 31 December 2022 across the six regions. IM will continue to operate in the NT and across 12 Place-Based IM locations with no legislated end date (although IM has no legislated sunset date, the instruments that determine each location as a declared IM site do sunset). Legislative amendments would need to be passed to continue the CDC program beyond 31 December 2022.

State and territory governments will continue to have a minor role in implementation. Each IM measure currently has a legislative instrument to operate in the relevant state or territory, however, the implementation of two measures - Child Protection and SPaR – relies heavily on the cooperation of state and territory-run authorities to refer relevant individuals to the program.

3.1.1 The ability of the 'status quo' option to address the problem

Maintaining the status quo and retaining both programs will not address the problem given that they have not achieved their objectives, they maintain stigma in the community and they do not reflect contemporary evidence and policy landscape where community driven initiatives offer better support for participants, reducing the need for compulsory programs.

The CDC program has been criticised that it affects people without a history of substance misuse or problem gambling, and it is potentially discriminatory as a high proportion of those affected by the program are First Nations people. IM has also been criticised for disproportionately affecting First Nations people and for encouraging increased reliance on the welfare system instead of developing participants' skills, which may lead to longer term benefits. Evaluations of IM have found that people who volunteer for IM or are otherwise identified as vulnerable experience more positive outcomes, although additional

services are often required. Evaluations have also found that compulsory IM participants experience fewer positive outcomes, therefore, alternatives should be available to support participant's and community's choice

Consequently, expenditure on the compulsory nature of the programs no longer represents the most appropriate and effective use of Government funds to support individuals or communities. In addition, option 1 also does not address the Government's 2022 election commitment of abolishing the CDC program.

3.2 Option 2 – Reform the Cashless Debit Card and Income Management programs

Option 2 provides Government the opportunity to reform the programs. The information below sets out the option in detail.

3.2.1 Key elements

This option:

- 1) **Abolishes the Cashless Debit Card program** – The CDC program will be abolished and participants will be transitioned off the program before 31 December 2022.

The CDC program will cease on 31 December 2022 (inclusive).
- 2) **Transition arrangements from the Cashless Debit Card** – will also be established to ensure a smooth transition off the CDC program.
 - a. From 1 August 2022, no new participants will be placed onto the CDC program.
 - b. From the day after the legislation receives Royal Assent until 31 December 2022, participants in the 4 trial sites can opt out or volunteer for IM. Services Australia will exit people progressively off the program. A participant's CDC account will be closed.
 - c. Communication to affected individuals will be provided before, during and after their transition off the CDC program.
 - d. CDC participants in Cape York will be automatically referred to IM and the FRC will retain its ability to refer and support Volunteers onto the IM program.
 - e. CDC participants in the NT will revert back to IM, where eligible, until reforms are made.
 - f. Maintain existing policy and program parameters for IM in Place Based Income Management sites and NT until reforms commence.
 - g. People will have a card with similar functions that exist in the CDC program.
- 3) **Supports services** – will include a range of locally driven solutions to support people within the communities. The current suite of services will provide an initial platform of support with funds available to fill service gaps. These initiatives will be further developed in partnership with local communities, including First Nations leaders to target the specific issues within the different sites. These supports will complement other programs in the community and be monitored to measure implementation and impact. Any CDC participant transitioning from the program or IM participant will be able to access support services. Current services include financial literacy and counselling support, youth engagement and employment readiness initiatives. Analysis of the support services component of this option will be informed by the current suite of services, noting that the detail on further services are subject to co-design process with communities and will inform a future decision of government.
- 4) **IM technology enhancements** – enhance the technology to provide a modern experience for participants who want to remain on IM, including having debit card type functions, allow for online shopping, BPAY and access to a significantly larger range of merchants.

- 5) **Opt-in referral based IM arrangements** – The Government will consult with communities on whether the IM program should allow for referrals from community based committees similar to the Family Responsibilities Commission in the Cape York region, or from other statutory bodies. The adoption by any community into an opt-in referral based IM arrangement will be subject to a future decision of government.
- 6) **Continuation of Child Protection Measure and extending SPaR measures** - This will allow state and territory governments to nominate people who may benefit from the program such as continuing child protection orders that already exist. Note this is subject to take up by state and territory governments and is subject to a future decision of government.
- 7) **National expansion of voluntary cashless IM** – The government will consult on whether the voluntary income management program should be expanded nationally. An expansion will ensure people who want to can continue to access budgeting support or protection of their payments. Note the national expansion of voluntary IM will be subject to a future decision of government.

3.2.2 Abolish the Cashless Debit Card

This element will abolish the CDC program and allow a participant to move to IM by 31 December 2022.

3.2.3 Card technology for voluntary IM participants

Rather than returning to the use of stored value cards, individuals who choose to participate in the voluntary IM program, or who transition to IM in Cape York and the NT, will be provided with a contemporary card that ensures a modern technological functionality. This provides continuity and a consistent approach for persons transitioning to enhanced IM from CDC. Participants would receive a VISA/eftpos debit card which would incorporate basic features that currently do not exist under IM such as:

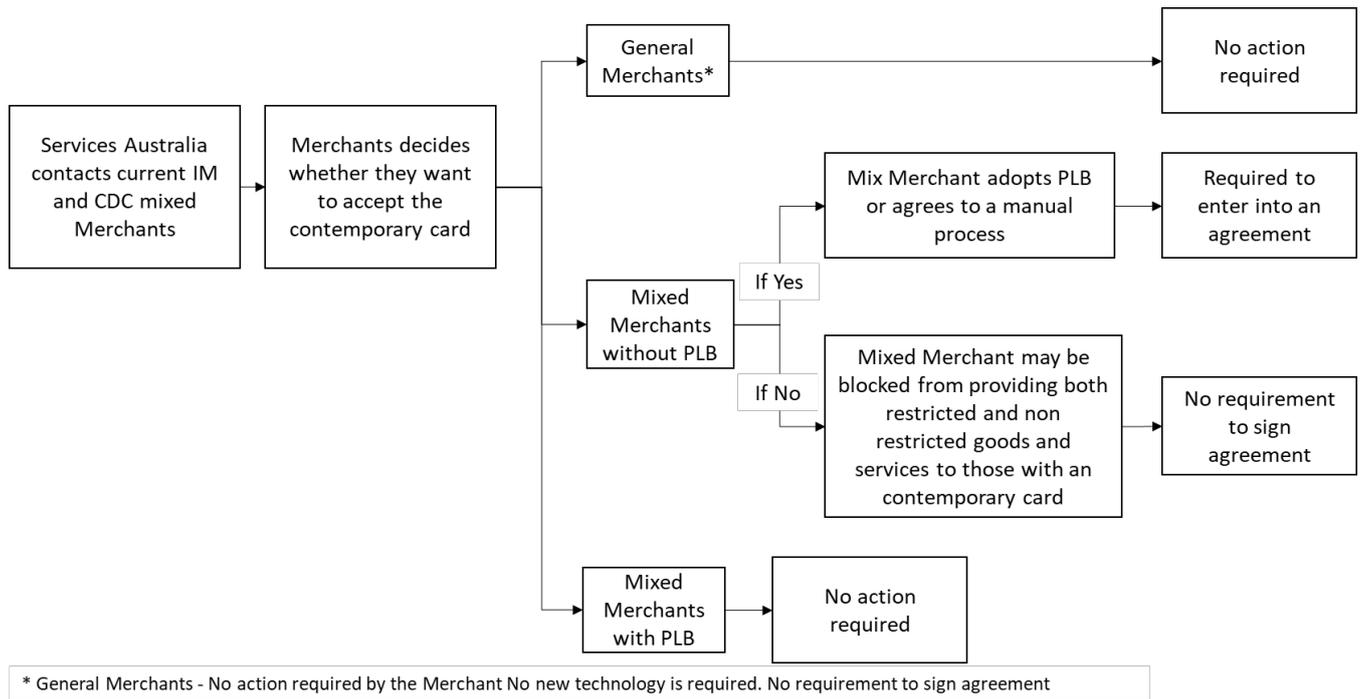
- BPAY;
- able to shop with a broader range of merchants;
- e-commerce and online shopping;
- online banking and transfers; and
- tap and go capability.

Current IM participants will continue to use the BasicsCard, and move to a new card with enhanced functionality from 1 July 2023.

An important difference between the contemporary card and the current CDC card is that all client interactions will be done by Services Australia and not the card provider. The card provider will only do those services which are necessary for the card to be accepted by merchants and the merchants to be paid. The card provider would also provide all transaction information to Services Australia so they can respond to inquiries from cardholders.

Merchants that were part of the CDC program should readily be able to adopt the new technology to accept the contemporary card. Merchants will no longer have to be on the IM program. There will be some adjustments to using the contemporary card, however, as it uses similar technology as other cards it should be easy to apply in their business. The Government will develop transitional arrangements to support merchants during this time. Figure 5 below provides an outline of the process for onboarding Merchants to accept the contemporary card.

Figure 5: Contemporary card Merchant onboarding



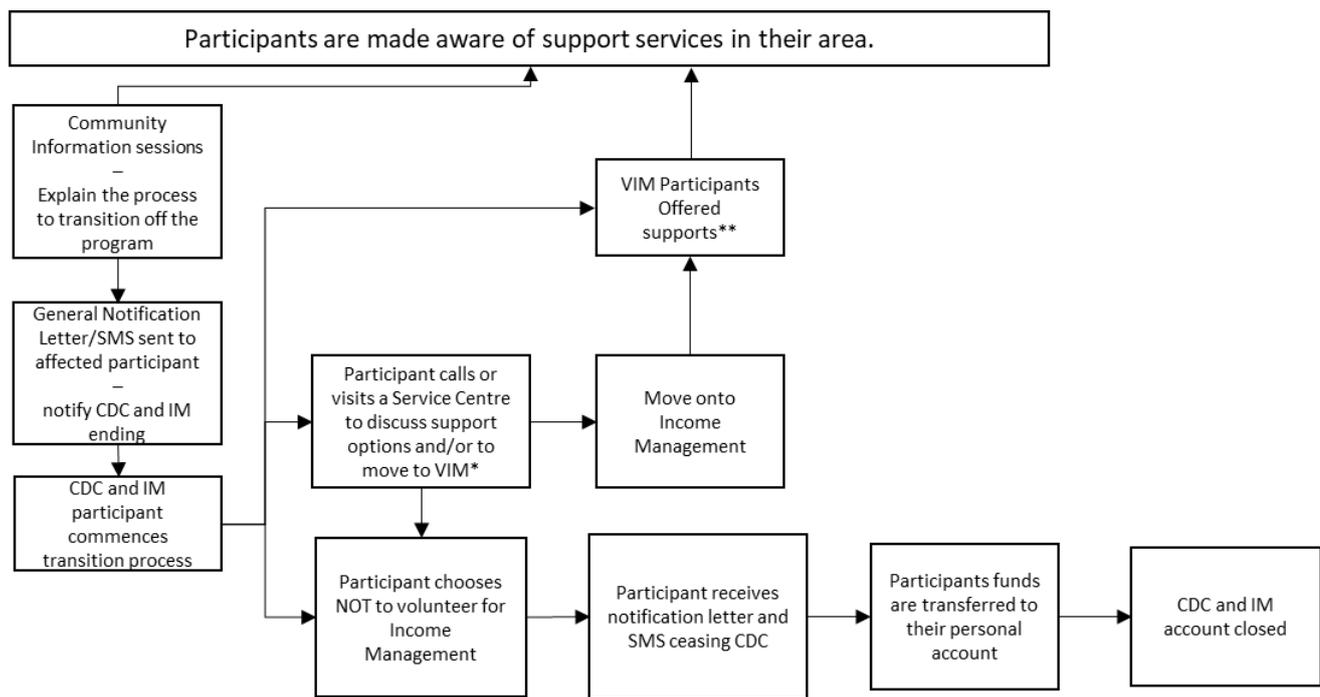
3.2.4 Supporting participants exiting the Cashless Debit Card programs through transitional arrangements

To support people exiting the programs, the Government will develop transitional arrangements for ending both the programs. The Department and Services Australia will undertake community engagement in each region prior to transition. As Figures 6, 7 and 8 illustrate the transition progress will include:

- providing participants with information on the transition arrangement (written and verbally)
- informing participants how to set up direct debits or utilise Centrepay if they need assistance scheduling payments
- informing participants on their option to volunteer for IM, and
- providing information to participants about local support services and referrals where appropriate.

Figure 6 provides a summary of how affected participants will transition off the CDC program until the end of the transitional period. Note people may want to exit without the need for support. This will mean they can transition as soon as possible subject to legislation.

Figure 6: Summary of participant transition off CDC and IM programs

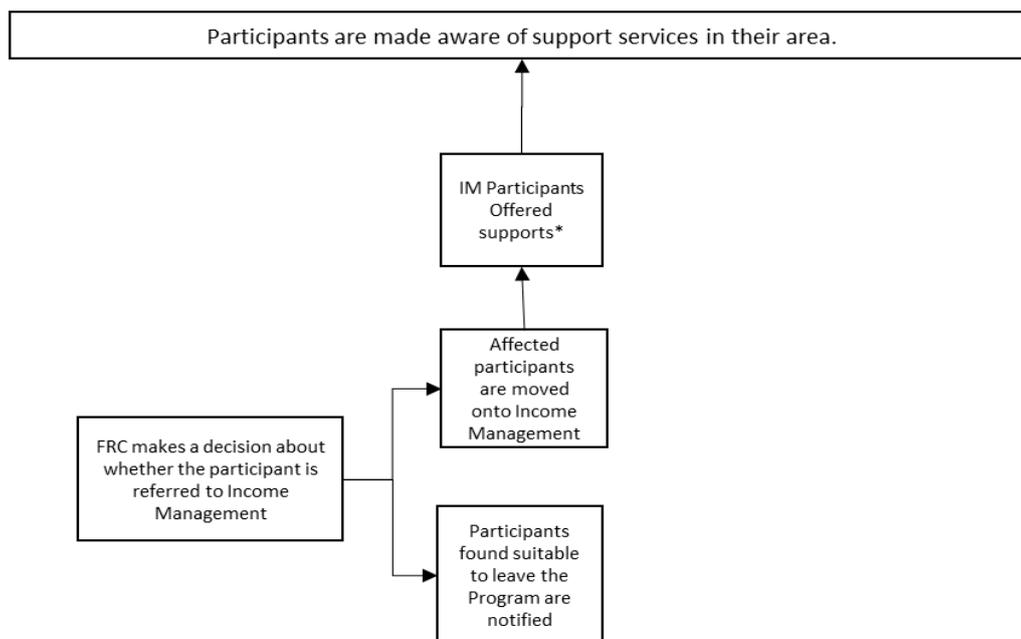


* Not all participants will have a face to face review process.

** Support provided under the Income Management process.

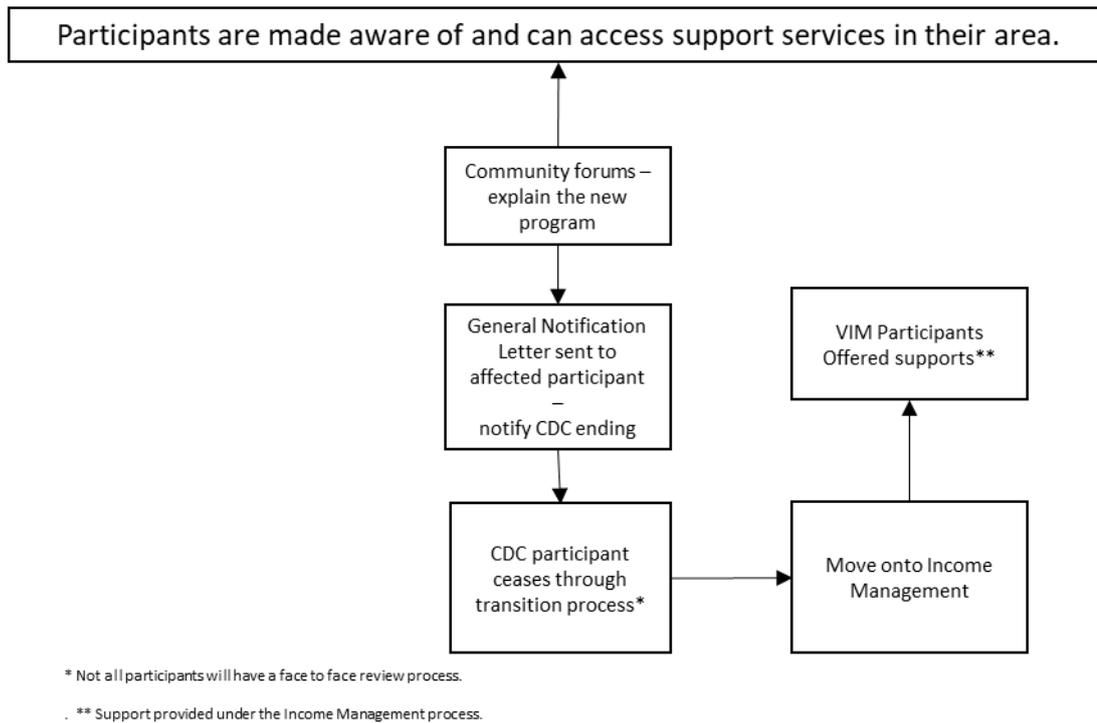
For those in the NT and Cape York the process is different. Consistent with the arrangements that have been in place for many years, the FRC in Cape York will make decisions on whether a person would benefit from having part of their income support payments quarantined see Figure 7. Participants in the NT will revert to the IM program see Figure 8.

Figure 7: Summary of participants under Community led models



* Support provided under the Income Management process.

Figure 8: Summary of participant expected transition off CDC program NT



From 1 August 2022, there have been no new entrants to the CDC program. Under new legislation, existing participants will be transitioned off in a staged approach. A staged transition will allow people to request to leave the program. All participants will receive a letter from Services Australia advising them of their options. This recognises that some CDC participants have been using CDC for up to six years, and allows time for Services Australia and the Department, along with their contracted card providers, to provide targeted support to people as needed.

The Department along with Services Australia will raise awareness and provide information to educate participants and communities on upcoming transitional arrangements.

Services Australia will offer targeted transition interviews to those who require more assistance. Transition interviews will provide CDC participants with a supported transition, support to understand how their circumstances will change including the impact on established direct debits, offer voluntary IM, and offer referrals to local support services assistance with financial counselling, money management support, and Centrepay arrangements.

Interviews will be either face-to-face or by telephone.

3.2.5 Transition from mandatory to voluntary IM

Similar to the CDC transition, people in the IM site will be able to transition off IM. The Government will consult on the appropriate way to transition to a voluntary IM system. People will cease being placed onto the IM program, and existing participants will be transitioned off in a staged approach. Changes will be communicated to all affected participants and they will be supported throughout. Support services will be available 12 months prior to removal off IM to provide digital and financial literacy support.

Services Australia and the Department will undertake community engagement in each region prior to transition in order to:

- provide participants with information on the transition,
- inform participants on their option to volunteer for IM, and
- refer vulnerable participants to local support services where needed.

The Minister will consult with states and territories as each IM measure currently has a legislative instrument to operate in the relevant state or territory. The implementation of two measures - Child Protection and SPaR – relies heavily on the cooperation of state and territory-run authorities to refer relevant individuals to the program.

Community model for referrals to IM will also be explored (subject to future consideration by government). The Government will consult with communities whether they want a community model for referrals. This will mean communities could make determinations on who should be on the program, how long they should be on it and what level of quarantining should apply.

3.2.6 Opt-in referral based IM arrangements

An opt-in community based IM referral model would enable a suitable community authority or representative body to make referrals to IM or facilitate voluntary participation in IM. This could be similar to the existing model employed by the FRC in Cape York where individuals are referred to Income Management based on their individual needs. Alternatively, the opt-in approach could see a model that supports a collective community decision to opt in to IM for all eligible community members, where the community determines that IM is a useful tool to assist the community.

Such models would require several months of deep and thorough consultation to test the community support and capacity for such a model. Depending on the model, compulsory referral by community to IM would require Commonwealth or State legislation to authorise such powers for opt-in communities.

Final proposals will be determined through consultation and subject to future consideration by government. Based on the models chosen and the number of communities that choose to opt –in, the population figures in this regulatory costing could be less.

3.2.7 The Transition Communications Strategy

The communication strategy for abolishing the CDC program and reforming IM will involve:

- Inform and educate participants of the:
 - cessation of the CDC program
 - when the transition occurs
 - ability to volunteer for IM or the change to IM (location specific)
 - support services available
 - need to make alternative arrangements for any scheduled financial arrangements, such as direct debits attached to the CDC card
 - options for transferring funds from CDC account to unrestricted accounts
 - options available such as Centrepay and the Rent Deduction Scheme
 - need to make alternative arrangements for buy now pay later arrangements
- Educate intermediaries about the changes to support the transition.
- Inform and educate merchants through specifically designed communications such as factsheets and information packs at the individual business and or corporate level and through on the ground engagement.
- Raise awareness among the general public.

It is expected there will be a variety of communication channels including face-to-face meetings, correspondence and social media.

3.2.8 Expanded support services for affected communities

Currently there are time limited supports funded across the CDC regions. These supports were funded under a range of Budget initiatives as part of the roll out of the CDC, including \$82 million provided under the Economic and Employment

Support package announced in the 2021-22 Budget; \$50 million of which was provided to the Department of Health and Ageing for Alcohol and Other Drug (AOD) rehabilitation services (yet to be decided). Further information on the support services in CDC locations are at Attachment D.

The election commitment to abolish the CDC was also clear that the Government would consult with First Nations people to understand the supports needed to not only support participants leaving the program, but address priorities and gaps in services addressing a range of social and economic priorities.

The Ministerial consultations conducted to date have confirmed the critical importance of such services and in most cases that these supports are more important than the CDC and IM in building financial independence and managing social issues.

The Department, the National Indigenous Australians Agency and Services Australia will work with local communities, organisations and leaders to understand these immediate and longer-term priorities. This would include how current funding could be repurposed and consolidated to ensure investments are complementary, maximised and targeted to the needs and aspirations of these communities.

This work will leverage existing mechanisms such as the Department's cashless welfare Community Reference Group, Empowered Communities, the FRC, and Stronger Places, Stronger People to ensure local solutions are ultimately designed and owned locally.

Co-designed supports will provide a range of benefits to individuals, families and the broader community, from initiatives supporting financial literacy and money management, targeted support to address addiction to alcohol and other drugs, and programs that support pathways to greater economic independence.

It is proposed individuals, their families and communities will have access to enhanced supports that may include:

- support to assist participants to transition off CDC such as financial literacy, budgeting and money management skills
- maintaining stability through domestic and family violence support, alcohol and drug use harm reduction services and gambling harm prevention
- building individual, family and community social and emotional well-being to minimise social harm, and build community strength and empowerment
- gaining skills and building capacity to move to economic independence by removing or reduce entrenched barriers to employment, to move individuals and communities towards greater self-reliance and economic independence.

Income support recipients will be eligible to access these support services in former CDC regions in the NT, Ceduna in South Australia, the East Kimberley and Goldfields in Western Australia, and Bundaberg/Hervey Bay and Cape York in Queensland and former IM sites.

Any CDC participant transitioning from the program will be able to access support from the support services.

There are 2 elements that respond to the needs and voice of the communities. These are:

1. **First element** – maintains services that are having an impact in communities. Existing support services will be engaged to outreach to CDC participants as they start to transition off the CDC program. These programs provide a mix of services promoting community building, health and social well-being outcomes and include community-led initiatives such as youth programs, community buses, local community night patrols and parenting programs.
2. **Second element** – will be a longer term approach aligned with the priority reforms under the National Agreement on Closing the Gap and will deliver co-designed initiatives with joint decision making in each former CDC region. This work would leverage established community leadership structures to both inform and promote the development of community priorities and co-designed grant activities.

An outcomes evaluation strategy will be developed, in partnership with community, to monitor the implementation as well as the impact of these supports. While the complexity of measuring social impact of discrete pragmatic responses is acknowledged, the strategy will include the ongoing development of the data asset including State and local data partnerships to assist future evaluations and ongoing monitoring. Data collections and evaluation outcomes will be shared with community, supporting the National Agreement on Closing the Gap priority reforms.

3.2.9 Options for later transition

It is anticipated most people will be transitioned off the CDC program by 31 December 2022. Key to ensuring participants can transition in a timely manner is having a destination to pay the balance of their CDC account and any ongoing income support payments. For the majority of people on the CDC program, Services Australia will be able to identify an alternative bank account. However, there will be some people, due to exceptional circumstances, who may not have residual CDC funds transferred to their nominated account. Services Australia will prioritise those participants identified as not having an alternative destination so their accounts can be transitioned prior to 31 December 2022.

It is possible post 31 December 2022 there will be some participants whose CDC accounts will remain open. These people will no longer be CDC participants and their card provider can close their account in accordance with their terms and conditions.

3.2.10 Required Legislative changes to the programs

Amendments to the Administration Act are required to repeal part 3D. These amendments will also insert transitional provisions to provide for the transition of persons off the CDC. These transition arrangements will commence once Royal Assent is received. Changes will also be made to allow people in CDC locations to volunteer for IM.

As part of this work the following legislative changes will be made:

- **12 month deferral of six legislative instruments due to sunset on 1 October 2022.**
These instruments (see Attachment C) enable more than 80 per cent of IM arrangements. The deferral of these instruments are consistent with the policy to maintain IM until it is reformed.
- **Amending four IM instruments**
These instruments (see Attachment C) need to be amended to make voluntary IM available in all existing CDC locations and remove compulsory IM from existing CDC areas, specifically Ceduna and Laverton.
- **Amending two IM instruments**
These instruments (see Attachment C) specify vulnerable income management areas for the purposes of paragraph 123UCA(1)(b) of the Administration Act. This will mean people in these areas will not be mandatorily placed in IM, but will allow for voluntary participant in IM.

In order to complete the implementation of the election commitment, reforms will be made to the IM program to make it voluntary. This will require further policy development, consultation and legislative changes. The scope of this work would involve:

- amending part 3B of the Administration Act to cease all compulsory forms of the IM regime
- inserting transitional and application provisions to provide for the supported transition of persons out of IM
- inserting transitional arrangements to include provision for the transition of participants from the CDC or mandatory IM arrangements to IM on a voluntary basis
- including provisions for suitable referral to IM.

These changes will ensure those in affected communities will be able to exercise their choice in how they manage their finances but also allow those who want further support in their management of their finances the opportunity to volunteer for IM once CDC program is abolished.

3.2.11 The ability to reform the Cashless Debit Card and Income Management programs option to address the problem

Reforming both the CDC and the IM programs will allow the Government to develop strategies which best address social harm. It will also free up both time and resources associated with compulsory programs allowing communities to develop their own strategies.

The CDC program has been criticised that it affects people without a history of substance misuse or problem gambling, and it is potentially discriminatory as it affects a high proportion of First Nations peoples. Therefore, expenditure on the CDC program no longer represents the most appropriate and effective use of Government funds to support individuals or communities.

Reforming IM is supported by evidence that a voluntary program can achieve a better outcome than a compulsory IM program¹⁹. The card and account technology will be updated and the current IM card will be replaced to provide a modern experience for participants who want to remain on IM.

Option 2 also addresses the Government’s 2022 election commitment of abolishing the CDC program and reforming IM. This commitment included that any future solutions moving forward would be developed after consulting with affected communities.

3.3 Comparison of the two options

Table 6 below demonstrates the key differences between the two options.

Table 6: Key differences between the two options

	Option 1: Status Quo	Option 2: Reform CDC and IM including providing card technology for voluntary IM participants
CDC	<ul style="list-style-type: none"> Participants continue to use the CDC in all CDC locations, assuming the legislation scheduled to sunset by 31 December 2022 is extended. CDC support services may expire June 2023 when the current funding terminates. 	<ul style="list-style-type: none"> CDC is abolished and participants are given the option to opt-in to voluntary IM. CDC participants in Cape York will revert to IM if subject to a notice by the FRC. CDC participants in the NT revert back to compulsory IM if they are eligible, ensuring the NT has a consistent and coordinated transition whilst government consults on the future of IM. CDC participants transitioning to the IM program retain a card with similar functionality as their current CDC card. Support services are expanded based on co-design and community need. These services will continue beyond 30 June 2023. New services focussing on supporting individuals and families, and enhancing community-stability will be offered from early 2023.
IM	<ul style="list-style-type: none"> IM stays with current policy arrangements including the use of the BasicsCard and IM support. 	<ul style="list-style-type: none"> IM is reformed to an opt-in voluntary program.* The FRC will continue to be able to place people on the program. Participants start transitioning off the compulsory IM program through a staged approach, providing participants with progressive targeted staged support.* A new card with updated technology*available for those of enhanced IM. Communities will be offered the option of working with Government on their own referral IM arrangement.* Voluntary IM is expanded nationally to allow people to choose to go on the program if it benefits them.*
Transition and communications	<ul style="list-style-type: none"> No transitional process required. No change in policy therefore no communication process 	<ul style="list-style-type: none"> Staged transitional process will commence from the day after legislation receives Royal Assent.

¹⁹ Deloitte Access Economics, 27 May 2015, *Consolidated Place Based Income Management Evaluation Report 2012-2015*, Executive Summary piv.

	Option 1: Status Quo	Option 2: Reform CDC and IM including providing card technology for voluntary IM participants
	required other than business as usual.	<ul style="list-style-type: none"> Letters will be sent out, media channels will be used to promote the changes, and there will be a series of community forums. CDC participants can request 1-on-1 face to face or telephone support to transition off cashless welfare or onto voluntary welfare. CDC participants will be transitioned off in a staged approach. Compulsory IM will cease with the Government consulting with communities on how this will be done, including community based approaches, referrals and transition processes.
Government action	<ul style="list-style-type: none"> Legislation would be needed to extend the CDC program beyond 31 December 2022. Funding for both programs to be extended. 	<ul style="list-style-type: none"> Action required to reform both CDC and IM legislation. Government resources required to transition participants and merchants, and to expand support services, however this would be offset by the reduction in the scope of the program.

*These are subject to further consideration by government

4. What is the likely net benefit of each option?

4.1 Option 1 – (Status quo) Maintain both programs

Continuing the existing CDC and IM programs for participants and maintaining the same service delivery arrangements with Services Australia would introduce no new regulatory impacts, however would extend existing impacts. As such, there are no changes to the costs and benefits currently experienced by each stakeholder group however, the existing burden of the program for participants, merchants and other stakeholders will continue.

4.1.1 Overall impacts

4.1.1.1 Participants

There are currently over 17,300 CDC participants and nearly 25,000 IM participants (as of 27 May 2022). Continuing this option under its current settings will see little change over time for the impact on participants in the program. Participants from both the CDC and IM program have similar benefits and costs when it comes to the potential social impacts and exclusion, circumventing the restrictions of the programs and perceived stigma.

Benefits

- **Potential social impacts:** The Second Impact Evaluation found mixed results from the CDC program. There was some evidence of reductions in alcohol consumption and gambling, and suggestions of a reduction in the use of illicit drugs. However, the evaluators noted that analysis had been constrained by limitations of available data. The evaluators noted that a range of programs and policies impact on outcomes in CDC regions, making it very difficult to attribute impacts to the CDC. However, the Process and Short Term Outcomes Report²⁰ shows that some people who volunteer for IM have improved their ability to manage their money and are now less likely to run out of money for food, rent or mortgage payments.
- **CDC cohort will continue to benefit from technological improvements with easy access to goods and online banking:** CDC participants have access to more than 1 million merchants in Australia and overseas. The BasicsCard will retain its current functionality and a restricted number of merchants from whom they can purchase goods.
- **Participants can stay on a familiar program:** Continuing both programs would not require participants to engage with transitioning from one program to another or to a new service. This means there will be no time cost associated with these types of activities for option 1. Current consultations have indicated that the majority of participants do not want to be on the CDC program and those who may wish to retain some form of income management would like some choice as to the type of card and program they engage with.

Costs

- **Negative perception and stigma:** Many participants do not want to be on the programs and report feelings of discrimination and a lack of autonomy. The CDC program has widely been criticised that it 'paints everyone with the same brush' because of the compulsory nature and eligibility is at a geographical level and not based on individual personal circumstances or need. Current consultation also reported that people felt the use of the card led to negative perceptions of their willingness to work, and assumptions that they were at risk of antisocial behaviour. IM

²⁰ Deloitte Access Economics, Place Based Income Management - Process and short term outcomes evaluation, 2014, Executive Summary [Place Based Income Management – Process and short term outcomes evaluation | Department of Social Services, Australian Government \(dss.gov.au\)](#) accessed on 17 August 2022

evaluations show that compulsory participants were more likely to report that they felt embarrassed and judged when using the BasicsCard compared with voluntary IM participants.

- **Time cost for participants joining the existing programs:** there will be a cost associated for new participants to adjust to making purchases by cash and card. People who need access to cash would have to ensure they use the card for the purchase of unrestricted goods. That is, everything except alcohol, gambling products and cash like products such as unrestricted gift cards. This will free up the maximum amount of cash available to spend each fortnight. For some people this may be easier than others particularly those younger cohorts.
- **The BasicsCard technology is not user friendly:** BasicsCard technology has not kept up with the significant advancements in card functionality. IM participants do not have access to a range of mainstream banking functions such as real time account balances, internet shopping or use of BPAY. Participants are also only able to purchase goods from approved merchants.
- **Women are over represented:** As at 27 May 2022, 60 per cent of CDC participants and 55 per cent of IM participants were women. This percentage is higher for women IM participants in Western Australia (69 per cent) and South Australia (62 per cent). This reflects the fact that women are over represented as income support recipients. One of the CDC trigger payments is Parenting Payment in which women have a higher representation as they are more likely to be primary carers for children. Concerns have also been raised that the lack of cash makes it more difficult for a woman to leave an abusive relationship.
- **Social exclusion:** many activities, goods and services in the community, especially in regional areas²¹, still operate on a cash basis. Restricting access to cash restricts access to these markets. As a result, some participants have reported feeling socially excluded, particularly as parents not being able to provide cash for their children to attend such things as school fairs and sporting events. Not being able to transact in cash also limits the ability for participants to buy second hand goods, therefore limiting their purchasing power and managing their budget.

Regulatory cost to individuals

Approximately 8,500 people are placed on the CDC program each year. This is mostly offset by a similar number of people who leave the program for various reasons. When a person starts on the program, they must learn how to use the card and adjust the way they shop and take care of bills and other disbursements. Of those newly placed on the CDC program, around 15 per cent (1,275) of them will seek to leave the program and of those, 50 per cent (637) will have an exit interview to assess whether they meet the criteria to exit the CDC program. There are 4,206 people who join the IM program with no previous interaction with the program. There is no similar application process for those who want to exit IM as most are placed onto the program for a set time. Therefore, there is no equivalent regulatory impact.

New Program participants – new participants (8,500 CDC and 4206 IM participants a year)

	New entrants on IM and CDC
Learning how to use the card (CDC and IM) <ul style="list-style-type: none"> • E.g. Looking up approved merchants and changing shopping behaviour, learning the features of the card 	<p><i>1hr 15 mins for new entrants onto the card</i> $1.25 \times \\$36 = \\45.00 per participant</p> <p><i>(CDC) $\\$45.00 \times 8,500 = \\$382,500$</i> <i>(IM) $\\$45.00 \times 4,206 = \\$189,270$</i></p> <p><i>Total = $\\$571,770$</i></p>
Exit application (CDC) no Exit applications required for IM <ul style="list-style-type: none"> • Only 15 per cent of the total population will seek an exit application based on current trends. 	<p><i>1,275 = 15% of CDC participants will apply per year from 2023</i></p> <p><i>1hr x $\\$36.00 = \\36.00</i></p> <p><i>$\\$36.00 \times 1,275 = \\$45,900$</i></p>
Exit interview (CDC) no exit applications for IM <ul style="list-style-type: none"> • Only half of those who seek an exit application will continue the process to exit interview based on current trends. 	<p><i>637 = 50% of 1,275 will proceed to interview</i> <i>1.5 x $\\$36$ applications that go through to interview</i></p> <p><i>$1.5 \times \\$36 = \\54 per participant</i></p>

²¹ Reserve Bank of Australia, 2020, Cash Use in Australian: Results from the 2019 Consumer Payments Survey, www.rba.gov.au

	New entrants on IM and CDC
	$\$54 \times 637 = \$34,398$
Total (\$)	Yr1 = \$652,068 per year 10 Years = \$6,520,680

Net Benefit

The CDC evaluations have not been conclusive in finding any observed benefits to individuals such as reduced alcohol or drug consumption in participating communities due to the introduction of the CDC program. Feedback from recent consultations have found there is evidence that some people are finding ways to get around the restrictions to purchase restricted goods. This reduces the effectiveness of the programs. In addition, the CDC and IM evaluations and current consultations reported stigma that people felt with being on the programs. The arrangements attempt to achieve community wide outcomes but in doing so they impinge upon the individual freedoms of those without identified problems with drugs, alcohol and/or gambling. By focusing on geographical sites, critics claim the CDC perpetuates the stigma faced by minority communities. Also, not changing the BasicsCard technology will perpetuate the outdated functionality of the card keeping IM participants with limited access to merchants and a range of mainstream banking functions, internet shopping or use of BPAY. In conclusion, the cost of the programs outweighs the benefits for individuals.

4.1.1.2 Merchants

Benefits

- **Impact to the majority of retailers is minimal.** The majority of retailers do not sell restricted items and will be unaffected by the continuation of the CDC program.
- **No additional costs of complying with the programs.** As this option offers no change to current program settings for CDC program or IM, existing merchants that accept income managed funds will not have to incur additional costs of complying with the programs.

Costs

- **No change to current program settings** means that merchants must maintain dual systems if they are to accept BasicsCard and the CDC.
- **Mix Merchant are required to enter into agreements.** The Department engages mainly with mixed merchants who sell a combination of restricted and unrestricted products to discuss entering into an agreement, which could be either a merchant participant agreement (to implement PLB) or a mixed merchant agreement (not compatible with PLB).
- **There are costs to merchants that may want to participate in the CDC program.**
 - To benefit from PLB, mixed merchants need to invest in PLB technology. There are around 400 mixed merchants in the current CDC sites of which 80 already have PLB in their business. There are approximately 267 merchants who will need to enable the PLB technology on their point of sale system, train their staff and update their product listing to identify restricted items. We expect by year 5 there will be a further 53 mixed merchants who would have upgraded their systems to accept PLB. Once PLB is enabled there is little difference between using the CDC or any other card. Some small ongoing costs exist for compliance monitoring and maintenance of merchants' PLB hardware and software. Most of the banks charge a higher card payment terminal rental fee if a merchant upgrades to an integrated PIN Pad. Given this is merchant technology that is required for any business which accepts credit and debt cards the majority of merchants will have the infrastructure in place and there will only be a small number affected, if any, that would need to purchase new pin pads. Therefore, we have not costed the regulatory costs as these will be very small and unlikely.
 - Merchants that do not participate in PLB will need to go through a manual process of identifying products and whether they are restricted at the point of sale. This puts the focus and burden of compliance on the merchant rather than relying on the technology available. The regulatory costs have not been assessed, as

there will be a very small number of merchant impacted in this way. There are no merchant costs for exiting.

- **The cost of being on IM.**

- The costs to a merchant who wants to participate in the IM program are very different to the CDC program. They must be approved by Services Australia to be a merchant. There is a higher burden on their staff to identify restricted goods and identify people on the IM program so they do not sell these goods to them.
- Some merchants also retain separate pin pads for BasicsCard purchases or maintain separate counters where restricted items cannot be purchased.

Cost to CDC merchants over 10 years for program

Cost to merchants (\$m)	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
Without PLB technology roll out)	\$2,070	\$1,593	\$1,593	\$1,593	\$1,593	0	0	0	0	0	\$8,441
After PLB technology roll out)	\$2,166	\$4,332	\$6,498	\$8,664	\$9,395	\$9,395	\$9,395	\$9,395	\$9,395	\$9,395	\$78,028
TOTAL (\$)	\$4,236	\$5,924	\$8,090	\$10,256	\$10,987	\$9,395	\$9,395	\$9,395	\$9,395	\$9,395	\$86,469

Note, it is expected that the 53 merchants without PLB technology will transition to PLB over 5 years.

CDC Merchants (Program expansion: without PLB technology roll out) – 53 merchants total cost is \$8,441

Application one off cost calculations

	Unrestricted	Restricted	Mixed			total
			population	time	cost	
Year 1	0	0	13	0.5	\$79.63	\$517.60
Year 2	0	0	10	0.5	\$79.63	\$398.15
Year 3	0	0	10	0.5	\$79.63	\$398.15
Year 4	0	0	10	0.5	\$79.63	\$398.15
Year 5	0	0	10	0.5	\$79.63	\$398.15
Year 6	0	0	0	0	0	\$ -
Year 7	0	0	0	0	0	\$ -
Year 8	0	0	0	0	0	\$ -
Year 9	0	0	0	0	0	\$ -
Year 10	0	0	0	0	0	\$ -
					total	\$2,110

Initial set up calculations (hardware, software and staff training)

	Unrestricted	Restricted	Mixed			total
			population	time	cost	
Year 1	0	0	13	1.5	\$79.63	\$1,552.79
Year 2	0	0	10	1.5	\$79.63	\$1,194.45
Year 3	0	0	10	1.5	\$79.63	\$1,194.45
Year 4	0	0	10	1.5	\$79.63	\$1,194.45
Year 5	0	0	10	1.5	\$79.63	\$1,194.45
Year 6	0	0	0	0	0	\$ -
Year 7	0	0	0	0	0	\$ -
Year 8	0	0	0	0	0	\$ -
Year 9	0	0	0	0	0	\$ -
Year 10	0	0	0	0	0	\$ -
					total	\$6,331

It is estimated there are around 400 mixed merchants in the current CDC sites. Of these, 80 already have PLB running in their store. The application process is a one off cost for merchants to enter into a mixed merchant agreement with the Department. This will take around 30 minutes per merchant. Initial set up is also a one off cost and would take around 1.5 hours to complete.

Annual compliance assumes that a merchant will have to spend around 1 hour per year to do compliance activities and ongoing maintenance. These costs only apply to mixed merchants as unrestricted merchants do not require PLB and restricted merchants are blocked.

CDC Merchants (with PLB technology roll out), merchant total cost is \$78,028

Ongoing maintenance

	Unrestricted	Restricted	Mixed			total
			Population	time	cost	
Year 1	0	0	80	0.17	\$79.63	\$1,082.97
Year 2	0	0	160	0.17	\$79.63	\$2,165.94
Year 3	0	0	240	0.17	\$79.63	\$3,248.90
Year 4	0	0	320	0.17	\$79.63	\$4,331.87
Year 5	0	0	347	0.17	\$79.63	\$4,697.37
Year 6	0	0	347	0.17	\$79.63	\$4,697.37
Year 7	0	0	347	0.17	\$79.63	\$4,697.37
Year 8	0	0	347	0.17	\$79.63	\$4,697.37
Year 9	0	0	347	0.17	\$79.63	\$4,697.37
Year 10	0	0	347	0.17	\$79.63	\$4,697.37
					total	\$39,014

Annual Compliance

	Unrestricted	Restricted	Mixed			total
			Population	time	cost	
Year 1	0	0	80	0.17	\$79.63	\$1,082.97
Year 2	0	0	160	0.17	\$79.63	\$2,165.94
Year 3	0	0	240	0.17	\$79.63	\$3,248.90
Year 4	0	0	320	0.17	\$79.63	\$4,331.87
Year 5	0	0	347	0.17	\$79.63	\$4,697.37
Year 6	0	0	347	0.17	\$79.63	\$4,697.37
Year 7	0	0	347	0.17	\$79.63	\$4,697.37
Year 8	0	0	347	0.17	\$79.63	\$4,697.37
Year 9	0	0	347	0.17	\$79.63	\$4,697.37
Year 10	0	0	347	0.17	\$79.63	\$4,697.37
					total	\$39,014

It is assumed that a further 53 merchants will gradually move onto PLB over 5 years. There are no application costs as merchants are engaged with by the Department to implement PLB. It is assumed that ongoing maintenance and compliance takes around 10 minutes per merchant.

IM merchant costs

There are approximately 18,000 IM merchants. Many of these merchants are large to medium corporate entities which allows for a broad number of business to accept the card. To be a merchant requires about 0.5 hours to complete an application, including signing the agreement and 1 hour in set up time for 10 new merchants per year. There is also 0.25 hour in ongoing training and 1 hour of compliance per year.

There is a regulatory total cost of \$18,015,163 over 10 years for IM merchants.

Cost to merchants	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL (\$)
One off cost for new merchants	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$11,945*
Ongoing training for staffing	\$358,335	\$358,335	\$358,335	\$358,335	\$358,335	\$358,335	\$358,335	\$358,335	\$358,335	\$358,335	\$3,583,350
Annual compliance	\$1,433,340	\$1,433,340	\$1,433,340	\$1,433,340	\$1,433,340	\$1,433,340	\$1,433,340	\$1,433,340	\$1,433,340	\$1,433,340	\$14,333,400
TOTAL (\$)	\$1,792,869	\$17,928,690									

*Please note this number has been rounded and so the individual row totals will not add up to the 10-year total which is calculated based on the yearly total.

One off cost for new IM merchants

	ALL				Total
	population	number of staff	time	Cost	
Year 1	10	1	1.5	\$79.63	\$1,194
Year 2	10	1	1.5	\$79.63	\$1,194
Year 3	10	1	1.5	\$79.63	\$1,194
Year 4	10	1	1.5	\$79.63	\$1,194
Year 5	10	1	1.5	\$79.63	\$1,194
Year 6	10	1	1.5	\$79.63	\$1,194
Year 7	10	1	1.5	\$79.63	\$1,194
Year 8	10	1	1.5	\$79.63	\$1,194
Year 9	10	1	1.5	\$79.63	\$1,194
Year 10	10	1	1.5	\$79.63	\$1,194
				Total	\$11,945

Ongoing training for staff

	All				Total
	population	number of staff	time	cost	
Year 1	18000	1	0.25	\$79.63	\$358,335
Year 2	18000	1	0.25	\$79.63	\$358,335
Year 3	18000	1	0.25	\$79.63	\$358,335
Year 4	18000	1	0.25	\$79.63	\$358,335
Year 5	18000	1	0.25	\$79.63	\$358,335
Year 6	18000	1	0.25	\$79.63	\$358,335
Year 7	18000	1	0.25	\$79.63	\$358,335
Year 8	18000	1	0.25	\$79.63	\$358,335
Year 9	18000	1	0.25	\$79.63	\$358,335
Year 10	18000	1	0.25	\$79.63	\$358,335
				Total	\$3,583,350

Annual Compliance

	All				Total
	population	number of staff	time	cost	
Year 1	18000	2	0.5	\$79.63	\$1,433,340
Year 2	18000	2	0.5	\$79.63	\$1,433,340
Year 3	18000	2	0.5	\$79.63	\$1,433,340
Year 4	18000	2	0.5	\$79.63	\$1,433,340
Year 5	18000	2	0.5	\$79.63	\$1,433,340
Year 6	18000	2	0.5	\$79.63	\$1,433,340
Year 7	18000	2	0.5	\$79.63	\$1,433,340
Year 8	18000	2	0.5	\$79.63	\$1,433,340
Year 9	18000	2	0.5	\$79.63	\$1,433,340
Year 10	18000	2	0.5	\$79.63	\$1,433,340
				Total	\$14,333,400

We assume that there will be only 10 new merchants per year signing up to be an IM merchant. The low number is because IM has been in the market for an extended period and therefore the market for new merchants has matured. The 10 new merchants will be those that change hands during the year and need to learn the IM system. It is also expected IM merchants will be required to provide ongoing training for 1 staff member for 15 minutes each year.

Net Benefit

Some merchants would be required to maintain two systems to accept both BasicsCard and the CDC. The overall costs to businesses in the CDC program are lower than the IM program for the reasons set out above. PLB reduces the amount of training merchants have to do with staff as the identification of restricted products is done via a terminal rather than the merchant needing to train staff to identify the card and then applying any restrictions as participants try to buy items.

4.1.1.3 Government

Benefits

- The program objective seeks to reduce the consumption of alcohol and drugs and reduce gambling by some individuals, noting there is limited evidence supporting the effectiveness of the card in achieving reductions in these social harms.
- A potential reduction in these activities would meet the government's objectives. It may also reduce crime and the associated fiscal costs by addressing the known social determinants.

Costs

- Maintaining both programs side by side presents a net cost to the Government and the taxpayer. Since its inception, the CDC has cost over \$180.7 million. Since 2016-17 the IM program has cost \$341.2 million.
- The BasicsCard utilises old and outdated technology, which presents a number of costs to ensure its ongoing operation. It is possible that the Government will have to subsidise merchants to maintain pin pads for the IM program that are able to accept magnetic strip cards as they are being phased out in favour of modern tap and go technology pin pads.
- Table 7 assumes there would be 20 agencies across Australia that would be able to refer a person to Services Australia for the CDC and IM, taking approximately 1.5 hours. There are no costs for assessments as these authorities would have undertaken work to assess individuals already and the only change is to refer a person to Services Australia for

the CDC where they believe it would assist. This is assumed to take around 1 hour for around 200 referrals. This totals \$175,186 over 10 years.

- The number of agencies is based on the number of States and Territories who could potential provide referrals for SPaR and Child Protection. It is assumed there are 4 agencies who could refer across 5 jurisdictions.

Table 7: Annual cost to state and territory-run authorities to refer individuals to CDC and IM

Activity	State/territory referrals to CDC and IM (200 total referrals)
Training/briefing for authorities	<i>1 hrs x 20 agencies x 1 staff member x \$79.63/hr = \$1,592.60 (1 year cost)</i> Total over 10 years = \$15,926.00
Assessment	\$0
Referral	<i>1hr x 20 agencies x 10 referrals each x \$79.63/hr = \$15,926.00</i> Total over 10 years = \$159,260.00
Total over 10 years (\$)	\$175,186

Net Benefit

Maintaining the status quo provides a net cost for the Government as running both programs simultaneously does not represent value for money. The administrative complexities of the dual system means the Government must resource both systems and provide intensive frontline services for IM that ultimately impacts the program’s delivery. States and Territories would have an additional tool to assist people through times where income management may benefit them dealing with particular circumstances meaning they would not need to develop a similar program.

4.1.1.4 Community Organisations

Benefits

- There is no regulatory burden increase as current processes and systems continue to carry on without change.
- The Cape York region has established a community led model which enables community controlled decision making. The CDC program is used by the FRC to support their objective which is to help people in welfare reform communities to resume primary responsibility for the wellbeing of their communities and the individuals and families of their communities.

Costs

- There are no direct costs placed on community organisations however running both programs simultaneously may cause some confusion for community organisations who may provide information on the programs. This may be especially evident in places like the NT where both programs overlap. The regulatory impact table provides a cost to community organisations where there may pass on information about the program such as a pamphlet/factsheet.
- Although violence against community organisations has not been largely reported, there is always the possibility that angered participants that have recently been placed on the program may criticise community organisations in the current operating sites.
- There is a small regulatory cost for the FRC to advise Services Australia that they want an individual to be referred to the CDC program.
- It is estimated there will be 32 new participants referred to the CDC program in Cape York per year based on the assumption there is a higher turnover due to the number of people moving through the community and the fact that decisions about moving on and off are made at the community level. FRC will provide advice to Services Australia on the participation of these new people on the CDC program. Therefore, the regulatory cost of FRC includes training and the process to advise Services Australia.

Cost to community organisations

This table sets out the cost to community organisations for CDC program and IM.

Cost to general community organisations	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
TOTAL (\$)	\$688	\$688	\$688	\$688	\$688	\$688	\$688	\$688	\$688	\$688	\$6,880

This table sets out the cost for the Family Responsibilities Commission refer to the CDC program.

Activity	Family Responsibilities Commission led referrals (32 advises per year)
Training/briefing for authorities	1 hrs x 1 agency x 1 staff member x \$79.63/hr = \$79.63 (1 year cost) Total over 10 years = \$796.30
Process to advise Service Australia	0.5 hrs x 1 agency x 1 staff member x \$79.63/hr x 32 advise to Service Australia = \$1,274.08 Total over 10 years = \$12,741
Total over 10 years (\$)	\$13,537

Net Benefit

For community organisations, excluding FRC, there is no net additional regulatory cost or benefit as both programs will continue to run simultaneously as before. There is a small regulatory cost for the FRC to advise Services Australia of a new participant to the CDC program. However, the CDC program uses a community led model and therefore the benefit of having the decisions being self-determined at a community level outweighs the small regulatory cost.

4.1.2 Regulatory impacts – benchmark

Under this option there is a regulatory cost of **\$24,556,260 over 10 years**. This cost is underpinned by the above tables and assumptions.

Change in costs	Business	Community organisations	Individuals	Total change in costs
Total, by sector	\$18,015,163	\$20,417	\$6,520,680	\$24,556,260

4.2 Option 2 – Reform of the CDC and IM programs

This option will abolish the CDC program, move to a voluntary model of IM program based on consultation with communities, provide a modern card service offering to IM participants and establish culturally suitable support services, co-designed with affected communities to address local issues and priorities and assist people who transition off the program.

The option also considers options for communities and state authorities to refer people onto a reformed IM program (subject to further government consideration).

4.2.1 Overall impacts

The lack of conclusive evidence from the evaluations on the difference the programs are having on reduced alcohol, drugs and gambling means it is not possible to estimate the effect of abolishing or reforming the programs. This has been emphasised through the consultations with communities, with law enforcement agencies saying there has been no noticeable difference in crime as a result of the CDC while others in the community holding the view that there has been a positive impact.

There is no quantitative research which would provide the Department with the ability to determine the impact of this option. The Department has therefore made assumptions on the potential social impacts of the proposal. The economic and regulatory impacts of the proposal are based on the most up to date information available.

There are no environmental and competition impacts to be explored.

4.2.2 Reforming CDC and IM programs including technology enhancements

4.2.2.1 Participants

It is expected that the following number of participants transition on and off the CDC and IM over the next 10 years starting from 2022-23. See [Attachment F](#) for a summary of CDC and IM participant numbers justification and assumptions.

Cashless Debit Card

All CDC participants will transition off the CDC program. It is anticipated approximately all 17,300 CDC participants will transition off the program. Of these approximately:

- 3,800 CDC participants in the NT will revert to IM.
- 100 CDC participants in Cape York will transition to the IM program.
- 13,400 will leave CDC, noting that these participants will be given the option to volunteer for IM.

Income Management

Currently, there are nearly 25,000 participants on the IM program.

In 2022-23:

- 3,800 will revert from CDC to IM in the NT. This is in addition to those in the NT who are already on IM.
- 100 will revert from CDC to IM in Cape York.
- 400 former CDC participants are estimated to volunteer for IM. This estimate is based on 10 to 11 percent of the population of CDC participants after removing participants from NT and Cape York who revert back to IM (4,000), CDC participants who live out of a CDC region and are unable to volunteer for IM (3,800) and Bundaberg and Harvey Bay participants where no one has volunteered to stay on CDC after they turn 36 (4,800).

In 2023-24 it is assumed:

- 570 new NT IM participants and a similar number leave so the net impact is zero.

- 32 new Cape York IM participants referred by the FRC and a similar number leave so the net impact is zero.

In 2024-25 (subject to further government consideration):

- 28,200 will transition off compulsory IM including the 3,800 ex CDC participants who reverted back to the IM in the NT in 2022-23.
- It is assumed 4,000 people who were on the IM program will volunteer to remain on the program in 2023-24.
- It is assumed there will be 1,600* who will volunteer from sites other than the current CDC and IM designated sites.

There will also be:

- 400 participants who have volunteered from a previous CDC location; 110* referrals from State and Territories (50 for SPaR and 60 for Child Protection, this is based on current referral trends); and
- 1,340* people from a previous CDC community that volunteer to be on the IM program.

In 2025-26 (subject to further government consideration):

- 840 people will volunteer made up of 600 from current IM sites and 240 for other sites.

These numbers will remain constant from 2025-26 onwards.

Participant population assumptions

From year 3 to 10 it is anticipated there will be a consistent 7,550 participants (made up of 5,600 VIM, 60* child protection, 50* SPaR and 1,340* other community led referrals), in total, on the IM program per year. The following assumptions were made in arriving at this number:

- 4,000 from the CDC in the NT and IM programs will volunteer. This is approximately 14% of all IM participants and CDC participants in the NT who revert to IM in year 1 (28,200). This is slightly higher than the current 11 per cent volunteer rate in the IM program as it is assumed some participants that have been on compulsory IM for an extended period will want to volunteer.
- 1,600* from current trend of participants' population will volunteer from sites other than CDC and IM sites. This is subject to further Government consideration.
- Community led is an estimate of a current CDC site and assumes the community has agreed to be placed on the new IM program. This is subject to community consultation and further Government consideration. There is a risk that participation from community led sites is lower or takes longer time to be established.
- The Cape York population is based on current participants.
- Each year 15 per cent of participants will transition off and 15 per cent will transition onto the IM program. This is a net impact of zero. This is consistent in the experience of turnover in the IM. Therefore, flow impacts is calculated at 15 per cent each year. There are no exit costs for IM.
- It is noted that these estimates consider the current public perceptions around IM. These reforms afford greater control and agency to individuals and communities where IM is a voluntary tool to help build capacity and provide protective factors for those who need it and choose it. A more positive framing of this program aligned with better-connected supports for financial literacy and management may result in greater demand beyond the estimates in this section.

*These numbers are contingent on further consideration of program arrangements by Government.

4.2.2.1.1 Abolishing the CDC and reforming IM for participants

This section covers participants who leave the CDC and move off the program or onto voluntary IM. Note that there are 3,500 participants living outside current CDC location who will not be given the option to going onto voluntary IM.

Benefits

- **Provides more personal autonomy and increases access to potentially cheaper goods and services.** Under the new system, more people will have control over their finances, including the ability to use cash to purchase second hand goods. People have said during consultations, that the ability to purchase cheaper second hand goods is one way which they can save on expenses which is important for people on welfare payments.
- **Increased access to cash for activities where digital payments are not available:** the evaluation of the CDC in the Ceduna, East Kimberley and Goldfields regions conducted by the University of Adelaide²², found that many CDC participants considered not being able to access cash problematic. The concerns expressed included the inability to provide money to children for pocket money, school lunches and excursions, and not being able to attend community activities.
- **Improves wellbeing by reducing stigma.** A high percentage of CDC participants surveyed in the second impact evaluation into the CDC in the Ceduna, East Kimberley and Goldfields regions²³ said they felt a stigma due to being on the CDC. A large majority of respondents, 75 per cent felt discriminated against as a result of being on the CDC, 73 per cent reported that they felt embarrassed and 75 per cent said it was not fair that they were on the CDC. In-depth interviews further highlighted that being on the card resulted in CDC participants being easily identified as welfare recipients in the community and created misperceptions of them as being either 'dole bludgers' or 'addicts', creating feelings of shame and embarrassment. People on the CDC also reported an inability to participate in some social and community activities due to the restriction of their finances, and being treated differently by other community members and in shops and businesses. Under Option 2 there is a strong likelihood that these participants will no longer feel the stigma, increasing their sense of wellbeing.
- **Services that are targeted to support the needs of individuals.** Co-designed supports will provide a range of benefits to individuals, families and the broader community, from initiatives supporting financial literacy and money management, targeted support to address addiction to alcohol and other drugs, and programs that support pathways to greater economic independence. A clear finding from the consultations is that in many cases, support services are more highly valued than the actual card. In Ceduna, the consultations found that community programs foster cooperation and collaboration between service providers and communities, which can be critical in the success of such services. As previously noted, evidence indicates that successful community-driven programs in First Nations communities allow for the solutions to be individualised, culturally appropriate and for the community to have ownership of and control over decisions about the allocation of resources. In addition, IM evaluations highlighted better results when a person volunteered for the program²⁴.

Costs

- There may be a perception that the removal of CDC could lead to more drinking, gambling and drug taking within communities. The evidence from the evaluations do not support this view. The Department is unable to estimate such an impact and note that there is evidence from the consultations that people have still found ways to circumvent the card to access alcohol. As a result, we consider the impacts from any increased drug and alcohol consumption are likely to be minimal.
- Participants outside CDC locations will not be offered the option to transition to voluntary IM. However, there may be an option for these individuals to join IM through a subsequent national rollout of the voluntary IM program, subject to further government consideration.
- As part of the staged transition from the CDC, current participants may opt into voluntary IM or will engage with Services Australia for assistance. This will include time taken to discuss the changes and make necessary decisions which is anticipated to take on average 30 minutes per participant which could include a Services Australia interview

²² Future of Employment and Skills Research Centre, University of Adelaide, 2021, Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Regions: Consolidated Report, p192 [https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021\[PDF 8.1MB\]](https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021[PDF 8.1MB]) accessed on 17 August 2022

²³ Mavromaras, K., Maskos, M., Mahuteau, S., Isherwood, L. (January 2021), Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Region – Consolidated Report, The University of Adelaide Future of Employment and Skills Research Centre, Adelaide.

²⁴ Deloitte Access Economics, 27 May 2015, *Consolidated Place Based Income Management Evaluation Report 2012-2015*

(conducted either face-to-face or by telephone). This will have a regulatory cost of \$311,400 to transition from CDC program based on a population of 17,300 participants at 0.5 of an hour at the rate of \$36.00 per hour.

- As the current IM program has a BasicsCard functionality the transition off, on average, will not take as long as for CDC participants. Based on a population of 28,200 participants at 0.5 of an hour at the rate of \$36.00 per hour the estimated regulatory cost to transition from the IM program is \$507,600.

Reduction in costs for abolishing the CDC over 10 years

	New entrants on IM and CDC
Learning how to use the card (CDC) <ul style="list-style-type: none"> E.g. Looking up approved merchants and changing shopping behaviour, learning the features of the card 	<i>1hr 15 mins for new entrants onto the card</i> $1.25 \times -\$36 = -\$45.00 \text{ per participant}$ $(\text{CDC}) = -\$45.00 \times 8,500 = -\$382,500$ <i>Total = -\\$382,500</i>
Exit application (CDC) <ul style="list-style-type: none"> Only 15 per cent of the total population will seek an exit application based on current trends. 	$1,275 = 15\% \text{ of CDC participants will apply per year from 2023}$ $1 \text{ hr} \times -\$36.00 = -\36.00 $-\$36.00 \times 1,275 = -\$45,900$
Exit interview (CDC) <ul style="list-style-type: none"> Only half of those who seek an exit application will continue the process to exit interview based on current trends. 	$637 = 50\% \text{ of } 1275 \text{ will proceed to interview}$ $1.5 \times -\$36 \text{ applications that go through to interview}$ $1.5 \times -\$36 = -\$54 \text{ per participant}$ $-\$54 \times 637 = -\$34,398$
Total (\$)	Yr1 = -\$462,798 per year 10 Years = -\$4,627,980

Costs for transitioning off CDC over 10 years

Cost to individuals	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
Average transitional support	\$311,400	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$311,400
TOTAL (\$)	\$311,400	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$311,400

	population	time	cost	

Reduction in costs for reforming IM over 10 years

	New entrants on IM and CDC
Learning how to use the card (IM) <ul style="list-style-type: none"> E.g. Looking up approved merchants and changing shopping behaviour, learning the features of the card 	<i>1hr 15 mins for new entrants onto the card</i> $1.25 \times -\$36 = -\$45.00 \text{ per participant}$ $(IM) -\$45.00 \times 4206 = -\$189,270$ <i>Total = -\\$189,270</i>
Exit application (IM) <ul style="list-style-type: none"> No similar process in IM as in CDC 	\$0
Exit application interview (IM) <ul style="list-style-type: none"> No similar process in IM as in CDC 	\$0
Total (\$)	Yr1 = -\\$189,270 per year 10 Years = -\\$1,892,700

Costs for transitioning off IM over 10 years

Cost to individuals	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
Transition requirement	\$0	\$0	\$507,600	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$507,600
TOTAL (\$)	\$0	\$0	\$507,600	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$507,600

Net Benefit

Abolishing the CDC program and reforming IM gives people the opportunity to make their own decisions about how and when they use their income support payments. People who do not have drug, alcohol, or gambling issues will not have their payments quarantined and stigma of being on the CDC or IM program will no longer exist. There is a perceived risk from some stakeholders of an increase in social harm; however, this has been contested during the consultations with some people expecting no change in social harm and others expecting an increase.

There will be a **one off regulatory cost** of transitioning participants from the **CDC program of \$311,400**. For IM it is **\$507,600** totalling a one off regulatory cost **\$819,000**. However, there is a **\$4,627,980 regulatory save** with abolishing the CDC program and a **\$1,892,700 save** for reforming IM, totalling a **regulatory save of \$6,520,680**. With benefits outweighing the costs, abolishing the CDC program and reforming IM is expected to provide a net benefit for participants of **\$5,701,680**.

Programs	Save	Cost	Total
CDC program	-\$4,627,980	\$311,400	-\$4,316,580
IM program	-\$1,892,700	\$507,600	-\$1,385,100
Total	-\$6,520,680	\$819,000	-\$5,701,680

4.2.2.1.2 Participants who move to voluntary IM

This includes those that chose to volunteer from former CDC sites and IM locations.

Benefits

- **IM can provide financial management support for those who want it:** Some participants may wish to continue cashless welfare arrangements as they experience the benefits of protection against financial harassment and increased financial stability. IM evaluations reflect some key positive findings such as 85.5 per cent of voluntary IM participants reporting improvements in their ability to pay rent and bills, 74.2 per cent reporting improvement in ability to manage money, and 54 per cent reporting improvement in ability to save money.²⁵
- **Voluntary IM participants could benefit from safeguards,** such as protection from humbugging and other activities that seek to take advantage of welfare recipients in the community. Humbugging is a practice of demanding money from relatives. Consultations have indicated that women and the elderly are common targets for such behaviour and as cash is unable to be withdrawn from both the CDC and BasicsCard, the programs may provide some protection against humbugging. The IM evaluations illustrate that recipients who use income management as a form of protection, usually voluntary IM, are more likely to stay on it for a long period to ensure they remain protected. 38.1 per cent of social workers²⁶, customer service officers and IM contact officers found that voluntary IM is a useful tool to “reduce the likelihood that welfare payment recipients will be subject to harassment and abuse in relation to their welfare payments”. Allowing a person to volunteer for IM allows a person to make a decision to keep quarantining their income support payments if it is in their interests. There may be pressure from family members to cease an arrangement. Currently around 2,700 people volunteer for the IM program which suggests that there is a demand for a voluntary arrangement even if pressure exists to leave the program.

Costs

- In year 3* (2024-25) there will be:
 - 5,600 new volunteers, 4,000 from current CDC and IM location and 1,600* from other locations. These participants will need to learn how they can use the contemporary card. It is anticipated this will take 0.75 hours which will have a regulatory cost of \$36 per participant per hour.
 - From year 4 onwards there will be a total of 840 new voluntary IM participants. These participants will need to learn how they can use the contemporary card. It is anticipated this will take 0.75 hours which will have a regulatory cost of \$36 per participant per hour.
- As previously stated it is anticipated there is a 15 per cent turnover per year.

*These numbers are contingent on further consideration by government.

²⁵Deloitte Access Economics, 2015 Consolidated Place Based Income Management Evaluation Report 2012-2015, <https://www.dss.gov.au/families-and-children/programmes-services/welfare-conditionality/income-management/consolidated-place-based-income-management-evaluation-report-2012-2015> accessed 14 August 2022 p.26.

²⁶ Deloitte Access Economics, 2015, *Place Based Income Management - Medium Term Outcomes Evaluation Report* <https://www.dss.gov.au/families-and-children/programmes-services/welfare-conditionality/income-management/place-based-income-management-medium-term-outcomes-evaluation-report> accessed on 23 August 2022

Costs for participants who move onto voluntary IM

Cost to participant	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
Learn how to use the contemporary Card for ongoing participants	\$0	\$7,200	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$7,200
Learn how to use the contemporary Card new participants (subject to further consideration by government)	\$0	\$0	\$151,200	\$22,680	\$22,680	\$22,680	\$22,680	\$22,680	\$22,680	\$22,680	\$309,960
TOTAL (\$)	\$0	\$7,200	\$151,200	\$22,680	\$22,680	\$22,680	\$22,680	\$22,680	\$22,680	\$22,680	\$317,160

Learn how to use the contemporary card ongoing VIM in current CDC sites

	population	time	cost	total
Year 1	0	0	0	\$0
Year 2	400	0.5	36	\$7,200
Year 3	0	0	0	\$0
Year 4	0	0	0	\$0
Year 5	0	0	0	\$0
Year 6	0	0	0	\$0
Year 7	0	0	0	\$0
Year 8	0	0	0	\$0
Year 9	0	0	0	\$0
Year 10	0	0	0	\$0
			total	\$7,200

Learn how to use the contemporary card new (subject to further consideration by government)

	population	time	cost	total
Year 1	0	0		\$0
Year 2	0	0	0	\$0
Year 3	5600	0.75	36	\$151,200
Year 4	840	0.75	36	\$22,680
Year 5	840	0.75	36	\$22,680
Year 6	840	0.75	36	\$22,680
Year 7	840	0.75	36	\$22,680
Year 8	840	0.75	36	\$22,680
Year 9	840	0.75	36	\$22,680
Year 10	840	0.75	36	\$22,680
			total	\$309,960

4.2.2.1.3 Participants who go onto IM (NT)

3,800 people in the NT have chosen to move from IM to CDC since March 2021. These participants may have on-going eligibility for IM under existing legislation. CDC participants in the NT will revert back to IM following their transition off the CDC. The NT is the only place with multiple participants on both the CDC and IM programs in the same communities. In one example, a town in the NT has 140 CDC participants and 280 IM participants. Reverting CDC participants back to IM will allow the Government to have a coordinated transition of participants in both programs at the same time. IM is the dominant program in the NT in the overwhelming majority of communities. The provision of support services will be more effective if they are designed for the community as a whole, including both IM and CDC participants.

Those participants moving back to IM in the NT will not return to the BasicsCard but will have similar card functionality to what they are currently using but under the IM program.

Therefore, there is no regulatory costs associated with this change in policy.

4.2.2.1.4 Participants who go onto IM through a community led model or SPaR or Child Protection

The FRC will still be able to place people onto the IM program. This allows the FRC to make determinations on who should be on the program, how long they should be on it and what level of quarantining should apply.

The Government will consult with communities whether they want to have similar arrangements in place, noting that these complex consultations will take several months. Consultation will also be held with state and territory government agencies who may seek ongoing arrangements to refer people to IM for such things as child protection or because they are something like the banned drinkers register in the NT (ie SPaR) (subject to future consideration by government).

Benefits

- These determinations are different to the triggers that apply in the CDC and IM programs as they are made after taking into account a person's or communities circumstances and whether the IM program will benefit the individual or community. An individual or communities ongoing participation on the program can be assessed by the referring authority or community so participants may come off the program if they show improvements in their circumstances. Whether those under child protection orders or SPaR can exit is determined by the relevant jurisdiction that has referred the individual to the IM program.
- IM can provide a secondary benefit of improved health and wellbeing outcomes for children: IM can support participants to allocate a proportion of their welfare payments towards groceries and educational needs of their children and dependents. Many recipients on the Child Protection measure acknowledged that IM had helped improve their ability to meet their basic needs. About a third of interviewed recipients on Child Protection IM wanted to remain on it, and a further third wanted to go off once their income managed period was over but retain the opportunity to return to it in future if they needed to. The remaining third wanted nothing more to do with income management.²⁷
- Evaluation of the impact of the Child Protection measure for parents, carers or young people referred for IM has found that IM had the potential to positively impact on children's welfare, mainly due to improving individual's housing stability. Stable accommodation for customers and their children meant there were fewer occurrences of families sleeping rough and children being placed in out of home or kinship care. It was also noted it had a positive influence on children's attendance at school and educational attainment. It was noted that stable housing for families reduced the need for child protection interventions, as children living in stable accommodation were more likely to be clothed, fed and attending school.²⁸

²⁷ Department of Social Services, 2014, *Review of Child Protection Income Management in WA*, accessed February 2022, from <[A review of Child Protection Income Management in Western Australia | Department of Social Services, Australian Government \(dss.gov.au\)](#)>

²⁸ Deloitte Access Economics, 2012, *Evaluation of Place-Based Income Management (2014 and 2015)*, accessed February 2022, from <[Consolidated Place Based Income Management Evaluation Report 2012-2015 | Department of Social Services, Australian Government \(dss.gov.au\)](#)>

- Social workers interviewed said that they saw a reduction in drug or alcohol consumption, a stabilisation of living situation, and improved access to other community services (e.g. Home and Community Care and Meals on Wheels)²⁹.

Costs

- Cape York:
 - There are currently just over 100 people on the CDC program in the Cape York area. These individuals were only eligible for the CDC program from 17 March 2021 and before this, they were participating in IM. There is no regulatory impact as the participants will continue to access the functionality of the CDC card but under the IM program.
 - From year 2, it is expected there would be 32 new Cape York IM participants per year. These new participants will not have experience with IM and therefore require more time to understand the IM program. As a result, it will take 1.25 hours with a regulatory cost of \$45 per participant. This represents the net flow of participants into the IM program.
- New community led model:
 - It is anticipated from year 3 (2024-25) there will be 1,340 participants through a community led model who will require 0.5 hours to become familiar with the IM program with a regulatory cost of \$45 per participant.
 - As previously stated it is assumed there will be a 15 per cent turnover per year from year 3 (2024-25) onwards. As a result, it is estimated 195 new participants each year with a regulatory cost of \$45 per participant. This represents the net flow of participants into the IM program.
 - Over the 10 years it is anticipated a community led model may have a regulatory impact totalling \$85,545.
- SPaR:
 - It is anticipated from year 3 (2024-25) there will be 50 participants through SPaR who will require 1.25 hours to become familiar with the IM program, with a regulatory cost of \$45 per participant. As previously stated it is assumed there will be a 15 per cent turnover per year from year 4 (2025-26) onwards. As a result, it is estimated 7 to 8 new participants in total each year with a regulatory cost of \$45 per participant.
- Child Protection:
 - It is anticipated from year 3 (2024-25) there will be 60 participants referred through Child Protection State and Territory Authorities who will require 1.25 hours to become familiar with the IM program, with a regulatory cost of \$45 per participant. As previously stated it is assumed there will be a 15 per cent turnover per year from year 4 (2025-26) onwards. As a result, it is estimated there will be 9 new participants in total each year with a regulatory cost of \$45.

Cost to participant	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
Cape York	\$0	\$1,400	\$1,440	\$1,440	\$1,440	\$1,440	\$1,440	\$1,440	\$1,440	\$1,440	\$12,960
New community led model	\$0	\$0	\$24,120	\$8,775	\$8,775	\$8,775	\$8,775	\$8,775	\$8,775	\$8,775	\$85,545
SPaR	\$0	\$0	\$2,250	\$338	\$338	\$338	\$338	\$338	\$338	\$338	\$4,613

²⁹ UNSW, 2014, *The Evaluation of New Income Management in the NT*, accessed February 2022, <[Evaluation of New Income Management in the Northern Territory | Department of Social Services, Australian Government \(dss.gov.au\)](#)>

Cost to participant	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
Child Protection	\$0	\$0	\$2,700	\$405	\$405	\$405	\$405	\$405	\$405	\$405	\$5,535
TOTAL (\$)	\$1,800	\$1,400	\$30,510	\$10,958	10,958	10,958	10,958	10,958	10,958	10,958	\$108,653

Net Benefits

- The addition of an independent community group, or government agency, making decisions on whether a person should be an IM participant should result in people joining the program because it is considered to be in their interests. Co-design will used to establish transparency arrangements for community referral pathways.

Gender Impact

As at 27 May 2022, 3 out of every 5 voluntary IM participants (or 62 per cent of the total voluntary IM population) were female. Therefore, it is expected with abolishing the CDC program and reforming IM the percentage of females will continue to be strongly represented in the program. Under the new arrangements, female participants may benefit through:

- **Increased financial autonomy:** participants will be able to make routine payments, such as rent from one account rather than having to manage these payments from two accounts. This will make it easier for people to budget for large payments such as rents and utilities.
- **Reduced negative impact on those experiencing family, domestic and sexual violence:** Restrictions on cash withdrawals can reduce the flexibility of women experiencing family and/or domestic violence to access funds to support and care for themselves and their children. Under the new system, participants experiencing domestic violence can have greater control over their finances in addition to accessing other crisis payments, such as the Escaping Violence Payment. By leaving the CDC program, victim-survivors do not have the added burden of transferring a set amount of cash from their CDC program every 28 days to another bank account, or additional step of requesting access to the cash component by calling the Services Australia Helpline. They will also have greater access to cash to purchase second hand goods to furnish a new home.
- **Reduced social exclusion of parents with caring responsibilities:** Parents have been quoted as saying that a lack of access to cash has meant their children have been unable to purchase food from their school canteens, are unable to go on school excursions, or buy items at school fetes. This has the ability for their children to also feel stigmatised by other students because their parents are on the programs.
- **Reduced stigma:** Evidence from the Second Evaluation Report³⁰ reflects that some single mothers felt they were being judged as an alcoholic or drug addicts despite not experiencing challenges with alcohol, drugs or gambling prior to being placed on the programs. Option 2 will reduce this stigma.

Costs

- **Economic coercion:** Some women may risk increased pressure as their partners and families seek to increase control over their welfare payments. For example, a woman in an abusive relationship may be pressured to hand over welfare payments to a partner instead of allocating funds towards rent, bills, groceries or children's educational needs. In such instances, women may opt in for voluntary IM, if they choose to do so, or have a portion of their income support payments diverted to Centrepay to ensure utilities like rent and electricity get paid. There is a risk that in a voluntary system that they may be pressured to cease these arrangements.

³⁰ Future of Employment and Skills Research Centre, University of Adelaide, 2021, Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Regions: Consolidated Report, https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021.pdf

First Nation people

Currently, 50 per cent of CDC participants and 82 per cent of IM participants are First Nations people (as at 27 May 2022), compared with 3.2 per cent of people who identify as First Nations with the Australia community³¹. For example, as at 27 May 2022 in Ceduna, there were 700 CDC participants in the Ceduna region of which around 75 per cent of participants identify as Aboriginal or Torres Strait Islanders. This portion of First Nations people is higher in East Kimberley (84 per cent) and Cape York (95 per cent). In the Northern Territory 84 per cent of IM participants identify as First Nations with Western Australia and South Australia at 71 per cent, and 50 per cent, respectively.

Table 8 provides a breakdown of the number of first nations participants by current location.

Table 8: Active CDC participants – current location (as at 27 May 2022)

CDC region	Number of participants	First Nations participants
Bundaberg and Hervey Bay	4,709	18%
Northern Territory	3,846	77%
Out of area*	3,819	46%
Goldfields	2,805	48%
East Kimberley	1,335	84%
Ceduna	700	75%
Cape York	108	95%
Total	17,322	50%

*Participants who have moved out of a CDC program region but remain on the program

In line with data confidentiality requirements, numbers less than 5 have been suppressed and some other figures are not provided (n.p.)
These point-in-time data show active CDC participants, as at 27 May 2022, based on their current location.

Both the CDC and IM programs affects a high proportion of First Nations people and has attracted criticism that these programs could be in breach of the *Racial Discrimination Act 1975*. Some First Nations People have questioned whether the CDC is consistent with the right of self-determination.

Under the new arrangements, First Nations people may benefit through:

- **Increased choice in their financial affairs:** First Nations participants will be able to opt into voluntary IM which can provide the benefit of increased financial stability through budgeting and financial management support. Ministerial consultations recently conducted face-to-face in communities indicated a desire for more financial literacy and digital supports for different First Nations cohorts in the communities. These services will be co-designed with community leaders.
- **Stronger supports services:** these will be co-designed with communities including the most effective way these can be delivered.
- **Removes stigma:** The majority of CDC and IM participants are First Nations people. Updates to technology on the BasicsCard and allowing people to transition off the program will remove the need to identify themselves as a participant on these programs prior to purchasing goods.

³¹ Australian Bureau of Statistics, 2022, Aboriginal and Torres Strait Islander people: Census, [Aboriginal and Torres Strait Islander people: Census, 2021 | Australian Bureau of Statistics \(abs.gov.au\)](https://www.abs.gov.au/australian-bureau-of-statistics)

- **Protection from humbugging, family and domestic violence.** First Nations people will still be able to maintain quarantining of payments through voluntary IM, which can reduce the cash that would leave them vulnerable to these forms of abuse.
- **Additional support services to meet service gaps and future priorities.** New support services that are designed in authentic partnership with First Nations people will deliver better outcomes for these communities, including addressing social harms and providing pathways to economic independence.

Costs

- **Economic coercion:** People may be pressured to cease a voluntary arrangement.

4.2.2.2 Merchants

The impact of Option 2 on merchants will differ depending on the nature of their business, their engagement with the current CDC and IM programs, and whether they will be classified as a ‘mixed merchant’.

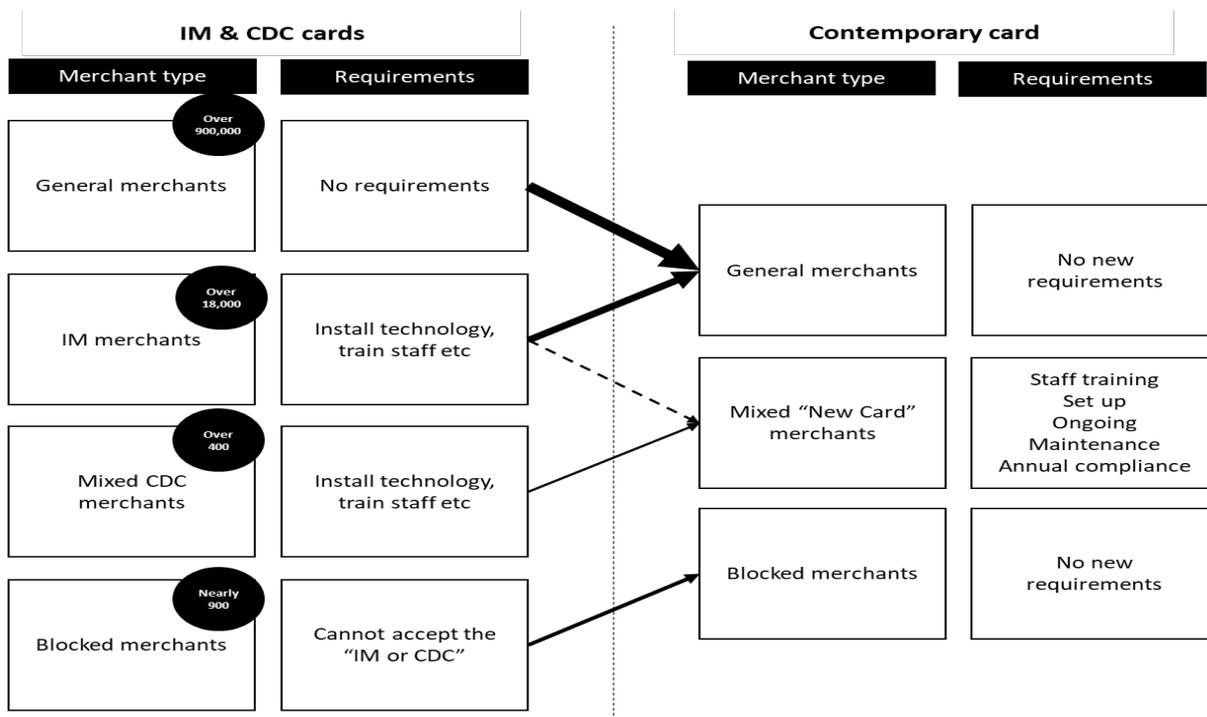
Under the current CDC program, the CDC card automatically works at most merchants’ premises without these merchants signing up to the program. These businesses will be referred to as ‘general merchants’. There are also merchants that sell both restricted items and unrestricted items. These are called ‘mixed CDC merchants’ and there are approximately 400 of these in the current CDC sites. These merchants can either complete a participation agreement and install product level blocking technology or enter into a mixed merchant agreement where they agree not to sell restricted items to program participants. Under the current IM program, the IM BasicsCard can only be used at ‘approved merchants’. Approved merchants must also complete a process and install technology in order to sell goods to CDC participants. There are 18,000 approved IM merchants nationally.

Under Option 2, most merchants will leave the CDC and IM programs. The contemporary card will operate in a similar manner as a normal debit card. Most merchants will be able to accept the contemporary card without having to sign up to the IM program, meaning they will operate as ‘general merchants’. Merchants that sell restricted products will be classified as a ‘mixed merchant’ and install product level blocking technology and train staff to accept the contemporary card. Other options for merchants could be a mixed merchant agreement or choosing not to accept the card if the costs of implementing the technology outweigh the benefits. In limited circumstances, mixed merchants in small communities will be compensated for implementing the technology to accept the contemporary card due to their importance to the community. The number of merchants compensated will depend on where people will volunteer for the program. We do not know what these places will be at this time.

Details about Merchants can be found at **Attachment E**.

Figure 9: Summary of merchants requirements below demonstrates the types of merchants under the former and contemporary card systems.

Figure 9: Summary of merchants requirements



4.2.2.2.1 Abolishing current CDC and IM compliance requirements

This impacts the 400 mixed merchants and 18,000 IM merchants. The impacts moving to the contemporary card is considered in the next section. BasicsCard merchants will continue to service IM participants in year 1 with transitioning starting from year 3 to accept the contemporary card. Therefore, current IM BasicsCard technology will eventually become obsolete.

Benefits

- Reduced onboarding costs:** Under IM, if a merchant wants to join the program it typically will take each merchant on average 30 minutes to fill in the BasicsCard Merchant application form (a one-off regulatory cost). Under the enhanced IM program, these businesses no longer need to on board to IM resulting in a regulatory benefit.
 - Reduced onboarding costs: 10 x \$79.63 taking 0.5 hours, totalling -\$398 per year
 - CDC merchants will no longer have the costs of implementing PLB
- Reduced ongoing compliance costs:** Under IM, each merchant has approximately 1 hour of compliance cost per year. This includes training staff, record keeping and compliance reviews as required. They must also maintain a BasicsCard terminal to process sales. Under the enhanced IM program, these businesses no longer need to comply with the IM program.
 - Reduced compliance costs: 18,000 x 1 instance x 2 staff x 0.5 hours x \$79.63 = \$1,433,000 per year
 - Under the CDC program over 10 years, there is a reduced compliance cost of \$39,014.
- Removed complexities associated with running two separate programs:** Some IM merchants may also operate as a CDC mixed merchant. These businesses need to identify the participants on both the IM and CDC and train their staff on the different items that cannot be purchased. Moving to a single card will reduce this burden.
- Time cost of removing the IM BasicsCard technology and systems:** If the merchant is transitioning from IM they will need to remove the IM technology and educate the staff on the process changes.
 - One off cost of removing the IM BasicsCard for 18,000 merchants that takes 0.25 hours for one staff member at the rate of \$79.63 per hour, totalling a cost of \$358,335.

Costs

- Potential increase in crime:** There is no clear evidence to suggest a link between the CDC or IM programs and the incidence of crime. Feedback through Ministerial consultations have expressed mixed views on whether crime will increase as a result of the CDC being abolished. Stakeholder have stated that appropriate supports in communities where the CDC is removed will be critical to mitigate any effects from the removal of card.

Cost to CDC merchants over 10 years for program

Cost to merchants (- \$m)	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
Without PLB technology roll out)	-\$2,070	-\$1,593	-\$1,593	-\$1,593	-\$1,593	0	0	0	0	0	-\$8,441
After PLB technology roll out)	-\$2,166	-\$4,332	-\$6,498	-\$8,664	-\$9,395	-\$9,395	-\$9,395	-\$9,395	-\$9,395	-\$9,395	-\$78,028
TOTAL (\$)	-\$4,236	-\$5,924	-\$8,090	-\$10,256	-\$10,987	\$9,395	-\$9,395	-\$9,395	-\$9,395	-\$9,395	-\$86,469

Note, it is expected that the 53 merchants without PLB technology will transition to PLB over 5 years.

Cost to IM merchants over 10 years for program

	yr1	yr2	yr3	yr4	yr5	yr6	yr7	yr8	yr9	yr10	total
Reduced onboarding	-\$398	-\$398	-\$398	-\$398	-\$398	-\$398	-\$398	-\$398	-\$398	-\$398	-\$3,982
Reduced ongoing compliance	-	-	-	-	-	-	-	-	-	-	-
Removed complexities associated with running two separate programs	-\$796	-\$796	-\$796	-\$796	-\$796	-\$796	-\$796	-\$796	-\$796	-\$796	-\$7,960
Time cost of removing the IM BasicsCard technology and systems	-\$358,335	-\$358,335	-\$358,335	-\$358,335	-\$358,335	-\$358,335	-\$358,335	-\$358,335	-\$358,335	-\$358,335	-\$3,583,350
Total (\$)	\$1,792,869	\$17,928,692									

Net Benefit

IM merchants will have a reduced regulatory burden and some minimal negative impacts. On balance, there is a benefit to former CDC and IM merchants that transition off cashless welfare Under Option 2. By removing the two programs there is a regulatory save of \$18,015,160 over the 10 years.

4.2.2.2.2 Movement to contemporary card

From 1 July 2023 an interim technology solution will be designed to maintain the functionality of the former CDC card but under the Income Management program. This will see the phase out of the more complicated IM arrangements for merchants.

Quantifiable regulatory impacts

Nil

4.2.2.2.3 Merchants onboarding to contemporary card

In year 2 the contemporary card will be made available to those who volunteer for IM. All merchants except for those who sell both restricted and non-restricted goods and services will be required to enhance their POS technology to be able to distinguish purchases made by those with a contemporary card. There is no regulatory cost to general merchants who only sell non-restricted goods and services as there is no requirement for them to sign an agreement or adopt any new technology to support the contemporary card.

Those affected are the former CDC program merchants and IM merchants that sell a mix of restricted and unrestricted goods and services.

Of the 18,000 IM merchants it is estimated 8,000 do not sell restricted items and will therefore transition to becoming 'general merchants'. Of the 10,000 remaining 9,500 will be larger merchants with existing PLB technology where there is no cost to use the contemporary card. Therefore, only 500 IM merchants need to be costed.

It is assumed of the 400 former CDC mixed merchants, only 347 will adopt the contemporary card. There will be 450 of the 500 IM merchants will also adopt the contemporary card bringing the total number of merchants with a regulatory cost to 797.

It is acknowledged in some smaller communities, merchants play a variety of roles and are likely to be mixed merchants who also provide essential services. To support these merchants it is proposed to make funding available to support such businesses in small communities. This will offset the financial and regulatory cost of joining the program so is included as an offset to the cost rather than a benefit.

There are approximately 2.5 million businesses in Australia.³² All businesses that are not classified as a mixed or blocked merchant can be classified as a general merchant, including online Australian businesses, and online business overseas. However, contemporary card users would likely only engage with a small number of businesses given their locations. The exact number also depends on the use of online stores by participants. The number of 'general merchants' impacted is unknown however there are no costs associated with them accepting a new card so can be discounted from these calculations.

There are also no costs to Block merchants as they will not be able to accept purchases from the card. There are approximately 890 merchants blocked in current CDC and IM locations. It is difficult to estimate whether the number of blocked merchants will increase or decrease as some will become unblocked as there may not be a voluntary participant in their area and others may be blocked as they do not want to implement PLB technology.

The regulatory costs for merchants transitioning to accept the contemporary card has been calculated based on a population of 797 and it is assumed there will be 10 new merchants seeking to accept the contemporary card from year 2.

Benefits

- **Revenue from contemporary card users:** Mixed merchants will receive revenue from contemporary card users if they choose to sign up as a mixed merchant. The financial impact of this would depend on the uptake of the reformed IM.
- **Increased consumption:** There may be an increase in demand for certain goods and services depending on the nature of what the general or mixed merchant sells. These impacts are expected to be minor as the total amount of

³² Counts of Australian Businesses (2020-21) [Counts of Australian Businesses, including Entries and Exits, July 2017 - June 2021 | Australian Bureau of Statistics \(abs.gov.au\)](https://www.abs.gov.au/australian-businesses)

money from welfare in the economy remains the same, and the Review³³ suggests there will be limited change in consumption patterns (eg. an increase in alcohol consumption) that would lead to some businesses gaining increased revenue.

- **For General Merchants there is no new regulation:** There is no new regulatory impact as ‘general CDC merchants’ did not have to complete any forms, training or software installation to accept payments from CDC participants. Therefore, the abolishment of CDC does not reduce the regulatory burden.

Costs

- **One off costs for new merchants:** There will be one off costs for new merchants required to support participants through the IM program. It is expected in year 2 there will be 797 new merchants requiring 1.5 hours for 1 staff member at the rate of the \$79.63 per hour. From year 3 onwards is expected only 10 new merchants per year requiring 1.5 hours for 1 staff member at the rate of the \$79.63 per hour. Therefore, the total regulatory cost is \$104,753 over 10 years.
- **Ongoing costs:** The cost of continuing to train staff will be the same as the cost under the CDC and IM. Therefore, there is no additional ongoing training cost for existing merchants. For new merchants, they will have to spend around 1 hour per year to do compliance activities and ongoing maintenance.

Quantifiable regulatory impacts

	yr 1	yr 2	yr 3	yr 4	yr 5	yr 6	yr 7	yr 8	yr 9	yr 10	total
One off costs for new merchants	\$0	\$95,198	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$1,194	\$104,753
Ongoing Training for staff	\$0	\$15,866	\$15,866	\$15,866	\$15,866	\$15,866	\$15,866	\$15,866	\$15,866	\$15,866	\$142,796
Annual Compliance	\$0	\$63,465	\$63,465	\$63,465	\$63,465	\$63,465	\$63,465	\$63,465	\$63,465	\$63,465	\$571,186
Total	\$0	\$174,529	\$2,190	\$2,190	\$2,190	\$2,190	\$2,190	\$2,190	\$2,190	\$2,190	\$818,736

One off costs for new merchants

			All				total
			population	no staff	Time	cost	
Year 1	0	0	0	0	0	0	\$0
Year 2	0	0	797	1	1.5	79.63	\$95,198
Year 3	0	0	10	1	1.5	79.63	\$1,194
Year 4	0	0	10	1	1.5	79.63	\$1,194
Year 5	0	0	10	1	1.5	79.63	\$1,194
Year 6	0	0	10	1	1.5	79.63	\$1,194
Year 7	0	0	10	1	1.5	79.63	\$1,194
Year 8	0	0	10	1	1.5	79.63	\$1,194
Year 9	0	0	10	1	1.5	79.63	\$1,194
Year 10	0	0	10	1	1.5	79.63	\$1,194
						Total	\$104,753

³³ Future of Employment and Skills Research Centre, University of Adelaide, 2021, Evaluation of the Cashless Debit Card in Ceduna, East Kimberley and the Goldfields Regions: Consolidated Report, https://www.dss.gov.au/sites/default/files/documents/02_2021/fac_evaluation-cdc-ceduna-east-kimberley-and-goldfields-region-consolidated-report_012021.pdf

Ongoing Training for staff

			All				total
			population	no staff	Time	cost	
Year 1	0	0	0	0	0	0	\$0
Year 2	0	0	797	1	0.25	79.63	\$15,866
Year 3	0	0	797	1	0.25	79.63	\$15,866
Year 4	0	0	797	1	0.25	79.63	\$15,866
Year 5	0	0	797	1	0.25	79.63	\$15,866
Year 6	0	0	797	1	0.25	79.63	\$15,866
Year 7	0	0	797	1	0.25	79.63	\$15,866
Year 8	0	0	797	1	0.25	79.63	\$15,866
Year 9	0	0	797	1	0.25	79.63	\$15,866
Year 10	0	0	797	1	0.25	79.63	\$15,866
						Total	\$142,796

Annual Compliance

			All				total
			population	no staff	Time	cost	
Year 1	0	0	0	0	0	0	\$0
Year 2	0	0	797	2	0.5	79.63	\$63,465
Year 3	0	0	797	2	0.5	79.63	\$63,465
Year 4	0	0	797	2	0.5	79.63	\$63,465
Year 5	0	0	797	2	0.5	79.63	\$63,465
Year 6	0	0	797	2	0.5	79.63	\$63,465
Year 7	0	0	797	2	0.5	79.63	\$63,465
Year 8	0	0	797	2	0.5	79.63	\$63,465
Year 9	0	0	797	2	0.5	79.63	\$63,465
Year 10	0	0	797	2	0.5	79.63	\$63,465
						Total	\$571,186

Net benefit

Most mixed merchants will face limited additional costs as a result of enabling contemporary card users to purchase goods, but would receive some increased revenue. Therefore, on balance there is a net benefit to them from the changed program. There will no additional costs for the larger corporates who would continue to maintain their existing systems.

Merchants that were on IM BasicsCard technology and now progress to the new contemporary card will have reduced compliance and engagement costs with the Department.

Merchants new to the program will have new costs. Some of these businesses may be eligible for support to join the program. This means on balance there is likely to be a slight net benefit for these merchants.

There are no regulatory impact on general merchants as they will continue to operate normally. There may be some moderate changes in consumption patterns benefitting some merchants due to increased demand for restricted goods. Overall, the impacts on general merchants in most locations are likely to be minimal.

4.2.2.2.4 Summary – impacts on merchants

The contemporary card system will be easy to use for the majority of merchants who will not need to change their practices. Some merchants will need to install PLB or agree to not sell restricted items to participants. Former IM merchants will benefit from moving from the more complicated BasicsCard system to the contemporary card which is similar to other debit cards. It will have a limited impact on former CDC merchants and those merchants that were already blocked as there will be no changes in their day-to-day operations. Given the small numbers of participants, the competition and economic impacts on merchants are also likely to be minimal.

Total regulatory cost for merchants

Merchants	Cost	Impact
Abolishing CDC and IM requirements for merchants	-\$18,015,160	save
Movement to current IM Card technology	Nil	-
Merchants onboarding for contemporary card	\$818,736	cost
Total (\$)	-\$17,196,424	save

4.2.2.3 Government

Benefits

- There will be a **decrease in the administrative cost** to the Government of not having to deliver the CDC program and compulsory measures of the IM program therefore a decrease in total program expenditure.
- State and territory governments will be able to refer people to the IM program in certain circumstances as a way of supporting welfare recipients residing in their jurisdictions.

Cost

- It costs more to deliver IM than CDC per capita however, there is a greater level of service delivery support provided to participants in IM than CDC.
- There will be an upfront investment of Government funding to ensure the staged transition is implemented and CDC participants are transitioned off the program by the CDC legislative sunset date of 31 December 2022. [sentence deleted]
- While the evidence does not support a positive effect from the programs, there may be an increase in demand for government run services such as hospitals or policing due to the impact of an increase in social harm within the communities.

Annual cost to state and territory-run authorities to refer individuals to IM

	State/territory referrals to IM (60 total referrals)
Training/briefing for authorities	<i>1 hrs x 20 agencies x 1 staff member x \$79.63/hr = \$1,592 (1 year cost)</i> Total over 10 years (costing only required from year 2) = \$14,333
Assessment	\$0
Referral	<i>\$1hr x 20 agencies x 3 referrals each x \$79.63/hr = \$4,777.80</i> Total over 10 years (costing only required from year 2) = \$43,000.20
Total over 10 years (\$)	\$57,334

Net benefit

Services Australia will provide information to individuals to assist them to exit the CDC and volunteer for IM if they choose to do so. The Government will save on the administrative costs of running the CDC program which has already cost over \$180.7 million since 2016. As a result, there will be a net benefit to the government, however, the net financial impact is yet to be determined.

4.2.2.4 Community Organisations

Benefits

- There will be less burden on community groups to explain the program to participants.
- The support services will also provide opportunity for local organisations to access funding to provide services such as providing employment opportunities and building the capacity of these organisations for growth.
- The community led model promotes self-determined decision making at a local level. The IM program could be used to support local assessed referral based IM arrangements.

Cost

- The Department is unable to quantify this cost for increased demands on health or related services given the minimal evidence on social harm available from the evaluations. Support services will act to reduce any such impacts if they emerge.
- There will be a small regulatory cost for each community led IM model.

Cost to community organisations

This table sets out the cost to general community organisations for IM program. These include activities such as having factsheets available in community locations such as medical services.

Cost to general community organisations	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	TOTAL
TOTAL (\$)	\$344	\$344	\$344	\$344	\$344	\$344	\$344	\$344	\$344	\$344	\$3,440

This table sets out the cost to community organisations for IM program costs.

Activity	Community led model*
Training/briefing for community led model	<p><i>1hr x 2 community led organisations x 1 staff member x \$79.63/hr = \$159.26 (3 year onwards cost)</i></p> <p>Total over 10 years = \$1,274.08</p>
Advise Services Australia on participants to engage in IM	<p><i>0.5hr x 1 community led organisations x 30 participants (Cape York) x \$79.63/hr = \$1,194.45 (year 2)</i></p> <p><i>0.5hr x 2 community led organisations x 1,370 participants (1 x Cape York model plus 1 x TBA the location community led model) x \$79.63/hr = \$109,093 (year 3)</i></p> <p><i>0.5hr x 2 community led organisations x 231 participants x \$79.63/hr = \$18,395 (per year from year 4 to 10)</i></p> <p>Total over 10 years = \$239,049</p>
Total over 10 years (\$)	\$240,323

* Note any additional community led models would commence from 2023-24 financial year onwards.

Net benefit

The overall direct role of community organisations in the CDC program may decrease as people exit the CDC program. However, services in the community may see a slight increase initially but with the additional support services provided as part of Option 2 and once transition is completed, the impact is expected to be negligible. There may be a regulatory cost for community led IM referral. However, as the community has volunteered to go on the IM program it is expected that the benefits of a community designed and referral base outweighs the small regulatory cost.

4.2.3 Accessing Support Services

Continuation of support services demonstrates the Government's commitment to support communities and individuals during the abolition of the CDC and compulsory IM. Support services will continue to reduce social harm and strengthen community stability – responding to community need. The proposed place-based and co-designed support services will strengthen engagement with First Nations people, consistent with Closing the Gap priority reforms.

The aim of these support services is to respond to the needs and voice of the communities to address the social and economic disadvantage that exists in communities where the CDC operates and in IM location in the NT. It will also demonstrate the Government is investing in practical solutions for these communities, and help maintain relationships and trust with local stakeholders who have publicly supported the former Government's CDC program. IM recipients in the NT will be able to access services under the second element of this proposal.

Benefits

- **Increased funding into the community** – providers increase funding to services provider located in communities which in turn provides greater services and more job opportunities in these areas.
- **Strengthen participants' ability to determine how and when they spend their money** through targeting supports that will improve participant's financial management skills. Participants will have the opportunity to upskill (digitally and financially) to incentivise saving, facilitate better informed decisions, including whether to opt into voluntary IM. This can result in increased financial stability through better budgeting and financial management.
- **Improve the social wellbeing of communities** through targeting supports that will improve social cohesion through community-led initiatives such as youth programs, community buses, local community night patrols, drug and alcohol support and parenting programs.
- **Improved Service provision through the creation of an evidence base.** The continuation of support services will serve to provide an ongoing data source and evidence base on the effectiveness of such services and the utility of the co-design approach.

Cost

- **Data collection may place an extra burden of service providers.** The Department's Administrative, data collection and reporting requirements may place added burden on service providers.
- **Operational planning impacted by Short-term funding.** It is the intention to provide a short-term grant round to allow co-design to occur to inform future funding rounds. By only extending grants for a short period, this may impact operational planning and effect services delivery and outcomes for their clients.
- **Change of service providers as a result of grant outcomes.** Any new providers may require some time to build trust within communities. Whereas current providers already have developed trust/ relationships.

Net Benefits

There is an expected net benefit for all key stakeholder groups;

- For Individuals and Communities – will be supported and afforded a choice in how they manage their money. New support services (i.e to tackle social harms, including the misuse of AOD and DV) will support individuals and families and keep communities safe. This in turn, will strengthen community stability.
- For Government – over time there will be improvement in the impact of support services and drive better social and employment outcomes for communities.
- For services providers – there will be an increase in available funding to support the provision of services that reduce self-harm and social and emotional harm, AOD use, violence and gambling, improved money management, digital literacy and improved community safety.

4.2.3.1 First element costs

The continuation of currently funded services, acting as an immediate response as CDC participants start to transition off the card from September 2022 funding for additional services immediately following the abolition of the CDC.

4.2.3.1.1 Participants

There will be approximately 42,000 former CDC and former and ongoing IM participants who will be eligible for support services.

The uptake of support services by former CDC participants and IM participants will vary depending on the regions and the level of need by individuals, noting at this stage, it is also difficult to quantify and there are too many variables to be able to accurately cost the regulatory impact. Costing the regulatory impact is also made difficult by the fact that those that need help may not identify themselves. For example, according to the Australian Institute of Health and Welfare, 54 per cent of people with mental illness do not access any treatment³⁴.

Therefore, the regulatory cost is too uncertain to be quantified.

4.2.3.1.2 Businesses

In year 1 (2022-23):

- 33 organisations in receipt of funding for the provision of current support services programs will have their agreements extended for an additional 12 months.

Extension of Support Services Grants

	cohort	no of staff	time in hours	cost per hour	total
Year 1	33	2	0.5	\$79.63	\$2,628

4.2.3.1.3 Government

There are no government cost

4.2.3.1.4 Community Organisations

There are no community organisation cost.

4.2.3.2 Second element costs

This is the longer term approach which is aligned with the priority reforms under the National Agreement on Closing the Gap. This includes delivery of co-designed initiatives with joint decision making in each former CDC region. This work would

³⁴ Australian Institute of Health and Welfare. (2014). Australia's Health 2014. AIHW: Canberra. <https://www.aihw.gov.au/reports/australias-health/australias-health-2014/data> accessed on 19 August 2022

leverage established community leadership structures to both inform and promote the development of community priorities and co-designed grant activities.

In year 2 (2023-24):

- Test the market for co-design providers/facilitators with a focus on organisations who are Indigenous owned or controlled or have experience with working with indigenous communities. It is assumed there will be about 5 organisations who may provide a proposal.
- Co-design activities will cover the 6 former CDC locations and 10 locations in the NT taking the total number of locations to 16.
- For costings purposes it is assumed that at least 3 meetings in each location of 3 hours in duration.
- Each location will include the following numbers of participants in the co-design activities:
 - 10 former participants
 - 5 local businesses
 - 5 state and territory organisations
 - 10 community organisations (including Land Councils)
- It is assumed that co-design activities will continue in years 3 and 4 (2024-25 and 2025-26) to provide further guidance and feedback on the delivery of services and whether the intended outcomes are evident in the community.
- Based on the outcomes of the co-design activities new guidance will be developed to support an approach to market for new support services.
- It is assumed there will be a greater number of providers seeking to provide services and it is anticipated that there will be approximately 60 organisations that will submit a response to an approach to market of which it is assumed around 55 will be successful in becoming a provider of support services.

4.2.3.2.1 Participants

This includes the regulatory cost of former CDC and IM participants being involved in local co-design activities.

Co-design of Support Services - Individual participation

						Total
	no of locations	no of meetings	no of ex participants	no of hours	cost per hour	
Year 1	0	0	0		0	\$0
Year 2	16	3	10	3	36	\$51,840
Year 3	16	3	10	3	36	\$51,840
Year 4	16	3	10	3	36	\$51,840
Year 5	0	0			0	\$0
Year 6	0	0			0	\$0
Year 7	0	0			0	\$0
Year 8	0	0			0	\$0
Year 9	0	0			0	\$0
Year 10	0	0			0	\$0
					total	\$155,520

4.2.3.3.2 Businesses

Testing of the market for co-design providers

This will take place with a focus on organisations who are Indigenous owned or controlled or have experience with working with indigenous communities – it is assumed there will be about 5 organisations who may provide a proposal. This includes the regulatory costs of testing the market for providers to deliver co-design activities across all locations. It is assumed that co-design activities will continue in years 3 and 4 (2024-25 and 2025-26) to provide further guidance and feedback on the delivery of services and whether the intended outcomes are evident in the community. Costed regulatory activities include;

- Testing the market for co-design providers

- Co-design provider signs agreement
- Final Report received from Co-design provider

Testing the market for co-design providers

		no of businesses	time in hours	cost per hour	Total
Year 1		5	1.5	\$79.63	\$597

Co-design provider signs agreement

		no of businesses	time in hours	cost per hour	Total
Year 1		1	1.5	\$79.63	\$119

Final Report received from Co-design provider

		no of businesses	time in hours	cost per hour	Total
Year 1		1	0.17	\$79.63	\$14

Testing the market for co-design providers	\$597
Co-design provider signs agreement	\$119
Final Report received from Co-design provider	\$14
Total	\$730

Co-design of Support Services - local businesses involvement

This includes the regulatory costs for local businesses to be involved in the co-design of support services in their communities.

	no of locations	no of meetings	no of organisations	no of hours	cost per hour	Total
Year 1	0	0	0		0	\$0
Year 2	16	3	5	3	79.63	\$57,334
Year 3	16	3	5	3	79.63	\$57,334
Year 4	16	3	5	3	79.63	\$57,334
Year 5	0	0			0	\$0
Year 6	0	0			0	\$0
Year 7	0	0			0	\$0
Year 8	0	0			0	\$0
Year 9	0	0			0	\$0
Year 10	0	0			0	\$0
					total	\$172,001

Testing the market for additional Support Services

Based on the outcomes of the co-design activities new guidance will be developed to support an approach to market for new support services. It is assumed there will be approximately 60 organisations that will submit a response to an approach to market of which it is assumed around 55 will be successful in becoming a provider of support services. The regulatory cost of testing the market for additional Support Services includes;

- Testing the market for additional Support Services
- Providers of Support Services sign agreements
- Providers of Support Services do performance reporting

Testing the market for additional Support Services

					total
	no of businesses	no of staff	time in hours	cost per hour	
Year 1					\$0
Year 2					\$0
Year 3	60	2	2	\$79.63	\$9,556
Year 4	0		0	0	\$0
Year 5	0		0	0	\$0
Year 6	0		0	0	\$0
Year 7	0		0	0	\$0
Year 8	0		0	0	\$0
Year 9	0		0	0	\$0
Year 10	0		0	0	\$0
				total	\$9,556

Providers of Support services sign agreements

					total
	no of businesses	number of staff	time in hours	cost per hour	
Year 1	0		0		\$0
Year 2	0		0		\$0
Year 3	55	2	0.5	\$79.63	\$2,190
Year 4	0		0	0	\$0
Year 5	0		0	0	\$0
Year 6	0		0	0	\$0
Year 7	0		0	0	\$0
Year 8	0		0	0	\$0
Year 9	0		0	0	\$0
Year 10	0		0	0	\$0
				total	\$2,190

Providers of Support services do performance reporting

					total
	no of businesses	number of staff	time in hours	cost per hour	
Year 1	0		0		\$0
Year 2	0		0		\$0
Year 3	55	2	2	\$79.63	\$8,759
Year 4	55	2	2	\$79.63	\$8,759
Year 5	55	2	2	\$79.63	\$8,759
Year 6	0		0	0	\$0
Year 7	0		0	0	\$0
Year 8	0		0	0	\$0
Year 9	0		0	0	\$0
Year 10	0		0	0	\$0
				total	\$26,278

Testing the market for new Support Services	\$9,556
Providers of Support services sign agreements	\$2,190
Providers of Support services do performance reporting	\$26,278
Total	\$38,023

Total Business regulatory cost: \$213,382

4.2.3.4.3 Government

This includes the regulatory cost of government entities such as the police, hospital administrator and school administrators to participant in local co-design activities.

Co-design of Support Services - state and territory involvement

	no of locations	no of meetings	no of organisations	no of hours	cost per hour	total
Year 1	0	0	0		0	\$0
Year 2	16	3	5	3	79.63	\$57,334
Year 3	16	3	5	3	79.63	\$57,334
Year 4	16	3	5	3	79.63	\$57,334
Year 5	0	0			0	\$0
Year 6	0	0			0	\$0
Year 7	0	0			0	\$0
Year 8	0	0			0	\$0
Year 9	0	0			0	\$0
Year 10	0	0			0	\$0
					total	\$172,001

4.2.3.5.4 Community Organisations

This includes the regulatory cost of community organisations to participant in local co-design activities.

Co-design of Support Services -community organisations

	no of locations	no of meetings	no of organisations	no of hours	cost per hour	total
Year 1	0	0	0		0	\$0
Year 2	16	3	10	3	79.63	\$114,667
Year 3	16	3	10	3	79.63	\$114,667
Year 4	16	3	10	3	79.63	\$114,667
Year 5	0	0			0	\$0
Year 6	0	0			0	\$0
Year 7	0	0			0	\$0
Year 8	0	0			0	\$0
Year 9	0	0			0	\$0
Year 10	0	0			0	\$0
					total	\$344,002

4.2.4 Regulatory impacts – benchmark

It is expected that Option 2 will provide a benefit of \$23.3m in saving. Although there will be a short-term regulatory impact increase for CDC participants due to the transition arrangements, this cost is only expected for the first half of 2022-23 financial year. However, the ongoing costs for both individuals and businesses will deliver a save over time when the CDC is abolished.

Abolishing CDC and IM

Change in costs	Business	Community organisations	Individuals	Total change in costs
Total, by sector	-\$17,196,424	\$243,763	-\$5,275,868	-\$22,228,529

Support Services

Change in costs	Business	Community organisations	Individuals	Total change in costs
Total by sector	\$213,382	\$344,002	\$155,520	\$712,904

Total

Change in costs	Business	Community organisations	Individuals	Total change in costs
Total by sector	-\$16,983,042	\$587,765	-\$5,120,348	-\$21,515,625

5. Who did you consult and how did you incorporate their feedback?

Since the inception of the programs, the Department has consulted with a range of audiences, such as community leaders, representative groups, stakeholders and directly with participants. The Department maintains partnerships in current IM and CDC regions to provide a forum to discuss the impact of the programs, the social landscape in the wider community and to resolve issues as they arise from these programs in the relevant regions. The Department has drawn some lessons from these consultations which have been important in understanding and assessing Option 2.

Abolishing the CDC program and reforming IM was a 2022 election commitment for the Government. This commitment was clear that any future solutions moving forward would be developed after consulting with affected communities. To this end, the Minister has conducted consultations focusing on future support for these communities as described in Option 2, especially transition arrangements, support services and the design of voluntary IM.

Consultations have been essential to understand participants' experiences and tailor Option 2 possible impacts on participants and communities. Consultations are also informing changes in policy development of improvements to the function of the contemporary card and how it will be delivered. This will allow the Department and Services Australia to develop transitional and future arrangements informed by an understanding of the support needs of individuals, merchants and communities.

Ongoing consultation will continue to inform the implementation of Option 2. This will allow the Department and Services Australia to develop transitional and future arrangements informed by an understanding of the support needs of individuals, merchants and communities.

5.1 Feedback from the Senate hearing to repeal the cashless debit card and other measures

On 4 August 2022, the Senate referred the Social Security (Administration) Amendment (Repeal of Cashless Debit Card and Other Measures) Bill 2022 to the Community Affairs Legislation Committee for inquiry and report by 31 August 2022.

In total 77 submissions were received by the 10 August 2022. Submissions were received from participants of the CDC program, community organisations, peak advocacy groups, researchers, state government authorities and local government. Overall there was various level of support for the cessation of the CDC program. Commentary has been varied and fell into the following themes:

- Supports abolition of CDC and current Government's commitment
- Not supportive of the cessation of the CDC.
- Support for the cessation of CDC, however reservations about the mandatory transition to IM for NT participants.
- Support for the cessation of CDC, but has reservations about the Bill and future direction of IM.
- Support for providing operationalised IM where it is a community decision, to appropriately assist and address complex and entrenched disadvantage.
- Retention of CDC card technology.

5.2 Current Ministerial engagement with affected communities

The Department has undertaken consultation with those in affected locations including targeted Ministerial visits by the Minister and the Assistant Minister. Senator the Hon Patrick Dodson, Senator the Hon Malarndirri McCarthy, and Ms Marion Scrymgour MP have also participated in consultations. This has included consulting with CDC participants and other local stakeholders about the cessation of the CDC program. Consultations captured a wide range of stakeholders and captured a diversity of perspectives, including CDC participants, senior First Nations leaders, Community Reference Groups, service

providers, local police, health services and local councils. Engagement with communities will continue as part of the implementation of the reforms.

To date, the Minister has held consultations in Ceduna, the East Kimberley, Cape York, the NT and the Goldfields region, while the Assistant Minister for Social Services has held consultations in Bundaberg and Hervey Bay. During these consultations, the Ministers met with key community stakeholders from all levels of government, non-government agencies, and the community including First Nation leaders. Ministerial has visited all CDC sites plus the NT.

Consultations involved understanding what the impacts of the CDC program are and how these are impacting individuals and businesses in the affected regions. It also involves seeking their views on what a suitable process for people to transition off the CDC program needs to include and what supports the community feel are required. In addition, in preparation for further reforms to IM, discussions were held regarding what IM could look like.

There has been consistency in the findings. The Stakeholders have said:

- transition must be managed carefully so that CDC participants are adequately supported.
- the cooperation that has been developed between communities and government is critical for community based services to succeed
- the support services and grants that were provided with the CDC must endure. In many ways these supports have been more important than the card itself.
- Voluntary IM is important to have available for people who would still benefit from that extra support in managing their money.
- enforcement agencies informed that there has been no noticeable improvement in drug or alcohol related crime as a result of the CDC program.
- people have found ways around the restrictions of the card to get cash to purchase drugs and alcohol.
- people in Cape York and the NT have concerns about returning to old technology.

Key themes from the Minister’s consultation can be found in Table 10 below.

Table 9: Summary of key themes from the Minister’s consultation

<i>Theme</i>	<i>Considerations</i>
Voluntary IM Views	The compulsory measure of CDC took away individual agency. A voluntary model of IM is more acceptable.
	Acknowledged that the CDC has provided a level of protection for vulnerable participants, e.g. elderly or disabled. The voluntary option is important so that people have a choice to continue.
Participant Cohorts	Support needs during the transition phase will vary for different cohorts, ranging from highly intensive, intensive to moderate.
	Ongoing needs will require intensive support over an extended period.
	Determining the financial literacy and digital supports required for each cohort will be important consideration. Planning is required on how this is offered and maintained.
	Youth supports such as messaging and support services needs to be tailored for this group.
Messaging / Communications	There needs to be clear and defined messaging about the transitioning off process and it needs to be tailored for the different affected groups.
	The timeframes for transitioning need to be explicitly clear for participants and other stakeholders.

	Tailored messaging needs to be developed that caters to the varied participant groups in different areas e.g. in very remote, remote, or regional areas.
	Contact centres, can be confronting for some participants. Improved interaction with participants is required particularly for highly vulnerable groups.
Support Services	It is imperative that support services are continued and strengthened. There needs to be tailored to the individual needs.
	Financial and digital capabilities of individuals needs to be a strong focus for vulnerable participants.
	The support services have generated the most success with the CDC, not the actual the CDC itself.
	Funded support services need to be with locally based organisations, wherever possible, rather than having out of town services that require commuting, which has resulted in gaps in service delivery.
	There is a need for greater certainty and control with longer term funding arrangements for services.
	Support for education and building numeracy and literacy skills for young people is required.
Social Impacts	AOD appear to be the main driver of behaviours that create social harm. Access has still been readily available even with the introduction of the CDC.
	Elderly and disabled participants are at most risk of financial abuse due to the ease of use of the card, e.g. tap & go capability.
	CDC limits some communities from 'pooling' funds for a community outcome, which is a local decision made by some communities.
	There are circumstances where the cash economy is still essential to people.
Fraud	Experiences of fraud and misuse of the CDC, particularly from taxi services, is a common occurrence. Stricter controls to prevent instances of fraud needs to be built into future design.
	There is a need to build in capability for transferring of funds to others such as family members. There are examples of participants giving their cards to boarding school students when they are away at school, as its easier than having to organise to transfer the money.
Evaluation	It is important to measure the impacts of the CDC removal and transition experience for participants.

5.3 Engagement with Merchants

The current Ministerial consultations focuses on discussions with communities about future policy solutions. However, the Department has been engaging with merchants on the implementation of the programs for a number of years. Feedback has been that the CDC is closer to the systems they have in place for other customers and easier to implement than IM.

Critical to the success of enhancing the technology experience previous consultations have been undertaken to:

- ensure the CDC can operate as much like a standard banking product as possible;
- understand and limit opportunities for circumvention;
- support merchants via automated identification of restricted products; and

- improve the CDC user experience.

Previous consultation has been undertaken with mixed merchant stakeholders and those stakeholders who would assist with implementing technological advancements, such as:

- financial institutions, including banks that provide pin pads to merchants, Point of Sale software providers, and PIN Pad manufacturers;
- large corporate merchants to integrate PLB into their own Point of Sale systems
- merchant networks e.g. franchises; and
- small and medium mixed merchants

Consultations with the financial sector and merchants made sure that the experience for participants using the CDC was no different to anyone else going into any shop and paying using their bank or credit card. Ongoing engagements with banks and merchants ensured that payment systems between the retail outlets, the eftpos machine and the bank were more streamlined for someone using the CDC. PLB technology and the development of the Merchant Portal were products of this constant engagement with banks, merchants and financial sector.

The Department have recently engaged with corporate merchants to discuss the abolition of the CDC and reforming IM. Further consultation will occur with merchants on the updated technology for the BasicsCard. This will include both smaller merchants who operate within the existing IM and CDC sites as well as larger national retailers who could accept the contemporary card across their network.

6. What is the best option from those you have considered?

The recommended option (Option 2) addresses the policy problem best, offers the most net benefit for participants while also reducing the regulatory burden costs in both the short and long-term, and will deliver the best value for money to Government. It was informed by consultation and is consistent with the Government's election commitment to provide more and better individuals choices, including managing their finances and decision on how and where they spend their income support payments.

It will address the policy problem of stigmatisation CDC and IM participants' experience as highlighted in the CDC and IM evaluations and current Ministerial consultations. Abolishing CDC and reforming IM to a voluntary program is a response to the issue of the generalisation faced by program participants who do not have a history of substance misuse or problem gambling.

Likewise, Option 2 aligns with IM evaluations that have noted that participants volunteering for the program experienced a better social and wellbeing outcomes as there is evidence supporting improvement of their ability to manage money, pay for food, rent, mortgage and being able to better provide for their families.

Consultation has informed a number of key elements of option 2:

- Stakeholders have emphasised the need for support services especially those done in consultation with communities. This led to the development of the co-design support services package.
- They also highlighted some of the problems with the current policy that it is too broad and is easy to circumvent. This affirms the government's election commitment to abolish the CDC and reform IM programs.
- Responds to those stakeholders who want an income management alternative through the offer of voluntary IM and support services.
- The need to respond to stakeholder concerns with people going back to the BasicsCard. Option 2 retains a card with similar functionality as the current CDC card.

In contrast to Option 2, Option 1 maintains an ineffective status quo. The continuation of the status quo is not supported by evidence based on findings from multiple CDC and IM evaluations and current consultations. Also it does not offer the level of net benefits as Option 2 does, such as reducing stigma and allowing people to be able to choose to purchase what they want and where they want it. It would continue the current practice of putting on the program who do have drug or alcohol problems.

Further, by removing the two programs the preferred option has a regulatory save of \$21.5m over the 10 years for the Government. In comparison, maintaining both IM and the CDC programs operating unchanged, existing costs across participants, merchants and Government, will stay as is.

Under Option 2, there will be transitional arrangements for participants who wish to volunteer to IM. The focus will also be on a process that ensures participants are supported and any individuals who have significant vulnerabilities are identified and given appropriate levels of support when. This option provides greater autonomy for participants, less regulatory compliance for merchants and enable Government to offer more 'fit for purpose' initiatives for their communities.

6.1 Option 2

Option 2 delivers on the objectives of the change to the CDC and IM programs by:

- complementing the Government's strategic priority to move towards removing restrictions on purchases using welfare payments in both program locations, increasing financial autonomy and reducing some social exclusion experienced by participants, and provides the steps to achieve this
- removes the stigma people experience by being a participant on the program
- provides support for participants transitioning off the CDC program
- provides participants the ability to volunteer for IM giving more autonomy for the choices they make
- updates the technology of the card so that people who volunteer get a modern banking experience; and
- provides value for money to Government.

7. How will you implement and evaluate your chosen option?

7.1 Implementation of Option 2 (preferred option)

7.1.1 Implementation plan

7.1.1.1 Timing

There are several key dates important to the implementation of this option:

- From 1 August 2022, no new participants will be placed onto the CDC program (with the exception of Cape York).
- From the day after the legislation receives Royal Assent to 31 December 2022. Services Australia will exit participants progressively, including moving them to IM if applicable.
- Communication to affected individuals will be provided before, during and after their transition off the CDC program.
- Consultation with communities will continue throughout the 2022-23 financial year.
- New IM arrangements will be put in place, based on community views: and
- The CDC program abolishment is expected to be substantially completed by 31 December 2022.

7.1.1.2 Roles of delivery partners and engagement with stakeholders

Clearly defined roles and responsibilities are critical to successfully implement a new policy, ensuring it can achieve its intended outcomes. The Department will work closely with our implementation partner, Services Australia, as well as communities and state, territory and local governments to manage the transition of program participants.

- **The Department of Social Services** is the policy lead and will play a leadership and coordination role. In addition, the Department will be responsible for program design and enabling legislative changes, communications materials, running Ministerial engagement and community forums, and establishing a grants program for the delivery of the support services. The Department will also be responsible for managing the evaluation of the new program.
- **Services Australia** will be responsible for engaging directly with the participants throughout the transition, including sending communications materials, running the one on one transition sessions, and making referrals to other services. Services Australia will also be responsible for running the 'exit survey' to collect data to support monitoring and evaluation.

Key stakeholders impacted by this plan include participants, community organisations and businesses in the CDC and IM locations. Community organisations will provide information to participants and may also deliver support services. Mixed

merchants will need to know how they will be able to not sell restricted items to participants. State and territory governments will be able to refer people to the new IM program. The Department will engage with them on how they can use the IM program to support people where it is relevant. Stakeholders will continue to be engaged throughout the implementation process through ongoing Ministerial engagement and community forums, and during monitoring and evaluation which will be detailed further below.

7.1.1.2.1 Challenges

There will be a number of challenges in implementing the new policy given the number of participants, their locations and the nature of the policy. These challenges are detailed in answer to RIS Question 2. The Department's approach to address these challenges and mitigate any risks to the implementation of the new policy changes are set out below.

- **Time constraints and limited government resources** – the intention is to transition all CDC participant off the card between Royal assent and the 31 December 2022. The legislation allows the Minister to set a repeal date of for the CDC legislation 6 months after Royal Assent if additional transitional time is required, but the expectation is that all participants will be transitioned by the end of the year. The Government will take a staged approach to ensure there are adequate resources to support participants to understand the changes, to exit the CDC transition to voluntary IM arrangements, and access support services. Services Australia have also drawn on similar experiences to estimate the number of staff needed on the ground to deliver this transition in a timely manner.
- **Limited uptake of support services**– participants will have access to educational materials as well as one on one advice to explain the services that are on offer. In addition, the Department will work closely with the community in developing future support services to ensure these are the kinds of services that the community wants and will utilise if funded.
- **Difficulties engaging with stakeholders** – the Department has engaged extensively with stakeholders in developing this policy and related support. The Government will work hard to ensure that stakeholders are listened to, and their feedback is reflected in the program. This will demonstrate the utility of continuing to engage in these conversations with Government.
- **Reaching participants - COVID-19 and participants outside CDC and IM locations** – over the phone interviews will be available to CDC participants so they are supported if face-to-face support cannot be accessed or is not suitable.

7.1.1.2.2 Risks

In addition to the challenges above, the department has considered risks to the successful delivery of the new program and how these risks can be mitigated. Table 11 provides an outline of the risks associated with Option 2.

Table 10: Risk Table

Risk	Likelihood	Impact	Mitigation
Unable to transition all participants off the CDC program by 31 December 2022	low	medium	<ol style="list-style-type: none"> Services Australia will work with the Department to inform local service networks of changes. Provide guidance on where to receive support. Brief service partners, Indue call staff DSS community engagement teams and NIAA on opt out process and support Ensure identify early those who are at risk and may need extra support for example those with no: <ul style="list-style-type: none"> fixed address main bank account
ICT changes cannot be delivered within the timeframe	low	medium	<ol style="list-style-type: none"> Ensure there are adequate resources that are agile and flexible to meet demand and need. There is cross department support with DSS and NIAA staff working alongside Services Australia.
Potential increase in adverse social outcomes such as alcohol and illicit drug misuse.	low	high	<ol style="list-style-type: none"> Effective transitional arrangements, including the transition interview allowing referral/s to support (as needed) and the targeted communication messaging. Continuation of CDC support services and the option for people to participate in IM. Provide support services identified in partnership with local communities, including First Nations leaders.

7.1.1.2.3 Transition arrangements

As outlined in response to RIS question 3, transition arrangements have been developed to support all CDC and IM participants, whether they leave the programs or move to voluntary IM.

Important aspects of these transition arrangements that will enable the successful implementation of the new program include:

- extensive communications to participants to explain the changes.
- one on one guidance to support participants to transition, provided by Services Australia who is experienced in managing changes to people’s welfare arrangements.
- the option for all former and continuing CDC and IM participants to be referred to existing programs and new support services, ensuring that if they need support with employment, substance issues, domestic violence or other concerns they are able to access support.

7.1.2 Monitoring and evaluation

Implementation of the transition off the CDC and reform of IM will be closely monitored and evaluated. To monitor activities, the Department and Services Australia will generate real-time reports and undertake analysis using social security payment data and other administrative data. In each region, data will be used to inform community engagement, deployment of transition support, and coordination with local service providers.

Progress of transitions off the CDC program will be tracked at the national and local levels, to ensure that all participants are transitioned in advance of the program end dates. As well as tracking the progress of implementation, transition monitoring

will focus on potential unintended impacts. In addition, Services Australia will conduct a Post Implementation Review (PIR), including capturing lessons learned.

An evaluation strategy will be developed, in partnership with community, to analyse implementation and outcomes, as well as impact of the extended or new support services. The Department will consult with affected communities to ensure that the approach and methods are fit for purpose. This may include co-design evaluation with communities and identifying measures the communities see as important. Data and evaluation findings will be shared with communities, supporting the Government's National Agreement on Closing the Gap priority reforms.

Analysis and evaluation activities will aim to understand the experience of participants coming off the CDC program. This will include collecting data on CDC participants' experiences transitioning off the CDC and participants' circumstances, such as financial, social and health status.

Measuring the impact of discrete social policies and programs is complex. Monitoring, analysis and evaluation will use mixed methods, with both qualitative and quantitative data. This will include data analytics using a Department data asset. The Department will also engage with state and territory agencies and other service providers about data sharing and the possibility of accessing data related to social outcomes such as financial wellbeing and community safety.

Attachment A

Income Management

On 8 August 2006, the NT Government established a Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse to investigate reports of child sexual abuse in the NT and suggest possible solutions. The resulting report, *Little Children Are Sacred*, was published on 30 April 2007³⁵. The report contained 97 recommendations to the NT Chief Minister, including designating the issue of child protection as one of urgent national significance by both the Australian and NT governments, and improving policies around:

- education and school attendance
- coordination with Family and Child Services
- alcohol management and reduction of alcohol-related harm
- illicit substance abuse
- employment opportunities
- housing, in particular overcrowding
- pornography and
- gambling.

In response to the findings and recommendations from *Little Children are Sacred*, the then Commonwealth Government introduced IM in 2007 as part of the Northern Territory Emergency Response (NTER), authorised under the *Northern Territory National Emergency Response Act 2007* (the NTER Act). IM was one of a raft of policies across the areas of service coordination, law and order, family support, employment, health, education, and housing and land reform.

The NTER Act facilitated IM for income support payment recipients in 73 prescribed Aboriginal communities and town camps, with 50 per cent of a person's income support payment income managed and reserved for priority needs to support that person and their family, in particular any children.

A review titled the *Northern Territory Emergency Response: One Year On*, reported in the first year of Income Management being introduced into the Northern Territory, more than 90 per cent of income managed funds had been spent on priority. At this point in time there were more than 13,300 participants in the NT.³⁶

The NTER board was appointed to conduct an independent review of the NTER measures which was released on 13 October 2008. The Board found the benefits of Income Management were increasingly being experienced by participants. The then Government formally responded to the review in May 2009 with the release of *Future directions for the Northern Territory Emergency Response: a discussion paper*.

The discussion paper set out a number of proposals of how NTER measures should be continued and community views were being sought when evaluation was being completed. The then Government's view in the paper stated that IM should be continued as it was helping children, improving families' financial security and community safety by minimising the amount of money available to purchase alcohol and gambling.

³⁵ Northern Territory Government, *Little Children Are Sacred*, http://www.inquirysaac.nt.gov.au/pdf/bipacsa_final_report.pdf

³⁶ Australian Government, *Northern Territory Emergency Response: One Year On*, https://www.dss.gov.au/sites/default/files/documents/05_2012/nter_review.pdf

Table 1: Income Management measures

2008 – 2009	
<p><u>Child Protection</u></p> <p>Individuals referred by child protection caseworker if that caseworker believes a child in their care is at risk of neglect.</p> <p>70-30 payment split.</p> <p><u>Voluntary</u></p> <p>Individuals volunteer through the Department.</p> <p>50-50 payment split.</p>	<p>Introduced Child Protection and voluntary IM measures to Cannington, in Perth, and the Kimberley region, Western Australia, in response to the Western Australian State Coroner’s report into the deaths of 22 people from the Kimberley region.</p> <p>Expanded IM to the remainder of metropolitan Perth.</p>
<p><u>Cape York</u></p> <p>Individuals referred by the FRC if the individual is failing to uphold positive community norms.</p> <p>60-40, 75-25 or 90-10 payment split, at discretion of FRC.</p>	<p>Introduced IM to the Cape York, Queensland, communities of Aurukun, Coen, Hope Vale and Mossman Gorge, as part of the Cape York Welfare Reform package.</p>
2010	
<p><u>Child Protection, Voluntary</u></p> <p><u>Disengaged Youth</u></p> <p>Individuals, aged 15 to 24 years old, are placed onto this measure if they have received a welfare payment for more than 13 out of the last 26 weeks.</p> <p>50-50 payment split.</p> <p><u>Long-term Welfare Payment Recipient</u></p> <p>Individuals, aged 25 years and above, but below Age Pension age, are placed onto this measure if have they received a welfare payment for more than 52 of the last 104 weeks.</p> <p>50-50 payment split.</p> <p><u>Vulnerable Welfare Payment Recipient</u></p> <p>Individuals referred by a Centrelink social worker.</p> <p>50-50 payment split.</p>	<p>Introduced New IM, which repealed the compulsory model that applied to all welfare payment recipients in the NT and introduced the following measures:</p> <ul style="list-style-type: none"> • Disengaged Youth • Long-term Welfare Payment Recipient • Vulnerable Welfare Payment Recipient • Child Protection and • Voluntary.
2011 – 2012	
<p><u>Place-Based IM</u></p> <p>Child Protection, Voluntary and Vulnerable Welfare Payment Recipient.</p>	<p>Introduced Place-Based IM to five Local Government Areas (LGA), chosen due to high unemployment rates and an overreliance on income support payments:</p> <ul style="list-style-type: none"> • Playford, South Australia • Bankstown, New South Wales

	<ul style="list-style-type: none"> • Logan, Queensland • Rockhampton, Queensland and • Greater Shepparton, Victoria. <p>Expanded Place-Based IM to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, South Australia, at the community's request.</p>
<p><u>Supporting People at Risk</u></p> <p>Complementing the Banned Drinkers' Register, individuals are referred by a state or territory statutory body.</p> <p>70-30 payment split.</p>	<p>Introduced the Supporting People at Risk measure to the NT and authorised the Northern Territory Alcohol Mandatory Treatment Tribunal as the referring body.</p>
2013	
Place-Based IM	Expanded Place-Based Income Management to Laverton and the Ngaanyatjarra (Ng) Lands in Western Australia, following community consultations.
2014 – 2015	
Place-Based IM	Expanded to Ceduna after multiple requests from the mayor and other local peak bodies.
Child Protection and Voluntary	Introduced to the Greater Adelaide region following a recommendation from the South Australian State Coroner's inquest into the death of Chloe Lee Valentine.

The different Income Management measures have different payment splits, with anywhere from 50 to 90 per cent of a participant's income support payment being placed on their BasicsCard. The multiple payment splits are a result of policy targeting of the separate measures and have been informed by community consultation. Continuing to implement the eight Income Management measures with five payment splits contributes to the costliness and complexity of the program.

Attachment B

Cashless Debit Card (CDC)

History of CDC

In 2014 The Forrest Review: Creating Parity was published which made 27 recommendations around Indigenous education, welfare reform, housing and training and employment opportunities.³⁷ The Forrest Review noted that while IM had been successful in helping people stabilise their financial circumstances and protecting vulnerable people from harm, it was becoming too complex and costly to sustain. A recommendation in the report was to replace IM with a Healthy Welfare Card.

The then Commonwealth Government accepted the recommendations of the Forrest Review around improving IM.

The Review identified the challenges of ensuring Australia's welfare system was used to build healthy lifestyles and support people make the best choices for themselves and their families – particularly their children.

A lack of financial understanding was identified as a key contributor to ongoing poverty and exclusion from economic participation. The Review also identified that the use of welfare funds on alcohol or gambling can further exacerbate problems and directly lead to social harm and poor community outcomes.

Table 2: Summary of consultation in CDC sites and the Northern Territory and Cape York

Location	Consultation Dates	Number	Who	Format
Ceduna and surrounds, SA	April 2015 – March 2016	Approximately 300 consultation sessions held, over 1,000 people consulted.	Indigenous leaders (incl. Aboriginal corporations), local government, service providers, state government, local merchants and the general public.	Face to face meetings (round table or one on one meetings), teleconference.
East Kimberley, WA	April 2015 – September 2016	110 consultation sessions.	Community members, Indigenous leaders, service providers, police, and local and state government agencies.	Face to face meetings (round table or one on one meetings), teleconference.
Goldfields region, WA	May 2017 – September 2017	Over 270 consultation sessions.	Community members (church leaders, business owners, general public), service providers (health, family & child support and financial counselling), business sector (Chamber of Commerce & local merchants), community sector, local government, and other Commonwealth Government agencies.	Formal and informal community information sessions, one on one meetings and written consultation.

³⁷ The Minderoo Foundation, *The Forrest Review: Creating Parity*, <https://cdn.minderoo.com.au/content/uploads/2019/02/05183022/3838-Forrest-Review-Update-Full-Report-Complete-PDF-PRO1-p.pdf>

Location	Consultation Dates	Number	Who	Format
Bundaberg and Hervey Bay, QLD	May 2017 – December 2017	220 consultation sessions prior to trial establishment.	Community members, service providers, all levels of government, emergency relief and housing services.	One on one and round table meetings.
Northern Territory and Cape York, QLD	October 2019 – March 2020	83 information sessions to over 70 communities, engaged nearly 3,500 community members and met with over 120 stakeholders and local organisations.	Land Councils and other Aboriginal corporations, local providers and councils, community groups, police, state and territory government departments.	One on one meetings, round table, large and small community information sessions.

To address the policy problem identified, the Department undertook consultation with representatives from business and industry, the community sector, community leaders, and all levels of government on the issue. These consultations resulted in the development of the CDC, which aligned with community and industry expectations and capabilities.

Ongoing consultation on the CDC

The card provider, engages local partners to assist participants with practical enquiries and support, such as card activations, online account set up, paying bills and arranging housing and other transfer limits.

Community panels were also established in Ceduna, Kununurra and Wyndham so that CDC participants could apply to reduce the percentage of their income support payment placed onto the card and thus have greater access to cash.

The Department worked closely with the community leaders to develop the guidelines and membership of the panels, in line with each community's identified objectives and agreed-upon social norms. The community panel model allows community leaders to be involved in the delivery of the program, in the same manner as the models of local partners, consultation and co-design.

Stakeholders

Identifying and approaching appropriate stakeholders is essential to a successful consultation process with the CDC. Local departmental staff and other government agencies with a presence in the location have provided information on local politics, key stakeholders, previous government engagement and current government programs. This information will enable departmental staff to identify local leaders and other key stakeholders to be consulted.

The Department engaged Indigenous Liaison Officers to guide a consultation process in a location with a high Indigenous population.

Attachment C

Summary of legislation related to the CDC and IM

Six deferral instruments

IM legislative instruments		Income Management Impacted State/Territory & Measures
1	Social Security (Administration) (Declared child protection State – New South Wales, Queensland, South Australia and Victoria) Determination 2012	New South Wales Queensland South Australia Victoria <ul style="list-style-type: none"> Child Protection Measure
2	Social Security (Administration) (Specified income management Territory – Northern Territory) Specification 2012	Northern Territory <ul style="list-style-type: none"> Disengaged Youth Long-term Welfare Payment Recipient
3	Social Security (Administration) (Recognised State or Territory – Northern Territory) Determination 2012	Northern Territory <ul style="list-style-type: none"> Supporting People at Risk
4	Social Security (Administration) (Declared voluntary income management areas – New South Wales, Queensland, South Australia and Victoria) Determination 2012	New South Wales (Bankstown) Queensland (Logan, Livingstone & Rockhampton) South Australia (Greater Adelaide, Playford & APY Lands) Victoria (Greater Shepparton) <ul style="list-style-type: none"> Voluntary Measure
5	Social Security (Administration) (Declared income management area – Anangu Pitjantjatjara Yankunytjatjara lands) Determination 2012	Anangu Pitjantjatjara Yankunytjatjara (APY) lands <ul style="list-style-type: none"> Vulnerable Welfare Payment Recipient Vulnerable Welfare Payment Recipient – Youth Voluntary Measure
6	Social Security (Administration) (Vulnerable income management areas) Specification 2012	Northern Territory New South Wales (Bankstown) Queensland (Logan, Livingstone & Rockhampton) South Australia (Greater Adelaide, Playford & APY Lands) Victoria (Greater Shepparton) <ul style="list-style-type: none"> Vulnerable Welfare Payment Recipient Vulnerable Welfare Payment Recipient – Youth

Amend 4 instruments

Legislative Instrument	Impact
Social Security (Administration) Declared income management areas — Ngaanyatjarra Lands and Laverton) Determination 2013	This instrument will be amended to remove the compulsory Vulnerable Welfare Payment Recipient (VWPR) IM measure and maintain voluntary IM in Laverton.
Social Security (Administration) (Declared income management areas — Ceduna and Surrounding Region) Determination 2014	This instrument will be amended to remove the compulsory VWPR IM measure and maintain voluntary IM in Ceduna.
Social Security (Administration) (Declared voluntary income management areas — Western Australia) Determination 2022	This instrument will be amended to include Goldfields (not including Laverton) and East Kimberley as voluntary IM areas. Laverton, which is within the Goldfields area, is already a voluntary IM area under the Social Security (Administration) Declared income management areas — Ngaanyatjarra Lands and Laverton) Determination 2013.
Social Security (Administration) (Declared voluntary income management areas — New South Wales, Queensland, South Australia and Victoria) Determination 2012	This instrument will be amended to include Bundaberg and Hervey Bay and Cape York as voluntary IM areas.

Amend two Instruments

- Social Security (Administration) (Declared voluntary income management areas—Ceduna and Surrounding Region) Determination 2014 (Ceduna Determination)
- Social Security (Administration) (Declared voluntary income management areas—Ngaanyatjarra Lands and Laverton) Determination 2013 (Laverton Determination).

Attachment D

Support services summary managed by the CDC area of the Department

Location	Initiative	Organisation
East Kimberley	Assistance for people severely impacted by Mental Illness - A Better Life (ABLE)	Boab Health Services Pty Ltd
		Ord Valley Aboriginal Health Service Aboriginal Corporation
		Ngnowar-Aerwah Aboriginal Corporation
		Waringarri Arts Aboriginal Corporation
		Wyndham Early Learning Activity Centre (WELA) Incorporated
		Ngnowar-Aerwah Aboriginal Corporation
	National Plan to Reduce Violence against Women and their Children	Joongari House \ Wyndham Family Support Incorporated
		Kununurra Waringarri Aboriginal Corporation
	Strong and Resilient Communities - Cashless Debit Card Support Services	Wunan Foundation Inc.
		Kununurra Waringarri Aboriginal Corporation
East Kimberley Job Pathways Pty Ltd Cocus Way		
Bundaberg and Harvey Bay	Inclusive Communities Grants	Hervey Bay Neighbourhood Centre Incorporated
		IMPACT Community Services
	Strong and Resilient Communities - Cashless Debit Card Support Services	Bayside Transformations Limited
		Fraser Coast Regional Council
		IMPACT Community Services
		Wide Bay Sexual Assault Service Incorporated
Hervey Bay Neighbourhood Centre Incorporated		
Northern Territory	Strong and Resilient Communities - Cashless Debit Card Support Services	CatholicCare NT
		Waltja Tjutangu Palyapayi (Aboriginal Corporation)
		Lutheran Church of Australia, South Australia and Northern Territory District In
		HK Training & Consultancy Pty Ltd
Ceduna	Children and Parent Support Services	Oak Valley (Maralinga) Aboriginal Corporation
		Yalata Anangu Aboriginal Corporation
		Koonibba Community Aboriginal Corporation
	Strong and Resilient Communities - Cashless Debit Card Support Services	Australian Red Cross Society
		Ceduna Aboriginal Corporation-Land Management Rangers
		Ceduna Aboriginal Corporation-Youth Leadership
		Ceduna Aboriginal Corporation-Employment Hub
		Ceduna Aboriginal Corporation-Far West Aboriginal Tourism Dev. Project
		Ceduna Aboriginal Corporation – Youth Hub
		Oak Valley (Maralinga) Aboriginal Corporation- Housing & Community Maintenance
		Oak Valley (Maralinga) Aboriginal Corporation-Camping on Country
		Centacare Catholic Country SA Limited
		Scotdesco Aboriginal Corporation-School Camps Project
	Koonibba Community Aboriginal Corporation-farming Ranger	
	National Plan to Reduce Violence against Women and their Children	Scotdesco Aboriginal Corporation-Women’s Engagement

Location	Initiative	Organisation
Goldfields	Strong and Resilient Communities - Cashless Debit Card Support Services	Anglicare WA Inc.
		Anglicare WA Inc.
	Job Support Hubs - GOLDFIELDS	City of Kalgoorlie-Boulder
		Shire of Coolgardie
	Shire of Laverton	
Cape York	Money Support Hubs – Pama platform	Cape York Institute-Pama Platform
	*– Mpower	Cape York Institute

Attachment E

Outline of Merchants

There are approximately 2.5 million businesses in Australia.³⁸ All businesses that are not classified as a mixed or blocked merchant can be classified as a general merchant, including online Australian businesses, and online business overseas. However, contemporary card users would likely only engage with a small number of businesses given their locations. The exact number also depends on use of online retail by participants. The number of 'general merchants' impacted is unknown however as there are no costs associated with them accepting a new card we have not quantified the cost for the RIS.

Of the 18,000 IM merchants it is estimated 8,000 do not sell restricted items and will therefore transition to becoming 'general merchants'. Of the 10,000 remaining 9,500 will be larger merchants and 500 smaller merchants.

It is estimated that over 3,000 merchants that sell restricted items could become contemporary card mixed card merchants in the current CDC and IM sites.

Of these, currently nine are large organisations (eg. Woolworths, Coles) with over 7,500 stores nationally having PLB technology. There are 150 smaller merchants that already have PLB or are working towards having PLB in place. These organisations will be required to undertake minimal/no steps to sign up to the contemporary card. It is expected all these merchants would accept the contemporary card being proposed as it is similar technology to what they currently have and will maintain a status quo in relation to how POS currently works.

Based on the current take up of PLB we would expect that around 15 per cent of mixed merchants in the sites may not want to implement PLB. Given the numbers of participants likely to participate in the new program will be less than the combined total of CDC and IM therefore rate of merchants not willing to participate could increase. Some other merchants may not join unless they are compensated.

³⁸ Counts of Australian Businesses (2020-21) [Counts of Australian Businesses, including Entries and Exits, July 2017 - June 2021 | Australian Bureau of Statistics \(abs.gov.au\)](https://www.abs.gov.au/australian-bureau-of-statistics/publications/most-recent)

Attachment F:

CDC and IM participant numbers justification and assumptions

Program	Year of movement	Description of participant movements	Justification/assumption to support movement	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
				2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32
CDC	All	Start at beginning of each year		17300	0	0	0	0	0	0	0	0	0
	Year 1	All leave CDC	CDC program ceases	-17300									
		TOTAL by end of year		0	0	0	0	0	0	0	0	0	0
Comp IM		Start at beginning of each year		24400	28200	28200	0	0	0	0	0	0	0
	Year 1	Add CDC NT participants	NT agreed to transition from CDC to IM	3800									
	Year 1	Add Cape York CDC participants	None - assume move onto voluntary straight away	0									
	Year 3	All leave compulsory IM	Compulsory IM program ceases			-28200							
		TOTAL by end of year		28200	28200	0							
Vol IM		Start at beginning of each year		0	500	500	7550	7550	7550	7550	7550	7550	7550
	Year 1	Add Vol IM from CDC	10 to 11 percent of the population of CDC participants after removing participants from NT and Cape York and BHB and outside of area.	400									
	Year 1	Add '100 for Cape York'	All Cape York transitions	100									
	Year 3	Add '4,000 who continue to volunteer'	14% of IM and CDC participants in the NT who revert to IM in year 1.			4000							
	Year 3	Add 'National IM volunteers'	Who will volunteer from sites other than the current CDC and IM designated sites. This figure is approximately a third of the expected volunteers from CDC and IM sites reflecting other sites have no experience with the program.			1600*							
	Year 3	Add '1340 for a new community referral'	One 'medium sized' community			1340*							
	Year 3	Add '110 SPaR and Child Protection'	Based on current no. of participants			110*							
	Year 4-10	No change in numbers	Assume people leaving = people coming on (approx 15% turnover)				0	0	0	0	0	0	0

		TOTAL by end of year		500	500	7550							
--	--	-----------------------------	--	------------	------------	-------------	-------------	-------------	-------------	-------------	-------------	-------------	-------------

*These numbers are contingent on further consideration by government.