# Social Impact Bonds

## Statement of Opportunities

July 2016

Department of Treasury and Finance

VICTORIA State Government | Treasury and Finance

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# Contents

# 1. Introduction

As outlined in the 2016-17 State Budget, the Victorian Government has announced its intention to investigate and pilot Social Impact Bonds (SIBs).

The pilot will explore funding and evaluation approaches that can improve outcomes for some of the most disadvantaged groups within our society.

This Statement of Opportunities (SoO) provides a broad overview of social impact bonds, the principles the Victorian Government will apply when considering proposals, and the policy areas the Government is exploring.

In particular, the Government is seeking to explore programs that can lead to improved outcomes for:

- young people leaving out-of-home care; and
- people experiencing problems associated with harmful alcohol and other drug use.

For each of these areas, this paper outlines the challenging, multi-faceted issues that the Government is interested in addressing, and identifies possible outcomes that could be sought in these areas. Feedback through market engagement and related processes will also inform development of outcome measures and target cohorts in these areas.

The Victorian Department of Treasury and Finance (DTF), working with other departments, will issue a request for proposals (RFP) in the next few months. The RFP will provide more detail on the criteria used to assess proposals.

# 2. Social Impact Bonds in the Victorian context

## 2.1 The Social Impact Bond model

SIBs involve partnerships between government, service providers and private investors. The intent of these partnerships is to deliver new and innovative programs for people who experience significant and complex issues where the most effective policies are not clear. A key feature of a SIB is the focus on achieving positive outcomes for that group of people, and the emphasis on effectively measuring the achievement of outcomes.

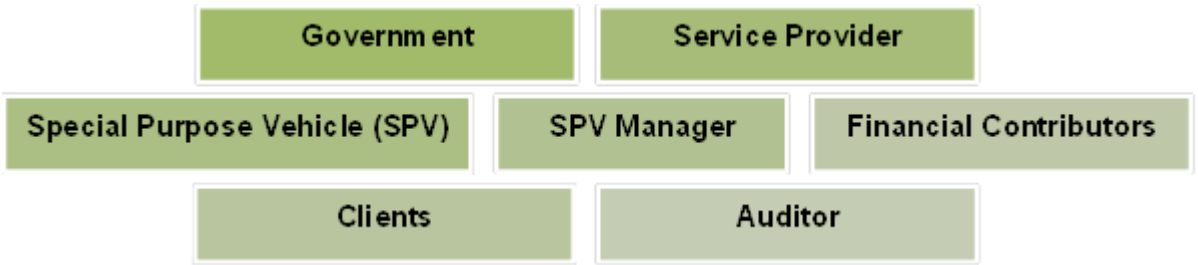
Successful intervention programs lead to better outcomes for individuals and the community more broadly. They also enable the government to reduce or avoid more expensive crisis services such as acute hospital services, corrections services and housing support. The government can provide a return to investors based on these reduced or avoided costs.

SIBs were initially trialled in the United Kingdom, where they have been used to support people leaving prison reduce their chance of reoffending, and to improve outcomes for people who have experienced long-term homelessness. More recently New South Wales has issued two social benefit bonds, one which seeks to prevent children going into out-of-home care, and another which aims to restore children in care to their families. Initial results have been moderately positive, with improved outcomes for the intervention group compared to the control or counterfactual group.

Social impact bonds are different from the more traditional approach of government funding a community service provider to deliver a specific program or service. Typically government will have a service contract with a service provider, with payment made based on delivering certain services and meeting the obligations of the contract.

By contrast, a social impact bond involves not-for-profit organisations delivering a program to achieve specified outcomes, such as reducing the likelihood of a person going to jail, or meeting education and employment outcomes. Achievement of outcomes is over the longer-term, usually five to seven years. Private investors fund some or all of the initial investment and program costs. Government payments are made for the achievement of agreed outcomes. The service provider has flexibility to tailor services to an individual, and to adjust its program as needed.

**Figure 2.1.1: Possible range of participants in the Social Impact Bond model**



SIBs combine risk-sharing, funding from private investors and innovative service delivery models to provide a return on those funds when outcomes agreed with government are met. Potential benefits include:

- a greater focus on providing agreed outcomes for clients through the measurement and collection of outcomes-driven data;
- providing service delivery organisations with a degree of flexibility in the way in which services are delivered, allowing providers to deliver solutions that are specifically tailored to client need;
- providing an evidence base for innovative service models that emphasise cost-effective early intervention and prevention, rather than providing crisis services at later stages when interventions may be more complex or costly; and
- promoting a greater focus on outcomes measurement, data collection, validation and evaluation of effective client outcomes for policy makers.

SIBs are suited best to situations where there are a number of complex, often interrelated, factors that impact negatively on individuals and there are no clear, effective and existing programs directly targeting the problem.

# 3. Principles for social impact bonds

The following principles are designed to provide some guidance to the development of SIB proposals. More detail will be provided as part of any formal request for proposals.

### 1. Clearly defined problem.

The issues facing a specific group of individuals need to be clearly articulated and understood. The particular cohort of individuals needs to be defined and an independent means of referral to the service provider established.

### 2. Deliver measurable benefits to individuals

The intervention needs to be able to demonstrate an evidence based approach to delivering measurable benefits to the individuals participating in the social impact bond program.

### 3. Robust measurement of outcomes.

Desired outcomes need to be clearly identified. They should be independently measurable, and not lead to perverse incentives for service providers.

Outcomes should be measured in relation to a control group, where it can be demonstrated that the intervention is directly responsible for the outcomes. If this is not possible, then a counterfactual or baseline measure is required, to ensure that outcomes are the result of the program.

### 4. Delivering a positive return to government.

The achievement of outcomes needs to deliver measurable benefits to the Victorian government, in terms of savings, avoided costs and possible productivity improvements. Broader economic and social benefits could also be considered.

### 5. Service providers have evidence of the efficacy of their program, and their capability and capacity to deliver.

Although one goal of a SIB is to test an intervention, there should be enough research or evidence that government, investors and service providers can have confidence that there is a reasonable chance of success. This could be in the form of research or the experience in other jurisdictions.

Consortia partners should have appropriate experience and expertise that, in total, means that Government can have reasonable confidence in the consortia's governance, solvency, intervention delivery expertise and ability to work through the Joint Development Phase (JDP).

### 6. There is scope for innovation or experimentation.

SIBs are useful in situations where innovation is required to tackle difficult problems, particularly for multi-dimensional, intractable problems. In the face of difficult and complex problems, new integrated service models can be tested. SIBs are a way for government to trial new programs that can ultimately shape wider government service delivery by demonstrating effective interventions.

### 7. There is an appropriate sharing of risk and returns

The balance of sharing risk and returns between investors, service providers and government needs to ensure value for money for the public and private investors. Risks should be allocated to those parties that are best able to manage them.

# 4. Policy Areas

The SIB pilot program is open to proposals that meet the principles outlined in chapter 3, however preference will be given to the two government priority areas of young people leaving out-of-home care, and ameliorating the impact of drug and alcohol abuse.

## 4.1 Increasing support for young people leaving out-of-home care

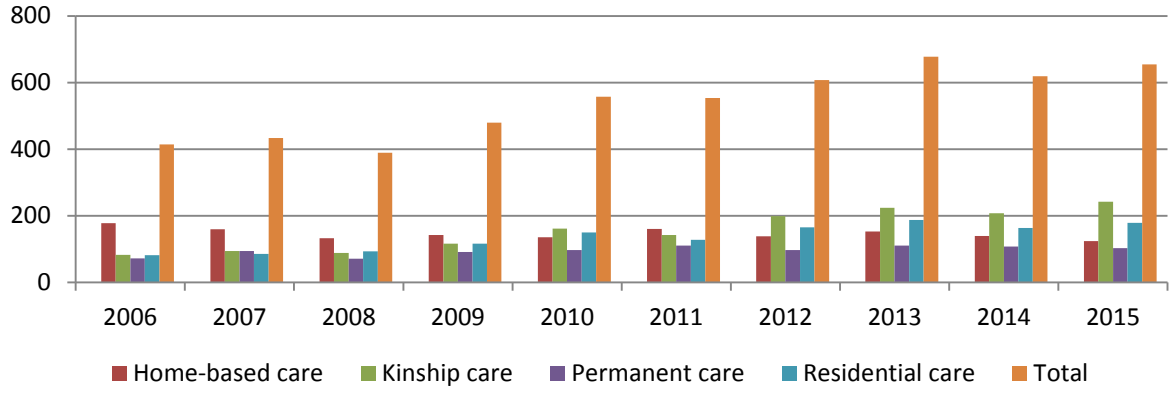
Academic research discussed below indicates that young people leaving out-of-home care (OOHC) are at significantly greater risk of experiencing poorer social and economic outcomes relative to other adolescents that have not previously been cared for in OOHC settings.

This evidence indicates that adolescents transitioning from OOHC settings:

- are less likely to pursue further education as a pathway to employment;
- are more likely to come into contact with police, justice and correctional services;
- are more likely to have child protection involvement with their own children.

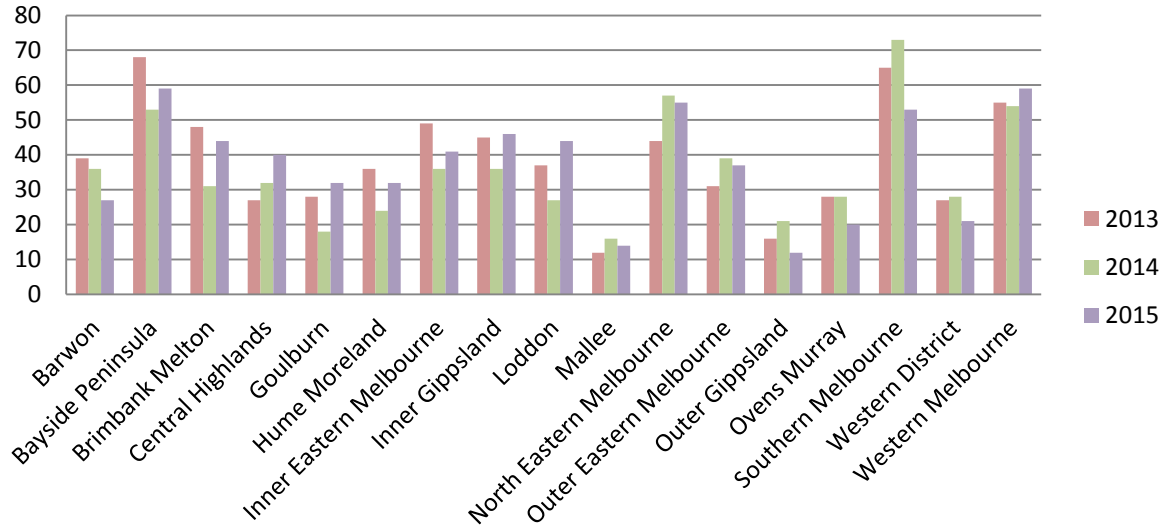
In 2015, 654 young people aged 16-18 left OOHC and transitioned to independence. In 2014, this figure was 619, and in 2013, this figure was 677.

**Chart 4.1.1: Number of Children leaving OOHC by placement type**




Information on the geographical location of the last known residences of those leaving OOHC settings over the years 2013-2015 is included in the following table.

**Chart 4.1.2: Last known address – of OOHC leavers**




An example of a government-funded program is Springboard, which provides intensive support for young people who are on Victorian Custody or Guardianship orders, to transition from residential OOHC. Services include education and training support, assessment and planning that is individually tailored, and referral to other services.

### *Possible outcomes*

The key objective of a SIB funding model is to support young people to transition from OOHC, with success measured in terms of outcomes achieved relative to a control group who have not received the additional program.

While the state does provide support services for young people leaving care, there is an opportunity to develop and assess the effectiveness of innovative service models that assist these young people to transition to successful adult members of society and avoid contact with the criminal justice system.

Depending on the intervention and availability of data, outcome or success measures that may be used include:

- reductions in frequency of contact between young people in the cohort group, and police, justice and corrective services, relative to a control group;
- improved social connection, physical and mental health, and well-being;
- number of participants transitioning to and participating in education, training and/or employment; and,
- for young people in the cohort that are parents – reductions in frequency or absence of contact with social services on matters pertaining to, and necessitating interventions to protect the welfare of those children.

In the SIB design process, interventions and payments for successful achievement of outcomes may be tailored to the specific needs of young people in each of these groups. For example,

children previously in residential care are likely to be a cohort with more complex issues and present more challenges for those delivering an intervention.

### *Cost data*

Data on the costs of providing 'additional' services for young people that leave OOHC settings, over and above services that are provided to young people that are similar in all other respects - but have not had involvement with the OOHC system – is difficult.

Few studies have attempted to place a cost against the additional delivered services that might be used by OOHC leavers, relative to the rest of the population. There are a range of costs that could be considered including health costs, housing, alcohol and other drug services and income support A Monash University study[1] conducted in 2005-2006 indicated the major cost differential between these groups was in courts, police and correctional costs incurred by the leaving OOHC group, but not incurred by young people (on average) with no exposure to the OOHC system.

**Table 4.1.3: Estimated costs for State Government support, per person ($2005, $2015)**

| Category ($2005) | Care | General | Gap | Per Year * (2005) | Per Year* (2015) |
|---|---|---|---|---|---|
| **Police** | $240,134 | $4,543 | $235,591 | $5,609 | $7,156 |
| **Justice and Correctional Services** | $175,598 | $2,918 | $172,680 | $4,111 | $6,913 |

** 'Gap' divided over lifetime assumed to be 42 years which is used to estimate lifetime costs in the Monash study.*

Based on the Monash University study, preliminary modelling suggests that the difference in police, courts and corrections costs occurred between these two groups is on average around $14,000 per year. These costs are calculated by estimating the average costs in these areas for the general population multiplied by the increased likelihood that costs will be incurred in these areas for out-of-home care leavers in the Monash study. The Monash study itself was based on experiences of 60 out-of-home care leavers with at least two years' exposure to the out-of-home care system.

The cost estimates should be used with caution as they are based on a number of assumptions and simplifications, however they provide an indication of probable costs. Further data and / or analysis may be released to inform proposals at a later stage in the SIB process.

[1] Forbes, C, Inder B & Raman, S (2006), *Measuring the cost of leaving care in Victoria*, Monash University, http://webdoc.sub.gwdg.de/ebook/serien/e/monash_univ/wp18-06.pdf, and Forbes, C, Inder B & Raman, S (2005), *Investing for Success – The economics of supporting young people leaving care*, Centre for Excellence in Child and Family Welfare, http://www.cfecfw.asn.au/sites/default/files/Monograph%205%20Investing%20for%20Success%20Web.pdf

## 4.2 Reducing harmful alcohol and other drug use

Harmful alcohol and other drug (AOD) use is a complex and entrenched issue in the Victorian community. It represents a significant cost to the State, placing unnecessary pressure on the health, community services, justice and child protection services.

AOD use has been associated with:

- poor health outcomes including increased risk of injury and poorer mental and physical health;
- family violence;
- homelessness;
- increased anti-social behaviour and contact with police and the criminal justice system; and,
- potentially greater demand for child protection services.

The separation of alcohol and other drug *use* and *harmful use* is a challenging and important aspect of the issues in this area.

For example, the *National Drug Strategy Household Survey 2013* found that more than three-quarters of Victorians consumed alcohol in the 12 months prior to the survey.[2] However most alcohol use does not result in any significant harm although the evidence suggests that there are devastating consequences arising from harmful use for individuals over prolonged periods. Harmful alcohol use resulted in an estimated 819 deaths in Victoria in 2012.[3]

The same survey also concluded that about 14 per cent of Victorians aged 14 or over used an illicit drug in the 12 months prior to the survey.[4] In 2012, there were an estimated 66 deaths in Victoria as a direct result of harmful illicit drug use.[5]

Harmful AOD use places increased pressure on our health and emergency services. Overall, around 40,000 people access treatment through the Victorian alcohol and drug treatment system each year.[6] In 2013-14, the Australian Institute of Health and Welfare found that alcohol was the primary drug of concern in 41 per cent of treatment episodes, followed by cannabis (21 per cent), amphetamines (16 per cent) and heroin (10 per cent).[7]

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2 Australian Institute of Health and Welfare (2014). *National Drug Strategy Household Survey detailed report: 2013,* Illicit drug tables, Table A7.3, Drug statistics series no.28, Cat. no. PHE 183, Canberra, http://www.aihw.gov.au/publication-detail/?id=60129549469

3 Turning Point (2015). *AODstats,* alcohol death events in 2012, Melbourne, http://www.aodstats.org.au/#overview

4 Australian Institute of Health and Welfare (2014). *National Drug Strategy Household Survey detailed report: 2013,* Illicit drug tables, Table A7.3, Drug statistics series no.28, Cat. no. PHE 183, Canberra, http://www.aihw.gov.au/publication-detail/?id=60129549469

5 Turning Point (2015). *AODstats,* illicit drug death events in 2012, Melbourne, http://www.aodstats.org.au/#overview

6 Department of Health and Human Services (2015). *Alcohol and other drug treatment services,* Melbourne, https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services

7 Australian Institute of Health and Welfare (2015). *Alcohol and other drug treatment services in Australia 2013-14: state and territory summaries,* Table SD.8, Drug treatment series no. 25, Cat. no. HSE 158, Canberra, http://www.aihw.gov.au/publication-detail/?id=60129551120

Approximately 4 percent of all emergency department presentations included alcohol and other drugs as a factor in 2012-13.[8]

Ambulance attendances for alcohol and other drug related issues represent a substantial burden on our emergency services. It can cost up to $39 million to provide ambulance callouts for alcohol and other drug related issues per year. On an annual basis, there are approximately 34,000 ambulance attendances for alcohol and other drug related issues.[9]

In terms of criminal behaviour and offending, drug use and possession offences were by far the most common offence recorded in relation to broader drug offences for the year ended March 2016.[10] There were about 23,400 drug use and possession offences recorded during this time.[11] It is important to note that these recorded offences may understate the actual prevalence of alcohol and other drug related crime, as AOD use has been shown to be associated with other offences, including property damage and assault.[12]

As the previous discussion illustrates, a broad cross section of the community experiences and is affected by harmful AOD use. While there are some who manage to limit the effect of their AOD use, for others it is associated with a myriad of negative outcomes. In these cases causality is difficult to ascertain, as cause and effect become confused.

A challenge for a possible SIB in this area is in defining a clear cohort of people at whom the program is aimed. It will involve linking alcohol and drug use with other defining characteristics, such as geographic or social-demographic factors, or those characteristics relating to a specific social problem. The cohort could also be identified by linking other related issues which are associated with harmful AOD use, such as contact with the criminal justice system, homelessness, mental health, or experience of family violence.

Data on the costs of providing services to people with AOD issues is complex and imperfect. This is partly due to the complicated interrelationship that exists between harmful AOD use and the problem behaviours that result in costs to the State.

A summary of the available cost and usage data for various government services by people with AOD related issues is presented in Table 4.2.1. Please note that the justice costs have not been linked with AOD related issues.

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8 Turning Point Alcohol & Drug Centre, AODstats, http://aodstats.org.au. Note that this data only relates to where alcohol and other drugs were the primary reason for presentation.

9 Turning Point Alcohol & Drug Centre, AODstats, http://aodstats.org.au

10 Crime Statistics Agency (2016). *Data tables – Recorded offences,* Tables 1 and 3, Melbourne, http://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/recorded-offences.

11 Ibid.

12 Payne, J. & Gaffney, A. (2012). *How much crime is drug or alcohol related? Self-reported attributions of police detainees,* Trends & issues in crime and criminal justice No.439, Australian Institute of Criminology, Canberra, http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi439.pdf

**Table 4.2.1: Estimated State Government cost and usage data**

| Cost category | Unit of measure | Amount/usage level |
|---|---|---|
| **Justice costs** | | |
| Net operating expenditure, prisons, in 2014-15.[13] | Per prisoner, per day | $297 |
| Real net court costs, 2014-15.[14] (a) | Per finalisation | $317 |
| Police costs associated with court finalisations.[15] (b) | Per finalisation | Approx. $2,700 |
| **Health costs and usage data** | | |
| Number of average annual ambulance attendances for alcohol and other drug issues.[16] | Per year | 34,000 |
| Unweighted estimated metropolitan ambulance attendance cost from 1 July 2016.[17] (c) | Per attendance | $1,174 |
| Proportion of total emergency department presentations for alcohol and other drug issues in 2012-13.[18] | Total presentations (per cent) | Approx. 4 per cent |

**Notes:**

(a) This figure includes cases finalised in all Magistrates' Courts (including Children's Courts) in Victoria only.

(b) Based on Allard et al.'s (2013) findings in Queensland. Figure is indicative only.

(c) This cost is based on fees charged for a standard metro ambulance call out. It does not take into consideration any regional loading or transportation needs (i.e. to hospital).

Preliminary cost modelling suggests that the total expected costs of one person with AOD issues in the health and prison systems is likely to be between $10,000 and $15,000. The actual costs are

13 Steering Committee for the Review of Government Service Provision (2016), *Report on Government Services 2016,* Table 8A.35, Productivity Commission, Canberra. http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/justice

14 Ibid, Table 7A.31.

15 Allard, T., et al. (2013). "The monetary cost of offender trajectories: Findings from Queensland (Australia)", *Australian and New Zealand Journal of Criminology,* 47(1), pp. 47-81. http://www98.griffith.edu.au/dspace/bitstream/handle/10072/57216/92249_1.pdf?sequence=1

16 Turning Point Alcohol & Drug Centre, AODstats, http://aodstats.org.au

17 Ibid. *Ambulance fees,* Melbourne. https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-fees

18 Ibid. Turning Point Alcohol & Drug Centre, AODstats, http://aodstats.org.au

indicative only and are subject to vary on a case-by-case basis, particularly where imprisonment durations and individual supports are concerned.

A cohort that has been explored in further detail is the group of people for which harmful AOD use and offending, particularly re-offending, is associated.

Many people who are in prison experience problems with alcohol and other drug use, and for some of those AOD use may be a significant factor in the offences for which they have been convicted. However these people may not always get access to the treatment and support they need to receive in order to address their AOD issues. Often, they will not be in prison for long enough in order to receive the appropriate transitional support that other offenders may receive.

The available evidence indicates a strong link between people with alcohol and other drug issues and offending behaviour.[19]

- Payne and Gaffney (2012) concluded that about two in every three offenders detained by police tested positive to at least one illicit drug;[20]
- In a meta-analytic review of recidivist predictor domains, Gendreau et al. (1996) found that substance use (amongst other factors) was a strong predictor of recidivism;[21]
- In a study of adult male prisoners in 2001, Makkai and Payne (2003) found that around 62 per cent reported being influenced by illicit drugs or alcohol at the time of their offence which resulted in their later incarceration;[22] and
- The Victorian Ombudsman noted in a 2015 report that alcohol and drug issues are highly prevalent amongst prison populations, and that substance issues are often linked with higher rates of re-offending, in addition to other health complications.[23]

Interventions that are able to provide targeted and integrated support and assistance to pre- and post-release prisoners with harmful AOD use issues may potentially reduce further contact with the criminal justice system.

As at 31 May 2016, there were 6,511 people in the Victorian prison system.[24] This consisted of 6,076 male prisoners (around 93 per cent) and 435 female prisoners (about 7 per cent). In the year ended April 2015, around 65 per cent of prisoners received an effective sentence of less than 12 months with no minimum sentence.[25]

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19 Payne, J. & Gaffney, A. (2012). *How much crime is drug or alcohol related? Self-reported attributions of police detainees,* Trends & issues in crime and criminal justice No.439, Australian Institute of Criminology, Canberra. http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi439.pdf

20 Ibid.

21 Gendreau, P., Little, T., & Goggin, C. (1996). "A meta-analysis of the predictors of adult offender recidivism: what works!", *Criminology,* 34(4), 575-607. https://www.gwern.net/docs/iq/1996-gendreau.pdf

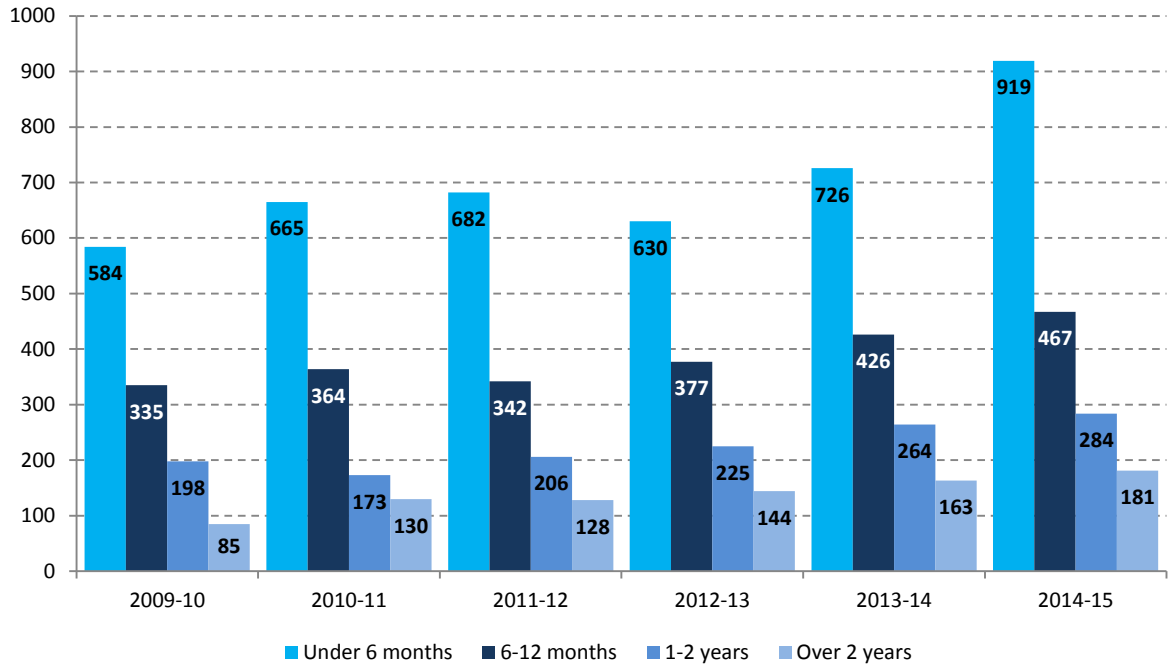
22 Payne, J. & Makkai, T. (2003). *Key findings from the Drug Use Careers of Offenders (DUCO) Study,* Trends & issues in crime and criminal justice No.267, Australian Institute of Criminology, Canberra. http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi267.pdf

23 Glass, D. (2015). *Investigation into the rehabilitation and reintegration of prisoners in Victoria,* p.56, Victorian Ombudsman, Melbourne. https://www.ombudsman.vic.gov.au/getattachment/5188692a-35b6-411f-907e-3e7704f45e17

24 Corrections Victoria (2016), *Monthly prisoner and offender statistics – 2015-16 (to May 2016)*, Department of Justice and Regulation, Melbourne. Retrieved 30 June 2016 from http://www.corrections.vic.gov.au/utility/publications+manuals+and+statistics/monthly+prisoner+and+offender+statistics

25 Corrections Victoria (2015) unpublished data.

**Figure 4.2.2: The number of prisoners returning to prison within two years, by sentence length at discharge, 2009-10 to 2014-15, Victoria.**[26]




*Source:* Corrections Victoria (2015) unpublished.

The major costs associated with imprisonment include various costs associated with involvement in the criminal justice system. These are corrective services costs, court finalisation costs and police costs associated with the court process.

AOD use issues are pervasive and touch every part of society, including the health system and the criminal justice system. As such, there are many other possible groups of people who suffer adverse outcomes associated with alcohol and other drug use.

The cohorts discussed in this section are by no means exhaustive and could potentially include additional cohorts not previously identified.

26 Ibid.

# 5. Process

The release of this Statement of Opportunities is the first step in a formal process designed to bring government and non-government stakeholders together. The Victorian Government anticipates that two workshops and a RFP process will precede a formal JDP with one or more stakeholders/consortia with sufficiently developed proposals.

The proposed consultation stages are outlined below.

## Workshops

Post the information day, there will be two workshops, to be tentatively held on 9 and 31 August 2016. The workshops are planned to provide those interested in developing proposals with a further degree of guidance and opportunity to test assumptions about the development of proposals.

The intention of the workshops is to provide more detailed information on the procurement process while allowing interaction between possible proponents and procurement, legal and financial experts. This should allow stakeholders and consortia to better understand the resources required to bid for involvement in a SIB, and the Government's expectations in that process.

The workshops are intended for parties that have the capability and capacity to engage in the process to attend. The intent is for providers to make an early decision about whether they wish to participate further to ensure resources are not unnecessarily wasted.

It is expected that participants attending the first workshop are those who have formed a consortia, including lead service providers and financial advisors. The half-day workshop would focus on sharing lessons and the experience of SIBs in other jurisdictions, with speakers who have been involved in previous SIBs.

A second workshop would be for providers who have a defined cohort, a proposed intervention, and an idea of the appropriate outcome measures and how they will be assessed. This workshop will provide more specific support and advice. This would include providing access to procurement, legal and financial experts. Details that could be discussed with participants will include how to construct and measure possible outcomes.

## Request for Proposal

The third stage would be the RFP, expected to be released in October 2016. The RFP would require information such as:

- Which organisations are involved in the tender, what are their relationships and capabilities;
- A definition of the proposed cohort, how they will be identified and referred to the program;
- An overview of the proposed intervention, including any case studies or evidence around its efficacy;
- An estimate of the avoided costs to government if the proposed intervention was successful; and
- Possible outcome measures, and how the data would be collected and verified.

## Joint Development Phase (JDP)

Following the RFP, selection and development of preferred proposals would occur towards the end of 2016 and early 2017, including a JDP and contract negotiations.

# 6. Further information

If you would like to register your interest in the SIBs market engagement process and receive regular emails about the progress of this project, we invite you to register your interest by contacting the social impact bonds team at: socialimpactbonds@dtf.vic.gov.au.

Further information about the Victorian Government's SIBs market engagement process is available at www.dtf.vic.gov.au/socialimpactbonds.

Participants are also able to submit questions to the DTF via the email listed above. DTF welcomes questions about this Statement of Opportunities or about the SIBs development process. Questions and answers may be periodically posted on the DTF website.

If you wish a question to be treated in confidence, please include information indicating why and on what grounds you seek confidentiality.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