

Mirror, Mirror, on the Wall, Who Is the Most Responsible for Evidence-Based Practices of All?

by Frank Domurad

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In the year 1812, the German Brothers Grimm published a book of peasant folk tales for children. Among these often gruesome stories was that of Little Snow White. The fable revolved around a vain and wicked Queen, who admired nothing more than her own beauty. Every morning she looked at herself in a magic mirror and asked, "Mirror, mirror on the wall, who is the fairest of them all?" Invariably, the mirror responded that it was the Queen. But one day the mirror surprised its mistress by claiming that Snow White was "fairer far to see." The Queen was understandably furious. In a fit of denial, she tried numerous ingenious ways to kill her innocent rival, but in the end she was defeated by the love of a prince and was forced to pay a horrendous penalty for her evil deeds.

Today's correctional managers practice a more updated version of this fable as they seek to implement evidence-based practices (EBP) in their agencies. Every morning upon arriving in the office, they ask, "Mirror, mirror on the wall, who is the most responsible of us all?" Invariably the mirror responds, "Those below you." They are satisfied with this message because it fits neatly with their image of how an organization should work. As managers, they have been taught that under the rules of a hierarchical bureaucracy, those at the top of a governmental agency strategize the big plan, while those who report to them are accountable for carrying it out. But one day the magic mirror on their wall mysteriously threatens the peace and tranquility of the correctional kingdom. In response to the executive's usual inquiry, it says in a most unexpected fashion, "If you really want to do evidence-based practices, then you must become the one most truly responsible of all."

While the temptation is great to follow the lead of the evil Queen in the Brothers Grimm fairy tale and deny the message of the mirror, correctional managers must come to grips with the fact that they can no longer be left outside the equation of organizational change. The hard reality is that doing evidence-based practices in the public sector is the functional equivalent of staying competitive in a global economy in the private sector. Both require moving from a "bureaucratic" to a "collaborative" way of doing business, from a world where managers formally delegate responsibility to others to one where they come to embrace and own it, not only personally but also publicly.

A New Way of Doing Correctional Business

The struggle to implement evidence-based practices is in essence a struggle to establish legitimacy, both inside and outside the correctional agency. Charles Heckscher and Nathaniel Foote (2006), Process (SFP), a method of collaborative strategic discourse designed to overcome the normative barriers of bureaucracy, contend that in periods of organizational transition and transformation, leaders are inclined to remain too distant from those who will actually make the change happen. They are seen as people high above the fray who refuse to understand the trials and tribulations that the middle manager, supervisor, and line employee must endure. Heckscher and Foote (2006) argue that in such situations, management's power and influence will inevitably erode and can not be regained through appeals to bureaucratic authority and deference. It must be legitimize[d] and mobilize[d] in a different way," by shifting from a "'grand vision' to one of 'grand vision *that can be implemented*'—that is, the leader's view of the future is not legitimate unless those who have to carry it out understand it and believe that it makes sense in terms of their own areas of knowledge" (p. 494). Staff must become confident that their leaders will accept responsibility for what they do *not* know and are willing to learn from those who *do* know it. Only in this way will followers begin to entertain and accept a new definition of reality that is more compelling and practical than the one that exists.

Evidence-Based Management

In effect, executives and senior managers must begin to practice what Jeffrey Pfeffer and Robert I. Sutton (2006b) call evidence-based management (EBM). These two Stanford University professors recognize that any organizational change on the scale of evidence-based practices can not be a lopsided affair. All the learning, the acceptance of different norms and values, and the institution of a "new way of doing business" cannot stop at the headquarters' door. Research and knowledge must penetrate the inner as well as the outer sanctum in both private-sector firms and governmental agencies. Managers can not blithely ignore the new message of the magic mirror (i.e., that they are "the most responsible of all") and expect to be successful.

Pfeffer and Sutton (2006b) define evidence -based management as a way of viewing the world of management: a way that uses logic and data to be effective and that is committed to fact-based decision making. Its practitioners are willing to put aside deeply held beliefs and convictions when the dictates of research and knowledge require such a move. But most of all, evidence-based managers are adept in the practice and art of wisdom.

Pfeffer and Sutton (2006b) cite the psychologists John Meacham and Robert Sternberg, who have studied the difference between being wise and being smart, and who note that wisdom means, as Plato asserted, "knowing what you know and knowing what you don't know." Cultivating wisdom involves striking a balance between arrogance (the assumption that you know more than you do) and insecurity (the belief that you know too little to act). In the words of Pfeffer and Sutton (2006b), "[P]racticing evidence-based

management means adopting beliefs and designing settings that enable people to keep acting with knowledge while doubting what they know, and to openly acknowledge the imperfections in even their best ideas along the way” (pp. 52-53).

From the perspective of evidence-based management, nothing can destroy an organization’s credibility in terms of implementing evidence-based practices faster than the refusal of its leaders to practice wisdom. When Pfeffer and Sutton (2006b) want to learn whether a company’s executives have the attitude of wisdom, they pose a very simple question: What happens when people fail? “If you look at how the most effective systems in the world are managed,” they write, “a hallmark is that when something goes wrong, people face the hard facts, learn what happened and why, and keep using those facts to make the system better” (pp. 232-233). They point out that while research shows that bad leaders keep making the same mistakes repeatedly, good leaders, because they are learners, “make new and different mistakes.” They conclude that “It is the leaders of large companies who admit when they make mistakes, and show that they’ve learned from it, who help their companies perform best over the long haul, not those who only take credit for good news and blame others or bad luck for setbacks.” (pp. 232-233).

The profession of medicine constantly expresses its adherence to wisdom through the motto, “forgive and remember.” Leaders in the medical profession use forgiveness as a tool for ensuring that people remain willing to discuss and admit to errors. They then use remembrance as a method for guaranteeing that the same mistakes are not repeated over and over. Without remembrance, the organization never learns from its mishaps; without forgiveness, it generally never discovers that the mishaps even occurred in the first place.

In short, evidence-based managerial responsibility, on a very personal level, goes a long way toward establishing the type of legitimacy with staff required for effective organizational change. Using research and data to underpin managerial accountability for the implementation of evidence-based practices not only revives and maintains the prestige and influence of leaders during times of stress and strain; it also, by establishing a new bond of collaborative trust across old hierarchical fences, provides staff with incentives for holding themselves responsible for their own progress.

Why Does Bureaucracy Still Thrive?

Unfortunately, even with such prospects for success, many correctional managers continue to march down the path of evidence-based practices attired in the best of their traditional bureaucratic finery. They simply do not comprehend that in the knowledge-based world of public practice and governance, to which they now rhetorically pledge allegiance, authority no longer flows just from rules and regulations but also is generated by “acting as a role model and by justifying decisions in terms of contribution to the group. By operating ‘within’ the group rather than ‘above’ the group, such a leader reinforces the connections of mutual help and understanding that are at the core of collaborative relationships” (Maccoby & Heckscher, 2006, p. 471). The failure of correctional officials to grasp this new role of managerial responsibility bounces them

between the poles of arrogance and insecurity. The former attitude leads them to engage in punishing behaviors with their staff, while the latter results in an emotional paralysis that makes effective decision making by someone of their rank almost impossible.

In part, this state of affairs results from a dearth of appropriate training. While data about the education of correctional managers is sparse, it is known that it is inadequate. According to a 2003 National Institute of Corrections needs assessment on correctional management and executive leadership development, 29% of executive positions in institutional and community agencies had been filled within 12 months of the survey's date. Most departments were in general "unsatisfied with the development opportunities they provided to their upper leadership staff," with smaller agencies being more content than larger ones. Only 29% of probation and parole agencies felt that they had the capacity to deliver such training to executives, and only half were somewhat confident that they could do so for senior level managers (Clem, 2003, pp. 2-4). As Mario Papanozzi and Christopher Lowenkamp (2000) bluntly summarized, "Components of the American correctional system have frequently been subjected . . . to professional leaders who assume the cloak of the profession almost as if by political decree with little consideration for professional credentials" (p. 10). They concluded, "If specious credentials are acceptable at the top, then why not throughout the entire organization?" (p. 10).

The fact of the matter is that, even with adequate managerial training, wisdom would probably still be overshadowed by arrogance and insecurity among correctional officials trying to implement evidence-based practices. It is not that the leaders in our field are mean-spirited or cowardly or that they are not committed and motivated. It is just that, as with our delinquents and offenders, they don't know that they don't know. When it comes to recognizing their need to adopt the principles of evidence-based management, they reside firmly, and even with conviction, in a pre-contemplative stage of behavioral change. They are not usually bothered by research that reveals how roughly three quarters of new programs in our field fail during implementation, or by numbers that have shown little or no change in recidivism rates over the last two decades for the persons under their control (Austin, 2006). Instead, they tend to take a "blame the victim" stance, transferring both the problem and the accountability for its solution to others inside and outside their agencies. After all, this *is* what the magic mirror has been telling them to do—year after year after year.

Finding the Ambivalence in Ourselves

If evidence-based practice has taught correctional practitioners anything about altering human behavior, it is that motivation for change arises from the creation of an emotional ambivalence in a person between her or his stated goals and desires and the way in which he or she goes about achieving them. Leaders in the field of medicine and health care experienced such ambivalence in a rather dramatic fashion when one research study after another revealed that existing organizational practices in hospitals were killing almost 100,000 people every year (Domurad, 2005a). These outcomes sullied medicine's self-image of being caring and compassionate, of curing patients and saving lives. They

forced the people in charge to return to their evidence-based scientific roots and expand these to envelop the practice of management itself. “Evidence-based management means that managers, like their clinical practitioner counterparts, should search for, appraise, and apply empirical evidence from management research in their practice,” wrote one national committee on nursing and patient safety. “Managers also must be prepared to have their own decisions and actions systematically recorded and evaluated in a way that will further add to the evidence base for effective management practices” (Institute of Medicine, 2004, p. 113).

Although corrections has yet to be accused of killing thousands of people under its supervision, there is ample research evidence that it can, through its organizational and programmatic practices, make delinquents and offenders worse, create new victims, and erode public safety (Domurad, 2005b). As a result, its external stakeholders are increasingly viewing the profession as incapable at best and superfluous at worst. Faye Taxman, a renowned criminal justice scholar who is diligently working with many community correctional jurisdictions to destroy the old message of the magic mirror, describes the situation in no uncertain terms: “A general dissatisfaction exists with probation by the legal community, as it is seen as ineffective, underresourced, elusive in its punishment capabilities, and uneven in the provision of treatment services” (Taxman & Thanner, 2003/2004, p. 39).

Simply ignoring such discontent on the part of important stakeholders can lead to unwanted consequences for public correctional service providers. In Great Britain, for example, frustration with the National Probation Service and the value that it is or is not adding to public safety has led to a move to introduce competition into the profession and may even lead ultimately to its privatization. On July 26, 2007, Queen Elizabeth gave royal assent to the Offender Management Bill, which establishes a new National Offender Management Service (NOMS) that will go into effect in April 2008. NOMS calls for local consortia of public, not-for-profit, and private service providers, coordinated by a Regional Offender Manager, to deal with the country’s to “work with those services that are most effective in making our communities safer by reducing re-offending, managing offenders and protecting the public” (National Offender Management Service, 2007a). It intends to “drive up standards, both by introducing new service providers, and by providing incentives to existing providers to raise their game” (National Offender Management Service, 2007b). Those entities, whether public or private, that can not meet this challenge will simply be eliminated from consideration for future governmental funding.

So what *will* move correctional officials in this country from pre-contemplation to determination and action when it comes to acceptance of managerial evidence-based responsibility for the implementation of evidence-based practices? As in health care, it will take nothing short of a proclamation of public accountability for the achievement of the primary outcome promised by evidence-based practices—namely, a reduction in future criminal victimization caused by delinquents and offenders under their supervision. To accomplish this end, correctional leaders must commit to lowering the annual rate of reoffense for the populations in their charge and to documenting and

learning from “errors in practice” through the periodic release of so-called “never event” reports.

The Health Care Model

In December 2004, the Institute for Healthcare Improvement (IHI) launched a 100,000 Lives Campaign, designed within an 18-month period to prevent 100,000 deaths in hospitals due to medical and clinical errors. It focused on the introduction of just six interventions, whose implementation research showed would most likely avoid the occurrence of unacceptable mistakes. These steps ranged from delivery of evidence-based practices for the care of patients with heart attacks to the interdiction of surgical site infections. Over 300,000 hospitals, representing more than 75% of the nation’s bed space, voluntarily joined the project.

Their efforts were met with unprecedented success. With roughly one third of the participating hospitals using all six measures and more than half applying at least three, an estimated 122,342 deaths were prevented, based on a comparison of mortality rates prior to and during the campaign (Commonwealth Fund, 2006). While more rigorous evaluation of these numbers remains to be done, in the words of a *New York Times* editorial, “The results may seem hard to believe, but if the so-called 100,000 Lives Campaign has prevented even half of the needless hospital deaths it is claiming, the medical system is becoming a whole lot safer for patients.” The *Times* credited the campaign “for the boldness of its goal and the aggressiveness of its efforts” and called for an expansion of future efforts “that cut down on errors and needless deaths” (“Hospital-Caused Deaths,” 2006). Indeed, IHI has now announced a 5 Million Lives from Harm initiative between December 2006 and December 2008, aimed at enlisting at least 4,000 hospitals committed to introducing six additional interventions targeted at the reduction or elimination of harm (Institute for Healthcare Improvement, 2007).

As for “never event” reports, the state of Minnesota, one of several to move down this road at the recommendation of the National Quality Forum (NQF), a health policy group representing some of the most important stakeholders in the field, has just issued its second annual publication. Hospitals across the state forward to the Department of Health (DOH) notice of any instance of the 27 adverse and harmful events defined by the NQF as ones that should never occur in their institutions, along with an analysis of the root cause of each such incident and an action plan for its correction. The DOH compiles this information into a publicly released document, whose purpose is not to punish and blame, but to discover and learn for the sake of patient safety. As the Minneapolis *Star Tribune* commented in an editorial on the first annual report, “The report’s details on botched incisions and lost surgical clamps will make many readers squeamish. But they should also make medicine safer in Minnesota, and the hospitals and the Health Department deserve credit for a courageous and innovative step” (qtd. in Domurad, 2005a, pp. 49-50). Clearly, health care leaders, at least in this one state, have learned that practicing evidence-based management and applying the skill of managerial wisdom are singularly important pathways to the realization of the cherished goal of patient safety.

The Community Corrections 100,000 Victims Alliance

To our professional discredit, there are no reliable statistics on the number of reoffenses,

rearrests, and reconvictions that result each year from the actions of the almost 5 million men and women who are on parole or probation in the United States. What is known is that roughly 60% of the nation's almost 800,000 parolees will be rearrested *at least once* within two years of their release from prison (Solomon, 2006). Similarly, for those probation agencies that do collect recidivism data, it is not uncommon for at least 30% of their new cases to be rearrested within the first 12 months after sentencing. By making an admittedly great leap of mathematical faith, one might therefore assume that roughly one million new crimes are committed by probationers and parolees in the United States each year. In light of this number, it is also logical, one might even say ethical, to pose the following two questions to correctional leaders who claim that they are serious about doing evidence-based practices:

1. Are they willing to commit to reducing probation and parole rearrest rates by a fixed amount, say 10% a year? and
2. If 10% is an acceptable figure, are they then willing to launch a 100,000 Victims Alliance that mirrors the initiatives that are occurring in medicine and health care?

As scholar James C. Howell (2003) has noted, Mark Lipsey has shown that such an expectation of performance by the senior staff of probation and parole agencies is eminently achievable, even in the "real world" of corrections. He has spent almost two decades conducting meta-analyses of adult and juvenile programs. Regarding juveniles, he has demonstrated that treatments designed and managed by system professionals can indeed reduce the rate of recidivism. These interventions, in the words of Howell (2003), "had a rehabilitative orientation, did not involve researchers directly, were sponsored by public or private agencies, and had clients that came to the programs through public or private agencies, rather than being recruited by researchers" (pp. 216-217). In effect, they were not costly academic demonstration projects conducted in an artificial environment, but practical initiatives undertaken by practical men and women in the field. Lipsey found in his meta-analysis of 196 evaluations of such programs that 93% of those reviewed reduced recidivism, with nearly half lowering the rate by 10 to 24% and almost one fifth achieving a decline of 20-25%. The key to success was "the provision of certain [behavioral] services, a distinct role for the juvenile justice system, a sufficient amount of service, and administration of services to the most appropriate juvenile population" (Howell, 2003, pp. 216-217).

A Community Corrections 100,000 Victims Alliance would be a nationwide, voluntary alliance of probation and parole agencies committed to reducing adult and/or juvenile recidivism in their jurisdictions by 10% each year for a period of four years. It would rest on three pillars. First, it would establish a consensus of core, evidence-based practices that each agency would implement to address the problem of continued delinquent or criminal behavior on the part of its clients. These might include:

- Conducting actuarial risk assessments on all new cases for purposes of classification;
- Completing needs assessments of all high- and extreme-high-risk cases, with medium-risk delinquents and offenders included where resources allow;
- Constructing case plans whose goals and objectives are focused on criminogenic needs for high- and extreme-high-risk probationers and parolees;
- Establishing (cognitive) behavioral interventions to address each client's array of criminogenic needs;
- Matching treatment delivery with the learning styles of the delinquent or offender; and
- Providing staff with training in key skill areas, such as Core Correctional Practices and Motivational Interviewing, in order to establish an appropriate therapeutic relationship with the juveniles or adults under supervision.

The second pillar would be the introduction of a “never events” report. The Victims Alliance would determine those incidents which, if they happened, would constitute an adverse or harmful event that would seriously weaken an agency's ability to do evidence-based practices and to achieve its annual goal of reducing recidivism by 10%. Each member organization would report the occurrence of such an event to the Alliance along with an analysis of its root cause and an action plan for its rectification. The goal of such a report would be to learn from those actions that create harm and to prevent their reoccurrence in future. Community correctional “never events” might include:

- Appointing someone to a senior or executive position in an agency without fully training and testing him or her in the principles and practices of evidence-based management;
- Targeting low-risk delinquents and offenders for intensive supervision or programming;
- Introducing programs or interventions that do not have some support in research and/or do not adhere to the precepts of evidence-based practices;
- Ignoring the criminogenic needs of medium-, high- and extreme-high-risk clients;
- Using punishment as the primary behavioral intervention with probationers and parolees; and
- Failing to provide constant feedback loops on agency practice, without which learning about errors being committed can not occur.

The establishment of community correctional Evidence-Based Management Collaboratives would be the third pillar in this process. In health care, the Center for Health Management Research (CHMR) provides the model. Led by the University of Washington and the University of California at Berkeley, it conducts a regular forum for managers, clinicians, and researchers to develop a research agenda for health care management that suits the practical need for information and knowledge by corporate participants. It also provides the resources to undertake evaluation projects that accomplish that agenda. Currently CHMR consists of 17 academic centers and ten

member health systems (Institute of Medicine, 2004, pp. 154-155). In community corrections, such collaboratives would:

- Be responsible for establishing recidivism baselines for each member agency;
- Measure individual agency and collective progress toward achieving the annual 10% goal;
- Analyze the information contained in the “never events” reports and condense the findings into guides for future practice;
- Develop, test, and evaluate management practices in accordance with the fundamentals of evidence-based management; and
- Provide systematic reviews of and conduct forums about those management practices that research shows best support the implementation, maintenance, and improvement of evidence-based practices in member organizations.

Answering Objections

Without a doubt, a plethora of objections can be raised against this proposal. Some might argue, as does James Austin (2006), that behavioral change and recidivism reduction are much too complex and costly goals for probation and parole to contemplate:

If one were to look at the evidence to date, one would have to conclude that parole supervision is not a viable method for reducing crime or recidivism. My position is that we need to have a far more realistic view of what parole (and probation) supervision can achieve with the resources it now has (p. 52).

Others might contend that community corrections alone does not have the ability to control its clients and their social environment to the degree that might result in significant changes in delinquent or criminal behavior. Still others might worry about organizational constraints: either their agency is too big and chaotic or too small and impoverished to do evidence-based practices in anything but a piecemeal fashion.

Although space does not allow a detailed discussion of each of these considerations, it might be worthwhile to remember again what Pfeffer and Sutton (2006a) said about personal managerial wisdom and responsibility:

Evidence-based management is conducted best not by know-it-alls but by managers who profoundly appreciate how much they do not know. These managers aren't frozen into inaction by ignorance; rather they act on the best of their knowledge while questioning what they know (p. 73).

A Lesson From “The Little Hospital That Could”

Consider St. Peter, a small town situated in the southern reaches of Minnesota. In the gigantic universe of American health care, its hospital verges on being almost invisible. Even in its busiest times, it can accommodate no more than 17 patients. Yet Dr.

Benjamin Chaska, its medical director, has transformed his institution into one of the 100 “mentor hospitals” in the Institute for Healthcare’s 100,000 Lives Campaign. Undeterred by the size of their hospital, Chaska and his team creatively applied those elements of the recommended interventions that would work in their modest environment. In one instance, they reduced the risk of infection simply by dispensing with the traditional razor blades used to shave the skin around surgical sites. They replaced these blades with electric shavers, because razor blades caused minute nicks and cuts that acted as portals for the invasion of germs and electric shavers did not. In another case, Chaska and his crew bought “Bair Paws”® surgical gowns equipped with an air hose to warm patients before and during surgery. It seems that the stress of cold temperatures in operating rooms actually impaired the body’s immune system. The result has been 28% fewer patients being transferred to bigger hospitals for more intensive care, with a monetary savings of \$6,200 for each patient who stayed. “We are all coming up to [Chaska], looking at his results and going wow,” observed Jo Ann Endo of the Institute for Healthcare (Lerner, 2006).

Clearly, when Dr. Chaska looked into his magic mirror one fine morning, he heard the new message about evidence-based managerial responsibility in both personal and public terms. Chaska wanted to prevent harm, protect patient safety, and save lives, and he knew that his being held accountable for doing evidence-based practices in his tiny hospital was the only way that these outcomes would occur. If he were to speak to correctional leaders and managers, he would probably admonish them for continuing to savor the magic mirror’s old message of making knowledge and research applicable to everyone else but themselves, of always making the achievement of evidence-based practices’ promise of public safety someone else’s responsibility. He would certainly remind his audience about what happened to the evil Queen as she persevered in her denial and ignorance. Unable to rest until she had seen her competitor in person, she went to Snow White’s wedding feast. No sooner did the Queen recognize Snow White and realize in terror that she was indeed “fairer to see,” when a pair of red-hot iron shoes were placed on her feet. She was forced to dance in them until she fell down dead.

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Frank Domurad, a contributing editor of Community Corrections Report, is Vice President of the Carey Group in White Bear Lake, MN. ■