Social impact investment – statement of requirements

Note: this statement formed part of the documentation for the South Australian Government’s Expression of Interest, which closed in February 2015. This is an archive copy.

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BACKGROUND

The information contained in this document is provided to help inform proposals in the following focus areas:

- preventing and reducing hospital presentations and admissions for older people from residential aged care facilities (RACFs)
- improving outcomes for people experiencing homelessness
- helping long stay older patients in public hospitals find more appropriate accommodation
- preventing and reducing hospital admissions for people with Borderline Personality Disorder
- reducing the number of children and young people entering the out-of-home care system
- reducing recidivism.

The key driver for a social impact bond or pay by results contract trial in South Australia is to address social problems that cause significant costs to the community but which could be potentially avoided or alleviated through earlier interventions.

While this document contains information relating to the above focus areas, proposals in other areas will be considered if it can be demonstrated that they meet the following criteria:

1. New or innovative approaches to intervention exist, and there is evidence to suggest that they will be effective in addressing the problem, based on experience either locally or in other jurisdictions.

2. The impact of the intervention program(s) on the focus area can be measured accurately and with confidence against current or recent historical performance and cost or a matched control group.

3. The expected outcomes of the new approach can be demonstrated to:
   a. Improve wellbeing for individuals and the broader community.
   b. Reduce the cost per intervention on the public sector within a five to seven year timeframe and deliver financial savings to the State Government.

Proposals may be for new programs or for the expansion of existing programs.
GENERAL INFORMATION

Social impact bond structure

Government’s preferred structure is to contract with a single party which could either be the service delivery agency or a special purpose entity that subcontracts to one or more service delivery agencies to deliver services to meet agreed outcomes. The contract will specify payments to be made dependent on the outcomes achieved. Legal agreements with investors will be managed by the contracting entity.

The successful respondent/s will have ultimate responsibility for performance against the agreed outcomes. The Government will not have any contractual arrangements with investors or with sub-contracted service providers as part of the social impact bond trial.

Returns to investors will vary depending on program performance (measured against a pre-determined baseline). The Government’s expectation is that investor principal will be at risk for below baseline performance, while performance at baseline will result in the return of investor principal only. Returns on investment will be paid for performance above baseline with higher returns achievable for exceptional performance.

Pay by results contracts

Proposals may be submitted for pay by results contracts with Government without the involvement of external investors. Pay by results proposals may be for existing contracts with Government or new contract proposals.

Proposals for pay by results contracts should address all relevant criteria identified in this statement of requirements and Part C Response Schedule, other than those criteria that relate to relationships with external investors (bond structure, investor engagement).

At a minimum, pay by results proposals should include information on the target population and cohort, program location, entry and referral arrangements, outcome measures, baselines and data availability, how outcome measures are tied to payments, and program timeframes.

Competitive dialogue

This request for expressions of interest is the first stage of a possible two-stage procurement process. If the expression of interest stage does not result in proposals that are assessed as viable, the Government would not proceed to the second stage. If viable proposals are received, preferred proponent(s) will be invited to engage with Government on a confidential basis to further develop the details on the technical, financial and legal aspects of their proposals, including:

- the target cohort (identify the sub group of the target population to receive intervention under the social impact investment trial)
- location(s) of program delivery
- program referral and entry arrangements (note that Government intends to participate in program referral arrangements)
- outcome measurement(s)
- data to support outcome measurements and program referral
- bond duration*
- timeframes for key program milestones
- bond structure and contractual relationships*
• risk allocation between parties
• size of bond issue*
• investor returns and payment structure*
• investor engagement*
• baselines, comparison groups
• intellectual property
• dispute resolution provisions and termination clauses
• program evaluation
• independent audit arrangements
• program delivery personnel (programs to be delivered by personnel with appropriate qualifications and approvals)
• cash flows for program delivery (drawdown requirements).

(* does not apply to a pay by results trial)

Proponents should consider these issues when developing proposals and address them in response to the expression of interest.

Requesting further information

Should respondents require further data or information to inform their proposals they may request this information by contacting the nominated contact person until the last queries date (see Part A Expression of Interest).

The only person authorised by the Principal to communicate with respondents is the Contact Person. Therefore, respondents cannot rely on communications with any other person. Any communication with the Contact Person should be in writing and addressed to the Contact Person.

Requests for data and information will be attended to in accordance with the Bid Rules.
INFORMATION TO INFORM PROPOSALS IN THE GOVERNMENT’S FOCUS AREAS

1. Preventing and reducing hospital admissions/transfers for residential aged care facility residents

1.1 Nature of the problem

The South Australian Government is seeking to ensure the appropriateness of admission to hospital for residents of residential aged care facilities (RACFs).

RACF residents may be inappropriately transferred/admitted to hospital for a range of reasons; including:

- due to poor understanding of available palliative clinical support options
- RACF reduced capacity to manage and care for patients at the end of life
- family preference.

Appropriate care of RACF residents, especially those at end of life, is an expectation of individuals, families and communities. Contemporary practice supports the minimisation of acute hospital clinical interventions, as these interventions are ineffective and/or of marginal value for residents of RACFs.¹

The South Australian Government supports the universal application of end-of-life planning and palliative care provided within RACFs, to optimise end-of-life care. This is to support the uptake of advance care plans, ensuring individual needs are known and can be supported.

A social impact investment reducing and preventing hospital admissions for RACF residents may present an opportunity to both improve health outcomes for RACF residents and reduce preventable hospital admissions.

1.2 Size of the problem

10% of acute hospitalisations are RACF transferred patients. As the elderly population in South Australia continues to increase, the acute demand for hospital services from RACF residents is forecast to increase.

In 2012-13 there were 4,710 separations of RACF residents aged 65 and over from metropolitan public hospitals that had been admitted through emergency departments, accounting for 25,293 bed days at a cost of $35.2 million.

Transfers to emergency departments and hospitals from RACFs are a common first response when a resident’s condition deteriorates. It is noted that prior General Practice assessment is only undertaken in 25% of these cases.

The causes for the transfer of RACF residents vary across individual RACFs. Each entity has its own individual operational capacity, processes and staffing models. In some instances, ineffective staffing models result in skill gaps and an inability of the workforce to support hospital avoidance strategies.

Table 1.1 and Table 1.2 below show metropolitan Adelaide RACF resident hospitalisations through emergency department, by Service Related Group cost (top 5) and associated

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There are opportunities for innovative approaches in the clinical management and/or preventative service delivery of:

- Respiratory Infections/Inflammation
- Other Orthopaedics – Surgical
- Hip & Knee Replacement
- Dementia, Delirium & Non-Traumatic Stupor/Coma
- Non-Acute Rehabilitation
- Kidney & Urinary Tract Infections
- Major Psychiatric Disorder

**Table 1.1: RACF Patients (age 65+) Top 5 Conditions, Emergency Admissions, Metropolitan, 2011-12**

<table>
<thead>
<tr>
<th>Service Related Group - Condition</th>
<th>Separations</th>
<th>Days</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections/Inflammation</td>
<td>493</td>
<td>2,989</td>
<td>$4,235,833</td>
</tr>
<tr>
<td>Other Orthopaedics - Surgical</td>
<td>146</td>
<td>1,394</td>
<td>$3,016,443</td>
</tr>
<tr>
<td>Dementia, Delirium &amp; Non-Traumatic Stupor/Coma</td>
<td>170</td>
<td>2,035</td>
<td>$2,747,911</td>
</tr>
<tr>
<td>Major Psychiatric Disorder</td>
<td>58</td>
<td>1,775</td>
<td>$1,901,443</td>
</tr>
<tr>
<td>Hip &amp; Knee Replacement</td>
<td>76</td>
<td>682</td>
<td>$1,658,739</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>943</strong></td>
<td><strong>8,875</strong></td>
<td><strong>$13,560,368</strong></td>
</tr>
</tbody>
</table>

2011-12 Metropolitan Hospital Cost and Morbidity Data

**Table 1.2: RACF Patients (age 65+) Top 5 Conditions, Emergency Admissions, Metropolitan, 2012-13**

<table>
<thead>
<tr>
<th>Service Related Group - Condition</th>
<th>Separations</th>
<th>Days</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections/Inflammation</td>
<td>538</td>
<td>2,861</td>
<td>$3,640,709</td>
</tr>
<tr>
<td>Other Orthopaedics - Surgical</td>
<td>155</td>
<td>1,319</td>
<td>$2,675,451</td>
</tr>
<tr>
<td>Dementia, Delirium &amp; Non-Traumatic Stupor/Coma</td>
<td>231</td>
<td>2,227</td>
<td>$2,559,144</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>247</td>
<td>1,226</td>
<td>$1,631,899</td>
</tr>
<tr>
<td>Hip &amp; Knee Replacement</td>
<td>77</td>
<td>655</td>
<td>$1,504,443</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,248</strong></td>
<td><strong>8,288</strong></td>
<td><strong>$12,011,646</strong></td>
</tr>
</tbody>
</table>

2012-13 Metropolitan Hospital Cost and Morbidity Data

**1.3 Government costs**

The total cost of clinical care for RACF residents aged 65 and over that had been admitted to metropolitan hospitals through emergency departments for 2011-12 was $39,358,193 and for 2012-13 was $35,238,826. The breakdown by local health network (LHN) is provided below:

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2 Separation numbers are provided as a proxy for hospital admissions.
Table 1.3: RACF Patients LHN Metropolitan 2011-12

<table>
<thead>
<tr>
<th>Local Health Network</th>
<th>Separations</th>
<th>Days</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Adelaide</td>
<td>2,275</td>
<td>12,718</td>
<td>$19,440,977</td>
</tr>
<tr>
<td>Northern Adelaide</td>
<td>468</td>
<td>3,418</td>
<td>$4,438,294</td>
</tr>
<tr>
<td>Southern Adelaide</td>
<td>1,450</td>
<td>10,005</td>
<td>$15,478,920</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4,193</strong></td>
<td><strong>26,141</strong></td>
<td><strong>$39,358,193</strong></td>
</tr>
</tbody>
</table>

2011-12 Metropolitan Hospital Cost and Morbidity Data

Table 1.4: RACF Patients LHN Metropolitan 2012-13

<table>
<thead>
<tr>
<th>Local Health Network</th>
<th>Separations</th>
<th>Days</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Adelaide</td>
<td>2,422</td>
<td>12,323</td>
<td>$17,131,900</td>
</tr>
<tr>
<td>Northern Adelaide</td>
<td>1,076</td>
<td>5,961</td>
<td>$6,332,064</td>
</tr>
<tr>
<td>Southern Adelaide</td>
<td>1,212</td>
<td>7,009</td>
<td>$11,774,861</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4,710</strong></td>
<td><strong>25,293</strong></td>
<td><strong>$35,238,826</strong></td>
</tr>
</tbody>
</table>

2012-13 Metropolitan Hospital Cost and Morbidity Data

1.4 Target cohort

The South Australian Government is seeking appropriate clinical management and/or preventative services for metropolitan RACF residents, who:

- are 65 years or older;
- are likely to be admitted to an acute public hospital service through an emergency department; and
- have a usual type of accommodation as a residential aged care facility.

1.5 Measurement framework

- an overall reduction in the numbers of hospital separations for RACF residents

1.6 Program requirements

Proposals for interventions that target the problem should clearly identify:

- the particular cohort that will be targeted
- the nature of the intervention and how this will demonstrate it will meet the outcomes and potential savings to Government.
Table 1.5: RACF Patients (age 65+) All Conditions, Emergency Admissions, Metropolitan, 2011-12

<table>
<thead>
<tr>
<th>Service Related Group - Condition</th>
<th>Separations</th>
<th>Days</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>32</td>
<td>83</td>
<td>$124,565</td>
</tr>
<tr>
<td>Ami W/O Invasive Cardiac Inves Proc</td>
<td>68</td>
<td>319</td>
<td>$445,952</td>
</tr>
<tr>
<td>Anal &amp; Stomal Procs</td>
<td>4</td>
<td>41</td>
<td>$63,224</td>
</tr>
<tr>
<td>Back &amp; Neck Procedures</td>
<td>2</td>
<td>72</td>
<td>$156,755</td>
</tr>
<tr>
<td>Bronchitis &amp; Asthma</td>
<td>4</td>
<td>24</td>
<td>$30,005</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>75</td>
<td>450</td>
<td>$557,685</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>86</td>
<td>132</td>
<td>$222,725</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>4</td>
<td>52</td>
<td>$93,945</td>
</tr>
<tr>
<td>Chronic Obstructive Airways Disease</td>
<td>150</td>
<td>805</td>
<td>$1,096,998</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>15</td>
<td>116</td>
<td>$164,038</td>
</tr>
<tr>
<td>Conisation, Vagina, Cervix &amp; Vulva Procedures</td>
<td>1</td>
<td>2</td>
<td>$4,661</td>
</tr>
<tr>
<td>Coronary Bypass</td>
<td>1</td>
<td>11</td>
<td>$37,074</td>
</tr>
<tr>
<td>Craniotomy</td>
<td>3</td>
<td>83</td>
<td>$156,981</td>
</tr>
<tr>
<td>Dementia, Delirium &amp; Non-Traumatic Stupor/Coma</td>
<td>170</td>
<td>2,035</td>
<td>$2,747,911</td>
</tr>
<tr>
<td>Dental &amp; Oral Disease Excluding Extractions</td>
<td>8</td>
<td>10</td>
<td>$15,366</td>
</tr>
<tr>
<td>Dermatology</td>
<td>17</td>
<td>96</td>
<td>$136,170</td>
</tr>
<tr>
<td>Diabetes</td>
<td>32</td>
<td>154</td>
<td>$224,215</td>
</tr>
<tr>
<td>Digestive Malignancy</td>
<td>13</td>
<td>105</td>
<td>$140,704</td>
</tr>
<tr>
<td>Disorders Of Liver, Biliary Tract &amp; Pancreas</td>
<td>44</td>
<td>272</td>
<td>$414,536</td>
</tr>
<tr>
<td>Drug &amp; Alcohol</td>
<td>2</td>
<td>8</td>
<td>$8,623</td>
</tr>
<tr>
<td>ERCP</td>
<td>13</td>
<td>103</td>
<td>$143,680</td>
</tr>
<tr>
<td>Extensive Burns, Medical</td>
<td>1</td>
<td>3</td>
<td>$6,802</td>
</tr>
<tr>
<td>Extensive Burns, Surgical</td>
<td>2</td>
<td>6</td>
<td>$15,674</td>
</tr>
<tr>
<td>Gastroscopy</td>
<td>58</td>
<td>362</td>
<td>$559,952</td>
</tr>
<tr>
<td>GI Obstruction</td>
<td>44</td>
<td>191</td>
<td>$281,938</td>
</tr>
<tr>
<td>Haematological Surgery</td>
<td>5</td>
<td>101</td>
<td>$171,613</td>
</tr>
<tr>
<td>Head Injuries</td>
<td>55</td>
<td>265</td>
<td>$406,908</td>
</tr>
<tr>
<td>Headache</td>
<td>3</td>
<td>4</td>
<td>$8,750</td>
</tr>
<tr>
<td>Heart Failure &amp; Shock</td>
<td>143</td>
<td>881</td>
<td>$1,127,482</td>
</tr>
<tr>
<td>Hip &amp; Knee Replacement</td>
<td>76</td>
<td>682</td>
<td>$1,658,739</td>
</tr>
<tr>
<td>Injuries - Non-Surgical</td>
<td>145</td>
<td>456</td>
<td>$623,505</td>
</tr>
<tr>
<td>Injuries To Limbs - Medical</td>
<td>142</td>
<td>570</td>
<td>$807,970</td>
</tr>
<tr>
<td>Invasive Cardiac Inves Proc</td>
<td>10</td>
<td>55</td>
<td>$92,645</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>227</td>
<td>1,100</td>
<td>$1,530,657</td>
</tr>
<tr>
<td>Lymphoma &amp; Non-Acute Leukaemia</td>
<td>10</td>
<td>121</td>
<td>$191,065</td>
</tr>
<tr>
<td>Major Psychiatric Disorder</td>
<td>58</td>
<td>1,775</td>
<td>$1,901,443</td>
</tr>
<tr>
<td>Major S &amp; L Bowel Procs Incl Rectal Resection</td>
<td>16</td>
<td>313</td>
<td>$579,926</td>
</tr>
<tr>
<td>Microvascular Tissue Transfer Or Skin Grafts</td>
<td>9</td>
<td>114</td>
<td>$183,733</td>
</tr>
<tr>
<td>Non-Procedural ENT</td>
<td>36</td>
<td>101</td>
<td>$148,303</td>
</tr>
<tr>
<td>Non-Procedural Gynaecology</td>
<td>5</td>
<td>13</td>
<td>$19,298</td>
</tr>
<tr>
<td>Non-Procedural Neurosurgery</td>
<td>24</td>
<td>209</td>
<td>$329,036</td>
</tr>
<tr>
<td>Non-Procedural Ophthalmology</td>
<td>19</td>
<td>71</td>
<td>$99,506</td>
</tr>
<tr>
<td>Non-Surgical Back &amp; Neck Problems</td>
<td>45</td>
<td>277</td>
<td>$389,329</td>
</tr>
<tr>
<td>Oesophagitis, Gastroent &amp; Misc Digestive System Disorders</td>
<td>53</td>
<td>200</td>
<td>$295,405</td>
</tr>
<tr>
<td>Or Procedures For Injuries</td>
<td>4</td>
<td>42</td>
<td>$66,048</td>
</tr>
<tr>
<td>Other Cardiology</td>
<td>128</td>
<td>470</td>
<td>$771,994</td>
</tr>
<tr>
<td>Other Cardiothoracic Surgery</td>
<td>3</td>
<td>36</td>
<td>$52,330</td>
</tr>
<tr>
<td>Service Related Group - Condition</td>
<td>Separations</td>
<td>Days</td>
<td>Total Cost</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------</td>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>Other Endocrinology &amp; Metabolic Dis</td>
<td>82</td>
<td>387</td>
<td>$539,365</td>
</tr>
<tr>
<td>Other Eye Procedures</td>
<td>2</td>
<td>9</td>
<td>$20,867</td>
</tr>
<tr>
<td>Other Gastroenterology</td>
<td>189</td>
<td>693</td>
<td>$996,238</td>
</tr>
<tr>
<td>Other General Medicine</td>
<td>36</td>
<td>141</td>
<td>$185,792</td>
</tr>
<tr>
<td>Other General Surgery</td>
<td>14</td>
<td>171</td>
<td>$266,162</td>
</tr>
<tr>
<td>Other Haematology</td>
<td>21</td>
<td>141</td>
<td>$186,587</td>
</tr>
<tr>
<td>Other Interventional Cardiology</td>
<td>13</td>
<td>65</td>
<td>$212,241</td>
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<tr>
<td>Other Medical Oncology</td>
<td>18</td>
<td>92</td>
<td>$121,776</td>
</tr>
<tr>
<td>Other Neurology</td>
<td>84</td>
<td>617</td>
<td>$801,114</td>
</tr>
<tr>
<td>Other Non-Procedural Urology</td>
<td>56</td>
<td>247</td>
<td>$344,630</td>
</tr>
<tr>
<td>Other Orthopaedics - Non-Surgical</td>
<td>20</td>
<td>139</td>
<td>$211,594</td>
</tr>
<tr>
<td>Other Orthopaedics - Surgical</td>
<td>146</td>
<td>1,394</td>
<td>$3,016,443</td>
</tr>
<tr>
<td>Other Plastic &amp; Reconstructive Surgery</td>
<td>1</td>
<td>3</td>
<td>$7,357</td>
</tr>
<tr>
<td>Other Procedural ENT</td>
<td>2</td>
<td>4</td>
<td>$14,500</td>
</tr>
<tr>
<td>Other Psychiatry</td>
<td>30</td>
<td>234</td>
<td>$244,438</td>
</tr>
<tr>
<td>Other Renal Medicine</td>
<td>47</td>
<td>202</td>
<td>$280,353</td>
</tr>
<tr>
<td>Other Respiratory Medicine</td>
<td>142</td>
<td>744</td>
<td>$1,184,110</td>
</tr>
<tr>
<td>Other Upper GIT Surgery</td>
<td>9</td>
<td>133</td>
<td>$284,541</td>
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<tr>
<td>Other Urological Procedures</td>
<td>9</td>
<td>68</td>
<td>$119,422</td>
</tr>
<tr>
<td>Other Vascular Surgery Procedures</td>
<td>38</td>
<td>522</td>
<td>$910,379</td>
</tr>
<tr>
<td>Otitis Media &amp; URTI</td>
<td>10</td>
<td>59</td>
<td>$71,747</td>
</tr>
<tr>
<td>Percutaneous Coronary Angioplasty W Ami</td>
<td>2</td>
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</table>

2011-12 Metropolitan Hospital Cost and Morbidity Data
Table 1.6: RACF Patients (age 65+) All Conditions, Emergency Admissions, Metropolitan, 2012-13

<table>
<thead>
<tr>
<th>Service Related Group - Condition</th>
<th>Separations</th>
<th>Days</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
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<td>Other Gastroenterology</td>
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<tr>
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<td>$11,479</td>
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<td>$10,659</td>
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<td><strong>4,710</strong></td>
<td><strong>25,293</strong></td>
<td><strong>$35,238,826</strong></td>
</tr>
</tbody>
</table>

2012-13 Metropolitan Hospital Cost and Morbidity Data
2. Helping long stay older patients in public hospitals find more appropriate accommodation

2.1 Nature of the problem

There are older people in public hospitals who have completed their acute and post-acute care and have been assessed for Commonwealth aged care. These people remain in hospital during the process of securing an appropriate community and/or residential aged care place. This means that hospital resources are maintaining these patients rather than providing acute complex care to other cases.

Maintenance care is defined as care in which the primary clinical purpose or treatment goal is support for a patient with:

- impairment
- activity limitation, or
- participation restriction.

A long stay older patient is defined as a patient who:

- is over 65 years of age
- is receiving maintenance care
- has a length of stay greater than 35 days
- does not require acute care, and
- is medically ready for discharge.

Public hospitals do not provide the most appropriate accommodation for these patients. Their needs are best met in residential accommodation. It also means public hospital beds will be available for acute hospital care.

Maintenance care patients represent 1% of total public hospital separations, however they contribute to 6% of total bed days across South Australia. The South Australian Government is interested in ensuring these patients can find and move to the most appropriate accommodation in a timely manner.

2.2 Government cost

In 2012-13, there were 1,853 separations from metropolitan public hospitals in South Australia for maintenance care of patients aged 65 years and older. The average cost of each separation was $12,052. The total cost of these patients in public hospitals was $22,332,539 (Table 2.1 below).³

Table 2.1: Metropolitan Adelaide Maintenance Care Patients 2012-13

<table>
<thead>
<tr>
<th>Local Health Network</th>
<th>Separations</th>
<th>Total Days</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
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</tr>
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<td>Northern Adelaide</td>
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<tr>
<td>Southern Adelaide</td>
<td>803</td>
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<tr>
<td>TOTAL</td>
<td>1,853</td>
<td>20,321</td>
<td>$22,332,539</td>
</tr>
</tbody>
</table>

12-13 costs for patient with an episode of care = maintenance care and 65+ years by LHN - Metropolitan Hospitals

³ Separation numbers are provided as a proxy for hospital admissions.
2.3 Target cohort
The South Australian Government is interested in interventions that will target patients in metropolitan public hospitals that:

- are 65 years or over (50 years or over for Aboriginal people);
- have been assessed by an Aged Care Assessment Team as being eligible for permanent aged care services (residential care or packaged care); and are unable to return to the community without that care in place; and
- no longer require inpatient or post-acute care (including rehabilitation) and are declared medically ready for discharge.

2.4 Outcomes sought
- long stay older patients who are ready for discharge are placed in the most appropriate accommodation in a prompt manner.

This will contribute to:

- improved quality of life, health and wellbeing for individuals
- improved optimal end-of-life care for individuals and their families
- appropriate use and allocation of public health resources across South Australia
- improved capacity to support people to die at home if that is their wish.

2.5 Measurement framework
Specific targets that include:

- a reduction in the number of maintenance bed days
- a decrease in the number of separations for patients (65 years+) with maintenance care and subsequently placed in appropriate accommodation.

2.6 Program requirements
Proposals for interventions that target the problem should clearly identify:

- the particular cohort that will be targeted
- the nature of the intervention and how this will demonstrate it will meet the outcomes and potential savings to Government.
3. Preventing and reducing hospital admissions for people with Borderline Personality Disorder

3.1 Nature of the problem

Borderline Personality Disorder is a highly complex condition with significant negative consequences characterised by instability across several areas of an individual’s life. Borderline Personality Disorder is often hard to diagnose, varies amongst consumers in presentation, complexity and severity and can affect individuals across all social groups. The potential consequences of the condition include loss of productivity, social and occupational breakdown, carer stress, family breakdown and risk to self and others. Treatment requires a sustained, flexible and multidisciplinary approach in order to maximise potential for recovery.

The diagnosis of Borderline Personality Disorder often co-exists with depression and anxiety, eating disorders, psychosis, PTSD, substance misuse, bipolar disorder and a range of medical conditions. Assessment and treatment requires a structured approach that may involve multiple agencies. Whilst recognising the challenges, evidence based and effective interventions are available and present opportunities to enhance service provision through the implementation of a stepped approach building on the services that already exist. The interpersonal interactional style that is associated with Borderline Personality Disorder is such that treatment in a community based low stigma setting can optimise the potential for recovery and reduce the risk of harm.

Consumers and carers often report that a diagnosis of Borderline Personality Disorder can result in discrimination and exclusion. People with a diagnosis of Borderline Personality Disorder have reported feeling “actively excluded from services, not feeling respected, and their concerns dismissed as not important or their mental illness considered not being severe enough”.

Borderline Personality Disorder has a marked effect on health services and consumers and carers who live with the impact of frequent suicidal thoughts as well as self-harming behaviours. These can be distressing to both consumers with Borderline Personality Disorder and carers. The threat of suicide generates considerable anxiety for carers particularly and sometimes these are child carers of adults with Borderline Personality Disorder.

Emergency Departments are often the first port of call for people with Borderline Personality Disorder who have engaged in deliberate self-harm so it is important that attending staff are appropriately trained to deal with these presentations. Consumers have reported experiencing negative stigma in these environments, that waiting times can be long, that their injuries are sometimes overlooked, disregarded or trivialised despite the seriousness or that they are blamed for their distress. This results in consumers feeling dismissed and their carers and family experiencing high levels of anxiety relating to the survival and wellbeing of their loved one.

Across South Australia there is a great variability of services provided to people with Borderline Personality Disorder. Whilst there are some “pockets of excellence” in metropolitan Adelaide, particularly in the north, north east, outer south and west, there are also areas with very few or no specific services for consumers with a diagnosis with Borderline Personality Disorder.

Evidence-based psychological therapies - informed by an individualised management plan and thorough assessment - can significantly improve symptoms and functions, stability and growth. Establishing consistency across these service domains and across healthcare settings through education, service development and linkage stands to deliver benefits beyond the health care system.
3.2 Size of the problem

There were 1,264 separations from public hospitals in South Australia in 2013-14 with a diagnosis of Borderline Personality Disorder recorded in the primary, secondary or other field. These patients had 8,326 bed days and the average length of stay was 6.6 days.

As illustrated below, there was an increase of 19.2% in the number of hospital bed days for people diagnosed with Borderline Personality Disorder between 2009-10 and 2013-14.

Table 3.1: Borderline Personality Disorder separations, length of stay and average length of stay 2009-10 to 2013-14

<table>
<thead>
<tr>
<th>Separation FY</th>
<th>Separations</th>
<th>Length of stay (days)</th>
<th>Average LOS (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>1,259</td>
<td>6,985</td>
<td>5.5</td>
</tr>
<tr>
<td>2010/11</td>
<td>1,119</td>
<td>7,356</td>
<td>6.6</td>
</tr>
<tr>
<td>2011/12</td>
<td>1,384</td>
<td>7,710</td>
<td>5.6</td>
</tr>
<tr>
<td>2012/13</td>
<td>1,243</td>
<td>7,853</td>
<td>6.3</td>
</tr>
<tr>
<td>2013/14</td>
<td>1,264</td>
<td>8,326</td>
<td>6.6</td>
</tr>
<tr>
<td>Variance (13/14 to 09/10)</td>
<td>5</td>
<td>1,341</td>
<td>1.0</td>
</tr>
<tr>
<td>% Change</td>
<td></td>
<td>0.4%</td>
<td>19.2%</td>
</tr>
</tbody>
</table>

In addition, there were 690 separations in 2012-13 involving self-harm, involving 7,001 hospital bed days (average length of stay 10.1 days).

People with a diagnosis of Borderline Personality Disorder will often present to an emergency department with physical complaints which, on discharge, will be coded as the reason for admission (and not the Borderline Personality Disorder). Accordingly the figures above will not reflect the entire number of people in South Australia with a diagnosis of Borderline Personality Disorder who have accessed public hospitals.

3.3 Cost of the problem

In 2009 the National Collaborating Centre for Mental Health in the United Kingdom published “Borderline Personality Disorder: The NICE guideline on treatment and management” which identified the costs of Borderline Personality Disorder to society in general and to the health system in particular. The report’s key findings are relevant in the Australian context:

- Besides functional impairment and emotional distress, Borderline Personality Disorder is also associated with significant financial costs to the health care system, social services and the wider society.

- In comparison with people with other mental illness, those with personality disorders have been reported to place a high economic cost on society, as people with Borderline Personality Disorder frequently use intensive treatments, such as emergency department visits and psychiatric hospital services leading to higher related health care costs.

- With the exception of self-help groups those with Borderline Personality Disorder are more likely to use almost every type of psychosocial treatment and compared with people with depression, will have used most classes of medication.

- Other areas warranting further consideration and which incur significant financial and psychological costs to broader society include engagement with social services, housing issues, unemployment and the criminal justice system interaction. To date, little work relating to people with Borderline Personality Disorder has been done in these areas.
3.4 Target cohort

The Government is interested in interventions that will target people in country and metropolitan South Australia who:

- have a diagnosis of Borderline Personality Disorder from a psychiatrist
- attend a public hospital emergency department with a principal or secondary diagnosis of Borderline Personality Disorder and meet agreed criteria for complexity, severity and frequency of attendance, and
- may have received services from community based mental health care teams.

3.5 Outcomes sought

People diagnosed with Borderline Personality Disorder receive the appropriate services in a timely manner. This will contribute to:

- reduced emergency department attendances
- reduced acute crisis interventions
- diminished distress levels among patients
- joined up services providing care across the patients’ needs
- better outcomes for carers and family members.

3.6 Potential savings to Government

It is increasingly understood that service optimisation actually leads to direct and indirect savings to public health services as well as decreasing adverse outcomes to this group in relation to hospital presentations, self-harm and suicide. Borderline Personality Disorder that is not managed early can result in ongoing acute interventions occurring over a significant number of years, hence reducing adverse outcomes early will prevent future ongoing public health service use.

There are also longer-term benefits to broader society including reduced engagement with social services, housing issues, unemployment and the criminal justice system interaction.

3.7 Measurement framework

The trial group would be measured relative to a control group benchmark or to a proportionate comparable average of the previous year.

Specific targets that could be sought include:

- a reduction in the number of emergency department attendances and hospital bed days for people presenting with Borderline Personality Disorder.

3.8 Program requirements

Proposals for interventions that target this problem should clearly identify:

- how they reach the proposed target cohort (including options to target people with Borderline Personality Disorder who may not have been diagnosed or coded correctly)
- the geographical area that will be targeted
- referral, intake and discharge mechanisms
• the nature of the intervention and how this will demonstrate it will meet the outcomes and potential savings to Government
• partnership arrangements to facilitate appropriate service delivery and referral, sector development, consistency of referral pathways and coordination of service delivery and response.
4. Homelessness

4.1 Nature of the problem

The Government is seeking to improve the outcomes for people experiencing homelessness in South Australia.

Governments across Australia currently fund specialist homelessness services to pursue a number of outcomes relating to homelessness, including that:

- fewer people will become homeless and fewer of these will sleep rough
- fewer people will become homeless more than once
- people at risk of or experiencing homelessness will maintain or improve connections with their families and communities, and maintain or improve their education, training or employment participation
- people at risk of or experiencing homelessness will be supported by quality services, with improved access to sustainable housing.

Studies of homelessness have found that homeless people incur a much higher than average cost for non-homeless services, most notably health care and justice services. Homelessness program evaluations have concluded that non-homeless service costs can be reduced through the implementation of programs aimed at improving outcomes for homeless people. Interventions targeting homelessness may present an opportunity both to improve outcomes relating to homelessness and create savings to government through the decreased use of non-homeless services.

4.2 Size of the problem

On the night of the 2011 Census 5,982 people were recorded as homeless in South Australia (56.5% male, 43.5% female). This represented a 6.7% increase from the 2006 Census, which was similar to the 5.4% increase seen in the total South Australian population. Around 4% were recorded as sleeping rough or in improvised dwellings; the most common accommodation arrangements on Census night were staying in supported accommodation for the homeless and living in ‘severely’ crowded dwellings (see Table 4.1).

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8 Ibid.
Table 4.1: Persons in South Australia identified as homeless on 2011 and 2006 Census nights, by homeless operational group

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons who are in improvised dwellings, tents or sleeping out</td>
<td>436</td>
<td>7.7%</td>
<td>257</td>
<td>4.3%</td>
</tr>
<tr>
<td>Persons in supported accommodation for the homeless</td>
<td>1,474</td>
<td>26.3%</td>
<td>1,620</td>
<td>27.1%</td>
</tr>
<tr>
<td>Persons staying temporarily with other households</td>
<td>1,328</td>
<td>23.7%</td>
<td>1,389</td>
<td>23.2%</td>
</tr>
<tr>
<td>Persons staying in boarding houses</td>
<td>977</td>
<td>17.4%</td>
<td>975</td>
<td>16.3%</td>
</tr>
<tr>
<td>Persons in other temporary lodging</td>
<td>30</td>
<td>0.5%</td>
<td>27</td>
<td>0.4%</td>
</tr>
<tr>
<td>Persons living in ‘severely’ crowded dwellings</td>
<td>1,362</td>
<td>24.3%</td>
<td>1,714</td>
<td>28.7%</td>
</tr>
<tr>
<td>Total persons in South Australia identified as homeless in Census</td>
<td>5,607</td>
<td>100%</td>
<td>5,982</td>
<td>100%</td>
</tr>
</tbody>
</table>

Homelessness can take different forms and is more likely to affect particular sub-groups of the population, including Aboriginal and Torres Strait Islander people, people suffering from mental illness, people who use drugs and alcohol at high levels, and people experiencing domestic violence.11

A 2011-2013 Australian longitudinal study into homelessness, Journeys Home, found that different population subgroups experience different durations of homelessness. Males, both the relatively young and the relatively old, migrants and people from Aboriginal or Torres Strait Islander backgrounds were found to experience longer periods of homelessness on average. The study also found that people are less likely to exit homelessness the longer they remain homeless.12 The 2010 ABS General Social Survey estimates that of the 1.1 million Australians who had experienced homelessness in the last ten years, 22% were homeless for longer than six months during their most recent period of homelessness.13

4.3 Use of homelessness services

The 2010 ABS General Social Survey estimates that 40% of people who experienced homelessness in the last ten years sought assistance from a service provider while they were most recently homeless.14

In 2013–14, 23,916 persons in South Australian (41% male, 59% female) received support from a government-funded specialist homelessness agency for a total 30,750 support

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12 Ibid.
14 Ibid.
periods. Around 27% of clients (6,478) were homeless at intake; the remaining clients (17,438) were classified as at risk of homelessness.\textsuperscript{15}

Many clients belong to a cohort identified as being particularly vulnerable to homelessness, and many of these clients belong to more than one cohort or ‘client group’ (see Table 4.2).\textsuperscript{16}

Table 4.2: Clients of Specialist Homelessness Services in South Australia, 2013-2014 Financial Year, by client group\textsuperscript{17}

<table>
<thead>
<tr>
<th>Client group</th>
<th>Number of clients</th>
<th>Proportion of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified as Aboriginal or Torres Strait Islander</td>
<td>6,331</td>
<td>26.5%</td>
</tr>
<tr>
<td>Born overseas</td>
<td>1,870</td>
<td>7.8%</td>
</tr>
<tr>
<td>Identified as having a disability</td>
<td>509</td>
<td>2.1%</td>
</tr>
<tr>
<td>Identified as having mental health issues</td>
<td>5,974</td>
<td>25.0%</td>
</tr>
<tr>
<td>Identified as experiencing domestic or family violence</td>
<td>9,082</td>
<td>38.0%</td>
</tr>
<tr>
<td>Aged under 18 years at intake</td>
<td>7,169</td>
<td>30.0%</td>
</tr>
<tr>
<td><strong>Total clients of Specialist Homelessness Services in South Australia, 2013-2014</strong></td>
<td><strong>23,916</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Note: Categories do not add to total because individuals may be counted in more than one category

\textbf{4.4 Government costs}

The Department for Communities and Social Inclusion is responsible for the management and implementation of housing and homelessness programs in South Australia.

The state’s homelessness service sector provides a range of services and support to people who are homeless or at risk of homelessness. The sector provides integrated support, where agencies act as gateways for client referral to appropriate support. Client pathways from intake and assessment to case plan may involve different agencies.

In 2012-13, the Department for Communities and Social Inclusion spent $56.5 million on homelessness services ($54.0 million on service delivery and $2.5 million administrative expenditure). This equates to $34.14 per person in the South Australian population, which is slightly higher than the Australian average of $26.06 per person, and to a cost per client accessing homelessness services of $2,647, which is slightly higher than the Australian average of $2,421 per client.\textsuperscript{18} Funded services include specialist homelessness services such as Domestic Violence, Aboriginal Family Violence, Aboriginal and Torres Strait Islander Specific, Child, Youth and Generic, as well as programs such as Common Ground and Street to Home. In addition, SA Health contributed $919,200 funding during 2013-14 to the Street to Home outreach service, provided by a multidisciplinary team in the Central Adelaide Local Health Network.

A recent AIHW report highlights the fact that while homelessness services can be effective, the complex pattern of needs of clients has a strong influence on client outcomes and the number of support days to arrive at outcomes.\textsuperscript{19}


\textsuperscript{16} Australian Institute of Health and Welfare (2014) Housing outcomes for groups vulnerable to homelessness. Cat. no. HOU 274. AIHW, Canberra.

\textsuperscript{17} Department for Communities and Social Inclusion (2014) Op Cit.

\textsuperscript{18} SCRGSP (2014) Op Cit.

The cost of providing assistance to the homeless population extends beyond the provision of homelessness programs. Several recent Australian studies have found that the government costs associated with non-homeless services accrued by the homeless population are much higher than that for the general population, particularly in the areas of health care and justice. The cost estimates for services accessed are fairly consistent between studies; the costs range from $15,168 to $22,080 higher annually for a homeless person than for an average person in the general population. Inpatient costs (nights in hospital, mental health facility or drug and alcohol centre) account for the majority of this difference, and are estimated to be from $9,000 to $18,000 higher annually for a homeless person.20 21 22

Figure 4.1 (below) illustrates the average annual inpatient costs, other health costs and justice costs reported in a study of a group of 183 men and women who were involved in homeless case-managed programs, compared with the same types of government costs for the general population.23 A summary of the cost differences found in three recent studies can be found in Table 4.3.

Figure 4.1: Government costs for a group of homeless people and the general population, by cost type24

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23 Ibid.
24 Ibid.
Table 4.3: Average differences in annual government-funded costs per person between homeless and general populations as reported in recent Australian studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Target cohort</th>
<th>Difference of health costs between target cohort and general population</th>
<th>Difference of justice costs between target cohort and general population</th>
<th>Total difference of government-funded health and justice costs between target cohort and general population</th>
</tr>
</thead>
<tbody>
<tr>
<td>MISHA project – 2010 to 2013</td>
<td>Men in NSW aged 25 years or older</td>
<td>$8,913</td>
<td>$2,973</td>
<td>$3,241</td>
</tr>
<tr>
<td>Michael project – 2007 to 2010</td>
<td>Men in Sydney (NSW)</td>
<td>$17,999</td>
<td>$1,082</td>
<td>$3,000</td>
</tr>
<tr>
<td>AHURI - 2010 to 2012</td>
<td>Men and women involved in homeless programs in NSW, Vic, SA and WA (a)</td>
<td>$12,002</td>
<td>$2,504</td>
<td>$5,905</td>
</tr>
</tbody>
</table>

(a) Reported cost differences are for case managed clients only. A small number of Day Centre clients also participated in the study.

(b) Additional costs were also measured but were excluded from table for consistency with other studies. Additional costs were Welfare and tax forgone, Children placed in care and Eviction, and came to a total cost difference of $9,037 between target cohort and general population.

According to SA Health data, there were 561 hospital separations for people with no fixed address in 2012-13, which amounted to 2795 bed days and a total cost of $4,132,759. This compares with 460 separations in 2011-12, for 3293 bed days and a total cost of $4,374,813.

Over the course of a lifetime, cumulative costs to government incurred by people who have cycled in and out of homelessness can be very significant. Baldry et al. (2012) undertook a case study of 11 such people in New South Wales, using administrative data from a range of sources, and estimated that lifetime costs for these individuals ranged from around $900,000 to $5.5 million.

Several program evaluations have demonstrated the potential for homelessness programs to generate savings in areas such as health and justice. Table 4.4 lists the annual cost offsets reported in several recent Australian homelessness program evaluations, broken down by health (inpatient costs and other health costs), justice, and welfare payments. To calculate the cost saving generated by the program, the costs incurred in the 12 months prior to the start of the program (‘baseline’) are subtracted from the costs incurred in a 12-month period after the program’s implementation. Therefore negative numbers indicate a saving in government costs, while positive numbers indicate that an additional cost was incurred compared to baseline.

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26 Flatau et al (2012), Op cit
27 Zaretsky et al (2013), Op cit
Table 4.4: Annual cost offsets achieved by several recent Australian homelessness programs

<table>
<thead>
<tr>
<th>Study</th>
<th>Target cohort</th>
<th>Total annual offsets in health costs (a)(b)</th>
<th>Total annual offsets in justice costs (a)(b)</th>
<th>Total annual offsets in welfare payments (a)(b)</th>
<th>Total annual offsets (a)(b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Inpatient costs(c)</td>
<td>Other health costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MISHA project – 2010 to 2013</td>
<td>Men aged 25 years or older 12 months post-program</td>
<td>-$697</td>
<td>-$481</td>
<td>-$1,064</td>
<td>$1,220</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-$5,532</td>
<td>-$1,035</td>
<td>-$1,977</td>
<td>$542</td>
</tr>
<tr>
<td>Michael project – 2007 to 2010</td>
<td>Short and medium term accommodation clients (men)</td>
<td>-$12,739</td>
<td>$243</td>
<td>$231</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-$1,014</td>
<td>-$581</td>
<td>$793</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Emergency accommodation clients (men)</td>
<td>$4,687</td>
<td>$131</td>
<td>-$5,588</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Street-based outreach clients (men)</td>
<td>$3,773</td>
<td>$866</td>
<td>-$6,447</td>
<td>$418</td>
</tr>
<tr>
<td></td>
<td>Single Men</td>
<td>-$7,220</td>
<td>-$2,074</td>
<td>$146</td>
<td>$229</td>
</tr>
<tr>
<td></td>
<td>Single Women</td>
<td>$4,747</td>
<td>-$1,301</td>
<td>-$1,540</td>
<td>$26</td>
</tr>
<tr>
<td></td>
<td>Tenancy Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a) Total offsets calculated comparing costs during 12 months prior to baseline to costs during the 12 months post-program implementation unless stated otherwise.

(b) A negative figure represents a reduction in costs to government; a positive figure (shown in red text) represents additional costs to government. In the original reports, cost savings were reported in varying ways. Costs savings for individual studies may be reported differently in this table compared to the original report for the purposes of consistency.

(c) Inpatient costs include nights in hospital, nights in mental health facility and nights in drug and alcohol centre

The particular cohort targeted by the program appears to have a strong influence on the program’s likelihood of generating savings. For example, Zaretzky et al. (2013) found that a cost saving of $8,919 was generated within the cohort of single women, while the cohort of single men realised a much smaller cost saving of $1,390 and the tenancy support cohort realised an additional cost to government of $1,932. In all three studies, a key driver of the costs to government is nights spent in a hospital, mental health facility or drug and alcohol centre (‘inpatient costs’). A significant saving on inpatient costs is found post-program in some cohorts, while in others the inpatient costs are higher after the program’s implementation. To explain this pattern, Zaretzky et al. (2013) report anecdotal evidence that “a significant proportion of single men do not seek assistance for health-related issues, and when they do obtain assistance the costs are often high.”

Furthermore, the size of cost offsets appears to change over time. Conroy et al. (2014) found that annual cost saving at 24 months post-program implementation was $8,002, which was almost eight times that achieved in the first 12 months post-program implementation, and which was mostly driven by a large drop in inpatient costs (see Figure 4.2).29

The cost offsets reported below do not take into account the cost of running the program. Conroy et al. (2014) estimated that it would take 4.36 years of cost offsets for the MISHA program to become cost neutral, after which time cost savings could be generated.30

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30 Ibid.
It should be noted that measures of average costs incurred by homeless people can be strongly influenced by a small number of ‘outliers’ who have a much greater use of services than the majority of people in that cohort.

**Figure 4.2: Average annual cost offset achieved per person by type of cost, at 12 months and 24 months post program implementation, MISHA project**

![Chart showing average annual cost offset by type of cost at 12 and 24 months post program implementation.]

**4.5 A current homelessness social impact bond example**

The London Homelessness Social Impact Bond, launched in November 2012, is the first social impact bond that has been trialled in the area of homelessness. The bond targets rough sleepers identified using a database for organisations who work with rough sleepers in London. The program involves a personalised approach by workers who help the program participants access existing provisions and achieve sustained long-term positive outcomes.

The London Homelessness Social Impact Bond measures outcomes based on achievements beyond the baseline for the target cohort and payments are linked to the savings generated from achievements above baseline levels. The social impact bond has five goals or outcomes for which metrics have been identified and an associated payment structure determined (see Table 4.5).

Goals were determined through detailed analysis and modelling using the rough sleeper database and through consultation with relevant parties. Despite recognition that reduction in crime was another important potential outcome, this was not included due to issues in accessing appropriate measurement data.

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31 Ibid.
Table 4.5: Goals, metrics and payment structure for London Homelessness Social Impact Bond.\(^{32}\)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Metric</th>
<th>Payment Mechanism</th>
<th>Payment Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced rough sleeping.</td>
<td>Reduced number of individuals rough sleeping each quarter.</td>
<td>Payments based on progress beyond expected baseline.</td>
<td>25%</td>
</tr>
<tr>
<td>Sustained stable accommodation.</td>
<td>Entry to non-hostel tenancy, and sustained for 12 and 18 months.</td>
<td>Payment on entry to accommodation, and at 12 and 18 month points.</td>
<td>40%</td>
</tr>
<tr>
<td>Sustained reconnection.</td>
<td>Confirmed reconnection outside of the UK.</td>
<td>Payment on reconnection and at 6 month point.</td>
<td>25%</td>
</tr>
<tr>
<td>Employability and employment.</td>
<td>Level 2 qualification achieved Sustained volunteering Sustained part-time employment Sustained full-time employment</td>
<td>Payment for achievement. Payments when volunteering or employment sustained for 13 and 26 weeks.</td>
<td>5%</td>
</tr>
<tr>
<td>Better managed health.</td>
<td>Reduction in Accident and Emergency episodes.</td>
<td>Payments for reduction in episodes against baseline data from Department of Health.</td>
<td>5%</td>
</tr>
</tbody>
</table>

4.6 Measurement framework

Particular outcome measures could include:

- an increase in the sustainability of tenancies
- a reduction in episodes of repeat homelessness
- a reduction in hospital admissions and presentations
- a reduction in justice services.

4.7 Program requirements

The Government is interested in developing opportunities to fund service delivery through social impact investment where possible.

Proposals for interventions that target this problem should clearly identify:

- the particular cohort that will be targeted
- the nature of the intervention and how this will demonstrate it will meet the outcomes and potential savings to Government.

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5. Out-of-Home Care

5.1 Objective

The government is seeking to reduce the number of children and young people entering the out-of-home care system.

5.2 Background

South Australia’s child protection system is administered by Families SA in the Department of Education and Child Development, with statutory powers and obligations under the Children’s Protection Act 1993.

Families SA relies on the community or people who are legally responsible (these people are called mandated notifiers’ and they include police, teachers, doctors and priests) to tell Families SA when they suspect children or young people are at risk of or experiencing abuse or neglect. These reports are called ‘notifications’.

Families SA will then look into the notification and decide what course of action to take. There are times when it is decided that there is no need to take action at all, other times advice might be given to the family or families guided to more formal training or advised to seek assistance from organisations that specialise in helping families cope with day-to-day issues.

If it is suspected that someone outside the family is responsible for the abuse the relevant authorities (such as South Australia Police) will be notified.

Sometimes Families SA will need to be intensively involved with a family. In the more extreme circumstances they will have to remove children from their families because it is not safe for them. Where they can, they will work with those families to improve the home environment enough for the children to remain in or return home. During the time children are not in the care of their parents, Families SA will make sure the child is in a safe and stable home, preferably with another family member.

When the breakdown of the family is beyond help and children will not be safe no matter what, an application for the child to be placed under the Guardianship of the Minister is made. That child will be legally cared for by a responsible person, either another family member or a foster carer.

5.3 Size of child protection in South Australia

Families SA received 39,733 child protection concern reports in 2012-13, of which 19,120 were ‘screened-in’ notifications. Of the 5,333 (children at risk and imminent risk of significant harm) notifications that were investigated, 2,221 cases were substantiated.

Substantiation occurs when an investigation concludes that there is reasonable cause to believe that the child has been, is being or is likely to be abused, neglected or otherwise harmed. Where a notification of abuse is substantiated but a child is not separated – and also in some cases where an investigation occurs but the abuse is not substantiated – children will receive intensive family support services. These services are currently provided by non-government providers on behalf of Families SA.

Where Families SA recommends – and court orders\textsuperscript{35} – that a child needs to be separated, various out-of-home care types are available, depending on the needs of the child. The majority of children (86.5% in 2012-13) are placed in family-based care, such as living with relatives or kin, with foster carers, or other home-based care arrangement.

**Figure 5.1: Number of children in out-of-home care by placement type (as at 30 June)\textsuperscript{36}**

![Chart showing number of children in out-of-home care by placement type]

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014 (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other home based care</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Independent living (incl. private board)</td>
<td>20</td>
<td>28</td>
<td>26</td>
<td>26</td>
<td>29</td>
<td>-</td>
</tr>
<tr>
<td>Other (incl. unknown)</td>
<td>76</td>
<td>80</td>
<td>71</td>
<td>80</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Residential care</td>
<td>173</td>
<td>216</td>
<td>250</td>
<td>246</td>
<td>330</td>
<td>359</td>
</tr>
<tr>
<td>Foster care</td>
<td>977</td>
<td>1,013</td>
<td>1,032</td>
<td>1,087</td>
<td>1,102</td>
<td>1,127</td>
</tr>
<tr>
<td>Relative/kinship care</td>
<td>767</td>
<td>847</td>
<td>985</td>
<td>1,104</td>
<td>1,190</td>
<td>1,371</td>
</tr>
</tbody>
</table>

(a) 2014 estimated numbers provided by the Department of Education and Child Department

Some children are not able to be accommodated in a family-based type of care, for example children with special needs or children with complex and challenging behaviour. For these children, different types of care – at significantly higher cost – are needed.

Aboriginal children continue to be over-represented in all child protection categories in South Australia and Australia. Aboriginal children represent approximately 3.6% of the total population of young people in South Australia but accounted for more than 20% of children in screened-in notifications and more than 30% of children in substantiations.

Analysis of data reported by the Productivity Commission\textsuperscript{37} and the Australian Institute of Health and Welfare\textsuperscript{38} also shows the following in respect to out-of-home care in South Australia:

- As at 30 June 2013, there were 2,657 children in out-of-home care.\textsuperscript{39}
- Between 2008-09 and 2012-13, the rate per 1,000 children in South Australia (aged 0-17 years old) in such care placements increased from 7.1 to 7.4. Over the same period, the remaining Australian jurisdictions (except Tasmania) all reported decreases in their rate per 1,000 children placed in out-of-home care placements.
- There is an upward trend in the number of children placed in out-of-home care placements, with an annual growth rate of 7% over the past five years due to a

\textsuperscript{35} The Youth Court. *Children’s Protection Act*
\textsuperscript{36} SCRGSP (2014) *Op Cit.*
\textsuperscript{37} *Ibid.*
\textsuperscript{38} Annual reports published by the Australian Institute of Health and Welfare.
\textsuperscript{39} Department of Education and Child Development (2014) *Op Cit.*
number of systematic factors (i.e. increasingly complex cases and greater public awareness).

- Indigenous children comprise 29.6% of all children in such care placements.
- Typically, about three quarters of children in out-of-home care have been placed continuously for more than two years and many more have been placed for more than five years.
- On average, the majority of children admitted into out-of-home care are under the age of 10 – 21% under the age of one, 24% for children aged 1 to 4 and 22% for children aged 5 to 9. The remaining 33% consist of children aged above 10.
- In contrast, the age distribution of children exiting out-of-home care is higher than that of children admitted into out-of-home care. On average, 61% of children discharged from out-of-home care were above the age of 10. This may indicate that children are being admitted into out-of-home care at a younger age and staying in these care arrangements for a longer duration.
- Foster care and relative/kinship care remain the main placement types for children in out-of-home care arrangements. On average, 86% of all children in out-of-home care arrangements are placed in these two placement types – 44% in foster care and 41% in relative/kinship care. The majority of the remaining children (around 10%) are generally placed in residential care.

Further information about the children and young people in care can be found in the annual Report on Government Services.

5.4 Cost of the problem

South Australia’s total real recurrent expenditure on out-of-home care services in 2012-13 was $156 million. Since 2003-04, the State’s expenditure on these services has shown an average annual increase of 19.5%, equating to an increase of around $125 million since 2003-04.40

For every child aged 0-17 in the South Australian population, real recurrent expenditure on out-of-home services was approximately $435 in 2012-13. Since 2003-04, the real expenditure per child on out-of-home services in South Australia has shown an average annual increase of 19%, which is the second highest (below Northern Territory) among all Australian jurisdictions.

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The cost to the state government per child in care in 2013-14 is estimated to be:\(^1\)
- $63,600 for foster care;
- $50,860 for relative and kinship care; and
- From $174,906 for community residential care to $279,000 for government residential care, and up to $353,250 for emergency accommodation.

\section*{5.5 Indicative benefit}

Successful early intervention program could be expected to result in better outcomes for families and children notified to Families SA, and at the same time increase Families SA’s capacity to respond to high risk notifications.

Given the costs to government of out of home care identified above, a successful program could also be expected to result in real savings to government through costs avoided of families and children escalating to higher risk (and higher cost) investigations and interventions.

The government benefits to be used in calculating reward payments will be determined by negotiation with the proponents selected through the EOI process.

There are other economic and social benefits associated with reducing time for children in OOHC. These may include benefits from reduced future involvement in the child protection system, increased educational engagement, reduction in offending, increased employment opportunities and establishment of a more secure home for younger siblings and future generations.

Final costs and benefits will be determined through collaborative work with the preferred proponents selected through the EOI process. Intangible benefits may include the value of

\(^{1}\) Source: SCRGSP (2014) \textit{Op Cit.}

\(^{2}\) Estimated costs provided by the Department of Education and Child Department, Adelaide.
the pilot for testing investor willingness and the practicalities of setting and measuring outcomes for reward payments, as well as the opportunity to test innovative service delivery approaches in this area.

5.6 Target cohort

The intervention group for a trial social impact investment intervention could be chosen from a range of cohorts of children who are in or facing the prospect of being placed in out-of-home-care. In order to meet the selection criteria, some factors to consider in selecting a cohort would include – but not limited to:

- families who have been notified to the Child Abuse Report Line (CARL) and referred to a Families SA office, where a priority response to children at low or moderate to high risk of harm is required or
- children or young people who are at risk of entering the child protection system, but who are not currently on a Supervision, Custody or Guardianship of the Minister Order
- the majority of families will have at least one child aged under five years old
- one third of children and young people will identify as Aboriginal or Torres Strait Islander.

In considering other cohorts like young people in high cost residential care or young people transitioning from care, consideration needs to be given to the issue that in South Australia, Families SA currently case manages all children and young people in care.

5.7 Outcome and measurement

As noted in the government’s discussion paper on social impact investment, the following outcomes are sought:

- reduction in the number of families that are the subject of a child protection re-notification
- reduction in the number of children and young people entering out-of-home care
- preserve and strengthen family relationships to ensure children and young people reside in a safe and stable home environment.

Specific targets that could be sought include:

- a reduction in the number of days in care
- families not receiving a confirmed child protection re-notification for a defined period after the service has ceased involvement with a family
- children and young people have been maintained with their family as a result of the service
- families have reported that the service has assisted them to achieve their Case Plan goals.

Data could be collected for an intervention group and a comparison group for the measurement period, following entry to the intervention. There may be multiple measurement periods as part of one social impact investment, which the Government envisages will have a term of five to seven years.
6. Recidivism

6.1 The issue

The Government is seeking to reduce recidivism - reoffending by offenders after they are released from prison or forensic treatment facilities – and in particular, the rate of return to custody, within a 12 month period, for offenders on short sentences.

6.2 Size of the problem

At 30 June 2013, the overall prison population in South Australia was 2,266 (2,119 males and 147 females), a 9% increase (189 prisoners) from the previous year.\(^{43}\) Prisoners were located in one of ten different facilities – nine of which are correctional facilities, as well as James Nash House which is a forensic mental health facility (see Table 6.1).

<table>
<thead>
<tr>
<th>Table 6.1: Prisoners in South Australia at 30 June 2013 by location (ABS, 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Yatala Labour Prison</td>
</tr>
<tr>
<td>James Nash House</td>
</tr>
<tr>
<td>Cadell Training Centre</td>
</tr>
<tr>
<td>Port Augusta Prison</td>
</tr>
<tr>
<td>Port Lincoln Prison</td>
</tr>
<tr>
<td>Mount Gambier Prison</td>
</tr>
<tr>
<td>Adelaide Remand Centre</td>
</tr>
<tr>
<td>Mobilong Prison</td>
</tr>
<tr>
<td>Adelaide Pre-Release Centre</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>James Nash House</td>
</tr>
<tr>
<td>Port Augusta Gaol</td>
</tr>
<tr>
<td>Adelaide Women's Prison</td>
</tr>
<tr>
<td><strong>Total (includes unknown location)</strong></td>
</tr>
<tr>
<td>All prisoners</td>
</tr>
</tbody>
</table>

Aboriginal prisoners made up 21.9% of the prison population (496 prisoners) as of 30 June 2013. The age standardised imprisonment rate for Aboriginal prisoners in South Australia was 14.7 times higher than the rate for the non-Indigenous population at 30 June 2013.\(^{44}\)

Recidivism is difficult to measure and is influenced by a number of social, legal, economic and political factors.

Each Australian correctional agency is required to collate and measure figures relating to reoffending through the national Report on Government Services. The report publishes data on the extent to which people who have had contact with the criminal justice system are re-arrested, re-convicted, or return to community corrections – and also on the proportion that are re-imprisoned within a two year period of release.

The 2013 Report on Government Services shows that 29.1% of prisoners released from South Australian prisons during 2009-10 returned to prison within two years. This figure is

\(^{43}\) Unsentenced prisoners comprised 34% of all prisoners (ABS cat 4517.0 *Prisoners in Australia* 2013).

approximately 10% lower than the national average of 39.3% and has slowly reduced over the last few years from 33.2% for prisoners released in 2005-06.\textsuperscript{45}

\textit{Figure 6.1: Percentage of prisoners re-imprisoned within two years of release, 2005-06 to 2009-10, South Australia and Australia}

However, the total number of prisoners in South Australia has risen over the last ten years from 1,455 in 2003 to 2,266 in 2013.

\textit{Figure 6.2: Number of prisoners in South Australia, 2003 to 2013\textsuperscript{46}}

A longitudinal study by the Australian Bureau of Statistics found that reimprisonment was strongly associated with being young, being of Aboriginal or Torres Strait Islander origin, having been previously imprisoned, and to a lesser extent, reimprisonment was found to be more likely in males. Prisoners released after being imprisoned for burglary or theft were most likely to be reimprisoned, compared with other offences.\textsuperscript{47}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{46} ABS (2013) \textit{Op Cit.}
\item \textsuperscript{47} Australian Bureau of Statistics (2010) \textit{An Analysis of Repeat Imprisonment Trends in Australia}, Australian Bureau of Statistics, Catalogue No. 1351.0.55.031, Canberra.
\end{itemize}
\end{footnotesize}
Unemployment, limited or low level education, poor residential location, a history of mental health problems, family instability and serious, prolonged drug use are factors that have been identified in other studies as being associated with higher rates of recidivism.\textsuperscript{48}

6.3 Government costs

The impact of recidivism on the state budget is significant. Government costs associated with recidivism include prison, court, police and legal aid, as well as future capital expenditure.

- **Prison costs**
  South Australia’s total recurrent expenditure on prisons in 2012-13 was $163.3 million, excluding capital costs, transport costs and payroll tax. Net operating expenditure for community corrections was $35.9 million, excluding capital costs. On average, it costs approximately $75,000 per year to house one prisoner for a year in South Australia (2012-13 dollars), excluding capital costs.\textsuperscript{49}

- **Court costs**
  Net real recurrent expenditure on South Australia’s criminal courts was approximately $68 million (2012-13 dollars, excluding payroll tax). There were 62,695 finalisations in criminal courts in 2012-13. Excluding payroll tax, the real net cost per finalisation ranged from $26,414 in the Supreme Court to $521 in the Magistrates’ courts (excluding children’s courts). The average cost per finalisation for all criminal courts was $1,019.\textsuperscript{50}

- **Police costs**
  Total SA Police expenditure in 2012-13 was $755.6 million.\textsuperscript{51} The number of offences recorded in SA by Police in 2012 was 191,505.\textsuperscript{52} Through consultation with NSW Police, Baldry et al. (2012) estimated that around 70% of police expenses can be assumed to be for work directly related to crime.\textsuperscript{53} Using the same methodology as Baldry et al., an estimate of the SA Police costs per offence in 2012-13 is $2,760.

- **Legal aid costs**
  The Legal Services Commission of South Australia (LSCSA) reported an expenditure of $15.7 million in 2012-13 for criminal law services, for a total of 28,678 services - an average expenditure of $548 per service. Additionally LSCSA provided 11,449 episodes of telephone advice services related to criminal law (expenditure not able to be reported).\textsuperscript{54}

In addition to costs within the legal system, there are costs associated with offending linked to unemployment, welfare and housing as well as multiple social costs.

6.4 Target cohort

The Government is looking to reduce the return to prison rates for prisoners leaving prison in South Australia, and community offenders at risk of re-imprisonment.

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\textsuperscript{50} SCRGSP (2014) *Op Cit*.


\textsuperscript{54} Legal Services Commission of South Australia (2013) *Annual Report 2012-13*, Legal Services Commission of South Australia, Adelaide.
The target cohort for a recidivism social impact investment program will include both male and female prisoners who are leaving prison, and community offenders who are at risk of re-imprisonment. The focus will be on individuals discharged after serving an aggregate sentence of 12 months or less.

A key outcome measure will be the rate of return to prison within 12 months of release, and will use the same counting rules as included in the Report on Government Services.

The Government is particularly keen to explore opportunities to address the need of Aboriginal people in the criminal justice system, and in reducing return to prison rates for Aboriginal offenders; and programs that are designed to reduce return to prison rates for female prisoners.

Given the diverse and multiple needs of the prisoner population, the program would need to address the needs of prisoners with complex needs including poor mental and physical health, disability including cognitive disability, substance misuse issues, homelessness and poor education and employment skills.

The following table presents the number of adult offenders discharged from South Australian prisons after serving an aggregate sentence of 12 months or less, the number of these individuals returned to prison within 12 months, and average days imprisoned.

**Table 6.2: Numbers of prisoners discharged and re-imprisoned, South Australia**

<table>
<thead>
<tr>
<th>Year of discharge</th>
<th>Total discharges</th>
<th>Discharges &lt; 12 months aggregate sentence</th>
<th>Return to prison 12 months</th>
<th>Average days Remand</th>
<th>Average days sentence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>4238</td>
<td>691</td>
<td>276</td>
<td>236</td>
<td>246</td>
</tr>
<tr>
<td>2009-10</td>
<td>4236</td>
<td>868</td>
<td>334</td>
<td>202</td>
<td>240</td>
</tr>
<tr>
<td>2010-11</td>
<td>4189</td>
<td>892</td>
<td>376</td>
<td>176</td>
<td>195</td>
</tr>
<tr>
<td>2011-12</td>
<td>4281</td>
<td>946</td>
<td>410</td>
<td>156</td>
<td>127</td>
</tr>
<tr>
<td>2012-13</td>
<td>3994</td>
<td>729</td>
<td>308</td>
<td>117</td>
<td>96</td>
</tr>
</tbody>
</table>

Note: the return to prison output has been standardised so that a prisoner can be counted only once in the discharge column and only once in the return column - however once a return to prison is triggered if the prisoner has returned multiple times all the days are aggregated in the average days columns.

**6.5 Potential savings**

There is a significant body of research that describes interventions that have been proven to effectively reduce recidivism.

Social impact investment, including social impact bonds and payment by results have been used nationally and internationally to tackle recidivism.

The first social impact bond in the target area of recidivism was launched in 2010 in Peterborough, UK. In the first cohort of 1,000 male prisoners sentenced to than 12 months imprisonment who were selected for the program, the rate of reoffending was 8.4% less than a matched comparison group. The Ministry of Justice announced in April 2014 that it would bring the Peterborough pilot to a close early as part of the Transforming Rehabilitation policy reforms. The Peterborough pilot will continue in its current form until June 2015 when the delivery of support for the second cohort is due to end.  

There are benefits to the community and Government in reducing recidivism. While the costs of imprisonment are largely fixed, each avoided case of reimprisonment will reduce the stress on the system and the requirement to add future capacity.

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Similarly, a reduction in recidivism would lessen the demand on police and court resources.

### 6.6 Program requirements

Proposed programs should be designed around evidence-based interventions to reduce reoffending and specifically, return to prison rates.

Programs will need to address the specific needs of prisoners leaving prison and offenders in the community who are at risk of re-imprisonment, including those who present with complex and multiple needs, such as poor mental and physical health, disability including intellectual disability, substance misuse issues, homelessness and poor education and employment skills.

The Government recognises that there are a number of strategies that have been shown to reduce rates of reoffending, and is keen to explore programs that are designed around protective factors of reoffending as cited in the desistance of crime literature. These include, although are not limited to, housing, employment and/or meaningful activity, sobriety and pro-social relationships. As such programs that are designed around these outcomes, and those that include a robust case management element, will be viewed favourably.

Programs should target both male and female prisoners and offenders, and ensure that the needs of Aboriginal offenders are addressed.

Programs will need to complement existing service provision to ensure to avoid duplication and ensure resources realise maximum benefit.

### 6.7 SA Government data

Data resources for a recidivism trial include the SA NT DataLink, the Department of Human Services, and the South Australian Office of Crime Statistics & Research (OCSAR). The SA NT DataLink provides a linkage service to enable research and policy analysis of de-identified data from multiple databases. OCSAR is responsible for research into and the monitoring of crime trends and the criminal justice system within the state.