Evaluation of the Minnesota Statewide Initiative to Reduce Recidivism (MNSIRR): A Summary

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Submitted to:
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Introduction

Between October 2015 and September 2018, staff from the WestEd Justice & Prevention Research Center worked with the Minnesota Department of Corrections (MN DOC) as the external evaluator for the Minnesota Statewide Initiative to Reduce Recidivism (MNSIRR), a recidivism-reduction effort funded through a grant from the U.S. Bureau of Justice Assistance Second Chance Grants for Planning and Implementing Statewide Recidivism Reduction. MN DOC used this funding to implement MNSIRR as a systemwide change model that included a set of research-based correctional practices, including changes to programming for incarcerated men and women, as well as new programming targeted toward the people and places with the highest recidivism.

MNSIRR Description

MNSIRR is a multi-agency recidivism-reduction effort led by the MN DOC during the years 2015–2018 in collaboration with other state agencies, community-based service providers, and additional key stakeholders. It was conceived to improve the post-release success of high-risk offenders who are returning to the community after being incarcerated so that they do not reoffend and return to prison. Under the funding grant, MN DOC targeted male and female adult offenders who were determined to be at high or very high risk of reoffending (henceforth referred to as being at high risk) and who were going to be released to one of the following 11 counties: Beltrami, St. Louis, Carlton, Stearns, Wright, Hennepin, Anoka, Washington, Ramsey, Dakota, and Olmsted.

Focus Areas of the MNSIRR

The initiative’s major focus areas are described below, with details on the activities and expected outcomes described in the logic model (appendix A).

1 An individual’s level of risk for recidivism is determined by the Minnesota Screening Tool Assessing Recidivism Risk (MnSTARR), a validated risk assessment instrument.

2 These counties were selected because over half of all high-risk offenders in the state had been released to these counties and were returning to prison at nearly twice the state average.
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- **Enhancing supervision practices and policy.** The primary activities in this focus area included an independent review (by an external consultant) of intensive supervised release practices to ensure that they align with individuals’ level of risk rather than with offense type; the adoption of new policies related to conditions of release; and the implementation of a new practice model. As used under MNSIRR, a practice model is an integrated set of evidenced-based practices and principles that, when implemented with fidelity by agency staff, are intended to result in improved public safety outcomes.

- **Improving case management practices.** Case management practices were expanded through this initiative. Specifically, integrated pre-release case management services were added for high-risk offenders, and embedded training and quality assurance was implemented to improve case management practices in job descriptions and promotion practices for newly hired case managers.

- **Expanding staff skills.** A large part of the MNSIRR grant was focused on activities to bolster staff skills, including training correctional staff and community-based providers on evidence-based practices, including core correctional practices such as effective reinforcement, effective disapproval, effective use of authority, cognitive restructuring, anti-criminal modeling, structured skill building, problem solving, and effective alliance. Specifically, during the grant period, MN DOC held seven Evidence-Based Practice Academies to train providers on core correctional practices and produced three statewide summits to increase staff capacity and knowledge around evidence-based skills and practices.

- **Promoting quality programs.** Initiative activities included formal assessments of MN DOC’s community-based providers, with the intent of improving their use of evidence-based practices for high-risk offenders. MN DOC staff were trained to conduct these assessments using the Correctional Program Checklist (CPC) and to complete reports of findings and recommendations from each assessment. The CPC is an instrument designed by the University of Cincinnati to assess the use of evidenced-based practices. Once an assessment was completed, MNSIRR regional coordinators (i.e., MN DOC staff assigned to work with community providers in the 11 targeted counties) facilitated CPC report-out meetings in which the coordinator and provider staff reviewed assessment findings and discussed strategies to improve provider services and practices.

- **Increasing access to services.** Within this area of focus, there were various attempts to change policy or practices in order to improve offenders’ access to services while reentering the community. For example, the MN DOC and Minnesota Department of Human Services collaborated on a pilot program of the Combined Application Form (CAF) that allows targeted offenders to apply for benefits and assistance before leaving prison so that those services and benefits are available immediately upon the offenders’ release.
Evaluation Design

The MNSIRR evaluation had two components: a process evaluation and an outcome evaluation. During most of the initiative’s three years, the evaluation focus was on process, that is, evaluating the implementation of policies and practices under MNSIRR. The evaluation design and data-collection tools were informed by the logic model (appendix A) and by the MNSIRR leadership team, which consisted of three DOC staff members from the department’s Community Services Division who were responsible for guiding implementation of the initiative. The leadership team met weekly with the evaluation team, during which the evaluators gleaned much about MNSIRR implementation; in addition, leadership team members were formally interviewed as key informants for the process evaluation.

Toward the end of the three-year grant period, a preliminary outcome evaluation was also conducted, with the primary outcome examined being recidivism among offenders whose experience was affected by MNSIRR. The outcome evaluation is described as preliminary because offenders who were potentially affected by MNSIRR were not released until June 2016, which means they were exposed to MNSIRR-driven changes in practice and policy for only a relatively short time before the end of the grant period. That relatively short period also meant there was not a lot of time for offenders to be convicted of a new felony offense prior to the end of the evaluation.

Findings From Process Evaluation

Question 1: What changes in policy and practices have been implemented as a result of MNSIRR?

MNSIRR has facilitated changes in policy and, also, has adopted new practices for agencies working with high-risk offenders in Minnesota. In interviews, surveys, and a review of documents collected by the evaluation team, the following changes were identified:

- **Use of Integrated Case Management:** There is now a policy that all high- or very-high-risk offenders who are returning to the community in the 11 counties included in the MNSIRR
grant will receive integrated case management (ICM) services. Although ICM was not funded by the MNSIRR grant, work carried out under the grant helped to launch this new practice, build capacity to deliver it, and plan for sustaining it. The MN DOC intends to bring this practice to scale in all Minnesota counties; to do so, it is decreasing non-value-added work tasks in order to free up resources to hire more case managers for the DOC.

- Changes in Supervision Practices: MNSIRR funded an independent analysis of current intensive supervised release (ISR) practices and their alignment to the research about what works for reducing recidivism and changing behavior. A committee was established to make recommendations based on this analysis; and, in 2018, new screening criteria to apply to ISR-eligible offenders when released from prison were put into place. For most offenses, these new criteria use a validated risk assessment tool (MnSTARR) instead of only using the offense type to determine the appropriate ISR status for a soon-to-be-released offender. As a result, offenders considered to be at the highest risk for recidivism, particularly those with offenses against people (versus property), are now receiving the most supervision. Additionally, the new criteria sparked further commitment to change release conditions for offenders, specifically, to decrease conditions or add conditions only when directly related to individual risk or need.

- Changes in Promotional Practice for MN DOC Staff: Job expectations and, along with them, promotional practices have been changed for a number of staff roles. For example, case workers are now responsible for using interventions that focus on changing offenders’ distorted thinking patterns (e.g., The Thinking for a Change [T4C] curriculum developed by the National Institute of Corrections). This shift brings case worker job descriptions into alignment with other MN DOC job descriptions in probation and supervision. To advance in their position, case managers are also now required to implement evidence-based practices (EBPs) and demonstrate knowledge of best practice in general. Program Directors in MN DOC facilities will also be trained in EBPs so they are prepared to support case managers.

- Use of Correctional Program Checklist Assessments: As a result of MNSIRR, professional-technical contracts that are executed by the MN DOC with community service providers for pre- and post-release services now include language to establish initial and ongoing program assessments such as the Correctional Program Checklist.

- Evidence-Based Practices (EBP) Academies for Community Service Providers: EBP Academies were conducted for community service providers, mainly those with which the MN DOC contracted, for their staff to learn about and be trained in specific evidence-based practices for working with high-risk offenders. This was a new way of connecting with community providers. While the trainings showed promise, it was evident that ongoing relationship-building with providers is needed. Further, the evaluation was not able to address whether the trainings led to changes in how providers conducted their work.
Question 2: What have been the successes, challenges, and lessons learned from implementation of MNSIRR?

MNSIRR activities yielded a number of successes, challenges, and lessons learned throughout the grant period. This section discusses these topics, drawing on the perspectives of the MNSIRR leadership and other information gathered from formative evaluation activities.

Successes

- **MN DOC Partnerships with Community Providers and Other State Agencies to Improve Use of Evidence-Based Practices.** Many MN DOC partnerships with community providers and with other state agencies were established and grown under MNSIRR. Although development of such partnerships was one of the initiative’s intended goals, the ease with which they were established, the positive reception to them, and the high level of participation in them exceeded the expectations of MNSIRR leaders. Throughout the grant period, interest in partnering with the MN DOC was evident through community organizations’ participation in trainings, assessments, and events, such as the Collaborative Summit, a day of learning that featured local and national experts in criminal thinking, behavior modification, and the science of recidivism reduction. The purpose of partnership efforts was to increase use of evidence-based practices in treating high-risk offenders, by having partners learn about these approaches, and having them reflect on how to integrate core correctional practices into a community-based setting.

  The MN DOC’s collaboration with other state agencies was another area of success, as evident in implementation of a new pilot program called “The Joint Departmental Pilot Initiative.” The initiative is a MN DOC and DHS effort to share data on all high-risk offenders and to create a combined application form. The intent of having such a form is to improve offenders’ access to services and benefits when released by having them go through an application process before their release. Early findings from a DHS report (2018) found that people who used the combined application form were more likely than other offenders to have immediate access to their benefits upon release.

- **Intensive Supervised Release (ISR) Analysis and Policy Change.** The MNSIRR grant enabled the MN DOC to fund an independent analysis of the ISR data (Ericson, Stricker, Doom, & Sagvold, 2016) to see what changes should be made to the current policy. As mentioned earlier, a committee was established to make recommendations based on this analysis and new ISR criteria were released in July 2018. MNSIRR leadership describe the criteria changes as an important success under the grant. Whereas the old criteria for receiving ISR were based on offense rather than risk, the new criteria rely on a validated risk tool (MnSTARR) that incorporates several factors including criminal history and current offense (Hill, 2018).

- **Practice Model for Community Supervision of Offenders.** In July 2016, six counties began to pilot a new practice model for community supervision. The goal was to change how offenders are supervised in the community, irrespective of their ISR status, by integrating
Evidence-based practices and principles into that supervision. The critical components of this work, according to MNSIRR leadership, are giving staff the time to reflect on factors that drive implementation success; providing them with the opportunity to practice their coaching skills; and using continuous assessments to improve practice.

- **Correctional Program Checklist (CPC) Assessment.** According to the MNSIRR leadership team, using this checklist to assess community-based service partners has, in some ways, been more successful than MN DOC’s internal efforts to change its own practice culture so as to implement evidence-based practices within DOC facilities (this challenge is described more in the next section). The community providers are reported to have been open to — and thankful for — the assessment, objective feedback as a result of that assessment, and help in understanding and implementing evidenced-based practices.

- **Presence of Regional Coordinators.** In interviews with the evaluation team, community-based service providers pointed to the role of regional coordinators as an MNSIRR success. Providers said that their regional coordinator provided a valued connection to the CPC assessment process and gave helpful support based in the results.

- **Programs and Policy to Increase Access to Treatment.** Increasing access to treatment for released high-risk offenders in order to achieve improved outcomes for them was an MNSIRR priority. New programs and policies implemented to increase access for high-risk offenders included:
  - Establishment of a peer recovery support contract from the MN DOC to a provider of peer recovery services that engages former high-risk offenders to counsel and deliver services;
  - Institution of a healthcare navigation services contract from the MN DOC to assist offenders in accessing health care by providing someone who can act as a “broker” for what they need; and
  - Provision of transportation services for released men and women.

**Challenges**

In addition to describing MNSIRR successes, the leadership team also reflected on the challenges of implementing MNSIRR. These challenges are clustered around three main themes: internal challenges (i.e., buy-in, adequacy of staffing level), communication, and implementation.

- **Internal Challenges.** A primary MNSIRR focus was to improve practices among community providers working with high-risk offenders, but the MNSIRR leadership team quickly realized that if providers were to implement best practices in their work with offenders, there would first need to be changes in internal practices and policies within the MN DOC’s own facilities and central office administration. But internal change efforts were met with resistance. The MNSIRR leadership team reflected that each facility had its own culture and that staff response to change depended on the culture of the facility in which they worked. Overall, the time it took to create change and introduce new practices in each MN DOC.
facility far exceed initial estimates. A second internal challenge identified by MNSIRR leadership was the relatively small number of staff charged with implementing such a large initiative. This challenge was compounded by the geographic distribution of remote staff who were engaged in the day-to-day work, such as the regional coordinators who were located in different parts of the state.

- **Communication.** Despite the creation of an MNSIRR newsletter and website, communication remained a challenge throughout the grant period. The types of communication challenges discussed by the leadership team included a lack of clear and consistent messaging from those involved in MNSIRR about initiative goals and about what was being done within MN DOC facilities and community-based programs to achieve those goals. One inherent challenge was the complexity of the network of stakeholders across departments and jurisdictions who had key roles in MNSIRR implementation. Although the MN DOC had the primary leadership role for the initiative, the grant guidance document prescribed collaboration and engagement with and among these stakeholders, specifically requiring that MNSIRR implementation be a statewide, cross-stakeholder effort. MNSIRR leadership reported that it was difficult at times to respond to questions from so many different stakeholders across multiple agencies and departments and to keep them updated about MNSIRR.

- **Implementation Challenges.** Given MNSIRR’s large scope and scale, implementation was a challenge. MNSIRR leadership agreed with each other that there was not enough time or understanding before initiative activities were defined, and not enough tools, to assess implementation capacity and to understand the factors that drive implementation success. Specific examples of MNSIRR components that did not work well are the use of an enhanced rate to providers that focused on chemical dependency treatment so as to increase treatment access for high-risk offenders needing such treatment, and the adoption across DOC facilities of a cognitive behavioral treatment program called “Thinking for Change.”

**Lessons Learned**

Feedback from the MNSIRR leadership team, as well as data gathered throughout the grant period from community providers, suggest some lessons for any MNSIRR-related efforts that continue:

- **Time is needed for implementation of core correctional practices (CCP).** Based on the evaluation surveys from case managers and community supervision agents, personnel need to have more time each day to implement CCP in their jobs.

- **Communication is key.** Those working on MNSIRR need more opportunities to speak with different audiences, especially frontline staff, to help ensure that staff practices change and that the benefits of MNSIRR are clearly understood.

- **High-level support and buy-in are essential.** Support in the form of written and oral statements from high-level leaders within MN DOC could potentially contribute to the
adoption of new practices and policies both by community service providers and by DOC staff.

- Keep it focused. The implementation scope for this grant was broad and crossed many different content areas, which made it difficult to manage implementation of all its components, especially given the small number of staff managing the grant. As the DOC considers future grants to continue its efforts to improve reentry, keeping the scope of the grant more focused might have enabled both those overseeing the initiative and those frontline providers changing their practice to dive deeper into some of the key changes.

**Question 3: What programs and services did offenders receive as a result of MNSIRR?**

In the MNSIRR’s 11 target counties, the initiative was largely focused on training and capacity building for community providers to help them better serve high-risk offenders, as described in the previous sections. This section of the evaluation report summary describes the pre- and post-release services that high-risk offenders received as part of MNSIRR.

**Pre-Release Services**

The following services have been offered to offenders prior to their release.

**Portico Healthcare Navigation**

Portico Healthcare Navigation helps connect offenders to healthcare. The service works with soon-to-be-released offenders to help them find post-release healthcare insurance coverage, to support them as they navigate the enrollment process, and to answer any questions that come up during the process.

**Thinking for a Change (T4C)**

T4C is an evidence-based cognitive-behavioral intervention that has been shown to help reduce recidivism in corrections-based populations, including adult and juvenile offenders. The intervention includes 25 lessons that are designed for delivery to small groups of 8 to 12 people and that can be administered in an institution or community-based setting. T4C has three main components: 1) helping participants identify and address irrational or faulty thinking through a process called cognitive self-change; 2) teaching social skills; and 3) teaching problem-solving skills.

**Combined Application Form**

Beginning in September 2017, MN DOC and the Minnesota Department of Human Services (MN DHS) processed applications for healthcare and food or cash assistance in advance for individuals who would soon be released from Minnesota correctional facilities. The combined
application form also served as a bridge for offenders to housing supports that are aimed at decreasing homelessness and to social security benefits. After an incarcerated person’s release, MN DHS helped transfer that individual’s case to the offender’s receiving county and provided them with ongoing support (e.g., to get appropriate housing).

**JPay**

MN DOC partnered with JPay, a computer- and phone-based application, to allow offenders to contact friends and family members in the community through electronic messages or video visitation. This type of communication can strengthen or re-establish family ties, which, in turn, can improve an offender’s likelihood of successful reentry, thereby reducing recidivism.

**Moving On**

This is a curriculum-based, gender-responsive intervention created to address the different cognitive and behavioral needs of incarcerated women. Moving On is delivered in 26 sessions over 12 weeks to small groups of 5 to 10 participants. Each session lasts one and a half to two hours.

**Transportation for Visitors**

Peace of Hope, Inc., provides fee-based transportation for approved visitors to MN DOC correctional facilities. Family members could email Peace of Hope and receive a quick resource information sheet; access to workshops with essential information for families of individuals incarcerated at a MN DOC facility; information on transportation provisions for qualified family members of high-risk offenders who want to visit loved ones in prison; and a JPay video credit application for eligible visitors.

**Integrated Case Management**

The MNSIRR grant played a role in the implementation and scale-up of integrated case management as a pre-release service for high-risk offenders.

**Post-Release Services**

The following services were offered to offenders after their release.

**Bus Pass & Taxi Service**

Participants in Olmstead County and the Twin Cities Metro Area were eligible to receive transportation funds specifically for improving access to, and encouraging completion of, behavioral health treatment programs.
Enhanced Rate Treatment Services

MNSIRR grant funds were used to incentivize behavioral health providers to deliver a recognized cognitive-behavioral treatment curriculum to released high-risk offenders. According to Minnesota’s MNSIRR grant proposal, “The goal was to demonstrate that by providing an enhanced per diem through grant funds, qualified providers will target interventions more appropriately and ultimately reduce recidivism” (Minnesota, 2014).

Peer Support (Face It TOGETHER Contract)

Face It TOGETHER is a nonprofit organization that provides coaching for people living with addiction and their loved ones.

Findings From Outcome Evaluation

This section provides results from analyses comparing outcomes for a group of offenders exposed to MNSIRR with those from a similar group of offenders released from prison before MNSIRR was in place. Two variables were used to examine the recidivism rate for both groups: 1) reimprisonment on a new felony, and 2) return to prison for technical violations.

To control for any pre-existing differences between the groups, the evaluation team used multivariate regression analyses to explore the relationship between MNSIRR implementation and offender outcomes. This allowed the team to control for variables that might influence each outcome and for which it had data, such as gender, race, marital status, age at release, and felony convictions. Controlling for these pre-existing differences between the groups, the evaluation found that the MNSIRR treatment group experienced

- less reimprisonment for a new felony,
- more returns to prison for technical violations,
- a similar length of time in the community before readmissions, and
- fewer months in prison following the first and second admission to prison.
Evaluation Limitations

The evaluation approach allowed for an in-depth look at some of the new policies and practices implemented under the MNSIRR. However, like any evaluation, this one had limitations. The evaluation team used comprehensive methods to conduct interviews and surveys to ensure stakeholders were represented throughout the evaluation. Because MNSIRR was largely focused on building capacity of corrections staff and other providers to use evidence-based practices, the evaluation team did not interview offenders or family members, theorizing that they would not be able to speak to the training, new policies, or other operational changes that came as a result of the MNSIRR.

It is important to recognize the limitations of the outcome evaluation. The evaluation includes analysis of MN DOC data on recidivism for those offenders released to an MNSIRR county compared to recidivism data for an historical comparison group released to the same county prior to MNSIRR. However, given the treatment group’s relatively short exposure time to the policies and practices implemented under the grant, the likelihood of detecting meaningful recidivism differences between the MNSIRR and pre-MNSIRR cohorts is low. There may have also been unrelated policy or practice changes that could have influenced how offenders in both the treatment and comparison groups experienced pre- and post-release services that were not captured by the evaluation. The outcome analysis was restricted to a sample of offenders exposed to MNSIRR who were released between November 2016 and June 2017 to allow for at least a six-month period for offenders to be in the community and experience MNSIRR-related policy or practice changes. Measuring changes in recidivism usually requires at least a 12-month or greater follow-up period. Finally, the outcome data were limited to conviction data so outcomes on arrests could not be included in this analysis.

Recommendations

Based on the findings described above, the evaluation team offers the first four recommendations below to the MNSIRR team and MN DOC as they continue to improve policies and practices for high-risk offenders. The fifth recommendation is for funders.

- **Measure capacity before implementation of new policy and practice.** There were varying levels of capacity for implementing changes, both internally at the MN DOC and among community service providers. One way to ensure greater implementation fidelity would be to measure the organizational readiness of MN DOC, individual community providers, and
others to implement components of MNSIRR. Then training and implementation could be tailored to match the readiness of organizations making practice changes.

- **Embed implementation science training early in the change effort.** For staff who are responsible for implementing a complex grant such as MNSIRR across systems and organizations, it would be helpful to have training on implementation science — that is, the strategies and approaches to put a new policy, practice, or intervention in place.

- **Manage scope and scale of MNSIRR.** The scope of MNSIRR activities was broad, with numerous components in the initiative. Yet those responsible for implementing, overseeing, and managing the activities consisted just of the three-person leadership team from the DOC’s central administrative office and the regional coordinators. Tightening and better defining the scope would help ensure successful implementation that can gradually be scaled to all MN counties over time.

- **Improve communication and buy-in.** The MNSIRR executive team, comprising Commissioners and Directors from across state and county agencies and key stakeholders who met a few times a year throughout the grant, could initiate improved communication, education and discussion of the grant activities, accomplishments, and challenges by convening frequent meetings and providing regular updates to the team and their staff about MNSIRR. In addition, to help the public and MN DOC staff understand the positive role of the initiative, community providers and others who have attended the evidence-based practices academies or CPC assessments could be asked to share their stories about how these experiences have changed the practice of their organizations or the lives of the offenders and families they are serving.

- **Allow more time for measuring recidivism.** The 3-year implementation grant funding under MNSIRR did not allow enough time to measure the effects on recidivism rates of new policy and changes in practice.
References


Appendix A. Minnesota Statewide Recidivism Reduction Logic Model (Updated February 2018)

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<td>• Amended sanctions grid</td>
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<td>• Strengthen CM and case planning</td>
<td>• Increase community contacts with CSPs</td>
<td>• DOC decides what recommendations/policy changes to adopt</td>
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<td>• Mi Training</td>
<td>• Establish EBP Implementation Team</td>
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<td>• Communities of Practice established</td>
<td>• CCP Coaches trained</td>
<td>• Policy changes for EBP alignment</td>
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<td>• QA for LSC/MI</td>
<td>• QA measures for LS/CMI</td>
<td>• Decrease technical violations, increase conditions compliance</td>
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<td>• Development of shared, electronic case plan</td>
<td>• CCPs for case planning, Mi are established</td>
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<td>• Prototype for shared case plan; statutory is changed to allow information sharing between agencies</td>
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<td>• Cognitive Skills Summit (Training)</td>
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<td>• Statewide EBP plan includes QA</td>
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<td></td>
<td>• Reentry Summits</td>
<td></td>
<td>• Online resource catalog is launched</td>
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<td></td>
<td>• Cog Skills Curriculum Training</td>
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<td>• Electronic case plan is launched</td>
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<tr>
<td>Promoting Quality Programs</td>
<td>• Conduct CPC assessments with CSPs</td>
<td>• CSP (3 cohorts of CSP assessments completed)</td>
<td>• Increase use of EBP by CSPs and staff</td>
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<td></td>
<td>• Select facilities to pilot cognitive skills (Jan. 2016)</td>
<td>• 3 male/1 female facilities selected</td>
<td>• Sustained dosage of cognitive behavioral interventions</td>
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<td>• EBPs Academies are sustained</td>
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<td>Direct Services/ Access to Services</td>
<td>• Enhanced rate for treatment providers serving high-risk offenders</td>
<td>• Regional coordinators provide roadmap to improve alignment with EBP</td>
<td>• Implementation of CPC plan</td>
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<td>• Combined Application Form for public benefits</td>
<td>• Increased #s of participants in cohort</td>
<td>• Increase use of EBP by CSP</td>
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<td>• Peer supports for offenders with no connections</td>
<td>• Increased # of CPC assessments done in MN</td>
<td>• Increase # of CPC assessments</td>
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<td>• Video visiting credits/ transportation help</td>
<td>• Build sustainable cog skills groups</td>
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<td></td>
<td>• CD Treatment providers</td>
<td>• Enhanced rate pilot</td>
<td>• Review pilot results &amp; request funding</td>
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<td>• Financial Workers/subcommittee</td>
<td>• 50–100 offenders enrolled in CD treatment</td>
<td>• Improved health outcomes of offenders</td>
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<td>• Families/social supports</td>
<td>• Processing of CAF</td>
<td>• Increased in-person and video visitation</td>
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<td>• Case managers and agents</td>
<td>• Offenders receiving peer supports</td>
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<tr>
<td></td>
<td>• Peer coaches</td>
<td>• Increase access to video and in-person and video visits</td>
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