Minnesota Statewide Initiative to Reduce Recidivism

Combined Application Form Joint Departmental Pilot Initiative

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Abbreviations

Programs

DWP	Diversionary Work Program
EA	Emergency Assistance
GA	General Assistance
MA	Medical Assistance (Medicaid)
MFIP	Minnesota Family Investment Program
MSA	Minnesota Supplemental Aid
RSDI	Retirement, Survivors, and Disability Insurance
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income

Other

EBT	Electronic Benefits Transfer
CAF	Combined Application Form
DOC	Minnesota Department of Corrections
DHS	Minnesota Department of Human Services
MNSIRR	Minnesota Statewide Initiative to Reduce Recidivism
MNSTARR	Minnesota Screening Tool Assessing Recidivism Risk
SOAR	SSI/SSDI Outreach, Access and Recovery

Executive Summary

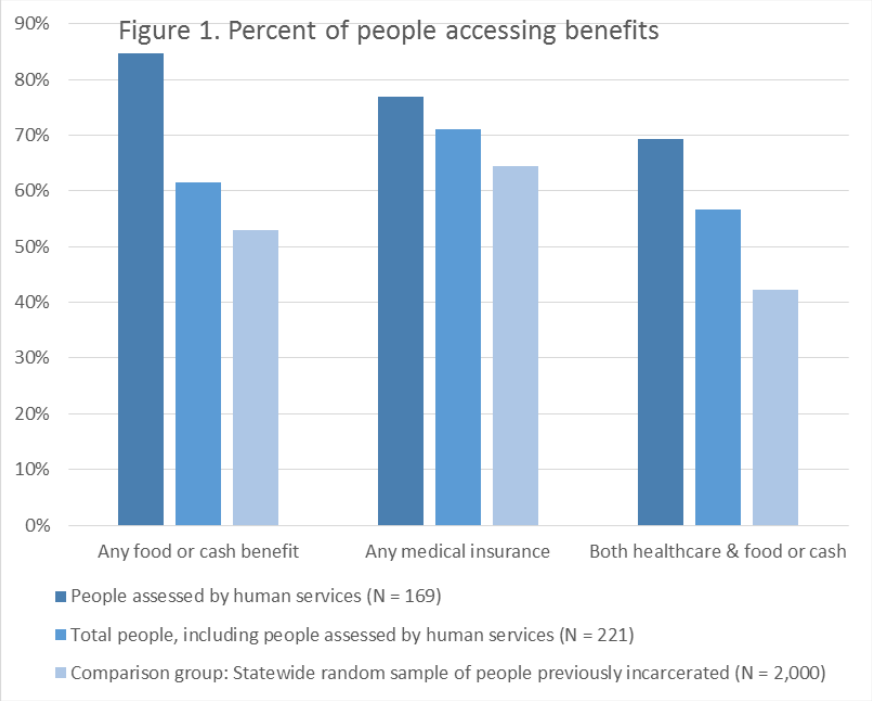
The Joint Departmental Pilot Initiative is a new collaboration between Minnesota's Departments of Corrections (DOC) and Human Services (DHS) to better assist people re-entering the community after release from a Minnesota Correctional Facility. The Pilot was initiated as a part of the Minnesota Statewide Initiative to Reduce Recidivism (MNSIRR) and focused on gaps in the pre-release planning processes that act as barriers to essential services and benefits. By providing the supports needed to have a stable and successful community re-entry, the Joint Departmental Pilot Initiative aims to reduce recidivism.

Beginning in September 2017, DOC and DHS processed applications for healthcare and food or cash assistance for people released from a Minnesota Correctional Facility. After release, DHS helped transfer people's cases to one of the 11 participating counties and provide ongoing support.

Using administrative data for Pilot Initiative participants released September 2017 through May 2018, DHS staff evaluated the benefits accessed by the total 221 people who received DOC services. Additional focus was given to the 169 people assessed by DHS for human services as part of the Pilot Initiative. These early results were compared with results from a statewide random sample of people released from a correctional facility in previous years who would otherwise have been eligible.

Key evaluation findings

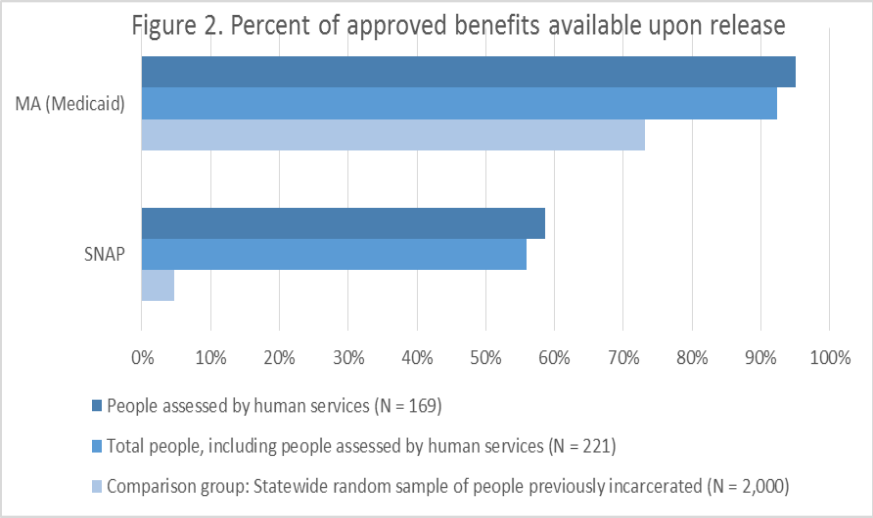
- Most people in the Pilot Initiative have experienced homelessness, been on some type of public assistance in the past, and have been diagnosed with a chemical dependency and/or mental health disorder.
- People in the Pilot Initiative were more likely to receive benefits, and more likely to receive them sooner, than those in the comparison group.
- Over half the people accessed food assistance, with the majority having the benefit ready for use upon release.



- Nearly three-fourths of the people accessed healthcare benefits, and over 90 percent of these benefits were available upon release.

- Over one-fifth of the people were released into homelessness and one-fourth were homeless within one month of release.

- DOC and DHS identified barriers to accessing assistance as well as ways to improve collaboration, case management, and service delivery.



Introduction

The Joint Departmental Pilot Initiative (Pilot Initiative, herein) is a collaboration between Minnesota's Departments of Corrections (DOC) and Human Services (DHS) that was created to identify gaps in the pre-release planning processes that may hurt an individual's best chance for successful re-entry into the community. As part of this Pilot Initiative, DOC and DHS process applications for healthcare and food or cash assistance for people being released from Minnesota Correctional Facilities thirty days or less before release. DOC is responsible for identifying the eligible target population of adults considered to be at a high risk of recidivism per the Minnesota Screening Tool Assessing Recidivism Risk (MNSTARR), and who will be released to one of the 11 participating MNSIRR counties: Anoka, Beltrami, Carlton, Dakota, Hennepin, Olmsted, Ramsey, St. Louis, Stearns, Washington, and Wright.

As part of the collaboration, DOC funded and DHS hired two staff for the Pilot Initiative. These hired staff ensure that processed forms are transferred to the appropriate county upon a person's release. They also meet with correctional facility staff, offenders, and/or county workers to exchange information and to identify and improve any gaps in the process. Over the course of their work, DHS staff track data on the release and enrollment process and its outcomes. With assistance from DOC staff, DHS evaluators examined early results from the work performed as part of the Pilot Initiative. The findings to date and recommendations form the body of this report. Figure 3 highlights DOC and DHS roles and responsibilities as part of the Pilot Initiative.

Figure 3: DOC and DHS collaboration and Pilot Initiative responsibilities

Department of Corrections Responsibilities

- Identify eligible offenders who are at a high or very high risk of recidivism
- Provide intensive case management to eligible participants
- Fund staff at DHS for the Pilot Initiative
- Complete medical opinion forms for eligibility as needed
- Refer participants to DHS within 30 days of participants' release

Department of Human Services Responsibilities

- Interview participants in person or over the phone to assess eligibility for healthcare and food or cash assistance
- Approve and process applications
- Provide ongoing case management assistance
    - Help coordinate care
    - Address barriers to access or administrative errors
    - Refer participants to additional service

The Bureau of Justice Assistance awarded a Second Chance Act Grant to Minnesota to fund the MNSIRR collaboration bringing together state and county systems, community service providers and other stakeholders to reduce recidivism. MNSIRR's vision is that upon release, every offender will have access to the services, support and resources they need to succeed in the community. The Pilot Initiative was a part of the MNSIRR implementation.

The Combined Application Form (CAF) workgroup was also instrumental in supporting the Pilot Initiative. The workgroup theorizes, based on available data, experience and observation, that the CAF process for pre-release offenders is crucial to how well criminally vulnerable offenders re-enter the community.

This project is supported by Grant No. 2014-CZ-BX-0023 awarded by the Bureau of Justice Assistance (BJA). BJA is a component of the Department of Justice's Office of Justice Programs, which includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for the Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Background literature

Recidivism, defined here as being re-arrested after release from a correctional institution, reflects the inability for some offenders to successfully integrate back into society. While recidivism statistics are not widely collected, the available evidence suggests relatively low success rates for offenders released into the community. The Bureau of Justice Statistics (Carson & Golinelli, 2013) reported in 2007 that 68 percent of released offenders were rearrested within 3 years. The social cost of new crimes and the economic costs of policing and imprisonment make reducing recidivism an important goal. As a consequence, recent years have seen a growing effort to study what causes recidivism and what can be done to reduce it. A reference list for the literature cited in this section is included as Appendix A.

Predictors of recidivism: Demographics and personal history

A review of the available research literature found several commonly cited predictors of recidivism. Some of these predictors are based on demographics. These predictors include age, sex, education, and marital status. On average, research has found that people who are younger, male, less educated, and/or single are more likely to re-offend than other individuals. Having a diagnosis of anti-social personality disorder or having used a weapon in a past crime also signal a greater likelihood of reoffending (Gendreau, Little, & Goggin, 1996; Hanson & Bussiere, 1998; Makarios, Steiner, &Travis III, 2010; Olver, Stockdale, & Wormith, 2011).

Predictors of recidivism: Housing stability and healthcare systems use

Additional research has shown how one's post-release housing stability and access to services affects recidivism. Multiple meta-analyses of studies on recidivism highlight housing stability as crucial to successful re-entry into society and decreases the risk of re-offense (Makarios, Steiner, &Travis III, 2010; Lutze, Rosky, & Hamilton, 2014). A groundbreaking 1999 study of recidivism in New York City found those living in temporary shelters upon release faced greater challenges in resisting drugs and finding jobs. People who were expecting to rely on shelters for housing upon release were also over seven times more likely to flee from parole supervision than people who said they were not going to be living in a shelter after release (Nelson, Deess, & Allen 1999).

An earlier study on recidivism in Georgia found that the odds of a new arrest increased 25 percent for every address move experienced by parolees (Meredith, Speir, & Johnson, 2007; Makarios, Steiner, &Travis III, 2010). A more recent example comes from Washington State, which offers up to 12 months of housing support to

qualified offenders willing to engage in treatment and work toward self-sustainability. An evaluation of this program found that the housing support provided reduced recidivism for new crimes, and that periods of homelessness contributed to revocations and new convictions (Lutze, Rosky, & Hamilton, 2014).

Supportive housing, and housing stability more generally, has been shown to reduce emergency department use, hospital admissions, and follow-through with psychological and/or chemical dependency treatment (Culhane, Metraux, & Hadley, 2002; Makarios, Steiner, &Travis III, 2010). Such healthcare system utilization has also been shown to help predict recidivism (Gendreau, Little, & Goggin, 1996; Olver, Stockdale, & Wormith, 2011). Therefore, the effects of housing and healthcare on recidivism are very closely linked. However, most public housing policies forbid people with a criminal record for either drug convictions or sex offenses from accessing public housing (Hall, Wooten & Lundgren, 2016).

Predictors of recidivism: Employment and income supports

Economic security, including both work and other income supports, improves the odds for successful reentry into the community after release from prison (Lutze, Rosky, & Hamilton, 2014). A prior intensive case management program in Minnesota highlighted that employment reduced recidivism among its high risk participants (Duwe, 2012). Other research on programs meant to reduce recidivism has found that offenders who kept stable employment were significantly less likely to be rearrested than those without a job, but people who had other sources of income (including Social Security, VA pension, disability, or other public assistance) were less likely to reoffend (Makarios, Steiner, &Travis III, 2010).

Past efforts in Minnesota

In 2008 Minnesota's DOC implemented a pilot project for offenders called the Minnesota Comprehensive Offender Reentry Plan (MCORP). As described in the final evaluation of the project, "The MCORP pilot project attempted to increase offender access to community services and programming by producing greater case management collaboration between caseworkers in prison and supervision agents in the community" (Duwe, 2013, p. 2). Participants worked with their prison caseworkers and community supervision agents to develop strategies to prevent recidivism through motivational interviewing and goal planning strategies to address gaps between incarceration and release. The findings suggest that the pilot project reduced both recidivism and costs. The MCORP pilot project shares similarities with the Joint Departmental Pilot Initiative evaluated in this report, such as intensive case management and a focus on improving the release process.

Structure of the report

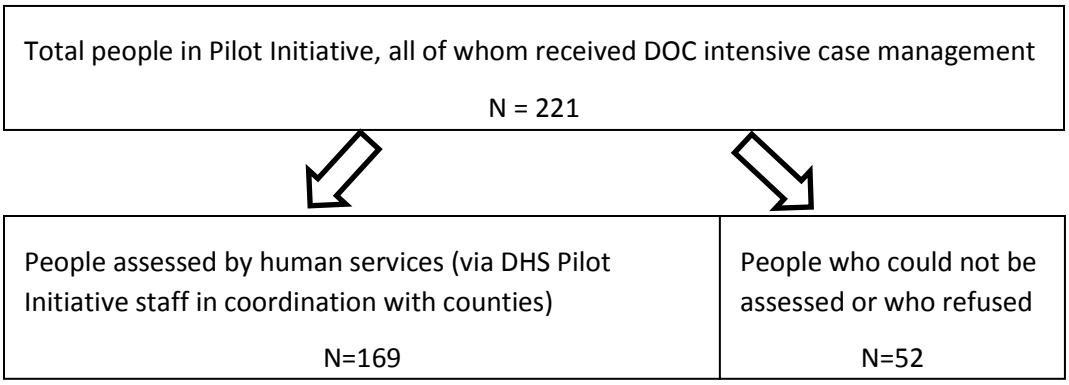
The remainder of this report first describes the characteristics of people served in the Pilot Initiative. Next the report discusses the process and structure of release and the Pilot Initiative intervention efforts to assess and provide services to individuals. The evaluation then analyzes the extent to which people accessed various public assistance programs and services. To the extent possible, these findings will be compared against similar groups of high risk released offenders who did not have the opportunity to participate in the project. After discussing the results, the report concludes with lessons learned to date, and recommendations for future efforts.

Data Evaluation of People Served and Benefits Accessed

Participant characteristics

In total, DOC identified more than 700 people to participate in the collaborative Pilot Initiative. Of those 700 people, 221 were released between September 2017, the start of the Pilot Initiative, and May 2018 and are included in this evaluation. These people all received DOC intensive case management services as part of the Pilot Initiative and were referred to DHS for additional services. After examining the characteristics and history of all people in the Pilot Initiative, the data evaluation focuses on the 169 people assessed by DHS Pilot Initiative staff for benefit eligibility and for whom DHS helped coordinate benefits. This group of 169 people will be referred as "people assessed by human services" for the remainder of this section, compared to the overall group of 221 people. Figure 4 illustrates how people in the Pilot Initiative were categorized for this report.

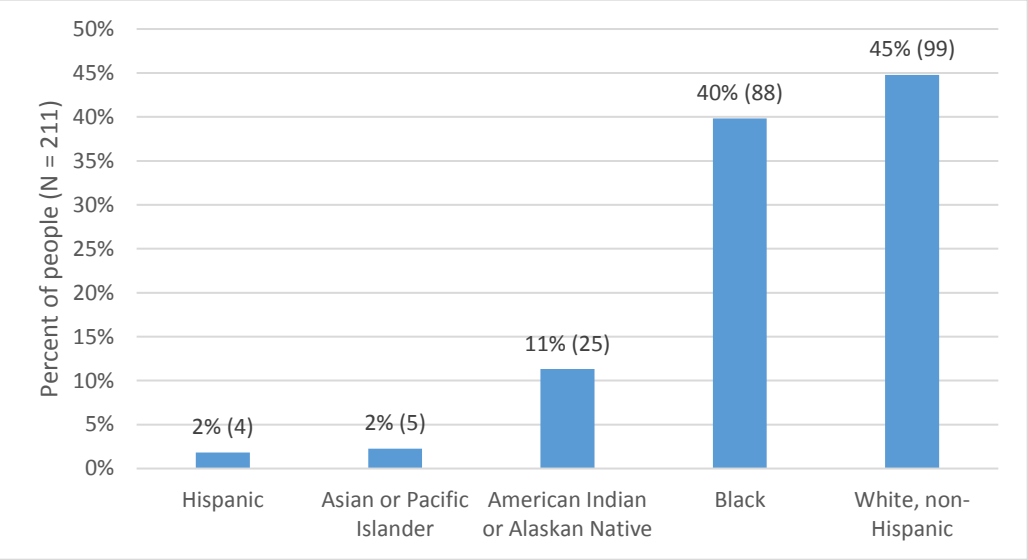
Figure 4. Breakout of Pilot Initiative participants by whether they were assessed by human services.



Demographics

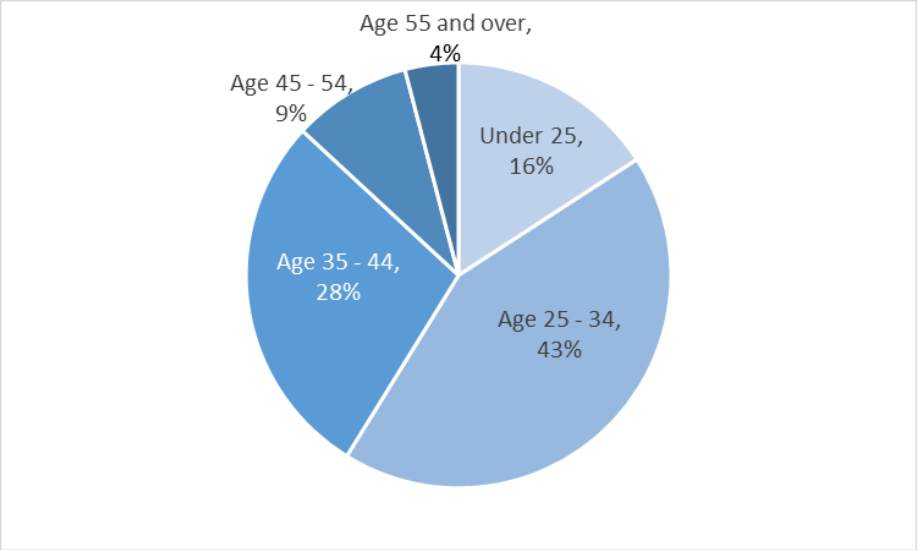
Nine out of ten people in the Pilot Initiative were male. Most participants were either white non-Hispanic (45 percent), or black (40 percent). Female participants were more likely to be American Indian than male participants, with 47 percent of female participants being American Indian compared to 8 percent of male participants. Figure 5 shows the percentage of people in the Pilot Initiative by their race and ethnicity (person counts for each category are included in parentheses).

Figure 5. Race and ethnicity of people released September 2017 through May 2018



The largest number of people in the Pilot Initiative were aged 25 to 34 (43 percent), followed by those aged 35 to 44 (28 percent), and those under 25 (16 percent). Figure 6 illustrates the distribution of participants by their age upon release from prison.

Figure 6. Age of people in Pilot Initiative upon release

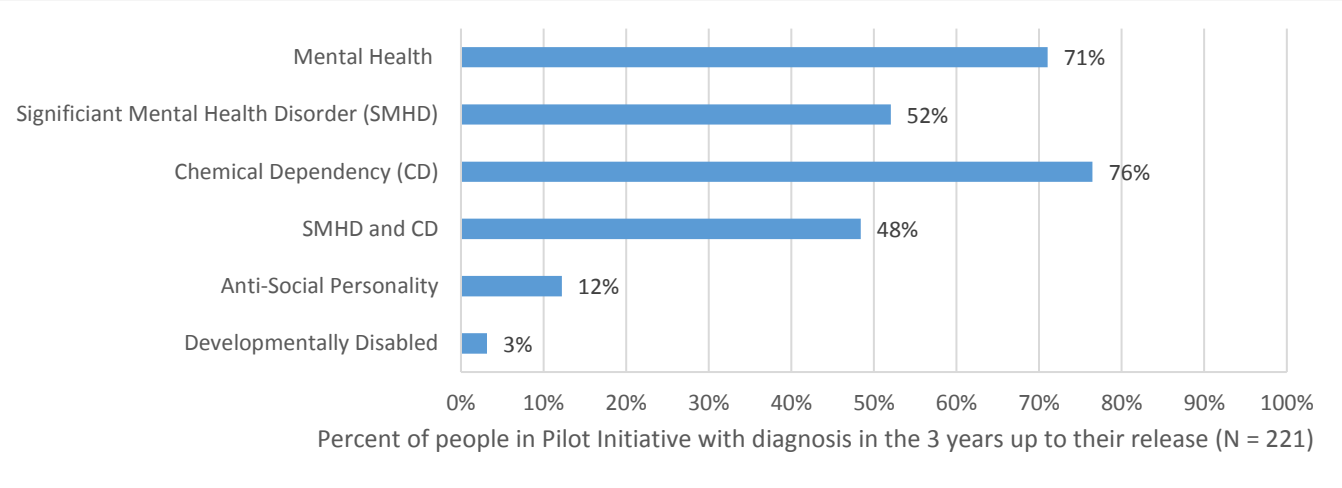


Public medical insurance history

Ninety-six percent of people in the Pilot Initiative had at some point received public health insurance before incarceration; 93 percent had enrolled in Medical Assistance. Public medical insurance claims data show that prior to their release, many participants had documented mental and/or chemical health issues. Chemical dependency issues were the most common health conditions examined, with 76 percent having had a diagnosis related to drug and/or alcohol dependency in the three years prior to release. Seventy percent of participants have a history of mental health diagnoses, including 59 percent diagnosed with a significant mental health disorder. The following diagnoses were included in this category: bipolar disorder, schizophrenia and schizoaffective disorder, PTSD, and other serious psychotic or delusional disorders. Nearly half of those in the Pilot Initiative had diagnoses for *both* significant mental health disorder and chemical dependency within the last three years. Figure 7 provides a breakout of these public health insurance diagnosis groupings.

In addition, 30 people (14 percent) were diagnosed as having anti-social personality disorder, which was cited in the background literature as having been shown to be associated with criminal behavior and recidivism. Seven people were diagnosed with a developmental disability, which can be a barrier to navigating the application and eligibility process for benefits, not to mention re-entry into the community.

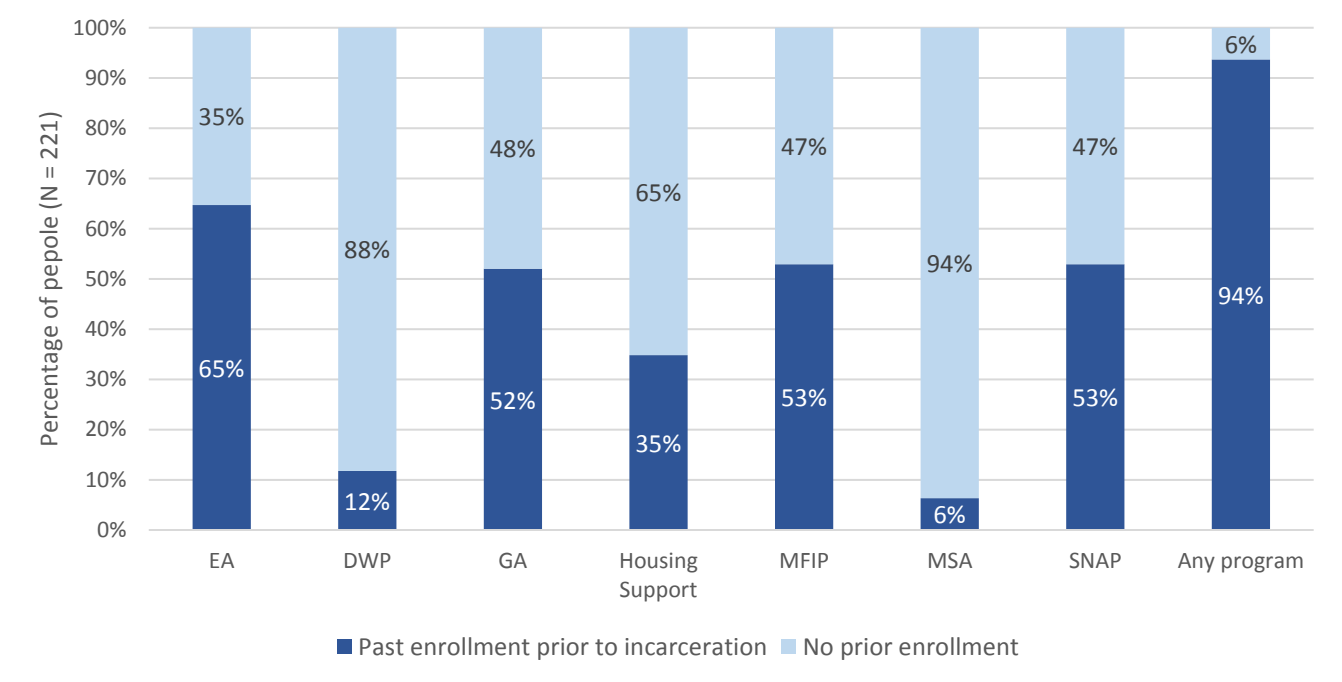
Figure 7. Public health insurance diagnoses in the three years prior to release



Public food and cash assistance history

Similar to the high rates of prior public medical health insurance, nearly everyone in the Pilot Initiative had been enrolled in one of several food or cash assistance programs at some prior to incarceration.[1] The most commonly used food and cash assistance programs were temporary Emergency Assistance (EA), with 65 percent of participants; Minnesota Family Investment Program (MFIP) and Supplemental Nutritional Assistance Program (SNAP), each with 53 percent; and General Assistance (GA), with 52 percent. Other food and cash assistance programs previously used by participants included Housing Support (formerly known as Group Residential Housing), Diversionary Work Program (DWP), and Minnesota Supplemental Aid (MSA). Figure 8 shows the proportions of participants who had enrolled in food or cash assistance programs prior to prison. Appendix B provides a brief description of these food and cash programs.

Figure 8. Percent of people previously enrolled in public food or cash assistance programs



Earned income and SSI/RSDI income history

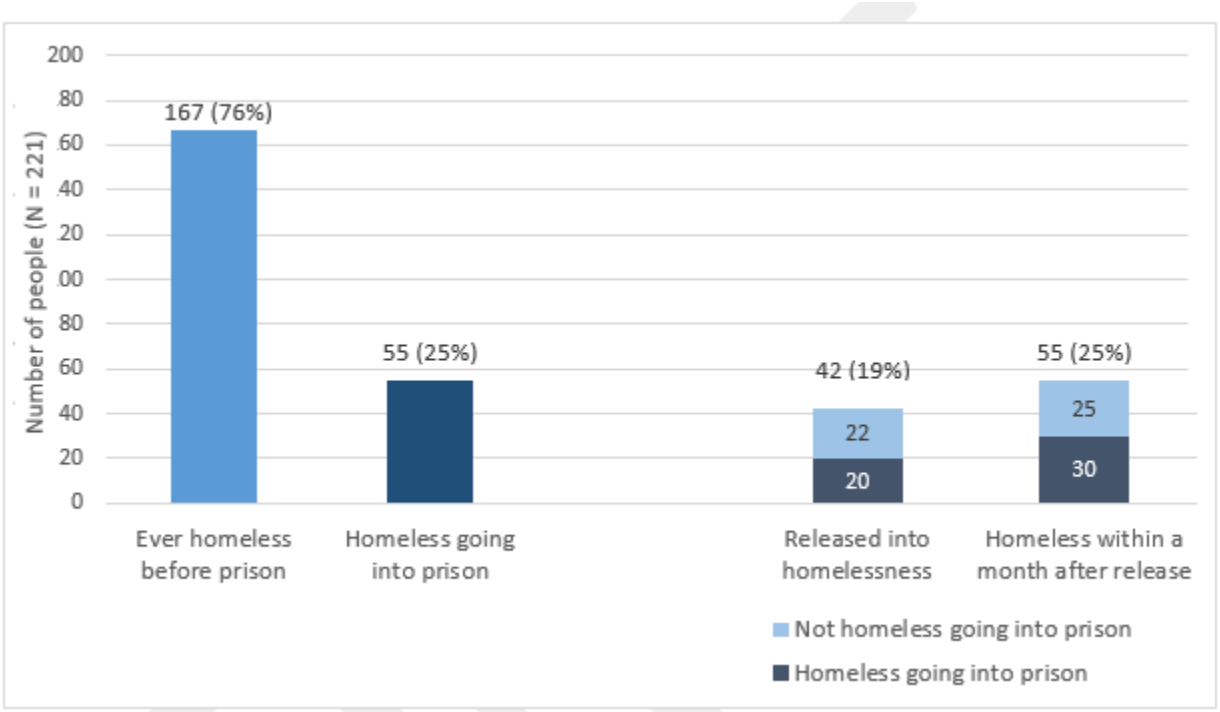
People enrolled in public cash or food assistance must also report any earned or unearned income during their period of enrollment. A majority of people in the Pilot Initiative (62 percent) had reported earned income prior to incarceration. For unearned income, 15 percent of participants had reported either Supplemental Security Income (SSI) or Retirement, Survivors, Disability Insurance (RSDI) income. In addition, five percent had a disability verified by a State Medical Review Team before being incarcerated.

[1] While medical diagnoses can be given while someone is incarcerated, one would not be eligible for the food and cash programs while incarcerated. This is why prior medical claims were analyzed up to a person's release while food and cash assistance use was analyzed up to a person's incarceration.

Homelessness

Using data on those enrolled in public cash or food assistance programs, 167 of the 221 total people in the Pilot Initiative (76 percent) were identified as having experienced homelessness prior to incarceration. One-fourth of all participants were homeless at the time of their incarceration. Similarly, one out of every four participants experienced homelessness within a month of release, and nearly one-fifth of participants were released directly into homeless living situations. Close to half of those homeless after release had been homeless at the time of their incarceration. Figure 9 shows how many people in the Pilot Initiative have experienced homelessness.

Figure 9. Homelessness before and after incarceration



Release from corrections and Pilot Initiative staff efforts

While incarcerated, DOC staff provided additional case management services and identified people eligible to participate in the Pilot Initiative. DOC also helped ensure that people obtained signed medical opinion forms needed to be eligible for certain types of public assistance. Throughout the Pilot Initiative effort, DOC will regularly provide updated lists of participants with upcoming release dates so that these people could be assessed by human services in a timely way.

As part of their work, DHS Pilot Initiative staff compiled DOC lists of participants with upcoming release dates and attempted to contact and assess these people for benefits in the month prior to their release. This assessment process was completed either by phone or in-person interview. This involved DHS Pilot Initiative staff contacting and coordinating with Correctional Facility staff to identify periods when an incarcerated participant might be free for the required interview to assess eligibility for benefits. Some programs, such as

MFIP, require an in-person interview so DHS Pilot Initiative staff travelled to Correctional Facilities for interviewing participants as needed. Upon release, DHS Pilot Initiative staff provided case management, assisted in coordinating benefits, and aimed to meet people where they are at when possible. When participants' benefit cases were transferred to their county of service, DHS Pilot Initiative staff persistently followed up with financial workers, supervision agents, and participants to ensure that required application materials were submitted.

DHS Pilot Initiative staff took on the added task of correcting any administrative barriers or errors that adversely affect a participant's eligibility. Otherwise, people typically must navigate layers of government bureaucracy themselves when gathering documents, applying for benefits, and correcting errors that affect their benefits—all of which is done by the Pilot Initiative. Some of the many examples of the added benefits participants experienced include having Pilot Initiative staff:

- Correct when participants are incorrectly assigned another person's Electronic Benefits Transfer (EBT) card;
- Resolve barriers to accessing pharmacy prescriptions by providing needed authorization on behalf of participants when formal paperwork has not yet arrived;
- Refer people with disabling conditions and/or prior SSI or RSDI disability history to SSI/SSDI Outreach, Access and Recovery (SOAR) providers for help applying for these benefits; and
- Expedite food assistance benefits for those experiencing homelessness and assist these people in applying for Housing Support.
- Coordinate with county offices and state agencies to provide valid photo ID and birth certificate copies needed for participants to verify their work authorization with new employers.

Highlighted Success Stories

- *Pilot Initiative staff helped a participant access chemical dependency treatment after release, traveled to the facility to assess benefit eligibility, and worked with child protection in re-uniting the participant with her children.*
- *Pilot Initiative staff coordinated with agency and local pharmacy staff when a participant was denied needed prescriptions during a mental health crisis—ensuring the participant accessed the needed medication the same day.*
- *After participants' release, Pilot Initiative staff navigated health care barriers and worked with primary care physicians to obtain the medial opinion forms needed to verify eligibility for cash assistance programs.*

Eleven counties agreed to assist with the Pilot Initiative. Table 1 provides a breakout by county for the 221 participants released from Minnesota Correctional Facilities from September 2017 through May 2018.

Table 1: Pilot Initiative participants by county

County	Number of Participants	Percentage
Anoka	21	10%
Beltrami	8	4%
Carlton	4	2%
Dakota	34	15%
Hennepin	10	5%
Olmsted	15	7%
Ramsey	73	33%
St. Louis	24	11%
Stearns	20	9%
Washington	7	3%
Wright	5	2%
All	221	100%

In their collaboration efforts with DOC and county staff, DHS Pilot Initiative staff were able to successfully assess 169 of the 221 people for public assistance. As listed in Table 2, the most common barriers to assessing and engaging participants were county staff not responding to phone calls and emails, inability to interview participants before their release, and participant refusal of services.

Table 2: Ability to contact and assess people for benefits

Result of DHS Outreach Efforts	Number of People	Percentage
DHS successfully contacted and assessed for public assistance	169	76.5%
County would not respond to attempts to gain needed participant information for assistance	28	12.7%
Participant refused all assistance	9	4.1%
Participant refused cash and food assistance	3	1.4%
DHS could not contact participants before release	12	5.4%
List of identified people was not received until after their release	8	3.6%
Lino Lakes correctional facility unexpectedly ceased participating in the Pilot Initiative	2	0.9%
"Privileged" case with information withheld	1	0.5%
Participant held in restrictive housing until release	1	0.5%
Total	221	100.0%

Methodology for analyzing and comparing benefits accessed

At the time of this evaluation, complete data for healthcare and food or cash assistance eligibility were available through May 2018. The primary treatment group for the Pilot Initiative includes the 169 people who were assessed by human services in addition to having received DOC pre-release services. To provide a similar analysis for those are considered failed attempts at contacting participants as part of the treatment effort, public assistance benefits were also analyzed for the full group of the 221 total people in the Pilot Initiative. Examining assistance use for all 221 people also helps address potential self-selection bias (i.e., account for those who were offered assistance by DHS but who refused).

While no randomized control group was assigned over the course of Pilot Initiative activities, comparison groups can be constructed based on combined DOC and DHS data. To help form a comparison group, DOC provided statewide data for persons considered high or very high risk of recidivism who were released from a Minnesota Correctional Facility between 2014 and 2016. A random sample of 2,000 people from this dataset served as one method of comparison.

A second method narrowed the DOC dataset to a comparison group of 500 people whose most recent public food or cash assistance was handled by one of the 11 counties participating in the Pilot Initiatives. This method assumes that once released, if this population were to seek assistance it would likely be in the participating county they were most recently affiliated with. The method has the advantage of helping control for differences between how the participating counties administer eligibility and operate compared to the other 76 counties in Minnesota. However, limiting the comparison group to those with prior public assistance may bias rates for post release benefit use slightly upward.

For members in each of the two comparison groups of people released 2014 through 2016, nine months of post release public assistance data were examined. Nine months was chosen because this is the maximum number of post release months of data available for Pilot Initiative participants released in September 2017 (the start of the Pilot Initiative's efforts). However, participants in this treatment group released in each subsequent month through May 2018 have comparatively fewer months' of data available. In this sense, the across-the-board look at nine months' data is generous in counting benefits accessed by the two comparison groups.

Comparing across groups as follows assumes similar populations and assumes that there were no external factors specific to the time period included for each group that would differently affect how benefits are applied for and approved.

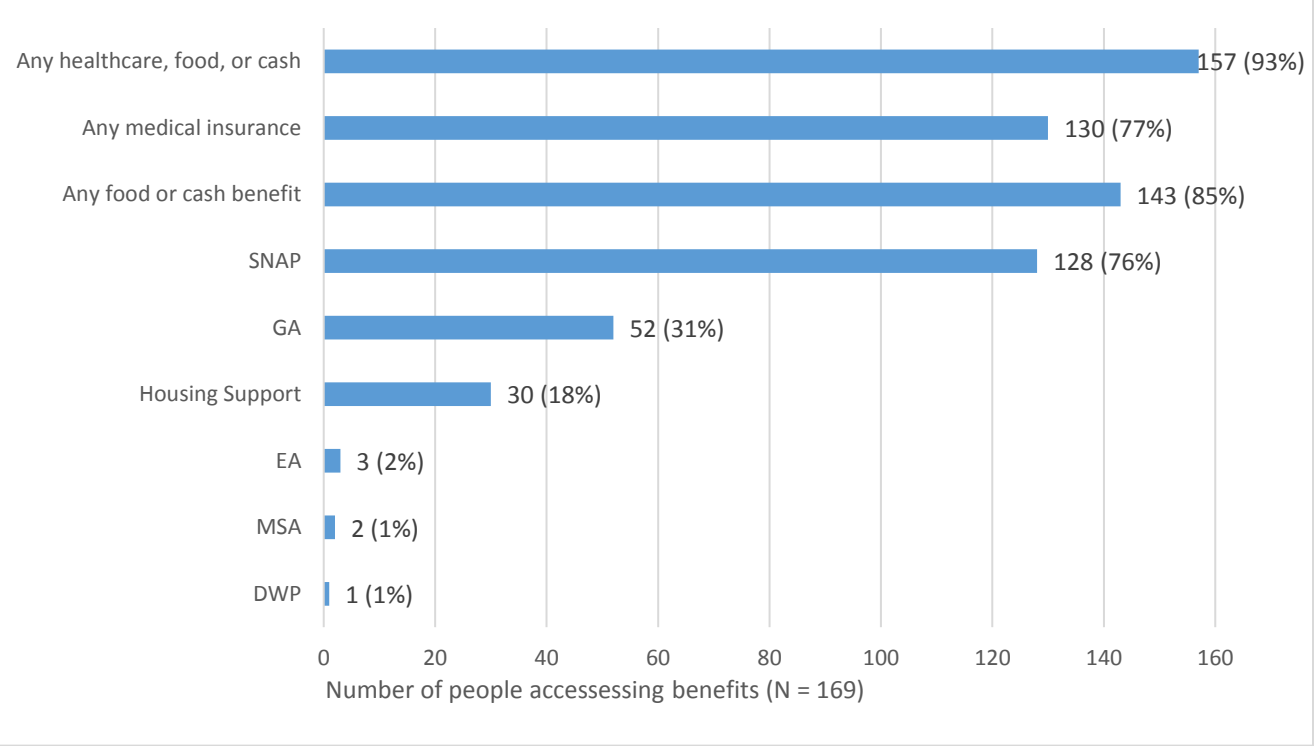
Initial results

The following results section begins by focusing on the 169 people assessed for services by DHS Pilot Initiative staff. The results for these 169 people, who will be referred as "people assessed by human services", will then be compared with the 221 total people in the Pilot Initiative, as well as by the two comparison groups formed from high and very high risk persons released between 2014 and 2016.

Benefits accessed by people assessed by human services

Of the 169 people assessed by human services, 157 (93 percent) were approved for either healthcare or food or cash benefits. Medical insurance, which primarily included Medical Assistance, was approved for 130 people (77 percent). Food or cash benefits were accessed by 143 people (85 percent). Over three-fourths of people assessed by human services enrolled in SNAP, while 52 people (31 percent) enrolled in GA, and 30 people (18 percent) enrolled in Housing Support. Figure 10 charts the range of benefits approved for the 169 people assessed by human services.

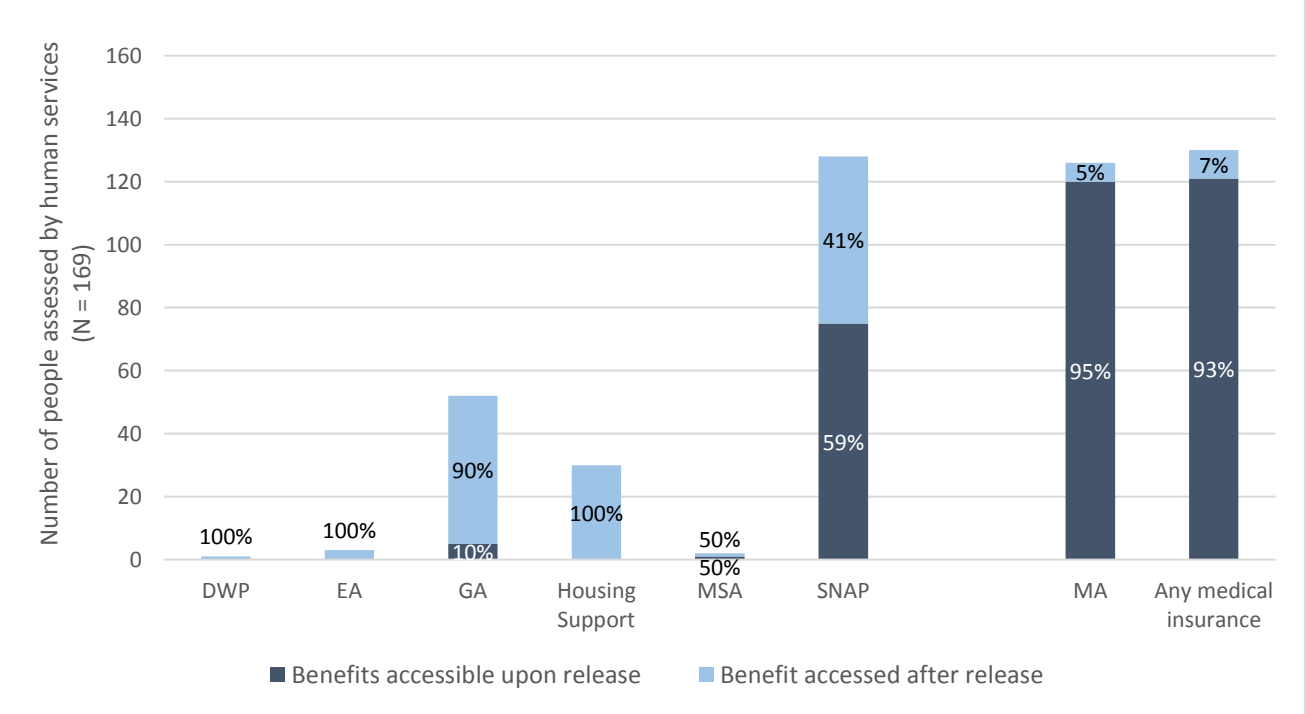
Figure 10. Benefits approved for people assessed by human services



One goal of the Pilot Initiative was to approve and enroll people in benefits as early as possible to reduce barriers for re-entering the community. Through coordination between DOC, DHS, and participating counties, nearly all of the participants who received public health insurance had their healthcare benefits available upon release from prison. Six out of every ten participants approved for SNAP were also able to access their benefit as soon as they were released. Among those who did not have SNAP available immediately upon release, over half were approved for SNAP within two weeks of release.

For other programs, it is more difficult to become eligible while still incarcerated. For example, parents who have lost custody of their children as a result of being incarcerated may not be eligible for DWP or MFIP until they are released and able to regain custody. For EA, people need income beyond the benefit amount sought, which is a barrier for those incarcerated with low amounts of income. Figure 11 provides a breakout of the number of people assessed by human services who were approved for benefits, by whether their benefits were available upon release.

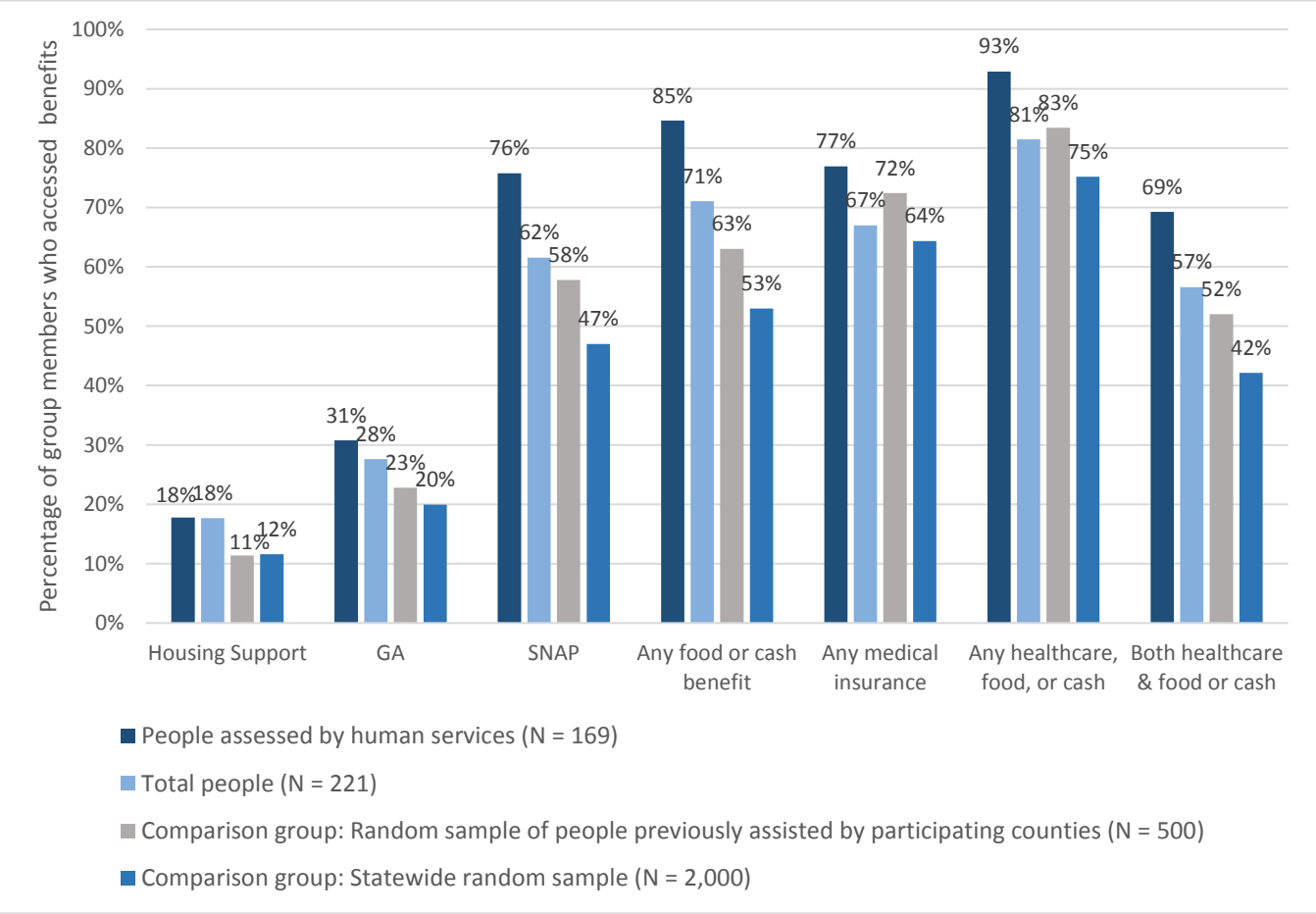
Figure 11. Percentage of people assessed by human services who had benefits available upon release versus available after release



Comparison of benefits

People in the Pilot Initiative who were assessed by human services were more likely to access each healthcare and food or cash assistance benefit than members of either comparison group; they were also more likely to access benefits than when looking at all 221 people in the Pilot Initiative. The overall Pilot Initiative population of 221 was still more likely to access Housing Support, GA, SNAP, and to be enrolled in both healthcare and food or cash assistance programs over the nine months analyzed than members of either comparison group. Figure 12 visualizes this comparison in benefits, while not depicting the public assistance programs with very low post release enrollments across all groups.

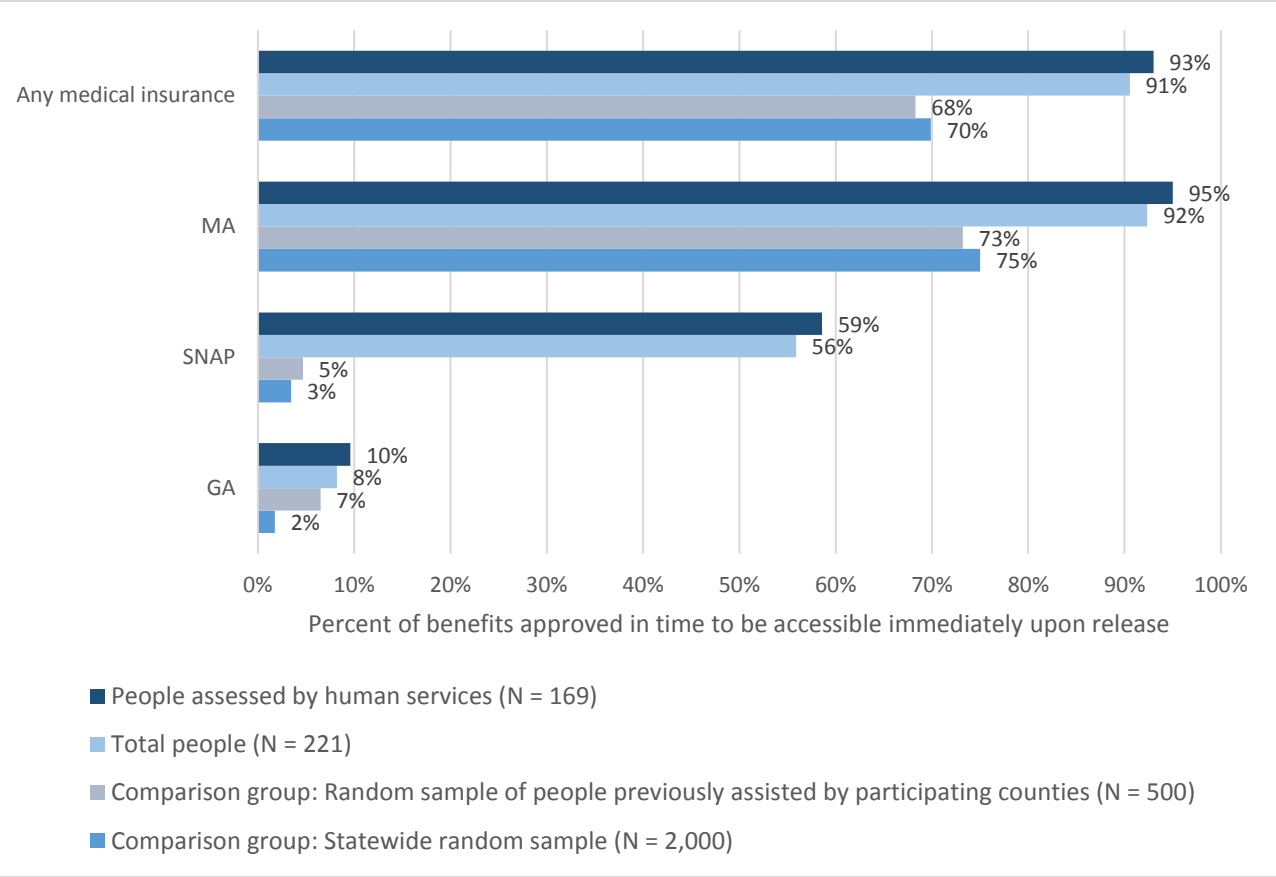
Figure 12. Comparison of public assistance benefits accessed



People in the Pilot Initiative were more likely to have healthcare and food or cash assistance benefits available immediately upon their release than either comparison group. This difference was starkest for SNAP. Over half the people in the Pilot Initiative who were approved for SNAP had their food assistance available upon their release, compared to five percent of the comparison group of those previously served by participating counties and three percent of the statewide comparison group.

Regarding healthcare benefits, people in the Pilot Initiative were more likely to have their health insurance ready upon re-entering the community than were members of either comparison group. Figure 13 compares what proportions of those approved for benefits had their benefits ready upon release.

Figure 13. Comparison of approved benefits accessible immediately upon release



Discussion of initial findings

Even with the acknowledged limitations, early results from the Pilot Initiative are quite promising. When compared to similar groups, people in the Pilot Initiative were more likely to access important healthcare, food, and certain cash benefits. With over 90 percent of people accessing health insurance—and 90 percent of these having healthcare available upon release—people in the Pilot Initiative re-entered the community with the ability to better take care of their physical and mental wellbeing. Over half of people assessed by human services also achieved greater food security by enrolling in SNAP and were more likely to have GA and Housing Support cash assistance. Taken together, these results suggest that the initial goals of the Pilot Initiative are largely being

met to date. It is too soon to judge access to other cash assistance programs, as these were seldom used among comparable groups, and people released September 2017 through May 2018 may not yet have had sufficient time to establish eligibility criteria post release.

Suggestions for future evaluation efforts

At the time of this evaluation, too few months have passed to have any substantive data on re-offenses and recidivism. Future evaluations should include data on recidivism for people served by the Pilot Initiative, and then compare recidivism rates with a similar population. It is also too early to gauge how well people are accessing certain cash assistance programs, so follow-up evaluations should examine if assistance has improved over time. If resources allow, future evaluations may apply more rigorous statistical methods when defining a comparison group, such as attempting to statistically control for age, gender, race, education, and other relevant factors that may influence the likelihood one applies for and/or receives benefits (for example, through propensity score matching and/or regression analysis).

Implementation Lessons Learned

Over the course of the Pilot Initiative, DOC and DHS's collaboration has identified several gaps in the pre-and post-release process. Both agencies have worked to correct these gaps to improve ongoing and future operations so that people are released with the best chance of success. This section summarizes areas where staff have identified gaps around the release process and their proposed solutions.

Medical opinion forms

In the early months of the Pilot Initiative, fewer people were released with a signed a medical opinion form than expected. Medical opinion forms are typically administered and signed by medical providers working in the correctional facility. These forms are required to help determine eligibility for most food and cash assistance programs. To ensure that participants have these medical opinion forms signed and ready upon release, DOC has added new language to its contracts with medical providers requiring that these forms be completed prior to release. DHS plans to give additional trainings to staff on how to best complete medical opinion forms, and to emphasize why they are important for participants re-entering the community.

Communication between agencies

Part of the mission shared by DOC, DHS, and participating counties is to improve collaboration and communication between bureaucratic "silos." People in the Pilot Initiative have encountered barriers related to these information silos in a variety of ways. However, there are practical ways to address these barriers and improve the release and enrollment process for future participants.

Participants held in restrictive housing prior to release

While incarcerated, participants who violate correctional facility rules may be held in restrictive housing away from others and given very little time outside of confinement. DHS staff typically require one hour to interview participants and assess their eligibility, but those held in restrictive housing are generally not provided this much time outside of confinement. As a result, a participant can be released without having first been assessed for public assistance eligibility. To address this gap in the release process, DHS and DOC will work to coordinate logistics to better allow an individual held in restrictive housing to be interviewed and assessed by DHS Pilot Initiative staff in person or over the phone.

Updating participants' information

Participants in the Pilot Initiative have personal data maintained across multiple data systems and multiple government entities. When information on a person that affects their participation or program eligibility changes, it is important for agencies, where possible, to share and update this information to make service delivery as seamless as possible. Potential areas where outdated or unshared data may be an issue include:

- Ensuring that information on DOC's online *Offender Locator* webpage remains up to date. While this webpage is meant to provide accurate information about a person's supervision agent and release date, DHS staff identified times when such changes were not reflected on the webpage. Having accurate information on participants increases efficiencies in service delivery and case management.
- Ensuring timely updates for when an individual's release is extended or when an individual is re-incarcerated. These situations affect when public assistance benefits should be approved and when they should be closed—more frequent sharing of information between DOC and DHS can reduce the risk of fraud and benefit overpayments.
- Participants incorrectly being referred to county-level case workers for fulfilling work requirements after having already been exempted from these requirements. For example, someone in MFIP who has been assessed as eligible for the program's Family Stabilization Services should be temporarily exempt from work requirements while receiving needed services. County and state staff should double check whether an individual is required to meet work requirements before referring the individual for services.

Increasing Pilot Initiative awareness and buy-in

While DOC and DHS provided informational presentations, trainings, and announcements about the Pilot Initiative prior to its start in September 2017, some supervision agents, and county financial workers were unaware of the project when contacted by DHS Pilot Initiative staff. Having to explain the Pilot Initiative at later stages of service delivery can cause confusion and frustration among workers learning about this new collaboration for the first time. One correctional facility (Lino Lakes) opted-out of the Pilot Initiative toward the end of the period evaluated for this report; this resulted in participants from that correctional facility not being served by DOC and DHS staff as part of the Pilot Initiative. This facility explained that it has its own intensive case management services and suggested that Pilot Initiative services may therefore be duplicative.

To ensure greater awareness of their new collaboration, DHS will send a reminder announcement to all county financial and eligibility workers. DOC and DHS will continue to introduce and present on the Pilot Initiative at statewide gatherings of public assistance workers, and will provide additional training sessions to county and correctional facility workers. Additional efforts should also better engage supervision agents. Supervision agents are vital to the success of many participants, and are often the main point of contact for participants with no permanent address. Finally, to ensure everyone identified for Pilot Initiative participation receive the services they are eligible for, DOC and DHS will need to re-engage with current, former, and potential participating correctional facilities.

Addressing homelessness

As mentioned, one out of every four of the total 221 people in the Pilot Initiative were released into a homeless living situation. Experiencing homelessness can hurt the odds of successful re-entry into society and makes it difficult for DOC and DHS staff to locate participants and provide them with services. Going forward, DOC and DHS will work to identify new ways to improve housing stability for those released. Potential solutions may involve partnering with Minnesota's Heading Home Alliance and other groups to coordinate and target housing resources to participants, as well as suggesting changes in statutory language that would allow participants expecting to be released into homelessness to become eligible for Housing Support prior to release.

Conclusion

The Joint Departmental Pilot Initiative is a new and promising collaboration between Minnesota's Departments of Corrections and Human Services, working with 11 participating counties to better assist people released from incarceration. The population served by this collaboration is considered at a high risk for recidivism and face many barriers to stability and success after incarceration. Nearly all participants have enrolled in public assistance in the past, and most participants have a history of homelessness, as well as a history of chemical dependency or mental health barriers. In addition, participants are disproportionately from under-served populations in Minnesota.

While it is too early to tell long-term results regarding reduced recidivism, initial findings are promising. The large majority of those in the Pilot Initiative have accessed healthcare, and most have also accessed food or cash assistance. These rates of public assistance enrollment are impressive compared with other groups of people at a high risk for re-offense. Further, people in the Pilot Initiative were more likely to have their benefits available immediately upon release. As part of their work, Pilot Initiative staff provided more intensive and person-focused case management than what people typically receive. This added effort has helped participants in crisis address problems that might otherwise go unsolved.

Staff at both collaborating agencies have identified administrative barriers and information silos that can impact service delivery. Some of these barriers have already been removed, while other more structural barriers continue to be addressed. As the Pilot Initiative enters its second year of operation, the Departments of Corrections and Human Services remain committed to increasing awareness and improving service delivery.

Future evaluations will build on the analyses discussed in this report, and will incorporate new data to provide a fuller picture of how participants have been impacted over time.

Appendix A: Reference List for Background Literature

Reference list

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Appendix B: Public Food and Cash Assistance Programs

Diversionary Work Program

The Diversionary Work Program (DWP) is a four-month program that helps Minnesota parents find jobs. The goal is to help parents quickly find work so that they do not need to go on the Minnesota Family Investment Program (MFIP). When families first apply for cash assistance, most will be enrolled in this program. For more information, please visit: https://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/income/programs-and-services/diversionary-work-program.jsp

Emergency Assistance

Emergency Assistance (EA) gives aid to families with an emergency such as an eviction or loss from a fire. EA can also be used to assist with utility bills or first month's rent on a new lease. For more information, please visit a local county human services office.

General Assistance

The General Assistance (GA) program helps adults without children pay for basic needs. It provides money to people who cannot work enough to support themselves, and whose income and resources are very low. People who get GA are also eligible for help with medical and food costs through Medical Assistance (MA) and the Supplemental Nutrition Assistance Program (SNAP). For more information, please visit: https://mn.gov/dhs/people-we-serve/adults/economic-assistance/income/programs-and-services/ga.jsp

Housing Support (formerly known as Group Residential Housing)

The Housing Support program pays for room and board for seniors and adults with disabilities who have low incomes. The program aims to reduce and prevent people from living in institutions or becoming homeless. Over 20,000 Minnesotans receive Housing Support assistance each month to help pay for rent and food. About 27 percent of program recipients also receive Housing Support supplemental service funding to provide other services, including but not limited to: medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services. For more information, please visit: https://mn.gov/dhs/people-we-serve/adults/economic-assistance/housing/programs-and-services/housing-support.jsp

Minnesota Family Investment Program

The Minnesota Family Investment Program (MFIP) is the state's welfare reform program for low-income families with children. MFIP helps families with children meet their basic needs, while helping parents move to financial stability through work. Parents are expected to work, and are supported in working with both cash and food assistance. Most families have a lifetime limit of 60 months on MFIP.

When families first apply for cash assistance, they usually start in the Diversionary Work Program. For more information, please visit: https://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/income/programs-and-services/mfip.jsp

Minnesota Supplemental Aid

Minnesota Supplemental Aid (MSA) provides cash assistance to help adults who get Supplemental Security Income (SSI) pay for their basic needs. Some people who are blind, have a disability or are older than 65 but do not get SSI because their other income is too high may also be eligible for MSA if they meet the income limit. For more information, please visit: https://mn.gov/dhs/people-we-serve/adults/economic-assistance/income/programs-and-services/msa.jsp

Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, helps Minnesotans with low incomes get the food they need for nutritious and well-balanced meals. The program provides support to help stretch a household food budget. It is not intended to meet all of a household's food needs. It is a supplement. If approved for SNAP, benefits can be used at many stores, farmers markets and senior dining sites. For more information, please visit: https://mn.gov/dhs/people-we-serve/adults/economic-assistance/food-nutrition/programs-and-services/supplemental-nutrition-assistance-program.jsp