Subversive Control Via Punitive Means? The role of stigma and profit in Australia's cashless debit card policy

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The cashless debit card is Australia's recent and most punitive form of income management; a social-security focused social policy approach to behaviour change. Evidence suggests the policy is a harmful social experiment which does not reduce the social harms or dysfunction it set out to perform. This paper questions the underlying motivations of cashless debit card policy implementation via contrasting policy theory and objectives with existing and emerging evidence of policy impact. Three key issues concern the creation and implementation of cashless debit card policy in terms of the vague aims and lack of evidence of the policy's success; issues of stigmatisation in relation to power, morality, and deviance; and the influence of economic ideology and profit making in social governance. An alternative approach to policy making is suggested based on addressing lived social contexts instead of problematising dysfunction resulting from individual deficits.

KEY WORDS: Income management, stigma, policy, power, cashless debit card.

The cashless debit card (CDC) policy was introduced as a trial in the year 2016 and is an extension of Income Management (IM), a conditional welfare focused social policy approach to behavioural change. The IM policy approach aims to address social dysfunction through limiting the choices of people receiving income support payments. Evidence continues to grow that overall, compulsory IM does not deliver the social benefits claimed for it. Instead, unintended consequences are emerging that distances IM from being a version of social support but may place IM as a form of profitable social punishment.

IM policy is argued to individualise dysfunction, placing responsibility of hardship onto the individual alone. This is because IM disregards the realities of existing structural inequalities that come to influence all opportunities for individual actions. Underpinning much of what drives current Australian political decision making is the adherence to neoliberal-capitalist ideological conceptions of individualism, self-reliance and market freedom as the path to a good life. Such ideology is reflected in the IM approach to social policy: Individualising dysfunction stigmatises by framing IM recipients as deviant, in behavioural deficit, undeserving and subordinate to those who do not seek income support. Others profit from what can be commodified, in this case, profiting off those receiving income support payments via IM; profit which may render poverty a consumable 'product' in need of protection.

The IM approach may unintentionally limit the ability for achievement of a good life for all. The good life is defined here as where one has what one needs to comfortably, peacefully and safely navigate one's life, without excess, without harm to the self or others. Unintended social harms may instead challenge egalitarian and democratic society where outcomes serve to entrench, not alleviate, inequality. The reality of how the CDC may change behaviours can include outcomes that cause more social harm than good, as people seek to overcome entrenched hardship.

Little political attention is directed toward the CDC's unintended social harms related to stigma (Humpage 2018; Klein and Razi 2017; Vincent 2019), nor to the profit-making resulting from CDC policy – consequences which have both largely gone unseen. Weis and Fine (2012: 177) have defined what may be designed to be unseen as the 'invisible hand of capital, racism and neoliberalism'. Without attention to what goes unseen, continued implementation of IM overall may be argued as a harmful social experiment.

Identifying possible unintended consequences prior to policy implementation then becomes an important tool

for critical policy analysis and the reduction of social harms. The identification of such harms, it is suggested, emerges from conducting a social contextual analysis of how people come to navigate their lives given the opportunities afforded to them.

In this paper, the CDC as the latest iteration of IM policy is first briefly introduced and outlined, followed by a review of evidence regarding the effects which have been found. Evidence includes existing research alongside narratives from an ongoing primary investigation aimed at providing insight into contextualising the lived experiences of CDC recipients. Three key issues around unintended consequences are discussed: the vague aims and lack of evidence of CDC success; issues of stigmatisation in relation to power, morality, and deviance; and the influence of economic ideology and profit making in social governance. Finally, the paper concludes by addressing what we can learn from such an approach, suggesting alternative ways forward for evidence-based social policy.

Background of IM-CDC Policy

IM was first introduced via the 'basics card' in the year 2007 as part of the Northern Territory Emergency Response and initially targeted only Aboriginal Australians in the Northern Territory (Buckmaster et al. 2012; Dee 2013). Initial introduction of IM saw the repealing of the Racial Discrimination Act (RDA) in 2007 (Buckmaster et al. 2012). The IM policy approach has been expanded to specific sites nationwide since 2010 and made compatible with the RDA because IM legislation is now extended to include non-Aboriginal Australians.

IM is a form of conditional welfare policy approach to social support, and the CDC is the most recent iteration of IM. Conditional welfare arrangements are those in which the recipient is required to behave and act within controlled parameters in order to be eligible to receive support. Watts and Fitzpatrick (2018: 44) describe components of Australia's techniques of IM conditional welfare to include the 'deprivation of freedom or choice' via: certain conduct of behaviours required for initial or continued access to benefits; *sanctions* or *incentives* that are made contingent on specific behavioural conduct; and *monitoring/surveillance* is made of adherence to the specific behavioural requirements.

Currently, for those on the CDC, income-support payments are sanctioned, with 20% of the payment available as cash, and the remaining eighty per cent quarantined. The recipient is monitored by the government by placing the quarantined portion in a specified IM account, only accessible by the income-support recipient by using a 'cashless debit card'. The remaining twenty per cent of the payment is allocated to a non-restricted, personal bank account that is available as cash. The recipient's conduct is hence sought to be controlled by having the eighty per cent quarantined portion of payments restricted via legislation to prohibit the purchase of alcohol, gambling and pornographic products (Australian Government 2019a). It is argued that the cash restriction is to limit access to illicit drugs.

The CDC is presently defined by the Australian Government as a 'trial' and is currently deployed in four trial regions with approximately 11,000 recipients: Ceduna (SA) and the East Kimberley region (WA) since 2016, Kalgoorlie (WA) in mid 2018 and Bundaberg/Hervey Bay (QLD) beginning implementation in 2019 (Australian Government 2019a). The CDC looks set to be expanded across Australia's Northern Territory, replacing IMs basics card and impacting on approximately a further 25,000 people. Mainly *compulsorily* (Australian Government 2018a), the CDC targets almost all persons receiving a working age income support payment in the trial sites, and mostly excludes those on the aged or veteran's pension. The Hinkler region trial site includes additional age and trigger payment conditions, targeting people under 35 years of age who are unemployed and/or single parents (Australian Government 2019a).

Aboriginal Australians are overwhelmingly the recipients of IM policy, including the CDC, representing approximately seventy-eight per cent of all IM recipients nationwide (Australian Government 2018b; ORIMA 2017). This over-representation of Aboriginal Australians has been argued by academics as an extension of colonial oppression and neo-paternalism focused on the control of income of Australia's Aboriginal Peoples via IM social policy (Bielefeld 2018; Dee 2013).

Effects, Intended and Unintended: Review of existing and emerging research

There is no definitive evidence that CDC policy reduces excess alcohol consumption or access to illicit drugs, gambling products or pornography: the very items it aims to restrict consumption of. Nor does evidence show clear reduction of social harms or dysfunction as the approach is theorised to produce. This lack of evidence of positive outcomes has been outlined repeatedly by others (Cox 2011; Bray et al. 2015; Mendes et al. 2016; Hunt 2017; Mendes 2019), yet has often been ignored and reframed as successful by IM supporters. The notion that dysfunction is related to such things as excessive alcohol consumption as exclusively a problem of the poor is challenged by existing health data. Evidence from the Australian Bureau of Statistics (2018) clearly shows that those of least socio-economic disadvantage in society, consume more alcohol more frequently than those living in the greatest areas of disadvantage. Political rhetoric has

come to normalise IM as a needed social intervention to combat the individual's 'problem' of being poor as a kind of personal failure, with this view produced by adherence to neoliberal ideological reasoning (Lovell 2016).

The government's aims of the CDC relate to what is theorised as promoting beneficial, healthy and positive social behaviours, otherwise conceptualised here as what might enable access to live a good life. What remains unclear is how a good life is characterised in terms of what needs to be present, not just absent from the equation. A good life is unsurprisingly difficult to define as such a definition requires a narrow determination based on a particular worldview. Nonetheless, in an attempt to outline more than define, a good life is conceptualised here as where one has what one needs to comfortably, peacefully and safely navigate one's life, without excess, and without harm to the self or others. However, achievement of this is challenged through unintentional consequences identified through analysis of CDC policy.

The Evidence: CDC successfully makes conditions worse

Where policy is conceptualised as having a powerful impact on a variety of life conditions, it becomes a contextual force dictating how people are able to navigate their lives.

Stigma and social exclusion

IM has been shown to increase social stigma and isolation for those in receipt of social support (Doel-Mackaway 2017) and to increase family stress (Cobb-Clark et al. 2017).

Poor mental health and stigmatisation are already experienced by people in receipt of conditional welfare arrangements more broadly (Samuel et al. 2018; Grover 2019). Indeed, it must be noted that stigmatisation from IM policy has been found by both independent researchers as well as research commissioned by the Australian Government (ORIMA 2017: 88; Mavromas et al. 2019: 74). Wright and Patrick (2019) maintain that conditional welfare policies negatively impact mental health and can exacerbate poverty to the point of crisis. Where crisis occurs, very poor outcomes for people and their families may result. For example, when investigating the thirteen deaths by suicide of young people in the Kimberly region, the Western Australian coroner argued for IM to be offered voluntarily, as opposed to its compulsory form (Coroners Court Western Australia 2019). The coroner cited the complexities relating to existing hardship such as poverty, trauma and racism that affect these poor outcomes. The adversity faced by people often already living in poverty may be exacerbated via policies that make conditions worse.

The evidence shows us that compulsory versions of IM have worked to aggravate already adverse structural conditions that limit people's ability to overcome hardship. For example, Peterie et al. (2019a) outline dominant structural causes of homelessness. They argue that economic disadvantages, housing market issues, stigma, relationship issues, health, and addiction all contribute to homelessness. Indeed, these causes of homelessness are echoed by others (Fowler et al. 2019). Peterie et al. (2019a) conclude by stating that compulsory IM policy works to inflame the structural foundations of homelessness via aggravating these inter-related stressors.

The work by Klein and Razi (2017) regarding the impact of the CDC in the East Kimberly region shows that the policy has embedded financial hardship and fragmented social connectedness through excluding and disempowering those in receipt of the payment. Financial hardship was combined with the participants reporting the CDC to be a colonial, racist and discriminatory policy. Social fragmentation was argued to increase social division between not only the unemployed and employed, but between Aboriginal and non-Aboriginal Australians (Klein and Razi 2017).

The deterioration of social inclusion and the promotion of social division is aided by stigmatisation which only entrenches poverty (Samuel et al. 2018). Vincent (2019) identified that stigmatisation was experienced by most recipients of the CDC; they were treated as lesser human beings and felt insulted and targeted by this policy. This was inter-related with expressions of the CDC being racially discriminatory and incorporating complex issues of shame, othering and blame *between* people in receipt of the CDC (Vincent 2019: 21). The effect of stigmatisation can be argued as weakening solidarity and connectivity between people. This is done via undermining agency and through creation of anxiety, fear and shame for those who are poor and receive income support (Samuel et al. 2018). Recent research by Peterie et al. (2019b) regarding people who are long-term unemployed identified that associated stigma negatively impacts relationship management. They suggest that to manage stigma, people withdraw from social networks and can become isolated, contributing to barriers in gaining employment.

Social division and exclusion are extended through a lack of adequate community consultation. This can be seen in the research by Vincent (2019) and Mendes (2019) who outline the absence of bottom-up consultation regarding the creation and roll out of the CDC. It has been suggested that the problems that social policy can unintentionally cause may be prevented through a more inclusive process of policy design (Lamb and Young 2011). Mendes (2019)

argues that the process of CDC consultations did not include necessary strategies for positive community development: this process was not diverse, inclusive, nor empowering, and did not allow for democratic participation regarding the co-design or implementation of the policy.

The outcomes of stigma and social exclusion resulting from compulsory IM policy are argued here to be present because the CDC changes the shape of surrounding life conditions. Consequently, changes to behaviours occur, however, not in ways that reduce social harms. Ongoing evidence being collected as a part of this critical analysis of the CDC indicates that the social exclusion and stigma already experienced by income-support recipients is exacerbated via the CDC's sanctions, conduct requirements and related monitoring. Circumvention behaviours are those where people may seek to get around the card's restrictions. These behaviours can result from the way the CDC reinforces stigma and exclusion. This can be seen through initial analysis of primary data currently being collected via interviews with CDC recipients.

The narratives below emerge from an ongoing qualitative investigation of lived experiences of the CDC in the lives of recipients and their broader communities. This research includes one CDC location as a case-study to conduct a social-contextual analysis focused on the CDC's influences on social networks and behaviours. The investigation which has an ethics clearance involves conducting in-depth, open-ended interviews, alongside researcher reflections and observations. Emerging themes are outlined below.

The CDC creates social division by removal of dignity through begging, relative to people who have greater access to wealth and cash:

'People go to the shop, buy a 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, they're still finding ways to get alcohol, it's not gonna stop, it's not working, it takes away dignity'. (Stevens, field notes, 2019)

People have expressed how the CDC creates the need for certain behaviours due to social exclusion and related substance dependence issues; these behaviours may result in *more* harm due to the CDC:

'Addiction doesn't go away, they need the alcohol if they are addicted, this old lady she was shaking in the street, she was addicted, she would do anything cause she needed that grog, there's no other services that help, but if I try and help, I gotta find cash too'.

'A lot of people want to kill themselves over the indue card here … it does cause mental stress you know'.

'The elderly have become targets cause they're exempt from the card, the ice epidemic that's getting through this town, the people saying oh give me your money, they become targets cause they have cash, that's what happened to my grandmother, another fella broke his mother's arm, over ice, couldn't get the cash'.

'Others took off with my indue card, bought cigarettes so they could get alcohol, swap them, for drugs, too… people still gamble, there's ways around it, do that, do this, clever…but what can I do about them, can't dob them in, then there's trouble'. (Stevens, field notes, 2019)

CDC recipients are further excluded through in-built system limitations relevant to the operation of the card itself, putting pressure on recipients to try and maintain stable housing through other means:

'People can't pay their rent, the card stops them, makes it hard, you can buy goods but can't pay the rent with goods can you? This is why people are going in and buying a fridge and putting it on buy and sell to exchange to get the cash … selling for a loss though, phones, fridges, TVs'. (Stevens, field notes, 2019)

Three Key Policy Issues To Learn From The Unintended Consequences

1. *CDC aims and evidence-free policy making: A harmful social experiment*

Current aims of the CDC reflect that of a social experiment rather than evidence-based policy making. Whilst technically the CDC remains a trial, political will to expand the CDC nationwide is increasing. As outlined by relevant Social Policy Law (Australian Government 2019b), the current stated objectives of the CDC trial (inclusive of all four trial sites) are to:

- Reduce the amount of money in the community that is available to be spent on alcohol, gambling and illegal drugs,
- Determine whether such a reduction decreases violence or harm in trial areas,
- Determine whether such arrangements are more effective when community bodies are involved, and
- Encourage socially responsible behaviour.

These stated aims raise concern regarding unintentional consequences that may go unaccounted for as a result of the realities of policy implementation. Where the aims seek to determine if the CDC changes behaviour, risks remain regarding how the reality of policy in its implementation will create conditions that encourage other behaviours that may actually cause more harm. Three main issues are contained within the aims which may allow for more unintentional consequences to emerge from the CDC policy: the assumption that money is the only thing with social value; the vagueness and presumptions regarding socially responsible behaviour; and social dysfunction is individualised.

Reducing the amount of *money* available may encourage unintentional harmful behaviours where the exchange of other *forms/things of value* through barter becomes favoured. Innovative circumvention behaviours occur where CDC recipients find ways to navigate around policy purchase restrictions. Aforementioned evidence of circumvention behaviours often involves the barter of goods, such as swapping allowable purchases with restricted items like tobacco, or whitegoods for alcohol. These forms of circumvention often involve the purchase of allowable goods being swapped for a substantially lower cash equivalent. These circumventions may provide insight regarding what else may be occurring that has yet gone uncaptured. For example, substance dependence cannot be rectified via a plastic card that does nothing to treat the reasons for dependence. Where dependence remains, attention needs to be given toward what products, other than money, can be determined to have value and to what there may be a market for. Without attention given to all forms of potential circumvention, this policy may be creating the potential to cause far more harm than good.

The determination of *socially responsible behaviour* remains vague. This lack of clear definition presumes that 'socially responsible behaviour' is a commonly understood phenomenon with clear and uncontested boundaries. However, such a presumption is questioned as it is based on flawed ideas of rationality and disregards the structural factors that may come to shape behaviour. Where the notion is removed that there is one version of shared rationality, we can begin to interpret 'socially responsible behaviour' in a variety of creative ways. For example, the ways that allow for irrational reactions to life events to be seen as *rational*, given the *structural conditions* afforded to that person at that time. The issue taken with this objective is that adherence to the presumption of universal rationality creates room for those with power to determine and individualise dysfunction. This risks problematising social dysfunction as individualistic via encouraging the sole focus of blame to rest with the individual. Structural conditions that create behaviour may then go unnoticed and unaddressed.

While the CDC, and IM policy more broadly, do take a structural approach to behavioural change, the problematisation of social dysfunction is individualised. This occurs via its focus on personal consumption of certain products as the reason for dysfunction with no consideration given to the impacts of why people may do so to excess. For example, the Australian Institute of Health and Welfare (2019) states that alcohol consumption and illicit drug use are strongly associated with poor mental health. Additional evidence provides some insight suggesting excessive consumption of drugs and alcohol may relate to coping with past and current trauma related to poverty (Golin et al. 2017) and colonisation (Menzies 2019; Skewes and Blume 2019). Overall, the CDC policy disregards the contextual factors that come to create conditions that promote harmful behaviours, limit positive wellbeing, and limit access to a good life. Where contextual factors are overlooked, there may be little long-term positive effects of such policies rendering them a waste of time and nothing more than an unethical social experiment.

2. *CDC, individual blame, new paternalism and intentional stigmatisation*

The Australian Government parliamentary report by Buckmaster et al. (2012) outlines how successive Australian governments have approached social-security policy and IM. Buckmaster et al. (2012: 18) characterise IM policies as built on paternalism theory in addressing disadvantage, and that 'Underpinning new paternalism is the idea that disadvantage is primarily a result of a deficit of necessary social values'. New paternalism was forecast to solve what the government defines as the 'poverty problem', aiming to reduce reliance on income-support. Instead, evidence consistently shows that compulsory IM may increase recipients' reliance on income-support payments (Bray et al. 2014; Bray et al. 2015; Bray 2016; Bray et al. 2016). Moreover, rates of poverty have not declined since the implementation of IM in 2007 and CDC in 2016, with evidence suggesting poverty rates have increased since 2012 (Australian Council of Social Service 2018). Buckmaster et al. (2012: 18) reason that a 'culture of poverty' is to blame and argue that the poor lack a work-based mindset resulting from 'low self-efficacy, disempowerment, lack of knowledge, low coping skills and poor sense of mastery'. Parents are then blamed for their children's likelihood of seeking income support, termed the 'transmission of poverty'. Buckmaster's analysis disregards that parents' behaviours are themselves shaped by wider social conditions and structures. The normalisation of seeking income support is framed as undesirable, where people who experience inter-

generational poverty are further argued to not be as susceptible to stigma:

> The direct means of transmission of values giving rise to welfare dependency is said to be that reliance on income support by parents, desensitises their children to the stigma and negative views usually associated with the receipt of income support (Buckmaster et al. 2012: 19).

The review of the report by Buckmaster et al. (2012) raised concern regarding the alignment of theory underpinning IM policy to the idea that desensitisation to stigma is undesirable. Such a suggestion infers that IM's theoretical approach seeks to reduce this reliance without reducing stigmatisation, and that stigmatisation may be considered a useful part in reducing the number of people seeking income support.

The CDC policy may position the CDC recipient as the 'underclass' subordinate or as the undeserving poor through labelling recipients as socially deviant and undesirable citizens. The public framing of welfare consumption by the powerful as a problem based on individual deficits of the poor may work to enforce social hegemony through perceived social consent of punitive social policies. This, Gramsci has described, is done by removing choice from one group for 'the greater good', thus encouraging acceptance of a person's own subordination (Madison 2005: 54). Where the CDC policy works to reinforce class structures, the combination of subordination with social stigmatisation may cement effects of 'othering' by way of socially isolating CDC policy recipients as undeserving and undesirable citizens. If stigmatisation is a welcomed unintentional consequence of IM policy, this represents a socially unjust approach to social 'support' where stigma may represent a version of social punishment for the consumption of income support.

3. *CDC, poverty and profit: economic ideology and governance*

IM policy is profitable off the back of the financially poor. Introduction of the CDC has seen the privatisation of income-support payments via the appointment of Indue Ltd, a private company contracted by the Australian Government to distribute income-support payments for a prescribed fee. 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, is approximately $19m or $10,000 per CDC recipient, with 44% ($7.9m) of this cost going directly to Indue Ltd (Australian Government 2017a). The government's extension by limited tender to Indue Ltd to continue delivering the CDC along with other versions of IM between 2016 to 2018 equated to $38.6m, paid directly to Indue Ltd (AustTender 2017). In the 2016-17 financial year, Indue recorded a $11.2m profit (Indue 2017). Indue's profit margins look set to increase as the Australian Government begins transitioning approximately 25,000 people from the basics card to the CDC where related legislation is passed in the senate (Parliament of Australia 2019).

When we see that the CDC policy does not work in the ways intended, the question arises of whom is really benefitting from such an approach to social 'support'. Globally, neoliberal capitalism has come to not only shape our economies but also every element of how we are able to conduct and experience our lived realities (Harvey 2007). This economic system has increasingly encouraged us to see others as generalised strangers we are in competition with. This is not to say some competition does not have its benefits, rather, where policy embodies such an approach there remains an assumption of initial equality between people, which is not the reality.

The CDC is an expected progression of social policy under neoliberal capitalism. Evidence suggests the CDC creates conditions that entrenche poverty while others profit from it. Grover (2019) argued that welfare conditionality (defined as active proletarianisation) uses known social injustices and inequalities on the working class by forcing commodification of labour through the destitution of the unemployed. The CDC forces us to separate ourselves even further into categories designed to promote competition for the proliferation of profit. For example, as the deserving and undeserving poor, and the morally just and the deviant. This is because the card remains a physical symbol of lack of wealth, status and power (Klein and Razi 2017) allowing distinction and stigmatisation of recipients where discrimination and competition become potential foundations for active classism. When everyone becomes a stranger and the primary form of interaction with most others is generally based on some form of economic contract, it becomes easy to stigmatise, to not need to empathise with others; it becomes easier to forget the real problem.

The neo-liberals in power have devised a way of commodifying rising financial inequality, and so we cannot expect such policy to disappear under our current economic framework. We are rewarded for financial successes; that is the way our economic system is designed. Here we find an unintentional contradiction: that while increasing stigma may relate to deterring people from seeking income-support, the need for increasing profit encourages IM consumption. Further consideration regarding this contradiction is needed. Where the CDC in reality entrenches poverty, this approach is suggested

as economic recklessness. Increasing poverty leads to decreasing economic and social prosperity (Hail 2018) and represents not only an economic but a social argument that must be taken seriously.

Moving Forward: Context-based policy can better assist people to live a good life

Socially responsible behaviour can be better conceptualised as what determines a 'good life', through shifting the weight of responsibility off the shoulders of the individual alone and refocusing action on non-individualised structural conditions: the contexts within which people live that come to influence every choice they are able to make. Wilkinson and Pickett (2010) have written extensively on the elements that may come to determine a good life, more often described as wellbeing. They discuss the conditions that impact wellbeing occur from social division including those linked to social dysfunction such as homelessness, crime and substance abuse. Others have come to describe the external factors that shape and influence people's lived realities as individually immovable contexts that people have little choice but to navigate within. These contexts are numerable and often dependent on situation specifics, although typically include economic, social, historical, cultural, policy and opportunity conditions that determine human behaviours, how we interact with each other and why (Guerin 2016).

It is not a new argument that human behaviour is largely influenced by external life conditions that limit individual and group agency and choices – a debate most commonly found within sociology and its related literature. A variety of influential organisations have framed much of their policy recommendations on such an argument. For example, there are the World Heath Organisation (2019) reports regarding the social determinants of health, and the Australian Institute of Criminology's National Crime Prevention Framework (Morgan et al. 2012). Both such organisations overtly focus their recommendations toward positive social change, on how governments can and should direct policy attention to concentrate on broader structural social conditions such as social inclusion and cohesiveness, and social opportunities related to housing, poverty and employment.

What Can We Learn About Policy?

From what has been discussed, we can see that the CDC acts as a significant symbol that has the power to re-shape social contexts and behaviours, associated meanings and determinations of deviance, and consequently, overall wellbeing. However, we can see that when policy focuses on individualising responsibility for social dysfunction, it does not positively address the conditions leading to an individual's struggles in the first place. We can see that where policy creation is influenced through ignorance of evidence and the embracing of unintentional injustices such as stigma and exclusion, life conditions can become worse for many affected by that policy. This approach is made all the more questionable when profit is made off those who suffer.

What is needed is a dedicated willingness to address the issues that trouble society, through developing greater contextual understandings of how people actually live their lives given the opportunities they are afforded. This can be done through analysis of the contextual factors that people already navigate within, and requires attention to be given to the evidence that emerges from such pivotal investigations. Undertaking an evidenced-based contextual analysis to better inform social policy becomes an action of social justice through identifying possible unintended consequences before they can cause lasting harm.

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Hope

The night falls without a sound, fearful am I,
evil haunts my mind like an ungodly force.
Planes, missiles, soldiers,
rubble, screams, rockets firing.
These are my dreams, erupting in the night.
Tragic ending of my generation destroyed,
swept away by madness, all hope is disappearing,
like a never-ending black hole.

Around, the dark memories gather,
mourning of my husband. My dread grows as the
angry hand of Heaven falls against my heart.
It mutilates me, and darkly my life's blood drips
to the wicked earth that is my prison.
In my madness, I cry out, while Hell laughs cruelly.
I hear the screaming of kids, buried
underneath the rubble.

I see an electrolier, silently still, not moving.
My phone is my connection, to the living and the lost.
Freedom is an imagination, a place to hope,
something to dream and explore.
I am seeking Asylum.
A place where my children can laugh, play and
discover. A haven that they are not
afraid of death.

I dream when the torture in my mind, escapes
like an animal released from its cage.
My child asks, "can I take any toys?"
My son says, "we can learn English."
I mourn within, leaving my mother.
"I'm too sick to travel," she says.
The night falls in a heavy, suffocating
cloak, soulless are we.

The salvation for which I pine.
"It's time to go," I say to my relatives.
My passion for life throbs no more. How could
you tear us asunder?
I watch the crumbling buildings, the bombed
shopping centre, the playground with the
eerie spirits of time passed.
The decision to leave this forsaken place.

Memory of my husband having breakfast,
Then, with a click of a finger, disappears,
with a black hood on his head,
his helpless arms tied around his neck.
I still hear the screaming of my children.
He promises them a pony.
I feel the angels surround us, crying,
saving us from ourselves.

Hope is far yet, within reach.
I am seeking Asylum.

Penelope Greentree,
Melton, VIC

This poem was shortlisted in the 2019 BR4R (Ballina Region For Refugees) 'Seeking Asylum' Poetry Prize, proudly supported by Southern Cross University.