Contextualising Social Policy: Australia's Cashless Debit Card in the Lives of Recipients and their Communities in Ceduna, South Australia

Kristen Stevens, BHlthSc (Hons)

Justice and Society
University of South Australia

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Abbreviations

AIHW	Australia Institute of Health and Welfare
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
CDC	Cashless Debit Card
CDEP	Community Development Employment Program
CDP	Community Development Program
DSP	Disability Support Pension
DV	Domestic Violence
ED	Emergency Department
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
SAPOL	South Australian Police

Summary of Thesis

The Australian cashless debit card (CDC) policy intervention is a form of welfare conditionality that aims to change the behaviours of welfare recipients by restricting how recipients can spend their government support payments. Rather than measuring the targeted post-policy outcomes, this thesis documents the crucial role of peoples' lived experiences both before and after the implementation of the CDC, as described by participants in Ceduna, South Australia. This contextualisation includes capturing how recipients described the processes of behaviours, interactions, and relationships in their ongoing life contexts as well as critically analysing the socio-political background from which the CDC emerges.

The data for this thesis was collected using a critical ethnographic methodology, involving repeated, conversational interactions, and active participant observations over time, with 19 main participants and other community informants. This thesis finds that the life issues participants' experienced are persistent, interrelated and developed in part as a result of the constraining circumstances of poverty, powerlessness and marginalisation in which people found themselves living. These issues are interrelated in how they affected participants and include lived experiences of unemployment, violence and crime, discrimination, mental health problems, the cumulative impact of other policy interventions, and local social relationship interactions within and between card recipients, service providers, friends and family, and the wider community. Such complex local contexts shape on-going behaviours, relationships, opportunities, and resources, which are difficult for both individuals and new policies to change.

This thesis argues that when the CDC is overlaid onto existing interrelated life issues it exacerbates discrimination, unemployment, poor mental health, violence, and crime, and negatively impacts social relationships. In the research conducted for this thesis the card did not ameliorate the problems it was designed to address. Instead, participants explained that the card made many negative things, worse. The qualitative research undertaken with participants in Ceduna, suggests that in combination with existing conditions, the CDC served to magnify perceptions of injustice, contributed to negative social interactions, and promoted community divisions. These perceptions can work alongside the poverty and

alienation people are already experiencing to threaten cohesion and promote distrust in the state.

This thesis explores the value of longitudinal critical qualitative methodologies in capturing the processes of how CDC recipients are affected by this form of welfare conditionality. Using critical ethnographic methodologies for developing, applying, and measuring policy interventions, can improve policy effectiveness by amplifying the experiences and voices of the people these interventions act upon. Improving policy interventions remains important for helping to identify and prevent unintended harmful consequences; to prevent the waste of public resources; and to ensure that recipients have improved lives as a result.

I declare that:

This thesis presents work carried out by myself and does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; to the best of my knowledge it does not contain any materials previously published or written by another person except where due reference is made in the text; and all substantive contributions by others to the work presented, including jointly authored publications, is clearly acknowledged.

Kristen S. Stevens

Date: 9th of December 2022

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1 Introduction

In 2016, the cashless debit card policy (CDC) was introduced within several targeted Australian communities, beginning in March 2016 in Ceduna, South Australia, followed successively by introduction in April 2016 into the Kimberly region, Western Australia, Kalgoorlie, Western Australia in March 2018, and the Bundeberg-Hervey Bay region, Queensland in September 2018 (Department of Social Services, 2022a). The CDC was not the first version of welfare conditionality or 'welfare' quarantining in Australia but was the most recent and most restrictive. Such policies place or 'quarantine' a portion (in the case of the CDC, 80%) of people's welfare payments into a separate restricted account, with those funds only accessible by a plastic debit-only card. The remaining portion (20%) is paid directly into the welfare recipient's regular bank account for other uses. Cash cannot be withdrawn from the quarantined account and recipients are restricted in what they are allowed to buy.

The CDC policy objectives have changed only slightly overtime. Overall, the CDC policy objectives saw the legislation of specific purchase exclusions, with the card excluding purchases of alcohol and gambling products. The policy was also aimed at limiting illicit drug purchasing and use through reducing access to cash.

The CDC policy objectives in 2016 were to: a) reduce the amount of certain restrictable payments available to be spent on alcoholic beverages, gambling and illegal drugs; and b) determine whether such a reduction decreases violence or harm in trial areas; and c) determine whether such arrangements are more effective when community bodies are involved; and d) encourage socially responsible behaviour (Australian National Audit Office, 2022, p. 16). In 2020, as part of the Social Security (Administration) Amendment (Continuation of Cashless Welfare) Act 2020; and in response to the Australian Government's review of evaluations conducted thus far; and in order to shift the policy from a trial to an ongoing program (Australian National Audit Office, 2022), the CDC policy objectives changed to: a) reduce the amount of certain restrictable payments available to be spent on alcoholic beverages, gambling and illegal drugs; and b) support program participants and voluntary participants with their budgeting strategies; and c) encourage socially responsible behaviour (Australian National Audit Office, 2022, p. 16).

The use of income support payments was framed by the Australian Government as a way of curbing social problems in Australian communities related to excess alcohol, gambling, and illicit drug consumption (Bielefeld, 2021). The introduction of the CDC policy was seen as a way of reducing alcohol, gambling and drug problems through regulating how people could use their income support payments. As described by Morris Janowitz (1975; 1991), social policy, as a way to regulate and order society, individuals and groups, is a form of social control toward a variety of desired aims, with aims influenced by a variety of ideas of what society ought to be. However, as will be shown in Chapter 3, the research undertaken for this thesis, shows that participants felt the CDC had little effect on the targeted behaviours, and in some cases, social problems were made worse. This thesis argues that the implementation of the CDC in Ceduna did not appear to be overly effective in regulating or controlling recipient behaviours as planned. My PhD research aimed at finding out how the ideological framing of the CDC and its roll out, was experienced by on-the-ground, and what we can learn from participant feedback for future social policy interventions.

Some years before the CDC, income management policy via what was called the 'basics card' was formulated in 2007 and implemented in September 2008, affecting 13,300 Aboriginal welfare recipients (Northern Territory Emergency Response Report, 2008). The basics card was the first version of the welfare quarantining policy approach in both Australia and globally (Mendes, Waugh, & Flynn, 2014). The income management basics card saw a portion of a recipient's income support payment (typically between 50%-70%) quarantined to an account accessible only by a plastic debit-only 'basics card', with the remaining portion paid directly into the recipient's regular bank account. As further addressed in Chapter 2.4, this income management basics card policy legislated welfare quarantining measures through cash and purchase restrictions very similar to the later CDC policy, where:

> The Basics Card was introduced in 2007 to support the Australian Government's Income Management initiative. It can only be used at approved merchants. It differs from the CDC in that it cannot be used to purchase cigarettes or pornographic material, in addition to the common restrictions on alcohol purchase, gambling and cash withdrawals (Australian National Audit Office, 2022a, p. 18).

The basics card had first been introduced as one of the policy responses to a variety of purported social issues reported in the 'Little Children are Sacred' Report into child welfare and wellbeing (Anderson & Wild, 2007). This report was the result of a 2006 Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse and was publicly published by the Northern Territory Government in 2007. The report highlighted that which many had known for some time, that Aboriginal Australian children in the Northern Territory experienced much greater disparity in their health and wellbeing than their non-Aboriginal counterparts. The report also outlined that there were widespread social issues experienced by Aboriginal Australian Peoples in the Northern Territory, identified in major themes as: health issues, housing issues, unemployment, poverty, barriers to education, responses by government agencies, law and justice problems, rehabilitation of offenders, and high levels of drug and alcohol abuse, pornography use and gambling amongst Aboriginal Australians (Anderson & Wild, 2007, p. 15). This report linked much of these problems to historical and ongoing contemporary issues relating to colonisation and institutional discrimination. The report claimed that as a result of these social problems experienced by adults and young people in many Aboriginal communities, in extreme cases they resulted in the abuse and neglect of children. As a public response, the Northern Territory Emergency Response was enacted as one result from this report, alongside income management that affected thousands of people, most of whom were not involved in child abuse, drug and alcohol use, and gambling.

To counter this, the basics card was forcibly implemented on all eligible groups in the Northern Territory as one social policy response designed to deal with the political discourse generated by intense media reporting focused on the social problems identified in the report by Anderson and Wild (2007). The introduction off the basics card was done *whether or not* there was evidence of child abuse, drug and alcohol use, and gambling in the lives of the intervention recipients (Northern Territory Emergency Response Report, 2008). Income management was initially applied in Australia's Northern Territory *to all and only* Aboriginal Australians who received income support payments, through the repeal of the Racial Discrimination Act (RDA) in 2007. The repeal of the RDA was enacted specifically to accommodate the basics card's implementation; with the Act being later reinstated in 2010 (Lovell, 2016). For the people on basics card, this meant that their welfare payments were effectively be managed by the Federal Government with little individual discretion on spending and consuming, and no spending allowed on alcohol, gambling, and other

prohibited activities. Underpinning the CDC policy was the assumption that individual spending habits were the drivers for people's overindulgence in alcohol, drugs and gambling:

> Income management explicitly attempts to address the behavioural or cultural aspects that may be associated with social disadvantage by restricting access to harmful products, seeking to promote socially responsible choices and behaviours (Buckmaster & Ey, 2012, p. 5).

This targeted policy was widely condemned by researchers, welfare industry professionals and other relevant commentators, as a paternalistic and punitive response to a limited problem, but it satisfied politics and social policy makers in Canberra (Bielefeld, 2012; Cox, 2011; Klein, 2016; Lovell, 2016). Then in 2010, the policy was extended by the Federal Government to include persons who were non-Aboriginal Australians and in other targeted locations, not just in the Northern Territory. This extension from 2010 now included welfare recipients in these other targeted locations across Australia through 'place-based income management' schemes, including Perth, Western Australia, Cape York, Queensland, Shepparton, Victoria, Logan, Queensland, Rockhampton, Queensland, Playford, South Australia, and Bankstown, New South Wales (Arthur, 2019; Buckmaster, Ey & Klapdor 2012; Mendes 2017).

Even though the policy approach did not directly address structural causes of 'social disadvantage' such as those well-established problems of poverty, discrimination and inequality in general (Stiglitz, 2013, p. 287), it was reasoned in the policy logic that income management would help control and redirect welfare payment spending. Further, that it would prevent welfare dependency through 'stabilising a persons' circumstances through limiting exposure to harmful goods, can increase their chances of finding training or employment, and thus reduce the risk of entrenching welfare dependence within their family' (Regulation Impact Statement, Social Security (Administration) Amendment (Continuation of Cashless Welfare Bill 2020, p. 20). Using this reasoning, control of spending would therefore reduce social problems and promote child wellbeing, as is indicated in the parliamentary library review of federal government policy legislation by Buckmaster, Ey, and Klapdor (2012). However, the policy was implemented with little evidenced reasoning of the beneficial effects and went way beyond any findings or recommendations of the original 'Little Children are Sacred' Report. An initial government-commissioned review even

suggested that the forced or compulsory income management policy be ceased due to the hardship it had produced (Northern Territory Emergency Response Report, 2008).

In 2016 the Federal Government then implemented the new version of welfare quarantining called the 'CDC' (Social Security Guide, 2022). The CDC policy was made possible through a series of legislative changes to social security legislation amendments beginning in 2015 with the Social Security Legislation Amendment (Debit Card Trial) Act (Australian National Audit Office, 2022a). The CDC was initially framed as the 'healthy welfare card' and lobbied as a required intervention by the Creating Parity Forrest Review, authored by Andrew Forrest, the wealthy founder and owner, and former CEO of mining company Fortescue Metals (A. Forrest, 2014).

The logic of the Forrest Review argued that to reduce disparity between Aboriginal and non-Aboriginal Australians, there needed to be an emphasis on education and jobs and an end to passive welfare consumption, and the implicit ideology emphasised that individual responsibility was in fact the reason for this ongoing disparity. As the Forrest Review stated, "These outcomes are not caused by their Indigeneity, but result from unemployment, welfare dependency, poor choices, limited capacity, remoteness, and a lack of education, prenatal care and early childhood development" (A. Forrest, 2014, p. 7).

The Department of Social Services (2019) also used that same reasoning as Forrest (2014) for restricting access to alcohol and drugs related to the subsequent outcomes of crime, mental illness, hospital admissions, family violence, poverty and homelessness. Further political arguments justifying the implementation of the CDC included those by Minister Fletcher who argued that a reduction of substance use would translate into seeking employment, and reduction of spending welfare on drugs and alcohol would result in more spent on "food, rent and clothes for children" (Mendes et al., 2021, p. 155), despite any evidence for this reasoning.

The CDC and the basics card are sometimes combined or referred to as part of a largely compulsory *income management scheme* or approach in policy making by parliamentary and academic researchers (Arthur, 2017; Mendes, 2020a). Outside of location specific program interventions, persons can be court-ordered onto income management under advice made to the courts, such as in relation to child protection order (Social Security (Administration) Social Services and Other Legislation Amendment (Workforce Incentive) Act, 2022, p. 311).

However, both the CDC and income management's basics card technically remain separate pieces of legislation and policy as reflected in the Social Security (Administration) Act 1999 (Australian Government, 2019a) and addressed in further detail in later sections in Chapter 2. The CDC again restricts income support payments similar to the older basics card but to a greater degree, in an effort to restrict the spending and purchases of eligible people receiving welfare income support.

On the 15th of March 2016 in the Ceduna region of South Australia, and then again on the 26th of April in the Kimberly region in Western Australia, this new CDC was introduced to welfare recipients in these new locations who had not been previously targeted with income management schemes (Department of Social Services, 2022a). These new locations were followed two years later by the card's implementation on 26th March 2018 in Kalgoorlie, Western Australia, and on the 21st of September 2018 in the Bundeberg-Hervey Bay region, Queensland (Department of Social Services, 2022a). One of these initial locations, Ceduna, is a small, remote town on the far-west coast of South Australia and became the focus for the present research.

The numbers of recipients of both the basic card and the CDC schemes have steadily increased since their implementation in part due to expansion of targeted locations. The basics card recipient numbers had increased by approximately 83.5% in 2022 since its policy implementation in 2008 (Department of Social Services, 2022b; Northern Territory Emergency Response Report, 2008), while the CDC recipient numbers had increased by 726.5% in 2022, from 2016 (Australian National Audit Office, 2019; Department of Social Services, 2022a). For the Ceduna community that was the focus of the present research, the CDC increased from 783 in March 2016, to 1,035 in June 2022, an increase of 32.2%, with the percentage of recipients who identify as Aboriginal Australians in this location remaining steady at 74% (Australian National Audit Office, 2019; Department of Social Services, 2022a).

Of equal importance to the outright numbers using these cards is whether these cards were enforced as either compulsory or through voluntary agreement. As of June 2022, the number of people in receipt of the older basics card was 24,405, with 21,757 or 89.2% having compulsory implementation (Department of Social Services, 2022b). As of June 2022, the number of CDC recipients was 17,382, with 17,354 or 99.8% having compulsory

implementation across all four sites. For the Ceduna community there were no voluntary participants (Department of Social Services, 2022a). Through new legislation introduced by the new incoming Australian Labor government in 2022, the CDC has now been made *voluntary only* in trial locations as of October 2022 and will now be ending in other locations replaced by yet another version of income management, further explained in Section 2.4 below.

Despite the increased use of welfare quarantining or 'income management' approaches in Australia, there was no publicly available research done prior to the implementation of the basics card in 2008, nor regarding Ceduna specifically, in relation the suitability of the CDC in that location, to ascertain whether the approach would be useful for people or effective in practice. A critical review of evaluations and research on the CDC is provided in Chapter 3. Post-implementation, the primary evaluations conducted were minimal and I argue only looked at capturing data that aligned with policy objectives. In research more broadly, this review of evaluations highlights that there was a paucity of information about:

- why this policy was developed in the first place;
- the complex, lived effects of the CDC and how this policy approach had influenced peoples' lives from the point of view of the recipients;
- how recipients determined what was important in their lives;
- and how people described the ways they were living their lives before and after the arrival of the various income management approaches and associated cards.

This PhD research addresses these gaps in discussions about the CDC policy, focussing on data collected through field work in Ceduna, South Australia. This research concentrates on a combination of:

- identifying the *relational complexities* between what card recipients and their communities determine is important in their lives irrespective of the card itself;
- *how and why* the card influenced the lives of its recipients and their communities.

This thesis identifies gaps in the literature by undertaking a critical literature review in Chapter 3, and then addressing issues further in Chapters 4 and 5, including discussing the methods used in previous research. The thesis also considers how the use of more local

contextual qualitative and critical ethnographic particular methods may help improve our understanding of the impact of policies on the already complex lives of vulnerable people.

Methodologically, my research differs from much previous research, in that it uses an interpretivist and constructivist, critical ethnographic approach to inquiry, doing so three years after the CDC was originally introduced in Ceduna. In this research, I have sought the views of both card recipients and the broader community members, alongside the recording of active participant observations and researcher reflections over a total time of 12 months spent in the Ceduna community.

I argue here and will further evidence and explore throughout this thesis that a more contextualised approach to analysing policy can help:

- improve the way we understand the impact of policy interventions at the local level;
- contribute to preventing unintentional harm associated with poorly designed and/or poorly executed policy interventions.

The focus period of my research begins in 2019 and ends in early 2022. This thesis therefore does not interrogate later changes made to the CDC policy nor the circumstances relating to the repealing of the program in mid-2022 (Ministers for the Department of Social Services, 2022). The thesis begins with a review of the social policy settings from which the CDC emerged; followed by a critical review of research and evaluations related to the CDC, paying particular attention to methods employed to do so; a discussion of the methodology and methods I employed; and finishes with presentation of the findings and their discussion, including an analysis of the findings in relation to social policy development and implementation. In the concluding section of the thesis, I explore the notion of social policy as social control and reflect on the use of methods in social policy research
The following sections outline in further detail what each Chapter does throughout this thesis:

Chapter 2 discusses social policy as a strategy of governance and how this is guided by ideas and ideologies of what society *ought* to be as opposed to a balanced inclusion of theory and evidence reflecting lived experiences, and what ‘is’. This chapter highlights patterns of Australian welfare social policy over time and addresses its international influences, using

examples of policies which show increasingly punitive approaches to social policy with the intention of directing welfare recipients' behaviour changes.

Chapter 2 traces Australian welfare reforms in the 1990s through to 2006 and shows how social policies have reflected an increasing ideology of *individualised responsibility for social harms* since the 1970s, by which individual people are held responsible for their behaviour whether they have any control over the conditions and events in their lives. It reveals how this led social welfare policy to become increasingly punitive, framing welfare recipients as deviant and incapable, and in need of intervention.

The social and political ideologies that have underpinned this gradual Australian and international shift in welfare conditionality related social policy, are argued to largely reflect conservative, neoliberal and paternalist ideas. These ideas have been gradually operationalised since the 1970s through policies which constructed the welfare recipient as primarily responsible for their social circumstances, and welfare consumption as indicative of poor morality which needs fixing. Such ideas foster social policies that are increasingly punitive in an effort to change the behaviours of the welfare recipient to align with specific ideas of morality. The promotion of *active economic participation under capitalism* is one such example (as seen in the earlier mentioned 'Creating Parity Forrest Review'; A. Forrest, 2014), meaning that where unemployed welfare recipients are framed through neoliberal and conservative ideas as passive social participants, inactive in their contribution to the economy, these ideas under capitalism seek to 'shift' people into employment and off welfare support, in order that they 'become active' more economic participants (Clarke, 2004; Rees et al. 2014). The CDC is one of the most recent iterations of this increasingly punitive and individualised approach to social policy.

Although it is not the intent of his thesis to focus specifically on First Nations participants nor to address the CDC as one of the more recent iterations of settler colonial policy, Chapter 2 will briefly canvass the body of literature that analyses the CDC as part of an ongoing continuum of settler colonial policymaking in Australia. Settler colonial policy it is argued, seeks to mask its deeply problematic intent to 'eliminate the native' by representing itself as 'benefitting' all while systematically disempowering already vulnerable Indigenous peoples, who face structural erasure at the hands of the colonising state (Wolfe, 2006; Veracini, 2013). While acknowledging the importance of this powerful framing of the CDC - as well as

acknowledging the over-representation of Indigenous peoples affected in the areas targeted by Governments for initial CDC roll-out, this thesis looks through a broader lens at how the CDC constructs, normalises and reproduces, ideas of deviance and conformity, and how it impacts a diverse group of individuals in the Ceduna community, including both Indigenous and non-Indigenous participants.

Chapter 3 outlines methods and general approaches to evaluating and researching social policy, and critically reviews the associated research and literature regarding the CDC and the preceding income management approaches more broadly. The review shows that a majority of methods used in previous research did not capture recipients' views *from their own perspectives and lived experiences in their own way*, nor extensively consult with communities on research ethics and co-created approaches. This chapter also shows that overall, existing methods and evidence have not attempted to show *how* the CDC has an influence on the lives of recipients and their communities based on lived experiences, nor *how* that influence may occur *within the broader already existing and persistent contexts of peoples' lives*, that is, in the contexts of how life was run prior to the card/s. Instead, social issues have been largely treated as separate, unrelated problems in the related primary research inquiries and evaluations. Finally, the review suggests that there have been no concerted efforts to investigate what might be, if any, other catalysts of change in the community that may underlay or connect social issues, whether in relation to the card or not.

Chapter 4 first summarises and very briefly synthesises what the previous Chapters have revealed so far and introduces the Research Questions in relation to gaps in knowledge.

Chapter 5 presents and justifies the research methodology and methods which follow from an understanding of the limitation and critiques of previous research and what has been missed out (Chapter 3). A critical ethnographic approach is selected with a worldview informed by critical constructivism. The aim in choosing this approach has been to embrace, prioritise and respect peoples' lived experiences and explicate the multiple, subjective realities of people in their communities and society. In applying this critical lens, the approach then works to position these experiences within the socio-political contexts from which they emerge. Discussions include how this worldview and methodology corresponds with qualitative data collection, by way of: interviews and observations; analysis methods; and reflexive thematic analysis. Participatory research (part of ethnography) guided the research by encouraging

extended time in communities, incorporating interviews with observations and interacting with people in active ways where I was welcomed to do so. I saw this approach as best suited to my research which seeks to capture social patterns, social and systems complexities and the nuances that individuals and communities experience before and after the card implementation. The approach is argued as best to provide insight regarding how the CDC operates in community and recipient lives, how this relates to persistent contextual conditions and identify catalysts of change where they may occur in the community and lives of CDC recipients.

Chapter 6 presents the research results. Analysis of the data shows that at best, the card did nothing to influence the many persistent social problems: the card did nothing to help change the conditions that reinforce persistent unemployment, and little to reduce issues with substance abuse. At worst, the card was a misdirected and extra barrier or burden in the lives of recipients and seemed to exacerbate the persistent social problems. Data showed that largely, card recipients' lives were already tumultuous and difficult, and that when the card and its rules were overlayed on the persistent issues people faced, the card was shown at times to exacerbate these problems, as well as increase hardship and promote old and new social divisions in community. Such exacerbated effects included: making bad mental health worse; exacerbating discrimination between groups; and in some cases, created the conditions that promoted violent behaviours against others are highlighted in the data. The card also created new divisions within longstanding family and friend networks, and in many cases, enhanced distrust and conspiracy-type beliefs towards the government. The data analysis also showed that the real catalysts for change were not policy- but people-related. Behaviour change happened due to certain types of social interactions and relationships that helped people navigate a complicated welfare system and deal with their persistent problems in real time.

As summarized in Chapter 7, overall, from my research the card did not do what it set out to do and instead may have generated a legacy of unintentional negative consequences. Chapter 7 also discusses findings from this research that may help prevent the sorts of problems shown in Chapter 2 for social policy formulation, and the sorts of limitations show in Chapter 3 for research methodologies and their use in relation to social policy.

1.1 Setting the Scene

This excerpt below emerges from my own field note reflections during participant observation, which was one method used to collect data under the guidance of the critical ethnographic methodology employed in this work. This methodology is described in more detail in Chapter 5. This excerpt below is a combination of two reflective entries at either end of one of my visits to Ceduna. By including this here I aim to set the scene and provide some explanation of my experiences of the location into which the CDC was implemented, and how I went about engaging at the local level.

Table 1: Fieldnotes, Ceduna, December 2020.

'Just whack it up on the blackboard, here', I was handed a bucket of chalk and directions by a familiar worker slowly arriving to start their day around 10am. It's December which means it's hot and it's Friday, so, you know 'nothing much gets done on Fridays' as was reflected in the local ebbs and flows of the town that I had become familiar with throughout 2019. 'What am I writing...?', 'write 'BBQ here on Monday', and don't worry about those flyers you made, word'l get around, it's free food and music!'. The worker rumbled off inside and left me to my volunteering. Come Monday they were right about word getting around. The BBQ saw about 100 people come along which is a big crowd in Ceduna. As I was helping put up shades and serve up the food, the music played, some people had a dance, and people seemed to be enjoying the lunch. Kids were running around playing and laughing as kids do, some people seemed to have even dressed up.

The people seemed relaxed, laughing, and I reflected on how many of the people there were CDC recipients and had shared with me so much about their often-difficult lives. I reflected on how there were almost no community spaces for this kind of event in Ceduna where people could get together, other than the pub or yacht club which for many was not financially or socially a viable option. I tried to think about the general seemingly mundane things, like a fun occasion a week before where I had helped a participant move their cousin's new fridge (a new fridge was a big deal). How I had gone with another participant to a women's group and listened to local gossip about who's marrying who, and learned about who to talk to if you need extra freezer space to store meat you got from a local farmer. However much more of what I had learned was often far from mundane or fun for these people I had come to know.

As people lined up for second (and third) helpings, I chatted with another participant, who a few weeks before told me about the serious abuse they had suffered as a child. As I served up food, I thought about how another family had previously explained how drug-use was still a problem in community and had made violence worse. I thought about how at the beginning of this particular trip a month ago, I had learned of two very recent suicides in community. All the while, extra food was being prepared by some people to take to their family whose alcohol reliance meant they couldn't make it to the alcohol-free BBQ. 'Take some water too, ay?' said as we handed out bottled water and helped stack the plates for their walk down to their family on the foreshore.

Overall, the Ceduna community had showed me their problems and pain, and also their resilience. And now they had also showed me how despite all this, to still have a bit of fun at a BBQ on a hot Ceduna day. Of all had I learned over the past year, the data indicated that the difficult, persistent problems people experienced seemed to relate to complex, interrelated social issues. Issues that the CDC has been, in part, aiming to stop since 2016, with other policies prior to that attempting to do the same. The card tries to reduce drug and alcohol consumption, violence, crime, and to promote socially responsible behaviours. These 'factors' were all rationalised by the card policy as driving negative outcomes for all community members in some way. Even while at a fun BBQ, it seemed to me necessary to continue to question whether policy aims had actually been met.

For many on the CDC a tumultuous or hard life was largely the norm. Going back through the seemingly endless pages of data during the next few weeks that followed the BBQ, I noted some interesting points to consider. That through the data shone the clear point that none of these social issues people experienced existed in isolation. Instead, every concern or problem or opportunity (or lack of) that was expressed, was in direct relation to a series of other issues experienced simultaneously. I noted the ways this complex interplay appeared to often negate many chances for new opportunities to maybe overcome these issues, even when people were trying to do things differently in effort to help themselves. I again continued to consider what might positively interrupt the often-downward spiral of life many of my participants seemed to express as typical.

This December, the usual questions prevailed as evidence was critiqued:

Why were the mostly happy people being controlled in this way by the government?
Is this really helping the problems reported by the 2007 'Little Children are Sacred Report' or how the policy intervention had framed problems since then?
How was the CDC involved in all this?
Where did the card fit in to the seemingly complex and persistent problems in people's lives?
If change happens, how is it happening?

My data had begun to tell the story and provide responses to these questions.

My research aimed to capture nuanced influences of the card through focusing on lived experiences, both before and after card implementation, with the intent being to garner ways to better inform social policy formulation and the evaluation and research of policy implementation in people's lives.

The findings show that introduction of the CDC into Ceduna was imposed onto an already complex set of social, family and community relationships. These contexts are described in sociological and health literatures for example, as those social conditions or contexts within which people live and that are uniquely experienced. Social contexts can include social policies, social interactions, politics, cultures, economies, histories, discrimination, and education, and how these all interrelate to shape opportunity contexts for agency (Giddens, 1984; Guerin, 2016; Marmot & Allen, 2014; Wilkinson & Marmot, 2003).

Taking account of the lived experiences of these existing, as well as persistent or changed circumstances and contexts, must be described if we are to understand more accurately what is happening. Furthermore, it is well established that making and implementing social policy does not take place in isolation from local and international cultural, socio-political, and economic influences (Neale, 2021). So, the processes behind policy formulation and delivery (Chapter 2) need to be examined as well as the existing or persistent community contexts prior to and regardless of the CDC's implementation. Alongside all this, analysing how social policy and the CDC is researched and what is or is not then learned from those methods used, can help us to improve how we go about understanding the influence of social policy in the lives of recipients and their communities (Neale, 2021) (Chapter 3).

2 Social Policy in Australia: The Ideology, the History and the Evolving Logic of the Cashless Debit Card

2.1 Introduction

This chapter focuses on welfare social policies and welfare conditionality as strategies for governance, the ideologies and logic that shape the policies, and how these led to the CDC appearing at times in a positive light to diverse politicians and the media (Hunt, 2021; Ruston, 2021, para. 1). While only a partial theoretical and historical review of the vast field of social policy discussions of relevance to welfare conditionality can be presented in the space available, this chapter covers the main points regarding the policy logic and broader international influences behind the Australian welfare-related social policy for the years 1970 to 2022 [for more comprehensive reviews on social policy during this period , see Jamrozik and Nocella (1998); Marston & McDonald (2007); Mendes (2017)].

This literature review shows how the CDC and income management more generally, were developed as a policy approach for organising and controlling society in particular ways. This discussion starts in Section 2.2 by conceptualising governance through social policy as a form of social control, alongside the different ideas within ideologies of what society *ought to be*. That is, how social policy structures and strategies shape social norms which generate our understandings of social problems and social deviance; and how people requiring welfare, and their circumstances are represented to and by, both policymakers and the broader public (Bacchi, 2009; Colebatch, 2006). The Australian history of welfare policies and reform is then briefly reviewed in Section 2.3 using policy examples from 1970 to 2022, plus some minor reflections on policy approaches post-second world war. Discussion includes where the CDC has come from with respect to ideologies and social policy developments locally and internationally, leading to CDC policy itself which forms the focus of this research in Section 2.4. The review shows how social policy decreasingly focussed on the complexities of structural conditions that shape how people can behave and make choices and turned towards a stronger focus on individual mutual responsibility or what can be viewed as punitive welfare. Discussion includes what this means for the efficacy of social security

policy in Australia leading up to the introduction and implementation of income management and eventually the CDC.

2.2 The Ideology and Strategies of Governance Through Social Policy

Social policy can be conceived of as a consequence of governance and social control, directed by ideologies that embrace some ideal of society, where social control links to social problems and is "a vehicle for joining sociological analysis to issues of social policy and for dealing with issues of deviance" (Janowitz, 1975, p. 92). Ultimately, people in power make choices regarding how to create and implement policy, where choices are influenced by ideas of what they believe to be correct actions in society. These politicized public choices are influenced by a variety of factors, including perceptions of the prevailing mood of the general public; media influence in shaping and framing the rise (or fall) of perceptions of social problems in the public's eyes; and advocacy and lobbying efforts, occurring both locally and globally (Farnsworth & O`Brien, 2022; Bacchi, 2009; Colebatch, 2006). Policy here becomes the expression of the complex interplay between these factors influencing decisions and ideas to some degree (Colebatch, Hoppe, & Noordegraaf, 2010). Various frameworks have been developed to advance understandings about the intricate process of decision-making within the realm of social policy. This is due to the fact that ideologies shape conceptions of what should be, which are then addressed through policy decisions in one way or another, as noted by Bacchi (2009). These frameworks remain relevant regardless of which one is employed, as they all can help in understanding the systems and processes of governing through social policy. These frameworks and approaches to policy making are discussed in detail in section 2.2.2.

Social policy decisions relate to how belief and values are shaped by ideologies framing what society ought to be (Bacchi, 2009; Béland, 2016). Doherty (2000) argues that the influence of ideology on policy, involves what is considered important in the decision-making processes, where "…ideology acts as a purposeful 'filter' through which evidence is passed and selected before it impacts on policy" (p.180).

This figurative ideological 'filter' influences policy in the way it constructs deviance, and identifies who then ought to be acted upon (Carson & Kerr, 2017). For example, ideology influences perceptions of social norms about welfare consumption, framing this as a

'problem' and then postulates what to do about it and how (Bacchi, 2009). It is this broader focus on the influence of ideology on systems and processes of governance that remains the focus of the following section 2.2.1. This focus intends to address policy making through a macro-lens of ideological influences, as opposed to focusing on specific varieties of analytic or theoretical policy-making frameworks more generally.

However, legislation and policy implementation cannot occur without the systems and people in positions of power to do so – through elected politicians and bureaucrats as lawmakers (Althaus, Bridgman & Davis, 2007). This chapter discusses the ideologies and structures influencing the enacting of policy by persons in the positions of power to do so. The following sections explore how social welfare is conceptualised, represented and then enacted. To begin, social policy is considered within two primary framings: policy as a governance approach with a limited purpose for specific groups; and policy as a dynamic mechanism of social control, where powerful ideologies and politics influence how problems are defined and addressed.

2.2.1 Governing Through Social Policies

Social policy can be described as an act of governance, influenced by ideology aiming for social control (Dean, 2004; A. Schneider, 2015; Weis & Fine, 2012; Bacchi, 2009; Wolfe, 2006; Veracini, 2013). Policy as one strategy of social control is well established as creating the main social, cultural, opportunity and economic contexts within which we live, having a profound influence on our lives and our well-being (F. Baum & Harris, 2006; Maddison & Denniss, 2013; Marmot & Allen, 2014; Marmot & Wilkinson, 2005; Wilkinson & Pickett, 2010; Wilkinson & Marmot, 2003; Dean, 2004). The following section outlines the links between governing through social policy, and social policy as a form of social control.

Morris Janowitz has described, social policy as a form of social regulation and order, with the term 'social control' not intending, he argues, to infer this as being inherently 'good or bad' (Janowitz, 1975). Nonetheless, the term social control often implies negative connotations as it regulates and restricts peoples' choices and behaviours (Deflem & Wellford, 2018). Social policy as a form of social regulation or control, is often categorised as universal or specific, meaning policy applies to either society overall, or to more targeted groups, respectively (Carson & Kerr, 2017). Whether directly 'subjected' to, or in other words, being a recipient

of a specific social policy intervention or not, social policy as an influential social structure, works to shape cultures and values across the citizenry through shaping social norms and discourses (Carson & Kerr, 2017).

During social interactions, social norms are reproduced through discourse and other behaviours (Barker & Jane, 2016). Where social norms are reproduced through these actions, such as those norms influenced generally by social policy decisions regarding the deserving or underserving poor (B. Marshall & Robert, 2014), these actions can perpetuate broader harmful ideas of deviance and conformity. For example, these influences can be generally described on one hand as policy creating discriminatory conditions where one group becomes submissive to powerful others where they have little choice but to 'conform' to policy rules in some way to get by, where social norms, reinforced by social policy decisions, frame one group as 'undeserving' or deviant relative to another (Barnes & Prior, 2009; Bacchi, 2009; Colebatch, 2006; Dean, 2004). Similarly, policy rules and decisions can enhance norms and values which can also be discriminatory where some segments of society can use norms related to constructions of deviance to position themselves as better than others (Jamrozik, 2001; Crandall & Stangor, 2005; Carson and Kerr, 2017; Dean, 2004). The allowance for such positioning can be influenced by the same policy decisions and what those policies inherently embody and define as what is deviant or not, and thus who is 'deserving' or undeserving of certain types of social control enacted through social policy decisions.

2.2.1.1 Social Policy as Settler Colonialism

Where social policy works to shape norms and frame deviance, this links to the noteworthy work of authors who address social policy, such as the CDC, as an ongoing expression of colonialism in Australia (Strakosch, 2016; Bielefeld, 2021; Vincent, 2021) and specifically as a settler colonial policy in Australian society (Klein, 2020; Maddison, 2011; Verancini, 2013; Wolfe, 2006). In its widest meaning, colonialism refers to the process by which a foreign power exercises political, economic, and cultural control over a territory and its people (Holmes, Hughes & Julian, 2012, p. 51). In the case of the land now known as Australia, colonialisation or invasion began with the 'arrival' of the British explorers/invaders in 1770, and the subsequent proliferation of 'settler' colonies in 1788 (Holmes, Hughes & Julian, 2012, p. 84-5). Since this time, Indigenous Australians have been systematically subjected to unprecedented acts of frontier violence; been dispossessed of their lands; had their cultures

and languages suppressed; had their children removed; and been subjected to a range of discriminatory and some argue genocidal policies and practices, which many argue continue to this day (Veracini, 2015; Markus, 2001; Maddison, 2011; Wolfe, 2006; Klein, 2020; Tatz, 2001; 2016; Tedmanson, 2008; Tedmanson & Wadiwel, 2010).

Settler colonialism is a specific form of colonialism that involves the permanent settlement and influence of a foreign population in a colonised territory (Barker, 2012; Tuck & Yang, 2012; Veracini, 2010, 2015). According to Barker (2012, p. 1), settler colonialism is "a distinct method of colonising involving the creation and consumption of a whole array of spaces by settler collectives that claim and transform places through the exercise of their sovereign capacity". Settler colonialism not only seeks to exercise political and economic control over a territory but also aims to displace and replace the indigenous population with settlers (Banivanua Mar & Edmonds, 2010). In the Australian context, settler colonialism refers to the ongoing process of colonisation that began with British settlement and continues today. Contemporary social policy decisions can perpetuate the legacy of discrimination and oppression of Australia's First Nations people, relative to settler or non-Indigenous population groups, as policy including the CDC has framed First Nations Australians as 'deviant' to some degree (Lovell, 2016; Marston & McDonald, 2007; O`Keefe & Papadoupolos, 2022).

It has been argued that the ongoing impact of settler colonialism and subsequent ideological influences are significant and continue to shape social policy in Australia, undermining Indigenous autonomy and self-determination (Banivanua Mar & Edmonds, 2010; Maddison, 2011; Veracini, 2015). Extensive analysis by Strakosch (2016) highlights the ways in which neoliberal policies have contributed to the ongoing colonization of Indigenous peoples in an Australian context and how this contributes to the ongoing erosion of First Nations rights and sovereignty. As Strakosch (2016, p. 7) argues, where once the change from the Aboriginal non-citizen to citizen in the 1960s "coincided with capacity" the uptake of neoliberal ideology influencing social policy and economy, continues "to facilitate settler colonialism" through its selective inclusion and exclusion facilitated in social policy.

Strakosch (2016, p. 7) deliberates that:

> …neoliberalism introduces the figure of the incapable citizen. This ambiguous position allows a subject to be formally included as a citizen, and simultaneously

excludes from regimes of freedom for being temporarily 'undeserving' of this existing citizenship.

Strakosch (2016) explains neoliberalism's workings as depoliticising and technicalising the impacts of ongoing "colonial hierarchies, where the individualising prioritisation of neoliberalism frames Aboriginal social 'failures' "as the result of natural economic processes and individual capacity failures (p. 7)"

A useful way of addressing policy as a form of control over society is by applying the frame of settler colonial analysis as a way of understanding the CDC. However, in this thesis I have purposely adopted a broader lens of social control more generally, rather than focusing specifically on settler colonialism as the lens through which to analyse the CDC's impact on Indigenous communities. By viewing the CDC through a lens of social control alongside neoliberal ideological influences in the broadest sense, further outlined in chapters to follow, I aim to facilitate the prioritisation of diverse lived experiences to inform what we know of the CDCs influence, which I argue is inextricably linked with the broader macro structures shaping society.

The intent of this thesis is to capture the lived experiences and contexts of people who experience the card, including those representative of groups described as colonising or colonised. Additionally, predominantly framing the CDC as a settler colonial policy alone can risk centralizing Indigeneity with the danger of reinforcing the 'victim' status. For example, Tuck (2009, p. 409) argues that such a framing needs to be reconsidered, as it can contribute to a sense of brokenness within communities, where researchers should work "not only to recognize the need to document the effects of oppression on our communities but also to consider the long-term repercussions of thinking of ourselves as broken". Previous work regarding welfare reforms in Australia has made significant positive progress in this space (for an example see Vincent, 2019).

Although this thesis does not exhaustively critique the CDC or welfare conditionality more broadly through a critique of policy as settler colonialism, others have done so to great effect. The CDC and social policy in Australia in general, has been addressed through a useful and narrower lens applying theoretical perspectives that explicitly position the CDC as an ongoing version of colonial control over First Nations people specifically. Although the CDC does not only target First Nations Australians, unlike its basics card predecessor did through

the removal of the Racial Discrimination Act, before being reinstated (Lovell, 2016), the CDC does still impact mostly First Nations Australians (Bielefeld, 2021). In particular, authors such as Bielefeld (2021), Klein (2020) and Vincent, (2021) have written extensively on the CDC, specifically positioning the approach as an ongoing expression of colonialisation, and as a version of pernicious settler colonial policy in Australia.

The CDC has been described as a form of settler colonial policy because it reinforces the ongoing dispossession and marginalization of Indigenous peoples (Bielefeld, 2021). Regarding social policies in Australia in general, Vincent (2021) examines how welfare reform policies in Australia have reinforced negative stereotypes and stigmatization of First Nations communities. Vincent (2021) suggests that these policies portray Indigenous peoples as "lazy," "unproductive," and "dependent," and that they perpetuate a colonial discourse of control and domination. Bielefeld (2021) examines the income management approach in Australia and its impact on First Nations people, arguing that this system represents a form of violence that perpetuates colonialism and undermines Indigenous autonomy and self-determination. Bielefeld (2021) argues that the approach reinforces a colonial narrative that positions First Nations people as inferior and in need of control and discipline. Bielefeld (2021) suggests that this narrative is not new, has been present in Australian history since colonisation and has been used to justify ongoing dispossession and marginalisation of Indigenous peoples. It is because of this history that the income management approach to social policy has been described as harking back to past colonial repressive policies such as during the ration days where First Nations Australian's income was heavily controlled by the state (Bielefeld, 2012). Klein (2020) argues that the CDC policy represents a continuation of settler colonialism in Australia. Klein (2020) discusses that the policy is a product of a colonial history that has sought to control, assimilate and dominate Indigenous peoples, and that it perpetuates negative stereotypes and stigmatization of Indigenous communities.

The CDC, whether addressed through a general or specific lens regarding the targeting of specific groups, is widely agreed to be a discriminative and oppressive policy unequally and inequitably targeting welfare recipients (Marston, Mendes et al., 2020; O`Keefe & Papadopoulos, 2022; Peterie et al., 2022). Through its eligibility and income quarantining rules, the CDC policy has been argued to construct, define, and necessitate the control of a targeted group of people in society, namely the 'deviant welfare recipient' (O`Keefe & Papadopoulos, 2022).

Overall, the effects of actions and discourses related to discriminatory social norms and values however addressed, can result in social division and conflict (Humphrey & Schmalleger, 2019). So, interrogating how social policy acts as one form of social control to regulate and order society and inherently all its individuals and groups, matters when it comes to understanding how social policy influences society, groups and individuals. The following sections explore and critically discuss the broad lens this thesis adopts regarding social policy as a general form of social control, including constructions of deviance and the influence of ideology in social policy decision making.

2.2.1.2 Social Policy and Social Control

In general terms, social policy aims to direct and order society through policy 'instruments' being programs and interventions, typically categorised as either regulation, public enterprise, or direct provision (Howlett & Ramesh, 2009). In contrast to voluntary instruments, where the government does not directly get involved in private affairs, compulsory policy instruments "compel or direct the action of target individuals and firms, who are left with little or no discretion in devising a response" (Howlett & Ramesh, 2009, p. 87). The CDC is one example of a policy intervention that aimed to control purchase behaviours of targeted welfare recipients.

Doing social control through social policy has been addressed in different ways over time, including framing this control as a product of governance and a useful tool or process for organising society (A. Schneider, 2015). Because social control is an outcome of governance, Dean (2004, p. 15) suggested that governance necessitates a power imbalance between the governors and the governed, where "government concerns the shaping of human conduct and acts on the governed as a locus of action and freedom". Prior to Dean (2004), this power imbalance was addressed by Foucault (1979, 1991), who famously described policy as a governance practice *reinforcing* power imbalances between the governors and those governed to exert and legitimise social control enacted by the state. In contrast, Janowitz (1975, 1991) framed social control in relation to a continuous process of social regulation through different forms of social order and socialisation, where social policy is one mechanism to organise society and do social control.

Social control, whether considered an outcome or process, remains layered with what have been described as formal and informal control strategies to encourage socialisation, social order and organisation (Deflem & Wellford, 2018). As Cohen (1989) and White and Perrone (2005) suggest, social control is not unidirectional. Instead, they suggest it consists of dynamic interactions between social forces that work together to reflect and construct norms, conformity, deviance and crime. Social policy as a form of social control, therefore, should be considered dynamic in its influences, and whilst appearing formalised in conception and delivery, social policy will incorporate unavoidable, informal, and diverse mechanisms of organising society.

Policy interventions shape conditions within which people live, which changes how people interact with one another. Social policy's formal strategies of control include institutionalised delivery of policy and legislation through government departments, often targeting defined groups so to change their behaviours (Kubrin & Weitzer, 2003). Although social control can be either formal or informal (Bursik & Robert, 1993; Kubrin & Weitzer, 2003), social control strategies are a complex interaction between both approaches.

This complexity is argued as better explained as an informal-formal social control nexus (Kubrin & Weitzer, 2003). This nexus reflects the iterative reality of the role of *formal* institutions in delivering *formalised* social control strategies but relying on elements of *informal* social interaction mechanisms. Informal mechanisms relate to how those institutions socialise and organise communities and individuals, which determines how society will respond to formal control efforts (Janowitz, 1975). These formal institutions and strategies influence the construction of social norms and cultures at the informal level of individual and group interactions. They subsequently influence how people interact through avenues of reciprocity and reproduction of social norms and values, all working to influence formal control related to conformity or deviance (Sargeant, Murphy, McCarthy, & Williamson, 2021).

So, policy interventions as formal acts of social control also influence informal control mechanisms through shaping social norms and cultures, with these directing how people interact. In contemporary times, social control is often meant to describe both conformity and deviance, where the concept of deviance is relative to social norms and formal rule *violations* (Denisoff & McCaghy, 1973; Goode, 2019). Social control is conceived as not only a product

related to social solidarity or motivations to conform (Dépelteau, 2018; Weber, 1946), but also as a changing civil dynamic emerging from moving social networks, interactions, power dynamics, and aspects of group and individual motivations (Deflem & Wellford, 2018; Foucault, 1979, 1991; Janowitz, 1975, 1991). Social norms and rules related to conformity and deviance have been commonly argued as constructed from ideas based on different versions of morality and that such constructions shift over time (F. Williams & McShane, 2010). Similarly to the 1980s-90s, recent ideas of morality embedded in law and policy often reflect conservative morality intertwined with neoliberalism's individualised responsibility for self-control (Dean, 2004; F. Williams & McShane, 2010), discussed further in the following sections here.

Informal strategies of control include how policy influences perceptions of governance via individual and group experiences of policy, informing perceptions of state legitimacy to enact control (Dépelteau, 2018; Janowitz, 1975; Weber, 1946). As evidenced by A. Schneider (2015, p. 224) who outlines how social policy decisions and interventions relate to constructions of deviance framing recipients as deserving or undeserving, which links to the subsequent formation of social perceptions of legitimacy of the state to govern:

> People’s experiences with government as targets shapes their view of government and their understanding of their role in government…the way targets are treated by policy is central to justice, citizenship, support for democratic institutions, and democratic problem solving. Policy can either reinforce or undermine government legitimacy and sense of civic duty.

How social control and regulation is enacted through social policy and governance has been described by some as a process of governmentality. The term 'governmentality', originally developed by Foucault (1991), was with respect to what it meant to be governed and to govern. Governmentality refers to the way in which power is exercised and maintained in society through a range of institutions, practices, and discourses. It encompasses not only formal governmental structures but also a range of social and cultural practices that shape how people think and act (Dean, 1991; 2004). In Foucault's (1991) lecture titled ’Governmentality’, he reflected on ideas of governance over time, with governance translating in its contemporary versions as reminiscent of 'paternal governance'. The art of governing was suggested as being about the management of populations, so people do as they

ought, alongside the idea of 'economy' as a process relying on a paternal figurehead or 'government' where:

> To govern a state will therefore mean to apply economy, to set up an economy at the level of the entire state, which means exercising towards its inhabitants, and the wealth and behaviour of each and all, a form of surveillance and control as attentive as that of the head of a family over his household and his goods (Foucault, 1991, p. 92).

Governmentality therefore means to describe the myriad of different ideas and 'mentalities' informing the way we govern, who is governed, why, and in what ways. Dean (2004) extends the description of governmentality to elaborate on the *art* of governance by asserting that governmentality relates to the conduct of conduct. Dean (2004) describes conduct and governance where "government concerns not only the practices of government but also practices of the self" (p. 12). This includes the influences of ideologies on government conduct and who is acted upon in society. Ideas of governance relate to "tactics of responsibilisation" where the poor are made responsible for their living standard (Dean, 1991, p. 218). As A. Schneider (2015, p. 224) describes:

> Policies allocate values—benefits and burdens—to target groups…Target groups are sent messages by policy design of what they deserve or do not deserve. Persons without jobs during the virtual collapse of the US economy were told, on the one hand, that they deserved jobless benefits and that the amount of time they would be eligible would be extended, and on the other hand, that paying jobless benefits encouraged people to not look for jobs and in fact became a factor that prolonged unemployment.

Where social policy aims for control, this links to welfare where policy can intend to direct, or control the social welfare of targeted groups, and society more broadly (Carson & Kerr, 2017). The purpose of social policy in promoting social welfare and wellbeing has been generally described as needing to be based on the understanding that it promotes 'those values and attributes which enable life to go well rather than badly' (Fitzpatrick 2011, p. 1). Since the construction of Australia's welfare state in the 1940s (Jamrozik, 2001; Carson & Kerr, 2017), social policy has worked to control various social contexts with the outcomes intended

to improve welfare in three primarily different categorisations. These categorisations are social welfare, fiscal welfare and occupational welfare, with the latter two delivered through the taxation system via tax breaks and fringe benefits as outlined by Richard Titmuss in 1951 (Titmuss, 2019). In this thesis I pay particular attention to social welfare as this aligns directly to the CDCs provision as a form of income support intervention. Social welfare can be defined broadly as welfare state support via provision of social assistance through services and programs, including those 'visible benefits (such as pensions and child allowances) as well as services in areas like education and health care' (Carson & Kerr, 2017, p. 18). Fitzpatrick (2011, p. 3) conceptualises the welfare system as a 'set of socioeconomic and cultural relations that affects social change by trying to address social problems and to promote wellbeing.

Overall, in relation to social welfare such as provision of income support payments (Carson & Kerr, 2017), social policy has come to describe specific policies that work to address or 'govern' the deviant 'poor' in need of and eligible for income support, inherently treating the 'poor' as responsible for their 'poverty' (Dean, 1991). Most welfare approaches to contemporary social policy in Australia have primarily focussed on governing and regulating forms of morality and levels of economic participation of a particular, selective category of people in society (Arthur, 2021). As discussed further in the coming sections, the individualising influence of neoliberalism shifted Australia's initial ideas of a universal welfare state, toward one reflecting this selective and enabling welfare system (Jamrozik, 2009). This enabling meant to describe the selective targeting or control of behaviours of the 'deviant poor', with social policies aiming to 'enable' such groups through motivation to participate in the neoliberal market system, by way of entering the labour market and no longer passively claiming income support payments, framing this as economic activation through employment (Carson & Kerr, 2017).

However, what is meant by welfare in a policy context is diverse. In terms of governance, Esping-Andersen (1990) suggests that most definitions denote welfare as having at least some level of state responsibility to provide essential support for its citizens. This essential support for welfare as 'positive wellbeing' can be explained further by the Australian Institute of Health and Welfare (AIHW) (2021). The AIHW discuss welfare as aligning to wellbeing and identify two ways the term welfare is used. First welfare is aligned with wellbeing in terms of what creates happiness and health in society. Second, they describe

welfare as also relating to the system of financial services and support functions related to improving or maintaining welfare for people in need of assistance. The purpose of social policy regarding welfare and wellbeing has been generally described as needing to be based on the understanding that promotes “those values and attributes which enable life to go well rather than badly” (Fitzpatrick 2011, p. 1).

The following sections elaborate on these arguments presented. This is done by discussing the socio-political influences on Australian social policy, alongside the problematisation of welfare recipients and welfare consumption, and ideologies that inform these problems.

2.2.2 Ways of Enacting Social Policy in Practice

Throughout many Western democracies, there are a variety of approaches to making social policy, including: issue identification; policy analysis; policy instruments; consultation; coordination; decision; implementation and evaluation (Althaus et al., 2007, p. 37). As will be discussed further below, ideologies influence governance and policy-making by constructing a picture or theory of what society ought to be. Regardless of the prevailing ideology, the commonality between the variety of policy-making approaches is that they all relate to different ways to describe how to do social governance, and that social governance is based on social regulation that aims to change the choices of and interactions between people.

Maddison and Denniss (2013) suggest two primary ways policy is created in practice, the first following an authoritative or rationalist choice framework, the second via the structured interaction framework, with Colebatch (2006a) including a third as social construction. Colebatch (2006a) explains that authoritative choice approaches to making social policy depend primarily on only choices of government as the most powerful and knowledgeable to do so. Also defined as the rational choice approach by Maddison and Denniss (2013), *authoritative choice* tends to theorise and define social issues and policy processes as logical, where following clear and idealised sequences of activities 'lead to pre-defined goals and the authority of government to make decisions' (p. 83). In contrast to authoritative choice, *structured interaction* aims to describe the practice of doing policy in reality. The structured interaction approach aims to reflect that there is more than one powerful decision-maker in the practice of doing policy, therefore dismissing the exclusive rationality that can occur

under authoritative choice in favour of knowledge being developed by multiple subjectivities of people involved in a social issue (Colebatch, 2006b, 2020). The *social construction* approach frames policy in terms of how issues are constructed or created through the process of doing policy (Colebatch, 2006b). This also incorporates what Bacchi (2009) described as *problem representation*, where the creation of policy itself comes to define and construct social phenomena as a problem needing fixing.

A variety of other frameworks and models have been developed that also aim to address how social policy decisions are influenced. For example, the Garbage Can Model describing decision-making developed by Cohen et al. (1972) and still used today, in contrast to a rationalist view of social problems and actions, suggests policy making is not a rational or systematic process. Instead, it is a chaotic and unpredictable activity that is influenced by various external and internal factors. This model describes that problems are seen as independent from solutions, participants, and decision-making opportunities, which can arise from within or outside of the organization and are often ambiguous and ill-defined. Solutions are generated independently of problems and may be based on prior experiences, available resources, or arbitrary preferences (Nutley & Webb, 2000).

Other frameworks describing policy-making influences include the Advocacy Coalition Framework. The Advocacy Coalition Framework suggests that policy making is a process of conflict and negotiation between competing policy advocates or coalitions (Sebatier & Weible, 2019). These coalitions consist of individuals, interest groups, and organizations that share a common set of beliefs and values about a particular policy issue (Sebatier & Weible, 2019). In comparison, the Garbage Can Model sees problems, solutions, participants, and decision-making opportunities as separate and independent streams that come together randomly (Trein, Maggetti & Myer, 2021), while the Advocacy Coalition Framework sees policy issues as part of a larger policy subsystem, where coalitions form around different policy beliefs and values. Overall, both models mentioned here highlight the role of belief and values in policy-making to some degree, as influencing whatever decisions are made and however problems are defined.

The authoritative choice framework is dominant in policy making in Australia, also referred to as rationalist or authoritative instrumentalism (Colebatch et al., 2010). With this approach, social policy applying authoritative choice reflects a paternalist ideology and frames

government as made up of expert authorised decision-makers, collectively operating as an official problem-solving mechanism, with practice occurring through the implementation of rational decisions (Althaus et al., 2007; Dye, 1985; Friedrich, 2019; Hale, 1988). Although most common, authoritative/rationalist choice approaches have been criticised for being far removed "from the experiences of policy participants" in context, such as those tasked with implementing a policy, where authoritative choice can primarily represent policy in theory relying on ideas of those in power (Colebatch, 2006a, p. 320).

Most efforts to address social problems follow the policy cycle to some degree, a bureaucratic process for identifying, dealing with and measuring social problems and efforts to address them (Jann & Wegrich, 2017). Some policy practitioners have described policymaking as the bureaucratic policy cycle (Howlett, Ramesh, & Perl, 2009). The policy cycle provides tidy categorisations of stages of policy. Althaus et al. (2007, p. xi) present the policy cycle, which "starts with an issue, seeks evidence, tests proposals and puts recommendations before cabinet". This rational-looking, but abstract, policy cycle is a framework formally adopted by many in the creation and evaluation of policy and is represented by the following 'stages': issue identification; policy analysis; policy instruments; consultation; coordination; decision; implementation, and evaluation (Althaus et al., 2007, p. 37). Even where those stages do not often occur in order in reality, the process is argued as useful to address a problem, where in practice that problem is thought to be needing a clear definition and be well-structured (Althaus et al., 2007, p. 52). Ill-structured or overly complex problems are often avoided in policymaking (Nair & Howlett, 2017), and are suggested to elude straightforward solutions and solving. Instead, clear structure and definitions better "shape the options for a solution" (Althaus, Bridgman & Davis 2007, p. 53).

Well-structured looking problems make for well-structured political solutions and action through policy making. Although it is commonly accepted that whilst such clarity is desirable, it is often not close to reality in practice due to associated social complexities that are not captured by a rationalist use of the policy cycle (Maddison & Denniss, 2013; McClelland, Smyth, & Marston, 2021; Turnpenny, Jordan, Benson, & Rayner, 2015). Where social problems are made to be neatly defined, structured and simplified, then measured against parallel objectives, this is symptomatic of a positivist form of conceptualising society and establishing linear, unidirectional cause and effect (Caldwell, 2015; Comte, 1848). Such

linear conceptualisations of social issues permeate across political ideologies and actions. The process of policymaking can be seen as similar across political divides, even where the finer details of action are often contested (Turnpenny et al., 2015).

The policy process may reduce social complexity out of political necessity. Some arguments suggest that linear policy-making processes occur out of necessity to maintain public faith in the ability of political action to be seen to quickly address 'bad' social issues in some way depending on favoured political ideology (Goode & Ben-Yehuda, 1994; Walsh, 2017). Policy is often presented as a political solution, and the politicisation of policy in the public sphere of political action influences the overall policy cycle (Howlett & Mukherjee, 2017). However, this influence of political power on policy processes has been argued as needing to be accounted for in the policy cycle (McClelland et al., 2021). Indeed, policy characterisation has been argued as an extension of the process of political agenda-setting (Turnpenny et al., 2015, p. 8), making the policy process an inherently political act needing to be clearly translated into the public sphere.

Political pressure necessitates fast, linear, rational action on fixing simplified 'bad' social issues that may work to constrain options for alternative approaches and instead reinforce choosing a rationalist approach to policy making. For example, the authoritative or rationalist process of 'doing social policy' as it is currently and most commonly done in Australia (Colebatch et al., 2010), can be presumed logical given political constraints such as public pressure and constructed expectations of governance. This pressure includes defining and acting on constructs of 'bad' social issues to maintain public 'faith' in governance and political will (Althaus et al., 2007; French, 2018). Defining and acting in this way therefore will include reducing complex social issues (Jamrozik & Nocella, 1998) into categorised and orderly problems following dominant ideas of governance. What is determined as a bad social issue is in turn partly constructed and reinforced by mechanisms of governance, such as policy, political expressions, and media. Here we can see the link that ideas of governance relate to favoured ideologies or ideas of what society ought to be (Béland, 2016; Gstrein, 2018). These ideas become actions in observable bureaucratic behaviour through social policy decisions that can be traced and linked over time.

2.2.3 The Importance of How Welfare is Represented

Dominant ideologies inform much of contemporary problem identification and subsequent policy decisions in Australia today. Problem identification in social policy has been argued to be mostly based on abstractions from reality shaped by different social constructs informed by different worldviews (Althaus et al., 2007, p. 55; Béland, 2016, p. 737) or ideologies (Bacchi, 2009). These ideologies or worldviews inform what Bacchi (2009) describes as problematisations. Problematisation of social issues are defined as the framing mechanisms determining what is and what is not important and therefore considered to be a problem to be fixed. Bacchi (2009, p. 263) suggests in their analysis that policy reflects how social problems are represented or problematised, that "policies constitute problems", making "a problem exist as a particular type of problem" based on ideologies informing governance decisions.

Use of ideologies frame what is deviant by underpinning systems of social, economic and political regulation and governance, and the role of the state, or government, in people's lives (Maddison & Denniss, 2013). The labelling of who and what is deviant and, therefore who is deserving of social support and welfare assistance is socially constructed through narratives and social policy decisions by the powerful (B. Marshall & Robert, 2014). When a person fails to behave as desired according to localised social norms, the individual can be considered deviant (Franzese, 2015), become the site of dysfunction, and be framed as an underserving citizen (A. Schneider, 2015).

Dominant ideologies such as those assigned to neoliberalism and conservativism have widely influenced how problems are conceived in the Australian social policy context. Through influencing governance processes, neoliberal ideas of individual responsibility largely shape how deviance is defined in Australian society and this has ramifications for the construction of social welfare and aligning social policies (Carson & Kerr, 2017). Neoliberalism's displacement of responsibility onto the individual is supplemented through the parallel social redefining of deviance (Carson & Kerr, 2017). Dysfunctional and deviant behaviours under neoliberalism have been described by Spitzer (1975, p. 642) and Rodger (2012) as those classified as economically redundant and not economically contributing to society by way of waged labour. In other words, social failures here include poverty, being poor and unemployed, and the result and responsibility of individual failure and deviance. Thus, if

framing deviance in this way through applying these ideas, proceeding logic infers poverty and unemployment need related governance strategies to be directed and rectified at the site of the individual.

Definitions of deviance and its related changes have been argued as inclusive of but not limited to neoliberal ideas alone. Australian politics and social policy, as they currently exist, are described as being influenced by ideas embraced by a combination of conservative (Arthur, 2021), paternalist (Altman, 2014; Klein, 2016b) and neoliberal ideologies (Mendes, 2017). Some researchers have predominantly focussed on neoliberalism, describing social policy as one form of action of social governance, taken to uphold and reinforce neoliberal ideals (Schram, 2018). However, researchers such as Arthur (2021) and Cahill (2013) observe that to solely consider social governance and social policy as only a neoliberal project disregards much more complicated nuances of how conservative commentators and politicians have used neoliberal ideas.

Arthur's (2021) review of neoliberal ideas of liberty and responsibility shows that neoliberal ideas were not inherently value-laden as bad or good. Instead, there was a bigger picture conservative framing of what these ideas were applied to and by whom (Van Oorschot, 2005). The way ideas were applied and by whom contributed to increasing conditionality imposed on certain groups in society, namely the welfare-dependent poor/unemployed. The problematisation of welfare dependency is reflected on by Arthur (2021) as a new label for 19th century pauperism, and that aligning the changes to Australian welfare policies only to neoliberalism, obscures the combination of *how conservatives used neoliberal ideas.*

For example, Cahill (2013) explains that policy during the Australian conservative-liberal coalition Howard government era in the 1990s cannot be accurately attributed to neoliberal ideas alone, as this subverts the nuance and complexity regarding how such ideas were applied to policy affecting the poor and unemployed. Cahill (2013) shows that policy influences reflect ideas of conservative think tanks, commentators and politics combined with the uptake of neoliberal economic rationalism. Neoliberal ideas promoted individualised responsibility, participation in waged labour, and the decrease of state responsibility for social issues in people's lives (Marston & McDonald, 2007). However, conservative commentators and politicians further problematised welfare consumption, who combined preference for individualised responsibility with further 'moral problems' (Arthur, 2021).

Here the individual could be made responsible for what was deemed *morally wrong* according to conservative values. Thus, concepts of deviance were further changed.

Social, political and religious conservatives have been suggested as usurping neoliberal economic ideas as part of a moral argument of what society ought to be, based on various values constructed from particular historical social norms. For example, neo or 'new/contemporary' conservatives combined neoliberal economic ideas with ideas of what behaviours constitute good character. Political and policy observations by neoconservative Wilson (1985) in the 1980s suggested that governance-related actions had begun to focus more on an individual's character based on moral ideals. Wilson (1985) rejected value-free governance and argued for policy encouraging people to act virtuously. Behaviours threatening conservative ideas of virtue include those related to criminality, self-interest and consuming welfare instead of those committed to waged employment (Cozzarelli, Wilkinson, & Tagler, 2001; Fridberg & Ploug, 2000). Ideas of morality were aligned to individualised notions of responsibility for character building, where at the time, Wilson (1995, p. 108) argued:

> Moral virtue is the same as good character, and good character is formed not through moral instruction or personal self-discovery but through the regular repetition of right actions.

Overall, who was deemed deviant occurred through problematisation of targeted behaviours deemed 'bad, immoral and lacking virtue', which were constructed through decisions influenced by conservative ideas where neoliberalism locates responsibility for social problems at the site of the individual.

While conservativism has been regarded as framing the poor as deviant (Cozzarelli et al., 2001), paternalism can then effectively work to decide on behalf of the ‘deviant’ what they can and cannot do, in effort to redirect behaviour toward that reflective of conservative morality. Saint-Paul (2011, p. 6) defines paternalism in contrast with liberty, arguing that paternalism fundamentally removes individual liberty and challenges the right to personal freedoms *for some people*, where instead a powerful other determines what is best. In this case, the powerful other is the policy maker and politician. DeCew (2011, pp. 814-815) refers to the work of John Stuart Mill, who argued paternalism was only ever appropriate regarding the governance of minors or “those without maturity of their own faculties”. Others further

suggest that the right of a powerful other to intervene and restrict personal liberty is justified but only when behaviours are deemed high risk of leading to irreversible harm; relate to extreme psychological or sociological distress; or there is insufficient education regarding potential harms from those behaviours (Dworkin, 1971).

This paternalistic removal of liberty and freedoms has its limits and usage. The included authors in the above paragraph all claim paternalism has its uses to an extent. Nevertheless, some also argue it should have clear limits concerning how much power is provided regarding the right to restrict individual liberty, arguing that paternalism should not go unrestricted (DeCew, 2011, p. 815). Overall, when paired with conservative and neoliberal ideas framing the welfare recipient as deviant, paternalism meant these people were also positioned as incapable of having the responsibility to fix, yet remain simultaneously responsible for the origin of, their social problems. This kind of contradictory framing has been said to justify punitive policy approaches, such as those based on constructions of crises of welfare consumption and dependence by certain political groups with the aim of getting people off welfare, or otherwise controlling behaviours of 'deviant' welfare consumers in some way (Lovell, 2016).

Since 1788, Australia has had a range of social welfare policy approaches over time (Mendes, 2018). These approaches to the construction of the Australian welfare-state have shifted since the 1940s from an initial focus on universal coverage, to a more selective approach, due to the influences of neo-liberal, conservative and paternalistic ideologies (Mendes, 2018). Recently in Australia, social policy has commonly attempted to govern the poor by combining political adherence to free-market capitalism with neoliberal paternalism (Marston & McDonald, 2007; Mendes, 2018). As outlined throughout Section 2.2, the determination of the poor and unemployed as morally wrong or deviant can be further attributed to conservative problematisations of what is framed as right and wrong (Archer, 2009; Van Oorschot, 2005; Wilson, 1985, 1995). Here conservative ideas of 'virtue' combine with economic rationalism (D. Arthur, 2021) to frame the poor as morally deviant (Franzese, 2015; B. Marshall & Robert, 2014) and their economic and moral dysfunction as an individual's problem and responsibility (Beeson & Firth, 1998; Béland, 2019; Dean, 2004). The next section discusses these contemporary socio-political changes as applied to social policy in an Australian context over time.

2.3 Changes in Australian Social Policy Over Time

Social policy and governance change over time as successive governments attempt to conceptualise and manage social issues in line with their platforms and party ideologies. The purpose of this section is to provide some brief contemporary historical context regarding the development of welfare conditionality in Australia and to show the influences of ideology on governance using examples of how social policy was created and changed over time. Taylor, Gray, and Stanton (2016, p. 6) have described this alteration of policy focus in Australia as a pendulum, where since the inception of social security or welfare policy specifically, different cycles have reflected different ideological, political, and macroeconomic trends.

This brief review of policy spans from the 1970s until the introduction of income management in Australia in 2007 (then followed further in the next section). The contemporary changes identified in Australia's policy approach are discussed. These include discussions of the changing ideologies which have influenced social policy decisions over this time summarised in Figure 1 below. These ideologies include the increasing attribution of responsibility for social issues such as poverty and unemployment to individuals, the framing of deviance and social issues through a conservative and neoliberal lens, and the decrease in reliance on positioning these issues in relation to structural origins. Changes are shown to parallel global events alongside the shifts in political discourse framing deviance around the predominantly western or 'developed' world. The following Section 2.4 then narrows to focus on income management introduced after 2007, focussing on the CDC specifically.

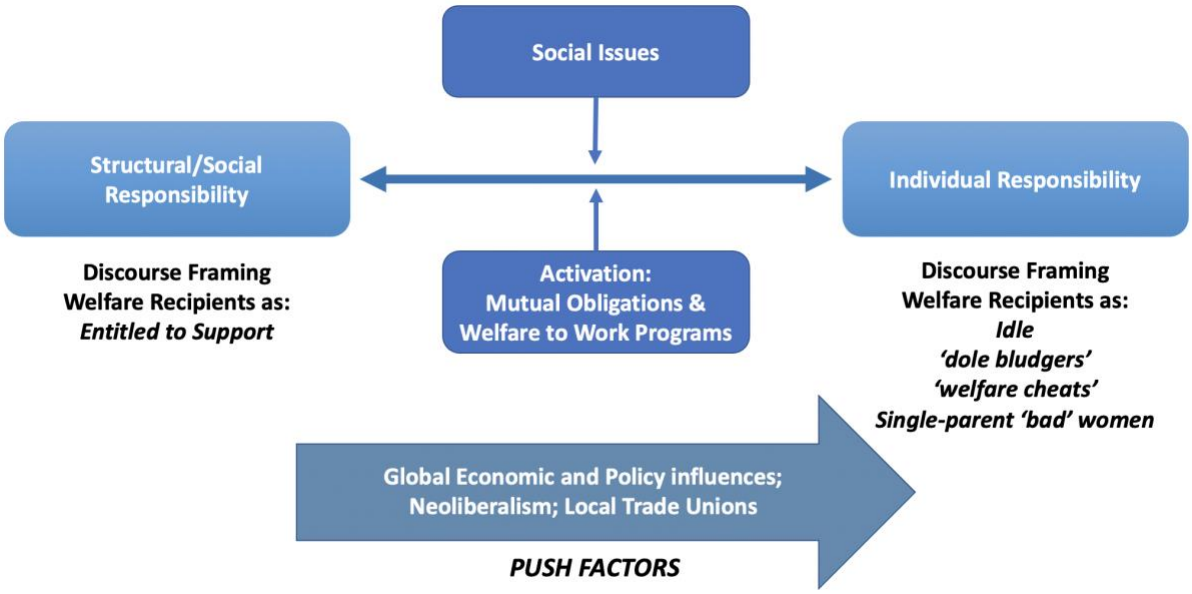

Figure 1: Responsibility for social issues changing from structural to individual over time and the push factors and related discourse to these changes

2.3.1 Global Influences on Problem Responsibility Change from Society to the Individual

The aims of emerging social policy in Australia at the time of welfare reforms in the 1990s were strongly influenced by simultaneous shifts in ideas of governance, including global economic shifts, influences from international welfare policies colliding with local trade union actions, and subsequent changes in general local political discourse over time. In combination, these influences can be shown through examples to reshape conceptions of social deviance in Australian social welfare policy and welfare reforms. The following section builds on how new discourses included justifying an increase in punishment, and how to use regulatory policy instruments and interventions as forms of deterrence for non-compliance with welfare policy rules.

2.3.1.1 Global Economic Influences and the Attributions for the Causes of Social Issues

The economic recovery from the Second World War saw a Keynesian capitalist welfare-state approach to social policy in many western nations globally, which increased government responsibility for social issues and woes in the lives of citizens through policy and regulation (Maddison & Denniss, 2013). During this time, in many western capitalist countries, the role of the state and subsequent social policy, was mainly through the state assuming some responsibility for social issues such as poverty, employment, housing and healthcare (Alcock et al., 2022). Bacchi (2009, p. 62) discusses the direction of social governance during this

post-war period as defending the view that the state had a duty of responsibility and accepted the risk in delivering to its citizens wide-ranging (as opposed to individually targeted) economic opportunities for social stability. Taylor, Gray and Stanton (2016) describe a person's entitlement to support as based on foundations that systems of governance were responsible for creating social structures within which people lived. This entitlement approach to welfare before the 1990s reflected a UK Marshallian rights-based approach to providing social support, where the right to receive support was universal and based on need. T. Marshall (1950, 1964, 2006) argued in part that the social right to welfare support was both universal and largely unconditional, preserved within the notions of social citizenship and equality. Here the individual had a right to receive social support, although eligibility requirements still needed to be met.

Australia did not adopt Keynesian welfare-state policies as fully as some Scandinavian counterparts it has been observed (D. Mitchell, 1997). However, the Australian benefits system still showed state acceptance of responsibility for social issues during this time, shortly after the Second World War (Arthur, 2021). Social issues, otherwise framed as social risk, are also described as socialised post-Second World War (Rose, 1999). From the 1970s, however, the Keynesian welfare-state approach to social governance was eroded and slowly replaced by an increasing economic rationalism in Australia and elsewhere (Fenna, 2004).

The dissolving of the Whitlam Labor government in the 1970s and the incoming conservative Fraser Liberal coalition (Parliament of Australia, 2014) saw social welfare expenditure face reductions through ongoing rationalist economic restructurings under neoliberal capitalism (Jamrozik, 2001; Pusey, 1991). The phase of the welfare-state post second world war is also argued as having been terminated due to the 1970s global inflationary crisis (Marsh, 2011, p. 324). Following the economic inflationary crisis, ideas from a neoliberal ideology were pivotal in restoring lost capitalist profitability. They encouraged the upward shift of wealth across classes and in many countries, meaning a decline in the power of organised labour (D. Harvey, 2007). Such neoliberalism, in theory, reflects: the freedom of the individual; prioritisation of the capitalist economic free-market; the liberation of capital; privatisation of social services; and supports other possibilities of private accumulation of financial profit (D. Harvey, 2007). In contrast to Keynesian capitalism which promoted a rationale of structuralism for economic decisions such as dealing with unemployment, neoliberal capitalism promoted individualisation of responsibility for such issues (Palley, 2005).

Historically, the social issue of unemployment in the early twentieth century has been described by Walters (2001) as a primarily systemic, structural issue resulting from conditions external to individual choices. The economic growth and government stimulus policies in Australia in the 1960s and 1970s provided jobs and low unemployment levels for those two decades (Marston & McDonald, 2007). This focus on infrastructure and jobs as alternatives to welfare has been argued as to why Australia did not adopt Keynesian welfare-state approaches as strongly as other countries such as Scandinavia (Deeming, 2014). Structural conditions can be described as 'causes of causes' of social issues or risks. Esping-Andersen (1999) defined social risk as relating to structural, contextual influences of class, life course and intergenerational factors. Others have similarly defined social risk to emerge from structural conditions such as low economic stability and poverty (Armingeon & Bonoli, 2007), which are also defined as risks themselves, highlighting the complex and non-static nature of the causes of social issues.

Overall, social issues/risk post-Second World War and into the 1970s were framed as outcomes of poor social conditions shared by many, not individuals alone. For example, Crammond & Carey (2017, p. 85) described social risk during this time to "derive from… social, economic and political structures and are beyond the control of most (if not all) individuals". Such conditions, in more general terms and regardless of government popularity, have been consistently argued by many as remaining outside the direct control or choice of individuals and instead relate to the combination of indirect effects of social structures that work to influence individual behaviours (Bacchi 2009; Coburn, 2016; Cockerham, 2005; Stewart, 2005; Weber, 1978).

2.3.1.2 Influence of International Welfare Policy Directions and Local Trade Unions

Implementing neoliberal ideas in Australia was encouraged by similar adoption in the governments of the United States of America (USA) and United Kingdom (UK). Emerging in the USA via the Reagan government and in the UK via the Thatcher government in the 1970s, Friedman and Hayek's neoliberal capitalism was adopted as official policy there, where the role of government was to facilitate and support the free market to 'cure' social woes, and little more (Schram, 2018, p. 6). This meant the pulling back and reduction of responsibility of the state in citizens' lives, with academics describing this as a return to classic laissez-faire governance, as seen prior to the Second World War (Mendes, 2017,

2018; Schram, 2018, p. 6). Overall, adherents of neoliberalism championed individualism (in the form of individual responsibility for their woes) and prioritised the economy as the guiding structure in social governance.

Alongside the inflationary crisis, neoliberal ideas were encouraged in Australia by related trade union influence (Jamrozik, 2001, p. 64). Humphrys (2019) argued that it was not the rise of right-wing conservative politics but the left who brought neoliberalism to the foreground in Australia, in part through the social contract known as the Accord (Humphrys, 2019). The Accord was developed and supported through the combined efforts of powerful social groups in Australia, such as the Australian Council of Trade Unions and the Australian Labor party (Marsh 2011, p. 324). These efforts and reforms under the Accord saw the demise of the welfare-state-managed economy in preference for a greater focus on individual freedoms and economic competitiveness (Beeson & Firth, 1998). They contributed to a decline in government assuming responsibility for social issues in the private lives of citizens. Together the combination of the Accord and neoliberalism resulted in outcomes that: further restored the accumulation of capital lost during the economic fall-out in Australia post-1970s economic inflation crisis; entrenched neoliberal ideals of individual freedoms; and contributed to the subsequent disorganisation of the labour movement (Humphrys, 2019).

2.3.2 Changing Discourses of Australian Welfare Reform and Conditionality: From Entitlement to Obligation and Punishment

The combinations of shifts in welfare-related political discourse, global economic influences, international policy directions, and local trade union actions, culminated in entrenching individualised behavioural-based welfare conditionality reflected in the 1990s Australian welfare reforms onward. However, conditionality of some form has always been present in Australian social policy and welfare support (Dwyer & Wright, 2014a, p. 33; B. Watts, Fitzpatrick, Bramley, & Watkins, 2014), the *type* of conditionality operationalised in welfare policies has merely changed over time. Aligning with changes in political discourse, contemporary policy approaches came to reflect ideas of entitlement to support the promotion of mutual obligations to receive support, with political discourse and policy logic working on framing 'correct' behaviours and punishing those considered 'bad'.

2.3.2.1 Political Discourse Influences Responsibility for Social Issues

Alongside shifts in the 1970s, 1980s and 1990s global economic and policy influences and local trade union powers, political discourse also began to reflect changes in state conceptualisation of who was responsible for social risk, which also influenced social policy. Saunders (2001, p. 153) emphasises that "one of the initial goals of the welfare state… was to institutionalise the management of risk". Reflected in Australian Hansard parliamentary debates in the 1970s-80s are patterns of discourse showing the state assuming responsibility for social risks, but this gradually declined leading up to the 1990s (Lovell, 2016). Social risks included social issues beyond the immediate control of the individual, such as disability, low income, poverty, job loss and unemployment, inequitable and unequal access to healthcare and suitable safe housing (Giddens, 2000; Holzmann, Sherburne-Benz, & Telsuic, 2003). Policy examples include those in the 1970s with little behavioural conduct components demonstrating the limited focus on individualised responsibility for social issues. Examples include policy without means-testing on pensions, widow and disability mobility payments, and low-income supplements for families to help address child poverty (Herscovitch & Stanton, 2008).

The gradual uptake of neoliberal ideas in governance strategies also promoted individualised responsibility for social risk and, correspondingly, the reduction of state responsibility in most peoples' lives (Marston & McDonald, 2007). As further described by Marston and McDonald (2007), the low unemployment rate of 2% in the 1970s was achieved through policy directing infrastructure building which focussed on the supply of jobs. By the 1980s, this approach had changed. Social issues such as rising unemployment began to be politically framed as an individual's failure and responsibility. Here, policy direction shifted from one related to a supply of jobs to one related to a 'supply of labour' (Marston & McDonald, 2007).

There was a growing unwillingness of the government to create jobs through similar infrastructure investment using public money during the 1980s as there once had been. This saw the focus of the welfare system begin to change from alleviating poverty to supplying and increasing labour and encouraging neoliberal economic participation (Ziguras, 2006). During the 1980s-90s, social risk continued to be increasingly individualised, where the neoliberal promotion of self-reliance further displaced the responsibility of risk from the state onto the individual (Foucault, 2008; Larner, 2000; Lewis, 2014; Rose, 1993). Here it was politically argued that social risks were largely preventable with adequate *individual* action

and could be individually mitigated, for example, through upskilling or training of the individual to protect against unemployment or purchasing private health insurance to protect against poor health outcomes (O'Malley, 1996).

Alongside the increasing individualisation of responsibility for social issues regarding governance and policy (Jamrozik, 2001), there was subsequently a broader political and social reconstruction of how social responsibility for social issues was defined. Through social policy and political discourse, *governance increasingly problematised the individual as responsible for experiencing social harms/issues*. Influenced by social policy and political conditions, Australian society was thus stimulated to believe the same, where policy and political discourse influenced broader social norms. Overall, these changes culminated in welfare reform in Australia in the 1990s, where governance adopted a largely neoliberal approach to social policy going forward (Maddison & Denniss, 2013), discussed further here.

2.3.2.2 Discourses of Framing 'Correct' Behaviours According to Conservative Neoliberalism and Paternalism

It has been well established that people receiving welfare, particularly those who are single parents, without a disability, and not 'elderly', have been negatively stereotyped internationally in Australia and similar countries (Schofield et al., 2021). How these stereotypes or framing occur includes political influence through targeted public discourse supported by key figures, including academics and commentators.

Political narratives that work to frame social perceptions of the poor by the powerful, reflect Erving Goffman's (1974) theory of frame analysis, which in brief, posits that reality and its definitions are culturally determined using differential value embedded in recognisable symbols. These narratives, employed by some policymakers who frame how society should view the poor who consume welfare, relied increasingly on multiple frames relevant to conservative morality during Australian welfare reforms. These frames and their narratives constructed a version of reality by using and changing the symbolic value of representations of poverty and morality. This therefore influenced what could be considered deviant in society more broadly to reinforce state legitimacy to enact punishment on certain groups through policy decisions. These changes in framing through discourse are exampled as follows.

During the Australian welfare reforms in the mid-1990s, academics such as Mead (1997b, 2012) argued that individual choice and behaviours resulted from an individual's psychology, and as such, behaviours were not the direct result of structural conditions but of individual choices. This focus on individualism and behaviour is the basis of Mead's theory of 'new' paternalism adopted into Australian welfare reform in the 1990s onwards (Buckmaster, Ey, & Klapdor, 2012). New paternalism is considered the most recent iteration of paternalist ideology. The adoption of paternalist ideas into social policy further encouraged policy decisions to focus on behavioural conduct as an essential eligibility requirement for social support. Once described as the 'third way', new paternalism had been argued as the next welfare-focussed policy instalment of social governance after the welfare state and neoliberalism respectively (MacGregor, 1999). This third way described new paternalism as an attempt to rectify the increasingly conservative-inspired apparent lack of social cohesion (Perri, Fletcher-Morgan, & Leyland, 2010) and inequality resulting from neoliberal capitalism alone (Arthur, 2021).

During the 1980s and 1990s, conservative politicians and commentators increasingly argued that positive character-building habits were chiefly formed in the family (Arthur, 2021). For conservatives, family values primarily related to cis-gender relationships, where parents had clear gender roles regarding raising children and related responsibilities, including maintaining waged employment and not being 'idle'. In the 1980s and 90s, in the welfare reforms in the USA and UK, negative character traits such as crime, alcohol consumption and nonmarital sex largely aligned to apparent idleness (Stryker & Wald, 2009). Conservatives often attributed such traits to long-term welfare consumption and that these traits were the mistake of the deviant, idle, and demoralised individuals who consumed welfare (Haskins, 2007, p. 11)

In part, the aim of focusing social policies on changing character and instilling virtue was about altering moral values argued as in decline. These included the changing family dynamics that resulted from increasing divorce rates in the 1980s and the subsequent rise in single parenting, combined with rising unemployment (Marston & McDonald, 2007). All these things were problematised through a conservative lens and attempted to be rectified through welfare policy reform, where family dynamic, welfare dependency and idleness were framed as deviant and were interrelated aspects/drivers/outcomes of ‘moral problems’.

In Australia, the conservative problematisation and policy logic of welfare consumption occurred by way of reframing welfare dependency as deviant through conservative moralising and political labelling of people who consume welfare (Martin, Schofield, & Butterworth, 2022; Mendes et al., 2021; O'Keeffe & Papadopoulos, 2022). This labelling was seen prior to welfare reform in 1976 through the use of the term 'dole bludgers' for the first time in public media address and politically by Liberal-Conservative Australian Prime Minister at the time Malcolm Fraser (Parliament of Australia, 1976). Archer (2009) discusses welfare discourses regarding the 'dole bludger' and how this new discourse helped to reframe how welfare consumption was socially conceived and problematised. As Marston and McDonald (2007, p. 235) describe:

> The derogatory term was indicative of the Australian government's reframing of the problem of unemployment away from the failure of the economy to deliver sufficient jobs, towards a moralising and individualising notion that unemployment was primarily a problem of the unemployed.

In combination with neoliberal ideas regarding individualised economic responsibility, conservative ideology provided a further value-laden attempt to direct people away from idleness and toward conservative ideas of what was morally good.

Conservative and neoliberal problematisations of deviance can be further evidenced in Wilcock's (2014) review of the deviant 'welfare cheat', reflecting gendered targeting of the deserving and undeserving poor. Here they show the framing of single-parent 'bad women' during Australian welfare reform in the 1990s, where the official discourse of the welfare cheat was "highly gendered, and serve to legitimise the prosecution of women for welfare-fraud offences" (Wilcock, 2014, p. 177). Similar, systematic reframing of public discourse and social policy legislation also occurred more subtly during the lead-up to and after Australia's welfare reforms in the 1990s, such as through renaming the Government Department of Social Services to 'Centrelink' in 1997. This renaming is suggested as aiming to remove any symbolism of government responsibility for services which began to include private industry involvement in service provision, such as outsourcing employment services to private entities (Marston & McDonald, 2007, p. 235).

Recent examples of the continued negative framing of welfare recipients relating to welfare quarantining in Australia can be seen in the research by Lovell (2016) and others such as Mendes (2020b), Mendes et al. (2021), O'Keeffe and Papadopoulos (2022), and in reports and speeches by P. Fletcher (2019), A. Forrest (2014), and Parliament of Australia (2007). For example, Lovell's (2016, p. 436) review of Australian Hansard parliamentary debates identify the increasing adherence to and use of neoliberal reasoning in discourse across 2007-2010 to introduce income management and justify increasing welfare conditionality in Australia. Debates here showed adherence to neoliberal social policy ideas across Australian Liberal and Labor political parties. In Lovell's (2016) examples, they identify from across the Labor and Liberal Coalition divide, the discourse that individualised responsibility for unemployment and other bad life conditions, problematised welfare as 'passive' and positioned recipients as in need of 'activation' into waged employment. For example, in August 2007 previous Minister for Indigenous affairs, Mal Brough is quoted as saying that the objective of income management was:

> For the person [welfare recipient] to take responsibility for their own welfare and for the welfare of their family and for individuals to take control over their lives (Parliament of Australia, 2007, p. 3).

Discourses particularly targeted the parenting behaviours of Aboriginal Australian welfare recipients as inadequate, which Lovell (2016, p. 440) argues that this created a political rhetoric of crisis, justifying extreme measures of intervention and new social policies such as income management to 'fix' and 'activate' problem communities. Such framing can also be seen in the Forrest Review (A. Forrest, 2014, p. 19), which positions particularly Aboriginal parents as largely unaware and incapable and in need of government intervention:

> Without access to programmes that nurture good parenting, many Indigenous children face lives ruined by parents who are simply not aware of the devastating impact that their lifestyle (drugs, alcohol, poor nutrition) has on their children's entire future.

This discursive formation of crisis is referred to by O'Keeffe and Papadopoulos (2022, p. 4) as 'discursive legitimation'. They argue this worked to intensify welfare conditionality through constructing the social identity of the Australian welfare recipient as misaligned to neoliberal market values, underpinned by morality where "unemployment is caused by the

characteristics or agency of the person seeking support and warrants correction". Further examples of this framing of deficiency and individualisation of social problems of welfare recipients are evidenced in a 2019 ministerial speech given by previous federal Minister for Families and Social Services, Paul Fletcher, whose statements positioned the welfare recipient as irresponsible and in need of intervention:

> The key reasons for using the cashless debit card as the means to deliver welfare payments are pretty clear. It helps ensure that welfare payments are used for their intended purpose: so vulnerable Australians can put food on the table, can pay the rent, can buy clothes for their children. Every time a welfare dollar goes to a drug dealer or grog seller, it is not being used to provide this primary support. Very importantly, the cashless debit card helps people stabilise their lives and reduce key risk factors. In turn this helps people deal with key responsibilities in their lives such as looking after children (P. Fletcher, 2019, para. 1).

The relevance of the social framing of deviance can be aligned with how some have paralleled these frames to conceptions of control and state legitimacy to enact social policies to direct behaviours. For example, influencing and normalising specific frames of deviancy in public opinions and inspiring related belief reflects what Max Weber described as reinforcing state legitimacy, where "the basis of every system of authority, and correspondingly of every kind of willingness to obey, is a belief, a belief by virtue of which persons exercising authority are lent prestige" (Weber, 1978, p. 382). The maintenance of state legitimacy remains absolute in its importance of effectively governing, ordering, socialising and controlling society, whatever the approach to governance used (Jackson & Gau, 2016; Tyler & Jackson, 2014; Wang, 2020). As described at length by authors such as Foucault (1979), the treatment and deterrence of deviance through punishment has long been a strategy of governance, and its contemporary use in Australian social policy is addressed in the section below.

2.3.2.3 Entitlement

Regarding conditionality, Australian welfare reforms in the 1990s saw a shift reflected in policy from a structural, philosophical position of Marshallian *entitlement* to one focussed on individual *behavioural conduct* requirements (Dwyer, 2016, pp. 41-42; Taylor et al., 2016).

Marshallian eligibility requirements reflect what has been termed basic conditionality. Basic conditionality has mainly been based on some form of non-behavioural requirement in the past, such as *status*, for example, age or residency; and *need*, for example sickness, abilities and low/no income (B. Watts & Fitzpatrick, 2018, p. 2).

The contemporary welfare conditionality techniques are different from those of such basic conditionality (Taylor et al., 2016, p. 5). Emerging in many western economies in the 1990s, policies employing contemporary or new conditionality included more specific behavioural conduct measures, where a person needed to *behave in defined ways* to be eligible for initial and ongoing welfare support (D. Fletcher, 2015, pp. 330-331; Larsen, 2001). These behavioural conduct measures are evidenced in the emergence of mutual obligations and 'activation' approaches to welfare support in Australia and internationally, reflecting neoliberal individualisation of responsibility combined with conservative moralising of deviance. The logic of these moved Australia close and closer to the approach of using debit-only cards.

The conservative use of neoliberal ideas of individualisation and subsequent problematisation of the individual who consumed welfare across the 1970s-1980s, is also credited as providing an additional catalyst for welfare reforms in Australia in the 1990s. This was aided by the reconstruction of deviance politically and socially and is evidenced in social welfare policy decisions during this timeframe. The embracing of conservative neoliberal ideas in governance and subsequent policy decisions is reflected in a moral case for welfare reform by the then Minister for Families and Communities, Senator Jocelyn Newman, who addressed the National Press Club in 1999 saying:

> Too many payments are still focused on incapacity for work, rather than emphasising development of capacity. And more can be done to emphasise individual responsibility – the responsibility that people and communities have to help themselves, to the extent possible. In short, the system still doesn't do enough to discourage welfare dependency (Newman, 1999, p. 2).

Such an address reveals the political favouring of reducing the apparent need for welfare consumption and, indeed, reducing events of welfare dependency by increasing individual responsibility for capacity building and gaining waged employment.

The same ideologies have permeated the pseudo-political boundaries of the left and right. Neoliberal ideology in particular has been argued as usurping political agendas across the conservative-liberal and labor political divide (Mendes, 2003, p. 31) indicating that ideological influence in social governance is not mutually exclusive to traditional linear conceptions of the political left or right. Behavioural-based conditionality relies on political adherence to ideology that is reflected in policies of both the figurative political left and right (Larsen, 2001, p. 5). For example, welfare policies in Australia followed those introduced by left-leaning New Labour in the UK and began to reflect new or contemporary behavioural-based conditionality. Mutual obligations similar to those in the UK were introduced in Australia in the mid-1990s as a result of the conservative coalition or right-wing Howard Government's welfare reforms (Dee, 2013; Gatens et al., 2002). These reforms, both in Australia and internationally, were suggested to represent the materialisation of neoliberal influence on social governance, which traversed the political spectrum (Whitworth, 2016, p. 2). Notably, Mendes' (2017) review of social policy and ideological influences in Australian political parties argued that whilst all primary parties are influenced by neoliberal ideas, the conservative Australian Liberal Party had more completely absorbed ideas set out in neoliberal ideology.

2.3.2.4 Mutual Obligations

The conservative Howard Government's neoliberal ideas manifested in their 'mutual obligations' approach to policy in Australia in the 1995 welfare reform, reflecting how the state changed how it problematised responsibility for social risks (Mendes, 2018). The Howard government's welfare reforms and mutual obligations placed more responsibility of being susceptible to social risk onto the individual and less responsibility applied to social structures, such as the state or the market. Dee (2013, p. 274) describes this shift in responsibilities of risk from the state to the individual, as an effort of the state to progress the individual toward self-reliance. Neoliberalism provided a corresponding framework on which to achieve this. This reform was manifest politically from conservative coalition policy statements between 1988 to the 1990s, which argued for radical welfare policy cutbacks such as "placing time limits on unemployment benefit eligibility and reducing the eligibility period for parenting payment" (Mendes, 2018, p. 145). The aims of doing so related to encouraging people away from welfare and into waged employment.

Gatens, Braithwaite, and D. Mitchell (2002, p. 225), A. Gray (2002), and Powell and Hewitt all (1998) suggest the liberal-conservative Howard governments ‘mutual obligations’ approach to welfare reform in Australia in the year 1995, copied the reformist trends in the UK and US a few years earlier. For example, in the 1990s, the UK government's New Labour is touted as casting aside previous policy approaches guided by Marshallian-type structuralism in favour of what was purported to be a more balanced approach between addressing behaviours arising from both structural and individual agency factors (Deacon 2004, p. 912). Similar to Australia, this shift in approach manifested a few years earlier in the UK as 'mutual obligations', a policy approach that positioned welfare consumers as dysfunctional and 'passive' consumers of support needing 'activation' (Dwyer, 2004; Grover & Soldatic, 2013). This approach required welfare consumers to engage in activities designed to teach them desirable behaviours under capitalism, such as gaining waged employment via ‘workfare’ and later ‘welfare to work’ programs (Bessant, R. Watts, Dalton, & Smyth, 2006; Dwyer, 2004; Grover & Soldatic, 2013; Powell & Hewitt, 1998, p. 8; Rees, Whitworth, & Carter, 2014). UK Labour’s workfare and Conservative’s “welfare to work” initiatives (Powell & Hewitt, 1998, p. 8) both aimed to incorporate active reciprocity between the individual and the state via incorporating behavioural conduct requirements to be eligible to receive state support. Some have argued that such welfare reforms occurred recklessly in Australia due to the significant reduction in government expenditure on social services and over-enthusiastic privatisation (Jamrozik, 2001, p. 281).

During the welfare reforms in the UK in the 1990s, the passive receipt of welfare was politically argued as incompatible with socially responsible behaviours framed under conservative neoliberal capitalism. Instead, neoliberal social governance sought active participation by citizens in the labour market where that labour power can be used for continued “capital production and accumulation” (Clarke, 2004, pp. 90-91). These behavioural requirements under mutual obligations aimed to get welfare recipients work-ready and move them off state welfare support (Rees et al., 2014). Described as moving welfare recipients from passive to active participants, the UK 'welfare to work' strategy has been argued as an assimilationist project of neoliberal governance aimed at instilling desired productive and 'work-ready' competencies to engage people in the market system (Bessant et al., 2006). This policy approach's change mirrors neoliberalist governance's underlying efforts in creating active neoliberal capitalist citizens.

The welfare reforms in the UK and Australia in the early 2000s saw a continual shift toward new versions of contemporary welfare conditionality. Examples of the continued use of neoliberal ideas by conservative policymakers and politicians in the mutual obligations approach in Australian social policy are seen in reports such as that by Saunders and Tsumori (2003), which made a case for reducing welfare dependency by reforming single-parenting payments. Framing of deviance here saw single parents who do not work as not adhering to traditional concepts of virtue or good character under conservative ideals (Haskins, 2007; Marston & McDonald, 2007; Wilcock, 2014). This payment reform recommendation included reducing eligibility and increasing conditionality requirements of single parents to engage in work-related behaviours (such as job seeking or training) starting from their child's age of 16 to instead begin at eight years (Saunders & Tsumori, 2003). Recommendations such as these were then applied, changing how single parents were able to receive welfare support.

Recommendations such as those by Saunders and Tsumori (2003) saw policy legislation introduced to increase the conditionality of single-parent payments in 2006. For example, in 2006, changes were introduced where to remain eligible for any payment, parents now had to begin working part-time or engage in work-related activities once their child turned six (as opposed to the recommended eight) years of age instead of the previous age of 16 years (Harding, Vu, Percival, & Beer, 2005). Such policy changes were maintained into the year 2007 at the election of the Australian Labor Party into government. Versions of this policy remain into 2022, which include active participation and managed behavioural requirements such as education, job seeking and attending meetings to maintain eligibility for parenting payment support (Services Australia, 2021).

Through the Australian welfare reform in the 1990s, we can see a parallel alignment between ideology and policy approach outlined in Section 2.2. These are the adherence to conservative neoliberal ideology and preference for an authoritative choice/rationalist approach to policy creation and implementation in an Australian setting. Reflecting on Colebatch et al. (2010) claims of authoritative choice/instrumentalism being the most dominant approach in the Australian policy landscape, this approach can be paired with Fawcett's (2009) review of Australian political parties' ideologies and social policy decisions. Here Fawcett (2009) shows that the conservative Australian Liberal Party has, over time, often incorporated less external community input into policy decisions, assuming the

role of the dominant authorised decision maker. As described by authors such as Althaus et al. (2007 and Dye (1985), such an approach reflects rationalism or authoritative instrumentalism, which has been criticised by Colebatch (2006a) as not including other subjective perspectives of policy participants in the decision-making process, instead relying only on a select powerful few to decide what is best. This exclusion further reflects what Foucault (1991) suggests, that government is a 'paternal other', where power is displaced toward the government to survey, control and decide as the principal authoritative figure.

2.3.2.5 Punishment and Paternalism

Using punishment as a strategy for behaviour change is not a new phenomenon. Punishment, as suitable deterrence to deviant behaviours, is also found in efforts of contemporary welfare conditionality in Australia. This has often meant that framing 'being poor' as a deviant behaviour (Staines et al., 2020) resulting in the poor being punished for being poor as an attempt to deter them from being poor, overlooking the intergenerational conditions leading to poverty and its impact on individuals. Using such punishment has not worked well, considering that the rate of people living below the poverty line has remained relatively steady in Australia at approximately 12% between 1999-2015 (Australian Council of Social Service, 2018). If it had worked well, we could reasonably expect this poverty rate to have declined over time.

Ben-Ishai (2012, p. 4) outlines that new paternalism represents an amplified form of punitive social service delivery that focuses on welfare policies in particular. The poor and the deviant were argued as excessive consumers of income support payments by those in favour of new paternalist approaches to welfare provision (Mead, 1997a, 1997b). One prominent scholar supporting paternalism in social policy (Mead, 2012), argued that welfare consumption depends on a cycle of intergenerational poverty. Here the poor are constructed as suffering a defeatist attitude that they pass to their children, continuing the poverty cycle. Punishments were largely justified as beneficial under paternal approaches to policy and aimed at changing poor people's behaviours that are suggested as responsible for keeping them poor. No evidence was given for this assumed chain of events.

Regulatory policy instruments that involved punishment for non-compliance to policy rules increasingly became the norm for welfare-related social policy throughout and after Australian welfare reforms in the 1990s. Conservative authors such as Himmelfarb (1995)

and Kristol (1995) maintained that the poor lacked moral values and therefore required encouragement toward behaviours of virtue, such as attending to poverty through employment and upholding traditional family values. Mead (2012) extended this idea of morality by arguing that the poor do not have the will to try hard enough to succeed, whether through gaining employment or education. Thus, it was argued that recipients must be deterred from welfare support via punitive sanctions (Mead, 2007). For example, Schooneveldt and Tomlinson (2002) describe penalty breaches imposed mostly on Newstart welfare recipients resulting from the compliance control strategy under Australia's mutual obligations policy approach. The penalty resulted in a part or total withholding of income support payment where a recipient did not meet behavioural conduct requirements, where Nevile (2001, p. 3) discerns that "penalties have come to dominate the entire system". Penalties were imposed and accepted as individuals were framed as responsible for their consumption of welfare yet remained incapable and in need of paternal direction, reflected in policy under the mutual obligations approach (Schooneveldt & Tomlinson, 2002).

Ideas of paternalism have been questioned regarding whether they translate from theory into reality. Indeed, the increase in punitive actions taken by the state with the aim of altering behaviours has been argued as both effective and ineffective by some. Regardless of evidence otherwise, strategic punishment is suggested as motivating those in poverty toward actively seeking waged employment (Mead, 2012). Mead (2007) purports the benefits of harsh sanctions and eligibility requirements as helpful in moving people off welfare, such as single mothers moving off parenting payments. Intentions of paternalism may have been good, such as to decrease inequality through changing individual behaviours that were theorised to lead to poverty. Such as shown in the study by Parsell and Marston (2016), who observed that some neoliberal paternalist approaches to supportive housing policies have positively influenced recipients' lives.

In contrast to those supporting paternalism, others have argued otherwise. Manning's (2009, p. 31) analysis showed no significant change in the job-seeking behaviours of welfare recipients regardless of harsh financial sanctions. Others describe paternal punishment as a form of legislated social abuse of people claiming social support benefits (Grover, 2019; Grover & Soldatic, 2013). For example, Wright, D. Fletcher, and Stewart (2020) argued that welfare sanctions can sometimes lead to severe negative outcomes, sometimes having life-threatening effects. Others predicted use of paternalist strategies regarding social equality and

the Australian welfare reform in the 1990s would lead to significant inequality (Jamrozik, 2001). Such predictions in extreme social inequality have materialised, as Wilkinson & Pickett (2010) discussed, although clear attribution to paternalism was not made. Some have challenged social policy adopting paternalist ideas as bothersome and negatively interventionist for certain categorised groups only (Bielefeld, 2016a, 2016b; Klein, 2016a, 2016b). For example, MacGregor, (1999, p. 95) suggests paternalist attempts to rectify inequality occurs via accepting neoliberal orthodoxies and trying to "patch society together again with a mix of exhortation and intervention into the lives of the poor and deviant".

Arguments that explain the lack of positive outcomes related to paternal interventions suggest this is because such interventions individualise responsibility and risk for social issues, and do not take account of the well-established structural contexts that can act as barriers to any social change. For example, Marmot and Bell (2019) describe the social conditions or contexts that create opportunities to experience good 'health' and good 'wellbeing', arguing that poor social conditions shape behaviours related to chronic stress and excess drug and alcohol consumption:

> Living in deprived conditions can mean experiencing adverse environmental, living, working, and social conditions that create stress. Coping mechanisms for stress vary according to individual resilience and levels of social support, but ways to cope may include smoking, drinking alcohol, and comfort eating, all of which contribute to inequalities in NCDs (Marmot & Bell, 2019, p. 11).

The positioning of this argument is supported by others (Crammond & Carey, 2017) and challenges the directionality of association put forward under the CDC policy that drug and alcohol use cause poor life outcomes. Marmot and Bell's example suggests that things are more complicated, and it is the broader, interrelated and persistent life contexts described by participants that are responsible for ongoing issues. Behaviours such as drug and alcohol consumption, smoking and poor mental health are perhaps instead a *result* of the troubling social conditions of unemployment, discrimination, poverty, violence, crime and related trauma, and effects of inequitable social policy (Wilkinson & Pickett, 2010; Crammond & Carey, 2017). Work by Baker (2018), Townsend (2009) and others argues addressing foundational 'causes' should be the focus of policy if it is to succeed and provide people with opportunities for good health, wellbeing and welfare (Baker et al. 2018; Townsend et al.

2020; Bacchi, 2009; Carson and Kerr, 2017). Such arguments that challenge paternalist policy regarding origins of social problems reposition these as structural as opposed to individual in origin.

Alongside outlining how ideas of deviance changed through ideological influences, it is also the argument of this chapter that contemporary paternalism disregards the inherent structural problems of inequality that arise from Australia's adoption of the neoliberal capitalist ethos in policy making. I argue that paternalism leads nowhere without the state dealing with the related structural causes of social problems, and shifting away from its punitive approach to regulating the poor and maintaining the status quo (MacGregor, 1999). This chapter discusses the beginnings of one research aim of the present study, that of the on-going social issues of those receiving the CDC and whether these issues caused the problems and whether they were changed at all by the CDC.

2.4 The Cashless Debit Card in Australian Social Policy

Following on from the Australian welfare reform and mutual obligations in the 1990s, increasing conditionality and punishments coalesced into the social welfare policy of income management, implemented in 2008. This policy approach was embraced to some degree by both major political parties, the conservative Liberal Coalition and The Australian Labor Party. It arose from a combination of everything in Sections 2.2 and 2.3, the conservative, neoliberal and paternalist ideologies producing a policy logic of governmentality that required and enforced self-governance by individuals. Income management emerged as a punitive, behaviour-based policy approach that would supposedly reinforce the good behaviours of the poor who were demoralised and deviant (Schram, Soss, Houser, & Fording, 2010). Contemporary conditional welfare policies emerging in the year 2007 onwards are described as follows by B. Watts and Fitzpatrick (2018, p. 32, italics in original):

> …Conditional forms of welfare with a conduct component differ from other forms of welfare provision in three respects: they specify *behavioural requirements* which determine initial access to and/or continued receipt of benefits, goods, and services; they employ *monitoring and surveillance processes* that verify compliance with those

requirements; and they impose *sanctions* in the event of non-compliance or, in some cases, offer *incentives* for compliance.

2.4.1 The Functioning of the Basics Card and Cashless Debit Card

The CDC is the most recent version of an income management approach to social policy. The first iteration of income management was the basics card. The basics card is briefly described to clearly show how the newer CDC relates to and differs from the original policy approach.

2.4.1.1 Basics Card

The income management legislation introduced in 2007 and policy implementation in 2008 embraced behavioural-based conditionality, sanctions and monitoring and eligibility was initially applied to all and only Aboriginal Australians living in Australia's Northern Territory who received income support payments (Bielefeld, 2012). In 2008, income management was implemented, targeting 73 Aboriginal Australian communities in the Northern Territory (Mendes et al., 2021; O'Keeffe & Papadopoulos, 2022). Income management was operationalised via the basics card as one blanket-measure reaction to the 'Little Children are Sacred Report' (Northern Territory Government, 2007) into child abuse and the related Northern Territory Emergency Response (Bielefeld, 2014a; Billings, 2010). After the Racial Discrimination Act was repealed in 2007, specifically in order to accommodate the basics card's implementation, it was then reinstated in 2010 (Lovell, 2016). This basics card intervention then changed in 2010 to include persons who were also non-Aboriginal Australians as policy recipients in some targeted locations across Australia in addition to the Northern Territory. It was reasoned that income management would help control and redirect all welfare payment spending away from harmful products, reducing crime and promoting child wellbeing (A. Forrest, 2014).

The basics card restrictions typically see between 50%-70% of welfare payments quarantined for approved purchases only. These purchases exclude tobacco, gambling, alcohol, home-brew kits or concentrate, and pornographic products (Buckmaster, Ey & Klapdor 2012; Services Australia, 2020). The remainder of the non-quarantined portion is deposited into the recipient's regular bank account to use without restriction. Eligibility for the basics card is organised around a combination of specific locations and via specific measures. These

measures include the targeting of particular groups of income support recipients[1]. Basics card locations where income management (but not the CDC) initiatives have been implemented in Australia include Perth, Western Australia, Cape York, Queensland, Shepparton, Victoria, Logan, Queensland, Rockhampton, Queensland, Playford, South Australia and Bankstown, New South Wales (Arthur, 2019; Buckmaster, Ey & Klapdor 2012; Mendes 2017).

All versions of income management initiatives have been both voluntary, where recipients can opt-in to the scheme through their own choosing, and compulsory where people are placed onto the scheme regardless of their own choosing. Compulsory income management is the most common. As of June 2022, the number of people in receipt of the basics card was 24,405, where 21,757 or 89.2% experience the basics card compulsorily, with the remaining 10.8% being voluntary recipients (Department of Social Services, 2022b), with this evidence also showing the rate of compulsory recipients remaining similar and steady over the life of the policy. The basics card recipient numbers increased approximately 83.5% in 2022 since policy implementation in 2008 (Department of Social Services, 2022b; Northern Territory Emergency Response Report, 2008).

2.4.1.2 Cashless Debit Card

The CDC was introduced in Australia in 2016 and has the highest monetary percentage of welfare payment quarantining of any CDC or basics card income management initiative in Australia thus far. 'Indue Ltd' is the name of the private provider that was tendered by the Australian Government to issue the CDC itself, and receive payments for this. This management includes the transaction accounts into which the Australian Government makes income support payments and from which CDC recipients access the quarantined portion of their income support payment (Indue, 2017, 2018). Due to this company managing the CDC and incorporating its logo onto the physical card, the CDC is sometimes also referred to as the 'Indue' card by card recipients.

For people receiving the CDC, 20% of their welfare payment is available as cash being deposited electronically into a regular bank account, with the remaining 80% quarantined to a separate, privately managed Indue account, which restricts cash access, and this theoretically

[1] See information re. Basics Card: here (Social Security Guide, 2020) & CDC: here (Social Security Guide, 2022a).

restricts illicit drug purchasing, and purchases of alcohol and gambling products (Social Security Guide, 2020). The reasoning for these objectives rationalises that through influencing behaviours in these ways, there will be improvements to overall health and wellbeing of recipients, their families, and the community by way of reducing spending on things that are reasoned to create problems and social harms. Later changing in 2020 as part of the Social Security (Administration) Amendment (Continuation of Cashless Welfare) Act 2020, the Australian Government's review of evaluations conducted thus far and to shift the policy from a trial to become an ongoing program (Australian National Audit Office, 2022), the CDC policy objectives in 2016 were to:

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

(Australian National Audit Office, 2022, p. 16; Social Security Guide, 2020).

In 2020, these objectives changed to:

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

(Australian National Audit Office, 2022, p. 16).

The CDC was introduced on the 15th of March 2016 in the Ceduna region, SA, and then again on the 26th of April in the Kimberly region in WA. This new CDC was introduced to welfare recipients (both Indigenous and non-Indigenous) in those new locations which had not been targeted with income management before (Department of Social Services, 2022a). The new locations were followed two years later by the card's implementation on 26th of March 2018 in Kalgoorlie, WA, and on the 21st of September 2018 in Bundeberg-Hervey Bay region, Queensland (Department of Social Services, 2022a). As of June 2022, the number of CDC recipients was 17,382, where 17,354 or 99.8% experienced the card compulsorily across all four sites with *no voluntary participants in Ceduna, South Australia* (Department of Social

Services, 2022a). The CDC recipient numbers increased by 726.5% in 2022 from the original recipient number of 2,103 in the Ceduna and East Kimberly regions in 2016 (Australian National Audit Office, 2019; Department of Social Services, 2022a). The increase in CDC recipients in Ceduna, SA, has increased from 783 in March 2016 to 1,035 in June 2022, an increase of 32.2%, with the percentage of recipients who identify as Aboriginal Australians in this location remaining steady at 74% (Australian National Audit Office, 2019; Department of Social Services, 2022a).

The CDC was planned to be expanded into the Northern Territory, replacing the basics card and impacting a further ~25,000 people (Department of Social Services, 2022b; Parliament of Australia, 2019a). The Australian Liberal Coalition Government introduced legislation to transition approximately 25,000 people from the basic's card to the CDC (Parliament of Australia 2019a). However, the compulsory measure was not passed in the Senate, and the transition to the CDC from the basics card was made voluntary only.

The incoming Australian Labor Party elected in 2022 vowed to 'abolish' the CDC as an election promise, as outlined in the 3rd of June 2022 media release by the newly elected Labor government's Minister for Social Services, Amanda Rishworth (Ministers for the Department of Social Services, 2022). The Australian Labor Party has since introduced and passed legislation that now sees the compulsory CDC trial introduced in select locations in 2016 to become a voluntary-only measure, with the voluntary exit from the CDC now allowable since the 3rd of October 2022 (Department of Social Services, 2022c). Alongside CDC trial recipients, people who transitioned onto the CDC in the Northern Territory have now been informed that the CDC intervention is ending across all regions in March 2023 and if seeking to remain on the CDC passed that time, recipients will need to actively opt-in (Services Australia, 2022). However, recipients in the Northern Territory will remain on what is described as enhanced income management once the CDC ends in this region (Services Australia, 2022), although little is currently known at the time of writing in November 2022 what this new enhanced version will incorporate for Northern Territory welfare recipients.

The introduction of the CDC also saw for the first time the *privatisation of income-support payments* via the appointment of Indue Ltd, the private company contracted by limited tender by the Australian Government to distribute income-support payments for a prescribed fee

(Arthur, 2017; Australian National Audit Office, 2019). Evidence shows that the cost to the Australian Government associated with the 2016 initial roll out and the one-year trial of the CDC in Ceduna and East Kimberly alone, was approximately $19m or $10,000 per CDC recipient, with 44% ($7.9m) of this cost going directly to Indue Ltd (Australian Government, 2017). The Government's extension by limited tender to Indue Ltd to continue delivering the CDC along with other versions of income management between 2016 to 2018 equated to $38.6m, paid directly to Indue Ltd (AustTender, 2017). In the 2016-17 financial year, Indue recorded an $11.2m profit, with their facilitation of the CDC representing an undisclosed portion of that margin (Indue, 2017).

As presented in Table 2 below, primarily *compulsorily,* the CDC targeted almost all persons receiving a working-age income-support payment in the trial sites, only excluding those on the aged or veteran's pension (Australian Government, 2018a; Department of Social Services, 2022a). The Hinkler region trial site included different age and trigger payment conditions than other sites, targeting people under 35 years of age who are unemployed and/or single parents (Australian Government, 2019a). Technically the CDC eligibility is limited to specific eligible payments, defined in policy legislation as 'restrictable' or 'trigger' payments (Social Security Guide, 2022). This list is lengthy and broadly includes almost all income support payments with few exceptions (Social Security Guide, 2020, 2022a). To be eligible for the CDC, a recipient must already receive at least one of a series of income support payments, which includes almost all payments, largely excluding the aged and veterans' pensions in most locations where the approach is applied.

The CDC has been described by the Australian Government in 2021 as more functional than the basics card and therefore is suggested as more straightforward and cheaper to facilitate, which had underpinned to the argument to move people off the basics card and onto the CDC (Arthur, 2017; Australian National Audit Office, 2022a). There are differing ways that businesses can operate under basics card income management and CDC legislation, with the differing payment platforms for the basics card (eftpos) and CDC (visa) dictating the differences in how businesses or ‘merchants’ function and the cost of delivery of the scheme over these platforms, with the visa platform being cheaper (Arthur, 2017). For merchants to participate in allowing the basics card to be used in their stores, each merchant requires the Government to approve their business as allowable under the basics card scheme (Arthur, 2017). Merchants who do not sell prohibited items are automatically included as facilitating

the CDC. However, merchants who sell a mix of prohibited and non-prohibited goods can apply for an exemption with compliance criteria needing to be met to maintain ongoing CDC participation. In these circumstances where mixed goods are sold, customers wishing to use the CDC need to have their card and goods sighted by the store clerk at the point of transaction for sale to proceed per legislation. This then involves a store clerk, whether an adult or not, as accepting a role to decide and make decisions in accordance with legislation of the Federal Government.

Table 2: CDC trial locations and recipient characteristics.

Trial Region and Date Introduced	Approximate number of CDC recipients and Aboriginality percentage at June 2022	Percentage Change of Participant Numbers Over Time – from Implementation date to June 2022	Targeted welfare payments
15th March 2016 **Ceduna region, South Australia. (REGION OF STUDY FOCUS)** Communities include: Ceduna, Koonibba, Scotdesco, Yalata and Oak Valley	1,035 74% Aboriginal Australians No Voluntary recipients	783 in March 2016, to 1,035 in June 2022, an increase of 32.2%	All welfare payments except aged and veterans' pension.
26th April 2016 **East Kimberly region, Western Australia.** Townships include: Kununurra and Wyndham, Communities include: Alligator Hole, Bell Springs, Cockatoo Springs, Dingo Springs, Four Mile, Geboowama, Gulberang, Hollow Springs, Ngulwirriwirri, Red Creek, Dillon Springs, Wuggabun, Woolah, Glen	2,031 83% Aboriginal Australians <5 Voluntary recipients	1,320 in April 2016, to 2031 in June 2022, an increase of 53.9%	All welfare payments except aged and veterans' pension.

Hill, Munthanmar, Mud Springs and Miniata.			
26th March 2018 **Kalgoorlie (Goldfields) region, Western Australia.** Local government areas include: Kalgoorlie-Boulder, Laverton, Leonora, Coolgardie and the state suburbs of Menzies, Kookynie and Ularring, in the Shire of Menzies	3,790 49% Aboriginal Australians <5 Voluntary recipients	3,422 in December 2019 (when first publicly reported), to 3,790 in June 2022, an increase of 10.7%	All welfare payments except aged and veterans' pension.
21st September 2018 **Bundaberg/Hervey Bay region, Queensland.** Townships include: Bagara, Elliot Heads, Woodgate, Branyan, Booyal, Burrum Heads, Torbanlea, Toogoom, Howard, Childers, Burnett Heads, River Heads and Point Vernon	6,488 20% Aboriginal Australians No Voluntary recipients	5,878 in December 2019 (when first publicly reported), to 6,488 in June 2022, an increase of 10.4%	Persons under age 35 years receiving: Newstart, Youth Allowance, Parenting payments (single and partnered) 12% Aboriginal (forecast) 88% non-Aboriginal
Transitions from basics card to CDC - Transition began in May 2021			

Cape York Region Townships include: Aurukun, Coen, Hope Vale, Mossman Gorge, Doomadgee and associated outstations.	107 90% Aboriginal Australians 13 Voluntary recipients	Na Transition to CDC began in May 2021 118 in May 2021, to 107 in June 2022, a decrease of 10.3%	People receiving income support payments and referred for Income Management by the Family Responsibilities Commission People who volunteer to the Family Responsibilities Commission for Income Management.
Northern Territory Territory wide as of 2010 People on the CDC living in the Northern Territory are transitioning from the basics card onto the CDC.	3,931 78% Aboriginal Australians <5 Voluntary recipients	Transition to CDC began in May 2021 5 in May 2021, to 3,931 in June 2022, an increase of 78,520% Note: not an accurate reflection of income management participant increase as these recipients are only	All welfare payments except aged and veterans' pension.

		transitioning across policies	
As of June 2022, the number of CDC recipients in TOTAL was 17,382, where 17,354 or 99.8% experience the card compulsorily across all sites. Data drawn from Australian Government, 2018a, 2018b, 2018c; Australian National Audit Office 2019, 2022a; Department of Social Services, 2022a; Social Security Guide 2020, 2022. Ceduna is the only region to be included in this research.			

2.4.2 The Place of the Cashless Debit Card in Australian Social Policy Trajectories

Like other conditional welfare policies, the basics card and CDC versions of welfare quarantining or income management as general policy approach reflect an individualised focus on behavioural responsibility and risk (Staines et al., 2020) as seen in Section 2.3. But unlike other conditional welfare policies, this approach problematises welfare spending and uses preventative financially focussed restrictions instead of economic penalties when aiming to direct behaviours.

The approach reflects the idea that problems partly arose from how people 'irresponsibly' spent the money provided to them by the Government and that this needed intervention. Such is the argument outlined in Lovell's (2016) discourse analysis of parliamentary debates on basics card income management development and evolution. This framing is extended by others who argue in their political discourse analysis (O'Keeffe & Papadopoulos, 2022, p. 9) that the CDC policy effectively frames welfare recipients as deviant and in need of government intervention to rectify their problem behaviours, saying that:

> The card is framed as an essential mechanism for correcting consumption behaviours, and the government is positioned as protecting the taxpayer from morally compromised consumption.

This reflection of welfare recipients' morally compromised consumption of alcohol, drugs and gambling is echoed in speeches and media releases, such as those by the previous Minister for Social Services, Anne Ruston, who has emphasised spending of welfare

payments as problematic and rationalised that spending restrictions via the CDC translated into the prevention of consumption of alcohol, drugs and gambling. For example, in reference to the CDC, Minister Ruston stated:

> Over the life of the program over $125 million has been spent at businesses that sell groceries and food that could not be spent on restricted items like alcohol, drugs and gambling products (Ruston, 2020, para. 2) [and] this program helps limit the ability for problem consumption to cause social harm for individuals, their families and communities (Ruston, 2021, para. 1).

Through the increases to income support payment quarantining relative to the original basics card, the CDC approach to attempting to change peoples' behaviour can be considered a more punitive approach overall than has been applied in the past (K. Stevens, 2021). The suggestion that income management was possibly the most punitive of contemporary conditional welfare approaches at the time of its original introduction is supported, when consideration is given to the fact that the policy was designed and applied to people already subjected to conditional, behavioural-based income support payments (Klein & Razi, 2018), the shift to the CDC was a further restriction on already highly regulated people. The CDC targeted partnered and single-parenting payments, working-age payments including jobseeker (previously Newstart), the disability support pension, and Abstudy or Youth Allowance (Social Security Guide, 2020). Already conditional payments include single parenting payments (Harding et al., 2005; Saunders & Tsumori, 2003) and unemployment/income support payment reforms where payments are conditional on job-seeking or upskilling/training. Such categorisations of payments reflect conservative issues with character and morality previously discussed, such as those regarding single parents and the unemployed (Himmelfarb, 1995; Wilson, 1985, 1995). These conditions further reflect the embedded 'activation' and welfare-to-work schemes from the 1990s onwards (Fridberg & Ploug, 2000; Haskins, 2007).

Through income management, welfare recipients and their purchasing behaviours were problematised as issues which challenged morality, categorised as social failures of the individual which needed intervention (Staines et al., 2020; Section 2.3). The objectives in the basics card reflect a problematisation and focus on individual behaviour change toward how money is spent, with this problematisation continued and reinforced under the CDC. For

example, the basics card policy rules frame recipients as exhibiting immoral behaviours against society and family, inferring a lack of expenditure on children and excess on alcohol, drug and gambling products (Lovell, 2016). Dean (2004, p. 172) has reasoned that the combination of conservative cultural and moral exhortation, and neoliberal ideas of market freedom and individuality in governance, thus require the citizen to learn to behave in accordance with both the market and conservative 'cultural reformation'. This is reflected in the CDC, where ideas of morality, such as parenting and employment, are tied to needing to behave in specific ways.

The formation of these behaviours as problems linking to social issues relies on decisions made by the powerful, excluding recipients of the policy in these policy-making decision processes. This exclusion and linear, reductionist and positivist conceptualisation of what behaviours cause what social issues shows an authoritative policy making approach as described by (Althaus et al., 2007; Colebatch, 2006a; Colebatch et al., 2010; Dye, 1985; Larner, 2000). Where welfare consumption is framed as a lack of economic participation and the individual is blamed for their 'dysfunction', the CDC and income management more broadly, attempt to rectify this. Rectification is attempted through the direction of behaviour conservatively problematised as impeding access to waged employment by those who consume welfare: namely alcohol and drug consumption and socially 'irresponsible' behaviours (Himmelfarb, 1995; J. Q. Wilson, 1985, 1995).

Overall, in theory, the income management approach inclusive of the basics card and CDC is a policy tool aimed to change the behaviours of people receiving welfare and income support. The objectives of the approach and aligning legislation reflect policy problematisations of specific social issues. These problematisations and policy interventions mirror ideas of what society should be in accordance with a combination of ideas across different ideologies. Although paternalistic and punitive, these ideas are framed as implemented via this policy approach in order to help communities and individuals. For example, the basics card includes objectives to 'help affected welfare payment recipients to budget so that they can meet their priority needs' and reduce immediate hardship and deprivation by directing welfare payments to the priority needs of recipients, their partner, children and any other dependents' (Social Security Guide, 2022b). Where the CDCs objectives are similar and include aims to 'support program participants with their budgeting strategies'; 'encourage socially responsible

behaviour', and 'reduce the amount of certain welfare payments available to be spent on alcohol, gambling products and illicit drugs' (Social Security Guide, 2022a).

Shown in Table 2 above, the CDC was first implemented in Australia in the remote town of Ceduna on the 15th March 2016. As the first location of implementation, alongside there being little related research conducted, Ceduna is the location where investigation of the CDC for this research occurred, as discussed in Chapters 3 and 4. The CDC was not designed to be implemented into this specific location as evidenced by the subsequent policy roll-out to additional locations across Australia, hence a targeted discussion of Ceduna in relation to the CDC policy is not provided. Nonetheless, the unique experience of the CDC in this location is acknowledged and accounted for further in Chapters 5 and 6, and addressed briefly here. The broader social framings of deviance and social norms regarding the consumption of welfare in an Australian context as discussed and evidenced throughout Chapter 2 and explicitly in section 2.3 are impactful regarding how the CDC is locally experienced in Ceduna specifically. As discussed, the CDC individualises responsibility and frames the welfare recipient as deviant in that they need to have their 'income' compulsorily managed by the state and/ or its agents. An analysis of the experience and subjective meaning making of those CDC recipients in Ceduna who engaged with my PhD research, follows from these broader framings and is further explicated in Chapters 6 and 7.

To provide local context, the remote town of Ceduna is located on South Australia's Far West Coast. Ceduna is 775.6 kilometres from Adelaide, the state capital city of South Australia. The CDC policy began operating in the Ceduna region in 2016 and the surrounding areas included the communities of Koonibba, Scotdesco, Yalata and Oak Valley (Australian Government, 2020a). According to the Australian Bureau of Statistics (2021), the town of Ceduna and broader region affected by the CDC, has a population of approximately 3,505; a median age of 40 years; with approximately 24% (n=870) of the total population identifying as Aboriginal or Torres Strait Islander (ATSI) First Nations Australians. As shown in Table 2 as of June 2022, there were 1,035 CDC recipients in this region, equating to approximately one-third of this population receiving the CDC. This current number of CDC recipients reflects a 32.2% increase from when the CDC was first implemented in 2016 (as addressed in Table 2) with 74% of persons in this region affected by the CDC identifying as Aboriginal/Torres Strait Islander First Nations Australians (Australian Government, 2020a).

As discussed, the CDC's predecessor, the basics card, remains in place at the time of finalising this thesis in 2022, with basics card recipients still under a compulsory income management scheme. The legacy of compulsory income management as a policy approach to welfare provision remains an active policy tool that transcends political divides with supporters across the political parties into the year 2022 onward. This ongoing political commitment to compulsory welfare quarantining via an income management approach to welfare makes understanding the emergence and influences of such policies paramount in policymaking going forward. My aim in focusing on the lived experiences of CDC recipients in Ceduna is to further understandings of the local impact of the CDC in particular but also to reflect more broadly on the efficacy of regimes of income management as a tool of social control.

2.5 Summary

Social policy is informed by the uptake of preferred ideologies in the processes of decision-making. Social policy can be considered an act of governance and often (but not always) social control which is used to regulate groups in society. The discursive framing of recipients of government support as either the deserving or undeserving poor influences and is influenced by conceptions of deviance and social norms in society. As shown in the literature review, changes in the ideological basis for decision-making for policy interventions is associated with a shift in how social risk is defined and changed over time. This shift in who is responsible for creating and managing social risks, visualised in Figure 1 (p. 26) on a spectrum going from an ideological and policy position embracing structural entitlement to individualised mutual obligations.

Contemporary conditional welfare arrangements in Australia evolved from those introduced during Australian welfare reforms in the 1990s and the preceding years of increasing individualisation and welfare conditionality. Since Australian welfare reforms in the 1990s, current welfare conditionality income management approaches in Australia still incorporate systems where the recipient is required to behave and act within controlled parameters to be eligible for social support (B. Watts & Fitzpatrick, 2018). Welfare policies still incorporate some form of punishment for 'undesirable' behaviours of welfare recipients, including sanctioning monetary payments to encourage preferred behaviours. The CDC and income

management approach aim to increase responsible economic participation and promote positive behaviours for individuals and their communities.

The CDC can be thought to reflect ideas that consumption of welfare is immoral and deviant and has been shown to relate to problem representation regarding behaviours of a good neoliberal productive citizen. In the broadest terms, contemporary welfare conditionality and income management social policy became the operationalisation of particular ideologies, where welfare conditionality is shown to reflect conservative and neoliberal ideas regarding social governance. Paternalism guides the related delivery that supports conservative and neoliberalist conceptions of historically virtuous morality combined with a preference for individualism, competition and profit.

The following Chapter 3 addresses research for and about the income management approach to welfare conditionality and the CDC. Chapter 3 then reviews research conducted thus far regarding the CDC. In doing so, the following Chapter seeks to understand what we know of the income management approach in practice, how the CDC has been researched thus far and what we have yet to learn about its impacts.

3 Research on Social Policy and the Cashless Debit Card

3.1 Introduction

This chapter presents a critical review of research on the influence of the CDC policy intervention in Australia, with particular attention to the research methods used across studies to learn about how policy influences people's lives. The methods focus of this review aims to account for methods and methodologies used in social policy research, as they are crucial for understanding the impact of social policies on their recipients. As discussed in Chapter 2, social policy decisions are informed by ideologies and work to regulate society and frame social norms regarding deviance. This Chapter discusses the methods used in relevant research and evaluations about the CDC in an effort to understand not only the impacts of the policy, but to address the processes used to produce diverse arguments.

Much like other forms of literature reviews, a critical review involves a conducting a detailed analysis of a specific research study or set of studies, with a specific focus, such as a review of methods and/or methodologies used across a body of work (DeCarlo, 2018). The purpose of a critical review is to evaluate the quality of the study or studies, identify strengths and weaknesses, and assess the relevance of the findings to the purpose of the review. As defined by Grant and Booth (2009, p. 93) "A critical review provides an opportunity to 'take stock' and evaluate what is of value from the previous body of work", which necessarily requires a subjective formation of what is decided to be 'valued' relevant to the topic in question. In the case of this review of studies addressing the influences of the CDC, what is of value for understanding policy influence focuses specifically on the research methods that have been used through which to understand the influence of the policy on recipients and their communities.

This critical literature review begins with a brief overview discussing how social policy is typically researched and evaluated before narrowing the focus into analyses of CDC policy research and the forms of inquiry conducted thus far. The various critiques of CDC research are summarized with a critical synthesis of the CDC policy research publications. This synthesis outlines themed issues from the review which will be the focus of the present

research. These themes include: the general methodological issues found across studies particularly in capturing lived experiences; issues with measurements of variables reflecting policy objectives; and problems found in measuring contextual complexities outside of policy objectives according to the lived experiences of policy recipients. The review then summarises what is not yet known and what needs to be done to better capture the complex influences of the CDC policy in the lived contexts of recipients and their communities.

This critical review only takes account of research regarding the welfare quarantining income management approaches within an Australian context, focusing specifically on the CDC intervention. The only other country that employs a welfare quarantining approach in the form of income management to conditional welfare is New Zealand (Humpage, 2015; Humpage et al., 2020). The review does not attempt to include all conditional welfare policies that exist globally, as to do so remains outside this project's scope (for a more complete review of international welfare conditionality see B. Watts & Fitzpatrick, 2018). Each nation and its societies are unique culturally, where meanings and discursive contexts are contextually produced and locally relevant (Barker & Jane, 2016). Thus, the Australian policy context is locally experienced, but nonetheless remains heavily influenced by global situations (Althaus et al., 2007), as has been shown throughout Chapter 2.

The primary focus of this review is the *compulsory version* of welfare quarantining income management, specifically the CDC unless otherwise stated. This focus arises as most of the research has concentrated on the compulsory version and because persons experiencing either the CDC or basics card policy predominantly come under the forced or compulsory measure (see Section 2.4). Some inclusion of evidence of the basics card's influence and impact on recipients compliments this review as the basics card policy remains the first iteration of welfare quarantining through an income management approach to policy in Australia, as addressed in Chapters 1 and 2.

The following Section briefly outlines some of the common strategies that have been used when researching for policy development and about the influences of social policy in application, to help position the CDC policy research within the broader Australian policy research context.

3.2 Issues of Researching Social Policy Outcomes

The methods and methodologies used in social policy research are crucial for understanding the impact of social policies on their recipients. The choice of methods and methodologies used can affect the accuracy and reliability of the data collected, which in turn affects the conclusions that can be drawn from the research (Creswell, 2009). For example, quantitative research methods are often used to measure the effects of social policies on large populations. These methods can provide valuable information about the prevalence of a particular issue and the general trends in social policy (Neuman, 2013). However, they may not capture the experiences of individual recipients or provide a detailed understanding of the social and cultural factors that influence their lives. On the other hand, qualitative research methods can provide a more detailed and nuanced understanding of the experiences of social policy recipients (Creswell & Clark, 2004) while garnering results which are not generalisable across broader populations. By using methods such as in-depth interviews, focus groups, and ethnographic observation, researchers can gain insight into the ways that social policies affect the lives of a sample of their recipients (Neale, 2021). Qualitative research can provide a more human-centered perspective on social policy, highlighting the perspectives, experiences, and needs of some of those who are affected by it.

In addition to the methods used, the choice of research methodologies can also influence what can be learned about social policy's influence on recipients. For example, a critical policy approach might examine how social policies reinforce existing power structures and inequalities (Beland, 2016; Fischer, Torgerson et al., 2015), while a feminist policy approach might focus on the ways that social policies affect women and gender relations (Williams, 2021; McPhail, 2003). Overall, the methods and methodologies used in social policy research are important because they affect what can be learned about the influence of social policy on recipients. The following section discusses the general methods used in studying social policy impacts, and addresses some of the strengths and weaknesses of these approaches.

In their description of policy Carson and Kerr (2017) frame social policy as both a field of study and as a set of governance practices. In considering how to study social policy, Blackmore and Lauder (2005, p. 97) further define what is researched in social policy by describing what policy intends to do, where “policy could be considered to be a text, a process, a discourse, a political decision, a programme, even an outcome”. Each of these is an

area researched when assessing social policy. Alcock and Becker (2022, p. 15) suggest that researching policy takes two approaches, often occurring together: *research for policy* which aims to "analyse, understand and inform" the formulation through to implementation of a policy; and *research of or about policy* which is "concerned with how social problems and issues are defined, agendas are set, policy is formulated, decisions made, how policy is delivered in the real world, and later evaluated and changed".

Whatever the categorical separation, these ways that policy is often researched relate to how we understand what we could and should do through a policy's programs, interventions and instruments (Araral, Fritzen, Howlett, Ramesh & Wu, 2015). This includes how we understand what kind of socio-political decision-making space that policy came from, and then what effects the policy had in practice. Whereas Chapter 2 has outlined where social policy comes from, I now focus on what social policy does in terms of how this has been measured and addressed in social policy research in general terms before narrowing in on the CDC more specifically.

How we understand what is measured or analysed in social policy research relates to the intent of the research itself and what is decided as important to learn about. This intent is combined with how related problems are defined by those doing the research for policy or about a policy, alongside how problems have been determined by and are embedded in the policy itself, otherwise described as the policy's 'logic' (Maddison & Denniss, 2013). Policy researchers make decisions about what to measure and learn for or about a policy, including whether to explicitly address the logic of the policy itself (Blackmore & Lauder, 2005). Section 2.2.1 outlined that social policy and its interventions, are one form of enacting formal social control. Section 2.2.1 also showed that informal social control in part relies on the interactions between people regarding reciprocity and the reproduction of social norms based on constructions of deviance. Yet what is measured regarding the effects or influences of social policy interventions often does little to capture those interactions, otherwise framed as processes of how policy has an effect in context (Neale, 2021).

Policy and interventions necessarily define problems to act on, and what is researched and how policy influence is measured usually has depended on how problems are constructed. These problematisations embedded in policy further discussed in Chapter 2, have been described by Yeatman (1998) and others (Bacchi, 2009) as policy being more about problem-

setting than problem-solving, where policy actions through related processes and programmes reflect an agenda set by how problems are defined and by whom. As outlined in Section 2.2, changes in responsibility for social issues and political discourse overtime have framed what is determined to be a problem in the first place and why. What is researched is also often reflective of this agenda, with research often done to ascertain how well these efforts of problem-setting have or will work in problem-solving through that particular policy intervention, program or instrument (Nair & Howlett, 2017). Where the processes of how policy has effect on interactions between people have not been identified as problems, this will mean that those interactions will not be researched or measured according to typical policy problematisation strategies.

Alongside what are determined as problems, social policy is also dependent on how policy researchers engage with social policy (Dall & Danneris, 2019; Neale, 2021). This engagement often ranges from being close in practice on the ground or learning from afar through theory or secondary data analyses. A suggestion has been made that research for and about social policy is "a social field marked out by players outside" of that space where a policy is implemented (Blackmore & Lauder, 2005, p. 98). What is meant by 'players' can be interpreted here to include the researchers themselves regarding how they research policy. How policy is researched includes whether researchers have any direct experience of the policy instruments and programs in application, and if so, how this experienced has occurred.

Blackmore and Lauder (2005) contend that the policy researcher needs to identify their status as an insider or outsider concerning connectivity to policy influence in practice. They suggest an insider is most likely for participatory practitioner-type researchers in the field as opposed to outsiders being those far removed from the policy in action with policy recipients. It is now well established (Goodwin & Phillips, 2011; Lea, 2020; Lipsky, 2010; Phillips, 2010; Phillips & Goodwin, 2014), that the position a researcher thus takes to learn about the influences of policy, whether far removed or closely experienced, bears significant weight on the knowledge produced through policy research and therefore any associated decisions made with that data.

The kind of knowledge produced from policy research has been found in some instances to reflect mostly the kind of research from those far-removed from an insider relationship. For example, Mamouney and Coffey (2015) analysed 120 peer-reviewed journal articles across

two Australian policy journals between 2012-2014. The research shows most (over 50% of studies reviewed) social policy research in Australia during this time and reported in these journals employs qualitative description, which means to describe studies that analyse existing, or indirect data sources, from academic or grey literature (Mamouney & Coffey, 2015, pp. 14-16). Such studies largely reflect research far removed from practice-based fieldwork, often described as secondary research (DeCarlo, Cummings & Agnelli, 2021; Neuman, 2013). Studies that used direct data sources, such as data collected through interviews or survey methods to understand policy influence, made up only 13% (Mamouney & Coffey, 2015, pp. 14-16). Mamouney and Coffey (2015, p. 16) argue that "this means researchers are relying heavily on what other researchers are saying rather than collecting primary data". They suggest this may result in social policy becoming inward-looking, limiting capacity regarding what can be learned of policy influence in practice.

The way policy is researched is also linked to a frequent disconnect between where policy comes from versus what policy does in application. Blackmore and Lauder (2005), alongside others (Lea, 2020; Lipsky, 2010; Prior & Barnes, 2011), have paid direct attention in their studies of policy research concerning the disconnect between where policy comes from and what policy does, highlighting the divide as problematic. Blackmore and Lauder (2005, p. 98) have explained that this disconnect results because where policy comes from is not where it operates or has an effect. Drawing on Ladwig's (1994) conceptualisation of education policy, Blackmore and Lauder (2005) alongside policy researchers such as Byrne, Olsen and Duggan (2009) show the disjuncture between where policy comes from and what policy does. They argue this is because making policy has little to do with what goes on on-the-ground and often includes decision makers that are far removed from an insider's perspective. Making policy has been defined in part as a political act that includes ideological problematisations and ways to solve them, already addressed earlier in Chapter 2.

Recent approaches to measuring or capturing what policy does, or the effects of social policy on recipients and communities, have been mostly guided by an 'evidence-based policy research' approach (Alcock & Becker, 2022; Neale, 2021; Parkhurst & Abeysinghe, 2016). Policy research, including an evidence-based approach, is largely dominated by employing quantitative research methods to assess policy overall (Dall & Danneris, 2019; Schmitt, 2015). The evidence-based approach to policy aligns with trends in the medical field and frames what is considered important and trustworthy in research, including what ought to be

measured (Mullen & Streiner, 2006). Primarily this has meant that objective, quantifiable, numerical data has been preferred by policy-makers, framed as more 'reliable' when using an evidence-based approach to research about policy, particularly when trying to evidence and evaluate policy outcomes and impact (Baron, 2018; Head, 2010; Supplee & Metz, 2015). This quantitative assessment has then mostly been done to establish a level of change or effect relative to baseline policy measurements per policy objectives using a rationalist approach (Mullen & Streiner, 2006). If outcomes vary too far from objectives, this is categorised as an implementation or application failure (Prior & Barnes, 2011; Schmitt, 2015). The rationalist approach is often juxtaposed with research employing a constructivist and interpretivist approach, which in contrast, relies on matters of context-related subjective interpretation and interactions within and between people and spaces (Neale, 2021; Newman, 2017; Prior & Barnes, 2011).

Regarding preference being given more recently for evidence-based policy, this has then influenced "what counts" as relevant evidence (Alcock & Becker, 2022, p. 15). This has meant that what is problematised and captured needs to meet specific criteria to be adequately quantifiable so to better inform an evidence-based approach. In policy evaluations and research about policy impact on recipients, this has then influenced the collection of data measuring influence toward that which both aligns with objectives and can be quantified (Bulmer, 2021, p. 201). For example, dependent on policy intentions and similar to measuring intervention impacts and outcomes regarding health initiatives, research regarding social policy programmes and interventions have included measures focussing on changes to incidence and prevalence rates of defined factors (Byrne et al., 2009). These factors include drug and alcohol consumption rates; crime rates; wellbeing and health outcomes such as smoking and hospitalisation rates (Bulmer, 2021). Information into these factors has often involved assessing administrative data to quantify changes in the association between factors over time.

Alongside collecting associated information through routinely collected administrative data, this has often meant that recipients' subjective perspectives regarding policy lived experience are also captured in ways that can be quantified. These subjective perspectives are usually collected by surveying people through quantitative questionnaires using rating scales that pre-set and limit responses to some degree (Greve, 2017; Voukelatou et al., 2021). Assessing and quantifying change across defined factors can provide insight into levels of association

between factors of interest. However, many experimental quantitative measures considered most rigorous are either unsuitable in practice or can miss the detailed context of individual cases (DeCarlo, Cummings, & Agnelli, 2021). This inability to capture nuance and reliance on what Neale (2021) describes as simple causality, has meant that much policy research about intervention influences has been able to report linear and ambiguous association but cannot capture the processes of how nor why interventions work in context to have effect.

Furthermore, whether using a rationalist or more constructivist approach, whether with quantitative or qualitative methodologies, data is often collected cross-sectionally and does not habitually incorporate longitudinal analyses when working to collect data directly from policy recipients due to resource restrictions (Alcock & Becker, 2022; Bulmer, 2021; Neale, 2021). Capturing data at single time points again limits how we come to understand complexity or nuance in policy influence. Getting a single cross-sectional time-point is taken as providing enough data about related phenomena but may only reflect a subjective perspective influenced by current mood, incentives or other reporting bias, thus limiting the relative accuracy of data collected (DeCarlo et al., 2021; Rindfleisch, Malter, Ganesan, & Moorman, 2008).

In contrast to the rational measures, more contextual or constructivist measures are also an option when researching policy. More contextual or constructivist methods can include primary research regarding policy influence on recipients, critical discourse analyses of policy-related documents and texts, or descriptive secondary research from more theoretical positionings (Alcock & Becker, 2022; Blackmore & Lauder, 2005). These efforts work to understand lived experiences with and without reflecting the pre-set problems the policy attempts to solve. For example, these measures include more explorative efforts of inquiry that seek out those policy influences, sometimes based on experiences of recipients and communities' overtime without attempts to quantify associations between pre-set problems or use pre-set responses (Bulmer, 2021; McIntosh & Wright, 2019).

Such an approach has been described broadly as qualitative longitudinal research by policy researchers such as Neale (2021). Neale (2021) argued that when applying such an approach we are better able to appreciate change and policy influence from within the complex conditions and fluidity of time that people negotiate in their day to day lives. They suggest that this makes the approach to understanding policy impacts more aligned to the real-world

processes within which policy operates. As Neale (2021, p. 654) argues, by employing a relatively novel approach to researching about policy influences, longitudinal qualitative research is then better positioned as:

> Real-world research, which gives insights into how people narrate, understand, practice and shape their evolving lives, and the evolving world of which they are a part. Qualitative Longitudinal research takes human agency and subjectivity seriously, enabling understandings of lived experiences, and gaining an intimate familiarity with lives as they are being lived.

The contextual and often critical approach to how we learn about policy and its effects can generate new types of data and analyses. This new data can highlight theoretical or lived unintended consequences related to policy influences in defined locations and for defined cases, that otherwise can go uncaptured in more narrow, quantitative inquiries focused only on the targeted outcomes (Bulmer, 2021). Methods that are better able to capture complex contexts of how policy influences recipients' lives, parallel those in the broader social sciences (Neale, 2021). These methods include repeated measures over time, mostly qualitative interviewing and observational strategies, with the open-ended and participatory versions considered most exploratory (Ayres, 2008; Cannella & Lincoln, 2009; deMarrais & Lapan, 2003; Draus, 2017; Elfenbein & Schwarze, 2020; Hignett & McDermott, 2015; Holland, Thomson, & Henderson, 2006; Patton, 2002; Saldaña, 2003; D. Turner, 2010). However, this kind of information cannot tell us how widespread any issues may be as typically this data cannot be generalised to any degree outside of those persons participating in the research (DeCarlo et al., 2021; Neuman, 2013). However, as has long been argued and accepted, not having an accurate picture of the contexts within which a policy is implemented is bad practice, often leading to wasteful resource allocation and harmful unintended outcomes (Alcock & Becker, 2022; Bulmer, 2021; Edwards, Howard, & Miller, 2020; Okongwu & Mencher, 2000; Spicker, 2006).

Some have argued that instead of classifying methodological approaches and methods as good or bad, for social policy research, what data is considered important and how that data is collected and analysed, should instead be about the appropriateness of what we need to learn about a policy's impact (Bulmer, 2021; Parkhurst & Abeysinghe, 2016). This inherently relates to how problems are conceived, as addressed above and throughout Chapter 2.

Whether policy research is guided by more rationalist or interpretivist and constructivist, quantitative or qualitative paradigms, will depend on what the researcher seeks to learn. The division of importance between rationalist or constructivist, quantitative or qualitative, has been argued by Bulmer (2021, p. 187) as ideological, instead it is how these paradigms may suit what is aimed to be learned from an inquiry that matters more. As outlined in Section 2.2, the political nature of policymaking regarding the political need to act on neatly defined problems, can be aligned to methods that measure social issues as simple, categorised and linear (Goode & Ben-Yehuda, 1994; Walsh, 2017). However, as Bacchi (2009), Colebatch et al. (2020), Jamrozik and Nocella (1998) and others have argued, such simple presentation does not often address the reality of issues in context. As addressed in Section 2.2, instead policy researchers suggest issues are complex, not linear and require multifaceted ways of defining and solving those problems. These complexities include accounting for influence of socio-political factors influencing policy processes in the policy cycle, as argued by McClelland et al. (2021) further in Section 2.2.

Indeed, a balance between paradigms, research approach and methods used may be more helpful to improve what we think we know. However, an imbalance in social policy research occurring through favouring certain approaches and methods consistently over others may constrain policy effectiveness by limiting the range of knowledge captured that informs it (Qureshi, 2017). This imbalance remains the case in evaluation and research of policy impacts and outcomes after implementation, as shown by Mamouney and Coffey (2015), who indicated there needed to be more research done collecting data from participants in the field. Furthermore, whatever the approach employed, where policy objectives have set the problems that needs to be solved, this can leave little room to assess influence outside of those pre-set problems. Researching issues related only to policy objectives has then been described as a problem in itself (Ahlin Marceta, 2021; Neale, 2021; Newman, 2017; Standring, 2017). However, such research is often far-removed from the policy in practice. Instead, such work becomes research on policy, departing from being research about policy and leaving that for others to contend with.

3.3 Research on the Cashless Debit Card

Having briefly discussed research on policy in general, I now turn to the research on the CDC and what was found. An overview is first given on whether the results in general support the

effects intended by the CDC, followed by more detailed analysis. A full Table of the results with commentary is to be found in Appendix 1.

3.3.1 Overview of the Research and Evaluation Studies on the Cashless Debit Card

This critical review was guided by the following questions: Did the CDC work, how was the CDC researched or evaluated, and how do those methods used relate to what we can understand regarding the influence of the CDC? A thorough and repeated search over multiple databases for research regarding the CDC and income management in Australia was undertaken to inform this critical review. The following section summarises the critical analysis of the 36 publications and reports emerging from 27 separate studies that specifically assess the influence of the CDC policy intervention on recipients and communities in Australian society between 2016-2022.

As shown in Tables 3 and 4 below, most of the findings regarding the CDC's influence on recipients' lives found that the CDC was *not beneficial* and *did not meet policy objectives*. However, the reasons for such findings occurring have largely not been addressed nor have previous studies focused on how the CDC impacted recipients within the broader social contexts of their daily lives, alongside other policy and programmatic influences. While studies have explored whether policy aims were being met or not, the impact of the CDC as a compounding stressor and negative enabler have not been specifically explored. 'Intersectionality' is a term developed by Crenshaw (Cho, Crenshaw & McCall, 2013) to refer to ways in which different aspects of a person's identity are affected when they are exposed to overlapping forms of either discrimination or marginalisation. While referring to the identify effects overlapping influences, I argue that there are also cumulative effects when vulnerable citizens are besieged by overlapping policy and program interventions in their lives.

Previous evaluations of the influence of the first iteration of income management through the basics card shows the approach did not have a beneficial impact in recipients' lives either. The basics card research by Bray et al. (2014) and others (see for example, Altman, 2016; Bielefeld, 2012, 2014, 2016; Brimblecombe et al., 2010; Cox, 2011; Deloitte Access Economics, 2015; Klein, 2016; Marston, Cowling, & Bielefeld, 2016) found that overall, compulsory income management has limited positive behavioural outcomes in line with

policy objectives, a broad finding later reviewed and confirmed by Bray (2020) in their review of updated administrative data.

The influences and impact of the CDC policy on recipients' lives have been addressed by a variety of studies, namely through consultants and academics conducting evaluations and research on the outcomes from the CDC. Three primary studies were conducted into the influence of the CDC. The first was an evaluation conducted by ORIMA (2017) in 2017; Followed by the evaluation by Mavromaras, Moskos, Mahuteau, and Isherwood (2019a; 2019b; 2021) and Mavromaras, Mahuteau, & Wei (2020) in 2019-2020, with their publication in 2021 representing the consolidated report from each of the previous publications in 2019-2020. These evaluations are complimented by an additional large primary academic study by Marston, Mendes, et al. (2020) in 2019, which has subsequently produced a series of focussed publications that draw off the same data (Mendes et al., 2021; Peterie et al., 2022; Roche et al., 2021a, 2021b). The latter two large main studies by Marston, Mendes et al. (2020) and Mavromaras et al. (2021) reflect methodological improvements in their approach compared to ORIMA, as discussed below.

Of these three studies, two were government-commissioned (Mavromaras et al., 2021; ORIMA, 2017) with either mixed or positive findings respectively, and one stand-alone study (Marston, Mendes, et al., 2020) whose findings did not support the CDC or basics card as having beneficial effects. Little primary research outright supports the CDC as having a dominant, positive influence on recipients' lives. Such outcomes are only prevalent in one primary-research study, the government-commissioned ORIMA (2017) evaluation of the influence of the CDC, later supported by one brief narrative review by Smith (2017). All other work assessing the influence of the CDC claim either mixed outcomes or that the policy is associated with no identified change in accordance with measured, pre-determined variables and that the CDC is a bad policy with negative consequences.

Table 3 below provides an overview of the number of research publications reviewed, the nature of the research being either primary or secondary data collection and analysis, the type of corresponding research approach and aligning number of publications and whether each found the CDC to have beneficial, not beneficial or inconclusive overall influence on recipients and communities.

Table 3: Overview of studies reviewed by research approach and general findings of CDC research.

Number of Studies: 27 - Number of Publications: 36 (some study results are published more than once)				
Type and Number of Primary Research and Approach	Findings			
	Number with data from CDC recipients	Policy as beneficial	Policy as not beneficial	Inconclusive
Quantitative: 2	2	0	1	1
Qualitative: 9	9	0	7	2
Mixed Methods of Quantitative and Qualitative: 4	4	1	2	1
Discourse Analysis: 5	0	0	5	0
Totals overall: 20	15	1	15	4

Mix of Primary and Secondary Research publications – data here captured directly from CDC recipients	Findings			
	Number with data from CDC recipients	Policy as beneficial	Policy as not beneficial	Inconclusive
Qualitative + Integrative Review	1	0	1	0
Qualitative + Discourse Analysis	1	0	1	0
Totals: 2	2	0	2	0
Total publications using primary research: 22				
Totals engaging CDC recipients: 17				

Type and Number of Secondary Research Publications	Findings		
	Policy as beneficial	Policy as not beneficial	Inconclusive
Narrative/ Integrative Review: 11	1	10	0
Policy Analysis: 2	0	2	0
Combination:1	0	1	0
Totals based on analysis of theory or secondary data analysis: 14	1	13	0

Table 4 below outlines that of the 17 primary research publications conducted into the influences of the CDC that directly engaged CDC recipients, these publications employed at least one of five different methods to collect data. Six publications used more than one

method. Further nuances of these methods are addressed in Appendix 1 in the individual critique of each publication, and throughout the research synthesis that follows.

Table 4: Overview of studies reviewed by research methods used in CDC research.

Number of primary research publications (17) that included CDC recipients' views and how – (treating methods separately in mixed-methods studies)	Findings		
	Policy as beneficial	Policy as not beneficial	Inconclusive
Quantitative Subjective questionnaires: 3	1	1	1
Qualitative Open-ended interviews: 4	0	4	0
Qualitative Semi-structured interviews: 7	0	5	2
Qualitative Structured interviews: 1	0	1	0
Unknown qualitative interview structure: 2	0	2	0
Observations: 5	0	5	0
Totals: 22	1	18	3

As shown in Table 3 above, there is a relatively even spread of research into the CDC thus far that can be categorised as either primary research with respondents in the field (22 publications), or secondary research based on analysis of theory or secondary data analysis (14 publications). How this research was conducted with CDC recipients can be seen in Table 4. Across the 17 publications involving primary research that captured data directly from CDC recipients, these studies included 22 different methods in those publications that addressed CDC recipients' views in some way.

Table 4 shows that only four publications report on data that uses open-ended interviews, often considered a more exploratory way of capturing complex context in research participants' lives relative to the other methods used (Agar, 2008; Ayres, 2008; Briggs, 2003; Brounéus, 2011; Bruner, 1987; Carspecken, 2005; Clandinin, 2007; Creswell & Clark, 2004; Elfenbein & Schwarze, 2020; Gobo, 2008; Johnson, 2001; Patton, 2002; D. Turner, 2010). Of these four publications using the most exploratory method of interviewing, data emerges from two main studies, across two distinct CDC trial locations being the East Kimberly (Daley, 2020) and Ceduna (E. Vincent, 2019). The vast majority of qualitative interview data collection regarding CDC recipients' views has emerged from semi-structured interviews, with three quantitative subjective questionnaires used to survey CDC recipients. Five have

incorporated any observations into their analyses, all done to complement forms of interviewing to differing degrees.

Most of the research conducted thus far into the influences of the CDC on meeting policy objectives or otherwise positioned the policy as not beneficial or as bad policy. Of the 36 publications produced thus far, Table 3 shows two studies found the CDC to be beneficial or good policy. Four publications have found the influence of the CDC to be inconclusive. The remaining 30 publications have argued that the CDC not to be beneficial or that the CDC is overall a bad policy. However, many of these studies do include that the reasons for the CDC being bad policy also relate to the CDC's influences being dependent on other social complexities. Although few do much to explain or capture as data what exactly these complexities are in their lived contexts using primary research. The ways each of these publications has reached these findings is discussed in further detail below.

The 36 publications reviewed discuss the CDC to some degree. Some studies focus exclusively on the CDC, where others discuss the CDC in combination with the basics card. The analysis of each publication in Appendix 1 is divided into four main sections: A critique of publications from 24 stand-alone studies; and three studies that have each produced more than one publication from the same data. Of these three studies, data collected in the first study by Marston and colleagues have contributed to five publications, the second by Mavromaras and colleagues has contributed to four publications, and the third by E. Vincent has contributed to three publications.

Following from individual critiques, the sources were then explored, contrasted and themes synthesised in the following sections below. The synthesis that follows elucidates what the research in combination tells us in relation to the question guiding the review, and what is yet to be learnt and suggestions of how best this might be done given gaps in existing knowledge and methodological limitations identified.

Overall, the critical review of associated research and evaluations relating to the CDC suggests that to enrich understandings of the influences of the CDC in people’s lives the following matters might need to be addressed. The review shows that engaging with the lived experiences of CDC recipients – their stories, felt needs and opinions - can be a constructive way to better understand the CDC’s impact. Recipients’ interactions within their

communities and with and amongst other service providers, with family members and in local networks is also important. I argue that this is particularly so in Ceduna, where networks are a powerful force in people's daily lives in a small, rural/remote community with strong class and race divides. Developing an understanding of such communities and their CDC recipients' lived experiences within their social context over time, is I believe, key to appreciating the CDC's impact. I argue that future inquiries might benefit from considering:

- What the relevant issues/contexts are in sites under study, regardless of the CDC implementation, and how these identified issues/contexts interrelate and are experienced, *as described or problematised by the CDC recipients and their communities*.
- What we do or do not know about *how the card works in the complex, on-going social contexts* that card recipients define as important outside of the direct influence of the card, *as experienced and described by card recipients and their community*.
- What card recipients and their communities say has changed in their lives for better or for worse, whether in relation to the card or not and whether the card was pivotal or not in these changes.
- Little is known about *how changes happen* if they do or not for CDC recipients, particularly for example in relation to the CDC influencing recipients' social relationships with other people in their lives.
- Little is known about how qualitative methodologies that consider the specific local social context of interventions like the CDC might deepen understandings of the impact of such policies.

These issues are then further summarised in the context of the Research Questions posed in Chapter 4. Chapter 5 then works to explain how the chosen methodology works to address the gaps in research to date as identified above.

3.3.2 Limitations in Methods Used in Cashless Debit Card Evaluations and Research

The methodological issues raised here are important for Chapter 5 and in helping to guide how my PhD research was carried out. How the methods used in this research pair to the gaps in knowledge identified throughout this review are further addressed in Chapter 5.

The following key points were revealed as general and common problems across most studies regarding methodologies and methods used in much of the primary research investigating the

influence of the CDC on recipients and communities. These issues primarily arise when efforts are being made to capture subjective qualitative perspectives of how recipients experience the CDC:

- establishing that changes were due to the CDC
- understanding the general lived contexts of recipients' lives outside of the CDC
- problems with the amount of time spent in communities
- a lack of research exploring how CDC recipients define and describe what the problems are from their perspective and
- how the CDC operates within a broader social context

The review then synthesises and addresses the aligning limitations in research that aimed to capture or theorise influence beyond policy objectives.

3.3.2.1 The CDC Trial and The First Evaluation: An Introductory Overview

The government commissioned ORIMA (2017) evaluation was the first to be conducted into the impacts of the CDC, occurring in 2017, one year after the CDC implementation in Ceduna and East Kimberly regions in 2016. This evaluation reported that the CDC had vastly positive influences on the lives of policy recipients including reduced alcohol, gambling and illicit drug consumption, all of which have since been contested. The evaluation approach employed by ORIMA (2017) sought to cross-sectionally capture and analyse data in accordance with already identified policy objectives only (see Section 2.4), determined as the important problems by powerful policymakers. The findings were drawn from quantitatively surveying mostly compulsory recipients and interviewing service providers. No exploratory interviews were conducted with CDC recipients.

The generally positive outcomes reported by ORIMA (2017), and supported by Smith (2017), have been since challenged by a variety of further research. This other research largely argues that the ORIMA evaluation was insufficient and used flawed methods to establish their positive policy outcomes, effectively misrepresenting the level of effect of the intervention (Australian National Audit Office, 2019, 2022a; Cox, 2020; Doel-Mackaway, 2017; Doyle, Schurer, & Silburn, 2017; Greenacre, Akbar, Brimblecombe, & McMahon, 2020; Hunt, 2017, 2020; Klein & Razi, 2017; Marston, Mendes, et al., 2020; Peterie, Bielefeld, Marston, Mendes, & Humpage, 2019, Tilley, 2018). This misrepresentation of data occurred by

excluding some CDC recipient responses, which when included showed that most of the sample reported not consuming those substances regardless of the CDC. This misrepresentation led some researchers to argue that the evaluation findings were "grossly exaggerated, they [outcomes] were not supported by the evaluation evidence available" (Hunt, 2020b, p. 20).

Despite its methodological issues, the ORIMA CDC evaluation still formed the basis of political arguments in government for extending the CDC trial past its original sunset period geared to end in 2018 (Hunt, 2017, 2020a; Klein & Razi, 2017). Since its implementation in 2016, the CDC trial has been extended twice, once in 2018 and 2020. Extensions were supported by the Liberal Coalition and many in the Australian Labor Party, alongside some independent politicians. The incoming Labor Government in 2022 introduced legislation to scrap the CDC as a compulsory measure, meeting this election promise as discussed in Section 2.4 (Ministers for The Department of Social Service, 2022). These methodological issues in general have since been reproduced, although to a lesser degree, in some subsequent research. Efforts in other work has also been made to rectify some of those methodological problems. These core issues in methods used to understand the influence of the CDC intervention are addressed in the sections below.

3.3.2.2 Issues with Establishing Baseline to Argue Policy Influence

No research has been published or made public that has reviewed what CDC recipients' lives were like prior to the CDC's implementation, whether defined and described by income support/CDC recipients or otherwise. This has meant that irrespective of recommendations regarding good policy making and evaluation strategies that argue the need for such evidence prior to implementation (Alcock & Becker, 2022; Althaus, Bridgman, & Davis, 2007; Blackmore & Lauder, 2005; Maddison & Denniss, 2013), the CDC policy appears to have been implemented without sufficient information regarding the context into which the policy was supposed to operate or why/how the CDC may be beneficial.

As outlined earlier in this chapter, research regarding social policy should include capturing the setting or contexts into which a policy intervention is applied. Capturing contexts is something that the CDC policy research, whether for or about policy, did not appear to do well. All evaluation and research regarding the CDC and its legislated policy objectives (see Section 2.4) or otherwise was conducted after CDC implementation. As mentioned earlier

regarding the ORIMA (2017) evaluation, overall, there have been flaws in evaluation methods regarding the policy argued by some as mainly related to inadequacy in establishing an adequate baseline on which to establish quantifiable change (Australian National Audit Office, 2022a; Hunt, 2017). Additional issues in the initial ORIMA (2017) evaluation, and subsequently all other studies that followed, relate to no comparable baseline analysis of levels of consumption or harm related to use of drugs, alcohol or gambling conducted prior to the CDC policy implementation. Notably, for all studies of the CDC policy and its influence in the lives of policy recipients and their communities (Marston, Mendes, et al., 2020; Mavromaras et al., 2021; ORIMA, 2017), evaluation was not built into the policy designs (Hunt 2020b). Not having evaluation built into policy design has been suggested as a flaw in the policy cycle (Althaus, Bridgman, & Davis, 2007), and a common flaw in social policy evaluation much more broadly than the CDC (Reichardt, 2011, p. 247).

Even with the methodological improvements made by Mavromaras et al. (2021), relative to the original evaluation by ORIMA (2017), the Australian National Audit Office (2022a) review found that this government commissioned yet independent evaluation of the CDC by Mavromaras et al. (2021) did not find sufficient evidence of the CDC policy meeting its objectives. Surveys and interviews with CDC recipients and non-recipient community members relied on retrospective reflection and ratings of perspectives of change across the studies (Marston, Mendes, et al., 2020; Mavromaras et al., 2021; ORIMA, 2017), which all focus on the influence of the CDC in target communities. Methods researchers argue that quantitative data based on retrospective reflection is inherently problematic, inaccurate and subjective to biases that can misrepresent what actually occurred and that important details can be forgotten altogether (DeCarlo, Cummings, & Agnelli, 2021; Neuman, 2013). This lack of adequate baseline limits what claims of change can be made because no evaluative reference point was clearly established to base accurate, quantifiable claims of change (Bryman, 2015; DeCarlo et al., 2021; Neuman, 2013).

The Australian National Audit Office (2022a, p. 12) has since recommended that a better understanding of social issues at baseline must be incorporated across all similar welfare policies or programs in all government departments to avoid resource waste and reduce potential for harm. To overcome issues with how life was for policy recipients before the CDC implementation and to establish quantifiable change, some research has drawn from existing administrative data where available and aligned this data to CDC policy objectives

and trial areas. However, the volume of studies doing so is minimal in relation to assessing the CDC (Greenacre, Akbar, Brimblecombe, & McMahon, 2020), and this is addressed in further detail in Section 3.2.4 below. Regarding the CDC, further measures of assessing the policy's influence are required to help overcome the issues of no longer being able to establish a quantifiable baseline.

3.3.2.3 Little is Discussed About Recipient's Lives Outside Of Policy Influence According to Policy Recipients

Even without establishing an adequate quantifiable baseline, little CDC research has focused on understanding the broader social conditions into which the CDC was rolled out. There was a dearth of open-ended, exploratory, longitudinal qualitative enquiry seeking the lived experiences from recipients and their communities.

This limited understanding of contextual conditions not directly related to the CDC includes evaluations and other secondary research regarding the CDC that, even though acknowledging that complexities exist, do not go far towards capturing what those complexities might be from the standpoint of recipients' lived experience. Although still useful in acknowledging lived complexities occur, such efforts ambiguously capture that there is an effect, but do little to describe the processes of how and why that effect occurs, as described over-time by recipients' (Neale, 2021).

For example, Marston, Mendes, et al. (2020) found that the reasons for social harms and issues beyond only the CDC or basics card were reported by policy recipients as not entirely their fault and, "tended to instead point to contextual factors that lead to people receiving welfare" (Marston, Mendes, et al., 2020, p. 31). However, contextual factors were vaguely defined as participants saying there were additional reasons why they had little choice but to need income support (Marston, Mendes, et al., 2020). Little indication was given in this study about what participants defined as 'contextual' complexities. Capturing these complexities may provide further insight regarding how and why outcomes of income management influences in people's lives have been stated as not beneficial.

Overall, there is much research that has sought to explore the socio-political conditions that both gave rise to the CDC as a policy approach, as well as the likely ramifications and impacts a policy like the CDC may have on recipients. These approaches are discussed in the

second half of this review (for examples see Bielefeld, 2019; Klein & Razi, 2017; Marston, Mendes, et al., 2020; Marston, Peterie, Mendes, & Staines, 2020; Peterie, Bielefeld, Marston, Mendes, & Humpage, 2019; Staines et al., 2020; Tilley, 2018, 2020; E. Vincent, Markham, & Klein, 2020). However, many of these studies do not address how CDC recipients experience their lives regardless of the CDC or use longitudinal, repeat measures over the longer term (Klein & Razi, 2017; Marston, Mendes, et al., 2020; Marston, Peterie, Mendes, & Staines, 2020; Peterie, Bielefeld, Marston, Mendes, & Humpage, 2019; Staines et al., 2020; Tilley, 2018, 2020)).

This previous research regarding the CDC, reflects what Neale, (2021) and others (Byrne et al., 2009; Dall & Danneris, 2019; Monaghan & Ingold, 2019) describe as policy research that mostly engages methodologies that have not been able to adequately capture what works and how in an applied setting, according to those that experience it. Without capturing information repeatedly, overtime from observations and in-depth interviews, it is suggested such approaches may not fully indicate complex 'causality' or associations that arise during the *processes of how and why* policy recipients' go about navigating their lives (Neale, 2021). Those few efforts focussing on the CDC in the broader contexts of people's lives using such strategies include the anthropological research by only Dalley (2020) in the East Kimberly region and E. Vincent (2019) in Ceduna.

In seeking to understand the influence of the CDC in recipients' lives, capturing longitudinal information from CDC recipients and their communities which describes what life is like for people outside of the card's direct impact, may help understandings of the broader conditions people are navigating. In doing so, research may help to enrich understandings about *how* the CDC policy works in the context of recipients' lives. Capturing information about social conditions may inform research both for and about social policy, helping to improve the rigour of policymaking.

3.3.2.4 Time Spent and Observations Conducted are Limited

Limitations relating to time can assist researchers in the process of engaging CDC policy in practice. One issue is the short amount of time spent with CDC or basics card income management recipients, whether this is the time with participants in interviews, number of times respondents were interviewed or engaged with, the amount of time spent in the community and with respondents more generally, or how the policy is experienced over time

by recipients since policy implementation. For example, in interviews in all three primary studies, interview duration is only reported by Marston, Mendes, et al. (2020), and Mavromaras et al. (2019a, 2021). These interviews were once-off, and interview durations ranged between approximately 10 minutes to 1.5 hours per person. In each of the main studies that collected evidence from CDC recipients directly, interactions and time spent beyond interviews in communities were short, with interactions with recipients occurring once with no ongoing interactions or observations informing the findings (Klien & Razi, 2017; Marston, Mendes et al., 2020; Mavromaras et al., 2019a, 2021; ORIMA, 2017; Tilley, 2022). A variety of evidence has shown that alongside the use of open-ended forms of inquiry, greater time allocation is needed to unpack complexity, often through repeat interviews and participatory observations (Jeffrey & Troman, 2004). Methods that are better able to capture complexity include those occurring over time, including repeat interactions that are often lengthy and require management of relationships and trust (Patton, 2002).

Often the time spent interacting with participants' lives was once-off and brief, with very few studies engaging in repeat interactions of any kind, whether with repeated interviews or observations. None of the three primary studies included participant observations, which aim to include descriptions of events as they occur in context, often by the researcher working alongside and with participants (M. Atkinson & Coffey, 2001). Evidence suggests that to capture complexities, methods need to include longitudinal, repeat participant observations (Saldaña, 2003); broad and repeat capturing of information in addition to topics of interest through open-ended interviews (Neuman, 2013; Osborne & Grant-Smith, 2021; Patton, 1990); or narratives of existing life conditions (Fontana, 2003). Such methods are typically combined, often forming part of lengthy sociological or anthropological academic inquiries (M. Hammersley, 2007a; S. Schensul, J. Schensul, & M. LeCompte, 1999).

Efforts to address the lived realities of the CDC's influence in practice, can be found in the longitudinal and contextual approaches to research by E. Vincent (2019) in Ceduna, and Dalley (2020) in the East Kimberly. Each of these studies captured some of the influences of the CDC over time close to policy implementation. For example, the work by E. Vincent (2019) sought to qualitatively capture people's broader lived experiences of the CDC using open-ended ethnographic methods. These methods meant that not long after the CDC implementation from March 2016, E. Vincent (2019) spent time intermittently in Ceduna over 12 months between 2017-2018, equating to three months total, hearing people's stories

who had either directly or indirectly experienced the CDC. During this time, 22 in-depth, open-ended, confidential interviews with CDC recipients were conducted, and an additional 64 'focussed discussions' with other community members were undertaken, alongside observations. However, the study by E. Vincent focused on the CDC experience and did not contain much discussion of the complexities people may be experiencing outside of the CDC.

This longitudinal approach was also reflected in anthropological research by Dalley (2020), who spent five months in the East Kimberly region learning about the influences of the CDC on communities. In contrast to E. Vincent, Dalley (2020) did work to explore and report on further contexts CDC recipients experience, which provided insight into the lived complexities of the policy being yet another strategy of colonial social control within a broader socio-political narrative that recipients had to contend with. Such a finding of the CDC within a broader context works to reposition the relative significance of the CDC in people's lives as less prominent in terms of the further conditions people are living with. Dalley's (2020) work does not, however, suggest the CDC has a benign or beneficial influence. By placing the focus on broader social contexts, Dalley redistributes the CDC's dominance to show that it is as not the only thing that is troubling in people's lives.

In Ceduna, E. Vincent's (2019) methods produced findings that included expressions from CDC recipients of apprehension and perceptions related to discrimination stemming from the CDC, whilst also showing some CDC recipients liked the card and were quite happy with it in their lives. E. Vincent's (2019, p. 18) analysis centralised on how divergent views of the card could emerge, finding that "the most articulate and passionate critics of the card were often those attuned to broader colonial, racial and social injustices".

Largely, E. Vincent (2019) found that the CDC negatively influenced recipients' lives in the Ceduna community. One area of positivity emerged from E. Vincent's (2019) research regarding some CDC recipients expressing an increased propensity for them to save money resulting from the CDC. The remainder of the themes pertain to negative experiences, including that data identified respondents were cynical and confused about the CDC. Thematic analysis was conducted and resulted in the following themes emerging: people were dissatisfied with the consultation process; considered the CDC to have negative racial dimensions; the policy fuelled complex shame responses relevant to Aboriginal peoples in particular; people were able to navigate around the card; the card has practical function

problems; people had distrust in the community panel; and the card was disempowering (E. Vincent, 2019, pp. 3-4). In terms of E. Vincent (2019) finding little positive influence of the CDC in Ceduna, this has also been reflected in other assessments of the impacts of basics card compulsory income management policy in people's lives in varying ways (Altman, 2016; Bielefeld, 2012, 2014a; Dee, 2013; Mendes, 2013, 2019).

Relative to the limited-time forms of inquiry and evaluations, such methods employed by E. Vincent (2019) often mean the researcher can better embed themselves within the community, gaining trust over time from participants and improving the accuracy of their insights (O'Reilly, 2005). Trust was a task E. Vincent had the opportunity to develop over their long-term engagement in the region since 2009, and similarly with Dalley beginning in 2013, which for both in the beginning report that their research was unrelated to the CDC. While beneficial and recommended for policy making and assessing impact (Garthwaite, 2016), such long-term engagement of up to nine-years preceding the time policy research was conducted, is not reflective of most research assessing policy influence (A. Stevens, 2011), often due to resource and political constraints (Althaus et al., 2007). Hence establishing if somewhat shorter research timeframes for repeat interactions and building community relationships and capturing contextual information may also find a similar depth of data, is needed as this may be more representational of policy research resources restrictions in most cases.

Capturing multiple time-points of policy influence extending some years after implementation can work to capture impact after such disruption (E. Jupp, 2022). Whilst E. Vincent's (2019) findings and methods were able to capture much broader aspects of subjective experiences of the policy, the timing of this inquiry in 2017 being so close to implementation may reflect heightened emotive reactions to a relatively drastic policy intervention, being the CDC, an aspect which E. Vincent acknowledges. This close timing to policy implementation is also reflected in work by Klein and Razi (2017), who collected data from CDC policy recipients in the East Kimberly in 2017, very close to the policy roll-out in 2016. Both E. Vincent (2019) and Klein and Razi (2017) noted the wide-spread anger and dislike regarding the CDC in their respondents. Such heightened emotional responses by recipients to actual or potential policy and service delivery change have been highlighted elsewhere (E. Jupp, 2022). Therefore, the relevance of the findings may not accurately reflect

experiences over the longer term in the case that increased time after the intervention, people may get used to the card and no longer see the policy as so invasive or troublesome.

3.3.2.5 CDC Recipients Do Not Get To Define What Issues Are Important to Them

In addition to the issues above, further issues remain regarding how data was collected. CDC recipients were infrequently asked how they defined what the issues are from their perspectives. The typical surveying and interviewing strategies used for data collection in the primary evaluations and research (Tables 3 & 4), do not incorporate CDC recipient perspectives regarding what issues they may define as important in their own lives regardless of the CDC (ORIMA, 2017; Mavromaras et al., 2021; Marston, Mendes et al., 2020)., Even studies that incorporated more critical analyses of the CDC, often did not include open-ended, exploratory, inductive methods with CDC recipients.

Research by Klein and Razi (2017) found the CDC to be racist and a version of ongoing oppressive paternal governance. However, their investigation into the CDC in the East Kimberly region did not indicate the structured qualitative interview schedule used with CDC recipients (Klein & Razi, 2017). This makes it difficult to ascertain how CDC recipients experienced the card beyond what the researchers may have asked. Interviews occurred only once, and CDC recipients were not asked follow-up interview questions which may have helped to explore policy influence from the recipients' perspectives.

Inductive, exploratory data collection methods such as exploratory interviews are paramount in establishing accurate reflections of lived experiences of change, that only those experiencing something directly can accurately reflect (Fontana, 2003, p. 52). However, much research has often excluded CDC and basics card recipient's experiences and where they have been included, they have mostly been limited to restrictive quantitative questionnaires (Bray, Gray, Hand, & Katz, 2014; Deloitte Access Economics, 2015) or deductive qualitative interviews (Department of Social Services, 2014; Mavromaras et al., 2019a, 2019b, 2021).

Researchers have often decided what variables to measure in accordance with policy objectives, reflecting a dominance of deductive, rationalist approach to assessing policy influence (Althaus et al., 2007; Colebatch et al., 2010; Maddison & Denniss, 2013; Neale, 2021) as outlined in Chapter 2. This preference can include some qualitative research

regarding the structuring of interview questions, alongside quantitative studies assessing self-report rating-scale data, administrative data and card-user data, which are described in the sections below. Such approaches are argued by methods-focused researchers such as Neuman (2013) as leaving little room for the emergence of new or divergent views to be expressed by participants. This narrow view means that such data collection strategies cannot capture information that might exist outside of the deductive, rationalist scope of inquiry (Caldwell, 2015; DeCarlo, Cummings, & Agnelli, 2021; Neale, 2021), limiting what can be learned about policy influences.

The CDC was a novel intervention, implemented in new trial locations and more punitive than its basics card predecessor. Other research suggests that when dealing with the new or unknown, exploratory and inductive research approaches can be more suitable for capturing unaccounted-for policy influences (Clark, 2008; Creswell & Clark, 2004, 2011). Inductive and exploratory approaches typically include research strategies that diversify and naturalise how researchers correspond to field participants (Ingold, 2017). This includes interacting or corresponding with participants through open-ended, conversational interviewing, active participant observations and doing these repeatedly over time (Madden, 2017; Madison, 2005; O'Reilly, 2009).

While there is more inductive, exploratory inquiry with CDC recipients conducted by Tilley (2022), such approaches are limited to only two major studies mentioned above by E. Vincent (2019) and Dalley (2020). Tilley's (2022) findings argue that the CDC causes social harm and suffering based on interviews conducted with CDC recipients. However, there were no mentions by Tilley (2022) about the structure or timing of the interviews conducted and only one participant is included as an example of recipients' CDC experiences.

More recent evaluations of CDC influence conducted after the initial ORIMA evaluation in 2017 still did not employ inductive, exploratory methods, although they did interview CDC recipients. For example, one of the most recent government-commissioned evaluations regarding the impact of the CDC in Ceduna, East Kimberly and Goldfields regions combined was conducted by Mavromaras et al. (2021) in 2019 by way of a mixed-methods evaluation. Mixed-methods evaluations are typically stated as providing a balanced enquiry countering limitations and drawing on the strengths of both the quantitative and qualitative research paradigms (Creswell & Clark, 2011; Owen, 2006). All the data in the evaluation by

Mavromaras et al. (2021) was collected cross-sectionally, however, at single time points without follow-up (Neuman, 2013), over approximately a 12-month timeframe. Unlike the ORIMA (2017) CDC evaluation, the evaluation by Mavromaras et al. (2021) did take account of a range of data types from different sources, including deductive, quantitative surveys (n=1963 CDC recipients) and administrative data analysis; and once-off deductive semi-structured qualitative interviews paired to predetermined topics related to policy objectives with both CDC and non-CDC participants (n=178 non-CDC recipients, n=231 CDC recipients).

While the interviews with CDC recipients were open-ended and semi-structured (Mavromaras et al., 2021, p. 217), the analysis was based on a thematic framework developed from the interview questions alone (p. 19). Such a procedure reflects what Hyde (2000, p. 86) has described as a deductive approach in qualitative research labelled "theory testing by pattern matching". This theory testing aims to link data to propositions, such as those made in the thematic framework by Mavromaras et al. (2021, p. 19, 217), where data was coded based on the propositions embedded in the interview questions asked and nothing further. Any emergent categories were accounted for by modifying propositions embedded in interview questions as the study progressed (Mavromaras et al., 2021, p. 19), which is identified as a deductive strategy to confirm idea or theory testing in some form (Hyde, 2000). As such, the exploratory approach to inquiry remains limited in the evaluation by Mavromaras et al. (2021), and although an improvement from the original ORIMA (2017) evaluation, it was still limited in capturing broad issues that fall outside of variables based on policy objectives.

Overall, inductive, exploratory, longitudinal qualitative methods are posited as better at discovering processes about how or why something happens (Neale, 2021; Neuman, 2013). However, almost all evaluations or research that used qualitative interviews as a data collection strategy with the CDC (Bray et al., 2014; Deloitte Access Economics, 2015; Klien & Razi, 2017; Marston, Mendes, et al., 2020; Mavromaras et al., 2021; ORIMA, 2017) were either structured or semi-structured in style. Other researchers have suggested that conversational, unstructured are more likely to capture information beyond the question's intention (Clandinin, 2007; Czarniawska, 2004; deMarrais & Lapan, 2003; Elfenbein & Schwarze, 2020; Gubrium & Holstein, 2003; Neale, 2021).

Only two studies incorporate interviewing without such structured, defined questions or narrow directionality, namely Dalley (2020) and E. Vincent (2019). Research suggests that more participatory and unstructured approaches may encourage more varied and broader responses (Czarniawska, 2004; Fontana, 2003; Tedmanson, 2016), and that approaching the research from a more inductive, constructionist perspective can capture more rich firsthand experience (Azungah, 2018; Patton, 1990; D. Thomas, 2003). Broader investigative and response range may increase the ability to capture unforeseen outcomes (Jabeen, 2016, p. 147); strengthen the inquiry and help capture the complexities that research and evaluations often posit as problematic. Trust-building has been argued to be critical to such approaches (Bergman Blix & Wettergren, 2015; J. Watts, 2008). Similarly, repeated and often lengthy interviews and situational, participatory observations are argued to deepen understandings of complex social environments (Guerin, 2016; Guerin, Leugi, & Thain, 2018).

3.3.3 Problems Arising from Limitations in Methodology Regarding Measuring Policy Objectives and Problem Representations

The following sections below narrow the literature synthesis to explicate in further detail the issues with measurements of variables reflecting policy objectives, with research mostly emerging from a rationalist perspective. The themed issues from the research review discussed here are:

- Health and wellbeing exclude social and mental health impact
- Impact on healthy purchases
- Limited focus on behavioural influences of policy surveillance
- No change to gambling and social complexities not captured
- Issues with perceptions and incidence of crime
- Alcohol, drug use and crime
- No focus on underlying reasons for ongoing alcohol or drug use

3.3.3.1 Health and Wellbeing Excludes Social and Mental Health Impact

Health and wellbeing have famously been described by the World Health Organisation (WHO), where 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 2019). Although the CDC policy objectives do not explicitly include aims related to improving health, improvements in health may be inferred as indirect through objectives of reducing alcohol consumption. However,

where the WHO definition of health is applied, it can be seen in research synthesis that little effort has addressed the impact of the CDC on health in a holistic way incorporating social or mental health measures such as wellbeing or those related to a cohesive and supportive society such as conflict, violence or victimisation (Elands, Peters, & De Vries, 2018; Florez et al., 2020; A. Williams, Maguire, Morrissey, Taylor, & Wyatt, 2020), with priority taken to assess physical health in isolation.

Measuring community health and wellbeing more broadly has been done by measuring hospital presentation of illness and, more commonly, through product-level analyses of food and beverage expenditure. No research includes in their measures of wellbeing efforts to capture the impacts of the CDC policy explicitly on mental health or social conflict. Research assessing the influence of the CDC or basics card on health and wellbeing has shown the CDC to have typically had no beneficial effect. Further, the influence of the CDC and basics card on child wellbeing specifically, has been shown to have little positive influence (Doyle et al., 2017; Hand, Katz, Gray, & Bray, 2016; Parkinson, 2015; Productivity Commission, 2020; Roche et al., 2021b).

The assessment of health through analysis of hospital presentations has only been addressed briefly by two studies where both showed an increase in presentations since the implementation of the CDC and basics card. For example, one study assessed presentations to the emergency department (ED) at the Ceduna hospital between September 2013-June 2018, where data indicated there may be some evidence of a short-term increase in ED presentations following CDC implementation (Greenacre et al., 2020), although the authors suggest this be interpreted with caution due to limitations in statistical analyses of available administrative data (p. 9). Previous analysis by Bray et al. (2014, p. 229) suggests that relative to pre and post basics card implementation in 2007, ED presentations across the Northern Territory increased between 129% to 142% between 2005-2013.

3.3.3.2 Impact on Healthy Purchases

More commonly, health has been assessed by analysing the impact on health purchases by assessing food and beverage expenditure through either self-report or administrative data. However, this kind of analysis applies primarily to the basics card. Healthy food and drink type purchases are defined as those that exclude sugary drinks, tobacco, alcohol and illicit

drugs as consumption of these items are determined as risk factors for poor health (AIHW, 2017).

Overall, most research into healthy purchase habits shows there has been no wide-spread change in the purchase habits of basics card or CDC recipients since their implementation. Some studies based on analyses of data from self-report questionnaires, suggest that income management basics card recipients and non-income management community members *perceived* there to be positive effects on purchase habits since the implementation of the basics card (Cape York Welfare Reform, 2012; ORIMA, 2010, 2017; Shaw & d'Abbs, 2011). However, other quantitative assessments of the basics card focus on product-level analysis of purchase habits and argue that the card has little effect on what recipients' purchase (Altman, 2016; Bray et al., 2015; Bray, 2016b; Bray et al., 2014; Brimblecombe et al., 2010; Marston, Mendes, et al., 2020).

For the CDC, the effect of no change in purchasing habits is reiterated by a separate statistical analysis of administrative data from the Ceduna CDC trial region. For example, expenditure on food and beverages between January 2015-August 2018 in a town near Ceduna showed there had been an increase in food purchases, but that the proportion of spending on unhealthy or discretionary items had increased by 9.79% (Greenacre et al., 2020, p. 7). The work regarding product-level purchasing habits by Greenacre et al. (2020) is limited to an analysis of one store located outside of the Ceduna township.

Patterns in the research suggest that policy influence on purchase habits have not paired well with policy logic predictions. Evidence shows that when restrictions are placed on set products, this does not automatically translate into people purchasing and consuming 'healthy' products instead. The policy logic of the CDC, as addressed by Mavromaras et al. (2021) and Smith (2017), is described as the CDC restrictions being expected to change expenditure patterns of CDC recipients and therefore promote more desirable behaviours in accordance with policy objectives. Basics card restrictions were predicted to encourage people toward healthy purchases and choices and therefore promote wellbeing for communities and families, including children (Social Policy Research Centre, 2010). However, the related studies suggest otherwise and do little to indicate why there may be no lasting change to purchase behaviours. Such differences between theorised policy logic and actual outcomes

suggest that there needs to be more accurate policy problem representation, measurement, and rectification regarding the income management approach to social policy.

3.3.3.3 Limited Focus on Behavioural Influences of Policy Surveillance

Much of the research addressing policy objectives, such as assessing user purchases, has used information drawn from either existing administrative data or analysis of card-user data. Some researchers have taken issue with basics card and CDC user data analysis, arguing that income management is illustrative of *increasing welfare surveillance* (Bielefeld, 2018a, 2018b; Dalley, 2020; Dee, 2013; Tilley, 2020; Tilley, 2022; Zuboff, 2019). For example, Deloitte Access Economics (2015, p. 45) extend the product-level analysis of the basics card, analysing user data of purchases and spending, where the basics card functionality allows for direct analysis of user purchase habits. First emerging through new paternalism's rationality in 1972 regarding the need to closely supervise the poor in Australia, increased welfare surveillance is argued to align with past and contemporary neoliberal conceptions of self-reliance and mutual obligation, now seen in income management policy (Dee, 2013). Dalley (2020) explains that income management acts as disciplining surveillance, where a combination of usage and monitoring of collected purchase data and discreet awareness of privacy threats are 'weaponised' via a small, grey card (being the CDC).

This concern of privacy via increased surveillance or personal scrutiny is also addressed by Tilley (2020), where the risks related to how data is shared are aligned to the ‘function creep’ of income management products. Tilley (2020) argues that the basics card and CDC functionality pose ethical challenges between private and government actors tasked with collecting and protecting such data. Whilst the issue of welfare surveillance remains somewhat contentious, these anxieties do not include concerns regarding the changing nature of governance and what such possibilities of increased surveillance may mean as a structural influence on behaviours and interactions of policy recipients. Furthermore, regardless of card-user surveillance and related data analysis, research has consistently reported that CDC and basics card recipients find ways of navigating or circumventing policy rules, further discussed in the sections below.

3.3.3.4 No Change to Gambling and Social Complexities Not Captured

The influence of the CDC on gambling behaviours has been shown through research to mostly have minimal or no effect on overall gaming expenditure. For example, Greenacre et

al.'s (2020, p. 6) quantitative analysis of existing administrative user-data of total Ceduna region-specific gaming-machine expenditure between January 2014-December 2016, showed no association of a reduction or increase in gambling expenditure in the Ceduna CDC trial region. This work by Greenacre et al. (2020) contrasts with the CDC evaluation findings by Mavromaras et al. (2021). They claim there to have been 'short-term evidence' from once-off, self-report questionnaires of perceptions of gambling behaviours, equate to an insignificant 3.5% reduction in gambling associated to the CDC's implementation (Mavromaras et al., 2021, p. 78). This reduction was stated as relevant to people who reported to gamble before the CDC, in all sites since CDC implementation, with 44% of the overall sample (n=1963) surveyed self-reporting there was no change (Mavromaras et al., 2021, p. 79).

Issues reportedly remain regarding what has not been adequately captured concerning the influence of welfare quarantining on gambling behaviours. These issues include what cannot be captured using quantitative research approaches. Greenacre et al. (2020), Lamb and Young (2011), and the Social Policy Research Centre (2010) all argue the need for socio-ecological investigations of income management's influence using qualitative research methods. Both Greenacre et al. (2020) regarding the CDC and Lamb and Young (2011) regarding the basics card, describe that investigations seeking to deduce and quantify effect and change do not adequately capture complex factors outside of related predetermined variables of interest. This includes assessing the actual or potential for private (e. g., Online) (Lamb & Young, 2011, p. 135) or illegal gambling (Greenacre et al., 2020), which can relate to facilitating the distribution of scarce cash resources not captured through quantitative analysis alone. They suggest that additional qualitative work be done on ascertaining indirect influences on behaviours.

3.3.3.5 Issues with Perceptions and Incidence of Crime

Much research reflects the relationship between income management and crime as complicated, and that outcomes largely depend on persistent social complexities. With mixed methods research by some (Brodie, 2003; Department of Families Housing Community Services and Indigenous Affairs, 2012; Hunt, 2017; Hunt, 2020b; Katz & Bates, 2014; Marston, Mendes, et al., 2020; ORIMA, 2017; Scott et al., 2018) and further theoretical reviews by others (Staines et al., 2020) claiming that the impact of the CDC and basics card on crime is unclear due to inherent existing social complexities. Although these complexities are not captured in primary research thus far. There is a noticeable difference in how crime is

measured across studies that may provide insight into why various outcomes are seen in related research. Differences in study outcomes are largely seen between *crime-related rates or statistics* relative to *the perception of crime*.

In contrast to what was perceived, quantitative inquiry of administrative crime occurrence data has shown in some cases that there has been no change or an increase in crime rates, pre- and post-CDC or basics card implementation. The research by Greenacre et al. (2020) and further statistical research of administrative data crime rates by others (Bray, 2016; Catholic Social Services Australia, 2017; Department of Families Housing Community Services and Indigenous Affairs, 2012; Mavromaras et al., 2021) suggests there has been no reduction of reported crime occurrences related to implementation of income management. For example, Greenacre et al. (2020) assessed police charges related to breaches to 'socially responsible behaviours', such as acts of criminal trespass and acts of theft. These charges were drawn from South Australian Police (SAPOL) public databases between July 2012-September 2017, showing monthly crime rates did not change relative to pre-post CDC implementation in 2016 in Ceduna. This lack of change suggests that the CDC is not correlated to any change in crime rates related to these charges.

Other evaluations and research have shown that crime incidence rates increased after income management implementation (Bray et al., 2014; Catholic Social Services Australia, 2017; Hunt, 2017). For example, a significant and steady increase was seen in imprisonment rates of Aboriginal Australians between 2002-2012 in the Northern Territory (where Aboriginal Australians made up 90% of basics card recipients at the time of the evaluation) relative to pre and post basics card implementation in 2007 (Bray et al., 2014, p. 233). These imprisonment increases are mirrored by an increase in reported assaults to police in the East Kimberly region where the CDC was implemented in 2016 (Hunt, 2017). Hunt's (2017, p.2) analysis of public assault incidence reporting data made to Western Australia Police between 2010-2017 indicates a sharp increase in assaults reported in the East Kimberly CDC location of Kununurra. Incidence rates increased from an average of approximately 30 assaults per month in mid-2016, increasing to an average of 50 per month one year after CDC implementation, a rate of increase not seen any time in the six years preceding the CDC implementation (Hunt, 2017, p. 2). Thus far, there has been little investigation regarding why such increases in crime may occur, whether in relation to the influence of the CDC or other factors.

Importantly, *perceptions* of crime do not necessarily reflect actual crime occurrence as they may not be based on personal *experiences* of crime, as was the case in some studies. However, these perceptions of crime still do not capture why people do or do not perceive what they do, including why there may have been any decreases or increases in the incidence of crime, such as those increases evidenced above by Bray et al. (2014, p. 233) and Hunt (2017). For example, a decrease in the social perception of crime was argued in some qualitative inquiries (Department of Social Services, 2014) and mixed methods evaluation by ORIMA (2010) across *non-recipient stakeholders* regarding specific child protection basics-card income management policy. However, these findings are contested by Mavromaras et al. (2021) when surveying and interviewing *CDC recipients* about their perceptions of crime in relation to feelings of 'safety' regarding victimisation from crime. Mavromaras et al. (2021) found that most respondents reported not feeling safer since the introduction of the card.

Such research regarding the perceptions of crime has so far neglected how perceptions are socially constructed and reproduced in isolated groups and that perceptions can directly relate to broader problems in a community associated with discrimination, othering, injustice and social cohesion (Beauvais & Jenson, 2002; Burns, Hull, Lefko-Everett, & Njozela, 2018; Delhey et al., 2018; Dinesen, Schaeffer, & Sønderskov, 2020; Hewstone, 2015; Markus & Kirpitchenko, 2007; Reitz & Banerjee, 2007). Where researchers then only engaged a particular group, they may then only capture that group's dominant narratives/perceptions, potentially missing out on complexities and counterclaims from other groups, thus rendering the perception of crime from one group alone as inaccurate. Further research may benefit from expanding the understanding of how perceptions are constructed socially and through engaging and capturing different perceptions and complexity across groups.

3.3.3.6 Alcohol, Drug Use and Crime

The research suggests that there has been no change in alcohol/illicit drug consumption in relation to rates of associated police apprehension charges in one CDC location (Greenacre et al., 2020). Research related to the CDC or basics card influence on alcohol and drug use behaviours has focussed on either assessment of administrative data regarding alcohol or drug consumption, or self-report reflections of perceptions of change in alcohol consumption. No administrative data analysis yet examines changes in charge or conviction rates of drug crime in CDC locations over time. Some research has attempted to assess rates of alcohol and

drug use combined, by way of analysing administrative data publicly available through the South Australian Police (SAPOL). The number of people apprehended under the Public Intoxication Act (intoxicated by alcohol/drug use) and detained but not charged by SAPOL officers between July 2015-March 2018, did not change over this timeframe (Greenacre et al., 2020, p. 6), indicating the CDC did not affect the rate of those apprehensions in Ceduna.

One evaluation has collected baseline data from the year 2018 where analysis of Queensland Police Service administrative data includes incidence of drug offences in the Hinkler (Bundaberg-Hervey Bay) trial region before the CDC was implemented (Mavromaras, 2020, p. 21). However, change in drug charge offences or use overtime have yet to be established, with no other analysis of similar data having been conducted in the years leading up to 2022. Other drug-use data does exist, however, is not directly comparable to the analysis by Mavromaras (2020). For example, further publicly available drug consumption data is limited to population-level national wastewater analysis that does not include all trial sites (Australian Criminal Intelligence Commission, 2022). Other publicly available information is also limited to drug consumption data from urinalysis and subjective questionnaires of police detainees only in Australian capital cities (Voce & Sullivan, 2022). Without comparable follow-up using similar data, little can be ascertained regarding related changes over time in terms of variable correlation. However, such analyses do not tell us much about how or why consumption rates change if they were found to, meaning any changes cannot accurately be attributed to the CDC alone.

In addition to administrative data, other research focuses on self-report perceptions of change in alcohol and drug use with varying findings (Marston, Mendes, et al., 2020; Mavromaras et al., 2019a, 2019b; ORIMA, 2017). Some older qualitative research on the basics card influence challenges Greenacre et al.'s (2020) recent analysis that alcohol and drug use have not changed in relation to CDC welfare payment quarantining. For example, the Department of Social Services (2014) evaluated compulsory child-protection basics card income management in Western Australia by assessing the perception of non-income management recipients. This evaluation identified that overall, the basics card indirectly reduced family violence through a reduction in access to alcohol; and that reduced access to cash was perceived to limit access to illicit drug abuse. However, as addressed in sections above, qualitative interviews, including only staff and non-basics card recipients, limit what can be

learned when people who directly experience the policy themselves as policy recipients are not included in the research (Fontana, 2003, p. 52).

The link between alcohol consumption with welfare quarantining as a tool to prevent crime, has been argued to emerge more from propositions in political discourse than in primary research, as shown in the discourse and narrative review of evidence by Staines et al. (2020). Instead of preventing crime, Staines et al. (2020) argued that welfare quarantining can create crime through the social labelling of deviance through the symbolic value inherent in the social use of these plastic CDC and basics cards. They briefly theorise and provide some helpful theoretical guidance that this labelling changes a person's internalised social identity, pushing people away from protective social networks and toward those that are crime productive. In this idea, social interactions may be relevant regarding the social use of the cards during interactions between people, such as during grocery shopping between clerk, other customers and purchaser of goods. However, Staines et al. (2020) refrain from incorporating into their debates analyses relating to social constructions of deviance emerging from the policy's influence on social interactions and social exchange. Instead, similar to the psychological framing of behaviours mentioned above, they briefly suppose the policy affects internalised feelings of the cardholder, leading them into crime due to changes in their individualised psychology.

3.3.3.7 No Focus on Underlying Reasons for Ongoing Alcohol or Drug Use

The underlying reasons for alcohol and drug abuse are an issue not often addressed in CDC-related primary research, although has been acknowledge as important elsewhere. Regarding the CDC, only Mendes et al., (2021) has begun to unpack this connection in relation to policy circumvention as discussed below. Instead, most related research in this space has sought to address non-recipient perceptions or incidence rates related to use of these substances. With most studies ignoring if or how CDC recipients may explain the issue of alcohol or drug abuse, including reasons for over-consumption where it occurs (Mavromaras Mahuteau, & Wei, 2020; Marston, Mendes et al., 2020; ORIMA; 2017; Smith, 2017).

Using substances like alcohol and drugs has been linked to personal efforts to cope with bad life circumstances in other research (Bountress et al., 2019; Guise, Horyniak, Melo, McNeil, & Werb, 2017; R. Hammersley & Dalgarno, 2013). Excluding the CDC and basics card, evidence shows coping can occur via drug and alcohol use in relation to experiencing trauma

and severe hardship (Golin et al., 2017). Importantly, evidence shows that doing these as coping behaviours also relates to a person having opportunities in which to do so (Guerin, 2016), such as when opportunities are limited in relation to economic barriers, lack of services or stigma-social norms restricting access to counselling services. Here opportunities can become so constrained regarding coping with bad life situations (Guerin, 2020), that substance use may, in reality, provide the only realistic, immediately available relief for some people.

Regardless of the approaches used to ascertain whether CDC recipients do or do not use these substances to excess, there remains a need to assess the reasons people may excessively use drugs and alcohol in the first place. Substance use and abuse need to be better contextualised and rebalanced to account for structural conditions and related individual responsibility for substance use. As opposed to the prominent location of dysfunction being overly individualised, as seen in the CDC and basics card policies detailed in Chapter 2. It is well established that policy is one of many social conditions, which has long been acknowledged to influence opportunities for individual choices, otherwise addressed as agency (Brewer, 2004; Coburn, 2016; Denzin, 1990; Fuller, 2006; Mills, 2000; Scott & Nilsen, 2013). So just like policy can be framed to direct behaviours toward positive outcomes, it then remains logical that policy may have some responsibility in creating conditions that encourage reasons for harmful behaviours. Increased contextualisation of the interplay between social conditions, such as policy and individual actions, may work to address how conditions provide the *need and opportunities* to behave in specific ways without entirely removing individual responsibility for behaviours. There then remains a need to address how the CDC may operate and interrelate with persistent conditions in people's lives, and what this means in terms of the behaviours people may do to continue to seek access to harmful substances.

3.3.4 Problems Measuring Contextual Complexity in Research Looking Beyond Policy Objectives

The following Section now synthesises and addresses the aligning limitations in research raised in the first sections of this chapter that aimed to capture or theorise influence beyond policy objectives. These issues include:

- Circumvention of using the card mostly framed as good neglecting harmful behaviours

- Social harm, and theories related to social control and state legitimacy infrequently addressed
- Social divisions relating to discrimination
- Interactions with other policies not addressed
- No explicit focus on social interactions as structural influence

3.3.4.1 Circumvention Mostly Framed as Good Neglecting Harmful Behaviours

Circumvention behaviours have been commonly addressed across CDC and basics card research to some degree, largely focussing on framing circumvention behaviours as necessary responses to punitive policy practices (Altman, 2016; Bielefeld, 2014b; Dalley, 2020; Mavromaras et al., 2019a, 2021; E. Vincent, 2019). Similarities across these included studies incorporate the direct exchange of resources in general, which can include swapping goods purchased via the CDC for cash, sometimes at a loss, and through sharing of the cards with others. There are some variations in the ways researchers frame such efforts of getting around policy restrictions, for example, where policy is framed as existing via a set of rules to be obeyed or broken in alignment with policy legislation, Mavromaras et al. (2019a, p. 73) discusses this as CDC 'workarounds', Bray et al. (2014, p. 135) as inappropriate use or misuse of the basics card, and K. Stevens (2020, p. 8) as circumvention behaviours relative to those policy rules.

Often these circumvention behaviours have been addressed in relation to maintaining alcohol and drug access. Researchers against the policy approach argue that maintaining access contributes to proving the ineffectiveness of the policy approach in relation to policy objectives of reducing alcohol and drug consumption by policy recipients (Mendes et al., 2021). Although limited in their focus on location-specific nuance and in only having once-off interactions with respondents during interviews only, Mendes et al., (2021, p. 166) argue that their findings suggest that alongside the realities of policy rule circumvention, the reasons for continued consumption relate to "complex underlying social, psychological and medical causes of alcohol and drug abuse such as poverty, a history of childhood trauma, and poor mental health". They argue that the policies do not address these issues at their core, explaining that instead, reasons for circumvention relate to 'need' imposed by personal trauma and structural barriers. They challenge the CDC and basics card policy logic that centralises

choices made as 'irrational' and best treated by “removing access to the means of purchasing addictive substances” through the CDC or basics card (Mendes et al., 2021, p. 166). This challenge is seen in their theorised suggestion that the policies can cause harm, for example, by encouraging theft or prostitution as a means to access cash, which “may ultimately lead those individuals to have contact with the criminal justice system” (Mendes et al., 2021, p. 167). Other research does not work to address such harms as realities of circumvention, instead positioning such circumvention as foundationally good.

In the analyses of other related research regarding the circumvention of policy rules, there remains a politicised framing of income management recipients being 'just' in resisting formal control strategies of paternal structural governance (Altman, 2014, 2016; Bielefeld, 2012, 2018b; Dalley, 2020; Klein, 2016b; E. Vincent, 2019). Efforts here infer individual or group resistance to governance remains a positive endeavour. This framing occurs regardless of the behaviours presented, even where those behaviours may relate to social harms interrelated to problem alcohol or drug consumption and crime. For example, Altman (2016, p. 499) and Bielefeld (2014a) frame circumvention behaviours as positive resistance strategies in the face of paternalistic control. More information regarding the impact of circumvention or resistance behaviours and strategies would be helpful in generating ways to support and/or ameliorate any adverse effects

Without addressing how the CDC may relate to broader social issues potential impacts of the CDC may be missed. Where circumvention is represented as a positive resistance to oppression (Altman, 2016; Bielefeld, (2014a), there is little assessment of what the range of circumvention behaviours and strategies consist of and/or of how for example, retaining access to alcohol and drug use, contribute to related harm with indirect consequences in communities, as theorised by Mendes et al., (2021).

The issues of direct harm (Coomber et al., 2021) and indirect victimisation (Shelley, 2012; Smith & Hickman, 2022) have been well-established as related to the consumption of illicit drugs and the global drug trade. The ability to navigate around CDC rules to access such substances, suggests social issues with alcohol, drug use and crime persists as one of E. Vincent’s (2019, p. 16) themes exhibited. Like Altman and Bielefeld, E. Vincent's (2019) research does not appear to fully consider the subsequent harms that might occur to others in relation to individual responsibility for the problem consumption of alcohol or drugs. Even

where policy circumvention is framed as resistance to oppressive and disempowering paternal governance, the realities of harm that does and can occur in relation to ongoing illicit substance use cannot be ignored.

3.3.4.2 Social Harm, and Theories Related to Social Control and State Legitimacy Infrequently Addressed

Studies investigating the influence of the CDC or basics card to date have not yet included analyses that reflect on the broader, indirect consequences posed by circumvention or resistance behaviours in relation to different forms of social control through policy-related governance strategies (Altman, 2014, 2016; Bielefeld, 2012, 2018b; Bray et al., 2014; Dalley, 2020; Klein, 2016b; Marston, Peterie, Mendes, & Staines, 2020; Mavromaras et al., 2021; E. Vincent, 2019). An exception to this is the work by Dalley (2020, pp. 56-57), who postulates that the CDC is a "site of reinterpretation and rearticulation" through subversive practices framed as the "labour of endurance", necessitated by the policy so to manage its invasiveness and carry on with life. The critical review by Mendes (2017) argues that inadequate government consultations regarding the policy approach have encouraged community resistance through the formation of activist groups coalescing around related perceptions of injustice. Mendes (2017) makes no judgement however on resistance being good or bad nor does he contextualise the many forms of resistance and their potential Trajectories. There appears to be a gap in research related to resistance and, activism and the potential for positive and negative behavioural and/or social outcomes, including considerations of resistance that challenges state legitimacy.

Resistance is further reflected on in the recent qualitative analysis of CDC recipients' experiences by Peterie et al., (2022). Peterie et al. (2022) investigate the complex nuances of resistance that continue, doing so some years after the topic being initially addressed by Mendes (2017). Through once-off interviews, Peterie et al. (2022) draws attention to everyday resistance strategies in showing the CDC as an oppressive policy that relies on social interactions between individuals and groups. For example, through CDC-dedicated online support groups that share information regarding how to get around the card and share actions of "toothless resistance" that include following rules but subverting power through harmless inclusion of angry expressions about the policy on CDC paperwork/forms (Peterie et al., 2022, pp. 160-1).

Recent research by Bielefeld (2021) frames the CDC and basics card as bad policy. This research explicitly focuses on governance and policy issues and how these impact on the behaviour of recipients, be that regarding conforming or resistance to 'bad policy', the state or other people. Although not addressed by Peterie et al. (2022) nor Dalley (2020), these resistance strategies as interactions also reflect mechanisms of challenges to state-supportive informal social control described in Chapter 2. Informal social control relies on social interactions between individuals and groups to construct and reproduce norms in support of the state (Jamrozik, 1976).

Reflections by Peterie et al. (2022) suggest that in the case of those in the Bundaberg-Hervey Bay region, the CDC became a mechanism that inspired online collective interactions that facilitated sharing and support of perceptions of oppression that recipients believed related directly to the policy. However, Peterie et al. (2022) and Dalley's (2020) analyses do not consider the figurative other side of the coin in relation to how policy can inspire subversive resistance, and what this can mean for state legitimacy, and in more extreme cases, crime and victimisation.

As outlined in Section 2.2, government is a social construction tasked with delivering different forms of social control to maintain beneficial social order (Chapter 2; Dean, 2004; Deflem & Wellford, 2018; Foucault, 1991). In their literature review regarding the Australian welfare state and income management overall, Mendes (2020b) defines the welfare state as in practice performing both supportive and oppressive functions. In doing so, social control is defined as specifically oppressive, which has also been addressed by scholars such as Janowitz (1975, 1991) as misleading when considering the original intended meaning of the term. Social control intends to describe social order, organisation and regulation, ie all necessary processes of social governance in modern states (Deflem & Welland, 2018; Innes, 2003). Social control can be positioned as an umbrella term intended to incorporate all efforts of governance to influence citizenry in accordance with preferred norms and ideologies.

State legitimacy is constructed through governance practices, and without a social conception of state legitimacy, these practices may lessen in the effect of regulating the citizenry (Button, 2020). As addressed in Section 2.2, how citizens conceive the state, influences how groups and individuals will act on behalf of the state and either conform to laws and policy (Foucault, 1979; Weber, 1968) or resist themwhich may ultimately have ramifications for

damaging actions against people or property. Subsequently, the actions of the state may create further 'deviance' if the state is perceived to act without legitimacy (Alda, Bennett, Marion, Morabito, & Baxter, 2020; Jackson & Gau, 2016; Tyler & Jackson, 2014).

Where social policy negatively influences perceptions of state legitimacy, as is suggested in this research review is the case for the CDC, there may be ramifications through the construction of harmful forms of social deviance. Such perceptions have been shown in more general research to increase the likelihood of crime behaviours in some groups who perceive state actions as unjust (McLean & Wolfe, 2016; Tyler & Jackson, 2014), or otherwise as necessary to continue to 'get by' as briefly suggested as a possible outcome of welfare quarantining by Mendes et al. (2021, p. 167). Whether these circumvention behaviours relate to harm, distrust and perceptions of injustice or a delegitimised state, these matters have not yet been adequately accounted for in research regarding the influences of the CDC or basics card.

3.3.4.3 Social Divisions Relating to Discrimination

Racism has been well established as reducing overall social cohesion and contributing to poor mental health and wellbeing (Bodkin-Andrews & Carlson, 2016; J. Forrest & Dunn, 2013; Larson, Gillies, Howard, & Coffin, 2007; Macedo, Smithers, Roberts, Paradies, & Jamieson, 2019). Income management has been framed as a racist policy by many as it is argued to repeat and reinforce past and current colonial oppression of Australian Aboriginal peoples, through ignoring the pervasiveness of ongoing racism in Australian society (Bielefeld, 2012, 2014a, 2014b, 2016a, 2018a, 2018b; Bielefeld & Beaupert, 2019; Doel-Mackaway, 2017; Hunt, 2017; J Hunt, 2020b; Klein, 2016b, 2020; Klein & Razi, 2017; Watt, 2020). Expression of this discrimination includes discussions regarding oppression through ineffective and tokenistic community consultation (e. g., Mendes, 2017); studies focussing on ongoing colonial oppression (e.g., Bielefeld, 2016; Klein, 2020); and ideas of oppressive, paternal social governance and control of 'undeserving' citizens reflected in relevant discourse analyses (e. g., Lovell, 2016; O'Keeffe & Papadopoulos, 2022).

Further specific examples of the basics card and the CDC as discriminatory can be seen in the analyses provided by Altman (2016) and Bielefeld (2018c). Both Altman and Bielefeld argue that income management policies, particularly those targeted at Indigenous communities in Australia, can be understood as a form of systemic racism. Altman argues that income

management policies reinforce negative stereotypes of Indigenous people as unable to manage their finances and reinforce colonial power structures that deny Indigenous communities' autonomy and self-determination. He also suggests that these policies are often implemented without proper consultation with affected communities, further marginalizing Indigenous voices (Altman, 2016). Similarly, Bielefeld (2018c) contends that the government's income management policy is based on a "mythology" that portrays Indigenous people as inherently prone to addiction and lacking in the ability to manage their finances. She argues that this view is based on stereotypes and ignores the systemic factors that contribute to poverty and disadvantage in Indigenous communities (Bielefeld, 2018c). Both authors also challenge the government's claim that income management policies are effective in reducing alcohol consumption and addiction in Indigenous communities, arguing that the evidence supporting these claims is weak and that the policies may even exacerbate social problems by stigmatizing and marginalizing welfare recipients. Overall, both Altman and Bielefeld suggest that income management policies can be seen as a form of systemic racism that reinforces negative stereotypes of Indigenous people and denies communities autonomy and self-determination. They argue for alternative policies that address the root causes of social problems and are developed in partnership with affected communities, rather than being imposed from above.

Ongoing, embedded institutionalised racism has been suggested in the research as involving the framing of persons in need of income support as the undeserving poor or the 'never deserving citizen' often combined with racialized discourse (Bielefeld, 2021; Lovell, 2016; Marston & McDonald, 2007; O'Keeffe & Papadopoulos, 2022). For example, O'Keeffe and Papadopoulos (2022) outline in their discourse analysis of Australian policy documents and speeches that the CDC represents changes to imagined Australian social identity, where to claim welfare is framed in political discourse through discursive legitimation as un-Australian, as the welfare consumer is positioned as a flawed consumer in relation to market liberalism. Further, in the critical discourse analysis of various data focussing on the East Kimberly region by Klein (2020), they explain how the CDC trial in the East Kimberley region reflects contemporary assimilation of First Nations Peoples through reproducing discourses of dysfunction and dependency in Australian welfare policy.

Further, research by Klein (2020) argues that compulsory income management entrenches racism and poverty through individualisation of social responsibility, lack of targeting of

social problems and presumptions of the (in)capability of predominantly Australia's First Nations people. The analyses by Bielefeld (2014a) and Tilley (2018) extend this argument, as each display through critical discourse analysis and using postcolonial theory that income management is representative of a broader colonial project that disregards and negatively impacts already bad structural conditions. These academics have included in their arguments that structural racism can often lead to poverty, with racism an ongoing legacy of colonialism creating conditions of vulnerability in the first place (Bielefeld, 2014a; Tilley, 2018). This vulnerability is argued to include the effects of racism on not gaining employment, with some researchers arguing that income management does little to overcome barriers to employment (Hunt, 2020a; Marston, 2013; Peterie, Ramia, Marston, & Patulny, 2019). While insightful and beneficial in highlighting contextual complexity through theoretical analyses, this important research may have furthered its aims by including CDC recipients voices to portray how policy may work or not as predicted in recipients' lives. These authors however, do provide some key exploration of the views of CDC recipients and the influences of the CDC in their lives.

Some researchers have addressed the role of income management in creating experiences of stigma and shame in already disadvantaged groups as political and complex. For example, Mendes (2020a, p. 51) outlines that recent political rejection of "approaches that stigmatised disadvantaged groups" contributed to a political shift away from the approach by the Australian Labor Party, who had originally supported the idea. In relation to the influence of the CDC resulting in a form of othering through discrimination, the qualitative anthropological works by E. Mitchell and E. Vincent (2021) discuss the complexities related to experiences of shame. E. Mitchell and E. Vincent (2021) suggest that caution must be taken regarding simplifying and rationalising experiences such as stigma and shame, as a singular construction having simple meaning across cultures. Whilst useful in addressing and indicating the prevalence of social complexity and complex processes of discrimination, this research by E. Mitchell and E. Vincent (2021) remains limited in its reach regarding the influence of the CDC. The work focuses only on one form of cultural conception of shame. It does not go far to incorporate further contextual complexities that may confound perceptions of discrimination, division, or injustice. Further research may benefit from extending the range of factors that contribute to and shape policy experiences of social division across cultures, communities and interactions.

The effects of ongoing discrimination and social divisions in society, more broadly, still need to be addressed in relation to the influences of the CDC. Overall, no related research regarding the CDC approach to policy has addressed the evidenced relationship between discrimination and oppression, the creation of social divisions and perceptions of injustice, which may have ramifications for social cohesion and governance (Delhey et al., 2018; Dinesen et al., 2020; Offer, 2012; Reitz & Banerjee, 2007). A study by Cox (2020) mentions that the CDC may have ramifications for social cohesion which suggests that more research needs to address the impact of the CDC on social cohesion regarding how the card influences interactions between individuals and groups. Addressing the relationship between CDC policy and the processes of if and how discrimination occurs, as expressed by those who experience it, may help unpack how the CDC may influence such experiences and what this may mean for social cohesion.

3.3.4.4 Interactions with Other Policies Infrequently Addressed

The existence of other welfare-related policies that parallel and work alongside the CDC or basics card, has also been addressed by others (Altman, 2016; Cape York Welfare Reform, 2012, p. 98; Marston, Cowling, & Bielefeld, 2016b; E. Mitchell & E. Vincent, 2021; E. Vincent, 2019). These discussions have mostly either stated that policy interactions occur and that those interactions cannot be adequately addressed empirically in those studies (Altman, 2016; Cape York Welfare Reform, 2012, p. 98; Marston, Cowling, & Bielefeld, 2016b; E. Mitchell & E. Vincent, 2021; E. Vincent, 2019); or that these interactions have been analysed theoretically, providing a beneficial overview of how contemporary policy is linked with historical contextual influences that have ongoing ramifications in contemporary times (Bielefeld, 2018; 2021; Klein, 2020). Theoretical analyses include the work by Klein (2020) and Bielefeld (2018) which have paired the analyses of income management approaches to social welfare by aligning the basics card or CDC with settler colonial policies. They argue that settler colonial policies are ongoing in contemporary times and point to income management as a part of colonisation's continuum.

Both Klein (2020) and Bielefeld (2018) argue that contemporary social policies, specifically the CDC policy in Australia, are part of a continuum that reflects and reinforces colonialism, racism, and neoliberalism. They suggest that the CDC policy should be understood within the broader context of settler colonial policy and neoliberalism, which have sought to control and manage Indigenous populations and reduce the role of the state in social provision. Klein

(2020) highlights that the CDC policy is part of a broader system of settler colonialism that seeks to deny Indigenous people's autonomy and self-determination. She argues that the policy is rooted in historical policies that aimed to assimilate Indigenous peoples into mainstream society and control their behaviours, citing historical policies that rationed and limited payment of earned income to Indigenous workers (Klein, 2020). Klein draws on the work of Indigenous scholars and activists who have argued that settler colonialism is not a thing of the past but rather an ongoing process that continues to shape social and political structures in Australia. She suggests that the CDC policy is a manifestation of this ongoing colonialism, which seeks to deny Indigenous people's autonomy and self-determination. Klein's study highlights the connections between contemporary social policy and historical settler colonialism in Australia, arguing that policies such as the CDC are best understood in the context of ongoing colonisation.

Bielefeld (2018) similarly to Klein (2020) examines how neoliberal policies in Australia have had a disproportionate impact on Indigenous peoples. Research by Bielefeld (2018; 2021) suggests that the cashless welfare card policy is part of a broader shift towards "responsibilisation" in social policy, which has been linked to the neoliberal economic policies of the 1980s and 1990s. Bielefeld's (2018) study highlights the connections between contemporary social policy, historical colonialism, and neoliberalism in Australia. Further research by Bielefeld (2021) and like Klein (2020), argues that the CDC policy has similar effects to paternal policy reflective of Australia's colonial ration days, which was used in the past to control the lives of Indigenous peoples through providing rations for labour as opposed to financial payment. In comparing the CDC and the basics card approaches to welfare policy with historical policy approaches, Bielefeld (2021) specifically addresses how such paternal approaches have often framed such oppressive governance actions through a lens of 'care'. Where "colonial care dictates that Indigenous peoples be constructed as inferiorised-subjects for the benefit of non-Indigenous interests, which then serves as the rationale for an endless cycle of interventions" that are argued as subversively framed as an illusion of missionary goodwill (Bielefeld, 2021, p. 14). Both the contemporary CDC and historical rations approaches to policy involve restricting access to money, goods, and services, and both are justified on the basis of concerns about the behaviour of Indigenous peoples. Bielefeld (2018c; 2021) argues that policies such as the CDC should be understood in this paternal, historical context and that alternative strengths-based policies that respect the autonomy and self-determination of Indigenous peoples are needed to address social

problems and empower Indigenous aspirations. These powerful analyses describe how the income management approach is reflective of historical policy influences which helps contemporary researchers to contextualise the emergence of the CDC and interpret how the CDC will likely be received on the ground.

There is limited research on the extent to which the existing policy context in target locations beyond the CDC or basics card, has been studied in terms of describing how the CDC is experienced and described by policy recipients, while prioritizing the significance of their lived expertise. Potential reasoning regarding why policy-interaction acknowledgement has occurred in studies that have sought to capture subjective experiences of the basics card or CDC, yet there has been little incorporation of the CDC or basics card lived experiences alongside other policies in contemporary settings. This is suggested by relevant researchers to be outside the scope of their study's predetermined variables, combined with policy research and evaluation resource restrictions (Altman, 2016; Cape York Welfare Reform, 2012, p. 98; Marston et al., 2016b).

As discussed in this review, much analysis of the CDC that attempts to capture CDC recipient experiences, has been done by establishing and measuring predetermined variables aligning with policy objectives. Doing so relates to policy practices primarily emerging from a rationalist choice framework that limits the assessment of policy influences to focus on those in accordance with policy objectives (Althaus et al., 2007; Jann & Wegrich, 2017). The CDC does not include in its objectives any mention of how the policy may interact with other existing policies in target locations, hence no such inclusion of influence is incorporated into policy evaluations. Only capturing information related to policy influence from limited, predetermined variables is argued as limiting the scope of an accurate analysis of policy influence (Peters, 2005). Quantitative field-based survey research does not allow an investigation to capture what may occur outside of any defined parameters (Queirós, Faria, & Almeida, 2017, pp. 381-383).

Where the influence of other policy interventions or programs may interact with how the CDC works and influences human behaviours and social relationships, such interaction becomes an integral part of the contextual, localised conditions within which people live. The effort made to capture these complex interactions can be time-consuming and hence outside of typical resources afforded to most policy evaluations (Clemens & Tierney, 2020, p. 396).

Nonetheless, when seeking accuracy in policy influence, policy development and evaluation improvement remain prominent in cost-effectiveness long-term and in reducing unintended harms from poor planning (Althaus et al., 2007). In relation to the accuracy of influence, capturing the subjective, lived experiences of policy recipients has been argued as paramount in more accurately grasping the broad influences of policy in communities (McIntosh & Wright, 2019).

3.3.4.5 No Explicit Focus on Social Interactions as Structural Influence

As similarly described in Section 2.2 as important, and outlined in Section 3.2, a missed consideration of much income management research thus far, is the explicit influence of the CDC on *relational social interactions*. Little research has worked to directly include if or how social interactions or relationships may come into play with policy influence. For example, in the evaluations by Bray et al. (2014) and studies elsewhere (Cape York Welfare Reform, 2012; Department of Social Services, 2014; Katz & Bates, 2014; Marston, Mendes, et al., 2020; Mavromaras et al., 2021; Parkinson, 2015; Scott et al., 2018), they include examples of social interactions as facilitating or being influenced by an income management policy approach in some way. For example, it remains clear that social interactions were involved in what led to experiences of events such as humbugging in work by Bray et al. (2014), or the perceptions of crime and safety by non-card holders found by Mavromaras et al. (2021). In addition, he social interactions when using the card itself to purchase things were impacted by the CDC, creating perceptions and discourses of shame as E. Vincent (2019) described, or general stigma found by Marston, Peterie, Mendes, & Staines (2020).

Some work has indicated that the CDC may impact on family relationships. Roche et al. (2021a) conducted one-off semi-structured interviews in Ceduna. They argued that the CDC did not meet policy objectives and may create more harm than good. These harms include unintentional outcomes that detract from child wellbeing, divide the community, and create exclusion. In arguing that the findings reflect exclusion and community division, the authors briefly mention the related negative influence of the CDC on family relationships (Roche et al., 2021a). However, the work does not address these policy influences on social interactions in detail beyond limited attribution of association between the policy and related outcomes. Limited attention is given to the processes regarding how these outcomes happen in process.

An additional study by Peterie et al. (2019) began to theorise the influence of compulsory income management on social relationships in relation to domestic violence and homelessness, however, primary research has yet to be undertaken. Although positive in addressing an array of interrelated structural conditions related to homelessness and becoming homeless, Peterie et al. (2019) does not address how the policies work to influence the behaviours of recipients in relation to social relationships. The research addresses the influence of the policies on social relationships through aligning the categorisation of the card causing stigma, with creating complications for escaping domestic violence. In doing so, the focus remains on correlation, as opposed to the processes regarding how the policies influence what behaviours and how those behaviours then relate to response pathways and why. Making these behavioural pathways clear may further add to their argument that structural conditions influence behaviours and explain how that occurs more clearly.

Broader research has discussed, albeit in different ways, the reliance on interactions and exchanges with other people to access life resources, making our relationships and interactions pivotal for survival in modern life (Goffman, 1959; Guerin, 2016). These relationships or interactions thus become localised *structural conditions of influence* alongside others. Further analyses, excluding the basics card or CDC, suggest influences informing interactions and perceptions are socially constructed through socio-political norms and cultures, reproduced during interactions between people and groups (Beauvais & Jenson, 2002; Burns et al., 2018; Delhey et al., 2018; Dinesen et al., 2020; Hewstone, 2015; Markus & Kirpitchenko, 2007; Reitz & Banerjee, 2007).

As addressed in Chapter 2, the CDC becomes one operationalisation of ideas of governance that works to reinforce conceptions of deviance in society. Where the CDC then relates to influencing social interactions both locally and through interactional reproduction of norms, this needs to be addressed to better unpack the regulative impacts on these social interactions. As yet, little research has directly considered the relevance of these social interactions as themselves being impacted by the policy, nor the relevance of these interactions in shaping behaviours which may or may not conform with those intended by the CDC policies.

3.4 Summary

The Findings of Complex Measurements and the Problems Discovered

This review of research regarding what we know about the CDC shows that assessing policy influence has been directed toward particular questions and methodologies. These ways of assessing policy influences largely focus on measuring against predetermined variables that align with legislated policy objectives and often exclude capturing subjective experiences of the CDC from policy recipients' overtime in all but a few cases. Much research has then focused on what the CDC means in relation to conceptions of policy as surveillance, policy circumvention and resistance, and policy as a discriminatory practice.

In contrast, there is a gap in research about the role of the CDC in people's lives through primary research efforts that attempt to capture the lived complexities that the CDC was inserted into, and to do so without predetermining what variables to address. Research has often not measured a broad range of contextual conditions outside of direct CDC influence, inclusive of mental health impacts or interactions with other policy, that may interrelate to influence the opportunities recipients may have to navigate their social worlds and interactions with one another.

Current research has also yet to address what the CDC as a punitive policy and strategy of governance may mean for social order and state legitimacy. Research efforts that address the broader, complex conditions and multiple subjective realities of lived experiences in relation to the CDC or basics card are, few in number, were conducted close to the time of CDC roll out, and are dispersed across trial locations. Such research efforts have begun to challenge linear ways of conceiving the CDC policy's influence in people's lives. However future efforts that position the CDC within the broader lived-contexts that recipients experience outside of the policy's influence, may enhance understandings of CDC policy influence in the context of the persistent conditions within which recipients live. The gaps in knowledge outlined through the review of related research above and their relative significance are also summarised in Table 5 in the following Chapter 4.

4 What Can Be Learned from Policy, Ideology and Previous Research on the Cashless Debit Card and What Do We Still Need to Know?

4.1 What We Do Know

Chapter 2 provides a brief trajectory of Australian social policy, and that the CDC emerged from particular ideologies that led to policy decisions. These policy decisions have mainly been created through a succession of conservative neoliberal ideologies, rather than through social theory or a review of targeted primary research. We have learned that evaluations and research accurately assessing the impact of the CDC are limited by methodological problems that cannot adequately capture the influence of the CDC in its broader social contexts. We know that researchers have theorised that the CDC will be bad for communities, and some primary research has begun to address these issues related to policy circumvention, ongoing social harm and discrimination. However, the review of related research in Chapter 3 found that there remain important gaps in what we know.

Chapter 3 has shown that issues in research methodology and methods used have meant that what has been learned about the CDC policy could be improved to better capture the influence of the policy in context. This means that there needs to be a focus on *capturing information about people's lives beyond just the CDC policy and its predicted outcomes*, so we can better situate how the policy intervention operates within those persistent contexts. This has been shown as best done through methods that employ an open-ended, exploratory interaction approach, with the researcher closely engaging with policy recipients over time in various ways to learn about the policy and social contexts people are dealing with. This then needs to be combined with a critical analysis of corresponding theory that can help situate these experiences within the broader socio-political context that the policy itself comes from. Overall, this means that we need to document experiences other than those that align to just named social policy objectives, and that these need to be defined and described by those closest to the CDC – the recipients.

4.2 What We Do Not Know

As outlined in Table 5 below, Chapter 3 summarized many methodological strengths and limitations of previous research and evaluations. As addressed in the introduction and discussed as needed in Chapter 3, understanding policy influences includes needing to capture how recipients and their communities experience the complex interrelated lived contexts they navigate during their lives. Guerin (2016) argues that the variety of social contexts we navigate ultimately liberates or constrains our opportunities to behave in certain ways. When referring to contexts, these include although are not limited to, social policies, social relationship interactions, politics, cultures, economies, histories, discrimination, education, and how these all interrelate to shape opportunity contexts for agency (Giddens, 1984; Guerin, 2016; Marmot & Allen, 2014; Wilkinson & Marmot, 2003).

Research highlighted in Chapter 3 has worked to address some of these contexts in useful ways that help us to grasp how policy and the CDC specifically, may operate in society and why. Less research has worked to capture the influence of the CDC from the lived experience of recipients and the communities that directly experience its implementation. This generates a need to:

- Find out what the relevant issues/contexts actually are regardless of the CDC implementation, and how these identified issues/contexts interrelate and are experienced *as described by the CDC recipients and their communities*.
- We do not know much about *how the card works in the complex, on-going contexts* that card recipients define as important, *as experienced and described by card recipients and their community*.
- There is also little research on how the issues people may experience are *described or problematised by CDC recipients and their community.*
- We do not know much about what card recipients and their communities say has changed in their lives for better or for worse, whether in relation to the card or not.

As part of these social contexts yet unexplored, there are additional considerations that may be learned through studying what we do not know as defined above.

- We know little about *how changes happen* if they do for CDC recipients, especially in relation to the CDC influencing recipients' social relationship interaction contexts with other people in their lives.

- Additionally, we do not know much about how what we can learn through new methodologies contextualising CDC intervention influences, can help us to understand policy in relation to particular socio-political contexts currently left unexplored in relation to the CDC.

These socio-political contexts include how the CDC social policy intervention relates to strategies of state control, regulation and legitimacy. Improved learning may help improve future policymaking and avoid unintentional, negative consequences for future recipients and their communities.

Table 5: Gaps in research and knowledge and relative significance which guided the current research.

Knowledge Gap	**Why This is Important**
A lack of primary research exists addressing broader complexities outside of variables related to policy objectives as defined by CDC recipients, which when combined may misrepresent policy influence and miss impactful policy consequences	
CDC recipients do not get to define what issues are important or why	There may be other issues and why they occur that have gone unnoticed that can only be addressed through open-ended engagement with policy recipients
How CDC recipients explain subjective experiences of discrimination infrequently explored	There may be other issues and why they occur that have gone unnoticed that can only be addressed through open-ended engagement with policy recipients
Exclusion of data in evaluations	Misrepresents level and type of policy impact
Little is known about the broader lives of CDC recipients beyond the direct scope of inquiry assessing the influence of CDC policy in any CDC location. Without knowing more about people's lives outside of direct policy inquiry, establishing policy influence thus remains limited	
Issues with establishing baseline to argue policy influence	Cannot accurately quantify policy influence, other measures are thus needed to understand change
Little is known about life prior to CDC implementation or outside of policy influence and life more recently, determined by CDC recipients	Without knowing more about people's lives outside of direct policy inquiry, establishing policy influence thus remains limited
Time spent is limited and observations not often conducted	Complex issues may be missed in the absence of repeat interactions that include a variety of methods
Health and wellbeing exclude mental health impact	
No change to gambling and social complexities not captured	
Issues with perceptions and incidence of crime	
No focus on underlying reasons for ongoing alcohol or drug use	

Other policy interactions infrequently addressed	
Circumvention/resistance mostly framed as good, neglecting related harmful behaviours	
There is little effort to align policy influence with broader theories related to social governance strategies of control and relevant known potential social impacts. Without doing so, we may miss potential impacts of the CDC beyond the intentional scope of policy influence	
Social harm, and theories related to social control and state legitimacy infrequently addressed	Without addressing how the CDC may relate to broader social theories that correspond to social governance, we may miss potential impacts of the CDC beyond the intentional scope of policy influence. These social theories form part of those contextual, persistent conditions within which people live and policy emerges from.
Limited understanding of the relevance of social interactions and how these interactions relate to change that may occur or not for people in the broader contexts of their lives. Where we are able to identify how the CDC policy may interact with and shape social interactions/relationships, we may better address complexity and map how change occurs (or not) through mechanisms that influence related human behaviours in their interrelated contexts	
No explicit focus on social interactions as structural/contextual influence	Where we are able to identify how the CDC policy may interact with and shape social interactions/relationships, we may better address complexity and map how change occurs (or not) through *mechanisms* that influence related human behaviours in their interrelated contexts
Recent exploratory, inductive research in the Ceduna region has not been conducted which limits the understanding of how policy has been received overtime	
Little recent longitudinal, exploratory evidence from Ceduna	Older research may not reflect if or how the CDC policy has settled into the lives of policy recipients

4.3 What Do We Need to Do Now?

The present research sought to address the problems outlined in Table 5 above, stemming from the review in Chapter 3. Clearly, new methodology was required as this was the source of most shortcomings in the previous research, and this is addressed in Chapter 5. This led to the specific Questions addressed in the current research project.

4.4 Research Questions

The two primary research questions are stated below. These primary questions are complemented by one sub-question that aimed to help explore the findings in relation to the primary Research Questions. The sub-question is reflective of what researchers such as Agee (2009) and Mirhosseini (2020) describe as common and encouraged in reflexive qualitative research, such as research guided by ethnographic methodology. Agee (2009) argues that sub-questions become necessary during such approaches to research, where the researcher learns through the process of data collection and analysis guided by the primary research questions. Through this learning, the researcher is better able to then develop the inquiry, developing additional questions reflexively that emerge from this process of learning (Mirhosseini, 2020).

The primary Research Questions in this study guided the process and focussed the research. The sub-question helped to frame the critical analysis of this learning through the process of discovery. The sub-question was not posed as a primary question at the outset. This is because, as discussed in Chapter 3 regarding exploring what we do not know, I did not seek to presume to know what contexts and issues *respondents* may experience and describe as relevant in their lives. The sub-question was developed through learning about CDC recipients' experiences, where this sub-question aimed to explore the findings and reposition what was learned within a broader socio-political context. The methodology and reflexivity are discussed further in Chapter 5, which outlines the aligning worldview and critical ethnographic approach applied in this research.

Primary Questions – Addressed in the research reported in Chapter 6 and 7:

1. What are the contexts into which the CDC was imposed for CDC recipients and their community in Ceduna, and how are those contexts experienced?

2. How does the CDC influence those contexts and behaviours of CDC recipients and their community in Ceduna?

Sub-Question – Addressed in Chapter 7:

3. What can we learn about the importance of establishing the influences of continuing life contexts on behaviours of CDC recipients in Ceduna, regarding improving policy making and research for effective social policy and control?

5 Research Design and Methods

5.1 Introduction

This chapter outlines how I approached the research task based on the summary gaps in Chapter 4. I start with a brief discussion acknowledging the underlying critical constructivist philosophical worldview reflected in this work, alongside an explanation and application of the guiding critical ethnographic and related methods. The procedures used are then described, and these include: the entry to and time spent in Ceduna with CDC Recipients and the broader community; my positionality in relation to the project; ethical considerations; and an overview of the respondents who chose to participate in this study. I then outline the qualitative data collection strategies of informal interactions comprising active participant observations paired with both informal conversations and formal interviews, finishing with a description of reflexive thematic analysis of data collected across the year spent with CDC recipients and the broader community on location in Ceduna, South Australia.

As explained in detail in the following sections, to respond to the research questions, my research employed sociological methods guided by critical ethnography and informed by critical constructivism to learn about the influences of the CDC in the context of peoples' lives. This research was conducted in Ceduna, South Australia, with the reason for choosing this location related to relevant gaps in research. As discussed in Chapter 3, there is little research thus far that qualitatively and longitudinally assesses the complex influences of the CDC in recipients' lives. In Ceduna, the only other similar study that was conducted was quite close to the CDC rollout, whereas I sought to collect data some three to four years after the intervention. Ceduna was the closest CDC trial region to me, but it was also of interest because this was the first region to receive the CDC. I was welcomed into the community to hear related experiences to inform this study.

5.1.1 Ceduna, South Australia

The remote town of Ceduna is located on South Australia's Far West Coast. Ceduna is 775.6 kilometres from Adelaide, the state capital city of South Australia, as shown in Figure 2 below. The CDC policy began operating in the Ceduna region in 2019 and the surrounding areas included the communities of Koonibba, Scotdesco, Yalata and Oak Valley (Australian Government, 2020a) indicated on Figures 2, 3 and 4. According to the Australian Bureau of

Statistics (2021), the town of Ceduna and broader region affected by the CDC, shown in Figure 2 below, has a population of approximately 3,505; a median age of 40 years; with approximately 24% (n=870) of the total population identifying as Aboriginal or Torres Strait Islander (ATSI) First Nations Australians. As shown in Table 2 in Chapter 2.4, as of June 2022, there were 1,035 CDC recipients in this region, equating to approximately one-third of this population receiving the CDC. This current number of CDC recipients reflects a 32.2% increase from when the CDC was first implemented in 2016 (as addressed in Table 2 Chapter 2.4), with 74% of persons in this region affected by the CDC identifying as Aboriginal/Torres Strait Islander First Nations Australians.

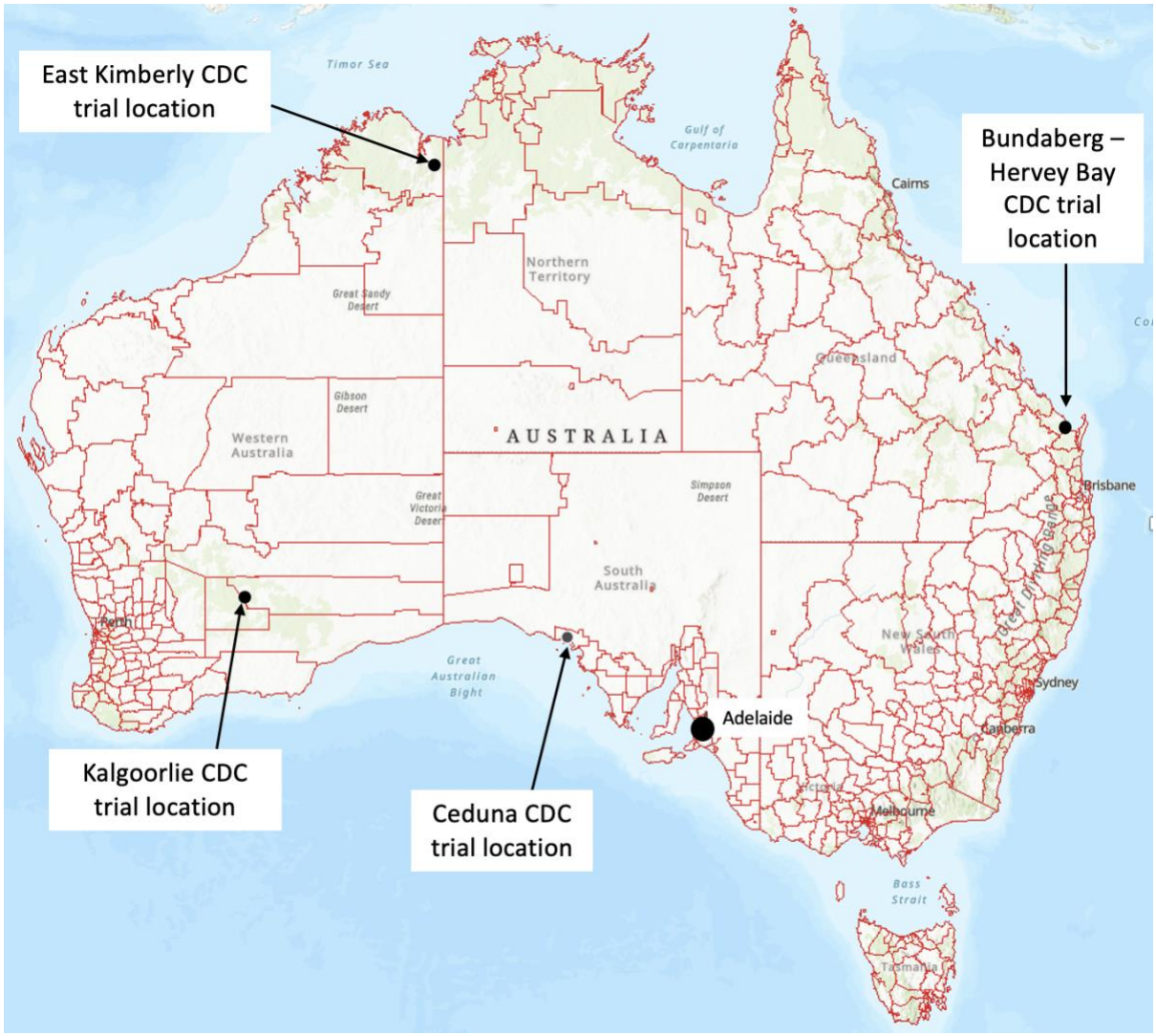

Figure 2: Local Government Area of CDC implementation, Location of all CDC trial Locations including Ceduna, South Australia.

(Australian Bureau of Statistics, 2021).

(Australian Bureau of Statistics, 2021).

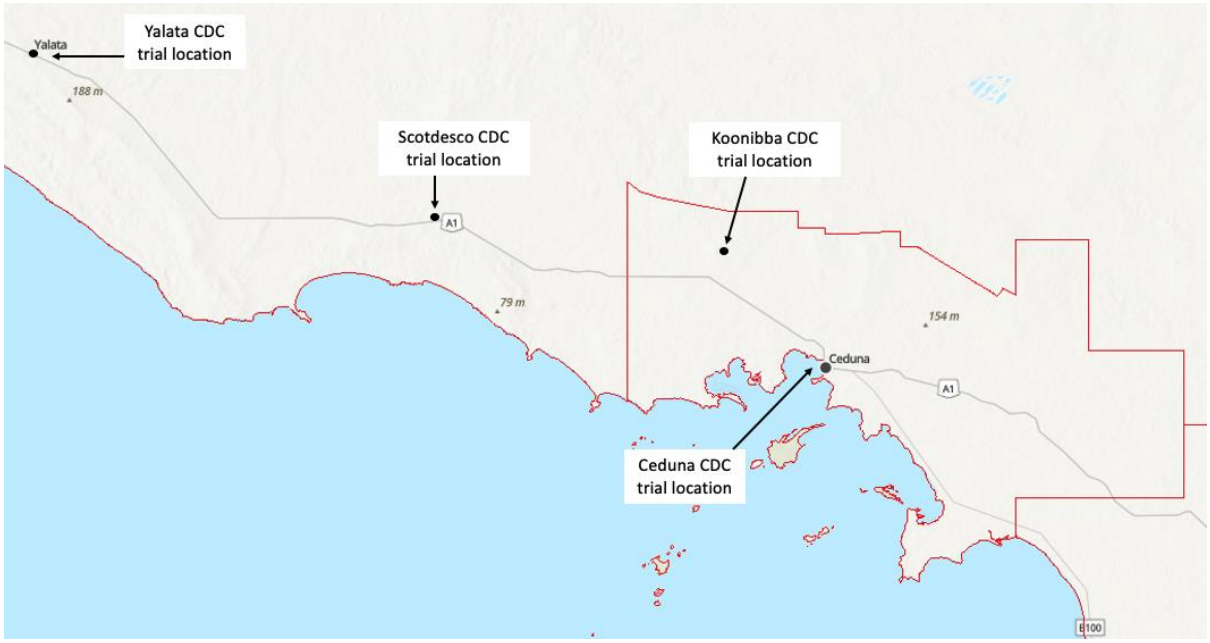

Figure 3: Local Government Area of CDC implementation, Location of Ceduna, South Australia with overlay of CDC trial locations of Yalata, Scotdesco, Koonibba and Ceduna in South Australia.

(Australian Bureau of Statistics, 2021).

5.2 Critical Constructivism

This research reflects a critical constructivist worldview. Here I describe core elements of critical constructivist epistemology and how it aligns to this research approach. I acknowledge the philosophical worldview that is reflected in this research as doing so is important in terms of having a broader awareness of research direction and what the research can and cannot do (Sefotho, 2015). However, it must be noted that this acknowledgement does not mean to provide a lengthy analysis of critical constructivism itself, as I argue that such a discussion is not required as this is not a thesis about philosophy in the traditional sense. Instead, I focus on how this worldview relates to setting up the research process specifically and with brevity.

Critical constructivism takes root and extends on constructivism, where constructivism asserts that the world and what we know, is a human, social construction where meaning making is subjective as each person experiences their world differently than another

(Kincheloe, 2005; C. Lee, 2012). Lincoln and Guba (2013), Crotty (1998) and Le Blanc (2016) similarly explain constructivism, adding that meaning and experiences are inherently and continually socially created, transmitted and intersubjectively shared. Constructivism on its own has been critiqued as restraining subjective realities to only what a person directly experiences, thus limiting research to not consider the influences of broader structural socio-political or hegemonic forces that also influences how people experience their worlds (Caton, 2013, p. 131). Crotty (1998, p. 59) argues that to overcome the traps of constructivism, we need to take a critical approach when apply it. In developing what Crotty calls a 'critical spirit' we may avoid the pitfalls of abstraction, where interpretation of personalised meaning can remove us from the shared, tangible world (Crotty, 1998, p. 59).

Critical constructivism embraces the notion that nothing exists in neutrality and that we all come to see and make sense of our worlds from within our own position in that world (Coghlan & Brydon-Miller, 2014). In extending the constructivist worldview, critical constructivism applies critique to the broader social structures that come to shape how the social world is viewed and created, such as social ideologies, cultures, economies, histories and gender norms to name a few (Coghlan & Brydon-Miller, 2014; Kincheloe, 2005; Kincheloe & McLaren, 2011). My research study engages with the critical constructivist worldview that social conditions and individual experiences are iteratively created thus inextricably linked (Coghlan & Brydon-Miller, 2014; Kincheloe, 2005; Kincheloe & McLaren, 2011).

Critical constructionism is argued to require the application of critical theory when interpreting what is learned from research reflecting this worldview (Kincheloe, 2005; Kincheloe & McLaren, 2011). Contemporary critical theory encourages us to question the status quo and critique the naturalisation and acculturation of structures reinforcing dominance and subordination (Kincheloe & McLaren, 2011; Steinberg & Kincheloe, 2010). Attention is given to who gains and loses, where those in power often have the incentive to maintain structures that reinforce their own authority or dominance (Crotty, 1998; Kincheloe & McLaren, 2011; Steinberg & Kincheloe, 2010). Critical theory aims to confront ideology by encouraging the researcher to assess how subjective meaning and experience of phenomena may reflect dominant power structures. The application of critique involves the use of 'dialectic, reason and ethics' concerning studying the conditions within which people live, focusing on what occurs and why for individuals relative to broader structural conditions

(Budd, 2012, p. 175). The application of any one version of critical theory in this research project was not determined at the outset. Instead, critical theory is applied throughout the entire research process as a broad foundational perspective.

The CDC policy itself is outlined in Chapter 2 and argued by researchers such as Klein (2016b) as created and shaped by ideas of social governance, otherwise termed ideologies and social norms. The CDC and its influence on people's lives emerge from a broader dominant structural condition of ideology embedded within social governance in Australia. As outlined in Chapter 2, ideology reflects socially composed ideas regarding what is determined as right and wrong, where these values are primarily reflective of a society's powerful, whose dominant views serve to naturalise or maintain the status quo (Holmes, Huges, & Julian, 2012). Power has been argued as maintained through ideological social actions, such as media representations or policy processes (Holmes et al., 2012). The CDC, as one policy process, reflects the influences of power and ideology in social governance. The influences of ideology informing social governance can be expressed through the lived realities and influences of the CDC policy in the lives of people who directly experience the CDC. Hence in assessing the influence of the CDC in recipients' lives, the assessment of ideological theory underpinning the creation of the policy and policy objectives needs to be analysed to ascertain if theory and lived reality align as intended.

In an applied sense, the critical constructivist approach means that when attempting to assess the influence of CDC policy in people's lives, I considered how each person might experience that policy in their own particular world and own individual way. Further, I aimed to position these experiences within the shared social contexts that extend beyond the individual so to ensure these experiences remain firmly embedded within the ideological, socio-political, historical and economic landscape that makes those subjective experiences possible. My research methods thus aimed to best capture different, subjective experiences in context by applying an inductive, critical and open-ended exploratory approach to social inquiry (Cannella & Lincoln, 2009, p. 56; Neysmith, Bezanson, & O'Connell, 2005).

5.3 Methodology

The following sections explain the qualitative methodology and methods/techniques I used in detail. To answer the research questions, I employed techniques guided by a critical

ethnographic approach to social enquiry. These qualitative research techniques of conversational and repeat interviewing, active embedded participant observation, and having many informal conversations, are iteratively and reflexively employed dependent on what was best suited to the participants and location at a given time (Gaskin & Chapman, 2014; Guerin, Leugi & Thain, 2018; Hignett & McDermott, 2015; Robson, 2011). Methods align with the critical constructivist worldview in that they are inductive and do not seek to determine a singular version of events or truth but embrace and assess subjective experiences and broad complexities that shape people's lives (Azungah, 2018; Patton, 1990; D. Thomas, 2003).

Overall, the critical review of associated research and evaluations relating to the CDC showed that the following needed to be addressed to improve how we understand the influences of the CDC social policy in people's lives. The review showed we need to:

- Find out what the relevant issues/contexts actually are regardless of the CDC implementation, and how these identified issues/contexts interrelate and are experienced *as described by the CDC recipients and their communities*.
- We do not know much about *how the card works in the complex, on-going contexts* that card recipients define as important outside of the direct influence of the card, *as experienced and described by card recipients and their community*.
- There is also little research on how the issues people may experience are *described or problematised by CDC recipients and their community.*
- We do not know much about what card recipients and their communities say has changed in their lives for better or for worse, whether in relation to the card or not.

As part of these social contexts yet unexplored, there are additional considerations that may be learned through studying what we do not know as defined above:

- We know little about *how changes happen* if they do for CDC recipients, especially in relation to the CDC influencing recipients' social relationship interaction contexts with other people in their lives.
- We do not know much about how what we can learn through new methodologies contextualising CDC intervention influences, can help us to understand policy in relation to particular socio-political contexts currently left unexplored in relation to the CDC.

Methods that can capture complex contexts of how policy influences recipients' lives, parallel those in the broader social sciences (Neale, 2021). These methods include repeated measures over time, mostly qualitative interviewing and observational strategies, with the open-ended and participatory versions considered most exploratory (Ayres, 2008; Cannella & Lincoln, 2009; deMarrais & Lapan, 2003; Draus, 2017; Elfenbein & Schwarze, 2020; Hignett & McDermott, 2015; Holland, Thomson, & Henderson, 2006; Patton, 2002; Saldaña, 2003; D. Turner, 2010). All such methods parallel those used in ethnographic approaches to inquiry as is explored further below, making the use of an ethnographic approach to capture complexity and contextual influences of social policy, well suited to the task (Clemens & Tierney, 2020; McIntosh & Wright, 2019). The following sections of Chapter 5 work to explain how the chosen methodology and methods work to address these gaps identified above.

5.3.1 Critical Ethnography

Critical ethnography has been described by Karen O`Reilly (2009) as relying on the same sets of methods and in most cases, the same methodology as conventional ethnography. "However, critical ethnography goes a little further, enabling the ethnographer to actually choose between competing ways of seeing the world" (O`Reilly, 2009, p. 52). As described by May and Fitzpatrick (2019, p. 365) "Critical ethnography is concerned with relations of power and related issues of dis/advantage in wider social, educational, and political contexts. Critical ethnography can thus best be described as conventional ethnography with a political purpose". The socio-political reality of social policy shaping and reflecting social norms, and then how those structures came to influence the subjective experiences of respondents, are reminiscent of a critical ethnographic approach to inquiry (Carspecken, 1996; Carspecken, 2005; Cook, 2012; Kincheloe & McLaren, 2011; Madison, 2005).

In this thesis, I do not aim to provide a traditional ethnography but instead, apply ethnographic techniques to produce a critical ethnographic account of the CDC's influences in context. Jones and Watt (2010, p. 25) reflect on the idea that ethnographic enquiry need not be based on actually doing *an ethnography*. Ethnography has been argued to be an ambiguous term that defines both a process and product (Agar 2008, p.53), with Seim (2021)

suggesting that no other form of social analysis is more divisive or contested than ethnography.

Jones and Watt refer to doing a traditional ethnography in terms of ethnography's original Malinowskian model (Jones & Watt, 2010, p. 23). They explain this model is historically focused on researcher neutrality, finding and describing a group of persons or 'natives' in their 'natural' setting, and diligently writing a body of text describing and theorising on cultural behaviours, amongst other factors. This historical 'traditional' ethnography of a whole group and their interlocking events has been described as a reflection of positivism and colonial dominance, where the Malinowski method or 'myth' was later replaced by a post-structuralist ethnography guided by the postmodern that challenged the myth of impartiality and neutrality and embraced researcher reflexivity and redistribution of power (Geertz, 1973; G. Harvey, 2021).

More recently resulting from the post-structuralist shift in the 1960s, ethnography in broad terms has evolved to embody postmodernist approaches, commonly with the use of inductivism, reflexivity challenging researcher neutrality, concerns with ethics, complex determinations of 'truth' and power constructions, and issues of data representation (Jones & Watt, 2010, p. 24; Parker, 2007). The application of such contemporary factors in the field has been called taking a humanistic approach to ethnography. A humanistic approach to critical ethnography sees the researcher interact with and centralise the experiences of the people within the contextual complexities of their lives, whilst challenging ideas of neutrality through reflexivity, by addressing and accounting for the role and positionality of the researcher in the lives of those studied (E. Turner, 2007).

In line with how critical ethnography informed this study, described by Ingold (2017, p. 21), ethnography “is to *render an account*…of life as it is actually lived and experienced by a people, somewhere, sometime” [emphasis added]. The ethnographic account can be derived from different ways of corresponding or interacting with people. Such processes of corresponding involve participating, talking with, and observing people that form a way of learning about people and place (Ingold, 2014). Others have described similar key factors that permeate varying conceptions of ethnography over time, however, focus more on descriptions of what are considered ethnographic ways to collect information, summarised in brief in Table 6 below.

Table 6 below summarises techniques argued as needed in a critical ethnographic approach to research and describes how I employed these recommendations. These techniques are then expanded on in greater detail in the corresponding sections below. This list is not intended to be exhaustive of every researcher that has argued for these techniques but to show how evidenced consideration has been applied in the choice of research methods used.

Table 6: Ethnographic research techniques for remaining ethical and critical in practice.

Authors	Techniques	How I Applied Techniques	Section Discussed in Greater Detail
(Bohannan & Van der Elst, 1998, p. 24; Brewer, 2000; Carspecken, 2005; M. Hammersley, 2007a; Ingold, 2017, p. 23; Jones & Watt, 2010; Kincheloe & McLaren, 2011; Madison, 2005; O'Reilly, 2005)	Talking with and observing people are interconnected and itself not a method, but a *way* of meaningfully corresponding (interacting) *with* people. Need to employ embedded, participatory and observational interactions, involving direct and sustained contact with human agents over time, within the context of their daily lives (and cultures). Often involves using multiple data collection methods including talking and observing through engaging and relating with people in their lives on their terms.	Engaged with people repeatedly over-time on their terms, gaining access through building rapport and collecting data through interviews and participant observations.	Time in the Field; Gaining Access to Community; Volunteering as Giving Back; Interactions with Participants to Learn About Their Lives.
(Brewer, 2000; Carspecken, 2005; M. Hammersley, 2007a; Jones & Watt, 2010; Kincheloe & McLaren,	Need to identify the theoretical framework/worldview they operate within and to what degree, that acknowledges the role of theory as well as the researcher's own role. Need to establish authority of the data, show complexity of the data by avoiding simplified critique, use iterative-inductive research processes (that evolves	Outlined my own worldview and approach to conducting the research. Accurately capture and reflect on complex subjective perspectives and their	Critical Constructivism; Interactions with Participants to Learn About Their Lives;

2011; Madison, 2005; O'Reilly, 2005)	in design through the study) drawing on a family of methods and producing a richly written account that respects the irreducibility of human experience.	socio-political complexities combining theory with rich, empirical findings.	Data Analysis; Chapters 6 & 7
(Brewer, 2000; Carspecken, 2005; M. Hammersley, 2007a; Higginbottom & Liamputtong 2017; Jones & Watt, 2010; Kincheloe & McLaren, 2011; Madison, 2005; O'Reilly, 2005; Parker, 2007)	Maintain researcher reflexivity, establish integrity through descriptions of self, study characteristics and reflections on positionality and constraints. Need to ensure extended and empowering co-construction of knowledge throughout the research processes between participants and researcher. Act ethically.	Remained aware of positionality in relation to the project and participants, remained open and transparent about myself and the research. Planned and acted reflexively and ethically.	Reflexivity & Positionality; Gaining Access; Ethical Considerations; Sampling and Recruitment.

So, to ensure the rigorous application of the methodology, a range of ethnographic elements have been considered and incorporated into this study. Ingold (2017, p. 23) argues that ethnography is not a method unto itself but a form of inquiry, a craft, that may have its typical techniques and ways of working. Ingold (2017) argues that ethnography remains distinct from anthropology in terms of purpose and outcomes. Where ethnography produces a product about people, anthropology is more about learning with people via ongoing, critical dialogue. The approach employed in this project about the CDC was used to produce a product describing experiences relating to the influence of CDC policy on a group of people in context, using different forms of talking with people and observations as strategies to collect information. Critical ethnography then incorporated the guiding framework to help make sense of these lived experiences of the CDC policy in the contexts of people's lives, by encouraging analysis to address how experiences "makes sense for the participants, then reframe the data, using images and metaphors that show them in a new way, to reveal the hidden depths of exploitation, power, and disadvantage." (O`Reilly, 2009, p. 54).

Similar examples comparable to Brewer (2000), O'Reilly's (2005) 'critical minimums', Higginbottom and Liamputtong (2017), and Ingold's (2017) focus on corresponding with people, are found in general disciplinary approaches of enquiry related to sociology (Ayala & Koch, 2019), and anthropology (Shah, 2017), and critical participatory research methods more specifically (Carspecken, 2005; Cook, 2012; Madison, 2005; O'Reilly, 2005, 2009). What all these strategies have in common is that when applying a critical ethnographic approach to inquiry, the researcher needs to consider positionality, plan and act reflexively and ethically, repeatedly engage and interact with participants over-time on their terms, accurately capture and reflect on subjective perspectives and their socio-political complexities, in the research product produced. All such strategies are incorporated into this body of work. These specific methods used are described in detail in the following section below.

Critical ethnographic techniques were employed to inquire about peoples' life contexts and analyse the CDC policy influence in those contexts. Using a critical ethnographic approach was so to apply a critical lens through which to understand the policy context in its related social ecology. Or more simply, the society and contexts the policy relates to as well as the influences of the policy on individuals. There remained a need then to simultaneously address the experiences of CDC recipients while also considering the contextual, socio-political landscape from which the policy emerges, as addressed in detail in Chapter 2. Alongside capturing the lived experiences of the CDCs influences, analysis included making sense of these experiences in conjunction with social policy as a version of social control and regulation. As discussed in Chapter 2, social policy decisions are influenced by ideologies informing constructions of deviance, thus analysis of experiences pays particular attention to how influences of the policy may impact and have broader ramifications for social control and regulation.

In relation to responding to the research questions, a critical ethnographic methodological approach was most useful in contextualising: the related structural social conditions people experience; how people described the influence of the CDC in their lives; when changes happened for participants, how did those occur; and how this all paired with much broader ideologically influenced policy intentions and outcomes. As has been argued by policy

researchers such as Neale (2021, p. 666), researching policy will benefit from doing things differently, such as:

> Researching the multiple, fluid and relational dimensions of causal processes enables fresh insights into how things work in particular contexts and settings of change. Moreover, using qualitative longitudinal research as a design, co-ordinating and navigational tool means that causal processes are not simply documented or observed, but are actively shaped as the research unfolds.

The approach applied here in 2019 guided how to best interact with people in their daily lives to learn about complex policy influences where they exist. This approach included becoming a part of things people experienced as far as possible, learning with people over time, and producing a written account of what I learned so to capture the structures and processes of how and why people experience what they do. Such an approach reflects what researchers such Neale (2021) argue, that capturing accurate policy influence is not only about capturing structural conditions people describe, but also about the dynamic relationship between those things that is most significant. In combining capturing these *social structures/ conditions/ contexts* with the relational *process of how and why* things occur, this reflects what Neale (2021) has recently argued can overcome methodological problems with much policy research that otherwise relies on simple correlation and causal models of inquiry leading to vague and ambiguous outcomes.

5.4 Methods

The following section details the methods used in this study that provide data to best respond to the research aims and questions posed, as described in Chapter 4. These methods, outlined in Table 6 above, apply the corresponding worldview of critical constructivism and the methodological frame of critical ethnography guiding the inquiry. Data collected is then analysed and discussed in the following Chapters using a critical lens that positions what has been learned within the localised and broader socio-political environment from which the CDC emerges and is experienced.

5.5 Data Collection

The following Section outlines the data collection methods employed in this research.

5.5.1 Time, Reflexivity, Positionality and Access

5.5.1.1 Time in the Field

The field is conceptualised here as the setting, location, time, or space where the research 'takes place'. In this thesis, the field refers to the Ceduna region as the setting where research was conducted (Figure 3). Population details about the Ceduna region impacted by the CDC were discussed earlier in the introduction to this Chapter 5. Overall, entry into the field is preceded by preparation that guides what will be addressed. Yet how this happens depends on the field – or context - itself. O'Reilly (2005, p. 37-8) argues that the process of ethnographic enquiry requires an iterative approach to making sense of what you are investigating, where in the field, we start wherever we can and spend much time going around in necessary circles but learning more each time. What this means in practice looks different depending on the particulars of the research being undertaken and has been argued as being directed by circumstances often beyond the researcher's control (Agar 2008, p. 75).

Time is needed to adequately conduct research designed to seek to get-to-know, become embedded, do in-depth investigative work with people, and in some cases, explore inconsistencies found during inquiry (Bohannan & Van der Elst, 1998). Extended time interacting in the field “enables the strange to become familiar, and the familiar strange” patterns (O'Reilly 2005, p. 92). Adequate time also allows the increased frequency of interactions and thus relationships to develop, and suitable discussions and observations of macro and micro processes and contextual complexities in people's lives (M. Atkinson & Coffey, 2001; Bohannan & Van der Elst; Guerin, 2016; Guerin et al., 2018; Holland, Thomson, & Henderson, 2006; K. Vincent, 2013). Contexts include structural social, economic, historical, cultural and environmental surroundings that create conditions within which people live (Crammond & Carey, 2017; Kim, 2008). Such conditions are interrelated and provide opportunities for behaviours, often described as a social ecology of interrelated contexts, including human behaviours and relationships (Bronfenbrenner, 1979; Guerin, 2016; Crammond & Carey, 2017; Oishi & Graham, 2010). Asking someone about an event or experience in isolation on one occasion may not allow for the discovery of how or why an event or experience may have occurred in its broader contexts. Doing so only tells us that it did occur.

To understand how and why people experience things and do the behaviours they do, we need to map the mechanisms of influence in context. To do so means we need to see how contexts relate to each other and speak with and observe people multiple times to ensure we have understood accurately (J. Lee & Ingold, 2020; Stellmach, Beshar, Bedford, Du Cros, & Stringer, 2018). In terms of responding to the research questions, only visiting Ceduna and interacting with people once or twice was not suitable for this study to answer the Research Questions. To gain insight into social behaviours, ethnographic researchers have argued for the use of formal interviews, combined with repeated informal conversations and observations (Hockey & Forsey, 2020) and with interactions frequently happening over an extended timeframe (Agar, 2008; P. Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001; M. Hammersley, 2007b; Ingold, 2017; Seim, 2021). For this research, a variety of repeated interactions over time were more suitable for understanding individual descriptions of CDC influences and structural social influences more broadly.

A four to 12-month timeframe is argued as an adequate range for researchers to conduct such investigations when planned and executed well (Brewer, 2000, p. 103; Jeffery & Troman, 2004). Similar results in four to 12-month studies have been found in those of extended timeframes of interaction beyond 12 months (Monrouxe & Ajjawi, 2020). Furthermore, an intermittent, extended-interaction approach is accepted as remaining reflexive to community needs, a core element of an ethnographic approach to investigations (P. Atkinson, Coffey, Delamont, Lofland, & Lofland, 2000). Ultimately, the length of time spent in the field relates to situational research and setting nuances.

This study comprised intermittent, repeat visits to Ceduna and repeat interactions with participants across a 12-month timeframe. This 12-month timeframe was also a practical consideration concerning the time restrictions on PhD research submission requirements. Furthermore, this interaction timeframe may more accurately reflect similar resource concerns relevant to social policy research, as outlined in Chapter 3. Even though additional time had been hoped for beyond the initial planned 12 months, this was untenable due to restrictions relating to the impacts of the Covid19 pandemic. The pandemic interrupted the final part of my data collection and led to my exit from the field at that time.

The total time I spent in the field equates to approximately 140 days, or five months over a 12-month timeframe across the year of March 2019 to February 2020. Further details

regarding when and for how long I spent during specific visits to Ceduna, alongside the purpose and outcome per visit, are outlined below in Table 7.

Table 7: Field visits and time spent in Ceduna and purpose/outcome per visit.

Research Trip: March 2019- February 2020	Days In Field	Primary Purpose/Outcome of Visit
One: 2019 March	7	Introductions
Two: 2019 May	7	Introductions, follow-ups
Three: 2019 June	28	First interviews, interactions, observations
Four: 2019 September	14	Interviews, interactions, observations
Five: 2019 October – December	70	Interviews, interactions, observations
Six: 2020 February	14	Interviews, interactions, observations
	Total: 140 days	

5.5.1.2 Reflexivity and Positionality

Madison (2005, p. 19) and Jones and Watt (2010, p. 182) describe positionality of the researcher as starting where you are, acknowledging that personal history, experiences and knowledge about the world will unavoidably shape research interests and approach. O'Reilly (2005, p. 222) and Call-Cummings and Ross (2019) agree that positionality and reflexivity need to be acknowledged in social research and suggest that in being aware and honest about our own selves in relation to the research, we better ensure rigour through disclosure. Positionality is also fundamentally about relations of 'power' between those studied and the researcher, where if, as researchers, we can reflect on and see differences and privilege, then we may be closer to understanding our power in the 'authoring' of 'others' (Bourke, 2014; Holmes, 2020; Merriam et al., 2001). The representation and interpretation of participant narratives required when assuming an ethnographic approach to research is argued as inherently influenced by the researcher's positionality (Jones & Watt, 2010, p. 183). Furthermore, who we are in relation to those we interact with during the course of doing

research has been argued to directly relate to how we are able to access participants (Agar, 2008; Brimbal et al., 2021; Massoud, 2022).

As outlined by Massoud (2022), although being forthcoming about one's positionality can risk inviting criticisms from participants and reviewers alike, doing so remains paramount for transparency and improves research rigour. My described positionality here formed part of what I self-disclosed to participants, and also informed what I paid attention to and helped me understand what I might miss so I could counter that in the research process. I do not pretend to be impartial or detached. Instead in making my own positionality explicit, I aim to improve my own reflexivity and research rigour.

So, who am I in relation to the research, participants and setting? My background positions me as a middle-class, first-generation white-Australian female researcher in my mid-thirties, with a family comprising of an ethnically diverse immigrant background, with some family requiring government welfare assistance during certain times in their lives. My interest in policy influencing human behaviours relates to previous university studies in the sociology of health, my family's experiences with navigating the Australian welfare system, and other research work I have been involved in for several years. This work includes having previously undertaken research (not in the Ceduna region) where my role was to connect with police detainees and gain insight regarding detainee engagement in what Australian law defines as crime-related behaviours, with particular attention paid to detainee use of illicit drugs. As the CDC policy objectives include the aims to reduce alcohol use and promote 'socially responsible behaviour' inferred to include a reduction in drug use and crime behaviours such as violence (see Chapter 2.4 for a review of CDC policy objectives), I took great interest in the CDC policy as a proposed strategy aiming to reduce those related social issues.

This PhD project is not directly related to my past research work in any technical/formal sense. However, what I had seen and learned over time during this work encouraged me to explore the interrelatedness between social structures, such as social policy, and related individual actions, as I was interested in helping to improve social policy practices and outcomes. In being professionally transparent about family and work and other aspects of my background, this self-disclosure to participants helped to redistribute power between myself and participants and encouraged participants to share with me their own experiences of the

CDC policy. This increase in participant willingness to share information has been found to be a typical outcome of researcher self-disclosure strategies elsewhere concerning building rapport (Abbe & Brandon, 2013; Adler, 1990; Brimbal et al., 2021; Crough, Dion Larivière, Snow, & Eastwood, 2022; Massoud, 2022). What I told, to what degree and to whom heavily depended on nuances within any given interaction at the time remained within my own ethical framework and professional standards. In remaining reflexive to participant needs, such as 'reading the room' regarding mood, other interactions, and what kind of day a person might be having, the process of sharing what and when changed across interactions with each participant.

Mostly, what was shared worked well to develop reciprocal rapport and trust. Although I can only speculate, as I did not seek to follow this up at the time, I acknowledge that this disclosure of past time spent researching crime and drug use with law enforcement groups, may have prevented some participants from explaining certain aspects of their lives. Such as not sharing any involvement that participants themselves or their family may have had in crime-related activities for fear of persecution, a factor considered further in results Chapter 6, sections 6.3 and 6.4 alongside relevant data. Further, these experiences of mine are acknowledged to shape how I explored participant narratives and what I paid attention to or not throughout the process of data collection and analysis. The guiding research worldview and methodology were consistently referred to throughout the research process to be aware of my own experiences and privilege and how they may shape what I could learn from this research project.

5.5.1.3 Connecting with Community

Overall, there are a variety of ways to connect with participants. However, the approach employed depends wholly on the situational context of the location, ethical considerations, the people, and the topic, otherwise described as the nature of the 'field' itself (O'Reilly 2005, p. 86-7). Gobo (2008) has described the beginning phases of ethnographic research as some of the most difficult throughout the process. Agar (2008, p. 133) elaborates, suggesting the beginning of some ethnographic fieldwork in unknown groups is a process of becoming less and less dazed and confused of new cultures and surroundings, where initially “you are adrift, trusted by no one, and unsure of what is going on around you”. Overall, accessing the communities of interest by building trust and rapport through actions and transparency, and by facilitating key persons, also described by others as gatekeepers, is recommended by many

social researchers and was incorporated throughout my research process (O'Reilly 2005, p. 85; Brewer 2000, p. 82; Gobo 2008, p. 120-1; Jones & Watt 2010, p. 116-7; Plows 2018, p. 72-6).

O'Reilly (2005, p. 85) describes gaining access to people and communities as an often-difficult task and a primary consideration in ethnographic research. Access can be gained through actions such as meeting formally and informally with community members, negotiating, and establishing benefits, identities and guarantees (Gobo, 2008, p. 120). The difficulty of gaining access can relate to a variety of realities. These can include: the personal attributes of the researcher (O'Reilly, 2005, pp. 85-6); existing connections or relationships between a target group and researcher (Brewer, 2000, pp. 82-3); or through identifying and facilitating 'gatekeepers' in a community (Schensul, Schensul & LeCompte 1999, pp. 76–7). Schensul, Schensul and LeCompte (1999, pp. 81–4) define gatekeepers as people who would help gain further access to communities of interest. However, the term gatekeeper is contentious and often used to describe people who may also act as barriers (Chaudhuri, 2017).

The ability to form and maintain trust through action is described by Gobo (2008, p. 122) as an ongoing iterative process, where gatekeepers, otherwise described as key people in community or ‘allies’, play a large role in monitoring researcher actions. Brewer (2000, p. 85) and others (Agar, 2008, p. 110; O'Reilly, 2005, p. 96; Gobo, 2008, p. 122) stress the need for trust and that in establishing trust, the researcher's actions speak louder than words. Or, in other words, are you consistent and do you do what you say you do and thus, can you be trusted?

In terms of how a researcher can build trust through interactions with people and what interactions people may allow (Bohannan & Van der Elst, 1998), Agar (2000, pp. 104-5) described the presentation of the self relates to explaining who you are to people through your behaviours and talking in the field, which become a series of acts “to which you are held accountable”. In terms of my presentation of my 'self' which inherently included my relevant positionality, my actions included what I wore and with whom I was seen in town. Such actions work to construct a version of identity that can influence community perceptions of belonging and impact crossing boundaries between insider-outsider interactions (Liong, 2015; Sherif, 2001). In practice, this meant I wore clothes that reflected social and cultural

symbolic-value constructions deemed suitable by whom I aimed to access, which I ascertained through ongoing, reflexive observations. It meant I wore longer shorts or skirts, jeans, and loose-fitting tops and did not wear certain clothes associated with higher-income groups, such as specific brand-name clothing. I became aware that because I was married, some community norms dictated that I should refrain from being alone with other men without good reason – an important factor some Australian Aboriginal elders informed me during my research. All this may seem extensive and be considered to emerge from profiling. However, my experiences in Ceduna and life, in general, had taught me that paying attention to these particular value constructions and responding accordingly was significant. These behaviours were significant in helping me engage in respectful and effective ways with the Ceduna community to connect with participants.

Gaining gentle entry and connecting with people was not a singular event but an ongoing effort that was initiated by being open and transparent and speaking with many people about the purpose of the research (O'Reilly, 2005, p. 85). My first few trips to Ceduna were short (one week each time approximately). I spoke with community service providers in planned and unplanned on-site meetings in their organisations. I also met people spontaneously on the street, locally important socially interactive places such as the jetty, grocery and thrift stores, who would smile and welcome me to town and, who I would later learn commonly ask newcomers to the small remote town, what they were doing there and why. In these encounters I spoke about who I was, what I was doing and what this meant for the people involved. I made myself available and kept returning to the town, finding people would wave again or stop for a chat about how things were going and sometimes refer or introduce me to others. Remaining reflexive in action (O'Reilly, 2005, pp. 89-90) where I did not push or force interest, interviews or participation, I instead focussed on developing some sense of rapport and familiarity with the people and places of Ceduna – just as I felt they were doing in ‘getting to know’ me as an outsider who frequently returned and contributed to the community (Moran, 2007) as discussed further below. This approach to informal networking was encouraged and supported by community members and service providers who all seemed keen to have a 'yarn' with an increasingly familiar 'outsider'.

In time, I identified key people in the community who helped me gain access to participants and learn more about the contextual conditions on which the CDC was overlaid. These key people in the community acted as the mediators and often controllers of peoples' access to

various entitlements and opportunities, providing a point of access that helped me gain further referrals into key communities of interest and influence. Early on in this fieldwork, I was invited to volunteer with a key organisation. Many key supporters assisted me in the importance of this 'ground up' research. This regular volunteering enabled me to find new informal and formal opportunities to negotiate access to parts of the community that may otherwise not have been available to me, which is further discussed below.

5.5.1.4 Volunteering as Giving Back and Rapport Building

Volunteering offered an opportunity to show people who I was and to do something immediately useful with the community through and alongside the research journey. Volunteering with one organisation provided opportunities to get to know and see more of the community and give back to people on their terms, building trust through immediately useful actions. The organisation (not named here to maintain the anonymity of participants in a small town) suggested that volunteering would be a way I could give back and provide a service that would be immediately beneficial to locals. They argued that, in comparison, research outcomes are not always immediately apparent to participants. They claimed that many researchers who had come to Ceduna previously were accused of taking data but doing little to give back to the community in a way the community may directly benefit from outside of a lengthy research project. Other organisations also expressed these powerful sentiments. I volunteered at only one organisation while building access to many other services through them.

During my initial visits and before volunteering, I noticed that the organisation I volunteered with appeared to work across and link people with other services, making them a window to many other small parts of life in the region. This organisation (not named here to maintain the anonymity of participants in a small town) was mentioned by almost all of the service providers I spoke with as a pivotal access point for support and referral across the community. I saw their cars travelling around town, and most community members I asked about them inferred they were well-liked. I negotiated a beneficial reciprocal relationship through volunteering that could build trust (Brewer, 2000, pp. 85-6) between the organisation and me. In addition, the organisation no doubt saw an opportunity to gain insights and reflections from the 'ground' through me that they may not have had access to otherwise, alongside gaining the benefit of my volunteer labour.

The locations, activities and people I had gained access to through volunteering represent what P. Atkinson et al. (2000, p. 221) have described as typical and required to become a part of a community as best as possible. These activities and participation align with what Moran (2007) reflected on as helping to negotiate the relational boundaries between insider or incomer/outsider relationships. Drawing on their research in a small remote community in Ireland, they found that "incomers who were seen to participate achieved local status more quickly than those who chose not to do so" (Moran, 2007, p. 143).

Activities I did with participants (who were also often clients of the volunteer organisation) and also the broader non-participant client base that the volunteer organisation served included: cooking community lunches and eating meals with participants, clients and their families; writing reports for the volunteer organisation about their client services based on their own data; answering phones; helping clients write resumes and fill in forms where they asked for assistance; taking clients to hospital; going to local state-government and not-for-profit organisation policy meetings; cleaning bathrooms; helping clients move furniture; driving participants and clients around and teaching participants and clients to drive. During my interactions through these activities, I heard stories about places and people's experiences in the town.

The more time I spent with people, the more stories were shared, often as I drove people home or to appointments. For example, I was shown the good fishing spots, which buildings used to house which families and why they moved for work or lack of it. We would see people walking or sitting whilst we drove. I was told stories about who was related to who in the region, and who was in a fight with each other. On a particular occasion, I was told about the passing of a husband and the 'rigmarole' of the funeral home not releasing his body until fees were paid and having to come up with the money so he could be buried and the family could grieve properly. Parents told me stories about their children whom authorities had recently taken, and tears often accompanied these stories. I was asked if I was married, about my research, what I wanted from the work, and just about my life, which I shared honestly. These stories were shared often in passing, and much of what I learned was not because I asked endless research/interview questions but mainly occurred through observations and conversations in the process of me helping people do something. This sharing formed a part of the trust, rapport and relationships building process between myself and the broader community (Jeffrey & Troman, 2004). Over time, my role of outsider and newcomer moved

closer toward an accepted insider-outsider (Khalili, 2011, p. 71; O'Reilly, 2005, pp. 12-3), where my role and engagement with the community became more of a part of their everyday lives.

5.5.2 Ethical Considerations

The University of South Australia's Human Research Ethics Committee approved this research project, where the committee determined that the project met the requirements of the National Statement on Ethical Conduct in Human Research. Ethical clearance was gained prior to entry into the field. The University of South Australia's Ethics Approval number is 201335.

Informed consent was sought from all participants prior to being included in the study using ongoing communication and included providing participant information sheets to respondents, which outlined all relevant ethical requirements and information about the study. Informed consent is explained in detail below. All information provided by participants was confirmed as permissible prior to inclusion into the study by the participants themselves. Throughout the study, participants reviewed information collected about themselves and corrections/ clarification/ additions were made where a participant requested. Brewer (2000, p. 88) discusses this transparency, where openly showing participants everything recorded about them helps to alleviate concerns that may negatively impact trust, and full transparency can thus constitute good ethical practice. Participants had ongoing access to data relevant to them only where they asked and no other persons per confidentiality requirements.

Informed consent is a fundamental principle of social research (M. Boulton & Parker, 2007; Miller & M. Boulton, 2007; Neuman, 2006; Nijhawan et al., 2013). Neuman (2006, p. 135) describes informed consent to include a written agreement of participant engagement, and that research participation must remain voluntary and without coercion, where “it is not enough to get permission from people; they need to know what they are being asked to participate in so they can make an informed decision”. In drawing on the powerful guidelines for research espoused by the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) (2022, p. 20), I remained mindful of a quote from the guidelines on power/ informed consent:

> The consent form is a record of an agreement and the process of informed consent between you, the researcher, and individual participants on the conditions, rights and obligations of both parties. It ensures that the participants are aware of all the potential risks and benefits of the project… Informed consent is a process of communication between a participant and you that results in the participant's authorisation or agreement to participate in the project.

While not focused on nor working with Aboriginal peoples exclusively (See Sections 2.4 and 5.1 for data on the proportions of Aboriginal peoples on the card generally and in the population in Ceduna), I was sensitive to and consistently aware of the implications of working respectfully with Aboriginal Peoples. I remained mindful of the National Health and Medical Research Council (NHMRC) (2018, p. 5) requirements when working with all research participants who identify as Aboriginal/Torres Strait Islanders or otherwise, which states:

> Respect for human beings is a recognition of their intrinsic value. In human research, this recognition includes abiding by the values of research merit and integrity, justice and beneficence. Respect also requires having due regard for the welfare, beliefs, perceptions, customs and cultural heritage, both individual and collective, of those involved in research.

I followed related guidelines to act supportively and respectfully with all persons involved in the research at all times. Importantly, I was guided by one of my supervisors, who is a Waljen woman with a doctorate working as a lecturer at the University of South Australia. In combination, this guidance within my supervisory team and those written by AIATSIS and the NHMRC aided my reflexive and ethical practice. Considerations of reflexivity and redistribution of power between myself and the participants are discussed in detail above.

I was aware of my actions and how they would translate and align with the diverse significance people placed on who I was, what I was doing, research transparency, the importance of 'informed consent' and the empowerment of participants. Informal conversations, sometimes described as Yarning outlined in the AIATSIS (2022, p. 20) guidelines, was used as a strategy and process of communication between participants and me. Yarning was used to explain what the study was about, to learn from participants how the

study could improve and to ensure informed consent was gained and maintained throughout the study process. Such use of Yarning to do so at the beginning and indeed throughout a study is outlined by Murrup-Stewart, P. Atkinson and Adams (2022) as a valuable and inclusive approach to co-construct knowledge and understanding particularly needed for research interactions with Aboriginal peoples in ongoing settler-colonialist settings – which is the case for the CDC policy. Yarning is described further in Section 5.5.4 below.

As part of the postmodern turn in ethnography, ethics have been called into question regarding the ethnographic approach to research (Parker, 2007; Smette, 2019). This questioning of ethics in ethnographic approaches to enquiry relates to the emergent nature of research focus, the need to capture contextual details requiring observation of a whole community beyond those participants immediately involved, and establishing trust with the community, argued as developing over time (Parker, 2007). Ethnographers have suggested that defining consent prior to the beginning of the research can construct for participants an inaccurate representation of what the research will entail (Murphy & Dingwall, 2007, p. 5). However, as my research did have defined parameters of topic focus being the influence of the CDC, I was better able to ensure participants were able to be informed of what the research process and focus was, thereby ensuring informed consent could be gained prior to a participant engaging in the study.

Nonetheless, a need remained to ensure consent was maintained throughout the data collection, and that the broader community was fully aware of who I was and what I was doing. Keeping in mind that "Ethnographic consent is a relational and sequential process rather than a contractual agreement and lasts throughout the period of research" Parker (2007, p. 2252), I consistently checked with participants regarding their awareness and engagement with the research as the project evolved. I made efforts to ensure the community were aware of my work by making myself available for questions, comments, or queries throughout the process. I did this by regularly speaking with many people beyond the participants involved. This engagement occurred through my volunteering and my activities with many community members across the region. Such a process of checking and discussing is what Strathern (2000) has described as ensuring ongoing negotiation in ethnographic research.

5.5.3 Sampling and Recruitment

There were two subsets in the overall sample, as outlined in Table 8, describing participant characteristics below. Both subsets were recruited using the same sampling strategy outlined below. The two subsets were: CDC recipient (n=12), and service provider (n=7) sample groups, with a total of n=19 participants.

Arguments of 'adequate' sample size in qualitative research vary, with most referring to data quality relating to higher samples typically arising from saturation in themes or outcomes identified (Boddy, 2016; Hennink & Kaiser, 2021; B. Marshall, Cardon, Poddar, & Fontenot, 2013; Morse, 2000; Sandelowski, 1995). Saturation refers to no new themes or outcomes being identified in the data. Some researchers and journals have gone so far as to suggest a range of what they determine as an adequate sample size for 'qualitative research', in the case of one well-used quality indicator, this range falls between 25-30 participants (Dworkin, 2012).

Others, such as Staller (2021) and Blaikie (2018), have argued that such a rigid categorisation of what determines an adequate sample size is far more nuanced regarding what is suitable and needs to account for more than just categorising a study as 'qualitative' and findings being 'saturated' or not. These nuances are suggested as needing to account for factors such as the study's purpose, depth and logic (Blaikie, 2018) and the researcher's creativity in their approach to the data collected (Dworkin, 2012). In accounting for such factors, Small and Calarco (2022) have argued that for longitudinal, repeat and in-depth interactions in ethnographic approaches to research, using sample size as an indicator of study quality remains unhelpful.

Similar arguments are made regarding saturation for reasons related to sample size, amount of data collected per participant and item salience. Weller et al. (2018) show that irrespective of sample size, with greater volumes of information per participant, this lessened the ability of saturation to be determined and was beneficial for highlighting the most salient items across participants. Weller et al. (2018) argued that instead of saturation, focussing on item salience is more culturally appropriate and more accurate than assuming saturation based on sample size alone. Further, Small and Calarco (2022) argue the need to focus assumptions of quality on the form of exposure the researcher has to the field, the data, and the participants.

Small and Calarco (2022) remind us that the purpose of in-depth ethnographic accounts is not about generalisability but to provide a rich account of people, location and experiences.

In this vein, regarding capturing a high level of research depth and non-generalisability, Creswell and Clark (2004) have suggested as few as 1-2 cases may be sufficient in highly contextual narrative research, but that this number should increase if seeking to explain a collective story, with as many as 20-30 cases if seeking to develop a grounded theory. Whereas Guetterman (2015) has reiterated this number of 20-30 cases when conducting traditional ethnographies but suggested that as few as six cases may be adequate in explaining the essence of a defined experience. As I was applying an ethnographic approach for guidance and seeking to gain an in-depth, contextual account over time of the defined experience of the CDC policy with specific people in the processes of their day-to-day lives (Patton, 2002), I did aim for a minimum number of participants. In remaining respectful of the ongoing and numerous debates related to what makes an adequate sample size relevant to my study's nuances, I sought to recruit a minimum of 10 CDC Recipients (and recruited 12) and five service providers (and recruited 7) and interact with them in-depth and over-time (where welcomed to do so). The number of participants recruited exceeded these minimums and totalled 19 participants, as explained below.

1. Sample group cases: CDC Recipients: N=12

The main reason for recruiting CDC recipients was because I sought to understand the subjective experiences of the CDC policy in the context of the lives of those who experience the policy. Both voluntary and compulsory CDC recipients were sought to participate in the study, defined as people who were personally in receipt of the CDC. Only compulsory CDC recipients were encountered in the field, meaning only compulsory recipients could be recruited into the study. Encountering only compulsory participants was not at all surprising considering that official figures (in Chapter 2.4) show that there were no voluntary CDC Ceduna recipients on the CDC. However, allowance was made for voluntary inclusion to account for anyone who may have sought to volunteer onto the policy during the data collection phase.

The following inclusion criteria applied:

- Over 18 years of age
- Self-identified as currently experiencing/experienced the CDC as a recipient

- Residing in the Ceduna trial region

The following exclusion criteria applied:

- Self-identified as currently experiencing mental health concerns or currently in crisis
- Self-identified that involvement in the study may not be beneficial for their wellbeing
- Self-identified or appearing as intoxicated or heavily medicated
- Appeared/ Not able or willing to issue free and informed consent for the purpose of participation in the study

2. Sample group cases: Service Providers: N=7

Reasons for recruiting service providers were because I sought to understand the broader socio-political/contextual structures within which CDC recipients live, as service providers are often the deliverers and mediators of policy on the ground. Furthermore, in a small remote town such as Ceduna, service providers are a large part of the communities of CDC Recipients, where service providers in this setting were often simultaneously providing formal services as well as being friends and family of CDC recipients. Service providers were positioned to help inform on the influences of the CDC due to their oversight of the complex lives of CDC recipients, the general policy landscape and policy implementation. Service providers included those close to CDC recipients who work or volunteer as community service providers in locally based organisations or government departments providing community services, including delivery or support of state or federal social policy.

The following inclusion criteria applied:

- Over 18 years of age
- Working/involved directly with CDC recipients in the Ceduna trial region

The following exclusion criteria applied:

- Currently a CDC recipient
- Appeared/ Not able or willing to issue free and informed consent for the purpose of participation in the study

5.5.3.1 Sampling Strategy

I wanted to hear from people who have experienced the CDC in their lives in Ceduna. This requires a targeted strategy of purposive recruitment rather than a randomised approach to ensure I recruited the cases sought for the study to meet the study's aims. The sampling strategy employed a purposive sample where participants were drawn from the Ceduna region. These purposive sampling strategies are common to the qualitative research design pursued (Neergaard et al., 2009). Where randomisation is argued to aide outcome generalisability in positivist approaches to research, it is not the intention of this inductive qualitative research for information collected to directly apply to any other group (Neuman, 2013) other than those who participated in this study in the Ceduna region.

5.5.3.2 Recruitment Process

The following recruitment strategy was planned and followed with all research participants included in the study:

- Initial visits to Ceduna were aimed at introducing myself and finding options on which to begin to build a positive reputation and trust with the broader community.
- Upon first meeting with any potential participants, I explained the study, including that I welcome people to share their thoughts/stories over time if they felt they would like to, but often I did not directly ask them to participate at that time, so to not push their engagement in the study but instead ensure they had time to understand its purpose and what involvement might mean.
- When suitable, I discussed possible involvement in the study – a suitable interaction being, for example, alone with the person to not place any inadvertent pressure on them from others, and to ensure privacy and confidentiality regarding their participation should they wish to engage.
- Overall, this recruitment strategy was taken to engage with as many community members as possible in order to ensure a broad range of possible participants and to ensure participant confidentiality and anonymity: where I am seen speaking to everyone in a small town, the identification of participants from other community members becomes less likely through the diffusion of my interactions with everyone.

5.5.3.3 Reimbursement for Participation: Community Events

I did not give people individual vouchers as reimbursement for participation. Instead, I worked with the community to help out where I could, including getting funding for community social events. This helping out was not always immediately contractual in terms of reciprocity. As discussed above, the activities and interactions afforded to me during my volunteering gave me opportunities to build relationships and give back through doing useful things over time, guided and determined as useful by the community. This helping out reflects an approach is framed by Buchanan, Collard, and Palmer (2018) to reflect a process of building *ngapartji ngapartji*, an Australian Aboriginal way of respectful reciprocity, which in Pitjantjatjara translates loosely as 'you give, and I give in return'. Respectful reciprocity is addressed through doing something useful as described by community, and in my case by not giving vouchers. Refraining from giving vouchers as a sign of respect for community wishes was related to details communicated to me by various community members and participants about the relatiy of some people's use of vouchers, alongside wanting to thank as much of the community as I could alongside people who directly participated in the study.

As previously outlined in the review of literature in Chapter 3, many studies investigating or evaluating the influences of the CDC have used vouchers to reward participation in research (Marston et al., 2020; Mavromaras, Moskos, Mahuteau, & Isherwood, 2021; ORIMA, 2017; E. Vincent, 2019). Reimbursement or compensation has been argued as a necessary and respectful form of thanking participants for their participation (Collins et al., 2017). However, researchers such as Mduluza, Midzi, Duruza, & Ndebele (2013) and Resnik (2015) have argued that reward-related complexities must be carefully considered in local settings and contexts, and that the risk of unintentional coercion or undue inducement is especially prominent for low-income groups.

Early in my field engagement, I learned from community members and participants that vouchers or other subsidies or rewards could be used to pay for illicit substances or alcohol directly or through informal barter systems. These learnings included some participants explaining to me that they themselves have used vouchers in these ways. Although the purpose of my research was not to cast any judgement in this regard, it was considered unethical to create additional potential for any harm that may arise by distributing such reimbursements in any way. So, in informal discussions with participants and other community members, I decided to pursue a different form of thanks other than individual

vouchers or rewards. This consultation was informal, where I actively went around and asked the people I was getting to know what they thought the community needed and would like to do or see happen. During these general discussions across about a week, I did not get to speak with everyone in town, and I made clear that I was unsure if I would even be successful in being able to organise such activities.

Participants encouraged the idea of doing something for everyone that included a broader scope of community members than only the research participants. Following this advice, I pursued alternative funding, applied for and successfully received $5000 in funding to pay for five community social events through a Freilich Foundation Project for the Study of Bigotry Early Career Researcher Grant. Many participants expressed their interest yet financial inability to participate in family-friendly (or any) social events in the Ceduna community. The funding, therefore, paid for food and soft drinks during a series of lunch-time family-friendly, alcohol-free community barbeques. Everyone was welcome, local musicians played music, and venues and transport were provided in-kind by other community services. The five events were held across the final six months of the data collection period at two different locations in town, where each event saw between 50-110 people attend. One event location was with the organisation where I volunteered. My role at these events included helping with set-up, clean-up, cooking and dishing-up lunch. I did not use these events to recruit or interview people. Instead, these events were about people having fun and provided a free social event for the community.

5.5.3.4 Description of Sample and Participant Characteristics

Table 8 below outlines individual characteristics and descriptors of both the CDC recipient and service provider research participants to help the reader understand the contextual factors of individual participants. As Ceduna is a small community and most participants are known to each other, every effort is made not to include any information that may serve to identify any individual, this includes refraining from directly addressing or including certain personal information alongside quotes presented in Chapter 6. Full transcripts of interviews are also not presented as appendices for this same reason. All participant names used in all data presented have been changed to protect participant anonymity. Participants are allocated a participant number that also identifies which sub-sample group they belong to, either the CDC recipients (e.g., CDC-1), or service providers (e.g. SP-1). All names of local organisations have been withheld to protect participant anonymity. Some names of federal

departments operating in Ceduna (such as Centrelink, more recently renamed to Services Australia, the government department responsible for welfare support in Australia) have not been changed as these departments operate in major centres across Australia and relative anonymity can therefore be preserved.

Presenting qualitative results and participants in numerical form has been argued as both useful and limiting by qualitative scholars (Wiles, Charles, Crow & Heath, 2006). Largely the concerns relate to the potential dehumanizing effect that numbering, as opposed to naming, can have on participants. However, as Wiles et al. (2006) explain, in cases where participants may be easily known or identifiable, anonymisation beyond that of changing names to pseudonyms and instead using number conventions can improve anonymisation. Such is the case for this study in the small town and region of Ceduna. The purpose of presenting participants in basic numerical form is to further anonymise data to protect the anonymity and confidentiality of participants.

Ceduna had seen prior researchers visit and talk to people. Four of the 12 CDC recipient participants interviewed had been interviewed by researchers before for any reason. The eight other CDC recipient participants had reportedly never participated in academic research. All the service provider participants informed me they had been interviewed by a researcher before, including but not limited to their experiences with the CDC. Five of the seven service providers in the study were currently acting as managers in their not-for-profit organisation or government department. One of the two non-manager service providers was a current frontline worker for a state government authority. The other is a retired frontline worker. Further details specific to each service provider are not provided so to better ensure confidentiality and anonymity. This is because, in a small, remote town such as Ceduna, where most people know each other to some degree, and there are a limited number of locations where people work, people may be more easily identifiable with further information given.

An adequate representation of people within the sample was planned for and achieved, which reflected the general reported characteristics of CDC recipients, where 70% (n=8/12) of CDC recipient participants identified as Aboriginal Australians. This is similar to the percentage of people in Ceduna (74%) who are Aboriginal and in receipt of the CDC more broadly, as outlined in this Chapter's introduction and in Chapter 2, Section 2.4. The remaining CDC

recipients (n=4/12) did not identify as Aboriginal, as did all of the service provider participants (n=7). The total number of participants who identified as Aboriginal represents approximately half of the sample (n=8/19). By recruiting a sample that reflects general characteristics of the larger target group of people in Ceduna, I was aiming to ensure a robust qualitative sample suited to the critical ethnographic approach and topic of inquiry (Brewer, 2000; Schensul, Schensul & LeCompte, 1999, pp. 231-2).

5.5.3.5 Community Informants

Across the year spent in Ceduna, I observed informal interactions with non-participant, community informants, and captured these interactions anonymously through writing field notes. Such interactions are argued as required to help inform understanding of broader complexities of context in a community and typical practice of ethnographic forms of inquiry (P. Atkinson, et al., 2000; Carspecken, 1996; Fetterman, 2010; Gobo, 2008; M. Hammersley, 2007; M. Hammersley & P. Atkinson, 2019; Jeffrey & Troman, 2004; Jones & Watt, 2010; Madden, 2017; Madison, 2005; Shah, 2017; J. Thomas, 1993). Community informants were not research participants, and no information was collected about the informants themselves. These observations instead represent very general interactions with people who wanted to share their experiences and relevant information about the region and knew I was a researcher investigating the CDC.

These interactions are further defined as informally chatting with people, mostly once-off, about a comprehensive range of topics. Such as the CDC, the town, the day or their life. Such interactions were typically where people sought to understand who I was and why I was in town (often because they had 'seen me around') and where people wanted to share with me the information they thought necessary. Such interactions were inclusive of people who defined themselves as medical staff, university and college students, law enforcement, the family of participants, local shop and accommodation providers/workers, government and not-for-profit service providers, Aboriginal elders, and people I assisted through my volunteering. These interactions with non-participant community members assisted in my observational reflections on events and broader contextual factors regarding Ceduna communities. I include acknowledgment of these interactions here and in the data where appropriate, as addressed in Table 10 in Chapter 6, as community informants helped me understand Ceduna, the region and its people in context.

Table 8: Participant characteristics.

PARTICIPANT NUMBER	SUB GROUP	ETHNICITY	GENDER	AGE RANGE (YRS)	INTERACTION LENGTH TOTAL & FREQUENCY	FORMAL INTERVIEW LENGTH & MONTH	CONTEXTUAL BIO
CDC RECIPIENTS						**YEAR 2019**	
1	CDC	Non-First Nations	F	60-69	6hrs, HIGH	2hrs November	I met CDC-1 whilst they were a CDC recipient. CDC-1 has a history of DV and related injuries, currently lives alone and requires a mobility aid to comfortably complete daily activities. In 2019 they were no longer in receipt of the CDC, having been removed from the trial (related to disability concerns). However, were placed back onto the CDC before being removed once again in 2020.
2	CDC	Non-First Nations	F	60-69	8hrs, HIGH	2hrs JUNE	I met CDC-2 prior to their being placed into the CDC trial. They were placed onto the CDC trial during the study, although have since been removed from the trial due to disability issues. They have a history of

							abuse in their childhood and into adulthood.
3	CDC	First Nations	F	40-49	6hrs, HIGH	1.5hrs^ (CDC-3 & CDC-4 together) JUNE 1hr (CDC-3 alone) NOVEMBER	I met CDC-3 and their family member CDC-4 at the same time they were being placed into the CDC trial. CDC-3 is also an informal volunteer at a local organisation. They have a history of DV & they have five children, some of whom are under 10 years of age. CDC-3 is now no longer a recipient of the CDC due to now being ineligible for income support payments for reasons related to citizenship status.
4	CDC	First Nations	M	<20	2hrs, MID	1.5hrs^ (CDC-3, CDC-4 together) JUNE	(See CDC-3 also) CDC-4 was their school captain and recently completed high school. My interactions with CDC-4 often involved their female family members (CDC-3, others) due to cultural division of gender-norm requirements. CDC-4 is no longer on the CDC as they currently work more than one job and are no longer eligible for income support payments.
5	CDC	First Nations	F	60-69	2hrs, MID	1.5hrs* JUNE	CDC-5 is a respected member of their family and language group. They are a

						0.5 hrs CDC-3 alone Remaining 1hr CDC-5, CDC-6, CDC-7 together	qualified carer although currently are unemployed as they returned to Ceduna (from another location) to care for their elderly parent and were placed onto the CDC trial. CDC-5, CDC-6, CDC-7 are related.
6	CDC	First Nations	F	30-39	1.5hrs, LOW	1hr* JUNE (CDC-5, CDC-6, CDC-7 together)	CDC-5, CDC-6, CDC-7 are related. CDC-6 has children, little else is known about 6.17 as they were difficult to reach due to their frequent travel.
7	CDC	First Nations	M	30-39	1.5hrs, LOW	1hr* JUNE (CDC-5, CDC-6, CDC-7 together)	CDC-5, CDC-6, CDC-7 are related. CDC-2 has children, little else is known about CDC-7 as they were difficult to reach due to their frequent travel.
8	CDC	First Nations	F	30-39	3hrs, MID	1hr JUNE	CDC-8 may have a history of DV. Their now adult children and other family do not live in Ceduna. They have a history of drug and alcohol abuse, but now do not.
9	CDC	Non-First Nations	M	60-69	2hrs, MID	1hr NOVEMBER	CDC-9 has severe disability related to chronic health conditions, past work injuries and a history of violence.
10	CDC	First Nations	M	<20	3hrs, MID	1hr DECEMBER	Interactions with CDC-10 were limited to certain shared volunteering activities only

							due to cultural division of gender-norm requirements, especially prominent as CDC-10 is an unmarried initiated man. Interactions include their family members during all non-recorded interactions (only the recorded interview was conducted alone with family permission and whilst doing an approved shared activity). CDC-10 has a history of being a 'ward of the state' in their youth, where they spent much time in foster care.
11	CDC	Non-First Nations	M	40-49	5hrs, HIGH	1hr DECEMBER	CDC-11 has no family in Ceduna as they moved to the town a number of years ago. They occasionally experience some discrimination by different community members.
12	CDC	First Nations	F	60-69	1hr, LOW	30mins DECEMBER	Interactions with CDC-12 were limited due to chronic health issues CDC-12 was experiencing with increasing intensity. CDC-12 is a respected member of their family and language group.
SERVICE PROVIDERS						**2020**	

13	SP	Non-First Nations	M	50-59	6hrs, HIGH	1hr FEBRUARY	SP-13 is a retired service provider having lived in Ceduna their whole life.
14	SP	Non-First Nations	F	50-59	2hrs, MID	Notes only, FEBRUARY	SP-14 is a manager and has worked in Ceduna for some time and travels frequently for work between Adelaide and Ceduna.
15	SP	Non-First Nations	F	20-29	3.5hrs, MID	3hrs FEBRUARY	SP-15 is not a manager and has been working and living in Ceduna for approximately one year, they are soon to leave Ceduna and their role.
16	SP	Non-First Nations	M	30-39	>10hrs, HIGH	1.5hrs FEBRUARY	SP-27 is a manager, they have been living and working in Ceduna for approximately 3 years.
17	SP	Non-First Nations	F	50-59	>8hrs, HIGH	1hr FEBRUARY	SP-17 is a manager, they have been living and working in Ceduna for most of their working life.
18	SP	Non-First Nations	F	30-39	5hrs, HIGH	1.5hrs FEBRUARY	SP-18 is a manager, they have been living and working in Ceduna for approximately 10 years.
19	SP	Non-First Nations	M	30-39	3hrs, MID	35mins FEBRUARY	SP-19 is a manager, they have been living and working in Ceduna intermittently for much of their working life.

TOTALS:	12xCDC 7xSP	FN: 8 (CDC) NFN: 11 (7xSP, 4xCDC)	F: 11 M: 8	<20: 2 20-29: 1 30-39: 6 40-49: 2 50-59: 3 60-69: 5	Low: <2hrs (3x) Mid: 2-4hrs (8x) High: >4hrs (8x)	Av: 1hr 25mins approx. per formal, audio-recorded interview (Not per participant) • 35 mins (2x) • 1 hr (8x) • 1.5hrs (4x) • 2hrs (4x) • 3hrs (1x)	

^/*all in same interview for full or part of interview duration; FN: First Nations; NFN: non-First Nations.

5.5.4 Interactions with Participants to Learn About Their Lives

To better capture the broad contextual complexities of participants' lives, I used informal interactions via actively embedded *participant observation* and *formal interviews* as strategies to understand how people see their worlds, interacting with people repeatedly over time. Doing so better allowed me to understand how participants determined their life contexts and the issues they may experience, regardless of only focusing on the CDC. Gaining this insight then allowed a clearer understanding of how the CDC fit into recipients' lives and illuminated the processes and mechanisms through which the CDC worked to influence their broader life contexts. The following sections explain data collection and analysis methods in detail.

5.5.4.1 Talking with people: Conversational and Open-Ended

In keeping with methods outlined in Table 6, this part of the research employed a conversational (Guerin, Leugi & Thain, 2018; Hoffman, 2007), open-ended style also often described by some academics as an 'in-depth' (Brounéus, 2011; Johnson, 2001; Osborne & Grant-Smith, 2021) which has been suggested as similar to a Yarning interview strategy (Bessarab & Ng'andu, 2010; Tedmanson, 2016; Walker, Fredericks, Mills, & Anderson, 2014). This was considered suitable for both Aboriginal and non-Aboriginal participants, with similarities to Yarning as method discussed below. The same techniques were applied to *formal interviews and informal conversations for all CDC recipient and service provider participants*.

The interactions with people in Ceduna happened repeatedly, over time and through different ways of talking with and observing people. Some of this talking was in *formal interviews*, and much of this talking and observing happened informally during *participant observation* alongside people in their daily lives, which some have described as Yarning described further below (Bessarab & Ng'andu, 2010; Tedmanson, 2016; Walker et al., 2014). The two categorisations of interactions with both the CDC recipients and service providers, are outlined here and elaborated on below:

- Informal Interactions: Participant Observation – comprised of field notes and jottings relating to *observation in action* paired with *informal conversations* where the two occurred simultaneously. These conversations are described as informal as they were

not audio recorded and occurred without being planned. Conversations included discussing information relevant to the CDC and peoples' life contexts but were not always directly related and often went off topic, which provided insight into broader life contexts in a very relaxed way. Permission was sought to include such information in the study when such conversations occurred. Observations included jottings at the time or as soon as feasible after field observations were made in the field, where longer and more descriptive notes were then written up later prompted by jottings. These field notes became the *informal interactions* data and were aimed to inform and help contextualise the experiences and voices of participants. Observations and informal conversations *repeatedly* occurred throughout the time spent in Ceduna. Informal conversations were conversational, open-ended and often in-depth regarding what was discussed.

- Formal Interviews - Open-ended Formal Participant Interviews: Interviewing where conversational interview data were digitally recorded using a recording device totalled 26 hours across all participants. The term formal relates to these interviews being *audio recorded* and effort made to *organise a time* to sit and talk specifically for research purposes. Formal interviews occurred *once* per participant after having informally interacted with them for some time prior, meaning we had gotten to know each other somewhat and were comfortable interacting. These interviews were aimed at directing discussions toward the research questions in a more 'formal' setting, where I could ask questions about events and behaviours I had observed, specifically about the CDC. Formal interviews were conversational, open-ended and often in-depth.

The distinction between the two ways of talking with people for this project is that informal conversations were treated similarly to formal interviews regarding potential questions and directional flow of conversation where suitable. Although dissimilar to formal interviews, informal conversations were not planned and happened whilst doing something with someone in the process of them living their life. Informal conversations did not assume the format of sitting down for an organised formal interview. Observations can include conversations but are more about what I, the researcher, actually saw happening. Informal conversations provide an opportunity to ask about what is seen in action, with formal interviews an opportunity to further interact and reflect with the participant about these things (Hockey & Forsey, 2020). Alongside building trusting relationships with participants, both formal and

informal strategies of talking with people were combined in this study. This combination mitigated the limitations of each, as addressed below, thereby strengthening the reliability of overall study outcomes.

5.5.4.2 Conversational, Open-ended Interactions

For both the informal and formal interviews or forms of engaging with people, I employed conversational, open-ended (otherwise described as unstructured) interviewing, which is defined as a form of qualitative interviewing where the respondent can direct and more freely discuss or share their story about what they believe as important, relative to more rigid, directive forms of interviewing (de Marrais & Lapan, 2003; Patton, 2002, p. 341). Conversational, open-ended discussion can also be in-depth, where the conversational strategy can be used in an empowering and non-judgemental way of interacting with people in a more relaxed format (de Marrais & Lapan, 2003; Johnson, 2001; Osborne & Grant-Smith, 2021). In-depth interviewing is often defined as conversational and open-ended in approach, similar to how one would speak with a friend, including sharing elements about yourself as researcher, however more directed and with the aim of collecting and using data (Johnson, 2001).

Johnson (2001) argued that the application of conversational in-depth interviewing is best suited to research seeking insight that can be highly conflicted, political or emotional, and where complicated multiple subjective perspectives exist about a topic. Such is the case in this research, where the CDC is considered highly political (Hunt, 2020; Klein, 2016b). Further, the CDC, like other phenomena, is argued as perceived and experienced very differently by different people and groups. Moreover, in an attempt to grasp how people describe the influence of a particular phenomenon in their life, this often involves people sharing emotional or difficult stories about themselves (Brounéus, 2011; Osborne & Grant-Smith, 2021).

Although not specifically used as a data collection method, similarities in conversational interviewing can be seen in the method of Yarning (Bessarab & Ng'andu, 2010; Shay, 2016, 2021; Tedmanson, 2016; Walker et al., 2014). Yarning is often used as an interview method when interacting with Aboriginal communities, but its use in settler-colonial contexts is not without concern (Murrup-Stewart et al., 2022). Inspiration has been drawn from the application of Yarning as method in this study, however, was not applied explicitly as a

method of interaction. Yarning seeks to capture holistic and contextual knowledge about a person's experiences in their own world (Bessarab & Ng'andu, 2010; Shay, 2016, 2021). To yarn is to have a conversation, with understandings emerging from a coming together of shared meanings (Tedmanson, 2016). For example, Bessarab and Ng'andu (2010, p. 38) describe Yarning to mean "When an Aboriginal person says, 'let's have a yarn', what they are saying is, let us have a talk or conversation. This talk/conversation/yarn can entail the sharing and exchange of information between two or more people socially or more formally". Yarning about life experiences through storytelling allows the participant to explain their life contexts and how their life and who they are, came to be (Bessarab & Ng'andu, 2010).

The method of Yarning has been identified as an effective and culturally appropriate conversational approach to narrative-based interviewing with Aboriginal Australians (Bessarab & Ng'andu, 2010; Walker, Fredericks, Mills, & Anderson, 2014). Where Yarning includes ongoing, reciprocal dialogue, the approach helps to create "mutually shared accountability", strengthening relationships between all involved in the research (Tedmanson, 2016, p. 80). Others such as Murrup-Stewart et al. (2022) challenge the inaccurate use of Yarning as method in settler-colonial spaces by non-Aboriginal persons. They argue that too often, the inclusion of Yarning is misinterpreted or misused where instead, the focus is on interviews and the method used as a catch-all term to infer capturing the depth of Indigenous knowledge.

Murrup-Stewart et al. (2022, p. 787) suggest that devaluing of Yarning can occur where they suggest that "power issues arise with the character Settler-Colonialism claiming ownership of the Yarning method via an assumed entitlement to use it and using Aboriginal peoples as research resource, all under the guise of virtuous activity". I have drawn a guiding frame of inquiry from the method to improve reflexivity through the research process. This meant that I engaged with people in an open-ended and ongoing way, remained transparent about who I was and the research process and made myself available to discuss the research and incorporate recommendations for any changes to my own behaviour (outlined in Section 5.5.1) and the research process should the need arise. On one occasion, after learning of a community member's death, this meant I withheld from interviewing participants out of respect for community grief processes, resuming when told it was suitable to do so (further reflected on in Chapter 6). To ensure accuracy and inclusion in meaning regarding describing how I interacted with people in this study to collect data, I use the terms conversational

interviewing and interactions. I use these terms to include the multiple ways that such similar researcher-participant exchanges have come to be known across fields and groups and hopefully to diversify the data captured in its origins and refrain from making social policy an 'Aboriginal issue'.

5.5.4.3 Combining the Informal and Formal

Participant observation is one process of interacting with people involving informal conversational talk and observations of people, repeatedly over time, as they go about their lives (M. Atkinson & Coffey, 2001; Bohannan & Van der Elst, 1998; Ingold, 2014). Guerin et al. (2018, p. 77) suggest that attempting to understand what is happening in a person's life requires a contextual understanding of events and conditions, as well as getting someone to describe how they see these events and conditions. To do this, M. Atkinson (2016) suggested that only relying on formal interviews does little to provide broader contextual information about social conditions around a person. Additional methods need to be used, such as direct participant observations and conversations with people about what is observed, done so over extended timeframes and in diverse settings of a person's life (M. Hammersley & P. Atkinson, 2019).

The distinction between these two forms of talking with people, either informally or through formal interviews, is argued by Hockey and Forsey (2020, p. 71) as necessarily separate yet complementary. They suggest participant observation's mostly informal conversation approach, although useful, can more accurately be described as 'engaged listening' and is limited as a form of enquiry on its own. This is because we need to ask people directly about what we see and hear in an organised form that complements the informal to accurately interpret why people do what they do. Hockey and Forsey (2020, p. 83) suggest that to overcome the distinction between what people say and do, engaging formal interviews in participant observation fieldwork can capture how participants experience distinctions and provide clearer insight regarding how they can navigate their lives.

5.5.4.3.1 Interactions as Social Relationships in the Field

However beneficial the combination of formal and informal interactions is, an issue is taken here regarding *how* interactions are conceived as involved in generating data. There remain assumptions in arguments by Hockey and Forsey (2020) that relationships lead to

interactions, and these are somehow separate. Instead, it can be conceived that the interactions are another form of relationship unto themselves, and the relationships we have with people are what we describe when we try to define what, how and who we 'interact' with in the field. These relationships are influenced and created and change through the actions we do. Actions include how we talk and how we observe in the process of doing research, discussed in relation to positionality and access discussed above. Thus, formal or informal interactions can be described as formal or informal relationships with people, where the relationships are not static but shift and change depending on a myriad of factors, inclusive of setting and purpose.

We can conceptualise the need for both formal and informal interactions with people here as an extension of what it means to be an *active embedded participant*, described in detail below. This research's original methodological contribution is partly the categorisation of *what the researcher actually does in their interactions with people and what this means for what we can learn from the data*. Here, we can further conceptualise what we mean by *active embedded interactions* by focussing on what different *interactions* represent in reality in the field. These interactions can be understood as different types of relationships we have with people, where these relationships can be defined in part through how we interact to collect data. Formal interviews and informal interactions each require particular and different actions, be they (un) organised and (un)structured, where each can define the type of relationship we may have with a person *because* of these particular and different actions/behaviours. Here I argue that how we come to define different forms of interaction categorised across forms of participant observation, can be better understood as the types of relationships that generate data. Therefore, what we can learn from data relates to the types of relationships we have with people in the field, and diversifying these types of interactions may diversify what we can learn about how participants experience the influence of policy in the diverse contexts of their lives.

5.5.5 Informal Interactions

The following Section discusses employing informal conversations and observational data collection strategies, as outlined earlier in Table 6. I separate these two elements of participant observation here in semantics only in an effort to describe more directly what I did and why.

5.5.5.1 Participant Observation

I actively participated with people in aspects of their lives, observing and listening with people about what was happening or had happened across various shared activities and settings. I did not seek to remain actively distant, as described further below, but instead become embedded with the daily processes of people's lives as best and as much (or as little) as I was invited to. I did so to understand the contexts of people's experiences from as close to their perspective as I was able to grasp. Much like observant participators discussed below, the nature of the field in Ceduna shaped my role as an observant type of participator. I was encouraged by social dynamics to become an embedded part of life in Ceduna and to do behaviours within my volunteer role that fit into local social norms.

Hockey and Forsey (2020, p. 73) argue that participant observation is often employed in an ethnographic approach to produce an ethnographic product. However, participant observation has also been described in various ways (Brewer, 2000; Gobo, 2008; M. Hammersley, 2007b; Hockey & Forsey, 2020; O'Reilly, 2005), where participant observation primarily relates to repeatedly talking with and observing people. In participant observation, 'talk' mainly relates to informal conversations occurring in the field and does not often include the more structured formal interviews (Hockey & Forsey, 2020). Agar (2008, p. 156-7) and Brewer (2000, p. 88) describe observation as a counter to only capturing talk or what people say because sometimes people say and do things that may appear contradictory at times first glance. In acknowledging that there is often a distinction between what people say and do (Hockey & Forsey, 2020), Agar (2008, p. 157) contends that we cannot clearly understand what we observe without talking with people "before, during and after". In this way, the separation of talk and observation is arbitrary. Instead, they are inherently linked and, in combination, are a way of interacting with people to more accurately understand how people experience their lives (Ingold, 2017; Shah, 2017).

The degree or type of observation and conversation in participant observation may vary significantly depending on the context. Three general categorisations of participant observation reflect degrees of active or inactive engagement with participants and are conceived here regarding how they may influence types of relationships. These are described in detail below and summary here as the:

- *Researcher as Inactive participant* - mainly observing as a ‘fly on the wall’.
- *Researcher as Actively Distant participant* – participating in activities with people but also frequently actively distancing themselves to observe and not participate; and
- *Researcher as Active Embedded participant* – the observant participator, becoming a part of through doing things with people and not distancing to observe.

These categorisations relate directly to descriptions of what the researcher actually does in their interactions with people, framing interactions as influencing types of relationships, and what this means for what we can learn from the data.

5.5.5.1.1 Types of Participant Observation

A participant observer can be described as either an active or inactive participant. An *inactive participant* means that the researcher's position resembles a person who 'hangs around' and primarily observes but does not actively participate much in the daily lives of the people being observed (Gobo, 2008; M. Hammersley, 2007b; Seim, 2021). Some have described such inactive participation and its primary focus on observation as a form of objectively determining truth when done unobtrusively to avoid influencing participants (R. Lee, 2000). This approach mostly applied to conventional forms of participant observation interactions often attributed to anthropological methodologies prior to the reflexive, post-positivist turn occurring in the 1960s (Brewer, 2000; Gobo, 2008; Madison, 2005; O’Reilly, 2005). However, later post-positivist efforts have challenged the idea of singular truth and objectivity (P. Atkinson et al., 2000; Cannella & Lincoln, 2009; Clandinin, 2007; Gubrium & Holstein, 2003; Kincheloe & McLaren, 2011). Such inactive observation relies only on the subjective inference of meaning from the observer, which may be limited to its worldviews, restricting the scope of understanding why someone does what they do (Cannella & Lincoln, 2009, p. 56; Kincheloe, 2005; C. Lee, 2012; Neysmith, Bezanson, & O’Connell, 2005).

Researchers can also be described as an *actively distant participant*, who may be present and actively engaged in an activity, participating, not only primarily observing. However, even during such active participation, they may routinely attempt to step back mentally and physically from an activity to note things down, describing what they see happening and sometimes inferring meaning (O’Reilly, 2005; S. L. Schensul, J. J. Schensul, & M. D. LeCompte, 1999). Such active participation can be better conceived as remaining *actively*

distant, common in contemporary participant observation, reflected in 'stepping back' to just observe. When active participant observation is suggested as requiring the researcher to remain *actively distant,* this may not always actually be suitable in making sense of what we observe. There may be times when (in)actively, or distantly standing by, watching and writing down what we see happening in front of us may be inappropriate, cause disruption or suspicion, and impede our understanding of what we see in context (G. Harvey, 2021).

As was the approach employed in this study, the *active embedded participant* researcher can be described as becoming a part of what and who is being studied as an active participant without removing oneself. This approach is argued as beneficial in improving our contextual understandings of behaviours and events. Guerin et al. (2018, p. 80) argue that social research embracing participant observation requires an active or 'hands-on' approach over extended timeframes, building relationships with people and learning about the contexts and conditions of their lives. Wacquant (2015) reasoned that at the very core of being an ethnographer, we must acknowledge that how we come to know relies on the body of the researcher as the interface of experiencing the field. Wacquant further explains that because the body is the interface, to gain a deeper insight into understanding social phenomena, the researcher must get as close as possible and should “dive into the stream of action to the greatest possible depth, rather than watch it from the bank” (Wacquant, 2015, p. 5). To become an embedded, active part of life, see and hear and improve my contextual understandings of peoples’ experiences, actively participating alongside people is argued as necessary (Agar, 2008; Bohannan & Van der Elst, 1998; Brewer, 2000; Madison, 2005; O'Reilly, 2009; O’Reilly, 2005).

Active, embedded forms of participant observation have been generally defined as becoming an embedded part of the lives of people being studied, sometimes inverting the traditional term to *observant participation* (Seim, 2021; Wacquant, 2015). 'Becoming a part of' means getting inside of day-to-day life, such as living with people, or working as an employee, or volunteering in a role or organisation you are researching, as was done for this study. Belonging and access require us to do behaviours considered acceptable and required as 'normal' behaviour for a group, thus, where we seek to gain access, behaving according to group rules becomes required (Agar 2008, p. 158-9). However, forms of observant participation will greatly depend on what is available and realistic in the field itself,

sometimes confounded by the ethical need to avoid social hazards such as illegal activity (Agar, 2008; Dickson et al., 2004).

5.5.5.2 Observations and Reflexivity

My active embedded participant observations inherently included informal conversations. I actively participated in the daily lives of many people in Ceduna. To attempt to remove myself, whether wholly or intermittently, as if I were observing the action as a fly-on-the-wall, so to speak, is to ignore the critical constructivist worldview of the existence of subjective and diverse realities and their influence. My subjectivity involved actively experiencing whatever I was doing alongside participants. Doing things with people also formed a large part of gaining a sense of their worlds on their terms. Once I had begun the journey of becoming engaged in participants' lives, I realised that standing back to observe people doing things was to create a deterioration of insight, trust and relationship. This engagement is also important because my ability to engage in sense-making relied on giving back and immersing myself in the local context.

To watch and write down from a distance would be problematic. It was considered suspicious because such behaviour was attributed to the social division between consumers and distributors of services: for participants, the people who 'dobbed you in' wrote things down about you and did not get to know you. Being a traditional participant observer would not work in my study. In this way, being embedded, reflexive, employing conversational informal and formal interactions, alongside my positionality and self-disclosure discussed earlier in Section 5.5.1, also worked to redistribute power between myself and participants (Call-Cummings & Ross, 2019; Karnieli-Miller, Strier, & Pessach, 2009; Thambinathan & Kinsella, 2021). Power imbalances between the researcher and the 'researched' may be unable to be removed entirely due to the nature of doing research necessitating a person learning and a person being learned from (Call-Cummings & Ross, 2019). However, redistributing this power toward improved power-balance can improve ethical practice and enhance what can be learned through the research process. Such efforts are described as occurring through researcher reflexivity which is inherently linked with positionality and how we relate to participants and communities as researchers (Call-Cummings & Ross, 2019), described further in sections above.

My notes in action on observations were brief, often shorthand, when no one was around and done in between driving someone home and going on to the next designated volunteer activity. Notes were often added to later and primarily consisted of self-reflection as I monitored my reactions and potential for 'othering'. Occasionally, when a person explicitly may wish for me to write something down during an informal conversation, my hands were often making lunch or driving the steering wheel and writing at that time was just not feasible. Although whatever was written down was checked with participants as soon as possible afterwards, usually at our next meeting, where I was able to ensure they were ok with the accuracy and reporting of what I had written. This also helped to rebalance power between myself as researcher and participants as the tellers of their own story through transparency. In relation to community informants, this information was mostly jotted down anonymously at the time and checked with them then and there for the same reasons and because there was likely no chance for follow-up afterwards.

5.5.5.3 Informal Conversations

Informal conversations were not digitally recorded and generally happened in an ad-hoc fashion as directed by participants. Direction by participants includes where participants would seek me out, generate discussion, and inform me of their wish to include their experience in the study. Such interactions include observations, where I would be helping them with something such as cooking a meal, driving them home or babysitting their kids. If I wanted to understand complexities, I needed to interact in a way that the participants directed which can include doing things with people and simultaneously talking about and observing events in action (Seim, 2021; Wacquant, 2015).

On some occasions, it was not always appropriate to be writing things down due to the location where the interaction may occur and who was able to see our interaction and any issues that may arise because of it, such as issues with domestic violence. Concerns for the anonymity of participants in a small town were paramount, and often interactions could not always occur away from other community members. During such times I did not have a notebook out to write things down, but instead wrote notes immediately after our interaction, a strategy accepted by field-based ethnographers during such interactions (Carspecken, 1996; Gobo, 2008; M. Hammersley & P. Atkinson, 2019).

The total hours of informal conversations are approximately 45 hours, with all participants combined. See Table 8 regarding participant characteristics for individual information regarding levels of interactions with each participant.

The length and richness of description of informal conversation notes varied, often dependent on the activity or location where the interview occurred. For example, as discussed above regarding shared activities, writing full notes during an interview was impractical where we may have our hands busily making sausage rolls. During such times, brief notes or quotes were taken where possible and permitted during an interaction.

Informal conversations remain a useful form of corresponding with people in this study. All participants welcomed being digitally recorded once. However, conversation appeared to flow more freely for participants when they were not being recorded. This ease of conversation without an audio device present during conversational ethnographic interviews is not uncommon (O'Reilly, 2005, p. 150). People expressed being more relaxed without a digital audio recorder present, which became especially prominent the more our relationships developed. Informal conversations often elicited information not readily shared when being interviewed formally with a recording device, a common phenomenon among other qualitative social research efforts (Neuman, 2013). Although noting interviews has its limitations, informal conversations and observations were effective in helping to contextualise how people live their lives. In all instances, I ensured participants had provided full and informed consent before noting anything of our discussions, and all participants had access to my write-ups of our discussions.

5.5.6 Formal Interviews

Alongside the informal interactions during active participant observation discussed in sections above, I used formal interviews methods as another strategy to understand how people see their worlds. Formal interactions occurred through formal qualitative interviews, Formal meaning that these interviews were scheduled with participants and were audio recorded. These formal interviews used the same unstructured, conversational approach as outlined in section 5.5.5 regarding informal interactions during participant observations, and in sections below.

A qualitative research interview has been described as one of the dominant ways of interacting with people, particularly individuals, in the course of doing social research (Kvale, 2007). All these forms of interviewing rely on the researcher to create a moment in space and time in which they conduct the interview, sometimes audio recording what was said, controlling who may or may not be present to some degree. In this way, the interview itself can be conceived as a form of formal interaction that is controlled and managed somehow, distinct as a form of interaction with participants outside of other interactions. Interviews are described as a type of conversation and a way of finding things out about people that we cannot always observe (M. Hammersley, 2008). Many different forms of qualitative interviews aim to learn about a person's reality or perspective differently. Conversational, open-ended interviewing is one form of interviewing strategy that offers the greatest flexibility in researcher inquiry (Patton, 2002). Such is the approach applied here to elucidate information that may have gone uncaptured during more rigid or structured approaches to inquiry outlined as common throughout Chapter 3.

As outlined in Chapter 3, previous research regarding the CDC mostly used other more controlled approaches to interviewing, which mostly rely on the formation or type of question posed but do not always allow wide exploratory exploration of phenomena (Roulston 2010). These include structured or semi-structured interviews, where questions are open-ended yet remain fixed or standardised across all participants; and the general interview guide approach, framing inquiry around topics, allowing moderate flexibility in inquiry (Patton, 2002).

5.5.6.1.1 Framing Interview Questions

There remain several different names of strategies for how to ask whatever question may be relevant during a conversational interview as outlined in section 5.5.4.2 (Madison, 2005, p. 26-30) which broadly relate to those outlined by Agar (2008). Even when prepared, guiding interview questions were not always used. Such questions are often developed to ensure the researcher prepared for the complexities of conducting qualitative, conversational open-ended interviewing, a recommended strategy supported by (de Marrais & Lapan, 2003, p. 53) and Schensul, Schensul & LeCompte (1999, p. 136). Agar describes the need for the researcher to not necessarily rely on a defined list of questions as interview preparation. Instead, the argument is made to prepare potential strategies for asking questions relating to

probing or follow-up depending on the flow of conversation (Agar, 2008, pp. 140-4). These strategies supported by Agar include asking questions that relate to: checking distribution of events; probing estimates of shared values; contrasting; making statements that frame participant understanding; and linguistic strategies aimed to explore meaning and value of niche language that may arise.

Although interviews may help provide insight into how people describe their worlds, they are not without limitations and critique. M. Hammersley (2010, p. 91) outlines contemporary limitations arising from broad academic debate about using interviews as the sole form of research information. Issues include whether participants are telling the truth (Bohannan & Van der Elst, 1998; Dean & White, 1958); arguments of incompleteness relative to observations (Becker & Geer, 1957); and distinctions between what is said and done (Hockey & Forsey, 2020). Further critique also argues that the interview alone represents a 'social occasion' limited to that moment and cannot account much for broader structural contexts (Murphy et al., 1998, p. 120). Guerin et al. (2018) suggest that these limitations are confounded by only ever interviewing a person once rather than repeatedly. Other concerns are argued to relate to interviewees' performative actions, where talk itself as a behaviour has social effects, designed in part to convince or persuade as opposed to present facts alone (Hammersely, 2010, p. 91).

General guiding questions were prepared to assist and guide the interview in association with the research questions posed. There were two broad questions/lines of inquiry designed to ensure the participant could respond in whichever way they preferred regarding what they deem as important:

- Tell me about Ceduna and your life in Ceduna – aimed to ascertain existing conditions
- Tell me about the CDC – aimed to direct discussion toward the target policy

Additional potential questions included the following and were framed to help contextualise the influence of the CDC in relation to the study's research questions. Potential questions prepared included the following:

- Tell me about Ceduna, tell me about the people here?

- Tell me about (your) life, how is the/your day going today/yesterday/general?
- Has it always been this way? when/why did these feelings/things change (if they changed)?
- What have you seen/experienced (that makes you feel this way), what is an example of what happens/doesn't happen?
- If you speak with others about the card, what are the typical/common things talked about?
- What is it about the CDC you like/don't like? Why?
- How can/cannot people/you use the card?
- Are there other things important in your life other than the card? If so, what things and why?
- What do people in Ceduna need? How do you think that would help people?
- What supports happen already that work well for people? Tell me about that
- When support is good, what makes it good?
- What makes for bad support? What happens that makes it so bad?
- What do people do when things are bad/good?

The purpose of this research about the CDC included gaining insight regarding how people explain the influence of the CDC in their lives. Meaning that to do so adequately a person needed to be able to define for themselves what things they determine to be significant, as outlined throughout review of methodological limitations in Chapter 3. Subsequently, an open-ended and conversational approach were positioned as most suitable as they empower the person to tell their own story, explaining events and issues as they see fit (de Marrais & Lapan, 2003; D. Turner, 2010).

5.5.6.2 Formal Interview Duration

I did not have a pre-organised timeframe required for formal interview duration however, I anticipated interviews would range between 1-3 hours in length, based on advice from other social researchers conducting similar conversational interviews. It remained paramount that I work with participants within the confines of their lives and do my best not to dictate set times or duration for our interactions.

Formal interviews equate to approximately 26 hours across all participants combined. Individual formal interview duration ranged between approximately 35 minutes to 3 hours which is further outlined in participant characteristic Table 8. The average time of audio recorded interview duration for all 19 participants was approximately 1 hr 25 mins, with typical duration between 1-2 hours and some up to 3 hours.

5.5.6.3 Formal Interview Locations

The location of recorded interviews varied, with most interviews occurring in an agreed-upon public location. Discretion during audio recording involved positioning the audio recorder inconspicuously out of general view to ensure relative community anonymity regarding their participation (with the participant's knowledge, I put my hat over the recorder). Some interviews occurred in the participants' household where this was their preferred location, and it was deemed safe for me to do so.

5.6 Data Analysis

Reflexive thematic analysis was employed to analyse data in this research (Braun, Clarke, Hayfield, & Terry, 2019). Participant narratives, combined with observations, directed the identification of themes rather than structuring the interview based on predetermined areas where certain themes are already in mind. Once interview data were prepared and checked for accuracy, the first three rounds of coding for patterned themes began.

5.6.1 Informal Interactions

Observation and informal conversation data were collected through handwritten field notes and jottings. These notes were coded alongside the formal interview data.

5.6.2 Formal Interviews

Digitally recorded interview data collected from all participants were transcribed and then analysed by the same researcher using a process guided by reflexive thematic analysis and aided by NVivo 12 software. Digitally recorded interviews were transcribed verbatim using Microsoft Word and checked for accuracy against the recording before coding and transferral into NVivo 12 software.

5.6.3 Reflexive Thematic Analysis

In this research, I have employed reflexive thematic analysis as the process by which to assess, categorise and make sense of collected data. In general terms, thematic analysis aims to identify recurrent concepts within qualitative data, whereby researchers intuitively organise/code data into groupings or themes based on similarity (Creswell, 2009; Franzosi, 2004; Patton, 2002; Patton, 2015). Thematic analysis is suggested to have different schools of general approaches, with Braun et al. (2019, p. 843) explaining three primary procedures to undertaking thematic analysis: a reliability, a codebook, or reflexive approach. In general terms, descriptions of each can place the approaches along a continuum (Braun et al., 2019). Where exploratory, inductive, reflexive, flexible, and embedded engagement apply to the reflexive approach. The reliability and codebook approaches reflect traits such as deductive, generalisable, objective and hypothesis testing more associated with partially qualitative or quantifiable qualitative research.

The reliability and codebook approaches can be conceptualised as a partially qualitative investigation, often using questionnaires, where codes or themes are pre-ordained and drive the coding process, so to ascertain and qualify 'correct' data (Braun et al., 2019, p. 847). Such approaches can be further described as post-positivist and an attempt to bridge the divide between quantitative and qualitative research paradigms. The reliability approach seeks to apply procedures to the thematic analysis process that reflect those similar to quantitative efforts regarding reliability and validity. Such as using multiple coders, coding separately according to an agreed codebook of themes, and the level of agreement between coders calculated using Cohens Kappa (Braun et al., 2019, p. 847).

In contrast, a reflexive approach to thematic analysis reflects the core tenets of my applied methodological approach in this study and is employed here. Braun et al. (2019) describe this reflexive approach to thematic analysis as characterised by the active role of the researcher in the knowledge-making process. They argue that this approach generates themes as outputs of the analysis process, where themes are more than basic summaries and not pre-organised to align with interview schedules or codebooks. The researcher makes sense of the data by remaining reflexive, an inherent quality and requirement for the application of an ethnographic methodology more broadly. The aim is to consider data analysis as inductive and flexible, where 'meaning based patterns' and coding is open and not fixed at the start, and "themes result from considerable analytic work on the part of the researcher to explore and

develop an understanding of patterned meaning across the dataset" (Braun et al., 2019, p. 848).

Exploring and identifying patterned meaning through the analytical work of the researcher is what can often be described by others as intuitively identifying themes in the data (Creswell, 2009; Franzosi, 2004; Patton, 2002, 2015). As noted previously, qualitative ethnographic methodologies require the researcher to become a part of, or embedded within a group, to see beneath superficial explanations of behaviours whilst accounting for the researcher's role and positionality in interpretation (O'Reilly, 2005). Where this is the case, even where we may have some idea based on related evidence, we cannot accurately assume what patterns will emerge before commencing the study. This is because our ideas may be evidenced by reports that fail to adequately capture experiences outside of pre-ordained categories of significance; and subsequently disregard the existence of multiple subjective realities as a consequence. Remaining reflexive to such possibilities requires us to apply open-ended and inductive techniques to data collection and the corresponding analysis to avoid thinking we know what is true (Braun et al., 2019) when the need for singular truth may not actually provide accurate insight into the influence of specific phenomena. Thus, reflexive thematic analysis becomes the aligning approach to making sense of the data collected in this study.

The reasoning for categorising data into patterns of similarity allegedly allows the researcher to attribute meaning to swathes of qualitative data rendering it translatable. For my approach, I sought to provide the reader with clear articulation in-situ that both centralises participant voices while ensuring the reader is aware of thematic links between theme categorisations. How this was achieved is described below.

5.6.3.1 Stages of the Analysis Process and How I Joined Informal with Formal

Three distinct data analysis rounds involved formal interviews and observational and informal conversation data.

5.6.3.2 Phase One

The first occurred iteratively throughout the research data collection process to remain respondent and reflexive to emergent ideas and learning trajectories. This iterative analysis process during data collection is commonly applied during qualitative ethnographic research (O'Reilly, 2005). The reasoning for this is argued as ensuring the researcher's insight into

their research topic develops over time, with a more comprehensive understanding occurring through such a process (Brewer, 2000). This form of initial analysis in-action was conducted in basic prose, in the form of what can be described as memo-ing (McGrath, 2021), or as entries in an analysis field diary (Schensul, Schensul & LeCompte, 1999). This meant that during my reviews of collected data while in the field, I made notes apart from any observational entries that were designed to assist in further stages of my data analysis. These notes were used during the second and more comprehensive data analysis stage, which occurred after all data were collected and I was no longer in the field.

5.6.3.3 Phase Two

The second data analysis phase involved significant time spent reading and re-reading through formal interviews and observational and informal conversation data. The secondary process consisted of two distinct parts: the first involved the hardcopy analysis of all data, the second involved the digitisation of hardcopy analysis, involving checking, re-coding and analysis using NVivo 12 qualitative data analysis software. There were two reasons why the second phase was split in this way. The hardcopy analysis saw me print, note, highlight and cut and paste hardcopy interview quotes, and observational and conversation notes. I did this because for me, the tangible immersion of being amongst the data in a physical way, allowed me to see the data as a total body of work. I was able to see the whole story at once, read, move, touch and see the data on paper, making connections and using analysis notes from the first initial phase to direct and highlight patterns within the data. This hardcopy process also allowed me to identify things or patterns I may have missed and ensured I could question myself regarding why and how I had come to notice or interpret the data in relation to my own subjective reality of interpretation. This hardcopy secondary phase allowed me to begin to make sense of the ‘mess’ of complex and sometimes seemingly disparate data.

The digital component of the second phase occurred in NVivo 12, where the emergent themes identified in the hardcopy phase were tested and challenged through the use of NVivo 12. To clarify what I mean by the terms 'tested and challenged', the action of entering the hardcopy themes and associated quotes into the software allowed me to check patterns of similarity during the actual process of digitising themes. This repeated and iterative digitisation saw me further clarify themes. At times, the analysis required checking and further assessment to ensure my interpretations were true to patterned themes in the data and not patterned themes purely of my own interpretation.

5.6.3.4 Phase Three

Once the secondary process and digitisation, challenging and checking of themes was completed, I commenced the final process of analysis which involved further analytic challenging, reflexivity and reforming of some themes. During this process, further sub-themes were identified, top-level themes were clarified, and links between interconnected and complex participant experiences within themes were refined. The final phase involved a lengthy review of all data and themes, ensuring nuance and complexity were accurately based on participant voices and experiences and were paired with observational data accordingly. Following establishment of themes, later sense making of the data sought to reposition the data in its broader socio-political, cultural, economic, and interactional contexts from which the policy was positioned as emerging, outlined earlier in Chapter 2, namely those related to social control, deviance and contemporary influences of related ideology. Specific processing of interview and observational data is discussed in the following sections.

5.7 Summary

In combination, the methods, guiding methodology and worldview provided a suitable avenue through which to collect and analyse data to provide responses to the research questions posed. To answer the research questions regarding how participants explain their life contexts and how the CDC influences their lives in those contexts, I employed research techniques guided by a critical ethnographic approach to social enquiry. These qualitative research techniques of conversational and repeat interviewing, active embedded participant observation, and having many informal conversations, were iteratively and reflexively employed overtime to learn about participant's lives and the CDC. Methods align with the critical constructivist worldview in that they are inductive and do not seek to determine a singular version of events or truth but embrace and assess subjective experiences and broad complexities that shape people's lives. The next Chapters present and discuss the findings resulting from the research approach employed. This is done using a critical lens that positions what has been learned within the localised and broader socio-political environment from which the CDC emerges and is experienced.

6 Findings and Discussion

6.1 Introduction

This chapter presents the findings of the research that captures the relevant lived social contexts described by participants, and how and why CDC recipients experience their lives with the CDC added in. This addresses the Research Questions from Chapter 4.

The organisation and coding conventions of data used are first provided, followed by a brief table summarising the themes that inform the findings. The findings are then organised into two main sections within Chapter 6. The first (Section 6.2) explains in detail the persistent social contexts and how they were experienced by participants in their day to day lives. The second (Section 6.3) then details how the CDC influenced recipients' lives when it was overlayed onto these persistent contexts. Discussion of themes identified occurs alongside presentation of findings throughout Sections 6.2 and 6.3, with these findings further discussed in the following Chapter 7.

6.1.1 Organization and Presentation of the Results

The data collected consisted of a large volume of typed and handwritten transcripts and fieldnotes arising from both formal interviews and repeat informal interactions across a 12-month period in Ceduna, South Australia. As outlined in Chapter 5, themes were identified through reflexive thematic analysis and in combination provides responsive insight regarding the research questions posed. Identification of all themes relied firmly on the available data and repeat rounds of data checking via reflexive thematic analysis of participant narratives and observations as discussed in Chapter 5. Theme naming was done by iteratively checking for accuracy of theme name representation against aligning data. The analysis was conducted by the primary researcher. Discussion and consideration of the themes identified was assisted through ongoing discussions with my supervisory team. As detailed in Chapter 5, the initial analysis round was conducted using hardcopies (printed/handwritten) of data and done by hand by me, with the secondary and final third round of thematic analysis being aided by use of NVivo12 software.

There were 19 identified participants in total, 12 CDC recipients and 7 service providers, as well as 48 community informants who shared information but did not want to be identified or

interviewed. Table 8 in Chapter 5 outlined further information including demographics and duration of interactions, regarding each participant. Data was de-identified, so no names are presented. Participant's names are not included alongside quotes, and instead, participants were allocated a participant number unique to them to ensure anonymity and confidentiality. In addition, observational data were drawn from informal interactions and from information shared by 48 community informants. To report observations and quotes from interviews and chatting in the text, each participant was coded as a CDC recipient or service provider and numbered 1-19, and the results coded as reflective of formal (FOR) or informal (INFOR) interactions.

Community informants were not allocated a participant number to further protect anonymity and confidentiality, however alongside these references coded as OTHERS-INFOR, dates are provided to indicate when I interacted with community informants. All these are given in Table 9 for ease of reading the Results.

Table 9: Naming convention for data.

12 CDC recipients	**7 service providers (SP)**	**48 others not wanting to be identified**
Formal Interviews CDC-FOR	Formal Interviews SP-FOR	--
Informal Chatting and Observations CDC-INFOR	Informal Chatting and Observations SP-INFOR	Informal Chatting and Observations OTHERS-INFOR

An example of a quote from talking formally with a CDC recipient is the following and note at the end of the quote a number is added (CDC-13-FOR-**1**). This added number indicates each excerpt of unique data in the findings chapter and is included for ease of reference. Where I am not included in the quote and there is only one participant speaking, the naming convention code is placed at the end of the quote. Where I, or multiple participants, are included in the quote speaking alongside participants, the labels for participants and 'I' for Interviewer appears to distinguish between speakers. Table 8 in Chapter 5, section 5.5.3.4 outlines individual characteristics and descriptors of both the CDC recipient and service

provider research participants to help the reader understand the contextual factors of individual participants. As Ceduna is a small community and most participants are known to each other, every effort is made not to include any information that may serve to identify any individual. Alongside the participant's quote, relevant personal information related to Table 8 is often included to help contextualise that participant's life contexts further. This personal information presented alongside the findings is not exhaustive due to the need to protect a participant's anonymity and maintain confidentiality of their data, where it was determined that doing otherwise in the small town of Ceduna (where many people are known to one another) would risk breaching anonymity and data confidentiality. This decision was made in conjunction with the participants with our discussions, about what could or should be included and what people were happy to have discussed alongside their data, ongoing throughout the research project. How a participant's data is presented as follows, for example:

> CDC-13: well in all of the time that I've lived in Ceduna it's been racist and at the time when Aboriginal people were given the vote, we had the highest numbers of people voting against them of having that right, in the 1960 days, Penong and Ceduna voted against them, them having the right to vote. And to me this card is just a follow through from that same type of attitude. Nothing has changed.
>
> I: nothing has changed over all that time?
>
> (CDC-13-FOR-1)

Informal Interactions Box 1

The data presentation also includes numbered Informal Interactions break-out boxes in this format that highlight a combination of themed informal interactions alongside my own reflections across participants and community informants. This aims to contextualise findings through bringing together informal interactions and reflections that are pertinent to exploring contextual complexities in the region. These are my own observations, and I wanted to make clear the distinction between what I observed and what participants explained to me about their lived experiences of the CDC. The aim of separating these observations using these Informal Interactions Boxes throughout the findings chapter is so to not detract from the significance of participants sharing their

personal experiences relative to my own 'relative outsider' observations, nor confuse their expressions with my own observations. Participant voices were privileged relative to my own observations, hence were made to standout to ensure distinction for the reader.

Alongside the numbering of quotes, at the beginning of each theme, data is given of numerical counts and percentages of participant coverage per primary theme. This information aims to clarify the spread of the theme relevance across the subgroups. Where there is divergence in the data between CDC recipients and service providers this is made clear. Further, the reasoning for presenting the coverage numerically here does not mean to detract from the nuance found within the narratives, nor deduct the participants' patterned expressions as important only as occurrences defined by neat categorisations.

Analysis and discussion of meaning making including linking findings to theory and other research, is included throughout this Chapter 6 in-part alongside the presentation and analysis of data, which is then elaborated upon in the following Chapter 7 – the main discussion chapter.

6.1.2 Overview Summary of Main Themes and Findings

Prior to discussing the findings in detail, a brief summary is provided that outlines the primary themes emerging from the data analysis and the contexts participants explained were significant. The processes of how these contexts interrelate is addressed throughout each theme. These themes are paired with knowledge gaps identified in Chapter 3 and are aligned to research questions. There were six main themes in the results, each of which had subthemes. These are shown below in Table 10 for guidance.

Table 10: The six main themes found in the results with subthemes in relation to the research questions.

Research Question 1: Describing Interrelated Persistent Issues for Cashless Debit Card Recipients and their Community in Ceduna
Theme 1: The Interrelated, Persistent and Limiting Social Conditions
Unemployment
Crime and Victimisation

Substance Use / Dependence: Alcohol
Persistent Discrimination
Poor Mental Health

Theme 2: Problems with Existing Policies
Disconnect Between Social Policy and Lived Complexity
Problems of Specific Policies

Theme 3: Local Social Interactions and Policy Delivery
CDC Recipients Discussing Their Relationships with Service providers
Service providers Discussing Their Relationships with CDC Recipients
Impactful Relationships Extend to those Between Agencies

Research Question 2: Describing the Influence of The Cashless Debit Card on the Card Recipients and Community

Theme 4: The Specific Influence of the CDC on Persistent Social Conditions
Crime and Victimisation
Ongoing Substance Use/Dependence and Policy Circumvention
Exacerbating Discrimination and Historical Racism
Exacerbating Poor Mental Health and Disempowerment

Theme 5: Problems of CDC Policy Interfering with Priority Needs
The CDC Increases Problems of Paying for Housing
The CDC Limits Purchasing of Necessary Household Items

Theme 6: Social Interactions and New Forms of Unintentional Social Division and Distrust Created by the CDC
Dividing Relationships Within CDC Recipient Group and Promoting 'Us and Them'
Dividing Relationships Between CDC Recipients and Non-Recipient Friendships/Family Groups
Social Division and Distrust in Systems of Governance

In succinct summary of the results to follow, analysis of the data found that CDC recipients in Ceduna who participated in this study, experience persistent and complex interrelated conditions. Those persistent contexts are highly interdependent and structural. When the CDC was overlaid onto those conditions in 2016, it did *not* have a beneficial influence in

people's lives as predicted by the policy formulation. Further, the CDC, which focused on specific individualised behaviour changes, did not have any beneficial effect on those persistent structural conditions that are the actual constraints on behaviours. The findings instead show the significance of pre-existing social community relationship interactions as the real catalysts of change, and shows how the CDC in fact worked to *deteriorate* those connections and positive interactions. These deteriorations then work to create conditions which exacerbated existing and persistent social divisions. Having described briefly an overview of the main findings, the details are now set out with responses to the research questions posed in Chapter 4 provided in Chapter 7.

6.2 Describing Interrelated Persistent Issues for Cashless Debit Card Recipients and their Community

6.2.1 Theme 1: Interrelated, Persistent and Limiting Social Conditions

This Section 6.2.1 describes and explains how CDC recipients experienced their lives. These themes and subthemes reflect the interrelated, complex, persistent conditions that CDC recipients and service providers described as important in the daily lives of people receiving, or in need of, social support. This includes how participants explained what is significant in terms of the issues people faced and the persistent hurdles that remained to overcome these issues. The following information presents the subthemes relevant in this primary theme, with frequencies across subgroups outlined in Table 11 below. Differences across subgroups can be seen between CDC recipients and service providers. Service provider's reflections offer a broader view across cases and big picture macro structures, explained through generalised examples of things *they had seen others do* in the process of their work. CDC recipients *discussed what life is like for themselves and things they have done and seen* in the process of living their life however they can.

Theme 1: Interrelated, Persistent and Limiting Social Conditions
Subthemes:

- Unemployment
- Crime and Victimisation
- Substance Use / Dependence: Alcohol
- Persistent Discrimination
- Poor Mental Health

Table 11: Frequency of interrelated, persistent and limiting social conditions.

INTERRELATED, PERSISTENT AND LIMITING SOCIAL CONDITIONS
COVERAGE: 16 PARTICIPANTS, 178 REFERENCES QUOTED

SUBGROUPING	Interview Participant	References	Coverage Percentage (% of Overall Total: 178)
CDC (N=12)	CDC-1	33	18.5
	CDC-2	7	3.9
	CDC-3	11	6.2
	CDC-3 /CDC-4	26	14.6
	CDC-5/CDC-6/CDC-7	19	10.7
	CDC-8	1	0.6
	CDC-9	11	6.2
	CDC-11	7	3.9
	Total: 10	Total: 115	Total: 64.6%
SP (N=7)	SP-13	8	4.5
	SP-14	1	0.6
	SP-15	22	12.4
	SP-16	8	4.5
	SP-18	11	6.2
	SP-19	13	7.3
	Total: 6	Total: 63	Total: 35.4%
TOTALS	16	178	100%

The following data represents participants' expressions of *'Interrelated, Persistent and Limiting Social Conditions'*. Areas discussed under this theme are without direct reference to the CDC. Instead, data analysis shows the broader picture of issues that participants were facing in their lives, which were then overlaid by the CDC policy. All participants directed their primary attention toward discussing the issues faced by people who are in receipt of welfare services and income support payments in general. Issues discussed represent personal experiences of broader patterned structural conditions across the entire participant group inclusive of CDC recipients and service providers. Overall, the core features relate to employment, violence and crime, discrimination, substance dependence and mental health that come to determine dominant *'Interrelated, Persistent and Limiting Social Conditions'* are interrelated and do not exist exclusively.

To situate the specific experiences from individual CDC recipients within a broader context, it is useful to first reflect on how such nuanced experiences can combine. Service providers,

although not experiencing the CDC as recipients, often reflected on this bigger picture combination of difficult life experiences by the people they assist. These reflections included the concern about how complex issues interrelate in context. For example, the CDC and other policies can provide added burdens of stress, exacerbating enduring bad conditions, often making these conditions, in combination with others, more difficult to deal with (link forward to Stress Section 6.3.1.4.1). This intersectionality of experiences is potent in the lives of respondents and figures prominently in responses during interviews.

How these issues intertwine to create difficult situations for CDC recipients can be summarised by reflections from service providers. Analysis shows how these interrelated social issues work to constrain CDC recipients' opportunities to easily overcome those issues or when seeking support:

> The relevance of people's existing life conditions have a huge influence in how people are able to maintain good health/get help – if their environments are not good/supportive or safe, they are not going to find it easy to succeed. (SP-14-1)

> You know, and I will say that even our most high functioning clientele when you actually start to break it down, they still have a bunch of really big complex issues. But there's people with really clear day to day challenges around life and mental health and family violence and parenting skills, comprehension skills, all sorts of things and stuff. (SP-19-2)

> Well, unless you're skilled at navigating the system and you can understand it. And you can go yep, to get my payment. I need to do whatever and when all things are going okay then that's pretty good. You know, people do turn up to the CDP (sic) [community development program] you know when things are going good. So when things are going okay, and if they've got good experiences with those systems, and if they've got basic numeracy and literacy to get them through that stuff, then fine but when they don't it just all turns to shit. (SP-19-3)

6.2.1.1 Unemployment

Participants expressed issues with CDC recipients finding and/or keeping employment. Almost all CDC recipients that were able to work (e. g., not in receipt of a disability support pension (DSP) payment), expressed a willingness and desire to find paid employment. Data indicates not a lack of individual willingness or action, but that there may be other persistent structural barriers regarding finding and/or keeping employment. Data analysis suggests that individual agency expressed in participant's actions to find paid work, are not enough to help overcome unemployment. Persistent employment barriers related to job availability, variety, access and discrimination, all reduced an individual's ability to gain paid employment regardless of their choices.

Interrelated issues with employment and other welfare policies can be exampled by CDC-3 who discussed their experiences of finding and trying to keep, employment. Data analysis reveals the complexities related to why they were having such difficulties doing so. These included needing more flexibility in the type of employment and working hours suitable for their unique circumstances. As outlined in the participant characteristics table (Table 8, Chapter 5) participant CDC-3 was a single parent raising young children at the time with no other family living in the town to provide care for the children overnight and could not leave the young children home alone overnight whilst they (parent) worked in a motel. Such needs reflect evidence of people navigating the accompanying social norms and laws requiring them to care for children in certain ways (Hepburn, 2018). In this instance, such structural social norms, in parallel with other limited structural opportunities related to available job-types, prevented them from accepting employment overnight narrowing the choice of work available. Furthermore, finding employment required interaction with the local job network provider (link forward to Job-Network Provider Section 6.2.2.2.2), which in practice was the reason why they were 'cut' from a suitable job, before the end of financial year, or not hired directly by local businesses:

> CDC-3: I was like I've been looking for work you know, and what they do here is they hire you for so long, but rather than have you long term they cut you off before the next financial year, so when I got my first job here, I was working for one of the motels up on the highway, I would've been there for the whole year but the financial year come up and they cut me before that and yeah (CDC-3 /CDC-4-FOR-1)

I: So will you be able to find a job on your own without them [job network provider]?

CDC-3: Well yeah, what I've been doing is dropping in my CV at motels and hotels and inquiring and places if they've got any job vacancies, they'll send me back to [job network provider] like the motels or the hotels, saying that they only hire through them. And these ones here will only say well what are your circumstances, because I've got the children you see, I need to be here before the kids get to and from school and otherwise I'm still at work when they finish, my babies. Like, I can't be walking home at two o'clock in the morning and have the kids at home by themselves. Plus my safety, if I don't make it home to my kids you know, it's bad for them. And then Centerlink will say 'now you're just blowing it out of proportion'. But you see, for me to work that provides income for me and my children and me getting to and from work, and in the reasonable hours that you'll let me work, because I've got minors, it's up to me. Centerlink they don't care if I don't make it home or not. They're trying to put barriers up. (CDC-3-FOR-2)

Issues with unemployment remained a concern for other CDC recipients as they tried but could not get a job. In this participant's experience they suggest possible reasons may relate to some form of discrimination related to they being a First Nations person as outlined in the participant characteristics table (Table 8, Chapter 5). Participant CDC-5 later explained trying to find employment but not finding a job because of barriers relating to structural racism (link forward to Racism Section 6.2.1.4.1), where issues related to problems with having access to positive social relationships and inclusion in the community. The interplay between discrimination and unemployment has been evidenced by many (Biddle, Howlett, Hunter, & Paradies, 2013; Hepburn, 2018; Larkin, 2014; Larson, Gillies, Howard, & Coffin, 2007; Macedo, Smithers, Roberts, Paradies, & Jamieson, 2019; Trenerry, Franklin, & Paradies, 2012) indicating this experience is not confined to this participant's personal perceptions and is a widespread structural condition. Exampled in participant CDC-5s experiences are their individual efforts and choices aimed at gaining employment being constrained by structural conditions of discrimination:

> I know I've put my resume in the pub, to work in the evening and that, and I never got no phone call, nothing back to say nothing, they've been putting other people on, maybe because I'm too overqualified, that's what I'm thinking. (CDC-5-FOR-3)

Concern of unemployment extended to participant CDC-5s children's future employment opportunities as well. Defences were given highlighting their own parental support for their children's development and showing their awareness of existing evidenced correlation between education and employment. This indicates that lack of such knowledge of educational attainment pairs with gaining employment was not the issue, but instead embedded racism was the problem, also evidenced in other studies regarding ongoing racism preventing access for Aboriginal Australians in the Australian labour-market (Bodkin-Andrews & Carlson, 2016; Guenther, 2021). Participant CDC-5 explain that they know education level can link to employment but express concern that even education may not prevent unemployment due to other issues related to discrimination and barriers in social relationships:

> well I'm not really worried about myself, I know I'm not really gonna get a job now cause of my age cause they do discriminate cause of your age but I don't mind doing paintings and that but I'm just thinking about the young kids growing up, I've always stood by my children and because I was a good role model like I was going to TAFE and I went to school and I sit down and help them with their work and things like that, and talk to them about things you know, yeah, but I'm just that person that won't keep my mouth shut, I'll never get a job in this town! (CDC-5-INFORM-4)

Similarly, to some CDC recipients, service providers indicated that more jobs, and of a greater variety of job types, are needed to help people access employment. However, service providers also suggested that this increase in variety exists alongside consideration related to equity. Specifically, that not everyone may be ready to work in the same way at the same moment in time and this also cannot be ignored when assisting people in gaining employment:

> So we look at what you've just described about, hey, let's not just keep everyone on welfare, let's create jobs. It's the same thing. That money then goes into the economy. So it's just a different way of looking at that. Like, you know, Morrison says the best form of welfare is a job, well let's create some jobs then mate. The thing is you've also got to understand that the people you want to target also might not all be job ready. (SP-16-FOR-5)

Data analysis reflects the interplay between individual choices and behaviours with related structural issues which are out of their control (and hence responsibility). These issues include: gaining employment but not being able to keep it due to technicalities embedded in social norms and related policies; trying but not finding work related to possible discrimination; and there not being enough of a variety of jobs for people who want and need employment related to inherent differences in abilities and job-readiness. Data in later sections shows that access to, flexibility and variety, of types of jobs are also expressed in relation to navigating poor mental health (link forward to Mental Health Section 6.2.1.5).

Many studies suggest that unemployment negatively impacts life satisfaction, mental health, and social well-being by increasing social exclusion and affecting interpersonal relationships. For example, the meta-analyses by Gedikli et al. (2022) explains how unemployment is a social context that impacts how people can live their lives by reducing their well-being. According to the study, individuals who are unemployed are more likely to experience negative emotions, such as stress, anxiety, and depression, than those who are employed, a finding reiterated in earlier research by Bambra and Eikemo (2009). This can have a significant impact on an individuals and their community's overall well-being, as well as an individual's ability to engage in activities that promote well-being, such as exercise, socializing, and pursuing hobbies.

In addition to issues presented here regarding unemployment, many participants are navigating parallel experiences related to issues of violence and crime as shown in the following section.

6.2.1.2 Crime and Victimisation

6.2.1.2.1 Violence

Almost every CDC recipient discussed personal experiences with violence, abuse and/or crime. These personal experiences included being a victim and/or perpetrator or in providing assistance/being a bystander to other people's experiences of these issues. Issues that are addressed here include multiple, complex features of social relationships that prove harmful in some way. Not all violence and abuse are discussed in terms of being 'a crime' by CDC recipients, even though I may understand and describe such behaviours as being a crime in legal definition. Hence the distinction here of crime being separated into its own quasi-category.

Those that did not directly speak with me about their personal experiences were often later described by others in general conversation as having had such experiences before. Participants often described a personal experience and talked about others that were involved or people they had helped at the time. Violence, abuse and crime were experienced directly or indirectly for most participants and were prevalent in the lives of CDC recipients.

For example, as outlined in the participant characteristics table (Table 8, Chapter 5) participant CDC-9 explained the interrelatedness between: their past social relationship issues with people known to them; their violent history as a potential perpetrator *and* victim-survivor of violence; and their worsening health issues and deteriorating living conditions. Although apprehensive in disclosing details of criminality, participant CDC-9 explained some elements of the interplay between the issues in their life that reflect their choices, such as arguing and conflict, and confounding conditions outside their immediate control, such as having belongings stolen whilst away from home. The reasons for being away from home may relate to previous criminal behaviours in this instance, although were not elaborated on by this participant. These issues in combination indicate inseparable and simultaneous reiteration between conditions and choice of behaviours, such as doing and being affected by violence. Combined, the data analysis suggests that the interplay of issues may act as limiters to positive social opportunities and in effect, choices and conditions are self-reinforcing. These interrelated factors indicate the difficulties in navigating complex and conflicting situations that do not appear conducive to having good wellbeing:

> See the thing that lets me down is I was supposed to have stabbed a guy but I, it's more complicated, I was supposed to have stabbed him with a screwdriver, that wasn't me. But my lawyer told me to plead guilty. Well, the incident with my neighbour where I, where I apparently stabbed him. I was having a bit of an argument with another neighbour. Like he came over from next door the screen door was open. And I thought I'd try and calm him down. But he got me. Then he had a gun. I have a very violent past. (CDC-9-FOR-6)

> See, when I left the farm, I was told to go to Port Lincoln for my health. It wasn't my fault that I left and they stole everything. My health got worse. You see I rang the hospital, and I told them that I was either having a heart attack or a stroke. But the cops came, had a warrant [for my arrest], dragged me off, dragged me off the cops did. They took me to the hospital. Got out of hospital one day later got out the taxi. My door been left open, people had just stolen everything, there was some guy walking down the side with my toolbox, my fishing gear they just took what they wanted, they just took what they wanted. (CDC-9-FOR-7)

Other participants discussed the exposure to social relationships as providing opportunities for criminal-forms of behaviours of their family members, and they reflected on the indirect stress this can cause for the broader family unit. Participant CDC-3 describes how friends and family they care for have had contact with the criminal justice system, indicating the subsequent stressful impact on family members of perpetrators. In this case, a son of participant CDC-3 had been convicted as a perpetrator of recent and previous criminal offences. They indicated that opportunities for such behaviour related to the social relationships their son had formed when they moved to Ceduna. Participant CDC-3 was very upset when sharing the following, crying and becoming angry at times:

> CDC-3: when my son got charged they were trying to say that one of the houses that got burgled was a detectives house and he was supposedly home at the time, they changed it as home invasion, so my son went down for all them, they had him locked up for seven months before he even went to jail, they had him in

suspended custody or something, so he was already doing jail time before he even knew what the charges were!

I: so who was this?

CDC-3: my oldest son

I: so he was held in custody for seven months without having seen the charges?

CDC-3: well he didn't know the charges, so what had happened was he was already on a good behaviour bond, and we had left Western Australia and came this way, and all he had to do was behave you know, but he was hanging out with all the runamuk kids in Ceduna. (CDC-3-FOR-8)

In further data, violence extended to self-harm, and serious harm against another person in some rare instances. Some behaviours of self-harm and serious violence resulting in death, had profound ramifications on related family and the broader Ceduna community. Whilst behaviours above regarding participants involvement in violence and crime reflect individual nuance of experiences, behaviours in the observation below reflect how experiences of violence are also shared across community. Violence was thus not only experienced as unique to individuals but was clearly reflected as a shared structural condition contributing to those unique experiences. Violence can thus be considered as difficult to escape for many people as it permeated private and shared lived experiences. The observation below explains how this occurs at the community level.

Informal Interactions Box 1

Incidences of social violence and self-harm and the negative impact on those close to the victims. Many people I came to know, who did not want to be named, deal with violence in their day to day lives. Some people are directly involved in this violence, whereas others experienced violence indirectly through seeing family or friend's direct involvement, or through broader community discussions where most people are known to each other in a remote small town/region. I came to experience violence indirectly through hearing other's experiences, and through observing occasional public violent behaviours.

OTHERS-INFORM-25/09/19 – Situation: fourth visit to Ceduna. Shorter visit. Volunteering continues. I was informed today through two people, both non-participant informants at the time, that there have been two deaths by suicide in the Ceduna community since my last visit. During my first day in town, early in the morning I arrived at a location I was volunteering at for the day. I made myself a cup of tea and went to sit and warm up in the front of the organisation. It was a colder morning. There were a number of end-users milling about, speaking and socialising with one another as I had become familiar with as a normal pattern of behaviours at this time on a Monday morning. The bus had not yet come into town after picking people up from the outer suburbs of Ceduna, so there were not as many people about as there may typically be after 9am. Within a short space of time, some people drifted off and there was only me and two people finishing our hot drinks. One person spoke quietly relative to regular conversational volume, they told me the following:

"Have you heard about that fella that hung himself?", I had said that I hadn't. The other person continued "both white fellas, one was the [prominent local person]". The first person explained the other suicide death, saying "that other whitefella, his missus left him for some other bloke, he hung himself, her family though, they blamed her, set her house on fire". One of these people are extended family of the lady whose house was set on fire. Later I came to learn more about these events, and that these people who died were known to many people in town.

On a later trip, I learned of further violence that required me to refrain from interviewing people for a short time.

OTHERS-INFORM-11/11/19 – Situation: Fifth visit to Ceduna. Two domestic violence murders have occurred in town. Another non-related incident saw a local store also have its front windows smashed overnight and goods were stolen. The break-in aftermath including damage and police in attendance, I observed on my way to an organisation I had planned to visit that morning. I have been in town for approximately one week. Day off from volunteering. I arrived at the organisation, waiting in a communal area before an informal meeting with a service provider. I noticed there what looked like unmarked police vehicles parked on the street nearby, along with many marked police vehicles driving around town. I engaged in conversation with a community member I knew, who was also waiting. They spoke in a hush, they seemed a little distressed in their tone and behaviours, I was told the following:

"Kris, things are bad at the moment, have you heard about what happened? A man died, his wife, she stabbed him", I had asked if this is why there are so many police around, they said "Na that's for the break-in". They continued, telling me that this stabbing had happened last week but it's all coming out now, but this was not the only violent event that had happened recently "it's all so bad, and after that other murder a while back, so sad". We sat quietly for a moment before I asked carefully about this other murder, "oh that was bad, couple of weeks ago, but can't talk about that", I nodded, shared words of sorrow for these losses and did not ask any more questions of this person out of respect. After learning about all this and sitting in silence side by side for a while, I was called into the meeting where I asked if there had been a couple of murders recently. The SP confirmed but declined to discuss the events. After this, I refrained from interviewing people for a number of weeks, only recommencing on advice from many service providers so to not place any accidental additional strain on the broader community.

6.2.1.2.1.1 Domestic Violence

The experiences of domestic violence are expressed by most female CDC recipients. Domestic violence includes a variety of behaviours including physical, emotional, sexual and financial abuse by persons in a domestic relationship (such as caregiver, spouse, child) against a victim (Alderton, Henry, Foster, & Badland, 2020; Fitz-Gibbon, D. Meyer, Boxall, Maher, & Roberts, 2022). These experiences are discussed as having occurred in a variety of ways throughout their lives. Such as describing instances of abuse having happened in the distant past, and that those experiences are still having negative impactful resonance in their lives today.

Evidence more broadly shows that the experiences of domestic violence are common to women and children (Bostock, Plumpton, & Pratt, 2009; Fitz-Gibbon et al., 2022; McCarry & Lombard, 2016) in Australia, and more so to women and/or children who experience poverty (Alderton et al., 2020; Hetling & Zhang, 2010). Indeed, much research suggests that people who claim income support payments in Australia are in effect, living below the poverty line (Morris & Wilson, 2014; Murphy, Murray, Chalmers, Martin, & Marston, 2020). It comes then as no surprise that CDC recipients in Ceduna are likely to have experienced high levels of domestic violence, which data in this study confirms.

Some participants discussed abuse they experienced as a child, perpetrated by members of their own family, which indicates a history of a harmful social relationship that continued to have an influence in current times. For example, although not directly included in the participant characteristics table (Table 8, Chapter 5), participant CDC-1 discussed sexual abuse they experienced as a child by a family member, and how this negatively impacted their life going forward:

> The other life changing moment as I told you was my grandfather's sexual abuse when I was five years old and I had been taught to shut up to say nothing, and to do as you're told and to respect your elders and no matter what they tell you to do that's what you gotta do, and so this bloody predator does what he does, so I had that when I was five then again when I was 8, then I remember my first thought of suicide was when I was 13, yeah so this has been a life long struggle and I'm fucking tired I can tell you I am so tired and I'm so… I've had enough, and I would be happy to die today, I'm happy to die today. (CDC-1-FOR-9)

Some participants described their experiences with domestic violence from their intimate or domestic partner, such as participant CDC-2, as outlined in the participant characteristics table (Table 8, Chapter 5). The mental and physical abuse they endured as a negative feature of this social relationship, confounded their need to receive income support assistance even after the violence had stopped:

> CDC-2: yeah, and that was the same year I was given the DSP [disability support pension], so yeah
>
> I: so the DSP was that in relation to some previous history things?
>
> CDC-2: it was mainly arthritis at that time it was after that I got a whole lot worse cause of the violence, I was a prisoner in my own home for 9 years, couldn't go out, couldn't do any shopping, ended up he wouldn't let me cook either cause he thought I was poisoning him, he would buy me all my clothes at the opp shops, that's when I started knitting and cross stitching and things like that to get my mind off it all, and um yeah, and he had my bank card one night and I went to grab it off him and um…well he shoved me away and I slapped him, half past seven the next morning I had the cops at the door saying that I had

> assaulted him, so that was straw that broke the camel's back, they could see what was going on, yeah. I got out, went to live in a shelter for a bit, before I could find my own place, those ladies at [service provider] really helped me get out. (CDC-2-FOR-10)

Some CDC recipients expressed having witnessed violence/abuse occurring to others and describe some features of positive social relationships that helped reduce the issue. Participants CDC-4 and CDC-5 as outlined in the participant characteristics table (Table 8, Chapter 5), described how they were able to assist through providing a victim with the opportunity to change where the victim lived and thereby reduce the violence the victim experienced. This positive change for the victim related to the positive social relationships available to them outside of their negative family interactions, providing the victim an opportunity to escape these harmful interactions:

> CDC-4: like even my brother's girlfriend she used to get beaten up from her dad, her step mum and the siblings, the step siblings, so we moved her into our house.

> CDC-3: and the parents, she used to live around the corner with all the aunties and then the father when he would have a gut full of beer would go round to where she was staying, flog her in front of all their family and then just leave and like he's ripping her clothes off her, now she's half naked cause he's bashed her, ripping her hair out and she's on the road like less than a dog and this is the father of the girl, and we thought na, if the family is gonna let that happen you might as well come and live with us, and she was my sons first girlfriend. (CDC-3/CDC-4-FOR-11)

Issues with domestic violence included those surviving intimate partner violence having occurred more recently:

Informal Interactions Box 2

Domestic violence and abuse can include coercive and violent control to benefit the perpetrator. The CDC and other welfare policies do not seem to prevent such behaviours as they continue to occur, and survivors continue to deal with their experiences however they can.

OTHERS-INFOR-08/02/20 -Situation: Sixth visit to Ceduna (which turns out to be the final visit due to the Covid19 pandemic). Volunteering everyday of this visit. Low staffed. Sitting out the front of a local organisation, I am chatting casually with a community informant, whilst they wait for an end-user/client they are helping that day.
A person named Patricia (pseudonym, not their real name) arrives, I have met Patricia a few times across the year I have been visiting. This is the second time I have seen her with facial injuries. Today both her eyes are black/bruised and swollen, and she has bruises on her face. She seems to be behaving more erratic than other times I have seen her, pacing back and forth and looking around a lot. She begins crying whilst she speaks with a female friend. The community informant then tells me what they believe has happened to Patricia:
"She's been bashed by her fella again, she works down at [local motel], you know, lady of the night, he beats her if she doesn't, makes her do it, he already has a restraining order, nearly killed her once". They seem worried but not alarmed in their tone "I'm really worried about her, but she won't leave him, the police know about it all, she's been arrested and all that before, but if she doesn't [work in prostitution], he just bashes her".

Patricia appears trapped in a negative cycle of violence within a harmful social relationship, this harm is known to others that may have contact with Patricia. I do not have access to Patricia's close friends or family to see a more contextual view of her other, perhaps closer relationships to see how those interactions are involved in this cycle of harm.

There are times that I needed to be aware of the threat of violence toward myself, and how this would also relate to the end-users/clients I was interacting with. On one occasion I was informed of the possible violent nature of a participant's husband.

Informal Interactions Box 3

The threat of violence permeated into the volunteering I did and became something I needed to consider regarding safety for myself and others when interacting with participant and non-participant end-users.
OTHERS-INFOR-13/06/19 – Situation: Third visit to Ceduna, during my day-session of volunteering at a local organisation. I was organising my second learner-driving session of the day, going through the details and location I needed to pick the person (end-user, CDC-8)

up from. I had not met this person before, so I wanted to make sure I had details correct which meant taking a little extra time organising things. Prior to leaving the office for the session, another community informant who knew CDC-8, motioned for me to come and speak with them in private. Here, they describe very briefly the possible risk involved in me interacting with another person that may be present in the house and directed me regarding what I should and should not do:
They discreetly told me that CDC-8s husband can be very controlling and had a criminal conviction related to DV, they told me to stay in the car and beep the horn, "at the most if you have to knock, do not go inside, knock and go back to the vehicle, wait for the end-user in the car where you can".

CDC-8-INFOR – Situation: During a third interaction with CDC-8 two weeks later. At the end of our session on our way to dropping them home, we needed to stop at the chemist so they could pick up a script which was ready and waiting for them, taking less than five minutes to collect. I observed this person temporarily misplace their mobile phone (it had fallen under the car-seat). Whilst we were both looking in the vehicle for the phone, they begun to panic, repeatedly saying "he's going to kill me if I lose another phone". They became erratic and appeared very stressed. They were pacing in between efforts to find the phone in the vehicle. When the phone was found (within five minutes from misplacing it) the relief expressed seemed profound. I had not witnessed any kind of similar behaviour with the person at any other time we had been interacting over the past three weeks. This participant did not often talk about their husband who they had been in a relationship with for a very long time. The participant had said earlier that her husband was not allowed to drive, and he wanted her to get her license so he could get around easier. They did not mention any violence during our interactions/interview prior to this event of misplacing the phone. Only ever mentioning women's refuges as a good and needed thing but not expressing why, often just changing the subject if I probed:
"I've been to Perth, Alice Springs, all around, back in the day it was easy with the women's refuges, if I had enough, I was like oh well, I could get away and get my head together for a while" CDC-8-FOR.
Their husband was waiting for them after our session as we were 15 minutes late to return due to having misplaced the phone. He did not speak to me directly in any way only asking us why we were late. The interaction felt very tense and unwelcoming as the participant

continued to engage me in conversation whilst I remained in the vehicle and the husband watched us both silently. Having witnessed the participant interact with the husband for approximately five minutes outside of their house, during this time participant CDC-8 did not mention having misplaced the phone as the reason we were late and neither did I. Instead, participant CDC-8 said the wait at the chemist was very long, whereas I knew it was not a long wait at all as I had witnessed her go in and out of the chemist in less than five minutes. Her secrecy concerned me as to me it indicated a possibility of an attempt to avoid some kind of negative behaviours by the husband toward her, possibly regarding having misplaced her belongings/phone. However, any inference remains speculation as I did not see this participant again after this and could not follow-up to probe further. I was informed they no longer had a need to interact with the organisation as they had successfully gotten their driver's licence.

6.2.1.2.1.2 Domestic Violence, Crime and Housing

The data analysis explains that the violence-related issues faced by many, are interrelated with other life conditions and are often very complex. Here the data analysis shows how a combination of conditions can work to limit behavioural opportunities such that certain choices are the only ones actually available in lived reality.

A lengthy example of the prohibitive complexity of interrelated DV, crime and housing issues is provided by participant CDC-3. On requiring emergency support after a previous violent event where they and their partner 'had a blue' (discussed in Section immediately below), participant CDC-3 was granted two-days of housing in a local motel by government support services but no further accommodation assistance. Other emergency public housing was not suitable due to racial violence they have previously experienced.

They shared with me informally that immediately after the 'blue', they and their children moved out of the house for a bit, and they needed to '*kinda hide the kids for a couple of weeks, you know saying we were renting off friends*' (CDC-3). This was because they were worried their children would be removed by government services if they were technically 'homeless' after being the victim of a domestic violence incident, being granted short-term housing and then being evicted from that housing after the typical two-days assistance provided. After all this, CDC-3 returned to the family home with the husband having 'moved

out' and was placed onto the CDC which caused further issues paying rent (links forward to Resistance Behaviours: Housing Section 6.3.2.1), and they were still stressed and worried (linking to Section 6.2.1.5) that their children may be taken away (which further links to CDC exacerbating Problems Paying for Housing 6.3.2.1):

> Ridiculous. And the only way they wanted to help me, is if I was evicted. And then they were going to jump out and take my kids off me, which would have made it worse. Like, I've been in your care Since 2016 yous did fuck, fuck all for me. And now you want to help by taking my kids off me. It would have made it worse. Get fucked. So, now we're getting evicted from the emergency housing. It's worse than when I originally came to yous and yous want to help by taking my kids off me. Ya mongrels. (CDC-3-FOR-12)

There are a multitude of interactions between having a criminal history, being a victim and securing suitable housing. There are further considerations that relate to the relationship between domestic violence, court and police bail conditions and housing (link forward to Public Housing Section 6.2.2.2.1). These factors may provide unexpected burdens on extended family, survivors and perpetrators regarding options for housing, where bail conditions necessarily exclude perpetrator interaction with victims (Government of South Australia, 2022c). Limited housing options may further constrain opportunities for alternative behaviours such as moving out/leaving (S. Meyer, 2014), requiring those in shared contexts to continue to interact so they can 'get by' (Clarke & Wydall, 2013; Hester et al., 2006). Further, issues with limitations to housing access may increase the risk of DV recidivism, and place heightened stress on victims/survivors as well as perpetrators who may have excessive stress levels already (Clarke & Wydall, 2013), further exacerbating other worries such as avoiding violence, caring for children and moving on with life without fear of abuse (McGinn, Taylor, & McColgan, 2021).

Following from the example provided in the Section above, participant CDC-3 highlighted that after a domestic violence incident, an intervention order was placed on their partner that excluded them from seeing one another and living together. They explained this did not necessarily mean the partner would not actually be living/visiting with them. They explained that the partner had nowhere else to go, and they previously outlined that they as the victim with the children are also limited in their own housing options. They described the additional

stress this all placed on them where limited housing opportunities saw them all need to return to a 'family home' or risk becoming homeless and having children removed. This then created the stress of needing to avoid police and being further charged with breaching the intervention order placed on the perpetrator partner:

> See, when I was on a different benefit, we [CDC-3 and husband] had a bit of a blow up. And we were getting hassled from the cops because of my oldest son's criminal history and he got reported again. And they were watching me, and we were getting hounded by the cops, and we were getting hounded by our community. And Centerlink wasn't helping out. And it came to the situation where I couldn't find work in Ceduna, I wasn't working. So that was added stress, and then we had a blue.
>
> And then the cops were involved. And before we knew it there was an intervention order, which split our family, but yet, remember, we've got nobody in South Australia. Where was he gonna go? We've come here as a family. And it took two years for me to get that intervention order off. And then I was on a Centerlink benefit for two years. But now it's [intervention order] off he can come and stay with us and we don't have to worry about him staying with us and the cops coming around and getting him in trouble, and that was a big thing for the kids, you know, they was scared whenever dad came home for birthdays or holidays, they was scared that the cops would come to the house. That's all since gone and that's sorted now. (CDC-3-FOR-13)

This excerpt above also shows how CDC recipients can become confined in their specific worlds/contexts and associated social interactions embedded in those contexts. Where there are few alternative options for people to get access to things they need (e.g., housing) to get by in their lives through different social interactions, data analysis shows how CDC recipients are constrained to interacting with people in those shared contexts.

This example shows that broader structural conditions designed to limit and prevent domestic violence, influence individual behaviours in sometimes unintended ways. In South Australia, when a person is released from prison or released from police custody, they often are required to have a residential address where they are 'bailed'/released to (Department for

Correctional Services, 2017; Government of South Australia, 2022c). Otherwise, if a person does not have a residential address, they are required to 'sign in' to a police station/ corrections department at a set frequency, however, the nature of the offence and myriad other conditions need to be met to apply the latter (Government of South Australia, 2022b). Nonetheless, bail conditions need to be altered to reflect a new address/living circumstance when they change, and many things can impact whether the new address is an allowable address for that person's bail. These conditions include other persons who may be technically living at or who visit that address, and who may not be allowed to interact together in accordance with the law. The lived reality of some people's lives means the issue of having suitable housing combined with criminal history and being bailed is complex and complicated. For example, there may be no other option (outside of being remanded in prison by the court) deemed suitable outside of homelessness. Some research shows such complications can lead to reoffending (breaches of bail conditions), resulting from complications of housing and homelessness, which is considered a risk factor for recidivism and thus impacts court bail decisions related to offender release on bail or their ongoing incarceration (Travers et al., 2020).

Where a person may have bail conditions that precludes them from interacting with another person, this can also be difficult for service provider workers who may seek to allocate a person to a residential housing facility. This is made difficult especially where a person is unaware of their bail conditions or has few other options for housing (link forward to Public Housing Policy 6.2.2.2.1), with service provider experiences reiterating those by CDC recipients.

Such were the reflections from a service provider related to providing some end-users public housing in Ceduna who may have been to prison and then been released to an address. This relates to their tenant's criminal history and bail conditions, and what this can mean for housing provision and further crime:

> I: Does anyone ever say anything about, like the social aspect or something of the prison, does anyone ever mention that
>
> SP-15: na and I want to ask, cuz people don't really talk about it. They're like, yeah, I went to prison. Well, you know, and they've been to Port Augusta prison, so how long were you there for? Oh three months and I'm kinda like, why were

you there? And they're like, I was in prison, der, and they kind of look at you like you're dopey. Yeah, well, I had to make sure you know. Yeah. So yeah, just interesting.

I: like I was in prison...? yes but why were you in prison...?

SP-15: yeah and maybe that's, well yeah, sometimes it's not… well sometimes they don't even know why they were in prison,

I: oh what so oh okay

SP-15: cause they had like five different charges against them so it could be DV, could be assault it could be break and enter, it could be, or it could be one of five assaults you know what I mean, and like people don't know their bail conditions

I: oh

SP-15: it's not something that people understand I don't think, like it's very complex

I: Oh

SP-15: Because we have a thing about, well we can't accept people with bail conditions because that tends to mean that they're bailed to an address. And that's why we asked what your bail conditions are

I: and they don't know what they are?

SP-15: no, and then we get a phone call from SAPOL [South Australian Police] saying, they've breached their bail cause so and so's here, they're here, have you seen this person and you sit there, and you have to tell them

I: so if they don't know their bail conditions, do you know how to find out?

SP-15: yeah we call SAPOL or DC [Department of Corrections]. (SP-15-FOR-14)

6.2.1.2.2 Drug Crime

Few participants discussed with me use of illicit drugs in the community when talking about general persistent issues in their lives. However, further data has indicated in this results section, and later sections in regard to the influence of the CDC, that drug related behaviours do occur in Ceduna. Considering that many drug-related behaviours are legislated as crimes in South Australia and Australia more broadly (Australian Government, 2019c), such behaviours are unsurprisingly not widely discussed due to probable avoidance of being reprimanded, as evidenced in other studies regarding sharing about drug use (Miles, Chapman, & Francis, 2012; Strike et al., 2020). The discussion of illicit drugs arose primarily during discussions that related directly to the CDC, as presented in Section 6.3 and largely related to what participants observe others doing.

Without inclusion of the CDC, the relevance of drug crime in the community emerged through informal observations, where data was not formally recorded regarding any information of the people sharing the information, time of day or specific date due to concern of my own reporting of the behaviours observed and possible safety issues that could arise for myself and others. It is acknowledged that such observations may only infer or speculate and are limited in accuracy due to an unfortunate inability to follow-up and gain confirmation of intent/actions from the people directly involved, hence caution is advised in interpretation. Nonetheless these observations are reported to ensure transparency in the data collection and reporting processes, and to reflect the realities of myself as a researcher collecting data in the field regarding illicit drug use.

Informal Interactions Box 4

CDC-10-INFOR: Informal interactions and observations include being informed by participant CDC-10 that their mother was *'on ice all the time'* after I had witnessed the mother's very public, erratic and aggressive behaviour and then given the family a lift home. Later informal discussions included service providers (non-participant) indicating the mother is known to have an issue with drug addiction and caution is needed when interacting with her due to her volatility. This volatility was discussed with me by participant CDC-10 outside of recorded interviews, where participant CDC-10 explained it was hard seeing their mum when she came to town because it made their dad upset and dad would start drinking again (the parents lived apart mostly). Participant CDC-10 explained the government had taken

them away from their mum when they were young and that their dad had worked hard to get them out of state care and back living in Ceduna with him. Whilst in state care in a large city away from Ceduna, participant CDC-10 describe how they were involved in "all sorts of shit, stealing cars and driving around" at the age of 13 because "well that's what you do, I don't know, just what it was" and that they prefer being in Ceduna because it's "not like that here". Participant CDC-10 was also well aware of the trauma their mother had lived, explaining that "mum's hard [to deal with], you know, but she's had a real hard life, hey". This highlights the interrelated issues and relationships over time that come to influence current social interactions and outcomes.

OTHER-INFOR 10/09/19: Other observations include witnessing retrieval of seemingly hidden packages in the rocks along the Ceduna foreshore, by (presumably) adult males. Such secrecy behaviours often can indicate corresponding clandestine activity of some kind. The rocks were later confirmed as well-known drop points for alcohol, drugs and cash, by three other people in the community.
OTHERS-INFOR 02/20: Finally, general discussions during February 2020 with a variety of community informants inferred that public and private transport services in Ceduna (cars, boats, trucks, planes) are known to be frequently used (sometimes unknowingly to the driver) for illicit drug delivery, and that police stops and checks of some transport services are done in attempt to deter this. These transport services are described as involving door-to-door delivery and dead-drops along roadsides or elsewhere. On one occasion whilst travelling with a community informant when seeing what appeared to be a series of tightly plastic-wrapped packages off the side of a remote roadway about 200kms outside of Ceduna, I was informed we could not stop to collect them or check them out in case it was an illicit drug dead-drop. Instead, we would need to inform police of the location and time of day that we saw the packages and just keep travelling.

Only one participant expressed personal use of drugs without reference to the CDC, however informal interactions indicated possible existence of illicit drug dealing in the community more broadly. As outlined in the participant characteristics table (Table 8, Chapter 5), participant CDC-9 briefly describes their own drug use even though they are a CDC recipient. The referral to juice here is a reference to GHB, which is typically a liquid often

added to beverages and classified as an illicit substance across Australian states and territories (Australian Criminal Intelligence Commission, 2022):

> Other places I go to. In the past they put me up and give me meals and stuff. But there was one night. I got on the juice. I was walking down Hindley St. that's where I was staying. I was so drunk I could hardly walk. (CDC-9-FOR-14)

Informal Interactions Box 5

Dealing of possible illicit substances between people (participant and non-participant, both CDC recipients) who consume such substances were observed occurring in public locations and with some effort to conceal transactions. However, what has been observed cannot be confirmed if the exchange actually included illicit substances as whatever was being exchanged was not overtly confirmed. Nonetheless, in prior and post interactions, these people involved casually addressed their drug use with me, giving me further reason to suspect the exchanges were potentially illicit substances. I didn't seek to overtly confirm out of concern for personal safety. Incidents witnessed were appropriately reported.
OTHERS-INFOR-11/11/19 – Situation: Public location, substance and price discussed in hushed tones in public location in front of myself and others. A small item was transferred from one person to another where the item was placed directly into the hand of one person in attempt to not show what the item was, with the item quickly shoved into a small bag the receiver was wearing. Promises were made to 'sort it out later'.
OTHERS-INFOR-04/12/19 – Situation: Discreet public location and effort was made by the two people involved that there be no other people were around. Having recently completed an interview the participant left, I began chatting to another person, saying a brief hello and discussing the weather. A second person approached and seemed apprehensive and looking around, the first person stated "don't worry man, she's cool" referring to me, with that a small item was exchanged very discreetly from the second to the first person, there were no other people around during this interaction.
During later interactions with SP-16 regarding local required reporting of these witnessed behaviours, I was informed that such behaviours may be more about testing me regarding how much I could be trusted in community. To me, this indicated the form of relationship I had with community members (includes what I 'represent' as researcher, friendly volunteer, female, white, etc.) was influencing some social interactions and had ongoing relevance regarding what I could learn about people in context.

The conflicting duality of needing to adhere to both reporting of such behaviours and building trusted relationships, became ever present in my efforts throughout my time in the region. In my wanting to become a part of the community so to accurately capture policy influences, whilst also not contributing to any possible drug-related social harms through indifference, I found myself reacting to this duality by telling people after the second observation that 'I wasn't cool with drug use' when appropriate in non-specific, general conversation in effort to redirect and avoid this duality. I did not observe any other behaviour that could be indicative of exchange of illicit substances after this.

6.2.1.3 Substance Use / Dependence: Alcohol

Substance dependence was described as ongoing for many people regardless of social policies trying to prevent access to alcohol. Participants discussed issues with alcohol in the community to be of primary concern. Mostly participants discussed what they have observed other people do, as opposed to expressing what they do. Further, the relationship between dependence and associated social issues was addressed by some participants, who explained the interrelatedness between dependence, racism and need for support services.

Participant CDC-1 described what they had witnessed others do during their volunteering for a local organisation. They described persistent excessive alcohol consumption by some people. They discussed how they believe the money spent on alcohol negatively impacts healthy eating, as this participant has witnessed people with dependence prioritising alcohol over food:

> CDC-1: yeah, yeah I know but you know some people don't have $2, some people don't have cash at all, some people will go and ask their friends for 50c or 1$ or whatever and things are out of balance because like you can see people that are drinking and have no food
>
> I: even now?
>
> CDC-1: well remember that gentleman
>
> I: before?

CDC-1: yeah, that happens a bit you know, can you give me some money cause I need to go get some meat but you can smell the alcohol.

CDC-1: the alcohol is a huge problem

I: what have you seen

CDC-1: I think um people that I've seen in this area, I saw a man asking another lady to go and get him, he came in and could barely rake up 2 for that (in the op shop) but they gave $50 of their money to get a bottle of Jim Beam, so that sort of, that is unbalanced to me you know. (CDC-1-FOR-15)

In an interview with some family members who are all recipients of the CDC, participants discussed their experiences and views regarding the relationship between alcohol dependence, support services and racism. In conjunction with pharmacological treatments, it is well established that treatment to help overcome alcohol dependence relies heavily on mental health support services (AIHW, 2019). Of which Ceduna has almost no effective services available on location in Ceduna, as described by participants previously in this data. Interwoven in this conversation is the issue of racism as highlighted by participants CDC-5, CDC-6 and CDC-7, as outlined in the participant characteristics table (Table 8, Chapter 5), and their views on government assistance for Aboriginal peoples with dependence issues. Combined, the connections between dependence, the need for services inclusive of mental health, and the effects of racism are expressed as related to ongoing issues:

CDC-7: see a lot of the alcohol addiction like peoples got problems that goes way back, there's no services here that help people get on their feet. (CDC-5/CDC-6/CDC-7-FOR-16)

CDC-6: I seen one person that must of drank for years and years but actually needs it now otherwise she starts shaking like that [holding out hand to show how it shakes for people with alcohol dependence], doesn't the government see that, that there's people like that, don't they think about that before they try and put a stop to it.

> CDC-5: the gov not gonna worry, that'll be just another black fella gone
>
> CDC-6: they look at them like they're already dead hey
>
> CDC-7: if they provided more services in this community like drug and alcohol counselling rehabilitation services, there's nothing, look at all the millions that goes into getting this card funded! (CDC-5/CDC-6/CDC-7-FOR-17)

Research has shown the benefits of addressing addiction issues and their often-related criminal behaviours and that benefit comes more from treatment, harm minimisation and prevention strategies than reliance on punishment for behaviour change. For example, according to a study by McLellan et al. (2006), substance abuse treatment can reduce drug and alcohol use and related criminal behaviour. The authors suggest that treatment is effective because it addresses the underlying causes of addiction and helps individuals develop coping skills and support networks that can prevent relapse. Harm reduction strategies, such as needle exchange programs and medication-assisted treatment, have been shown to be effective in reducing drug use and related harms. A study by Strang et al. (2019) found that medication-assisted treatment can reduce drug use, overdose deaths, and criminal behaviour. These authors suggest that harm reduction approaches are more effective than punishment because they address the health and social needs of individuals who use drugs. Prevention programs, such as school-based drug education and community outreach, can also be effective in reducing drug and alcohol use and related criminal behaviour. A meta-analysis by Tobler et al. (2000) found that prevention programs that are interactive, social, and comprehensive are more effective than those that rely solely on information and fear-based messages. Punishment alone has been shown to be ineffective in reducing drug use and related crime behaviours. According to a report by the National Institute on Drug Abuse (NIDA, 2021), incarceration and other criminal justice interventions have not been shown to reduce drug use or related criminal behaviour. Instead, these interventions can have negative effects, such as stigmatization, family disruption, and limited access to healthcare. However, as recipients explained, Ceduna did not have these extensive wrap-around services and the CDC as a punishment strategy unsurprisingly had little effect on changing addiction behaviours of people reliant on alcohol in their day-to-day life.

Consideration regarding motivations to consume alcohol may relate to more complex social interactions. For example, where individual behaviours such as excessive alcohol consumption, also involve how those behaviours create connections and impact social relationships. These include behaviours related to social belonging, participation and social norms. Data analysis shows that the consumption of alcohol is described as a social behaviour. For example, where drinking was required to maintain ongoing participation in a group where drinking alcohol was encouraged and normalised. This indicates that for some, the continued consumption of alcohol may involve broader social factors and although consumption may be harmful in excess, not drinking may limit access to other things people need and shape behaviours going forward (link forward to CDC Resistance Behaviours Section 6.3.1.2):

> SP-15: Yeah. And that one thing, like, when you, when I talk to the clients about why they drink because, you know just to find out a little bit more, just to ask, yeah, and its pressure from family. There's like, their forced to do it with their family, it's their bonding time.
>
> I: ok
>
> SP-15: it could be a shame thing, and it could put them at risk. Because then they're angry, that you're not drinking. You're not on that level, that you don't understand. Like, I'm just thinking about how people are when they're intoxicated as a general thing. (SP-15-FOR-18)

6.2.1.4 Persistent Discrimination

Following on from persistent issues of unemployment, crime and violence experienced by CDC recipients, persistent experiences of racism and other discrimination were expressed as having profound negative influences on agency and further confounded other limitations they experience. It is well established that the persistent experience of discrimination has profound impacts on mental health (linking to Section 6.3.1.4.1) (Berger & Sarnyai, 2015; Elias & Paradies, 2016; Kairuz et al., 2020; Shim & Compton, 2020). People acknowledged that discrimination and its impacts are not just a personal issue, but many express experiences with discrimination as outside of their control, and that impacted many others than only themselves. In terms of racism and discrimination impacting people's mental health, this was not explicitly addressed by participants nor measured by myself. However, the potential for

discrimination influencing mental health can be established by previous research, and is seen through clear stress and anger responses in the data as follows, acknowledged as indicating potential for issues aligned with mental health.

6.2.1.4.1 Racism

Overall, experiences of racism permeated most First Nations participant's narratives in some way during our interactions. In conjunction, service providers reflected on what they know and have seen regarding racism in Ceduna and what this means for social interactions and the social divide between First Nations and non-First Nations peoples. Analysis explains that existing racism can be seen as impacting social cohesion and increasing social division (link to Social Division Section 6.3.3). Further, racism negatively impacts on social cohesion which is then shown to be exacerbated by the CDC policy (link to Discrimination and the CDC Section 6.3.1.3).

The primary form of discrimination discussed was *existing racism* that First Nations participants experienced throughout their daily lives and what this discrimination does to shape the broader conditions within which people live. Racism experienced during interactions with community members and potential employers, links to how and if people find employment, and experience equal opportunities to non-First Nations counterparts in more broader terms. For example, as outlined in the participant characteristics table (Table 8, Chapter 5), participant CDC-5 discusses their efforts to find a job linking racism here to employment (link back to persistent Unemployment issues Section 6.2.1.1).

> CDC-5: the Aboriginal people can't get a job in this town, but the white people move from job to job,
>
> I: why is that going on?
>
> CDC-5: it's a racist town!
>
> I: had that thought but didn't want to put words in your mouth, yeah
>
> CDC-5: yeah, it's a racist town, I said look I've studied for 10 years I've worked all my life and I can't even get a job here but there's white people jumping from

job to job, I begged for a job in [grocery store] when I came here, he wouldn't budge he just puts white people on. (CDC-5/CDC-6/CDC-7-FOR-19)

CDC-5: I know, it's not fair, there was no aboriginal kids, when they come out of school there's no jobs, so they have babies, you know, it's sad in a way. (CDC-5/CDC-6/CDC-7-FOR-20)

CDC-5: there were a lot of white kids out in the community with traineeships and that, but not one Aboriginal girl or boy. (CDC-5/CDC-6/CDC-7-FOR-21)

The people who experienced this discrimination were wholly aware of how it impacted their lives and the lives of others. Some have expressed views that racism sometimes combines with differing policies, and how funding is actually spent. Such as being spent on delivering case-management which does not always translate into immediate positive outcomes for people being managed. Here we can see people were choosing to participate in programs designed to promote opportunities. Yet they remained limited in further choices due to other issues related to discrimination in the social interactions between case-managers and clients, which then promoted anger and frustration:

CDC-5: but I do, I know, the Aboriginal supporting parents awareness scheme, ASPA, I was on that, and there was young girls in year 10 and 11 they had a lady working at the school because there was big money coming in, it was called case-management, and there was big money supposed to get Aboriginal kids out in the community and they said 'ohhhh what do you wanna do', 'well I wanna do hairdressing', 'oh I don't think you can do that because I reckon you should do something other than that…' that's negative thinking, if they wanna do it then do it!

I: yeah wow

CDC-5: I rang up the school and I said to the school, ohhh can you tell [case manager] that I want a pie chart and I want it done up in colours and I want the percentages where the money is actually going to, whose it being spent on and

> things like that, break it up into percentages, and I got a pie chart, I could see it, there was no money being spent on the Aboriginal kids, she lost it, that position as a case manager! (CDC-5-FOR-22)

Racism was not exclusively impacting Aboriginal Australians and was experienced by other First Nations Peoples in different ways which limited access to other resources in times of need. The impacts of racism expressed in social interactions has broader ramifications negatively impacting on social cohesion (Burns, Hull, Lefko-Everett, & Njozela, 2018; Chan, To, & Chan, 2006; Delhey et al., 2018; Dinesen, Schaeffer, & Sønderskov, 2020; Hewstone, 2015; Jenson, 1998; Jupp, Nieuwenhuysen, & Dawson, 2007; Reitz & Banerjee, 2007). These social divisions relating to problems of discrimination in social interactions are not limited to a simple duality between distinctly limited groups determined by belonging to either this or that group. Instead, social division relates to broader social framing and reproduction of a variety of social norms.

The way these norms occur between people and groups are complex, dynamic and change, and are operationalised through what and some others have defined as ‘diversity climates’ (Watters, Ward, & Stuart, 2020). Division is shown to be mediated by intergroup contact based on friendships and opportunities for positive interactions that build trust (Pettigrew, Tropp, Wagner, & Christ, 2011). However, discrimination and othering often lead to social division and avoidance of outsider groups to one’s own, thereby limiting group interactions and constraining opportunities to build friendships and trust, which can foster harmful negative contact and division (Hewstone, 2015). Data analysis shows violence was common more broadly in the social interactions between CDC recipients and others in community, but also became an outcome of racism, clearly showing racism as a threat to social cohesion and socially responsible behaviour:

> It was getting hard cause we were fighting in the community we’re different and they don’t want different, us being [non-white & non-Aboriginal] and different to Indigenous and living in an area where they’re all Indigenous and all their families around us, they saw us as change, like they said this is our land, these [non-white & non-Aboriginal] are coming in here thinking they can change our place, they’re like this is our land, yunmunder, and all that, but we’ve got the

> same fight, the same cause, we're not trying to change anything we just wanted where we are to be safe, but my kids were getting smashed by them. (CDC-3-FOR-23)

Some participants explained further complexity related to individual behaviours aimed at alleviating the influences of racism in their lives. For example, participants CDC-4 and CDC-3 (in separate interviews) described how their individual behaviours included efforts to mitigate racism they experienced. These included being alert to possible racial violence when alone, and trying to 'fit in' to dominant, westernised social norms so to be more unnoticeable:

> CDC-4: what they don't realise is when we're by ourselves we're extra alert, but when we're together we're more relaxed and more happy, if we have to be by ourselves we have to be alert. (CDC-3 /CDC-4-FOR-24)

> We're driven, enthusiastic, we've got a lot of drive and the main thing is we're trying to blend in, only because it just makes our life a bit easier if they don't notice us! So we're trying to do our thing about what we need to do, without making a big fuss for everybody else, like because we're not white but we get a backlash from all the blackfellas like they give us grief for everything, and then there's others they just look at us like oh dumb black people, um that's the white community here cause they're very racist, and then when we start firing questions at them they then think oh ok they're willing to get off their ass, like we know the talk too, don't look at us like we're stupid black cunts you know! Or we don't know nothing! And even the cops have backed off from us now, we know our rights. (CDC-3-FOR-25)

The awareness of racism experienced by First Nations peoples, extended to some service providers who work or have worked inside community organisations. Many service providers I spoke with were well aware of the racism that people experienced through their personal interactions with their communities over time.

> You know, we've been talking about that a lot with young people we work with, that being Aboriginal tends to put you on the wrong side of the fence. As far as

> strength and culture and identity goes. Look, I'll give an example because I'm not sure I'm explaining that well. So we talked with a group of young men here and they doing work for the dole. And their sense of self was there. You know, they're in their early 20s, older teenagers. That kind of thing. They know who they are as individuals and that, But then we asked you know what's keeping you guys on the dole? What is it you know? Let's really break this down, and they go they go like oh well you know lack of experience no one will give us a go. And we'll ask you know what, why is that, what do you think that's got to do with, and then it comes back, And one of the young fellas straight out said it's cause were black. It's because we're black. You know, how do we break out of that, you know, we are who we are. It wasn't positive to say You know, hey, yeah, we're black and we're strong and we're proud. It was like a we're not getting this because we're black. We're unemployed because we're black. We've got poor health outcomes because we're black. We're getting locked up. We're drinking more, that kind of thing. (SP-19-FOR-26)

Some service providers addressed racism as related to 'white privilege' in general society. Some participants explained their view that reasons for persistent racism may relate to dominant understandings of social and cultural differences to be viewed through a 'white lens', which further research shows can work to perpetuate racism (Hastie & Rimmington, 2014). Service provider participants explain their observations of how First Nations peoples have been treated by many community members as well as other service providers, with experiences including observations of intentional othering, where people position themselves as 'better than others' in some way. Explanations of the power imbalances related to privilege of one group over another, have been shown to exacerbate discrimination through dismissal of the effects of such discourse, also described as the 'positive self and negative other' presentation (Augoustinos & Every, 2007). Consequently, this enforcement of privilege negatively impacts and constrains opportunities for those made the 'other' through stereotyping and its exclusionary power (Hall, 2013, p. 248), ultimately preventing opportunities that may help overcome social obstacles and relieve negative and inaccurate stereotypes and intergroup contact.

Overall I heard views expressing awareness of the existing social division related to racism in the region, which some reflected on by linking history to contemporary times:

> Well in all of the time that I've lived in Ceduna it's been racist and at the time when Aboriginal people were given the vote we had the highest numbers of people voting against them of having that right, in the 1960 days, Penong and Ceduna voted against them, them having the right to vote. And to me this card is just a follow through from that same type of attitude. Nothing has changed. (SP-13-FOR-27)

> It's whitewashed. It's quite racist. (SP-13-INFORM-28)

> SP-15: and it's a huge white lens, and I sit there and, well it's a privileged lens. You know, there's all these people in the services that are here to help people but

> I: yeah

> SP-15: you know, it is literally well, I'm better than you. I'm up here, you're down here. But the help given, it's not to bring you to my level. It's to just bring you up a peg or two. (SP-15-FOR-28)

Linking with racism as a form of pervasive discrimination with mental health and substance abuse, research has explained how such social problems worked to confound one another. For example, racism can encourage substance addiction to cope with trauma (Borrell et al., 2014; Bryant-Davis et al. 2011; Whiteback et al., 2004). These studies explain how historical trauma, social disadvantage, racial trauma, and oppression can contribute to substance abuse as a coping mechanism. Understanding the relationship between racism and substance abuse can help inform prevention and intervention efforts that address the root causes of addiction, and may illuminate how the CDC is unable to address positive behavioural change as it is still experienced as a racist policy with colonial legacies.

6.2.1.4.2 Other Forms of Discrimination

With relevance to the participants overall, other forms of discrimination are not expressed as commonly as racism. Other discrimination includes that which relates to being in receipt of income support payments and being a person who identifies as a part of the LGTBIQA+ communities. Although less frequent in the data, these other forms of discrimination still appear to relate to social division, however the extent of which is not sought to be compared with racism.

All personal experiences of discrimination remained significant factors in how participants were able to navigate their lives comfortably. For example, being discriminated against regarding visible disability and requiring income support, and regarding a person's sexuality. Such expressions indicate social division occurred for many participants in different ways:

> The wisdom and the knowledge and the help you could afford other people if you're not working why can't you do something to use those skills in a non-paid capacity and be appreciated, not (in a deep mocking voice) 'oh the pensioners this and the pensioners that and she gets a DSP and she shouldn't be entitled to that, look at her she's normal', bloody far from normal. (CDC-1-FOR-29)

> Being a gay male is not easy. The only thing is that there's a lot of narrow-minded people up here. And the thing is, I was only saying to [friend], you wouldn't even know about this. Going back before you came back to town again. On this particular morning I was coming up to, was coming up here. I saw four guys, who were really quite abrupt to me about my sexuality. I mean they were hardcore. And I came up here, devastated. (CDC-11-FOR-30)

6.2.1.5 Poor Mental Health

Concerns regarding existing issues related to mental health, include what is missing in terms of support services, as well as people having difficulties throughout their lives. People have complex needs that may require ongoing support.

Broader research has established clear correlation between personal experiences of unemployment, violence, crime, substance dependence, discrimination, stress and poor mental health (Baranyi, Di Marco, Russ, Dibben, & Pearce, 2021; Battams et al., 2021; World Health Organisation, 2004). However, much less evidence reflects on *how* such correlations occur and focusses predominantly on directionality of cause and effect in some way as evidenced in the recent related systematic review by Baranyi et al. (2021). This review's outcomes assessing research on the associations between unemployment, violence, crime, substance dependence, and stress, and poor mental health, argue for what my data attempts to capture: that there remains a need to focus on the related social interaction mechanisms involved in these associations, defined as capturing the "social processes such as the collective norms or networks and cohesion between residents" alongside the broader social and economic policies that may come to influence such interactions (Baranyi et al., 2021, p. 14).

Where some CDC recipients expressed how they navigated their mental health issues, there can be links made back to issues finding employment. Where a person may seek to work, their mental health concerns and ways of coping, such as working with more autonomy and flexibility (link back to Unemployment Section 6.2.1.1), may be even more prevalent in the face of receiving no other support. Participant CDC-1 has experienced severe stress and trauma in their past due to sexual abuse as a child and continues to struggle with the related effects now. They explained that they manage their current volunteer work and their mental health through trying to balance commitments to reduce stress and this was better than previous alternatives of receiving psychiatric assistance:

> CDC-1: and I have no desire to be on this earth if I'm not being productive but I can't work, and I don't wanna work a lot cause I can't be flogged by a boss again I just melt down I go, I lose the plot, I melt down I go into a panic attack and then it's all on again and then I have to crawl my way out of a huge hole and I just can't do it
>
> I: see what you mean, yeah
>
> CDC-1: so I have to manage my life the way I manage it which is do a shift have a day off rest do a shift have a day off rest and then it's the weekend so that's all I can manage right now, at one stage a few years ago before my marriage broke

down up I was actually so paralysed I was in my bedroom and could not come out, my life was my bedroom…they had medicated me so much

I: I was gonna ask

CDC-1: with the psychiatrist and the pills I had a big bag of zanax stillnox, I had all these pills and I was completely shattered I had no idea what day it was I couldn't put words together, my son came to see me one day and he said mum what are they doing to you and I couldn't even answer him, I could hear and I could understand what he was saying but I couldn't give the words back because my… my all my everything wasn't working together and he said I'm not watching this I'll come back when you're normal, so he left and he wasn't coming back. (CDC-1-FOR-31)

CDC recipients and service providers expressed that few to no mental health support services currently exist in the Ceduna region. The overlap between mental health support services and recovery from alcohol dependence is later described in the following section. The need for mental health support services is reflected on briefly by Participant CDC-9:

They don't really have a mental health anything here, you know, there's no mental health team here. (CDC-9-INFORM-32)

Lack of mental health staff on the ground can further impact access to other services, such as public housing in some cases. Mental health service provision related in part to housing issues for those who potentially needed supported housing, and are experiencing complex mental health concerns, but often do not get the support needed because there is no support staff:

Even like we have mental health housing up in Thevenard for housing, but we have no support worker because we don't have a mental health aid. Like there's no mental health here. So we can't get the mental health support worker. So we can't put anybody in that particular house. (SP-15-FOR-33)

SP-15: we don't have the mental health team within Ceduna to provide that mental health service. So if you put a person in [supported public housing] well

> There's no point because they [the client] can't go in and do their appointments and the things that they need to do. So if they're discharged from Glenside into this house without a support worker…
>
> I: and then what?
>
> SP-15: They can't then go to the appointments at the hospital for follow up, because there isn't a mental health person, and there's two of those units [motioning to the units nearby]. Like three-bedroom units just sitting there, and there's people that go in those, but the services aren't there. (SP-15-FOR-34)

There remains a high need for mental health services and staff in remote regions across Australia (De Cotta, Knox, Farmer, White, & Davis, 2021; Perkins, Farmer, Salvador-Carulla, Dalton, & Luscombe, 2019; Sutarsa, Banfield, Passioura, Konings, & Moore, 2021). This need is highlighted by service providers who identify the lack of mental health practitioners and highlight the need for educated professionals, in the remote Ceduna region. Issues identified in the data relate to the lack of mental health services that are argued to require in-person care. Although mental health services via telehealth existed at the time in 2019 in Ceduna for people to access remote care, this telehealth service does not meet requirements for 24/7 in-person, in-house and on-call workers needed in mental health housing facilities offered by government housing services (Government of South Australia, 2022a).

Reasons for lack of in-person staffing in remote Australian regions (prior to the Covid-19 pandemic in 2019) are shown in further research to be confounded by factors related to: a lack of qualified training-staff for facilitating early-career placements as well as assisting other community workers; and infrastructure issues in remote locations (relative to metropolitan centres) that acts as barriers stopping staff moving to those remote regions (Byrne, Happell, & Reid-Searl, 2017; Sutarsa, Banfield, Passioura, Konings, & Moore, 2021; Van Spijker et al., 2019). Participant SP-17, a service provider for over 20 years, described the need for both capacity building for existing staff, alongside attracting and retaining skilled staff to the remote region, both of which are difficult:

> There's a need for capacity building to use the language that, you know, we have to because what we really like is people with expertise. And so when people with expertise come to Ceduna, they get very heavily used. And they get burnt out, and they can't cope. And they leave. And so we've got lots of good people that are local, but often don't have the expertise to deal with the complexity and the issues with clients and the issues that go on here and so you either build the capacity of the local people, which they're trying to do through the Ceduna services collaboration. But you know, what we really need is expert, mental health workers. We need expert family violence workers, expert drug and alcohol workers and they're few and far between. (SP-17-FOR-35)

6.2.1.6 Theme Summary

Primary issues emerging from the data analysis include difficulties in gaining employment, experiences of violence and crime, finding secure housing, discrimination, substance dependence and getting help with ongoing mental health problems. These issues are directly related to social interactions between community members, where these interactions become the mechanisms that facilitate and reproduce localised and general social norms often applied to frame and categorise individuals and groups in relation to one another. These interactions are shown throughout to have ramifications for social division and cohesion, which where interaction have divisive effect, work to perpetuate division and constrain opportunities for positive and helpful changes. These issues combine and all reflect the enduring and often extreme stressors CDC recipients report dealing with in their lives regardless of any particular social policy.

Where the issues interrelate, they appear to confound one another, and are commonly experienced across almost all CDC recipients, then reconfirmed by reflections from service providers. The commonality of these problems experienced across the CDC recipient sample challenges notions of sole responsibility for these bad social issues, indicating that other forces may come to create the conditions that promote such problems. These conditions are reflected on as largely outside of the direct control of CDC recipients, often no matter their effort of trying to change circumstances. These conditions work to constrain opportunities and actions done by individuals in effort to overcome or change those problems. Instead, the

options people have regarding their behaviours remain much the same as structural conditions largely do not change to allow different opportunities for diverse behaviours.

6.2.2 Theme 2: Problems with Existing Policies

The existing policy context addresses what mainly service provider participants expressed as relevant in terms of the broader conditions they saw as significant in how the CDC recipients were able to navigate their lives. Frequencies across both sample groups are similar, outlined in Table 12 below. Overall, participants expressed the reality that although the CDC may influence recipients and the community, there are problems with other policies that also influenced the way people could live their lives. Priority needs related to housing, income, waged employment and skills training, transport, and health/wellbeing support. This theme was common to all participants and indirectly related to use of the CDC.

Theme 2: Problems of Existing Policies
Subthemes:

Disconnect Between Social Policy and Lived Complexity

Problems of Specific Policies

Table 12: Frequency of existing-policy context.

EXISTING-POLICY CONTEXT – **COVERAGE: 15 PARTICIPANTS, 92 REFERENCES QUOTED**			
SUBGROUPING	Interview Participant	References	Coverage Percentage (%)
CDC (N=12)	CDC-1	6	5.5
	CDC-2	6	6.5
	CDC-3	18	19.6
	CDC-3 /CDC-4	8	8.7
	CDC-5/CDC-6/CDC-7	5	5.4
	CDC-8	2	2.2
	CDC-11	1	1.1
	Total: 9	Total: 46	Total: 50%

SP (N=7)	SP-13	9	9.8
	SP-15	18	19.6
	SP-16	6	6.5
	SP-17	5	5.4
	SP-18	6	6.5
	SP-19	2	2.2
	Total: 6	Total: 46	Total: 50%
TOTALS	15	92	100

6.2.2.1 Disconnect Between Social Policy and Lived Complexity

It was predominantly service providers who indicated that policy in general terms often does not pair well with needs or planned outcome delivery, and regardless of individual policy, little has changed overtime in terms of improving outcomes for general policy recipients or policy 'end-users'. Reasons for this are addressed, with service providers stating the disconnect may relate to structural policy and systems inadequately accounting for lived complexities people face; and policy actually being designed to respond to bureaucracy and the policy process as opposed to the needs of end-users. Data analysis shows that all service providers interviewed had an appreciation of the interrelated issues their clients faced on a daily basis (link forward to Service provider/CDC recipient relationships Section 6.2.4.2), and also articulated an applied understanding of the broader structural forces such as other policies and economic conditions that comes to create the conditions within which themselves and clients operate in.

Such awareness of lived complexities clients face contrasts with research such as that by Agllias, Howard, Schubert, and Gray (2016) who qualitatively captured Australian frontline social and service worker and manager narratives about client complexities and policy awareness. All but one of the n=32 service providers were shown in Agllias' research to reflect a neoliberal influence in their narratives. The research shows explanations and solutions for client problems favoured simplistic, individualised responsibility over complex structural inequalities as the causes for poverty, with workers then inevitably applying ineffective simple solutions that then aligned to this neoliberal narrative (Agllias et al., 2016). Such limited awareness indicates a potential disconnect between consideration of structural complexities inclusive of social policies, influencing behaviours in context. Only one manager was shown to have an appreciation of the broader structural policy and economic

complexities that come to create the conditions that influence client behaviours in Agllias' research. Unlike the research by Agllias et al (2016), findings show all service providers in this CDC research whether manager or worker, expressed an appreciation of multifaceted structural problems inclusive of policy and economic conditions shaping behaviours, requiring parallel solutions.

Some service providers reflected on this disconnect between lived experiences, how social policy is conceived and then policy programs/interventions are applied to peoples' lives. Here the disconnect between general social policy strategies be they programs/interventions and lived complexities is discussed. This disconnect, highlighted by service providers between social policy programs in theory and application, reflects those arguments made by policy researchers such as Blackmore and Lauder (2005), Lea (2020) and Lipsky (2010). These policy researchers have shown that those closest to policy implementation are often best placed to understand the interrelatedness between the needs of recipients and disconnect that often occurs in policy implementation relevant to theory or policy-logic. This disconnect was articulated by service provider participant SP-17, who suggested the bureaucratic system and related policies and their interventions, may not align well to the conditions people navigate in their daily lives:

> I: And with regard to welfare policy such as any issues, delivery, etc. Do you see any of them in general having made a difference? Any kind of difference, helped or anything, regardless of what ones they are?
>
> SP-17: No, not really. And I'm thinking broadly and the ones I know quite well and the ones I've come up against, it's far too bureaucratic. And I say that and, and I can deal with bureaucracy, but gosh if I can't deal with it the people who have English as a second language or having really complex shit going on in their lives or they're struggling, how will they? They're struggling to understand policy. (SP-17-FOR-36)

Participant SP-16 is another service provider, extended on this discussion on bureaucratic processes suggesting that related system and policies were well intended but were unable to respond adequately to people's needs. Instead, the system was better designed to respond to itself, resulting in the exclusion of the people the system is supposed to support.

I: so policy, all the rules, those decisions, How have they come to be, or what are they responding to?

SP-16: I think it's well intended. It's good intent. It's like, well, people need homes. So we need to make sure we've got a mechanism to access public housing. And then we need processes that allow people to access housing and then rah rah, rah. But then all of a sudden, you've created a bureaucracy that, once again, was designed to respond to itself, not to the needs of people who need houses. (SP-16-FOR-37)

So, if you look at this community as a whole. It's like, it's like previous policies and programs have actually pushed this community, out of its own community. (SP-16-INFOR-38)

Participant SP-16 explained the related influences of misaligned policy and bureaucratic processes. They suggested that this was because policy did not address the underlying issues that relate to social problems. These underlying issues are discussed above and here (link to Social Interactions and Policy Delivery Section 6.2.4), and are explained by SP-16 as broader, interrelated structural conditions that needed addressing so to ensure adequate and helpful change for communities:

See all these models that don't work? And you see all these programs that are designed and don't work. What shits me the most is you get this program, and it's not designed for people and then when it doesn't fit the people, the people get blamed. It's like school attendance. You know, it's always the family, the violence, the drinking, the sexual abuse, the lack of food, the insecurity staying up late, and the gambling the walking around at night. It's every community issue as to why the children don't go to school, right? Is it ever the school, is it ever the curriculum? Is it ever the physical design of the school? Is it ever the teachers, is it ever the school leadership. No! none of these things are the problem. (sarcastically) You're the problem. You're the reason why you're not coming to our school. It happens time and time again. When do we ever question the school? All we do is we throw money at getting the kids to school like we're

> jamming a square peg in a round hole. And we spend so much money pushing that peg. How about we change the shape of the hole? (SP-16-FOR-39)

Some service provider participants addressed specific ways that certain policies do not work as they are intended, such as using punitive measures of fines as deterrence for certain behaviours. In C. Mills and Klein's (2021) conception of Australia's contemporary welfare system, they frame the system as one built on deterrence of deviant and dysfunctional behaviours through punitive actions and policies. In addition to arguing against the use of financial sanctions on benefit recipients due to being inhumane, these sanctions are shown by others to not actually work well as effective or consistent deterrence (D. Fletcher & Wright, 2018). This ineffectiveness is because sanctions have been argued to not address lived social complexities people face. Often the risk of fines are outweighed by social expectations and needs in some communities where people have little choice but to breach benefit rules in many cases (D. Fletcher & Redman, 2022). Instead benefit sanctions, including fines for breaching rules governing behaviours legislated as required to receive payment, have been argued to reinforce poverty, putting further pressure on people which sometimes can exacerbate crime, violence and drug use, and associated social stigma of claiming welfare (D. Fletcher & Redman, 2022).

Punitive approaches to behaviour change or influence, such as punishments for non-compliance to policy rules, do not appear to be effective in the Ceduna region, which has a large Aboriginal population who are mostly the people affected by these fines. Participant SP-19 outlined this through the example of court related issues and fines people may receive. They suggested that fines do not change behaviours as intended because the broader conditions of people's lives have not changed regardless of fines:

> So you look at you look at fines as another one, You look at the amount of people in Yalata and oak Valley who have 10s of thousands of dollars worth of court fines because that system and I know that they have country court circuit and all of that and that kind of stuff, but it's still that system that says oh You didn't turn up for this or that. Let's whack some more dollars on top, it's those financial penalties for not doing something which is also a big thing in like the CDP [community development program], and Centrelink seek financial penalties (for non-compliance). It doesn't change people's behaviour. It doesn't at all to

> be honest. Because you still have to live life with what you've got. (SP-19-FOR-40)

Data analysis here and in Section 6.3 below shows that policy circumvention strategies relate to existing conditions, where these conditions have created need and have enhanced or restricted opportunities for different behaviours. These conditions are multifaceted and combine individual choices and structural conditions where people act in ways available to them to get whatever it is they need. There was an awareness of policy end-users innovatively navigating the system to make it work for them somehow based on need and desperation with little alternatives to do otherwise.

> Well, yeah, people find their way around, people are desperate, and people are resilient. They need the money. And it's like, well, that's what you've got to do. (SP-19-FOR-41)

6.2.2.2 Problems of Specific Policies

Specific policies, other than the CDC policy, are addressed by all participants with relatively equal coverage overall across the two subgroups. These specific policy interventions that are discussed are:

- Public Housing
- Job-Network Providers
- Community Development Program
- National Disability Insurance Scheme
- Street-Beat

The importance of these for the current research is that the CDC implementation was carried out on top of these existing interventions, and there are real effects from these schemes interfering with one another.

The following shows the policies that are addressed by all participants as having some form of influence in the lives of policy recipients. These policy interventions existed simultaneously to the CDC in the Ceduna location and were often experienced in conjunction

with each other. Where multiple interventions are expressed as relevant, this highlights the significance that they are not experienced in isolation. Policies are shown as experienced together which has consequences in how each operates 'on the ground' through their combined influence.

In considering the different policy interventions that operate simultaneously in Ceduna, service providers reflected on what they see as a broader problem with social policy in general. This problem relates to ignoring or dismissing similar policy approaches that may have been used historically. Where this occurs, it is largely because there is no way to account for policy effect overtime. Participant SP-14 addressed the need to collect and account for evidence of effective policy strategies from an overarching perspective overtime:

> The issue with policy is often that there are "new" ideas or models that did not consider previous evidence, research or evaluations. Often, they were rehashed old ideas that did not always work, every 20 years or so there appears to be a redo of policy, possibly due to lack of corporate knowledge and turnover of policy makers. There needs to be a way that the policy makers can avoid repetition of policy that has not worked – otherwise this is just a waste of resources. (SP-14-INFORM-42)

An example of how multiple policy interventions are experienced in conjunction with one another was provided by participant CDC-3, who expressed their frustration with having to navigate between different interventions. This frustration led to powerlessness, where social security system requirements often mean recipients need to go between different services to meet different policy requirements, and that without assistance to navigate the complex welfare system, the task of help seeking can seem insurmountable. Participant CDC-3 explained navigating different interventions across different providers after dealing with a bad DV incident and, along with their children, needing to live apart from the perpetrator as directed by police:

> I: so they're sending you back and forth. Is that what's happening.

CDC-3: yeah. I was ropeable. When I first joined up with them, they were saying you know, all that Centrelink and [job network provider] and all that, are going to be combined as well as housing so they're all going to come under the one.

I: Are they under the one?

CDC-3: its bullshit. No, still have to go to all of them.

I: So, all to the different places?

CDC-3: yeah yeah it's bullshit its bullshit because by the time you get out of one building go the next one, and you've got the paperwork to go there. It's lunchtime and then everybody's on lunch and then by the time they come back, they're like, oh, you'll need to see somebody, and it's going to be a bit longer. It's not just going to be a five minute write this down, write that down and then you're out again. (CDC-3-FOR-43)

After sitting with each other quietly for a little while, CDC-3 continued:

And till I got to these ones at the [local organisation] and that's when [service provider] came in and helped me. Because by the time I got to Centrelink and [other local organisation] I was a blubbering mess, they didn't help... I was always in tears and Centrelink they used to make me feel like I was less than human. Like I was taking money out of their own pockets. I was like, look, I was told to ask for help from you guys and this is what I was told to do, and now you're telling me no, I've come to you lot and there's no help available. And you can't help me today. Well, what am I supposed to do with my children now, like, I'll just bring them here and drop them off and yous can help me and take them!! (angry sarcasm). (CDC-3-FOR-44)

6.2.2.2.1 Public Housing Policy

Public housing policy rules and ongoing homelessness were addressed as an issue in the region. The reasons for housing provision and homelessness do not appear simple and are interrelated to other existing personal issues that people may be experiencing (link back to Domestic Violence in Section 6.2.1.2.1.2). Ceduna's public housing was suggested as

operating in a unique way compared to other locations, resulting in people not being housed that would otherwise have the right to be. This may create other conditions that negatively impact the end-user, such as homelessness or additional contact with the criminal justice system (link back to Housing and Crime in Section 6.2.1.2.1.2).

Participant SP-15 was a service provider with experience related to public housing in the Ceduna region at the time of interview. They described localised public housing policy as influencing subsequent choices of those impacted by this policy. Here it is evidenced that local housing policy restrictions mean those who are needing housing, could not access that housing. They described the realities of policy application to people the policy is supposed to support. Such evidence shows that this housing policy did not actually relieve homelessness for many people with complex needs due to other persistent issues. Indicating further the interrelatedness of conditions experienced by people in need of support specifically in the Ceduna region:

> SP-15: the people that we have at the moment that are sleeping rough, that aren't allowed into our service. If we were in Adelaide, they would be housed. They have health or bail conditions. They have, like their risk factors. Yes, yes. But they don't want them to be housed here. And they are left. You know. They are what social housing is for
>
> I: Yeah. Yeah.
>
> SP-15: You know, and it's not. It's management saying no, if you read our policies and procedures, I mean I can't say that technically but…
>
> I: ok
>
> SP-15: but I'm just saying, you know, it's like this: Ceduna operates in its own way. And so the managers from [other town], the regional manager is in [other town]. So, and this is what she's pushing. And so we struggle to keep people in and people are homeless, they will say 'but they're from Yalata so they can go back to Yalata'. And you sit there and you go, no they can't, do you understand. I've had the conversations about homelessness, what the definition of homelessness is, and it's like 'well they have family there', but is it safe for them

> to return there and further can they return home? Yeah. And you sit there and you're like, actually this person has said to me, they can't go. They haven't, like they have nowhere to go. Yes, they have family. But also, the other thing is how many people are already in that house? We don't know that. Because sometimes, you know, they can't go because, you know, court restrictions. Because of something like that.
>
> And we're the only accommodation service within this town. Yeah. (SP-15-FOR-45)

6.2.2.2.2 Job-Network Provider

Job-network providers, as outlined in Australian national policy documents, aim to get income support recipients off welfare payments and into paid employment (Agllias et al., 2016). Incentives are provided to job-network providers (not recipients of the scheme) when they sign a jobseeker up to their services after referral, then again after a person has remained employed with employment gained through the provider at four, 12 and 26 weeks of employment (Parliament of Australia, 2019b). Some issues with integrity of incentives paid to job-network providers have been raised by the Australian National Audit Office's (2022b) review of the program. Their review has indicated that although mostly effectively managed, the potential remains for incorrect sign-up and length of recipient employment payment 'errors' to occur that challenges the integrity of the program (Australian National Audit Office, 2022b). The review also indicates other issues with the program related to promoting short-term employment, where providers are paid after relatively short-term duration of recipient employment of 4, 12 and 26 weeks. Here, the more often a person gains short term employment and then needs to come back to the provider to again find employment, the more the provider gets 'paid' through the program, a problem identified by the Audit Office's review.

Participants expressed issues they experienced with the local Job-Network Provider. Moreover, previous data regarding employment issues (link back to persistent Unemployment issues Section 6.2.1.1) indicated Job-Network provider policies were negatively associated to helping people find work, which contradicts the intent of the policy. This indicates that the efforts of people seeking work in some instances may be impeded by such policy, where findings indicate the policy structure and financial incentives for

employers as a problem. Incentives are linked to higher recruitment meaning more financial incentives for the provider as opposed to job seekers. This can unintentionally result in short-term employment sometimes through firing and re-hiring of existing staff by employers, thereby increasing financial incentives for the provider who provides access to those jobs. The reality of this for people in Ceduna needing employment to get off the CDC is evidence by participants CDC-3 and CDC-4. They explained that although they were actively seeking work, these related policies were not conducive to gaining paid employment over the longer term:

> CDC-4: see in Ceduna you can't get a job unless you're hooked up with the job network, the provider. See the jobs we've been getting were all up to us, putting our resume around and word of mouth
>
> CDC-3: but we get in trouble with [job-network provider] see if you register with them and get employment they get a subsidy, but because we weren't hooked up with [job-network provider] they were sending us back and forth to Centrelink, sending us to Centrelink to get a number and Centrelink were saying no you don't need a number register with them as voluntary, but [job-network provider] were not allowing us, see when you register as voluntary they don't seem to get off their ass to help, they only find you work or help you that they get a subsidy for. (CDC-3 /CDC-4-FOR-46)

The job-network provider and their requirements were not easily navigated demonstrating further hurdles to gaining employment. Navigating complex policy and bureaucracy has been addressed by other service provider participants in sections above as difficult for clients, especially where the client may have existing multiple issues they are dealing with. Participant CDC-3 described in detail the labour required and hurdles experienced as they continue to try to find local employment as a cleaner:

> I: so you've mentioned a while back about the cleaner's jobs and stuff. And you needed certain things, what was that about?
>
> CDC-3: Yeah, so for a cleaning job. Just now through [job network provider] You need your first aid, as well as you need your (car) license. And I've only

just got the first aid. And that's because the course was available to me. See, they're supposed to help us with these courses if there's any requirements that the job needs. And now I only got on the first one, because that one was going at the time, but I wanted to do my drivers but because I wasn't hooked up with them at the time. I couldn't do it.

I: I remember you saying that, but because it was a few days out or something, you couldn't do it.

CDC-3: Yeah, that's right. The next driving course they pay for isn't until next year. And the thing of doing it was... okay I miss that driving course for that period, the next one's next year but if I wanted to get my license Before then, I could do that on my own, but I still need the funding to be able to do that. But through [job network provider], they can get the funding for me, and I can just sit the test, but I've got to be hooked up with Centrelink to get the [job-network provider] funding.

I: so you can you do the test at other times?

CDC-3: Well yeah, see I can do it on my own, but I've got to pay. See, I've got to be registered with Centrelink. And then, and then that if the course comes available within the time that I'm registered with them, they'll pay for it, and I'm allowed to do it. So I've registered with [job-network provider] today. (CDC-3-FOR-47)

6.2.2.2.3 Community Development Program

The Community Development Program (CDP) is a policy intervention aimed at addressing and rectifying issues of unemployment in remote communities nationally (Australian Government, 2022b). Experiences of the CDP seemed more positive than the CDC policy, although the CDP still had its negatives. Many of the CDC recipients also participated in the CDP. Participant SP-18 explained why the CDP seemed more beneficial than the CDC because the CDP aligned to a similar successful program in Ceduna previously. This previous version of the CDP was the Community Development Employment Program (CDEP). Participant SP-18 discussed how the CDP can create opportunities for socialisation and in some cases, employment:

> I think the thing was that well, the CDEP (Community Development Employment Program) its predecessor (to the CDP), which was held by the Ceduna Aboriginal organisation was seen as real positive here. And now it's going back to [job network provider]. So currently it [the CDP] doesn't feel like such an imposition because of this familiarity and some benefits that it's currently been driven by, well, I don't know, Aboriginal control, but it also provides an opportunity for people to get together and the card doesn't do that. The card doesn't do that. The card is a financial arrangement run by a financial institution. And people have different levels of knowledge, but they all know that there's someone making money off of them with the CDC, whereas the CDP I feel like for some it could be a positive experience because it's about skill building and a thing around family and community. For some it's leading to employment. But some of the rules around well, especially at the time last year around the penalties if you didn't show up was really concerning to people and I have no idea into the politics around these things, but I'm sure it's a factor around who's doing what and who the coordinators are. (SP-18-FOR-48)

CDC recipient participant CDC-5 reflected on the CDP in Ceduna, where discussion indicated a level of acceptance of the CDP and some benefits, such as making 'real money'. Some apprehension remained however regarding the long-term usefulness of the policy overall indicating further issues remain:

> I: are there folks who are on CDP who are also on the card?
>
> CDC-5: yeah
>
> I: so work for the dole and you're on the indue card
>
> CDC-5: yeah, I think CDEP is coming back, its CDEP (unsure),
>
> I: so changing again
>
> CDC-5: yes and its getting people, and I don't know if its gonna get them off the dole but they're working for real money, yeah I don't know if it's ever going to get them off but if jobs come up they gotta apply for it. (CDC-5-FOR-49)

The CDP policy rules also have been shown to prompt unintended behaviours in response to the policy, where people will learn to navigate around rules to get on with their lives as best they can:

> I guess what you see people doing is they learn how to navigate that system and go well. For example, one thing I heard first when I got back here, a few of the older fellas that were doing the CDP said Oh, just tell Centrelink you're an alcoholic. It's a diagnosed disorder, blah blah blah. They will not challenge you on that. And you know, tell them that you're an alcoholic and you won't have to turn up for work at that and that sort of stuff. (SP-19-FOR-50)

6.2.2.2.4 National Disability Insurance Scheme

The national disability insurance scheme (NDIS) is a national policy that aims to support people with disabilities and promote choice and control in client-hiring of services they may need, as opposed to government only allocation of providers to clients (National Disability Insurance Scheme, 2022). The NDIS overall was not widely discussed. However, some potential risks were addressed by participant SP-18, which suggest the NDIS had potential to negatively impact end-users it is designed to assist. They suggested that the NDIS policy may not adequately safe-guard vulnerable people or their families, as they believed the NDIS had loopholes including those that allow potential exploitation of desperation for assistance:

> The other policy I was going to mention is the NDIS in terms of, well then again, we don't have too much to do with it but when we have tried to link families and just knowing, that with regards to the NDIS and that structure, it seems really complicated. And so it seems really long winded. So obviously, if you kind of wade through that people might have some good support, potentially. But yeah, there seems to be a lot of opportunity for loopholes and a lot of opportunities where things could go really wrong.
>
> The checks and balances seem pretty minimal to me, in terms of, from a child safeguarding perspective around the quality and the structure and support for people who are potentially dealing with you know, people who are in very vulnerable situations like child abuse or kids with disabilities, the risk seems much, much higher and that their families are also much more desperate for

> support. So you know, yeah. So I can't speak much on that, but I would say it's a really interesting policy, the NDIS National Disability Insurance Scheme. (SP-18-FOR-51)

6.2.2.2.5 Street-Beat

Ceduna participates in a local Street-Beat program, which is a part of local harm-reduction efforts in the community. Street-Beat still operates in Ceduna and works in conjunction with the Mobile Assistance Patrol (Drug and Alcohol Services South Australia, 2022), with more recent versions of Street-Beat inferred as being better than the previous iterations. Previous versions were addressed by participant SP-19 who described the approach as having unintended consequences that may have stigmatised and isolated some community members. Such stigmatisation and isolation have been shown in other research to relate to disengagement in service support structures where people may need assistance (Aguirre Velasco, Cruz, Billings, Jimenez, & Rowe, 2020; McCann & Lubman, 2018). This example in data here provides insight regarding how certain approaches may work to further isolate people from their own communities through labelling and othering, even when those approaches may be well intended:

> The old street beat model, which was a fucking disaster, which was someone in a blue vest, walking around with a clipboard up to people sitting out the front of Foodland, waiting for their family to come out with shopping, going and saying to those people, are you okay today? Do you need any help today? You look like, for one they used to make assumptions, you look like you're from Yalata or Oak Valley. You don't look like you're from here. We're telling this person you're not familiar here, but this is their home. You're, you look like you're at a loose end. Because you're not sitting in a car or waiting at someone's house, having a cup of tea while your family's doing shopping. They used to say, you look different, this is harmful. Do you need some help today? Eh (flabbergasted). (SP-19-FOR-52)

6.2.2.3 Theme Summary

There are lots of policies in addition to the CDC but still issues persist, and because they persist, we can infer those issues are not being addressed at the core of their origins by any policy. We can see through analysis of data here that policies do not appear to act/occur in a complimentary way to how policy recipients actually live regardless of policy intentions, and that policy seemingly fails to contextualise the complexity and nuance of social problems as they are experienced.

6.2.3 Theme 3: Local Social Interactions and Policy Delivery

I have shown through the analysis above that the CDC is experienced as one of many social policy interventions in Ceduna. Data in this result Section expands further on particular mechanisms regarding *how* people experience or navigate their lives through the interrelated, persistent contexts, in addition to the CDC.

Throughout the many conversations had with participants over the year 2019, people explained to me that the CDC was just one thing that they had to deal with. The emergence of data in relation to assessing what was most important in the contexts that drove change, was iterative, lengthy and culminated during the beginning of 2020, immediately prior to the Covid19 global pandemic. I sought to address how (or if) contextual changes happened for participants who I had learned are mostly constrained to their often difficult and complex life contexts. On review of all previously collected data, additional interviews and observations, the following findings came into clarity.

Subthemes in this Section are made distinct between how CDC recipients and service provider discussed their relationships with one another with similarities between supportive and unsupportive relationships made clear in the data analysis which are similarly expressed by each subgroup. However, CDC recipients did not discuss relationships between service providers themselves, and this subtheme regarding relationships between service providers, only includes data from service providers themselves. Overall, the theme regarding relationships is dominated by data from service providers which can be seen in Table 13 below, further explored alongside data where relevant.

Theme 3: Local Social Interactions and Policy Delivery
Subthemes:

- CDC Recipients Discussing Their Relationships with Service providers
- Service providers Discussing Their Relationships with CDC Recipients
- Impactful Relationships Extend to those Between Agencies

Table 13: Frequency of relationships with service providers and CDC recipients.

RELATIONSHIPS WITH SERVICE PROVIDERS AND CDC RECIPIENTS – COVERAGE: 17 PARTICIPANTS, 96 REFERENCES QUOTED			
SUBGROUPING	Interview Participant	References	Coverage Percentage (%)
CDC (N=12)	CDC-1	10	7.2
	CDC-2	1	0.7
	CDC-3	10	7.2
	CDC-3 /CDC-4	13	9.4
	CDC-5/CDC-6/CDC-7	2	1.4
	CDC-9	2	1.4
	CDC-11	2	1.4
	CDC-12	6	4.3
	Total: 10	Total: 46	33.3%
SP (N=7)	SP-13	3	2.2
	SP-14	4	2.9
	SP-15	22	15.9
	SP-16	18	13.0
	SP-17	30	21.7
	SP-18	10	7.2
	SP-19	5	3.6
	Total: all	Total: 92	66.7%
TOTALS	17	138	100

The prominence of relationships between CDC recipients and service providers emerged from the data, where the type of relationship between them determines how CDC recipients could navigate complex social policies within the social security system. Data analysis indicates that although there are many policy and program options for people to find assistance depending on their needs, people can struggle to access this assistance. This is due to the combination of existing stressors and personal issues CDC recipients may face, alongside often confusing system requirements and existing policies people are required to comply with (link back to Existing Policy Context 6.2.2.1).

Analysis of the data explains that people find it easier to comply and navigate the system when they have a particular form of help from service providers. This help is described as

either an unsupportive or a supportive relationship. These forms of relationships between people such as CDC recipients and service providers, mirror those described by Thomas and Griffin (2021, p. 21) as professional-type relationships people in need of support may have with those outside their personal community or social group. These professional-type relationships are shown to be pivotal in providing avenues of vertical mobility across groups because these interactions can facilitate opportunities to overcome social barriers (Mor Barak, 2019; Carpiano, 2006; Thomas & Griffin, 2021). How these relationships do or do not achieve this is shown in data and discussed here. It was uncovered through data analysis that not all types of professional relationships are equal, and reasons for this are explained. These interactions are shown to link to Social Divisions in later sections 6.3.3.2.

Unsupportive relationships between policy end-users and service providers unintentionally acted as barriers to facilitating beneficial change. Often these unsupportive relationships are those where a service provider only dealt with one issue at a time, outside of the context the issue arises in, and are dismissive of the broader contexts that a person may experience. These interactions did not facilitate social mobility as they did not work to provide access to resources that help end-users to overcome their issues.

Supportive relationships include the service provider works to equitably and holistically address issues in context. Here providers assist across multiple issues and interact with end-users through providers taking the time to get to know about the broader life contexts of the people they are assisting. Importantly, effective relationships between providers directly relates to translation of policies in action at street-level and assist CDC recipients and other policy end-users to access information and systems via these beneficial interactions that otherwise may not be available to them.

6.2.3.1 CDC Recipients Discussing Their Relationships with Service providers

The following subtheme outlines the nuances between different types of service provider/CDC recipient relationship interactions described by CDC recipients only.

6.2.3.1.1 Unsupportive Relationships as Barriers to Beneficial Change

Unsupportive, dismissive or bad relationships are described as those that only address a singular social factor in isolation that a person may be dealing with, and where a provider is

unable to spend time discussing or assisting in any capacity outside of that singular issue. Further research assessing narratives of Australian frontline service worker narratives works to provide some possible explanations to these claims by CDC recipients. Research by Agllias et al. (2016) found that workers often reduced clients complex needs and problems to individualised 'bad' choices of clients, with little appreciation of worker power to help change complex client circumstances. Such relationships may not necessarily represent the level of issue-awareness or care/altruism of a worker but may instead reflect the systems and rules that the workers must abide and by and comply to (Agllias et al., 2016). Nonetheless, end-users experience the worker as representative of the approach to assistance and the dismissive, unsupportive approach was not successful in helping people overcome complex issues that are often beyond their immediate control:

> They don't care, so like Housing SA, I had Centrelink telling me to tell the [other service provider] people I had to be with a financial adviser, I'm with one now, its cause I kept pushing, pushing, she said well there's a long waiting list I said yeah but, well so what. What had happened was I was on the Family Tax Benefit and I was trying to get with the budgeter cause I had no clue how to budget, like my rent power water not to mention having food in cupboard for kids or what they needed, I needed to meet with a budgeter and when we got put in the DV unit cause the domestic violence happened and everything, they were all willing to help me then, and what they did is they got me on the Family Tax Benefit, and once I got that they just dropped me and now I gotta do all the rest by myself and I have no clue cause the kids father did all that (after a DV incident caused them to separate on police orders). (CDC-3-FOR-53)

The notion of what constitutes an unsupportive relationship is also confounded by delivery or enforcement of law designed to keep people safe. Participant reflections highlight the issues that exist regarding the need to overcome social problems and deal with harmful behaviours, but how other factors contribute to whether people decide to involve services such as police to help intervene. These other factors relate to illegal behaviours that combine, such as drug consumption or distribution, with outcomes of conflict, where involving law enforcement is perceived to not be able to occur without making the situation worse for those doing such behaviours. Other research such as that by Moallef and Hayashi (2021), has shown that

where there are multiple confounding factors such as illicit drug use or conflicts occurring, the parties involved are less likely to call police for assistance for fear of being arrested. When outside assistance is not involved this may limit opportunities for intervention or assistance of victims. As outlined in the participant characteristics table (Table 8, Chapter 5), participant CDC-11 explained the interactions between people in community that can become harmful and how police are not called for fear of further 'trouble':

> I: so when the arguments happen. Perhaps they get serious. Perhaps they're part of the group. It might be a couple. What happens? do people call the police to try and help sort it out. Did they get help if there's violence?
>
> CDC-11: that's a tricky question. Yes, logics would say you would call the police. Sure. But on the other side. Depending on where you are at. You keep that out. You keep the police out.
>
> I: so what about in the situation where people are pooling money. There's that pot of money in the center for the [drug] habit. And perhaps, an argument. Are The police called, or are they not called, or?
>
> CDC-11: no, definitely not. Not with those kinds of things at all. No. I definitely wouldn't call them. It makes it worse.
>
> I: why do you think they wouldn't call?
>
> CDC-11: because of the situation. Not to involve the law cause then there's more trouble. You see after a while, this becomes a day-to-day thing, and people get used to it. They get used to the violence. It becomes a day-to-day, natural thing. Does that make sense? The only way out is to go, to leave. (CDC-11-FOR-54)

6.2.3.1.2 Supportive Relationships as Promoting Beneficial Change

Alternatively supportive relationships with service providers may help a client to better navigate confusing difficulties and system rules. System navigation is difficult especially when people are dealing with multiple issues and need help so they can comply and get what they need at that time. Where end-users are sent back and forth to different agencies, this

demonstrates the singular treatment of a social factor or issue in isolation. When in reality such social issues are experienced simultaneously, and a more equitable approach may be more successful in helping people overcome those issues.

I: so you're coming here if you need help?

CDC-12: oh I come here all the time. They're really perfect here, can't go wrong. Even with computers. And I came back here from Port Augusta for my eyes, and I didn't know about forms and so many things and they said, come sit down [own name] we will make you a cup of tea, you relax we will help, went through all the computer, other services don't do it. Only here. (CDC-12-FOR-55)

I: So how did it happen here, how did that work?

CDC-3: Well, like I was in a really really bad place. And they [motions to the service agency] were the people that I could turn to if I needed help. I don't know if you know [service provider name]? But I started talking to her and she said come on come on, come and have a chat. And you know, I just started having little talks with her and opened up and told her how things were going. And then she was like, look we can help you. You see, I just thought the [service provider] was just for the locals, or just for the Aboriginal community. I didn't realize it was open to everybody but after talking to [service provider], I felt safe talking to her, which opened me up, and I felt like, oh yeah, this is a good place I can bring my kids in here.

CDC-3: And I was opening up to her and she was able to go into detail for me, the ins and outs of how Centrelink works, because nobody told me all of that shit. And then when those other ladies from the women's refuge, when they dropped me, I was just left to do everything. And I had no idea what to do cuz my partner used to do everything for me, and I was just overwhelmed. (CDC-3-FOR-56)

6.2.3.2 Service providers Discussing Their Relationships with CDC Recipients

The following subtheme outlines the nuances between different types of service provider/CDC recipient relationship interactions described by service providers only.

Service providers expressed that there is often a disconnect between community and end-user needs, and policy meeting those needs (link back to Existing Policy Context Section 6.2.2.1). They suggested that needs are not homogenous across individuals and the community, instead arguing that a more equitable approach is more successful in meeting needs. Participants described needing to work within existing policy frameworks designed as blanket solutions to broad issues and find methods of implementing such policy in more equitable ways. This is done through translating policy to make it work on the ground, where ultimately relationships between agencies, communities and end-users are paramount for successful policy delivery.

6.2.3.2.1 Unsupportive Relationships Through Superficial Engagement

A distinction is made here where service providers explained that unsupportive relationships with end-users are also those that are superficial and lacking assertive outreach to people in need. Participant SP-17 explains that these superficial relationships that are unsupportive of client needs, also relate to limits in staff experience and skills of those on the front line:

> SP-17: yeah. So relationships are crucial. You can't just work with families, clients, people, whatever you want to call them if you haven't got a relationship otherwise it just ends up being a superficial engagement. That doesn't help anybody except ticks a box for the funding provider to the agency, and I think that's a real issue, because what we really need is much more relationship building and assertive outreach to support people. And what do I mean by assertive outreach? I mean, actually knocking on the door and getting inside and you can't do that unless you've got a relationship
>
> It takes a while to build the relationship. So you've really you've actually got to be really committed to getting somewhere and getting to know someone. And there's very few people around here with the services that do that. Well, most of what's going on around here is a superficial engagement. And they give up when

the door gets shut on you, and they'll be like, Oh, how are you going today? I'm fine. Oh, Okay then. And that's it. And it's really tricky stuff. It's not for everybody to delve into people's private traumas, their private lives.

I: why do you think some services do that well and others don't?

SP-17: again, it's down to the people working there. And their expertise and their skills. And some people are just naturally good communicators. And some people have lived here all their lives, and they've got great relationship skills already with some clients. It's down to relationships and experience and not everybody's got that. (SP-17-FOR-57)

6.2.3.2.2 Supportive Relationships and Contextualising Need

Good relationships alongside active observations and working with people overtime, help providers to understand the contextual needs of end-users.

By saying something works it's when we've contextualized learning within an activity, So for example, when (SP) and (SP) went up to Oak Valley and delivered some land management projects stuff that worked really well because what they were doing with the people was building their capacity in reading and writing through the actual activity, so contextualized learning. It's a little bit tricky. It's like saying, Let's go and do something really fun that you want to engage in. But you're also going to be learning stuff. And it works really well. I mean, the other reason it worked is that they are highly skilled, and they're really good educators. (SP-17-FOR-58)

Good relationships are formed when providers addressed multiple social factors simultaneously that a person may be experiencing. From a service provider's position, this is achieved through spending time in conversations with end-users and getting to know each person, their regular behaviours and their family if applicable, so to better address complex issues they may be experiencing:

I: how do people find out what the need is?

SP-15: you ask people.

I: does that happen?

SP-15: well I do, I always go to a client and I'm like what do you need?

I: yeah.

SP-15: and they always tell me housing because I work in housing

I: yep

SP-15: and then I'm like, well, what else do you need cuz that's gonna be hard work to get, we can work on that and I'm happy to focus on that. But is there anything else like how's your finances? How's your mental health, how's your wellbeing? How's your cultural connection? How's your relationships? How's your, how's your drinking? Do you take any drugs? Like I don't care, tell me? You know? And I'm like, how do you feel about that? And just have those sort of conversations, Oh, I had a client this morning who rocked back up, I said hey where'd you stay last night. He said oh I Was out drinking, I was like oh so you had a bit of a party then? and he was like yep Yeah (haha). And I was like, oh, good work and off I go. You know, and I probably shouldn't facilitate that. But he's also a person that doesn't drink regularly. So I was like, well, you went out. You had me worried, because I didn't know where you were and you're always here. (SP-15-FOR-59)

Service providers made clear that needs of end-users and their communities vary, are interrelated, not homogenous and need to be addressed equitably. In accurately identifying and addressing different needs between their clients, some service providers were better able to meet people's needs at whatever point they are at. Addressing interrelated needs equitably comes from their accurate identification through having built inclusive and supportive relationships with end-users:

SP-16: okay. So, if we were looking at the overarching goal, say, that was for the economic development of the people of Ceduna that journey will look very different for every single person trying to obtain that goal. So we can't have a

one size fits all approach. So that approach might be, well, you might actually need some help with the literacy and numeracy skills and. So, in order to ever get close to that goal, you're going to need to deal with that particular issue. And another person might be well further down the track, and they might need help with a resume.

I: Ok

SP-16: someone might actually need some practical experience say in a volunteering capacity. So that journey is gonna look different for everyone. And you can't just have one program that says, Okay, we're going to have all of these people and help them with their resumes. Well, the reality is, maybe they're not all resume ready, you know. And so how do you respond to the differences. And so the goal is to help, but everybody's entry point is different.

I: so how do you reckon you folks have noticed or learned about that those patterns and seeing those things?

SP-16: we watch it over time. We live it. We know mornings are crazy and chaotic. That's when people are dealing with immediate need issues. In afternoons people are usually coming in, saying, Oh, I want to do my learner's permit etc. Different people are coming in at different times to. And so we've learned that pattern of how this community works. And that would look very different in other communities.

I: so you've spent the time observing?

SP-16: well yeah, you just reflect on what's working and just being there to see that. And we've collected that data over time. To see what you know is going on. We're not collecting it because anyone asks us to, we're just collecting it, because we want to keep track of what people are needing and wanting. And so that we can better respond to it.

So, the community hasn't come to us and said, Hello. We need social and emotional support, please. But through their actual actions. like nobody came to us and said, hello, we need a xyz. Please make one, but through the action of people coming into the old office, and that whole model, they have told us. So,

you know, communities will tell you things in different ways. They're not going to sit there in a community meeting and say, actually we need this. The movement of people will tell you what they need, or the lack of movement of people will tell you what they don't need or whatever, you know. And so, it's actually just sitting back and watching what's happening. And thinking, Oh, shit. A lot of people are coming through for this. Maybe we need to do something about that. Do you know what I mean. But the community is not going to articulate it in that way. Because nobody does. (SP-16-FOR-60)

In review of service providers experiences of assisting community, part of contextualising need is related to the expertise of staff and evolving capacity within organisations. Internal efforts to train staff, to meet staff at their current abilities and work with that, is how service providers better address the needs of their end-users. These efforts included facilitating strengths of each individual worker, as well as providing ongoing internal training and upskilling where needed:

I think it's about a real strengths-based approach, team training, to building a team because it's like, well, some of our workers might have very poor literacy skills. Well, not even poor, just different. And sometimes they just need more time. And time is one of our resources that is always short. But in terms of mapping out where someone fits in the community or understanding what might be going on, their knowledge on that is huge. So it's about well, look, you could not write that in an email, but you could talk to me about it though over a cup of tea. It's about recognizing each other's strengths.

You know, and look, I am the weirdo who can type it all up. And that's why I landed this bloody job because I can translate it into essentially what funders and policymakers want to hear from me.

Part of the wrestling of my job is that I'm trying to build this really strong team so we can help people well, but I have to translate that into ‘ways of the world’ as it stands now. Which is well look, I don't bullshit but you know, I have to understand how both of those worlds work to make it mesh, whilst trying to make some change in community, it’s not just about leaving things as they are. (SP-18-FOR-61)

6.2.3.3 Impactful Relationships Extend to those Between Agencies

Service providers express clear examples of what works in terms of the delivery of policies and corresponding programs. These examples reiterated the need for effective relationships between agencies to meet those needs of end-users. This subtheme includes data by service providers only as CDC recipients did not discuss relationships between service providers in any way.

6.2.3.3.1 Supportive Inter-Agency Relationships Help End-Users

Supportive relationships between agencies and service providers work to find beneficial outcomes for clients in need. Alongside relationships with end-users, analysis of the data outlined that finding success for end-users includes there being effective relationships *between service agencies*, and where there are effective relationships, everyone wins.

As stated below by participant SP-14, and elaborated on by participant SP-16, where agencies are better able to work collaboratively and build effective working relationships, this ultimately benefitted end-users:

> People are better helped when local services work together and build community trust – this is more sustainable. (SP-14-INFOR-62)

> I: so thinking about professional relationships between the people who work in service provision, how important are they?
>
> SP-16: heaps, very important, heaps important because if you want to be using people's relationships or resources you need to know who to call. And especially if you also need to stretch the rules. Or you need to be like, Okay, I'm putting the person in the centre and figuring out what their needs are, and being like, Okay, how do we respond to this? And how do we do it within the policy framework that exists, but how much of that can be massage to suit this individual's needs. That's what I'm talking about with blanket rules. You always need to be able to respond differently to everyone. So they can't be too rigid.

So for example, especially around criminality and that sort of stuff, policy and legislation is incredibly rigid. And that's fine, that's fine. But within that, when you've got relationships with people then you can actually get a really positive outcome for that person. And you know, everything will be safe and fine. That's so important like with the SAPOL situation [where this service provider was brought in by SAPOL to mediate a bad situation as the service provider had a good relationship with the accused offender and also with SAPOL, a non-police outcome was achieved to the delight of all involved]. It was like how do we navigate this policy position without making anything worse. (SP-16-FOR-63)

6.2.3.3.2 Unsupportive Inter-Agency Relationships are Not Beneficial for End-Users

Unsupportive relationships between agencies and service providers work as barriers to finding support for clients. Service providers discussed how they had little knowledge of what other services did, or how other services worked with their clients. Effects of poor inter-service relationships can impact knowledge translation across services regarding what each service can do or does do, negatively impacting efficiencies in real outcomes for end-users/community. Where there is a need to direct and manage end-user cases, lack of knowledge and inter-service relationships may negatively impact a SP ability to adequately provide efficient cross-service case-management:

SP-15: see this is the thing I don’t know what [other organisation] do

I: because I was gonna ask you, are you familiar? That was the other thing are you familiar with what other services actually provide?

SP-15: I don't think Anybody is familiar with what any service does

I: I mean other than the community paramedics?

SP-15: yeah. But even then, people aren’t so sure what they do.

I: and why do you reckon that is?

SP-15: oh, because there's nowhere anywhere that describes it all

I: yeah.

SP-15: what... So like, if you go to the city, there's a directory,

I: and there's no directory here?

SP-15: no, well there is, but it's very, very basic. And it sort of goes, these are the programs for each of these aspects of, well that you would use like financial counselling, drug and alcohol. Yeah, yeah, you know

But there's nothing to say like, [other local organisation] can help with you know, with x, y, and z. There's no words that says or goes by organisation and says these are the services they provide and this is how to speak to others. x y & z service there's nothing. So when we walk into town and we've got this camp fire lunch which is great because people go to [colleague] and I 'oh what do you to do?' and cause we're the only case managers at [own local organisation]. So, you know, a lot of people are like, I just thought it was an accommodation thing. And it's like, well, no, we're case managing them to be able to advocate for housing to get them to go through. But we're different to [another local organisation that does housing]. Because we're working with them [clients] through our system. (SP-15-FOR-64)

Aligning service provider agencies is challenging and when challenges cannot be overcome, inevitably some agencies are not included in strategies for positive change in the community:

And the whole premise behind that is about developing systems that are sustainable and that work. And we're still doing that. Because it's really hard to ask 15 different services to align their systems, which is really what we're trying to do, and we're getting pushback. There, it's all happening. But you've worked your way through it. And then at the end, you go right, well, 80% of people are on board. We're just going to have to leave the other 20% behind, because we haven't got the time or the energy to do the things that keeps everyone happy. (SP-17-FOR-65)

The interactions between CDC recipients and service providers, and between service providers themselves is shown in this data to have great bearing on outcomes for CDC

recipients in that these interactions work to influence social outcomes for better or worse. Similar reflections have been made elsewhere in the work by policy researchers Lipsky (1980), Lea (2016) and M. Gray (2010) who each work to explore how the interpersonal interactions on the ground between policy recipients and people providing services, works to impact and determine how policy is able to operate on the ground and what this means for outcomes for recipients.

Studies suggest that service providers, or street-level bureaucrats (Lipsky, 1980) play a crucial role in policy implementation by using professional discretion, reflecting the values of the constituencies they serve, and being responsive to the public, ultimately shaping public policies and their effectiveness. For example, Lipsky's (1980) concept of street-level bureaucracy suggests that frontline service providers play a critical role in shaping the experiences and outcomes of policy recipients. Service providers are tasked with implementing policies, but they also have discretion in how they interpret and apply policies in practice. Lipsky argues that the quality of interactions between service providers in communities can impact the behaviours and experiences of policy recipients. Lipsky's (1980) classic book outlines the challenges faced by frontline service providers, who operate at the "street-level" of public services. He argues that service providers often have to navigate conflicting demands and limited resources, leading to discretionary decision-making (Lipsky, 1980). Lipsky suggests that the quality of interactions between service providers and policy recipients can impact policy outcomes.

Research by M. Gray (2010) and others such as Lea (2016) suggests that policymakers should prioritize the development of networks and collaborations between service providers to improve the quality and consistency of services. M. Gray's (2010) article examines the role of provider networks and collaborations in social policy implementation, arguing that effective collaborations between service providers can improve the quality and consistency of services, leading to better outcomes for policy recipients. M. Gray suggests that policymakers should prioritize the development of networks and collaborations between service providers.

Tess Lea (2016) has expanded on these concepts from Lipsky by examining the interactions between service providers in rural communities. Lea (2016) examines the interactions between service providers in Indigenous health services in northern Australia. Si milarly, to Lipsky and M. Gray above, Lea argues that frontline service providers have a significant

impact on the experiences and outcomes of Indigenous policy recipients. Lea suggests that effective collaborations between service providers can improve the quality of services and promote better health outcomes for Indigenous communities.

Overall, the finding that interactions between service providers in communities can impact the behaviours and experiences of policy recipients has Been reflected elsewhere. Findings here highlight the significance of these social interactions and specifically the type of interactions that CDC recipients in Ceduna explain are most beneficial are those that are supportive, and are able to incorporate consideration of and assistance to indirect social problems and constraints a person may be facing. The findings here remain unique in that they work to describe the localised mechanisms related to how those interactions can facilitate social mobility away from social constraints a person may be experiencing. This is because through these supportive interactions, participants explained that beneficial interactions and relationships were able to facilitate change and access to services that can help liberate social mobility. Such findings are reflective of contextual views of behavioural change explored by Guerin (2016), who argues that it is through our interconnected social networks that people gain access to resources, which Putnam (2015) has described as helping individuals to overcome barriers and change their patterns of social mobility through improving access to social capital.

6.2.3.4 Theme Summary

Data analysis shows that social relationships between CDC recipients and service providers, and between service providers themselves, are pivotal in providing avenues for CDC recipients to overcome constraints. Analysis of the data explains that when seeking assistance with the social security system from support services to overcome bad life issues, CDC recipients' experiences of different types of relationships with service providers act as catalysts of change. Alongside other social interactions, and predominantly those between CDC recipients and service providers are shown in data to facilitate how a person experiences mobility within their life contexts when needing support, and how or if they are then able to overcome constraining social conditions.

Social interactions matter regarding assessing the process of how people navigate their lives. These interactions include those between CDC recipients and others in their lives more broadly, highlighted throughout previous themes identified. Furthermore, interactions

between service providers and their clients/CDC recipients, and between service providers themselves, directly influence success of the delivery of policy at street-level. Types of relationships and interactions within and between CDC recipients, and CDC recipients and service providers, directly relate to how people are able to effectively navigate their lives well and overcome bad problems or not. Good relationships emerge from interactions which are supportive of the influences of structural /contextual life conditions that shape the actions of CDC recipients. Bad relationships emerge from interactions that do not consider contextual conditions and instead frame problems in isolation and the individual as solely responsible for their social problems. Analysis of the data explains that when seeking assistance with the social security system from support services to overcome bad life issues, CDC recipients' experiences of different types of relationships with service providers act as catalysts of change which determine how or if they are then able to overcome constraining social conditions.

6.2.4 Findings Section Summary

The data expressed in Section 6.2 contraindicates what is proposed by conservative neoliberal policy logic. In Chapter 2, policy logic generally, and of the CDC specifically, was shown to be based on ideas of what 'ought to be' regarding conservative constructions of morality and deviance, and neoliberal promotion of individualised responsibility for behaviours. Data captured in my research encourages a reconceptualization of the dominant authoritative/ rationalist choice framework guiding policy making in general. I argue here that to use this approach alone does not adequately capture the complexity in context that is represented in the empirical data.

Participants and in particular, CDC recipients, described the contexts and issues that persist in their lives and explain them to be experienced as persistent, interrelated and difficult to overcome without supportive relationships and assistance. Some of the contexts and issues described as important by participants are different to those framed as relevant within the CDC policy objectives, whilst others are similar. However, there remains clear divergence when assessing how these issues are experienced, between CDC recipient explanations relative to rationalisations embedded in CDC policy logic.

As outlined in Chapter 2, the CDC policy logic positions the individual on welfare as the site of dysfunction and responsible for any social issues they experience, and through rationalist reasoning argues that quarantining welfare payments will redirect choice toward desired behaviours largely framed by conservative use of neoliberal ideology in a capitalist economy. Analysis of the empirical data, however, show that issues for respondents are largely *experienced as structural and outside of an individual's direct control*, and that subsequent actions arising from these conditions often worked to reinforce structural constraints. The realities of dealing with these issues restrict peoples' abilities to function in a way that policy logic and governance ideas suggest they should.

Instead, the issues created conditions that construct narrow opportunities for behaviours. Once analysed in their interrelated contexts, these behaviours challenge ideas of linear rationality, causation, or association. Instead, findings suggest responsibility is diversified across elements of structure *and* agency, otherwise described as an individual's opportunities to behave unavoidably depends on the structural contexts within which they live. The ramifications of this are analysed below and discussed alongside data presented. The following sub-themes express this complexity in detail as experienced and shared by study participants.

6.3 Describing the Influence of The Cashless Debit Card on the Card Recipients and the Community

This section findings focus on the influence of the CDC in the contexts of recipients and community's lives. This influence is established through the overlay of the CDC onto persistent conditions outlined in detail above, in Section 6.2. In doing so we can begin to appreciate the processes of how the CDC works to shape behaviours of CDC recipients and their community. The CDC is shown to exacerbate already bad social issues CDC recipients experience and does little to alleviate those issues. The CDC may not directly cause these bad social issues, but the exacerbation of those issues, and in some cases encourages new forms of behaviour and interactions, do not work to promote change either directly or indirectly in line with policy objectives and can make conditions worse for some people.

6.3.1 Theme 4: The Specific Influence of the Cashless Debit Card on Persistent Social Conditions

Data analysis shows that when overlaid onto persistent, interrelated conditions the CDC did not have beneficial influences in the Ceduna community and lives of recipients. Frequencies across both sample groups are outlined in Table 14 below, with the majority of data here resulting from the CDC recipient sample group. Mapping the mechanisms of how the CDC overlaid onto persistent conditions, is addressed as follows.

Theme 4: The Specific Influence of the CDC on Persistent Social Conditions
Subthemes:

Crime and Victimisation
Ongoing Substance Use/Dependence and Policy Circumvention
Exacerbating Discrimination and Historical Racism
Exacerbating Poor Mental Health and Disempowerment

Table 14: Frequency of the influence of the CDC on persistent issues.

THE INFLUENCE OF THE CDC ON PERSISTENT ISSUES –

PARTICIPANT COVERAGE: 17, REFERENCES QUOTED: 131			
SUBGROUP	Participant no.	References	Percentage coverage
CDC (N=11)	CDC-1	10	8
	CDC-2	8	6
	CDC-3	3	2
	CDC-3 /CDC-4	7	5
	CDC-5/CDC-6/CDC-7	29	22
	CDC-8	8	6
	CDC-9	13	10
	CDC-10	5	4
	CDC-11	15	11
		CDC: 98	CDC: 75%
SP (N=6)	SP-13	13	10
	CDC-12	3	2
	SP-15	6	5
	SP-16	2	2
	SP-18	5	4
	SP-19	4	3
		SP: 33	SP: 25%
TOTALS	17	131	100%

Participants did not discuss employment in relation to the CDC. The policy objectives of the CDC did not include moving people toward employment. Although as outlined in Chapter 2 regarding conservative neoliberal ideology embedded in CDC policy logic, gaining employment can be framed or inferred as 'promoting socially responsible behaviour'. The CDC did not change opportunities to find employment, but through making other issues worse (e. g., racism) may unintentionally and indirectly limit employment opportunities because of its exacerbation of related issues that promote unemployment, such as racism. These indirect issues regarding employment alongside other social problems, are presented as follows.

6.3.1.1 Crime and Victimisation: Violent Crime and Illicit Drugs

The following section explains the influence of the CDC in recipients lives when overlaid into persistent issues related to crime and victimisation. Some people who have experienced the CDC as recipients claimed the card caused more harm than it did good. Some participants describe increasing violence as a result of having little access to cash and requiring access to

drugs or alcohol. The following narratives explain how the CDC can relate to increased levels of violence in relation to ongoing substance dependencies.

Data analysis has outlined that some behaviours to get around the CDC are not always without harmful consequences to the self and others. In a broader sense, excluding the CDC policy impacts, the need to access something, such as an addictive substance, has been linked to creating behaviours that can victimise others and harm the self (Darke, Torok, Kaye & Ross, 2010). However, individual responsibility for these actions cannot be put aside even where social conditions have come to influence individual actions (Rhodes, 2009) and even if related to past traumas. Such findings have been theorised in the CDC and basics card research by Mendes et al. (2021) and are now shown here, explained further in relation to mental health below.

Participants expressed the victimisation of others that has occurred in relation to attempted resistance to the CDC policy rules to maintain access to illicit substances. In this instance two participants described violent harm that has occurred within a family that relates to substance dependence and limited access to cash due to being recipients of the CDC card:

> CDC-7: it does cause mental stress you know, the people that are exempt from the card, like the elderly, that sort of makes them vulnerable open targets, cause the epidemic of ice that's getting through this town, the people saying oh give me your money, they become targets cause they have money, two years ago that's what was happening to my grandmother, she was getting harassed by one of my cousins for money but lucky my other cousin pulled him up, yeah another fella, broke his mother's arm out at the mission, over ice
>
> CDC-6: yeah cause he wanted the money but the money wasn't accessible it was in the indue. (CDC-5/CDC-6/CDC-7-FOR-66)

Participant CDC-11 explained that through the legislation of the CDC policy, people could access 'a once per month' additional $200 in cash which is then pooled amongst many people to purchase larger volumes of drugs or alcohol. Larger purchases, or buying in bulk, are often 'better value for money' than smaller purchases. This bulk-buying is evidenced in systematic reviews and primary research related to illicit drug-market price modifiers for consumers

(Lebin et al., 2019; J. Payne, Manning, Fleming, & Pham, 2020; Wilkins, Romeo, Rychert, Prasad, & Graydon-Guy, 2020), which may help explain the 'pooling' of finances here. Participant CDC-11 explained the violence that can occur when people take more than their 'share'. Furthermore, they described that when it comes to dependence, described here as a 'habit', the options of trade to access a substance for personal consumption are limited to cash. Such reflections indicate that although the CDC may be effective in making it harder to access cash, the outcomes of this limitation does not necessarily translate in reduced drug or alcohol consumption. Instead, there may be unintended consequences such as an increase in volatility and violence in social interactions where cash maintains its priority after purchase from dealers and *between consumers*:

> I: so do you think that the card actually does anything good or bad, does it do anything?
>
> CDC-11: haha, no, Not at all. No, no, hahahahahahaha. In fact, it makes it worse.
>
> I: why does it make it worse?
>
> CDC-11: right. Okay. Here we go. It makes it worse. Because for the sole reason. It is a fact. There is a card. And there is another card, you can put money on to every month. You can draw $200 out. Now, come with me on my little escapade here. Haha. So, 200 400 600, The list goes on. Put it all into a nice little pile. Oh boy. We've got enough for the next three to four days. 100 a pop hundred that's today. Okay, there you go.
>
> I: so everybody puts it in the pot?
>
> CDC-11: yeah, yeah. course they do work it out, you work this out. You've got a bad habit. You've got a habit. So that's a $100 a day habit, alcohol, or ice, whatever. It's a habit. Hello. You go Get $200, you other person go get $200. You other person go get $200 as well. Pool it. And sit back, and the government doesn't ask what are you doing with it. (CDC-11-FOR-67)

After some time had passed, and other people had left after saying hello (recording was paused) we continued our conversation:

I: so thinking about people coming together and pooling the money. How do people know they can trust each other?

CDC-11: well, it's like everything. Since the cards come on in the community. But what happens at the end of the day, is that there's arguments. Because for the sole reason. And I'll talk from the alcohol side (wink), there's always going to be people in there that drink or whatever more than another person. You can't, You can't overcome the arguments. What are you gonna do. You can't sit back and say ‘you can't keep drinking, you can't take more’

I: taking more than their share?

CDC-11: yeah yeah yeah yeah, exactly. And that's what's happening here in Ceduna, is that the community is fighting. And the binding together, but it's not good. It's a negative, not a positive. It's not a positive. It's a positive to a habit. But it's a negative because it's the flip side to everything in the community group that there's going to be people in there that will be greedier. And in that way there's going to be upsets.

I: so what happens when there's upsets?

CDC-11: it just keeps going.

I: so say people take more than their share, more than what’s fair. Do they give back in other ways?

CDC-11: no, that's why you fight and your arguments come into it, now that's where all the arguments happen, because for the sole reason. When you've got a habit of some sort. There's no such thing as this to that. All you're thinking about is what's there. And that's it. If you took away the card, you took it away on that score. Everyone's got their money. You can’t say I'll bring a six pack, for argument's sake, or I'll bring this, or I'll bring that. It's a bit different. You see now, because when you have cash you're cutting out all the arguments, the massive arguments that are going to happen regularly, compared to just the normal things. The normal abuse.

I: do people get hurt in these arguments. More than they did before?

CDC-11: yes, sure. Yes, they do. Have a look at people's views before in Ceduna, when that card came compared to now. I guarantee you, it was a lot better back then, but there's more violence now. Because of that, when you think about it logically, it makes sense.

I: so, is the card really doing what it's meant to do, or is it causing more harm, or..?

CDC-11: more harm, Sure.

I: so think of people putting things in the pot, pooling. The bartering, to clarify do people ever put things in other things in, for example,

CDC-11: not for a habit. It has to be money. It's got to be

I: as opposed to swapping something else?

CDC-11: no, no way. Not gonna happen. Not gonna happen. It can't. No. No. It doesn't happen that way, its only cash… as far as I'm concerned, the card is not. They say it is. but It's not working. But if it is, how come people still have addiction. They have their addiction as heavy as they still had it, how come it's still there. They keep putting it in the centre. The money. It's a fact, I've seen it, there's people out there. I've spoken to them. (CDC-11-FOR-68)

As discussed in Chapter 2, the CDC policy legislation frames the purchase and consumption of illicit drugs as driving poor social outcomes as an individual's problem. Some argue that the CDC policy logic (Klein, 2016) ignores structural conditions that promote irresponsible behaviours such as crime. However, The CDC policy does not necessarily frame drug use concerning the broader social consideration of crime, except where this could be inferred where reducing access to illicit drugs may 'promote socially responsible behaviour' as per CDC objectives (Klein, 2016, p. 512). Some have framed irresponsible behaviours as occurring through the depoliticization of origins of social problems as once structural, now individualised through capitalist economic rationalism (Klein, 2016). Others, such as Wacquant (2009), argue that such behaviours are inclusive of those deemed 'criminal' and are socially constructed and emerge from conditions of socio-economic crises and poverty, mainly outside of an individual's control. Concerning how drug crime may occur and what

policy may do to influence this, no research thus far has discussed how social interactions between users of illicit drugs are influenced in relation to the impact of the CDC.

As participant CDC-11 discussed above regarding the CDC exacerbating violence and the pooling of money to purchase drugs, there is some indication that this pooling may be changing how people interact with each other with the aim of maintaining access to drugs. Participant CDC-11 highlighted the reality of dependency is ongoing and the CDC may be creating conditions that encourage new interactions in relation to maintaining drug use:

> CDC-11: a habit is a habit. the card doesn't change that
>
> I: did you see people do this before the into the card. Pooling the money?
>
> CDC-11: no, well with the card it made it a bit harder, But over time. There's always a loophole.
>
> I: are people coming together that didn't before to help each other now?
>
> CDC-11: oh yeah, for sure. (CDC-11-FOR-69)

Similar findings expressed in the analyses of data provided by participant CDC-11 regarding changes to social interactions relating to violence and drug use have emerged elsewhere (Draus & Carlson, 2007; Jacques & Wright, 2011, 2014). Some efforts assess the impacts of social policies on how people who use illicit drugs can engage with one another (Dickson-Gomez, Weeks, Martinez, & Radda, 2004). These similarities can be seen in the work by (Dickson-Gomez et al., 2004), whose anthropological study examined the role of drug-harm minimisation policy. They did so through engaging in conversations and observations of illicit drug users in private drug-consumption locations, and their work examples how the policy (peer-led intervention designed to teach dealers and users safer consumption practices in private home locations) relies on existing social relationships between users in order to work well. However, in work by Dickson-Gomez et al. (2004) the complexities of social interactions and reciprocity over time and over interactions with different persons were found to not work well with the policy's intention because the policy did not account for such complexities. The policy created conditions that encouraged increased use of drugs in some cases and facilitated people coming together who may not have otherwise, which increased the occurrence of conflict (Dickson-Gomez et al., 2004).

The consumption of and purchase/access to illicit drugs of dependence, such as methamphetamine, is described by some participants as: facilitated by the CDC itself; and interwoven with trading non-monetary resources in some cases. Participants expressed the use of illicit drugs as having not ceased since the introduction of the CDC policy. Participant SP-13 described circumvention strategies that include facilitation of the policy rules themselves in some cases, where both the dealer and consumer have CDC Indue accounts:

> SP-13: what's happened is people are buying ice from him and transferring Indue funds into his Indue account. Indue are onto it and the police have been asking him questions about the funds turning up in his bank
>
> It [CDC] hasn't interfered with his business in the least in fact it was easier for him because he doesn't get caught with cash
>
> I: but the money is tracked via electronic transfers...?
>
> SP-13: yes but ice and cash are not in the same place are they
>
> I: ahhhhh
>
> SP-13: how do they link the two, they can't stop him from saying he lent money to people and they owe him, after all that's how his people work. (SP-13-INFORM-70)

Similar to alcohol use and selling groceries purchased on the card to access cash to buy alcohol, participant CDC-9 described their experiences with some CDC recipients swapping groceries explicitly for methamphetamine. This reality of bartering goods as a form of exchange to circumnavigate policy rules was evidenced in much earlier research regarding the basics card by Bray et al. (2014) and continues with the CDC as evidenced here regarding illicit drugs, and more generally in the following Section below:

> People go into [grocery store] and buy food, and then if they're a junkie they come out and sell it for a small bag of ice. well swap it like. (CDC-9-INFOR-71)

In summary, as established in the review of participants' persistent issues in Section 6.3, most CDC recipients have experienced high levels of violence in their lives in some way, regardless of the CDC. When persistent issues are overlaid with the CDC policy, the effects can exacerbate violence and drug use. This relationship between the iterative nature of violence and drug use has been evidenced elsewhere. First, research has shown that violence has a heightened probability of becoming a normalised part of everyday life when experienced at consistently high levels (Bouchet, 2018; McCarry & Lombard, 2016; Varman, Goswami, & Vijay, 2018).

Second, further research has suggested that personal experiences of violence as a victim and/or perpetrator can establish a skewed baseline of behaviour that increases the likelihood of continued experience of violence in some way (Bostock et al., 2009; Fitz-Gibbon et al., 2022; Middleton, Sachs, & Dorahy, 2017). This includes young people who experience violence in their home, who have been found to be significantly more likely to use violence in their own homes with their family as they age (relative to those who have not experienced family violence), underscoring the perpetuation of family violence through generations (Fitz-Gibbon et al., 2022). This research by Fitz-Gibbon et al. (2022) surveyed over five thousand young Australians (aged between 16-20 years), finding that young people who are the victims of abuse as children are nine times more likely to use violence in their own homes. These children are also nearly three times more likely to use violence where they have witnessed but were not subject to the violence themselves.

Third, some research has stressed that when people experience persistent violence, particularly family violence, they are at twice the risk of using illicit drugs than those who do not experience family violence (Coomber et al., 2021). These three points regarding violence are essential to consider in combination. This is because we can see through previous research and in this data section, alongside the persistent violence explained in Section 6.3, that the role the CDC plays in violence may exacerbate ongoing violent behaviours and victimisation in already bad relationships where drug use occurs. Importantly, because violence also has the potential to increase the use of illicit drugs where there once was not, where the CDC has the potential of increasing the perpetuation of violence, it may also indirectly increase the rate and prevalence of drug use.

What is absent in the data are reflections of violence without the use of drugs concerning the direct influence of the CDC in recipients' lives. Instead, connections between the CDC and violence in the absence of drug use can be seen indirectly in later sections regarding the CDC stimulating social conflict and increasing stress, two known precursors to escalation into violence (Krahé, 2020). Notably, this escalation is not categorised as a definite outcome across the same experiences but is mediated through perceptions of injustice (Alda, Bennett, Marion, Morabito, & Baxter, 2020; Holtfreter, 2015; McLean & Wolfe, 2016; Tyler & Jackson, 2014) and social interactions related to having beneficial resource-relationship pathways (Guerin, 2020b) and social cohesion (Beauvais & Jenson, 2002; Chan et al., 2006; Hewstone, 2015; McKeown & Dixon, 2017; Pettigrew et al., 2011). As opposed to the CDC causing or being the origin of those violent behaviours, here we can see that the CDC does not prevent violence and instead may exacerbate the persistent violence some people experience.

6.3.1.2 Ongoing Substance Use/Dependence and Policy Circumvention

In this sub theme, participants described observable behaviours that they or others do to circumvent the CDC policy restrictions so to get on with their life and re-establish agency. These resistance behaviours depend on existing conditions and personal issues participants already experience. Behaviours described indicate the CDC does not influence or impede behaviours in ways that align with policy objectives. Instead, resistance behaviours reflect how the policy does change behaviour but not necessarily in line with the aim of policy objectives. This includes resisting the CDC rules to maintain access to persistent 'negatively framed behaviours' under the CDC policy objectives, such as drug and alcohol consumption, and gambling.

Resistance or circumvention behaviours may relate to social inclusion and social participation, where these behaviours are required and/or encouraged to maintain access to social groups or social norms. These groups or norms may provide further access to, or avoidance of, desired and needed outcomes, such as drinking alcohol as a family activity where in not doing so, insults others you rely on for food and shelter, thus risking access to those necessities (link back to Substance Dependence Section 6.2.1.3). Doing behaviours so to gain or maintain access to social groups because those groups are useful in some way has been evidenced elsewhere (Ennett & Bauman, 1993; Ennett et al., 2010). Such evidence provides an alternative analysis of behaviour regarding the often-argued theory in the

psychology field that people are convinced to do things by others by internalising presented ideas then acting on them (Postmes, Haslam, & Swaab, 2005; J. Turner & Oakes, 1986), a theory that has been challenged elsewhere (Bauman & Ennett, 1996; Guerin, 2016; 2022). In contrast, this idea of internalisation cannot be observed in the data here, but what can be observed is the social reasons people may be doing such behaviours based on the observable effects those behaviours have. Where the CDC policy rules may provide hurdles to continued access to these groups or norms and there are no other access options, reasoning for actions favours resistance of the CDC rules.

6.3.1.2.1 Trading resources

Overall, the trading of resources other than money is expressed as required where someone sought to circumvent the CDC policy rules. These circumvention strategies have been reflected in sub theme 'Problems of Existing Policies', where for welfare and CDC recipients, social policies can be bothersome hurdles and do little to direct desired behaviours. Data here shows people were innovative and resisted the card in many ways, depending on what was available to them and what they needed to get access to:

> There's always ways around though, that indue card, take the money out into some others account or get someone else's indue. (CDC-8-FOR-72)

> I: what do you see with the indue card, you're saying lots of people have it so what happens with it?
>
> SP-15: they share it. And so putting money on an indue card, they just swap it and trade it for something they can use.
>
> I: Yeah. So have you seen people trade and swap?
>
> SP-15: Yes, yes. Like we find, we found somebody who we don't even know. isn't even from Ceduna had an indue card in one of our rooms. And we're like who is this person. (SP-15-FOR-73)

> CDC-7: what I was gonna say that people doing trading, people are trying to trade people everywhere they go, doubling, like I'll trade you 40 for 20 cash, or balya, 40 on your card there, trading. (CDC-5, CDC-6,CDC-7-FOR-74)

6.3.1.2.2 Alcohol Dependence

Trading resources includes behaviours changing for continued access to alcohol, which alongside drug use, is framed as 'bad' behaviours within and between CDC recipients and non-recipients which work to Divide community (linking to Section 6.3.3.1). Where we consider dependence to be a health issue, alcohol dependence remains a prominent issue nationwide, particularly in rural areas (Australian Criminal Intelligence Commission, 2022) and continues to harm people who suffer from dependence (AIHW, 2019). Additional evidence from my observations and informal reports from community members have confirmed the reality of continuing alcohol abuse and dependence issues in the region. These additional reports and observations include extreme negative outcomes (public unintentional death) for some people, where on one occasion I was informed by a service provider participant that a known community member died in a public location in Ceduna in the year 2020 due to their long-term alcohol dependence. Other participants confirmed this event and shared some rumours which included that the person who died had been turned away from the local hospital not long prior to their death, but I have not confirmed this with other local authorities. Observational analysis of this event is not addressed further because: this occurred outside of the main data collection period of 2019; out of respect for this person's family and the broader community; and because I had limited access to the community during 2020-onward due to the Covid-19 pandemic. One participant explained how they have previously tried to assist others who still rely on alcohol due to dependence issues:

> CDC-6: yeah, I've had someone, first thing I was thinking we gotta get her alcohol, I couldn't buy alcohol with my card, I had to go and trade somebody to get the stuff for her to stop the shakes, for somebody else, doing it to help em, look I'm against the alcohol and all that anyway, but just to see that person sitting back shaking and needing it. (CDC-5/CDC-6/CDC-7-FOR-75)

Overall participants expressed that there was continued problematic alcohol consumption that the CDC policy did not prevent:

CDC-5: it's not working, people still finding out things and when they go to the shop and buy big lot of groceries and they'll give it to someone saying oh you give me some dollars and I'll give you all these groceries and that, they're finding ways to buy alcohol, it's not gonna stop, it's not working. (CDC-5/CDC-6/CDC-7-FOR-76)

I: thinking about the card, has the card reduced access to alcohol?

CDC-3: no

CDC-4: see that doesn't happen! They just put the money into the other persons account, the other person gives the money back, and then they transfer the same amount to that person

I: what do you mean?

CDC-4: they can do transfer and bpays

CDC-3: yes! They transfer a payment, like a rent payment, they transfer the money from the indue account (person 1) into someone else's bank account (person 2), and put it down as a rent payment, other purpose, and then that person will transfer from their (person 2) bank account back into their (person 1) bank account, cause the bank card is not linked to the indue, so they're still finding loop holes. (CDC- /CDC-4-FOR-77)

CDC-5: well people are asking other people for IDs and that stuff and to buy alcohol for them, I said I've got an ID but I say no I've got nothing cause I'm not gonna get in trouble just for them, just to meet their needs,

I: so are there still a fair few folks still drinking like before?

CDC-5: yeah cause you can transfer money over from the indue into a bank account so there are ways of still transfer money to buy alcohol and things like that (CDC-5-FOR-78)

Informal Interactions Box 6

Circumvention behaviours regarding gaining/maintaining access to alcohol can involve grog-running, although it remains unclear if this occurred prior to the CDC in Ceduna, and also may link to existence of other policy regarding non-CDC related alcohol restrictions. Where ID with address is needed to purchase alcohol at the local pub, people with addresses from dry-communities (where in those communities the sale and consumption of alcohol is prohibited) are excluded from purchasing alcohol in Ceduna under a Special Circumstances License issued to premises in Ceduna adjacent to Aboriginal dry-communities (Government of South Australia, 2022d; National Drug Research Institute, 2007).

SP-16- INFORM-78 – Situation: Third visit to Ceduna. Volunteering day, Friday. Patterns of movement seem to indicate Fridays as very quiet in town, many people have referred to Fridays as 'slow day' where people don't do much, others leave work early and the town is a little more quiet than other days of the week. I had been wondering if this was typical or generalised patterned behaviour. Speaking with SP-16 I asked about Fridays and town seeming quiet. They had lived in Ceduna for a number of years.
SP-16: "oh yeah Fridays are quiet everywhere, that and the bus comes in Thursdays, so there's a bit of grog about", I asked about what they meant by this, and how are the bus and alcohol related, "people bring grog up on the bus, other ways as well but yeah, the bus, Thursday is party night".

OTHERS-INFORM-06/19 - Later interactions with a different person helped further explain grog-running to Ceduna – this person asked that I do not include the specific date we spoke or any other general locations regarding what they told me out of fear of being reprimanded. Such reflections suggest continuation of crime in association with dependence issues, regardless of the CDC (or other policies) implementation: "yeah I run grog up Ceduna way, stop at many places not just Ceduna, I get the grog, steal it you know, then drive it up there, makes good money hey, sell to family only though, can't trust others" I asked them how long they've been doing this, they explained briefly without elaborating "for ages".

Although not discussed by participants, the relationship between alcohol and family violence in Australia has been established as a known, common problem where high rates of alcohol consumption are strongly correlated to a higher incidence of family violence (Curtis et al.,

2019; Hulme, Morgan, & Boxall, 2019; Mayshak et al., 2022). Such a consistent finding across research regarding the strong relationship between alcohol consumption and increase risk of family violence should be considered problematic when combined with further data already presented in these findings more broadly. Research in Section 6.3 has shown an already high incidence of family violence occurs as a persistent issue for participants. Considering that data in this Section shows that the CDC does little to reduce alcohol consumption, this may combine with other themes identified in Section 6.3, which when brought together further positions the CDC as having a high potential for exacerbating violence. Such indirect combinations of data challenges the linear conception of events and proposed logic of behavioural causation embedded in the CDC policy logic. Instead of the CDC reducing access to alcohol or drugs and therefor reducing family violence, data analysis thus far suggests the interactions between these social problems and policy are not linear and such rational logic of theories of causation need to be reconsidered so to better understand the problems in context.

6.3.1.2.3 Gambling

The topic of gambling was not really discussed as an issue in interviews. Occasionally during shared activities, key informants suggested and pointed out houses where people go to partake in informal gambling activities. This avenue of informal gambling was not pursued due to a variety of reasons, largely relating to my inability to follow-up having been restricted by the Covid-19 pandemic beginning in Australia in early 2020 which prevented me from returning to this topic. Other reasons include those related to timing and patience regarding me inquiring about illegal activities. Previous research experience had taught me to not rush nor push for such information about illegal activities but to wait and ask slowly another time, a time which did not eventuate due to the pandemic lockdowns. Additional reasons relate to the possible combination of illegal activities taking place together inside those locations as was inferred by some participants and this may have posed a problem regarding safety hence was another reason for not rushing in. In the formal interviews only one participant addressed their desire to gamble but that the CDC made that difficult for them:

> I: what else about the indue card should I know?

CDC-10: I just want to get off of it, like then I can play the pokies you know, haha, like I was supposed to get 180 but the 100 goes on the card

I: but what happens if you spent all your money on the pokies?

CDC-10: well I made 170 on the pokies last week

I: haha so how much did you put in?

CDC-10: hahaha yeah, I was gonna take it out but then I was like na. (CDC-10-FOR-79)

Through analysis, the CDC is shown thus far to not stop access to drugs or alcohol, which has also been identified in other studies investigating the impacts of CDC or basics card (Altman, 2016; Bielefeld, 2018a; J. R. Bray, Gray, Hand, & Katz, 2014; Dalley, 2020; Marston et al., 2020; Mavromaras, Moskos, Mahuteau, & Isherwood, 2021; K. Stevens, 2020; E. Vincent, 2019). However, unlike previous research, data analysis here has shown that the CDC does work to change behaviours of policy recipients. Instead of in accordance with policy intentions, the policy changes the way people need to behave to maintain access to these substances, which can be an added social and individual burden and relate to increased violence in some cases. However, little can be said regarding the role of the CDC on influencing gambling behaviours, as when considering persistent issues in Section 6.3 gambling was not addressed as a persistent problem that participants are experiencing and has not been addressed by participants in relation to the CDC.

6.3.1.3 Exacerbating Discrimination and Historical Racism

CDC recipients and service providers expressed similarities regarding the CDC and discrimination with some suggesting directly that the CDC relates to a history of past racism now reinvented. Data analysis shows that the CDC does this as it perpetuates the social division that occurs because of racism. Firstly, the CDC itself is described as socially divisive, where use of the physical card can be seen by others representing an observable physical division. The socially constructed symbolism represented by the card comes from past policy that legislated social division based on classifications of ‘race’ or ‘type’ of person. Secondly, this division is shown to also occur even between people who are all in receipt of the CDC (link forward to Divisive - Us and Them Section 6.3.3.1). Here these two issues are

expressed by CDC participants, with CDC-5/CDC-6/CDC-7 intermittently speaking with me in between painting and organising artwork:

> CDC-6: the disgraceful thing about it is like what about our people back in the 50s 60s, that lived on the rations, this card is a modern day discriminant against Indigenous, this was originally aimed at Indigenous people and then some people put in a federal complaint and now it's for all of us, this give white people a taste of what's done in the past to us, this is modern day repeated history, it's a discriminant racist thing that's happening, it's against our human rights, our rights have been taken away. (CDC-5/CDC-6/CDC-7-FOR-80)

> CDC-7 there's this racist history coming into modern times. (CDC-5/CDC-6/CDC-7-FOR-81)

> CDC-5: the reason why it come up to us because all the Yalata people from Yalata, they coming here to Ceduna and they were drinking and getting hit by cars and then the council brushed everybody with the same brush, then about a year ago all the whitefella started coming off the indue, and left all the aboriginal people on there. (CDC-5/CDC-6/CDC-7-FOR-82)

> CDC-12: I don't like it I don't like it at all. Why did I get it there in the first place. Why? is it because we speak a second language, we don't speak English? Because we were brought up with this English, And the two languages I do anyway. (CDC-12-FOR-83)

Such division occurring through use of the CDC and the policy approach more generally, is also reflected on by service providers:

> SP-16: yes, but also, even just walking into [grocery store]. I would suggest that if you're an Aboriginal person who goes into [grocery store]. You're going to

well, especially if you've come off the lands, and you might not necessarily be dressed in the way that you're expected to be dressed in mainstream society. People are looking at you. you see those looks, you feel those looks, then you pull out your indue card and that also says yes I'm one of them. That whole experience is quite negative. (SP-16-FOR-84)

I: so there's a history, current and previous history of racism?

SP-13: yeah. And all they've done is polished the racism. And they've used the card to enforce it. (SP-13-INFOR-85)

Informal Interactions Box 7

Discrimination regarding the CDC is not exclusively directly related to the CDC itself, but CDC associated discrimination exists because of existing discrimination toward welfare recipients and First Nations Australians more broadly. The CDC perpetuates stereotyping and discrimination where polarised views find another platform for expression.
OTHERS-INFORM-211119 – with addition of CDC-2-INFOR-86
Situation: visit to a local not-for-profit, volunteer run store in Ceduna. A participant CDC-2 was volunteering here and had invited me to visit them where I spent nearly two hours helping them around the store. During this visit I observed what became a very heated interaction between this participant and another person who was not a local but appeared to be travelling through the town.
When I arrived, participant CDC-2 and I hugged hello, it was a warm greeting. There were two others in the store at the time: a man sitting nearby who appeared to be CDC-2s friend and who left soon after I arrived, and another lady who appeared to be shopping. CDC-2 and I got chatting about the hot weather the day prior. The lady (OTHERS-INFOR) joined in discussing her caravan air-conditioner, motioning toward the caravan park which may suggest she was travelling through town. The lady discussed places they had visited and lived over the past two years, asking me what brings me to town, and I explained my role as researcher. She wanted to contribute and shared a story about her experiences with the CDC type policies, how that when they were in Wilcannia their friends owned the local store and how when welfare was delivered to people via cheque – the lady explained: “that if the man got the money he would spend it all at the pub, whereas the women cashed it and spent it on

groceries" referring to these welfare recipients as 'Aborigines' and that even though they (the lady) were white, they had many 'dark' friends. The lady explained her time living in Townsville where "you were lucky to leave NOT a racist, the Aborigines up there, everything is handed to them for nothing". They explained how they believed the CDC to be a good thing "because people can still use their money but can't buy all the alcohol".
I noticed at this point that CDC-2, was shaking her head, responding to the lady saying CDC-2: "but I'm on the card and I tell you it's awful". The lady seemed surprised, CDC-2 asked the lady "are you on the card?" in an increasingly agitated tone. The lady responded "no…but.." with CDC-2 cutting her off "well you don't know, but I can tell you it doesn't help". The lady seemed embarrassed, CDC-2 was upset now, the lady said "well you shouldn't be on it…", CDC-2 replied "no one should".
The door to the shop opened with other customers arriving, and the lady left. CDC-2 is a non-First Nations Australian who has suffered extreme domestic violence in their past and is now disabled due to this violence they experienced.

Racism and the CDC links back to Persistent Discrimination Section 6.2.1.4.1, where the CDC can be seen as not the original cause of racism but works to perpetuate it because it ignores historical and existing discriminatory conditions. Here participants explained how the experience they CDC as inequitable. This is expressed through labelling the CDC as racist policy, because it ignores structural impacts of historical and existing racism and social exclusion, and because of this, works to reinforce persistent discrimination outlined in Section 6.3 and repeats past injustices of historically discriminatory policy.

Racism can result in historical and ongoing trauma as outlined in the study of Australian First Nations People by O`Brien (2021). This past and present trauma related to racism refers to "cumulative emotional and psychological wounding across generations and an individual's lifespan" (Brave Heart, 1998, p. 2). This historical and ongoing trauma associated with experiences of racism can contribute to substance abuse as a way to cope with the emotional pain and stress associated with racism. For example, for Australian First Nations people who experience racism and related abuses as historical and contemporary trauma, the work by Menzies (2019) contends that the "consequences of these human rights abuse violations are evident within Aboriginal communities, which experience high documented rates of self-harm, drug and alcohol use, violence, unresolved grief, mental illness, depression, transience,

homelessness, marginalization, discrimination, feelings of insecurity and hopelessness". Such outcomes are similar for First Nations people globally. A study by Whitbeck et al. (2004) found that Native American youth who experienced historical trauma were more likely to use alcohol and drugs. Racism can also result in social disadvantage, which can increase the likelihood of substance abuse. A study by Borrell et al. (2010) found that African Americans who experienced racial discrimination were more likely to smoke cigarettes and use drugs. These authors suggest that social disadvantage may lead to substance abuse as a way to cope with stress and negative emotions. Racial trauma refers to the emotional and psychological impact of racism, including experiences of discrimination, racism, and microaggressions. Furthermore, a study by Comas-Diaz, Hall and Neville (2019) found that racial trauma was associated with substance abuse among First Nations people in North America. The authors suggest that substance abuse may be a coping mechanism for the emotional pain and distress associated with racial trauma. Racism as a form of oppression, can also lead to feelings of powerlessness and hopelessness. A study by Cave et al. (2020) found that American youth who experienced racism were more likely to engage in risky behaviours, including substance abuse. Cave et al. (2020 alongside other authors (see Amaro et al. 2021) suggest that substance abuse may be a way to cope with feelings of powerlessness and hopelessness associated with oppression. Where the CDC is experienced as a racist policy, this may have the effect of intentionally contributing to problems with poor mental health and substance abuse, alongside preventing employment and access to social capital already discussed.

6.3.1.4 Exacerbating Poor Mental Health and Disempowerment

The following subtheme emerged from the analysis where data reflected the influences of the CDC on mental health. This influence was spread across two focus areas, including: outcomes of disempowerment which can relate to extreme stress having negative impacts on people, and promoting anger toward decision makers indicating further social division; further, shame responses may arise through social stigmatisation and labelling of card recipients. The production of stress and shame, become consequences of the contextual constraints of the CDC. These constraints are described in ways that show participants are further disempowered within their social world to enact agency within already constrained contexts such as those relating to unemployment, violence, historical trauma and discrimination as outlined in Section 6.2.

All these persistent issues identified in Section 6.2 are known to directly reduce mental and physical wellbeing and quality of life for individuals (A. Baum, Garofalo, & Yali, 1999; Belle, 1990; English, Rendina, & Parsons, 2018). These issues have also been shown to indirectly negatively impact the broader societies within which these issues persist, such as through promotion of crime and reduction in economic productivity (Wilkinson & Pickett, 2010). In extending findings by researchers such as Mendes et al. (2021) addressed in Chapter 3 regarding the trauma related reasons for ongoing substance dependence, findings work to contextualise those pathways that lead to origins and outcomes of trauma that then exacerbate problems with mental health and substance use issues. Furthermore, mental health issues as discussed below, are shown to be interrelated to other problems, including issues with violence, racism and other stressors related to relationship deterioration and financial stressors (Inglis, McHardy, Sosu, McAteer, & Biggs, 2019; Marquez, Francis, & Gerstenberger, 2019; Murali & Oyebode, 2004), all exacerbated by the CDC. In this way the CDC is positioned as not beneficial for mental health because of how mental health is unavoidably interrelated to persistent issues CDC recipients experience.

6.3.1.4.1 The CDC, Mental Health and Production of Stress

Stress and the CDC needs to be emphasised as being about a complex interrelatedness between existing stressors (link back to Persistent Issues Section 6.2.1) such as those related to poverty, discrimination, historical trauma, and violence, and how the CDC adds to this stress. Other research whether quantitative or qualitative, has consistently shown the associations between poverty, discrimination (linking to Section 6.2.1.4), historical trauma and violence and creation of stress and outcomes of poor mental health and perceptions of disempowerment (A. Baum, Garofalo, & Yali, 1999; Belle, 1990; English, Rendina, & Parsons, 2018; Inglis, McHardy, Sosu, McAteer, & Biggs, 2019; Marquez, Francis, & Gerstenberger, 2019; Murali & Oyebode, 2004; Reiss et al., 2019).

Data analysis indicates that the CDCs removal of agency, creates disempowerment and stress, an outcome also found in research elsewhere which is shown to have negative consequences on mental health and mortality. For example, in the work by Whittle et al. (2020) regarding the interrelatedness between persistent stress creating poor mental health. Their work argues that stress and perceptions of disempowerment emerge from interactions between people seeking welfare assistance and the related social safety net systems, such as

during the delivery of social policy by government departments or not for profits (Whittle et al., 2020). Disempowerment in such research has also been shown to occur through toxic or chronic stress related to poverty and constraints to liberty, alongside system and policy inability to address core foundations for social problems (Smith, 2018). These issues lead to a significant increase in mortality rates due to 'diseases of despair' such as suicide, substance abuse and violence (Smith, 2018). This disempowerment and related stress are shown to occur for CDC recipients in this research as the CDC constrains opportunities for people to have a positive effect in their own lives. Such outcomes related to the CDC may have latent consequences regarding exacerbating persistent issues with mental health problems going forward which should not be ignored as a policy consequence.

Analysis shows the CDC becomes yet another thing to deal with that does not work to alleviate the complex web of issues that persist, and people must deal with. Some participants directly articulated the interconnectedness between how not being heard by community authorities and friends about their experiences being on the CDC, had led them to feel isolated and stressed:

> My doctor alongside a med student, said he supports the card even after I told him it had really negatively impacted me and my mental health, he ignored me and just said how good the card was, that everyone at the hospital supports the card, that admissions were down. Well, this made me feel more stressed that they didn't listen, they don't hear me. (CDC-2-FOR-87)

Participant CDC-1 had recently been placed onto the CDC, as outlined in the participant characteristics table (Table 8, Chapter 5). When I first interviewed them, they were not in receipt of the card but had just moved to town and were temporarily staying and volunteering at a local organisation. Having discussed their anger at the decision of the Ceduna CDC community panel to not remove them from the CDC trial, they explained they had unsuccessfully contacted the ombudsman. Participant CDC-1 described the panel as a faceless 'power unto themselves' who cannot be reached. They expressed feeling powerless and having choice removed by some arbitrary 'other' which relates to feelings of high stress.

Being placed onto the CDC created a harmful social condition, as they were already managing some mental health issues. In relation to being placed on the CDC, this severely stressed and exacerbated their existing mental health concerns:

> CDC-1: I was on the doorstep (of Centrelink) on the Monday morning at eight o'clock to go and try and sort this mess out, and she was really nice, but she couldn't do this or give me any answers because it was, before the CDC panel, it had gone past the point of no return.
>
> So then I got home I rang them. And I said, I'm very distressed about the whole thing. And I started to cry, because the girl couldn't, couldn't tell me anything You know. I started to cry and she said, Look, I'll put you through to the welfare department, which when I got to that bloke and he said to me straight up he says, hey, you're ringing every day. Like that's not helping. You're not helping your appeal.
>
> And I said, Okay, so have you ever had anxiety disorder? I said, that's what happens, when things are out of control. You trying to shore up your world because your world's gonna crash. That's what you do when you have a disorder. And so he kept, he kept priming me and next minute I'm in a full panic attack, I'm sobbing And he said, he said, have you got someone with you.
>
> I said no I don't, I don't have family here I don't have anything, My sons in Canada, my parents away. I don't have anyone to talk to I'm estranged from my family because of my mental health issues. And he said, okay, he said, well I have to hang up now. I suggest you ring lifeline.
>
> I: just said that and then hung up?
>
> CDC-1: and hung up. (CDC-1-FOR-88)

Added stress was expressed as too much for some to deal with, people report on how others have dealt with it although they themselves do not express having considered such behaviours:

> CDC-7: it does cause mental stress you know

> CDC-6: see up in WA [Western Australia], up there, yeah… that card caused one family's death up there
>
> CDC-5: a lot of people want to kill themselves over the indue card here, yep
>
> I: really?
>
> CDC-5: yep, put them under a lot of stress, a lot of pressure, that was the white people. (CDC-5/CDC-6/CDC-7-FOR-89)

The financial stress experienced by people on the CDC placed an additional burden on recipients who were also experiencing being unemployed. In this way the findings highlight how the confounding effects of stress with ongoing unemployment has negative consequences for recipients' mental health. According to Paul and Moser (2009), unemployment is associated with an increased risk of depression, anxiety, and other mental health problems and that this may be due to the negative effects of job loss on self-esteem, identity, and social connections. Another study by Wanberg et al. (2015) found that unemployment can lead to a loss of purpose and meaning in life, which can exacerbate mental health problems. Furthermore, Gedikli et al. (2022) note that unemployment can lead to a loss of social connections and a decrease in social capital, a finding supported in the work by Peterie et al. (2019) and others (see Bambra & Eikemo, 2009). According to a study by Azzollini (2023), unemployment is associated with decreased trust in others and lower levels of social participation. Unemployed individuals may feel isolated and disconnected from their communities, which can have negative effects on their well-being and that of those around them (Azzollini, 2023). Unemployed individuals may feel isolated and disconnected from their communities, which can have negative effects on their well-being and their ability to find employment in the future (Gedikli et al., 2022; Peterie et al., 2019). On the other hand, the study by Gedikli et al. (2022) also suggests that well-being can reduce unemployment, where individuals who reported higher levels of well-being were more likely to be employed and less likely to become unemployed in the future.

Discussion of indifference/tolerating the CDC may relate to time since implementation having passed (time of interview was four years since year 2016) where people still find the card a stressor, a burden, an inconvenience, and an added frustration, but may not always

experience the heightened acute anxiety as when the CDC was first introduced, they have little option but to live with the CDC. This acute anxiety may have been replaced with what many mental health researchers describe as chronic stress, where people may become used to a heightened level of sustained stress which overtime, can have negative impacts on mental and physical health and wellbeing (A. Baum et al., 1999; Inglis et al., 2019; Murali & Oyebode, 2004; Reiss et al., 2019; Smith, 2018). Participant SP-18 explained what they see in their clients who they have come to know well and see every day, followed by participant SP-13 who explained what the ongoing stress can do to some people:

> I: so the anxiety [you mentioned earlier] has that declined? Have people gotten used to it? Or how have the anxiety levels gone over time for people?
>
> SP-18: now we could probably better describe the card is frustrating of when it doesn't work and stuff and frustration. I think it's... there's different points in time, you know, when they were that first kind of, Oh, is it going to wrap up in the original 12 month time or not? And I think there's been some work you know, with [another researcher re the CDC], and others, trying to harness some stuff Around the senate inquiries and things so there's some energy around that. But we're not seeing a lot of change. Yeah, look, it doesn't come up as much. It's just that you know, sometimes we'll hear Oh, I bloody hate this card. Or people will say I still hate this card. More it's sort of all this didn't work or that didn't work, that ongoing stress. Yeah. (SP-18-FOR-90)

> I: so I've heard that people figure out ways to get around the card to continue with their lives. Can you tell me about that?
>
> SP-13: they do that, yep, they just get on with it with the way that they can make it work for them. And basically, just carrying an extra third of the weight that they never had to carry before
>
> I: what do you think that added weight does to people?
>
> SP-13: it stresses them that much more They look for more alcohol. They look for more ways out of this shitty situation that the government has put them in. They were doing stuff anyway. That when you poke people and you stress

people and you stress them more, more. I used to smoke 20 a day. Now I smoke 30 a day. And it's because I'm stressing out about how to get this and that done, how to fight, how to fight the card.

The numbers of them that I know have gone between killing themselves or not killing themselves. They're torn between getting drunk and getting stupid. Torn.

I: was that as common before?

SP-13: not around me before. It's become more prevalent now, Now I'm seeing more of it and other people as well. More of it. (SP-13-FOR-91)

6.3.1.4.2 The CDC, Mental Health and the Production of Shame

Conceptions of shame are not congruent across people where shame can be represented differently and relate to different meanings, depending on cultural factors. Although concepts of shame are not explored in great depth in terms of cultural meaning, participants reported they experienced their own versions of shame or embarrassment in relation to using the card. These ideas of shame relate to being identified as different than the majority/others, and this was expressed as a negative experience by family members CDC-5, CDC6 and CDC-7 as outlined in the participant characteristics table (Table 8, Chapter 5):

I: so when you're in the town here, when you've got that card and you go to use it, how does that feel

CDC-5: shame

CDC-6: shame!

CDC-7: it's humiliating

CDC-5: I went to the shop and I took my [another person] indue there and it said declined, and I had to walk out with the biggest mob of fellas there, you know. Watching. (CDC-5/CDC-6/CDC-7-FOR-92)

CDC-12: It's shame job coming in here, shame job makes shame. And there's about eight of them waiting in the fast lane or in the other one. It's shame job.

And they say, Come on, thank you and the girls say Come on, and the young girl. And the big girls. And you need help. (CDC-12-FOR-93)

CDC-12: the indue card. It's horrible. It's horrible. I'm educated and they're making me look dumb. I've been a bookkeeper a coordinator. They make me look like I'm stupid and worthless like I'm useless. Even though I'm not. My dreaming. My dreaming is a story. And I'm strong with it. And I heal babies and young people, even old people. I'm a healer. (CDC-12-FOR-94)

CDC-2: so not long after the card came in the women's group took a trip down there and both [friend] and I had our card, and we couldn't pay for our lunch we had to borrow money off other friends, cause the card wouldn't work

I: regardless if you didn't have alcohol?

CDC-2: no we didn't have it

I: but you still weren't allowed to buy your food, on a social outing

CDC-2: yes, yes,

I: how did that feel, when..

CDC-2: oh, you can only imagine, then you gotta try and find the cash to pay back the person that lent you some money, cause it's on the card, but you can't use that. (CDC-2-FOR-95)

In combination with the already persistent issues that people experience described in Section 6.3 that negatively influence their mental health, recipients of the card can be seen to experience the CDC as added stress or burden in their already stressful lives. The CDC has further negative influences on mental health relating to stress and disempowerment, which additional evidence shows can further impact mortality rates through elevating rates of substance abuse and suicide in many cases.

6.3.1.5 Theme Summary

The CDC did not change opportunities to find employment, but through making other issues worse (e. g., racism) may unintentionally and indirectly limit employment opportunities because of its exacerbation of related issues that promote unemployment, such as racism. The CDC perpetuated and reinforced racism and discrimination. The CDC does this because the card acts as a signifier of othering and deviance as it ignores social constructions of existing racism. Such exacerbation of division has negative ramifications for perpetuating social division and negatively influencing social cohesion. When overlaid onto persistent, interrelated conditions the CDC was shown through data analysis to not prevent violence; and to not prevent drug-related crime, but instead just changed how people behaved to maintain access to those things. The CDC did not prevent drug use/dependence and analysis shows that violence was often interrelated here. This is because circumvention of policy rules may result in violence in some cases and can change the dynamics of social interactions where conflict is exacerbated or becomes more likely. The CDC did not reduce dependency or ability to purchase alcohol, but similarly to drug use did change the related behaviours to maintain access to alcohol. The CDC can make issues with mental health, worse due to stress and relationship breakdown, which has an added burden where there remains a lack of support services for preventing or treating mental health issues in the Ceduna region.

6.3.2 Theme 5: Problems of Cashless Debit Card Policy Interfering with Priority Needs

This theme was smaller than most other themes identified. Nonetheless, data within this theme stood out as unique compared to other themes and the previous research. Frequencies across both sample groups are outlined in Table 15 below and is dominated by views from CDC recipients. Although perhaps not as substantial a problem compared to others, this theme nonetheless reflects unique data that identifies experiences of CDC recipients which create problems in their lives. This lower weighting may indicate a somewhat low prominence of the technical issues the card creates in creating barriers to CDC recipients meeting priority needs. However, when the card does create barriers, these are experienced as very problematic for people in different ways.

Theme 5: Problems of CDC Policy Interfering with Priority Needs

Subthemes:

The CDC Increases Problems of Paying for Housing

The CDC Limits Purchasing of Necessary Household Items

Table 15: Frequency of problems of CDC policy interfering with priority needs.

PROBLEMS OF CDC POLICY INTERFERING WITH PRIORITY NEEDS – PARTICIPANT COVERAGE: 11, REFERENCES QUOTED: 16			
SUBGROUPING	Interview Participant	References	Coverage Percentage (%)
CDC (N=12)	CDC-1	1	6.3
	CDC-2	3	18.8
	CDC-3	2	12.5
	CDC-3 /CDC-4	2	12.5
	CDC-5/CDC-6/CDC-7	2	12.5
	CDC-8	1	6.3
	CDC-9	3	18.8
	CDC-11	1	6.3
	Total: 10	Total: 15	Total: 90.9%
SP (N=7)	SP-13	1	6.3
	Total: 1	Total: 1	Total: 9.1%
TOTALS	11	14	100

As shown in data in Section 6.2 regarding linking back to Problems of Existing Policy, persistent issues related to social policy include: policy not adequately accounting for or addressing lived complexities of policy recipient's lives; and policy was suggested as inadequately responding to needs. Instead, general social policy related more to meeting requirements of a bureaucratic policy process or system, which unintentionally deprioritises the importance of recipients' needs. Where these issues persist with existing policies it was shown that such approaches to policy do not effectively do enough to create conditions to positively redirect behaviour, and issues then persist that the policies are designed to address.

The CDC represents a continued policy disconnect through ignoring lived complexity. Like data represented in Problems with Existing Policy, the CDC is suggested by some as not addressing lived complexities nor the needs of recipients. Specific issues are addressed by some CDC recipients regarding how the CDC interfered with serious social conditions in their lives. These conditions include the CDC disrupting housing payments; and constraining choice regarding escaping domestic violence; no cash to purchase cheap second-hand household items; and accessing food and supplies during power outages due to very minimal cash access. The CDC, like other policies, did not adequately address these needs and instead provided an additional barrier to navigate around.

6.3.2.1 The CDC Increases Problems of Paying for Housing

Data shows the CDC created related difficulties when paying for housing with the card. This sometimes-rendered people at increased risk of further hardship due to consequences of difficulties related to CDC policy rules. This increased hardship includes paying for housing so to provide secure accommodation for small children, and avoid children being taken by the state (link back to Public Housing & DV Section 6.2.1.2.1.2).

In discussions with some participants, a common story shared was how people had trouble paying for housing with their CDC. Examples included stories where a friend of theirs had difficulty paying their mortgage, or that direct debits to private rentals are difficult to make because the payments from the CDC are not reliable. However, the mechanisms regarding why this may be the case is often unknown or not shared:

> CDC-2: yeah, so I had that set up before the card that didn't change, I didn't miss a payment there, so but if I had been paying rent say cash to somebody I couldn't have done it, still can't, and then they brought in this thing you could get, $200 a month or something you could put in your bank account well that wasn't even enough, I mean there were people, I know people who couldn't pay their mortgage and couldn't pay their rent and that's still happening
>
> I: so why is that the case? How does it happen?
>
> CDC-2: because it's not enough money actually going into your bank account to actually pay your mortgage, it's on the card. (CDC-2-FOR-98)

I: did they tell you how to pay the rent with the CDC card?

CDC-3: no they just said go to CAC and get them to sort it out

CDC-4: they said you might have to set up a direct debit

CDC-3: which we tried to do ourselves on the thing and we were getting all the drama,

CDC-4: even the financial aid got dramas from doing it, she was like now I gotta ring this and that number and all that

I: so did you get your rent paid?

CDC-3: yeah and it was late but I still got to pay it

I: is it a private rental?

CDC-3: yeah,

I: how did the private rental person go with all this?

CDC-3: well she's ok now, because once we got the rent sorted it was good. (CDC-3 /CDC-4-FOR-99)

During a follow-up interview, the same participant CDC-3 they later explained in great detail that they are still having trouble paying rent using the CDC. Greater detail was expressed about this along with the mechanisms and behaviours they needed to do to pay their rent (private rental). As outlined in the participant characteristics table (Table 8, Chapter 5), they explained the difficulties they needed to overcome so to ensure they had stable housing for themselves and their children after a domestic violence event (links back to Public Housing & DV Section 6.2.1.2.1.2):

I: so, you're not on that card anymore. So, when we first chatted. I know you'd only just been on the card. And so how did all that work, how is the card, relevant, where does it fit?

CDC-3: well, now see the card was bullshit, what happened was, once I was on the indue the money went that into the indue was supposed to entitle me to pay my bills and all that. But what happened was, every fortnight. I would get the indue, all the money would go on my indue card, but I couldn't even pay my rent, I couldn't pay my water rates, because I had to keep ringing them to say to them. I need more money on my indue or my bank account.

I: did you have a private rental.

CDC-3: yes, yes. You see, I'd be paying my bills with my indue card but you can't put that money into a bank account to get the funds. And so the only way you can use your Indue card is if you're paying into somebody like if you go to food land or do your shopping or pay your power bills or whatever. But my rent would come out of my indue card portion. But every fortnight, I'd have to ring them to increase the amount and they would say. So how much do you pay in rent, and I would say, $640, every fortnight every fortnight. The only time it changes... Well the rent doesn't change. It's a four-bedroom home with a double garage, but I have lots and lots of kids. So it's a good area. So I get my rent. Because my rent and my water get paid to the landlord. I have to increase it every fortnight. When I got the payment, I'd have to ring them to increase it, so I could pay my rent, but my rent would often be paid late because I'd have to ring them to tell them once I've been paid that I needed to increase it and on top of that I was trying to pay the water bill through it.

I: so when the payments were late, what happened?

CDC-3: well, you see, I have to ring her my landlord. She was like, Look, I'm sick of the bullshit. I don't want to have to chase you for my rent money that was on you. you're supposed to make sure that the rent money is in my account beforehand, I don't want to keep chasing you. You see, this was the first time I had ever been on the card. The Indue. And I was trying to get it sorted. And so, the rent would come straight out of the card before I even got the money. So she

get the money. And she's like, thank you, I appreciate all you're doing but this has to be a regular thing. It can't be like every fortnight there's an issue. You see, every fortnight when I got paid I'd have to ring them and get them to increase it. So for me to pay my rent as well as my water rights I'd have to increase the amount that I transferred to my landlord, even though it was going to the same lady.

I: so they couldn't organize it to just come out beforehand. Like a direct debit.

CDC-3: no. They were mongrels, to fast track that what we do is, I would pay what I could out of my indue. And then what was ever left over that I need to pay for my rent and my water rates. I transfer that amount into my son's indue account. And for that, and then he transfer that amount into my landlords account, it was bullshit.

I: so you could transfer money from the card into his account. But not into your landlord's account.

CDC-3: yeah. Yes, see I can transfer a portion into hers. And when I transfer the money in to his account. He can't get the money out in cash but he can pay the rest from his card into her bank. It's just extra steps. It's the only way that I could transfer money was out of my indue, into my son's indue. So from my card into my son's card.

I: so was this because of the limit on the card?

CDC-3: yeah, exactly. And that was just to cut out, so we don't have to ring them to increase that to try and pay rent on time.

I: so how much was the limit?

CDC-3: I don't know. You see some weeks they'd let the 640 go through and then other weeks It wouldn't, and I'd have to ring them and increase. They were mongrels. You see, we were told when we got put on the card that it was to pay our bills but then you go and try to pay bills but then you can't pay your bills because the money won't get released, because the amounts too high. (CDC-3-FOR-100)

6.3.2.2 The CDC Limits Purchasing of Necessary Household Items

The CDC removes the use of cash as a choice of payment which can negatively impact everyday purchases of food and general household items in some circumstances. Although the CDC is similar to other credit or debit cards in terms of paying for things electronically, the inability to pay in cash where there may be a real need to do so, became an impactful hazard addressed by some participants:

> If I had been on the card there and then, I couldn't have done it, I would've had to buy new furniture, new white goods, see even the second hand furniture place here sure they've got a machine in there, but they're still very expensive for second hand stuff, you're getting how it could be, at a garage sale, markets, there was a car boot sale at Penong Sunday, all that is much cheaper but you can only use cash. (CDC-2-FOR-101; in relation to experiencing a serious DV issue and leaving their partner)

> CDC-7: that's like when the power was out, when the power is out the card is useless, you cannot use it, not only myself there was a white behind me, all of us couldn't use any cards you know, there was three days without power you know, had a fridge full of meat there, that all went off, you know living on this indue and Newstart that's a real problem financially, you're living life like a battler, especially if you got responsibilities like having your own house paying bills, looking after yourself and all that. (CDC-5/CDC-6/CDC-7-FOR-102; a participant who has been on the CDP and CDC for years and cannot find paid employment)

6.3.2.3 Theme Summary

Similar to data presented in the subtheme Problems with Existing Policy in Section 6.3, the CDC has its own unique form of unintentional policy consequences. These consequences disregard persistent issues and their complexities, which then means the CDC is incapable of

addressing recipient needs and instead works as an unintentional barrier to accessing goods and housing.

6.3.3 Theme 6: Social Interactions and New Forms of Unintentional Social Division and Distrust Created by the Cashless Debit Card

This section can be seen to build on the findings regarding the significance of social interactions and relationships in the Ceduna community as catalysts of change. Overall, the CDC at best had no effect and at worst remained a constraint, on structural opportunities and social interactions that people experience, where opportunities and interactions influence how CDC recipients can overcome persistent issues they face in their lives.

Analysis of data here diverges beyond interactions between CDC recipients and service providers, and extends to those broader community interactions between CDC recipients themselves, as well as those interactions with friends and family, and generalised others in the Ceduna community. Section 6.2 shows the significance of inclusive and supportive relationship interactions between CDC recipients and service providers are paramount to promote beneficial change so to overcome obstacles. Further analysis of relationship interactions explains what can happen when relationships deteriorate, as was the case described by CDC recipients in Ceduna in direct relation to the CDC policy more broadly. Frequencies across both sample groups are outlined in Table 16 below.

Theme 6: Social Interactions and New Forms of Unintentional Social Division and Distrust Created by the CDC

Subthemes:

- Dividing Relationships Within CDC Recipient Group and Promoting ‘Us and Them’
- Dividing Relationships Between CDC Recipients and Non-Recipient Friendships/Family Groups
- Social Division and Distrust in Systems of Governance

Table 16: Frequency of social interactions and new forms of unintentional social division and distrust created by the CDC.

SOCIAL INTERACTIONS AND NEW FORMS OF UNINTENTIONAL SOCIAL DIVISION AND DISTRUST CREATED BY THE CDC – PARTICIPANT COVERAGE: 16, REFERENCES QUOTED: 82			
Subgrouping	Interview Participant	References	Coverage Percentage (%)
CDC (n=12)	CDC-1	5	6.1
	CDC-2	10	12.2
	CDC-3 /CDC-4 June	4	4.9
	CDC-3 -Nov	1	1.2
	CDC-5/CDC-6/CDC-7	21	25.6
	CDC-8	2	2.4
	CDC-9	5	6.1
	CDC-10	3	3.7
	CDC-11	6	7.3
	CDC-12	2	2.4
	Total: 12	59	72.0
SP (n=7)	SP-13	11	13.4
	SP-15	6	7.3
	SP-16	1	1.2
	SP-18	5	6.1
	Total: 4	23	28.0
TOTALS	16	82	100.0

Overall, through analysis the CDC policy is shown to promote social divisions in the broader Ceduna community, however the extent to which social relationship interactions are influenced by the CDC was not anticipated. The policy's influence is also shown to exacerbate distrust in decision makers and government which may challenge legitimacy of decision-makers to govern, including that of service providers who seek to provide inclusive and supportive assistance. This division and distrust promoted by the CDC has implications that relate to but extend beyond those conditions identified in the persistent issues Chapter. These divisions associated to the CDC may pose newly identified, far-reaching problems

related to social regulation and control, as the CDC further destabilises the social worlds of the communities it was created to help, discussed further in Chapter 7.

Some service providers expressed an overarching view of feelings of lack of community within Ceduna. Other participants have referred to experiences of Racism and Discrimination (linking to Section 6.2.1.4.1), which may reinform some of what a service provider participant addresses here as limited or poor community interactions. Participant SP-13 summarised what they perceive to be a diminished sense of community in Ceduna in a very general way providing an overarching view of a significant problem of community deterioration, which they argued relates to the influence of the CDC:

> All I see is a street you could probably lick with your tongue and not catch a disease simply because everybody's left. I see a contrived township. It's not a community anymore. It's a contrived thing. You come to shopping now, after that piss off and don't come back, piss off we don't want to see that's the kind of situation we see now. pissed off peace. It's not a community. You don't see the kids running around the place with big smiles on their faces. You don't see any of that anymore. It changed when the card came in. (SP-13-FOR-103)

6.3.3.1 Dividing Relationships Within CDC Recipient Group and Promoting 'Us and Them'

Participants expressed the division within the CDC recipient group receiving income support, signifying 'us and them, good and bad'. Views related to the CDC as not needing to be a blanket measure, instead that it could be targeted based on ideas of 'good' or 'problem' behaviours. This division may indicate the card implementation has 'some kind of support' but that ideas of support for the policy relate specifically to certain behaviours only, and that only those people doing those behaviours should be targeted. However, who and what is considered bad is not as clear cut as might be assumed, with some participants defining themselves as good even though other evidence in Section 6.3 indicates some may participate in those behaviours themselves that other CDC recipients define as 'bad'.

Data analysis indicates that these perceptions can be described as levels of deservingness expressed within the CDC recipient group, with these expressions having a negative effect on social interactions which work to weaken relationships and promote othering and social

division. Other research has explored similar distinctions made where people seek to exclude themselves from ‘bad’ behaviours often to avoid social consequences during interactions related to reputation or status of a known ‘bad’ or stigmatised group. These behaviours that are framed as wrong or bad, include those that have been conceptualised as deviant in social and political discourse (Goode & Ben-Yehuda, 2010; Himmelfarb, 1995; O’Keeffe & Papadopoulos, 2022) as evidenced throughout Chapter 2. These bad or deviant behaviours are those defined in relation to conservative ideas of what is immoral or dysfunctional, combined with neoliberal ideas positioning the individual as solely responsible for those bad social problems. These ‘immoral’ behaviours often included those related to crime, violence, drug use, single parenting, general lack of compliance to social norms (including framing deviance as relating behaviours to ethnicity and racial profiling) and welfare consumption more broadly (O’Keeffe & Papadopoulos, 2022). All such issues persist for CDC recipients and combine here to exacerbate social divisions in relation to the added pressure of the CDC.

Evidence of the political framing of deviant behaviours at the local level in Ceduna can be seen in reflections by participant SP-18, who explained how this occurred locally in the Ceduna community during the implementation of the CDC in 2016:

> In terms of the framing of it all, it wasn't just the policy implementation. It never is. with things like this, it's, it's a political piece. It's an ideological piece. It comes through the media. So we had the mayor telling people that they were lazy. The mayor was telling people if you were against it, you were for child abuse. Really similar rhetoric that you had with the Northern Territory intervention. (SP-18-FOR-104)

Such rhetoric positions the individual who consumes welfare as the site of dysfunction and encourages people to reproduce social norms that work to divide creating ‘us and them’ and ‘othering’ through labelling of ‘deviant’ behaviours. As we have seen in data Chapter 6.2 describing persistent issues CDC recipients experience, these persistent social problems are often not always due to a person’s lack of effort or intent to have a good life. Data analysis shows that CDC recipients often tried to do things considered ‘good’ in accordance with social norms, such as getting a job, or taking care of the health and wellbeing of themselves or children. Data shows that their efforts were often constrained by conditions outside of their

direct control, such as needing to survive violence against them, or being cut from jobs provided by job-network providers. Nonetheless, these social norms reproduced through political and other social narratives related to what is deviant, persist as evidenced in the data analysis in this section. The analysis shows that when the CDC was inserted into these interrelated social contexts, that it exacerbated those divisive norms by facilitating othering through concepts of deservedness related to certain conservative and neoliberal inspired 'immoral' behaviours.

Data analysis indicates that these divisions facilitated perceptions of injustice, where CDC recipients explained that others and not them, should be on the CDC, because they were good, and others were not. Even where interviews with participants also previously state that it is easy to get around the card (link to Ongoing Substance Dependence Section 6.3.1.2.2), there remains division between 'us and them' regarding people who are all CDC recipients (link to Discrimination Section 6.3.1.3), and these issues are used as signifiers of bad 'others' framed as more deserving of the CDC:

> CDC-7: yeah you have to prove that you are in financial control of your money, you have to explain your actions, To get off it, you gotta jump through the hoops
>
> CDC-6: you gotta go through the minister, the indue, it's like a little kid's card, the card should be given to the kids you know
>
> CDC-7: they should just target the repeat offenders of drugs and alcohol, the constant being in hospital, the sobering up centres. (CDC-5/CDC-6/CDC-7-FOR-105)

> I: what are your thoughts about getting off the card?
>
> CDC-8: yeah I probably will, it'll be good if they just cancel it all out, but its good in other ways, for other aboriginals here
>
> I: why do you reckon that is?
>
> CDC-8: alcohol
>
> I: ahh ok

CDC-8: drugs

I: ahh yeah you mentioned that before, do you reckon it's lessened the grog and stuff? Or not?

CDC-8: I think of the last year I've been here, them coming up and asking me ID, ID

I: so whose asking for ID?

CDC-8: all them mob, them blackfellas there, going up to buy alcohol with it and they don't go for a little box or a couple of bottles, they go for cartons and that, I told them straight out no. (CDC-8-FOR-106)

CDC-1: ok so why can't they do it on proven results? If you've been all your life, paying your bills, you've never defaulted, you've got it you've bought things on mortgage and you pay them off and didn't default that should be in the green, you go forward with and just look after yourself, the people that have not been able to manage their money or have slipped into drug abuse or alcohol abuse or whatever, their the people that can't, they, they can't manage, because they're not all there half the time. (CDC-1-FOR-107)

CDC-1: so as far as the cards concerned, I just think it's so freakin disrespectful for people that have always managed their own finances, yep. You hear stories about people who want to buy alcohol or whatever with the card but they would be offended that they couldn't do that, I am so offended about the whole concept of the card, taking away choices, I have never relied on anyone to do anything for me, how dare they think they can just come in and start restricting me and to be honest my biggest addiction is a vanilla slice, cake, I can't help myself, and sugar I'm addicted to sugar as well, I certainly don't go out socially, I can't socialise. (CDC-1-FOR-108)

In these data, the CDC is positioned by CDC recipients as unfair or unjust because it is argued to target everyone and not just the people doing deviant behaviours. These perceptions of injustice rely on othering, which is facilitated through labelling of bad behaviours of others. This othering occurs between CDC recipients, but also by some of whom have a history of this 'bad' behaviour themselves. For example, CDC recipient participant CDC-9 explained that in their view, only certain people doing disruptive or bad behaviours should be on the card. Although occurring in the recent past, they do not include their own behaviours in this, which as outlined previously in Section 6.2.1.2 includes violence and drug use:

> I just have the belief that you shouldn't be on it unless, if you're a disruptive person, and you can't pay your bills or you don't pay bills, and you've got family with kids, and all that, you don't feed them, you know a disruptive person you get pissed and all that, put too much money in the pokies etc. (CDC-9-FOR-109)

6.3.3.2 Dividing Relationships Between CDC Recipients and Non-Recipient Friendships/Family Groups

Some participants expressed how the CDC policy negatively impacted relationships with some friends and family alongside generalised community members, due to differences of opinions regarding the policy overall. These differences in this Section are distinctly between people who are 'on the card' and those who have never experienced the card first-hand. Data analysis indicates that perceptions of deservingness and injustice are expressed between these two groups, with these expressions having a negative effect on social interactions which work to weaken relationships.

Other research has indicated similar findings in perceptions of deservingness. For example, some qualitative research has indicated the relevance of perceptions of responsibility regarding self-control and blame in assessing deservingness of receiving welfare. The distinction of for example, being unwell (not your fault) versus being unemployed (your fault) influences conceptions of neediness and then deservingness when determining who should be entitled to or receive welfare in general (Hrast & Zimmermann, 2022). This relative level of deservingness was shown to be scaled along a spectrum of wealth, with people of lower wealth more likely to perceive welfare deservingness as more universal.

However, this work by Hrast and Zimmerman (2022) only included *perceptions* about behaviours of deservingness of welfare, but those people asked were not in recipient of welfare themselves.

Data analysis in this study provides further consideration of the relative closeness of relationships and direct experiences of CDC policy, alongside pervasive social norms related to deviance and welfare consumption. The analysis provides insight regarding how experiences and norms work together to change the dynamics of interactions between people who are already friends or family, and who either are, or are not, on the card. Analysis shows that outcomes of these factors work to divide these existing relationships, as described by CDC recipients and service providers alike:

> CDC-2: I've nearly lost friends, actually I have lost a friend over this because she thinks the card's a great thing, I was actually in tears one day because of the card and she finally saw what it was doing to me,
>
> I: do you still get on?
>
> CDC-2: yeah it's starting to come right but we just don't mention it anymore, do you, you know, well we were really good friends, we went to NZ together, we were really, really good friends
>
> I: has she changed her mind or?
>
> CDC-2: no, she a rich farmer's wife, widow, not on the card, so she's trying to get a part pension, I said alright, have fun, you'll see, but I don't think she'll get it she's got too much money, plus she's got her family all around her that helps her out all the time and that sort of carry on. (CDC-2-FOR-110)

Some service providers have expressed views related to the CDC and social division that relate to anger and belief the CDC is unfair and unjust. They explained how these negative divisions created by the CDC relate to severe issues for those involved:

> SP-13: it destroys community. It has split people. It has isolated bunches. It has made people you wouldn't hate, hate. These people are interfering in what was

your normal life. They've tipped the normal life upside down because they thought they had the right.

I: so the people in power that implemented the card, how has all of this impacted your life and your relationships?

SP-13: I hate them with a vehemence. Whereas I never did. And I mean, I really hate them with a vehemence.

I: I remember you mentioned that you had been ostracized as a keyboard warrior. pushed aside because you came out against the card. Another version of the separation because of the policy?

SP-13: people I've known all my life don't want to talk to me, I don't want nothing to do with them anymore. They started the ball rolling themselves. When they wouldn't accept letters or emails from us telling them that the card was no good. They refuse to answer any questions. (SP-13-FOR-111)

I: so what have you seen the card do to people if you're willing to share?

SP-13: I've seen it drive people to tears. I've seen it drive people close to committing suicide. The girl I was talking to you about before. And that man, he was right on the edge. When you see your older friends, your next-door neighbour, she's maybe got 15 or 20 years on me. She hates it with a vengeance. What they've done to Ceduna and she complains how it's isolated people and it's isolated her from her own friends. She still has the friends. They still talk and come see her but she's not the same anymore

I: why, what do you mean? How is she not the same? How is the situation not the same?

SP-13: not the same type of friends anymore because of the division

I: so why do you think it divides? How is it dividing?

SP-13: I suppose the division comes with, like, I'm telling you how to live your life. And people don't operate too well under that kind of system. There's

> freedom. When you've lived in the country most of your life, freedom means everything. And these bastards are taking it away, piece by piece inch by inch. (SP-13-FOR-112)

When layered over persistent issues, the CDC's influence of promoting divisions within and between groups, is shown to result in social disconnect and breakdown of social networks that are already fragile regardless of the CDC implementation. Social isolation and division are well established as being bad for mental wellbeing and general cohesion (Kim, 2020; G. Payne, 2020; Rogers & Pilgrim, 2003). Furthermore, our social networks have been shown to provide us with valuable resources, such as possibility for employment, and social or emotional support in general and during adversity (Krug & Prechsl, 2022; McArthur, 2019; Peterie et al., 2022; Peterie, Ramia, Marston, & Patulny, 2019; Ramia, Peterie, Patulny, & Marston, 2020).

In considering social isolation, divisions and importance of networks, this deterioration of existing social relationships and networks within and between CDC recipients and others, may have further ramifications for wellbeing and how people are able to access needed resources in their life. Valenzuela, Martinez, and Cumsille (2018) argue that interactions overtime in close relationships with others facilitate inclusion and promote trust and positive interactions, when isolation and division occurs inclusion and its benefits are broken-down. Social division is linked directly to social cohesion, which is described by Thomas and Griffin (2021, p. 2) as inextricably linked to preventing conditions that promote division:

> A cohesive society works towards the well-being of all its members, fights exclusion and marginalisation, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward mobility (Thomas & Griffin, 2021, p. 2).

As analysis has shown throughout Sections 6.2 and 6.3 including combination with data here, it is argued that CDC recipients already face issues that impede beneficial and supportive social interactions that can work to build trust and inclusion. These barriers include Unsupportive Interactions evidenced in Section 6.2.4 with some types of service provider organisations which can limit the building of vertical social mobility to overcome obstacles. Alongside persistent barriers to employment due to discrimination and other challenges

relating to violence and crime. In promoting further relationship deterioration, the CDC therefore places an additional barrier on social networks preventing opportunities through those networks to help positively overcome social issues people may be facing.

6.3.3.3 Social Division and Distrust in Systems of Governance

The CDC is shown through analysis of data to promote distrust in systems of governance. This distrust occurs in combination with perceptions of injustice related to the CDC, poor consultation and implementation of CDC policy, and perceptions of CDC operational issues which relate to lack of transparency in governance decisions. These issues stimulating distrust do not exist exclusively but are interrelated to perceptions of persistent inaction or inadequacy to help improve social outcomes for people receiving assistance.

This inability for the CDC to improve social contexts for people receiving welfare support can be linked to persistent issues such as ongoing unemployment, poor mental health, racism and the divisive social outcomes these stimulate. It has been earlier addressed that unemployment also affects social cohesion and community wellbeing. For example, the study by Azzollini (2023) found that unemployment is associated with decreased trust in others and lower levels of social participation. This research highlighted how unemployed individuals may feel isolated and disconnected from their communities, which can have negative effects on their wellbeing and that of those around them (Azzollini, 2023) which may go some way to explain the linkages across contexts that come to shape the experiences CDC recipients describe.

Concerns are raised where people describe issues with the implementation and consultation of the initial CDC roll-out. Participants described the lack of clarity regarding community consultation prior to policy introduction, alongside disregard of any advice offered during consultations. The contribution of such issues to enhancing distrust with community leaders is expressed by all participants who addressed consultation and implementation as a concern for them.

6.3.3.3.1 Ignoring Advice from Service Providers

In terms of consultation with service providers and the implementation of CDC policy, there is some indication that efforts were made to consult with service providers regarding the

CDC implementation. However, service provider participants expressed that the issues and advice they raised during implementation were not adequately heeded by public officials or policy makers, even when asked. These include issues of inadequate community consultation, inaccurate measures of social impact of the CDC, and requests for evidence that supported the CDC implementation regarding effectiveness of helping people:

> So, you can't just cater towards. Hmm. Okay, let's look at community development as a whole. You can't just pluck one part of the community out, and then work with that group only. It doesn't work. The community needs to be brought in, and that's what we said to the cashless card people. (SP-16-FOR-113)

> But in terms of so even the timing of when that first ORIMA evaluation was conducted and was going to kick in, we were noticing impacts regarding the anxiety and the uncertainty and the confusion at just the announcement stage and the community meeting and then different things in the timeframes and people waiting for the card in the mail. And so we advocated that the evaluation should take that in because that's when it started, but it didn't. But even raising some of those concerns. So we had one playgroup, for instance. And it [the CDC] dominated the whole session, two hours, and that's all they talked about. And you know, the session was supposed to be about them, engaging about parenting skills and seeing how they're celebrating their children's development and things. This was all the mums, and this was just prior to people receiving the card or just after. And that group really is a soft entry point. (SP-18-FOR-114)

> So the implementation of policies, look, the card has been really high profile. And I think there's a disconnect about how people thinking it would go. And thinking that they're mitigating challenges for people who it would impact directly. There's a big disconnect there
>
> And we were seeking information as a service provider to say, Can we have some direction? And we basically got, well, you give them this page of writing

and tell them to call this number and we were like, that's it? That seems simple, but that's actually not, that's not an answer. That's doesn't take into account how complex this is, and all what you're imposing on people.

But as a service based as a human rights organisation, where we have public meetings, we wanted to see the evidence, where was the evidence, that it would actually benefit children? Because previous iterations of the card have not. There was no evidence, it was just like, well, of course, people will buy lunches for their kids. And we were saying no, that's not actually how it works. So there was no justification. There was just very emotive people and those people speaking out against it were accused of being emotive not rational. (SP-18-FOR-115)

6.3.3.3.2 Subversive Consultation with Welfare Recipients

Meetings about the CDC before implementation were held, but their purpose is described as misleading, and participants argue they do not equate to adequate consultation. Participants expressed they were unaware that these meetings may have been considered formal consultation, and others describe they were not aware at all of the CDC prior to receiving it:

I: so I had heard about the government consultation of community. I was gonna ask you how did that play out?

SP-13: there wasn't one. It never happened. All of the communities and the service providers they turned up at these meetings. They were told to keep their mouths shut. But the legal services people they were questioning and they were saying how can ‘come for a cup of coffee’ be called a meeting? There was nothing talked through no actual consultation. All they did was have a coffee with everybody, tick them off. And then they said there, that's our consultation. Done. (SP-13-FOR-116)

I: did you hear about it before it came in?

CDC-10: na, I was like what the fuck is the Indue card, I got it in the mail, I was calling up Centrelink and was like what’s this? Where’s my pay gone yeah?

> They said na its now on the government card, I was like whaaaat, no good. (CDC-10-FOR-117)

The issues with lack of clarity or transparency regarding the implementation of the CDC, include information meetings that were held, but that the way these meetings occurred created opportunities for people to distrust community leaders:

> CDC-5: some of the community leaders that sat around with [Ceduna council member], these governments, they sold out our rights without consulting us, they had secret meetings at the football club, and when people found out it was too late, only 10 people turned up to the meeting
>
> CDC-6: I didn't even know they had a meeting before, all they done was trialled the card in front of the minister
>
> CDC-7: all this bullshit saying they informed the community, they said they went door knocking, there was nothing, no consultation, no one has ever been consulted about it, and those meetings they were secretly organised for the people that was in favour for it, there was nothing briefed to the community at all, our rights have been taken over. (CDC-5/CDC-6/CDC-7-FOR-118)

Both CDC recipients and service provider participants explained how the delivery of the CDC and the card itself, stimulated distrust in community emerging from the differences between what was said by politicians and policy makers, relative to what they experienced on the ground. Some service providers then reflected on the anger and related actions this distrust stimulated in some recipients:

> Yep, 2022, says March 2022 on the card here [showing me the date on the card in 2019], but when it first came out we were told it was going to be a year's trial and when everyone got their cards in 2016 and it says 2019 we were all like hang on, its only meant to be a year! So we knew straight away it wasn't a trial, the consultation was a joke, there was no public meetings at all until after the card came in. (CDC-2-FOR-119)

> And the other big thing is the decision, you know, how did it come and the distrust, and it's been confirmed, because people instantly knew it wasn't going to be a trial. They instantly knew based on experience, that it was gonna be ongoing. So some people, well, that motivated people to fight against it. But they were demonized in the media fairly heavily. And perhaps some of those campaigners made some poor choices. Some of the images they created, but you know. (SP-18-FOR-120)

6.3.3.3.3 Distrust, Extreme Views and Conspiracy

Participants expressed distrust in governance systems where lack of information, clarity and transparency exacerbated negative views of the CDC policy as unjust and systems of governance in general. As has been argued in research elsewhere, end-user trust in professional others who represent governance systems and processes occurs through interactions on the ground (G. Payne, 2020; Thomas & Griffin, 2021). This trust in the state as legitimate to govern, has been addressed as challenged where social policy interventions are experienced as inequitable and unjust, thereby promoting perceptions of injustice for the state to govern in that way (A. Schneider, 2015). Importantly, issues raised here link with and build on these participants expressing the view that the CDC is unfair and that they should not be in recipient of the policy, especially relative to 'others'. These perceptions of the CDC being unfair feed into views here regarding anger and distrust in systems of governance, with a focus on the CDC specifically.

Several CDC recipients expressed the belief that money in their indue CDC account would be deducted without reason and with no transparency. Whether this occurred or there was reason or not, is not of dominant significance here. What is of importance is how this belief has the effect of creating extreme distrust in the system designed to assist them. Examples of distrust can be seen in how participant CDC-3 describes money going 'missing' from their account without reason. Participants CDC-5, CDC-6 and CDC-7 extended on belief of missing funds to suggest the CDC makes money for other groups such as miners, angrily describing the CDC policy as a scheme that is against them:

CDC-3: see when I got my first payment it said, balance 400 and something, but my available balance says 300 and something, so what happened to that other money? I was told whatever's in the indue card is mine!

I: where did the other money go?

CDC-3: well that's it who do I ask where the other 100 went? I was told my direct debits have already been taken out before I get the money, so whatever's in the indue is mine to spend, all the bills have been taken out, the bills, the water…

I: so did the 100 come back?

CDC-3: well na, I used the 300 to pay my rent but where's the other 100, I don't know who to ask, was that originally mine or does that go to the government again, you know, like I see a balance 400 and something so I think I can spend 400 and something, how I am I supposed to know, like if that's going to happen every time I get the payment where the hell is it going and why the hell don't I get it, like I'm the one that's doing without the 100! (CDC-3-FOR-121)

CDC-7: you know this card is just a making money scheme, this card is making benefits of people under the poverty line in remote community areas, helps support the mining corporation, that's what it is, cause if you ask anyone everyone's money is being taken from their account

CDC-5: yes, yes

CDC-6: $30 been taken from my account, today too! Yeah from my partners card, he left the money in there last night and we check it in the morning and it's not even all there, where's it going?

I: direct debits?

CDC-5/CDC-6/CDC-7: (simultaneously) na na no! (CDC-5/CDC-6/CDC-7-FOR-122)

Distrust in the systems controlled by government is described by participant CDC-11, who expresses the belief that data is collected from scans of driver's licenses when purchasing alcohol (another alcohol restriction policy in Ceduna) that are then paired with CDC recipient card data even where alcohol was purchased with cash and not the card. This belief whether true or not, stimulates a frustrated apathy toward systems of governance as a necessity to just keep getting by in life. This apathy verges on anger and interrelates with suspicion of the government surveilling people through unseen systems, and therefore the government is framed as being against them:

> CDC-11: so think about this a lot of people don't realize this but every time you might go down to say the bottle'o. Every time you go there and buy alcohol and you give your ID, and you're on the indue card. And they're recording you as to how many times you go down to that bottle shop. There's no ifs buts about it, it's a fact. And then what happens after a long period, they pull you over. You think about it for one minute.
>
> I: so how do they know, if you're on one of those CDC cards at the bottle`o, because you can't use it to buy alcohol?
>
> CDC-11: oh, you think about it, it's all connected. They keep a record. The sole reason is, we give you this percentage on your card this percentage in cash, the percentage on the card is for food, la la la, and cash is for whatever. And you go there, and you get a bottle of wine and you show your license. It goes in a computer. The next time goes again if you're on the card. It goes into the computer again. And what happens is that card association, go straight to it, and in there. They know.
>
> I: so how do you know this?
>
> CDC-11: because I've been told. I know this for a fact. See, the thing is the people don't know what the government's doing!
>
> You're fighting against yourself. The government's not gonna listen. So you're just going to fight against yourself. You're going to fight against it. And you're just going to keep getting angry with it, and you're not going to get anywhere. The way I see it is. This is the way the government has done it. This is what they believe is supposed to be right. When really, It's not right. It takes away

> everybody's rights. At the same time, we were not notified or asked, or even voted upon it, or anything, But it was just put upon us. In other words, you otherwise go with it, or you're out on the street, that's basically it. That's how it works. (CDC-11-FOR-123)

These ideas of the government and those in favour of the CDC being against them, is seen in expressions by participant SP-13. Here they describe the CDC policy and its process of implementation as a farce, inferring the CDC involved ulterior motives outside those contained in the policy objectives. They explained the related social divisions regarding how they have been labelled by speaking against the card and its supporters. They expressed the belief that the policy is based on lies, and that they have been targeted and isolated through these labels. The effect these beliefs have included promotion of anger toward government systems and a reason to group with liked minded others to continue to express this 'truth' to help similar people:

> They wanted the clean streets. They wanted to make sure that the card looked good. It's a well-orchestrated plot, very well-orchestrated. And it's all lies. It's based on lies. Which is probably the most aggravating thing for me. Because I get branded as I'm no good a druggie, I'm no good. I don't even drink or do any of that. I get called a keyboard warrior. But I say if it wasn't for us, Bloody keyboard warriors, none of you would know anything. (SP-13-FOR-124)

6.3.3.4 Theme Summary

In summary, the card has the effect of being divisive. This division relates to social constructions of what behaviours are normalised as 'deviant' and then who 'deserves' to be on the card for their deviant behaviour. This division relies on 'othering' within and between CDC recipients, which deteriorates relationships between general community members, friends and family. This location of the 'other' as different from the 'self' also stimulates perceptions of people arguing they do not deserve to be on the CDC, and that this is therefore unfair and unjust. Combined with and exacerbated by perceptions of unfairness, CDC recipients' express frustration and distrust in government systems. Confusion and lack of clarity of CDC implementation and consultation relates to enhancing distrust in community leaders. Newly identified outcomes of distrust are evidenced through discussion of

perceptions or belief regarding the CDC, which relate to lack of transparency and perceived errors arising in the operation of the card accounts. These ideas combine with further beliefs the card has ulterior motives which encourages further distrust in systems of governance, which may have ramifications for social regulation and control.

6.4 Summary

Section 6.2 shows that life issues are complex, interrelated, and persistent. Throughout the conversations, participants talked of persistent problematic structural conditions, and subsequent problematic outcomes of those conditions. We can infer that these issues are not new, but nor are they only because of the CDC. These issues have persisted regardless of the CDC and regardless of most other social policies that are implemented in the Ceduna region. The data analysis shows that persistent issues act as constraints regarding how/if people are able to overcome bad life contexts.

Overall, in all cases the social interactions between people and groups in community, and that CDC recipients have with institutions or organisations, work as the mechanism determining how participants can navigate their lives. There are issues in these interactions that come to impede or constrain how CDC recipients are able to find employment, overcome violence, and in some cases contribute to reasoning for substance abuse. These social issues that negatively impact interactions include discrimination, especially racism, which is described as already existing and a problem in the Ceduna region. Racism is a confounding factor to/exacerbates unemployment, and other persistent social issues. Overall, discrimination happens between many 'groups' for different reasons, indicating existing and problematic social division in the region. Social division can have broader ramifications for social cohesion, which can become a significant problem and barrier for the health and security of Australian societies.

Section 6.3 shows that when the CDC was overlaid onto persistent conditions, the complexity of interrelated and persistent issues meant that regardless of the CDC or other policies and interventions separate to the CDC, recipient's lives, and opportunities, are ultimately constrained by the difficult contexts they experience. Subsequently, opportunities for behaviours to help overcome bad problems such as discrimination, violence or unemployment are seemingly inhibited to change. Instead, at best opportunities stayed the same, meaning that people found it very hard to overcome the broader contexts that constrained them even when they tried to have such an effect in their social worlds. The findings suggest that whether a person is receiving the CDC or other policy interventions in the region, those policy interventions may not adequately contextualise the complexity and

nuance of social problems as they are experienced. This lack of beneficial influence by such interventions is reasoned because social issues persist. This lack of effect may indicate that problems remain with approaches to researching and making social policy and their interventions overall that need to be addressed, with these issues discussed further in Chapter 7 below.

Overall, it was found overall that when compared to current CDC policy logic regarding individualised responsibility for social harm, we see emerging a much more complicated process going on regarding what CDC recipients and service providers explain the issues are, and how and why these occur. We can see that social issues discussed may relate to categorisations of commonly recognised social issues in contemporary western societies that have been ignored in the logic of CDC policy. These include the social issues of unemployment, racism, domestic violence, issues with housing and mental health problems. Findings indicate that regardless of the 3-years since the CDC's implementation, that in 2019-2020 when data were collected, recipients were still stressed, angry and frustrated about the CDC. This extended time since policy implementation in 2016 means that recipients were still unhappy with the intervention in their lives. Although, the way the CDC was discussed and dealt with by recipients may reflect an unwilling acceptance of the policy as part of life where there was little other option to do otherwise.

Through employing the methodology justified in Chapter 3 and outlined in Chapter 5, the Figure 4 below explains the active links reflected in the data analysis in Chapter 6, with inclusion of CDC policy logic captured in Chapter 2. Figure 4 presents the contexts that participants explained they experience. The links reflect the simplified connections showing how and why those contexts are connected, as evidenced in data throughout this chapter. Taken as a whole, these experiences and links between them represent the interconnected and largely multidirectional processes including constraining feedback loops, that show how CDC recipients experience their lives. The majority of these links are facilitated via relational interactions between people and groups.

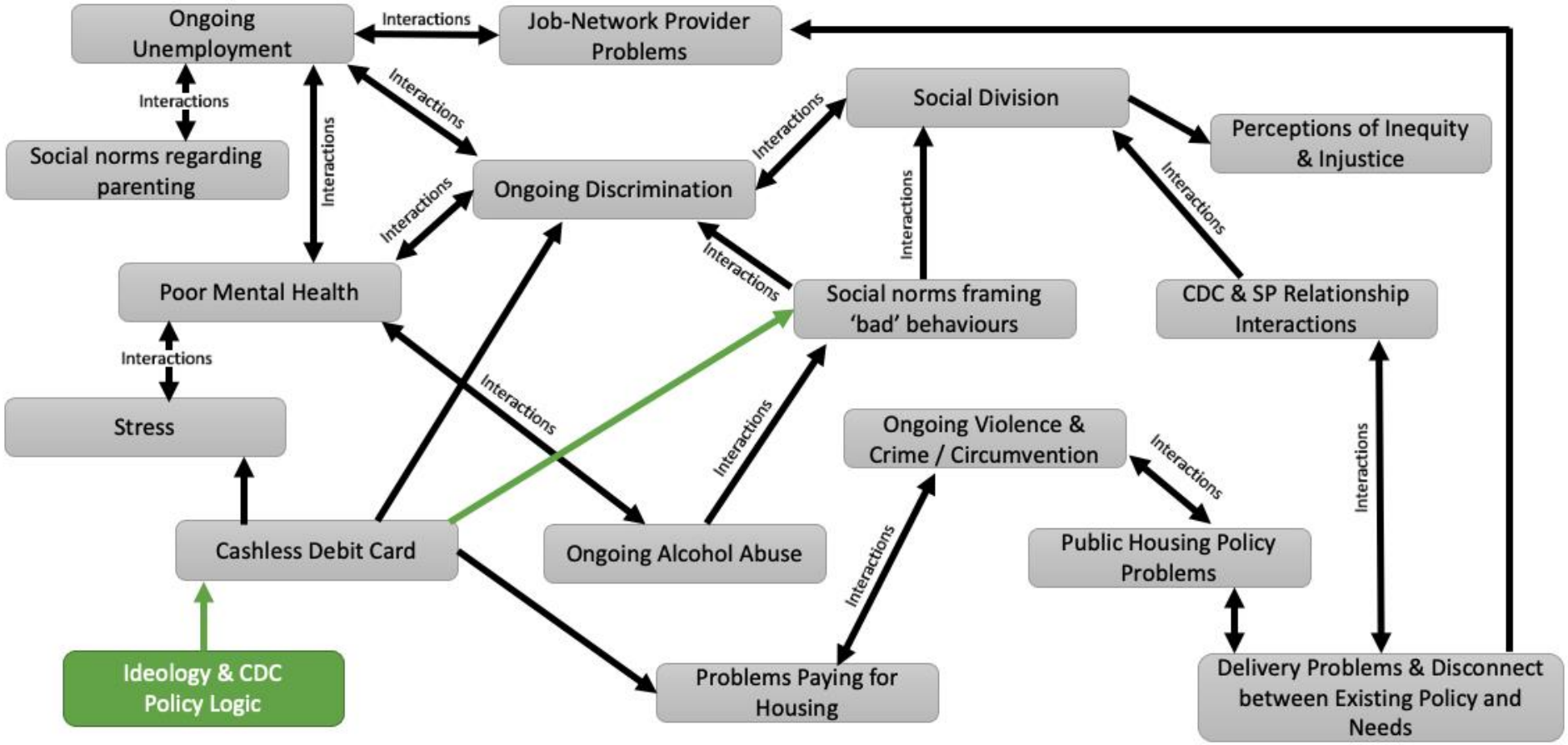

Figure 4: The evidenced interactional links showing the processes between contexts that influence how people can behave.

Without opportunities to overcome negative issues through changes to social conditions, the data also shows the CDC contributed to the continuation of, and sometimes emergence of new, dysfunctional behaviours that combined to keep people trapped where they are. These social conditions included the social interactions and relationships with other people, be they service providers, friends and family or general others in the community, as an important consideration of influence, not realised in other research addressing the CDC. Across all themes, these relationship interactions that are shown to be important regarding how people navigated through persistent conditions, the CDC was shown to then exacerbate discrimination and othering, which then worked to deteriorate those same relationships people relied on. Those deteriorations subsequently enhanced opportunities for social divisions. By enhancing discrimination, stress, and prompting perceptions of unfairness related to the CDC, the related outcome of social division is argued to risk creating additional problems with cohesion explored further in Chapter 7. The following Table 17 summarises the findings in relation to providing responses to the Research Questions, linking responses to the research gaps identified in Chapter 3, evidenced by data collected and discussed throughout Chapter 6.

Table 17: Summary of findings paired with research questions.

Little is known about the broader lives of CDC recipients beyond the direct scope of inquiry assessing the influence of CDC policy in any CDC location. Without knowing more about people's lives outside of direct policy inquiry, establishing policy influence thus remains limited. ***Relevant Research Question:*** ***What are the contexts into which the CDC was implemented for CDC recipients and their community in Ceduna, and how are those contexts experienced?*** Overall, it was found that people experience complex, interrelated persistent issues and their behaviours to overcome their bad life contexts are constrained by social conditions largely outside of their control, meaning people have little opportunity to change their social world as it is currently constructed – hence, issues persist.		
Knowledge Gap	**Significance**	**Using Findings to Respond to Research Question**
Issues with establishing baseline	Cannot accurately quantify policy influence,	A more contextual insight into how life is experienced for CDC recipients and service

to argue policy influence	other measures are thus needed to understand change	providers whether in direct relation to the CDC or not, has been facilitated by improved research methods better designed to capture contextual complexity. These methods include working directly with CDC recipients using longitudinal qualitative methods of repeat interviews and informal conversations, alongside active participant observations through engaging alongside participants and community in general in their day to day lives.
Little is known about life prior to CDC implementation or outside of policy influence and life more recently, determined by CDC recipients	Without knowing more about people's lives outside of direct policy inquiry, establishing policy influence thus remains limited	
Time spent is limited and observations not often conducted	Complex issues may be missed in the absence of repeat interactions that include a variety of methods	
Health and wellbeing exclude mental health impact	Complexities outside of measuring policy objectives have gone unaddressed which may misrepresent policy impact	Many people have issues with poor mental health due to having had bad experiences in their life. There are limited mental health services in the Ceduna region to help people deal with these bad experiences (whether historical or current), which includes not enough services alongside issues with recruiting for workforce expertise.
No change to gambling and social complexities not captured		Gambling was not expressed as a problem for participants interviewed. Some indication 'illegal' or home-based gambling may occur but could not be pursued.
Issues with perceptions and incidence of crime		Already lots of violence is experienced in community, mainly DV. This violence has implications and impacts other issues such as access to housing, or housing availability and housing arrangements between victims and perpetrators. When drug use is involved, some evidence has indicated that services such as police are not called to assist in such matters. Data indicates links between violence and drug use.

No focus on underlying reasons for ongoing alcohol or drug use		Alcohol dependence remains an issue for *some* people, not all. Illicit drugs are consumed by some not all. Some general and dependence drug use occurs but not widely or overtly discussed. Excessive drug use links with other contexts people experience, where there is some indication substance abuse may relate to coping with past and current violence/trauma for some people. Drug use also may exacerbate current violence, however the relationship is not unidirectional.
Other policy interactions not addressed		The CDC is just another policy among many others that already are implemented in the Ceduna region, that does not adequately address complex issues in context

A lack of primary research exists addressing broader complexities outside of variables related to policy objectives as defined by CDC recipients, which when combined may misrepresent policy influence and miss impactful policy consequences.

Relevant Research Question:

How does the CDC influence those contexts and behaviours of CDC recipients and their community in Ceduna?

The CDC does not stop behaviours related to violence, drug and alcohol abuse, or unemployment. The CDC does not change behaviours in accordance with objectives, but does change them in ways that work to create further opportunities for conflict between people who have already difficult lives. The CDC does not promote positive mental health. The CDC may exacerbate social division through aggravating discrimination and working to deteriorate relationships through changing the dynamics of social interactions between relative strangers as well as family and friends. This exacerbation of social divisions may have further negative impacts on social cohesion, and in some cases work to promote existing anger and belief of a delegitimised state that is unfit to govern.

Knowledge Gap	**Significance**	**Using Findings to Respond to Research Question**
Exclusion of data in evaluations	Misrepresents level and type of policy impact	The CDC does not change opportunities to find employment, but through making other issues worse (e.g., racism) may unintentionally limit employment opportunities. Does not prevent violence.
CDC recipients do not get to define what	There may be other issues and why they occur that have gone	

issues are important or why	unnoticed that can only be addressed through open-ended engagement with policy recipients	Does not prevent drug-related crime, just changes how people behave to maintain access. Drug use/dependence and violence are often interrelated. Does not reduce dependency or ability to purchase alcohol, changes the related behaviours to maintain access to alcohol. Can make issues with mental health, worse, which has an added burden where there remains a lack of support services for preventing or treating mental health issues in the Ceduna region.
Circumvention mostly framed as good, neglecting related harmful behaviours	Complexities outside of measuring policy objectives have gone unaddressed which may misrepresent policy impact	Circumvention of policy rules may result in violence in some cases and can change the dynamics of social interactions where conflict is exacerbated or becomes more likely.
How CDC recipients explain subjective experiences of discrimination infrequently explored	There may be other issues and why they occur that have gone unnoticed that can only be addressed through open-ended engagement with policy recipients	Perpetuates and reinforces racism and discrimination as a signifier of othering and deviance because it ignores social constructions of existing racism. Has negative ramifications for perpetuating social division and negatively influencing social cohesion.

Limited understanding of the relevance of social interactions and how these interactions relate to change that may occur or not for people in the broader contexts of their lives. Where we are able to identify how the CDC policy may interact with and shape social interactions/relationships, we may better address complexity and map how change occurs (or not) through mechanisms that influence related human behaviours in their interrelated contexts.

Relevant Research Question:

How does the CDC influence those contexts and behaviours of CDC recipients and their community in Ceduna?

The CDC is delivered in a contextual environment that is not often supportive of positive social outcomes and experiences, evidenced through social divisions related to violence, crime, poor mental health, substance abuse and discrimination. The CDC exacerbates these issues because it does not consider them as they occur in their interrelated contexts.

The CDC changes social interactions through promoting persistent issues and then welfare consumption (by people who experience those issues) as deviant and in turn breaks down good relationships which are the catalysts of support for social navigation and positive change. This break-down negatively impacts social cohesion through exacerbating persistent social divisions.		
Knowledge Gap	**Significance**	**Using Findings to Respond to Research Question**
No explicit focus on social interactions as structural influence	Where we are able to identify how the CDC policy may interact with and shape social interactions/relationships, we may better address complexity and map how change occurs (or not) through *mechanisms* that influence related human behaviours in their interrelated contexts	The CDC is delivered in a contextual environment that is not often supportive of positive social outcomes and experiences. This is evidenced through the persistent negative social divisions related to perceptions of unfairness, violence, crime, poor mental health, substance abuse and discrimination. The CDC exacerbates these issues because it does not consider them as they occur in their interrelated contexts. The CDC changes social interactions through promoting persistent issues and frames welfare consumption (by people who experience those issues) as deviant, which in turn breaks down good relationships that are the catalysts of support for social navigation and positive change. Through exacerbating persistent social divisions, this break-down creates further anger and frustration, and negatively impacts trust in systems of governance.

7 Contextualising the Findings to Learn More About Social Policy and the Cashless Debit Card

7.1 Introduction

This chapter explores what may be learned from the findings in Chapter 6 in relation to issues raised about policymaking (Chapter 2), and research methods used for assessing the CDC intervention (Chapter 3). The first section, 7.2, explores the concerns of Chapter 2 regarding the ideology and policy logic of the CDC. Policy logic is then explored in contrast with what the data has shown about the CDC and the effects this has had on communities. The second section, 7.3, builds on 7.2 and addresses the issues of Chapter 3 in terms of what can be learned about social policy research and what this means for income management approaches as an act of governance. To conclude, this chapter responds to the research sub-question three using what has been learned to discuss ways forward to assist decisions related to future social policy making.

The data collected informed the following summarised responses to the Research Questions. These responses are presented here evidenced by findings throughout Chapter 6.

Research Question 1. What are the contexts into which the CDC was implemented for CDC recipients and their community in Ceduna, and how are those contexts experienced?

In responding to this research question, analysis shows us that for CDC recipients, they experience many negative social problems as complex, interrelated, and persistent. Both CDC recipients and service providers talk of persistent problematic structural conditions, and subsequent problematic outcomes of those conditions, as the primary problems that CDC recipients are dealing with in their lives. Data shows that persistent issues act as constraints on how or even if people are able to overcome bad life contexts. We can infer that these issues are not new and nor are they because of the CDC. These issues persist regardless of the CDC which does little to beneficially change conditions so that people may be able to overcome these persistent issues.

The main specific persistent issues were unemployment, crime and violence, substance use, poor mental health and discrimination, especially racism, and are described as already existing and continuing problems in the Ceduna region. Racism is found to be a confounding factor to and exacerbates unemployment, alongside other bad enduring issues such as poor mental health. Discrimination and violence happen between many 'groups' for different reasons, indicating existing and problematic social division in the region. Social division has broader ramifications for the health and security of Australian societies.

Service providers also describe that there were lots of policies already implemented prior to the CDC, but issues persist for CDC recipients, and because issues persist, we can infer those issues are not being addressed at the core of their origins by any of these policies. We can also infer that policies do not appear to act/occur in a complimentary way with one another to help people overcome persistent issues, regardless of policy intentions.

The data analysis also shows us that social interactions are always important for how people navigate their lives and how they might make behaviour changes. These interactions include those between CDC recipients and other people such as service providers, friends, family and other community members and governance systems, highlighted throughout themes identified. Furthermore, social interactions between service providers and their clients/end-users/CDC recipients, and between service providers themselves, are found to directly influence success of the delivery of policies at street-level.

Research Question 2. How does the CDC influence those contexts and behaviours of CDC recipients and their community in Ceduna?

After analysing the persistent conditions that the CDC recipients are experiencing, data analysis then sought to understand how the CDC policy functioned when overlaid onto these persistent issues. In responding to this research question, participants reported that the CDC did not stop access to the things it was designed to stop and did not make their lives better but instead constrained opportunities for positive change in many cases. When the CDC is overlaid onto these persistent conditions, the CDC policy changes the way people need to behave to maintain access to resources they need to get by, and this was often reported as an added burden and stress in their already stressful lives.

The overlay of the CDC did not necessarily *cause* discrimination and racism, which was ongoing, but the CDC did *exacerbate* the existing racism through ignoring historical and existing racism and social divisions. Poor mental health and disempowerment was exacerbated by the CDC policy operating to reduce individual and group agency and liberty. Further, CDC recipient expressions of indifference may mask emerging despair. Outcomes of disempowerment related to the card includes extreme stress and anger, and shame from stigma.

The CDC is shown thus far to not stop access to drugs or alcohol, which has also been identified as an outcome in other studies investigating the impacts of CDC or basics card. The CDC does not stop access, it just changes the way people need to behave to maintain access, which can be an added burden and led to increased violence in some cases. These changed behaviours for maintaining access to things people wanted, link to persistent constraints/opportunities and relied on pathways of social relationship interactions as conduits of accessing resources needed. To get things they needed (whether healthy/harmless or otherwise) this involved doing behaviours to maintain relationships with people involved in accessing those resources. Participating in resistance behaviours became necessary in many cases, as few other opportunities for other interactions and resource access exist or are available for people.

As an example, CDC recipients needed to circumvent CDC rules to pay for housing in some cases. This meant they needed to transfer CDC funds to other CDC holders to pay for rent/housing on time. This saw rent being paid from multiple CDC accounts, due to daily transfer limits placed on the CDC when paying into a non-CDC account (landlord). This circumvention was required so to pay rent and maintain a good relationship with that landlord and access to that housing. Similar interaction issues are discussed below relating to use of illicit substances and circumvention behaviours. Instead, social issues persisted as the CDC did not remove those constraining social conditions related to the origins of persistent issues.

The findings overall indicate the importance of local social interactions in promoting or constraining opportunities for behaviours across all themes, where alongside structural conditions, social interactions are consistently discussed as influencing behaviours in some way. The CDC was found to influence social relationship interactions in negative ways and

therefore found to be socially divisive which threatened social cohesion. The CDC relates to promotion of 'othering' within and between CDC recipients, and deterioration of relationships between general CDC recipients and non-CDC community members, friends and family. This division occurs within and between those who are on the card, and those who are not. This division relates to social constructions of what behaviours are normalised as 'deviant' and then who 'deserves' to be on the card for their deviant behaviour. CDC recipients' express distrust in government systems, which related to confusion and clarity of CDC implementation and consultation related to enhancing distrust in community leaders. This distrust is evidenced through discussion of the CDC and related to lack of transparency and perceived errors arising in the operation of the card accounts, as well as beliefs the card has ulterior motives and encroaches on privacy rights.

7.2 Contrasting the Research Findings with The Cashless Debit Card Logic and Underlying Ideologies

As reflected in Figure 5 below, findings show that policymakers did not properly contextualise or seek to understand what was already happening in people's lives when considering the impact of the CDC, not even the social policies already in place. Policy decisions did not include the complex processes of how or why social problems are occurring for people in receipt of welfare support in the Ceduna region. These inaccuracies emerged in the CDC intervention because Governments focussed on a narrow, rationalist way of thinking about, approaching and measuring social 'problems'. They used specific ideas that theorised and framed behaviour as rational and predominantly individualised. Ideas of what to do about social problems embedded in the CDC logic are based mainly on what ought to be and seemingly neglect the lived experiences that are the social realities for people needing welfare support. The following sections explore CDC policy logic, ideology and problematisations concerning the findings in Chapter 6.

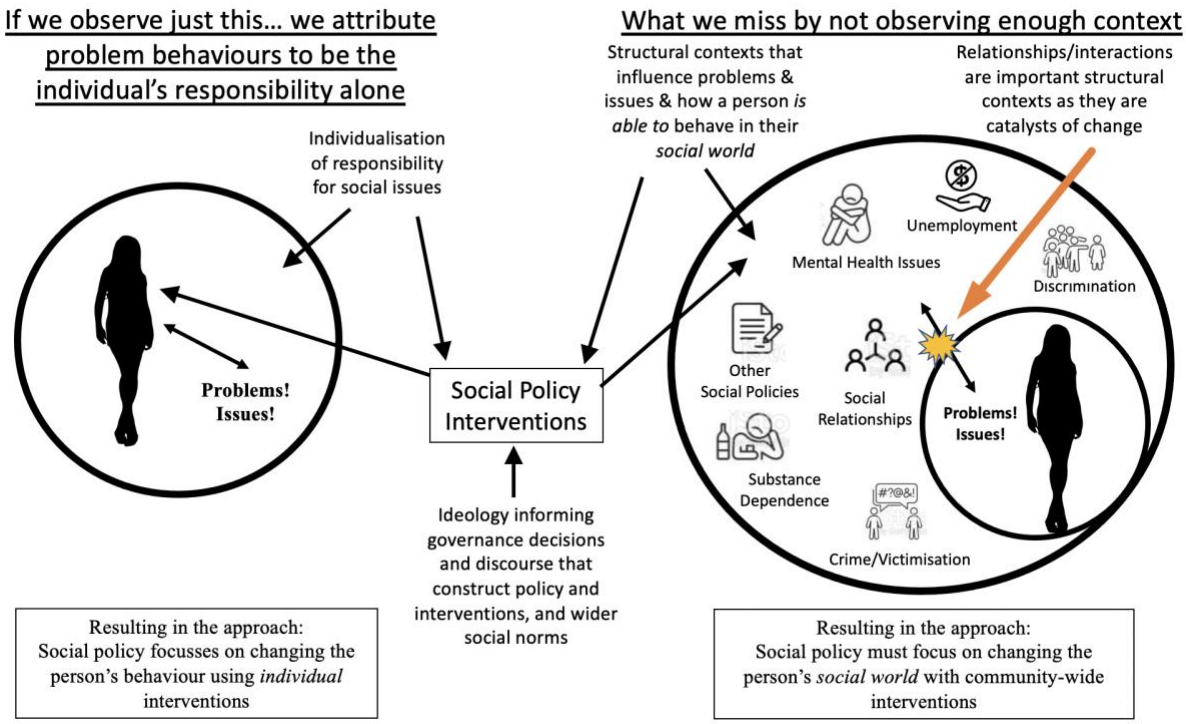

Figure 5: Policy with and without capturing adequate context.

7.2.1 Challenging How the Cashless Debit Card Frames Ideology and Behaviour, and Problematises Social Issues

When I observed and asked people about their lives over time through my community-embedded interactions, I learned that the CDC policy framing of social issues was missing some key features. The data indicates a disconnect between issue problematisation reflected in the CDC policy and the lived realities of how CDC recipients experience these social contexts and problems. Problematisations are only partially accurate in terms of what is being problematised. The social issues identified in CDC policy logic pair with some issues participants identify through the data, including drug and alcohol use, and 'irresponsible behaviours' such as violence against others. Predominantly though, the inaccuracy relates to the ideologies and problematisation of processes of *how* the issues occur or continue and are then acted on through policy such as the CDC. These processes were in effect, the social interactions otherwise described as relationships that acted as catalysts or conduits to navigate the conditions that shaped people's lives, where ultimately these interactions can be described as conditions themselves.

As outlined in Section 2.4, the CDC problematises social issues, such as alcohol and drug use, to exclusively encompass how welfare recipients spend welfare money. The CDC frames consumption of alcohol, drugs and gambling accessed by welfare money, as leading to the social issues people may experience. In this way, the CDC individualises responsibility for associated harms. The findings challenge the CDC's attribution of the weighting of individualised responsibility for social problems. Data analysis instead shows that a balance is needed to account for behaviours constrained by conditions that are contextually difficult for the individual to change given their unique and complex circumstances. The sections below explain how these issues occurred, how the CDC was found to work in those conditions and how this challenges the ideology and policy logic embedded in the CDC.

7.2.2 Findings Indicate Social Origins of Behaviours Challenging CDC Problematisation

As addressed in Section 2.2, problematisation, or what we choose to determine as a problem, is influenced by ideology or belief in different versions of what is right and why (Bacchi, 2009). Rethinking *how* the behaviours of policy recipients can occur has been identified by Capano and Howlett (2020) as a significant area underrepresented in policy research. Their argument is presented through a review of policy research that accounts for various policy approaches and theoretical influences on governance strategies. Capano and Howlett (2020) make further reflections regarding the need to consider related ideational paradigms. These paradigms inform "what ideas matter when policy instruments are developed" with such paradigms providing "guidance to policymakers because their normative and cognitive dimensions structure the goals they pursue" (Capano & Howlett, 2020, pp. 5-6).

When we rethink problems through observation of the effects of constrained opportunities, this directs attention to what those constraints actually are as opposed to solely looking at individual behaviours without the context of what might shape them. As outlined in Chapter 2.2, ideas of governance, or ideology, underpin systems of social, economic and political regulation and governance and the role of the state, or government, in people's lives (Maddison & Denniss, 2013). Ideology is a part of the process informing dominant approaches to social policy, such as the CDC, and determines conceptions of dysfunctional and deviant behaviours. Conception of social failures and deviance in the CDC logic shown in Section 2.4, are related to poverty, being poor and unemployed, and the result and responsibility of individual failure. This research, however, works to reconfirm that social

problems largely remain outside the direct control or choice of individuals. Instead, as Chapter 6 shows alongside other evidence, behaviours are related to the combination of the effects of social structures or contexts that influence individual behaviours and choices people can make (Bacchi, 2009; Coburn, 2016; Cockerham, 2005; Stewart, 2005; Weber, 1978). This effect is because those choices are confined to those contexts and occur within those conditions.

Data analysis reflects what some researchers have addressed regarding the dynamic interplay between conditions that come to create the contexts within which people live and related actions or agency of individuals and groups (Brannen & Nilsen, 2005; Coburn, 2016; Crammond & Carey, 2017; Foucault, 2008; Guerin, 2016; Wilkinson & Pickett, 2010). One common way of exploring these conditions shaping individual behaviours is through the concept of social structure and individual agency. This concept has long been addressed as acknowledging and identifying the role that social forces or structural conditions have on shaping individual and collective 'agency' or human behaviours (Brewer, 2004; Coburn, 2016; Denzin, 1990; Fuller, 2006; C. W. Mills, 2000; Scott & Nilsen, 2013). Although described differently over time, sociologists have primarily argued that structural conditions influence human behaviours because of the way these conditions change access to opportunities to behave in one way or another (Hironimus-Wendt & Wallace, 2009).

When taking a macro view, it can be observed throughout the findings that these constraints, and limited opportunities to do much otherwise (given their subjective contexts), are the 'problem'. This reframing of the problem challenges the polarised conception of an overly individualised framing of the 'lack of action' of welfare consumers favoured under a conservative paternalist stance regarding moving 'passive' people off welfare (Mead, 1997a, 1997b, 1997c, 2007, 2012; Mestan, 2014). As opposed to addressing the dynamic interplay between structures shaping opportunities for agency and choices, the CDC policy does little to account for these conditions as structural constraints on agency in context.

What this means is that the CDC cannot have its desired effect because it acts on the individual, not on their social conditions. Musolf (2017) contends that the concept of agency has been mythologised through the Enlightenment and notions of the Bourgeoisie to romanticise the sovereign and autonomous individual, coming to fruition with Adam Smith (Chapter 2). These results in Chapter 6 challenge ideas of the relative impact of individual

autonomy to improve social and economic conditions, supporting Musolf's (2017) argument of the romantic mythology remaining in policy as being informed by contemporary neoliberal ideas.

The data analysis challenges conservative-paternalist, neoliberal ideological conceptions of how individuals behave because the findings clearly show that people are not passively engaged in their lives. Instead, they are actively trying to have an effect but are constrained by what is available to them. CDC recipients consistently attempted to have some kind of effect or self-agency in their worlds. The constraining, dynamic contexts defining processes of behaviours, are explained in examples such as participant CDC-3 and their efforts to find employment during the day so as to continue caring for their young children at night whilst also navigating job-network provider barriers, welfare rules and DV; participant CDC-2 and their efforts to overcome DV through challenging the perpetrator and hoping the police could see what was really happening to them; or participant CDC-9 and their efforts to try and deal with their health issues whilst simultaneously navigate their past crimes, arrest and having their belongings stolen whilst in hospital seeking healthcare. These efforts do not reflect conservative ideas of welfare provision producing idleness and malaise (Barany, 2018), but represent action within constrained opportunities.

Expressions of agency are seen in the data where CDC recipients attempted to enact changes in their lives in different ways, such as through applying for jobs and escaping from, or helping others with, domestic violence. However, this agency is limited insofar by the structural boundaries imposed on recipients that are largely outside of an individual's direct control. These barriers include the effects of societal racism, the normalisation of violence and victimisation, and social policy interventions in general, which structure how people can navigate their lives. These structural boundaries are found to include the deterioration of social relationship interactions exacerbated by the CDC. These interactions are shown to facilitate various kinds of support from various people and are argued to be catalysts for overcoming barriers or not. In this way, these structures are reflections of the social conditions that provide foundations of shaping behaviours where findings in this study for these participants indicate that origins of behaviour are 'social', which includes relationships and interactions with other people.

7.2.3 Social Origins of Behaviours and the Limitations of a Dominant, Rationalist Approach to Policymaking and Policy Evaluation

Similar to the flaws in the application of limited ideology informing decisions for policy more broadly, are those same ideas also informing applied approaches to policymaking, interventions and measurement. As outlined in detail in Section 2.2.3, and evidenced throughout the findings of Chapter 6, social problems are not simple.

In the dominant rational choice approach from which the CDC policymaking emerges, little attention is paid to the social world's complex realities and influences on human behaviours and actions (Archer & Tritter, 2000). Instead, behaviours are modelled on individualised ideas of the origins of human behaviours (Cruickchank, 2000); and rely on neat and separated classifications of social issues decided as important by powerful politicians or policymakers, as opposed to the policy recipients (Althaus et al., 2007; French, 2018; Jamrozik & Nocella, 1998). In Section 2.2.3 it was argued that the policy process may reduce social complexity out of political necessity. Political pressure necessitates fast, linear, rational action on fixing simplified 'bad' social issues. As evidenced in Chapter 6 and addressed in Section 2.2.3, simplifying the causes of problems in this way may work to constrain options for alternative approaches to fix or prevent issues, and instead reinforce choosing a rationalist approach to policy making.

In challenging the dominant approaches to policy making, such as rationalist choice, Fischer and Miller (2017, p. 21) suggest that the rationalist choice approach alone does not adequately “produce the kind of knowledge needed for policy making”. Green and Shapiro (1994) assert that rationalist choice foundations rest on unrealistic and inadequately tested assumptions. Nonetheless the approach remains dominant (Griggs, 2017).

A primary concern with the rational choice approach is its idea of an unquestioned universal characterisation of human action (Archer & Tritter, 2000). Decisions emerging from the approach assert a singular version of rationality, effectively moralising behaviours per a favoured set of ideas of what society ought to be (Colebatch, Hoppe, & Noordegraaf, 2010; Neale, 2021). This rationalisation of human action, which rests on assumptions of unchallenged, individualised behavioural origins, means rationalist choice theory may not adequately frame nor address complex social issues due to its restrictive premises (Krstić, 2022). According to rational choice theory, actions by individuals are also attributed with

moralised ideas of rational and internalised behaviours, where individual actors are framed as behaving in accordance with beliefs, preferences, and desires of some variety (Green & Shapiro, 1994, p. 20). Limitations relate to constructing the actor the policy affects, as either rational or irrational, with policy outcomes focussed on individualised, goal-orientated actions (MacDonald, 2003).

This individualisation and these behavioural assumptions within the rationalist approach have been suggested as negating the need to investigate motives for behaviours (Sciulli, 1992), rendering the approach unable to adequately address reasons for behaviours as they occur in context (Krstić, 2022; Neale, 2021). This conception of behaviour under rationalist choice approaches, models all behaviour as emerging from self-interest and related to ideas of singular logic, stability, fixed personalities, or identities concerning belief and desire as being internalised and then acted upon. Such conceptions are typical in mainstream psychological models of human behaviour where unlike in findings in this project, behaviour is modelled as *originating* from internal processes of the brain (for examples, see Schwarzer, 2001; Van Lange, Kruglanski, & Higgins, 2012), addressed further below.

Data analysis in Chapter 6 consistently showed that issues were not linear nor separate, were not neatly categorised, and behaviours resulted from the interrelated ‘external’ social contexts a person experienced. This reality of messy issues has been argued elsewhere as more accurately reflective of what happens that a rationalist approach cannot address (Maddison & Denniss, 2013; McClelland, Smyth, & Marston, 2021; Turnpenny, Jordan, Benson, & Rayner, 2015). Data analysis has shown that these 'messy' or complex issues are common for these participants. For example, where experiences of traumatic events were, in some cases, shown to influence excessive alcohol drinking reflected on by some participants. Such attempts to cope with past trauma were shaped by a lack of other options also shown in the analysis, such as poor access to mental health professionals and support facilities. It has been posited elsewhere that where appropriate support exists, it can provide alternatives to self-medication with harmful use of substances (AIHW, 2019; Mendes et al., 2021).

Such examples show that the constraints on agency and opportunities of individuals interact with structural barriers that are hard for the individual to change, such as coping strategies influenced by access to appropriate care options. Archer and Tritter (2000) argue that rationalism is unable to address the inherent relationship between structure and individual

actions due to favouring individualism and mostly ignoring the structural conditions that shape how people can behave. All this means that through applying a rationalist approach, so much has been missed in all stages of the CDC policy in terms of understanding why people do what they do, and why they do not do what the policy intends.

Dominant ideas of *origins* of behaviour are challenged in the data. Instead of actions originating in the brain and thus individualised as 'problems within the individual', data analysis shows that the *reasons* for actions are already entrenched in complexities of the social world. The processes regarding *how* people then navigated their life contexts were shown in Chapter 6 to directly relate to the relational interactions between people. As stated by social anthropologists Russell and Edgar (1988, p. 7) in assessing the influence of welfare related social policies, we can assess social networks and interactions and "rather than assuming that networks are or will be ubiquitous, we need to look at how they are formed and maintained, with a view to deciding which networks are more effective and why".

As an example, complex realities can be seen in Chapter 6 where reasons why people may experience violence or excessively consume alcohol or use drugs, can relate to social interactions and doing things to maintain valuable relationships with others. Reasons included helping family-member's partners escape violence in times of need, publicly dealing (possible) drugs to test trust in relationships with newcomers and needing to maintain relationships with important family members through drinking to keep others happy with you. The CDC policy intervention did not account for the influence it may have on diverse lived contexts, nor the influence it was shown to have on these relational interactions. As outlined in Section 2.2.1, policy interventions shape conditions within which people live, and how this occurs is because policy shapes lived contexts, which changes the processes of how people interact.

7.2.4 Social Interactions as Catalysts and Pathways of Change

There are many ways to consider the reasons for human behaviours, and these cannot all be included here. Findings of my research highlight the significance of social interactions, which show how and why people behave to get what they need to deal with or avoid social issues. Similarly, Peterie et al. (2019) found that the social networks of unemployed persons are entrenched with stigma-related social barriers. They suggest that unemployment causes

shame resulting in the dissociation of the unemployed from various social networks (as does poverty, Thain, 2020). This disassociation further exacerbates unemployment possibly gained through those networks (Peterie et al., 2019). However, there may be additional ways, beyond simplifying internalised conceptions of shame, to explore how social interactions operate as catalysts for accessing things we need or avoiding things we do not. The following discussion highlights *how and why* when these relationships are damaged, this can result in social isolation and perpetuation of persistent social issues.

Explanations of the origins and consequences of human behaviours are used here that may best explore and explain social interactions as they are reflected in Chapter 6, drawing on contemporary ideas that merge fields and theory. As Denzin (1992, pp. 159-160) has explained, how we come to sociologically conceive of interactions and the social world all rely on using different words and explanations for similar things. These explanations are then argued as better explored by going beyond the canon of aligning to one explanation only, or from one field, or relying solely on historical traditions and theory. When researchers do so, they position the 'current' within the problems of the past, meaning 'the social dies in front of them' as they persist in 'studying an empirical world of their own making' without doing much to reposition the current within contemporary concerns (Denzin, 1992). Overcoming such concerns requires a contemporary and dynamic approach to assessing structural influences on behaviours and interactions.

The merging of differing sociological and social psychological concepts relating to social interactions and human behaviours is captured in the contemporary work by Guerin (2016, 2022). Alongside other approaches discussed below, the work by Guerin can be applied to explain the significance of social relationship interactions seen throughout Chapter 6, particularly relevant to explore the processes of how and why these contexts and behaviours occur. For example, Guerin's work explains that how we behave or interact with others may promote or restrict access to an individual or group and the resources an individual or group provides (or consequences they help us avoid). Guerin argue for the need to analyse these interactions without categorising behaviours using labels that *infer* emotions or reasons why behaviour is occurring. He suggests that those labels do not tell us much about what actually occurs regarding the associated behaviours (Guerin, 2016, 2022). Here, the focus is on the observable behaviours that occur or, more simply, the interactions that people have with others and the effects the actions that people do, have in their contexts. These behaviours

relate to interactions with others to get access to resources or avoid consequences (Guerin, 2016), where others such as J. Schneider (1971) have described this access as just as important as the resources themselves.

These social resource exchanges can be defined as what is exchanged (or withheld) during interactions and how those exchanges operate and have flow-on effects along a pathway of other interactions. Resources can be framed as symbolic, such as information or employment, or tangible such as food or shelter. Although such a clear-cut distinction is only relevant to how a resource has an effect, resources are often both symbolic and tangible, depending on their relevance in an interaction. Whether tangible or symbolic, this depends on the social value embedded in resources exchanged or the withholding of assistance (Guerin, 2016). These localised social values are described by authors such as Goffman (1967) as ritualised and required to save-face or avoid disgrace in relation to maintaining beneficial social encounters. What is determined to have value, changes across cultures and history, is socially and discursively constructed and determined as important by social groups and individuals (Derrida, 1976; Guerin, 2016).

Common presumptions mostly frame behaviours as related to in-group peer pressure combined with individualised attributes of internal problems such as poor self-control or low self-esteem (Schaefer, 2018). In contrast, structural determinations of value and related interactions working to shape social norms (and vice versa), have been shown to effectively encourage particular behaviours as required to manage access to groups and what they provide or help us avoid (Ennett & Bauman, 1994; Ennett et al., 2010; McKeown & Dixon, 2017; Marsden & Lee, 2022). Subsequently, interactions and exchanges for resources can be conceived as providing access to other interactions and resources (Marsden & Lee, 2022), otherwise defined as accessing resources along an interactional pathway. The relationship interactions we do or do not have access to, can therefore restrict or liberate our options for how we behave to get or maintain resource access. Similarly, such ‘bonding’ and ‘bridging’ social capital is theorised by Putnam (1993, 2015) as the glue that links and/or stretches our relational networks of support and assistance.

Whom we interact with and how that happens in context, can mean that our social interactions and contexts influence opportunities for further behaviours, as if along an interactional pathway (Denzin, 1992; Geertz, 1983; Putnam, 1993; Sartre, 1976; Wolf, 1950).

The relevance of interactional pathways for resources and people doing this to access groups and what they provide, are reflected in work by Marsden and Lee (2022) and Ennett and Bauman (1994). For example, although dated, Ennett and Bauman (1994) found that behaviours of smoking or other drug consumption related to social relationships and group norms. Their findings showed that such behaviours were often about group-outsiders doing them when seeking to gain or maintain access to a clique or group, indicating social influence to be far more nuanced than commonly presumed. In terms of relationship maintenance, other research has addressed the behaviours of managing access to resources the group can provide, whether a person is already a part of that group or not (Guerin, 2016, 2020a, 2020b). Further research has discussed that the kind of relationship/interaction we have access to shapes how we need to behave to influence the conditions around us, given the relative constraints of our social worlds (Campbell, 2009). While this may indicate that we might have a high level of agency to influence those around us, how we behave may also promote or restrict access to a group.

Where there are barriers that impede these interactions between people, social mobility is thus constrained, and othering, anger, and distrust can result (Carpiano, 2006; Mor Barak, 2019; G. Payne, 2020; Thomas & Griffin, 2020). These barriers in this research include the CDC deteriorating relationships and not facilitating other opportunities to construct more beneficial networks. Issues were shown to arise where there were limited individuals and groups to interact with or when faced with structural issues such as overcoming racism due to discrimination and prejudice. Researchers employing network theory and analysis have constructed similar frames of conceptualising social interactions, where they have shown that coping capacity and challenges of life events are facilitated through the nature of potential and actual social networks (Davies, 1998; C. Mitchell, 1966; Trevillion, 1992).

Unfortunately, where exclusion or other negative events occur, and few alternatives exist to escape these negative life conditions through beneficial or useful social networks and interactions, people can remain stuck where they are, for example leading to ongoing unemployment (Davies, 1998; Peterie et al., 2019). In some severe circumstances, research has shown that these constraints and few alternatives to access resources otherwise, can relate to behaviours that are inherently harmful to the self or others in effort to maintain access to resources (Guerin, 2022; Liang, Goodman, Tumala-Narra & Weintraub, 2005; Robinson, Ravi & Voth Schrag, 2021). By identifying how the CDC policy may interact with and shape

social interactions/relationships, we can better address the complexity and map the *mechanisms* that influence related human behaviours in their interrelated contexts.

In reflecting on the findings in Chapter 6 that address the importance of relationship interactions, the work by researchers such as Ennett and Bauman (1994), Marsden and Lee (2022) and Guerin (2016, 2020a, 2020b, 2022), helps us to understand the significance of maintaining positive social relationships that diversify access to things people need to support positive social outcomes. Chapter 6 explored the persistent conditions CDC recipients were dealing with, where all experiences included relationship interactions with others in their lives across all conditions in some way. These interactional examples include victimisation from violence or discrimination. Regarding discrimination, these issues link to not getting a job and unemployment, which subsequently works to perpetuate poverty. The resulting lack of beneficial interactional opportunities further constrained access to resources including employed people that may help alleviate the same issues through access to employment. Chapter 6 also showed the significance of positive interactions between CDC recipients and service providers which help to overcome issues and barriers for recipients. Such interactions created space for trust and therefore opportunities to dealt with multiple problems through targeted assistance and sharing information about what can be done to assist.

As Chapter 3 and 6 outlined, what was previously measured in other research regarding the effects or influences of the CDC intervention did little to capture those interactions, otherwise framed as processes of how the CDC policy had an effect on people in context. Findings show that these changes to conditions altered how people interacted when navigating their lives and seeking access to resources they required in their locally lived contexts. Subsequently, these changes to conditions and interactions corresponded with an increase in social divisions, summarised in Figure 4.

In applying a critical ethnographic contextual methodology supported by policy researchers such as Neale (2021), ethnographers as discussed in Chapter 5, and carefully highlighting processes of how and why relationship deteriorations work to divide people and constrain opportunities, the negative effects of the CDC intervention at the local level are made more evident. Where these deteriorations of social relationships occur, people became more isolated which served to further block access to resources and other networks and supports, otherwise provided along a more supportive interactional pathway. This deterioration of

social relationships results in the breaking down of both bonding and bridging social capital and an increase in social alienation (Putnam, 1993, 2015). Therefore, by employing a critical and contextual methodology, this can aide in centralising those interactions as significant and needing research attention.

The following Section now explores how employing a critical approach to learning about policy can be useful in identifying related unintentional consequences that may arise.

7.3 The Cashless Debit Card, Social Division and its Consequences

This section builds on 7.2 and addresses the methodological issues identified in Chapter 3 in terms of what can be learned about researching social policy and what this means for governance strategies. These issues are explored to argue the relevance of the applied contextual methodology which is shown to improve knowledge about the influence and impact of the CDC policy intervention. These improvements and findings are then applied to what these can mean for policy as a strategy of social governance in relation to unintentional consequences that may arise without application of diverse, critical methodologies.

It is well established that *how* we go about learning or researching phenomena directly relates to *what* research can uncover in any given study. As Section 3.2 addressed, alongside what are determined as social problems, is that what can be learned about social policy is also dependent on *how* policy researchers engage with social policy itself. For example, regarding preference being given more recently for evidence-based policy described in Section 3.2, this has then influenced 'what counts' as relevant evidence. The evidence-based approach is often touted as restricted in ability to capture complex nuances of influence in context due to its often rationalist, quantitative limitations. As explained further in Section 3.2 and addressed in 7.2 above, this inability to capture nuance and reliance on what Neale (2021) describes as simple causality, has limited what can be learned. Specifically, it has meant that much policy research about intervention influences has been able to report linear and ambiguous associations but cannot capture the processes of how nor why interventions work in context to have effect (Neale, 2021).

As outlined in Section 3.2, how we understand what is measured or analysed in social policy research relates to the intent of the research itself and what is decided as important to learn about. As Section 2.2 outlined, intent is politically constrained where ideology and resource contexts come to influence choices regarding what policy and its measurement, intends to achieve. As discussed on Section 3.2, policy decisions, interventions and research necessarily define problems to act on, and what is researched and how policy influence is measured depends on how problems are constructed. A contextual and critical approach to how we define what is important and how we learn about policy, can generate new types of data and analyses as has been done here. This approach may help researchers identify and address the processes of how social policy interventions influence targeted communities and individuals.

Overall, by employing this critical and contextual methodology, this research repositioned what 'problems' could be identified as important to understand and therefore measure. Furthermore, this work also helped to illuminate the processes of how and why those problems or conditions were influenced by the CDC, which research efforts previously had not yet done. Relative to policy objectives, the influence of the CDC was found to have had unintended consequences in the lives of recipients and their communities. These following sections below outline what these novel findings of 'unintended consequences' mean the CDC policy intervention can have in a contextualised local socio-political environment. These 'unintended consequences' include potential deleterious ramifications for social cohesion, othering, symbolic and real social violence, and a degradation of governance strategies.

7.3.1 The Cashless Debit Card, Social Division and Social Cohesion

Social interactions are shown to be pivotal overall in shaping behavioural opportunities people have across all theme areas to some degree. Findings in Chapter 6 showed the CDC damaged social relationships within and between groups, including generalised community members perceptions of those receiving the CDC and those not, and similarly between and within closer friends and family relationships. While innovative in depth these findings have also been reflected in other research unrelated to the CDC (see Pawlak, 2015; Taylor & Davis, 2018; Thomas & Griffin, 2021 for example). How these deteriorations in social interactions and relationships relates to social division, and what this can mean for strategies of governance are addressed as follows.

The CDC as a social symbol representing deviant behaviours, feeds the ongoing divisive social construction of the welfare recipient as 'other'. Where the CDC is framed as responding to and regulating socially irresponsible behaviours such as crime, I found in this study that instead of reducing these, the CDC may exacerbate crime or violence because of the way it amplifies social divisions. For example, perceptions of crime are argued to often reflect a fear of the 'other', often perpetuated by media and political discourse in favour of certain moral narratives based on ideas of what society ought to be or not to be (Barker & Jane, 2016). Perceptions such as these relate to social norms and value construction and have been described as mechanisms of social control and regulation in society (Denisoff & McCaghy, 1973; Goode, 2019). Addressed in Section 2.2.1 was that policy interventions as formal acts of social control, influence informal control mechanisms through shaping social norms and cultures, with these directing how people interact. Informal social control discussed further in Sections below, relies partly on constructing perceptions of 'others' informed by ideas of deviance and conformity, which influence interactions and direct social behaviours of groups (Deflem & Wellford, 2018; Janowitz, 1975). However, without directing attention to potential risks of social divisions, any potential beneficial effects accruing from social regulation may be negated by the social harms also stimulated by such policy interventions.

Examples of political discourse representing varying ideologies regarding deviance and welfare, then translating into social policy, have been addressed further throughout Chapter 2. Manifestations of normalised dichotomies of 'othering', such as those constructing binaries of you and me; or right and wrong, can result in discrimination where certain groups are framed as worse or better than others. The emergence of such manifestations has been described by Fischer (2003) as a complex outcome of a nation's discursive contexts over time. As Humphrey and Schmalleger (2019) describe, this includes the ideas and actions embedded in legislation, political and policy discourse, and what is decided by the state as representational of ideas of morality, and what is 'right or wrong', which changes over time. These discursive contexts position certain behaviours as deviant, alongside certain people (for example welfare recipients) as representative of deviance more generally. The degree to which this occurs in different societies varies but the outcome is the creation of perceptions of 'us and them', often followed by social discrimination, distrust and isolation (Barker & Jane, 2016).

Where people perceive others as 'bad' and presenting an increased fear or risk, this does not necessarily mean they have experienced crime or victimisation by 'those others', but these perceptions nonetheless have real power in influencing how groups interact. Symbols of risk or fear are constructions of social deviance concerning that which challenges conformity determined by a certain social group (Goode & Ben-Yehuda, 2010). Farrall, Gray, & Jackson (2007) and Jackson (2008) argue that these interpretations are unique to groups and locations, influenced by shared cultural understandings about what represents disorder, deviance, or risk. These symbols of risk, such as I argue the CDC is part, are constructed by social norms promoting othering, separating people as 'good' or 'bad' and hampering positive social interactions.

Where groups are kept separate through othering and division, there is little opportunity for developing shared understandings, and harmful conflict can develop. Contemporary research has suggested that the greater the connectivity and trust across groups, the lower the rate of fear and risk of crime (Farrall et al., 2007; Jackson, 2004, 2008). However, if values and norms are disparate across groups, and there is little room or support for embracing difference, discrimination through exclusion often occurs (Barker & Jane, 2016). This exclusion can lead to issues with social cohesion, control, and crime in communities (Bradford & Myhill, 2015; McLean & Wolfe, 2016). Where a community is disconnected, and individuals and groups are excluded, individuals and their behaviours are more readily framed as threats or risks and something to fear (Dinesen et al., 2020; Jupp et al., 2007; Markus & Kirpitchenko, 2007). In other words, where people are socially disconnected across groups and have no opportunity that encourages positive interaction with others unlike them, they may feel that they have little choice but to engage in behaviours that reproduce group norms, such as fear of the other, so to remain members of a ‘subgroup’. Exclusion then occurs, leading to discrimination, crime and victimisation, and perceptions of injustice by the feared 'other', which is reflected as a finding in this research.

The concept of a cohesive society being undermined by divisions and discriminations of some form have long been established in research and theory. Social cohesion has been conceptualised and applied very differently over time and across nations, governments, and non-government organisations (Markus & Kirpitchenko, 2007; McKeown & Dixon, 2017). As addressed by Cantle (2012, 2016, 2018), social cohesion relates to social divisions that can occur through social exclusion, often based on social constructions of difference and

othering related to race, gender, social class and economic position. In extending conceptions of cohesion, Cantle (2018) describes the disadvantage, discrimination and disaffection experienced by an identifiable community of people as a distinct form of cohesion, namely community cohesion. Described as a once popular 'catch all' phrase (Chan et al., 2006), and as emerging from seminal works by Durkheim (2004, pp. 19-35) and Tönnies (1955) in the late 19th century, social cohesion's meaning and measurement has been argued more recently as context-dependent, differing across academic and political fields (Delhey et al., 2018). Its potential for misuse has been framed as occurring through acquiring meaning depending on the most powerful party using the term (Burns et al., 2018).

However, while the term cohesion is used, it remains that a socially cohesive society is significant because of the well-established social benefits of effectively reducing social divisions and managing adverse outcomes of poor cohesion. Benefits include stable democracies, productivity and economic resilience (Beauvais & Jenson, 2002; Dheret, 2015); good quality of life and better health outcomes (van Staveren, Pervaiz, & Chaudhary, 2013); and effective conflict resolution (Dheret, 2015; United Nations Development Programme, 2015). Adverse outcomes of a highly divided and non-cohesive society include the risk of othering and subsequent social violence of different kinds (Holslag, 2015; Mayblin, 2019; Mooney, 2009); social risks related to perceptions of injustice (Wolfowicz, Litmanovitz, Weisburd, & Hasisi, 2020); perceptions of injustice then negatively impacting state legitimacy to enact governance (Allan et al., 2015; Hegtvedt & Johnson, 2009) and the risk of perceptions of injustice in relation to disruptive social movements and actions (Della Porta, 2008, 2013; Yassan, 2021).

Contemporary conceptualisations include some primary ways social cohesion has been addressed, such as focusing social cohesion as relating to shared values; or as a continuous process toward harmony; or as a property of a group or community (Markus & Kirpitchenko, 2007). Scholars such as Jenson (1998), Beauvais and Jenson (2002) and Chan et al. (2006) have worked to construct more specific guiding principles of what constitutes a socially cohesive society and communities therein. For example, Jenson (1998) famously outlined five different dimensions that promote (former) or restrict (latter) social cohesion, which include: belonging versus isolation; inclusion versus exclusion; participation versus non-involvement; recognition versus rejection; and legitimacy versus illegitimacy of the state.

Arguments to how trust, belonging, inclusion and participation makes a socially cohesive society have also varied theoretically (Dinesen et al., 2020; Markus & Kirpitchenko, 2007; Reitz & Banerjee, 2007). Some have argued that increased social diversity is bad for social cohesion (Putnam, 2007), and others have argued the opposite (Hewstone, 2015). Hewstone's (2015) research aimed to address processes of intergroup contact, drawing on the contact hypothesis and highlighting how different forms of *positive contact* between diverse groups work to reduce prejudice and promote inter-group cohesion. This contact theory or hypothesis has been developed over the past three decades and has become well-established as a theory in social psychology, which however is not without its limitations (McKeown & Dixon, 2017).

In my efforts to explain what a socially cohesive society or community is in relation to the influences of the CDC on relationship interactions, common themes can be seen in the above. These include the primary concerns of inclusion or exclusion impacting social participation, identity and belonging; and trust within and between citizens and the state. A socially cohesive society can occur through the social relationship exchange that facilitates reciprocity between individuals and groups (Cantle, 2016; Markus & Kirpitchenko, 2007). During these exchanges, negative social division is arguably reduced through the social rejection of behaviours that promote it. In light of the above, these rejections through social policy decisions would therefore include rejecting policy interventions that exacerbate negative divisions. These include: rejecting harm from violence and discrimination as these are often consequences and causes of exclusion and distrust; rejecting political actions that threaten distrust of others in community, such as othering in political discourse and policy; and rejecting governance actions perceived as unjust that subsequently promote distrust in the state to enact governance. Unfortunately, the CDC did little to create conditions conducive to rejecting these categorisations regarding what can promote a socially cohesive society. Instead, the CDC intervention deteriorated relationships and allowed for the expression of broader social norms constructed about welfare recipients and their apparent 'bad' behaviours.

The following sections outline the risks of poor social cohesion concerning social divisions associated with violence, discrimination, distrust, and perceptions of injustice, which parallel findings related to the influences of the CDC in people's lives. These risks while not explicitly presented in the data remain a possibility where conditions are conducive to fostering social disruption. Sections include discussion and consequences focussing on social

othering and subsequent social violence; social risks related to perceptions of injustice; perceptions of injustice then negatively impacting on perceptions of the legitimacy of the state to enact governance; and the risk of perceptions of injustice in relation to possibilities of disruptive or reactionary social movements and actions.

7.3.2 The Cashless Debit Card, Perceptions of Injustice and State Legitimacy

Data analysis in Chapter 6 showed that for most participants, a perception prevails that the CDC is not a socially just policy, both because of the way the card regulates purchases alongside how the card is socially divisive. Group perceptions of injustice in systems or processes of governance relate to the conception of legitimacy of the state to govern, regulate and organise society (Allan et al., 2015), meaning the CDC policy may disrupt how people perceive the state as legitimate in regulating their lives. This link between social policy, injustice and inequality has been discussed by Craig (2006, p. 1266) and elsewhere by others such as Donnison (1997) and Rawls (2004). As evidenced by A. Schneider (2015, p. 224), the link between social policy and perceptions of injustice directly relates to perceptions of the state as legitimate to govern, where "the way targets are treated by policy is central to justice, citizenship, support for democratic institutions, and democratic problem solving" and that "policy can either reinforce or undermine government legitimacy and sense of civic duty". Legitimacy constructed via governance relates to how the state is conceived by the citizenry influencing how groups and individuals will act on behalf of the state and conform to laws and policy (Button, 2020; McLean & Wolfe, 2015; Tyler, 1990).

According to research by Wilkinson and Pickett (2010), and further supported by others such as Fitzpatrick (2011), equality and fairness, or social justice, are better for everyone. In describing how this can occur at the general social level, Fitzpatrick contends that "unequal societies are ones in which everyday bonds of trust begin to fray as people see others as strangers, obstacles and competitors" (Fitzpatrick, 2011, p. 38). These economic and social costs of unequal societies include those associated with remedying crime rises, poor mental and physical health, impoverishment, and poverty (Wilkinson & Pickett, 2010).

In terms of governance strategies, how people perceive others outside of their 'group' has ramifications for informal social control, which will influence formal regulation and order. Informal strategies include how policy influences perceptions of governance via individual

and group experiences of policy informing perceptions of state legitimacy to enact control. Social control, whether considered an outcome or process, remains layered with what have been described as formal and informal control strategies to encourage socialisation, social order and organisation (Deflem & Wellford, 2018). As Cohen (1989) and White and Perrone (2005) suggest, social control is not unidirectional. Instead, it consists of dynamic interactions between social forces that work together to reflect and construct norms, conformity, deviance and crime. In remembering the informal-formal social control nexus (Kubrin & Weitzer, 2003), the nexus reflects the iterative reality of the role of formal institutions in delivering formalised social control strategies to incorporate elements of informal social interaction mechanisms.

Informal mechanisms relate to how those institutions socialise and organise communities and individuals, which determines how society will respond to formal control efforts (Janowitz, 1975). Subsequently, formal efforts such as social policy interventions will have effects on social interactions, as seen in this research. These efforts shape perceptions of the state which impact on interactions and influence the publics' actions associated with formal control related to conformity or deviance in line with formal rules and regulations (Sargeant, Murphy, McCarthy, & Williamson, 2021). As Section 2.2.1 outlined, informal strategies of control include how policy influences perceptions of governance via individual and group experiences of policy, informing perceptions of state legitimacy to enact control. Where formal control via policy interventions, such as the CDC, work to deteriorate positive relationships and instead promote othering, consequences impacting informal control include distrust and fear of 'others'. This othering and social construction of the CDC recipient as deviant can promote stress, anger and frustration alongside division, which all have ramifications for informal control mechanisms being impacted by perceptions of injustice. This injustice can damage perceptions of the state as legitimate to govern, thus negating conformity to rules and challenging the formal control strategies of the state in different ways.

Notably, research suggests the *subjective perception* of injustice is of concern, not necessarily the objective measures of indicators that may reflect statistical inequities or inequalities (Franc & Pavlović, 2018; Poli & Arun, 2019). The seminal work regarding a theory of justice by theorist John Rawls (2004, p. 4) has theorised justice as akin to fairness, and that “a society is well-ordered when it is not only designed to advance the good of its members but

when it is also effectively regulated by a public conception of justice". This public conception of what is just or unjust varies, and what is considered fair or equitable in a society is not perceived equally across individuals or groups. Rawls (2004) observes that even during these definition disputes, societies often agree to a set of defined characteristics of what justice is. These foundational or basic agreements are then ideally maintained by policy, legislation and law. In application, this difference means that the perceptions of what is just, or fair can be relative, imbued with the politics of individual and group identities and lived experiences related to cultural, historical and social, constructions and norms (Barker & Jane; 2016:Campbell, 2000).

Like CDC social policy concerns, the impacts of perceptions of injustice have been addressed elsewhere in areas that seek to address deviance and promote conformity, namely in criminological theory and debate. For example, drawing on Tyler's (1990) Procedural Justice Theory, sociology and criminology scholars have argued that ensuring justice is deemed fair in accordance with broad social norms helps legitimise the state's acts of social control. Where groups perceive justice processes as fair, evidence has shown that this increases public trust in the justice system, meaning individuals are less likely to break the law and more likely to comply with social norms (Bradford & Myhill, 2015; McLean & Wolfe, 2016). This perception of fairness may reduce social stressors experienced as a result of injustice, such as stress from discrimination or social exclusion (Alegría, NeMoyer, Falgàs Bagué, Wang, & Alvarez, 2018; Shim & Compton, 2020).

In this way, the perception of fairness and related stressors reflects ideas embedded within Agnew's General Strain Theory (Agnew, 2006). Here stressors are framed as an inability to avoid negative stimuli, that when combined with the loss or absence of positive stimuli, such as good relationships and other coping strategies, the likelihood of a person engaging in crime and delinquency is increased (F. Williams & McShane, 2010). Such ideas focus primarily on the behaviour of individuals. However, they remain significant regarding how the influence of institutional practices can modify conditions that may promote group deviance when socially excluded individuals coalesce to form groups around a shared perception of injustice, challenging state legitimacy.

Where social division and exclusion occur via policy interventions that negate effective strategies of social control (Sargent, Nilan & Winter, 1997) this indicates that interventions

which promote inclusion across groups may work as a beneficial strategy for more effective social regulation. As outlined in Figure 4 in Chapter 6, the current research shows the processual interactional pathways that work to constrain opportunities for positive change. The problematic contexts that participants experience are shown through the analysis to be facilitated by *reproduction of constraints and social norms through interactions* that occur between individuals and groups. Such reproduction via interaction aligns to those arguments made by interactionists such as Denzin (1992), Geertz (1983), Satre (1976) and Simmel (Simmel as described by Wolff, 1950). These authors, although in varying ways, all contend that the iterative influences of social structures and social relationships create and reproduce social norms, cultures and therefore, contextual constraints. For example, Denzin (1992, p. 27) explains that:

> These constraining features are woven through the structures of social relationships and ensembles of action, that connect individuals with one another in differentially coercive ways.

As argued by Bilton et al., (1981), drawing on theory first explored by Weber, social regulation through the coercive use of ideas as opposed to harsh sanctions or punishment, is more effective at regulating society. They suggest this occurs through using ideas to construct legitimacy of the state or dominant other, to govern, where ideas "engineer the consent of the ruled" (Bilton et al., 1981, p. 30). Here ideas can be repostitioned as constructed by social norms, which when reproduced through social interactions work to stimulate how these ideas are accepted or not between people and groups. Where ideas work to divide society (Sargeant et al., 1997) they take effect through implying othering and competition and stigma between groups, effectively constraining individuals to those groups and preventing beneficial interactions and social mobility. Social control in this way relies on social division, however does not adequately consider the social costs of doing so.

Social control and regulation via dynamic and diverse strategies that enhance positive social interactions and social inclusion, may be more effective at promoting state legitimacy than those that work to divide society. Analysis in this research shows that the effect of the contextual, interrelated conditions on those interactions and vice versa, promote problematic social divisions that work to challenge the state. The CDC is shown to enhance constraints and certain social norms framing deviant behaviours. This framing indirectly sustains

processual interactions that exacerbate social divisions via multiple pathways. This exacerbation also occurs because the CDC is shown to not have beneficial influence to mitigate persistent problematic conditions. To redirect and promote beneficial interactional pathways to negate social divisions, policy interventions should instead direct attention to act on those contexts in ways that incorporate interactions as conduits of social regulation. This will mean incorporating regulation strategies that work to *promote inclusion* by dealing with various pathways that promote discrimination, violence and crime, mental health and stress which all interact and correspond to social divisions.

7.3.3 Social Policy, the Risk of Injustice and Social Disruption

Although not necessarily the intention of governance and social policy processes more broadly, the socialised norms of othering are shown to permeate into policy discourses, influencing groups that make decisions and their interactions with the governed citizenry. Where these discourses are perceived to relate to the perpetuation of inequity and inequality by groups of the citizenry, actions taken by those governed may challenge state legitimacy by questioning the state's ability to exercise power and punishment fairly.

As previous research regarding the influence of the CDC and basics card interventions has begun to explore, these perceptions of injustice have been linked to resistance behaviours, as further addressed in Chapter 3 and expanded on in Chapter 6. For example, Peterie et al. (2022) highlighted that resistance against policy rules inspired online collective action against the CDC. Likewise, Mendes (2017) argued that inadequate consultation and distrust thus encouraged activism against the CDC. Dalley (2020) identified subtle resistance against the card, such as rule circumvention so to get on with life. Findings in Chapter 6 confirm alongside this previous research, that circumvention or resistance strategies are common for people needing to get around CDC policy rules. Research suggests that resistance activities and activism can encourage positive social actions against such interventions, which can be beneficial in creating political change (Merkel, 2022; Yakhnich & Walsh, 2022). However, resistance is not always positive and cannot safely be considered as permanently benign.

Outcomes of division, injustice and distrust in governance have been shown to stimulate unintentional social risks (Araral et al., 2015; Cable, 2018). These risks include crime, radical or extreme outcomes in response to injustice, divisions and poor social cohesion. Although

not explicitly referred to in the data, the way in which the CDC intervention promoted perceptions of injustice amongst recipients may result in undermining state legitimacy. As explored elsewhere, the overrepresentation of groups such as Aboriginal people and people with mental health issues in the criminal justice system, has led to analyses which focus on the divisive social narratives that frame systems of governance as discriminatory and predatory toward certain social groups and not others (for examples see (Capurri, 2021; Jellison-Hounkanrin, 2020; Taylor, Brannon, Valladares, Mukherjee, & Salter, 2019). This overrepresentation has largely been focused on the criminal justice system and is shown to translate into narratives of injustice that have spurred social movements and activism that challenge the legitimacy of the state and justice system specifically (Cable, 2018). For example, recent research has established that perceptions of hardship, inequity and inequality, such as discrimination and social injustice, combine with other social indicators, such as poverty (Fisher & Dugan, 2019; Franc & Pavlović, 2018; Gupta, 2020; Poli & Arun, 2019) or social exclusion (Centre for Resilient and Inclusive Societies, 2021), to increase the likelihood of some people participating in extreme resistance behaviours including violence (Allan et al., 2015; Mirahmadi, 2016; RTI International, 2018; Veldhuis & Staun, 2009).

Social movement theorists such as Cable (2018) and Staggenborg (2002) have described the emergence of groups coalescing around a shared perception of injustice as itself a development inherently related to structural problems. Research has shown that groups work to frame, construct and interpret political opportunities and threats (Snow & Benford, 1992) in alignment with perceptions of injustice linking individuals to movements (Kimmel, 2017; Swart, 1995), and linking across groups with compatible aims or beliefs (Carroll & Ratner, 1996). The potential exists for once non-affiliated individuals and groups to interact and construct shared meaning and links across ideological divides allowing movement spillover (D. Meyer & Whittier, 1994; Zhou & Yang, 2021). Research shows that the emergence of multiple groups can see them sometimes conjoining, or otherwise collaborating to support their social movement organisation or campaign (D. Meyer & Whittier, 1994; Zhou & Yang, 2021).

Concerns regarding perceptions of injustice and harmful resistance, sometimes occurring through social movements, have ramifications for state legitimacy and, in some extreme cases, national security. This is because such perceptions may provide avenues for inflaming social tensions through challenges to peace and social cohesion. One area of contemporary

concern relates to increased potential for usurpation and enhancement of existing divisive narratives by unfriendly actors (Cull et al., 2017). Such subversive action against the state can occur via fuelling the fire with misinformation, which Cull et al. (2017) show was often the case during times of historical global conflict. Wigell (2021) explains how this subversion of public discontent by unfriendly actors to destabilise society remains a contemporary concern. For example, social injustice researchers have shown that there is precedence for perceptions of injustice to escalate into radical actions or violence on rare occasions, often through groups and social movements (Aumer, 2021; Kruglanski et al., 2014; Vegetti & Littvay, 2021). As described by prominent social movement sociologist Della Porta (2008), social upheaval or escalation into violence can result in relation to ideological and political unrest. Destabilisation may occur by strategically directing or preventing groups from forming, finding belonging or sharing narratives. Doing so successfully has been argued as requiring localised attention to historical events and conditions (Staggenborg, 2002) and inflaming perceptions of injustice already existing within groups and institutions (Cull et al., 2017; McLean & Wolfe, 2016). Promoting opportunities and resources to enable social movements and groups to continue campaigns and form organisations has been a well-used strategy to politically destabilise the citizenry and, therefore, the state (Cull, Gatov, Pomerantsev, Applebaum, & Shawcross, 2017; Herman, 1996; Kragh & Åsberg, 2017; Kux, 1985; Matthews et al., 2021; Pearson, 2019; Walton, 2019).

Such reflections in the paragraphs above suggest that actions taken to promote cohesion and inclusion within society and communities are therefore beneficial in protecting against actions that may seek to further exacerbate existing social divisions. Recommendations made by researchers such as Cull et al. (2017) and Fitzpatrick (2011) to counter the effects of the promotion of social divisions and injustice, include promoting social resilience through indirect strategies of rectifying existing social issues that could be exacerbating social divisions and conflict, and threaten state legitimacy.

Social policy interventions such as the CDC can be shown to inflame social division, and in some cases promote social conflicts. In this sense the CDC can be conceived as an immaturely constructed and ill-conceived approach that has not fully considered the potential for negative ramifications in diverse contexts. Cull et al. (2017) and Fitzpatrick (2011), along with others such as Cantle (2016), argue efforts should focus on repairing those conditions that exacerbate division and distrust. In the case of the CDC, the analysis of recipient data

shows that reducing perceptions of injustice rather than fostering additional constraints that deteriorate relationships is needed. Addressing already constrained opportunities including those structural and divisive barriers that prevent employment, entrench violence, substance abuse and other crime along with promoting access to housing and education are important in promoting social inclusion and avoiding social isolation.

7.4 Summarising Ways Forward

Through analysing the influences of the CDC this PhD research contributes and adds to knowledge relating to social policy implementation. It has done so through addressing knowledge gaps and employing a critical ethnographic methodology that shows both diversity of impact of policy implementation and describing how policy interventions work in a local context. This thesis has explicated the importance of relational interactions as conduits or catalysts providing or constraining access to resources and opportunities for change.

By analysing a local context and revealing the influences of the CDC's intervention in peoples' lives in this thesis, I have deliberately focused on processes of social interactions and how these were influenced by the CDC. Improving decision making by including the lived experiences of diverse communities and localities is important to reduce unintentional waste of public resources on similar interventions that do not achieve what they set out to. Greater consideration of the interactivity of policy implementation in contexts where persistent, interrelated conditions occur - such as those described by recipients and communities in Ceduna in this thesis –is paramount to also reduce unintentional consequences that risk perceptions of state legitimacy. Better understanding of the local contexts where policy implementation is occurring can enlighten and enhance local benefits over disbenefits.

Research Sub-Question 3: What can we learn about the importance of establishing the influences of continuing life contexts on behaviours of CDC recipients in Ceduna, regarding improving policy making and research for effective social policy?

In responding to this research sub-question, through this research, I argue that the CDC did not positively change what it set out to change. Local conditions and the situation of

recipients did not change because the CDC framed problems and what to do about them in particular ways that could not accurately capture *how* people in Ceduna experience their lives in all its complexity. However, the CDC unintentionally affected social interactions and relationships, which enhanced some already-persistent problems. I argue that the CDC overall promoted social divisions, and it did this by enabling instances of violence, promoting discrimination, creating divisions within social relationships, and prompting distrust in processes of governance. Consequently, the CDC unintentionally challenged social cohesion and social connectivity by contributing to these divisions.

Those divisions were created by, and reiteratively promoted, further othering within and between groups, which related to the negative impacts of social constructions of deservingness and perceptions of injustice. In some cases, those perceptions of injustice may also work to challenge social conceptions of the state as fit or legitimate to govern. These challenges may risk efforts of social regulation via the CDC. These outcomes emerge because of the interrelated persistent negative conditions, relationship interaction deterioration, anger and distrust related to this implementation of the CDC.

Given what has been revealed in this thesis about participants' lives and the effects of the CDC in the Ceduna region, a number of important points can be made. The following comprise a summary of key points which emerge from this thesis beginning with some general points about methodology:

- Research that emphasises critical ethnographic and contextualised qualitative approaches allows for more nuanced longitudinal analysis that reflects lived experiences of the CDC implementation.
- Employing critical and contextual methodologies in policy research is a beneficial way to identify social issues, alongside the processes of how those issues are experienced recipients' lives.
- This type of methodological approach that centralises the lived experiences of policy recipients and their communities, also helps us to better learn what we need to prioritise or as Bacchi (2009) suggests 'problematise'.
- Reconsidering the way we conceive of peoples' social relationship interactions in policy making and research is important, as focusing more on how relationships

operate to liberate or constrain people may better illuminate the processes of *how* structural influences occur. This may include relationships between welfare recipients and service providers, but also those relationships between welfare recipients and the broader community.

- When we improve the accuracy of how policy has effect by capturing that effect in process, we may better prevent unintended consequences that are not beneficial for recipients and their communities, which can have negative implications regarding the legitimacy of the state to govern.

The following points emerge as specific key-areas that participants expressed were significant in their lives and that of their communities:

- Participants argued for the greater promotion of employment opportunities, diverse training/upskilling to be made more available for people and were particularly concerned that racism needs to be addressed and actively mitigated.
- Participants also argued for more services focused on preventative assistance which improve and reflect 'supportive relationships' pivotal in providing interactional catalysts to help people overcome constraints and access beneficial resource pathways they need – the bridging and bonding social capital that Putnam (2015) emphasises.
- Alongside prevention, treatment services for alcohol and drug addiction problems were viewed as necessary to help support people make the structural changes that ameliorate harmful coping behaviours.
- Prevention and treatment supports can involve diverse strategies that address the persistent conditions people have difficulties in overcoming, including employment, housing and health issues.
- The local co-design of prevention and treatment services can better reflect community needs and both prioritise and coordinate primary and tertiary service delivery.

8 Conclusion

There is no doubt that for many of the people receiving welfare support who spoke to me for this research, their lives were mostly difficult and constrained by a variety of interrelated, persistent conditions out of their control. The CDC was but yet another one of those difficulties that participants were navigating, from what they perceived to be a position of enforced powerlessness. This is not to say that life did not have its highlights and positives for all involved. However, mostly, when people told me about and showed me their lives, life was often poignantly expressed as more difficult than easy. These difficulties were particularly attributed to the trials of poverty and extreme hardship, which remain challenging to overcome.

When this data was collected in 2019/2020, three or so years after the CDC policy implementation, the CDC had not changed the underlying opportunities people had to live a good life. In its attempt to redirect behaviours away from substance consumption and gambling, the CDC failed. The CDC had not changed opportunities to find stable employment, overcome poor mental health, substance dependence, or hardship related to discrimination and trauma, all described by participants as the primary issues they are dealing with.

In many cases, recipients' experiences of the CDC were that it exacerbated othering and the deterioration of social relationships. Some people who talked with me about their experiences of the CDC, expressed that they became frustrated, stressed, and angry at what they described as their inequitable treatment relative to others. At times this all combined to promote their distrust and perceptions of the illegitimacy of 'the government' to decide what their problems were and how those problems should be treated. In the meantime, I observed that the problems and hardship people were experiencing, continued unabated, and little seemed to change. Instead of being a successful attempt at social regulation, the CDC damaged social relationships and social cohesion. It enhanced distrust of government rules and procedures, and in some cases, may have created conditions that risk state legitimacy, which could disrupt strategies of state governance.

In responding to the Research Questions posed in Chapter 4, this thesis has argued that the CDC policy and rollout did not adequately account for the complex realities that people were

living with in Ceduna and made limiting ideologically based assumptions about behavioural change. Through capturing some of the more nuanced, locally lived, and complex experiences, this thesis shows that much information, accuracy and subtlety was missing from consideration within the CDC policy logic. Chapter 2 explains the Australian policy trajectory that led to the CDC and highlights the limitations of the CDC policy through its over-reliance on rigid conservative and neo-liberal ideologies. Chapter 3 outlines the problems associated with previous CDC policy interventions and research. Chapter 4 focuses on summarising knowledge gaps and presenting the research questions. Chapter 5 outlines the rationale for the critical ethnographic methodological approach adopted in this thesis and its focus on establishing those local contextual complexities often missing in previous research. The findings in Chapter 6 provide an exploration of the impact of the CDC intervention in the lived experience of recipients and responds to Research Question 1 and 2. Chapter 7 then explores how the CDC policy logic misses the important underlying issues of most concern to participants in this study and responds to Research Sub-Question 3. Chapter 7 also outlines the many socio-political and structural issues impeding participants' lives and the compounding effects of the CDC in disempowering those it targets. Chapter 7 then extends this discussion on the findings and explores the risks to society and local governance and other related negative possibilities that may emerge from the unintentional consequences of the CDC exacerbating social divisions in the region.

The findings in Chapter 6 provided an exploration of the impact of the CDC intervention in the lived experience of recipients and responded to Research Questions 1 and 2. Chapter 7 then explored how the CDC policy logic misses the important underlying issues of most concern to participants in this study, and responded to Research Sub-Question 3. Chapter 7 also outlined the many socio-political and structural issues impeding participants' lives and the compounding effects of the CDC in disempowering those it targets. Chapter 7 then extended this discussion on the findings and explores the risks to society and local governance and other related negative possibilities that may emerge from the unintentional consequences of the CDC exacerbating social divisions in the region.

Through contextualising its impact on the lived experiences of people in Ceduna, in this thesis I have argued that applying what has been learned about the influences of the CDC policy intervention has ramifications for changing how we make and assess policy, programs and interventions in the future. Indeed, critical qualitative longitudinal research has been

recently argued as a needed and valuable way of engaging the multiple, fluid, and relational dimensions of complex contexts and causality related to policy intervention 'impacts' (Neale, 2021). Future research regarding the CDC, income management and social policy, should consider including the contextualisation of policy interventions. This means moving past only using a quantitative, evidence-based rationalist approach to assess policy influence. As I argue in this thesis, future research should rebalance inquiry and include the simultaneous capture of the dynamic influences of policy interventions and the processes of how and why those effects occur, alongside addressing the socio-political environment from which an intervention emerges.

Using critical ethnographic methodologies in future policy research, will broaden the scope of identifying what problems need to be learned more about, alongside capturing the processes of how and why social policy influences recipients and their communities in practice. Doing so will improve clarity regarding capturing unintentional consequences that can result from implementing policy and make clear consequences that may have negative ramifications for strategies of governance and control. Further, such methodological improvements to research about policy may also help make ideological influences on policy making, evaluation and political discourse explicit in decision making throughout the policy cycle. Narrow thinking may render policy and decision making at greater risk of harmful impacts. By making the underlying ideological foundations of policies explicit we can better assess how they constrain or enhance opportunities in the lives of those impacted. In centralising the voices of those who experience policy interventions directly and learning about how policy influences the processes of how people 'get by', research will be better positioned to target interventions in ways that provide opportunities to overcome barriers that trap people in negative situations. In the words of one CDC recipient who expressed both hardship, resilience and perseverance in trying to overcome the many problems they were facing:

> It used to kill me as a parent watching my two older children go without because the two babies haven't got enough, but we're trying to spread what little we've got and do what we can to get money in the house to feed all of us. We're driven, enthusiastic, we've got a lot of drive. But this life, it's a struggle, trying to stay positive. But it's okay... Tomorrow's another day (CDC-4-FOR).

9 References

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10 Addendum

The focus period for this PhD research begins in 2019 and ends in early 2022. Since the completion of this period changes have been implemented in relation to the CDC intervention that are significant yet outside this focus period. The incoming Australian Labor Party elected in May 2022 vowed to 'abolish' the CDC as an election promise, as outlined in the 3rd of June 2022 media release by the newly elected Labor government's Minister for Social Services, Amanda Rishworth (Ministers for the Department of Social Services, 2022). The Australian Labor Party has since introduced and passed legislation that now sees the compulsory CDC trial that was introduced in select locations in 2016, to become a voluntary-only measure.

The voluntary exit from the CDC has taken effect since the 3rd of October 2022 (Department of Social Services, 2022c). Alongside CDC trial recipients, people who transitioned onto the CDC in the Northern Territory have now been informed that the CDC intervention is ending across all regions in March 2023 and if seeking to remain on the CDC passed that time, recipients will need to actively opt-in (Services Australia, 2022). However, recipients in the Northern Territory will remain on what is described as enhanced income management once the CDC ends in this region (Services Australia, 2022). At the time of thesis submission in December 2022 little is known about what this new enhanced version of income management will incorporate for Northern Territory welfare recipients.