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Translating Policy to Procedure: Participatory Management in Corrections

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Translating policy into procedure is a problem endemic to all large organizations. Policy provides the direction, the philosophy, and the goals of the organization. For policy to be effective and for the policy to be meaningful within the organization, it must be translated into day-to-day and step-by-step procedures that are consistent throughout the organization. The procedures must be workable, avoid redundancy, minimize effort, and wherever possible be acceptable to staff. The procedures must conform to the word and spirit of the policy and by so doing accomplish the task at hand.

This problem is no less apparent in corrections than any other organization. Correctional agencies can generally be described as centralized hierarchical organizations with a military style chain of command. In this type of organization policy and procedure are formulated in the upper echelons and passed down through the rank and file for implementation. Unlike the military organizations after which they are modeled, personnel in correctional organizations lack the intense training, discipline, and loyalty associated with military operations. Without these qualities, the large centralized corrections department is subject to uneven interpretation and application of policy, with various elements sometimes working at cross purposes.

The central administrative component of the correctional agency generally has the difficult task of formulating policy. The policy must comply with State and Federal law, administrative directives from elected officials, and the wishes of various public and private special interest groups. With many competing external forces, centralized policymaking seems necessary in order to comply, cooperate, and compromise with the various extra-system pressures and demands.

However, the correctional agency with a number of prison facilities and/or functional commands cannot simply hand down policy and leave procedure formulation to each discrete facility or command. This process would produce idiosyncratic procedures which will lack the consistency and standardization necessary for the agency to function as an integrated system. Conversely, if the policymakers dictate both policy and procedure, the procedures may well be unworkable at the local level, lack support by the local staff, and eventually be subverted and altered to meet the local staff's perceived needs. The end result is again a lack of consistency and standardization.

Some middle ground must be found between these two approaches; a way must be found to translate policy into consistent and standardized procedures for all the operational components. The resultant procedures should certainly conform to both the word and spirit of the policy, be practical within the contraints of correction's limited resources and prison dynamics, and receive the support of the staff who are expected to implement them.

The North Carolina Problem

As with any other complex organization, the problem of translating policy into procedure can be witnessed in corrections in North Carolina. The North Carolina Department of Correction is a centrally controlled organization with 11 diagnostic centers located across the State. These centers perform evaluations of each of the approximate 13,000 new admissions per year. The prisoners are then transferred to one of the Department's 79 prison units and this diagnostic center information travels with them. In addition to complying with State law and interpretations of various court rulings, these centers must comply with the policy and procedure developed in the central offices and passed down to them in the form of a guidebook and/or memoranda. Until the advent of the innovative efforts to be described

later, each diagnostic center was performing its duties, as defined by centralized procedure and policy, differently.

Record jackets were set up differently, forms completed differently, some forms were omitted altogether, some diagnostic centers created their own forms, psychometric testing was administered under different conditions, and many more small and large differences existed. There is no evidence that any of these differences resulted from malicious or antiauthoritarian motivation. These deviations occurred in a slow, evolutionary fashion. The staffs were well intentioned in their efforts to make the diagnostic center processes more efficient and effective. These differences arose out of each center's practical consideration of the available resources, the prisoners' needs and the perception of the prison units' needs.

It is easily recognized that there was no consistency or standardization. There was confusion —in the diagnostic centers, in the prison units, and in the central offices. The word and spirit of policy was sometimes violated. Central office staff was sometimes viewed by diagnostic center staff as distant and out of touch. Diagnostic center staff was sometimes viewed by central office staff as provincial and without awareness of the larger system needs of the department.

The North Carolina Solution

The solution to this problem was not an easy one; the diagnostic center problems were symptomatic of problems existing throughout the system. If the central staff were to formulate and distribute new procedures, it is likely that after initial compliance the same process would occur and each center gradually evolve its own procedures. The decision was made to compromise the hierarchical military model and to initiate two-way communication between the centers and the central office via participatory management. It is important to note that this decision was made at the mid-management level for one small component of the Department without benefit of Departmental policy directing a change in management style.

The participatory model developed in North Carolina does not place the diagnostic centers in the position of ruling as in the ideal participatory democracy in which "the people rule." The model, in its simplest terms, consists of three steps: (1) The central administration formulates policy; (2) representatives from each of the diagnostic centers meet and through consensus decisionmaking they formulate procedures conforming to the policy; and (3) the procedures are reviewed and approved by the central administration. This model places the policymaking role at the central administrative level, while allowing procedures to be developed within the practical considerations best understood by the staff that must implement them. While there are certainly several means available for instituting participatory management, the success of the North Carolina strategy makes it worthy of discussion. It is supposed that this strategy can be transferred to correctional organizations suffering from similar problems.

The first and most important step in the participatory management strategy used by diagnostic services was to bring together the directors of the centers in one day conferences, occurring at one month intervals, for several months. The goal of these meetings was threefold: first, to provide the directors and central staff with the opportunity to meet and know each other; secondly, to provide the opportunity for them to recognize and discuss common problems; and finally, and probably most importantly, for the directors to develop an identity as a team with common goals. The importance of this first step should not be underestimated, for without it it is unlikely that the total strategy would have succeeded. Regardless of what strategy is used, it is imperative that the central and line staffs meet together to gain a group identity and mutual respect.

After an awareness of common problems and a common identity was achieved through monthly meetings, a workshop was organized with the explicit purpose of preparing a procedural manual containing consistent systemwide procedures for the diagnostic centers. The workshop was begun with a small group exercise aimed at assisting the participants in working together, compromising, and making decisions by consensus. This exercise presented a fictional situation in which the small groups had to decide which three of seven candidates would receive the services of a kidney machine and thus continue to live. The exercise required that the group's solution be based upon a consensus decision. Not only was the exercise successful in facilitating group cohesion and effectiveness, but it served as a continuing source of humor and stress reduction throughout the workshop.

The participants remained in these small groups and were organized into three Task

Groups and a Review Committee. Each Task Group was comprised of three permanent members. These members represented the grass roots organizational components for which the procedures were being developed. Each Task Group was assigned a number of procedural topics necessary for completing the manual. Each topic was accompanied by a skeleton outline which presented general questions concerning procedures and standards. In simple terms, the outlines requested the following information: purpose of the procedure, existing policies, step-by-step instructions, distribution of any forms, who should perform the duties, and when in the operational process the duties should be performed. The Task Groups were given a set amount of time to reach a consensus and complete these outlines in detail.

Each Task Group was joined by a central office staff member who served as a facilitator. The difficulty and importance of the facilitator role is evident in the following written instructions which were provided each facilitator prior to the workshop: "The final product should be the work of the participants; it is their process, their procedure, and their responsibility. The facilitator should not guide, direct, structure, or dominate the group. The facilitator's role is to make the participants' task as easy as possible and to assist in maintaining goal-directed group functioning." The following lists the facilitators' specific duties and limitations:

(1) Insure that the group understands its tasks and time limitations.

(2) Act as logistical liaison between the groups.

(3) Insure that workshop facilities are comfortable and that needed supplies are available.

(4) Mediate conflict by accurately reflecting, clarifying, and summarizing differences. The participants are responsible for resolving differences.

(5) Make input into the procedural topic discussions as long as the group is aware that the input is the facilitator's personal opinion and is in no way a reflection of administrative opinion.

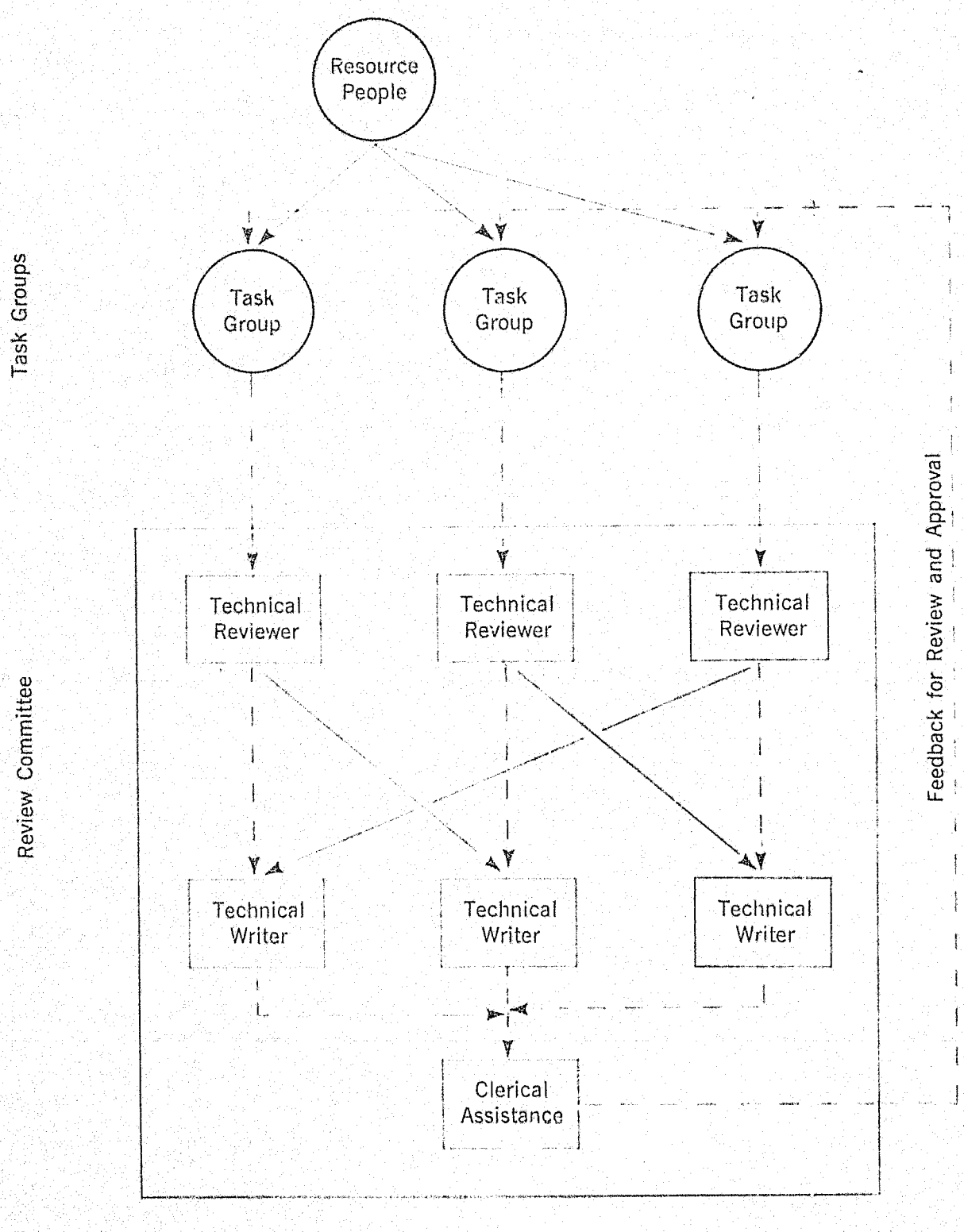
(6) Take notes concerning the group's output to insure that the full flavor of the group's results is recorded.

These four member Task Groups were also joined by a resource person(s) who specialized in the particular topic under consideration. The resource people were drawn from both line and staff functions. Their role was to provide technical assistance. The number of resource people joining the Task Group varied from one to three and was dependent upon the scope and complexity of the procedural topic. Once the Task Group completed the outline for its procedural topic, its work was submitted to the Review Committee and the group continued to the next topic.

The Review Committee consisted of three teams comprised of two persons each: a technical reviewer and a technical writer. The technical reviewers were individuals who worked in the diagnostic centers and were respected by the other participants for their comprehensive knowledge of the organization and for their years of experience. The technical writers were persons who were respected for their ability to write clearly and concisely. Once the Task Group completed a procedural topic, the technical reviewer assigned to that group reviewed the completed outline to insure consistency, comprehensiveness, and compliance with existing policies and goals. If any one of these three qualities were missing, the Task Group's material was returned to it for needed alterations. Once the technical reviewer was satisfied, the technical writer transcribed the outline into a narrative form. Guidelines for the format and reference numbering of the written procedures were provided so that narratives would be prepared in a consistent fashion. These narratives were typed and distributed as soon as possible so that all of the participants in both the Task Groups and Review Committee received rapid feedback as to the productivity and quality of their work. At the end of the workshop, the participants were able to return to their diagnostic centers with a typed, rough draft of the procedural manual.

Diagram I presents the structure and function of the workshop components. Four important elements are noted. First, the Task Groups and the Review Committee were not directly interacting; each was situated in a separate conference room and the Review Committee personnel were unaware of the discussion and debates leading to the Task Groups' output. Secondly, after reviewing and accepting the Task Group's work, the technical reviewer moved to assist another group's technical writer in preparing the final narrative. This aided in "spreading out" the Review Committee's expertise. The next element is that the narratives were quickly typed and fed back to the participants for their consideration and to reinforce the quantity and quality of their output. The fourth important element is that the narratives were fed

DIAGRAM I.—*Structure and Function of Procedural Manual Workshop**



*Solid lines designate movement of people. Dashed lines designate flow of information.

back to *all* the participants in all Task Groups and the Review Committee, so that the total workshop product was available for their critique and so that they would identify with the total product.

The final important element of the workshop is the chief method used for reducing and resolving conflict. Each participant was given a packet of "Issues Questions" forms upon which they could record any difficulties or obstacles faced by their group. The problem and alternative solutions were recorded on the sheets and submitted to the Review Committee for their consideration. If the Review Committee as a whole could agree upon a resolution, this resolution was recorded in the response section of the form and returned to the Task Group. Most of the 66 issues and questions were resolved by the Review Committee, but in some cases it was necessary to receive opinions from legal experts or other persons outside the workshop. If the issue or question required a policy decision, the workshop responses were considered to be temporary crisis resolutions and official and permanent resolutions were solicited from top level administrators after the workshop. As it occurred, none of the temporary resolutions were significantly different from the permanent resolutions and the workshop's final product was not substantially affected.

The final step in creating the procedural manual involved the final approval process. Because of the rapid feedback process built into the workshop, the participants left the workshop with a typed draft of the procedural manual. They shared the manual with the staffs at their local centers and after four weeks they met again for a one day session to review and approve the manual. This session involved the total workshop group reviewing the manual, section by section, making minor revisions and approving it. After the participants' final approval, the revised manual was submitted to the top level administrators for their approval. Probably due to the grass roots support the manual had received during its development and the practicality inherent in a document created by persons intimately aware of the day-to-day operations of the organization, the manual was approved by these administrators with only very minor changes.

Discussion

This participatory management model of system-wide procedure development was very successful for diagnostic services in North Carolina. The overall goal of developing consistent, standardized procedures among eleven operationally independent facilities was achieved. This accomplishment is manifest in a Diagnostic Procedure Manual which documents 32 different procedural topics in terms of Departmental policy and North Carolina law. These procedures are by definition workable because they were developed by the staff responsible for their implementation and most knowledgeable concerning the day to day work site problems.

A number of additional positive results were accomplished by the participatory management workshop. Some of these assets were anticipated but others were unexpected byproducts. The following list outlines some of the benefits derived from the process:

(1) The diagnostic center staffs intellectually and emotionally invested in the procedures and deviation from procedure is less likely to occur. The procedures belonged to the diagnostic center and there is staff commitment to them.

(2) The diagnostic center directors' professional self-respect and the respect afforded them by central office staff increased. There is now two-way communication and a willingness to share and work together on common problems.

(3) Central office staff has a more comprehensive understanding of the diagnostic centers' problems and limitations and are now able to be of more practical service to the centers.

(4) Now, policy formulation and change can be developed in the context of actual operations and within the principle of minimizing impact on day-to-day staff routine.

(5) The diagnostic centers are able to use the procedures to gauge and maintain the quality of their work. The procedural manual provides not only step-by-step procedures but standards against which they can measure their performance.

There is, however, a major liability in using the participatory management model in procedure development which must be considered. Initially, it is expensive in terms of time and money. Staff members are pulled away from their regular routine and in some instances required to expend travel funds. The North Carolina project used many staff hours which could have been saved if central staff had simply prepared the manual. However, judging from the situation which existed prior to the participatory management workshops, the central staff would have spent many many more hours in attempting to reconcile the

diagnostic centers to the procedures and attempting to "patch up holes" in the procedures that would inevitably occur. Even though the centers would have complied initially with the mandated procedures, it would probably have been only a matter of time before each center would have evolved slightly different procedures to meet their individual needs and thus the writing of more procedures would have been required.

Of the many parts of the strategy used in the process discussed earlier, probably the one most important to the success of the total strategy was providing a forum through which the staff could develop a common identity and purpose. Without the monthly meetings in advance of the workshop, it is unlikely that the continuing compliance with the procedures would exist. It is quite possible that the workshop as designed would have appeared successful and it probably would have produced a procedural manual; however, it is unlikely that the true compromise which occurred at the workshop would have taken place if the participants were not already conscious of each other's common and individual problems. Due to the monthly meetings, the participants began the workshop with an understanding and mutual respect which can only be achieved after months of meaningful communication.

The participatory model continues to be used in coordinating diagnostic center functions. As policy or laws are generated or changed, diagnostic center task groups are assigned to change and develop procedures as necessary. This process, in combination with the continuing monthly meetings of the directors, gives some guarantee that consistent and standardized procedures will be maintained on a continuing basis. Again this is a time-consuming business and there is sometimes a time lag of as much as 2 months between policy and written procedures. However, this lag is not altogether negative. There is less of a crisis orientation; the centers are able to experiment for a few weeks with various ways of attaining the policy goals. They then meet together to draft a compromise procedure which accomplishes the necessary ends and is within the constraints and capabilities of all the centers. The procedural manual is an organic document and this model provides a planning and systems orientation for adapting procedures to new circumstances.

Whether or not the strategy used for diagnostic services in North Carolina is adaptable to other correctional agencies is a question that cannot be easily answered. This specific strategy is probably best suited to coordinating the operations of a number of discrete operations which perform essentially the same task. The concept of participatory management can be applied to corrections in general using variations of this strategy. When North Carolina instituted a Central Transfer Authority for monitoring and coordinating transfers between complexes of prison units, representatives in classification from each of these complexes were brought together to prepare the necessary criteria and procedures for transfer. Likewise, before two new youthful offender prisons became operational, representatives from the five established youthful units and from the two new facilities met. Within the general policy guidelines developed by the central administration, this group decided what types of inmates the two new units would serve and developed the procedures for coordinating the services among all seven units. Both of these participatory management efforts used a slightly different strategy but were predicated on first establishing rapport between the various staffs involved.

From the experience of the comprehensive procedural manual developed by diagnostic services to the rather limited problem of developing transfer procedures, it has been demonstrated that participatory management can succeed in corrections. Because of the military model of organization and the traditional reliance upon authoritarian control, there are some difficult attitudinal obstacles which must be overcome. Nevertheless, the payoff of improved staff relations, standardization and consistency, planning and systemwide orientation, and pragmatism are well worth the effort and time costs. This participatory model—administrative staff develop policy, field staff develop procedure, and administrative staff approve procedure—gives field staff input, but also responsibility, and gives administrative staff control, but also practicality.

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